COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

(b)(2)-2

Why was this person detained? Shooting at [redacted] in Al-Fallujah

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses.

How was this person traveling (car, bus, on foot)?

Who was with this person?

What weapons was this person carrying?

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information:

MEDICAL RECORD | 1 NOV 1800 ABBREVIATED MEDICAL RECORD

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

20 y/o ? typing ?? c̄ multiple BLE GSW, operated at FST + tx'd. Wounds healed but site, arrived FST @830, op 1230 today

Med, ō allo PMH ⊖

PHYSICAL EXAMINATION

(W) (D) in some pain

HEENT - NT ⊖

chest cl

ab - ō (M)

abd - soft

pelv - stable

genital rectal ⊖

extr - soft tissue inj (R) lateral aspect post thigh, + post (R) leg, small area (L) post thigh

XLNT PT bil, senso intact, - ō DP each side

A - soft tissue inj

P - admit for wound tx

PROGRESS (Enter date of discharge and final diagnosis)

SIGN [redacted]	DATE 1 Nov 03	IDENTIFICATION NO.	ORGANIZATION

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

(b)(6)-2

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

539-106

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 Nov, 03	Chief complaint: ↑ Multiple gsw to legs.
1730	PMH: Ø PSH: Ø All: Ø Meds: Ø Tob: Ø
T: 98.1	Morphine 10 mg IV at 1740 - [redacted] (b)(6)-2
BP: 138/97	
HR: 113	
RR:	
SPO2: 97	

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

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

[redacted] (b)(6)-4

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

USAPA V2.00

2.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1 NOV 03 1930	Received from EMT via stretcher. Alert & oriented. IV (L) FA & (L) AC. (L) FA IV patent & intact infusing LR @ 150cc/hr. (L) AC IV d/c with cath intact. Peripheral pulses palpable +2. VSS. Dry to bilateral lower extremities dry sterile Kerlix dressing. Voiding clear yellow urine via foley cath. Tolerating P.O Fluids. Lungs clear, BS (+) x 4 quadrants. Abd soft nondistended. Informed pt of NPO status p MN for OR tomorrow. 2+ restraints applied. Will continue plan of care. [redacted] (b)(6)-2
02 NOV 03	(1955) Assumed care of pt. Pt alert, speaking Arabic. VSS. Pt to OR this am for washout of wounds. Kerlex dressings to BLEs c̄ small amount sero-sang drainage. Abd dressing pad to buttock c̄ mod amount sero sang drainage. IVFs infusing into IV in (L) forearm s̄ S/Sx infiltration. Foley draining quantity sufficient clear yellow urine. Ø c/o pain @ this time. +2 pedal pulses equal bilat. 2 point restraints in place s̄ S/Sx complications. Will cont. to monitor. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other) (b)(6)-2
	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	NUMBER

DATE	NOTES
02NOV03	(1700) Drsgs to BLE and buttocks reinforced d/t mod. amount sero-sang drainage. Pt mod. c̄ Percs c̄ good relief of pain. monitoring. [redacted]
02 NOV03 2000	VSS. Alert & Oriented. Dry to Bil LE (b)(6)-2 reinforced c̄ combined dry d/t dry soiled c̄ serosanguious fluids. Pedal pulses palpable +2 Toes c̄ capillary refill brisk. (L) FA IV patent & intact infusing LR @ 150cc/hr. Consumed 80% of Results diet for breakfast. Foley [redacted] draining clear yellow urine Quantity sufficient. Reposition in bed for comfort (b)(6)-2 Will continue care as planned. [redacted]
3NOV. 03 1400	V.S.S., A&O×3. Pt. resting quietly in bed. All DRSNG Δ'd, Silvadine applied to graft sites. W ID BRSNG @ the (R) LE. Colostomy care done by patient. Pt. ambulates c̄ difficulty to BR, and in hallway. J-tube D/C'd by MD this AM. DRY DRSNG applied. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL.
	(ERROR) [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
3NOV03 @1800	Pt. A&O x3. V.S.S. Pt. given 2mg MSO4 for pain prior to DRSNG Δ. Pt. had W→D DRSNG Δ's to multiple GSW's to LE bilat & (L) buttocks, wrapped c̄ Kerlex, moderate sero-sang. drainage to wounds, penrose drains intact. LR infusing. to (L) forearm @ 150 cc/h. Foley to gravity, light clear urine. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL, [redacted] (6)(6)-2
3NOV03 @2245	assumed care of pt @1800. VSS. Pt in bed c̄ pain, relieved c̄ Percocet. (R) thigh, (L) thigh, & buttocks dsgs CDI. (L) FA IV Hep, tol pr well. LS CTA, Foley draining yellow urine QS. Plan: cont IV abx as ordered, monitor neurovasc status to BILLegs, pain control. 2pt restraints on SS/Sx of skin or circulation compromise. Will monitor. [illegible]
4NOV03 @0600	Pt voided approx 2000cc this shift per policy. [redacted] (6)(6)-2 CDI. [redacted]
04NOV03	(1015) Assumed care @ 0600. Pt alert, speaking Arabic. VSS. Pt medicated c̄ II Percs prior to dsg Δ - tol. well. Dsgs to BLE Δd, wounds packed WTD. Pen rose drains intact draining sm. amount sero. sang drainage. Sutures intact to BLE. [redacted] (6)(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] (6)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.(

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
04NOV03 (1020)	(cont.) drain to ⓒ buttock intact. Ø S/Sx infection @ wound sites. Pt moves well in bed. SL in ⓒ forearm flushes well ~~s~~ S/Sx infiltration/ infection. Pt tol. reg diet well. Foley draining quantity sufficient clear yellow urine. 2-point restraints in place ~~s~~ S/Sx complications. Will cont. to monitor. [redacted] (6)(6)-2
	(1745) Foley dlcd this pm. Pt aware he is DTV in urinal by 2015. Pt OOB to amb in hallway ~~c~~ assist of walker. Pt favors ⓡ leg, but amb ~~c~~ steady gait. medicated ~~c~~ ~~T~~ Perc prior to amb - tol. well. Monitoring. [redacted] (6)(6)-2
4NOV03 @2345	assumed care of pt @1800. VSS, no c/o. alert, LSCTA, ⊕BS, tol reg diet & po pain meds well; ⊕ void approx 2000hrs of 600cc clear/yellow urine. BLE & ⓓ buttocks drsgs CDI; ⊕ CMS to BLE. ⓓ FA heplock flushes well, IVAbx q4hrs as ordered. 2pt restraints on ~~s~~ S/Sx skin/circulation compromise. Plan: monitor drsgs, pain control, IVAbx. [redacted] (6)(6)-2
05NOV03	(0915) Assumed care @ Ø600. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt OOB to chair. Personal hygiene

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. KW

[redacted] (6)(6)-2

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
05NOV03	(cont) done by pt c̄ min. assist from staff. Pt amb in hallway c̄ assist of walker - tol. well. Gait steady - pt placing pressure on BLE. Drsgs to BLE/buttock c̄ mod. amount sero-sang drainage. Awaiting MD for drsg Δs per his request. SL in ⓒ forearm flushes well s̄ S/Sx infection/infiltration. Pt eating breakfast in chair @ this time. Will continue to monitor. [redacted]
	(1315) Drsgs to BLE/buttock Δd. Penrose drains intact draining sm. amount sero-sang drainage. WTD drsg applied to multiple GSWs. ⊕ S/Sx infection. Will cont. to monitor. [redacted] (b)(6)-2
5NOV03@ 2330	assumed care of pt @1800. VSS. C/o pain to RLE, percocet given c̄ good relief noted. Alert, understands English. LSCTA, ⊕BS, tol po well, voids s̄ difficulty to urinal. Pt ↑ AMB to BR c̄ walker. ⓛ buttocks & BIL LE drsgs reinforced P/t ↑ sero-sanguinous drainage. 2pt restraints on s̄ S/Sx of skin/circulation compromise. Plan: monitor drsgs, pain control, IVAbx as ordered. Will monitor. [redacted] (b)(6)-2
6NOV03 (1105)	Pt c/o, VSS, premedicated c̄ 5mg MSO4 for drsg Δ. mod. serous drainage noted to ⓡ thigh wound. scant drainage to all other wounds. packed c̄ WTD gauze & wrapped c̄ Kerlix, MD @ BS during drsg Δ. Penrose drains removed by MD (Dr Davis). Pt voiding s̄ difficulty via urinal. ⊕ peripheral pulses. HL ⓓ wrist flushing easily. Plan: monitor

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

(b)(6)-4

[redacted]

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MEDICAL RECORD | **PROGRESS N S**

DATE	NOTES
	6 Nov [redacted] (b)(6)-2
	Wound clean, pressure removed, pt ambulatory
	P- clean & [redacted]
	(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1(

USAPA V1.0

[redacted]
(b)(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
6NOV@1105 (cont)	drsg's, ambulate, pain control. IV ABX per MD orders. Will monitor [redacted]
6NOV 2340	VSS. ↓BP 97/46. Will continue to monitor BP. Pt denies (b)(6)-2 any pain. Prior to DSG Δ's, premed c̄ 5mg MSO4. Completed DSG c̄ WTD, NS soaked gauze, + kerlix wrap. (L) LE sutures ⊖ S/Sx of infection. Well approximated X̄ for superior portion of sutures. ⊗ Serosanginous drainage from area 2° ↓ approximation. (R) upper thigh DSG had ⊗ mod. amt serosanginous drainage. Sutures approximated ↓ approximation to ~~the sutures~~ medial sutures. Packed openning c̄ NS soaked gauze. Pt attempted to amb however only stood at side of bed 2° ↑ pain. Pt requires assistance OOB + vice versa. Voiding in urinal ⊖ difficulty. 2 pt restraints ⊖ compromise to skin. Pt able to move toes, (+) Pedal pulses BIL, (+) cap. Refill BIL. Plan: Cont IV ABX, WTD DSG, Ambas tolerated. [redacted]
7 NOV 03 (1140)	Pt alg VSS, ∅ complaints, drsgs Δ'd. (premedicated). (R) calf c̄ mod amt bloody drainage. (R) thigh wound (largest) c̄ sero-sang drainage. Wounds packed c̄ NS soaked gauze and wrapped c̄ Kerlix. (b)(6)-2

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

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)
scribed 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
7NOV@1140	(cont) Pt ambulated around room c̄ walker (requires assistance). OOB to chair for 60 min. ⊕ pedal pulses, brisk cap refill. Ancep cont. voiding ugu via urinal. 2 pt restraints on while in bed. Ø compromise to skin or circulation will monitor [redacted]
8NOV@0005	VSS. Temp slightly elevated. Will continue to monitor. (b)(6)-2 Completed DSG Δ's to B/L LE. WTD. ⊕ Pedal pulses B/L. ⊕ Cap Refill B/L. Mod amt of serosang drainage noted on (R) buttock, (L) calf, (R) calf. Pt tol. ~~DSG~~ DSG Δ well. Premedicated c̄ 5mg MSO4 IV. Pt Refused dinner. Pt has IV ABX infusing. Voiding in urinal ⅀ difficulty. Pt asleep at this time. [redacted]
8NOV 03 0700	- Assumed care of pt. VSS Ø c/o pain or discomfort. Multiple 6SW to BLE and butt wet to dry dsg intact minimal active bleeding serous drainage to dsg 5mg premedicat MSO4 for dsg change. Lungs clear HRRR urinate spontaneously per [redacted] urinal Cont IV ABX Tx Remains afebrile Will cont to monitor [redacted] (b)(6)-2
8NOV.03 2000	Pt A+OX3, VSS, LS CTA (B), (+) BSx4, multiple dsg on LE x2, W→D dsg, Ø s/sx of infex, blood drainage noted on dd dsg's, wounds beety red, medicated c̄ ⅟ perc. tol well IV SL (D) FA intact, Ø s/sx of infex, cont IV abx, ate most of diet, voiding ⅀ diff per urinal, 2 point restraint, Ø complications. [redacted]

STANDARD FORM 509 (REV. 5/1999) BA
(b)(6)-2
USAPA V1

[redacted]

(b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

9/10/03 D/C Summary:

Pt admitted 1 November with multiple gun shot wounds of both lower extremities, all soft tissue - no fractures or neuro vascular impairment. Pt taken to surgery and wounds debrided and partially closed, penrose drains left in place till 5th day then removed and saline wet to dry dressing continued. Wounds are clean and pt is ambulatory.

Pt has (R) buttock wound will need stitch removal on 10th - 14th day, also on (L) calf. Wet to dry dressing to continue til wounds have granulated, will heal spontaneously with time or graft could be done at later date.

[redacted] (b)(6)-2

[redacted] (b)(2)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

Flow Op note

Debridement/irrigation of (R) lateral, (R) medial thigh + (R) calf wound

(L) lateral + (L) calf wound

11000 EBL 100

[redacted]

(b)(6) 2

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

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

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

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATIN[illegible]OM
VIA letter BY anesthesia

2. PATIENT IDENTI[illegible] RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted]

3. DATE 2NOV03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 0910 NUMBER 1-1 (b)(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt not english speaker.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt prone. padded rolls placed under chest. Bilateral arms on padded arm boards. Pillows under knees and legs.

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

COMMENTS: Pt positioned by [redacted] (b)(6)-2

8. SKIN PREPARATION

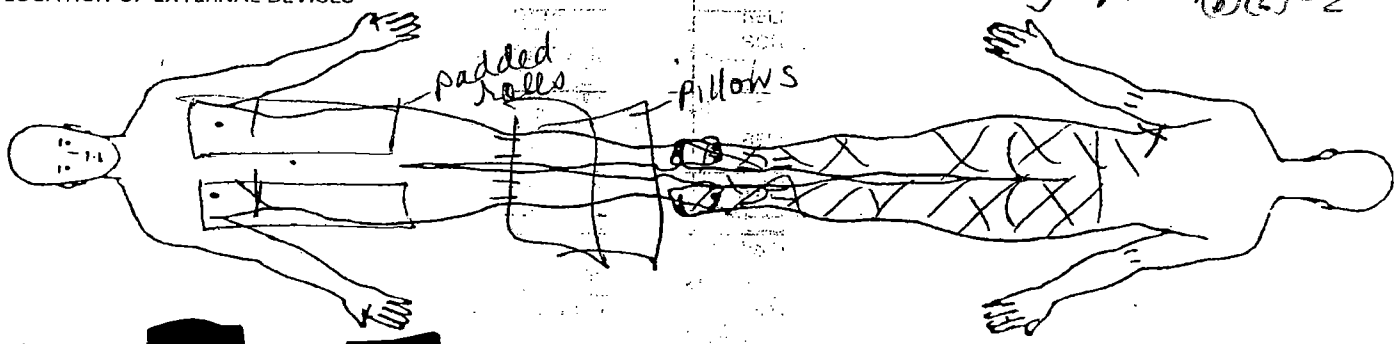
HAIR REMOVAL ☒ YES ☐ NO [redacted]
DONE BY: ☒ OR ☐ NURSING UNIT (b)(6)-2
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: no nicks or cuts noted.

PREP SOLUTION *(Specify)* Beta/Beta
SITE: (L) leg BY WHOM:
SITE: (R) leg to hip. BY WHOM: [redacted]

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

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] Pad -- [redacted] Wrap = = = Tourniquet XXX - prep

needle - 2
blades - 2

10. COUNTS

C = Correct I = Incorrect

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

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

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

[redacted] (b)(2)-2

2NOV03

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

CUT 45 COAG 45

☒ ESU NO: Valleylab E7507
GROUND PAD: BRAND Valleylab
LOT NO: 65706 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
~~TOF Foley to gravity drain~~	~~intraop~~	CP [redacted]
		(b)(6)-2

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 1" Penrose.	2.	3.
SITE	1. buttocks.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
- fluffs
- kerlix
- xeroform.

19. ADDITIONAL INFORMATION
surgeon: Dr [redacted] (b)(6)-2

anesthesia:
May. [redacted] (b)(6)-2

20. OPERATION(S) PERFORMED
I & D lower extremity wounds.

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	1100	letter

22. REGISTERED NURSE SIGNATURE [redacted] CRT/AN
(b)(6)-2

REVERSE O

MEDCOM - 23055

USAPA V1.00

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

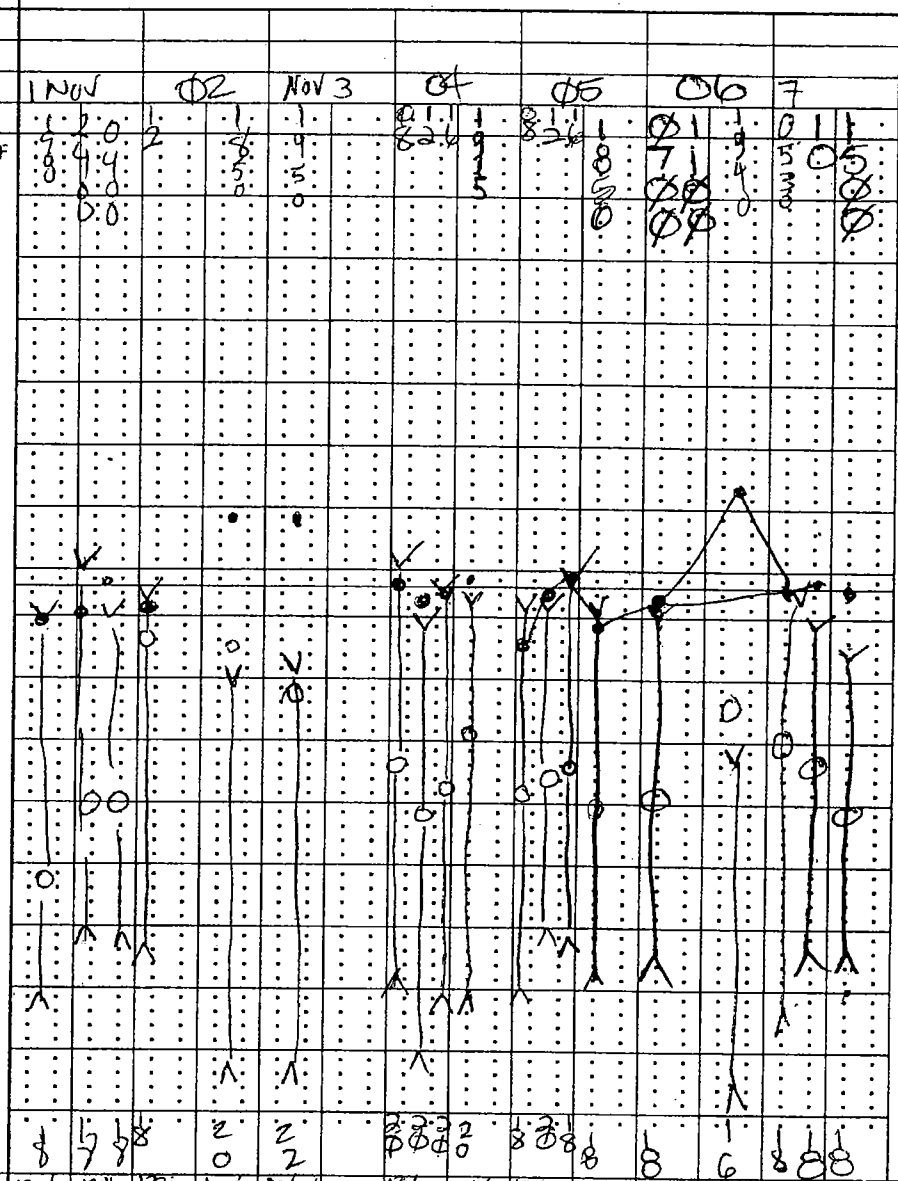
HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 1 NOV | 02 | NOV 3 | 04 | 05 | 06 | 7

19 | HOUR

PULSE (0) | TEMP. F (°) | TEMP. C



RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW#1

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOVEMBER DAY 7/8 8/9

19 2003 HOUR 2 0700 20 0

PULSE (O) — TEMP. F (•) — TEMP. C

105° — 40.6°

180 — 104° — 40.0°

170 — 103° — 39.4°

160 — 102° — 38.9°

150 — 101° — 38.3°

140 — 100° — 37.8°

130 — 99° — 37.2°

98.6° — 37.0°

120 — 98° — 36.7°

110 — 97° — 36.1°

100 — 96° — 35.6°

90 — 95° — 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

	16	18		18
BLOOD PRESSURE	120/66	124/55	126/[illegible]	
B/P		99L	99	
Temp	99.6	99.2	98.9	
HEIGHT: WEIGHT Temp		98.6	98.6	
O2Sat	96%	RA		99% RA
O2Sat				
Pulse	105			
Pulse				

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**

Ward/Section: EMT | REQUES[illegible] Dr [redacted] (b)(6)-2 | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] | DATE: 1 NOV | TIME: 1735 | SSN/PSEUDO SSN: [redacted]

(Hematology) CBC (b)(6)-4

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10³ 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)	
Sed Rate			
Other			

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
Appr		N/A
Glu		Negative
Bil		Negative
Ke		
SG		
Bld		
pH		
Pr		
Ur		
Ni		
Le		
Hi		
Ce		
Co		
Directig		

(b)(6)-4

ID: [redacted]
WB 01-11-03 17:50

			Patient Limits	
WBC	7.2	x10^3/uL	4.5	10.5
RBC	3.14 L	x10^6/uL	4.00	6.00
Hgb	9.2 L	g/dL	11.0	16.0
Hct	29.0 L	%	35.0	60.0
MCV	92.3	fL	80.0	99.9
MCH	29.4	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	198.	x10^3/uL	150.	450.
LY%	16.0 *L	%	20.5	51.1
LY#	1.1 *L	x10^3/uL	1.2	3.4

Misc. Serology (b)(6)-4

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
am		
ain		
ic Bld		Negative
pylori		Negative
icro		
rasites		
alaria		
& P		
ther		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

BO/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

REQUESTING PHYSICIAN: Dr [redacted]

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

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

DATE: 1 Nov

TIME: 1735

SSN/PSEUDO SSN: [redacted] (6)(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol
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. RANG
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

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

01/11/03 18:06

REFERENCE RANGE: MALE

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

BASIC METABOLIC

DISC LOT #: 3325AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	121*	73-118	MG/DL
BUN	9	7-22	MG/DL
CA++	7.7*	8.0-10.3	MG/DL
CRE	0.7	0.6-1.2	MG/DL
NA+	140	128-145	MMOL
K+	5.2*	3.3-4.7	MMOL
CL-	102	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
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: DATE: LAB ID NO.:

21y/o ? drugs ♂ 11/1 9.2 / 29.0 < 198 140 / 102 / 5.0 / 25 / 1.7 / 9 / 121 Ca

Anesf

NKDA 11/1 Hx Shoulder (B) ↓ exp workout 98.6 – 90 120/68 SaO2 98%

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 / 50 / (100)		50		100		100								
( )														
( )														
( )														
( )														
( )														
VOLAT AGENT	Forane % del	1.2	1.2	1.5		1¼				1¼	1¼			
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2 3	L/Min													

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

FLUIDS

LINE site														
RL-550	☐ Warmed				RL-1000								1150	
	☐ Warmed													
	☐ Warmed													
	☐ Warmed													

LOSSES — EST BLOOD LOSS; URINE -

TOTALS — TOTAL EBL: <100; TOTAL URINE:

FLUIDS - SUMMARY — CRYSTALLOID- 1150; COLLOID-; BLOOD-

REMARKS — Code drugs with numbers, events with letters

(1) U/S Taked
(2) Induced c Diprivan 160, Anectine 100mg Intubated
(3) Procedure beg
(4) Procedure ended
(5) O2, Breathing well, suctioned & cuff, extubated To recovery

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 29

INITIAL DATA: BP- 95 / 41 HR- 123

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

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

TIME → 900 15 30 45 1000 15 30 45 1100 15 30

VENTIL

VT - ml	610	590	550	710	690		
f - breaths/min	10	10	10	10	10	13	20
Peak inf pres / PEEP	23	22	22	25	24		
MODE - S(pon), A(ssist), C(on)	CV	CV	CV	CV	CV	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	32	32	33	29	33		
BP/oth	✓ FIO2 (Frac or %)	65%	65%	65	64	64		
ART line	✓ SpO2 (%)	100%	100%	100%	100	100	100	100
Steth- PC/ES	✓ ECG	ST	ST	ST	SR	SR	SR	SR
✓ Gas analyzer	TEMP-site							
	N-M Block (T/4)							
Warming blkt								
Conv warmer								

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

RECOVERY AT PACU ICU _____ (Specify) OTHER _____

CONDITION: RESP- 20 SpO2- 100 BP- 104/44 HR- 97

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0841	0908	1048
PROC	Ready	Begin	End
	0944	0947	1042

PROCEDURES and CPT Codes: I&D c W/o Leg Wounds 6 i/o

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

[redacted] (b)(6)-4 Wd 1 Bed 36? 36

[redacted] (b)(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

Gen Endo

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

#7.0 ET Tube c #4 Miller Smoothly

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

ANESTHETISTS: [redacted] CRNA

PROCEDURE LOCATION:

DATE: 02 NOV '03

PAGE 1 OF

MEDCOM - 23060 [redacted] (b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

Admit 1 CGW 1
Cond stable
Diet - ne
Act - ad lib
VS - q 4 h
Dx - left tibia wound
W LRL at 150 cc/h

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

Jelly to grow dim
NPO 7 MN for OR in AM
2 Nov
Percocet 2 po q 4 pain till MN
then - 5 q MS 10 q 1-2 h prn pain

PATIENT IDENTIFICATION

Noted
WS
1915
1 NOV

DATE OF ORDER | TIME OF ORDER ____ HOURS

Ancef gm IV PB
XR pelvis (R) femur (R) [redacted]
Lt toe
1/2 cc IM

NURSING UNIT | ROOM NO. | BED NO.

2 NOV 1000

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

Noted
[redacted]
0021
0031

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ____ HOURS

(R) Resume preop order
(R) Reg diet

[redacted]

DA FORM 1 APR 79 4256 | [redacted] | MEDCOM - 23061 | [redacted] MAY BE USED.

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (6)(6)-4

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

NURSING UNIT	ROOM NO.	BED NO.
ICW#1	24	02524

DATE OF ORDER: 3NOV03 TIME OF ORDER: 2000 HOURS

LIST TIME ORDER NOTED AND SIGN

1. HL IV.

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

4NOV03

PATIENT IDENTIFICATION

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

NURSING UNIT	ROOM NO.	BED NO.
24W / 2B15	4004 [redacted]	32

DATE OF ORDER: 4 Nov 1300 TIME OF ORDER: HOURS

1. DC
2. [illegible]

[redacted] (6)(6)-2

PATIENT IDENTIFICATION

[redacted] (6)(6)-4

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

NURSING UNIT	ROOM NO.	BED NO.
ICW#1	6NOV03 (1010)	

DATE OF ORDER: 6NOV03 TIME OF ORDER: 1000 HOURS

1. BID drsg Δ's to (B) LE & (L) buttock. (WTD) & wrap c̄ Kerlix.

V.O.: Dr [redacted] (6)(6)-2 / SPC [redacted] (6)(6)-2

24W [redacted] 2LT/AN 7NOV@0130

PATIENT IDENTIFICATION

[redacted] (6)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 9 NOV 03 TIME OF ORDER: 0900 HOURS

1. D/C ANCEF IVPB
2. D/C IVSL

V.O. DR. [redacted] (6)(6)-2 / [redacted] (6)(6)-2 2 CT, AN

NURSING UNIT	ROOM NO.	BED NO.

DA FORM 1 APR 79 4256 REPLACES MEDCOM - 23062 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
[redacted] (6)(6)-4				6 Nov '03	1200 HOURS	
				Chg drsg q12hr NS moistened gauze [redacted] (6)(6)-2		[redacted] (6)(6)-2
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER ____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER ____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER ____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

DA FORM 4256 REPLAC MEDCOM - 23063 ...H 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. ~~04~~ 11 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	04	05	06	07	8	9				
1	[redacted]	DIET: regular	6	[redacted]												
			18													
1	[redacted]	VS: Q4°	6													
			18													
1	[redacted]	Foley to gravity	6						DC 01 OCT 03							
			18													
04 OCT 03	[redacted]	Ambulate	06 18													
			18 06													
6 NOV 03	[redacted]	WTD drsg Δ's to (B)	10													
		LE & (L) buttock &	22													
		wrap c Kerlix BID	X													
6 NOV 03	[redacted]	Δ drsg q 12 hr NS	10													
	[redacted]	soaked gauze	22													
										(b)(6)-2						

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: soft tissue wound

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

MEDCOM - 23064

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 11 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
1	[redacted]	admit IC#1, stable	Ø1	—	[redacted]	[redacted]
1	[redacted]	NPO p MN for OR washout 2NOV	1NOV	2400	—	[redacted]
1	[redacted]	XR pelvis (L) femur/tib/fib	1NOV	[redacted]		
	----	(R) femur/tib/fib				
Ø2 NOV03	[redacted]	Resume pre-op orders	Ø2	—	—	[redacted]
Ø4 NOVØ3	[redacted]	DIC foley	Ø4 OCTØ3	—	1415	[redacted]

	----					

b(6)-2

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

USAPA V1.00

CLINICAL RECORD

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

Mo. 11 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3	04	05	06	07	08	09					
1	[redacted]	LR @ 150cc/hr	6	[redacted]													
	-----		18														
1	[redacted]	Ancef 1gm IVPB	6														
	-----	Q8°	14										(6)(6)-2				
	-----		22														
4	[redacted]	N:HL	10														
	-----		18	/	/												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: soft tissue wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]
(6)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678 EDITION MEDCOM - 23066 TIL EXHAUSTED.

