LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(4) CAM
16 Nov 03 1640	Assume care of PT @ 0600. VSS, A+O x3, Ambulate to restroom. Ø c/o pain today. Maintains a regular diet. (R) arm is in a splint, Ø signs of bleeding or any signs of fluids. Splint is intact. Conducted personal hygiene. Will cont. to monitor ~ 9/USMC [redacted]
16 Nov 03 1645	I concur c above. Assessed for pink nailbeds & brisk capillary refill. WNL ~ [redacted]
16 NOV 03 2018	VSS. Alert & oriented. Consumed 60% of Kosher diet for dinner. (R) arm splint in place. (R) radial pulse +2. (R) fingers capillary refill brisk. Ø c/o pain or discomfort. (L) FA IV patent & intact. +2 restraints applied without compromising circulation or sensation. Will continue care as planned. [redacted]
17 NOV 03 0140	c/o pain to (R) FA IV site. Site is slightly swollen. Ø flashback noted. (L) FA IV d/c c cath intact. Moist warm compress applied. Will restart IV later due to unable to use (R) arm. d/c splint to (R) arm. [redacted]
17 Nov 03 1240	Pt A+O x3, VSS. Pt has Ø c/o of pain at this time. Pt NPO awaiting surgery. IV started left wristwatch area. patent. Given IV meds as ordered. (R) hand capillary refill good. Pt c/o pain during surgery. Pt cup was right arm splint intact. Pt returned from OR with pennrose in right elbow. Pt eating regular diet. Restraints x2 in place. Ø circulation. ~ Sgt [redacted]
17 Nov 03 1640	I concur c above note. Will continue to monitor ~ [redacted]

[redacted] ARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUC

ICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

b(6)-2
A1

17 Nov 03 On the Op Table

1420

Pre Op Dx: Lateral epicondyle (R) elbow fx
Post Op Dx: Same
Procedure: 2 + 3 (R) elbow
Surgeon: [redacted]
Anesthesia: Wound clean. Irrigated with pulse lavage. Lesser wounds closed with 3-0 nylon. Closed up. Plan: Next to Op slaving. Surgeon Report [redacted]

PITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED
NSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

ENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD N

CHRONOLOGICAL RECORD OF MEDICAL C
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

b(6)-2 A11

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
18 Nov 03 @ 0515	Assumed care @ 1900; USS, pt A&O speaking arabic; Ø C/O pain @ this time; dsg to (R) arm CDI, ⊕ CMS + 2 PP, brisk cap ref to affected extremity; S/L patent, easily flushes, cont ∈ IV abx; pt OOB to amb in hall/B.R. x2 ∃ difficulty; pt TOL Reg diet; voiding ∃ difficulty; Restraints in place, ⊕ circ, Ø skin break d/t, cont to monitor. [redacted]
18 NOV 03 0700	-Assumed care of pt. A+O x3. USS Denies having pain or discomfort @ this time Lungs clear HRRR Active BS x4 Tolerating PO well. (R) elbow wound wet to dry dsg A CDI Neurovascular check intact AEB pt being able to wiggle fingers, strong radial pulse Cap refill and skin coloration WNL. error [redacted] ~~Foley to gravity amber color [redacted]~~. Afebrile IV ABX IV cont Will monitor. [redacted] 2/nurse
18 Nov 03 @ 0505	Assumed care @ 1800; USS, pt A&O speaking arabic; Ø C/O pain/discomfort @ this time; dsg to (R) elbow Δd w → D, Ø drainage, Ø S/Sx infection, penrose drain intact; pt OOB to BR x2; pt TOL Reg diet well; S/L to (L) wrist patent, easily flushes, cont ∈ IV abx; NV intact to affected arm; Restraints in place, ⊕ circ, Ø skin break d/t, cont to monitor. [redacted]
19 NOV 03 0600	-Assumed care of pt. USS. A+O x3. AM shower care given. Lungs clear bilat. HRRR Active BS x4 quads. Tolerating PO well. Urinating spontaneously ∃ difficulty Wound assessment

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

b(4)-2 A/1

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
cont 19 NOV 03 0300	(R) elbow dsg wet → dry kerlix wrapped c̄ pen rose drain present several open wounds. Ø s/o of infection IV ABX Tx cont. PIV (L) FA New site: 20 g HL patent. Pt. remains afebrile Will cont to monitor — [redacted] 91WM6
19 Nov 03 2118	Assumed care @ 1800. A&O Denies pain. VSS LS CTA(B), HRRR. (+) BS x4quads. Drsg to R elbow d/d. 4 open wounds on elbow pink, moist & health in appearance. Will cont to monitor. — [redacted] Spc 91WM6
20 NOV03 @1045	Pt a/o, VSS, Ø c/o pain expressed, drsg to (R) arm D&WD Ø S/Sx infection noted, 4 small open wounds. pen. IV cipro + primaxin cont per MD orders. ambulated x2 c̄ difficulty. voiding c/u, (+) pulses to (R) arm c̄ brisk cap refill. (+) movement. awaiting d/c to EPW camp. c̄ follow up in 1 week. Will cont to monitor — [redacted] 91WM6.
1400	(R) arm now splinted ([redacted] LPN.
20 Nov 03 2100	Pt A&O VSS Ø c/o pain. Cast on (R) arm. Cont IV Antibiotics. Pt awaiting Transfer to EPW camp. Will cont to monitor. — [redacted] Spc 91WM6
21 NOV03 @0900	Pt a/o, VSS, Ø c/o pain, (R) arm splinted, (+) CMS, voiding c/u, ambulating c̄ difficulty. brisk cap refill to extr. all other findings WNL. 2 pt re-straints on while in bed c̄ compromise to skin or circulation. — [redacted] 91WM6.

STANDARD FORM 509 (REV. 5/1999) BAC
USAPA V1.

[redacted]

b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
24NOV03 @0800	assumed care of pt @1800. VSS, no c/o, laughing, speaking some English. ~~Acute~~ [redacted] LS CTA, +BBS, voiding qs, ↑ amb to BR. RUE in splint, small x3 WTD dsgs around elbow, ~~+~~ drainage noted, +cms, +2 radial pulse. 2 pt restraints m̄ s/sx of skin/circulation compromise. Pain: enc independence, monitor pain, D/C to EPW camp when ride available. [redacted] CRP
	(1210) Pt stable for d/c to camp - amb - escorted by MPs. RL given - [redacted] mrh
	b(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

b(6)-4

[redacted]

MEDCOM - 24645

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

STREET ADDRESS

PATIENT'S HOME ADDRESS OR DUTY STATION

CITY

LOG NUMBER | TREATMENT FACIL...

F S MAINTAINED AT

SEX: B

AGE: 21

DUTY/LOCAL PHONE: AREA CODE | NUMBER

STATE | ZIP CODE

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			
MEDICAL HISTORY OBTAINED FROM			

ARRIVAL

DATE *(Day, Month, Year)* | TIME

TRANSPORTATION TO FACILITY

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: Ø

ALLERGIES: NKA

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	
IS THIS AN INJURY?			WHEN *(Date)*
INJURY/SAFETY FORMS			
HOW			WHERE

CHIEF COMPLAINT: (R) ARM/ELBOW

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

DATE LAST SHOT | TETANUS COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME: 1554

INITIALS: [redacted]

VITAL SIGNS

TIME	1553
BP	124/79
PULSE	99
RESP	14
TEMP	
WT	

LAB ORDERS

☐ CBC/DIFF ☐ URINE C&S ☐ BLOOD C&S X ☐ ABG ☐ UA MSCC/CATH ☐ PT/PTT ☐ BHCG/URINE/BLOOD/QUANT ☐ CHEM:

☐ PULSE OX

TIME

ORDERS

X-RAY ORDERS

☐ CXR PA & LAT/PORTABLE ☐ ACUTE ABDOMEN ☐ SINUS ☐ ANKLE R/L ☐ C-SPINE ☐ LS SPINE ☐ HEAD CT

ORDERS | BY | ☐ MONITOR | COMPLETED BY | TIME

...SITION

...OME ☐ FULL DUTY

...ED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT'S RESPONSE ☐ ECG

...ON UPON RELEASE

...OVED

...IORATED ☐ UNCHANGED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

PATIENT/DISCHARGE INSTRUCTIONS

REFERRED ▶ TO

I have received and understand these instructions.

PATIENT'S SIGNATURE | WHEN

...DENTIFICATION *(For typed or written entries, give: Name – last, first, middle; ID no. (SSN or other); hospital or medical facility)*

[redacted]

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT FOR Use this form. See AR 40-407: the Proponent agency is The Office of the Surgeon General.
1. AGE 21 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodin, Tape, Medication) ☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD REACTION: 3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
I+D (R) Elbow

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition (R) elbow +x
Tobacco ? ppd X___vrs Body Piercing ✓ Diabetes (Y) (N) ROM (R) ASA/Motrin W 72hrs (Y) (N)
ETOH ✓ Implants ✓ Respiratory Disease (Asthma COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures ✓ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: See chart

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ potential for anxiety related to: ✓ 1) Surgical Procedure& Operating Room Environment ___ 2) Separation Anxiety (Child). ✓ 3) Surgical Outcomes	O Pt. verbalizes any specific anxiety. O Pt. Exhibits relaxed body posture. communication as possible, pt. is Iraqi national, does not speak English	O Allow pt. to verbalize freely. O Explain Or environment and answer questions regarding surgery. O. Offer comfort measures. (e.g. warm blanket. touch). O. Explain all nursing procedures before they are done. O. Remain with pt. Whenever possible. O. Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ___ 3) Medical/Smoking History	O Pt. will be able to breath without difficulty during immediate intraoperative phase.	O. Offer to elevate head of litter or offer pillow. O. Observe pt. While awaiting surgery for signs of distress. O. Assist anesthesia during intubatior and extubation.
C. INTEGUMENT ✓ Potential Impairment of Skin Integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ✓ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	O Pt. will exhibit signs of impairment of skin integrity (e.g., reddened areas).	O. Utilize pressure preventing devices on OR table and accessories. O. Check for proper positioning and support to maintain good body alignment. O. Pad pressure points. O. Place ESU ground pad on non compromised skin surface area. O. Keep prep fluids form pooling.

9. PATIENT'S IDENTIFICATION: (For typed or written entries give: Name-last, first, middle; grade, data; hospital or medical facility)
#[redacted] blank
[redacted]
15 NOV 03 blank

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ✓ ! Dentures Removed ✓
! H & P ✓ ! Contacts Removed ✓
! NPO Since MN ! Jewelry Removed ✓
! ~~UHCG/LMP~~ ! Body Pierce Removed ✓
! Consent/Blood Transfusion Signed/Witnessed/Dated ✓
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon ✓
! Contact precautions (Y) (N)
! Family/Friend: ✓

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ O: Pt. will exhibit signs of adequate tissue perfusion (e.g. color, warmth. pedal pulse.	O Check foe support stocking or ace warps. if none, check with doctors. ✓ O Check that safety straps are correctly applied. O Offer pillow for under knees. O Place and take down legs from stirrups with slow bilateral motion. ✓ O Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.I. ✓ Potential Impairment of Mobility due to: ✓ 1) Pain ✓ 2) Intra operative Hazzards 3) prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. To/form OR table E.2. ✓ Potential Discomfort Due to: ✓ 1) Length of Surgery ✓ 2) Positioning 3) Arthritis	O pt. will be transferred to OR table without difficultly. O pt. will be not experience unnecessary physical discomfort.	O Have sufficient people available for transfer. O Insure proper body alignment. O Allow patient to lie in position of comfort while waiting for surgery. O Offer support (i,e..pillows. Bath towel. etc) for positioning.
F. Special Senses F.I. ✓ Diminished visual perception due to being: ✓ 1) . pre-medicated 2) W O GLASSES F.2. ✓ Potential for Decreased Communication due to: 1) Diminished Hearing ✓ 2) Language Barrier – Iraqi national F.3. Potential Injury due to Dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	O pt. will be made aware of surroundings prior to anesthesia induction. O pt. will be transferred safely to OR table. O pt. will be able to understand instructions. O Minimize danger of injury during intraop period.	O Introduce self. keep pt informed as to where he. she is and what is happening. O Inform pt. in which direction to move and assist if necessary. O Speak clearly and slowly. O Address pt. from Iraqi side. O Validate pt.'s understanding of verbal communication. as possible O Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS OR Continuation of Above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS OR continuation of above interventions.

10. OR NURSING INTERVENTION COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

(b)(2) [redacted] CPT/AN 15 NOV 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y) (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: (Y) (N)

LEVEL OF ACTIVITY: ☒ MOVES ALL EXTREMITIES except (R) ☐ Moves Upper Extremities ☐ Transferred to Litter With roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT/AN (b)(2)

DATE: 15 NOV 03 TIME: 0300

13. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT/AN (b)(2)

DATE: 15 NOV 03 TIME: 0915

REVERS OF FORM 5179, JUN 91 USAPA V1.0

MEDICAL RECO[illegible] **INTRAOPE[illegible] [illegible]OCUMENT**

For use of this form, see AR 40-407, the propo[illegible]ncy is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING [illegible]M VIA Litter (fitted bed) BY Anesthesia	2. PATIENT IDENTIFI[illegible] [illegible]CORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2
3. DATE 15 NOV 03 TIME PATIENT ARRIVED IN SUITE /	4. PATIENT IN ROOM TIME 0805 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: ø

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

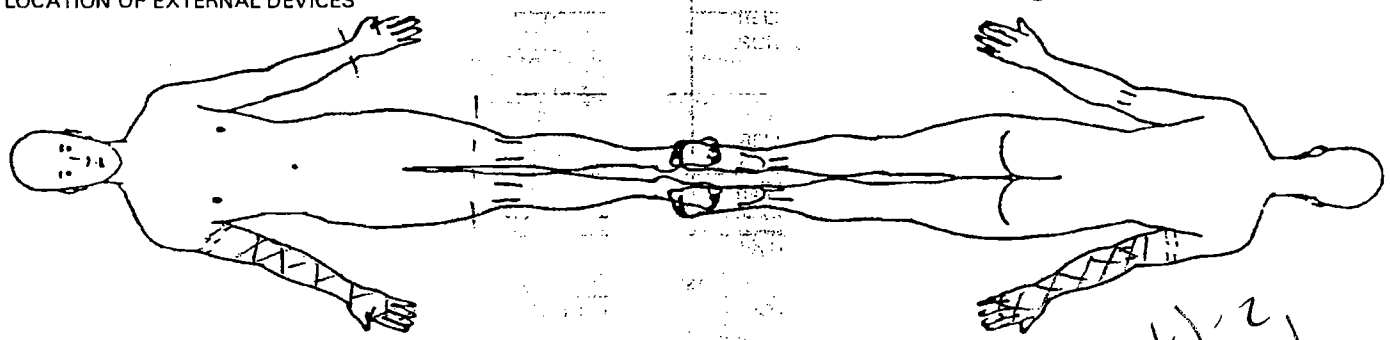
☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Correct body alignment maintained. (L) arm padded arm board at less than 90° (R) arm restin on 2 padded arm boards used as hand table / position approved by surgeon + anesthesia

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO DONE BY: ☐ OR ☐ NURSING UNIT METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP COMMENTS:	PREP SOLUTION *(Specify)* Beta Scrub / Beta Paint SITE (R) arm up to 2in BY WHOM: [redacted] SITE: olive ellbow BY WHOM: b(6)-2 COMMENTS: no peeling or skin d's noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pa[redacted] -- Safety Strap [redacted] = = = Tourniquet placed by Dr. [redacted] b(6)-2

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	/	/	C	[redacted]	[redacted]
Needle Sharp	☒ Yes	☐ No	/	/			
Instrument	☐ Yes	☒ No	/	/	/	/	/
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted] b(6)-2

[redacted]

15 NOV 03 b(6)-2

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☒ NO

☒ ESU NO: Valleylab Force 40 ARE 105305
GROUND PAD: BRAND VL Rem Polyhesive II
LOT NO: 65706 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER UFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl
(QS)

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM
YES ☒ NO ☐ C-arm IF YES, SITE (R) elbow

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☒ NO ☐	NAME (1) Aerobic Cx (R) elbow wound	NAME (2) Anaerobic Cx (R) elbow wound
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1/4 in Iodoform	2.	3.
SITE	1. (R) elbow	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs Airway
Kerlix
ABD
Webril
Splint

19. ADDITIONAL INFORMATION
Surgeon: [redacted]
Anesthesia: [redacted]

20. OPERATION(S) PERFORMED
I + D (R) elbow

21. PATIENT TRANSFERRED TO
ICU3 (PACU)

TIME SEE DA7389

METHOD
PACU bed

22. REGISTERED NURSE SIGNATURE
[redacted] CPT LAW

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA gurney BY Anesthesia

2. PATIENT IDENTIFIED AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2

3. DATE 17NOV03 TIME PATIENT ARRIVED IN SUITE 1325

4. PATIENT IN ROOM TIME 1325 NUMBER 1-3

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

COMMENTS: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D b(6)-2	RELIEF SCRUB	Ø
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	Ø

7. POSITION AND POSITIONAL AIDS (Specify) Pt on padded OR Bed, Head on foam doughnut. LUE extended out to side <90° in CAP secured to padded armboard c̄ safety strap

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

RUE prepped into sterile field.

COMMENTS: Correct Body Alignment Maintained.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

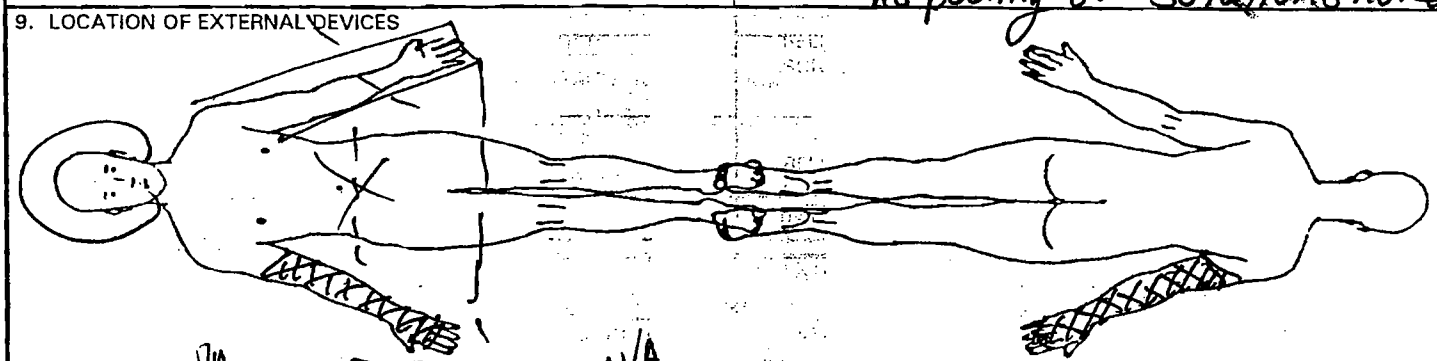
PREP SOLUTION (Specify) Beta/Beta

SITE (R) BY WHOM: CPT [redacted]

SITE: BY WHOM:

COMMENTS: no pooling of solutions noted b(6)-2

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad N/A [redacted] Safety Strap N/A = = = Tourniquet

C = Correct I = Incorrect b(6)-2

10. COUNTS

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☒ No					
Needle Sharp	☒ Yes	☐ No	C		C	SPC [redacted]	CPT [redacted]
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

[redacted] b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☒ NO

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ ☒ IF YES NAME: ID NUMBER UFACTUR

[redacted] b6-2

14. MEDICATIONS/ORD[redacted]

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl - QS (>3000cc)

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	3/8" penrose		
SITE	(R) Elbow		

18. DRESSING/IMMOBILIZATION *(Specify)*
Kerlex Fluffs, Kerlex Roll
Webril, ACE, Plaster Splint

19. ADDITIONAL INFORMATION
WC-IV
Surgeon; Dr [redacted]
Anesthesia: CPT [redacted]
b(u)-2

20. OPERATION(S) PERFORMED
I+D (R) Elbow
b(u)-2

21. PATIENT TRANSFERRED TO PACU TIME 1415 METHOD gurney

22. [redacted] CPT/AN

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOV 2003 | DAY: 14, 15, 15, 16, 16, 17, 18, 19 | HOUR

PULSE (O) — TEMP. F (°): 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

PULSE (O): 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

TEMP. C: 40.6°, 40.0°, 39.4°, 38.9°, 38.3°, 37.8°, 37.2°, 37.0°, 36.7°, 36.1°, 35.6°, 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

	14	15	15	16	16	17	18	19
BP	123/62	121/44	131/52	123	P	128/46	P53	132/59
		97.9	96.2	63	71	T 97.6	98.5	134/52
		50	69		T	99.1	97%	80
					97.5			98.4
		98%	98%	96	102	97%	100%	98%
					97	RA		RA
								98% RA

Record special data only when so ordered

HEIGHT: WEIGHT →

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

REGISTER NO.

WARD NO. ICW1

[redacted]

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY		
POST- DAY		
MONTH-YEAR / DAY	20	21
19 / HOUR	0800	0730

PULSE (O)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

	20 / 0800	21 / 0730
RESPIRATION RECORD	16	18
BLOOD PRESSURE ①	132/58	129/62
②		
① TEMP	98'	
HEIGHT: / WEIGHT ② TEMP →		
① O2 Sat	98%	98%
Source	(RA)	(RA)
② O2 Sat Source		

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

[redacted] b(6)-4

MEDCOM - 24654

IBN-SINA HOSPITAL

[redacted] b(2)-2

① Aerobic Cx
~~② Anaerobic Cx~~

Microbiology Request Form

Last Name 1317 | Ward: ICW1
First Name: | Room:
Patient # or SSN: | Bed:
Physician: [redacted] b(a)-2
Collected by: Dr. [redacted] b(a)-2
Date: 15 NOV 03 | Source: wound
Time: 0835 | Site: (R) elbow

[redacted]

Received by: [redacted] b(a)-2 | Specimen #: W127
Date: 15 NOV 03
Time: 1015

Laboratory Results

Acinetobacter baumannii/haemolyticus

Reported
Date: 18 NOV 03
Time: 1000
Tech: IO
Reviewer: | Number of attached sheets:

MEDCOM - 24655

Microbiology Report

IBN SINA - HOSPITAL Laboratory

Name:	[redacted] b(4)-4	Specimen:	**W127**	Status:	**Final**
Patient ID:		Source:	Wound/Sterile site	Collected:	
Ward/Rm:	W1/	Ward of Iso:		Attd. Phys:	

1 Acinetobacter baumannii/haemolyticus Status: Final

1 Ac baumann/haem

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	<=8/4				
Amp/Sulbactam (c)	<=8/4	S			
Ampicillin	>16				
Aztreonam	<=8	S			
Cefazolin	>16				
Cefepime	<=8	S			
Cefotaxime (c)	32	I			
Cefotetan	>32				
Cefoxitin	>16				
Ceftazidime (a)	<=8	S			
Ceftriaxone (c)	32	I			
Cefuroxime (b)	>16				
Cephalothin	>16				
Chloramphenicol	>16	R			
Ciprofloxacin	<=1	S			
ESBL-a Scrn	>4				
ESBL-b Scrn	>1				
Gatifloxacin	<=2				
Gentamicin	>8	R			
Imipenem (c)	<=4	S			
Levofloxacin	<=2	S			
Meropenem (c)	<=4	S			
Moxifloxacin	<=2				
Nitrofurantoin	>64				
Norfloxacin	<=4				
Piperacillin (a)	<=16	S			
Tetracycline	>8	R			
Ticar/K Clav (a)	<=16	S			
Tobramycin	>8	R			
Trimeth/Sulfa	>2/38	R			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL Confirmatory tests needed to differentiate ESBL from other beta-lactamases
IB = Inducible Beta-lactamase Appears in place of Sensitive with species known to possess inducible beta-lactamases, potentially they may become resistant to all beta-lactam drugs Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs

For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002 Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints
For S pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name:	[redacted] b(4)-4	Specimen:	**W127**	Status:	**Final**
Patient ID:		Source:	Wound/Sterile site	Collected:	b(4)-2
Ward/Rm:	W1/	Ward of Iso:		Req. Phys:	[redacted]

Printed 11/18/2003 10:01:29 AM

Tech: ID

IBN SINA HOSPITAL [redacted] b(2)-2

(1) Aerobic Cx
~~(2) Anaerobic Cx~~

Microbiology Request Form

Last Name 1317
First Name:
Patient # or SSN:

Collected by: Dr. [redacted] b(6)-2
Date: 15 Nov 03
Time: 0835

Ward: ICW
Room:
Bed:
Physician: [redacted]

Source: Wound
Site: (R) elbow

[redacted]

Received by: [redacted]
Date 15 Nov 03
Time: 1015

Specimen # W127

Laboratory Results

Acinetobacter baumannii/haemolyticus

Reported
Date: 18 Nov 03
Time: 1000
Tech: IO
Reviewer: [redacted] b(6)-2

Number of attached sheets:

MEDCOM - 24657

Microbiology Report

[redacted] b(2)-2

Name: [redacted] b(6)-4
Patient ID:
Ward/Rm: W1/

Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1 Acinetobacter baumannii/haemolyticus Status: Final

1 Ac baumann/haem

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	<=8/4				
Amp/Sulbactam (c)	<=8/4	S			
Ampicillin	>16				
Aztreonam	<=8	S			
Cefazolin	>16				
Cefepime	<=8	S			
Cefotaxime (c)	32	I			
Cefotetan	>32				
Cefoxitin	>16				
Ceftazidime (a)	<=8	S			
Ceftriaxone (c)	32	I			
Cefuroxime (b)	>16				
Cephalothin	>16				
Chloramphenicol	>16	R			
Ciprofloxacin	<=1	S			
ESBL-a Scrn	>4				
ESBL-b Scrn	>1				
Gatifloxacin	<=2				
Gentamicin	>8	R			
Imipenem (c)	<=4	S			
Levofloxacin	<=2	S			
Meropenem (c)	<=4	S			
Moxifloxacin	<=2				
Nitrofurantoin	>64				
Norfloxacin	<=4				
Piperacillin (a)	<=16	S			
Tetracycline	>8	R			
Ticar/K Clav (a)	<=16	S			
Tobramycin	>8	R			
Trimeth/Sulfa	>2/38	R			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
ESBL? = Suspected ESBL Confirmatory tests needed to differentiate ESBL from other beta-lactamases
IB = Inducible Beta-lactamase Appears in place of Sensitive with species known to possess inducible beta-lactamases potentially they may become resistant to all beta-lactam drugs Monitoring of patients during/after therapy is recommended Avoid other/combined beta-lactam drugs

For blood and CSF isolates a beta-lactamase test is recommended for Enterococcus species

(a) Use maximum doses of drug with an aminoglycoside for P aeruginosa in patients with granulocytopenia or serious infections
(b) Breakpoints based on parenteral dose For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R) Footnote (c) applies to this drug
(c) For streptococci refer to penicillin interpretations For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci refer to the penicillin interpretation
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Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002 Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints
For S pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis For non-meningitis infections use <2=S 2=I >2=R

Name: [redacted] b(6)-4
Patient ID:
Ward/Rm: W1/

Specimen: W127
Source: Wound/Sterile site
Ward of Iso:

Status: Final b(6)-2
Collected:
Req. Phys: [redacted]

Printed 11/18/2003 10:01:29 AM

Tech: IO

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: OR [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
[redacted] b(6)-4	19 Nov 03	16:45	[redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	*RESULT*	*REF. RANGE*	*UNIT*	*TYPE*	*CROSSMATCH*
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: EMT	REQUESTING PHYSICIAN: Dr [redacted] b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST: [redacted] b(6)-4	DATE: 14Nov03	TIME: 16:45	SSN/PSEUDO SSN: [redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

PMH Ø PSH Ø NKA

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "1" = CONSTANT INFUSION

DRUG	(Units)													
Prop	(mg)	180												
Fent	(mg)	(100)		50										
	( )													
	( )													
	( )													
	( )													
VOLAT AGENT	5.0 % del	2.2	2.2	2.2	2.2	2.4								
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	8	2	2	2	2	8							

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → 1 2 3 4 5

FLUIDS

LINE site		
18ga L FA	☐ Warmed	1000
PIVT	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS / URINE -

TOTALS	TOTAL EBL
150/100 min	
	TOTAL URINE
	Ø measured

FLUIDS - SUMMARY

CRYSTALLOID- 600

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with lettters

PT IDD on IV w/
Pt in room
Induction OSH
Stop Anesthesia
IVP & ETP &
wound cultures ASR
Ø to PACU,
DNA Removed. SV
cont to PACU
Report to PACU
Nurse
[redacted]
b(6)-2 NCMA

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: 70 KG LB

HEMATOCRIT:

INITIAL DATA:

BP-

HR-

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 0800

TIME → 0800 0900 0930 1000 1030

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate ✓; BR (transduced) ‡; TOURNIQUET T—T; ANES- X-X; PROC- ⊙-Ø

VENTIL

VT - ml		510	540	550	
f - breaths/min		5	5	5	5
Peak inf pres / PEEP					
MODE - S(pon), A(ssist), C(on)	SA	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	+	52	54	53	36
BP/oth	FIO2 (Frac or %)	.63	.63	.60	.65	.73
ART line	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	ECG	SR	SB	SB	SB	SB
Gas analyzer	TEMP-site					
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS EVENTS *Position* →

RECOVERY AT 0916

PACU ICU _____ (Specify)

OTHER _____

CONDITION: Pt in NSD

T 95.0 RESP 16 SpO2- 99 BP- 143/71 HR- 72

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0785	0802	0921
	Ready	**Begin**	**End**
PROC	0810	0820	0913

PROCEDURES and CPT Codes: I+D Elbow

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

LMA #5 difficulty ⊕ ETCO2

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: 1-1

DATE: 15 Nov 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — COPY 2 - ANESTHESIA PROVIDER — USAPA V1.00

MEDCOM - 24661

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG (Units)														TOTALS	TOTAL EBL
FENTANYL (MCG)		100	100	50										250	min
( )															TOTAL URINE
( )															
( )															
( )															
( )															
VOLAT AGENT	SEVO % del	3.0	2.0	1.5	1.5										FLUIDS - SUMMARY
	% e.t.														CRYSTALLOID- 300
AIR	L/Min														
N2O	L/Min														COLLOID- 0
O2	L/Min	8	2	2	2										BLOOD- 0

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →

FLUIDS

LINE site													
☐ Warmed													
☐ Warmed													
☐ Warmed													
☐ Warmed													

REMARKS

Code drugs with numbers, events with letters

LOSSES

EST BLOOD LOSS													
URINE -													

PHYS STATUS: 1 (2) 3 4 5 (E)

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT:

INITIAL DATA:

BP- 136 / 58

HR- 70

EQUIP CHECK

OK?- (Y) N

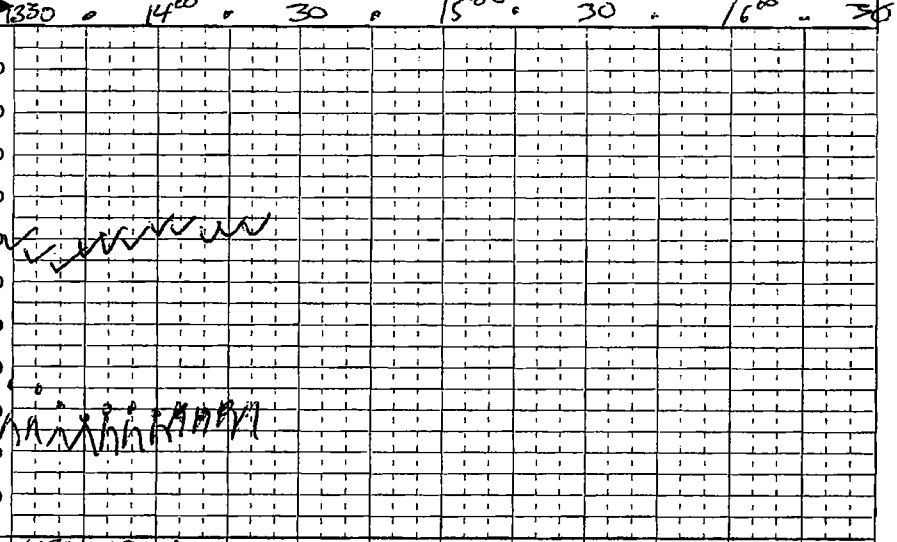
PATIENT RECHECK

OK for PROCEDURE? yes

TIME-

TIME → 1330 1400 30 1500 30 1600 30

SYMBOLS: BP by cuff V; Heart rate ∧; Resp rate ●; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-⊘



VENTIL

VT - ml		420	480	450	640								
f - breaths/min		7	5	8	10								
Peak inf pres / PEEP													
MODE - S(pon), A(ssist), C(on)		S	S	S	S								

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	38	56	54	50								
BP/oth	FIO2 (Frac or %)	.61	.61	.59	.59								
ART line	SpO2 (%)	100	100	100	100								
Steth- PC/ES	ECG	SR	SB	SR	SR								
Gas analyzer	TEMP-site	AXIL	AXIL										
	N-M Block (T/4)												
Warming blkt													
Conv warmer													

Mark with letters & symbols, explain under REMARKS EVENTS *Position* → 6 J

RECOVERY AT 1418

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1315	1325	1420
	Ready	Begin	End
PROC	1335	1300	1418

PROCEDURES and CPT Codes:

(R) ARM WASHOUT

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

General MASK

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted] b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* - Natural airway, mask induction; nasal airway placed

SURGEONS: [redacted] b(6)-1

ANESTHESIOLOGISTS: STAS [redacted]

PROCEDURE LOCATION: OR1

DATE: 17 NOV 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 [redacted] 2 - ANESTHESIA PROVIDER USAPA V1.00

MEDCOM - 24662

b(a)-2 unless marked diff.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: b(a)-4 [redacted]

DATE OF ORDER: 11-14-03 TIME OF ORDER: _____ HOURS

LIST TIME ORDER NOTED AND SIGN

- Admit (CW-1 [redacted]
- (R) elbow Fx
- Stable
- Routine V.Sigs
- IVF - D5 1/2NS @100cc/hr
- Percocet 1-2 PO q 4 prn
- Demerol 50mg IV q 4-6 prn [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: Noted [redacted] 14NOV03 1700

DATE OF ORDER: TIME OF ORDER: HOURS

- NPO
- Bath Patient today or Assist [redacted]
- Phenergan 25mg IVP q 6 prn nau
- Ambien 10mg PO q HS prn

NURSING UNIT | ROOM NO. | BED NO.

