OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
2200	500 (SP)	500			
0100	200 (urethra)	700			
0500	600 SP	1300			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

OSTOMY STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
	120	LARGE SOUP BOWL	240
SMALL FRUIT CUP	160	LARGE WATER GLASS	240
COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 06 HOURS TO 06 HOURS | TOTAL HOURS COVERED 24 | DATE 15OCT03 16OCT03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0700	Juice	180	180
	H_2O	360	540
1000	H_2O	250	790
1200	Juice	180	970
1200	H_2O	200	1170
1400	H_2O	250	1420
1600	H_2O	250	1670
16OCT03 0530			

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
06 15	750cc	LR	900	1800	900
1000	100	Cipro	100	1100	1000
1200	100	Tagamet	100	1300	1100
15OCT03 1800	750cc	LR IVF	900	0500	900cc
15OCT03 2200	100cc	Cipro	100	2300	1000cc
16OCT03 2400	100cc	Tagamet	100	0100	1100cc
16OCT03 0300	100cc	Tagamet	100	0600	1200 cc = IV Shift Total

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
GRAND TOTAL INTAKE			

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE.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

[redacted] (b)(b)-4

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0800	500	500			
1300	450	950			
1600	470	1420			
2030	375	375			
2200	425	800			
0040	425	1225			
0530	900 →	2125			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

(Residual) ~~CHEST~~ Suprapubic

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1300	30	30	0040	275	550
1600	15	45	0530	∅	550cc
2030	200	200	12-29 shift total =		550cc
2200	75	275			

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
0700	Brown	Loose	150	150
1600	Brown	Loose	340	490
0040	Brown	Loose	100	100

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
	120	LARGE SOUP BOWL	240
SMALL FRUIT CUP	160	LARGE WATER GLASS	240
COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM ____ HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE 16 Oct 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1200 ~~0600~~	~~400~~ H_2O	400	400
1800	juice	200	
1800	H_2O	200	800
2200	H_2O	100	900

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0600	75cc	LR, Cipro, Tagament		1800	900
1800	75cc/h	LR	900		
1800		Cipro, Tagam	300		2100

IRRIGATIONS *(N/G, Bladder, etc.)*

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

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

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0000	450	450			
0900	250	700			
1200	150	850			
2100	1000	1850	SP		
2200	100 void	1950			
05	200 SP	2150			
05	200 void	2350			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
1200	200	SP cath	200

GRAND TOTAL OUTPUT

REMARKS

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

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

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
	120	LARGE SOUP BOWL	240
SMALL FRUIT CUP	160	LARGE WATER GLASS	240
COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 06 HOURS TO 06 HOURS | TOTAL HOURS COVERED | DATE 170903

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0600	Bottle water	152	
	@ bedside		
800	juice	180	1680
1400	H_2O	400	2080

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0000		LR D5W			

Suprapubic ~~IRRIGATIONS (N/G, Bladder, etc.)~~ Cath

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0100	Clear yellow Urine	400cc	400cc
1000	clamped suprapubic		
1345	Urinated ~~[illegible]~~	100cc	residual

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, Alb, P. cells etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

OUTPUT

URINE						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
1345	250cc								
1700	500	750cc							
2100	600	1350							
0400	300	1650							

CHEST						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

OSTOMY

STOOLS					OTHER OUTPUT			
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
2100	brown	semi-solid	200	200				
					GRAND TOTAL OUTPUT			

REMARKS

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

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
	120	LARGE SOUP BOWL	240
SMALL FRUIT CUP	160	LARGE WATER GLASS	240
COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74

MEDCOM - 21047

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 0/0 HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE 18 Oct

INTAKE

ORAL				INTRAVENOUS					
TIME	TYPE	AMOUNT	ACCUM TOTAL	TIME STARTED	AMOUNT	TYPE *(Include Medications)*	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS *(N/G, Bladder, etc.)*			
TIME	TYPE Suprapubic Cath	AMOUNT	ACCUMULATIVE TOTAL
06-1000	light yellow	600cc	

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

OTHER INTAKE			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
GRAND TOTAL INTAKE			

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

OUTPUT

URINE (VOID)			URINE (RESIDUAL)			NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
1000	200cc	200cc							
VOID@2000	200cc	→	2000	50cc					
VOID@0400	200	→	0400	<10cc					
VOID@0400	200	→	0400	<10cc					

CHEST						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS				
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT			
TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

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

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

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS (1 oz)	30	HALF PINT MILK	240
	120	LARGE SOUP BOWL	240
SMALL FRUIT CUP	160	LARGE WATER GLASS	240
COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74