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 11 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
1	[redacted]	Toxoid 1/2cc IM	1 NOV	—	2 NOV 0400	[redacted]
						(6)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
1	[redacted]	PERCOCET Hpo q4° prn pain until MN then 2	D/T	2NOV 1700	2NOV 2030	3NOV 0830	3NOV 1630	5NOV 0915	5NOV 1600	5NOV 2000	6NOV 1830	6NOV 2200	7NOV 0142			
			D/I	Hpo	Hpo	Hpo	Hpo	Hpo	Hpo	Hpo	Hpo	Hpo	Hpo			
			[redacted]											(6)(6)-2		
1	[redacted]	MSO4 5mg IV Q1-2H prn pain	D/T	2NOV 0330 5mg	2NOV 0530 5mg	3NOV 1520 Tcmo	6NOV 2000 5mg im	6NOV 2130 5mg im	6NOV 1000	7NOV 1920	7NOV 2045	8NOV 0415	8NOV 1000	9NOV 1100		
			D/I	[illegible]	[illegible]	[illegible]			5mg	5mg	5mg	5mg	5mg	5mg		
			[redacted]													
													(6)(6)-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: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 2 NOV 03
Time In: [illegible]
Allergies: NKDA
Pre-op V/S: 95/41 123
Procedures: I&D R/L leg, wound
Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1150 Colloid
OR Output: UOP EBL 100 cc
Meds/Times: Per Pharm

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

Pre Op Meds History

Time	1045	1130	1155	1110	1220
SaO2	98	95	98	95	95
FIO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140					
120					✓
100	✓	✓	✓	✓	✓
80					
60			^	^	^
40	^	^			
20					
RR	22	24	19	17	14
T	98.6				
Time					
Pain (0-10)			1		
LOS					

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1045	LR	400	L Forar	CC	600

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	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			-
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	7	9	9

Codes

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

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

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

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

PREPARED BY [redacted] (6)(6)-2 CPN

DEPARTMENT/SERVICE/CLINIC PACU

DATE 2 NOV 03

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

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

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	B/L	LROM	+	+	B	N	PK
15'	B/L	LROM	+	+	B	N	PK
30'							
45'							
60'							
90'							
D/C							

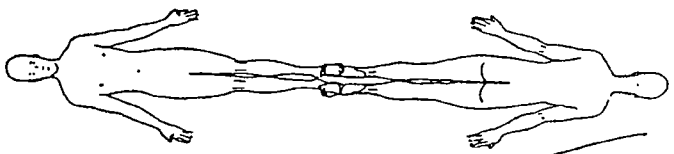
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) leg	Kling	Mod
30'	(L) leg	Kling	CD
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1045	SR	CD	CD

WAMC OP 173-E

NURSING NOTES

Pt to recovery room from OR s/p bil Washout legs. (R) leg c Kling mod drainage (L) leg c Kling CD drainage. Hx of IV of 18 infiltrating into (L) arm CD. S/S of redness OR swelling. NVI's intact. KSS. c c/o [redacted] (b)(6)-2

Discharge Criteria:

Date: 2 NW Time: 1120 PARS: 9
BP: 124/71 T: 97.2 HR: 119 RR: 20 Sa02: 96
Pain Level at D/C (0-10):
Intake: [redacted] Output [redacted]
Additional Data:
Transferred To: 1(W)#1
Report Given To: [redacted]
Transferred Via: W/C Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOPN: [redacted]
Charge Nurse Signatur [redacted]

(b)(6)-2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 0 1		[redacted]	(6)(6) - 4 [redacted]		

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

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

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

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
		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)
		2 0 0 3 1 1 0 1

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
N B A		2 0 0 3 1 1 0 1

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

FOR LOCAL USE

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

Admission [illegible] Coding Information

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

1. Reporting MTF (b)(6)-2 [redacted]	2. MTF Locatic IZ			
3. Register Number (b)(6)-4 [redacted]	Name (Last, First, MI) (b)(6)-4 [redacted]		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission [redacted]	8. Race X	9. Ethnicity [redacted] 9	Religion
10. Length of Service	ETS	11. FMP 99	12. Social Security Number (b)(6)-4 [redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 17:24	Branch / Corps:
14. Flying Status N/A	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	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: [redacted] No Install Provided (b)(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-11-09		
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-11-01		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-11-01		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: SOFT TISSUE WOUND

Procedure Narrative(s):

Cause of Injury Narrative:

Admitting Officer (Signature, as require (b)(6)-2 [redacted] DAVIS	Signature of Admitting Clerk (b)(6)-2 [redacted]

Automated Facsimile

ATIENT TREATMENT RECORD COVER SHEET

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

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

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	42Y	Z				NO

11. FMP	12. SSN	13. Organization	14. Ward
~~09~~ 80	[redacted] (b)(6)-4		ICU3

15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case
NO	K78-PRISONER OF WAR/INTER	ARMY		BC

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	23:37	ABD - NEUROSURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-15

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-01	ARMONDA

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] (b)(2)-2	2003-11-01	

31. Selected Administrative Data

Marital Status: DoB: [redacted]

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW HEAD

803.20
344.40
784.3
E991.2

02.02
01.39
02.99

DX	PROC	T ING
80320	0202	1 450
34440	0139	
7843		
E9912		

[redacted] (b)(6)-2

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~~ 15	~~14~~ 15

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~~ 15	~~14~~ 15

S[redacted]	Signature of PAD or Medical Records Officer
	[redacted]

(b)(6)-2

MEDCOM

(b)(6)-2

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

Iraqi ♂ GSW to (L) parietal region. Initially thought expired (+) pulse transported to 28th CSH. BP responded to IV fluid/PRBC's w/ GCS ~~7~~ T M 4 E 2 S(T). Pt underwent CT w/ evidence of open depressed GSW (L) parietal region, pneumocephalus, minimal brainstem compression.

PHYSICAL EXAMINATION

Isolated (L) Parietal open penetrating wound, through skull brain exposed

pupils small reactive

unable to test EOM

motor central localization prior to EMT arrival only on the (L), hemiplegic on (R)

no additional penetrating injuries

PROGRESS (Enter date of discharge and final diagnosis)

(1) Immediate (L) F-T Craniotomy
Decompression of Intraparenchymal Hematoma

CT of C-Spine normal,

[redacted] | DATE 11/1/03 | IDENTIFICATION NO. | ORGANIZATION

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

(b)(6)-2

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR (41 CFR) 201-45.505
OCTOBER 1975

539-106

[redacted]

(b)(6)-4

117.

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MEDICAL RECORD	PROGRESS NOTES
DATE	Neurosy POD#1 SIP NOTES
	(L) Parietal GSW w/ Intraventricular hematoma
11/2/03	Pt. flex (B) UE twitchy, spontaneously moving (L) UE
1430	extending (R) UE. Pupils Anisocoria intact d'd = 2 mm.
	Pupils small Brisk bilat.
Propofol	ICP (5-9) I/O's: 141/3.51
Dilantin	JP: 110 Ventric: 85 bloody
Zantac	121 24/7.5 127
Ancef	A/B: (C) ICP controlled moving all but (R) arm.
INR: 1.49	(D). INR 1.49 cont monitor.
CO_2: 30?	pH: 13
PO_2: 178	~~mode~~: [redacted]
	SIMV mode
	FIO2: 40
	Peep: 5 (b)(6)-2
11/03/03	Neurosy POD#2
Meds added	Pt. noted to have spontaneous twitch (L) arm/leg movement
Fentanyl	no (R) side movement. JP Removed, I/O (-75), Ventric 24
	@ height of 10 cm. Tolerated removal, drain JP site d/c other
	wound d/c. Staples intact. INR: 1.2. Hct 25.7
	A/P: Plan attempt to wean to extubate ABG: CO_2: 31.4
	[redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

[redacted] (b)(6)-4

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

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD (6X6) – 2 **PROGRESS NOTES**

Admission Date: 2 NOV 03 **Diagnosis:** [redacted] (SW) **HD:** 02 **POD:** 02

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)			

Add the total score ***Total Score:*** 11

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 X No__ Location: (R) Parietal Size: 5" Drainage: JP
Tubes: JP Pins:_____ Appearance: Patent
Dressing change: q day

Burn wound (s): Yes__ No X % BSA_____ Partial_____ Full_____
Location:_____ Size_____
Appearance:_____
Dressing change:_____

Pressure Ulcer (s): Yes___ No X
Stage I, II, III, IV (Circle the one that applies and describe below)
Location:_____ Size:_____
Wound character: Pink___ Moist X Dry___ Granulation tissue___ Yellow slough _____ Tunneling___
Undermining___ Odor___ Purulent discharge___ Eschar___ Exudates _____
Type of dressing change: Wet-to-dry___ Comfeel dressing___ Carrasyn-V Gel___ Alginate_____

Physician notified/consulted for wound debridement: Yes___ No___ Date/time MD notified N/A
CNS notified/consulted for Stage II and greater: Yes___ No___
Nutrition Referral: Yes___ No___
Physical Therapy Referral: Yes___ No___
Action taken:_____ Date & Time_____

REGISTER NO.	WARD NO.

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facility)

PROGRESS NOTES
Medical Record
STANDARD FORM 509

PLAN OF CARE FOR SKIN BREAKDOWN AND WOUND MANAGEMENT

MEDICAL RECORD @ Parietal **PROGRESS NOTES**

Admission Date: [illegible] Diagnosis: [redacted] HD: [illegible] POD: [illegible]

Date: 2 NOV 03 Time: 1215 RN Signature: [redacted] LT/AN

Skin breakdown as evidenced by immobility, friction, shear, moisture, abrasions, surgical wound, skin tear.

Wound type: (Surgical wound (s)) Location: @ Parietal Size: 5" Drainage: JP

Diabetic ulcer Tubes: JP Pins: _____ Appearance: CDI

Venous stasis ulcer Dressing change: _____

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: _____

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facility)

Medical Record, SF 509

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11/2/03	0330 Rec'd pt from OR S/p GSW head c̄ (L) f-temporal craniotomy; Evacuation of depressed open skull fracture. pt hooked up to monitor. Vent settings as follows V_T 700 Peep 5 FiO_2 100% BPM 12. ETT 26 @ lip. Pt has NGT, Ventriculostomy, JP drain, and (R) Femoral Cordis. D5NS c̄ 20mEq KCl & Propofol infusing into (R) Femoral Cordis. pt's head wrapped c̄ Kerlex c̄ Serosanguous fluid draining from (L) side. Pt has (R) AC IV H/L'd. FTG draining light, clear yellow urine. pt's Temp 94.4. Chief Cuddler applied to pt. See DA4700 for complete assessment — SGT [redacted] (b)(6)-2
11/2/03	0335 #1 FFP started VS as follows: 114/46, 78, 12, 35.7. 0340 116/59, 84, 12, 35.9. 0345 115/61, 85, 12, 36. 0400 117/63, 86, 13, 36.1 — SGT [redacted] RN
11/2/03	0425 #2 FFP started VS as follows: 115/55, 85, 12, 36.6 (b)(6)-2 0430 110/53, 85, 12, 36.6. 0435 127/64, 85, 12, 37.1. 0450 131/64, 81, 12, 37.1. — SGT [redacted] (b)(6)-2
11/2/03	0500 prp #2 finished. ∅ reaction noted. VSS — SGT [redacted]
11/3/03	Nursing: Pt hemodinamically stable during shift afebrile. Vent settings SIMV 11 TV 700 FiO_2 40% PEEP 5 no variations during day. Wean sedation per doctors order pt wakes easily & agitated Propofol @ 20mcg/kg/min Fentanyl 75mcg (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	ICP < 20 mmHg. Suctioned for mouth & ETT. Urine output adequate amounts of [redacted] accumulator. NGT to LIS. 100cc drained during shift. [redacted] LE/AN.
	(b)(6) - 2

STANDARD FORM 509 (REV. 5/1999) BACK

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(6)(6)-2 whole page except last at bottom

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
11/3/03 1900	Recvd pt from LT [redacted] 1815. Assessment and VS done. See DA4700 for details — SGT [redacted]
11/3/03	2000 pt sx'd via ETT C. Mod thick white to tan color thick mucous obtained. pt became agitated and given a total of 5cc bolus propofol. pt calmed down, HR ↓ to low 100's. — SGT [redacted]
11/3/03 2130	pt began to wake up again and become agitated. 2cc bolus propofol given via IV8 and IV propofol ↑ to 30 mcg/hr. Fentanyl ↑ to 125 mcg/hr also. pt calm now and resting comfortably — SGT [redacted]
11/3/03 2200	pt's temp ↑ 103.5. 1050mg Tylenol given through NGT. Will cont to monitor — SGT [redacted]
11/3/03 2205	MOD notified of pt's temp. Urine and blood culture X1 ordered. Both completed. Fan turned onto pt. Will cont to monitor — SGT [redacted]
11/3/03 2235	pt's temp ↑ 103.8. Will cont to monitor — SGT [redacted]
11/3/03 2300	pt's temp ↓ 103.3. Will cont to monitor — SGT [redacted]
11/3/03 0000	temp 101.7 — SGT [redacted]
11/3/03 0030	temp 101.8. — SGT [redacted]
11/3/03 0300	Temp ↓ 100.9. pt resting comfortably. — SGT [redacted]
11/3/03 0800	Bed bath given and oral care done. pt tol well →

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

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

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Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	NUMBER

DATE	NOTES
	(b)(6)-2
(Cont'd)	pt resting comfortably — SGT [redacted]
LATE ENTRY	11/4/03 0530 (R) AC PIV leaking IVF, d/c'd and restarted in (L) AC @ 2230. (R) Radial A-Line no longer patent, d/c'd also. — SGT [redacted]
	(b)(6)-2
11/04/03	Recovery POD# 3
Fentanyl	A. showing more spontaneous (L) side movement, sitting up with
Propofol	increased alertness & (R) leg movement.
Zofran	Thrax: 103.5 I/O: (+) 1249 ICP: 9-13
Anal	
Distention	Incis: Clean dry well-opposed
	motor Spontaneous movement (L) UE/LE
	No movement of (R) UE
	(R) LE withdrawal some spontaneous flexion.
	A/P: - ICP controlled
	- Improved alertness
	- Temp w/ ↑ WBC of ↑ in WBC (9.3)
	Plan: T-piece and if tolerating w/ attemp extubation.
	[redacted]
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
5 Nov 03 0615	Pt VSS during this shift ē exception of Temp which the max was 102.0, given Tylenol 650mg PR X2, Temp now 101.1. Pt NGT D/C'd @ 2200 per [redacted] (b)(6)-2 Dr made aware of pts early agitation 15min p̄ getting 1mg Ativan IVP, told to just observe pt. @ 0300 pt's ICP auto D/C'd by pt moving around in bed, Dr notified. Pt weened ↓ to room air ē stayed 95%-97% until this time, SaO2 93%, placed back on 1L O2 NC. Report given to oncoming shift. [redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES						
11-5-2005	BLOOD TRANSFUSION SERVICES INT. [redacted]						
TIME	1120	1125	1130	1140	1155	1200	1205
HR	135	130	122	128	117	125	131
BP	94/49	96/50	102/60	100/54	102/61	98/60	94/47
(T)	100.7		100.7				100.7
RR	20	20	30	28	24	24	28
SpO2	100	100	100	97	100	100	97
	infusion complete no s/s of hemolytic reaction.						

[redacted]

	2nd unit						memory lost
time	1215	1220	1225	1230	1240	1200	-1300 infusion
HR	128	140	130	133	135	132	complete.
BP	94/57	99/50	92/50	92/50	90/47	100/53	⌀ s/s, 15 min f/u
(T)	100.3						[redacted]
RR	34	30	33	33	32	33	
SpO2	100	99	100	100		97	

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Neurosurgery Notes POD#4
11/5/03	Pt. with increased activity & tracking. More
17:25	spontaneous movement.
	Temp 101.5
	HEENT: increased swelling of (L) forehead/face
	Pupils small reactive
	Eomt
	Neuro: GCS
	motor: (R) arm monoplegia
	o/w briskly moves (R) LE.
	likely expressive/comprehension/receptive aphasia.
	[redacted] (b)(6)-2
11/6/03	Neurosurgery POD#5
0600	S/P improved with persistant (R) arm monoplegia.
	Transient appropriateness vs. confusion
Dilantin	Tmax 100.6
Zosyn	HEENT: & Edema pupils briskly RL
Zantac	iris clear well intact / flap soft
Cancef	(Reports drainage from right).
	Acute: DIC [redacted] (b)(6)-2
	↑ Diet Clears
	DIC [redacted] (b)(6)-2
	[redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

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(b)(6) - 2 whole page

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
6 Nov 03 (0630)	Assumed PT care @ 0600, PT resting in bed; Consumed part of this morning breakfast, (D) orange juice 250 cc approx. old drainage noted on (L) side of head, Dressing Re-reinforced c̄ gauzes & Tape; ~~No s/s of~~ VSS staple, Temp 99.7, No s/s of distress [redacted] AN
6 Nov 03 (1100)	PT c̄ Temp of 101.0, Acetaminophen 650mg supp PR PRN given, pt's Temp ↓ 99.8 @ 1100, No s/s of distress [redacted] 1/4/AN
6 Nov 03 (1200)	PT able to eat 100% of lunch, ~~check~~, able to point at what he wanted first, second and third in order of preference; mouth care, bath, skin care, foley care and ROM exercises performed around 1245; pt was able to brush his teeth, and wash the front of his body c̄ minimal assistance using (D) ARM, unable to move (R) arm s̄ support, unable to wash his back; (D) side stronger than (R) side, pt able to move bilateral lower extremities and (L) arm more than (R) arm. [redacted] 1/4/AN
6 Nov 03 (1305)	Dressing to (L) side of head, changed c̄ gauzes dry intact, ~~dry~~ staples intact, ∅ active bleeding noted, No s/s of infection. PT tolerated procedure well [illegible]
6 Nov 03 (1640)	PT c̄ Temp of 101.1, Acetaminophen 650mg supp PR PRN given, ~~Temp~~ ↓ 98.6 [illegible] 1/4/AN
6 Nov 03 (1830)	[redacted] ~~of the~~ 0600 the use of Flagyl / Cortis line, PT c̄ weakness & pain on (R) ARM, (R) ARM He uses it

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

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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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	To support & move Himself, only good place for a line, would be in leg which he to his cordes ground line still patent & good for use. PTS condition improving greatly, able to follow commands, feed himself c spoon, understands simple commands - report given to SPC Dickens, PT states in best of S/S of distress or complaint, also PT eat 100% of dinner — [redacted] /[redacted]
6Jan03 1900	assumed PT care @ 1900. Received report from LT [redacted]. assessment in flow chart. PT ate 100% of dinner (clears diet) is now resting on left side. will continue to monitor — SPC [redacted]
2100	VSS PT rolling from side to side during sleep, is in NAD will continue to monitor — SPC [redacted]
2200	started IVFL for Dilaudid med run. PT still sleeping comfortably. temp at 100.1 has not risen in last 2 hrs — [redacted]
2330	VSS temp steady @ 100.1 PT sleeping meds are running will continue to monitor — SPC [redacted]
0145	VSS PT resting. temp remains slightly elevated. UOP still above 100 cc/hr. PT is in NAD will continue to monitor temp — SPC [redacted]
0440	LABS drawn, ABG done. IV 0600 med. hanging. PT still sleeping comfortably. will continue to monitor — SPC [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
	Nursing Note
11/7/03	Pt. awake alert appropriate. Participating in
09:18	self care, brushing teeth washing self.
	AFEBS VSS
	Incis - clean dry well-opposed
	motor: Briskly moving (L) arm. (R) leg
	(R) arm monoplegic
	A/P: Pl to transfer to ICW
	D/c IVs advance diet.
	[redacted] (6)(6)-2
7 Nov 03	Nutrition Note
1010	Pt doing well on CLD today + yesterday. Ø GI complaints.
	Recommend advancing to FLD + to Reg as tol. (6)(6)-2
	[redacted] (PT, SP
7 Nov 03	Pt alert and responsive to tactile and
1010.	verbal stimuli. Pt able to move (L) hand and both
	feet. (R) hand is limp. Pt able to practice own PROM
	with use of (L) arm. Also to sit up in bed [redacted] (6)(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] (6)(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	tolerated his early AM meds TUPBs and IVF. BS well hydrated. Urine output adequate. BS has slightly elevated temp of 100.9°F, temp decreased to 100.5. Staples in head wound/incision intact - 25 staples rtd. BS oozing DIC, oozing DIC, ferrous lines DIC. BS prep for TCW D. Elevate other legs and 150cc well [redacted] (b)(6)-2
4/1 07/03	HPO/BS report given & [redacted] (b)(6)-2

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(b)(6) - 2 wide page

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08NOV03	(cont) diet well. Voiding ~~s~~ difficulty. 2-point restraints in place ~~s~~ S/Sx complications. Will continue to monitor. [redacted]
9NOV03 @ 0030	Assumed care of pt @1800. VSS. Alert, speaking garbled noises, but follows commands & seems to understand English. PERRLA, (R) side facial droop noted c̄ smiling, RUE weakness noted, but marked improvement in last 24° c̄ pt unable to move fingers. BUE equal, steady gait noted c̄ ambulation, but pt drags (R) foot slightly. LS CTA; (+) BS, tol reg diet well; voids to urinal ~~s~~ difficulty. Pt ↑ amb x 20-25 min ~~s~~ difficulty. 2 pt restraints w/o S/Sx of skin or circulation compromise. Plan: monitor neuro, monitor VS, encourage intake. Use [redacted] bandage provided for pt for hand exercises. [redacted]
09 NOV 03 1015	Assumed care @ 0600. VSS. Alert & O able to make needs known c̄ interpreter asst. RUE weakness. Unable to arm ~~s~~ asst. Can move fingers slowly. Purposeful movement of LUE & BLE. Ambulates slowly c̄ minimal asst to bathroom for AM Care & in hall ~~s~~ asst. Staples C&I to (L) side of head. PERRL. Will continue monitoring neuro status & encouraging hand exercise c̄ Kerlix pack. 2 pt restraint ~~s~~ [redacted] compromise to skin or circulation. [redacted]
09 NOV 03 1700	Ambulating in halls ~~s~~ difficulty. Drags (R) foot when ambulating. Will continue to monitor. [redacted]

STANDARD FORM 509 (REV. 5/1999) BA

USAPA V

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11/8/03	Neurosurgery
0830	Pt. awake, alert appropriate Residual (R)
	monoplegia & receptive aphasia
	AP&B VSS
	incis clean dry well approximated
	MB OOB Ambulate w/ assistance
	[redacted] (6)(6)-2
ERROR WRONG PT	
~~0800V03~~	~~(1200) Assumed care of pt from ICU3 via gurney in stable cond. Pt alert, speaking Arabic. VSS 0 c/o pain. Drsg to RLE CDI. Drsg to RLE c̄ small amount serosang drainage ∂ the knee. Drsg to LLE CDI.~~ [redacted]
0800V03	(1210) Assumed care of pt ∂ 0800. Pt alert. Able to follow verbal commands. VSS. 0 c/o pain. (L) sided facial drooping noted. Pt cont. to be unable to control (R) hand/forearm, has min. control over (R) shoulder. ROM done c̄ pt. Amb in hallway c̄ small episode of dizziness ∂ start of amb. Staples to (L) side of head CDI s̄ S/Sx infection. Tol. reg

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] (6)(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
8/10/05	(CONT); (R) sided facial weakness noted, especially to mouth, dysfunctions drinking H_2O noted. RUE weakness significant, can go arm, able to use shoulder & upper arm strength, but cannot grasp or maintain control of (R) hand. BLE equal in strength, but pt c̄ unsteady gait when ambulating. Incision to (L) temporal lobe OTA, staples intact, o drainage noted. Pt ↑ to BRC assistance, tol well. LSCTA, (+) BS, voids difficulty to urinal. Plan: monitor neuros, Dilantin as ordered. 2pt restraints m/s (S/Sx skin/circulation compromise). Will monitor. [redacted] (6)(6)-2

STANDARD FORM 509 (REV. 5/1999) BA

USAPA V

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7 NOV Ø3 1210	Pt admitted via gurney from ICU#2. Pt ~~awak~~ awake, making gestures c̄ hand, trying to communicate c̄ roommate. Pupils small & reactive, old dry blood noted to (R) nostril. Pt c/o not being able to taste his food. Pt is also unable to speak @ this time. (R) sided weakness noted, unable to move (R) arm but can wiggle (R) toes (*at the same time as left toes). (+)1 edema noted to (R) hand & foot. (L) hand & foot c̄ (+)2 pulses, (R) hand & foot c̄ (+)1 pulses. 25 staples noted to (L) temporal ~~lobe~~ side of head. Well approximated c̄ Ø drainage noted. Foley d/c'd in ICU. Pt due to void by 2000 hrs. Pt able to ambulate c̄ assistance, could not use crutches due to (R) sided weakness. had soft-brn formed BM x 1. Ø IV access. Ø skin breakdown. 2 pt restraints on ~~S~~ compromise to skin/circulation. Will monitor [redacted] (b)(6)-2
8 NOV Ø3 @ 0205	assumed care of pt @ 1800.. VSS, no c/o pain. alert, speaks unclear arabic but understands English commands. PERRLA, c/o unable to taste food. (CONT)

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*	REGISTER NO.	WARD NO. ICW# 1

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
9 NOV. 03 2030	Pt A+Ox3, VSS, LS CTA (B), (+) BS x4, staples to (L) side of head CDI, Ø drainage noted, weakness to RUE, able to move extremity slowly, voiding CVU to urinal, tol most of diet, encouraged exercising RUE, will continue to monitor, 2 pt restraint, Ø complications. [redacted]
	Neurosurgery (b)(6)-2
11/10/03 0922	Pt c/o (L) radicular leg pain. Has progressive increase in strength & activity. in (R) arm & hand. Previously (R) monoplegic now has antigravity strength. AFEB
	Motor ambulate. Pains (R) arm no resistance but able to move individual fingers & thumb
	A/R: OT Activity
	(2) DOB & chair walking (Vision for radiologists)
	(3). DR Dietitian.
	(b)(6)-2 [redacted]

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

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[redacted] (b)(6)-4

(6)(6) - 2 whole page

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10NOV03	(1010) Assumed care @ 0600. Pt alert, speaking Arabic. VSS. Pt c/o back pain radiating down legs. MD notified - pt started on Vioxx. Pt given IS c̄ instruction. Demonstrated correct use of IS. ROM c̄ RUE improving. ROM exercises done. Staples to @ side of head CDI. Pt tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. will cont. to monitor. [redacted] MA
	(1630) Pt OOB to amb in hallway. ROM exercises being done c̄ @ arm while amb. Tol. well. Ø c/o pain. monitoring. [redacted] MA
11NOV03	VSS. Pt c/o scrotal pain. VO for Tylenol 650mg. Pt amb on floor. Tolerated well. Sat up in chair. Pt request to sleep in chair 2° ↓ scrotal pain. Pt sleeping in Room in chair. Appears to be comfortable. Pt has sutures to (L) side of head. Sutures well-approximated c̄ ⊖ s/sx of infections. Pt has ↓ strength in (R) UE compared to (L) UE. Pt needs to assist (R) side in mvmt. [redacted]
11NOV03	(0830) Assumed care @ 0600. Pt alert, speaking few words in Arabic. VSS. Ø c/o pain. Pt OOB to amb in hallway while doing ROM exercises c̄ @ arm. ROM cont. to improve. Pt able to lift @ arm above head and move fingers. ↑ in chair @ this time. Staples to @ side of head CDI s̄ s/sx infection. Tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place while in bed. Ø [redacted]

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[redacted]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13NOV03@1500	Assumed care of pt. @ 0600. V.S.S., A&O x 3, Ø c/o pain. Incision to (L) side of head, edges well approximated, Ø drainage, staples removed yesterday. Pt. ambulates well in hallway, steady gait. Slight weakness noted to (R) UE. Pt. performed (R) UE excercises. Pt. demonstrates correct use of I.S., lungs clear bilaterally. Urinal at bedside, clear dark yellow urine. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. [redacted] (b)(6)-2
13NOV03 2000	VSS alert + oriented. Denies pain, discomfort N/V @ this time. Incision to (L) side of head edges well approximated. Up ad lib c steady gait. Consumed 80% of dinner. Perfm (R) arm exercise properly. Wanting to know when will leave to Return to Camp. 2+ extra applied without compromising circulation or skin integrity. Will continue care as planned. [redacted] (b)(6)-2
14NOV03	(1210) Assumed care @ 0600. Pt alert, not speaking words clearly. Able to verbalize needs c gestures. VSS Ø c/o pain. Amb in hallway s difficulty ↑ to chair. Performs arm ROM exercises c (R) arm. Incision to scalp CDI. Tol. reg diet well. voiding s difficulty. 2-point restraints in place s s/sx complications. Will continue to monitor. [redacted] (b)(6)-2

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USAPA V

[redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11NOV03 (0930)	(cont) complications. Will cont. to monitor. [redacted] MA
12NOV03@ 0045	VSS. Pt ⊖ c/o pain. ⊕ ~~staples~~ Staples on (L) side head well approximated, ⊖ s/sx of infection. Pt still unable to verbalize wants + needs. Uses hand motions ~~to~~ + gestures to make needs known. (R) weakness. Pt uses (L) hand to move (R) hand. Pt able to amb ō steady gait. ~~&~~ Urinates ⊼ difficulty in urinal. Tol PO diet. Will continue to monitor. [redacted] (b)(6)-2 /AN
12NOV03	(1125) Assumed care @ 0800. Pt alert, not speaking this am. VSS. ⊖ c/o pain. Pt OOB to amb in hallway ⊼ difficulty. ROM to (R) arm done by pt. ROM cont. to improve. Staples to scalp dlcd by MD. Incision CDI. Tol reg diet well. Voiding ⊼ difficulty. 2 point restraints in place ⊼ s/sx complications. Will cont. to monitor [redacted] (b)(6)-2 MA
12NOV.03 1930	Pt resting in bed, A+Ox3, VSS, encouraged (R) arm exercising, (R) side of head incision CDI, consumed 90% of diet, voiding ⊼ difficulties to urinal, 2 point restraint, ⊼ complications, peripheral pulses +2, equal (B), [redacted] (b)(6)-2 QIW

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		[redacted]
	LAST	FIRST	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	

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

PROGRESS NOTES
Medical Record

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[redacted] (b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

11/14/03 Neurosurgery Narrative Summary

07:53 Pt. is a twenty yo EPW Iraqi ♂ who arrived with a GSW to the head (L) fronto-temporal region. Pt. arrived 11/1/03 with an initial GCS 6T; 4 motor, 1 verbal, 1 eye opening, pupils sluggish @ 2mm in size. Entry wound on the (R) superior temporal lobe no exit wound; noted to be hemiplegic on the (R) and localizing (R). CT demonstrated an open depressed skull fracture with intraparenchymal hematoma, subarachnoid shift vian fissure blood. He underwent emergent (L) fronto temporal craniectomy (bone flap left not due to ICP). [redacted], evacuation of hematoma, bone fragments & placement of a ventricular/ICP monitor in the subdural space. He tolerated the procedure well, the JP drain was removed on POD#2 was subsequently extubated POD#4. He was subsequently transferred to ICW step-down. Post-operatively he has significantly regain function of his (R) arm/ambulating independently, he has a partial aphasia (expressive less so than receptive) which is improving.

meds: Dilantin 200mg q 8°

DIC DX: (1). (L) Penetrating Brain Injury
(2). Residual Aphasia 2° to PBI to (L) Fronto temporal Region.
(3). Mild (R) proximal UE extremity weakness (improving).