24° ✓ [redacted] 24 IAN 15NOV03 @ 0315

PATIENT IDENTIFICATION: Noted [redacted] 15NOV03 0845

DATE OF ORDER: 15 NOV 03 TIME OF ORDER: 0915 HOURS

1. Resume previous orders
2. Keep lock IV when taking PO well
3. Regular diet
4. NPO after midnight 16 NOV for OR 17 NOV.
5. Gentamicin 350mg IVPB Q DAY
6. Ancef 1 gm IVPB Q 8 hrs.

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION: 24° ✓ [redacted]

DATE OF ORDER: 17 NOV @ 0200 TIME OF ORDER: [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

[redacted] b(4)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 17 NOV 03 TIME OF ORDER: 1410 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. Regular diet
3. Flip lock when taking P.O. med
4. X-ray: bilateral L2-5, oblique of elbow
5. Next to day shift to (R)

[redacted] b(4)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 6230W TIME OF ORDER: BID beginning HOURS in A.M.

[redacted] b(4)-2

24° ✓ 17NOV03 @ 2000 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 19 NOV 03 TIME OF ORDER: 0830 HOURS

1. D/C Gent
2. D/C Bicef
3. Ciprofloxacin 400mg IVPB Q12 HRS
4. Piperacillin 500mg IVPB Q 8 HRS

[redacted]

b(4)-2 Noted [redacted] 19NOV03 0830

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 20 NOV 03 TIME OF ORDER: 1100 HOURS

1. DISCHARGE TO FDW CAMP
2. LEVOFLOXACIN 250 MG Q DAY #14
3. F/U IN WEEK.
4. PAPERWORK IN CHART.

[redacted] b(4)-2

b(4)-2 Noted [redacted] 20NOV03 1135

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 14	15	16	17	18	19	20	21
14 Nov03	[redacted]	Routine vitals	06 15	[redacted]							
			18 06	[redacted]							
14	[redacted]	NPO	06 15	[redacted]	DIC 15NOV03						
			18 06								
15 Nov03	[redacted]	Regular diet	06 15	/	[redacted]						
			18 06	/	[redacted]						
17 Nov	[redacted]	Wet to dry dress to	10		/	[redacted]					
	[redacted]	(R) elbow BID beginning	20		/	[redacted]					
		in A.M.	/								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) ELBOW FX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

#[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

b(6)-2 All

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 11 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
14 NOV	[redacted]	Admit to ICW' - Stable	14 NOV	—	—	[redacted]
14	[redacted]	Bath pt today or assist	14	—	1710	[redacted]
15 NOV	[redacted]	Resume previous orders	15	—	—	[redacted]
15	[redacted]	NPO p MN 16NOV03 for OR 17NOV03	17 NOV03	0001		
11/17	[redacted]	Resume previous Orders	17 Nov	[redacted]		[redacted]
11/17	[redacted]	AP / Lat Oblique of (R) elbow	17 Nov			[redacted]
20 NOV	[redacted]	DC to EPW camp, f/u 1 week				
20	[redacted]	Paperwork in chart	20	—	—	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION / TIME/DATE COMPLETED													
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
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----	----															
----	----															

USAPA V1.00

b(6)-2 A11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 03

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 14	15	16	17	18	19	20	21
14 Nov03	[redacted]	IV: D5½NS @ 100cc/hr	06	[redacted]							
		(HL when taking po well)	18								
			06								
15 Nov03	[redacted]	Gentamycin 350mg	10								
		IVPB q day									
15	[redacted]	Ancef 1gm IVPB q	08								
		8°	16								
			24								
19 Nov03	[redacted]	Ciprofloxacin 400mg	10								
		IVPB q12°	22								
19	[redacted]	Primaxin 500mg	08								
		IVPB q8°	16								
			24								
19	[redacted]	Ciprofloxacin 400mg	08								
		IVPB q12°	20								
19	[redacted]	Primaxin 500mg IVPB	06								
		q8°	14								
			22								

DC 19 NOV

SEE BELOW

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: @ ELBOW FX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

#[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

MEDCOM 2467

b(6)-2 All

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 11 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
19 NOV	[redacted]	D/C Gent, Ancef	19	—	—	[redacted]
20 NOV	[redacted]	Levofloxacin 250mg q day	20 NOV	Rx to pharm.		

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
14 NOV	[redacted]	Percocet II po q4° pm	D/T													
			D/T													
14	[redacted]	Demerol 50mg IV q6° pm breakthrough	D/T													
			D/T													
14	[redacted]	Phenergan 25mg IVP q6° prn nausea	D/T													
			D/T													
14	[redacted]	Ambien 10mg po q HS pm	D/T													
			D/T													

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 15 Nov 03
Time In: 0910
Allergies: NKDA
Pre-op V/S:
Procedures: 1qtr
Anesthesia Type (Circle): General Spinal Epidural [redacted] IV Sedation Nerve Block
OR Intake: Crystalloid 600 Colloid
OR Output: UOP EBL
Meds/Times: Fentanyl

b(6)-2

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds History

Time	0910	0915	0920	1235
SaO2	99	98	97	97
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140	V	V	V	V
120				
100				
80				
60	^	^	^	^
40				
20				
RR	16	17	16	
T	95		96	

Pacu Intake

Time	Solution	Amount	Site	[redacted]	Infused
0910	LR	400	D Arm		600

b(4)-2

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	1	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1 2	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	8	9

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
^ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Time									
Pain (0-10)	[redacted]								
LOS									

Patient teaching done; Wound Care, Pain Management, T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

b(6)-2

[redacted] CPT

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 15 Nov 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle; grade; date; hospital or medical facility)

[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) Arm	WDM	+	+	B	W	PK
15'							
30'							
45'							
60'							
90'							
D/C							

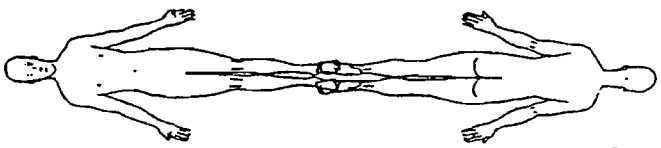
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) Arm	Splint	-0-
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0910	SR	-0-	-0-

NURSING NOTES

Pt to recovery room from OR via gurney s/p H.D. (R) elbow splint w/ Hct. IV of NR infusing into (L) hand. D/S/S of Medical Dx Swelling to the R/S. Will continue to monitor [redacted] b(6)-2

b(6)-2 All

Discharge Criteria:
Date: **Time:** **PARS:**
BP: 140/85 **T:** 96 **HR:** 57 **RR:** 16 **Sa02:** 96
Pain Level at D/C (0-10):
Intake: 100 **Output:** -0-
Additional Data:
Transferred To: ICW #1
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOP R-2
Charge Nurse Signature [redacted]

WAMC OP 173-E

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 11/17/03
Time In: 1415
Allergies: NKA
Pre-op V/S: 135/75 HR 70
Procedures: Wosiborc (R) ACM

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 300 cc Colloid
OR Output: UOP EBL MIN.
Meds/Times: ASD 4MG, 100 mcg

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds History

Time	1415	1430	1445	1530	1445	1530										
SaO2	98	100	98	98	100											
FiO2	\	\	\	\	\	\										
Methods	RA	RA	RA	RA	RA	RA										
240																
220																
200																
180																
160																
140																
		V	V	V	V											
120																
100	V															
80																
60	^	^	^	^	^											
40					^											
20																
RR	19	18	04	20	12											
T	98.6															

Time									
Pain (0-10)									
LOS									

Pacu Intake

b(4)-2

Time	Solution	Amount	Site	By	Infused
1415	LR	200	LA	[redacted]	100

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	\	\	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	10	

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done: Wound Care, Pain Management, T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] b(4)-2 SN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 11/17/03

PATIENT [redacted] (For typed or written entries give: Name – last, first, middle; gra[redacted] hospital or medical facility)

[redacted]

b(4)-4

☐ HISTORY/PHYSICAL
☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER (Specify)
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
1415	(R) arm	Limited	+	+	+	W	Pk
Adm	(R) arm	Limited	+	+	+	W	Pk
15'	(R) arm	Limited	+	cast	+	W	Pk
30'							
45'							
60'							
90'							
D/C							

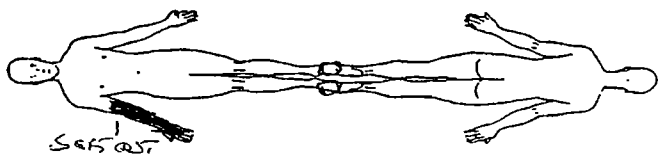
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm 1415	(R) arm	soft cast	+
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1415	S		

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1415	S, S2 +	No.	

NURSING NOTES

1415 Pt escorted on gurney to PACU. Pt alert and oriented. (R) arm in soft cast, no S/S of drainage (pressure bitten dressing). Pt on RA 100%, infusing in (L) arm. Pt has bilateral breath sounds, bowel sounds. Strong feb/ pulses and radial pulse present in (L) arm. [redacted]

1430 Pt alert and oriented x3. Fully awake. (R) arm elevated [redacted]

1500 Pt alert and oriented x3 VS stable. - no drainage - on external dressing. Cap refill (R) arm present - pt b/c pressure cast and reported in arm [redacted]

b(6)-2 All

Discharge Criteria:
Date: 11/7/03 **Time:** 1500 **PARS:** 10
BP: 106/50 **T:** **HR:** 52 **RR:** 10 **SaO2:** 100%
Pain Level at D/C (0-10):
Intake: 100cc RL **Output:** +
Additional Data: —
Transferred To: ICWI
Report Given To: SPC SKIPP - TAKWA
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: (R) Bry
Cleared IAW Recovery Room SOP P-3 [redacted]
Charge Nurse Signature: [redacted]

Admission and Coding Information

For use of this form, see AR 40-400; the proponent agency is OTSG

1. Reporting MTF (b)-2 0580 [redacted]	2. MTF Location IZ			
3. Register Number 0015271	Name (Last, First, MI) [redacted] b(a)-4		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) [redacted]	7. Age at Admission 21Y	8. Race X	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. FMP 20	12. Social Security Number 000-00[redacted] b(a)-4	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 15:50	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma DIS	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW1	Name / Relationship of Emergency Addressee Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted] b2-2		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-11-22		
24. Clinic Svc - Admitting AEA - ORTHOPEDICS	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-11-14		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-11-14		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: R ELBOW FX

Procedure Narrative(s):

Cause of Injury Narrative:

b(a)-2

Admitting Officer (Signature, as required) [redacted]	Signature of Admitting Clerk [redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

9	10	11	12	13	14	15

4. PAY GRADE		5. SEX
16	17	18

6. DATE OF BIRTH (YYYYMMDD)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER								
32	33	34		35	36	37	38	39	40	41	42	43	44	45

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46		

14. FLYING STATUS			15. BENEFICIARY CATEGORY			16. ZIP CODE OF RESIDENCE								
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61

17. UNIT LOCATION (State or Country Code)		18. MOS							19. TRAUMA	PREV. ADMISSION YEAR	
62	63	64	65	66	67	68	69	70	71		☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (YYMMDD)					
73	74	75	76	77	78	79	80	81	82	83	84	85	86

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (YYMMDD)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102

27. LOCATION OF OCCURRENCE (Battle Casualty Only)		28. MTF OF INITIAL ADMISSION						29. DATE INITIAL ADMISSION (YYMMDD)					
103	104	105	106	107	108	109	110	111	112	113	114	115	116

FOR LOCAL USE

Dx 81253
E9919

Pr 7961 (3)

tm 443

Trauma
1

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400, the proponent agency is OTSG

1. Register Nbr	2. Name	3. Grade	Admission Remarks
[redacted]	[redacted] b(6)-4	FGN	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	34Y	X				NO

11. FMP	12. SSN	13. Organization	14. Ward
~~99~~ 20	[redacted]	b(6)-4	ICU3

15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case
	K78-PRISONER OF WAR/INTER			DIS

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	23:00	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	HOME	2004-01-22

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-17	[redacted] b(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] b(2)-2	2003-11-17	

31. Selected Administrative Data

Marital Status: DoB: [redacted]

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW L ARM/ABDOMIN

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
Ø	Ø	Ø	Ø	6	6

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
Ø	Ø	Ø	Ø	6	6

Signature of Attending Medical Officer	Signature of PA[redacted] Officer
[redacted] b(6)-2	For [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11 JAN 04 @	0800 - Assumed care of pt A+O x3. VSS. Denies pain or discomfort @ this time. Lungs CTA. HRRR. Abd soft, BS x 4 q Vent. Tolerating PO well. Urinating spontaneously c̄ difficulty. (B) LE external fixators remain, pin care given. DSG to (R) upper extremity complete flap remains intact. Afebrile. Ø s/s of infection. Will cont. to monitor. b(6)-2 [redacted]
11 JAN 04 @ 2200	Assumed care @ 1400 - VSS. A&O. Ø c/o pn nor discomfort at this time - pin care done c̄ Ø s/sx of infex on site. Drsg on (R) arm CDI. CL on (L) SC patent, drsg intact. Tol diet well. Voiding clear yellow urine c̄ difficulty. Will cont. to monitor. [redacted] b(6)-2 [redacted]
12 JAN 04	(DAYS) Assumed care @ 2200. Pt alert, speaking Arabic. VSS. Ø c/o pain @ this time. Pin care done to BLE ex fix. Abd/(R) arm dsg CDI, arm bolstered c̄ ace wrap. (L) SC TL flushes well c̄ s/sx infection/infiltration. 2 point restraints in place c̄ s/sx b(6)-2 complications. Will cont. to monitor. [redacted]
12 JAN 04	@ 0800 - Assumed care pt. A+O x3. VSS. Denies pain or discomfort. medicated for pain percocet II tabs @ 0630 - Lungs CTA. HRRR. Central line (L) subclavian DSG

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1989)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(a)-2 A11
cont	CDI triple lumen patent. Active BS x4 quads. Voiding spontaneously s̄ difficulty. External fixator to bilat upper extremities intact pin care given. (R)UE immobilized. Skin flap intact DSG CDI will cont to monitor — [redacted] wrns.
12 Jan04 (1630)	Pt a&o, VSS, demerol for pain, premedicated for drsg Δ. Flap irrigated c̄ MD @ BS. Gauze applied, (R) arm bolstered & supported. ex fix intact (B)UE, pin care done, (+) pulses (L) hand c̄ some sensation & movement except for pinky finger. Restraints on LE s̄ compromise. Cont to monitor — [redacted] LPN
13 JAN03	(0005) Assumed care @ 2200. Pt alert, speaking Arabic. VSS. Φ c/o pain. Pin care done to B/UE ex fix. min. amount sero-sang drainage @ pin sites. (R) arm remains bolstered to abd c̄ ace wrap. Dsg CDI. voiding s̄ difficulty. (L) SC TL flushes well s̄ S/Sx infection/infiltration. 2-point restraints in place s̄ S/Sx complications. Will cont. to monitor. — [redacted]
13 JAN04	@ 0630 - Assumed care of pt. A&Ox3. VSS Ø c/o pain or discomfort. Medicated prior shift. Lungs CTA HRRR. Active BS x4 quads. Tolerating reg diet s̄ diff. External fix to (B)UE in place. pin care given. Dressing to (R)UE skin flap intact. Afebrile Ø S/S of infection. Will cont to monitor — [redacted]
(1800)	Pt a&o, VSS, med c̄ Demerol for drsg Δ. LCTAB, (+) BS x4, pin care done, drsgs Δ'd, NPO p̄ MN for OR tom. (R) arm bolstered & supported, (L) SC TL drsg CDI flushes x2 ports. IV abx cont. IS enc. c̄ ambulat.

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES b(6)-2 #11
cont (1800) 13JAN04	ance. good appetite today, drinking H2O often amb to BR x 1, 2pt restraint on left 5 any compromise. Cont to monitor [redacted]
15JAN04@0330	Assumed care of pt. @ 2200. VSS. Demerol 75mg IV for c/o pain to (R) UE. (R) UE intact to abd. c bolster, CDI, able to move fingers. Ex-fix to (L) UE, pins are dry, scant serosang. drainage. Pt. NPO since MN. Pt. asleep @ this time. TLC to to (L) SC, 2 ports flush well, 1 port occluded. Pt. in 2 pt. restraints. Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted] ICT, RN
14JAN04@	0700 - Assumed care of pt. A+O x 3. VSS. Remains NPO pr MN on call for surgery. lungs ctx RRRR. Central line Groubclavian in place. (R) UE ex fix in place. (R) UE remains immobile - skin flap intact. A+ female. DSG to active bleeding small amounts. irrigation c̄ dsg & IV + PO ABX. To cont. with monitor [redacted] WMA
(1530)	Pt back from PACU, S/P removal of ex-fix (R) + (L) arm, ORIF (L) radius c̄ interoseary fibular autograft, + iliac crest bone graft. Pt alert VSS, med c̄ Demerol 75mg IVP for pain per orders. drsgs CDI to (L) + (R) arm, (L) iliac crest (R) abd. (cont

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

[redacted] b(6)-4

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE	

Op Note

1-14-04 Prop Dx : Open (R) Distal humerus fx c soft tissue defect
: Open (L) BB L/A Fx c segmental bone loss fracture.
Post Op Dx : Same
Procedure : Take down of abdominal flap c SIS G (R) Arm
: ORIF (L) RADIUS c intercalary fibula & ICBG, removal of Ex Fix (R) UE
Surgeon [redacted] / [redacted] / [redacted] b(6)-2
Asst :
Fluids : 2000cc LR, 1u PRBC
Findings : viable abdominal flap, degenerated tissue (R) Arm, segmental bone loss ulna shaft (L) RADIUS.
Complications
Drains : Penrose 3/8 (R) Arm. b(6)-2

[redacted]

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; [redacted] hospital or medical facility)

[redacted]

b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

b(w)-2 #1

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
4Jan04 (1530)	(cont). JP intact to (L) LE, drsg intact (L) LE c̄ ace wrap, no drainage noted. (+) ~~pulses~~ error [redacted], brisk cap refill. (L) arm elevated, IVF NS TKO from OR/PACU transfer. (L) SC TL drsg CDI. ICT AB, (+) BS, given H2O. 2 pt restraints on 3 compromise. Cont to monitor ([redacted] LPN
	unable to palpate upper extr. pulses. d/T drsgs c̄ ace/cast. ([redacted] LPN
2000	
[redacted]	1500-2000 JP output [redacted]
5JAN04@0300	Assumed care of pt @ 2200. Temp 101.1, HR 133, 8mg MSO4 IV for C/O severe pain to (L) UE @ 2400. ii Percs for C/O pain @ 020 7mg MSO4 for C/O pain to (L) UE @ 0300, I.S. encouraged & assisted, TCL to (L) SC, 1 port occluded. Drg's to (L) UE, (R) UE, (R) LE, (L) LE, CDI, Ø DSG Δ's as per MD order. Pt. assisted c̄ PO H2O intake, voids dark CYUE assistance. (+) BS x 4 quads. Pt. in 1 pt. restraints, Ø signs of skin breakdown. Will cont. to monitor. [redacted] ICT, AM
15 Jan 03	VSS WNL. Drain serosanguinous fluid to outside of (R) arm.
1035	Remove drain intact. DSG to (L) arm CDI. (+) CVS to (R) hand and (+) 2 pulse. CVS diminished to (L) hand @ four fingers. (+) 1 pulse to (L) radial. JP drain c̄ 7cc of BRB output this AM. CL DSG Δ'd c̄ difficulty. LSCI AB. BS (+) x 4. PERLA. Several c/o severe pain to (L) and (R) arm and receiving RTC morphine, demerol, percocet pcn. Ø s/s of infection to wound sites. Ø s/s of skin breakdown. [redacted]
1100	Transfer to FCW-2

STANDARD FORM 509 (REV. 6/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0 JAN 04	S: 34 y/o RHD civilian male s/p (R) Distal Humerus Fx w/ soft tissue defect and open (L) BB Fx w/ segmental bone loss of Radius + ext. muscle comp. loss (L) DOI: 11 JAN 04. DOS: 12 JAN 04
	ORIF [redacted] (L) Radius w/ autograft + iliac crest bone graft + ABD free flap to (R) arm. Patient demonstrating understanding + motivation to perform exercise program. He reports "I have to be able to use my hands"
	Translator present. ADLS - min ASSIST = DRESSING UE/LE - BATHING - DSG CHANGE
	O: AROM (R) shoulder ✓ 70 (L) SHLDR ✓ 130
	(R) elbow 40/90 e/f (L) elbow e/f 20/130
	(R) wrist 65/65 (L) wrist e/f 0/50
	(R) 1st UPPER RE + (R) (-) (R) composite fist (actively) (L) Digits (-) composite fist
	MMT (R) Intrinsics 2-/5 (+) hook fist posture (L)
	A: Instructed patient in home program. (B) shoulder r/l, ABD; ADD; elbow e/f, forearm sup/pro, wrist e/f, ud/rd, and fisting / w/ opposition. Splint wrist cock-up during HS - + ulnar palsy splint during waking hours.
	A: Patient is 10 days s/p ORIF (L) Radius w/ autograft + iliac crest bonegraft + ABD free flap to (R) Arm.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

[redacted]

b(6)-4

STANDARD FORM 509 (REV. 5/1989) BACK
USAFA V1.00

Patient is performing ADLs w/ min-mod Assist
2' to Burning s to BUE + decreased BUE ROM.
P: In patient care / treatment. AROM / AAROM
: to (B) SHLDR, elbow, forearm, wrist + digits
splint fabrication. HEP. AROM (see above)
10x each hour -
STG 1) Increase (B) SHLDR e/f by 10° each x 1 week
2) Increase (B) elbow e/f by 10° each x 1 week
3) Increase (B) forearm sup/pro by 10° each x 1 week
4) Increase (B) wrist e/f by 5° x each x 1 week.
LTG 1) [redacted] full composite (B) fists x 12 wks -
2) Patient will perform UE + LE DSG
+ Bathing independently x 12 wks -
Patient motivated + concurs w/ plan -
[redacted] CPT/OT, OTR/L
b(6),2

DATE	NOTES			
			FIRST NAME	LAST NAME
		MIDDLE INITIAL		ID NUMBER

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1-22-04	D/C Summary
	Iraqi male, initially EPW, shot by U.S. Forces sustaining injuries to (B) UE.
	Open (R) distal humerus fx c̄ ulnar nerve loss & large soft tissue defect. (L) BB F.A. fx c̄ soft tissue + radial bone loss & ulnar palsy
	Inpt > 90 days c̄ multiple procedures.
	(1) ORIF (R) distal humerus c̄ abdominal & STSG
	(2) ORIF (L) ulna + radius c̄ fibular bone graft & STSG, iliac crest bone graft.
	Wounds are healed. Pt is D/C'd home & to f/u for wound c/, suture removal & XR 1 week.
	[redacted]
	b(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* [redacted] | REGISTER NO. | WARD NO.

b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

1/15/04 ght shift

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 1-16-04 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 7 | HOSPITAL DAY: 7

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400											
BP ARTERIAL LINE	99													
BP CUFF	62	124/60	90/40											
TEMPERATURE	99.4	100.4	99.3											
PULSE	114	101	103											
RESPIRATORY RATE	18	15	16											
OXYGEN (L/%)	✓													
PULSE OXIMETER	97%	88%	97%											
O2 METHOD	RA	RA	2L											

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0850	0400						
PAIN INTENSITY (10 / 5 / 0)	0	2						
MED ADMINISTERED (Y/N)	N	N						
RELIEF ACCEPTABLE (Y/N)	Y	NA						

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

	TIME: 2300		
*Skin breakdown prevention	NA		
*Falls prevention protocol	↓		
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

C[redacted] b(6)-4

DIAGNOSIS: GSW BUE

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

b(6)-2

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 2300 INITIALS: [redacted]	TIME: 0850 INITIALS: [redacted]	TIME: 1915 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies constipation, diarrhea or rectal bleeding.	☑ mL ABD incision COI	☑	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ DSG to BUE. ↓ROM fingers (B) hand x little finger. DSG to LLE 2° inf. fix.	☐ Dsgs to BUE COI. Penrose drain to (B)UE draining bloody drainage. mL Dsg incision intact. Dsg LLE COI. Unable to move (B) hand.	☑ ~~Ace wrap~~ ↓ROM (B)UE 2D ace wrap, unable to bend ring, middle and pointer fingers ↓ROM (L)LE 2D to injury
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ GSW to BUE JP to LLE Penrose RUE	☐ Dsgs to (B)UE, LLE - intact.	☐ x (B)UE, (L)LE and (L) abd (lower)
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑ See pg 1	☑	☐ see pg 1
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐ b(6)-2	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 2300 INITIALS: [redacted]	TIME: 0850 INITIALS: [redacted]	TIME: 1915 INITIALS: [redacted]
IV patency ✓ q 8 hr: PRN	IV patency ✓ q 8 hr:	IV patency ✓ q hr:
IV site care provided: assessed/flushed	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: CL / only 1 part funct.	IV Site #1: (L)SC * / 0	IV Site #1: (L)SC / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: SC	Comments: Distal part patent only.	Comments: SC-distal part patent only

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: BUF / LLE

TIME:	2300		0850				1915		
COLOR	L P	R P	P	P	P	P	P	P	P
CAPILLARY REFILL	1	1	1	1	1	1	1	1	1
TEMPERATURE	W	W	W	W	W	W	W	W	W
EDEMA	/	/	Ø	Ø	Ø	Ø	Ø	Ø	Ø
SENSATION	S	S	S	S	S	S	S	S	S
MOTION	/	/	P	U	M	M	M	U	M
PASSIVE FLEXION	/	/	Ø	/	/	Ø	UTA	UTA	Ø
PERIPHERAL PULSE	/	/	2+	/	/	2P	UTA (R upper)	UTA (L)	2P (LLE)

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	2300	0850	1915
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up	NA	NA	
Bed position low			
Call light within reach			

OTHER

Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn		[redacted]	
Turn/reposition q2h		NA	
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE:	TYPE: Reg
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED: 10%
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: well
☐ SELF ☑ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☒ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☑ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☑ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 2300 INITIALS: [redacted]	TIME: 0850 INITIALS: [redacted]	TIME: 1915 INITIALS: [redacted]
CONTENT: 1.) Pain management 2) Call for assist PRN	CONTENT: - Plan of care - pain management	CONTENT: explained - pain management - call for assist
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

b(6)-2

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
b(6)-4 [redacted]	[redacted]	[redacted] RTAN	N
		[redacted]	
		[redacted] RN	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1800			
	1915	(R) LE	gauze & acewrap - CDI	Δ QD
		(L) LE	gauze wrap - CDI	Δ QD
		(L) LE	gauze wrap - CDI	Δ QD
		a bd	staples - ϕ S&S of infection	ϕ

SECTION IV - NOTES

0850: Awake & alert. Denies pain @ this time. Unable to move (L) hand. Will continue to monitor. [redacted] b(6)-7

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: [redacted] | PATIENT ACUITY LEVEL: III | POST-OP DAY: ? | HOSPITAL DAY: 3

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1300	2000	0400													
BP ARTERIAL LINE			—													
BP CUFF	99/73	102/71	98/70													
TEMPERATURE	97.6	100.3	99.1													
PULSE	133	107	109													
RESPIRATORY RATE	16	18	18													
OXYGEN (L/%)	—	—	—													
PULSE OXIMETER	98%	95%	95%													
O2 METHOD	RA	RA	RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1200	1800	2000	0400				
PAIN INTENSITY (10 / 5 / 0)	X	X	X	X				
MED ADMINISTERED (Y/N)	Y	Y						
RELIEF ACCEPTABLE (Y/N)	Y	Y						
Percocet	2	—						
Demerol	—	75mg						

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:			
*Skin breakdown prevention			
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DIAGNOSIS: GSW Upper Extremities

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1300 INITIALS:	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☐	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☐ tachy	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies constipation, diarrhea or rectal bleeding.	☐ Midline Abd incision Covered & dressing C/D/I	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ ↓ ROM in RUE/LUE ↓ Rom in LLE but weight bearing ok	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Dressing on GSW wound on LUE, RUE. Dressing on Bone graft site LLE, Dressing on marrow site + Skin	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ graft site, RUE drain serous fluid w/ Penrose tubed Pain 4/10/7/10 Percocet Demerol given	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0300 INITIALS: ZGB	TIME: INITIALS:	TIME: INITIALS:
IV patency ✓ q 8 hr: PRN	IV patency ✓ q hr:	IV patency ✓ q hr:
IV site care provided: Flushed	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: * L Subclave / OK	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: Flushed, Red Bot will not flush	Comments:	Comments:

LLE

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RUE, RLE,	TIME: 1300	1300	1300			
COLOR	W	P	P			
CAPILLARY REFILL	1	1	1			
TEMPERATURE	C	W	W			
EDEMA	0	0	0			
SENSATION	A	S	S			
MOTION	U	P	M			
PASSIVE FLEXION	—	—	—			
PERIPHERAL PULSE	—	—	—			

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

	TIME: 7CB		
ID band visible/legible			
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile	✓		
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE: Reg	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED: 0%	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED: —	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☒ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
CONTENT: (1) Pain Control (2) Call for assist	CONTENT:	CONTENT:
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

INITIALS	SIGNATURE	SHIFT
7CB	[redacted]	D

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1:30c	RUE, ~~RT~~LUE, LLE	all covered c̄ Bandages CDII	Ø

SECTION IV - NOTES

1745-Pt voided 500cc urine, urine was yellow & blood, ~~tagged~~ MD to be called [redacted]

b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 17 Jan 04 | PATIENT ACUITY LEVEL: III | POST-OP DAY: ? | HOSPITAL DAY: ?

