Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 04 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11	(b)(6)-2	MSO4 5mg IM x1	11	09:20	09:20	(b)(6)-2
11		Tetanus 0.5 ml IM	11	11:00	11:00	
13APR03		Cncf Tsgn HPB q8° x48 then keflex 250 QID.	Noted			

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
-11-	(b)(6)-2	Morphine Sulfate ~~2-8~~ mg IV q ~~2-4~~ hr PRN pain	1610 3mg	1700 3mg	1930 11Apr	2315 11Apr	12Apr 5:30	12Apr 10:03	12Apr 1640	12Apr 05:16						
-11-		Phenergan 12.5-25mg IV q 4-6 hrs ~~prn N/V~~		MF	3mg	4mg	8mg	8mg	4mg	8mg						
-----		MOM 30cc PRN Gastric Upset														
-----		NS / LR bolus X ___ liters														
-----		T #3 1-11 PO q6hr	1945 11Apr	/	/	2300 11Apr	1300 12Apr 03	1815 12Apr 03	13Apr 01:00 2Tab	13Apr 10:30	13Apr 1600	13Apr 2110	14Apr 01:00			
-----		PRN pain														
-12-		Motrin 800mg PO	12Apr 1900		13Apr 1530	13Apr 2345										
-----	-----	PRN Breakthrough pain														
-----	-----															
-----	-----															

USAPA V1.00

NON

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-40. 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 20	21	22	23	24	25	26	27	28	29	30
20 Apr 03	(b)(6)-2	vitals signs routine	07 19	(b)(6)-2										
			19 07											
4/23/03 20 Apr 03	(b)(6)-2	regular diet	07 19							(b)(6)-2				
4/23			19 07											
4/23/03	(b)(6)-2	Wet to Dry dressing Δ to	07/19	/	/	/	/	(b)(6)-2						
		(R) thigh & (L) heel BID pin	19/07	/	/	/	/							
		care BID												
4/23/03	(b)(6)-2	V.S. Q 4 Hours	7/19	/	/	/	/							
			PM/7	/	/	/	(b)(6)-2							
4/23/03	(b)(6)-2	Activity Up Ad lib on	7/19	/	/	/								
		crutches Wt. bearing as	19/7	/	/	/								
		tol'd on (L) LE												
4/23/03	(b)(6)-2	Nursing: Up on Crutches	7/19	/	/	/	(b)(6)-2							
		BID	19/7	/	/	/								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) segment femur fx (L) heal wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(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 NON (MEDICATIONS)				Mo. ____ Yr. ____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	------	Heplock IV	19 Apr 03	ASAP	1630	(b)(6)-2
	------	NPO ⊼ midnight	19 APR 03	2359	2359	
20Apr03	(b)(6)-2	Heplock IV ī good po	20 Apr 03			
		Admit patient to ward				
23Apr03		Admit to ICW 3	23 Apr 03			
	------	DX (R) open femur fx				
	------	Cond: Stable				
	------	Nursing: Up on crutches BID				
	------	VS q 4°				
	------	DIET: Reg				
	------	Activity: Up Ad lib on crutches Wt.				
	------	bearing A stol'd on (L) LE				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
------	------															
------	------															
------	------															
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U.S. GOVERNMENT PRINTING OFFICE: 1993 342-027/70450

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													
				13	14	15	16										
13 APR 03	(b)(6)-2	Keflex 250mg p.o. QID	0600	/	/	/											
			12	/	/	/											
			18	/	/	/											
			24	/	/	/											

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

(R) Femur fracture, (L) heel wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(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.

MEDCOM - 4176

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
21Apr03	(b)(6)-2	Restoril 15-30g PO q HS PRN	1840 [illegible]	2030 [illegible]													
21Apr03		Demerol 50-100mg PO q 4° PRN															
21Apr03		Dilaudid 2-4mg PO q 4° PRN															
21Apr03		Benadryl 25-50mg IV q 4° PRN	[illegible]														

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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. 04 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	22	23	24	25	26	27
14 Apr 03	(b)(6)-2	Heparin 5000u SQ BID	10	/	(b)(6)-2												
			22														
14 Apr 03		Ancef 1gm q8 IVx72h	06														
			14							DC							
			22														
3 ~~14 Apr 03~~	(b)(6)-2	Gentamycin 300mg IV q24	10										(b)(6)-2				
~~17 Apr 03~~		Lovenox 30mg SQ BID	10	/	/	/	(b)(6)-2										D/C
			22	/	/	/											D/C
17 Apr 03	(b)(6)-4	Ancef 1gm q8° IV	06	/	/	/											
			14	/	/	/											
			22	/	/	/											
20 Apr 03	(b)(6)-2	Ancef 1g IV q8°	06	/	/	/	/	/	/	/	(b)(6)-2						
			14	/	/	/	/	/	/	/							
			22	/	/	/	/	/	/	/							
20 Apr 03	(b)(6)-2	Heplock Flush Q shift	07 19	/	/	/	/	/	/	(b)(6)-2	(b)(6)-2						
			19 07	/	/	/	/	/	/								
23/APR 21 APR 03		Ancef 1g IVPB Q8°	06	/	/	/	/	/	/	/	/	/	10	0			
			14	/	/	/	/	/	/	/	/	(b)(6)-2					
			22	/	/	/	/	/	/	/	/						
4/23/03	(b)(6)-2	Gentamycin 400mg IVQD	10	/	/	/	/	/	/	/	/						
4/23/03		IVLR @ 125 heplock when	7/19	/	/	/	/	/	/	/	/	/	(b)(6)-2				
		tol'g PO meds	19/7	/	/	/	/	/	/	/	/	/		D/C			
4/23/03		Colace 100mg Cap PO BID	0800	/	/	/	/	/	/	/	/	/		(b)(6)-2			
			2100	/	/	/	/	/	/	/	/	/					
4/24/03		Flush Heplock Q shift	7/19	/	/	/	/	/	/	/	/	/	(b)(6)-2				
			19/7	/	/	/	/	/	/	/	/	/					

Transcribed to new med sheet 26 APR 03 (b)(6)-2

Transcribed to new med sheet 26 APR 03 (b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) femur fx (L) heal wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: (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 4678 EDITION OF 1 FEB 79 MEDCOM - 4178

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	
19 Apr	(b)(6)-2	Heplock IV ERROR	19 Apr		1600	(b)(6)-2	
19 Apr		NPO after midnig ERROR (b)(6)-2					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
14 Apr 03	(b)(6)-2	N8092 mg IV q4-6h prn pain														
14 Apr 03		Tylenol #3 po q4-6h prn for pain														
14 Apr 03		Motrin 600 mg po TID														
		Phenergan 25 mg IV														
17 Apr 03		Vicodin 1-2 po q4°	NOT AVAILABLE													
17 Apr 03		M8054 2-4 mg IV q2° prn														
18 Apr 03		Ambien 10 mg po HS prn														
18 Apr 03		T-3 1-2 po q4° for pn														
20 Apr 03		T-3 + II po q4° prn pn														
20 Apr 03		Percocet + II po q4° pn	RECOPIED (SEE bottom of sheet)													
20 Apr 03		M8054 2-4 mg IV q2° pn														
20 Apr 03		Phenergan 12.5-25 mg IM q6° prn														
21 Apr 03		Percocet + II po q4° prn														

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

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. 04 Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23	24	25	26	27	28	29	30						
23Apr03	(b)(6)-2	Diet: Reg	7/19	(b)(6)-2													
			19/7														
23Apr03		VS Q4°	7/19	(b)(6)-2				D/C									
			19/7														
23Apr03		Wet to dry dressing A to (R)	7/19														
		thigh + (L) heel Bid pin	19/7														
		care BID		/	/	/	/	/	/	/	/	/	/	/	/	/	/
23Apr03		Activity: Up Adlib on	7/19	(b)(6)-2													
		crutches wt. bearing as	19/7														
		tol'd on LLE		/	/	/	/	/	/	/	/	/	/	/	/	/	/
23Apr03		Nursing: Up on crutches	7/19	(b)(6)-2													
		Bid	19/7														
24Apr03		VS Q8°	7/19														
			19/7														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) segment femur fx (L) heal wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: (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. 4 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
4/23/03	(b)(6)-2	Admit to ICW3	23Apr03			(b)(6)-2
4/23/03		Dx (R) open femur fx	23Apr03			
4/23/03		Cond: stable	23Apr03			
4/23/03		Hep lock IV when tol's PO meds	23Apr03			

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
23Apr-	(b)(6)-2	MSO4 2-10mg IVP Q 3-6° PRN	23Apr 1600 4mg	23Apr 1900 3mg	23Apr 0030 2mg	24Apr 4mg 0840	24Apr 10mg 1150	24Apr 2mg 2454	24Apr 4mg 0020	24Apr 4mg 0320	25Apr 0235	25Apr 4mg 1445	25Apr 4mg 2220		
23Apr-		Restoril 15-30mg PO QHS PRN B/EEP	23Apr 30 PO	24Apr 30 PO 2400	25Apr 2300										
23Apr		Phenergan 12.5-25mg IV Q6° PRN NAUSEA	23Apr 25mg												
23Apr03		Percocet 1/1 - 2/1 PO Q4° PRN	23Apr 0030 1/1	24Apr 0850 2/1	24Apr 1250 1/1	24Apr 1630	24Apr 2/1	24Apr 2/1 0900	25Apr 2/1 1300						

Transcribed to new med sheet 26 APR 03. (b)(6)-2

☆ U.S. GOVERNMENT PRINTING OFFICE: 1993 342-027/70450

CLINICAL RECORD

Th...APEUTIC DOCUMENTATION CA... ...AN ...EDICATIONS)
For use of this form, see A... ...7; the proponent agency is the Office of T... ...urgeon General.

Mo. 04 Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 26	27	28	29	30
23APR03	(b)(6)-2 --	Ancef 1gm IVPB Q8°	06	(b)(6)-2				
	--		14					
	--		22					
23APR03	--	Gentamycin 400mg IVQD	10					
23APR03	--	Colace 100mg Cap PO BID	08					
	--		20					
23APR03	--	Flush Heplock Q shift &	07					
	--	PRN	19					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:
(R) femur fx
(L) heal wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:
(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. 04 Yr. 03
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED												
23APR	(b)(6)-2	MSO4 2-10mg IV Q3-4H	26APR 0955 5mg	26APR 1410	26APR 2015	27APR 0530 10mg	27APR 0715 5mg								
		PRN Pain		(b)(6)-2											
23APR	(b)(6)-2	Restoril 15-30mg PO QHS													
		PRN Sleep													
23APR	(b)(6)-2	Phenergan 12.5-25mg IV													
		Q6H PRN nausea													
23APR	(b)(6)-2	Percocet 1-2 PO Q4H	26APR 1120	26APR 1530	26APR 1610	27APR 0715									
		PRN	(b)(6)-2												

U.S. GOVERNMENT PRINTING OFFICE: 1993 342-027/70450

(b)(6)-4

MSP11

1. NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. S[illegible]	4. PRECEDENCE U / P / R X	5. GRADE

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A TO 5F)--	11. ACCEPTING MD	12. CITE/AUTH #
	X MALE / FEMALE			AMBUL / X LITTER		

13. APPT/SURG DATE	14a. ORIGINATING FACILITY (b)(3)-1	15a. DESTINATION FACILITY	16. # OF ATTENDANTS	
			16a. MED	16b. NON-MED
	14b. ORIGINATING FACILITY PHONE NUMBER Tent #3 558 (b)(3)-1	15B. DESTINATION FACILITY PHONE NUMBER		

17. DIAGNOSIS

(1) (R) Femur fracture

(2) (L) Foot soft tissue injury

18. X BATTLE CASUALTY | DISEASE | NON BATTLE INJURY

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
4 APR 03	1500	NKA

20d. DIET X REG | 3GM NA | CARDIAC | DIABETIC ___ CALS

RENAL ___ Gm Prot ___ Gm Na ___ MagK ___ mg PO4

TUBE ___ TYPE ___ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for max of ___ days

TUBE FEEDING: ___ at ___ strength at ___ cc/hr

20e. IV / BLOOD

20f. SPECIAL EQUIPMENT

			FOLEY CATH
SUCTION		TRACTION	ORTHO BRACES
NG TUBE		IV PUMP	CHEST/HEIMLICH
STRYKER		TRACH	RESTRAINTS
INCUBATOR		MONITOR	OTHER (USE 23)

OXYGEN: ___ PERCENT or ___ LITERS ROUTE: ___

VENT SETTINGS:

20g. ALTITUDE RESTRICTION: Yes / No ___ feet

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT RECORDS	X	XRAYS
X	INPATIENT RECORDS		OB
	NARRATIVE SUMMARY		DENTAL
	FINANCIAL		

OTHER:

20i. MEDICATIONS / TREATMENTS

(1) (R) Femur IDS & ex fixation

(2) (L) foot IDS

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	
a.			Hypertension	i.			Bowel Problem
b.			Cardiac Hx	j.			Self-care
c.			Diabetes	k.	X		Ambulatory
d.			Respiratory	l.			Ambulatory Aid
e.			Ears/Sinus	m.			Self-meds
f.			Motion Sick	n.			Adequate Supply of Meds
g.			Vision Impaired	o.			Other:
h.			Voiding Prob.				

21. PRE-FLIGHT VITALS

21a. DATE / TIME	21b. TEMP:	21c. PULSE	21e. BP
	21d. RESP:		

22. BRIEF NARRATIVE

(1) (R) femur fx

(2) (L) foot

soft tissue injury

23. ASSESSMENT / PROGRESS

DATE / TIME	NOTES

24. STAMP AND SIGNATURE OF ATTENDING PH[illegible]

(b)(6)-2

AF[illegible] 3899 (433 AES Excel v[illegible]

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: (b)(3)-1
2. MTF LOCATION (State or Country Code.): 7 8
3. REGISTER NUMBER: 9 10 11 12 13 14 15 (b)(6)-4
NAME (Last, First, Middle In): (b)(6)-4 (b)(6)-4
4. PAY GRADE: 16 17
5. SEX: 18 M
6. DATE OF BIRTH (Y Y Y Y M M D D): 19 20 21 22 23 24 25 26 — 1980 01 01
7. AGE AT ADMISSION: 27 28 29 — 23 4
8. RACE: 30 X
9. ETHNIC BACK-GROUND: 31 9
RELIGION:
10. LENGTH OF SERVICE: 32 33 34
ETS:
11. FMP: 35 36 — 99 20
12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45 (b)(6)-4
ORGANIZATION (Active Duty Only):
13. MARITAL STATUS: 46 Z
HOUR OF ADMISSION:
BRANCH / CORPS:
14. FLYING STATUS: 47 48 49
15. BENEFICIARY CATEGORY: 50 51 52 — X 9 1 78
16. ZIP CODE OF RESIDENCE: 53 54 55 56 57 58 59 60 61 — 0 9 3 3 0 0 0 0 0
17. UNIT LOCATION (State or Country Code): 62 63
18. MOS: 64 65 66 67 68 69 70
19. TRAUMA: 71 inj
PREV. ADMISSION: YEAR / NO X
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 1
WARD: ICW3
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:
21. TYPE OF DISPOSITION: 73 74 — 25
22. MTF TRANSFERRED TO: 75 76 77 78 79 80 (b)(3)-1
23. DATE OF DISPOSITION (Y Y Y Y M M D D): 81 82 83 84 85 86 87 88 — 2 0 0 3 0 4 2 7
24. CLINIC SVC - ADMITTING: 89 90 91 92 — A B 4 A
25. MTF TRANSFERRED FROM: 93 94 95 96 97 98
26. DATE THIS ADMISSION (Y Y Y Y M M D D): 99 100 101 102 103 104 105 106 — 2 0 0 3 0 4 0 7
27. LOCATION OF OCCURRENCE (Battle Casualty Only): 107 108 — I Z
28. MTF OF INITIAL ADMISSION: 109 110 111 112 113 114
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D): 115 116 117 118 119 120 121 122

FOR LOCAL USE

R Femur Fx, L Heel wound
Dx: 82019
8921
E9912
Px: 7905
7845

Trauma
1
Injury
4(50)

ADMITTING OFFICER (Signature, as required): (b)(6)-2
SIGNATURE OF ADMITTING CLERK: (b)(3)-1

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

MEDCOM - 4185

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6) (b)(6)-2
2. MTF LOCATION (7–8) (State or Country Code.)
3. REGISTER NUMBER (9–15) (b)(6)-4
NAME (Last, First, Middle Initial) (b)(6)-4 (b)(6)-4
4. PAY GRADE (16–17)
5. SEX (18) M
6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26)
7. AGE AT ADMISSION (27–29)
8. RACE (30) Hagi
9. ETHNIC BACKGROUND (31)
RELIGION
10. LENGTH OF SERVICE (32–34)
ETS
11. FMP (35–36) 99
12. SOCIAL SECURITY NUMBER (37–45) (b)(6)-4
ORGANIZATION (Active Duty Only)
13. MARITAL STATUS (46)
HOUR OF ADMISSION
BRANCH / CORPS
14. FLYING STATUS (47–49)
15. BENEFICIARY CATEGORY (50–52)
16. ZIP CODE OF RESIDENCE (53–61)
17. UNIT LOCATION (State or Country Code) (62–63)
18. MOS (64–70)
19. TRAUMA (71) IRS
PREV. ADMISSION YEAR ☒ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72) A
WARD ICW3
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
21. TYPE OF DISPOSITION (73–74) D/C: Trans
22. MTF TRANSFERRED TO (75–80)
23. DATE OF DISPOSITION (Y Y Y Y M M D D) (81–88) 20030427
24. CLINIC SVC - ADMITTING (89–92) ABAA
25. MTF TRANSFERRED FROM (93–98)
26. DATE THIS ADMISSION (Y Y Y Y M M D D) (99–106) 20030407
27. LOCATION OF OCCURRENCE (Battle Casualty Only) (107–108)
28. MTF OF INITIAL ADMISSION (109–114)
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D) (115–122)
FOR LOCAL USE

R Femur Fx, L Heel wound

SIGNATURE OFFICER (Signature as required) (b)(6)-2
SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA FORM 2985, MAR 2000 EDITION OF M USAPA V1.00

IN ENT TREATMENT RECORD COVER

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

1. (b)(6)-4	2. NAME (Last, First, MI) (b)(6)-4 (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX: M	5. AGE	6. RACE: IRAQI	7. RELIGION	8. LENGTH OF SVC	9. ETS
10. PREVIOUS ADMISSION					
11. EMP: 99	12. SSN (b)(6)-4	13. ORGANIZATION		14. WARD: ICW1	
15. FLYING STATUS	16. RATING/DSG	17. DEPT./BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE: INJ
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct			22. HOURS OF ADMISSION: 2203	23. CLINIC SERVICE: ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE		25. TYPE DISPOSITION		26. DATE OF DISPOSITION: 29APR03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)		27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION: 12APR03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW L Chest
E991.2

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
13	13				13

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2 (b)(6)-2 MD MAJ MC

SIGNATURE OF RAD OR MEDICAL RECORDS OFFICER (b)(6)-2

DA FORM 1 JUL 79 EDITION OF 1 USAPPC V1.10

IN[illegible]ENT TREATMENT RECORD COVER S

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

1. REGISTER NUMBER (b)(6)-4			(b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE IRAQI	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP 99		12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD ICW1	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE INJ	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct				22. HOURS OF ADMISSION 2203		23. CLINIC SERVICE ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION			26. DATE OF DISPOSITION 29APR03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.			28. DATE OF THIS ADMISSION 12APR03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1						30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW L Chest
E991.2

III
879.2

II
879.2
864.01
47562
44320
47350

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
13	13				13

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2 (b)(6)-2 MD MAJ MC

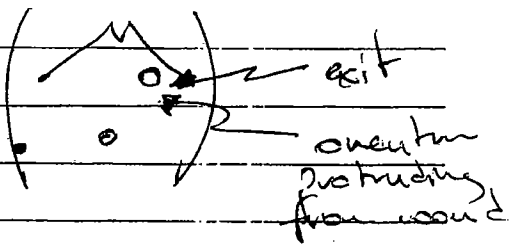
(b)(6)-2

DA[illegible]Y 79

MEDCOM - 4188

USAPPC V1.10

MEDICAL RECORD	PROGRESS NOTES
DATE	274TH FORWARD SURGICAL TEAM
BP: 152/88	FBW c̄ GSW to abdomen.
P: 118	Unknown time of injury.
R: 18	Awake/alert - HD stable.
T:	
O2 SAT: 96%	PE) AAO, alert
	NC/AT PERRL, op ok
ALLERGIES	Neck supple
unknown	Chest - CTA = BS
PMH:	CV - RRR
unknown	Abd - tense, distended
PSH:	Rectal - Obvious entrance
	Ext - AT/PERRL
	Neuro - nonfocal
	APPL) GSW to abd
	JVF c̄ 2 large bore
	Foley
	Urinary
	To OR for exp lap.
	MD
	(b)(6)-2
	(Identification and rank/grade)



PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility)*

NAME:

SSN:

UNIT:

REGISTER NO.

WARD NO. (b)(3)-1

PROGRESS NOTES

Medical Record

STANDARD FORM 519 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)

USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES

DATE

23 MAR 03 Surgery

OPERATIVE NOTE

DIAGNOSIS: GSW to abd.

PROCEDURE: Exp lap / Repair liver fracture / cholecystectomy / transverse colon resection c colostomy + Hartman's.

(b)(6)-2

SURGEON:

FINDINGS: Fractured liver, contused GB, transverse colon injury.
⊖ retroperitoneal hematoma ⊖ duod. injury
⊖ CBD injury ⊖ stomach injury.

FLUIDS: 9 L crystalloid EBL: 750 cc

U/O: 3 L U/O.

2 Pb x 2 / NGT / Foley

To SICU, stable, intubated

(b)(6)-2

MD

(Continue on reverse side)

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

24 MAR 03

Surgery POD #1

s/p exp lap / liver repair / cholecystectomy / colon rsx

2° GSW

Comfortable but tachycardia / tachypnea

AFeb 136/80 120 20

Chest ↓ BS (B)

CV - RRR

Abd - soft, distended, min tender

Dressing - saturated superiorly

Colostomy - pink / patent

36 40

CKR ↓ lung volumes

ATP) - stable postop

Tachycardia ~ afeb / stats ok / but stable

Δ dressing

↓ fluids

Chest PT

Cont abx

[redacted]

25 MAR 03

Surgery POD #2

s/p GSW to abd.

Comfortable

↓ HR ↓ tachypnea good pressure u/o good IPs ↓ lung

Chest still junky

Abd soft, NT, ND

Incis c/d/i ostomy pink

ATP) less hyperdynamic ~ tolerated

Urosyn → Cefotetan

IVC NGT

Ambulate

Cont deep breath / cough

[redacted]

PROGRESS NOTES

DATE	
27 Mar 03	2100 - ⊖ stool from ostomy x 8°, ⊖ BS, T 101.8F ⊕ Tend ⊕ Ogin ⊕ Ill-ness MD aware & order written. IV Shrter Receptin Driver will nebilter [redacted]
27 Mar 03 2350	No changes from previous exam. sleeping well. [redacted] /CT/AN
28 Mar 03 0650h	VS - 118/84, P 115, R 24, SpO2 91%, T 97.4 [redacted] /CT/AN
28 Mar 03 0651	LE 0600 colostomy bag change, output moderate [redacted] /CT/AN
28 March 2003 0715	stool, mg, tem low Ativan infusion will offer diet [redacted]
28 March 03 0000	Culture MSCA 5mg ⊕ result [redacted] /CT
28 March	H. [redacted] drained 40cc dark red fluid. colostomy bag emptied. no signs of infection around colostomy site. [redacted] /CT
1200	Culture Receptin tem and Clyndamycin Gentamycin [redacted]
28 Mar	[redacted] JP #1 pulled. Will get pt up and ambulate to improve pulmonary [redacted]
28 MAR 03 1630	P - 119 B/P - 134/78 R - 21 SaO2 90% T - 101.5 Acetaminophen 325 mg po tabs X 2 given 1640 /PL

☆U.S. GPO: 1995-397-405 STANDARD FORM 509 BACK (Rev. 11-77)

[redacted] maj AN [redacted]

PROGRESS NOTES

DATE	
27 Mar 03	2100 – ⊖ stool from ostomy x 8°, ⊖ BS, T 101.8F ⊕ Tend ⊖ gas ⊕ fullness MD aware & order written. IV Shorten Rocephin given will rewrite [redacted] b6-2
27 Mar 03 2350	No changes from previous exam. sleeping well. [(b)(6)-2] ICT/AN
28 Mar 03 0650L	VS - 118/84, P 115, R 24, SpO2 91%, T 97.4 [(b)(6)-2] ICT/AN
28 Mar 03 0651	LF 0600 colostomy bag change, output moderate [(b)(6)-2] ICT/AN
28 March 2003 0753	stool, mg, tem low Abdomen soft will offer diet [(b)(6)-2]
28 March 03 / 0700	Culture MSCA smy ⊕ result — [(b)(6)-2] IG
28 March	H. [(b)(6)-2] drained 40cc dark red fluid. colostomy bag emptied. no signs of infection around colostomy site. [(b)(6)-2] Swanc
1200	Culture Rocephin 1gm and Clindamycin 600mg — [(b)(6)-2]
28 Mar	[(b)(6)-2] JP #1 pulled. Will get pt up and ambulate to improve pulmonary toilet [(b)(6)-2]
28 MAR 03 1630	P - 119 B/P - 134/78 R - 21 SaO2 90% T - 101.5 Acetaminophen 325 mg po tabs X 2 given 1640 PK

☆U.S. GPO:1995-397-405 STANDARD FORM 509 BACK (Rev. 11-77)

[(b)(6)-2] maj Ard [(b)(3)-1]

MEDICAL RECORD	PROGRESS NOTES
DATE	
27 Mar 03	0900 - Pt resting, states minimal abd pain via interpreter. ABD dsg CDI, stomen red ⊖ necrosis ⊕ output. JP x2 with 15 serosang and 7.5 mL serous drainage. Mild erythema at JP site. ⊕ BS, ST 110 pulse 12 x4. Extreme difficult maintain colostomy collection. Voids per urinal 1150 mL amber concentrated urine T 97.1 HR 120 R 21 — [redacted] JG
	1030 Pt c/o pain to abdn. Adm T3 x II — [redacted] JG
1430	Pt ambs in new location ate some food. ambulated hall. Pt alert and oriented. [redacted]
1540	VS taken 130/70 P 90 T 96.9 — [redacted]
2020	Dressing was changed @ 2000. Aux temp 101.8 [redacted] SG
2045	IV started ⊕ wrist [redacted] JUT
27 March 2003	General Surgery
2100	S/P repair liver laceration, colostomy 23 March 2003. Has been having good colostomy output until today. No stool no flatus; abdomen more distended. temp 101.8 HR 120.
	Acknowledges only small amount of pain
	PE: Does not appear septic
	↓ BS ⊕ side
	Abdomen quiet, distended
	imp: Paralytic ileus will Reexamine 28 March 03

(Continue on reverse side)

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

[redacted]

REGISTER NO. [redacted] D NO. [redacted]

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR(41CFR)201-45.505
509-111

DATE	NOTES
4APR03 1905	Tmp 98.7 (b)(6)-2 LPN, SGT
2250	TMP 97.3 Erythromycin 500mg PO LPN SGT
0135	Pt colostomy ruptured, leaked all over, started cleaning, c̄ No problems. when cut shirt away pt removed cigarett & matches from pocket. and attempted to hide. I SGT (b)(6)-2 started to retrieve and pt grabed my wrist to stop me. I continued to reach for pack showing unprecedented restraint in handling the situation. After taking he was ~~finished~~ (b)(6)-2 cleaned and given a new shirt. No shorts were to be found so his were cut from him at the area of soilage. Pt attempted to get out of bed to retreive cigrets told him no when he started up. I called the MP Guard and in and the pt went to wash basin and washed hand's and returned to bed. Denied assistance with bed. He aroused other pt's wich became disruptive. I talked with ~~other~~ [redacted] the interpreter earlier in the day and he stated that the pt was being the leader for the others. (b)(6)-2 SGT. LPN

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STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
06 APR 03 1705	Δ OF SHIFT ASSMT COMPLETE. PT A&O. LUNGS CTA. DIMINISHED BASES. PT ON O2 NON-REBREATHER MASK - 10L. SaO2 @ 100%. PT ENCOURAGED TO USE PULMONARY TOILET & INSTRUCTED ON USE OF INCENTIVE SPIROMETER. PT HAS DRESSING TO ABD ML. CDI. PT HAS FOLEY TO GRAVITY. (b)(6)-2 SAT/LPN
07 APR 03 0145	HEMATURIA NOTED IN FOLEY BAG. MD SAW BAG EARLIER IN SHIFT & STATED IT WAS FINE 500 cc DARK RED COLORED URINE EMPTIED FROM FOLEY. PT T-100.5 A. WILL CONTINUE TO MONITOR (b)(6)-2 SAT/LPN
07 APR 03 0700Z	Pt VSS, Ronchi in upper lobes, lower lobes sound CTA. Bowel sounds absent x4 quadrants. Abd. tender, soft to palpate. Dressing Δ'd, no signs of infection. repacked wet to dry. urine pink in color. Urine dip stick to be done. Pt on 9L O2 via face mask stating 93%. Pt A+O X3, neuro in tact. Pt ERLA bilat. Cap refill <2 sec. skin turgor good. Pt uses IS Q h°. (b)(6)-2 9/WMG
07 APR 03	1600Z Pt. had episode today when SaO2 stats went down to 85%. Pt is on 10L NR stating 93% now. Pt had episode when attempting to get out of bed. Emptied 700cc of green liquid from NG tube. Urine ~~output~~ UPDATE 07APR02 output was 750cc urine yellow with tinge of pink. (b)(6)-2 9/WMG

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.
(b)(6)-4		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

AUTHORIZED FOR LOCAL R

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

7 apr 03 1630 PT A&O x3, Pupils Perrla, Resp Shallow, diminshed in bases c̄ wheezing upon expiration, PT Sao2 92% - 94% on 10L via concentrater & NR. had PT use incentive spirometer, During use sao2 droped to 85%, PT became agitated & showed signs of dypsnea. HR Tachycardic from 110 - 130 elevated upon agitation all distal pulses +3. Diet NPO c̄ BS non-active not Passing Flatus, Foley to Gravity QS Urine is blood-tinged. Status Post X-Lap. Dressings CDI, PT moves all ext independently. [redacted] SPC LPN

7 apr 03 1800 PT running a/temp 101.3 wet towels applied to forehead & chest wool blanket removed [redacted] SPC LPN

8 apr 03 0230 - PT slept most of night without complaint, temp down from to 100.7 [redacted] SPC LPN

8 apr 03 0235 - PT Urine continues to be blood tinged, dark & concentrated. [redacted] SPC LPN

8 APR 03 0615 PT started 2a PRBC's initial VS T 100.4 P 122 B/P 123/72, 5 min VS 118/70, 124, 100.4, 15 min VS HR 122 BP 117/67, T. 100.7, 45 min VS HR 122 B.P. 116/68, T. 100.6, 1 Hour VS 112/65 HR 119, T 100.5 1st Set VS 1st unit BP 116/70, 117 HR, T. 100.3

[redacted] 556 [redacted] 9/4/06

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

RT./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

IT'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]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

AUTHORIZED FOR LOCAL REPRODUCT

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8 APR 03 0750z	2nd unit PRBC's started. Initial VS are T 100.3 BP 116/76 P 117, 5 min VS BP 121/72, P 116, T. 100.4, 15 min VS 122/76 HR 119 T. 100.4 1 hour VS BP 123/72 P 114 T. 100.5, last set VS BP 126/74 HR 116 T 100.7 No reactions noted. SSG (b)(6)-2 9/14/06
8 APR 03 1030z	PT. resting comfortably. C/o some pain @ midline incision. Drsg Δ done to midline. Wet to dry done. No foul smell or discharge noted. Appears to be healing well. Abd. is slightly distended. No gas or bm yet noted. New IV started in (R) hand. 2u PRBCs given. H+H 25-9, pre PRBCs. No reaction noted to PRBCs. NG to LIS c̄ some greenish drainage. Foly to gravity c̄ gs u/o. Clearing from blood tinge to cls. yellow. 10L O2 given per face mask. O2 Sats 92-93%. PT ambulated c̄ O2 and Sats dropped to 67%. PT. gets very weak quickly but ambulated well. Vital Signs Stable. SSG (b)(6)-2 (b)(6)-2 9/14/06
8 APR 03 1132z	I Stat done — H+H 30/10. SSG (b)(6)-2 9/14/06
8 APR 03 @ 1550z	PT output 600 urine, 500 NG tube greenish in color. SSG (b)(6)-2 9/14/06

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. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
9 Apr 03	(b)(6)-4 Alert & Oriented x 3. PT Pearl.
0353	PT Sclera appears to be somewhat Jaundice in nature. PT skin color also appears out of text with Rare. PT has NG to left nares connected to low Intermittent suction. PT on NRB @ 40% with SpO2 in 94-95% range. PT lung sounds coarse and wet. PT position of comfort is at HOB @ 45% but pt displays a decreased angle by not staying at proper angle in bed. PT HAS midline Dressing to Abdomen. PT has PIV to Rt Forearm. PT has LR IV flowing @ 140cc/HR. PT continues to be on Cipro IV and Unasyn IV, as well as Zantac. PT had one Temp spike during the night. Dr (b)(6)-2 present and 650mg of Tylenol was ordered and given P.O. Low Intermittent Suction turned off. PT HAS Foley draining dark Amber colored urine. PT was encourage to ambulate, but refused. PT Teaching was conducted on PTs condition and what helps and worsens PT's condition. PT STATED that he would try to ambulate some time this AM. PT did Receive MSO4 PRN for Pain x 3 doses during the night. NO additional problems to work. (b)(6)-2 CPT/AN

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.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
11 APR 03 1200	Pts O_2 @ 83% RA Sup O_2 Non Rebreather at 6 L/min 96%
	Pt Given 2.6 mg Nob
	HR 110 120/70
1800	101.2° Aux Wait an hour till next dose of vicodin [(b)(6)-2] CRN, SOT
1910	Pt complaining of 10/10 pain in Abd.
	Vicodin PO II for pain. Ciprofoxin 500mg PO, Augmentin 875mg PO
	amitriptyline 25mg PO [(b)(6)-2] CPN, SOT [(b)(6)-2]
12 Apr 03	0700 430 BP 110/70 P 72 R 24 T 99.0 — SOT [(b)(6)-2]
4/12/03 0455	Pt C/O (R) posterior back (upper) pain
	HAS BEEN febrile, tachypneic; O2 requiring
	ON AUGMENTIN / CIPRO for ? etiology
	lungs - upper air way noises (R) base posteriorly
	CXR (4/7/03) (R) ml/u opacification
	A) Pleural Effusion vs Pneumonia
	P) > Repeat CXR / need decubitus films
	> Cont Abx
	> If bagers will need to perform thoracentesis - ? if able to perform such procedure here; if no bagging ? loculations
	> D/W Surgery [(b)(6)-2]
	[(b)(6)-2]
12 April 03 0600	3mg MSO4 for pain [(b)(6)-2] per 92 WOD
12 April 03	0600 Dressing Dan Midline Incision, dressing is saturated c̄ serosanguous drainage and bowel. Site appears healing well on lower half, upper half is leaking Bowel, Physician Dr. Notified @ Bedside, going back to Surgery. Regarding wound c̄ W=Dry, 4X4, + Tape. Open wounds L + Right of midline

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STANDARD FORM 509 (REV. 5-99) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10Apr 03 1600	Recieved pt resting in bed, HOB 50° Pt wearing non-rebreather simple face mask at 11 O_2 consentrator. Lungs have expiratory rales. SaO_2 95%. Pt has white coating and tounge. S. S_2 NSR. Abdominal dressing c/D/I. +2 radial & pedal pulses. @ 2000 pt refused med, c/o nausia. 12.5mg phenergan given 2030 medication crushed & mixed with water pt took only one sip, pt refused the rest. [redacted]
11APR03 0618	RT Notes: Pt received HHN via MP ā Ocsu Proventil/ipo Atrovent/ HR 110-114 RR-24 BS: ā + p̄ tr bilateral insp + exp wheezes throughout. NPC SpO_2 97% on NRB. NAD @ this time [redacted] 9/120
0840	Pa
0830 Z	Pt admitted to MCU #1. VS obtained: BP 102/68, P 126, T 100.0, 32 RR, O_2 sat 88% on RA, 92% on 3L O_2 [redacted] 12
0840Z	PT A&O x3, PERLA, receiving O_2 via non-rebreather @ 5 L/min, A dressing to abdomen wet to dry draining moderate amounts of serous sanguinous fluid, Lungs sounds rough in all lobes, PT. c/o pain in abdomen given ⅓ vicoden, has ⊕ pulses in all extremities. [redacted] SGT 9/WMC

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]		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
12APR03	OP NOTE
0830Z	PREOP: WOUND DEHISCENCE
	POST OP: SAME
	PROCEDURE: REVISION OF FASCIAL CLOSURE
	RETENTION SUTURES
	SURGEONS: KAPLAN MD AND BURNETT MD
	EBL <50 cc
	FLUIDS:
	COMPS: ϕ
	FINDINGS: FASCIAL BREAKDOWN
	ϕ EVIDENCE OF SEPSIS OR
	SONAZÉ ϕ PUS
	TRANS TO ICU IN STABLE CONDITION
	(b)(6)-2
	MD
0900	STABLE. C/O PAIN 5mg OF MSO4 GIVEN [redacted] BY ANOTHER 5mg AFTER 10 MINUTES. B/P 148/86, SATS 90%. T 104/min FFM AND NEBULIZER TX IN PLACE NOW. LUNGS MICKLY CONSTRICTED UPPER LOBES, ϕ BS, GOOD PULSES / CAPILLARY REFILL x4, A&Ox3 P. 119, T° 99.7
0930	5mg OF MSO4 GIVEN IV FOR ABDOMINAL PAIN — [redacted] (b)(6)-2
0935	75mg OF DEMEROL GIVEN IV — [redacted] (b)(6)-2
1000.	V.O. OF DR. CHAPMAN 2.5mg OF VALIUM x2 THEN REFUSE — [redacted] (b)(6)-2
1100	VOMITED 600cc OF CLEAR / YELLOW VOMIT — [redacted] (b)(6)-2
	SLEEPING COMFORTABLY NOW — [redacted] (b)(6)-2
1245	300mg OF VOMIT, 30mg OF TORADOL GIVEN C̄ 5,000 UNITS OF HEPARIN SQ

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STANDARD FORM 509 (REV. 5-99) BACK

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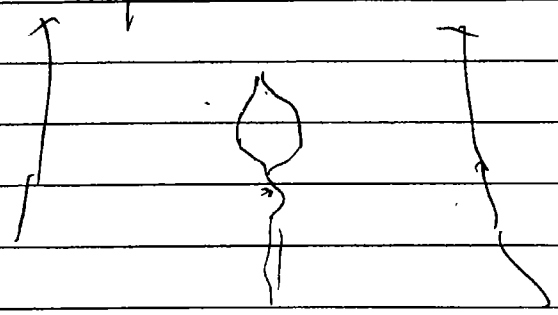
MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

12 Apr 06 Cont → appear healing c Vascular tissue trimmed/ drainage [redacted] 2CT 1W

12 Apr 03 ~~SURG STAFF NOTE~~
0700Z ON ROUNDS, PT NOTED TO HAVE WOUND BREAKDOWN TO INCLUDE PARTIAL FASCIAL SEPARATION
PT POD 5 S/P COLOSTOMY TAKEDOWN
T 99.
ON CIPRO



IMP: WOUND BREAKDOWN POD 5
RISK FACTORS MALNOURISHMENT, O2 REQUIREMENT, IMMUNOSUPPRESSION
PLAN: ROTATION SUTURES IN OR [redacted]

13 Apr 03 0829 Nutrition - Patient with poor intake for last 2 wks (+) due to surgery for s/p GSW. patient on J-tube feeding @ 10 cc hr provides 264 calories day estimated needs 2700 per day, good rate for Ensure 90 cc/hr. [redacted]
MAJ SP RD

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) [redacted]	REGISTER NO.		WARD NO.	