Rec: (1). Continue Dilantin x 3 months. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
	[redacted]	(6)(6)-2		

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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[redacted] (6)(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14NOV03 @2245	assumed care of pt @1800. VSS. no c/o. alert, understands English, slurred speech noted. PERRLA, slight (R) sided facial weakness noted. RUE strength < LUE, but improving; able to control RUE & (R) hand. (Performing exercises independently). Pt ↑ AMB s̄ difficulty. Tol reg diet (85% of meal), void s̄ difficulty. Plan: D/C orders noted, cont enc. independence & enc. exercises. Addendum: inclusion to (L) occipital/temporal lobe OTA, CDI. 2pt restraints on s̄ s/sx of skin/circulation compromise. Will cont. to monitor. [redacted] (b)(6)-2
15NOV03	(1205) Pt stable for d/c to camp. Ambulatory - escorted by MPs. [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

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[redacted] (b)(6)-4

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

Brief Memory OP note

11/1/03 Pre-op Dx: (L) Parietal GSW Head

0299 Post-op Dx: (L) GSW parietal, Parietal Hematoma, Premeningo

Proced: (L) Parietal Temp. Front Craniotomy

Evacuation of Hematoma, Bone Fragments

Placement of Subdural Fiberoptic Ventricular

Catheter, Subgaleal Drain

Left Bone flap out.

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

EBL: 500cc UO: 1100 Fluids: 4L Crystaloid 3000 cc 3700 NS

Comp: Ø 2U FFP

Drains: 1 P subgaleal / Subdural ventricular Catheter Fiberoptic

[redacted]

(b)(6)-2

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

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

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

PO's NOTE

[redacted]

[redacted]

2 SLs

[redacted]

PO NOMS

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

[redacted]

see translation

PO's ON WHITE FAMILY

Translation Bates page Medcom 23099:

[redacted]

(rest of translation does not make sense in Arabic)

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
11-2-03	0625		Pt received from outgoing shift, MOB ↑,
			midline (R) neck @ 6cm for external drainage
			system, bright red blood spurts, cuff ICP; 5;
			head is wrapped in gauze, ½ dollar size blood
			drainage ⊕ position scalp; Ø resp. to pain other
			than PMR; Ø movement, Ø eye opening; PERRL @ 2mm
			(R) smaller than (L); (R) # 7.5 ETT 22cm to lip,
			FiO2 40%, TV 700, RR 12, PEEP 5, PK 18-22,
			CO2 on last ABG 35.2; CTA (B) - SpO2 100%, (-)
			S/S rales, Q (L), NSR without PVCs ST wave
			Stimulated (SVS), sight MVs (Rad), MVPs 80s,
			+S1, S2, +3 pulses x 4 ext (-) edema, warm, pink
			(GCS) BS x 4 (hypo) NGT (L) nare R tube),
			(GCS) Sedy ⊕ stable, clear, yellow drainage (see flow)
			(Skin) C spine, large gauze wrapped around head c
			soiled intake (L nares) NC to (R) eye, (R) frontal
			tart, (R) fem [illegible] - BS2 not work P @ 175
			(Pmx) Mentor ICP to keep ↓ 20, CO2 (32-35) —
	800		P [illegible]
			— [redacted] (6)(6)-2
	[redacted]	973	ABG results for 0500 result, CO2 [illegible], will
			↑ RR up ↑ to obtain ↓ CO2 desired range of 30-35.
			— [redacted] (6)(6)-2
			— [redacted] (6)(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] (6)(6)-4

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
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NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
02 nov		1800	Pt. ~~jind~~ neuro surg re: spnt mnmnt. Pt. pt's left side UE flex, LE flexing, left side only, Ø response to painful stimuli, Ø purposeful movement, spnt flexing, ~~X~~m ICP 9 to 12, HR 90 to 120, [redacted] 1W/AN
3 nov 03	0300		[redacted] in to check on pt. MD notified of A line discrepancies & inability to draw blood. MD ~~of~~ c̄ NBP readings notified of ↑ temps. Tylenol ordered. Ventriculostomy repositioned @ 10 cm above EAC. Pentomyl drip ordered for pain. [redacted]
3 nov 03	0400		Pt's urine now c̄ grenish discoloration. Pt receiving propofol. Green urine known side effect. UOP adequate. Will continue to monitor. [redacted] (P) 1AW

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
11-4-2003	0650		Pt recieved from off going shift. HOSP pt nickline. [illegible] Ventric ⊘ loca abs sac; Minimal drainage; red → clear in color; ICP monitor from 10-13; Eyes PERRL 2mm ⊖ strabismus ⊖ nystagmus (in sedation); Attempts to open eyes to painful stimuli; (↑ HR noted); ⊘ retraction; spont. movement to (L) side - raises arm; wiggles leg; wiggles (R) leg; ⊘ movement noted to (R) UE [illegible] # 7½ @ 17 26cm to lip; SIMV 11; TV 700; 40%; PEEP 5; ~~CTA (B)~~ ⊖ ↓ breaths; coarse (B); sats 100% on alone setting; ⊖ cyanosis noted; minimal clear-white secretions upon oral suctioning [illegible] ST 100s-120s febrile; NIBP 100s/60s; +3 pulses, ~~sent edema~~ ⊘ edema noted [illegible] hyperactive BS noted; NT, ND; NBM to lines; foley to small ↓ o/o ↓ (sec to ↑ I/O) (Sacral) large fluid wound with large weeping; (Sacral) (R) PIC cordis; (L) PIV; foley, NBM; ABGs w/ 20% @ 100; fent @ 150 mcg/hr; prop. @ 9cc/hr; (PIV) ↓ in relation; attempt to exhibit: [redacted] (b)(6)-2
	0910		D'cd out ventric drainage system; CSF seen flowing - will record on I/O; CXR taken [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. ICU

[redacted] (b)(6)-4

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
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(b)(6)-2 whole page

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11/4/03	1100		T injection started will get ABG in 30 min; Pulled out ETT 2 cm - 25 cm @ lip. [redacted]
	1200		Extubated with RT/ Dr Wynn assisting; SpO2 100% on SFM (30%); Ø follow commands; cannot NR 15-23; SpO2 100%; HR 140; BP 110-120/60; Pt Intubated post extubation on CPAP; Ø secretion/pain medication not received. [redacted]
03 NOV 2003	1645		Pt. Pin NR/NR; Pt breathing easily; Pt sport mount; HR 130s; NR 30s-40s; SpO2 & HR 92%; ABG obtained at 40% FiO2 = PaO2 200; Interpreter in area to talk with patient

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

[redacted]

(b)(6)-2 whole page

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
5 Nov 03	1200		Initial neurosurgery w/ 9 in small to (D) side of forehead. Will continue elevate head c suction thick nasal tracheal. [redacted]
			[redacted]
6 Nov 03	0630		Pt stable throughout this shift, given 650mg Tylenol PR for 101.4 Temp & 100.4. Pt had 2 watery stools on this shift. Pt restless throughout shift, interpretor called up to try to talk to pt. Pt unable to speak but able to write, interpretor stated most of it was "gibberish". Report given to oncoming shift & pt in stable condition. [redacted]

510-112 (b)(6)-2 except for very bottom 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
			Pt recieved from off going shift; HOB P; Antbx & medication for ocular hung as order.
			Assessment as follows: [N] Pt tracks staff as they walk.
			Spont movement noted x3 extremity (Ⓛ UA, Ⓡ LA); PARRL 3mm
			~~Pt appears to be very~~ ↑ in activity level from
			yesterday & last night. Resting comfortably; [R] Clear
			BS Ⓑ (most notably Ⓛ>Ⓡ); SrO2 93% L on 1L NC;
			[C] ST 110s-120s; 90s/40s - 110s/40 MAP; +3 pulses
			x4 extremity; AFEBRILE; ⊖ JVD (Ⓛ7) RT, ND, hyperactive
			bowel sounds (GI) Foley to gravity with clear
			yellow urine; (SKIN) posterior scalp has former medic
			site - C/D/I; [LINES] Ⓡ femoral cath - NS with 20k @ 125;
			Ⓛ PIV: EKG monitor; Central movement / neurostatus; ?
			first for ↑ 4/14 (6.2/19.9) [redacted] 14/hr
			[redacted]
	1030		Nasally tracheal suction removed large amount
			of clear-yellow secretions. Repositioned patient.
			[redacted]
			[redacted]
	1300		2 units PRBC transfused. V.S/s & results;
			Pt repositioned x 2; Nasal suctioned x3
			for thick yellow secretions. EKG in sector —
			[redacted]

(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. 1203

[redacted] (b)(6)-4

NURSING NOTES
Medical Record

[redacted]

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

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

4. PROPOSED SURGICAL PROCEDURE:

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

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

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

#[redacted] (6)(6)-4
♂

(b)(6) - 2 whole page

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

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

[redacted] CPT/AN 2 Oct 03 DATE

11. POSTOPERATIVE EVALUATION:

Bowie: D&I
Dsg: C&D
LOC: Intubated
Resp:

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. ~~PRE~~ Post OPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] CPT/AN DATE: 2 Nov 03 TIME: 0006	[redacted] CPT/AN DATE: 2 Nov 03 TIME: 0223

REVERSE OF DA FORM 5179, JUN 91 USAPA V1.01

(b)(6)-2 except for very bottom

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY

3. DATE 2 Nov 03 TIME PATIENT ARRIVED IN SUITE 0007

4. PATIENT IN ROOM TIME 0007 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

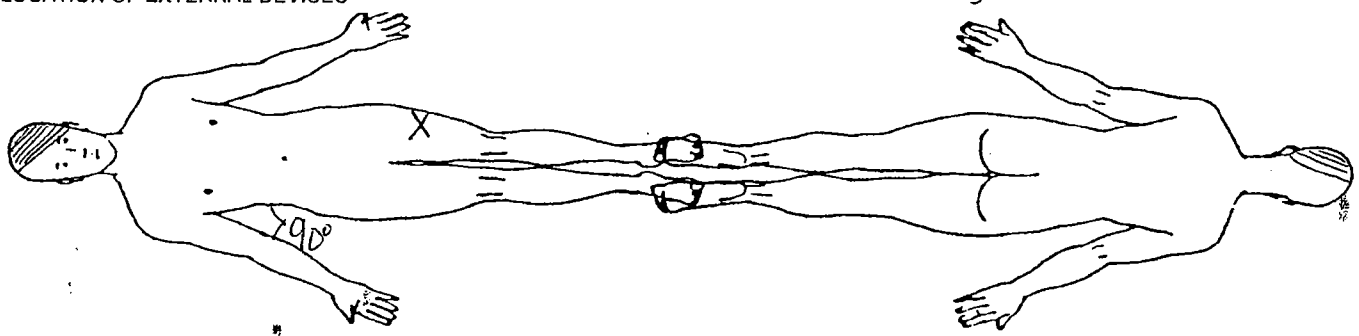
COMMENTS: Head in Mayfield headrest, (L) arm tucked at side

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine scrub/sol'n
SITE: Lt. [redacted] BY WHOM: [redacted]
SITE: BY WHOM:
COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Initial [redacted]

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

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

[redacted]

(b)(6)-4

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

☒ ESU NO: Force 40 #1 50/50
GROUND PAD: BRAND Valleylab REM
LOT NO: 68245

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☒ BIPOLAR NO: Force 40 #1

MEDCOM - 23108

(b)(6) - 2 whole page

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

Ventricular ICP Monitor
Lot #EV 235

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Xylocaine w/EPI 1:100,000	10cc	intraop	inj		[redacted]
Thrombin 20,000u		intraop	topical		↓
Surgicel		intraop	topical		↓
Bicol #AV226	X	intraop	topical		↓

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	JP Drain 10mm		
SITE	Lt head		

18. DRESSING/IMMOBILIZATION *(Specify)*
4x4
Kerlix

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: [redacted] CRNA Anesthesia Type: General

Bovie Pad site intact pre-op ✓; post-op_____ Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op_____: post-op_____
Tourniquet Time: Up____ Down_____

Watch w/pt.

20. OPERATION(S) PERFORMED
1. Evacuation of intraparenchemal hematoma

21. PATIENT TRANSFERRED TO: ICU 3 TIME: 0213 METHOD: Litter

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

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

(b)(2)-2 PACU #[redacted] (b)(6)-4

[redacted] VENTILATOR FLOW SHEET

GSW Head 8.0 ETT 26 @ 114

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
2100	0230	SIMV	12	700	100	5	23	12	123	100	137/69	7.35	39.7	288	-7	18	100	[redacted]
	0330	SIMV	12	700	50	5	25	12	100	100	—							
	0500	SIM	12	700	40	5	20	12	85	100	108/56							
	0800	SIMV	14	700	40	5	18	14	93	100	125/61							
	1000	SIMV	↑15	700	40	5	17	15	94	100	125/62							
	1330	SIMV	↓13	700	40	5	19	14	93	100	139/73							
	1600	SIMV	13	700	40	5	19	14	104	100	137/73							
	1800	SIMV	13	700	40	5	21	14	110	100	139/70							
	2000	SIMV	13	700	40	5	22	14	112	100	136/69							
	2200	SIMV	13	700	40	5	19	14	111	100	116/75							
	2330	SIMV	13	700	40	5	19	21	121	98	—							
	0140	SIMV	13	700	40	5	20	14	100	100	111/71							
	0400	SIMV	11	700	40	5	17	13	111	100	97/78							
	0500	SIMV	11	700	40	5	18	11	108	100	99/79	7.42	31.4	135	-4	21	99	
	0800	SIMV	11	700	40	5	16	15		100	104/68							
	1000	SIMV	11	700	40	5	15	16	112	100	93/64							
	1230	SIMV	11	700	40	5	21	11	94	100	87/78							
	1400	SIMV	11	700	40	5	21	11	95	100	120/68							
	1600	SIMV	11	700	40	5	18	11	94	100	81/71							
	1800	SIMV	11	700	40	5	18	11	100	100	84/71							
	2130	SIMV	11	700	40	5	20	11	100	100	101/59							
	2340	SIMV	11	700	40	5	21	11	119	100	102/55							
	0200	SIMV	11	700	40	5	19	11	112	100	91/58							
	0400	SIMV	11	700	40	5	19	11	121	100	98/55							
	0600	SIMV	11	700	40	5	21	11	110	100	97/54							
	0900				PL	extubated												
	0000							one										
	0520				RA		20		103 99%			23	Post 129	100%				[redacted] Alb neb given

(b)(6)-2

MEDCOM - 23110

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOVEMBER DAY 12 13 14 15

19 2003 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 (O)
180
170
160
150
140
130
120
110
100
90
80
70
60
50
40

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE		94/52	108/48	99/48		101/56		108/49		99/52		94/45											
				813																			
TEMP		98.0		98.5		97.5																	
HEIGHT:	WEIGHT ~~LEMT~~					98%																	
	O_2 Sat	99%	98(CA)	99%		100%		98(CA)		99%		98(CA)											
	O_2 Sat					RA				RA													
	pulse	84				78																	
	pulse																						

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

REGISTER NO.

WARD NO.

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

[redacted]

(b)(6)-4

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

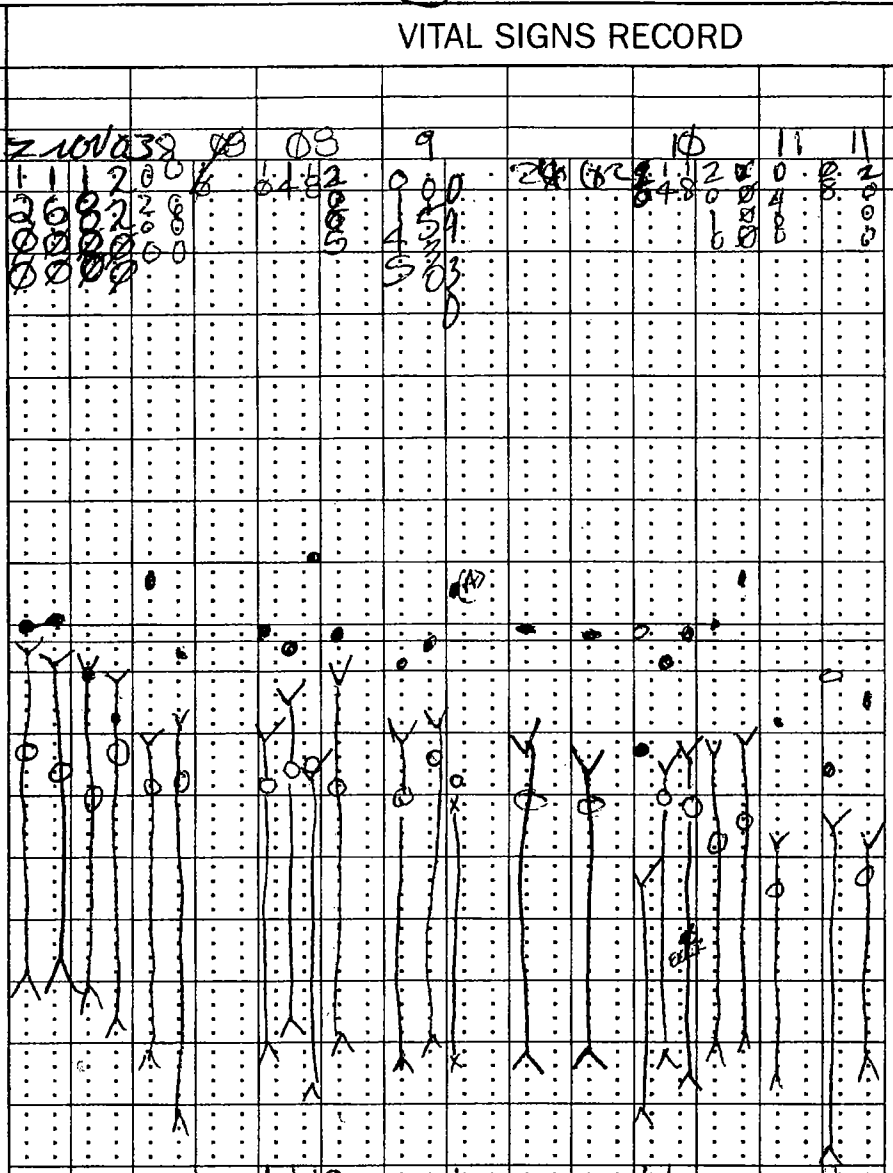
HOSPITAL DAY

POST- DAY

MONTH-YEAR NOV DAY

2003 HOUR

PULSE (0) — TEMP. F (°) — TEMP. C



(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

Pulse

HEIGHT: WEIGHT →

Temp.

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.

E #[redacted]

(b)(6)-2

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 whole page

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/02/03 08:11

Patient ID: [redacted]
Test Name :PT
Test Result:= 15.6 sec.
Ratio = 1.3
Calculated INR = 1.49
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :08:10
Card Lot :080201
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/02/03 08:14

Patient ID: [redacted]
Test Name :APTT
Test Result:= 41.9 sec.
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :08:11
Card Lot :030201
Operator [redacted]

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

REQUESTING PHYSICAN: [redacted]

DATE	TIME	SSN/PEEUDO SSN:
11-2-03	0812	

Urinalysis

RESULT	REF. RANGE
	N/A
	N/A
	Negative
	Negative
	Negative
	N/A
	Negative
	N/A
	Negative
	0.2-1.0
	Negative
	Negative
	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

CSF

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

n		Negative	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.:

4 Ur. 18-1

(b)(6)-2

Ward/Section: 1C03	REQUESTING PHYSICAN: [redacted] (b)(6)-4	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted]	DATE 11-2-03 / TIME 8:00	SSN/PEEUDO SSN:

EG6+

Pt: [redacted]

Pt Name:_____

Na_____141 mmol/L

K_____3.5 mmol/L

TCO2_____26 mmol/L

Hct_____20 %PCV

Hb*_____7 g/dL

*via Hct

At 37C

pH_____7.417

PCO2_____38.7 mmHg

PO2_____173 mmHg

HCO3_____25 mmol/L

BEecf_____0 mmol/L

sO2*_____100 %

*calculated

At Patient Temp

pH_____7.418

PCO2_____38.5 mmHg

PO2_____173 mmHg

Patient Temp: 98.4F

FIO2_____: 40

Sample Type_:

02NOV03 08:08

Oper: [redacted]

Physician:

Ser# [redacted]

Ver: [redacted]

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
LB		3.5-5.5 g/dl
LP		26-84 u/l
LT		10-47 u/l
MY		14-97 u/l
ST		11-38 u/l
BIL		0.2-1.6 mg/dl
UN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
HOL		100-200 mg/dl
RE		0.6-1.2 mg/dl
LU		73-118 mg/dl
P		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
LU		73-118 mg/dl
UN		7-22 mg/dl
RE		0.6-1.2 mg/dl
K		39-380 /l (M) 30-190 /l (F)
A^+		128-145 mmol/l
$^+$		3.3-4.7 mmol/l
L^-		98-108 mmol/l
CO2		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

DATE: | LAB ID NO.:

402 101.1

(b)(6)-4

Ward/Section [redacted]	REQUESTING PHYSICAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 11-2-03 / TIME 1645	SSN/PEEUDO SSN:

Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Color		N/A	RPR		Negative
App		N/A	Mono		Negative
Glu		Negative	**Microbiology**		
Bili		Negative	Source		
Ket		Negative	Gram Stain		
SG		N/A	Occ Bld		Negative
Bld		Negative	H. pylori		Negative
pH		N/A	Micro Parasites		
Prot		Negative	Malaria		
Urob		0.2-1.0	O & P		
Nit		Negative	Other		
Leuk		Negative	**Macroscopic Urinalysis**		
HCG		Negative			

			CSF			Blood Bank	
Spun Hematocrit		42-52%(M) 37-47%(F)					
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.:

Thu 10/21

i-STAT EG6+

Pt: [redacted]

Pt Name:_____

Na_____143 mmol/L
K_____3.7 mmol/L
TCO2_____28 mmol/L
Hct_____23 %PCV
Hb*_____8 g/dL
*via Hct

At 37C
PH_____7.492
PCO2_____34.6 mmHg
PO2_____159 mmHg
HCO3_____26 mmol/L
BEecf_____3 mmol/L
sO2*_____100 %
*calculated

At Patient Temp
PH_____7.471
PCO2_____36.8 mmHg
PO2_____167 mmHg

Patient Temp: 101.1F
FIO2_____: 40
Sample Type_:

08NOV03 16:53
Oper: [redacted]
Physician:_____
Ser# [redacted]
Ver: [redacted]

REQUESTING PHYSICAN:

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

DATE	TIME	SSN/PEEUDO SSN:

(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

REPORTED BY:	DATE:	LAB ID NO.:

402 101.1

Ward/Section: 1C03	REQUESTING PHYSICAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted] (b)(6)-4	DATE 11-2-03 / TIME 1645	SSN/PEEUDO SSN: 1451

[redacted]

[redacted] 02-11-03
MD 16:54

			Patient Limits	
WBC	10.8 H	x10^3/uL	4.5	10.5
RBC	2.99 L	x10^6/uL	4.00	6.00
Hgb	8.0 L	g/dL	11.0	18.0
Hct	25.2 L	%	35.0	60.0
MCV	84.4	fL	80.0	99.9
MCH	26.8 L	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	130. L	x10^3/uL	150.	450.
LYM%	14.7 ML	%	20.5	51.1
LYM	1.6 *	x10^3/uL	1.2	3.4

Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Color		N/A	RPR		Negative
App		N/A	Mono		Negative
Glu		Negative	**Microbiology**		
Bili		Negative	Source		
Ket		Negative	Gram Stain		
SG		N/A	Occ Bld		Negative
Bld		Negative	H. pylori		Negative
pH		N/A	Micro Parasites		
Prot		Negative	Malaria		
Urob		0.2-1.0	O & P		
Nit		Negative	Other		
Leuk		Negative	**Macroscopic Urinalysis**		
HCG		Negative			

			CSF			Blood Bank	
Spun Hematocrit		42-52%(M) 37-47%(F)	Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Set Rate			Directigen		Negative	ABO/Rh	
Other							

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

TESTING PHYSICIA[redacted]

CHEMISTRY RESULT FORM
Subject to the Privacy Act of 1974)

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

DATE 11-4-03 TIME 1400

SSN/PSEUDO SSN:

101.5
402

(i-STAT)

i-STAT EG6+

Pt: [redacted]

Pt Name:_____

Na_____138 mmol/L
K_____3.3 mmol/L
TCO2_____26 mmol/L
Hct_____22 %PCV
Hb*_____7 g/dL
*via Hct

At 37C
PH_____7.534
PCO2_____29.3 mmHg
PO2_____211 mmHg
HCO3_____25 mmol/L
BEecf_____2 mmol/L
SO2*_____100 %
*calculated

At Patient Temp
PH_____7.509
PCO2_____31.4 mmHg
PO2_____219 mmHg

Patient Temp: 101.5F
FIO2_____: 40
Sample Type_:

04NOV03 16:27

Oper: [redacted]

Physician:_____

Ser# [redacted]
Ver: [redacted]

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

DATE: [redacted] 4/11/03

LAB ID NO.:

100.7 4 (6)(6)-2

Ward/Section: 1C03	REQUESTING PHYSICIAN: [redacted]	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] (6)(6)-4	DATE 11-4-03	TIME 13 00	SSN/PSEUDO SSN:

i-STAT EQC-

Pt: [redacted]

Pt Name:_____

Na_____139 mmol/L

K_____3.5 mmol/L

TCO2_____24 mmol/L

_____20 %PCV

_____7 g/dL

Hct

At 37C

PH_____7.503

PCO2_____29.4 mmHg

PO2_____95 mmHg

HCO3_____23 mmol/L

BEecf_____0 mmol/L

SO2*_____98 %

*Calculated

Sample Type_:

04NOV03 13:09

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver:

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

F-Dx 75% 35.1 EGT, Chem, PT/PTT

Ward/Section:

REQUESTING PHYSICIAN

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

DATE 02 Nov 03 TIME 0030

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

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymph		
(Hem		
Segs		

ID: [redacted] 02-11-03
AHB 00:39

			Patient Limits	
WBC	32.3 H	x10^3/uL	4.5	10.5
RBC	4.02	x10^6/uL	4.00	6.00
Hgb	10.7 L	g/dL	11.0	18.0
Hct	34.3 L	%	35.0	60.0
MCV	85.2	fL	80.0	99.9
MCH	26.7 L	pg	27.0	31.0
MCHC	31.4 L	g/dL	33.0	37.0
Plt	194.	x10^3/uL	150.	450.
LY%	9.4	%	20.5	51.1
LYM	3.0	x10^3/uL	1.2	3.4

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Pct		Negative
S		N/A
d		Negative
f		N/A
ot		Negative
ob		0.2-1.0
		Negative
		Negative
		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

CSF

t		
ligen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

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

UNIT	TIPE	CROSSMATCH

E: 10/03

LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/02/03 00:42
Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 17.1 sec.
Ratio:= 1.4
Calculated INR = 1.73
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :00:39
Card Lot :080201
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/02/03 00:46
Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 35.2 sec.
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :00:43
Card Lot :030201
Operator [redacted] (b)(6)-2

pH 7.387
pCO_2 35.6
pO_2 450
BExcf -4
HCO_3 21
TCO_2 22
SO_2% 100
Na 141
K 2.8
Hct 30
Hb 10

Ward/Section: ER | REQUESTING [redacted] (b)(6)-2

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

LAST, FIRST, MI: [redacted] (b)(6)-4 | DATE: 1 Nov | TIME | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
MIC		
Plt		
Lymp		
(H		
Segs		
Bands		
Lymph		
Atyp		Imm

ID: [redacted]
MB
01-11-03
23:44

			Patient Limits	
WBC	32.0 H	x10^3/uL	4.5	10.5
RBC	4.27	x10^6/uL	4.00	6.00
Hgb	11.3	g/dL	11.0	18.0
Hct	35.8	%	35.0	60.0
MCV	83.7	fL	80.0	99.9
MCH	26.4 L	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	299.	x10^3/uL	150.	450.
LY%	....	%	20.5	51.1
LY#	----	x10^3/uL	1.2	3.4

Urinalysis

TEST	RESULT	REF. RANGE
Color	yel	N/A
App	clr	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.010	N/A
Bld	sm	Negative
pH	7.5	N/A
rot	neg	Negative
rob	neg	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		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

CSF

t		
igen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh: A pos

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

UNIT	TYPE	CROSSMATCH

LAB ID NO.: [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/01/03 23:50

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 16.3 sec.
Ratio = 1.3
Calculated INR = 1.60
Sample Type:citrated wh. blood
Test Date :11/01/03
Test Time :23:48
Card Lot [redacted] (b)(6)-2
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/01/03 23:52

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 20.9 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/01/03
Test Time :23:50
Card Lot [redacted] (b)(6)-2
Operator [redacted]

(b)(6)-2

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

Ward/Section: ER	REQUESTING PHYSICIAN: [redacted]	
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 2 Nov 03 · TIME:	SSN/PSEUDO SSN:

(i-STAT) | **(Piccolo) Chemistry 12** | **(Piccolo) Metabolic Panel**

TEST	RESULT	REF. RANGE
Na		138-146 mmo
K		3.5-4.9 mmol/
Cl		98-109 mmol/
pH		7.31-7.45
PCO2		35-45 mmHg (41-51 mmHg (v
PO2		80-105 mmHg (N/A (ven)
TCO2		23-27 mmol/L (24-29 mmol/L (
HCO3		22-26 mmol/L (23-28 mmol/L (
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmo
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

```
======= PICCOLO =======
01/11/03          23:47
REFERENCE RANGE:     MALE
PATIENT #: [redacted] (b)(6)-4
LIVER PANEL PLUS
DISC LOT #:       3153AA7
OPER #: [redacted]    DR #: 000
SERIAL #: [redacted]
..........................
ALB    3.6    3.3-5.5    G/DL
ALP    52     26-84      U/L
ALT    13     10-47      U/L
AMY    31     14-97      U/L
AST    20     11-38      U/L
TBIL   0.6    0.2-1.6    MG/DL
GGT    <5*    5-65       U/L
TP     6.0*   6.4-8.1    G/DL

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

```
======= PICCOLO =======
01/11/03          23:44
REFERENCE RANGE:     MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #:       3151AA4
OPER #: [redacted]    DR #: 000
SERIAL #: [redacted]
..........................
GLU   217*   73-118    MG/DL
BUN   12     7-22      MG/DL
CRE   1.2    0.6-1.2   MG/DL
CK    127    39-380    U/L
NA+   128    128-145   MMOL/L
K+    3.7    3.3-4.7   MMOL/L
CL-   102    98-108    MMOL/L
tCO2  20     18-33     MMOL/L

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

Ward/Section [redacted]	REQUESTING PHYSICAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: 1003	DATE: 11/2/03 TIME	SSN/REF ID/SSN:

