1275 NOV 19, 03

DATE NOV 19, 03 — DX — HOSPITAL DAY

VITAL SIGNS	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~		~~08~~	~~09~~	~~10~~	~~11~~	12	13	14	15	
BP Arterial line	103/46	103/42	104/41	129/51	130/57	129/57	130/57	130/58		138/70	127/53	129/53	132/52	129/48	130/52	132/50	133/57	
BP Cuff																		
Temperature	98.6						98.3					99			99.1			
Pulse	116	118	118	115	119	113	115	115		119	111	121	109	118	117	118	119	
Respiratory Rate	24	24	24	30	30	30	30	30		30	30	30	30	30	30	30	30	
MAP	64	61	63	74	77	81	81	81		78	76	76	75	73	78	79	79	
CVP	16	20	22	—	—	—	23	20		22	18	19	20	22	18	19	19	
Dz sat	90	92	91	90	95	93	93	93		93	95	95	94	94	94	96	96	
FiO2	85	85	85	87	87	80	87	87		87	87	80	75	75	75	100	100	
Mode	SIMV	SIMV	S	S	S	S	S	S		S	S	S	S	S	SIMV	SIMV	SIMV	
PEEP	15	15	15	15	15	15	15	15		15	15	15	15	15	15	15	15	
PIP	44	44	42	48	53	48	46	46		46	43	45	46	47	45	57	50	
Bladder Pressure											23							

INTAKE	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~		~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	
MIVF	200/200	200	200	200	~~200~~ Hold	hold	100	100	600	100	100	150	150	150	150	150	180	1900
IVPB	100/100		60	300		200	60		720	50		60		50		250		410
Dobutamine	5/5	5	5	5	5	5	5	5	40	5	5	10	10	10	10	10	10	70
Dopa	9/9	9	9	9	9	9	9	9	72	9	9	9	9	9	9	9	9	72
Versed	10/10	10	10	10	10	10	10	10	80	10	10	10	10	10	10	10	10	80
Vecuronium	4/4	4	4	4	4	4	4	4	32	4	4	4	4	4	4	4	4	32
MSO4	8/8	8	8	8	8	8	8	8	64	8	8	8	8	8	8	8	8	64
Lasix	40/3	40	40	40	40	40	40	40	320	40	40	40	40	40	40	40	40	320
TF	10/10	10	10	10	10	hold	10	10	70	10	10	10	10	10	10	10	10	70
PRBC		#1	143	753	250	300 #2			554									20
									+2548									
TOTALS																		2208

OUTPUT		06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
URINE	HOUR	3	12	36	30	50	30	15	30	60	28	31	34	18	14	14	20	20
	TOTAL										284	265	295	313	327	341	361	381
	SP gr																	
	S/A																	
NG	OUTPUT												250					
	PH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS	ABDO: BAG	270					300			570								
TOTALS																		

POST-OP DAY 22 23 24 01 02 03 04 05

VITAL SIGNS	22	23	24	01	02	03	04	05
	16	17	18	19	20	21	22	23
	136/51	126/49	130/52	134/54	139/55	140/56	150/67	141/47
	98.8		98.9		99.2			97.4
	120	116	115	114	116	115	120	117
	30	30	30	30	30	30	30	30
MAR	78	78	81	81	82	83	83	84
	18	18	18	18	18	19	20	16
	96	95	94	93	93	93	94	93
	80	80	75	75	75	75	80	85
	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
	15	15	15	15	15	15	15	15
	50	50	50	50	50	47	51	48
	22	23	24	01	02	03	04	05

INTAKE	22	23	24	01	02	03	04	05	8°T
	16	17	18	19	20	21	22	23	
	150	150	150	150	150	150	150	150	1200
	50		50						100
	10	10	10	10	10	10	10	10	80
	9	9	9	9	9	9	9	9	72
	10	10	10	10	10	10	10	10	80
	4	4	4	4	4	4	4	4	32
	8	8	8	8	8	8	8	8	64
	40	40	40	40	40	40	40	40	320
	10	10	10	10	10	10	10	10	80
									2028
	22	23	24	01	02	03	04	05	

OUTPUT	22	23	24	01	02	03	04	05	
	30/411	22/394	21/455	28/450	25/405	21/330	24/550	16/566	560

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	5:30	1200	1645	1500	1730	1900	2300	0300	0500
	MODE		S	S	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
	F_IO_2		80	80	75	60	80	75	80	90
	TV		690	690	690	690	690	690	690	690
	RATE		30	30	30	30	30	30	30	30
	PEEP		15	15	15	15	15	15	15	15
ABG	pH	7.041	7.16	7.23						
	PCO_2	53.1	49.7	48.7						
	pO_2	66	61	67						
	HCO_3	14	18	20						
	SAT	81	84	89						
	BASE	-16	-11	-7						

LABORATORY	TIME	5:30
	GLUCOSE	106
	Na/K	148 / 5.6
	Cl/CO_2	120 / 16
	BUN/Cr	/ 5.2
	WBC/PLATELET	19.8
	Hct/Hgb	9.0 / 28.3

ACTIVITY DAILY LIVING	TIME	8:00
	MOUTH CARE	
	BATCH	
	SKIN CARE	✓
	FOLEY CARE	✓
	TRACH CARE	
	ROM EXERCISES	

TURN	TIME					
SUCTION	1200 trach plug	1400 trach plug				

24°180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	566
Po			825
TOTAL		TOTAL	1380

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	KM
	Ad
b(6)-2	

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0715	INITIALS [redacted]	18:30	INITIALS [redacted]		INITIALS
NEURO	PUPILS		2.5mm sluggish		2.5mm PERRL sluggish			
	SENSORIUM		Vecuronium 4cc/h		Vec 4cc/° ∅ movement			
			no moist, MSO4 8cc/h		MSO4 8cc/° Versed 10cc/°			
			Versed 10cc/h					
			Sclera slightly yellow					
RESPIRATORY	RESPIRATORY PATTERN		Bilat + equal		Ventilated c̄ bilat = rise + fall			
	BREATH SOUNDS		Coarse throughout. Rhonchi		Coarse rales/ronchi			
	SECRETIONS		@ times in upper lobes/apex		suctioned via ETtube			
			@ times rales in base B lobe		S/P resp Rx c̄ thick yellow			
			MV: SIMV RR 24/TV 500		UniVent SIMV rate 24		ETT @ 26/teeth. size 8	
			PEEP 15 FiO2 100%. ETT 26 @ teeth		T.V. 750 PEEP 15 FiO2 85		Sats 91-93%	
SKIN	COLOR		Normal for race.		Brown normal for race.			
	INTEGRITY		dependent edema -		Generalized whole body edema 3+ pitting.			
			Sacrum. See wound sheet		penis + scrotum edema			
IV SITE	LOCATION		(L) TLC - Prox - Dopamine		(L) subclavian TLC			
	CONDITION		CVP esmolol in proximal port		Proximal - CVP line Distal - .9NS 20cc/° Dopa @ 3mic Dobutamine			
			Distal - Dobutamine @		Medial - Versed gtt 10mg/° MSO4 8mg/° Vec @ 4mg/° @ 5mic			
			5mcg/kg/min. Medial		(R) radial A-line - zeroed Q4°			
	(R) radial line		lumen - NS @ 20cc/h		All sites c̄ S+S of infection.			
			Vased @ 10 mcg/min					
GASTRO	ABDOMEN		large distended		large c̄ taut distention			
	BOWEL SOUNDS		firm. hypoactive BS		hypoactive BS (R) ant Quad.			
			TFC 10cc/h through		TF @ 10cc c̄ flush via Dobhoff tube			
			Dobhoff. NGT (R) nare → LIS		N/G LIS c̄ brown green drainage			
GU	URINE:		foley to gravity		Foley to gravity drain			
	COLOR/CLARITY		Amber yellow		tan/yellow sediment			
			<30cc/h		>30/° Lasix gtt @ 40/°			
CARDIOVASCULAR	CARDIAC RHYTHM		S1 S2 ST 140's		distant S1 S2 ST 120's no ectopy			
			MAPs in 70's CVP 10-20		MAP 70 CVP 25			
			pulses weak due to edema		pulses 2+ x 4 extremities palpable			
			pedal pulses dopplered					
			+ hard.					

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

b(6)-2

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] CPT/RN [redacted] written entries [redacted] or medical facility)

DEPARTMENT/SERVICE/CLINIC: ICU1

DATE: 18NOV03

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

[redacted]

b(6)-4

b(6)-4

[redacted] 18 NOV 03

DATE 18NOV03 | DX | HOSPITAL DAY

VITAL SIGNS																		
TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
BP Arterial Line	125/69	129/65	119/64	115/61	106/84	119/55	111/55	119/55		108/53	107/51	119/51	121/62	124/56	113/57	114/50	112/50	
BP Cuff	127/5	119/55																
Temperature	96.6	96.8		97	96.3		96.5					96.7			97.4			
Pulse	99	101	101	95	95	97	96	98		98	102	104	101	101	114	117	117	
Respiratory Rate	25	24	24	24	24	24	24	24		24	24	24	24	24	26	33	30	
SaO2	94	94	94	91	93	94	92	93		95	94	93	92	93	92	91	92	
FIO2	100	100	100	100	100	90	90	90		90	85	85	78	85	85	85	85	
Mode	S	S	S	S	S	S	S	S		S	S	S	S	S	SIMV	SIMV	SIMV	
MAP	82	81	80	77	69	74	71	71		68	68	68	68	74	70	70	69	
PEEP	15	15	15	15	15	15	15	15		15	15	15	15	15	15	15	15	
PIP	53	46	49	48	47	44	47	46		48	45	41	46	43	42	43	43	
CVP		19	24	24	26	27		27		23	20	off	off	off	21	24	23	

INTAKE																			
TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
MIVF	200	200	200	200	200	200	200	200	1600	200	200	200	200	200	200	200	200	
IVPB	100		250				55		405	5		50	35	50	50	50		3200
MSO4	8	8	8	8	8	8	8	8	64	8	8	8	8	8	8	8	8	
Versed	10	10	10	10	10	10	10	10	80	10	10	10	10	10	10	10	10	
Vecuronium	4	4	4	4	4	4	4	4	32	4	4	4	4	4	4	4	4	
Tube feed	10	10	10	10	10	10	10	10	80	10	10	10	10	10	10	10	10	
NGT/DOBHOFF			10				60		130	7.2		60				60		
~~Dopamine~~																		
~~Bolus~~										8	7.2	7.2	7.2	7.2	9	9	9	
Dobutamine	5	5	5	5	5	5	5	5	40	5	5	5	5	5	5	5	5	
LASIX 9/4										8					120	40	40	
TOTALS									1491									

OUTPUT																			
URINE	HOUR	30	28	10	24	20	18	16	17	163	6	18	19	16	50	36	30	30	
	TOTAL	30																	
	sp gr																		
	S/A																		
NG	OUTPUT								200/200	200					300/300				500
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS									363										

POST-OP DAY

VITAL SIGNS	22	23	24	01	02	03	04	05
	110/47	115/49	114/50	115/51	124/60	133/64	106/45	103/45
			98.9					98.1
	125	121	124	120	120	120	121	116
	48	46	36	24	24	27	24	24
	94	92	90	90	89-90	92	90	90
	85	100	100	90	100	90	85	85
	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
	67	70	70	71	80	85	65	63
	15	15	15	15	15	15	15	15
	48	44	46	46	48	40	44	46
	23	24	25	25	24	18	16	19

INTAKE									
									8° T
I.V.	200	200	200	200	200	200	200	200	4800
	50		100						995
	8	8	8	8	8	8	8	8	96
	10	10	10	10	10	10	10	10	120
	4	4	4	4	4	4	4	4	96
	10								240
			60				60		377
	9	9	9	9	9	9	9	9	135
	5	5	5	5	5	5	5	5	60
	40	40	40	40	40	40	40	40	408
									7327

OUTPUT									
	31	38	25	30	30	30	10	26	588
								400/900	900
									1488

ACUITY LEVEL CLASSIFICATION VI

RESPIRATORY	TIME	4A	10A	12N	1300					
	MODE	SIMV								
	F_IO_2	100%	90%	80%	90%					
	TV	750								
	RATE	24								
	PEEP	15								
ABG	pH	7.478								
	PCO_2	42.7								
	pO_2	66								
	HCO_3	16								
	SAT	89								
	BASE	-13								

LABORATORY	TIME									
	GLUCOSE	109								
	Na/K	149/4.6								
	Cl/CO_2	118/18								
	BUN/Cr	58/3.8								
	WBC/PLATELET	13.2								
	Hct/Hgb	9.5/29.9								

ACTIVITIES OF DAILY LIVING	TIME	0500	2100	400
	MOUTH CARE	✓	✓	✓
	BATH	✓		
	SKIN CARE	✓	✓	✓
	FOLEY CARE	✓	✓	✓
	TRACH CARE	✓	✓	
	ROM EXERCISES	✓		

TURN	TIME			
	0000 (R)	0300 (M)	0600 (L)	
				2200
				0400

SUCTION				
	0600 Thick (R)	0900 Thick	1200 Thin	1430 Thin
				02

24 I&O TOTALS			
wt Yesterday		wt Today	
INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL	7327	TOTAL	1488
BALANCE	+5839		

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

NEUROLOGICAL ASSESSMENT

		HOURS	07	12	18
COMA SCALE	EYES OPEN	SPONTANEOUSLY 4			
		TO SPEECH 3			
		TO PAIN 2			
		NO EYE OPENING 1	1	1	1
	BEST VERBAL RESPONSE	ORIENTED 5			
		CONFUSED 4			
		VERBALIZES 3			
		VOCALIZES 2			
		NO VOCALIZATION 1	ET	ET	ET
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6			
		LOCALIZES PAIN 5			
		FLEXION WITHDRAWAL 4			
		ABNORMAL FLEXION 3			
		EXTENSION TO PAIN 2			
		NO MOTOR RESPONSE 1	1 @ wrists	1 @ wrists	
LIMB MOVEMENT	ARMS	NORMAL POWER			
		MILD WEAKNESS			
		SEVERE WEAKNESS			
		ABNORMAL FLEXION			
		ABNORMAL EXTENSION			
		NO RESPONSE	1	1	1
	LEGS	NORMAL POWER			
		MILD WEAKNESS			
		SEVERE WEAKNESS			
		ABNORMAL FLEXION			
		ABNORMAL EXTENSION			
		NO RESPONSE	1	1	1
PUPILS	RIGHT	SIZE	2.5	2.5	2.5
		REACTION	+	+	+
	LEFT	SIZE	2.5	2.5	2.5
		REACTION	+	+	+
PUPIL SCALE			2	3	4 5 6 7 mm
ICP					
CEREBRAL PERFUSION PRESSURE					

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 two sides.

++ Brisk
+ Slow
- No Response

+ Intact
- Abnormal

VASCULAR ASSESSMENT

		HOURS	07	12
Upper E	R		+	+
	L		+	+
LE	R		D	D
	L		D	D
	R			
	L			
	R			
	L			
	R			
	L			

LEGEND

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

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 b(6)-2

INITIAL SHIFT ASSESSMENT

	TIME	0630	INITIAL [redacted] b(6)-2	INITIALS	1830	INITIAL [redacted]
NEURO	PUPILS	PERL 2.5mm Slow			2.5mm PERRL sluggish	
	SENSORIUM	no Movement Noted.			sedated c̄ vecuronium @	
		Deep pain response.			4mg/h, versed 10mg/h, MSO4	
					@ 8mg/h.	
RESPIRATORY	RESPIRATORY PATTERN	Orally intubated #8			ETT 8.0 2cm @ teeth SIMV 24,	
	BREATH SOUNDS	Rhonchi in bases			TV 750, FiO2 65%, P-15, PIP 40s	
	SECRETIONS	Thin, copious with			Rales throughout	
		suctioning.			thick yellowish secretions	
		Vented.			noted	
SKIN	COLOR	Normal			WNL for race. Abd drsg c̄,	
	INTEGRITY	Surgical wounds B/W			(R) flank drsg c̄ serous drainage	
		Multiple dressings			drsg to back c̄ C.D.I	
IV SITE	LOCATION	TLC left SC. intact.			(R) SC TLC c̄ Dobutamine @	
	CONDITION	A-line (R) Rad.			5mcg/k/min in distal port,	
		Versed 10 mg/h			NS @ 200cc/h, versed @ 10mg/h +	
		MSO4 8mg			MSO4 @ 8mg/h infusing into	
		Vecuronium 4mg/h			medial port, CVP monitored	
		NS 25cc/h			in proximal port	
GASTRO	ABDOMEN	Large.			distended	
	BOWEL SOUNDS	hyperactive.			hypoactive in all 4 quad	
		Dressing to Mid Abdomen			(R) Nare NGT to LIS c̄ small and large	
		Salem Sump to suction			drainage, (R) nare ETT c̄ osmolite @	
		Drainage clamped.			40cc/hr c̄ amber	
GU	URINE:	Foley			urine HO = 30-40s	
	COLOR/CLARITY	amber				
		30-35cc/h				
CARDIOVASCULAR	CARDIAC RHYTHM	ST. HR 107-110 BP 152			SR to ST c̄ (1) ectopy 90s-100s	
		Bulset (+) generalized			+1 palpable pulses (B) LE	
		edema. A-line (R) Rad			+2 palpable pulses (B) UE.	
		TLC left SC			Edema throughout	
					<3 sec cap refill in all 4 quad	

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)

PREPA[redacted] & Title) [redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC ICU

DATE 17 Nov 03

[redacted] written entries give: Name—last, first, initials, grade, date, hospital or medical facility)

[redacted] b(6)-4

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

17 NOV 03

DATE | DX | HOSPITAL DAY

VITAL SIGNS																		
TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	
BP Arterial Line	145/80	126/71	135/72	117/65	119/68	132/74	133/70	109/71	109/54	108/57	147/74	139/74	117/81	151/88	138/88	107/66	111/67	
BP Cuff	132/75	109/72	135/74	117/68	107/63	118/62	135/65		129/65	138/70		123/62	126/61	137/67	135/65	106/66	111/60	
Temperature	96.8	96.7		96.7		96	95.4	0	95	94.6	94.7	95.1	95.8	95.8	95.8	95.7	96.1	
Pulse	107	110	107	99	91	93	89	89	92	94	97	98	99	96	101	93	92	
Respiratory Rate	21	24	24	24	24	24	24	24	24	24	24	27	24	24	23	23	24	
SaO2	98%	99	100	98	95	94	92	93	96	96	96	94	94	93	93	88	96	
FiO2	75%	75	75	70	65	60	60	60	70	70	70	65	65	65	65	65	100	
MODE	S	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	
MAP	95	87	80	84	85	95	91	87	Low	109	107	102	102	91	90	73	72	
PEEP	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	15	
PIP	41	40	41	43	42	43	42	41	44	41	44	42	45	44	44	46	44	
CVP	12	10	11	15	N	16	25	26	16	18	15	15	17	16	17	19	17	

INTAKE																			
TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	8°T
MIVF	25	25	25		250	250	250	250	250	250	250	250	250	250	250	250	[illegible]	
IVPB	50		300						50								50	
[illegible]											5	5	5	0				
MSO4	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	
Versed	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	
Vecuronium	3	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	
Labetalol																		
Tube Feed	hold			10	10	10	10	10	10	10	10	10	10	10	10	10	10	
Bolus				1000														
H2O					60		60				60				115		500	
TOTALS																		

OUTPUT																			
URINE	HOUR / TOTAL	35/35	30/65	35/70	30/100	35/135	30/165	70/235	45/280	60/340	45/385	60/445	40/485	40/525	42/567	42/609	32/641	15/656	
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS	23	24	01	02	03	04	05
	113/60	124/79	118/64	118/63	114/63	119/65	117/64
	114/51	119/85	123/55	122/53	125/51	120/55	122/53
	96.2	95.5	95.7	95.8	96.1	96.3	96.5
	94	89	89	86	90	94	96
	24	42	22	16	21	24	24
	96	90	93	91	90	91	92
	90	90	80	80	100	100	100
	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
	74	100	80	80	84	79	80
	15	15	15	15	15	15	15
	43	48	41	35	46	47	47
	20	26	28	29	26	22	24

INTAKE	23	24	01	02	03	04	05	Total	8° T
	125	—	150	300	200	200	200	4375	
		100						550	
								15	
	8	8	8	8	8	8	8	192	
	10	10	10	10	10	10	10	240	
	4	4	4	4	4	4	4	95	
	10	10	10	10	10	10	10	210	
	500	500	500					3000	
		60				60		415	
								9092	

OUTPUT	23	24	01	02	03	04	05	Total
	14/60	27/67	30/69	30/72	10/73	35/72	25/47	191
							450	450

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	0630	0830	0900	1000	1100				
	MODE	SIMV	SIMV	SIMV	SIMV	SIMV				
	F_iO_2	75	70	65	60	65				
	TV	750	750	750	750	750				
	RATE	24	24	24	24	24				
	PEEP	15	15	15	15	15				
ARTERIAL BLOOD GAS	A: pH									
	A: PCO_2									
	A: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

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

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

TURN	TIME							
	09							
	left							
SUCTION	09							

24 H I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	9092	Urine:	1297
po			
TOTAL		TOTAL	

BALANCE 7795

NURSE'S SIGNATURE	INITIALS
[redacted]	[illegible]
[redacted]	[illegible]
b/w-2	

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS	0630	1000
EYES OPEN	SPONTANEOUSLY	4		
	TO SPEECH	3		
	TO PAIN	2		
	NO EYE OPENING	1	1	1
BEST VERBAL RESPONSE	ORIENTED	5		
	CONFUSED	4		
	VERBALIZES	3		
	VOCALIZES	2		
	NO VOCALIZATION	1	1	ET
BEST MOTOR RESPONSE	OBEYS COMMANDS	6		
	LOCALIZES PAIN	5		
	FLEXION WITHDRAWAL	4		
	ABNORMAL FLEXION	3		
	EXTENSION TO PAIN	2		
	NO MOTOR RESPONSE	1	1	1

LIMB MOVEMENT			0630	1000
ARMS	NORMAL POWER			
	MILD WEAKNESS			
	SEVERE WEAKNESS			
	ABNORMAL FLEXION			
	ABNORMAL EXTENSION			
	NO RESPONSE		✓	1
LEGS	NORMAL POWER			
	MILD WEAKNESS			
	SEVERE WEAKNESS			
	ABNORMAL FLEXION			
	ABNORMAL EXTENSION			
	NO RESPONSE		✓	1
PUPILS RIGHT	SIZE		2	2.5
	REACTION		+	+
PUPILS LEFT	SIZE		2	2.5
	REACTION		+	+
PUPIL SCALE			● 2	● 3 ● 4 ● 5 ● 6 ● 7 mm
ICP				
CEREBRAL PERFUSION PRESSURE				

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 two sides.

+ + Brisk
+ Slow
- No Response

+ Intact
- Abnormal

VASCULAR ASSESSMENT

		HOURS	06	10
UE	R		+	+
	L		+	+
LE	R		+	+
	L		+	+
	R			
	L			
	R			
	L			
	R			
	L			

LEGEND

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED *(Date)* QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0635	INI[redacted]	INITIALS	1820 INITIALS [redacted]
	PUPILS	2.5 mm + RL sluggish			2.5mm PERRL sluggish
	SENSORIUM	sedated c̄ versed @ 10cc/h			sedated c̄ vecuronium @
		cd analgesic of			4mg/°, versed @ 10mg/°, +
		MSO4 @ 8cc/h			MSO4 @ 8mg/°
		hrs ⊕ grey			⊘ movement
RESPIRATORY	RESPIRATORY PATTERN	Equal + Blad			ETT #8.0 28.5@ lub
	BREATH SOUNDS	Coarse + Rhonchi			rales throughout
	SECRETIONS	Throughout			copious yellow sputum
		Copious, occ'l's frag			ord ETT
		Dol + hard cough			SIMV 24, TV 750, FiO2 70%
		ETT - fair suction			P-10, O2 sats 95%.
SKIN	COLOR	MV RR24 TV 750 FiO2 55%			WNL for race. midline abdominal
	INTEGRITY	peep 5 · intact			C,D,I. ⊕ Plank drsg saturated
		for race. See Nurse Note			c̄ serous fluid, back drsg C,D,I
IV SITE	LOCATION	⊕ SC TLC Distal lumen			⊕ SC TLC c̄ versed, vec
	CONDITION	clotted. D5½NS @			MSO4 + NS @ 17cc/° infusing
		30cc/h. Versed			⊕ radial A-line c̄ good waveform
		cd MSO4 infusing			but doesn't correspond c̄ NBP
		⊕ patency c̄ good			
		blood flow			
GASTRO	ABDOMEN	Lg Round, Distended			distended
	BOWEL SOUNDS	hypoactive			hyperactive BS in all 4 quad.
	Tubes -	⊕ none NGT to LIS			⊕ dobhoff @ 10cc/° c̄ motility
		⊕ none Dobhoff			⊕ NGT to LIS c̄ yellowish fluid
GU	URINE:	foley to gravity			foley to gravity c̄ amber urine
	COLOR/CLARITY	Amber >30cc/h			UO c̄ 50cc/°
CARDIOVASCULAR	CARDIAC RHYTHM	S1 S2 ⊘ murmur			ST c̄ ectopy HR 90-100
		⊘ JVD ST-100's ↓			⊘ JVD, BP 140/50
		BP c̄ meds 1 ∩ 110's			+1 palpable pulse ⊕ LE, +2 ⊕ UE
					< 3 sec cap refill in all
					4 ext. edema throughout

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: ICU 1

DATE: 15 NOV 03

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

[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 15 NOV 03 | DX | HOSPITAL DAY

VITAL SIGNS																		
TIME	0600	07	08	09	10	11	12	13	8°	14	15	16	17	18	19	20	21	
BP Arterial Line	155/90	153/88	150/76	157/76	124/63	127/68	148/90	159/83		159/75	142/69	147/70	149/72	156/76	149/71	157/75	131/69	
BP Cuff	92														130/91	135/82	117/71	
Temperature	98.6			99.2	99		98.6				99.2			98.5	98.3	97.9	98.4	
Pulse	96	100	88	96	101	101	102	98		86	103	105	106	103	105	104	94	
Respiratory Rate	24	24	24	24	24	24	24	24		24	24	24	24	24	24	24	24	
SaO_2	96	96	93	94	91	90	93	91		96	92	91	95	93	95%	91%	86%	
FiO_2	50	50	50	50	65	80	70	70		90	75	75	75	70	70	100	100	
MODE	S	S	S	S	S	S	S	S		S	S	S	S	S	S	S	S	
MAP	111	112	99	98	82	99	100	104		99	90	90	92	102	99	102	80	
peep	5	5	5	5	5	5	8	8		10	10	10	10	10	10	10	10	
PIP	34	40	40	40	40	45	38	37		40	35	35	33	40	42	42	40	
CVP	14	14	17	18	15	14	13	17		12	11	10	9	14	13	15	17	

INTAKE																		
TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20°	21	8° T
MIVF	200	200	200	175	175	175	175	175	175	175	175	175	175	175	175	175	175	1400
IVPB	50		50						100			50		2		200		252
NGT				60			60		120			60				110		170
MSO4	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	64
Versed	10	10	10	10	10	10	10	10	80	10	10	10	10	10	10	10	10	80
Vecuronium	off	off	—				—					14	4	4	4	4	4	34
labetalol	4						4		8	—	—	—	—					
DHT				10	10	10	10	10	50	10	10	10	10	10	10	10	10	80
									1897									2088
TOTALS																		

OUTPUT																			
URINE	HOUR	75	74	50	60	35	50	70	74	48	50	42	60	33	50	55	55	115	
	TOTAL										468	510	570	603	653	708	763	878	878
	sp gr																		
	S/A																		
~~DHT~~ NG	OUTPUT				~~60~~	280		120		400	100		100		150				
								400			500		600		750				
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS									1898										

POST-OP DAY

VITALS	22	23	24	01	02	03	04	05
	135/71	134/71	135/69	124/83	146/77	144/77	136/76	155/84
	127/68	120/70	129/72	126/76	123/74	124/74	124/73	135/75
	97.5	97.4	97.5	97.1	96.9	96.8	98.4	98.6
	96	97	76	94	96	96	106	105
	24	24	8	24	31	31	24	24
	88%	93%	92%	94%	98%	98%	100%	99%
	100%	100%	100%	100%	100%	100%	90%	90%
	S	S	S	S	S	S	S	S
	88	89	93	94	91	91	91	96
	10	15	15	15	15	15	15	15
	42	46	46	45	47	46	46	46
	16	19	23	17	18	8	6	13

INTAKE	22	23	24	01	02	03	04	05	8°T
	25	25	25	25	25	25	25	25	200
	50		50						100
			60				hold		60
	8	8	8	8	8	8	8	8	64
	10	10	10	10	10	10	10	10	80
	4	4	4	4	4	4	4	4	32
	10	10	hold	hold	hold	hold	hold	hold	20

OUTPUT									
	175/105	145/119	75/273	70/343	100/143	70/513	40/553	70/623	1623
								475	475

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	0830	1230		0720	2240	0315		
	MODE	S	S				S		
	F_IO_2	50	70		↑100%		100%		
	TV	750	750				750		
	RATE	24	24				24		
	PEEP	5	8	↑10		↑15	15		
ARTERIAL BLOOD GAS	pH	7.28	7.29				7.2817		
	PCO_2	39.7	37.7				44.8		
	pO_2	74	62				70		
	HCO_3	19	18				19		
	SAT	93	89				90		
	BASE	-8	-8				-9		

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

ACTIVITIES OF DAILY LIVING	TIME	08		
	MOUTH CARE	✓		
	BATH	✓		
	SKIN CARE	✓		
	FOLEY CARE	✓		
	TRACH CARE	✓		
	ROM EXERCISES	✓		

TURN	TIME	1630	1930	1730		
		L	L	L		

SUCTION					
	06 Thick	0730 Thick	0830 Thick	1030 Thick	1100 Thick
	22 Thick	1400 Thick	0730 Thick		

24 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE: IV 4535 po _____ TOTAL _____

OUTPUT: Urine: 2840 TOTAL _____

BALANCE +1695

NURSE'S SIGNATURE	INITIALS
[redacted] CRT	[redacted]
[redacted] RN	
[redacted]	

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	1830	INITIALS [redacted] b(6)-2	INITIALS
NEURO	PUPILS	2 mm Rxt slow		2mm sluggish RXN		
	SENSORIUM	ETT and on		ETT. versed 10mg		
		Vec. 3cc/h MSO4 7cc/h				
		and Versed 7cc/h				
RESPIRATORY	RESPIRATORY PATTERN	RR (B) equal		SIMV: 20 TV 750		
	BREATH SOUNDS	MV peep 5 TV 750		PEEP 5 FiO2 40.		
	SECRETIONS	RR 20 FiO2 40%.		Rhonchous BS		
		PIP in 30s rel 40s		Dim. bases.		
		Copious oral. Nasal		Trach secretions		
		thick ETT yellow		orally & nasally.		
SKIN	COLOR	Normal for race		NFR		
	INTEGRITY	Warm & W → Dry		(R) side W → DRY		
				Abd. W → DRY		
IV SITE	LOCATION	(L) SCTLC c̄ D5NS		(L) Sub. TLC D5.45		
	CONDITION	250cc/h		NS @ 200 cc/hr.		
		(R) art line c̄ good		R rad. Good		
		wave form		Wave form.		
				NO sx's of		
				infection.		
GASTRO	ABDOMEN	Round distended		Round. distended		
	BOWEL SOUNDS	hypoactive BS		hypoactive ∅ BM		
		∅ BM		Dobhoff (R) nares		
		NGT (R) NARE to LIS		NGT. (R) nares		
GU	URINE:	foley to gravity		foley to gravity		
	COLOR/CLARITY	Amber > 30cc/h		yellow > 30cc/h		
CARDIOVASCULAR	CARDIAC RHYTHM	S1 S2 ∅ ectopy		S1 S2 ∅ ectopy		
		HR 110's		HR 90's, MAP		
		MAPS (100's)		110's. Gen. Edema		
		synergized edema		1+ pitting ankle.		

