33 yo ♂ NKDA

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 33 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

ASA Physical State 1 2 3 4 5 E
WT: 50 KG/LB HT: ___ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: I&D (R) leg
SURGICAL SERVICE: ortho/[redacted] (b)(6)-2
NPO SINCE: MID

HABITS:
TOBACCO: + cigarettes attach
ETOH: + Qn/occ
DRUGS: denies Drug Use

CURRENT MEDICATIONS:
( ) = ordered as premed

() Ancef - last dose 6am
() Toradol
() Ativan
() Thiamine
()
()

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

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

5 | 11 | 302
35

136/104/7
3.9/19/0.5 95

PT 12.4 PTT 31.6
INR 1.03

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	N Y	
Angina	N Y	
MI	N Y	
CVA	N Y	
Other	N Y	
Pulmonary System:		
Asthma	N Y	
Bronchitis/URI	N Y	
COPD	N Y	
Other	N Y	
Renal System:		
Acute/Chronic RF	N Y	
Gastrointestinal:		
Hepatitis	N Y	
Hiatal Hernia	N Y	
PUD/GERD	N Y	
Endocrine System:		
Diabetes	N Y	
Steriods	N Y	
Thyroid	N Y	
Neurological:		
Seizures	N Y	
Neuropathy	N Y	
Other	N Y	
Gynecological :		
Pregnancy	N Y	N/A
Other Significant Hx:		
	N Y	EPW s/p mine blast
	N Y	(R) arm dangling c open
Familial HX	N Y	Tib/Fib injury (L) leg (10 wks ago) (R) Prox tibia c exposed black bone

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Sx on Arm stumps p mine blast

PHYSICAL EXAMINATION
BP 152/63 HR 70 R ___ T 98 100 HO
Pain Scale 0-10 1
HEENT - Teeth Intact
Trachea Midline
TMJ/Neck
Oropharnyx MP II-III
Nares
CHEST: CTA
CARDIAC:
EXTREMITIES:
IV Access (L) 18g EJ
Ulnar Filling:
BACK:
OTHER:
NPO Since MID

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ___ (X) General: Mask Intubation
Pt counseled via Interpreter

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

The patient [redacted] ems to understand and agrees. Questions answered.
Signed: [redacted] CPT/RNA (b)(6)-2 Date: 26 Sep 03 Time: 1045 Hrs

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

Signed: ___ Date: ___ Time: ___ Hrs

Patient Identification: (Ward) ICW #1

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

SEDATION KEY:

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

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

Previous edition is obsolete

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS	DRUG	(Units)	
CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "I" = CONSTANT INFUSION	Fentanyl	(mcg)	250
	Midazolam	(mg)	100
	Propofol	(mg)	110
	Rocuronium	(mg)	40 10
		( )	
		( )	
	VOLAT AGENT Iso	% del	0.1–0.6–0.6–0.6 X
		% e.t.	
	AIR	L/Min	
	N2O	L/Min	
	O2	L/Min	10–2–2–2–10
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS			

FLUIDS	LINE site		
	(C) EJ	☐ Warmed	
		☐ Warmed	LR (300)
		☐ Warmed	(500+)
		☐ Warmed	

LOSSES		
	EST BLOOD LOSS	
	URINE–	(Not measured)

TOTALS	
256	
TOTAL URINE	
Not measured	

FLUIDS - SUMMARY
CRYSTALLOID– 300cc
COLLOID– Ø
BLOOD– Ø

REMARKS-
Code drugs with numbers, events with letters
1200 Pt rec'd in ICW 1, Chart reviewed. To OR via litter
1215 In room. Monitors (+) oxygen. Smooth IV induction, easy ventilation, PP padded, eyes taped. Burgundy (R) HHP.
1245 Procedure started.
1315 Reversed c̄ Sug Neostig (+) O.K. by Robbins.
1316 Pt awake, follows, extubated s̄ difficulty, To PACU stable report to RN

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT 50 (KG) LB

HEMATOCRIT: 41/35

INITIAL DATA: BP – 117/73 HR– 78

EQUIP CHECK OK?– (Y) N

PATIENT VERIFICATION OK for PROCED[redacted] TIME– 1200

SYMBOLS: BP by cuff (V ^); Heart rate (●); Resp rate; BP (transduced) (⊥ T); TOURNIQUET T – ✓ (b)(6)-2; ANES– X-X; PROC– ⊙–Ø

TIME 1215 30 45 1300 15 30

VENTILATION						
	VT – ml	600	590	550	560	400
	f – breaths/min	16	9	3	12	16
	Peak inf'pres / PEEP	–	16	17	15	–
	MODE– S(pon), A(ssist), C(on)	S	C	C	C	S

MONITORS / ACCESSORIES						
X BP/Auto Cuff	X ET CO2 (torr)	(+)	31	32	36	36
BP / oth	X FIO2 (Frac or %)	.55	.57	.59	.59	.59
ART line	X SpO2 (%)	100	100	100	100	100
Steth- PC/ES	X ECG	SR	SR	SR	SR	SR
Gas analyzer	X TEMP- site Skin	98	98	97	97	
	X N-M Block (T/4)			2/4	1/4	4/4 ESTE50
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS

EVENTS Position → OR → → →

RECOVERY AT 1320
PACU ICU _____ (Specify)
OTHER _____
CONDITION: Stable/awake
RESP– 20 SpO2– 98%
BP– 101/71 HR– 107

ANES	Start	Room	End
	1200	1215	1325
PROC	Ready	Begin	End
	1222	1245	1315

PROCEDURES and CPT Codes
I&D (B) legs

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Blade #7 ETT. Grade I view, (+) BBS (+) ETCO2. secured @ 23cm teeth, oral airway [illegible]

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

[redacted] (b)(6)-4

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

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

PROCEDURE LOCATION OR 2

DATE 26 Sep 03

PAGE 1 OF 1

OP 376 REVISED 1 Jan 99

PATIENT RECORD

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: [redacted] (b)(6)-4 [redacted] (b)(6)-2 1300 Room

DATE OF ORDER: 18 Oct 03 TIME OF ORDER: 1150 HOURS

LIST TIME ORDER NOTED AND SIGN

~~Order~~ Cancel

1. Resume previous orders
2. Regular diet
3. Keep lock IV
4. Resume antibiotics
5. VSL to low continuous suction

NURSING UNIT	ROOM NO.	BED NO.
24°	2315	180703

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

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

NURSING UNIT	ROOM NO.	BED NO.
DCWT		

PATIENT IDENTIFICATION: [redacted] (b)(6)-4 Not [redacted] (b)(6)-2

DATE OF ORDER: 10/20/03 TIME OF ORDER: 2013 HOURS

Add Dilaudid & C Sy PO BID 1st dose now

[redacted] (b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
24°	2100	210703 [redacted]

PATIENT IDENTIFICATION: (b)(6)-2 (b)(6)-4 # [redacted] noted & done.

DATE OF ORDER: d/c TIME OF ORDER: 21 OCT @ 1530 HOURS

Suprapubic catheter

VO Dr [redacted] (b)(6)-2 / Spc [redacted] (b)(6)-2

NURSING UNIT	ROOM NO.
(b)(6)-2	[redacted]

21 Oct @ 1530

24° V 2300d @ 0046 [redacted] (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

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

NURSING UNIT: ICW#1 | ROOM NO.: [redacted] | BED NO.: [redacted]

DATE OF ORDER: 26 SEP 03 | TIME OF ORDER: 1310 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. Regular diet
3. IV - D5 ½ NS 100 cc/Hr, hep lock when taking po's well.
4. NPO after midnight 27 SEP 03 for surgery 28 SEP [redacted]

(b)(6)-2

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

DATE OF ORDER | TIME OF ORDER

(b)(6)-2 [redacted]

1. Change previous Ativan to Ativan 1mg IV or PO q12°

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 28 SEP 03 | TIME OF ORDER: @ 0100 HOURS

1. Place Foley
V.O. DR [redacted]

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

NURSING UNIT: 2W / 28 Sep @ 0202 | ROOM NO. | BED NO. [redacted]

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW	9/29/03	24°N

DATE OF ORDER: 28 SEPT 03 TIME OF ORDER: 0430 HOURS

LIST TIME ORDER NOTED AND SIGN

1. REGULAR DIET
2. NPO after MIDNIGHT, ID OR TOMORROW

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

[redacted] (b)(6)-2 [redacted] mb 0 (b)(6)-2 Stop ID

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 1 OCT 03 TIME OF ORDER: 1015 HOURS

1. RESUME PRESENT ORDERS
2. REGULAR DIET
3. CLEAR ENSURE TID
4. N-LR at 125cc/hr, HEP LOCK WITH FLUSHES P.O. WELL
5. VAC DEVICE ON (R) LEG TO LOW CONTINUOUS SUCTION
6. NPO after MIDNIGHT 3 OCT 03, FOR OR 4 OCT 03

PATIENT IDENTIFICATION

(b)(6)-2 [redacted] Noted 1 OCT 03 1145

NURSING UNIT	ROOM NO.	BED NO.
24°V	1 OCT 03	2100

(b)(6)-2 [redacted] 1 OCT/AN

(b)(6)-2 [redacted] IV Pt OR Tomorrow

PATIENT IDENTIFICATION

(b)(6)-2 [redacted] 02OCT 1200

NURSING UNIT	ROOM NO.	BED NO.
24/0020	3 OCT 03	[redacted]

DATE OF ORDER: TIME OF ORDER: HOURS

1. D/C Thiamine
2. MVI qD PO
3. Δ Ativan to 0.5mg PO or IV x 3 days then 0.5mg PO or IV Q12° x 3 days then 0.5mg PO or IV qHS x 3 days then stop

98°

[redacted] (b)(6)-2

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

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

29 Sep 03 1800 [redacted] W/A

NURSING UNIT | ROOM NO. (b)(6)-2 | BED NO.

DATE OF ORDER 29 SEPT 03 TIME OF ORDER 1715 HOURS

LIST TIME ORDER NOTED AND SIGN

1. RESUME PRIOR DIET
2. RESUME DIET
3. WD LOWC IV WITH FLUSH PICC WK
4. SUPPLEMENTAL FUNCTIONS TO CLEARITY
5. NOT TO HAVE PRESSURE CLEANING TO (R) FIBIA BID.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER [redacted]

6. NPO after midnight 30 September for OR 1 October

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

24D / 29 Sep 03 | 1800 [redacted] W/A

PATIENT IDENTIFICATION

(b)(6)-2

DATE OF ORDER TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

DATE OF ORDER TIME OF ORDER _____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

MEDICAL RECORD - DOCTOR'S ORDERS

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

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS 9.29.03 1725	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen. [redacted] (b)(6)-2		
3	Morphine / ~~Meperidine~~ ~~2-5 mg IV~~ now and 2.5 mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
4	Zofran____ mg IV prn N/V q 15 min, may repeat x ____.		
5	Metoclopramide____ mg IV prn N/V x 1.		
6	Droperidol____ mg IV prn N/V x 1.		
7	Phenergan 12.5 mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF:_____@_____cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	THANKS		
	(b)(6)-2 [redacted] MC CRNA		

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU [redacted]			1 of 1

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

(b)(2)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
		[redacted]

DATE OF ORDER 25 SEPT 03 TIME OF ORDER 1440 HOURS

LIST TIME ORDER NOTED AND SIGN

1. ADMIT TO ICW-1
2. DX: OPEN (R) TIBIA, MULTIPLE FRACTURES
3. CONDITION - STABLE
4. VS: ROUTINE
5. OOB TO CHAIR TID.
6. NPO AFTER MIDNIGHT

PATIENT IDENTIFICATION

[redacted]

(b)(6)-2

1738 25 Sep 03

DATE OF ORDER TIME OF ORDER HOURS

7. REGULAR DIET.
8. IV: HEP LOCK
9. ANCEF 1 GRAM IVPB Q 8 HRS
10. TYLENOL 650 mg P.O. Q 4 HRS PRN
11. TYLENOL #3, 1-2 P.O. Q 4-6 HRS PRN
12. [redacted] ~~25 mg P.O. OR IV Q 6 HRS PRN~~
13. TORADOL 30 mg IVP Q 6 HRS X 24 HRS
14. TO OR IN AM.

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

15. ATIVAN 1 mg IVP Q 8 HRS HOLD IF LETHARGIC.
16.

(b)(6)-2

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

DATE OF ORDER TIME OF ORDER HOURS

(b)(6)-2 [redacted]

Ranitidine 150 mg IV or PO QD

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
ICW 29	041[redacted]	

[redacted] (b)(6)-2

(b)(6)-2

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

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
29 SEPT 83 1711	Orthro Op Note Pre-Op Dx: Infected (R) tibia Post-Op Dx: Same Procedure: I+D (R) tibia Surgeon: [redacted] (b)(6)-2 Specimen: culture swab (R) tibia Findings: Left tibia open injury of tibia has necrotic tissue pus in wound. Cleaned with 3L pulse lavage Plan: B/D wet to dry dressings. Repeat I+D 48 hours (b)(6)-2 [redacted]

ELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

SPONSOR'S ID NUMBER (SSN or Other)

EPART./SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 4 OCT 03 TIME OF ORDER: 1015 HOURS

LIST TIME ORDER NOTED AND SIGN

1. RESUSCITATE PRIMARY ORDERS
2. DK ALREADY
3. BEGIN: LANOXIN 500 mcg IVPB Q 6 HRS
4. 20 SYN 3.375 Gm IVPB Q 6 HRS
5. RESTRICT DIET WITH ICW ENSURE/MEALS
6. N-ZA AT 125 cc/HR DO NOT LOCK WITH

PATIENT IDENTIFICATION

(b)(6)-2 [redacted] Noted 04OCT03 1125

DATE OF ORDER: TIME OF ORDER: HOURS

FURTHER D.O. WORK

7. VAC DRAIN TO LOW CONTINUOUS SUCTION.

(b)(6)-2 [redacted]

NURSING UNIT: ICW | ROOM NO.: 24 | BED NO.: 5 OCT @ 0130 [redacted]

PATIENT IDENTIFICATION

(b)(6)-2

DATE OF ORDER: 04OCT03 TIME OF ORDER: 1630 HOURS

May d/c cont. suction @ hs

NPO p MN for SX 07OCT03

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

NURSING UNIT: ICW | ROOM NO.: 030 | BED NO.: 700B [redacted]

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

PATIENT IDENTIFICATION

DATE OF ORDER: 9 OCT 03 TIME OF ORDER: 1950 HOURS

1. NPO after midnight, PSA on 10 mg morphine

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2 [redacted]

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

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
4 OCT 03 1013	Orthro Op Note Pre-Op Dx - Infected open (R) tibia Post Op Dx - Same Procedure: I+D (R) tibia, apply VAC dressing Surgeon: [redacted] (b)(6)-2 Findings - Purulent exudate, but good granulation tissue. Culture results from 25 SEPT 03: ① Proteus penneri - resistant to all except Aminoglycosides, Moxifloxacin and Gatifloxacin, and intermediate to Levofloxacin. ② Pseudomonas aeruginosa - sensitive to all except Levofloxacin SOO-no IV Q 8 hours, Zosyn 3.375 gm IV Q 6 hours Plan: repeat I+D in 72 hours (b)(6)-2 [redacted] (b)(6)-2 [redacted] CDR MC

RELATIONSHIP TO SPONSOR

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

BRANCH/SERVICE

HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

USAPA V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 7 OCT 03 TIME OF ORDER: 1326 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders.
2. Hep lock IV.
3. VBL to have continuous aspiration may clamp at bedtime if turn off suction
4. Regular diet.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT: ICW 1 | ROOM NO.: 2A | BED NO.: 1

DATE OF ORDER: 10 OCT 03 TIME OF ORDER: 1200 HOURS (b)(6)-2

1. Resume previous orders
2. Hep lock IV.
3. VBL to have continuous aspiration
4. Regular diet.

Noted [redacted] 10/10/03 1400 (b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER [redacted] HOURS

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28 Oct 03 1523	Other Ops Note Pre-Op Dx: Infertility (N) tubal Post-Op Dx - same Procedure: ~~Surgeon~~ I+O (N) tubal ligation, ~~n~~ application of VBL device Surgeon: [redacted] (b)(6)-2 EBL: min Fluids: LR Findings: bandelting walls [redacted] (b)(6)-2

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

MEDICAL RECORD - DOCTOR'S ORDERS

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

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
1Oct03 0950	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen. (PRN SaO_2 < 95%)		
3	Morphine / Meperidine 2 mg IV now and 2 mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
4	~~Zofran~~ ____ mg IV prn N/V q 15 min, may repeat x ____.		
5	Metoclopramide 10 mg IV prn N/V x 1.		
6	~~Droperidol~~ ____ mg IV prn N/V x 1.		
7	Phenergan 25 mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF: LR @ TKO cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
11	Demerol 12.5 mg IV x 2 max dose 25 mg PRN for post-op [redacted] (b)(6)-2 CRNA/MAJ		
	[redacted] (b)(6)-2 [redacted]		

PATIENT IDENTIFICATION

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

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU [redacted]			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE (b)(2)-2 MC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 OCT 03	Ortho Op - Note
	Pre-Op Dx - Open (R) tibia fracture
	Post-Op Dx - same
	Procedure - I+D, replace VAC (R) tibia,
	Surgeon - [redacted] (b)(6)-2
	Cont - MW
	Findings - Wound clean Gangrenous tissue over 60% of tibia
	Plan - Repeat I+D with eventually need skin flap.
	(b)(6)-2 [redacted]

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

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

[redacted] (b)(6)-4

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

(b)(6)-2 [redacted]

NURSING UNIT: 24° | ROOM NO.: 15 OCT 03 | BED NO.: [redacted]

DATE OF ORDER: 15 OCT 03 | TIME OF ORDER: 1100 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. Regular diet
3. Keep lock IV
4. VAC to low continuous suction

(b)(6)-2 [redacted]

15 OCT @ 1815

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 16 OCT 03 | TIME OF ORDER: 2200 HOURS

1. RESTORIL 15mg po QHS PRN.

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

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

(b)(6)-2 [redacted]

NURSING UNIT: 24° 0100 | ROOM NO.: 17 OCT 03 | BED NO.: (b)(6)-2 [redacted]

DATE OF ORDER: 16 OCT 03 | TIME OF ORDER: 2245 HOURS

1. RESTORIL 30 mg PO QHS PRN

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 17 OCT 03 | TIME OF ORDER: 1600 HOURS

1. NPO PMN + To OR Tomorrow

[redacted]

(b)(6)-2

NURSING UNIT: 24° / 18 OCT 03 0100 | ROOM NO. | BED NO.: (b)(6)-2 [redacted]

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

MEDICAL RECORD - DOCTOR'S ORDERS

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

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS 10/15/03 1147	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen.		
3	Morphine / ~~Meperidine~~ ~~2-4 mg IV~~ now and 2 mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
4	Zofran_____mg IV prn N/V q 15 min, may repeat x _____.		
5	Metoclopramide_____mg IV prn N/V x 1.		
6	Droperidol_____mg IV prn N/V x 1.		
7	Phenergan 12.5 mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF:_____@_____cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] (b)(6)-2		
	[redacted] (b)(6)-2		

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU [redacted]			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE (b)(2)-2 MC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Ortho Op Note
15 Oct 03	
1140	Pre-Op Dx - Infected (R) tibia,
	Post Op Dx: Same
	Procedure: I+D (R) tibia, change V+C
	Findings - Wound very clean, bleeding red granulation tissue over 75% of bone.
	Plan: Repeat I+D prepare for STSG
	(b)(6)-2 [redacted]

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

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

[redacted] (b)(6)-4

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

Well 1730 [redacted]

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
24° /	18 OCT 03	0200 [redacted]

DATE OF ORDER: 17 Oct — TIME OF ORDER: 1730 HOURS — LIST TIME ORDER NOTED AND SIGN

(1) Hold IV ABT

V.O Dr [redacted] [redacted] 2LT N

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

(b)(6)-2

PATIENT IDENTIFICATION

Well 19 Oct 1600 [redacted]

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
24° ✓	20 OCT @	0200 [redacted] 2LT AN

DATE OF ORDER: 19 OCT 03 — TIME OF ORDER: 1600 HOURS

Hold 8mg q6° prn IVP

V.O. Dr. [redacted] [redacted] AN

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

(b)(6)-2 [redacted]

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

Well 23 Oct 1700 [redacted]

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
7EW	24° ✓	[redacted] 2LT AN 24 OCT 03 @ 0500

DATE OF ORDER: 23 OCT 03 — TIME OF ORDER: 1547 HOURS

(1) 2mg after midnight

to Dr tomorrow

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2

24° ✓ [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 24 OCT 03 — TIME OF ORDER: HOURS

VO- U/A

25 OCT @ 0049

(b)(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
18 Oct 03	Outline Op Note
1150	
	Pre-Op Dx: Infected (R) tibia
	Post Op Dx: Same
	Procedure: I&D (R) tibia
	Surgeon: [redacted] (b)(6)-2
	Findings: Wound granulating,
	Plan: Repeat I&D, wait until
	ready for STSG.
	[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 - DOCTOR'S ORDE.

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

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
18 Oct 03 1300	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen.		
3	Morphine / Meperidine 3 mg IV now and 2 mg q 3-5 min prn pain for a		
	max dose of 15 mg.		
4	Zofran 4 mg IV prn N/V q 15 min, may repeat x _____.		
5	Metoclopramide_____mg IV prn N/V x 1.		
6	Droperidol_____mg IV prn N/V x 1.		
7	Phenergan_____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF:_____@_____cc/hr.		
10	Discharge [redacted] status when PACU discharge criteria met.		
	[redacted] CPT CRNA		
	(b)(6)-2		

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU [redacted]			1 of 1

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

(b)(2)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 24 OCT 03 TIME OF ORDER: 1125 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. N-LR at 100 cc/hr, HOB LOWR WHEN TOLERATE P.O. WATER
3. RESUME DIET
4. GBC, MORPHINE-8 IV q.m.
5. UBZ to LOW CONTINUOUS SUCTION

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 31 OCT 03 TIME OF ORDER: 1415 HOURS

1. Resume previous orders
2. Regular diet
3. OOB to chair TID
4. GBC IV q.m.

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: (b)(6)-2 [redacted] TIME OF ORDER: _____ HOURS

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
24 Aug 03 1125	Ortho Op Note
	Pre-Op Dx - Open (R) tibia,
	Post Op Dx - Same
	Procedure: I&D (R) tibia
	Surgeon: [redacted] (b)(6)-2
	ASA - IV
	Findings - Recovered both sure bone.
	Still 1x3 cm area exposed bone
	Plan: Wet dressing VAC x 3-4 days.
	(b)(6)-2 [redacted]
31 Aug 03 1430	Ortho Op Note
	Pre-Op Dx - Open (R) tibia
	Post Op Dx - Same
	Procedure: STSG from (R) thigh to (R) calf
	Surgeon: [redacted] (b)(6)-2
	ASA - IV

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Findings - 3 Foreign entrances flags worth.
	SPSC from Thefts to staff.
	Plan: Pursuing applicant. Will
	check in Sodapi.
	(b)(6)-2 [redacted]
	(b)(6)-2 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 1405 TIME OF ORDER: 25 OCT 03 HOURS

LIST TIME ORDER NOTED AND SIGNED

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

(1) Lopressimide 4mg X1 now then 2mg after every stool for total of 8 mg after initial

(2) Stool culture [redacted] 25 OCT 03 1430

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

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

(b)(6)-2 [redacted] noted 26 OCT 03 (1510)

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 26 OCT 03 TIME OF ORDER: 1500 HOURS

(1) Foley to gravity

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

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

NURSING UNIT	ROOM NO.	BED NO.
24°/0100	29 OCT 03	[redacted]

DATE OF ORDER: 28 OCT 03 TIME OF ORDER: 1950 HOURS

(1) Benadryl 25mg IV/PO/IM q6° PRN ITCH

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

PATIENT IDENTIFICATION

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

NURSING UNIT	ROOM NO.	BED NO.
24°/ [redacted]	1630 29 OCT	

DATE OF ORDER: 29 OCT 03 TIME OF ORDER: 1420 HOURS

(1) Resume previous orders

(2) Regular diet

(3) IV - keep lock when taking PO well

(4) Reinforce dressing prn

(5) NPO after midnight 30 OCT for surgery 31 OCT.

[redacted]

(b)(6)-2

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

(b)(6)-2

MEDICAL RECORD - DOCTOR'S ORDER

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

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
29 Oct 03 / 400	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen. PRN SaO_2 <95%		
3	Morphine / Meperidine 2 mg IV now and 2 mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
X 4	Zofran____mg IV prn N/V q 15 min, may repeat x ____.		
5	Metoclopramide 10 mg IV prn N/V x 1.		
X 6	Droperidol____mg IV prn N/V x 1.		
X 7	Phenergan____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF: LR @ TKO cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] CRNA/MAJ		
	(b)(6)-2 [redacted]		
	(b)(6)-2		

PATIENT IDENTIFICATION

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

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU, [redacted]			1 of 1

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

(b)(2)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] Noted

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW#1	noted	

DATE OF ORDER	TIME OF ORDER ____ HOURS	LIST TIME ORDER NOTED AND SIGN
3NOV03 @ 1930 (b)(6)-2		
VO Dr [redacted] / LT [redacted]		(b)(6)-2
25mg Benadryl IV x1 now		
3NOV03 @ 2240 (b)(6)-2		
VO Dr [redacted] / LT [redacted]		(b)(6)-2
25mg Atarax PO Q6° PRN		

PATIENT IDENTIFICATION

24° [redacted] (b)(6)-2

[redacted] (b)(6)-4

noted

(b)(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
(b)(6)-2	[redacted]	3NOV03

DATE OF ORDER	TIME OF ORDER ____ HOURS	
~~24/0400 4NOV03~~	0100	
5 NOV 03	1820	
① Tram 25mg Form Tab	tid	
Warm daily		
② Ambulate as tolerated.		
③ Ambien 5mg PO. @ HS PRN		
(b)(6)-2		

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

noted

(b)(6)-2 [redacted]

6NOV03 @1600

NURSING UNIT	ROOM NO.	BED NO.
ICW 1		[redacted]

DATE OF ORDER	TIME OF ORDER ____ HOURS	
6NOV03	1600	[redacted]
① daily drsg Δ (R) leg		
apply bacitracin, fluffs		
and wrap c Kerlix.		
(b)(6)-2		
VO DR [redacted] / SPC		(b)(6)-2
24°/0230 @NOV03 [redacted]		[redacted]

PATIENT IDENTIFICATION (b)(6)-2

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW#1		

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT: (b)(6)-2 | ROOM NO. [redacted]

↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	11 NOV 03	0910 HOURS	
1	DISCHARGE TODAY. TO EPW CORP.		
2	LEVOFLOXACIN 250mg P.O. Q DAY. #30		
3	PREDNISONE 1-2 P.O Q 4-6 HRS PRN #20		
4	ACETAMINOPHEN SUPPOSITORY TID WEEKS EVERY DAY.		
5	PLEASE PROVIDE THERAPIX WORKS W/(b) PATIENT DISPOSAL.		
6	FOLLOW-UP 1 WEEK	[redacted] HOURS	

(b)(6)-2

11 NOV 03 0950

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	
	HOURS	

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

MEDICAL RECORD | **PROGRESS NOTES**

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
	Author Discharge Note, [redacted] (b)(2)-2
11 NOV 03	33 Y.O. IRAQI MALE 25 SEP 03, who had been injured at least 10 weeks prior by bomb blast, 18 cm open wound over (R) tibial tubercle with exposed, shock bone. Also (B) upper extremity amputation and skin graft (L) leg.
	Found to have chronic infection over tibia with multiple organisms. IV antibiotics, and multiple I+Ds but unable to get wound to close over bone. Had fascio-cutaneous flap placed over tibia, followed by split-thickness skin graft. Pt is doing well.
	PLAN: LEVOFLOXACIN 250mg P.O. Q DAY #30
	DRESSING CHANGES TO (R) LEG SKIN GRAFT Q DAY WITH BACITRACIN OINTMENT.
	FOLLOW UP IN 1 WEEK.
	PENICILLIN 1.2 MU. Q4-6 HRS PRN [redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

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

.EDICAL RECORD - DOCTOR'S ORDER.

