LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	pulse. Pt able to wiggle toes. lungs CTA. B(+)x4. Will continue to monitor - [redacted] 91WM6
1930	Pt sleeping, easily aroused. VSS, lungs CTAB HRRR, (+)BS, Ø complaints @ this time. (R) leg drsg D/I. (+) pedal pulses. Pt can move toes. LR @ 125cc/hr into (L) AC 5 risk infection or infiltration. Will monitor [redacted] 91WM6.
24 Sep 2355	abx given. pt voiding clr via urinal. Ø distress noted. (L) leg elevated. Will mon [redacted] 91WM6.
24 Sep (0200)	Received pt resting in bed, VSS, Ø acute distress noted @ this time. Sleeping intermittently but easily awakened. (L) LE drsg [redacted] C/D/I (+) pulse, pt able to wiggle toes. (+) cap refill. LR @ 125cc/hr via (L) ac access infusing w/o apparent complication. Pt has (L) LE ↑, but will "kick" blankets for elevation away. Pt also needs assist. to be OOB. VUS: clr red yellow urine. Will cont to monitor [redacted]
24 Sep (1950)	Pt a/o, VSS, Ø c/o pain, (L) LE drsg CDI, (+) distal pulses, able to move toes. IV HL to (L) AC (-) edema (-) redness. pt does not want to get OOB. voiding mod. yellow urine via urinal. TOL reg diet well. Ø N/V/D. LCTAB, HRRR (+)BS x4 qd. Will monitor - [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24 Sep 03 KD	Orthos Discharge Note [redacted] (b)(2)-2
	Originally in hotel bombing 22 Sep 03. Wound over fibula (R) tibia. Xrs OK. I&D, irrigated & debrided. Small fracture in tibial cortex otherwise fracture stable. Wound repaired clean and dry. Penrose drain removed today. PLB: Crutches for comfort. Weight bear as tolerated. Keflex 250 mg P.O. QID x 10 days. T#3, 1-2 PO. Q 4-6 hrs PRN #20. Sutures out in 7 days.
	[redacted] (b)(6)-2
	CDR MC

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 Sep 03 0709	Pt sleep. Awakens easily. Oriented. NAD Lungs CTA Abd. soft nontender c̄ (+)BS x 4 quads. LLE drsg c̄ Ace Wrap C.D.I. Pedal pulses strong. Brisk capillary refill. Moves toes c̄ difficulty. Heplock patent. Ancef one Gram infusing. Pt denies pain/discomfort @ this time. Preparing for AM Care & breakfast. [redacted]
25 Sept 03 0712	Will continue monitoring. [redacted] sending D/C today. [redacted]
25 Sep 03 1000	Pt ambulating well in room. No complaints offered. Pt refused breakfast. [redacted]
25 Sep 03 ~~1430~~ 1630	Pt A&O. NAD. D/C per md order. Escorted to [redacted] PAD.
26 Sep 03	Pt A+O x3 ~~w~~ c/o pain or discomfort. OK for discharge this morning. DC medication @ bedside ambulates well c̄ crutches. Escorted to PAD c̄ chart and interpreter to ensure pt. gets home. [redacted]

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

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

REGISTER NO. | WARD NO.

Civ [redacted] (5)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25Sep03	1930: VSS, A+O, c/o pain, crutch walks OOB WBAT c̄ difficulty, (R)LE wrapped in Dsg c̄ Ace, neurovascularly intact c̄ 2+ pedal pulse, CRT<3secs & (+) sensation + movement of (L) toes. (R)LE elevated when in bed. Pt has D/C meds @ BS, pending D/C at next soonest possible time. Will monitor. [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE	AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
22 Sept 03 1406	Author Op Note: [redacted] (b)(2)-2
	Pre Op Dx: Open (L) tibia fx
	Post Op Dx: Same
	Procedure: I+D (L) tibia with wound closure
	Surgeon: [redacted] (b)(6)-2
	GBL: [redacted] MRSI: [redacted]
	PLVISL:
	Findings: Grade II open fx, with small 3x3 mm puncture of anterior of tibia. Curetted, irrigated & debrided wound closed primarily in layers over penrose drain
	PLAN: Dressing change in 2 days. Pull drain after IV Ancef x 72 hours; then oral keflex
	[redacted] (b)(6)-2

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

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

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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER [redacted]
		RECORDS MAINTAINED AT (b)(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 22 Sep 05 | TIME 960

TRANSPORTATION TO FACILITY

SEX: M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

AGE: 32

HOME PHONE: AREA CODE | NUMBER

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

THIRD PARTY INSURANCE ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: PO Denies

ALLERGIES: PO Denies

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☒ YES ☐ NO

CHIEF COMPLAINT: Exert injury

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME

INITIALS: (b)(6)-2

VITAL SIGNS

TIME	956	0930			
BP	120/69	120/80			
PULSE	101	105			
RESP	16				
TEMP	99.5				
WT					

LAB ORDERS

✓ CBC/DIFF [redacted]	ABG	✓ PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		CHEM:
BLOOD C&S X			
✓ met 8 met 12 0910 pm			
Type & Screen 0910 pm			

X-RAY ORDERS

	CXR PA & LAT/PORTABLE		C-SPINE
	ACUTE ABDOMEN		LS SPINE
	SINUS		HEAD CT
	ANKLE R/L	X	tib/fib (2)

ORDERS (b)(6)-2

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	TIME	PATIENT'S RESPONSE
910	Ketoro Irrigation	[redacted]	0924	
925	1g Ancef	[redacted]	0920	

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATE

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER

TEST RESULTS

CBC		SMAC										
	WBC					ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐		
	H/H					SUP 02	PH	PO2	RESULTS			
	PLT					PCO2	SAT	OTHER				
PT						U/A	DIP		EKG INTERPRETATION			
APTT		BHCG	ETOH	GLU			MICRO					

PROVIDER HISTORY/PHYSICAL

see HP admission form by COL [redacted] (b)(6)-2

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
			PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

510-112

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
09/22/03	0900		32 y/o ♂ presented in ED c/o pain to (L) t/b/fib area, pt states he heard a large explosion and something hit his (L) lower tibial area. pt reports PMHX (-) Clear all fields skin warm dry (+) Neuro motor & sensory, Bloods drawn, ortho consult done Dr [redacted] pt vitals assessed, pt given tetanus [redacted] Xray on (L) t/b fib done [redacted]
	1007		pt [redacted] to ICU Sgt [redacted]

(b)(6)-2

(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.

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 32 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): 3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:

I+D left leg

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications:
Jewelry removed: yes/no Family waiting: yes/no

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; ~~family separation~~; surgical environment	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

#[redacted] (b)(6)-4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ___ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; ~~shock; previous surgery~~	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ___ Potential impairment of mobility due to sedation; pain; injury E.2. ___ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ___ Diminished visual perception due to being injury; sedation; F.2. ___ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures. none	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from either side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CPT MN 22 Sept 03 DATE

11. POSTOPERATIVE [redacted]ION:

Brie Site: intact
Drsg: clean
Breathing: ⊘ SOB

(b)(6)-2

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) Maj [redacted]

DATE: 22 Sept 03 TIME: 1810

13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted]

DATE: 22 Sept 03 TIME: 1915

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD — **INTRAOPERATIVE** [redacted]**MENT**

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

1. PATIENT TRANSPORTED TO OPERAT[redacted]OOM VIA Litter B[redacted]

2. PATIENT IDEN[redacted] RECORD REVIEWED AND PROCEDURE VERIFIED B[redacted] MAJAN

3. DATE 22 Sept 03 TIME PATIENT ARRIVED IN SUITE 1815

4. PATIENT IN ROOM TIME 1816 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA

(b)(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	CPT [redacted] (1845 - EOC)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: arms on armboards <90° bilaterally

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO

DONE BY: ☒ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: Ø Knicks or Cuts

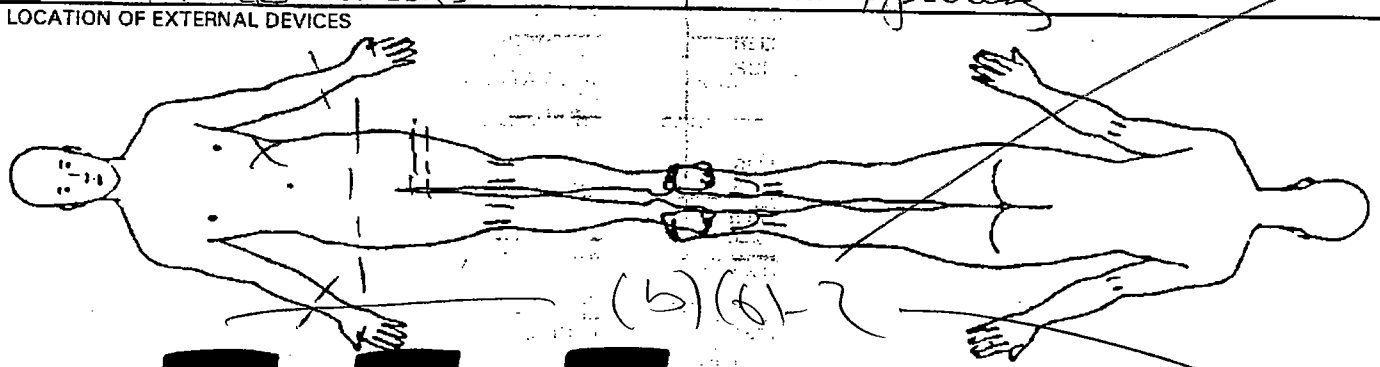
PREP SOLUTION *(Specify)* Betadine / Betadine

SITE: Left leg BY WHOM: MAJ [redacted]

SITE: BY WHOM:

COMMENTS: Ø pooling

9. LOCATION OF EXTERNAL DEVICES



(b)(6)-2

LEGEND X G[redacted] – S[redacted] = [redacted]iquet

C = Correct I = Incorre[redacted] Initial [redacted]

10. COUNTS

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

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

[redacted] (b)(6)-2

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

Cut 30 coag 30

☒ ESU NO: Valleylab Force 40

GROUND PAD: BRAND Valleylab Rem Polyhesive

LOT NO: 70011

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): NS

OTHER ORDERS None

	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 3/8 in Penrose	2.	3.
SITE	1. Ocaez	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Ace wrap
Kerlix
fluffs

19. ADDITIONAL INFORMATION

WCI

Surgeon: [redacted]

Anesthesia: [redacted]

pre-op: Bowie site and Tourniquet site intact.

20. OPERATION(S) PERFORMED

I + D (L) leg (b)(6)-2

21. PATIENT TRANSFERRED TO PACU | TIME 1 set DA7329 | METHOD Litter

[redacted] MAJ AN [redacted] CPT IAN

REVISED OF DA FORM 5179-1, OCT 87

USAPA V1.00

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 22 Sept, 23 Sept, 24 Sept, 25 Sept

19 | HOUR

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

105° 40.6°
180 104° 40.0°
170 103° 39.4°
160 102° 38.9°
150 101° 38.3°
140 100° 37.8°
130 99° 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

BLOOD PRESSURE: 105/68; 107/58; 105/58; 112/64; 114/64

HEIGHT: | WEIGHT

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (5)(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 — ANESTHESIA

DRUG	(Units)	
Fentanyl	(50µ)	150 80
Norcuron	(1/1)	2
VOLAT AGENT	Forane % del / % e.t.	F25-2-15-4
AIR	L/Min	
N2O	L/Min	
O2	3 L/Min	

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

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

FLUIDS: LINE site — NS-850 — Warmed / Warmed / Warmed / Warmed

LOSSES: EST BLOOD LOSS — URINE –

PHYS STATUS: 1 2/3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP – 124/72 HR – 115-95%

COMP CHECK: OK? – Y N

PATIENT RECHECK: OK for PROCEDURE? TIME –

TIME → 1800 15 30 45 1900 15 30 45

SYMBOLS: BP by cuff V ^ ; 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		16 12 10
Peak inf pres / PEEP		
MODE – S(pon) A(ssist) C(on)		A A S
✓ BP/Auto Cuff	✓ ET-CO2 (torr)	38
BP / oth	✓ FIO2 (Frac or %)	65%
ART line	✓ SpO2 (%)	100 100
Steth- PC/ES	✓ ECG	ST SR
✓ Gas analyzer	TEMP- site	
	N-M Block (T/4)	
Warming blkt		
Conv warmer		

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (1) (2) (3) (4) (5)

TOTALS — TOTAL FLUID: 815cc — TOTAL URINE

FLUIDS - SUMMARY: CRYSTALLOID – 250cc — COLLOID – — BLOOD – 0

REMARKS – Code drugs with numbers, events with letters

(1) V/S Taken
(2) Induced c Lidocaine 20mg Diprivan 140mg Anectine 80mg O2 Forane
(3) Procedure begin.
(4) Procedure ended
(5) O2, breathing To recovery

RECOVERY AT: PACU ICU _____ (Specify) OTHER _____

CONDITION: RESP – 11 SpO2 – 99 BP – 88/33 HR – 74

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1805	1816	1912
PROC	Ready 1830	Begin 1834	End 1902

PROCEDURES and CPT Codes: Washing – Debridement (2) leg wound; c closure

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: MASK

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: 90mg [redacted]

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

[redacted]

(b)(6)-4

SURGEONS:

ANESTHETIST: [redacted] (b)(6)-2

PROCEDURE LOCATION

DATE: 22 Sep '03

PAGE 1 OF

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 20254

ANESTHESIA PLAN OF CARE PRE CEDURAL ASSESSMENT (Sedation/Ar sia)

Age 3 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: I&D L leg open (R) tib Fx 2° Blast inj
SURGICAL SERVICE: ortho [redacted]
NPO SINCE: (b)(6)-2

A Physical State 1 2 3 4 5 E
WT: 20 KG/LB HT: ____ IN.
ALLERGIES: Ø

HABITS:
TOBACCO: ____
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) 0715 Ancef
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

PREMEDICATIONS:
None Yes (@ ____ Hrs) /CC
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: ____/____
U/A: ____
OTHER: ____

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION
BP 105/68 HR 64 R 16 T 98.1 98%
Pain Scale 0-10 ____
HEENT - Teeth WNL
Trachea ____
TMJ/Neck Mod I
Oropharnyx 3 FB M-II
Nares Edema
CHEST: RR. BS CTA
CARDIAC: RRR w/m
EXTREMITIES:
IV Access: (L) PIV ✓
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since 0700 AFR Breakfast

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (X) General: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

The patient/legal guardian (b)(6)-2 seems to understand and agrees. Questions answered.
Signed: [redacted] Date: 9.22.03 Time: 1145 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) I&D L leg ICW 2 Rm 10
[redacted] (b)(6)-4
[redacted]

SEDATION KEY:
1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may be necessary.
4. ANESTHESIA. Patient does not respond to painful stimulation.

MEDICAL RECORD - DOCTOR'S ORD.

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
Tu	POST ANESTHESIA ORDERS (circled Items) 9/22/03	1925	
~~1~~	~~VS q 5 min X 15 min, then q 15 min~~ until discharge.		
2	Supplemental ~~oxygen.~~		
3	Morphine / Meperidine ____ mg IV now and ____ mg q 3-5 min prn pain for a		
	max dose of ____ mg.		
4	Zofran ____ ~~mg IV prn N/V q 15 min, may repeat~~ x ____.		
5	~~Metoclopramide~~ ____ ~~mg IV prn~~ N/V x 1.		
~~6~~	~~Droperidol~~ ____ mg IV prn ~~N/V x 1.~~		
7	Phenergan 12.5-25 mg IV prn N/V x 1.		
~~8~~	~~Benadryl 25-50mg IVP q1 hr prn, itching while in~~ PACU.		
~~9~~	~~IVF: ____ @ ____ cc/hr.~~		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] / STASS, CDR, CRNA		
	(b)(6)-2		

PATIENT IDENTIFICATION

[redacted] (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.
PACU, 28th CSH			1 of 1

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 22 SEPT 03 TIME OF ORDER: 0945 HOURS

LIST TIME ORDER NOTED AND SIGN

1. BD REST TO ICW-1
2. Rx - OPEN (L) TIBIA FX
3. CONTINUE STRICT
4. VS - MONITOR
5. BED REST
6. TO OR. TODAY

PATIENT IDENTIFICATION

Noted [redacted] 22SEP03 1025

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER:

7. NPO HOURS
8. MSO4 2-8mg IVP Q 1 HR PRN

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 22 SEPT 03 TIME OF ORDER: 1900 HOURS

1. TO ICW-1
2. S/P I&D (L) OPEN TIBIA FX
3. CONTINUE STRICT
4. VS - MONITOR
5. VP 6D 2D3, WBAT
6. GENTLE (L) LEG
7. REGULAR DIET

(b)(6)-2

PATIENT IDENTIFICATION

Noted [redacted]

8. N LR at 125cc/hr. DO LOCK WITH TUBE P.O.
9. TYLENOL 650mg P.O. Q 4 HRS PRN
10. PERCOCET, 1-2 P.O. Q 4-6 HRS PRN
11. MSO4 - 2-8mg IVP Q 1 HR PRN
12. BECLOT + GRAN IVPB Q 8 HRS.

NURSING UNIT | ROOM NO. | BED NO.

24P | 2145 | 208[redacted]

[redacted]

DA FORM 1 APR 79 4256 REPLACE[redacted]F 1 JUL 77, WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

Noted [redacted]

NURSING UNIT | ROOM NO. | BED NO.

[redacted] 1450 135

PAT[redacted]ICATION 25Sep2000 [redacted]

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	24 SEP 03	1630 HOURS	
1	REGULAR DIET		
2	DISCHARGE TOMORROW		
3	KEFLEX 250mg P.O. Q 10x10 DAYS		
4	P.T. FOR GRADED AMBULATION, WBC		
5	SUTURES OUT IN 7 DAYS		
6	T3, 1-2 P.O. Q 4-6 HRS [redacted]		LD

DATE OF ORDER | TIME OF ORDER ____ HOURS

(b)(6)-2

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.

CLINICAL RECORD

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

Mo. ____ *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 22	23	24	25	26	27	28	29
22 Sep 03	[redacted]	VS routine	06	[redacted]							
			18								
22	[redacted]	Bed rest	06			D/C'd					
			18	X							
22	[redacted]	~~NPO~~ KAS	06			D/C'd					
			18								
22	[redacted]	ACT: up ad lib, WBAT	6	X	[redacted]						
			18								
22	[redacted]	Elevate (L) leg	6	X	[redacted]						
			18								
22	[redacted]	Regular diet	6	X	[redacted]						
			18								

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: OPEN (R) TIBIA FX / S/P I+D

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
22 SEP03	[redacted]	Admit to ICW #1 - Cond. - stable	22 SEP03	—	—	[redacted]	
22	[redacted]	To OR today	22				
22	[redacted]	To ICW-1, stable					
24 SEP03	[redacted]	D/C tomorrow	25 SEP03				
24	[redacted]	PT for crutches/ambulation WBAT					
24	[redacted]	Sutures out in 7 days	24	NOTED		[redacted]	

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

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

USAPA V1.00

DATE	TIME	MEDICATIONS, TREATMENTS, DIETS, ASSESSMENTS	22 23 24 25 26 27 28 29
22	48	LR @ 125cc/hr HL when taking PO	6 X [redacted] 18 [redacted] X
22	4pm	Ancef + gm IVPB Q8°	8 X [redacted] 16 X [redacted] 2 [redacted]
24	BR	Keflex 250mg PO QD x 10 days	10 X X X ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ X

(b)(6)-2

D/C'd

D/C'd (disch. med)

OPEN @ TIBIA FX / S/P I+D

#[redacted]

(b)(6)-7

Verify by Initials | Date | Time | PHYSICIAN'S ORDERS (Approved Drugs) | No. 09 of 03

Date Time Order Written	Date Time	SINGLE ORDER PER LINE	Order Taken By (Signature)	Order Given By (Signature)		
24 Sep03	[redacted]	DIC meds: Keflex 250mg po QID x 10 days T3 1-2 po q4-6° prn				

(b)(6)-2

Date Time Order Written	Date Time	PRN MEDICATIONS, CARE, PROCEDURES	OTHER PROPER COURSE FOLLOWING ADMINISTRATION VALID DATE DISPENSED	
22 Sep03	[redacted]	MSO4 2-8mg IVP q1° prn	D/T 22Sep 1605	
			D/L 6mg VAS	
22	[redacted]	Tylenol 650mg po q4° prn	D/T	
			D/I	
22	[redacted]	Percocet 1-2 po q4-6° prn	D/T	
			D/I	
24 Sep	[redacted]	Tylenol #3 1-2 po q4°-6° prn.	D/I	(Discharge med)
			D/T	

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 22 Sept
Time In: 915
Allergies: NKDA
Pre-op V/S: 124/76 115
Procedures: I/D L Ankle

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

OR Intake: Crystalloid 250 Colloid 0
OR Output: UOP 0 EBL <150cc
Meds/Times: Fentanyl

[redacted] (b)(6)-2

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds / History

Time	915	920	925	930	935	940
SaO2	99	98	98	100	100	100
FiO2						
Methods	RA	RA	RA	RA	RA	RA
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	13	10	12	11	15	10
T	96.4					

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	Infused
2000	NS	—	[redacted]	2000

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

(b)(6)-2

PREPARED BY (Signature & Title): [redacted] 67 A

DEPARTMENT/SERVICE/CLINIC: PACU / ICU #2

DATE: 22 Sep 03

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

[redacted] (b)(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1935		Phenergan 12.5mg	IVP			[redacted]
					(b)(6)-2	

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) leg	+	+	P	B	C	P
15'	(L) leg	+	+	P	B	C	Pk
30'							
45'							
60'							
90'							
D/C	(L) leg	+	+	P	B	C	Pk

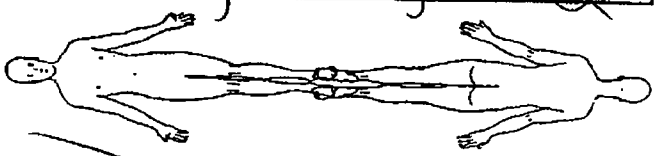
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	bulky	Ø
30'	(L) leg	bulky	Ø
60'			
D/C	(L) leg	bulky	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1945	NSR	No	No

NURSING NOTES

1915 Recv'd pt from OR, pt had oral airway. NS infusing into (L) AC. pt able to follow commands. O2 Sats 99-100%, SGT [redacted] 2025 pt transferred to ICW1 in Stable Cond. VSS SGT [redacted]

(b)(6)-2

Discharge Criteria:
Date: 9.22.03 Time: 2025 PARS: 9
BP: 117/59 T: 97° HR: 64 RR: 10 Sa02: 100
Pain Level at D/C (0-10):
Intake: 600 Output: Ø
Additional Data:
Transferred To: ICW2
Report Given To: SGT [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: (b)(6)-2
Cleared IAW Recovery Room SOP
Charge Nurse Signature: [redacted]

WAMC OP 173-E

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A I I D I	I Z (State or Country Code.)		[redacted]		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
U N K	3 2 Y	Z	9	UNK

(b)(6)-4

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	—	9 9	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	Z	0900	—

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 9	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	
		1		☒ NO

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

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

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A E A A		0 3 0 9 2 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

DX: OPEN (L) TIB FIB Fx

DX 82390
E993
Proc 7966
Trauma 9
Inj 999

ADMITTING OFFI[redacted]

(b)(6)-2

SIGNATURE [redacted]

DA FORM 3985 MAR 89

MEDCOM - 20265

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) UNK - NAME# [redacted]			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 32y	6. RACE X	7. RELIGION MUSLIM	8. LENGTH OF SVC (b)(6)-4	9. ETS	10. PREVIOUS ADMISSION NO
11. FMP 99	12. SSN [redacted]		13. ORGANIZATION			14. WARD ICW2
15. FLYING STATUS	16. OSG	17. DEPT BEN K78	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct From ER	22. HOURS OF ADMISSION: 1900	23. CLINIC SERVICE: Gen Surg.	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION: D/C TO CAMP	26. DATE OF DISPOSITION: ~~27 Sep 2003~~	01 oct 2003
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION: 23 Sep 2003	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]		30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. [redacted] ADMINISTRATIVE DATA

(b)(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: S/P EX LAP GSW TO ABD

Dx
873.40
879.2
881.10
E991.2
E.991.9

Px
23.19
24.5
86.59
54.11
93.54
88.24
99.04

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
0	0	0	0	4	4

36. Total Days All Facilities

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	[redacted]	0	0	4	4

SIGNATURE OF ATTENDING MEDICAL OFFICER

DR [redacted]

DD FORM 3647, MAY [redacted]

MEDCOM - 20266

(b)(6)-2

USAPPC V1.

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23Sept03 1645	ORTHO consult - Intra-op.
	1 32 male Iraqi EPW GSW Face, Abd, shrapnel to (R) Forearm. Consult was intra-op, so no preop NV exam is available. Pt is recently S/P ex Lab for GSW abdomen and facial soft tissue repair pending.
*	exam (R) LE.
	multiple shrapnel entrance wounds volar forearm all less than 1cm Φ. no gross deformity or crepitus noted. FROM wrist/Elbow. easily palpable radial pulse. hand well perfused. (-) Allen test.
	XRAYS - previous hardware (plate) Radial diaphysis Φ acute Fx. Soft tissue shrapnel only Φ intra-artic shrapnel. Compartments soft and compressible.
A/P	Soft tissues peppered c̄ shrapnel.
-	Applied volar splint p̄ surgical scrub to forearm
-	Abx for skin flora x 48. (b)(6)-2
-	will want to follow with you
-	reinforce dressing pr. [redacted] update

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

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	OMFS Brief OP NOTE
23 Sep 03 @1900	Pre OP dx: GSW to face
	Post op dx: Same
	Procedure: I&D of lower anterior teeth, alveoloplasty and irrigation and closure of facial wounds
	Surgeon: [redacted] (b)(6)-2
	Anesth: NETA
	finding: Shattered anterior mandibular teeth, avulsed lower left commissure
	EBL: 250cc
	U/O: 1700cc
	fluids: 3300LR 2u PRBC 1000cc Hespan
	Comp: Ø
	Cond: Stable, remained intubated & transferred to ICU 2 Serent on standard monitors.
	(b)(6)-2 [redacted] MPU/DOC

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

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

#[redacted] (b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24 Sept 03 0840	OR#40 HD# 1 intubated / sedated. (R) UE Splinted. ∅ active bleeding Fingers well perfused. - Soft tissue swelling (R) Forearm. ∅ Fx - May remove splint in 1-2 days. local wound care - will sign off. contact me c̄ questions. [redacted]
24 SEP 03 (0845hrs)	Assumed care of patient @ 0615hrs. See DA Form 4700 "Intensive Care Nursing Flow Sheet" for initial shift assessment info. Pt. currently sedated & relaxed. Will continue c̄ current plan of care and monitor accordingly. [redacted] (b)(6)-2
24 Sept 03 0900	POD#1 s/p Exp Lap. gsw to abd. VSS u.o. good Vent SIMV 10/800/5/40% abd sept [redacted] CDR

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST (b)(6)-2	FIRST [redacted]	NUMBER
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

EPW

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24 Sept 03	cont
	10.0 / 13.6 / 218 / 42.2 — 141 / 3.8 — 1 — 1 Ca++ 1.1
	7.36 / 38 / 93 / 21 / 97%
	Doing well.
	cont NGT til passes gas from below
	Vent management up to Dr [redacted]
	[redacted]
24 Sep 03 (1000 hrs)	Patient relaxed/comfortable. Sedation regimen of Versed/Fentanyl effective. SaO_2 remains > 98% on FiO_2 @ 40% via ventilator. Vent settings remain: SIMV-10, PEEP-5, TV-800ml. N/G remains patent through (R) nare collecting gastric drainage via LIS. Cardiovascular remains unremarkable, as well as GI/GU. (R) hand c̄ ace wrap dressing C,D,I. Edema to (R) UE unchanged @ 1+. Capillary refill still < 3 secs. All lines are currently patent & intact. Received a.m. care, reapplied bacitracin ointment to [redacted] will continue c̄ present plan of care. [redacted]
24 SEP 03 (1030 hrs)	Sedation (Versed/Fentanyl) now off to start vent weaning. 7.5mm nasal/tracheal tube, suction catheter (14 fr), O_2 mask and syringe @ the bedside in preparation for extubation per order of Dr [redacted]. R.T. (SGT [redacted]) informed of weaning initiation. Monitor accordingly until ready for extubation. [redacted]
24 SEP 03 (1235 hrs)	Patient alert c̄ eyes open. MAE c̄ limitations to (R) UE D/T restraints. Understands plan to extubate from vent & is ready. Dr [redacted] @ bedside along c̄ R.T. (SGT [redacted]). Nasal/tracheal tube cuff deflated c̄ 10cc syringe. Suction on @ bedside c̄ Yankauer. Tube removed from (R) nare. Encouraged to cough, but did not. (+) bloody drainage from (L) nare. Suction applied to clear nare. SaO_2 > 96% c̄ 7L O_2 via NRB. Tolerated extubation well c̄ no respiratory compromise. Currently resting comfortably in bed c̄ no acute distress. Plan to monitor SaO_2 post extubation, maintain N/G to LIS and pain management. [redacted]

STANDARD [redacted] USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
(24 SEP 03) 1535hrs	Patient continuing to do well post-extubation; now 3hrs ago. SaO_2 99% via O_2 FE MASK. c/o abd discomfort x 1 briefly, but went back to sleep. Resting comfortably now ō indications of discomfort. Will request IV analgesic for mild/moderate discomfort. — [redacted]
24 Sep 03 (1840hrs)	Post-extubation blood draw for ABG. Await results and provide for Dis [redacted]
(1800hrs)	ABG results: PH - 7.36, PCO_2 - 44.7, PO_2 - 100, HCO_3 - 26, BE - Ø. Remains on FE via mask c̄ SaO_2 @ 99%. Resting ō respiratory distress or abd discomfort. — [redacted]
24 SEPT 03 2017	S/p extubation pt. tolerating 5 FM well sats @ 98%. Pt. from Post-Care to transfer. Issue: personal effects c̄ IRAQI PRICE and [illegible] (R) arm. Dr to be consult for [redacted]
24 Sep 03 2030	Rec'd pt from previous nurse. Alert & active. Communicating via interpreter. Oriented ~~to surroundings~~ error in conversation. Respiration even and unlabored. O_2 via FM c̄ NL ō SpO2 97%. No c/o pain c̄ present. VSS. (R) hand c̄ ace bandage. No drainage. At resting ō any distress noted. Will cont. to monitor - Angel Weston
25 Sep 03 0500	At resting comfortably. Assisting c̄ turning. Pm care due. O_2 via FM 4L. NGT LWS. No changes in status. VSS. No distress noted throughout night — [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] EPW

(b)(6)-7

REGISTER NO.	WARD NO.