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)

b(6)-2

PREPARED BY (Name & Title) [redacted] CPT / AN

DEPARTMENT/SERVICE/CLINIC ICU

DATE 15 NOV 03

(Written entries give: Name—last, first, medical facility)

[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITALS	TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
	BP Arterial Line	159/86	149/86	144/84	138/69	136/106	137/108	141/111	102/102		159/94	165/118	134/96	138/89	159/90	166/93	129/94
	BP Cuff	147/88	161/93					131/101	136/91								
	Temperature	98.3				97.0			97.5				97.1	96.6	96.8	96.2	96.6
	Pulse	113	112	119	111	111	107	109	88		92	93	97		92	94	91
	Respiratory Rate	20	20	20	20	20	20	20	20		20	20	20	20	20	20	20
	SaO2	93	95	93	96	97	98	97	98		99	97	97	96	95	95	94	94
	FiO2	40%	40%	40	40	40	40	40	40		40	40	40	40	40	40	40	40
	Source	Vent	SIMV	S	S	S	S	S	S		S	S	S	S	S	S	S	S
	MAP	109	111	124	121	137	137	140	123		120	124	123	122	114	115	110	120
	peep	5	5	5	5	5	5	5	5		5	5	5	5	5	5	5	5
	PIP	46	48	42	39	40	39	40	41		40	40	40	43	44	45	44	39
	CVP	20	19	21	14	15	12	7	8		8	9	10	14	14	16	20	19

INTAKE	TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
	MIVF	250	250	250	250	200	200	200	200	500	200	200	200	200	200	200	200	200	
	IVPB	50		50						100	50		50						
	NGT																		
	MSO4	7	7	7	7	8	8	8	8	10	8	8	8	8	8	8	8	8	
	Versed	7	7	7	10	10	10	10	10	71	10	10	10	10	10	10	10	10	
	Vecuronium	3	3	3	3	880	—	—	—	12	—	—	—	—	—	—	—	—	
	albuterol							4		4					4				
	Flush							10		10	10				10				
	Reglan														2				
	TOTALS									1057									

OUTPUT		HOUR / TOTAL	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
	URINE		100	112	110	90	115	94	85	70	522	55	60	60	32	100	90	60	60
				212	322							55	165	225	257	357	447	507	567
		sp gr																	
		S/A																	
	NG	OUTPUT			100				100		500		50			150			
									100				50			150			
		pH																	
		GUIAC																	
	EMESIS				Ø		Ø						Ø						
	STOOL				Ø		Ø						Ø						
	~~DRAINS~~	Blood Dam											—						
	TOTALS										1022								

1st 8° IN: 1057

Out 1022

POST-OP DAY

VITAL SIGNS	22	23	24	01	02	03	04	05
	175/84	160/92	155/82	161/90	151/81	167/95	175/89	185/99
		133/86					136/84	155/94
	98.7	97	97	97.6	98.2	98.4	99	
	92	92	94	95	94	94	100	102
	20	20	20	20	20	20	24	24
	90	93	90	94	94	93	94	96
	40	40	40	40	40	40	50	50
	5	5	5	5	5	5	3	5
	116	116	119	117	120	122	127	128
	5	5	5	5	5	5	5	5
	38	41	43	42	41	45	47	42
	17	14	13	13	13	15	14	21

INTAKE	22	23	24	01	02	03	04	05	8° T
	200	200	200	200	200	200	200	200	2400
			100						100
	8	8	8	8	8	8	8	8	96
	10	10	10	10	10	10	10	10	120
	4								12
		10			10				60
			2						4
								2764	2764

OUTPUT	22	23	24	01	02	03	04	05	8° T
	60/607	80/707	60/762	60/822	60/882	50/932	50/982	60/1032	1032
								200	200
									1082

ACUITY LEVEL CLASSIFICATION

RESPIRATORY		TIME	0400	1900	0400	0600
		MODE	SIMV	SIMV	SIMV	
		F_IO_2	40	40	40	
		TV	790	750	750	
		RATE	20	20	20	
		PEEP	5	5	5	
ARTERIAL BLOOD GAS	A	pH	7.25	7.225	7.256	
		PCO_2	39.4	45	46	
		pO_2	81	69	57	
	B	HCO_3	19	19	20	
		SAT	94	90	85	
	G	BASE	-7	-9	-7	

LABORATORY	TIME	0420
	GLUCOSE	138
	Na/K	137/4.3
	Cl/CO_2	124/21
	BUN/Cr	3.2
	WBC/PLATELET	7.7/192
	Hct/Hgb	30.5/9.9
	Ca^{++}	7.9

ACTIVITIES OF DAILY LIVING	TIME	0800	2300
	MOUTH CARE	✓	
	BATH	✓	
	SKIN CARE	✓	
	FOLEY CARE	✓	
	~~TRACH~~ ETT CARE	✓	✓
	ROM EXERCISES	✓	

TURN	TIME				
	0900	1200	1500	1800	2200
	0300	0600			

SUCTION					
	0630 Thick	1200 Thick	1500 Thick	1845 Thick	1730 Thick
	1830 Thick	1530 Thick	2030 Thick	2100 Thick	0200 Thick

24 hr I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE | INITIALS

[redacted] EPT/[redacted]

b(6) - 2

24 IN 2764 — MEDCOM - 23856

24 out 1082 INT + 1357.1

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS	06	12	18
EYES OPEN	SPONTANEOUSLY	4			
	TO SPEECH	3			
	TO PAIN	2			
	NO EYE OPENING	1	1	1	1
BEST VERBAL RESPONSE	ORIENTED	5			
	CONFUSED	4			
	VERBALIZES	3			
	VOCALIZES	2			
	NO VOCALIZATION	1	ETT	ETT	ETT
BEST MOTOR RESPONSE	OBEYS COMMANDS	6			
	LOCALIZES PAIN	5			
	FLEXION WITHDRAWAL	4			
	ABNORMAL FLEXION	3			
	EXTENSION TO PAIN	2			
	NO MOTOR RESPONSE	1			

LIMB MOVEMENT			06	12	18
ARMS	NORMAL POWER				
	MILD WEAKNESS				
	SEVERE WEAKNESS				✓
	ABNORMAL FLEXION				
	ABNORMAL EXTENSION				
	NO RESPONSE		1	1	
LEGS	NORMAL POWER				
	MILD WEAKNESS				
	SEVERE WEAKNESS				✓
	ABNORMAL FLEXION				
	ABNORMAL EXTENSION				
	NO RESPONSE		1	1	
PUPILS	RIGHT	SIZE	2	2	2
		REACTION	+	+	+
	LEFT	SIZE	2	2	2
		REACTION	+	+	+
PUPIL SCALE			● 2	● 3	● 4 ● 5 ● 6 ● 7 mm
ICP					
CEREBRAL PERFUSION PRESSURE					

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 two sides.
- + + Brisk
- + Slow
- - No Response
- + Intact
- - Abnormal

VASCULAR ASSESSMENT

		HOURS	06	12	18
UE	R		++	++	+
	L		++	++	+
LE	R		+	++	+
	L		++	++	+
	R				
	L				
	R				
	L				
	R				
	L				

LEGEND

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0750	INT[redacted]		INTILAS	1845	IN[redacted]
NEURO	PUPLIS		2mm and Rxt slowly				2mm PERRL sluggish	
	SENSORIUM		sedated c̄ VDC @ 2cc/h				sedated c̄ vecuronium	
			Versed @ 5cc/h MOT				@ .3mg/h versed @ 1mg/h	
			@ Fech				MSO4 @ 7mg/h	
RESPIRATORY	RESPIRATION PATTERN		RR 20 equal (B)				ETT # 8.0 28cm @ hub	
	BREATH SOUNDS		Coarse sounds throughout				SIMV 20, TV 750, p-S	
	SECRETIONS		c̄ ↓ bases				FiO2 45%, PIP 30s-40s O2 sat 98%	
			thick secretions from				rales (B) + coarse (B)	
			ETT c̄ NS				thick yellowish secretions	
							from ETT	
SKIN	COLOR		Normal for race				normal for race. ABD drsg C,D,I	
	INTEGRITY		D @ this time				@ Plant drsg serous drainage	
			Carry ABD drsg C,D,I					
IV SITE	LOCATION		(L) SCL TLC @ infusing				(L) SC 3-lumen c̄ NS @ 15cc/h	
	CONDITION		NS @ 75cc/h				versed, vecuronium, + versed	
			@ Port line				infusing. CVP in proximal port	
							@ radial A line c̄ good waveform	
							No s/s of infection	
GASTRO	ABDOMEN		Soft Round				rounded, somewhat hard	
	BOWEL SOUNDS		hyperactive				(+) hyperactive in all 4 quad	
							@ rare BGT to US c̄ light	
							brown drainage	
GU	URINE		Foley to gravity				Foley to gravity c̄ yellow	
	COLOR/CLARITY		Amber colored urine				urine. UO ≈ 100cc/h	
			30-40 cc/h				@ sediment noted	
CARDIOVASCULAR	CARDIACRHYTHM		SR - ST mid 90s -				ST c̄ HR 110s c̄ @ ectopy	
			100's. Generalized				Generalized edema	
			Edema				throughout, (+) palpable	
							pulses + cap refill < 3sec in all ext.	

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)

[redacted] CPT/AN b(6)-2

PAT[redacted] written entries give: Name --Last, First, middle; grade, date; hospital or medical facility)

DEPARTMENT/SERVICE/CINC ICU#1

DATE 14NOV03

[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIGNOSTIC STUDIES

☐ TRETMENT

PRBC #1 = 300cc 157/92 on (R) #2 PRBC Ordered 350

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	157/88	96/61	99/60	89/55	87/61	99/67	112/70	115/71	178/104	128/74	134/79	141/89	168/84	188/101	174/98	188/95	167/92	
BP Cuff		183/88	96/61	98/60	88/55	89/62	e							157/93	160/99	158/94		
Temperature	99.4		99.8		99.1		98.3	97.8					97.1	97.8	98.4			
Pulse	138	127	116	113	111	106	102	101	99	99	99	109	101	105	115	111	99	
Respiratory Rate	7	18	18	18	66	20	20	20	20	20	20	20	20	20	20	20	20	
FiO2	60	60	60	60	60	60	55	50	50	50	45	45	45	45	45	50%	50%	
MODE	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	S	
Peep	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	
MAP	116	74	70	65	71	73	82	85	92	91	97	116	112	122	27	118	112	
SaO2	93	97	98	99	97	99	100	100		100	100	99	100	100	100	97	100	
PIP										35	42	40	36	36	36	38	39	
CVP																		

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	175	175	175	175	175	175	175	175	1400	175	175	175	175	175	175	175	175	1400
IVPB	50							50	50	1000						50		1050
NGT	0		0		0		0											
MSO4	7	7	7	7	7	7	7	7	56	7	7	7	7	7	7	7	7	56
Versed	4	8	8	8	6	6	6	6	52	6	6	6	6	0	0	0	0	24
Vec	2	2	2	2	2	2	2	2	16	2	2	2	2	2	3	3	3	19
PRBC													150	150	175	175		650
Ativan IVP														2	10	2	2	16
Labetalol IVPB																4		4
CASix																		
TOTALS									1574									3219

OUTPUT																		
URINE HOUR / TOTAL	100	120	120	100	110	120	120	38	810	40	45	47	90	80	48	70 / 450	50 / 500	500
URINE SP gr																		
URINE S/A																		
NG OUTPUT							50		50						140 / 190		20 / 210	160
NG PH																		
NG GUIAC																		
EMESIS							0							0				—
STOOL							0											—
DRAINS CT1							130 / 500		130	60 / 860	pulled out			0				60
DRAINS Bladder											9				3	3		15
TOTALS									1990									735

158° IN = 1574 2nd 8

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
	165/88	165/87	153/83	154/46	18/93	161/80	165/87	129/105
								149/93
	98.6		98.9	98.4	99.0	98.4	98.6	98.3
	102	104	107	108	113	111	109	116
	20	20	20	20	19	20	20	26
	45	45	45	45	80	45	50	45
	9	9	9	9	9	9	9	9
	5	5	5	5	5	5	5	5
	116	112	112	110	123	112	114	135
	99	98	96	96	98	97	99%	98%
	39	38	39	37	40	38	39	39
				17	13	14	12	8

INTAKE	16	17	18	19	20	21	22	23	8°T
	175	175	175	175	175	175	175	—	2975
	50						50		1200
		0	0						
	7	7	7	7	7	7	7	7	105
	8b	1	1	2	2	2	2	5	21
	3	3	3	3	3	3	3	3	47
Bolus								100	1650
									16
									4
	1								

OUTPUT	16	17	18	19	20	21	22	23	8°T
	85	230	150	170	140	100	160	110	1815
			98/300						300
			0						
			0						
									190
	3								18

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
TIME		14NOV 0900	14NOV 1200	14NOV 1345	14NOV 1545	14NOV 2120	2245	0100	0409	
MODE		SIMV	SIMV	SIMV	SIMV	SIMV			SIMV	
F_IO_2		50	45	45	50%	50%	↓45	↓40	40	
TV		750	750	750	750	750			750	
RATE		20	20	20	20	20			20	
PEEP		5	5	5	5	5			5	
ABG	pH	7.32	7.32	7.29	7.3	7.291			7.295	
	PCO_2	35.5	35.9	35.6	35.5	39.4			39.0	
	pO_2	125	103	73	133	80			81	
	HCO_3	18	19	17	17	19			19	
	SAT	99	98	93	99	94			94	
	BASE	-8	-7	-9	-9	-8			-7	

LABORATORY DATA										
TIME		0400	0900	1900						
GLUCOSE		88								
Na/K		138/4.5								
Cl/CO_2		113								
BUN/Cr		29/32								
WBC/PLATELET		8.9/159	8.6/N6	10/181						
Hct/Hgb		24.1/7.6	23.4/7.5	31.3/9.9						

ACTIVITY DAILY LIVING										
TIME		0900								
MOUTH CARE		✓								
BATH		✓								
SKIN CARE		✓								
FOLEY CARE		✓								
~~TRACH~~ ETT CARE		✓								
ROM EXERCISES										

TURN	TIME			
	0800 R	1200 M	1600 L	2000 M

SUCTION				
	0800 Thick yellow	1000 Thick yellow	1300 Thick beige	1700 Thick white

24°180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE _____

NURSE'S SIGNATURE | INITIALS

[redacted] CMT/RN [redacted]

b(6)-c

in: 6018 out:

NEUROLOGICAL ASSESSMENT

14 NOV

		HOURS	08	12	16
COMA SCALE	EYES OPEN	SPONTANEOUSLY 4			
		TO SPEECH 3			
		TO PAIN 2			
		NO EYE OPENING 1	1	1	1
	BEST VERAL RESPONSE	ORIENTED 5			
		CONFUSED 4			
		VERBALIZES 3			
		VOCALIZES 2			
		NO VOCALIZATION 1	ET	ET	ET
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6			
		LOCALIZESPAIN 5			
		FLEXION WITHDRAWAL 4	Bilateral Flex	Bilateral Flex	Sedated
		ABNORMAL FLEXION 3			
		EXTENSION TO PAIN 2			
		NO RESPONSE 1			
LIMB MOVEMENT	ARMS	NORMAL POWER			
		MILD WEAKNESS			
		SEVERE WEAKNESS			
		ABNORMAL FLEXION			
		ABNORMAL EXTENSION			
		NO RESPONSE	1	1	1
	LEGS	NORMAL POWER			
		MILD WEAKNESS			
		SEVEREWEAKNESS			
		ABNORMAL FLEXION			
		ABNORMAL EXTENSION			
		NO RESPONSE	1	1	1
PUPILS	RIGHT	SIZE	2	2	2
		REACTION	+	+	+
	LEFT	SIZE	2	2	2
		REACTION	+	+	+
PUPIL SCALE			2 3 4 5 6 7 mm		
ICP					
CEREBRAL PERFUSION PRESSURE					

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	08	12	16
UE	R	++	++	++
	L	++	++	++
LE	R	+	+	+
	L	+	+	+
	R			
	L			
	R			
	L			
	R			
	L			

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

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
field	ET Intubation	8	☐ Oral ☐ Nasal Teeth		☐ $ETCO_2$ Change ☐ BBS Post Int ☐ Post CXR
	Gastric Tube		☐ Oral ☐ Nasal		☐ Air ☐ Contents ☐ Verified_____ Suction: Y N
field	Urinary	16	☐ Meatus ☐ Supra-Public		☐ Return_____cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed		☐ Grossly: + - Cell count Sent@_____
field	Chest Tube #1		L (R)		☐ Air ☐ Blood ☒ Pleuravac 10 cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:		Comments	

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

LABS

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

X-RAYS

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

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

IV ACCESS & FLUIDS

TIME	#	GA	IAW SOP		SITE	IVF TYPE	AMT UP	AMT IN
prehosp	18		(Y)	N	RA AC			
field	18		(Y)	N	LA AC			
field	centline		(Y)	N	Rt clavicle			
			Y	N				

MEDICATIONS

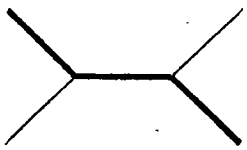
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Tetanus 0.5cc IM	0920								
Versed 2mg	0925								
Morphine 15mg	0925								
Vecuronium 10mg	0945								

BLOOD PRODUCTS

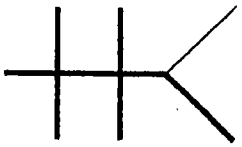
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	RATE

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	Gomez			
Surgeon	Blair			
~~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 _____

☐ Stretcher ☐ Wheelchair

b(2)-2

[redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE	OTSG APPROVED *(Date)*
TRAUMA FLOWSHEET The proponent is Dept of Surgery	QI Appr 11 Jun 97

EMS REPORT

TIME: 0900 ETA: ≈ 20 min UNIT:

MED COM: [Y] [N]

GSW (R) side

back

ARRIVAL STATUS

TIME 093 ☐ IV x ____ ☐ O_2 ____ 1/min ☐ C-Spine Immob

Meds: ☐ UKN ☐ None ☒ Yes: Propofol drip

Allergies: ☒ UKN ☐ None ☐ Yes:

Tetanus: ☒ UKN ☐ Current Last Meal/Fluid Intake ____ hrs

LMP: ____ ☐

PRIMARY SURVEY

AIRWAY

☐ Natural Patient [Y] [N]

☐ ETT 8 ☐ field

☐ Secretions 0

BREATHING

☐ Labored ☐ Unlabored ☐ Absent jagged

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 ____ V ____ M ____

Intubated Meds

SPHINCTER TONE: ☐ WNL ☒ None

HEAD

PUPILS: ☒ Equal ☐ Fixed ☒ React ☐ Dilated [L] [R] sluggish

TM: ☒ Clear ☐ Blood [L] [R]

NECK

C-Spine Tenderness: N/A [Y] [N]

Pain @ ____

JVD: [Y] [N]

HEART

RHYTHM: ☒ Regular ☐ 90

PULSES: ☐ Central ☒ Peripheral

LUNGS

BREATH SOUNDS: ☒ Bilat ☐ Equal ☐ Clear

Decreased ☒ [L] [R] Absent [L] [R]

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

ABDOMEN

☐ Soft ☐ Rigid ☐ Non-Tender

☐ Tender: ____ midline incision

PELVIS

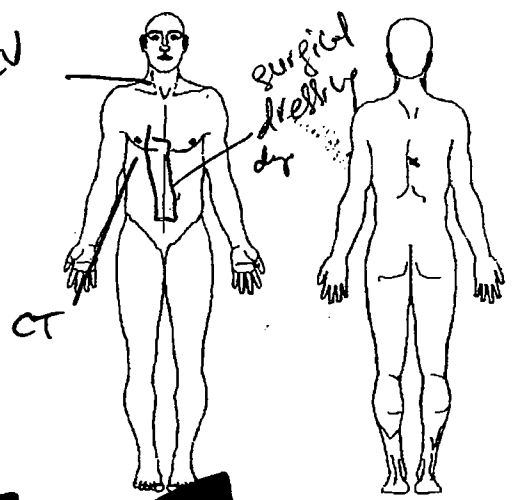
☒ Stable ☐ Unstable ☐ ____

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

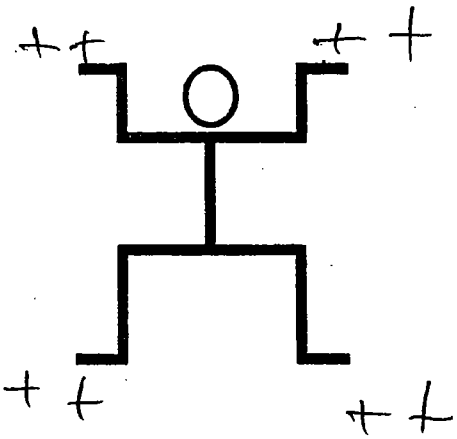
Heme + / - Prostate: ☐ WNL ☐ Abnl

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 [redacted]

PHYSICIAN [redacted] b(4)-2

PREPARED BY (Signature & Title) [redacted]

DEPARTMENT/SERVICE [redacted] OMT

DATE 11 Nov 03

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

[redacted]

b(4)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

[redacted]

→ 2° [redacted] unnecessarily / OTT

VITAL SIGNS

Rectal Temp:

GCS: (3)

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
0918	114/65	85	vent		98%						
0922	129/77	92	NSR		92%						
b 0928	128/77	93	vent		97%						
0935	/										
	/										
	/										
	/										
	/										
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	/										

GLASGOW COMA SCALE

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

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

NOTES

Staff Note

Pt reported to have been shot while arm[illegible] unclear. Seen by PST Team. Gave to (R) side back. Reported to have (R) diaphragmatic injy, small liver lac, (R) PTX CT placed, dislodged, developed tension PTX, CT replaced by EMEDS. Reported as stable. Arrived c USS, cool. Labs sent. Paralytic wore off. Pt moves ext x 4. CT @ 100cc blood. Pt 700cc clear urine

→ Admit ICU

[redacted] b(ce) c

U.S. GOVERNMENT PRINTING OFFICE

Admission and Coding Information

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

1. Reporting MTF	2. MTF Code	3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted]	b(2)-2	[redacted]	b(6)-4	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
		X	9	

10. Length of Service	ETS	11. FMP	12. Social Security Number
		20	[redacted]

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
		09:20	

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
		DIS	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICU1	Address of Emergency Addressee

Name and Location of Medical Treatment Facility:	Telephone Number of Emergency Addressee
[redacted] b(2)-2	

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
~~HOME~~ 30		2003-11-23

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
ABA - GENERAL SURGERY		2003-11-11

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
IZ		2003-11-11

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW R CHEST/ ABDOMEN RENAL FAILURE

Procedure Narrative(s):

Cause of Injury Narrative:

Blood Y

Trauma I

Inj 450

Cause Death #3

Aut N

Dx: 8605 7885 9584 8621 86610 86419 4019 E9912 8628(x3)

Rx: 5061 5589 3482 8689(x3) 311 9004 9670 9396 9394 9903

Admitting Officer (Signature, as requi[redacted]

[redacted]

Signature of Admitti[redacted]

Automated Facsimile - DA FORM 2985, MAR 2000 b(6)-2

b(2)-2

Admission and Coding Information

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

1. Reporting MTF [redacted]	2. MTF Location IZ			
3. Register Number [redacted]	Name (Last, First, MI) [redacted] b(6)-4		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race X	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. FMP 20	12. Social Security Number [redacted]	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 09:20	Branch / Corps:
14. Flying Status NO	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS		19. Trauma DIS	Prev. Admission NO
20. Source of Admission Direct from ER	Ward: ICU1		Name / Relationship of Emergency Addressee	
			Address of Emergency Addressee	
Name and Location of Medical Treatment Facility: [redacted] b(2)-2			Telephone Number of Emergency Addressee	
21. Type of Disposition HOME	22. MTF Transferred To		23. Date of Disposition (YYYYMMDD) 2003-11-23	
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From		26. Date this Admission (YYYYMMDD) 2003-11-11	
27. Location of Occurrence	28. MTF of Initial Admission		29. Date of Initial Admission 2003-11-11	

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW R CHEST/ ABDOMEN RENAL FAILURE

Procedure Narrative(s):

Cause of Injury Narrative:

b(6)-2

Admitting Officer (Signature, as requir [redacted]

Signature of Admitting Clerk [redacted]

b(6)-4

CERTIFICATE OF DEATH *(OVERSEAS)*
Acte de décès *(D'Outre-Mer)*

NAME OF DECEASED [redacted] prénoms)	GRADE Grade DETAINEE	BRANCH OF SERVICE Arme DETAINEE	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale [redacted]
ORGANIZATION Organisation [redacted] (e.g., United States) UNKNOWN		DATE OF BIRTH Date de naissance UNKNOWN	SEX Sexe ☒ MALE Masculin ☐ FEMALE Féminin

b(2)-2

RACE Race	MARITAL STATUS État Civil	RELIGION Culte	
CAUCASOID Caucasique	SINGLE Célibataire	DIVORCED Divorcé	PROTESTANT Protestant
NEGROID Négroïde	MARRIED Marié	SEPARATED Séparé	CATHOLIC Catholique
OTHER (Specify) Autre (Spécifier) ARAB	WIDOWED Veuf		JEWISH Juif
			OTHER *(Specify)* Autre *(Spécifier)*

NAME OF NEXT OF KIN Nom du plus proche parent UNKNOWN	RELATIONSHIP TO DECEASED Parenté du décéde avec le susdit
STREET ADDRESS Domicilé à (Rue)	CITY OF TOWN AND STATE *(Include ZIP Code)* Ville (Code postal compris) b(6)-2 [redacted]

MEDICAL STATEMENT Declaration médicale

CAUSE OF DEATH *(Enter only one cause per line)*
Cause du décès (N'indiquer qu'une cause par ligne)

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort[1]		GSW to Abdomen [redacted]
ANTECEDENT CAUSES Symptômes précurseurs de la mort.	MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	Acute Renal failure
	UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire	TRAUMATIC injury secondary to GUN SHOT WOUND TO THE ABDOMEN
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]		

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ☐ NO Non	CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitees par des causes exterieures
NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie ~~Arrest~~	
ACCIDENT Mort accidentelle		
SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste	
HOMICIDE Homicide	SIGNATURE Signature / DATE Date	AVIATION ACCIDENT Accident à Avion ☐ YES Oui ☐ NO Non

DATE OF DEATH *(Hour, day, month, year)* Date de décès *(l'heure, le jour, le mois, l'année)* 23 NOV 03 1113 hrs	PLACE OF DEATH [redacted] b(2)-2

b(6)-2 I HAVE VEIWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
J'ai examiné les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à, la suite des causes énumérées ci dessus

NAME OF [redacted] militaire ou du médicin sanitaire MCD	TITLE OR DEGREE Titre ou diplômé M.D.
GRADE Grade O5 b(2)-2	INSTALLATION OR ADDRESS Installation ou adresse [redacted]
DATE Date 23 NOV 03	SIGNATURE [redacted] b(6)-4

[1] *State disease, injury or complication which caused death, [redacted] etc.*
[2] *State conditions contributing to the death, but not related to the di[redacted] causing death.*
[1] *Préciser la nature de la maladie, de la blessure ou de la complica[redacted] contribué à la mort, mais n'ayant [redacted] la manière de mourir, telle qu'un arrêt du coeur, etc.*
[2] *Préiser la condition qui a contribué à la mort, mais n'ayant aucun rapport avec la maladie ou à la condition qui a provoqué la mort.*

b(2)-2

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-2; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL

NAME AND LOCATION OF HOSPITAL [redacted]

Instructions - Medical Officer in attendance will:

Prepare, in one copy only, Items 1 through 10 and sign Item 11. Print or type entries.

Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*

[redacted] ~~EPW~~ (DETAINEE)

b(6)-4

Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(Hour-day-month-year)*: 0113

3. MEDICAL EXAMINER/ CORONER'S CASE: ☐ YES ☐ NO

4. RELIGION: UNKNOWN

5. CHAPLAIN NOTIFIED: ☐ YES ☑ NO

6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(or as a consequence of)* GSW to chest/ABDOMEN	13 DAYS
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(or as a consequence of)* (1)	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a. ARDS	
	b. Renal Failure	

9. DATE: 23 NOV 2003

10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER [redacted] OF MEDIC[redacted] ENDANCE IN ATTENDANCE [redacted] b(6)-2 [redacted]

SECTION B - ADMINISTRATIVE [redacted]

TYPE OF ACTION	HOUR	DAY	MONTH	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)* ☐ YES ☐ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

23. DATE	24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY	25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY
26. DATE	27. TYPED NAME AND GRADE OF REGISTRAR	28. SIGNATURE OF REGISTRAR

DA FORM 3894, OCT 72 REPLACES DA FORM 8-257, 1 JAN 51, WHICH WILL BE USED. USAPPC V2.00

BATES PAGE MEDCOM 23869 HAS BEEN WITHHELD IN ITS ENTIRITY PURSUANT TO FOIA EXEMPTIONS 6 AND 7, 5 U.S.C. 552(B)(6) AMD (B)(7)(C).

Photo depicting deceased.

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 [redacted] b(6)-4
3. Grade: FGN
Admission Remarks

4. Sex: M
5. Age: 13Y
6. Race: X
7. Religion
8. LnthOfSvc
9. ETS
10. PrevAdm: NO

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

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

21. Source of Admission: Direct from ER
22. Hour Of Adm: 06:35
23. Clinic Service: AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee
25. Type Disp: TRF-OTH
26. Date of Disp: 2003-12-20

27a. Address of Emergency Addressee
27b. Telephone No
28. Date This Adm: 2003-11-12
AdmittingOfficer: OLIVERIO

29. ReportingMTF [redacted] b(2)-2
30. Date Init Adm: 2003-11-12
32. Units Blood Components

31. Selected Administrative Data

Marital Status:
DoB: 1990-01-01
In/Out Patient: Inpatient
MOS:

33. Cause Of Injury:

34 Diagnosis / Operations and Special Procedures:

OPEN R FEMUR/~~TIBULA~~ TIBIA FX

35. Total Days This Facility

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

35. Total Days This Facility

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

Signature of Attending Medical Officer

[redacted] b(6)-2 [redacted] Mark R. White [redacted]

Automated Facsimile - DA FORM 3647, May 79

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. [redacted]

3. Grade
FGN

Admission Remarks

4. Sex
M

5. Age
13Y

6. Race
X

7. Religion

8. LnthOfSvc

9. ETS

10. PrevAdm
NO

11. FMP
99

12. SSN
[redacted]

13. Organization
b(6)-4

14. Ward
ICW1

15. FlyStatus
NO

17. Dept / Ben
K78-PRISONER OF WAR/INTER

18. BranchCorps

19. UIC / ZIP

20. Type Case
DIS

21. Source of Admission
Direct from ER

22. Hour Of Adm:
06:35

23. Clinic Service
AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee

25. Type Disp
TRF-OTH

26. Date of Disp
2003-12-20

27a. Address of Emergency Addressee

27b. Telephone No

28. Date This Adm:
2003-11-12

AdmittingOfficer:
OLIVERIO

29. ReportingMTF
[redacted]
b(2)-2

30. Date Init Adm
2003-11-12

32. Units Blood Components

31. Selected Administrative Data

Marital Status:

DoB: 1990-01-01

In/Out Patient: Inpatient

MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

OPEN R FEMUR/~~TIBULA~~ FX
TIBIA

35. Total Days This Facility

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

35. Total Days This Facility

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

Sig[redacted]ing Medical Officer

[redacted]

b(6)-2

Signature of PAD or Medical Records Officer

[redacted]

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

13 X.O. ♂ PASSENGER IN TRUCK THAT GOT SHOT AT A CHECKPOINT. ETA NOW AT 78th'ND FST, (R) FEMUR AND (R) TIBIA X-FIXES APPLIED. STATES HE HAS ↓'D SENSATION OVER TOES

PMH (-)

ROS (-)

NKDA

PHYSICAL EXAMINATION

HEENT - SMALL ABRASION (R) EXT. LID
NECK - SUPPLE
LUNGS - CLEAR CVOST AT/NC
ABDM SOFT, NONTENDER
EXT - (R) FEMUR, (R) TIBIA X-FIX, 10 FOOT, SPINS CIRCLE DRESSINGS. ↓ SENSATION
(R) FOOT, MOVES TOES WEAKLY, POOR SUPPORT
DRESSING (L)
2X5 CM WOUND (L) CALF 2×2 CM WOUND (R) BUTTOCK
(R) MID WOUND

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

XIRAYS: (1) COMMINUTED (R) MID SHAFT
FEMUR FX, ABX BONES
(2) COMMINUTED DISTAL 1/3 TIBIA FX, FIB FX, ABX BONES
(L) FIB. FIB PLATE
(P) PLACEMENT (R) TIBIA; (R) FEMUR, APPR WORKING
(P) I+D TOMORROW

[redacted] b(6)-2

SIGNATURE [redacted]	DATE 12 NOV 03	IDENTIFICATION NO	ORGANIZATION
PATIENT [redacted]	*(Typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	NAPC NO

[redacted]

b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
PRESCRIBED BY 41 CFR 201-45.303
OCTOBER 1975
USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE	
12 Nov 2003	

OPERATIVE NOTE

DIAGNOSIS: 1) (R) Open Femur Fx - Type III
2) (R) Open Distal Tibia Fx - Type III 3) (L) Leg soft tissue inj

PROCEDURE: 1) I&D, Fx-Fix (R) Femur
2) I&D, Fx-Fix (R) Tibia
3) I&D (L) Leg soft tissue inj.

SURGEON: [redacted] b(6)-2

FINDINGS: Severe soft tissue injury to (R) Thigh and (R) Leg. Obtained Doppler DP pulse.
Placed #10 Abx beads in Ant thigh, #7 Abx beads in post thigh, and #10 Abx beads in (R) tibia wound

FLUIDS: 2,000 cc LR
3 units PRBC

EBL: 500 cc

Received Ancef, PCN, and Tetanus Pre-op.

b(6)-2 [redacted] Bal

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

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

14 yr old.

b(6) - 2 A 11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13 Nov 03	100 cc/h. Pt LLE ⊂ Ace wrap CDI. RLE has Ex Fix in place. Drsg Draining Sero Sang Fluid. Triple lumin in (R) Femoral Artery. No S/Sx of infection. PT NPO ⊜ midnight for OR on 13NOV 03. [redacted] 91WM6
13NOV03@1930	Pt. care assumed @ 0600. Pt. to O.R. for I&D of (R) femur, (R) tibia, and (L) lower leg. Pt. ~~to~~ (M.D.) recieved from PACU @ 1315, pt. tachy (130s), temp 100.5°. Other V.S.S. Pt. drowsy, ex-fix to (R) femur & (R) tibia, dressings to (R) upper & lower leg & (L) lower leg. DRSNG's CDI, ace-wrapped. Pt. given H_2O PO, tolerating well. Lungs clear bilat. (+) BS all four quads. Foley to gravity, clear dark yellow. LR infusing at 100cc/° to (L) femoral art. line. Will cont. to monitor. [redacted] RCT, RN
13NOV.03 ~~1935~~ 1935	Pt asleep, responsive to verbal stimuli, VSS. T-101.6, adm Tylenol 650mg as per orders, will continue to monitor, LS CTA (B), (+) BS x4, encouraged use of IS, pt understands, IV FL LR @ 100cc/hr, (Ø) S/Sx of infex/infiltration, Ex Fix on (R) thigh + (R) Tibia intact, dsg + ace wrap CDI, blood drainage noted on (R) foot area, FTG draining CVV, pt on BR, refuses to eat diet, encourag'd to increase fluid intake, (R) eye lid swollen, scratch ⊂ scap on middle of eyelid, Ø drainage noted, gtts tx 2 point restraint, Ø complications. [redacted] HW I concur ⊂ above assessment [redacted] RCT

STANDARD FORM 509 (REV. 6/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

11 Nov 2003

14 yo ♂ sustained multiple GSW's to (B) LE's. No head, chest, or abd trauma. Arrives awake & alert

PE (R) LE – Unable to assess neuro exam 2° to pt distress. No palpable PP of TP. Good cap refill.
Obvious (R) Femur Fx c̄ large soft tissue wound.
Obvious distal tibia Fx c̄ large soft tissue wound.
Partial amputation (R) 5th toe

Xrays – 1) (R) Femur Fx – prox shaft, comminuted
2) (R) Distal tibia Fx – comminuted
No Radiographs of foot (L) Tibia – No Fx

(A/P) 1) Open (R) Femur Fx
2) Open (R) Distal tibia Fx
3) (L) Leg soft tissue wound
4) (R) 5th toe near amputation

HOSPITAL OR MEDICAL FACILITY	STATUS b(4) –	DEPART.JS[redacted]	[redacted]ONED AT
SPONSOR'S NAME	SSN/ID NO.	RELA[redacted]	
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Dat[redacted]*		[redacted]	WARD NO.