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 4203
509-114

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

13 APR 03

Brief Op Note:

Preop Dx: Anastomotic breakdown S/P colocolostomy

Postop Dx: Same

Procedure: Ex lap / End Ileostomy / mucous Fistula / J-tube / Drainage

Surgeons: (b)(6)-2

Anesthesia: GETA

EBL: 250 UOP: 250

Fluids: 4100 cc crystalloid

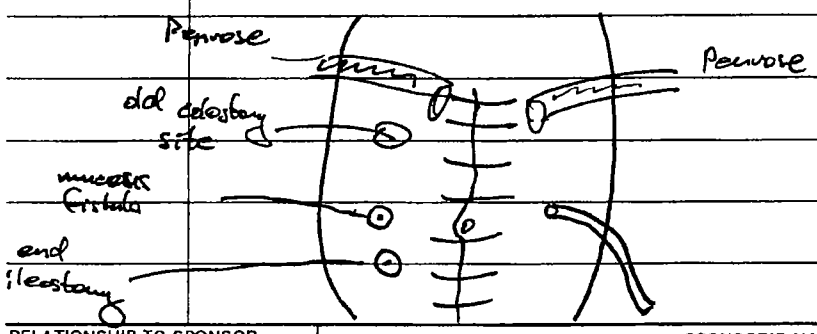
Findings: Anastomotic disruption c̄ (both ends) retraction, stool in peritoneum ō intense inflammatory rxn, fecal necrosis

Drains: ET, NG, Foley, Penrose x 2 (at colonic openings), J-tube

Complications: ϕ

Counts: Correct x 2

Disposition: To ICU / Fair / intubated



(b)(6)-2

MAJ, MC (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. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
16APR03 1150	RT Notes: Pt extubated approximately 1035 and placed on PRB @ 12 4pm. Pt received HHN via aerosol mask c̄ 0.5cc Albuterol/2.5cc NS. HR 120-121 RR 28-23 BS: Coarse Rhonchi throughout c̄ mild wheezes in apices bilaterally. SpO_2 98%. Pt stable @ this time. Will continue to monitor pt's status (b)(6)-2 91V20
16Apr03 2000	

DATE	NOTES
12 APR 03 1830 Z	Pt sedated, intubated from OR s/p ex lap ~~colostomy revision~~ WIA error. Foley draining clear, yellow urine, VS: Sinus tach, Hypotensive 66/27, RR: 23, Vent settings SIMV, 14, 700, 50%, Jp-tube to gravity, NG to LIWS, Colostomy bag empty at this time lungs: CTA(B), (+) BS. Abdominal dressing is C,D,I. Pt has 2 IV sites, Rt arm D5NS @160 cc/hr + TKO in other IV. Received IV MSO4 + Versed as pt became agitated + began to pull on dressings, tubes. Pt also attempted to spit out bite block/ET tube. RT called, pt sedated. all secure. B/P returning to normal levels: 85/66. Pt orientated x 2 5 result, ∅ ~~secretions~~ secretions. [redacted], 91C3H
13 Apr 03 1700 Z	Resp Care Note: pt. c.a. mech vent as ordered, all settings checked + set properly. All alarms set + working. Ambu @ bedside. BBS fairly clear c̄ dim bases. Vent settings SIMV, RR 16, V_T 700, Peep 5 cmH_2O, I:E 1:2, PIP 31 cmH_2O Mean 13 cmH_2O, High pressure 50 cmH_2O, Low Pressure 5 cmH_2O. [redacted] 91V3H
2145 Z	Resp Care Note: Vent settings SIMV RR 16 V_T 700, peep 5, FIO_2 100% I:E 1:2, High Press 50 cmH_2O, Low Pressure 5 cmH_2O, PIP 30, Mean 14. [redacted] 91V3H
14 Apr 03 00:05	Resp Care Note: Vent settings SIMV, RR 16, V_T 700, peep 5 cmH_2O FIO_2 100%, I:E 1:2, PIP 31, Mean 12, SpO_2 100%, High Press 50 Low Pressure 5. [redacted] 91V3H
14 APR 03 0500	Patient report rec'd, sedated, PERRL, MAE when stimulated. Lungs CTA, Vent SIMV 16-700-1.0+5 RR 16/16. Patient becomes very anxious when aroused. Abd soft tender guarding MSO4 for pain, Haldol started. Versed for sedation. Abd dressings solid c̄ serosanguinous drainage. J tube d/d. from drainage to 10 cc PS Green colour q10 with ✓ residuals ~~q4hr~~. ETT 26 cm @ teeth mouth guard as place. NTG ~~to LISW~~ Green clear bile like secretion. foley drainage dark amber [redacted] 500 cc

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1300	Cipro 400mg and Avelox 875 mg given now PO, resting in bed now c̄ FAN at 8 L/min
1600	T° 102.0, P-130 B/P-126/73, sats 97%, no changes in physical condition, lungs CTA, ↓ BS, AaOx3 resting in bed now [redacted]
1630	Pt A+Ox3, lungs little wheezing on exhale, Pt having some difficulty breathing, Perrla, bowl sounds active, Pulses x3, Pt has dressing on Abdomen some drainage, IV(R) AC. Pt stats @95% via NR at 8 l/min. [redacted] 9W
0300	Drained 400cc clear yellow fluid out of foley
0700 2 13 APR 03	Pt is resting c̄ some clo pain. Pain meds given c̄ good relief. Ambulated to BR. Midline incision covered c̄ bulky drsg p̄ drsg Δ this AM. Large amount of brownish drainage from abd wound. IV(R) arm patent c̄ SLS of infx. Lungs CTA open to base Bilat c̄ ↓ air intake. O² @ 7L/M sats 92-96%. VS stable. Bowel sounds hyperactive. [redacted] 556 9W MC
1500 3 13 APR 03	Pt. started to drain stool through midline incision. Dr. notified. Pt. O/c for OR @ this time. T. 102.3 AX. 3 gms Unasyn given @ 1500z. [redacted] 556 9W MC

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. 2W1

[redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 APR 0500	(continued) USS, IM (L) Hand 16ga infusing ↓ 4% of compromise IV (R) Pt ↓ SKIN compromise. Pulses +2/4 PL = Great Cobed/Pedal. Patient restrained Chest wounds to protect airway.
0500	Pant Away Air Mattress Patient Sutures Cir plane, Saturated Serosanguineous fluid (R) colostomy Bag intact pink appearance scant drainage. Penrose [redacted] (L) Foley pink.
0800	Urine output still dark. Dr Kaplan here. report given. US [redacted]
0810	4mg of Versed given IV per ABERNATHY
14 Apr 03	Resp Note: Vent settings SIMV RR 16, V_T 700, Peep 5, FIO_2
0915 Z	100%, I:E 1:1.5, PIP 32, Mean 12, V_T exhaled 700ml/ SpO_2 100% [redacted]
	High Pressure 55 Low Pressure 5. BBS Clear ↓ clear bases. [redacted]
14 APR 1000	Patient tolerating bolus ↓ Tube feeding ↓ residual. Urine output ↑ ↓ boles. Vasopressor ↑ medication. Bound ↓ RT ↓ FIO_2 but Dr [redacted] agrees he wants to vent ↑
14 Apr 03	Resp Care Note: Vent settings SIMV RR 16, V_T 700, peep 5, FIO_2
1220 Z	100%, I:E 1:1.5, V_T exhaled 700ml, PIP 31, Mean 15, SpO_2 100%
14 APR 03 1300 Z	Patient became extremely agitated & violently pulling against staff. Broke Bite Block in place. Patient given MSO4/Versed/Haldol ↓ effect. Vecuronium used to paralyze patient & patient seemed unresponsive exhibited HR went to 165 ↓ decline. Dr [redacted] notified of Patient condition. New order [illegible] Valium
	10mg IVP slow over 5 min now @ 1310 patient still awake & struggling against ventilator. Lungs CTA Bilat Breath sounds ETT in place ↓ compromise
14 APR 03 1430	Patient finally settled down, HR 138, Sat 100% Resting. ETT adjusted. Cut to 26cm @ Teeth. Previous patient had pushed it out to 23cm @ Teeth. NGT continues to suction out bile like secretion. HOB 30° Resting ↓ 50° suction.
1530	Colostomy remain pink, patient calm, sedation continues
1630	Assumed care of pt. T 100.3 (R) P 126 R 18 BP 113/67 SaO_2 100.
	Pt sedated. Lts have crackles in upper lobes Pt

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
	[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]		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
(con't)	currently on a vent, PEEP 5. SIMV, RR 16, V_T 700, NGT in place to to suction. Draining dk green bile. Oral tube in place. Lg abd dressing that is dry and intact. IV in (R) hand ~~s~~ redness or swelling. Colostomy draining brown liquid stool. Red Robin Off dressing ~ 60cc syringe in place. FC draining clear yellow urine. - [redacted]
4/14/03 1220	Resp Care Note: Vent settings SIMV RR 16 V_T 700, peep 5 FIO_2 100%, I:E 1:1.5, PIP 30, Mean 9, Exhaled V_T 696 ml, High pressure alarm 55 cmH2O Low Pressure 5 cmH2O, SpO2 100%. BBS fairly clear. [redacted]
14 APR 03	0400 while checking pt pulses distal to restraints discovered edema in (L) arm worsened but wrist band cutting off circulation cut wrist band off. [redacted] SPC CPN
14 APR 03	0400 PT had episode of fighting ventilator twice during night [redacted] SPC CPN
15 APR 03 0500	PT. is on vent ~ set vent settings @ 16 BPM, 700ml, 100% O_2 on A/C. Lungs are wet apex to base. No output from suctioning. NG to LIS putting out green liquid. About 200cc per 12°. Foley to gravity ~ gs output. Vital signs stable. HR ↑ 110-120s. low grade temp 100.5 avg. Bowel sounds absent. Colostomy LLQ ~ output. Incision midline open ~ red subbands as sutures. Drsg in place. Penrose x2. Wet to dry done ~ copious amounts of leakage from incision. Some foul smell noted. IV (R) arm ETKO ~ sts of infx. IV (R) hand ~ sts of infx or infiltration. Peg tube LLQ flushed ~ 10cc H_2O QS. Morphine + Versed given QI° for sedation. No edema noted on extremities. SSG [redacted] SWM6

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15APR03 1930	Δ OF SHIFT ASSMT COMPLETED. PT AROUSABLE BY VERBAL STIMULATION. LUNGS SOUND CONGESTED & WET THROUGHOUT. PT ON VENT. SETS @ 16 BPM, 700 ml 100% O2 SATS ON A/C. HEART @ SINUS TACH - 109 BPM. BULKY DRSG TO ABD. CDI. BS ARE ABSENT. OSTOMY TO RLQ. Ø OUTPUT IN BAG. PT HAS NGT TO LIS. Ø OUTPUT NOTED. FOLEY CATH. TO GRAVITY. CLEAR YELLOW QS URINE. PT HAS 2 PENROSE DRAINS Ī DRAINAGE. PEG TO LLQ. PERIPHERAL IV TO (R) ARM. Ø S/SX INFILTRATION IV TO (L) HAND Ø S/SX INFILTRATION. WILL CONT. TO MONITOR PT. (b)(6)-2 ETLR
4-16-03 1300	Pt extubated 1145 o/o pr DR [redacted], b6-2 pt TOI - on vent at 10 LPM. HR 118, 105/69, RR 24, 94%, T - 99.5 Sx large amounts of thick bloody secretions. N - pt responding to simple commands, Dx, R - Lungs clear Rhonchi thruout after cough clear up. CV - Ø JVD Trach ms, Ø edema, GI - TF started at 10 cc/hr pr DR [redacted] b6-2 BS, colon by Entact & mod dry SC ABD Ent drainage changed wet to dry, removed drains out clear serous drg. GU - foley to gravity UOP 95. Skin warm dry. Ice Pt 1. 189 (D) BP - 85 1/2 MS at 180/100 (b)(6)-2
4-16-03 1600	Nutrition - Patient started on J-tube feedings of 10 cc/hr Enrone Patient s/p exp lap now without vent. Patient's estimated energy needs 2400 calories per day. Currently getting 264 calories per day will stimulate & sustain Enterocytes. Advance as tolerated to goal TF

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.
(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)*
4-16-03	Nutrition Enteral rate of 90 cc/hr oe Diet advancement to regular.
4-16-03	Pt resting comfortably s/p extubation [redacted] b6-2 MAT SPRD at 1100 today. Pt confused tried to get out of bed, Pt restrained. Pt with T.T to 103 ↑, reported to PATMW 800mg to Pt. Ice pack to groin, lumpits. now temp 99.6 (R). B/S 87/47, HR 96, sats 100, RR 22, T 99.6 [redacted] b6-2 [redacted] (b)(6)-2 [redacted]
4/16 2015	Report received, initial assessment complete no c/o of pain sees pt extubated @ 1130 O2 Non-rebreather sats 92-93%. Pt alert & oriented and follows stimulation will continue to [redacted] (b)(6)-2 [redacted]
4/17/03 0700	Report received, PT in bed. IV in (R) AC, positioned, resting very slow pulsed c some difficulty - New to H/C treated in (R) wrists 18g - Tube feeding infusing in J-tube. Foley → B&B. Noted - Dir yellow urine, O2 NRB mask in place. Abd c Drsgs intact c small amount of drainage. Noted lungs aux. Noted c Diminished B/S Bil Bases Noted - rest of assessment unremarkable [redacted] (b)(6)-2 [redacted]
	PT's mother & cousin in to visit PT - PT repositioned in bed. c/o Pain
1230	medicated c MSO4 4mg IVP - [redacted] (b)(6)-2 [redacted]
1420	Drsgs D'd To Abd wounds, c old drsgs Noted c Serous/bloody fluid from incisions. Penrose drain, noted on each side of Abd. J-Tube in place c drainage noted - New wet Kerlix gauze placed, covered c 4x4's Abd Pads c Tape - PT Lateral Drsg D c minimal c/o Pain - [redacted] b6-2 911WMGA - colostomy emptied of 400cc Brown liquid [redacted] (b)(6)-2 [redacted]
1500	PT appears to be asleep, NAD Noted SAO2 94% [redacted] (b)(6)-2 [redacted]
1655	Medicated c MSO4 2mg IJP for c/o Pain - Foley emptied of 800cc Pale yellow [redacted] (b)(6)-2 [redacted] (b)(6)-2 [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11.16.03 1505	medicated c MSO4 2 mg IVP [redacted] b6-2
1500	colostomy emptied of 300 liquid stool
1700	Pt given 4mg MSO4 for pain SPC [(b)(6)-2] [illegible]
12 APR 03	bowel sounds CTA @ UL - ↓ @ LL, ASD Drsg c/d/i. O2 @
1520	2L via nasal c PCA for sat 95-96. Colostomy bag leaking -
	placed chux under pt - AW sat around colostomy until Pt awake
	for D. re-taped @ Hand IV. Counts & Urine DVPs ↑ —
	[(b)(6)-2]
	Cent DVPs ↑ 2130, Lovenox ↓ @ 2100 — [(b)(6)-2]
	4 mg MSO4 for ↑ pain @ 2154 — [(b)(6)-2]
2300 —	Drsg d/d - Pt awake - requesting pain med - 2 mg MSO4 for
	leg tied 2000 for foley - cath urine — [(b)(6)-2]
18 APR 0100	Urine DVP ↑ @ 0200 —
0420	4 mg MSO4 IVP for ↑ pain —
0600 —	See VS sheet T 100.5 AX — [(b)(6)-2]
0615 —	4 mg MSO4
0700	↑ Urine DVPs @ 0730
	foley 1200 cc at
0730	Received report on pt. Pt resting in bed w/o c/o pain. Will monitor [(b)(6)-2]
	0815 Ostomy appliance leaking. Emptied bag. Reinforced seal
	and cleaned pt. 300 cc watery dark green fluid emptied. Pt
	tolerated juice w/o c/o N/V. Pt c/o pain 2 mg MSO4 given. [(b)(6)-2]
	1000 Δ ABD DRSG. Premedicated pt w/ 4mg Versed & 2 mg MSO4.
	PT tolerated procedure well. Tissue around area pink. No
	strong or foul odor noted from wound. Ostomy appliance
	changed b/c leakage from around area. Stoma care done.
	Stoma pink and moist. [(b)(6)-2] [illegible]
	1415 Gave pt 2 tabs Tylenol 325 mg PO for temp 100.9 [illegible] [(b)(6)-2]
	1630 Pt c/o pain in abdomen 3 mg MSO4 given [(b)(6)-2] [illegible]

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17APR03	1930- ABD. DRESSING DRY AND INTACT, COLOSTOMY (R) SIDE OF ABD, ENSURE FEEDING @ 20cc/HR PER PEG TUBE, FOLEY TO GRAVITY IV- D5NS @ 60cc/HR INFUSING IN (L) HAND, EXPIRATORY WHEEZING IN ALL LOBES, PT. ON 10L O2 VIA NON-REBREATHER MASK - POX 92% SGT [redacted] 9/WM6 2115 - T. 101.9 (A) RN NOTIFIED AND 650mg TYLENOL GIVEN PER FEEDING TUBE. FOLEY OUTPUT - 1100cc CLEAR YELLOW URINE. SGT [redacted] 9/WM6 2200- BP 122/69 P121 R22 POX 92% ON 10L O2 VIA NON-REBREATHER SGT [redacted] 9/WM6 0630- FOLEY OUTPUT - 2000cc AND COLOSTOMY 100cc OUTPUT. T. 103.5 (A) 650mg TYLENOL SUPPOSITORIES GIVEN. SGT [redacted] 9/WM6
18APR03 0730	0700 meds given, T 101.5(A) - SA 90 96% - Tube feeding, infusing well @ 20cc/hr. IV infusing well into (L) hand. Lungs CTA & ↓ BS BIL Bases. BS +. Abd round softer than yesterday. Abd Dressing intact. O2 12-15L/m via NRB. Pt c/o Pain + Being cold, explained to Pt that he is cold b/c ↑ Temp & he was medicated less than an hour ago — [redacted] 9/WM6
0830	Dr [redacted] b6-2 in orders received - Pt's Am care done. Foley care done. Pt tolerated to minimal complaint - [redacted] 9/WM6
0930	Pt's G-Tube clamped off per Dr [redacted] order [redacted] 9/WM6
1130	Foley emptied of 700 dark yellow urine - [redacted] 9/WM6
1140	Pt placed on litter & readied for transport - [redacted] 9/WM6
1400	Pt now being transferred - Dressing D & Parkin solution - Pre medicated & MSO4 4mg WPT Versed 4mg IVP - Pt tolerated Dressing - Then c/o Pain & placed back to bed [redacted]

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

ATIENT'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]

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)
20 Apr 03	1345 A ABD DRSG w/ Dakens solution. Patient premedicated w/ 4mg MSO4 & 4mg Versed. Pt tolerated procedure well. 1515 Pt voided 300 cc yellow urine. Pt resting in bed. [redacted] 91WM6
	1630 75 cc dark green water stool emptied from bag. Pt voided 300 cc clear yellow urine. [redacted] 91WM6
1934	received report from offgoing staff, pt. care assumed. pt. walked up and back down hallway. Assessment done, no significant changes noted. pt c/o pain b6-2 4mg MSO4 given IV. pt. resting at this time. [redacted] 91WM6
2343	dressing A on abdomen completed. pt. medicated but continues to c/o pain [redacted] 91WM6
21 Apr 0548	95/54 hr 92 97 SpO2 FiO2 97.3 T. pt resting, Ø c/o pain, Ø signs of distress. Ø significant changes in condition. [redacted] 91WM6
0715	Received report on pt, assessment done. No sig. changes. P 110 BP 95/58 T 99.2 ⊕. Pt resting in bed w/ NO c/o pain. 0930 Drsg A by physician. Commented not as much oozing & feces from wound. tissue around wound looks good. Stoma care done. Rect x moist. Did drsg w/ NS instead of Dakens per MD instruction. Pt given 4mg MSO4 when DRSG A complete [redacted]
	1415 Pt voided 350 cc dark yellow urine. Pt. ate pear and orange w/ Ø c/o N/V. [redacted] 91WM6
	1730 Emptied 100cc green liquid w/ some formed stool. Pt. ate 30% of dinner w/ Ø c/o N/V. Ø c/o pain. 3mg MSO4 given. [redacted] 91WM6
	2045 - PT. VOIDED 400cc URINE. [redacted] 91WM6

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19 APR 03	1645 750cc Clear yellow urine emptied [redacted] 91WMC
	1720 Pt OOB to chair. Tolerated w/ no SOB or c/o pain. Pt ate banana and drank water w/ no N/V.
	Pt in chair looking at magazine. [redacted] 91WMC
	1800 Foley clamped for bladder training. [redacted] 91WMC
	~~2000~~ 1930 - IV RESTARTED 18G (L) WRIST - D5 1/2 NS @ 160cc/HR. 2000 -
	ABD. DRESSING DRY AND INTACT, COLOSTOMY (R) SIDE OF ABD - 125cc
	SEMI FORMED STOOL OUTPUT, LUNGS CLEAR IN ALL LOBES, POX 92% ON
	9L O^2 VIA NON-REBREATHER MASK. 2100 - PT. c/o URGENCY TO VOID -
	FOLEY UNCLAMPED - 500cc URINE OUTPUT AT THAT TIME. SGT [redacted] 91WMC
	0500 - ABD. DRESSING CHANGED WITH DAKINS WET TO DRY DRESSING
	COLOSTOMY OUTPUT 175cc SEMI FORMED STOOL. SGT [redacted] 91WMC
	0615 - FOLEY OUTPUT 850cc SGT [redacted] 91WMC
20 APR 03	Urine + 2 bulk [redacted]
0730	0730 - Received report on Pt. Assessment done - drug on ABD CDI. Foley clamped for bladder training. IV in (R) hand. Ostomy draining dark watery stool. [redacted] 91WMC
	0740 Foley D/C'd. [redacted] 91WMC
	0915 150cc dark green watery stool emptied from bag. [redacted]
	1000 PT voided 350cc clear dark yellow urine. Pt c/o pain in abdomen. 3mg MSO4 given. [redacted] 91WMC

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.

6

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)*
23 APR 03	Pt back w bed medicated c 5 morphine [illegible] sleep [illegible]
2410	+ agitated
0100	Urney IVP1 ↑
0400	Pt c/o pain — refused Motrin po
0430	(P) emesis 300cc GRN with undigested food — medicated c 12.5 g phen IVP
0550	(P) small emesis — 100cc GRN
0600	Total Intake — IV = 600cc PO = 240cc 840cc
	Output = emesis = 400cc voided 5W = 950 cc
	VS BP 107/61 P 103 R 28 T 98.7 RA
0700	f Urney + Zantac IVPB
0800	800 mg Motrin po
4-23-03	AM assessed s'd wounds red pink (-) pus smell, colostomy
PM	draining, G-Tube intact. PO-HC IV, ambulated, eaten PO, percocet for pain.
4-23-03	Throughout day pt agitated frequently, ambulated 2x today sat outside, colostomy leaking clear green fluids. Pt ate apple 1x today but appetite ↓.
23 APR 03	Assessment completed — Abd Dg c/d/i, colostomy intact c
1912	mod liquid green stool. stoma surrounded, HC capped - syringe removed - retained - reoperated. Pt c/o pain
2011	1 Vicodin po for ↑ pain
	void 800cc urine
2100	Coumadin 30mg - SQ — Zantac 150mg po
2300	Pt refused bed bath — c/o pain
2330	Dsg s'd — (P) liquid stool - juice w colostomy —
	stool coming from mid abd wound & lateral wound —
	c NS — Abd dsg applied & Montgomery strips secure — 10 [illegible]

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22APR03	0005- ABD. DRESSING CHANGED WITH DAKINS WET TO DRY DRESSING, COLOSTOMY BAG CHANGED - 100cc SEMI FORMED STOOL, PT. VOIDED X 1. SGT [redacted] 9/WM6 0230 - PT. VOIDED cc URINE. SGT [redacted] 9/WM6
22 APR03	0705 Received report on pt. Pt in bed c/o pain. Told time had not passed to get more medicine. Zantac ↑. [redacted] 9/WM6 0815 Pt given 800 mg motrin per MO order for c/o pain 0915 ABD DRSG Δ - bacitracin applied to areas irritated by tape. Drainage noted by ostube. Lovenox given. [redacted] 1145- PT OOB to chair outside. NO c/o pain. Episode of emesis x1 50cc. 12.5 phenergan given. [redacted] 9/WM6 1325 Pt resting in bed c/o pain. Told too early to medication. Percocet ↑. [redacted] 9/WM6 1715 IV infiltrated. 16' restarted (R) AC. Pt at 40% of dinner and drank juice w/ Ø c/o N/V. [redacted]
22 APR03 1900	Assessment completed - Pt sleeping - easy arousal abd dry & I/Δ - colostomy draining yellow formed + liquid stool - [redacted]
2000	Medicated Pt 2 Sy Vicodin IVP [redacted]
23 APR03 2400	Dry (ASD) Δ'd & colostomy Δ'd X2 - bed changed while pt w/ OS Chaplain - Bacitracin applied to irritated skin area from tape application. Medicated 2 Sy Morphine IV Dry Δ & [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEP[redacted]	RECORDS MAINTAINED AT
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[redacted]		

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24 APR 03	1 Tab Vicodin for ↑ pain po — [redacted] (b)(6)-2
0300	Pt continues to refuse to drink Ensure — [redacted] (b)(6)-2
0600	VS - BP 98/61 P 103 R 22 T 98.2 ⓪
	Intake - po 720 (total) Output voided = 300 Colostomy = 300 = 600 (total)
	Colost - loose thin — Bd chart under colostomy — [redacted] (b)(6)-2
0900	Dsg Δ'd and minimally debrided. Yellow stool noted at Penrose site. Wound bed beefy red c̄ area of pale fibrosis extensive aspects c̄ Tube intact c̄ small amount purulent drainage at insertion site. Rectal tube intact. Covered c̄ ABD pads and secured c̄ Montgomery straps. Tol well c̄ 5 mg Diazepam. ABD soft and appropriate tender. Stoma intact and beefy red. Drainage moderate amount liquid green stool. Signs of difficulty observed with adhering colostomy bag. — [redacted] (b)(6)-2
1000	Pt ambulated throughout hosp. Tol well but fatigued at end of walk. Pt states to be — [redacted] (b)(6)-2
1600	Emptied 450 ml liquid stool with bits in it. Ambulated about hospital, became fatigued in 5 min. Pt c̄ ≈ 600 po intake but denies need to urinate. Will cont to monitor. — [redacted] (b)(6)-2
1700	Pt consumed 75% of dinner and ambulated again. Tol well. Cont with good PO intake. 240 c̄ dinner — [redacted] (b)(6)-2
1720	Pt colostomy again unattached. Cleansed skin at site which is somewhat abraded, applied Benzo to skin rapidly [redacted] (b)(6)-2

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[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)*
24 April 03	1730 - VS T 97.4 P 115 SPO2 96 RA R 20 BP 108/68
	Pt tol meal G emesis or nausea. Takes 400 cc PO
	this shift, Dark Amber ST to 115, +2 & 4 Resp Pulse (b)(6)-2
	lun clear upper & diminished bases. addit 200 output
	per colostomy bag — (b)(6)-2 LPN
	1820 - Pt C/O Pain cur Vicodin ✓. Pt Centurion to
	Hatly refuse ensure supp. Offered anti emetic + pt declin
	and refused drink — (b)(6)-2 LPN
	1830 Dd pt dressi. wound unchanged free Am assum
	Hydrol G Tube. Prior to dsg Δ - admi Vicodin X1 tablet
	Pt declined valium prior to dsg Δ — (b)(6)-2 LPN
2036	Pt. c/o pain, gave 50 mg Morphine.
	Pt. wanted no MSO4 (hand signals). Pt. is
	now sleeping. S/S2. Lung sounds diminished.
	Dark Amber urine @ 300cc (spilled onto
	floor). (b)(6)-2 - 9LWM6 — Stool @ 300 cc of colostomy output
	0430 Pt. c/o pain Gave ✓ of Vicodin.
	Heplock came out/blown upon flushing
	0500 Dsg. change done. Bright red, no
	heavy oozing. Flushed G-tube w/ 10cc water.
	Tol. dsg. change well. T 97°, BP 83/50
	P92 R22 96% O2 - (b)(6)-2 9LWM6
	0600 - Pt. decline want Ensure.
25 APR 03	0715 Received report on pt. Pt resting in
	bed w/ no c/o pain. (0630) Am care provided. Pt
	003 to chair. (b)(6)-2 9LWM6
	1215 ABD DR (b)(6)-2 - MD notified that wound appears
	deeper. Pt tolerated procedure well. (b)(6)-2 9LWM6

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
25 April 03	Nutrition Note - Per nursing, pt having emesis after meals ~ 10-15 min.
1710	Pt appears to [redacted] b6-2 have problems c̄ spicy foods. ∅ problems c̄ fruits & liquids. Refuses to drink vanilla Ensure. Will try chocolate Ensure and carnation instant breakfast 4 oz @ time. Will send pt bland diet to possibly help ↓ vomiting. Will continue to monitor. — CPT [redacted] b(6)-2 RD, LD
1830	PT VOIDED TOTAL of 1050 cc dark yellow urine this shift. Encourage pt to drink H_2O. Pt had emisis +/ after dinner ≈ 200 cc emisis. Ambulated in the ward before returning to bed. No further complaints of N/V. Patient had c/o pain @ 1730 and received 1 Vicodin. [redacted] b(6)-2 9CWM6
25 Apr. 2020	Report received initial assessment complete pt has colostomy. Pt has Vicodin 1-2 tabs for pain resting quietly ambulates ad lib. Will cont. to monitor / — [redacted] b(6)-2 14E
	Drainage & colostomy Δ @ 0500. Will cont. to monitor / — [redacted] b(6)-2 14F/L
26 Apr 0600	Pt. VSS ~~minimal~~ c/o of pain and SOB received Vicodin 1 po last dose @ 0545 / — [redacted] b(6)-2 28M
0730	VS P 102, SpO2 94RA, BP 102/64 R16 T 97.0 oral. Pt resting quietly in supine position. Lungs clear upper ⅔ ↓ bases R > L. ⊕ output from colostomy — [redacted] b(6)-2

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CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1000	Δ'd dsg + colostomy bag. Stoma bedsg red c̄ swollen skin improving in condition wound bed healthy red s̄ foul odor, some fibrous tissue rubbed off inferior aspect. Lung sounds to R middle + lower lobes very diminished c̄ musical 'squeak' rales to RLL, Pt ambulated in hall briefly + rest to bed. [redacted] b6-2 Pt semi-ulcerated ambulation. Ceramed on oppw + tol well s̄ N/V [redacted] (b)(6)-2 LT
1230	Pt tol meal s̄ N/V. Ambulated about hospital set outside tol well. Pt refused enema. [redacted] (b)(6)-2 LT
1600	Pt ambulate in halls, tol well. Colostomy bag in place s̄ leaks [redacted] (b)(6)-2 LT
1645	Pt tol dinner s̄ N/V [redacted] (b)(6)-2 LT
1935	Strong S.S.2. Lung sounds diminished on bases x2. Pt. drank juice for me @ 100cc. Colostomy bag intact. Left cond. tomorrow [redacted] (b)(6)-2 9WM6
	2035 Pt. ambulated outside to smoke a cigarette, drank @ 60cc fluid, ate a banana. [redacted] (b)(6)-2 9WM6
2200	Dsg change done. Green sanguenous fluid oozing out of bottom abd. & wound w/foul odor. Wound under (D) Penrose has green d/c w/foul odor. (A) Wet to dry. 10cc flushed in G-tube. [redacted] (b)(6)-2 9WM6