PROGRESS NOTES
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	OMFS POD #2 Ancef #3
25 Sep 03 @0800	Pt lying in bed asking questions about his injury c̄ NGT in place doing well. Oral & skin facial wounds healing well and closed 1° c̄ no active bleeding. CN III intact. (+) Paresthesia 1/3 lower left lip area.
	VS: BP 132/78 P 109 SO_2 97 RA T 97
	CV RRR
	Lungs CTA (B)
	Abd ⊕ BS heard
	ext: (R) arm dressing in place ⊕ c/c/E
	A/P S/P GSW to face + abdomen
	(1) will clamp + D/C NGT per Gen Sx
	(2) continue bacitracin to face
	(3) oral care today [redacted] (b)(6)-2

wounds

paresthesia

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] PW (b)(6)-4		

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 Sept 03	Gen Surg
0830	POD #2
	Doing well
	extubated yesterday
	HR 84 BP 119/70 96% on 4L O_2 n.c.
	NGT output 300/24°
	will clamp for 8° then pull if ↓ nausea or vomiting
	OOB → chair
	d/c foley
	will evaluate for transfer to floor this pm [redacted]
25 SEP 03 (0930hrs)	Assumed care of pt @ 0615hrs ~~p~~ receiving Δ-of-shift report. Initial c/o lower abd discomfort unrelieved by bed repositioning. Given 3mg MSO4 IVP for moderate, which resulted in ↓ discomfort and visual relaxation / sleep ~~s~~ further c/o pain. (done @ 0645hrs). See DA Form 4700 "Intensive Care Nursing Flow Sheet" for initial shift assessment info. Received order from Dr [redacted] to clamp NG x 8°, followed by D/C'ing if ~~o~~ nausea / vomiting (order carried out @ 0730hrs). Foley cath D/C'd as ordered. Explained procedure to patient, as well as importance of voiding in the next 6-8hrs. Verbalized understanding through translator. Plan today to ↑ in chair, wean ↓ O_2 (currently 2L via NC [redacted] SaO_2 > 95%. possible D/C NG ~~p~~ 8° re-eval and then clear liquids. [redacted]
25 Sep 03 (1000hrs)	Patient ~~c~~ spontaneous void into urinal (100cc). No c/o discomfort during void. Verbalized void complete. Will continue to monitor urine out, post foley cath, and ~~abd~~ potential for abd distent[redacted]
25 Sep 03 (1130hrs)	Pt ~~c~~ c/o lower abd discomfort. Assessment shows no Δ in GI status since Δ of shift. ~~o~~ nausea / ~~o~~ vomiting @ this time. Given MSO4 3mg IVP for abd pain. Will monitor for aff[redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
25 Sep 03 (1420hrs)	Pt doing very well this afternoon. Continues to tolerate clamped N/G tube, as well as voiding spontaneously w/ discomfort. SAO2 >95% w/ 2l O2 NC. Remains in NSR, lungs CTA all lobes w/ RRR. No Δ in care this afternoon w/ plan to still get OOB — [redacted]
25 Sep 03 (1730hrs)	Pt remained w/o c/o nausea or vomiting episode. Abd unchanged from start of shift. N/G clamped @ 1530hrs. Tolerated w/o emesis or respiratory compromise. Oral care completed w/ swish and suction. Cepacol mouth wash. Tolerating po fluids (water) w/o problem as long as he drinks from (R) side of mouth through a straw. OOB in chair @ 1630hrs. Tolerated very well w/o ↓ SAO2, although remains on O2 @ 2l NC. Noted serosanguinous drainage from underneath bottom of abd incision dsg. Reinforced w/ ABD pad for extra absorbance. H&H drawn and sent to lab; awaiting results. Finally, received order for Chest PT. Will start this evening by unit. Plan: remain up in chair for awhile longer, give clear liquid diet, monitor SAO2 w/ Chest PT [redacted] as well drainage from abd incision. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] EPW
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PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
26Sep03 0630	Assumed care of pt resting comfortably in bed. Denies discomfort at present time. See SA 4700 for initial assessment [redacted]
26 Sept 03 0907	gen surg Dominick on 2l O_2 now Sat 98% HR 72 BP 111/62 labs pend. nutrition consult transfer to floor [redacted]
0915	SA gives Nebs 2mg IVP for c/o abdominal discomfort SA to be transferred to ICW1 [redacted] CPT ho

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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] (b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
26 Sep 03 1000	Nursing: Assumed care of pt. transfer from IC #2 per wheelchair. Dx. s/p exp. lap and facial repair. Dressing to abdomin reenforced. Ø post op dressing Δ order. Minimal bleeding noticed to dressing. Facial laceration @ corner of mouth to cheek approx. 4 inches sutures intact bacitracin applied TID. VSS afebrile Active BS x4 quads Ø BM noted. Tolerating CL diet advance as tolerated. Nutrition consult pending. Lungs CTA. HCKR suction @ BS. Will continue to monitor [redacted]
26 Sep @ 2145	Assumed care of pt @ 1800. Pt Adult, speaking arabic. LS CTA, IS encouraged. (+) BS tolerated smamt of regular diet. (R) cheek and gum c̄ sutures, CDI, bacitracin applied. ML abd incision c̄ drsg c̄ marked drainage noted. Percocet given for pain c̄ good relief noted. (R) IJ Triple lumen c̄ IVFS, all ports flush well, drsg to be Δ'd tomorrow. 2 pt restraint on s̄ s/sx of skin or circulation compromise. HOB T 30°. (R) FA/hand in splint, wrapped in Kerlix CDI. (+) CMS to (R) hand. Plan: encourage CDB, monitor pain control, will monitor [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S [redacted]
	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)*

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PROGRESS NOTES
Medical Record

[redacted] (b)(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27Sep03	Gen Surg Aft VBS "½ roof of hard palate irritated not eating well just start Ensure trial cont IVF until taking po better [redacted] (b)(6)-4

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

OMS POD#4

27 Sep 03 @ 1508

Pt lying in bed & c/o pain this pm. Pt not tolerating PO diet well. most likely 2° to recent extractions and oral wounds. Oral wounds healing well c̄ no s/s of infx. skin sutures in place and wounds closed 1° c̄ no s/s of infx. left commissure area granulating in. bacitracin on all external wounds.

2

VSS, AF

CV RRR

lungs CTA (B)

Abd: midline staples in place

Ext: (R) forearm dressing in place

A/P s/p GSW to face

① nutrition consult submitted

② will D/C skin sutures in 2-4 days.

(b)(6)-2 [redacted] MAJ TOC

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
[redacted] (b)(6)-4		

PROGRESS NOTES
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USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
29 Sep 03	OMS PDD #6
@1600	Pt healing c (L) commissure granulating in. Skin sutures in place and chin wound closed 1°. intra oral wounds healing well. defect present (L) commissure.
	removed Prolene sutures c̄ difficulty replaced bacitracin.
	plan for D/C to Prison hospital on 1st of OCT 03.
	[redacted] (b)(6)-2
	MAJ Roe

STANDARD FORM 509 (REV. 5/1998) BACK

USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9/28/03	(Cont) Medicated c̄ one percocet p.o. for c/o facial pain. Will monitor for effect. Will assist c̄ ambulation in halls for exercise. — [redacted]
9/28/03 1500	Sleeping. NAD. Will continue [redacted] monitor — [redacted]
(1930)	Rt c̄ lo, VSS, LCTAB, HRR, [redacted], (R) IJ TLC IVF @ 45cc/hr ∅ redness or edema noted. Bacitracin applied to face wounds. (R) arm c̄ ace wrap CDI. facial incisions c̄ sutures intact. suction @ BS, HOB ↑30°. ambulated in hallway x1. abd midline incision OTA. ∅ c/o pain @ this time. Ancef cont. Restraints on (+) circulation. Will monitor — [redacted] 9LMG.
29Sept@0800	Rec'd report and assumed care of pt. Pt has triple lumen (R) EJ patent D5½NS @ TKO. ⊖ redness or swelling @ insertion site. (R) forearm bandage D&I cap refill brisk. Pt able to wiggle fingers. Mid abd staples intact. 4x4 [redacted] @ umbilical site D&I. ⊖ skin breakdown under restraints. Left (L) side of face intact. Bactrin to keep moist. Lungs CTA. BS(+). Continue to monitor [redacted] WHG

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPO[redacted]UMBER (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

[redacted] (5)(6)-4

STANDARD FORM 509 (REV. 6/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27 Sep 03 0700	Nursing: Assumed care A+O X3. VSS Ø c/o pain or discomfort @ this time s/p exp lap. Abdominal dressing d/c'd staples open to air CDI betadine cleansed. IVF 125 cc/hr (R) IJ triple lumen lungs CTA HRRR S1 S2 present. Active BS tolerating PO c̄ some difficulty due to incision and cuts to to pdnt. reg diet c̄ ensure. Urinating s̄ difficulty BM this AM. Encouraged to ambulate X2 this am. Will cont to monitor — [redacted] (1630) I concur c̄ above assessment. — [redacted]
27 Sep @ 2000	- assumed care of pt @ 1800. VSS, no c/o c̄ exception of n/a, 1 percocet given c̄ good relief noted. LS CTA, (+) BS x4 quads. Mid incision DTA c̄ exception 2x2 drsg CDI. (R) FA splint c̄ drsg CDI. (R) IJ TL c̄ IVFs @ 75cc/hr. Drsg A'd c̄ sterile technique. Diet A'd to mech soft for ease in chewing 2° cheek s gumline incision. Bacitracin applied to cheek incision. According to urinal s̄ difficulty, quantity sufficient. ↑ AMB in hallway x1 c̄ difficulty. Plan: monitor pain, monitor ol status, encourage CDB, AMB. — [redacted]
28 Sep 03 0600	A & O. VSS. Lungs CTA (B). Resp even & unlabored. Encouraging deep breathing exercise. Abd. soft & tender to touch (+) BS x4. Tolerated breakfast (mechanical soft). (R) IJ, triple lumen patent c̄ D5½NS @ 75cc/hr. (R) Arm Ace wrap drsg intact. Facial incisions c̄ sutures intact. Bacitracin applied. Abd. midline staples CDI s̄ open to air.

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

29Sep 2145 — assumed care of pt @1800. VSS, no c/o. MI abd ~~drsg~~ incision OTA, c exception 2x2 CDI. (A) BS (+)BM per pt report. is CTA, encouraged CDB. (P) check incision & sutures removed healing well, bacitracin applied as ordered. (R) NJTL & IVFs @75cc/hr flushed well. Drsg to be Δd tomorrow. Tol mech soft diet. diff urinating. plan: monitor wounds, pain.

[redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
30Sept 1200	Assumed care of pt. Pt ambulated in hallway. Med abd staples taken out per Dr [redacted]. Area clean and dry. Triple lumen DLC per Dr [redacted] 2x2 ~~on dsg~~ dsg area pressure held x5 minutes. Lungs CTA. Pt has soft cast on (R). Cap. refill brisk. BS(+). Will continue to monitor [redacted] IWMo
1700	Pt c/o pain while eating. Pt has ulcer looking sores in and around mouth. Pt given 1 percocet per MD order [redacted] IWMo
30SEP(a) 1930	- assumed care by pt @1800. VSS. c/o pain in his mouth and inability to eat food served. Encouraged ↑ soft food (ie pudding, jello, juice). LSCTA, NC incision abdomen healing well (staples removed) (R) IJ removed, insertion site ∅ S/Sx of infection. (L) chest incision healing, though still bothers pt to eat. Plan: monitor pain control, enc po intake. 2pt restraints on ∅ S/Sx of skin or circulation compromise. Will monitor [redacted]
1Oct05	0717 - assumed care of pt. @0800 assessment completed. VSS. AO - [redacted] PERERA Pt.

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

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[redacted] (b)(6)-4

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(cont'd)	c/o pain in mouth. LS CTA (B), Resp even unlabored, abd tender, firm, BSX4, voiding per urinal. TWO restraints in place (B), E ((+) circulation (-) skin breakdown. mid line incision CTA. (-) s/sx inf. splint (R) arm. <3 cap refill. will cont. to monitor pt. [redacted]
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1988) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

Transfer Summary

01 OCT 03

@0737 PT S/P GSW to Face, Abdomen and right forearm. Pt taken to the OR ON 23 SEPTEMBER 03 for an Exploratory Laparotomy (negative), washout of Right forearm wound and extraction of fractured teeth and closure of mouth wounds.

D/C cond: Stable
D/C diet: soft
D/C meds Keflex 500mg po q6° until gone
Percocet 1-2 tab po q4-6° prn pain
Bacitracin to wounds TID

Plan
① Pt needs abdominal wound checked prn
② Right forearm dressing can be changed and D/C'd prn
③ mouth will need bacitracin TID
Pt will need removable partial, dentures or implants.

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

#[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER TREAT[redacted]
		RECORDS MAINTAINED AT (b)(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)* 23/09/03	TIME 1452
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY FLA	

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
34	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS	INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT	
unable to answer	ITEM	YES	NO	WHEN *(Date)*	DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
	IS THIS AN INJURY?			WHERE	TETANUS	
ALLERGIES unable to answer	INJURY/SAFETY FORMS				DATE LAST SHOT	COMPLETED INTITIAL SERIES ☐ YES ☐ NO
	HOW					

CHIEF COMPLAINT GSW

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 1452	TIME 1452					
☑ URGENT		BP 139/94					
		PULSE 110/57					
☐ NON-URGENT	INITIALS	RESP					
		TEMP					
		WT 02 99%					

LAB ORDERS						X-RAY ORDERS		
✓	CBC/DIFF	ABG	PT/PTT		BHCG/URINE/BLOOD/QUANT	✓	CXR PA & LAT/PORTABLE	C-SPINE
	URINE C&S	UA MSCC/CATH		✓	CHEM: 12 E lytes		ACUTE ABDOMEN	LS SPINE
	BLOOD C&S X						SINUS	HEAD CT
							ANKLE R/L	

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION	DISPOSITION QUARTERS /OFF DUTY	PATIENT/DISCHARGE INSTRUCTIONS
☐ HOME ☐ FULL DUTY	☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.	
MODIFIED DUTY UNTIL	RETURN TO DUTY	

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶	TO	WHEN
☐ IMPROVED ☐ UNCHANGED				
☐ DETERIORATE	TIME OF RELEASE	I have received and understand these instructions.		
		PATIENT'S SIGNATURE		

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

[redacted]

(b)(6)-7

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER

TEST RESULTS

CBC		SMAC								
	WBC				ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
	H/H				SUP 02	PH	PO2	RESULTS	
	PLT				PCO2	SAT	OTHER		
PT					U/A	DIP		EKG INTERPRETATION	
APTT		BHCG	ETOH	GLU		MICRO			

PROVIDER HISTORY/PHYSICAL A&O x3. Airway patent - ST on monitor no ectopy
GSW cheek left side CTA (B).
IV - 18g (L) AC infusing NS
on arrival - 18g AC rt infusing NS - 600 in bag - bag change dou
1500 - Foley cath in no gross blood noted (P) CXR done
clear yellow urine

Injuries - GSW left cheek - airway patent
GSW rt abd - posterior clear

To OR @ 1503 T Dr [redacted]
(b)(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

NSN 7540-01-165-7294 [redacted] 519-301

~~RADIOLOGIC~~ CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
Nutrition Consult		M	EPW [redacted]	ICU2	
	FILM NO.				PREGNANT ☐ YES ☒ NO
	REQUESTED BY (Print)		CPT [redacted]		TELEPHONE/PAGE NO.
	SIGNATURE O		CPT [redacted]		DATE REQUESTED 20/9/03

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

(1) Pt will be here long term

(2) 9p Ex Icp / GSW to Face + PBD / Missing teeth

(b)(6)-2

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*

EPW

[redacted] (b)(6)-7

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 20288 LTATION ORT

3 — RADIOLOGY

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

Emergency – no pre-op assessment

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 32 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): 3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE: Ex LAP

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications:
Jewelry removed: yes/no Family waiting: yes/no

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; ~~family separation,~~ surgical environment	✓ Pt. verbalizes any specific anxiety. ✓ Pt. exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures, (e.g., warm blanket, touch) ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. ~~✓ Maintain family interface.~~
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	✓ PT. will be able to breathe without difficulty during immediate intra-operative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress ✓ Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	✓ PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

#[redacted] (b)(1)-2

EPW

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	ø Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	ø Check for support stockings or ace wraps. If none, check with doctors. ø Check that safety straps are correctly applied. ø Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ø Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	ø Pt. will be transferred to OR table without difficulty. ø Pt. will not experience unnecessary physical discomfort.	ø Have sufficient people available for transfer. ø Insure proper body alignment. ø Allow patient to lie in position of comfort while waiting for surgery. ø Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	ø Pt. will be made aware of surroundings prior to anesthesia induction. ø Pt. will be transferred safely to OR table. ø Pt. will be able to understand instructions. ø Minimize danger of injury during intraop period.	ø Introduce self. Keep pt. informed as to where he/she is and what is happening. ø Inform pt. in which direction to move and assist if necessary. ø Speak clearly and slowly. ø Address pt. from either side. ø Validate pt.'s understanding of verbal communications. ø Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CPT USN 23 Sept 03 DATE

11. POSTOPERATIVE EVALUATION.

Bric site: intact
Drsg: cldli
Breathing: intubated

(b)(6)-2

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title
[redacted] CPT USN	[redacted] CPT USN
DATE: 23 Sept 03 TIME: 1510	DATE: 23 Sept 03 TIME: 1900

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the prop[illegible] is t[illegible] ffice of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATIN[illegible] RO[illegible]
VIA litter BY anesthesia

2. PATIENT IDENTIFI[illegible], R[illegible]ORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted]

3. DATE 23 Sept 03 TIME PATIENT ARRIVED IN SUITE 1510

4. PATIENT IN ROO[illegible] [redacted] TIME 1510 NUMBER 5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: (b)(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	Sgt [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] / CPT [redacted]	RELIEF CIRCULATOR INT.	Maj [redacted] (1285-1800)

7. POSITION AND POSITIONAL A[illegible]

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

COMMENTS: proper body alignment maintained, arms on padded armboards at less than 90°, position approved by surgeon + anesthesia

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

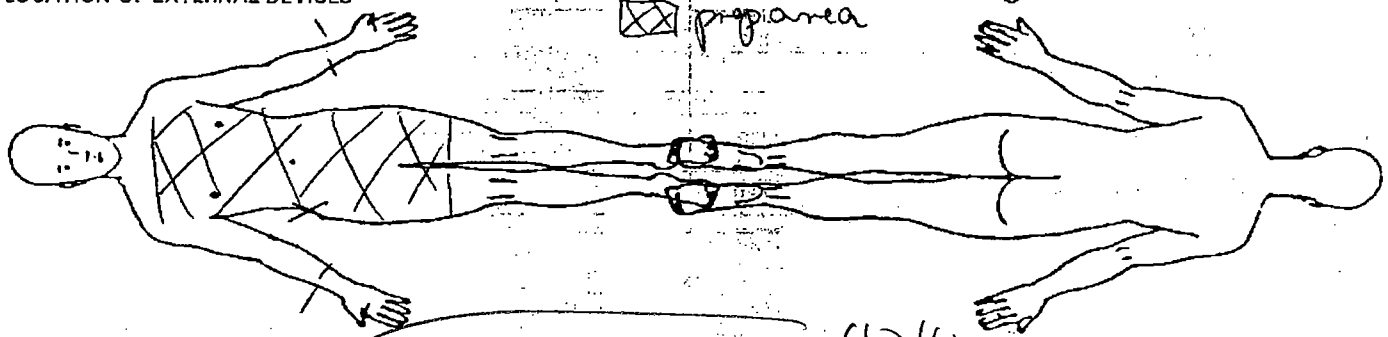
COMMENTS: no nicks or cuts noted

PREP SOLUTION *(Specify)* Betadine (Betadine)
SITE: Abdomen BY WHOM [redacted]
SITE: BY WHOM:

COMMENTS: no pooling or skin d's noted

9. LOCATION OF EXTERNAL DEVICES

☒ prep area



LEGEND X Ground Pa[illegible] [redacted] Safety [redacted] = = Tourniquet N/A (b)(6)-2

C = Correct I = Incorrect Initial [redacted]

10. COUNTS

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

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

[redacted] (b)(6)-7

EPW

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

☒ ESU NO: Valleylab Force
GROUND PAD: BRAND VL Ram Polyhesive II
LOT NO: 70011 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ Y NO IF YES NAME: ID NUMB M FACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Lidocaine c̄ Epi 1:100,000	8 cc	I.10	Inj.	[redacted]	[redacted]
Bacitracin ointment	QS	I.10	Topical		
				(b)(6)-2	

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

OTHER ORDERS	TIME	CARRIED OUT BY
none		

[redacted]

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME (b)(6)-2	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8
Tape
Splint → (R) arm

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

- 16F FIC in place upon arrival to OR → placed in OR

20. OPERATION(S) PERFORMED
Ex Lap, Closure of facial wounds
I+D (R) arm

21. PATIENT TRANSFERRED TO ICU-2 TIME see D47389 METHOD Litter

22. [redacted] CPT IAN

(b)(6)-2

(b)(2)-2

[redacted] **VENTILATOR FLOW SHEET** ICU #2 [redacted] (b)(6)-4

G-SW to mouth 7.5 ETT nasal intubation

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS	INT
23 Sept.	1900	SIMV	10	800	50	5	23	11	68	100		7.36	38.7	174	-4	22	100		[redacted]
	2315	SIMV	10	800	40	5	27	10	66	100	135/79								[redacted]
24 Sept	0140	SIMV	10	800	40	5	27	10	67	100	127/72								[redacted]
	0600	SIMV	10	800	40	5	28	10	62	98	116/61								[redacted]
	0800	SIMV	10	800	40	5	27	10	60	99	112/63								[redacted]
	1000	SIMV	10	800	40	5	27	10	60	99	113/62								[redacted]
	1200	SIMV	10	800	40	5	24	13	85	100	130/78								[redacted]
			EXT		1300														

(b)(6)-2

75 @ nar

MEDCOM - 20293

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY										
POST- DAY										
MONTH-YEAR / DAY	26 sep	27 sep	28	29	30	10/03				
19 / HOUR	1000	0700								
PULSE (O) / TEMP. F (•)	94 / 95	99 / 100	98 / 100	98 / 95	98 / 95	98 / 95				

TEMP. F: 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD	20	18	18				18	16	16			
BLOOD PRESSURE	128/100	104/64	113/64	108/56	108/64		106/60	113/61	119/76		110/60	
	H 97		H 86		87		97		117/65			
	T 97.4		T 97.9		98.5							
HEIGHT: / WEIGHT →	98%		98%									
	RA	98% RA	RA	96% RA	95% RA		95% RA	96% RA	96 RA	98% RA	98% RA	
					114/66							

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) **BACK**

[redacted] (5)(6)-4

(b)(6)-2

Ward/Section: EM7

REQUESTE[redacted]

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, M[redacted]

DATE | TIME | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
W[redacted]		4.8-10.8 x 10³
R[redacted]		
H[redacted]		
H[redacted]		
M[redacted]		
Pl[redacted]		
L[redacted]		
S[redacted]		
B[redacted]		
Lymph		Baso

ID: [redacted]
WB
23-09-03
15:06

			Patient Limits	
WBC	11.3 H	x10^3/uL	4.5	10.5
RBC	5.04	x10^6/uL	4.00	6.00
Hgb	14.6	g/dL	11.0	18.0
Hct	46.0	%	35.0	60.0
MCV	91.3	fL	80.0	99.9
MCH	28.9	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	285.	x10^3/uL	150.	450.
LY%	12.6 *L	%	20.5	51.1
LYM	1.4 *	x10^3/uL	1.2	3.4

Urinalysis

TEST	RESULT	REF. RANGE
Color		
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
[redacted]uk		Negative
[redacted]CG		Negative

[redacted]c. Serology

TEST	RESULT	REF. RANGE
[redacted]		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

[redacted]ell [redacted]ount		
[redacted]irectigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

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

UNIT	TYPE	CROSSMATCH

[redacted]TE: | LAB ID NO.:

(b)(6)-5

RAPID[redacted]
SERIAL [redacted]

Patient ID: [redacted]
Test Name :PT
Test Result:= 12.4 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.0
Calculated INR = 1.03
Sample Type:citrated wh. blood
Test Date :09/23/03
Test Time :03:05 PM
Card Lot :010301
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/23/03 03:10 PM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 16.5 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/23/03
Test Time :03:07 PM
Card Lot :100208
Operator : [redacted]

(b)(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, M: [redacted]	DATE: 23Sep TIME: 1450	SSN/DOD ID NO: [redacted]

(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
			GLU		73-118 mg/dl

Pt: [redacted]

Pt Name: _____

(b)(6)-4

Na_____144 mmol/L
K_____3.6 mmol/L
TCO2_____19 mmol/L
iCa_____1.13 mmol/L
Hct_____29 %PCV
Hb*_____10 g/dL
*via Hct

At 37C
pH_____7.276
PCO2_____39.0 mmHg
PO2_____399 mmHg
HCO3_____18 mmol/L
BEecf_____-9 mmol/L
sO2*_____100 %
*calculated

At Patient Temp
pH_____7.304
PCO2_____35.8 mmHg
PO2_____387 mmHg

Patient Temp: 35.0C
FIO2_____: 76
Sample Type_:

23SEP

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

======= PICCOLO =======
09/23/03 03:16 PM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	105	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.5*	0.6-1.2	MG/DL
CK	555*	39-380	U/L
NA+	122*	128-145	MMOL/L
K+	3.7	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 1+, LIP 1+, ICT 0

======= PICCOLO =======
09/23/03 03:43 PM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	3.3	3.3-5.5	G/DL
ALP	49	26-84	U/L
ALT	35	10-47	U/L
AMY	42	14-97	U/L
AST	37	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
GGT	21	5-65	U/L
TP	6.3*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 2+, LIP 0 , ICT 0

(b)(6)-2

REPORTED BY: [redacted]	DATE: 23 Sep 03	LAB ID NO.:

(5)(6)-2

Ward/Section: ICU H2	REQUESTING PHYSICIAN: Dr. [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted]	DATE 23 SEP / TIME 2015	SSN/PEEUDO SSN:

(Hematology) CBC

ID: [redacted] 23-09-03 20:25

(5)(6)-7

TEST	RESULT		Patient Limits	
WBC	10.4	x10^3/uL	4.5	10.5
RBC	4.73	x10^6/uL	4.00	6.00
Hgb	13.8	g/dL	11.0	18.0
Hct	42.6	%	35.0	60.0
MCV	90.2	fL	80.0	99.9
MCH	29.2	pg	27.0	31.0
MCHC	32.4 L	g/dL	33.0	37.0
Plt	198.	x10^3/uL	150.	450.
Lymph %	LYZ 8.3 * L	%	20.5	51.1
	LY# 0.9 *	x10^3/uL	1.2	3.4

(Hematology) Manual Differential

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: ABG T: 984

REPORTED BY:	DATE:	LAB ID NO.:

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

LAST, FIRST,MI.		DATE	TIME		SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		3.5-5.5 g/dl
K		26-84 u/l
Cl		10-47 u/l
pH		14-97 u/l
PCO2		11-38 u/l
PO2		0.2-1.6 mg/dl
TCO2		7-22 mg/dl
HCO3		8.0-10.3 mg/dl
SO2		100-200 mg/dl
BEecf		0.6-1.2 mg/dl
AnGap		73-118 mg/dl
Ca		6.4-8.1 g/dl
BUN		
GLU		
Creat		73-118 mg/dl
Hct		7-22 mg/dl
Hgb		0.6-1.2 mg/dl
		39-380 /l (M) 30-190 /l (F)
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

Pt: [redacted] (b)(6)-4
Pt Name:_____

Na_____141 mmol/L
K_____4.1 mmol/L
TCO2_____23 mmol/L
iCa_____1.01 mmol/L
Hct_____39 %PCV
Hb*_____13 g/dL
*via Hct

At 37C
pH_____7.361
PCO2_____38.7 mmHg
PO2_____174 mmHg
HCO3_____22 mmol/L
BEecf_____-4 mmol/L
sO2*_____100 %
*calculated

At Patient Temp
pH_____7.362
PCO2_____38.5 mmHg
PO2_____174 mmHg

Patient Temp: 98.4F
Sample Type_: ART

23SEP03 20:23

Oper: [redacted]

Physician:_____

Ser# [redacted]

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/dl
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Electrolyte

REMAR

REPORTED BY:	DATE:	LAB ID NO.:

Temp 36.2 °C
FiO2 74%

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

LAST, FIRST,MI. [redacted]		DATE 9/23/03	TIME		SSN/PEEUDO SSN:

(i-STAT) [redacted]

TEST	RESULT	REF. RANGE
Na		3.5-5.5 g/dl
K		26-84 u/l
Cl		10-47 u/l
pH		14-97 u/l
PCO2		11-38 u/l
PO2		0.2-1.6 mg/dl
TCO2		7-22 mg/dl
HCO3		8.0-10.3 mg/dl
SO2		100-200 mg/dl
BEecf		0.6-1.2 mg/dl
AnGap		73-118 mg/dl
Ca		6.4-8.1 g/dl
BUN		
GLU		
Creat		73-118 mg/dl
Hct		7-22 mg/dl
Hgb		0.6-1.2 mg/dl
		39-380 /l (M) 30-190 /l (F)
TEST		128-145 mmol/l
Troponin-1		3.3-4.7 mmol/l
Drug of Abuse		98-108 mmol/l
		18-33 mmol/l
REMAI		

(b)(6)-4

Pt: [redacted]
Pt Name:_____

Na_____143 mmol/L
K_____3.9 mmol/L
TCO2_____22 mmol/L
iCa_____1.12 mmol/L
Hct_____32 %PCV
Hb*_____11 g/dL
*via Hct

At 37C
pH_____7.281
PCO2_____43.4 mmHg
PO2_____485 mmHg
HCO3_____20 mmol/L
BEecf_____-6 mmol/L
sO2*_____100 %
*calculated

At Patient Temp
pH_____7.293
PCO2_____41.9 mmHg
PO2_____480 mmHg

Patient Temp: 36.2C
Sample Type:

23SEP03 18:00

Oper: [redacted]
Physician:_____

Ser# [redacted]
Pat# [redacted]

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/dl
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

(Piccolo) Liver Panel Plus

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

(Piccolo) Metlyte 8

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		18-33 mmol/l

REPORTED BY:	DATE:	LAB ID NO.:

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

LAST, FIRST,MI.		DATE	TIME		SSN/PEEUDO SSN:

(i-STAT)

i-STAT 007+

Pt: [redacted] (b)(6)-7

Pt Name:_____

Na_____142 mmol/L

K_____3.7 mmol/L

TCO2_____23 mmol/L

iCa_____1.02 mmol/L

Hct_____39 %PCV

Hb*_____13 g/dL

*via Hct

At 37C

PH_____7.383

PCO2_____37.3 mmHg

PO2_____171 mmHg

HCO3_____22 mmol/L

BEecf_____-3 mmol/L

SO2*_____100 %

*calculated

Sample Type_:

23SEP03 23:09

Oper: [redacted]

Physician:_____

Ser# [redacted]

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M) 30-190 /l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/dl
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section: ICU #2	REQUESTING PHYSICIAN: Dr. [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. # [redacted] (b)(6)-4		DATE 29 Sep	TIME 0530	SSN/PEEUDO SSN:

(Hematology) CBC

ID: [redacted] (b)(6)-2 24-09-03 05:37

TEST				Patient Limits	
WBC	WBC	10.0	x10^3/uL	4.5	10.5
RBC	RBC	4.68	x10^6/uL	4.00	6.00
Hgb	Hgb	13.6	g/dL	11.0	18.0
Hct	Hct	42.2	%	35.0	60.0
MCV	MCV	90.3	fL	80.0	99.9
	MCH	29.1	pg	27.0	31.0
	MCHC	32.2 L	g/dL	33.0	37.0
Plt	Plt	218.	x10^3/uL	150.	450.
Lymph %	LY%	6.9 *L	%	20.5	51.1
	LY#	0.7 *L	x10^3/uL	1.2	3.4

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count	
Directigen	Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: ABG T: 97.1

REPORTED BY:	DATE:	LAB ID NO.:

(6)(6)-2

Ward/Section: ICU #2	REQUESTING PHYSICIAN: Dr. [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PEEUDO SSN:
#[redacted]	24SEP	0530	

(i-STAT) [redacted]

(3)(6)-4

Pt: [redacted]

Pt Name: _____

Na_____141 mmol/L
K_____3.8 mmol/L
TCO2_____23 mmol/L
iCa_____1.10 mmol/L
Hct_____40 %PCV
Hb*_____14 g/dL
*via Hct

At 37C
pH_____7.359
PCO2_____38.0 mmHg
PO2_____93 mmHg
HCO3_____21 mmol/L
BEecf_____-4 mmol/L
SO2*_____97 %
*calculated

Sample Type_:

24SEP03 05:37

Oper: [redacted]

Physician: _____

[redacted]

TEST
Na
K
Cl
pH
PCO2
PO2
TCO2
HCO3
SO2
BEecf
AnGap
Ca
BUN
GLU
Creat
Hct
Hgb

TEST	RESULT	REF. RANGE
Troponin-1		3.5-5.5 g/dl
Drug of Abuse		26-84 u/l
		10-47 u/l
		14-97 u/l
		11-38 u/l
		0.2-1.6 mg/dl
		7-22 mg/dl
		8.0-10.3 mg/dl
		100-200 mg/dl
		0.6-1.2 mg/dl
		73-118 mg/dl
		6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/dl
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Electrolyte

REMARKS: ABG T:97.9

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section: ICU #2

REQUESTING PHYSICAN: [redacted]

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI. # [redacted]

DATE 24 Sep | TIME 1540

SSN/PEEUDO SSN: # [redacted]

(b)(6)-4

EXTUBATED
O_2 40 MASK

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

[redacted] mmol/L
[redacted] 5.7 mmol/L
[redacted] 27 mmol/L
[redacted] 1.10 mmol/L
[redacted] 38 %PCV
[redacted] 13 g/dL
Avia Int
pH [redacted] 7.307
PCO2 [redacted] 44.7 mmHg
PO2 [redacted] 140 mmHg
[redacted] 26 mmol/L
[redacted] 9 mmol/L
[redacted] 97 %
*Calculated

Sample Type: 1

24SEP03 15:51

Oper [redacted]

Physician# [redacted]

Ser# [redacted]

Ver# [redacted]

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/dl
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS: ABG

REPORTED BY: [redacted]

DATE: 24Sep03

LAB ID NO.:

(b)(6)-2

(b)(6)-2

Ward/Section: ICU

REQUESTING PHYSICIAN: [redacted]