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400													
BP ARTERIAL LINE																
BP CUFF	120/80	96/58	115/52													
TEMPERATURE	97.8	99.8	99.5													
PULSE	76	97	80													
RESPIRATORY RATE	16	16	16													
OXYGEN (L/%)																
PULSE OXIMETER	99	99%	98%													
O2 METHOD	RA	RA	RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0700	1845						
PAIN INTENSITY (10 / 5 / 0)		X						
MED ADMINISTERED (Y/N)	N	N						
RELIEF ACCEPTABLE (Y/N)	Y	N/A						

SPECIAL NEEDS

TIME:	0700	1845
*Skin breakdown prevention	[redacted]	[redacted]
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

*Per hospital policy.

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

bkw-2

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

[redacted]

bkw-4

DIAGNOSIS: GSW BLE

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0700 INITIALS: [redacted]	TIME: 1845 INITIALS: [redacted] b(6)-2	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ DROP TO (L) HAND ↓ ROM TO RLE D/T CAST	☐ Weakness to LUE RUE ⊂ cast	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ DSGS TO BILET LLE RLE ONEW DRAINAGE LLE, LLE CDI	☐ ~~RLE Gauze~~ (R) Flank ⊂ sutures intact Staples to LLE intact (L) Flank staples intact	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ PT DENIES	☐ 6/10 percocet @ 1700	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1845 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
IV patency ✓ q 5 hr:	IV patency ✓ q hr:	IV patency ✓ q hr:
IV site care provided: assess	IV site care provided:	IV site care provided:
IV tubing changed: flush	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) SC / OK	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: DISTAL ⊕ Flush ⊕ bld return	Comments:	Comments:
Proximal tied off		
Medial ⊕ flush		

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: LLE LLE TIME:	0700	1845				
COLOR	P	P	P			
CAPILLARY REFILL	1	1	1			
TEMPERATURE	W	W	W			
EDEMA	1	2	1			
SENSATION	S	S	S			
MOTION	U/M	M	M			
PASSIVE FLEXION	0	0	0			
PERIPHERAL PULSE	2	2	N/A			

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

	TIME: 0700	1845	
ID band visible/legible	[redacted]	[redacted]	
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: REG	TYPE: REG	TYPE: Reg
PERCENT CONSUMED: 75%	PERCENT CONSUMED: 80%	PERCENT CONSUMED: 0 100
HOW TOLERATED: WELL	HOW TOLERATED: WELL	HOW TOLERATED: well
☐ SELF ☒ ASSIST ☐ COMPLETE	☐ SELF ☒ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR	BEDREST ☐ SELF ~~AMBULATE~~ ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR	BEDREST ☐ SELF AMBULATE ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR

TEACHING

TIME: 0700 INITIALS: CB	TIME: 1845 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: PAIN CONTROL RADLIB	CONTENT: Call for assist personal hygiene	CONTENT:
☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
b(6)-4 [redacted]	[redacted]	b(6)-2 [redacted] SGT, Guard	N
		SPC/SHARE	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1815	(L) LE	Staples intact	
	1815	(L) Flank	Staples intact	Assess
	1815	(R) Flank	Sutures intact. Dsg c̄ Vaseline gauze	

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 18JAN04 | PATIENT ACUITY LEVEL: III | POST-OP DAY: | HOSPITAL DAY:

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000
BP ARTERIAL LINE		
BP CUFF	110/54	100/44
TEMPERATURE	99.1	99.1
PULSE	93	99
RESPIRATORY RATE	16	16
OXYGEN (L/%)		
PULSE OXIMETER	97%	98%
O_2 METHOD	RA	RA

Oxygen Method Key: NC = Nasal cannula, NR = Non rebreather, FM = Face mask, VM = Venturi mask, MT = Mist tent, PR = Partial rebreather, A = Aerosol, TC = Trach collar

PAIN

TIME:	0745	1500
PAIN INTENSITY (10 / 5 / 0)	0	0
MED ADMINISTERED (Y/N)	N	N
RELIEF ACCEPTABLE (Y/N)	Y	N/A

OTHER

TIME:		
FINGER STICK GLUCOSE		
INSULIN (Y/N)		

N/A

SPECIAL NEEDS

TIME:	0745
*Skin breakdown prevention	b(6)-2 [redacted]
*Fall prevention protocol	
*Restraint protocol	
*Seizure precautions	
*Isolation precautions	

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2	TOTAL IN	Urine	Stool	TOTAL OUT

PATIENT IDENTIFICATION

Civ [redacted]

b(6)-4

LOCATION: GSW BLUE

ADMISSION DATE: 11JAN04

EXPECTED RELEASE:

b(6)-2 [redacted]

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0745 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2245 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	✓	✓ b(6)-2	✓
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	✓	✓	✓
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	✓	✓	✓
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	✓	✓	✓
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	✓	✓	✓
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Cast to RUE. Dsg to (L)UE, ↓ROM to (R)UE.	☐ Cast to RUE Small Dsg RUE ↓ROM RUE, ↓ROM (R) Hand	☐ ↓ROM (R)UE 2° to Cast on (R)UE and accuwrap (L)UE ↓ROM (L)LE 2° GSW
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Dsgs to (R)UE CDI. wound to (R) Flank - dsg intact. (L) CE incision, staples intact	☐ Dsg RUE, LUE CDI. (R) Hip Dsg intact LLE fucision staples intact	☐ Tx abd, (R)UE and (L)LE
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	✓	✓	☐ See pg 1
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	✓ b(6)-2	✓	✓

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

	TIME: 0745 INITIALS: [redacted]	TIME: 1500 INITIALS: [redacted]	TIME: 2245 INITIALS: [redacted]
IV patency ✓ q 8 hr:		PRN	
IV site care provided:		Flush Heparin	
IV tubing changed:			
	LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	(L)SC / OK	* (L)SC	(L)SC / OK
IV Site #2:			
Comments:	Distal port patent	Brown port patent	Distal port patent SL - flushed c̄ heparin

R —

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (B) UE TIME:	0745		1500		2245				
COLOR	P	D	P	P	P	P			
CAPILLARY REFILL	1	1	1	1	1	1			
TEMPERATURE	W	W	W	W	W	W			
EDEMA	4	1		1	Ø	1			
SENSATION	S	S	S	S	S	S			
MOTION	M	U	M	P	M	P			
PASSIVE FLEXION	/	/	/	/	/	/			
PERIPHERAL PULSE	UTA	2P	U	2P	UTA	2P			

LEGEND (R) (L)

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0745	1500	2245
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up	NA	NA	
Bed position low			
Call light within reach			

OTHER

Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn	[redacted]		
Turn/reposition q2h	NA	NA	
ROM q2h if immobile			
Antiembolic hose	D	↓	

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Reg	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED: 25%	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED: well	HOW TOLERATED:
☑ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☑ COMPLETE ☑ ASSIST ☐ TOTAL	☑ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☑ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☑ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☑ SELF ☑ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0745 INITIALS [redacted]	TIME: INITIALS:	TIME: 2245 INITIALS [redacted]
CONTENT: Plan of care	CONTENT: - Plan of Care - Call for pain meds.	CONTENT: explained - pain management - call for assist
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION b(6)-4 [redacted]

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted]	2/N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1800	① (L) FA ② (L) calf ② (L) hip ④ (R) abd	① staples intact ④ ② No S/S infection ③	Dry gauze
	0745	① LE (R) LE	gauze wrap - CDI cast - CDI	Δ QD
		(L) LE Abd	~~gauze wrap~~ staples OTA Ø S/S of infection staples / drsg CDI	

SECTION IV - NOTES

b(6)-2

0745: Awake & alert. No % pain @ this time. Sitting up in bed, will continue to monitor. [redacted] 1600 - MSO4 given 5 mg for Pain 6/10, Pt. states that pain [redacted] was relieved to 1/10. Pt. Drsg on LUE was loose and falling off. Δ'd Dressing @ 1600 C/DI. [redacted]

b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 19 Jan 04 | PATIENT ACUITY LEVEL: III | POST-OP DAY: ? | HOSPITAL DAY: ?

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/SR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	400	2000
BP ARTERIAL LINE		
BP CUFF	100/48	116/80
TEMPERATURE	98	98.8
PULSE	72	100
RESPIRATORY RATE	16	16
OXYGEN (L/%)		
PULSE OXIMETER	99	98
O2 METHOD	RA	RA

Oxygen Method Key: NC = Nasal cannula NR = Non rebreather FM = Face mask VM = Venturi mask
MT = Mist tent BM = Bag/mask/ventilator A = Aerosol TC = Trach collar

PAIN

TIME:	0730	2330
PAIN INTENSITY (10 / 5 / 0)	0	
MED ADMINISTERED (Y/N)	N	Y
RELIEF ACCEPTABLE (Y/N)	Y	Y

OTHER

TIME:		
FINGER STICK GLUCOSE		
INSULIN (Y/N)		

SPECIAL NEEDS

TIME:	0730	2330
Bed assignment (specialty)	66-2	[redacted]
[illegible]		
[illegible]		
[illegible]		
[illegible]		

YESTERDAY'S WEIGHT _____

TODAY'S WEIGHT _____

WEIGHT CHANGE _____

24 HOUR TOTALS	PO	IV #1	IV #2	TOTAL IN	Urine	Stool	TOTAL OUT

PATIENT IDENTIFICATION

[redacted] b(6)-4

GSW (BLUE)

ADMISSION DATE: 11 Jan 04

66-2

[redacted]

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0730 INITIALS: [redacted]	TIME: 1511 INITIALS: [redacted]	TIME: 2330 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	✓	✓	✓
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	✓	✓	✓
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	✓	✓	✓
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	✓	✓ b/(w) 2 A/11	✓
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	✓	✓	✓
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ CAST TO RUE INHIBITS ROM TO WRIST/ ELBOW	☐ cast to RUE, DSG to LUE c̄ ↓ ROM to BUE, ↓ ROM fingers @ hands	☐ cast to RUE LUE wound OTA ↓ ROM. BUE fingers
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ CAST TO RUE STAPLES TO LUE, LLE, @ HIP CDI	☐ Staples to LLE, @ hip. OTA CDI.	☐ Staples LLE OTA xeroform RUQ abd
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	✓	✓	✓
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	✓	✓	✓

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0730 INITIALS: [redacted]	TIME: 1513 INITIALS: [redacted]	TIME: 2330 INITIALS: [redacted]
IV patency ✓ q 5 hr:	IV patency ✓ q 8 hr: PRN	IV patency ✓ q 5 hr:
IV site care provided: FLUSH	IV site care provided: assessed/flushed	IV site care provided: assess
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) SC / OK	IV Site #1: (L) SC / OK	IV Site #1: (L) SC /
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL	Comments: SL. Distal port patent	Comments: blue port flush red port flush white port ø

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RUE/LUE TIME:	0730	1513					
COLOR	P	P	P	P	P		
CAPILLARY REFILL	1	1	1	1	1		
TEMPERATURE	W	W	W	W	W		
EDEMA	1	0	0	0	0		
SENSATION	T	S	S	S	S		
MOTION	M	P	P	P	P		
PASSIVE FLEXION	0	0	0	0	0		
PERIPHERAL PULSE	WA	/	/	/	2B		

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:	0730	1814	2830
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up		NA	NA
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: REG	TYPE: REG	TYPE: Reg
PERCENT CONSUMED: 25%	PERCENT CONSUMED: 70%	PERCENT CONSUMED:
HOW TOLERATED: WELL	HOW TOLERATED: WELL	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0730 INITIALS: [redacted]	TIME: 2330 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: ASSISTE ASG ADL'S TO ASSIST PAIN CONTROL	CONTENT: ~~0730~~ b(6)-2 call for assist pain control	CONTENT:
☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
b(6)-4 [redacted]	[redacted]	SGT, 91WZA6	D
	[redacted]	LOTAN	E

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	07 30	ABD, (L) HIP, (L) LE, 2 LUE	STABLES WELL APPROXIMATED ↓ ERYTHEMA ∅ S/S INFECTION	DRY GAUZE DSG TO LUE
		Abd	Staples Intact & dry Incision intact	Assess
		LLE (L) hip		

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 20Jan04 | PATIENT ACUITY LEVEL: | POST-OP DAY: 6 | HOSPITAL DAY: 10

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	400	1200	2000										
BP ARTERIAL LINE	/	122											
BP CUFF	97/58	69	100/72										
TEMPERATURE	98.6	98.3	100.3										
PULSE	97	90	114										
RESPIRATORY RATE	14	14	16										
OXYGEN (L/%)	/	—											
PULSE OXIMETER	98	99%	98%										
O2 METHOD	RA	RA	RA										

Oxygen Method Key: NC = Nasal cannula; NR = Non rebreather; FM = Face mask; VM = Venturi mask; MT = Mist tent; RR = Rebreather; A = Aerosol; TC = Trach collar

PAIN

TIME:	0700	1200	2000	2330	0045
PAIN INTENSITY (10 / 5 / 0)	X	X	X	X	X
MED ADMINISTERED (Y/N)	Y	[redacted]	N	Y	
RELIEF ACCEPTABLE (Y/N)	Y		NA	Y	
	Percocet		66-2	TI	

SPECIAL NEEDS

	0700	1600	2330
[redacted]	NA	NA	

YESTERDAY'S WEIGHT

TODAY'S WEIGHT

WEIGHT CHANGE:

OTHER

TIME:	
FINGER STICK GLUCOSE	
INSULIN (Y/N)	

24 HOUR TOTALS: PO | IV #1 | IV #2 | TOTAL IN | Urine | Stool | TOTAL OUT

PATIENT IDENTIFICATION: CIV [redacted]

GSW BUE

ADMISSION DATE: 11Jan04

Nice

MEDCOM FORM 40-5 PREVIOUS EDITIONS OBSOLETE MEDCOM / 24704

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0700 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	✓	✓	✓
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	✓	✓	✓
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	✓	✓	✓
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	✓	✓ 6(w)-2 AM	✓
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	✓	✓	✓
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ ↓ROM TO (L) HAND Ø ROM TO (R) ELBOW D/T CAST	☐ ↓Rom to (L) hand, (L) wrist, (R) shoulder, (R) elbow, (L) arm. needs assist amb.	☐ ↓ ROM to (R) LE 2° to wounds DSG. Able to move (R) fingers. Pt unable to move fingers on (L) hand
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ INTACT STAPLES TO (L) FOREARM, HIP, CALF XERO FORM TO (L) ABD CAST TO ACE TO RUE	☐ Staples to (L) arm, hip, calf. xeroform to RLQ ABD - Drsg to RUE	☐ Staples to (L) FA, DPI Staples to (L) calf Drainage but some redness
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ SEE Pg 1	✓	☐ See pg 1
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	✓	✓	✓

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

	TIME: 0700 INITIALS: [redacted]	TIME: 1600 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q	8 hr:	8 hr: PRN	8 hr:
IV site care provided:	FLUSHED	flushed	insertion site slightly redden
IV tubing changed:			
	LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1:	(L) SC [redacted] OK	(L) SC OK.	(L) SC OK
IV Site #2:			triple lumen
Comments:	2 PORTS FLUSH Ē DIFFICULTY	one port tied off, not working.	white port tied off blue port: flush + blood return brown: flush Ø blood return

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RUE TIME:	0700	1600	2330	2330	
COLOR	P	P	P	P	P
CAPILLARY REFILL	1	1	1	1	1
TEMPERATURE	W	W	W	W	W
EDEMA	1	1	1	Ø	Ø
SENSATION	T	T/N	S	T	S
MOTION	M	P	P	U	M
PASSIVE FLEXION	Ø	/	Ø	P	Ø
PERIPHERAL PULSE	UTA	2+	2 RUE	UTA LUE	1

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME: 0700	1613 2330	
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up		NA	NA
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: REG	TYPE: REG	TYPE: Reg
PERCENT CONSUMED: 70%	PERCENT CONSUMED: 60%	PERCENT CONSUMED:
HOW TOLERATED: Ø % and	HOW TOLERATED: well	HOW TOLERATED:
☐ SELF ☒ ASSIST ☐ COMPLETE	☐ SELF ☒ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0700 INITIALS: [redacted]	TIME: 2330 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: ↑ c ASSIST, PAIN CONTROL, CALL FOR ASSIST	CONTENT: Call for assist, Pain management, Ambulation	CONTENT: b(6)-2 AN
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
C [redacted] b(6)-4	[redacted]	[redacted] SGT, RWMG	D
		[redacted] /AN	F
			N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	Ø	(L) HIP, CALF, FOREARM	STAPLES INTACT EØ% INFECTION	OTA
	~~Ø~~	(R) ABD	DSG INTACT Ø DRAINAGE NOTED	▲ XEROFORM QD
	1600	(R) arm	DSG Δ'd by MO.	DSG CDI

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 21Jan04 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 7 | HOSPITAL DAY: 7

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER, RR PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure Diagnosis _____ B.P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	400	1200	2000
BP ARTERIAL LINE			103
BP CUFF	104/51	92/50	64
TEMPERATURE	96.4	97.2	97.9
PULSE	87	77	88
RESPIRATORY RATE	14	16	16
OXYGEN (L/%)			
PULSE OXIMETER	98	97	97%
O2 METHOD	RA	RA	RA

Oxygen Method Key: NC = Nasal cannula; NR = Non rebreather; FM = Face mask; VM = Venturi mask; VT = Vent tent; RR = Rebreather; A = Aerosol; TC = Trach collar

PAIN

TIME:	0640	1500	2000
PAIN INTENSITY		4	X
MED ADMINISTERED (Y/N)	X	Y	N
RELIEF ACCEPTABLE (Y/N)	Y	Y	NA

SPECIAL NEEDS

TIME:	0640	2000
[illegible]	b(6)-2 [redacted]	
[illegible]		NA

YESTERDAY'S WEIGHT

TODAY'S WEIGHT

WEIGHT CHANGE

*Per hospital policy

OTHER

TIME:			
FINGER STICK GLUCOSE			
INSULIN (Y/N)			

24 HOUR TOTALS	PO	IV #1	IV #2	TOTAL IN	Urine	Stool	TOTAL OUT

PATIENT IDENTIFICATION

b(6)-4

CIV [redacted]

GSW BUE

ADMISSION DATE: 11Jan04

b(6)-2 [redacted]

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0640 INITIALS: [redacted]	TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	✓	✓	✓
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	✓	✓	✓
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	✓	✓	✓
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	✓	✓ b(a)-2 AM	✓
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	✓	✓	✓
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ ∅ ROM (R) ELBOW MINIMAL ROM TO (R) HAND	☐ ↓ ROM 2° RUE + LUE. Slight ↓ ROM to LLE.	☐ ↓ ROM to RUE 2° to bulky dsg ↓ ROM to LUE 2° to incision & staples
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ SEE WOUND ASSESSMENT SHEET	☐ Dsg to RUE + LUE C/D/I. Staples to Abd + LLE open to air C/D/I	☐ - Dsg to (R) UE C/D/I - Staples to (L) FA C/D/I - Staples to (L) LE C/D/I
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	✓ PT DENIES PAIN	✓ see pg 1	☐ see pg 1
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	✓	✓	✓

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0640 INITIALS: [redacted]	TIME: 1500 INITIALS: [redacted]	TIME: 2230 INITIALS: [redacted]
IV patency ✓ q 5 hr:	IV patency ✓ q hr:	IV patency ✓ q 8 hr:
IV site care provided: HEPARINIZED	IV site care provided: Flushe	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: RSC ✓ / OK	IV Site #1: (R) SC / OK	IV Site #1: (R) TL SC / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: 2 PORTS FLUSH	Comments: 2 Ports Flush	Comments: 2 ports flush (White port tied off)

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RUE	TIME: 0640	1500	2230	2230		
COLOR	P	P	P	P	P	
CAPILLARY REFILL	2	2	1	1	1	
TEMPERATURE	W	W	W	W	W	
EDEMA	1	1	1	0	1	
SENSATION	T	T	S	T	S	
MOTION	M	M	P	P	P	
PASSIVE FLEXION	0	0	0	0	0	
PERIPHERAL PULSE	UTA	U	D	U	1	

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0640	1500	2230
ID band visible/legible	[redacted]		
Orient to environment prn	[redacted]		
Side rails (2/4) up		N/A	N/A
Bed position low			
Call light within reach			

OTHER

Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn		[redacted]	
Turn/reposition q2h		N/A	
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: REG	TYPE: REG	TYPE:
PERCENT CONSUMED: 50%	PERCENT CONSUMED: REF	PERCENT CONSUMED:
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☒ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0640 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2230 INITIALS: [redacted]
CONTENT: ↑ OOB, PAIN CONTROL, CALL FOR ASSIST b(6)	CONTENT: - Call for assist, - leaving tomorrow, - call for assist	CONTENT: - Call for assist, - Pain management, - OOB to chair
☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
Civ b(4)-4 [redacted]	[redacted]	b(6)-2 [redacted] SGT, SNUMB	D
		[redacted] LCC/AN	2
			N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	06.30	(L) ARM, CALF, HIP (R) ARM (R) ABD	STAPLES INTACT Ø ERYTHEMA DSG CDI XEROFORM DSG CDI	OTA DONE BY MD A&D
	5 6 D	LUE RUE LLE Abd	Drsg C/D/I Staples OTA, C/D/I	Assessed

SECTION IV - NOTES

MED[illegible] RECORD - PATIENT ACTIVITIES FLO[illegible]ET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 22 Jan 04	PATIENT ACUITY LEVEL: III	POST-OP DAY: 8	HOSPITAL DAY: 8

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia *(Specify)*: _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	400	1200														
BP ARTERIAL LINE																
BP CUFF	85/54	91/52														
TEMPERATURE	99.4	99.8														
PULSE	100	102														
RESPIRATORY RATE	16	14														
OXYGEN (L/%)																
PULSE OXIMETER	98	96														
O_2 METHOD	RA															

Oxygen Method Key: NC = Nasal cannula; NR = Non rebreather; FM = Face mask; VM = Venturi mask; MT = Mist tent; PR = Partial rebreather; A = Aerosol; TC = Trach collar

PAIN

TIME:	0800							
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N							
RELIEF ACCEPTABLE (Y/N)	Y							

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

	TIME: 0800		
*Skin breakdown prevention	b(6)-2 [redacted]		
*Falls prevention protocol	✓		
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

b(6)-4

C [redacted]

DIAGNOSIS: GSW (B) LE

DRG: _____ ADMISSION DATE: 16 Jan 04

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted] b(6)-2

ISOLATION REQUIRED (Y/N): _____

ON II - PATIENT ASSESSMENT - REVIEW OF S - MS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 0800 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ b(6)-2	☐	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑ MILD EDEMA TO (R) HAND	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Ø ROM TO (R) ELBOW W/T DSG ↓ ROM TO (L) HAND	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ SECURED ASSESSMENT SHEET	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑ ~~PT~~ DENIES	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others. b(6)-2	☑	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0800 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
IV patency ✓ q 5 hr:	IV patency ✓ q hr:	IV patency ✓ q hr:
IV site care provided: FLUSHED	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: RSC ✓ / OK	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: 2 PORTS FLUSH	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: LUE	TIME: 0800					
COLOR	P					
CAPILLARY REFILL	2					
TEMPERATURE	W					
EDEMA	0					
SENSATION	T					
MOTION	M					
PASSIVE FLEXION	0					
PERIPHERAL PULSE	2					

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

	TIME: 0800		
ID band visible/legible	[redacted]		
Orient to environment prn			
Side rails (2/4) up	✓		
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose	✓		

DIET

BREAKFAST	LUNCH	DINNER
TYPE: REG	TYPE: REG	TYPE:
PERCENT CONSUMED: 50%	PERCENT CONSUMED: 70%	PERCENT CONSUMED:
HOW TOLERATED: WELL	HOW TOLERATED: WELL	HOW TOLERATED:
☐ SELF ☑ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0800 INITIALS: [redacted] b(6)-2	TIME: INITIALS:	TIME: INITIALS:
CONTENT: PEDDING D/C PAD LIB PO INTAKE	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
C[redacted] b(6)-4	[redacted]	b(6)-2 [redacted] SGT, RN/MC	D

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

1400 PT D/C TO HOME ~ MEDS PT TO F/U IN 7 DAYS [redacted] PSGT, SIGNED

b/(6)-2

MEDICAL RECORD — **INTRAOPERA[illegible] DOCUMENT**

For use of this form, see AR 40-407, the propo[illegible] y is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATI[illegible]M
VIA stretcher BY anesthesia

2. PATIENT IDENTIFI[illegible]ORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN b(6)-2

3. DATE 14JAN04 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0756 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	MAJ [redacted] (0950-1150)

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

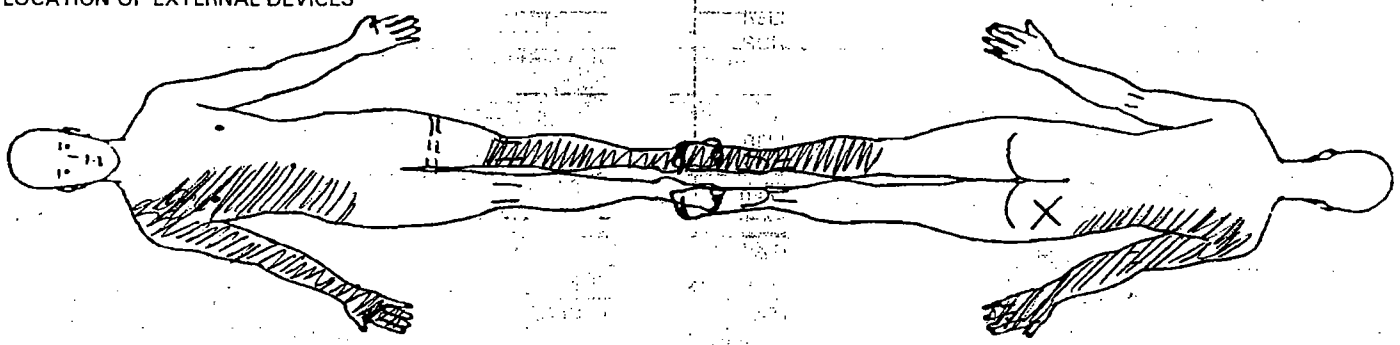
COMMENTS: b(6)-2

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO [redacted]
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: No nicks in skin noted

PREP SOLUTION *(Specify)* Betadine scrub/sol'n
SITE: Rt. arm/Abd BY WHOM: [redacted]
SITE: (L) leg BY WHOM: [redacted]
(R) arm
COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet

C = Correct I = Incorrect Initial C [redacted]

10. COUNTS

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No				[redacted]	[redacted]
Needle Sharp	☒ Yes	☐ No		C	C		
Instrument	☐ Yes	☒ No				b(6)-2	
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: Force 40 RBE105305 50/50
GROUND PAD: BRAND Valleylab REM
LOT NO: 74994

☐ ESU [illegible]
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☒ Y ☐ NO IF YES NAME: ID NUMBER ACTURER

Sm. Frag Set Load # 0500802 Screw set DCP Load # 0500802 | DCP plates Load # 0400202 | 9 hole plate | cortical screws 18mm X 4 20mm X 4 22mm X 1

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☒ NO ☐

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Mineral Oil		intraop	topical		[redacted]
Superstat		↓	topical		

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGN [redacted] b(a)-2

15. X-RAY IN OPERA[redacted] ROOM YES ☒ NO ☐ C-Arm IF YES, SITE (L) arm

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 7mm Jackson Pratt	2.	3.
SITE	1. Lt Lower Leg	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Lt lower leg - fluffs, kerlix, Ace
Rt arm - Bacitracin, Xeroform, Cotton Roll,
Lt arm - fluffs, kerlix, webril, plaster splint, ace
(L) iliac crest - fluffs, xeroform, tape

19. ADDITIONAL INFORMATION

Surg: [redacted] b(a)-2 Asst: [redacted] b(a)-2 Anesth: [redacted] CRNA Type: General

Zimmer ATS1500 Tourniquet #FE089617 (L) thigh 250mmHg ↑0924 ↓0955 ↑1108 ↓1308 (L) arm