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0745 27 April 2003	Received patient @ 0700, without complaints of pain or discomfort. VSS, afebrile. PERLA 1/2mm/reactive. NSR, S1-S2 auscultated. Capillary refill ~~>3 sec~~ [redacted] b6-2 <3 seconds, skin warm to touch. Colostomy bag in-tact w/ small amount of liquid stool. Midline abdominal dressing C/D/I at this time. Patient consumed 60-70% of breakfast w/ complications. OOB x 1 to smoke. Pt in bed resting at this time, will continue to monitor. (b)(6)-2 12T,AN
0845 27 April 03	Administered 10mg Valium and Percocet tab prior to dressing change. Dressing Δ completed w/ c/o pain. Wound healing appropriately per Dr. [redacted] b6-2 (b)(6)-2 1VT,D
1700	Pt's family members came in and ate dinner together @ 1752. Took (ambulated) pt. outside to smoke, & to say goodbye to family member. 1735 Dressing Δ done. Foul odor coming from wound, and drsg. (foul odor) from bottom of penrose drain. Put wet-to-dry drsg. on. [redacted] b6-2 Emptied colostomy bag @ 300cc of urine output. 1844 OOB to smoke with Pt. ate meal brought in by family member (b)(6)-2 9TWM6

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(b)(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2103	Pt. OOB x1 to smoke.
2237	~~Got~~ New colostomy bag changed. more Formed stools, non-liquidy. (b)(6)-2 [redacted] 911M6
27 Apr 2301	Pt: Resting c/o of pain or SOB day ~~CPT~~. Colostomy c̄ Semi-formed stool well ~~continue~~ to monitor (b)(6)-2 [redacted] 1/4
28 April	OPCW - Dsg Δ'd + wound observed by Dr (b)(6)-2 [redacted]. Wound healing well. ~~Pt~~ Colostomy bag coming off - Δ'd. Pt Vail 350 ml mod yellow & sediment. ~~Cut~~ Ileostomy stoma Beefy red with mod output of soft pudding text green output. Pt Ambulates to outside well. Personal parcel that was brought from home by c̄ musician reissue in upper fields on ↓ bases ~~R~~ (b)(6)-2 [redacted] (R & L). Pt remains intact. (b)(6)-2 [redacted] 1/4
1700	Dsg Δ done. Wet-to-dry b/o changes. Colostomy bag emptied - colostomy intact. Family member by side. Tol. dsg Δ well w/ Vicodin tab at @1600. Ate meal @ 755. ~~Walk~~ OOB x2. Will cont. to monitor (b)(6)-2 [redacted] 911M6 ~~Good~~ OOB x1 outside. (100) Meds given. (b)(6)-2 [redacted] 911M6
28 APR 2300	PT IS RESTING IN BED C̄ HOB @ 30°. PT HAS NO C/O PAIN. AOX3. LUNGS CTA. ACTIVE BS IN ALL 4 QUADS, NON TENDER, NON DISTENDED ABD. DRESSING C/D/I. COLOSTOMY DRAINING COPIOUS AMOUNTS OF SEMI-FORMED STOOL, VSS. WILL CONT TO MONITOR PT (b)(6)-2 [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50818

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 APR03	PT HAD C/O GENERALIZED PAIN, 1/2 TAB VICODIN ADM. NO ESSENTIAL Δ'S
0330	FROM PREVIOUS ASSESSMENT. COLOSTOMY CONTINUED TO DRAIN SEMI-FORMED
	STOOL, PT CONSUMED 120cc OF WATER, REFUSED ENSURE SUPPLEMENT,
	WILL CONTINUE TO MONITOR THE PT. (b)(6)-2 RTAN
0730	Did pt ABC exp. Midline Incision 1" wide 1/2-3/4" deep
	C health wound. Min fibrous involved at inferior aspect Gem
	green drainage noted from old drsg underneath from yesterday.
	Minimal/stable bleeding noted. Wound @ (R) exit of planer (+) foul smell/pus
	drainage underneath from yesterday. C/O small amount drain at insertion
	blood easily thrush pt complain of irritation with pulling.
	Colostomy bag c̄ small amt green liquid to semi-soft
	stool (b)(6)-2 RB

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(b)(6)-4		

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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FIRMR (41 CFR) 201-9.202-1

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES					
		NG OUT	J Tube ~~OUT~~ OUT / INTAKE	Foley OUT	IV IN	PO IN
13APR03	1600 - 0400	100	250 output	300	2080	Ø
14 APR 03	04-1600	350	100 output / 70	350 / 400 / 325	500+300 / 1920+50	Ø
14apr 03	1600-0400	200 cc	Ø	1250 cc	1920 cc	Ø
15APR03	04 - 1600	Ø	Ø	1150 cc	1400	Ø
15APR03	1900 - 0700		Ø			
15 Apr.03	0025		Ø	350	40	Ø
	0100	Ø	Ø	100	650	Ø
	0200	Ø	Ø	100	150	Ø
	0300	Ø	Ø	150	~~500~~ 350	
	0400	Ø	Ø	100	180	
	0500	Ø	Ø	125	180	
	0600	Ø	Ø	100	180	

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.
(b)(6)-4 (b)(3)-1 ICU-1		

4m 16 12 20 30

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 MAR 03	Surgery
	POD #3
	s/p GSW abd
	Comfortable
	HR 110 RR 20 130/80 Sat 93% JP [(b)(6)-2] [(b)(6)-2] Serosanguinous
	Abd soft, NT Good U/O. ∅ bile.
	Drains c/d/i
	Ostomy p/p/p
	A&P) Cont aggressive pulmonary toilet
	Dressing
	Ambulate
	Clear liquids → adv diet as tolerated.
	Wound care [(b)(6)-2]
	MP
1900 26 MAR	pt assumed - BP 130/90 - HR 100 - RR - pt voided 750 (peach color urine) abd dressing CDE - ostomy bag colostomy in place ∅ drainage - 5mg MSO4 given ⊕ though - pt told to stay in bed [(b)(6)-2]
26 Mar 03 2000	Late entry - ABD wound edges well approximated, staples intact, ∅ drainage ⊕ erythema, Dsg intact Δd by Dr [(b)(6)-2]. Stoma red & moist watery to particular drainage. ⊕BS. ⊕ flatus. Lung sound CTA bilat & ↓ bases. Strong min pond cough, Pt AXO, Ambulate 3 assist. Vitals per unit [(b)(6)-2]

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[(b)(6)-4]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 MAR 2100	[pt received @ 1900 – assessment completed @ that time] – (@ 2100 Now)
	pt make shift ostomy bag in place – VSS – [redacted]
2150	150 urine out put – [redacted]
2220	100 cc urine out – 3mg MSO4 given [redacted]
2310	7mg MSO4 IM given @ thigh – [redacted]
27 MAR 0100	Urine output – 400 – [redacted]
27 MAR 0400	Pt C/O Pain ↑ given 3mg MSO4 IM @ 0400 Am, PT VS T. 100.4 P 120 BP 112/74
	650mg Tylenol given PO. No other complaints @ this time [redacted] D/E Am
0600	T-98.8 – HR 120 – RR 24
27 MAR 03 0810	POD#4 S/P GSW to ABD
	Pt comfortable
	P-120 T-98.8 RR 24 TMAX 100.4 (last night)
	Voiding urine well
	JP's to serosanguinous drainage ? amount last 24°
	JP's drainage is less RBD and appears to be
	↓ output
	Lungs – IMPAIRED Breath Sounds
	ABD – ↑BS soft NT/ND
	Difficult maintaining colostomy
	gaseous output
	Mid line incision Inspected yesterday
	Bandages C/D/I → Granulating well
	SKIN – ∅ swelling ∅ tenderness
	A/P POD#4 S/P GSW ABD – Stable
	Should temp ↑ will add Triple Abx < AMP CLEO TOBRA
	Assure Pt ambulation
	Wound care / Pulmonary Toilet / Ambulate
	[redacted]

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
29 March 03	1230 - Pt Voided 250cc, Reddish Yellow — [redacted] LTAU
29MAR03 /	POD #6
1730 /	S/P X-lap / Liver Repair / Cholecystectomy / Colectomy
	ABX: Rocephin / Clinda x 2 days
	T max 101.5 yesterday
	JP x 1
	Ostomy ☐ copious output
	Foley x 1 tonight
	generally good po intake
	P) Cont. ABX
	JP pulled
	Staples out tomorrow
	Cont wound care
	[redacted]
29 Mar 03	Pt c/o N+ Dizziness, given 25mg Phenergan IM to (R) Shoulder @ 2100.
2115	A'd Abd Dssg, wound bed pink. [redacted] SSG / LPN
2249 ->	Pt awakened + pulled off ostomy bag. Bag replaced, Pt given 50mg Benadryl PO for sleep. — [redacted] SSG / LPN —
30 Mar 03	B/P = 127/84 P ~~93~~ 104 O2sat 92 T = 99.2
@ 7:15	— [redacted] 9 IW/O

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1837 28Mar03	Pt was given IV, Pt ripped out the IV - [redacted] SGT/USN
1847	T-98.6 (O) Pt
2204	Pt temp 98.9. Pt colostomy bag had about 300-350cc with some form in it. Bag was drained and put value in it to drain it. Pt c/o PN to Abdomin. Pt was given 800mg motrin 50mg of Benudral. Pt also had 800cc of urin output. SPC [redacted]
29Mar03 0415	Pt took colostomy bag off. Pt recieved last colostomy bag. SPC [redacted] clean wound and placed last colostomy bag. SPC [redacted]
29 Mar 03 0546	BP - 116/86 RR - 24 Sats - 94 P - 97 Temp - 98
0852 29Mar03	initial assessment of PT WNL ⊕ABC's PT has colostomy output of 100cc colostomy site appears not infected. incisional site to be dressed + clean no other appenent injuries [redacted] B/P 130/78 P = 115 T = 99.1 O2 = 94 P = 16
29 March 03	1000 Dressing Δ on mid line Abd incision, Site appears c̄ staples in the middle and open on the top and Bottom about 1in. No signs of infection dressing Δ was Sterile. Small open incision on left upper quadrant, packed Sterile and no signs of infection [redacted] SGT USN
29 March 03	1030 - 60 cc Drainage from Colostomy [redacted] SGT USN

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[redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 Mar 03 1925	T-99.5 (o) reported to Dr. [redacted] mj. [illegible] PP
30Mar 03 21:08	800mg Morphin given, PT awake, sitting up in bed. [redacted] 91WP
30 Mar 03 21:16	PT vomited [redacted] 91W10
30 Mar 03 2130	Midline + LUQ Assy's D'd. Colostomy bag D'd. mild pain noted c̄ dssg removal. Wound bed pink c̄ minimal sanguous fluid. See Flowsheet for meds. [redacted] SSG/LPN
31 Mar 03 0622	BP- 110/64 RR- 16 Sats- 98% v/g RA P- 92 Temp- 98° [redacted] SSG/LPN
31 March 03	2140 Pt AOx3, LS clear Bilaterally, Move all Extremities, 8 Pulses x4, VSS, Draining Δ no sign of infection staples in place Colostomy drain 60cc + 250cc from 0900 [redacted] 2CT
3/31/03 1200	POD#8 s/p X-LAP / Liver Repair / cholecystectomy / colectomy Ileostomy / CIWDR x4 days AF x 2 days
	ungs: IMPROVED BS (R) basal
	ABD: ostomy - beefy red / stool in bag
	Milky DISTENDED ↓ BS
	Mid TENDER TO Palpation (B) LQ's
	P) ① Cont. Abx
	② TO OR OZ APROZ (Reanastomosis)
	③ BID w→D Δ's
	④ ostomy care
	⑤ Pain Control
31 MAR 03 1438	108/48 RR 22 P. 113 POX 96 Temp 100.2 [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 March 03	1200 - Give pt Meds Rocephin 1 Gm IVP and Clindymycin 900mg IM Lt Buttocks [redacted] SRT AN
30 March 03	915 PT dressing change in ABD wound looks good wet to dry. [redacted] 91 w
30 MAR 03 1200	POD #7 s/p x-lap / bowel repair / cholecystectomy ? colectomy
	Abx: Rocephin / Clin-DA x 3 days
	AF/VSS
	CV: TACHY 116
	Lungs ↓ BS (B) base otherwise clear
	Ostomy ☆ good out put
	Belly soft
	wounds look good
	P) Cont Abx
	Staples out soon
	Cont ostomy / wound care
	Re Anastomosis in 3 days
	[redacted]
30 Mar 03 / 245	÷ Vicodin given for pain per Dr [redacted] MA [redacted] SRT AN

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SE[redacted]	[redacted]AINTAINED 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]		

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/1/03	POD #9
1030	GSW ABDOMEN S/P EXLAP / Liver Repair / cholecystectomy / colectomy
	Rocephin / Clindx X 4 days
	AF X 3 days 135/48 P-113 RR 22
	T - 100.2
	Lungs - Better BS (R) Base
	ABD - Ostomy - Beefy Red / Stool in bag
	wound clean incision granulating well
	P) Cont Abx
	NPO P MN
	Q D Dressing Δs WTD
	Ostomy Care
	Reanastomosis 4/2/03
4/2/03	POD#10
0730Z	GSW ABDOMEN S/P EXLAP /
	Liver Repair / cholecystectomy / colectomy
	Rocephin / Clindx X 5 days
	AF X 4 days 100/70 P-100 T 96.4 RR 26
	Lungs: Cont (R) base improvement
	ABD - ostomy - beefy red / Stool in Bag

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
	MIS Cont / Lung wound healing well		
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
P) D/C Abx			

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

(b)(6)-2

Regular Diet
Transfer Soon?
Reanastomosis?

...AL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4/3/03 1015	POD #11 S/P GSW ABD S/P EX-LAP / Liver Repair / Chole cystectomy / colectomy
	VITALS 98.1 99 98/60 95% SaO2 (RA)
	LUNGS - CTAB mildly ↓ (R)
	ABD: Soft / mildly distended / wound looks good / ostomy looks good
	Stool in Bag
	P ① Clears Liquids Diet
	② Begin Ertyhromycin 500mg Q 4° (TOTAL 2gms) on 4/4/03
	1st Dose @ 1100 Z
	2nd Dose @ 1500 Z
	3rd Dose @ 1900 Z
	4th Dose @ 2300 Z
	③ NPO P M N (4/4/05)
	④ 3gm Unasyn (IV) on call to OR (4/5/03)
	⑤ TAKE DOWN on 4/5/03
	⑥ 1gm Erymcin @ 0500 zulu (4/5/03)
	(b)(6)-2
4/3/03 1641	Sp02 93 HR 98 Temp 98.2 RR 20 107/76 Pt sitting in bed. Amb ∅ ~~Already~~ 66.2 pain. Translator talked to about doing Selfcare & needing to cooperate. 1) Noted clear diet
	2) Meds & remainder of above Note ↑ (b)(6)-2 SGT, LPN
3 APR 03	50 mg benadryl for sleep (b)(6)-2 LPN // SGT

STANDARD FORM 600 (REV. 6-97) BACK
U.S. GPO: 2002 - 491-600/50618

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
3apr03 5:25z	vitals - 93 SpO^2, 99 pulse, 98.1 temp, 98/60 BP RA, 25 rr [redacted]
	MD ORDERS
4/3/03	① Clear Liquid Diet (Push Fluids)
	② Erythromycin 500mg po Q 4° (Total 2 gms)
	1st Dose @ 1100 Zulu (4/4/03)
	✓ 2nd Dose @ 1500 Zulu "
	✓ 3rd Dose @ 1900 Zulu "
	✓ 4th Dose @ 2300 Zulu "
	~~③ Erythromycin 1/2 (one) gram po @ 0500 Zulu (4/5/03) To sip H2O~~
	④ Unasyn 3gm IV on call to OR (4/5/03)
	⑤ Surgery on 4/5/03
	[redacted]
4/4/03	- Soap Suds Enema until clear
	[redacted]

STANDARD FORM 600 (REV. 6-97) BACK

"U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/1/03 1035	MD ORDERS • NPO ⊽ MN • ON CAN ⊽ OR – Reanastomosis / 4/2/03
1 APR 03 1650	(b)(6)-2 HR 102 SPO2 93 10°/60 RR 28 TMP 99.1° Bay Ø Leak No Pain site Red [illegible] LPN SGT
2100z	900mg/6ml clindamycin
2Apr03 6:29 (2)	Vitals = 92 SPO2, 100 pulse, 26 RR, 96.4 temp, 100/70 BP
4/2/03 0730	D/C (b)(6)-2 Regular Diet (b)(6)-2 (b)(6)-2 Noted CPT
4/2/03 1620z	SPO2 93 HR 105 BP 110/80 RR 24 TMP 98.7 Pt sitting and talking when started shift. states will not walk with full colostomy bag. (b)(6)-2 LPN SGT
1813	Ate MRE but No meat (Pork) just broth & Candies
0241z	Pt awake and informed of need of Colostomy Δ' drained & cleaned at bedside for pt teaching. Attempted to Tell That he will do next Δ. (b)(6)-2 LPN, JLT

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.

Doctor's Order

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)*
5APR03 1130	MSO4 6mg IVP for Abd incisional pain (b)(6)-2
5APR03 1200	Resty p̄ MSO4 for pain, Fluid bolus 500/1000 VSS
	Abd dressing CDI, Abd soft, O2 4L → Sat 94% Ch-rales Phrgm
	12.5mg IVP given (b)(6)-2
1345	PT HAS 6mg of MSO4 for pain
1500	Patient c/o Abd pain increased, Abd soft, dressing c̄ serous fluid stains. MSO4 6mg
	IVP given. NGT scant secretion. Foley output 25cc/hr x 4 hours,
	notified. IV fluids KVO @ 140cc/hr. No new orders — (b)(6)-2
5APR03	Recieved pt resting in bed. Lungs CTA. S,S2
	tachycardia. Bowel sounds absent. Large abdominal
	dressing intact. IV infiltrated. New IV started
	in (b) forarm. No s/s of infiltration. +2 radial
	pedal pulses. Urine output to Foley 150cc at 2359
	dark Amber urine.
6APR03	@ 0315 100cc dark amber urine — (b)(6)-2
6APR03 0500	Patient alert oriented x3, orders Rx Po intake. NGT CLSX scant output. Ø
	Bowel sounds. Middle dressing serous soaked to Rt Abd Tube - Abd tube
	dressing NB Notified of ↓ U.O. ↑ lite LR bolus started drip ORS
	Tachy 135, Sat 92% c̄ O2 supplied (b)(6)-2
6APR 0700	Drain A dsg Abd Well healing tissue medium. Pacing W/D all around
	c̄ (RD) entry/exits wounds partial (b)(6)-2
LAB	140 / 4.6 / 106 / 25 / 20 / 165 ; 14 / 40 ph 7.322
6APR 0930	Patient c̄ ↓ Sat ↑ RR, Temp 101.0 Axo, IS taught thrift intervals c̄
	minimal ability. ~~Slow~~ Sat. puffs = 500ml on IS. Lungs c̄ rhonchi c̄ diminished
	Sounds. (b)(6)-2
6APR03 1200	Patient response to ~~resuscitation~~ lasix = 650cc urine. Febrile 101.6 Axo Sat
6APR 1300	only 90% c̄ NC/PM, (b)(6)-2 CPT to Back, poor cough. Labs notified
	PO2 ↓ 62. (b)(6)-2 CPT, (b)(6)-2 still requires O2 8L/PM NRB — (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5 APR 03	Brief Op note:
	Preop Dx: S/p Diverting colostomy for GSW to abdomen
	Postop Dx: Same
	Procedure: Colocolostomy (end → side)
	Surgeon: (b)(6)-2
	Anesthesia: GETA
	EBL: 250 UOP: 100 cc
	Fluids: 2700
	Findings: Diffuse anterior adhesions, viable stump, viable stoma
	Drains: Foley, NG tube
	Complications: ϕ
	Disposition: To ICU/ stable
	(b)(6)-2 MD
	MAJ, MC
5 APR 03 08:00	Patient arrived for OR, O2 tapered down to RA & Sats. Follows commands,
106/68 - 97.9 (A)	Good cough reflex & NGT (L) Nare. Midline & (R) of midline drainage CDI.
14 - 110	Lungs CTA, IV Vgn (R) AC infusing & S/S of compromise. One Episode
10% FM - 99%	of emesis scant amt. Foley drainage clear yellow urine scant amt. (b)(6)-2
0800	Pain medicine MSO4 2mg IV x 2 for pain.
1135	Urine output ↓, IV bolus 1 liter per (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	PATIENT ASSIGNED 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.)* (b)(6)-4 (b)(3)-1

REGISTER NO. | **WARD NO.**

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 APR 03 @ 11:45 Z	PT. ambulated x 3 today. Approx 200' each way. Tolerated well. Did have some low sats. 76-86% Roomair. Face mask @ 10L sats are 95% resting. Abd. midline open. Dsg Δ done. O foul smell. Some small grey liquid drainage noted. Medicated c̄ MSO4 x2 today for pain to abdomen. Bowel sounds non active. Tongue looks better c̄ 21° of thrush. Thrush treated yesterday. Foley DC'd @ 0500Z. PT. has not voided yet. NG DC'd @ 0500Z. Abdomen is distended, but not as much as yesterday. IV @ forearm c̄ LR @ 140/h. Δ infiltration or infx noted @ IV site. I+S used and enforced. — SSG (b)(6)-2 9 APR 03
10 APRIL 03 0100 Z	Pt A+O x 3, NAD, O_2 @ 6 L/MIN via O_2 concentrator via non-rebreather. Sats 93-94%. Pt used IS x 2 this shift, also ambulated to BR commode + chair. PAO_2 drops to 81-85% c̄ RA. C/O pain to abdomen. Dressing is C, D, I. No BS noted, pt not passing flatus. Abdomen is distended, tender to shallow palpation. (b)(6)-2 9 APR

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.

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)*
10 Apr 03	0515 Patient alert, oriented / language barrier. Requires O2 via NRB to keep Sat > 92%. Lungs coarse throughout. (+) BM & voids. W→D dressing B'd & midsection, (-) purulent drainage. Ambulatory steady gait. Skin color appropriate for ethnicity. IV to (D) hand infusion LRS @ 140 cc/hr. (-) redness or edema. [redacted] (b)(6)-2 ICT/AN

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1841		25mg Succinylcholine	IV			CPT Allison
1905		12.5mg Succinylcholine	IV			CPT Allison
1944		5mg MSO4	IV			SFC Kotsik
2236		2mg MSO4	IV			SFC Kotsik
2330		2mg MSO4	IV			SFC Kotsik

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

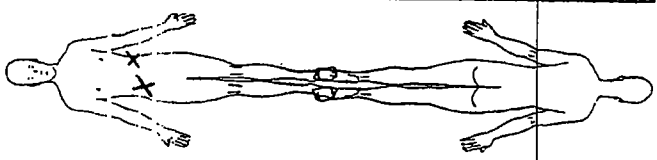
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

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
1849	Foley	Pale yellow	1450 mL
1930	Foley	Pale yellow	200 mL
2200	Foley	yellow	700 mL
2230	JP		100

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

(b)(6)-2

~~[illegible]~~

23MAR03 1824- Pt received from CPT (b)(6)-2 S/P Ex Lap, colostomy ~~[illegible]~~ & repair of liver laceration ~~[illegible]~~ (b)(6)-2 cholecystectomy. PT unresponsive x 2, alert to pain, intubated @ 25 depth as lips. Vent set @ 12 BPM, I:E 1:4.0, SIMV, 21% O_2 with supplemental O_2 added @ 700 mL. BS present, clear & equal all quadrants. IV's running 0.9% NaCl (L) wrist & (R) wrist. Strong pulses @ radial & carotid, weak pedal bilaterally. Foley draining to gravity. (b)(6)-2

1841- Pt starting to buck the vent & convulse, med given by CPT (b)(6)-2 noted above. (b)(6)-2

1846- Pt released, (b)(6)-2

1847- IV (R) wrist shut off, vent removed

1900- Dressings to mid abdomen have old blood under each, No new seepage noted.

1911- Go on Diprivan syringe started @ 25 mcg/kg/min into (L) IV site using syringe pump. VS ICG HR 127/74 b 12 RR 100% SpO_2. (b)(6)-2

1939- Vent malfunction, by pt manually ventilating corrected. Pt back on vent 1946 12 BPM 1:4.0 IE 21% w/ supplemented O_2 VS returning to baseline. (b)(6)-2

1945- Vent settings switched to CPAP RR 21 100% SaO_2

1957- Diprivan drip stopped per Anesthesia in preparation for extubation. CONT OA 3950 (b)(6)-2

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: _____
Report Given To: _____
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: _____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: _____

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

DTSG APPROVED (Date)

Date: 23MAR 03
Time In:
Allergies:
Pre-op V/S:
Procedures: ex lap colostomy cholecystectomy

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

OR Intake: Crystalloid ____ Colloid ____
OR Output: UOP ____ EBL ____
Meds/Times:

Drains: Hemovac, NG, JP, T-tube, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1824	1829	1834	1849	1904	1919	1934	1949	2004	2019	2034	2049	2104	2119	2134	2149
SaO2	100	100	99	100	99	100	100	97	100	98	95	98	96	97	95	97
FIO2																
Methods	Vent	Vent	Vent	Vent	Vent	Vent	Vent	Vent	RA	RA	RA	RA	RA	RA	RA	RA
240																
220																
200																
180																
160																
140											✓					
			✓						✓	✓		✓	✓	✓	•	•
120	✓	•		✓	✓				•	•	•	•	•	✓	✓	
		✓	✓	•	•		•		•							
100	•	•				•	✓	✓								
								•								
80									^		^	^	^			
	^			^	^	^			^	^				^	^	
60		^	^				^	^								
40																
20																
RR	15	16	21	12	21	12	11	16	24	23	23	26	27	25	18	14
T																
Time																
Pain (0-10)																
LOS																

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1900	0.9 NACL	700	RA	IV	
2300	0.9 NACL	600	RA	IV	

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	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	/	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	/	1	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	/	1	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	/	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.	/	7 (b)(6)-2	

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

PREPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC | DATE (Continue on reverse)

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

(b)(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDICAL RECORD — **PERIOPERATIVE 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 Litter BY 546 Ambulance

2. PATIENT IDENTIFIED BEFORE ANESTHESIA AND PROCEDURE
VERIFIED BY (b)(6)-2 Capt

3. DATE 23 MAR 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME 1345 NUMBER 5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Translator present pt cooperative

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Cpt (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

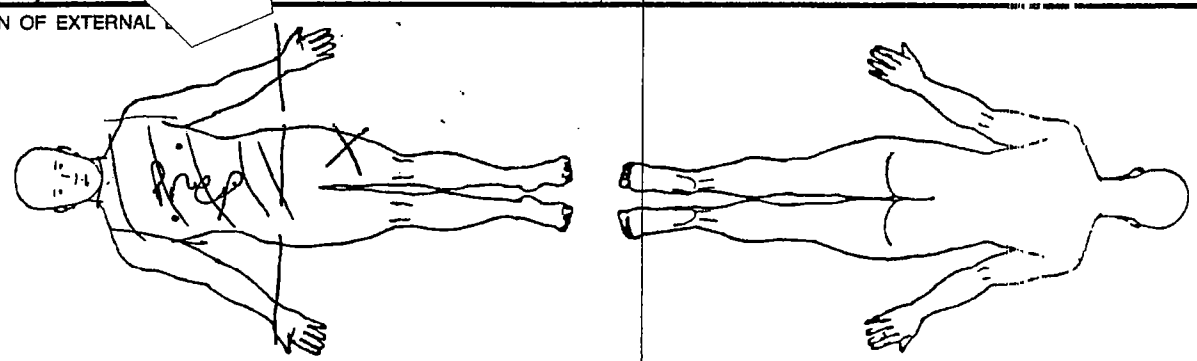
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: DR (b)(6)-2

PREP SOLUTION *(Specify)*
SITE: Betadine/Abd & Chest BY WHOM: Cpt (b)(6)-2
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL (b)(6)-2



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

C = Correct I = Incorrect

10. COUNTS		Initial Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No				(b)(6)-2	(b)(6)-2
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;)*

(b)(6)-4

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

☐ ESU NO: F1048
GROUND PAD: BRAND Valley Lab
LOT NO: 156870

☐ 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.

OPERATION REQUEST AND WORKSH

For use of this . ., see AR 40-407; the proponent agency is the Offi. he Surgeon General

SECTION A – REQUEST FOR SURGERY

1. PATIENT'S NAME (Last, First, MI) (Print)	2. STATUS	3. AGE	4. RELIGION	5. REGISTER NO	6. SSN (with Family Member Prefix)
(b)(6)-4	BD	N45			

7. PREOPERATIVE DIAGNOSIS: S/P Colostomy for colon injury

8. NURSING UNIT (from - to): MCU

9. OPERATION PROPOSED: Colo- colostomy

10. REQUESTING SERVICE: Gen Surg

11. DATE OF SURGERY	12. TIME OR CASE NO	13. SCHEDULE PRIORITY (check one)	14. BLOOD REQUIRED (Unit)	15. SEPTIC
5 APR 03	1 57	☐ EMERGENCY ☐ SEMI-EMERGENCY ☐ ROUTINE	0 cc	II

16. SURGEON	17. ASSISTANT(S)	18. POSITION OF PNT	19. PREP REQUIRED
(b)(6)-2	(b)(6)-2	Low Lith	Betadine

20. NURSING STAFF	21. ANESTHETIST(S)	22. ANESTHESIA
	~~GETA~~	GETA

23. SPECIAL INSTRUCTIONS AND REMARKS: Intestinal set, Silver bullet

24. REQUESTING OFFICER (Printed Name and Signature): (b)(6)-2 MD (b)(6)-2 MAJ, MC

SECTION B – OPERA

25. OPERATING ROOM NO	26. TIME OR CASE NO	27. SEPTIC	28. FLUIDS (other than blood)	29. BLOOD ADMINISTERED
			NS	Ø

30. SURGEON	31. ASSISTANT(S)	32. ANESTHETIST(S)	33. ANESTHESIA TIME (Began and Ended)
		PITCHER	0810 / 1109

	AGENT	TECHNIQUE	37. AIRWAY	39. SPECIAL PROCEDURES (Anesthesia)
34. INDUCTION ANESTHETIC	Propofol	RSI & CP	7.0 ETT	
35. PRIMARY ANESTHETIC	Forane	GETA	38. RELAXANTS: INTUBATION: Succinyl-choline; OTHER:	
36. SECONDARY ANESTHETIC				

40. NURSING TIME (Began and Ended)	41. SCRUBBED PERSON(S)	42. CIRCULATING PERSON(S)
0730	Jey	(b)(6)-2

43. OPERATION DATE	44. OPERATION TIME (Began and Ended)	45. DRAINS	46. SPONGE COUNT	47. LABORATORY SPECIMEN
5 April 03	0838 / 1055	Foley	Correct	9

48. OPERATIVE DIAGNOSIS

49. OPERATION(S) PERFORMED

☐ EPISODES OF SURGERY

50. COMPLICATIONS (Continue on reverse, if more space is required)

51. DICTATOR'S NAME, SERVICE & PHONE EXT

RECORDED IN REGISTER (Initials)

DA FORM MAR 82 4107 EDITION OF 1 JUN 73 MAY BE USED.

Name: (b)(6)-4
SSN:
DOB:
Unit:
Nationali

HT:
WT: lb
WT: kg

DATE: 23 MAR 03
TIME: 1900

Additional Orders/Charging:

24 MAR 03 1500
1) Δ Unasyn to 3gm IVB Q6H
2) Albumin 5% 250 cc bolus x 2 over 20-30 minutes.
(b)(6)-2
24 MARCH 03 7:00 hrs
1) Toradol 30mg IVP now. V.O.
(b)(6)-2
(b)(6)-2
24 MARCH 03 7:040 hrs
1) Δ Toradol to 30mg IVP Q6hrs. - V.O.
(b)(6)-2
(b)(6)-2
25 MAR 03
1) Continue toradol 30mg IVB Q6H
2) D/C Unasyn
3) Cefotaxtan 1 gms IVB Q12H
4) Urostomy bag today
5) Ambulate today.
6) D/C NGT
7) D/C Foley if ambulatory
(b)(6)-2

1. Admit: ICU: **POST-OP**
2. **Diagnosis:** s/p exp lap for GSW
3. Condition: VSI SI Stable
4. **Allergies:** NKDA
5. **VS:** Q5min x 3; Q15 min x 3, then Q1 hr; Q2 hrs; Q4 hrs;
Notify MD for SBP: > 160 or < 90; DBP: > 100 < 50;
HR: > 120, < 60; RR: > 20, < 10; Temp: > 102
6. **IVF:** ~~IVF LR~~ @ 80 cc/hr; ~~NS~~ @ 75 cc/hr;
Albumin @ cc/hr; Hespan @ cc/hr
7. Monitor: Cardiac; Pulse Ox; Neuro Q m/hr; A-line;
8. I&O: Q1 hr; Q hrs
9. Drains: NG to Low/Cont suction; Foley to gravity JP empty + Q4H
10. CT #1: 20 cm H2O suction, H2O seal; Heimlich
11. CT #2: 20 cm H2O suction, H2O seal; Heimlich
12. **LABS:** ABG now & Q1 hr; Q2 hrs; Q hrs; PRN
Hct now & Q 6 hrs; Chem now & Q 6 hrs; UA
13. **BLOOD:** T&S units; T&C units;
Transfuse: units PRBC or Whole Blood for Hc: < %
14. **Oxygen:** 2L NC; 4L NC; 5L FM; NRB;
Keep Stats > 92%, > 95%,
15. **VENT:** SIMV; TV: 700; RR: 12; Fio2: 21%; PEEP
ABG Q 1 hrs;
16. X-Ray:
17. **MEDS:**
Morphine 2, 4, or 6 mg IVP Q 30 min/hr prn Pain ✓
Demerol 12.5 mg; 25 mg; 50-75 mg IVP prn Pain/chills
Zofran 2-4 mg IVP Q 6 hrs prn Nausea
Zantac 50 mg IVPB Q 8 hrs ✓
Drip: Dopamine: (400mg/250cc) 2–10 mcg/kg/min
Drip: Epi: (8mg/250cc) 0.01-0.1 mcg/kg/min
Drip: Versed (1mg/ml) 1mg slow IVP q2-3min up to 5mg
Drip: Ativan 0.05-0.1 mg/kg IV over 2-5 min; (2-4mg IV)
Drip: Norepi/Levophed: (8mg/250) 0.01-0.2 mcg/kg/min
~~Propofol 25 mg/hr unit = OFF~~ DC'd SK
✓ Unasyn 1.5 gm IVB (b)(6)-2
18. **BURNS:** IVF: 4cc/% BSA burn/kg = total 24 hr fluids;
Give ½ over 1st 8 hrs from Time of Burn
19. **Head Injury:** Neuro checks (GCS) Q min/hrs;
C-Spine: Clear/NOT Clear; Keep Head in midline position;
Mannitol (20%): 0.25/0.50/1 gm/kg IVPB over 30-50 min
Notify MD for Mental Status changes
20. **EVAC:** Priority w/in 4-6 hrs; Routine w/in 24 hrs;

274th FST Post-OP Orders, By CRT as of 29 Nov 2001
(b)(6)-2

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS

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

WARD: (b)(3)-1 ICU

DATE: 24 Mar 03

This form may be used for more than one day by drawing a heavy line and adding date. Insert column headings as required.