(Hematology) CBC			Urinalysis					
TEST	RESULT	REF. RANGE	TEST	RESULT	REF.			F. RANGE
			r		N/A			ative
					N/A			ative
					Negati			
					Negati			
					Negati			
					N/A			egative
					Negati			egative
					N/A			
					Negati			
			b		0.2-1.0			
					Negati			
			k		Negati			lysis
			G		Negati			

ID: [redacted] 02-11-03
WB 02:58

			Patient Limits	
WBC	23.5 H	x10^3/uL	4.5	10.5
RBC	3.34 L	x10^6/uL	4.00	6.00
Hgb	9.8 L	g/dL	11.0	18.0
Hct	28.4 L	%	35.0	60.0
MCV	85.1	fL	80.0	99.9
MCH	26.4 L	pg	27.0	31.0
MCHC	31.1 L	g/dL	33.0	37.0
Plt	181.	x10^3/uL	150.	450.
LY%	....	%	20.5	51.1
LY#	----	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/02/03 03:01

(b)(6)-4

Patient ID: [redacted]
Test Name :PT
Test Result:= 15.8 sec.
Ratio = 1.3
Calculated INR = 1.52
Sample Type:citrated wh. blood
Test Date :11/03/03
Test Time :03:00
Card Lot :080201
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/02/03 03:04

(b)(6)-4

Patient ID: [redacted]
Test Name :APTT
Test Result:= 29.3 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :03:01
Card Lot :030201
Operator [redacted] (b)(6)-2

CSF			Blood Bank	
r			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
tigen		Negative	ABO/Rh	

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)					
			UNIT	TYPE	CROSSMATCH
APTT		21-34 SESS			
D dimer		<20 ug/ml			
FDP		< 10 ug /ml			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

DRG T 94.5

(b)(6) - 4 whole page

Ward/Section:	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE / TIME	SSN/PEBUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	142	138-146 mmol/dL
K	3.4	3.5-4.9 mmol/L
CI		98-109 mmol/L
pH	7.375	7.31-7.45
PCO2	30.7	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	288	80-105 mmHg (art) N/A (ven)
TCO2	19	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	18	22-26 mmol/L (art) 23-28 mmol/L (art)
SO2	100	95-98%
BEecf	-7	(-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	25	38-51% PCV
Hgb	9	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======
02/11/03 02:56
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	213*	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	173	39-380	U/L
NA+	128	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	109*	98-108	MMOL/L
tCO2	17*	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

======= PICCOLO =======
02/11/03 02:59
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3153AA7
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.7*	3.3-5.5	G/DL
ALP	43	26-84	U/L
ALT	11	10-47	U/L
AMY	37	14-97	U/L
AST	22	11-38	U/L
TBIL	1.7*	0.2-1.6	MG/DL
GGT	9	5-65	U/L
TP	4.4*	6.4-8.1	G/DL

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: 1CW3	REQUESTING PHYSICAN: [redacted] (6)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST,MI [redacted] (6)(6)-4	DATE 11/7/03	TIME 0535	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 fl(M) 81-99 fl(F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10³ 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		
					0.2-1.0	O & P		
					Negative	Other		
					Negative	**Macroscopic Urinalysis**		
					Negative			

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

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

UNIT	TYPE	CROSSMATCH

E: LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/02/03 05:41
Patient ID: [redacted] (6)(6)-4
Test Name :PT
Test Result:= 15.2 sec.
Ratio = 1.2
Calculated INR = 1.43
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :05:40
Card Lot :080201
Operator : [redacted] (6)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/02/03 05:44
Patient ID: [redacted] (6)(6)-4
Test Name :APTT
Test Result:= 26.2 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :05:42
Card Lot :030201
Operator : [redacted] (6)(6)-2

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
CI		98-109 mmol/L
pH	7.433	7.31-7.45
PCO2	35.2	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	169	80-105 mmHg (art) N/A (ven)
TCO2	24	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	23	22-26 mmol/L (art) 23-28 mmol/L (art)
SO2	100	95-98%
BEecf	-1	(-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.:
[redacted]	2Nov03	

(b)(6)-2

Ward/Section: ICU 3	REQUESTING PHYSICAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. #[redacted] (b)(6)-4	DATE 11/2/03 TIME 0620	SSN/PEEUDO SSN:

(Hematology) CBC

(b)(6)-4

ID [redacted] 02-11-03
NB 06:19

			Patient Limits	
WBC	12.1 H	x10^3/uL	4.5	10.5
RBC	2.85 L	x10^6/uL	4.00	6.00
Hgb	7.6 L	g/dL	11.0	18.0
Hct	24.2 L	%	35.0	60.0
MCV	84.7	fL	80.0	99.9
MCH	26.6 L	pg	27.0	31.0
MCHC	31.4 L	g/dL	33.0	37.0
Plt	127. L	x10^3/uL	150.	450.
LYM%	....	%	20.5	51.1
LYM#	-----	x10^3/uL	1.2	3.4

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

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

CSF

Cell Count			
Directigen		Negative	

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted] (b)(6)-2		**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 11/4/03	TIME 104-	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE

```
i-STAT EG6+
Pt: [redacted]
Pt Name:___________

Na__________140 mmol/L
K___________3.3 mmol/L
TCO2________26 mmol/L
[redacted]
 *via Hct

 37C
pH_______7.483
PCO2______33.3 mmHg
PO2________159 mmHg
HCO3________25 mmol/L
BEecf________1 mmol/L
sO2*_______100 %
 *calculated

At Patient Temp
pH_______7.465
PCO2______35.0 mmHg
PO2________166 mmHg

Patient Temp: 100.7F
FIO2________: 40
Sample Type_: ART

 04NOV03      10:57
Oper: [redacted]

Physician:_____________

Ser# [redacted]
Ver:
______________________
```

(b)(6)-4

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

ICU 2

[redacted]	DATE: 4Nov03	LAB ID NO.:

(b)(6)-2

Ward/Section:	REQUESTING PHYSICIAN:			LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.		DATE	TIME	SSN/PSEUDO SSN:

ANGE	Urinalysis			Misc. Serology		
	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
10^3	Color		N/A	RPR		Negative
10^9	App		N/A	Mono		Negative
(M) (F)	Glu		Negative	**Microbiology**		
	Bili		Negative	Source		
	Ket		Negative	Gram Stain		
	SG		N/A	Occ Bld		Negative
	Bld		Negative	H. pylori		Negative
ntial	pH		N/A	Micro Parasites		
	Prot		Negative	Malaria		
	Urob		0.2-1.0	O & P		
	Nit		Negative	Other		
	euk		Negative	**Microscopic Urinalysis**		
	ICG		Negative			

CSF			Blood Bank	
Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Directigen		Negative	ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

ATE: LAB ID NO.:

(6)(6)-4

ID: [redacted] 03-11-03 04:46
UD

			Patient Limits	
WBC	11.2 H	x10^3/uL	4.5	10.5
RBC	3.09 L	x10^6/uL	4.00	6.00
Hgb	8.3 L	g/dL	11.0	18.0
Hct	25.9 L	%	35.0	60.0
MCV	83.7	fL	80.0	99.9
MCH	26.9 L	pg	27.0	31.0
MCHC	32.2 L	g/dL	33.0	37.0
Plt	123. L	x10^3/uL	150.	450.
LY%	16.9 WL	%	20.5	51.1
LYM	1.9 *	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/03/03 04:44

Patient ID: [redacted] (6)(6)-4
Test Name :PT
Test Result:= 14.1 sec.
Ratio = 1.2
Calculated INR = 1.26
Sample Type:citrated wh. blood
Test Date :11/03/03
Test Time :04:43
Card Lot : [redacted] (6)(6)-2
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/03/03 04:47

Patient ID: [redacted] (6)(6)-4
Test Name :APTT
Test Result:= 43.7 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/03/03
Test Time :04:45
Card Lot : [redacted] (6)(6)-2
Operator : [redacted]

Ward/Section: ICU3

REQUESTING PHYSICIAN: [redacted] (6)(6)-2

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

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

SSN/PSEUDO SSN:

(i-STAT)

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____110 mg/dL
BUN_____4 mg/dL
Na_____144 mmol/L
* K_____3.0 mmol/L
Cl_____108 mmol/L
TCO2_____25 mmol/L
AnGap_____15 mmol/L
Hct_____20 %PCV
Hb*_____7 g/dL
*via Hct
pH_____7.427
PCO2_____35.9 mmHg
HCO3_____24 mmol/L
BEecf_____-1 mmol/L

Sample Type_:

03NOV03 04:46

Oper: [redacted]

Physician:_____

Ser# [redacted]
Ver: [redacted]

not enough sample

i-STAT CREA

Pt: [redacted]

Pt Name:_____

Crea_____1.0 mg/dL

Sample Type_:

03NOV03 04:47

Oper: [redacted]

Physician:_____

Ser# [redacted]
Ver: [redacted]

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Metlyte 8

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

(Piccolo) Electrolyte

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

REMARKS:

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

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
#[redacted] (b)(6)-4	11/4/03		

(Hematology) CBC

TEST	RESULT	REF. RANGE

(b)(6)-4

ID: [redacted]
WB 04-11-03 04:24

				Patient Limits	
WBC	9.3		x10^3/uL	4.5	10.5
RBC	2.79	L	x10^6/uL	4.00	6.00
Hgb	7.4	L	g/dL	11.0	18.0
Hct	23.9	L	%	35.0	60.0
MCV	85.5		fL	80.0	99.9
MCH	26.6	L	pg	27.0	31.0
MCHC	31.1	L	g/dL	33.0	37.0
Plt	143.	L	x10^3/uL	150.	450.
LYM	14.2	HL	%	20.5	51.1
LYM	1.3	*	x10^3/uL	1.2	3.4

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
		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

CSF

		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/04/03 04:15

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 13.5 sec.
Ratio = 1.1
Calculated INR = 1.18
Sample Type:citrated wh. blood
Test Date :11/04/03
Test Time :04:14
Card Lot [redacted] (b)(6)-2
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] /04/03 04:20

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 38.3 sec.
Sample Type:citrated wh. blood
Test Date :11/04/03
Test Time :04:17
Card Lot [redacted] (b)(6)-2
Operator [redacted]

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

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

(i-STAT)

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

Misc. Chemistry

TEST	*RESULT*	*REF. RANGE*
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	*RESULT*	*REF. RANGE*
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		
N		
K+		
CL		
tCC		

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	*RESULT*	*REF. RANGE*
+		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

======= PICCOLO =======
04/11/03 04:14
REFERENCE RANGE: MALE
PATIENT #: [redacted] (6)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	115	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	843*	39-380	U/L
NA+	130	128-145	MMOL/L
K+	3.4	3.3-4.7	MMOL/L
CL-	106	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

REMARKS:

REPORTED BY:	**DATE**

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

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted] (b)(6) -2		SSN/PSEUDO SSN:
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 5 Nov 03	TIME 0430	

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
pp		N/A
u		Negative
i		
t		
b		

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

d		Negative
ri		Negative
es		

Microscopic Urinalysis

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/05/03 05:27
(b)(6)-4
Patient ID: [redacted]
Test Name :PT
Test Result:= 13.5 sec.
Ratio = 1.1
Calculated INR = 1.18
Sample Type:citrated wh. blood
Test Date :11/05/03
Test Time :05:26
Card Lot [redacted] (b)(6)-2
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] /05/03 05:30
(b)(6)-4
Patient ID: [redacted]
Test Name :APTT
Test Result:= 40.5 sec.
Sample Type:citrated wh. blood
Test Date :11/05/03
Test Time :05:27
Card Lot [redacted] (b)(6)-2
Operator [redacted]

Blood Bank

SUBMIT SF 518 WITH EVERY UNIT REQUESTED

igen		Negative	ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

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

(b)(6)-4

[redacted]

(b)(6)-2

REQUESTING PHYSICAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

(b)(6)-4

DATE	TIME	SSN/PEEUDO SSN:
11-5-03	1330	

CBC

	REF. RANGE
	4.8-10.8 x10
	4.7-6.1 x10
	14-18 g/dl(M) 12-16 g/dl(F)
	42-52%(M) 37-47%(F)
	80-94 fl(M) 81-99 fl(F)
	130-500 x10³ verified
	20.5-51.1%

ual 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.:

Ward/Section: ICU 3

TESTING PHYSICIAN: [redacted] (b)(6)-2

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

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

DATE: 5 Nov 03 | TIME: 0430 | SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		
AST		
TBIL		
BUN		
CA^{++}		
CHOL		
CRE		
GLU		
TP		

(Piccolo) Met

TEST	RESULT
GLU	
BUN	
CRE	
CK	
NA^+	
K^+	
CL^-	
tCO_2	

(Piccolo) Metabolic Panel

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

Panel Plus

	REF. RANGE
	3.3-5.5 g/dl
	26-84 u/l
	10-47 u/l
	14-97 u/l
	11-38 u/l
	0.2-1.6 mg/dl
	5-65 u/l
	5.4-8.1 g/dl