20. OPERATION(S) PERFORMED

1. Completion of Abd free flap w/ STSG to (R) arm
2. ORIF (L) Radius w/ intercalary fibular autograft & iliac crest bone graft
3. Removal of Ex Fix (R) arm, (L) arm

21. PATIENT TRANSFERRED TO PACU b(a)-2 TIME 1330 METHOD stretcher c̄ siderails up

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN [redacted] MAJ AN

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 19 2004

DAY: 15 | 16 | 17 | 18 | 19 | 20 | 21

HOUR: 0 2 4 6 8 10 12 2 4 6 8 10 12 2 4 6 8 10 12 2 4 6 8 10 12 2 4 6 8 10 12

PULSE (O) / TEMP. F (•)

PULSE	TEMP. F	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

RESPIRATION RECORD

BLOOD PRESSURE: 100/71, 124, 100?, 97%, Rx

HEIGHT: WEIGHT →

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD

STANDARD FORM

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR JAN DAY 09 10 10 11 JAN 12 13 13 14 14

19 2004 HOUR

PULSE (0) — TEMP. F (°) — TEMP. C (Centigrade Equivalents, for Reference only)

105° 40.6°
180 104° 40.0°
170 103° 39.4°
160 102° 38.9°
150 101° 38.3°
140 100° 37.8°
130 99° 37.2°
98.6° 37.0°
120 98° 36.7°
110 97° 36.1°
100 96° 35.6°
90 95° 35.0°
80
70
60
50
40

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM ____ HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE

INTAKE

	TIME	~~ORAL~~ JP (L) Hb. TYPE	AMOUNT	ACCUM TOTAL	INTRAVENOUS TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
	~~1500~~ →									
4 JAN	2000	20cc bloody		20cc						
15 JAN	1040	7cc BRB		27cc						
16 JAN	0500									

IRRIGATIONS (N/G, Bladder, etc.)			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES				
TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
GRAND TOTAL INTAKE			

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

* JP OUTPUT *

MEDCOM - 24720

b(6)-2

Ward/Section: ICW#1	R ESTING [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO
# [redacted]	14JAN04	0500	# [redacted] b(6)-4

b(6)-4

(Hematology) CBC

TEST	[redacted]			Normal Limits	
WBC	[redacted]				
RBC	[redacted]	6.0	$\times 10^6$/uL	4.5	10.5
Hgb	[redacted]	3.75 L	$\times 10^6$/uL	4.00	5.00
Hct	[redacted]	6.2 L	g/dL	11.0	18.0
MCV	[redacted]	26.3 L	%	35.0	60.0
Plt	[redacted]	83.3	fL	80.0	99.0
Lymph %	[redacted]	20.7	pg	27.0	31.0
	[redacted]	32.6	g/dL	33.0	37.0
	[redacted]	334.	$\times 10^3$/uL	150.	450.
	[redacted]	40.2	%	20.5	51.1
	[redacted]	2.4	$\times 10^3$/uL	1.2	3.4

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source	
Gram Stain	
Occ Bld	Negative
H. pylori	Negative
Micro Parasites	
Malaria	
O & P	
Other	

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS: CBC

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
[redacted] b(6)-4	14 Jan 04	0830	

(Hematology) CBC

TEST	
WBC	
RBC	
Hgb	
Hct	
MCV	
Plt	
Lymph %	

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
[illegible]		0.2-1.0

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source	
Gram Stain	
Occ Bld	Negative
H. pylori	Negative
Micro Parasites	
Malaria	
O & P	
[illegible]her	

Microscopic Urinalysis

Blood Bank

[illegible]UST SUBMIT SF 518 WITH [illegible]VERY UNIT REQUESTED

[illegible]O/Rh

[illegible]rossmatch [illegible]VERY UNIT OF BLOOD [illegible]ED)

	CROSSMATCH

4
SERIAL #005485 01/14/04 09:08

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 14.1 sec.
Ratio = 1.2
Calculated INR = 1.26
Sample Type:citrated wh. blood
Test Date :01/14/04
Test Time :09:06
Card Lot :080201
Operator : [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 01/14/04 09:11

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 42.7 sec.
Sample Type:citrated wh. blood
Test Date :01/14/04
Test Time :09:08

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

T=36

Ward/Section:	REQUESTING PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI	FIO2 58%	DATE	TIME	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		
K		
Cl		
pH		
PCO2		
PO2		
TCO2		
HCO3		
sO2		
BEecf		
AnGap		
Ca		
BUN		
GLU		
Creat		
Hct		
Hgb		
TEST		
Troponin-I		
Drug of Abuse		

Pt: [redacted] b(6)-1

Pt Name:_____

Na_____135 mmol/L
K_____3.8 mmol/L
TCO2_____29 mmol/L
iCa_____1.18 mmol/L
Hct_____23 %PCV
Hb*_____8 g/dL
*via Hct

At 37C
pH_____7.466
PCO2_____38.3 mmHg
PO2_____312 mmHg
HCO3_____28 mmol/L
BEecf_____4 mmol/L
sO2*_____100 %
*calculated

Sample Type_:

14JAN04 09:04

Oper: [redacted] b(6)-2

Physician:_____

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
		3.5-5.5 g/dl
		26-84 u/l
		10-47 u/l
		14-97 u/l
		11-38 u/l
		0.2-1.6 mg/dl
		7-22 mg/dl
		8.0-10.3mg/dl
		100-200 mg/dl
		0.6-1.2 mg/dl
		73-118 mg/dl
		6.4-8.1 g/dl

(Piccolo) Metlyte 8

RESULT	REF. RANGE
	73-118 mg/dl
	7-22 mg/dl
	0.6-1.2 mg/dl
	39-380 u/l (M) 30-190 u/l (F)
	128-145 mmol/l
	3.3-4.7 mmol/l
	98-108 mmol/l
	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG	(Units)												
PROPIFOL	( )	190											
MS	( )	4					6						
Vecuronium	( )	10					10						2
LIDOCAINE	( )	100											
ANCEF	( )												
	( )												
VOLAT AGENT	1.50 % del	1.0	1.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	10 2	2 2	2 2	2 1	1 1	1 1	1 1	1 1	1 1	1 1	1 1	1 1

SINGLE DOSE DRUGS-MARK ON GRID → WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site TRIPLE L													
☒ Warmed	200	400	500	600	500	1000	1000	1050	1100	1200	1300	1500
PRBC ☐ Warmed									X---	---	---	---
☐ Warmed												
☐ Warmed												

LOSSES

EST BLOOD LOSS	—	—	—	—	—	—	—	—	—	—	—	—
URINE -	—	—	—	—	—	—	—	—	—	—	—	—

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 120 KG (LB)

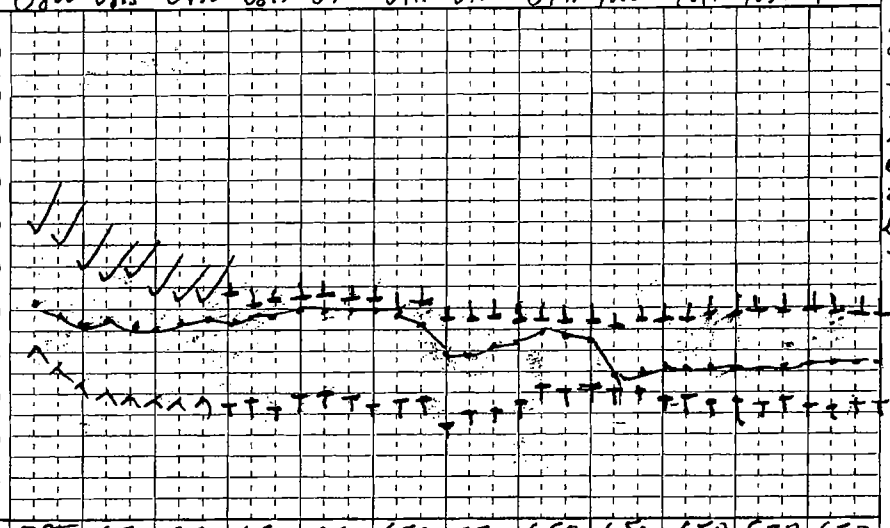
HEMATOCRIT: 8.2 / 24.2

INITIAL DATA: BP-124/89 ___/___ HR-75-55

EQUIP CHECK OK? - (Y) N

PATIENT RECHECK OK for PROCEDURE? Yes TIME- 0745

SYMBOLS: BP by cuff V ^ ; Heart rate ● ; Resp rate √ ; BR (transduced) ; TOURNIQUET T—T ; ANES- X-X ; PROC- ⊙-Ø



VENTIL

VT - ml	SPT	650	650	650	650	650	650	650	650	650	650	650
f - breaths/min	12	8	8	8	8	8	8	8	8	8	8	8
Peak inf pres / PEEP	—	20	20	19	19	19	19	19	19	19	19	19
MODE - S(pon), A(ssist), C(on)	S	A C	C	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	38	36	35	34	32	31	30	30	31	31	30	30
BP/oth	FIO2 (Frac or %)	.57	.57	.57	.57	.57	.57	.57	.57	.57	.57	.57	.57
ART line	SpO2 (%)	99	99	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	36	36	36	36	36	36	36	35	35	35	35	35
	N-M Block (T/4)	4/4	0/4	0/4	0/4	4/4	0/4	0/4	0/4	0/4	0/4	0/4	1/1
Warming blkt													
Conv warmer													

Mark with letters & symbols, explain under REMARKS EVENTS → *Position*

TOTALS	TOTAL EBL
	TOTAL URINE

FLUIDS - SUMMARY

CRYSTALLOID-

COLLOID- 0

BLOOD- 300

REMARKS

Code drugs with numbers, events with letters

Surgical Theatre 1
Supine. Head on pillow
EKG leads II, 5 lead
Apnea, arms at sides. 100% O2. Induction smooth atraumatic
8.0 ETT OW 885x2 apices
ETCO2 waveform
20g Venous A-line
(LD) by 3 attempts
sutures 050 applied

RECOVERY AT

PACU ICU ____ (Specify)

OTHER ____

CONDITION:

RESP- 16 SpO2- 0/9

BP- 108/72 HR- 75

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0745	0810	1345
	Ready	Begin	End
PROC	0900	0915	1315

PROCEDURES and CPT Codes:

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted]

b(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

IV- Induction b(6)-2

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

GA ETT 8.0 MMETT OW 885x2 apices ETCO2 (+)

SURGEONS: DR [redacted]

ANESTHETISTS: [redacted] CRNA

PROCEDURE LOCATION: 01

DATE: 14 Jan 04

PAGE 1 OF 2

Tourniquet 250mm Hg

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "T" = CONSTANT INFUSION

DRUG	(Units)												
Propofol	( )												
MS	( )	5	5							10			
Vecuronium	( )		2		2		2						
Lidocaine	( )												
Neo/Glyco	( )											4/8	
Fentanyl	( )									250			
VOLAT AGENT	% del												
	% e.t.	0.8	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0			
AIR	L/Min												
N2O	L/Min												
O2	L/Min	1.0	1.2	1.2	1.2	1.2	1.2	1.2	1.2	1.2			

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →

TOTALS	TOTAL EBL
190	200
28	
28	TOTAL URINE
190	
4/8	Ø
250	

FLUIDS - SUMMARY

CRYSTALLOID- 2000

COLLOID- Ø

BLOOD- 300

FLUIDS

LINE site TRIPW	☐ Warmed	1500	1500	1500	1600	1600	1600	1600	1600	1600	1700	1900	200
PRBC	☐ Warmed												
LR	☐ Warmed	—	—	200	—	—	300	300	—	—	—	—	—
	☐ Warmed												

LOSSES

EST BLOOD LOSS		—	—	—	200	—	—	—	—	—	—	—	—
URINE -		—	—	—	—	—	—	—	—	—	—	—	—

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 120 KG (LB)

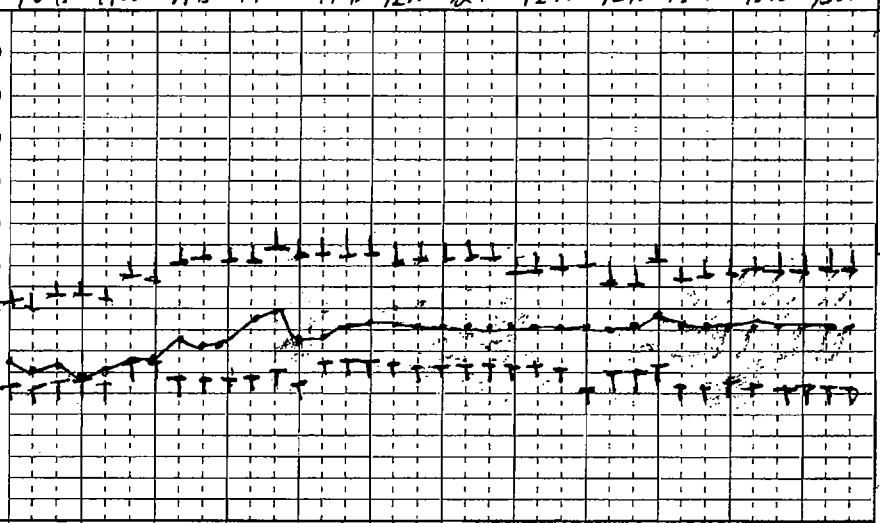
HEMATOCRIT: 8.2 / 24.2

INITIAL DATA: BP- 124/84 / HR- 75-95

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? yes TIME- 0745

SYMBOLS: BP by cuff V ∧; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-Ø



VENTIL

VT - ml	660	660	630	650	650	650	650	650	650	780	780	780
f - breaths/min	8	7	7	7	7	7	7	7	7	6	6	6
Peak inf pres / PEEP	18	18	17	17	17	17	19	19	19	21	21	21
MODE - S(pon), A(ssist), C(on)	S	S	S	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	28	29	32	32	32	32	31	31	31	32	32	32
BP/oth	FIO2 (Frac or %)	.60	.60	.60	.60	.60	.60	.60	.60	.60	.60	.60	.60
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	35	35	35	35	35	35	35	35	35	35	35	35
	N-M Block (T/4)	0/4	1/4	0/4	1/4	1/4	0/4	1/4	1/4	2/4	4/4	4/4	4/4
Warming blkt													
Conv warmer													

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 0 1 —

REMARKS

Code drugs with numbers, events with letters

↑ 11:08 TT = 120mm
↓ 1308

PRBC infused
Tourniquet thigh 1 hr (60min)
Surgeons infiltrate 1208PM.
90min surgery time 1238PM
Procedure Dr
Awake
Given T4 4/4
RAVSS
AA OX 3
Sitts, Sound

RECOVERY AT

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- 16 SpO2- 99

BP- 108/78 HR- 75

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0745	0810	1348
	Ready	Begin	End
PROC	0900	0915	1315

PROCEDURES and CPT Codes: COMPLETION AAA. FLAP. 5156 OKIF (2) RADIUS, T FIBULA, ILIAC CREST BONE GRAFT.

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility

[redacted]

b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

IV - INHALATIONAL

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

GA ETT 5.0 ASA I

SURGEONS: [redacted] b(6)-2 / [redacted]

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR

DATE: 14 Jan 04

PAGE 2 OF 2

DA FORM 7389, FEB 1998 — COPY 3 - ANESTHESIA DEPARTMENT — USAPA V1.00

518-124 NSN 7540-00-634-415

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of _____ units)
- [ ] CRYOPRECIPITATE (Pool of _____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) _____

VOLUME REQUESTED (If applicable) _____ ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 14 JAN 04

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN (Print) [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE TRAUMA.

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient [redacted] the specimen tube label to b

[redacted] VERIFIER [redacted] b(6)-2

[redacted] VERIFIED 14 JAN 04

TIME VERIFIED 0840

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(6)-4 [redacted]

ABO O

Rh Pos

TRANSFUSION NO.

PATIENT NO.

RECIPIENT

ABO O

Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN N/A

CROSSMATCH Comp b(6)

[redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONE[redacted]

REMARKS: Exp 14 Jan 04

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DATE

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature) [redacted] b(6)-2

TIME (Hour) 1000 ON (Date) 14 Jan 04

IDENTIFICATION

I h[redacted] Blood Component container label and this form and I find all info[redacted] the container with the intended recipient matches item by item. [redacted] the person named on this Blood Component Transfusion Form and [redacted] ation tag.

[redacted] (Signature)

[redacted] T, AN, CRNA b(6)-2

[redacted] MAS AN, CRNA

PRE-TRANSFUSION

TEMP. 36. PULSE 89 BP 128/74

DATE OF TRANSFUSION 14 Jan 04 TIME STARTED 1000 AM — 1130 AM

POST-TRANSFUSION DATA

AMOUNT GIVEN 300 (TOTAL) ML

TIME/DATE COMPLETED/INTERRUPTED 14 JAN 04

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 36 PULSE 87 BLOOD PRESSURE 120/71

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)

- [x] NO
- [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE b(6)-2 [redacted] MAS/AN/CRNA

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle, grade, rank, rate; hospital or medical facility)

SEX M

WARD OR

#[redacted] b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-

Medical Record Copy

MEDICAL RECORD - DOCTOR'S ORDERS

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen.		
3	Morphine / Meperidine 1-2 mg IV now and 2 mg q 3-5 min prn pain for a		
	max dose of 15 mg.		
4	~~Zofran 4 mg~~ IV prn N/V q 15 min, may repeat x ____. [redacted]		
5	Metoclopramide____mg IV prn N/V x 1.		
6	Droperidol .625 mg IV prn N/V x 1.		
7	Phenergan____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF:_____@_____cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted]		

PATIENT IDENTIFICATION

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC V1.00

b(6)-2 ATL unless marked otherwise

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]			11JAN04	1100 HOURS	
			CXR Port for Line Placement		
			[redacted]		
NURSING UNIT	ROOM NO.	BED NO.			
ICW1	240/	2320/1 [redacted]			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
b(6)-4 [redacted]			12JAN04	10:30 HOURS	
			- XRAY - AP+LAT		
			(R) forearm		
			[redacted]		
NURSING UNIT	ROOM NO.	BED NO.			

noted 12Jan04 1030 [redacted] DLT

[redacted]

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
b(6)-4			13JAN04	2000 HOURS	
# [redacted]			NPO F MN + CBC		
			Vo: DR [redacted]		
NURSING UNIT	ROOM NO.	BED NO.			

noted 13Jan 2030

[redacted]

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

b(6)-2; A/I unless marked otherwise

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]					HOURS	
				✓ - Resume fluid medication,		
				✓ Diet, & activity		
				- No dressing b's-to (R) arm until 1/19/04, (L) Arm 1/16/04, (L) leg 1/16/04, (R) abdomen 1/16/04		
NURSING UNIT	ROOM NO.	BED NO.				

noted 14Jan04 [redacted]

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
				14Jan04	1700 HOURS	
				V.O. - Dr [redacted] / LT [redacted]		
				MSO4 2-8mg IVP Q3° PRN PAIN		
				Demerol 50-75mg IV Q3° PRN		
NURSING UNIT	ROOM [redacted]	BED NO.				
				24° ✓ 15 JAN04 0320 [redacted] LT.AN		

noted 14Jan04

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
24 05 04 [redacted] STAN				05-04 2320	HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

- [redacted]

b(6)-6

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
1-15-04	1-15-04 HOURS	
- Transfer ICW-2 Dr. [redacted]		
- stable		
- Routine vitals		
- OOB and ambulate c assistance		
- Assist c voiding		
- Central line care c sterile dressing 1's q 3 days		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NOT [redacted] b(6)-2

1245 15 Jan 04

DATE OF ORDER	TIME OF ORDER	
- Dressing D (dry) (L) Arm, hip, leg, abdomen qD Neg. 1/Ke	HOURS	
- OOB to chair QID		
- Regular Diet		
- Record output JP drain q Shift		
- Percocet II PO q4h prn pain		
- Demerol 75 mg IV q4h prn breakthrough pain		
- Phenergan 25 mg IV q6h prn nausea		
- Neurontin 300 mg PO TID		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	
- Zantac 150 mg PO BID		
- Maalox 30 cc PO q6h prn upset stomach		
- Aspirin 325 mg PO qD		
- Augmentin 500 mg PO TID		
- Metformin 2 gm IVPB q8h b(6)-2		
- Colace 100 mg PO BID		
- Ambien 10 mg PO QHS [redacted]		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

CW [redacted]

b(6)-6

DATE OF ORDER	TIME OF ORDER	
	HOURS	

NURSING UNIT | ROOM NO. | BED NO.

ICW2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT: 1 W2 | ROOM NO. | BED NO.

DATE OF ORDER: 1-22-04 | TIME OF ORDER: 1330 HOURS | LIST TIME ORDER NOTED AND SIGN

- D/C to home
- Remove staples (L) hip, (L) Arm, (L) leg
- Continue Augmentin 500 mg po TID
- Provide Kerlex roll, fluffs, and bacitracin for daily dressing Δ's x 1 week.

PATIENT IDENTIFICATION

b(6)-2 NOTED [redacted] 225 Ambulit

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

- Pt may bath at home.
- F/u 1 week (1-29-04)
- D/C central line [redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

b(6)-2 A11

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. JAN Yr. 04

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17	18	19	20	21	22						
15	[redacted]	Vital Signs (q 8) / q 6 / q 4	D	[redacted]													
		Routine	E														
			N														
15	[redacted]	Activity: OOB AND AMBULATE	D	[redacted]													
		c̄ ASSISTANCE	E														
		ASSIST c̄ VOIDING	N	[redacted]													
15	[redacted]	Diet: (Regular) / Clear Liquids / Advance	B	[redacted]													
		as tolerated / Other _____	L	[redacted]													
			D	[redacted]													
		NIO: Time/date IV site and change q 72 hours and prn	10	[redacted]													
		NIO: Time/date IV tubing and change q 72 hours	10	[redacted]													
		NIO: Complete skin assessment on admission/transfer, q 7 days and prn	10	[redacted]	X	X	X	X	X	X	X	X	X	X	X	X	X
15	[redacted]	CENTRAL LINE CARE c̄ STERILE	10	[redacted]													
		DRESSING Δ's q̄ 3 DAYS															
15	[redacted]	DRESSING (DRY) (L) ARM, HIP, LEG	10	[redacted]													
		ABDOMEN q̄ D															
15	[redacted]	OOB TO CHAIR QID	D	[redacted]													
			E														
			N	[redacted]													
15	[redacted]	RECORD OUTPUT SPRAI q̄ SHIFT	D	[redacted]													
			E														
			N	[redacted]													

DCed

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: ICW 2

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: b(6)-4 [redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
15	[redacted]	Admit to ICW 2. Dr. OLIVARIO	15 JAN	—		[redacted]
15	[redacted]	Condition: STABLE	15 JAN	—		[redacted]
22	[redacted]	D/C TO HOME	22 JAN			
22	[redacted]	REMOVE STAPLES @ MID LOWER LEG		DONE		[redacted]
22	[redacted]	CONT AUGMENTIN 500mg TID		DONE		[redacted]
22	[redacted]	F/U 1 WK				
22	[redacted]	D/C CENTRAL LINE		DONE		[redacted]
22	[redacted]	KEFLEX ROCL FLMFFS & BACITRACIN FOR DAY				
~~22~~		DSGA's x 1 wk				
22	[redacted]	PT MAY BATHE AT HOME	22 JAN			
~~22~~						
		b(6) 2 ATI				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													

USAPA V1.00

b(6)-2 A21

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 01 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	06	07	08	09	10	11	12	13	14	15	16	17	18
28DEC	[redacted]	Routine vitals	06-14	[redacted]												
			14-22													
			22-06													
28	[redacted]	keep elbow bent &	06-14	[redacted]												
		supported w/ all	14-22													
		times	22-06													
	[redacted]	apply splint q 8-10	06-14													
		w/ NS/Betadine	16													
			24													
	[redacted]	call dr. if pt R arm	10	[redacted]												
		and red fab c saline														
		irrigation														
28	[redacted]	OOB to chair · amb	06-14	[redacted]												
		c arm support	14-22													
			22-06													
28	[redacted]	Regular diet	06-14	[redacted]												
			14-22													
			22-06													
28	[redacted]	central line dsg Δs	20	[redacted]			[redacted]			[redacted]			[redacted]			
		(sterile) q 3 days														
04 JAN	[redacted]	N10: Falls assessment	10					/	[redacted]	/					/	
		Q7D														
4Jan	[redacted]	Record JP output Q	06-14										[redacted]			
		shift (N10)	14-22								/	[redacted]				
			22-06								/	[redacted]				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ABD FLAP · RUE
S/P BUE EX FIX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-1

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

b(6) 2 A1

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 01 Yr 2004 ~~2003~~
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11	[redacted]	PCXR	11JAN	1100		
12	[redacted]	AP/LAT (L) Fore Arm	12Jan	—		[redacted]
13	[redacted]	NPO p̄ MN	14JAN	0001	0001	[redacted]
13	[redacted]	CBC	14JAN	0500	0500	[redacted]
13	[redacted]	Resume pre-op medications, diet, & activity	14Jan	—	—	[redacted]
14	[redacted]	No dressings Δ's for (R) arm until 1/19/04,	14Jan	—	—	[redacted]
	----	(L) arm 1/16/04, (L) hip 1/16/04, (R) abd 1/16/04	—	—	—	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															

USAPA V1.00

b(4)-2 A1

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 01 Yr. 04

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11	12	13	14	15	16	17	18	19	20	21	22	23	24
28Dec	[redacted]	Neurontin 300mg PO	06	[redacted]													
	-----	TID	14														
	-----		22														
30Dec	[redacted]	Metoxin 2gm IVPB	06														
	-----	Q8°	14														
	-----		22														
28Dec	[redacted]	ASA 325mg TPO QD	08														
28Dec	[redacted]	Zantac 150mg PO	08														
	-----	BID	20														
28Dec03	[redacted]	Augmentin 500mg PO	06														
	-----	TID	14														
	-----		22														
28Dec	[redacted]	Colace 100mg PO BID	08														
	-----		20														
28Dec	[redacted]	Ambien 10mg PO QHS	22														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (B) UE Ex-fix, S/P STSG

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

b(4)-1

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 01 Yr. 04
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
14Jan	[redacted]	Resume pre-op meds, diet, & activity	14Jan	—	—	[redacted]
		b(6)-2 A11				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
28Dec	[redacted]	Percocet II PO Q4° PRN	D/T	14JAN 1200	13JAN 1100	13Jan 1530	15JAN 0200	15JAN [redacted]								
		temp >100.5° or Pain	D/I	II	II	2	II									
28Dec	[redacted]	Demerol 50-75mg IV Q3°	D/T	12Jan 1600	12Jan 2000	13Jan 1600	13Jan 2035	14JAN 0025	14Jan 1600	14Jan 2000	15JAN 0004					
		PRN breakthrough pain	D/I	50mg	50mg	50mg	50mg	75mg	75mg	25mg	30					
28Dec	[redacted]	Phenergan 25mg IVP Q6°	D/T	14Jan 1600												
		PRN nausea	D/I	25mg												
28Dec	[redacted]	Maalox 2TBSP PO Q6°	D/T													
		PRN	D/I													
14Jan	[redacted]	MSO4 2-8mg IVP @ 1°-2° PRN pain	D/T	14Jan 1715	14Jan 2000	14Jan 2200	15JAN 0000	15JAN 0300	15JAN 0550	15JAN 0730						
			D/I	8mg	2mg	6mg	8mg	7mg	5mg	X						

*U.S. GPO: 1998-454-110/95216

b(6)-2 A1

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. Jan Yr. 04

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18	19	20	21	22
15	[redacted]	NEURONTIN 300mg PO TID	06	[redacted]							
	-----		14	[redacted]							
	-----		22	[redacted]							

15	[redacted]	ZANTAC 150mg PO BID	08	[redacted]							
	-----		20	[redacted]							

15	[redacted]	ASPIRIN 325mg PO QD	10	[redacted]							

15	[redacted]	AUGMENTIN 500mg TID	06	[redacted]							
	-----		14	[redacted]							
	-----		22	[redacted]							

15	[redacted]	COLACE 100mg PO BID	08	[redacted]							
	-----		20	[redacted]							

15	[redacted]	AMBIEN 10mg PO QHS	22	[redacted]							

	-----	MEFOXIN 2gm IVPB q8°	06	[redacted]							
	-----		14	[redacted]							
	-----		22	[redacted]							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. ____ Yr. ____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	

blw 2 ml

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
15	[redacted]	Percocet 1/1 PO q 4° PRN	1230 15 Jan	1·15 2005	1·15 [redacted]	1·15 [redacted]	16 Jan 1205	16 Jan 1615	16 Jan 2000	17 Jan 0800	17 Jan [redacted]	17 Jan 0230	18 Jan 1020	18 Jan 2230	19 Jan 0550	19 Jan 1000
		PAIN	1/1 1/1 703	1/1 [redacted]	1/1 [redacted]	0445 1/1 PO	1/1 PO	1/1 PO	1/1 PO	1/1 PO	1/1 PO	1/1 PO	1/1 PO	1/1 PO	1/1 PO	1/1 PO
15	[redacted]	Demerol 75mg IV q 4°	15 Jan 1351 75mg	[redacted]												
		PRN BREAKTHROUGH PAIN	[redacted]													
15	[redacted]	Phenergan 25mg IV	15 Jan 1355 25mg IVP													
		q 6° PRN NAUSEA	[redacted]													
15	[redacted]	Maalox 2 TBSP PO q 6°														
		PRN UPSET STOMACH														
15	[redacted]	MSO4 2-8mg IVP	1·15 1534	1·15 2110	1·15 0530	1·19	16 Jan 1300	16 Jan 1615	16 Jan 2330	18 Jan 0330	18 Jan 1020	18 Jan 1830	18 Jan 2100	1·19 2015	19 Jan 2330	20 Jan [redacted]
		Q 1-2° PRN Pain	8mg IVP	8mg IVP	8mg IV		5mg IVP	5mg IVP	6mg IV	5mg IV	5mg IV	5mg IV	5mg IV	5mg IV	5mg IV	033
			[redacted]				[redacted]									
1·19	[redacted]	Percocet 1/1 Q 4° PRN	1·19 1534	19 Jan 2230	20 Jan 0700	21 Jan 0930	21 Jan 2030	22 Jan 0330								
		Pain.	1/1 [redacted]	1/1 PO [redacted]	1/1 PO	1/1 [redacted]	1/1 [redacted]	1/1 PO [redacted]								

*U.S. GPO: 1996-454-110/95216

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DA...