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

LAST, FIRST, MI.	DATE	TIME	SSN/PEEUDO SSN:
[redacted] (b)(6)-4	4 oct 03	1925	[redacted] (b)(6)-4

```
======= PICCOLO =======
10/04/03                19:38
REFERENCE RANGE:                MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #:
OPER #: [redacted] (b)(6)-2 3142AA4
                        DR #: 000
SERIAL #: [redacted]
.............(b)(6)-4.....
ALB   3.3   3.3-5.5   G/DL
ALP   122*  26-84     U/L
ALT   31    10-47     U/L
AMY   152*  14-97     U/L
AST   35    11-38     U/L
TBIL  0.8   0.2-1.6   MG/DL
BUN   8     7-22      MG/DL
CA++  9.6   8.0-10.3  MG/DL
CHOL  115   100-200   MG/DL
CRE   0.8   0.6-1.2   MG/DL
GLU   99    73-118    MG/DL
TP    7.6   6.4-8.1   G/DL

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

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		39-380 /l (M) 30-190 /l (F)
GLU		128-145 mmol/l
Creat		3.3-4.7 mmol/l
Hct		98-108 mmol/l
Hgb		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
Tropoin-		
Drug of Abuse		

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
tCO2		18-33 mmol/l

TEST	RESULT	REF. RANGE
NA^{+}	136	128-145 mmol/l
K^{+}	4.0	3.3-4.7 mmol/l
CL^{-}	99	98-108 mmol/l
tCO2	36	18-33 mmol/l

(Piccolo) Electrolyte

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 10-4-03	LAB ID NO.:

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

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

(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 fi(M) 81-99 fi(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	12.8	9.8-13.6 secs
APTT	31.8	21-34 SESS
D dimer		<20 ug/ml
FDP		< 10 ug /ml

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Cloudy	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.010	N/A
Bld	Small	Negative
pH	8.0	N/A
Prot	30	Negative
Urob	0.2	0.2-1.0
Nit	Pos	Negative
Leuk	Pos	Negative
HCG		Negative

CSF

Cell Count			
Directigen		Negative	

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

UNIT	TYPE	CROSSMATCH

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

SSA - Small Bacteria Moderate
RBC - 10-15
WBC 20-30
Urine Culture Performed

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: [redacted]	DATE: 10-4-03	LAB ID NO.:

(b)(6)-2

[redacted] (b)(2)-2

Microbiology Request Form

Last Name: EPW
First Name:
Patient # or SSN: [redacted] (b)(6)-4

Ward: EMT / ICWI
Room:
Bed:
Physician:

Collected by:
Date:
Time:

Source: Urine
Site: Clean Catch

[redacted]

Received by: SPC [redacted] (b)(6)-2
Date: 10-4-03
Time: 2000

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

Laboratory Results

Escherichia coli,
Pseudomonas aeruginosa

Reported
Date: 9Oct03
Time: 0958
Tech: [redacted] (b)(6)-2
Reviewer: [redacted] (b)(6)-2

Number of attached sheets:

MEDCOM - 21052

[redacted] (b)(2)-2

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

Specimen: [redacted] (b)(6)-4
Source: Urine
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1 Escherichia coli
2 Pseudomonas aeruginosa

Status: Final
Status: Final

1 E. coli

Drug	MIC	Interps
Amox/K Clav (c)	<=8/4	S
Amp/Sulbactam (c)	>16/8	R
Ampicillin	>16	R
Aztreonam	<=8	S
Cefazolin	16	I
Cefepime	<=8	S
Cefotaxime (c)	<=8	S
Cefotetan	<=16	S
Cefoxitin	<=8	S
Ceftazidime (a)	<=8	S
Ceftriaxone (c)	<=8	S
Cefuroxime (b)	<=4	S
Cephalothin	>16	R
Chloramphenicol	<=8	S
Ciprofloxacin	<=1	S
ESBL-a Scrn	<=4	
ESBL-b Scrn	<=1	
Gatifloxacin	<=2	S
Gentamicin	<=4	S
Imipenem (c)	<=4	S
Levofloxacin	<=2	S
Meropenem (c)	<=4	S
Moxifloxacin	<=2	S
Nitrofurantoin	<=32	
Norfloxacin	<=4	
Pip/Tazo (d)	<=16	S
Piperacillin (a)	>64	R
Tetracycline	>8	R
Ticar/K Clav (a)	64	I
Tobramycin	<=4	S
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	R
Cefotetan	>32	
Cefoxitin	>16	
Ceftazidime (a)	>16	R
Ceftriaxone (c)	32	I
Cefuroxime (b)	>16	
Cephalothin	>16	
Chloramphenicol	>16	
Ciprofloxacin	<=1	S
ESBL-a Scrn	>4	
ESBL-b Scrn	>1	
Gentamicin	>8	R
Imipenem (c)	<=4	S
Levofloxacin	<=2	S
Meropenem (c)	<=4	S
Nitrofurantoin	>64	
Norfloxacin	<=4	
Pip/Tazo (d)	>64	R
Piperacillin (a)	>64	R
Tetracycline	>8	
Ticar/K Clav (a)	<=16	S
Tobramycin	>8	R
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] (b)(6)-4
Source: Urine
Ward of Iso:

Status: Final
Collected:
Req. Phys:

Printed 10/9/2003 9:44:06 AM

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

(b)(6)-2

Ward/Section: ICU #	REQUESTING PHYSICAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST,MI. [redacted] (b)(6)-4	DATE 6 OCT	TIME 0912	SSN/PEEUDO SSN: E[redacted] (b)(6)-4

(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 fi(M) 81-99 fi(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(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	Yellow	N/A
App	Clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.030	N/A
Bld	MoD	Negative
pH	6.0	N/A
Prot	1+	Negative
Urob	0.2	0.2-1.0
Nit	pos	Negative
Leuk	pos	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

SSA = 1+
25-30 WBC 1+ Bac
40-45 RBC 0-2 Hyline Casts/LPF

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]	DATE: 6 OCT 03	LAB ID NO.:

(b)(6)-2

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

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

URGENCY
- [x] ROUTINE
- TODAY [ ]
- [ ] PRE-OP
- STAT [ ]

PATIENT STATUS
- [ ] BED
- [ ] AMB
- OUTPATIENT [ ]
- [ ] NP
- [ ] DOM

SPECIMEN SOURCE
- [ ] VEIN
- [ ] CAP
- [ ] OTHER (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY MD TECH

DATE 60CT03

LAB. ID. NO.

REMARKS CBC

549-107

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED (X)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	PT CONTROL	PT PATIENT	PTT CONTROL	PTT PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
			RESULTS								WBC DIFF AND BLOOD CELL MORPH																					

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FPMR (41-CFR) 201-45.505

ID: [redacted] (b)(6)-4
WB

06-10-03
03:55

				Patient Limits	
WBC	16.6 H	x10^3/uL		4.5	10.5
RBC	3.90 L	x10^6/uL		4.00	6.00
Hgb	11.3	g/dL		11.0	18.0
Hct	35.3	%		35.0	60.0
MCV	90.4	fL		80.0	99.9
MCH	29.1	pg		27.0	31.0
MCHC	32.2 L	g/dL		33.0	37.0
Plt	608. H	x10^3/uL		150.	450.
LY%	13.8 *L	%		20.5	51.1
LYM	2.3 *	x10^3/uL		1.2	3.4

(b)(b)-4

ID [redacted] 04-10-03
WB 19:37

				Patient Limits	
WBC	15.4 H	x10^3/uL		4.5	10.5
RBC	3.99 L	x10^6/uL		4.00	6.00
Hgb	11.3	g/dL		11.0	18.0
Hct	36.7	%		35.0	60.0
MCV	91.9	fL		80.0	99.9
MCH	28.3	pg		27.0	31.0
MCHC	30.7 L	g/dL		33.0	37.0
Plt	549. H	x10^3/uL		150.	450.
LY%	20.0 *L	%		20.5	51.1
LY#	3.1 *	x10^3/uL		1.2	3.4

======= P[illegible]OLO =======
10/06/03 04:21
REFERENCE RANGE: [illegible] MALE
PATIENT #: [redacted] (b)(b)-4
METLYTE 8
DISC LOT #: (b)(b)-2 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(b)-4.....

GLU	108	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	30*	39-380	U/L
NA+	130	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	94*	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

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

(b)(b)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/06/03 09:20

Patient ID: [redacted] (b)(b)-4
Test Name :PT
Test Result:= 13.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.12
Sample Type:citrated wh. blood
Test Date :10/06/03
Test Time :09:19
Card Lot [redacted] (b)(b)-4
Operator [redacted] (b)(b)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/07/03 05:06
(b)(b)-4
Patient ID: [redacted] (b)(b)-4
Test Name :PT
Test Result:= 11.4 sec.
RESULT OUT OF RANGE
Ratio = 0.9
Calculated INR = 0.90
Sample Type:citrated wh. blood
Test Date :10/07/03
Test Time :05:05
Card Lot [redacted] (b)(b)-2
Operator [redacted] (b)(b)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/06/03 09:24
(b)(b)-4
Patient ID [redacted] (b)(b)-4
Test Name :APTT
Test Result:= 29.9 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :10/06/03
Test Time :09:21
Card Lot [redacted] (b)(b)-4
Operator [redacted] (b)(b)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/07/03 05:09
(b)(b)-4
Patient ID [redacted] (b)(b)-4
Test Name :APTT
Test Result:= 49.8 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :10/07/03
Test Time :05:06
Card Lot [redacted] (b)(b)-4
Operator [redacted] (b)(b)-2

[redacted] (b)(b)-4
ID [redacted] 06-10-03
WB (b)(b)-4 09:15

				Patient Limits	
WBC	15.8 H	x10^3/uL		4.5	10.5
RBC	3.87 L	x10^6/uL		4.00	6.00
Hgb	11.0 L	g/dL		11.0	18.0
Hct	35.0	%		35.0	60.0
MCV	90.5	fL		80.0	99.9
MCH	28.4	pg		27.0	31.0
MCHC	31.4 L	g/dL		33.0	37.0
Plt	615. H	x10^3/uL		150.	450.
LY%	15.5 *L	%		20.5	51.1
LY#	2.4 *	x10^3/uL		1.2	3.4

(b)(b)-4
ID [redacted] 07-10-03
WB [redacted] 05:06

				Patient Limits	
WBC	14.4 H	x10^3/uL		4.5	10.5
RBC	3.87 L	x10^6/uL		4.00	6.00
Hgb	11.0	g/dL		11.0	18.0
Hct	35.4	%		35.0	60.0
MCV	91.4	fL		80.0	99.9
MCH	28.5	pg		27.0	31.0
MCHC	31.2 L	g/dL		33.0	37.0
Plt	600. H	x10^3/uL		150.	450.
LY%	16.9 *L	%		20.5	51.1
LY#	2.4 *	x10^3/uL		1.2	3.4

(b)(b)-2

Ward/Section: ICU #1	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST,MI. [redacted] (b)(b)-4	DATE 10 OCT	TIME 0448	SSN/PEEUDO SSN:	

(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	Microbiology		
Hct		42-52%(M) 37-47%(F)	Bili		Negative	Source		
MCV		80-94 fi(M) 81-99 fi(F)	Ket		Negative	Gram Stain		
Plt		130-500 x10³ 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	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
TE		
BI		
C		
C		
C		
C		
T		

======= PICCOLO =======
10/07/03 05:02
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: (b)(6)-4 [redacted]

GLU	117	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	24*	39-380	U/L
NA+	127*	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	93*	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

(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
+		3.3-4.7 mmol/l
L⁻		98-108 mmol/l
CO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
LB		3.3-5.5 g/dl
LP		26-84 u/l
LT		10-47 u/l
ST		14-97 u/l
MY		11-38 u/l
BIL		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:

RAPIDPOINT COAG ANALYZER V4.[redacted]
SERIAL [redacted] 10/08/03 04:44
(b)(b)-4
Patient ID: [redacted] (b)(b)-4
Test Name :PT
Test Result:= 12.6 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR = 1.05
Sample Type:citrated wh. blood
Test Date :10/08/03
Test Time :04:42
Card Lot [redacted] (b)(b)-4
Operator [redacted] (b)(b)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/08/03 04:47
(b)(b)-4
Patient ID [redacted] (b)(b)-4
Test Name :APTT
Test Result:= 28.5 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :10/08/03
Test Time :04:44
Card Lot [redacted] (b)(b)-4
Operator [redacted] (b)(b)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/09/03 05:39
(b)(b)-4
Patient ID [redacted] (b)(b)-4
Test Name :PT
Test Result:= 12.1 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR = 0.99
Sample Type:citrated wh. blood
Test Date :10/09/03
Test Time :05:37
Card Lot [redacted] (b)(b)-4
Operator [redacted] (b)(b)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/09/03 05:41
(b)(b)-4
Patient ID [redacted] (b)(b)-4
Test Name :APTT
Test Result:= 33.7 sec.
Sample Type:citrated wh. blood
Test Date :10/09/03
Test Time :05:39
Card Lot [redacted] (b)(b)-4
Operator [redacted] (b)(b)-2

[redacted] (b)(b)-4

				Patient Limits	
WBC	12.1	H	x10^3/uL	4.5	10.5
RBC	4.01		x10^6/uL	4.00	6.00
Hgb	11.4		g/dL	11.0	18.0
Hct	36.7		%	35.0	60.0
MCV	91.4		fL	80.0	99.9
MCH	28.4		pg	27.0	31.0
MCHC	31.1	L	g/dL	33.0	37.0
Plt	596.	H	x10^3/uL	150.	450.
Lym	20.5	*	%	20.5	51.1
Lym	2.5	*	x10^3/uL	1.2	3.4

[redacted] (b)(b)-4

				Patient Limits	
WBC	11.2	h	x10^3/uL	4.5	10.5
RBC	3.82	L	x10^6/uL	4.00	6.00
Hgb	10.6	L	g/dL	11.0	18.0
Hct	34.8	L	%	35.0	60.0
MCV	91.1		fL	80.0	99.9
MCH	27.8		pg	27.0	31.0
MCHC	30.5	L	g/dL	33.0	37.0
Plt	571.	H	x10^3/uL	150.	450.
Lym	35.4	*	%	20.5	51.1
Lym	2.9	*	x10^3/uL	1.2	3.4

[redacted] (b)(b)-4

				Patient Limits	
WBC	[illegible]		x10^3/uL	4.5	10.5
RBC	[illegible]	L	x10^6/uL	4.00	6.00
Hgb	[illegible]	L	g/dL	11.0	18.0
Hct	[illegible]	L	%	35.0	60.0
MCV	90.2		fL	80.0	99.9
MCH	[illegible]		pg	27.0	31.0
MCHC	[illegible]	L	g/dL	33.0	37.0
Plt	[illegible]	H	x10^3/uL	150.	450.
Lym	[illegible]	*	%	20.5	51.1
Lym	2.0	*	x10^3/uL	1.2	3.4

======= PICCOLO =======
08/10/03 04:29
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(b)-4
METLYTE 8
DISC LOT #: (b)(b)-2 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] (b)(b)-4

GLU	97	73-118	MG/DL
BUN	11	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	26*	39-380	U/L
NA+	[redacted]*	128-145	MMOL
K+	4.2	3.3-4.7	MMOL
CL-	94*	98-108	MMOL
tCO2	26	18-33	MMOL

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

[redacted] (b)(b)-4

				Patient Limits	
WBC	[illegible]		x10^3/uL	4.5	10.5
RBC	[illegible]	L	x10^6/uL	4.00	6.00
Hgb	[illegible]	L	g/dL	11.0	18.0
Hct	[illegible]	L	%	35.0	60.0
MCV	[illegible]		fL	80.0	99.9
MCH	[illegible]		pg	27.0	31.0
MCHC	[illegible]	L	g/dL	33.0	37.0
Plt	[illegible]	H	x10^3/uL	150.	450.
Lym	[illegible]	*	%	20.5	51.1
Lym	2.0	*	x10^3/uL	1.2	3.4

(b)(6)-2

Ward/Section: ICU #1	REQUESTING PHYSICAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST,MI.	DATE	TIME	SSN/PEEUDO SSN:
[redacted] (b)(6)-4	80100	0430	[redacted] (b)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 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	**Microbiology**		
Hct		42-52%(M) 37-47%(F)	Bili		Negative	Source		
MCV		80-94 fi(M) 81-99 fi(F)	Ket		Negative	Gram Stain		
Plt		130-500 x10³ 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	**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.:

(b)(6)-2

Ward/Section: ICU#1	REQUESTING [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 90903	TIME (@0430)	[redacted] SSN: (b)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 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	**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 x10³ 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	**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: (b)(6)-4	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST,MI. [redacted]		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

PICCOLO
09/10/03 05:09
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3151AM
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] (b)(6)-4

GLU	107	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	20*	39-380	U/L
NA+	~~128*~~ B4	128-145	MMOL
K+	4.1	3.3-4.7	MMOL
CL-	92*	98-108	MMOL
tCO2	25	18-33	MMOL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
A++		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
A+		128-145 mmol/dl
+		3.3-4.7 mmol/l
=		98-108 mmol/l
O2		18-33 mmol/l

(Piccolo) Liver Panel Plus

ST	RESULT	REF. RANGE
B		3.3-5.5 g/dl
P		26-84 u/l
T		10-47 u/l
T		14-97 u/l
IY		11-38 u/l
IL		0.2-1.6 mg/dl
T		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

ST	RESULT	REF. RANGE
+		128-145 mmol/l
		3.3-4.7 mmol/l
-		98-108 mmol/l
2		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 [redacted] (b)(6)-4	DATE 10 Oct 03	TIME 0510	SSN/PEEUDO SSN: [redacted] (b)(6)-4

(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 fi(M) 81-99 fi(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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

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

Blood Bank (MUST SUBMIT SF 518 W REQ

TEST	RESULT	REF. RANGE	UNIT

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source	

======= PICCOLO =======
10/10/03 05:50
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(6)-4.....

GLU	102	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	16*	39-380	U/L
NA+	130	128-145	MMOL/L
K+	4.5	3.3-4.7	MMOL/L
CL-	95*	98-108	MMOL/L
tCO2	26	18-33	MMOL/L

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(b)-4

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

LAST, FIRST,MI [redacted] (b)(b)-4		DATE 100403	TIME 0510		SSN/PEEUDO SSN: [redacted] (b)(b)-4

(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/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.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/10/03 05:55
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 11.8 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR = 0.95
Sample Type:citrated wh. blood
Test Date :10/10/03
Test Time :05:53
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/10/03 05:59
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 36.2 sec.
Sample Type:citrated wh. blood
Test Date :10/10/03
Test Time :05:55
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/11/03 05:25
(b)(6)-4
Patient ID [redacted] (b)(6)-4
Test Name :PT
Test Result:= 11.7 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR = 0.93
Sample Type:citrated wh. blood
Test Date :10/11/03
Test Time :05:23
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/11/03 05:28
(b)(6)-4
Patient ID [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 32.8 sec.
Sample Type:citrated wh. blood
Test Date :10/11/03
Test Time :05:25
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

======= PICCOLO =======
11/10/03 05:22
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
(b)(6)-4

GLU	104	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	24*	39-380	U/L
NA+	132	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	99	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

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

ID: [redacted] 11-10-03
46 (b)(6)-4 05:20
Patient
Limits

WBC	7.9	x10^3/uL	4.5	10.5
RBC	3.63 L	x10^6/uL	4.30	6.30
Hgb	10.1 L	g/dL	11.0	18.0
Hct	33.0 L	%	35.0	60.0
MCV	90.9	fL	80.0	99.9
MCH	27.7	pg	27.0	31.0
MCHC	30.5 L	g/dL	33.0	37.0
Plt	433.	x10^3/uL	150.	450.
Lym%	25.0	%	20.5	51.1
Lym#	2.0	x10^3/uL	1.2	3.4

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

LAST, FIRST, MI. #[redacted] (b)(6)-4	DATE 110403	TIME 0455	SSN/PEEUDO SSN: #[redacted] (b)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 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	Microbiology		
Hct		42-52%(M) 37-47%(F)	Bili		Negative	Source		
MCV		80-94 fi(M) 81-99 fi(F)	Ket		Negative	Gram Stain		
Plt		130-500 x10³ 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	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: 10W1	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST,MI: #[redacted] (b)(6)-4		DATE 110403	TIME 0455		SSN/PEEUDO SSN: #[redacted] (b)(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		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/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: ICW 1	REQUESTING P[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: # [redacted] (b)(6)-4	DATE: 12 OCT	TIME: 0400	SSN/PEE[redacted] (b)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 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	Microbiology		
Hct		42-52%(M) 37-47%(F)	Bili		Negative	Source		
MCV		80-94 fi(M) 81-99 fi(F)	Ket		Negative	Gram Stain		
Plt		130-500 x10³ 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	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.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/12/03 03:43
(b)(b)-4
Patient ID: [redacted] (b)(b)-4
Test Name :PT
Test Result:= 12.3 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR = 1.01
Sample Type:citrated wh. blood
Test Date :10/12/03
Test Time :03:41
Card Lot [redacted] (b)(b)-4
Operator : [redacted] (b)(b)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/12/03 03:46
(b)(b)-4
Patient ID [redacted] (b)(b)-4
Test Name :APTT
Test Result:= 35.1 sec.
Sample Type:citrated wh. blood
Test Date :10/12/03
Test Time :03:43
Card Lot [redacted] (b)(b)-4
Operator [redacted] (b)(b)-2

======= PICCOLO =======
12/10/03 03:38
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(b)-4
METLYTE 8
DISC LOT #: (b)(b)-2 3151AA4
OPER # [redacted] DR #: 000
SERIAL #: [redacted]
(b)(b)-4

GLU	106	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	22*	39-380	U/L
NA+	~~125~~* 136	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	93*	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

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

(b)(b)-4
[redacted]
[illegible]

WBC	10.2	x10^3/uL	[illegible]	[illegible]
RBC	3.74 L	x10^6/uL	4.00	6.00
HGB	13.4 L	g/dL	11.0	18.0
HCT	33.5 L	%	35.0	50.0
MCV	90.6	fL	90.0	[illegible]
MCH	27.7	pg	27.0	31.0
MCHC	30.6 L	g/dL	33.0	37.0
Plt	444.	x10^3/uL	150.	450.
LYM	25.0 *	%	20.5	51.1
LYM	2.6 *	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/13/03 03:54
(b)(b)-4
Patient ID: [redacted] (b)(b)-4
Test Name :PT
Test Result:= 13.4 sec.
Ratio = 1.1
Calculated INR = 1.16
Sample Type:citrated wh. blood
Test Date :10/13/03
Test Time :03:53
Card Lot [redacted] (b)(b)-4
Operator [redacted] (b)(b)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/13/03 03:57
(b)(b)-4
Patient ID: [redacted] (b)(b)-4
Test Name :APTT
Test Result:= 33.5 sec.
Sample Type:citrated wh. blood
Test Date :10/13/03
Test Time :03:54
Card Lot [redacted] (b)(b)-4
Operator [redacted] (b)(b)-2

[redacted]
(b)(b)-4

======= PICCOLO =======
12/10/03 03:52
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(b)-4
METLYTE 8
DISC LOT #: (b)(b)-2 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
(b)(b)-4

GLU	134*	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	20*	39-380	U/L
NA+	~~1[illegible]~~* 136	128-145	MMOL/L
K+	3.9	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 1+, ICT 0

(b)(6)-2

Ward/Section: ICW1	REQUESTING PHYS[redacted]			CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. #[redacted] (b)(6)-4		DATE 12OCT	TIME 0400	SSN/PEEUDO SSN: #[redacted] (b)(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		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/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.:

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

LAST, FIRST,MI.		DATE 10-13-03	TIME		SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		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/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) Metabolic 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: ICW 1	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted] (b)(6)-4	DATE 13 OCT 03 / TIME 0400	SSN/PEF [redacted] (b)(6)4

Hematology/CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 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	**Microbiology**		
Hct		42-52%(M) 37-47%(F)	Bili		Negative	Source		
MCV		80-94 fi(M) 81-99 fi(F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10⁴ 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	**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*
[redacted]		9.8-13.6 secs			
[redacted]		21-34 SESS			
D dimer		<20 ug/ml			
FDP		< 10 ug /ml			

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

[redacted] (b)(6)-4

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

I/Section:	REQUESTING PHYSICAN:	DATE 10-14-04	TIME
T, FIRST,MI.			SSN/PEEUDO SSN:

[redacted]			Urinalysis			Misc. Serology		
ST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
BC		4.8-10.8 x10	Color		N/A	RPR		Negative
C		4.7-6.1 x10	App		N/A	Mono		Negative
b		14-18 g/dl(M) 12-16 g/dl(F)	Glu		Negative			
t		42-52%(M) 37-47%(F)	Bili		Negative			
CV		80-94 fi(M) 81-99 fi(F)	Ket		Negative			
lt		130-500 x 10³ verified	SG		N/A			
ymph %		20.5-51.1%	Bld		Negative			
[redacted]			pH		N/A			
Segs		Mono	Prot		Negative			
Bands		Eos	Urob		0.2-1.0			
Lymph		Baso	Nit		Negative			
Atyp		Imm	Leuk		Negative			
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52%(M) 37-47%(F)						
Set Rate								
Other								

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

Macroscopic Urinalysis

CSF		
Cell Count		
Directigen		Negative

Blood Bank
MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED
ABO/Rh

[redacted]		
TEST	RESULT	REF. RANGE
[redacted]		9.8-13.6 secs
[redacted]		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:	DATE:	LAB ID NO.:

(b)(6)-4 (b)(6)-2

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

Ward/Section: 1AW#1

REQUESTING PHYSICAN: [redacted]

SSN/PEEUDO SSN: [redacted] (b)(6)-4

LAST, FIRST,MI. [redacted] (b)(6)-4

DATE: 14OCT03 TIME: 0500

(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
Troponin-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/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

[redacted]

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.:

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

/Section: ICU#1	REQUESTING PHYSICAN:		SSN/PEEUDO SSN:
, FIRST,MI. [redacted] (b)(6)-4	DATE 10/15/03	TIME	

(Hematology) CBC

ST	RESULT	REF. RANGE
BC		4.8-10.8 x10
C		4.7-6.1 x10
b		14-18 g/dl(M) 12-16 g/dl(F)
t		42-52%(M) 37-47%(F)
CV		80-94 fl(M) 8 -99 fl(F)
lt		130-500 x10³ verified
ymph %		20.5-51.1%

(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:

REPORTED BY: DATE: LAB ID NO.:

======= PICCOLO =======
14/10/03 05:56
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(6)-4.....

GLU	107	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	19*	39-380	U/L
NA+	129	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

======= PICCOLO =======
15/10/03 05:16
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(6)-4.....

GLU	95	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	28*	39-380	U/L
NA+	130	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/14/03 05:58
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 13.8 sec.
Ratio = 1.1
Calculated INR = 1.22
Sample Type:citrated wh. blood
Test Date :10/14/03
Test Time :05:56
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/14/03 06:02
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 37.5 sec.
Sample Type:citrated wh. blood
Test Date :10/14/03
Test Time :05:58
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/15/03 05:33
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 12.4 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR = 1.03
Sample Type:citrated wh. blood
Test Date :10/15/03
Test Time :05:31
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/15/03 05:36
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 36.3 sec.
Sample Type:citrated wh. blood
Test Date :10/15/03
Test Time :05:33
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

(b)(6)-4

ID: [redacted] 15-10-03
[redacted] 05:12

			Patient Limits	
WBC	8.4	x10^3/uL	4.5	10.5
RBC	3.51 L	x10^6/uL	4.00	6.00
Hgb	10.0 L	g/dL	11.0	18.0
Hct	31.6 L	%	35.0	60.0
MCV	89.9	fL	80.0	99.9
MCH	28.5	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	292.	x10^3/uL	150.	450.
LYM	29.3	%	20.5	51.1
LYM	2.4	x10^3/uL	1.2	3.4

(b)(6)-4
[redacted]

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

Ward/Section: ICW#1	REQUESTING PHYSICAN: [redacted] (b)(6)-2		SSN/PEEUDO SSN: [redacted] (b)(6)-4
LAST, FIRST, M.I. [redacted] (b)(6)-4		DATE 150CT03	TIME 0830

(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/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.:

EPW#[redacted] (b)(6)-4
ICW#1

[redacted]

SPECIMEN/LAB RPT. NO.

HEMATOLOGY

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

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP; ☐ OTHER (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE | REPORTED BY | MD | DATE 16OCT03 @0400 | TECH | LAB. ID. NO.

REMARKS CBC

549-107

TEST(S)	SPECIMEN TAKEN TIME A.M. P.M.	REQUESTED (X)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	PTT: CONTROL	PATIENT	CONTROL	PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
DATE	RESULTS																														

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FPMR (41-CFR) 201-45.505

(b)(6)-4

ID: [redacted] 16-10-03
WB: [redacted] 04:47

			Patient Limits	
WBC	10.3	x10^3/uL	4.5	10.5
RBC	3.67 L	x10^6/uL	4.00	6.00
Hgb	10.4 L	g/dL	11.0	18.0
Hct	32.9 L	%	35.0	60.0
MCV	89.6	fL	80.0	99.9
MCH	28.5	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	289.	x10^3/uL	150.	450.
LY%	19.1 *L	%	20.5	51.1
LY#	2.0 *	x10^3/uL	1.2	3.4

RAPIDPOINT C[illegible]
SERIAL [redacted] 10/16/03 04:51
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 11.6 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR - 0.92
Sample Type:citrated wh. blood
Test Date :10/16/03
Test Time :04:49
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/16/03 04:55
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 18.3 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :10/16/03
Test Time :04:51
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

EPW

[redacted] (b)(6)-4

ICW#1

SPECIMEN/LAB RPT. NO

MISC

URGENCY
☑ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

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

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY MD TECH

DATE 16OCT03 0400

LAB ID NO.

REMARKS PT/PTT

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED	RESULTS

557-107

MISCELLANEOUS

STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ADM
FPMR (41 CFR) 201-45.505

EPW# [redacted] (b)(6)-4
ICU#1

SPECIMEN/LAB. RPT. NO.

CHEM 1

URGENCY
☑ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

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

SPECIMEN SOURCE
☐ BLOOD
☐ OTHER (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY MD TECH

DATE 16OCT03 0400

LAB. ID. NO.

REMARKS CHEM 8

TEST(S)	SPECIMEN TAKEN																														
	DATE	TIME	A.M. P.M.	REQUESTED (X)	GLUCOSE	UREA N.	CREATININE	URIC ACID	SODIUM	POTASSIUM	CHLORIDE	CO_2	PHOSPHATE	CALCIUM	TOTAL PROTEIN	ALBUMIN	GLOBULIN	ALKALINE PHOSPHATASE	ACID PHOSPHATASE	SGOT	LDH	CPK	BILIRUBIN (TOTAL)	BILIRUBIN (DIRECT)	CHOLESTEROL	TRIGLYCERIDES	AMYLASE	LIPASE	PROFILE (Specify)			
				RESULTS																											

546-107

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

===C= PICCOLO =======
16/10/03 04:57
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(6)-4.....

GLU	98	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	30*	39-380	U/L
NA+	132	128-145	MMOL
K+	4.3	3.3-4.7	MMOL
CL-	98	98-108	MMOL
tCO2	22	18-33	MMOL

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

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
(b)(6)-2 CT [redacted] / pelvis with / ~~contrast~~ / IV contrast	25	M	[redacted]	ER	
	FILM NO. (b)(6)-4				PREGNANT ☐ YES ☒ NO
	REQUESTED BY (Print) [redacted] (b)(6)-2				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR				DATE REQUESTED

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

Slip upp Lap 9/22. Prolonged ileus r/o Abscess

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
10/4		

RADIOLOGIC REPORT

[redacted] (b)(6)-2

6 x 3 x 4 cm (L) paracolic abscess right to (L) colon and lateral to colostomy site/chiari cath.

2) suprapubic catheter.

3) contrast collection extends through anterior (R) pelvic wall – 2nd colostomy site / hernia / rupture.

4) (+) free air.

(b)(6)-2

[redacted] MD

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

[redacted] (b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