LAST, FIRST, MI. [redacted]

LABORATORY RESULT FOR
(Subject to the Privacy Act of 1974)

DATE: 25 Sep 03 | TIME: 1120 hrs | SSN/PEEUDO SSN: [redacted] (b)(6)-7

(Hematology) CBC

ID: [redacted] (b)(6)-7 WB 25-09-03 17:36

				Patient Limits	
WBC	11.8 H	x10^3/uL		4.5	10.5
RBC	4.80	x10^6/uL		4.00	6.00
Hgb	13.8	g/dL		11.0	18.0
Hct	44.1	%		35.0	60.0
MCV	91.8	fL		80.0	99.9
MCH	28.7	pg		27.0	31.0
MCHC	31.2 L	g/dL		33.0	37.0
Plt	296.	x10^3/uL		150.	450.
LY%	7.2 *L	%		20.5	51.1
LY#	0.8 *	x10^3/uL		1.2	3.4

TEST	
WBC	
RBC	
Hgb	
Hct	
MCV	
Plt	
Lymph %	

(Hematology) Manual Differential

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

DATE: 25 Sep 03

LAB ID NO.:

(b)(6)-7 (b)(6)-2

Ward/Section: ICW#1	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. #[redacted]	DATE 27SEP	TIME 0520	SSN/PEEUDO SSN: #[redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fl(M)
Plt		
Lymph %		

(Hematolo

TEST	RESULT	REF. RANGE
Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		
Set Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Nep
Ket		Ne
		N/
		N
		N
		N
		N
		0.
		N
		N

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source

Negative

Negative

CSF

Cong

ST SUBMIT

F BLOOD

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-7

ID: [redacted] 27-09-03
WB 05:41

			Patient Limits	
WBC	6.0	x10^3/uL	4.5	10.5
RBC	4.70	x10^6/uL	4.00	6.00
Hgb	13.4	g/dL	11.0	18.0
Hct	42.8	%	35.0	50.0
MCV	91.0	fL	80.0	99.9
MCH	28.4	pg	27.0	31.0
MCHC	31.2 L	g/dL	33.0	37.0
Plt	193. *	x10^3/uL	150.	450.
LY%	27.9	%	20.5	51.1
LY#	1.7	x10^3/uL	1.2	3.4

======= PICCOLO =======
27/09/03 06:02
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	95	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	968*	39-380	U/L
NA+	130	128-145	MMOL/L
K+	3.7	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

(b)(6)-2

Ward/Section: ICU#1	REQUESTING PHYSICA[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST,MI [redacted]		DATE 8/28	TIME 0530	SSN/PEEUDO SSN [redacted] (b)(6)-4

(Hematology) CBC						Urinalysis			Misc. Serology		
TEST	[redacted]					TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC						Color		N/A	RPR		Negative
RBC						App		N/A	Mono		Negative
Hgb						Glu		Negative	Microbiology		
Hct						Bili		Negative	Source		
MCV						Ket		Negative	Gram Stain		
Plt						SG		N/A	Occ Bld		Negative
Lymph %						Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential						pH		N/A	Micro Parasites		
Segs		Mono				Prot		Negative	Malaria		
Bands		Eos				Urob		0.2-1.0	O & P		
Lymph		Baso				Nit		Negative	Other		
Atyp		Imm				Leuk		Negative	Macroscopic Urinalysis		
RBC Morph						HCG		Negative			
Spun Hematocrit		42-52%(M) 37-47%(F)				CSF			Blood Bank		
Set Rate						Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other						Directigen		Negative	ABO/Rh		

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

REMARKS:		
REPORTED BY:	DATE:	LAB ID NO.:

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

LAST, FIRST,MI.		DATE	TIME	SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 m
BUN		7-22 mg/
CRE		0.6-1.2 mg
CK		39-380 /l 30-190 /l
NA^+		128-145 m
K^+		3.3-4.7 m
CL^-		98-108 m
tCO2		18-33 mmol/l

```
======= PICCOLO =======
28/09/03                 06:00
REFERENCE RANGE:         MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #:              3203AA4
OPER #: [redacted]       DR #: 000
SERIAL #: [redacted]
.......................
GLU    104   73-118   MG/DL
BUN      8   7-22     MG/DL
CA++   8.0   8.0-10.3 MG/DL
CRE    0.8   0.6-1.2  MG/DL
NA+    136   128-145  MMOL
K+     3.8   3.3-4.7  MMOL
CL-    96*   98-108   MMOL
tCO2   27    18-33    MMOL

INST QC: OK     CHEM QC: OK
HEM 0 , LIP 0 , ICT 0
```

K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICW 1	REQUESTING PHYSICAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST,MI. CPW # [redacted]	DATE 29SEP	TIME 0400	SSN/PERIUD [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fl(M) 81-99 fl(F)
Plt		130-500 x10³
Lymph %		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negativ
SG		N/A
		Negativ
		N/A
		Negativ
		0.2-1.0
		Negativ
		Negativ
		Negativ

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono	--	Negative

Microbiology

(Hematology) D

TEST	RESULT	REF. RANGE
Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		
Set Rate		
Other		

CSF

Coagulation

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

Blood

(b)(6)-1

[redacted]

WBC	8.6	x10³/µL	4.5 10.5
RBC	5.13	x10⁶/µL	4.00 6.00
Hgb	14.9	g/dl	12.0 18.0
Hct	44.4	%	35.0 60.0
MCV	86.5	fL	80.0 97.0
MCH	29.1	pg	27.0 31.0
MCHC	32.2 L	g/dL	33.0 37.0
Plt	298.	x10³/µL	150. 450.
HCT	17.2	mL %	20.0 51.0
LYM#	1.5	# x10³/µL	1.2 4.0

Patient Limits

======= PICCOLO =======

29/09/03 03:55

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 8

DISC LOT #: 3141AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	108	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	145	39-380	U/L
NA+	129	128-145	MMOl/L
K+	4.3	3.3-4.7	MMOl/L
CL-	97*	98-108	MMOl/L
tCO2	24	18-33	MMOl/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

REMARKS: (CBC/met panel.)

REPORTED BY: DATE: LAB ID NO.:

10A

(b)(6)-2

Ward/Section: ICW#1	REQUESTING PHYSICAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST,MI. [redacted]	DATE 9/30	TIME 0500	SSN/PEEUDO SSN: [redacted]	

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10	Color		N/A	RPR		Negative
RBC		4.7-6.1 x10	App		N/A	Mono		Negative
Hgb		14-18 g/dl(M) 12-16 g/dl(F)	Glu		Negative			
Hct		42-52%(M) 37-47%(F)	Bili		Negative			
MCV		80-94 fi(M) 81-99 fi(F)	Ket		Negative			
Plt		130-500 x10³ verified	SG		N/A			
Lymph %					Negative			
(Hematolo					N/A			
Segs					Negative			
Bands					0.2-1.0			
Lymph					Negative			
Atyp					Negative			
RBC Morph					Negative			
Spun Hematocrit			CSF					
Set Rate								
Other					Negati			
Coag			Blood B					

(b)(6)-4

[redacted]

1.5	x10³/µL	1.2	3.4

IST SUBMIT SF 51 R D

TEST			UNIT	
PT		9.8-13.6 secs		
APTT		21-34 SESS		
D dimer		<20 ug/ml		
FDP		< 10 ug /ml		

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

======= PICCOLO =======
09/30/03 06:46 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: 3203AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	102	73-118	MG/DL
BUN	11	7-22	MG/DL
CA++	8.6	8.0-10.3	MG/DL
CRE	0.9	0.6-1.2	MG/DL
NA+	133	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

Ward/Section:	REQUESTING PHYSICAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE	TIME

SSN/PSEUDO SSN: [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		
Hct		
MCV		
Plt		
Lymph		

(Hem...

Segs	
Bands	
Lymph	
Atyp	
RBC Morph	
Spun Hematoc	
Set Rat	
Other	

(b)(6)-4

ID [redacted] 01-10-03
NO 05:40

			Patient Limits	
WBC	9.2	x10^3/uL	4.5	10.5
RBC	5.63	x10^6/uL	4.00	6.00
Hgb	16.2	g/dL	11.0	18.0
Hct	50.9	%	35.0	60.0
MCV	90.4	fL	80.0	97.9
MCH	28.8	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	371.	x10^3/uL	150.	450.
LY%	17.9 -L	%	20.5	51.1
LY#	1.6 *	x10^3/uL	1.2	3.4

Urinalysis

TEST	RESULT
Color	
App	

Misc. Serology

REF. RANGE
Negative
Negative
Negative
Negative

---- PICCOLO ----
01/10/03 05:50
REFERENCE RANGE: MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: 3203AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	99	73-118	MG/DL
BUN	12	7-22	MG/DL
CA++	8.8	8.0-10.3	MG/DL
CRE	1.0	0.6-1.2	MG/DL
NA+	137	128-145	MMOL/L
K+	5.0*	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

CSF

...alysis

...8 WITH ...ESTED

...tigen

Coagulation Studies

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

(MUST SUBMIT ... BLOOD

MATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Seen in EMT emergent OSW to nose, face (R) arm - NKDA per trauma. No other information obtained - to OR - USA in EMT 122/101/10/105 37/19/1.5

MEDICAL RECORD — ANESTHESIA

DRUG (Units)												
Versed (mg)	2											
Fent ( )	2 250	50			50				50		50	
Propofol ( )	140											
Succ ( )	100											
Roc Vec ( )		50		10		5						
VOLAT AGENT: Iso % del	1.0	0.5	0.4	X	1.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0
% et.												
AIR L/Min												
N2O L/Min												
O2 L/Min	10	2	2	2	2	2	2	2	2	2	2	2

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

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

FLUIDS												
(L) PIV Warmed	#1				Lev #3	1000			1400			1450
(R) PIV Warmed	#2 NS					1000						100
(R) IJ triple Hispan Warmed	NS #3					Bolus			#2			500
Warmed	(500)					500						
LOSSES: EST BLOOD LOSS					100			250				
URINE –					775		1000		1400		1550	

TOTALS	
5mg	250
500 mg	3500
TOTAL URINE	1700

FLUIDS - SUMMARY
CRYSTALLOID – LR 330
COLLOID – 2-Hispan 1000 cc
BLOOD – 2 PRBC

REMARKS-
Code drugs with numbers, events with letters
(1) Pagn monitor O2 induced OG placed Phenylephrine TTE 50-100mg
(2) Cefotetan 2gm IVP
(3) Scopolamine 0.4mg
(R) IJ [redacted] by IJ
Dr [redacted] replaced by MAJ Fedale
(4) Decadronig
(5) Thrust IK in
(6) Local 1% lidocaine epi 8cc
oral ETT Δ to 7-5 usual Rae cone attempt under visualization guide IVI (+) ETCO2 - (+) bilat BS @ 27 cm lips.

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

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT: 46

INITIAL DATA: BP 128/74 HR 106

COMP CHECK: OK? (Y) N

PATIENT IDCHECK: OK for PROCEDURE? TIME 1450

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

TIME → 1500, 30, 1600, 30, 1700, X, 20 X

VENTIL												
VT – ml	+	570	850	710	670	660	640	650	660	650	660	660
f – breaths/min	+	10	8	8	8	8	8	8	8	8	8	8
Peak inf pres / PEEP	–	22	18	18	18	20	21	23	23	23	23	23
MODE – S(pon), A(ssist), C(on)	S-C	C	C	C	C	C	C	C	C	C	C	C

MONITORS / ACCESSORIES												
BP/Auto Cuff / ET CO2 (torr)	+	27	28	33	32	32	32	31	31	31	31	31
BP / oth / FIO2 (Frac or %)	0.76	0.76	0.76	0.76	.76	.75	.74	.73	.74	.73	.74	.73
ART line / SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES / ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer / TEMP- site					36.1		35.8		36.0		36.0	36.4
N-M Block (T/4)		0/4	–							4/4		
Warming blkt												
Conv warmer												

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (1) (2) (3) (4) (5) (6)

RECOVERY AT: PACU (ICU) 2 (Specify) OTHER
CONDITION: Stable on vent
RESP – vent SpO2 – 100
BP – 118/67 HR – 68

ANESTHESIA / PROCEDURE TIME	Start	Room	End
ANES	1430	1510	1920
PROC	Ready 1520	Begin 1525	End 1858

PROCEDURES and CPT Codes: Ex lap, (R) forearm GSW (2) face

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA RSI Crucoid

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: 8.0 ETT placed @ 3 MAC grade I view, stylet (+) ETCO2 (+) BBS secured 23 cm @ teeth

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

SURGEON [redacted]

PROCEDURE LOCATION: 2 (1)
DATE: 23 Sept 03
PAGE 1 OF 2

[redacted]
(b)(6)-4

(b)(6)-2

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 20311

totals

MEDICAL RECORD — ANESTHESIA

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

DRUG (Units)				
Fent (200) ( )	50			
Versed 4mg ( )	1			
Vec ( )	5			
( )				
( )				
( )				
VOLAT AGENT Forane % del	1.5	1	1	1
% e.t.				
AIR L/Min				
N2O L/Min				
O2 L/Min	2	2	2	2

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

FLUIDS

LINE site			
(R) TL #3	☐ Warmed	1200	1750
(R) TL #4	☐ Warmed	700	1000
Peri IV #5 (L)	☐ Warmed	1550	1550
	☐ Warmed		

LOSSES

EST BLOOD LOSS	200	250
URINE –	1700	

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT KG LB

HEMATOCRIT

INITIAL DATA: BP – HR – (see pl)

MACHINE CHECK OK? – Y N

PATIENT RECHECK OK for PROCEDURE? TIME–

TIME → 1800 X 30 X 1900 X 30 X 20

SYMBOLS: BP by cuff V Λ; Heart rate •; Resp rate ○; BP (transduced) ⊥ T; TOURNIQUET T – ✗; ANES– X-X; PROC ⊙ – Ø

Grid scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

Grid notes: 7.28 / 48.9 / 481 / 20 / 24 / 11/3.2

VENT			
VT – ml	650	650	650
f – breaths/min	8	8	8
Peak insp pres / PEEP	23	24	25
MODE– S(pon), A(ssist), C(on)	C	C	C

MONITORS / ACCESSORIES				
✓ BP/Auto Cuff / ET CO2 (torr)	32	32	32	
BP / oth / ✓ FIO2 (Frac or %)	.74	.64	.67	
ART line / ✓ SpO2 (%)	100	100	100	
Steth- PC/ES / ✓ ECG	SR	SR	SR	
Gas analyzer ✓ TEMP- site	36.4	36.6	36.6	
✓ N-M Block (T/4)	4/4			
Warming blkt				
Conv warmer				

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

TOTALS — TOTAL URINE: see pl

FLUIDS - SUMMARY: CRYSTALLOID– COLLOID– BLOOD–

REMARKS- Code drugs with numbers, events with letters

1900 Pt transferred to bed. Vent c Hand bag valve mask — Pulse ox VCS Report given

RECOVERY AT: PACU ICU ____ (Specify) OTHER

CONDITION: see pl — RESP– SpO2– BP– HR–

ANESTHESIA / PROCEDURE TIME

ANES	Start	Room	End
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: (R) forearm — EX LAP GSW face

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — #

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

(b)(6)-4

#[redacted]

SURGEON [redacted] (K)

ANESTH [redacted]

(b)(6)-2

PROCEDURE LOCATION 2 (1)

DATE 23 Sept 03

PAGE 2 OF 2

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 20312

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)* 1 unit ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH 4

DATE REQUESTED 23 Sept

DATE AND HOUR REQUIRED 1453

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE GSW to abd

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 [redacted] CPT/L

DATE VERIFIED 23 Sept

TIME VERIFIED 1453

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO. [redacted]

DONOR

ABO O

Rh Neg

RECIPIENT

ABO O

Rh Neg

TEST INTERPRETATION

ANTIBODY SCREEN: NA

CROSSMATCH: compat

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 23 Sep03

REMARKS: exp 27 Sep03

(b)(6)-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted]

AT *(Hour)* 1552 ON *(Date)* 23 Sep03

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 VER [redacted]

2nd V [redacted]

PRE-TRANSFUSION

TEMP. 36.1 PULSE 89 BP 104/58

DATE OF TRANSFUSION 9/23/03 TIME STARTED 1600

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 U ML

TIME/DATE COMPLETED/INTERRUPTED 1638

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 35.8 PULSE 74 BLOOD PRESSURE 111/66

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [x] NO
- [ ] YES [redacted]

SIGNATURE [redacted]

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

[redacted] (b)(6)-4

SEX M

WARD EM7

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 - 20313

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)* _____

VOLUME REQUESTED *(If applicable)* 1unit ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH 2-4

DATE REQUESTED 23Sept

DATE AND HOUR REQUIRED 1455

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR [redacted]TIVE PROCEDURE [redacted]SWabd

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 [redacted]

DATE VERIFIED 23Sept

TIME VERIFIED 1453

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO. [redacted]

DONOR

ABO O

Rh Neg

RECIPIENT

ABO O

Rh NEG

TEST INTERPRETATION

ANTIBODY SCREEN: NA

CROSSMATCH: compat

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 23Sep03

REMARKS: exp 29 Sep03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted]

AT *(Hour)* 1553 ON *(Date)* 23 Sep03

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)* [redacted]

2nd V[redacted]

PRE-TR[redacted]

TEMP. 55.4 PULSE 80 BP 107/69

DATE OF TRANSFUSION 9/23/03

TIME STARTED 1640

POST-TRANSFUSION DATA

AMOUNT GIVEN 1U ML

TIME/DATE COMPLETED/INTERRUPTED 1735 9/23/03

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 36.2

PULSE 75

BLOOD PRESSURE 96/63

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

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

SIGN[redacted]

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

[redacted] (b)(6)-4

SEX M

WARD CM7

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

Medical Record Copy

MEDCOM - 20314

(b)(6)-2

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted]

(b)(6)-7

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 23Sep03 TIME OF ORDER 1900 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU #2
2. Dx: S/P Ex Lap GSW Abdomen
   WASH OUT (R) Forearm
   Ext of teeth + closure
   of facial wounds
   S/P GSW Face
3. Cond: Stable
4. Vitals: Per routine
5. Aller: UNK
6. Activ: Bedrest
7. Nurs: HOD ↑ 30°
   Foley to gravity
   Yankauer Suction to BS
8. Diet: NPO
9. IV: NS @ 125cc/hr
10. meds: Ancef 1gm IV q8°
    Decadron 10mg IV @ 2300
    then Decadron 8mg IV
    x 2 doses (q8°)
    then Decadron 6mg IV
    x 2 doses then D/C
    Lentanest / drip titrate
    to sedation
    Versed
    Bacitracin to face wounds
    TID
11. Vent: SIMV 10 TV 800 50% FIO2
    Peep 5
12. ABG + CBC now + AM

[redacted]

(b)(6)-2

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

Double Sided

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	LIST TIME ORDER NOTED AND SIGN
#[redacted] EPW	ICU #2		2	24 Sep 03	@ 0845 HOURS	
				(1) Hold Sedation		Noted @ 0845 24 SEP 03
				Wean to extubate		[redacted]
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
#[redacted] EPW	ICU #2		2	24 Sep 03	HOURS	
				MSO4 2-4 mg IV Q 1-2° prn		[redacted]
				[redacted]		2355 24 Sep 03
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
#[redacted] EPW	ICU #2		2		HOURS	
				Clamp NGT q 8°		Noted @ 0650 hrs 25 SEP 03
				If without emesis or		[redacted]
				aspirate for 8°		
				then D/C NGT		
				OOB → chair		[redacted]
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
#[redacted] EPW	ICU #2		2	25 Sep 03	0800 HOURS	
				(1) Start oral care		Noted @ 0800 25 Sep 03
[redacted]						[redacted]
				D/C Foley		CPT/ANT

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

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

b)(6)-4

b)(6)-2

Dd b/e - 3 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

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	HOURS	
~~Transfer to floor~~		
~~3 if OSW to add 1 face~~		
~~Supp lap / facial reconstruct~~		
25 Sep 03 @ 1630		Noted @ 1645 25 Sep 03
① H&H		
② Chest PT		[redacted]

PATIENT IDENTIFICATION

[redacted] EPW.

NURSING UNIT	ROOM NO.	BED NO.
ICU # 2		2

DATE OF ORDER	TIME OF ORDER	
	HOURS	
✓ 26 Sept 03	0910	
✓ Transfer to floor c̄ OK		
c̄ Dr [redacted]		
✓ Labs		
✓ 3rd Supp lap / Facial repair		
✓ allergy NKDA		
✓ NT D5 ½ NS at 100 c/h		[redacted]
✓ Vitals routine		

PATIENT IDENTIFICATION

[redacted] EPW

no bed [redacted] (b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
ICU # 2		2

DATE OF ORDER	TIME OF ORDER	
	HOURS	
26 Sept 03	0910	[redacted]
✓ Ancef 2 gm IVPB q 8°		
✓ packing to face & bound tid		
✓ Percocet 2 po q 4-6° p		
✓ Clear liquid		
advance as tolerated.		
✓ OOB → chair → ambulate in halls		
Chest PT		

PATIENT IDENTIFICATION

[redacted] EPW.

NURSING UNIT	ROOM NO.	BED NO.
ICU # 2		2

DATE OF ORDER	TIME OF ORDER	
	HOURS	
26 Sept 03	0910	[redacted]
~~Transfer~~		
✓ Yankauer suction to bedside		
✓ HOB at 30°		
Labs CBC c̄ plt		
SMA 7 @ 6H ? gam		
~~[illegible]~~		[redacted]

[redacted]

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

(b)(6)-2

(b)(6)-2

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

Doctor's Orders

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted] EPW

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.

DATE OF ORDER: 27 Sept 03 | TIME OF ORDER: 1020 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Ensure ⊕ cm tid
(2) ↓ IVF to 75 cc/hr
(3) ok to clean middle dressing ⊕/⊖

[redacted]

Noted on [redacted] 03 1020

[redacted]

(5)(6)-2

PATIENT IDENTIFICATION

#[redacted] EPW

NURSING UNIT: ICU #2 | ROOM NO. | BED NO. 2

DATE OF ORDER | TIME OF ORDER ____ HOURS

(5)(6)-5

PATIENT IDENTIFICATION

#[redacted] EPW

NURSING UNIT: ICU #2 | ROOM NO. | BED NO. 2

DATE OF ORDER | TIME OF ORDER ____ HOURS

PATIENT IDENTIFICATION

#[redacted] EPW

[redacted]

NURSING UNIT: ICU #2 | ROOM NO. | BED NO. 2

DATE OF ORDER | TIME OF ORDER ____ HOURS

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

☆ U.S. GPO 1979-0-363-710

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

#[redacted]

DATE OF ORDER: 27 Sep 03 TIME OF ORDER: @ 1810 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Δ diet to mechanical soft diet

[redacted]

MAJ/DC

NURSING UNIT: 24th 27 Sep 2003 ROOM NO. BED NO. [redacted]

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

[redacted]

DATE OF ORDER: 30 Sep 03 TIME OF ORDER: 1030 HOURS

D/C all IVF per Dr [redacted]

V.O. D[redacted] 27 [redacted]

NURSING UNIT: 24th ROOM NO.: 2300 BED NO.: 30 Sep 03 [redacted]

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 REPL/ HICH MAY BE USED.

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. 9 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 23	24	25	26	27	28	29	30
23Sep03	[redacted]	Vitals per Routine	06	/	[redacted]						
			18	[redacted]							
[redacted]											
23 Sep	[redacted]	HOB ↑ 30°	06	/	[redacted]						
			18	[redacted]							
[redacted]											
23Sep	[redacted]	Yankeur suction to	06	/	[redacted]						
		BS	18	[redacted]							
23Sep	[redacted]	~~Diet: NPO~~	06	/	[redacted]						
			18	[redacted]							
25 SEP 03	[redacted]	OOB TO CHAIR	06	/	/	[redacted]					
			18	/	/	[redacted]					
25SEP03	[redacted]	CHEST PT	06	/	/	[redacted]					
			18	/	/	[redacted]					
25Sep03	[redacted]	Diet: clear liquids	06	/	/						
		as tolerated	18	/	/	[redacted]					

Neuro Ther 26 Sept

[redacted] 26 Sept

DIC 25 Sep 03

[redacted] 26 Sept AHP

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO
Unknown

PRIMARY DIAGNOSIS:
SIP EX Lap, GSW Abdomen and face
washout (R) FA, Teeth extraction; closure facial wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: _____

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 9 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
23 Sep	[redacted]	Admit ICU2 ; Condition Stable	23 Sep	NOW	1915	[redacted]
23 Sep	[redacted]	ABG + CBC now	23 Sep	NOW	DON	[redacted]
23 Sep	[redacted]	ABG, + CBC in AM	24 Sep	0500	Done	[redacted]
25 SEP	[redacted]	CLAMP NG x 8°; IF WITHOUT EMESIS OR NAUSEA FOR 8°, THEN	25 SEP	NOW	CLAMPED 0730 D/C @ 1530	[redacted]
	[redacted]	NGT D/C'd				
25 Sep	[redacted]	D/C Foley	25 Sep	AM	pulled: 0930 1st void: 1000	[redacted]
25 Sep	[redacted]	H&H	25 Sep	pm	1720	[redacted]
	(b)(6)-2					(b)(6)-2

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

USAPA V1.00

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 26	27	28	29	30	1
26 Sept	[redacted]	Vitals routine	06 18	[redacted]					
			18 06						
26 Sept	[redacted]	Clear liquid	06 18	[redacted]					
		advance as tolerated	18 06						
26 Sept	[redacted]	OOB → chair → ambulate in halls	06 18	[redacted]					
			18 06						
26 Sept	[redacted]	chest PT	06 18	[redacted]					
			18 06						
26 Sept	[redacted]	Yanker suction	06 18	[redacted]					
		PS bedside	18 06						
26 Sept	[redacted]	HOB @ 30°	06 18	[redacted]					
			18 06						
26 Sep	[redacted]	labs CBC E plt	04	/	[redacted]				
		SMA 7 E CA+ q AM							
27 Sept 03	[redacted]	Ensure TID	08	/	[redacted]				
			12	/					
			17	/					
27	[redacted]	mechanical soft	6	/	/				
		diet	10	/	[redacted]				

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: ex lap / fascial repair

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
27 SEP 03	[redacted]	CK to leave midline drsg off	27 SEP 03			[redacted]
		(b)(6)-2				

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

USAPA V1.00

CLINICAL RECORD

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

Mo. 9 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
23 Sep	[redacted]	IV: NS @125/hr	06	/	[redacted]						
			18	[redacted]							
[redacted]											
23 Sep	[redacted]	Bacitracin to face wounds TID	06	/	[redacted]						
			14	/							
			22	[redacted]							
23 Sep	[redacted]	Ancef 1gm IV q8°	06	/	[redacted]						
			14	/							
			22	[redacted]							
[redacted]											
23 Sep	[redacted]	Decadron long IV 10 mg x 2 doses then D/C (3)	22	/	[redacted]						
			23	/							
[redacted]											
		(b)(6)-2									

he written 26 Sept [redacted]

he written 26 Sept [redacted]

ALLERGIES: ☐ YES ☐ NO
unknown

PRIMARY DIAGNOSIS:
SIP Ex Lap, GSW ABD and face, washout (R) FA
Teeth extraction, closure facial wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO. _____

PATIENT IDENTIFICATION:
EPW
[redacted] (b)(6)-7

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 — PREVIOUS EDITIONS WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 9 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
23 Sep	[redacted]	Decadron 10mg IV @ 2300	23 Sep	2300	2300	[redacted]
24 SEP	[redacted]	HOLD SEDATION; WEAN TO EXTUBATE	24 SEP	AM	1030hrs	[redacted]
		(b)(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
24Sep	[redacted]	MSO4 2-4mg IV	25 SEP 0145	25 Sep 1130	25 Sep 1615	25 SEP 03 2015	25 SEP 0945									
		q 1-2° prn	3mg	3mg	2mg	2mg	2mg									
			[redacted]													

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General	9 1-03

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	1
26Sept	[redacted]	D5½NS @ 100 cc/hr ↓ to 75cc/hr	06 18	[redacted]					D/Cd
26Sept	[redacted]	Ancef 1 gm IVPB q8°	06 14 22	[redacted]					D'cd 30Sept @ 1100
26Sept	[redacted]	Bacitracin to face wounds TID	06 14 22	[redacted]					

(5)(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: exp lap/facial repair

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION: # [redacted] (6)(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 1973, 1 FEB 79 — PREVIOUS EDITIONS ARE OBSOLETE — 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

(b)(6)-2

Order/ Expir Date	Clerk/ [redacted]	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED											
26 Sept	[redacted]	Percocet 1 PO q 4-6° PRN	2044 2349 9/25 9/26 1915 1915 [redacted]											
24 Sep	[redacted]	MSO4 2-4 mg IV q 1-2° PRN	28th 29th 2210 0545 4mg 4mg [redacted]											

USAFA V 1.02

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-68; the proponent agency is the Office of The Surgeon General.