14 yr old

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

14 yr old

b(2)-2

Epw 2

[redacted] Trauma Flow Sheet

Name: _____ SSN _____ Unit _____

Blood Type

Date and time of injury: 11 Nov 03 Time of Arrival 2350

MOI: GSW

HPI: FRAGL child presents to CMED via FLA after Gun fight near Tombstone Hospital this pm

Primary Survey

PMHX:

PSHX:

Meds:

Allergies:

Airway: Patent Mechanically maintained by _____

Breathing: Spontaneous Assisted by _____

Circulation:

Pulse: Present Absent CPR

Color: Normal Abnormal

Cap refill: Normal Delayed

Secondary Survey

Intial Vital Signs: b/p 140 / 100 pulse ~~135~~ 135 Resp 26 Pulse Ox 100 Temp ___

GEN: AOx3

HEAD: Laceration on (R) eyelid FB OD Cornea globe intact

NECK: Solid No step off Pain

HEART: $S_1 S_2$ 153 HR

LUNGS: Clear Bilat

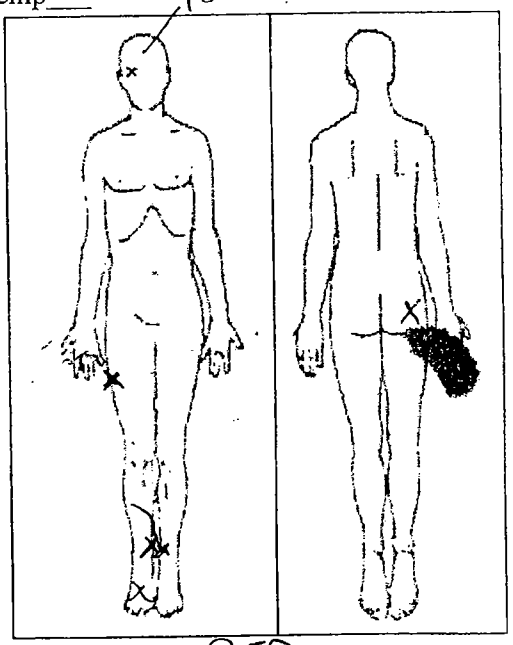
CHEST: Solid (-) crep NTTP

ABD: Soft No TRI NTTP (-) LL

PELVIS: Solid NTTP

EXT: GSW to (R) thigh, (R) Ankle, (L) calf

(-) posterior Tibial or pedal pulses (B)



RECTAL: Clear (-) grossly blood

NEURO: INTACT

(-) Pulse in (R)

CN II - XII grossly intact

LE unable to move (R) Rt

GLASCOW COMA		
EYES OPEN	Spontaneously	4
	To Speech	3
	To Pain	2
	None	1
BEST VERBAL RESPONSE	Oriented	5
	Confused	4
	Inappropriate sounds	3
	Incomprehensible sounds	2
	None	1
BEST MOTOR REPONSE	Obeys Commands	6
	Localizes Pain	5
	Withdraws to Pain	4
	Flexes to Pain	3
	Extends to Pain	2
	None	1
	TOTAL	

PED

Revised Trauma Score		
GLASCOW COMA TOTAL	13-15	4
	9-12	3
	6-8	2
	4-5	1
	3	0
SYSTOLIC BLOOD PRESSURE	>89 mmHg	4
	76-89 mmHg	3
	50-75 mmHg	2
	01-49 mmHg	1
	No pulse	0
RESPIRATORY RATE	10-29 / min	4
	>29 / min	3
	6-9 / min	2
	1-5 / min	1
	None	0
	TOTAL	

X-RAY:
1. (R) Thigh
2. (R) Ankle
3. Pelvis
4. (L) Leg

LAB
9
28

Interventions

Airway / Breathing: NRB mask @ 15 LPM

Circulation: (3) Lumen in (2) FEM
NS @ 700 ml Bolus x 1
20 ml/kg

Other:
Blood 20 ml/kg IV Bolus

MEDICATIONS

Time	Drug	Dose	Route	Initials
0017	Ancef	50 gm	IVPB	[redacted]

b(6)-2

Blood Components

Unit #	Type	Time	Response
1866318	O Neg	0016	HR ↓

1866318

1866350

Vital Signs

Time	B/P	Pulse	Resp	Pulse Ox	Temp	GCS
0010	79/48	153	14	98 %	100	
0030	90/50	114	20	99 %	97	
	/					
	/					
	/					
	/					

Transfer Instructions:

NOTES:

Personal Effects:
2 shirts
500 dinar

Prepared by [redacted] b(6)-2

Team Leader: [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12NOV03	(1200) Pt admitted to unit via gurney from ENTT in stable condition. Pt alert, speaking Arabic. VSS. Denies pain @ this time. Pt temp on adm. 101.° axillary. Pt c̄ shivering, medicated c̄ 650mg Tylenol po. Temp p̄ 1° -101.3 axillary. cont. IV fluids, enc. po fluids, and given IS. Demonstrated correct use of IS. Drsg to lower RLE reinforced d/t saturation c̄ sero-sang drainage. Drsg to upper RLE and LLE intact c̄ small amount sero sang drainage. Ex fix in place on femur and tibia. Pt able to move all extremities. Blood cleaned off face and torso. @ femoral TL infusing IVFs s̄ S/Sx infection/ infiltration. Pt tol. po well. Foley draining quantity sufficient clear yellow urine. 1 point restraint in place s̄ S/Sx complications. Will cont. to monitor. b(6)-2 [redacted] (1500) Pt temp 100.2. Pt cont. to drink water and use IS. Scrape noted on @ eyelid. Sclera of @ eye red. Denies pain. Will monitor. [redacted]
12Nov02 2200	Assumed care of Pt @ 1800. Pt Temp 101.3 @. 650 mg of tylenol administered. removed covers. Encouraged IS. Pt refused to comply. Pt has LR @

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.
		CW1

#[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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DICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Nov 08	Orthro Op Note
	Pre Op Dx: (1) Open (R) femur fracture
	(2) Open (L) tibia fracture
	(3) Multiple fragmentation wounds (L) calf
	(R) legs
	Post Op Dx: Same
	Procedure: I+D (R) legs.
	Surgeon - [redacted] b(6)-2
	Findings - Significant dead tissue excised from (R) & (L) lower legs, (R) thigh. Fascia OK. Bones irrigated, wounds irrigated & debrided. Both replaced in fascial tissue. [redacted] wound had dead pouch under (R) thigh. Had vessel loop weave done on thigh wound.
	PLAN: Repeat I+D in 48 hours

b(6)-2 [redacted]

PITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVIC[redacted]	NTAINED
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 C.
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 NOV 03	Author of Note Pre-Op Dx: (1) Open (R) femur fx (2) Open (R) tibia fx (3) Open (L) calf soft tissue wound Post Op Dx: Same Procedure: I&D of all wounds, adjust ex. fix Surgeon: [redacted] b(4)-2 Anesthesia: Findings: Able to pull muscle remnants out of tibia fx. Possible of debris found in possible report of trap.
	Plan: repeat I&D in 48 hrs
17 NOV 03	Author of Note
1245	Pre-Op Dx: Multiple frag wounds, open fx Post Op Dx: Same Procedure: I&D of muscle Surgeon: [illegible] Pro-Op: bone marks DPC's Kessel Swing being in finish. High sample Plan: repeat I&D in 48 hours
	b(4)-2 [redacted]

STANDARD FORM 600 (REV. 6-97) BA
*U.S. GPO: 2002 - 421-600/5

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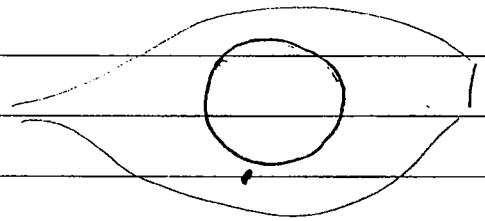
MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14NOV03 1238	Ophth Note
	Asked to see #1289
	Passenger in vehicle that got shot at-
	Doesn't speak English/read English
	Bedside exam
	1/L healing laceration
	corneal 3 mm small black spot inferior sclera
	cornea cl
	A/C D&Q
	iris WNL
	DFE lens cl
	Vitreous - ∅ sig inflammation
	white fibrin vs old heme
	small rock/fragment in vitreous
	macula: heme/commotio maculae
	V/P : commotio/heme
	over



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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b(6) - 4

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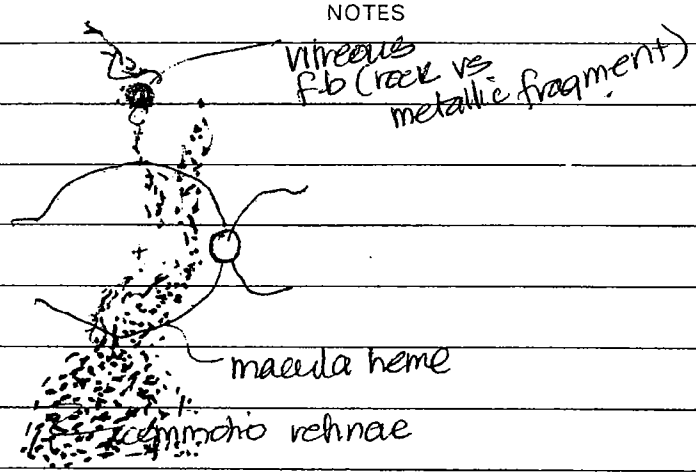
LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES



Imp: small IOFB/c̄ retinal heme/commotio
~~p~~endence of endophthalmitis ; will follow

Plan: ~~Cipro 400mg IV q12~~ on ancef & gent
Ocuflox 1 gtts OD q2° while awake
Ultimately should have foreign body removed
to decrease Retinal Detachment risk

[redacted]

b(6) - 2 GOA DTC

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14 Nov 03 Cont	Pt moves (L) LE Toes. ≤3 sec cap refil. (R) LE Ex fix pins in place & intact. Drsg on ~~RF~~ (R) LE Draining Sero Sang Fluid. (R) LE cap refil ≤3 sec. Warm & Dry to touch. Unable or refuses to move toes. Pt c/o abd Discomfort. ~~RF~~ checked Foley Cath. FTG Draining c/x/u. LR infusing @ 100 cc/h via 18G cath to upper Left arm. PERRLA Briskly. Puncture ~~wound~~ wound to OD inferior to pupil .5 mm in diameter. Will continue to monitor. b(6)-2 [redacted] Spc 91WM6
15 Nov 03 @ 1600	Assumed care of pt @ 0600. Temp 99.3°. other VSS. A&O. ∅ c/o pain, requesting apple. Pt. NPO for surgery. Pt. To OR. @ 1100. Returned from PACU @ 1400. V.S.S. A&O. Taking H_2O PO, refuses food including apple. LR @ 100cc/h to (L) upper arm. Ex-fix to (R) femur & (R) tibia, ace-wrapped, CDI. (L) lower leg ace-wrapped, CDI. ⊕ pulses bilat. LE. Pt. unable to move (R) LE. Tofradex to OD & GTTS Q 2° while awake. HCT low - 21.2, CRNA informed prior to SX. Pt. in 2-point restraints, ∅ signs of skin breakdown. ~~All the assessments~~ WNL. b(6)-2 [redacted] Spc 91WM6
15 Nov 03	2000 pt sleeping OD gtts held. [redacted] Spc 91WM6
15 Nov 03	2100 pt pulls out IV access. New IV access started on (R) hand. ⊖ swelling or redness on site. [redacted] 91W10. PFC.
15 Nov 03 @ 2130	Assumed care of pt. @ 1800 on 15 Nov. Temp. 102.9°F other VSS. Administer 650 mg Tylenol per order. pt. comply to proper use of IS. A+O. speaking Arabic. refuses to eat dinner but ate ice cream after persuasion. ⊖ c/o pn as of now. IV LR @ 100 cc/hr. ⊖ s/sx infex on IV site. HRRR. LSCTA (B) BSX4. Abd soft + nontender, firmness ⊕ on midsection of LQ.

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[redacted]

b(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14 Nov 03 1600	Assumed care of pt. @ 0600. Temp 101.4° @ 0900. Tylenol 650 mg given PO. Pt. drowsy & confused while febrile. Temp. @ 1030 was 98.8°. Pt. pulled out femoral line @ 1000, minimal drainage dressing applied & sutures removed. New IV started at (L) AC. IV became occluded @ 1700 due pt. abducting & flexing arm. New IV started to (L) upper arm. LR infusing @ 100 cc/h. Foley draining clear yellow urine, significant output. Pt. tolerating water PO, refused meals. Ex-fix to (R) ~~thigh~~ (ant.) femur & tibia, ace wrapped. (L) LE ace-wrapped, large amount of sero-sang. drainage. MD did not Δ any dressing this shift checks pods to LE Δ'd bilat. Pt. occasionally screams out for mother as translated by interpreter. Pt. in 2-point restraints. Ø signs of skin breakdown. All other assessments WNL. b(6)-2 [redacted] 2CT, ANC
14 Nov 03 2030	Assumed care @ 1800 hrs. Alert Speaking Arabic. Able to communicate needs. Denies pain @ this time. [redacted] Temp 101.4° F (A). Administered 650 mg Tylenol. Encouraged IS. Encouraged H_2O PO. LS in RLL Slightly Diminished. All other LS CTA. Heart Rate Rythm Regular. S_1 and S_2 present. Abd Soft Flat non tender (+) BS x 4 quad. LLE Drsg CDI. ~~RLE~~ (L) Foot cool and Dry to touch. (L) Femoral Pulse positive

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

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b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15 NOV @ 2130 CONT'	FTG draining CYU. (R) LE Ex Fix intact. (R) LE + (L) LE dsg CDI. ⊖ ROM on (R) LE. bilateral dorsalis pedis pulse nonpalpable. skin warm, dry, intact. pt. continuously picking on (R) eyelid causing minimal bleeding which easily clotted. told to stop touching (R) eye but refused to comply. restraints on both arms shortened to prevent from picking eye and IV access. will continue to monitor b(6)-2 [redacted] PFC 9/W/O
16 NOV 03 @ 0200	Temp. 101.8°F @ 2100. encouraged use of IS, AG refuse to use IS properly. blanket removed. Ice packs applied to nape, armpits and groin area. Temp 100.0°F (A) @ 2300. Administer Tylenol 650mg per order. Temp. lowered to 99.3°F (A) @ 0100. b(6)-2 [redacted] PFC 9/W/O
16 NOV 03	(0915) VSS. ~~⊖ c/o pain.~~ ⊖ c/o pain. (+) Foley draining clear, yellow urine. IV to (L) hand. Infusing IV ABx ⊖ difficulty. SL p̄ ABx. D/C. LR 50° tol PO well. Pt ate apple + orange for breakfast. ~~Refused~~ Ex-Fix to (R) femur + Tib-fib. intact. (R) ft has dark brown blood on ace bandage. ⊖ active bleeding. Will continue to monitor. Pt unable to move toes in (R) ft. Not able to ~~p~~ palpate ~~dorsalis~~ dorsal pulse. Toes warm to touch, (+) brisk cap Refill. (L) leg splint CDI. (+) 2 pedal pulse, warm to touch, able to move toes. Pt has superficial laceration ~~above~~ on (R) eyelid. Pt picks at wound. Encouraged pt not to pick, but continue to touch wound. b(6)-2 [redacted]

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

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#[redacted]
b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16NOV03	(1640) Pt requested to go commode. Transfered pt from bed to commode. ⊖ BM. Pt OOB ~ 1 hr. Pt on/off crying. (P) tibfib DSG felt wet. ⊖ order to Δ DSG. Reinforced DSG ⊡ ABD pad + kerlex. Will continue to monitor. b(6)-2 [redacted]
16 Nov 03 2050	Pt Awake and A&O. Temp 101.4°F (A). Blankets removed 650mg of Tylenol administered. Pt crying out for Mom. LS CTA (B) $S_1 S_2$ Present. (+) BS x4 quads. Pt pulled IV cath out. New IV 22g to (L) Upper Arm. (L) Arm restrained so Pt cannot bend Arm. (R) Arm restrained so pt cannot pull IV out. FT/r draining CYU ⊡ difficulty qs. (L)LE Drsg CDI. + pedal pulse ≤3 sec for cap refill. Pt can move toes. (R)LE Ex fix for femur and Tib Fib intact and in place. Drsg is CDI. Pt cannot move (R) Foot Toes. (+) pedal Pulse. [redacted] Warm & Dry. Will continue to monitor. [redacted]
16 Nov 03 2300	Pt had suppository inserted for BM [redacted] Will cont to Monitor. b(6)-2 [redacted]
17Nov03 1225	Pt To Bed Side comode. [redacted] x1 Large. [redacted]
17NOV03	(1045) NSG - Temp 100.9. Pt frequently calls out. Pt been told to keep voice ↓. Pt Refuses. Interpreter stated reason for pt calling 2° lonely or asks for mom. (+) Foley draining clear, yellow. Pt down to OR at this time. [redacted] b(6)-2

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17NOV03 2300	(CONT) on circulation compromise. New IV 22G started in (D) FA for IV ABX therapy. Plan: monitor temp, monitor neurovascular status RLE monitor drsgs, enc po intake enc IS. Will cont IV ABX's & gtts as ordered. Ingood
18NOV03 @0600	- nutrition consult sent D/T decreased appetite. b(6)-2 [redacted]
18NOV03	(1015) NSG - VSS. A+O. Premedicated pt c̄ total of 4mg MSO4 prior to DSG Δ's. Pt tol DSG Δ's well. WTD DSG to B/L LE. ⊖ S/Sx of infection. (R) upper thigh DSG saturated c̄ serosanguinous drainage. ⊖ order to Δ DSG. Removed superficial DSG + Reinforced c̄ ABD x2 + kerlex. Will clarify c̄ MD if wants to Δ DSG completely. Pt sat in chair c̄ B/L Legs elevated for ~2hrs. Pt tol well. Pt back in bed. IV ABX running. IV in (L) FA intact. ⊖ S/Sx of infection. (R) LE +1 pedal pulse. Pt unable to move toes, warm to touch, (+) cap Refill. (L) LE (+) 2 pedal pulse, warm to touch, pt able to move toes. Pt able to urinate s̄ any difficulty. b(6)-2 [redacted]
	(1230) Clarified c̄ Dr. [redacted] ~ Δ DSG to (R) upper Ex-fix. Dr. [redacted] does not want DSG Δ for (R) upper ex-fix. Pt aware will go for surgery 18NOV03. Pt poor appetite. Eats only fruit off tray. b(6)-2 [redacted]
19NOV03 0200	Assumed care of pt @ 1800. VSS. no c/o. Alert, speaking Arabic. LSCTA, (+) BS, ↓ appetite, void per urinal QS. RLE ex-fix x2, thigh drsg reinforced c̄ Kerlix, calf drsg Δd WTD c̄ ace wrap in place. (+) c/s, ↓ movement, (+) cap refill; LLE drsg Δd WTD c̄ ace wrap, (+) cms, (+) cap refill. (R) eye c̄ sm wound in lower cornea, eye gtts cont. Pt D/C'd own IV, new IV restarted, (D) FA 20G. (CONT) [redacted]

b(6)-4 [redacted]

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b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

17NOV03 (1530) NSG - Pt back from O.R. VS - 137/96, 99°, 98% RA, 147. Will Recheck ~~BP~~ BP + HR. Pt A+O. DIC'ed foley @ ~ 1300. Will monitor u/o. Ex-fix to (R) upper thigh DSG has bloody drainage on pin area. No new order to Δ DSG until 18NOV AM. Will continue to monitor. B/L calf-ankle ~~DE~~ DSG CDI. ~~Pt able to~~ (L) leg +2 palpable pedal pulse, move toes, warm to touch. (R) leg +1 pedal pulse, move toes, warm to touch. Did not administer Q2° eye gtts 2° to pt in O.R. Will Resume eye gtts + IV ABX. Pt tol po well. Pt asleep at this time. b(6)-2 [redacted] 29/00

17NOV03 @2300 assumed care of pt @1800. VS rechecked, WNL except tachycardic @120 bpm & temp 101.1 (oral). MD aware. Tylenol given c̄ T ↓ 99.4. No c/o, speaking arabic. Alert, follows commands; LS CTA, continues IS when reminded; (+) BS, tol very little food, only fruit & soda. DTV by 1930, void & I+O cath @2015 c̄ 250cc residual, foley D/c'd. Pt voided approx 600cc @2230. RLE c̄ 2 ex-fix c̄ dsg, upper thigh dsg reinforced PT sero-sanguinous drainage. (+) C/S, but unable to move toes. LLE calf dsg CDI, (+) CMS, cool to touch, +1 DP. ∅ pt restraints on & s/sx of skin (CONT)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME b(6)-2		
	LAST	FIRST	MI [redacted]
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[redacted] b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18 Nov 03	Nutrition Note: Nsg reports pt c̄ poor po intake, will only consume apples, oranges, + Soda. Pt communicates c̄ translator that his appetite is ↓, he wants the restraints removed to eat. He likes chicken + juice; Pt states he will eat after translator explains that he must eat to heal, grow. Pt began to eat meat, rice, muffin + drank all of juice box. Will provide pt c̄ extra juice at meals. Recommend continuing pt on current diet, provide lots of encouragement to ↑ po intake.
	b(6)-2 [redacted] RD/LD
7/14/15	

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

DATE	NOTES
(cont)	Both legwounds were beefy red with little drainage.
19NOV03	Ø odor present. Maintain pedal pulses and mobility in 2ro bags. Tobradex q2° is making a difference in ® eye. Doesn't have much of an appetite, seems to like apples. Will cont. to monitor? 9/USA Wash
	(1700) I concur c̄ above. ▷(b)-2 [redacted]
20NOV03 @0400	assumed care of pt @1800. VSS, Alert, yelling, c̄o restraints. Through interpreter, explained/reinforced rules c̄ pt. LS CTA; ⊕BS, tol reg diet; 75% of dinner meal; void per urinal QS; RLE c̄ x2 ex-fix, drsgs c̄ serosanguinous drainage noted. Drsgs Δ'd to BLE, all wound beds red c̄ drainage noted, sutures exposed to ® thigh wounds. RLE ⊕ c/s, ⊖ movement, ⊕ cap refill. LLE ⊕ CMS, ⊕ cap refill. ↑ OOBTC c̄ complete assistance. ® eye wound healing, cont eyegtts Q2°. new IV to ® FA, 20G flushes well. ® wrist IV D/C'd, cath intact. 2pt restraints MS S/Sx of skin/circulation compromise. Pain: cont IV Abx, monitor drsgs, monitor NV status. b(6)-2 [redacted]
20NOV03	(1330) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. ⊖ c̄o pain @ this time. Pt OOB to BSC. ⊕ large BM. Pt ↑ to chair. Tol. well. Dsgs to BLE Δd WTD. Pt assisted c̄ dsg Δ medicated c̄ 2mg MSO4 prior to dsg Δ - tol. well. Ex fix in place x 2 on RLE. Pt unable to move toes on ® foot. Cap refill <3secs. ® eye slightly swollen. cont OD gtts as ordered. SL in ® forearm flushes well c̄ S/Sx infection/infiltration. 1 point restraint in place c̄ S/Sx

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18NOV@ 0200	(CONT) 2 pt restraints on 5 S/Sx of skin/circulation compromise. Plan: NPO PMN for surgery tomorrow 11/19 pain control, monitor drsgs. [redacted] b(6)-2
19NOV03 1000	Ortho Op Note
	Pre Op Dx: Multiple fragmentation wounds
	Post Op Dx: Same
	Procedure: [redacted] of wounds
	Surgeon: [redacted] b(6)-2
	Anesthesia: IV
	Findings: Some granular slough in buttock wound debrided. Visual loop losing clot.
	Plan: Report I+D in 48-72 hrs
	b(6)-2 [redacted]
19NOV03 1730	Assume care of pt @ 0600. VSS, Ao ∅ c/o pain today. Went to OR this morning, pt stable upon return. Ex-fix to (R) leg remains intact, bandage around (R) leg reinforced. Aed drsg's to (R) and (L) leg achilles.

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[redacted] b(6)-4

b(6)-2 AM

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	[illegible] Pressure dressing after irrigating & debrided. Pt's repeat I+D in 48 hours Bedside bed / PICC line [redacted]
21 NOV 03 0800	-Assumed care of pt. AOx3. VSS Ø c/o pain @this time. Lungs CTA. HRRR Active BS x4 Remains NPO p MN o/c for surgery this AM. I+D of (R) thigh and LE. DSG CDI. thigh dsg re-inforced. IV ABX TX cont - Afebrile Will cont to monitor [redacted]
1000	- Pt off floor to OR [redacted]
1300	- Pt return from PACU VSS Ø c/o pain or discomfort. Denies N/V Resume previous orders. cont treatment regime [redacted]
22 Nov 03 0030-0450	Assumed care @ 1800, Pt slightly afebrile 101.5° ℉ tylenol administered, cont to monitor all other VSS; pt alert speaking arabic, able to verbalize needs; Ex-Fix to (R) LE in place, (+) CMS, +2 PP, brisk cap Ref, NV intact to (B) LE; dsg Δd W→D to both heels healing well; dsg to (R) upper thigh in place, mod. drainage, Ø signs active drainage, S/L patent; Cont ī IV abx; Pt tol Reg diet ī in between meals snacks; Restraints in place, (+) circ, Ø skin breakdown, cont to monitor [redacted]
22 NOV 03 0730	-Assumed care of pt. AOx3. VSS Denies pain Lungs clear HRRR Active BS Tolerating PO well Attempted to have a BM this morning wasn't able to. External ex fix to (R) femur and tibia dsg ī serous drainage changes PRN

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
20NOV03 (1330)	(cont) complications. Will cont to monitor. [redacted]
20 NOV03 2000hr	VSS. A&O. Consumed 60% of Regular diet for dinner. OOB → Chair +2 assist. (B) LE wound tissue red moist with tendon exposed. (R) [redacted] (R) LE ex fix pin sites without drainage or crustation. (R) FA Saline lock patent + intact. Pt aware of NPO p MN status for OR tomorrow. Voiding clear yellow urine. Tobradex gtt instilled to OD as ordered. Will continue care as planned. [redacted] 2CT AN
21 NOV 03 1200	Author Op Note Pre-Op Dx - Multiple GSW, open fx Post-Op same Procedure I+D (R) leg Surgeon - [redacted] GBL - MN Findings - Took pus from entire thigh and down to bone

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22NOV03	cont- (R) femur dsg reinforced as needed. OOB to chair this morning ADL care given. Afebrile IV ASX Cont will monitor [redacted] b(6)-2
23Nov03@0455	Assumed care @ 1800; VSS; pt a&o speaking arabic; ⊖ c/o pain/discomfort @ this time; pt OOBTC x1 for 1°; Ex-Fix x2 in place; dsgs ⊖ to (R) leg; ⊖ drainage noted; dsg to upper (R) thigh CDI; ⊖ s/sx infection; NV intact to affected extremity; S/L patent; cont ⊼ IV abx & ⊼ gtts; Restraints in place, ⊕ circ, ⊖ skin break ↓; pt NPO ⊼ MN for Sx 11/23. Cont to monitor. b(6)-2 [redacted]
23NOV03	(1425) NSG.- VSS. ⊖ c/o pain. NPO ⊃ MN for O.R. today. Pt taken to O.R. for washout. (L) subclavian central line placed in OR. Flushes well + ⊕ blood return. IV LR 100cc/hr infusing into central line. DSG to B/L ~~ankle~~ calves CDI. B/L Ex-fix LE intact. (R) upper thigh area ex-fix has ~~serosa~~ sm. amt serosang drainage. Will continue to monitor. Pt able to move toes B/L. L > R mvmt. +2 pedal pulse B/L. Brisk cap refill B/L. B/L cool to touch. b(6)-2 [redacted]
23 NOV. 03 1945	Pt A+O×3, VSS, T-101.7, adm 650mg Tylenol, T ↓ 99.6, warm + dry to touch, had episode x1 of fainting when attempting to place on bedside commode, rest made pt feel better,

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.

EPW

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Cont.	had a BM, formed brown stool, IV HL (R) FA intact, flushes well, CL → (L) SC intact ⊘ s/sx of infex, Ex Fix x2 on RLE, minimal amount of blood drainage from pin sites, dsg's on (R) buttock d'd, penrose drain intact packed WTD, ⊘ s/sx of infex, d'd dsg saturated c̄ blood, dsg (R) leg d'd, WTD, ⊘ s/sx of infex on wounds, beefy red, cont. eye drops Q 2°. — b(4)-2 [redacted] gll
	I cancel c̄ alone access [redacted] Luszcz
24NOV03	(1700) NSG. VSS. Pt c/o pain. Med c̄ 4mg MSO4 IV. Pt found adequate relief. AM had large soft, brown BM. Urinating clear yellow urine. Δ DSG to B/L calf + (R) upper thigh. Ex-fix x2 intact. ⊖ signs of infections. All open wounds pink c̄ minimal amt of yellow drainage. Penrose intact in (R) upper thigh (posterior) Attempted to remove gauze most proximal to inferior penrose. Gauze unable to be dislodged. Appears gauze sutured into penrose. Did not attempt to pull. Cut off excess. Informed Dr [redacted] of finding. Stated ~~he will~~ pt will go to O.R. on 25 NOV + will view finding. DSG WTD. Pt tol DSG Δ well. ~~So~~ OOB to chair for ~ hr. Pt receiving IV ABX through central line. (+) blood return. ⊖ resistance on infusion. D/Ced IV in (L) arm ⊘ infiltration. ~~Cont~~ Lesion to (R) eye lid appears to be healing well. ⊖ signs of infection. Continuing Q2° eye gtts. — [redacted] 4/MN b(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
23 NOV 03 1150	Ortho Op Note Pre-Op Dx: Infected (R) femur fracture GSW both legs Post-Op Dx: same Procedure: (1) I+D (R) femur fracture (2) central line placement Surgeon: [redacted] b(4)-2 GBL MN Fluids: 500 cc LR Findings: - Still some purulent drainage from (R) buttock wound. Abdomen wound clean. Plan: Drain surgeon x 1 NN for central line placement [redacted] b(4)-2 [redacted] COL [illegible]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted]

b(4)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 NOV 03 0930	Orthopedic Op Note
	Pre-Op Dx: GSW (R) leg
	Post Op Dx: same
	Procedure: [redacted] (R) leg
	Surgeon: [redacted] b(6)-2
	EBL: MN
	Findings: Massive soft tissue injury. No pulse. Gross [illegible] contusion, [redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1989) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

25NOV03 @0700 assumed care of pt @1800. VSS. C/o pain to RLE, percocet given c good relief. LSCTA, ⊕ BS tol po well, NPO @ this time. VO'd per urinal QS. BIL LE ex-fix intact, dsgs CDI. ⊕ thigh dsg CDI. RLE ⊕ C/M, ↓ sensation to toes. LLE ⊕ CMS. ⊕ DP equal BIL. ⊕ SC central line flushes easily. 2pt restraints m̄s s/sx of skin/circulation breakdown. Plan: NPO for OR, monitor dsgs & NV status. b(6)-2 [redacted]

25NOV03 (1150) NSG. VSS. Pt NPO p̄ MN for OR. Pt taken to O.R. for washout. Washout completed. DSG CDI to all 3 DSGS. ⊕ 2 pedal pulses B/L c̄ brisk cap refill, warm to touch. ~~⊕ foot, pt able~~ ⊕ ft, pt has ↓ mvmt to toes. Pt able to move toes well in ⊕ ft. Central line infusing NS til tol PO well + IV ABX. Ancef + gent D/C'ed. ~~IV~~ Eye gtts q2° administered. ~~⊕ central line~~ b(6)-2 [redacted]

(1600) Central line NSG Δ'ed. Used betadine + alcohol. ⊖ signs of infection. Ortho MD's spoked to pt. Plan to go to O.R. in 3 days. Pt verbalized understanding. b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

b(6)-4 [redacted]

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

DATE	NOTES
28NOV03 2340	assumed care of pt @1800. VSS. C/o pain to (R) thigh & femur, medicated c̄ percocet + tab c̄ good relief noted. Drsgs to (R) thigh, (R) calf & (L) calf Dry/intact, some serous drainage noted. Ex-fix x2 in place & intact. (R) LE (+) c/m, ↓ sensation ~~but~~ and cannot feel light touch. (L) LE (+) c/m. (BIL) +DP pulses equal @ ±2. LS CTA, (+) BS, tol reg diet c̄ good appetite noted. Void per urinal QS. ↑ OOBTC x̄ ½ hour, tol well. (L) SC central line flushes easily, IV Abx cont. 2pt restraints on & S/Sx of skin/circulation compromise. Plan: cont IV Abx, enc po intake, monitor drsgs & neuro-vascular status. b(6)-2 [redacted]
29NOV03 0600	Assumed care of pt. @ 0600. VSS, A&O, pt. given c̄ percocet as pre-med. for DSG Δ. WTD DSG Δ to all wounds, moderate sero-sang drainage to all wounds, belly red, (-) S/Sx of infx. Cushions applied to heels. (+) pulses bilat LE. Pt. refused lunch, but ate 2-3 slices of bread. Friend @ bedside → CTU. Pt. in 2-point restraints, (-) signs of skin breakdown. C-line to (L) SC, patent. All other assessments WNC. [redacted] b(6)-2
29NOV03 0700	Assumed care of pt @1800, VSS. C/o pain @ hs, + percocet given c̄ good relief noted. BIL heel/calf drsgs Δ, WTD, ∅ drainage noted, beefy red tissue noted. (R) thigh wound x2 WTD drsg Δ, pink-red tissue noted. Ex-fix x2 to (R) leg intact, pin care completed. Cushions to heels in place. ↓ sensation noted to (R) foot, BIL +2 DP pulses, equal BIL feet, (+) cms (BLE). Begin q2° turns to prevent decubitus. 2pt restraints on & S/Sx of skin compromise. (L) SC CL flushes well. IV Abx cont. Tol reg diet, but (CONT)

STANDARD [redacted] (BACK) SAPA V1.00

b(6)-2 [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
27NOV03 @0200	(CONT) only small amts of food. Voiding qs to urinal. PCAs: enc po, monitor drsgs, enc OOB, turn Q2°. URI continue to monitor.
27NOV03 @ 1630	Assumed care of pt. @ 0600. VSS. Ø C/O pain, A&O. Prepped for premed → OSG Δ'd to bilat. LE WTD. Pt.'s wounds improving, granulating tissue, beefy red. ⊕ pulses to bilat LE. Heel cushions in place. C-line to ⓛ SC, patent. Pt. turned Q2°, GTTs to ⓡ eye Q2° while awake. Pt. in 2-point restraints Ø signs of skin breakdown. Will cont. to monitor. [redacted] LT, AW b(6)-2
28Nov03 0415	Assumed care @ 1800; VSS, pain controlled ē percs; pt Alert speaking arabic; dsgs to ⓡ LE Δd w→D; dsg to upper ⓡ thigh, posteriorly & laterally packed w→D wrapped ē kerlix pin care completed; ~~[illegible]~~ +2 PP ⓡ; ⓛ SC CL patent, cont ē IV abx; heel cushions in place, turn pt Q2° & encouraged pt to turn self while awake; cont ē OD gtts Q2° while awake; BM attempt X1 ē no success; Restraints in place, ⊕ circ, ⊖ skin breakdown; cont to monitor [redacted] b(6)-2
28NOV03	(1530) Assumed care @ 0600. Pt alert, speaking Arabic. VSS. Pain controlled ē MSO4 prior to surgery. Pt to OR for I/D this am. Returned via gurney in stable cond. Ø C/O pain @ this time. ⓛ SC CL flushes well ē S/Sx infection/infiltration. Drgs to

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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PROGRESS NOTES
Medical Record

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[redacted] b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28 Mar 03 1323	Orthopedic Op Note Pre-Op Dx: Infected [illegible] from [illegible] Post-Op Dx: same Procedure: [illegible] [redacted] b(6)-2 Surgeon: [redacted] b(6)-2 BL [redacted] Findings: pus 1x2 cm [illegible] of abscess cavity removed. Irrigated & debrided Plan: STSG to heel / [illegible] in 3-4 days [redacted] b(6)-2

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NSN 7540-00-634-4176

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28NOV03 (1530)	(cont) BLE CDI. Ex fix x2 in place on RLE. X-rays done as ordered. IVFs infusing into @ SC CL ~~S~~ S/Sx infection/infiltration. Giving eye gtts as ordered. @ eye slightly swollen/red. 2 point restraints in place ~~S~~ S/Sx complications. Will cont. to monitor. b(6)-2 [redacted]
28Nov03@0305	Assumed care @ 1800; pt slightly Febrile, accompanied c̄ prn, T̄ perc given c̄ good relief; Ex-Fix X2 to (R) LE in place, pincare completed, serous drainage noted, dsgs reinforced c̄ kerlix; IVFs S/Ld; (L) SC CL patent, flushes well c̄ S/Sx infection/infiltration; cont c̄ IV abx & OD gtts; Restraints in place, (+) circ, (−) skin breakdown; cont to monitor b(6)-8 [redacted]
	Pt OOB to BSC; (+) large, brown, formed BM ~~S~~ difficulty [redacted]
29 Nov 03 1640	Nutrition Note: Pt c̄ poor po intake since admission "/13. Via translator, have encouraged pt to ↑ intake in order to heal/grow. Pt uninterested in eating; nutritional needs not being met. SNN: b(6)-4 [redacted] kcal/day (60-65 kcal/kg) + 60-80 g Pro/day (1.5-2.0 g/kg). Recommend initiating tube feed to meet ½ ENN to better meet nutritional needs while not diminishing appetite that would likely occur c̄ providing 100% ENN through tube feed. Recommend Osmolite @ 50 cc/hr to provide 1200 kcals + 53g Pro/day. Will continue to monitor & follow. [redacted] RD/LD
wt: 40kg	

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE CPT, 8	MAINTAINED AT b(6)-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* REGISTER NO. | WARD NO. 1CW1

[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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
29NOV03	(2000-5) Assumed care of pt @ 0000. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt OOB to chair - tol. well. Personal hygiene done by pt c̄ min assist. Dsgs to BLE Δd - WTD. Pt medicated c̄ MSO4 prior to dsg Δs. tol. well. ∅ S/Sx infection @ wound sites. Pt turning self in bed s̄ difficulty. ⊕ SC CL flushes well s̄ S/Sx infection/infiltration. Tol. reg diet well ≥75% of each meal. Voiding s̄ difficulty. 2 point restraints in place s̄ S/Sx complications. Will continue to monitor. b(6)-2 [redacted]
30NOV03 0200-220	Assumed care @ 1800; VSS, pt alert speaking arabic; ∅ c/o pain; Pt OOBTC, dsgs to BLE Δd W→D wrapped c̄ Kerlix, pt Tol well; wound sites beefy red, ⊖ S/Sx infections; ⊕ SCCL patent, easily Flushes s̄ S/Sx infection/infiltration; pt voiding s̄ difficulty; turns self in bed s̄ difficulty; pt Tol Reg diet well, ate ~~eats~~ ≥ 50% of dinner; Restraints in place, ⊕ circ, ⊖ skin breakdown; will cont to monitor b(6)-2 [redacted]
30NOV03	(1100) NSG. VSS. Pt A+O. At beginning of shift, pt c/o pain. Med c̄ 1 perc. Prior to DSG Δ, med c̄ 4mg MSO4 IV. Pt tol DSG Δ well. Pin care completed c̄ H_2O_2 + NaCl. ⊖ signs of infection. Heel cushions in place. Voiding s̄ →

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		CW1

PROGRESS NOTES
Medical Record

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USAPA V1.00

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont') difficulty. Clear, yellow urine. Tol po well. Consumed ~50% meal. (+) 2 pedal pulses B/L LE. ~~WF~~ Warm to touch c̄ brisk cap Refill. Pt Resting comfortably [redacted]
1DEC03	0010 – VSS – A+O pt. speaking arabic. LSCTA (B) BSX4 voiding clyu per urinal pt. medicated c̄ 4mg MSO4 prior to dsg Δ. dsg Δ completed. WTD to (R) LE = (L) LE wrapped c̄ hertex. (–) S/Sx inf. Ext. fix in place. Completed pin care. c̄ 1/2 NS + 1/2 peroxide. Pt. tolerated well. Maj. melton assessed pt. decubs to (B) heels. Elevated pt. legs to keep all pressure off heels. Encouraged pt to eat dinner but refused. Encouraging PO intake. Pt. resting @ this time c̄ to pt. restraints in place s̄ compromise to skin. Will monitor pt. [redacted] & Cindy with cafe [redacted]
01DEC03	(1525) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. Pt OOB to chair this am. pt tol. well. Dsgs to BLE Δd WTD. Wounds on thigh of RLE packed c̄ NS soaked gauze. All wounds moist and red s̄ S/Sx infection. Pt medicated c̄ MSO4 prior to dsg Δs tol. well. Pin care done to ex. fixes. RLE elevated on blanket in bed. Pt able to move toes. @ SC CL flushes well s̄ S/Sx infection/infiltration. Tol. ≥ 50% of meals. Voiding s̄ difficulty. Pt turning

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
01DEC03	(1525) self in bed ≅ diff. cont. eye gtts as ordered. (R) eye pink and slightly swollen. 2-point restraints in place ≅ S/Sx complications. Will continue to monitor. b(6)-2 [redacted]
2030	- Assumed care of pt. @ 1800. VSS - A+O LS CTA (B), Resp. even unlabored, BS x4, Ext. fix in-tact to (R) UE + (R) LE. drsng ept. Pt. has (+) pedal pulses. Pt. medicated ≅ 4mg MSO4 @ 1930. Pin care completed. Pt. (R) leg elevated on blanket. Decub to (L) heel elevated ≅ no pressure to area. (L) SC intact ≅ Ø S/Sx inf. Pt tolerated 75% of reg. diet + ensure. Pt. NPO after midnight for OR in AM. Pt. voiding cup per urinal. Will continue to monitor pt. + R/O [redacted] b(6)-2 [redacted]
2 Dec 03 1315	Nutrition Note: Feeding tube placed to provide tube feeding to help meet calorie needs. ENN: 2400-2600 kcals/day (60-65 kcal/kg) + 60-80 g Pro (1.5-2.0). Recommend tube feed to provide 50% of ENN to avoid diminishing

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

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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	cont. b(6)-2 [redacted]
	pt's appetite that may occur if 100% ENN are met. ~~[illegible]~~ Must continue to encourage pt to eat + consume high caloric fluids (juice, Ensure Plus) in order to meet pt's needs. Recommend goal rate for Jevity Plus tube feed @ 45cc/hr to provide 1296 kcals + 60g Pro/day. Initiate c̄ Osmolite HN, advancing to goal of 40cc/hr, then change to Jevity Plus c̄ goal @ 45cc/hr. Will b(6)-2 continue to monitor po intake + follow. [redacted] RD/CPT, SP
02DEC03	(1515) Assumed care of pt. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt to OR this am for I/D and STSG of LE. Pt returned from PACU via gurney in stable condition. Tx to bed s̄ difficulty. Dsgs to LE ⊙. Dsgs to RLE c̄ small amount of sero-sang drainage. Ex fix x2 in place on RLE. Pt able to move all toes. ⊕ pedal pulse equal bilat. Dobhoff in ⊕ nare pulled back ≈5" according to placement on x-ray. Awaiting orders to start TF. ⊕ SC cl infusing IVFs s̄ sisx infection/infiltration. Will SL if pt tol. dinner well. Cont. OD gtts as ordered. Sclera of OD pink. Voiding s̄ difficulty. 2 point restraints in place s̄ sisx complications. Will continue to monitor. b(6)-2 [redacted] RN
2 Nov 03 1640	Nutrition Note: TF in stomach, prefer bolus feeds. Recommend Osmolite HN 200cc q 4° to provide 1200 kcals + 53g Pro/day. b(6)-2 [redacted] RD/LD

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
02DEC03	(1835) Administered 1st bolus TF of Osmolite HN via Dobhoff p placement verified by MD. Pt tol. well. Abd flat, non-tender. ϕ c/o abd pain. Report given to oncoming shift. b(6)-2 [redacted]
2345-	assumed care of pt. @ 1800. VSS + A+O. Pt. resting in bed @ this time ∃ any complaints. Dsg Δ to (R) leg completed. LE packed c̄ gauze sponges - WTD wrapped c̄ Ace wrap. LE WTD applied Kerlex. all wounds beefy red ∃ s/sx infection. Pin care completed. Decub to (R) heel noted. Blanket placed under pt. leg to keep all pressure off heel. (L) leg dsg's CDI. Pt able to move toes. (+) pedal pulses. Administered 2200 bolus TF of osmolite via dobhoff (200cc) Pt. tol. well ∃ N/V. 4mg MSO4 given for pain + dsg Δ @ 2120. Tobradex + gtts administered to pt. QC while awake. (L) SC CDI ∃ s/sx infection. Pt. in bed resting @ this time c̄ one pt. restraint in place x2 Ext fix. Will monitor pt b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. ICU1

#[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

(b)(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1000 3Dec03	Consulted c̄ WoundCNS MAJ [redacted] She has looked at heel & finding (unable to stage due to necrotic tissue) Recommendation Keep heel off of mattress. LT [redacted] to show heel to COL [redacted] on rounds. [redacted] LTC an
3 DEC.03 @1900	Assumed care of pt. @ 0600. NSS, A&O, ÷ Pric. & 4mg MSO4 as premed. for WTD DSG Δ to (R) LE, Mod. sero-sang drainage to (R) LE wounds, wounds beefy red, ⊘ S/Sx of infection. Pincare done, Pt. OOB → BSC, from formed stool. Pt. has pressure ulcer to (R) heel, MD notified, unable to stage ulcer due to intact necrotic tissue. Heel cushion applied & ankle elevated c̄ Bolster roll (heel off of mattress) Pt. turned Q 2°. Foley to DD Q 2°. CL to (L) SC intact, flushes well. Pt. in 2-point restraints, ⊘ S/Sx of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted] LT, RN.
4Dec03@0430	Assumed care @ 1800; VSS, pt alert speaking arabic; pain controlled c̄ ÷ percocets; dsg Δd to RLE W→D; mod. sero-sang drainage to old dsg; ⊘ s/sx infection; pin care provided; (L) SC cl patent, easily flushes c̄ s/sx infection/infiltration; heel cushions in place, pt changing positions spontaneously to prevent skin breakdown; cont. eye gtts; Restrain in place c̄ compromise to skin/circ; cont to monitor [redacted]
4Dec03@0615	Pt while giving report to dayshift, [redacted] became aware of Dobhoff placement; tape was removed from nare & Dobhoff was almost completely pulled out by pt; Dobhoff was completely D/C'd per nurse; MD will be notified [redacted]

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

20 Feb 03
1100

Orthopedic Op Note

Pre-Op Dx: (1) Multiple GSW (B) extremities
(2) Open (R) femur and (R) tibia fx

Post Op Dx: Same

Procedure: (1) I+D with wound
(2) STSG to (L) leg

Surgeon: [redacted] b(6)-2

Anesthesia: MAC

Estimated: 400 cc LR

Findings: Still open (R) tibia. STSG
for posterior (L) thigh, lower (L)
lower leg x 2.

Plan: Staging changes in 5 days.

[redacted] b(6)-2

Ophth Note

EUA/DFE

FOREIGN BODY

OLD BLOOD

VITREOUS HEMORRHAGE

BLOOD

PLAN: TO AL HAYTHAN

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

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

REGISTER NO. | WARD NO.

[redacted]

b(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Dec 03	Orthopedic Op Note
	Pre Op Dx - Multiple GSW
	Post Op Dx - Same
	Procedure: I + D of wounds
	Surgeon: [redacted] b(6)-2
	GBL - MN
	Findings: 100% Viable of STSG to
	(L) Heel graft.
	[redacted] b(6)-2
	[redacted] COL MC

STANDARD FORM 600 (REV. 6-97) BACK

☆ U.S. GPO:1998-432-786/75236

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
cont'd	prior to dsg Δ. (+) decub to (R) heel. Placed donut cushion under heel to keep all pressure off. Pt. turned Q2; Tolerates Q2°, Pt. in bed resting @ this time c̄ onept. restraint in place. will cont. to monitor pt [redacted] Fcancun with abuse assessment [redacted]
0800-0800	(0935) Assumed care @ 0800. Pt alert, speaking Arabic. VSS. Pt medicated c̄ 4mg MSO4 prior to dsg Δ c̄ good relief of pain. WTD dsgs to RLE Δd c̄ NS soaked gauze. All wounds pink/moist s̄ s/sx infection. Pt OOB to chair this am. @ SC CL. Flushes well s̄ s/sx infection/infiltration. Pt tol. 75% of breakfast. Voiding s̄ difficulty in urinal. Restraints removed d/t pt being cleared to cunlian. Will tx to ICW' via WIC. Report given to [redacted]
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
4 DEC @ 1630	Assumed care of pt. @ 0600. NGT D/C'd @ change of shift, pt had pulled NGT out partially. MO notified. V.S.S. A&O + Percs. for C/O pain this AM to ®LE. Pt. ate 100% of breakfast, tol. well. WTD DSG Δ to all ®LE wounds, beefy red, mod. sero-sang drainage, Ø S/SX of infx. Pt. pre-medicated c̄ 4mg MSO4 for DSG Δ. Pincare done. Pt. turned Q2°, Tolroder to DD + GTTS Q2°. Pressure ulcer to ® heel, unable to stage due to necrotic tissue intact. Cushion placed under lower leg & ankle of ®LE to take pressure off of heel. ⊕ pulses to bilat LE, Cap refill 1 sec., able to move toes bilat. Pt. in 2-point restraints, Ø S/SX of skin breakdown. All other assessments WNL b(6) [redacted]
5 DEC @ 0830	0830- assumed care of pt. @ 1800. VSS-A&O medicated pt. c̄ + perc. for pain @ 2030. ⊕ pain relief. Pt. OOB → chair x2 hrs. this shift. Tol. well. ⊕ SC c̄ DI ⊖ S/SX inf. infusing [redacted] IV abx. pt. voiding c/u per urinal. ~~WTD~~ WTD dsg Δ to ® leg wounds, wounds beefy red c̄ S/SX inf. Pincare completed. medicated pt. c̄ 4mg MSO4

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

STANDARD FORM 509 (REV. 5
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.20
USAP.

#[redacted]

b(6)-4

MEDICAL RECORD	PROGRESS NOTES
DATE	
6 DEC 03	1045: Returned from OR via stretcher, VSS. Denies any pain @ this time. Awake and alert. HR - regular. Lung sounds clear bilat. Bowel sounds (+) x4. IV - (L) SC: Heplocked. Wound to (L) c/f Dsg CDE. Wounds to (R) LE - DSG CDE. Ex-fix to (R) LE + (L) LE. ↓ ROM to (B) LE. Will continue to monitor. [redacted] b(6)-2
6 Dec 03 1151	BP 118/59 P 111 PSQ 100 T-98.6 R-16 [redacted] 9/W
6 Dec 03 2330	Pt resting comfortably in bed. HR Regular, Lung sounds clear bilat, bowel sounds (+) x4 quads. (B) LE elevated on donut ring. Ext fix to (R) LE intact. DSG Δ'd to (R) LE, wounds red, moist, well granulated, Ø pseudomonas drainage noted. W&D DSG c̄ NS applied. Pincare done c̄ H_2O_2 & NS. Central line to (L) SC intact flushes well, Ø bld return. DSG & soft splint to (L) LE intact, ~~graft~~ donor site to (L) thigh c̄ xeroform gauze applied. Pt premedicated for DSG Δ, pt tolerated well. Ø complaints @ this time. Will continue to monitor. [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. ICW R

PROGRESS NOTES
Medical Record

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

Civ [redacted] b(6)-4

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

Dx - Open (R) femur + tibial fracture

Admission Date -

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
12/10/03	OpNote
	PreOpDx: open (R) femur Fx, open (R) TIBIA Fx
	PostOpDx: SAme
	Procedure: I&D of wounds
	Surgeon: [redacted] b(6)-2
	EBL: ✓
	Fluids: 600cc
	Drains: Healthy granulation tissue
	Cx: ✓
	[redacted]
	b(6)-2

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

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

REGISTER NO.	WARD NO.

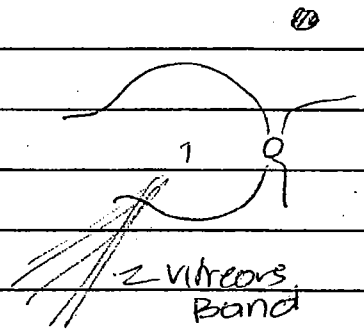
PROGRESS NOTES
Medical Record

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

[redacted] b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10Dec03	13y/o Iraqi child c̄ intraocular foreign Body OD – no significant vitrits however pt with large vitreous traction band. @ high risk for retinal detachment. Request eval for possible vitrectomy to relieve retina traction



Plan: referral to al-Hoythan for retinal eval of traction band in vitreous

[redacted] b(6)-2

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

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD	PROGRESS NOTES
DATE	Transfer Summary.
12-7-03	This is a 13 y/o ♂ who was shot by U.S. forces ≈ 12 NOV 03. In addition to ophthamologic injuries (see note) he sustained and open (1) R right femoral shaft fracture (2) open right distal fibula fracture and (3) soft tissue loss to bilateral lower extremities. The fractures have been stabilized and have undergone multiple debridements. The soft tissue envelope is closed over femur, the left leg has had skin grafting performed, but there is still a large soft tissue defect with exposed tibia. This region will need microvascular flap coverage which is not available at this institution. In addition, remainder of wounds on right leg are ready for skin grafting in conjunction c̄ microvascular flap.
	b(6) - 2 [redacted]
	Ophthamology
	Orthopaedic Surgeon
	Hx as above. (R) eye : OD
	Pt had intravitreal foreign body without significant vitrh's but (+) blood in the inferomacular region then developed large thick vitreous traction band pulling on retina - threatens to pull of retina (over)

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted]

b (6) - 4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
	referral to [redacted] for examination possible vitrectomy
	b(e)-2 [redacted]
	cont
19 Dec 03	Nutrition Note: Nsg reports pt eating well, esp. when family is around. Will snack between meals. Pt appears thin despite improved appetite & intake. Recommend adding a meal replacement TID to pt's diet. Recommend providing pt c̄ Ensure/meal for pt to drink between meals in addition to his current intake. [redacted], RD/LD
	[redacted] PT, SP [redacted]
	b(e)-2

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

14 yr old

62-2

[redacted]

Name_____ SSN _____ Unit_____ Location_____

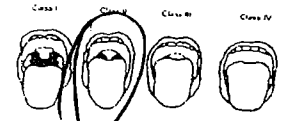
INITIAL ASSESSMENT

Airway

☑ Patent ☐ Nasal ☐ Oral

☐ Intubated ☐ Crich

☐ ETT #__ ☐ Trach



C-Spine

☐ CC ☐ BB ☐ Secured ☑ Clear

NORM MS, COMPETENT. O MS Δ's. GCS 15. O ML TENDER. O DISTRACTING. INJ's.

Breathing

☑ Spont Rate 32

Rhythm

☑ Reg ☐ Tachy ☐ Brady

☐ Sporad ☐ Even ☐ Abnl ___

Quality

☐ Reg ☐ Deep ☐ Labored

☑ Shall ☐ Sonorous ☐ Weak

☐ Assisted ☐ O_2 __ L/min

☐ Ambu ☐ Vent

BBS R ☑ CLR ☐ RLS ☐ WHZ ☐ ABS

L ☑ CLR ☐ RLS ☐ WHZ ☐ ABS

Circulation

☑ Spont ☐ CPR

Rhythm ☐ REG ☐ TACH ☐ BRDY

Pulse _____ ☐ Strong ☐ Weak ☐ Thread

B/P ☐ RAD >80 ☐ FEM >70 ☐ CTD >60

PASG ☐ Legs ☐ ABD ☐ Both

IV's #1__ ga_____

#2__ ga_____

#3__ ga_____

☐ Tourniquet Where _____ When _____ What _____ Why _____

☑ Other (L) FEM TLC

CNS

EYES		VERBAL		MOTOR	
SPONT	4	ALRT	5	ALRT	6
CMND	3	CONFD	4	LCL P	5
PAIN	2	INAPR	3	WDR P	4
UNRSP	1	INCMP	2	FLX	3
		UNRSP	1	EXT	2
				UNRSP	1

☐ PERLA ☐ ABNL_____

☐ DIA ☐ PIN ☐ UNI ☐ FIX ☐ SLOW

MOI/DESCRIPTION

☐ Blunt ☑ Penetrating ☐ Burn

☐ Blast ☑ GSW ☐ Heat

☐ MVC ☐ Shrapnel ☐ Chem

☐ Fall ☐ Stabbed ☐ Elect

☐ Assault WITH _____ SEE 9-'s ↓

☐ Other _____ EST %_____

EQUIPMENT

☐ Weapon _____

☐ Sens Items _____

☐ Other _____

Vitals: HR 173 B/P 90/50 RR_____ POX 100 % TEMP _____ °F °C

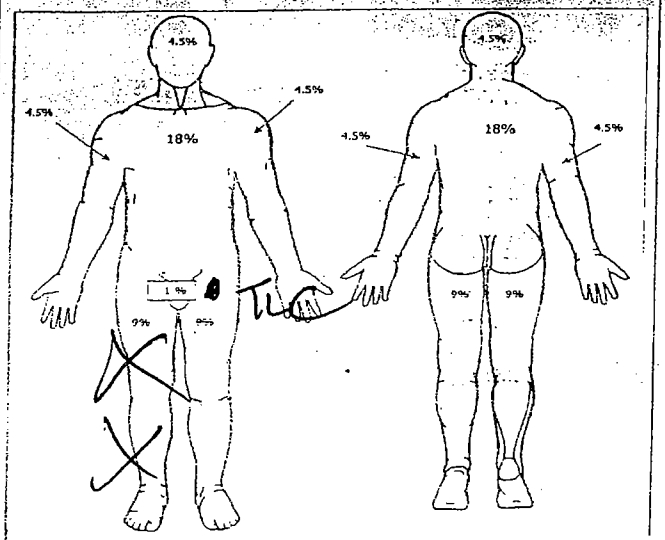
DATE/TIME	NOTES
2405 12NOV03	APPROX 1@ YO M C MULT GSW TO RLE. PLAN OR FOR (R) FEM FX-OPEN + POSS (R) ANKLE/FOOT. PT A+O x3, NON ENGLISH SPEAKING — [redacted] b(6)-2

62-2

[redacted]

Name _____ SSN _____ Unit _____ Location _____

Head-2-Toe/Burn Chart



INTERVENTIONS

Airway

☐ Suction ☐ Position ☐ Oral ☐ Nasal

☐ Intubated/Trach ☐ Crich By Whom _____

Breathing

☐ Assisted ☐ O_2 __ L/min ☐ Ambu ☐ Vent

☐ Chest tube R #1 _____ #2 _____

L #1 _____ #2 _____

Time _____ By Whom _____

☐ Needle decomp R Time _____ L Time _____

Circulation Bag # and time

Fluid ☐ NS ☐ ___ 1L bags ☐1 ____ ☐2 ____ ☐3 ____

Blood ☐ PRBC ☐ Whole ☐1 ____ ☐2 ____ ☐3 ____

PASG ☐ Legs ☐ ABD ☐ Both

☐ Foley _____ ☐ NGT _____

Other _____

ALLERGIES _____

MEDICATIONS _____

PREVIOUS HX _____

LAST MEAL _____

EVENTS (see MOI) _____

Description of Illness

_____

_____

_____

MEDICATIONS

TIME	MEDICATION	DOSE	RTE	BY

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — **PROGRESS NOTES**

Admission Date: 12 NOV 03 **Diagnosis:** (R) Tib Fib Femur **FAHD:** 37 **POD:** 36/42

Skin assessment must be done initially and every 7 days.

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	(4)	4	**Mobility**	No limitations	4	2
	Slightly limited	3			Slightly limited	3	
	Very limited	2			Very limited	(2)	
	Completed	1			Completely immobile	1	
Moisture	Rarely moist	(4)	4	**Nutrition**	Excellent	4	3
	Occasionally moist	3			Adequate (Eats >50%)	(3)	
	Moist	2			Adequate (Rarely eats)	2	
	Constantly moist	1			Very poor	1	
Activity	Walks frequently	4	3	**Friction and Shear**	No apparent problem	3	2
	Walks occasionally	(3)			Potential problems	(2)	
	Chairfast	2			Problems	1	
	Bedfast	1					

Total Score: _____

Add the total score

~~Above 20~~	Low Risk
~~Between 16 and 20~~	~~Medium Risk~~
Between 11 and 15	~~High Risk~~
Below 10	Very High Risk

Note: A Braden Scale Score of less than 15 indicates **HIGH RISK**-requires immediate Ulcer Prevention program.

Surgical wound (s): Yes__ No__ Location:_____ Size:_____ Drainage: _____
Tubes:_____ Pins:_____ Appearance:_____
Dressing change:_____

Burn wound (s): Yes__ No__ % BSA_____ Partial_____ Full_____
Location:_____ Size_____
Appearance:_____
Dressing change:_____

Pressure Ulcer (s): Yes X No___
Stage I, II, III, IV (Circle the one that applies and describe below)
Location: (R) heel Size: 2cm x 2cm
Wound character: Pink Ø Moist Ø Dry Ø Granulation tissue Ø Yellow slough Ø Tunneling Ø
Undermining Ø Odor Ø Purulent discharge Ø Eschar Ø Exudates Ø
Type of dressing change: Wet-to-dry Ø Comfeel dressing Ø Carrasyn-V Gel Ø Alginate Ø

Physician notified/consulted for wound debridement: Yes Ø No___ Date/time MD notified _____
CNS notified/consulted for Stage II and greater: Yes___ No___
Nutrition Referral: Yes___ No Ø
Physical Therapy Referral: Yes Ø No___
Action taken: ~~[illegible]~~ Date & Time 20 Dec 03
↑ heel off bed

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 569

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — **PROGRESS NOTES**

Admission Date: 12 NOV 03 **Diagnosis:** (R) tib/femur fx **HD:** 37 ~~34~~ **POD:** 36/12 ~~38~~

Skin assessment must be done initially and every 7 days.

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	(4)	4	**Mobility**	No limitations	4	
	Slightly limited	3			Slightly limited	3	
	Very limited	2			Very limited	(2)	2
	Completed	1			Completely immobile	1	
Moisture	Rarely moist	(4)	4	**Nutrition**	Excellent	4	
	Occasionally moist	3			Adequate (Eats >50%)	(3)	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)	3		Potential problems	(2)	2
	Chairfast	2			Problems	1	
	Bedfast	1					

Total Score: 18

Add the total score

Above 20	Low Risk
(Between 16 and 20)	Medium Risk
Between 11 and 15	High Risk
Below 10	Very High Risk

Note: A Braden Scale Score of less than 15 indicates **HIGH RISK**-requires immediate Ulcer Prevention program.

Surgical wound (s): Yes__ No__ Location:_____ Size:_____ Drainage: _____
Tubes:_____ Pins:_____ Appearance:_____
Dressing change:_____

Burn wound (s): Yes__ No__ % BSA_____ Partial_____ Full_____
Location:_____ Size_____
Appearance:_____
Dressing change:_____

Pressure Ulcer (s): Yes X No___
Stage I, II, III, IV (Circle the one that applies and describe below)
Location: (R) heel Size: 2cm x 2cm
Wound character: Pink Ø Moist Ø Dry Ø Granulation tissue Ø Yellow slough Ø Tunneling Ø
Undermining Ø Odor Ø Purulent discharge Ø Eschar X Exudates Ø
Type of dressing change: Wet-to-dry Ø Comfeel dressing Ø Carrasyn-V Gel Ø Alginate Ø

Physician notified/consulted for wound debridement: Yes Ø No Ø Date/time MD notified _____
CNS notified/consulted for Stage II and greater: Yes X No_____
Nutrition Referral: Yes_____ No Ø
Physical Therapy Referral: Yes X No_____
Action taken: Ø Date & Time 19:44 17 Dec 03

REGISTER NO.	WARD NO.
	2W 2

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

Medical Record

Progress Notes

Braden Scale Evaluation

Date: 12-5-03

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

Total Score: 18

Score <15 requires Immediate Ulcer Prevention Program

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

Date: _____

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

Total Score: _____

Score <15 requires Immediate Ulcer Prevention Program

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

Unit No. _____

Standard Form 509

Patient ID:

b(6)-4

C [redacted]

Medical Record **Progress Notes**

Wound and Skin Assessment

Date and Time 12/5/03 1100 Wound number One.
Stage I-IV ~~Stage III~~ unstageable Surgical or Non-Surgical non-surgical
Location Rt. heel
Shape Oval Measurements < 1in width, < 1inch length.
Tissue Color Black
Drains and Type none
Drainage (amt and color) none
Dressing Type none
Dressing Change Frequency none Wound Cleansing none.
Additional Info (turning, elevation of extremeties, etc.) turn Q2°, elevate RLE, Keep heel off pressure.

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

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

Patient ID: Unit No. _____
Standard Form 509

b(6)-4

[redacted]

Medical Record **Progress Notes**

Wound and Skin Assessment

Date and Time 6 Dec 03 0622 Wound number 3
Stage I-IV Ø Surgical or Non-Surgical
Location inner, medial aspect of thigh
Shape undefined Measurements —
Tissue Color pink granulating tissue
Drains and Type Ø
Drainage (amt and color) yellow on old dressing Ø odor
Dressing Type W→D & NS
Dressing Change Frequency BID Wound Cleansing in OR
Additional Info (turning, elevation of extremeties, etc.)

Date and Time 6 Dec 03 0622 Wound number 4
Stage I-IV Ø Surgical or Non-Surgical
Location posterior, lateral aspect calf
Shape undefined Measurements —
Tissue Color pink granulating tissues
Drains and Type Ø
Drainage (amt and color) yellow odorless drainage on old dressing
Dressing Type W→D & NS
Dressing Change Frequency BID Wound Cleansing in OR
Additional Info (turning, elevation of extremeties, etc.)

Date and Time 6 Dec 03 0622 Wound number 5
Stage I-IV Ø Surgical or Non-Surgical
Location (R) E pin sites to Ex-fixes x2
Shape round Measurements —
Tissue Color To thigh: pink opened tissue / to calf: OTA and closed
Drains and Type Ø
Drainage (amt and color) To thigh serous scant blood
Dressing Type Ø
Dressing Change Frequency BID Wound Cleansing C NS and betadine 1/2 NS
Additional Info (turning, elevation of extremeties, etc.)

Patient ID: Unit No.
Standard Form 509

Medical Record **Progress Notes**

Wound and Skin Assessment

Date and Time 6 Dec 03 0622 Wound number 1
Stage I-IV unable to assess Surgical or ~~Non-Surgical~~
Location (R) heel
Shape oblong Measurements approx 2½cm x 1½cm
Tissue Color eschar
Drains and Type ~~Ø~~
Drainage (amt and color) ~~Ø~~
Dressing Type ~~Ø~~
Dressing Change Frequency ~~Ø~~ Wound Cleansing ~~Ø~~
Additional Info (turning, elevation of extremeties, etc.) Turning schedule, foam donut for padding

Date and Time 6 Dec 03 0622 Wound number 2
Stage I-IV Surgical or Non-Surgical RLE
Location Thigh
Shape undefined Measurements —
Tissue Color pink granulating
Drains and Type ~~Ø~~
Drainage (amt and color) old dressing c̄ yellow drainage
Dressing Type W→D c̄ NS
Dressing Change Frequency BID Wound Cleansing ~~Ø~~ PT to OR for washouts
Additional Info (turning, elevation of extremeties, etc.)

Date and Time 6 Dec 03 0625 Wound number 2
Stage I-IV Surgical or Non-Surgical
Location outter aspect of calf medial
Shape undefined Measurements —
Tissue Color pink granulating; bone visible
Drains and Type ~~Ø~~
Drainage (amt and color) yellow drainage to old dressing & odor
Dressing Type wet→Dry c̄ NS
Dressing Change Frequency BID Wound Cleansing in OR
Additional Info (turning, elevation of extremeties, etc.)

Patient ID: Unit No.
Standard Form 509

b(6)-4
[redacted]

Medical Record

Progress Notes

Braden Scale Evaluation

Date: 16 Dec 03

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

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

Total Score: 17

Score <15 requires Immediate Ulcer Prevention Program

Date: _____

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

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

Total Score: _____

Score <15 requires Immediate Ulcer Prevention Program

Patient ID:

Unit No. _____

Standard Form 509

[redacted] b(6)-4

PLAN OF CARE FOR SKIN BREAKDOWN AND WOUND MANAGEMENT

MEDICAL RECORD **PROGRESS NOTES**

Admission Date:_____ **Diagnosis:** Femur/tibfib **HD:** 25 **POD:** 26

Date: 6 Dec 03 Time 0600 RN Signature: [redacted] 10 (6) - 2

Skin breakdown as evidenced by immobility, friction, shea[redacted]re, abrasions, surgical wound, skin tear.

Wound type: Surgical wound (s) Location: B LE Size: See attached sheets Drainage: _____

Diabetic ulcer Tubes:_____ Pins:_____ Appearance:_____

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) unable to assess/eschar

Location: R heel Size:_____

Wound character: Pink____ Moist____ Dry____ Granulation tissue____ Yellow slough _____

Tunneling____ Undermining____ Odor____ Purulent discharge____ Eschar X 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

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 12-5-03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: | HOSPITAL DAY:

TRANSFER

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

Time 0935 To ICW 2 From ICW 1 ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☒ STRETCHER

Total ER/RR/PACU time _____ Physician [redacted] b(6)-2 Anesthesia (Specify): _____

Procedure/Diagnosis open Rt. femur/tibia Fx B/P 101/66 P 116 R 18 T 99.6 99% 18

LOC _____ Neurovascular checks _____

Dressing/cast ex-fix (x2) skin graft (L) calf Tubes _____

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

Medication Pre-med for dsg Δ's.

Other Turn Q2° b(6)-2

Report From LT [redacted] Received By LT [redacted]

VITAL SIGNS

TIME:	1000	2000	0400	0800											
BP ARTERIAL LINE				116											
BP CUFF	116/72	114/76	107/89	75											
TEMPERATURE	98.4	98.8	97.4	99.6											
PULSE	99	124	100	124											
RESPIRATORY RATE	18	18	20	16											
OXYGEN (L/%)			—	—											
PULSE OXIMETER	100%	100%	100	99%											
O2 METHOD	RA	RA	RA	RA											

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

PAIN

TIME:	1000	2000	0400	0800				
PAIN INTENSITY (10 / 5 / 0)				Premedicated for dressing				
MED ADMINISTERED (Y/N)	Y		N	Y				
RELIEF ACCEPTABLE (Y/N)			N/A	Y				
Percocet				1				
MSO4				4mg				

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	1100		2001
*Skin breakdown prevention	OS		EM
*Falls prevention protocol	N/A		EM
*Restraint protocol			NA
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION b(6)-4

C [redacted]

DIAGNOSIS: (R) open femur/tibia Fx

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: b(6)-2

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 1100 INITIALS: AB	TIME: INITIALS:	TIME: 0201 INITIALS: EM
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☐	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ ex-fix to ~~RUE, RL~~ Rt. femur, Rt. tibia	☐	☐ ex fix x 2 to (R) LE intact
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ wounds to (R) leg, skin graft. (L) calf	☐	☐ wounds (R) LE skin graft (L) calf
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐	☑
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☑

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

TIME: 1100 INITIALS: AB	TIME: INITIALS:	TIME: 0201 INITIALS: EM
IV patency ✓ q 8 hr: PRN	IV patency ✓ q hr:	IV patency ✓ q 8 hr: PRN
IV site care provided: assessed	IV site care provided:	IV site care provided: Assessed
IV tubing changed: /	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) SC / OK	IV Site #1:	IV Site #1: (L) SC / OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL'd.	Comments:	Comments: Blood return Flushes easily

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RLE TIME:	1100	0200 R	0200 L				
COLOR	P	P	P				
CAPILLARY REFILL	1	1	1				
TEMPERATURE	W	W	W				
EDEMA	Ø	Ø	Ø				
SENSATION	S	S	S				
MOTION	P	P	P				
PASSIVE FLEXION	✓		—				
PERIPHERAL PULSE	2+	2P	2P				

LEGEND

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

SAFETY / OTHER

	TIME:	1100		0200
SAFETY	ID band visible/legible	m		[redacted]
	Orient to environment prn	m		
	Side rails (2/4) up	N/A		[redacted]
	Bed position low			
	Call light within reach			
OTHER	Review & post lab results			
	Notify MD abnormal labs			
	Incontinent urine/stool			
	Linen change prn			
	Turn/reposition q2h			
	ROM q2h if immobile			
	Antiembolic hose	✓		

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE: Reg	TYPE: Reg
PERCENT CONSUMED:	PERCENT CONSUMED: 75%	PERCENT CONSUMED: 70%
HOW TOLERATED:	HOW TOLERATED: well	HOW TOLERATED: well
☐ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE

ADLs

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

TEACHING

TIME: 1108 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2200 INITIALS: [redacted]
CONTENT: 1.) Ward / staff orientation 2) Percocet for pain, Ø sleeping pills during the day	CONTENT:	CONTENT: Dressing Δ call for assist
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

b(6)-2

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
b(6)-4 C [redacted]	[redacted]	[redacted] STAN 21-09	D
		b(6)-2	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1100	RLE,	① ex-fix intact, DSGS CDI	assessed
		LLE	② DSGS CDI	
		① RLE	① Pink granulation tissue white bone exposed, yellow drainage	① Dressing D W SD
		② LLE	② ACE wrap dressing intact	② assessed

SECTION IV - NOTES

1100: Pt. tx to ward via wheelchair in stable condition from ICW #1. Will cont. to monitor [redacted]
0830 - Pt to OR via litter. Pt NPO since MN [redacted] AND

b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 7 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 2 | HOSPITAL DAY: 27

TRANSFER

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

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

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

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

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0800	1200	2000	0800												
BP ARTERIAL LINE	126	—	122	114												
BP CUFF	86	10/60	68	70												
TEMPERATURE	99.6	97.7	98.7	98.9												
PULSE	125	109	116	110												
RESPIRATORY RATE	20	18	20	20												
OXYGEN (L/%)																
PULSE OXIMETER	100%	99	99%	99%												
O2 METHOD	RA	RA	RA	RA												

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

PAIN

TIME:	0930	2200						
PAIN INTENSITY (10 / 5 / 0)	0	X						
MED ADMINISTERED (Y/N)	Y	N						
RELIEF ACCEPTABLE (Y/N)	Y	NA						
	MSO4							

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

NA

SPECIAL NEEDS

TIME:	0930	2200
*Skin breakdown prevention	AVM	NA
*Falls prevention protocol	NA	
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

b/le) - 4

C[redacted]

DIAGNOSIS: S/p open femur / tibia fx S/p washout

DRG: _____ ADMISSION DATE: 10 Nov 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 0930 INITIALS: [redacted]	TIME: 2200 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑ BM x1	☐ BM x1 @ 2000 soft formed Brn stool	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Ext fixes to (B) LE. ↓ ROM to (B) LE. Ambulates c̄ crutches, OOBTC x1	☐ - ext fix to (R) LE - pain c̄ ROM to (B) LE	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ wounds to (R) thigh, inner & outer calf. Pin sites.	☐ - donor site to (L) thigh - multiple wounds to (R) LE - wound to (L) LE	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ c/o pain to (B) LE. MSO4 4mg IV given.	☑ ∅ c/o pain	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

66-2 66-2

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

TIME: 0930 INITIALS: [redacted]	TIME: 2200 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q 3 hr:
IV site care provided:	IV site care provided: NA	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) SC / ok	IV Site #1: central line (L) SC / ok	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: HL, flushes well, ∅ Bld return	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (B) LE	TIME: 0730	2000				
COLOR	P	P	P			
CAPILLARY REFILL	1	1	1			
TEMPERATURE	W	W	W			
EDEMA	Ø	Ø	Ø			
SENSATION	S	S	S			
MOTION	M	P	P			
PASSIVE FLEXION	D/P	NA	NA			
PERIPHERAL PULSE	2	2P	2P			

LEGEND

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

SAFETY / OTHER

	TIME: 0730	2000
SAFETY: ID band visible/legible	NA	CA
SAFETY: Orient to environment prn	NA	CA
SAFETY: Side rails (2/4) up	NA	NA
SAFETY: Bed position low		CA
SAFETY: Call light within reach		NA
OTHER: Review & post lab results		CA
OTHER: Notify MD abnormal labs		CA
OTHER:		
OTHER: Incontinent urine/stool		NA
OTHER: Linen change prn	NA	CA
OTHER: Turn/reposition q2h	NA	CA
OTHER: ROM q2h if immobile		NA
OTHER: Antiembolic hose		

DIET

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

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☑ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☑ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT b6 2	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0930 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: - Plan of care - pain control	CONTENT: - pain management - PSG ΔS - call for assistance	CONTENT:
☑ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

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

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] RT, AN	4
[redacted]	[redacted] RT/AN	18-06
	b(6)-2	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
		(R) outer thigh	Pink, No s/s infection	
	1800	(R) inner & outer calf	Pink, bone exposed	W→D dsg Δ c̄ NS
	0900	(R) ANKLE	PINK, BLEEDING, BONE EXPOSED	
		(R) OUTER THIGH	PINK, DRAINAGE NOTED	W→D DSG Δ
				PW CARE c̄ 50/50 NS

SECTION IV - NOTES

0900: Awake and alert. Premedicated for dsg Δ c̄ MSO4 4mg IVP, OOB to chair x2. Will continue to monitor [redacted]

b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 8 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 2/3 | HOSPITAL DAY: 28

TRANSFER

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

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

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

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

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400													
BP ARTERIAL LINE	—		110													
BP CUFF	111/77	117/78	72													
TEMPERATURE	97.9	98°	97.6													
PULSE	113	109	108													
RESPIRATORY RATE	22	20	20													
OXYGEN (L/%)	0															
PULSE OXIMETER	100	100%	100%													
O2 METHOD	RA		RA													

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

PAIN

TIME:	0640	1200	2100					
PAIN INTENSITY (10 / 5 / 0)	0							
MED ADMINISTERED (Y/N)	Y	N	N					
RELIEF ACCEPTABLE (Y/N)	Y		NA					
Percocet	T							

OTHER

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

SPECIAL NEEDS

TIME:	0640	2100
*Skin breakdown prevention	Aqua	NA
*Falls prevention protocol	NA	
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

b(6) - 4

C[redacted]

DIAGNOSIS: S/p open femur/tibia fx; ex fix to RLE

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: 10 NOV 03

CASE MANAGER: _____

PRIMARY CARE MANAGER: Olivero

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

b(6)-2

	TIME: 0640 INITIALS: [redacted]	TIME: 2100 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑ gtts to OD	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑ voids per urinal	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Ex fix to (B) LE (↓) ROM to (B) LE. OOB To chair TID.	☐ Ex fix (B) LE limited ROM.	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ sm luc to (B) eyelid wounds to (B) hip + (R) inner & outer calf. Dsgs CDI. Pin sites s/s infection	☐ Wounds to (R) Leg Dsgs CDI (L) Leg Dsgs CDI	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ c/o pain in (B) LE. Percocet ÷ PO given.	☑	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ b6-2	☑	☐

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

TIME: 0640 INITIALS: [redacted]	TIME: 2100 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q hr:
IV site care provided:	IV site care provided: flush	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) SC / ok	IV Site #1: (L) SC / OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: B/LE TIME:	0640	2100				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	Ø	Ø				
SENSATION	S	S				
MOTION	M	M				
PASSIVE FLEXION	P/D	O				
PERIPHERAL PULSE	2P	2P				

LEGEND

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

SAFETY / OTHER

	TIME:	0640	2100		
SAFETY	ID band visible/legible	AVM	KW		
	Orient to environment prn	AVM	KW		
	Side rails (2/4) up	NA	NA		
	Bed position low	↓	↓		
	Call light within reach	↓	↓		
OTHER	Review & post lab results				
	Notify MD abnormal labs				
	Incontinent urine/stool	↓	↓		
	Linen change prn	AVM			
	Turn/reposition q2h	NA			
	ROM q2h if immobile	↓			
	Antiembolic hose	Ø			

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: Reg
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED: 50%
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: well
☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE

ADLs

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

TEACHING

TIME: 0640 INITIALS: [redacted]	TIME: 2100 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: Plan of care b(6)-2	CONTENT: call for assist	CONTENT: b(6)-2
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
b(4)-4 [redacted]	[redacted]	b(4)-2 [redacted]	
		[redacted]	4
		[redacted]	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1000	(R) Buttock; (R) thigh; (R) outer calf; (R) inner calf	Red, bleeding present No s/s infection.	W → D dsg & ⊂ NS

SECTION IV - NOTES

0640: Awake & alert. c/o pain 5/10 in (B)LE. Percocet [redacted] given. (B)LE ↑ on heel cushions. Will continue to monitor. [redacted] b(4)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 9Dec03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 28/4 | HOSPITAL DAY: 29

TRANSFER

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

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

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

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

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400													
BP ARTERIAL LINE		119														
BP CUFF	102/62	55	120/[illegible]													
TEMPERATURE	97.8	[illegible]	97.2													
PULSE	121	55	60													
RESPIRATORY RATE	16	20	16													
OXYGEN (L/%)		98%														
PULSE OXIMETER		98%	98%													
O2 METHOD	RA	RA	2A													

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

PAIN

TIME:	0810	2000						
PAIN INTENSITY (10 / 5 / 0)	X	X						
MED ADMINISTERED (Y/N)	Y	Y						
RELIEF ACCEPTABLE (Y/N)	Y	Y						

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0810		
*Skin breakdown prevention	✓		
*Falls prevention protocol	✓		
*Restraint protocol	✓		
*Seizure precautions	✓		
*Isolation precautions	✓		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

CIV [redacted]

b(6)-4

DIAGNOSIS: S/P open femur/tibia Rx ex fix

DRG: _____ ADMISSION DATE: 10Nov03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: [redacted] b(6)-7

PRIMARY CARE MANAGER: _____

QUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

b6-2

	TIME: 820 INITIALS: [redacted]	TIME: 2010 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ ↓ROM TO RLE PT COB TO CHAIRE 2 ASSIST	☐ ↓ ROM (R)LE 20 to ex-fix	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ PINS ET EXFIX TO RLE & INCISIONS CDI	☐ ↓ (B)LE	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ C/O PAIN 5/10 ↑ DERL GROIN	☐ see pg 1	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

b(6)-2

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

TIME: 820 INITIALS: [redacted]	TIME: 2010 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 5 hr:	IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:
IV site care provided: FLUSHED	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: ➤ CENTRAL LINE OK	IV Site #1: central line OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: SL	Comments:

b(6)-4

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: BLE	TIME: 0840	2010				
COLOR	P	P	P			
CAPILLARY REFILL	1	1	1			
TEMPERATURE	W	H	H			
EDEMA	0	0	0			
SENSATION	S	S	S			
MOTION	P	P	P			
PASSIVE FLEXION	0	/	0			
PERIPHERAL PULSE	3	2 R	4 L			

LEGEND

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

SAFETY

	TIME: 0840	2010	
ID band visible/legible	CB	ACB	
Orient to environment prn	CB	ACB	
Side rails (2/4) up	/	/	
Bed position low	/	/	
Call light within reach	/	/	

OTHER

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

DIET

BREAKFAST	LUNCH	DINNER
TYPE: RSG	TYPE: Reg	TYPE: Reg
PERCENT CONSUMED: 50	PERCENT CONSUMED: 30	PERCENT CONSUMED: ~~well~~ 60%
HOW TOLERATED: well	HOW TOLERATED: well	HOW TOLERATED: well
☑ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE

ADLs

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

TEACHING

TIME:	INITIALS:	TIME: 2010	INITIALS: [redacted]	TIME: b(6)-2	INITIALS:
CONTENT:	↑ COB TO CHAIR ↓ CANDY & EAT MEALS ↑ ORAL FLUIDS	CONTENT:	explained — pain management — call for assist	CONTENT:	
☑ Patient/Family Verbalizes Understanding		☑ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding	

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
b(6)-4 [redacted]	[redacted]	b(6)-2 [redacted] GT, RN/WMB	D
		[redacted] RT/RNS	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	2200	(R)LE (L)LE	beefy red, bone exposure (R) shine pmcore done gauze wrap	Δ drsg BID W-D -CDI - Ø

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 11 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 30/6 | HOSPITAL DAY: 31

TRANSFER

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

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

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

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

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400												
BP ARTERIAL LINE	—	—													
BP CUFF	111/70	97/65	118/70												
TEMPERATURE	98.1	96.4	99.4												
PULSE	105	114	118												
RESPIRATORY RATE	20	20	16												
OXYGEN (L/%)	0	—													
PULSE OXIMETER	100%	100	100%												
O2 METHOD	RA	RA	RA												

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

PAIN

TIME:	0845	1200	1800					
PAIN INTENSITY (10 / 5 / 0)	X	X	X					
MED ADMINISTERED (Y/N)	Y	NA	N					
RELIEF ACCEPTABLE (Y/N)	Y		NA					

OTHER

TIME:	0845							
FINGER STICK GLUCOSE	NA							
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0845	1830
*Skin breakdown prevention	ct	AW
*Falls prevention protocol	NA	NA
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

b(6)-4

C[redacted]

DIAGNOSIS: S/p open femur/tibia fx, ex-fix

DRG: _____ ADMISSION DATE: 10 NOV 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6)-6

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

b(4)-2

	TIME: 0845 INITIALS: [redacted]	TIME: INITIALS:	TIME: 1830 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☐	☑
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☑
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☑
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☑
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☑
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ -Ø ROM to (R) ankle 2° to ext fix -pain c̄ ROM to (R) LE	☐	☐ -PWB c̄ ROM to (R) LE 2° to ex-fix x2 and pain -passive ROM to (R) LE -Plant in half cast
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ -wounds to (R) LE & (L) shin -graft site to (L) thigh -stage 1 decubitis ulcer on (R) heel	☐	☐ -wound to (R) thigh and (R) calf -stage 1 decub to (R) heel -Pin sites CDI
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ -5/10 c/o pain T percocet given	☐	☐ See pg 1
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☑

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

TIME: 0845 INITIALS: CT	TIME: INITIALS:	TIME: 1830 INITIALS: AW
IV patency ✓ q 8 hr:	IV patency ✓ q hr:	IV patency ✓ q 8 hr:
IV site care provided: assessed	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: central line to (L) SC / OK	IV Site #1:	IV Site #1: (L) SC CL / OK*
IV Site #2:	IV Site #2:	IV Site #2:
Comments: line flushes well c̄ NS s̄ bld return.	Comments:	Comments: (+) blood return

b(4)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RLE LLE TIME:	0845	1830				
COLOR	P	P	P	P		
CAPILLARY REFILL	1	1	1	1		
TEMPERATURE	W	W	W	N		
EDEMA	1	Ø	1	Ø		
SENSATION	S	S	S	S		
MOTION (ankle / digits)	P / P	M / M	P / P	M / M		
PASSIVE FLEXION	NA	Ø	DP	Ø		
PERIPHERAL PULSE	1P	2P	1	2		

LEGEND

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

SAFETY / OTHER

	TIME: 0845	1530		
ID band visible/legible	[redacted]			
Orient to environment prn				
Side rails (2/4) up				
Bed position low				
Call light within reach				
Review & post lab results	[redacted]			
Notify MD abnormal labs				
Incontinent urine/stool	[redacted]			
Linen change prn				
Turn/reposition q2h				
ROM q2h if immobile				
Antiembolic hose				

DIET

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

ADLS

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE (crutches), BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT b(4)-2	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST (crutches); # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0845 INITIAL: [redacted]	TIME: 1830 INITIAL: [redacted] b(6)-2	TIME: INITIALS:
CONTENT: - pain management - DSG Δ's - COB ⇒ chair - ambulate c̄ crutches	CONTENT: - Call for assist - Pain management - Ambulate c̄ Walker	CONTENT:
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION b(6)-4 [redacted]

INITIALS	b(6)-2 SIGNATURE	SHIFT
[redacted]	RT/AN	06-18
[redacted]	CO/AN	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1100	① back of (R) thigh ② inner aspect of (R) calf ③ outer aspect of (R) calf ④ (R) calf	① tissue well granulated, Ø S/S of infection ② tissue well granulated, tibia visible & broken, Ø S/S of infection ③ tissue red, well granulated, Ø S/S of infection ④ graft site intact, staples intact, graft appears to be taking well	① ② ③ W/ 2D c̄ NS ④ dry 4x4 & helix applied

SECTION IV - NOTES

1430 - Attempted to ambulate pt c̄ crutches, pt was very uncooperative. A walker was given to him to assist c̄ ambulation & pt continued to be uncooperative. PT was notified & attempted to encourage pt & he would not move [redacted] b(6)-2

2000 - Pt ambulated approx 20 ft c̄ walker. Stood in hallway c̄ walker for 45 min. Pt cried but Ø C/O pain or request for pain meds [redacted] b(6)-2 VAN

2230 Dsg changed one to (R) thigh and (R) calf wounds. Pin Care done to femur and tibia ex fixes using Betadine and NS. Pin sites to upper ex fix c̄ some drainage & amb skin tight around pins. Pins to lower ex fix CDI, minimal drainage to pin sites. Wounds to (R) thigh c̄ purulent drainage, well granulated c̄ S/S infection. Packed w/ Dt NS gauze. Dsg to (R) calf c̄ S/S infection, back section of calf tissue well granulated, minimal bleeding. Wound to (R) shin c̄ bone visible wound around bone healing well, (+) granulation tissue Ø S/S infection [redacted] b(6)-2 VAN

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	2200	(R)LE	Ex-fixes thigh and calf ~~thigh~~ /buttock areas red ⊘ drainage	W→D DSG Δ pin care
			JP drain ~~thigh~~ wound ankle wound red	

SECTION IV - NOTES

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (R)LE	TIME: 1030	2000				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	0	0				
SENSATION	S	S				
MOTION	P	M				
PASSIVE FLEXION	0	0				
PERIPHERAL PULSE	P	P				

LEGEND

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

SAFETY / OTHER

	TIME:		2000	
ID band visible/legible	✓	✓	✓	
Orient to environment prn	✓			
Side rails (2/4) up	✓			
Bed position low	✓			
Call light within reach	✓			
Review & post lab results	✓			
Notify MD abnormal labs	✓			
Incontinent urine/stool	✓			
Linen change prn	✓		✓	
Turn/reposition q2h	✓		✓	
ROM q2h if immobile	✓			
Antiembolic hose	✓		✓	

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE: Reg	TYPE: Reg
PERCENT CONSUMED: 70%	PERCENT CONSUMED: 50%	PERCENT CONSUMED: 50%
HOW TOLERATED: well	HOW TOLERATED: well	HOW TOLERATED: well
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLS

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

TEACHING

TIME: 1030 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: PAIN CONTROL, ↑ c̄ ASSIST, SAFETY	CONTENT: · Pain control · DSG Δ · Ambulate c̄ walker	CONTENT: b(6)-2
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

C[redacted]
b(6)-4

INITIALS	SIGNATURE	SHIFT
[redacted]	SGT, 4 MPB	D
[redacted]	SPC/9 MMC	N

MEDCOM - 23949

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 1050 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Drain RLE Ambulates c walker	☐ Amb c walker. Ex fixes to upper and lower (R) LE	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Drain incisions to RLE & WTD dxs Ex fix (x2)	☐ Skin graft donor site (D) LE open wounds w/l (R) LE	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ No pain ambulator	☐ percocet for pain	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ b(6)-2	☑	☐

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

TIME: 1050 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 5 hr:	IV patency ✓ q 5 hr:	IV patency ✓ q hr:
IV site care provided: Flushed	IV site care provided: flush	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) SC * OK	IV Site #1: (L) SC OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: (SL)	Comments:

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 12Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 31/7 | HOSPITAL DAY: 32

TRANSFER

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

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

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

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

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400													
BP ARTERIAL LINE																
BP CUFF	106/74	115/73	110/75													
TEMPERATURE	97.0	98.2	98.3													
PULSE	103	106	100													
RESPIRATORY RATE	18	20	16													
OXYGEN (L/%)																
PULSE OXIMETER	100%	100%	100													
O2 METHOD	RA	RA														

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

PAIN

TIME:	1200	2000						
PAIN INTENSITY (10 / 5 / 0)	1	0						
MED ADMINISTERED (Y/N)	Y	Y						
RELIEF ACCEPTABLE (Y/N)	Y	Y						
		percocet						

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

	TIME: 1015	2000	
*Skin breakdown prevention b(6)-2 [redacted]			
*Falls prevention protocol			
*Restraint protocol			
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

b(6)-4

C[redacted]

DIAGNOSIS: S/p open femur/tibia fx; ex-fix

DRG: _____ ADMISSION DATE: 10Nov03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

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

ISOLATION REQUIRED (*Specify*): _____

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 13Dec03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 32/8 | HOSPITAL DAY: 33

TRANSFER

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

☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Time _____ To _____ From _____

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

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

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	20	04												
BP ARTERIAL LINE															
BP CUFF	109/60	114/81	100/76												
TEMPERATURE	96.1	97.9	96.5												
PULSE	107	111	97												
RESPIRATORY RATE	18	18	16												
OXYGEN (L/%)															
PULSE OXIMETER	100%	99%	100%												
O2 METHOD	RA	RA	RA												

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

PAIN

TIME:	1200	20						
PAIN INTENSITY (10 / 5 / 0)	X							
MED ADMINISTERED (Y/N)								
RELIEF ACCEPTABLE (Y/N)								

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

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

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

CIV [redacted]

b(6)-4

DIAGNOSIS: open (R) femur & tibia fx

DRG: _____ ADMISSION DATE: 10NOV03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): b(6)-2

b(4)-2 A1

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: INITIALS:	TIME: 20 INITIA[redacted]	TIME: 1 INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐	☑	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☐	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☐	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☐	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐	☑	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐	☐ Ex Fix to RLE	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐	☐ Multiple wounds to RLE	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐	☐ percocet prn	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☐	☑	☐

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

TIME: _____ INITIALS: _____	TIME: 2100 INITIALS: [redacted]	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____
IV site care provided: _____	IV site care provided: Flushed	IV site care provided: _____
IV tubing changed: _____	IV tubing changed: _____	IV tubing changed: _____
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: _____ / _____	IV Site #1: single lumen ⊕ subclavian / ok	IV Site #1: _____ / _____
IV Site #2: _____ / _____	IV Site #2: _____ / _____	IV Site #2: _____ / _____
Comments:	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

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

LEGEND

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

SAFETY

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

OTHER

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

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE: Reg	TYPE:
PERCENT CONSUMED: 30%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: Cut-11	HOW TOLERATED:	HOW TOLERATED:
☑ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLS

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

TEACHING

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

PATIENT IDENTIFICATION

INITIALS	SIGNATURE	SHIFT

MEDCOM - 23954

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 14 DEC 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 33/9 | HOSPITAL DAY: 34

TRANSFER

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

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

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

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

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000														
BP ARTERIAL LINE	—															
BP CUFF	121/84	107/68														
TEMPERATURE	97.0	99.7														
PULSE	111	113														
RESPIRATORY RATE	20	22														
OXYGEN (L/%)	0	—														
PULSE OXIMETER	100	99%														
O2 METHOD	RA	RA														

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

PAIN

TIME:	0725	1200	2000					
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N	~~N~~ NA	N					
RELIEF ACCEPTABLE (Y/N)	Y							

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

NA

SPECIAL NEEDS

TIME:	0725	1830
*Skin breakdown prevention	AVM	AW
*Falls prevention protocol	NA	NA
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

DIAGNOSIS: s/p open femur/tibia fx; ex fix RLE

DRG: _____ ADMISSION DATE: 12 NOV 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6)-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): [redacted]

b(6)-2 A11

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 0725 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐ Pt c/o inability to void, but put out 960cc clear yellow urine in 8hr	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Ex fix to (R) LE ↓ mobility, Ambulates c̄ walker/crutches.	☐ Ex fix to (R) LE ↓ ROM to (R) knee Ambulates c̄ walker	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Large wounds to (R) buttock, (R) thigh, (R) inner calf, (R) outer calf, Donor site to (R) thigh, Graft site to (R) calf.	☐ Wound to (R) LE c̄ DSG CDI	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐ see pg 1	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

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

TIME: 0725 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) SC * / OK	IV Site #1: (L) SC CL / OK *	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

b/w-2 ALL

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RLE TIME:	0725	1830				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	Ø	Ø				
SENSATION	S	S				
MOTION	M	M				
PASSIVE FLEXION	/	Ø				
PERIPHERAL PULSE	2P	2P				

LEGEND

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

SAFETY / OTHER

TIME:	0725	1830		
ID band visible/legible	[redacted]			
Orient to environment prn				
Side rails (2/4) up				
Bed position low				
Call light within reach				
Review & post lab results				
Notify MD abnormal labs				
Incontinent urine/stool				
Linen change prn				
Turn/reposition q2h				
ROM q2h if immobile				
Antiembolic hose				

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Reg	TYPE: Reg
PERCENT CONSUMED: 20%	PERCENT CONSUMED:	PERCENT CONSUMED: 50%
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED: well
☑ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLS

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

TEACHING

TIME: 0725 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: - Plan of care -	CONTENT: - Care for assist - Pain management - Amb - ROM	CONTENT:
☑ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

C[redacted]

b/w-4

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted]	
	[redacted] CO/RN	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1000	(R) buttock, (R) thigh, (R) inner and outer calf, (L) calf	Red, granulating well, staples intact to skin graft	W→D Dsg △ Dry dsg △
	2300	(R) thigh, (R) buttock	Red, good granulation tissue, sutures intact to (R) thigh	W→D Dsg △ T NSSoaked gauze
		(R) Calf (lateral & medial)	- lateral side red T granulation tissue - medial side T fibrin visible tissue of wound bed	
		Pin sites	- Sites T minimal serous drainage	Cleaned T Betadine & H2O

SECTION IV - NOTES

0725: Awake & alert - Eating breakfast. No c/o pain @ this time. (B)CE ↑ - heals off of bed. Will continue to monitor. [redacted]

b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 15 Dec 03 | PATIENT ACUITY LEVEL: VII | POST-OP DAY: 34/10 | HOSPITAL DAY: 35

TRANSFER

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

☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Time _____ To _____ From _____ Anesthesia (*Specify*): _____

Total ER/RR/PACU time _____ Physician _____ B/P _____ P _____ R _____ T _____

Procedure/Diagnosis _____ Neurovascular checks _____

LOC _____ Tubes _____

Dressing/cast _____ Voided ☐ No ☐ Yes Amount: _____

Intake (IV, po) _____ Output (EBL, other) _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400												
BP ARTERIAL LINE		—	—												
BP CUFF	107/78	104/68	101/59												
TEMPERATURE	98.8	98.9	99.0												
PULSE	100	102	100												
RESPIRATORY RATE	16	16	18												
OXYGEN (L/%)	0	—	—												
PULSE OXIMETER	99%	98	98%												
O_2 METHOD	RA	RA	RA												

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

PAIN

TIME:	1900	1200	1830	2000	0400			
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)			N					
RELIEF ACCEPTABLE (Y/N)			NA					

OTHER

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

SPECIAL NEEDS

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

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

C[redacted] b(6)-4

DIAGNOSIS: S/p open femur/tibia fx; ex fix (R) LE

DRG: _____ ADMISSION DATE: 12 Nov 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6)-2

PRIMARY CARE MANAGER [redacted]

ISOLATION REQUIRED (*Specify*): _____

b(6)-2 A11

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 0900 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☐ Pt states PN c̄ difficulty d̄ 77. urinating	☐ Pt states he has difficulty voiding but Ø S/S of difficulty	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Ex Zip (R) leg ↓ ROM, Pt ambulates c̄ walker	☐ ↓ ROM to (R) LE 2° to ex fix amb c̄ walker	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ warm to (R) L ext. Pt has Distal Pulse	☐ Dsg to (R) LE c̄ wounds healing well	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ Ø c/c PN	☐ See pg 1	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

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

TIME: 0900 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (D) SC / OK	IV Site #1: (D) SC CL / OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (R) LE TIME:	0900	1830				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	1	1				
SENSATION	S	S				
MOTION	P	P				
PASSIVE FLEXION	—	DP				
PERIPHERAL PULSE	2	2				

LEGEND

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

SAFETY

TIME:	0900	1830	
ID band visible/legible		[redacted]	
Orient to environment prn		[redacted]	
Side rails (2/4) up	/	[redacted]	
Bed position low	/		
Call light within reach	/		

OTHER

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

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE: Reg	TYPE: Reg
PERCENT CONSUMED: 100%	PERCENT CONSUMED: 60%	PERCENT CONSUMED: 50%
HOW TOLERATED: well	HOW TOLERATED: well	HOW TOLERATED: well
☑ SELF ☐ ASSIST ☐ COMPLETE	☑ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLS

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

TEACHING

TIME: 0900 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: — Plan of Care	CONTENT: b6-2 — Call for assist — Pain management — DSG D — ROM	CONTENT:
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

b(6)-4

[redacted]

INITIALS	SIGNATURE	SHIFT
[redacted]		D
	[redacted] RN/RN	N

b(6)-2

MEDCOM - 23961

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
		(1) (R) calf (2) (R) buttock (R) thigh	signs erythema edges white, slight drainage, color yellowish/brownish drainage	wet to dry dsg Δ
	0900	(R) calf		(R) calf dry dsg Δ
	0930	(R) thigh, (R) buttock	wound ≤ 0.5/5 infect (+) granulation tissue	W&D dsg (+) done & NS soaked gauze
		medial calf (R)	wound ≤ (+) gran tissue (-) drainage noted, bone visible in wound	
		lateral (R) calf	(+) gran tissue, 0.5/5 inf	
		pins to upper and lower ex-fix		pins cleaned ≤ betadine/NS

SECTION IV - NOTES

Pt CAO x3, O c/o Pn @ this time. Pt ate small amount of breakfast. Dis DSG Δ. Pt tolerated well. Sights has (-) odor slight drainage (yellowish/brownish) c white edges (scar tissue) heels off bed. Placed on Donuts to ↓ decubs ulcers. Will continue to monitor heels of Pt. Pt has (-) c/o Pn this time. Will
1600
INSTRUCTS EAGLE OF THE ABOVE ASSESSMENT [redacted] IWM

b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 16 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 35/11 | HOSPITAL DAY: 36

TRANSFER

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

☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Time _____ To _____ From _____

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

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

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400
BP ARTERIAL LINE			
BP CUFF	114/70	104/71	114/74
TEMPERATURE	99.6	98.8	98.1
PULSE	111	119	111
RESPIRATORY RATE	14	16	16
OXYGEN (L/%)			
PULSE OXIMETER	99%	100%	100%
O_2 METHOD	RA	RA	RA

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

PAIN

TIME:	1000	1200	1830	2030
PAIN INTENSITY (10 / 5 / 0)	0	0	0	5
MED ADMINISTERED (Y/N)	N	N	N	Y
RELIEF ACCEPTABLE (Y/N)	NA	NA	NA	Y
Percocet				1

OTHER

TIME:	1000
FINGER STICK GLUCOSE	NA
INSULIN (Y/N)	

SPECIAL NEEDS

TIME:	1000	1830
*Skin breakdown prevention	[redacted]	
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions b(6)-2		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

b(6)-4

C[redacted]

DIAGNOSIS: S/P open femur/tibia fx; ex fix

DRG: _____ ADMISSION DATE: 12 Nov 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6)-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 1000 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: (INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	✓	✓	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	✓	✓	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	✓	✓	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	✓	✓ b(w)-2 ATV	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	✓	✓ Voiding ↓ difficulty to BR	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ -Ø ROM to (R) ankle 2° to ext fix -minimal ROM to (R) knee -pain ROM to (R) LE	☐ Ø ROM (R) ankle ↓ ROM to (R) knee exercises done t pin care -ptamb t walker ↓ assist	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ -wounds to (R) LE -graft site to (L) calf	☐ Dsg to (R) LE Δ'd Ø S/S infection to wounds. Pin sites t minimal drainage	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	✓ Ø c/o pain	☐ see pg 1	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	✓	✓	☐

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

TIME: 1000 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: ____ INITIALS: ____
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided: dsg Δ'd	IV site care provided: flushed	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: Central line (L) SC / OK	IV Site #1: (L) SC CL / OK*	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL'd	Comments: Heplocked between meds	Comments:

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (B)LE TIME:	1000	1830				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	Ø	Ø				
SENSATION	S	S				
MOTION Knee/ankle	P/U	P/U				
PASSIVE FLEXION ~~Knee~~	N/A	✓				
PERIPHERAL PULSE	2P	2P				

LEGEND

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

SAFETY

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

OTHER

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

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Regular	TYPE: Regular
PERCENT CONSUMED: 75%	PERCENT CONSUMED:	PERCENT CONSUMED: 50%
HOW TOLERATED: well	HOW TOLERATED:	HOW TOLERATED: well
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLS

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

TEACHING

TIME: 1000 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: b(6)-2 - pain management - call for assistance - ambulation	CONTENT: b(6)-2 - Call for assist - Pain management - Turning - Ambulation	CONTENT:
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

[redacted]

b(6)-4

INITIALS	b(6)-2 SIGNATURE	SHIFT
[redacted]	DUPLAN	0678
[redacted]	CW/AN	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0100	(R) thigh, (R) buttock	- Ø S/S infection, good granulation tissue	W→D dsg ▷ done
		(R) medial calf	- fibra visible in wound, Ø S/S infection	
		(R) lateral calf	- good granulation tissue, minbleeding Ø S/S infection	
		(R) Femur ex-fix	- serous drainage from pins	pin care c Betadine & NS
		(R) tibia ex fix	- Ø drainage from pins	

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 17 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 36/12 | HOSPITAL DAY: 37

TRANSFER

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

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

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

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

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400 1200														
BP ARTERIAL LINE	—														
BP CUFF	111/79														
TEMPERATURE	99'														
PULSE	108														
RESPIRATORY RATE	18														
OXYGEN (L/%)	—														
PULSE OXIMETER	99														
O_2 METHOD	RA														

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

PAIN

TIME:	0910	1830						
PAIN INTENSITY (10 / 5 / 0)	/	x						
MED ADMINISTERED (Y/N)	Y	N						
RELIEF ACCEPTABLE (Y/N)	Y	NA						

OTHER

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

SPECIAL NEEDS

TIME:	0910	1830
*Skin breakdown prevention	/	[redacted] b6-2
*Falls prevention protocol		
*Restraint protocol		NO
*Seizure precautions		
*Isolation precautions	/	

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DIAGNOSIS: S/P open femur/tibia fx; ex fix (R) LE

DRG: _____ ADMISSION DATE: 12 NOV

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6)-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

b(6)-2 A71

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 0915 INITIALS [redacted]	TIME: 1830 INITIA[redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Ambulate with Walker and Minimal assist.	☐ ↓ROM to (R) Knee exercises done pin care ↓ROM (R) ankle amb I Walker	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ (R) thigh, (R) buttock (R) calf, (R) Femur/Tib ex Fix IV (L) IJ	☐ (R) thigh / buttock medial & lateral Calf - Femur/ Tibex fix	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ Medicated for Pain stated	☐ See pg 1	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

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

TIME: 0915 INITIALS [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) CL / OK	IV Site #1: (L) SC CL / OK*	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL	Comments: HL	Comments:

66-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (R) LE TIME:	0910	1830				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	Ø	Ø				
SENSATION	S	S				
MOTION	P	P				
PASSIVE FLEXION	/	DP				
PERIPHERAL PULSE	2P	2P				

LEGEND

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

SAFETY / OTHER

	TIME: 0910	1830	
ID band visible/legible	/	[redacted]	
Orient to environment prn	/	[redacted]	
Side rails (2/4) up	/	NA	
Bed position low	/		
Call light within reach	/		
Review & post lab results	/		
Notify MD abnormal labs	/		
Incontinent urine/stool	/		
Linen change prn	/		
Turn/reposition q2h	Self		
ROM q2h if immobile	/		
Antiembolic hose	/		

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Regular	Regular	Reg
PERCENT CONSUMED:	100%	0	25%
HOW TOLERATED:	Wheelchair	—	Well
	☒ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

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

TEACHING

TIME: 0910 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: Call for assist	~~CONTENT:~~ 66-2 — Call for assist — Pain management — Dog Δ — ROM	CONTENT:
☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

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

INITIALS	b(6)-2 SIGNATURE	SHIFT
[redacted]	SGT 91WM6	4
[redacted]	T/Aa	N

MEDCOM - 23969

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0910	(R) thigh, (R) calf, (R) buttocks	Sites ≅ S/S of infection Good granulation	W-D DRSG Δ
	2310	(R) thigh (R) calf (R) buttock wounds	sites ≅ S/S infection good granulation tissue	W & D dsg Δ
		pin sites (R) femur & fix	- sites open - serous drainage - area reddened to ↓ pins	Pins Cleaned c̄ Betadine and Water
		(R) tibia & fix	pin sites CDI	

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 18 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 37/13 | HOSPITAL DAY: 38

TRANSFER

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

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

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

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

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	0400												
BP ARTERIAL LINE	—	—	—												
BP CUFF	108/74	122/85	112/76												
TEMPERATURE	97.8	97.9	97.2												
PULSE	100	116	107												
RESPIRATORY RATE	20	20	20												
OXYGEN (L/%)	0	—	—												
PULSE OXIMETER	100	100	99												
O2 METHOD	RA	RA	RA												

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

PAIN

TIME:	0730	1200	2000	0400				
PAIN INTENSITY (10 / 5 / 0)	X	X	X	X				
MED ADMINISTERED (Y/N)	Y	NA						
RELIEF ACCEPTABLE (Y/N)	Y							

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0730	2000
*Skin breakdown prevention	[redacted]	662
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

C [redacted]

b(6) - 4

DIAGNOSIS: S/p open femur/tibia fx; ex fix & ORIF

DRG: _____ ADMISSION DATE: 12 Nov

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6) - 2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 0745 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☑ gets to (R) eye q 2h	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☑	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☑	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☑ b(u) - ↓ A11	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ ↓ ROM TO RLE INT x2 EX FIX	☐ AMB C walker to BR ex-fixes to RLE intact	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ MULTIPLE WOUND SITES TO RLE C/D/I, WELL GRANULATED (R) GRAFT SITE TO LLE	☐ Wounds to RLE, healing well Graft site/donor site LLE	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ C/O PAIN TO RLE	☐ ↑ percocet for pain	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

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

TIME: 0730 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 5 hr:	IV patency ✓ q 5 hr:	IV patency ✓ q hr:
IV site care provided: FLUSHED	IV site care provided: flush	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) SUBC * / OK	IV Site #1: (L) SC / OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: SL	Comments:

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RLE TIME:	0730	2000				
COLOR	P	P				
CAPILLARY REFILL	2	2				
TEMPERATURE	W	W				
EDEMA	Ø	Ø				
SENSATION	S	S				
MOTION	P(RLE)	M				
PASSIVE FLEXION	Ø	Ø				
PERIPHERAL PULSE	2	2				

LEGEND

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

SAFETY

TIME:	0730	2000
ID band visible/legible	✓	[redacted]
Orient to environment prn	[redacted]	[redacted]
Side rails (2/4) up	✓	✓
Bed position low	✓	✓
Call light within reach	✓	✓

OTHER

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

DIET

BREAKFAST	LUNCH	DINNER
TYPE: REG	TYPE: REG	TYPE: REG
PERCENT CONSUMED: 75%	PERCENT CONSUMED: 100%	PERCENT CONSUMED: 100%
HOW TOLERATED: no problems	HOW TOLERATED: Good	HOW TOLERATED: well
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

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

TEACHING

TIME: 0735 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: AT C WALKER AMBULATE TID RPO FLUIDS b6-2	CONTENT: . Ambulate c walker . personal hygiene	CONTENT:
☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
C [redacted] b(6)-4	[redacted]	[redacted] SPC/SIGNM	[redacted]
		b(6)-2	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1000	upper (R) Thigh & Lower (L) Leg.	Sites S Both ↓ bright red in APP.	Packed NS Sol And dressed with Kerlix.
	2000	RLE	ex-fixes open wound to buttocks pink top of thigh pink Lower R leg open wound pink	W→D DSG Δ pin care done
				b(6) -

SECTION IV - NOTES

0900 [redacted] PT PROBING TRANSFER TO CIVILIAN HOSP PER APD. [redacted] SGT, SI WARD

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 19DEC03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 38/14 | HOSPITAL DAY: 39

TRANSFER

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

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

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

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

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200	2000	400													
BP ARTERIAL LINE	—															
BP CUFF	119/78	130/71	113/75													
TEMPERATURE	97.5	99.1	98.7													
PULSE	105	121	105													
RESPIRATORY RATE	20	18	18													
OXYGEN (L/%)	0															
PULSE OXIMETER	98	100	99													
O_2 METHOD	RA	RA	RA													

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

PAIN

TIME:	1200	2000						
PAIN INTENSITY (10 / 5 / 0)	X	X						
MED ADMINISTERED (Y/N)	N	Y						
RELIEF ACCEPTABLE (Y/N)	NA	Y						
		revised						

OTHER

TIME:	1200	2000						
FINGER STICK GLUCOSE	NA	NA						
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	1200	2000
*Skin breakdown prevention 66-2	[redacted]	
*Falls prevention protocol	NA	NA
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

Civ [redacted] b(6)-4

DIAGNOSIS: S/P open femur/tibia fx: 2ex fix

DRG: _____ ADMISSION DATE: 12NOV03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: 66-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 1200 INITIALS [redacted]	TIME: 2000 INITIALS [redacted]	TIME: (INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	✓	✓ OD. stb 82° WA	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	✓	✓	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	✓ b(6)-2 A11	✓	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	✓	✓	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	✓	✓	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ - limited ROM to (R) knee, pain c̄ ROM - ∅ ROM to (R) ankle 2° to ext fix - pain c̄ ROM to (R) hip	☐ up c̄ walker ↓ ROM RLE 2 ex-fixes	☐
7. SKIN: Warm; dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ - wounds to (R) LE, graft site to (L) calf - stage I decub on (R) heel	☐ wounds to RLE graft site (L) calf (R) heel wound donor site stage II (L) thigh	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	✓ ∅ c/o pain	☐ ↑ percocet for pain	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	✓	✓	☐

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

TIME: 1200 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]	TIME: _____ INITIALS: _____
IV patency ✓ q 8 hr:	IV patency ✓ q 5 hr:	IV patency ✓ q ___ hr:
IV site care provided: needs D/ing	IV site care provided: (flush	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: central line (L) sc / ok	IV Site #1: (L) SC / OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: SL	Comments:

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (R)LE TIME:	1200	2000				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	Ø	Ø				
SENSATION	S	S				
MOTION ankle/knee	U/P	U/M				
PASSIVE FLEXION	UTA	UTA				
PERIPHERAL PULSE	2P	2P				

UTA: unable to assess

LEGEND

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

SAFETY

TIME:	1200	2000	
ID band visible/legible	✓	[redacted]	
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			

OTHER

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

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Regular	Regular	Reg
PERCENT CONSUMED:	100%	75%	75%
HOW TOLERATED:	well	well	well
	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

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

TEACHING

TIME: 1200 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: - pain management - ambulate c̄ walker - call for assistance - ROM to (R) knee	CONTENT: b6-2 · ambulate c̄ walker · personal hygiene · call for assist	CONTENT:
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

b(6)-4

C[redacted]

INITIALS	b(6)-2	SIGNATURE	SHIFT
[redacted]		LT/AN	06-18
[redacted]		SPC/RN/RNC	N

MEDCOM FORM 680 R (TEST) (MCHO) MAR 00

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1000	① Anterior (R) thigh ② inner & anterior (R) calf ③ (L) calf	① red moist, S S/S of infection, well-granulated ② jagged bone visible on inner medial, both calf wounds red well granulated tissue ③ graft site c̄ small area open & draining scant amt of serosanguinous fluid.	① ② W→D c̄ NS pincare completed ③ dry kerlix applied

SECTION IV - NOTES

662

1000 staples removed from graft site on (L) LE. [redacted]

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 20DEC03 | PATIENT ACUITY LEVEL: VII | POST-OP DAY: 39/15 | HOSPITAL DAY: 4/0

TRANSFER

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

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

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

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

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

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

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	1200															
BP ARTERIAL LINE	—															
BP CUFF	111/78															
TEMPERATURE	98.9															
PULSE	115															
RESPIRATORY RATE	14															
OXYGEN (L/%)	—															
PULSE OXIMETER	99															
O_2 METHOD	—															

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

PAIN

TIME:	0710							
PAIN INTENSITY (10 / 5 / 0)								
MED ADMINISTERED (Y/N)	N							
RELIEF ACCEPTABLE (Y/N)	Y							

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

TIME:	0710		
*Skin breakdown prevention	U3		
*Falls prevention protocol	—		
*Restraint protocol	—		
*Seizure precautions	—		
*Isolation precautions	—		

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DIAGNOSIS: S/P open femur/tibia fx

DRG: _____ ADMISSION DATE: 12NOV03

LOS: _____ EXPECTED RELEASE: b(6)-2

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

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

	TIME: 0720 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑ b(6)-2	☐	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ (+) ROM & WALKER AMBULATES WELL & WALKER	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ PT DENIES S/S PAIN THIS TIME	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ MULTIPLE WOUND SITES TO RLE WELL GRANULATED & LE GRAFT SITE Ø STAPLES	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☐

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

TIME: 0800 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
IV patency ✓ q 5 hr:	IV patency ✓ q hr:	IV patency ✓ q hr:
IV site care provided: FLUSHED	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: LE BUAC * / OK	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: Ø BLOOD RETURN	Comments:	Comments:

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	0715					
COLOR	P					
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	0					
SENSATION	S					
MOTION	D					
PASSIVE FLEXION	0					
PERIPHERAL PULSE	3					

LEGEND

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

SAFETY

TIME:	0715			
ID band visible/legible	✓	[redacted]		
Orient to environment prn				
Side rails (2/4) up	✓			
Bed position low				
Call light within reach				

OTHER

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

DIET

BREAKFAST	LUNCH	DINNER
TYPE: REG	TYPE:	TYPE:
PERCENT CONSUMED: 90%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: WELL	HOW TOLERATED:	HOW TOLERATED:
☑ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☑ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, (AMBULATE), BSC, BRP, CHAIR — ☐ SELF ☐ ASSIST — # TIMES/SHIFT b6-2	BEDREST, AMBULATE, BSC, BRP, CHAIR — ☐ SELF ☐ ASSIST — # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR — ☐ SELF ☐ ASSIST — # TIMES/SHIFT

TEACHING

TIME: 0715 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: ↑ c WALKER > TID ↑ COB TC TID ↑ ENSURE BTWN MEALS	CONTENT:	CONTENT:
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] SGT, 91W/MC	D
	b(6)-2	

MEDICAL RECORD

INTRAOPERATI[illegible]UMENT

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
A BY

2. PATIENT IDENTIFIED [redacted] D PROCEDURE
VERIFIED BY [redacted] CPT

3. DATE TIME PATIENT ARRIVED IN SUITE

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

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)* Head to towel arms std <90° to

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

COMMENTS padded armboards, legs straight bed padded. Position approved by surgeon

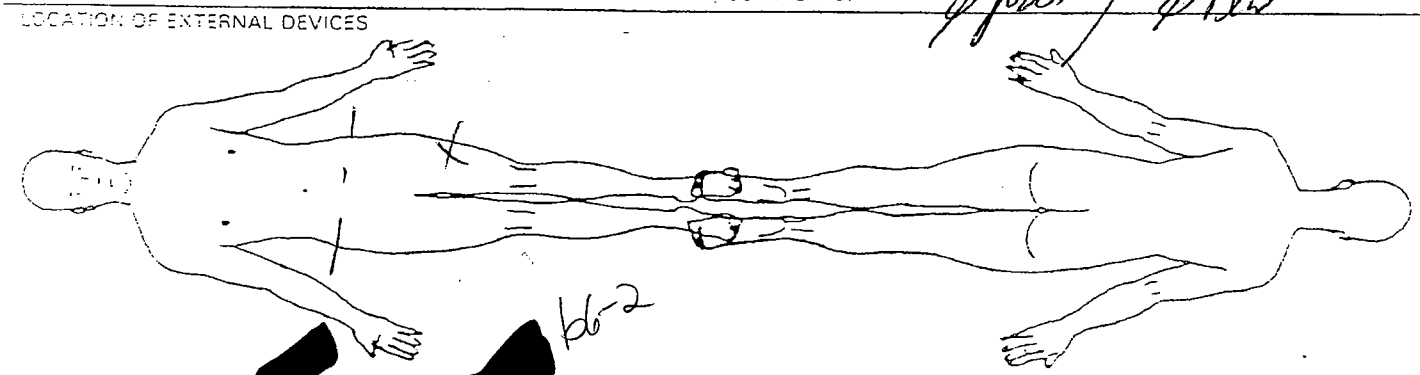
8. SKIN PREPARATION

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

COMMENTS

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: (R) leg BY WHOM: [redacted]
SITE: (L) leg BY WHOM: [redacted]
COMMENTS: ⌀ prep / ⌀ prep b(6)-2

LOCATION OF EXTERNAL DEVICES



[redacted] b6-2

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

C = Correct I = Incorrect

9. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C	SPC [redacted]	CPT [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;)*

Iraqi boy

14 yr old.

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

☒ ESU NO: B
GROUND PAD: BRAND 3m
LOT NO: 1999-11CU

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

MEDCOM - 23982

Distributed by:
Stryker®
Howmedica
OSTEONICS
Full Dose
Cat. No. 6197-9-001
Control No. MEK003

X 27 Right leg

14. IRRIGATION/MEDICATIONS GIVEN

ERS ANESTHESIA) YES ☐ NO ☒

MEDICATIONS SOLUTION	DOSAGE	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO. TYPE(S): NSS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN(S) YES ☐ NO ☒	NAME	NAME
PROCEDURE CULTURES YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES DRAINS PACKING YES ☒ NO ☐

TYPE SIZE	1. 8 Fr Foley	2.	3.
SITE	1. Bladder	2.	3.

18. DRESSING/IMMOBILIZATION (Specify) fluffs Ace wrap Posterior Posterior Velcro Posterior loop (R) leg

19. ADDITIONAL INFORMATION

WC II

Surgeon [redacted]

20. OPERATION(S) PERFORMED

Ex Fix (R)

21. PATIENT TRANSFERRED TO PACU b(a)-7 TIME METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] OCT 4

REVERSE OF DA FORM 5179-1, OCT.

USAPA V1.0

IBN SINA HOSPITAL
28th Combat Support Hospital
Baghdad, Iraq

Microbiology Request Form

#1 Culture

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

Collected by: Dr [redacted]
Date: 10 Dec 03 b(6)-2
Time: 0900

Ward: ICW-2 (OR)
Room:
Bed:
Physician: Dr [redacted]
Source: Wound
Site: (R) Thigh

[redacted]

Received by [redacted]
Date: 10 Dec 03
Time: 1000

Specimen #: 4174

Laboratory Results

1) Klebsiella pneumoniae
2) Staphylococcus haemolyticus
3) Staphylococcus auricularis

Reported
Date: 13 Dec 03
Time: 1117
Tech: rgw
Reviewer:

Number of attached sheets:

MEDCOM - 23984

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Fentanyl	(mcg)	50 20
Ketamine	(mg)	50
SCh	(mg)	100
Vecuronium	( )	2 1
Atropine	( )	0.4
MSO4	( )	
VOLAT AGENT	% del	0.5 — 0.25 — 0.5 0.5 1.0 — 1.0 2 2
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	5 — 5 — 5 — 5

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

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: Ancef 500mg IVPB strtby; prep PCN 800,000 u IVPB @ 0205 – 0240

LINE site		
CUC	☐ Warmed	PRBC — 0.NS — 500 — 1000
CUC	☐ Warmed	LR — 500 — 500/1000
CUC	☐ Warmed	PRBC — PRBC
	☐ Warmed	

LOSSES	
EST BLOOD LOSS	500 100/500 — 500
URINE –	400 100/500

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

BODY WEIGHT: 40 (KG) LB

HEMATOCRIT: —

INITIAL DATA: BP – 101/70 HR – 125

SLIP CHECK: ID OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? 1240 TIME – 1245

TIME → 0030 0040 X 30 X 0200 X 30 X 0300

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

220 200 180 160 140 120 100 80 60 40 20

HCT 33% PRBC PRBC PRBC PRBC FS

VT – ml										
f – breaths/min	14	14	16	16	14	14	12	14	22	
Peak inf pres / PEEP										
MODE – S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	A	S
BP/Auto Cuff — ET CO2 (torr)	32	30	30	34	—	32	37	45		51
BP / oth — FIO2 (Frac or %)	.60	.34	.32	.37	.38	.39	.48	.53		.63
ART line — SpO2 (%)	100	100	100	100	100	100	100	100		100
Steth – PC/ES — ECG	ST	ST	ST	ST	ST	ST	ST	ST		ST
Gas analyzer — TEMP – site		37	37.1							
N-M Block (T/4)										
Warming blkt										
Conv warmer										

Mark with letters & symbols, explain under REMARKS

EVENTS A (B) (C) (D) (E)

Position → Arm > 90° Pelvis up – P.P.P.

PROCEDURES and CPT Codes: ~~ORIF~~ EXFIX, Femur, Right. Tibia, R. & LT

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA 6.0 ord cuffed ETT 17cm @ Teeth RSI

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Oral DLX I Stylet View: Intubated, cuff ↑ 7cc air EBBS ETCO2 (+) CP Released

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility: Iraqi Boy 14 yr old

SURGEON [redacted]

[redacted] CRNA

[redacted] MEDICAL RECORD – ANESTHESIA

TOTALS	
TOTAL IN	500cc
TOTAL URINE	500 cc

FLUIDS – SUMMARY
CRYSTALLOID – 2000cc
COLLOID – Albumin 5% 50cc
BLOOD – PRBC 111 units

REMARKS – Code drugs with numbers, events with letters

(A) Pt Accessed, CUC per Montgomery (C) Femoral Kath Stem Term (B) TOOR – O2 RCF Monitors ON (C) RSI Pt to bed well O UT Tied OG Tube Placed (D) Sponge Sponge Sinus SXN & Remove OG Tube Extubate (E) To PACU – Sponge Rose E Good Air Exchange Report to Surg

RECOVERY AT 0253
(PACU) ICU ____ (Specify)
OTHER ____
CONDITION: STABLE
(T) RESP – 22 SpO2 – 100%
BP – 100/66 HR – 148

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0030	0040	0300
	Ready	Begin	End
PROC	0050	0058	0245

PROCEDURE 722 FST
LOCATION Fallujah Iraq
DATE 12 Nov 03
PAGE 1 OF 1

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
	ET Intubation		☐ Oral ☐ Nasal Teeth		☐ $ETCO_2$ Change ☐ BBS Post Int ☐ Post CXR
	Gastric Tube		☐ Oral ☐ Nasal		☐ Air ☐ Contents ☐ Verified_____ Suction: Y N
arr.	Urinary	8Fr	☑ Meatus ☐ Supra-Public		☐ Return_____cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed		☐ Grossly: + - Cell count Sent@_____
	Chest Tube #1		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:	Comments		

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

LABS

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

X-RAYS

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

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

IV ACCESS & FLUIDS

TIME	#	GA	IAW SOP		SITE	IVF TYPE	AMT UP	AMT IN
arr	1	Brant	N		(D) Femoral	LR		
			Y	N				
			Y	N				
			Y	N				

MEDICATIONS

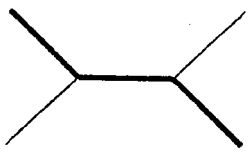
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Fentanyl	0750	50mg	IV						

BLOOD PRODUCTS

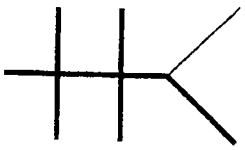
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	WIT

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 _____

Via: ☐ Stretcher ☐ Wheelchair

VITAL SIGNS

Rectal Temp: 98.8

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	GCS: E	V	M	T
0700	115/82	120	ST	24	100			4	5	6	15
0740	119/83	114	ST	26	100%						
0740	123/93	123	ST	24	100%						
0750	121/81	124	ST	22	99%						
	/										
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GLASGOW COMA SCALE

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

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

NOTES

b(a)-4

[redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED *(Date)*: QI Appr 11 Jun 97

EMS REPORT

TIME: _____ ETA: _____ UNIT: _____

MED COM: [Y] [N]

ARRIVAL STATUS

TIME 0700 ☐ IV x 1 ☐ O_2 _____ 1/min ☐ C-Spine Immob

Meds: ☐ UKN ☐ None ☐ Yes: _____

Allergies: ☐ UKN ☐ None ☐ Yes: _____

Tetanus: ☐ UKN ☐ Current Last Meal/Fluid Intake _____ hrs

LMP: NA ☐ _____

PRIMARY SURVEY

AIRWAY

☐ Natural Patient [Y] [N]

☐ ETT _____ ☐ _____

☐ Secretions _____

BRETHING

☐ Labored ☐ Unlabored ☐ Absent

TRACHEA: ☐ Midline ☐ Deviated [L] [R]

CHEST SYMMETRY: [L] > = < [R]

CIRCULATION

PULSE: ☐ Present ☐ Absent

BLEEDING: [Y] [N]

HEART TONES: ☐ Clear ☐ Muffled

SKIN: ☐ Warm ☐ Cool ☐ Hot

☐ Pink ☐ Pale ☐ Cyanotic ☐ _____

☐ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY

GCS: E 4 V 5 M 6

SPHINCTER TONE: ☐ WNL ☐ None

HEAD

PUPILS: ☐ Equal ☐ Fixed ☐ React ☐ Dilated [L] [R]

TM: ☐ Clear ☐ Blood [L] [R]

NECK

C-Spine Tenderness: [Y] [N]

Pain @ _____

JVD: [Y] [N]

HEART

RHYTHM: ☐ Regular ☐ _____

PULSES: ☐ Central ☐ Peripheral

LUNGS

BREATH SOUNDS: ☐ Bilat ☐ Equal ☐ Clear

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

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

ABDOMEN

☐ Soft ☐ Rigid ☐ Non-Tender

☐ Tender: _____

PELVIS

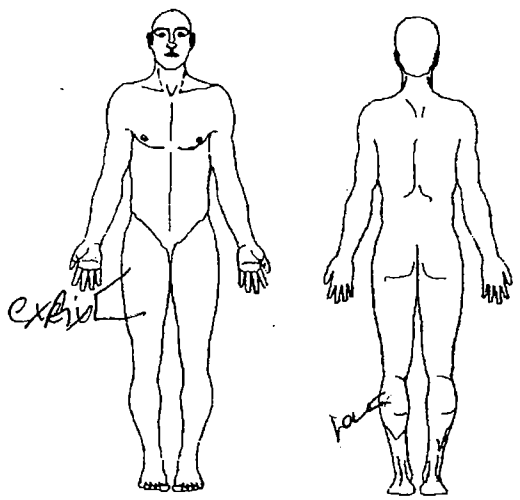
☐ Stable ☐ Unstable ☐ _____

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

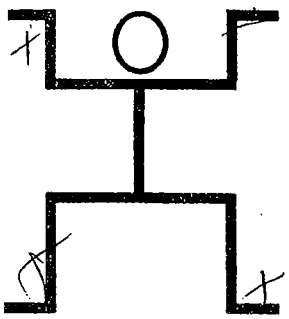
Heme + / - Prostate: ☐ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion
(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 b(6)-2

PHYSICIAN [redacted] b(6)-2

(Continue on reverse)

[redacted]

DEPARTMENT/SERVICE/CLINIC: Crit

DATE: 12 Nov 00

PA[redacted] *entries give: Name--last, first, middle; grade;* [redacted]

[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

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: 12 NOV 03

TIME IN: 0255

PROCEDURE: Ex fix of (R) Femur / (R) tibia

PRE-OP VS: 101/70 BP 125 HR

TYPE ANESTHESIA: (GEN) SAB EPIDURI NERVE BLOCK IV SED.

OR INTAKE: Crystalloid: 2000 Colloid 3 units 50cc a/b

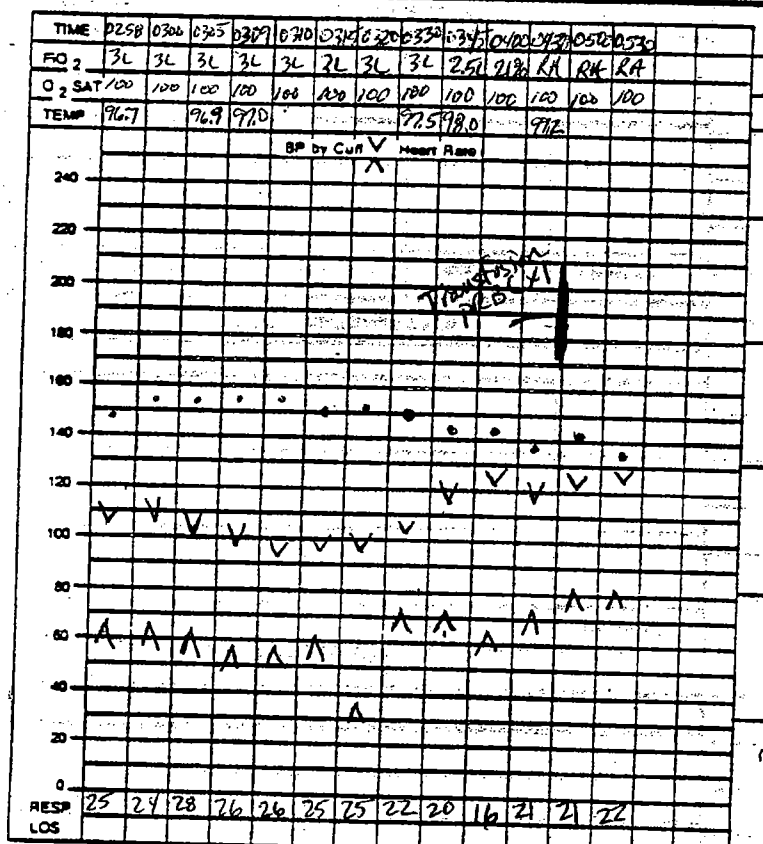
OR OUTPUT: Urine Output 500cc EBL 500cc

INTAKE						OUTPUT			
TIME	SOLUTION	Amt. Hung	SITE	BY	Amt. Infused	TIME	SOURCE	COLOR	AMT
ADM	LR	500	(L) Fem.	ESC					
	LR	500	(L) Fem.	ESC					

X-RAYS DONE:

LABS DRAWN:

TIME	0258	0300	0305	0309	0310	0315	0320	0330	0335	0400	0430	0500	0530
FIO2	3L	3L	3L	3L	3L	2L	3L	3L	2.5L	21%	RA	RA	RA
O2 SAT	100	100	100	100	100	100	100	100	100	100	100	100	100
TEMP	96.7		96.9	97.0				97.5	98.0		97.2		
RESP	25	24	28	26	26	25	25	22	20	16	21	21	22
LOS													



* LOS Level of Sensation

REACT SCORE — ACTIVITY SCORE	IN	30 Min	OUT
(R)espirations: 0 Vencessar essential; 1 Spont. resp., <10/min: airway essential; 2 Spont. resp.: no support: >10/min	2	2	2
(E)nergy: 0 Does not move legs; 1 Moves legs, cannot sustain head lift; 2 Sustains head lift, moves legs	0	0	2
(A)lertness: 0 Awakens only with vigorous stimulation; 1 Awake only when stimulated gently; 2 Awake, seldom dozes	0	0	
(C)irculation Adults: 0 BP 20% pre-anesthesia level; 1 BP 20-50% pre-anesthesia level; 2 BP 50% pre-anesthesia level	2	2	2
Infants: 0 Carotid only reliable pulse palpable; 1 Axillary pulse felt feet but not wrist; 2 Pulse can be felt easily at wrist			
(T)emperature: 0 Axillary temp. <95 F; 1 Temp. 95-98 F; 2 Temp. >98 F	2	2	2

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: WARD 2-D

DATE

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

14 yrs old ~40 kg

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

MEDCOM - 23989

IEDDAC FBg OP 173 (Revised)

MEDCOM - 23990

INITIAL ASSESSMENT:

LEVEL OF CONSCIOUSNESS:
- Alert
- Responsive
- Unresponsive

AIRWAY:
- Nasal
- Oral
- Endotracheal
- Tracheostomy

OXYGEN
- Hudson Mask 40%
- Oxygen Mist
- Nasal Cannula
- Room Air

DRAINS
- Hemovac
- Jackson-Prat
- N/G
- Foley

SIGNATURE: [redacted]

MEDICATIONS

ALLERGIES:

Time	Medication/AMT	Route/Site	BY
0325	MSO4 / 2mg	IV	[redacted]
0342	MSO4 / 2mg	IV	[redacted]
0340	Gentamicin 80mg	IV	[redacted]
			b(6)-2

NURSES NOTES:

0300 Pt received from OR status post Ex fix (R) femur and (R) tibia. Pt. on 3L simple mask sating @ 100%. Pt is in sinus tach. Clear bilat. breath sounds. Pt. has central Triple lumen catheter in (L) femoral vein. Flushed by CPT [redacted]

0440 H/H 28/9 Transfuse x1 PRBC 277395

DRESSINGS

	SITE	TYPE	DRAINAGE
	(R) Thigh	Ace wrap	minimal
	(R) Calf	Kerlex	minimal

CBI INFORMATION

TIME	CBI IN	URINE OUT	COLOR	URINE BAL

PACU FLUID TOTALS

CRYSTALLOID IN		URINE OUTPUT	
COLLOID IN		EMESIS	
P.O		NG TUBE	
		JP DRAIN/HEMOVAC	
TOTAL INTAKE		TOTAL OUTPUT	

DISCHARGE CRITERIA Time: Date:

REACT Score:

VS: BP R HR T

Cleared according to WARD 2-D SOP C-2

Charge Nurse Signature:

800 units Pen

500mg Ancef

4mg Morph

Medcom 23990

Admission and Coding Information

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

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

3. Register Number Name (Last, First, MI) [redacted] b(6)-4

4. Pay Grade: FGN

5. Sex: M

6. DoB (YYYYMMDD): 1990-01-01

7. Age at Admission: 13Y

8. Race: X

9. Ethnicity: 9

Religion:

10. Length of Service: ETS

11. FMP: 99

12. Social Security Number [redacted] b(6)-4

Organization (Active Duty Only):

13. Marital Status:

Hour of Admission: 06:35

Branch / Corps:

14. Flying Status: NO

15. Beneficiary Category: K78-PRISONER OF WAR/INTERNEES

16. Zip Code of Residence:

17. Unit Location:

18. MOS:

19. Trauma: DIS

Prev. Admission: NO

20. Source of Admission: Direct from ER

Ward: ICW1

Name / Relationship of Emergency Addressee

Address of Emergency Addressee

Telephone Number of Emergency Addressee

Name and Location of Medical Treatment Facility: [redacted] b(2)-2

21. Type of Disposition: TRF-OTH

22. MTF Transferred To:

23. Date of Disposition (YYYYMMDD): 2003-12-20

24. Clinic Svc - Admitting: AEA - ORTHOPEDICS

25. MTF Transferred From:

26. Date this Admission (YYYYMMDD): 2003-11-12

27. Location of Occurrence:

28. MTF of Initial Admission:

29. Date of Initial Admission: 2003-11-12

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: OPEN R FEMUR/TIBULA FX

Dx: 82110
82390
9910
8951
9100
8716
88191

7165 (x9)
7966
785
7936 (x8)
8622
8302

Procedure Narrative(s):

Cause of Injury Narrative:

Admitting Officer (Signature, as required) [redacted] b(6)-2

Signature of Admitting Clerk [redacted]

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: 13 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): nkda 3. PREVIOUS SURGERY [ ] NO [X] YES (type): Ex Fix Placement

4. PROPOSED SURGICAL PROCEDURE: I+D of Wounds

5. ADDITIONAL INFORMATION: Last PO: MN Medical Hx: see chart Implants: Ex Fix Medications: see chart
Jewelry removed: yes/no Family waiting: yes/no

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

9. PATIENT'S IDENTIFICATION (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)
#1 [redacted] b(6)-4
[redacted] b(2)2
13 Nov 03

DA FORM 5179, JUN 91 Previoius editions are obsolete. USAPA V1.01

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; ~~shock~~; previous surgery	✓ 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. ✓ Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ✓ Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation Imaginational F.3. Potential injury due to dentures. N/A	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from either side. o Validate pt.'s understanding of verbal communications. - as possible o Verify removal of dentures. N/A
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 HN b(6)-2 13 NOV 03 DATE

11. POSTOPERATIVE EVALUATION:

Bovie Site: clear
Drsg: cldli
~~Anesthesia:~~ emergence
Breathing: OSOB

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

DATE: 13 NOV 03 TIME: 0845 b(6)-2

13. ~~PRE~~ POST OPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT HN

DATE: 13 NOV 03 TIME: 1130 b(6)-2

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD	INTRAOPERATI DOCUMENT For use of this form, see AR 40-407, the pro agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

2. PATIENT IDENT RECORD REVIEWED AND PROCEDURE
VERIFIED BY CPT [redacted] b(6)-1

3. DATE 13 Nov 03 TIME PATIENT ARRIVED IN SUITE /

4. PATIENT IN ROOM TIME 0924 NUMBER 5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Ø

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

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

8. SKIN PREPARATION

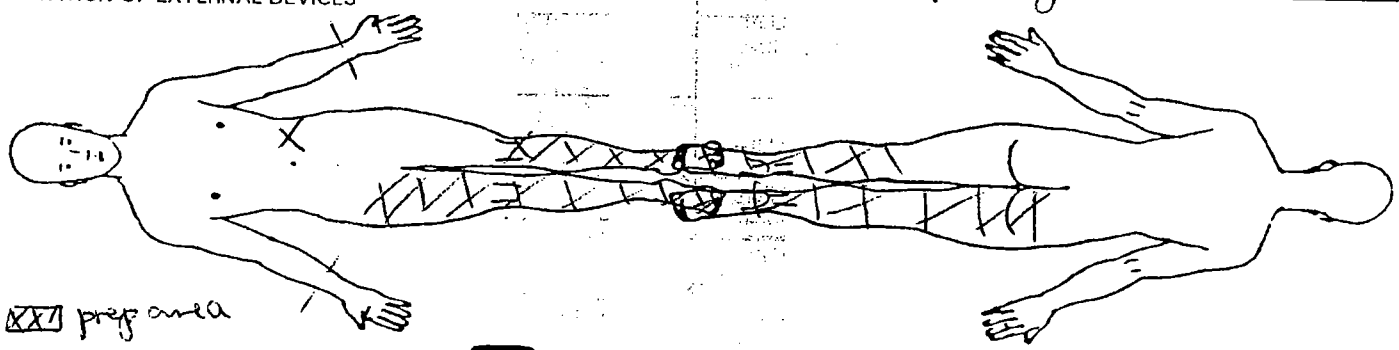
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine / Betadine Paint
SITE (R) Leg BY WHOM: [redacted]
SITE (L) Lower Leg BY WHOM: [redacted]

COMMENTS: no pitting or skin Δ's noted b(6)-2

9. LOCATION OF EXTERNAL DEVICES



XXX prep area

LEGEND X Ground Pad [redacted] -- Safety Strap [redacted] = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect Initial [redacted]

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	/	/	C	[redacted] b(4)	[redacted]
Needle Sharp	☒ Yes	☐ No	/	/	C		
Instrument	☐ Yes	☒ No	/	/			
Other	☐ Yes	☒ No	/	/			

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

[redacted] b(4)-4
[redacted]
13 NOV 03 b(2)-2

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO
30130

☒ ESU NO: Valleylab Force 40 RBB105305
GROUND PAD: BRAND VL Rem Polyhesive II
LOT NO: 70337 2005-05

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS

	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1. FIC *	2.	3.
SITE	1. Bladder	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Ioban (R Lower Leg)
Fluffs
Kerlix
ABD
Acewrap

19. ADDITIONAL INFORMATION

Surgeon: [redacted]
Anesthesia: [redacted]

* FIC already in place upon arrival to OR
- DA5179 initiated

b(6) - 2 All

20. OPERATION(S) PERFORMED
I+D of wounds (L Lower Leg, R Tib/Fib Fx, R Femur Fx + Buttocks wound)

21. PATIENT TRANSFERRED TO ICU3 (PACU) | TIME see DA7339 | METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT IAN

REVERSE OF DA FORM 5179-1, Oct 87

USAPA V1.0

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA PACU bed BY Anesthesia
2. PATIENT IDENTIFICATION RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2
3. DATE 15 NOV 03 TIME PATIENT ARRIVED IN SUITE /
4. PATIENT IN ROOM TIME 1126 NUMBER 5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	CPT [redacted] (1210-1240)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

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

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

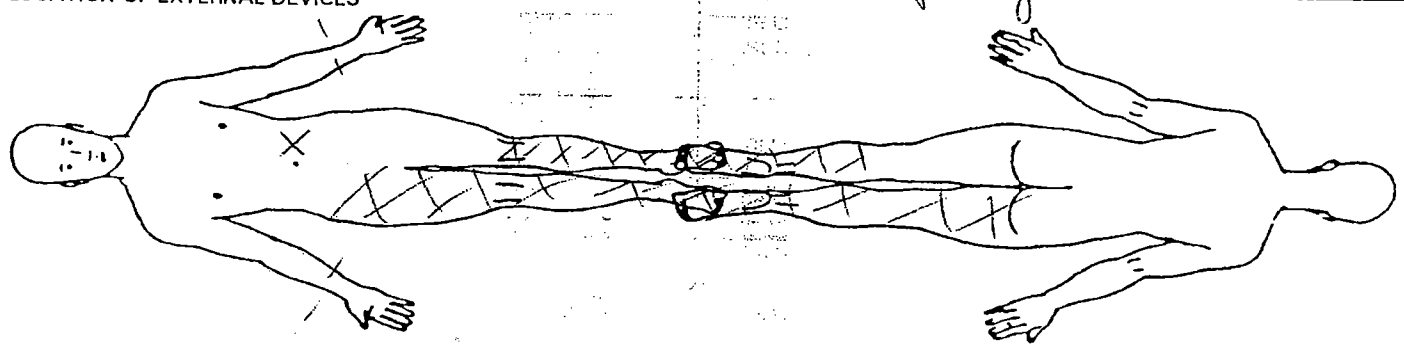
PREP SOLUTION *(Specify)* Betadine / Betapaint

SITE: (R) leg 11-lip BY WHOM: [redacted]

SITE: (L) lower leg BY WHOM: [redacted] b(6)-2

COMMENTS: no peeling or skin d's noted

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS — C = Correct I = Incorrect

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

b(6)-2

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

[redacted] b(6)-4

[redacted] b(2)-2

15 NOV 03

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

30130

☒ ESU NO: Valleylab Force 40 RBE 105365

GROUND PAD: BRAND 3M

LOT NO: 9165

☐ 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

IF YES NAME: ID NUMBER; MA TURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS
none

	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

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	NAME

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. FIC *	2.	3.
SITE	1. Bladder	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
ABD
Kerlix
Ace wrap

19. ADDITIONAL INFORMATION
Surgeon: [redacted]
Anesthesia [redacted]
b(6)-2
- DA5179 on chart, ✓'s noted
- * not placed in OR

20. OPERATION(S) PERFORMED
I+D wounds (R) leg, I+D wound (L) leg

21. PATIENT TRANSFERRED TO
ICU3 (PACU)

TIME	METHOD
see DA7389	PACU bed

22. REGISTERED NURSE SIGNATURE
[redacted] CPT IAN

REVERSE OF DA FORM 5179-1, OCT 87
Blue - 2

USAPA V1.00

MEDICAL RECORD

INTRAOPER. VE DOCUMENT

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

1. PATIENT TRANSPORTED TO OP. ROOM
VIA gurney BY Anesthesia

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

3. DATE 17NOV03 TIME PATIENT ARRIVED IN SUITE 1100

4. PATIENT IN ROOM TIME 1100 NUMBER 1-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 910 b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR INT.	MAJ Durst 66E (1230-End)

7. POSITION AND POSITIONAL AIDS (Specify) Pt on padded OR bed, head on foam doughnut. Arms extended out to sides <90° in CAP secured to padded Armboards c safety straps. BLE prepped into sterile field.

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

COMMENTS: Correct Body Alignment Maintained.

8. SKIN PREPARATION

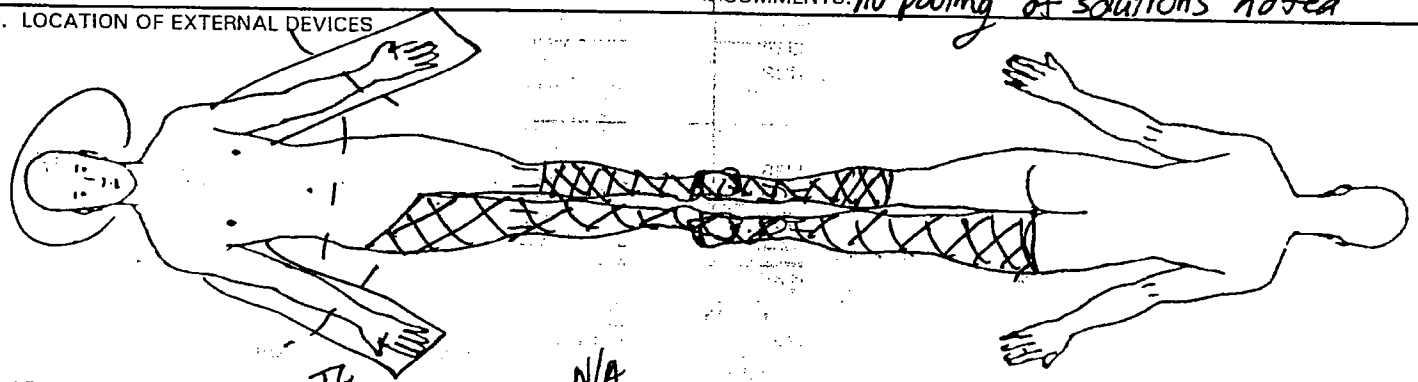
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Beta-Beta b(6)-2
SITE: RLE+LLE BY WHOM: CPT [redacted]
SITE: (as below) BY WHOM:

COMMENTS: no pooling of solutions noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad TG Safety Strap N/A Tourniquet

C = Correct I = Incorrect

10. COUNTS

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

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

[redacted]

b(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% NaCl - QS >

OTHER ORDERS	TIME	CARRIED OUT BY

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	

18. DRESSING/IMMOBILIZATION *(Specify)*

Kerlex Fluffs, Kerlex Roll, ABD pads, ACE wrap x2

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

19. ADDITIONAL INFORMATION

WC-IV

Surgeon: Dr [redacted]

Anesthesia: Gen/LMA; CPT [redacted] CRNA

~~Both~~

b(6)-2

20. OPERATION(S) PERFORMED

I&D Bilateral Lower Extremities.

21. PATIENT TRANSFERRED TO PACU TIME 1250 METHOD gurney

[redacted] CPT/AN

[redacted] 5179-1, OCT 87

b(6)-2

USAPA V1.00

MEDCOM - 23999

MEDICAL RECORD

INTRAOPER. VE DOCUMENT

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

1. PATIENT TRANSPORTED TO OF ROOM
VIA PACU bed BY Anesthesia

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

3. DATE 19 NOV 03 TIME PATIENT ARRIVED IN SUITE / 0845

4. PATIENT IN ROOM TIME 0845 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: ø

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Both arms on padded armboards at angle < 90°

8. SKIN PREPARATION

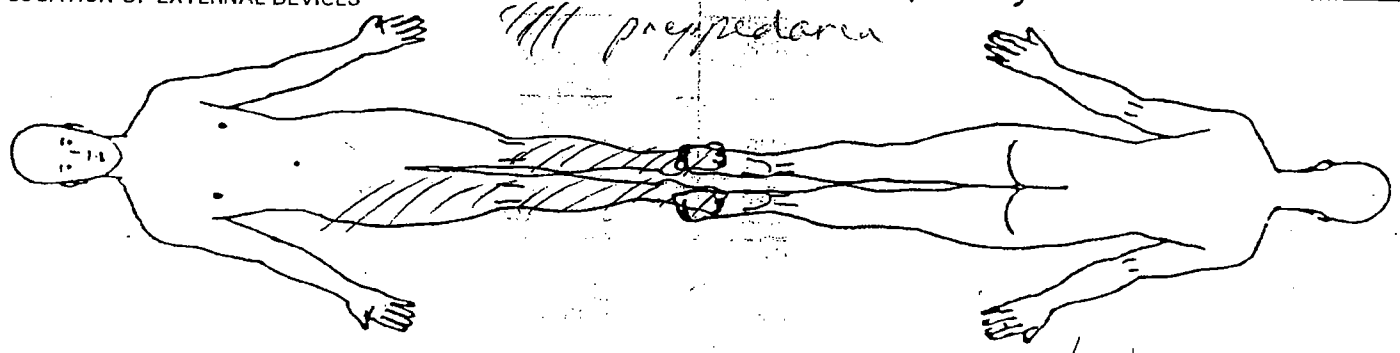
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub solution
SITE: Left leg BY WHOM:
SITE: Rt leg BY WHOM:

COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

10. COUNTS

C = Correct I = Incorrect

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

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

[redacted] b(6)-4

[redacted] b(6)-2
19 NOV 03

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

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

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
(GS)

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix x 3
~~Acewrap~~ E/J

19. ADDITIONAL INFORMATION
Surgeon: [redacted]
Anesthesia: [redacted]
b(6)-2

-DA5179 on chart, ea's noted

20. OPERATION(S) PERFORMED
I + D, wounds on Lt Lower Leg and Rt thigh, hip and Lower Leg

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU3 (PACU) to b(6)-2	See DA 7389	PACU bed

22. [redacted] MAJ AN

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.00

b(6)-2

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

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

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

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

3. DATE 21 Nov 03 TIME PATIENT ARRIVED IN SUITE 1050

4. PATIENT IN ROOM TIME 1050 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Both arms on padded armboards at angle <90°.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

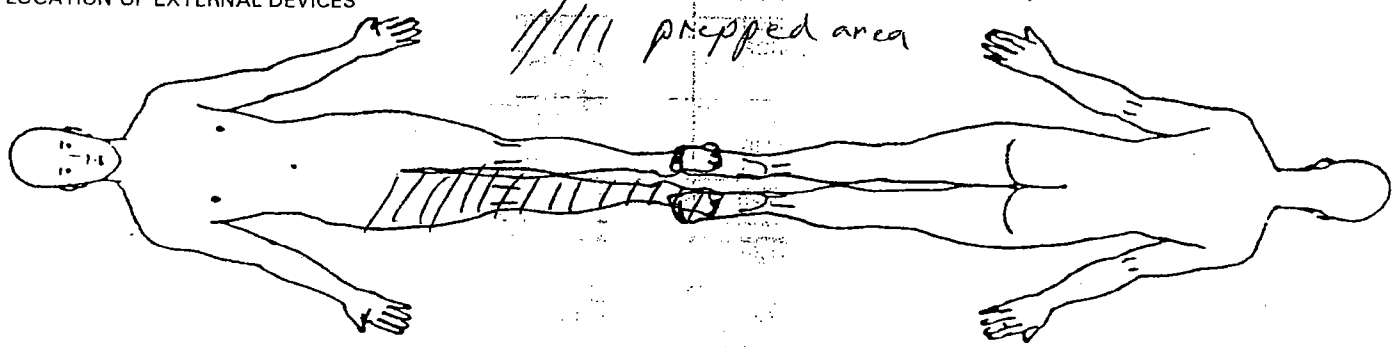
PREP SOLUTION *(Specify)* Betadine scrub & solution

SITE: Rt Leg toes to hip BY WHOM: MAJ [redacted] b(6)-2

SITE: BY WHOM:

COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

10. COUNTS

C = Correct I = Incorrect

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

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

[redacted] b(6)-4

b(2)-2

21 Nov 03 [redacted]

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

☐ ESU NO: _____

GROUND PAD: BRAND _____ LOT NO: _____

☐ ESU NO: _____

GROUND PAD: BRAND _____ LOT NO: _____

☐ BIPOLAR NO: _____

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

13. PROSTHESIS, IMPLANTS ☐ YE .NO IF YES NAME: ID NUMBER; MA: TURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME c) Swabs x2 of Rt thigh	NAME wound
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. Right Thigh	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs, Kerlix, ABD } to Rt hip

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted]

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

Kerlix, Fluffs } Bil LL.

20. OPERATION(S) PERFORMED

I&D of wounds Rt Leg

21. PATIENT TRANSFERRED TO PACU b(6)-2 TIME 1205 See SF512 METHOD OR litter c̄ siderails up

22. [redacted] MAJ AN 21 Nov 03

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

b(6)-2

MEDICAL RECORD

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

1. PATIENT TRANSPORTED TO OPERAT[illegible] VIA Litter BY MAJ [redacted]	2. PATIENT IDENTIF[illegible] VERIFIED BY MAJ [redacted] CORD REVIEWED AND PROCEDURE
3. DATE 23 Nov 03 TIME PATIENT ARRIVED IN SUITE 1042	4. PATIENT IN ROOM TIME 1042 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: ~~Both~~ pt's Rt arm on padded armboard at angle < 90°. Lt arm at side

8. SKIN PREPARATION

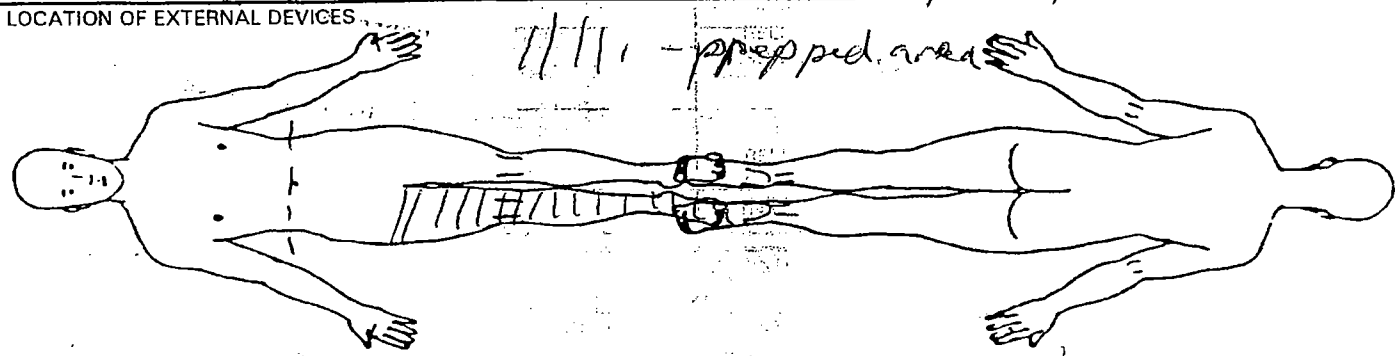
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub & solution
SITE: Rt Leg BY WHOM: MAJ [redacted]
SITE: BY WHOM: b(6)-2

COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

C = Correct I = Incorrect

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

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

[redacted]

b(6)-4

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

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

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

☐ BIPOLAR NO: _____

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

13. PROSTHESIS, IMPLANTS YES ☑ NO IF YES NAME: ID NUMBER CTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 3/8" Penrose	2.	3.
SITE	1. Rt hip	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted]
ones: MAJ [redacted]

b(6)-2

20. OPERATION(S) PERFORMED

I&D Rt leg, Dressing change Lt Lower Leg, Central Line placement

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	See SF517	OR Litter

22. [redacted] MAJ AN 23 Nov 03

REVERSE OF [redacted]

b(6)-2

USAPA V1.00

MEDICAL RECORD — b(6)-2 — **INTRAOPERATIVE DOCUMENT**

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

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

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

3. DATE 25 Nov 03 TIME PATIENT ARRIVED IN SUITE 0827

4. PATIENT IN ROOM TIME 0827 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Pt's arms on padded armboards at angle < 90°

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

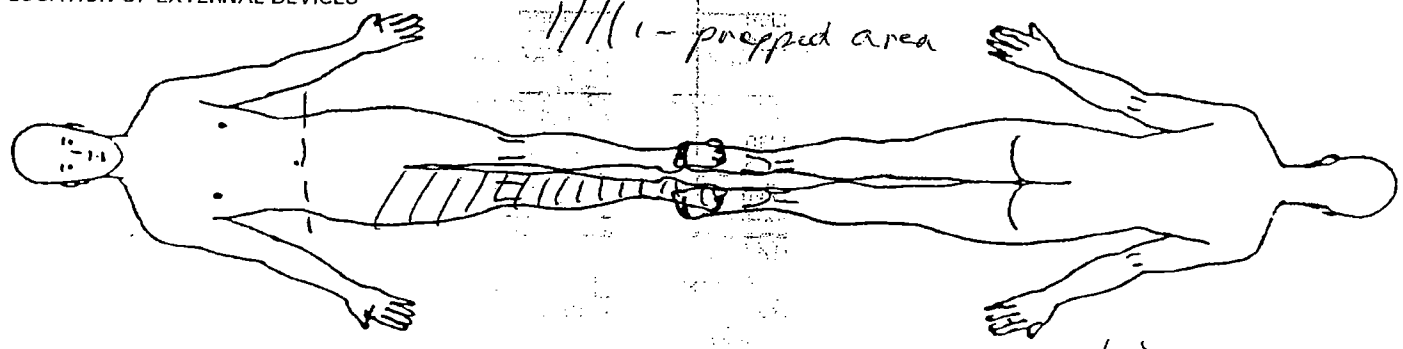
PREP SOLUTION *(Specify)* Betadine scrub & solution

SITE: Rt leg BY WHOM: MAJ [redacted]

SITE: BY WHOM: b(6)-2

COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

10. COUNTS — C = Correct I = Incorrect

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

25 Nov 03 b(2)-2 [redacted]

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

☐ ESU NO: _____

GROUND PAD: BRAND _____ LOT NO: _____

☐ ESU NO: _____

GROUND PAD: BRAND _____ LOT NO: _____

☐ BIPOLAR NO: _____

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs, Kerlix, Ace } to Rt hip, Rt Lower leg, Lt Rt Lower leg

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted]

Anes: CPT [redacted]

b(w)-2-A11

20. OPERATION(S) PERFORMED

I&D wounds Rt Leg - Dressing change Left lower leg

21. PATIENT TRANSFERRED TO PACU TIME See SESTG METHOD OR Litter c sidrails up

22. REGISTERED NURSE SIGNATURE [redacted] MAJAN 25 Nov 03

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.00

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia
2. PATIENT IDENTIFICATION RECORD REVIEWED AND PROCEDURE VERIFIED BY 1LT [redacted] b(6)-2
3. DATE 28 Nov 03 TIME PATIENT ARRIVED IN SUITE
4. PATIENT IN ROOM TIME 1235 NUMBER 2-3 #5

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER (Specify)

COMMENTS: NPO, NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

[X] SUPINE [ ] LITHOTOMY [ ] PRONE [ ] KRASKE LATERAL: [ ] LEFT SIDE UP [ ] RIGHT SIDE UP

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

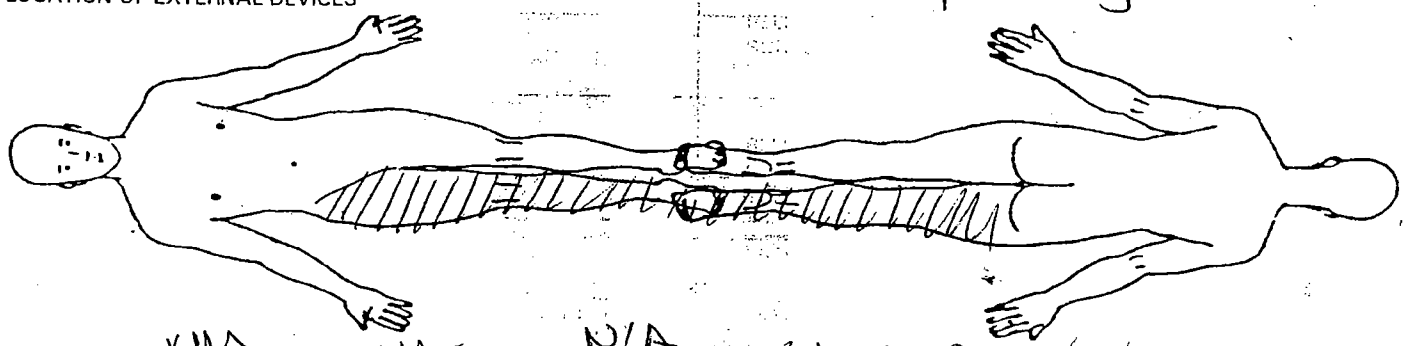
HAIR REMOVAL [ ] YES [X] NO
DONE BY: [ ] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS:

PREP SOLUTION (Specify) Betadine/Betadine
SITE: (R) leg BY WHOM: 1LT [redacted] b(6)-2
SITE: BY WHOM:

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad KW -- Safety Strap KW = = = Tourniquet N/A - prep b(6)-2

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes	[ ] No			C	SGT [redacted]	1LT [redacted]
Needle Sharp	[X] Yes	[ ] No					
Instrument	[ ] Yes	[X] No					
Other	[ ] Yes	[X] No					

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

b(6)-4
[redacted]

[redacted] b(2)-2

12. ELECTROSURGERY DEVICE(S) (ESU) [X] YES [ ] NO

[X] ESU NO: VL Force 40 cut 30 coag 30
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 69441 EXP 2005-03

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

[ ] BIPOLAR NO:

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

MEDCOM - 24008

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl - Q.S

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
thuts
kerlix

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

to (6) - 2 A71

DA5179 in Chart

20. OPERATION(S) PERFORMED
I&D (R) femur

21. PATIENT TRANSFERRED TO PACU TIME See DA7389 METHOD Litter EO2

22. REGISTERED NURSE SIGN [redacted] MA

REVERSE OF DA FORM 5179-1, O[redacted]

USAPA V1.00

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA LITTER BY ANESTHESIA

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

3. DATE 2 DEC 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0855 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER (Specify)