PATIENT'S NAME: (b)(6)-4

		BP	HR	RR	SpO2			Out
0700	Labs ABG: pH 7.337,	PCO2	37.6,	PO2 65	HCO3	20 TCO2	21	BE -6
	i-STAT #7 → Na	150,	K 3.1	Cr 0.92	Hct 36	Hgb 12	—	(b)(6)-2
	i-STAT #6 → Na	148	K 3.3	Cl 118,	Bun 10	Glu 120	Hct	40
0745	IV Fluid changed to LR		@ 80 cc/hr					(b)(6)-2
0900	MSO4 3mg IVP c/o Thrt pain	128/76	131	22	94			(b)(6)-2
0900	Unasyn 1.5g IVPB given							(b)(6)-2
1000	Dsg Change		JP drains 1 & 2			65cc total		54
1020	MSO4 3mg IVP	125/71	121	20	100			(b)(6)-2
1200	MSO4 4mg IVP	128/74	140	37	94			
1245	Urine Output		141	20	96		→	600cc output
1245	JP drains marked #1 & 2		#1 output 60cc			#2 20cc		(b)(6)-2
1245	IVF LR @ 80cc/hr		via dial-a-flo					(b)(6)-2 (b)(6)-2
1315	Temp 101.0 HR 140-146;		Albumin 25% 100cc mixed					
	with 400 cc of LR	→	250 cc/hr				→	(b)(6)-2
1410	VS - output	120/74	133	21	93%	100 cc	U/O	(b)(6)-2
1430	i-STAT - Lab #6	Na 139	K 3.5	Cl 108	Bun 11	Glu 118	Hct 38	
1507	VS, pt resting in bed	120/74	146	29	94%			(b)(6)-2
1530	Δ'd unasyn to 3g IVPB and started albumin 5% 250cc bolus per MD							(b)(6)-2
1600	Pt c/o pain and becomes restless HR ↑150. 4mg MSO4 given IVP.							(b)(6)-2
1600	Zantac 50mg IVPB							
1700	400cc dark urine from foley catheter.							(b)(6)-2
1730	Unasyn 3g IVPB							(b)(6)-2
	Pt sleeping. Vitals	124/71	138	20	90%			
1800	Pt resting	120/68	137	23	91%			
1900	Pt sleeping. Vitals	115/70	140	22	91%			

DA FORM 3950, JUN 91 — Previous editions are obsolete. USAPA V1.01

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS

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

WARD (b)(3)-1 ICU

DATE

• *This form may be used for more than one day by drawing a heavy line and adding date. Insert column headings as required.*

PATIENT'S NAME (b)(6)-4

		T	P	R	BP	SPO_2		
1930	Drained JP's #1 yielded 75cc, #2 yielded 25cc							(b)(6)-2
1930	4mg MSO_4 IVP for 8/10 pain. Encouraged PT to sit up in bed and cough.							
2000	30mg Toradol slow IVP for fever per MD	101.8	139	22	121/72	90%		
2030	Rechecked temp	100.4						
1230	4mg MSO_4 IVP for pain	99.0	122	25	120/65	93%		
1230	Urinsyn 3.0mg IVPB							
0100	500cc clear dark yellow urine							
0100	Zantac 50mg IVPB							
0300	Pt asleep HOB↑ no T pt asleep		125	28	139/85	92%		
0730	30mg Toradol slow IVP for pain							
0730	4mg MSO_4 IVP for pain							
0745	DC'd NG Tube ~~tom~~ 5ml of	return	da					
0200 ~~0745~~	JP drain 75 ml ~~of of~~ out of	drain 1	20ml drain 2				fluid dark Sero Sanguinus	(b)(6)-2 (b)(6)-2
0800	Foley drain 700cc dark yellow urine clear							(b)(6)-2
~~0900~~	Pt resting comfortably	MTK	133	21 ~~133~~	114/65	91		(b)(6)-2
0905	ZANTAC 50mg IVPB							
0910	Ad Urnasyn 3g Q6h to Cefotan 2mG q 12 hrs. per MD. Gave Cefotan 1G IV							
0930	6mg MSO_4 IVP prior to dsg Δ.							
1000	Placed colostomy bag on patient.							
1030	Ambulated patient to front door and return. Pt tolerated this well. D/C'd Foley on return to room. Pt c/o pain 5mg MSO_4 IVP given.			250ml dark yellow urine in foley				(b)(6)-2
1245	Vitals. Pt resting in bed.	99.7	135	22	109/63	87% on 5L Nasal Cannula		(b)(6)-2
1300	Toradol 30mg IV. Vitals		132	20	132/73	87% on 5L Nasal Cannula		(b)(6)-2
1420	4mg MSO_4 IVP. Transferred PT to holding via litter.							(b)(6)-2

DA FORM 3950, JUN 91 Previous editions are obsolete. USAPA V1.01

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS

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

WARD: (b)(3)-1

This form may be used for more than one day by drawing a heavy line and adding date. Insert column headings as required.

DATE: 23MAR03

PATIENT'S NAME: (b)(6)-4

2034	Dressing to WL quad weeping, order to reinforce							(b)(6)-2
2104	Pt started to wake up, c/o pain							
	"A LOT" per translator. 2mg IV			(b)(6)-2				
	MSO4 given. pt relaxing at this time							
2340	↑ 1000mL NaCl							(b)(6)-2
2350	JP drain out 75 mL							(b)(6)-2
2400	1.5g Unasyn SQ6h per order							
	1st Dose Now			(b)(6)-2				
0205	4mg IVP Zofran							(b)(6)-2
0348	Pulse G. Drawn for STAT: NA 143							
	K 3.9 Cl 111 BUN 9 Glu 150							
	HCT 42; Dr. Kepler notified							(b)(6)-2
0100	VS: HR 128 RR 21 BP 143/77							
	SAO2 96, Anterior chest/AL dressing							
	leaking serosanguinous fluid,							
	reinforced							(b)(6)-2
0200	VS: HR 128 BP 130/79 RR 26 SaO2 96							
	UOP 500cc NG 40 JP 46							
0307	VS: HR 133 BP 127/79 RR 31							
	SaO2 93 NC							
0402	VS HR 132 BP 145/91 RR 34 SpO2 92%							
	UOP 150 mL JP 30							
0500	VS HR 132 BP 141/79 RR 32							
	SaO2 93%							

DA FORM 3950, JUN 91 — Previous editions are obsolete. — USAPA V1.01

0600
1.5g UNASYN
IVPB

HCT

March
2003

1	2	3	4	5
6	7			
24	25	26	27	28

Cont. from front

0600 UOP 400 mL
JP 60 mL

HR 133
BP 124/50
RR 23
SPO2 96%

0700 4mg MSO4 given IVP
per Dr [redacted] (b)(6)-2 order

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY / POST-DAY: 13 APR, 14 APR, 15 APR, 16 APR, 17 APR 03, 18 APR 03

MONTH-YEAR: 2003

DAY / HOUR: 23:00, 24:00, 01:00, 02:00, 03:00, 04:00, 08, 08, 08, 08, 12, 14, 16, 18, 20, 22, 24

PULSE (O) / TEMP. F (•): 180 / 105°; 170 / 104°; 160 / 103°; 150 / 102°; 140 / 101°; 130 / 100°; 120 / 99; 110 / 98.6; 100 / 98; 90 / 97; 80 / 96; 70 / 95; 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: 10, 14, 16, 16, 16, 16, 16, 16, 16, 18

BLOOD PRESSURE: 103/74, 109/70, 104, 98/58

HR: 141, 141, 66, 145

T: 100.8, 100.7, 99.0, 99.0°

HEIGHT: WEIGHT → 102.3

SaO2: 100, 100, 100, 100, 100, 98, 98, 98, 98, 98, 98, 98, 98

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)

(b)(6)-4

(b)(3)-1

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

*U.S.GPO:1998-404-783/40069

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		27th															
POST- DAY																	
MONTH-YEAR	DAY	10 Apr 03		11 APR		12 APR 03		13 April		13		13		13			
APRIL 19 2003	HOUR	1200	1600	0100	0	1630		0800	0900		1430	1600	1800	2100	2200		

PULSE (O) / TEMP. F (°) / TEMP. C (Centigrade Equivalents, for Reference only)

SYSTOLIC BP ✓ / DIASTOLIC BP ∧

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		

RESPIRATION RECORD: 34 | 28 | 20 | 71

BLOOD PRESSURE: 124/66 | 118/54 | 92 | 95 | 120 | 95% | 100/62 | 106 118 121 / 59 66 70 | 179 | 153 141 139 | 179 | 149 | 179 | 149

TPR: 97.9 | 98% | 98 94 94 | 24 26 20 | 99.3 | 99.5 | 99.3 | 100.8 | 100.9

RmAir SAT: 104 | 103 | 96 | 89 | 138 | 147

HEIGHT: | WEIGHT: 78

Output: X7 Total

Intake - PO

100% | 100% | SIMV 700, 14, 50, .5 | SIMV 700, 14, 50, .5

SAT - PAO2 VENT Settings

NG

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

(b)(6)-4

REGISTER NO.

WARD NO.

Record special data only when so ordered

(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

MEDCOM - 4250

MEDICAL RECORD

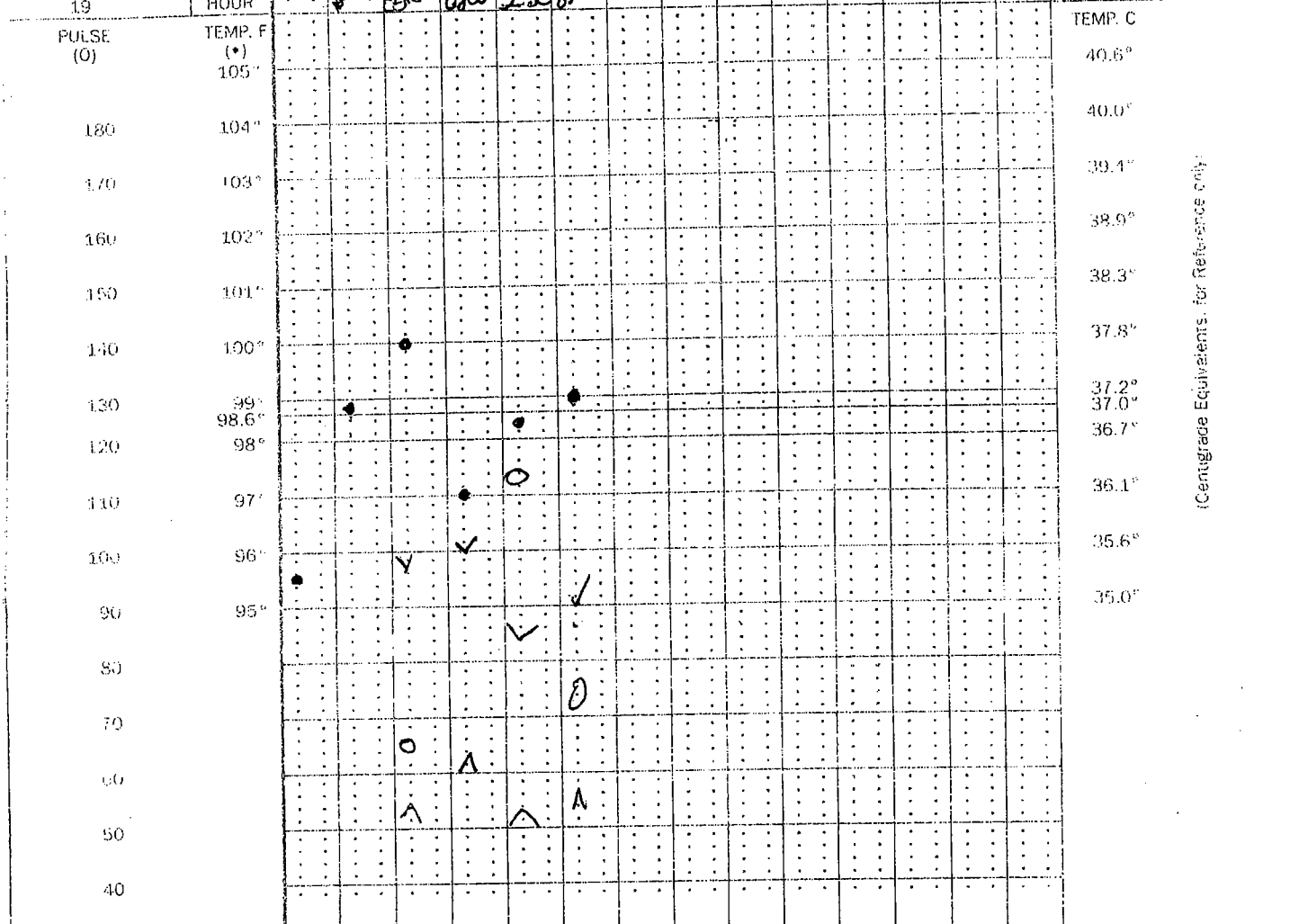
VITAL SIGNS RECORD

HOSPITAL DAY

T DAY

TH-YEAR | DAY: 27 APR 03 | 28 Apr | 29 APR

19 | HOUR: 1800 | 0400 | 0800 | 2300 | 0500



PIRATION RECORD

BLOOD PRESSURE	102/72	97/78	98/56	104/64	97/52
P	72	84	68	102	110
R	14	20	18	18	18
HEIGHT: / WEIGHT →	RA		RA	RA	RA
				96	85

SPU2

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

(b)(6)-4

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

*U.S. Government Printing Office: 1995 - 609-628

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST-OP DAY: 16 | 16

MONTH-YEAR: 19

DAY | HOUR

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

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: 95/50 | 81/49

PR: 16 32 27

SYS: 100 100

HEIGHT: | WEIGHT →

Record special data only when so ordered

1800 | 800 | 1200 + 1600 2800

Colostomy

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

(b)(6)-4

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) BACK

*U.S. Government Printing Office: 1995 - 609-626

511-118

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																
POST- DAY																
MONTH-YEAR	DAY	19 Apr				20 Apr				21 Apr			22 Apr			
19	HOUR	06	1030	1415	1800	06	1000	1415	1800	0545	1015	1400	[illegible]	1000	1400	
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																
RESPIRATION RECORD		26				22										
BLOOD PRESSURE		100/58	105/56	104/60	104/56	107/60	104/60	102/60	100/63	95/54	102/60	104/61	[illegible]	[illegible]	108/68	
		114	109	105		112	110	105	111	92	95	104				
	100%	95%	94%	94%		96%	[illegible]	95%	95%	97%	96	95		95	96	
HEIGHT:	WEIGHT →					100.3		99%	99.2	97.3						

Record special data only when so ordered

(Centigrade Equivalents, for Reference only)

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.

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		22 APR		25 APR		27 Apr										
MONTH-YEAR	DAY															
19	HOUR	1500		1950		0000										

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)

RESPIRATION RECORD

BLOOD PRESSURE				94/57	94/59	98/56										
SPO2 %				94%		94%										
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.

STANDARD FORM 511 (REV. 7-95) BACK

OD (b)(6)-4

*U.S. Government Printing Office: 1995 - 609-626

...AL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		005														
...ST- DAY		5APR03														
MONTH-YEAR	DAY	[illegible]		16—6APR	6APR		6APR03		6APR03			07APR03		07APR03		
19	HOUR	8 [illegible]	2 [illegible] 8	0000	0300	0500	09	1200	16[illegible]			0600Z	1000Z	1400Z	1900Z	

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)

Systolic ✓ Diastolic ^

RESPIRATION RECORD

		18	20	20	110/81		22	28	26			138/76	124/60			
BLOOD PRESSURE	Scale		4L 95%	2L 96%	HR 133		4L22	RA 89%	10L FM	10 FM		HR	128	139		
					RR 24			10 FM 89%	190%	94%		RR	28	20		
		•			SpO2 90						SpO2		93	93		
HEIGHT:	WEIGHT →										Temp		100.5	100.7		
Intake		3000		400+50		1200		600	450	600					550 urine	
Output	Urine	100		100		100		400	850	300					400 NG	2
	NGT			0						100					150 K	

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.

#(b)(6)-4

STANDARD FORM 511 (REV. 7–95) B/

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																		
POST-	DAY																	
MONTH-YEAR	DAY	7APR03		8APR03		8APR03 0430Z		8APR03 0200Z		9APR03 0320		9APR03 0430Z		10APR03 0213Z				
19	HOUR	1830		0200														
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° 98.6°																37.2° 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				117/66		116/65		126/71		120		96%		124				
BLOOD PRESSURE		115/65		~~[illegible]~~						69				120				
	T	101.3		100.3		99%		101.0		99.3				69				
	R	22		21		113		22						24				
HEIGHT:	WEIGHT →					24												
	P	132		119		100.3		120		121								
	SPO2	94%		91				93		95								
								NG 200cc OUTPUT / INPUT 1,750cc IV Urine 700cc										

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.

(Centigrade Equivalents, for Reference only)

VITAL SIGNS RECORDS

Medical Record

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

Initial Assessment

Date _____ Time _____

(b)(3)-1

ICU____
OR____

NEUROLOGICAL ASSESSMENT

2 3 4 5 6 7 8 9

Pupil	Size	Reaction	Pupil	Size	Reaction
OD			OS		

Pupil Reaction: R - Reactive N - Non-Reactive

Level on Consciousness
- __Awake __Alert __Drowsy
- X Restlessness __Lethargic
- __Unconscious

Orientation:
- __Time __Place __Person

Eyes Open:
- __Spontaneous
- X To Speech
- __To Pain
- __No Response

Best Verbal:
- __Oriented & Converses
- __Disoriented & Converses
- __Inappropriate Words
- __Incomprehensible Sounds
- __No Response

Best Motor:
- __Obeys Commands
- X Localizes Pain
- __Extension
- __No Response

Motor Ability & Strength:

	Strong	Weak	Absent
RA			
LA			
RL			
LL			

PSYCHOLOGICAL
- __Calm __Combative
- __Cooperative __Anxious

INTEGUMENTARY

Color:
- X Normal
- __Pale
- __Flushed
- __Cyanotic
- __Jaundiced

Skin:
- __Warm
- __Dry
- __Diaphoretic
- X Cool
- __Clammy

RESPIRATORY
- __Unlabored X Labored

Breath Sounds:
- __Clear Bilaterally
- __Absent R L
- __Rales R L
- __Wheezes R L

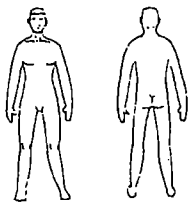
ABDOMINAL
- __Soft __Tender
- __Rigid __Non-Tender
- __Distended __Rebound

Bowel Sounds:
- __Active __Hypoactive
- __Hyperactive __Absent

CARDIOVASCULAR

Pulses	Right	Left
Brachial		
Radial		
Femoral		
Pedal		
Edema		

0-Absent + 2-Normal
- 1-Weak + 3-Bounding



Time	Temp	P	R	B/P	NURSING OBSERVATIONS/INTERVENTIONS
1352		128		167/86	Pt to FST from FLA awake & GSW to (L) chest. Pt restless has spontaneous respirations. Bleeding controlled. Lungs CTA (B). Entrance wound to (R) flank - exit (L) chest. Abd distended. Pt being induced to surgery. Translator @ bedside.

Allergies

Time	IV MEDICATIONS (dose/route site)

INTAKE/OUTPUT	Time	IV	Urine	Chest	Gastric	Pertinent Lab Values
	Total:					

(b)(6)-4

35 y/o ♂
EPW

ATLS WORKUP SHEET

DA FORM 4700 274th FST OP 1

MEDCOM - 4257

13. PROSTHESIS, IMPLANTS ☐ YES ☐ NO NAME: ID NU 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):

NSS

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	10FR JP x 3		
SITE	Abd		

18. DRESSING/IMMOBILIZATION (Specify)

4X8 Fluffs 4X4 Silk Tape

19. ADDITIONAL INFORMATION

DR. (b)(6)-2

DR. (b)(6)-2

DR. (b)(6)-2

Anes - May (b)(6)-2 - Gen

20. OPERATION(S) PERFORMED

Exploratory Laparotomy

21. PATIENT TRANSFERRED TO ICU TIME METHOD Litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. Government Printing Office: 1995 — 386-733/23952

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)	
VEC	( )	5
	( )	
	( )	
	( )	
	( )	
	( )	
VOLAT AGENT: Forane	% del / % e.t.	1 1 1 1
AIR	L/Min	
N2O	L/Min	
O2	L/Min	3 3 3 3

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

FLUIDS

LINE site	
16 G	☐ Warmed
18 G	☐ Warmed
	☐ Warmed
	☐ Warmed

LOSSES: EST BLOOD LOSS; URINE –

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP – / ; HR–

EQUIP CHECK: OK?– Y N

PATIENT RECHECK: OK for PROCEDURE? TIME–

TIME → 1700 X 30 X 1800 X 30 X 1900 C 30

SYMBOLS: BP by cuff (V / Λ); Heart rate (●); Resp rate; BP (transduced); TOURNIQUET (T – X); ANES– X-X; PROC– ⊙ – Ø

220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

VT – ml	
f – breaths/min	
Peak inf pres / PEEP	
MODE– S(pon), A(ssist), C(on)	C C C
ET CO2 (torr)	
FIO2 (Frac or %)	7.41
SpO2 (%)	100 100 100
ECG	SR SR SR
TEMP- site	
N-M Block (T/4)	

P/Auto Cuff; I / oth; RT line; Steth- PC/ES; Gas analyzer; Warming blkt; Conv warmer

TOTALS — TOTAL BIL; TOTAL URINE

FLUIDS – SUMMARY: CRYSTALLOID– 8500 ml; COLLOID– Ø; BLOOD– Ø

REMARKS – Code drugs with numbers, events with letters

TO PACU intubated

RECOVERY AT: PACU – ICU _____ (Specify); CARRIER _____; CONDITION: BP– SpO2– HR–

PROCEDURE TIMES

	Start	Room	End
PREP			
	Ready	Begin	End

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

PROCEDURES and CPT Codes: EXP lap, Chole, colostomy, colon resection, Repair of Liver lac

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: Gen Bal #1

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

(b)(6)-4

SURGEONS:

ANESTHETISTS (b)(6)-2

PROCEDURE LOCATION

DATE

– ANESTHESIA

(b)(3)-1

PAGE 2 OF 2

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)
Ketamine	(MG)
Sux	(MG)
Vec	(MG)
Versed	(MG)
Fent	(CC)
Morphine	(mg)
VOLAT AGENT: Forane	% des
	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min

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

FLUIDS: LINE site (R) hand 18G ☐ Warmed; (L) 16G ☐ Warmed; ☐ Warmed; ☐ Warmed

LOSSES: EST BLOOD LOSS; URINE –

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

BODY WEIGHT: KG / LB

HEMATOCRIT:

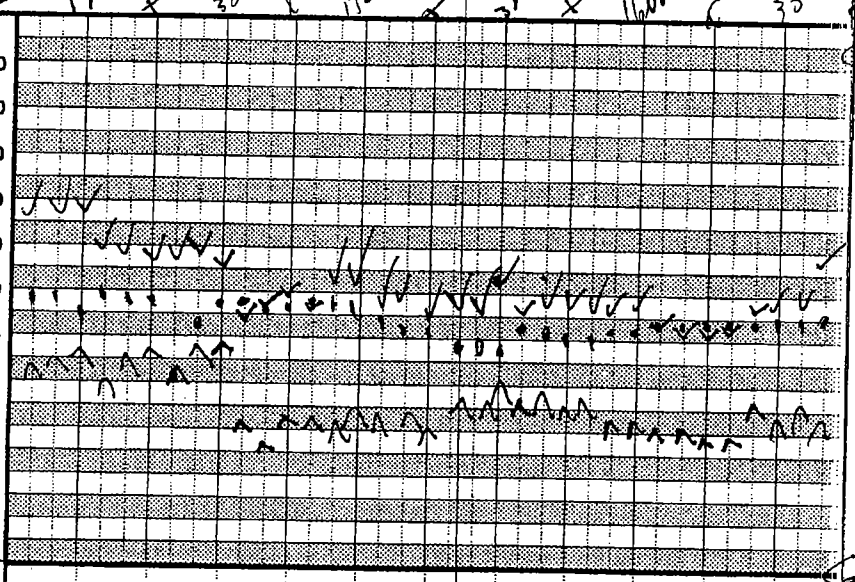
INITIAL DATA: BP – / ; HR –

EQUIP CHECK: OK?– Y N

PATIENT RECHECK: OK for PROCEDURE? TIME–

TIME →

SYMBOLS: BP by cuff; Heart rate; Resp rate; BP (transduced); TOURNIQUET T – ; ANES– X-X; PROC-⊙-Ø



VENTIL: VT – ml; f – breaths/min; Peak inf pres / PEEP; MODE– S(pon), A(ssist), C(on)

MONITORS / ACCESSORIES: BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES; Gas analyzer; ET CO2 (torr); FIO2 (Frac or %); SpO2 (%); ECG; TEMP- site; N-M Block (T/4); Warming blkt; Conv warmer

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

TOTALS: TOTAL EBL 750; TOTAL URINE 3,000

FLUIDS – SUMMARY: CRYSTALLOID– 9 L; COLLOID–; BLOOD–

REMARKS– Code drugs with numbers, events with letters

(A) IV Room warmer placed
(B) RSI
(C) Continue page #2

(D) Ketorolac 1.5 gm
(D) Ketorolac 1.5

RECOVERY AT: PACU ICU (Specify) OTHER

CONDITION: RESP– SpO2– BP– HR–

ANES	Start	Room	End
	1345		1745

PROC	Ready	Begin	End
	1400	1425	1730

PROCEDURES and CPT Codes: EXP LAP, colon resection, colostomy, cholecystectomy, Repair of Lion Lac

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: mill 8.0 oral OLT under

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility: (b)(6)-4

35 y/o ♂ EPW.

SURGEONS: (b)(6)-2; (b)(6)-2

ANESTHETI[illegible] – CRNA; (b)(6)-2

PROCEDURE LOCATION: Telecal AF

DATE: 23 Mar 03

PAGE 1 OF 2

MEDICAL RECORD – ANESTHESIA

(b)(3)-1

1 Jan 99

MEDCOM - 4260

☆ U.S. GPO: 1999 – 528-336/10085

Iraqi national, no translator available

NAME: SURGEON: Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE	M / F	HEIGHT	WEIGHT

PROPOSED OPERATION

PREOPERATIVE VITAL SIGNS: B /P P R

PREVIOUS ANESTHESIA / OPERATIONS ☐ NEGATIVE

CURRENT MEDICATIONS ☐ NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☐ NEGATIVE

ALLERGIES ☐ NKDA

AIRWAY / TEETH / HEAD & NECK

SYSTEM			WN	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY Asthma Dyspnea Recent cold	Bronchitis Pneumonia SOB	COPD Productive Cough Tuberculosis	☐	Tobacco Use: ☐ No ☐ Yes____ Pack/Day for____ Years	Chest X-ray Pulmonary Studies
CARDIOVASCULAR Angina Exercise Tolerance Murmur Rheumatic fever	Arrhythmia Hypertension MVP	CHF MI Pacemaker	☐		EKG
HEPATO/GASTROINTESTINAL Bowel obstruction Hiatal Hernia Reflux/Heartburn	Cirrhosis Jaundice Ulcers	Hepatitis N&V	☐	Ethanol Use : ☐ No ☐ Yes Frequency _____	LFTs
NEURO/MUSCULOSKELETAL Arthritis DJD Neuromuscular disease Syncope Weakness	Back problems Headaches Paralysis Seizures	CVA/Stroke Loss of consciousness Paresthesia TIAs	☐		
RENAL/ENDOCRINE Diabetes Urinary retention	Renal failure/Dialysis Urinary tract infection	Thyroid disease Weight loss/gain	☐		Urinalysis Thyroid FBS
OTHER Anemia Pregnancy	Bleeding tendencies Sickle cell trait	Hemophilia Transfusion history			Hgb / Hct / CBC Lytes

PROBLEM LIST / DIAGNOSES

ASA	PREOPERATIVE MEDICATIONS ORDERED
1	
2	
3	
4	
5	
E	

COUNSELING STATEMENT

Anesthesia alternatives, benefits and risks from minor to death explained. All questions answered.
Patient / legal guardian voices understanding and gives consent for :
Local / MAC, SAB, Epidural, IVR, General Anes.
Other: _____
Appropriate alternative as backup.
NPO status explained.

PATIENT'S SIGNATURE DATE

EVALUATOR(S) SIGNATURE

CRNA (b)(6)-2 MJ CRNA DATE 5/9/03

PHYSICIAN _____ DATE

POST ANESTHESIA VISITS

ANESTHESIA RECOVERY COMPLICATED BY THE FOLLOWING PROBLEMS: (IF NONE, SO STATE)

DATE:

SIGNED: TIME:

MRN (b)(6)-2 Surgeon: 0815

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF ... AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 220

ANESTHESIA RECORD

Page 1 of 1

START	IN OR	ANES. END	DATE
	0815	1109	5 APR 03

TOTS	SURG START	DRESSING	OR NO
0820	0838	1055	

OPERATION PERFORMED: Ostomy take down

SURGEON(S): (b)(6)-2 / (b)(6)-2

PREOPERATIVE

- [x] IDENTIFIED [x] ID BAND [ ] QUESTIONING
- [ ] CHART REVIEWED [ ] NPO SINCE
- [ ] PRE-OP MEDICATION:

Drug	Dose	Route	Time

Pre-Anesthetic State:
- [x] CALM
- [ ] APPREHENSIVE
- [ ] AWAKE
- [ ] SEDATE
- [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # 3 [x] & EQUIP. CHECKED
- [x] NON-INV. B/P [x] PNS
- [x] CONT. EKG [ ] V LEAD EKG
- [ ] ESOPH. STETH. [ ] PRECORD STETH.
- [x] PULSE OXIMETER [x] O2 ANALYZER
- [x] END TIDAL CO2 [ ] MASS SPEC.
- [ ] TEMPERATURE
- [ ] WARMING BLANKET [ ] FLUID WARMER
- [x] AIRWAY HUMIDIFIER
- [x] N / G TUBE [ ] O / G TUBE
- [x] IV(s) 18g @ forearm
- [ ] ARTERIAL LINE
- [ ] CENTRAL LINE
- [ ] SWAN-GANZ
- [x] FOLEY INSERTED: [x] O.R. [ ] FLOOR
- [x] EYE CARE Taped
- [ ] PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

- [x] GENERAL [ ] LOCAL / MAC
- [ ] REGIONAL [ ] NERVE BLOCK

INDUCTION

- [x] PREOXYGENATION [ ] INHALATION
- [x] RAPID SEQUENCE [ ] INTRAMUSCULAR
- [ ] INTRAVENOUS [ ] RECTAL

AIRWAY MANAGEMENT

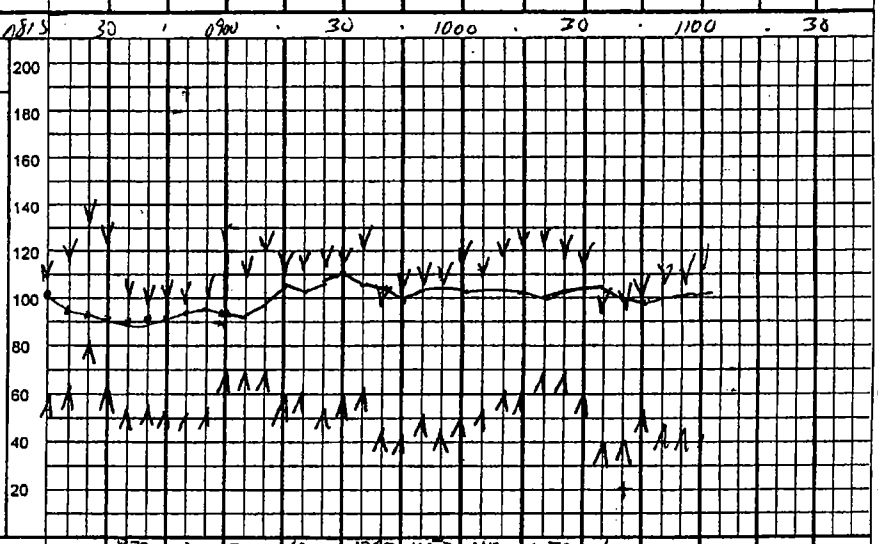
- [x] INTUBATION [x] ORAL [ ] NASAL
- [x] DIRECT VISION [ ] BLIND [ ] AWAKE
- [ ] FIBER OPTIC [x] STYLET USED
- [x] ATTEMPTS x 1 [x] BLADE Miller 2
- [x] ETT SIZE 7.0 [ ] DOUBLE LUMEN
- [ ] STRAIGHT [ ] RAE [ ] ANODE
- [x] CUFFED 1 ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ____ CM H2O
- [x] ETT SECURED AT ____ CM
- [x] BREATH SOUNDS equal
- [ ] AIRWAY [ ] ORAL [ ] NASAL [ ] NATURAL
- [ ] MASK CASE [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA [ ] SIMPLE O2 MASK
- [ ] LMA SIZE

																	TOTAL
AGENTS	Versed mg	2															
	Propofol mg	180															
	Succinylcholine mg	100															
	Fentanyl mg	3 2															
	MSO4 mg			5	5			10									
	Vecuronium mg	3			2				3								
	Neostigmine mg											5					
	Robinul mg											1.8					
	FORANE	2.3	2.0	2.2	2.2	2.7	2.9	1.5	1.8	1.8	1.5						
	~~N2O~~ Umin																
	O2 Umin	5-2	2	2	2	2	2	2	2	2	2						
FLUIDS																	
	NS					1000		2000				2700					
	Urine									100							
	EBL					200			250								
MONITORS	EKG	ST	SR	SR	SR	SR	ST	SR	SR	SR	SR	ST					
	% O2 Inspired	.76	.77	.77	.78	.78	.77	.78	.78	.78	.79						
	O2 Saturation	100	100	100	100	100	100	100	100	100	100						
	End Tidal CO2	41	40	42	42	32.	34	34									
	Temperature																
	PNS	0/4	0/4	0/4	3/4	4/4	4/4	4/4	4/4	4/4	4/4	4/4					
												Slightly					
												Tachy					

SYMBOLS: X ANESTH; ⊙ OPERAT; V ^ B/P CL PRESSI; ⊥ T ARTER LINE PRESSI; ● PULS; C SPONT. OUS RI; ¢ ASSIS RES; ⊠ CONTRO RES; T TOURNI; F CRYS LOID F; B BLO

TIME: 0815 30 0900 30 1000 30 1100 30

VITAL SIGNS (PRE-OP VALUES: B/P 107/59; P 101; R; SAT; H/H)



RESP	Tidal Volume		830	730	750	1200	1200	1150	1420	750	760						
	Resp Rate	14	10	12	12	14	10	10	9	12	12						
	Peak Pressure		25	24	24	26	28	26	28	24	24	18					
		SV/A	CMV	CMV	CMV	AV	AV	AV	AV	CMV		SV					
Symbols for Remarks																	
Position																	

RECOVERY

TIME IN PACU	CONDITION		
1104	STABLE		
B/P 104/68	PULSE 119	RESP	O2 SAT 96
REMARKS			TEMP

REPORT TO: PARRS:

REMARKS:
- [ ] Patient reevaluated. No change from preop plan / evaluation.
- [ ] Significant changes from preop plan / evaluation.