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

OTSG APPROVED (Date)

Date: 22 SEP
Time In: 1415
Allergies: NKDA
Pre-op V/S: 120/74 HR 106
Procedures: GSW (R) Forearm, Exlap (-)
Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 3240 Colloid 1000 Hespan
OR Output: UOP 1400 EBL 250 Tf Lund RBL
Meds/Times: Sumex 5mg, Versed 2mg, Morphine 2mg, Fentanyl 100mcg, Ancef 1gm, Gowning blanket to (L) side of face, tape out teeth

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1415	1420	1425	1430	1435	1440										
SaO2																
FIO2																
Methods																
240																
220																
200																
180																
160																
140	140															
120		120	125		129											
100																
80	86	87	81	85	85											
60																
40																
20																
RR	10	18	9	10	10											
T	97															
Time																
Pain (0-10)																
LOS																

Pacu Intake

Time	Solution	Amount	Site	By	Infused

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

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

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

PREPARED BY (Signature & Title): [redacted]

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU2

DATE: 22 SEP

PATIENT'S IDENTIFICATION (For typed or [redacted] Name — last, first, middle; grade; date; hospital or medical facility)

EPW

(b)(6)-2

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

N

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

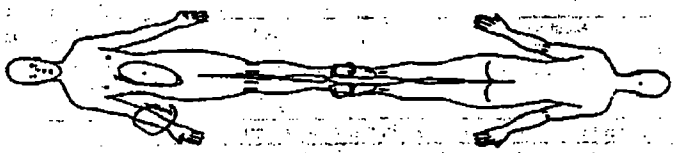
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Bilateral AB	Bulky	On-ABD
30'	"	"	"
60'	"	"	"
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
2030	Foley	Clear yellow	1000 cc

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

1415: Pt. to ICU2 from OR via gurney being bagged. Pt. arrived intubated via (L) nares. Pt. arrived sedated. V.S.O. Pt. placed on monitors. — CR [redacted] (b)(6)-3

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **SaO2:**
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:_____

WAMC OP 173-E

INITIAL SHIFT ASSESSMENT

		Time: 1920 Initials: [redacted] (b)(6)-2	Time: Initials:
NEURO	Pupils	2mm No reative to light	
	Sensorium	Sedated Versed at 6mg/hr	
	LOC / GCS	↓ NGT @ 25 at (L) nares	
CARDIAC	Cardiac Rhythm	NSR	
	PRI / QRS:		
	Pulse Strength	3 x4 extremities	
	Cap Refil / JVD	<3sec x4 / Ø JVP	
	Edema	to abd and (L) face	
	Chest Pain	Ø	
RESP	Respiratory Pattern	SIMV 10 / equal rise & fall of chest	
	Breath Sounds	clear	
	Secretions	Ø	
	Cough	Ø	
SKIN	Color	Normal	
	Integrity	(R) forearm Cow, (L) side of face Ø	
	Backside	sutures, Ex L4P	
IV	Access Devices	Triple lumen catether to (R) side	
	Location	of neck. IV (L) AC	
	Condition	Ø signs of infection	
GI	Abdomen	slight edema around surgical site	
	Bowel Sounds	Hyperactive x4 quad	
	Stoma/Ostomy	Ø	
GU	Device	Foley	
	Color / Clarity	clear + yellow	
		(b)(6)-2	

PREPARED BY (Sign) [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU [redacted]

DATE: 23SEP03

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

NAME: H [redacted] RANK: AGE:

UNIT: (b)(6)-4 GENDER: M

STATUS: US: AD / CIV IRAQI: CIV / EPW

(b)(2)-2

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

DA FORM 4700, MAY 78

USAPPC V2.00

PT'S NAME: [redacted] (6)(6)-4

DATE: ~~23SEP @ 2100~~
23SEP - 24SEP

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV															146/89	141/82	138/79	141/84	130/78	136/79	124/74	117/67	116/68	118/70
NIBP														132/88	127/83	120/74	116/72	118/73	114/71	111/66	106/62	105/57	101/56	103/56
																98	99		99		96.4		97.4	
TEMP														69	69	68	65	67	67	65	69	59	62	61
PULSE														11	10	10	10	10	10	10	10	10	10	10
RESP														100	100	100	100	100	100	100	100	98	98	97
SP02															45	40	40	40	40	40	40	40	40	40
FIO2															5	5	5	5	5	5	5	5	5	5
Peep															10	10	10	10	10	10	10	10	10	10
SIMV															800	800	800	800	800	800	800	800	800	800
TVolume																								
INPUT															125	125	125	125	125	125	125	125	125	125
IV															6	6	10	6	9	8	8	8	7	7
Versed															24	24	24.5	24	24	24	24	24	24	24
Fent																50								
Ancef																		45						
Decadron																								
PO																								
NGT																								
O.R. IN															155	205	155	154.5	156	157	157	157	156	156
SUB TOTAL															155	360	515	674.5	929.5	886.5	1043.5	1200.5	1356.5	1512.5
TOTAL																	154							
OUTPUT															1000	700	275	325	275	275	225	125	125	100
URINE																								200
NGT																								
STOOL																								
O.R. OUT															1000	700	275	325	275	275	225	125	125	300
SUB TOTAL															1000	1700	1975	2300	2575	2850	3075	3200	3325	3625
TOTAL																								

MEDCOM - 20331

INTENSIVE CARE NURSING FLOW SHEET | QA Appr 8 Mar 89

(b)(6)-2

INITIAL SHIFT ASSESSMENT

		Time: 0630hrs Initals: [redacted]	Time: Initals: [redacted]
NEURO	Pupils	2mm (B) PERRLA → sluggish	Pupils 2mm reactive
	Sensorium	(+) MAE, TURNS HEAD, OPENS EYES	Moves extremities Alert
	LOC / GCS	SEDATED (VERSED @ 8mg/hr ; FENTO 120mcg/hr)	talkative. Communicating via interpreter
CARDIAC	Cardiac Rhythm	NSR c̄ RATE @ 61 bpm	SR 3 ectopy
	PRI / QRS	S_1S_2 ⊼ ⓜ	
	Pulse Strength	3+ x 4 EXTREMITIES	
	Cap Refil / JVD	< 3 SECS ALL EXTREMITIES / Ø JVD	< 3 secs
	Edema	1+ (B) HAND, (+) FACIAL EDEMA	facial edema
	Chest Pain	Ø	
RESP	Respiratory Pattern	INTUBATED NASALLY (L) NARE (25cm NOSE : SIZE-7.5)	O2 via Mask Reg unlabored
	Breath Sounds	CTA ALL LOBES; EQUAL RISE/FALL OF CHEST	BBS CTA equal chest expansion
	Secretions	MNL → ABSENT	
	Cough	N/A	NA
		SIMV @ 10, PEEP-5, TV-800cc, FiO2-40%	
SKIN	Color	NORMAL FOR NATIONALITY	Normal
	Integrity	INTACT ⊼ FOR (B) UE ACE WRAP DRSG (NO NEW DRNG)	sutures to (L) mandible
	Backside	(L) MANDIBLE c̄ SUTURES INTACT (BACITRACIN)	
IV	Access Devices	(R) IJ DOUBLE LUMEN (NPC 125 / VERSED @ 2mg/hr) PATENT/INTACT	(R) IJ PIVX 1
	Location	(B) AC # 18ga HL c̄ FENT @ 120 mcg/hr (PATENT/INTACT)	18G
	Condition	(L) RADIAL A-LINE (PATENT/INTACT)	(L) Radial Aline CPI, Ø SS infection
GI	Abdomen	ROUND / SOFT c̄ midline incision / dressing intact (old blood during stool)	NO bowel sounds, round
	Bowel Sounds	ABSENT ALL QUADS	midline incision drsg c̄ old
	Stoma/Ostomy	Ø	drainage noted
		N/G LIS (Greenish colored DRNG)	NGT LIS (R) nare
GU	Device	Foley CATH TO GRAVITY DRNG	Foley
	Color / Clarity	yellow / clear	yellow clear urine
		U/O ~ 125 c/hr	

Continue on reverse

PREP[redacted]	DEPARTMENT/SERVICE/CLINIC	DATE
[redacted] (b)(6)-2 [redacted]/AN	ICU #1, [redacted]	24 SEP 03

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

NAME: #[redacted] RANK: AGE: 32-34 (b)(6)-2

UNIT: (b)(6)-4 GENDER: ♂

STATUS: US: AD / CIV IRAQI: CIV / EPW

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

DA FORM 4700, MAY 78 USAPPC V1.00

#[redacted] (b)(6)-4 EPW

PT'S NAME #[redacted] EPW (b)(6)-4

DATE: 24SEP-25SEP

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
INV	108/64	110/63	110/66	117/69	120/68	124/70	122/77	118/64	104/68	119/71	123/72	117/64	119/70	133/76	115/69	108/65	104/63	99/56	97/58	112/68	112/59	108/65	119/70	118/69
NIBP	97/51	99/49	96/50	100/57	114/58	105/55	116/60	113/60	110/60	116/57	109/58	121/66	120/68	133/74	113/61	108/53		93/43	97/46			97		
TEMP	96 TM			97 TM		98 TM		99 TM		98 TM		98.8				98.4								
PULSE	61	62	60	61	74	61	106	85	89	92	88	96	107	123	95	99	90	94	97	84	101	99	86	87
RESP	10	10	10	10	16	10	18	17	17	15	17	20	15	17	20	18	18	19	19	19	20	24	16	12
SP02	96%	99%	99%	99%	100%	100%	100%	99%	99%	99%	98%	98%	98	98	96	97	97	97	98	97	97	97	97	97
FIO2	40%	40%	40%	40%	40%	40%	7L	6L	4L	4L	4L	4L	4L	4L	4L	4	4L	4L	4	4L	4L	4L	4L	4L
PEEP	5	5	5	5	5	5	NPB	NPB	MASK	MASK	MASK	MASK	MASK	MASK	M									
TV	800	800	800	800	800	800	—	—	—	—	—	—	—	—										
SIMV	10	10	10	10	10	10	—	—	—	—	—	—	—	—										
MAP	70	68	68	70	82	79	75	82	80	80	79	87	86	93	88									
INPUT																								
IV (MAINT)	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
IVPB	BEC 1 NS 5L															50								50
VERSED	8	8	8	8	0	0																		
FENT	12.5	12.5	12.5	12.5	0	0																		
PO	NPO	—	—	—	—	—	—	—	—	—	—	—												
NGT																								
O.R. IN																175								175
SUB TOTAL	150.5	145.5	145.5	140.5	125	125	125	125	125	125	125	125	125	125		175								
TOTAL	150.5	296.0	441.5	582.0	707	832	957	1082	1207	1332	1457	1582	1707	1832	1952	2127	2252	2377	2502	2627	2752	2877	3002	3177
OUTPUT																								
URINE	200	180		150	125		275		350		300		520	250	300	200	150	200	175	200	250	150	350 ~~150~~	175
NGT											300													
STOOL																								
O.R. OUT																								
SUBTOTAL	200	180		150	125		275		350		600		520	250										
TOTAL	200	380		530	655		930		1280		1880		2400	2650	2950	3150	3300	3500	3675	3875	4125	4275	4625	4800

MEDCOM - 20333

INITIAL SHIFT ASSESSMENT

		Time: 0630hrs Initals: [redacted]	Time: Initals:
NEURO	Pupils	3mm, PERRLA (BRISK) (b)(6)-2	
	Sensorium	INTACT TO TACTILE STIMULATION	
	LOC / GCS	ALERT, ORIENTED. RESPONDS TO ALL HAND GESTURES & TRANSLATED COMMANDS	
CARDIAC	Cardiac Rhythm	RRR (NSR @ 80 bpm)	
	PRI / QRS:	$S_1 S_2$ S (+)	
	Pulse Strength	3+ (L) UE / (R) LE (RADIAL), (L) UE (BRACHIAL)	
	Cap Refil / JVD	< 3 secs x 4 extremities / Ø JVD	
	Edema	facial edema mod / 1+ (R) hand	
	Chest Pain	ABSENT / denies	
RESP	Respiratory Pattern	RRR @ 18 bpm. S SOB / OR Difficulty breathing	
	Breath Sounds	CTA in all lobes, equal RISE/FALL of chest	
	Secretions	ABSENT	
	Cough	ABSENT	
SKIN	Color	NORMAL for NATIONALITY	
	Integrity	INTACT x for (R) UE ACE WRAP / (L) cheek LAC c SUTURES	
	Backside	INTACT (S s/s infection)	
		BACKSIDE (UNREMARKABLE)	
IV	Access Devices	(L) RADIAL ALINE INTACT / PATENT	
	Location	(L) AC #18ga HL INTACT / PATENT	
	Condition	(R) IJ IV INTACT / PATENT (NS @ 125cc/hr)	
GI	Abdomen	ROUND, tender	
	Bowel Sounds	ABSENT throughout	
	Stoma/Ostomy	N/A	
		N/G Clamp for next 8° > poss D/c	
GU	Device	Foley Cath to gravity DRAINAGE	
	Color / Clarity	yellow / clear (S s/s of infection	

[redacted] (b)(6)-2 | DEPARTMENT/SERVICE/CLINIC (b)(6)-2 ICU #1, [redacted] | DATE 25 SEP 03

PATIENT [redacted] CATION (For typed or written entries give; Name – last, first, m[redacted] grade; date; hospital or medical facility)

NAME: #[redacted] RANK: AGE: 32-34?

UNIT: GENDER: ♂

STATUS: US: AD / CIV IRAQI: CIV EPW

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

DA FORM 4700, MAY 78 USAPPC V1.00

#[redacted] EPW

(b)(6)-7

PT'S NAME: #[redacted] EPW

♂ (5)(6)-4

DATE: 25 Sep 03

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
INV	128/71	114/64	115/68	116/70	115/67	119/69	122/74	124/74	119/71	125/67	140/84	132/80	118/76	127/76	122/53	114/58	122/56	115/62	115/58	120/60	116/70	114/68	96/57	94/56 113/50
P NIBP	107/55	120/95	107/57	117/63	104/56	116/64	107/63	110/60	111/59	117/70		97		99		98		99		98	82	88	72	72
TEMP	97		97 bx	98 TM		97 TM		98 TM		98 TM														
PULSE	80	97	73	93	83	84	86	94	96	91	90	91	76	85	73	72	90	72	85	78	82	80	18	10
RESP	17	16	18	15	12	15	18	17	21	21	15	14	18	13	14	12	16	18	16	17	18	20	18	95
SPO2	99%	95%	96%	95%	96%	95%	96%	95%	96%	96%	95%	97	96	96	97	92	97	98	98	98	98	98	94	NC
FIO2	4L	4L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	NC
MODE	MASK	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	2L	NC
INPUT																								
IV	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
IVPB								50								50								50
DECADRON	5																							
										60	60		30		60		60		30					
PO	NPO	–	–	–	–	–	–	–	–															
NGT																								
O.R. IN										185	185	125	155	125	185	175	165	125	155	125	125	125		
SUB TOTAL	130	125	125	125	125	125	125	125	125	1315	1500	1625	1780	1905	1990	2165	2250	2375	2530	2655	2780	2905		
TOTAL	130	255	380	505	630	755	880	1005	1130															
OUTPUT				1st void						250	225			175		150			175					
URINE	300	200	150	100			350																	
NGT	300																							
STOOL																								
O.R. OUT							350			250	225			250		200			375					
SUBTOTAL	600	200	150	100			1400			1650	1875			2050		2200			2375					
TOTAL	600	800	950	1050																				

MEDCOM - 20335

INITIAL SHIFT ASSESSMENT

	Time: 0630 Initials: [redacted] (b)(6)	Time: Initials:
Pupils Sensorium LOC / GCS	Pupils 4mm + react. Moves all extremities. Follows simple commands c̄ difficulty	
Cardiac Rhythm PRI: / QRS: Pulse Strength Cap Refil / JVD Edema	NSR c̄ HR in 100's. Palpable pulses in all extremities. Cap refill < 3 seconds. No evidence of JVD. Slight swelling noted on R jaw	
Chest Pain		
Respiratory Pattern Breath Sounds Secretions Cough	Lungs CTA bilaterally c̄ O2 sats 96-97% on RA's & 2L O2 via N/C. Has productive cough c̄ yellow mucous noted.	
Color Integrity Backside	Color normal for race. No evidence of skin breakdown	
Access Devices Location Condition	R IJ patent dual 18ga CVC. NS infusing @ 125cc/hr	
Abdomen Bowel Sounds Stoma/Ostomy	Abdomen round and slightly distended. Hypoactive bowel sounds noted. Drsg c̄ small amt of old drainage noted	
Device Color / Clarity	Voiding spontaneously c̄ difficulty via urinal	

(b)(6)-7

PREPARED BY: [redacted] CPT/AN	DEPARTMENT/SERVICE/CLINIC: ICU #1 [redacted]	DATE: 24 Sep 03

PATIENT'S IDENTIFI[redacted] (Typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

NAME: [redacted] RANK: AGE:

UNIT: (b)(6)-4 GENDER: Male

STATUS: US. AD / CIV IRAQI: CIV / EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78 USAPPC V2.00

PT'S NAME #[redacted]

(b)(6)-7

DATE: 26 Sept 03

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV	108/65	109/67	112/63																					
BP NIBP	114/57	119/60	128/63																					
TEMP	97.9																							
PULSE	76	78	72																					
RESP	18	16	16																					
SP02	96	96	98																					
FIO2	2L	2L	2L																					
SOURCE	N/C	N/C	N/C																					
INPUT																								
IV /NS	125	125	125																					
IVPB																								
PO		200																						
NGT																								
O.R. IN																								
SUB TOTAL																								
TOTAL																								
OUTPUT																								
URINE		360																						
NGT																								
STOOL																								
O.R. OUT																								
SUBTOTAL																								
TOTAL																								

MEDCOM - 20337

[redacted] (b)(6)-4

Name:- [redacted]

Date of birth :- 1971 or 1970

The charges :- Stealing + Kidnapping
Rape [redacted] + Shooting
The IP's

The IP who is incharge of the case:-

1LT [redacted] (b)(6)-4

The Police Station:- [redacted]

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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 D 1	I E	[redacted]	UNK - EPW (b)(6)-4	EPW	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
—	32	X	9	MUSLIM

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
—	—	99 20	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	U	1900	—

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	K 7 8	—

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
—	—	1	YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICU 2	—

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] (b)(6)-7	—

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
—

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)	24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
Ø 5		~~030927~~ 030001	A B A A		030923

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

FOR LOCAL USE

DX: S/P EX LAP GSW TO ABD

Dx	Px		Trauma	Injury
873.40	23.19	93.54	9	569
879.2	24.5	88.24	9	[illegible]
881.10	86.59	99.04		
E991.2	54.11			
E991.9				

ADMITTING OFFICER (Signature) [redacted]

SIGNATURE OF ADMITTING CLERK [redacted]

DR [redacted]

DA FORM 3095, MAR [redacted]

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	[redacted]			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 33Y	6. RACE Z	UNK	10. PREVIOUS ADMISSION N	
11. FMP 99	12. SSN [redacted]	13. ORGANIZATION (b)(6)-7		14. WARD ICW1	
15. FLYING STATUS	16. RATING/DSG	17. DEPT./BEN K79	18. BRANCH/CORPS 78	19. UIC/ZIP	20. TYPE CASE NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: DIRECT FROM ER	22. HOURS OF ADMISSION: 1010	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK	25. TYPE DISPOSITION: 04	26. DATE OF DISPOSITION: 031111	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION: 020925	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]		30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE

(b)(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: (L) OPEN CHEST WOUND
(R) OPEN BACK WOUND

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

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: DR [redacted]

SIGNA [redacted]

(b)(6)-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

33 YOV GPW, MULTIPLE UPPER EXTREMITY FRACTURE SINCE 10 WKS AGO. ALSO WAS, SUSTAINED TO (L) LEG WITH SKIN GRAFT, AND OVER (R) ANTERIOR TIBIA. WAS DEAD, EXPOSED BONE OVER (R) ANTERIOR TIBIA.

PMH ?

PSH ?

ROS ?

ALLERGIES ?

PHYSICAL EXAMINATION

HEENT: WNL
NECK: SUPPLE
LUNGS: CLEAR
CARDIAC: S/M
EXT: (R) ACA, (L) BKA.
(R) LEG - OPEN, CHRONIC WOUND OVER (R) ANTERIOR TIBIA, WITH DEAD, EXPOSED TIBIA WAS SEPARATION (L) GRAFT GRAFT SITE

PROGRESS *(Enter date of discharge and final diagnosis)*

(A). (R) OPEN TIBIA WOUND / (L) OPEN GRAFT SITE

(P). I + D, REMOVE DEAD BONE.

(b)(6)-2

SIGNATURE OF [redacted]	DATE 25 SEP 03	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION	*(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.

[redacted]

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201 45.505
OCTOBER 1975
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
25 Sep 03 0500	Received pt in stable condition, VSS afebrile. (L) fa amp Below elbow, healed. (R) fa amputated above elbow. Abrasions noted on (L) LE. (R) LE w/ open wound below knee w/ blackened bone showing. Toradol given per md order. E/(C) patent intact. Pt has no tremors noted. Talkative and active on arrival, currently sleeping. Restraint on (L) LE w/ kerlix wrapped around leg under restraint. [redacted]
25 SEP 03 0240	VSS. AO. (R) [redacted] open Fx dirtied, black @ marrow and evident of infection. WTD DSG placed over wound. Wound wrapped over. Multiple abrasions to amputated extremities. (+) pulse to BLE. (R) leg stumpfed c/t (R) leg. HAV. Fed minimal amount of PM meal. Sent to mouth. [redacted]

(5)(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.

E # [redacted] (5)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26SEP03 1310	Author Op Note Pre Op Dx - [redacted] (B) Tibia fracture Post Op Dx - [redacted] Procedure - I&D [redacted] Tibia. Surgeon - [redacted] GBL - 2W Fluids - 300 cc Findings - Exposed tibial tuberosity removed, and skin edges mobilized Closed with 0 problems Pt's Report I&D in 48 hours. [redacted]
26SEP03	(1450) Assumed care of pt @ 1600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. ↑ agitated most of this shift. Amb to BR this am ⊼ difficulty. To OR today @ 1130 via gurney. Tx to gurney ⊼ difficulty. Returned from OR in stable cond. INF infusing ⊼ S/Sx infection/infiltration into @ t.d. Pt tol. po fluids ⊼ difficulty. Drsgs to BLE CDI. Pt able to move BLE ⊼ difficulty. ⊕ peds ⊕ pulse equal bilat. Cap refill <3 secs. 1 point restraint in place ⊼ S/Sx complications. Will cont. to monitor. [redacted]
27Sep03 0345	Assumed care @ 1800; All VSS, pt A&O speaking arabic, pt agitated & multiple outbursts @ other pts; pt amb to BR x 3 ⊼ difficulty

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

2-19(G)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	(cont) dsg to bilat LE CDI ∅ drainage; ⊕ CMS in ⊕ LE, brisk cap Refill, ⊕ pedal pulses, persistent edema in ⊕ LE, non-pitting; pain controlled ∅ T3 ×1; 1 point restraint in place; ⊕ circulation, ⊖ skin breakdown; cont to monitor [redacted]
	IVF @ 100 cc/hr infusing ∅ s/sx infection/infiltration [redacted]
27SEP03	(1530) Assumed care of pt. w/ report from night shift. Pt alert, speaking Arabic. Pt cont to be angry and be disruptive. VSS. Pt medicated ∅ Tylenol for pain. Dsg to BLE ∆d. Small amount of drainage noted w/ both sites. Pt amb well to BR. ⊕ EJ flushes well ∅ s/sx infection/infiltration. Tol. reg diet well. Voiding ∅ diff. 1 point restraint in place ∅ s/sx complications. Will cont. to monitor. [redacted]
28sep03@0015	Assumed care @ 1800; All VSS, pt A&O being very temperamental ∅ multiple outbursts to other pts as well as ∅ staff; cont ∅ scheduled Advil & meds given for pain, pt ↑ amb to BR x2 ∅ difficulty; Dsg's to BLE CDI, ⊖ drainage noted; voiding ∅ difficulty; EJ flushes well, ∅ s/sx infection/infiltration; restraint in place, ⊕ circ. ⊖ skin breakdown cont to monitor [redacted]
28sep03@0530	Attempt to place 16F Foley catheter failed; Went to ICU & asked 1Lt [redacted] to come assist, then grabbed a 10F catheter; after many

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	attempts, none were successful; suggested Urology consult c Dr. [redacted] (b)(6)-2 [redacted]
28Sep03	0922 - Assumed care of pt. @ 0000. Assessment completed. PERRLA, lungs CTA (B). Resp even unlabored, abd soft nontender, BS x4. voiding per urinal. Ambulated to BR x 1 this AM. personal hygiene conducted. One restraint in place to (L) LE. (+) circulation (-) skin breakdown HL IV cdi to (L) EJ. (-) s/s infection/infiltration Pt. NPO for surgery this AM. Pt. resting well @ this time. w/ll cont. to monitor. [redacted]
28Sep03	0940 - 1155 A+O Pt. resting well @ this time. Pt. encouraged to do LE. Range exercises. (+) edema to (B) feet. (+) pedal pulses (+) circulation. Will cont. to monitor [redacted]
28Sep03	1515 - Pt. resting well @ this time. Tol lunch well. Pt. will go to surgery tomorrow. NPO p MN. Dr. [redacted] attempted to insert foley cather. Unsuccessful due to closure of urethra. Pt. scheduled for OR tomorrow. follow up per Dr. [redacted] (b)(6)-2 [redacted]
28 Sep 03 2000	Pt A+O x3, VSS, LS CTA (B), (+) BS x4, abd soft flat nontender, HL (D) EJ intact, medicated for pain, dsg on (R) LE c drainage noted, dsg LLE CDI, NPO q MN, proper circulation +

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DATE	NOTES
28 Sep. 03 Cont.	∅ skin breakdown on pts of restraint. [redacted] 9W0 [redacted] 9W
29 Sept	around care ∅ ∅ pt. WDS PERRLA, lungs CTA(B) respiration even and unlabored, abd soft non-tender, BS x4, pt c/o difficulty urinating, pt NPO awaiting surgery (when foley may be inserted) restraints x1, circulation intact except for injury site skin intact ∅ edema, no other noticeable [redacted] findings
29 Sep. 03 1915	Pt recieved from OR, VSS, BP-97/68 P-74 R-20 SPO2-98% T-98.8, c/o pain, medicated c̄ 2 ~~peres~~ Tylenol #3, Tol PO well, HL IV (L) EJ, SP Cath to gravity draining cly urine, amount sufficient, wound on LLE wrapped c̄ kerlix CDI, RLE wrapped c̄ ace wrap CDI, pt ambulates c̄ shuffled gait, LS CTA (B), (+) BS x4, abd soft flat non tender, ∅ s/sx of ~~infex on pts of~~ DVT poor circulation or skin breakdown on pts of restraint. [redacted] 9W

(b)(6)-2

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[redacted] (b)(6)-4

LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

DATE	NOTES
28 Sep 03	I concur c above assessment. [redacted]
30 Sep 03 0700	- Assumed care of pt. A+O x3. VSS. Ø c/o pain or discomfort @ this time. Superpubic cath to gravity draining clear yellow urine. Remains NPO p MN on call for OR 1 Oct 03. Wound bilat LE Dressing intact Ø active bleeding noted. Will cont to monitor [redacted]
(2000)	Pt alert, VSS, c/o pain often. SP cath intact and draining cyu. drags to (B) LE CDI. NPO for OR in AM. IV Hld to (L) RT. Ø edema or redness @ site. Pt amb. to BR's difficulty @ circulation, Restrain on. Will monitor [redacted] Plumb SPC
30/01 Oct 03 0700	- Assumed care pt. A+O x3. VSS Remains NPO on call for surgery this morning. IV antibiotics cont. Superpubic cath to gravity clear yellow urine QS. Dressing to bilat lower extremities. Central line care given to (1) IJ Ø s/s of infection. Will cont to monitor [redacted] Plumb
1 Oct 03 1015	Post Op Note Pre Op Dx: Exposed open (R) tibia Post Op Dx Procedure: (1) I+D (R) tibia (2) Application of VAC device Surgeon: [illegible] Findings: Wound clean after I+D, VAC applied PLAN: re look in 3 days [redacted] (b)(6)-7

[redacted] (b)(6)-7

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DATE	NOTES
Ø1 OCT 03 (12ØØ)	Pt returned from OR via gurney in stable cond. VSS. Pt medicated c̄ ii T3 for pain. Drsg to RLE c̄ vac. device to cont. suction. IVF infusing into Ⓓ W c̄ s/sx infection/infiltration. Pt alert, speaking Arabic. Drsg to LLE ⓓ. monitoring. [redacted]
1OCTØ3 1900	Pt resting in bed, easily aroused, VSS, medicated for pain c̄ 2 T#3, dsg's to LE Ⓑ CDI, suction continuous to RLE, Ø drng noted, IV HL to Ⓓ W c̄ Ø s/sx of infex, Ø s/sx of poor circulation or skin break down on pts of restraint, LS CTA Ⓑ, Ⓣ BSx4 [redacted]
1OCt03	2100: I concur c̄ above asse[redacted]
1 Oct 03	Hemotogy Note. No reported seizure activity. Will start tapering of Ativan. No need for continued use of Thiamine IV. Will start on MVI q D. [redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2Oct03@1400	Received pt resting in bed, VSS, Tol PO, SVQ3. AAOX3, speaks arabic. Wound vac to @LE in place & on low sex. Pt sleeping most of shift. Med. x1 w/ ## tabs tylenol for pain. IV to @ EJ patent & intact, flushes easily. Restraints per CPN protocol, ∅ breakdown noted. ∅ other remarkable assessments. Will cont to monitor. [redacted]
2Oct03@2130	Assumed care @ 1900; All VSS, pt AAOX3; NV intact; pt amb's ∅ diff, tol PO; sucker to R LE c̄ wound Vac in place; pt sleeping most shift; ∅ c/o pain; EJ patent flushes easily; Restraints in place, ⊕ circ. ⊖ skin breakdown; ∅ other assessment; Cont to monitor. [redacted]
3Oct03@0400	Received pt resting in bed, VSS, tol PO, arabic speaking, alert & oriented. Wound vac to @LE intact, @LE wound dsg w/ healed, min to scant serous drainage noted. EJ to @ neck patent and flushes easily. Med rated x1 ## percocets for pain. restraints per CPN protocol. FFGM supraprubic catheter to gravity drainage, qs dk yellow. ∅ other remarkable assessments at this time. Will cont to monitor pt. [redacted]
3Oct03@2145	Assumed care @ 1900; All VSS; pt ↑ to speaking [illegible] ∅ meds given for pain; wound vac intact, draining minimal amt fluid; dsg to @ LE CDI, ⊖ draining SP tube draining qs, clear, dark yellow urine; EJ patent & flushes well; cont c̄ IV abx; pt ↑ to amb to BR; ⊖ BM; ⊖ significant Δs in assessments; Restraints in place, ⊕ circ. ⊖ skin breakdown; cont to monitor. [redacted]

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DATE	NOTES
4Oct03 BW	Received from PACU Alert & oriented. Speaking loudly about wanting to return to EPW Camp. VSS. Lungs clear BS (+) x4 quadrants. Surgical site with patent & intact drains clear yellow urine. (R) lower extremity vac. device connected to LCS. drsg to (L) lower extremity dry & intact. Lungs 500mg IVPB given. (L) IJ patent & heplock. Pt tolerated regular diet for lunch. Will continue plan of care. [redacted]
4Oct03@2310	Assumed care @ 1800; All VSS, pt A&O, pt. OOB to BSC, (+) BM; SP tube patent & draining QS, clear, yellow urine; wound vac to (R) LE intact hooked to LCS; drsg to (L) LE CDI; EJ patent, flushes easily; cont c (U abx); & pertinent A's; Res. cont to monitor. [redacted]
5Oct'03	pt A+O×3, WNL, PERRLA, pt c/o stomach pain, moved OOB to bedside commode where it had (+) BM, SP catheter draining clear yellow urine, wound to (R) lower extremity hooked to suction, skin warm, dry and intact, sensation x 1 in place, (+) circulation [redacted]
5Oct 1735	Pt given atrovan. 5mg @ 1735 [redacted]

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AST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5OCT.03 2030	Pt sleeping but easily aroused, pain controlled c̄ ⅓ T#3, LS CTA (B), (+) BS x4, foley → gravity draining c/y urine LCS to (R) leg wound, minimal amount of greenish drainage noted, pt able to move LE x2, pedal pulses equal (B), SP cath intact, ø s/sx of infex, ø s/sx of poor circulation + skin breakdown on pts of restraint. [redacted] GW
06OCT03	(1715) Assumed care of pt @ 0000 ṗ report from night shift. Pt alert, speaking Arabic. VSS. ø c/o pain. (e) IV d/c'd this am d/t infiltration. Awaiting anesthesia to start new IV. Drsg to LLE d/t this am. Drsg to RLE intact c̄ vac. device to low cont. suction. (+) pedal pulses equal bilat. Pt able to move BLE. SP cath. draining quantity sufficient clear yellow urine. Tol. reg diet well. 1 point restraint in place s̄ s/sx complications. Will cont to monitor. [redacted] AW (1755) (e) IV started per anesthesia. Levaquin started @ 1750. ø s/sx infiltration. monitoring. [redacted] AW
6OCT.03 2000	Pt A x OX3, VSS, ~~[illegible]~~ LS CTA (B) (+) BS x4, HL IV (R) IJ intact, ø s/sx of infiltration, pain controlled c̄ T#3, opsite dsg on (R) LE CDI, dsg (L) LE CDI, NPO p̄ MN to OR in AM, sux turned off for hrs of sleep, SP cath draining c/y urine, intact, pedal pulses equal (B), tol reg diet well, ø s/sx of poor circulation or skin break down on pts of restraint. [redacted] GW

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DATE	NOTES
7 Oct 03 0700	— Assumed care of pt. AT O x 3 VSS. Ø c/o pain or discomfort @ this time. Foley to gravity clear yellow urine. Suction to (L) LE continuous small amount of serosanguous fluid. Cont. IV Antibiotic tx. Central line (R) IJ patent site CDI. Multi amputation. Remain NPO for surgery. Will cont to monitor
7 Oct 03 2100	Pt asleep, easily aroused, A+O x3, VSS, [redacted] LS CTA (B), @ BS x4, SP cath in place draining c/y urine, amount sufficient, dsg on abd CDI, LCS to RLE, dsg on LE x2 CDI, pain controlled c T#3, IV HL (R) IJ intact, Ø s/sx of infex or infiltration, 2 pt restraint in place, Ø s/sx of poor circulation or skin breakdown [redacted]
8 Oct 03 0700	— Assumed care of pt. A+O x3. VSS lungs clear. Suprapubic cath to gravity clear yellow urine. HCCK IV ABX continue. Suction to LLE small amt of serous fluid. Central line (R) IJ is patent. Will cont to monitor

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08OCT03	(1645) I concur c above assessment. [redacted]
2800CT03	Pt Awake. Aad speaking arabic. VSS Ø
2030	c/o pain. Drsg to RLE Intact. Vac device turned
	off for hs. SP draining qs cx u. consumed
	10% of dit this pm. 1 point restrain in place.
	Will continue to monitor. [redacted]
9 OCT03	Assumed pt. care @ 0800. Pt. A+O x3. VSS.
0940	lungs CTA. VAC to (R) tib continuous c brownish drain.
	Supra pubic tube to gravity c clear yellow urine o/p.
	IV LR @ 125cc/hr infusing in (R) neck c signs of infiltration
	& complaints @ this time. will cont to monitor —
	[redacted]
9oct03@1930	Assumed care@1800; All USS, pt A+O, Ø ΔΔN; dsg to (R) tib CDI, wound
	Vac intact, cont suction draining brown w/red liquid; will be D/C'd
	@ HS, Ø s/sx infection; SP Tube in place draining QS, clear
	yellow urine; TOL PO c poor diet; IV patent infusing LR @
	125c/hr c s/s infection; cont to monitor. [redacted]
10 Oct 03	Assumed care pt. A+O x3 VSS. Remains NPO
0700	on call to OR this morning. LIC suction to (R) LE wound
	small amt of serous brown fluid. Lungs clear. HRRR Active
	BS x4 Super pubic cath draining clear yellow urine QS. (R) IJ
	cath. site CDI Ø s/s of infection will cont to monitor —
	[redacted]
10 OCT.03	Pt sleeping, easily aroused, pain controlled
1915	c Tylenol #3, LS CTA (B), (+) BS x4, dsg's on
	LE x2 CDI, Suction in place on (R) LE,
	small amount of drainage noted, suction