STANDARD FORM 519-B (6-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
Abd / Pelvis CT				ICW 1	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print)				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR [redacted]				DATE REQUESTED

(b)(6)-2

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

R/O Abscess

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)
10/16/07		

RADIOLOGIC REPORT

No evidence of abscess, free fluid/air as queried. Sig/ air in bladder

No other sig S.

[redacted] (b)(6)-2

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

#

[redacted] (b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

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

NSN 7540-00-634-4165

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

Abscess Drainage Cath

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____ *(Description of operation or procedure in layman's language)*

CT guided Abscess drainage w/ use of local anesthetic.
Risks include, bleeding, infection, organ injury, failure, drug reaction, add death.

which is to be performed by or under the direction of Dr. [redacted] (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: NKDA *(If "none", so state)*

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

[redacted] (b)(6)-2

(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

[redacted] (b)(6)-2 [redacted] (b)(6)-4 6 OCT 03

(Signature of Witness, excluding members of operating team) *(Signature of Patient)* *(Date and Time)*

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) *(Signature of Sponsor/Legal Guardian)* *(Date and Time)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; rank; rate; hospital or medical facility)*	REGISTER NO.	WARD NO.
[redacted] (b)(6)-4		

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Medical Record

STANDARD FORM 522 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)

USAPPC V2.00

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: ICW#1 | ROOM NO. | BED NO.

DATE OF ORDER: 10/4 | TIME OF ORDER: _____ HOURS | LIST TIME ORDER NOTED AND SIGN

- Admit ICW
- G/P GSW Abdomen 8/30
- Stat SG
- VS Notify
- Incentive Spirometer
- Ambulate daily
- TF + Density 30 cc/hr

PATIENT IDENTIFICATION

[redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

- Nutrition consult
- ~~Resume diet~~ (po) NPO
- CBC / Chem 8 q AM
- Zantac 50 mg IVP q 8 — Augmentin 300 mg
- Percocet 1-2 q 4-6 pm pain
- Lt c 75 cc/hr
- Neb CXR insert 20 [redacted] (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF [redacted] (b)(6)-2

- Change out Foley
- Cipro 400 mg IV q 12°
- Wet soak dressing to (c) hip (R) butt bid
- Decubitus precautions
- TLC care [redacted] (b)(6)-2 [redacted] (b)(6)-2

PATIENT IDENTIFICATION

Soon c 10 [redacted] (b)(6)-2

Soon c 10 [redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

- MSO4 3-5 mg IVP q 2-3° pm
- Vered 1 mg IVP q 2-3° pm
- Δ Nantac to Tagamet 300 mg IV [redacted] (b)(6)-2

NURSING UNIT | ROOM NO. 340 | BED NO. 30 [redacted] IV/AN 2130 (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION [redacted] (b)(6)-4 (b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. [redacted]

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

1) No feeds.
2) Pt to CT for ABCESS DRAINAGE procedure at 1250 on 6OCT03.
[redacted] MD (b)(6)-2

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

Labs: Am
CBC
PT/PTT
[redacted] MD (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 6 OCT | TIME OF ORDER 1500 HOURS

① Abcess drain to gravity
record 1600 q8°
VO DR. [redacted] (b)(6)-2 [redacted] (b)(6)-2 (b)(6)-2

JAN 6015 7OCT03 [redacted] (b)(6)-2

PATIENT IDENTIFICATION (b)(6)-2 [redacted] 1220

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 07OCT03 | TIME OF ORDER 1210 HOURS

D/C tube feeding
V.O. Dr [redacted] MD
(b)(6)-2 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24°/ 0000 8OCT03 [redacted] (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
ICW#	10	B

DATE OF ORDER 1900 — TIME OF ORDER 80CT03 HOURS

LIST TIME ORDER NOTED AND SIGN

1. DIC NGT
2. START JEVITY @ 30cc/hr per Reg
3. Clear liquid diet.

V.O. DR [redacted] (b)(6)-2 [redacted] (b)(6)-2 (b)(6)-2

240/2145 8OCT03 [redacted] (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
[redacted]		

DATE OF ORDER 10/4 TIME OF ORDER _____ HOURS

1. Reg diet

[redacted] (b)(6)-2

(b)(6)-2

11OCT@2200-1

PATIENT IDENTIFICATION

(b)(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 10/13 TIME OF ORDER 2030 HOURS

~~1. CT to SXN~~

~~V.O. DR [redacted] (b)(6)-2 [redacted]~~

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

PATIENT IDENTIFICATION

(b)(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
[redacted]		

DATE OF ORDER 10/15 TIME OF ORDER 10A HOURS

1. Clamp suprapubic tube
2. After voiding unclamp tube and record output from tube

[redacted] (b)(6)-2

[redacted] (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

[redacted] 10/17/03 (b)(6)-2

DATE OF ORDER: 10/17 TIME OF ORDER: 1115 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Change Cipro to 500mg po bid

(2) ~~Change~~ D/C Tazewell

(3) Zantac 150mg po bid

(4) D/C ZOP

(b)(6)-2 [redacted]

NURSING UNIT: 24° ✓ ROOM NO.: 900 BED NO.: 18OCT03 [redacted] (b)(6)-2 (b)(6)-2 [redacted]

PATIENT IDENTIFICATION: Noted 19Oct03 [redacted] (b)(6)-2

DATE OF ORDER: 10/19 TIME OF ORDER: 900 HOURS

(1) Please check residual from Suprapubic catheter after each void.

(b)(6)-2

NURSING UNIT: 24° ✓ ROOM NO.: 20 BED NO.: Oct 03 0034 [redacted]

PATIENT IDENTIFICATION: [redacted] (b)(6)-4 [redacted] (b)(6)-2

DATE OF ORDER: 10/22 TIME OF ORDER: 0800 HOURS

(1) Start Tube feeding Jevity 40ml/hr

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

NURSING UNIT: 24° / ROOM NO.: 020 BED NO.: 23OCT03 [redacted] (b)(6)-2 (b)(6)-2

PATIENT IDENTIFICATION: 24° ✓ 0520 [redacted] (b)(6)-4

DATE OF ORDER: 24OCT03 [redacted] HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-2 [redacted]				1 NOV 03	(b)(2)-2 HOURS	
NURSING UNIT	ROOM NO.	BED NO.		21) Transfer to [redacted] with Arrangements made/Complete		
24	0220	200V03 [redacted]		[redacted]	(b)(6)-2	

Noted 03 NOV 03

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
(b)(6)-2					HOURS	
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	4	5	6	7	8	9	10	11	12	13	14	15	16
(b)(6)-2 4	[redacted]	VS: routine	6	X	[redacted]											
			18	[redacted]												
(b)(6)-2 4	[redacted]	incentive spirometer	6	X	[redacted]											
			18	[redacted]												
(b)(6)-2 4	[redacted]	Ambulate daily	6	X	[redacted]											
			18	[redacted]												
[redacted]																
(b)(6)-2 4	[redacted]	NPO	6	X	[redacted]											
			18	[redacted]												
(b)(6)-2 4	[redacted]	CBC & Chem8 QAM	04	[redacted]												
(b)(6)-2	(PT)	PTD Dr [redacted]	X													
(b)(6)-2 4	[redacted]	NG to LIS,	02	X	X	[redacted]										
		IRRIGATE 30cc	06	X	[redacted]											
		Q4° c water	10	X	[redacted]											
			14	X	[redacted]											
			18	X	[redacted]											
			22	X	[redacted]											
(b)(6)-2 4	[redacted]	Wet → dry drsg	10	X	[redacted]											
		to (L) hip, (R) butt	22	X	[redacted]											
		BID	X													
(b)(6)-2 4	[redacted]	Decubitus prec	6	X	[redacted]											
			18	X	[redacted]											
(b)(6)-2 4	[redacted]	NIO: (R) Subclavian	10	/	/	[redacted]	/	/	[redacted]	/	/	[redacted]	/	/	/	/
		CL drsg Δ, sterile	X													
		technique Q3D.	X													
(b)(6)-2 6	[redacted]	Abcess drain log qaw	06	/	/	[redacted]										
		Ltos qs°	18	/	/	[redacted]										

(b)(6)-

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW abdomen

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

(b)(6)-4 [redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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 _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(b)(6)-2 4	[redacted]	admit ICU, stable				
(b)(6)-2 4	[redacted]	Nutrition consult	10/5			
(b)(6)-2 4	[redacted]	Change out Foley (3)	10/5			
(b)(6)-2 07 Oct 03	[redacted]	D/C tube feeding	10/7	—	1300	[redacted] (b)(6)-
(b)(6)-2 8	[redacted]	D/C NGT	done 10/02			[redacted] (b)(6)-2
(b)(6)-2 15 Oct 03	[redacted]	Clamp suprapubic tube				
(b)(6)-2 15	[redacted]	After voiding, unclamp tube/record output from tube				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION / TIME/DATE COMPLETED													
----	----															
----	----															
----	----															
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CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. ____ Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 8	9	10	11	12	13	14	15
(b)(6)-2 8	[redacted]	Clear liquid diet	6	\	[redacted]						
			18	8h							
(b)(6)-2 8	[redacted]	Jevity @ 30cc/hr	6	\	[redacted]						
		per Peg tube	18	8h	[redacted]				Hold		
(b)(6)-2 8	[redacted]	NIO: ✓ Peg tube	6	\	[redacted]						
		residuals & chart	18	8h	[redacted]		[redacted]		Hold		
		amt on I to sheet	\								
		Q8°	\								
(b)(6)-2 8	[redacted]	NIO: Δ TF & TF line Q24°	20	[redacted]			[redacted]		Hold		
(b)(6)-2 11 OCT 03	[redacted]	Regular diet	06	/	/	/	[redacted]				
			18	/	/	/	[redacted]				
(b)(6)-2 RECON of 15 OCT 03	[redacted]	VS Routine	06						[redacted]		
			18						/		
		Incentive sp ironeter	06	/	/				/		
			18						/		
		Ambulate Daily	06								
			18								
		CBC & Chem 8 QAM	04								
		PT/PTT	X								
		Wet → dry drsg	10	/	/	/	/	/	/	/	/ [redacted]
		to (L) hip & (R) buttock BID	22	/	/	/	/	/	/	/	/
		NIO (R) subclavian	10	/	/	/	/	/	/	/	☒ ☒ /
		CL drsg Δ, Sterile									
		technique Q3D									
		Decubitus precau.	06	/	/	/	/	/	/	/	/
(b)(6)-2 15 OCT 03	[redacted]		18	/	/	/	/	/	/	/	/

(b)(6)-2

RECONSIDER 13 OCT 03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW abdomen

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

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. 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

	ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17	18	19	20	21	22	23	24	25	26	27	28
(b)(6)-2	recopied 15 OCT	[redacted]	Regular diet	06	[redacted]													
				18	[redacted]													
(b)(6)-2		[redacted]	Routine Vital Sign	06	[redacted]													
				18	[redacted]													
(b)(6)-2		[redacted]	Incentive Spirometer	06	[redacted]													
				18	[redacted]													
(b)(6)-2		[redacted]	Ambulate Daily	06	[redacted]													
				18	[redacted]													
(b)(6)-2		[redacted]	C BC & Chem 8, ~~PT/PTT~~	04	[redacted]													
			PT / PTT @ Am		[redacted]													
(b)(6)-2		[redacted]	Wet → Dry drsg	10	[redacted]													
			to (L) hip & (R) buttock	22	[redacted]													
			BID															
			[redacted]															
			[redacted]															
			[redacted]															
(b)(6)-2	recopied 15 OCT	[redacted]	Decubitus precau.	06	[redacted]													
				18	[redacted]													
(b)(6)-2	19 Oct	[redacted]	Vaseline gauze dsg	10	[redacted]													
			to LUQ stoma QOD.															
(b)(6)-2	19 Oct	[redacted]	Please check residual	06 18	[redacted]													
			from suprapubic cath	18 06	[redacted]													
			after each void															
(b)(6)-2	22 OCT	[redacted]	START TUBE FEEDING -	06 18	[redacted]													
			JEVITY 40cc/hr	18 06	[redacted]													

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to ABD

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(b)(b)-2 15 oct	[redacted]	Clamp supra pubic tube	15 oct	—	1015	[redacted] (b)(b)-2
(b)(b)-2 15 oct	[redacted]	P Voiding, unclamp tube &	15 oct	—	1300	[redacted] (b)(b)-2
	-----	record output from tube	/	/	/	/

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
-----	-----															
-----	-----															
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USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (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 29	30	31	1	2								
(b)(6)-2	1709	[redacted]	Regular diet	6	[redacted]												
	CONTINUE			18	[redacted]												
(b)(6)-2		[redacted]	Routine VS	6	[redacted]												
				18	[redacted]												
(b)(6)-2		[redacted]	IS	6	[redacted]												
				18	[redacted]												
(b)(6)-2		[redacted]	AMB daily	6	[redacted]												
				18	[redacted]												
(b)(6)-2		[redacted]	WTD drsg Δ to (D) hip	6	[redacted]												
			& (R) buttock BID	18	[redacted]												
(b)(6)-2		[redacted]	Decubitus precautions	6	[redacted]												
				18	[redacted]												
(b)(6)-2		[redacted]	NIO: vaseline gauze drsg	10	/		/	[redacted]	/	/		/		/		/	
			to LUQ stoma QOD	/													
(b)(6)-2		[redacted]	TF: Jenny @ 40cc/h	6	[redacted]												
				18	[redacted]												
(b)(6)-2	✓	[redacted]	NIO: ✓ residuals QS	6	[redacted]												
			& document	18	[redacted]												

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P EX-LAP

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 _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	----	Tx to [redacted] when arrangement made				
	----	(b)(2)-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. ___ Yr. ___

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

	ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2	3	4	5	6	7	8	9	10
(b)(6)-2	2Oct03	[redacted]	IVF DS ½ NS c̄ 20 KCL	06	[redacted]								
			@ 125cc/hr	18	[redacted]								
(b)(6)-2	2Oct03	[redacted]	Zantac 50mg IV q	06	[redacted]								
			q8°	14	[redacted]								
				22	[redacted]								
(b)(6)-2	2Oct03	[redacted]	Erythromycin 500mg										
			IV q8°										
(b)(6)-2	03Oct03	[redacted]	Reglan 10mg IV Q6°	06	[redacted]		[redacted]						
				12	[redacted]		[redacted]						
				18	[redacted]								
				24	[redacted]		[redacted]						
(b)(6)-2	4Oct03	[redacted]	Erythromycin 200mg	06									
			IV q8° 30 minutes before	12									
			meals	18			[redacted]						
(b)(6)-2	2Oct03	[redacted]	Zantac 50mg IV q8°	08									
		[redacted]		16									
				24									

Time changed 4 Oct 03

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS: 1 S/P EXP/Lap adhesions Cond. Stable 1-tube placement	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO. ___

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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 2 Oct	[redacted]	NS 1000ml bolus	2 Oct	2145	2200	[redacted] (b)(6)-2
(b)(6)-2 3 Oct	[redacted]	NS 1000ml bolus	3 Oct	0945	0930	[redacted] (b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
(b)(6)-2 27 Sept	[redacted]	Reglan 10mg IV	Date	3 Oct	3 Oct											
		q 4-6° prn / Nausea Pain	Time	1600	2000											
			Dose	10mg	10mg											
			Initial	[redacted]												
(b)(6)-2 26 Sept	[redacted]	Phenergan 12.5-25mg	Date													
		IV q 6° prn nausea	Time													
			Dose													
			Initial													
(b)(6)-2 27 Sept	[redacted]	Morphine 2-8mg	Date	4 Oct												
		IV q 2° prn pain	Time	1000	1600											
			Dose													
			Initial	[redacted]												

(b)(6)-2

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. ____ Yr. ____

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4	5	6	7	8	9	10	11	12	13	14	15
(b)(6)-2 4	[redacted]	Zantac 50mg IVP q8°	6	X											
			14	X			D/C								
			22	X											
(b)(6)-2 4	[redacted]	LR @ 75cc/hr	6	X	[redacted]										
			18												
(b)(6)-2 4	[redacted]	Cipro 400mg IV q12°	10	X	[redacted]										
			22	X											
(b)(6)-2 5	[redacted]	Tagamet 300mg IVPB q6°	06	/	[redacted]										
			12												
			18	/											
			24	/											
		PRN meds *													
(b)(6)-2 4	[redacted]	Percocet 1-2 q4-6° PRN pain	D/T	0230	2020	0030	2045	1030	1545	2225	0100	0500	1100	0945	
			D/I	[redacted]											
(b)(6)-2 5cc IM	[redacted]	MSO4 3-5mg IVP q 2-3° pain	D/T	1030	1430	0230	2000	0030	0800	1900	1030	2130	1545	0800	1630
			D/I	5mg	5mg	5mg	5mg	5mg	3mg	5mg	4mg	5mg	5mg	5mg	5mg
(b)(6)-2 50cc IV	[redacted]	Versed 1mg IVP q2-3° PRN pain	D/T/I												
							D/C'd								
(b)(6)-2 5cc IM	[redacted]	MSO4 3-5 mg IVP q2-3° PRN	D/T	1200	1800	1330	0415								
			D/I	5mg	5mg	5mg	4mg								

Results after ISO [redacted] (b)(6)-2

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS: GSW abdomen

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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. Ø Yr. Ø3

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

	ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18	19	20	21	22	23	24	25	26	27	28
(b)(6)-2	recopied 15OCT03	[redacted]	LR @ 75cc/hr	06	[redacted]			DC'ed 17 Oct 03								[redacted]		
		-----		18	[redacted]													
(b)(6)-2	recopied 15OCT03	[redacted]	Cipro 400mg IV	10	[redacted]			D/C'ed 17 Oct 03								[redacted]		
		-----	Q 12° (started 4 Oct 03)	22	[redacted]													
(b)(6)-2	recopied 15Oct	[redacted]	Tagament 300mg	06	[redacted]													
		-----	IVPB Q6°	12	[redacted]			D/C'ed 17 Oct 03								[redacted]		
		-----		18	[redacted]													
		-----		24	[redacted]													
(b)(6)-2	17Oct	[redacted]	Cipro 500 mg P.O	10	/	/	[redacted]											
		-----	BID	22	/	/	[redacted]									/	[redacted]	
(b)(6)-2	17Oct	[redacted]	Zantac 150 mg	10	/	/	[redacted]											
		-----	P.O BID	22	/	/	[redacted]									/	[redacted]	

(b)(6)-

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to ABD

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

MEDCOM - 21099

DA FORM 4672 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. 10 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
(b)(6)-2 4	[redacted]	Percocet 1-2 q 4-6°	14 OCT 1330	14 OCT 1830	14 OCT 2300	15 OCT 0500	15 OCT 0900	15 OCT 2045	16 OCT 0800	16 OCT 2215	17 OCT 0600	17 OCT 1895	18 OCT 1200	18 OCT 1600	18 OCT 2000	19 OCT 0100
		PRN PAIN	[redacted]													
5 Oct		MSO4 3-5mg IVP	1600 1200													
		q 2-3° PRN	[redacted]													
(b)(6)-2 4	[redacted]	Percocet 1-2 po q4-6° PRN	D/T	19 OCT 1700	20 OCT 0800	20 OCT 1436	20 OCT 1950	21 OCT 0145	21 OCT 2000	22 OCT 0125	22 OCT 1355	23 OCT 0845	23 OCT 1430	23 2000	24 0000	24 OCT 1945
			D/1	[redacted]												
(b)(6)-2 4	[redacted]	Percocet 1-2 po q4-6° PRN	D/T	25 OCT 2230	26 OCT 2020	26 OCT 0400	26 OCT 1000	27 OCT 0745	27 OCT 1542	27 OCT 2200	28 OCT 2115	29 OCT 0230				
			D/1	[redacted]												

(b)(6)-2

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

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

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

	ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
					29	30	31	1	2									
(b)(6)-2	17OCT	[redacted] -	Cipro 500mg po BID	10	[redacted]													
		-----		22	[redacted]													
(b)(6)-2	17OCT	[redacted] -	Zantac 150mg po BID	10	[redacted]													
		-----		22	[redacted]													

(b)(6)-

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: S/P EX-LAP

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
5 OCT	[redacted]	MSO4 3.5mg IVP Q2-3°	D/T													
		PRN														
4 OCT	[redacted]	PERCOCET 1-2 PO Q4-6° PRN	D/T	29 OCT 0830 [redacted]	30 OCT 0900 [redacted]	[redacted]	30 OCT 1930	NOV 2015								

(b)(b)-2

(b)(b)-2

(b)(b)-2

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

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.)
1 2 3 4 5 6 7 8	
A	

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15	(b)(6)-4	16 17	18
[redacted]			M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	
	2 4 Y			

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46		(b)(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61
	K 7 8	

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

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
73 74	75 76 77 78 79 80	81 82 83 84 85 86 87 88
		2 0 0 3 1 1 0 2

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
89 90 91 92	93 94 95 96 97 98	99 100 101 102 103 104 105 106
		2 0 0 3 1 0 0 4

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
107 108	109 110 111 112 113 114	115 116 117 118 119 120 121 122

FOR LOCAL USE

Dx: V5843 5695

Pr: 5459 8962 4503 966 8801

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

Admission and Coding Information

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

1. Reporting MTF	2. [illegible]	
0580 [redacted]	(b)(2)-2 IZ	

3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
(b)(6)-4 [redacted]	[redacted] (b)(6)-4	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
[redacted]	24Y	X	9	UNKNOWN

10. Length of Service	ETS	11. FMP	12. Social Security Number
		99	[redacted] (b)(6)-4

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
	Z	19:00	ARMY

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
	K78-PRISONER OF WAR/INTERNEES	

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
IZ		BC	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICW1	Address of Emergency Addressee
Name and Location of Medical Treatment Facility: 0580 - 28th CSH - Iraq; No Install Provided		Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH		2003-11-02 –

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
ABA - GENERAL SURGERY		2003-10-04

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
IZ		2003-10-04 –

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW ABDOMEN

Procedure Narrative(s):

Cause of Injury Narrative:

[redacted]

Admitting O[redacted]quired)	Signature of Admitting Clerk
[redacted] (b)(6)-2	[redacted] (b)(6)-2

Automated Facsimile - DA FORM 2985, MAR 2000

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

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

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	40Y		UNKNOWN			NO

11. FMP	12. SSN	13. Organization	14. Ward
99	[redacted]	(b)(6)-4	ICW1

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	02:05	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF C-ACF	2003-10-08

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-05	[redacted] (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
0580 [redacted] - Iraq (b)(2)-2	2003-10-05	

31. Selected Administrative Data

Marital Status: Z DoB: [redacted]

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW SHOULDER

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
Ø	Ø	Ø	Ø	4	4

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
Ø	Ø	Ø	Ø	4	4

Sig[redacted]ding Medical Officer	Signature of PAD or Medical Records Officer
[redacted] (b)(6)-2	MAJ[redacted] (b)(6)-2

(b)(6)-2

MEDCOM - 21105

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

[illegible]

PHYSICAL EXAMINATION

[illegible]

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

[illegible]

(b)(6)-2

SIG[redacted]	DATE [illegible]	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 | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5Oct03@0450	pt Admitted to (CW) via W/C in stable condition; A&O x3 speaking arabic c̄ little English, ⊕CMS, NV intact throughout; brisk cap Ref, ⊕pulses x4; SS2, LS CTA(B); ⊕BS x4 abd soft ⊖TTP; pt voiding clear, yellow urine per urinal; dsg to (R) shoulder, GSW through & through CDI, 4x4 in place; PIV to (L) AC patent & s/sx infection/infiltration; Cont to monitor (b)(b)-2 [redacted]
5Oct03	0813 - assumed care of pt. @0600. Assessment completed. VSS - A+O speaking arabic. PERRLA - LS CTA(B), HR normal sinus, S1S2 present, Resp. even, unlabored, abd. soft - nontender, voiding per urinal, restraints in place c̄ ⊖ skin breakdown ⊕ circulation. TU (R) FA CDI c̄ ⊖ s/sx inf/infiltration. Pt. tol PO well. GSW to (R) shoulder. Dsng CDI. Will cont. to monitor pt. (b)(b)-2 [redacted]
1430	~~Took pt. to x-ray via wheel chair [redacted] pt. tolerated well. Dressing change to (L) LE per MD. Pt. resting well (b)(b)-7 @ this time. Will cont. to monitor pt.~~ [redacted]
(1955)	Pt A/O, VSS, LCTAB, HRRR, ⊕BS x4 abd. resp. even & unlabored. GSW to (R) shoulder c̄ dsg CDI. voiding c̄ yellow via urinal, ∅ complaint

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)(b)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
(1955)	of pain or discomfort @ time. HL to (L)
Ø5OCTØ3	ARM (AC) flushing easily ⊖ redness or
	edema noted. 2 pt restraints on ⅁ comp-
	romise to circulation/skin Ancs cont (b)(6)-2
	per orders. Will monitor [redacted]
0500	Ø clo pain all shift, drsg c̄ scant bloody
	show [redacted]
	(b)(6)-2
6OCT03	0900- VSS-AO Assumed care of pt @
	0600. Assessment completed. PERRLA,
	LS CTA (B), HR NSR, respirations even, unlabored
	abd. soft, nontender BS x4. LSW (R)
	shoulder. Drsng Δ completed c̄ min
	drainage. sutures intact. Pt. ambulated
	in hallway x 15 mins + conducted
	personal hygiene. HL IV (L) FA. CDI
	flushes well. Pt resting well @ this (b)(6)-2
	time. Will cont. to monitor pt. [redacted]
6Oct03	I concur c̄ above assessment. Will continue
1000	monitoring pt. throughout shift [redacted]
6OCT03	1725- Pt. tolerates PO well. Pt (b)(6)-2
	up in bed @ this time. Ø c/o. (b)(6)-2
	pain. Will cont. to monitor [redacted]
(1915)	Pt a/o, VSS, Ø c/o pain, LCTAB, ⊕BS, HRRR, drsg to
	(R) shoulder CDI, sutures intact. HL (L) FA
	flushing well. Abx given as ordered. 2 pt
	restraints on ⅁ compromise to skin or
	circulation. Will monitor [redacted]
	(b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
7 Oct 03 1240	Assumed care @ 0600. VSS. A&O. Speaks arabic but responds appropriately to english. HRRR. Ø resp. issues. Ø abd issues. Voiding clear yellow urine per urinal. MAE. Skin warm & dry. (R) shoulder drsg CDI. Sutures intact. Wound healing well. (L) FAHL flushed & patent. Pt denies pain. AM Care done. Will continue to monitor 2 pt restraint ∵ skin/circulation compromise. (b)(6)-2 [redacted] MAC
(2010)	Pt a10, VSS, Ø complaints of pain or discomfort. ~~Resp distress~~. Resp even & unlabored, (+) BS x4, HRRR, getting OOB often to void. drsg to (R) shoulder CDI. Sutures intact. HL (L) hand flushed. 2 pt restraints on ∵ compromise to skin/circulation. will monitor. [redacted] 91WM6
8 Oct 03 drsg CDI	Pt A&Ox3, VSS. Pt has Ø pain or discomfort at this time, right shoulder wound sealed with sutures and looks pinkish in color, healing well, HRRR Ø resp issues, HL d/c'd, restraints x2 in place, (b)(6)-2 [redacted] awaiting d/c to Iraqi Hospital
	(1330) I concur c̄ above. Pt d/c to Iraqi hospital —

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

AST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08OCT03	(cont) ambulatory - in stable condition. [redacted] (b)(b)-2

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

[redacted] (b)(6)-2

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER	TREATMENT FACILITY [redacted] (b)(2)-2
	RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

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

CITY [redacted] | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 05 OCT 03 | TIME 0200

TRANSPORTATION TO FACILITY AIR evac

SEX: M

AGE: 34

DUTY/LOCAL PHONE	
AREA CODE	NUMBER
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: Ø

ALLERGIES: nkda

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 INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW (R) shoulder

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT (b)(6)-2

TIME: 0200

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

VITAL SIGNS

TIME	0200				
BP	144/73				
PULSE	64				
RESP	12				
TEMP	97				
WT	52 kg				

LAB ORDERS

CBC/D[redacted]	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH	CHEM: 12	[redacted] (b)(6)-2
BLOOD C&S X		Lytes	[redacted] (b)(6)-2

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 100 (b)(6)-2 ☐ MONITOR (b)(6)-2 ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0210	IV NS 1000 cc	[redacted]	[redacted] (b)(6)-2	0210	
0210	Tetanus			0210	
0245	1gm Ancef (b)(6)-2		(b)(6)-2	0245	

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 ☐ DETERIORATED

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

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/CMR
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	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC			SUP O2	PH	PO2	RESULTS	
H/H			PCO2	SAT	OTHER		
PLT							
PT			U/A	DIP		EKG INTERPRETATION	
APTT	BHCG	ETOH	GLU	MICRO			

PROVIDER HISTORY/PHYSICAL

See H&P

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)(b)-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
16/4/03			Warrior Spring
			Admit c/s
			D/C 10/8
			Dx: [illegible] GSW shoulder
			Hosp course: Pt to OR & GSW shoulder
			wound cleaned in ER, closed. Pt
			tolerated well. D/c to Iraqi hosp PDX#3
			stably
			Diagnosis Iraqi hosp
			[redacted] (b)(6)-2
			[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.

[redacted] (b)(6)-4

NURSING NOTES

Medical Record

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

[redacted]

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																
POST- DAY																
MONTH-YEAR	DAY	5 04 03	5	16		7		8 at								
19	HOUR	8 9	1		6	2		1095								
PULSE (O)	TEMP. F (°)	4 9	9		8	0										
		5 3	2		8	0										
	105°	5	5		5	0										
180	104°		5		8											
170	103°															
160	102°															
150	101°															
140	100°															
130	99° 98.6°															
120	98°															
110	97°															
100	96°															
90	95°															
80																
70																
60																
50																
40																
RESPIRATION RECORD		6	6		8	8		10/96								
BLOOD PRESSURE		135/70	117/70	120/64	99/63	112/66		P 57								
					104/62	67		T 96.9								
						97		1002								
HEIGHT:	WEIGHT →					98%		98%								
O2		99%	99%	98%	98%											
O2 Source		RA	RA	RA												
						108/71										

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)

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: EMT	REQUESTING PHYSICAN: DOC [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. ~~FI~~ [redacted] (b)(6)-4	DATE 05OCT03	TIME 0200	SSN/PEEUDO SSN: ~~FI~~ [redacted] (b)(6)-4

(Hematology/CBC)

TEST	RESULT	REF. RANGE
WBC		
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymph %		
(Hemat		

ID: [redacted] (b)(6)-4 05-10-03 02:22

WB

			Patient Limits	
WBC	16.7 H	x10^3/uL	4.5	10.5
RBC	5.48	x10^6/uL	4.00	6.00
Hgb	15.6	g/dL	11.0	18.0
Hct	49.3	%	35.0	60.0
MCV	89.9	fL	80.0	99.9
MCH	28.4	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	361.	x10^3/uL	150.	450.
LY%	9.0 *L	%	20.5	51.1
LY#	1.5 *	x10^3/uL	1.2	3.4

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:

REPORTED BY:	DATE:	LAB ID NO.:

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

LAST, FIRST,MI [redacted] (b)(6)-4		DATE 05OCT03	TIME 0200		SSN/PEEUDO SSN: (b)(6)-4 [redacted]

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na								3-118 mg/dl
K								-22 mg/dl
CI								.0-10.3 mg/dl
pH								.6-1.2 mg/dl
PCO2								28-145 mmol/dl
PO2								.3-4.7 mmol/l
TCO2								98-108 mmol/l
HCO3								18-33 mmol/l
SO2								nel Plus
BEecf								EF. RANGE
AnGap								3.3-5.5 g/dl
Ca								26-84 u/l
BUN								10-47 u/l
GLU								14-97 u/l
Creat								11-38 u/l
Hct								0.2-1.6 mg/dl
Hgb								5-65 u/l
Mis								.4-8.1 g/dl
TEST	RI							olyte
Tropoin-1								EF. RANGE
Drug of Abuse								8-145 mmol/l
								-4.7 mmol/l
								-108 mmol/l
						tCO2		18-33 mmol/l

======= PICCOLO =======
10/05/03 02:25
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(6)-4.....

GLU	126*	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	298	39-380	U/L
NA+	134	128-145	MMOL/L
K+	4.7	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 1+, LIP 0 , ICT 0

olo) Metly
ESULT

======= PICCOLO =======
05/10/03 02:24
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: (b)(6)-2 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(6)-4.....

ALB	4.3	3.3-5.5	G/DL
ALP	59	26-84	U/L
ALT	22	10-47	U/L
AMY	32	14-97	U/L
AST	34	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
BUN	7	7-22	MG/DL
CA++	9.4	8.0-10.3	MG/DL
CHOL	145	100-200	MG/DL
CRE	0.9	0.6-1.2	MG/DL
GLU	127*	73-118	MG/DL
TP	7.6	6.4-8.1	G/DL

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4 [redacted]				CSF	0820 HOURS	
			①	D/C today to Iraq Hosp		
				NO meds		
(b)(6)-2 [redacted]				[redacted] (b)(6)		-2
NURSING UNIT	ROOM NO.	BED NO.		[redacted]		(b)(6)-2
	0800	0855				
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.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

(b)(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW	24	[redacted]

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
4 J	HOURS	
1	Admit IEW	
2	Stp GSW shoulder	
3	VS routine	
4	Ad lib activity	
5	Amoxy 875 mg q8 x 6 doses	
6	Reg diet	
7	Percocet 1-2 tabs q4 to pain	[redacted]

PATIENT IDENTIFICATION (b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	(b)(6)-2
	HOURS	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
	HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
	HOURS

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

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 5	6	7	8									
(b)(6)-2 5	[redacted]	VS routine	6	[redacted]												
			18	[redacted]												
b)(6)-2 5	[redacted]	ACT: ad lib	6	[redacted]												
			18	[redacted]												
b)(6)-2 5	[redacted]	Reg diet	6	[redacted]												
			18	[redacted]												

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW shoulder

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 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/03	[redacted]	D/C today to Iraqi hosp. -0 meds				
	----	(b)(6)-2				

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5	6	7												
5	[redacted]	Ancef + gm	8	[redacted]														
(b)(6)-2		IVPB Q8°	16	[redacted]														
		x 6 doses	24	[redacted]														
(b)(6)-2		PRN meds																
5	[redacted]	Percocet 1-2 tabs																
		4-6° prn																

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS: GSW 1 thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

(b)(2)-2

(b)(6)-4

Admission and Coding Information

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

1. Reporting MTF 0580 - [redacted]	2. MTF Loc IZ			
3. Register Number [redacted]	Name (Last, First, MI) [redacted] (b)(6)-4		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) [redacted]	7. Age at Admission 40Y	8. Race	9. Ethnicity	Religion UNKNOWN
10. Length of Service	ETS	11. FMP 99	12. Social Security Number [redacted] (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission 02:05	Branch / Corps:
14. Flying Status N/A	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location IZ	18. MOS	19. Trauma BC	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICW1	Name / Relationship of Emergency Addressee Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: 0580[redacted] Iraq; No Install Provided (b)(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF C-ACF	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-10-08		
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-10-05		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-10-05		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW SHOULDER

T: 1 Dx: 88000
E9912

Procedure Narrative(s): Inj: 450

Cause of Injury Narrative:

86.59

Adm[redacted] Signature, as required) [redacted] (b)(6)-2	Signature of Admitting Clerk [redacted] (b)(6)-2 [redacted], SPC, 91G6B (b)(6)-2

MEDCOM - 21122

Automated Facsimile DA FORM 2005, MAR 2000

(b)(6)-4

TREATMENT RECORD COVER SHEET

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

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

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	18Y	X	ISLAMIC			NO

11. FMP	12. SSN	13. Organization	14. Ward
~~99~~ 20	[redacted]	(b)(6)-4	ICW1

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	17:36	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-10-26

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-18	[redacted] (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
0580 [redacted] Iraq (b)(2)-2	~~2003-10-05~~	

31. Selected Administrative Data

Marital Status: Z

In/Out Patient: Inpatient

DoB: [redacted]

MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

R FEMUR FX

Dx / [illegible]

35. Total Days This Facility					
Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	17	17

35. Total Days This Facility					
Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	17	17

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

Automated Facsimile - DA FORM 3647, May 79

(b)(6)-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

18yo Iraqi male sustained GSW to (R) lat femur
injury by US soldier.
Developmentally delayed.
In traction-splint
allergies ?
Meds ?
PMH ?

PHYSICAL EXAMINATION

AAO x3
NCAT PERRLA
lungs CTA
CV RRR
ext - (R) femur fx
(R) 2+DP 0PT pulse

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

To OR for Ex Fix
admit to ortho

(6)(6) - 2

SIGNATURE OF PHYSICIAN [redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION [redacted] *(For typ[redacted]ries give Name last, first, middle; grad[redacted]pital or medical facility)*	REGISTER NO.	WARD NO.

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

18 OCT 03 Assumed care of Pt @ 1640 From EMT.
1730 Recived via Gurney. Pt has open wound
on ~~anterior~~ (b)(b)-2 [redacted] ~~R BRAST~~ ~~R thigh~~ (R) Anterior thigh.
Wound cleaned c̄ ½ NS & Hydrogen Peroxide.
Then Packed c̄ wet dressing. Pt recieving 2U
of O⊕ Blood. VSS. No S/Sx of reaction.
(b)(b)-2 Will continue to monitor. [redacted] Spc 91WM6
(1830) I concur c̄ above assessment. Pt premedicated
c̄ po Benadryl / Tylenol prior to start of blood
transfusion. Φ adv. rxn noted. VSS. See SF 511.
Report given to oncoming shift. (b)(b)-2 [redacted] 91WM6
(1830) assumed care @ 1800. Pt sleeping but arousable.
[redacted] Pt recieving 1st unit of O+ blood @ this time.
(b)(b)-4 VS recorded on SF511. Pt now awake, no S/Sx
of reaction, resp. even & unlabored, LCTAB, O2
Sats @ 98-99% RA. Tol. 10% dinner. tolerating
PO fluids well. Drsg. to (R) anterior thigh dry
& intact. small amt sero-sang drainage
noted. Drsg S/d. Monitoring [redacted] 91WM6
(b)(b)-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.

EPW
[redacted] (b)(b)-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
8OCT(2208) (b)(6)-4 [redacted]	2nd unit started. (O+ blood) BP 84/47, R: 20 P: 67 temp 98.4 (AX), O2 sats 99% RA. LOC VS: See SF 511. [redacted] (b)(6)-2 91WM.
	2310: no reaction noted, LCTAB, O2 sats 98% RA.
10CT @0030	Infusion completed s/sx of reaction. See SF 511 for VS record. CBC due in AM @0700. MM cont. to monitor [redacted] (b)(6)-2 CPR
190CT@1300	Pt. sitting up in bed, A & O but drowsy. Pt. refused both breakfast & lunch, complaint c̄ drinking water. Pt. has Ø c/o pain. V.S.S. Pt. given bed bath & oral care. W. to D DRSNG Δ'd at (R) thigh. Small amount of serosanguinous drainage to old DRSNG. Pt. transferred to BSC this AM loose BM. Pt. responds inappropriately at times. Pt. not given Colace because of loose stool. CBC drawn @ 0745. HCT=28. [redacted] (b)(6)-2 2CT, AN
19OCT@1330	All other assessments WNL. EPW restraint protocol used. Ø sign of skin breakdown. [redacted] (b)(6)-2 2CT, AN
	Assumed care @ 1800; All VSS, [redacted] (b)(6)-2 alert, able to verbalize [redacted] (b)(6)-2 needs pt TOLPO, but refuses to eat; was able to get him to eat 1 slice of bread from dinner; denies pain; dsg to (R) thigh Δd; sm amt sero-sang drng to old dsg; Ø significant Δs in assessment; Restraints in place; (+) circ (−) skin breakd; Cont to monitor. [redacted] (b)(6)-2
20OCT03	1215 - VSS - AO. Assumed care of pt @ 0100. Pt. pulled out IV. Attempted to restart new IV x3. Pt. had BM in bed. BM was dark black tarry stool. Abd. soft non-tender. Drsng B to (R)

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

(cont'd) hup. cdi c̄ min drainage. (−) s/sx infection. Pt. had one waffle for breakfast and refused the rest. Ber for med personal hygiene + pt. refused mouth care @ this time. Pt. restraint in place (b)(6)-2 [redacted] c̄ ∅ skin breakdown @ this time [redacted]

1415 – Pt. had Bm. Liquid dark black bm. Will monitor. (b)(6)-2 [redacted]

20 Oct 03 (b)(6) 2300 Assumed care @ 1800; All VSS, pt alert, verbalizes needs; pt ate 75% of dinner, Tol well; ∅ c/o pain or discomfort @ this time; dsg to (R) anterior thigh Δd, min. drainage on old dsg, ∅ s/sx infection; pt voiding s̄ difficulty per urinal; oral care provided; ∅ significant Δs; Restraints in place, ⊕ circ, ∅ skin breakdown, cont to monitor (b)(6)-2 [redacted]

21 OCT 03 (1605) Assumed care of pt @ 0700 p̄ report from night shift. Pt alert, speaking Arabic. VSS. ∅ c/o pain. Dsg to RLE Δd – wet → dry. ∅ s/sx infection @ site. Personal hygiene done by pt this am c̄ assist. from staff. Oral hygiene done. Pt OOB to chair – tol well. Tol. reg diet ≈ 50% of lunch. voiding s̄ difficulty. Awaiting Bm for stool cx. 2-point restraints in place s̄ s/sx complications. Will cont. to monitor. (b)(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21 OCT 2003	on [illegible]
2029	Reports of melena. ∅ quiet yet
	AF VSS
	Wound unS'd. HCT 28 on 10/19
	Dist NVI CX - Eentaron Feeder
	D/C Heparin
	Start Zantac
	rec HCT
	Δ Kyzol → cipro.
	OOB c̄ PT
	(b)(b)-2 [redacted] (b)(b)-2
21OCT03	VSS. Alert. Lungs clear. Abd soft non-dis
(b)(b)-2 [redacted]	tended. BS (+) x4 quad. Oral cavity clear.
0020	Peripheral pulses palpable ±2. ∅ IV access.
	20 gauge IV inserted to (R) FA and Saline locked.
	Started Cipro IV as ordered. (R) thigh dsg dry.
	Old dsg c̄ serosanguin drainage. Hct H lab
	results given to Dr [redacted]. Voided amber colored
	urine. Will continue care as planned. [redacted] (b)(b)-2
2300-0830	(0835) Assumed care of pt @ [illegible] p̄ report from night
	shift. Pt alert, speaking Arabic. VSS. ∅ c/o pain.
	Personal hygiene done by pt this am, c̄ min. assist.
	from staff. Oral hygiene done. Pt OOB to chair @
	this time. Tol. well. SL in (R) forearm flushes well
	c̄ sign infection/infiltration. Pt refused to eat

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22OCT03 (0935)	(cont) breakfast this am. Voiding ⅁ difficulty. Cont. to wait for BM for stool cx. 2-point restraints in place ⅁ S/Sx complications. Will cont. to monitor. [redacted] (b)(6)-2 W/A
	(1400) Pt back to bed. Wet→dry drsg on RLE Δd. Pt tol. well. Monitoring. [redacted] (b)(6)-2 W/A
22OCT03 1940	Pt Alert. Lungs clear. BS (+) x4 quad. Abd soft non-distended. Peripheral pulses ⅁. Pt pulled out (R) FA Saline lock. Restarted 20g 1¼ inch IV cath to (R) FA X1 attempt. (L) Arm restrained to prevent pulling out IV. Repositioned for comfort & to prevent pressure area. Will continue care as ordered. [redacted] 2C7A (b)(6)-2
23OCT03	(1355) Assumed care of pt @ report from night shift. Pt alert, speaking Arabic. VSS. ∅ c/o pain. Pt OOB to chair this am - tol. well. Drsg to RLE Δd, wet→dry. ∅ S/Sx infection. SL in ⊕ ac flushes well ⅁ S/Sx infiltration. Tol. 25% of breakfast and lunch. Good juice/H2O intake. Voiding ⅁ difficulty. 2-point restraints in place ⅁ S/Sx complications. Will continue to monitor. [redacted] (b)(6)-2 W/A
	(1740) ⊕ large black tarry BM. Sample taken to lab

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. ICW1

#[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

ST NAME | NAME | MI | IE MBER

DATE	NOTES
	(b)(b)-2
	(cont) For quiac. monitoring - [redacted]
23 OCT 03	VSS. Alert & Oriented. Lungs clear. BS (+)
1500	X4 quad. Abd soft non-distended. Voiding clear yellow urine. (R) FA Saline lock patent & intact. Ate 70% of dinner. (R) thigh wound with pink tissue noted. Old dry & serosanguous drainage. Oral care done. Dinner: small amt of bloody mucus to gums. Reported. Repositioned for comfort. Will continue care as ordered. [redacted]
	(b)(b)-2
24 OCT 03	VSS. AO. Oral care performed by technician. WTD DSG d'd
1000	performed to (R) thigh & difficult. (+) 2 pulses to BLE's. 25 C 2 AB. Tolerated ≤ 50% of AM meal. Encouraged to eat. Provided comfort to technicians. HRR. PERRLA. Lost to monitor. [redacted]
	(b)(b)-2
1300	COBTC and then to BSC for BM x1. Soft, formed, large amount of brown stool. [redacted]
	(b)(b)-2 (b)(b)-2
1600	Changed linen & placed back in bed. [redacted]
24 OCT 03 @ 2015	Pt laying in bed. c/o (-) pain. Lung sounds clear through all lobes. (b)(b)-2
	(+) Bowel sounds. (R) thigh DSG completed. (-) S/Sx of infection. W→D. packed c̄ gauze + NS. Pt ate only ice cream + bread for dinner. Refused meal. [redacted] RN/AN
24 OCT 03	MTN STAFF (b)(b)-2
	- (R) thigh wound clean c̄ no drainage.
	(b)(b)-2 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
25 OCT 03 1140	VSS. AO. DSG intact to ⓔ inner thigh. ⊕ pulses. Refused AM meal. Encouraged to eat and drink water. Pleasant ODBTC @ this time. No s/s of skin breakdown @ this time. Minimal amount of urine produced, light amber in color. [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.		WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

RECORD - PATIENT ACTIVITIES FLOWSHEET
For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 10/25/03 | PATIENT ACUITY LEVEL: 2 | POST-OP DAY: 2 | HOSPITAL DAY: 25

TRANSFER

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

Time 1530 To ICW1 From ICW2 ☐ AMBULATORY ☐ CRUTCHES ☒ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician Dr [redacted]

Procedure/Diagnosis _____ Anesthesia (Specify): _____

LOC A&O x 3 (b)(6)-2 B/P 95/44 P 78 R 18 T 98.3

Dressing/cast: REAR @ FEMORAL Neurovascular checks _____

Intake (IV, po) _____ Tubes _____

Medication _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Other _____

Report From 2T [redacted] (b)(6)-2 Received By [redacted] (b)(6)-2

TIME:	1530	2000	0400												
BP ARTERIAL LINE															
BP CUFF	95/44	95/47	96/42												
TEMPERATURE	98.3	99.2	98.7												
PULSE	78	78	79												
RESPIRATORY RATE	17	18	18												
OXYGEN (L/%)															
PULSE OXIMETER	100	99	98												
O2 METHOD	RA	RA	RA												

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

TIME:	2000	2130	0400												
PAIN INTENSITY (10 / 5 / 0)															
MED ADMINISTERED (Y/N)	X	O	X												
RELIEF ACCEPTABLE (Y/N)		NA	NA												
TIME:															
FINGER STICK GLUCOSE															
BUN (Y/N)															
HOURS	PO	IV #1	IV #2												

NA

SPECIAL NEEDS

TIME: 1530 2130

*Falls prevention protocol [redacted]

*Restraint protocol

*Seizure precautions

*Isolation precautions

(b)(6)-2

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

TOTAL IN	Urine		Stool			TOTAL OUT

IDENTIFICATION

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

DIAGNOSIS: CHRONIC ANEMIA / s/p ⊗ ASSUREFX.

DRG: _____ ADMISSION DATE: 05/15/03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

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

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 1530 INITI[redacted]	TIME: 2130 INITIALS [redacted]	TIME: INITIALS:
. NEUROLOGICAL: Alert and oriented to me place and name. Responds appropriately. ommunication is adequate to express needs. upils equal and reactive to light.	☑ (b)(b)-2	☑ (b)(b)-2	☐
. CARDIOVASCULAR: Pulse regular & rate ithin range for age. No dependent edema. ailbeds and mucous membranes pink. No call ndderness. *(See page 3 for extremity erfusion)*	☑	☑	☐
. PULMONARY: Respirations within normal te for age group; quiet and regular. Depth is gular. No cough. No abnormal breath ounds.	☑	☑	☐
. G.I.: Abdomen soft and non-distended. owel sounds active. Reports no N/V/pain ith eating and no problems chewing/ vallowing. Denies constipation, diarrhea or ectal bleeding.	☑	☑	☐
G.U.: Reports no dysuria, retention, gency, frequency, nocturia. Urine clear, ellow/amber. No unusual discharge.	☑	☑	☐
MUSCULOSKELETAL: Normal muscle evelopment and mass for age. No eformities. No assistive devices needed. ormal active ROM without pain. No joint velling/tenderness, weakness or paresthesia.	☐ small for gestational age.	☐ Developmentally delayed.	☐
SKIN: Warm, dry, intact. Good turgor. No ches, inflammation, ulcers, breaks in skin. - redness, blanching, irritation over bony ominences. Mucous membranes moist.	☐ dry.	☐ wound to (R) thigh.	☐
PAIN: No complaints of pain/ discomfort. *ee page 1 for documenting pain intensity.)*	☑	☑	☐
PSYCHOSOCIAL: Behavior is appropriate the situation. Anxiety is controlled or mild d appropriate to situation. Interacts propriately with others. (b)(b)-2	☑	☑	☐

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

TIME: 1530 INITI[redacted]	TIME: 2130 INITIAL[redacted]	TIME: INITIALS:
IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr: (b)(b)-2	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
Site #1: (R) arm / Clear	IV Site #1: (R) arm / ok	IV Site #1:
Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

NEUROVASCULAR

CAPILLARY REFILL	→					
TEMPERATURE	W					
EDEMA	0					
SENSATION	S					
MOTION	~~S~~					
PASSIVE FLEXION	D					
PERIPHERAL PULSE	2					

LEGEND

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

SAFETY

Orient to environment pr[redacted]	[redacted]		
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

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

(b)(6)

DIET

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

ADLs

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

TEACHING

TIME: INITIALS:	TIME: 2/30 INITIAL [redacted]	TIME: INITIALS:
CONTENT: 1. go notify staff if getting out of bed. 2. to get pcc food.	CONTENT: - Plan of care - (b)(6)-2	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
(b)(6)-4 C [redacted]	(b)(6)-2 [redacted]	(b)(6)-2 [redacted]	06-18 N
	(b)(6)-2 [redacted]	(b)(6)-2	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
		NSN -		
	1830	(R) FEMORAL	DRESSING - NORMAL	D&C, INTACT
			SPAN WOUND.	
	2100	(R) thigh	Red	W→D = NS

SECTION IV - NOTES

1530 - Pt alert and oriented x 3. Stable to both of fellow Iraqis. VIS stable - i cont'd in to ask for help of getting out of bed - [redacted] (b)(6)-2 (b)(6)-2 (R) leg inverted. Has gained control of (R) leg [redacted]

1800: Pt alert and responsive to others - eats Iraqi food. Takes meds PO. - most as of this time [redacted] (b)(6)-2

2130: Awake. No verbal communication. [redacted] No % pain [redacted] (b)(6)-2 signs of pain or distress. Will continue to monitor [redacted]

0520: To OR via stretcher. [redacted] (b)(6)-2

3-R (TEST) (MCHC) MAR 99

Page 4 of 4

RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 26 OCT 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 21 | HOSPITAL DAY: 26

TRANSFER

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

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

Total ER/RR/PACU time _____ Physician _____

Procedure/Diagnosis _____ Anesthesia (Specify): _____

LOC _____ B/P _____ P _____ R _____ T _____

Dressing/cast _____ Neurovascular checks _____

Intake (IV, po) _____ Tubes _____

Medication _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Other _____

Report From _____

Received By _____

TIME:	0400	0600	1200	2000	0400
BP ARTERIAL LINE	/	/	/	/	/
BP CUFF	96/42	84/40	98/60	107/52	101/62
TEMPERATURE	98.7	99.3	100.9	99.6	99.2
PULSE	79	77	98	76	79
RESPIRATORY RATE	18	16	18	18	18
OXYGEN (L/%)	/	/	/	/	/
PULSE OXIMETER	98	100%	99%	99%	98
O2 METHOD	RA	RA	RA	RA	RA

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

TIME:	0730	2045	0400
PAIN INTENSITY (10 / 5 / 0)			
MED ADMINISTERED (Y/N)	N	NA	
RELIEF ACCEPTABLE (Y/N)	NA	NA	
TIME:	NA		
FINGER STICK GLUCOSE			
INSULIN (Y/N)			

SPECIAL NEEDS

TIME:	0730	2045
[redacted]		
*Falls prevention protocol	NA	NA
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

(b)(6)-2

YESTERDAY'S WEIGHT: NA

TODAY'S WEIGHT: /

WEIGHT CHANGE: /

*Per hospital policy.

HOUR ALS	PO	IV #1	IV #2													
	NA															

TOTAL IN | Urine | Stool | TOTAL OUT

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

DIAGNOSIS: Chronic Anemia s/p Ø femur fx

DRG: _____ ADMISSION DATE: 05 OCT 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column. (b)(6)-2 (b)(6)-2

	TIME: 0730 INITIALS [redacted]	TIME: 2045 INITIALS [redacted]	TIME: INITIALS:
NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ - mentally delayed	☑	☐
CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. (See page 3 for extremity perfusion)	☑	☑	☐
PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☐
MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ - generalized weakness	☐ Generalized weakness Developmentally delayed	☐
SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ - (R) hip wound	☐ (R) hip wound	☐
PAIN: No complaints of pain/ discomfort. (See page 1 for documenting pain intensity.)	☑ Ø c/o pain	☑	☐
PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others. (b)(6)-2	☑	☑ (b)(6)-2	☐

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

TIME: 0730 INITIALS [redacted]	TIME: 2045 INITIALS [redacted]	TIME: INITIALS:
IV patency ✓ q 12 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) FA / CK	IV Site #1: NO	IV Site #1:
IV Site #2:	IV Site #2: ACCESS	IV Site #2:
Comments: HL'a IV.	Comments:	Comments:

NEUROVASCULAR							
CAPILLARY REFILL							
TEMPERATURE							
EDEMA							
SENSATION							
MOTION							
PASSIVE FLEXION							
PERIPHERAL PULSE							

N/A

LEGEND

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

SAFETY				
Bound visible/legible	[redacted]			(b)(6)-2
Orient to environment prn	[redacted]			(b)(6)-2
Side rails (2/4) up	NA	NA		
Bed position low	[redacted]			(b)(6)-2
Call light within reach	NA			

OTHER				
Review & post lab results	[redacted]			(b)(6)-2
Notify MD abnormal labs	[redacted]			(b)(6)-2
Incontinent urine/stool	NA	[redacted]		
Linen change prn	[redacted]			(b)(6)-2
Turn/reposition q2h	NA	NA		
ROM q2h if immobile				
Antiembolic hose				

DIET	BREAKFAST	LUNCH	DINNER
TYPE:	NPO	Regular	Regular
PERCENT CONSUMED:			
HOW TOLERATED:			
	☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

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

TEACHING			
TIME: 0730 INITIALS: [redacted]	TIME: 2045 INITIALS: [redacted]	TIME: INITIALS:	
CONTENT: (b)(6)-2 – comfort care	CONTENT: (b)(6)-2 – Plan of care –	CONTENT:	
☒ Patient/Family Verbalizes Understanding	☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	

PATIENT IDENTIFICATION	INITIALS	SIGNATURE (b)(6)-2	SHIFT
C [redacted] (b)(6)-4 (b)(6)-2	[redacted]	[redacted] DUT/AW	0618
(b)(6)-2	[redacted]	[redacted] DUT, AW	✓
		(b)(6)-2	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

0600 Pt to OR via litter. (b)(b)-2 [redacted] JULIAN

0700 Pt back from OR via litter. VSS. Pt c̄ D/C orders to go home today.

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

2045: Awake & alert. Denies any pain or discomfort @ this time. Oral care done. Will continue to monitor. [redacted] An

(b)(b)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 27 OCT 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 22 | HOSPITAL DAY: 27

TRANSFER

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

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

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

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

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400															
BP ARTERIAL LINE	/															
BP CUFF	101/60															
TEMPERATURE	99.2															
PULSE	79															
RESPIRATORY RATE	18															
OXYGEN (L/%)	/															
PULSE OXIMETER	98															
O_2 METHOD	RA															

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

PAIN

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

OTHER

TIME:	NA								
FINGER STICK GLUCOSE	/								
INSULIN (Y/N)	/								

SPECIAL NEEDS

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

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

(b)(6)-4

C [redacted]

DIAGNOSIS: Chronic Anemia s/p @ femur fx

DRG: _____ ADMISSION DATE: 5 Oct 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column. (b)(6)-2

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

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

TIME: 0800 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: NO IV	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: access	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

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

N/A

LEGEND

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

SAFETY

	TIME: 0800		
ID band visible/legible	[redacted]	(b)(6)-2	
Orient to environment prn	[redacted]	(b)(6)-2	
Side rails (2/4) up	NA		
Bed position low	[redacted]	(b)(6)-2	
Call light within reach	NA		

OTHER

Review & post lab results	[redacted]	(b)(6)-2	
Notify MD abnormal labs	[redacted]	(b)(6)-2	
Incontinent urine/stool	NA		
Linen change prn	[redacted]	(b)(6)-2	
Turn/reposition q2h	NA		
ROM q2h if immobile			
Antiembolic hose			

DIET

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

ADLs

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

TEACHING

TIME: 0800 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: (b)(6)-2 - ambulation - COB → chair - awaiting D/C home	CONTENT:	CONTENT:
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

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

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] 2LT/AN	0678
(b)(6)-2	[redacted] (b)(6)-2	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

1310 Pt. father @ bedside ready to bring pt home. Ø meds ordered. Pt understands instructions regarding suture removal & non weight bearing on (R) feet via interpreter. Pt. D/c'd home- [redacted] 22 TAN

(b)(6) - 2

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERA[illegible]G ROOM
VIA Litter BY ANESTHESIA

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

3. DATE 26 OCT 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0520 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: able to follow cmmnds, aware, NPO pmn ϕ allergic.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Pt placed in Sed. Arm on arm boards <90° supported. warm blankets used. ALL PPP.

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

COMMENTS:

8. SKIN PREPARATION

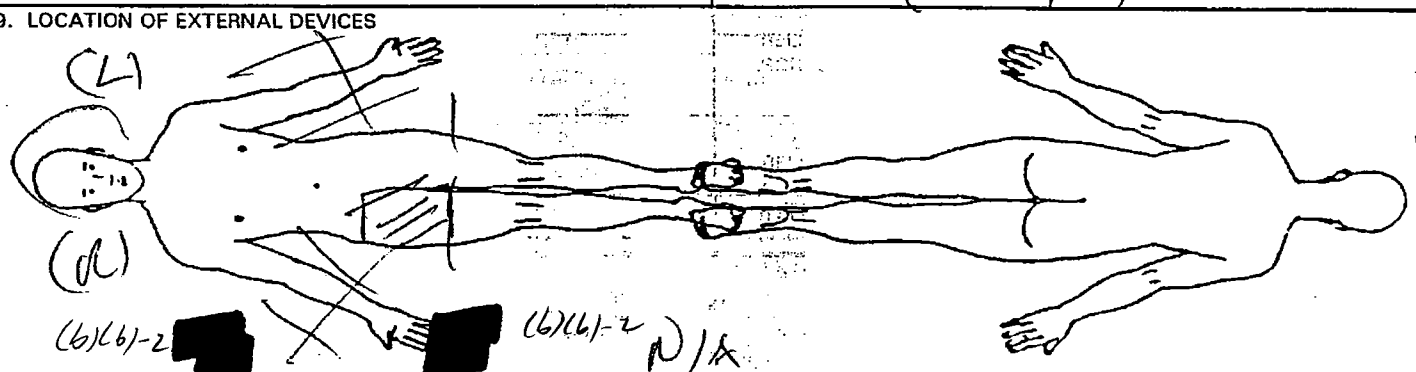
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) BETADINE Sol
SITE: (R) flank BY WHOM: [redacted] (b)(6)-2
SITE: BY WHOM: [redacted]

COMMENTS: ϕ pooling of solution noted

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 [redacted]	CIRCULATOR (b)(6)-2 [redacted]
Sponge	☑ Yes	☐ No					
Needle Sharp	☐ Yes	☐ No					
Instrument	☐ Yes	☐ No				SPC	MAJ
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: MANUFACTURER

(b)(6)-2

14. MEDICATIONS/ORDERS YES ☑ NO [redacted]

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA)

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Xylo - Epi 1:100,000	7.0cc	Until	injection	[redacted] (b)(6)-2	[redacted] (b)(6)-2

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S): Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] (b)(6)-2

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)* fluff 4x8 Kerlix TAPE

19. ADDITIONAL INFORMATION

S: [redacted] (b)(6)-2 ANESTHESIA TYPE Local & Sedation

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

20. OPERATION(S) PERFORMED

DPC (R) thigh

21. PATIENT TRANSFERRED TO 8AW TIME 0545 METHOD Lifter

22. [redacted] SIGNATURE Matt Bow (b)(6)-2

MEDCOM - 21145

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

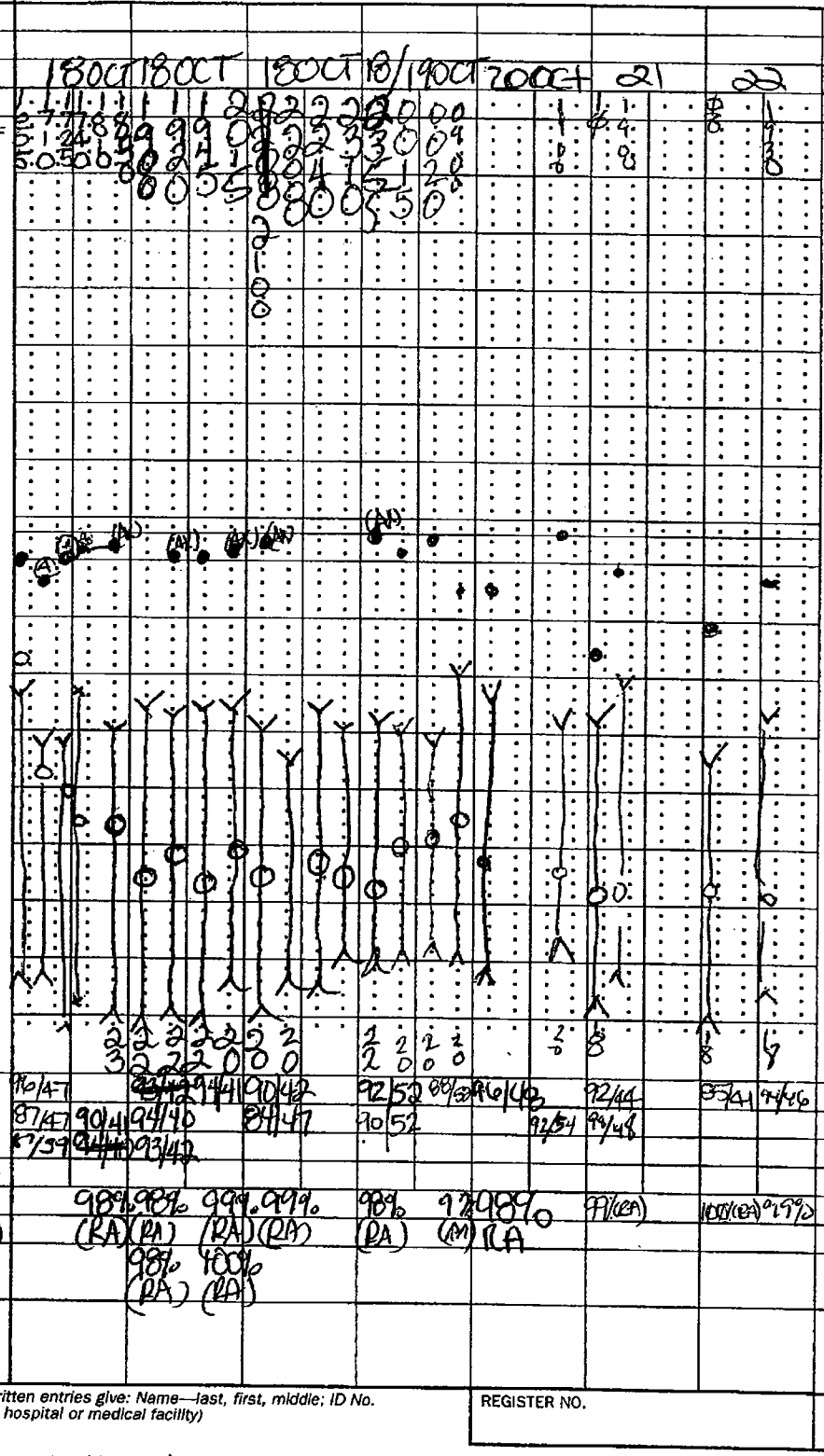
POST- DAY

MONTH-YEAR | DAY: 18OCT 18OCT 18OCT 18/19OCT 20OCT 21 22

19 | HOUR

PULSE (O) | TEMP. F (•)

TEMP. C



RESPIRATION RECORD

BLOOD PRESSURE: 96/47 94/41 90/42 92/52 88/46 96/48 92/44 94/46 87/47 90/41 94/40 84/47 90/52 92/54 94/48 87/39 94/40 93/42

HEIGHT: | WEIGHT →

O2sats: 98% 98% 99% 99% 98% 92% 98% 98% (RA) 100% (RA) 99%

(Source): (RA) (RA) (RA) (RA) (RA) (M) (RA) (RA) (RA)

98% 100% (RA) (RA)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

#[redacted] (b)(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-OPERATIVE DAY

MONTH-YEAR | DAY | 19 | HOUR

PULSE (O) | TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)

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

PULSE	TEMP. F
180	104°
170	103°
160	102°
150	101°
140	100°
130	98.6°
120	98°
110	97°
100	96°
90	95°
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.

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

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

[redacted] (b)(2)-2

Microbiology Request Form

Last Name: EPW [redacted] (b)(b)-4

First Name:

Patient # or SSN: [redacted] (b)(b)-4

Collected by: [redacted] (b)(b)-2

Date: 18 Oct 03

Time: 1430

Ward: EnT

Room:

Bed:

Physician: [redacted] (b)(b)-2

Source: R wound

Site: R thigh

[redacted]

Received by: [redacted] (b)(b)-2

Date: 18Oct03

Time: 1441

Specimen #: [redacted] (b)(b)-4

Laboratory Results

Enterococcus faecalis

Reported

Date: 21Oct03

Time: 1417

Tech: [redacted] (b)(b)-2

Reviewer: [redacted] (b)(b)-2

Number of attached sheets:

MEDCOM - 21148

Ward/Section: Emt | REQUES[redacted] (b)(6)-2

LAST, FIRST, MI: EPW [redacted] (b)(6)-4

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

DATE: 180ct03 | TIME: 1435 | SSN/PS[redacted]N: (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	[redacted]	
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymph%		

[redacted] (b)(6)-4

10-10-03
14:40

			Patient Limits	
WBC	2.3 L	x10^3/uL	4.5	10.5
RBC	2.61 L	x10^6/uL	4.00	6.00
Hgb	5.7 L	g/dL	11.0	18.0
Hct	18.6 L	%	35.0	60.0
MCV	71.0 L	fL	80.0	99.9
MCH	21.9 L	pg	27.0	31.0
MCHC	30.8 L	g/dL	33.0	37.0
Plt	447. *	x10^3/uL	150.	450.
LYZ	33.3 *	%	20.5	51.1
LYW	0.8 *L	x10^3/uL	1.2	3.4

(Hemat

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

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Small	Negative
Ket	Neg	Negative
SG	1.015	N/A
Bld	Neg	Negative
pH	8.5	N/A
Prot	Trace	Negative
Urob	8	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Tcto- Neg

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

Ward/Section: Emt	REQUEST [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW [redacted] (b)(6)-4	DATE 180ct03 / TIME 1435	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	[redacted]	
RBC	(b)(6)-4	
Hgb		
Hct		
MCV		
Plt		
Lymph %		

18-10-03 14:40 Patient Limits

WBC	2.3 L	x10^3/uL		4.5	10.5
RBC	2.61 L	x10^6/uL		4.00	6.00
Hgb	5.7 L	g/dL		11.0	18.0
Hct	18.6 L	%		35.0	60.0
MCV	71.0 L	fL		80.0	99.9
MCH	21.9 L	pg		27.0	31.0
MCHC	30.8 L	g/dL		33.0	37.0
Plt	447. *	x10^3/uL		150.	450.
LY%	33.3 *	%		20.5	51.1
LYM	0.8 *L	x10^3/uL		1.2	3.4

(Hemat

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	small	Negative
Ket	Neg	Negative
SG	1.015	N/A
Bld	Neg	Negative
pH	8.5	N/A
Prot	Trace	Negative
Urob	8	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Epi- Neg

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 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section: ICW1	[redacted] CIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW# [redacted]	DATE 19OCT TIME 0700	SSN/PSEUDO [redacted] (b)(6)-4

(Hematology) CBC

(b)(6)-4

TEST	RESULT	REF. RANGE
WBC	[redacted]	
RBC		
Hgb		
Hct	28.0	
MCV		
Plt		
Lymph %		
(Hema		

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis (b)(6)-4

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

[redacted] (b)(6)-4

[redacted]logy Report (b)(2)-2

Name:	Specimen: [redacted] (b)(6)-4	Status: Final
Patient ID: [redacted] (b)(6)-4	Source: Wound/Sterile site	Collected:
Ward/Rm: /	Ward of Iso:	Attd. Phys:

1 Enterococcus faecalis Status: Final

1 E. faecalis

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	<=4/2				
Amp/Sulbactam (c)	<=8/4				
Ampicillin	2	S			
Cefazolin	16				
Cefepime	16				
Cefotaxime (c)	32				
Ceftriaxone (c)	>32				
Cephalothin	16				
Chloramphenicol	<=8	S			
Ciprofloxacin	<=1	S			
Clindamycin	>2				
Erythromycin	<=0.5	S			
Gatifloxacin	<=2				
Gent. Synergy	<=500	S			
Gentamicin	8				
Imipenem (c)	<=4				
Levofloxacin	<=2	S			
Linezolid	<=2	S			
Moxifloxacin	<=2				
Nitrofurantoin	<=32				
Norfloxacin	<=4				
Ofloxacin	4				
Oxacillin	>2				
Penicillin	2	S			
Pip/Tazo (d)	<=4				
Rifampin	<=1	S			
Strep. Synergy	<=1000	S			
Synercid	>2	R			
Tetracycline	<=4	S			
Trimeth/Sulfa	<=2/38				
Vancomycin	<=2	S			

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:	Specimen: [redacted] (b)(6)-4	Status: Final (b)(6)-2
Patient ID: [redacted] (b)(6)-4	Source: Wound/Sterile site	Collected:
Ward/Rm: /	Ward of Iso:	Req. Phys: [redacted]

(b)(6)-2

Ward/Section: ICW 1	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 2104	TIME: 2115	SSN/PSEUDO SSN:

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC	[redacted]	
RBC	(b)(6)-4	
Hgb		
Hct		
MCV		
Plt		
Lymph %		
(Hem		

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Microscopic 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 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(2)-2 [redacted]

Microbiology Request Form

F.08

Last Name: [redacted] (b)(6)-4
First Name:
Patient # or SSN: [redacted] (b)(6)-4
Collected by: [redacted] (b)(6)-2
Date: 23 Oct 03
Time: 1740

Ward: ICW
Room: 2
Bed: 2E
Physician:
Source: Stool
Site:

[redacted]

Received by: SPC [redacted] (b)(6)-2
Date: 23 OCT 03
Time: 1740

Specimen #:

Laboratory Results

Fecal Occult Blood Negative

Reported
Date: 23 OCT 03
Time: 1830
Tech: [redacted] (b)(6)-2
Reviewer:

Number of attached sheets:

MEDCOM - 21154

NKDA

MEDICAL RECORD — ANESTHESIA

DRUG	Units	
Versed	(mg)	2
Propofol	(g)	10-10
	(g)	
	( )	
	( )	
	( )	
% del		
% e.t.		
AIR	L/Min	
N2O	L/Min	
O2	L/Min	RA →

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "1"=CONSTANT INFUSION

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

TOTALS	
2	
20	

TOTALS TO: MIN

TOTAL URINE: Ø

FLUIDS – SUMMARY
CRYSTALLOID 150
COLLOID – Ø
BLOOD – Ø

FLUIDS		
LINE site	20G (R) AC	☐ Warmed
		☐ Warmed
		☐ Warmed
		☐ Warmed
		IR #1

LOSSES	
EST BLOOD LOSS	
URINE –	

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 50 (KG) LB

HEMATOCRIT: —

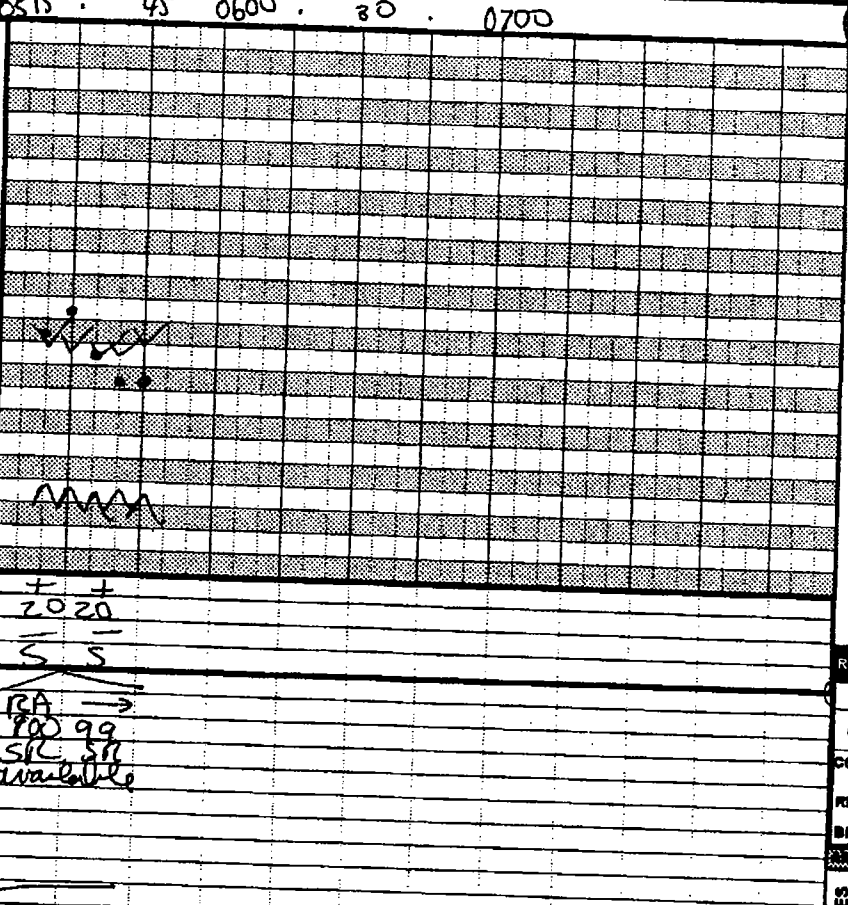
INITIAL DATA: BP – 101/39; HR – 101

BODY CHECK: OK? – (Y) N

PATIENT ID CHECK: OK for PROCEDURE [redacted] (b)(6)-2; TIME – 0536

TIME → 0515 . 45 0600 . 30 . 0700

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



VT – ml	+ +
f – breaths/min	20 20
Peak inf pres / PEEP	— —
MODE – S(pon), A(ssist), C(on)	S S
ET CO2 (torr)	
FIO2 (Frac or %)	RA →
SpO2 (%)	100 99
ECG	SR SR
TEMP- site	available
N-M Block (T/4)	
Warming blkt	blankets
Conv warmer	

BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES; Gas analyzer

REMARKS – Code drugs with numbers, events with letters

(1) Room, monitor Sedation TTE
(2) Lidocaine 1% c 1:200K epi 7ml injected into wound
(3) To PACU Report to [redacted]

RECOVERY AT 0580
PACU ICU (Specify) OTHER T 96.7
CONDITION: Stable; awake
RESP – 20 SpO2 – 100
BP – 90/48 HR – 102

	Start	Room	End
ANES	0515	0525	0555
PROC	Ready	Begin	End
	0530	0535	0545

Mark with letters & symbols, explain under REMARKS

EVENTS (1) (2) (3)
Position → 0 →

PROCEDURES and CPT Codes: DPC (R) thigh wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: MAC c sedation + local

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

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

[redacted] (b)(6)-1

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

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

PROCEDURE LOCATION 2(2)

DATE 26 Oct 03

PAGE 1 OF 1

WAMC OP 376 REVISED

518-124

NSN 7540-00-634-415.

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS: 1 u

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 18 Oct 03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

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

DIAGNOSIS OR OPERATIVE PROCEDURE: Anemia

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. (b)(6)-2

SIGNATURE OF VERIFIER [redacted]

DATE 18 Oct 03

TIME VERIFIED 1540

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)-4

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

TRANSFUSION NO.

PATIENT NO.

DONOR ABO O Rh POS

RECIPIENT ABO O Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Compatible

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

(b)(6)-2

S [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 18 Oct 03

REMARKS: EXP 23 OCT 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

[redacted] (b)(6)-2

AT *(Hour)* 1641 ON *(Date)* 18 Oct 03

IDENTIFICATION

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

[redacted] (b)(6)-2

[redacted] (b)(6)-2 Spec 91WMB

TEMP. 98° PULSE 103 BP 96/47

DATE OF TRANSFUSION 18 Oct 03 TIME STARTED 1655

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED 2015/18 Oct 03

REACTION [x] NONE [ ] SUSPECTED

TEMPERATURE 98.5 PULSE 65 BLOOD PRESSURE 90/42

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)* none

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

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

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2 [redacted] 91WMB

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

SEX Male WARD EMT

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

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 21156

Medical Record Copy

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 10-18-03 TIME OF ORDER _____ HOURS | LIST TIME ORDER NOTED AND SIGN

- Resident ICW - Dr. Chugale
- Stable
- Routine vitals
- Bed rest - OOB to chair c̄ assist
- Not to dangle legs
- BID dressing (R) thigh
- IVF D5NS @ 125 cc/hr

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

Noted

(b)(6)-4 [redacted] 1800 OB

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

- Regular Diet
- Oral hygiene BID
- Keflex 500 mg QID
- Tylenol 650 mg po q4h prn pain
- Tramfuse 2mg PRN
  Benadryl 25 mg Benadryl 1
  + 650 mg Tylenol

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 10-18-03 TIME OF ORDER 1600 HOURS [redacted] (b)(6)-2

Ofesay 325 mg po TID

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

10/18/03
2248

- Heparin 5000 u SQ BID (10+22)
- FFNWB c̄ PT only, otherwise bedrest
- OOB to chair BID q4h [redacted] (b)(6)-2
- Colace 1 po bid [redacted] MD.
- rev HCT tomorrow [redacted] (b)(6)-2
- percocet 1-2 po q4h prn
- heparin IV [redacted] (b)(6)-2

(10+22)

- Q shift Vital Sign [redacted] (b)(6)-2
- [illegible] DS (R) Thigh [redacted] (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

(b)(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW1	24	20

DATE OF ORDER: 20 OCT 03 — TIME OF ORDER: 1600 HOURS

(1) Guiac next stool.
V.O. Dr [redacted] / [redacted] (b)(6)-2 (b)(6)-2

(b)(6)-2

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW1		[redacted]

DATE OF ORDER: 21 OCT 2003 — TIME OF ORDER: ✓ HOURS

2027 - D/C Heparin
- Zantac 50 mg IV q 8° — 08, 16, 24
- D/C Keyzal
- Cipro 400 mg IV BID ✓
- H/H please ✓ [redacted] (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2

DATE OF ORDER: OOB to chair BID at least — TIME OF ORDER: HOURS
Skin breakdown precaution [redacted] (b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

(b)(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW1	24	23

DATE OF ORDER: 22 OCT 03 — TIME OF ORDER: HOURS
Clarification order
D/C Keflex
V.O Dr [redacted] / [redacted] 2027
(b)(6)-2 (b)(6)-2

22 Oct 03 0030 [redacted] 2027
(b)(6)-2

MEDCOM - 21158

DA FORM 1 APR 70 4256 REPLACES EDITION OF 1 JUL 77 WHICH MAY BE USED

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

CW [redacted]

(b)(6)-4

(b)(6)-2 [redacted]

Noted 25OCT03 1910 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
10-25-03	HOURS	
NPO ~~φ~~ MN		
[redacted]		(b)(6)-2
		(b)(6)-2
24° ✓ 26 OCT 03 0710 [redacted]		

PATIENT IDENTIFICATION

CW [redacted]

(b)(6)-4

(b)(6)-2 [redacted]

Noted 26OCT 0200 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		

DATE OF ORDER	TIME OF ORDER	
10-26-03	0530 HOURS	
✓ - Resume pre op orders (regular) then		
✓ - D/C pt today to home		
✓ - Remove sutures at civilian hospital in 10 days.		
✓ - Non weight bearing on Right leg x 8 weeks.		

PATIENT IDENTIFICATION

(b)(6)-2 [redacted]

Noted 26OCT 1030 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
26 OCT 03 (b)(6)-2	1600 HOURS	[redacted] (b)(6)-2
V.O. from Dr. [redacted] to LT [redacted]:		(b)(6)-2
① D/C all meds		(b)(6)-2
② D/C IV	[redacted]	
24° ✓ 27 OCT 03 0455		[redacted]
		(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
	HOURS

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

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

25 OCT 03 | 1000

V.O. Dr. [redacted] (b)(6)-2 | (b)(6)-2

(1) Zantac 150mg PO BID

(2) D/C 50mg Zantac IVPB

(3) Include Ensure TID [redacted] RN

[redacted] (b)(6)-2 | 1000 | 25 OCT 02

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

[redacted] (b)(6)-4

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. 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

	ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18	19	20	21	22	23	24	25	26	27	28
(b)(6)-2	18 Oct 03	[redacted]	Routine vitals	06	[redacted]										
			(Q Shift)	18											
(b)(6)-2	18	[redacted]	BR - OOB to chair c	06											
			assist BID (at least)	18											
(b)(6)-2	18	[redacted]	Wet → dry dressing	10											
			BID @ thigh c NS	22											
(b)(6)-2	18	[redacted]	Regular diet	06											
				18											
(b)(6)-2	18	[redacted]	Oral hygiene BID	10	/										
				22											
(b)(6)-2	18 OCT	[redacted]	FFNWB c PT only	6	/										
			otherwise bedrest	18											
(b)(6)-2	21 Oct	[redacted]	OOB to chair	06			/								
			BID @ Least	18			/								
(b)(6)-2	21 Oct	[redacted]	Skin Breakdown	06			/								
			precautions	18			/								
(b)(6)-2	25 Oct	[redacted]	Ensure c Meals TID	6	/							/			
				12	/										
				18	/										

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: CHRONIC ANEMIA

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(b)(6)-2 18 OCT03	[redacted]	Readmit ICW#1 – Dr [redacted]	18 OCT03	—	—	[redacted]
(b)(6)-2 18	[redacted]	stable (b)(6)-2	18	—	—	[redacted]
(b)(6)-2 18	[redacted]	Transfuse 2 units PRBC	18 OCT03	① ASAP	1655	[redacted]
	-----		18	@ —	2200	[redacted]
(b)(6)-2 18OCT	[redacted]	✓ HCT in AM	19OCT	0700	0745	[redacted]
(b)(6)-2 20OCT	[redacted]	Guiac next stool	20OCT	—	20OCT03 1740	[redacted]
(b)(6)-2 21OCT	[redacted]	Ht / Lt plesse	21OCT	/	2175	[redacted]
(b)(6)-2 25OCT	[redacted]	NPO ∓ MN	26OCT	2000	done	[redacted]
(b)(6)-2 26OCT	[redacted]	DC pt today to home	26OCT	today		
(b)(6)-2 26OCT	[redacted]	Remove sutures @ civilian hospital	26OCT			
	-----	in 10 days				
(b)(6)-2 26OCT	[redacted]	Non wt bearing on (R) leg x 8 wks	26OCT			

(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. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19	20	21	22	23	24	25	26
(b)(6)-2 18 OCT 03	- [redacted]	IVF D5½NS @ 125cc/	08 18	[redacted]								
	-----	hr → Heplocked	18 06	[redacted]				D/C'd				
(b)(6)-2 18	- [redacted]	Keflex 500mg QID	06	/ [redacted]								
	-----		12	/ [redacted]				D/C'd 21 OCT 03				
	-----		18	[redacted]								
(b)(6)-2	----- [redacted]		24	[redacted]								
(b)(6)-2 18	- [redacted]	FeSO4 325mg PO TID	06	/ [redacted]								D/C'd
	-----		14	/ [redacted]								
	-----		22	[redacted]								
(b)(6)-2 18 OCT	- [redacted]	Heplock IV	6	/ [redacted]				D/C'd				
(b)(6)-2	-----		18	[redacted]								
(b)(6)-2 18 OCT	- [redacted]	Colace + PO BID	10	/ [redacted]								D/C'd
	-----		22	/ [redacted]								
(b)(6)-2 18 OCT	- [redacted]	Heparin 5000 u	10	/ [redacted]				D/C'd 21 OCT 03				
	-----	SQ BID	22	/ [redacted]								
(b)(6)-2 21 OCT	[redacted] -	Zantac 50mg	08	—	—	/	[redacted]					
	-----	IVPB Q8°	16	—	—	/	[redacted]					D/C'd
(b)(6)-2	[redacted] ----		24	—	—	/	[redacted]					
(b)(6)-2 21 OCT	- [redacted]	CIPRO ~~B~~ 400mg	10	—	—	/	[redacted]					D/C'd
	-----	IVPB BID	22	—	—	/	[redacted]					
(b)(6)-2	[redacted] -											
(b)(6)-2 25 OCT	- [redacted]	Zantac 150mg PO	10	/ —	—	—	—	—	[redacted]			Recycled
	-----	BID	22	/ —	—	—	—	—	[redacted]			
(b)(6)-2 25 OCT	[redacted] -	Zantac 150mg PO	10	—	—	—	—	—	—	[redacted]		D/C'd
	-----	BID	22	—	—	—	—	—	—	[redacted]		

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: CHRONIC ANEMIA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

MEDCOM - 21163

DA FORM 4670 EDITION OF 1 DEC 77 WILL BE USED UNTIL

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 10 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
18 OCT03	[redacted]	Premedicate c 25mg Benadryl/650mg Tylenol	18 OCT03	—	1650	[redacted] (b)(6)-2
26Oct	[redacted]	D/c all meds, D/c IV	26Oct	NMW	Done	[redacted] (b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
18OCT03	[redacted]	Tylenol 650mg po q4° prn pain	D/T	26Oct 1428												
			D/I	650mg po												
18OCT	[redacted]	percocet 1-2 tabs PO Q4° PRN	D/T	[redacted]												
			D/I													

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

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: **TRAUMA FLOWSHEET**
The proponent is Dept of Surgery

OTSG APPROVED (Date): QI Appr 11 Jun 97

EMS REPORT

TIME: 1350 ETA: _____ UNIT: _____
MED COM: [Y] [N] GSW to (R) femur

ARRIVAL STATUS

TIME 1354 ☐ IV x _____ ☐ O_2 _____ l/min ☐ C-Spine Immob
Meds: ☑ UKN ☐ None ☐ Yes: _____
Allergies: ☑ UKN ☐ None ☐ Yes: _____
Tetanus: ☑ UKN ☐ Current Last Meal/Fluid Intake _____ hrs
LMP: _____ ☑ 1550 GSW to (R) femur on 6 D 5th

PRIMARY SURVEY

AIRWAY
☐ Natural Patient [Y] [N]
☐ ETT ____ ☐ _____
☐ Secretions _____

BRETHING
☐ Labored ☐ Unlabored ☐ Absent
TRACHEA: ☐ Midline ☐ Deviated [L] [R]
CHEST SYMMETRY: [L] > = < [R]

CIRCULATION
PULSE: ☐ Present ☐ Absent
BLEEDING: [Y] [N]
HEART TONES: ☐ Clear ☐ Muffled
SKIN: ☐ Warm ☐ Cool ☐ Hot
☐ Pink ☐ Pale ☐ Cyanotic ☐ _____
☐ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY
GCS: E 4
V 5
M 6
SPHINCTER TONE: ☑ WNL ☐ None

HEAD
PUPILS: ☑ Equal ☐ Fixed ☑ React ☐ Dilated [L] [R]
TM: ☐ Clear ☐ Blood [L] [R]

NECK
C-Spine Tenderness: [Y] [N]
Pain @ _____
JVD: [Y] [N]

HEART
RHYTHM: ☑ Regular ☐ _____
PULSES: ☐ Central ☐ Peripheral

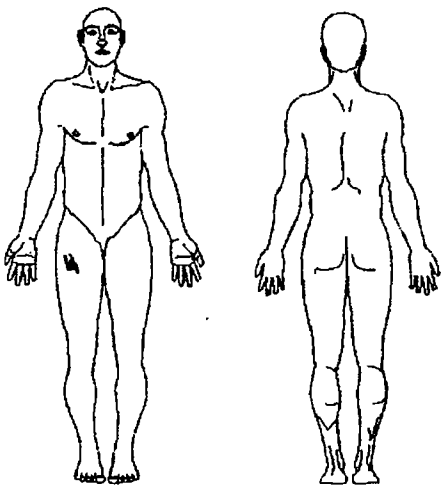
LUNGS
BREATH SOUNDS: ☑ Bilat ☑ Equal ☑ Clear
Decreased [L] [R] Absent [L] [R]
Wheezes [L] [R] Crackles [L] [R]

ABDOMEN
☑ Soft ☐ Rigid ☑ Non-Tender
☐ Tender: _____

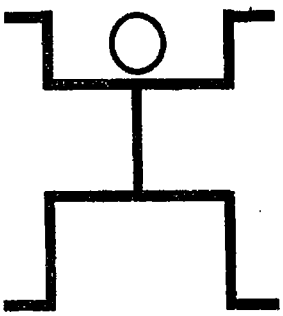
PELVIS
☑ Stable ☐ Unstable ☐ _____
Blood at meatus/vagina: [Y] [N]
Heme +/ - Prostate: ☐ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration
(P)uncture (W)ound
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound
b/s



VASCULAR ASSESSMENT



+ Strong	+ Palpable	D Doppler

RN [redacted] (b)(6)-2
PREPA[redacted] (b)(6)-2
PHYSICIAN
(Continue on reverse)
DEPARTMENT/SERVICE/CLINIC
DATE

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

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

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

VITAL SIGNS

~~Rectal~~ Temp: 97.1 99 [illegible]

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
1350	89/45	88	SR	14	100						
1400	90/38	84	SR	14	100						
1415	83/44	86	SR	14	100						
1430	83/44	86									
1450	87/35	86									
1520	87/34	84									

GCS:

GLASGOW COMA SCALE

EYE OPENING	VREBLE RESPONSE	MOTOR RESPONSE
(4) Spontaneous	(5) Oriented	(6) Obeys Commands
3 - To Voice	4 - Confused	5 - Localizes Pain
2 - To Pain	3 - Inapp Words	4 - Withdraws to Pain
1 - None	2 - Incomp Speech	3 - Flexion to Pain
	1 - None	2 - Extension to Pain
		1 - None

TIME	PROCEDURE	PERFORMED BY:
	☐ Backboard Removed	BY:
	☐ Downgraded	BY:

NOTES

1350 [illegible] presented in ED unknown complaints [illegible] GCW to (R) femur. Bloods drawn via venipuncture, pt bloods as per transfer [illegible] pt hypotensive pt due to urinary 700cc [illegible] urine, blood cultures drawn [redacted] (b)(6)-2 pt pulse ox 100% on [redacted] (b)(6)-2

1430 labs pending [redacted] (b)(6)-2

1530 Dr [redacted] covering pt along c [illegible] (b)(6)-2

1600 Patient [illegible] to Nurse [redacted] ICU (b)(6)-2

[redacted] (b)(6)-2

S: Pt is a 20 yo Iraqi EPW s/p GSW to (R) thigh c̄ ORIF who was sent to EPW camp today instead of EPW hospital. EPW camp immediately sent him to the 28th CSH (b)(2)-2

Pmhx ?
Psx
(R) Femur ORIF
Meds
Keflex
NKDA

O: WDWN Thin Iraqi ♂ NAD Nontoxic ⊖ resp distress
HEENT: WNL.
Lungs: (B) eq CTA.
Cor: RRR ⊖
Abd: [illegible] S. NT no ORG.
Ext: (R) femur c̄ lat healed surgical incision.
1x1½" ant pocket c̄ purulent D/c & old Dsg ⊖ red streaks. Nl [illegible]

A: Post op ORIF (R) Femur: ① Anemic ② Leukopenic ③ Hypotensive
R/o Sepsis

P: IVF Bolus. Labs + Cx.
Admit to ORTHO. (b)(6)-2

2.3) 5/18 (440

130 / 3.5 | 23 (140

AG 16

UA:

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
	ET Intubation		☐ Oral ☐ Nasal Teeth		☐ $ETCO_2$ Change ☐ BBS Post Int ☐ Post CXR
	Gastric Tube		☐ Oral ☐ Nasal		☐ Air ☐ Contents ☐ Verified_____ Suction: Y N
	Urinary		☐ Meatus ☐ Supra-Public		☐ Return_____cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed		☐ Grossly: + - Cell count Sent@_____
	Chest Tube #1		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:		Comments	

ABG SITE	TIME	$\%O_2$	pH	BE	pCO_2	PO_2	O_2 Sat	HCO_3
1)								
2)								

LABS

TIME	LABS
	☐ D-stick_____ ☐ SHct_____
	☐ D-stick_____ ☐ SHct_____
	☐ CBC ☐ Chem ☐ PT/PTT ☐ ETOH ☐ T&S ☐ T&C x_____
	☐ Tox Screen
	☐ UA ☐ HCG
	☐ OTHER
	☐ OTHER

X-RAYS

TIME	LABS
	☐ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
	☐ Pelvis
	☐
	☐
	☐

TIME	PROCEDURE	ACCOMPANED BY	RETURN
	CT Scan: ☐ Contrast		
	☐ Head ☐ Abd ☐ Pelvis		
	☐ C-Spine ☐ T/L Spine ☐ Chest		
	☐		
	A-Gram Site:		

IV ACCESS & FLUIDS

TIME	#	GA	IAW SOP		SITE	IVF TYPE	AMT UP	AMT IN
1415	1	18	Y	N	L AC	NS	1000cc	
1430	2	18	Y	N	L AC	NS	1000cc	
			Y	N				
			Y	N				

MEDICATIONS

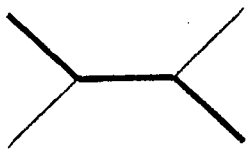
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE

BLOOD PRODUCTS

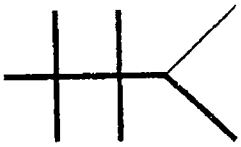
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INIT

LAB RESULTS

CBC:



Chem:



INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other	Urine	Other	700cc Dark
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys	[redacted]			
Surgeon	(b)(6)-2			
Anesth				
X-Ray				
RT				
Ortho				
Neuro				
Chaplain				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOD See DA Form 3696	
	Other: See Nursing Notes	

DISPOSITION

☐ Home ☐ _____

Admitted to_____

Report Called to_____

Time Transferred_____

Accompanied By_____

Via: ☐ Stretcher ☐ Wheelchair

utions: ☐ Yes ☐ No

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: 26 Oct 03
Time In: 0552
Allergies: NKDA
Pre-op V/S: 101/59 / 101
Procedures: wound closure

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

OR Intake: Crystalloid 150 Colloid
OR Output: UOP 0 EBL min
Meds/Times: L Cefsev

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

Pre Op Meds History

Time	0552	0600	0607	0627	0637	0647
SaO2	100	100	100	100	100	
FiO2						
Methods	RA	RA	RA	NC	RA	
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	19	14	12	16	18	
T	96.7				98.1	
Time						
Pain (0-10)						
LOS						

FOK

Pacu Intake

(b)(6)-2

Time	Solution	Amount	Site	By	Infused
0552	4000 NS	900	R AC	[redacted]	

X-rays: Labs:

Post-Anesthesia Recovery score

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

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

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

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

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

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

(Continue on reverse)

[redacted] (b)(6)-2 91WM6

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 26 OCT 03

[redacted] typed or written entries give: Name – last, [redacted] grade; date; hospital or medical facility)

[redacted] (b)(6)-4

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

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

USAPPC V2.00

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'	(R) thigh	+	+	P	~~>3~~ <3	W	Pk
30'	(R) thigh	+	+	P	~~>3~~ <3	W	Pk
45'							
60'							
90'							
D/C							

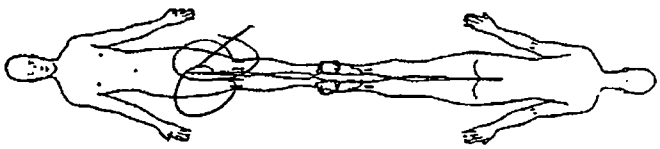
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	R thigh	222	Ø
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0552	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Pt Received from OR. SP "warm" Closure to R thigh. PARS 9 (b)(6)-2
SpO2 100% on RA — SP[redacted]
Face Report to SGT [redacted] — SPC [redacted]
(b)(6)-2 (b)(6)-2

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

Automated Facsimile

(b)(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

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

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	21Y	X	ISLAMIC			NO

11. FMP	12. SSN	13. Organization	14. Ward
~~99~~ 20	(b)(6)-4 [redacted]	(b)(6)-4	ICU1

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	08:42	AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF C-ACF	2003-10-19

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-06	[redacted] (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
0580 [redacted] Iraq (b)(2)-2	~~2003-10-06~~	

31. Selected Administrative Data

Marital Status: DoB: [redacted]

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

LLE FEMUR FX segmental

Dx 73381
9053
V5415
E9290

Inj Trauma
299 9

Pr: 7935
9904 (2)
8877
9338

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	14	14

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	14	14

Signature of Attending Medical Officer [redacted] (b)(6)-2 [redacted] or Medical Records Officer MAJ [redacted] (b)(6)-2

(b)(6)-2

(b)(6)-2

Automated Facsimile - DA FORM 3647, May 79

PERSONAL DATA REPORT

GENERAL INFORMATION

Dossier: [redacted] (b)(6)-4

Name (F,M,L): [redacted]

Full Name: (b)(6)-4

WMD Category:

Operational Status:

Occupation:

National ID #: [redacted] (b)(6)-4

Gender: MALE

Race:

Hair Color:

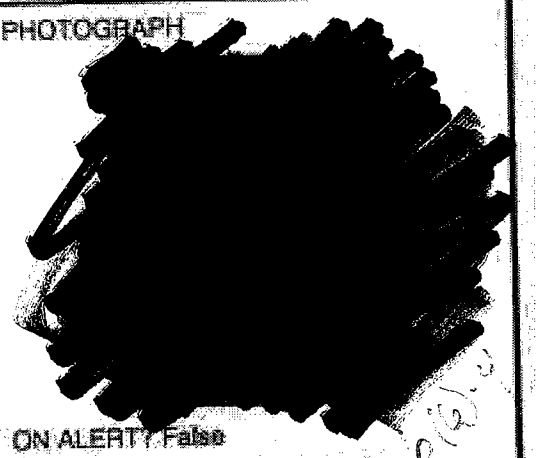
Eye Color:

Build:

Height (in): Min: Max:

Weight (lb): Min: Max:

PHOTOGRAPH



ON ALERT? False

T/A W/COALITION VEHICLE /ILL ENTERING IRAQ

PERSONAL DATA

Birthdate: 01JAN82

Birthplace: , ,

Death Date:

Religion:

Nationality:

Primary Citizenship:

2nd Citizenship:

Ethnicity:

Marital Status: Unknown

Personnel Status: Unknown

EXTENDED EPW INFORMATION

EPW Status: DETAINED

Camp Name: BCF

Compound: HARDSITE

Blood Type:

Accused Crime: T/A W/COALITION VEHICLE /ILL ENTERING IRAQ

Dietary Notes:

DNA Sample?

Physical Exam?

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

21 y/o ~~AD~~ Iraqi ♂, passenger in car, involved in MVC while driving 9 days ago. Taken to EPW CAMP

PMHx: ∅
PSHx: ∅
MEDS ∅
Allergies NKDA

PHYSICAL EXAMINATION

XR: comminuted supracondylar femur fx
Knower proximal femur

HEAD: NC/AT
Chest: CTA
CVR: S1 S2
ABD: soft
EXT: (E) bx, marked edema (L) labral thigh hip → knee
2 swelling, skin intact, 2+DP/PT, 5/5 EHL/FHL
Sensory intact

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

(A) (L) Proximal femur fx, Distal femur fx

(P) ORIF

(b)(b)-2

[redacted]	DATE 10/6/03	IDENTIFICATION NO.	ORGANIZATION
PATIENT IDENTIFICATION *(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*		REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

[redacted] (b)(b)-4

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

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PROGRESS NOTES

DICAL RECORD	NOTES
ATE	
2 Oct 03 50	Nursing: Pt admitted from ER @ 1215 for (L) Femur Fx. VS: T-99.2, HR-95, BP-135/76, R-22, Sats 99% on RA. (L) leg swollen, strong pedal pulses palpated, feet cool to [redacted] touch, cap refill <3 secs, (+) movement, (+) sensation. Assisted Dr. [redacted] (b)(b)-2 [redacted] (b)(b)-2 c pin insertion and traction [redacted] (b)(b)-2 Pt given 50 mg Fentanyl IV and [redacted] Versed 2 mg IVP during procedure. Pt placed on 10lb traction [redacted] weights hanging freely. IV in (R) AC infiltrated. 18 G IV started in (R) Hand. Receiving D5 1/2 NS @ 100 cc/hr. HOB ↑ 45° [redacted] (b)(b)-2 [redacted] /An continue to monitor.
06 OCT 03 1800	Received report from previous shift. Pt awake in bed c̄ Ø % pain/discomfort @ this time. Pt (L) LE in traction c̄ 10lb weight suspended from guard. DPSG C,D,I. Pt ate dinner ≈ 50%. Ø needs expressed. [redacted] (b)(b)-2 [redacted] /CT/An Will cont. care.
2100	Pt resting c̄ eyes closed. Ø % pain @ this time [redacted] (b)(b)-2 [redacted] /CT/An Will cont. care.
07 OCT 03 0600	Pt c̄ % HA. Gave Percocet ii tabs. Will cont to assess [redacted] (b)(b)-2 [redacted] /CT/An pain level.

SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
RELATIONSHIP TO SPONSOR	LAST	FIRST	MI
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	WARD NO.
		REGISTER NO.	

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/19
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V

[redacted] (b)(b)-4

(b)(6)-4

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CHRONOLOGICAL RECORD OF MEDICAL CARE

DICAL RECORD

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

DATE

7 OCT 03

Time:

P: 90

BP: 126/72

T: –

R: 12-24

SpO2: 98%

Meds: ~~Tylenol~~ Ibuprofen

ALL: NKDA

PMHX: MVA 1/14/03

FMHX:

LMC:

TOB:

Detainee [redacted] Adult ♂ Detainee c̄ Hx of MVA prior to detention. Initially presented c̄ lower leg splint and c/o (L) leg pain p̄ seeing Iraqi physician. Now c/o r (L) leg pain, deformity and swelling.

Exam: Moderate pain (L) leg.
obvious deformity to (L) distal femur
Mod amount swelling & ecchymosis
VSS afebrile
(+) (L) knee effusion
Normal CMS distal
(+) pedal & post tib pulses
Normal ROM @ Ankle

A: (1) Initial assessment showed ∅ swelling ecchymosis or deformity above the knee.
(2) Now Appears device applied by Iraqi physician and lack of x-ray have caused distal femur fx to become malaligned (OVER-S

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

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

Name: (b)(6)-4 Rank:
SSN: #[redacted] Sex:
DOB: Out time:
Unit: (b)(2)-2

[redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

(Con't)

(b)(2)-2

Plan: ① Transfer to [redacted] for Orthopedic consult and definitive treatment as soon as transport can be arranged.

② Splint applied in mean time. Splint material substandard but providing relief.

③ Continued checks to ensure no deterioration prior to transport.

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

5 OCT 03 Patients splint slipped out of place last evening. Continue to provide relief to leg. Maintains fair to good immobilization. ? How long.

A: Continued ++ CMS distal no deterioration of condition

P: Routine transfer 6 OCT 7 OCT at the latest.

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

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PROGRESS NOTES

CAL RECORD

NOTES

TE

-03

Discharge Summary

This is a 21 y/o Iraqi male who sustained closed (2) proximal femur fracture and distal supracondylar femur fracture in a car accident ten days prior to admission here (1/6/03). Subsequently he had ORIF of both his fractures of his L/L femur. He has done well post operatively. He should remain non weightbearing on his left leg for 6 weeks. At 4w - 12 weeks he can be toe touch weightbearing with gradual resumption of full weightbearing after 12 weeks. Range of motion exercises should be emphasized at knee and hip. Remain on lovenox 30 mg SQ BID until pt more independent on crutches and then change to aspirin 325 mg QD.

(b)(6)-2 [redacted]

SPONSOR'S NAME | MI | SPONSOR'S ID NUMBER (SSN or Other)

RELATIONSHIP TO SPONSOR | LAST | FIRST | RECORDS MAINTAINED AT

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | REGISTER NO. | WARD NO.

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

[redacted] (b)(6)-4

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC			SUP O2	PH	PO2	RESULTS	
H/H			PCO2	SAT	OTHER	X-ray → (L) femur transverse. distal - femur comm.	
PLT						EKG INTERPRETATION	
PT			UA	DIP			
APTT	BHCG	ETOH / GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

pt arrived from EPW camp c c/o (L) leg injury. Arrived c splint & ACE externally rotated, ⊕ pedal pulses (B). ptunable to bear weight per interpreter. pt state MVC x 3 days ago. Lungs CTA, denies other c/o. [redacted] (b)(6)-2