Tourniquet Time: N/A

IN	FLUIDS TOTALS	OUT
Crystalloid	EBL	
	Urine	
	Gastric	
Blood		

(b)(6)-2

MJ CRNA
SICIAN / CRNA

PATIENT'S IDENTIFICATION

(b)(6)-4

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF ... - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 220

ANESTHESIA RECORD

Page 1 of

TART	IN OR	ANES. END	DATE
18	0959	1145	12 APR 03
TOTS	SURG START	DRESSING	OR NO
1026	1030	1125	188

OPERATION PERFORMED: ROV. ABD WOUND PERITONEUM

SURGEON(S): (b)(6)-2

PREOPERATIVE

- [x] IDENTIFIED [x] ID BAND [ ] QUESTIONING
- [ ] CHART REVIEWED [ ] NPO SINCE
- [ ] PRE-OP MEDICATION:

Drug	Dose	Route	Time

Pre-Anesthetic State: [x] AWAKE [ ] SEDATE [ ] CALM [ ] UNRESPONSIVE [x] APPREHENSIVE

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # ____ & EQUIP. CHECKED
- [x] NON-INV. B/P [ ] PNS
- [x] CONT. EKG [ ] V LEAD EKG
- [ ] ESOPH. STETH. [ ] PRECORD STETH.
- [x] PULSE OXIMETER [x] O2 ANALYZER
- [ ] END TIDAL CO2 [ ] MASS SPEC.
- [ ] TEMPERATURE
- [ ] WARMING BLANKET [ ] FLUID WARMER
- [ ] AIRWAY HUMIDIFIER
- [ ] N / G TUBE [ ] O / G TUBE
- [x] IV(s) [illegible] 1 NO-R. 18g (R) AC
- [ ] ARTERIAL LINE
- [ ] CENTRAL LINE
- [ ] SWAN-GANZ
- [ ] FOLEY INSERTED: [ ] O.R. [ ] FLOOR
- [x] EYE CARE
- [ ] PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

- [x] GENERAL [ ] LOCAL / MAC
- [ ] REGIONAL [ ] NERVE BLOCK

INDUCTION

- [x] PREOXYGENATION [ ] INHALATION
- [x] RAPID SEQUENCE [ ] INTRAMUSCULAR
- [x] INTRAVENOUS [ ] RECTAL

AIRWAY MANAGEMENT

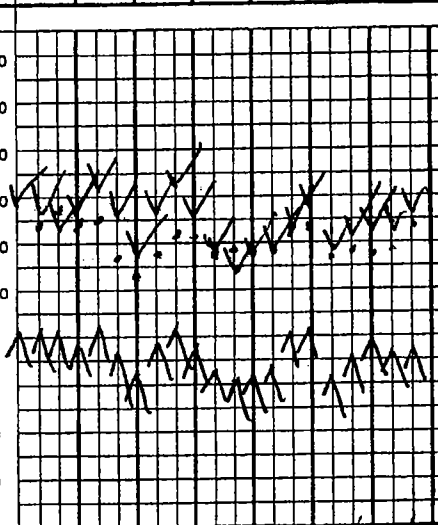
- [x] INTUBATION [x] ORAL [ ] NASAL
- [x] DIRECT VISION [ ] BLIND [ ] AWAKE
- [ ] FIBER OPTIC [x] STYLET USED
- [x] ATTEMPTS x 1 [x] BLADE MAC 3
- [x] ETT SIZE 7.0 [ ] DOUBLE LUMEN
- [x] STRAIGHT [ ] RAE [ ] ANODE
- [x] CUFFED 3 ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ____ CM H2O
- [x] ETT SECURED AT 22 CM
- [x] BREATH SOUNDS =
- [x] AIRWAY [x] ORAL [ ] NASAL [ ] NATURAL
- [ ] MASK CASE [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA [ ] SIMPLE O2 MASK
- [ ] LMA SIZE

		18	30	11	30	17	TOTAL
AGENTS	Versed IV	2.5			2.5		5 mg
	Fentanyl	100		50, 50	50		250 mcg
	Propofol	150			30		180 mg
	Succ	100					100 mg
	Vecuronium	3	3	2	2		9 mg
	Norcuron				3		3 mg
	Isoflurane	1.5	1.5	2	2	2	0%
	~~N2O~~ L/min AIR	2	2	1	1	1	0%
	O2 L/min	1	1	.4	.4	.4	0%
FLUIDS	.9NS	1000		1000			
	Urine						
	EBL						
MONITORS	EKG	SR	SR	SR	SR	SR	SR
	% O2 Inspired	.95	.43	.32	.31	.49	.50 .50
	O2 Saturation	100	100	97	97	99	98 99
	End Tidal CO2	(+)	42	40	35	33	33 (+)
	Temperature	–	–	–	–	–	99.3
	PNS	4/4		4/4		4/4	– 4/4

SYMBOLS: X ANESTH; ⊙ OPERAT; V ^ B/P CL PRESSI; ⊥ T ARTER LINE PRESSI; ● PULS; C SPONTA OUS RI; ◐ ASSIS RES; ⊠ CONTRO RES; T TOURNI; F CRYS LOID F; B BLO

TIME

VITAL SIGNS	PRE-OP VALUES
B/P	137/82
P	130
R	18
SAT	93 RA
H/H	–



RESP	18	30	11	30	17
Tidal Volume	730	725	850	870	880	850	850
Resp Rate	8	10	11	12	12	18	18
Peak Pressure	26	29	28	34	35	(+)	(+)
I:E	1:2	→	→	→	→	→	→

Symbols for Remarks: X ⊙ Ø X

Position: Supine

RECOVERY

TIME IN PACU	CONDITION		
1143	TRANSFERRED CONSCIOUS		
B/P 155/92	PULSE 111	RESP 26	O2 SAT
REMARKS			TEMP

REPORT TO: PARRS:

REMARKS: [x] Patient reevaluated. No change from preop plan / evaluation. [ ] Significant changes from preop plan / evaluation.

NO IV IN PRE-OP

Tourniquet Time:

IN	FLUIDS TOTALS	OUT
Crystalloid .9NS	EBL	
	Urine N.M.	
	Gastric	
Blood		

MRAD (b)(6)-2 CRNA, VSAA, RN

PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION: (b)(6)-4

NAME: (b)(6)-4 SURGEON: (b)(6)-2 / (b)(6)-2 Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE 40's | (M) F | HEIGHT 5'9" | WEIGHT ~175#

PROPOSED OPERATION: RSV. ABD WOUND DEHISCENCE / S/P COLOSTOMY TAKEDOWN

PREOPERATIVE VITAL SIGNS: B/P 137/82 P 133 R 16

PREVIOUS ANESTHESIA / OPERATIONS ☐ NEGATIVE
TOPL. LAP. S/P GSW → ABD (23MAR03)
COLOSTOMY TAKEDOWN

CURRENT MEDICATIONS ☐ NONE
CIPRO 500mg PO BID
FLUDMONTIN 875mg PO BID
MORPHIN 8-10mg PO, q 4-8° prn
Albuterol/Atrovent Nebulizer TID q 6°

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☒ NEGATIVE

ALLERGIES ☒ NKDA
NKDA

AIRWAY / TEETH / HEAD & NECK
INTACT. DENTI.; FROM WORK SUPPLY; OTMJ MPR

SYSTEM	WN	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY Asthma, Bronchitis, COPD Dyspnea, Pneumonia, Productive Cough Recent cold, SOB, Tuberculosis	☒	Tobacco Use: ☒ No ☐ Yes ____ Pack/Day for ____ Years (B) PULMONARY INFILTRATES ?	Chest X-ray, Pulmonary Studies CONSIDERED FOR TODAY PROCEDURE.
CARDIOVASCULAR Angina, Arrhythmia, CHF Exercise Tolerance, Hypertension, MI Murmur, MVP, Pacemaker Rheumatic fever	☒		EKG
HEPATO/GASTROINTESTINAL Bowel obstruction, Cirrhosis, Hepatitis Hiatal Hernia, Jaundice, N&V Reflux/Heartburn, Ulcers	☒	Ethanol Use: ☒ No ☐ Yes Frequency _____	LFTs
NEURO/MUSCULOSKELETAL Arthritis, Back problems (low back pain), CVA/Stroke DJD, Headaches, Loss of consciousness Neuromuscular disease, Paralysis, Paresthesia Syncope, Seizures, TIAs Weakness	☒		
RENAL/ENDOCRINE Diabetes, Renal failure/Dialysis, Thyroid disease Urinary retention, Urinary tract infection, Weight loss/gain	☒		Urinalysis, Thyroid, FBS
OTHER Anemia, Bleeding tendancies, Hemophilia Pregnancy, Sickle cell trait, Transfusion history			Hgb / Hct / CBC, Lytes

PROBLEM LIST / DIAGNOSES
- SEPSIS / INFECTION, POTENTIAL FOR
- SKIN INTEGRITY, ALTERATION OF
- FLUID / ELECTROLYTE IMBALANCE, POT. FOR
- ALT. IN PATTERNS OF ELIMINATION, POT. FOR
- GAS EXCHANGE / RESP. PATTERNS, ALT. OF

ASA: 1 2 3 4 5 E

PREOPERATIVE MEDICATIONS ORDERED

COUNSELING STATEMENT

Anesthesia alternatives, benefits and risks from minor to death explained. All questions answered.
Patient / legal guardian voices understanding and gives consent for :
Local / MAC, SAB, Epidural, IVR, General Anes.
Other: _____
Appropriate alternative as backup.
NPO status explained.

PATIENT'S SIGNATURE _____ DATE _____

EVALUATOR(S) SIGNATURE

CRNA _____ DATE _____

PHYSICIAN _____ DATE _____

POST ANESTHESIA VISITS

ANESTHESIA RECOVERY COMPLICATED BY THE FOLLOWING PROBLEMS: (IF NONE, SO STATE)

DATE: _____

SIGNED: _____ TIME: _____

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - AS A CLINICAL RECORD FORM, IT IS COVERED BY DD 220

ANESTHESIA RECORD

Page 1 of 1 | ANES. START 1927 | IN OR 1940 | ANES. END 2220 | DATE 13 APR 03

OPERATION PERFORMED: Ex-lap | SURGEON(S) (b)(6)-2 / (b)(6)-2 | TOTS 1948 | SURG START 1955 | DRESSING 2210 | OR NO

PREOPERATIVE

- [x] IDENTIFIED [x] ID BAND [ ] QUESTIONING
- [x] CHART REVIEWED [ ] NPO SINCE
- [ ] PRE-OP MEDICATION:

Drug	Dose	Route	Time

Pre-Anesthetic State: [x] CALM [ ] APPREHENSIVE [ ] AWAKE [ ] SEDATE [ ] UNRESPONSIVE

MONITORS AND EQUIPMENT

- [x] ANES. MACHINE # 3 & EQUIP. CHECKED
- [x] NON-INV. B/P [ ] PNS
- [x] CONT. EKG [ ] V LEAD EKG
- [ ] ESOPH. STETH. [ ] PRECORD STETH.
- [x] PULSE OXIMETER [x] O2 ANALYZER
- [x] END TIDAL CO2 [ ] MASS SPEC.
- [ ] TEMPERATURE
- [ ] WARMING BLANKET [x] FLUID WARMER
- [x] AIRWAY HUMIDIFIER
- [x] N / G TUBE ~~[x] O/G TUBE~~
- [x] IV(s) 16s (L) Hand, 18s (R) AC.
- [ ] ARTERIAL LINE
- [ ] CENTRAL LINE
- [ ] SWAN-GANZ
- [x] FOLEY INSERTED: [ ] O.R. [x] FLOOR
- [x] EYE CARE taped
- [ ] PRESSURE POINTS CHECKED / PADDED

ANESTHETIC TECHNIQUE

- [x] GENERAL [ ] LOCAL / MAC
- [ ] REGIONAL [ ] NERVE BLOCK

INDUCTION

- [x] PREOXYGENATION [ ] INHALATION
- [x] RAPID SEQUENCE [ ] INTRAMUSCULAR
- [ ] INTRAVENOUS [ ] RECTAL

AIRWAY MANAGEMENT

- [x] INTUBATION [x] ORAL [ ] NASAL
- [x] DIRECT VISION [ ] BLIND [ ] AWAKE
- [ ] FIBER OPTIC [x] STYLET USED
- [x] ATTEMPTS x 1 [x] BLADE Miller 2
- [x] ETT SIZE 8.0 [ ] DOUBLE LUMEN
- [ ] STRAIGHT [ ] RAE [ ] ANODE
- [x] CUFFED 7 ML AIR INJECTED
- [ ] UNCUFFED, LEAKS AT ____ CM H2O
- [x] ETT SECURED AT 27 CM
- [x] BREATH SOUNDS equal
- [ ] AIRWAY [ ] ORAL [x] NASAL [ ] NATURAL
- [ ] MASK CASE [ ] VIA TRACHEOSTOMY
- [ ] NASAL CANNULA [ ] SIMPLE O2 MASK
- [ ] LMA SIZE

AGENTS

											TOTAL
Versed mg	Versed	2.5									2.5 mg
Propofol mg	150										150 mg
Succinylcholine mg	100										100 mg
Fentanyl mcg	2 3	3		2			5				15 mcg
Vecuronium mg	10			10			10				20 mg
FORANE	2.8	2.5	2.5	2.5	2.5	2.0	2.0	1.5	1.6		
~~N2O~~ L/min AIR	1	1	1	1	1	1	1	1X			
O2 L/min	5-.4	.4	1	1	1	1	1	1-2	2	2	

FLUIDS

LR		700	1500	2400	3000		1000	4100		
Urine				200			250			
EBL		150		250	300					

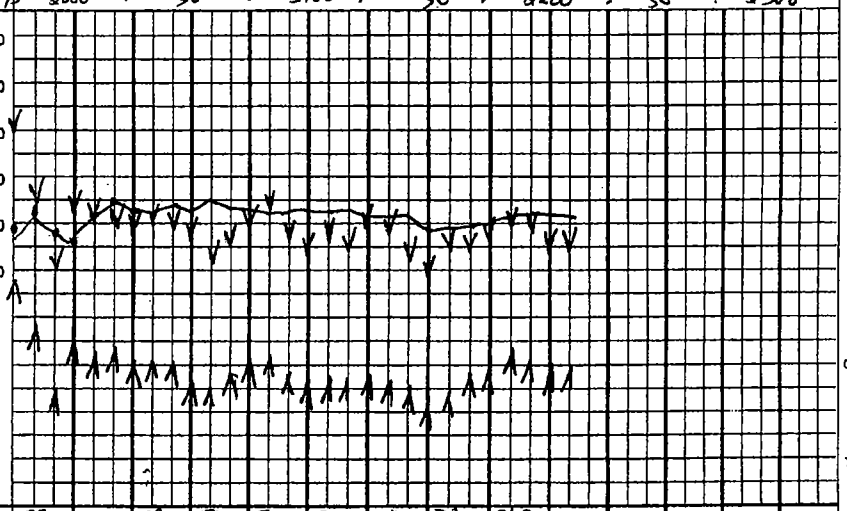
MONITORS

EKG	SR	SR	ST	ST	ST	ST	ST	ST	ST	ST
% O2 Inspired	.98	.40	.50	.50	.55	.56	.55	.57	.99	1.0
O2 Saturation	100	98	97	98	99	98	98	98	100	100
End Tidal CO2	+ 38	34	37	35	37	36	37	36	38	40
Temperature										
PNS	0/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4	0/4

VITAL SIGNS

TIME 1945 2000 30 2100 30 2200 30 2300

PRE-OP VALUES: B/P 139/71; P 136; R 18; SAT 94; H/H



RESP

Tidal Volume	830	880	890	740	730	720	740	720	560	560
Resp Rate	12	12	12	14	14	14	14	14	15	18
Peak Pressure	30	31	30	30	29	29	30	30	30	
	SI/CMV	CMV	CMV	CMV	CMV	CMV	CMV	CMV	CMV	CMV

Symbols for Remarks

Position

SYMBOLS: X ANESTH; ⊙ OPERAT; V ^ B/P CU PRESSI; ⊥ T ARTER LINE PRESSI; ● PULS; C SPONT OUS RI; ¢ ASSIS RES; ⊠ CONTRC RES; T TOURNI; F CRYST LOID FI; B BLOC

REMARKS: [x] Patient reevaluated. No change from preop plan / evaluation. [ ] Significant changes from preop plan / evaluation.

RECOVERY

TIME IN PACU	CONDITION		
2213	STABLE INTUBATED		
B/P	PULSE	RESP	O2 SAT
/	133	14	99

REMARKS | TEMP

REPORT TO: PARRS:

Tourniquet Time: N/A

FLUIDS TOTALS

IN		OUT	
Crystalloid	4100	EBL	300
		Urine	200
		Gastric	
Blood			

(b)(6)-2 CRNA / (b)(6)-2 CRNA

PHYSICIAN / CRNA

PATIENT'S IDENTIFICATION

(b)(6)-4

Lungs normal, no interpretation available -

NAME: SURGEON: Planned Surgery Date:

ANESTHESIA PREOPERATIVE EVALUATION

AGE ~48 | M / F | HEIGHT 70" | WEIGHT ~100 Kg

PROPOSED OPERATION

PREOPERATIVE VITAL SIGNS: B/P P R

PREVIOUS ANESTHESIA / OPERATIONS ☐ NEGATIVE

CURRENT MEDICATIONS ☐ NONE

FAMILY HISTORY OF ANESTHESIA COMPLICATIONS ☐ NEGATIVE

ALLERGIES ☐ NKDA

AIRWAY / TEETH / HEAD & NECK

SYSTEM	WN	COMMENTS	PERTINENT STUDY RESULTS
RESPIRATORY Asthma, Dyspnea, Recent cold, Bronchitis, Pneumonia, SOB, COPD, Productive Cough, Tuberculosis	☐	Tobacco Use: ☐ No ☐ Yes____ Pack/Day for____ Years	Chest X-ray, Pulmonary Studies
CARDIOVASCULAR Angina, Exercise Tolerance, Murmur, Rheumatic fever, Arrhythmia, Hypertension, MVP, CHF, MI, Pacemaker	☐		EKG
HEPATO/GASTROINTESTINAL Bowel obstruction, Hiatal Hernia, Reflux/Heartburn, Cirrhosis, Jaundice, Ulcers, Hepatitis, N&V	☐	Ethanol Use: ☐ No ☐ Yes Frequency _____	LFTs
NEURO/MUSCULOSKELETAL Arthritis, DJD, Neuromuscular disease, Syncope, Weakness, Back problems, Headaches, Paralysis, Seizures, CVA/Stroke, Loss of consciousness, Paresthesia, TIAs	☐		
RENAL/ENDOCRINE Diabetes, Urinary retention, Renal failure/Dialysis, Urinary tract infection, Thyroid disease, Weight loss/gain	☐		Urinalysis, Thyroid, FBS
OTHER Anemia, Pregnancy, Bleeding tendancies, Sickle cell trait, Hemophilia, Transfusion history			Hgb / Hct / CBC, Lytes

PROBLEM LIST / DIAGNOSES

ASA: ~~1~~ (2) 3 4 ~~5~~ (E)

PREOPERATIVE MEDICATIONS ORDERED

COUNSELING STATEMENT

Anesthesia alternatives, benefits and risks from minor to death explained. All questions answered.
Patient / legal guardian voices understanding and gives consent for :
Local / MAC, SAB, Epidural, IVR, General Anes.
Other: _____
Appropriate alternative as backup.
NPO status explained.

PATIENT'S SIGNATURE _____ DATE _____

EVALUATOR(S) SIGNATURE

CRN (b)(6)-2 MT J CRNA DATE 13 Apr 03

PHYSICIAN _____ DATE _____

POST ANESTHESIA VISITS

ANESTHESIA RECOVERY COMPLICATED BY THE FOLLOWING PROBLEMS: (IF NONE, SO STATE)

DATE: _____

SIGNED: _____ TIME: _____

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 CARE UNIT ORDERS		
1	OXYGEN: 3 litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: NS @ 100 cc/hr, bolus ____ cc x 1		
3	MORPHINE: 2 mg IV q 5-10 minutes PRN pain. MAX dose of 10 mg		
4	DEMEROL: 25 mg IV q 5-10 minutes PRN pain. MAX dose of 50 mg		
5	ZOFRAN: Give 4 mg IV PRN nausea. May repeat after 10 minutes X 1		
6	~~DROPERIDOL~~: 0.625 mg (1/4 cc) OR 1.25 mg (1/2 cc) IV PRN Nausea X 1		
7	~~REGLAN: Give~~ 10 mg IV PRN nausea X 1		
8	Release from "PACU" when Aldrete score is ____ or greater		
9	Call Anesthesia for any questions or concerns		
10	Phenergan 25 mg IV PRN N/V may repeat once -		
	SIGNED (b)(6)-2 MJ, CRNA.		

PATIENT IDENTIFICATION

(b)(6)-4

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.

518-124 NSN 7540-00-634-4159

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
- [ ] CROSSMATCH

DATE REQUESTED 8 Apr 03

DATE AND HOUR REQUIRED 0600

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)* Dr (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR O

ABO

Rh POS

RECIPIENT

ABO

Rh

TEST INTERPRETATION

ANTIBODY SCREEN N/A

CROSSMATCH N/A

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

[x] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 8 Apr 03

REMARKS:

Exp 15 Apr 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (b)(6)-2 (b)(6)-2

AT *(Hour)* 0600 ON *(Date)* 8 Apr 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* (b)(6)-2

2nd VERIFIER *(Signature)* (b)(6)-2 SJWM6

PRE-TRANSFUSION

TEMP. 100.3 PULSE 117 BP 116/70

DATE OF TRANSFUSION

TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 ML

TIME/DATE COMPLETED/INTERRUPTED 8APR03 0938Z

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
100.7	116	12/84

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.)*

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

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2 SJWM6

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

(b)(6)-4

(b)(6)-4

SEX M

WARD ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 4268

Medical Record Copy

518-124

NSN 7540-00-634-4159

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)* _____

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

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED: 8 Apr 03

DATE AND HOUR REQUIRED: 0600

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: N/A

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: Dr (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: Ex-lap

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR: O

ABO

Rh: POS

RECIPIENT

ABO

Rh

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	N/A

[x] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE 8 Apr 03

REMARKS:

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

(b)(6)-2 15 Apr 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* (b)(6)-2

AT *(Hour)* 0600 ON *(Date)* 8 Apr 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* (b)(6)-2 WATA

2nd VERIFIER *(Signature)* (b)(6)-2 9/WM6

PRE-TRANSFUSION TEMP. 100.4 PULSE 122 BP 123/72

DATE OF TRANSFUSION 8 APR 03

TIME STARTED 09

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 U ML

TIME/DATE COMPLETED/INTERRUPTED 8 APR 03 0738z

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[x] NONE [ ] SUSPECTED	100.3	117	116/70

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.)*

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

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2 9/WM6

SEX: M

WARD: ICU 1

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

(b)(6)-2

(b)(6)-4 (b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 4269

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 CARE UNIT ORDERS	(b)(6)-2	1105
1	OXYGEN: 2 litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: LR @ 125 cc/hr, bolus 250 cc x 1		
3	MORPHINE: 2-4 mg IV q 5-10 minutes PRN pain. MAX dose of 10 mg		
4	DEMEROL: 25 mg IV q 5-10 minutes PRN pain. MAX dose of 50 mg		
~~5~~	~~ZOFRAN: Give 4 mg IV PRN nausea. May repeat after 10 minutes X 1~~		
~~6~~	~~DROPERIDOL: 0.625 mg (1/4 cc) OR 1.25 mg (1/2 cc) IV PRN Nausea X 1~~		
~~7~~	~~REGLAN: Give 10 mg IV PRN nausea X 1~~		
8	Release from "PACU" when Aldrete score is 9 or greater		
9	Call Anesthesia for any questions or concerns		
	(b)(6)-2 MD, CRNA, LVN, RN		

PATIENT IDENTIFICATION

(b)(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages. S/P Colostomy TAKEDOWN

Diagnosis: S/P ORX. Lap w/ wound dehis.

Height: ~5'9" Weight: 175# Diet:

Allergies: NKDA

Nursing Unit	Room No.	Bed No.	Page No.

AUTHORIZED FOR LOCAL REPRODUCT

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

07ARR03

UA 0715Z

Glucose = (−)

Bil = Small

Ketones = (+) 5 trace

SG = 1.030

Blood = moderate

pH = 7.5

Protein = 30+

Urobilinogen = .2 normal

Nitrite = (−)

TEST(S)

SPECIMEN TAKEN

DATE	TIME 0640 A.M. P.M.	
RESULTS	REQUESTED	(X)
100	GLUCOSE	
10	UREA N.	
	CREATININE	
	URIC ACID	
135	SODIUM	
4.5	POTASSIUM	
	CHLORIDE 103	
	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	
35	Hct	
12	Hb (est)	
	Ph	

CHEMISTRY I 546-107

TEST(S)

SPECIMEN TAKEN

DATE 6APR03	TIME 1600 A.M. P.M.	
RESULTS	REQUESTED	(X)
164	GLUCOSE	
16	UREA N.	
	CREATININE	
	URIC ACID	
140	SODIUM	
4.1	POTASSIUM	
104	CHLORIDE	
27	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	
35	Hct	
12	Hb (est)	
7.441	Ph	

CHEMISTRY I 546-107

STANDARD FORM 546 (Rev. 8-77)
General Services Administration and Interagency Committee on Medical Records, FIRMR (41 CFR) 201-45.505

REMARKS

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY

MD DATE

CH 6 Apr 03

Arterial
ph 7.444
PCO2 39.2
PO2 62
HCO3 25
BEecf 1

CHEM I

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ DOM ☐ NP

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

LABORATORY FILE

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.

404525

Labs

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11 203(b)(10)

13. PROSTHESIS, IMPLANTS ☐ YE NO IF YES NAME: ID NU MANUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

☆U.S.GOVERNMENT PRINTI ☆U.S.GOVERNMENT PRINTING OFFICE 1996-404-766/40008

NSN 7540-00-181-8358 NSN 7540-00-181-8358

TEST(S)			TEST(S)		
SPECIMEN TAKEN			SPECIMEN TAKEN		
DATE	TIME		DATE	TIME	A.M. P.M.
RESULTS	REQUESTED		RESULTS	REQUESTED	(X)
111	GLUCOSE		106	GLUCOSE	
12	UREA N.		11	UREA N.	
	CREATININE			CREATININE	
	URIC ACID			URIC ACID	
143	SODIUM		142	SODIUM	
3.5	POTASSIUM		3.6	POTASSIUM	
103	CHLORIDE		105	CHLORIDE	
33	CO_2		32	CO_2	
	PHOSPHATE			PHOSPHATE	
	CALCIUM			CALCIUM	
	TOTAL PROTEIN			TOTAL PROTEIN	
	ALBUMIN			ALBUMIN	
	GLOBULIN			GLOBULIN	
	ALKALINE PHOSPHATASE			ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE			ACID PHOSPHATASE	
	SGOT			SGOT	
	LDH			LDH	
	CPK			CPK	
	BILIRUBIN (TOTAL)			BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)			BILIRUBIN (DIRECT)	
	CHOLESTEROL			CHOLESTEROL	
	TRIGLYCERIDE			TRIGLYCERIDES	
	AMYLASE			AMYLASE	
	LIPASE			LIPASE	
	PROFILE (Specify)			PROFILE (Specify)	
25	Hct		30	Hct	
9	Hb (Est)		10	Hb (Est)	
7.495	pH		7.36	pH	

CHEMISTRY I
STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

CHEMISTRY I
STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

546-107

REMARKS: Or

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE: (b)(6)-2

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY: (b)(6)-2

TECH: 8 Apr 03

MD DATE

LAB. ID. NO.

12. REASSESSMENT / REASSESSMENT

DATE / DATE (YYMMDD)	TIME OF ARRIVAL / HEURE D'ARRIVÉE
03 MAR 23	1000

TIME / HEURE		1020	1115	1212
BP / PS	130/70	140/120	120/60	125/100
PULSE / POULS	120	108	108	110
RESP / RESP				

DATE / TIME
DATE / HEURE

13. CLINICAL COMMENTS / DIAGNOSIS
INFORMATION MÉDICALE / DIAGNOSTIQUES

14. ORDERS / ANTIBIOTICS (Specify) / TETANUS / IV FLUIDS
DIRECTIVES MÉDICALES / ANTIBIOTIQUES (Specifier) / TÉTANOS / IV FLUIDE

GSW to R
Foley c LVO
ext wound,
3L IVF
Morphine
Fade
Time

(b)(6)-2

15. (b)(6)-2 DATE (YYMMDD)

16. DISPOSITION | EVACUATED / EVACUÉ | DECEASED / DÉCÉDÉ | TIME / HEURE

17. RELIGIOUS SERVICES / SERVICES RELIGIEUX | BAPTISM / BAPTISÉ | ANOINTING / ONCTION | CONFESSION / CONFESSION | PRAYER / PRIÈRE | COMMUNION / COMMUNION | OTHER / AUTRE

CHAPLAIN / CHAPELAIN

DD Form 1380, DEC 91 (Back)

20. OPERATION(S) PERFORMED

21. PATIENT TRANSFERRED TO TIM

22. REGISTERED NURSE SIGNATURE

REVERSE OF DA FORM 5179-1, OCT 87

*U.S. Government Printing Office: 1995 — 388-733/23952

pH 7.357
PCO2 37.6
PO2 65
HCO3 20
TCO2 21
SO2 91
BEecf -6

NA 150
K 3.1
Cl 0.92

Hct 36
Hgb 12

7+

NA 148
K 3.3
CL 118

BUN 10
Glu 120
Hct 40

6

☆U.S.GOVERNMENT PRINTING OFFICE 1996-404-755/40008

NSN 7540-00-181-8358

PREVIOUS EDITION USABLE

TEST(S)		
SPECIMEN TAKEN		
DATE 13 April	TIME 1830	A.M. P.M.
RESULTS	REQUESTED	(X)
134	GLUCOSE	
5	UREA N.	
	CREATININE	
	URIC ACID	
133	SODIUM	
4.3	POTASSIUM	
100	CHLORIDE	
28	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	
37	HCT	
13	Hb (est)	

CHEMISTRY I
STANDARD FORM 546 (Rev 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

546-107

REMARKS

REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2

Enter in above space

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

(b)(6)-4

REPORTED BY (b)(6)-2

MD DATE

LAB. ID. NO.

CHEM I

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

SPECIMEN/LAB. REF. NO.

PATIENT'S MED. RECORD

ARTERIAL
pH 7.287
PCO2 54.5
PO2 119
HCO3 26
BEecf -1
PT Temp 98.6
FIO2 100%

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS | LIST TIME ORDER NOTED AND SIGN

27 March 2003

2100 ① CBC, I-stat

AM 28 March 2003

(b)(6)-2 — ② Morphin I gm IV q 2 hr

(b)(6)-2 ③ Clindamycin 900 mg IV q 8 hr

(b)(6)-2 ④ NPO

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

28 March 2003

Diet as tolerated

(b)(6)-2

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

28 Mar Pt to be up and ambulating

1350

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

5/30/03

Diet: Clears starting 10 4/1/03

NPO p 2359 hrs 4/1/03

(b)(6)-2 MD

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

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 CARE UNIT ORDERS		
1	OXYGEN: 3 litres via Mask /Prongs to maintain O2 Sats greater than 94%;		
	Wean to room air.		
2	IVF: NS @ 90 cc/hr, bolus — cc x 1		
3	MORPHINE: 2 mg IV q 5-10 minutes PRN pain. MAX dose of 10 mg		
4	DEMEROL: 25 mg IV q 5-10 minutes PRN pain. MAX dose of 50 mg		
5	~~ZOFRAN:~~ Give 4 mg IV PRN nausea. May repeat after 10 minutes X 1		
6	~~DROPERIDOL~~: 0.625 mg (1/4 cc) OR 1.25 mg (1/2 cc) IV PRN Nausea X 1		
7	REGLAN: Give 10 mg IV PRN nausea X 1		
8	Release from "PACU" when Aldrete score is _____ or greater		
9	Call Anesthesia for any questions or concerns		
10	Phenergan 25mg IV PRN N/V may repeat once		
	SIGNE (b)(6)-2 , MD, CRNA		

PATIENT IDENTIFICATION

(b)(6)-4

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.

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

O [redacted] 08 00 2400 4/5/03

(b)(6)-4

(b)(3)-1

NURSING UNIT: ICU-1 | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS | LIST TIME ORDER NOTED AND SIGN

- Tylenol
- S/P Tracheobronchial colostomy
- Stable
- VS per routine
- NKDA
- Activity ad lib
- NG to suction

(b)(6)-2 0843 (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

- Foley to gravity
- W-D to all wounds daily
- Call MD for low urine output, fever or hypotension.
- NPO
- D5LR @ 140cc/hr
- ☐ 50g bag IV Q1° prn pain

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

- Phenergan 12.5g IV Q4° prn
- Unasyn 3.0g IV Q6°
- Zantac 50g IV Q12°
- ✓ O2 2L NC
- ✓ H&H, Chem-7 in am.

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF _____ HOURS

5 APR 03 1145

(1) Give 1° Ceftriaxone Sodium IVP now

Verbal Order Rec (b)(6)-2 (b)(6)-2 (b)(6)-2 1145 5 APR 03

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 (b)(6)-4

NURSING UNIT: ICU-1 | ROOM NO. | BED NO.

DATE OF ORDER: 6 APR 03 | TIME OF ORDER: 0450 HOURS | LIST TIME ORDER NOTED AND SIGN

1. LR ÷ L bolus — day 6 APR 03 0500 Z (b)(6)-2

Anion Gap 14 (>10) (b)(6)-2 MD

ph 7.322 140 | 106 / 4.6 | 25 (<165)

PATIENT IDENTIFICATION

NURSING UNIT: ICU-1 | ROOM NO. | BED NO.: 2

DATE OF ORDER: 6 APR 03 | TIME OF ORDER: 1046 Z HOURS (b)(6)-2

1. LASIX, 20 mg IV x 1 — chart 6 APR 1050 Z (b)(6)-2 (b)(6)-2 MD (b)(6)-2

PATIENT IDENTIFICATION

pH 7.44 8 PM 1300 hrs
pCO2 39.2 (39.2
pO2 62
BE +1 (>2 / <25)
HCO3 25 140 | 104 / 4.1 | 27 (<164
TCO2 26
Sat 90%

4/6/03 1230

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 6 APR 03 | TIME OF ORDER: _____ HOURS

HH, ABG, Chem 7 now (b)(6)-2 (b)(6)-2

6 April 2003 Chart 2000 (b)(6)-2 (b)(6)-2 JP

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 7 APR 03 | TIME OF ORDER: 0445 HOURS

1. DIUE to LR
2. UA dip now
3. Ambulate TID

4/7/03 0800

Cipro 400 IV q12° (b)(6)-2 MD

1st dose now (b)(6)-2 (b)(6)-2 (b)(6)-2 (b)(6)-2 MD

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77.

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
(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 8 April 2003 TIME OF ORDER: 0450 Z HOURS

LIST TIME ORDER NOTED AND SIGN

Istat 8 (b)(6)-2 (b)(6)-2

0553 02 8 APR 03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 8 April 2003 TIME OF ORDER: 0605 Z HOURS

Transfuse = 2 units Blood (b)(6)-2 (b)(6)-2

8 APR 03 0615 Z

PATIENT IDENTIFICATION
(b)(6)-4

NURSING UNIT: ICU1 | ROOM NO.: ICU1 | BED NO.: 2

DATE OF ORDER: 8 April 03 TIME OF ORDER: 1600 HOURS

Tylenol 650 mg PO X1 Dose Now please. (b)(6)-2

8 April 03 @ 1600

V.O. Dr. (b)(6)-2 (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9 APR 03 TIME OF ORDER: 0440 HOURS (b)(6)-2

1. D/C NG
2. D/C Foley
3. Ambulate TID

(b)(6)-2 (b)(6)-2 (b)(6)-2

9 APR 03 @ 0450

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

NURSING UNIT	ROOM NO.	BED NO.
ICU 1		2

DATE OF ORDER: 11 April 2003 | TIME OF ORDER: _____ HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Have RT to try weaning off vent.

(2) Continue to ambulate QID

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 10 APR 03 | TIME OF ORDER: 0955 HOURS

1) Δ Antibiotics to Cipro 500 mg PO BID
? Augmentin ~~500 mg~~ 875 mg PO BID

2) D/C IV & D/C Zantac IV

VO: Dr. (b)(6)-2 / LT (b)(6)-2 ILT/AN/BSN/OTC gmd

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

1 Vicodin 1-2 PO q 3-4° PRN Pain

2 Amitriptyline 25 mg PO qHS

VO: Dr (b)(6)-2 / LT (b)(6)-2 Note (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 10 APR 03 | TIME OF ORDER: 1600 HOURS

1) Ketorolac 30 mg IM x 1 Now done

TO: Dr. (b)(6)-2 / LT (b)(6)-2

(b)(6)-2

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1984 [illegible]

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 (b)(3)-1

DATE OF ORDER: 11 April 2003 TIME OF ORDER: 0545 HOURS

LIST TIME ORDER NOTED AND SIGN

✓ I stat 8

(b)(6)-2

(b)(6)-2

137/97/6
35/32/

NURSING UNIT: ICU-1 ROOM NO. BED NO.

38
13

PATIENT IDENTIFICATION

DATE OF ORDER: 11 April 2003 TIME OF ORDER: 0550 HOURS

Nebs c albuterol & atrovent q4h

(b)(6)-2

NURSING UNIT ROOM NO. BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 11 April 2003 TIME OF ORDER: 0605 HOURS

1. Transfer to mild care tent
2. Rx: S/P GSW to abdomen
3. O2 @ FiO2 20% by (b)(6)-2
4. ~~IVF's~~ — heparin lock

NURSING UNIT ROOM NO. BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIM (b)(6)-2

5. Vicodin I-II tabs po q4h prn pain
6. Nebs c albuterol & atrovent Q4P

NURSING UNIT ROOM NO. BED NO.

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHI (b)(6)-2

☆ U.S. GOVERNMENT PRINTING OFFICE

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

DATE OF ORDER: 11 April 2003 TIME OF ORDER: 0745 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Transfer to medical care (continued orders)
2. Cipro 500mg PO BID (b)(6)-2
3. Augmentin 875mg PO BID (b)(6)-2

NURSING UNIT: 1 ROOM NO. BED NO.