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

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen.	(b)(b)-2	(b)(b)-2
3	Morphine / Meperidine 3 mg IV now and 2 mg q 3-5 min prn pain for a	1330 [redacted]	[redacted]
	max dose of 15 mg.		
4	Zofran 4 mg IV prn N/V q 15 min, may repeat x _____.		
5	Metoclopramide_____mg IV prn N/V x 1.		
6	Droperidol_____mg IV prn N/V x 1.		
7	Phenergan_____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF:_____@_____cc/hr.		
10	Dischar[redacted]status when PACU discharge criteria met.		
	[redacted] CPT CAWA (b)(b)-2		
	[redacted] (b)(b)-2		

PATIENT IDENTIFICATION

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

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU[redacted]			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE (b)(2)-2 MC V1.00

EDICAL RECORD - DOCTOR'S ORDER

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

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen. to keep sat 95%		
3	Morphine / Meperidine 2 mg IV now and 1-2 mg q 3-5 min prn pain for a		
	max dose of 10 mg.		
4	~~Zofran ____ mg IV prn N/V q 15 min, may repeat x ____~~.		
5	Metoclopramide 10 mg IV prn N/V x 1.		
6	~~Droperidol ____ mg IV prn N/V~~ x 1.		
7	~~Phenergan ____ mg IV prn N/V~~ x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF: LR @ TKO cc/hr.		
10	Dis[redacted] recovery status when PACU discharge criteria met.		
	[redacted] CRNA		
	(b)(6)-2		

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU [redacted]			1 of 1

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

(b)(2)-2

.EDICAL RECORD - DOCTOR'S ORDER.

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

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen.		
3	Morphine / Meperidine 2 mg IV now and 2 mg q 3-5 min prn pain for a		
	max dose of 15 mg.		
4	Zofran 4 mg IV prn N/V q 15 min, may repeat x ____.		
5	Metoclopramide____mg IV prn N/V x 1.		
6	Droperidol____mg IV prn N/V x 1.		
7	Phenergan____mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF:_____@_____cc/hr.		
10	Disch[redacted]ery status when PACU discharge criteria met.		
	[redacted] CPT / CKNurse (b)(6)-2		
	[redacted] (b)(6)-2		

PATIENT IDENTIFICATION

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

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU[redacted]			1 of 1

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

(b)(2)-2

★ RE-WRITTEN ★

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

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 22	23	24	25	26	27	28	29	30	31	1	2	3	4
25Sept (b)(6)-2	[redacted]	VS Routine	06	[redacted]													
			12														
			18														
			06														
25Spt (b)(6)-2	[redacted]	OOB TC TID	06														
			12														
			18														
			06														
25Spt (b)(6)-2	[redacted]	Regular Diet	06														
			12														
			18														
			06														
1OCT03 (b)(6)-2	[redacted]	I can ensure TID	06														
			12														
			17														
1OCT (b)(6)-2	[redacted]	Vac device on (R) Lg to low continuous suction (may d/c suction @ HS)	06														
			18														
			18														
			16														
																	D/C
25 OCT (b)(6)-2	[redacted]	CL DSG Δ's Q72°	22														
26OCT (b)(6)-2	[redacted]	NTO (HL'd) foley to gravity (b)(6)-2	06														
		reinforce drsg ([redacted])	18														

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (P) tibia, multiple amputations

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: ___

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
25	[redacted]	Admit ICW #1; condition stable	25	—	—	[redacted]
25	[redacted]	NPO after MN; To OR in AM	26 SEP03	0001	—	[redacted]
26 SEP03	[redacted]	Resume previous orders	26	—	—	[redacted]
26	[redacted]	NPO p MN 27SEP03 for surgery 28SEP03	28 SEP03	0001		
28	[redacted]	Place Foley	28 Sep			
9/28	[redacted]	NPO p MN	29 Sep	2400	—	[redacted]
9/28	[redacted]	To OR tomorrow	29 Sep			
9/29	[redacted]	Resume previous orders (post-op)	29 Sep03	—	—	[redacted]
28 SEP03	[redacted]	NPO p MN 30 Sep for OR 1 Oct	1 OCT	0001		[redacted]
01 OCT03	[redacted]	Resume previous orders	01 OCT03	—	—	[redacted]
01	[redacted]	NPO after MN 03OCT03 for OR 04OCT03	04 OCT03	0001	—	[redacted]
04 OCT03	[redacted]	Resume previous orders	04	—	—	[redacted]
06 OCT03	[redacted]	May d/c suction 2) ns	06 OCT03	2000	2200	[redacted]
06 OCT03	[redacted]	NPO p MN for sx 07OCT03	07 OCT03	0001	0001	[redacted]
		(b)(6)-2 all				

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

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

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

Mo. 09 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27	28	29	30	31	2	3	4	5	6	7	8
25 (b)(6)-2	[redacted]	VS - routine	06	/	[redacted]										[redacted]		
			18	[redacted]													
25 (b)(6)-2	[redacted]	OOB TC TID	06	/	[redacted]										[redacted]		
			18	[redacted]													
25 (b)(6)-2	[redacted]	Regular Diet	06	/	[redacted]										[redacted]		
			18	[redacted]													
29 Sep 03 (b)(6)-2	[redacted]	Suprapubic tube to gravity	06	—	—	/	/	/	[redacted]						[redacted]		
			18	—	—	/	/	[redacted]									
29 Sep 03 (b)(6)-2	[redacted]	W→D Dsg Δ to (R) tibia BID	10	—	—	/	/	[redacted]							[redacted]		
			20	—	—	/	[redacted]										
Ø1 Oct Ø3 (b)(6)-2	[redacted]	1 can ensure TID	06	/	/	/	/	/	/	[redacted]					[redacted]		
			12	/	/	/	/	/	/	[redacted]					[redacted]		
			17	/	/	/	/	/	/	[redacted]							
Ø1 (b)(6)-2	[redacted]	Vac device on (R) leg to low continuous suction (may D/C sxn @ HS)	06	/	/	/	/	/	/	[redacted]					[redacted]		
			18	/	/	/	/	/	/	[redacted]							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open (R) tibia; multiple amputations

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

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

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

(b)(6)-2

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

REWRITTEN

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	08	09	10	11	12	13				
25Sep	[redacted]	VS: routine	6	[redacted]												
(b)(6)-2			18	[redacted]												
25Sep	[redacted]	OOBTC TID	6	[redacted]												
(b)(6)-2			18	[redacted]												
25Sep	[redacted]	Regular diet	6	[redacted]												
(10CT)	(b)(6)-2	c̄ canensure TID	18	[redacted]												
(b)(6)-2 25OCT	[redacted]	CL drsg Δ Q 72°	22	X	X		X	X		X	X		X	X		
26OCT	[redacted]	Foley to gravity	6	[redacted]												
(b)(6)-2			18	[redacted]					DC 07NOV03							
5NOV	[redacted]	TRIM xeroform	10	[redacted]						DC 10NOV03						
(b)(6)-2		from thigh wound	X													
S		daily	X													
5NOV	[redacted]	ambulate as	06	[redacted]												
(b)(6)-2		tolerated	18	[redacted]												
6NOV	[redacted]	drsg Δ daily (R) leg	10	[redacted]												
(b)(6)-2		& apply bactracin,	X													
		fluffs and wrap	X													
		c̄ Kerlix.														

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open (R) tibia, mult. amputations

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

CLINICAL RECORD

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

Mo. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2	3	4	5	6	7	8	9	10	11	12	13	14	15
10CT03	[redacted]	IV LR @125cc/hr, HL	6	X	[redacted]												
(b)(6)-2	------	when taking po	18	X	[redacted]												
	------	well	X														
25SEPT	[redacted]	Ancef 1gm IVPB	6	X	[redacted]												
(b)(6)-2	------		14	X	[redacted]												
(b)(6)-2	------		22	X	[redacted]												
20CT	[redacted]	MVI po QD	10	X	[redacted]			[redacted]									
20CT	[redacted]	ATIVAN taper:															
(b)(6)-2	------	0.5mg IV/PO Q8° x 3D	6		[redacted]												
	------	then	14		[redacted]												
	------	↓	22		[redacted]												
	------	0.5mg PO/IV Q12° x 3D	10					[redacted]									
	------	then	22					[redacted]									
	------	0.5mg po/IV QHS x 3D	22								[redacted]						
	------	then stop!															
04 OCT03	[redacted]	Levaquin 500mg IVPB	06														
(b)(6)-2	------	q 6°	12														
	------		18														
	------		24														
04	[redacted]	Zosyn 3.375gm IVPB	04					[redacted]									
(b)(6)-2	------	q 6°	10					[redacted]									
	------		16					[redacted]									
	------		22					[redacted]									
04	[redacted]	Levaquin 500mg IVPB	10					[redacted]									
(b)(6)-2	(b)(6)-2	po Daily															
15 OCT03	[redacted]	Heplock IV: flush q	06														[redacted]
	(b)(6)-2	shift	18														
			06														[redacted]

DC

ERROR

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open (R) tibia, mult. amputations

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. 10 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
04 OCT 03	[redacted]	DIC Ancef	04 OCT 03	—	—	[redacted]	(b)(6)-2
10/10	[redacted]	Heplock IV	10/10				

(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
25	[redacted]	Tylenol 650mg po Q4° prn	D/T	9OCT 650mg 0730	10OCT 1215	11OCT 1620	11OCT 1400	13OCT								
			D/1	1720 D6	[redacted]											
25	[redacted]	Tylenol #3 1-2 tabs po Q4-6° prn	D/T	3OCT 1500	4OCT 1940	5OCT 1935	6OCT 831	8OCT 1400	9OCT 1000	10OCT 1750	12OCT 1100	12OCT 1220	13OCT 0020	14OCT 2145	15OCT 0200	15OCT 1530
			D/1	[redacted]										2	2	2

(b)(6)-2

USAPA V1.00

CLINICAL RECORD

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

Mo. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

	ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 01	02												
b)(b)-2	01 OCT03	[redacted]	IV LR @125cc/hr, HL	06	[redacted]													
			when taking po well	18	[redacted]													
b)(b)-2	25 SEP03	[redacted]	Ancef 1 gm IVPB	06	[redacted]													
				14	[redacted]													
				22	[redacted]													
b)(b)-2	25 SEP03	[redacted]	Thiamine 100mg IV	10	[redacted]													
			or PO qD															
b)(b)-2	27 SEP03	[redacted]	Ativan 1mg IV or PO	10	[redacted]													
			q12°	22	[redacted]													
b)(b)-2	OCT	[redacted]	MVI qD PO	10														
(b)(b)-2	OR OCT	[redacted]	Ativan tab 0.5 mg PO	06														
			or IV q8° x 3 days	14														
			then 0.5 mg PO or	22														
			IV q12° x 3 days															
			then 0.5 mg PO or	10														
			IV qHS x 3 days	22														
			then stop															
				22														

(b)(b)-2

reviewed

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open @ tibia, multiple amputation

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 10 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
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	- - - - -					
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	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
b)(6)-2 ~~31OCT03~~ 28SEP03	[redacted]	Tylenol 650mg po 94° pm	D/I	20CT 1000												
- - - - -	- - - - -		D/I	[redacted]												
28SEP03	[redacted]	Tylenol #3 1-2 tabs po 946° pm	D/I	20CT 1850	10CT 1853	10CT 2330										
b)(6)-2 - - - - -	- - - - -		D/I	[redacted]												
- - - - -	- - - - -															
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(b)(6)-2

USAPA V1.00

CLINICAL RECORD

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

Mo. 09 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25	26	27	28	29	30	01	02	03	04	05	06
25 Sept (b)(6)-2	[redacted]	IV heplock	06	/ [redacted]											
			18	[redacted]											
25 Sept (b)(6)-2	[redacted]	Ancef 1gm IVPB	06	[redacted]											
			14	/ [redacted]											
			22	[redacted]											
25 Sept (b)(6)-2	[redacted]	Tonadol 30mg IVP q6hrs x24 hrs	06	/ [redacted]											
			12	/ [redacted]											
			18	[redacted]											
			24	[redacted]											
25 Sept (b)(6)-2	[redacted]	Ativan 1mg IVP q8hrs – HOLD if Lethargic	06	/ [redacted]											
			14	/ [redacted]											
			22	[redacted]											
25 Sept (b)(6)-2	[redacted]	Thiamine 100mg IV or PO qD	10	/ [redacted]											
26 SEP 03 (b)(6)-2	[redacted]	LRD 100cc/hr (HL when taking po well) ~~Ativan~~ [redacted] (b)(6)-2	06	/ [redacted]											
			18	/ [redacted]											
27 SEP 03 (b)(6)-2	[redacted]	Ativan 1mg IV or PO q 12°	10	/ / [redacted]											
			22	/ / [redacted]											
28 Sept (b)(6)-2	[redacted]	HL IV when tol PO well	06	—											
			18	—				/ [redacted]							

DIC 26 SEP 03

DIC 26 SEP 03

see Δ below

DIC 01 OCT 03

(See above)

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: open @ tibia, multi amputations

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. 09 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
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Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
25Sep	[redacted]	Tylenol 650mg	D/T	25Sep 1710	27Sep 1130												
- - - - -	- - - - -	PO q4hrs PRN	D/I	650	650mg	[redacted]											
25Sep	[redacted]	Tylenol #3 PRN	D/T	25Sep 1900	26Sep 2200	27Sep 0300	28Sep 2020	28Sep 1830	28Sep 0530	29Sep 1600	30Sep 0000						
- - - - -		1-2 tabs PO q4-6hrs	D/I	2	1	1	1	1	1	1	2						
- - - - -	- - - - -	/ / /	E/I	E	[redacted]												
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b)(6)-2

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USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED														
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ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHA 'ED.

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
(b)(6)-2 3NOV	[redacted]	Atarax 25mg PO Q6° prn	3NOV 2300	4NOV 0500		4NOV 1100	4NOV 2130	5NOV 0945	5NOV 1745	6NOV 0000	6NOV 1600	6NOV 2330	7NOV 0700	7NOV 1500	7NOV 2130
			[redacted]			25mg	20mg	25mg	25mg	25mg	25mg	25mg	25	25mg	25mg
(b)(6)-2 5NOV	[redacted]	Ambien 5mg PO QHS PRN	D/T	5NOV 2145	6NOV 2330	7NOV 2300	8NOV 2115	10NOV 2100							
			D/T	5mg	5mg	5mg	5mg	5mg							
			E/I	[redacted]											
(b)(6)-2 2NOV	[redacted]	Atarax 25mg PO Q6° prn	D/T	2NOV 2230	2NOV 1815	2NOV 2115	9NOV 0730	9NOV 1410	9NOV 2000	10NOV 0500	10NOV 1230	10NOV 1435	11NOV 0110	11NOV 0700	
			D/T	25mg	25mg	25mg	25mg	25mg	25mg	25mg	25mg	25mg	25mg	25mg	
			[redacted]												
		~~Loperamide 4 20mg PO p q stool for total~~													
25OCT (b)(6)-2	[redacted]	Loperamide 2mg PO PD q stool for total 8 mg after initial	D/T												
			D/I												

(b)(6)-2

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 16	17	18	19	20	21	22	23	24	25	26	27	28	29
04 OCT 03	- [redacted]	Zosyn 3.375 gm IVPB	04	[redacted]													
(b)(6)-2	-----	q6°	10	[redacted]													
	-----		16	[redacted]													
	-----		22	[redacted]													
04	- [redacted]	Levaquin 500mg IVPB	10	[redacted]													
(b)(6)-2	-----	daily															
15 OCT 03	[redacted]	Heplock IV: flush q	06 18	[redacted]													
(b)(6)-2	-----	shift	18 06	[redacted]													
02 OCT 03	- [redacted]	mvi po QD	10	[redacted]													
30 OCT	[redacted] -	Ditropan XL 5mg po	08	/	/	/	/	/	[redacted]								
(b)(6)-2	-----	BID	20	/	/	/	/		[redacted]								
	-----																
25 OCT	- [redacted]	Lopressor 2mg PO	6	/									25 OCT				
(b)(6)-2	-----	after every vital	18	/									9 1480		(H)	(H)	
	-----	for total 8mg															

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: OPEN @ TIBIA MULTIPLE AMPUTATIONS

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. _____

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

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 10 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
(b)(6)-2 7 Oct	[redacted]	Hold IV ABT	17 Oct	NOW	1720	[redacted] (b)(6)-2
(b)(6)-2 16	[redacted]	Heplock IV, assume antibiotics	18 OCT			[redacted] (b)(6)-2
(b)(6)-2 25	[redacted]	Kapvinab 2mg x1 IVW	25 OCT	1430	1431	[redacted] (b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
25 Sept 03	[redacted]	Tylenol 650mg po q 4° pm	D/T	16 Oct 0726	23 Oct 1930	24 Oct 0100	24 Oct 1000									
			D/I	[redacted]	ii	2	650									
25 Sept 03	[redacted]	Tylenol #3 1-2 tabs PO q 4-6° pm (b)(6)-2	D/T	16 Oct 0726	16 Oct 1150	16 Oct 1740	16 Oct 2200	17 Oct 1030	17 Oct 2230	18 Oct 1300	18 Oct 2000	19 Oct 0800	20 Oct 2245	21 Oct 0740	21 Oct 2030	22 Oct 0426
			D/I	ii	ii	ii	#po	[redacted]	#po	ii	#po	ii po	#po	2	2	2
16 Oct	[redacted]	RESTORIL [redacted] po QHS PRN 30mg	D/T	16 Oct 2230		20 Oct 2245										
			D/I	#po		#po										
19 Oct 03	[redacted]	Haldol 5mg IVP q6° pm	D/T	19 Oct 1600	20 Oct 0900	20 Oct 1900	23 Oct 1600									
			D/I	5mg	5mg	5mg										
25 Sept	[redacted]	Rewritten Tylenol #3 1-2 tabs	D/T	22 Oct 1930	25 Oct 0000	[illegible]	26 1600	2080								
		PO Q4-6° PRN	D/I	ii	[redacted]	2	2									
25	[redacted]	Benadryl 25mg N/PO/IM q6° PRN	D/T	25 Oct 2245	19 Oct 1080	20 Oct 1700										
			D/I	IV	PO	[redacted]										

(b)(6)-2

MEDCOM - 20486

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

30CT63C

RE-WRITTEN

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr.

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30	31	1	2	3	4	5	6	7	8	9	10	11
04OCT	[redacted]	Zosyn 3.375 gm IVPB	04	[redacted]												
(b)(6)-2	-----	q 6°	10	[redacted]												
	-----		16	[redacted]												
	-----		22	[redacted]												

04OCT	[redacted]	Levaquin 500mg IVPB	10	[redacted]												
(b)(6)-2	-----	daily														

15OCT	[redacted]	Heplock IV: Flush q	06 18	[redacted]												
(b)(6)-2	-----	shift	18 06	[redacted]												

02OCT	[redacted]	MVI PO QD	10	[redacted]												
(b)(6)-2	-----															
2OCT	[redacted]	Ditropan XL 5mg PO	08	[redacted]												
(b)(6)-2	-----	BID	20	[redacted]												

25OCT	[redacted]	Loperamide 2mg PO		PRN												
(b)(6)-2	-----	after every stool for														
	-----	total 8mg after initial														

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (R) Tibia Multiple amputations

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

(b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. 11 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
(b)(6)-2 3NOV	[redacted]	25mg Benadryl IV x1 now	3NOV	-	2150 1750	[redacted]	(b)(6)-2
(b)(6)-2 11 NOV03	[redacted]	D/C meds: Levofloxacin 250mg po QD, Bactrim Forte bid qq, Percocet 1-2 po q4-6 prn	11	—		[redacted]	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
(b)(6)-2 5OCT	[redacted]	Tylenol 650mg Po q4° PRN														
(b)(6)-2 25OCT	[redacted]	Tylenol #3 1-2 tabs po IV q4-6 PRN	3OCT 0500	3OCT 1940	31 1100	31OCT 2300	1NOV 1600	2NOV 0830	4NOV 1615	5NOV 1210	5NOV 1740	5NOV 2215	6NOV 2330	7NOV 2300	7NOV 0805	9NOV 1625
			[redacted]													
(b)(6)-2 16OCT	[redacted]	Restoril po q1-5 PRN 30mg	4NOV 0330													
			[redacted]													
(b)(6)-2 19OCT	[redacted]	Haldol 5mg IVP Q6° PRN	N/C													
(b)(6)-2 25Sept	[redacted]	Tylenol #3 1-2 tabs Po q4-6° PRN	3NOV 2115	4 NOV 0730	3NOV 1610	4NOV 0000	4NOV 0955	4NOV 1715	11NOV 0505							
			[redacted]													
(b)(6)-2 28OCT	[redacted]	Benadryl 25mg IV/PO/IM Q6° PRN	3NOV 1200	3NOV 1900	5NOV 0130	[redacted]	12NOV 0900	14NOV 1500	1NOV 0610	11NOV 1190						
			25IV	25IV	25IV	[redacted]	25mg IV	25mg	25mg	25mg IV						
			[redacted]													

(b)(6)-2

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

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION: CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

	ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 9	10	11	12	13	14	15	16	17	18	19	20	21
(b)(6)-2	25	[redacted]	V/S Routine	06	[redacted]												
				18													
				18													
				06													
(b)(6)-2	25	[redacted]	DDSTC TID	06													
				18													
				18													
				06													
(b)(6)-2	25	[redacted]	Regular Diet	06													
				18													
				18													
				06													
(b)(6)-2	28	[redacted]	Suprapubic tube	06													
			to gravity	18													
				18													
				06													
(b)(6)-2	1 Oct	[redacted]	1 can ensure TID	06													
				12													
				17													
(b)(6)-2	1 Oct	[redacted]	Vac. device on (R)	98													
			leg to low continuous	18													
			suction (May d/c suction	06													
			@ HS)														

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (R) fx tibia; multiple amputations

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 2

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Oct Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	----	Resume previous orders				
(b)(6)-2 15 OCT03	[redacted]	Resume previous orders	15 OCT03	—	—	[redacted] (b)(6)-2
(b)(6)-2 18 OCT	[redacted]	Resume previous orders	18 OCT			[redacted] (b)(6)-2
(b)(6)-2 21 OCT	[redacted]	remove SP cath	21 OCT	1400	done	[redacted] (b)(6)-2

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
b)(6)-2 23 Oct	[redacted]	NPO p MN to OR Tomorrow	24 Oct	0001	000[redacted]	
b)(6)-2 24 Oct	[redacted]	U/A	[redacted]		[redacted]	
b)(6)-2 25 Oct	[redacted]	Stool culture	ASAP			
b)(6)-2 29 OCT	[redacted]	Resume prev. orders				
b)(6)-2 29 OCT	[redacted]	NPO p MN 30 OCT	30 OCT	0001	[redacted]	
b)(6)-2 29 OCT	[redacted]	for OR 31 OCT 03	31 OCT			

2-(b)(6)

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
b)(6)-2 29 OCT	[redacted]	reinforce drsg PRN	D/T
			D/T

USAPA V1.00

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE

INTAKE

~~ORAL~~ (condom catheter)

TIME	TYPE	AMOUNT	ACCUM TOTAL
1400	C/U	350	350
0450		1000	1350

~~INTRAVENOUS~~ (S/P catheter)

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
(06-1800)		Ø			Ø

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

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

(21OCT-22OCTØ3
06-0600)

TWENTY-FOUR HOUR PATIENT I[illegible]KE AND OUTPUT WORKSHEET

FROM 0000 HOURS TO 0000 HOURS | TOTAL HOURS COVERED 24 | DATE 21-22OCT

INTAKE

~~ORAL~~ (ORAL)*

TIME	TYPE	AMOUNT	ACCUM TOTAL
1000	H2O	500	500cc
1600	JUICE X3	600	1100cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
		Zosyn			50cc
		Levaquin			100cc

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

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

21OCT-22OCT03
(06 - 0600)

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 1800 HOURS TO 1800 HOURS | TOTAL HOURS COVERED 24 | DATE 15OCT03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1930	500cc H20	500	500cc
2210	100 H20	600	600cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
2200	50ml	Zosyn	50cc	2235	50
0400	50ml	Zosyn	50cc	0440	100cc

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG)

EDITION OF 1 SEP 54 IS OBSOLETE.

Designed using Perform Pro, WHS/DIOR, Jun 94

(b)(6)-4

[redacted]

1800 → 1800

MEDCOM - 20494

OUTPUT

URINE (SP cath) *

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0300	300 (Y0)	300cc			

* (R tibia suction)

~~NASOGASTRIC~~

TIME	AMOUNT	TYPE	ACCUM TOTAL
0400	25cc	brown.	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

10w - 30

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM	HOURS	TOTAL HOURS COVERED	DATE
TO	HOURS	24	2004

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

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

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG)

EDITION OF 1 SEP 54 IS OBSOLETE.

Designed using Perform Pro, WHS/DIOR, Jun 94

[redacted] (b)(6)-4

OUTPUT

(R) leg vac.

URINE S/P cath.

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0900	300cc	300cc			
1700	150cc	450cc			
1900	? x1	void to bed			
2030	? x1	void to bed			
0200	x1	void to bed			
0500	200	650 (+)			

~~NASOGASTRIC~~

TIME	AMOUNT	TYPE	ACCUM TOTAL
0600	15cc	bm	15cc
0500	Ø		15cc

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)*

20 DEC 03
(0600-0600)

#[redacted]

(6)(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

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS TO _____ HOURS | TOTAL HOURS COVERED | DATE 140403

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1200	juice	240	240
1800	H2O	200	440
1830	juice	240	680cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
2200	500cc	200yn	500cc	2250	500cc
0400	500cc	200yn cns	500cc	0455	1000cc

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG)

EDITION OF 1 SEP 54 IS OBSOLETE.

Designed using Perform Pro, WHS/DIOR, Jun 94

OUTPUT

(SP foley) URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
Oct 1125	525	525			
~~300~~ 2300	400	925			

(R) leg vac ~~NASOGASTRIC~~

TIME	AMOUNT	TYPE	ACCUM TOTAL
0445	10cc	green/brn.	10cc

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1215 ~~0715~~	Juice x3	600	600cc
1730 ~~0930~~	H_2O	800	1400cc
1800	Ensure		
1900	H_2O		
2000	H_2O		
0500	H_2O		
1800	coffee	250	

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
		Zosyn	~~S~~		50cc
		Levaquin			100cc
2200	3375gm	Zosyn			

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

(b)(6)-4

[redacted]

22OCT03

(~~22~~OCT – ~~23~~OCT)
(0600 – 0600)

TWENTY-FOUR HOUR PATIENT I[illegible]KE AND OUTPUT WORKSHEET

FROM ___ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE

~~INTAKE~~ Output

~~ORAL~~ Texas Catheter

TIME	TYPE	AMOUNT	ACCUM TOTAL
1730	clear yellow urine	1100	1100
0525	dark yellow urine	1200	2300

INTRAVENOUS

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

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

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

23 OCT - 24 OCT
(06 - 0600)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ______ HOURS TO ______ HOURS	TOTAL HOURS COVERED	DATE

INTAKE

~~ORAL~~ (foley)*

TIME	TYPE	AMOUNT	ACCUM TOTAL
1000	900cc cyu		900
1500	600 cyu		1500cc
5 NOV 03 06-1800			
1700	1100cc cyu		1100cc

~~INTRAVENOUS~~

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

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

[redacted] (b)(6)-4

OUTPUT

(FOLEY) URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1540	150cc	150cc			
1610	130cc	280cc			
0500	550	830cc			
1530	200	1030cc			
1700	200	1230cc			
2010	600	1830cc			
1000	300	300cc			
1200	200	500cc			
0550	1200	1200			
1330	700	1900cc			
2100	400	2300			
1NOV06	800	3100cc			

~~NASOGASTRIC~~ (R) log SXN

TIME	AMOUNT	TYPE	ACCUM TOTAL
1610	15cc	brown	15cc
0500	~~0~~	—	15cc
		(d/c'd)	

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
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 1500 HOURS TO 0600 HOURS | TOTAL HOURS COVERED 15 | DATE 26OCT03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1600	H2O	500	500cc

INTRAVENOUS

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

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

[redacted] (b)(6)-4

OUTPUT

URINE *SP foley*						NASOGASTRIC *(R) ICG suction*			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL

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

STOOLS				
TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT			
TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

1500 (06-06)

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM 0600 HOURS TO 0600 HOURS	TOTAL HOURS COVERED 24	DATE 15OCT03

INTAKE

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

IRRIGATIONS *(N/G, Bladder, etc.)*			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

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

OTHER INTAKE			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
GRAND TOTAL INTAKE			

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

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

15OCT03
(06-06)

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 11 Yr 2003

Verity by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(b)(6)-2 11 Nov	[redacted]	Dictate to EPW camp				
(b)(6)-2 11	[redacted]	Please provide 7 Kerlex rolls when pt departs				
(b)(6)-2 11	[redacted]	Follow up 1 week	18	—	—	[redacted] (b)(6)-
	----					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED												
(b)(6)-2 29 OCT	[redacted]	Reinforce dsg PRN	D/T/I												
----	----														
----	----														
----	----														
----	----														
----	----														
----	----														
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USAPA V1.00

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: 26SEP03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
Time In: 1422
Allergies: NKNA OR Intake: Crystalloid 300 Colloid Ø
Pre-op V/S: 117/75/ 78 OR Output: UOP Ø EBL Ø
Procedures: BIL. 1&D legs Meds/Times: 150 Fent.

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1422	1424	1435	1440	1445	1450
SaO2	96	97	96	94	96	96
FIO2						
Methods	M	RA	RA	RA	RA	RA
240						
220						
200						
180						
160						
140		V	V	V	V	V
120	V					
100	•					
80		•				
60	^		•	•	•	•
		^	^	^	^	^
40						
20						
RR	11	10	10	7	9	7
T	95.6		96.2		96.4	
Time						
Pain (0-10)						
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1410	LR	425 cc	EJ	IV	100cc

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 26SEP03

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

[redacted] (b)(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1326		MSO4 5mg	IV	(b)(6)	-2	[redacted]
1335		MSO4 3mg	IV	(b)(6)	-2	[redacted]

NEUROVASCULAR

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

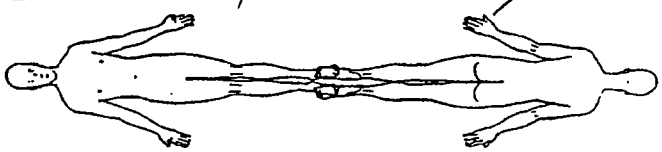
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Both Legs	curlex	Ø
30'	Both Legs	curlex	Ø
60'			
D/C	Both Legs	curlex	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1410	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Pt Admitted to PACU SP 1810 Both legs. PARS 10. PAIN controlled w/ 5mg MSO4. (b)(6)-2
Dressing CDI w/ pulse present — pfc [redacted]
Pt discharged to ICW1 Report Given to (b)(6)-2
LT [redacted]. Transferred by pfc [redacted] (b)(6)-2
via Litter — pfc [redacted] (b)(6)-2

Discharge Criteria:
Date: 26Sep05 **Time:** 1910 **PARS:** 10
BP: 134/50 **T:** 96.5 **HR:** 60 **RR:** 7 **Sa02:** 95%
Pain Level at D/C (0-10):
Intake: 100cc/hr **Output:** Ø
Additional Data: Ø
Transferred To: ICW1
Report Given To: LT [redacted] (b)(6)-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: pfc [redacted] (b)(6)-2
Cleared IAW Recovery Room [redacted] B (b)(6)-2
Charge Nurse Signature: [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: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 10.24
Time In: 1140
Allergies: NKDA
Pre-op V/S:
Procedures: SP 7 DR Bag
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 100 Colloid
OR Output: UOP 100 EBL minimal
Meds/Times:

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

Pre Op Meds History

Time	1130	1135	1140													
SaO2	100	100	100													
FiO2	RA	RA	RA													
Methods																
240																
220																
200																
180																
160																
140																
120																
100	V	V	V	V												
80																
60																
40																
20																
RR																
T	98			98												

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 10 Oct

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

[redacted] (b)(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	[redacted]						
15'						(b)(6)-2	
30'							
45'							
60'							
90'							
D/C							

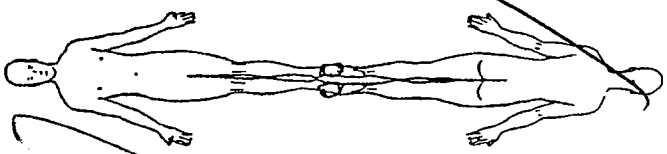
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Assumed pt care from pt [illegible], pt hemodynamically stable & in no apparent distress. A/O x3 appropriate. Non contributive circulatory sluggish [illegible]
CV [illegible] c edema, S1 S2, +1 pedal pulses
Resp even unlabored [illegible] 100% on RA c̄ [illegible] (B) IC Gauges.
GI [illegible] BS hypo x4
GU Foley cath
Lines CEJ patent

[redacted] (b)(6)-2

Discharge Criteria:
Date: 10/24 **Time:** 1150 **PARS:** 10
BP: [illegible] **T:** 98.0 **HR:** 60 **RR:** 10 **Sa02:** 100
Pain Level at D/C (0-10):
Intake: 0 **Output:** 600 cc
Additional Data:
Transferred To: ICU
Report Given To: SPC [redacted] (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: LT [redacted] (b)(6)-2
Cleared IAW Recovery Room [redacted] (b)(6)-2
Charge Nurse Signature: [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: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

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

Time In: 1725

Allergies: NKDA OR Intake: Crystalloid 900 Colloid _____

Pre-op V/S: 94/45 86 OR Output: UOP 160 EBL min

Procedures: cystoscopy

S/P cath ZTD (2) cat

ASA II

Prop

Gas

2 comp ient

Supraglottic

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1725	1730	1735	1740	1745	1750
SaO2	94	93	100	100	95	98
FiO2	RA	RA	RA	RA	RA	RA
Methods						
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	28	13	12	12	21	
T	95.8				97	

Time	
Pain (0-10)	
LOS	

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1726	UR	300	OES	AS	400
1600	Lactated	100	S/P Cath	MS	100
1600	NS Flush	~120	S/P Cath	MS	120

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

Patient teaching done; Wound Care, Pain Management, T, C, & DB,. Incentive Spirometer, Comfort Measures

Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PRE[redacted] (b)(6)-2 SSG/CPN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 29 Aug 03

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

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1740 2120	Helan	2mg MSO4	IVP	/	/	[redacted] (b)(6)-2
1750	Helan	2mg MSO4	IVP	/	/	[redacted] (b)(6)-2
1800	Helan	2mg MSO4	IVP	/	/	[redacted] (b)(6)-2

NEUROVASCULAR

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

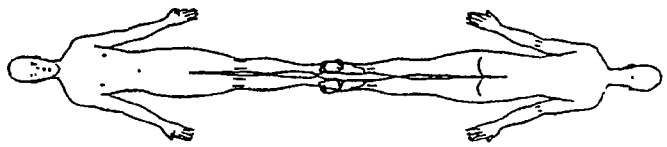
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

1725 male EPW admitted to PACU
S/P I+D @ leg; suprapubic cath; cystoscopy
Pt A+O, PSO2 99% RA VSS DSG to
legs CDI. Suprapubic cath draining
yellow urine tegrity. @ EJ & LR @
TKO patent. Pt c/o pain 2mg MSO4 given
[redacted] SSG/LPN (b)(6)-2
1600 Suprapubic catheter xray c contrast
done by Dr [redacted] (b)(6)-2 Placement confirmed
by Dr [redacted] (b)(6)-2 [redacted] SSG/LPN (b)(6)-2

Discharge Criteria:
Date: 29 Sep 05 **Time:** 1810 **PARS:** 10
BP: 164/62 **T:** 97.4 **HR:** 81 **RR:** 18 **Sa02:** 95
Pain Level at D/C (0-10):
Intake: 620 **Output:** 600
Additional Data:
Transferred To: ICW
Report Given To: SPC [redacted] (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SSG [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

WAMC OP 173-E

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: 01 Oct 03
Time In: 1030
Allergies: NKDA
Pre-op V/S: 140/58 80
Procedures: I+O R leg, 2 JP placement

Anesthesia Type (Circle): General, Spinal, Epidural, LMA, IV Sedation, Nerve Block
OR Intake: Crystalloid 400cc Colloid
OR Output: UOP 500 EBL 650cc
Meds/Times: 300mg Fent

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds | History

Time	1030	1035	1040	1045	1050
SaO2	96	100	100	100	98
FiO2					
Methods	RA	RA	NP	RA	RA
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	16	10	20	24	12
T	96.4				

Time	
Pain (0-10)	
LOS	

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1120	LR	150	IV		

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

PREPARED BY: [redacted] Sig (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 01 Oct 03

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

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

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1030		Fent 100 mcg	IV		(b)(6)-2	Mg [redacted]
1040		Demerol 12.5 mg	IV		(b)(6)-2	Cpt [redacted]

NEUROVASCULAR

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

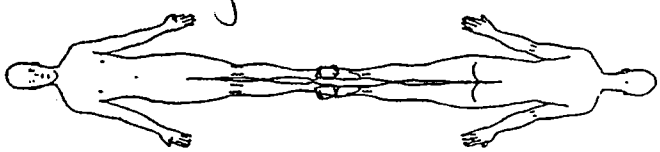
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1034	R leg		JP drain
30' 1100	R leg		JP drain
60'			
D/C 1140	R leg		JP drain



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1030	NSR	Ø	Ø

NURSING NOTES

Pt received from OR. VSS. O2 sats 96% RA. Pt very verbal and moving around. Pt keeps c/o pain. 100 mcg Fent & 12.5 mg Demerol given. Pt has JP drain that will be hooked up to wall suction.

Discharge Criteria:
Date: 01 Oct 03 **Time:** 1040 **PARS:** 10
BP: 150/48 **T:** 96.6 **HR:** 68 **RR:** 10 **Sa02:** 100
Pain Level at D/C (0-10): 0
Intake: 100cc **Output:** 0
Additional Data: None
Transferred To: ICW
Report Given To: Li [redacted] (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery Room [redacted]
Charge Nurse Signature: [redacted] (b)(6)-2

WAMC OP 173-E

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: 4 OCT 03
Time In: 1025
Allergies: NKDA
Pre-op V/S: 100/59 78
Procedures: LAD 109

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block MAC
OR Intake: Crystalloid 250 Colloid ~~0~~
OR Output: UOP 100 EBL ~~0~~
Meds/Times: Fentanyl, Versed

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

Pre Op Meds History

Time	1025	1035	1045	1050
SaO2	99	98	102	98
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120	V	V	V	V
100				
80	^	^	^	^
60				
40				
20				
RR	22	10	18	
T	96			

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1025	LR	700	(D) IJ	OR	300

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

PREPARED BY: [redacted] LPN (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 4 OCT 03

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

[redacted] (b)(6)-2

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

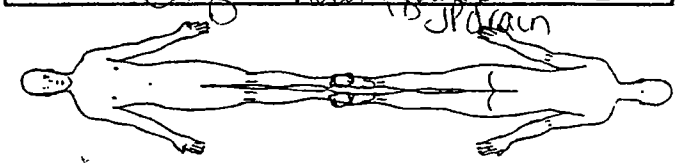
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) leg	Ioban, Gauze & JP drain	∅
30'			
60'			
D/C	(R) leg	Ioban, gauze & JP drain	∅



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1025	SR	∅	∅

WAMC OP 173-E

NURSING NOTES

Pt to recovery room from OR via litter s/p I&D (R) leg. IV of LR infusing into (L) IJ. ∅ s/s of reactions OR labs to date. 1 Ioban dressing to (R) leg & gauze & JP drain intact. ∅ drainage noted. VSS ∅ c/o @ this time. Will continue to monitor. — [redacted] LA

(b)(6)-2

Discharge Criteria:
Date: 4 OCT **Time:** 1110 **PARS:** 9
BP: 121/72 **T:** 96 **HR:** 98 **RR:** 12 **Sa02:** 97% RA
Pain Level at D/C (0-10):
Intake: 50 **Output:** ∅
Additional Data:
Transferred To: PCU #1
Report Given To: [redacted] (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery Room S[redacted]
Charge Nurse Signature: [redacted] (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: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: _____ Anesthesia Type (Circle)): General Spinal Epidural
Time In: _____ IV Sedation Nerve Block
Allergies: NKDA OR Intake: Crystalloid 300 LR Colloid _____
Pre-op V/S: 90/56 86 OR Output: UOP 300cc EBL m.m
Procedures: 710 Meds/Times: _____

20 MSO4
250 Fent

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

Airway: Nasal, Oral, ETT, Trach, Other

out

Pre Op Meds History

Time	1530	1535	1545	1715	1600											
SaO2	99	99	97	99	98											
FiO2	RA	RA	RA	RA	RA											
Methods																
240																
220																
200																
180																
160																
140																
120																
100																
80																
60																
40																
20																
RR	22	16	8	12	9											
T																

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1530	NS	750	RE3	[redacted]	(b)(6)-2

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 9 Oct 03

PATIENT'S IDENTIFICATION (For typed or [redacted] e: Name – last, first, middle; grade; date; hospital or medical [redacted]

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

[redacted] (b)(6)-4

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

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

USAPPC V2.00

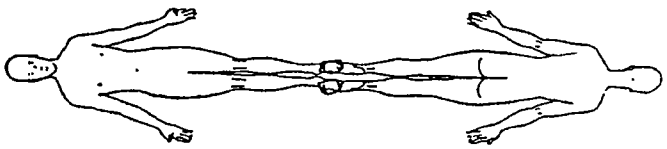
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

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

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1530 male Iraqi IPW admitted to PACU S/P ⓡ leg I&D. Pt's 98% RA. USS NPA removed upon admission. IV ⓡ EJ NS @ TKO. Intact. Drain to ⓡ leg clamped off. Foley to gravity [redacted] SSG/CPL

(b)(b)-2

Discharge Criteria:
Date: 20 Mar 03 Time: 1618 PARS: 10
BP: 98/48 T: 98.3 HR: 104 RR: 12 Sa02: 98%
Pain Level at D/C (0-10):
Intake: 200 Output:
Additional Data:
Transferred To: IRW 7
Report Given To: SPC [redacted] (b)(b)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SSG [redacted] (b)(b)-2
Cleared IAW Recovery Room S[redacted]-3
Charge Nurse Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

OTSG APPROVED (Date)

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

Date: 10 Oct 03
Time In: 1205
Allergies: NKDA
Pre-op V/S: 98/55 63
Procedures:

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1000 LR Colloid
OR Output: UOP Ø EBL Ø
Meds/Times:

5mg Versed
10mg MSO_4

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1201	1210	1215	1220	1230
SaO2	100	99	98	99	99
FIO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140					
120					
100					
80					
60					
40					
20					
RR	9	19	20	18	19
T	97				

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1205	LR	400	(R) EJ	[redacted]	(b)(6)-2

X-rays:

Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

PREPARED BY (Signature): (b)(6)-2 [redacted] SSG/LPN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 10 Oct 03

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

[redacted] (b)(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1210	Ifolan	2 mg MSO4	IV		(b)(6)-2	[redacted]
1230	Ifolan	2 mg MSO4	IV		(b)(6)-2	[redacted]
1230	Ifolan	1 mg MSO4	IV		(b)(6)-2	[redacted]

NEUROVASCULAR

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

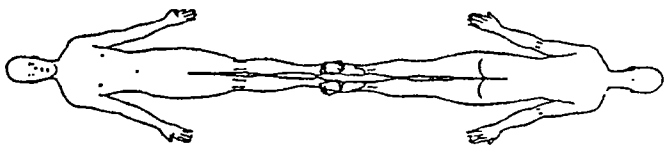
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

1400 - Male Iraq: CPW admitted to PACU S/P I&D (R) Tibia / Replace Vac. Adm Dsg's CDI, Vacuum hose clamped off. IV NS @ 125 KO @ TKO Pain [illegible] Fely to Fracture, — [redacted] SSG/LA (b)(6)-2

Discharge Criteria:
Date: 10 Oct 03 Time: 1221 PARS: 10
BP: 97/59 T: HR: 50 RR: 14 Sa02: 99% RA
Pain Level at D/C (0-10):
Intake: <100 cc Output: 500
Additional Data:
Transferred To: ICW / [redacted] (b)(6)-2
Report Given To: SSG [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SSG [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

WAMC OP 173-E

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

DTSG APPROVED (Date)

Date: 15 Oct 03
Time In: 1152
Allergies: NKDA
Pre-op V/S: 109/56 40
Procedures:

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid
OR Output: UOP Ø EBL Ø
Meds/Times: 2 Versed, 50 Fent,

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1152	1155	1202	1212
SaO2	100	100	100	100
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				✓
120		✓	✓	
100	✓			
80	•			•
60		•	•	
40	^	^	^	^
20				
RR	15	12	12	15
T	96.0			
Time				
Pain (0-10)				
LOS				

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1220	LR	100	IV		

X-rays:
Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

[redacted] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 15 Oct 03

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

Name — last,

[redacted] (b)(6)-4

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

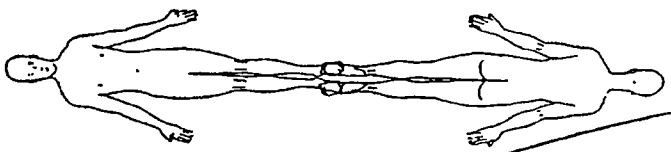
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1213		5mg Haldol				

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

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm 1152	Rleg		to suction
30' 1222	Rleg		To suction
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1152	NSR	Ø	Ø

NURSING NOTES

Pt to pacu S/p I+D. O2 sats 100% RA. Pt very verbally about leg. No c/o pain. Pt given 5mg Haldol for extreme agitation — [redacted] (b)(6)-2 PA
PA report given to Spc [redacted] (b)(6)-2
by Capt [redacted] (b)(6)-2 (b)(6)-2 CPA

Discharge Criteria:
Date: 15Oct03 Time: 1220 PARS: 10
BP: 139/54 T: 96.0 HR: 55 RR: 19 Sa02: 100
Pain Level at D/C (0-10): 0
Intake: Ø Output: Ø
Additional Data: none
Transferred To: ICW1
Report Given To: Spc [redacted] (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: Sgt [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

WAMC OP 173-E

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: 18 Oct 03
Time In: 1157
Allergies: NKDA
Pre-op V/S: 115/58 75
Procedures: washout

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid _____ Colloid 400
OR Output: UOP 0 EBL 0
Meds/Times: 100 Fent 200 propofol

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1157	1202	1207	1212
SaO2	100	99	99	99
FiO2				
Methods	RA	NX	NX	NX
240				
220				
200				
180				
160				
140				
120	✓			
100		•		•
80		^		
60		•		•
40	^		^	
20				
RR	10	30	20	10
T	96			

Time									
Pain (0-10)									
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 18 Oct 03

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

[redacted] (b)(6)-4

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

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

USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

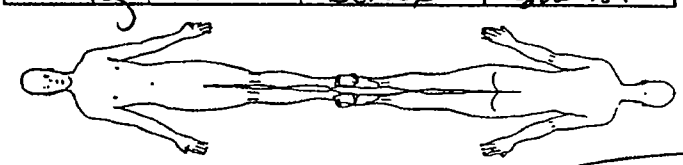
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, PK = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm L leg	→	Kerlex	Suction
30' L leg	→	Kerlex	Suction
60'			
D/C L leg	→	Kerlex	Suction



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1157	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Pt received from OR s/p I&D. Pt O2 sats 100% RA Pt awake, very agitated, asking for Valium. Pt calmed down after talking to interpreter (b)(6)-2 Pt VSS. Not c/o pain — Sgt [redacted] Report given to Lt [redacted] (b)(6)-2

Discharge Criteria:
Date: ~~15/4/7~~ 15 Oct Time: 1225 PARS: 10
BP: 153/47 T: 96.0 HR: 73 RR: 10 Sa02: 100
Pain Level at D/C (0-10): 0
Intake: 0 Output: 0
Additional Data: None
Transferred To: ICW
Report Given To: Lt [redacted] (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: Sgt [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 3 OCT
Time In: 1423
Allergies: —
Pre-op V/S: 102/58 64
Procedures: STSG Dorsum Thigh @ to (R) Shin

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 300 Colloid
OR Output: UOP 300/50 EBL 50
Meds/Times: 250 Fent, Reinserted a DD 1/2 dose

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

Pre Op Meds History

Time	1423	1433	1503	1513	14
SaO2	100	99	100	99	
FiO2					
Methods	RA	RA	RA	RA	
240					
220					
200					
180					
160					
140					
		✓	✓	✓	
120	✓				
100					
80					
		•	•		
60	^	^	^		
				•	
40					
20					
RR	20	12	10	9	
T				98	
Time					
Pain (0-10)					
LOS					

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

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

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

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

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

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

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

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

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

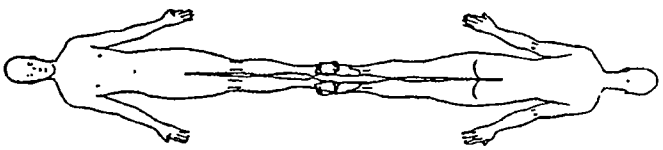
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) Leg	ace	Ø
30'	(L) Leg	ace	Ø
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

received pt from OR in stable condition. (R) leg w/ ace wrap + gauze from thigh (donor) to foot (recipient) S/P STSG. (L) EJ patent. FTG w/ chyellow urine. USS. Report given to ICU I. [redacted] (b)(6)-2

Discharge Criteria:
Date: 3/07 **Time:** 1400 **PARS:** 10
BP: 125/91 **T:** 96.5 **HR:** 55 **RR:** 9 **Sa02:** 99
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data:
Transferred To: ICU I
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery [redacted]
Charge Nurse Signature [redacted] (b)(6)-2

#[redacted]

(b)(6)-4

ABU GHARAIB MEDICAL TRANSFER REQUEST FORM

(b)(6)-2

DATE OF REQUEST: [redacted] 24 ~~23~~ SEP 03

REQUESTOR: LTC [redacted], 820th MP BN Surgeon (b)(6)-2

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

COMPOUND: New Prison Out patient Clinic

PRIORITY: ASAP

LITTER/ AMBULATORY (CIRCLE)

DESCRIPTION OF INJURIES: Open, infected wound (R) Knee (right)
Open wound (L) leg

* Requesting surgical consultation

NUMBER OF MEDICAL PERSONNEL ACCOMPANYING: 0

DATE OF TRANSFER: _____

TIME OF TRANSFER: _____

DESTINATION: _____

POC AT DESTINATION: _____

ANTICIPATED LENGTH OF TRANSFER: _____

EQUIPMENT REQUESTS:

_____

_____

NOTE: COORIDINATION IS ALSO REQUIRED THROUGH MOVEMENT CONTROL FOR A TRIP TICKET.

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
UNK	33Y	Z	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	1010	(b)(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	K79	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
O (b)(2)-2	ICWI	UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted]	UNK	UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
24		20031111

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
AEAA		20030925

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

FOR LOCAL USE

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

DX; 8911
9583
29181
30391
30411
78039
0416
0417
V4965
V4966
E9919

Trauma
9
Injury
599

ADMITTING OFFICER (Signature, as required)

(b)(6)-2

DR [redacted]

SIGNATURE OF ADMITTING CLERK [redacted] (b)(6)-2

DA FORM 2985, MAR 2000

EDITION OF MAR 89 IS OBSOLETE

USAPA V1.00

PX: 8622
8674
8669

MEDCOM - 20529

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

(b)(6)-4

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) (b)(6)-4 [redacted]			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE ~~15~~ 18	6. RACE X	7. RELIGION MUSLIM	8. LENGTH OF SVC N/A	9. DTS N/A	10. PREVIOUS ADMISSION
11. FMP ~~N/A~~ 20	12. SSN (b)(6)-4 [redacted]		13. ORGANIZATION N/A		14. WARD ICW1
15. LYING STATUS N/A	16. RATING/DSG K78	17. DEPT./BEN	18. BRANCH/CORPS N/A	19. UIC/ZIP	20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Ø			22. HOURS OF ADMISSION 1010	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION 24	26. DATE OF DISPOSITION 2003 11 11	
27a. ADDRESS OF EMERGENCY ADDRESSEE (include ZIP Code)			27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 2003 09 25	ADMITTING OFFICER (b)(6)-2 DR [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

PT WAS P/C TO ABU GHARIB PRISON CAMP ON 11 NOV 2003

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

GSW

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: OPEN ⓛ TIB/FIB FX

PROC: DEBRIDEMENT
EXT FIX

DX:
905.4
730.86
041.11
V09.0
E99.8

PX:
77.07 77.17 (x8)
78.27 77.67
78.17
93.53

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	47	47

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	47	47

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2 COL [redacted] (b)(6)-2

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

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.00

ABU GHRAIB MEDICAL TRANSFER REQUEST FORM

DATE OF REQUEST: 22SEP 03

REQUESTOR: LTC [redacted] 820 MP BN Surgeon (b)(6)-2

ISN #: [redacted] (b)(6)-4 SEQ # [redacted] (b)(6)-4

COMPOUND: # 1

PRIORITY: ASAP

LITTER/AMBULATORY (CIRCLE) with crutches

DESCRIPTION OF INJURIES: Traumatic injury > LLE External Fixator

* Requesting evaluation & Rx

NUMBER OF MEDICAL PERSONNEL ACCOMPANYING: [redacted] (b)(2)-2

DATE OF TRANSFER: _____

TIME OF TRANSFER: _____

DESTINATION: _____

POC AT DESTINATION: _____

ANTICIPATED LENGTH OF TRANSFER: _____

EQUIPMENT REQUESTS: _____

NOTE: COORDINATION IS ALSO REQUIRED THROUGH MOVEMENT CONTROL FOR A TRIP TICKET.

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 SEP 03 ~1500	Brought in by Iraqi police. Has an external fixator in the left lower extremity, for four months now
	O: PX ambulates c̄ use of crutches External fixator, LLE. Foot is swollen and erythematous. Good pulses. No medical records available
	A: Traumatic injury External Fixator → Left lower extremity
	P: Rocephin 1 gm given at intake processing but DN cephalosporin. Refer to [redacted] (b)(2)-2 to be evaluated
	(b)(6)-2 [redacted] ICM
	[redacted] (b)(6)-4

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

MEDICAL RECORD

ABBREVIATED MEDICAL RECORD

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

[illegible] GSW s/p GSW to (2) LLE, [illegible]
ex-fix in place x 4 months. c/o pain, drainage
from wound, loose to stay pin-
pms (-)
NDS (-)

WLBA

PHYSICAL EXAMINATION

HEENT - WNL
WNL - supple
CVS - (L) LLE - ex-fix in place. stable, warm
wound on lateral thigh with drainage.
skin post [illegible]
[illegible] moderate [illegible] by [illegible]
LLE [illegible] of [illegible]. [illegible] old

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

(5) Infection [illegible] by
(P). I&D [illegible] [illegible]

(b)(6)-2

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

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

[redacted] (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 Sep 03 1520	Admitted to ICW #1 from EMT via litter. A&O. Lungs CTA(B). Resp. even & unlabored. Abd. soft non tender c̄ (+) BS x4 quads. (L) Tib/Fib external fixator intact. Purulent drainage from wound in mid tibia area. Open to air. Pedal pulse palpable. Brisk capillary refil. (L) foot edematous. Heplock (L) AC patent & O. D/S N.S infusing from EMT. Will d/c IV as ordered & continue monitoring & Abx Therapy (b)(6)-2 [redacted]
25 Sep 03 @ 2100	Assumed care @ 1800; All VSS, pt A&O X3 speaking & able; (+) CMS, brisk cap Ref, palpable pulses x4; N/V intact; S1 S2, LSCTA(B); (+) BS x4, pt voiding QS c̄ difficulty; pin care to (L) LE complete c̄ 1/2 sterile water, 1/2 peroxide-aggressively cleaned; 4x4 placed over open wound to mid Tibia area; purulent drainage noted; (L) foot remains edematous; pt NPO f̄ MN, to OR in AM; SL in (R) AC patent, ∅ s/s infection/infiltration; Cont c̄ (W) abx; restraint in place; (+) circulation, (−) skin break ↓; cont to monitor (b)(6)-2 [redacted]
26 Sep 03	Assume care of PT. VSS. A+O x3 c/o pain given percocets. Went to OR and returned at 1300 hrs. Performed Surgery on left Tibia. Distal pulse is intact. Given Ancef at 1400 hrs. Maintains a regular diet. Ambulate on crutches. Will continue to monitor. (b)(6)-2 SPC [redacted] SPW

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NO. (SSN or Other) [redacted]

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)*

SPW

[redacted] (b)(6)-4

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

(b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
# [redacted]			

DATE	NOTES
26Sep03 (1930)	Rt a10, VSS, LCTAB, HRRR, ⊕BS×4 qd, ex-fix intact ⊕LE. pin care done, (Perlix) reinforced drsg pm bloody drainage noted. (minimal amt). pedal pulses palpable. Percocet given for pain c̄ noted relief. Ancef cont. 2 pt restraints on, ⊕ circulation will monitor (b)(6)-2 [redacted] 91WM6 SC (b)(6)-2 [redacted] CPT
27Sep03	pt a+o x3, VSS, LCTAB, HRRR, ⊕BS×4, ex fix intact and wrapped with cotex to absorb drainage. pedal pulse palpable, hep lock flushed in ⊕ac. pt ambulated with little difficulty, ϕ c/o of pain. pt voiding clear yellow urine via urinal & other unremarkable findings. (b)(6)-2 [redacted] (1750) I concur c̄ above assessment. (b)(6)-2 [redacted]
2010	Rt a10, VSS, ϕ c/o pain or discomfort @ this time. Drsg to ⊕LE reinforced PRN. Pin care done. pulses (pedal) palpable. brisk cap refill. HL to ⊕AC patent. voiding w/o c̄ any difficulty. All other findings WNL. 2pt restraints on. ⊕ circulation. will monitor (b)(6)-2 [redacted] 91WM6 SC (b)(6)-2 [redacted] CPT
0001	N+0 p MN for OR in AM. [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 6/1999) BACK

USAPA V1.00

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DATE	NOTES
28 Sep 03	Received pt resting w/bed uss, A+O x3 arabic speaking. Pms are done, (L) LE, ex fix in place w/ gauze dressing intact. Ambs w/ crutches independently. NPO @ MN for OR in AM (OR for today cancelled). Staff notified by MD (Dr. [redacted] that pt was MRSA (+), MRSA precautions taken. Pt has (D) ac access patent + intact. flushes easily. Tol PO, SVS, urinal @ BS. Restraints on per EOW protocol. ∅ skin breakdown noted. ∅ other remarkable assessments noted. Will cont to monitor. Dr [redacted] (b)(6)-2
1945	Pt A&O, ABS, LCTAB, HRRR (+) BS x4 qd. ex-fix intact (L) LE. pin care done. drsg to (L) leg CDI. NPO p MN for OR in am. MRSA precautions taken. (R) AC HL-flushing easily. ancef cont. (R) foot c minimal edema. + elevated. Restraints on. (+) circulation, will monitor (b)(6)-2 [redacted] 911WMC.
29 Sep 03 (0001)	NPO for OR in AM. new 20ga IV started to (L)

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	LAST	FIRST	MI	

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PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(0001) (CONT)	FA x 1 attempt. HL'd. (previous IV removed - C catheter intact) Will monitor [redacted]
29 Sept 2003	Received pt resting in bed [redacted] (b)(6)-2 see SF511 for (b)(6)-2 VS; A+O x3. DOB and ambs w/ crutches. R arm PIN care done. C/O saline lock patent + intact flushes easily. MRSA precautions taken. LLE ↑. Restraints on per CPW protocol, ∅ breakdown noted. Pt is time. will cont to monitor pt. [redacted] (b)(6)-2
29 Sept 2045	- assumed care of pt @1800. Pt arrived from OR/PACU @ 1945. VSS. Placed in bed, 2pt restraints in SS/Sx of skin or circulation compromise. A+O, speaking arabic, c/o pain to LLE. LLE: ⊕ CMS, EX-FIX & KEMIX dsg CDI. (R) hand IV started in PACU c NS @ TKO. Tol po well ∅ Sx, no N/V. Percocet given for pain. LS CTA ⊕ BS, encouraged IS. MRSA ⊕ contact precautions in place. Plan: monitor NV status, monitor pain control. (b)(6)-2 [redacted]
30 Sept 03 0900	VSS @ Ort & Oriented Peripheral pulses palpable. (R) ~~Hand~~ hand IV infiltrated. Warm compress applied to IV site. Restarted IV (R) FA. Pt c/o pressure to (L) FA from previous IV site. Warm compress applied to (L) FA IV site. (R) FA IV 18 gauge 1 1/4 in cath attempt x 1. ∅ c/o pain. OOB → BR for AM care. MRSA [redacted] (b)(6)-2 precaution used. Will continue plan of care. [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
29 Oct 03 1830	Author Op Note Pre Op Dx Infected (T0230) (L) tibia fracture Post Op Dx Same Procedure I&D (L) tibia Surgeon [redacted] (b)(6)-2 ASA 4N Findings Necrotic Plan Repeat I&D in 48 hrs [redacted] (b)(6)-2
1 Oct 03 1510	Author Op Note Pre Op Dx Infected (L) tibia fx Post Op Dx Same Procedure I&D (L) tibia Surgeon [redacted] (b)(6)-2 Findings Necrotic 3x3 cm open wound over tibia Plan VAC in 48-72 hrs [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
30 sep03 @2200	assumed care of pt @1800. A VSS, A+O, speaking arabic c/o pain to LLE - medicated c̄ Percocet c̄ good relief noted. LLE W→D dsg Δ completed granulating tissue noted c̄ pkg placed in deep wound approx 1in deep. (Sterile technique used c̄ MRSA /contact precautions) Pin care performed to Ex-fix. IV abx given as ordered. Plan: NPO p̄ MN for washout, monitor pain control. (b)(6)-2 [redacted] CPT addendum: 2pt restraints on ∃ S/Sx of skin or circulation compromise. [redacted]
1 Oct 03 @0500	VSS Alert & Oriented. (R) FA IV patent secured Peripheral pulses palpable. (L) LE dry dyst tolerated Pt informed of NPO status & d/c for OR. Verbalized understanding. OOB to BR for AM Care. Denies pain. Pt discharged @ this time. Will continue care as planned. (b)(6)-2 [redacted]
(2000)	Pt returned from OR. fully awake, VSS, Ø c/o pain or discomfort. drsg CDI. to (L) LE. pin care performed to ex fix. IV Abx cont. 2 pt restraints on, ⊕ circulation, Ø skin breakdown

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

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PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(2000)	noted (+) pulses) Will monitor [redacted] (b)(b)-2 9WM6
10CT03	(2130) c/o pain to (L) LE ⅈⅈ Percocet given c̄ noted ord-
(CONT)	ered. Will monitor [redacted] (b)(b)-2 9WM6
20CT03	Pt ab, VSS, amb in hallway c̄ crutches without diff.
(1950)	c/o pain to (L) ex fix, ⅈⅈ Percocet given. LCTAB, HRRR,
	(+) BS x4, (L) ex fix pin care done c̄ pt assistance,
	drsg s/d. moderate amt serosang drainage
	noted. IV abx con't as ordered, (+) pedal pulses.
	Tol. PO well, IV HL'd. 2 pt restraints on. Will mon-
	[redacted] (b)(b)-2 9WM6
30OCT03	Author Op Note:
1045	Pre-Op Dx - open infected (L) tibia fx w/ bone
	Post-Op Dx - same
	Procedure: DI + D (L) tibia
	& application of VAC device.
	Surgeon: [redacted] (b)(b)-2
	EBL - 50
	5/10-02 Wound clean, irrigated 6L,
	VAC device applied
	PLAN: relook in 72 hours
	[redacted]
	(b)(b)-2 [redacted]
	(b)(b)-2 [redacted] COL [illegible]

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
03 OCT 03	~~[illegible]~~ Pt A&O x 5, S2 present, LS CTA (B) (+) BS x 4 quads VSS, Antibiotics given, Denies Pain at this time. Am care completed. [redacted] (b)(6)-2 Sgt 9WM1
(1940)	Pt alo, VSS, pen care done by pt c̄ assistance drsg Δ'd. Vac device to (L) leg c̄ continuous low suction. π Percocet given for pain. Abx con't. amb x 1 in hallway. cont MRSA precautions. (+) pedal pulses. ∑ V infusing ∑ redness or edema. Restraints on, (+) circulation. Will monitor [redacted] 9WM6. (b)(6)-2
04 OCT 03	PT Awake A&O LS CTA (B), Pin care and Drsg 1 completed Vac → LLE
1320	continuous low suction [redacted] (b)(6)-2 MRSA precautions. Denies pain at this time will continue to monitor. [redacted] (b)(6)-2 Sgt 9WM6
(1535)	I concur c̄ above assessment. [redacted] (b)(6)-2 [redacted] USAF
4 OCT. 03	Pt A&OX3, VSS, LS CTA (B), BS x 4, OOB →
2000	BR, pain controlled c̄ percs, continuous [redacted] (b)(6)-2 low suction to LLE, EX FIX, (L) leg in place, dsg on pins CDI, MRSA precautions, pt able to move toes, pedal pulses equal (B), HL IV (R) AC intact, ø s/sx of poor circulation or skin break↓ on pts of restraint. [redacted] (b)(6)-2 9WM

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

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[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
05OCT03 1400	Received pt resting in bed, VSS, tol PO, ax ox 3, arabic speaking. IV to (R) fa patent + intact, flushes easily. Amb w/ crutches independently. Pin care to (L) LE done, vac device w/ occlusive dsg intact and to low cont suction. MRSA precautions taken, restraints per CPW protocol, ∅ breakdown noted. (+) pedal pulse, toes warm. ∅ other remarkable assessments c this time. Will cont to monitor [redacted] (b)(b)-2
5OCT03 (1910)	Pt a&o, VSS, LCTAB HRRR, (+) BS x4, (L) leg to cont low suction, minimal brn drainage noted. dsg Δ'd (Kerlix). dsg c ∅ saturation. (+) pedal pulses. MRSA precautions. Pin care done by pt c assistance. Cipro & Gentamycin cont per orders. 2 pt restraints on 3 any compromise to circulation/skin. Will monitor [redacted] (b)(b)-2 9 WM6
6OCT03 0700	Received pt resting in bed, VSS, NPO, A&Ox3, self pin care. (L) LE wound to low cont suction, amb w/ crutches. OR this afternoon, cont IV ABX. MRSA precautions. [redacted] (b)(b)-2
7OCT03 0700	Assume care of pt. Pt sitting & eating breakfast. (-) s/s of resp distress or discomfort @ present time. Suction on low continuous to (R) leg. Dsg D&I. Ext fix in place. (-) skin breakdown under restraints. Lungs CTA. BS (+). Believed that pt pulled H/L out. Will restart. Continue to monitor [redacted] 9 WM6 (b)(b)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
6 OCT 03 1605	Orthe Op Note
	Pre Op Dx - Infected (L) tibia fracture
	Post Op Dx - Same
	Procedure - I+D (L) tibia, replace VAC dressing
	Surgeon - [redacted] (b)(b)-2
	Anes - MAC
	Findings - Beginning to get granulation at fracture site.
	(b)(b)-2 [redacted]

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

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
6OCTØ3 @(1910)	Rt a/o, VSS, lx fix intact to (L) LE, pin care done, low cont suction c̄ minimal brn. drainage. Percocet 2 tabs given for pain. 2 pt restraints on ≅ compromise to circulation or skin. Will monitor - [redacted] (b)(b)-2 9WM6.
7OCTØ3 2000	Rt a/o, VSS, LCTAB, HRRR, (+) BS, amb x 1, ex-fix to (L) leg, pin care done, minimal amt brown drainage via suction. c/o pain ⅡI percocet given for pain per MD orders. Gent & cipro cont. 2 pt restraints on ≅ compromise to skin/circulation. Will monitor (b)(b)-2 [redacted] 9WM6.
8OCTØ3	0935 assumed care of pt. @ 0600 - pt. A/O - VSS LS CTA (B) ⊖ resp distress @ this time. Abd. soft, nontender, BS x4. Ext fix intact to (L) LE. Pin care completed. ⊖ SSI infection. MRSA Precautions. min drainage from drsng via suction. voiding per urinal. Restraints in place. ⊖ skin breakdown (+) circulation. Will cont. monitor - [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID (SSN or Other) [redacted] (b)(b)-2
	LAST	FIRST	MI	
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(b)(b)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES (b)(6)-2
080CT03	(1700) I concur c above assessment. [redacted]
~~0600~~	Pt A&O. VSS Pt LS CTA (B), $S_1 S_2$ present,
080CT03	HRRR, (+) BS x4 quads. (L) LE Drsg CDI.
1830	proceed to control pain. Will continue to
	monitor. (b)(6)-2 [redacted] Spc 91WM6
09OCT03	Pt completed self pin care. Pt cont. LCS. Denies
	pain at this time. Will continue to Monitor
	(b)(6)-2 [redacted] Spc 91WM6
9OCT03 1330	Received pt restingin bed, VSS, [illegible], A&OX3,
	wound vac to (L) LE in place & on LCS. pin
	care performed by pt. amb indep w/ crutches,
	pin care done. IV to (L) fa intact, patent, flushes
	easily. ∅ redness or swelling noted. ∅ remarkable
	assessments at this time, ∅ c/o pain. Restraints on
	apu pidoral w/ ∅ skin breakdown noted [redacted] (b)(6)-2
9OCT03	2040 = VSS, c/o pain, medicating c Percs
	as needed, A+O, OOB & crutch walks to
	BR's difficulty. (L) LE c ex fix intact,
	pin care done, drain putting out
	sanguinous fluid, Dsg Δ'd to (L) LE CDI,
	(L) LE ↑, neurovascularly intact, continuing
	IV Gent & Cipro around the clock, HL IV
	to (L) arm flushed + patent. x2 restraints
	when in bed, ∅ skin breakdown. Continue
	to Monitor. (b)(6)-2 [redacted]

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

[redacted] (b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10 OCT 03 0615	Pt Awake A&O. LS CTA (B) S_1 S_2 present HRRR. (+) BS x4 quads. Abdomen soft flat non tender. (b)(6)-2 [redacted] EX fix on Left Lower extremity. (+) Pulses in all extremities. Skin warm and dry on (R) LE suction to LLE orsg c Kerlix roll CDI. Pt completes own pin care. Will cont. to monitor. [redacted] Spc 9 1W MG (b)(6)-2
10 OCT 03 1345	Pre'Op Dx - Open, infected (G) tibia fx Post'Op Dx Same Procedure I+D (G) tibia, application of V.A.C. device. Surgeon: [redacted] (b)(6)-2 Anes - MN Surgs: LR 300 cc Findings - Viously clean cutting taken. Good motion at fracture site (b)(6)-2 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
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PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10OCT03 @2100	- assumed care of pt @ 1800. VSS. hoc to this time. (R) EJ line D/C D/C pt discomfort, poss infiltration? (D) FA IV D/C D/C infiltration. (R) FA 20G IV started flushes well. (+) CMS to LLE, ex-fix in place, wound ~~to~~ sealed c̄ opsite, sandbag attached, minimal serosanguineous drainage noted. ↑ OOB amb c̄ crutches. MRSA precautions in place. Plan: monitor NV status, pain control. Opt restraints on s̄ S/Sx of skin/circulation compromise. (b)(6)-2 [redacted] CPT
	Addendum: pt did own pain care c̄ standby assist. Demonstrated good technique. [redacted] (b)(6)-2
11OCT03 1630	Assumed care of Pt @ 0600hrs. A&O. Pt Ambulated x1. Am care completed DLE Ex-Fix to continues L/w suction. Pt c/o pain controlled with percocet. LS CTA (B). S, S2 present (+) BM x 4 quads. Will continue to monitor. (b)(6)-2 [redacted] Spc 91W/MB
	(1630) I concur c̄ above assessment. (b)(6)-2 [redacted]
11OCT03 @2200	Assumed care of pt @ 1800. VSS. alert, speaking Arabic. LLE c̄ ex-fix in place, pincare done. Wound covered c̄ dsg & opsite, attached to suction, minimal drainage noted. (+) CMS to LLE, ±2 PP & popliteal pulses. ↑ amb to BR c̄ crutches s̄ difficulty. Opt restraints on s̄ S/Sx of skin/circulation compromise. Plan: monitor NV status, monitor pain control, monitor suction device (b)(6)-2 [redacted] CPT

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10 Dec 03	Outpt Op Note
(b)(6)	Pre-Op Dx: Infected Cyst left foot
	Post Op Dx: same
	Procedure: Suture removal, cast application (LLC) at removal of x-fix
	Surgeon: [redacted] / [redacted] (b)(6)-2
	Findings: LLC, ~~removal~~ applied, x-fix removal
	(b)(6)-2 [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
12Oct@2400	Assumed care @ 1800; All VSS, pt A&O x3, pain controlled c̄ meds; ⊕ CMS throughout, bilat SK cap Ref, ⊕ pulses; wound vac intact to low-cont. suction, minimal output noted; Ex-fix in place, pt performed own pin care; voiding ∃ difficulty; pt ↑ amb c̄ crutch assistance ∃ difficulty; Restraints in place, ⊕ circ, ⊖ skin breakdown, cont to monitor (b)(6)-2 [redacted]
13 Oct 03	Assumed care of pt @ 0600. Awake A&O LS CTA ⊕, S1 S2 present ⊕ BS x4 quads. Abdomen soft flat nontender. ⊕ Pulses ~~SF~~ in all extremities. ⊕ LE Ex fix Pin care completed. wound c̄ Drain on low continuous suction. Denies pain will continue to monitor. (b)(6)-2 [redacted] 9 1/2
13 Oct 03 2037	Assumed care @ 1800; All VSS, pt A&O x3, ⊘ c/o pain or discomfort @ this time; ⊕ CMS throughout, +2 pulses bilat cap. Ref; Wound vac intact to cont. suct, minimal o.p. noted; Ex-fix in place, pt performed own pin care; pt ↑ amb c̄ crutch assistance ∃ difficulty, voiding ∃ difficulty; HL patient easily flushes; Restraints in place, ⊕ circ, ⊖ skin breakdown, cont to monitor (b)(6)-2 [redacted]
14 Oct 03 0900	VSS A&O. Lungs clear. BS ⊕ x4 quad. Abd. soft non-distended. Peripheral pulses +2. Ex fix pin sites without crusting or drainage. Suct intact to LLE c̄ opsite dry. MRSA precaution in use. Will continue care as planned [redacted] 2LT (b)(6)-2

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PROGRESS NOTES
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STANDARD FORM 509 (REV. 5/1999)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14Oct03@2000	Assumed care @1800; All VSS, pt A&O X3, Ⓓ CMS, +2 PP, brisk cap Refill; Ø c/o pain or discomfort @ this time, NV intact throughout; pt OOB to amb in hall ĉ crutch assistance; wound vac intact; minimal drainage noted; Ex-fix in place, pt performed own pin care; pt voiding ĉ difficulty; HL patent; Ø significant Δ's; Restraints in place, Ⓓ circ. Ø skin breakdown; Cont to monitor [redacted] (b)(6)-2
15 Oct 03	Ortho Op Note Pre-Op Dx – (L) infected open tibia fracture Post Op Dx – Same Procedure: I&D (L) tibia Findings – Wound edema. Cultures taken Plan: WBA, NPO, VSL, plan to try soft trigger flap coverage Wet to dry dressings [redacted] (b)(6)-2
15OCT03@1530	Pt. sitting up in bed eating MRE. Pt. received from Surg. @ 1345. (L) LE washed out. Drain D/C'd. IV hep locked. Pt. has Ø c/o pain. [redacted] (b)(6)-2 2LT, AN
15OCT03@1630	Pt has W to D DSNG wrapped ĉ Cerlex to (L) LE, DSNG, CDI. Pt. has no c/o pain. [redacted] (b)(6)-2 2LT, AN

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
15OCT.03 2015	Pt A+Ox3, VSS, LS CTA (B), (T) BS x4, S1 S2 present, Ex Fix to LLE covered c̄ kerlix dsg. CDI, dsg to wound LLE CDI, pain controlled c̄ percs, IV HL (R) Hand patent, flushes well, ∅ s/sx of infex or infiltration, 2 pt restraint c̄ s/sx of complications. [redacted] (b)(6)-2
16OCT03 1000	VSS Alert & oriented. Lungs clear bilaterally BS (T) x4 grad. (L) LE wound beefy & moist. (L) LE ex fix pin sites without crustation or drainage. (R) hand saline lock patent & intact. OOB c̄ crutches to BR independently. Will [redacted] (b)(6)-2 Pedal pulses +2 c̄ toes capillary refill c̄ 3sec. Will continue care as planned. (b)(6)-2 [redacted] RCN
16OCT.03 1845	Pt A+Ox3, VSS, IV (R) hand d/c'd due to inflammation. Started new IV on (R) hand, flushes well, dsg (L) LE Δ'd, wound appeared beefy re, dsg W→D covered c̄ kerlix, LS CTA (B) (T) BS x4, OOB to BR + ambulate, 2 pt restraint c̄ complications. (b)(6)-2 [redacted] 9IW

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[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17OCT03 0900	VSS Alert & Oriented. @LLE covered with beefy red tissue and small amt of bone exposed. Old dsg removed (b)(6)-2 [redacted] drained with serosang drainage. @LLE ext fix pin sites without crusting or drainage. Pedal pulses palpable. Toes capillary refill < 3 sec. Tolerating regular diet. Had BM today. Lungs clear. Will continue care as planned. (b)(6)-2 [redacted]
17OCT03 2015	Pt A+O×3, VSS, OOB → BR c crutches, pain controlled c percs, Ex Fix LLE pin sites CDI, wound LLE covered c W→D dsg + kerlix, voiding c̄ diff, NPO p̄ MN to OR in AM, LS CTA(B), ⊕ BS×4, wound LLE appeared healthy, beefy red, minimal blood drainage, peripheral pulses +2, 2 pt restraint in place c̄ s/sx of complications, cap ref < 3sec. (b)(6)-2 [redacted] gw (b)(6)-2 [redacted]
18OCT03	Received pt resting in bed, VSS, NPO for OR today. Amb independent c crutches thru am. Left for OR @ 1200. Cipro hung prior to OR. Returned from OR @ approx 1530. Pt w/ new ex fix to (R) LE w/ dsg c/d/i. JP drain w/ sanguinous fluid (b)(6)-2 [redacted] 25cc @ end of shift (1640). Order for MSO4 to help control pain obtained. Pt assist w/ transfer on arrival to ward. Restraints per CPW protocol, ∅ breakdown noted @ site. Will cont to monitor [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19OCT.03 2030	Pt A+OX3, VSS, LS CTA(B), (+) BS X4, MRSA precautions, Ex Fix LLE, dsg covering wound CDI, JP draining small amount of blood, medicated for pain c̄ 2 percs, ate small amount of diet, HL IV (R) Hand intact s̄ s/sx of infex, 2 pt restraint s̄ s/sx of complications. [redacted] GIW (b)(6)-2 I concur with above assessment [redacted] (b)(6)-2
20OCT03 0730	VSS. AO. DSG to LLE CDI. XF-ix in place and pins CDI. (+) 1 pulse @ LLE. (+) 2 edema @ (L) foot. CR ≤ 2 seconds. (−) CNS @ all toes. (−) pressure sensation or pain. c/o moderate pain and provided 5 mg H_5O_4 & 2 percocet. Safety PO well and easily but swallows wires s̄ difficulty. MRSA (+). (b)(6)-2 [redacted]
1800	25cc Serosanguinous drainage from JP. [redacted] (b)(6)-2
20OCT.03 2030	Pt A+OX3, VSS, Ex Fix on LLE, dsg covering wound CDI, spots of blood around pin sites, NPO p̄ MN to OR in AM, medicated c̄ 2 percs for pain, HL (R) Hand intact, ∅ s/sx of infex, voiding c/y urine to urinal, JP suction to LLE draining minimal amount of blood, ate well, pt on abx tx, 2 pt restraint s̄ s/sx of complications. (b)(6)-2 [redacted] GIW (b)(6)-2 [redacted]
0545	JP drain emptied, had 10cc of blood.
21OCT.03	(b)(6)-2 [redacted] GIW

STANDAR[redacted]09 (REV. 5/1999) BACK
USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES (b)(6)-2
18OCT03 1902	Emptied 43cc BRB from JP drain site. — [redacted]
18OCT03 2205	VSS. AO. ⊕ pulse to LLE c new X-fix in place. JP draining BRB in moderate amounts. c/o pain @ 6/10 and provided 2 percocet. Foot is cool to touch and CR sluggish @ 2-3 seconds. Visibly tight yellow urine quantity sufficient. PSG's to XFX CDZ.
19OCT03 0330	No further c/o pain. — (b)(6)-2 [redacted] Emptied
19OCT03	0950- assumed care of pt. @ 0600. VSS-AO. Pt. resting well @ this time. Ex fix in place to ⊕ LE. JP drain intact. drained 20cc (b)(6)-2 [redacted] @ 0940. HL ⊕ FA CDT (b)(6)-2 ⊖ S/SX infect- will cont to monitor [redacted]
19OCT03	1600- Pt. c/o pain. 8mg MSO4 given @ 1100 via Jackson. Resting well at this time c ⊖ c/o pain. will (b)(6)-2 cont. to monitor. — [redacted]
	(1740) I concur c above assessment. — [redacted] (b)(6)-2

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

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21 OCT 03 0707	VSS. AO Resting comfortably in bed ∓ c/o pain @ this time. ⊕ pulse to LE. Prepared for OR this AM and remains NPO. CR ≤ 2 seconds. Pt. unable to feel pressure or pain @ distal toes of LE. Voiding light yellow urine, BS ∓ diffusely. LS CTAB. HRRR. (b)(6)-2 [redacted]
21 OCT 03 2000	Pt A+O×3, VSS, OOB to ambulate, medicated for pain ∓ percs, abd soft flat non-tender, Ex Fix to LLE, dsg covered ∓ ace wrap CDI, ambulate ∓ crutches well, LS CTA(B), active BS, Tol PO well, HL (R) AC intact, peripheral pulses equal (B), cap ref <3 sec, 2 pt restraint ∓ s/sx of infex. (b)(6)-2 [redacted] (b)(6)-2 [redacted]
22 Oct 03	Surge →
	3 lumen
	[redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	LAST	[redacted]AME	MI	SPONSOR'S ID NUMBER (SSN or Other)
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PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22OCT03	1400 - VSS AO assumed care of pt @0600. LS CTA (B), Resp. even un-labored, abd. soft non-tender, BS X4, pt. voiding per urinal. Pt. IV infultrated. Upon re-insertion pt. become combative swing arms wildly. Pt. then restrained per MP 3 point restraint. Multiple attempts to regain IV access failed. MD notified central line (L) SC placed. X-RAY ordered @ bedside notified MD. Drsg [redacted] Will cont. to monitor pt. (b)(6)-2 [redacted]
22OCT03	2030- Assumed Pt care @ 1800hrs. Pt A&O. LS CTA (B). S_1 S_2 present, (+) BS X 4 quads. Pt voiding qs cyu. LLE Ex Fx ⊂̄ Drsg CDI. Denies pain at this time will continue to monitor. — [redacted] (b)(6)-2 Spc 9/1WN
23Oct03	Assume care of PT @ 0600. VSS, A+O x3 Ambulatory with crutches. C/O pain, given two percocets. Pin care was completed. Δ drsg, BΞΔ wet to dry Skin intact @ 2pt restraint site. Will continue to monitor. — (b)(6)-2 9/W Spc [redacted]
23OCT03 2300	Assumed care @ 1800 hrs. VSS LS CTA (B). (+) BS x4 quads. S_1 S_2 present. Pt voiding cyu ⊂̄ difficulty Tol PO well. Discontinue LR. LLE Ex Fix in place Drsg [redacted] Pain controlled ⊂̄ percocet — [redacted] Spc 9/1WN16 (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD | **PROGRESS**

DATE	NOTES
24Oct03 1539	Assume care of PT @ 0600. VSS, A+O x3 Ambulatory to bathroom c̄ crutches. Performed PT today. Drsg Δed on (R) leg. Site looks to be healing, staples intact ∅ bleeding or swelling. C/O pain given percocets 2x restraints present ∅ skin irritation present. Will cont. to monitor. 9/6/[redacted] (b)(6)-2 [redacted] (b)(6)-2
24Oct03 2100	- Assumed care of pt. @ 1800. Assessment completed. LS CTA (B), Resp. even - unlabored S1S2 present. Abd. soft non tender BS x4 voiding per urinal. ambulated in pt. room x 10 minutes. Tolerates PO + Reg diet well. Drsng Δ conducted to (L) LE. Ext. fix in place. conducted Pin care c̄ 1/2 Peroxide + 1/2 NS. cleaned wound c̄ staples intact c̄ 1/2 Peroxide + 1/2 NS also. ∅ S/Sx infection Placed w→D drsng on wound + wrapped c̄ Kerlex. Gauze sponges placed around pin sites + wrapped leg c̄ ace bandages. [redacted] (b)(6)-2 ~~cont~~ pt. has (+) edema to (L) foot. Elevated leg on blanket. pt. has

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PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

LAST NAME	ME	MIDDLE	NUMBER

DATE	NOTES
(Cont'd)	no other complaints @ this time will continue to monitor pt (b)(6)-2 [redacted] (b)(6)-2 [redacted] 2nd/A
25 Oct 03 1604	Assume care of Pt @ 0600. VSS, A+O x3 c/o pain given two percocets. 2 pt restraints leave ∅ skin breakdown. Δed drsg on (L) leg, WTD ∅ sign of infection or bleeding. Pin care provided. Will cont. to monitor. (b)(6)-2 [redacted] 91W SPC
	~~(1735) Assumed care of pt @ 0600 ∅ report from~~ [redacted] (b)(6)-2
	concur c̄ above assessment (b)(6)-2 [redacted] 17A
25 Oct 03 1930	VSS alert & oriented. (L) LE ex fix pin sites without drainage or crustation. (L) LE incision to anterior thigh c̄ sutures intact but edges not approximate pink moist tissue noted. Percocet given for pain. Pedal pulses palpable + 2. Capillary refill to toes c̄ 3 sec. (L) Jugular triple lumen cath patent & intact. Will continue care as planned. (b)(6)-2 [redacted] 2C7 A2
26 OCT (1130)	Pt alo, VSS, medicated c̄ II Percocet for pain. pin care done (L) LE ex-fix. WTD drsg Δ'd. (+) pulses equal bil. brisk cap refill. (L) SC TL cath drsg CDI ∅ redness or edema @ site. flushes easily. amb. around room x 2. 2 pt restraints on while in bed. ∅ compromise to skin or circulation. Will monitor (b)(6)-2 [redacted] 91WMC

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

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MEDICAL RECORD — **PROGRESS**

DATE	NOTES
26Oct03 1900	VSS Alert & Oriented. OOB c crutches to BR. (L) Subclavian triple lumen cath patent & intact. (b) LE external fix. pin sites without [redacted] (b)(6)-2 drainage or crusting. Drsg dry & intact. (L) LE Toes folded blanket. Pedal pulses palpable +2. Toes c̄ capillary refill <3sec. Will continue care as plan. [redacted] (b)(6)-2
27Oct03 0920	VSS. A&O. Able to make needs known. (L) Triple lumen catheter patent & intact. LLE external fixator intact c̄ Kerlix drsg c̄ small amount serosanguinous drainage [redacted] (b)(6)-2 Moves toes. Capillary refill brisk. (+) pedal pulse. Will do pin care & drsg Δ. [redacted] (b)(6)-2
27Oct03 1430	Drsg Δ & pin care complete. Medicated c̄ Percocet two tabs p.o. for pain control [redacted] (b)(6)-2
27Oct03 1600	Pt sleeping. Will continue monitoring. [redacted] (b)(6)-2
27OCT.03 2000	Pt A+Ox3, VSS, LS CTA (B), (+) BS x4, OOB > BR c̄ crutches, LLE Ex Fix intact, dsg LLE Δ'd, yellow purulent drainage noted, medicated for pain.

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[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	NAME	MIL	NUMBER

DATE	NOTES
Cont.	∅ s/sx of infex, triple lumen IV flushes well, ∅ s/sx of infex or infiltration, pedal pulses equal (B), cap ref < 3sec, voiding ⊼ diff (b)(6)-2 [redacted] 91W ∅ s/sx of complications on points of restraint. [redacted] (b)(6)-2
10/28/03 1000	A&O. Able to make needs known. Medicated c̄ two percocet tabs p.o. for c/o LLE pain. Will monitor for effect. (b)(6)-2 [redacted]
28 Oct 03 1556	Assume care of PT @ 0800. VSS, A+O x3. Ambulate c̄ aid of crutches. c/o pain given percocets. Had bile movement twice today, not normal for PT. In 2x restraints without any skin irritation. Dry Δ ed on ⓡ leg, pin care completed on ⓛ leg ex fix as well. Will cont. to monitor. (b)(6)-2 [redacted]
28 Oct 03 1630	I concur c̄ above assessment. Will continue to monitor (b)(6)-2 [redacted]
28OCT03 1930	Pt A+O x3, LS CTA (B), (+) BS x4, dsg LLE Δ'd, sero-sang drainage on old dsg, sutures on wound intact, ∅ s/sx of infex, pain controlled c̄ percs. Pt ambulates c̄ crutches, Ex Fix LLE intact, ~~HL IV~~ (b)(6)-2 [redacted] CL intact, flushes well, ∅ s/sx of infex, IV abx adm, pt ambulates c̄ crutches, 2 point restraint ⊼ complications. (b)(6)-2 [redacted] 91W (b)(6)-2 [redacted]

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28 Dec 03 1445	Ortho Op Note Pre Op Dx: Infected Graft RT ⓐ Post Op Dx: Same Procedure: ① Revision of infected fistula ② Fistulogram ③ I+D ④ Exchange x 1 PLL ⑤ NPC [redacted] (b)(6)-2 [redacted] (b)(6)-2 Surgeon: [redacted] / [redacted] Brown-JAR Findings: Infected graft noted, ≈ 2-3 cm excised, shortened, 3 cm of fistula excised. Compared with Kaplan I fistula using same pins, plus 2 additional pins. Wound NPC'd. Plan: I+D in 24-72 hours, with close fistulogram since then!
	[redacted] (b)(6)-2
	[redacted] (b)(6)-2

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PROGRESS NOTES
Medical Record

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

USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29Oct07	Assume care of PT @ 0600. c/o pain given two percocets.
1430	A+O, VSS ambulatory c̄ crutches. Aid drsg to (R) leg CDI. Pin care done to (R) leg. 2 pt restraints without any irritation. Will cont. to monitor. (b)(6)-2 [redacted]
29OCT@2340	c/o pain. Med ō 2 perc. Will continue to monitor. DSG to (L) leg CDI. VSS. Ex fix ⊖ s/sx of infection. Sutures intact. Pt cont. IV ABX. (b)(6)-2 [redacted]
30Oct 0830	pt asleep, VSS, DRG to left leg CDI, sutures + ex-fix intact. will monitor. 0948 pt awake A+O3. Proceed with pincare and drsg change. pt c/o pain during drsg change esp. from the 3 in laceration to the left of the main wound which had some red thick cloudy drainage, drsg replaced pin-care complete. ⊕ circulation ⊖ sp of infection. Pt c/o of pain but was just given 2 percs ago. (b)(6)-2 [redacted] ~~[illegible]~~. Pt ~~to give~~ ii perc. (b)(6)-2 [redacted] (1730) I concur c̄ above assessment. (b)(6)-2 [redacted]
30 Oct 03 1900	VSS. Alert & Oriented. (L) subclavian IV patent & intact. (L) Ex fix pin sites without drainage or crustation. (L) Pedal pulses +2. (L) Toes capillary refill brisk. Percocet effective for pain mgmt. Will continue plan of care (b)(6)-2 [redacted]

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[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	E	MI	NUMBER

DATE	NOTES
3/Oct	Pt A+Ox3 pin-care completed, drsg Δ completed with minimal reddish drainage noted, sutures look intact wound approximating nicely. Bacitracin applied over suture line before redressing wound. Pt had c/o pain after pin-care and dressing change given 2 percs. Medic restraints x2 in place circulation intact. (b)(6)-2 Spc [redacted]
1Nov@ 0330	assumed care of pt @ 1800. VSS. no c/o. (D) LE ex-fix CDI, drsg CDI, pt did pin care. (+) CMS LLE, +2DP pulse, equal (BIL). (D) SC CL flushes well, HL'd. abx given as ordered. 2pt restraints on S/Sx of skin/circulation breakdown - Plan cont IV abx, monitor CMS. (b)(6)-2 [redacted] 1.12 addendum: MRSA precautions in effect. (b)(6)-2 [redacted] PD
1Nov03@1755	Assumed care @ 0600; AAOx3, pt A&O speaking arabic; pain controlled c̄ perc x1; pt performed own pin care, Δ'd drsg, CDI, ⊖ s/sx infection; (+) CMS, +2PP, brisk cap Ref; (D) SC CL patent, easily flushes; cont c̄ IV abx; MRSA precautions taken; Restraints in place, (+) circ, ⊖ skin breakdown, cont to monitor. (b)(6)-2 [redacted]
2Nov03@ 0100	assumed care of pt @ 1800. VSS, medicated c̄ Percocet for pain to LE, good relief noted. LLE c̄ ex fix, to tib/fib, (+) CMS, +2DP pulse, (D) ankle slightly edematous, (+1). LE wound healing well, drsg Δ'd pt did pin care; demonstrated good technique. (D) SC central line HL'd, flushes easily, IV ABX cont. Pt ambs c̄ crutches S̄ difficulty. Plan: cont IV ABX, monitor pain, cont MRSA precautions. 2pt restraints on S̄ S/Sx of skin/circulation compromise. Will monitor. (b)(6)-2 [redacted]

STANDA[redacted]RM 509 (REV. 5/1999) BACK
USAPA V1.00

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11/2/03 0838	Assumed care @ 0600. Pt A&O. Able to make needs known. VSS. LLE c̄ external fixator intact. Wounds c̄ stitches intact. Pt did good pin care. Wet → dry dsg Δ done. Bacitracin to wounds. Arm care done. Pt ambulating c̄ crutches for exercise. (L) Subclavian catheter intact & patent. Will cont. Abx therapy & pain control as ordered. Will continue to monitor & provide emotional support. 2 pt restraints while in bed. Assess throughout shift for skin integrity & circulation. Intact. (b)(6)-2 [redacted]
11/2/03 1645	Ambulating c̄ crutches for exercise. Denies pain. Will continue to monitor. (b)(6)-2 [redacted]
11/2/03 1800	Medicated c̄ percocet two tabs p.o. for c/o (b)(6)-2 LLE pain. Will continue monitoring. [redacted]
3NOV@0300	Pt consumed small amount of food. Had emesis x1 on previous shift. ⊖ emesis at this time. Pt did self pin care. W-D DSG to (L) LE wound. Sutures intact. ~~Wound~~ Sutures ~~[illegible]~~ not well ~~approximated~~ approximated. ~~Will con~~ Small amount of drainage noted on gauze. Med pt c̄ 2

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PROGRESS NOTES
Medical Record

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

LAST NAME	ME	MI	NUMBER

DATE	NOTES
	(cont') percocets. Continuing IV ABX. ~~Pt amb~~ Pt amb on ward x 1 c̄ steady gait on crutches. Pt resting quietly in bed. (b)(6)-2 [redacted]
3 nov Ø3 (124Ø)	Pt alo, VSS, Ø c/o pain, amb. x 2 ∃ difficulty (c̄ crutches). ex-fix intact ⓛLE, pin care done by pt, drsg Δ'd, sutures intact c̄ ↓scant amt sang. drainage on drsg. ⊕ pulses equal bil. to ⓑ ↓feet. IV ABX con't per orders. 2 pt restraints on ∃ compromise to skin or circulation. Will monitor [redacted] 9 INMO.
4NOV@0030	⊖ c/o pain. Cont' IV ABX. Amb x 1 c̄ crutchs (b)(6)-2 + steady gait. Pt aid own pin care. Δ'ed DSG to sutures on ⓛ fib-fib. W→D. Sutures poorly approximated, but healing. Sm amt of yellow drainage from sutures. ⊖ odor. Pt tol. Reg diet. ⊖ N/V. (b)(6)-2 [redacted]
4Nov 03 0054	Pt awake + oriented x3, pt has ⊖ c/o pain, pt ate breakfast am care complete, pt ambulated down ward with crutches, pin care completed w/ Hydrogen peroxide pt assisted pins look clean with ⊖ drainage some skin around pins has a little redness & scabbing around a couple; sutures ⊖ Δ'd ↓drainage, sutures intact developing some reddish discoloration and slight swelling, small amount of yellow drainage from initial ~~dressing~~ on ⓛ fib-fib. restraints x2 in place. circulation intact decreased in left foot. (b)(6)-2 [redacted]

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
5 NOV @ 0015	Pt did own pin care using hydrogen peroxide + Sterile saline. D'ed DSG to sutures. Sutures to anterior portion of (L) LE poorly approximated. Small amount of yellow purulent drainage from sutures. 2 x 2 cm raised lump on ~~[illegible]~~ sutures. Pt communicated that lump has been getting larger. No lump noted on previous night shift. Will continue to monitor. Sutures laterally on (L) LE not well approximated. (+) yellow drainage from suture site. W → D completed. Pt requested to ambulate on ward. Request denied. Pt cont IV ABX, tol reg diet. (b)(b)-2 [redacted] RN/PN
5 NOV 03 0200	- Assumed care pt. sleep yet easily arousable VSS ∅ c/o pain or discomfort @ this time. (L) LE external fixator intact pin care self. kerlix wrap to incision under ex fix serous drainage to dsg. Cont MRSA protocol. Lungs clear HRRR Active BS. Ambulates well c crutches Will cont to monitor (b)(b)-2 [redacted]
1000	Upon further accessment of wound to (L) LE suture wound has a lump pus and dark red blood filled. Oozing @ site. Will inform MD (b)(b)-2 [redacted]

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	LAST	FIRST	MI	

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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)(b)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5NOV.03 2000	Pt resting in bed, A+Ox3, VSS, LS CTA (B), (+)BS x4, Ex Fix LLE intact, self pin care, dsg Δ'd sero sang drainage noted on old dsg, lump on wound drained minimal amount of blood when applied pressure sutures intact, pt able to wiggle toes except big toe but with limited movement, cap ref <3sec, OOB to ambulate ē crutches, tol well, ate 90% of diet, CL intact flushes well, Ø S/Sx of infex, MRSA precautions, Cont on IV abx, 2 point restraint, Ø complications. (b)(6)-2 [redacted] 91W (b)(6)-2
6NOV03 0700	-Assumed care pt sleep yet easily arousable. External fixator to (L)LE intact surgical incision ē sutures intact Wound ē dark red blood oozing small amt. dsg CDI kerlix wrapped extremity warm to touch able to wiggle toes- Upon ambulation coloration becomes pale than dark- MD notified will and to monitor (b)(6)-2 [redacted] 91WM
6NOV.03 1900	Pt A+Ox3, VSS, OOB to ambulate ē crutches, tol well, Ø c/o pain, Ex Fix LLE intact, sero sang drainage noted on old dsg, dsg Δ'd CDI, Ø drainage from lump on wound, sutures CDI, cap ref <3 sec, limited movement on foot + toes in LLE, pt had an episodes of emesis, adm 25mg phenergan after c/o nausea tol well, 2pt restraint, Ø complications, CL flushes

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
Cont.	well, ∅ s/sx of infex, dsg intact, cont on abx therapy. (b)(6)-2 [redacted] RW
7 Nov 2003	I Concur c̄ above assessment [redacted] assumed care of sleeping so i woke him up and gave (b)(6)-2 food pt c/o that MCS food tastes nasty and encourages him to projectile vomit, pt stated that if he had to eat he would vomit on the floor, pt requested MRE so i wouldn't have to mop puke. Pt care complete, sutures intact, reddish drainage noted ∅ S/S of infection, restraints x2 in place @ circulation pt Dtail contac. (b)(6)-2 "Medic" [redacted]
7Nov03 @2330	assumed care of pt @ 1800. VSS. No c/o pain. Only c/o food served, tol sm amt of MRE. LLE c̄ ex-fix, drsg Δd & bacitracin applied, sm amt serosang drng noted. Pt performed non pincare c̄ good technique. +2 DP pulse to LLE, equal (B/L). (D) subclavian flushes well, IV Abx cont. Pt c̄ xt̄ emesis. approx 2300. Through interpreter, pt states nausea onset was quick & relieved p̄ emesis. Emesis approx. 200cc. Plan: cont IV Abx, monitor n/v, monitor dsg. (b)(6)-2 [redacted] CA
	Addendum: 2pt restraints MS s/sx of skin or circulation compromise. (b)(6)-2 [redacted] UPTA

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Ø8NOVØ3	(1515) Assumed care @ Ø600. Pt alert speaking Arabic. VSS. ØC/O pain. Pt had 2 episodes of emesis this shift. Pt medicated c̄ Phenergan IV p̄ 1st episode c̄ sm. amount of relief. MD aware of N/V. Labs drawn and sent to lab. Ø blood noted in vomit. Pt amb in hallway c̄ crutches s̄ diff. Drsg to LLE Δd. Ø drainage noted from wound. Pin care done. Pt refuses to eat NCD food. Given apple and crackers. Voiding s̄ difficulty. @ SC triple lumen flushes well s̄ s/sx infection/infiltration. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor [redacted] (b)(6)-2
8NOV.Ø3 1900	Pt A+Ox3, VSS, LS CTA(B), (+)BS x4, Ex Fix LLE intact, dsg LLE Δ'd, scant amount blood drainage noted on old dsg, sutures to wounds intact, Ø s/sx of infex, pt moves (L) foot with limited mobility, cap ref < 3sec, pt refused dinner due to feeling nauseas, x2 episodes of vomiting, mostly liquid vomit, refused phenergan stating it made him more nauseous, voiding s̄ diff, Ø c/o pain, CL (L) SC patent, Ø s/sx of infex. 2 pt restraint, Ø complications. [redacted] (b)(6)-2

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

[redacted] (b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
09Nov 03 1620	Assume care of PT @ 0600. A+O x3, VSS, PT isn't eating any food only drinking water and juice. Med drug to ① 1g CDT. Dr Wynn DC Gentamycin, due to go to surgery tomorrow. Used crutches for exercise c/o dizziness. Given zofran for vomiting. PT in 2pt restraints without any skin irritation. Will cont. to monitor. [redacted] (b)(6)-2
09Nov03 1500	I concur c above assessment note. Chem 12, electrolytes, UA to lab. Results pending. Will have Abd Flat/Upright ok to Radiology [redacted] (b)(6)-2
9NOV03 2000	VSS; A&O. Pt aware of NPO status for MA. Lungs clear BS(+) X4 grid. Denies N/V @ this time. Consumed 40% of reg diet for dinner. ⓛ chest SC heplock patent & intact ⓡ Tib/Fib dry dry & intact. ACE pins also to ex fix without drainage/crustation. OOB → BR c crutches. Will continue cimer as planned [redacted] ZCM (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.

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 Nov 03 [redacted] (b)(6)-2 1549	Assume care of PT @ 0600. VSS, Ato Ambulate this morning c̄ aid of crutches. Had surgery today removed ex fix replaced with cast also removed centre line replaced with IV. Medicated with morphine. X-Ray's requested for (D) leg. Will cont to monitor. — 9/a SPC [redacted] (b)(6)-2
10 Nov 03	Medicine Note:
KUB = Nl	Pt. c̄ N/V x3-4 days. Pt. describes N/V after eating ~~cross~~ c̄ epigastric
9 Nov	pain. No loss of appetite, no pain before meals. Denies dysphagia, denies
nl 1.6 2.0	~~bowel~~ hememesis. BM regular N/V even with liquids. Ø Flomyfesin/N/A
UA 1030, 4+ protein	Pt. has been on Gentamycin x 6wks. Has no hx of GI problems.
LFT's = nl	Wreaned c̄ Zantac.
	(O) Thin Non icterus ♂ ABD = flat/soft/NB NT NABS
	(A) nonspecific N/V; doubt stricture/PUD/mass/viral.
	Preserved Renal function: 2° ↓ PO intake (2° #1) & 2° to Aminoglycoside
	(P) IVF x 2L LR; Zofran x ∞; d/c Gentamycin.
	F/u 10 Nov; No N/V today; tol PO well, but cre ↑ 2.2
	Recommend repeat Cre in 2-3wks; No Renal toxic Rx
	Still able to transfer to Iraqi Civilian Hospital. [redacted] (b)(6)-2
11 NOV 0005	VSS. Pt amb c crutches on ward. ⊖ c/o pain. Infusing IV ABX. (D) Leg ⊖ Ex fix ⊕ cast. Toes warm to touch, ⊕ brisk capr fill, pt able to move toes. ⊖ c/o pain. ⊖ N/V on shift. Will continue to monitor. — [redacted] 20/m (b)(6)-2

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

[redacted] (b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11 Nov 03	Assume care of PT @ 0600. VSS, Afeb. Ambulate c crutches. C/O pain @ hand due to IV, DC'ed IV. Cast (R) leg intact, able to move toes. Waiting to be released to Iraqi hospital. Will continue to monitor.

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES (b)(2)-2
	Orths Discharge Summary, [redacted]
11 NOV 03	ADMITTED: 25 SEPT 03
0745	18 YO Iraqi male brought here 4 months after open (L) tibia fracture. Come with X-fix in place, large draining wound. Found to have MRSA osteomyelitis. Multiple I+Ds, attempts at VAC closure.
	Had shorting of tibia & fibula to remove dead bone, & new fixator placed. Wound now mostly closed. Patient refused to remain to complete his care. Placed in long leg cast yesterday at his request even though he has been told this may lead to amputation.
	PLAN: LEVOFLOXACIN 250mg P.O. Q DAY
	LONG-LEG CAST - WEIGHT BEARING AS TOLERATED
	FOLLOW UP IN 4 WEEKS
	PERCOCET 1-2 P.O. Q 4-6 HRS [redacted] (b)(6)-2
	(b)(6)-2 [redacted] CDR

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

S: Pt is a 18 yo Iraqi, ♂ EPW s/p GSW to (L) Tib/fib c̄ ex fix placed in Iraqi MTF ~4ma. C/o pain & d/c at wound site. Fevers, Chills.

PMHx ∅.
PSHx
Ex Fix.
Meds ?
Abx
NKDA.

O: WD/WN in NAD Ambulc̄ Crutches. NAT/OTN
HEENT: WNL
Lungs: (D) CTA
Cor: RRR ∅.
Abd: (D) BS+ NTND
Ext: (L) Tib/fib ex fix c̄ mod purulent D/c from wound near Tibia mid shaft.
N/V intact.

7.5 > 15/49 < 276
ESR: 15
XRay: comminuted Tib fib fx, good alignment.

Admit to ICW.

(b)(6)-2
D/w Dr [redacted], Ortho

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
			[redacted]

(b)(6)-2

DIAGNOSIS

Osteomyelitis

CODE

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

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day/Month, Year)*: 25/09/03 | TIME: 1040

TRANSPORTATION TO FACILITY: wheel vehicle

SEX: M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

AGE: 18

MILITARY STATUS

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

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS: names unknown

ALLERGIES: Ø

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☑ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: LLE Elixation

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☑ NON-URGENT

TIME: 1050

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

VITAL SIGNS

TIME	1055.				
BP	118/62.				
PULSE	74.				
RESP.	14.				
TEMP	98.5				
WT	97% RA				

LAB ORDERS

✓ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		CHEM:
BLOOD C&S X			

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	(L) Tib/fib XRay				
	CBC				
1100	MSOR DX Percocet 1 po.	Kosma	Lt [redacted] (b)(6)-2	1100	

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL | RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE | TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] EPW

(b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

26 SEP 03
1135

Ortho Op Note

Pre-Op Dx - Infected delayed union of (L) tibia-fib

Post-Op Dx - same

Procedure - I&D, debrided (L) tibia

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

Anes - LIDU CLS

Findings - Lots of fibrous tissue, no frank pus. Bone viable.

Plan - Closed over pronose. Left cultures (-), will pack with bone graft, remove fixator, place in cast.

[redacted] (b)(6)-2

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

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

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 OCT 03	Orthopedic Note
1230	
	Pre-Op Dx - Infected (L) tibial fx
	Post Op Dx - same
	Procedure - I&D DPC (L) tibial fx
	Surgeon [redacted] (b)(6)-2
	Findings - Wound clean. Fibular wound
	gross, closed with 2-0 nylon.
	Plan - IV ABX
	[redacted] (b)(6)-2

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

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

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 23Sept03 | 26Sept03 | 27Sept | 28Sept | 29Sept | 30 | Oct 1 | OCT 2

19 | HOUR: 1900 | 0 1 | 1100 | 1 | 08 | 1 | 8 | 9 | 8 | 8 | 2

PULSE (O) | TEMP. F (•) | TEMP. C

105° 40.6°

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 37.2°

98.6° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

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)*

[redacted] (b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY | 19 | HOUR

PULSE (O) | TEMP. F (•) | TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(b)-4

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 17 Oct | 18 Oct | 19 Oct 03 | 20 Oct 03 | 21 Oct | 22 Oct | 24 Oct 03

19 | HOUR: 8 20 01 1 20 0 20 2 8

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

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

(Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

BLOOD PRESSURE: 115/53 | 114/68 | 125/70 | 110/68 | 127/53 | 125/70 | 124/67 | 112/61 | 124/70 | 116/58 | 114/63 | 123/76

81 | 114 | 100 | 111 | 103 | 112 | 101 | 95

97 | 98.6 | 98 | 98 | 98.1 | 98.9 | 98.2 | 99.9

HEIGHT: | WEIGHT →

O_2 SAT 98 | 98 | 100% RA | 97 | 100% RA | 97% | 98.1 | 98.1 | 99% | 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.

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- 1 DAY

MONTH-YEAR OCT 03 DAY 10 11 12 OCT 03 13 OCT 14 OCT 03 Kan 1 16 OCT

19 HOUR 1 1 1 10 20 8 20

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

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

PULSE	
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

	10	11	12 OCT 03	13 OCT	14 OCT 03	Kan 1		16 OCT
Resp.	16 8	8			8	8	8	8
BP	109/61	102/66	125/61		110/64	115/70	109/69	109/66
	73		79	115/65	97.3	102/68	72	81
	97		98.3		168		95 98	
	98%		98.1					
	98%	98%		98.7 2A	98%	98% 2A	—	98%
	RA	RA						

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

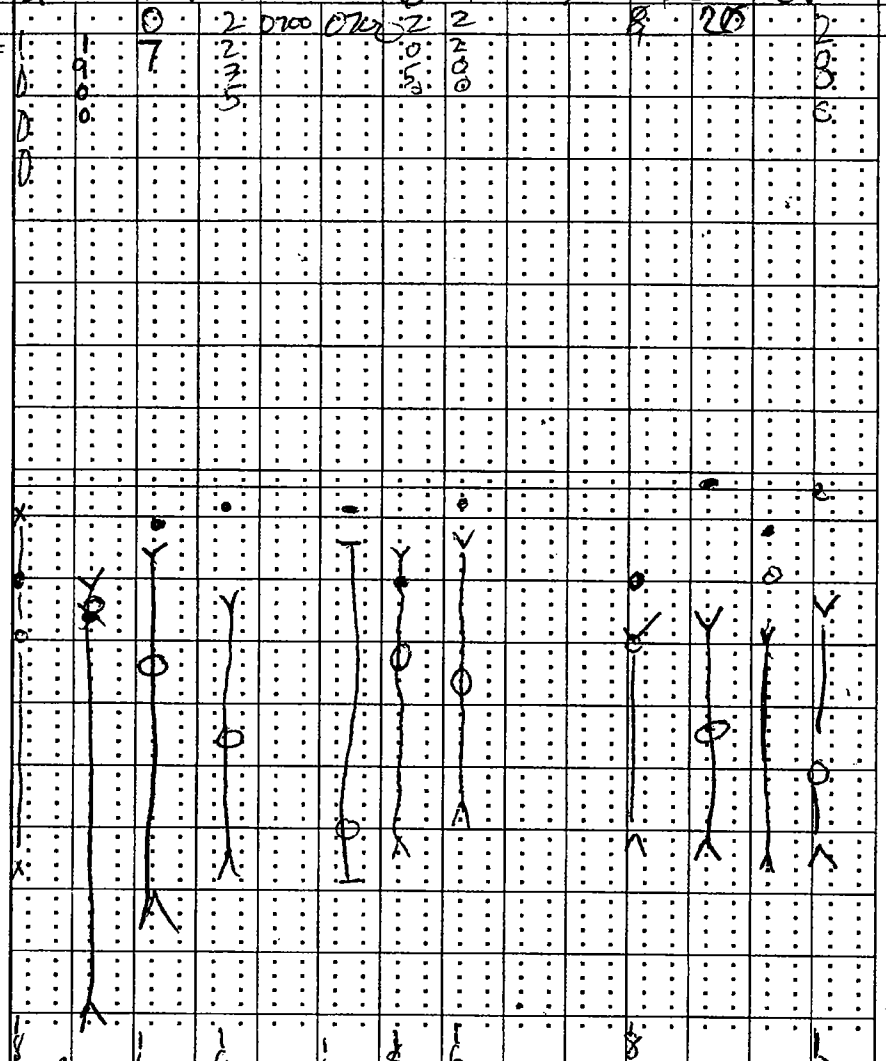
MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Nov 2003 | DAY | HOUR

PULSE (O) | TEMP. F (•) | TEMP. C



(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

P

T

HEIGHT: | WEIGHT →

Record special data only when so ordered

Sat

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																		
POST- DAY													HALLOWEEN					
MONTH-YEAR Oct 19	DAY	25 Oct		27		28		29		30		31		1 Nov				
	HOUR																	
PULSE (O)	TEMP. F (•)																	TEMP. C
	105°																	40.6°
180	104°																	40.0°
170	103°																	39.4°
160	102°																	38.9°
150	101°																	38.3°
140	100°																	37.8°
130	99°																	37.2°
	98.6°																	37.0°
120	98°																	36.7°
110	97°																	36.1°
100	96°																	35.6°
90	95°																	35.0°
80																		
70																		
60																		
50																		
40																		
RESPIRATION RECORD																		
BLOOD PRESSURE		122/70	118/70	124/70	120/85	120/65		123/74	119/61	122/72	124/88	110/64			120/72			
		T98		T98	T97	T97		T99.4	97.5	98.2				124/66				
		H74		H77	H75	H75		H77	92	77								
HEIGHT:	WEIGHT →																	
RA		95%	96		94%	94%		98%	96%	98%	98%	99% RA		97%	98% RA			

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																	
POST- DAY																	
MONTH-YEAR Nov	DAY	16		11													
1963	HOUR		1														
PULSE (0)	TEMP. F (°)		8 3 0														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		8	4	6													
BLOOD PRESSURE		118/69	122/69	115/69													
		92		85													
	Temp	98.5	98.4	97.3													
HEIGHT:	WEIGHT ~~Temp~~																
	RA O2	95%	99%	98%													
	O2																
	Pulse Pulse		77														

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

~~TWENTY FOUR~~ HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM ________ HOURS TO ________ HOURS	TOTAL HOURS COVERED	DATE 18-19 OCT

~~INTAKE~~ OUTPUT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

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

JP bulb ~~IRRIGATIONS (N/G, Bladder, etc.)~~ (L) LE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1640	SANG.	25cc	25cc
19OCT 0940	Blood	20cc	45cc
19OCT 1730	Blood	30cc	75cc
0545	Blood	10cc	85cc

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET	FROM 06 HOURS TO 06 HOURS	TOTAL HOURS COVERED	DATE 19 Oct

INTAKE

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

IRRIGATIONS *(N/G, Bladder, etc.)*			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

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

OTHER INTAKE			
TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
GRAND TOTAL INTAKE			

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

14 OCT 5

OUTPUT

Voided

URINE						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
0800	300cc	300							
1500	200	500							
1610	200	200							
1780	200	900							
1840	200	1100							
0030	350	1450							
0400	400	1850							
0620	300	2150							

~~[illegible]~~ Residual gm supra pubic

						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
1500	10	10	0030	30	95				
1610	20	30	0400	10	105				
1330	25	55	0600	Ø	105				
1840	10	65							

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

20 OCT 03

OUTPUT

Void ~~URINE~~						NASOGASTRIC			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
1050	250cc	250							
1757	525	775							
0200	550	1325							

Suprapubic ~~CHEST~~ Residual						EMESIS			
TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	TYPE	ACCUM TOTAL
1050	0	0							
1757	0	0							
0200	0	0							

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 06 HRS TO _____ HOURS | TOTAL HOURS COVERED | DATE 21 OCT

INTAKE

Void per ~~Oral~~ Urinal

TIME	TYPE	AMOUNT	ACCUM TOTAL
0700	Clear yellow	350	
0930	clear yellow	275	

INTRAVENOUS

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

Residual ~~IRRIGATIONS (N/G, Bladder, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0700	- clear yellow	20cc	20cc
0930	clear yellow	8-	20cc

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

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

4. PROPOSED SURGICAL PROCEDURE:

I&D Lt tibia, Replace VAC

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

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

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

[redacted] (b)(6)-4

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

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

[redacted] MAJ AN 10 Oct 03 DATE

11. POSTOPERATIVE EVALUATION: (b)(6)-2

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2

[redacted] MAJ AN

DATE: 10 Oct 03 TIME:

13. PREOPERTIVE [redacted] ON PREP[redacted] BY (Signature and [redacted] (b)(6)-4 [redacted] MAJ/A

DATE: 10 Oct 03 TIME: 1400

MEDCOM - 20591

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT FOR Use this form. See AR 40-407: the Proponent agency is The Office of the Surgeon General.
1. AGE HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodin, Tape, Medication) ☐ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD REACTION: unknown. 3. PREVIOUS SURGERY [ ] NO [✓] YES (type):

4. PROPOSED SURGICAL PROCEDURE:

I&D Lt Tibia

Pt not english speaker. Unable to ask Hx. [redacted] CRT(AW) (b)(6)-2

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____

Tobacco_____ ppd X___vrs Body Piercing _____ Diabetes (Y) (N) ROM _____ ASA/Motrin W 72hrs (Y) (N)

ETOH _____ Implants _____ Respiratory Disease (Asthma COPD) (Y) (N) Anticoagulants (Y) (N)

Glasses/Contact (Y) (N) Dentures _____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ potential for anxiety related to: ✓ 1) Surgical Procedure& Operating Room Environment _____ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	O Pt. verbalizes any specific anxiety. O Pt. Exhibits relaxed body posture.	O. Allow pt. to verbalize freely. O. Explain Or environment and answer questions regarding surgery. O. Offer comfort measures. (e.g. warm blanket. touch). O. Explain all nursing procedures before they are done. O. Remain with pt. Whenever possible. ~~O. Maintain family interface. Parents to stay with pt.~~ N/A [redacted] (b)(6)-2
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia _____ 3) Medical/Smoking History	O Pt. will be able to breath without difficulty during immediate intraoperative 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 intubatior and extubation.
C. INTEGUMENT ✓ Potential Impairment of Skin Integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement _____ 3) Positional Aids ✓ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	O Pt. will 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 form pooling.

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

[redacted] (b)(6)-4

[redacted] (b)(2)-2

18 OCT 03

VERIFICATIONS AT HOLDING AREA:

! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since_____ ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact precautions (Y) (N)
! Family/Friend:_____

N/A [redacted] (b)(6)-2

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease 4) Safety Devices 5) Hypothermia	O. Pt. will exhibit signs of adequate tissue perfusion (e.g. color, warmth. pedal pulse.	O Check foe support stocking or ace warps. if none, check with doctors. O Check that safety straps are correctly applied. ~~O Offer pillow for under knees.~~ ~~O Place and take down legs from stirrups with slow bilateral mot~~ [redacted] N/A O Check that rings and all bo[redacted] piercing has been removed. (b)(6)-2
E. NEUROMUSCULAR CONTROL E.I. ✓ Potential Impairment of Mobility due to: ✓ 1) Pain 2) Intra operative Hazzards 3) prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. To/form OR table E.2. ✓ Potential Discomfort Due to: ✓ 1) Length of Surgery 2) Positioning 3) Arthritis	O pt. will be transferred to OR table without difficultly. O pt. will be 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. Bath towel. etc) for positioning.
F. Special Senses F.I. ____ Diminished visual perception due to being: 1) pre-medicated 2) W O GLASSES F.2. ____ Potential for Decreased Communication due to: 1) Diminished Hearing 2) Language Barrier F.3. ____ Potential Injury due to Dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	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. Speak clearly and slowly. O Address pt. from ____ side. O Validate pt.'s understanding of verbal communication. O Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS OR Continuation of Above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS OR continuation of above interventions.

10. OR NURSING INTERVENTION COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

(b)(6)-2 [redacted] MAJ AN 18OCT03 DATE

11. POSTOPERATIVE EVALUATION : SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y) (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated

LEVEL OF ACTIVITY: ☐ MOVES ALL EXTREMITIES ☐ Moves Upper Extremities ☐ Transferred to Litter With roller due to spinal

BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature) (b)(6)-2 [redacted] MAJ AN DATE: 18OCT03 TIME: 1150

13. PREOPERATIVE EVALUATION PREPARED BY (Signature) (b)(6)-2 [redacted] CPT/AN DATE: 18OCT03 TIME: 1943

REVERS OF FORM 5179, JUN 91

USAPA V1.0

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

4. PROPOSED SURGICAL PROCEDURE:

I+D Lt tibia

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: See chart Implants: yes. LE 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	✓ Pt. verbalizes any specific anxiety. ✓ Pt. exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures, (e.g., warm blanket, touch) ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. o Maintain family interface. as possible via translator
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	✓ PT. will be able to breathe without difficulty during immediate intra-operative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress ✓ Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad position; fluid shift	✓ PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

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

DA FORM 5179, JUN 91 Previoius editions are obsolete. USAPA V1.01

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

[redacted] 21 Oct 03

(b)(2)-2

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

10. [redacted] G INTERVENT[redacted] LETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CRT/AN (b)(6)-2 21OCT03 DATE

1[redacted] OSTOP[redacted]IVE EVALUATION:

Dressing CDI
Resp- Even + unlabored.
Ø S/S of acute distress
Bovie pad site CDI

12. [redacted] PREPARED BY (b)(6)-2

[redacted] CRT/AN

[redacted] TE: 21OCT03 TIME: 1130

13. P[redacted]OPERTIVE EVALUA[redacted]N PREPARED

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

[redacted] E: 21OCT03 TIME: 1245

MEDCOM - 20595

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA gurney BY anesthesia

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

3. DATE 26 Sep 03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN [redacted] (b)(6)-2 TIME 1010 NUMBER 2-1 (4)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

(b)(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D (b)(6)-2	RELIEF SCRUB	(b)(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] AN/66E	RELIEF CIRCULATOR	CPT [redacted] AN (b)(6)-2

7. POSITION AND POSITIONAL AIDS (Specify) Pt transferred to OR table, anatomically aligned for surgical procedure c padding under head (B) arms on pads

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

COMMENTS:

(b)(6)-2

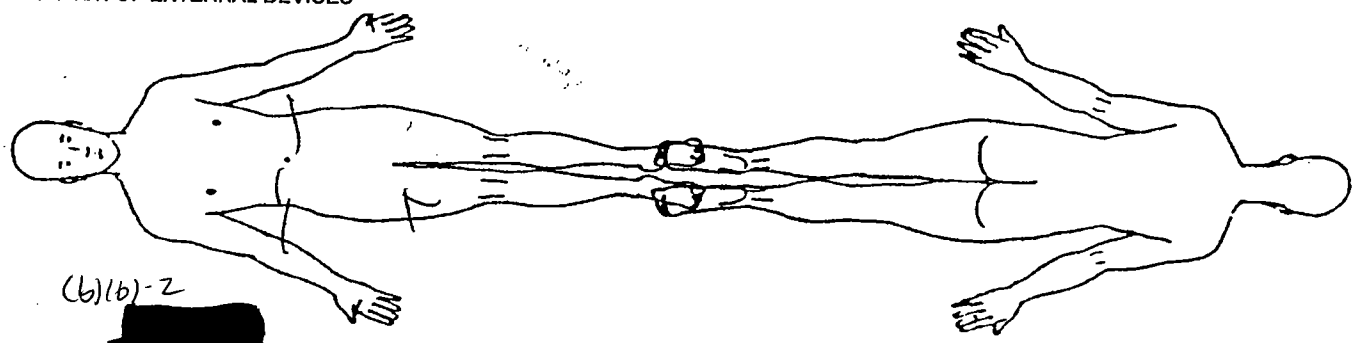
8. SKIN PREPARATION

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

COMMENTS: No nicks or cuts noted.

PREP SOLUTION (Specify)
SITE: BY WHOM:
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



(b)(6)-2 [redacted]

LEGEND [redacted] and Pad -- Safety Strap === Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☒ Yes ☐ No	C	/	C	SSG [redacted]	CPT [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)(2)-2

26 Sep 03

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

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

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

☐ BIPOLAR NO: _____

MEDCOM - 20596

DA FORM 5179-4, OCT 87 REPLACES DA FORM 5179, 1 MAY 80, WHICH IS OBSOLETE

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE ARM (L) Leg

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☒ NO ☐	NAME Infected bone (L) leg	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☒ NO ☐	NAME Infected bone (L) leg	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 3/8 Penrose	2.	3.
SITE	1. (L) leg	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
fluff
Kerlix

19. ADDITIONAL INFORMATION
WC [redacted] (b)(6)-2
Surgeons [redacted] Anesthesia: CRT [redacted] (b)(6)-2 Anesthesia Type:
[redacted] (b)(6)-2

Bovie Pad site intact pre-op [redacted] (b)(6)-2 post-[redacted] (b)(6)-2 Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op ____ : post-op
Tourniquet Time: Up ____ Down ____ [redacted] N/A
(b)(6)-2

20. OPERATION(S) PERFORMED
I & D (L) Leg wound

21. PATIENT TRANSFERRED TO ICU 3 (b)(6)-2 TIME 1155 METHOD gurney

22. REGISTERED NURSE SIGNATU[redacted] CRT/AN

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-407, the r ency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERA OOM VIA litter BY anesthesia	2. PATIENT IDEN CORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT / AN
3. DATE 29Sept 03 TIME PATIENT ARRIVED IN SUITE 1800	4. PATIENT IN ROOM (b)(6)-2 [redacted] TIME 1800 NUMBER 9

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

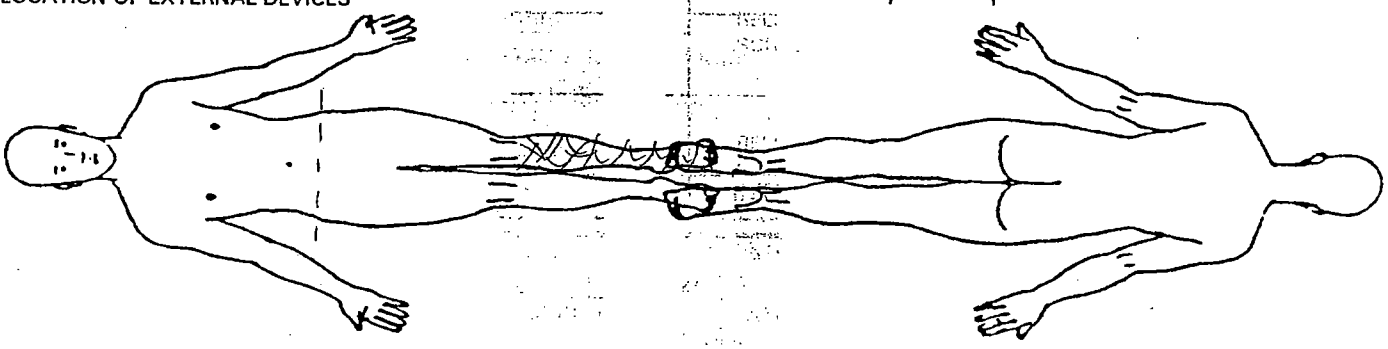
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/soln
SITE: (L) lower leg BY WHOM: [redacted] (b)(6)-2
SITE: BY WHOM:

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

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

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

[redacted] (b)(6)-4

[redacted] (b)(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO; TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

19. ADDITIONAL INFORMATION

Surg: [redacted] (b)(6)-2 Anesth: [redacted] (b)(6)-2 CRNA General

20. OPERATION(S) PERFORMED

I & D (L) Lower Leg Wound

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU recovered in OR	1843	Litter

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

REVERSE OF DA FORM [redacted]CT 87 USAPA V1.00

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERA[illegible] [illegible]OOM
VIA litter BY [illegible] Anesia

2. PATIENT IDENTIF[illegible] CORD REVIEWED AND PROCEDURE
VERIFIED BY CPT [redacted] (b)(b)-2

3. DATE 1 Oct 03 TIME PA[illegible]NT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME 1810 NUMBER 1-5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: - proper body alignment maintained

8. SKIN PREPARATION

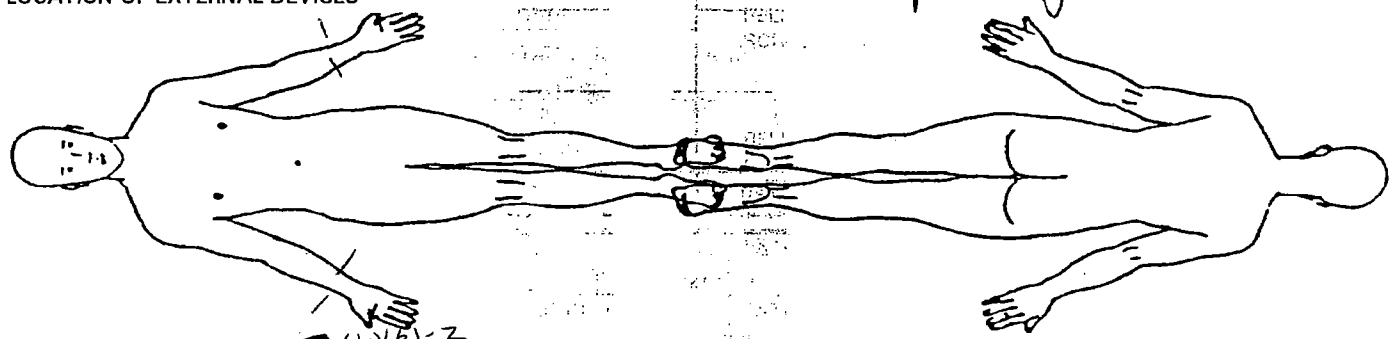
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine
SITE: (L) leg BY WHOM: [redacted]
SITE: BY WHOM: (b)(b)-2

COMMENTS: no pooling or skin A's noted

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

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

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

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

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

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

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

☐ BIPOLAR NO: _____

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

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.	2.	3.
SITE	1.	2.	3.

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

19. ADDITIONAL INFORMATION

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

* MRSA precautions followed

- DA 5179 on chart, Ø Δ's noted

20. OPERATION(S) PERFORMED
I+D (L) leg

21. PATIENT TRANSFERRED TO PACU in OR ICW-1 | TIME see DA 7390 | METHOD Litter

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

REVERSE OF DA [redacted] 87

USAPA V1.00

MEDICAL RECORD — **INTRAOPERA[illegible] DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERA[illegible] ROOM
VIA litter BY anesthesia

2. PATIENT IDENTIFI[illegible] PROCEDURE
VERIFIED BY [redacted] CPT / AW

3. DATE 30CT 03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 0949 (b)(6)-2 NUMBER 1-1 (3)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:
pt not english speaker.

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

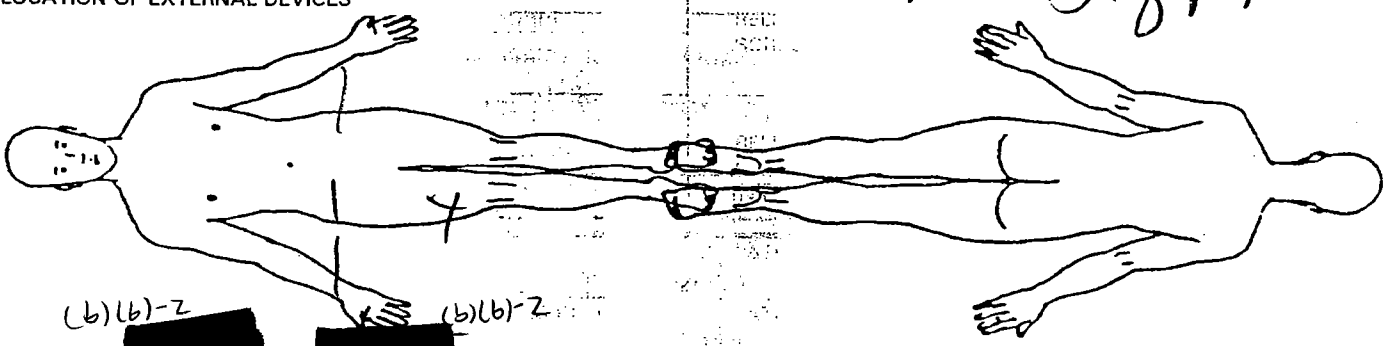
8. SKIN PREPARATION

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

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

COMMENTS: no pooling of prep noted

9. LOCATION OF EXTERNAL DEVICES



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

LEGEND [redacted] Safety Strap = = = Tourniquet

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☑ Yes	☐ No	C	/	C	PFC [redacted]	CPT [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

(b)(2)-2

[redacted]

30CT03

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, :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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

(b)(6)-2

17. TUBES, DRAINS/PACKING YES ☒ NO [redacted]

TYPE/SIZE	1. JP Drain	2.	3.
SITE	1. (L) leg.	2.	3.

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

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

I & D (L) fem

21. PATIENT TRANSFERRED TO 1 CU3 TIME 1047 METHOD gurney

22. REGIS[redacted] CPT/AN

REVERSE OF [redacted] *DRM 5179-1, OCT 87* (b)(6)-2 MEDCOM - 20603 USAPA V1.00

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPER OM VIA litter B. thesia	2. PATIENT IDENTI CORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN (b)(6)-2
3. DATE 6 Oct 03 TIME PATIENT ARRIVED IN SUITE 1531	4. PATIENT IN ROOM [redacted] TIME 1531 NUMBER

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] (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Proper body alignment maintained

8. SKIN PREPARATION

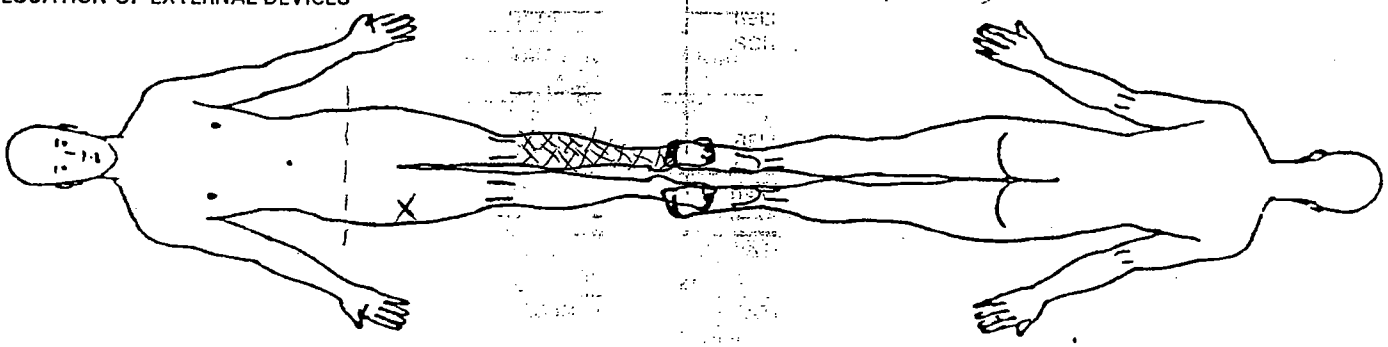
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/sol'n
SITE: Lt. Lower Leg BY WHOM: Meyer
SITE: BY WHOM:

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS C = Correct I = Incorrect I→C [redacted] (b)(6)-2

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

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

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

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

☐ ESU NO:
GROUND PAD: BRAND Valleylab
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; :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% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. JP Drain	2.	3.
SITE	1. Lt. Lower Leg	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Ioban

Fluffs

19. ADDITIONAL INFORMATION

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

Anesth: [redacted] (b)(6)-2 CRNA Anes. Masic

20. OPERATION(S) PERFORMED

I & D Lt. Lower Leg

21. PATIENT TRANSFERRED TO (b)(6)-2 [redacted] TIME 1627 METHOD Litter

Recov. by PACU ~~no OR per MRSA policy~~

22. REGISTERED NURSE SIGNATURE

[redacted] CPT JAN

REVERSE OF DA FORM 517 OCT 87

USAPA V1.00

(b)(6)-2

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For t[illegible] of this form, see AR 40-407, the prop[illegible] [illegible]ncy is the office o[illegible] [illegible]e Surgeon General.

1. PATIENT TRANSPORTED TO OPERA[illegible] [illegible]OOM [illegible] (b)(b)-2
VIA Litter BY MAJ [redacted]

2. PATIENT IDENTIFI[illegible] [illegible]CORD REVIEWED AND PROCEDURE
VERIFIED BY MAJ [redacted] (b)(b)-2

3. DATE 10 OCT 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

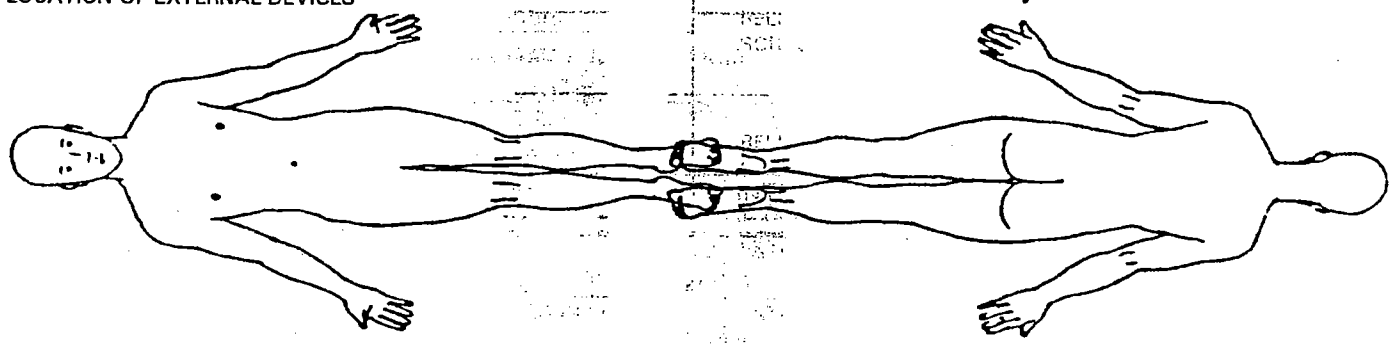
HAIR REMOVAL ☐ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub & sol.
SITE: Left Leg BY WHOM: MAJ [redacted] (b)(b)-2
SITE: BY WHOM:

COMMENTS: No pooling of solution

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				(b)(b)-2	(b)(b)-2 [redacted]
Needle Sharp	☑ Yes	☐ No				SPC [redacted]	MAJ
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)(b)-4

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

☐ ESU NO: [redacted] (b)(b)-4
GROUND PAD: BRAND Valley lab
LOT NO: [redacted] Exp 2005-04
(b)(b)-4

☐ 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, IMPLAN' ☐ YES ☐ NO IF YES NAME: I 'UMBER; 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 IF YES, SITE
YES ☐ NO ☑

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

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

18. DRESSING/IMMOBILIZATION *(Specify)*

19. ADDITIONAL INFORMATION

(b)(6)-2

Surgeon: Dr [redacted]

Anes: MAJ [redacted]

(b)(6)-2

20. OPERATION(S) PERFORMED

I & D Lt Tibia, Replace VAC

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	See SF54	GR litter

22. REGISTERED NURSE SIGNATURE

[redacted] MAJ AN 10 Oct 03

(b)(6)-2

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 15 Oct TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 1210 NUMBER 1 #4

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER *(Specify)*

COMMENTS: NKDA, NPO p MN

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D (b)(6)-2	RELIEF SCRUB	N/A
ASSIGNED CIRCULATOR	ILT [redacted] 66E (b)(6)-2	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

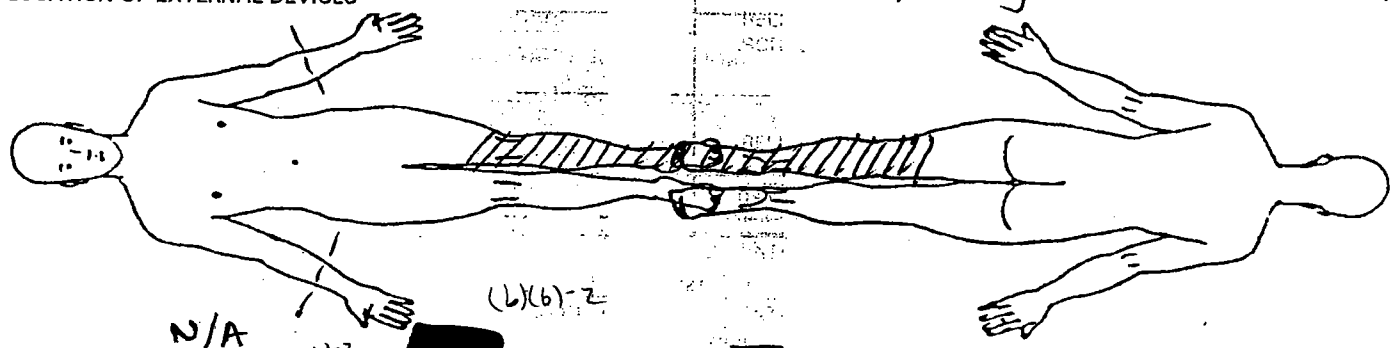
HAIR REMOVAL [ ] YES [X] NO
DONE BY: [ ] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: Left 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 (b)(6)-2 -- Safety Strap [redacted] = = = Tourniquet N/A prep

Initial: PFC [redacted] ILT (b)(6)-2

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
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:
GROUND PAD: BRAND N/A
LOT NO:

[ ] ESU NO:
GROUND PAD: BRAND N/A
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; TURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

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

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME (A) wound inf. (L) tibia (C)	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☒ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	Fluffs		
SITE	(L) tibia		

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

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted] (b)(6)-2
Anesthesia: MAJ [redacted] (b)(6)-2

20. OPERATION(S) PERFORMED
I&D (L) tibia

21. PATIENT TRANSFERRED TO PACU TIME See DA7389 METHOD Liter c̄ O2

22. REGISTERED NURSE SIGNATU [redacted] (b)(6)-2

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 pro[illegible]ency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERA[illegible] ROOM (b)(6)-2 (b)(6)-2 2. PATIENT IDENTIF[illegible] RECORD REVIEWED AND PROCEDURE

VIA Litter BY MAJ [redacted] / MAJ [redacted] BY MAJ [redacted] (b)(6)-2

3. DATE 18 Oct 03 TIME PATIENT ARRIVED IN SUITE 1200 4. PATIENT IN ROOM TIME 1200 NUMBER 1-1 (2)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] (b)(6)-2 CPT [redacted] (b)(6)-2 (12:10 - end)	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

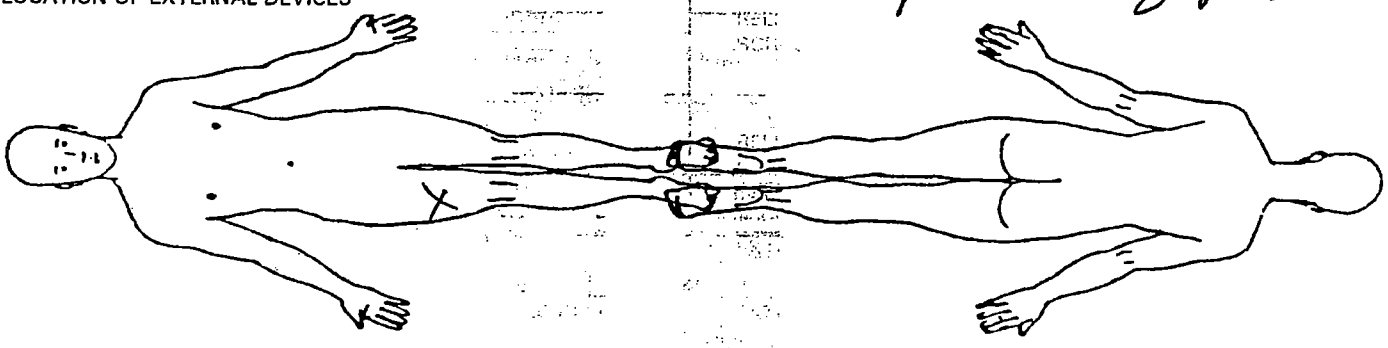
PREP SOLUTION *(Specify)* Beta / Beta

SITE: (L) Leg BY WHOM: MAJ [redacted] (b)(6)-2

SITE: BY WHOM:

COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

			Initial Other	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☐ Yes	☐ No	C		C	SSG [redacted]	CPT [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)(2)-2

18 OCT 03

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

☑ ESU NO: [redacted] (b)(6)-4

GROUND PAD: BRAND Valleylab

LOT NO [redacted] Exp 2005-04

☐ ESU NO: (b)(6)-4

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): NS.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE C-ARM (L) 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 (b)(6)-2	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 10 mm JP	2.	3.
SITE	1. (L) leg	2.	3.

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

19. ADDITIONAL INFORMATION

Surgeon Dr [redacted] (b)(6)-2 Dr. [redacted] (b)(6)-2

anes: MAJ [redacted] (b)(6)-2

20. OPERATION(S) PERFORMED Excision of non-union, DOPC of wound. I & D (L) leg, EX-FIX removal & application

21. PATIENT TRANSFERRED TO ICU 3 TIME 1743 METHOD Litter

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

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERA[illegible] ROOM MAJ [redacted] (b)(6)-2
VIA Litter BY MAJ [redacted] (b)(6)-2

2. PATIENT IDENTIF[illegible] RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] (b)(6)-2

3. DATE 21 Oct 03 TIME PATIENT ARRIVED IN SUITE 1140

4. PATIENT IN ROOM TIME 1140 NUMBER 1-1-3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPEC [redacted] (b)(6)-2 9AD (b)(6)-2	RELIEF SCRUB	Ø
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	Ø

7. POSITION AND POSITIONAL AIDS *(Specify)* PT on padded OR Bed, Head on foam doughnut, Bilateral Arms extended out to sides <90° in CAP secured to padded armboards c safety straps

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

Folded towel under (R) heel.

COMMENTS: Correct Body Alignment maintained.

8. SKIN PREPARATION

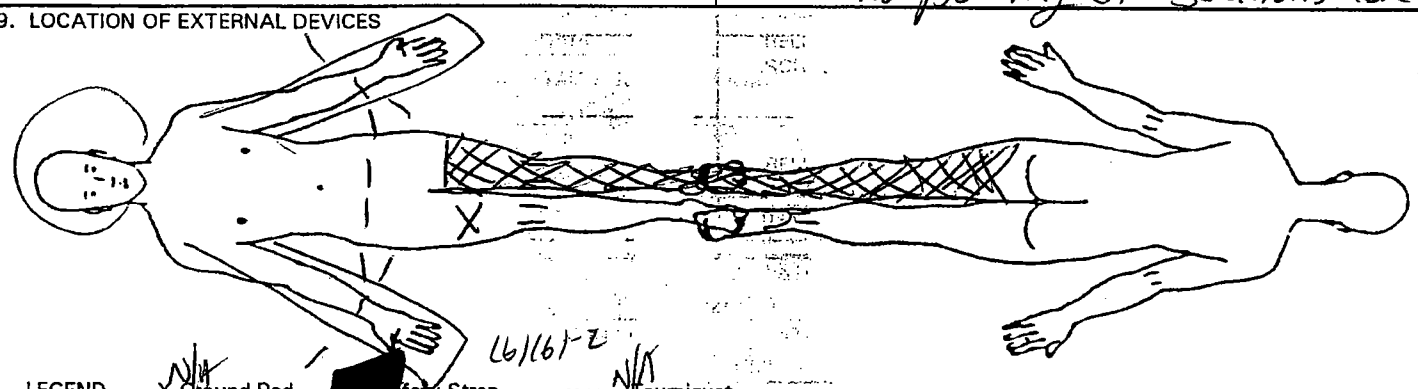
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine Scrub & solution
SITE: LLE BY WHOM: CPT [redacted]
SITE: BY WHOM: (b)(6)-2

COMMENTS: no pooling of solutions noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS

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

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

[redacted] (b)(6)-4

(b)(2)-2

[redacted] 21 Oct 03

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

☐ ESU NO: [redacted] (b)(6)-4 - not used.
GROUND PAD: BRAND Valleylab
LOT NO [redacted] Exp 2005-04

☐ ESU NO: (b)(6)-4
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: :TURER

ex-fix previously in place

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.

0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix Roll
ACE

19. ADDITIONAL INFORMATION WC-IV

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

anes: MAJ [redacted] (b)(6)-2 CRNA - Gen/Endo

Bovie pad site pre-op + post-op COI Bovie not used

DD 5179 redone.

20. OPERATION(S) PERFORMED

IM Lt Tibia

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	1235	Litter

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

[redacted] M 5179-1, OCT 87

USAPA V1.00

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY Anesthesia

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

3. DATE 10NOV03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 1345 NUMBER 7

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: ø concerns voiced

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ 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:

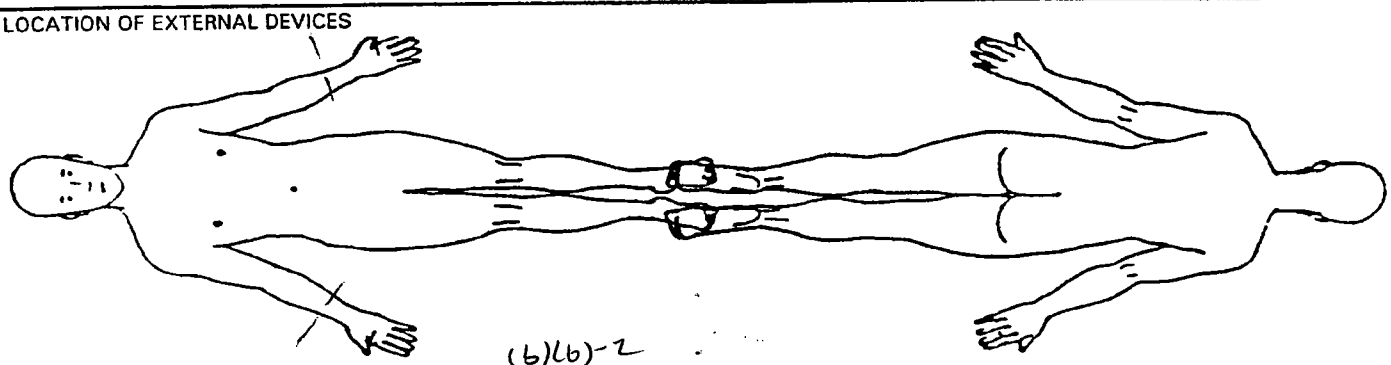
PREP SOLUTION *(Specify)* ø

SITE: BY WHOM:

SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



(b)(6)-2

LEGEND X Ground Pad -- Safety Stra[redacted] = = = Tourniquet

C = Correct I = Incorrect

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

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

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

[redacted] (b)(2)-2

10NOV03

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

☐ ESU NO: _____

GROUND PAD: BRAND _____

LOT NO: _____

☐ ESU NO: _____

GROUND PAD: BRAND _____

LOT NO: _____

☐ BIPOLAR NO: _____

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☐ YES ☒ NO, TYPE(S):

OTHER ORDERS	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

19. ADDITIONAL INFORMATION

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

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

-DA5179 on chart, Ø's noted

20. OPERATION(S) PERFORMED

Removal (L) LE ExFix

21. PATIENT TRANSFERRED TO PACU (ICU3) | TIME see DA1389 | METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] RN (b)(6)-2

REVERSE OF DA FORM [redacted]

USAPA V1.01

Ward/Section: ETT	REQUESTING PHYSICAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 25 Sep 03	TIME 1130	SSN/PREFIXED SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		
Plt		
Lym		
(Hi		
Segs		
Ban		
Lym		
Atyp		
RBC Morp		
Spun Hematocrit		42-52%(M) 37-47%(F)
Set Rate	15	
Other		

ID [redacted] (b)(6)-4 25-09-03
WB 11:31

			Patient Limits	
WBC	7.5	x10^3/uL	4.5	10.5
RBC	5.58	x10^6/uL	4.00	6.00
Hgb	15.5	g/dL	11.0	18.0
Hct	49.2	%	35.0	60.0
MCV	88.1	fL	80.0	99.9
MCH	27.9	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	276.	x10^3/uL	150.	450.
LY%	31.8	%	20.5	51.1
LY#	2.4	x10^3/uL	1.2	3.4

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

CSF

Cell Count		Directigen	Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]	DATE: 9-25-03	LAB ID NO.:

ABN-SINA HOSPITAL
[redacted] (b)(2)-2
Baghdad, Iraq

Microbiology Request Form

Last Name: #[redacted] (b)(6)-4
First Name:
Patient # or SSN:
Collected by: Dr. [redacted] (b)(6)-2
Date: 26
Time: 1106

Ward: OR
Room:
Bed:
Physician: [redacted] (b)(6)-2
Source: (L) leg
Site: infected bone

[redacted]

Received by: SPC [redacted] (b)(6)-2
Date: 26 Sep 03
Time: 1155

Specimen #: WO 27

Laboratory Results

MRSA S. aureus

Reported
Date: 9/28
Time: 11 30
Tech: SP
Reviewer: [redacted] (b)(6)-2

Number of attached sheets:

MEDCOM - 20617

Microbiology Report

IBN SINA - HOSPITAL Laboratory

Name:		Specimen:	**W027**	Status:	**Final**
Patient ID: [redacted]	(b)(6)-4	Source:	Wound/Sterile site	Collected:	
Ward/Rm: OR/		Ward of Iso:		Attd. Phys:	

1 Staphylococcus aureus — Status: Final

1 S. aureus

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

Methicillin Resistant S. aureus

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.

Microbiology Report

IBN SINA - HOSPITAL Laboratory

Name:		Specimen:	**W027**	Status:	**Final**
Patient ID: [redacted]	(b)(6)-4	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	OR/	Ward of Iso:		Attd. Phys:	

1 Staphylococcus aureus -- Status: Final MRSA/ORSA

1 S. aureus

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

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints.
For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name:		Specimen:	**W027**	Status:	**Final**
Patient ID: [redacted]	(b)(6)-4	Source:	Wound/Sterile site	Collected:	(b)(6)-2
Ward/Rm:	OR/	W	MEDCOM - 20619	Req. Phys:	[redacted]

(b)(6)-2

IBN-SINA HOSPITAL
[redacted] (b)(2)-2
Baghdad, Iraq

Microbiology Request Form

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

Collected by: Dr. [redacted] (b)(6)-2
Date: 10 OCT 03
Time: 1335

Ward: ICW-1
Room:
Bed:
Physician: [redacted] (b)(6)-2
Source: (L) Tibia / Wound W052
Site: (L) Leg W053

[redacted]

Received by: rac
Date: 10 Oct 03
Time: 1349

Specimen #: anaerobic W
aerobic W

Laboratory Results

No Growth @ 48 hours

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

Number of attached sheets:

MEDCOM - 20620

IBN-SINA HOSPITAL
[redacted] (b)(2)-2
Baghdad, Iraq

Microbiology Request Form

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

Collected by: Dr. [redacted] (b)(6)-2
Date: 10 OCT 03
Time: 1335

Ward: ICW-1
Room:
Bed:
Physician: [redacted] (b)(6)-2

Source: (L) Tibia / Wound M052
Site: (L) Leg M053

[redacted]

Received by: rqc
Date: 10 Oct 03
Time: 1349

Specimen #: anaerobic W
aerobic W

Laboratory Results

No Growth @ 48 hours

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

Number of attached sheets:

MEDCOM - 20621

IBN-SINA HOSPITAL
[redacted] (b)(2)-2
Baghdad, Iraq

Microbiology Request Form

Last Name: Al [redacted] (b)(6)-4
First Name:
Patient # or SSN: [redacted] (b)(6)-4
Collected by: Dr. [redacted] (b)(6)-2
Date: 15 OCT 03
Time: 1300

Ward: ICU 1
Room:
Bed:
Physician: Dr. [redacted] (b)(6)-2
Source: Wound Infection
Site: (L) Tibia

[redacted]

Received by: rgc
Date: 15 Oct 03
Time: 1330

Specimen #: Wo67

Laboratory Results

Staphylococcus aureus (MRSA)

Reported
Date: 17 Oct 03
Time: 1353
Tech: rgc
Reviewer: [redacted] (b)(6)-2

Number of attached sheets:

MEDCOM - 20622

Microbiology Report

IBN SINA - HOSPITAL Laboratory

Name:		Specimen:	**W067**	Status:	**Final**
Patient ID:	864	Source:	Wound/Sterile site	Collected:	
Ward/Rm:	OR/	Ward of Iso:		Attd. Phys:	

1 Staphylococcus aureus Status: Final MRSA/ORSA

1 S. aureus

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R			
Amp/Sulbactam (c)	<=8/4	R			
Ampicillin	>8	BLAC			
Azithromycin	>4	R			
Cefazolin	>16	R			
Cefepime	>16	R			
Cefotaxime (c)	>32	R			
Ceftriaxone (c)	>32	R			
Cephalothin	>16	R			
Chloramphenicol	<=8	S			
Ciprofloxacin	>2	R			
Clindamycin	>2	R			
Erythromycin	>4	R			
Gatifloxacin	<=2	S			
Gentamicin	>8	R			
Imipenem (c)	>8	R			
Levofloxacin	<=2	S			
Linezolid	<=2	S			
Moxifloxacin	<=2	S			
Nitrofurantoin	<=32				
Norfloxacin	>8				
Ofloxacin	4	I			
Oxacillin	>2	R			
Penicillin	>8	BLAC			
Rifampin	>2	R			
Synercid	<=1	S			
Tetracycline	>8	R			
Trimeth/Sulfa	<=2/38	S			
Vancomycin	<=2	S			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
— = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints.
For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name:		Specimen:	**W067**	Status:	**Final**
Patient ID: [redacted]	(b)(6)-4	Source:	Wound/Sterile site	Collected:	(b)(6)-2
Ward/Rm:	OR/	Ward of Iso:		Req. Phys:	[redacted]

Printed 10/17/2003 1:45:52 PM

MEDCOM - 20623

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

ICW#1

(b)(6)-2

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

LAST, FIRST,MI. (b)(6)-4	DATE 11OCT	TIME 0502	SSN/PEEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10	Color		N/A	RPR		Negative
RBC		4.7-6.1 x10	App		N/A			ative
Hgb		14-18 g/dl(M) 12-16 g/dl(F)	Glu		Neg			
Hct		42-52%(M) 37-47%(F)	Bili		Neg			
MCV		80-94 fi(M) 81-99 fi(F)	Ket		Neg			
Plt		130-500 x10³ verified	SG		N/			Negative
Ly			Bld		Ne			Negative
(			pH		N/			
S			Prot		N			
B			Urob		0.			
Ly			Nit		N			
A			Leuk		N			nalysis
R M			HCG		N			
S H			CSF					k
S			Cell Count					18 WITH ESTED
O			Directigen					

PICCOLO
11/10/03 05:17
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] (b)(6)-2 DR #: 000
SERIAL #: [redacted] (b)(6)-4

GLU	99	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	65	39-380	U/L
NA+	135	128-145	MMOL/L
K+	4.5	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

(MUST SUBM F BLOOD

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU 1	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI [redacted]	(b)(6)-4	DATE 6NOV	TIME 0500	SSN [redacted] (b)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^6	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		[illegible] (M) (F)	Ket		Negative	Gram Stain		
		x 10^3	SG		N/A	Occ Bld		Negative
		1%	Bld		Negative	H. pylori		Negative
		rential	pH		N/A	Micro Parasites		
			Prot		Negative	Malaria		
			Urob		0.2-1.0	O & P		
			Nit		Negative	Other		
			Leuk		Negative	**Microscopic Urinalysis**		
			HCG		Negative			
		0	**CSF**			**Blood Bank**		
			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.:

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

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

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art)
Drug of Abuse		

---

i-STAT CREA

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

Pt Name:_____

Crea_____1.5 mg/dL

Sample Type_:

06NOV03 05:40

Oper:

Physician:_____

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

Ver: JAMS046A
CLEW A93

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
A		
A		
A		
A		
T		
B		
C		
C		
C		
G		
T		
G		
B		
C		
C		
N		
K		
C		
tC		

---

i-STAT EC8+

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

Pt Name:_____

Glu_____102 mg/dL

BUN_____16 mg/dL

Na_____137 mmol/L

K_____3.1 mmol/L

Cl_____97 mmol/L

TCO2_____35 mmol/L

AnGap_____9 mmol/L

Hct_____36 %PCV

Hb*_____12 g/dL

*via Hct

pH_____7.449

PCO2_____48.2 mmHg

HCO3_____33 mmol/L

BEecf_____9 mmol/L

Sample Type_:

06NOV03 05:39

Oper:

Physician:_____

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

Ver: JAMS046A
CLEW A93

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
LB		3.3-5.5 g/dl
LP		26-84 u/l
LT		10-47 u/l
MY		14-97 u/l
ST		11-38 u/l
BIL		0.2-1.6 mg/dl
GT		5-65 u/l
P		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
A+		128-145 mmol/l
		3.3-4.7 mmol/l
L-		98-108 mmol/l
O2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICW1	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE 08NOV03	TIME 1430	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
I		
F		
L		
S		
B		
Ly		
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

ID: [redacted] (b)(6)-4 08-11-03 14:41
WB

			Patient Limits	
WBC	9.4	x10^3/uL	4.5	10.5
RBC	4.32	x10^6/uL	4.00	6.00
Hgb	11.6	g/dL	11.0	18.0
Hct	37.1	%	35.0	60.0
MCV	85.9	fL	80.0	99.9
MCH	27.0 L	pg	27.0	31.0
MCHC	31.4 L	g/dL	33.0	37.0
Plt	457. H	x10^3/uL	150.	450.
LY%	18.8 *L	%	20.5	51.1
LY#	1.8 *	x10^3/uL	1.2	3.4

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

LAST, FIRST, M[redacted] (b)(6)-4	DATE	TIME	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
A+		128-145 mmol/l
		3.3-4.7 mmol/l
-		98-108 mmol/l
O_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
LB		3.3-5.5 g/dl
LP		26-84 u/l
LT		10-47 u/l
MY		14-97 u/l
ST		11-38 u/l
BIL		0.2-1.6 mg/dl
GT		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
A+		128-145 mmol/l
		3.3-4.7 mmol/l
-		98-108 mmol/l
O_2		18-33 mmol/l

```
======= PICCOLO =======
08/11/03          14:40
REFERENCE RANGE:     MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3151AA4
OPER #: [redacted]   DR #: 000
SERIAL #: [redacted]
..........(b)(6)-4.......
GLU   100   73-118   MG/DL
BUN    19    7-22    MG/DL
CRE   2.0*  0.6-1.2  MG/DL
CK     58   39-380    U/L
NA+   130   128-145  MMOl/L
K+    3.6   3.3-4.7  MMOl/L
CL-   90*   98-108   MMOl/L
tCO2   26   18-33    MMOl/L

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

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 8 NOV 03	LAB ID NO.:

(b)(6)-4 1C 1 (b)(6)-2

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

LAST, FIRST, MI. [redacted] (b)(6)-4	DATE: 9NOV03	TIME: 1430	SSN/PS[redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yel	N/A
App	Hzy	N/A
Glu	N	Negative
Bili	N	Negative
Ket	Mod	Negative
SG	1.030	N/A
Bld	Trace	Negative
pH	5.0	N/A
Prot	+++4	Negative
Urob	N	0.2-1.0
Nit	N	Negative
Leuk	N	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

SSA: Pos WBC- None
Acetest: Large RBC- 1-3
Fatty cast - Mod Amorph: Heavy
Bact: Mod

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

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

(i-STAT)

```
======= PICCOLO =======
09/11/03                14:57
REFERENCE RANGE:          MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3151AA1
OPER #: [redacted]  DR #: 000
SERIAL #: [redacted]
.....(b)(6)-4.....
GLU    95    73-118    MG/DL
BUN    26*   7-22      MG/DL
CRE    2.0*  0.6-1.2   MG/DL
CK     58    39-380    U/L
NA+    131   128-145   MMOL/L
K+     3.9   3.3-4.7   MMOL/L
CL-    88*   98-108    MMOL/L
tCO2   21    18-33     MMOL/L

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

(Piccolo) Chemistry 12

```
======= PICCOLO =======
09/11/03                15:06
REFERENCE RANGE:          MALE
PATIENT #: [redacted] (b)(6)-4
LIVER PANEL PLUS
DISC LOT #: (b)(6)-2 3154AA7
OPER #: [redacted]  DR #: 000
SERIAL #: [redacted]
.....(b)(6)-4.....
ALB    4.6   [illegible]-5.5   G/DL
ALP    118*  [illegible]       U/L
ALT    9*    [illegible]       U/L
AMY    72    [illegible]       U/L
AST    39*   [illegible]       U/L
TBIL   1.2   [illegible] 1.5   MG/DL
[illegible] 28  [illegible]    U/L
TP     9.3*  6.4-8.1           G/DL

INST QC: OK     CHEM QC: OK
HEM [illegible] LIP [illegible] , ICT 0
```

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
Na		73-118 mg/dl
K		7-22 mg/dl
Cl		8.0-10.3 mg/dl
pH		0.6-1.2 mg/dl
PCO		128-145 mmol/l
PO2		3.3-4.7 mmol/l
TCC		98-108 mmol/l
HCC		18-33 mmol/l
sO2		
BEe		
AnG		
Ca		
BUN		
GLU		
Cre		
Hct		
Hgb		

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
Trop		
Dru		
Abu		
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l
RE		

EL

UA (over)

REPORTED BY:	DATE:	

Ward/Section: ICW A

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

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

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

DATE: 10NOV

TIME: 0400

SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	134	138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg
PO2		80-105 mmH N/A (ven)
TCO2		23-27 mmol/l 24-29 mmol/l
HCO3		22-26 mmol/L 23-28 mmol/L
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/l
Ca		1.12-1.32 mm
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
CO_2		18-33 mmol/l

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

10/11/03 04:52

REFERENCE RANGE: MALE

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

METLYTE 8

DISC LOT #: (b)(6)-2 3151AA4

OPER # [redacted] DR #: 000

SERIAL #: [redacted]

.....(b)(6)-7.....