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DATE	NOTES
12 Oct 03 @ 1112	Received pt resting in bed, VSS, tol PO, wound vac to RLE intact + on LCS. (L) LE (shin) dressing in gauze. (R) e) intact ∅ swelling or tenderness noted @ this time. cont IV ABX, pred. ±1 T3s for pain. restraints per CPW protocol ∅ breakdown noted. Will cont to monitor. [redacted]
12 Oct 03 @ 1930	Assumed care @ 1800; All VSS, pt A&O; [redacted], although minimal appetite; wound vac intact; dsg ~~all~~ CDI ∅ drainage; (R) EJ patent, ∅ s/sx infection/infiltration; Cont ∅ alert; ∅ c/o pain @ this time; Restraints in place, (+) circ, (−) skin breakdown, cont to monitor [redacted]
13 Oct 03 @ 1400	Received pt resting in bed, VSS, tol PO, ABOX3. wound vac to RLE intact to LCS. Gauze to (R) LE intact, clean, dry. Suprapubic cath intact, ∅ leakage noted, drain of yellow urine. (R) e) intact, flushes easily, ∅ redness or swelling noted. cont IV ABX, restraints per CPW protocol ∅ breakdown noted. Will cont to monitor [redacted]
13 Oct 03 @ 2055	Assumed care @ 1800; All VSS, pt alert, in NAD, ∅ c/o pain @ this time; pt appetite ↑, ate 100% of dinner in addition to another plate; wound vac to RLE intact on cont suction, minimal OP noted; SP tube patent & intact draining ∅ s, clear, yellow urine ∅ difficulty, (R) EJ patent, easily flushes, ∅ s/sx infection/infiltration;

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(Cont) cont c IV abx; Restraints in place, (+) circ. (-) skin break; cont to monitor [redacted]
13Oct03@2315	(R) EJ became dislodged; Cpt Waters successfully placed 18g cath in (L) EJ p 1 failed attempt; patent & easily flushes c 5 cc x infusion/infiltration. Cont to monitor [redacted]
14Oct03 @1038	Recd report and assumed care of pt. Pt awake lying in bed tolerated reg meal. Foley (S/P) to gravity. Drain to (R) leg to low continuous suction. EJ flushed c 5cc of NS good blood return heparin cap (+) BS. (-) S/S of resp distress pain or discomfort. Will continue to monitor - [redacted] 91WM 6
(1930)	Pt alert, sitting ↑ in bed, ∅ c/o pain @ this time. consumed 100% of dinner. (L) EJ patent, ∅ s/s/sx infection/infiltration, SP foley intact draining cyu. H2O @ BS. (R) leg to low cont suction c̄ scant drainage. Restraint in place ō compromise to skin/circulation. Will monitor [redacted] 91WM6
2200	2 Tylenol #3 tabs given for (L) stump pain c̄ noted relief. vac device c̄ scant drainage. Will monitor [redacted] 91WM6
15OCT03 1026	Assumed care of Pt @ 0100. (L) EJ patent, SP Foley draining cyu. (R) LE to low cont suction c̄ minimal drainage. Pain controlled c̄ Tylenol #3. Will continue to monitor. [redacted] 91WM6
	(1300) I concur c̄ above assessment. [redacted]

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DATE	NOTES
15OCT03 (1950)	Pt alert, speaking arabic, Ø c/o pain, sleepi often. tol. 100% dinner today. LCTAB, HRRR, ⊕BS×4, VSS, ⓡ leg to cont. low suction c̄ minimal drainage. ⓛ IJ patent. IV zosyn cont per MD orders. 1 pt restraint on ⅁ compromise to skin or circulation. Will monitor —
0300	Pt slept thru night c̄ Ø complaints, [redacted] 91WM6 — SP cath intact draining cyn. (for output see form DD 792. [redacted] 91WM6.
16Oct@0726	Pt ate 75% breakfast c̄ assist. VSS. ⓡ wound vac drainage serous sanguinous minimal. Med c̄ Ty #3 ⅡⅡ for pain. Will continue to monitor. Lung sounds clear through all lobes. ⊕ pedal pulses. EJ in ⓛ side appears CDI. ⊕ Foley draining clear yellow urine ⊕ Bowel sounds.
16OCT03 @2130	Assumed care of pt @1800. VSS, alert, speaking arabic [redacted] LS CTA, ⊕BS, tol regular diet, voiding per SP cath cly urine. ⓡ LE wound connected to vacuum device, min. output noted, ⊕ CMS to RLE, +2 DP pulses, equal bilat. ⓛ IJ patent drsg Δ'd & now CDI. ⊥ pt restraint ⅁S/Sx q. skin or circulation compromise. Plan: IV abx as ordered (CONT)

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2145	(CONT) Monitor NV status, monitor output from LE wound, pain control. [redacted]
0500	minimal drainage noted from RLE wound. [redacted]
0510	Pt output per SP cath = 900cc for 12 shift. [redacted]
17 Oct 03	VSS alert (L) IJ IV patent & intact. Lungs
0900	clear. BS(+) x4 quad. Abd soft non distended. Suprapubic cath intact & patent drainage clear yellow urine. (R)LE warm to LCS & second and
	of drainage. Peripheral pulses palpable (3)+2. Reposition (Q2hr) for comfort. Will continue
	plan of care. [redacted]
17 Oct	(L) IJ IV ~~infiltrated~~ infiltrated. IV D/C. Dr
1730	Albertson informed. New order to Hold ABX
	NPO p MN for OR in AM. Will report
	to on coming shift. [redacted]
17 Oct 03	assumed care of pt @1800. VSS, c/o pain, controlled c
2330	#3 tabs. Alert, speaking arabic. LSCTA, (+)BS, void per
	SP cath, draining clear yellow urine to foley bag. RLE
	wound to suction, drsg CDI, minimal drainage noted.
	(+)CMS to RLE, +2 DP pulses, equal (B/L). IVF & Abx on hold.
	Pt restlessness & S/Sx of skin/circulation compromise.
	Plan: NPO p MN to OR in AM. Monitor pain control,
	monitor wound & drainage. [redacted]
18 Oct 03	Pt voided a total of 1600cc clear urine from 1800-0600
@0345	hrs per SP cath. [redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18OCT03 @2300	Assumed care of pt @ 1800. VSS. 9/10 pain to LLE & head(?). (Pt points to head & leg.) Tylenol #3 given c̄ good relief noted. LS CTA, ⊕ BS, tol reg diet well assisted feeding. SPcath to foley bag yellow urine. RLE c̄ opsite dsg CDI, attached to skin, min drainage noted. (L) JP replaced, dsg CDI. Plan: cont IV abx as ordered, monitor wound & suction, pain control. Pt restraint on & s/sx of skin/circulation compromise. Will cont to monitor. — [redacted]
@0500	Pt shift totals: ins: Meds = 100cc; PO = ~~500cc~~ 600cc; Outs = UOP = 900cc
19 Oct03 1705	Assume care of PT @ 0600. A+Ox3, VSS. Sat in chair for an hour. C/O pain given Tylenol. 2pt restraint & skin compromise, distal pulse present. Foley to gravity, clear yellow urine. Ambulatory to restroom. Will cont. to monitor. — [redacted]
	(1745) I concur c̄ above assessment [redacted]
19OCT03 2030	Pt Awake & agitated. Pt voiding small amount of urine via urethra sporatically. Drsg to (R) LE CDI c̄ cont suction on Drain. Pt in 1 point restrain. Given 30 mg [redacted] Will continue to monitor. — [redacted]

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DATE	NOTES
18 [illegible] 0400	Received pt this am resting in bed, OSS, NPO for surgery. ∅ IV access, no awareness of surgery per night shift nurse, abx on hold. held po meds due to NPO status. Pt returned from surgery in stable condition. (L) leg unwrapped upon [illegible] per pt request. Tol PO, pt medicated for pain w/ ⅓ T3, pt demanding valium (∅ order). (L) IV access patent to (R) neck, placed during OR time. Wound vac to (R) LE in place and to low cont suction, ∅ recordable drainage noted c this time. Suprapubic catheter intact & voided [redacted] yellow urine, some sediment noted. IV access heplocked c this time. Restraints per epw protocol, ∅ breakdown noted c SUTS. Restraints to (R) LE, pt removed [redacted] gauze placed under restraint (at pt request) w/ [redacted] by pt. Abrasions noted on LE w/o change. Will cont to monitor pt [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
20OCT03 @ 1000	Pt awake, VSS, ø c/o pain. pt upset about urine leaking from penis. c/o urgency to void. Suprapubic catheter intact draining dark yellow urine. (R) leg to high cont suction c̄ minimal drainage. Am care done. 1 pt restraint on & compromise to skin/circulation. Will monitor ((b)(6)-2 [redacted] 9 WM6 —
1030	MD ([redacted]) @ BS. sutures to SP cath site removed. new SP cath placed /14 French foley catheter). Monitoring ([redacted] 9 WM6.
1345	Pt had formed BM x2 (L) IJ patent, flushing easily. ø skin breakdown noted @ this time. total UOP this shift 450cc. Encouraging H2O. Monitoring ([redacted] 9 WM6
1630	Pt still c̄ frequent c/o urgency to void. MD aware. bladder non-distended @ this time. [redacted]
20 OCT @ 2330	assumed care @ 1800. VSS. Pt yelling, kicking @ leg drsg & sxn tubing, attempting to pull SP cath, shifting body in bed to move chux padding from under hips. Haldol 5mg IV given to calm pt @ 1900. Pt continues to yell, turn, slide (CONT)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			S[redacted]
	LAST	FIRST	MI	
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[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2330	(CONT) up & down in bed. RLE wound drsg pulled down from top of wound as a result of pt shifting & kicking. 2pt restraints placed on legs. MD @ BS, checking SP cath. SP removed & replaced c̄ 14Fr by MD. Through interpreter, pt stated he could not control void through urethra. (Pt. @ this time had 2 voids to bed pads. Ditropan ordered & given. Pt ↑ amb to BR for BM s̄ difficulties. RLE drsg secured c̄ tape, sxn on. SP cath secured to thigh c̄ tape. ⓓ IJ HL, flushes well. Plan: monitor SP cath & UOP, monitor behavior, IV Rx as ordered. 2nd restraint removed @ 2300 c̄ promise not to disturb SP & leg dressing. + pt restraint on s̄ S/Sx of skin or circulation compromise. Will cont. to monitor [redacted]
21 OCT03 (0800)	Pt aware, still upset about not having control over void. SP cath foley empty @ this time. Due to saturation of bed pads condom catheter put on pt. Due to pt shifting frequently ⓡ leg drsg coming off. reinforced c̄ tape & Kerlix. Ditropan given as ordered. Pt ambulated x 3 in hall & to bathroom. Ø skin breakdown noted @ this time. Pt consumed 50% breakfast this AM. ⓓ IJ flushed well, site cleaned & drsg ↓'d. Will monitor [redacted] 9 IWMC SC
1330	Pt c̄ 300cc cyu in condom cath foley bag. S/P cath c̄ Ø drainage today. Pt calm @ this time. Monitoring [redacted] 9 IWMC

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
(1600) 21OCT03	Suprapubic cath. removed per MD orders. Ø output from SP cath. today. Cont to monitor [redacted] 1WMC.
21OCT03 2035	Pt laying in bed. c/o pain. Medicated c̄ Tylenol 3# 1. Will continue to monitor. Pt c̄ condom cath draining clear, yellow urine. Has wound vac to (R) lower leg. Suctioning c̄ difficulty. Lung sounds clear ~~thr~~ through all lobes. (+) bowel sounds. (D) IV flushes well. Ø S/Sx infection. [redacted] 1WMC
22 OCT 03 0700	Assumed care of pt. AFOX3 VSS Ø c/o pain or discomfort @ this time. Lungs clear HCRR Active BS x 4 quads. Condom catheter in place secured c̄ tape. CYU QS. Wound vac to (R) LE cont. suction serous drainage minimal amts. (L) IV Intact HL IV ASX ~~tx~~ cont Remains afebrile Will cont to monitor [redacted] 1WMC
22OCT03 2100	Assumed care of Pt at 1800 hrs. VSS c/o pain controled c̄ Tylenol 3. LS CTA (B). S1 S2 Present (+) BS X4 quads. (R) LE Drsg C/D/I c̄ LC Suction Draining. (-) S/Sx of infection. Will continue to monitor Pt. [redacted] Spc 91WMC

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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[redacted] (5)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23 Oct 03 1458	Assume care of PT @ 0600. A+O x3, VSS C/O pain given ~~Hydrocodone~~ tylenol. Broke out in sweat for brief period. Drsg Δ on (L) leg, Δed Keflix on (R) leg. Bacitracin applied to graft site. Is ambulatory. Will continue to monitor. ——— 91W [redacted]
23 OCT 03 ~~1800~~ 2350	Assumed care of Pt @ 1800 hrs. Pt A&O Temp 104.9°F(O). Administered 650mg Tylenol. Encouraged IS removed covers (Blankets). Applied Ice pack To posterior neck (L) Axilla. groin region. Temp ↓ 102.1°F(O) @ 2130 hours. LSCTA(B) S_1 S_2 present (+) BS x4 quads. Pt void via condom cath. Dark amber urine. Pt NPO p̄ midnight for OR on 24 oct 03. (R)LE Drsg CDI. Drain to RLE on Low continuous suction. Will cont. to monitor. ——— [redacted] Spc 91WM6
24 OCT 03 1005	A.O. T @ 1014 and provided 2 Tylenol & [redacted] 15 to bring down T. Diaphoretic @ times. Accompanied to BR and had diarrhea x1. DSG reinforced to RLE & minimal serosanguinous drainage upon ambulating & offloaded. Condom cath in place and draining light amber urine, BS. FTG. LSCTAB. HRP. ——— [redacted] RG
24 OCT 03	0730 - assumed care of pt @ [redacted] C temp of 103.3. checked temp again @ 1900 Temp 104.4. Ice pack applied to groin area + back of neck. cool wash cloth applied to forehead Encouraging to drink plenty of water. will cont. to monitor pt. + temp. ——— [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
240ct03	2000 - U/A collected per MD order. Awaiting Results. [redacted]
2120	- Pt. temp. 102.4 [redacted]
2230	- Temp. 100.3. IV infiltrated previous shift. New IV started to (L) EJ. CDI. (-) edema (-) Redness. Pt. resting well [redacted] @ this time.
0130	- Pt. ambulated to latrine (+) B[redacted]. Assessment completed LS CTA (B), Resp even unlabored abdeso ft mamtender. BS x4 quads. Foley to gravity draining clear yellow urine. Drsng in place, to (R) CE c VAC on low continous suction. Minimal drainage. Small wound on (L) ankle. drsng applied to prevent irritation from restraint. IV (L) [redacted] EJ CDI. Pt. resting well @ this time will cont. to monitor for further changes. [redacted]

(b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 OCT 03 1205	VSS. AO. Jaw-drain intact to RLE. Sustaining moderate amount of serosanguinous drainage. CL (triple) placed to (L) ES. Hematoma to (R) ES. region from first attempt. Pressure dsg applied. FTG = warm with intact. Justify moderate amount to order more. Provided fluids and performed BM x1. [redacted]
25 OCT 03 1930	VSS. Alert & oriented. Central line patent & intact. (R) LE = dry drsg intact and wound vac to continue low suction. Voiding clear yellow urine. No pain or distress noted. Will continue care as planned. [redacted]
26 OCT 0900	Pt a/o, VSS, Ø c/o pain. pt pulled condom cath off x2. Pt requests foley via translator. Pt ambulated x1. vac drain to LOW con't wsn c̄ minimal serosang drainage. Pt refuses surgery via translator but requests supra-pubic catheter being reinserted. UOP since 0600 1000cc ayu. (L) IJ central line drsg CDI, flushing easily. MD informed of pt requests. Will monitor [redacted] 91WM6 SPC

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LAST NAME	FI	NAME	MIDDLE	AL	ID NUMBER

DATE	NOTES
(1030)	Pt urinated 300cc via urinal. Pt non-compliant c̄ care @ this time. Linen Δ'd x 3 due to void. MD aware of pt condition. Will monitor [redacted] 91WM6
(1100)	Pt yelling, interpreter @ BS to comfort pt. Pt uncooperative, Pt tells translator that he wants a needle to pierce his penis because he is unable to void. Dr. [redacted] @ BS to talk c̄ pt (attempted to put in 8 FR. foley cath) & failed. Pt voided approx 200cc @ this time on bedpad. Condom cath put back on per pt request, within 10 min pt pulled cath. off again. Plan: attempt to put condom cath. back on, or assist pt c̄ using urinal frequently, monitor UOP & pain control. [redacted] 91WM6
1300	Pt still yelling, c/o urge to void, bladder distended. Ø UOP since 1100. MD aware of situation. Translator @ BS. [redacted] 91WM6
1450	Pt still c̄ urge to void. 8 FR foley inserted c̄ difficulty. Will monitor output. [redacted]
1600	Pt UOP since foley insertion: 280cc c̄ v.u. bladder no longer distended. Monitoring [redacted] 91WM6
1630	Pt now calm & sleeping c̄ Ø complaints. [redacted]
~~2702103~~	~~Pt Δ to OPS Outpatient Rm E [redacted] Drawing Dark~~
~~0700~~	~~urine. Δ'd to R E [redacted]~~
	~~EDT. Denies pain. Will mo[redacted]~~ 91WM6

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
27OCT03 0200	Pt A&O VSS FTG CXU, Antibiotics continue Pt cooperative and unagitated. Will continue to Monitor. [redacted] CPT/WMC
27OCT03 1200	VSS. AO. BS@x4. LSCTAB. Denied c̄ AM feeding this AM. FTG voiding clear yellow urine c̄ difficulty. Cont c̄ AB Tx. CL DSG d/d c̄ difficulty. Cont to monitor. [redacted]
27OCT03 2200	Assumed care @ 1700. Denies pain. Foley FS gravity draining small amount of CXU. Cont c̄ Abtx. CL Dsg CDI. Will continue to Monitor. [redacted] CPT WMC
28 Oct	Pt. AOx3, VSS pt c/o pain in his penis and headache from junction attached to his lower left leg extremity. Pt ambulated with ~~assist~~ some difficulty pt c/o stiff also from ~~[redacted]~~ left leg. chest [illegible] — (1700) I concur. [redacted]
28OCT03 @0140	assumed care of pt @ 1800. VSS, alert, speaking arabic. LSCTA, @BS, @BM this p.m.; (R) LE wound c̄ dsg, attached to sxn, CDI, some serosanguinous drainage noted in sxn tubing. Foley draining yellow urine, some sediment noted. (L) neck CL (TL) distal port = medical port flush, proX port does not flush. CL dressing Δ done c̄ sterile technique.

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2145	(CONT) Pt c/o itching; order obtained for Benadryl, given c good relief noted. Pt restraint m̄ s/sx of skin/circulation compromise. Plan: NPO p MN for SX, monitor
29OCT03	drsg. will cont to monitor. — [redacted]
(0755)	Pt sleeping, easily aroused. VSS, NPO for OR today. Cxn to (R) leg c̄ minimal serosang drainage in tubing. Ø c/o pain. Foley putting out ayu. 100cc since 0600 LCTAB (+) BS x4 qd, 0800 dose Demerol given. 1 pt restraint on s̄ compromise to skin or circulation. Will monitor [redacted] 9MM
29OCT03 1420	Ortho Op Note Pre-Op Dx → Open (R) tibia Post Op Dx Procedure - Excision - cutaneous flap to (R) tibia. Surgeon - [redacted] EBL - <50 cc's Findings - no granulation tissue over fibula in the 1 x 3cm area. Lowing medial myocutaneous flap cross defect, with no tension on graft, good bleeding from flap. Plan: recheck in 2-3 days. Split thickness skin graft to cover donor area.

[redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
(1530) 29OCT03	Rt back from OR, a/o, VSS, Ø c/o pain, (R) leg c̄ bandage & ace wrap. Rt tol. PO well. (+) pulses equal bil to (B) feet. (+) BS x4 qds, 1 pt restraint on 5 compromise to skin or circulation well monitor [redacted] 91WM6.
1700	pt c/o itching. 25mg Benadryl given PO [redacted].
29OCT @ 2030	Pt asleep. ~~Denies any p~~ ⊖ c/o pain at this time. Pt has (+) foley draining clear, yellow urine. VSS. (L) leg wrapped 2° old wound healing. (R) Leg wrapped to ace bandage. CDI. (+) pedal pulses B/L. Tolerating PO. [redacted]
30OCT (0900)	Rt a/o, VSS, Ø complaints, LCTAB, (+) BS x4, abd: soft NT, ND (non-distended). foley draining (8 FR). cyu. drsg to (R) leg dry & intact c̄ ace bandage. (+) pedal pulses equal bil. Tol. 90% Reg diet. foley care done. (L) neck CL (TL). drsg CDI. ⊖ edema or redness @ site. Pt OOB to amb. to BR x1. 1 pt restraint on 5 compromise to skin or circulation well monitor [redacted] 91WM6.

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#[redacted] (5)(6)-4

LAST NAME	FI	NAME	MIDDLE	AL	ID NUMBER

DATE	NOTES
30OCT@2330	Pt AAOx3, VSS. Pt c/o pain to groin area where foley placed. Foley appears patent + draining clear, yellow urine. Medicated c̄ 2 Ty#3. Will continue to monitor. TLC-2/3 flush well. Cont' IV ABX. Tol Reg diet. DSG to (R) Lower leg CDI. Kerlex gauze ~~pta~~ wrapped around (L) ankle to ↓ friction c̄ restraint. [redacted]
31OCT03 (1000)	Pt c/o, VSS, Ø c/o pain, foley draining QS cyu. abd: soft, NT, ND. NPO for OR today. (R) CL Th Ø redness or edema @ site. (R) leg drsg dry + intact, Ø drainage noted thru bandage. 1 pt restraint on ≤ compromise to skin or circulation. Will monitor [redacted]
(1615)	Pt back from OR, VSS, Ø c/o pain. (R) leg c̄ bandage + ace wrap. Ø drainage noted thru ace wrap. Pt tol. 100% Reg diet, (+) + equal pulses, brisk cap refill. 1 pt restraint on - Will monitor [redacted]
~~31OCT03~~ 1NOV03 @0145	Assumed care of pt @1800. VSS. Sleeping most of shift. When awake, alert & arguing. (L) neck c̄ flushes well. LS CTA, (+) BS x4 quads, RLE c̄ drsg from ankle to hip, CDI, (+) CMS to LE, +2 DP pulse equal BIL. Foley to gravity, draining c/y urine. Pt requesting (yelling) for foley to be flushed c̄ a syringe, though foley working properly. Refused to flush foley, pt arguing & demanding Tr#3 tabs given for pain c̄ good relief noted. Plan: Cont IV Abx, monitor drsg, pain control, UDI cont. to monitor) [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1 NOV 03 0700	Assumed care of pt. A+O x3. VSS IV ABX TX cont. Afebrile. Ø c/o pain @ this time. Lungs clear HRRR Active BS Tolerating PO well. Urinary catheter drained to gravity - Clear yellow urine BS @ leg wound dressing Ace wrapped CDI upper extremities amputations. Ø evidence of skin breakdown noted Will cont to monitor [redacted] Kuma
01 NOV 03 PM	VSS A+O. Foley draining clear yellow urine Consumed 100% of Regular diet for dinner @ leg dry dry covered. @ IV Replaced patent and intact. Will continue plan of care [redacted]
2 NOV 03 0700	Assumed care of pt. A+O x3. Ø s/s of infection afebrile IV ABX TX. c/o pain medicated c̄ tylenol #3 II tabs. Lungs clear HRRR Active BS BM this AM Foley to gravity CYU Multi upper extremity amputation @ LE fib-tib fracture @ leg Ace wrapped. Will cont to monitor [redacted] Kuma
3 NOV @ 0030	VSS. Pt c/o itching on chest + back. Called interpreter to converse c̄ pt. Pt stated cannot sleep at night 2° itching. Medicated c̄ 30mg Restoril to help sleep at night. Will continue to monitor. DSG to @ tib-fib CDI — D

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LAST NAME	FIRST NAME	MIDDLE	LAST NUMBER

DATE	NOTES
	(cont). Pt has foley draining yellow urine c̄ small amount of ~~urine~~ sediment noted. Pt has IV ABX infusing into TLC. Rechecked pt. Pt asleep & resting comfortably. Pt consumed sm amount of dinner. Will monitor throughout night on pt's status. [redacted]
0430	Pt became loud + c/o itching + pain. ~~Intervene~~ Offered Tylenol #3 ½ for pain. Pt refused. Pt continued to raise voice p̄ repeated attempts to ~~tell~~ verbally to keep voice ↓. Called interpreter to find out what pt saying. Interpreter said that pt do itching. Spoke through interpreter to tell pt will inform MD ~ itching, but offered tylenol #3 again. pt refused. Pt warned multiple times to keep voice ↓. Pt did not. Kerlex placed in mouth for about 5 seconds x2. Taken out + pt lowered ~~re~~ voice. Pt laying in bed. [redacted]
3 NOV 03 (1300)	Pt A&O, VSS, Ø c/o pain, (R) leg re-wrapped c̄ Kerlix + ace bandage. old blood noted on Kerlix. (+) pulses to (R) legs. drsg to (R) leg (ankle) S&D (WTD). Pt c̄ c/o itching, medicated c̄ 25mg Benadryl IV c̄ noted relief. foley to gravity draining cyl. (flushed x1). abd: soft, NT, ND. Pt had BM x2. today on BSC. Zosyn + levaquin IV con't per MD orders. (R) SC ch c̄ red port. flushing easily. Ø redness or edema @ site. 1 pt re-straint on ≅ compromise to skin/circulation. Will monitor [redacted] 91WM6 (SPC)

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(5)(6)-2

LAST NAME	FI AME	MIDDLE	L NUMBER

DATE	NOTES
	(cont). Pt has foley draining yellow urine c̄ small amount of ~~urine~~ sediment noted - Pt has IV ABX infusing into TLC. Rechecked pt. Pt asleep & resting comfortably. Pt consumed sm amount of dinner. Will monitor throughout night on pt's status. [redacted]
0430	Pt became loud + c/o itching + pain. ~~Intervene~~ Offered Tylenol #3 ½ for pain. Pt refused. Pt continued to raise voice p̄ repeated attempts to ~~tell~~ verbally to keep voice ↓. Called interpreter to find out what pt saying. Interpreter said that pt do itching. Spoke through interpreter to tell pt will inform MD ~ itching, but offered tylenol #3 again. pt refused. Pt warned multiple times to keep voice ↓. Pt did not. Kerlex placed in mouth for about 5 seconds x2. Taken out + pt lowered ~~pt~~ voice. Pt laying in bed. [redacted]
3 NOV 03 (1300)	Rt A&O, VSS, Ø c/o pain, (R) leg re-wrapped c̄ Kerlix + ace bandage. old blood noted on Kerlix. ⊕ pulses to (B) legs. drsg to (R) leg (ankle) S&D (WTD). Pt c̄ c/o itching, medicated c̄ 25mg Benadryl IV c̄ noted relief. foley to gravity draining cyl. (flushed x1). abd: soft, NT, ND. Pt had BM x2. today on BSC. Zosyn + levaquin IV con't per MD orders. (R) SC ch c̄ red port flushing easily. ⊖ redness or edema @ site. 1 pt restraint on ≅ compromise to skin/circulation. Will monitor [redacted] 91WM6(SPC)

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5NOV03 @0248	Pt complained of itching throughout night, not relieved from Benadryl (though pt fell asleep) or from atarax. No rash present. Will monitor [redacted]
(0755)	Pt a&o, VSS, ∅ complaints, AM care done, Pt had formed BM x1 to BSC. Nitropan given per orders. Pt consumed 95% breakfast this AM. Foley to gravity c̄ cyu noted. drsg to (R) leg CDI. (+) CMS, 1 pt restraint on to (R) leg. ō compromise to skin/circulation. Will monitor [redacted]
(1620)	Kerlix removed by Du [redacted] (R) calf now ~~OTA~~ [redacted] c̄ wrapped c̄ fluffs & Kerlix, (R) thigh c̄ xeroform OTA trimmed edges pm. Will monitor [redacted] 9mm
5NOV03 1900	Pt A&Ox3, VSS, ate 90% of dinner, did not want ensure, CL dsg Δ'd, ∅ s/sx of infex to site, dsg (R) leg CDI, voices ∅ c/o pain, xeroform on (R) thigh intact + trimmed on sides, foley to gravity draining cyu, 5mg Ambien adm. as per orders, IV meds given, CL flushes well, 2 point restraint, ∅ complications. [redacted] 9mm
2020	Pt c/o pain to (R) LE, adm [redacted] tabs 1y/#3, will cont. to monitor. [redacted] 9mm

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DATE	NOTES
3NOV@2330	Pt c/o itching. Informed Dr [redacted] that pt c/o itching + too early to give Benadryl. Dr. [redacted] NO 1x order now Benadryl. Medicated pt. Pt found ~~for~~ relief for ~20min. Pt c/o itching cont. Got ~~verb~~ VO from Dr. [redacted] for Atarax 25mg PO PRN Q6°. Medicated pt. Will continue to monitor pt's status. Pt cont' IV ABX. Pt has (R) LE wrapped c̄ kerlex + ace wrap DSG CDI. (b)(6)-2
4NOV@0030	Pt slept most of night. ⊖ c/o itching til 0500. Med [redacted] again c̄ 25mg Atarax PO. Will monitor. [redacted]
4NOV 03 0700	Assumed care of pt. A+O x3. VSS ⊘ c/o pain [redacted] @ this time c/o itching to lower extremities and trunk of body. IV ABX TX cont pt Afebrile. BM x2 this am AM care given (R) LE kerlix wrapped dry blood present ⊘ order for dsg change. Will wait to monitor [redacted]
4nov03 @2200	assumed care of pt @1800. VSS. c/o itching, but pt [redacted] asleep soon ⊘ eating. Medicated @2200 for itching c̄ Atarax po, minimum relief. RLE kerlix dsg CDI, (+) ams to RLE (foot) + 2DP pulse. Foley draining clear yellow urine. ↓pt restraint ⊘ s/sx skin/circulation compromise. Plan: monitor itching, monitor dsg (Rt tol. ease ant ↓ po for ainer.) [redacted] (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
6 NOV Ø3 (1Ø2Ø)	Pt a&O, VSS, C/O pain often but refusing Tylenol #3. Atarax PO 25mg given for itching. (R) leg drsg c̄ small amt. serous drainage. Drsg re-inforced. Pt attempted to walk but said (via translator) there was too much pain. AM care complete. foley draining QS cyu (care done to foley). (R) SC TL c̄ blue port not flushing. IV levaquin & zosyn cont per MD orders. ⊖ edema or redness @ CL site. drsg CDI. xeroform to (R) thigh trimmed. 1 pt restraint. ⊖ compromise to skin or circulation. Will monitor (b)(6)-2 [redacted] 91WM67
1615	Dr [redacted] @ BS. drsg Δ'd to (R) leg, bacitracin applied, fluffs applied then wrapped c̄ Kerlix. Vo given to do this drsg Δ daily. Will monitor [redacted] 91WM6
6 NOV. Ø3 1930	Pt A+O x3. VSS, drsg RLE CDI, c/o pain + itching, adm Tyl #3 + Atarax as per orders, xeroform to (R) thigh wound CDI, foley draining cyu, CL site ⊖ s/Sx of infex, ate most of diet, 1 point restraint, ⊖ complications. [redacted] 91W

RELATIONSHIP TO SPONSOR | LAST | SPONSOR'S NAME | 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. ICW#1

#[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7 NOV Ø3 (143Ø)	Rt a10, VSS, Ø c/o pain, (R) leg drsg Δ'd (bacitracin applied) to graft site. (R) thigh c̄ xeroform intact - edges trimmed. Drsg to (L) leg Δ'd, area scabbing up - wrapped c̄ Kerlix for pt comfort/request. +2 pulses to (B) feet, ambulated to BR x2 c̄ mild pain c/o itching cont, medicated c̄ atarax c̄ relief noted. foley draining @S c/u. 1 pt restraint on while in bed 3 compromise to skin or circulation. Will monitor [redacted] 11MMC
(153Ø)	foley removed d/t pt. c/o pain. Rt now voiding in urinal c̄ assistance. no longer c̄ c/o pain or urge to void. Will monitor [redacted] 11MMC
8NOV03 @0145	assumed care of pt @ 1800. VSS. c/o itching & pain, Atarax given c̄ relief noted. T#3 tabs given for pain @HS & relief noted. LS CTA, (+) BS, void pt urinal c̄ assistance & difficulty. RLE drsg CDI, (+) CMS. (L) neck CL flushes well. IV Abx cont. 2 pt restraints on S/S skin/circulation compromise. Pain cont IV Abx, monitor drsg, itch/pain control [redacted]
18NOV03	(1800) Assumed care of pt @ 0600. A alert, speaking Arabic. VSS. T3s given for pain c̄ good relief. A c/o itching - medicated c̄ 25mg Benadryl po and given bath for relief. Relief of itching noted. A amb in hallway c̄ difficulty. Drsg to RLE Δd - Bacitracin

STANDARD FORM 509 (REV. 5/1999) BA
USAPA V

(b)(6)-4

[redacted]

MEDCOM - 20377

MEDICAL RECORD	PROGRESS NOTES	AUTHORIZED FOR LOCAL REPRODUCTION
DATE	NOTES	

08NOV03 (cont) applied to wound. ⊘ S/Sx infection. ⓒ N flushes well ⅁ S/Sx infection/infiltration. Tol. reg diet well. Voiding ≈ 2000cc clear yellow urine. ⅁ each void into urinal. Bladder nondistended. ⊕BM this am. 1 point restraint in place ⅁ S/Sx complications. Will cont. to monitor. [redacted]

9NOV03 @0115 assumed care of pt @1800. VSS. ~~7~~ c/o constant ↓ pain & itching. Atarax & T#3 given ⅁ good relief noted. Tol powell. Ⓛ neck CL flushes well. RLE drsg CDI, Ⓡ thigh graft healing ⅁ S/Sx of infection. Voiding per urinal ⅁ assistance. ? urinary incontinence D/T pt urinating sm amt ~~before~~ [redacted] immediately ⅁ asking for urinal. 1 pt restraint on ⅁ S/Sx skin/circulation compromise. Plan: Lec po, monitor drsg, itch/pain control. [redacted]

9 Nov 03 0833 Assumed care @ 1800. A & O. Able to make needs known. VSS. ↑ to bathroom ⅁ asst for AM care. Ⓛ neck central line flushed & patent. ⊘ sign infection or infiltration. Ⓡ thigh xeroform drsg intact & trimmed. Site healing. RLE drsg Δ ⅁ plenty of bacitracin & Kerlix fluffs. Wound site ⅁ intact sutures.