4/11/03 / 0835

1. AMBULATE TID

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

2. w/ D L's Q Day
3. Nutrition Consult
4. O2 to keep SaO2 > 90% (FM/NC) (b)(6)-2 (b)(6)-2

MD

NURSING UNIT ROOM NO. BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

4/12/03 0445 HOURS

1. CXR (PA/LAT) today (R) (L) Decubiti Plus
2. Q INCENTIVE SPIRIOMETRY / Pulmonary Toilet
3. Morphine 30mg PO Q6-8° prn (b)(6)-2 (b)(6)-2

Noted 12 Apr 03 (b)(6)-2

NURSING UNIT NO. BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

12 APR 03 0800 Z HOURS

1. CONTINUE AN PROP ORDERS
2. NPO
3. ~~READMIT~~ TO ICU → (b)(6)-2 (b)(6)-2

MD

NURSING UNIT ROOM NO. BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-303-710

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

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
12 APR 03	1220 Z HOURS	
(1) Toradol, 30 mg IV TID PRN Pain		(b)(6)-2
(2) Heparin, 5000 u SQ BID		
	(b)(6)-2	MD

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
13 APR 03	1450 Z HOURS
(1) NPO	
(2) Kinevac 30 gm IVPB now	
(3) Prepare for OR	
	(b)(6)-2 MD
	MAJ, MC

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
	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.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994—363-710

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)-2 7/13/03 18 00 2do

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER _____ HOURS — LIST TIME ORDER NOTED AND SIGN

- ✓ To ICU
- ✓ S/P Ileostomy/mucous fistula
- ✓ Condition critical
- ✓ VS Q1°
- ✓ NKDA
- ✓ Bedrest 2 HOB 30°
- ✓ Strict I/O

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER _____ HOURS

- ✓ NG to suction
- ✓ Foley to gravity
- ✓ J-tube to ~~suction~~ gravity
- ✓ Penrose x 2 in place
- ✓ Wet to dry dressing changes all wounds daily
- ✓ NPO

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER _____ HOURS

- ✓ D5NS @ 160cc/hr
- ✓ MSO4 1-4mg IV Q1° prn pain
- ✓ Phenergan 12.5mg IV Q4° prn nau (b)(6)-2
- ✓ Versed 1-4mg IV Q1° prn sedation
- ✓ Unasyn 3.0g IV Q6°
- ✓ Gentamycin 280mg IV Qday
- ✓ Zantac 50mg IV Q12°

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER _____ HOURS

- ✓ Tylenol 650mg PR Qday
- ✓ Vent 700/14/30%/+5
- ✓ Chem-7, ABG, H&H now
- ✓ Heparin 5000 U SQ BID (b)(6)-2 7/14/03
- Flush J-tube ē 10cc H2O (b)(6)-2
- q shift
- ✓ PCXR in AM + ABG in AM

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

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
4/14/03	NS 500 cc bolus over 30 min	Noted 14 APR 0232 (b)(6)-2
0420	Heldol 2mg IV @ 2° sedation	
	J tube @ 100	
	(Ensure) (b)(6)-2	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
14 APR 03	0830 HOURS	(b)(6)-2 14 APR 0830
(1)	NS bolus 500cc	
	V.O. Dr (b)(6)-2 / (b)(6)-2	(b)(6)-2
14 APR 03	1300	
(1)	Valium 5-10mg IVP q 4-6° prn agitation.	Noted. 1300 14 APR
	Verbal Order Dr (b)(6)-2 / (b)(6)-2	
	(b)(6)-2	(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
14 APR 03	1330 HOURS	
(1)	Hold Tube Feeds	
(2)	Valium 10mg IV now	done 1340 (b)(6)-2
	Verbal order Dr (b)(6)-2 / (b)(6)-2	
	(b)(6)-2	
	14 April 2003 Chart (b)(6)-2	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
15 Apr.	HOURS	
	Valium 5mg IV now	
	V.O. (b)(6)-2 / Dr (b)(6)-2	
	(b)(6)-2	

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 4-16-03 TIME OF ORDER: 0900 HOURS

1. TF 10cc/HR cont.
2. aggressive weaning

V/O DR (b)(6)-2 (b)(6)-2 (b)(6)-2 MD

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

1. NA TF ↑ 20cc/h

Dx. (b)(6)-2 (b)(6)-2 (b)(6)-2

[redacted]

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 17 APR 03 TIME OF ORDER: 0840 HOURS

1. Lovenox 30 mg SQ BID
2. B VS To Q4°

(b)(6)-2 (b)(6)-2 (b)(6)-2 (b)(6)-2 MD

T/LUNGH 4/17/03 0845

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 18 APR 03 TIME OF ORDER: 0830 HOURS

1. M→D Dressing Δ c̄ Dakin's solution BID
2. Clamp G-tube
3. Check → Advance as tolerated
4. Tylenol ⅛-II PO q 4-6° PRN T>101

(b)(6)-2 (b)(6)-2 (b)(6)-2 MD

9/WARNBH 18 APR 03 0920

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-383-710

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

DATE OF ORDER: 22 April 03 TIME OF ORDER: 0710 HOURS

LIST TIME ORDER NOTED AND SIGN (b)(6)-2

1) MVI + PO QD

2) D/C MSO4 & Versed (b)(6)-2

3) N Sdressing Ds (b)(6)-2

4) Medication 8mg PO q8° p pain.

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 23 April 03 TIME OF ORDER: 0810 HOURS

1) Zantac 150mg PO BID

2) Vicodin 1 tab PO Q6° pm

3) Stop all ABX

4) DC IV Zantac

5) Heparin IV

6) MVI 1 tab PO QD (b)(6)-2

7) Wean off O2 (b)(6)-2 94%

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER:

8) Ensure + Can PO TID HOURS

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 4/29/03 TIME OF ORDER: 0720 HOURS

Discharge to (b)(3)-1

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo APR Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5 APR	(b)(6)-2	Hgb Hct, Chem 7 in AM	06 APR	0400	0500	(b)(6)-2
5 AM		Stable condition	5 APR	0815	0815	
07 APR 03		UA dip	07 APR	0700	0715	
8		I Stat	8 APR	0530 2	0530 2	
8		Transfuse c 2 units Blood	8 APR	0600 2	0615	
9		DC foley	9 APR	0449	0449	
9		DC NG	9 APR	0449	0449	
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED												
SAM - - - - -	(b)(6)-2	Call MD for low urine													
- - - - -	- - - - -	output, fever, hypotension													
- - - - -	- - - - -														
- - - - -	- - - - -														
- - - - -	- - - - -														
- - - - -	- - - - -														
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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. APR Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	8	9	10	11
5APR03	(b)(6)-2	VS per routine q 4°	04/16	(b)(6)-2						
5APR03		NGT to Low Int Sto	04/16							
5APR03		VS per Routine q 4°	04/16	(b)(6)-2						
			16/04	(b)(6)-2						
5APR03		NGT to Low Int Sto	04/16							
			16/04							
5APR03		Activity Ad Lib	04/16							
			16/04							
5APR03		Foley to Gravity	04/16							
			16/09							
5APR03		Wet Dry Dressings to	06							
		all wounds q Day				(b)(6)-2				
5APR03		O2 @ 2 L NC	04/16	(b)(6)-2						
			16/04							
5APR03		Ambulate TID	04/16			(b)(6)-2				
			16/04							

DCd 5 APR03

DCd 5 APR03

TREATMENTS

ALLERGIES: ☐ YES ☐ NO

NKA

PRIMARY DIAGNOSIS:

S/P Colostomy Takedown

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

(b)(6)-4

(b)(6)-2 (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		02	03	04	05	06	07

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. ____

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 22	23	24	25	26	27	28	29
02APR08	(b)(6)-2	NS DRESSING Δs TID	08	(b)(6)-2							
			16								
			24								
18APR	(b)(6)-2	CLAMP G-Tube, Flush	D								
		10cc H20 qs. CLD ADV	N								
		AS TOL									
13APR	(b)(6)-2	VS q SHIFT	D	(b)(6)-2							
			N								
13APR	(b)(6)-2	HOB 30°	D								
			N								
13APR	(b)(6)-2	AMBULATE TID	08								
			16								
			22								

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/p colostomy Repeat 2° colostomy takedown

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4-23	(b)(6)-2	Wean off O^2	4-23	0900	0900	(b)(6)-2
4-23		HL DV	4-23	0900	0900	
	- - - - -					
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	- - - - -					

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

USAPA V1.00

Recurrent Medications and Treatments		3/25 date	26	27	
~~Zantac 50mg IV q8°~~	1600				
	2400				
	0800				
~~Toradol 30mg IVP q6°~~	1800				
	0100				
	0700				
~~Cefotetan 2 gms IV q12°~~	1800				
	2400				
SEE New times					
Vital signs					
	4	99.6 110/65 P125		100.4 112/74 P120	
	8				
	12				
	16	120/70 133 98.6			
	20				
	24		133 99.8 P02 117/70 26		
PRN Medications and Treatments					
Morphine 4mg Q30mins PRN	d/t amt/int	25 March 03 1720 2.5 mg	25 March 03 1705 (b)(6)-2	26 March 0400 (b)(6)-2	27 March 0 March 3 mg
~~Morphine 2.5 mg~~	d/t amt/int				
Lasix 10-20mg IV prn wheezing	d/t amt/int	25 March 03 15mg 1700	25 March 03 2115		
~~Tylenol 325-650mg PO q4-6° prn~~	d/t amt/int			TT @ 0715	
Motrin	d/t amt/int	27 Mar 03 2008 IGM			
	d/t amt/int				

Name: (b)(6)-4

SSN:

Unit:

Dx:

All:

Blood type:

(b)(6)-4

IVF	Time	amount	Total		
LR @ 75cc/hr					

Hourly Input and Output		IV			UOP
	0100				
JP x 1	0200				
JP x 2	0300				
	0400				
	0500				
	0600				
	0700				
	0800				
8 hour totals					
	0900				
	1000				
	1100				
	1200				
	1300				
	1400				
	1500				
	1600				
8 hour totals					
	1700				450
	1800				
	1900				
	2000				
	2100				
	2200				
	2300				
	0000				
8 hour totals					

24 hour totals

Total input:

Total output:

Balance:

Recurrent Medications and Treatments		3/26 date	27	28	29
Zantac 50mg IV Q8°	08 14 22	(b)(6)-2			
Toradol 30mg IVP Q6°	1200 1800				
Cefotetan 2gms IV Q12°	1200 2400	(b)(6)-2			(b)(6)-2 D/C'd 2apr
~~Rocephin 1 Gm IM q24~~					
~~Clindamycin 900mg IM q8h~~	1200 2000 0400				1200 D/C'd 2apr02
start 2apr03 Regular Diet					
Vital signs					
	4	CK-6 110/65 P125			
	8	P T			
	12				
	16				
	20				
	24				
PRN Medications and Treatments					
Motrin 800 mg PO PRN	d/t amt/int	1500 (b)(6)-2			
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				

Name: (b)(6)-4

SSN:

Unit:

Dx:

All:

Blood type:

Recurrent Medications and Treatments	date	March 30	31	April 1	2
~~Rocephin 1 Gm IM q 24~~	[illegible]	(b)(6)-2	(b)(6)-2	(b)(6)-2	
~~Clindamycin 900mg IM q8h~~	[illegible]		(b)(6)-2		
	~~1600~~ 1300			(b)(6)-2	
	~~2400~~ 2100	(b)(6)-2			
Vital signs					
Regular Diet	4				(b)(6)-2
	8				
	12				
	16				
	20				
	24				
PRN Medications and Treatments					
Motrin 800mg Po PRN Pain	d/t amt/int				
Phenergan. 25mg IM PRN N&V	d/t amt/int	30 March 2130 25mg (b)(6)-2			
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				

D/C'd 2 April

Name: (b)(6)-4

Dx:

SSN:

All:

Unit:

Blood type:

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. APR Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5	6	7	8	9	10	11	12	13
5APR03	(b)(6)-2	DSLR @ 140cc/hr	04/16	(b)(6)-2								
			14/04	(b)(6)-2								
5APR03		Zantac 50mg IV q 12°	03					(b)(6)-2				
			15	(b)(6)-2								
5APR03		Unasyn 3.0 Gm IV q 6°	05	X (b)(6)-2								
	-----		11	(b)(6)-2								
	-----		17									
	-----		23									
07APR03	(b)(6)-2	IV fluids LR 140cc/hr	04 16			(b)(6)-2						
			16 04									
07APR03		AMBULATE TID	04 16									
	-----		16 04									
7APR03	(b)(6)-2	Ciprofloxacin 400mg IV	08			(b)(6)-2						
		q 12° 1st dose Now	20			(b)(6)-2						
10APR		Ciprofloxacin 500mg	08							(b)(6)-2		
		PO BID	20						(b)(6)-2			
10 Apr		Augmentin 875 PO BID	08							(b)(6)-2		
			20						see note	(b)(6)-2		
10 Apr		Amitriptyline 25mg PO	19						see note	(b)(6)-2		
		q HS										
11APR		Albuterol/Atrovent Nebulizer Tx	04/08						X	(b)(6)-2		
	-----	q4°	12/16						X	(b)(6)-2		
	-----		20/24						X			
	-----											
12 Apr 03	(b)(6)-2	HEPARIN 5000 U	06							(b)(6)-2		
	-----		18									

ALLERGIES: ☐ YES ☒ NO
NKA

PRIMARY DIAGNOSIS: S/P Colostomy Takedown 5APR

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO
PAGE NO. 1

PATIENT IDENTIFICATION:
(b)(6)-4

(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. APR Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
5 APR	(b)(6)-2	NS ⊼ lite 10 Bolus	5 APR	now	1145Z	(b)(6)-2
6 APR		CR ⊼ lite Golus	6 APR	now	0500Z	
6 APR		Albuterol Nebulizer Tx 0.5ml / 2.5cc NS	6 APR	now	0955Z	
6 APR		Lasix 20mg IV X ⊼	6 APR	now	1050Z	
10 APR		Tylenol 650mg PO XL DOSE.	8 APR 03	NOW	1615	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
5 APR	(b)(6)-2	MSO4 6mg IV q 1°	5 APR 1600 (b)(6)-2	5 APR 1649	6mg 1349	6mg 1500	6mg 1701	6mg 2030	6mg 2320 (b)(6)-2	6 APR 2325 (b)(6)-2	6 APR 0550	6 APR 0640	6 APR 0625	6 APR 1630	6 APR 1845	6 APR 2020
		prn pain	10 APR 2320	11 APR 0300Z (b)(6)-2												
5 APR	(b)(6)-2	Phenergan 12.5mg IV q 4°	5 APR 1955 (b)(6)-2													
6 APR 03		MSO4 6mg IV q 1°	6 APR 03 2300	6 APR 0145 610	6 APR 03 5mg 0400Z	6 APR 03	6 APR 1145Z 4mg	7 APR 1565	7 APR 1700		8 APR 0530	8 APR 0710	8 APR 2000 (b)(6)-2	8 APR 2200	8 APR 0630	
		PRN PAIN	10 APR 0930	(b)(6)-2	13 APR 0800		13 APR 1350Z					(b)(6)-2				
			10 APR 4mg 0255Z (b)(6)-2		(b)(6)-2		(b)(6)-2									
10		Vicodin 2-4 PO prn pain	11 APR 1500Z	11 APR	2010	13 APR	13 APR 1200	1202								
12 APR		Toradol 30mg IV TID PRN PAIN	1245 12 APR 2005	1700 (b)(6)-2	13 APR 1630 (b)(6)-2		(b)(6)-2									

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

TX's

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. APR Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15	16	17
13 APR 03	(b)(6)-2	VS Q1°	04 16	(b)(6)-2				
			16 04					
13 APR 03		BR: HOB @ 30°	04 16					
			16 04					
13 APR 03		Strict I+O's	04 16					
			16 04					
13 APR 03		NG to suction	04 16					
			16 04					
13 APR 03		Foley to gravity	04 16					
			16 04					
13 APR 03		J-tube to gravity	04 16					
			16 04					
13 APR 03		Wet to dry dressing Δ all wounds daily	06					
13 APR 03		NPO	04 16					
			16 04					
13 APR 03		Flush [redacted] J-tube ē	04 16					
		10cc H_2O @ Shift	16 06					
14 APR		Tube Fed via J-Tube Ensure	04 16		Hold			
	-----	@ 10cc/hr	16 04	/	/			

	-----	Yellowed out						
	-----	13 Apr 03						
	-----	See New Sheets						

Treatments

Dil 14 APR

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P Colostomy Repeat 2° Ileostomy Takedown ē Adhesiolysis 13 APR

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO. _____

PATIENT IDENTIFICATION: (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
13APR03	(b)(6)-2	To ICU, s/p Hemorrhoid/mucous fistula, condition critical	13APR03	1900	1900	(b)(6)-2
		NKDA, Penrose x 2 in place	13APR03	1900	1900	
13APR03		chem 7, ABG, H+H now	13APR03	1900	1900	
13APR03		PCXR in AM.	14APR03	0200	0330	
13APR03		ABG in AM	14APR03	0300	0330	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													

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

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. APR Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 13	14	15	16	17
13 APR 03	(b)(6)-2	D5NS @ 160 cc/hr	24 16	/	(b)(6)-2			
			16 04		(b)(6)-2			
13APR03		Unasyn 3.0 gm IV Q6	03	/	(b)(6)-2			
	-----		09					
	-----		15					
	-----		21	/	(b)(6)-2			
13APR03	(b)(6)-2	Gentamycin 500mg QD IV	19	NO				
13APR03		Zantac 50mg Q12°	03	/	(b)(6)-2			
			15	/	(b)(6)-2			
13APR03		Tylenol 650 mg PR QD	07	/	(b)(6)-2			
13APR03		Heparin 5000u SQ BID	03	/				
			15	/	(b)(6)-2			
~~13APR03~~ 14APR03		~~E~~						

	-----	Yellowed out						

	-----	15 APR 03 See New Sheets						

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P Colostomy 13 MAR 2° Takedown/Dehiscence/Leakage 13 MAR

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: (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.

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. APR Yr. 03

Verify by Initialing: Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
14 APR	(b)(6)-2	NS 800 / 8 hr IV on 3	14 APR	now	0430	(b)(6)-2
14 APR		NS Bolus 500ml IV	14 APR	now	0845	
14 APR		Valium 10mg IV now	14 APR	now	1340	
	......					
	......					
	......					
	......					
	......					
	......					
	......					
	......					
	......					
	......					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
13 APR 03	(b)(6)-2	MSO4 1-4mg IV Q1° prn pain	13 APR 03, 13 APR, 13 APR, 13 APR, 13 APR, 13 APR, 14 APR, 14 APR, 14 APR, 14 APR, 14 APR, 14 APR, 14 APR, 14 APR; (b)(6)-2; 3mg 1930, 4mg 1930, 4mg 2030, 4mg 2130, 4mg 2215, 4mg 2315, 4mg 0015, 4mg 0115, 4mg 0245, 4mg 0300, 4mg 0330, 4mg 0520, 4mg 1200, 14 APR 1323 4mg; 14 APR 1530 4mg, 1630, 1650, 1720 4mg, 1830 4mg, 1930 4mg, 2045 4mg, 2110, 2320 2mg, 0100 4mg, 0330 4mg, 0430 4mg, 0530 4mg, 0632 4mg
/		See below	
13 APR 03		Phenergan 12.5mg IV Q4° prn nausea	(b)(6)-2; 15 APR 150 12.5mg
.....			
13 APR 03		Versed 1-4mg IV Q1° prn sedation	13 APR 03, 13 APR 03, 13 APR, 13 APR, 13 APR, 13 APR, 14 APR ...; (b)(6)-2; 4mg 1900, 4mg 2010, 4mg 2100, 2130, 2230, 4mg, 4mg, 0130, 0230, 0300, 0350, 0430 ...; 14 APR 1005 4mg, 14 APR 4mg, 14 APR 1310, 14 APR 1450 4mg, 1700 4mg, 1800 4mg, 1950 4mg, 2045 4mg, 2110 4mg, 2320 4mg, 0100 4mg, 0330 4mg, 0430, 0530
.....			(b)(6)-2; 0630 4mg, 15 APR 4mg, 15 APR, 3?? ; 15 APR 4mg (b)(6)-2
14 APR		Haldol 2mg IV q 2° prn Sedation	14 APR 0630, 14 APR 1200; (b)(6)-2
.....			
14 APR		Valium 5-10mg IV Pr ... q 4-6° prn agitation/restlessness	14 APR 10mg 1340, 14 APR 1840, 15 APR 0100; (b)(6)-2
15		MSO4 1-4mg IV Q1° prn pain	15 APR 0700, 4mg, 1700 4mg, 1850, 4mg, 4mg ...; (b)(6)-2; (b)(6)-2; (b)(6)-2; (b)(6)-2; (b)(6)-2
.....	.....		

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

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. 4 Yr. 03

VERIFY BY INITIALING [illegible] 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	23
13APR	(b)(6)-2	D5NS @ 160/hr	07	(b)(6)-2								
	-----		19									
	-----		19									
			07									
13APR	(b)(6)-2	Unasyn 3.0gm IV Q6	07	(b)(6)-2								
	-----		13									
	-----		19									
	-----		01									

13APR	(b)(6)-2	Gentamycin 500mg IV	21	(b)(6)-2								
13APR		Zantac 50mg Q12°	07	(b)(6)-2								
	-----		19	(b)(6)-2								

[redacted]	(b)(6)-2	[redacted]	[redacted]	(b)(6)-2								
[redacted]		[redacted]	[redacted]	(b)(6)-2								
			[redacted]									
[redacted]		[redacted]	[redacted]	(b)(6)-2								
			[redacted]	(b)(6)-2								
[redacted]		[redacted]	[redacted]	(b)(6)-2								
			[redacted]	(b)(6)-2								
17APR03		Lovenox 30mg SQ BID	09									
			21									
22APR		MMI TPO QD	10									

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Colostomy 2° Takedown (Revision) Leakage 13APR03

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: (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

MEDSHEET

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

MEDCOM - 4301

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													
13 APR	(b)(6)-2	[redacted]	[redacted] 4mg	15 APR 0430	[redacted] 1530	[redacted] 4mg 1645	[redacted] 4mg 1800	[redacted] 4mg 1915	15 APR 2000	15 APR 2100 4mg	2330 4mg	1930 4mg 4/17	4/17 4mg	4/17	2200 4mg	4/17 2345
			1330 (b)(6)-2						4mg (b)(6)-2			(b)(6)-2	(b)(6)-2			4mg (b)(6)-2
			(b)(6)-2													
			4/18 0310 4mg	4/18 0410 4mg	4/18 0510 4mg	4/18 0645 2mg	4/19 0800 2mg	4/19 1000 2mg	19 APR 8mg	19 APR 4mg	19 APR 2100	4/19 2330 4mg	4/20 0045 4mg	4/20 0400 4mg	4/20 0500 4mg	4/20 1930 4mg 4/20 2245 4mg
13 APR	(b)(6)-2	Phenergan 12.5-g IV Q4° PRN nausea	(b)(6)-2													
			(b)(6)-2													
13 APR		versed 1-4mg IV Q1° PRN Sedation	15 APR 0400 4mg 1230	15 APR 0500 4mg 1530	15 APR 0600 4mg 1645	15 APR 0700 90°	15 APR 0800 4mg	15 APR 2000 4mg	15 APR 2100 4mg	15/13 2400 (b)(6)-2	4/16 2100	4/17 4mg 2345 (b)(6)-2	4/17 0110 4mg	4/18 1010 4mg (b)(6)-2	4/19 2335 3mg (b)(6)-2	4/20 0045 0 2mg 3
			(b)(6)-2													
13 APR		Haldol 2-g IV q2° PRN Sedation														
13 APR		Valium 5-10-g IVP Q4-6° PRN agitation	4/12 32 (b)(6)-2	4/12 1000 (b)(6)-2												
15 APR	(b)(6)-2	Tylenol #-III PO Q 4-6° PRN T 101														

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

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. 4 Yr. 03

VERIFY BY INITIALING PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15 16 17 18 19 20 21 22 23
13APR	(b)(6)-2	V.S [redacted] BID To 24°	07 19 19 07	(b)(6)-2
13APR		BR: HOB 30°	07 19 19 07	(b)(6)-2
13APR		Start I+O's	07 19 15 07	(b)(6)-2
[redacted]		[redacted]	[redacted]	(b)(6)-2 [redacted]
13APR		Foley to Gravity	07 19 19 07	(b)(6)-2 Dc'd 20 APR
[redacted]		[redacted]	[redacted]	(b)(6)-2 [redacted]
13APR		Flush J-tube c 10cc H2O Q Shift	07 19 19 07	(b)(6)-2
14APR03		DM-D Drsg Δ c Dakin's Sol BID	10 20	(b)(6)-2 Dc'd 22APR
14 APR 03		Clamp G-Tube.	07	(b)(6)-2 (b)(6)-2
	-----	Clears ⇒ advance as	19	(b)(6)-2
	-----	Tolerated		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Colostomy Repair 2° Colostomy / Takedown

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(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.

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 23	24	25	26	27	28	29
22 APR	(b)(6)-2	LOVENOX 30 mg SQ BID	09	(b)(6)-2						
			21							
22 APR		MVI T PO QD	09							
23 APR		ZANTAC 150 mg PO BID	09	(b)(6)-2						
			21							
23 APR		ENSURE 1 CAN PO TID	08							
			16							
			23							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(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
		(b)(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
13APR	(b)(6)-2	MSO4 1-4mg IV Q1° PRN	4/21 2100	4/21 2245	4/21 2345	4/22 0045	4/22 0230	4/22 0630	DC'd 22 APR 03							
			4mg	4mg	4mg	4mg	4mg	4mg								
			(b)(6)-2													
13APR		VERSED 1-4mg IV Q1°	4/21 2245	4/22 0230	DC'd 22 APR 03											
		PRN SEDATION	1mg	4mg												
			(b)(6)-2													
22APR		~~MVI 1 PO Q1 4~~														
22APR		Motrin 800 mg Q8 prn pain	22APR 0830	22APR 1745	4/23 0700	4/23 2130	4/25 2130	4/27 0700	28APR 1400							
			(b)(6)-2													
13APR		phenergan 12.5mg IV q4°	23APR 0800 IM		(b)(6)-2											
13APR03		Valium 5-10mg IVP q4-6°	4/23 2100	24APR 0400	25APR 1000											
		prn AGITATION	(b)(6)-2													
18APR03		Tylenol #3 1-2 PO q4-6° prn T>101														
13APR03		Haldol 2-4 IV q 2° prn sed														
23APR		Vicodin 1 TAB q6° prn	4/23 1400 PRN	4/23 1700	24APR 1700	24APR 1700	4/25 0435 1700	25APR 1030	23 APR 2205	26 APR 0215	26APR 0100	27APR 0000	27APR 1700	28APR 0515	29APR Kim	29APR 0333
			(b)(6)-2	(b)(6)-2	(b)(6)-2				(b)(6)-2		(b)(6)-2					

*U.S. GPO: 1998-454-110/95218

DD FORM 1 FEB 63 602

REPLACES DD FORM 602, 1 OCT 51
PREVIOUS EDITIONS ARE OBSOLETE
REMPLACE DD FORM 602, 1 er OCTOBRE 1951
LES ÉDITIONS PRÉCÉDENTS SONT CADUQUES

☆ U.S. GPO: 1991—301-765

PATIENT EVACUATION TAG – FICHE D'ÉVACUATION DE PATIENT
(Tie this tag to patient – Attacher cette fiche au patient)

FROM *(Medical treatment facility)*
ORIGINE *(Installation de traitement médical)*
(b)(3)-1

NAME *(Last–first–middle initial)*
NOM *(Nom de famille–premier prénom–initiale deuxième prénom)*
(b)(6)-4

SERVICE NUMBER NUMÉRO MATRICULE	RANK/RATING/GRADE GRADE	CATEGORY OF PERSONNEL *(Service or employer and nationality)* CATÉGORIE DE PERSONNEL *(Service ou employeur et nationalité)*
		Other Detainee (Iraqi)

DIAGNOSIS
DIAGNOSTIC
S/P Colostomy 2° Takedown / Revision

CLASS–CLASSE Litter		DISEASE MALADIE	BATTLE CASUALTY BLESSÉ AU COMBAT	INJURY BLESSURE
1A	2A	✓		
1B	2B			
1C				
3	4			

CABIN OR COMPARTMENT NO.
NO. CABINE OU COMPARTIMENT

BUNK NUMBER
NUMÉRO COUCHETTE

VSI
TRÈS GRAV. MAL.
☐ Yes Oui ☐ No Non

BAGGAGE TAG NUMBER(S)
NUMÉROS ÉTIQUETTES BAGAGE

DESTINATION
DESTINATION

SHIP/AC *(Number/type)*
NAVIRE/AVION *(Matricule/type)*

TREATMENT RECOMMENDED EN ROUTE *(If no treatment is required a notation to this effect is made)*
TRAITEMENT RECOMMANDÉ EN ROUTE *(Indiquer si aucun traitement n'est nécessaire)*
D5NS @ 160/hr – Jtube flush Qshift
Unasyn 3.0gm IV Q6 (19,01,07,13) – 10L O2 via simple mask
Gentamycin 500 QD IV (21)
Zantac 50mg Q12° (07,19)
Lovenox 30mg SQ BID (09,21)

SIGNATURE OF MEDICAL OFFICER
SIGNATURE DU MÉDECIN
(b)(6)-2 MD (b)(6)-2 MT, MC

DATE
DATE

REGULAR DIET
RÉGIME NORMAL
☒

SPECIAL DIET *(Describe)*
RÉGIME SPÉCIAL *(Description)*
Clear lqd – advance as tolerated

SHIP'S RECORD OFFICE TAB – FICHE POUR ARCHIVES TRANSPORTS

FROM *(Medical treatment facility)*
ORIGINE *(Installation de traitement médical)*

NAME *(Last–first–middle initial)*
NOM *(Nom de famille–premier prénom–initiale deuxième prénom)*

SERVICE NUMBER NUMÉRO MATRICULE	RANK/RATING/GRADE GRADE	CATEGORY OF PERSONNEL CATÉGORIE DE PERSONNEL

BAGGAGE TAG NUMBER(S)
NUMÉROS ÉTIQUETTES BAGAGES

DATE OF SHIPMENT
DATE DÉPART

DESTINATION
DESTINATION

ARRIVAL DATE
DATE ARRIVÉE

EMBARKATION TAB – FICHE D'EMBARQUEMENT

MEDCOM - 4306

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. LOCATION (State or Country Code)
(b)(3)-1	I 9

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(6)-4	EPW (b)(6)-4 (b)(6)-4		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
			(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		2203	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
		AA INJ	YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
D+R	MCWI	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
		0 3 0 4 2 9

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A B A A		0 3 0 4 1 2

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)

FOR LOCAL USE

RSW

(L) Chest

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
(b)(6)-2 (b)(6)-2 MATTINE	(b)(6)-2

DA FORM 2963, MAR 89 EDITION OF MAY 79 IS OBSOLETE

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136
			N																

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
	E	9	9	1		2																	

39. FOURTH DIAGNOSIS								40. FIFTH DIAGNOSIS								41. SIXTH DIAGNOSIS							
161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184

42. SEVENTH DIAGNOSIS								43. EIGHTH DIAGNOSIS							
185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200

44. FIRST PROCEDURE *(Principal Diagnosis)*								45. SECOND PROCEDURE								46. THIRD PROCEDURE							
201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224

47. FOURTH PROCEDURE								48. FIFTH PROCEDURE								49. SIXTH PROCEDURE							
225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248

50. SEVENTH PROCEDURE								51. EIGHTH PROCEDURE							
249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES		53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES		54. PRIMARY PROVIDER SPECIALTY CODE			55. BLOOD USAGE Y/N
265	266	267	268	269	270	271	272
0	1						

MEDCOM - 4308

ADMISSION A[illegible]CODING INFORMATION

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

1. REPORTING MTF: (b)(3)-1
2. [illegible]CATION (State or Country Code): I Z
3. REGISTER NUMBER: (b)(6)-4
NAME (Last, First, Middle Initial): EPW (b)(6)-4 (b)(6)-4
4. PAY GRADE:
5. SEX: M
6. DATE OF BIRTH (Y Y Y Y M M D D): 1963 01 01
7. AGE AT ADMISSION: 40 Y
8. RACE: X
9. ETHNIC BACKGROUND: 9
RELIGION:
10. LENGTH OF SERVICE:
ETS:
11. FMP: 20
12. SOCIAL SECURITY NUMBER: (b)(6)-4
ORGANIZATION (Active Duty Only):
13. MARITAL STATUS: Z
HOUR OF ADMISSION: 2203
BRANCH / CORPS:
14. FLYING STATUS:
15. BENEFICIARY CATEGORY: K 7 8
16. ZIP CODE OF RESIDENCE: 0 9 3 3 0 0 0 0 0
17. UNIT LOCATION (State or Country Code):
18. MOS:
19. TRAUMA: AA INJ
PREV. ADMISSION: YEAR ☐ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 1 DTR
WARD: MCWI
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:
21. TYPE OF DISPOSITION: 26
22. MTF TRANSFERRED TO: (b)(3)-1
23. DATE OF DISPOSITION (Y Y M M D D): 20 0 3 0 4 2 9
24. CLINIC SVC - ADMITTING: A B A A
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (Y Y M M D D): 20 0 3 0 4 1 1
27. LOCATION OF OCCURRENCE (Battle Casualty Only): I Z
28. MTF OF INITIAL ADMISSION:
29. DATE INITIAL ADMISSION (Y Y M M D D):

FOR LOCAL USE

DX: 86352
86415
86812
9974
E9912
E8782
Rx: 4574
4613
4652, 4579, 5122, 5069, 8365

Trauma 1

Inj 450

ASW

(D) Chest

ADMITTING OFFICER (Signature, as require (b)(6)-2 (b)(6)-2

SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA FORM 2008, MAR 89 EDITION OF MAY 79 IS OBSOLETE

INPATIENT TREATMENT RECORD COVE...

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

1. (b)(6)-4	2. NAME (Last, First, MI) (b)(6)-4 (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. M	RACE IRAQI	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP	12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE INJ	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct			22. HOURS OF ADMISSION 0920	23. CLINIC SERVICE ABAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE		25. TYPE DISPOSITION		26. DATE OF DISPOSITION 02 MAY 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)		27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 18 APR 03		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1 IRAQ				30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW to Ranterior 3 posterior chest ~~E991.2~~
" to R Lower Quadrant of abdomen

III
879.2
860.2
V58.3
E991.2

II
880.00
879.2
785.50
991.6
860.2
879.8
E991.2

11040
32020
47015
44202
47741

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
14	14				14

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

SIGNA (b)(6)-2 MD SIGNAT (b)(6)-2 CER

DA F

EDITION OF 1 AUG 76 IS OBSOLETE

USAPPC V1.10

MEDCOM - 4310

INPATIENT TREATMENT RECORD COVE... ...ET

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

1. REGISTER NUMBER (b)(6)-4	2. NAME (Last, First, MI) (b)(6)-4 # (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE IRAQI	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
11. FMP	12. SSN (b)(6)-4		13. ORGANIZATION			14. WARD
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE INJ
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct				22. HOURS OF ADMISSION 0920	23. CLINIC SERVICE ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION 02 MAY 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 18 APR 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1 IRAQ					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW to Rantenior 3 posterior chest ~~E994.2~~
" to R Lower Quadrant of abdomen

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
14	14				14

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS

(b)(6)-2 (b)(6)-2

S R

D

EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

MEDCOM - 4311

DEPARTMENT OF THE ARMY

(b)(3)-1

(b)(3)-1 IRAQ APO AE 09331

02 MAR 03

MEMORANDUM FOR Record

SUBJECT: Hospitalization for Patient # (b)(3)-1 (b)(6)-4 (b)(6)-4 (b)(6)-4

1. Patient # (b)(6)-4 admitted on 23 March 2003 during the Operation Iraqi Freedom war to the (b)(3)-1, located at (b)(3)-1 Iraq. His injuries consisted of gun shot wounds to the right anterior and posterior chest and gun shot wounds to the right lower quadrant of his abdomen.

2. On 23 March 2003, Patient (b)(6)-4 received an exploratory laparatomy discovering a right liver fracture and repaired two gastrointestinal injuries. Surgeon noted a negative pericardial window and placed a right chest tube, naso-gastric tube, foley catheter and patient placed on oxygen per nasal cannula. These injuries occurred during his service with the Iraqi military unit assigned to protect (b)(3)-1.