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: Post-Anesthesia Care Unit (PACU) Flow Sheet — OTSG APPROVED (Date)

Completion ABD Flap, Fibular Tibial Bone

Date: 14 JAN 04
Time In: 1745
Allergies:
Pre-op V/S:
Procedures:
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 2L Colloid
OR Output: UOP EBL 200
Meds/Times: 30 MSO4 5 mg Fent Vec Rocuro 1 propofol

Drains: Hemovac, NG, JP, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds 1gm Ancef 100 History

Time																
SaO2																
FiO2																
Methods																
240																
220																
200																
180																
160																
140																
120																
100																
80																
60																
40																
20																
RR																
T																
Time																
Pain (0-10)																
LOS																

124/89

75%

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1410	NS	450	L Arm	[redacted]	

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	1	1
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	1	1	1
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	9	9

Codes:
AIRWAY: A = Ambu, BB = Blow-by, M = Mask, FT = Face Tent, RA = RoomAir, NC = Nasal Cannula
V/S: X = A-line BP, " = Cuff BP, = Pulse
TEMP: S = Skin, O = Oral, A = Axillary, T = Tympanic, R = Rectal
LOS: C = Cervical, T = Thoracic, L = Lumbar, S = Sacral

Patient teaching done: ~~Wound Care~~, Pain Management, T. C. & DB, Incentive Spirometer, Comfort Measures, Safety, SR up X 2, Falls Precautions, Privacy Maintained

(continue on reverse)

PREPARED BY: [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC: TRU 3

DATE: 14 JAN 04

PATIENT: [redacted] Name – last, first, middle, grade, date, hospital or medical [redacted] b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1410	[illegible]	[illegible] 2mg	IV			[redacted]
1425	↓	[illegible] 2mg	IV			
1445		[illegible] 2mg	IVP	—	—	
1450	—	[illegible] 2mg	IVP	—		

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(x4 ep)	—	+	+	<3	cool	[illegible]
15'							
30'							
45'							
60'							
90'							
D/C							

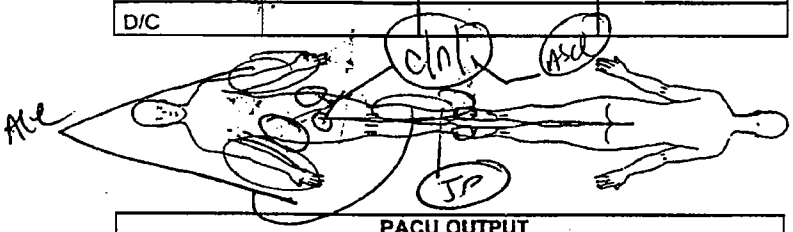
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1715	JP	bloody	25

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt received for or. Pt c/o [illegible] pain; [illegible] [illegible] on UL leg, will decrease as [illegible] [illegible] D/C'd [illegible] [illegible] for. [illegible] @ 1350. [illegible] [redacted] [illegible] [illegible]. [illegible] x3 [illegible] intact; [illegible] [illegible]; [illegible] 95°. [illegible] [illegible] [redacted]

1425: 2mg IVP [illegible] for [illegible] [illegible]. [redacted]

b(w)-2 All

Discharge Criteria:
Date: 14 JAN Time: 1515 PARS: 9
BP: 170/80 T: 96.5 HR: 94 RR: 10 Sa02: 97
Pain Level at D/C (0-10):
Intake: [redacted] Output: 25 (JP
Additional Data:
Transferred To: [illegible]
Report Given To: [redacted]
Transferred Via [redacted] Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recov[redacted]
Charge Nurse Signat[redacted]

b(2)-2

Admission and Discharge Information

For use of this form, see AR 40-400; the proponent agency is OTSG

1. Reporting MTF	2. MTF Location			
[redacted]	[redacted]			
3. Register Number	Name (Last, First, MI)		4. Pay Grade	5. Sex
[redacted]	[redacted]		FGN	M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1969-02-01	34Y	X	9	
10. Length of Service	ETS	11. FMP	12. Social Security Number	
		99	[redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission	Branch / Corps:
			23:00	
14. Flying Status	15. Beneficiary Category		16. Zip Code of Residence:	
	K78-PRISONER OF WAR/INTERNEES			
17. Unit Location	18. MOS	19. Trauma	Prev. Admission	
		DIS	NO	
20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee		
Direct from ER	ICU3	Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted]		Telephone Number of Emergency Addressee		
21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)		
HOME		2004-01-22		
24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)		
ABA - GENERAL SURGERY		2003-11-17		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission		
IZ		2003-11-17		

b(2)-2

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW L ARM/ABDOMIN

Procedure Narrative(s):

Cause of Injury Narrative:

Dx:
81250
81393
E9912
9571

Px: 7931
7961
7932
7962
7803
7779
0581
8069

Admitting Officer (Signature, as requi[redacted]	Signature of [redacted]
[redacted]	[redacted]

b(6)-2

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400, the proponent agency is OTSG

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted]	b(4)-4					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	24Y	X				NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted]	b(4)-4				ICU1	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
	K78-PRISONER OF WAR/INTER			BC			
21. Source of Admission		22. Hour Of Adm:	23. Clinic Service				
Direct from ER		23:00	AEA - ORTHOPEDICS				
24. Name/Relation of Emergency Addressee		25. Type Disp	26. Date of Disp				
		TRF-OTH	2003-11-25				
27a. Address of Emergency Addressee		27b. Telephone No	28. Date This Adm:	AdmittingOfficer:			
			2003-11-17	[redacted]			
29. [redacted]MTF			30. Date Init Adm	32. Units Blood Components			
[redacted] b(2)-2			2003-11-17				

31. Selected Administrative Data

Marital Status: DoB: 1979-06-16

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

S/P I & D L SHOULDER/ L RING FINGER PARTIAL AMP

(L) proximal humerus Fx

812.19
886.0
910.0
E991.2
(11/18) 79.61
(11/18) 84.01
(11/20) 79.61

DX	PROC.	T	I
8219			
8860	8401	1	450
9100	7961		
E9912			

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	9	9

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	9	9

Sign[redacted]ing Medical Officer b(6)-2

Signature of [redacted]

MEDCOM - 24743

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD | 0100 18 Nov ~~ABB~~REVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION (Enter date of admission)

25 y/o ♂ passenger in vehicle, shot ~ 4h ago

Medic dello PMH per apply ō med prob

GCS 15 130/80 110 20 100% ra

PHYSICAL EXAMINATION

cing - scalp abrasion
PERRL
mouth OK
neck - non tender
chest c clear
cv - ō (M)
abd - soft
ext - stable
rectal - good tone

ext - RUE, LLE OK
RLE puncture wound mid lg
xLNT pulse bil LE
xLNT (L) radial
Ax prox LUE (proximal humerus shaft, radial/median/ulna n. intact, Ax 4th digit
rec'd Anvil pins to animal
rec'd ATTA tape

PROGRESS (Enter date of discharge and final diagnosis)

A - 25 y/o ♂ shattered proximal humerus (L) 4th distal digit fx/f
px wound RLE (xLNT pulse

17 14/45 203 142/106 3.8/23 PT16 PTT35 anyl 1A BUN 14

P - OR per ortho

head CT nl
CXR OK? right top on (L) crest 1,2
[redacted] b(6)-2

SIGNATURE OF PHYSICIAN | DATE | IDENTIFICATION 18 Nov | ORGANIZATION

PATIENT IDENTIFICATION (For typed or written entries give name last, first, middle; grade, date, hospital or medical facility)

REGISTER NO | WARD NO

[redacted] b(6)-1

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR 41 CFR 201-45.5
OCTOBER 1963
USAPPC (1 00)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

b(6)-2 Ant

DATE	NOTES
18 Nov 03 0615	Received report + care of patient from previous shift [redacted] SK LPN
0930	Pt c/o pain to (R) shoulder + received 5mg MsO4 for pain control. VSS. Will cont to monitor [redacted]
1100	Pt c/o pain and received 5mg MsO4 for pain control VSS. Will cont to monitor [redacted]
1400	Pt VSS c/o pain and received 5mg MsO4 for pain control will continue to monitor [redacted] SK LPN
1600	Pt VSS. Pt c/o pain and was given 5mg MsO4 for pain control will cont to monitor [redacted]
1800	Report + care of pt given to oncoming shift [redacted] SK LPN
1820	Report recieved from PFC [redacted]
1830	Received report on Pt-1340. PT stable at this time. PT request interpreter. Will continue to monitor. [redacted] LT/AW
1900	5mg morphine given. [redacted] LT/AW
2000	5mg morphine given. PT temp 102. MD aware. states to encourage incentive spirometry ~~Abx~~ already started. [redacted] LT/AW

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.

WARD NO. ICU 1

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

[redacted]

b(6)-4

b(6)-2 A-11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0200	PT repeatedly keep asking for pain medication 2mg given - PT is drowsy but arousable and RR dropping below 8. Will hold all medication for atleast the next 4hrs. [redacted]
0400	Morning Labs drawn. [redacted]
0600	T. 102.5. 1000mg Tylenol given [redacted]
0615	Received report + care of pt. from previous shift. [redacted]
11/19/03	[illegible] - H/P 11/36. T: 100.8 - decreased urine output - D/C Foley, new RRA, [illegible] [redacted]
1800	PT VSS. & c/o pain or distress. T. 101.5 pt. given 1000 mg Tylenol. will continue to monitor [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

b(a)-2 #11

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
19NOV03	(1715) Pt admitted to unit via WIC in stable cond. Pt alert, speaking Arabic. VSS. ℥ temp 101.3. Pt medicated c̄ ⅋ Percs for temp and pain. Temp @ this time 100.8. @ femoral cath is dlcd - cathete intact. 20g IV started in ® forearm - sld - flushe ⅋ slsx infiltration. Pt amb in hallway. WE in sling. Hemovac intact draining sm. amount sero. sang drainage. 2 point restraints intact ⅋ slsx complications. Will cont. to monitor. [redacted]
19Nov03 2110	Assumed Pt care 1800. A&O. Able to communicate needs. Temp 101.8 @ 1900. @ 2030 101.4. Encouraged IS To Pt 10x hr while Awake. Will monitor temp. Pt c/o pain in ® Shoulder. 2 percocets given. 20G IV R EA flushe & Patent. Drsg to R shoulder CDI. RUE in sling. Hemo vac to R shoulder. Will cont [redacted] Spec 91WM6
20nov03 @ 1100	Pt c/o, temp 100.8, ⅋ Percocet given for c/o pain to ® shoulder. ® arm in sling, hemovac in-tact draining small amt. bloody drainage. drsg to ® shoulder, ∅ shadowing or drng seen thru drsg. IS use encouraged. ⊕ pulses to ®

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO. | WARD NO.

[redacted] b(a)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1995)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(6)-2 A11
	(con't)
20NOV03 @ 1100	UE. brisk cap refill. Pt amb x2, had Bm x1, brown & formed. drsg to (L) ankle & ⓓ, dry drsg applied. (+) edema (non-pitting) to (B) feet. elevated, NPO for OR today. (Pt consumed a piece of turkey bacon & sips of H2O this AM, although NPO). MD aware. Will monitor [redacted] LPN.
1720	Pt back from PACU, S/P I&D (L) shoulder, A&O, VSS & temp 99.2, Ø c/o pain. bulky drsg to (L) shoulder, hemovac intact, bloody drainage in tubing. Tol fluids & PO well. Will monitor [redacted] 91WMB.
20Nov03	Assumed care @1800. A&O VSS. Demerol & Phergan for pain. LS CTA (B). HRRR. (+) BS x4 quads. Voids spontaneously c/o. (R) shoulder Drsg CDI. Hemovac in place. Drsg [redacted] (R) LE CDI. Will cont to monitor. [redacted] 91WM4
21NOV03 0835	Pt A&O, VSS & temp 99.1, medicated c̄ Percocet for pain to (L) shoulder. (L) shoulder c̄ bulky drsg CDI. Hemovac intact draining bloody fluid. 95cc emptied @0700 this am. (+) pulses to (B) UE, brisk cap refill. ~~pt does not move (L) arm or hand~~ (EFFOR [redacted]), (L) arm in sling. pt able to move fingers c̄ difficulty. Pt does not move (L) arm or hand d/t pain. Pt tol. Reg diet well, consumed 50% of breakfast this AM. AM care provided. IV ancef & levaquin cont per MD orders. Will monitor [redacted] 91WMB.

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.0

[redacted] b(6)-1

b(6)-2 +1

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
21 Nov 03 2300	Pt A&O VSS. C/O pain controlled c̄ percocet. Drsg to (L) shoulder CDI c̄ removal. Neuro V to (L) hand WNL. Lung sounds CTA Bilaterally. S_1 S_2 present. HRRR. (+) BS x4 quads. Pt void spontaneously c̄ difficulty. Pt recieved Ambien for insomnia. Ineffective. Pt pulled IV out of (R) FA. Will cont to monitor [redacted] Spec 9 WMC
22 NOV 03 1600	Assumed care of pt. @ 0600. VSS, A&O. C/O pain to (L) shoulder frequently. ⅐ Percs x 2 this shift for pain. Physical therapist A'd DRSNG to (L) shoulder & removed hemvac drain, staples intact to (L) shoulder incision, Ø drainage, edges well approx, Ø S/Sx of infection. Pt. ambulates c̄ difficulty to BR and is hobbling (L) arm is sling, elevated in bed. Moved @ bedside → CYU. New IVSL to (R) hand, 20G, flushes well. Pt. is 3-point restraints, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted] 2CE ARC
22 NOV 03 1900	VSS (L) shoulder drsg dry/intact. (L) arm sling intact (L) radial pulse palpable +2. (R) hand distal limb pink/intact. 2+ restraints implace without compromise circulation or skin integrity. Vrdy clear —

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	over
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

[redacted] b(6)-4

MEDCOM - 24749

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	(Continued) NOTES b(6)-2 A11
22NOV03 (1900)	yellow urine. No c/o pain or discomfort @ this time [redacted]
23NOV03@1600	VSS. A&O. Ø c/o pain this shift. Dressing to shoulder intact, small amount of serous drainage to del removal site. (L) arm in sling & elevated on blankets. 2+ pitting edema to (L) UE. Pt. OOB to BR, ambulates ∓ assist. Pt. in 2-point restraints. Ø signs of skin breakdown. Friend @ bedside. CTU. (+) BS all 4 quads. All other assessments WNL. [redacted]
23NOV03 1900	VSS Alert & Oriented (L) shoulder dry dry & intact. (L) UE ∓ sling in place. (L) Radial pulses palpable +2. OOB → BR Consumed 80% of Regular diet for ~~[illegible]~~ dinner. Percocets effective for pain management. HOB ↑ 15°. 2 point restraints in place with out compromising circulation or skin integrity. Will continue plan of care. [redacted]
23NOV03@1500	Assumed care of pt. @ 0600. VSS. A&O. (Ø) c/o pain. Pt OOB → shower this AM. Staples to (L) shoulder intact, Ø drainage. (L) UE in sling, elevated in bed. 2+ pitting edema to (L) hand. Pt. ambulates ∓ difficulty in hallway. Pt. in 2-point restraints, Ø sign of skin breakdown. All other assessments WNL. 20G to (R) hand NSL, flushes well. Will cont. to monitor. [redacted]

#[redacted]

b(6)-4

STANDARD FORM 509 (REV. 5/1999) BACI
USAPA V1.0

Medical Record Progress Notes

Braden Scale Evaluation

Date: 24Nov03

Sensory Perception	No Impairment	4	Mobility	No Limitations	4
	Slightly Limited	3		Slightly Limited	3
	Very Limited	2		Very Limited	2
	Completely Impaired	1		Completely Immobile	1
Moisture	Rarely Moist	4	Nutrition	Excellent	4
	Occasionally Moist	3		Adequate (Eats >50%)	3
	Moist	2		Adequate (rarely eats)	2
	Constantly Moist	1		Very Poor	1
Activity	Walks Frequently	4	Friction and Shear	No Apparent Problem	3
	Walks Occasionally	3		Potential Problem	2
	Chairfast	2		Problems	1
	Bedfast	1			

Total Score: 20

Above 20	Low Risk
16-19	Med Risk
11-15	High Risk
Below 10	Very High Risk

Score <15 requires Immediate Ulcer Prevention Program

Date: _____

Sensory Perception	No Impairment	4	Mobility	No Limitations	4
	Slightly Limited	3		Slightly Limited	3
	Very Limited	2		Very Limited	2
	Completely Impaired	1		Completely Immobile	1
Moisture	Rarely Moist	4	Nutrition	Excellent	4
	Occasionally Moist	3		Adequate (Eats >50%)	3
	Moist	2		Adequate (rarely eats)	2
	Constantly Moist	1		Very Poor	1
Activity	Walks Frequently	4	Friction and Shear	No Apparent Problem	3
	Walks Occasionally	3		Potential Problem	2
	Chairfast	2		Problems	1
	Bedfast	1			

Total Score: _____

Above 20	Low Risk
16-19	Med Risk
11-15	High Risk
Below 10	Very High Risk

Score <15 requires Immediate Ulcer Prevention Program

Patient ID:

Unit No. _____
Standard Form 509

EPW [redacted] b(a)-4

Medical Record **Progress Notes**

Wound and Skin Assessment

Date and Time 24Nov 03 Wound number 1
Stage I-IV — Surgical or Non-Surgical
Location Shoulder
Shape linear Measurements approx 5inches
Tissue Color pink/well approximated
Drains and Type Ø
Drainage (amt and color) Ø
Dressing Type staples OTA
Dressing Change Frequency — Wound Cleansing Ø
Additional Info (turning, elevation of extremeties, etc.) Ø

Date and Time _____ Wound number _____
Stage I-IV _____ Surgical or Non-Surgical _____
Location _____
Shape _____ Measurements _____
Tissue Color _____
Drains and Type _____
Drainage (amt and color) _____
Dressing Type _____
Dressing Change Frequency _____ Wound Cleansing _____
Additional Info (turning, elevation of extremeties, etc.) _____

Date and Time _____ Wound number _____
Stage I-IV _____ Surgical or Non-Surgical _____
Location _____
Shape _____ Measurements _____
Tissue Color _____
Drains and Type _____
Drainage (amt and color) _____
Dressing Type _____
Dressing Change Frequency _____ Wound Cleansing _____
Additional Info (turning, elevation of extremeties, etc.) _____

Patient ID: Unit No. _____
Standard Form 509

EPW

[redacted]

b(6)-4

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 24 Dec 2003 | PATIENT ACUITY LEVEL: II | POST-OP DAY: / | HOSPITAL DAY: —

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:																
BP ARTERIAL LINE																
BP CUFF																
TEMPERATURE																
PULSE																
RESPIRATORY RATE																
OXYGEN (L/%)																
PULSE OXIMETER																
O_2 METHOD																

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:									
PAIN INTENSITY (10 / 5 / 0)									
MED ADMINISTERED (Y/N)									
RELIEF ACCEPTABLE (Y/N)									

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)									

SPECIAL NEEDS

TIME:			
*Skin breakdown prevention			
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

EPW [redacted] b(6)-1

DIAGNOSIS: S/P I&D L Shoulder / Bring finger amputation

DRG: _____ ADMISSION DATE: 2

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted] b(6)

ISOLATION REQUIRED (*Specify*): [redacted]

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐	☐	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☐	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☐	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☐	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____
IV site care provided: _____	IV site care provided: _____	IV site care provided: _____
IV tubing changed: _____	IV tubing changed: _____	IV tubing changed: _____
LOCATION CONDITION	LOCATION CONDITION	LOCATION CONDITION
IV Site #1: _____ _____	IV Site #1: _____ _____	IV Site #1: _____ _____
IV Site #2: _____ _____	IV Site #2: _____ _____	IV Site #2: _____ _____
Comments:	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:			
ID band visible/legible			
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT _____	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT _____	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT _____

TEACHING

TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
CONTENT:	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

EPW

[redacted] b(6)-4

INITIALS	SIGNATURE	SHIFT

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
				b(6)-2

SECTION IV - NOTES

1300: PT D/c'd. to camp in stable cond. [redacted]

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 24 Nov 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: — | HOSPITAL DAY:

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time 1600 To ICW2 From ICW1 ☒ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (*Specify*): _____

Procedure/Diagnosis (L) shoulder / (R) finger partial amp B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast Staples to (L) shoulder / drsg to hemorrage site Tubes _____

Intake (IV, po) 200g (R) hand Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other (L) arm elevated / in sling / 2+ pitting edema

Report From LT [redacted] b(6) Received By LT [redacted]

VITAL SIGNS

TIME:	1730	0400													
BP ARTERIAL LINE															
BP CUFF	140/109	99/67													
TEMPERATURE	99.3	97.6													
PULSE	84	88													
RESPIRATORY RATE	16	16													
OXYGEN (L/%)															
PULSE OXIMETER	98%	96													
O2 METHOD	RA	RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	1730	2300						
PAIN INTENSITY (10 / 5 / 0)	X	A						
MED ADMINISTERED (Y/N)	N	Y						
RELIEF ACCEPTABLE (Y/N)	NA	Y						
Tylenol		650mg						

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	1730		2300
*Skin breakdown prevention	NA		NA
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

EPW # [redacted] b(6)-4

DIAGNOSIS: S/P I&D (L) shoulder / (R) ring finger partial amp

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1730 INITIALS: [redacted]	TIME: INITIALS:	TIME: 0200 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☐	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑ b/u x2 AM	☐	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ ↓ ROM to (L) shoulder 2° to GSW; (L) arm in splint	☐	☐ ↓ ROM (L) shoulder GSW (L) Arm C sling Staples
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Dsg to (L) hand CDI, dsg to (L) shoulder intact	☐	☐ staples to (L) shoulder intact (+) 4 pitting edema (R) hand
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ see pg 1	☐	☐ see pg 1
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☑

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 1730 INITIALS: [redacted]	TIME: INITIALS:	TIME: 0200 INITIALS: [redacted]
IV patency ✓ q (8) hr:	IV patency ✓ q hr:	IV patency ✓ q 8 hr: PRN
IV site care provided:	IV site care provided:	IV site care provided: Assessed
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) FA / OK	IV Site #1:	IV Site #1: (R) FA / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: flushed	Comments:	Comments: SCCNS flushed

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (L) FA	TIME: 1730	0200				
COLOR	P	P				
CAPILLARY REFILL	2	2				
TEMPERATURE	W	W				
EDEMA	1	1				
SENSATION	S	S				
MOTION	M	M				
PASSIVE FLEXION	unable to move					
PERIPHERAL PULSE	2	2P				

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	1730		0200
ID band visible/legible	[redacted]		[redacted]
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: Reg
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: well
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☒ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☒ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: 1730 INITIALS: [redacted]	TIME: INITIALS:	TIME: 0200 INITIALS: [redacted]
CONTENT: - Call for assist - EPW restraints	CONTENT: b(6)-2	CONTENT: Call for assist
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
EPW #[redacted] b(6)-2	[redacted]	[redacted] LT/AN [redacted]/AN	D 9P/9A

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

24 Nov 03 1730 Pt transferred from ICW1 in Stable Condition Ambulatory at time of transfer. ☒ Questions or Concerns [redacted] MD/RN

b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

B/c Note

11/24/03 Frogi male sustained GSW to (L) shoulder and hand. Pt totally lost (L) proximal humerus from blast. Not a candidate for fusion or reconstruction. Needs humeral head prosthesis which is not available here. He will have good function at elbow and hand but shoulder motion will be severely limited. Pt also sustained partial ring finger amputation. Staples and sutures should be removed in 10 days. Continue oral antibiotics for two weeks. Keep incisions clean & dry.

[redacted]

b(6)-7

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* REGISTER NO. | WARD NO.

[redacted]

b(6)-1

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

C 0

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT FOR Use this form. See AR 40-407: the Proponent agency is The Office of the Surgeon General.
1. AGE 23 HEIGHT: ? WEIGHT: ?	2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodin, Tape, Medication) ☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD REACTION:
	3. PREVIOUS SURGERY [ ] NO [X] YES (type): APPY

4. PROPOSED SURGICAL PROCEDURE:
I&D (L) Shoulder / I&D (L) Ring Finger

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition multiple wounds
Tobacco 1 ppd X 10 vrs Body Piercing Ø Diabetes (Y) (N) ROM (L) Arm injury ASA/Motrin W 72hrs (Y) (N)
ETOH ? Implants Ø Respiratory Disease (Asthma COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X potential for anxiety related to: X 1) Surgical Procedure& Operating Room Environment X 2) Separation Anxiety (Child) X 3) Surgical Outcomes	O Pt. verbalizes any specific anxiety. O Pt. Exhibits relaxed body posture.	O. Allow pt. to verbalize freely. O. Explain Or environment and answer questions regarding surgery. O. Offer comfort measures. (e.g. warm blanket. touch). O. Explain all nursing procedures before they are done. O. Remain with pt. Whenever possible. O. Maintain family interface. Parents to stay with pt.
B. AERATION X Potential for respiratory dysfunction due to: X 1) Positioning X 2) Effects of Anesthesia X 3) Medical/Smoking History	O Pt. will be able to breath without difficulty during immediate intraoperative phase.	O. Offer to elevate head of litter or offer pillow. O. Observe pt. While awaiting surgery for signs of distress. O. Assist anesthesia during intubatior and extubation.
C. INTEGUMENT X Potential Impairment of Skin Integrity due to: X 1) Intraoperative Immobility X 2) ESU Pad Placement X 3) Positional Aids N/A 4) Prosthesis X 5) Pooling of Prep Solutions	O Pt. will exhibit signs of impairment of skin integrity (e.g., reddened areas).	O. Utilize pressure preventing devices on OR table and accessories. O. Check for proper positioning and support to maintain good body alignment. O. Pad pressure points. O. Place ESU ground pad on non compromised skin surface area. O. Keep prep fluids form pooling.

9. PATIENT'S IDENTIFICATION: (For typed or written entries give: Name-last, first, middle; grade, data; hospital or medical facility)

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since_____ ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact precautions (Y) (N)
! Family/Friend:_____

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to: X 1) Intraoperative Mobility X 2) Positioning X 3) Existing Disease X 4) Safety Devices X 5) Hypothermia	O. Pt. will exhibit signs of adequate tissue perfusion (e.g. color, warmth. pedal pulse.	O Check foe support stocking or ace warps. if none, check with doctors. O Check that safety straps are correctly applied. O Offer pillow for under knees. O Place and take down legs from stirrups with slow bilateral motion. O Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.I. X Potential Impairment of Mobility due to: X 1) Pain X 2) Intra operative Hazzards N/A 3) prosthesis X 4) Positioning X 5) Transfer pt. To/form OR table E.2. X Potential Discomfort Due to: X 1) Length of Surgery X 2) Positioning X 3) Arthritis	O pt. will be transferred to OR table without difficultly. O pt. will be not experience unnecessary physical discomfort.	O Have sufficient people available for transfer. O Insure proper body alignment. O Allow patient to lie in position of comfort while waiting for surgery. O Offer support (i,e..pillows. Bath towel. etc) for positioning.
F. Special Senses F.I. X Diminished visual perception due to being: X 1) pre-medicated N/A 2) W O GLASSES F.2. X Potential for Decreased Communication due to: N/A 1) Diminished Hearing X 2) Language Barrier F.3. N/A Potential Injury due to Dentures: ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	o pt. will be made aware of surroundings prior to anesthesia induction. o pt. will be transferred safely to OR table. o pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	O Introduce self. keep pt informed as to where he. she is and what is happening. O Inform pt. in which direction to move and assist if necessary. Speak clearly and slowly. O Address pt. from _____ side. O Validate pt.'s understanding of verbal communication. O Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS OR Continuation of Above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes. blue 2 All	OTHER NURSING INTERVENTIONS OR continuation of above Interventions.

10. OR NURSING INTERVENTION COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

[redacted] 18Nov03 DATE

11. POSTOPERATIVE EVALUATION :
LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☒ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☒ MOVES ALL EXTREMITIES ☐ Moves Upper Extremities
☐ Transferred to Litter With roller due to spinal
SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT: (Y) (N)
BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted]
DATE: 18Nov03 TIME: 0415

13. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted]
DATE: 18Nov03 TIME: 0555

REVERS OF FORM 5179, JUN 91

USAPA V1.0

b(6)-2 All unless marked otherwise

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

For use of th[redacted] AR 40-407, t[redacted]y is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPER[redacted]
VIA Litter BY MT[redacted]

2. PATIENT I[redacted]ORD REVIEWED AND PROCEDURE VERIFIED BY [redacted]

3. DATE 18 NOV 2005 TIME PATIE[redacted]IN [redacted] 0400

4. PATIENT IN ROOM [redacted] TIME 0700 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

Beach chair – Allow under knees. Blankets folded under (L) arm.

☐ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS:

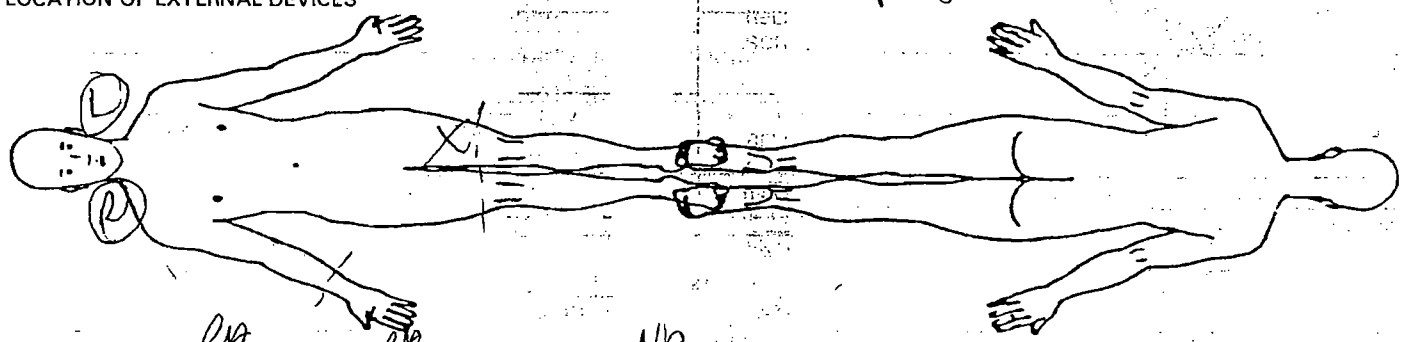
8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* betadine swab/paint
SITE: left arm/shoulder BY WHOM: CPT [redacted]
SITE: BY WHOM:
COMMENTS: no painting betadine

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

Initial count – SPC [redacted] / CPT [redacted]

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No				SPC [redacted]	[redacted]
Needle Sharp	☒ Yes	☐ No		C	C		
Instrument	☐ Yes	☒ No					CPT
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted] b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: RBB 102395
GROUND PAD: BRAND Valleylab
LOT NO: 69441

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ Y IF YES NAME: ID NUMBER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): 0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 3/16" Penrose	2.	3.
SITE	1. (L) shoulder	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

4"x8 & Tape (L) shoulder
4x4 & Tubegauze (L) ring finger

19. ADDITIONAL INFORMATION

Anesthesia - MAJ [redacted] CRNA
Surgeon - Dr [redacted]
b(w)-2 A

20. OPERATION(S) PERFORMED

I&D (L) shoulder / (L) Ring Finger I&D c̄ partial amputation

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU #1	0550	Litter

22. REGISTERED NURSE SIGNATURE [redacted]

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDCOM - 24765

b(6)-2 All unless marked otherwise

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-407, the proponent agency is the office of The Surgeon General.
1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Stretcher BY anesthesia	2. PATIENT IDENTIFIED, RECORDS REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN
3. DATE 20 Nov 03 TIME PATIENT ARRIVED IN SUITE	4. PATIENT IN ROOM [redacted] TIME 1445 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR INT	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☐ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Beach Chair Proper body alignment maintained.