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

REGISTER NO.

WARD NO. ICW

PROGRESS NOTES
Medical Record

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

E	ST NAME	MI	INITIAL	ID NUMBER

ATE	NOTES
1 Nov 03	(Cont.) Pt medicated c̄ T#3 two tabs p.o. for c/o RLE pain & atarax 25mg p.o for c/o itching all over esp. to LLE. See DA Form 4678 for med times. Done pt. restraint s̄ compromise to skin or circulation. Will continue Abx therapy, pain/itch control & ambulation. [redacted]
09 Nov 03 1410	Medicated c̄ atarax 25mg p.o [redacted] to c/o itching. Will monitor [redacted]
09 Nov 03 1515	Pt sleeping. No acute distress [redacted]
09 Nov 03 1610	Medicated c̄ T#3 two tabs for c/o pain. Will monitor for effect [redacted]
09 Nov 03 1725	Ambulating in hall s̄ difficulty. Pt loves eating icecream. Denies pain & states at this time. [redacted]
09 Nov @ 2340	Pt amb onward + ~~at~~ sat in chair in early evening. @ Foley. Pt urinated s̄ difficulty into urinal. c/o itching. Med c̄ 25mg Atarax. Will monitor effects. DSG to @ LE CDI. VSS. Infusing IV ABX. Tol well. TLC occluded x2. White lumen functional. Pt asleep. Will monitor pain + itching. [redacted]
10 Nov @ 0000	Pt c/o pain to @ LE. Med c̄ 2 Ty #3. Will continue to monitor. Pt laying in bed + attempting to sleep. [redacted]
10 Nov 03	(0000) Assumed care of pt @ 0000. Pt alert, speaking Arabic. VSS. Pt medicated c̄ T3s for pain and Benadryl for itching. Will monitor for relief. @ SC flushes well s̄ S/Sx infection/infiltration. Pt OOB to chair and amb in hallway s̄ difficulty. DSG to @

STANDARD FORM 509 (REV. 5/1999) USA

[redacted] (b)(6)-4

MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
10NOV03	(cont) Δd. Bacitracin applied to wound. Ø s/sx infection. Sutures to RLE CDI. Pt tol. reg diet well. Voiding ≈150-250cc clear yellow urine into urinal c̄ each void. Bladder nondistended. Ø 1 point restraint in place s̄ s/sx complications. Will cont. to monitor. [redacted]
	(1730) Drsg to RLE reapplied p̄ wound was open to air for 1°. Pt OOB to chair w/ this time. Will monitor. [redacted]
9NOV@0015	Pt amb on ward c̄ steady gait. Pt conversing c̄ staff. Appears to have (+) demeanor. Aware to DIC to EPN. Pt c/o itching. Med c̄ 25mg PO Atarax. Will continue to monitor. Pt requires assistance c̄ urinal. Urinating clear, yellow + sufficient amt. DSG to (⊗) BIL LE CDI. TLC x2 occluded. Write flushes well, (−) blood return. Cont IV ABX. [redacted]
11NOV 0010	Pt c/o itching. Med c̄ Benadryl IV 25mg. Will monitor. [redacted]
11NOV03	(1010) Assumed care w/ Ø. Pt alert, speaking Arabic. VSS. Ø c/o pain. Cont. to c/o itching. medicated c̄ Atarax this am. Pt OOB to amb in hallway s̄ difficulty. ↑ to chair for 1°. Drsg to RLE Δd.

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

(5)(6)-2

[redacted] (5)(6)-7

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11Nov03 (1010)	(cont) Bacitracin applied to wound. Ø S/Sx infection. @ IV flushes well ē S/Sx infection/infiltration. Tol. reg diet well. ⊕BM this am. Voiding clear yellow urine into urinal 100-200cc ē q void. 1 point restraint in place ē S/Sx complications. Awaiting trans. to EPW camp. will cont. to monitor. [redacted] (1430) @ IV d/cd - cathete intact. Pt stable for d/c ambulatory - escorted by MPs. — [redacted] (b)(6)-2

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

ISN# 180 70

23 SEP 03
192[redacted] "Seizing & foaming at the mouth"
Friend says pt seizes all the time
Could not get a clear history from friend
Pt had asked for Valium earlier in evening

BP 124/52
P80

Pt was jerking in all four extremities & foaming at the mouth
No apparent trouble c respiration
Lungs clear
WSS - Reg cardiac rhythm
Loud systolic murmur along L sternal border
Other physical features described above
* Valium 5mg given IM
Jerking stopped
Sleeping

A Seizure - ? withdrawal; Leg wounds (as above)
P Delivered to prison O/Pt Clinic for overnight stay
To [redacted] for Surgical consultation

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
24 SEP 03	S - Injected & brought to
1750	Clem Grunaye.
	Lost arm in bomb blast
5'5"	Has wounds on both legs
96 lbs	
	O & has no (R) upper extremity
	+ an amputation mid (L) forearm
Meds:	5 X 7 cm open wound anti
Penicillin	(R) knee, caudal to patella
Cephalexin	tendon is exposed & eroded
Promafen	8 X 3 cm open superficial
Allerdrine 25mg	wound posteriomedial (L)
F Bacitracin	calf, site of previous graft
Sulfate 0.5% eye oint	A Infected wound, (R) knee
	open wound (L) calf
	Double amputation, upper extremity
	P To new O/PA clinic + treatment
	by physiatry (done)
	Medivac in A.M for surgical
	consideration

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	[redacted]
SPONSOR'S NAME Ollen	SSN/ID NO.	RELATIONSHIP TO SPONSOR	(5)(6)-2

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.

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

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD Navy 0

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
25 SEP 1440	33 y/o Iraqi OF EPW who presents for evaluation of an open (R) tibial injury / multiple amputations and possible GTC seizure while at EPW camp (23 Sep). Patient (through interpreter) admits to a 18 year history of seizure and drug use including significant alcohol consumption ("12 packs of beer" per day) in addition to use of Valium / Ativan. Patient says he has at least one seizure per day for years.
	Neuro exam: limited due to patient multiple injuries and language barrier, awake, alert, fairly cooperative but with non physiologic / inconsistent findings, responds to visual threat bilaterally, verbose, speech fluent, persistent, but questionable judgment / insight, moves extremities but (R) arm amputated at shoulder / (L) arm below elbow, sensation = variable response to PP
	Imp: Probable withdrawal seizure related to chronic alcohol use/abuse and use of Valium
	Rec: (1) Ativan 1mg IV/IM q8 (hold if lethargic) for Sz prevention as patient scheduled to go to OR tomorrow
	(2) Thiamine 100mg q D (3) call neuro & freight for seizure

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV [redacted]	DS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP [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. (b)(6)-3 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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREATMENT FACILITY [redacted]
		RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)* 25 Sept 2003	TIME 1040
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY Ground mp	

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
33	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS	INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT	
Valium	ITEM	YES	NO	WHEN *(Date)*	DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
	IS THIS AN INJURY?			WHERE	TETANUS	
ALLERGIES	INJURY/SAFETY FORMS				DATE LAST SHOT	COMPLETED INTITIAL SERIES ☐ YES ☐ NO
Ø	HOW					

CHIEF COMPLAINT (L) Tib Fib Injury

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 1040	TIME 1040	1400	14:30			
☐ URGENT		BP 119/64		116/92			
	INITIALS [redacted]	PULSE 82	87	91			
		RESP 18	16	20			
☒ NON-URGENT		TEMP 97.1		96.9			
		~~WT~~ 98%	98 100%				

LAB ORDERS						X-RAY ORDERS			
X	CBC/DIFF	ABG	PT/PTT		BHCG/URINE/BLOOD/QUANT		CXR PA & LAT/PORTABLE		C-SPINE
	URINE C&S	UA MSCC/CATH		X	CHEM: Met 8		ACUTE ABDOMEN		LS SPINE
	BLOOD C&S X		X		SED RATE		SINUS		HEAD CT
							ANKLE R/L	X	(L) Knee
						X	(L) Leg		

(b)(6)-2

ORDERS

☒ PULSE OX 100% ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1100	Percocet ÷ 10	[redacted]	[redacted]	1100	
1400	MSO4 10mg IV.			1400	

DISPOSITION	DISPOSITION QUARTERS /OFF DUTY	PATIENT/DISCHARGE INSTRUCTIONS
☐ HOME ☐ FULL DUTY	☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.	
MODIFIED DUTY UNTIL	RETURN TO DUTY	

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶	TO	WHEN
☐ IMPROVED ☐ UNCHANGED				
☐ DETERIORATE	TIME OF RELEASE	I have received and understand these instructions.		
		PATIENT'S SIGNATURE		

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

#[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER 1050.

TEST RESULTS

CBC		SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC			SUP 02	PH	PO2	RESULTS	
H/H			PCO2	SAT	OTHER		
PLT							
PT			U/A	DIP		EKG INTERPRETATION	
APTT	BHCG	ETOH / GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

S: Pt is a 37yo Iraqi EPW s/p mine blast 3mo. Told he needed surgery for his open Tibia + (L) Tib/fib injury. Denies Yest. Pt lost (B) Arms in same mine blast 3mo + had surgery done to stumps.

PMHx ⊖.
NKDA.
PSHx
(B) UE Amps. 3mo.
⊖ meds.

O: warm mod-sev dist
HEENT: wnl
Lungs: (B) CTA.
Cor RRR
Abd: BS's, NTTD
Ext: (R) Prox Tibia c̄ exposed black bone @ plateau.
(L) Tib fib c̄ open puncture wound. (+) Dried blood on LE c̄ mod swelling
↑ TTP over entire (L) LE below knee. + crepitus.

5 11 35 302.
ESR 42
136 104 7.5
3.9 19 .95
CK 614
XRay: (L) mid shaft Cortical Tibia Defect
(R) Tibia Plateau bony defect
Chm 20
PT/PTT INS pending

Admit to J ward D/w Dr [redacted]

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
(b)(6)-2

PRO[redacted] STAMP
[redacted]

DIAGNOSIS
Osteomyelitis

CODES

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name – last, first, middle; ID no. (SSN or other); hospital or medical facility)*
[redacted]
(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
Cont.			turned off during HS as per orders, SP cath in place, dsg on abd CDI, Pt tol PO well, had good appettite, IV (R) IJ intact, ∅ s/sx of infex or infiltration, 2 pt restraint in place, ∅ skin breakdown or poor circulation noted. [redacted]
11 ∅CT ∅3		1550	Assumed care of pt @ ∅∅∅∅ ~~p~~ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Tylenol. Pt OOB to BR for personal hygiene c̄ assistance from staff. Amb well. Pt c/o HA from suction machine noise. Suction machine moved into BR. Pt sleeping @ this time. Drsg to RLE Δd. Drsg to RLE CDI c̄ vac. device to low cont. suction. Pt tol. reg diet well c̄ assist. in feedings. Foley draining quantity sufficient clear yellow urine ⊕Bm. IVF infusing into (R) IV s̄ s/sx infection infiltration. 1 point restraint in place s̄ s/sx complications. Will cont. to monitor [redacted]
		1750	Pt tol. po well. IVFs Sld in (R) IV [redacted]
11 OCT. ∅3		2100	Pt A+Ox3, VSS, medicated for pain, continuous suction to RLE draining minimal amount of drainage, SP cath draining c/y urine, IV HL (L) IJ patent Pt tol diet well, 1pt restraint in

510-112

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
Cont.			place 5 s/sx of complications [redacted] 9/W
			[redacted] (b)(6)-2

(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.

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): 3. PREVIOUS SURGERY [ ] NO [✓] YES (type):

4. PROPOSED SURGICAL PROCEDURE:

I&D Bil Lags

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications:
Jewelry removed: yes/no Family waiting: yes/no See previous 5179

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; ~~language barrier~~; family separation; surgical environment	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. o Maintain family interface.
B. AERATION ___ Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress ✓ Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. o Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

#[redacted] (b)(6)-4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ___ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ___ Potential impairment of mobility due to sedation; pain; injury E.2. ___ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ___ Disminished visual perception due to being injury; sedation; F.2. ___ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures. NA	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communications. NA o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] MAJ AN 26 Sep 03 DATE

11. POSTOPERATIVE EVALUATION:

Pt awake but drowsy; attempting to communicate. Pt breathing room air. Dressings dry & intact.

(b)(6)-2

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] MAJ AN	[redacted] MAJ AN
DATE: 26 Sep 03 TIME: 1215	DATE: 26 Sept 03 TIME: 1325

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY CPT [redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY MAJ [redacted]

3. DATE 31 Oct 03 TIME PATIENT ARRIVED IN SUITE 1305

4. PATIENT IN ROOM TIME 1305 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: (b)(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Left arm on padded armboard out @ 90° (b)(6)-2

8. SKIN PREPARATION

HAIR REMOVAL ☑ YES ☐ NO

DONE BY: ☑ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☑ RAZOR ☐ CLIP

COMMENTS: Rt thigh

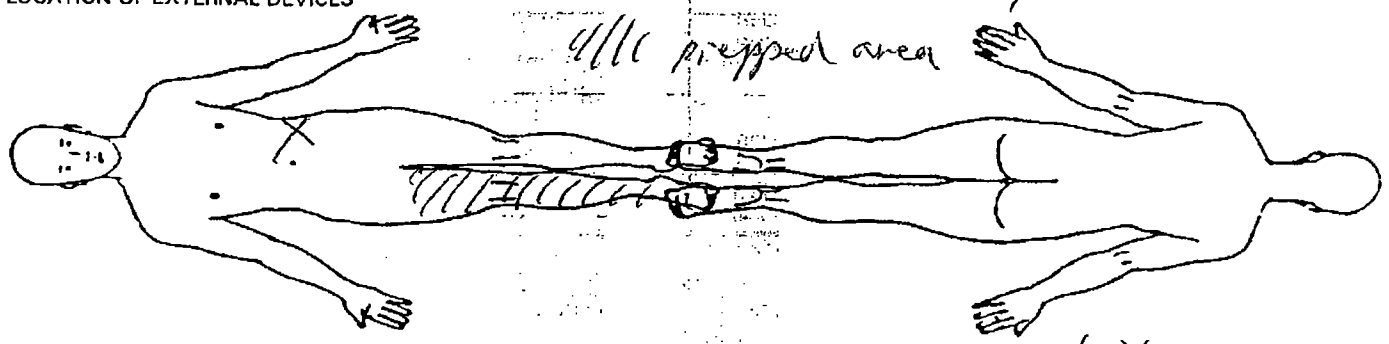
PREP SOLUTION *(Specify)* Betadine scrub & solution

SITE: Rt leg BY WHOM: MAJ [redacted]

SITE: BY WHOM:

COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet (b)(6)-2

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No		C	C	[redacted]	[redacted]
Needle Sharp	☑ Yes	☐ No		C	C		
Instrument	☐ Yes	☑ No				PFC	MAJ
Other	☐ Yes	☑ No				PFC	MAJ

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

[redacted] (b)(6)-4

(b)(2)-2

31 Oct 03 [redacted]

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

☑ ESU NO: RSE 102395

GROUND PAD: BRAND Valleylab

LOT NO: 65206 Exp 2004-11

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

13. PROSTHESIS, IMPLANTS ☐ YES ☐ NO IF YES NAME: ID NUMBER; M IFACT'JRER

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): NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Xeroform, 4x8's } Rt thigh

Xeroform, Bacitracin, Flutti, Kerlix, Ace } Rt thigh

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted] assistant Dr [redacted]

Anes: CPT [redacted] (b)(6)-2

Cautery: Cut-30 Coag 30 Bone plate site post-op-

20. OPERATION(S) PERFORMED

STSG from Rt thigh to Rt calf

21. PATIENT TRANSFERRED TO PACU | TIME | METHOD Lifter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ AN 31 Oct 03

(b)(6)-2

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted]

3. DATE 29 Oct 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: (b)(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted]	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: Right lower leg

PREP SOLUTION *(Specify)* Betadine + Saline

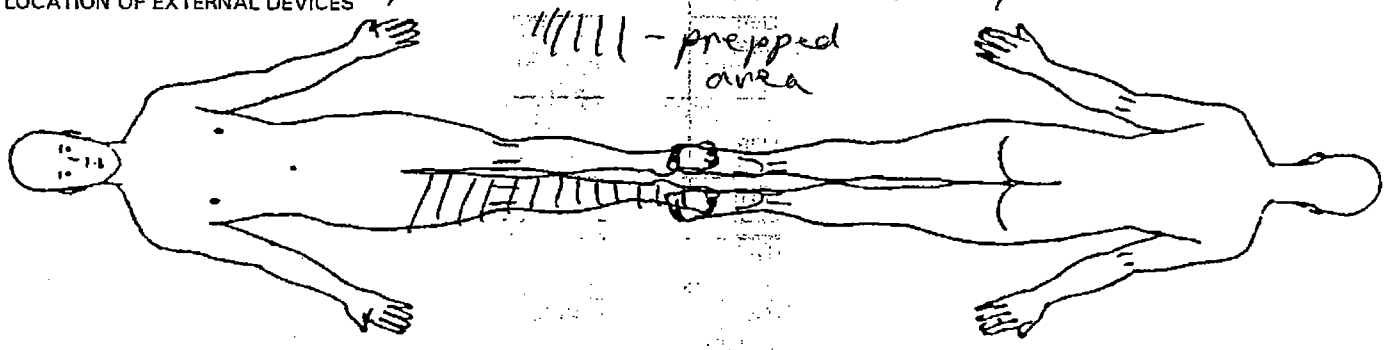
SITE: Rt Leg BY WHOM: CPT [redacted]

SITE: BY WHOM:

(b)(6)-2

COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

(b)(6)-2

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

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

[redacted] (b)(6)-4

[redacted] (b)(6)-2

29 Oct 03

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

☑ ESU NO: Valleylab Force 2

GROUND PAD: BRAND VL Dual Polyhesive II

LOT NO: 70011 Exp 2005-04

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO; TYPE(S):
0.9% Normal

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Xeroform
Fluffs
Ace

19. ADDITIONAL INFORMATION
Surgeon: [redacted] Assist: Dr [redacted]
Anesthesia: (b)(6)-2
Cautery: Coag: 30 Cut: 30

20. OPERATION(S) PERFORMED
I+D ® Tibia

21. PATIENT TRANSFERRED TO PACU (I CU3) (b)(6)-2 TIME See DA7389 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ AN 29 Oct 03

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECO[illegible]VED AND PROCEDURE VERIFIED BY ILT [redacted]

3. DATE 18 OCT 03 TIME PATIENT ARRIVED IN SUITE 1040

4. PATIENT IN ROOM TIME 1045 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA, NPO (b)(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	ILT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

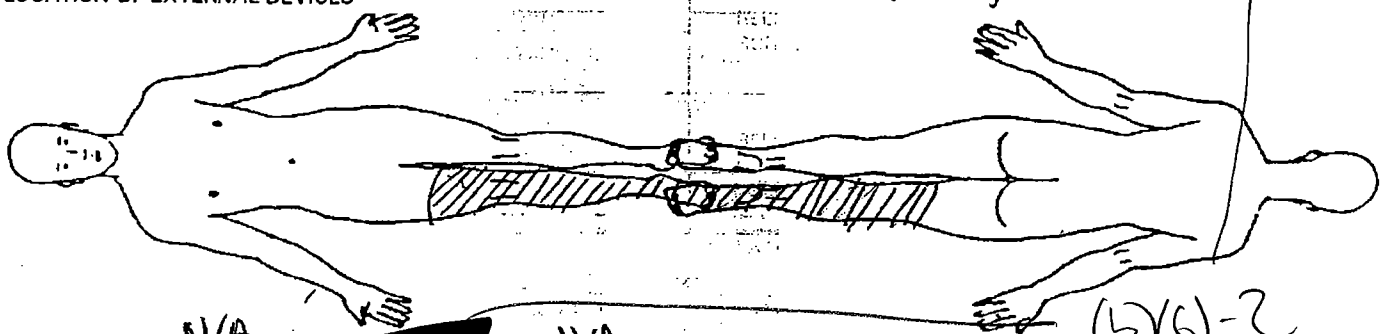
COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS: N/A

PREP SOLUTION *(Specify)* Hibiclens [redacted] ~~Betadine/Betadine~~
SITE: Right leg BY WHOM:
SITE: BY WHOM: ILT [redacted]
COMMENTS: No pooling or adv

9. LOCATION OF EXTERNAL DEVICES



(b)(6)-2

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

INITIAL: SPC Day ILT Malachi

10. COUNTS

			C = Correct I = Incorrect				
			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No					
Needle Sharp	☒ Yes	☐ No			C	SPC [redacted]	ILT [redacted]
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

[redacted] (b)(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS [ ] YES [X] NO IF YES NAME: ID NUMBER IFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES [ ] NO [X]

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S):
0.9% NaCl - QS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES [ ] NO [X]

16. LABORATORY SPECIMENS

SPECIMEN (S) YES [ ] NO [X]	NAME	NAME
FROZEN SECTION (FS) YES [ ] NO [X]	NAME	NAME
CULTURE (C) YES [ ] NO [X]	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES [X] NO [ ]

	1.	2.	3.
TYPE/SIZE	10mm J-P		
SITE	(R) tibia		

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Ioban

19. ADDITIONAL INFORMATION
Surgeon: Dr [redacted]
Anesthesia: CPT [redacted]
(b)(6)-2
DA 5179 in Chart

20. OPERATION(S) PERFORMED
IED (R) tibia

21. PATIENT TRANSFERRED TO PACU TIME See DA7389 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] IT/AN

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

2. PATIENT [redacted] AND PROCEDURE
VERIFIED BY [redacted] NAJ/th

3. DATE 15 OCT 03 TIME PATIENT ARRIVED IN SUITE 1105

4. PATIENT [redacted] TIME 1105 NUMBER 1-3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: (b)(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	NAJ [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt transferred to OR table, anatomically aligned for surgical procedure a pad under head (B) arms on padded arm boards less 90°

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

COMMENTS:

8. SKIN PREPARATION

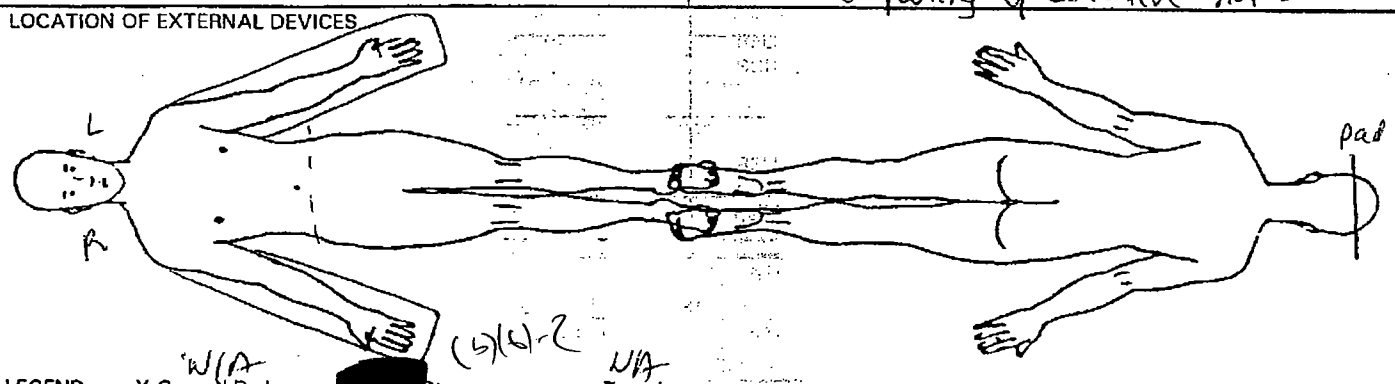
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: (R) leg BY WHOM: NAJ [redacted]
SITE: BY WHOM:

COMMENTS: ⊘ Pooling of Solution noted

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No					
Needle Sharp	☐ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

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

[redacted] (b)(6)-4

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

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ BIPOLAR NO: _____

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

13. PROSTHESIS, IMPLANTS ☐ YE ☐ NO IF YES NAME: ID NUMBER; FACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
Ioban

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 10mm JP	2.	3.
SITE	1. (R) Tibia	2.	3.

19. ADDITIONAL INFORMATION
Surgeon [redacted]
Anesthesia
LTC [redacted]
(b)(6)-2

20. OPERATION(S) PERFORMED
I & D (R) Tibia

21. PATIENT TRANSFERRED TO ACU TIME 1140 METHOD litter c or

22. REGISTE[redacted] MAJ/AN

REVERSE OF DA FORM 5179-1, OCT[redacted] USAPA V1.00

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] MAJ/AN

3. DATE 0 OCT 03 TIME PATIENT ARRIVED IN SUITE 1110

4. PATIENT IN ROOM TIME 1110 NUMBER 2-3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] ORT	RELIEF SCRUB	(b)(6)-2
ASSIGNED CIRCULATOR	MAJ [redacted], AN	RELIEF CIRCULATOR INT	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt transferred to OR table, anatomically aligned for surgical procedure & pad under food Pt (B) amputee upper extremities

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betta/Betta

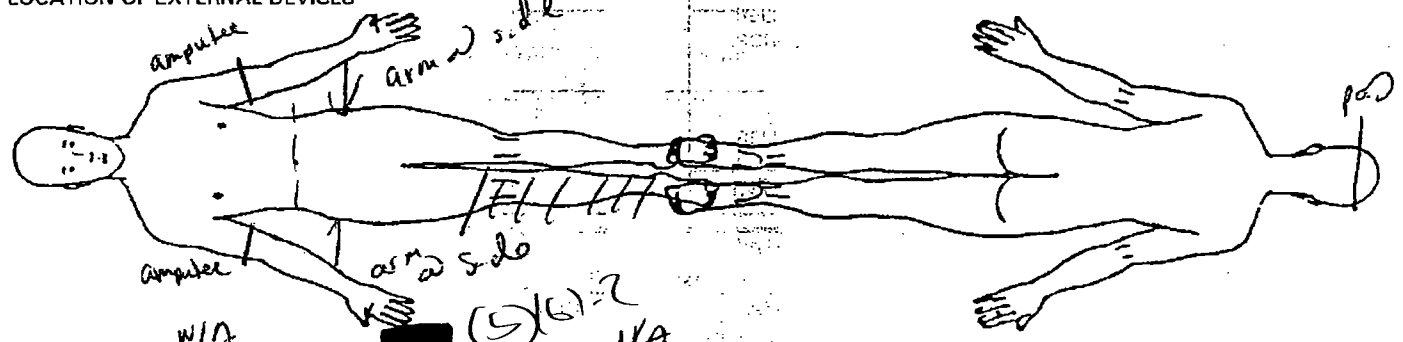
SITE: (R) leg BY WHOM: MAJ [redacted]

SITE: BY WHOM:

☒ See #9

COMMENTS: ☒ Pooling of Solution noted

9. LOCATION OF EXTERNAL DEVICES



N/A [redacted] (b)(6)-2 N/A

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

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No					
Needle Sharp	☐ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

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

[redacted] (b)(6)-4

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

☐ ESU NO: _____

GROUND PAD: BRAND _____ LOT NO: _____

☐ ESU NO: _____

GROUND PAD: BRAND _____ LOT NO: _____

☐ BIPOLAR NO: _____

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; M CTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Ioban
Kerlix

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 10mm JP	2.	3.
SITE	1. (R) Leg	2.	3.

19. ADDITIONAL INFORMATION

Surgeon [redacted] Anesthesia [redacted]

(b)(6)-2

20. OPERATION(S) PERFORMED

I+D (R) Tibia

21. PATIENT TRANSFERRED TO PACU TIME 1205 METHOD Litter c O2

22. REGIST[redacted] MAJ/AN

REVERSE OF DA FORM 5179-1, OCT [redacted] USAPA V1.00

MEDCOM - 20400

MEDICAL RECORD — **INTRAOPERA[illegible] D[illegible]UMENT**

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 letter BY anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED B[redacted] CPT/AN

3. DATE 70CT03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 1445 NUMBER 1-1 (4)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:
English speaker.

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D	RELIEF SCRUB	(b)(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	CPT [redacted] (1500 - EOC)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

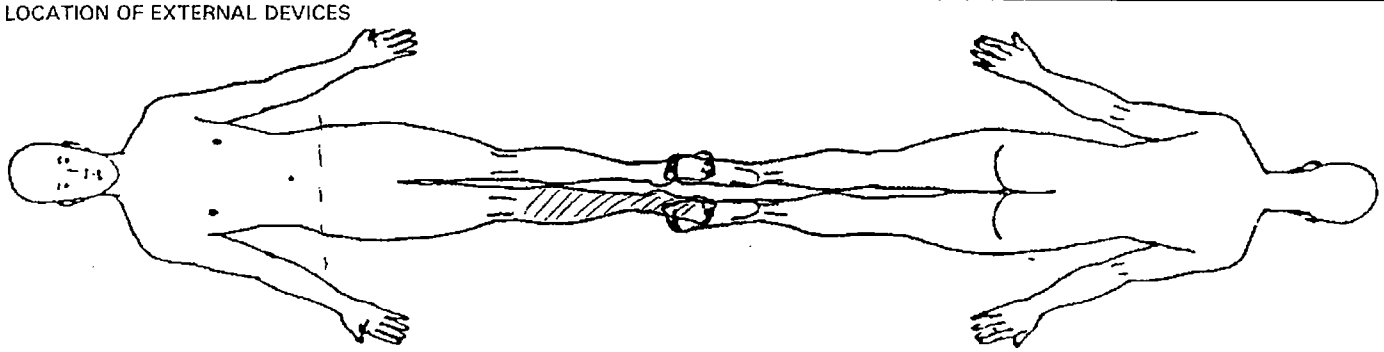
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☒ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: BY WHOM:
SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

#[redacted] (b)(6)-4

[redacted] (b)(2)-2

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

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ BIPOLAR NO: _____

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluff [redacted]
Fluffs
Ace bar

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. JP Drain	2.	3.
SITE	1. (R) leg	2.	3.