3. On 18 April 2003, Patient (b)(6)-4 transferred to the (b)(3)-1 to the Intermediate Care Ward #2, under the care of LTC (b)(6)-2 staff. Patient's wounds cared for with wet to dry wound care twice each day that the nursing staff taught the patient to perform. Nursing staff assisted patient with his personal hygiene each day. The patient ambulated without assistance, but used crutches at times to provide support. He is being discharged on 2 May 2003 with Ibuprofen 800mg every 8 hours for pain. His wound today is clean, free of infection and healing nicely by secondary intention with bright red granulation tissue. Patient will receive 7-10 days worth of dressing supplies to care for his wound himself at his home.

4. Point of contact is the undersigned.

(b)(6)-2

(b)(6)-2

Lieutenant Colonel, Army Nurse

Head Nurse, Intermediate Care Ward #2

(b)(3)-1

(b)(3)-1 Iraq APO AE 09331

Bed 14 [redacted]

(b)(6)-4

☐ HdH 3 apr03 in AM

(b)(6)-4

- Patient Name

DEBRIEFED ~~EPW~~ Deserter

NOT EPW

By SGT (b)(6)-2

(b)(6)-2

(b)(3)-1

13 APR03

25 APR 03

(b)(6)-4

EPWE

23 Oct 02 1721

Name:
SSN: (b)(6)-4
DOB:
Unit:
Nationality:

HT:
WT: lb
WT: kg

DATE: 23 Oct 02
TIME: 1721

Additional Orders/Charting:

(1) W→D Kerlex q12h Abdot + RLQ Wnds

(2) HOB ↑ 45° a) all times encourage deep breathing

(3) CXR a) earliest possible time

(b)(6)-2

24 Mar 8 Am
Δ VS + I+O to q4h
OOB ambulate c̄ [illegible] labs
Maybe transferred to ward later.

(b)(6)-2

1. Admit: ICU: **POST-OP**
2. **Diagnosis:** Multiple GSW to chest/Abdomen
3. Condition: VSI SI Stable
4. **Allergies:** Unknown
5. **VS:** ~~Q5min x 3; Q15 min x 3,~~ then Q1 hr; Q2 hrs; Q4 hrs;
   Notify MD for SBP: > 90 or < 90; DBP: > ____ < 50;
   HR: > 130, < ____; RR: > ____, < ____; Temp: >
6. **IVF: IVF:** LR @ 150 cc/hr; NS @ ____ cc/hr;
   Albumin @ ____ cc/hr; Hespan @ ____ cc/hr
7. Monitor: Cardiac; Pulse Ox; ~~Neuro~~ Q4h m/hr; A-line;
8. I&O: ~~Q1 hr~~; Q 2 hrs
9. Drains: NG to Low/Cont suction; Foley to gravity q2h
10. CT #1: 20 cm H2O suction, ~~H2O seal; Heimlich~~ second [illegible] q4h
11. CT #2: 20 cm H2O suction, H2O seal; Heimlich
12. **LABS:** ABG now ~~& Q1 hr;~~ ~~Q2 hrs; Q ____ hrs;~~ PRN
    Hct now & Q 24 hrs; Chem now & Q 24 hrs; ~~UA~~
13. **BLOOD:** T&S ____ units; T&C ____ units;
    Transfuse: ____ units PRBC or Whole Blood for Hc: < ____%
14. **Oxygen:** 2L NC; 4L NC; 5L FM; NRB; _____
    Keep Stats > 92%, > 95%, _____
15. **VENT:** SIMV; TV: ____; RR: ____; Fio2: ____%; PEEP
    ABG Q ____ hrs;
16. X-Ray:
17. **MEDS:**
    - Morphine 2, 4, or 6 mg IVP Q 1 ~~min/hr~~ prn Pain
    - Demerol 12.5 mg; 25 mg; 50-75 mg IVP prn Pain/chills
    - ~~Zofran 2-4 mg IVP Q ____ hrs prn Nausea~~
    - Zantac 50 mg IVPB Q 8 hrs
    - ~~Drip: Dopamine: (400mg/250cc) 2-10 mcg/kg/min~~
    - ~~Drip: Epi: (8mg/250cc) 0.01-0.1 mcg/kg/min~~
    - ~~Drip: Versed (1mg/ml) 1mg slow IVP q2-3min a u3 to 5mg~~
    - Drip: Ativan 0.05-0.1 mg/kg IV over 2-5 min; (2-4mg IV)
    - ~~Drip: Norepi/Levophed: (8mg/250) 0.01-0.2 mcg/kg/min~~
    - Cefotetan 2gm IV q12h x 2
    - Heparin 5000U SQ q12h
18. **BURNS:** IVF: 4cc/% BSA burn/kg = total 24 hr fluids;
    Give ½ over 1st 8 hrs from Time of Burn
19. **Head Injury:** Neuro checks (GCS) Q ____ min/hrs;
    C-Spine: Clear/NOT Clear; Keep Head in midline position;
    Mannitol (20%): 0.25/0.50/1 gm/kg IVPB over 30-50 min
    Notify MD for Mental Status changes
20. **EVAC:** Priority w/in 4-6 hrs; Routine w/in 24 hrs;

(b)(3)-1 Post-OP Orders, By CPT (b)(6)-2 as of 29 Nov 2001

(b)(6)-2 (b)(6)-2

MEDICAL RECORD | PROGRESS NOTES

DATE 23 Mar 03 (b)(3)-1

1740 BP: 100/62

P: 125

R: 22

T: 98.8

O2 SAT: 96%

ALLERGIES

PMH:

PSH:

POD # (b)(6)-4 Y-- GPW male s/p GSW to (R) ant / + (R) posterior chest, s/p GSW to (L) abdomen → RLQ.
At surgery he underwent ex lap SBR with stable anastomosis control (R) liver fx, repair of GC gastrotomy x2, neg pericardial window, and (R) side chest tube.
Clinically seriously injured with NG, foley, chest tube, open abdomen, and O2 cast / dual gene 9 Aur. Surgery performed 22 Mar 03 by (b)(3)-1

Hb 7.2

Pt awake, alert, much more comfortable after IV MSO4. NG with black bile, foley. Back wounds dressed. Lungs fair by clear. Heart tachycardic. Abdo wounds dressed. Abdo appropriately tender. Foley decompressed. Ext still edema & tenderness. Neuro now all fours, GCS 15.

Imp: Critically ill patient — well acute ICU care. Multiple injured GSW. repair of multiple laparotomy + liver fx care.

Plan: IV Abx. Chest tube care. IV fluid. CXR in Am. labs. Watch fluids

(Continue on reverse side)

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

REGISTER NO. | WARD NO. 274 FSU

NAME: (b)(6)-4

SSN:

UNIT:

(b)(6)-2

NOTES

Ord

(V. 7-91)

GPW (b)(6)-4

(b)(6)-2

MEDCOM - 4315

USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES

DATE

(b)(3)-1

8A

Progress note

~~OPERATIVE NOTE~~

24 Mar ~~DIAGNOSIS:~~ POD #(b)(6)-4

98.2

VS: 116/62 P119 R16 Sa02 102

~~PROCEDURE:~~ Tm Rfeb VSS.

meds: cefotaxin I/O

MRO4 UOP 50 - 150 cc/h.

~~SQ Heparin~~ CT 445 cc since 2pm. ⊕ Airleak

~~SURGEON:~~ NG 220 cc since 2p

~~FINDINGS:~~ TVF @ 150.

GCS 15. Alert. Comfortable

Hgb 7 NG + pleur + CT functional

Hct 22 lungs clear / ⊖ wheeze ⊖ base

Na 138 K 4.8 Heart tachycardic

iCa 1.17 ~~FLUIDS:~~ Abdo flat, soft ⊖ BS. ~~SKIN:~~ Wounds dressed, clear

ABG 7.32/44/99/26 OXT 0% sli pedal edema

~~SUP~~: POD#2 s/p R Hemothorax. R liver fx. SBR;

repair Gastrostomy - Stable.

Hgb low

plan: transfer to holding p review of Am labs

and CXR. OOB ambulate with assist

Ultab + I/O q4h. Deep Breathing

IVF NS @ 110 (Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or ward)

(b)(6)-4

EPW #(b)(6)-4

(b)(6)-4

(b)(6)-2

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-

Prescribed by GSA/ICMR,

FIRMR (41 CFR) 201-45.505

509-111

(b)(6)-2

(b)(3)-1 [redacted] PN POD# (b)(6)-4 [redacted]

915 Am
25 Mar 03

Tm 102° (12N) now 99%
VSS. P104 BP 100/50 SaO2 100%
CT ⊕ air leak. 25cc/24h. → Waterseal
foley 1500/24
NG 20cc/24h.

labs
141 | 30 | 34
7 / 22
Hct 1.17

CXR: No PTX, pneumonia
Atelectasis

uncomfortable this am
lungs clear c̄ slight ↓ R base
Heart tachycardic, stable
Abdo ⊕ BS, tender.
Wounds clean + dressed. edge of exit wound red c̄ small medial area of ischemic tissue.
foley intact. UOP: ok (b)(6)-2 [redacted]

Imp: 1. GSW ® chest → plate atelectasis, ↓ CT output
2. GSW to abdo → Gastrotomy repair, SBO, contusion liver lac
- slow return of Bowel function
NPO.

Plan: CT to waterseal, prob pull in 24 hrs
Start Toradol 30 mg IV q6 x 4 days.
Continue MSO4 PRN
IVF keep ~ 110.
OOB. incept dep. (b)(6)-2 [redacted] (b)(6)-2 [redacted]

(b)(3)-1 [redacted] PN

25 Mar 03
730 pm

Pt ambulatory. SaO2 96% RA
lungs clear c̄ a few crackles R base
® CT ~~placed~~ removed. 30 mins post CT
SaO2 99% RA. Comfortable
Plan: AP/lateral CXR in Am. Also ✓ lab in Am
Do not remove [illegible] for 72 hrs (b)(6)-2 [redacted]

VS q8h.

MEDICAL RECORD	PROGRESS NOTES
DATE 26 Mar 03 2155	I agree with previous assessment. Morphine 4mg given for (R) arm pain. VSS. CTA, (b)(6)-2 ICT/AN.
27 Mar 03	pt ~~hes~~ (R) forearm phlebitis ~~c̄ [illegible]~~, pt c/o (R) arm ~~tightness~~. pt given 25mg phenergan c̄ 25mg Demerol followed by 5cc flush. Resp=16 (b)(6)-2
1420	pt bathed soap with a sponge. Pt sleeping at this time (b)(6)-2
1530	VS taken BP 140/90 P80 T 97.1
27 Mar 03 1700	Patient with thirsty by gestures. IV continues, but confused c̄ Dr. (b)(6)-2 and now verbal given orders to start intake of clear liquids 100 cc/hr until revised by Dr. (b)(6)-2 (b)(6)-2 may AN
27 Mar 03 2359	4mg Morphine given x1. P 74, BP 137/78 R 20 T 96.2 No changes from last exam except pain level wants bath also ICT/AN
28 Mar 03 0100	275cc urine, sleeping well (b)(6)-2 ICT AN
28 Mar 03 0600	200 urine out for shift (b)(6)-2 ICT/AN
28 Mar 03	1000 - OSG Chest wound healthy, open and draining well. Pt afebrile overnite, c/o pain to abdomen, given Morphine see mar. (b)(6)-2
28 Mar 03 1310	POD (b)(6)-4 S/P GSW TO (R) ANT / (R) posterior chest S/P GSW TO (L) ABD → RLQ S/P SBR S/P repair gastrostomy AF/VSS GOOD UOP Rhonchi (R) base c̄ ↓ BS wounds look good A/P / D/C IV Advance Diet (b)(6)-2

(Continued on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FIRMR(41CFR)201-45.505

509-111

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 Mar 03 (b)(6)-2	2 day post op (b)(6)-4
	Tm 99.7 VSS SaO2 100% → 98% RA
	UOP - diuresing
	IVF: 2500 } Currently SaO2 98% pulse 9[illegible]
	UOP 2800
	CT out
	foley D/c'ed thru Am
	c/o (R) sided CP esp deep breathing
	Heart reg. lungs clear i LBS (R) base
	Abdo (+) BS. W/ [illegible] pt hosp, awaiting dressing change
	pt ambulatory
(Machineshop)	CXR thru Am (PA/LA) ipsilateral - ¢ PTX RML atelectasis
	Imp: GSW (R) chest s/p removal CT 12 hrs ago. hard RML atel
	GSW to abdomen ↑ BBR, refeed gastrotomy
	Plan: please ↓ CXR to R/o PTX
	Keep O2 to keep SaO2 94%
	Start diet in 48 hrs (clear)
	Needs new IV site (b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
	RML atelectasis	— weeks from Forward	(b)(6)-2
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.

(b)(6)-4

EPW (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)*
28 Mar 03	Surgery POD # (b)(6)-4
14[00]	Pt very quiet. Flatus? Pain well controlled
	Vomit clear...
	Plan advance diet to clear.
24 MAR 03	Pt (b)(6)-2 (b)(6)-2
1520	Pt. ambulated well walk to end of tent and back. (b)(6)-2
24 MAR	B/P 112/70 SaO2 - 97%
1615	P - 105 T - 98.3
	R - 20
28 Mar 03	Pt alert & requesting meds for sleep. Given 50 mg Benadryl
1930	PO. S1 & S2 audible. Lungs CTA from Apex to base anteriorly.
	Hyperactive Bowel Sounds x 4 quads. Pt voided 750cc via urinal. Distal pulses
2 Tylenol 2230	present. Assy c/o/I. (b)(6)-2 SSG/LPN
29 Mar 03	Pt c/o H/A and PN, PN woke Pt up out of sleep after
0120	~~one motrin~~ 11 Tylenol / one Bendryl. Pt B/P 116/62 P 100 R 16 T 100
	Pt drank H2O about .5L Pt also ate pastery. Pt also
	c/o PN on wound. SPC change dressing wet to dry.
	Wound look okay. Might need Bedside Bereavement
	a.m. Have Dr. (b)(6)-2 check wound on wound change SPC (b)(6)-2
29 Mar 03	BP - 100/60 RR - 20 Sats - 97% via RA
0530	P - 94 Temp - 99.3
29 mar 03	1710. Pt. c/o of pain from wound. Dr. (b)(6)-2 gave
	verbal Orders for Vicodin Tab 1 po now. Given (b)(6)-2 Maj. AD[illegible]

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

PROGRESS NOTES

DATE	
29 March 03 0910	~~Upon~~ Upon assessment to PT PT c/o Tenderness c̄ RN TO ABD & radiates to upper (R) Thigh. BP 110/64 100.8 P.95 97% RR 16 (+) BBC's WNL (+) Pulses
29 March 03	1200- Pt in Bed for dressing Δ on Mid line Abd incision. Wound open 1in in with and about 12in long. Little drainage of a clearish white appearance. No signs of infection, dressing Δ was stric. Dressing change on open wound in upper right lateral thoracic region. No signs of infection. Dressing Δ on mid upper, Back no signs of infection. (b)(6)-2 ZCTAN
29 March 03	1313- Pt BS are Absent, did Digital Rectal check, no Constipation present will continue to monitor. (b)(6)-2 ZCT/RN
29 mar 03 1710	POD # (b)(6)-4 S/P GSW ABDOMEN - S/P (R) GSW Chest c̄ SBR & gastrotomy repair Patient c/o ABDominal pain T 100.8 Lungs - ↓ BS (R) Chest (R) CT site - good
Belly: soft ↓ BS but present	ABD WOUND - ? NECROSIS deep in tissue Midline INCISION - good Posterior (R) chest wound good P D/W Surgery to R/O NECROSIS Pain control low threshold for DSX (b)(6)-2

☆U.S. GPO:1995-397-405

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24 Mar 03 2009	no changes from previous exam. BP 92/46, P102, R 20, T ___. Fluids encouraged will continue to monitor (b)(6)-2 KT/AN
29 Mar 03 2358	Vicodin 1 tab PO for c/o pain (b)(6)-2 KT/AN
30 Mar 03 725	T = 96.2 F P: 94 O2 95 118/72 (b)(6)-2 AN
30 Mar 03 1017	Changed dressings on pt. abdomen, wet to dry. Dr. (b)(6)-2 looked at his wounds & said he needs debridement either today or tomorrow. Vicoden 1 tab was given orally for pain. SPC (b)(6)-2
30 MAR 03 1200	POD# (b)(6)-4 S/P GSW ABD. S/P (R) GSW Chest & SBR & gastrotomy repair AF/VSS ABD (R) UQ wound needs debridement MIDLINE INCISION good Posterior (R) chest wound good P) Surgery for Debridement — When? Pain Control (b)(6)-2 Wound care
31 MAR 03 1440	115/50 RR 18 P. 118 POX 94 TEMP 100.8 (b)(6)-2
31 MAR 1530	MS04 4mg IM @ 1530. CPT (b)(6)-2 AN

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.

(b)(6)-4

EPW (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)*
30 March 03	1515 - Pt Complains of Pain in Rt Shoulder, Give T Vicodin (b)(6)-2
30 Mar 03	1900 Pain uncontrolled. MSO4 4mg Inj given. Prior to this patient up bed unassisted plan set in chair for 20 mins. (b)(6)-2 Inj. Ax) FNP
30 Mar 03 2140	Pt lying in bed awake c/o pain to midline incision. Given MSO4. Assg CD+I. (b)(6)-2 SSG / LPN
31 Mar 03 03:40	Pt awake c/o pain, given 2mg of MSO4 to relieve pain. Given water. (b)(6)-2 91W
31 Mar 03 0625	BP - 100/48 RR - 20 Sats - 94% v/s RA P - 106 Temp - 100.4
31 March 03	0940 - Pt in Bed A+OX3, Breath Sound Clear Upper lobe, ↓ Lower, BS x4 Quadrant SLS2 Present, All pulses Present (b)(6)-2 ZUT/AW
0954	B/P 115/45 P102 R 16 SAT 95% T 99.2
31 March 03	2145 - Pt c/o pain S/MG Tab R+ Deltoid per Dr. Vitalwalk (b)(6)-2
3/31/03 1145	POD # (b)(6)-4 GSW ABD / GSW (R) Chest s/p (R) CT s/p SBR / gastrotomy repair T - 100.4 P - 106 BP 100/48 RR 20 SpO2 94% Lungs: ↓ BS (R) basal ABD: (R) UQ EXIT WOUND c̄ NECROSIS EXTENDING to FASCIA. Mid-line incision c̄ NECROSIS @ epigastric area. ⊕ Pseudomonas/colonization * Debridement carried out at bedside → w→D Δ's BID Vitals Q6° - Low threshold for Abx Nutrition Cont AMBULATE BID Pain control (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1 apr 03	BP 115/70 temp 97.7 Pulse 122 Sp02 99 RR 18-20 short shallow (b)(6)-2 9/W/O
4/1/03 1007	POD # (b)(6)-4 GSW ABD / GSW (R) Chest S/P (R) CT S/P SBR / gastrotomy repair T-97.7 BP 115/70 P 122 Sp02 99% Cings ↓ (R) base ABD: Mid line incision / (R) UQ ∘ necrosis Bed side loose necrotic tissue removed P) ✓ H/H ∴ I - start w→ D BID Δ's Pain Control Ambulate (b)(6)-2 Nutrition ok
1 April 03	1130 zulu time - Pt c/o pain Given 2T3 (b)(6)-2
1 April 03	.2ml MSO4 IM @ 1205Z (b)(6)-2 9/W/O
1 April 03	1520z - Pt c/o Pain 4 MG MSO4 given (b)(6)-2
1 APR 03	1635z - Pt amb floor c/o pain & sleep 50 mg Benadryl, 50 mg Motrin PO CPN HR 106 RR 20 SPO2 95 TMP 99.6 100/50 (b)(6)-2 LPN, SJT

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV	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.

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)
20pr03	Vitals = Temp 100.9, BP 113/48 Pulse 110, SpO2 96% Resp 22 Given MRE @ 0619 z
4/2/03 0710	POD # (b)(6)-4 [redacted] GSW ABD / (R) Chest s/p (R) CT s/p SBR / gastrotomy repair Vitals: 100.9 BP 113/48 P. 110 SpO2 96% Lungs: ↓ BS (R) base ABD: distended / (R) UQ wound ↓ necrosis tissue noted ↑ H/H AM 4/3/03 AMBULATE TID BAT!!!! Ensure Shakes (b)(6)-2 [redacted]
	(b)(6)-2 [redacted]
2Apr03	Nutrition Note - will send Ensure shakes and more Data to ↑ calorie intake (b)(6)-2 [redacted] MAT SP RD
2APR03 1715 temp 101.9-A	pt. c/o pain given 2 T3 for pain. Spc (b)(6)-2 [redacted] took pt for a walk, would not walk for more than 5 minutes. Pt. states he wishes to die. Spc (b)(6)-2 [redacted] also given an additional 325mg tylenol. Spc (b)(6)-2 [redacted]
2APR03 1500	B/P 112/38 Spc (b)(6)-2 [redacted]
2APR03 1630	B/P P 97 RR SAO2 95+ 110/56 99.7°, pt ambulated floor x2 ∅ complaint of pain. (b)(6)-2 [redacted] LPN, SGT

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
30Apr03 5:00Z	pt eating MRE - vitals ⇒ temp 95.8, Spo2 98%, pulse 98, 98/40 BP (RA) 20 resp, 90/40 BP (LA)
3 Apr 03 0600Z	Pt DSg Δ per MD. Bandage placed around chest. Pt ambulated this AM w/ problem. Lungs ↓ (B). — (b)(6)-2
3	Nutrition — Patient agreed to drink 3 cans of Ensure a day, instead of getting a feeding tube. Translator explained that the IV did not have sufficient nutrition to heal his wounds. (b)(6)-2 MAJ SA RD
03Apr03 0930(Z)	Two Tylenol #3's administered per DR (b)(6)-2 order for pain management — SPC (b)(6)-2 9NWM
4/3/03	POD #(b)(6)-4 — Patient walking more!! Looks better! GSW ABD / GSW (R) Chest s/p (R) CT s/p SBR / gastrostomy repair T - 95.8 P - 98 BP 98/40 20 lungs ↓ (R) basal ABD: Scaphoid / soft / NABS wounds - dehiscence ↓ necrotic tissue H/H - 7/22

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME (LAST, FIRST)	SPONSOR'S ID NUMBER (SSN or Other)
P	Centrone CCAgWM	(b)(6)-2
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	
AMBU CAT		

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

Wounds on OAT!

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
4 April 03	Vitals - 22 rr, 97 SpO^2, 92 pulse, 100.1 temp, 100/60 BP (b)(6)-2 91W
4/4/03	POD # (b)(6)-4
	GSW ABD / GSW (R) Chest
	s/p (R) CT s/p SBR / gastrotomy repair
	MIDLINE INCISION - Dehiscence
	ō NEUROSIS
	T - 100.1 P - 92 RR 22 100/60 97% SaO_2
	↓ BS (R) base
	Patient very looks worse than yesterday
	P) ① Locate Dobhoff tube for TF's
	② Cont Levaquin
	③ Ambulate
	④ wound care
	⑤ Pain Control /
	(b)(6)-2
4 April 03	1000 - NG Tube placed in Rt nostril, Aspirate Gastric Content for placement, placement Confirmed (b)(6)-2 2LT AW
	1020 - 240cc of Tube feeding Bolused, Received tube feeding from Dietect, Need to hang 240cc Bolus Q3 hrs (b)(6)-2 2LT AW
	1030 - Pt up out of Bed, having Runny Bowel Movement, will continue to monitor and Tube Feedings Q3 (b)(6)-2 2LT AW
	1030 - Q3 Tube Feedings, check residuals before each TF, if 100cc held feeding x 1 hr recheck residual until ↓ 100cc then Give TF 240cc Bolus (b)(6)-2 2LT AW

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4APR03	Vitals: temp 101.3, 22 resp 100/56 BP, 97 SpO2, 115 pulse (b)(6)-2 [redacted] 9/W
4APR03 16:30	20RR 96O2 114HR 101.8° Temp 90/60. Pt sitting in bed. ate ½ jello cup.
4APR03 1650	650 Tylenol for pain and Temp. (b)(6)-2 [redacted] SST, LPN
4APR03 1716	Drank 3/4 cup of Ensure. Note to watch if spilling out.
18:30	Pt drank 3/4 cup of Ensure. Pt request Potatoes, vegetables, Bread, chicken and other solid items.
18:45	TMP 99.1 (b)(6)-2 [redacted] SST, LPN
22:42	TMP 98.4 (b)(6)-2 [redacted] SST, LPN
0307	TMP 98.4° Aux pt asleep at this time (b)(6)-2 [redacted] SST, LPN
4/5/03	0420-98.2-Aux, 100/62, 95, 97% (b)(6)-2 [redacted] 2LT AW
	0515-Pt Received his cup of Ensure and is drinking (b)(6)-2 [redacted] 2LT AW
	0530-Pt OOB to Latrine by himself, had a Bowel Movement (b)(6)-2 [redacted] 2LT AW
	0640-Pt OOB to Ambulate, talking other Pt, Looking More energetic, has more strength, moves and ambulate on his own. (b)(6)-2 [redacted] 2LT AW
	(2) changed pts dressing, wet to dry, no odor bandage, still very painful (b)(6)-2 [redacted] 9/W

OUT

...L OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SP...NSO...'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.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4/5/03	POD # (b)(6)-4 (b)(6)-4 DH (b)(6)-4
	GSW ABD / (R) Chest s/p (R) CT
	s/p SBR / gastrotomy repair
	T max: 101 (4/4/03 / 1630)
	TC 98.2 100/62 95 97% RA
	Lungs ✓ BS (R) Basal
	ABD: Scaphoid / Soft / NNBS
	wound - looks better
	BM yesterday
	P ① Cup ensure Q 3° while awake
	② Ambulate more
	③ Arg wound care (b)(6)-2
	④ Cont course (b)(6)-2
4/4/03 0945	- Pt c/o Pain two T#3 Given PO (b)(6)-2
1200	Pt had 240 cc ensure by mouth (b)(6)-2
4/5/03 1230	- Pt received 240 cc of Ensure and Orange H. all also saw pt ~~drinking~~ Eating MRA meal (b)(6)-2
1230	- Late Entry 0710 c - Assisted c Dressing Δ, wound Red, appears more alive tissue, no debridement necessary, w-D continue will continue to monitor (b)(6)-2
1350	Two T#3 Given for pain PO (b)(6)-2
5APR03 1630	TMP (oral) 98.9° HR 86 BP 98/68 O2 99 RA RR 20. Pt sitting up in bed eating crackers. Says stomach was hurting him a little bit. Lungs Clear x4 Bowel active x4. (b)(6)-2 LPN, SOT

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*U.S. GPO: 2002 - 491-600/50618

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5 APR 03 1205	Pt starts on his Cup of Ensure. Pt spitts Ensure out of bed. Nurse strongly communicates to patient that he is wrong for it. Pt receives chuck to clean up. Interpreter talks to pt and he downs the second cup of ensure. (b)(6)-2 — LPN, SGT
23:10	97.5° pt complains of Abd pain. 8 on my metric (b)(6)-2 SGT, LPN
0300	Pt asleep
06 APR 03	Vitals – temp 97.4, B/P 108/74, Pulse 90, SpO2 98%
0430	Resp 18 — SGT (b)(6)-2 – [illegible]
0545	Pt Drank 240cc Cup of Ensure to no problems, pt tolerated pt his ensure (b)(6)-2
06 APR 03	POD # (b)(6)-4 LEVAQUIN D# 5
0730	GSW ABD/(R) Chest s/p (R) CT
	s/p SBR/gastrom repair
	T 97.4 108/74 90 98% 2LO2
	Cast Temp 101 (4/4/03 @ 1630)
	Midline incision looks good ✓ NEC 10.5
	W → D Δ D
	D C R Tusil
	Cont Levaquin
	Ambulate
	Pain Control

(b)(6)-2

RELATIONSHIP TO SPONSOR | LAST | OR'S ID NUMBER (Other)

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DATE	NOTES
4/6/03	0900 → Pt Received 2nd Cup of ensure and drank all, pt c/o of pain and received 800mg Motrin PO. At 0600 Pt Drank 1st Cup of ensure and ambulated. At 0700 pt Dressing Δ done, wound Approximated and well vascularized, no sign of infection or ↑ in Necrosis. Pt up to ambulate 2nd time. (b)(6)-2
	1330 Pt Drinks 240cc Ensure, up + Ambulate. Pt eats little of dinner (b)(6)-2
6APR03	1638 RR 16 RA 98/102 99 HR TMP 98.3° ORAL 98/62
	1721 Pt drank cup of ensure. Light complaints of pain in abd.
	1900 50mg Benadryl for Sleep (b)(6)-2 LPN, SDT
	0320 Pt Sleep through night ∃ complaint, still sleep at this time. (b)(6)-2 [redacted]
7Apr03	0400 → Temp 98.3 BP 100/58, HR 58, Resp 16 (b)(6)-2
	0530 - Pt in Bed, Given Ensure, doesn't want to drink, encouragement is working, Given Two T#3 for pain, ensure gone (b)(6)-2
4/7/03 0715z	DOD # (b)(6)-4 LEUAQUIN D#6
	GSW ABD / (R) CHEST s/p (R) CT
	s/p SBR / gastrotomy, epsin
	AF/VSS (LAST TEMP 4/4/03)
	MODERATE INGESTION - GIVEN LAXATIVE WELL
	W → D Δ's
	1) Cont Ensure
	Cont Levaquin
	Ambulate
	Pain Control/ (b)(6)-2
4/7/03	1030 Z Admin 2 Tylenol #3 - 1 tab (PO) per dr orders. Pt c/o of pain in abdomen (b)(6)-2 (b)(6)-2
4/7/03	1330 z Pt eating apple. Ensure held at this time (b)(6)-2

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DATE	NOTES
4/7/03	RR 20. HR 98 SPO2 99% RA TMP 98.1 oral BP 88/72 pt WOB AWB Flow
16:55	x3. Cleared up AO c̄ instruction. Mild pain to ABD. (b)(6)-2 LPN, SOT
17:30	pt drank cup of ensure c̄ difficulty (b)(6)-2 LPN, SOT
2335	Pt woke c̄ abdominal PN, Pt given 500mg Tylenol — Spc (b)(6)-2
8 APRIL 03 0345	pt slept c̄ little trouble (b)(6)-2 LPN, SOT
8 APRIL 03 0430	VS obtained. O2 sat on RA 93%, P 77, RR 20, T 97.8°F, BP 92/50 — (b)(6)-2 DH, PN
4/8/03	POD# (b)(6)-4 LEVAQUIN D#7
	GSW ABD / (R) Chest s/p (R) CT
	s/p SBR / gastrotomy repair
	Tc 97.8 (LAST Fever 4/4/03)
	MIDLINE INCISION looks good
	P) Cont ENSURE
	D/C LEVAQUIN (b)(6)-2
	AMBULATE
	Draw CBC
0630 2010 8 Apr 03	PT recieved ii T3 i
	(b)(6)-2
1030 8 APR 03	pt ambulated [illegible] c/o pain gave ii T3 Spc (b)(6)-2

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09 Apr 03 0740 Z	(S) Pt admitted to MCWR this AM from MEWI. Pt A+O x3. Assessment completed. BS are Hyporactive x4. All other assessments WNLs.
	(O) Pt Vitals are stable and presents c̄ Dx: GSW to Abdomen/(R) Chest and S/p (R) CT
	- Mid line incision / wound on Abdomen. Beefy red tissue present, Wound vascularized, small amnt of fibrinous (b)(6)-2 exudate noted in wound. Ø drainage noted Ø erythema around wound
	- (R) GSW chest, wound 6-7cm X 6-7cm, Red vascularized Tissue present. Wound edges aproximated. Ø S/S of infection
	(A+P) - Continue Woundcare / Dressing Δ.
	- Treat pain as needed.
	- Continue Ensure feedings
	- Encourage Walking. (b)(6)-2 2LT AN
9 Apr 03 8:30	- Vitals. 85/70 B/P, 20 rr, 84 pulse, 99.2 temp.
	Crypta (b)(6)-2 91W
0940	FNP Note
	S/O S/P GSW. See 0740 note. No Δ in Status, Drank 240cc Ensure @ lunch. Ambulating on own.
	A/P Continue to monitor Nutritional status, Ø Δ in tx plan.
	(b)(6)-2 LTC, MC F

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(b)(6)-4

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DATE	NOTES
09 Apr 03 1030	Patient given 11 tabs of Tylenol 3 for pain (b)(6)-2 SLMM
1130Z	Pt drank 240cc of Ensure and Ambulated (b)(6)-2 2LT AN
1400Z	Pt had 240cc of Ensure and Ambulated (b)(6)-2 2LT AN
1700Z	T 98.5 P 85 R 18 BP 90/50 Pt alert for assessment & cooperative. Pt denies pain & is in no apparent distress. Lungs CTA. HRRR. bowel sounds hypo in LUQ & RUQ. Active sounds in lower quads. Pt drank 240 cc ensure w/o difficulty — (b)(6)-2 2LT AN
10 Apr 03 0505	Pulse 86, R-18, Temp 98.7, B/P 96/58 — Spr (b)(6)-2 SLMSO
0630Z	Pt has Dressings taken down. Wounds x 2 to Midline ABD and GSW® Chest. ABD midline wound is looking very good. Wound is Red & beefy tissue that is well vascularized, small amt of fibrinous exudate noted. Edges approximated. No s/s of infection. R Chest GSW wound is 1cx1cm. Wound can be characterized as above. Except the fibrinous tissue noted. No s/s of infection — (b)(6)-2 2LT AN
0950Z	FNP PN S/O S/P GSW, See above notes re: Wound Care et Status, MAE. Ambulates S assistance. ⊘ s/s of infection. VSS. AF. A/P Wound improved, (1) Tylenol 650 to 100mg PO ⊘ 4-6° prn pain. (2) Ibuprofen 800mg PO ⊘ 8° prn pain (3) Tylenol #3 PO ⊘ 4-6° prn pain ONLY if trying Tylenol et Motrin orders S relief. — (b)(6)-2 LTC, AN FNP
1000Z	Pt ambulated & drank Ensure 240ml @ 0700Z. — (b)(6)-2 2LT AN
1200Z	Pt drank 240 ml Ensure (b)(6)-2 2LT AN

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10Apr03 1952	V/S B/P = 94/58 P: 80 R = 16 = T: 98.1 PT. dressing clean + intact. P.T. setting in bed. talking with other PT. P.T. was eat food (b)(6)-2 91WM
11Apr03	2050 BP 110/70 P 68 R 16 T 97.5 (b)(6)-2
11Apr03 0621	MD PN Pt c̄ GSW Abd & (R) Chest POD# (b)(6)-4 AFVSS Abd superior pole wounds beefy c̄ good granulation scant sanguinopurulent exudate.
	A/P (1) cont wound care, pain meds. (2) Cont to encourage feedings. (b)(6)-2 MD
2045	BP 110/68 RR - 18 T-97.8 P-76 Pt c̄ GSW Abd + (R) chest Dsg CDI. Pt c/o PN. Pt was given 500mg of tylenol (b)(6)-2
12Apr03 0445	P. 82 RR 16 Temp 97.0 BP 100/50 Spc [illegible]
12Apr03 0500	Abd. Dsg Δ'd - Wet to dry midline. Wound looks good and beefy, scant exudate on left border of wound, Nad c chest from previous day. Pt rotate Pain R/T wound, pt. received Motrin 800mg - Spc (b)(6)-2 91WM