8. SKIN PREPARATION

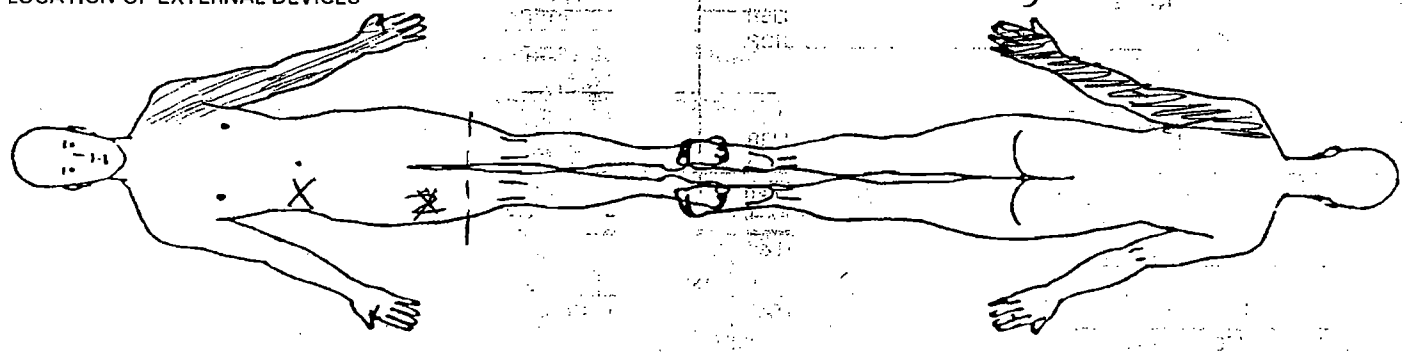
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/sol'n
SITE: Rt. Shoulder BY WHOM [redacted]
SITE: BY WHOM:

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet

C = Correct I = Incorrect INITIAL C [redacted]

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No			C	[redacted]	[redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: Force 40 R8E10530S 50/50
GROUND PAD: BRAND Valleylab REM
LOT NO: 69441

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ IF YES NAME: ID NUMBER: URER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNAT [redacted]

15. X-RAY IN OP ATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

18. DRESSING/IMMOBILIZATION *(Specify)*
4X8
ABD
Tape

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	Hemovac		
SITE	Lt. shoulder		

19. ADDITIONAL INFORMATION

Surg: [redacted] Anesth: [redacted] CRNA General

to (6) - 2 AM

20. OPERATION(S) PERFORMED

1. I & D Lt. shoulder

21. PATIENT TRANSFERRED TO PACU (ICW1) TIME 1559 METHOD Stretcher

22. REGIST NURSE SIGNATURE [redacted] CPT/AN

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

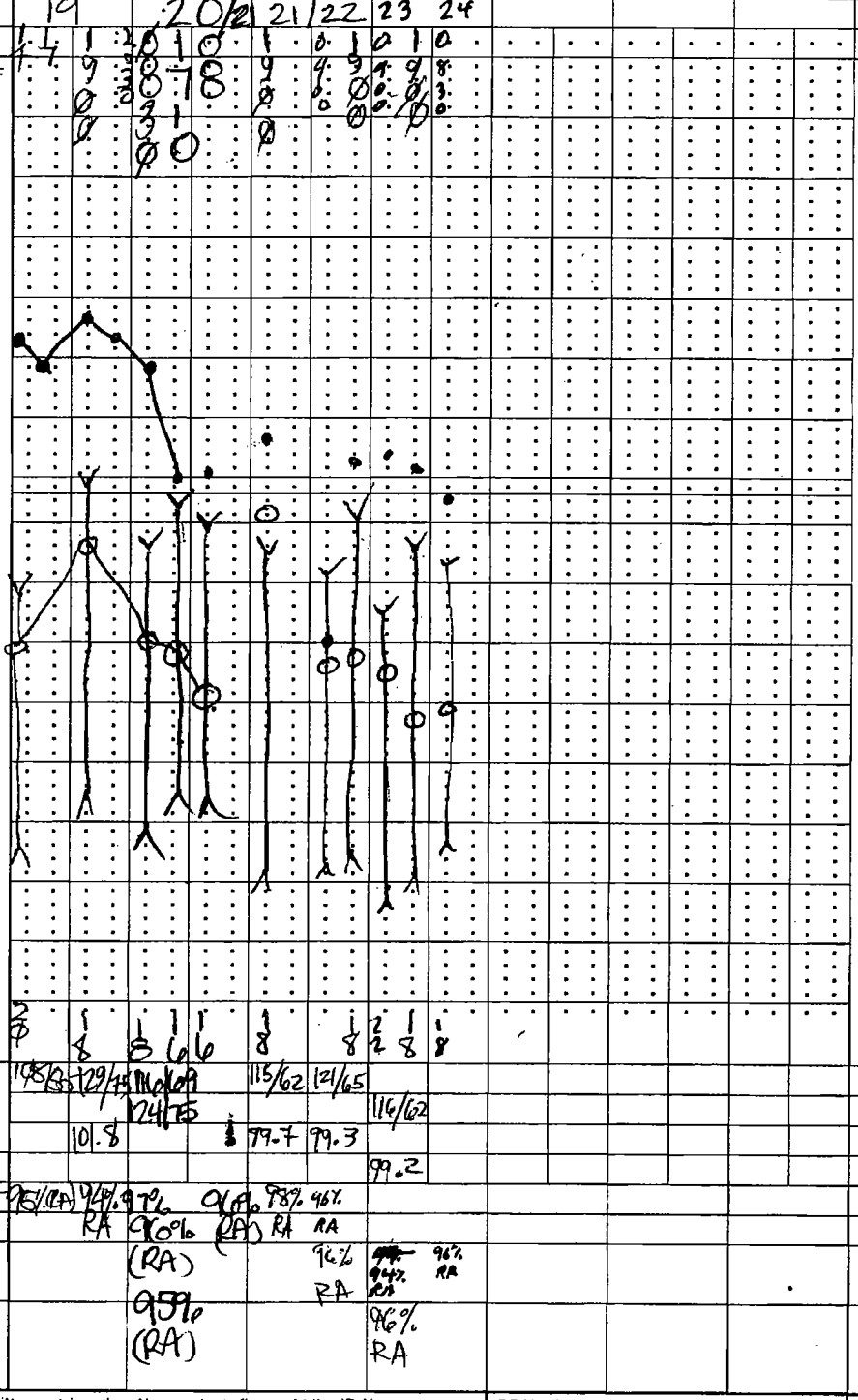
HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY 19 20/21 21/22 23 24

19 HOUR 14 9 10 11 12 1 2 3 4 5 6 7 8

PULSE (O) — TEMP. F (•) — TEMP. C



(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 108/65 129/75 110/69 124/75 115/62 121/65 116/62

HEIGHT: WEIGHT →

10.8 99.7 99.3 99.2

O_2 Sat: 95% (RA) 94% RA 97% 96% (RA) 96% (RA) 98% RA 96% RA 96% RA 94% RA 96% (RA) 95% (RA) 96% RA

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

[redacted]

b(a)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY															
POST-	DAY														
MONTH-YEAR	DAY			25											
19	HOUR	1		0											
PULSE (O)	TEMP. F (°)	3		8											TEMP. C
	105°	0													40.6°
180	104°														40.0°
170	103°														39.4°
160	102°														38.9°
150	101°														38.3°
140	100°														37.8°
130	99°														37.2°
	98.6°														37.0°
120	98°														36.7°
110	97°														36.1°
100	96°														35.6°
90	95°														35.0°
80															
70															
60															
50															
40															

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE

HEIGHT: WEIGHT →

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

EPW# [redacted] b(6)-1

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

OUTPUT

URINE						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

20 NOV 03 [redacted] HEMOVAC

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
(20 NOV 2100 1800-0600)				Ø

(20 NOV @ 1800) HEMOVAC

OTHER OUTPUT			
TIME	AMOUNT	TYPE	ACCUM TOTAL
1800	10	Blood	10cc
0600	Ø	N/A	10cc
1800	5cc	bloody	15cc
GRAND TOTAL OUTPUT			

REMARKS

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

[redacted]

P W-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

OUTPUT

Hemovac *						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
0001-0700(bloody)		95cc							
1435	25cc	120cc							

CHEST						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS				
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT			
TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

21 NOV 03

(0001 - 2365)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

[redacted] b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

b(6)-2 Sgt [redacted] b(6)-2

Ward/Section: EMT	REQUESTING PH[redacted] Dr [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 17NOV03	TIME 2253	SSN [redacted] b(6)-4

(i-STAT) [redacted]

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat	1.2	0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 17

TEST	RESULT	REF. RANGE

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l

======= PICCOLO =======
17/11/03 23:22
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
~~DISC LOT #:~~ 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 000010069?

ALB.	3.6	3.3-5.5	G/DL
ALP	61	26-84	U/L
ALT	27	10-47	U/L
AMY	18	14-97	U/L
AST	38	11-38	U/L
TBIL	0.9	0.2-1.6	MG/DL
GGT	11	5-65	U/L
TP	6.1*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 1+, LIP 0, ICT 0

Where is the CRT?

i-STAT EC8+
Pt: [redacted] b(6)-4
Pt Name:_____

Glu_____127 mg/dL
BUN_____14 mg/dL
Na_____142 mmol/L
K_____3.8 mmol/L
Cl_____106 mmol/L
TCO2_____28 mmol/L
AnGap_____14 mmol/L
Hct_____44 %PCV
Hb*_____15 g/dL
*via Hct
pH_____7.341
PCO2_____49.3 mmHg
HCO3_____27 mmol/L
BEecf_____1 mmol/L

Sample Type_:
17NOV03 23:20
Oper: [redacted] b(6)-2
Physician:_____
Ser# 42011
Ver: JAMS046A
CLEW A93

REMARKS: T+S

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
[redacted] 66-4		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	hazy	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.020	N/A
Bld	trace	Negative
pH	5.0	N/A
Prot	neg	Negative
Urob	norm	0.2-1
Nit	neg	Neg
Leuk	neg	Neg
HCG		Neg

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		

CSF

Cell Count	
Directigen	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

BI (MUST SUBMIT

UNIT

REMARKS: 1+S

REPORTED BY: **DATE:** **LA**

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/17/03 23:24

Patient ID: [redacted] b(6) c
Test Name :PT
Test Result:= 16.0 sec.
Ratio = 1.3
Calculated INR = 1.55
Sample Type:citrated wh. blood
Test Date :11/17/03
Test Time :23:22
Card Lot :080201
Operator : [redacted] b(6)

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/17/03 23:26

Patient ID: [redacted]
Test Name :APTT
Test Result:= 35.6 sec.
Sample Type:citrated wh. blood
Test Date :11/17/03
Test Time :23:24
Card Lot :110214
Operator : [redacted]

Ward/Section:	REQUESTING PHYSICIAN: [redacted] b(6)-1	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 19/03 TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
W			Color		N/A	RPR		Negative
RI			App		N/A	Mono		Negative
H			Glu		Negative	**Microbiology**		
H			Bili		Negative	Source		
M			Ket		Negative	Gram Stain		
PI			SG		N/A	Occ Bld		Negative
L			Bld		Negative	H. pylori		Negative
			pH		N/A	Micro Parasites		
S			Prot		Negative	Malaria		
B			Urob		0.2-1.0	O & P		
Lym			Nit		Negative	Other		
Atyp			Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			

b6-4

ID: [redacted]
MB

19-11-03
04:06

			Patient Limits	
WBC	10.5	x10^3/uL	4.5	10.5
RBC	4.25	x10^6/uL	4.00	6.00
Hgb	11.7	g/dL	11.0	18.0
Hct	36.2	%	35.0	60.0
MCV	85.2	fL	80.0	99.9
MCH	27.5	pg	27.0	31.0
MCHC	32.3 L	g/dL	33.0	37.0
Plt	175.	x10^3/uL	150.	450.
LY%	16.2 *L	%	20.5	51.1
LY#	1.7 *	x10^3/uL	1.2	3.4

Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**	
Sed Rate			Cell Count			*MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Other			Directigen		Negative	ABO/Rh	

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU1	REQUESTING PHYSICIAN: Davis	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, [redacted] b(6)-4	DATE 19/11 / TIME 0400	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	132	138-146 mmol/l
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

======= PICCOLO =======

19/11/03 04:07

REFERENCE RANGE: MALE

PATIENT #: [redacted]

LIVER PANEL PLUS

DISC LOT #: 3154AA7

OPER #: [redacted] DR #: 000

SERIAL #: 0000100697

ALB	2.7*	3.3-5.5	G/DL
ALP	52	26-84	U/L
ALT	12	10-47	U/L
AMY	11*	14-97	U/L
AST	37	11-38	U/L
TBIL	1.8*	0.2-1.6	MG/DL
GGT	9	5-65	U/L
TP	5.5*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

======= PICCOLO =======

19/11/03 04:22

REFERENCE RANGE: MALE

PATIENT #: [redacted] b(6)-4

METLYTE 8

DISC LOT #: 3152AA4

OPER [redacted] DR #: 000

SERIAL #: 0000100697

GLU	139*	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	1496*	39-380	U/L
NA+	***	128-145	MMOL/L
K+	3.8	3.3-4.7	MMOL/L
CL-	94*	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

Na		
K		
Cl		
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDICAL RECORD - ANESTH

his form, see AR 40-66; the proponent ... a ...SG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG	(Units)																		
Fentany	(Mg)	150	100																
propofol	(mg)	200																	
SUX	(g)	120																	
RCB	(mg)	30																	
MSO4	(mg)				4	4	2												
	(g)																		
VOLAT AGENT — I-50	% del	1.5	1.5	1.5	1.5	1.2	X												
	% e.t.																		
AIR	L/Min																		
N2O	L/Min																		
O2	L/Min	6	2	2	2	2	4												
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		(1) (2)					(3)												

TOTALS	TOTAL EBL
250	75cc
	TOTAL URINE
10	475cc

FLUIDS SUMMARY

CRYSTALLOID- 1000

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site																		
Lt femoral	☐ Warmed	LR 500	9/#2	—	1000													
	☐ Warmed																	
	☐ Warmed																	
	☐ Warmed																	

LOSSES																		
EST BLOOD LOSS																		
URINE -		400					475											

REMARKS

Code drugs with numbers, events with letters

(1) To OR via litter, SOC monitors, pre O2.
(2) RSI & IE CCP.
(3) SBP, to ICU stable

PHYS STATUS: 1 (2) 3 4 5 (E)

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT: 44

INITIAL DATA:

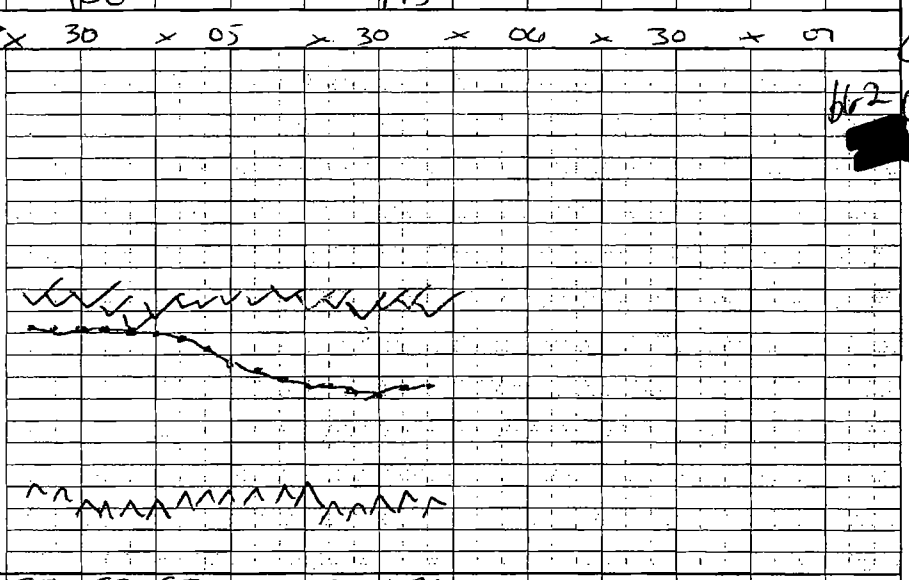
BP- 124/39

HR- 114

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? ✓

TIME- 0415



VENTIL

VT - ml	850	850	850	300	500	470	
f - breaths/min	10	10	10	12	10	10	
Peak inf pres / PEEP	20	20	20	—	—	—	
MODE - S(pon), A(ssist), C(on)	C	C	C	S	S	S	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	38	38	35	48	48	48
BP/oth	FIO2 (Frac or %)	0.6	0.6	0.6	0.6	0.6	0.6
ART line	SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	SR	SR	SR
Gas analyzer	TEMP-site						
	N-M Block (T/4)						
Warming blkt							
Conv warmer							

Mark with letters & symbols, explain under REMARKS EVENTS *Position*

RECOVERY AT

PACU (ICU) (Specify)

OTHER

CONDITION:

RESP- 16 SpO2- 95

BP- 109/43 HR- 102

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0415	0420	0600
PROC	Ready	Begin	End
	0425	0445	0540

PROCEDURES and CPT Codes:
I&D Lt shoulder & RF

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GETA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] b(4) 23 yo ♂
S/P GSW
Smoker, otherwise healthy
NKDA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
Eyes taped, DLV 3 trauma, ⊕ETCO2, BVEB, 8.0 ETT, 3 miller, 22cm @ teeth.

SURGEONS: [redacted]

ANES [redacted] b(4) CRNA

PROCEDURE LOCATION: 2-2

DATE: 11/18/03

PAGE 1 OF 1

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION

DRUG	(Units)	1450	1500			
Fentanyl	(µg)	150	100			
Lidocaine	(mg)	(40)	50			
Succ vec	(mg)	1 (120)	4			
	( )					
	( )					
	( )					
VOLAT AGENT: Sevo	% del		2 →	(*)		
	% e.t.					
AIR	L/Min					
N2O	L/Min					
O2	L/Min	10 →	(2) →	(16) →		

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS →

FLUIDS

LINE site					
(R) FA 20g.	☐ Warmed	→	→	→	→
	☐ Warmed				
	☐ Warmed				
	☐ Warmed				

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT:

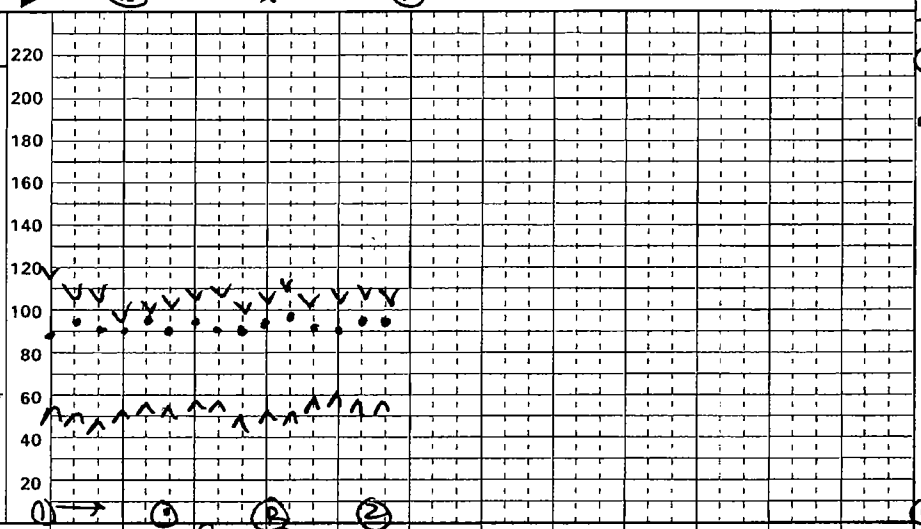
INITIAL DATA: BP- 112 / 61; HR- 90

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME- 1450

TIME → 1445 (15) • X • (16) • X

SYMBOLS: BP by cuff V; Heart rate Λ; Resp rate ●; BR (transduced) ╪; TOURNIQUET T—⊥; ANES- X-X; PROC- ⊙-Ø



VENTIL

	1450	1500			
VT - ml	–	800	900	900	700
f - breaths/min	12	12	10	12	14
Peak inf pres / PEEP	–	20	22	—	–
MODE - S(pon), A(ssist), C(on)	S	C	C	S	S

MONITORS/ACCESSORIES

(X) BP/Auto Cuff	(X) ET CO2 (torr)	–	39	41	40	42
BP/oth	(X) FIO2 (Frac or %)	85	85	69	69	70
ART line	(X) SpO2 (%)	100	100	100	100	100
Steth- PC/ES	(X) ECG	SR	SR	SR	SR	SR
Gas analyzer	(X) TEMP-site ak	–	96	96	96	
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS *Position* → beachchair, RUE secured e side on board

TOTALS	TOTAL EBL
	50
	TOTAL URINE
	N/M

FLUIDS - SUMMARY

CRYSTALLOID- 800

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

(1) room/O2/monitors. SIVI, eyes taped, easy mask vent. DVL#1 → OETT AFT → (+) ETCO2 XT, BSBS

(2) pt supine, sxid, opens eyes, extubated, PACU, report.

(R) nearly 4 yr robenac 0.6 mg/kg IV

RECOVERY AT 1600

(PACU) ICU _____ (Specify)

OTHER _____

CONDITION: stable

RESP- 14 SpO2- 96

BP- 120/75 HR- 100

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1440	1450	1605
	Ready	Begin	End
PROC	1500	1510	1550

PROCEDURES and CPT Codes: I+D (L) shoulder

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*: GETA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*

[redacted] b(6)-1

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*: #8.0 OETT, 23 clip, Mil 2, AFT → see (1)

SURGEONS: [redacted] b(6)-1

ANESTHETISTS: [redacted] b(6)-1

PROCEDURE LOCATION: 1

DATE: 20 NOV 03

PAGE 1 OF 1

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18NOV03	Op Note
0800	Pre Op Dx: Open Comminuted (2) humeral head Fx
	(1) RF Pa Fx
	Post Op Dx: Same
	Procedure: ORIF (2) proximal humerus, Partial
	[redacted] (1) RF (Pa level)
	Surgeon: [redacted]
	EBL: 100cc
	Fluids: 1000cc
	Findings: Extensive comminution proximal humerus.
	Drains: None
	[redacted]

b(4)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION: [redacted] b(6)-4

NURSING UNIT: ICU 1 | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS | LIST TIME ORDER NOTED AND SIGN

0100 18 Nov
Admit ICU
Gtd - fx
Diet - NPO
Act - BR
VS - q1h
Call MD if P>130
SBP<90

PATIENT IDENTIFICATION: [redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

sat < 90%
Dx - GSW LUE
IV LR at 150/h
foley to gravity drain
Ampicillin 1gm IVPB q8h
MS - 2-6mg IV q1h prn [redacted]

b(6)-2

PATIENT IDENTIFICATION: [redacted] b(6)-4

NURSING UNIT: ICU 1 | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

0600 18 NOV 03

Resume preop orders
Add levoquin 500mg IVPB qD [redacted]
- Remove Foley output [redacted]

Noted [redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

18 NOV 2300

1. CBC lytes in am
2. Reg diet
3. IS
4. BP Tgs pr [redacted] q4 T>101

b(6)-2

Noted

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

0900 No Foley 11-18-03 [redacted] Noted

MEDCOM-24779

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

[redacted] b(6)-4

ICW-1

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 11-19-03 TIME OF ORDER 0910 HOURS | LIST TIME ORDER NOTED AND SIGN

- Transfer ICW-1 - Dr. [redacted]
- Stable
- Routine Vitals
- Up ad lib c̄ sling on (R) ARM
- Heplock IV
- Record output Removal q Shift
- Regular Diet

PATIENT IDENTIFICATION

b(6)-2 Noted [redacted] 19NOV03 1400

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

- Percocet T&O q4° prn pain
- Demerol 75mg IV q4° prn breakthrough pain
- Phenergan 25mg IV q6° prn nausea
- Ambien 10mg po qHS prn insomnia
- Ancef 1gm IVPB q8° — [redacted]
- Levoquin 500mg IV qD — [redacted]

PATIENT IDENTIFICATION

b(6)-2 noted [redacted]

NURSING UNIT | ROOM NO. | BED NO.

JAV 0220 20NOV03

DATE OF ORDER 19NOV03 TIME OF ORDER 2100 HOURS

(1) NPO pMN, to OR in AM 11/20.
V.O. DR [redacted] [redacted] b(6)-2

[redacted] b(6)-2

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 24780

AUTHORIZED FOR LOCAL REPRODUCT

DICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Optics
11/26/13	Fundoscopy - Open (1) Normal Comments
	Pertoptics - same
	Fundus - Report DD (2) Should
	Sign [redacted]
	ESC : SCC b(6)-2
	Thus - Dxx
	Cx.. C
	[redacted]

PITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED
NSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

ENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO

CHRONOLOGICAL RECORD OF MEDICAL C.
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
b(6)-4 [redacted]			11/20/03	1650 HOURS	
			Resume prev P orders		
			~~Trans~~		
			[redacted] b(6)-2		
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
[redacted] b(6)-4			24 Nov	1730 HOURS	
			V.O. Dr [redacted] LT [redacted]		
			Transfer to K(6)2		
			b(6)-2		
			[redacted]		
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
b(6)-4 [redacted]			11/24/03	2250 HOURS	
			D/C pt to EPW CAMP [redacted]		
			b(6)-2		
			b(6)-2		
NURSING UNIT	ROOM NO.	BED NO.			
24P/None	[redacted]		b(6)-2		

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
1340 [redacted]			25 Nov 03	0755 HOURS	
			VO Dr [redacted] LT [redacted]		
			Levaquin 500mg POQD		
			D/C IV		
b(6)-2			b(6)-2		
NURSING UNIT	ROOM NO.	BED NO.			
24P/None	[redacted]				

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

b(6)-2

Condition Fair GSW ⓓ ↑ EXTREMITY

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. ____ Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 16	19												
NOV 18	[redacted]	Diet NPO	06	[redacted]													
			18	[redacted]													
NOV 18	[redacted]	Activity - BR	06	[redacted]													
			18	[redacted]													
NOV 18	[redacted]	VS Q1° call MD if sat < 90 P > 130 SBP < 90	06	[redacted]													
	[redacted]		18	[redacted]													
NOV 18	[redacted]	Foley → SD	06	[redacted]													
			18	[redacted]													
NOV 18		Reg. diet	06	[redacted]													
			18														
NOV 18		IS	06	[redacted]													
			18														

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b(6)-4

ICU #1

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
18 Nov	[redacted]	CBC, Lytes in am.	19 Nov			
	----	b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING COMPLETION* TIME/DATE COMPLETED													
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															

USAPA V1.00

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24
19 Nov 03	[redacted]	Routine vitals	[redacted]				
19	[redacted]	up ad lib c̄ sling					
		on R arm					
19	[redacted]	Record output					
		hemovac q. shift					
19	[redacted]	Regular diet					

Hemovac D/C'd 22 Nov 03 1600

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P RD OSHOULDER / ORING FINGER PARTIAL AMP

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: [redacted] b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

b(6)-2

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 11 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19 NOV	[redacted]	Transfer ICW-1, Dr.O. - Stable	19			[redacted]
19	[redacted]	NPOP MN for OR in AM 11/20	11/20	0001		
20NW	[redacted]	Resume prev. orders	20NW	1600	1600	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
----	----															
----	----															
----	----															
----	----															
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USAPA V1.00

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. ____ Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 24	25											
19 Nov	[redacted]	Vital Signs	D	[redacted]												
		q shift	N	[redacted]												
19 Nov	[redacted]	pad lib + sling	D	[redacted]												
		on L arm	N	[redacted]												
19 Nov	[redacted]	Regular diet	B	/												
			L	/												
			D	[redacted]												

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
s/p I&D L shoulder / L ring finger partial amp

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: _____

PATIENT IDENTIFICATION:
EPW # [redacted]
b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
24Nov	[redacted]	Transfer to ICWZ	24Nov		1730	[redacted]
24Nov	[redacted]	DC PA to EPW Camp	25Nov			
25Nov	[redacted]	D/C IV	25Nov	0251	0251	[redacted]

	----	b(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
----	----															
----	----															
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USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. Nov Yr. 03

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19
Nov 18	[redacted]	IV RL @ 150/0	06	[redacted]	
	[redacted]		18		
Nov 18	[redacted]	ANCEF + GM IVPB Q8°	06		
			14		
			22		
18 Nov	[redacted]	Levaquin IVPB	10		
		QD			
		b(4)-2			

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

#1340

ICU#1

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo._____ Yr. _____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
Nov 18-	[redacted]	MSO4 2-6mg IV Q1°	Nov 18 0200 5mg	18 Nov 03 0330 5mg	18 Nov 03 0400 5mg	18 Nov 03 1355 5mg	18 Nov 03 1630 5mg	18 Nov 03 1745 5mg	18 Nov 03 1900	18 Nov 03 2000	18 Nov 03 2340	19 Nov 03 0200	19 Nov 03 0325	19 Nov 03 0600		
- - - - -	- - - - -		[redacted]													
- - - - -	- - - - -															
- - - - -	- - - - -	Tylenol 1gr · po	19 Nov 03 0600													
- - - - -	- - - - -	T. 101 94°	CS													
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
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- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

USAPA V1.00

#[redacted] b(6)-4 I CU #1

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo.____ Yr. ____

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 24	25
19Nov	[redacted]	Heplock IV: flush	D	[redacted]	
	-----	q shift	N		

19Nov	[redacted]	Ancef 1 gm IVPB	06		
	-----	q8°	14		Rewritten see below
	-----		22		

19Nov	[redacted]	Levaquin 500mg	08	[redacted]	
	-----	IV qD			DCd 0951 25Nov05
24Nov	[redacted]	Ancef 1 gm IVPB	06	[redacted]	
	-----	q8°	14		
	-----		22	[redacted]	
25Nov05	[redacted]	Levaquin 500mg PO	08		
	-----	qD			

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: S/P I&D L Shoulder / L ring finger partial amp

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW # [redacted] b(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