trolyte

	REF. RANGE
	128-145 mmol/l
	3.3-4.7 mmol/l
	98-108 mmol/l
	18-33 mmol/l

```
======= PICCOLO =======
05/11/03          05:06
REFERENCE RANGE:     MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #:        3151AA4
OPER #: [redacted]  DR #: 000
SERIAL #: [redacted]
.........................
GLU   195*  73-118   MG/DL
BUN     6*  7-22     MG/DL
CRE   0.8   0.6-1.2  MG/DL
CK   4142*  39-380   U/L
NA+   130   128-145  MMOL/L
K+    4.1   3.3-4.7  MMOL/L
CL-   105   98-108   MMOL/L
tCO2   23   18-33    MMOL/L

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU 3	REQUESTING PHYSICAN: (b)(6)-2 [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 6 Nov 03 / TIME 0430	SSN/PEEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
R		
H		
H		
M		
I		
I		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		
Bld		
pH		
Prot		
Urob		
Nit		
Leuk		
HCG		
Cell Count		
Directigen		

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source	
Gram	

Other

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/06/03 05:44

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 12.9 sec.
Ratio = 1.1
Calculated INR = 1.09
Sample Type:citrated wh. blood
Test Date :11/06/03
Test Time :05:43
Card Lot [redacted] (b)(6)-2
Operator :

Coagulation Studies

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

(MUST SU

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/06/03 05:52

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 32.2 sec.
Sample Type:citrated wh. blood
Test Date :11/06/03
Test Time :05:49
Card Lot [redacted]
Operator [redacted] (b)(6)-2

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		
AST		
TBIL		
BUN		
CA+		
CHO		
CRE		
GLU		
TP		
TES		
GLU		
BUN		
CRE		
CK		
NA+		
K+		
CL-		
tCO2		

(Piccolo) Metabolic Panel

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

Piccolo) Liver Panel Plus

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

Piccolo) Electrolyte

	RESULT	REF. RANGE
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

======= PICCOLO =======
06/11/03 05:19
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
BASIC METABOLIC
DISC LOT #: 3325AM
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	140*	73-118	MG/DL
BUN	7	7-22	MG/DL
CA++	7.9*	8.0-10.3	MG/DL
CRE	0.7	0.6-1.2	MG/DL
NA+	137	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	109*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

REMARKS:

REPORTED BY: DATE:

Ward/Section: ICUS	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE 7NOV03 / TIME 0900	SSN/PEEUDO SSN:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/07/03 05:01

Patient ID: [redacted] (b)(6)-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 :11/07/03
Test Time :05:00
Card Lot [redacted] (b)(6)-2
Operator :

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/07/03 05:04

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 33.9 sec.
Sample Type:citrated wh. blood
Test Date :11/07/03
Test Time :05:01
Card Lot : [redacted] (b)(6)-2
Operator [redacted]

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		
Glu		
Bili		
Ket		
SG		
Bld		
pH		
Prob		
Nit		
Leuk		
ICG		

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
		Negative
		Negative
		Negative

ID: [redacted] (b)(6)-4
WB 07-11-03 04:55

			Patient Limits	
WBC	10.0	x10^3/uL	4.5	10.5
RBC	2.86 L	x10^6/uL	4.00	6.00
Hgb	7.7 L	g/dL	11.0	18.0
Hct	24.7 L	%	35.0	60.0
MCV	86.5	fL	80.0	99.9
MCH	26.9 L	pg	27.0	31.0
MCHC	31.1 L	g/dL	33.0	37.0
Plt	286.	x10^3/uL	150.	450.
LY%	21.1 *	%	20.5	51.1
LY#	2.1 *	x10^3/uL	1.2	3.4

biology

opic Urinalysis

ood Bank

ell ount

MIT SF 518 WITH HT REQUESTED

rectigen		Negative	ABO/Rh	

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

			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.:

W

L

i-STAT EG6+

Pt: [redacted]

Pt Name:_____

Na_____138 mmol/L
K_____3.6 mmol/L
TCO2_____29 mmol/L
Hct_____23 %PCV
Hb*_____8 g/dL
*via Hct

At 37C
pH_____7.395
PCO2_____45.3 mmHg
PO2_____54 mmHg
HCO3_____28 mmol/L
BEecf_____3 mmol/L
SO2*_____87 %
*calculated

Sample Type_:

07NOV03 04:51

Oper: 0

Physician:_____

Ser# [redacted]
Ver: [redacted]

FING PHYSICAN:

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

	DATE	TIME	SSN/PEEUDO SSN:

(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		
AST		
TBIL		
BUN		
CA++		
CHOL		
CRE		
GLU		
TP		

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
GLU		3.3-5.5 g/dl
TP		26-84 u/l
		10-47 u/l
		14-97 u/l
		11-38 u/l
		0.2-1.6 mg/dl
		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

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

======= PICCOLO =======
11/07/03 16:0= AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (6)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	130*	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	1394*	39-380	U/L
NA+	♦♦♦	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	95*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

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

REPORTED BY: DATE: LAB ID NO.:

[redacted] (b)(2)-2

Baghdad, Iraq

Microbiology Request Form

Last Name

First Name:

Patient # or SSN: [redacted] (b)(6)-4

Collected by: [redacted] (b)(6)-2

Date: 03NOV03

Time: 2215

Ward: ICU3

Room:

Bed: 4

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

Source: urine

Site:

[redacted]

Received by: [redacted] (b)(6)-2

Date: 3NOV03

Time: 2237

Specimen #: [redacted]

Laboratory Results

No Growth

Reported

Date: 4NOV 03

Time: 1000

Tech: [redacted]

Reviewer: [redacted]

Number of attached sheets:

MEDCOM - 23141

[redacted] (b)(2)-2

Baghdad, Iraq

Microbiology Request Form

Last Name

First Name:

Patient # or SSN: #[redacted] (b)(6)-4

Collected by: [redacted] (b)(6)-2

Date: 03NOV03

Time: 2215

Ward: ICU3

Room:

Bed: 4

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

Source: urine

Site:

[redacted]

Received by: SGT [redacted] (b)(6)-2

Date: 3NOV03

Time: 2237

Specimen #: [redacted]

Laboratory Results

No Growth

Reported

Date: 4NOV 03

Time: 1000

Tech: [redacted]

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

Number of attached sheets:

MEDCOM - 23142

(b)(2)-2

[redacted]

Baghdad, Iraq

Microbiology Request Form

Last Name

First Name:

Patient # or SSN: [redacted] (b)(6)-4

Collected by: [redacted] (b)(6)-2

Date: 03NOV03

Time: 2230

Ward: ICU3

Room:

Bed: 4

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

Source: [redacted] ~~(R) Femoral cordis~~ blood

Site: (R) Femoral cordis

[redacted]

Received by: SGT [redacted] (b)(6)-2

Date: 3 NOV03

Time: 2237

Specimen #: [redacted]

Laboratory Results

Kluyvera ascorbata

Reported

Date: 7Nov03

Time: 1040

Tech [redacted]

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

Number of attached sheets:

MEDCOM - 23143

Microbiology Report

[redacted] (b)(2)-2

Name: [redacted] (b)(6)-4
Patient ID:
Ward/Rm: U3/

Specimen: [redacted]
Source: Blood
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1 Kluyvera ascorbata Status: Final

1 K. ascorbata

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	>16/8	R			
Amp/Sulbactam (c)	>16/8	R			
Ampicillin	>16	R			
Aztreonam	<=8	S			
Cefazolin	>16	R			
Cefepime	<=8	S			
Cefotaxime (c)	<=8	S			
Cefotetan	<=16	S			
Cefoxitin	>16	R			
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	<=4	S			
Ticar/K Clav (a)	64	I			
Tobramycin	<=4	S			
Trimeth/Sulfa	<=2/38	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:
Patient ID: [redacted] (b)(6)-4
Ward/Rm: U3/

Specimen: [redacted]
Source: Blood
Ward of Iso:

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

Printed 11/7/2003 8:32:50 AM

Tech: [redacted]

- GSW to Parie → Lobe

- Allergies ?
- Unknown medical Hx
- PSH ?

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)														TOTALS	TOTAL EBL
Fentanyl (mcg)		100	50	100										250	500
UCB (mg)		6	6			2		2						16	
( )															TOTAL URINE
MSO4 (mg)								5		5				10	1100
( )															
( )															
VOLAT AGENT: Iso % del / % e.t.		0.7 / 1.0	0.8	1.0	0.8	1.0	1.0	1.5	X						
AIR L/Min															
N2O L/Min															
O2 L/Min		2	2	2	2	2	2	2	2	2					

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

FLUIDS

LINE site 16G (R) IV ☐ Warmed	NS #1		1000									
CVL (R) femoral ☐ Warmed	NS #2	#3 #4			LR #5	3L						
Arterial 18g ☐ Warmed	IVPB											
☐ Warmed				PRBC #1 / #2								

LOSSES

EST BLOOD LOSS	100		200			300						
URINE -	350			PFP /	900	1000						

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

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 35.8

INITIAL DATA: BP- 150/91 HR- 116

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? JF TIME- 1800

TIME 0015 30 45 0100 30 0200 30 0300

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

PH 7.39 / 7.41; PaCO2 35.6 / 42.8; PaO2 450 / 430; BE -4 / 10; FiO2 21 / 100; ICP

VENTIL

VT - ml	620	620	610	780	770	740	760	780	780
f - breaths/min	13	13	13	10	10	10	10	10	10
Peak inf pres / PEEP	15	15	14	17	17	18	17	17	17
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	26	26	24	24	25	24	26	26	26
BP/oth	FIO2 (Frac or %)	100	100	0.87	0.86	0.86	0.87	0.89	0.89	0.89
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	ST	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site Nasal	35	35.1	34.5	34.9	34.4	34	off		
	N-M Block (T/4)			0/4	1/4	0/4	0/4	1/4	1/4	
	BS	F								
Warming blkt	Room warmed									
Conv warmer										

Mark with letters & symbols, explain under REMARKS — EVENTS Position → ① on turned 45°

FLUIDS - SUMMARY

CRYSTALLOID- (300 ml 3700 ml) 4L

COLLOID- 2U SP

BLOOD- 2U FFP

REMARKS

Code drugs with numbers, events with letters

① EMT intubated CT done to trauma Rm Manfield Tube in place.

② PT - 12.1 INR 1.73 PTT 10.7 32.3 / 34.3 (194

③ FFP #1 2 45 113 #2 5 30 42 54

④ To ICU-3 (SaO2 on ICU monitor used Vented SIMV TV 700ml/TS PEEP 100 FIO

Quinta PRBC's

PT - 16.3 FIB 1.6 32 / 11.3 (249 35.8

PTT 20.9

128/102/12 37 / 20 / 1.25 217

RECOVERY AT 0820

PACU (ICU) 3 (Specify)

OTHER ICP = 1

CONDITION: Stable vent

RESP- 12 SpO2- 99

BP- 125/77 HR- 64

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0000	0015	0028
	Ready	Begin	End
PROC	0020	0025	0220

PROCEDURES and CPT Codes: Craniotomy: Intraparenchymal evacuation

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility — POS # [redacted] (b)(6)-1

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — [redacted] (b)(6)-2

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

ANESTHETISTS: [redacted] CRNA/AMAJ (b)(6)-2

PROCEDURE LOCATION: Trauma

DATE: 11/2/03

PAGE 1 OF 1

(b)(6) - 2 except for very bottom

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1 unit ML

REMARKS: 16 Mar 04

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

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW (Head)

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

SI[redacted]

1 Nov 03

DATE VERIFIED

TIME VERIFIED 0005

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN: NA

CROSSMATCH: CMNR

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DONOR: ABO A; Rh pos

RECIPIENT: ABO A; Rh pos

- [x] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 2 NOV 03

REMARKS: ex 3 Nov 03 0140

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* 0315 [redacted] ON *(Date)* 2 NOV 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted]

2nd VERIFIER *(Signature)* [redacted]

PRE-TRANSFUSION TEMP. 36.1 PULSE 78 BP 114/46

DATE OF TRANSFUSION 11/2/03

TIME STARTED 0335

POST-TRANSFUSION DATA

AMOUNT GIVEN 288 ML

TIME/DATE COMPLETED/INTERRUPTED 0424 11/2/03

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 36.9 PULSE 85 BLOOD PRESSURE 100/58

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 [redacted]

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

SEX M

WARD Emt

[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 - 23146

Medical Record Copy

(b)(6)-2 all except those indicated otherwise

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1 unit ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE

GSW (Head)

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 co[redacted]

SIGNATURE OF VERIFIER

1 Nov 03

DATE VERIFIED

TIME VERIFIED 0005

SECTION II – PRE-TRANSFUSION TESTING

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

TRANSFUSION NO. (b)(6)-4

PATIENT NO. [redacted]

TEST INTERPRETATION

ANTIBODY SCREEN: NA

CROSSMATCH: NA CNK

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DONOR: ABO A; Rh pos

RECIPIENT: ABO A; Rh pos

[X] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE 2 NOV 03

REMARKS: exp 3 NOV 03 0100

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* 0100 ON *(Date)* 02 NOV 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted]

2nd VERIFIER *(Signature)* [redacted] CRNA

PRE-TRANSFUSION TEMP. 35 PULSE 80 BP 132/62

DATE OF TRANSFUSION 2 NOV 03 TIME STARTED 0100

POST-TRANSFUSION DATA

AMOUNT GIVEN all ML

TIME/DATE COMPLETED/INTERRUPTED 0115 2 NOV 03

REACTION [X] NONE [ ] SUSPECTED

TEMPERATURE PULSE BLOOD PRESSURE

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

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

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

SIGNATURE OF PERSON NOTING ABOVE [redacted] CRNA

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

[redacted] (b)(6)-4

SEX M

WARD EMT

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 - 23147

(b)(6)-2 except very bottom

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)*: 1 unit ML

REMARKS: 26 Mar 04

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

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW (Head)

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

SIGNA[redacted]ER

1 Nov 03

DATE VERIFIED: 0005

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

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

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO A; Rh POS

RECIPIENT: ABO A; Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	CMNR

PREVIOUS RECORD CHECK: [x] RECORD [ ] NO RECORD

SIGN[redacted]ON PERFORMING TEST [redacted]

[x] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED [redacted] DATE 2 Nov 03

REMARKS: ex 3 Nov 03 0140

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* 0315 ON *(Date)* 2 Nov 03

IDENTIFICATION

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

1st VERIFIER *(Signature)*: [redacted] ST/AW

2nd VERIFIER *(Signature)*: [redacted]

PRE-TRANSFUSION TEMP. 35.6 PULSE 92 BP 143/77

DATE OF TRANSFUSION 2 Nov 03 TIME STARTED 0335

POST-TRANSFUSION DATA

AMOUNT GIVEN 288 ML

TIME/DATE COMPLETED/INTERRUPTED 0448 11/2/03

REACTION [x] NONE [ ] SUSPECTED

TEMPERATURE 36.9 PULSE 85 BLOOD PRESSURE 105/58

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: [redacted]

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

SEX [redacted] M

WARD Emt

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

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

MEDCOM - 23148

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

(b)(6)-2 all unless indicated otherwise

518-124 NSN 7540-00-634-4159

MEDICAL RECORD	BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

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

- ☐ TYPE AND SCREEN
- ☐ CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW (Head)

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

VOLUME REQUESTED *(If applicable)*: 1 unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER: 1 Nov 03

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED: ØØØS

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

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

TRANSFUSION NO. (b)(6)-4

PATIENT NO. [redacted]

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	NA CNR

PREVIOUS RECORD CHECK: ☒ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted]

DONOR	RECIPIENT
ABO A	ABO A
Rh POS	Rh POS

☒ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE 2 NOV 03

REMARKS: EXP 3NOV03 0100

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)*: 0100 ON *(Date)*: 02 NOV 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 [redacted]

1st VERIFIER *(Sig[redacted]*

2nd [redacted]

PRE-TRA[redacted]

TEMP. [redacted]4.1 PULSE 92 BP [redacted]/42

DATE OF TRANSFUSION: 11/02/03 TIME STARTED: 11/02/03 0115

POST-TRANSFUSION DATA

AMOUNT GIVEN: all ML

TIME/DATE COMPLETED/INTERRUPTED: 1120 02 NOV 03

REACTION: ☒ NONE ☐ SUSPECTED

TEMPERATURE | PULSE | BLOOD PRESSURE

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN

☐ OTHER *(Specify)*

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

☒ NO ☐ YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE: [redacted] (PW) A

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

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

SEX: M

WARD: EMT

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 - 23149

Medical Record Copy

(b)(6)-2 all except very bottom

EMERGENCY RELEASE OF BLOOD COMPONENTS

SECTION I - REQUISITION

COMPONENTS REQUESTED (Check One)

☒ RED BLOOD CELLS (Crossmatch not performed)

☐ OTHER (Specify) _____

THE FOLLOWING TESTS HAVE NOT BEEN PERFORMED:

ALANINE AMINOTRANSFERASE
CYTOMEGALOVIRUS TEST
HEPATITIS TESTS
RETROVIRUS TESTS
SYPHILIS SEROLOGY TEST

DUE TO THE CRITICAL CONDITION OF THE BELOW NAMED PATIENT, I REQUEST THE IMMEDIATE RELEASE OF THESE BLOOD PRODUCTS FOR TRANSFUSION WITHOUT COMPLETE TESTING. I UNDERSTAND THE INCREASED RISK TO THE PATIENT AND ACCEPT RESPONSIBILITY FOR THE ADMINISTRATION OF THIS TRANSFUSION.

PHYSICIAN'S SIGNATURE [redacted]

DATE 1 Nov 03

SECTION II - ISSUE/TRANSFUSION DATA

TRANSFUSION NUMBER: 2

RECIPIENT ABO/Rh:

INSP [redacted]

AT [redacted] 2340

INDIVIDUAL ACCEPTING COMPONENTS [redacted]

ON (Date) 1 Nov 03

UNIT NUMBER	ABO/Rh	1ST VERIFIER (Signature)	2D VERIFIER (Signature)	DATE/TIME STARTED	DATE/TIME COMPLETED	AMOUNT GIVEN	REACTION YES/NO
ex 3 Nov [redacted]	O pos	[redacted]		2 Nov 03 2330	2 Nov 03 2340	500 cc	N
ex 3 Nov [redacted]	O pos	[redacted]		2 Nov 03 2340	2 Nov 03 2350	500 cc	N

IDENTIFICATION VERIFICATION

The transfusionist (1st Verifier) must examine the blood bag label, tag and emergency release form to ensure that it matches the patient's name or trauma number on his/her ID bracelet. He/She must sign the emergency release form in the "1st Verifier" block above to indicate that the correct patient identification was made and to document who started the transfusion. The SECOND individual (2d Verifier) must confirm that positive identification of the patient and the blood unit was made by the transfusionist and must sign the form in the "2d Verifier" block.

TRANSFUSION REACTION

If reation is SUSPECTED - IMMEDIATELY:

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

Description

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN

☐ OTHER _____

OTHER DIFFICULTIES (EQUIPMENT, CLOTS, ETC.)

☐ NO ☐ YES (SPECIFY) _____

SIGNATURE OF PERSON NOTING ABOVE

PRE-TRANSFUSION

TEMP: PULSE: B/P:

PREPARED BY (Signature & Title) Lt [redacted] BN

WARD EMT

DATE 2 Nov 03

PATIENT'S IDENTIFICATION (NAME- LAST, FIRST, SSN)

[redacted] (b)(6)-4

One copy is placed in the medical records. One copy is return to the blood bank. Red, Purple or Pink top should be drawn and submitted to lab for retroactive crossmatch.

518-123 (b)(6)-2 except very bottom NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* 1 unit (#2) ML.

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 05 NOV 03

DATE AND HOUR REQUIRED 0940

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE S/P esw to liver

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

SIGNATURE OF VERIFIER [redacted]

DATE VERIFIED 05 NOV 2003

TIME VERIFIED 0940

SECTION II – PRE-TRANSFUSION TESTING

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

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION	
ANTIBODY SCREEN	CROSSMATCH
	Comp

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

DONOR	RECIPIENT
ABO A	ABO A
Rh POS	Rh POS

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 5 NOV 03

REMARKS: EXP: 6 NOV 03 @ 2355

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* 1207 ON *(Date)* 05 NOV 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 recip[redacted] same person named on this Blood Component Transfusion Form and on th[redacted]ification tag.

1st [redacted] 1 [redacted]

2n[redacted]

PRE-TRANSFU[redacted]

TEMP. [redacted] 128 BP 94/57

DATE OF TRAN[redacted] 05 NOV 03 TIME STARTED 1215

POST-TRANSFUSION DATA

AMOUNT GIVEN 300 ML

TIME/DATE COMPLETED/INTERRUPTED 05 NOV 03

REACTION [X] NONE [ ] SUSPECTED

TEMPERATURE 100.9 PULSE 132 BLOOD PRESSURE 100/53

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

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

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE [redacted]

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

[redacted] (b)(6)-4

SEX [redacted] WARD 1 CU7

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

(b)(6)-2 except very bottom

518-123 NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* 1 unit (Hi) ML

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 0940

DATE AND HOUR REQUIRED 5 NOV 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE s/p GSW to chest

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

SIGNATURE OF VERIFIER [redacted]

DATE VERIFIED 05 Nov 03

TIME VERIFIED 0940

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

RECIPIENT

ABO A

Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN

CROSSMATCH Comp

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 5 Nov 03

REMARKS: Exp 6 Nov 03 @ 2355

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* 1106 ON *(Date)* 5 Nov 03

IDENTIFICATION

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

1st VERIFIER *(Signature)* [redacted] 1LT

PRE-TRANSFUSION

TEMP. 102.7 PULSE 132 BP 84/65

DATE OF TRANSFUSION 11/5/03 TIME STARTED [redacted]

POST-TRANSFUSION DATA

AMOUNT GIVEN 350 ML

TIME/DATE COMPLETED/INTERRUPTED 05 Nov 03 1205

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE 104.7 PULSE 132 BLOOD PRESSURE 94/47

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)* [redacted]

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE [redacted] 1LT

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

[redacted]

SEX MALE

WARD 1C03

(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

(b)(6)-2 all unless indicated otherwise

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 11/2/03 TIME OF ORDER 0241 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit ICU
2. Dx: S/P GSW Head w/ (L) f-Temporal
3. Craniotomy & Evacuation of depressed open skull fracture.
4. Vital q1° w/ neuro V/S.
5. NKDA
6. IV D5 0.9NSW 20KCL @ 125 cc

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

7. ~~pre Op~~: Ancef 1gm IVPB q8° Propofol drip prn sedation Dilantin 100mg IVPB q8° Zantac 50mg IVPB q8°
8. Foley to gravity
9. I/O's
10. CBC/Platelet Chem 7, ABG qd
11. Ventilator: RR 12 FiO2: 100% mode SIMV PEEP: 5cm H2O

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

12. ABG now CO2 30-35
13. ICP call Hx if > 20
14. Ventricular @ 6cm above EAC
15. Tx 2u FFP; ✓ PT/PTT keep INR < 1.2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

24 hr CC Done 11/3/03 @ 0100 [redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 72 WHICH MAY BE USED.

MEDCOM - 23153

(b)(6)-2 all unless indicated otherwise

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4 [redacted]			11/03/03	1206 HOURS	
			① Fentanyl titrate pm agitation/pain		
			[redacted]		
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			11/03/03	1205 HOURS	
			① Tylenol 650 mg per rectum/NG q4h PRN fever		
			~~V.O. Dr Arton~~ [redacted]		
			② Ventriculostomy 10cm above EAC		
NURSING UNIT	ROOM NO.	BED NO.	V.O. Dr [redacted]		
24 hr cc Dow		11/03/03	& drooke [redacted]		

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
		11/03/03 0d4 Deale	11/3/03	HOURS	
			① ~~Attemp~~ to Urean w/ lightening sedation.		
			② ~~#~~ 20 meq KCl [redacted] 4° 250cc [redacted]		
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			11/3/03	2205 HOURS	[redacted] 11/3/03 2210
		6121824	① Blood & Urine Culture x1 NOW		
			② Zosyn 3.375 gm IVPB q6°		
			[redacted]		
NURSING UNIT	ROOM NO.	BED NO.			

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

(b)(6)-2 unless otherwise indicated

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
[redacted] (b)(6)-4				4 NOV 2003 1200 HOURS	
				T.O	
			1	D/C all sedation / analgesics	
				[redacted]	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4				1600 HOURS	1600 [redacted]
			1	Per V/O Dr. [redacted] neb treatment 1600. V/O Provided by LT Beeger	
				T.O. 04 NOV 2003 1713	
[redacted] Noted			1	1mg ATIVAN IVP x 1 NOW for agitation	
NURSING UNIT	ROOM NO.	BED NO.		[redacted]	VIC, MC

PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER	
[redacted] (b)(6)-4				11/4/03 [redacted]	
			1	D/C NG tube	
[redacted] Noted				[redacted]	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION				DATE OF ORDER / TIME OF ORDER	
				11-5-03 1730 HOURS	
				T.O.	
				① tiagabin 2 wks p.r.n. - clon	1000 5 NOV 03
				② advance diet to chows -	
				[redacted]	
NURSING UNIT	ROOM NO.	BED NO.		[redacted]	

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

(b)(6)-2 unless indicated otherwise

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 6 Nov 03 TIME OF ORDER: 1735 HOURS

V.O. from [redacted]

(1) D/C Ancef [redacted] /a

(2) D/C Peripheral Cardio

(3) F Clear Liquid

(4) ↓ Nasal [redacted]

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 6 Nov 03 TIME OF ORDER: 1815 HOURS

V.O from [redacted] TAKEN BY [redacted] /a

- FEMORAL CORDIS LINE MAY 8TH

NL USED.

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.

MEDCOM - 23156

(b)(6)-2 unless otherwise indicated

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW1		

DATE OF ORDER 11/7/03 TIME OF ORDER 0913 HOURS

LIST TIME ORDER NOTED AND SIGN

(1). Transfer To ICW-1

(2). Dx: (1) Penetrating Head Injury / Depressed Skull Fracture

(3). Stable

(4). Vital q 4°

(5). NSDA

(6). D/C Femoral line / D/C Arterial D/C-IV

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
24° / 0200 8NOV03		[redacted]

DATE OF ORDER TIME OF ORDER HOURS

(7) Advance Diet as Tolerated

(8). MEDS: Dilantin 300mg po qhs / Zantac 150mg po BID

(9). D/C Foley

(10). Ambulate w/ assistance

(11). D/C Zoxpen

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
24° / 0030 9NOV03		[redacted]

DATE OF ORDER 11/8/03 TIME OF ORDER HOURS

(1) Ambulate w/ assistance.

[redacted]

Noted [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
24° 1900 10NOV03		[redacted]

DATE OF ORDER 11/10/03 TIME OF ORDER HOURS

(1) OOB ambulate w/ (R) arm exercises.

(2) Vicox 50mg po qd.

(3) D/C Dilantin

(4) Therapeutic Spin[redacted]

Noted [redacted]

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

MEDCOM - 23157

(b)(6)-2 unless otherwise indicated

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
[redacted] (b)(6)-4			11NOV03@0000	HOURS	
			VO-Dr [redacted] / LT [redacted]		
			Tylenol 650mg PO x1 now		
NURSING UNIT			11NOV03@[redacted]00 [redacted]		

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
[redacted] (b)(6)-4			11/14/03	0813 HOURS	
			D/C to Prison ~~Hospital~~ Camp.		
			[redacted]		
NURSING UNIT	ROOM NO.	BED NO.	270/0215 15NOV03 [redacted]		

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
[redacted] (b)(6)-4				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
[redacted] (b)(6)-4				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

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

(b)(6)-2 except for very bottom

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	4	5	6	7					
2 nov 03	[redacted]	Vitals q1° ; neuro	06	[redacted]											
		L/S	18												
2 nov 03	[redacted]	Foley to gravity	06												
			18												
2 nov 03	[redacted]	I/O's	06												
		~~CBC/PT/PTT/Chem7~~	18												
		~~ABG qD~~	X												
2 nov 03	[redacted]	CBC/PT/PTT/Chem7	04												
		ABG qD	X												
2 nov 03	[redacted]	vent: RR 12, FiO2 100%	06												
		SIMV PEEP 5	18												
2 nov 03	[redacted]	keep CO_2 30-35	06												
			18												
2 nov 03	[redacted]	ICP call MD if >30	06												
			18												
2 nov 03	[redacted]	Ventric @ 6 cm above	06												
		EAC	18												
3 nov 03	[redacted]	Ventriculostomy @	06												
		10 cm above EAC	18												
11/5/03	[redacted]	ADAT (TO CLEANS)	06	X			X								
	[redacted]		18	X			X								

D/C'd 4 Nov 03 ek

D/C'd 5 Nov 03 ek

D/C'd 3 nov 03

D/C'd 5 Nov 03 [redacted]

ALLERGIES: ☐ YES ☐ NO
hiCDA

PRIMARY DIAGNOSIS: S/P GSW head w/ (L) F-Temporal craniotomy, evacuation of depressed open skull fx

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

PATIENT IDENTIFICATION:
EPW
[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

Verify 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
2 NOV 03	[redacted]	Tx 2 u FFP; r PT/PTT keep IWR	2 NOV 03	ASAP	0448	[redacted] (b)(6)-2
	-----	< 1.2				
2 NOV 03	[redacted]	ABG Now	2 NOV 03	ASAP	0320	[redacted]
3 NOV 03	[redacted]	Blood and Urine Culture NOW	3 NOV	NOW	2235	[redacted]
4 Nov 03	[redacted]	D/C NG tube	4 Nov 03		0040	[redacted]

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.	Month Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 7	8	9	10	11	12	13	14	15				
7 nov	[redacted]	Vitals: q 4°	6	/	[redacted]								(b)(6)-2			