19. ADDITIONAL INFORMATION

Surgs: [redacted]

Anesth [redacted] CRNA

Anesth General w/ mask

(b)(6)-2

20. OPERATION(S) PERFORMED

I & D (R) tibia

21. PATIENT TRANSFERRED TO ICU3 TIME 1526 METHOD Litter

22. REGISTERED NURSE [redacted] CPT/AN

REVERSE OF [redacted]

MEDCOM - 20402

USAPA V1.00

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-407, the propo[illegible] agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY anesthesia

2. PATIENT IDENTIFIED [redacted] AND PROCEDURE
VERIFIED BY [redacted] CPT/AN

3. DATE 4 OCT 03 TIME PATIENT ARRIVED IN SUITE —

4. PATIEN[redacted]
TIME 0935 NUMBER 2-2 (3)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted], 9TD	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	

(b)(6)-2

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

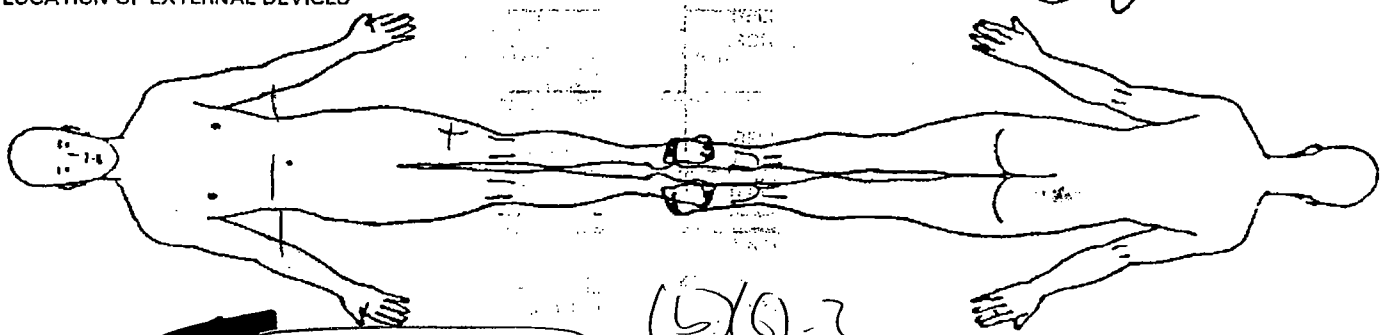
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine
SITE: R leg BY WHOM: CPT [redacted]
SITE: BY WHOM:

COMMENTS: no pooling of prep noted

9. LOCATION OF EXTERNAL DEVICES



(b)(6)-2

LEGEND X [redacted] Pad -- Safety Strap === Tourniquet

C = Correct I = Incorrect

10. COUNTS			Initial Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	C		C		
Needle Sharp	☒ Yes	☐ No	C		C	PFC [redacted]	CPT [redacted]
Instrument	☐ Yes	☒ No	/	/	/	/	/
Other	☐ Yes	☒ No					

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

#[redacted] (b)(6)-4

[redacted] (b)(2)-2

4 OCT 03

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

☒ ESU NO: CUT [redacted] CDAG
GROUND PAD: [redacted] E7507
LOT NO: 200 [redacted] 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; M FA JRER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. JP Drain	2.	3.
SITE	1. (R) leg	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
- fluffs
- kerlix
- ace wrap
- Ioban

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED
I & D Right Tibia

21. PATIENT TRANSFERRED TO ICU 3 (b)(6)-2 TIME 1030 METHOD later

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.00

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

PATIENT TRANSPORTED TO OPERATING ROOM: 1400 BY: Anesthesia

DATE: 1 OCT 03 — TIME PATIENT ARRIVED IN SUITE:

2. PATIENT [redacted] PROCEDURE VERIFIED BY [redacted] CPT(P) Ar

4. PATIENT IN ROOM [redacted] TIME: NUMBER 1-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted], OR	RELIEF SCRUB	(b)(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] Ar	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

Pt transferred to OR table, anatomically aligned for surgical procedure c̄ padding under head (B) arms on padded arm boards

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL: ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

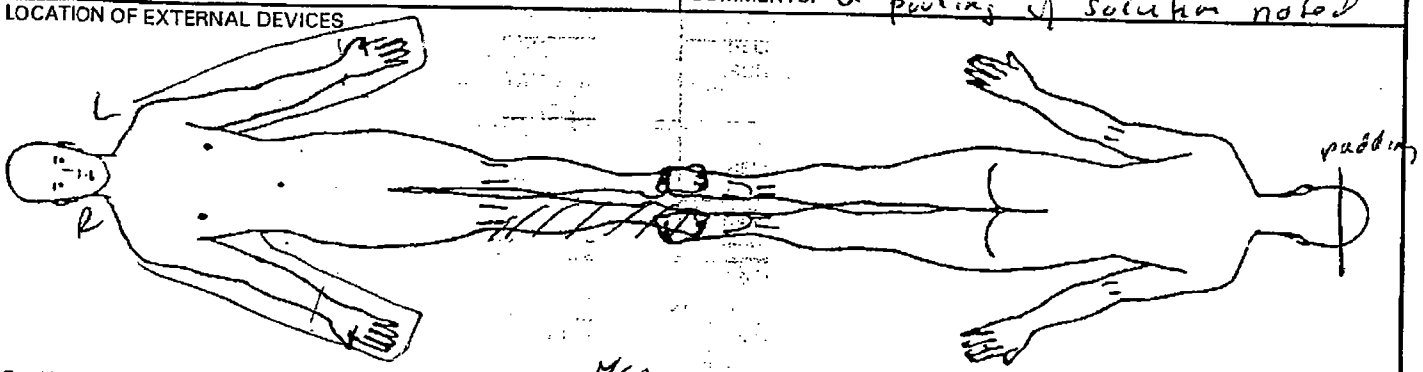
PREP SOLUTION (Specify): Betadine

SITE: (R) Leg BY WHOM: CPT [redacted] Ar

SITE: BY WHOM:

COMMENTS: ⊖ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND: X Ground Pad -- Safety Strap = = = Tourniquet N/A

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No					
Needle Sharp	☐ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

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

[redacted]

(b)(6)-4

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

Not used

☒ ESU NO: 405 RSE 105305

GROUND PAD: BRAND Valley lab

LOT NO: 72011 EXP 2005-04

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBE IUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO; TYPE(S): 0.9-1 NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. ~~Hemovac~~ 10mm JP Drain	2.	3.
SITE	1. (R) leg	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs Ioban
Kerlix Benzoin
ACE

19. ADDITIONAL INFORMATION
Surgeon Anesthesia
[redacted] [redacted]
(b)(6)-2

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

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	1030	litter

22. REGISTERED NURSE SIGNATURE
[redacted] CPT/AN

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ..OOM
VIA Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 29 Sept 03 TIME PATIENT ARRIVED IN SUITE 1602

4. PATIENT IN [redacted] TIME 1602 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

(b)(6) 2

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

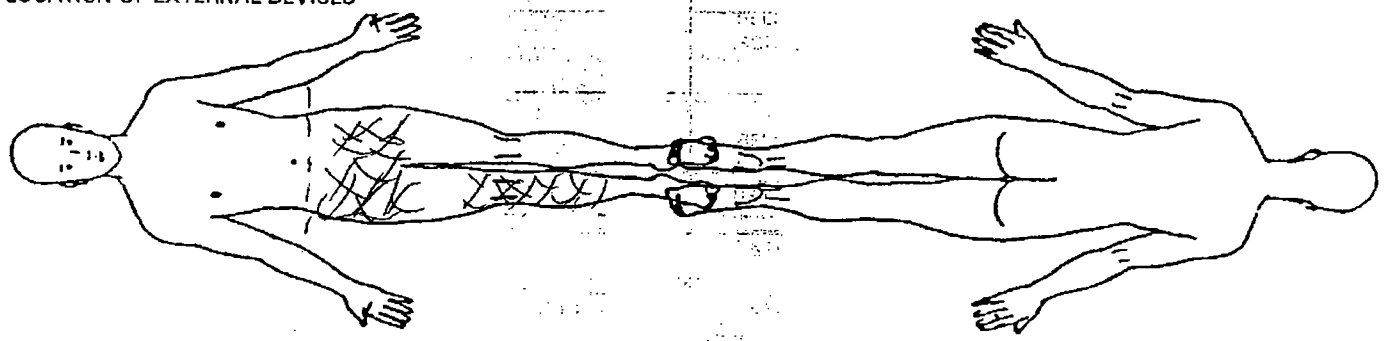
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/sol'n
SITE: Abd. BY WHOM [redacted]
SITE: Rt. Leg BY WHOM [redacted]

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☒ No					
Needle Sharp	☐ Yes	☒ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

[redacted] (b)(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND Valleylab
LOT NO: 68245

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; M FACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

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 Rt. Leg Wound	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	Suprapubic cath		
SITE	lower abd		

18. DRESSING/IMMOBILIZATION *(Specify)*

4x8 Tape } Abd.

Fluffs Kerlix } leg

19. ADDITIONAL INFORMATION

Surg: [redacted] Anesth [redacted] General

(b)(6)-2

20. OPERATION(S) PERFORMED

1. Dilation of meatus
2. Percutaneous Placement of Suprapubic tube
3. I & D Rt. Leg Wound

21. PATIENT TRANSFERRED TO	TIME	METHOD
~~OR rec'd by~~ PACU ~~to OR~~	1721	Lifter

22. REGISTERED NURSE SIGNATURE

[redacted] CDT/AN

REVERSE OF DA FORM [redacted] *OCT 87* USAPA V1.00

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY CPT [redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY MAJ [redacted]

3. DATE 26 Sep 03 TIME PATIENT ARRIVED IN SUITE 1215

4. PATIENT IN ROOM TIME 1215 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

(b)(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

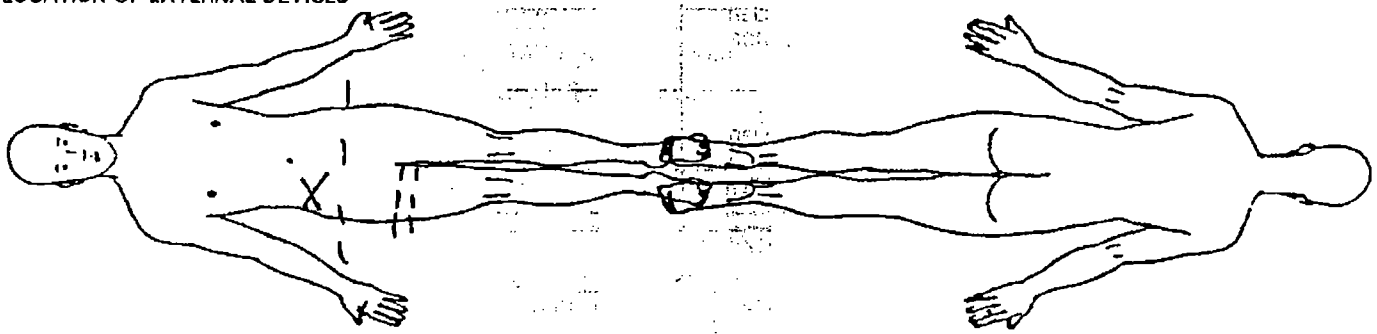
COMMENTS: Left arm on padded armboard at < 90° angle (b)(6)-2

8. SKIN PREPARATION

HAIR REMOVAL ☑ YES ☐ NO
DONE BY: ☑ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☑ RAZOR ☐ CLIP
COMMENTS: Rt knee

PREP SOLUTION *(Specify)* Betadine scrub & solution
SITE: Rt leg BY WHOM: MAJ [redacted]
SITE: BY WHOM:
COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

(b)(6)-2

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No		C	C	[redacted]	[redacted]
Needle Sharp	☑ Yes	☐ No		C	C	[redacted]	[redacted]
Instrument	☐ Yes	☑ No				SSG [redacted]	MAJ [redacted]
Other	☐ Yes	☑ No				SSG [redacted]	

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

[redacted] (b)(6)-4

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

☐ ESU NO: R8B 102395
GROUND PAD: BRAND Valleylab
LOT NO: 68936 Exp 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

13. PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; N JF. URER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S): N.S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs, Kerlix, Tape } Lt Ll

Fluffs, Kerlix, Ace } Rt Leg

19. ADDITIONAL INFORMATION

Surgeon Dr [redacted] assist: Dr [redacted]

anes: CRT [redacted]

Bovie 30 cut/30 coag Bovie plate site clear & intact post-op

(5)(6)-2

20. OPERATION(S) PERFORMED

Dressing change & debridement Lt calf

I&D with closure Rt Leg

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	1320	Litter

22. REGISTERED NURSE SIGNATURE

[redacted] MA, RN 26 Sep 03

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY CPT [redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY MAJ [redacted]

3. DATE TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME NUMBER 2-2

(b)(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Left arm on padded armboard at angle < 90°

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

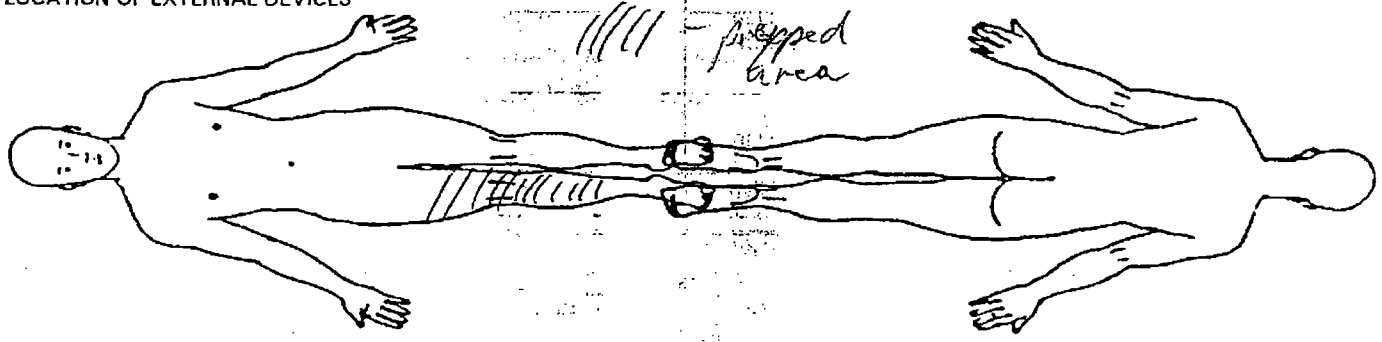
COMMENTS:

PREP SOLUTION *(Specify)* Alcohol & saline ~~Betadine scrub & solution~~
SITE: Right Leg BY WHOM: MAJ [redacted]
SITE: BY WHOM:

COMMENTS: No pooling of solution

(b)(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☒ No					
Needle Sharp	☐ Yes	☒ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

[redacted]

(b)(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; M IFACTURER

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): N.S

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 10fr J.P.	2.	3.
SITE	1. Rt Tibia	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Ioban

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted]
anes: CPT [redacted]

(b)(6)-2

20. OPERATION(S) PERFORMED

I+D Rt Tibia

21. PATIENT TRANSFERRED TO PACU TIME 1130 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ AN 24 Oct 03

REVERSE OF DA FORM 5179-1, OCT 87

MEDCOM - 20412

USAPA V1.00

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOVEMBER 19 2003

DAY	7		08		9		10		11						
HOUR	2	8	1	7	2	8	1	7	2	8					
PULSE (O) / TEMP. F (°)	200	90	90	80	80	80	80	80	80	80					
RESPIRATION RECORD	14		08	18	18		16		18						
BLOOD PRESSURE	101/56		97/51	100/59	94/53	94/57	95/56		110/69						
						77	101/68								
Temp.	97.5				98(A)										
HEIGHT: WEIGHT / Temp						Temp	97.04								
O_2	98%		(RA)	98% RA	98%		98%								
O_2					RA		98%		99%(RA)						
Pulse / Pulse	80				85	Pulse	83								

TEMP. C (Centigrade Equivalents, for Reference only): 40.6°, 40.0°, 39.4°, 38.9°, 38.3°, 37.8°, 37.2°, 37.0°, 36.7°, 36.1°, 35.6°, 35.0°

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) **BACK**

#[redacted] (b)(6)-4

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

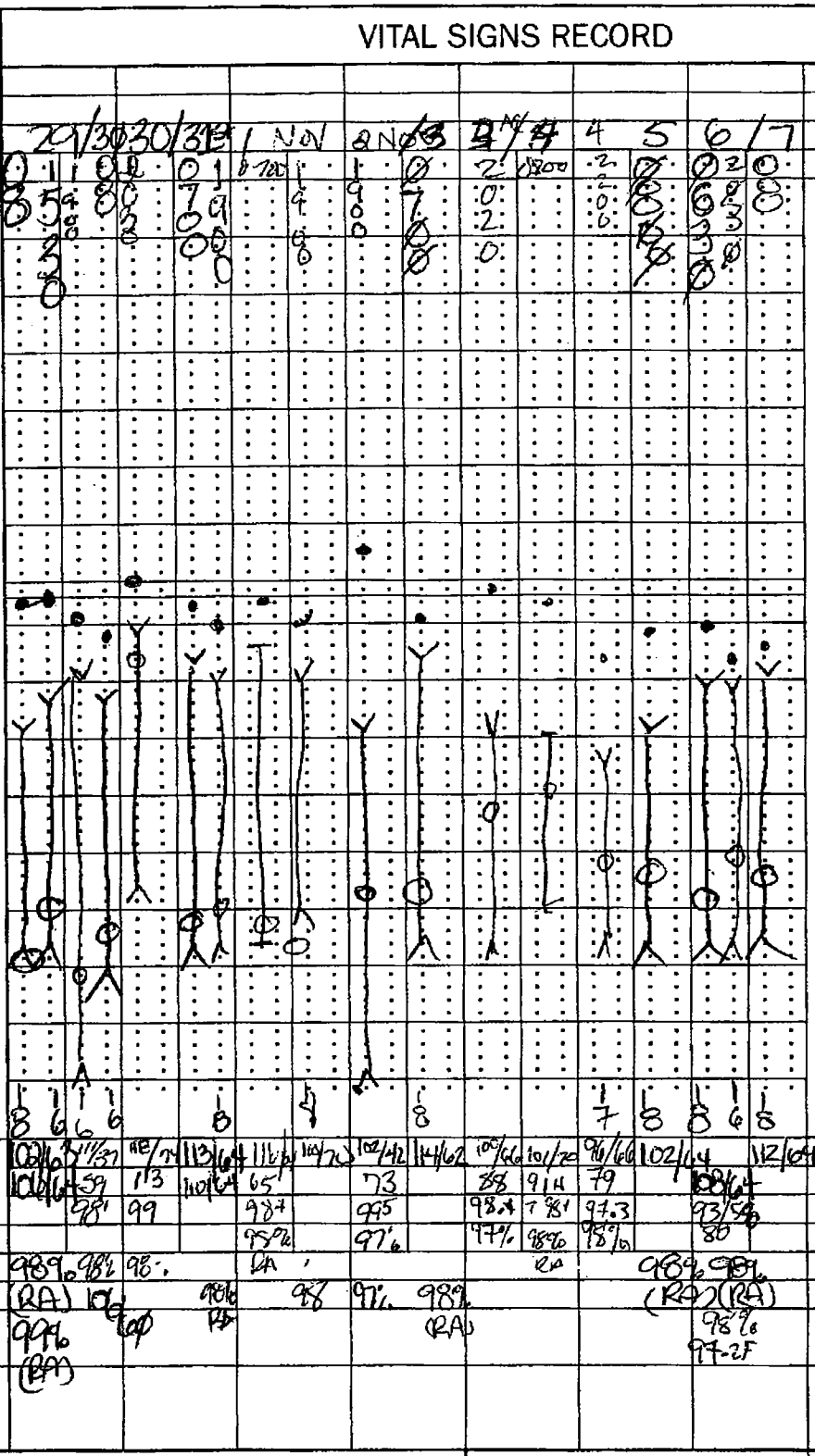
HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (O) — TEMP. F (•) — TEMP. C



RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 9 Oct | 10 Oct | 10 OCT 03 | 11 | 12 OCT | 12 OCT 03 | 13 OCT | 14 OCT 03

19 | HOUR: 0700 | 2000 | 8 | 20 | 08 | 08

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

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)

180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

EPW # [redacted] (b)(6)-7

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 OCTOBER 19 | DAY: 23, 24 OCT, 24 OCT, 25 OCT, 26, 27, 28

HOUR

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

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

STANDARD FORM 511 (REV. 7-95) BACK

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

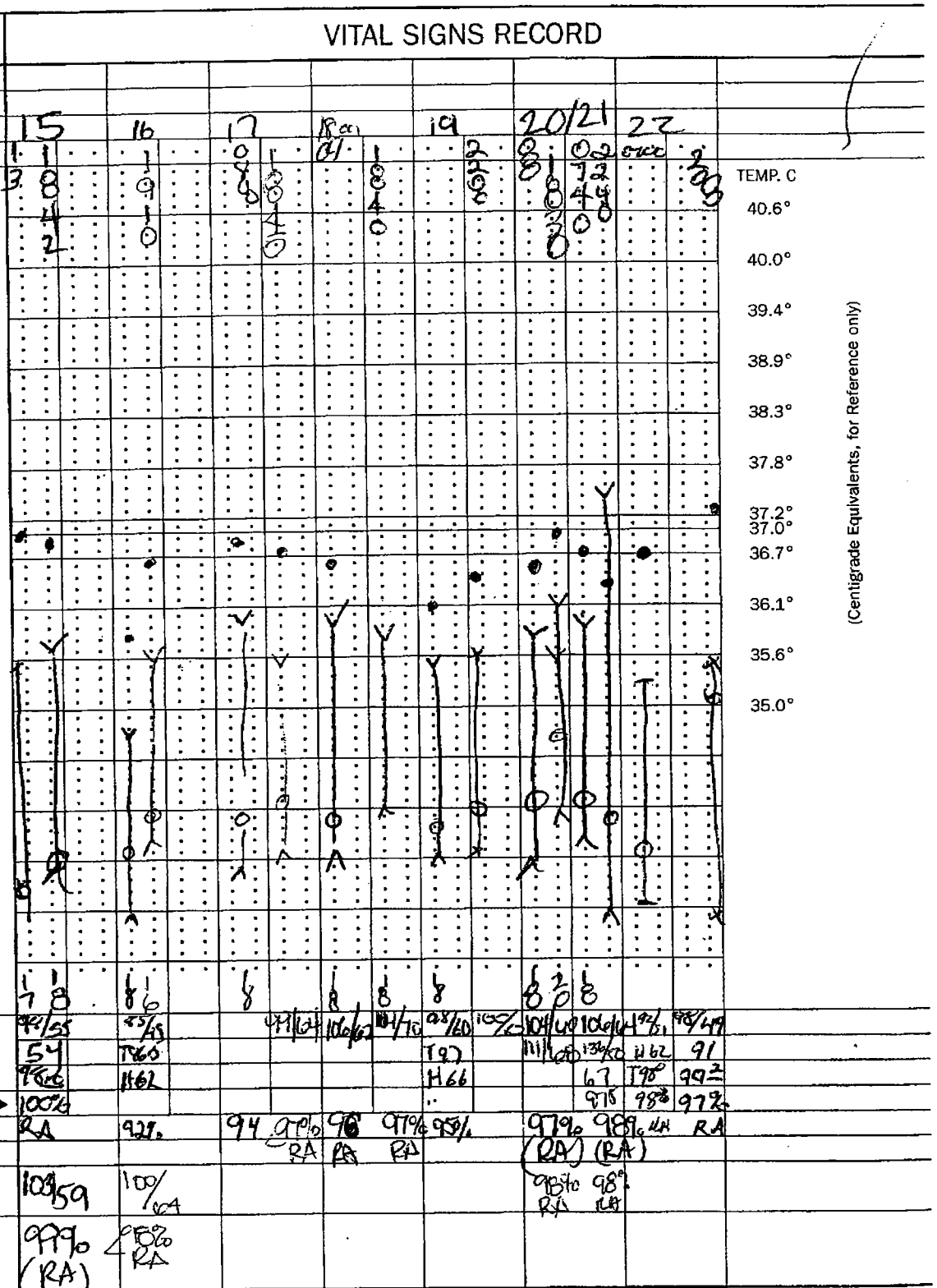
HOSPITAL DAY

POST- OLT DAY

MONTH-YEAR | DAY | HOUR

19

PULSE (0) | TEMP. F (°) | TEMP. C



RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY															
MONTH-YEAR	DAY	01 OCT 03	2 OCT		3 OCT 03			4 OCT	5 OCT		6 OCT 03				
19	HOUR	12	18	09				6	12	0015	19	12	20		20

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: 111/50 83/48 105/52 84/44 85/46 85/53 86/42 82/49 86/63 81/46

85 98 2 177 79/62 104/58 T97.8 98.2 57 99.9 60 98.2 97.9

HEIGHT: WEIGHT →

98 98 98% 98% 98 98% 98% 98% 97%

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**

E # [redacted] (b)(6)-4

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

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° 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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

(b)(6)-2

Ward/Section: TW: TCWH	[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. EPW # [redacted] (b)(6)-7	DATE 24OCT03	TIME 1000	SSN/PSEUDO SSN: [redacted]

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color	Yellow	N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App	HAZY	N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu	Nes	Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili	Nes	Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket	Nes	Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG	1.030	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	Large	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	6.0	N/A	Micro Parasites		
Segs		Mono	Prot	30	Negative	Malaria		
Bands		Eos	Urob	0.2	0.2-1.0	O & P		
Lymph		Baso	Nit	Nes	Negative	Other		
Atyp		Imm	Leuk	Nes	Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative	RBC 10-20 Amorphous Sediment WBC 5-10 SSH 3+ Yeast present - Large Quanti		
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:

REPORTED BY: [redacted]	DATE: 22OCT03	LAB ID NO.:

(b)(6)-2

(b)(6)-2

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

(b)(6)-4

LAS[redacted]	DATE 25 Sept 03	TIME 1110	SSN[redacted] (b)(6)-7

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

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

REMARKS:

REPORTED BY: [redacted]	DATE: 9-25-03	LAB ID NO.:

(b)(6)-2

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:

(6)(b)-2

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na+		138-146 mmol/l	AJ			U		73-118 mg/dl
			A			N		7-22 mg/dl
			A			+		8.0-10.3 mg/dl
			A			E		0.6-1.2 mg/dl
			A			F		128-145 mmol/l
			T					3.3-4.7 mmol/l
			B					98-108 mmol/l
			C			h_2		18-33 mmol/l
			C			(Piccolo) Liver Panel Plus		
			C			EST	RESULT	REF. RANGE
			G			B		3.3-5.5 g/dl
			T			P		26-84 u/l
						T		10-47 u/l
						IY		14-97 u/l
			C			T		11-38 u/l
			E			IL		0.2-1.6 mg/dl
			C			T		5-65 u/l
			C					6.4-8.1 g/dl
			N			(Piccolo) Electrolyte		
			I			EST	RESULT	REF. RANGE
			J			+		128-145 mmol/l
			1					3.3-4.7 mmol/l
								98-108 mmol/l
						O_2		18-33 mmol/l

------- PICCOLO -------
25/09/03 14:11
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	3.6	3.3-5.5	G/DL
ALP	65	26-84	U/L
ALT	<5*	10-47	U/L
AMY	47	14-97	U/L
AST	33	11-38	U/L
TBIL	0.7	0.2-1.6	MG/DL
GGT	16	5-65	U/L
TP	7.1	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

------- PICCOLO -------
09/25/03 12:08 PM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	95	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	0.5*	0.6-1.2	MG/DL
CK	614*	39-380	U/L
NA+	136	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 1+, ICT 0

REMARKS:		
REPORTED BY:	DATE:	LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [illegible] 09/25/03 02:10 PM

Patient ID: [redacted]
Test Name :PT
Test Result:= 12.4 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.0
Calculated INR = 1.03
Sample Type:citrated wh. blood
Test Date :09/25/03
Test Time :02:07 PM
Card Lot :010301
Operator [redacted]

(5)(6)-2

(5)(6)-4

ID: [redacted]
DOB

			25-09-03 11:18 Patient Limits	
WBC	5.0	x10^3/uL	4.5	10.5
RBC	3.80 L	x10^6/uL	4.00	6.00
Hgb	11.3	g/dL	11.0	18.0
Hct	35.3	%	35.0	50.0
MCV	92.8	fL	80.0	99.9
MCH	29.7	pg	27.0	31.0
MCHC	32.1 L	g/dL	33.0	37.0
Plt	302.	x10^3/uL	150.	450.
Lym	49.6	%	20.5	51.1
Lym	2.5	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/25/03 02:11 PM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 31.6 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/25/03
Test Time :02:08 PM
Card Lot :100208
Operator [redacted]

[redacted] (b)(2)

Microbiology Request Form

Last Name: [redacted]
First Name: (b)(6)-4
Patient # or SSN: [redacted]

Ward: 1GW-1
Room:
Bed:
Physician: [redacted] (b)(6)-2

Collected by: [redacted]
Date: 29Sept 03
Time: 1705

Source: WOUND + BONE (R) TIBIA
Site: (R) TIBIA

[redacted]

Received by: [redacted]
Date: 29Sep03
Time: 1800

Specimen #: [redacted]

Laboratory Results

initial gram stain - no bacteria seen

Proteus penneri Pseudomonas aeruginosa

Reported
Date: 10-2-03
Time: 1230
Tech: [redacted]
Reviewer: [redacted] (b)(6)-2

Number of attached sheets:

MEDCOM - 20424

(b)(6)-2 **Microbiology Report**

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

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1 Proteus penneri — Status: Final
2 Pseudomonas aeruginosa — Status: Final

1 P. penneri

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

2 P. aeruginosa

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

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

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

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

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

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

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

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

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

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Req. Phys: [redacted]

Printed 10/2/2003 9:56:38 AM

Tech: (b)(6)-2

Amcef Lyn [redacted] (b)(2)-2

Microbiology Request Form

Last Name: [redacted]
First Name: [redacted] (b)(6)-4
Patient # or SSN: [redacted]

Ward: ICW-1
Room:
Bed:
Physician: [redacted]

Collected by: [redacted]
Date: 29 Sep 03
Time: 1705 (b)(6)-2

Source: (R) Tibia
Site:

[redacted]

Received by: [redacted]
Date: 29 Sep 03
Time: 1400

Specimen #: [redacted]

Laboratory Results

Proteus penneri, Pseudomonas aeruginosa

Reported
Date: 10-2-03
Time: 1230
Tech: [redacted]
Reviewer: [redacted]

Number of attached sheets:

MEDCOM - 20426

Microbiology Report

(b)(2)-2 [redacted]

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

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1 Proteus penneri — Status: Final
2 Pseudomonas aeruginosa — Status: Final

1 P. penneri

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

2 P. aeruginosa

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

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

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

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

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

Levaquin 500mg IV QD

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

Zosyn 3.375gm IV q 6°

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

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

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

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

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

Printed 10/2/2003 9:56:38 AM

Tech:

[redacted] (b)(2)-2

Microbiology Request Form

Last Name:

First Name:

Patient # or SSN: [redacted] (b)(6)-4

Collected by: [redacted]

Date: 29 SEP 03 (b)(6)-2

Time: 1705

Ward: ICW1

Room:

Bed:

Physician: [redacted]

Source:

Site: R TIBIA

[redacted]

Received by: [redacted]

Date: 29 SEP 03

Time: 1800

Specimen #: [redacted]

Laboratory Results

PROTEUS PENNERI/	**PSEUDOMONAS AERUGINOSA**

Reported

Date: 2 OCT 03

Time: 1230

Tech: [redacted]

Reviewer: [redacted]

Number of attached sheets:

MEDCOM - 20428

(b)(6)-2

Microbiology Report

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

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1 Proteus penneri — Status: Final
2 Pseudomonas aeruginosa — Status: Final

1 P. penneri

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

2 P. aeruginosa

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

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

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

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

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

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

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

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

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

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

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

Printed 10/5/2003 10:04:45 AM

Tech:

(b)(6)-2

Microbiology Report

Name:
Patient ID: [redacted]
Ward/Rm: W1/ (b)(6)-7

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1	Proteus penneri	Status:	Final
2	Pseudomonas aeruginosa	Status:	Final

1 P. penneri

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

2 P. aeruginosa

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

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

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

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

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

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

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

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

Name:
Patient ID: [redacted] (b)(6)-7
Ward/Rm: W1/

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

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

Printed 10/11/2003 10:20:26 AM

Tech:

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS	DRUG	(Units)	
CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION	FENTANYL	( )	150/100
	propofol	( )	150
		( )	
		( )	
		( )	
		( )	
	VOLAT AGENT	FORANE – % del	2.0/2.0/1.5/1.0/0.0
		% e.t.	
	AIR	L/Min	
	N2O	L/Min	
	O2	L/Min	7/4/4/4/-8

(1) SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS (2)

FLUIDS	LINE site	
	(L) ES 18g	☐ Warmed
		☐ Warmed
		☐ Warmed
		☐ Warmed
LOSSES	EST BLOOD LOSS	
	URINE –	

TOTALS	TOTAL EBL
250	min
	TOTAL URINE
	100

FLUIDS - SUMMARY
CRYSTALLOID – LR 700
COLLOID – 0
BLOOD – 0

REMARKS –
Code drugs with numbers, events with letters
(1) pt ID in KW3-TO OR
(2) RM-O2-monitors

procedure done to gurney & assist to PACU awake

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT 50 KG LB

HEMATOCRIT:

INITIAL DATA: BP – 94/49 HR – 86

BOXIP CHECK OK? – (Y) N

PATIENT IN/CHECK OK for PROCEDURE? Y TIME – 1605

TIME → 1600 x 1630 x 1700 0 1730

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

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

VENTIL						
	VT – ml	700	700	700	600	
	f – breaths/min	6	6	6	4	6 8
	Peak inf pres / PEEP	/	/	/	/	
	MODE – S(pon), A(ssist), C(on)	SV	SV	SV	SV	SV
MONITORS & ACCESSORIES	(L) BP/Auto Cuff / ET CO2 (torr)	51	53	42	60	60
	BP / oth / (L) FIO2 (Frac or %)	0.55	0.55	0.55	0.55	55
	ART line / (L) SpO2 (%)	100	100	100	100	100
	Steth- PC/ES / (L) ECG	SR	SR	SR	SR	SR
	Gas analyzer / (L) TEMP- site	>34° (skin)				SR
	(L) N-M Block (T/4)					
	Warming blkt					
	Conv warmer					

RECOVERY AT 1722
(PACU) ICU _____ (Specify)
OTHER
CONDITION: awake
RESP – 12 SpO2 – 96% on RA
BP – 122/44 HR – 110

ANESTHESIA PROVIDER TIMES	Start	Room	End
ANES	1750	1603	1725
PROC	Ready	Begin	End
	1607	1617	1715

Mark with letters & symbols, explain under REMARKS

EVENTS
Position → [illegible]

PROCEDURES and CPT Codes
cystoscopy I&D (L) EXT.

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GA-MASK

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments – 4 10 ETT Anest. FM
c̄ stop

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

[redacted]

(b)(6)-4

SURGEONS: [redacted]

ANESTHETISTS: [redacted] CAT CRNA

(b)(6)-2

PROCEDURE LOCATION OR 1

DATE 9.29.03

PAGE 1 OF

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

NKDA

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS	DRUG (Units)					
CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "=" = CONSTANT INFUSION	Fentanyl (mcg)	50-50-50	50	50		
	Lidocaine (mg)	90				
	Propofol (mg)	200				
	( )					
	( )					
	( )					
VOLAT AGENT	Iso % del / % e.t.	1.0	2.0	1.5	0.4	
	AIR L/Min					
	N2O L/Min					
	O2 L/Min	10~	2~	2	2	10

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

TOTALS	
250	
90	
200	
TOTAL BLD	< 50
TOTAL URINE	500

FLUIDS - SUMMARY
CRYSTALLOID – 400
COLLOID – Ø
BLOOD – Ø

FLUIDS		
LINE site 18 (R) (L) EJ ☐ Warmed	LR	
☐ Warmed		
☐ Warmed		
☐ Warmed		

LOSSES		
EST BLOOD LOSS	MIN	
URINE –	500	

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 50 (KG) LB

HEMATOCRIT: 35

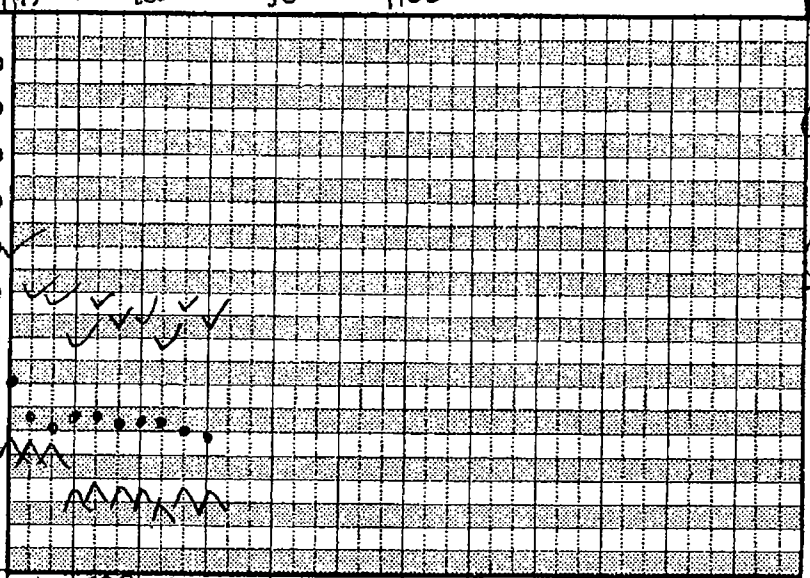
INITIAL DATA: BP – 140/58 HR – 80

DOUBLE CHECK: OK? – (Y) N

PATIENT RECORD CHECK: OK for PROCEDURE? Jr TIME – 0915

TIME → 930 · 1000 · 30 · 1100

SYMBOLS: BP by cuff V ^ ; Heart rate ● ; Resp rate ; BP (transduced) ⅟T ; TOURNIQUET T – ✓ ; ANES – X-X ; PROC – (•) – Ø



VENTILATION					
	VT – ml	+	500	500	500
	f – breaths/min	+	6	4	4
	Peak Inf pres / PEEP	—	13	13	13
	MODE – S(pon), A(ssist), C(on)	S	C	C	C

MONITORS & ACCESSORIES					
BP/Auto Cuff	ET CO2 (torr)	+	45	53	54
BP / oth	FIO2 (Frac or %)	0.7	0.7	0.7	0.7
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP- site available				
	N-M Block (T/4)				
	BS	+			
Warming blkt	Sheet				
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS (1) (2) (3) (4)
Position → 0 — 1

REMARKS – Code drugs with numbers, events with letters

(1) Induce CTA (B) HLR (E) (2)
(2) Room, monitors 100% O2, induced eyelids taped
(3) RR > 8 + < 30 BPM TV > 4 ml/kg LMA removed no complications
(4) To PACU. Report to nurse.

RECOVERY AT: 1025
(PACU) ICU _____ (Specify)
OTHER _____
CONDITION: Stable
RESP – 30 SpO2 – 99
BP – 143/50 HR – 117

ANESTHESIA PROCEDURE TIMES

	Start	Room	End
ANES	0910	0930	1035
	Ready	Begin	End
PROC	0945	0948	1018

PROCEDURES and CPT Codes: I+D (R) leg wound + JP placement Drain

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GLMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: LMA #4; heated 40ml air into cuff + BBS sust ETCO2

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

[redacted] (b)(6)-4 (b)(6)-2

SURGEONS: [redacted]

ANESTHETISTS: [redacted] CRNA/MA

PROCEDURE LOCATION: 1 (one)

DATE: 1 Oct 03

PAGE 1 OF 1

NAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

NKDA No Δ from last Anesthetic 29 Oct 03

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)				TOTALS
Fentanyl (mcg)	150	100		250
Zemuron (mg)	30	10		40
Propofol (mg)	150			150
MSO4 (mg)			5	5
( )				
( )				

VOLAT AGENT: Iso % del	1.0 — 1.0 — 0.8 X
% e.t.	
AIR L/Min	
N2O L/Min	
O2 L/Min	10 — 2 — 2 — 2 — 10

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

TOTAL EBL: 50

TOTAL URINE: 50

FLUIDS

LINE site: (L) IJ x3 ☐ Warmed — LR — 200 — 300

☐ Warmed

☐ Warmed

☐ Warmed

FLUIDS SUMMARY
- CRYSTALLOID- 300
- COLLOID- Ø
- BLOOD- Ø

LOSSES

EST BLOOD LOSS

URINE - Foley 300

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 50 (KG) LB

HEMATOCRIT: N/A

INITIAL DATA:
BP- 102/58
HR- 64

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Okay
TIME-

TIME → 1300 15 30 45 1400 15 30 45 1500

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

Scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

VENTIL

VT - ml	—	660	620	600	1000
f - breaths/min	16	8	8	8	10
Peak inf pres / PEEP	—	18	18	18	—
MODE - S(pon), A(ssist), C(on)	S	C	C	C	S

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	(+)	31	32	32	34
BP/oth	X FIO2 (Frac or %)	.77	.77	.77	.77	.77
ART line	X SpO2 (%)	100	100	100	100	100
Steth- PC/ES	X ECG	SR	SR	SR	SR	SR
Gas analyzer	X TEMP-site	Axillary				
	X N-M Block (T/4)	4/4			4/4	4/4 strong
Warming blkt						
Conv warmer						

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

REMARKS
Code drugs with numbers, events with letters

1300 Pt id as ICW, chart reviewed.
1305 In OR, monitors (+) O2, Smooth IV induction, easy ventilation, AP padded, Eyes taped.
1345 4mg Zofran IV
1400 Propofol ...
1405 Pt awake, No sxn, Extubated ... Moved self to litter To PACU [redacted]

RECOVERY AT: 1315
(PACU) ICU ___ (Specify)
OTHER
CONDITION: Stable
RESP- 16 SpO2- 100
BP- 126/80 HR- 82

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1300	1305	1320
	Ready	**Begin**	**End**
PROC	1315	1338	1310

PROCEDURES and CPT Codes: I&D (R) leg · STSG (R) Thigh

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
DVL x1 attempt c MAC 3, # 7.0 ETT, Grade I view, (+)BBS, (+)ETCO2, secured @ 22 cm teeth ...

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

#[redacted]

(5)(6)-4

SURGEONS: (5)(6)[redacted]

ANESTHETIST: [redacted] CPT CRNA

PROCEDURE LOCATION: OR 2

DATE: 2 Oct 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998

COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

MEDICAL RECORD — ANESTHESIA

DRUGS	(Route)	
Fentanyl	(mcg)	150
Propofol	(mg)	200
Versed	(mg)	2.0
	( )	
	( )	
	( )	
ISOLAT AGENT	I-50	% del
		% e.t.
AIR		L/Min
N2O		L/Min
O2		L/Min

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

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

2.0X

10 – 3 – 10 – 10

LINE/site		
18g (L) ES	☐ Warmed	LR (1000) +
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOCHES: EST BLOOD LOSS

URINE – 1700

TOTALS	
150	DOSE
2	min
	TOTAL URINE
	100 cc

FLUIDS – SUMMARY

CRYSTALLOID – 250 cc

COLLOID – Ø

BLOOD – Ø

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 50 KG LB

HEMATOCRIT:

INITIAL DATA: BP – 100, 59 HR – 78

SCHP CHECK: OK? – Y N

PATIENT TRANSFER: OK for PROCEDURE – Y/N TIME – 1030

TIME 0930 M5 1000 15 30

SYMBOLS: BP by cuff (V ^); 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		700
f – breaths/min		20 16
Peak inf pres / PEEP		– –
MODE – S(pon), A(ssist), C(on)		S A A S
BP/Auto Cuff	ET CO2 (torr)	(+) 30
BP / oth	FIO2 (Frac or %)	156 156
ART line	SpO2 (%)	100 100
Steth – PC/ES	ECG	SR SR
Gas analyzer	TEMP – site Skin	Available
	N-M Block (T/4)	
Warming blkt		
Conv warmer		

Mark with letters & symbols, explain under REMARKS

EVENTS — Position

REMARKS – Code drugs with numbers, events with letters

0930 Aid in ICW, Chart reviewed. To OR via litter.

0940 In room, (+) monitors (+) O2, smooth IV/mask induction, Eyes taped, PP padded.

0957 Procedure started

1025 Awake, to PACU awake. Report to [redacted]

RECOVERY AT 1030

PACU ICU (Specify) OTHER

CONDITION: Stable/Awake

RESP – SpO2 –

BP – 120/74 HR – 96

ANESTHESIA / PROCEDURE TIMES	Start	Room	End
ANES	0930	0940	1035
PROC	Ready	Begin	End
	0950	0957	1023

PROCEDURES and CPT Codes: I&D (R) leg

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — airway, (b)(6)-2 #5 FM, oral

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

EPW # [redacted]

(b)(6)-7

SURGEONS: [redacted]

ANESTH[redacted]PT

PROCEDURE LOCATION: OR 2

DATE: 4 Oct 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED Jan 99

MEDCOM - 20434

*U.S. GPO: 2002-729-160/40137

(b)(6)-2

Inf. open (R) tib NKA Proteus/Pseudomonas 8-149-54 SP2 882 [redacted] HT cm

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)													
Fent	( )	250												
Sux	( )													
propofol	( )	100												
Versed	( )	2.5												
MSO4	( )	10/10												
	( )													
VOLAT AGENT: Forane del	% e.t.	06	6.6	X										
AIR	L/Min													
N2O	L/Min													
O2	L/Min	8	2	8										

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

FLUIDS

LINE site														
18g (2) IV	☐ Warmed													
	☐ Warmed													
	☐ Warmed													
	☐ Warmed													

LOSSES

EST BLOOD LOSS														
URINE -														

TOTALS	TOTAL EBL
	0
	TOTAL URINE
	0

FLUIDS - SUMMARY

CRYSTALLOID- 300

COLLOID- 0

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

(1) RTO IN ICW1 - moves self to stretcher

(2) RM-02-MON.

(3) OOR TO PACU

(4) RPT TO PACU

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 50 (KG) LB

HEMATOCRIT:

INITIAL DATA:

BP- 90/50

HR- 86

EQUIP CHECK

OK?- (Y) N

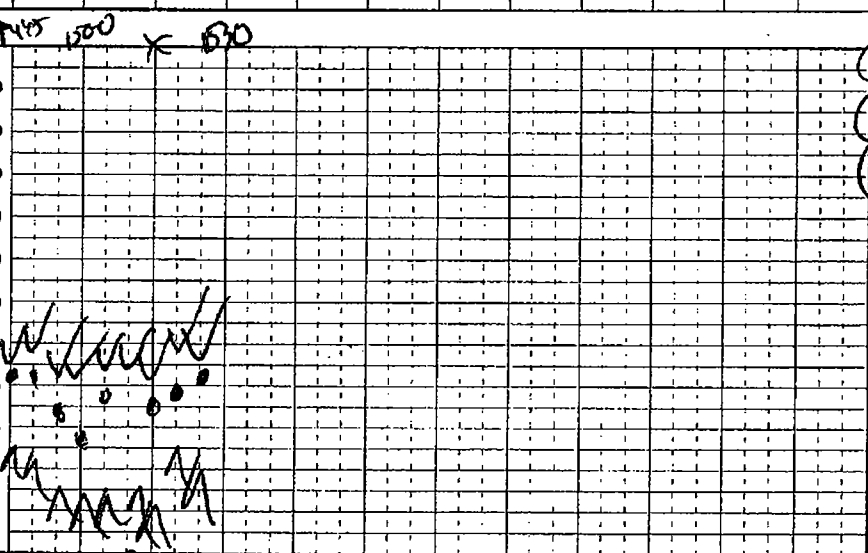
PATIENT RECHECK

OK for PROCEDURE? Y

TIME-

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

TIME → 1445 1500 X 1530



VENTIL

VT - ml	600	810	710
f - breaths/min	16	16	8
Peak inf pres / PEEP			
MODE - S(pon), A(ssist), C(on)	SV	AV	

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	39	48	52
BP/oth	✓ FIO2 (Frac or %)	0.62	0.62	0.62
ART line	✓ SpO2 (%)	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR
Gas analyzer	✓ TEMP-site	Avail		
	✓ N-M Block (T/4)			
Warming blkt				
Conv warmer				

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

RECOVERY AT 1530

PACU/SCU (Specify)

OTHER

CONDITION: alert - talking

RESP- SpO2- 99

BP- HR- 118

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1435	1445	1535
	Ready	Begin	End
PROC	1457	1500	1520

PROCEDURES and CPT Codes:

I & D R Tib

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GA - Mask

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

Mask c #90A

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

[redacted] W d I 2G

(b)(6)-4

SURGEON: [redacted] (b)(6)-2

ANESTHESIOLOGIST:

PROCEDURE LOCATION: 1-1

DATE: 7 OCT 05

PAGE 1 OF 1

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986

MVI
Ativan 20SM
Levegain

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)				
Versed	(mg)	3/2			
MSO4	(mg)	5/5			
Lido Propofol	(mg)	50/200			
	( )				
	( )				
	( )				
VOLAT AGENT	Forane % del		2	1	X
	% e.t.				
AIR	L/Min				
N2O	L/Min				
O2	L/Min	8	2	1	10

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

FLUIDS

LINE site		
LR 1000	☐ Warmed	
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES

EST BLOOD LOSS	
URINE -	

TOTALS	TOTAL EBL
5mg 10mg	Ø
	TOTAL URINE
	Ø

FLUIDS - SUMMARY

CRYSTALLOID- LR 750

COLLOID- Ø

BLOOD- Ø

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 5 (KG) LB

HEMATOCRIT:

INITIAL DATA:

BP- 98/59

HR- 67

EQUIP CHECK

OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? TIME- 1100

TIME → X 30 X 12

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

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

VENTIL

VT - ml	S-C	SQ	SV	SV
f - breaths/min	5	5	8	10
Peak inf pres / PEEP	12	12		
MODE - S(pon), A(ssist), C(on)	C	C	SV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	42	42	46	44
BP/oth	FIO2 (Frac or %)	.78	.78	.79	.78
ART line	SpO2 (%)	100	100	100	
Steth- PC/ES	ECG	SR	SR		
Gas analyzer	TEMP-site	Available			
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

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

REMARKS

Code drugs with numbers, events with letters

1110 in OR
monitors applied
1116 prosea placed ⊕ ETCO2 ⊕ BBS
1205 pt resp ovr/suction prosea out to PACU, talking
report given.

RECOVERY AT 1205

(PACU) ICU _____ (Specify)

OTHER _____

CONDITION: acute to King

RESP- 10 SpO2- 100

BP- 88/44 HR- 63

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1045	1110	1220 1215
	Ready	Begin	End
PROC	1120	1130	1151

PROCEDURES and CPT Codes:

I&D (R) Tibia, Replace Vac

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

[redacted] ICW1

(b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

#4 Prosea/ placed x2 attempts

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

⊕ ETCO2 ⊕ BBS

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

PROCEDURE LOCATION: OR 2

DATE: 10/10/03

PAGE 1 OF 1

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[redacted] 97.3-64-18 SpO2 98% 107/54 10/10/03 [redacted]

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	
Versed	(mg)	2
	( )	
Fentanyl	( )	50
Lidocaine	( )	100
Propofol	( )	
	( )	
VOLAT AGENT: Forane	% del	X 2 — 2 — 1.2
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	4 — 2 — 4

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

FLUIDS

LINE site L#1		
☐ Warmed	200	800
☐ Warmed		
☐ Warmed		
☐ Warmed		

LOSSES: EST BLOOD LOSS; URINE -

TOTALS	TOTAL EBL
	nil
	TOTAL URINE
	∅

FLUIDS - SUMMARY
CRYSTALLOID- LR 400
COLLOID- 0
BLOOD- 0

REMARKS
Code drugs with numbers, events with letters
preop PIV ✓
stable mask
induction and
procedure
done to
PACU Awake

PHYS STATUS: 1 2 3 4 5 E (6)

BODY WEIGHT: 50 KG LB

HEMATOCRIT:

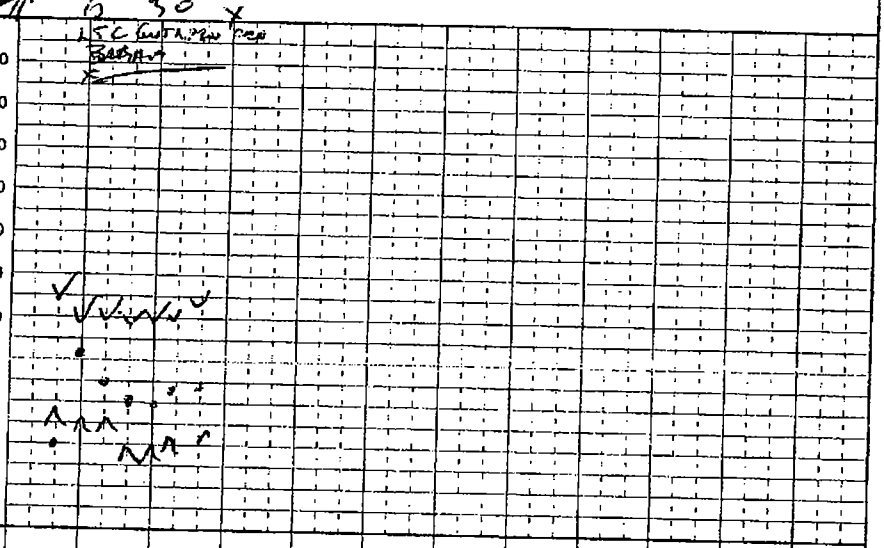
INITIAL DATA: BP- 109/55 HR- 40

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE TM TIME- 1050

TIME → 11 10 30 X

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



VENTIL

VT - ml			
f - breaths/min		6	4
Peak inf pres / PEEP			
MODE - S(pon), A(ssist), C(on)	S	C A	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	+	50	38
BP/oth	✓ FIO2 (Frac or %)	.6	.6	.6
ART line	✓ SpO2 (%)	100	100	99
Steth- PC/ES	✓ ECG	SR	SR	SR
Gas analyzer	TEMP-site	AVAILABLE		
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

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

RECOVERY AT 1145
PACU ICU _____ (Specify)
OTHER _____
CONDITION: T.96
RESP- 16 SpO2-
BP- HR- 64

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1050	1105	1150
PROC	Ready	Begin	End
	1110	1120	1140

PROCEDURES and CPT Codes:
I & D open (R) tibia

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] W21 Bed 4B
(b)(6)-4
[redacted]

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

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

SURGEONS: [redacted]

ANESTHETISTS: [redacted] CRNA

PROCEDURE LOCATION: OR 1
DATE: 10/15/03
PAGE 1 OF 1

DA FORM 7389, FEB 1998 (b)(6)-2 COPY 2 - ANESTHESIA PROVIDER [redacted] USAPA V1.00

No Δ from last Anesthetic NKDA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	1045	1100	15	30	45	1200
Propofol	( )			200			
Fentanyl	(mcg)			100			
	( )						
	( )						
	( )						
	( )						
VOLAT AGENT	Sevo % del			1.5	1.5 X		
	% e.t.						
AIR	L/Min						
N2O	L/Min						
O2	L/Min			10	3	10	

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

FLUIDS

LINE site		1045	1100	15	30	45	1200
(L) ES	☐ Warmed						
	☐ Warmed		LR	—	—	(400)	
	☐ Warmed						
	☐ Warmed						

LOSSES

EST BLOOD LOSS							
URINE -	Foley		(300)				

TOTALS	TOTAL EBL
200	n.h
100	
	TOTAL URINE
	300

FLUIDS - SUMMARY

CRYSTALLOID- 400cc

COLLOID- Ø

BLOOD- Ø

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 50 KG LB

HEMATOCRIT:

INITIAL DATA:

BP- 115/58

HR- 75

EQUIP CHECK

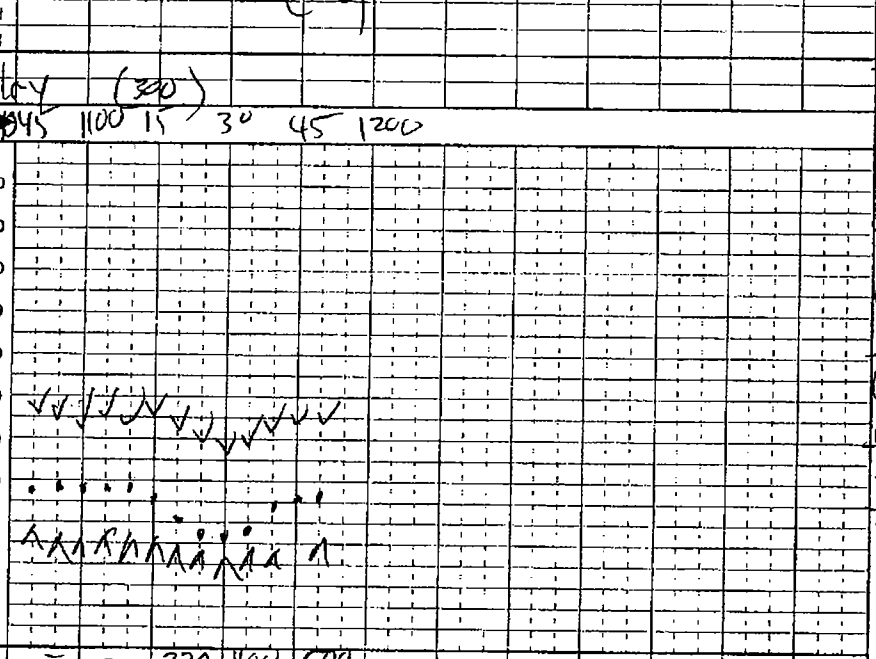
OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? Nay

TIME- 1045

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



VENTIL

	1045	1100	15	30	45	1200
VT - ml	—	—	370	400	500	
f - breaths/min	20	16	10	10	12	
Peak inf pres / PEEP	—	—	13	13	—	
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S	

MONITORS/ACCESSORIES

		1045	1100	15	30	45	1200
X BP/Auto Cuff	X ET CO2 (torr)	(+)	(+)	(+)	42	38	
BP/oth	FIO2 (Frac or %)	.69	.69	.69	.69	.69	
ART line	SpO2 (%)	100	100	100	100	100	
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	
Gas analyzer	TEMP-site	Available					
	N-M Block (T/4)						
Warming blkt							
Conv warmer							

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

REMARKS

Code drugs with numbers, events with letters

1030 VA. Jab ICWS, To OR via litter,
1045 In room, ⊕ monitors, ⊕ O_2, All pt IV (L) Hand, (R) ES,
1110 IV started (L) ES,
1155 To PACU — Stable, Report to [redacted]

RECOVERY AT 1155

PACU ICU _____ (Specify)

OTHER

CONDITION: Stable

RESP- 16 SpO2- 100

BP- 120/40 HR- 89

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1030	1045	1200
	Ready	Begin	End
PROC	1120	1130	1150

PROCEDURES and CPT Codes: IV (R) ES

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GA

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

[redacted] (b)(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Anesthesia mask - oral Airway

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

A[redacted]

PROCEDURE LOCATION: OR 2

DATE: 18 Oct 03

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MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	
MSO4	(mg)	5
Propofol	(mg)	150
Fentanyl	(mg)	50
Ephedrine	(mg)	10 50
	( )	
	( )	
VOLAT AGENT: Hal	% del	1.3 - .9 - .8
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	3 - 3 - 3 - 10

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

FLUIDS

LINE site		
18g (L) IJ	☐ Warmed	LR →
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES

EST BLOOD LOSS	
URINE -	Foley 100

TOTALS	TOTAL EBL
	min
100	TOTAL URINE
10	100

FLUIDS - SUMMARY

CRYSTALLOID- 100cc

COLLOID- Ø

BLOOD- Ø

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT- 50 KG LB

HEMATOCRIT:

INITIAL DATA: BP 92/57 HR- 59

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE- Okay TIME-

TIME → 1045 1100 15 30 45

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	—	—	—
f - breaths/min	16	12	12
Peak inf pres / PEEP	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	40	43	41
BP/oth	X FIO2 (Frac or %)	>.21	>.21	>.21
ART line	X SpO2 (%)	100	100	100
Steth- PC/ES	X ECG	SR	SR	SR
Gas analyzer	TEMP-site	Available		
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

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

REMARKS

Code drugs with numbers, events with letters

1030 Pt id on TCW, chart reviewed, to OR.
1045 In room, ⊕ monitors, ⊕ O2, Sux, IV/induction induction. Eyes taped, nose/ears free pressure.
1025 Pt awake to PACU - stable

RECOVERY AT 1125

PACU ICU ____ (Specify) OTHER ____

CONDITION: Stable

RESP- 7 SpO2- 100 97

BP- 104/58 HR- 73

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1030	1045	1130
	Ready	Begin	End
PROC	1050	1103	1122

PROCEDURES and CPT Codes: I&D (R) LES

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: Drawover Anesthetic — oral Airway

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

[redacted]

(b)(6)-4

AIRWAY MANAGEMENT: Incubation route, blade, technique, comments: Anesthesia Mask

SURGEON: [redacted] (b)(6)-2

ANESTHETIC: [redacted]

PROCEDURE LOCATION: OR 2

DATE: 24 Oct 03

PAGE 1 OF 1

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

MEDICAL RECORD - ANESTHE[illegible]

F[illegible] this form, see AR 40-66; the proponent agenc[illegible] OTSG

NKDA

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)							TOTALS
Phenergan (mg)	25						25
MSO4 ( )	5	2	3				10
Lidocaine (mg)	100						100
Propofol (mg)	200	80					280
( )							
( )							

TOTAL EBL: 50

TOTAL URINE: 300

VOLAT AGENT ISO	% del / % e.t.	0.6	2.0	2.0	2.0	2.0	X
AIR	L/Min						
N2O	L/Min						
O2	L/Min	10 → 2	2	2	2	2	2

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

FLUIDS

LINE site ② IJcw [ ] Warmed LR #1

[ ] Warmed

[ ] Warmed

[ ] Warmed

FLUIDS - SUMMARY

CRYSTALLOID- 500

COLLOID- Ø

BLOOD- Ø

LOSSES

EST BLOOD LOSS 25 50

URINE - 300

PHYS STATUS: 1 ②3 4 5 E

TIME → 1300 · 30 · 1400 · 30 · 1500

BODY WEIGHT: 50 (KG) LB

HEMATOCRIT: —

INITIAL DATA:

BP- 112/54

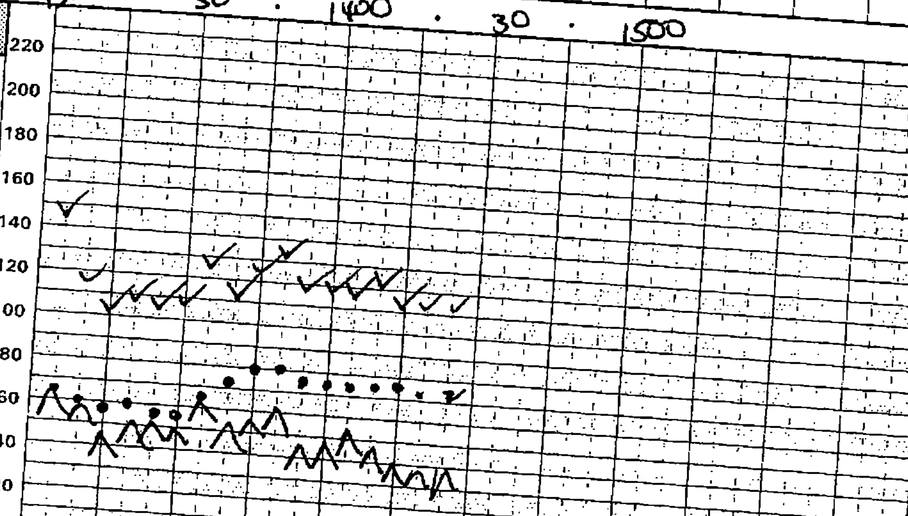
HR- 60

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? JR

TIME- 1245

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



REMARKS

Code drugs with numbers, events with letters

① Pre-op. 100R monitors; O2 Induced; eyelids taped closed

② OA placed c̄ removal of LMA SV>8+<30BPM TV>4mL/kg. +ETCO2

③ To PACU. Report to nurse

VENTIL

VT - ml	+	610	520	330	230	250
f - breaths/min	—	7	6	12	11	8
Peak inf pres / PEEP	—	16	15	—	—	—
MODE - S(pon), A(ssist), C(on)	S ~	C	C	S	S	—

MONITORS/ACCESSORIES

~~BP/Auto Cuff~~	ET CO2 (torr)	+	34	36	53	55	5
~~BP/oth~~	FiO2 (Frac or %)	0.64	0.64	0.64	0.64	0.64	60
ART line	SpO2 (%)	100	100	100	100	100	0.64
Steth- PC/ES	ECG	SR	SR	SR	SR	100	100
Gas analyzer	TEMP-site axillary					SR	SR
	N-M Block (T/4)				35.4°C —		
	BS	+	/	+			

Warming blkt — X 1 wool blanket →

Conv warmer

Mark with letters & symbols, explain under REMARKS

EVENTS ①

Position ○ — ②③

RECOVERY AT 1420

(PACU) ICU ____ (Specify)

OTHER

CONDITION: Stable; asleep

RESP- 8 SpO2- 99

BP 116/48 HR- 70

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1245	1300	1425
	Ready	Begin	End
PROC	1310	1330	1415

PROCEDURES and CPT Codes: I+D (R) tibia c̄ soft tissue flap

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

[redacted]

(b)(6)-1

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GLMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

LMA #4 placed, sealed 20mL air cuff +BBS Sust ETCO2

SURGEONS: [redacted]

ANESTHE[redacted]

PROCEDURE LOCATION: 2 (1)

DATE: 29 Oct 03

[redacted]A/MA PAGE 1 OF 1

(b)(6)-2