MEDCOM - 24791

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	22	23	24
19 Nov	[redacted]	Heplock IV: flush q	08 18	[redacted]					
	-----	shift	18 06	[redacted]					
19	[redacted]	Ancef 1gm IVPB q8°	06	[redacted]					
	-----		14	[redacted]					
	-----		22	[redacted]					
19	[redacted]	Levaquin 500mg IV	08	[redacted]					
	-----	qD							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p I&D (L) shoulder (L) Ring fing partial amput

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

#[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 11 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		b(6)-2 All				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
19NOV	[redacted]	Percocet II po 9 4° pm pain	D/T	19 Nov 1907	20 NOV 1030	21 NOV 0815	21 NOV 1940	22 NOV 0215	22 NOV 0845	22 NOV 1308	22 NOV 1720	23 NOV 2140	23 NOV 1520	[redacted]	
			D/I	II	2	8	2	2	II	II	II	1	--		
19	[redacted]	Demerol 75mg IV 94° pm breakthrough pain	D/T	21 Nov 1930	22 NOV 2230	23 NOV 0530									
			D/I	75mg	75mg	75mg									
19	[redacted]	Phenergan 25mg IV 96° pm nausea	D/T	20 NOV 1930	21 NOV 2230	23 NOV 0530									
			D/I	25mg	[redacted]										
19	[redacted]	Ambien 10mg po 9 HS pm insomnia	D/T	21 NOV 2130											
			D/I	10mg	[redacted]										

*U.S. GPO: 1998-454-110/95216

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	OTSG APPROVED *(Date)*
TRAUMA FLOWSHEET The proponent is Dept of Surgery	QI Appr 11 Jun 97

EMS REPORT

TIME: _____ ETA: _____ UNIT: _____

MED COM: [Y] [N]

ARRIVAL STATUS

TIME 2250 ☒ IV x 1 ☐ O_2 _____ 1/min ☐ C-Spine Immob

Meds: ☐ UKN ☒ None ☐ Yes: _____

Allergies: ☐ UKN ☒ None ☐ Yes: _____

Tetanus: ☐ UKN ☐ Current Last Meal/Fluid Intake 4 hrs

LMP: NA ☐ _____

PRIMARY SURVEY

AIRWAY

☒ Natural Patient [Y] [N]

☐ ETT _____ ☐ _____

☐ Secretions _____

BRETHING

☐ Labored ☒ Unlabored ☐ Absent

TRACHEA: ☒ Midline ☐ Deviated [L] [R]

CHEST SYMMETRY: [L] > = < [R]

CIRCULATION

PULSE: ☒ Present ☐ Absent

BLEEDING: [Y] [N]

HEART TONES: ☐ Clear ☐ Muffled

SKIN: ☐ Warm ☒ Cool ☐ Hot

☐ Pink ☐ Pale ☐ Cyanotic ☐ _____

☐ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY

GCS: E 4 V 5 M 6

SPHINCTER TONE: ☐ WNL ☐ None

HEAD

PUPILS: ☒ Equal ☐ Fixed ☒ React ☐ Dilated [L] [R]

TM: ☒ Clear ☐ Blood [L] [R]

NECK

C-Spine Tenderness: [Y] [N]

Pain @ _____

JVD: [Y] [N]

HEART

RHYTHM: ☒ Regular ☐ _____

PULSES: ☐ Central ☐ Peripheral

LUNGS

BREATH SOUNDS: ☒ Bilat ☐ Equal ☒ Clear

Decreased [L] [R] Absent [L] [R]

Wheezes [L] [R] Crackles [L] [R]

ABDOMEN

☒ Soft ☐ Rigid ☒ Non-Tender

☐ Tender: —

PELVIS

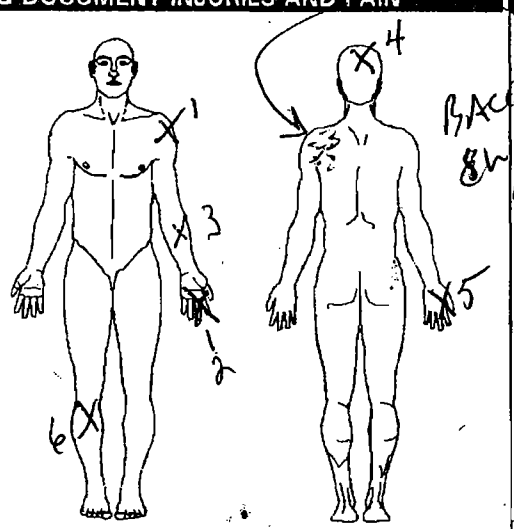
☒ Stable ☐ Unstable ☐ _____

Blood at meatus/vagina: [Y] [N]

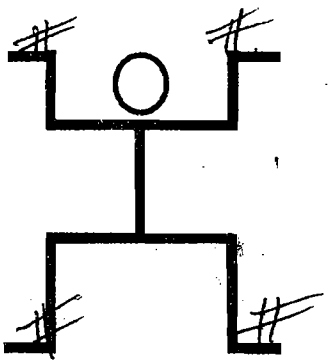
Heme +/- Prostate: ☐ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion 4
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity 3, 5
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration 2
(P)uncture (W)ound 1, 6
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound



VASCULAR ASSESSMENT



++ Strong	+ Palpable	D Dopler

RN Lt. [redacted]

PHYSICIAN Dr. [redacted]

(Continue on reverse)

PREPARED BY [redacted] PFC LAW

DEPARTMENT/SERVICE/CLINIC EMT 28CSH

DATE 17 Nov 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)*

Tob (+), Ethol (-)

[redacted]

16 June 1979

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 **4700**

REQUIREMENT OF PRIVACY ACT OF 1974 IS COVERED BY DD FORM 2005. PREVIOUS EDITION IS OBSOLETE.

EAMC OP 503, 1 Dec 98

b(6)-2 A1

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
	ET Intubation		☐ Oral ☐ Nasal Teeth		☐ $ETCO_2$ Change ☐ BBS Post Int ☐ Post CXR
	Gastric Tube		☐ Oral ☐ Nasal		☐ Air ☐ Contents ☐ Verified_____ Suction: Y N
2316	Urinary	18	☒ Meatus ☐ Supra-Public	PFC [redacted]	☐ Return_____cc Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed	b6 2	☐ Grossly: + - Cell count Sent@ _____
	Chest Tube #1		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:		Comments	

ABG SITE	TIME	$\%O_2$	pH	BE	pCO_2	PO_2	O_2 Sat	HCO_3
1)								
2)								

LABS

TIME	LABS
	☐ D-stick_____ ☐ SHct_____
	☐ D-stick_____ ☐ SHct_____
2255	☒ CBC ☒ Chem 12 ☒ PT/PTT 12 ☐ ETOH ☒ T&S ☒ T&C x 2
	☐ Tox Screen
2255	☒ UA ☐ HCG
	☐ OTHER
	☐ OTHER

X-RAYS

TIME	LABS
	☒ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
	☐ Pelvis
	☐ (R) leg, foot
	☐ (L) humerus
	☐ forearm, hand

TIME	PROCEDURE	ACCOMPANED BY	RETURN
	CT Scan: ☐ Contrast		
	☒ Head ☐ Abd ☐ Pelvis		
	☐ C-Spine ☐ T/L Spine ☐ Chest		
	☐		
	A-Gram Site:		

IV ACCESS & FLUIDS

TIME	#	GA	IAW	SOP	SITE	IVF TYPE	AMT UP	AMT IN
2255	1	18	Y	N	(R) AC	NS	500ml	500ml
2315	cc	cc	Y	N	cc	LR	1000ml	
			Y	N				
			Y	N				

MEDICATIONS

MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Tetanus	2255	.5	IM						
Fetanol	2300	100µg	IV						

BLOOD PRODUCTS

START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INIT

LAB RESULTS

CBC:

17.7 | 14 / 45 | 283

Chem: LFTs - wnl

142 | 106 | 14
3.8 | 28 | 1.2 | 127

UA - TPA+ blood PT/PTT 26/36

INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys	[redacted] on Pt arrival		[redacted]	
Surgeon	[redacted]			
Anesth		b(6) 2 All		
X-Ray	[redacted] on Pt arrival			
RT				
Ortho	[redacted]			
Neuro				
Chaplain				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOD See DA Form 3696	
	Other: See Nursing Notes	

DISPOSITION

☐ Home ☐ _____

Admitted to _____

Report Called to _____

Time Transferred _____

Accompanied By _____

Via: ☐ Stretcher ☐ Wheelchair

As per ACLS Precautions: ☐ Yes ☐ No

VITAL SIGNS

Rectal Temp:

GCS: 15

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
2255	134/146	111		23	100			4	5	6	
2300	132/156	101		15	97						
2310	132/158	104		12	99 RA						
2320	150/162	120		29	96 RA						
2330	150/164	104		20	100 @ LO_2						
	/										
	/										
	/										
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GLASGOW COMA SCALE

EYE OPENING	VREBLE RESPONSE	MOTOR RESPONSE
4 - Spontaneous	5 - Oriented	6 - Obeys Commands
3 - To Voice	4 - Confused	5 - Localizes Pain
2 - To Pain	3 - Inapp Words	4 - Withdraws to Pain
1 - None	2 - Incomp Speech	3 - Flexion to Pain
	1 - None	2 - Extension to Pain
		1 - None

TIME	PROCEDURE	PERFORMED BY:
	☐ Backboard Removed	BY:
	☐ Downgraded	BY:

NOTES

23y/o ♂ s/p CAR vs. U.S. vehicle then struck
@t. Pt lost time @ ≈1800. Pt denies ABD pain.
Pt c̄ ⓛ shoulder / ⓡ Hand / ⓛ hand / @ T-9 / LS
pain. Pt denies neck / back pain

PMH - ∅
PSH - Appy
Tx - ?
All - NKDA
meds - ∅
PRD x 10 yrs

∅

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0700 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]
NEURO	PUPILS	3mm PERRL	3mm DRSC.
	SENSORIUM	Awakens to touch. Moves	Alert
	EXTREMITY MOVEMENT	extremities q4 & purposeful	MAE
	SEDATION	movement	NA
	PAIN CONTROL	MSO4 2-6 mg Q1hr	MSO4 2-6 mg Q1H
RESP	RESPIRATORY PATTERN	RRR equal rise & fall of	Even & unlabored
	BREATH SOUNDS	chest CTA bilat	CTA
	SECRETIONS	RA SaO2 97%	—
	O2 SOURCE/FLOW/SAO2		RA 97-98%
	VENTILATOR SETTINGS		NA
CV	CARDIAC RHYTHM	S1 S2 +2 pulses x4 extremities	S1 S2 ST
	CAPILLARY REFILL	Cap refill <3 sec	<3 sec
	PULSES		2+ palpable
	EDEMA		ϕ
GI	ABDOMEN	+BS x 4 quads Abd soft	+BS x4 soft
	BOWEL SOUNDS	non distended	
	BOWEL MOVEMENT		ϕ
	NGT/OGT		ϕ
	TUBE FEDDINGS		ϕ
	DRAINS		ϕ
GU	VOIDING	Foley to Gravity	Foley to gravity
	COLOR/CLARITY	Clear yellow	Clear yellow
SKIN	COLOR	NFR DS bis to (L) shoulder	NFR. IAD (L) shoulder
	INTEGRITY	(R) hand & bicep Head	(L) RF amputation.
		(R) lower leg	(R) lower leg.
ACCESS	#1 TYPE/LOCATION/SIZE	Cordis to (L) femoral [redacted]	cordis (L) fem.
	DRESSING CONDITION	1R @ 15 cc/hr	CDI No S/S infection.
	IV FLUID/RATE		LR @ 100 /hr
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

[redacted] & Title) b(6)-2 SPC LPN

DEPARTMENT/SERVICE/CLINIC b2-2 ICU #1. [redacted]

DATE 18 Nov 93

PATIENT'S IDENTIFICATION (For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

NAME: RANK: AGE:

UNIT: [redacted] b(6)-2

GENDER: M

STATUS: US: AD / CIV IRAQI: CIV / EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

MEDCOM - 24798

ICU1 Patients Name: [redacted] 5(a)2 Date: 18 Nov 83

VITALS	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05
A-Line																								
NBP	109/43	110/53	126/53	120/53	127/57	118/52	122/56	120/57	119/55	122/52	130/48	133/50	139/47	141/56	146/48	152/50	139/55	146/60	141/54	142/73	138/53	154/44	141/52	147/53
TEMP	98.8		99.1		99.9			101.7		101.8		102.6	101.2	100.8	101.2	101.3	101.4	101	101.2	100.9	101.8	101.7	101	102.4
HR	110	110	108	105	109	114	117	116	114	122	104	110	113	116	115	117	118	114	118	119	119	121	121	118
RR	20	13	8	8	9	10	9	7	10	8	16	17	12	12	12	12	12	10	12	12	21	14	11	16
SaO2	96	96	97	98	95	96	96	97	95	97	95	96	96	96	95	94	96	95	94	95	95	94	95	96
FiO2	NA																							
Source	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
MAP	81	79	91	82	89	79	82	83	82	86	80	80	81							80	100	83	91	96

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	To
IVF	150	150	150	150	150	150	150	150	150	150	150	150	1800	150	150	150	150	150	150	150	150	150	150	150	150	18
IVPB	50				100				50				200					50								
NGT																										
													2000													
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	To
URINE	100/100	130/230	60/290	60/350	55/405	55/455	50/505	60/565	70/635	70/705	150/855	150/1005	1005	200	200	250	150	160	140	200	210	250	200	200	250	2
NGT																										
STOOL																										
DRAIN																										
Hemovac																										
													2000 in / 1025 out / +975 / -670													2
Total																										2

+ 325 24

- 670

MEDCOM - 24799

ICAL RECORD-SUPPLEMENTAL ME L DATA

For use o. m, see AR 40-66; the proponent agency is the Offi. of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0300 INITIALS:	TIME: INITIALS:
NEURO	PUPILS	PERRL 3mm brisk	
	SENSORIUM	Alert, oriented.	
	EXTREMITY MOVEMENT	Full ROM	
	SEDATION	ϕ	
	PAIN CONTROL	MSO4 5mg @ 0215	
RESP	RESPIRATORY PATTERN	Even. unlabored	
	BREATH SOUNDS	Clear	
	SECRETIONS	ϕ	
	O2 SOURCE/FLOW/SAO2	RA 96%	
	VENTILATOR SETTINGS	None	
CV	CARDIAC RHYTHM	Sinus Tach 100's.	
	CAPILLARY REFILL	<3sec	
	PULSES	palpable 2+	
	EDEMA	ϕ	
GI	ABDOMEN	Soft	
	BOWEL SOUNDS	BS x4	
	BOWEL MOVEMENT	ϕ	
	NGT/OGT	ϕ	
	TUBE FEDDINGS	ϕ	
	DRAINS	ϕ	
GU	VOIDING	Foley	
	COLOR/CLARITY	Yellow	
SKIN	COLOR	NER	
	INTEGRITY	(E) Shoulder injury	
ACCESS	#1 TYPE/LOCATION/SIZE	(C) arrow LR 15cc	
	DRESSING CONDITION	(R) AC Saline lock	
	IV FLUID/RATE	No SSS infection	
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC 62-2

DATE

ICU #1, [redacted]

PATIENT'S IDENTIFICATION (For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

NAME:

RANK:

AGE:

UNIT: [redacted] b(6)-4

GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

ICU I Patients Name: [redacted] Date: 18 NOV 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05
A-Line																									
NBP																						120/40	118/52	159/68	
TEMP																						98.8	98	98	
HR																						103	104	103	
RR																						15	15	16	
SaO2																						97	98	98	
FiO2																						NA	NA	NA	
Source																						RA	RA	RA	
MAP																						75			

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05
IVF																									
IVPB																									
NGT																									
UR																						150	100	150	
PO																									
Total																									

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05
URINE																						1200 / 1200			
NGT																									
STOOL																									
DRAIN																									
Total																									

MEDCOM - 24801

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0630 INITIALS: [redacted] b(6)-2	TIME: INITIALS:
N	PUPILS	3mm PERRL	
E	SENSORIUM	Awake Alert Moves extremities	
U	EXTREMITY MOVEMENT	x4 c purposeful movements	
R	SEDATION		
O	PAIN CONTROL		
R	RESPIRATORY PATTERN	RRR equal rise & fall of chest	
E	BREATH SOUNDS	CTA bilat	
S	SECRETIONS	Ø	
P	O2 SOURCE/FLOW/SAO2	SaO2 - 94% RA	
	VENTILATOR SETTINGS		
C	CARDIAC RHYTHM	S1S2 +2 pulses x 4 extremities	
V	CAPILLARY REFILL	<3 sec cap refill	
	PULSES		
	EDEMA		
G	ABDOMEN	+BS x 4 quads Abd soft non-	
I	BOWEL SOUNDS	tender non distended	
	BOWEL MOVEMENT	Ø	
	NGT/OGT	Ø	
	TUBE FEDDINGS	Ø	
	DRAINS		
G	VOIDING	Foley to Gravity	
U	COLOR/CLARITY	clear yellow	
S	COLOR	NFR	
K	INTEGRITY		
I			
N			
A	#1 TYPE/LOCATION/SIZE	Cordis to (L) Femoral	
C	DRESSING CONDITION	Site CDI LR @ 150 cc/hr	
C	IV FLUID/RATE		
E	#2 TYPE/LOCATION/SIZE		
S	DRESSING CONDITION		
S	IV FLUIDS/RATE		b(2)-2

(Continue on reverse)

PREPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC: [redacted] | DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

NAME: RANK: AGE:

UNIT: GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

ICU I Patients Name: [redacted] 9/8 Date: 14 NOV 05

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05
A-Line																									
NBP	142/43	138/57	129/47	137/50	158/47	115/59	127/52	138/48																	
TEMP	102.5	100.8			101.5		100.4																		
HR	116	117	109	107	109	123	127	118																	
RR	12	8	7	18	14	12	10																		
SaO2	94	92	95	96	95	95	94	95																	
FiO2	NA																								
Source	RA	RA	RA	RA	RA	RA	RA	RA																	
MAP	79	88	80	83	88	82	93	97																	

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	To
IVF	150	150	150	150	150	150	150	150																		
IVPB	50																									
NGT	0																									
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	To
URINE	200/200	150/550	125/505	200/725	210/935	170/1105	200/1325	220/1545																		
NGT	—																									
STOOL	—																									
DRAIN	—																									
Total																										

MEDCOM - 24803

b(2)-2

Admission and Coding Information

For use of this form, see AR 40-400; the proponent agency is OTSG

1. Reporting MTF	2. MTF			
[redacted] b(6)-4				
3. Register Number	Name (Last, First, MI)		4. Pay Grade	5. Sex
[redacted]			FGN	M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
1979-06-16	24Y	X	9	
10. Length of Service	ETS	11. FMP	12. Social Security Number	
		99	[redacted] b(6)-4	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission	Branch / Corps:
			23:00	
14. Flying Status	15. Beneficiary Category		16. Zip Code of Residence:	
	K78-PRISONER OF WAR/INTERNEES			
17. Unit Location	18. MOS	19. Trauma	Prev. Admission	
		BC	NO	
20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee		
Direct from ER	ICU1	Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted] b(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)		
TRF-OTH		2003-11-25		
24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)		
AEA - ORTHOPEDICS		2003-11-17		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission		
		2003-11-17		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: S/P I & D L SHOULDER/ L RING FINGER PARTIAL AMP

Procedure Narrative(s):

Cause of Injury Narrative:

b(6)-2 b(6)-2

Admitting Officer (Signature, as required)	Signature of Admitting Clerk
[redacted]	[redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400, the proponent agency is OTSG

1. Register Nbr [redacted]						3. Grade FGN	Admission Remarks
4. Sex M	5. Age	6. Race X	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm NO	
11. FMP 99	12. SSN [redacted]	13. Organization				14. Ward	
15. FlyStatus	17. Dept / Ben K78-PRISONER OF WAR/INTER		18. BranchCorps	19. UIC / ZIP		20. Type Case BC	
21. Source of Admission Direct from ER			22. Hour Of Adm: 03:35	23. Clinic Service XXX - CARDED FOR RECORD			
24. Name/Relation of Emergency Addressee			25. Type Disp CRO/DOA	26. Date of Disp 2003-11-18			
27a. Address of Emergency Addressee			27b. Telephone No	28. Date This Adm: 2003-11-18		AdmittingOfficer: [redacted] b(4)-2	
29. ReportingMTF 0580 [redacted] Iraq b2-2				30. Date Init Adm 2003-11-18		32. Units Blood Components	

b(4)-4

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures: 879.8

FRAGMENT WNDS

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	1	1

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	1	1

b(4)-2

Signature of Attending Medical Officer	Signature of PAD or Medical Records Officer
[redacted]	[redacted]

CERTIFICATE OF DEATH *(OVERSEAS)*
Acte de décès *(D'Outre-Mer)*

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
[redacted] b(6)-4			
ORGANIZATION Organisation	NATION *(e.g., United States)* Pays	DATE OF BIRTH Date de naissance	SEX Sexe ☐ MALE Masculin ☐ FEMALE Féminin

RACE Race	MARITAL STATUS État Civil		RELIGION Culte	
☐ CAUCASOID Caucasique	☐ SINGLE Célibataire	☐ DIVORCED Divorcé	☐ PROTESTANT Protestant	☐ OTHER *(Specify)* Autre *(Spécifier)*
☐ NEGROID Négroïde	☐ MARRIED Marié	☐ SEPARATED Séparé	☐ CATHOLIC Catholique	
☐ OTHER (Specify) Autre *(Spécifier)*	☐ WIDOWED Veuf		☐ JEWISH Juif	

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décéde avec le susdit
STREET ADDRESS Domicilé à (Rue)	CITY OF TOWN AND STATE *(Include ZIP Code)* Ville (Code postal compris)

MEDICAL STATEMENT Declaration médicale

CAUSE OF DEATH *(Enter only one cause per line)* Cause du décès (N'indiquer qu'une cause par ligne)			INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort.[1]		Dead on Arrival Due to multiple fragmentation wounds	15-30 minutes
ANTECEDENT CAUSES Symptômes précurseurs de la mort.	MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	Dead on Arrival Due to Multiple Fragmentation wounds	15-30 min
	UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire		
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]			

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☐ NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitees par des causes exterieures
☐ NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie	
☐ ACCIDENT Mort accidentelle		
☐ SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste	
☐ HOMICIDE Homicide	SIGNATURE Signature / DATE Date	AVIATION ACCIDENT Accident à Avion ☐ YES Oui ☐ NO Non

DATE OF DEATH *(Hour, day, month, year)* Date de décès *(l'heure, le jour, le mois, l'année)*	PLACE OF DEATH Lieu de décès

I HAVE VEIWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à, la suite des causes énumérées ci dessus

NA[redacted]icin sanitaire	TITLE OR DEGREE Titre ou diplômé M.D.
GRADE Grade O-4	INSTALL[redacted] ou adresse b(6)-2 AH
DATE Date 18 NOV 03	SIGN[redacted]

[1] *State disease, injury or complication which caused death, but not mode of dying such as heart failure, etc.*
[2] *State conditions contributing to the death, but not related to the disease or condition causing death.*
[1] *Préciser la nature de la maladie, de la blessure ou de la complication qui a contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du coeur, etc.*
[2] *Préiser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort.*

DD FORM 2064, APR 1977 REPLACES DA FORM 3565, 1 JAN 1972 AND DA FORM 3565-R(PAS), 26 SEP 1975, WHICH ARE OBSOLETE. USAPA V1.00

Record

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-2; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL.

NAME AND LOCATION OF HOSPITAL

Instructions - Medical Officer in attendance will:
Prepare, in one copy only, Items 1 through 10 and sign Item 11. Print or type entries.
Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*

#[redacted]

b(6)-4

Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(Hour-day-month-year)*: 0342

3. MEDICAL EXAMINER/ CORONER'S CASE ☐ YES ☐ NO

4. RELIGION

5. CHAPLAIN NOTIFIED ☐ YES ☐ NO

6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* Aeodon Arrest due to multiple fragmentation wounds	15 - 30 minutes
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1) Multiple fragmentation wounds	15-30 minutes
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b. b(6)-2	

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN[redacted]NDANCE	11. SIG[redacted]TTENDANCE
18 Nov 03	[redacted] MD O-4	[redacted]

SECTION B - ADMINISTRATIVE

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)* ☐ YES ☐ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

23. DATE	24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY	25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY
26. DATE	27. TYPED NAME AND GRADE OF REGISTRAR	28. SIGNATURE OF REGISTRAR

1. Reporting MTF	2. MTF Local	Admission and Coding Information For use of this form, see AR 40-400; the proponent agency is OTSG	
[redacted]	b(2)-2		

3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted]	[redacted] b(4)-4	~~FGN~~	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
		X	9	

10. Length of Service	ETS	11. FMP	12. Social Security Number
		~~99~~ 20	[redacted] b(4)-4

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
		03:35	b(2)-2

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
	K78-PRISONER OF WAR/INTERNEES	[redacted]

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
		BC	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
~~Direct from ER~~ C		Address of Emergency Addressee
[redacted] b(2)-2		Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
CRO/DOA		2003-11-18

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
XXX - CARDED FOR RECORD ONLY		2003-11-18

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
IZ		2003-11-18

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: FRAGMENT WNDS

DX 8799
E9289

Procedure Narrative(s): Cause death #1 Trauma / Injury 459

Cause of Injury Narrative:

DX 8799 E8928 Cause of death 1 Injury 459

JP

Admitting Officer (Signature, as required)	Signature of Admitting Clerk
[redacted] b(4)-2	[redacted]

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400, the proponent agency is OTSG

1. Register Nbr	2. Name	3. Grade	Admission Remarks
[redacted]	b(a)-4	FGN	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M		X				NO

11. FMP	12. SSN	13. Organization	14. Ward
99	[redacted]		ICW1

15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case
	K78-PRISONER OF WAR/INTER			BC

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	03:45	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-25

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-18	[redacted] b(2)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] b(2)-2	2003-11-18	

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW NECK, R ARM, ABDOMEN

DX	PROC	T	I
7892	PROC	1	450
86812	5123		
86500	4469		
8739			
8750			
8631/E9912			

863.1
868.12
865.00
860.1
879.8
786.05
786.2
E9912

51.22
44.69

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	8	8

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0 0	0	8	8

Signature of Attending Medical Officer [redacted] Medical Records Officer [redacted]

b(6)-2

Automated Facsimile - DA FORM 3647, M[redacted]

MEDCOM - 24809

MEDICAL RECORD | 0400 (3 NOV 68) ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION (Enter date of admission)

35 y/o c̄ shrapnel inj to abd chest

Med & Allo sh PMH

143/66 90 24 100%

PHYSICAL EXAMINATION

HEENT - multiple superficial perf

neck -

chest - superficial perf on MMR 5 (4)

abd - several perf c (+) peritn by CT

pelvis stable

extr - moves all

Hct 43

PROGRESS (Enter date of discharge and final diagnosis)

WBC 28

PT 34 | 137 / 108

PTT 15 | 38 / 20

IV at | glu 213 urat 1.0

b(4)-2

[redacted]

SIGNATURE OF PHYSICIAN [redacted] | DATE 18 NOV 03 | IDENTIFICATION NO. | ORGANIZATION

PATIENT'S IDENTIFICATION (For typed or written entries give Name, last, first, middle, grade; date; hospital or medical facility) | REGISTER NO. | WARD NO.