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12 Apr 03 - 0600	Pt drank ½ cup of ensure - Spc (b)(6)-2 9lwML
1200.	Pt drank ½ cups of ensure - Spc (b)(6)-2 9lwML
1700Z	T98.5 P80 R16 BP 90/58 Pt Resting comfortably @ time of assessment. Pt w/ midline dressing which is C/D/I. Pt also has dressing to (R) chest wall C/D/I. All other systems WNL (b)(6)-2 2CT AN
13 Apr 03 5:20 (2)	Vitals = 96.8 temp, 18 R/R, 84 pulse, 92/60 B/P (b)(6)-2 9lw
05:55 (2)	Pt dressing removed. Wounds x 2 to Midline abdomen and (R) chest. Wounds are healing very well, improvement every day, tissue is red and granulated, borders of wounds are closing. Dressing Apd W→D No c/o pain. (b)(6)-2 2LTAN
1625Z	T98.2 P90 R16 BP 90/55 Pt in bed @ time of assessment. Pt alert + denies pain. Dressing to midline abd + (R) chest wall C/D/I. All other systems, WNL (b)(6)-2 2CT AN
14 Apr 03 0600 (2)	Pt dressing removed. Pt has wounds x 2. (1) Mid line ABD wound is healing well. Noticable improvement on every exam. Ruffy granulated tissue present some fib exudate in wound, Ø necrotic Ø eryth, W→D Adone no s/s of infection present. (2) (R) chest GSW. wound is improving as well. above note on midline ABD applies to (R) chest, W→D A done no s/s of infection (b)(6)-2 LTAN

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DATE	NOTES
14 April 03 08:15 zulu	• Nutrition note - patient been consuming 5 cups of ensure a day and crackers & rice. approximally 1,500 cal/Day, reccomend pt drinks 6-7 cups ensure a day. Wounds are healing very well, patient advancing well. SPC (b)(6)-2
2210	Pt w/injury to abd (midline incision) → (R) chest wall dll dressings C/D/I. Pt resting comfortably, RR even & unlabored. Will continue to monitor (b)(6)-2

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DATE	NOTES
14Apr03 7:13	Vitals = 98.6 temp, 18 rr, 88 pulse, 115/60 B/P (b)(6)-2 9lw
14Apr03 2150	BP - 119/59 T - 98.5 P - 76 RR - 18
15Apr03 5:25	Vitals = 98.2 temp, 18 R/R, 78 pulse, 115/60 B/P (b)(6)-2 9lw
15Apr03 - 0600	Dsg Ck to Abd wound. Wound looks good & beefy pink, no exudate noted. Serosanguinous drainage on old bandage. No odor noted, no significant change from previous assess. Dsg CDI - W → D, ND c/o pain. (b)(6)-2 9lwmp
2230	BP: 84/80 Resp: 18 P: 66 Temp: 99.0 — Sgt (b)(6)-2
16Apr03	0600 Pt slept most of shift w/o complaint. Dressing midline abd c/o/I, RR even & unlabored — (b)(6)-2 2LT AN
16Apr03 @ 0945	Pt dressing removed Pt has wounds x 2 ① Midline ABD wound. Wound is healing very well. Wound is 3cm @ widest point. Red beefy tissue present, wound edges closing. Ø necrotic Ø eryth. Some Green drainage noted on dressing, though no pseudomonas noted in wound. ② ® Chest wound. Note on ABD wound is consistant with this wound, Ø necrotic Ø eryth. — (b)(6)-2 2LT AN

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DATE	NOTES
16Apr03 8:46	Vitals = 97.8 temp, 18 R/R, 78 pulse, 100/55 B/P (b)(6)-2 [redacted] 9W
2:09	BP - 100/60 T - 98.6
	P - 80 RR - 18 (b)(6)-2 [redacted]
17Apr03 0056	BP 100/60 P. 80 RR 16 Temp 98.1 Spc (b)(6)-2 [redacted]
17Apr03	Pt dressing removed. Pt has injuries X2
1100	① Midline ABD wound. Wound is healing very well. No noticable closure from previous exam. Red, beefy, granulated tissue present. Edges are proximated, Ø necrotic Ø Eryth Ø s/s of infection. Wound care is W → D dressing Δ done.
	② R Chest GSW: Wound is healing well 3cm x 3cm. ABD assessment is accurate for this wound and comparable. W → D dressing Δ done.
	(b)(6)-2 [redacted] 2LT AN
1436	BP - 100/60 T - 98.2
	P - 52 RR - 16 (b)(6)-2 [redacted]
18Apr03	Pt dressing Removed. Pt has injuries X2.
0985	① Midline ABD wound. Wound is begining to heal rapidly Wound red, beefy & granulated tissue. Wound edges closing. Dressing removed had some green discharge possibly ⊕ for psudemonas. Ø necrotic Ø Eryth Ø s/s of systemic infection. W → D dressing Δ done.
	② R Chest GSW: Wound assessment of ABD is congruent with this wound. W → D dressing in place.
	(b)(6)-2 [redacted] 2LT AN
18APR03	VITALS: Temp 98.3 Pulse 96
0910	Resp 16, BP 105/65 (b)(6)-2 [redacted] 9W

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DATE	NOTES
18 Apr 03	@1600 pt received to ward ambulatory via MD. Report given @ bedside per DR (b)(6)-2 pt c̄ abdominal dressing midline + (R) small dressing midaxillary line wet to dry. Dressing clean dry + intact. neuro intact. VSS BP 110/60 P 68 R 18 T 98.8 pt smiling. language barrier present. will continue to monitor (b)(6)-2 RN
18 Apr 2035	Nsg. Shift assessment completed, VSS. Dsg to abdominal midline - CD&I; dsg to (R) upper chest CD&I. Patient is comfortable. Continue to monitor (b)(6)-2 (RN)
BP 99/46 P-78 R-18 T-98.2 Sat 100%	
18 Apr 2300	Nsg. W→D dressing done of midline abdominal incision on (R) upper chest. Tissue c̄ good granulation no s/s of infection. (b)(6)-2 CN
19 Apr 0530	VS BP 99/48 P-65 R-14 T-96.7 Sat_2-100% on RA
19 APR @ 0830	Shift report received. VSS B/P-98/50 P-70 R16 T-97.0 pt resting quietly in position of comfort c̄ equal + even respirations. will continue to monitor. (b)(6)-2 RN
19 APR 03 @	1040 pt dressing changed wet to dry. Edges well approximated beefy red tissue present c̄ (+) granulation. no odor noted. pt tol procedure well. pt NAD. Will cont to monitor. (b)(6)-2 RN

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DATE	NOTES
	Asq.
19 Apr 03 2115	Shift assessment completed. No c/o @ this time. Will Δ dressing to mid abdomen (W → D). Abnl, lungs CTA (B); BS (+), voiding per urinal. HR-70. RRR. Well hydrated. (b)(6)-2 CMT
2300	W → D dsg done. No s/s of infection. (b)(6)-2 CMT
20 Apr 03	VS
0600	BP 96/46 P-80 R-16 T-97.2 SaO2-100%
20APR03@	0830 VS B/P-88/49 P-75 R-16 T-97. pt OOB to ambulate to BSC. pt ambulates c̄ steady gate. no c/o pain at this time. will continue to monitor. (b)(6)-2 LCT/AN
20apr03@	1145 wet to dry dressing change completed. midline abd incision (+) granulation c̄ beefy red granulated tissue. edges well approximated. midaxillary wound healing well. LSCTA, (+) BS will continue to monitor. pt c̄ no c/o or pain. NAD. (b)(6)-2 LCT/AN
20 April	Asq:
1920	VS 95/48 P-78 R 14 T-98.2 SaO2-97%
	Shift assessment completed, VSS, ∅ pain. Dressing to mid abd line Δ'd. No s/s of infection. Lungs CTA (B), Cbd-BS (+), voiding spontaneously clear yellow urine. Continue c̄ current plan of care. (b)(6)-2
21 Apr	VS BP 102/54 P-74 R-16 T-97.3 SaO2-100% on RA
0500	
21apr03@	0720 VS B/P-94/53 P-85 R-16 T-97.6 pt resting in position of comfort c̄ equal & even respirations. Dressing CDI. will continue to monitor (b)(6)-2 LCT/AN
21apr03@	1000 dressing Δ to midline incision (+) Beefy red granulation tissue present. Edges continuing to approximate. Will LSCTA (+) BS x 4 quads. pt c̄ no complaint of pain will cont. to monitor. (b)(6)-2 LCT/AN

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21 Apr 03 2000 Nsg. Pt spent beginning of shift outside the ward. Ambulatory, stable. Dressing to mid-abdomen Δ'd, skin granulating ē any s/s of infection. Encouraged po/supplement intake. (b)(6)-2 CN3 PA

21 apr 03 @ 0920 VSS see VS flowsheet. pt LSCTA ⊕ BS x 4 Quads. Dressing CDI. Dressing removed midline incision ē ⊕ beefy red tissue. edges continuing to approximate well. pt medicated ē nothing ē good relief. will continue to monitor. (b)(6)-2 2LT/AN

22 Apr 03 2000 Nsg. Dressing Δ'd done. No s/s of infection noted. pt is stable. BS+, urinating per urinal. Pain - o/ Plan Continue ē drsg Δ BID (b)(6)-2

23 apr 03 @ Dressing change ⊕ granulation no significant changes from prior assessment. Will D/C when arrangements made PAD involved. will cont to monitor. (b)(6)-2 2LT/AN

23 Apr 03 2115 Shift assessment completed. Drsg Δ to mid-abd area. No s/s of infection (b)(6)-2 CN3 PA

24 apr 03 @ 1300 VSS afebrile Dressing CDI ⊕ BS x 4 Quads. midline incision beefy red ē ⊕ granulation no other significant changes from last assessment. wound healing well. Will cont to monitor. (b)(6)-2 2LT/AN

24 Apr 03 2250 Dressing Δ done. No s/s of infection. VSS. No other c/o at this time (b)(6)-2 CPT PA

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25 Apr 03 @	1010 VSS pt dressing & teaching initiated. Sterile technique used. pt receptive to teaching. wound healing well. (+) granulation; beefy red color. will reinforce teaching in AM. no other significant changes. (b)(6)-2 2LT/AN
25 Apr 03 2000	Assumed care of patient. Pt sitting in bed in NAD. Ambulates freely on ward. See VS flowsheet for further (b)(6)-2 SSG Quinn
26 Apr 03 0540	Slept quietly all night. ∅ c/o. ∅ pain meds. Voiding spontaneously. Tolerating PO. (b)(6)-2 SSG Quinn
26 APR 03 @ 1500	VSS pt able to complete DRESS & C assistance. wound healing well. no other sig changes (b)(6)-2 2LT/AN

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2200	Nursing Note: Pt A&O. OOB ∓ difficulty. ~~Tolt~~ Tolerating diet well. DRSG D to abdomen pt completed ∓ minimal assistance ~~to~~ site ∓ S/S of infection. VSS. No distress noted @ present. (b)(6)-2 CPI/AW
27APR03 0545	Pt rested well tonight. % pain around 0300 → Naproxen 500 mg PO ∓ good effect. Voids spont. via urinals. Ambulates on ward. Drsg C/D/I. VSS. afebrile (b)(6)-2 SSG, 91WM6
27APR03 1400hrs	A&O x3 ↑ OOB to outside Drsg ∓ staff assistant, meals consumed ∓ c/o N/V. Resting well (b)(6)-2 91WM6 SSG
27APR03 1817	Noted what appeared to be a fungal rash on pt's R side of neck white: brown circular patches. Dr (b)(6)-2 ordered lotrimin BID which pt was instructed on how to apply. Pt able to demonstrate how to properly apply. (b)(6)-2 CPI
27APR03 2335	Assumed care of pt. Pt ∓ % @ this time. VSS afebrile Voiding per urinal (b)(6)-2 SSG 91WM6
28APR03 0540	Slept quietly throughout the shift. ∅ %. (b)(6)-2 SSG 91WM6
28APR03 1400	All vitals stable & Dressing Δ'd this shift, wounds absent of signs of infection. Pt currently w/o c/o complaints (b)(6)-2 91WM6

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Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
29 APR 03 0035	Pt resting quietly. Awakens easily. Ø c/o pain. Drsg c/d/I. VSS Afebrile. Continue to monitor — (b)(6)-2 SSG 91WM6
0535	Kept all shift c̄ c/o. Cont to monitor — (b)(6)-2 SSG 91WM6
29 APR 03 0900	Pt assisted w/ dressing Δ wounds absent of s/s of infection. premedicated w/ 800mg Motrin. Pt ate all of breakfast & currently without complaints. → (b)(6)-2 91WM
30 Apr 03 0540	Rested well this shift. Ø c/o pain — (b)(6)-2 SSG 91WM6
1030	Per Charge Nurse CID informed to re-evaluated Pt's status for possible transfer to EPW Camp. Drsg Ad̄ c̄ Pt assistance, limited staff assist. Medicated cream → neck area. ↑OOB → outside c̄ complaint. — (b)(6)-2
30 APR 03 1730	Nursing Note: Pt A&O on arrival to shift OOB. continue to encourage pt to stand erect and ~~to~~ (b)(6)-2 independant care. Pt completed dressing Δ to abdomen c̄ minimal assistance. Medicated p/l for pain wound sites c̄ s/s of infection. Tolerating reg diet well. VSS. No distress noted @ present. (b)(6)-2 CPT/AN
1 May 03 0545	Ø significant Δs tonight. Ø c/o. Rested well — (b)(6)-2 SSG WM6
1 MAY 03 1420	: Ø Alg Δs VSS-afebrile. Drsg Δ completed by pt. Wound beefy red c̄ granulation. Ø s/sx of infection. Pt resting ~~to~~ day. — (b)(6)-2 MC AW
1 May 03 2116	Nursing Note: Pt able to demonstrate dressing Δ to include handwashing before & ~~p~~ procedure. Pt also able to complete dressing Δ c̄ assistance. wound sites c̄ s/s of infection. Tried to communicate to pt he will do his own dressing Δs when he is d/c to home and he will have to see a Doctor for follow-up. Will reinforce when interpreter present (b)(6)-2

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
MAY ~~02APR03~~	Pt slept quietly throughout night w/out complaints. (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.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

(b)(3)-1

Intraoperative Documentation

1. Patient Identification:
EPW - name unknown
(IRAQ)

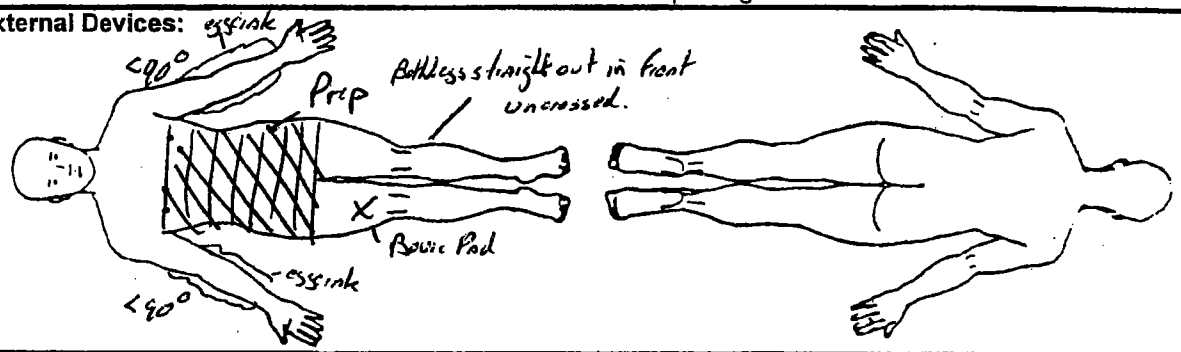
2. Assigned Scrub: SSG (b)(6)-2
SSG
PFC

3. Assigned Circulator: CPT

4. Position and Positional Aids:
Supine Prone Lateral - Right Side Up Left Side Up
Comments:
See #6

5. Skin Preparation:
Hair Removal - Yes No
Razor Clip
Prep Solution - Betadine Paint
Site: ABDomen
By CPT (b)(6)-2
Comments:
Comments: No pooling noted

6. Location of External Devices:



7. Counts: C = Correct I = Incorrect

	First	Final	Other
Sponge	C	C	
Needle/Sharp			
Instrument	N/A Emergency Case		

Scrub: ~~SSG~~ (b)(6)-2
SSG (b)(6)-2
PFC

Circulator: CPT (b)(6)-2

8. Implants Yes No

9. Electrosurgery Device Yes No
ESU #SN 2026073R
Ground Pad
Bovie pad site clear Post op
Brand 1 2nd Valleylab
Valleylab E7507
Lot # 62382 Exp 2004-07
Cut 30 Coag 30
Cut 70 Coag 70

10. Medications/Orders

Medications	Dosage	Time	Method	Prepared By	Given By
Surgical	QS	Intraop	Topical	MFR	(b)(6)-2

Wound Irrigation: .9% NaCl

Other Orders:	Time	Carried Out By

11. Additional Information
To OR c̄ Foley and chest tube

12. Dressing/Immobilization
(b)(6)-2
~~4x8's~~ ~~Tape~~
Skin not closed. Wound Packed c̄ moist 4x8's. 4x8's and Tape on Top.

13. Operation Performed
Exploratory Laparotomy
Segmental Enterectomy
Gastrotomy Repair x 2
Cholecystectomy

14. PT Transferred To	Time	Method
PACU ICU	See Anes record	Litter

15. Registered Nurse Signature: (b)(6)-2 CPT/USA

16. Physicians Signature: (b)(6)-2 (b)(6)-2

(see back page)

Op Note

Pre Op Dx: 1) GSW to (R) shoulder c̄ exit wound over (R) scapula

2) GSW to (L) mid-abdomen c̄ exit wound over RUQ abdomen

3) Shock

Post Op Dx: 1) Thru & thru gastrotomy over greater curvature
2) Multiple enterotomies of proximal jejunum
3) (R) lobe liver GSW fracture

Surgery: 1) Exp lap 2) segmental enterectomy c̄ 1° stapled anastomosis 3) Control of bleeding of (R) lobe liver
4) Repair of gastrotomy x 2 (hand sewn double layer c̄ 3° silk)
5) Negative pericardial window

Surgeons: (b)(6)-2 | (b)(6)-2

Anesthetist: (b)(6)-2 | (b)(6)-2 → 6 ETA

EBL: 1200 cc Fluid: 4400 cc crystalloid, 2u PRBC

Specimen: Jejunum (to disposal)

Drains: Ø

Complications: Extreme hypothermia c̄ coretemp 31°C
TO ICU / recovery intubated to be re-warmed.

(b)(6)-2 MD

(b)(6)-2

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS

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

WARD (b)(3)-1 ICU

DATE 24 Mar 03

This form may be used for more than one day by drawing a heavy line and adding date. Insert column headings as required.

	PATIENT'S NAME Katum	BP	HR	RR	SpO2	IVF	U/O	Pain/Temp
0800	Chest X-ray done VS	116/62	119	16	100%	NS @ 150		98.2
	Dsging Δ by Dr Carty							
0830	MSO4 4mg IVP	120/60	120	15	100	NS @ 110	110 cc/hr	(b)(6)-2
0845	Labs via i-STAT	Na 138	K 4.4	Cr 98	Bun 15	Glu 99	Hct 24	
1000	VS →	114/60	110	12	100	NS @ 110		
1030	VS pre Transport	115/61	119	14	100	SL	100	(b)(6)-2

DA FORM 3950, JUN 91 Previous editions are obsolete. USAPA V1.01

511-1'.9 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		27 Mar		31 Mar03											
POST- DAY															
MONTH-YEAR	DAY														
19	HOUR			2100	0600										

PULSE (SYSTOLIC BP (O) ✓; DIASTOLIC BP ^)

TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)

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

HEIGHT: WEIGHT →

Record special data only when so ordered

Output — PO

Input - PO

IV -

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

(b)(6)-4

Pvt
EPW

REGISTER NO.

WARD NO.

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		Mon		Tue		Wed		Wed		Thur		Thur					
MONTH-YEAR	DAY	21		22		23		23		24				25			
Apr 18 2003	HOUR	08		05	08	06		08		05	08	22		08	20	24	

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

TEMP. F (°)	TEMP. C
105°	40.6°
104°	40.0°
103°	39.4°
102°	38.9°
101°	38.3°
100°	37.8°
99°	37.2°
98.6°	37.0°
98°	36.7°
97°	36.1°
96°	35.6°
95°	35.0°

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

RESPIRATION RECORD	HR			67		79		78		75	71	76		84			
	BLOOD PRESSURE	94/53		102/45	98/46	93/43		110/65		90/44	101/53	104/49		116/62			
	R	16		16	16	16		16		14	16	18		18	18		
	O2Sat%	100%RA			100%					97	97	98		97			
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.

(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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST- DAY																	
MONTH-YEAR	DAY	26		27		28		29		30		1MAY63		2MAY63			
19	HOUR	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8 12

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)

RESPIRATION RECORD: 16 | 10 0 16 | 16 | 16 | 18 | 18 | 14 | 20 8 | 16 | 18 | 20 | 19 | 16

BLOOD PRESSURE: 110/52 | 124/68 | 105/53 | 64/52 | 70/52 | 100/55 | 89/46 | 95/42 | 91/40 | 112/59 | 110/48

HR: 68 | 68 | 72 | 67 | 79

HEIGHT: WEIGHT →

Temp: 97.4 | 97.2 | 97.4 | 98.6

SpO2: 98

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**

TEST(S)

SPECIMEN TAKEN

DATE 4/1/03 TIME A.M. P.M.

RESULTS	REQUESTED	(X)
145	GLUCOSE	
9	UREA N.	
	CREATININE	
	URIC ACID	
135	SODIUM	
3.1	POTASSIUM	
100	CHLORIDE	
30	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	
21	Hct	
7	Hb (est)	
7.435	ph	

CHEMISTRY I
STANDARD 546 (Rev. 8-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45 505
546-107

REMARKS Chem 7, Hgb & Hct

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY

(b)(6)-2

MD DATE 4/1/03

TECH

(b)(6)-4

CHEM I

URGENCY: ROUTINE; TODAY; PRE-OP; STAT

PATIENT STATUS: BED; AMB; OUTPATIENT; NP; DOM

SPECIMEN SOURCE: BLOOD; OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

TEST(S)

SPECIMEN TAKEN

DATE TIME 0445 A.M. P.M.

RESULTS	REQUESTED	(X)
116	GLUCOSE	
5	UREA N.	
	CREATININE	
	URIC ACID	
137	SODIUM	
3.4	POTASSIUM	
102	CHLORIDE	
33	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	
22	Hct	
7	Hb (est)	
7.422	ph	

CHEMISTRY I
STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505
546-107

REMARKS

(b)(6)-2

Enter in above space

REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY

(b)(6)-2

MD DATE 3 Apr 03

TECH

(b)(6)-4

CHEM I

URGENCY: ROUTINE; TODAY; PRE-OP; STAT

PATIENT STATUS: BED; AMB; OUTPATIENT; NP; DOM

SPECIMEN SOURCE: BLOOD; OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS | LIST TIME ORDER NOTED AND SIGN

28 Mar 03 1400 Clear liquid diet
Pt to ambulate to c
ambulate

(b)(6)-2

3/30/03

① MSO4 2-5mg IM Q 3° prn
Noted

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER

(b)(6)-2

3/31/03

① Regular Diet

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

② BID w/ D dressing c̄ 's

③ Nutrition Care for ENSURE SHAKES

④ AMBULATE BID

⑤ VITALS Q 6° X 24°

Flex BID

(b)(6)-2

3/31/03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

4/1/03

① ✓ H/H ; Chem 7

(b)(6)-2

Done 4/1/03

(b)(6)-2

DA FORM 1 APR 79 4256 REPL... EDITION OF 1 JUL 77, WHICH MAY BE U...

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4/2/03	MD ORDERS
0825Z	① ✓ H/H AM 4/3/03
	② AMBULATE TID
	(b)(6)-2
4/2/03	MD ORDERS
1530Z	① Levaquin 500mg po Q day
	② Don't forget the H/H in AM (4/3/03)
	(b)(6)-2
4/2/03	pt given Levaquin 500mg.
1535Z	(b)(6)-2
4/02/03	VITALS — B/P 116/52, temp 99.4 axillary, Pulse 102, SpO2 96%
1555Z	Resp 20
3APR03	Pt c/o pain T=99.7 HR 100 RR 26 102/60, Tylenol 650mg
0120Z	PO given.
3Apr03 0203	L/E Pt drank 170mL of Ensure @ 1930-2000
3Apr03	H&H drawn @ FA c̄ 18f sent to lab
0410Z	
	(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.

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)
3Apr03 0420Z	Pt lungs clear bases (B). Heart RRR, ↓BS (B) Midline DSG intact with signs of drainage. POC is for (B) Pt to ambulate twice TID, push PO fluids use IS. [redacted]
	ORDERS
3Apr03 1930	Pt states he has alot of PN on Abdomin Inscision. Also spinal PN below intrence wound. Pt given T T3's. Pt wound on back T.T also dressed. Pt given Ensure Plus to drink. B/P 98/52 P 109 R 10 SAO2 96 Temp - 101.0 Pt needs ~~spinal~~ [redacted] wound and spine evaluated a.m tomorro by Dr [redacted] SPC [redacted] Pt would no drink Ensure. So I gave Pt Strabery and vanallia shake c̄ 7.25L of H2O. SPC [redacted] Pt states he has has PN while eating and rinking liquids other than water. Pt states PN is against abdominal wall. Pt states no previous surgerys or injurys to abdomin at any age before current injury — SPC [redacted]
2235	Pt awaken c̄ PN 650mg Tylenol, 50mg Bendryl PO given SPC [redacted]
2240	Levigan is to be on day shift. [redacted] LPN, SPC [redacted]
4/4/03 0900Z	- Gave Pt Levigan
4 Apr 03 0435 Z	Orders (1) Ensure 240 cc @ 3° (2) Insert NG for tube feeding (Dobhoff unavailable [redacted] HC, AN FNP

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

MD ORDERS
DO NOT WRITE NOTES HERE

(1) Ensure 1 cup Q 3° (locked ICU #2)
(2) Do NOT feed between 2100Z and 0300Z (Allow patient to sleep)
(3) If refuses Ensure then Restrain patient and drop Dobhoff and feed 250cc Ensure Q 3°

(b)(6)-2

4/5/03 ERCP
0710 (1) KUB f/m
flat/upright

(b)(6)-2

(b)(6)-2

4/8/03 @ 0445
(1) D/C Ceftriaxone P 10 days Dosf

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

(b)(6)-2

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY

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

4/8/03 @ 1500
Transfer to MICU #3

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

(b)(6)-2

MEDCOM - 4357

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
10 Apr 03	Medical Orders
0950Z	Rx (1) Acetiminophen 650mg to 1000mg PO Q 4-6 hours prn pain.
	(2) Ibuprofen 800mg PO Q 8° prn pain.
	(3) Tylenol #3 PO Q 4-6° prn pain only
	P trying Acetaminophen and/or Ibuprofen

Notes (b)(6)-2 0958 10 Apr 03

(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.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	MD ORDERS
	D/C to OPW Compounds. (b)(6)-2
	MD
	2) Rotrimin cream Apply to area BID
	Noted 18/16 27 AUG
	(b)(6)-2 (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.

(b)(6)-4

MD ORDERS

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

CLIN... ...RD

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. ____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 04	05	06	07	08
4APR03	------	Ensure 1 cup Q 3°	03			(b)(6)-2		
	------	If refuses then restrain	06					
	------	and use NSG (Dobhoff)	09					
	------	@ 250cc ensure Q 3°	12					
			15	26				
	------		18	26				
			21					

4APR03	------	Levaquin 500mg, Qd	09	1	(b)(6)-2			D/C

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE N (NON-MEDICATION)				
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLU IN FOLLOWING COMPLETION TIME/D COMPLETED
10Apr03	(b)(6)-2	Acetiminophen 650mg to	
		1000mg PO q 4-6hr	
		prn for pain	
10Apr03	(b)(6)-2	Ibuprofen 800mg	
		PO q 8hr prn pain	
16Apr03	(b)(6)-2	Tylenol #3 PO q4-6hr	
		prn pain only if	
		trying acetaminophen or	
		Ibuprofen	

Recurrent Medications and Treatments		date 23	24	25	26
Fentanyl 30mg IV Q6° x 4 days	1200				
	1800				
	2400				
	0600				
		31	32	33	34
Bid w/ D Dressing Δ	0800	(b)(6)-2			
	2000				
Nutrition Care for Ensure shakes					
Ambulate BID	0800				
	2000				
Vitals Q6 x 24hrs then BID	0800				
	1400				
	2000				
Vital signs	0200				
Q 4°	4	P T 130/100	ICU		100 105/58 P105
	8	94/48 130/60	ICU	100% P104 T 99.8 100/50	
	12	130/72	120/55 86% 124 T102.4	109/52 SAO2 98%	12 noon P-114 T 99.
	16	ICU	130/60 88% R22 P119 98°	124/80 84% 117 R20 97.7	
	20	ICU			P 72 T 98.3 124/82
	24	ICU	110/74 95% 110 16	122/76 100	
PRN Medications and Treatments					
Morphine 4mg x1 IV now Dr. (b)(6)-2	d/t				
	amt/int				
Morphine 2mg prn x1 Fentanyl IV Dr. (b)(6)-2	d/t				
	amt/int				
Benadryl 50mg IV x1 Dr. (b)(6)-2	d/t				
	amt/int				
Vicodin Tab / Hydrocodone	d/t				
	amt/int				
7.5 mg / Acetaminophen 500mg	d/t	31	32	33	34 35 36 37 38
	amt/int		OIMR	3mg	
MSO4 2-5mg IVP Q3°	d/t				
	amt/int				

Name: (b)(6)-4 (b)(6)-4

SSN:

Unit:

Dx:

All:

Blood type:

labs and cxr in am ☐

23 March 03

~~I & O of 24 March 03~~

IVF	Time	amount	Total		
~~TR NS @110 cc/hr~~					
Hourly Input and Output		IV		CT	UOP
	0100				
	0200				
	0300				
	0400				
	0500				
	0600			100	
	0700				
	0800				
8 hour totals				100	
	0900	~~500~~			500
	1000				
	1100				
	1200				
	1300				
	1400			275	
	1500				
	1600	800			250
8 hour totals		800		275	750
	1700				
	1800				
	1900				
	2000	ICU			
	2100				
	2200				
	2300				
	0000				
8 hour totals					
24 hour totals					

Total input:

Total output:

Balance:

27 Mar 03 0230 1000 cc NS

I + O 24 Mc 03

IVF	Time	amount	Total		
NS @110 cc/hr IC4					
NS @110 cc/hr 800 T @ 1100	1800	750	750		
NS @110 cc/hr 1800 T	02	900	1650		
NS @110 cc/hr 500 T @ 0630	0630				

25 March 03
Out 700 cc urine
0522
0949
700 cc
1412 800
26 March
1300 cc 0500
300 cc 2350

Hourly Input and Output		IV	NG	CT	UOP
	0100				
	0200				
	0300				
	0400				
	0500				
	0600				
	0700				
	0800				
8 hour totals					
	0900				
	1000				
	1100				
	1200				
	1300				
	1400				
	1500				
	1600				500
8 hour totals			Ø		500
	1700				
	1800				
	1900				
	2000		15		
	2100				300
	2200				
	2300				
	0000		5		
8 hour totals			20		800
24 hour totals			20	75	800
Total input:					
Total output:					
Balance:					

Recurrent Medications and Treatments		date			
Vital signs					
	4	S 79 BP 140/6 P 122 T 98.7 89			
	8				
	12				
	16				
	20				
	24				
PRN Medications and Treatments					
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				
	d/t amt/int				

Name: Dx:

SSN: All:

Unit: Blood type:

Recurrent Medications and Treatments		date 3/30	3/31	1	2	3	4	5
Tylenol #3			1700 x2 (b)(6)-2					
Vital signs								
2 apros Ambulated TID	4							
EAT - Ensure shakes	8							
	12							
	16							
	20							
	24							
PRN Medications and Treatments								
MSO4 2-5 mg IM q3°	d/t	1900 / 3/30	1530 3/31 (b)(6)-2					
	amt/int	4mg PO	4mg					
pain prn	d/t		1915 3/31 (b)(6)-2					
	amt/int		2mg					
	d/t amt/int							
	d/t amt/int							
	d/t amt/int							
	d/t amt/int							

Name: (b)(6)-4

SSN:

Unit:

Dx:

All:

Blood type:

(b)(6)-4

MEDICINE

0500 Cefotaxin 2g IVPB

~~1100 Cefotaxin 2g IVPB~~

MED

~~Zofran 0020 25mg~~

~~25mg~~

0020 Phenergan 25mg

I & O

2200	BASE LINE	Chest	150 cc
	Input LR@500 cc	NG	10 cc
		urine	300 cc
2400	150cc PLR	Chest	135cc
		NG	10cc
		urine	200cc
0200	150cc LR	Chest	125 cc 350
		NG	50cc
		urine	150 cc
0400	150cc LR	chest	70
		NG	30
		urine	200 cc
0600	150 NACL	chest	30
		NG	30
		urine	100
0800			
1000			
1200			
1400			

PAIN Management

1445	5 mg	MSO4 IVP
1700	5 mg	MSO4 IVP
1900	5 mg	MSO4 IVP
2230	6 mg	MSO4 IVP
0130	2 mg	MSO4 IVP

Progress NOTE

2200) Pt. resting c̄ HOB ↑ @ 45°, NG tube is in place. IV in (R) AC @ 150cc/o s̄ complications, (L) IV ~~DW~~ (L) wrist locked & patent. Foley secure, chest tube in place as per X-ray. Dressing remain CDI. Note Chest tube & NG tube @ continuous low suction (80 mm Hg.)

Zofran 0020
25mg/mL

Vital Signs

~~0200 111/57 BP SpO2 RR Pain~~

Time	BP	HR	SpO2	RR	Pain
2200	111/57	107	98	14	8
2300	116/63	110	99	14	sleep
2400	120/62	119	99	14	
0100	119/60	117	99	25	4
0200	124/61	119	98	18	
0300	122/61	115	100	22	
0400	112/55	121	100	11	
0500	114/62	127	100	11	
0600	118/62	133	96	19	
0700	113/61	117	100	23	
0800	110/60	116	100	9	sleep
0900	110/64	111	100	10	
1000				10	Sleep
1100					
1200					

(b)(6)-4

0500 Cefotan 2g IVPB

I & O	
2200 LR @ 500 cc BASELINE	urine @ 300 cc chest tube @ 150 cc
2400	
0200	
0400	
0600	
0800	

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. 04 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19	20	21	22	23	24	25	26	27	28	29	30	1
18APR03	(b)(6)-2	nurse initiated	07 19	(b)(6)-2													
		VS	19 07														
		Diet Regular + supplement	15										(b)(6)-2				
		c̄ Ensure	/														
18APR03		Dressing changes BID	10	(b)(6)-2													
		Wet to dry	22														
			/														
18APR03		Cimzulate BID	10	(b)(6)-2													
			22														
17APR		Lotrimin cream apply	10	/	/	/	/	/	/	/	/	/	/	(b)(6)-2			
	-----	to area BID	22	/	/	/	/	/	/	/	/	/	(b)(6)-2				

	-----	Remove	5/2/03														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/p GSW ABD (R) chest
s/p SPR / gastrostomy repair

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(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.

MEDCOM - 4369

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
18APR03	(b)(6)-2	Admit to minimal care ward				
	------	S/P GSW to (R) ant + (R) posterior chest; GSW to (L) abd → RLQ				
	------	Condition stable				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
18APR03	(b)(6)-2	Ibuprofen 800 mg po	D 18APR03 T 1945	20APR03 1325	21Apr03 1740	21APR03 0900	23 Apr 0220	24Apr 1300	27APR 0300	28 APR	29 APR 03	29 APR 330	30Apr 1710
		po Q 8 prn pain	(b)(6)-2				(b)(6)-2	(b)(6)-2	(b)(6)-2				
		Remember 5/2/03	1MAY 1700 (b)(6)-2				(b)(6)-2						

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

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. 5 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2	3	4	5
	(b)(6)-2						
18APR03		Nurse Initiated	07	(b)(6)-2			
		vital signs	19				
18APR03		Diet: Reg. + Supp.	15				
		w/ Ensure	/				
18APR03		Dressing change BID	10				
		WET-DRY	22				
18APR03		Ambulate BID	15	(b)(6)-2			
			22				
27APR03		Lotrimin cream apply	10				
		to area BID	22				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW ABD/R chest
S/P SBR

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

BED # (b)(6)-4

pt # (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 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

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
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
6/8/[illegible]	.....	Ibuprofen 800 mg po														
.....	.....	Q 8 hr PRN pain														
.....	.....															
.....	.....															
.....	.....															
.....	.....															
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USAPA V1.00