GLU	98	73-118	MG/DL
BUN	27*	7-22	MG/DL
CRE	2.2*	0.6-1.2	MG/DL
CK	40	39-380	U/L
NA+	[redacted]	128-145	MMOL/L
K+	3.6	3.3-4.7	MMOL/L
CL-	88*	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

REMARKS:

REPORTED BY:

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION												
DRUG	(Units)											
Fentanyl	(mcg)	100	100	50								
Propofol	(mg)	200										
SUX	(mg)	100										
NS04	(mg)				6,4							
	( )											
	( )											
VOLAT AGENT 150	% del	2.5	3.5	3.5	3.0	1.5	1.5					
	% e.t.											
AIR	L/Min											
N20	L/Min											
O2	L/Min	8	2	2	2	2	2					
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS												

FLUIDS		
LINE site		
LR	18G (L) AC	☐ Warmed
		☐ Warmed
		☐ Warmed
		☐ Warmed

LOSSES	
EST BLOOD LOSS	
URINE –	

TOTALS	TOTAL SPL
280	mini
	TOTAL URINE
10	Ø

FLUIDS - SUMMARY
CRYSTALLOID – 700
COLLOID – Ø
BLOOD – Ø

REMARKS-
Code drugs with numbers, events with letters

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 78 (KG) LB

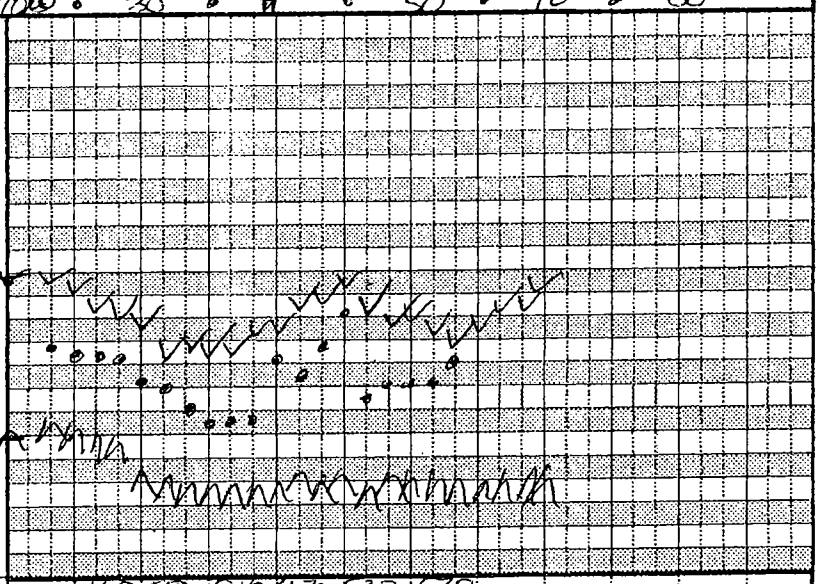
HEMATOCRIT:

INITIAL DATA: BP – 128,67 HR – 98

EQUIP CHECK: OK? – (Y) N

PATIENT CHECK: OK for PROCEDURE? yes TIME – 1015

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



VENTIL							
VT – ml		160	510	510	470	530	520
f – breaths/min		10	10	18	15	13	9
Peak inf pres / PEEP			25				
MODE – S(pon), A(ssist), C(on)		S/A	S	C	SV	SV	SV	SV
MONITORS / ACCESSORIES							
BP/Auto Cuff	ET CO2 (torr)	(+)	51	46	47	48	47	46
BP / oth	FIO2 (Frac or %)	.84	.84	.84	.84	.84	.84	.84
ART line	SpO2 (%)	100	100	98	98	99	99	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site	AVAILABLE						
	N-M Block (T/4)	4/4 2 post-op						
Warming blkt								
Conv warmer								

RECOVERY AT 1150
(PACU) ICU _____ (Specify)
OTHER _____
CONDITION:
RESP – SpO2 –
BP – HR –

ANESTHESIA / PROCEDURE TIMES	Start	Room	End
ANES	1000	1010	1200
PROC	Ready	Begin	End
	1015	1030	1040

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

PROCEDURES and CPT Codes
I+D (L) Tib/Fib Ex-Fix

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
Pre-op Cim 84% FIO2, IV induction, RNXT, Grade II view, mac 3 laryngoscopy, 8.0 ETT placed 22cm @ lips (+) BS

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

SURGEONS [redacted] (+) PRCO2

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

(b)(6)-2

PROCEDURE LOCATION OR 2

DATE 26 FEB 2003

PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 20632

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)	
Propofol	( )	200
Ludocaine	( )	100
Fentanyl	( )	
Versed	( )	(20)
Phenylephrine	( )	25
Succ	( )	100
VOLAT AGENT	Forane % del.	2.0/2.0/1.0/1
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	2/2/2/2

(1) SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → (2) (3)

FLUIDS

LINE site		
18g (L) arm	☐ Warmed	NS
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS — URINE –

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG / LB

HEMATOCRIT:

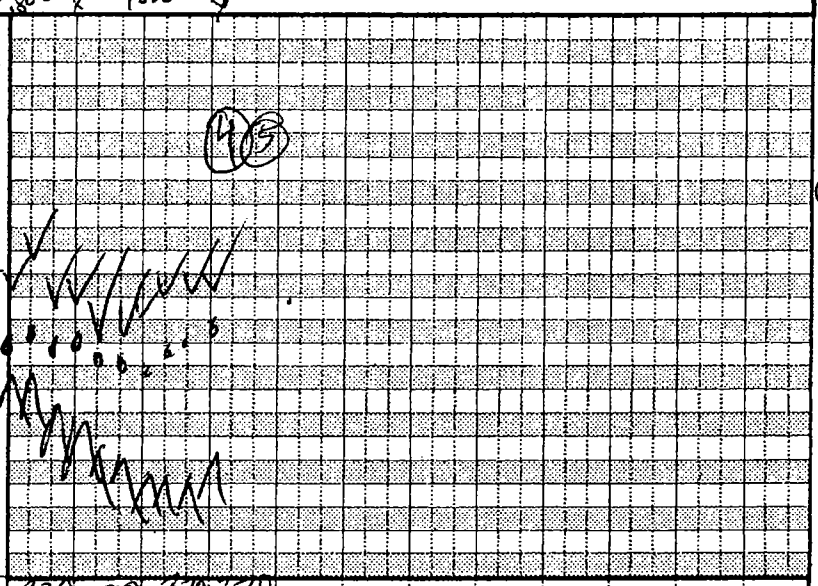
INITIAL DATA: BP – 126/86 HR – 102

EQUIP CHECK: OK? – Y N

PATIENT RECHECK: OK for PROCEDURE? Y TIME – 1805

TIME → 1800 x 1830 y

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



VENTILATION

VT – ml	320	800	370	510
f – breaths/min	14	6	6	22
Peak Inf pres / PEEP	/	28	/	/
MODE – S(pon), A(ssist), C(on)	SV	CV	SV	SV

MONITORS / ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	38	46	48	49
BP / oth	✓ FIO2 (Frac or %)	.52	.52	.52	.52
ART line	✓ SpO2 (%)	100	100	100	100
Steth- PC/ES	✓ ECG	ST	ST	ST	ST
Gas analyzer	TEMP- site	Axil			
	N-M Block (T/4)	4/4	0/4	4/4	
Warming blkt					
Conv warmer					

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

TOTALS

TOTAL EBL	MIN
TOTAL URINE	Ø
20	
25	

FLUIDS - SUMMARY

CRYSTALLOID – 500 NS

COLLOID – Ø

BLOOD – Ø

REMARKS-

Code drugs with numbers, events with letters

(1) PT 10-1CW1 – PT Adm TO OR

(2) Room-O2 MON

(3) PT intubated

(4) PT making purposeful mvmt PT extubated.

(5) PT stays in OR FOR Recovery

RECOVERY AT

PACU ICU _____ (Specify)

OTHER OR Recovery

CONDITION:

RESP – 22 SpO2 – 100

BP – 128/58 HR – 75

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1750	1800	1850
	Ready	Begin	End
PROC	1809	1820	1840

PROCEDURES and CPT Codes: I + D (E) TIM.

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments DLx1 – grade I view C 4 mark #7 ETT TO 21 @ lith, #10 OA in cuff + (+) BBS (+) ETCO2 tape to tube + secd. – DTB

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

(b)(6)-4 [redacted]

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

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

PROCEDURE LOCATION: OR

DATE: 29 Sep 03

PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 20633

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)				
Versed	(mg)	5/2			
Fent	(µg)	100	50	50	
propofol	(mg)	<200>			
	( )				
	( )				
	( )				
VOLAT AGENT	% del				
	% e.t.				
AIR	L/Min				
N2O	L/Min				
100% O2 ORS	L/Min	8	8	8	

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

FLUIDS

LINE site LR				
☐ Warmed	4		300	
☐ Warmed				
☐ Warmed				
☐ Warmed				

LOSSES — EST BLOOD LOSS / URINE –

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

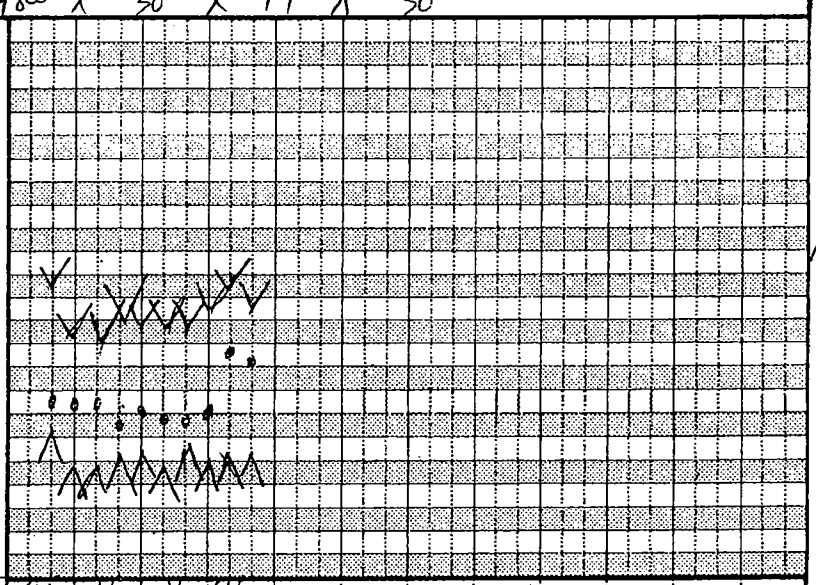
INITIAL DATA: BP – 124/60 HR – 76

CHECK: OK? – Y N

PATIENT RECHECK: OK for PROCEDURE? TIME –

TIME → 1800 X 30 X 19 X 30

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



VENTIL

VT – ml	SV	SV	SV	SV
f – breaths/min	14	8	8	10
Peak inf pres / PEEP				
MODE – S(pon), A(ssist), C(on)	S	S	S	S

MONITORS / ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)			
BP / oth	FIO2 (Frac or %)	>.21	>.21	>.21	>.21
ART line	SpO2 (%)	100	100	99	99
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP- site Axilla	Axilla			
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

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

TOTALS

	TOTAL BLD
5mg 200µg	Nil
	TOTAL URINE
	Ø

FLUIDS - SUMMARY

CRYSTALLOID – 300

COLLOID – Ø

BLOOD – Ø

REMARKS-

Code drugs with numbers, events with letters

1805 MRSA precautions to OR Monitors applied
1810 IV Sed begin
1825 Surg begin
5 pt movement
5 pt Resp
1850 Pt Acct to OR staff for Recovery
Report given

RECOVERY AT OR#1

PACU ICU (Specify) OTHER Staff

CONDITION: awake

RESP – 10 SpO2 – 100

BP – 115/55 HR – 73

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1700	1805	1900
	Ready	Begin	End
PROC	1815	1825	1838

PROCEDURES and CPT Codes: Lt Leg washout

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

[redacted] (b)(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: Natural O2 via mask IV Sed

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Mask 100% Rebreather

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

ANESTHE [redacted] CRNA

(b)(6)-2

PROCEDURE LOCATION OR 1

DATE 10/1/03

PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS	DRUG	(Units)	
CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION	Phenergan	(mg)	25
	Morphine	(mg)	5/5 5/5
		(mg)	
	Propofol	(mg)	200
		(mg)	
		( )	
	VOLAT AGENT Forane	% del	5—3—3—4
		% e.t.	
	AIR	L/Min	
	N2O	L/Min	
	O2	L/Min	5—4—4—4—
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS			

FLUIDS	LINE site	
	LR 20g (L)	☐ Warmed
		☐ Warmed
		☐ Warmed
		☐ Warmed
LOSSES	EST BLOOD LOSS	
	URINE –	

TOTALS	
25 g	
200 g	TOTAL URINE
200 g	

FLUIDS - SUMMARY	
CRYSTALLOID–	400
COLLOID–	∅
BLOOD–	∅

REMARKS-

Code drugs with numbers, events with letters

BOR #1 Pt Ready, O2 - Smooth IV induction easy mask ventilates Awake - Pleasant Report to

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

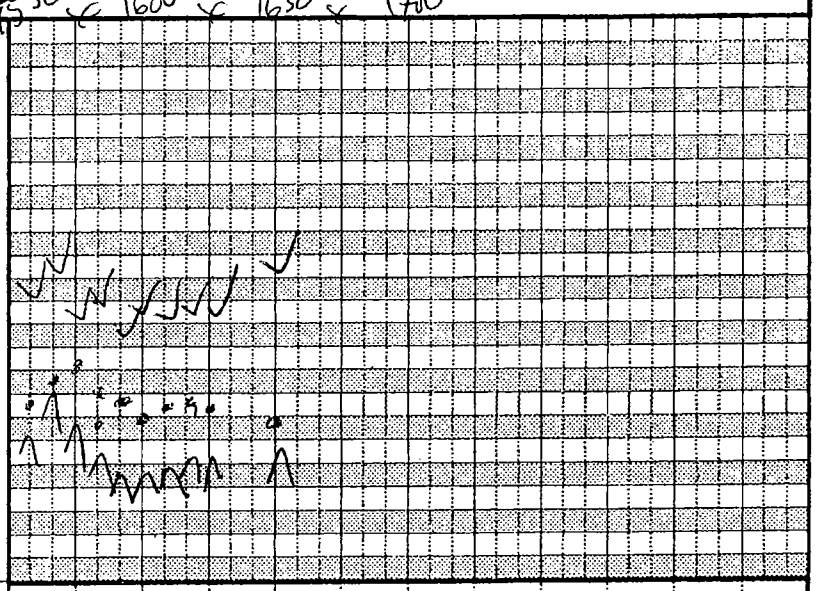
INITIAL DATA: BP – 120/60 HR – 72

SONIP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME –

TIME → 1530 1600 1630 1700

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



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

MONITORS / ACCESSORIES					
BP/Auto Cuff	ET CO2 (torr)	50	40	40	
BP / oth	FIO2 (Frac or %)	.67	.67	.67	RA
ART line	SpO2 (%)	100	100	100	98
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP- site				
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

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

RECOVERY AT: PACU / ICU _____ (Specify) OTHER _____

CONDITION: RESP – 16 SpO2 – 100% BP – 114/50 HR – 68

ANESTHESIA / PROCEDURE TIMES	Start	Room	End
ANES	1520	1531	1610
	Ready	Begin	End
PROC	1540	1552	1608

PROCEDURES and CPT Codes: Inf A (L) Abscess

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GA - mask

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

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

[redacted] (b)(6)-4

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

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

PROCEDURE LOCATION: OR #1

DATE: 6 OCT

PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 20635

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)													
Sufenta	( )	10	10	10										
Propofol	( )	<	200	>										
	( )													
	( )													
	( )													
	( )													
VOLAT AGENT	Sevo % del		.8	>										
	% e.t.													
AIR	L/Min													
N2O	L/Min													
Mask O2	L/Min	8	8	8										

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

TOTALS	TOTAL EBL
30 ~~300~~	min
	TOTAL URINE
	Ø

FLUIDS - SUMMARY
CRYSTALLOID- 400
COLLOID- Ø
BLOOD- Ø

FLUIDS

LINE site													
LR	☐ Warmed			400									
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP- 181/57; HR- 77

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? TIME- 1245

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

TIME → X 30 X 14 X 30

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

VENTIL

VT - ml	SV	SV	SV
f - breaths/min	12	8	10
Peak inf pres / PEEP			
MODE - S(pon), A(ssist), C(on)	SV	AV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	38	50	46
BP/oth	FIO2 (Frac or %)	.75	.65	.65
ART line	SpO2 (%)	100	100	100
Steth- PC/ES	ECG	SR	SR	SR
Gas analyzer	TEMP-site	Available		
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 6—1

REMARKS — Code drugs with numbers, events with letters

1300 in OR - monitors applied IV infeltrated 20ga (L) wrist started
1310 IV sed begin
1340 (L) EJ unsuccessful (R) EJ started 18ga 2". secured w/ opsite tape.
1350 Pt responsive cooperative transfered to PACU. Report given

RECOVERY AT 1355

(PACU) ICU ____ (Specify)

OTHER ____

CONDITION: T96.7

RESP- 12 SpO2- 96%

BP- 125/67 HR- 89

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1230	1300	1400
	Ready	Begin	End
PROC	1320	1325	1340

PROCEDURES and CPT Codes: Washout (L) L Leg

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: Mask O2

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

[redacted] (b)(6)-4

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

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

PROCEDURE LOCATION: 2

DATE: 10/18/03

PAGE 1 OF 1

MRSA +

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	11	20	45	1300
Versed	(mg)	< 5 >			
L100	(mg)	100			
	( )				
Propofol	(mg)		200		
	( )				
Fentanyl	(mcg)		50		
VOLAT AGENT	Forane % del		2.2-2.2		
	% e.t.				
AIR	L/Min	Ø			
N2O	L/Min	Ø			
O2	L/Min	4 →	4	8	

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

FLUIDS

LINE site		11	20	45	1300
(R) LR	☒ Warmed	1000			500
	☐ Warmed				
	☐ Warmed				
	☐ Warmed				

LOSSES

EST BLOOD LOSS					
URINE -					

TOTALS	TOTAL EBL
	TOTAL URINE
	Ø

FLUIDS - SUMMARY

CRYSTALLOID- LR 500

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

~~PCA~~ Versed 5

Fentanyl 50mg

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 78 (KG) LB

HEMATOCRIT: 44 110CT

INITIAL DATA:

BP- 112/68

HR- 68

EQUIP CHECK

OK?- (Y) N

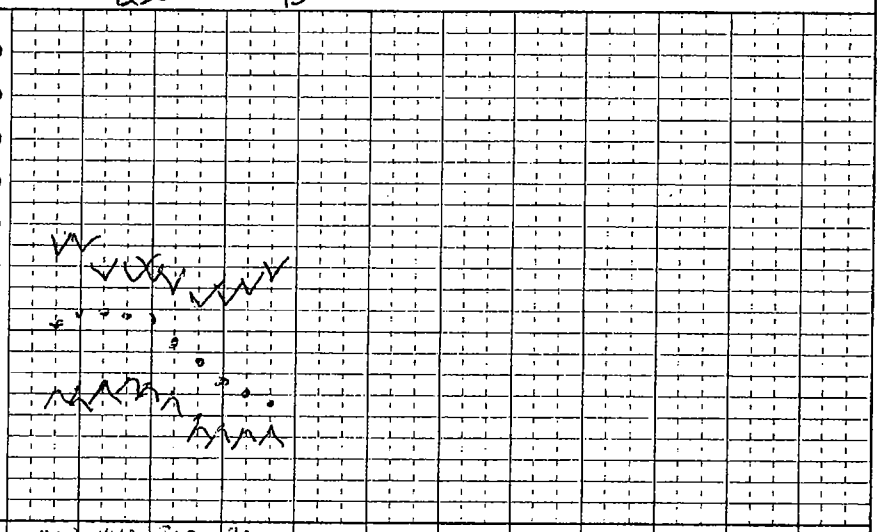
PATIENT RECHECK

OK for PROCEDURE?

TIME-

TIME → 1230 1300

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



VENTIL

VT - ml	400	440	500	400
f - breaths/min	18	22	17	14
Peak inf pres / PEEP	—	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	(B)	44	41	47
BP/oth	FIO2 (Frac or %)	100	100	100	100
ART line	SpO2 (%)	10	100	99	100
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site				
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

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

RECOVERY AT

(PACU) ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- 18 SpO2- 99

BP- 118/78 HR- 81

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1200	1210	1300
	Ready	Begin	End
PROC	1230	1230	1245

PROCEDURES and CPT Codes:

I & D

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

MASK GEN

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

MASK

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

#[redacted] Wd 1 Bed 7B

(b)(6)-4

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

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

PROCEDURE LOCATION: OR 1

DATE: 5 Oct 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 COPY 2 - ANESTHESIA PROVIDER USAPA V1.00

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)												
Versed	(ml)	3/2											
Sufenta	(mcg)	20/10		10	10								
MSO4	( )							32		52	12	5	
Lido / propofol	)	30/150	/										
Succs / vec	)	80		5									
Neostigmine / Robinul									2.5/0.5				
VOLAT AGENT	Forane % del	1.5	2	1.5	1.5	2	2	2	2	1	1	1.5	
	% e.t.												
AIR	L/Min												
N2O	L/Min												
O2	L/Min	8	1	1	1	1	1	1	1	2	2		

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

FLUIDS

LINE site LR											
☒ Warmed		300		800	1000	1500		1800		2000	
☐ Warmed											
☐ Warmed											
☐ Warmed											

LOSSES

EST BLOOD LOSS			100	200	300	400	450				
URINE -											

TOTALS	TOTAL EBL
5mg	450
50mg	
200mg	TOTAL URINE
	Ø

FLUIDS - SUMMARY
CRYSTALLOID- 2000
COLLOID- Ø
BLOOD- Ø

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 78 (KG) LB

HEMATOCRIT: 44.8

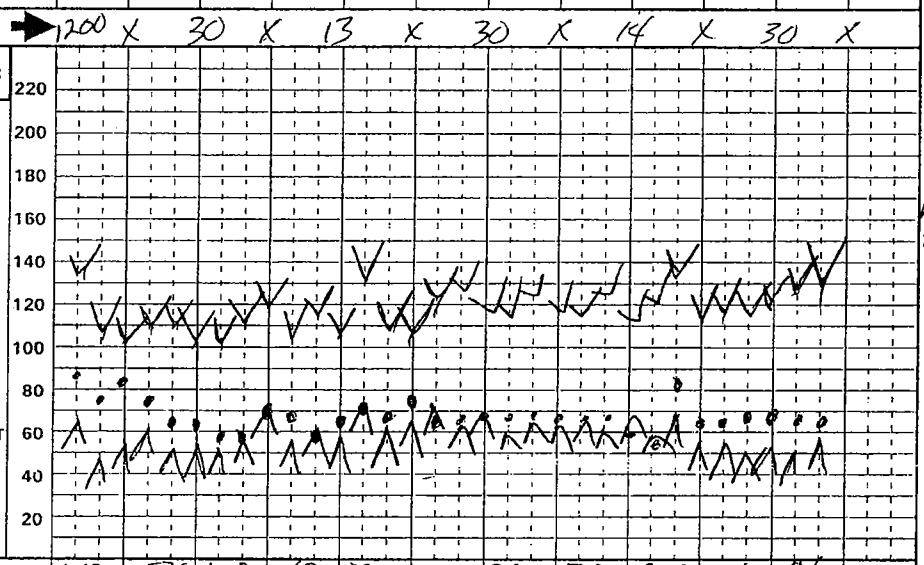
INITIAL DATA: BP- 131/66 HR- 88

EQUIP CHECK OK?- Y N

PATIENT RECHECK

OK for PROCEDURE? TIME-

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



VENTIL

VT - ml	780	570	600	580	700	710	700	730	370	350	SV
f - breaths/min	9	9	8	8	6	6	6	6	9	11	8
Peak inf pres / PEEP	14	14	14	16	15	16	16	17			
MODE - S(pon), A(ssist), C(on)	C-C	C	C	C	C	C	C	C	SV	SV	SV

MONITORS/ACCESSORIES

BP/Auto Cuff / ET CO2 (torr)	32	35	34	34	31	34	33	33	55	40	58
BP/oth / FIO2 (Frac or %)	.68	.68	.67	.67	.67	.66	.66	.66	.67	.67	.67
ART line / SpO2 (%)	100%	100%	100%	100%	100%	100	100	100	100	100	100
Steth- PC/ES / ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer / TEMP-site	skin		35		36	36	36	36	35		
/ N-M Block (T/4)					1/4	4/4	4/4		4/4		
									Sseteting		
Warming blkt											
Conv warmer											

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

REMARKS

Code drugs with numbers, events with letters

1200 in OR monitors applied
1208 I & I
⊕ ETCO2 ⊕ BBS
1440 Spont Resp
oral suction
purposful movement
extubated
to PACU
Report given

RECOVERY AT 1445

PACU ICU _____ (Specify)

OTHER _____

CONDITION: awake cooperative

RESP- 10 SpO2- 96%

BP- 129/72 HR- 136

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1115	1200	1500
	Ready	Begin	End
PROC	1210	1245	1440

PROCEDURES and CPT Codes: closure / LTT washout ~~skin graft~~ / ex fix

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

[redacted] (b)(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments 8.0 ETT placed c 3 miller blade one attempt grade 1 view ⊕ ETCO2 ⊕ BBS

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

ANESTHETIST[redacted] MAT CRNA

PROCEDURE LOCATION: OR 1

DATE: 10/16/03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 (b)(6)-2 COPY 2 - ANESTHESIA PROVIDER USAPA V1.00

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	45	1200	30
Ltoo	( )	100		
Propol	( )	200		
Sux	( )	100		
Fentanyl	( )	(200)		
	( )			
	( )			
VOLAT AGENT: Forane	% del		1.5	X
	% e.t.			
AIR	L/Min	0	0	0
N2O	L/Min	0	0	0
O2	L/Min	8	2	2
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		30	1200	30

FLUIDS

LINE site				
	☐ Warmed			
	☐ Warmed			
	☐ Warmed			
	☐ Warmed			

LOSSES: EST BLOOD LOSS; URINE -

TOTALS	TOTAL EBL
	TOTAL URINE

FLUIDS - SUMMARY

CRYSTALLOID- LR

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

Cipro IV 400 in infusion -

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA:

BP- 124 160

HR- 72

EQUIP CHECK

OK?- Y N

PATIENT RECHECK

OK for PROCEDURE?

TIME-

TIME → 45 1200 15 30

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	650	650	500
f - breaths/min	10	10	12
Peak inf pres / PEEP	21	21	20
MODE - S(pon), A(ssist), C(on)	C	C	C A

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	37	33	32	
BP/oth	FIO2 (Frac or %)	100	100	100	100
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site	Jkm	—		
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS *Position* → O/I

RECOVERY AT: PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- 13 SpO2- 98

BP- 120/60 HR- 97

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1130	1140	1258
	Ready	Begin	End
PROC	1150	115	1258

PROCEDURES and CPT Codes:

IFD 2 Leg

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

#[redacted]

(b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

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

Cetta MAC 3

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

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

PROCEDURE LOCATION: OR 1

DATE: 21 OCT 07

PAGE 1 OF

DA FORM 7389, FEB 1998 — COPY 2 - ANESTHESIA PROVIDER — USAPA V1.00

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

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

DRUG	(Units)	1345	1400	15	30	45	1500	15	30	45	1600	15	30	45
Fentanyl / sol / dil		100		50										
( )														
( )														
( )														
( )														
VOLAT AGENT	Forane % del	3-2-1				6								
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2 3	L/Min													

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

FLUIDS

LINE site														
	☐ Warmed													
	☐ Warmed													
N/S-500	☐ Warmed						350							
	☐ Warmed													

LOSSES	
EST BLOOD LOSS	
URINE -	

TOTALS	TOTAL EBL
	<1mL
	TOTAL URINE

FLUIDS - SUMMARY
CRYSTALLOID- 350
COLLOID-
BLOOD-

PHYS STATUS: 1 2 3 4 5 E

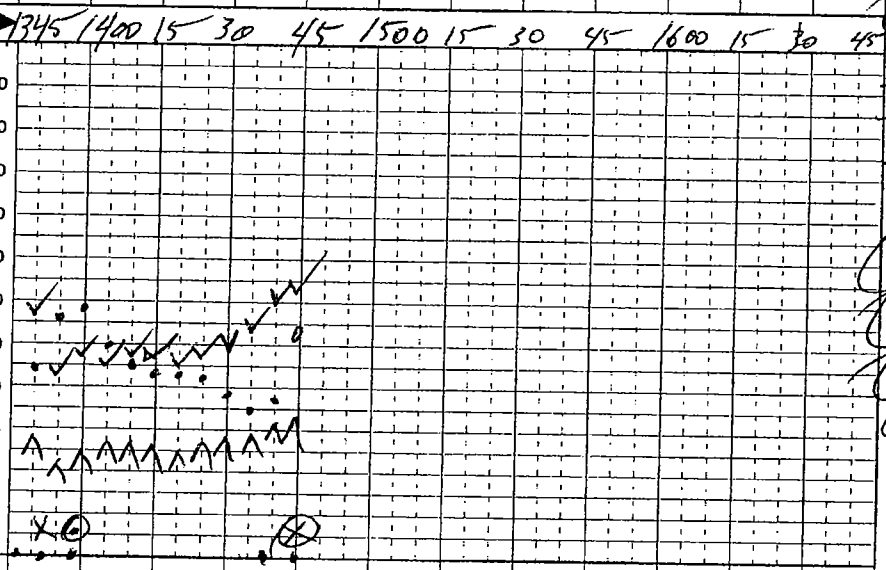
BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA:
BP- 114 156
HR- 89 97%

EQUIP CHECK
OK?- Y N
PATIENT RECHECK
OK for PROCEDURE?
TIME-

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



VENTIL

	1345	1400	15	30	45	1500	15	30	45	1600	15	30	45
VT - ml													
f - breaths/min		10	8										
Peak inf pres / PEEP													
MODE - S(pon), A(ssist), C(on)		AS	AS										

MONITORS/ACCESSORIES

		1345	1400	15	30	45	1500	15	30	45	1600	15	30	45
✓ BP/Auto Cuff	✓ ET CO2 (torr)		32	33										
BP/oth	FIO2 (Frac or %)		62%	65%										
ART line	✓ SpO2 (%)	97	100	100										
Steth- PC/ES	✓ ECG		ST	SR										
✓ Gas analyzer	TEMP-site													
	N-M Block (T/4)													
Warming blkt														
Conv warmer														

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

REMARKS
Code drugs with numbers, events with letters

1. V/S Taken
2. Induced w/ Lidocaine 20mg, Diprivan 170mg, Anectine 100mg, LMA O2
3. Procedure began
4. Procedure ended
5. O2 breathing well, to recovery

RECOVERY AT
PACU ICU _____ (Specify)
OTHER _____
CONDITION:
RESP- SpO2- 96
BP- 120/64 HR- 114

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1328	1347	1446
	Ready	Begin	End
PROC	1353	1358	~~1453~~ 1438

PROCEDURES and CPT Codes:
Removal Ex-Fix (L) Leg c̄ Cast

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
Gen

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
#5 LMA

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

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

ANES: [redacted] CRNA

(b)(6)-2

PROCEDURE LOCATION:
DATE: 10 Nov 03
PAGE 1 OF

DA FORM 7389, FEB 1998 — COPY 3 - ANESTHESIA DEPARTMENT — USAPA V1.00