[redacted]

b(4)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

539-108

117

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES b(6)-2 b7
18 NOV 03 1700	Pt awake, speaking in arabic, VSS, c/o pain, but falls asleep before medicated. HRRR, LCTAB, (+) BS x4, (+) peripheral pulses. NGT to (R) nare to LIS. green/br drainage noted in tubing. Pt transferred from ICW #2 for EPW status. Lips swollen c̄ blood (old + dried) inside of lips. multiple shrapnel wounds to upper body (superficial). 4x4 to (R) chest wall on arrival. Drsg to midline abd from ex-lap done earlier this AM. Drsg to lower abd., both drsgs c̄ bloody shadowing. Ø drsg Δ ordered @ this time. LR @ 125cc/° infusing into (L) AC ∑ complication. no diet ordered, PT NPO d/T NGT. Voiding via via foley. Will monitor [redacted] IWM6.
18 Nov 03 1730	I concur c̄ initial abd assessment above. — [redacted]
18 nov 03 @ 2315	assumed care of pt @ 1800. VSS, [redacted] pain but falls asleep quickly, awakens to verbal stimuli. Alert, speaks arabic; LS CTA, ↓ bases, sats 96-98% RA, IS i̇ CDB completed, instructed pt on splinting technique. (+) BS present, NG to LIS, dark green output noted, ML Abd incision (⊥) c̄ drsg c̄ marked drainage noted. (CONT)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		
	LAST	FIRST	MI [redacted]
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10
USAPA V1.00

#[redacted] b(6)-4

MEDCOM - 24811

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18NOV03@ 2345	(CONT) Foley to gravity QS clear/yellow urine. D/C IV c̄ NFS as ordered. Oral care provided. 2pt restraints on 3 S/SX skin/circulation compromise. Plan: cont CDB/IS, IVFS, IVABX, monitor HOS, monitor drsg, pain control [redacted]
19NOV03 @0545	1+05 24° b(6)-2 IN= IV=4200 OUT: NG= 250cc NPO UOP= 2800 4200 / 3050 [redacted]
19NOV03	Pt. Awake + Oriented x3, pt c/o pain, but pt fell into deep sleep. Pt dressing changed PBSO by myself and Dr Nordberg, wet to dry @ shoulder, mid sternum, @ lower abd (pubic region), @ lower abd, some require slight packing, foley to gravity pendy d/c today, NG tube draining dark brown mucus, pt VSS stable, LS CTA OBS x4, pt receiving LR 125cc/hr, wild monitor
1350 1801	Pt c/o of pain, given 6mg MSO4, pt foley d'ced ~~voiding via urinal~~ [redacted] Δ'd (1801) minimal drainage reddish in color, VSO D given 4mg MSO4 pre-medicate pt sleeping. [redacted]
	(1800) I concur c̄ assessment. [redacted] b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
20NOV03 @0245	assumed care of pt @ 1800. VSS, exception: slightly tachycardic 110-115, febrile @100.1. alert, but sleeps often, arouses to verbal stimulus. LS ō ↓ bases IS, CDB completed q1° before MN. Splinting technique encouraged. Hypoactive BS noted, cont NPO status, NG to LIS ō amount of lt green fluid output. Pt unable to void spontaneously, foley reinserted ō 700cc UOP noted (approx 2300 hrs). C/o pain when CDB, but falls asleep quickly. ML drsg CDI, SP drsg CDI. 2pt restraints in ō S/Sx of skin/circulation compromise. Plan: cont IS/CDB, enc ↑ OOB, monitor NG output, monitor drsgs.
	[redacted]
	addendum: new IV started in RFA, 20G. IVFS cont. [redacted]
20NOV03 @0530	24° totals 1to5
	In = IV = 2000 Out: Foley = 2020 b(4)-2
	NPO NG = 270
	2000 2290 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

[redacted] b(4)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20NOV03	(1340) NSG - VSS. Pt c/o pain to sutures on abdomen + (R) groin. Premedicated pt c̄ 2mg MSO4 IV prior to DSG Δ. Dr [redacted] b(6)-2 viewed sutures. Dr. [redacted] b(6)-2 ordered to pack lightly (R) groin openning. Sutures to ABD + (R) groin loosely sutured. ⊖ S/Sx of infection to either sutures. Dr. [redacted] removed sutures to suprapubic cath. Suprapubic intact + draining clear, yellow urine. Pt amb on ward c̄ steady gait. No bacitran applied to underside of penis 2° Dr [redacted] b(6)-2 request. Pt appears to be comfortable. Will continue to monitor pain. [redacted]
20NOV03	(1400) NSG. VSS x̄ temp 101. Will continue to monitor. MD made rounds + saw pt. New order for D/C Foley + NGT. Foley D/C'ed @ 0920. DTV @ 1520. Explained to pt to void by 1520. D/C'ed NGT @ 1520. 85cc output of dark green content. Pt taking sips + chips well. Pt has 125cc/hr LR infusing. MD ~~orde~~ verbal order that staff may do BID DSG Δ's. WTD DSG Δ completed c̄ ⊖ S/Sx of infection. Lung sounds clear through all lobes. Encouraged pt to ~~t~~ IS. Pt demonstrated proper use. Bowel sounds hyposactive. ⊖ BM since admission. Will continue to monitor pt on strict I/O's. Will continue to Record. [redacted] b(6)-2
21Nov03 @ 0455	Assumed care @ 1800; VSS, pt alert + speaking arabic, ⊖ c/o pain; pt c/o nausea, 25mg phenergan administered; All dsgs Δd W→D, ⊖ S/Sx infection; staples to midline CDI, well approximated; pt voiding QS, clear urine via urinal; pt TOL sips & chips; PIV patent infusing LR @ 125cc/hr ⊖ S/Sx infection/infiltration; ⊕ BS x4, hyposactive, ⊖ BM, restraints in place, ⊕ circ, ⊖ skin breakdown. Will cont to monitor. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.0

[redacted] b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11-20-03	GEN Surg
0900	Good pain control. Good Resp effort c̄ Cough
POD#2	Using IS. Unable to void spontaneously c̄ foley
	d/c yesterday — foley replaced.
	c̄ (P) temp 100.5 last PM — now afeb
	VS 121/79 104 28 93% RA T_c = 99°
	94% RA T_m = 100.5 @ 2000°
	I/O @ 24° : 2000 / Urine 2020 NGT 270
	A/O, NAD CXR (PVN) 11/18 = ∅ pneumo
	Lungs CTA (B)
	CVS mild tachycardic ∅ S3 S4 (M)
	ABD NB / (B) periincisional tenderness ∅ BS
	Imp · POD # 2 s/p Exlap / Cholecystectomy / gastric penetration repair
	good post op recovery
	Plan (1) D/c foley → replace if void c̄ 6°
	(2) D/c NGT
	(3) Sip / chips
	[redacted] MD
	LTC MC
	[redacted] b(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.		WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Gen Surg
11-21-03	~~Alert 3~~, overall improved. tolerated sips
0900	VS 121/71 104 99.6 = Tc/Tm 93% RA
	Alert x 3
	Lungs CTA (B)
	CVR RRR ⌀ S3 S4 m
	ABD (+) BS
	Imp · good post op recovery
	Plan (1) pain to clears
	(2) IS/OUB
	[redacted] CTL MC
11-22-03	Gen Surg b(6)-2 A11
0910	Tolerating clear. c/o pain @ surgical wound @ (R) JAW.
0900-1600	voiding spontaneously. (+) FLATUS Remains afeb.
	VS 121/71 104 99.6 = Tm/Tc 93%
	~~121/71 104 99.6 = Tm~~ 1300/1600
	A/O x 3.
	HEENT Mild edema (R) periorbital - surgical wound
	⌀ exudates
	Lungs CTA (B)
	CVR RRR ⌀ S3 S4
	ABD NO/NT ⌀ (+) gastrointestinal
	(+) NABS
	Imp · Contd post op recovery
	Plan (1) Advance to regular
	(2) close observation (R) antibiotics
	[redacted] CTL MC

STANDARD FORM 509 (REV. 5/1999) BAC
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

21NOV03 20-21NOV03 @0600 24° I/O

Input: 1800cc

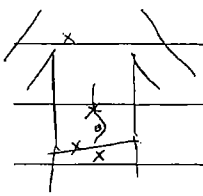
Output: NG - 85; Urine - 1600

b(6)-2 A-1

[redacted]

21 NOV03 (1730) NSG - VSS. c/o abd pain. Med c̄ 4mg MSO4. Pt OOB to chair ~2 hrs. Tol well. AM care done by pt. Strict I/O's. IS complete. Encourage pt to do IS. Pt to clears. Will monitor tolerance of PO diet. Pt diures in urinal. Dark, yellow c̄ difficulty flow bag of LR hung @ ~~1515~~ 1715. Will continue strict I/O's. [redacted]

22NOV03 @0245 Assumed care of pt @1800. VSS. Cont c/o abd pain ? (L) cheek pain. MSO4 5mg IV given c̄ good relief noted. LS CTA, (+) BS, tol clear liq diet well, enc po fluid intake; ML abd incision OTA, x4 small wounds c̄ NTD drsgs, CDI, ~~o~~ drainage. Pt OOB AMB c̄ min assist, tol well. IVFs cont. Voiding per urinal QS. 2pt restraints on S S/sx of skin/circulation compromise. Plan: cont IS, enc po intake, IVFs as ordered, enc AMB. Will monitor. [redacted]



22Nov '03 Assumed care of pt @0600 pt awake + oriented x3, pt c/o wild [illegible] (L) cheek pain and abd pain (1400) given 5mg MSO4. pt ambulated with walker to BR with difficulty, and vomited pt could not have

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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USAPA V1.00

[redacted] b(6)-4

MEDCOM - 24817

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(4)-2 A-1
	cont.
22 Nov '03	successful bowel movement, feels pain and constipation. Dsg CDI, with minimal drainage. Pt tolerating PO with some nausea, Restraints x2 in place ⊕ circulation ⊖ skin breakdown.
	Sp[redacted]
	(1710) I concur c above assessment [redacted]
23 Nov 03 @0300	assumed care of pt @ 1800. VSS. C/O abd pain c̄ IS & CDB, movement/activity: LS CTA, ⊕BS, Tol reg diet, some nausea p̄ dinner. Medicated c̄ Phenergan 25mg IV c̄ good relief, rated. M/abd incision OTA c̄ staples, CDI. x4 small WTD drsg Δs, all healing well s̄ drainage. Pt ↑ amb in hallway, ↑ in chair x2 hours. Cont IS & CDB. 2pt restraints on s̄ s/sx of skin/circulation compromise. Plan: cont enc PO, enc IS/CDB enc OOB. [redacted]
23 Nov '03 1000	Pt. Awake+Oriented x3, Vital signs stable, pt ambulated well, up and down stairs with ø c/o pain or dizziness. Pt out of bed to chair x 8 hours, pt tolerating po food with mild nausea. Pt. encouraged to perform pulmonary toilet exercises. Pt occasionally c/o pain in Abd area, as per Doctor Sandberg Q4. Restraints x2 in place. ⊖ skin breakdown, ⊕ circulation intact. [redacted]
Pt taken for OR PAIN	(1920) I concur c̄ above assessment. [redacted]
23 Nov 03 2140	Assumed care of Pt @ 1800 LS CTA ⊕ HRRR ⊕BS x4 quads, IV Abx Infused via 20G in ⓛ FA. ⊖ s/sx infection. Drsg to chest abdo CDI. Pt Pain controlled c̄ percocet. Will cont.

STANDARD FORM 509 (REV. 5/1999) BACI

MEDCOM - 24818

USAPA V1.0

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23Nov03 cont	to monitor pt — [redacted] b(4)-2 Spc 91WMb
24NOV03 0830	- Assumed care of pt A+O x3. VSS & c/o pain @ this time. Lungs clear. Active BS x4 quads. Tolerating PO well urinating spontaneously w/ difficulty. Mult. shrapnel wounds to abdomen, chest, and pelvic region & active bleeding noted 2x2 dsg applied. CDI. Assessment findings WNL OK for discharge to camp - [redacted]
1200 -	& c/o pain or discomfort @ this time 1200 percocet not given — [redacted]
1603	- Pt c/o pain to abdominal region percocet 1 tabs given per order — [redacted]
1800	Pt A+O VSS. LS CTA(B). HRRR. (+)BS x 4 quad. Drsg to Torso A/D. Wounds are pink c̄ dark Tissue peripherally. Pt c/o Pain to Abd. mid line Abd incision closed c̄ staples OTA. No s/s of infection noted. Will cont to monitor. — [redacted] Spc 91WMb
2400	Pt refuses Percocet. — [redacted] Spc 91WMb
24 NOV 03 0800	- Assumed care of pt. A+O x3 VSS. Minimal complaint of pain to surgical site. approx 12 inch midline abdominal incision & drainage open to air

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
[redacted] b(4)-4		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1C
USAPA V1.0(

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 NOV 03	secured c staple healing well. Multiple shrap
cont	wound small 2X2 gauze applied Lungs clear [redacted]
	Active BS tolerating PO well voiding spontaneo
	Pt OK for discharge med at pharmacy orders
	written. Will cont to monitor — [redacted]
1200	Pt discharged escorted by MP to camp condition
	stable & complaints — [redacted] Alhmed
	b(4)-2 A11

STANDARD FORM 509 (REV. 5/1999) BAC

USAPA V1.

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	GEN SURG
11-25-03	pt c/o SOB - c̄ pain (ABD/periumbilical) c̄ cough.
1000	∅ pleuritic pain. Tolerating Regular diet
POD #5	125/76 102 97 98.7 Tm 98°
	I/O 3000/1225
	Pulse ox RA 98%
	A&Ox3, NAD Cough c̄ thick white secretions
	Lung CTA (B) all fields
	Cor RRR ∅ S3 S4
	ABD (+) BS, ND/NT ∅ R/G/RBT
	(A) (1) POD #5 s/p EtOCAP/cholecystectomy/gastric penetration repair
	(2) Prob chest congestion - low prob for PE
	c̄ Resume small (2) Pneumo - w
	(P) (1) CXA PA/LAT
	(2) Resume ĪV po diet - pt may refuse
	(3) Pulm toilet [redacted] b(6)-2
	[redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.	WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	GEN SURG
11-24-03	PROGRESS NOTES from 11-20 to 11-23 missing from chart.
0843	Resent c/o previous 24° SOB ± (+) Sputum (White) CXR PA/LAT
POD #6	± E/O previous Pneumo Tx; ∅ infiltrate. Now ± overall improvement
	± Aggressive Pulm toilet. c/o ABD GAS PAINS. Tolerating p.o.
	V 124/73 104 16 98.1 98% RA I/O 1200/800
	A/O x3 NAD
	Lungs CTA(B)
	CVR RRR
	ABD NO/NT (+)BS ∅ R/G/KBT
	Wound intact, Staples in place
	Imp POD #6 s/p Ex Lap/Gastric Repair of penetrating wound/Chest tube for penetrating wound
	(1) ∅ E/O Sepsis/Hemodyn instability
	(2) Return of NL Bowel fx
	(3) ∅ E/O Pneumonia
	Plan (1) Observe x 24° for E/O Resp compromise
	(2) Antibiotic d/c 24°
	[redacted] b(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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[redacted] b(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

~~11-21-03~~

11/25/03

Narrative Summary DOA: 11-18-03 Day of Discharge:

ADMITTING DX ABDOMINAL INJURY c̄ PENETRATING WOUNDS to GALL BLADDER AND STOMACH

HPI / Hospital course 35 yo IRAQI ♂ s/p SHRAPNEL INJURIES to face, chest and ABDOMEN ON 18 NOV 03. EVACUATED and STABILIZED at 28th CSH EMT.

CXR (PREOP) c̄ SMALL (L) pneumothx. Pt underwent Emergent Surgery c̄ Ex-lap / cholecystectomy / REPAIR of penetrating wound to stomach. OPERATIVE Findings of 2 penetrating wounds (1 cm and 2 cm) to greater curvature to stomach and penetrating wound to GALL BLADDER. REMAINDER of Pelvic And ABDOMINAL ANATOMY WNL. POST op Recovery Unremarkable (L) Pneumothx c̄ spontaneous Resolution. Tolerating Regular diet.

Procedure (1) Ex-lap / Cholecystectomy / Repair of GASTRIC penetrating wound
(2) Pre op CT CHEST / ABD

DIET REGULAR

D/C MEDS (1) MOTRIN 800 mg po Q8° prn (2) percocet II po Q4-6° prn

F/U (1) FOLLOW up c̄ PRISION MD for Staple Removal from ABD on 28 NOV 03
(2) SEEK IMMEDIATE care for TEMP > 100.4°F, UNABLE to tolerate ~~Regular~~ liquids; ABNORMAL Bleeding

POSTOP DX: (1) Superficial shrapnel wounds to face, chest, ABD
(2) S/P Ex-lap / Cholecystectomy / GASTRIC REPAIR for penetrating ABD wound b(6)-2
(3) (L) pneumothorax - spontaneously resolved

[redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		SPONSOR'S ID NUMBER (SSN or Other) LTC MC
	LAST	FIRST	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	REC[redacted]	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

REGISTER NO.	WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10
USAPA V1.0C

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11-18-03	Brief OP NOTE
	Preop Dx Penetrating Wound ABD 2° explosion
	Post op Dx Penetrating Inj Stomach SURG SDANU / Sundberg
	Penetrating Inj Gall Bladder small ⊕ pneumto Anesthesia: GETA Anesthesiot: DOLAND
OP TIME	Procedure: Ex lap / Cholecystectomy / Repair of GASTRIC Injury
0500/0700	IVF 3200 ~~2500~~ [redacted] EBL 75 U.U 700 NGT 500
	Specimen ∅
	DKAM ① NOT ② Fully to gravity
	OP Finding - 1cm penetrating wound greater curvature Stomach
	- 2cm penetrating wound greater curvature Stomach
	- 5 mm penetrating wound Gall Bladder - ~ 50 cc hemoAmma
	- Colon / small Bowel / Bladder / ~~spleen~~ ∅ injury
	- Spleen c̄ 1-2 mm area of avulsion → hemostatic staple
	Complication None
	Dup PACU - extubated
	[redacted] m.D. LTC MC
	b(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* REGISTER NO. WARD NO.

#[redacted]

b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11/19/03	Gen Surg
0800	~~Abd~~ Remains c̄ NGT / NPO. Cont c̄ good pain control
	c̄ MSO4 prn.
	VS P 073 111/76 100 98³ Tm 99³ (7600 11/18/03) 99% RA
	I/O 4200 / 3050 NGT / 240 350 cc's
	Lungs CTA (B) Ø R/R/C
	Cor RRR Ø S3 S4 M
	Abd ND/NT Ø BS
	~~wound intact~~ incision intact c̄ staples
	Sigma pelvic wound –
	(B) HP / (G) HP wound } Ø E/O infection
	(R) mid CHEST wound
	Imp (1) POD 1 s/p Excap / Chole cystectomy / Repair of penetrating
	stomach wound. Remains Abd.
	c̄ Ø E/O Bowel Sx
	(2) Multiple superficial wounds – Ø E/O infection
Plan	(1) OOB ambulate (3) small (2) pneumothorax –
	Ø E/O Resp decompensation
	(2) IS use
	(3) D/C Foley
	(4) wet-dry dressing D BID
	(5) Cont NGT / NPO
	[redacted]
	D (u)-2

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 18Nov03 | PATIENT ACUITY LEVEL: | POST-OP DAY: | HOSPITAL DAY:

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time 0815 To ICW2 From ICW3 [redacted] ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☒ STRETCHER

Total ER/RR/PACU time _____ Physician Dr. [redacted] Anesthesia (Specify): _____

Procedure/Diagnosis Ex lap, schrapnel inj. BP 150/85/82 P 76 R 20 T 96.4

LOC A+O Neurovascular checks _____

Dressing/cast Abd. Tubes Foley NG→LIS

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication b(6)-2

Other X-ray on arrival Bedrest

Report From SGT [redacted] Received By MAJ [redacted]

VITAL SIGNS

TIME:	0900	1200	1600												
BP ARTERIAL LINE															
BP CUFF	156/80	136/74													
TEMPERATURE	97.2	97.1													
PULSE	98	91													
RESPIRATORY RATE	20	20													
OXYGEN (L/%)															
PULSE OXIMETER	96%	96%													
O2 METHOD	RA	RA													

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0900	1200						
PAIN INTENSITY (10 / 5 / 0)	X							
MED ADMINISTERED (Y/N)	X							
RELIEF ACCEPTABLE (Y/N)	X							

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

	TIME:		
*Skin breakdown prevention			
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT

PATIENT IDENTIFICATION

C[redacted] Iraqi Civ.

b(6)-4

DIAGNOSIS: S/P EXLAP; SHRAPNEL INJURY

DRG: _____ ADMISSION DATE: 18NOV03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

MEDCOM FORM 680-R (TEST) (MOHCH) MAR 03 PREVIOUS EDITIONS ARE OBSOLETE Page 1 of 1

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
MOTION						
PASSIVE FLEXION						
PERIPHERAL PULSE						

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(>5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY / OTHER

TIME:			
ID band visible/legible			
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE:
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT _____	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT _____	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT _____

TEACHING

TIME: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
CONTENT:	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
[redacted] b(4)-4	[redacted] b(4)-2	[redacted]	D

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT FOR Use this form. See AR 40-407: the Proponent agency is The Office of the Surgeon General.
1. AGE 35 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodin, Tape, Medication) ☑ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD REACTION:
	3. PREVIOUS SURGERY [ ] NO [ ] YES (type): ??

4. PROPOSED SURGICAL PROCEDURE:
Expl Lap.

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition Intact
Tobacco ?? ppd X ?? yrs Body Piercing Ø Diabetes (Y) (N) ?? ROM Clear ASA/Motrin W 72hrs (Y) (N) ??
ETOH ?? Implants Ø Respiratory Disease (Asthma COPD) (Y) (N) Anticoagulants (Y) (N) ??
Glasses/Contact (Y) (N) ?? Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) ?? MEDS: ??

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ potential for anxiety related to: ✓ 1) Surgical Procedure& Operating Room Environment ✓ 2) Separation Anxiety (Child) ___ 3) Surgical Outcomes	✓ O Pt. verbalizes any specific anxiety. ✓ O Pt. Exhibits relaxed body posture.	✓ O. Allow pt. to verbalize freely. ✓ O. Explain Or environment and answer questions regarding surgery. ✓ O. Offer comfort measures. (e.g. warm blanket. touch). ✓ O. Explain all nursing procedures before they are done. ✓ O. Remain with pt. Whenever possible. ~~O. Maintain family interface~~. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	✓ O Pt. will be able to breath without difficulty during immediate intraoperative phase.	✓ O. Offer to elevate head of litter or offer pillow. ✓ O. Observe pt. While awaiting surgery for signs of distress. ✓ O. Assist anesthesia during intubatior and extubation.
C. INTEGUMENT ✓ Potential Impairment of Skin Integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ✓ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	✓ O Pt. will exhibit signs of impairment of skin integrity (e.g., reddened areas).	✓ O. Utilize pressure preventing devices on OR table and accessories. ✓ O. Check for proper positioning and support to maintain good body alignment. ✓ O. Pad pressure points. ✓ O. Place ESU ground pad on non compromised skin surface area. ✓ O. Keep prep fluids form pooling.

9. PATIENT'S IDENTIFICATION: (For typed or written entries give: Name-last, first, middle; grade, data; hospital or medical facility)

[redacted] b(6)-4

VERIFICATIONS AT HOLDING AREA:

! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since_____ ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact precautions (Y) (N)
! Family/Friend:_____

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION _____Potential for inadequate tissue perfusion due to: _____1) Intraoperative Mobility _____2) Positioning _____3) Existing Disease _____4) Safety Devices _____5) Hypothermia	O. Pt. will exhibit signs of adequate tissue perfusion (e.g. color, warmth. pedal pulse.	O Check foe support stocking or ace warps. if none, check with doctors. O Check that safety straps are correctly applied. O Offer pillow for under knees. ~~O Place and take down legs from stirrups with slow bilateral motion.~~ O Check that rings and all body ~~piercing has been removed.~~
E. NEUROMUSCULAR CONTROL E.I. _____Potential Impairment of Mobility due to: _____1) Pain _____2) Intra operative Hazzards _____3) prosthesis _____4) Positioning _____5) Transfer pt. To/form OR table E.2. _____Potential Discomfort Due to: _____1) Length of Surgery _____2) Positioning _____3) Arthritis	O pt. will be transferred to OR table without difficultly. O pt. will be not experience unnecessary physical discomfort.	O Have sufficient people available for transfer. O Insure proper body alignment. O Allow patient to lie in position of comfort while waiting for surgery. O Offer support (i,e..pillows. Bath towel. etc) for positioning.
F. Special Senses F.I. _____Diminished visual perception due to being: _____1) pre-medicated _____2) W O GLASSES F.2. _____Potential for Decreased Communication due to: _____1) Diminished Hearing _____2) Language Barrier F.3. _____Potential Injury due to Dentures: _____1) Upper _____4) Caps _____2) Lower _____5) Crowns _____3) Bridges	o pt. will be made aware of surroundings prior to anesthesia induction. o pt. will be transferred safely to OR table. o pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	O Introduce self. keep pt informed as to where he. she is and what is happening. O Inform pt. in which direction to move and assist if necessary. Speak clearly and slowly. O Address pt. from _____ side. O Validate pt.'s understanding of verbal communication. O Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS OR Continuation of Above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS **OR continuation of above interventions.**

10. OR NURSING INTERVENTION COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

_____ _____ DATE

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☐ MOVES ALL EXTREMITIES ☐ Moves Upper Extremities ☐ Transferred to Litter With roller due to spinal
SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT: (Y)(N)
BREATHING EASY: (Y)(N)

12. PREOPERATIVE EVALUATION PREPARED BY
[redacted] b(6)-2
DATE: 18 NOV 03 TIME:

13. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] b(6)-2
DATE: 18 NOV 03 TIME: 07/s

REVERS OF FORM 5179, JUN 91 MEDCOM - 24829 USAPA V1.0

b(6)-2

MEDICAL RECORD — INTRAOP[illegible] DOCUMENT

For use of this form, see AR 40-407 — [illegible]ency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERA[illegible] VIA Litter BY Dr [redacted]

2. PATIENT IDENTIF[illegible] [illegible]ECORD REVIEWED AND PROCEDURE VERIFIED BY DE(A HH (EMERGENCY)

3. DATE 18 NOV 03 TIME PATIENT ARRIVED IN SUITE 0440

4. PATIENT IN ROOM TIME 0445 NUMBER 1-

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

COMMENTS: Pt able to move. able to follow commands

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Maj [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

Pt placed - OR Bed. Ana finally aligned correct (neutral)

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE ☐ LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Arm board, legs stripped - Strapped above knees 2". All PPP

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

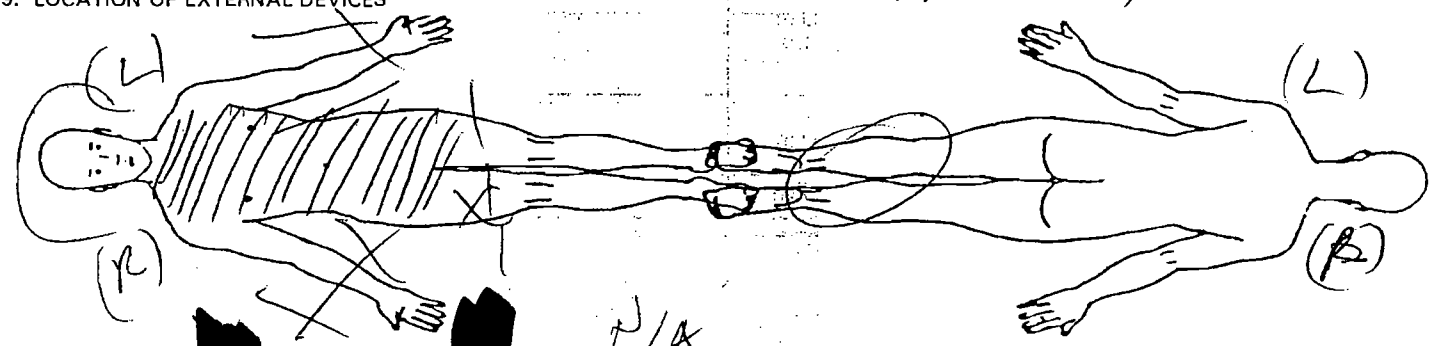
PREP SOLUTION (Specify) BETA / BETA

SITE: Neck / Groin BY WHOM: [redacted]

SITE: BY WHOM: b(6)-2

COMMENTS: ¢ pooling of Betadine

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] Pad -- Safety Strap = = = Tourniquet N/A

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C		
Needle Sharp	☒ Yes	☐ No		C	C		
Instrument	☒ Yes	☐ No		C	C	SPC [redacted]	[redacted]
Other	☐ Yes	☒ No					

b(6)-2

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)

[redacted]

b(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: Valleylab 40 Rev 1 Cat 45 Cog 45

GROUND PAD: BRAND Conmed

LOT NO: 69441 2005/03

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

13. PROSTHESIS, IMPLANTS ☐ YES IF YES NAME: ID NUMBER MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 16Fr Foley	2.	3.
SITE	1. Bladder (EH)	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8
Tape

19. ADDITIONAL INFORMATION
S: [redacted]
Sunburg b(u)-2
A: [redacted] Tyre Betta.
Bowel sounds clear, by auscult pre-post op
Dressing clear by auscult

20. OPERATION(S) PERFORMED
Exploratory lap / cholecystectomy

21. PATIENT TRANSFERRED TO b(6)-1 ICU, TIME 0715 METHOD LITTER

[redacted] NURSE SIGNATURE

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOV 19 03 — DAY: 18, 19, 19, 20, 21, 22, 22

HOUR: 0 1 2 0 0730 1530 2 0 0 0 2 1600 1800

PULSE (O) / TEMP. F (•) — TEMP. C (Centigrade Equivalents, for Reference only)

105° 40.6°
180 104° 40.0°
170 103° 39.4°
160 102° 38.9°
150 101° 38.3°
140 100° 37.8°
130 99° 37.2°
98.6° 37.0°
120 98° 36.7°
110 97° 36.1°
100 96° 35.6°
90 95° 35.0°
80
70
60
50
40

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

[redacted] b(4)-41 (epu) [redacted]

REGISTER NO.

WARD NO. ICW 2 / ICW#1

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																		
POST-	DAY		NOV		NOV													
MONTH-YEAR	DAY		23		24	25												
19	HOUR				7	0700												

PULSE (0)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD		125																
		76	6		8													
BLOOD PRESSURE	① P	102	124/78		110/60	113/70												
	② Spo2	97				H 102												
	③ TEMP	98.7	98.1		98.0	T 98.3												
HEIGHT:	WEIGHT ~~TEMP~~																	
	④ O2 Sat		98%		97%	97%												
	SOURCE		RA		RA	RA												
	⑤ O2 Sat SOURCE																	

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) **BACK**

[redacted]

b(6)-4

23Nov 03 0[illegible] 24 Nov 03 0600

OUTPUT

Input		URINE		Output		NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
1745	550cc		1745	500cc					
	240cc								
	790cc		0545	300					
0545	500								
	In			OUT					
	1290			800					

CHEST						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

[redacted] b(4)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1518	550cc				
2200	575	1125cc			
0800	350	1475cc			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

INS ~~CHEST~~

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1800	juice (180)	180			
1800	H2O (500)	680			
2200	juice (180)	860			

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

[redacted]

b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

19NOV03 0600

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0830	300cc				
1310	440cc				
1801 total	1020cc				
Foley 2300	700				
0530	300				
24° total =	2020				

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL
1801	220cc		
0530	50		
24° total =	270cc		

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

INTAKE (IV) ~~[illegible]~~

TIME	AMOUNT	TYPE	ACCUM TOTAL
1801	400cc		400
18-06	1500	LR	1900
2400	100	zantac	2000

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

[redacted] b(4)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

OUTPUT

URINE						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
1630	800	800cc				0500	250	dark green	250cc
2300	1000	1800cc							
0515	1000	2800cc							

CHEST						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS				
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT			
TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

[redacted]

blad-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
	120	LARGE SOUP BOWL	240
SMALL FRUIT CUP	160	LARGE WATER GLASS	240
COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74

MEDCOM - 24837

Transfer to CMI 1 @ 1615 (No. [illegible])

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM 0700 HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE 18 NOV 03

INTAKE

ORAL				INTRAVENOUS					
TIME	TYPE	AMOUNT	ACCUM TOTAL	TIME STARTED	AMOUNT	TYPE *(Include Medications)*	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
	(NGT)			?	1000	LACTATED RINGERS	1000cc	1030	1000
				1000	1400	LR	1000cc	1430	2000
				1400	1000	LR @ 125cc/°	1000cc	2200	3000
				2200	1000	LR	1000cc	0600	4000
				2000/04	50X2	Ancef	100		4100
				2400	100	zantac	100		4200

IRRIGATIONS *(N/G, Bladder, etc.)*

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT *(i.e. B1, Alb, P. cells etc.)*	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
	GRAND TOTAL INTAKE		

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

[redacted] b(6)-4

MEDCOM - 24838

Started NOV 03 @ 0600

OUTPUT Ends: 01 NOV 03 @ 0600

URINE					
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0800	~~400~~ 400	400			
1600	400	800			
2400	400	1600			
0500					

NASOGASTRIC			
TIME	AMOUNT	TYPE	ACCUM TOTAL
0930	85	NG	85

D/C'd

CHEST					
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

INTAKE (IV) ~~EMESIS~~

TIME	AMOUNT	TYPE	ACCUM TOTAL
0800	50	Zantac	50
~~0800~~			
920	~~50~~ 200	LR @ 125	
2400	50	Zantac	
1800-0600	1500	LR @ 125	
			1800

STOOLS				
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT			
TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

[redacted]

b(4)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1730	525	~~525~~			
1806	700	1225			

I V Input ~~NASOGASTRIC~~

TIME	AMOUNT	TYPE	ACCUM TOTAL
1730	1500	LR	
1806	1500	LR	3000

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

21NOV 0600 – 22NOV 0600

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

[redacted]

b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180