COMMENTS: NKDA, NPO

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] 66E	RELIEF CIRCULATOR INT	

7. POSITION AND POSITIONAL AIDS (Specify) Pt. prone on padded OR table. Pillows under legs. arms flexed on armboards

[ ] SUPINE [ ] LITHOTOMY [X] PRONE [ ] KRASKE LATERAL: [ ] LEFT SIDE UP [ ] RIGHT SIDE UP

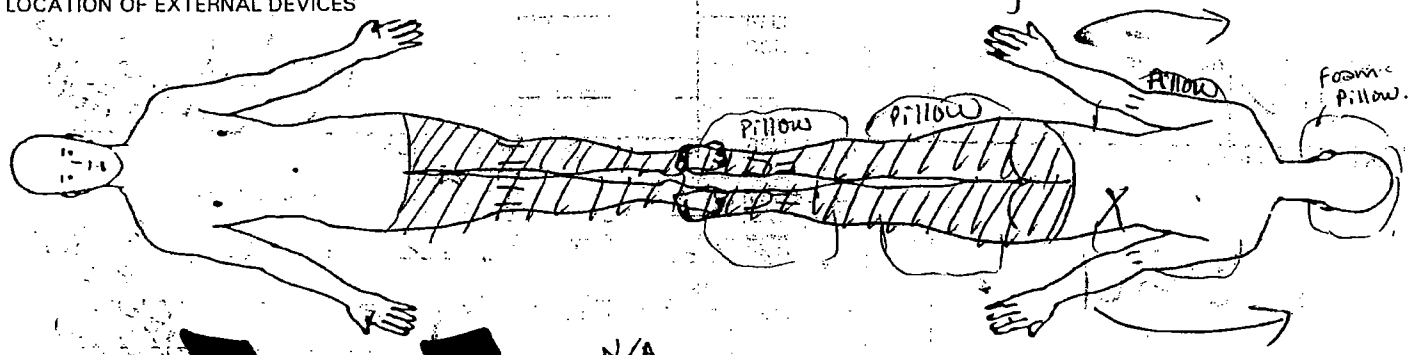
COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION b(6)-2

HAIR REMOVAL [X] YES [X] NO Dr. [redacted]
DONE BY: [X] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [X] RAZOR [ ] CLIP (E) medial thigh
COMMENTS: No nicks or cuts noted

PREP SOLUTION (Specify) Betadine/Betadine [redacted]
SITE: BLE BY WHOM: ILT [redacted]
SITE: BY WHOM: K MAJ [redacted]
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



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

INITIAL: PFC Gesellchen, ILT Malachi

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes	[ ] No			C	PFC [redacted]	ILT [redacted]
Needle Sharp	[X] Yes	[ ] No					
Instrument	[ ] Yes	[X] No					
Other	[ ] Yes	[X] No					

b(6)-2

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

[redacted] b(6)-4

b(2)-2

[redacted]

12. ELECTROSURGERY DEVICE(S) (ESU) [X] YES [ ] NO

[X] ESU NO: VL FORCE 40 CUT 30 COAG 30
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 69441 Exp: 2005-03

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

[ ] BIPOLAR NO:

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

13. PROSTHESIS, IMPLANTS [YES] NO IF YES NAME: ID NUMBER; CTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Tetracaine Opth. Soln. 0.5% LOT 58591 EXP. 2-04	1 gtt	intra-op	Topical	MFR: [redacted]	MAJ [redacted]
Mydriacyl 1% Opth. Soln. LOT 422746 EXP: 2003-08	2 gtts	intra-op	Topical	MFR: [redacted]	MAJ [redacted]
Phenylephrine HCl 2.5% Opth. LOT 365151 EXP. 7-04	2 gtts	intra-op	Topical	MFR: [redacted]	MAJ [redacted]
Mineral Oil LOT 092PW10A EXP Sep 04	Q.S.	intra-op	Topical	MFR: [redacted]	Dr. [redacted]
Bacitracin Oint LOT EXP Jan-06	Q.S	intra-op	Topical	MFR: [redacted]	Dr. [redacted]

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S):

0.9 % NaCl - Q.S.

b(6)-2

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted]		
b(6)-2		

PHYSICIAN'S SI[redacted]

15. X-RAY IN O[redacted] IF YES, SITE

YES [ ] NO [X]

16. LABORATORY SPECIMENS

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

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

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

18. DRESSING/IMMOBILIZATION *(Specify)*

LLE: Xeroform, fluffs, kerlix, webril, splint, ACE

RLE: fluffs, kerlix

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted] Dr [redacted] Dr [redacted]

Anesthesia: MAJ [redacted]

b(6)-2 + 11

DA5179 in chart

20. OPERATION(S) PERFORMED

10 Fr. Dobbhoff Feeding tube placed

STSG

21. PATIENT TRANSFERRED TO PACU | TIME See DA 7389 | METHOD Litter

22. REGISTERED NURSE SIGNATUR[redacted] 17AN

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.00

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

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

3. DATE 6 Dec 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0835 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER (Specify)

COMMENTS: NKDA, NPO

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	ILT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

[X] SUPINE [ ] LITHOTOMY [ ] PRONE [ ] KRASKE LATERAL: [ ] LEFT SIDE UP [ ] RIGHT SIDE UP

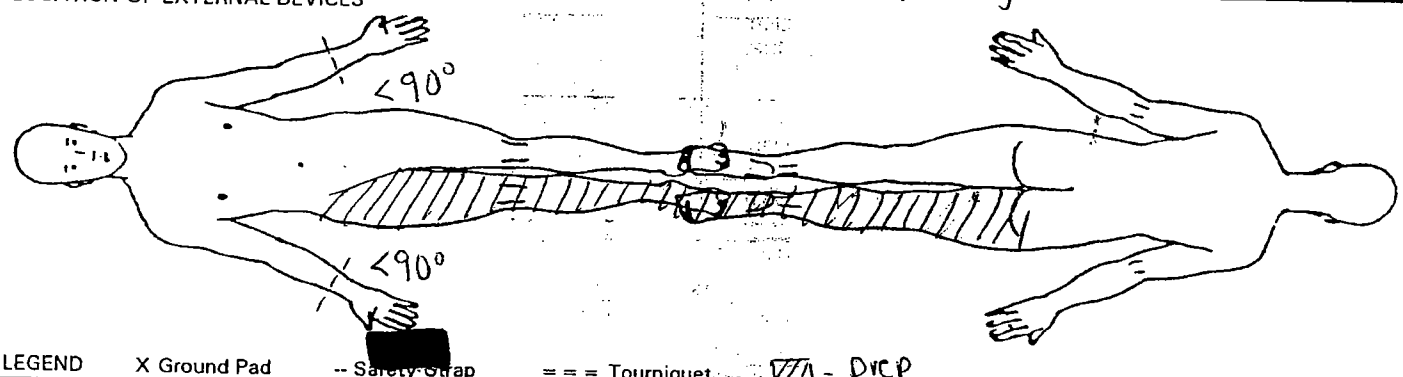
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO
DONE BY: [ ] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP
COMMENTS: N/A

PREP SOLUTION (Specify) Betadine/Betadine
SITE: (R) leg BY WHOM: ILT [redacted]
SITE: BY WHOM: b(6)-2
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



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

Initial: PFC Jones, 1LT Marsch b(6)-2

10. COUNTS

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes	[ ] No					
Needle Sharp	[X] Yes	[ ] No			C	PFC [redacted]	ILT [redacted]
Instrument	[ ] Yes	[X] No					
Other	[ ] Yes	[X] No					

C = Correct I = Incorrect

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 [X] NO

[ ] ESU NO: VL Force 40 CUT: Ø COAG: Ø
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 71516 EXP 2005-06

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

[ ] BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Bacitracin Oint LOT: K038 EXP: NOV-05	Q.S.	Intra-op	Topical	MFR: [redacted]	Dr. [redacted]
					b(6)-2

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl - Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
LLE: Xeroform, fluffs, kerix, Splint, ACE
RLE: ~~xero~~ KM fluffs, Kerlix

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted]
Anesthesia: 1LT Woodard, MAJ [redacted]
GETA
WC: IV
b(6)-2 A11
DA5179 In Chart

20. OPERATION(S) PERFORMED
- Drsg & LLE
- I&D RLE

21. PATIENT TRANSFERRED TO PACU | TIME See DA 7389 | METHOD Litter

22. REGISTERED NURSE SIGNAT[redacted] 17 AN

REVERSE OF DA FORM 5179-1, OCT 8[redacted] MEDCOM - 24013 USAPA V1.00

MEDICAL RECORD

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

1. PATIENT TRANSPORTED TO OPERAT[illegible] [illegible]OOM
VIA Litter BY Anesthesia

2. PATIENT IDENTIF[illegible] [illegible]EVIEWED AND PROCEDURE
VERIFIED BY ILT [redacted] b(6)-2

3. DATE 6 Dec 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0835 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER *(Specify)*

COMMENTS: NKA, NPO

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	ILT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

[X] SUPINE [ ] LITHOTOMY [ ] PRONE [ ] KRASKE LATERAL: [ ] LEFT SIDE UP [ ] RIGHT SIDE UP

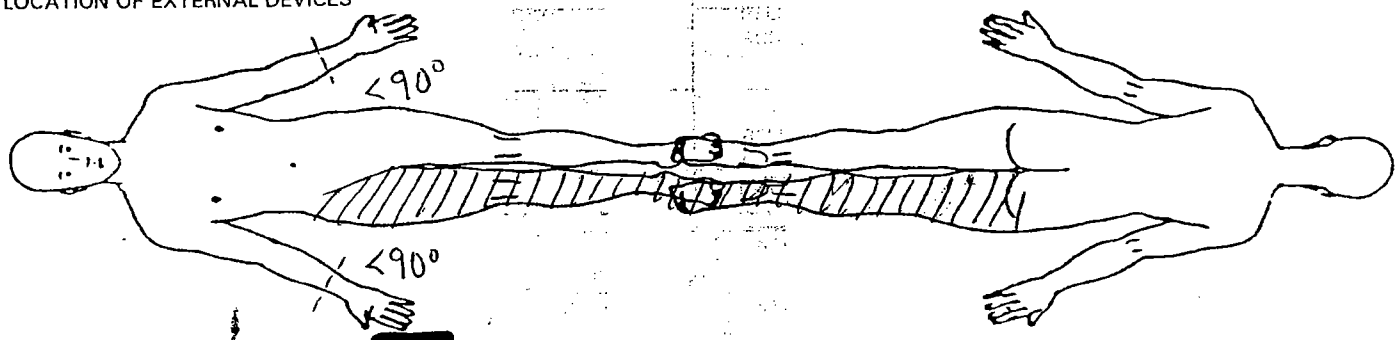
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO
DONE BY: [ ] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [ ] RAZOR
[ ] CLIP
COMMENTS: N/A

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: (R) leg BY WHOM: ILT [redacted] b(6)-2
SITE: BY WHOM:
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap [redacted] = = = Tourniquet - prep

Initial: PFC Jones, 1LT Marocki

C = Correct I = Incorrect

b(6)-2

10. COUNTS

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes	[ ] No			C	PFC [redacted]	ILT [redacted]
Needle Sharp	[X] Yes	[ ] No					
Instrument	[ ] Yes	[X] No					
Other	[ ] Yes	[X] 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 [X] NO

[ ] ESU NO: VL Force 40 CUT: Ø COAG: Ø
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 71516 Exp 2005-020

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

[ ] BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Bacitracin Oint LOT: K038 EXP: NOV-05	Q.S.	Intra-op	Topical	MFR: [redacted]	Dr. [redacted]

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

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

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

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

18. DRESSING/IMMOBILIZATION *(Specify)*
LLE: Xeroform, fluffs, kerlix, Splint, ACE
RLE: [redacted] fluffs, Kerlix

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted]
Anesthesia: 1LT [redacted], MAJ [redacted]
GETA
WC: IV
b(6)-2 A71
DA5179 In Chart

20. OPERATION(S) PERFORMED
- Drsg Δ LLE
- I&D RLE

21. PATIENT TRANSFERRED TO PACU TIME see DA7389 METHOD Litter

22. REGISTERED NURSE SIGNATU [redacted] T/AN

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.00

MEDICAL RECORD	INTRAOPERA[illegible]CUMENT For use of this form, see AR 40-407, the proponent [illegible]ncy 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 ILT [redacted] b(6)-2

3. DATE 10 Dec 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0810 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt. lateral on padded OR table. position supported by bean bag. Pillow between legs and arms.

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

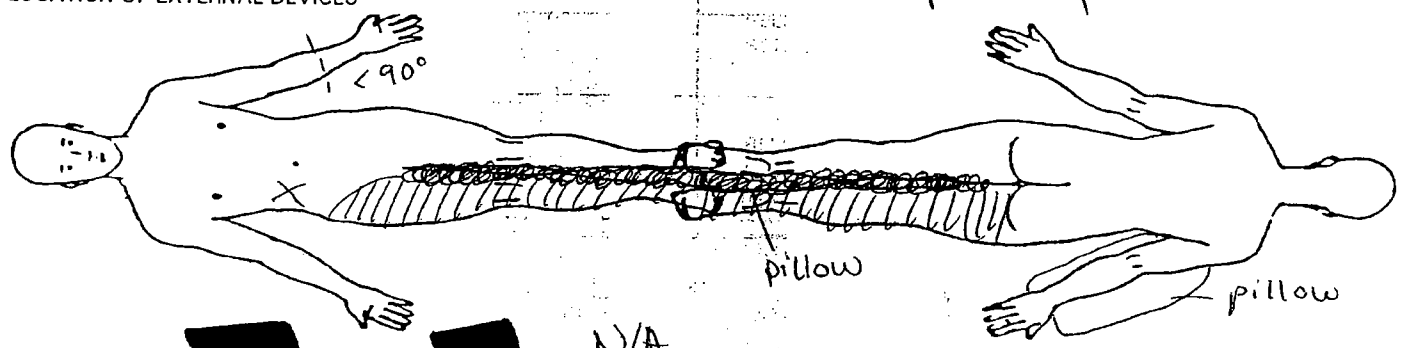
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: Right leg BY WHOM:
SITE: BY WHOM: ILT [redacted] b(6)-2
COMMENTS: No pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Grounded [redacted] -- Safety Strap [redacted] N/A = = = Tourniquet ▨ - prep

Initial: SPC [redacted] ILT b(6)-2

C = Correct I = Incorrect

10. COUNTS

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No				SPC [redacted]	ILT [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: VL Force 40
GROUND PAD: BRAND VL REM PolyHesive II
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ YE[illegible] ☒ NO IF YES NAME: ID NUMBER; MAN[illegible]CTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9 % NaCL - Q.S

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME (1) Wound (R) thigh (C)	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME (2) Wound (R) thigh (Gram stain)	NAME
CULTURE (C) YES ☒ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. #10 J-P drain	2.	3.
SITE	1. (R) thigh wound	2.	3.

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

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted]
Anesthesia: ILT [redacted]
b(6)-2

DA 5179 In Chart

20. OPERATION(S) PERFORMED
I&D RLE wounds
Dressing Δ LLE

21. PATIENT TRANSFERRED TO PACU | TIME See DA 7389 | METHOD Litter

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

REVERSE OF DA FORM 5179-1, OCT 87

MEDCOM - 24017

USAPA V1.00

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

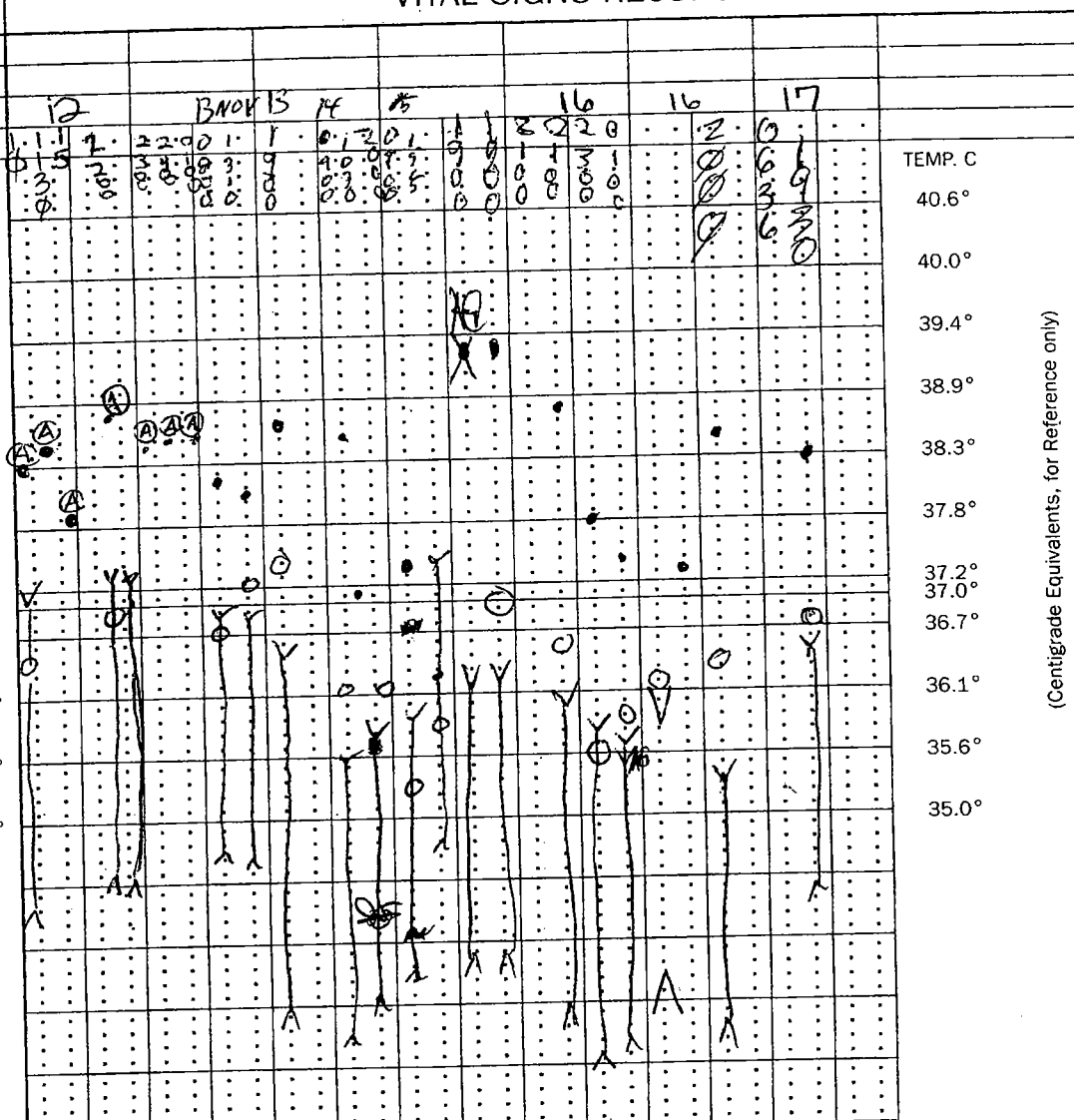
POST-OP DAY

MONTH-YEAR Nov 2003

DAY: 12, 13 Nov, 14, 15, 16, 16, 17

HOUR

PULSE (O) / TEMP. F (•) / TEMP. C



RESPIRATION RECORD

BLOOD PRESSURE

121/70 | 131/81 | 116/60 | 104/61 | 111/68 | 108/60 | 104/52 | 103/54 | 95/57 | 97/53

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

MEDICAL

VITAL SIGNS RECORDS

Medical Record

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

CAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

DAY: Nov

DAY: 18 | 19 | 20 | 21 | 21 | 22 | 22 | 23 | 24

HOUR: 0 1 0 1 0 1 2 0800 1200 1 0800 1 1 1

TEMP. F (°): 96 99 97 99 98 100 100 99 99 99 99 99 99 99 99

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

(Centigrade Equivalents, for Reference only)

180 170 160 150 140 130 120 110 100 90 80 70 60 50 40

RESPIRATION RECORD: 18 | 16 | 18 | 19/85 | 16 | 18 | 16 | 18 | 16

BLOOD PRESSURE: 118/72 | 112/72 | 104/79 | 114/62 | 105 | 106/77 | 127/71 | 122/84 | 101/60 | 101/57 | 100/62 | 99/61 | 108/69

99 | 97.5 | 99.1 | 114 | 99 | 104/63

98.6 | 108 | 101.4 | 99.2 | T 98.2 | T 98.8 | 101.5 | T 99.1 | 99.8 | 99.6 | 101.7

HEIGHT: | WEIGHT → 98.6 | 99% | 100% | 99 | 100% | 99% | 100 | 100.4

RA | 98% RA | RA | RA | 99% RA | RA | 99% RA | 99% RA | 99% RA

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

STANDARD FORM 511 (REV. 7-95) BACK

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOV 19 | DAY: 25, 26, 27, 28, 29, 30, 01 DEC | HOUR

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

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°

180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

RESPIRATION RECORD

BLOOD PRESSURE

	25	26	27	28	29	30	01 DEC
	102/64	123/70	113/74	114/80	122/81	108/69	115/78	104/68	119/78	115/77
	99.4	97.1				98.6				
	103	104.1	99.6	99.1	118/78	114/74	112			
HEIGHT: WEIGHT →										
LA	100%	99%	99% RA	99% RA	100% (RA)	99% (CA) 99% RA	99%	99% RA	100% (CA)	100% RA
	110/72			100% RA						
	98%									

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted]

b/(a) - 4

NSN 7540-00-634-4124

.DICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DEC DAY 02 3DEC 4DEC 5 1

2002003 HOUR 13 0 7 0 7 0

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

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

RESPIRATION RECORD: 20 18 16 18

BLOOD PRESSURE: 134/81 118/69 116 115/79 99.6 116

HEIGHT: WEIGHT →

O2 Sat: 99% 99% 99% 99% 99% 99%

RA RA RA RA

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Dec 03 DAY 5 6 7 8 9 10 11

19 HOUR

PULSE (0) | 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: 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. 1W2

[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 Dec DAY 12 14 15 16 17

19 63 HOUR

PULSE (0) — 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° / 98.6°	37.2° / 37.0°
98°	36.7°
97°	36.1°
96°	35.6°
95°	35.0°

PULSE (0): 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

HEIGHT: WEIGHT →

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

REGISTER NO.

WARD NO. 1CW2

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 Dec/03 DAY 18 19 20

19 HOUR

PULSE (0) TEMP. F (°)

PULSE (0)	TEMP. F (°)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

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. 1CW2

VITAL SIGNS RECORDS

Medical Record

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

C[redacted]

1CW2-4

OUTPUT

URINE						~~NASOGASTRIC~~ JP			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
							8cc	BRIGHT RED	8cc
						18-06	8cc	serosanguinous fluid	16cc
								24° =	16cc

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

STOOLS					OTHER OUTPUT			
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
					GRAND TOTAL OUTPUT			

REMARKS

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

[redacted]

b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

MEDCOM - 24025

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

JP drain ~~NASOGASTRIC~~ 11 Dec

TIME	AMOUNT	TYPE	ACCUM TOTAL
1415	10cc	clear, bloody, bright red drainage	10cc
0500	15cc	red bloody, clots	25cc
	24 hr total	25cc	

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted]

b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

-c03 06-06

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

~~NASOGASTRIC~~ JP

TIME	AMOUNT	TYPE	ACCUM TOTAL
0600-1400	7cc	RED & THIN	7cc
1400-2200	10cc	Red	17cc
2200-0600	0cc	———	17cc

24° total
17cc
12-13 Dec

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

C[redacted]

b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

13D 3 06-06 24°

OUTPUT

URINE						~~NASOGASTRIC~~ JP			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
2037	620	620				06-8	5cc	THIN RED	5cc

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

STOOLS				
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT			
TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

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

CIV [redacted]

b(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

b(6)-2

Ward/Section: ENT | REQUI[redacted] | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRS[redacted] b(6)-4 | DATE 12NW | TIME 07W | [redacted] SSN: b(6)-4

(Hematology) CBC

	RANGE
W	
R	
H	
H	
P	

ID: [redacted]
WB 12-11-03 07:07

			Patient Limits	
WBC	15.7 H	x10^3/uL	4.5	10.5
RBC	3.71 L	x10^6/uL	4.00	6.00
Hgb	10.8 L	g/dL	11.0	18.0
Hct	33.6 L	%	35.0	60.0
MCV	91.0	fL	80.0	99.9
MCH	29.1	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	252.	x10^3/uL	150.	450.
LYM	21.2 *	%	20.5	51.1
LYM	3.3 *	x10^3/uL	1.2	3.4

Urinalysis

TEST	RESULT	REF. RANGE
Color	Straw	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.005	N/A
Bld	Trace	Negative
pH	5.0	N/A
Prot	Neg	Negative
Urob	Neg	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	Negative
HCG		Negative

======= PICCOLO =======
12/11/03 07:17 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: 777 DR #: 000
SERIAL #: 0000100684

GLU	128*	73-118	MG/DL
BUN	11	7-22	MG/DL
CA++	7.6*	8.0-10.3	MG/DL
CRE	0.8	0.6-1.2	MG/DL
NA+	139	128-145	MMOL/L
K+	4.8*	3.3-4.7	MMOL/L
CL-	110*	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

WBC - 1-4
RBC - 0-2

Spun Hematocrit		37-47% (F)	CSF		Blood Bank
Sed Rate			Cell Count		MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED
Other			Directigen	Negative	

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

HEMATOLOGY
URGENCY: [X] ROUTINE [ ] TODAY [ ] PRE-OP [ ] STAT
PATIENT STATUS: [X] BED [ ] AMB [ ] OUTPATIENT [ ] NP [ ] DOM
SPECIMEN SOURCE: [X] VEIN [ ] CAP [ ] OTHER (Specify)
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD
POS
BLOOD
CROSSMATCH

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQU[redacted]'S SIGNATURE | REPORTED BY | MD | DATE 15Nov03 | LAB. ID. NO.
[redacted] b(6)-2 | TECH

TEST(S) | SPECIMEN TAKEN | DATE 15Nov03 | TIME 0555 A.M. P.M.

SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	PT CONTROL	PT PATIENT	PTT CONTROL	PTT PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP

549-107
HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

MEDCOM - 24029

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

LAST, FIRST, MI.	DATE 13 Nov	TIME 0500	SSN/PSEUDO SSN # [redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
W			Color		N/A	RPR		Negative
R			App		N/A	Mono		Negative
E			Glu		Negative	**Microbiology**		
E			Bili		Negative	Source		
R			Ket		Negative	Gram Stain		
Pl			SG		N/A	Occ Bld		Negative
L			Bld		Negative	H. pylori		Negative
			pH		N/A	Micro Parasites		
S			Prot		Negative	Malaria		
B			Urob		0.2-1.0	O & P		
L			Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			

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

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

REMARKS:

REPORTED BY: [redacted]	DATE: 13NOV03	LAB ID NO.:

b(6)-2

IBN-SINA HOSPITAL
28th Combat Support Hospital
Baghdad, Iraq

1290
1289

Microbiology Request Form

Last Name #[redacted] b(6)-4
First Name:
Patient # or SSN:
Collected by: Dr [redacted] b(6)-2
Date: 21 Nov 03
Time: 1145

Ward: CR / ICW 7
Room:
Bed:
Physician: [redacted] b(6)-2
Source: Wound
Site: Rt thigh

[redacted]

Received by [redacted] b(6)-2
Date: 21 Nov 03
Time: 12-00

Specimen #: 1N139

Laboratory Results

[redacted] Oxytoca
b(6)-2

Reported
Date: 23 Nov 03
Time: 1000
Tech: [illegible]
Reviewer: [redacted] b(6)-2

Number of attached sheets:

MEDCOM - 24031

Microbiology Report

[redacted] b(2)-2

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

Specimen: W139
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1 Klebsiella oxytoca Status: Final

1 K. oxytoca

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

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

NR = Not Reported
-- = Not Tested
TFG = Trimethoprim-sulfamethoxazole strains

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

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

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

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (I8=S, 8-16=I, >16=R). Footnote (c) applies to this drug
(c) For streptococci refer to penicillin interpretations. For amox/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 break-points are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints
For S. pneumoniae cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections use <2=S, 2=I, >2=R

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

Specimen: W139
Source: Wound/Sterile site
Ward of Iso:

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

Printed 11/23/2003 9:48:35 AM

MEDCOM - 24032

[redacted] b(2)-2

Microbiology Request Form

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

Collected by: [redacted]
Date: 21 Nov 03
Time: 1145

Ward: OR / ICW 7
Room:
Bed:
Physician [redacted] b(6)-2

Source: Wound
Site: Rt thigh

[redacted]

Received by [redacted] b(6)-2
Date: 21 NOV 03
Time: 1200

Specimen #: W139

Laboratory Results

Klebsiella oxytoca

Reported
Date: 23 Nov 03
Time: 1000
Tech: [redacted]
Reviewer: [redacted] b(6)-2

Number of attached sheets:

MEDCOM - 24033

Microbiology Report

[redacted] b(2)-2

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

Specimen: **W139**
Source: Wound/Sterile site
Ward of Iso:

Status: **Final**
Collected:
Attd. Phys:

1 Klebsiella oxytoca Status: Final

1 K. oxytoca

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

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

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

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

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

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

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

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

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

Specimen: **W139**
Source: Wound/Sterile site
Ward of Iso:

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

Tech: Ed

[redacted] b(2)-2

#2 Gram Stai

Microbiology Request Form

Last Name [redacted]
First Name: b(6)-4
Patient # or SSN: [redacted]
Collected by: Dr. [redacted] b(6)-2
Date: 10 Dec 03
Time: 0900

Ward: ICW2 (OR)
Room:
Bed:
Physician: DR. OLIVERIO
Source: Wound
Site: (R) thigh

[redacted]

Received by: [redacted] b(6)-2
Date: 10 Dec 03
Time: 1000

Specimen #: 4174

Laboratory Results

GPC / Gram positive cocci

Reported
Date:
Time:
Tech:
Reviewer:

Number of attached sheets:

MEDCOM - 24035

[redacted] b(2)-2

#1 - Cultr

Microbiology Request Form

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

Collected by: Dr. [redacted]
Date: 10 Dec 03
Time: 0900

Ward: ICW-2 (OR)
Room:
Bed:
Physician: Dr. OLIVERIO

Source: wound
Site: (R) Thigh

[redacted]

Received b[redacted] b(6)-2
Date: 10 Dec 03
Time: 1000

Specimen #: W174

Laboratory Results

1) Klebsiella pneumoniae
2) Staphylococcus haemolyticus
3) Staphylococcus auricularis

Reported
Date: 13 Dec 03
Time: 1117
Tech: rgv
Reviewer: [redacted] b(6)-2

Number of attached sheets:

MEDCOM - 24036

Microbiology Report

[redacted] b(2)-2

Name:	[redacted]	Specimen:	W174	Status:	Final
Patient ID:		Source:	Wound/Sterile site	Collected:	
Ward/Rm:	W1/	Ward of Iso		Attd. Phys:	

1 K. pneumoniae

Drug	MIC	Interps
Tobramycin	>8	R
Trimeth/Sulfa	>2/38	R

2 S. haemolyticus

Drug	MIC	Interps

3 S. auricularis

Drug	MIC	Interps
Amox/K Clav (c)	<=4/2	R
Amp/Sulbactam (c)	<=8/4	R
Ampicillin	2	BLAC
Azithromycin	>4	R
Cefazolin	<=8	R
Cefepime	<=8	R
Cefotaxime (c)	<=8	R
Ceftriaxone (c)	<=8	R
Cephalothin	<=8	R
Chloramphenicol	16	I
Ciprofloxacin	>2	R
Clindamycin	>2	R
Erythromycin	4	I
Gatifloxacin	<=2	S
Gentamicin	>8	R
Imipenem (c)	<=4	R
Levofloxacin	4	I
Linezolid	<=2	S
Moxifloxacin	<=2	S
Nitrofurantoin	>64	
Norfloxacin	>8	
Ofloxacin	4	I
Oxacillin	>2	R
Penicillin	>8	BLAC
Rifampin	>2	R
Synercid	<=1	S
Tetracycline	>8	R
Trimeth/Sulfa	>2/38	R
Vancomycin	<=2	S

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

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

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

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

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

a. Use maximum doses of drug with an extended dosing interval for P. aeruginosa in patients with normal pharmacokinetics or serious infections
b. Breakpoints based on parenteral dose. For pseudomonas urine: [illegible] use [illegible] = [illegible] I=[illegible] R. Footnote (a) applies to this drug
c. For streptococci refer to penicillin interpretations. For amoxicillin/clavulanate, ampicillin/sulbactam, and 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, 8=I, >=8=R

Name:		Specimen:	W174	Status:	Final b(4)-2
Patient ID:	[redacted]	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	W1/ b(4)-4	Ward of Iso:		Req. Phys:	[redacted]

Microbiology Report

[redacted] b(2)-2

Name:
Patient ID: [redacted]
Ward/Rm: W1/ b(2)-2

Specimen: W174
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1	Klebsiella pneumoniae	Status: Final
2	Staphylococcus haemolyticus	Status: Final
3	Staphylococcus auricularis	Status: Final

1 K. pneumoniae

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

2 S. haemolyticus

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

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

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

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

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

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

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci refer to the penicillin interpretation
(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. Spectinomycin 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]
Ward/Rm: W1/ b(6)-4

Specimen: W174
Source: Wound/Sterile site
Ward of Iso:

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

Printed 12/13/2003 11:13:56 AM

Tech. [redacted]

b(6)-4

Ward/Section: KW 1	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 14NOV	TIME 0500	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	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		
Atyp		Imm	Leuk		Negative	Microscopic Urinalysis		
RBC Morph			HCG		Negative			

[redacted]

14-11-03
04:40
Patient
Limits

WBC	9.6	x10^3/uL	4.5	10.1
RBC	2.17 L	x10^6/uL	4.00	6.00
Hgb	6.5 L	g/dL	11.0	18.0
Hct	19.5 L	%	35.0	60.0
MCV	90.0	fL	80.0	99.9
MCH	29.8	pg	27.0	31.0
MCHC	33.1	g/dL	33.0	37.0
Plt	182.	x10^3/uL	150.	450.
Lym	21.5 *	%	20.5	51.1
Lym	2.1 *	x10^3/uL	1.2	3.4

M
Pl
Ly
Se
Ba
Ly

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

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-2

Ward/Section: ICW1	REQUEST [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE 16 NOV 03 / TIME 0530	SSN/PSEUDO SSN [redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC			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	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:

REPORTED BY: [redacted]	DATE: 16NOV03	LAB ID NO.:

b(6)-2