			10	/												
			14	[redacted]												
			18													
			22													
			2													
7 nov	[redacted]	Diet: Advance as tolerated	6													
			12													
			18													
7 nov	[redacted]	Ambulate c Assistance	6										SVCB			
			18													
1Φ Nov Φ	[redacted]	OOB ambulate c Φ	Φ6 13	—	—	/										
		arm exercises	18 Φ6	—	—	/										
1Φ	[redacted]	Incentive spirometry	Φ6 18	—	—	/										
			18 Φ6	—	—	/										

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: Head injury depressed skull fx.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

(b)(6)-2 all

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo NOV Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7 NOV	[redacted]	Transfer ICW-1 Stable	7 NOV	—	—	[redacted]
7 NOV	[redacted]	D/C Femoral line / D/C Arrof, IV	7 NOV	—	—	[redacted]
	----	Foley, Zosyn	/	/	/	/
14 NOV	[redacted]	DC to prison camp	15 NOV	—	—	[redacted]

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

(b)(6)-2 for all except the very bottom

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1 2 3 4 5 6 7
2 nov 03	[redacted]	IVF D5 0.9 NS @ 20	06	[redacted] DC 11/7/03 950
		KCL @ 125 cc/hr	18	
2 nov 03	[redacted]	Ancef 1 GM IVPB	06	[redacted] 4 Nov 03
		q8h	14	
			22	
2 nov 03	[redacted]	Propofol drip	06	[redacted]
		sedation	18	DC'd 4 Nov 03
2 nov 03	[redacted]	Dilantin [redacted] 100mg	06	[redacted]
		IVPB q8h [redacted]	14	CHANGED 11/7/03 950
			22	
2 nov 03	[redacted]	Zantac 50 mg	06	[redacted]
		IVPB q8	14	CHANGED 11/7/03 950 [redacted]
			22	
3 nov 03	[redacted]	Fentanyl titrate	06	[redacted]
		PRN agitation/pain	18	[redacted] 3
3 NOV 03	[redacted]	Attemp to wean up	06	[redacted]
		lightning sedation	18	
3 NOV 03	[redacted]	20 syn 3.375 gm IVPB	06	[redacted]
		q6°	12	11/7/03 [redacted]
			18	
			24	
4 NOV	[redacted]	Neb treatments q6°	06	[redacted]
			12	
			18	
			24	

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: S/P GSW Head w/ (L) F-Temporal Craniotomy; evacuation of depressed open skull fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

(b)(6)-2 all

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Nov Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
11/3/03	[redacted]	20 mEq KCl IV over 4° 250cc NS	11/3/03	ASAP	1500	[redacted]
11/4/03	[redacted]	1mg Ativan IVP X 1 now for agitation	11/4/03	—	2200	[redacted]
	-----	Transfer 2nd to PACU	11/5/03	1000	1000	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
3Nov03	[redacted]	Tylenol 650 mg	3Nov 0010	3Nov 0400	2200	1300	1400	3Nov 2100	4Nov 0025	4Nov 0145						
-----	-----	per rectum/hs&T														
-----	-----	q4h PRN fever														
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USAPA V1.00

(b)(6) - 2 except for very bottom

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 7	8	9	10	11	12	13	14	15					
7 NOV	[redacted]	Dilantin 300mg q HS	22	[redacted]			DC 10 NOV 03										
7 NOV	[redacted]	Zantac 150mg PO	10	/	[redacted]												
		BID	22	[redacted]													
10 Nov 03	[redacted]	Vioxx 50mg po QD	10	/	/	/	[redacted]										

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: (b) head injury depressed skull fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

MEDCOM - 23165

(b)(6)-2 all

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 11 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
10 Nov	[redacted]	D/C Dilantin	10 NOV 03		[redacted]	
11 NOV	[redacted]	Tylenol 650 mg PO x1 now	11 NOV		[redacted]	

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

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

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
2334	ET Intubation	8.0	☒ Oral ☐ Nasal Teeth	26	☐ $ETCO_2$ Change ☐ BBS Post Int ☐ Post CXR
2338	Gastric Tube		☐ Oral ☒ Nasal (L)		☐ Air ☐ Contents ☐ Verified_____ Suction: Y N
2340	Urinary	16	☒ 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) R Fem	2334							
2)								

LABS

TIME	LABS
	☐ D-stick_____ ☐ SHct_____
	☐ D-stick_____ ☐ SHct_____
	☒ CBC ☒ Chem ☒ PT/PTT Emergency
	☐ ETOH ☐ T&S ☒ T&C x 2units
	☐ Tox Screen 4 T&C
	☒ UA ☐ HCG
	☐ OTHER
	☐ OTHER

X-RAYS

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

TIME	PROCEDURE	ACCOMPANIED BY	RESULTS
	CT Scan: ☐ Contrast		
	☒ Head neck ☐ 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
		18	Y	N	LFA			
	Central		Y	N	~~RFemoral~~			
	Central		Y	N	RFemoral			
			Y	N				

MEDICATIONS

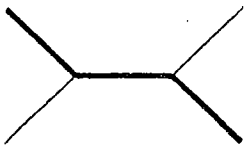
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Vec	2333	1							
Fent		100							
Atbm	2332	20							
Succs	2333	100							
Vec	2337	10							
Ancef	2337	1							
Tet	2338	.5							
Dilantin	2345	1							

BLOOD PRODUCTS

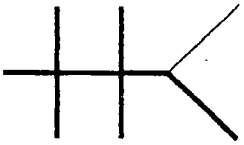
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INIT
2337		[redacted]					
2344							

LAB RESULTS

CBC:



Chem:



INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys				
Surgeon				
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

As per ACLS Precautions: ☐ Yes ☐ No

(b)(6)-c all

Rectal Temp:

TIME	BP	HR	RHY	RR		FIO_2	MODE	GCS: E	V	M	T
2329	53/21	130		38							
2335	91/55	127		28							
man 2340	95/70										
2341	33/83	117		24							
2355	125/71	81		22	100						

GLASGOW COMA SCALE		
EYE OPENING	VERBLE RESPONSE	MOTOR RESPONSE
4 - Spon.	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

Gucc - Neg.

* initially ACLS protocol followed. VSAs noted, initial GCS 6, agonal Resp efforts, ↑ secretions therefore RSI protocol initiated, BS Confirmed (B), (D) Condensation in tube, Pt c̄ (R) fem Line x PIV - Fluids Running c̄ initial Hypotensive x thready pulse 2U O⊖ Blood given. BP/Pulse improved c̄ IVF + Blood. NS on Scene. See Below for Details - [redacted]

~20-30%

Pt is an IRAQI ♂ S/P GSW to (L) temporal area, arrived on Liter c̄ head wrapped. initial VS noted, Pupils 2mm Sluggish Reactive, Moved (R) LE; ⊘ UE Movements. eyes appeared to open x1 when evaluating head wound But ⊘ spont thereafter, agonal Resp. effort, HR 130's. Pt sedated + paralyzed for intubation. CT head c̄ Localized fragments in (L) temporal Region, (D) edema. NS present. (R) fem line placed. 2U O⊖ Blood given. Pt to OR for eval/Removing fragments.

[redacted]

☆U.S.GOVERNMENT PRINTING OFFICE 1997-571-7000

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: TRAUMA ... WSHEET
The proponent is Dept of Surgery

OTSG APPROVED (Date): QI Appr 11 Jun 97

EMS REPORT

TIME: ____ ETA: ____ UNIT: ____

MED COM: [Y] [N] 1 mm.

ARRIVAL STATUS

TIME: 0338 ☐ 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: ____ ☐ ____

RAC

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 1 V 1 M 4

SPHINCTER TONE: ☐ WNL ☐ None

HEAD Slurred 2mm.

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 Poor Resp. Effort

BREATH SOUNDS: ☐ Bilat ☐ Equal ☐ Clear

Decreased [L] [R] Absent [L] [R]

Wheezes [L] [R] Crackles [L] [R]

ABDOMEN Distended

☒ Soft ☐ Rigid ☐ Non-Tender

☐ Tender: ____

PELVIS

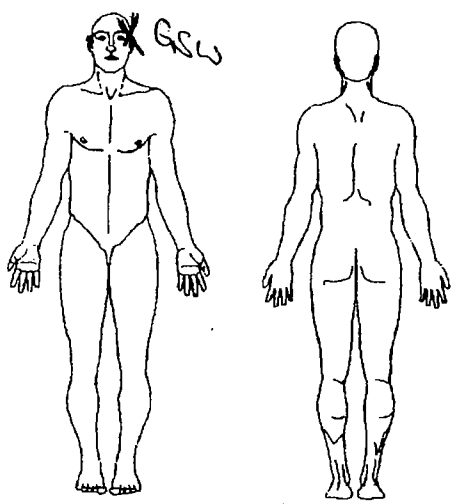
☐ Stable ☐ Unstable ☐ ____

Blood at meatus/vagina: [Y] [N]

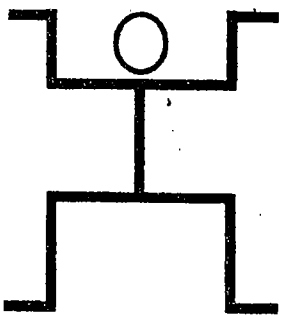
Heme + - Prostate: ☐ WNL ☐ Abnl

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



VASCULAR ASSESSMENT



+ + Strong	+ Palpable	D Dopler

RN

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

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted]

DEPARTMENT/SERVICE/CLINIC: ER

DATE: 1 Nov 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 1 MAY 78 4700

REQUIREMENT OF PRIVACY ACT OF 1974 IS COVERED BY DD FORM 2005.
PREVIOUS EDITION IS OBSOLETE.

EAMC OP 503, 1 Dec 98

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 8Mar 89

INITIAL SHIFT ASSESSMENT

2 nov 03

NEURO	TIME	0700 03 0830	INTILAS		INTILAS	0530	INTILAS [redacted] (b)(6)-2
	PUPLIS	Pinpoint/brisk/Perrla				3mm Slow	
	SENSORIUM	(+) corneal reflex/grimaces				unresponsive to painful	
		↑ moves LUE & pelinful				nverbal stimuli, sedated	
		stimuli. Ventricylostomy				on 16⁸ propofol	
		drain 20-30 cc/hr ICP 9					
RESPIRATORY	RESPIRATION PATTERN	normal on SIMV 13				Even, unlabored	
	BREATH SOUNDS	TV 700 Peep 5 FIO2 40%				Vent Vt 700 Peep 5 FIO2 40%	
	SECRETIONS	O2 sats 100% last				SPO2 100 BPM 12	
		ABG 1645 - O2 34%				∅ secretions	
		Suctioned at this time					
		LCTA (B)					
SKIN	COLOR	WFR				AFR / gauze to head	
	INTEGRITY	Intact x head				& Min Sanguinous fluid	
IV SITE	LOCATION	(R) ac PIV / (R) femoral				(R) Femoral Cordis, (R)	
	CONDITION	cordis / (R) radial				AC, (R) Radial A-line	
		art line ~~5~~				CDI, ∅ s/s infection	
		All lines patent					
		A line reading &					
		waveform tyrile.					
GASTRO	ABDOMEN	soft nondistended				Soft, nondistended	
	BOWEL SOUNDS	(+) BS X 4 quadrants				Hyper BS x 4 quads	
		⊖ flatus ⊖ BM				NG ↓	
GU	URINE	foley to gravity				FTG	
	COLOR/CLARITY	yellow/clear				Clear, light yellow	
		adequate output / 0					
CARDIOVASCULAR	CARDIACRHYTHM	Sinus tach 100-110's				Tachy ↓100's Ectopy	
		Radial/Pedal				+2 radial/pedal pulses	
		pulses palpable				Edema noted <3 sec	
		+1				Cap refill	

LEGEND
Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) SGT [redacted] (b)(6)-2
DEPARTMENT/SERVICE/CINC ICU3
DATE 2 NOV 03

PATIENT'S INDICATIONS (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)
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 APR 90 (HSXC - NU)

MEDCOM - 23170

DATE 11/2/03 DX SIP [illegible] to head HOSPITAL DAY 1

VITAL SIGNS	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line				161/84	120/65	127/61	131/61	101/52		122/72	142/70	127/84	142/73	140/71	142/72	122/69	131/71	
BP Cuff					100/58	108/56	112/61	111/53		106/57		107/61						
Temperature				94.4	36.1	37.2	37.4	37.7				100.6						
Pulse				79	86	83	76	87		83	81	91	87	98	97	99	100	
Respiratory Rate				12	12	13	12	12		12	12	13	13	13	13	13	13	
SPO2				100	100	100	100	100		100	100	100	100	100	100	100	100	
FiO2				70	50	60	40	40		40		40		40		40		
MODE				SIMV	SIMV	SIMV	SIMV	SIMV		SIMV		SIMV		SIMV				
ICP					0	2	4	7		9	9	7	6	5	8	8	8	
CPP								72		72	80	75	86	87	81	81	82	
ART MAP/CPP								79		81	89	82	92	92	89	89	90	

INTAKE	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D50.9NS c				125	125	125	125	125	625	125	125	125	125	125	125	125	125	1000
20 mEq KCl																		
IVPB								100	100	100						200		300
Propofol				168	168	168	168	164	884	18	18	20	20	20	20	20	20	116
FFP				288	288				566									
TOTALS									1375									1916

OUTPUT		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR / TOTAL					280	90 / 370	70 / 490	50 / 540		50 / 50	120 / 170	100 / 270	140 / 410	250 / 660	200 / 860	220 / 1080	180 / 1260	1260
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP						15			15			30						50
	Ventric					30	18	15	5	68	5	0	0	0					5
TOTALS										630									1315

(b)(6) - 2 all

POST-OP DAY

VITAL SIGNS	14	17	18	19	20	21	22	23
	114/94	102/81	100/84	104/85	96/80	92/88		
	110/70		120/72	110/69	117/74	111/72	116/75	119/68
T	101.1			101.0			101.2	
A	97	105	106	101	110	100	112	105
R	13	13	14	12	13	13	13	13
	100	100	100	100	100	100	100	100
	40	40	40	40	40	40	40	40
	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
I	9	9	9	8	10	8	6	6
G	90	92	82	85	80	77	90	83
N	99	101	91	90	90	87	84	81
S								

INTAKE	14	17	18	19	20	21	22	23	8°T
	125	125	125	125	125	125	125	125	1000
							100	100	200
	20	20	20	23	25	25	25	27	186
									1386

OUTPUT	14	17	18	19	20	21	22	23	8°T
	50	80	80	110	100	255	180	160	845
		80	40						
			200						200
			25					30	55
	50	20	20	30	20	20	20	25	205

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	0530	0800	1645						
	MODE	SIMV	SIMV	SIMV						
	F_IO_2	45	45	40						
	TV	700	700	700						
	RATE	12	12	13						
	PEEP	5	5	5						
ABG	pH	7.33	7.47	7.42						
	PCO_2	35.2	38.7	31.8						
	pO_2	169	173	159						
	HCO_3	23	25	26						
	SAT	100	100	100						
	BASE	-1	Ø	3						

LABORATORY	TIME	0500	0600	0800	1645					
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb	8.1/26.7	7.6/24.2		25.2/8.8					
	INR	1.52		1.49						

ACTIVITIES DAILY LIVING	TIME				TURN SUCTION	TIME				
	MOUTH CARE									
	BATCH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

24 HR TOTALS	NURSE'S SIGNATURE	INITIALS
	[redacted]	

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE _____

NEUROLOGICAL ASSESSMENT

COMA SCALE	HOURS	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	2
EYES OPEN: SPONTANEOUSLY 4																							
EYES OPEN: TO SPEECH 3																							
EYES OPEN: TO PAIN 2																							
EYES OPEN: NO EYE OPENING 1		1	1	1	1	1	1	1															
BEST VERAL RESPONSE: ORIENTED 5																							
BEST VERAL RESPONSE: CONFUSED 4																							
BEST VERAL RESPONSE: VERBALIZES 3																							
BEST VERAL RESPONSE: VOCALIZES 2																							
BEST VERAL RESPONSE: NO VOCALIZATION 1		T	T	T	T	T	T	T															
BEST MOTOR RESPONSE: OBEYS COMMANDS 6																							
BEST MOTOR RESPONSE: LOCALIZESPAIN 5																							
BEST MOTOR RESPONSE: FLEXION WITHDRAWAL 4																							
BEST MOTOR RESPONSE: ABNORMAL FLEXION 3																							
BEST MOTOR RESPONSE: EXTENSION TO PAIN 2																							
BEST MOTOR RESPONSE: NO RESPONSE 1		1	1	1	1	1	1	1															
LIMB MOVEMENT: ARMS: NORMAL POWER																							
ARMS: MILD WEAKNESS																							
ARMS: SEVERE WEAKNESS																							
ARMS: ABNORMAL FLEXION																							
ARMS: ABNORMAL EXTENSION								X															
ARMS: NO RESPONSE		R/L	R/L	R/L	R/L	R/L	R/L																
LEGS: NORMAL POWER																							
LEGS: MILD WEAKNESS																							
LEGS: SEVEREWEAKNESS																							
LEGS: ABNORMAL FLEXION																							
LEGS: ABNORMAL EXTENSION								X															
LEGS: NO RESPONSE		R/L	R/L	R/L	R/L	R/L	R/L																
PUPILS: RIGHT SIZE		3	3	3	3	2	2	2															
PUPILS: RIGHT REACTION		+	+	+	+	++	++	++															
PUPILS: LEFT SIZE		3	3	3	3	2	2	2															
PUPILS: LEFT REACTION		+	+	+	+	+	+	+															
PUPIL SCALE		2	3	4	5	6	7 mm																
ICP						7	9	9															
CEREBRAL PERFUSION PRESSURE (MAP-ICP)						72	72	80															

LEGEND

- C Closed by swelling
- T Trach/Endo
- S Slurring
- D Dysphasia
- R Receptive
- E Expressive
- R Right
- L Left
- Record Separately if there is a Difference between the tow sides
- ++ Brisk
- + Slow
- – No Response
- + Intact
- – Abnormal

VASCULAR ASSESSMENT

HOURS																							
	R L																						
	R L																						
	R L																						
	R L																						
	R L																						

LEGEND

- ++ Normal
- + Weak
- – Absent
- D Doppler
- R Right
- L Left

POST-OP DAY

VITAL SIGNS

INTAKE

8° T

OUTPUT

ACUITY LEVEL CLASSIFICATION

RESPIRATORY			
	TIME	0430	
	MODE		
	F_IO_2		
	TV		
	RATE		
	PEEP		
ABG	pH	7.463	
	PCO_2	35.7	
	pO_2	74	
	HCO_3	26	
	SAT	96	
	BASE	2	

LABORATORY		
	TIME	
	GLUCOSE	
	Na/K	137/3.6
	Cl/CO_2	
	BUN/Cr	
	WBC/PLATELET	
	Hct/Hgb	21/8

DAILY ACTIVITIES OF LIVING	TIME			
	MOUTH CARE			
	BATH			
	SKIN CARE			
	FOLEY CARE			
	TRACH CARE			
	ROM EXERCISES			

TURN	TIME				
SUCTION					

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	_____	Urine:	_____
po	_____		_____
	_____		_____
TOTAL	_____	TOTAL	_____

BALANCE _____

NURSE'S SIGNATURE	INITIALS

(b)(6)-2 -11

DATE 6NOV03 DX GSW TO HEAD HOSPITAL DAY

VITAL SIGNS																		
TIME	2400	0100	0200	0300	0400	0500	0600	0700		0800	0900	1000	1100	1200	1300	1400	1500	
BP Arterial Line																		
BP Cuff	100/63	100/61	110/66	100/63	110/61	111/67	110/67	110/59		96/52	93/52	100/65	114/62					
Temperature	100.4		100.3			100		100.7		100.9	100.5	99.7	99.5					
Pulse	95	105	104	94	97	94	97	111		109	102	103	106					
Respiratory Rate	27	25	25	26	25	25	27	20		27	26	28	34					
O2	100	100	100	100	100	100	100	100		100	100	100	100					
MODE	[redacted]																	

INTAKE																		
TIME									8° T									8° T
IVF	125	125	125	125	125			125	750	125	125	100						350
IVPB DIL.	50					100			150									
IVPB 20%							50		50									
IVPB 20%							50		50									
JUICE PO							100		100									
JELLO PO							50		50									
TOTALS									1150									350

OUTPUT																		
URINE HOUR	200	160	140	100	80	175	120	200			400	135						
URINE TOTAL		360	500	600	680	855	975	1175			400	800	930					930
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS [redacted]		INITIALS		INITIALS
NEURO	PUPILS	OPEN & SIMULTANEOUSLY					
	SENSORIUM	RESPONSIVE TO VERBAL					
		& PHYSICAL STIMULI.					
RESPIRATORY	RESPIRATORY PATTERN	SPONTANEOUS BREATHING					
	BREATH SOUNDS	CONGESTION LLL.					
	SECRETIONS	Ø					
SKIN	COLOR	PINK.					
	INTEGRITY	STAPLES IN SCALP INCIS.					
IV SITE	LOCATION	FEMORAL LINE.					
	CONDITION	PATENT & WARM.					
GASTRO	ABDOMEN	NORMAL.					
	BOWEL SOUNDS	PRESENT - TOL PO					
		FLUIDS & CLEAR DIET.					
GU	URINE:	ADEQUATE / [illegible]					
	COLOR/CLARITY	CLEAR YELLOW.					
CARDIOVASCULAR	CARDIAC RHYTHM	S_1 S_2 PRESENT -					

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] (b)(6)-2 91WM6

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 6 NOV 03

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

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☑ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)

(b)(6)-2 all

POST-OP DAY

VITALS SIGNS	16	17	18	19	20	21	22	23	~~24~~
	91/53	100/62	107/64	115/56	105/60	92/59	119/60	101/53	
	101.1	98.6			99.6	100.1	100.1	100.1	
	107	100	105	107	98	105	94	97	
	27	25	25	28	24	24	25	27	
	98	100	100	99	99	100	99	99	
	[redacted]								
	67	28							

INTAKE	16	17	18	19	20	21	22	23	8° T
	125	125		125	125	125	125	125	750
			50				100	50	200
									950

OUTPUT									
	300	240/500	300/810	220/1010	200/1210	100/1420	200/1620	150/1770	1770

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	95/00								
	MODE	[redacted]								
	F_IO_2									
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GAS	A: pH	7.486								
	A: PCO_2	31.5								
	B: pO_2	81								
	B: HCO_3	24								
	B: SAT	97%								
	G: BASE	0								

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES OF DAILY LIVING	TIME	1330								
	MOUTH CARE	✓								
	BATH	✓								
	SKIN CARE	✓								
	FOLEY CARE	✓								
	TRACH CARE	/								
	ROM EXERCISES	✓								

TURN	TIME					
SUCTION	0800					
	1000					
	1115					
	1230					

24* I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE	OUTPUT
IV	2950	Urine: 5000
po		
TOTAL		TOTAL

BALANCE → 2050

NURSE'S SIGNATURE [redacted]

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff	97/60	90/47	94/51	97/57	100/60	95/53	103/52	124/40		96/54	124/58	108/55	98/51	105/54	100/53	98/53	100/51	
Temperature					100.4							101.0	99.8					
Pulse	117	126	111	106	125	115	116	122		110	103	110	111	104	115	100	106	
Respiratory Rate	14	28	26	27	27	23	29	19		28	11	20	23	24	31	28	29	
SaO2	98%	97%	100%	100%	100%	99%	99%	99		99	99	100	99	99	99	100	100	
Mode	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	
MAP	77	64	67	77	75	68	71	67		69	74	78	65	75	70	69	68	

INTAKE

TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
D5NS+20KCl	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1000
IVPB	50						200							50		150		
ORAL										250				250		*		
TOTALS																		

OUTPUT

		HOUR / TOTAL	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
URINE			100/100	180/280	150/430	120/550	180/730	200/930	150/1080	200/1280	1280	250/250	220/470	280/750	205/955	190/1145	210/1355	225/1580	340/1920	1920
		sp gr																		
		S/A																		
NG		OUTPUT																		
		pH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)* QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0630	INITIALS	1700	INITIALS [redacted] (b)(6)-21	INITIALS
NEURO	PUPILS		Pierce 3mm brisk, p+able		Perrl A 3mm Brisk		
	SENSORIUM		PO wave all extremities,		(R) side weakness. Alert		
			(R) arm weaker than (L) arm, pt		Orientated can follow		
			able to follow some commands.		commands & assists		
					hd care		
RESPIRATORY	RESPIRATORY PATTERN		Reg, even, unlabored,		Reg even unlabored		
	BREATH SOUNDS		clear, ~~ptc~~ c̄ diminished bases,		CTA c̄ diminished		
	SECRETIONS		thick white secretions,		bases pt able to		
			nebulizers tx q6°.		deep breath has cough		
					no secretions so far		
					Neb q 6°		
SKIN	COLOR		NFR., surgical incision (L) side		NFR. surgical incision		
	INTEGRITY		staples, (L) Arm ecchy		(L) skull. (L) Arm		
			no sis.		ecchy noted.		
IV SITE	LOCATION		(R) Femoral cordis. (L) Ac patent		(R) Femoral cordis. D5		
	CONDITION		infusing. D5NS c̄ 20kcl		NS c̄ 20kcl. (L) Ac		
			@125cc/hr		IV D/C'd. no peripheral		
					access.		
GASTRO	ABDOMEN		Flat soft nontender, Hypo		Flat soft non tender		
	BOWEL SOUNDS		active x 4Q, (R) Hokus,		bowel sounds active		
			Clear liquid diet -		x 4.		
					Clear liquid diet 100%		
GU	URINE:		Pale ↓ gravity, clear		FTG light yellow		
	COLOR/CLARITY		yellow urine, Ø sediments		free from sediment		
			sufficient amount ≥ 100cc's		adequate amounts.		
CARDIOVASCULAR	CARDIAC RHYTHM		S1 S2 Ø ectopy (+) 2 pulses x		S1 S2 Ø ectopy.		
			4 ~~+2~~ (R) Hand, (L) side		Grade TACH. Ø Stenosis		
			Hand +2 EDEMA		Radials +2 Pedals +2		
					cap refill Brisk		
					edema R UE.		

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)* | DEPARTMENT/SERVICE/CLINIC | DATE

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

(b)(6)-2 all

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
	93/55	93/55	102/54	106/67	93/47	110/62	93/46	102/60
				101.4	101			101.3
	113	114	114	119	122	131	114	129
	33	25	30	30	30	28	29	27
	99	98	98	100%	98%	100%	100%	99%
[redacted]								

INTAKE	16	17	18	19	20	21	22	23	8° T
	125	125	125	125	125	125	125	125	3000
							100	100	700
									700

OUTPUT									
	100	120/200	80/300	120/420	140/560	140/700	120/820	90/910	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	0600								
	MODE	NC								
	F_IO_2	1L								
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GAS	A: pH	7.341								
	A: PCO_2	39.2								
	B: pO_2	98								
	B: HCO_3	29								
	B: SAT	98								
	G: BASE	7								

LABORATORY	TIME	0430	1330							
	GLUCOSE	195								
	Na/K	130/4.1								
	Cl/CO_2	105/23								
	BUN/Cr	6/.9								
	WBC/PLATELET	7.8/129								
	Hct/Hgb	19.9/6.2	23.5/9.5							

ACTIVITIES OF DAILY LIVING	TIME	[redacted]		
	MOUTH CARE	TPOV		
	BATH			
	SKIN CARE			
	FOLEY CARE			
	TRACH CARE			
	ROM EXERCISES			

TURN	TIME				
	100				
	SELF				
	1300				
SUCTION	100	130			
	1100	1700			
	1200				
	1220				

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	_____	Urine:	_____
po	_____		_____
	_____		_____
TOTAL	_____	TOTAL	_____

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	

DATE 05 Nov 03 | DX s/p ash th heart | HOSPITAL DAY | PAGE 2 OF

VITALS SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff	99/48	93/45	102/57	91/47	94/42	93/47	97/48	94/48		90/50	95/42	102/56	87/41	90/60	102/53	120/64	102/54	
Temperature			101.6		101.1			100.3						100.7		100.2		
Pulse	119	131	136	134	131	129	126	125		125	127	127	137	123	132	127	122	
Respiratory Rate	22	29	28	26	25	28	28	29		30	21	23	29	24	33	21	32	
SaO2	97%	100%	96%	99%	97%	97%	96%	95		100	100	98	99	100	97	100	100	
mode	IV NC	IV NC	IV NC	IV NC	IV NC	RA	RA	IV NC		IV NC	IV NC	IV NC	IV NC	IV NC	IV NC	IV NC	IV NC	
MAP	67	64	70	65	62	65	68			65	65	74						
ICP	4	4	10															
CPP	63	60	60															

INTAKE																			
TIME									8° T	08	09	10	11	12	13	14	15	8° T
D5NS E20 KCL	125	125	125	125	125	125	125	125	1000	125	125	125	127	125	125	125	125	1000
HEPB	50						150	100	300							200		
																200		200
PRBC													350	350				700
TOTALS									1500									2100

OUTPUT																				
URINE	HOUR / TOTAL	90	70/160	120/280	110/390	100/490	110/600	140/740	120/860	1500 / 860	120	152/27	140/41	120/53	150/60	120/72	110/85	70	1080
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	Ventric	5								5									
TOTALS										845									

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS [redacted]	(b)(6)-2	INITIALS	1800	INITIALS [redacted]
NEURO	PUPILS					BERRL (B)	(b)(6)-2
	SENSORIUM					Able to move all extremities, lifts @ c assistance, pt moving around on bed	
RESPIRATORY	RESPIRATORY PATTERN					Reg, even, unlabored	
	BREATH SOUNDS					CTA (B)	
	SECRETIONS					Thick white secretions coming from nasal trumpet Thin white secretions from mouth	
SKIN	COLOR					NFR	
	INTEGRITY					(D) sided skull incision, stapled	
IV SITE	LOCATION					(D) Fem cordis, (D) AC	
	CONDITION					~~Patent~~ cordis infusing D5 N/S w 20 KCL @ 75 cc/hr, (D) AC heplocked, both 3 2/3 of index	
GASTRO	ABDOMEN					~~Not soft~~ nontender	
	BOWEL SOUNDS					(D) in all quads	
GU	URINE:					Foley to gravity	
	COLOR/CLARITY					yellow clear	
CARDIOVASCULAR	CARDIAC RHYTHM					ST c S1 S2 noted, (D) ectopy	
						(B) peripheral pulses 3/4	
						(D) arm & (D) side of face & head swollen c (B) 4 pitting edema to head	

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] (b)(6)-2 PN

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 5 Nov 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 1 MAY 78 4700

Proponent: Dept of Nurs

MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
	91/41	101/52	91/53	91/55	98/49	91/54	94/48	95/48
	101.5					102		101.8
	135	156	131	127	128	125	129	130
	29	34	26	26	27	29	27	16
	95	92	99	100%	100%	97%	99%	99%
	40/pm	12a	4L NC	4L NC	4L NC	2L NC	2L NC	2L NC
	63	71	97	69	68	64	67	66
	10	6	6	5	8	5	11	9
	53	65	41	64	68	59	56	57

INTAKE	16	17	18	19	20	21	22	23	8°T
	125	125	125	125	125	125	125	125	
			50				100	100	

OUTPUT	16	17	18	19	20	21	22	23
	100	140/260	120/300	120/500	110/610	110/720	70/790	70/860
			300					
		50	30		40	10	20	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME	0400	1300	1600
	MODE	SIMV	PM	PM
	F_IO_2	40	40	40
	TV	700		
	RATE	11		
	PEEP	5		
ABG	pH	7.33	7.503	7.534
	PCO_2	37.3	29.4	29.3
	pO_2	83	95	211
	HCO_3	20	23	25
	SAT	96	98	100
	BASE	-6	Ø	2

LABORATORY DATA	TIME	430
	GLUCOSE	115
	Na/K	130/3.4
	Cl/CO_2	104/22
	BUN/Cr	5/1.1
	WBC/PLATELET	9.3/103
	Hct/Hgb	23.9/3.4
	Calc IUR	1.18

DAILY LIVING ACTIVITIES	TIME			
	MOUTH CARE			
	BATCH			
	SKIN CARE			
	FOLEY CARE			
	TRACH CARE			
	ROM EXERCISES			

TURN SUCTION	TIME
	0630
	0830
	1300

24 HR TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	

(b)(6)-2

DATE 4NOV 03 | DX GSW HEAD | HOSPITAL DAY

VITALS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial line																		
	BP Cuff	102/52	95/57	99/56	103/58	101/54	99/57	102/57	105/40		101/55	99/37	101/53	106/40	96/57	98/54	96/55	100/58	
	Temperature	101.9	101.5	101.4	100.9	100.6		100.6	100.9					100.7					
	Pulse	116	111	110	111	109	112	113	112		109	113	125	120	156	139	132	131	
	Respiratory Rate	11	11	11	11	11	11	11	11		11	11	15	16	24	21	23	26	
	SPO2	100	100	100	100	100	100	100	100		100	100	100	100	100	97	96	97	
	Mode/FiO2	Simv 40	Simv 40	Simv 40	Simv 40	Simv 40	Simv 40	Simv 40	Simv 40						Trach	Fm/40	Fm/40	Fm/40	
	MAP	69	67	73	73	71	69		75		74	73	72	78	74	72	74	74	
	ICP	13	11	12	11	11	11	11	13		12	12	7	10	10	10	8	13	
	CPP	56	56	61	62	60	58		62		62	61	65	68	64	62	62	61	

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	IVF	125	125	125	125	125	125	125	125	1200	125	125	125	125	125	125	125	125	1200
	IVPB	50						100	150	300							200		200
	Propofol	12.6	10.5	10.5	10.5	10.5	10.5	10.5	8	83	8	7	7	off	off	—	—	—	22
	fentanyl	125	125	125	125	125	125	10	10	95	10	8	8	off	off	—	—	—	26
	TOTALS									1678									1448

OUTPUT		HOUR / TOTAL																		
	URINE		110	60 / 170	38 / 208	40 / 248	50 / 298	40 / 338	35 / 373	50	425	70	100 / 170	50 / 220	60 / 280	100 / 380	120 / 500	110 / 610	200	840
		SP gr																		
		S/A																		
	NG	OUTPUT							150		150					50				50
		PH									7.35									
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS	Ventric	45	8	4	14	4	4		0	85		5				5		20	30
	TOTALS										660									890

(b)(6)-2 except very bottom

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 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	[redacted] INTILAS		INTILAS	1815	INTIL[redacted]
NEURO	PUPLIS	[redacted]			PERRL (R) 3mm brisk	
	SENSORIUM				Pt c̄ purposful movement in all extremities except (R) UE, doesn't follow commands	
RESPIRATORY	RESPIRATION PATTERN				Reg, even, unlabored	
	BREATH SOUNDS				CTA (R)	
	SECRETIONS				Coughs up white sputum	
SKIN	COLOR				NFR	
	INTEGRITY				(R) side skull incision, stapled	
IV SITE	LOCATION				(R) fem cordis c̄ (R) AC PIV	
	CONDITION				Patent 3 s/s of infx infusing D5½NS c̄ 20 KCL @ 125 cc/hr. PIV heplocked	
GASTRO	ABDOMEN				Flat soft nontender	
	BOWEL SOUNDS				Hyperactive X 4	
GU	URINE				Foley to gravity	
	COLOR/CLARITY				Yellow clear	
CARDIOVASCULAR	CARDIACRHYTHM				ST c̄ ±1, ±2 noted, (R) echopy	

See Nursing Note

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] LPN

DEPARTMENT/SERVICE/CINC ICU 3

DATE 4 Nov 03

PATIENT'S INDICATIONS (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)

☐ DIGNOSTIC STUDIES

☐ TRETMENT

POST-OP DAY

VITAL SIGNS	14	17	18	19	20	21	22	23
	120/61	120/69	119/70	121/68	98/47	91/53	100/51	102/59
		99.2		100			103.5	103.3
	93	107	103	130	121	124	140	122
	11	11	11	13	10	17	22	11
	100	100	100	100	100	100	100	100
	SIMV 40	SIMV 40	SIMV 40	Simv 40	Simv 40	SIMV 40	Simv 40	Simv 40
	87	91	88	88	67	70	72	77
	10	11	9	11	10	9	13	13
	77	80	79	77	57	61	59	64

INTAKE	14	17	18	19	20	21	22	23	8°T
	125	125	125	125	125	125	125	125	1000
							100	100	200
	8	8	8	12.6	12.6	8.4	12.6	12.6	70.2
	5	7.5	7.5	10	10	10	12.5	12.5	75
								1345.2	