~~Car Crash~~ Car Crash in Humvee

allergies: 0 PMH: 0 PSH: 0 Smoke: 1 ppd

MEDS: 0

abd HEAD: anicteric ⊕ hum - rel

lungs - clear A&P Heart - RR

Ext - pulses - soft B.S. - nml

Stretch marks abdomen

(L) leg - obvious deformity, external rotation, thigh - echymotic swollen 2-3" open laceration ⊕ free.

DP pulse - 2+, lower all toes: sensory - full

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP [redacted] M.D. (b)(6)-2

DIAGNOSIS Transverse fx (L) femur - subtrochanteric

(R) Distal femur - comminuted fx

CODES

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

H [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

SKIN AND WOUND ASSESSMENT

PROGRESS NOTES

MEDICAL RECORD

Admission Date: 6 Oct 03 Diagnosis: (1) Femur FX HD: 1 POD: Ø

Skin assessment must be done initially and every 7 days.

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	4	Mobility	No limitations	4
	Slightly limited	3		Slightly limited	3
	Very limited	2		Very limited	2
	Completed	1		Completely immobile	1
Moisture	Rarely moist	4	Nutrition	Excellent	4
	Occasionally moist	3		Adequate (Eats >50%)	3
	Moist	2		Adequate (Rarely eats)	2
	Constantly moist	1		Very poor	1
Activity	Walks frequently	4	Friction and Shear	No apparent problem	3
	Walks occasionally	3		Potential problems	2
	Chairfast	2		Problems	1
	Bedfast	1			

Total Score: 15

Add the total score
Above 20 Low Risk
Between 16 and 20 Medium Risk
Between 11 and 15 High Risk
Below 10 Very High Risk

Note: A Braden Scale Score of less than 15 indicates **HIGH RISK**-requires immediate Ulcer Prevention program.

Surgical wound (s): Yes ✓ No__ Location: (L) Knee Size:_____ Drainage: _____
Tubes:_____ Pins: Traction Pin Appearance: c/d/I
Dressing change: None Ordered

Burn wound (s): Yes__ No__ % BSA_____ Partial_____ Full_____
Location:_____ Size_____
Appearance:_____
Dressing change:_____

Pressure Ulcer (s): Yes___ No ✓
Stage I, II, III, IV (Circle the one that applies and describe below)
Location:_____ Size:_____ Tunneling_____
Wound character: Pink____ Moist____ Dry____ Granulation tissue_____ Yellow slough _____ Exudates _____
Undermining_____ Odor_____ Purulent discharge_____ Eschar_____ Alginate_____
Type of dressing change: Wet-to-dry_____ Comfeel dressing_____ Carrasyn-V Gel_____

Physician notified/consulted for wound debridement: Yes___ No____ Date/time MD notified _____
CNS notified/consulted for Stage II and greater: Yes____ No_____
Nutrition Referral: Yes_____ No_____
Physical Therapy Referral: Yes_____ No_____ Date & Time_____
Action taken:_____

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

REGISTER NO.	WARD NO.

Patient's Identification (For typed or written entries: [illegible] hospital or medical facility)

PROGRESS NOTES

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
07 OCT 03 0100	Pt resting c̄ eyes closed. VSS. Ø needs expressed. Will cont. care. (b)(6)-2 [redacted]
0600	Gave report to next shift. (b)(6)-2 [redacted]
0600	Received Pt in Icu, Bed #2. Pt Alert follows commands. No distress noted. See Intensive care flow sheet for more information. (b)(6)-2 [redacted]
0800	Pt c/o Pain to Ⓛ leg. Percocet II Tabs PO given. [redacted] (b)(6)-2 RN-1 LT
1200	VSS Pt c/o Pain to left leg. Percocet II Tabs PO given. (b)(6)-2 [redacted] 1LT.
1600	Pt c/o left leg pain. Percocet II Tabs PO given. [redacted] 1LT. Pt ambulated. Traction maintained to left leg. [redacted] (b)(6)-2 1LT
1600	VS: Alert, lengthened, pulses ⊕ IV D5 ½ NS 100cc continuous. Report given to relief nurse — [redacted] (b)(6)-2 RN-1LT
7 OCT 03	Unit Info Staff - No new Dx, ↓ edema ⊕ thigh, N/V, intact, no skin breakdown, pain well controlled. - Transfer ICU in AM. Delayed OR. (b)(6)-2
0800	See ICU flow sheet. [redacted] SPC, 9 WMC
08 Oct 2400	Pt resting comfortably in bed VSS. Neurovascular checks to ⊕ LCE ⊕ pulses. Pain controlled c̄ MSO4 & Percocet. Will continue to monitor. [redacted] SPC, 9 WMC (b)(6)-2
0600	Pt resting comfortably in bed. VSS. Vascular neuro checks ⊕ pulses to LCE. Reported off to on coming shift. [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

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PROGRESS NOTES

DICAL RECORD	NOTES
ATE	
0403	Received report from off going shift. Pt.
26	resting in bed c eyes closed. C/o ~~pain~~ pain (b)(6)-2
	to (L) leg. Percocet Tab II p.o. given for
	complaint. Left leg remain in traction +
	elevated. Will continue to monitor. —
	(b)(6)-2 [redacted]
812	AM care completed @ this time. c/o complaints
	of pain voiced. Will continue to monitor. [redacted]
	(b)(6)-2
0942	c/o pain. Percocet Tab II given for pain. Will
	continue to monitor. (b)(6)-2 [redacted]
1311	Pt resting in bed c eyes opened. Remain
	in traction to (L) leg. c/o pain @ present
	time. Percocet Tab II p.o. given for complaint. [redacted]
	Will continue to monitor. (b)(6)-2
8 oct 03	Assumed care of pt. transfer from ICU #1
1430 -	VSS Dx @ segmental femur fx. Lungs CTA HRRR
	Voids per urinal @ BS. Active BS x 4 quads. Medicated
	prior to transfer c/o pain or discomfort @ this
	time - Traction weight to LLE will cont to monitor —
	(b)(6)-2 [redacted]

SPONSOR'S NAME			MI	SPONSOR'S SERVICE NUMBER (SSN or Other)
RELATIONSHIP TO SPONSOR	LAST	FIRST	RECORDS MAINTAINED AT	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	REGISTER NO.	WARD NO.	

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

CPW, [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/19
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V1

LAST NAME

FIRST NAME

DATE	NOTES	MIDDLE INITIAL	ID NUMBER
08OCT03	(1705) I concur c̄ above assessment. (b)(6)-2 [redacted]		
08OCT03 @2015	Assumed care of pt @ 1800. VSS. C̄o pain tr LLE, medicated c̄ Demerol c̄ good relief noted. Alert, speaking some English, LS CTA, ⊕BS, void per urinal s̄ difficulty. LLE in 10# traction, LLE supported to maintain straight alignment. ⊕CMS to LLE, ⊕2 palpable DP/popliteal pulses. New IV started in (R) FA 20G, HL'd per Dr [redacted] (b)(6)-2 Plan: monitor NV status, monitor pain control, ⊖pt restraint on s̄ s/sx of skin/circulation compromise. (b)(6)-2		
9Oct03 1455	VSS. Assumed care @ 0600. Ai⊕ able to make needs known. Cardiovascular & Pulmonary function intact. ⊕BS. Ctl voiding clear yellow urine. Traction to LLE intact s̄ difficulty. (L) Thigh c̄ bruising all over. HL (R) FA patent. Medicated @ 1100 c̄ demerol 50mg IV for c/o pain [redacted] (b)(6)-2 Will continue to monitor		
9Oct03 1770	Medicated c̄ 50mg demerol IV for c/o pain [redacted] (b)(6)-2		
403610200	Assumed care @ 1800; All VSS, pt A&O; [redacted] (b)(6)-2 10lb traction to (L) LE in place s̄ difficulty, dsg CDI s̄ drainage; ⊕BS, ⊕B Micu bedpan; HL to (R) FA patent easily ⊕ blood; pt voiding ⊖S, clear yellow urine s̄ difficulty; ⊕CMS to (L) LE, ⊕ pulses, bowel sx cap ⊕, ⊖ c/o pain @ this time; Restraints in place, ⊕ circ, ⊖ skin breakdown, cont to monitor (b)(6)-2 [redacted]		
T03 24	Pt A&O LS CTA(B), S, S2 present ⊕ BS [redacted] (b)(6)-2 Leg in traction. Am care completed [redacted]		

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USAPA V1.00

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PROGRESS NOTES

MEDICAL RECORD	NOTES
DATE	
17-00	OpNote PreOpDX: Segmental (2) Femur Fx. Proximal subtroch, Distal supracondylar Fx PostOpDX: same Procedure: open (2) Lag, (2) Distal femur (b)(6)-2 & Fixed angle blade plates Surgeon: [redacted] / [redacted] (b)(6)-2 Anesthesia: GETA Fluids: 3200 LR NS 7800 1000 Aprotinin 2u PRBC EBL 1800 Urine 500cc Findings: Comminuted segmental fracture of femur Fx, transverse subtroch Complications: [redacted] (b)(6)-2
10-11-03 1100	PT c/o pain during Dry. 2+DP/PT, 3/5 EHL/FHL. Sat 97% RA. BP 134/65 HR 140 T 102. CBC pending. Drain = ~75cc. 1 mg Q4 g p. Pain control. (b)(6)-2 [redacted]

SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
RELATIONSHIP TO SPONSOR	LAST	FIRST	MI
RECORDS MAINTAINED AT			
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	REGISTER NO.	WARD NO.

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

PROGRESS NOTES
Medical Record

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PROGRESS NOTES

EDICAL RECORD	NOTES
DATE	
CTO3	pt Resting Quietly In bed VSS Assessment Complete IV in (L) wrist/hand
0630	infusing well @ 125cc/hr A-Line in (R) wrist, to monitor (L)LE elevated
	per doctors order pt complained of pain; Pain meds given per
	doctors orders No problems @ present will continue to monitor —
	(b)(6)-2 [redacted] PFC gwmc
	[redacted] (b)(6)-2
	Percocet Tab II p.o. given for c/o pain.
900	pt temp ↑ to 102.9 will recheck temp in 30 minute No other problems
2905	(b)(6)-2 [redacted] PFC gwmc
	present @ this time VSS will continue to monitor —
	(b)(6)-2
1155	temp ↓ c̄ percocet No problems @ present Pt c/o pain, pain med Frequency
	↑ VSS No S/s of acute distress noted will continue to monitor [redacted] LLT/AN
	(b)(6)-2
1800	Received report. [redacted] LLT/AN
	(b)(6)-2
1900	Assessment completed. [redacted] LLT/AN
	(b)(6)-2
2345	Pain managed c̄ MSO4 and Percocets.
12Oct03 0600	Patient slept intermittently throughout night. Pain
	managed c̄ MSO4 / Percocets. LE warm, pulses 2+,
	good sensation, able to move toes. No other [redacted] LLT/AN
	(b)(6)-2
	complaints throughout night. Report given
12Octo3 @0800	pt VSS Assessment complete see Flowsheet for details (+) movement
	sensation to (L)LE pulse (+)(+) No c/o @ Present No pain meds given @
	present pt. laying in bed c̄ eyes closed No problem @ present
	(b)(6)-2 [redacted] PFC gwmc
	will continue to monitor

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	REGISTER NO.	RECORDS MAINTAINED AT	WARD NO.

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1989)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.0

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12 OCT 03 2240	Pt c/o pain RLE. Gave 5mg MSO4 IVP. Will cont to assess pain level. (b)(b)-2 [redacted]
0200	pt VSS, afebrile (b)(b)-2 [redacted] ICT/SPC
13 OCT 03 @ 0920	pt report recieved VSS Assessment complete [redacted] pt c/o @ present will continue to monitor [redacted] BECA (b)(b)-2
13 Oct 03 @ 0555	pt given Fleet enema and Mag Citrate per doctors ordery Foley D/c'd VS stable. will continue to monitor [redacted] BECA (b)(b)-2
13 OCT 03 1400	ONCOMING STAFF. Pt resting comfortably Afebrile PMI Normal Sat 97% R.A. Urine out 10cc/hour Incision (2) dry clean & dry, staples soft 2+DP/PT, Cref WT Drain pulled, Dressing D/C'd. XR → Transfer ICW (b)(b)-2 [redacted]
13 oct 03 @ 1525	pt VSS dressing Δ completed 3 problems will transfer to ICW ⊕ X-ray of (L) Femur Hip to knee will continue to monitor (b)(b)-2 [redacted] PFC Simm
@ 1758	pt report given VSS pt waiting for X-Ray [redacted] PFC Simm
@ 1820	Report recieved from PFC [redacted]. PT VSS (b)(b)-2 [redacted]
@ 2200	pt transfered to ICW / (b)(b)-2 (b)(b)-2 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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PROGRESS NOTES

CAL RECORD

DATE	NOTES
03 30	- Pt transferred from ICU, placed in bed c̄ ∂pt restraints on. LLE wrapped in ace wrap disg CDI, ⊕CMS to LLE, +2 DP & popliteal pulses. LS CTA, ⊕BS x4 quads (⊕BM) today per report from ICU), void per urinal c̄ difficulty. MS04 given for pain relief during transfer. Percocet given for pain also @ this time. Plan: monitor NV status, pain control, OOBTR tomorrow, ABX as ordered. ∂pt restraints m̄s̄ S/Sx of skin/circulation compromise WILL cont. to monitor. [redacted] CMR (b)(6)-2
Oct 03 1100	V SS. Alert & oriented. OOB → chair for breakfast. Tolerated well. Lungs clear. BBT) x4 quad. Abd. soft - non distended. (L) Hand IV Saline locked intact & patent. @ LE disg dry & intact. Peripheral pulses palpable +2. (L) foot capillary refill < 3sec. Will continue care as planned. (b)(6)-2 [redacted] CMR
14 Oct 03 @2145	Assumed care of pt @1800. VSS. C/O pain to LE, percocets given c̄ good relief noted. LLE disg CDI, ⊕CMS, +2DP & popliteal pulses. Tolerating liquid po, refused dinner meal. Pt encouraged to lend (L) (CONT) [redacted] CMR

SPONSOR'S NAME

RELATIONSHIP TO SPONSOR | LAST | FIRST (b)(6)-2 | MI [redacted]

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | REGISTER NO. | RECORDS MAINTAINED AT | WARD NO.

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

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2145 (CONT)	↑ knee to ↑ ROM. Plan: pain control enc po intake, monitor NV status. (b)(6)-2 [redacted] CPT addendum: 1 pt restraint on 3 S/ox skin/circulation compromise. (b)(6)-2 [redacted] CPT
2245 -	Pt c/o chills, ~~du~~ sweating. T=101.6. Tylenol 650mg po given, IS encouraged (demonstrated properly to staff good technique) and po fluids encouraged. Will monitor. [redacted] CPT
0100 -	Pt ↓ 99.3. Will cont to enc IS & po intake. Linen Δ'd (b)(6)-2 D/t sweats. (b)(6)-2 [redacted] CPT
0400.	Pt temp ↑ 99.9. Percocet given. Will monitor [redacted] CPT
15Oct03 @ 0743	Pt laying in bed. Lung sounds clear through all lung fields. ⊕ pedal pulses B/L. Ⓡ leg restrained. ⊖ S/S of skin breakdown to Ⓡ restrained leg. ⊕ Bowel sounds. Abdomen soft & non-~~dis~~ distended. Pt refused breakfast. (b)(6)-2 [redacted]
0800	Pt c/o pain. Med'd w/ 1 percocet. D'ed drsg to Ⓛ leg. Sutures CDI, ~~Sith~~ Sutures well approximated. Sterile saline & betadine used to clean sutures. ~~Bacitracin~~ applied to abrasions on leg. Wrapped in ace bandage. (b)(6)-2 [redacted]
5Oct03@1915	VSS, A+O, c/o pain to Ⓛ LE, administered 2 percocets PO as ordered, Ⓛ LE c̄ Dsg & ACE CDI, neurovascularly intact, 2+ pulse Ⓛ pedal, Ⓡ edema (2+), Ⓛ LE ↑, IV to Ⓡ AC Hl'd, continuing IV antiby. x2 restraints c̄ skin breakdown. Ⓣ 101.4 but will reevaluate (gave Percocet as written earlier). Tolerates PO, voids adequate UOP, ∅ S/S of any distress, ∅ other remarkable findings. Continue to monitor for any acute Δ's. (b)(6)-2 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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PROGRESS NOTES

ICAL RECORD

DATE	NOTES
T03	Assumed care of Pt @ 0000. Pt Awake + A&O. Drsg
30	To LLE Drsg CDI. LLE +3 pitting edema noted. Anti-biotics infusing into 18G cath in R FA. Pain controlled c percocet. Will continue to monitor — [redacted] Spc. 9/W/MC (b)(6)-2
03@1930	Assumed care @ 1800; All WSS, temps slightly ↑, IS used, cold pack given; cont to monitor; pt A&O x3, pain controlled c percs; staples to (L) LE OTA, (-) drainage, well approximated, (-) s/sx infection; +2 pitting edema noted; HL to (R) FA patent cont c IV abx; pt OOBTC x1 for 2 hours; Rest cuffs in place (-) circ, (-) skin breakdown, cont to monitor. (b)(6)-2 [redacted]
OCT03	PT NOTE —
1000HRS	HX: GAIT TRAINING C CRUTCHES NWB (L) LE
	T/M: PTT ASSISTED BY TRANSLATOR. PNT DEMONSTRATED UNDERSTANDING OF BASIC COMMANDS/INSTRUCTION. PNT DENIED DIZZINESS OR NAUSEA OR EXCESSIVE PAIN. (b)(6)-2
	(+) EDEMA; (+) ECHYMOSIS (L) LE (KNEE, THIGH, ANKLE, TOES) PNT DEMONSTRATE [redacted] NORMAL (R) UE & (R) LE GRMT. PNT DEMONSTRATE MODERATE BALANCE (GAIT BELT APPLIED) & COOR.
	DX: AMBUL C CRUTCHES BID. SO (R) ANKLE PUMPS BID FOR EDEMA CONTROL.
	I: SAME. PNT AMBULATE ~10'.
	G: AMBUL PNT ~200' & ↓ (-) EDEMA @ ANKLE BY 75% X 2wks. (b)(6)-2 Spc [redacted] 9/W/ONG PT TECH

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	REGISTER NO.	RECORDS MAINTAINED AT	WARD NO.
				ICU/HH

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1995)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.0

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17OCT03@ 1330	Assessment done. V.S.S. although temp slightly elevated (99.6°F) (L) leg elevated. Pt. ambulated c̄ P.T. tech using crutches. 2+ pitting edema to (L) LE, DRSNG's to (L) LE Δ'd, small amount of reddish-brown [redacted] (b)(b)-2 drainage. Pt. has low urine output. Pt. encouraged to drink water. Pt. has refused to eat breakfast & lunch. Pt. encouraged to eat & drink via translator multiple times. [redacted] (b)(b)-2 2CT, AN
17OCT03@ 1530	Pt. sitting up in bed drinking water occasionally. Pt. diaphoretic c/o pain frequently. Pt given 2mg MSO4 IV for breakthrough pain as per MAR's. Pt. compliant c̄ using I.S. [redacted] (b)(b)-2 2CT, AN
17OCT03@1650	Pt. resting quietly in bed, semi-Fowlers. EPW restraint protocol used ∅ signs of skin breakdown. [redacted] (b)(b)-2 2CT, AN
(2000)	Rt sitting ↑ in bed, temp 99, c/o pain often, ⅡⅡ Percocet given @ 1900. (R) leg drsg dry & intact. non-compliant c̄ ambulating to chair - due to pain. H2O encouraged, Rt consumed 50% dinner. Rt able to move toes, +2 pitting edema (R) leg elevated on blanket. 2 pt restraints compromise to skin/circulation Will monitor. [redacted] (b)(b)-2 91WM6.
18OCT03 1100	Assumed care of Pt @ 0600 hr. A&O. LS CTA (B). S_1S_2 Present (+) BS x4 quads. Pt void qs c̄ difficulty. Pt LLE Incision on out aspect of thigh closed c̄ staples open to air. LLE c̄ +3 pitting edema. Pt [redacted] (b)(b)-2 Ambulated to Bathroom. LLE elevated c̄ Blanket. Antibiotics Running through 18g R AC. Will continue to monitor. [redacted] (b)(b)-2 Spec 91WM6

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

MEDICAL RECORD

DATE	NOTES
OCT03	VSS. AO. Med c/o pain to LLE and provided N_2O_4
0235	for pain. Tolerated PO well. ⊕ 2 pulse to LLE & CR
	± 2 records - ISCHAB. DSG's CDI to LLE. Voiding
	light yellow urine, BS ± diffusely. Ambulating without
	± minimal painless abnormal. Encouraged to eat PO
	and did well for dinner. [redacted]
	(b)(6)-2

SPONSOR'S NAME: LAST | FIRST | MI

SPONSOR'S ID NUMBER (SSN or Other)

RELATIONSHIP TO SPONSOR

RECORDS MAINTAINED AT

HOSPITAL OR MEDICAL FACILITY

WARD NO.

DEPART./SERVICE

REGISTER NO.

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/19
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.2030(b)
USAPA V

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

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

CAL RECORD

NOTES

TE

PT

18-03 Performed (L) hip/knee ROM.
Pt c/o pain throughout exercise.
Performed (L) PEAFs x50
(L) knee 0-15-90
Ambulated 50' c̄ cane c/o
dizziness.
Will cont Rehab. Pt NS [redacted] D/C
1-2 days. [redacted]

(b)(6)-2

10-18-03 Increase ther ex.
0-90° @ Rest c̄ assist
UCs today.

(b)(6)-2

[redacted]

18OCT03 Pt Δ¶0 LS CTA (B) S1 S2 present (D) BS x4 quads.
1720 NSS. (D) LE Lateral thigh incision c̄ staples OTA
Pt c/o pain controlled c̄ MSO4 p Percocet [redacted] Voiding
spontaneously. Will continue to monitor. [redacted] 911 ml
(1750) I CACUN

(b)(6)-2

(b)(6)-2

SPONSOR'S NAME			MI	SPONSOR'S ID NUMBER (SSN or Other)
RELATIONSHIP TO SPONSOR	LAST	FIRST	RECORDS MAINTAINED AT	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	REGISTER NO.	WARD NO. ICW#1	

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.

[redacted] (b)(6)-4

NSN 7540-01-075-3780

(b)(2)-2

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER | TREATM[redacted]

RECORDS MAINTAINED AT

ARRIVAL: DATE (Day, Month, Year) 04/10/03 | TIME 0850

TRANSPORTATION TO FACILITY: FLA

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: #[redacted] (b)(6)-4 | STATE | ZIP CODE

CITY

DUTY/LOCAL PHONE: AREA CODE | NUMBER

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		

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 INITIAL SERIES ☐ YES ☐ NO

CURRENT MEDICATIONS: ϕ

ALLERGIES: NKDA

ϕ SX

ϕ med

CHIEF COMPLAIN[T]: left Knee injury

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME: 0850

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

VITAL SIGNS

TIME	0850	0925	1045	1112	
BP	129/77	124/64		120/68	
PULSE	107	101		96	
RESP	16	18		16	
TEMP	99.1(O)				
WT	99/58A 98/8A			100 2/60	

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

X-RAY ORDERS: CXR PA & LAT/PORTABLE | ACUTE ABDOMEN | SINUS | ANKLE R/L | X (L) Leg/Knee | C-SPINE | LS SPINE | HEAD CT | X AP Pelvis, AP/LAT Distal Femur, X-table lateral HIPE

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	5mg MS04		[redacted] @ 0905		(b)(6)-2
	5mg MS04		[redacted] @ 1030		(b)(6)-2

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

REFERRED ▶ | TO | WHEN

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

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

PLAN OF CARE FOR SKIN BREAKDOWN AND WOUND MANAGEMENT

PROGRESS NOTES

MEDICAL RECORD **HD:** 1 **POD:** Ø

Admission Date: 6 Oct 03 **Diagnosis:** (L) Femur Fx

Date: 6 Oct 03 Time: 1625 RN Signature: [redacted] 44/SW (b)(6)-2

Skin breakdown as evidenced by immobility, friction, shear, moisture, abrasions, surgical wound, skin tear.

Wound type: Surgical wound (s) Location:_____ Size:_____ Drainage: _____
Diabetic ulcer Tubes:_____ Pins: Traction Pin Appearance: clear
Venous stasis ulcer Dressing change: None
Other_____ Describe_____

Burn wound (s): % BSA_____ Partial_____ Full_____
Location:_____ Size_____
Appearance:_____
Dressing change:_____

Pressure Ulcer (s):
Stage I, II, III, IV (Circle the one that applies and describe below)

Location:_____ Size:_____
Wound character: Pink____ Moist____ Dry____ Granulation tissue_____ Yellow slough _____
Tunneling_____ Undermining_____ Odor_____ Purulent discharge_____ Eschar_____ Exudates _____

Refer to SOP for Dressing Change Instrucitons.

Please check the appropriate dressing Change:

- ☐ Wet to Dry Dressing
- ☐ Carrasyn-V GelDressing
- ☐ Alginate Dressing
- ☐ Comfeel Dressing
- ☐ Pin Site Care
- ☐ J-Tube Care
- ☐ Colostomy Care
- ☐ Chest Tube Care
- ☐ Burn Care

NOTE: Document daily wound and dressing change on Progress Note or Nursing Note.

Select the appropriate products used:

- ☐ Sterile 4x4 gauze dressing
- ☐ Sterile 2x2 gauze dressing
- ☐ Sterile gloves
- ☐ Kerlix (super sponge)
- ☐ Gauze bandage
- ☐ Sterile Normal Saline
- ☐ Sterile Water
- ☐ 8 x 4 Sponge gauze
- ☐ Op-site
- ☐ Tegaderm clear dressing
- ☐ Alkare skin prep
- ☐ Comfeel clear
- ☐ Comfeel pressure ulcer drsg
- ☐ Carrasyn-V Gel
- ☐ Alginate
- ☐ Bacitracin
- ☐ Silvadene Cream
- ☐ Petrolatum gauze
- ☐ Hibicleanse
- ☐ Non-adhesive dressing
- ☐ Telpha Pad
- ☐ Carra-smart film
- ☐ Sterile Q-tip applicator
- ☐ Xeroform 5 x 9.
- ☐ Moisture barrier cream
- ☐ 0.125% Dakins sol
- ☐ Betadine Swab sticks
- ☐ ½ Hydrogen Peroxide & ½ Sterile Normal Saline

Select the frequency of dressing change:

- ☐ b.i.d.
- ☐ t.i.d

MD Signature and Date:

CNS Signature and Date:

Medical Record, SF 509

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facility)

[redacted] (b)(6)-4

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: 21 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [ ] NO [X] YES (type): Placement of Traction pin LLE

4. PROPOSED SURGICAL PROCEDURE:

ORIF proximal & distal femur (L)

5. ADDITIONAL INFORMATION: Last PO: lunch Medical Hx: ø Implants: Traction Bow LLE (b)(6)-2 [redacted] (b)(6)-2 [redacted] Medications: Phenergan pm Demerol pm Ambien q.HS.
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	ø Pt. verbalizes any specific anxiety. ø Pt. exhibits relaxed body posture.	ø Allow pt. to verbalize freely. ø Explain OR environment and answer questions regarding surgery. ø Offer comfort measures, (e.g., warm blanket, touch) ø Explain all nursing procedures before they are done. ø Remain with pt. whenever possible. ø Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	ø PT. will be able to breathe without difficulty during immediate intra-operative phase.	ø Offer to elevate head of litter or offer pillow. ø Observe pt. while awaiting surgery for signs of distress ø Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	ø PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	ø Utilize pressure preventing devices on OR table and accessories. ø Check for proper positioning and support to maintain good body alignment. ø Pad pressure points. ø Place ESU ground pad on non compromised skin surface area. ø 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)

EPW # [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	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.	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] IT/AN (b)(6)-2 10 OCT 03 DATE

11. POSTOPERATIVE EVALUATION:

Bovie site: intact
Dsg: C&D
Resp: spontaneous

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. ~~PRE~~ Post OPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] IT/AN (b)(6)-2 DATE: 10 OCT 03 TIME: 1510	[redacted] CPT/AN (b)(6)-2 DATE: 11 Oct 03 TIME: 0240

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERAT[illegible] VIA Litter BY Anesthesia

2. PATIENT IDENT[illegible] VERIFIED BY ILT [redacted] RECORD REVIEWED AND PROCEDURE (b)(6)-2

3. DATE 10 OCT 03 TIME PATIENT ARRIVED IN SUITE 1900

4. PATIENT IN ROOM TIME 1910 NUMBER) #14

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER (Specify)

COMMENTS: NKDA, NPO p 1200

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D (b)(6)-2	RELIEF SCRUB	(b)(6)-2
ASSIGNED CIRCULATOR	ILT [redacted] 66E (b)(6)-2	RELIEF CIRCULATOR	CPT [redacted] (2300 - EOC) CPT [redacted] (b)(6)-2 (0017 - 0050)

7. POSITION AND POSITIONAL AIDS (Specify) Pt. lateral on padded OR table, supported by bean bag. Axillary roll in (R) axilla. Pillow between legs. (R) arm on padded armboard. (L) arm in padded arm holder.

[ ] SUPINE [ ] LITHOTOMY [ ] PRONE [ ] KRASKE LATERAL: [X] LEFT SIDE UP [ ] RIGHT SIDE UP

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO

DONE BY: [ ] OR [ ] NURSING UNIT

METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS: N/A

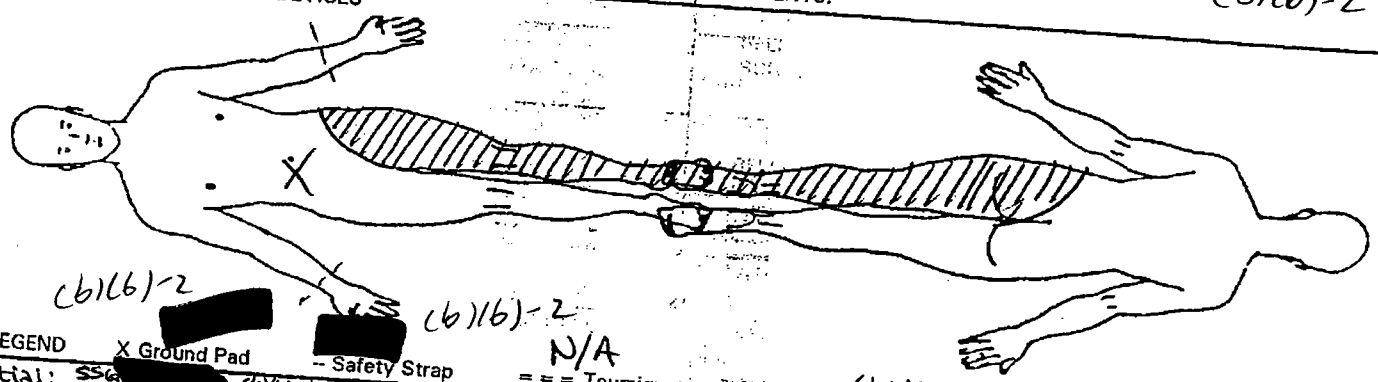
PREP SOLUTION (Specify) Betadine / Betadine

SITE: Left leg - hip to toes BY WHOM: ILT [redacted] (b)(6)-2

SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

Initial: SSG [redacted] (b)(6)-2 ILT [redacted] (b)(6)-2

C = Correct I = Incorrect

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

10. COUNTS

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

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

EPW # [redacted]

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) [X] YES [ ] NO

[X] ESU NO: VL Force 40 CUT: 50 COAG: 50 → 65

GROUND PAD: BRAND VL REM PolyHesive II

LOT NO: 70011 Exp: 2005-04

[ ] ESU NO:

GROUND PAD: BRAND

LOT NO:

[ ] BIPOLAR NO:

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

6.5 cancellous 75mm

13. PROSTHESIS, IMPLANTS [X] | IO | IF YES NAME: ID NUMBER | CTURER

Blade Plate set: 7 Hole plate - proximal, 12 Hole plate - distal
Load # 0228003
Hoffman II
Load # 0426301

Synthes ASTF Screw Set
Load # 0322301

proximal fx

cortical 40mm X3, 38mm X1

4.5 cortical 70mm X1, 40mm X1, 38mm X3, 36mm X1

3.5 cortical 55 x1, 60 x1

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. Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY
16 Fr Foley Cath	Intra-op	[redacted]

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES [X] NO [ ] C-Arm IF YES, SITE Left femur

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	1/4" Hemovac		
SITE	Lt. thigh		

18. DRESSING/IMMOBILIZATION (Specify)
Fluffs
Kerlix
ABD's
Ace

19. ADDITIONAL INFORMATION GETA WC:I

Surgeon: Dr. [redacted] (b)(6)-2 Dr. [redacted] (b)(6)-2
Anesthesia: MAS [redacted] (b)(6)-2

16 Fr Foley cath placed w/ problems, draining clear yellow urine - monitored by anesthesia.

DA5179 initiated

20. OPERATION(S) PERFORMED ORIF of proximal & distal femur (L)

0240

21. PATIENT TRANSFERRED TO ~~PACU~~ ICU 1 | TIME See DA 7389 | METHOD Litter c̄ O2

22. REGISTERED NURSE SIGNATURE (b)(6)-2 [redacted] LTC. 1 [redacted] CPT/AN (b)(6)-2

MEDCOM - 21196

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

NSN 7540-00-634-4124

VITAL SIGNS RECORD

ICAL RECORD

HOSPITAL DAY

DAY

EAR | DAY | HOUR

19 | 8 Oct | 9 Oct | 10 | 1430

PULSE (O) | TEMP. F (•)

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

	8	8			
	136/75	135/72	124/75		
	H 89		103	135/78	
	T 98.3		98.7	130/78	96
	97%		98		97
	RA	98%			97
		RA			98

Record special data only when so ordered

HEIGHT: | WEIGHT →

REGISTER NO.

WARD NO.

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

VITAL SIGNS RECORDS

Medical Record

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

NSN 7540-00-634-4124

VITAL SIGNS RECORD

ICAL RECORD

HOSPITAL DAY

DAY

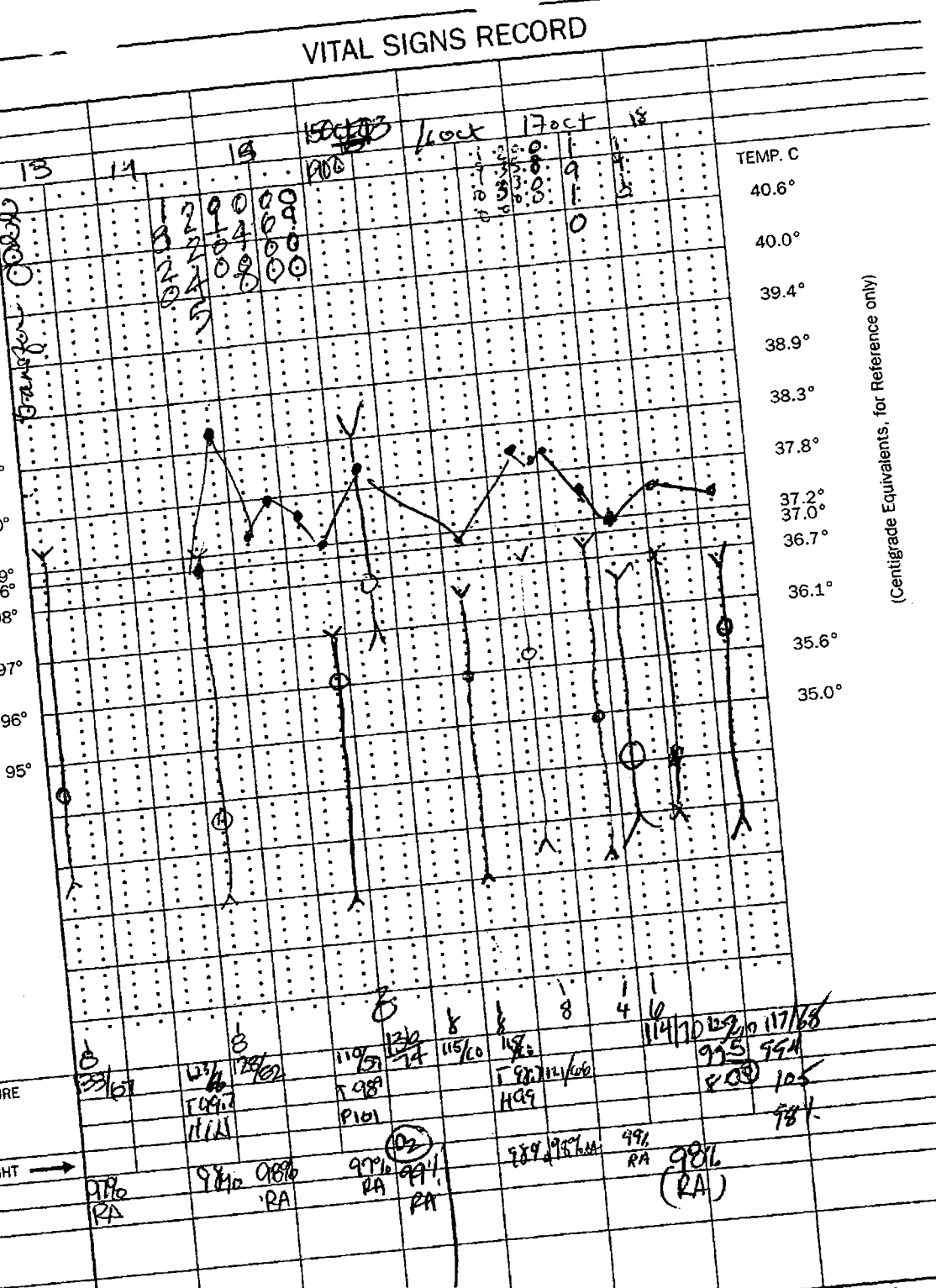
EAR | DAY | HOUR

19

PULSE (O) | TEMP. F (•)

TEMP. C

(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.

VITAL SIGNS RECORDS

Medical Record

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

[redacted] (b)(6)-4

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY 19

19 | HOUR 0 8

PULSE (O) | TEMP. F (•)

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

98%
RA

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

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

(b)(6)-2

Ward/Section: EMT	REQUESTING PHYSICAN [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, M [redacted] (b)(6)-4	DATE 6 Oct 03 / TIME 90G	SSN/PEEUDO SSN [redacted] (b)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10	Color		N/A	RPR		Negative
R			App		N/A	Mono		Negative
H	(b)(6)-4		Glu		Negative	Microbiology		
H	[redacted]		Bili		Negative	Source		
M			Ket		Negative	Gram Stain		
Pl			SG		N/A	Occ Bld		Negative
Ly			Bld		Negative	H. pylori		Negative
(			pH		N/A	Micro Parasites		
S			Prot		Negative	Malaria		
B			Urob		0.2-1.0	O & P		
Ly			Nit		Negative	Other		
At			Leuk		Negative	Macroscopic Urinalysis		
RL 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: (b)(6)-2 [redacted]	DATE: 6 Oct 03	LAB ID NO.:

Ward/Section: EMT	REQUESTING PHYSICAN (b)(6)-2 [redacted]					CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted]	(b)(6)-4	DATE 6 Oct 03	TIME 906		SSN/PERUDO SSN: [redacted] (b)(6)-4	

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
Na		138-146 mmol/dL	ALB		3.5-5.5 g/dl			
K		3.5-4.9 mmol/L	ALP		26-84 u/l			
CI		98-109 mmol/L	ALT		10-47 u/l			
pH		7.31-7.45	AMY		14-97 u/l			
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l			
PO2		80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl			
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl			
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)	CA^{++}		8.0-10.3 mg/dl			
SO2		95-98%	CHOL		100-200 mg/dl			
BEecf		(-2) - (+3) mmol/L	CRE		0.6-1.2 mg/dl			
AnGap		10-20 mmol/L	GLU		73-118 mg/dl			
Ca		1.12-1.32 mmol/L	TP		6.4-8.1 g/dl			
BUN		8-26 mg/dl	(Piccolo) Metlyte 8					
GLU		70-105 mg/dl	*TEST*	*RESULT*	*REF. RANGE*			
Creat		0.7-1.5 mg/dl	GLU		73-118 mg/dl			
Hct		38-51% PCV	BUN		7-22 mg/dl			
Hgb		12-17 g/dl	CRE		0.6-1.2 mg/dl			
Misc. Chemistry			CK		39-380 /l (M) 30-190 /l (F)			
TEST	*RESULT*	*REF. RANGE*	NA^+		128-145 mmol/l			
Tropoin-1			K^+		3.3-4.7 mmol/l			
Drug of Abuse			CL^-		98-108 mmol/l			
			tCO2		18-33 mmol/l			

```
======= PICCOLO =======
06/10/03            09:10
REFERENCE RANGE:      MALE
PATIENT #: [redacted] (b)(6)-4
BASIC METABOLIC
DISC LOT #:
OPER # [redacted] (b)(6)-2 3203AA4
                    DR #: 000
SERIAL #: [redacted]
.........(b)(6)-9.......
GLU    91    73-118   MG/DL
BUN    12    7-22     MG/DL
CA++   9.2   8.0-10.3 MG/DL
CRE    0.9   0.6-1.2  MG/DL
NA+    ♦♦♦   128-145  MMOL
K+     4.3   3.3-4.7  MMOL
CL-    101   98-108   MMOL
tCO2   23    18-33    MMOL

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

Na - 139

REMARKS: (b)(6)-2

REPORTED BY: [redacted]	DATE: 6 Oct 03	LAB ID NO.:

Ward/Section: OR	REQUESTING PHYSICIAN: [redacted] (b)(b)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted] (b)(b)-4	DATE 10 OCT TIME 2115	SSN/REFUND ORDER: [redacted] (b)(b)-2

(i-STAT) #6 + 7 continued

TEST	RESULT	REF. RANGE
Na	139	138-146 mmol/dL
K	3.5	3.5-4.9 mmol/L
CI		98-109 mmol/L
pH	7.388	7.31-7.45
PCO2	41.4	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	430	80-105 mmHg (art) N/A (ven)
TCO2	27	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	25	22-26 mmol/L (art) 23-28 mmol/L (art)
SO2	100	95-98%
BEecf	0	(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca	1.22	1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	29	38-51% PCV
Hgb	9.4	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/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: (b)(b)-2 [redacted]	DATE: 10 Oct 03	LAB ID NO.:

(b)(6)-2

Ward/Section: OR	REQUESTING PHY[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, M[redacted] (b)(6)-4	DATE 11 OCT 03	TIME 0020 ~~0000~~	SSN/P[redacted] (b)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
[illegible]		4.8-10.8 x10	Color		N/A	RPR		Negative
[illegible]			App		N/A	Mono		Negative
[illegible]			Glu		Negative	**Microbiology**		
[illegible]			Bili		Negative	Source		
[illegible]			Ket		Negative	Gram Stain		
[illegible]			SG		N/A	Occ Bld		Negative
[illegible]			Bld		Negative	H. pylori		Negative
[illegible]			pH		N/A	Micro Parasites		
[illegible]			Prot		Negative	Malaria		
[illegible]			Urob		0.2-1.0	O & P		
[illegible]			Nit		Negative	Other		
[illegible]			Leuk		Negative	**Macroscopic Urinalysis**		
[illegible]			HCG		Negative			
Morph								
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: OR	REQUESTING PHYSICAN: [redacted] (b)(6)-2			CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted]	(b)(6)-4	DATE 1 OCT 03	TIME 0000	SSN/PEEUDO SSN: [redacted] (b)(6)-4

(i-STAT) 6 & 7 (refrigerated)

TEST	RESULT	REF. RANGE
Na	144	138-146 mmol/dL
K	3.7	3.5-4.9 mmol/L
CI	109	98-109 mmol/L
pH	7.410	7.31-7.45
PCO2	39.5	35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2	26	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	25	22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf	0	(-2) - (+3) mmol/L
AnGap	10	10-20 mmol/L
Ca	1.24	1.12-1.32 mmol/L
BUN	7	8-26 mg/dl
GLU	107	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	41	38-51% PCV
Hgb	14	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/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.:

MEDICAL RECORD - ANESTHESIA

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

NKDA

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

DRUG (Units)													TOTALS
Midazolam (mg)	2		1			2							5
Fentanyl (mg)	50	<200>			<250>	X<250>			<250>		<250>		1750
Ketamine (mg)	20	20		20	20								80
Lidocaine (mg)	100	/MSO4	5		5			10		(20 mg MSO4 for cure)			
Propofol (mg)	200												500
VCR (mg)	5mx100	/	5	5	/ Nimbex - 4/10/10						10		
VOLAT AGENT % del	Sevo	2.0	2.0	2.0	2.5	1.0	1.0	2.0	2.0	1.5	2.0	1.0	
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	10	2	2	2	2	2	1	1	1	1	1	1	

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → (4)

TOTAL EBL: 1800

TOTAL URINE: 500

FLUIDS - SUMMARY

CRYSTALLOID: LR 3200 NS 2000

COLLOID: HESP 1000

BLOOD: 2 units

FLUIDS

LINE site 20G (R) RA	☐ Warmed	X											
18G (L) HD	☐ Warmed	LR #1						LR #1					
16G (R) A	☒ Warmed	NS #2			#3 LR (Hespan) 500								
	☐ Warmed												

LOSSES

EST BLOOD LOSS			50	20/300			20/250	20/400			120/550	
URINE -	foley		100	40/250			30/300					

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT: 34.4

INITIAL DATA:

BP- 133/75

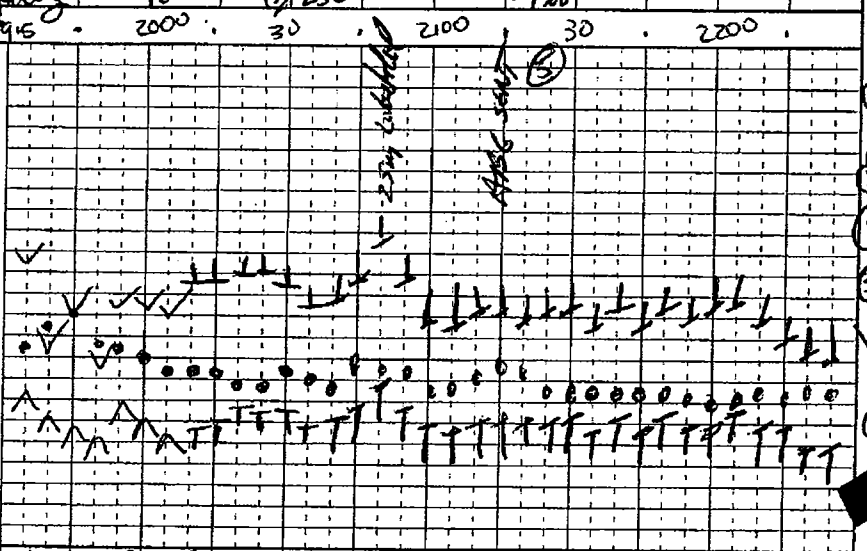
HR- 103

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDU[redacted] TIME- (b)(6)-2

TIME 1945 2000 30 2100 30 2200

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



VENTIL

VT - ml	+	770	740	760	760	770	600	700	720	720	730	720
f - breaths/min	+	10	10	10	10	10	8	8	8	8	8	10
Peak inf pres / PEEP	—	22	23	23	23	22	20	20	20	20	20	30
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 / EI CO2 (torr)	35	33	33	34	34	35	36	34	34	34	36	31
BP/oth / FIO2 (Frac or %)	0.6	0.6	0.6	0.6	0.6	0.55	0.59	0.61	0.61	0.62	0.62	0.65
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	Nasal		39	36.1	36.1	35.9	35.6	35.4	35.4	35.6	35.5	35.6
N-M Block (T/4)	0/4		4/4	0/4	0/4	1/4	0/4	0/4	0/4	0/4	0/4	0/4
BIS	+		+									
Warming blkt	X 1 blanket →											
Conv warmer												

Mark with letters & symbols, explain under REMARKS — EVENTS: (1) OKT (2) RLD (3) eyes: ar roll checked

REMARKS

Code drugs with numbers, events with letters

(1) Pre-operative Room, monitors O2 induced eyelids taped closed, left arm block + OK-P induction.

(2) 16G (R) arm — 18G (L) HD + A-line (R) radial

(3) Ancef 2gm IVPB

(4) LPT FROM MAO [redacted] (b)(6)-2

(5) LAB RESULTS REC'D - SEE CHART

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

RECOVERY AT 0245

PACU (ICU) ____ (Specify)

OTHER ____

CONDITION: talking

RESP- talking SpO2- 96

BP- 128/68 HR- 106

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1900	1910	0300
	Ready	Begin	End
PROC	1920	2005	0235

PROCEDURES and CPT Codes:

ORIF (L) femur fx

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

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

DL x1 MAC 4 Grade 1 view 8.0 stylETT 23cm @teeth + BBS + Sust ETCO2

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

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

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

PROCEDURE LOCATION: 1

DATE: 10 Oct 03

[redacted] CRNA/MA [redacted] ESTHESIA PROVIDER (b)(6)-2 CRNA

PAGE 1 OF

DA FORM 7389, FEB 1998

USAPA V1.00

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)													
Fentanyl (mcg)	<250>					100	50	50	50				
VOLAT AGENT: SEVO % del	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	1.75	2.0
% e.t.												
AIR L/Min												
N2O L/Min												
O2 L/Min	1	1	1	2	2	2	2	2	2	2	2	2	2

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → (6)

FLUIDS

LINE site													
18g (L) HO	☐ Warmed												
16g (R) A	☐ Warmed	LR4											
	☐ Warmed	LR5											
	☐ Warmed	NS4											

LOSSES

EST BLOOD LOSS	200/850				150/1000	250/1000			150/1000	100/500	100/1000		
URINE -			30/400				25/425					25/450	

TOTALS | **TOTAL EBL** | **TOTAL URINE**

FLUIDS - SUMMARY

CRYSTALLOID-

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

(6) Pt placed supine, arms secured on armboards.

(7) LABS Results - see chart

(8) OOR TO ICU

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: KG LB

HEMATOCRIT:

INITIAL DATA: BP HR

BODY CHECK OK? Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

TIME → 1730 1800 1830 1900 1930 2000 2030 2100 2130

SYMBOLS: [redacted]

BP by cuff V ∧ — Heart rate ● — Resp rate — BR (transduced) ‡ — TOURNIQUET T—T — ANES- X-X — PROC- ⊙-∅

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

VENTIL

VT - ml	730	730	730	750	600	680	690	680	700	680	750	570
f - breaths/min	10	10	10	8	7	8	8	8	8	8	8	12
Peak inf pres / PEEP	28	27	27	29	27	27	27	27	27	28	30	21
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff / ET CO2 (torr)	30	30	30	29	33	34	33	34	34	34	33	32
BP/oth / FIO2 (Frac or %)	0.6	0.6	0.6	0.65	0.65	0.60	0.60	0.61	0.52	0.51	0.53	0.51
ART line / SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES / ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer / TEMP-site	35.7	35.7	35.9	36.1	36.0	36.0	35.6	35.4	35.4	35.4	35.4	35.3
N-M Block (T/4)	0/4	0/4	1/4	2/4	4/4	4/4	4/4	4/4	4/4			
Warming blkt												
Conv warmer												

Mark with letters & symbols, explain under REMARKS — EVENTS *Position* → OH O-

RECOVERY AT

PACU ICU (Specify)

OTHER

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes:

ORIF (L) FEMUR FX / (R) KNEE

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

EPW # [redacted]

(b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

PAGE ONE

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

SURGEONS:

PAGE ONE

ANESTHETISTS:

PROCEDURE LOCATION: 1

DATE: 10 OCT 03

PAGE 2 OF

DA FORM 7389, FEB 1998 [redacted] -RBC 1 [redacted]

COPY 2 - ANESTHESIA PROVIDER

USAPA V1.00

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)	0130	0200	0230	0300	0330	0400	0430
FENTANYL	(MCG)	50/100/100						
PROPOFOL	( )		50/30/20/50/					
	( )							
	( )							
	( )							
	( )							
VOLATILE AGENT	% e.t.	2.0	1.5 X					
AIR	L/Min							
N2O	L/Min							
O2	L/Min	3	3 2 2	8	8			

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

FLUIDS

LINE site	Warmed	0130	0200	0230	0300	0330	0400	0430
Leg (R) arm	☐ Warmed	LR7						
Leg (R) arm	☐ Warmed	NS6				NS8		
	☐ Warmed	RBC2	X					

LOSSES

		0130	0200	0230	0300	0330	0400	0430
EST BLOOD LOSS		50/1750	0/1800					
URINE -								

TOTALS	TOTAL EBL
	TOTAL URINE
FLUIDS - SUMMARY	
CRYSTALLOID-	
COLLOID-	
BLOOD-	

REMARKS

Code drugs with numbers, events with lettters

PHYS STATUS: 1 2 3 4 5 / E

BODY WEIGHT: KG / LB

HEMATOCRIT:

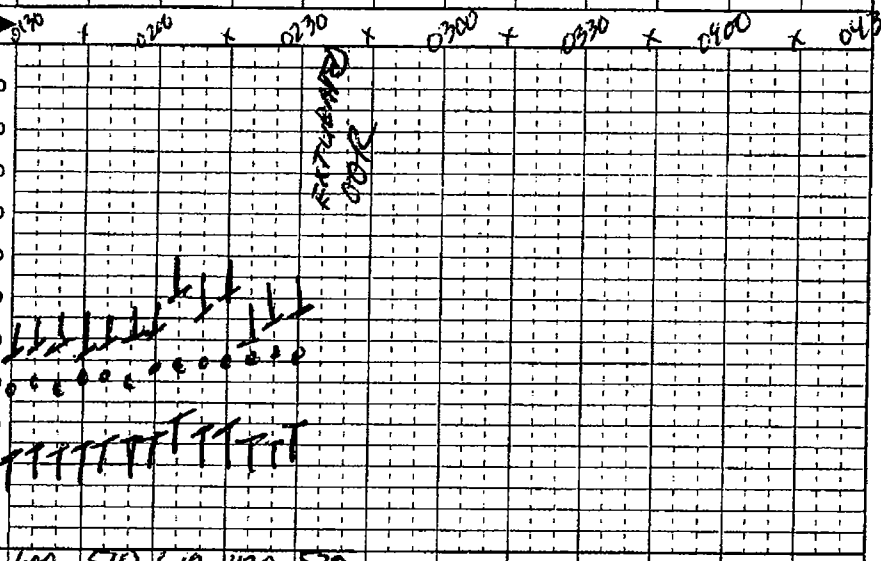
INITIAL DATA: BP- / HR-

EQUIP CHECK: OK? Y N

PATIENT RECHECK: OK for PROCEDURE? TIME-

TIME → 0130 0200 0230 0300 0330 0400 0430

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



VENTIL

	0130	0200	0230	0300	0330
VT - ml	600	510	610	420	530
f - breaths/min	12	8	7	9	10
Peak inf pres / PEEP	22				
MODE - S(pon), A(ssist), C(on)	CV	SV	SV	SV	SV

MONITORS/ACCESSORIES

		0130	0200	0230	0300	0330
BP/Auto Cuff	VET CO2 (torr)	32	48	44	46	44
BP/oth	FIO2 (Frac or %)	0.52	0.54	0.55	0.57	0.55
ART line	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	35.6	35.7 X	X	X	
	N-M Block (T/4)	4/4				
Warming blkt						
Conv warmer						

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

RECOVERY AT

PACU ICU (Specify)

OTHER

CONDITION:

RESP- SpO2-

BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
	Ready	Begin	End
PROC			

PROCEDURES and CPT Codes:

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

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

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

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

SURGEONS:

ANESTHETISTS:

PROCEDURE LOCATION: OR4

DATE: 10-11 OCT 03

PAGE 3 OF

PROPOSED PROCEDURE: Rt. O femur
SURGICAL SERVICE: ORTHO
NPO SINCE: 2000

Sex (✓) MALE ( ) FEMAL

ASA Physical State 1 (2) 3 4 5 (E)
WT: 80 (KG) LB HT: IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: yes
ETOH: no
DRUGS: no

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Ø pre-op
( ) In hospital on
( ) Lovenox 30mg SQ BID
( )
( )

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

LABORATORY STUDIES:
HB/HCT: _____ / _____
U/A: _____
OTHER:
60ct+ 4.3 | 101 | 12 | 91
23 | 0.9
16.6 | 11.5 | 657
36.4
90ct- Hct 34.4
T&C for 2 units

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 N/A
Other Significant Hx:
Familial HX N Y
N Y
N Y

MVA 8 plus days ago, EPW admitted Oct 6, 2002

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION
BP 133/75 HR 103 R ___ T 97 Sat 98%
Pain Scale 0-10 _____
HEENT - Teeth intact
Trachea midline
TMJ/Neck FROM
Oropharnyx MP II
Nares
CHEST: CTA (B)
CARDIAC: RRR (O) R
EXTREMITIES:
IV Access: 20G (R) A
Ulnar Filling:
BACK:
OTHER:

NPO Since 1200 noon

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): _____ { } 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 pa[redacted] (b)(6)-2 [redacted] understand and agrees. Questions answered.

Signed: [redacted] CRNA/MA Date: 10/10/03 Time: 1628 Hrs

POST-[redacted]STHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) _____

EPW [redacted] 9B
(b)(6)-4
[redacted] (b)(6)-4

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.

AMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

ANESTHESIA RECORD

Previous edition is obsolete
*U.S. GPO: 2001-629-183/40002

NSN 7540-00-634-4159

BLOOD OR BLOOD COMPONENT TRANSFUSION

RECORD

SECTION I – REQUISITION

REQUESTED (Check one)

OOD CELLS

FROZEN PLASMA

ETS (Pool of _____ units)

PRECIPITATE (Pool of _____ units)

MMUNE GLOBULIN

ER (Specify) _____

REQUESTED (If applicable) _____ ML

RKS:

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

☐ TYPE AND SCREEN

☒ CROSSMATCH

DATE REQUESTED 10-9-03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN (Print)

DIAGNOSIS OR OPERATIVE PROCEDURE

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

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

VERIFIED 10 OCT 03

TIME VERIFIED 2024

SECTION II – PRE-TRANSFUSION TESTING

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

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN NA

CROSSMATCH Compatible

PREVIOUS RECORD CHECK:

☐ RECORD ☒ NO RECORD

SIGNATURE OF PERSON P[redacted] (b)(6)-2

DATE 10-9-03

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DONOR

BO O

Rh POS

RECIPIENT

ABO B

Rh POS

REMARKS:

EXP 14 OCT 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT (Time) 0030 ON (Date) 11 Oct 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag. [redacted] (b)(6)-2

1st VERIFIER (Sig[redacted] (b)(6)-2

2n[redacted] CNA

PRE-TR[redacted] 80 BP 100/49

TEMP. 35.6

DATE OF TRANSFUSION 11 OCT (b)(6)-2 [redacted] TIME STARTED 0115

AMOUNT GIVEN ALL ML

REACTION ☒ NONE ☐ SUSPECTED

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.

POST-TRANSFUSION DATA

TIME/DATE COMPLETED/INTERRUPTED 0145 11 OCT 03

TEMPERATURE 35.7

PULSE 84

BLOOD PRESSURE 99/50

DESCRIPTION OF REACTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN

☐ OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)

☒ NO ☐ YES (Specify)

SIGNATURE [redacted] NOTING A[redacted] CNA (b)(6)-2

SEX [redacted]

WARD ICW

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

[redacted] (b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSI(

Medical Record

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

Medical Record Copy

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

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

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 10-9-03

DATE AND HOUR REQUIRED ASAP

REQUESTING PHYSICIAN *(Print)*

DIAGNOSIS OR OPERATIVE PROCEDURE

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

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

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

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

VERIFIED 9 OCT 03

TIME VERIFIED 2024

SECTION II – PRE-TRANSFUSION TESTING

[redacted] (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN: NA

CROSSMATCH: Compatible

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PE[redacted] (b)(6)-2

DONOR ABO O Rh POS

RECIPIENT ABO B Rh POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 10-9-03

REMARKS:

EXP 14 OCT 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* 0030 ON *(Date)* 11 Oct 03

IDENTIFICATION

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

1st VERIFIER *(Sig[redacted]* (b)(6)-2

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

PRE-TRANSFUSION

TEMP. 35.6 [redacted] 80 BP 100/49

DATE OF TRANSFUSION 11 OCT (b)(6)-2 [redacted]ME STARTED 0145 0115

POST-TRANSFUSION DATA

AMOUNT GIVEN ALL ML

TIME/DATE COMPLETED/INTERRUPTED 0145 11 OCT 03

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE 35.7 PULSE 84 BLOOD PRESSURE 99/50

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)*

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

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, [redacted] rate; hospital or medical facility)

[redacted] WARD ICW

[redacted] (b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 21210

Medical Record Copy

LCW1

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
U/S Duplex (L) LE					
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) [redacted] (b)(6)-2				TELEPHONE/PAGE NO.
	SIGNATURE [redacted] (b)(6)-2				DATE REQUESTED 10-28-03

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

R/O DVT (L) leg p femur fx

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

RADIOLOGIC REPORT

(L) LE Duplex color US.

No evid of DVT.

(b)(6)-2 [redacted]

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

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

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

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

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 10-6-03 TIME OF ORDER _____ HOURS | LIST TIME ORDER NOTED AND SIGN

- Admit ICU -
- (L) Segmental Femur Fx
- Vitals per SOP
- IV D5 1/2 NS @ 100 cc/hr
- Regular Diet
- Percocet 1 tab q 4° prn
- ~~Demerol~~ MSO4 2-8 mg IV q 2° prn breakthrough
- Lovenox 30 mg SQ BID
- Bed rest, traction to be applied.

(b)(b)-2 [redacted] 6 Oct 03 1245

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 6 Oct 03 TIME OF ORDER 1300 HOURS

① Fentanyl 50 mcg IVP Now 1630 6 Oct 03
② Versed 2 mg IVP Now [redacted] (b)(b)
V.O. per Dr. [redacted] (b)(b)-2 [redacted] (b)(b)-2
6 Oct 03 1809

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

240 Chart [redacted] (b)(b)-2

DATE OF ORDER 07 Oct 03 TIME OF ORDER 1500 HOURS

- Transfer to ICW-1 in AM - Dr. O
- Routine vitals
- 10 lb traction (L) LE, ensure (L) leg is bolstered & feet are not rubbing against bed frame
- Bed rest
- Regular Diet (Cont)

(b)(b)-2 [redacted] 0800 1500

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

(b)(6)-2 [redacted]

NURSING UNIT [redacted] ROOM NO. BED NO.

DATE OF ORDER 10-7-03 TIME OF ORDER 1900 HOURS

(cont)

- Demerol 50-75 mg IV q 4 PRN breakthrough
- Phenergan 25 mg IVP q 6 PRN nausea
- Ambien 10 mg po q HS
- Lovenox 30 mg SQ BID

(b)(6)-2 [redacted]

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

EPW # [redacted]

(b)(6)-4

NURSING UNIT ICW 1 ROOM NO. BED NO.

DATE OF ORDER 10-9-03 TIME OF ORDER 0800 HOURS

- NPO PMN
- D/c Lovenox now

(b)(6)-2 [redacted]

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

10/9/03 0830

PATIENT IDENTIFICATION

EPW # [redacted]

(b)(6)-4

NURSING UNIT ICW 1 ROOM NO. 24° BED NO. 180 [redacted]

DATE OF ORDER 10-9-03 TIME OF ORDER 1720 HOURS

CBC & T&S 2u PRBC tonight

(b)(6)-2 [redacted]

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

10/9/03 1720

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT ROOM NO. BED NO.

DATE OF ORDER 10Oct03 TIME OF ORDER 1630 HOURS

1. NPO to OR @ 1900, have ready
2. Bathe pt please
   Mouth care
3. LR @ 125mL/hr

[redacted] CRNA/MAJ [redacted]

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

10-11-03

Admit ICU - Dr D

Dx: Pistol Gun Chest Fx

Condition: Stable

Vitals: per unit SOP

Bed rest

I.S.

Elevate C-L E

PATIENT IDENTIFICATION

NOTED 0375 11 OCT [redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Foley to gravity

Regular Diet

Replace IV when tol p.o.

Percocet 1-2 p.o. q 4° prn

MSO4 2-8 mg IVP q 2° prn [illegible]

Phenergan 25 mg IVP q 6° prn nausea

Ancef 1 gm IVPB q 8°

Cefotaxime 100 mg BID

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Lovenox 30 mg SQ BID

Ambien 10 mg p.o. q HS

[redacted] (b)(6)-2

10-11-03 1115

CBC now

PM SO4 to q 1° dosing

Continue I.S. & pulm toilet

PATIENT IDENTIFICATION

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

24° ✓ [redacted] 12 Oct 0300

DATE OF ORDER | TIME OF ORDER | HOURS

Record hourly output q shift [redacted] (b)(6)-2

10-12-03 1500

Heparin IV

DIC IVF

(b)(6)-2 [redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° ✓ [redacted] 13 Oct 0300

DA FORM 1 APR 79 [redacted] CPT/PA REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

130ct03 0915

- MagCitrate ½ bottle p.o.
- Fleets enema x1
- D/C Foley

(b)(6)-2 [redacted]

130ct03 1400

- Portable XR AP + LAT (L) Femur
- Hip to knee p ORIF

} noted on pm [redacted] (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

- Transfer to ICW + After XR
- Regular Diet
- OOB to chair QID
- PT for gait training NWB (L) LE from knee
- Incentive Spirometry
- Routine Vitals
- Daily Dressing D's (L) Leg

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

- Regular Diet
- Ancef 1gm IVPB q 8°
- Levaquin 500mg IVq D
- Percocet 1 po q 4 PRN
- MSO4 2-8mg IVP q 2° PRN breakthrough
- Phenergan 25mg IVPB q 6° PRN nausea
- Ambien 10mg po q HS PRN insomnia

(b)(6)-

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

- Lovenox 30mg SQ BID

(b)(6)-2 [redacted]

10Oct03 1600

D/C pt to EPW Hospital

[redacted] 1620

(b)(6)-2 [redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

#[redacted]

(b)(6)-2 [redacted] Noted 18 Oct 03 1520

NURSING UNIT: ICW#1 | ROOM NO. | BED NO. 2/0 [redacted]

DATE OF ORDER: 10-18-03 | TIME OF ORDER: 10-18-03 HOURS | LIST TIME ORDER NOTED AND SIGN

- U/S Duplex (L) LE
R/o DVT

[redacted] (b)(6)-2

(b)(6)-2

[redacted] 10/15/03 2230

PATIENT IDENTIFICATION

(b)(6)-4

#[redacted]

(b)(6)-2 [redacted] Noted 19 Oct 03 1025

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 10-14-03 | TIME OF ORDER: _____ HOURS

XRAY - AP+LAT (L) HIP
AP+LAT (L) Distal Femur

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

DA FORM 1 APR 79 4256 REPLA[illegible] ICH 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. Oct Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 6	7	8	9	10
6 Oct 03	[redacted]	Vitals per SOP	06	[redacted]		D	E	
(b)(6)-2		(Q6°)	18	[redacted]				
6 Oct 03	[redacted]	Regular Diet	06	X	[redacted]			
(b)(6)-2			12	[redacted]				
			17	[redacted]				
6 Oct 03	[redacted]	Bedrest	06	[redacted]				
(b)(6)-2			18	[redacted]				
6 Oct 03	[redacted]	Traction to be	06	[redacted]		D	E	
(b)(6)-2		applied	18	[redacted]				
7 Oct 03	[redacted]	Vital Signs Routine	06	/	/	[redacted]		
(b)(6)-2			18	[redacted]				
7 Oct 03	[redacted]	10 lb traction (L) LE, ensure	06		[redacted]			
(b)(6)-2		(L) leg is bolstered & feet	18		[redacted]			
		are not rubbing against	/					
		bed frame						

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) Segmental Femur Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-2

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 Oct Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
(b)(6)-2 6Oct03	[redacted]	Admit to ICU	6Oct03		1215	[redacted]	(b)(6)
(b)(6)-2 7Oct03	[redacted]	Transfer to ICW 1 in am	8Oct03	AM			
(b)(6)-2 9Oct	[redacted]	NPO p MN	9Oct				
(b)(6)-2 9Oct	[redacted]	CBC c T&S 2U PRBC	9Oct	2000	2010	[redacted]	(b)(6)
	----	tonight					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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USAPA V1.00

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

	ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13	14									
(b)(6)-2	110CT	[redacted]	Condition Stable	06	[redacted]												
				18	[redacted]												
(b)(6)-2	110CT	[redacted]	Vitals per ward SOP	06	[redacted]												
				18	[redacted]												
(b)(6)-2	110ct	[redacted]	Bedrest	06	[redacted]												
				18	[redacted]												
(b)(6)-2	110ct	[redacted]	I.S.	06	[redacted]												
				18	[redacted]												
(b)(6)-2	110ct	[redacted]	Elevate LLE	06	[redacted]												
				18	[redacted]												
(b)(6)-2	110ct	[redacted]	Foley to gravity	06	[redacted]												
				18	[redacted]												
(b)(6)-2	110ct	[redacted]	Regular Diet	06	[redacted]												
				18	[redacted]												
(b)(6)-2	11 oct 03	[redacted]	Continue I.S. pulmonary toilet	06	[redacted]												
				18	[redacted]												
(b)(6)-2	11 oct 03	[redacted]	Record ~~documentation~~ Drain output q shift	06	[redacted]				D/C'D								
				18	[redacted]												
(b)(6)-2	12oct03	[redacted]	Heplock IV	06	[redacted]												
				18	[redacted]												
(b)(6)-2	12oct03	[redacted]	D/C IV Fluids	06	[redacted]												
				18	[redacted]												
(b)(6)-2	13oct03	[redacted]	D/C Foley	06	[redacted]												
				18	[redacted]												

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ORIF (L) femur Knee Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Oct Yr 2003

Verity by Initialing: Order Date	Verity by Initialing: Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(b)(6)-2 110ct	[redacted]	Admit ICU Dr [redacted]	110ct	/		[redacted]
(b)(6)-2 110ct	[redacted]	CBC Now	110ct03	[redacted]	[redacted]	[redacted]
	----	Portable X RAY AP+LAT Femur	8ct03	[redacted]	[redacted]	[redacted]
	----	Hip to Knee ō ORIF				
(b)(6)-2 10/17	[redacted]	D/C to EPW Hosp	10/17			

(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
----	----															
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USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(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 13	14	15	16	17	18	19	20	21
(b)(6)-2 13	[redacted]	Regular diet	6	✓	[redacted]							
			18	[redacted]								
(b)(6)-2 13	[redacted]	COB to chair QID	08	✓	[redacted]							
		NWB LLE	12	✓	[redacted]							
			16	✓	[redacted]							
			22	✓	[redacted]							
(b)(6)-2 13	[redacted]	Incentive spirometry	6	✓	[redacted]							
			18	[redacted]	[redacted]							
(b)(6)-2 13	[redacted]	Routine VS	6	✓	[redacted]							
			18	[redacted]	[redacted]							
(b)(6)-2 13	[redacted]	Daily drsg AS (b)(6)	10	✓	[redacted]							

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: LLE ORIF (femur)

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 _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(b)(6)-2 13	[redacted]	TRANSFER ICW#1				
(b)(6)-2 13	[redacted]	P.T. for gait training NWB LE				
(b)(6)-2 18	[redacted]	U/S Duplex (L) LE R/O DVT	18oct	ASAP	DONE	
(b)(6)-2 19 OCT 03	[redacted]	X-ray: AP/LAT (L) hip AP/LAT (L) distal femur			DR. DENT	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
----	----															
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----	----															
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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 ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
13	[redacted]	Ancef + gm IVPB Q8°		13 14 15 16 17 18 19 20 21
			6 /	[redacted]
			14 /	
			22 /	
13	[redacted]	Levaquin 500mg IVPB	10 /	
			2 /	
13	[redacted]	Levaquin 30mg po BID	10 /	
			20 /	
		PRN meds		
13	[redacted]	Percocet 1 po Q4 PRN		
13	[redacted]	MSO4 2-8mg IVP Q2 PRN Breakthrough		See below
13	[redacted]	Phenergan 25mg IVP Q6 PRN nausea		See below
13	[redacted]	Ambien 10mg po QHS PRN insomnia		
13	[redacted]	Percocet 1 po Q4 PRN		
		MSO4 2-8mg IVPQ2 PRN breakthrough		

ALLERGIES: ☐ YES ☐ NO PRIMARY DIAGNOSIS: (b)(6)-2 Femur ORIF

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 OBSOLETE USAMA V1.00

(b)(6)-2

MEDCOM - 21223

Green Sheet

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. 10 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
23 Oct	[redacted]	Regular diet	D	/	[redacted]			
			N					
25 Oct 03	[redacted]	CPB to chair QID	04	/	/	/	[redacted]	
			10	/	/	[redacted]		
			16	/	/	[redacted]		
			22	/	/	[redacted]		

b)(6)-2

b)(6)-2

b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Rule out / Ruled out

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 4 DEC 72 MAY BE USED. — USAPA V1.00

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 10 Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(b)(6)-2 23Oct	[redacted]	D/C Pt in Am to EPW	24Oct	AM	CANCEL	
		Hospital	/	/	/	/
(b)(6)-2 25 Oct03	[redacted]	PT for crutch ambulation	25			[redacted] (b)(6)-2
(b)(6)-2 25	[redacted]	XR - AP/LAT @ knee	25			[redacted] (b)(6)-2
(b)(6)-2 26 Oct03	[redacted]	D/C to EPW comp c crutches				

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.____ Yr. ____

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

	ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 6	7	8	9	10									
(b)(6)-2	6 Oct 03	[redacted]	IV: DS 1/2 NS @	06	[redacted]													
		-----	100cc/hr	18	[redacted]													
(b)(6)-2	6 Oct 03	[redacted]	Lovenox 30 mg	10	X	[redacted]												
		-----	SQ BID	22	[redacted]													
*	7 Oct 03	-----	Ambien 10mg PO qHS	22	[redacted]													

(b)(6)-

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) Segmental Femur Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 4672 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Oct Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
(b)(6)-2 6Oct03	[redacted]	Fentanyl 50 mcg IVP Now	6Oct03		1305	[redacted] (b)(6)-2
(b)(6)-2 6Oct03	[redacted]	Versed 2 mg IVP Now	6Oct03		1305	[redacted] (b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
(b)(6)-2 8Oct03	[redacted]	Percocet II PO Q4° PRN	6Oct 03 1213	7Oct 03 0010	7 Oct 03 0200	7 Oct 03 1200	7 Oct 03 1600	8Oct II 0300	8Oct II 0624	8Oct II 1005	8Oct II 1315					
(b)(6)-2 6Oct03	[redacted]	HSO4 2-8 mg IVP Q2° PRN Breakthrough	1830 7Oct 4mg	2300 7Oct 4mg	0230 8Oct 2mg											

(b)(6)-2

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

	ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 08 9												
(b)(6)-2	08 Oct 03	[redacted]	Lovenox 30mg SQ	10	/												
		-----	BID	22	[redacted]												
(b)(6)-2	08	[redacted]	Ambien 10mg SQ	20	[redacted]												
		-----	BID po qHS														

D/C 9 Oct 03 0800 30 (b)(6)-

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Ⓐ segmental femur fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4670

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION	TIME/DATE DISPENSED												
(b)(6)-2	[redacted]	Phenergan 25mg IVP q6° prn nausea	D/T													
			D/I													
(b)(6)-2	[redacted]	Demerol 50-75mg IV q 4° prn breakthrough	D/T	8OCT 1900	8OCT 2305	9OCT 0400	9OCT 1000	9OCT 1715	9OCT 0300							
			D/I	50mg	50mg	50mg	50mg	50mg	75mg							
				[redacted]												

(b)(6)-2

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

	ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11	12	13	14
(b)(6)-2	11Oct	[redacted]	Heplock IV when taking	06	[redacted]			
		-----	PO	18	[redacted]			
(b)(6)-2	11Oct	[redacted]	Ancef 1gm IVPB	06	[redacted]			
		-----	q8°	14	[redacted]			
		-----		20	[redacted]			
(b)(6)-2	11Oct	[redacted]	Colace 100mg BID	10	[redacted]			
		-----		22	[redacted]			
(b)(6)-2	11Oct	[redacted]	Lovenox 30mg SQ BID	10	[redacted]			
	11	-----		22	[redacted]			
(b)(6)-2	11Oct	[redacted]	Ambien 10mg PO qHS	22	[redacted]			

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ORIF (L) femur Knee Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. OCT Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
(b)(6)-2 11OCT	[redacted]	Ambien 10mg PO	11OCT	—	0320	[redacted]	(b)(6)-2
(b)(6)-2 13OCT03	[redacted]	Mag Citrate 1/2 bottle P.O.	13 Oct 03	—	0930	[redacted]	(b)(6)-2
(b)(6)-2 13OCT03	[redacted]	Fleets Enema x1	13 Oct 03	—	0930	[redacted]	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
b)(6)-2 11OCT	[redacted]	Percocet II PO	D	11OCT	11OCT	11OCT	11OCT	[redacted]	12OCT	12OCT	12OCT	12OCT	12OCT	12OCT	13OCT	13OCT	13OCT	13OCT
			T	0315	0900	1400	2200	[redacted]	1005	1400	1830	1900	0625	0412	1000	1400	1830	[redacted]
		q4° PRN	D	II	II	II	II		II	II	II	II	II	II	II	II	II	II
			I	[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
b)(6)-2 11OCT	[redacted]	MSO4 2-8 IVP q2°	D	11OCT	11OCT	11OCT	11OCT	11OCT										
			T	0320	0710	0615	0815	1110										
		prn Breakthrough pain	D	IV	4	8	2	8										
			I	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]										
b)(6)-2 11OCT	[redacted]	Phenergan 25mg																
		IVP q6° PRN Nausea																
b)(6)-2 11Oct	[redacted]	↑ MSO4 2-8 IVP q1°	D	11OCT	11OCT	11OCT	11OCT	11OCT	11OCT	11OCT	11OCT	11OCT	11OCT	12OCT	12OCT	12OCT	12OCT	12OCT
			T	1210	1410	1540	1700	1915	2215	2135	2240	2310	2340	0010	0040	0110	0140	
			D	8mg	4mg	8mg	8mg	4mg	4	8mg	8mg	4mg	4mg	4mg	4mg	4mg	4mg	
			I	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
b)(6)-2 11OCT	[redacted]	MSO4 2-8mg IVP	D	12OCT	12OCT	12OCT	12OCT	12OCT	13OCT	13OCT	13OCT	13OCT	13OCT					
			T	0330	0530	0915	1330	2100	0600	1050	1440	2020	2200					
		Q1°	D	8mg	6mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg	6mg					
			I	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
(b)(6)-2 11	[redacted]	Percocet II PO q4° PRN	D/T		13OCT 2230													
			D/I		II PO [redacted]													

Order

(b)(6)-2

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				23	24	25	26	27									
(b)(6)-2 23 Oct	[redacted]	Lovenox 30mg SQ	10	[redacted]													
	-----	BID	22	[redacted]													

(b)(6)

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: R/O DVT / Ruled out

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 10 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION	TIME/DATE DISPENSED												
(b)(b)-2 23 OCT	[redacted]	Percocet ii PO	D/T	23OCT 2000	24OCT 0300	24 OCT 0715	24OCT 1115	24OCT 1900	25OCT 0030	25OCT 0545	25OCT 1020	25OCT 1430	25OCT 2000	26OCT 0000	26OCT 0700	26OCT 1135
		Q4° PRN	D/I	2	2	[redacted]	[redacted]	2	2	2	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
			E/I	E	E											
				26OCT 1540	26OCT 2030	26OCT 2000	27 1440	27OCT 1010								
				[redacted]												

(b)(b)-2

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 1220 Initals [redacted] (b)(6)-2	Time: 1800 Initals [redacted] (b)(6)-2
NEURO	Pupils	PERRLA	PERRLA
	Sensorium	A-O x 3	At Oriented x 3, Follows
	LOC / GCS	Follows Commands, Cooperative	commands + express needs
CARDIAC	Cardiac Rhythm	SR to ST	SR to ST c̄ Ectopy HR 90s-100s
	PRI: / QRS:		
	Pulse Strength	+3 (R)(L) Radial; +3 (R)(L) Pedal	+3 palpable pulses in all ext
	Cap Refil / JVD	<3 secs, Ø JVD	<3 sec in all ext
	Edema	(L) LE	(L) LE.
	Chest Pain	None	—
RESP	Respiratory Pattern	Regular & Unlabored	RRR, equal chest rise
	Breath Sounds	CTA	CTA
	Secretions	None	—
	Cough	None	—
SKIN	Color	Normal for Race	WNL for race
	Integrity	lacerations to (L) knee	scab (R) knee
	Backside	Intact	Drsg (L) LE c̄ pins to traction C,D,I
IV	Access Devices	18G PIV	18 gauge PIV (R) Hand c̄ Ø
	Location	(R) AC	S/S of infection. NS infusing
	Condition	Patent c̄ s/s of infection	
GI	Abdomen	Soft, Nontender	soft, nontender
	Bowel Sounds	Active	(+) normal
	Stoma/Ostomy	—	—
		Ø N/V	
GU	Device	Voiding	Voiding in urinal
	Color / Clarity	Amber, Clear	

PREPARED BY (Sig [redacted] (b)(6)-2 [redacted] DEPARTMENT/SERVICE/CLINIC (b)(2)-2 ICU [redacted] DATE 6 Oct 03

(Continue on reverse)

PATIENT'S IDENTIFICATION (For typ[redacted]itten 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

DA FORM 4700, MAY 78

USAPPC V2.00

Patients Name: [redacted] (b)(6)-4 Date: 6 Oct 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP							133/76							131/86						140/84						
TEMP							99.2							99.2						100.5						
HR							95							95						104						
RR							22							19						22						
SaO2							99							97%						100%						
FiO2							RA							RA						RA						
Source														—						—						
MAP							96							86						101						
Pedal Pulse	R/L						+3/+3				+3/+3			+3/+3						+3/+3						

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
							100	100	100	100	100	100	600	100	100	100	100	100	100	100	100	100	100	100	100	1200
B																										
T																										
PO																										
Total																										1800

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE							700				925		1625				775									
NGT																									300	2900
STOOL																										
DRAIN																										
Total																										

Total in: 1200 Total Out: 2900 (−1700)

MEDCOM - 21235

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0630 Initials: [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	Reach 3mm Brisk	PERRL
	Sensorium	Alert Follow Commands	A+O able to follow
	LOC / GCS	Moves All extremities	commands able to
			move x3 extremities limited ROM to
CARDIAC	Cardiac Rhythm	SR	LLE. S1 S2
	PRI: / QRS:		
	Pulse Strength	All Peripheral Pulses (+)	(+) pulses to all 4 extremities
	Cap Refil / JVD	< 3 sec	<3 sec cap refill
	Edema	(2) LEG	LLE
	Chest Pain	Ø	
RESP	Respiratory Pattern	Reg.	KRR
	Breath Sounds	Clear Bilaterally Equal Chest Exp	CTA Bilat
	Secretions	Ø	
	Cough	Ø	
SKIN	Color	Normal / Ecchymotic (L) Leg at	NFR
	Integrity	Entry site Pin & Traction to	Fixator to LLE & traction
	Backside	(L) Leg. Pins to intact No bleeding	
IV	Access Devices	Right Hand PIV 18G	(R) Hand 18G IV &
	Location	D5 1/2 NS with (R) A-C	D5 1/2 NS 100 cc/hr
	Condition	Ø S/S infection/infiltration	Ø S/S infection
GI	Abdomen	Nontender Soft	Soft round nontender
	Bowel Sounds	(+)	(+) BS x4 quad
	Stoma/Ostomy	Ø	
GU	Device	Voids to urinal	voids via urinal
	Color / Clarity	Yellow clear	dark yellow

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(2)-2

DEPARTMENT/SERVICE/CLINIC ICU [redacted]

DATE 07 OCT 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

DA FORM 4700, MAY 78

USAPPC V2.00

Patients Name: [redacted] (b)(6)-4 Date: 07 OCT 05

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	121/66						137/70							137/73						137/78						
TEMP	97.9						98.6							98.7						98.9						
HR	89						92							92						91						
RR	17						16																			
SaO2	100%						100							98						98%						
FiO2	RA						RA																			
Source	—																									
MAP	88																									

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	
B																										
T																										
PO				360						360																
Total	100	100	100	460	100	100	100	100	100	460	100	100	5960	100												

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE		400		600			600				400		1800													
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 21237

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0658 Initals: [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	PERL.	
	Sensorium	Alert & Oriented; able to	
	LOC / GCS	make needs known	
CARDIAC	Cardiac Rhythm	HR 87	
	PRI: / QRS:		
	Pulse Strength	(+) pulses	
	Cap Refil / JVD	2-3 sec.	
	Edema		
	Chest Pain	⊖	
RESP	Respiratory Pattern	RR 12 even & nonlabored	
	Breath Sounds	CTA	
	Secretions	⊖	
	Cough	none noted	
SKIN	Color	normal for race	
	Integrity	warm + dry to touch.	
	Backside	Traction to (L) leg	
		(L) Segmental femur fx.	
IV	Access Devices	PIV to (R) hand	
	Location	(R) hand IV: D5½NS @ 100cc/hr	
	Condition	flushes & difficult	
GI	Abdomen	flat & nondistended	
	Bowel Sounds	All 4 quad.	
	Stoma/Ostomy	⊖	
GU	Device	⊖	
	Color / Clarity	Urinate per self - yellow	
		to urinal.	

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC (b)(2)-2
ICU3, [redacted]

DATE

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

DA FORM 4700, MAY 78

USAPPC V2.00

Patients Nam[redacted] (6)(6)-4 Date: 00 LCTUS

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	121/66							121/69																		
TEMP	98.4							98.6																		
HR	87							82																		
RR	12							17																		
SaO2	97							98																		
FiO2																										
Source	RA							RA																		
MAP																										

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
	100	100	100	100	100	100	100	100																		
B																										
T																										
PO	237	464			237		464																			
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE				750	600			700	625																	
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 21239

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0310 Initals: [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	PERRL	
	Sensorium	A+O responds to pain +	
	LOC / GCS	verbal commands	
CARDIAC	Cardiac Rhythm	S1 S2 ∓ any extra sounds	
	PRI: / QRS:		
	Pulse Strength	+3 x4 extremities	
	Cap Refil / JVD	<3 secs x4 extremities	
	Edema	Ø	
	Chest Pain	Ø noted	
RESP	Respiratory Pattern	= rise + fall of chest	
	Breath Sounds	CTA	
	Secretions	Ø	
	Cough	Ø	
SKIN	Color	NFR	
	Integrity	ORIF (R) leg	
	Backside		
IV	Access Devices	(L) hand NS 125 cc/hr	
	Location		
	Condition	Ø erythema or swelling	
GI	Abdomen	Soft round nondistended	
	Bowel Sounds	hypoactive	
	Stoma/Ostomy		
GU	Device	foley to gravity	
	Color / Clarity	clear yellow	

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (b)(2)-2
ICU3, [redacted]

DATE
10 OCT 03 – 11 OCT 03

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

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

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

DA FORM 4700, MAY 78

USAPPC V2.00