OUTPUT	14	17	18	19	20	21	22	23	
	100	115/215	60/275	120/395	70/465	70/535	120/655	120/775	775
			150						150
	5	15	20	50	17	18	11	10	146
									1071

ACUITY LEVEL CLASSIFICATION

RESPIRATORY										
	TIME	0400	0515							
	MODE	SIMV	SIMV							
	F_IO_2	40	40							
	TV	700	700							
	RATE	13	11							
	PEEP	5	5							
ABG	pH	7.56	7.42							
	PCO_2	27.1	31.4							
	pO_2	152	135							
	HCO_3	24	21							
	SAT	100	99							
	BASE	2	4							

LABORATORY										
	TIME									
	CLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES DAILY LIVING										
	TIME				TURN	TIME				
	MOUTH CARE									
	BATCH									
	SKIN CARE									
	FOLEY CARE				SUCTION					
	TRACH CARE									
	ROM EXERCISES									

24 HR TOTALS

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	4115.2	Urine:	2866.5
Po			
TOTAL		TOTAL	
		BALANCE	1248.7

NURSE'S SIGNATURE | INITIALS

[redacted] (b)(6)-2

DATE | DX | HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial line																		
	BP Cuff	109/64	105/65	112/69	112/66	111/77	116/73	120/70	118/66		114/63	117/67	129/74	125/69	126/70	122/68	122/71	124/51	
	Temperature		100.2			101.2		100.9			99.9					99.6			
	Pulse	112	104	100	119	106	110	100	100		97	98	114	104	95	90	90	111	
	Respiratory Rate	13	13	13	13	11	11	11	16		11	11	11	11	11	11	11	12	
	O2 sats	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	
	mode/FiO2	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40		SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40	
	MAP	83	80	83	87	93	89	91	85		82	81	98	89	91	90	91	79	
	ICP	5	9	9	10	12	11	5	10		8	10	11	9	9	11	9	12	
	CPP	78	71	74	77	81	78	89	75		74	71	87	80	82	79	82	67	

MAP - ICP

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	IVF	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1000
	IVPB						100	100		200							200		200
	Propofol	21	21	21	21	21	21	21	21	168	21	21	16	16	12	12	12	12	122
	fentanyl	5	5	5	5	5	5	5	5	40	5	5	5	5	5	5	5	5	40
	TOTALS									1408									1362

OUTPUT		TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	URINE	HOUR	60	140	80	50	50	45	50	70	575	35	60	70	75	60	90	60	115	585
		TOTAL		200	280	360	410	455	505				95	165	240	300	390	450	565	
		SP gr																		
		S/A																		
	NG	OUTPUT						300			300									
		PH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS	VENTRIC	35	3	0	15	5	45	20	18	133	15	10	50	15	15	2.5	40	25	172.5
		JP						30			30									
	TOTALS										1038									757.5

(b)(6)-2 all except very bottom

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 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0630	INTILAS [redacted]		INTILAS	1830	INTIL [redacted]
NEURO	PUPLIS	3mm PERRL Brisk				3mm Brisk PERRL	
	SENSORIUM	responsive to pain				Sedated on 75mg Fentanyl &	
		stimuli flex (R)				30mcg propofol. Moves (L) arm	
		arm and (L) leg				and leg. responds to pain stimuli	
		Propofol @ 30mcg/kg/hr					
RESPIRATORY	RESPIRATION PATTERN	Vent SIMV 11 TV 700				Even, unlabored	
	BREATH SOUNDS	F_IO_2 40% PEEP 5 lungs				Vent. ETT 28@teeth	
	SECRETIONS	CTA suctioned				V_T 700 Peep 5 F_IO_2 40%	
		small secretions				RM 11, SPO_2 100%	
SKIN	COLOR	NFR				NFR	
	INTEGRITY	(L) side head c				GSW to head, Kerlix @ head	
		Sutures draining serous				Ventriculostomy & drainage on	
IV SITE	LOCATION	Sanguinous fluid				(R) Radial A-line (R) AC, (R) Rad	
	CONDITION	small amount.				Femoral Cordis / all are	
		(R) AC PIV, (R) femoral				CDI, & S/S infection	
		cordis. Patent. &					
		signs infection.					
GASTRO	ABDOMEN	Soft nondistended				Soft, nondistended	
	BOWEL SOUNDS	+BS X4. Ø BM				&BM &BS x4 quads	
GU	URINE	Foley to gravity				FTG	
	COLOR/CLARITY	Clear green urine				Clear dark yellow urine	
		adequate amount					
CARDIOVASCULAR	CARDIACRHYTHM	S_1-S_2 Ø ectopy				S_1S_2 Ø ectopy Tachy	
		STach. to PSR.				in ↑110's to 120's.	
		+2 peripheral pulses				+2 radial/pedal pulses	
		X4 capillary 2-3 sec.					

LEGEND
Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PREPARED BY (Signature/Title) [redacted] /AW
DEPARTMENT/SERVICE/CINC ICU3
DATE 3 nov 03

PATIENT'S INDICATIONS (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)
☐ DIGNOSTIC STUDIES
☐ TRETMENT

(b)(6)-2 unless indicated otherwise

1. Reporting MTF	2. MTF Locat	Admission Coding Information For use of this form, see AR 40-400; the proponent agency is OTSG
[redacted]	IZ	

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

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
[redacted]	42Y	Z	9	

10. Length of Service	ETS	11. FMP	12. Social Security Number
		~~09~~ 50	[redacted] (b)(2)-4

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
		23:37	ARMY

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
NO	K78-PRISONER OF WAR/INTERNEES	

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

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICU3	Address of Emergency Addressee
Name and Location of Medical Treatment Facility: [redacted] (b)(2)-2		Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH		2003-11-15

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
ABD - NEUROSURGERY		2003-11-01

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
		2003-11-01

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW HEAD

Procedure Narrative(s):

Cause of Injury Narrative:

A[redacted]	Signature of [redacted]

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 23189

(b)(6)-

SI # [redacted]

(b)(6)-2 all unless indicated otherwise

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

☐ Offense against Civilian(s) [check one] If "Other" then describe: _____

- ☐ Arson (I.P.C. 342)
- ☐ Solicitation of Fornication/Prostitution (I.P.C. 399)
- ☐ Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)
- ☐ Murder (I.P.C. 405)
- ☐ Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)
- ☐ Maiming (I.P.C. 412)
- ☐ Simple Assault (I.P.C. 415)
- ☐ Kidnapping (I.P.C. 421)
- ☐ Burglary or Housebreaking (I.P.C. 428)
- ☐ Extortion/Communicating Threats (I.P.C. 430)
- ☐ Theft (I.P.C. 439)
- ☐ Destruction of Property (I.P.C. 477)
- ☐ Obstructing a Public Highway/Place (I.P.C. 487)
- ☐ Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
- ☐ Riot or Breach of Peace (I.P.C. 495(3))
- ☐ Other

☒ Offense against Coalition Forces [check one] If "Other" then describe: _____

- ☐ Violation of Curfew
- ☐ Illegal Possession of Weapon
- ☐ Assault/Attack on Coalition Forces
- ☐ Theft of Coalition Force Property
- ☐ Trespass on Military Installation or Facility
- ☐ Photographing/Surveilling Military Installation or Facility
- ☐ Obstructing Performance of Military Mission
- ☐ Other

Apprehending Unit: 4th INF DIV DIV ARTY Location Grid: [redacted]

Date of Incident (D/M/Y)	Time of Incident:	Date of Report (D/M/Y)	Time of Report:
01 / 11 / 03 to / /	hrs to hrs	21 / 11 / 03	[redacted]327 0650 hrs

Detainee # [redacted] (b)(6)-4	Key Connected Person: ☐ Victim ☐ Witness
Last Name: [redacted] (b)(6)-4	Last Name:
First Name: [redacted] Given Name: [redacted]	First Name: Given Name:
Hair Color: BN / Scars/Tattoos/Deformities:	Hair Color: / Scars/Tattoos/Deformities:
Eye-Color: BN / Weight: lb / Height: in	Eye-Color: / Weight: lb / Height: in
Address:	Address:
Place of Birth:	Place of Birth:
Ethn/Tribe/Sect: / Sex: ☒ M ☐ F / Phone#: / DOB D/M/Y: / ☐ Mobile ☐ Regular	Ethn/Tribe/Sect: / Sex: ☐ M ☐ F / Phone#: / DOB D/M/Y: / ☐ Mobile ☐ Regular
☐ Passport ☐ Dr. license ☐ Other (specify) Document #:	☐ Passport ☐ Dr. license ☐ Other (specify) Document #:

Total Number of Persons Involved _____ (list names/identifying info on reverse under "Additional Helpful Information")

☐ Vehicle Information	Vehicle Number _____ of _____ Vehicle(s)		Owner:
Make:	Color:	VIN:	
Model:	Type:	Plate No.:	Number of People in Vehicle:
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

☐ Property/Contraband	☐ Weapon	Photo Taken of Suspect with Weapon/Contraband. Yes/ No	
Type:		Model:	Color/Caliber:
Serial No:	Quantity:	Make:	Receipt Provided to Owner: Yes/ No
Other Details		Where Found:	Owner:

Name of Assisting Interpreter: Email, Phone, or Contact Info.

Detaining Soldier's Name (Print): [redacted] Last, First MI	Supervising Officer's Name (Print): CPT [redacted] Last, First MI
Signature: [redacted]	Signature:
Email:	Email: [redacted]
Unit Phone: Date: / /	Unit Phone [redacted] Date: / /

(b)(6)-2 unless otherwise indicated

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? At Flash Check Point in a station wagon. It turned away from check point, CP fired a warning shot. Kept going, fired again, he was shot. Car flipped. He fell out.

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses.

CPT [redacted]
Night Battle CAPTIN
4th INF DIV DIV ARTILLERY
[redacted]

How was this person traveling (car, bus, on foot)? Car station wagon

Who was with this person?

What weapons was this person carrying? IED material

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information: Sustained GSW to head, time obtained by phone call @ 0645 2 Nov 03 by Sgt [redacted] UCCIC PAD
[redacted] (b)(2)-2

(b)(6)-2 all unless otherwise indicated

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted] (b)(6)-4	[redacted] (b)(6)-4					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M		X				NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted] (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		09:38	ABA - GENERAL SURGERY				
24. Name/Relation of Emergency Addressee		25. Type Disp	26. Date of Disp				
		TRF-OTH	2003-12-09				
27a. Address of Emergency Addressee		27b. Telephone No	28. Date This Adm:	AdmittingOfficer:			
			2003-11-03	ELLISON			
29. ReportingMTF			30. Date Init Adm	32. Units Blood Components			
[redacted] (b)(2)-2			2003-11-03				

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW ABD/SCRTUM/GROIN

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	7	7

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	7	7

Signature of Attending Medical Officer [redacted]

Signature of PAD or Medical Records Officer [redacted]

Automated Facsimile DA FORM 364

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

20 year old Iraqi male with a GSW to the Abdomen + Right groin 12 hours ago. Arrived with no prior tx (other than dressing) states he is otherwise healthy

PHYSICAL EXAMINATION HR 65 BP = 112/51 Sat% = 100%

Awake + alert Lungs Clear
Small Ø flank wound and large anterior abdominal wound
Destruction of the scrotum with dark color testes
Large Right groin wound ± excellent distal pulses
Moves all extremities

PROGRESS (Enter date of discharge and final diagnosis)

A = GSW to Abd / Groin + Sciatica
Pla = Ex lap; (L) groin exploration + scrotal debridement

(b)(6)-2

[redacted]	DATE 310003	IDENTIFICATION NO.	ORGANIZATION
[redacted] (For typed or written entries give Name, last, first, middle, grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

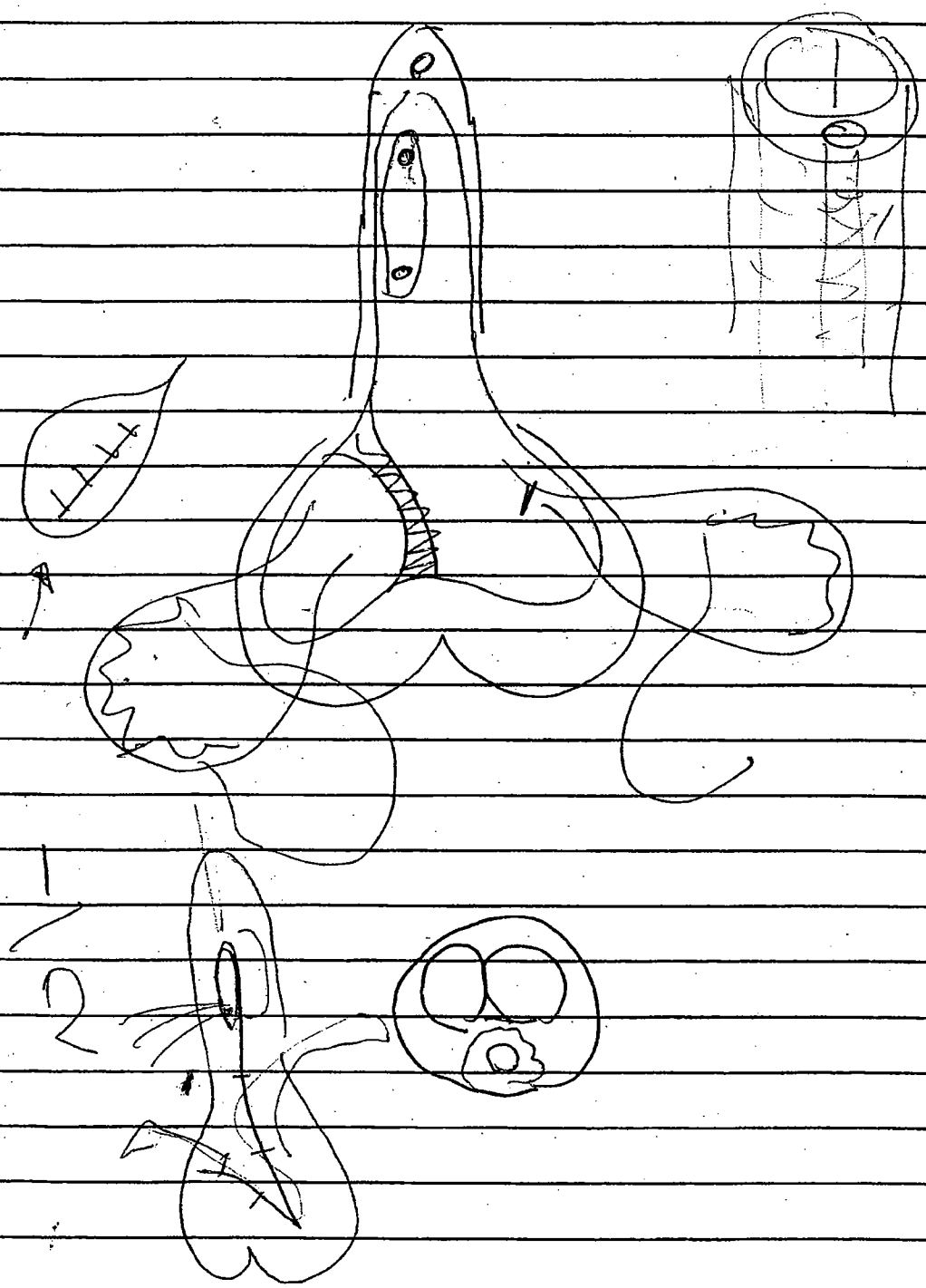
CD

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-108

[redacted]

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES



STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

(b)(6)-2 except very bottom

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
03 NOV03 @ 1450	pt recieved from OR @ 1470 pt VS- BP 128/69 T-94.9 HR-102 RR-16 SpO2 - 100% on 8L via face mask. Pt completing 1 unit of blood that was started in OR pt shows no sign or negative reaction pt given 6100 cc of crystaloids c̄ 800 output during procedure current vital signs- BP 121/55 T-96.8 HR-114 RR-16 SpO2 100% on 12L non rebreather no signs of acute distress noted @ present will continue to monitor [redacted]
@ 1530	pt assessment complete see flowsheet for details pt doing well @ present pt somewhat sleeping from procedure will continue to monitor pt VS. for A's no signs of acute distress noted @ present will continue to monitor [redacted]
@ 1730	pt VSS no problems @ present O2 weaned to RA c̄ Sats of 96% pt unable to take 1800 valium pt still drowsy from OR needs nasal trumpet remains in place pt ARMS (B) & (L) EGS (B) cleaned of blood & mucus pt shows no signs of acute distress @ present will continue to monitor [redacted] PCA
@ 1830	Report recieved from PFC [redacted]. Pt VSS, still sedated from OR today. [redacted]
@ 2030	Dressing to (R) IJ A'd [redacted]
@ 2040	A-line pulled while A'ing dressing. [redacted]
@ 2100	Received report from SPC [redacted]. VSS, Pt hard to wake, will continue to monitor. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
4NOV03 0030	Pt resting comfortably in bed, VSS. Will continue to monitor. [redacted]
0100	Pt SATs ↓ to 88%. Placed pt on O2 6L NR, SATs ↑ to 100%. Will continue to monitor. [redacted]
04NOV03 @0600	pt report recieved @ 0600 VSS pt shows no signs/symptoms of acute distress @ present will continue to monitor [redacted]
@0610	pt valium held pt unable to tolerate @ this time will monitor for S/s of pain to determine if pain medication needed [redacted]
@0800	pt dressings A&D c̄ no complication Pt tolerated well pt Temp @ 0600 101.3 Tylenol given pt ↓ temp to 100.5 will continue to monitor [redacted] Bresh
@1025	pt being weaned from O2 slowly Sat continue to drop s̄ O2 pt temp ↑ 100.7 will continue to monitor for Δ's [redacted]
@1710	pt temp remains in low 100's pt [redacted] SPO2 in mid 90's c̄ RA pt vital stable pt doing well @ this time will continue to monitor [redacted]
@1755	pt using I.S. often pt on RA will continue to monitor [redacted]
@1810	Report recieved from PFC [redacted] pt VSS, temp 100.6. TLC to (R) IJ, all ports flush well. Supra & pubic catheter draining clear yellow urine. [redacted]
@2200	pt VSS, temp 100.5. IS use encouraged. [redacted]
@2330	Drsg Δ done to scrotum & (R) groin wound. Wet to dry drsgs to both sites. [redacted]
@2400	Valium @ 2400 held BP 104/41 [redacted]
@0200	pt VSS Temp 100.1 [redacted]
@0600	Report given to Sgt [redacted] [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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(b)(6)-2

LAST NAME	NAME	INITIAL	ID NUMBER

DATE	NOTES
05NOV03 0914	All Drag. A completed @ this time. 25mg Fentanyl IVP given via Major [redacted]. IS done after drag A able to hold all 3 balls up x10. -0 Respiratory distress noted. Will continue to monitor. Sgt [redacted]
0945	Percocet Tab 1 po given for pain. Will continue to monitor. Sgt [redacted]
5NOV03 0545	Surgery HD#3 ICU D#3 POD#2 Laveson/Unaya D#3 Pt. did well over night. Has developed some nasal congestion. Dressings S'ed + Wounds look good. Will continue dressing S's. Penis dressing S'ed by Dr. [redacted] (Urology) today. Abd is slightly distended + hypoactive BS. Will continue to follow and slowly advance p.o. [redacted]
1038	Pt. resting in bed c̄ eyes closed. -0 distress noted. Will continue to monitor. Sgt [redacted]
1221	Consumed 85% of lunch - soft diet. -0 complications noted @ present time. Will continue to monitor for any S/S of complications. Sgt [redacted]
1427	.5L O2 per NC pos Sat. ↓89%. SpO2 91% @ present time. Will continue to monitor. Sgt [redacted]
1500	↑ O2 to 1L per NC SpO2 94%. Will monitor. Sgt [redacted]

STANDARD FOR[redacted]

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(b)(6) -2 except for very bottom

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
05NOV03	IVF A'ed to NS KCL 20 MEQ/Liter @ 100cc/hr.
1640	SpO2 95% on 1L per NC. [redacted]
1748	Ø distress noted @ present time. Ø voice of complaint of pain @ this time. Will continue to monitor. [redacted]
1800	Received report from day shift. Pt appearse to be resting comfortably in bed. VSS. (R) Side IJ & NS @ 100cc/hr. Foley draining to gravity, clear yellow urine. Pt on 1L O2 NC to maintain SATS @ 100% (>95%). Dressing to abd and penis C/D/I. Will continue to monitor. [redacted]
2000	DRSG Δ complete pt tolerated procedure well. Will continue to monitor. [redacted]
6NOV03 0200	Pt resting comfortable on bed. VSS. Will continue to monitor. [redacted]
0600	Reported off to day shift. [redacted]
6NOV03 @ 0650	pt report received from Sp[redacted] pt VSS, Assessment complete. See healthcare flowsheet for details pt ate apple for breakfast. No c/o pain @ present pt remains on 1L O2 via N.C due to SPO2 ↓ without. will continue to monitor for s/s of acute distress [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.

(b)(6)-4

ePW #[redacted]

PROGRESS NOTES
Medical Record

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

(b)(6) - 2 all

LAST NAME	T NAME	INITIAL	ID NUMBER

DATE	NOTES
06 NOV 03 @ 1025	pt dressing Δ's completed pt tolerated well dressing CDI pt VSS No problems @ present pt shows No S/S of [redacted] acute distress @ this time will continue to monitor [redacted]
@ 1730	pt weaned off O2 pt SpO2 @ 100% on RA T̄ 2° af no O2 will continue to monitor [redacted]
1800	Received report from day shift. Pt appears to be resting comfortably in bed. VSS. TL to (R) EJ (P) flush c̄ NS c̄ 20cc throw blue port @ 100cc/hr. Suprapubic cath draining quantity sufficient clear yellow urine. Will continue to monitor. [redacted]
2300	ΔRSG Δ complete. Pt tolerated procedures well. Areas look pink c̄ white splatches. Area of pus around the sutures. VSS. Will continue to monitor [redacted] SPC, 9/cm
7 NOV 03 0300	Pt appears to be resting comfortably in bed. VSS. Will continue to monitor [redacted]
0600	Reported off to day shift. [redacted]
0615	Reports + care of patient from previous shift received. Pt sleeping in bed. VSS. No S/S of pain or discomfort will cont to monitor [redacted]
0830	Dsg Δ's to Abdomen + (R) groin completed. Pt received 2mg MSO4 for pain. Dsg Δ's td. well. VSS. will cont to monitor [redacted]

STANDARD FORM 509 (REV. 6/1999) BACK

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(b)(6)-2 except for very bottom

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
0000	Recieved report from Sgt. [redacted]. Pt. resting in bed on (L) side c legs bandaged. Bandage intact to abd & (R) groin area. 0 complaints of pain voiced @ present time. Cathei intact draining S difficult. Will continue to monitor. — Sgt [redacted]
0705	MD visit. New Orders noted. — Sgt [redacted]
0752	Incentive Spirometry done @ this time. All 3 balls up x 7. Will continue to encourage. — Sgt [redacted]
	Progress Note - Urology Took down penile drain wound intact healing well - minimal drainage of suture
	Plan: Foley drainage x 10 days Penrose x 7 days
	[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.

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

PROGRESS NOTES
Medical Record

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USAPA V1.00

(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7 Nov 03	dsg for a little scratch on ⓛ flank. ⊕ circulation, skin intact restraints x2 in place. [redacted]
1 NOV @ 2340	VSS. Premedicated pt ō 4mg MSO4 prior to DSG Δ. WTD DSG completed to Abd, scrotum + ⓡ groin. Abd sutures well approximated c̄ ⊖ s/sx of infection. ⓡ groin packed c̄ NS soaked gauze. Sutures approximated ⓡ scrotum sutures approximated. Placed NS soaked gauze + used scrotum # bandage to reinforce. Pt tol DSG Δ well. Supra pubic catheter in place. ⊖ s/sx skin infection. Suprapubic draining clear, yellow urine. Clear, yellow drainage noted ~~around~~ on DSG around penis. Did not Δ 2° no. MD order to Δ DSG to penis. Infusing IV ABX as per order. Pt consumed small amount of food. IV maintenance fluid LR @ 75 cc/hr. Pt asleep + ⊖ c/o pain at this time. [redacted]
5 NOV 03	Surgery HD#6 POD#5 Levaquin / Vancyn D#6 Doing Well No issues Wounds healing. Excellent BS; ⊖ BM Will continue c̄ dressing Δ's [redacted]

STANDARD FORM 509 (REV. 6/1999) BACK

USAPA V1.00

[redacted]

(b)(6)-2 all

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
7NOV03	Surgery HD#5 ICU#5 POM#4 Lingolin/Vancyn D#5
	Pt. has done very well over night. No issues
114/6 /92	will transfer to ward today. Continue
45/24/0.8	dressing Δ's. Dr. [redacted] will eval pen/to
7.6	injury
(6.3) 30.4 (127	[redacted]
	X-rays of RLE = ϕ [redacted]
	Mild swelling of RLE p groin injury
	[redacted]
7Nov '03	pt arrives from ICU 1145 WS, A+O3 pt had mild c/o pain when moving from wheelchair to bed. pt numerous drsg Δ'd prior to admittance. Pt drsg appear CDI pt voided medium/dark urine via urinal. ⊕PERRLA, SKIN intact good perfusion, LUNGS CTA, but breathing appears labored with slight audible wheezing. Bowel sound x4 quads. Pt has suprapubic catheter intact, with wind jockstrap sort drsg under scrotum and a drsg on the penis which is. changed by the doc. Drsg down the stenum [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

USAPA V1.00

(b)(6)-2 except very bottom

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
8 NOV 03 0700	- Assumed care of pt. sleep yet easily arousable VSS Denies having pain @ this time. Lungs clear ARRR Active BS small BM this morning. Superpubic catheter to abdominal wall draing QS clear yellow urine. Urethra c̄ catheter clamped. Multiple GSW to abdomen Ex. Lap done midline incision closed c̄ staples healing. (R) inner thigh and penis testicle removed. scrotum support under wear. QD shower per MD. promote wound healing. Remain afebrile IV ABT IV will cont to monitor [redacted]
8 NOV.03 2030	Pt A+OX3, VSS, midline abd incision ∅ s/sx of infex, staples intact, area tender dsg to abd i'd, W→D, [redacted] wounds beefy red, scrotum support in place, dsg to scrotum blood tinged, pain controlled c̄ 4/10 percs, IS @ bedside, pt understands proper use, ate 40% of diet, FTG draining c/u, 2 point restraint, ∅ complications. [redacted]
2045	Pt ambulated c̄ walker assistance, ambulated on the tip of toes, tol well but painful. [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 V1.0(

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9NOV03 @ 1600	Assumed care of pt. @ 0600. Pt. resting quietly in bed, V.S.S. Ø C/O pain, A+O. DRSNG to abdomen & groin removed & pt. assisted to BR for shower, unsteady gait. Pt. assisted back to bed & DRSNG reapplied. W → Ø drsngs to abdomen, superficial wounds, small amt. sero-sang drainage. Bacitracin applied to open urethra, Foley Stent intact. Dry Kerlex to scrotum incision, penrose intact, serosanguinous drainage, scrotal support intact, [redacted] suppository @ 1000, ⊖ BM this shift, hyperactive BS. Pt. in 2-point restraints Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor, [redacted]
9 NOV03 @ 1800	Pt. has suprapubic catheter draining dark yellow urine, 1500cc out this shift. 1-2+ pitting edema to (R) foot. Pt. ambulates to BR, on toilet at this time. — [redacted]
9NOV.03 1930	Pt A+OX3, VSS, OOB → ambulate, ambulates c̄ slow unsteady gait, able to ambulate on his own, dsg on abd wound d'd, serosang drainage noted on old dsg, wound appears beefy red, packed c̄ W→D dsg, covered c̄ 4x4's, staples to midline abd incision CDI, Ø s/sx of infex, dsg around penis + ~~scrot~~ [redacted] scrotum d'd, drainage on old dsg, applied bacitricin to urethra and incision on scrotum, penrose drain intact, cath clamped in place, SP cath draining CYU, pain controlled c̄ 11 percs, IV (L) FA intact infusing LR @ 75 cc/hr, Ø s/sx of infex, scrotal support underwear in place. I concur c̄ above assessment [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
Cont.	2 point restrain, Ø complications [redacted]
09NOV03	I Concur c above assessment [redacted]
10NOV03	Surgery HD#8 POD#7 Levaquin/Vancyin D#8
	Afebrile
	Wound healthy
	Continue Dressing Δ's + shower [redacted]
10NOV03	55. AO. Ambulated c assist [redacted] on ward for 30 min.
1045	Performed wound care and showered after DSG's
	removed by MD - Dr [redacted]. Abdominal, (R) inner
	thigh, upper (L) torso wounds and scrotal wounds
	appear pink and healthy c s/s infection, malodor
	or overt bleeding. SP catheter intact c gravity
	flow - light amber, DS. Staples to Abdominal
	incision CDI as well to (R) inner thigh. Catheter
	through urethral opening intact c s/s of infection.
	Minimal drainage of serosanguinous fluid. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
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PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 NOV 03 1900	Pt A+O x3, VSS, LS CTA (B), Hypo active BSx 4 quads, pain controlled c̄ percs, IV-HD FA intact, infusing LR 75cc/hr, ø s/sx of infex or infiltration, staples to midline abd incision CDI, tender on abd, abd wound dsg Δ'd, appears beefy red granulated tissue, ø s/sx of infection, WTD dsg c̄ 4x4's covering it, (L) flank 2x2 dsg Δ'd, ø active bleeding or s/sx of infex, dsg's around penis + scrotum Δ'd, serosang drainage noted on old dsgs, penrose intact, bacitricin applied to urethra area, cath tip inserted + clamped, SP cath site ø s/sx of infex, SP draining CYU, supportive underwear in place, dsg on (R) groin Δ'd, moderate drainage on old wound, WTD dsg, 2 point restraint, ø complications. [redacted]
11 NOV 03 @ 0830	Pt. A&O*3, V.S.S., Ø c/o pain. All dressings removed, pt OOB to shower, ambulates c̄ assistance, slight unsteady gait. Midline incision, well approximated c̄ staples intact. Abdom. wounds red c̄ yellow exudate. (R) inguinal wound red c̄ yellow exudate, scant serosang. drainage to old penile dsng. Foley stent intact, visible from open urethra on ventral side of penis. Suprapubic catheter intact draining clear yellow urine. Pt. reported (+) BM this AM, Ø diarrhea or constipation. Will redress wounds p̄ pt. takes shower. [redacted]
11 NOV 03 @ 1030	All dressings Δ'd as per MD orders, 1-2+ pitting edema to (R) foot, (R) LE elevated on blanket, LR @ 75cc/°, All other assessments WNL [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11 Nov 03	Assumed care of Pt @ 1800 hrs. A&O Pain controlled
2300	c̄ percocet. LS CTA (B), TS 10x h. when Awake. HRRR.
	DBS x 4 quads. SP cath Draining c/x/u. Foley cath
	acting as stent. No Drainage. Midline Abd incision
	closed c̄ staples. Wound superior to incision Pink
	c̄ yellow Drainage on Drsg. W⊃D Drsg A'd. Wound
	to penis c̄ yellow Drainage on Drsg. Appears pink &
	Healthy. Covered c̄ Kerlex fluff c̄ coban. Wound to R
	Inguinal area pink and healthy in appearance W⊃D
	Drsg A'd. Kerlex fluff to scrotum A'd scrotum inc-
	sion closed c̄ sutures. No s/sx of infection noted
	on any wounds or incisions. Penrose Drain to
	scrotum intact and in place. (R) foot has +1 pitting
	edema (R) foot elevated. (+) 2 pulse. Warm & Dry
	to palpation. Will continue to monitor [redacted]
12 NOV 03	Surgery HD#10 POD#9 Leavenworth D#9
	Doing well; Abd incision healing well. will remove
	staples in 2 days; Abd wound c̄ good granulation.
	Groin wound healing well. will leave sutures for 14 days.
	Scrotum c̄ Drain still in place. + some exudate.

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12NOV03 1210	VSS, AO. Ambulated on own assist to shower. Seen by MD and DSG Δ's performed. Provided clean clothes, sheath and scrotal support. H&V per Dr. Rx. IV AB D/C'd and s'd to PO. Expressed concerns over missing family @ this time. MD stated wounds are healing well and offered to close (R) inguinal and abdominal incisions in a couple of days. ∅ S/S of infection to wound sites. ∅ S/S skin breakdown. Cont to monitor. [redacted]
12NOV 03 2300	VSS AO. Dsg's Δ'd. Scrotal support inplace c̄ Rerdex Fluff. Encourage IS, PO Fluid intake. Pt Denied pain @ this time. LS CTA (B), HRRR. (B) BS x4 quads. S/P cath inplace Draining clear yellow urine. HL To (R) FA. Will continue to monitor. [redacted]
13NOV 03 1720	VSS, AO. Ambulated to shower on own assist c̄ difficulty. DSG Δ'd to wounds c̄ healing well. Bacitracin applied to meatal cathet and opening. LS CTA AB. HRR. (B) pulses in all extremities. BS (B) x4 and states PO med. Noted c/o pain p̄ DSG Δ and provided comfort. S/P cath intact and voiding light amber urine, ∅ S. [redacted] ∅ S/S of skin breakdown [redacted]
13NOV.03 2000	Pt A+O x3, VSS, OOB to BR, SP cath site intact, draining CVU, dsg's Δ'd, abd wound healing well, ∅ s/sx of infex, minimal amount sero sang drainage to dd dsg. (R) groin wound packed c̄ WTD, ∅ s/sx of infex, staples to mid line abd CDI, cath tip in place. Bacitricin applied to urethra covered c̄ 4x4, supportive underwear in place, ∅ s/sx of skin breakd

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F conc. c̄ above as. [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14NOV03	Surgery HD#12 POD#11 Levaquin D#11 No new issues. Wound, healing well Staples removed. Pt, is an EFW & will have to remain here until wounds closed [redacted]
14NOV03 @ 1600	Assumed care of pt @ 0600, V.S.S., A&O x 3, ~~II~~ Percocet given for dressing Δ. MD removed staples to midline abdominal incision, Ø drainage, edges well approx. All Dressings Δ'd as per MD order, Ø signs of infection. ⊕1 pitting edema to ® ~~tt~~ (MM) foot. ® LE elevated on blankets. Supra pubic catheter intact → clear yellow urine. Pt. ambulates ∓ assistance, limps on ® foot. Pt. is 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. — [redacted]
14 Nov 03	Assumed care @ 15 hours. VSS A&O Perc for pain. Drsg Ad. Ø S/Sx of infection noted. +1 pitting edema to ® foot LS CTA ®, HRRR, ⊕ BS x 4 quads. Will cont to Monitor. [redacted]

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

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

DATE	NOTES
15 NOV03	Surgery, WD#13 POD#12 Levaquin D#12 Abd + groin wounds. Healing well May try to loosely approximate these wounds tomorrow [redacted]
15 NOV03 1600	Assumed care of pt. @ 0600. VSS, A&O, ~~#~~ PERCS for pain DRSNG Δ's. All DRSNG's Δ'd as per MD order, Ø signs of infection noted. Pt. OOB to BR to shower & use toilet. ⊕ BM. ⊕ 1 pitting edema to ® LE, elevated c̄ blanket in bed. Pt. in 2-point restraints, Ø signs of skin breakdown. Supra-pubic cath intact → CYU. All other assessments WNL. [redacted] CT, ANC
2210 -	assumed care of pt. @1800. VSS - A+O. drsng Δ's conducted. w→D to Abd. wound + ® UE. ⊖ s/sx inf. Drsng Δ completed to penis. Bactracin applied + wrapped c̄ tubian. ⊖ s/sx infection. ⊕ edema to ® Foot. Elevated c̄ Blanket. Foley intact. Supra pubic intact draining CYU. Pt. resting well @ this time will cont. to monitor. [redacted] I concur c̄ above assessment [redacted]
16NOV03	(0908) VSS. ⅡⅠ percocet for pain. Pt tol DSG Δ well. ~~Dsg~~ Packed DSG [redacted] to (L) side of mid-line abdominal incision. Dr [redacted] viewed wound. Dr [redacted] stated that he planned to close abdominal wound. ⊖ new orders pending. WD DSG to ® groin. —

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17NOV03	(1025) NSG - VSS. Pt amb to BR c̄ steady gait. Pt did own AM care. WTD DSG to ABD + (R) groin. Applied Bacitran to underside of penis + wrapped c̄ super sponge. Yellow catheter in place. Suprapubic catheter intact + draining clear, yellow urine. ⊖ drainage noted around tubing. ⊖ S/Sx of infection. c/o pain. Med c̄ ⅓ perc. Pt asleep at this time. [redacted]
17NOV03	(1540) NSG - Spoke to Dr. [redacted]. Requested to hold off on DSG Δ in AM 18NOV 2° MD will loosely suture ABD + (R) groin wounds. — [redacted]
2120	- VSS - A+O LS CTA (B), Resp. even unlabored NSR, Abd soft nontender, BS x4. drsng Δ completed. Bacitracin applied to underside of penis + wrapped c̄ 4x4's + kerlex. LWD drsng done to (L) side midline incision + (R) grain area. ⊖ S/Sx infection. Pt. voiding per supra pubic cath. foley catheter in place. ⊖ drainage noted around tubing. Two pt. restraints in place c̄ ⊖ skin break down (+) circulation. Will cont. to monitor pt. — [redacted]

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DATE	NOTES
18NOV03	(1440) NSG - VSS c/o pain. Medicated c̄ ii percetabs. c̄ adequate relief. Completed DSG Δ. ⊖S/Sx of infection. Bacitran applied to underside of penis. Scrotal support in place. Pt amb on ward x 1 c̄ steady gait. (+) Suprapubic catheter intact. drains clear, yellow urine. [redacted]
18NOV 2000	VSS. Tissue to open wounds pink & moist Bacitraten applied to incision & underside of penis. Dry dressing wrapped around penis. Suprapubic cath intact & draining clear yellow urine. Ambulating BR and BM x1. Scrotal support in place. Will continue care as planned. [redacted]
19NOV03	Surgery HD#17 POD#16 Levequin D#16 Doing well. Will approximate the abdominal & groin wounds today. Foley to be removed on 5-7 days. [redacted]
19NOV03@1440	Assumed care of pt. @ 0600. VSS, A&O. ii Percocet for pain & pre-med for dressing Δ. Pt. OOB to shower, ambulates c̄ assistance. MD closed abd. & (R) inguinal wounds c̄ sutures after

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WARD NO.

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DATE	NOTES
	pt. took shower, edges well approx., scant sero-sang drainage, covered c̄ dry gauze. Dry dressing Δ to penis, Kerlex fluffs to scrotum, scrotal support on, suprapubic cath intact → CYU. (R) LE elevated on blankets. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor, [redacted] LT AN
19NOV03	0030 assumed care of pt. @ 0000. pt. tolerated dinner well. no c/o pain @ this time. drsng Δ. completed to (L) side of mid line incision + (R) groin area. Sutures intact, well approximated c̄ (−) s/sx inf. dry drsng applied to penis & scrotum wrapped c̄ kerlex. (−) s/sx inf. pt. has foley in place. Supra pubic intact draining CYU. Two pt. restraints in place (−) skin breakdown, (+) circulation [redacted] Cont. to monitor pt. [redacted] I concur with above assessment [redacted]
20NOV03	0750. BP 117/56, P-51, 98% RA, R-16
20NOV03	POW #17 No new issues [redacted]

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DATE	NOTES
20NOV03	(1500) NSG-VSS. Pt c/o pain to sutures on abdomen & (R) groin. Premedicated pt 02mg MSO4 IV prior to DSG Δ. Dr. [redacted] viewed sutures. MD ordered to pack lightly suture to (R) groin. Sutures are loosely sutured c̄ ⊖ s/sx of infection. Dr. [redacted] removed sutures to suprapubic cath. Suprapubic intact + draining clear, yellow urine. Pt amb on ward c̄ steady gait. No Duoderm applied to penis 2° Dr. [redacted] request. Pt appears to be comfortable at this time. Will contine to monitor pain. —
2250	@1800 [redacted] assumed care of pt. [redacted] VSS-AVO pt has ∅ c/o pain @ this time. LS CTA (B), resp even. unlabored, RSR, abd soft nontender, BS x4. voiding cyu per supra pubic, foley in place. sutures to (L) of midline incision intact. sutures to (R) groin intact. packed lightly covered c̄ 4x4's. Dry gauze applied to penis + scrotum. ∅ s/sx infection. pt. ambulated in hallway x20mins. Tol. well. Trip pt. restraints in place. S. skin/cure. compromise. Will monitor. [redacted]

RELATIONSHIP TO SPONSOR [redacted]

LAST	FIRST	MI	NUMBER
			[redacted]

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DATE	NOTES
~~20F~~ 21NOV	(0700) 124/55, 61, 98%, RA, 20, 96.8, [redacted]
21NOV03	Surgery POD #18 Doing very well. Abd + Groin wounds approximated. Will remove foley in 4-7 days [redacted]
21NOV03	(1700) NSG - VSS. Pt. c/o pain to (R) groin + ABD. Med ō 2mg MSO4 prior to DSG Δ. Suture to ABD well approximated. ~~Ste~~ Cleaned ō H_2O_2 + covered ō dry DSG. (R) groin suture has 1/2 cm openning. Lightly packed WTD + covered ō dry DSG. 2x2 gauze placed on underside of penis. (P) suprapubic cath intact draining clear, yellow urine. [redacted]
~~21~~ Nov @ 0355	Assumed care @ 1800; VSS, pt A&O speaking arabic; Ø c/o pain/discomfort @ this tim abd sutures ~~[redacted]~~ CDI, well approximated, ~~cleaned w/ H_2O_2~~ error & dry dsg placed over; dsg to (R) groin Δd w→D, lightly packed; 4x4 placed to underside of penis; SP tube intact, ~~patent~~ draining clear, yellow urine; Restraints in place, (+) circ, Ø skin breakdown will cont to monitor [redacted]
22NOV03	Surgery POD #19 Doing well. Wounds healing. Foley out tomorrow [redacted]
22 NOV 03 @ 1500	Assumed care of pt @ 0600, VSS, A&O, ⅓ Percocet for c/o pain to (R) LE. Pt. OOB → shower. Dressings Δ'd as per MD order, Ø S/Sx of infx. Supra pubic cath intact → CYU. Foley stent intact Pt. in 2 point restraints, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monit [redacted] 2CT, A

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11/22/03	Day well [redacted]
	Plan catheter removal ~~today~~ tomorrow
	DC Bilty
	DC Valin [redacted]
	Wound continues to heal
	Plan leave foly
	VPVR [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
23 Nov 03 0300-0400	Assumed care @ 1900; VSS, pt A&O speaking arabic; pain controlled c̄ percs; All dsgs Δd per MD orders, ⊖ s/sx infection; SP tube in place, tube care provided SP tube draining clear yellow urine; Foley in place + clamped; Pt OOB to BR, Restraint in place, ⊕ circ, ⊖ skin breakdown; cont to monitor [redacted]
23 NOV 03 @ 1130	Pt alo, VSS, medicated c̄ percocet for pain @ 1000. Dsgs removed & pt showered. Dsgs reapplied SP tube intact, Dr [redacted] removed foley this AM. & ordered post void residual V's from SP cath. Heparin SQ & colace PO given per MD orders. ⊘ s/sx infection noted from wounds. all other findings WNL. Will monitor [redacted] LPN.
1830	Pt ~~has~~ voided x2 out of penile opening (urethral) unable to measure amount voided both times. Residual V's recorded on I/O sheet [redacted] MWM
23 Nov. 03 1930	Pt A+O x3, VSS, dsg's on penis, ⊕ groin + abd Δd, scant amount of drainage noted, pain controlled c̄ percs, SP intact, ⊘ s/sx of infex on SP cath site. Tis [redacted] ⊘ s/sx of infex on wounds. [redacted] BW Focus c̄ abdomen assessment [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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DATE	NOTES
	(cont) ⊖ s/sx of infection. Sutures to Ⓡ groin well approximated ⊖ s/sx of infection. Sutures to scrotum ⊖ s/sx of infection + well approximated. 2x2cm openning on underside of penis. Bacitran applied + wrapped c̄ supergauze, held c̄ koban. Scrotal support in place. Pt amb on ward c̄ steady gait. ⊕ ~~Foley draining clear, yellow~~ error Suprapubic catheter in place draining clear, yellow urine. Catheter intact. Very minimal amt of yellow drainage around catheter. [redacted]
2315 -	Assumed care of pt @ 1800. VSS-AFO! ⊘ c/o pain at this time. drsng Δ completed to Ⓛ side of mid-line incision. packed w→D. ⊖ s/sx infection. Drsng to Ⓡ femural area Δd. w→D. sutures intact ⊖ s/sx inf./Redness. [redacted] drsng Δ done to underside of penis. Bacitracin applied. wrapped c̄ 4x4s + Koban. ⊖ s/sx infection. Scrotal support in place. suprapubic catheter in placedraining clear yellow urine. foley in place, intact. ⊘ complaints @ this time. ⊕ edema to Ⓛ foot. elevated c̄ blanket. Will cont. to monitor. [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR [redacted]

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24NOV03 @ 1330	Pt a/o, VSS, medicated c̄ percocet for pain. Pt has not voided from urethra since last night. Residual v's being done from SP cath + amt documented on I/O sheet. ∅ bladder distention noted. Pt showered + drsgs Δ'd. Small amt serous drainage to penile drsg. Abd + (R) groin wound c̄ ∅ drainage. Pt amb x2. Tol Reg diet well. (+) appitite today. Will monitor. [redacted]
25NOV03 @ 0200	assumed care of pt @ 1800. VSS. no c/o. Alert, LSCTA, (+) BS, tol po well. voids per SP cath. Though interpreter, pt states he doesn't like voiding through urethra pt messiness when it leaks. Will notify MD. ML abd inc x2 OTA, small dry drsg applied, sutures in place. (R) groin drsg Δ'd small amt serosang drainage noted. Scrotal & penile incision c̄ VTD drsg Δ, ∅ drainage noted, sutures noted in penile wound. 2pt restraints in S/Sx of skin/circulation compromise. Plan: monitor drsg, pain control. Addendum: (R) foot noted c̄ + edema (+) DP pulse, equal (bilat). — [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25NOV03	Surgery POD#22
	(R) No New issues. Sutures removed from groin wound and will continue dressing changes. Probably 5-7 days before transfer to camp.
	[redacted]
25nov @0950	Pt a/o, VSS, c/o pain, controlled c̄ percocet. Dr [redacted] came & spoke c̄ pt. WTD drsg to (R) groin per MD. MD removed sutures today & wound is not closing completely. Small amt sero-sang drainage noted. Midline abd incision now OTA, ∅ drainage noted. Penile & scrotal drsg Δ'd, scant yellow drainage on drsg. Post void residual V's con't. SP intact - drsg Δ'd. ∅ s/sx infections to wounds. Will monitor [redacted]
23NOV.03 2000	Pt A+Ox3, VSS, LS CTA (B), (+) BSx4, percs adm. for pain, dsg (R) groin Δ'd, ∅ s/sx infex on wound, fluff placed around penis. SP cath clamped in place, ∅ s/sx of infex around site, scant amount

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)
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(b)(6) - 2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Cont.	serosang drainage on old dsg. GOB to ambulate, tol well. [redacted] GIM
2300	Pt voided 275cc CYU, [redacted] urine output from SP cath. [redacted]
	Ionan & abne assess [redacted]
	Urology
	SP out the AM
	PVR's ≠ 100
	Plan to Comp when leg wounds heal
	2nd stage: repair in 3-6 months
	[redacted]
26 NOV 03 0830	Assumed care of pt sleep yet easily arousable AAO x3. VSS ∅ c/o pain or discomfort @ this time Lungs clear HRRR Active BS x4 quads Urinating through his urethra spontaneously. Wound to (R) groin region healing 4x4 gauze CDI Wound to penis 4x4 gauze small amounts of serous drainage. Suprapubic catheter d/c'd per MD. Will cont to monitor [redacted]
27 NOV 03 @ 0800	assumed care of pt @ 1800. VSS. No c/o pain. Pt ↑ AMB to BR / in hallway S assist. voiding per urethral wound (underside of shaft) QS, but refused to void in urinal Pt lack of control of spray. Dry dsg to urethral wound applied & (R) groin wound, S drainage. Pt restraints on S S/Sx of skin / circulation compromise. CONT [redacted]

STANDARD FORM 509 [redacted]

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(b)(6) - 2 except for bottom

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
27NOV03 @0300	(CONT) Tol regdiet well, ∅ other issues. Plan: monitor output, enc fo intake, enc OOB. Will monitor. [redacted]
27NOV03	Surgery AVSS No New Issues Once wound healed, will transfer to E/W cary. [redacted]
27 nov 1110	Pt c/o, VSS, medicated c̄ percocet for pain @ 0900. drsgs S&D (R) groin c̄ scant sero-sang drainage voiding thru urethral wound, unable to document I/O's due to lack of control. Dry drsg over previous SP cath site. Pt amb. ∅ difficulty. Plan: monitor drsgs & any difficulty voiding. Will monitor [redacted]
27NOV03 1900	Pt A+Ox3, VSS, pain controlled c̄ percs, voiding through urethra ∅ difficulties, wound (R) groin dsg S&D, scant amount sero-sang drainage, SP cath old site ∅ s/sx of infx,

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

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

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

[redacted] (b)(6) - 4

PROGRESS NOTES
Medical Record

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(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Cont.	[redacted]
0430	Pt c/o pain, adm 2 percs as per [redacted] ers. will continue to monitor. [redacted]
	Jemar Calme [redacted]
28NOV03	Surgery Healing well Silver Nitrate Stick to Left Groin Wound to decrease granulation + assist healing [redacted]
28NOV03	(1535) Assumed care of pt. Pt alert, speaking Arabic. VSS. ∅ c/o pain. OOB to shower this am. Dry dsgs applied to ® groin and underside of penis. ∅ s/sx of infection. Pt amb in hallway ⅀ diff. Tol. reg diet well. Voiding ⅀ difficulty through urethral wound. 2 point restraints in place ⅀ s/sx complications. will cont. to monitor. [redacted]
28NOV03 1830	Pt A+OX3, VSS, OOB to BR, silver nitrate sticks used for ® groin wound, scant amount sero sang drainage noted on old dsg, ∅ s/sx of infex on wound or urethra, voiding ⅀ complications, percocet adm to relieve pain. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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(b)(6)-2 except for bottom

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29NOV03 (2000)	Assumed care @ 0600. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt OOB to BR this am for shower. Dsg applied to groin p̄ silver nitrate stick applied by MD. Fluffs placed between scrotum and penis. Pt voiding s̄ diff. Amb in hallway s̄ difficulty. Tol. reg diet well. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. [redacted]
29NOV03 2030	Pt A+Ox3, VSS, 11/11 percs adm for pain relief. OOB → BR, voiding s̄ difficulties, dsg on (R) groin Δ'd, scant amount sero sang drainage on old dsg, ∅ s/sx of infex on wound, fluffs placed between penis + scrotum. [redacted]
30NOV03	Surgery. No new issues. Continue to follow (R) groin wound [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
#[redacted] (b)(6)-4		1CW1

PROGRESS NOTES
Medical Record

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USAPA V1.00

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30NOV03	(1600) NSG. VSS. c/o pain x1. Med c̄ ½ percocet. Will continue to monitor. Pt showered. Redressed (R) groin c̄ dry fluff ⊖ signs of infection. Voids in urinal s̄ difficulty. pt tol po well. Amb c̄ steady gait. Limps on (R) Leg. [redacted]
30NOV03 2045	Pt A+Ox3, VSS, percs adm for pain relief, dsg (R) L'd, scant amount sero sang drainage noted on old dsg, wound s̄ s/sx of infex, fluff placed between penis + scrotum, OOB → BR, voiding s̄ difficulties, urethra appears healing well s̄ s/sx of infex. [redacted]
1 Dec03	Assume care of PT @ 0600. A+O, VSS c/o pain given percocets. Ambulate c̄ assistance. Showered, redressed (R) groin, CDI. Void c/y urine. In 2pt restraint s̄ skin breakdown. Will cont to monitor. [redacted]
2Dec03 0500	Assumed care @ 1800; VSS; pain controlled c̄ percs, pt alert + speaking arabic, all dsgs CDI; pt OOB → BR x2, amb in hall x1 s̄ difficulty; pt tol Reg diet, voiding s̄ difficu Restraints in place s̄ skin/circ ~~compromise~~ compromise; cont to mon to [redacted]
2DEC03	Doing Very well Awaiting closure of very small groin wound [redacted]

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(b)(6)-2 except bottom

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
02DEC03	(1015) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt OOB to shower this am. Amb well. 4x4 placed on (R) groin wound. ∅ S/Sx infection. Pt voiding s̄ difficulty through urethral. Tol. reg diet well. 2 point restraints in place s̄ S/Sx complications. Will continue to monitor. [redacted]
	Assumed care @ 1800, VSS, pt Alert + speaking arabic; pain controlled c̄ percs; Pt OOB to amb in hall & to BR s̄ difficulty; dsg to (R) groin CDI; pt Tol Reg diet well; voiding s̄ difficulty; Restraints in place s̄ compromise to skin/circ; cont to monitor [redacted]
3DEC03	assumed care @ 0600 pt awake + oriented x3 WNL. pt has ∅ c/o pain at this time, pt up and ambulating without difficult, (R) groin dsg CDI after pt's shower, restraints x2 in place ∅ skin breakdown (R) circulation. [redacted]
	(1345) I concur c̄ above assessment. [redacted]
3DEC03 @ 2340	Assumed care of pt @ 1800, VSS, no c/o. Alert, speaking arabic. LSCTA, tol reg diet, ambs assistance, but drags (R) foot. (R) groin wound small approx 1.0 cm x 1.0 cm x 0.5 cm ∅ drainage noted, dry dsg applied. Wound (CONT) [redacted]

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

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

REGISTER NO.

WARD NO. ICW1

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

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3DEC03 2340	(CONT) to underside shaft of penis OTA, sutures noted & intact. Voiding s̄ difficulty. Teary/crying @ ≈ 2200, refusing Heparin & colace. Explained through interpreter importance of Heparin. Pt stated he wanted to return to EPW camp. Opt restraints on s̄ S/Sx skin/circulation compromise. Plan: monitor pain, enc OOB, enc po. [redacted]
4DEC03 0700	Assumed care of pt @ 0000 pt sleeping, [redacted] pt awake + oriented x3, pt has 20 c/o pain at this time, spoke to Dr. [redacted] about d/c'd hep but because of pt level of activity he still needs it, 1100 pt ambulates without difficulty and showers, drsg to ⓒ groin CDI, restraints x2 in place ⊕ circulation ⊖ skin breakdown. Will monitor [redacted]
4DEC03 1900	VSS Alert + Oriented Consumed 80% of dinner. Ⓡ groin drsg dry & intact. ⊘ c/o pain or discomfort @ this time. OOB → BR Ⓘ upon supervision of MP's. Peripheral pulses +2. 2point restraints in place without compromising skin integrity or circulation. will continue plan of care [redacted]
5DEC03	Surgery Wounds closed dry & intact. Will rise to transfer summary. As soon as very stable [redacted] clean wound of Ⓡ groin [redacted] closed may go to prison camp. [redacted]

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(b)(6) - 2 except bottom

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
5 Dec 03 1450	Assume care of PT @ 0600. Ato, VSS c/o pain given ii percs. Ambulate and showers on own. 2pt restraint ∅ skin breakdown. Drsg to (R) groin dcd. Ap, drsg 4x4 and tape. Area CDI. Will cont. to monitor. [redacted]
	(1600) I concur c̄ above assessment [redacted]
5 Dec 03 (1900)	VSS Alert & oriented. Drsg to (R) groin Dry & clean. 2 point restraints in place without compromising circulation or skin integrity. Voiding without difficulty. OOB ambulate to BR c̄ supervision of MP's. ∅ c/o pain voiced or noted. Will continue care as planned. [redacted] 2LT AN
6 Dec 03 1350	Assume care of PT @ 0600. Ato, VSS c/o pain in (R) leg. Ambulate. Dcd drsg to (R) groin, dry, drsg c̄ 4x4. Wound has closed. 2 pt restraints. Will cont to monitor. [redacted] 2LT AN
6 DEC @ 1800	I agree c̄ previous assessment. [redacted] 2LT AN
7 Dec 03 @ 0210	Assumed care @ 1800; VSS, pt alert speaking arabic; Pain controlled c̄ percs; dsg to (R) groin CDI, ⊖ drainage; pt TOI Reg diet; voiding c̄ difficulty; pt amb to BR; Restraints in place c̄ compromise to

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

DEPARTMENT/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: Ser; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

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[redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(
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(b)(6)-2 all

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont) skin/circ; cont to monitor [redacted]
7DEC03 0815	Assumed pt. care @ 0600. pt. A+O, speaking arabic, able to ambulate and shower on his own ∅ difficulty. VSS. pt. c/o pn on (R) foot-(+) PMS, FROM on (R) foot but walks c̄ a slight limp. Wound on groin area appears to be healing well. (−) s/sx of infex. dry drsg applied, very minimal to (−) drainage. Will continue to monitor [redacted] RC9IWIO
7Dec03 2300	~~Assumed care @ 1800; VSS, pt alert speaking arabic, pain controlled c̄ Tylenol dry dsg to (R) groin CDI, (−) drainage; pt OOB → BR; pt amb ∅ difficulty c̄ slight limp, pt seems to be favoring (R) foot; pt TOL Reg diet; ++ voiding ∅ difficulty; Restraints in place ∅ compromise to skin/circ; will cont to monitor [redacted]~~
8Dec03 0810	Pt c/o pain in (R) foot. Pt given 11 percocet per MD order. Will continue to monitor [redacted] 9IWMS
8DEC03 0930	Assumed care @ 0600. pt. A+O, speaking Arabic. VSS. able to ambulate well and shower on his own. walks c̄ a limp on (R) foot. (+) PMS, FROM on (R) foot. Dry dsg applied to groin area wound. appears to be healing well c̄ no s/sx of infex. HRRR, LSCTA, BSX4. PO tol well. voiding ∅ difficulty no signs of skin breakdown on restraint and other prone areas [redacted] RC9IWIO
8DEC03	Surgery Wounds Healed. Transfer to Camp tomorrow. No meds needed Follow up c̄ Urology in 3 months [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
8Dec03 1725	Pt given tylenol for pain per MD orders [redacted]
08DEC03	(2335) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. 0 c/o pain. Dry dsg applied to @ groin wound. Scant amount of drainage noted. Groin and penis wound s/s infection. Tol reg diet well. Voiding s/s difficulty. 2 point restraints in place s/s complications. Will continue to monitor. [redacted]
9 Dec 03 0700	Assumed care of pt. AtO X3. VSS Denies having any pain or discomfort @ this time. Lungs CTA HRRR Active BS X4 quads Tolerating PO well. Urinating spontaneously s/s difficulty. Wound to @ groin and penis healing NO s/s of infection open to air pt Afebrile Will cont to monitor [redacted]
1300	Pt OK for discharge escorted by MP assessment findings WNL [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203
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MEDICAL RECORD	PROGRESS

DATE	NOTES
9 DEC 03	
1000	20 Y/O DOB/P 6 DAYS TO (R) THIGH FRACTURE & PENIS. URETHRA ALSO INJURED. SUPRAPUBIC CYSTOSTOMY PERFORMED. WOUNDS HEALING WELL. SUPRAPUBIC CATHETER D/C. PT. VOIDING S DIFFICULTY. AMBULATING & TOLERATING DIET. TRANSFER TO WARD. NO MEDS. PLAN: UROLOGY F/U IN 3 MOS.

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

(b)(6) - 2 all

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 NOV 03	Op Note
	Pre op Dx = GSW to Abd; (R) groin + scrotum
	Post op Dx = Negative Lap; (R) groin injury; scrotal injury
	Surgeons: [redacted]
	Indications = as above
	Procedure = Ex Lap; debridement of wounds + scrotum; (R) groin exploration
	EBL = 1000
	Fluids = Cry = 6 liters + unit PRBC's
	UOP = unmeasurable
	Findings = Negative Lap; Urethra injury; Bilateral testicle injury; negative Right groin
	Drains = Supra pubic Cath + Foley cath
	Will need further surgery to penis for recon;
	Dressing Δ's to open wounds
	[redacted]

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

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

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

(b)(6)-2 unless indicated otherwise

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

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

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

3. DATE 3 Nov 03 TIME PATIENT ARRIVED IN SUITE 1020

4. PATIENT IN ROOM TIME 1020 NUMBER Trauma OR

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: Unknown
pt. intubated.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] (Start - 1100)	RELIEF CIRCULATOR	CPT [redacted] (1030 - 1200)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

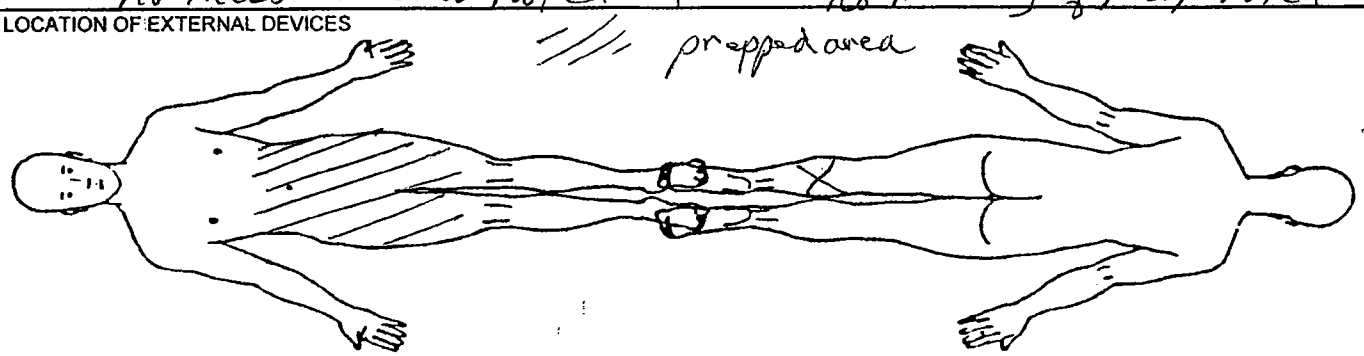
HAIR REMOVAL ☐ YES ☐ NO Dr. [redacted]
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☑ RAZOR ☐ CLIP

COMMENTS: no nicks or cuts noted.

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: nipple line to BY WHOM: CPT Heib
SITE: knees BY WHOM: —

COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS MAJ [redacted] SGT [redacted]

C = Correct I = Incorrect

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

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

#

3 Nov 03

[redacted] (b)(2)-2

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

☑ ESU NO: valleylab
GROUND PAD: BRAND Valleylab E7507
LOT NO: 68245 Exp 2005-02

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 23233

(b)(6)-2 all

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 16F Foley	2. 3/8 Penrose	3.
SITE	1. to gravity x2	2. Scrotum	3.

18. DRESSING/IMMOBILIZATION (Specify) ~~ABD~~
Bluffs 4x8
- Coban Silktape
- Scrotal Support

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia [redacted] Anesthesia Type:

Bovie Pad site intact pre-op [redacted] post-op [redacted] Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op [redacted] post-op ____
Tourniquet Time: Up ____ Down N/A

20. OPERATION(S) PERFORMED

Exp. Laparotomy, Scrotal Exploration, Groin wound I&D

21. PATIENT TRANSFERRED TO ICU [redacted] TIME 1400 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ AN 3 Nov 03 [redacted]

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DEC 2003

DAY: 05 06 07 08 09

HOUR: 0 1 2 0 1 2 0 1 0700

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

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

TEMP. C (Centigrade Equivalents, for Reference only): 40.6°, 40.0°, 39.4°, 38.9°, 38.3°, 37.8°, 37.2°, 37.0°, 36.7°, 36.1°, 35.6°, 35.0°

RESPIRATION RECORD

BLOOD PRESSURE: 134/67 136/D 134/63 134/81 132/73 124/60 122/74

98.2 98.1 132/73 H64

72 T97.6

HEIGHT: WEIGHT → 97.5

O2 SAT: 99% 98 NA 98% 98% 95% RA 96% 100% RA NA

Record special data only when so ordered

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

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

REGISTER NO.

WARD NO. ICW

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

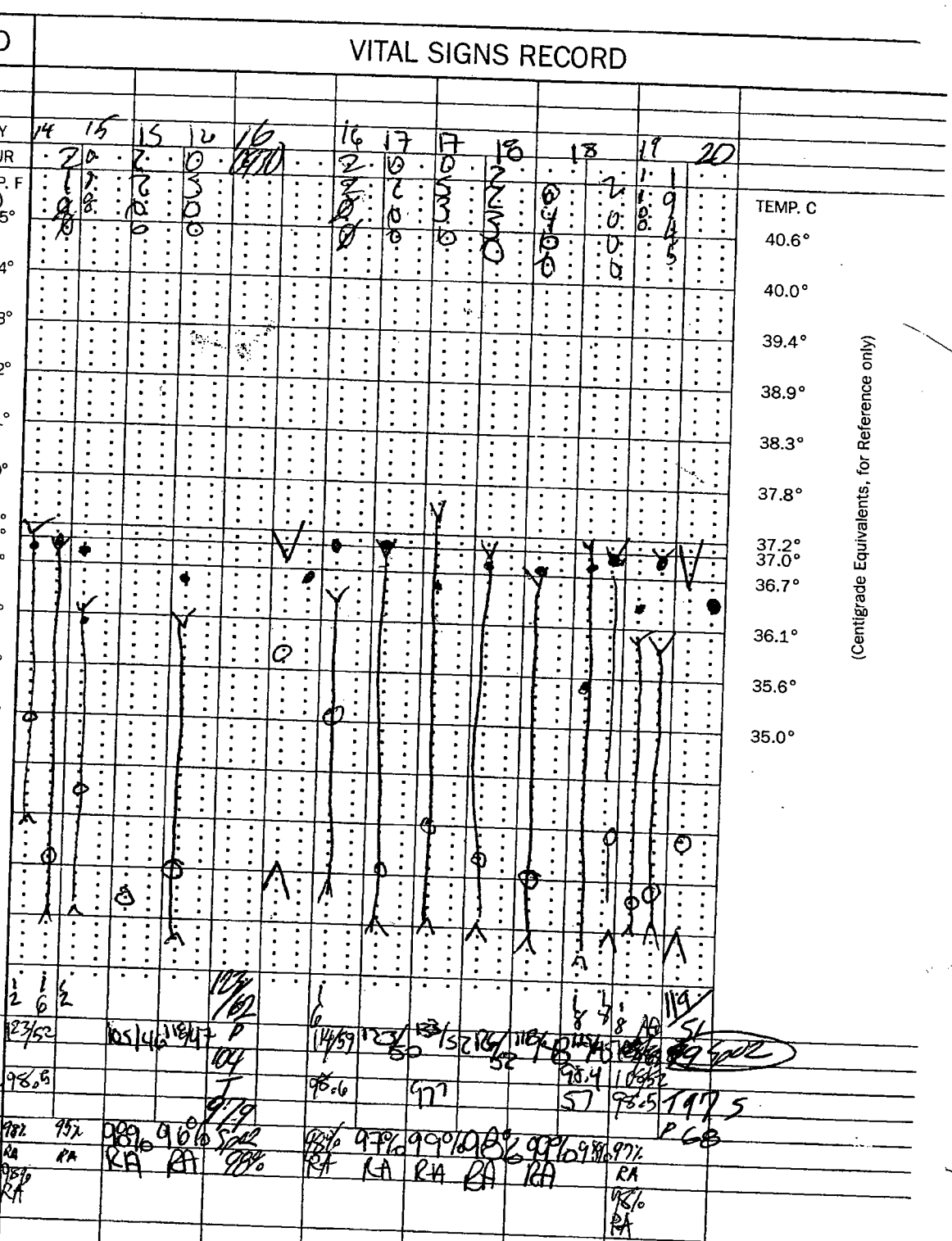
POST- DAY

MONTH-YEAR | DAY | 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.

[redacted] (b)(6)-4

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY: 7 Nov | 7 8 | 9 | 10 Nov 03 | 11 | 12 Nov | 13 Nov

19 HOUR: 1145 | 2 8 | 0 | 2 | 0 | 0 | 2

PULSE (O) / TEMP. F (•) / TEMP. C

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°

(Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD: 115/58 | 124/57 | 21 04 | 18 | 18 | 18 2 0 | 18

BLOOD PRESSURE: P 91 | P95 | 124/64 | 102/60 | 113/62 | 113/52 | 124/56 | 124/56 | 122/56 | 113/66 | 115/53 | 104/61 | 120/49

T 100.3 | T 100.5 | 109/56 | 90 | 88 | 88 | 101 | 91-P | 67 | 92 | 71

98 | 98 | 98 | 98 | 98 | 98 | 98.3 | 98.3 | 97.8 | 98.3 | 98 | 97.5

Record special data only when so ordered

HEIGHT: | WEIGHT →

97% | 95% | 95% | 97% | 97% | 97% | 97% | 97% RA | 98% RA | 98% RA | 98%

99% | 99.4 | 94% | 97% | 97% | RA | RA | RA

Temp | 97.7 | RA | Pulse 83 | Pulse 71

Pulse 87 | 92

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

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOV/DEC 2003

DAY: 28 | 29 | 30 | 01 | 2 Dec | 3 DEC | 4 DEC

HOUR: 20 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 8 | 0700 | 8 | 8

PULSE (O) / TEMP. F (•)

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

TEMP. C (Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 122/59 | 131/71 | 106/65 | 122/70 | 123/62 | 114/55 | 116/64 | 129/55 | 122/72 | 99/79 | 114/68 | 105/58

98 | 98 | 97.2 | 69 | 98.1 | 65 | 197.2 | P59

98 | 60 | 74 | 97 | 101 | 832 | Sp02 81 | T99.5

HEIGHT: | WEIGHT →

O2 SAT 98% | 99(RA) | 99% | 99% | 98% | 98% | 98% | 99% | 99% RA | 99% RA | Sp02 98%

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

STANDARD FORM 511 (REV. 7-95) BACK

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

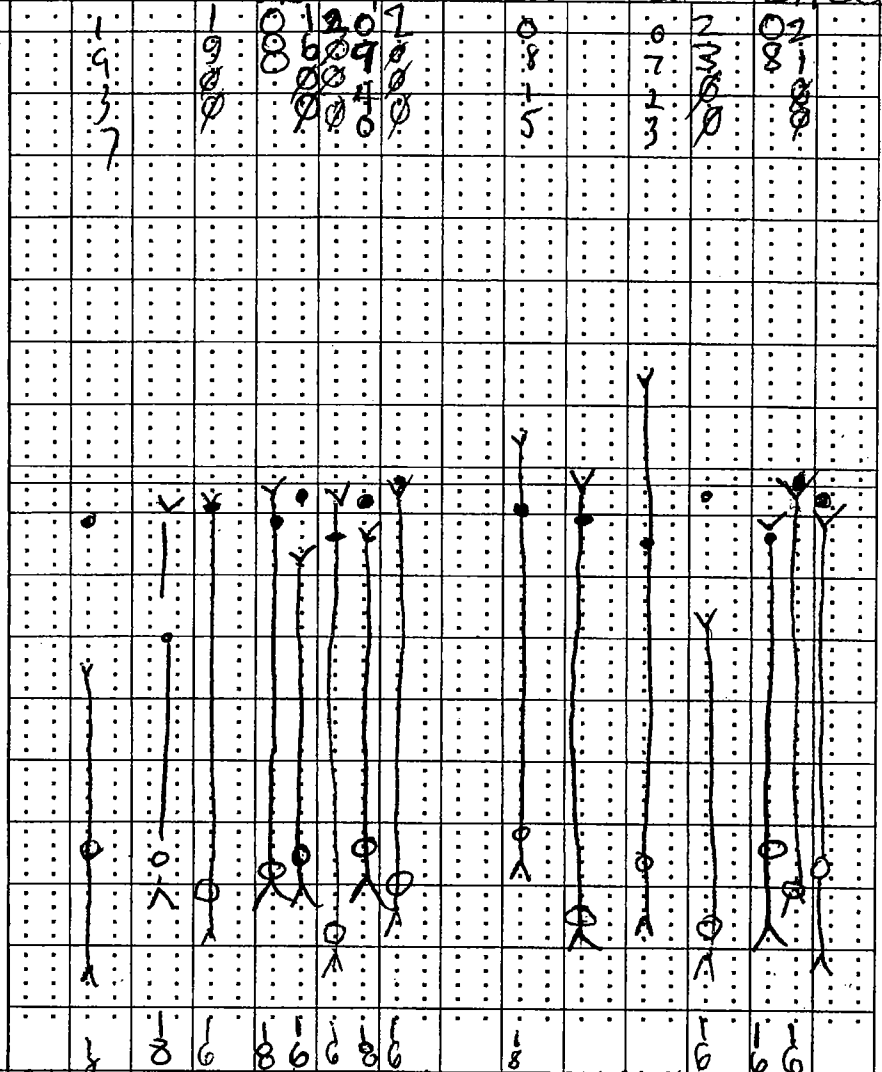
HOSPITAL DAY

POST- DAY

MONTH-YEAR NOV DAY 21 22 23/24 25 26 27/28

19 HOUR

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



RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

(Residual V's on I/O sheet)

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

REGISTER NO.

WARD NO.

(b)(6)-4

[redacted]

VITAL SIGNS RECORDS

Medical Record

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

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

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 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)	
Sed Rate			
Other			

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
Asp		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 Unit Crossmatch
(MUST SUBMIT SF 518 WITH 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	

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.: