ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 18 DAYS MOS YRS Sex (✓) MALE ( ) FEMALE

ASA Physical State 1 2 3 4 5 E
WT: 78 KG/LB HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: I+D
SURGICAL SERVICE: General/ORTHO
NPO SINCE: p MN

HABITS:
TOBACCO: (+)
ETOH: (-)
DRUGS: (-)

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) ____
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

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

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC

Ø

PHYSICAL EXAMINATION
BP ____ HR ____ R ____ T ____
Pain Scale 0-10 ____
HEENT - Teeth atrophy
Trachea midline
TMJ/Neck > 3 FBS,
Oropharnyx MP II
Nares ____
CHEST: CTA
CARDIAC: RRR
EXTREMITIES:
IV Access: (L) AC.
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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

INFOR[redacted]UNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and disc[redacted]nt/legal guardian.

Th[redacted] seems to understand and agrees. Questions answered.
Signed: [redacted] (b)(6)-2 Date: 26 SEP 05 Time: 1000 Hrs

POST[redacted]HESIA EVALUATION AND NOTE (NON ASU)
{ } NO[redacted]PARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

[redacted] (b)(6)-4
(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 - 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 9.26.03 1205	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. prn for SaO_2 ↓ 93%		
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		
	[redacted] HTC		
	[redacted] CRNA (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, 28th CSH			1 of 1

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

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
	POST ANESTHESIA ORDERS (circled Items)		
1	VS q 5 min X 15 min, then q 15 min until discharge.		
2	Supplemental oxygen. PRN		
3	Morphine / Meperidine 2-3 mg IV now and 2-3 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 25 mg IV prn N/V x 1.		
8	Benadryl 25-50mg IVP q1 hr prn, itching while in PACU.		
9	IVF: NS @ 100 cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] RNA (b)(6)-2		
10/Nov	Start IV c #20, peripheral		
	[redacted] RNA (b)(6)-2		

PATIENT IDENTIFICATION	Complete the following information on page 1 only. Note any changes on subsequent pages.			
	Diagnosis:			
	Height: ____ Weight: ____ Diet: ____			
	Allergies:			
	Nursing Unit (b)(2)-2 PACU [redacted]	Room No.	Bed No.	Page No. 1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC 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
	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 20 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 .625 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 @ 125 cc/hr.		
10	Discharge from recovery status when PACU discharge criteria met.		
	[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] (b)(2)-2			1 of 1

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IDENTIFICATION	DATE OF ORDER	TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
EPW #[redacted] (b)(6)-4	25 SEPT 03	1440	
	(1) ADMIT TO ICW-1		
	(2) DX - ADPW (L) TIB - FIB FX		
	(3) CONDITION - STABLE		
	(4) VS MONITOR		
	(5) UP AD LIB WITH CRUTCHES PRN EPW MONITOR		
NURSING UNIT: ICW1 / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER / HOURS	
	(6) REGULAR DIET, NPO after MIDNIGHT		
	(7) TO O.R. IN AM		
	(8) N - HEP LOCK		
	(9) MNCBT & OXIMS NPM Q 8 HRS		
06,14,22	(10) TYLENOL 650 mg P.O. Q 4 HRS PRN		
	(11) PERCOCET 1-2 P.O. Q 4-6 HRS PRN		
	(12) DIPHENHYDRAMINE 25 mg IVP Q 6 HRS PRN		
NURSING UNIT: ICW1 / ROOM NO.: 24 chart / BED NO.: 2330 25 SEP 03 [redacted]	(b)(6)-2		
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER / HOURS	
	26 SEPT 03	1140 [redacted]	
	(1) Resume previous orders		
	(2) Regular diet		
	(3) IV 2 L 5% Dextrose Ringer Lactate when taking P.O. well		
	(4) MSO4 2-8 mg IVP Q 2 HRS PRN		
	(5) NPO after midnight 27 [redacted]		
NURSING UNIT: ICW1 / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER / HOURS	
	SUNDAY 28 SEPTEMBER [redacted]		
NURSING UNIT / ROOM NO. / BED NO.			

[redacted] (b)(6)-2

[redacted] (b)(6)-2

[redacted] (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

(b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

[redacted] (b)(6)-4

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

LIST TIME ORDERS NOTED SIGNATURE

1. REGULAR DIET
2. NPO AFTER MIDNIGHT. TO OR TOMORROW

(b)(6)-2 [redacted]

NURSING UNIT: 24 V/29 Dep/03@ ROOM NO.: BED NO.: 030

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

[redacted] (b)(6)-2

DATE OF ORDER: 15 OCT 03 TIME OF ORDER: 1250 HOURS

1. Resume parenteral order
2. Regular diet
3. Keep lock N
4. Wet to dry dressing changed BID

(b)(6)-2 [redacted]

NURSING UNIT: 24V/0700 ROOM NO.: 1700 BED NO.: 03 [redacted]

PATIENT IDENTIFICATION (b)(6)-2

[redacted] (b)(6)-4

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

1. NPO after midnight
2. To OR tomorrow

(b)(6)-2 [redacted]

NURSING UNIT: 24V/0200 ROOM NO.: 1800 BED NO.: 03 [redacted] (b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-2

1600

DATE OF ORDER: 18 OCT TIME OF ORDER: 1600 HOURS

1. MSO4, 2-8mg q 1-2° PRN IV [redacted] (b)(6)-2

[redacted] (b)(6)-2

NURSING UNIT: ROOM NO.: 24V BED NO.: [redacted] RN 2230 10/15/03

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

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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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.

10-22

DATE OF ORDER: 29 SEP 03 TIME OF ORDER: 1830 HOURS

LIST TIME ORDER NOTED AND SIGN

1. RESUME PREVIOUS ORDERS
2. D/C SNCBF
3. GIPAD FLUXOLON 400mg IVPB Q 12 Hr
4. GENTAMYCIN 400mg IVPB Q DAY
5. RESUME DIET
6. IV - HEP LOCK WHEN FLUID PO WELL

PATIENT IDENTIFICATION

NOTED [redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

2400/0230 30 Sep 03 [redacted]

DATE OF ORDER | TIME OF ORDER

7. BID WET TO DRY DRESSING [redacted]

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NOTED [redacted]

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24 Nov 2230 [redacted] 30 Sep 03

DATE OF ORDER: 30 SEP 03 TIME OF ORDER: 2145 HOURS

1. NPO
2. TO OR TOMORROW [redacted]

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER: 20 OCT 03 TIME OF ORDER: 1845 HOURS

1. Resume previous orders
2. Regular diet
3. IV - D5W at 125 cc/hr. Heparin lock when taking PO well

NURSING UNIT: 24° ✓ ROOM NO. BED NO. 10CT @ 2040

PATIENT IDENTIFICATION: [redacted] (b)(6)-4 [redacted] Noted (b)(6)-2 SPC 9W/MB 30CT03 1400

DATE OF ORDER: 30 OCT 03 TIME OF ORDER: 1050 HOURS

1. Resume previous orders
2. Regular diet
3. IV - D5W at 125 cc/hr. HEP LOCK when taking P.O well
4. VAC device on (L) leg to low continuous suction

NURSING UNIT: ROOM NO. BED NO.

PATIENT IDENTIFICATION: 24° ✓ 30CT03 [redacted] (b)(6)-4 (b)(6)-2 [redacted] (b)(6)-2 [redacted] 1848

DATE OF ORDER: 30 OCT 03 TIME OF ORDER: 1510 [redacted] (b)(6)-2

NPO after midnight for OR 60CT03

(b)(6)-2 [redacted]

NURSING UNIT: 24° ✓ ROOM NO. [redacted] BED NO. 5OCT 2100.

PATIENT IDENTIFICATION: [redacted] (b)(6)-4. (b)(6)-2 9OCT03 2000 [redacted] (b)(6)-2

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

1. NPO after midnight for OR tomorrow

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

NURSING UNIT: 24° ✓ ROOM NO. 9OCT03 BED NO. 2000 [redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER 6 OCT 03 TIME OF ORDER 1605 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. Regular diet
3. IVD LR at 125 cc/hr. HLP
4. LOW WOUND TUBE PO. NDZ
5. VAC device to low, continuous suction

NURSING UNIT 1004 | ROOM NO. [redacted] | BED NO.

PATIENT IDENTIFICATION (b)(6)-2

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

[redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

DATE OF ORDER 16 OCT 03 TIME OF ORDER 1345 HOURS

1. Resume previous orders
2. Regular diet
3. IVD LR at 125 cc/hr. HLP LOW
4. WOUND TUBE PO. NDZ
5. VAC device to low, continuous suction

[redacted] (b)(6)-2

NURSING UNIT CW1 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

10/11/03 05 — 1. AP + LAT CL lib - pt in bed

10/11/03 04 — 2. CBC, METABOLIC 8 in AM

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

[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 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 18 OCT 03 | TIME OF ORDER: 1415 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. Regular diet
3. IV D5 LR at 125 cc/hr. Keep lock when taking PO, well
4. NPO after midnight 20 Oct for OR on 21 Oct.

PATIENT IDENTIFICATION: [redacted] 1546

DATE OF ORDER | TIME OF ORDER | HOURS

5. Empty and record drain Q shift.
6. CBC, MST & 2 U PRBC [redacted]
7. Lovenox 30mg SQ BID [redacted] (b)(6)-2.
to start 20 OCT 03 in PM

(b)(6)-2 [redacted]

NURSING UNIT: 24 | ROOM NO.: V | BED NO.: 20 OCT @ 0230 [redacted] 2L7A

PATIENT IDENTIFICATION: 24°V 24 OCT [redacted] 24°V 20 OCT [redacted] (b)(6)-2

DATE OF ORDER | HOURS

1 NOV 03 0735

1. AP ds LBT @ 7B 1/13 7B 5b1

(b)(6)-2 [redacted]

NURSING UNIT | BED NO.

24°/02 NOV 03 @ 0230 [redacted]

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

DATE OF ORDER: SEP 03 | TIME OF ORDER: 1620 HOURS

1. XGLUTAC 150mg P.O. BID
2. D/C PRBC LST
3. TYLENOL #3 1-2 P.O. Q 4-6 hrs PRN
4. CBC, MST & 2 U PRBC 8 in 2 hrs

(b)(6)-2 [redacted]

NURSING UNIT | BED NO.

24°/0400 [redacted] 1640

DA FORM 4 1 APR 79 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED [redacted] (b)(6)-2

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER 21 OCT 03 TIME OF ORDER 1220 HOURS

LIST TIME ORDERS NOTED [redacted] SIG [redacted] (b)(6)-2 21 OCT 03 1330

1. Resume previous orders
2. Regular diet
3. IVD LR at 125cc/hr. Hep lock when taking P.O. 21521
4. CBC, [redacted] (b)(6)-2

NURSING UNIT 2AN/OPD | ROOM NO. | BED NO. 22 OCT 03

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

DATE OF ORDER 22 Oct 03 TIME OF ORDER HOURS

Start PCTR line placement
"wet read"
call me result

NOTED 22 OCT 03 1345. [redacted] (b)(6)-2

NURSING UNIT 2AN/OPD | ROOM NO. | BED NO. 22 OCT 03 [redacted]

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

DATE OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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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.
ICU1	240	0445

DATE OF ORDER: 7 NOV 03 TIME OF ORDER: 1212 HOURS

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

D/C Zantac

(b)(6)-2

[redacted] (b)(6)-2

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
240	0214	9 NOV 03

DATE OF ORDER: 08NOV03 TIME OF ORDER: 1425 HOURS

CBC, Met-8 now

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

[redacted] (b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
240	10 NOV 03	@ 0100

DATE OF ORDER: 9 Nov 03 TIME OF ORDER: 1400 HOURS

1. Chem 12 / Electrolytes / U/A now
2. ABD Flat / upright (b)(6)-2
3. ~~IV Set~~ [redacted] / [redacted] (b)(6)-2

[redacted] (b)(6)-2

[redacted] (b)(6)-2

9 Nov 03 1355

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

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

noted

NURSING UNIT | ROOM NO. | BED NO.

10 9 NOV 03

	DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
	9 NOV 03	1600		
1	D/C GENTAMYCIN ✓			
2	N-LR AT 200 cc/HR			
	2 LITERS, FOW O/C			
3	ZOFRAN 2 mg IV NOW ✓			
4	MEPERIDINE 8 IM A.M. ✓			
5	ENSURE + CBH WITH MEALS. ✓			
6	NPO 8TH MIDNIGHT [redacted] ✓			

(b)(6)-2

PATIENT IDENTIFICATION

24 6 ✓ 0100 10 NOV 03 [redacted] 2CTM

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

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

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]

Noted 4 Nov

DATE OF ORDER: 10 NOV 03 TIME OF ORDER: 1990 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Resume previous orders
2. Regular diet
3. Keep clerk IV
4. AP 4x3 LET T15 PIX [redacted] K-RAD TODAY

NURSING UNIT | ROOM NO. | BED NO.

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

[redacted] 2 UTIAN 11 NOVOS @ 0130

PATIENT IDENTIFICATION

(b)(6)-2

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4 [redacted] (b)(6)-2 [redacted]				11 NOV 03	0929 HOURS	
			1	DISCHARGED TODAY TO EPW CAMP		
			2	CONTINUE WOUND CARE AS TOLERATED		
			3	LEVOFLOXACIN 250MG P.O. Q DAY		
			4	FOLLOW UP IN 4 WEEKS		
NURSING UNIT	ROOM NO.	BED NO.		(b)(6)-2 [redacted]		
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER ____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER ____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER ____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

Noted 11 NOV 03

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 9 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

	ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27	28	29	30	1	2	3	4	5	6	7
b)(6)-2	9/25	[redacted]	VS Routine	06	[redacted]												
				18													
				06													
b)(6)-2	9/25	[redacted]	Up ad lib with	06													
			crutches pen. EPW	18													
			Routine	06													
b)(6)-2	9/25	[redacted]	Regular diet	06	[redacted]												
				18													
				06													
b)(6)-2	9/26	[redacted]	BID dsg AS WTD	10													
				22													
b)(6)-2	10/03	[redacted]	Reg Diet	06													
				18													
b)(6)-2	10/3	[redacted]	Vac device on (L) leg	06													
			to low continuous suct.	18													

b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (L) Tib-Fib Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Sep Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(b)(6)-2 9/25	[redacted]	Admit to ICW #1, Condition	9/25		1520	[redacted]
	[redacted]	Stable				
b)(6)-2 9/25	[redacted]	NPO p MN. F 28	9/25	2400		[redacted]
b)(6)-2 9/25	[redacted]	to OR in AM	9/26			[redacted]
b)(6)-2 9/26	[redacted]	Resume previous orders	9/26	noted		[redacted]
b)(6)-2 9/26	[redacted]	NPO p MN 27 Sep	9/27	2400	noted	[redacted]
(b)(6)-2 9/26	[redacted]	Surgery 28 SEP (cancelled)	9/28			
(b)(6)-2 9/28	[redacted]	NPO p MN 28 Sep for OR in	9/29	0001	noted	[redacted]
(b)(6)-2 9/28	[redacted]	AM on 9/29 (OR)	9/29	done		
(b)(6)-2 9/29	[redacted]	NPO p MN for OR tom.	10/1	0001		[redacted]
(b)(6)-2 5 OCT	[redacted]	NPO p MN for OR	6 OCT	0001	noted	[redacted]
(b)(6)-2 5 OCT	[redacted]	OR 6 OCT 03	6 OCT			
b)(6)-2 6	[redacted]	Resume previous orders	now			[redacted]

(b)(6)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

	ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 8	9	10	11	12	13	14	15	16	17	18	19	20
(b)(6)-2	9/25	[redacted]	NS Routine	06 18	[redacted]												
		[redacted]		18 06	[redacted]												
(b)(6)-2	9/25	[redacted]	Up ad lib c crutches	06 18	[redacted]												
		[redacted]	pen. EPW routine	18 06	[redacted]												
(b)(6)-2	9/25	[redacted]	Regular diet	06 18	[redacted]												
		[redacted]	(b)(6)-2	18 06	[redacted]												
(b)(6)-2	9/25	[redacted]	~~BID drg A's WTD~~	06 18		[redacted]											
		[redacted]		18 06													
(b)(6)-2	9/25	[redacted]	BID drg A WTD	10	[redacted]												
		[redacted]		22	[redacted]												
(b)(6)-2	9/25	[redacted]	Vac device on (D)	06 18	[redacted]										D/C		
		[redacted]	leg to low continuous	18 06	[redacted]												
		[redacted]	suction														
(b)(6)-2	18	[redacted]	empty + record	06											[redacted]		
		[redacted]	drain qS	18											[redacted]		

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (D) tib-fib fx

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

	ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24	25	26	27	28	29	30/31	1	2
(b)(6)-2	9/25	[redacted]	VS Routine	6	[redacted]									[redacted]		[redacted]
				18	[redacted]											
(b)(6)-2	9/25	[redacted]	Up ad Lib ⊂ Crutches	6	[redacted]											[redacted]
				18	[redacted]											
(b)(6)-2	9/25	[redacted]	Regular Diet	6	[redacted]									[redacted]		[redacted]
				12	[redacted]									[redacted]		[redacted]
				18	[redacted]											
(b)(6)-2	9/25	[redacted]	BID DSG & WTD	10	[redacted]									[redacted]		[redacted]
				22	[redacted]											
			Empty & Record JP	6	[redacted]											
(b)(6)-2	10/18	[redacted]	& S	18												

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open ② Tib - Fib Fx

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

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(b)(6)-2 9 Oct	[redacted]	NPO p MN for OR tomorrow	10 OCT 03	2001		[redacted]
(b)(6)-2 10/10	[redacted]	Resume previous orders	10/10	—	—	[redacted]
(b)(6)-2 10/10	[redacted]	AP & Lat (L) lib-fib in AM	10/10	0500	—	[redacted]
(b)(6)-2 10/10	[redacted]	CBC, metlite 8 in A.M.	10/11	0400	—	[redacted]
(b)(6)-2 15 Oct	[redacted]	Resume previous orders, neg	15 Oct	—	—	[redacted]
	---	diet.				
(b)(6)-2 10/17	[redacted]	NPO p MN	10/17	2400	2400	[redacted]
(b)(6)-2 10/17	[redacted]	to OR tomorrow	10/18	O/C		
(b)(6)-2 18	[redacted]	Resume pre op orders	18 OCT	NOW		[redacted]
(b)(6)-2 18	[redacted]	NPO @ MN 20 OCT for OR on 21 OCT	20 OCT	0000		
(b)(6)-2 18	[redacted]	CBC, metlyte 8 in AM	19 OCT	0500		

(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 OCT 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 21OCT 03	[redacted]	CBC, Met 8 in AM	22OCT 03			
(b)(6)-2 22OCT 03	[redacted]	STAT P CXR, LINE PLACEMENT, "WET READ"	22OCT		1400	[redacted] (b)(6)-2
	----	CALL ME RESULT				
(b)(6)-2 WOV03	[redacted]	PA & LAT (D) Tib Fib today	WOV03		0900	[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

Recopied 11/2

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. 11 Yr. 2003

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

	ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	3	4	5	6	7	08	09	10	11	12			
b)(6)-2	9/25	[redacted]	VS Routine	06	[redacted]												
				18													
				06													
b)(6)-2	9/25	[redacted]	Up ad lib c crutch	06													
				18													
				06													
b)(6)-2	9/25	[redacted]	Regular diet	06													
				18													
				06													
b)(6)-2	9/25	[redacted]	BID DRSG Δ WTD	06													
				18													
				06													
(b)(6)-2	8NOV	[redacted]	NIO: CL drsg Δ c̄	30	/	/	/	/	/	[redacted]	/	/	[redacted]	/	/		/
			sterile technique QD	X													
(b)(6)-2	9NOV	[redacted]	encourage 1 can c̄	06							→		[redacted]				
			meals	12							→		[redacted]				
				18						→	[redacted]						

b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (L) Tib-Fib Fx

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 29

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 Nov Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
08 Nov	[redacted]	CBC, Metlyte 8 in AM	08 Nov 03	0500	0500	[redacted]	(b)(6)-2
08 Nov	[redacted]	CBC, met 8 now	08	1430	1430	[redacted]	(b)(6)-2
9 nov	[redacted]	Chem 12 / electrolytes / UA now	11/9	—	1430	[redacted]	(b)(6)-2
9 nov	[redacted]	Abd Flat / upright /	11/9	—	1456	[redacted]	(b)(6)-2
9 Nov	[redacted]	metlyte 8 in AM	10 Nov	0400	0400 ~~1430~~	[redacted]	(b)(6)-2
9 Nov	[redacted]	NPO p MN	10 Nov	0001	0001 1456	[redacted]	(b)(6)-2
10 Nov 03	[redacted]	Resume previous orders	10 Nov 03	—	—	[redacted]	(b)(6)-2
10	[redacted]	AP and LAT TIB FIB X-RAY TODAY	10				
11 nov	[redacted]	Discharge today to EPW camp					
11	[redacted]	Crutches-weight bearing as tol.					
11	[redacted]	Follow up in 4 weeks					

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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo.____ Yr.____

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	9	10	11	12	13	14	15	16	17	18	19	20	21	22
/26	[redacted]	IV LR @ 125cc° then	06	[redacted]													[redacted]
(b)(6)-2	-----	heplock when taking	18	[redacted]													
	-----	po well	X														
/29	[redacted]	Ciprofloxin 400mg	10	[redacted]													
(b)(6)-2	-----	IVPB Q12°	22	[redacted]													
2/29	[redacted]	Gentamycin 400mg	22	[redacted]													
(b)(6)-2	-----	IVPB Q Day	X														
8/27	[redacted]	Heplock W	06														
(b)(6)-2	-----		18														
18	[redacted]	LR @ 125cc/hr; heplock	06														
(b)(6)-2	-----	when tol po well	18														
20	[redacted]	Lovenox 30mg SQ	10														
(b)(6)-2	-----	BID	22														

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: OPEN (L) Tib Fib Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 10 Yr. 03

Verify by Initialing: Order Date	Clerk/Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
(b)(6)-2 15 OCT	[redacted]	Heplock IV	15 OCT	—		[redacted] (b)(6)-2

Order/Expir Date	Clerk/Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
(b)(6)-2 9/25	[redacted]	Percocet 1-2 po Q4°-6° PRN	D/T	11 OCT 1635	11 OCT 1915	12 OCT 2055	19 OCT 1720	15 OCT 2130	16 OCT 2215	17 OCT 2240	18 OCT 1547	19 OCT 2215	20 OCT 0627	20 OCT 1915	21 OCT 0515
			D/I	1	1 po	1	1		1	1	2	1	2	1	1
(b)(6)-2 9/25	[redacted]	Phenergan 25mg IVPQ6° PRN	D/T	[redacted]											
			D/I												
(b)(6)-2 9/25	[redacted]	Tylenol 650mg po Q4° PRN	D/T	20 OCT 0640											
			D/I	2											
(b)(6)-2 18 OCT	[redacted]	MSO4 2-8mg q 1-2° PRN	D/T	18 OCT 1615	18 OCT 1747	18 OCT 2011	18 OCT 2309	19 OCT 0036	19 OCT 1100	19 OCT 1830	20 OCT 0625	20 OCT 2230	21 OCT 0515		
			D/I	8mg	8mg	4	4	4	8mg	5mg	2	5mg	4		
(b)(6)-2 9/25	[redacted]	Percocet 1-2 po q4-6° PRN	D/T	20 OCT 1600	21 OCT 2000										
			D/I	2	1										

(b)(6)-2

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

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

VERIFY BY INITIALING: ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25 26 27 28 29 30 1 2 3 4 5 6 7 8
9/25	[redacted]	IV - Heplock	06	[redacted]
	[redacted]	(b)(6)-2	18	[redacted] DC
			18	
			06	
9/25	[redacted]	Ancef 1 gm	06	[redacted]
(b)(6)-2	[redacted]	IVPB q 8 hrs	14	[redacted] DC'd 9/29
	(b)(6)-2		22	[redacted]
9/26	[redacted]	IV LR @ 125cc then	06	[redacted]
	[redacted]	Heplock when taking	18	[redacted]
(b)(6)-2		p.o. well	X	
9/29	[redacted]	Ciprofloxacin 400mg	10	[redacted]
		IVPB Q12°	22	[redacted]
9/29	[redacted]	Gentamycin 400mg	22	[redacted]
(b)(6)-2		IVPB QDay	X	

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open ⓛ Tib-Fib Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

EPW # [redacted]

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. Sep Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
(b)(6)-2 6CT	[redacted]	Presume prev orders:				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY
(b)(6)-2 9/25	[redacted]	Tylenol 650mg po q 4hrs prn
(b)(6)-2 9/25 Exp 9/28	[redacted]	Percocet 1-2 p.o. q 4-6hrs prn
(b)(6)-2 9/25	[redacted]	Phenergan 25mg IVP q 6hrs prn
(b)(6)-2 9/26	[redacted]	MSO4 2-8mg IVP q 2hrs prn
(b)(6)-2 9/25	[redacted]	Percocet 1-2 PO Q4-6 HRS PRN

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

TIME/DATE DISPENSED

Date	25Sep	26	27	28	29	30 Sep	1Oct	2Oct	4Oct	5Oct	6Oct	7Oct	8Oct
Time	1310	1830	2215	2210	2010	2030	2130	2100	2010	2030	[illegible]	2000	2300
Dose	[illegible]	[illegible]	2	2	[illegible]	[illegible]	[illegible]	2	[illegible]	2	[illegible]	2	[illegible]
Initials	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Date	9Oct03	10 Oct	10Oct	10Oct
Time	2015	1000	1930	2045
Dose	[illegible]	[illegible]	[illegible]	HPO
Initials	[redacted]	[redacted]	[redacted]	[redacted]

(b)(6)-2

USAPA V1.00

CLINICAL RECORD

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

Mo. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

	ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23	24	25	26	27	28	29	30	31	1	2	3	4	5
(b)(6)-2	9/29	[redacted]	Ciprofloxin 400mg	10	[redacted]													
		-----	IVPB Q12°	22	[redacted]													
(b)(6)-2	9/29	[redacted]	Gentamycin 400mg	22	[redacted]													
		-----	IVPB QD	X	[redacted]	X	X	X	X	X	X	X	X	X	X	X	X	X
(b)(6)-2	10/18	[redacted]	Heplock IV	06	[redacted]													
		-----		18	[redacted]													
(b)(6)-2	10/18	[redacted]	LR@125 cc/hr;	06	[redacted]													
		-----	heplock when to	18	[redacted]													
		-----	PO well	X														
(b)(6)-2	10/20	[redacted]	Levenox 30mg SQ	10	[redacted]													
		-----	Bid	22	[redacted]													

(b)(6)-2

Heplocked

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (L) Tib fib Ex

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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

ICW #1

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. ____ Yr. ____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
(b)(6)-2 10/15	[redacted]	heplock IV	5oct			[redacted] (b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
(b)(6)-2 9/25	[redacted]	Percocet I-II PO Q4-Q6 PRN	D/T	23oct 1105	23oct 2000	24oct 0000	24oct 0440	24oct 2115	25oct 1330	25oct 2000	26oct 1100	26oct 2145	27oct 1045	27 oct 1430	27oct 1930	28 oct 1000
			D/T	II	II	II	II	Hpo	II	II	2	II	II	OD II	II	II [redacted]
(b)(6)-2 9/25	[redacted]	Phenergan 25mg IVP Q6° PRN	D/T	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
			D/T													
(b)(6)-2 9/25	[redacted]	Tylenol 650mg PO Q4° PRN	D/T													
			D/T													
(b)(6)-2 10/18	[redacted]	MS042-8mg q 1-2° PRN	D/T													
			D/T													
(b)(6)-2 9/25	[redacted]	Percocet tabs PO q 4-6° PRN	D/T	28oct 1640	28oct 2015	29oct 0205	30oct 1015	30oct 0500	30 1104	30oct 1740	30oct 2145	31oct 2200	1Nov 1500	1Nov 2000	2Nov 1800	
			D/T	II	II	II	II	II	II	II	II	Hpo	II	II	II	
(b)(6)-2 9/25	[redacted]	Percocet I-II PO Q4°-6° PRN	D/T													
			D/T													

(b)(6)-2

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

	ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5	6	7	08	09	10	11
(b)(6)-2	9/29	[redacted]	Ciprofloxin 400mg	10	[redacted]							D/C 9NOV @ 1600	[redacted]
		-----	IVPB Q12°	22	[redacted]								
(b)(6)-2	9/29	[redacted]	Gentamycin 400mg	22	[redacted]							D/C 9NOV 1600	[redacted]
		-----	IVPB BID										
(b)(6)-2	10/18	[redacted]	Heplock IV	06 18	[redacted]								
		-----		18 06	[redacted]								
(b)(6)-2	10/20	[redacted]	Lovenox 30mg SQ	10	[redacted]								
		-----	BID	22	[redacted]								
(b)(6)-2	08 NOV03	[redacted]	Zantac 150mg po BID	10	[redacted]						D/C 11NOV03		
		-----		22	[redacted]								
(b)(6)-2	9/29	[redacted]	CIPROFLAXIN 400mg	10								[redacted]	
		-----	IVPB Q12°	22								[redacted]	
(b)(6)-2	9NOV	[redacted]	LR@200cc/° x	06								[redacted] Completed	
		-----	2 Liters then D/C	18								[redacted]	

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Open (L) Tib-Fib Fx

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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

ICW # 1

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. 7 NOV Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
b)(6)-2 05 NOV	[redacted]	DIC Percocet	05 NOV	—	—	[redacted]
b)(6)-2 9 NOV	[redacted]	Zofran 2mg IV now	9 NOV	1600	1600	[redacted]
b)(6)-2 11 NOV	[redacted]	~~Levofloxacin~~ DIC mod - Levofloxacin 250mg po q day	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 9/25	[redacted]	Percocet 1-11 po q 4°-6° prn	Date 5 NOV												
			Time 1040												
			Dose 11												
			Init [redacted]												
			T/E												
b)(6)-2 9/25	[redacted]	Phenergan 25mg IVP q 6° prn	D/T	6 NOV											
			D/I	[redacted]											
b)(6)-2 9/25	[redacted]	Tylenol 650mg po q 4° prn													
b)(6)-2 10/18	[redacted]	MSO4 2-8mg q 1-2° prn	Date												
			Time												
			Dose												
			Init												
			T/E												
(b)(6)-2 05 NOV	[redacted]	Tylenol #3 1-2 po q 4 6° pm	D/T												
			D/I												

DIC 05 NOV 03

2-(b)(9)

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: 29 APR 05
Time In: 1842
Allergies: NKDA
Pre-op V/S: [illegible]
Procedures: [illegible] Tibia

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

OR Intake: Crystalloid 500 NS Colloid 0
OR Output: UOP 0 EBL: Min
Meds/Times: [illegible]

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

Pre Op Meds History

Time																
SaO2	100%	96%	97%	98%	97%											
FiO2																
Methods	NL	RA	RA	RA	RA											
240																
220																
200																
180																
160																
140			U													
120	U	U		U		U	U									
100																
80																
60																
40																
20																
RR	18	19	19	20	20	20										
T	97.0			97.7	97.7	97.7										
Time																
Pain (0-10)																
LOS																

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1845	NS	450	LH	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	0	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	1	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	0	0	0
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	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: [redacted] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 29 APR 05

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

NEUROVASCULAR

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

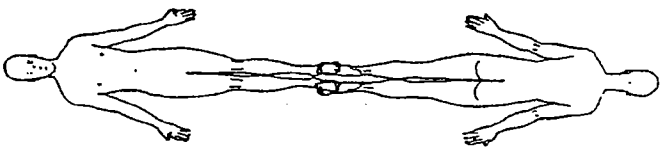
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1845	L Tibia	Curlex	Ø
30' 1915	L Tibia	Curlex	Ø
60'			
D/C 1935	L Tibia	Curlex	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1935	NSR	Ø	Ø

NURSING NOTES

PT recovered in OR due to MRSA. SIP 18 0 on L Tibia PARS Score 7 PT still asleep — PFC [redacted] (b)(6)-2
PT Awake @ 30 min Pain + Rom
Ø Drainage on OP site — PFC [redacted]
PT Transferred by PFC [redacted] to (b)(6)-2
ICW Report Given to CPT [redacted] (b)(6)-2
(b)(6)-2

Discharge Criteria:
Date: 29Sep05 **Time:** 1945 **PARS:** 10
BP: 122/79 **T:** 97 **HR:** 90 **RR:** 20 **Sa02:** 95
Pain Level at D/C (0-10):
Intake: 25 cc **Output:** Ø
Additional Data: Ø
Transferred To: ICW
Report Given To: CPT [redacted] (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: PFC [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Nurse Signature: [redacted] CPT/AN (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: 01 OCT

Anesthesia Type (Circle)): General Spinal Epidural Sa verral IV Sedation Nerve Block Dorsal foot

Time In:

Allergies: NKA

OR Intake: Crystalloid 300 Colloid

Pre-op V/S: 124/60-76

OR Output: UOP Ø EBL: Min

Procedures:

Meds/Times:

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

Pre Op Meds

History: ① LL wash out

Time	1845	1850	1855	1900	1915
SaO2	100	99	100	98	98
FiO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140					
120	V	V	V	V	V
100					
80					
60					
40					
20					
RR					
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
1845	NS	RAE	RAC	[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): SGT [redacted] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: Ø1OCTØ3

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

EPW [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
18						

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
1845							
Adm	L ⓓ leg	Limited	+	P	B	W	PK
15'	L ⓓ leg	Limited	+	P	B	W	PK
30'	L ⓓ leg	Limited	+	P	B	W	PK
45'							
60'							
90'							
D/C	L ⓓ leg	Limited	+	P	B	W	PK

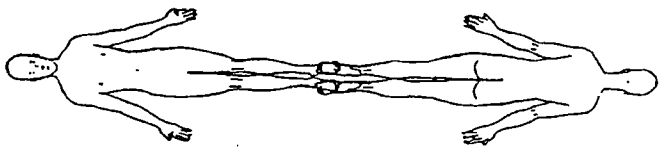
Movement/Sensation: + = present, - = absent, Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1845 L	ⓓ leg	Gauze	C/D/I
30' 1915 L	ⓓ leg	Gauze	C/D/I
60'			
D/C 1930	ⓓ leg	Gauze	C/D/I



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1845	NSR	Ø	Ø

NURSING NOTES

Received from OR via gurney To Room 14 OR To Recovery + NRSA. VSS- Alert x3 Gauze to L ⓓ leg C/D/I. Peular 3 m - HR NSR- Lungs CTA BIL Resp eur Reg. BS ⊕ x4 equals Pedal and Radial pulses +2. on RA O2 SAT 98%. Ø 4/0 L ⓓ leg Pain (b)(6)-2 @ present. — SGT [redacted] 9/C ⊕
Pins to operative site L ⓓ leg in place Ø drainage. — Sgt [redacted] 9/C ⊕
(b)(6)-2

Discharge Criteria:
Date Ø1 OCT Time: 1930 PARS: 10
BP: 115/50 T: 95 HR: 72 RR: 16 Sa02: 98
Pain Level at D/C (0-10):
Intake: _____ Output: _____
Additional Data: _____
Transferred To: ICW #1
Report Given To: _____
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SGT [redacted] 9/C ⊕ (b)(6)-2
Cleared IAW Recovery Room SOP [redacted] (b)(6)-2
Nurse Signature: Sgt [redacted]

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: 30 Oct 03
Time In: 1000
Allergies: NKDA
Pre-op V/S: 116-74-95
Procedures: Dc D (L) LE

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid D5 300 Colloid
OR Output: UOP EBL
Meds/Times:

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

Pre Op Meds History

Time	1000	1/2	1115	1130	1135
SaO2	96	95	96	96	96
FiO2	RA	BB	M	M	BB
Methods					
240					
220					
200					
180					
160					
140					
120	✓		✓	✓	✓
100		✓			
80			•		
60	•	•	•		•
40		^	^	^	^
20	^				
RR	10	12	12	14	12
T	97		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	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	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	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	✓	✓	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	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 (S: [redacted] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 10-3-03

PATIENT'S ID [redacted] e: Name – last, first, middle; grade; date; hospital or medical facility)

[redacted] (b)(6)-4

ICW 1

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

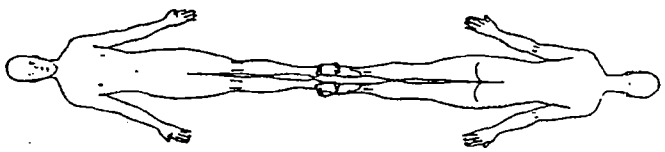
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) Lower leg	limited	full +	P	S	cool	
15'		limited	full +	P	S	cool	
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) lower leg	Kerlix	scant sanguinous
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount
1140	(L) leg	red/sanguinous	close

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

Assumed pt care from MAJ Fidelle. pt c/o, 455, afebrile @ time of arrival. Pt in no apparent distress. A alert, appropriate follows commands. Pupils 3mm sluggish. CV NSR, radial + 2 radial pulses radial & pedal.

Resp even, on ventilator, O2 (R) ⅜ lobectomy 1 spec 96-97 on RA.

GI soft, nontender, abdomen hypo BS. ⊕ N/V/D.

GU c foley @ c/o

Lines RA & PIV patent

Nathan [redacted] (b)(6)-2 10/3/03

Discharge Criteria:	
Date: 10/3/03 Time: 1140	PARS: 10
BP: 129/59 T: 97.4 HR: 66	RR: 14 Sa02: 96 on RA
Pain Level at D/C (0-10):	
Intake: ∅	Output: close c JP
Additional Data: ∅	
Transferred To: 4CW	
Report Given To: SPC [redacted] (b)(6)-2	
Transferred Via: W/C (Litter) Gurney Ambulance	
Transferred By: 1CT [redacted] SSG [redacted] (b)(6)-2	
Cleared IAW Recovery Room Score: 3	
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: 6 OCT 03
Time In: 1630
Allergies: NKDA
Pre-op V/S: 120/70
Procedures: HD, LD, TTBIR

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid
OR Output: UOP EBL
Meds/Times: MSO4, Propofol, Inhalgas

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

Pre Op Meds History

Time	1630	1635	1640	1650
SaO2	97	99	99	98
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120	V	V	V	V
100				
80	•	•	•	•
60	^	^	^	^
40				
20				
RR	17	16	18	18
T	97.2			

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1630	LR	400	(L) FA	LYC	600

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	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

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)

PREPA[redacted] (b)(6)-2 | DEPARTMENT/SERVICE/CLINIC: PACU | DATE: 6 OCT 03

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

EPN # [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	(L) leg	WDM	+	+	B	W	PK
15'							
30'							
45'							
60'							
90'							
D/C							

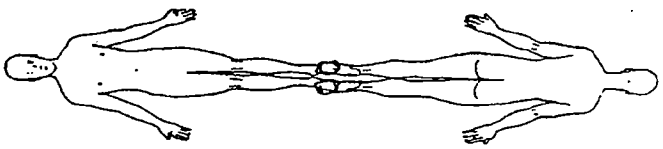
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	Ioban C	⊘
30'		Ext fix	
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1630	SR	⊘	⊘

NURSING NOTES

Pt to recovery room from OR via litter s/p ORIF (L) tibia. Ioban & ext fix C drain intact. ⊘ drainage noted. IV of LR infusing into (L) ankle. ⊘ S/S of redness or swelling to site. ⊘ c/o. Will continue to monitor. - [redacted] (b)(6)-2
Pt to PCW# [redacted] (b)(6)-2

(b)(6)-2

Discharge Criteria:
Date: 6 Oct 03 **Time:** **PARS:** 9
BP: 137/76 **T:** 96.3 **HR:** 69 **RR:** 16 **Sa02:** 98
Pain Level at D/C (0-10):
Intake: 50 **Output:** ⊘
Additional Data:
Transferred To: PCW#1
Report Given To: SSG [redacted] (b)(6)-2
Transferred Via: W/C Litter Journey Ambulance
Transferred By: SGT [redacted] (b)(6)-2
Cleared IAW Recovery Ro[redacted] (b)(6)-2
Signature of Nurse Signature: [redacted]

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: 10 OCT 03
Time In: 1353
Allergies: NKA
Pre-op V/S: 101/58, 77
Procedures: I&D left

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid 0
OR Output: UOP 0 EBL N/A
Meds/Times: Sublimaze, Propofol

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

Pre Op Meds History

Time	1353	1420	1430	1445
SaO2	96	95	97	98
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
	V	V		
120			V	V
100				
80				
	^	^	^	^
60				
40				
20				
RR	16	24	20	18
T	96.6			

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1355	LR	1000	RU	OR	400

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

(Continue on reverse)

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

NEUROVASCULAR

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

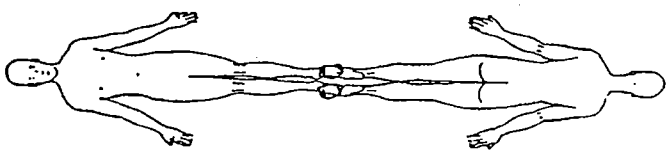
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	Wet fix c	
30'		tubular	
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1305	SR		

WAMC OP 173-E

NURSING NOTES

Pt to Recovery Room from OR, s/p I&D (L) leg. Ext fix c tubular dressing intact. IV of LR infusing into (R) IJ. c/o s/s of Medial Dysrhythmia to site. NVS intact. VSS. c/o (6) 4/10 pain. Will continue to monit[redacted] LR

(b)(6)-2

Discharge Criteria:
Date: 10/17 Time: 1715 PARS: 10
BP: 129/67 T: 96.7 HR: 65 RR: 14 Sa02: 97
Pain Level at D/C (0-10):
Intake: 300 Output: -0-
Additional Data:
Transferred To: ICW
Report Given To [redacted] (b)(6)-2
Transferred Via: W/C [redacted] Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery R[redacted]
Charge Nurse Si[redacted] LT AP

(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: 15 OCT 03
Time In: 1300
Allergies: NKDA
Pre-op V/S: 117/68 68
Procedures: Washout Debridement

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 350 Colloid ∅
OR Output: UOP ∅ EBL ∅
Meds/Times: Versed Fentanyl Propofol

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

Pre Op Meds History

Time	1300	1305	1310	1315
SaO2	99	98	99	99
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120	V	V	V	V
100				
80	A	A	A	A
60	•	•	•	•
40				
20				
RR	17	19	18	18
T	97			

Pacu Intake					
Time	Solution	Amount	Site	By	Infused
1300	LR	500	R hand	DR	500
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
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	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
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2		2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2		2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	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

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)

(b)(6)-2 PR[redacted] LR | 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,

(b)(6)-4 [redacted]

☐ 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	(D) leg	WDM	+	+	B	W	PK
15'							
30'							
45'							
60'							
90'							
D/C							

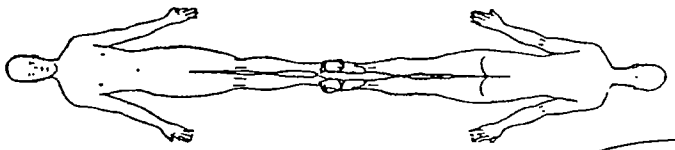
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(D) leg	Lt tibia c Kirlex	Ø
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1300	SR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Pt to recovery room from OR via litter s/p without (L) tibia. Ext fix c Kirlex intact. NVS intact. IV of LR infusing into (L) hand. ∅ c/o of tenderness or swelling to site. VSS, c/o @ this time. Will continue to monitor [redacted] (b)(6)-2

Discharge Criteria:
Date: 15/07 **Time:** **PARS:** 10
BP: 120/66 **T:** 97 **HR:** 62 **RR:** 10 **Sa02:** 98
Pain Level at D/C (0-10):
Intake: 100 **Output:** Ø
Additional Data:
Transferred To: ICU
Report Given To:
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: [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.

OTSG APPROVED (Date)

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

Date: 18 Oct 03
Time In: 1414
Allergies: 12/66 88
Pre-op V/S: WNL OA
Procedures: Log Wash out + closure EBFix

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

OR Intake: Crystalloid 3000 Colloid
OR Output: UOP EBL 450 EBL

5mg Versed
60mg Solu-Medrol
30mg MSO4

Meds/Times:

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1400	1450	1514	1530	1600	1630
SaO2	96	98	98	97	98	98
FiO2	RA	RA	RA	RA	RA	RA
Methods						
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	14	14	12	14	15	13
T	98					
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			
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)

PREPARE[redacted] SSC/CN

(b)(6)-2

DEPARTMENT/SERVICE/CLINIC: PACC

DATE: 18 Oct 03

PATIENT'S IDENTIFICATION (Print/Type or Write) [redacted] Name — last, first, middle; grade; date; hospital or medical f[redacted]

(b)(6)-4 [redacted]

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

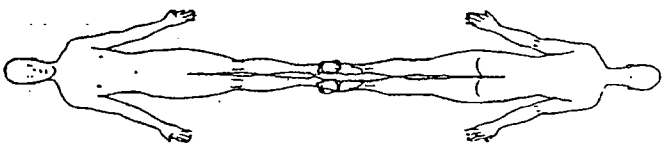
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

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			
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

Male Foreign National to PACU S/P ~~I&D~~ Wound Exp. + closure PSS 98% RA VSS. JP to (L) leg at Ext. site. All drsgs CDI. Bilat pedal pulses. [illegible] LR @ TKO Port. — SG[redacted]N/
(b)(6)-2

Discharge Criteria:
Date: 18 Oct 3 Time: 1520 PARS: 10
BP: 137/70 T: HR: 89 RR: 12 Sa02: 99
Pain Level at D/C (0-10):
Intake: Output: Ø
Additional Data:
Transferred To: IW 1
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [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

OTSG APPROVED (Date)

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

Date: 7/1
Time In: 1236
Allergies:
Pre-op V/S: 124/60 76
Procedures: I+D left leg

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 350 Colloid
OR Output: UOP EBL
Meds/Times: 2 Fent 2 versed

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

History

Pre Op Meds

Time	1236	1245	1245	1301
SaO2	100	99	99	99
FiO2				
Methods	RA	RA	RA	RA

240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

RR: 12 14 11 9
T: 97.7
Time
Pain (0-10)
LOS

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1240	LR	200	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			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] Spf

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 210ct03

(b)(6)-2

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

Name – last,

(b)(6)-4 [redacted]

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1136		2mg MSO4	IV			[redacted]
1247		2mg MSO4	IV			[redacted]
1256		2mg MSO4	IV			[redacted]
1306		2mg MSO4	IV			[redacted]
1315		2mg MSO4	IV			[redacted]

NEUROVASCULAR

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

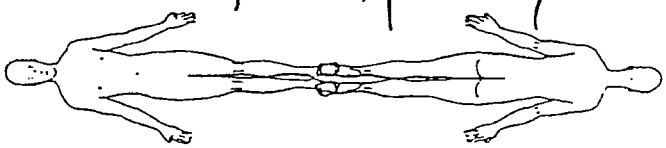
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1136	L leg	ex fix/ace	Ø
30' 1206	L leg	ex fix/ace	Ø
60'			
D/C	L leg	ex fix/ace	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1136	TSR	0	0

WAMC OP 173-E

NURSING NOTES

Pt received s/p I&D. Pt c/o pain 2mg MSO4 given SpO2 100% RA. Pt keeps c/o pain 2mg MSO4 given at a time Report given to Pt [redacted] VSS SpO2 99% [redacted] (b)(6)-2 Sgt [redacted] (b)(6)-2 LPN

Discharge Criteria:
Date: 20 Oct 03 Time: 1312 PARS: 10
BP: 118/69 T: 97.9 HR: 104 RR: 11 Sa02: 99
Pain Level at D/C (0-10):
Intake: 200 Output: 0
Additional Data: —
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.

OTSG APPROVED (Date)

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

Date: 10 Nov
Time In: 1415
Allergies: NKDA
Pre-op V/S: 1415 [illegible]
Procedures: [illegible] Bilateral, [illegible]

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

OR Intake: Crystalloid 350 Colloid
OR Output: UOP EBL
Meds/Times: [illegible]

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

Pre Op Meds

History

Time	1415	1430	1445	1515
SaO2	96	97	96	96
FiO2				
Methods	S	S	S	S
240				
220				
200				
180				
160				
140				
120	V	V	V	V
100	•	•	•	•
80	^	^	^	^
60				
40				
20				
RR	10	14	10	
T	96			

Time								
Pain (0-10)								
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1415	NS	150	SC	DL	350

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
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	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
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2		2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2		2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	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], LPN
(b)(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 10 Nov 03

IDENTIFICATION (If 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
1445		MSO4 3mg	IVP			[illegible]

NEUROVASCULAR

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

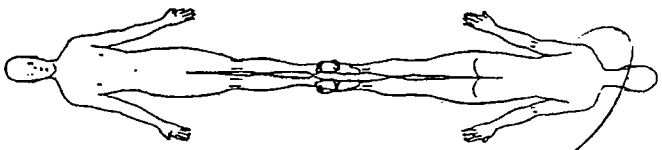
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) leg	cast	—
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1445	ST	—	—

NURSING NOTES

Pt to recovery room from OR s/p rt fix femoral. Long leg cast to (L) leg intact NV's intact IV NS infusing to hand. Up pain. Medicated c 3mg MSO4 will continue to monitor. [redacted] (b)(6)-2 Initial log removed. #20 Large IV started (L) hand. Will continue to Nm[redacted] (b)(6)-2

Discharge Criteria:
Date: 10 NOV **Time:** 1515 **PARS:** 10
BP: 170/[illegible] **T:** 96.8 **HR:** 87 **RR:** 18 **Sa02:** 96
Pain Level at D/C (0-10):
Intake: 200 **Output:** —
Additional Data:
Transferred To: ICW [redacted]
Report Given To:
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery R[redacted]
Charge Nurse Signature: (b)(6)-2 [redacted]

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	1 5 4	X	9	MOSLIM

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		~~9 4~~ 20	[redacted]

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

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW1	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
28TH CSH SOUTH (b)(2)-2	

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
2 4		Ø 3 Ø 1 1 1

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A E A A		Ø 3 Ø 9 2 5

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

FOR LOCAL USE

DX: OPEN ~~FIB~~ / FIB FX

(b)(6)-2

ADMITTING OFFICER (Signature, as required)

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

DR [redacted]

SIGNATURE OF ADMITTING CLERK

[redacted]

DA FORM 2085, MAR 80

(b)(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	2. [redacted] (b)(6)-4			3. GRADE CI	ADMISSION REMARKS
4. SEX M	5. AGE 17	6. RACE —	7. RELIGION —	8. [redacted]	9. ETS —	10. PREVIOUS ADMISSION NO
11. FMC 99	12. SSN (b)(6)-4 [redacted]		13. ORGANIZATION —			14. WARD ICU
15. FLYING STATUS NO	16. [redacted] DSG —	17. DSPT BEN K7878	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE —

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER	22. HOURS OF ADMISSION: 0100	23. CLINIC SERVICE: AAAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: unk	25. TYPE DISPOSITION: 50	26. DATE OF DISPOSITION: 28 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): unk	27b. TELEPHONE NO: unk	28. DATE OF THIS ADMISSION: 28 03	[redacted] (b)(6)-2
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

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: (1) [redacted] colon repair (b)(6)-2
(2) multi Shrapnal wounds

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LIMCOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	27	27

35. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LIMCOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
(b)(6)-2	(b)(6)-2				

SIGNA[redacted]NG MEDIC[redacted] MA [redacted]R MEDICAL RECORDS OFFICER (b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1 AUG 75 IS OBSOLETE USAPPC V1.1

MEDICAL RECORD | 28 Sep 0100 **ABBREVIATED MEDICAL RECORD**

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

17 y/o ♂ injured by grenade ~ 24 h ago presented to FST ~ 1700 c̄ c/o abd pain, arrived by ground ambulance, T 103 P 110 120/60
PMH ⊖ All ⊖ per FST hx

OR ~ 3 h
4.5 L
500 colloid
EBL ____

hrd 1° resection/~~repair~~ anastomosis (ileocolectomy c̄ 1° EEA) at FST, also exp ⊕ hrce - ō Ax - drain left in place
Pt extubated postop but had to be reintubated; tx'd c/o diff providing 100% O_2, PEEP

140/70 110 38° CVP 8

PHYSICAL EXAMINATION
PER TM
mucosa OK
neck - ō wounds
chest clear
cor - ō ⊕
abd - midline incision c̄ JP out ⊕ side
pelvis - stable
rectal - ⊕ tone
ext - moves all

PROGRESS *(Enter date of discharge and final diagnosis)*
CXR - bil alveolar infiltrate consistent c̄ ARDS, pulm edema (⊕ tube placed)
H&H 40 w DC 3.9

A - ARDS
P - PEEP 12 100% F_iO_2 TV 600 ~~rate~~ 16
[redacted] CTS, gm stain

7.26 42 HCO_3 19
~~7.306~~ ~~28~~ CO_2 ~~[illegible]~~
Sat 95%
BE - 12

SIGNA[redacted] MD (b)(6)-2	DATE 28 Sep	IDENTIFICATION NO.	ORGANIZATION

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

9/23/03 pre-op note (cont)
pt febrile c̄ perinatal signs c̄
Hemocult (+) stool. Location of (L) & (R)
flank injuries suspicion for possible
bowel injury; do not suspect intra-abd
hemorrhage based on Hb & US.
We do not have CT scan readily
available. Based on ↑T, (+) heme in
stool & perinatal signs we decided
to take pt to OR for exploration

plan: to OR now
fluid resus
Unasyn 3 gram IV now

(b)(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
[redacted] NKDA 17y/o ♂		

(b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9/27/03	Pre-op H&P (c̄ translation)
	17 y.o ♂ suffered frag injuries to (L)
	leg, back and (L) hip/flank region
PMH ∅	approx 18° prior. Arrived in stable cond^n
PSH ∅	via ground evac c̄ cc of abd pain
meds:	Exam: Gen: Thin ♂ appeared uncomfortable
Allergic:	Head: AT Neck: NT; trachea ML ∅JVD
All: ∅	Eyes: EOMI; PERRL; scleral ∅ icterus
SH: unknown	Heart: HR / 10 RR BP
	Temp 103 (P): (L) flank c̄
	Lung: BS = (B) CTA frag wounds
	Abd: soft; diffusely tender c̄ guarding
	Ext: (L) hip open wound 3 cm
	(L) knee c̄ wounds & (+) hematoma
	Neuro: GCS = 15
Hx unk	Rectal: Hemoccult (+) ∅ gross blood
	CV: (+) tachy; AT
	Labs: WBC 8 Hb 15 UA 3+ blood
	SNBH: CTA ∅ PTX ABD NIBGP
	∅ FA (+) shrapnel in pelvis
	(c) femur/knee ∅ fx
	I/P: PT arrived from outside hospital
	ⓟ suffering frag injuries ~ 18° prior
	(cont)
	(b)(6)-2 [redacted]

509-113 NSN 7540-00-634-4122

MEDICAL RECORD | PROGRESS NOTES

DATE

27 Sep 2003 2100

Op - Note - Ortho

Pre-op Dx - 1) multiple shrapnel wounds (L) thigh
2) ? (L) knee joint

Post-op Dx - 1) multiple shrapnel wounds (L) thigh
2) Penetrating wound (L) knee

Surg: Bal

Findings - Irrigated (L) knee I 40 cc NS - got 50 cc bloody aspirate back
Followed penetrating tract through quad tendon into joint.
Perforated anterior, lateral aspect - I & D
Knee joint I 3 l pulse lavage, closed arthrotomy over drain.
I & D multiple soft tissue wounds, thigh I 2 l pulse lavage.
Dressing I xeroform, fluffs
JP drain left knee [redacted]

(b)(6)-2 [redacted]

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

17/005

[redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
9/27/03	Post op open:
	Admit to post-op
	Dx: s/p ex LAP; Bowel resection
	Cond: stable
	Vitals: q 4°
	All: NKDA
	IV/Nursing: I's/O's; Foley to gravity; JP to bulb suction
	Nut to ICWS; call M.D. T > 38° HR > 100 < 60
	RR > 30 < 10 SBP > 160 < 100; UOP < 30cc/hr
	Diet: NPO (b)(6)-2 [redacted]
	IVF: ~~D5½NS + 20mEq KCl/L @~~ 120 cc/hr
	Meds: pitenergan 25 mg IV q 6° prn N/V
	morphine sulfate 2-4 mg IV q 2-4° prn pain
	Unasyn 3g IV q 6° (give 1st dose now)
	Labs: AM CBC, Chem 7
	(b)(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28Sep03	late entry: Dr [redacted] @ bedside, teach study. (b)(6)-2 [redacted]
	1510 ABG drawn per A-line. Reviewed by Dr [redacted] orders received, ↓ pressors, ↑ rate, TV 600, FiO2 40% (b)(6)-2 [redacted]
(b)(6)-2	1715 Dr [redacted] @ bedside, update given, almost elevate HR rate. 120's-130's. pressors beats noted (b)(6)-2 [redacted]
19(0)	report rec'd; pt sedated c̄ MSO4/Versed; vent; fshil (33%); UOS; tachy; assmt complete (b)(6)-2 [redacted]
6(00)	MD orders called for HR reaching 130's occasionally; CBC ordered + drn; amity pt @ 123 (b)(6)-2 [redacted]
6(00)	no change in assmt status; pressors ↓6; sat 279%; CTM
6(00)	CBC results seen by MD; no changes made; pt moved to purple; fio2 35%; (b)(6)-2 [redacted]
29Sep03	0700 assumed care. Report given. UOS. see TCU-3 Bluesheet for initial assessment. (b)(6)-2 [redacted]
	0630 Tylenol supp. given. Temp 102 ↓ sedation. (b)(6)-2 [redacted]
	0720 ↓ rate to 10, ↓ peep 5cm (b)(6)-2 [redacted]
	0800 ABG drawn per A-line, versed ↓ 2mg/hr. (b)(6)-2 (b)(6)-2 [redacted]
	0910 ABG reviewed by Dr [redacted] orders received to ↓ sedation, plan to extubate

(b)(6)-4 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

[redacted] (b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
28 Sep 03 0100 (2400hrs)	Direct admit from EST; pt packaged, bagged by EMT; NR, ETT c̄ BBS; SaO2 90%; VSS; Pt placed on monitors, TLC to (R) SC c̄ CXR; A line to (L) Radial, (+) waveform; FTG; HOB 30°; MSO4/ Versed for sedation; Vent settings for mod; to be weaned; multiple labs drawn + received; orders to RT for pulse; VSS @ this time [redacted] (b)(6)-2
(0400)	machine on status; VSS; vent A's c̄ ABG noted [redacted] (b)(6)-2
28 Sep 03	0610 Assumed care. Report given. See TIU-3 flow sheet for initial assessment [redacted] (b)(6)-2
(b)(6)-2	0700 Dr [redacted] @ bedside. Labs reviewed, orders received. U pump 10. @ other A's c̄ vent. [redacted] (b)(6)-2
	0810 updated Dr [redacted] on elevated temp 102.1 rectal Tylenol/suppository given [redacted] (b)(6)-2
	1200 ABG results in, notified Dr [redacted] (b)(6)-2 c̄ result. [redacted] (b)(6)-2
(b)(6)-2	1250 Dr [redacted] present, U rate 14, [illegible]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29Sep03	1400 D/C'd x2 PIV @ R/L arm. — [redacted] (b)(6)-2
	1150 ABG were drawn - results [illegible]
	1340 DASG on ABG done, O2 sat dropped. [illegible] & suctioned moderate amt secretions. O2 sat rebounded — [redacted] (b)(6)-2
	1500 & 1504 3mg/hr per Dr [redacted] (b)(6)-2
	1540 O2 sat TP drain pulled. drsg [illegible] (b)(6)-2
	O/VARS & neurochks received — [redacted]
(b)(6)-2	1615 Dr [redacted] present update given [illegible]
	1735 pt more alert, opens eyes to commands. Konsas [illegible] @ bedside update given. Family left & [illegible] once awake. — [redacted] (b)(6)-2
1900	pt sleepy but arousable; VSS; assessment complete & charted; no new c/o — [redacted] (b)(6)-2
2000	sedation turned on pm ↑ agitation; ↓ SaO2; ↑ RR, breathing vent; will inform MD ASAP — [redacted] (b)(6)-2
	SaO2 done c̄ above c̄ minimal secretions out; Tylenol 650mg pm NGT — [redacted] (b)(6)-2
2300	temp ↓ 33.2; VSS; SaO2 98% on 40% FiO2. — [redacted]
0100	no change in assessment status; VSS; temp ↓ — [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(Cont)	0430 ABG drawn CO2 45; pH 7.36; RR ↑ from 10 to 12; other labs pending [redacted] (b)(6)-2
30 Sept 03	0600 Resumed care. Report given. See TCU-3 flowsheet for initial assessment [redacted] (b)(6)-2
	0650 RR [redacted] @ bedside. Labs reviewed, sedation lines off. MSO4 off remains @ 1mg/hr. pt responsive opens eyes to command
	0915 RT @ bedside, pt arousable to command, instruction by translator for cough exercises. [redacted] (b)(6)-2
	1000 Translator @ bedside to support & stimulate pt. placed on O2 @ 2L/min pt remains drowsy, RR even at unlabored, rate 22-27. [redacted] (b)(6)-2
	1030 Sips of H2O given RR 25-28 15002 99%-100% [redacted] (b)(6)-2
30 Sep	1330
	S - arousable
	O - T 102 P123 150/85 sat 97% on nasal O2
	chest clear but cough productive
	abd - rare BS wound OK
	BS +
	extr - 3+ edema WBC 8 HCT 33 IV site OK
	A - fever ? 2° to atelect, will watch wound + IV site, may change
	P - pulmonary, intake & output

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

[redacted] (b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES (b)(6)-2
100403	1300 [redacted]
	1530 [redacted] cough, [redacted]
	[redacted] (b)(6)-2
	1730 [redacted]
	[redacted] (b)(6)-2
1900	pt alert, responsive; equal, reactive; [redacted]
	2L; NAD; pt resting; assement charted; [redacted] (b)(6)-2
(2400)	no change in assement status; pt [redacted]
	[redacted] (b)(6)-2
(0220)	pt [redacted] to ICW2 RN; pt to be [redacted]
	(b)(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

O/U [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	20 Oct POD 3
	BS(+) wound good, lo grade temp 100
	A total
	P - ↑ act + diet

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES (b)(6)-2 (b)(6)-2
	Management Palliative Measures [redacted]
30Oct03	0530: Dr [redacted] here, staples to midline wound removed, steri strips placed CDi, Dsg to (L) hip Δ'd CDi. (b)(6)-2 [redacted]
@30Oct03	(1500) Assumed care of pt @ @bbb̄ p̄ report from night shift. Pt alert, speaking some English. VSS. Pain controlled c̄ Tylenol. Pt OOB to amb in hallway X2 this shift. Drsgs to @ hip and thigh CDI. Sutures to @ knee CDI. midline abd incision intact c̄ steri strips. CL to @ SC infusing IVF s̄ s/sx infection/infiltration. Tol. small amount of reg diet. voiding clear yellow urine s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will continue to monitor. (b)(6)-2 [redacted]
30Oct03	1900: VSS, Ø c/o pain @ present time, A+O x3, speaks some English to verbalize needs, OOB to bathroom s̄ difficulty, x1 BM this evening, CL intact to (R) upper CW → running D5½NS c̄ 20meq KCl @ 75cc/° s̄ difficulty, dsg to site CDi, Ø s/s irritation/erythema, midline abdominal incision has steri strips applied CDi, Dsg to (L) hip CDi, shrapnel wounds scattered to back & open to air-healing. X2 restraints when in bed. Skin integrity intact. Continue to monitor for acute Δ's. (b)(6)-2 [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	(b)(6)-2 NOTES
20Oct03 0900	Received Pt from [redacted] ICW2 ambulatory. (R) SC Triple lumen IV patent infusing D5 1/2NS c̄ 20mEq KCl @ 75cc/hr. Peripheral pulses +2 Drsg to (R) flank, (L) thigh, (L) knee Dry/intact. VSS. Lungs clear Bilateral. BS (+) x4 quad. Abd soft, tender to touch, non distended. Midline Abd. incision c̄ staples intact & dry. Will continue plan of care. (b)(6)-2 [redacted] ICW
20Oct03	2045= VSS, Ø clo pain @ this time, A+O x3, CL to (R) upper chest wall (triple lumen) running D5 1/2NS c̄ 20meq KCl @ 75cc/° S̄ difficulty. CL site S̄ erythema/irritation or S/S infection. CL Dsg Δ done, NID initiated. Midline Abdominal incision c̄ staples intact and open to air, 2x2 Dsg CDI to (R) upper quad, Dsg to (L) hip area CDI (QDay Δ's). Shrapnel Wounds scattered to back, healing and open to air. Pt. got OOB & walked in hall for ~10 minutes c̄ walker c̄ assistance. x2 restraints when in bed. POC: Infection Control, Wound Care, Pain →

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
8 OCT 03 0135	VSS. AO. Abdomen abdominal incision replaced/reinforced c̄ steri strips @ base of incision. WTD saturated and d'd and deposited site. Approx pint 5 ml/s infusion. Tolerated well. Replaced WTD ABD's @ ⓛ hip and applied Bacitracin to scabbed sphacelated wounds. — (b)(b)-2 [redacted] RN
8 Oct 03	Pt A+O×3, VSS pt has ∅ c/o pain at this time, drsg to ⓛ hip ⓛ flank and sacral area changed minimal drainage, most appear reddish pink, a couple had some light greenish drainage, bacitracin applied to sacral sphacelated wound, restraints×2 in place circulation (b)(b)-2 [redacted]
	(1330) I concur c̄ above assessment. Pt dc to Iraqi hosp. - ambulatory in stable cond. [redacted] (b)(b)-2

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10Oct03	2030= VSS, ¢c/o pain @ this time, A+O X3, ambulates as needed c̄ minimal assist, Dsg to (L) hip CDI, Dsg W→D Δ'd to midline abdominal wound - scant sero-sanguinous drainage noted. Tolerates PO well, ¢ N/V/D. Abrasnel wounds scattered to back - healing & open to air. POC: Pain Mgt, wound care, infection control. ⅓ restraints when in bed, ⊖ Skin breakdown. Continue to monitor for acute Δ's. — [redacted] (b)(6)-2
10Oct03 0900	Assumed care of pt. Pt tolerated reg diet ⊖ S/S of resp distress, pain or discomfort @ present time. Suture removed from (L) hip and wet to dry dsg Δ. Wsg D&I on (L) thigh and abdomen. Lungs CTA BS(+) (R) distal pulses ⊖ skin breakdown under restraints. Will continue to monitor — [redacted] (b)(6)-2 SIWHG.
1115	Wsg Δ to abd, hip and (L) thigh. Abd wound pink. wet → dry — [redacted] (b)(6)-2 SIWHG

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE | NOTES

28 Sep - 8 Oct 2003

Patient a 17 year old male with fragment injuries to left back and flank 18 hours before arriving at FST with abdominal pain. Patient taken to OR and right hemicolectomy done for perforated ascending colon with primary end to end anastomosis. Right knee explored - no penetrating. Patient transferred to [redacted] (b)(2)-2 28 Sep intubated and had developed ARDS picture but was extubated 48 h later and has done well with rapid advancement of diet. On 7th postop day ~ 2 cm of wound opened below umbilicus and 2 cc pus released. Wound packed open with saline soaked gauze, changed every 8 hours. Small wounds on left hip also changed twice daily. Will need continued dressing change til wound heals in 2-3 weeks.

Patient received Unasyn for 5 days then discontinued and was on subcutaneous Heparin til ambulatory. No problem with knee. No fracture of knee; CXR now normal

1 Oct '03 Hct 30 WBC 6.5 platelets 291

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

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

PROGRESS NOTES
Medical Record

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Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10/4/03	light amber urine, quantity sufficient. (+) pulses. [redacted] RN (b)(6)-2
10/5/03 : 0920	Pt A&O. Communication adequate to express needs. HRR. Nailbeds pink c̄ brisk capillary refil. Lungs CTA(B). Resp even/unlabored. Abd. soft. (+) BS x 4 quads. Voiding s̄ difficulty clear yellow urine. MAE. Good ROM. Ambulates in hall for exercise. Skin warm & dry. Midline abd incision c̄ steristrips & drsg to open wound c̄ serosanguinous drainage. (2) Lip drsg Δ & shrapnel wounds c̄ drsg Δ. All sites healing. (2) Knee sutures to air. Bacitracin applied. Drsg CDI to old central line site (R) subclavian. Ø complaints @ this time. A.M. care done. Will [redacted] continue monitoring & providing emotional support (b)(6)-2 MAG/RN
10/5/03 1700	Pt ambulating in hall for exercise. OOB to chair for approx 25 min. Ate Grai chicken for dinner. Will continue to monitor [redacted] (b)(6)-2 MAG/RN
5 OCT 03 2105	VSS. AO. LSCTAB. S1, S2. BS (+) x 4. Voiding light yellow urine s̄ difficulty. OOBT ambulate s̄ difficulty. Δ'd abdominal DSG c̄ WTD. Noted serosanguinous drainage in small amount to abdominal dehisced area. [redacted] (b)(6)-2 RN
06 OCT 03 0850	Pt A&O S1S2 present LS CTA (B). (+) BS x 4 quads. small mid line abd. wound covered c̄ 2x2 CDI. Denies pain at this time. Will cont[redacted] to monitor. [redacted] (b)(6)-2 Sgt. 9WMB

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

(b)(6)-2

4OCT03 0530: D1 [redacted] here, abd wound a little opened to center of incision site, packed c̄ gauze W→D Dsg applied CDI—continuing 2S; ⊕ drainage noted light brown liquid scant amount. CL to ⓡ SC D/C'd intact, IVF's D/C'd. Continuing to monitor pt's PO status/tolerance [redacted] /AN

(b)(6)-2

04OCT03 (1500) Assumed care of pt w/ 0600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. ∅ c/o pain. Steri strips to abd incision CDI x̄ for small area in center. Wet → dry dsg applied to area. Dsg to ⓛ hip and thigh ΔD. Sutures intact to ⓛ knee. ∅ S/Sx infection w/ wound sites. Pt OOB to BR this am for personal hygiene. Pt amb well. Tol. small amount reg diet. Voiding s̄ difficulty. 2-point restraints in place s̄ S/Sx complications. Will continue to monitor. [redacted] /AN

(b)(6)-2

4OCT03 2306 VSS, Afeb. Speaking Arabic & English. BS ⊕x4. A'd ambulate. Abd. DSG. Wound is healing pink c̄ serosanguinous DSG removed. DSG intact to ⓡ flank and scrotal area. Voiding

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
01 30sep03	Tylenol supp 1(R) given for T of 102.4(R). Was drawing dk brown
2200	stool out @ this time. Foley to gravity 100-170 pm for chyfulness
	MSO4 4mg IVP given for c/o pain @ 2100. (b)(b)-2 [redacted]
01 Oct 03	MSO4 4mg given IVP for c/o pain. T-38.7C O2 @ 2L/m O2 sats
0200	@ 100%. (b)(b)-2 [redacted]
01 Oct	Tylenol supp 1(R) given for T of 38.4C. MSO4 2mg given for c/o
0300	pain. (b)(b)-2 [redacted]
01 Oct 03	MSO4 4mg IVP given for c/o pain. T-37.1C. Sitting c HOB ↑
0600	quietly. O2 on @ 2L/m O2 100%. (b)(b)-2 [redacted]
1 Oct 03	0600 Assumed care. Report given. See
	FCU-3 flowsheet for initial assessment (b)(b)-2 [redacted]
	0720 Sips of H2O given. Resting well
	VSS. (b)(b)-2 [redacted]
	0800 Dr [redacted] @ bedside. Orders received
	DC'd NG, removed. Fl. Gynsluts
	@ bedside to update pt on plan
	of care (b)(b)-2 [redacted]
	0930 pt up sitting in chair. Gynsluts
	@ bedside, medicine given for
	pt eating @ this time. (b)(b)-2 [redacted]
	1140 OOB to chair. IS given. Tylenol
	given for use. 2 attempts made
	only able to IS one ball. This (b)(b)-2
	SPA will continue to encourage. [redacted]
	1250 Sips of H2O given. Resting [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

(b)(6)-2

30Sep03/1330 [redacted] @ bedside. NPx4 (R) lower [redacted] removed. new orders received. 5ps of H2O. Tylenol 650mg per [redacted] given. (b)(6)-2 [redacted]

1350 DC'ed (R) A-line. pt [redacted] will monitor. (b)(6)-2 [redacted]

1700 pt more alert, able to cough up secretion and sit them on the bed. (b)(6)-2 [redacted]

1810 Report given. VSS. (b)(6)-2 [redacted]

30sep03 1900 VSS-arousable to verbal stimuli. (R) subclavian line multilumen all ports patent. infused D5½NS c̄ 20 meq of KCl @ 10ml/hr. Pecilar 3mm HR S-Tach-Lungs CTA Bil Resp Reg. BS(+) U quads hypoactive l quads. Pedal pulses +2 c̄ +2 edem Bil. Radial +2 +2 edem Bil. staples to midline abd intact ⊖ Redness or drainage. Dressing to (L) hip dry & intact. drsg to (R) [redacted] L abd dry intact. foley to gravity drainage clr yellow urine 100-150/hr. ⊖ c/o pain or discomfort c̄ present.

(b)(6)-2 SGT [redacted] 9/1/20

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.

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

PROGRESS NOTES
Medical Record

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CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDICAL RECORD	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
DATE	
17 Sept 2003	**O:** 17 yo ♂ s/p multiple GSW, shrapnel s/12 hrs ago. Presents alert, oriented, obvious abdominal pain. multiple penetrating wounds to (L) R leg. Evaluated by Gen Surg. Has swollen (L) knee ± and wound. RB (L) LE – NVI distally. (+) knee effusion still light exam. Severe pain ± ROM. ∅ Thigh pain. Scattered penetrating wounds prox thigh, pelvis. XS – Pelvis – multiple metal fragments. ∅ Fx. Femur – ∅ Fx. Knee – ∅ Fx, ∅ fragments.
	(A/O) 1) Multiple soft tissue wounds (L) Thigh 2) ? penetrating (L) knee injury. Will evaluate in OR after Gen Surg ex-lap.
	(b)(6)-2 [redacted]

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

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

[redacted] 17 y/o ♂

(b)(6)-4

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

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

9/27/03

Post-op note
pre-op Dx: R/O Bowel injury
post-op Dx: Ascending colon perforation
procedure: Ex laparotomy; partial Bowel resection of ascending colon including TI; placement of 10mm JP in @ pericolic gutter; 1° anastomosis of ileum to distal ascending colon
Surgeon: [redacted] (b)(6)-2
EBL: 200cc
Fluid:
UOP
Finding: perforation mid ascending colon c̄ localized contamination; small bowel, stomach, duodenum ureter, kidneys explored s̄ E/O injury d/c E/O injury to descending colon on solid organs
Drains: 10mm JP @ pericolic gutter
Compl: Ø

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

HOSPITAL OR MEDICAL FACILITY	STATUS	[redacted]	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. 8-97)
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 Aug	0100
	Alt 2145 at FST pH 7.17, pCO_2 45, pO_2 40, HCO_3 17, c̄ BE -12
	Alt 2214 7.32 pCO_2 29 pO_2 47
	(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.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

For use of this form, see MEDCOM Circula

SECTION I - PATIENT ASSESSMENT

DATE: 02Oct 03 | PATIENT ACUITY LEVEL: IA | POST-OP DAY: 6 | HOSPITAL DAY: 5

TRANSFER

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

Time 0230 To ICW2 From ICU3 ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☒ STRETCHER

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

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

LOC awake & alert Neurovascular checks _____

Dressing/cast (R) side, (L) knee Tubes _____

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

Medication _____

Other _____

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

VITAL SIGNS

TIME:	0400															
BP ARTERIAL LINE	/															
BP CUFF	124/67															
TEMPERATURE	99.4															
PULSE	97															
RESPIRATORY RATE	16															
OXYGEN (L/%)	/															
PULSE OXIMETER	98															
O_2 METHOD	/															

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

PAIN

TIME:	0230							
PAIN INTENSITY (10 / 5 / 0)	X							
MED ADMINISTERED (Y/N)	N							
RELIEF ACCEPTABLE (Y/N)	NA							

OTHER

TIME:								
FINGER STICK GLUCOSE								
INSULIN (Y/N)								

SPECIAL NEEDS

	TIME: 0230		
*Skin breakdown prevention (b)(6)-2	[redacted]		
*Falls prevention protocol	NA		
*Restraint protocol	/		
*Seizure precautions			
*Isolation precautions			

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

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

PATIENT IDENTIFICATION

CIU [redacted]

(b)(6)-4

DIAGNOSIS: Multiple Shrapnal wounds

DRG: _____ ADMISSION DATE: 28Sep03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (*Specify*): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box i[illegible] s patient assessment criteria have been MET. [illegible] he stated criteria are not met, a brief explanation of abnormal findings will be noted i[illegible] appropriate column.

	TIME: 0230 INITIALS: [redacted] (b)(6)-2	TIME: INITIALS:	TIME: INITIALS:
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☐	☐
2. CARDIOVASCULAR: Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☐
3. PULMONARY: Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☐
4. G.I.: Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☐
6. MUSCULOSKELETAL: Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ Pt ↓ ROM to (L) knee 2° to wounds	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Dsg to (R) side, (R) knee, CDI	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☐

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

TIME: 0230 INITIALS: [redacted] (b)(6)-2	TIME: INITIALS:	TIME: INITIALS:
IV patency ✓ q 4 hr:	IV patency ✓ q hr:	IV patency ✓ q hr:
IV site care provided: flushed	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: triple lumen	IV Site #1:	IV Site #1:
IV Site #2: subclavian	IV Site #2:	IV Site #2:
Comments: site OK flushing easily & drawing back blood.	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

(b)(6)-2

NEUROVASCULAR

SITE: (L) UE	TIME: [illegible]					
COLOR						
CAPILLARY REFILL	1					
TEMPERATURE	W					
EDEMA	Ø					
SENSATION	S					
MOTION	M					
PASSIVE FLEXION	Ø					
PERIPHERAL PULSE	2					

LEGEND

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

SAFETY

	TIME: 0230			
[illegible]d visible/legible	[redacted]			
Orient to environment prn	[redacted]			
Side rails (2/4) up	NA			
Bed position low				
Call light within reach	✓			

OTHER

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

DIET

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

ADLs

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

TEACHING

TIME: 0230 INITIAL [redacted] (b)(6)-2	TIME: INITIALS:	TIME: INITIALS:
CONTENT: - Orient toward/ staff - glds - pain meds	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
Ciu [redacted] (b)(6)-4	[redacted] (b)(6)-2	[redacted] (b)(6)-2 LT/AN	2206

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0230	(R) side (L) knee	} dsg CDI	} assessed

SECTION IV - NOTES

08Oct03 0230 Readmitted to ICW2 from ICU3 in stable condition via litter. Ø reported allergies. Ambulated from litter to bed I assistance. Ø C/O pain. [redacted] (CI/BN)

(b)(6)-2

MEDICAL RECORD

INTRAOPER[illegible]E DOCUMENT

For use of this form, see AR 40-66, the [illegible]a[illegible]y is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERA[illegible] [illegible]OOM
VIA BY

2. PATIENT IDEN[illegible]ED, RECORD REVIEWED AND PROCEDURE VERIFIED BY

3. DATE TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)* Head to foot, Arms add <90° to

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

COMMENTS: padded armboards legs straight, bed padded.

8. SKIN PREPARATION

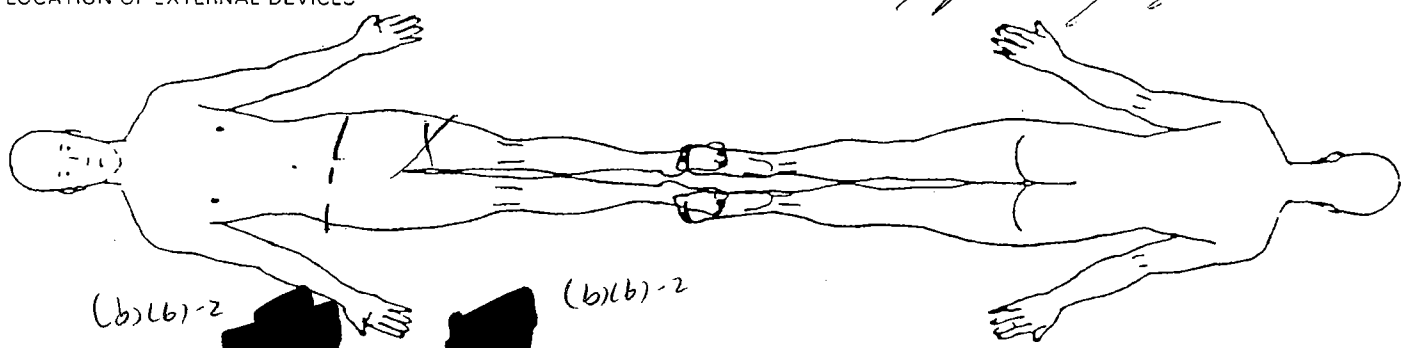
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betis / Betis
SITE: Abd BY WHO[illegible] [redacted] (b)(6)-2
SITE: BY WHOM:

COMMENTS: [illegible]

9. LOCATION OF EXTERNAL DEVICES



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

LEGEND X Ground [illegible] Safety S[illegible] = = = Tourniquet

C = Corr[illegible] 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	SGT [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;)*

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

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ~~☐ NO~~ [redacted]

☒ ESU NO: A
GROUND PAD: BRAND 3M (b)(6)-2
LOT NO: 1999 [redacted]

☐ 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): NSS

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

17. TUBES, DRAINS, PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE SIZE	16 F Foley	J/P 10mm	J/P 10mm
SITE	bladder	(L) knee	(R) side

18. DRESSING/IMMOBILIZATION (Specify) Xeroform 4X8 ABD 4X8 Elastic ACE Silk tape

19. ADDITIONAL INFORMATION

WC II

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

75cc out from Abd J/P

- Bone pad site clear

20. OPERATION(S) PERFORMED

Ex Lsp, (L) knee Arthroscopy

21. PATIENT TRANSFERRED TO PACU TIME METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 [redacted] CPT

REVERSE OF DA FORM 5179-1, OCT 87

MEDCOM - 20720

USAPA V1.01

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (O) — TEMP. F (•) — TEMP. C

105° — 40.6°

180 — 104° — 40.0°

170 — 103° — 39.4°

160 — 102° — 38.9°

150 — 101° — 38.3°

140 — 100° — 37.8°

130 — 99° — 98.6° — 37.2° — 37.0°

120 — 98° — 36.7°

110 — 97° — 36.1°

100 — 96° — 35.6°

90 — 95° — 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

EPW

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

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

(b)(6)-4

PACU

#[redacted]

174.0 ♂

8 SET 22 @ teeth

(b)(2)-2

[redacted] *VENTILATOR FLOW SHEET*

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
28 Sep	0010	SIMV	16	600	100	12	30	22	91	94	153/77	7.27	42	86	-8	19	95	[redacted] (R) maintain VS ARDS
	0230	SIMV	18	600	55	12	36	18	104	100	127/70	7.35	39	122	-4	21	98	[redacted]
	0430	SIMV	18	600	40	12	35	18	118	100	124/66							[redacted]
	0540	SIMV	18	600	40	12	36	18	115	100	126/62	7.35	37	133	-4	21	99	[redacted]
	0800	SIMV	18	600	40	↓10	30	18	122	100	114/59							[redacted]
	1200	SIMV	18	600	40	10	31	18	119	100	124/69							[redacted]
	1200	SIMV	18	600	40	10	33	18	118	100	130/68							[redacted]
	1400	SIMV	↓18	600	40	16	29	14	112	100	122/67	7.37	36	159	-2	22	99	[redacted]
	1810	SIMV	14	600	40	8	26	14	120	100	98/51							[redacted] OH
	2000	SIMV	14	600	40	8	30	15	121	99	124/60							[redacted] O.J
	2221	SIMV	14	600	40	8	25	14	119	100	112/64							[redacted]
29 Sep	0100	SIMV	14	600	40	8	29	14	110	100	123/63							[redacted]
	0400	SIMV	14	600	40	6	28	14	109	100	118/54							[redacted]
	0500	SIMV	14	600	35	6	28	14	109	100	126/53							[redacted]
	0800	SIMV	14	600	35	6	25	14	95	100	116/62							[redacted]
	1000	SIMV	↓10	600	35	6	23	10	96	100	118/63							[redacted]
	1545	SIMV	10	600	35	6	29	10	90	100	125/70							[redacted]
	1900	SIMV	10	600	35	5	25	12	114	97	146/92							[redacted]
	2217	SIMV	10	600	40	6	24	10	114	100	124/69							[redacted] 3
	2350	SIMV	10	600	40	6	24	12	107	100	131/70							[redacted]
	0240	SIMV	10	600	40	6	26	12	104	100	125/75							[redacted]
	0415	SIMV	10	600	35	6	28	13	107	99	126/74							[redacted]
	0540	SIMV	10	600	35	6	23	14	108	98	126/76							[redacted] - rollive, pt eyes open
	0800	SIMV	10	600	35	6	24	20	121	100								[redacted]
	0900		EXT.															

MEDCOM - 20722

(b)(6)-2
all

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY 8 Oct

19 | HOUR 0630

PULSE (O)	TEMP. F (•)	TEMP. C (Centigrade Equivalents, for Reference only)
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	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 119/60

P 72

T 97.7

SpO2 97

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

(b)(6)-4

[redacted]

1W3

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

DATE 28 Sep

SPECIMEN/LAB RPT. NO.

PATIENT STATUS ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP

SPECIMEN SO (Specify) Blood

LAB ID NO.

URGENCY ☐ ROUTINE ☐ TODAY ☐ ☐ PRE-OP STAT ☒

PATIENT'S MED. RECORD

MISCELLANEOUS

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/ICMR FIRMR 141 CFR) 201-45-505

557-107

SPECIMEN/LAB RPT. NO.

STATUS ☐ AMB ☐ ☐ DOM ☐ ☒ BED ☐ OUTPATIENT ☐ NP

SPECIMEN SOURCE (Specify) Blood

LAB ID NO.

URGENCY ☐ ROUTINE ☐ TODAY ☐ ☐ PRE-OP STAT ☒

(b)(6)-4

[redacted]

(b)(6)-4

[redacted]

DATE

(b)(6)-4

[redacted]

3

CILITY—WARD NO.—DATE

MD DATE 29 Sep 03

TECH

SPECIMEN/

PATIENT ST ☒ BED OUTPAT ☐ NP

URGENCY ☐ ROUTINE ☐ TODAY ☐ ☐ PRE-OP STAT ☒

SPECIMEN (Specify) Blood

LAB ID NO

(b)(6)-4

[redacted]

(b)(6)-4

[redacted]

(b)(6)-4

[redacted]

RESULTS

REQUEST

DATE

SPECIMEN

TESTI

MISCELL

STANDARD FORM Prescribed by FIRMR (41 CFR)

DATE

MEDCOM - 20724

14 Urate

Ser# [redacted] (b)(6)-4
Ver: JAM5046A
CLEW A93

[redacted] (b)(6)-4

_____118 mg/dL
_____6 mg/dL
_____137 mmol/L
_____3.6 mmol/L
_____105 mmol/L
_____23 mmol/L
_____14 mmol/L
_____37 %PCV
_____13 g/dL

_____7.291
_____44.7 mmHg
_____22 mmol/L
_____-5 mmol/L

Sample Type_: SRT
_____: 38.1

30SEP03 01:42

Physician:_____

Ver: JAM5046A
CLEW A93

i-STAT G3+

P 0
P ame:_____

TCO2_____25 mmol/L

At 37C
PH_____7.406
PCO2_____38.6 mmHg
_____57 mmHg
HCO3_____24 mmol/L
BEecf_____-1 mmol/L
sO2*_____89 %
*calculated

At Patient Temp
PH_____7.374
P _____42.3 mmHg
PO2_____66 mmHg

Patient Temp: 102.4F
FIO2_____: 21
ample Type_:

30SEP03 09:54

Oper: 0

Physician:_____

Ser# [redacted] (b)(6)-4
Ver: JAM5046A
CLEW A93

35%
K-10
Calculated

At Patient Temp
PH_____7.360
PCO2_____47.3 mmHg
PO2_____101 mmHg
Patient Temp: 98.6
FIO2_____: 35
Sample Type_: SRT
30SEP03 04:56

Physician: [redacted] (b)(6)-4
Ver: JAM5046A
CLEW A93

======= PICCOLO =======
29/09/03 04:34
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
BASIC METABOLIC
DISC LOT #: (b)(6)-2 3203AA4
OPER # [redacted] DR #: 000
SERIAL #: (b)(6)-4 [redacted]

GLU	99	73-118	MG/DL
BUN	10	7-22	MG/DL
CA++	7.8*	8.0-10.3	MG/DL
CRE	0.7	0.6-1.2	MG/DL
NA+	~~114*~~ 134	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	102	98-108	MMOL/L
tCO2	26	18-33	MMOL/L

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

REMARKS [redacted]

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE (b)(6)-2 REPORTED BY TECH MD DATE 29 Sep 03 LAB ID NO.
PRE-OP STAT SPECIMEN SOURCE (Specify)

[redacted] (b)(6)-4 1W3

KAPTOPUINT COAG ANALYZER V4.54
SERIAL #005485 09/30/03 05:02 AM
Patient ID [redacted] (b)(6)-4
Test Name :PT
Test Result:- 13.5 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.18
Sample Type:citrated wh. blood
Test Date :09/30/03
Test Time :05:01 AM
Card Lot :040302
Operator : MCCARTER

KAPTOPUINT COAG ANALYZER V4.54
SERIAL #005485 09/30/03 05:07 AM
Patient ID [redacted] (b)(6)-4
Test Name :APTT
Test Result:- 42.7 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/30/03
Test Time :05:03 AM
Card Lot :100208
Operator : MCCARTER

MISC
URGENCY ROUTINE BED STATUS AMB
SPECIMEN/LAB RPT. NO.
COPY

SPECIMEN/LAB RPT. NO.
MI
URGEN ROUTINE TODAY PRE-OP STAT
ATIENT STATUS BED AMB OUTPATIENT NP DOM
SPECIMEN SOURCE (Specify)
PATIENT'S MED. RECORD

[redacted] 1W3 (b)(6)-4

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE REPORTED BY MD DATE 29 Sep 03 LAB ID NO.

557-107
MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

Ward/Section:	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE	TIME G3+

(i-STAT) (Piccolo) Che[redacted] (b)(6)-4

TEST(S)

(b)(6)-4 [redacted]

WBC	3.9 L	x10^3/uL	4.5	1.5
RBC	4.60	x10^6/uL	4.00	6.00
Hgb	12.9	g/dL	11.0	15.0
Hct	40.0	%	35.0	60.0
MCV	84.9	fL	80.0	99.9
MCH	26.7 L	pg	27.0	31.0
MCHC	31.4 L	g/dL	33.0	37.0
Plt	252.	x10^3/uL	150.	450.
LYM	20.6 *	%	20.6	51.1
LYM	0.8 *L	x10^3/uL	1.2	3.4

TEST(S)

SPECIMEN TAKEN

DATE	TIME A.M. P.M.
27SEP03	1605

RESULTS	REQUESTED	(X)
	RBC COUNT	
1[illegible]	HEMOGLOBIN	
1[illegible]	HEMATOCRIT	
	MCV	
	MCH	
	MCHC	
3.6x10^3	WBC COUNT	
30	WBC DIF AND BLOOD CELL MORPH: IMMATURE	
47	NEUTRO-BANDS	
19	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
4	MONOCYTES	
	PLATELETS	
Normocytic	RBC	
	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PT CONTROL	
	PT PATIENT	
	PT % ACTIVITY	
	PT RATIO	
	SICKLING TEST	
	LE PREP	

edc

LAB ID NO.

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505
557-107

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
General Services Administration and Interagency
FIRMR (41 CFR) 201-45.505

SUMMARY

ame:_____

TCO2_____25 mmol

At 37C

pH_____7.351

PCO2_____43.6 mmHg

PO2_____184 mmHg

HC _____24 mmol

BEecf_____-1 mmol

sO2*_____100 %

*calculated

At Patient Temp

pH ____7.332

PCO2_____46.2 mmHg

PO2_____192 mmHg

Patient Temp: 101.0

FIO2_____: 35

Sample Type_: ART

30SEP03 08:39

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

Physician:_____

Ser# 42015

Ver: JAM5046A
CLEW A93

i-STAT EC8+

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

Pt Name:_____

Glu_____106 mg/dL

BUN_____5 mg/dL

Na_____134 mmol/L

K_____3.5 mmol/L

Cl_____102 mmol/L

TCO2_____28 mmol/L

AnGap_____9 mmol/L

Hct_____33 %PCV

Hb*_____11 g/dL

*via Hct

pH_____7.371

PCO2_____45.1 mmHg

HCO3_____26 mmol/L

BEecf_____1 mmol/L

Sample Type_:

30SEP03 04:50

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

Physician:_____

Ser# 42015

Ver: JAM5046A
CLEW A93

						Cl^-		98-108 mmol/l
						tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: KIU A3	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI [redacted] (b)(6)-4	DATE 010CT03	TIME 0100	SSN/PSEUDO SSN: [redacted] (b)(6)-4	

CBC			Urinalysis			Misc. Serology		
REF. RANGE	TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE		

(b)(6)-4

[redacted] 01-10-03 04:06

			Patient Limits	
WBC	6.5	x10^3/uL	4.5	10.5
RBC	3.62 L	x10^6/uL	4.00	6.00
Hgb	9.6 L	g/dL	11.0	18.0
Hct	30.1 L	%	35.0	60.0
MCV	83.2	fL	80.0	99.9
MCH	26.6 L	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	29L	x10^3/uL	150.	450.
LYM	13.5 *L	%	20.5	51.1
LYM	0.9 *L	x10^3/uL	1.2	3.4

DATE

i-STAT G3+

[redacted] (b)(6)-4

Pt Name:_____

TCO2_____25 mmol/L

At 37C

pH_____7.446

PCO2_____34.1 mmHg

PO2_____161 mmHg

HCO3_____24 mmol/L

BEecf_____-1 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

29SEP03 04:51

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

Physician:_____

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

Ver: JAMS046A
CLEW A93

i-STAT CREA

[redacted] (b)(6)-4

Pt Name:_____

Crea_____0.9 mg/dL

Sample Type_:

30SEP03 04:51

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

Physician:_____

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

Ver: JAMS046A
CLEW A93

Spun Hematocrit		
Sed Rate		
Other		

Coagulation

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MISC URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☒ STAT
PATIENT STATUS: ☐ BED ☐ OUTPATIENT ☐ AMB ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify): blood
SPECIMEN/LAB RPT. NO.
LAB ID NO.
DATE ID CH 30 Sep 03

PATIENT'S MED. RECORD

LABORATORY FILE

TEST(S)
SPECIMEN TAKEN
DATE 010103 TIME 0400 P.M.
REQUESTED
Chem 7
& PT
RESULTS

REMARKS [redacted]

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN SIGNATURE (b)(6)-2
REPORTED BY
TECH MD DATE
LAB ID NO.
SPECIMEN/LAB RPT.
MISC
EMERGENCY ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS ☐ BED ☐ OUTPATIENT ☐ NP
SPECIMEN SOURCE (Specify)

======= PICCOLO =======
01/10/03 05:29
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	2.1*	3.3-5.5	G/DL
ALP	114*	26-84	U/L
ALT	♦♦♦	10-47	U/L
AMY	228*	14-97	U/L
AST	71*	11-38	U/L
TBIL	0.8	0.2-1.6	MG/DL
GGT	27	5-65	U/L
TP	5.2*	6.4-8.1	G/DL

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

======= F .O ===
10/01/03 05:12 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3152AA1
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(6)-4.....

GLU	132*	73-118	MG/DL
BUN	♦♦♦	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	2141*	39-380	U/L
NA+	~~[illegible]~~* 132	128-145	MMOL
K+	3.9	3.3-4.7	MMOL
CL-	97*	98-108	MMOL
tCO2	23	18-33	MMOL

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

PREVIOUS EDITION USABLE
PATIENT
(b)(6)-4
[redacted] / 1C03
Enter in above space PATIENT IDENTIFICATION
SPECIMEN/LAB RPT. NO.
URGENT ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify)
PATIENT'S MED. RECORD

======= PICCOLO =======
09/28/03 06:05 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
BASIC METABOLIC
DISC LOT #: (b)(6)-2 3203AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] (b)(6)-4

GLU	104	73-118	MG/DL
BUN	~~[illegible]~~ 9	7-22	MG/DL
CA++	7.7*	8.0-10.3	MG/DL
CRE	0.6	0.6-1.2	MG/DL
NA+	~~121*~~ 141	128-145	MMOL
K+	4.2	3.3-4.7	MMOL
CL-	104	98-108	MMOL
tCO2	21	18-33	MMOL

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

Prescribed by GSA/ICMR FIRMR (41 CFR) 201-45-505

U.S. GPO: 1982-312-063/60027

IBN-SINA HOSPITAL

[redacted] (b)(2)-2

Baghdad, Iraq

Microbiology Request Form

Last Name: IRAQI

First Name:

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

Collected by:

Date: 28 Sep 03

Time: 0110

Ward: ICU3

Room:

Bed:

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

Source: Sputum

Site:

[redacted]

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

Date:

Time:

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

Laboratory Results

Alpha hemolytic Streptococcus, Not group pneumoniae
Streptococcus sanguis

Reported

Date: 10-2-03

Time: 1230

Tech: SP

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

Number of attached sheets:

MEDCOM - 20730

Microbiology Report

IBN SINA - HOSPITAL Laboratory

Name:	Specimen [redacted] (b)(b)-4	Status: **Final**
Patient ID [redacted] (b)(b)-4	Source: Sputum	Collected:
Ward/Rm: U3/	Ward of Iso:	Attd. Phys:

1 Streptococcus sanguis Status: Final

1 **S. sanguis**

Drug	MIC	Interps	Drug	MIC	Interps

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:	Specim [redacted] (b)(b)-4	Status: **Final**
Patient ID [redacted] (b)(b)-4	Source: Sputum	Collected: (b)(b)-2
Ward/Rm: U3/	Ward of Iso:	Req. Phys [redacted]

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

MEDICAL RECORD – ANESTHESIA

DRUG	(Units)											
Fentanyl	mcg)	100 <150>		100	50 <100>							
STP	mg)	250										
Sux	mg)	60										
Vec	mg)		5		2		2	1	2			
	( )											
Mec	(mg)										<5>	2
VOLAT AGENT (150)	% del											
	% e.t.	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	
AIR	L/Min											
N2O	L/Min											
O2	L/Min	5	2	2	2	2	2	2	2	2	2	2

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

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

TOTALS	
500	TOTAL BLD 200
250	
60	TOTAL URINE 500
12	
7	

FLUIDS – SUMMARY

CRYSTALLOID– 4.5L

COLLOID– 500ml

BLOOD–

FLUIDS

LINE site 18G x 2 ☐ Warmed — 2L

☐ Warmed — Hespan <500> — 3L — 4L — 4.5

☐ Warmed

☐ Warmed

LOSSES

EST BLOOD LOSS — 100

URINE – 100 — 150 — 350 — 500

REMARKS – Code drugs with numbers, events with letters

① Pre op / Lab / VSS.
② Room Monitor / O2
I/I as below.
③ [redacted] relieves for Airway
④ Pain Relief

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 60 (KG) LB

HEMATOCRIT: 45

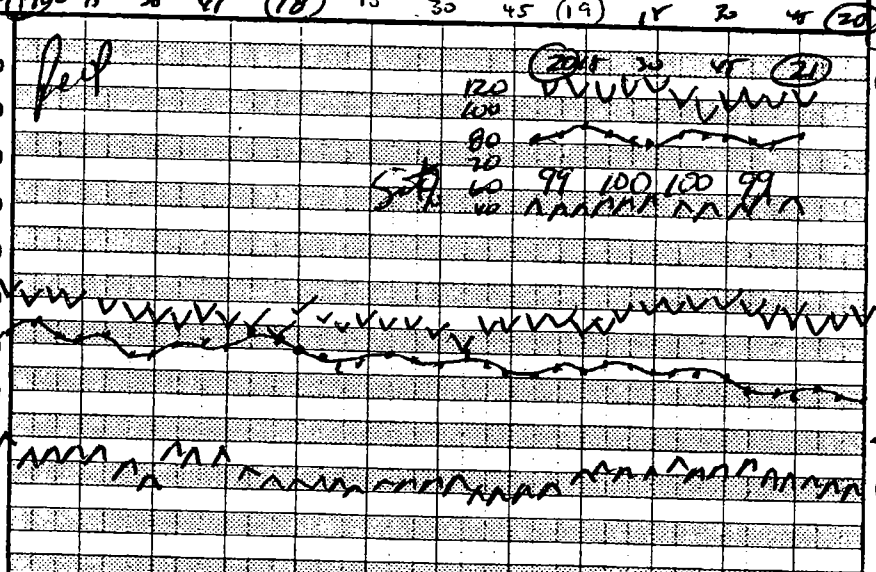
INITIAL DATA: BP – 122/61 HR – 106

EQUIP CHECK: OK? – (Y) N

PATIENT CHECK: OK for PROCEDURE? Y TIME 1700

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

TIME → 1700 15 30 45 (18) 15 30 45 (19) 15 30 45 (20) 20 30 45 (21)



PACU. initially O2 Sat 92% then ↓ to < 90%. Incision. O2 100% O2 Sat 100%. NRB → Pt. 85-90% Sat. ↑ Resp. → 85-90% Sat. ↑ Resp.

– CXR
– ABG

VITALS

VT – ml	UPAC →											
f – breaths/min	12	8	8	8	8	8	8	10	8	18	16	17
Peak inf pres / PEEP	UPAC →											
MODE – S(pon), A(ssist), C(on)	SA	SC	C	C	C	C	C	C	A	SS	S	S

MONITORS & ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	38	36	35	35	34	36	37	36	48	50	46
BP / oth	FIO2 (Frac or %)	.71	.71	.72	.74	.72	.71	.71	.72	.72	.68	.72 .71
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	90
Steth- PC/ES	ECG	ST	ST	ST	ST	SR	ST	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site (R)	38.9		38.5	38		37.2		37	37.1		36.9
	N-M Block (T/4)	4/4	4/4	4/4	3/4	1/4		1/4		2/4	4/4 X 25 ST	
Warming blkt	✗ upper blkt →											
Conv warmer												

Mark with letters & symbols, explain under REMARKS

EVENTS ① ② → ③ ④

Position — O —

RECOVERY AT

PACU ICU [redacted] (specify)

OTHER [redacted]

CONDITION: (b)(2)-2

RESP– SpO2–

BP– HR–

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1630	1700	
	Ready	Begin	End
PROC	1705	1720	2100

PROCEDURES and CPT Codes

EX LAP

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

17 y/o IRAQI ♂ NKDA

[redacted] (b)(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

UPAC / SCCS / GETA / RSI (CRICOID) / NGT Foley / IV x 2

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

OETT 8.0 ETCO2 ABS. Tape 22 teeth. OA

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

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

PROCEDURE LOCATION FST

DATE 22 SEP 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 9

MEDCOM - 20732

*U.S. GPO: 2002-729-180/40137

CLINICAL RECORD - DOCTOR'S ORDE

F ... f this form, see AR 40-66, the proponent age ... TSG

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 28 SEP TIME OF ORDER 2230 HOURS | LIST TIME ORDER NOTED AND SIGN

↓ PEEP to 8

Maintain sat ≥ 90%

[redacted] (b)(6)-2

2yo Cin F [redacted]

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 29 Sep TIME OF ORDER 0700 HOURS

(1) ↓ IMV to 10

(2) ↓ PEEP to 5

(3) portable CXR this am [redacted]

(b)(6)-2

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER 2100 HOURS

(1) Tylenol 650 mg PR or per NG q4 prn temp >101

(2) ↑ IV to 100 cc/h

(3) heparin 4000 ut SQ q12h

(4) PT, PTT i am labs

(b)(6)-2

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER 30 Sep HOURS

(1) CBC LFT's 'lyte am 10 cx

(2) portable cxr am 10 cx

(3) DC abd drain - done

(4) DC (2) radial A line done @ 1415

(5) OOB chair

(6) MS 2-4 mg IV q1-2 h prn pain

(7) DBC

(b)(6)-4

[redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH M [redacted] (b)(6)-2

☆ U.S. GOVERNM[redacted]

(b)(6)-2

[redacted]

MEDCOM - 20733

[redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

28 Sep 0100

Admit ICU

Cond fair (b)(6)-2

Diet - NPO ✓ [redacted]

Act - turn q 2h

VS - q 1h include CVP

Dx - colon inj ARDS

IV LR at 100cc/h ✓

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Unasyn 3 gm IVPB q 6h ✓

MS drip 2-5 mg/h ✓

Versed drip 2-5 mg/h ✓

ranitidine 50 mg IVPB q 8h ✓

NG to lo continuous suction ✓

foley to gravity drain ✓

central line -

portable CXR done - report 0400 ✓

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

CBC lyte ABG 0400 ✓

A line

100% F_iO_2 PEEP 12 IMV 16 IV 800

wean F_iO_2, maintain sat > 90%

(b)(6)-2

ABG at 0200 ✓ (b)(6)-2 [redacted]

24° chest drk [redacted]

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

28 Sep 0600

(1) ↓ PEEP to 10

(2) Δ IV to D_5 ½ NS 1000 cc + 20 meq KCl at 75 cc/hr [redacted] (b)(6)-2

[redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHI[redacted]E USED. (b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDE

f this form, see AR 40-66, the proponent ager ,TSG

THE DOCTOR SHALL RECORD DATE 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

6-12-18-24 [redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 30 ~~Oct~~ Sep 03 TIME OF ORDER: 2100 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Dc IVPB Zantac (due to out of stock in Pharmacy)
2. IVPB [redacted] (b)(6)-2 (b)(6)-2
V.O. Dr. [redacted]

MAJ [illegible]

note: Sat [redacted] 9/[redacted] CPT (AN)

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT: 1W3 | ROOM NO. | BED NO.

DATE OF O[redacted] E [redacted] (b)(6)-2 (b)(6)-2 HOURS

PATIENT IDENTIFICATION

NURSING UNIT: 1W3 | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

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

NICAL RECORD - DOCTOR'S ORDER

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]

C1

NURSING UNIT	ROOM NO.	BED NO.
ICW2	10	A

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

10 Oct 0800

DC NG done

DC foley done

OOB chair done

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

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

C1

NURSING UNIT	ROOM NO.	BED NO.
ICW2	10	A

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

20 Oct 0700

(1) change dressing (R) flank, (L) thigh + (L) knee q d[illegible] xeroform on (L) th[illegible]

(2) DC Zantac

(3) full liq diet

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

PATIENT IDENTIFICATION

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

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2	10	A

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

[redacted] 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.

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

'ICAL RECORD - DOCTOR'S ORDERS

For use s form, see AR 40-66, the proponent agency is .SG

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

CI

NURSING UNIT | ROOM NO. | BED NO.

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

20 Oct 0130 _____ HOURS

Transfer to ward lots this am

Cont stable

Diet - clear liq

Act - ambulate BID

BS q shift

Dx - GSW bladder colon repair

IV D5 1/2 NS 1000 cc c̄ 20 meq KCl

at 75 cc/h _____ HOURS

DC Urosyn

Heparin 4000 u SQ q12h

Acetaminophen ℞ gr pb q 4 prn pain or temp > 101

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

(b)(6)-2 [redacted]

CI [redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

_____ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

_____ HOURS

(b)(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW [redacted]

(b)(6)-4

30OCT03 0530 [redacted] 1LT/AN

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
24° V	30OCT03 1900	[redacted] 1LT/AN

DATE OF ORDER: 30 OCT 03 TIME OF ORDER: 0530 HOURS

V.O. DR [redacted] / 1LT [redacted] (b)(6)-2

ADVANCE Diet as tolerated

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

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

40OCT03 0530 [redacted] 1LT/AN

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
24° V		[redacted]

DATE OF ORDER: 4 Oct 0430 HOURS

(1) Pack abdl wound q 8h c̄ NS soaked gauze &

(2) DC IV + IV ABs

(b)(6)-2 [redacted]

(b)(6)-2

RN 10/5/03 0205

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
24° V		[redacted]

DATE OF ORDER: 7 Oct 0900 TIME OF ORDER: HOURS

Remove stitch (L) hip

Dress hip wounds &d c̄ NS gauze

Continue midline dressing change q 8h

(b)(6)-2 [redacted]

RN 10/5/03 0400

PATIENT IDENTIFICATION

(b)(6)-2

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			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4 (b)(6)-2 Noted [redacted] 030803 1220			8 Oct	1200 HOURS	
			Transfer pt to Tragui Hosp		
			Summary done		
			No meds [redacted]		
NURSING UNIT	R[redacted]	BED NO.	(b)(6)-2		
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

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

ADL's

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 27	28	29	30
(b)(6)-2	27 Sep	[redacted]	Dx S/P Ex-lap	08	/			
			Bowel Resec	16	/			
				24				
(b)(6)-2	27 Sep	[redacted]	Cond: Stable	08	/			
				16	/			
				24				
(b)(6)-2	27 Sep	[redacted]	V.S q 4°	08	/			
				16	/			
				24				
(b)(6)-2	27 Sep	[redacted]	All: NKDA	08	/			
				16	/			
				24				
(b)(6)-2	27 Sep	[redacted]	I&O	08	/			
				16	/			
				24				
(b)(6)-2	27 Sep	[redacted]	Foley to gravity	08	/			
				16	/			
				24				
(b)(6)-2	27 Sep	[redacted]	JP to Bulb Sx	08	/			
				16	/			
				24				
(b)(6)-2	27 Sep	[redacted]	NG → LCWS	08	/			
				16	/			
				24				
(b)(6)-2	27 Sep	[redacted]	Diet NPO	08	/			
				16	/			
				24				

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: S/P: Ex: lap / resection

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

17 1/08

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 ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(b)(6)-2 27 Sep	[redacted]	Admit to post-op	27 Sep	/	2110	[redacted] (b)(6)-2
(b)(6)-2 28 Sep	[redacted]	CBC, chem 7 in am	28 Sep		0800	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
(b)(6)-2 -----	27 Sep	[redacted]	Call MD T > 38.5													
-----	-----		HR > 100 < 60, RR < 10 > 30													
-----	-----		SBP > 160 < 100, UOP < 30/hr													
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

Initialing

(NON-MEDICATION)

Mo _____ Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
[redacted]	[redacted]	[redacted]			[redacted]	[redacted]
		(b)(b)-2				(b)(b)-2

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

USAPA V1.00

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	01	02	03	4	5	6	7	8	9	10
		Δ's see below											
2 Oct	[redacted]	~~Diet: clear liquids~~	06	/	[redacted]								
(b)(6)-2 2	[redacted]	Full liquid diet	12	/	[redacted]		/		D	C	d		
			17	/	[redacted]		/						
(b)(6)-2 2 Oct	[redacted]	Activity: ambulate BID	08	/	[redacted]								
			20	/	[redacted]								
(b)(6)-2 2 Oct	[redacted]	VS q shift	D	/	[redacted]								
			E	/	/	/	/	[redacted]	/	/	/	/	/
			N	[redacted]									
			/										
(b)(6)-2 2	[redacted]	change dressings on	10	/	[redacted]								
		(R) flank, (L) thigh, (L)	/										
		Knee QD	/										
		xeroform on (L) thigh	/										
			/										
(b)(6)-2 2 Oct 03	[redacted]	NIO: CL DSG Δ	20	X	[redacted]	/	/	[redacted]	/	/	[redacted]	/	/
		Q 3 Days											
(b)(6)-2 3 Oct 03	[redacted]	Advance diet as	06	X	X	[redacted]							
		tolerated	18	X	X	[redacted]							
(b)(6)-2 4 Oct 03	[redacted]	Pack abd wound q8h	06	X	X	[redacted]							
		c NS soaked gauze	14	X	X	X	[redacted]						
			22	X	X	X	[redacted]						

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: Oswald colon repair
Δ mult abdominal wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 10 Yr 2003

Initialing						
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(b)(6)-2 020ct	[redacted]	Transfer to ward later this am - Stable	020ct		0230	[redacted] (b)(b)-2
(b)(6)-2 020ct03	[redacted]	Transfer pt to Iraqi hosp. Summary done No meds				

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

USAPA V1.00

CLINICAL RECORD

...ERAPEUTIC 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 27	28	29	30
(b)(6)-2 27 Sep	[redacted]	LR @ 120 ml/hr	08	/			
			16	/			
			24				
(b)(6)-2 27 Sep	[redacted]	Unasyn 3gm EV q 6°	06	/			
			12	/			
			18	/			
			24	/			

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: S/P: Ex lap / Resection

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

17 y/o ♂

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. _____ *Yr.* _____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
(b)(6)-2 27 Sep	[redacted]	Ulnasyn 3gm I.V q 6° 1st dose now.	27 Sep 03	2252		[redacted]
						(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
(b)(6)-2 27 Sep	[redacted]	Phenergan 25mg IVD														
		q 6° PRN N/V A														
		T														
(b)(6)-2 27 Sep	[redacted]	MSO4 2-4mg IV q 2-4° D														
		PRN PM A														
		T														

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. Sep Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 28	29	30	1	2	3	4	5	6	7	8	9	10	11
(b)(6)-2 28 Sep	[redacted]	IVF: ~~LR c 125 ml/hr~~	06	[redacted]													
	-----	D5½NS 1000cc c 20KCL	18	[redacted]													
(b)(6)-2	[redacted]	Unasyn 3gm IV	06	[redacted]													
	-----	q 6°	12	[redacted]													
	-----		18	[redacted]													
	-----		24	[redacted]													
(b)(6)-2	[redacted]	~~MSO4 drip 2-5mg/hr~~	06	[redacted]													
	-----		18	[redacted]													
(b)(6)-2	[redacted]	Versed 2-5mg/hr	06	[redacted]													
	-----		18	[redacted]													
(b)(6)-2	[redacted]	Ranitidine 50mg	08	[redacted]													
	-----	IVPB q 8°	14	[redacted]													
	-----		22	[redacted]													
(b)(6)-2 29 Sep	[redacted]	Heparin 4000 units SQ	10	/ / [redacted]													
	-----	q 12	22	/ [redacted]													
(b)(6)-2 30 Sep	[redacted]	Tagamet 300mg	06	[redacted]													
	-----	Q 6 hrs	12	[redacted]													
	-----		18	[redacted]													
	-----		24	[redacted]													

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Colon schrapnel injury / ARDS

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.

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
(b)(6)-2 [redacted]	[redacted]	MS 2-4mg IV Q1-2 prn min	3 2100 [redacted]	01 [redacted]	03 [redacted]	04 [redacted]	2330 4mg [redacted]									
(b)(6)-2 [redacted]	[redacted]	Tylenol 650mg PR or per NG Q4 prn Temp >101	3050 [redacted]	0300 [redacted]												

(b)(6)-2

(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, 9	02	03	04	5	6	7	8	9	10				
(b)(6)-2 02Oct	[redacted]	IV D5 1/2 NS + 20mEq	D	/	[redacted]												
		KCL @75cc/hr	E	/	/	/	/	/	/	/	/	/	/	/	/	/	/
			N	[redacted]													
(b)(6)-2 02Oct	[redacted]	Heparin 4000 u SQ	08	/	[redacted]												
		9120	20	/	[redacted]												

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P Osawald Colon repair

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Oct Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
(b)(6)-2 02Oct	[redacted]	D/C Unasyn	—			None
(b)(6)-2 04 OCT03	[redacted]	D/C IV and IV ab's	04 OCT03	—		[redacted] (b)(6)

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
(b)(6)-2 02Oct	[redacted]	acetaminophen	2Oct 1330 TSM	03Oct 1300 TCM	5Oct 1530 TCM											
-----	-----	1gm PO q4h prn	[redacted]													
-----	-----	pain or temp>101														
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

(b)(6)-2

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

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INTILAS [redacted] (b)(6)-2	INTILAS		INTILAS
NEURO	PUPILS	pupils 2mm			2mm, sluggish; ∅	
	SENSORIUM	sluggish. sedated			response; pt on	
		on propofol @			vent/assist S/5mg	
		5mg/hr. MS 4@			∅ response to pain	
		4mg/hr. w/ fentanyl				
RESPIRATORY	RESPIRATION PATTERN	ETT localized,			equal and full; SaO2	
	BREATH SOUNDS	bilaterally inflated.			100% on 40% FiO2	
	SECRETIONS	ETT 8.0 cuffed @ 27-			vent. LCTA (3);	
		29 lower lip connect			ETT 22 cm teeth	
		to vent. c 50% and			SX blood tinged sputum	
		suctioned every hour				
SKIN	COLOR	skin warm c appropriate			NIPR; multiple surg	
	INTEGRITY	color. SR closure group			sites; peppered bruise.	
IV SITE	LOCATION	(R) SCVC all ports			PIV:	PIV	TLC
	CONDITION	patent, flushed c			(L) FA	(R) FA	(R) SC
		good blood return. CVP			CDI	CDF	CDI
		pulsed c transducer.					
		Dressing were					
		changed. Lines secured					
GASTRO	ABDOMEN	soft, NT/ND			Sgt; (+) BS x 4 quads	
	BOWEL SOUNDS	c hyperactive BS			JP drain c S/S fluid	
		NG patent, aspirated			on incision covered c	
		D&E c TPN & extending			bulky dressing.	
GU	URINE	clear amber urine			FTB; yellow foley	
	COLOR/CLARITY	drsg reinforced c minimal			quantity > 30 cc/hr.	
		white blood. PCO				
CARDIOVASCULAR	CARDIACRHYTHM	NSR, ectopic c sinus			ST; ∅ ectopy	
		tachycardia. (R) femoral			(+) P, dis, T inverse.	
		drsg clean, dry, intact				
		c ABG. Pedal pulses				
		palpable. Chest drsg				
		VEGETATIVE				
		dry, intact.				

Cr - Creatinine
FiO2 - Fraction of inspired O2
HCO3 - Bicarbonate
ICP - Intracranial Pressure
PCO2 - PRESSURE OF ARTRIAL CO2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

(Continue on reverse)

[redacted] RN (b)(6)-2 | DEPARTMENT/SERVICE/CLINIC ICU | DATE 28 Sep 03

[redacted] (b)(6)-4

EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DATE 28 Sep DX [illegible] Colon Granuloma, [illegible] HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial line	125/76	122/64	126/74	138/70	124/65	126/62	124/68	126/61		133/68	118/68	118/63	120/63	139/65	109/61	111/62	125/61	
	BP Cuff	123/64					104/54												
	Temperature	38.1	38.9	38.9	38.7	38.8	38.9	38.9	39.1		38.7	38.8	37.9	37.7	37.8	38	38	37.8	
	Pulse	104	112	103	114	114	116	115	126		121	125	115	114	113	114	112	111	
	Respiratory Rate	21	18	18	18	18	18	18	18		18	18	18	18	18	14	14	14	
	SaO2	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	
	FiO2	90	60	55	40	40	40	40	40		40	40	40	40	40	40	40	40	
	CVP	8	9	10	7	7	7	7	6		7	7	8	8	9	8	9	6	

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	~~LR 5%~~ 5%	100	100	100	100	100	100	100	100	800	75	75	75	75	75	75	75	75	800
	Versed	5	5	5	5	5	5	5	5	40	5	5	5	5	5	5	5	5	40
	MS04	3	3	3	3	3	3	3	3	24	3	3	3	3	3	3	3	3	24
	IV ADX		50 (Zantac)					100 (Lasix)		150	50						50		100
	TOTALS				(SKIP)					974									968

OUTPUT		HOUR / TOTAL	24 / 300	01 / 346	02 / 396	03 / 316	04 / 454	05 / 651	06 / 544	07 / 841	8°T	08 / 80	09 / 160	10 / 240	11 / 210	12 / 340	13 / 410	14 / 465	15 / 500	8°T
	URINE	SP gr																		
		S/A																		
	NG	OUTPUT																		
		PH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS	JP#1	80cc		70		40		40	250		50						80	130
		JP#2	70cc		0		0					10						10	20
	TOTALS																		150

POST-OP DAY

VITAL SIGNS	14	17	18	19	20	21	22	23
	134/60	158/73	104/54	105/61	127/60	123/57	106/68	126/65
							47/48	
	37.9	38.7	38.7	38.3	38.2	38.9	38.7	38.4
	110	121	124	114	120	123	119	112
RR	14	14	14	14	14	14	14	14
SaO2	100	100	100	97	99	100	100	100
FiO2	40	40	40	40	40	40	40	40
CVP	6	7	6	5	5	4	4	6

INTAKE	14	17	18	19	20	21	22	23	8°T
	75	75	75	75	75	75	75	75	88
	5	5	5	5	5	5	5	5	40
	3	3	3	5	5	6	6	6	37
									165

OUTPUT	14	17	18	19	20	21	22	23	8°T
	110	110/180	100/280	100/380	120/420	200/620	100/720	30/750	750
		40						50	90
									800

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA									
TIME		2400	0200	0500	1200	1630	1800		
MODE		SIMV	SIMV	SIMV	SIMV		SIMV		
F_IO_2		80	60	40	40	40	40		
TV		600	600	600	600	600	600		
RATE		16	18	18	18	14	14		
PEEP		12	12	12	10	8	8		
ABG	pH	7.29	7.35	7.35	7.4	7.38	7.38		
	PCO_2	44.7	39.2	37.7	31.6	37.8			
	pO_2	*	122	133	77	164			
	HCO_3	22	21	21	21	22			
	SAT	100	98	99	95	99			
	BASE	-5	-4	-4	-3	-2			

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

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

24 HR TOTALS

WT Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
Po			
TOTAL	2343	TOTAL	2340
BALANCE			

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

INITIALS

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

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

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INT [redacted]	1900	INT [redacted]		INTILAS
NEURO	PUPLIS	2mm sluggish to light. SEDRA		2mm sluggish lightly sedated			
	SENSORIUM	Edema. Nerved. sedated on VARSed @ 5mg/hr		on MS oral; awake to tactile stimulation			
RESPIRATORY	RESPIRATION PATTERN	T-MSX @ 600 [illegible]		equal used full			
	BREATH SOUNDS	[illegible]		Sa02 99% on			
	SECRETIONS	drawn to [illegible]		35% SIMV;			
		[illegible]					
		[illegible]					
		[illegible]					
SKIN	COLOR	[illegible]					
	INTEGRITY	[illegible]					
		[illegible]					
IV SITE	LOCATION	[illegible]					
	CONDITION	[illegible]					
		[illegible]					
		[illegible]					
		[illegible]					
		[illegible]					
GASTRO	ABDOMEN	[illegible]					
	BOWEL SOUNDS	[illegible]					
		[illegible]					
		[illegible]					
GU	URINE	[illegible]					
	COLOR/CLARITY	[illegible]					
		[illegible]					
CARDIOVASCULAR	CARDIACRHYTHM	[illegible]					
		[illegible]					
		[illegible]					
		[illegible]					
		[illegible]					
		[illegible]					
		[illegible]					

LEGEND

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

(Continue on reverse)

PREPARED BY (S [redacted] (b)(6)-2 | DEPARTMENT/SERVICE/CINC ICU-3 | DATE 29 Sep03

PATIENT'S INDICATIONS [redacted] of written entries give: Name—Last, First, middle; grade; date; ho [redacted] medical facility)

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIGNOSTIC STUDIES

☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

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

DATE 29 Sep 05 | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line	119/57	126/65	125/63	124/58	118/53	135/66	127/60	132/60		117/60	117/62	127/65	124/63	130/63	126/62	128/64	121/60	
BP Cuff																		
Temperature	38.5	38.5	38.4	38.5	38.9	38.8	38.9	37.9		37.7	37.4	37.3	37.2	37.2	37.3	37.6	37.7	
Pulse	112	110	110	106	105	114	109	112		111	94	92	91	83	89	95	90	
Respiratory Rate	15	14	14	14	14	14	14	14		10	10	10	10	10	10	10	10	
SaO2	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	
FIO2	40	40	35	35	35	35	35	35		35	35	35	35	35	35	35	35	
CVP	5	5	4	6	6	6	6	6		7	6	6	6	5	6	6	6	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5½120K	75	75	75	75	75	75	75	75	600	75	75	75	75	75	75	75	75	600
Vessel	5	5	5	5	5	5	5	5	40	5	2	2	2	1	1	0	0	13
NS04	6	6	6	6	6	6	6	6	48	6	6	6	6	6	6	6	6	23
ABX	50/100								150	50				100		50		250
TOTALS									838									886

OUTPUT

		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR	30	30	30	30	50	35	40	30		40	36	45	100	110	110	110	95	
	TOTAL	30	60	90	120	170	205	245	275	275		316	361	461	571	681	791	886	886
	SP gr																		
	S/A																		
NG	OUTPUT																		
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP1				20				20					30				30	
	JP2				10				10					5				5	
TOTALS									1111									941	

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23
	134	143	135	149	139	139	125	128
			68	91	60	67	71	77
	97.7	98.8	98.8	38.7	39.4	39.2	38.4	38.2
	92	108	109	111	119	119	114	112
	10	10	10	10	11	10	10	112
	100	100	100	97	100	98	99	98
	35	35	35	35	50	40	40	40
	4	5	5	5	7	6	6	4

INTAKE	14	17	18	19	20	21	22	23	8°T
	75	75	75	75	75	75	100	100	850
					3	3	3	3	12
	3	3	3	3	3	3	3	3	24
			100						
									886

OUTPUT									
	110	120	30	30	35	35	40	35	435
		130	20	90	30	30	100	135	
	10								10
									445

ACUITY LEVEL CLASSIFICATION

RESPIRATORY										
	TIME	0700	0710	0910						
	MODE	SIMV	SIMV							
	F_IO_2	35%	35%							
	TV	600	600							
	RATE	14	10							
	PEEP	6	5							
ABG	pH			7.33						
	PCO_2			46.5						
	pO_2			192						
	HCO_3			24						
	SAT			100						
	BASE			-1						

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

ACTIVITIES OF DAILY LIVING	TIME	0700	11		TURN SUCTION	TIME			
	MOUTH CARE	[redacted]		(b)(6)					
	BATCH	[redacted]							
	SKIN CARE								
	FOLEY CARE								
	TRACH CARE								
	ROM EXERCISES								

24°100 TOTALS | NURSE'S SIGNATURE | INITIALS

WT Yesterday _____ wt Today (b)(6)-2

(b)(6)-2

INTAKE | OUTPUT

IV _____ Urine: _____

Po _____

TOTAL 2610 TOTAL 1391

BALANCE (+) 1219

[redacted]

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

(b)(6)-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL [redacted] ASSESSMENT

		TIME	0600	INITIALS [redacted]	1800	[redacted]	(b)(6)-2	INITIALS
NEURO	PUPILS		pupils RMS		Peerla 3 m			
	SENSORIUM		AF RRousable		ARousable to verbal			
			to verbal stimuli		stimuli.			
			mildly sedated					
			on trayed					
RESPIRATORY	RESPIRATORY PATTERN		Bilat inflated		Regular			
	BREATH SOUNDS		Bilat Scattered		CTABIL			
	SECRETIONS		@ 22 cm, Seal					
			correct-ID tube					
			NS @ cmoe					
			Regularly					
SKIN	COLOR		Skin WD		Skin WD dry to			
	INTEGRITY				(R) L abd & (L) hypogastrium			
IV SITE	LOCATION		(R) R3, SC all		(R) subclavian central			
	CONDITION		ports Glucose		triphelumen all ports			
			Total. R. RA		patent			
			Hline Jackette					
			Dated					
GASTRO	ABDOMEN		Soft NT		soft flat NT			
	BOWEL SOUNDS		C BS active		(+) BS U Quads L			
			NG Gravity		quads hypoactive			
			NG Residual					
GU	URINE:		Foley. Fly		foley to gravity			
	COLOR/CLARITY		Clear		clr yellow			
			Foley cath					
CARDIOVASCULAR	CARDIAC RHYTHM		S-Tach		S-Tach			
			Occasional					
			premature					
			beats					
			noted					

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

(Continue on reverse)

PREPARED BY (Si[redacted]

(b)(6)-2

DEPARTMENT/SERVICE/CLINIC

DATE 30 Sep 0[illegible]

PATIENT'S IDENTIFI[redacted]ive: Name—last, first, middle; grade; da[redacted] medical facility)

[redacted]

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

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

[redacted] (b)(6)-4

DATE 30 Sep | DX | PAGE 2 OF | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line			119/63		125/63	124/63	132/56	133/80		132/70	133/76	125/75	162/74	128/85	140/42	124/75	129/80
BP Cuff	125/50	124/50	116/99		126/54	125/67											
Temperature	38.1	38.1	38.4		38.5	38.3	38.3	38.5		38.9	39	39	38.9	38.9	39.3	39.3	
Pulse	100	102	105		107	101	104	104		124	124	125	114	125	120	125	119
Respiratory Rate	10	10	12		13	12	12	13		22	22	25	23	24	29	25	30
SaO2	100	100	100		99	100	100	100		100	100	97	100	100	100	100	100
fiO2	40	40	35		35	35	35	35		35	8	8	8	8	8	8	8
CVP	/	/	6		6	6	6	6		6	8	8	8	8	8	8	8

INTAKE

TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
IVF	100	100	100	100	100	100	100	100	400	100	100	100	100	100	100	100	100	800
Vero	3	3	3	3	3	1	1		17									
MSO4	3	3	3	3	3	1	1		17									
Abx	100/50						100		850	50				100	50			200
TOTALS								1084										

OUTPUT

URINE	HOUR	30	30	40		80	30	30	50		75	110	130	100	70	100	110	180	1000
	TOTAL	30	60	100		180	210	240	290	290		186	500	405	475	575	685	865	865
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	HP (Alb)													25				25	
TOTALS																			890

POST-OP DAY

VITAL SIGNS

16	17	18	19	20	21	22	23	24
132/[illegible]	140/70	139/[illegible]	152/75	133/74	138/70	129/71	126/70	
80								
38	38	38	38.8		38.9	38.9	38.9	
114	110	102	100	104	109	104	101	
30	29	27	32	28	27	28	26	
100	100	100	100	100	100	99	97	
2L	2L	2L	2L	2L	2L	2L	2L	
7								

INTAKE

16	17	18						8° T
100	100	100	100	100	100	100	100	
		100						

OUTPUT

100	120/380	300/370	170/690	130	100	100	140/820	
N[illegible]		100	100	100	100	100	100	600

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME	
MODE	
F_IO_2	
TV	
RATE	
PEEP	
ABG pH	
ABG PCO_2	
ABG pO_2	
ABG HCO_3	
ABG SAT	
ABG BASE	

LABORATORY DATA

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

ACTIVITIES OF DAILY LIVING

TIME	
MOUTH CARE	
BATH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TURN — TIME

SUCTION

24° I&O TOTALS

wt Yesterday ________ wt Today (b)(6)-2

INTAKE: IV ________ po ________ ________

OUTPUT: Urine: ________ ________ ________

TOTAL ________ TOTAL ________

BALANCE ________

[redacted] INITIALS

(b)(6)-2

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89 (b)(6)-2

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS [redacted] (b)(6)-2	INITIALS	1900	INITIALS [redacted]
NEURO	PUPILS	PUPILS RTO			PERRLA 3mm	
	SENSORIUM	REACTIVE			sluggish; alert,	
		FOLLOWS COMMANDS			response; appropriate	
		MOVES ALL				
		EXTREMITIES				
RESPIRATORY	RESPIRATORY PATTERN	RR quiet & unlabored			equal use/full	
	BREATH SOUNDS	CLEAR			RNAO; ↓↑ WOB;	
	SECRETIONS	MODERATE			RR 20-25 Sat 298%	
		COMPANION ON			2LNC	
		SUCTION				
		SECRETION				
SKIN	COLOR	COLOR NORMAL			NPR	
	INTEGRITY	SKIN INTACT			ML incision c staples;	
		[illegible]			RLE c staples;	
IV SITE	LOCATION	RT SUBCLAV			R Hip CDI.	
	CONDITION	ALL PATS PATEN			TLC (R) SC CDI b	
GASTRO	ABDOMEN	SOFT NT			SOFT, NT; ↓ BS	
	BOWEL SOUNDS	HYPOACTIVE			throughout	
		BS X 4 QUADS				
		NO SIGNS				
GU	URINE:	YELLOW, CLEAR			Voids clear, yellow	
	COLOR/CLARITY	BSO PATENT				
		FOLEY WITHDRAWN				
CARDIOVASCULAR	CARDIAC RHYTHM	RSR @ 90-100			SR → ST; ∅ ectopy.	
		BP ↑ 160/80				
		HR 90-100				
		PERIPHERAL PULSES				
		2+				

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC ICU3

DATE 10 Oct 03

PATIENT'S IDENT[redacted] tries give: Name—last, first, middle; grad[redacted] facility)

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

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

DATE | DX | HOSPITAL DAY

VITALS SIGNS	TIME	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16
	BP Arterial Line	129																
	BP Cuff	120/61	125/61	120/71	125/73	122/60	125/66	129/73	131/74		126/67	120/75	130/66	126/74	129/75	118/65	133/76	132/76
	Temperature	38.7	38.7	38.4	38.4	38.2	37	37.7	37.4		37.6			36	36			
	Pulse	90	98	103	91	92	99	94	90		84	85	85	94	89	95	85	96
	Respiratory Rate	29	28	26	24	26	26	27	21		23	27	28	25	28	32	24	28
	SPO2	98	100	97	94	93	100	100	100		100	100	94	100	100	96	97	96
		2L NC	2L/m NC	2L/m NC	2L/m NC	2L/m NC	2L/m NC	2L NC	2L NC		2L NC	2L NC						

INTAKE	TIME									8° T									8° T
	IV 0.5½ as 20KCL	100	100/300	100/400	100/500	100/600	100/600	100/67		100	100	100	100	100	100	100	100	100	800
	IVF PO	200						100	50	300 350					100	50			150
	TOTALS																		950

OUTPUT		HOUR / TOTAL																	
	URINE		80		100	120/320	80/400	60/460	70/530	110/640	100/640	100	150/790				500/1140		300/1440	1050
		sp gr																	
		S/A																	
	NG	OUTPUT	125	125/250	100/350														
		pH																	
		GUIAC																	
	EMESIS																		
	STOOL																		
	DRAINS																		
	TOTALS																		

Dried Pyxis

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	TTL
	135	130	126	135	127	136	129	122	
	85	77	74	59	69	71	71	63	
	99					100.2			
	92	95	104	101	102	99	114	95	
	22	24	20	24	31	30	16	23	
	99	98	98	98	99	99	99	97	
				2L	2L	2L	2L	2L	
				NC	NC	NC	NC	NC	

INTAKE									8° T
I	100	100	100	100	100	100	100	100	800
							100		100

OUTPUT									
		400		500					900

900

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME	0400	0440
		MODE		
		F_IO_2		
		TV		
		RATE		
		PEEP	6	
ABG	A	pH	7.43	7.48
		PCO_2	47	41
		pO_2	43	76
	B	HCO_3	30	31
		SAT	32	96
	G	BASE	3	7

LABORATORY DATA	TIME	0
	GLUCOSE	
	Na/K	
	Cl/CO_2	
	BUN/Cr	
	WBC/PLATELET	
	Hct/Hgb	

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

24° I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday	wt Today (b)(6)-2	[redacted]	[redacted]
	(b)(6)-2		
INTAKE	OUTPUT		
IV	Urine: (b)(6)-2		
po			
TOTAL	TOTAL		
BALANCE			

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07	~~08~~	08								
BP Arterial Line																		
BP Cuff	124/64	122/65	124/66															
Temperature																		
Pulse	95	89	92															
Respiratory Rate	23	24	24															
SaO2	97	97	97															
Mode	RA	RA	RA															

INTAKE

TIME									8° T									8° T
IVF	100	100	100															
ABX																		
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL																		
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19860101	017	2	3	unk

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	2	0100	(b)(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
I 1	K 7 8	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
I 2		9	YEAR / X NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0 (b)(2)-2	Ical	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 (YYMMDD)
50		031008

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AAAA		030928

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

FOR LOCAL USE

Dx ① oswald colon repair
② multi Shrapnal wounds

Dx: 863.51, 890.1, 891.1, 518.5, E991.2, E991.9
Pr: 45.73, 45.94, 86.04, 80.16

ADMITTING OFFICER (Signature, as required) [redacted] (b)(6)-2 [redacted]

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

DA FORM 2085, MAR 80 EDITION OF [illegible] IS OBSOLETE

(b)(6)-2

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

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

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	26Y	X	ISLAMIC			NO

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

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

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

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

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-02	[redacted] (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] (b)(2)-2	2003-10-02	

31. Selected Administrative Data

Marital Status: DoB: 1977-01-01

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW TO THE ~~ABDOMEN~~ Chest

Hemothorax

Pulmonary Contusion

861.31

860.3

E991.2

R

87.41

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
Ø	Ø	Ø	Ø	6	6

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
[redacted]					

Signat[redacted] (b)(6)-2 [redacted] of PAD or Medical Records Officer [redacted] (b)(6)-2

MEDCOM - 20765

Automated Facsimile [redacted]7, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

28yo ♂ Iraqi (EPW or CI) s/p GSW (R) back approx 4-5 PM yesterday. Taken to Iraqi hospital, CT placed and, by report, 600 cc blood out. Arrive to 28CSH, arrival = 2AM. Pt upon admission c/o pain at entry site, pain anterior chest. Denies abd pain, other body pain.

PMHx: ø Meds: ø Allergies: NKDA

PHYSICAL EXAMINATION

130/60 RR 23 P96

NAD. Cooperative

Heart: AT & clear. Needle RUL Rom. NT.

Chest: Coarse BS (B) bases.

CV: tachy RR. S1 S2

Abd: benign. NT. ø peritoneal signs

Ext: ø edema. (R) LE & NV intact.

21 / 4 / 95 / 240

Cr 1.3

Hct 1.26

Crea ø PTx CT ABC

PAT: ø blood.

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

A/ GSW (R) back. Hemothorax

P/ Admit / observation.

[redacted] (b)(6)-2

PATIENT S[redacted]	DATE 10/2	IDENTIFICATION NO.	ORGANIZATION
(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
3 Oct 03 1800	UD Alb tx given pt awake & alert HR 71 RR 16 SPO2 97% on 2L NC BBS CTA Post tx HR 86 RR 18 SPO2 97% BBS No change (b)(6)-2 Sgt [redacted] 91W2Ø
4 Oct Ø3 Ø2Ø0	HR 115, RR 35, SPO_2 91% on 4L NC. (+) cough productive. UD Alb neb given. Post HR 106, RR 33, SPO_2 93%. BBS (b)(6)-2 Pleural rubs - bubbly, ⊖ wheezing. IS done. Sgt [redacted] Pt had bloody sputum X2 ≈ 3cc each time dark blood. (b)(6)-2 Sgt [redacted] 91W2Ø
4 Oct Ø3 Ø4Ø0	HR 92, RR 21, SPO_2 96% on 8L SM. UD Alb neb given. Post tx HR 97 RR 3Ø SPO_2 98% on 8L aerosol mask. BBS CTA but diminished. (+) cough IS done c̄ good effort. Pt asked about CT. coming out. (b)(6)-2 Sgt [redacted] 91W2Ø
4 OCT 1805	Pt resting Pre tx HR 106 RR 25 SPO2 92% on 3L NC BBS clear upper Dimished lower UD Alb tx given Pos UD Alb tx given post tx HR 105 RR 02 SPO2 94% BBS No change Pt instructed a doing I S (b)(6)-2 Sgt [redacted] 91W20
Ø5 Oct Ø3 Ø6Ø5	HR-86, RR-22, 94 SPO_2 on 4L NC. UD Alb neb given Post tx HR 85, RR 25, SPO_2 97 on 6L aerosol mask. BBS CTA. will continue to monitor (b)(6)-2 Sgt [redacted] 91W2Ø
5 Oct Ø3 1Ø1Ø	HR-106, RR 21, SPO_2 95 on 4L NC. UD Alb neb given. BBS CTA. Post TX 99, RR 25, SPO_2 96%. Pt tranfer to ICW — Sgt [redacted] 91W

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

Alb neb Q4

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
2015	restraints on ∃ compromise to skin or
00CT03	circulation — will mon — (b)(b)-2 [redacted] SPC
7OCT(0001)	Albuterol Treatment started, due for CXR in
	AM @ 0500 — (b)(b)-2 [redacted] 91WM6.
(0200)	X-ray consult put in per orders — [redacted] 91WM6.
	(not portable). (b)(b)-2
(0500)	CXR done — (b)(b)-2 [redacted] 91WM6, SPC
7OCT03	Assumed care of pt. A+O x3. VSS remains
0700-	afebrile. Denies SOB or chest pain @ this time. O2
	sats 90% on 3L O2. Orders to wean off O2. GSW to back
	entrance wound and exit wound dressing Δ CDI. OLD chest
	tube site sutures intact Ø s/s of infection. Will cont
	to monitor. (b)(b)-2 [redacted] SPC
(1910)	Pt A&O, VSS, sitting 1 in bed, POx @ 91% (RA), Ø SOB
	resp even & unlabored. Wounds OTA c̄ Ø drain-
	age noted. prev. CT site sutures intact, Ø
	s/s of infection noted. C/O chest pain (R), II.
	Percocet given. LCTAB, ⊕BS, HRRR, 2 pt restraints
	on ∃ compromise to skin/circulation. Will
	monitor (b)(b)-2 [redacted] 91WM6 SPC

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)(b)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8 October 2003	DC Summary
	Admit Date 2 October 03
	DC Date 8 Oct 03
	Dx: 1) GSW to Right Chest/Back extra
	2) Hemothorax
	Procedure: Chest tube placement outside facility
	Hospital Course: Pt admitted in transfer from Iraqi hospital with (R) chest GSW with reactive hemothorax which was treated with (R) chest tube. Pt stable on transfer. Cxr ~~ref~~ (c) revealed opacification of (R) lower lung field. Chest CT revealed Right lower lobe pulmonary contusion minimal residual hemothorax. Minimal PT output. CT removed HD #2. Patient continued to need aggressive pulmonary toilet and required O2 until 7 October. Weaned off O2 on 36° CXR showed RLL contusion.
	Disposition: 1) DC to EPW company 2) Still need tube removal in 2 weeks 3) Pt CXR in 6 weeks
	Meds: Percocet 7 po Q6° PRN pain
	Levaquin 500mg po QD F8
	Motrin 800mg po Q8 PRN.

(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	...NED AT

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10/10	Narrative Sum
	Admit 10/9
	D/C 10/10
	Diagnosis: Stroke
	Patient Readmitted c stroke from CT site.
	Pt stable. CT chest ⊖ for refractory hemothorax
	Pt D/C stable
	Disposition: Home
	Meds: none
	(b)(b)-2
	[redacted]
	(b)(b)-2
	[redacted] (b)(b)-4

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10/3/03	HD #2
	S/P GSW to R Chest. CTR
	shunt RLL contus. Manual vessel
	repair hemothorax, T02 required
	Cont PM. CXR shows T collapse and
	middle lobe.
	Pt doing agg[illegible] [illegible] stable
	[redacted] (b)(b)-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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5 OCT 1800	Pt awake HR 96 RR 16 SPO2 94% 4LNC BBS CTA
	UD Alb tx given Post tx HR 86 RR 18 SPO2 94%
	on 4L NC BBS No change (b)(6)-2 Sgt [redacted] 91V2Ø
5 Oct Ø3 Ø030	Nurse gave pt tx (b)(6)-2 Sgt [redacted] 91V2Ø
6 Oct Ø3 Ø645	Pt note: Pt awake HR 88, RR 18, SPO2 94% on 3LNC.
	BBS CTA still diminished @ bases. UD Alb given. Post tx
	HR 94 RR 22 SPO2 on 94% 3L NC (b)(6)-2 Sgt [redacted] 91V2Ø
6 OCT	Pt awake HR 86 RR 14 SPO2 95% 4LNC BBS CTA + Dimmish
1757	UD Alb tx given Post tx HR 86, SPO2 95 BBS clear
	Diminished in Bases (b)(6)-2 Sgt [redacted] 91V2Ø
7 Oct Ø3 ØØ45	O2 tank not working, removed flowmeter + notice
	threads were bent. Told nurse to Δ tanks.
	Call back when ready for tx - nurse went ahead +
	did tx (b)(6)-2 Sgt [redacted] 91V2Ø
7 Oct Ø3 Ø62Ø	Pre tx HR 76, RR 16, SPO2 94% on 3LNC. UD Alb given via
	HHN c̄ mouthpiece. BBS CTA c̄ slightly diminished bases.
	Post tx HR 72 RR 18 SPO2 93% on 3LNC. (b)(6)-2 Sgt [redacted]
8 OCT 03	- Assumed care pt. A+O x3. VSS O2 SAT throughout the
0700	night 92-94% RA. Lungs clear c̄ diminished (R) base. Encouraged
	deep breathing exercises. IS @ bedside. Increased ambulation.
	GSW to chest healing. Chest tube site c̄ sutures intact Ø active
	bleeding open to air Ø c/o pain or discomfort denies SOB
	Will cont to monitor (b)(6)-2 [redacted] nurse.

STANDARD FORM 509 (REV. 5/1998) BACK
USAPA V1.00

(b)(6)-4
FE [redacted] Alb X 72 Q6

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5 Oct 03	1300 I concur c̄ transfer note. Pt in 2pt restraints c̄ compromise to skin integrity or circulation. Will continue monitoring & providing emotional support — (b)(6)-2 [redacted] mb/on
(1930)	Pt a/o, sitting ↑ in bed to assist c̄ breathing. O2 4L by NC on, lungs: clear but diminished @ bases. HRRR, ⊕BS x4, drsg to ⓡ upper chest wall CDI, entrance wound to back c̄ opsite over area ∅ c/o pain or discomfort @ this time. resp even & unlabored, O2 sats 91-94%. Albuterol treatment to be done @ midnight. 2pt restraints on c̄ any compromise to circulation/skin. Will monitor (b)(6)-2 [redacted] 91WM6.
(6OCT) 0001	Albuterol treatment started. O2 sat between 90-94%. Will monitor (b)(6)-2 [redacted] 91WM6.
6 Oct 03 0900	Rec'd report and assume care of pt. Pt ↑ in bed. 3L NC POX 95. Dsg to ⓡ [redacted] (b)(6)-2 lateral chest D&I. Lungs CTA. BS⊕. Pt ambulated in hallway. Pt instructed to continue to use incentive spirometer q hr while awake and DB exercises. Will continue to monitor [redacted] 91WM6
1630	Pt ambulated in hallway POX 91% while ambulated.
(2015)	Pt a/o, sitting ↑ in bed POX 90%, IS & deep breathing encouraged. POX 93% while ambulating. drsg ⓡ chest CDI, ⅡT Percocet given for pain. On O2 by NC @ 3L @ this time. 2pt

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
05OCT03 0400	Pt sitting up in bed. Requesting H2O. O2 sats remain 94%. Will cont. care. (b)(6)-2 [redacted] RN/LPN
0600	Gave report to oncoming shift. (b)(6)-2 [redacted] RN/AN
0700	Received report from ongoing shift. Pt in bed resting. O2 4L NC in use, O2 sat @ 95%. Plan: Respiratory toilet, cough & deep breath, OOB-chair. (b)(6)-2 [redacted] Maj/AN
1000	Received MSO4 4mg @ 0930 for c/o minimal pain. Pt is cleared by MD for transfer to ICW. Pt A & O X3. Hxed to C & DB, use of incentive spirometer and O2 2-4L NC, maintain O2 sat > 95%. Ambulatory & self care. T98.6-102-17-118/58 (b)(6)-2 [redacted] Maj/AN
1100	Pt transferred: Transferred ambulatory to ICW I c̄ O2 tank @ 4L NC. Report given to ward nurse. (b)(6)-2 [redacted] Maj/AN
5 Oct 03 1110	- Assumed care of pt. transfer from ICU #2 to ICW #1 Ambulatory. Lungs clear diminished @ bases 4L O2 per NC O2 saturation between 92-96% @ this time 95% instructed on deep breathing exercises IS @ bedside instructions given. Dressing to (R) upper chest wall bulky dressing CDI. Chest tube d/c'd site c̄ sutures minimal bleeding dressing CDI. Entrance GSW to back c̄ opsite. Ø c/o pain or discomfort Will cont to monitor (b)(6)-2 [redacted] RN/LPN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
04 Oct 03 1500	Chest tube discontinued @ 1000 AM, chest X-ray done + reviewed. Pt OOB-chair x 3 this shift. Complaint c̄ C+DB and incentive spirometer. VSS (b)(6)-2 [redacted] Pt IA
4 Oct 03 2246	RT note: Pre tx HR 91, RR 28, SPO2 95% on 4L NC. UD Alb given. BBS diminished. Post tx HR 94, RR 26, SPO2 96 back on 4L NC. (b)(6)-2 Sgt [redacted]
04 OCT 03 1800	Received report from previous shift. Pt sitting up in bed. O2 @ [redacted] 3L via NC. O2 sats 94%. O2 humidified. 0% pain @ this time. Dresg (R) side C,D,I. IV (R) AC intact + H.L. 0 needs expressed @ this time. Will cont. care (b)(6)-2 [redacted]
1820	Pt temp 101.1, Will notify MD. O2 sats ↓ 92%. ↑ O2 to 4L via NC. O2 ↑ 94-96%. Pt ate 25% dinner. Pt cough + deep breath. 0% pain @ this time. Will cont. care (b)(6)-2 [redacted]
1925	MD notified of temp. tylenol given. Will cont to monitor temp. (b)(6)-2 [redacted]
2230	Pt c/o pain (R) flank. Gave 4mg MSO4 IVP. Will cont to assess pain level. Temp ↓ 99.7. Will cont. care [redacted]
Late entry 1935	New order for CBC + Blood Cx. Drew labs per order. CBC results: WBC 12.8, H+H 12.4 38.8, Plt 246. Will notify MD of results. (b)(6)-2 [redacted]
05 OCT 03 0200	Pt c/o pain on (R) side. Gave 4mg MSO4 IVP. RT tx done @ this time. Will cont. care. (b)(6)-2 [redacted]
0200	RT note: Pre tx HR 93, RR 22, SPO2 95% on 4 L NC. UD Alb given. BBS diminished. Post tx HR 97, RR 19, SPO2 96% on 4L NC. (b)(6)-2 Sgt [redacted]

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
03Oct03 1400	Pt wean off from NR to 3L-4L NC @ 4L NC @ this time, O2 sat @ 94%. Continue to encourage IS x5 qi. (b)(6)-2 [redacted] Nij 1Sm
1800	Received report from day shift. Pt has chest tube to (R) side of chest. Blisters to high chest around tape. Pt A+O, (b)(6)-2 will continue to monitor. [redacted] SPC 9/WMG
2000	Pt resting comfortably in bed. VSS (b)(6)-2 will continue to monitor. [redacted] SPC, 9/WMG
4Oct03 2400	Pt resting comfortably in bed. VSS. Moved pt up in bed. Gave pt 4 mg MSO4. Will continue to monitor. (b)(6)-2 [redacted] SPC, [redacted], 9/WMG (b)(6)-2
4Oct03 0230	Pt placed on simple masks. SATs ↓ to 89%. 6L O2 SATs ↑ to 94%. Will (b)(6)-2 continue to monitor. [redacted] SPC 9/WMG
0600	Received report from ongoing shift. Pt in bed, FM in place due to desaturation O2 last night. CT in place draining small amt of sero-sanguinous drainage. T 99.0. Plan: Pulmonary toilet, C+DB. Advance diet as tolerated. [redacted] (b)(6) Nij 1Sm

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
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C10 [redacted] (b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
~~3 Oct 03~~ 03 Oct 03 0800	Pt note: Pt awaken easily. Pre tx HR 94, RR 16, SPO2 98% on 10L NRB. Breathing even + unlabored. BBS diminished @ bases c̄ ® side surgery. UD Abb given via facemask. Post tx HR-110, RR 28, SPO2 98%. Pt tol well. — Sp[redacted]
2000	Pt ambulated, pulsox on ↓ 80's. Dr [redacted] (b)(6)-2 Place pt on NR mask. SPO2 ↑ to 99%. Will (b)(6)-2 continue to monitor. [redacted] (b)(6)-2 SPC, 91WM6 —
03 Oct 03 2400	Pt resting comfortably in bed. VSS. SPO2 @ 99% on NR 10L. Will continue to monitor. (b)(6)-2 [redacted] SPC, 91WM6 —
0200	Pt resting comfortably in bed. VSS. Will continue to monitor [redacted] (b)(6)-2 SPC, 91WM6 —
0600	Gave report to day shift [redacted] (b)(6)-2 SPC, 91WM6
03 Oct 03 0800	Pt note: Dx lethargic. Pre tx HR 90, RR 22, SPO2 96% on 10L NRB. UD Abb given. BBS diminished. Post tx HR 92, RR 22, 95% on 8L aerosol mask. Placed back on 10L NRB. JS done (b)(6)-2 — Sgt [redacted]
03 Oct 03 0800 T100.6	Received report from ongoing shift. Pt awake on NR FM, sat 94%. Verbalized need for pain medicine. IV LR @ 75 on the ® arm, site D+I, site started @ 2 Oct 03. ~~Afebrile~~ Low grade T100.1. Received nebs treatment by RR, see note above. CT ® mid axillary site intact draining serosanguinous drainage. Continue to monitor respiratory status (b)(6)-2 [redacted]
1300 T100.6	C+DB 3X hour, compliant c̄ coaching. O2 sat is maintained @ 98% from 92% this AM. Foley draining q 5 per hour. Medicated c̄ 1150 4 mg @ 0700 and 2 mg @ 1130. Pt alert c̄ intermittent sleepiness (b)(6)-2 [redacted]

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[redacted] (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	Nursing Notes
20 OCT 03	Received Pt in Icu Bed #6 Pt alert follow commands. See
0630	Intensive care flow sheet for more information included assessment
0700	Pt C/O pain to right side of chest MSO4 4mg IV given Pt encouraged
	to use and instructed on use of incentive spirometer able to get out
0730	bed to go. DR Matsumoto visited Pt. Chest tube has serosanguinous
0900	fluid draining. Pt resting No distress noted. Hbx Emphysema
0900	DR Mulligan visited and examined Pt He is now the attending MD.
	O_2 Tapered to 4L via NC tolerating well sat 96% via pulse oximeter. C/O
	pain MSO4 3mg IV given [redacted], LT (b)(6)-2
1100	Pt Placed OOB to chair chest tube to suction. C/O Pain MSO4 3mg IV
	given Pt has ground at bedside [redacted] (b)(6)-2 (b)(6)-2
1400	VS Pt's condition unchanged No distress Noted Pt OOB to chair [redacted]
1530	Blood drawn and sent to Lab for CBC. Pt C/O Pain MSO4 4mg IVP
1630	given. MSO4 3mg IV given Pt returned to bed. Foley Cath
	inserted. clear urine noted. Lasix 20mg IV given
1900	DR Mulligan aware of Pt's Condition. Pt Transported to CT Dept
1815	for CT of the Chest. CT of chest done Dr Mulligan aware
	of results. Pt returned to ICU. Report given to Nurse
	[redacted] in ICU (b)(6)-2
1830	Received report from day shift VSS, NC 4L, Foley
	to gravity, Chest tube to Pc chest [redacted] SPC 9 with

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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

PROGRESS NOTES
Medical Record

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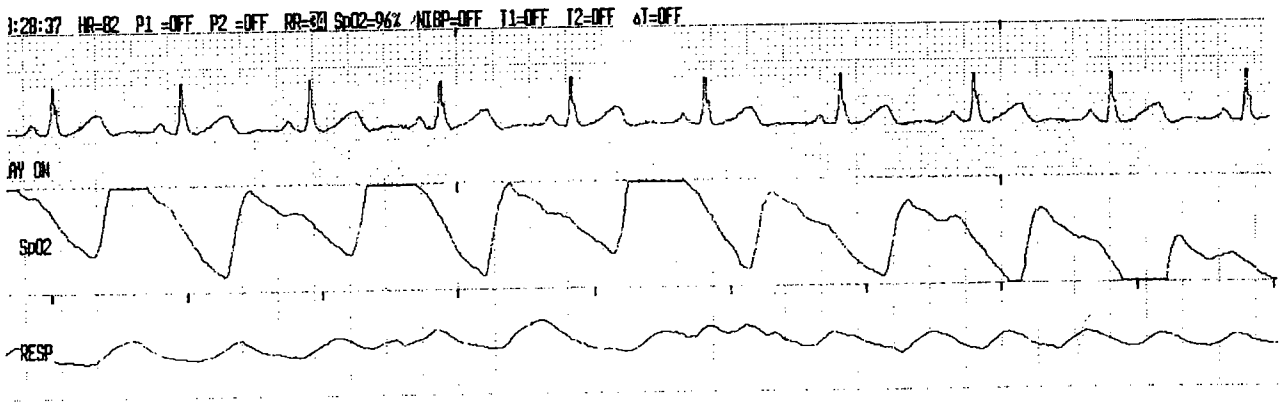
MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
02 OCT 03 0235	Received pt from EMT via stretcher. Pt on NRB mask. O2 sats 97%. (R) flank chest tube to 20cm continuous suction. Drsg on (R) upper chest C,D,I. Drsg (R) flank C,D,I. Pt arrived c̄ 23cc of bloody drainage in chest tube. Pt awake + able to speak some english. MP @ bedside. 1-point leather restraint on (R) ankle placed due to pt status. Interpretor @ bedside. Explained NPO status, restraints, + IS. Pt able to move up 2nd ball in IS. 0% pain @ this time. Pt does have pain if touch (R) flank. LR @ 15cc/° started. Will cont. care. (b)(6)-2 [redacted] ICT/AN
0245	Placed pt on NC 5L/min. O2 sats 94-95%. Will cont to monitor. (b)(6)-2 [redacted] ICT/AN
0330	Placed pt on NRB mask to ↑ sats to 100%. Will cont. to monitor. (b)(6)-2 [redacted] ICT/AN



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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
02 OCT 03 0440	Pt resting quietly c̄ eyes closed. NRB mask in place @ 10L/min O2. O2 sats 100%. Will cont to monitor. [redacted]
0507	Pt c̄o pain in (R) chest area. Gave 4mg MSO4 IVP. (b)(6)-2 Pt quietly resting c̄ eyes closed @ this time. PR low 20s O2 sat 98%. Will cont. care. (b)(6)-2 [redacted] 1/7 RN
0600	Drew labs per order. Gave report to next shift. (b)(6)-2 [redacted] 1LT/RN

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* | TIME

TRANSPORTATION TO FACILITY

SEX: M

AGE: 28

DUTY/LOCAL PHONE	
AREA CODE	NUMBER

HOME PHONE	
AREA CODE	NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: Ø

ALLERGIES: 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

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME: 1500

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

VITAL SIGNS

TIME 1500					
BP 112/63					
PULSE 128					
RESP 18					
TEMP 97.9					
WT					

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

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

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

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC					
WBC	11.5		129	103	14		
H/H	13/43		~~135~~		105		
PLT	571		4.6	21	1.1		

ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
SUP O2	PH	PO2	RESULTS	
PCO2	SAT	OTHER		

PT				U/A	DIP		EKG INTERPRETATION
APTT	BHCG	ETOH	GLU		MICRO		

PROVIDER HISTORY/PHYSICAL

27yo ♂ EPW brought back from EPW camp for DRNG @ CT site. Pt seen here + D/C'd yesterday. CT pulled by Dr [redacted]. (b)(6)-2

(b)(6)-2 [redacted] - C
(b)(6)-2 [redacted] - CT
Porcemotho 20CT03

O: ↓ BS ® side ō scattered rhonchi.

Alert + stable

CXR ® ® hemothorax

A: See gen. surg note.

P: Admit.

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

[redacted] (b)(6)-2

PROVI[redacted] AND STAMP

[redacted] (b)(2)-2

CODES

DIAGNOSIS

See "A"

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

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

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

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)* 20CT03	TIME 0128
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY AIR	

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE 28	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

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

CHIEF COMPLAINT Ø PSH Ø PMH GSW (R) flank Back

CATEGORY OF TREATMENT		VITAL SIGNS					
☒ EMERGENT	TIME 0128	TIME 0128	0135	0140	0155		
		BP 135/85	138/65		120/61		
☐ URGENT		PULSE 114	96	100	89		
	INITIALS	RESP 32	23	30	30		
☐ NON-URGENT		TEMP		98.3			
		WT					

LAB ORDERS					X-RAY ORDERS		
X	CBC/DIFF	ABG	X PT/PTT	BHCG/URINE/BLOOD/QUANT	X	CXR PA & LAT/PORTABLE	C-SPINE
	URINE C&S X	UA MSCC/CATH	X	CHEM: 12	X	ACUTE ABDOMEN	LS SPINE
X	BLOOD C&S X 2/hour 6		X	1 hr 65		SINUS	HEAD CT
						ANKLE R/L	

ORDERS

☒ PULSE OX 87, 97, 100 (b)(6)-2 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0140	50mg Ketorolac IV	[redacted]	Lt [redacted]	0140	(b)(6)-2
	Fentanyl 50mg IV (b)(6) [redacted]	0150			
	Fentanyl 50mg IV [redacted] (b)(6)-2	0200			

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

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶	TO	WHEN
☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATE	TIME OF RELEASE	I have received and understand these instructions.		
PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name – last, first, middle; ID no. (SSN or other); hospital or medical facility)*		PATIENT'S SIGNATURE		

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

[redacted] (b)(6)-4

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER [redacted] (b)(6)-2

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

Hema check (-)

28 yo ♂ seen by Iraqi hospital for GSW to (P) chest (back). Hx unclear. Pt states he was shot accidentally by another Iraqi teenager approx 1700 tonight. CT placed. Sent to 28th CST 2° to investigation by QRFs. Pt c/o SOB, ∅ N/V/Abd pain

O: A&O x1 – mod distress. VS 5.

Head: OP/NA clear pat mucosa neck supple, ∅ trach dev. aps clear

Chest ↓BS (P) side c̄ diffuse coarse sounds. (L) CTA

CT – place c̄

Abd: soft, BS+, NT

Ext: (P) 2 rad pulses (B) from arms/shoulders (B)

(P) to 66

Pulse NL

A/P GSW to back Stable → admit ICU

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

(b)(6)-2 [redacted]

PROVIDER SIGNATURE [redacted]

DIAGNOSIS

GSW to chest back

CODES

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

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

[redacted] (b)(6)-4

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		3															
POST- DAY																	
MONTH-YEAR Oct	DAY	5 Oct		6 Oct		7 Oct		8 Oct									
2003	HOUR	1 1 2		0 2 0		0100		0200									
PULSE (O)	TEMP. F (•)	1 9 3		0 0 2				9									TEMP. C
	105°	1 0 0		0 0 0				0 0									40.6°
180	104°	0 0 0															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		2 0		2 0		1~~20~~ 19		2 0									
BLOOD PRESSURE		128/71		128/71		124/72		P92	128/74	126/72							
		H94		89				T 99.5		H111							
		T 98.6						S 103		T 97							
HEIGHT:	WEIGHT →	95%	94%	95				92		92%							
		RA	4LNC						91%	RA							
		4L NC							(RA)								
		123/74		122/73													
		93% (RA)		POX													
		4LNC		90%													

Record special data only when so ordered

(Centigrade Equivalents, for Reference only)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)* 3L NC

REGISTER NO.

WARD NO.

C# [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

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

LAST, FIRST, MI: (b)(6)-4 [redacted]	DATE: 90ct03	TIME: 1505	SSN/PSEUDO SSN: ID# [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		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

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

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l

======= PICCOLO =======
09/10/03 15:17
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(b)-4
METLYTE 8
DISC LOT #: (b)(b)-2 3151AA1
OPER # [redacted] DR #: 000
SERIAL #: [redacted] (b)(b)-4

GLU	105	73-118	MG/DL
BUN	18	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	135	39-380	U/L
NA+	129	128-145	MMOL/L
K+	4.6	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

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)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Methyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

(b)(b)-2

Ward/Section: EMT	REQUESTING [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI: [redacted] (b)(b)-4		DATE: 20CT03	TIME: 0128	SSN/PSEUDO SSN: [redacted] (b)(b)-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 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			

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

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

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

Ward/Section: Ward 1	REQUESTING PHYSICIAN: DR [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 20 Oct	TIME: 1515	SSN/PSEUDO SSN: [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		

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 20 Oct 03	LAB ID NO.:

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

LAST, FIRST, MI. # [redacted] (b)(6)-4	DATE 4OCT03	TIME 1935	SSN/PSEUDO SSN:

(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		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: Blood culture

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

======= PICCOLO =======
10/02/03 01:49 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(6)-7...

GLU	112	73-118	MG/DL
BUN	19	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	583*	39-380	U/L
NA+	142	128-145	MMOL/L
K+	5.0*	3.3-4.7	MMOL/L
CL-	107	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

(b)(6)-4

ID [redacted] 02-10-03
WB 01:53

			Patient Limits	
WBC	24.4 H	x10^3/uL	4.5	10.5
RBC	4.93	x10^6/uL	4.00	6.00
Hgb	14.8	g/dL	11.0	18.0
Hct	45.9	%	35.0	60.0
MCV	93.2	fL	80.0	99.9
MCH	30.0	pg	27.0	31.0
MCHC	32.2 L	g/dL	33.0	37.0
Plt	248.	x10^3/uL	150.	450.
LY%	5.4 *L	%	20.5	51.1
LY#	1.3 *	x10^3/uL	1.2	3.4

======= PICCOLO =======
02/10/03 01:50
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] (b)(6)-2 DR #: 000
SERIAL #: [redacted]
.....(b)(6)-7.....

ALB	3.7	3.3-5.5	G/DL
ALP	61	26-84	U/L
ALT	182*	10-47	U/L
AMY	21	14-97	U/L
AST	107*	11-38	U/L
TBIL	2.3*	0.2-1.6	MG/DL
BUN	22	7-22	MG/DL
CA++	8.9	8.0-10.3	MG/DL
CHOL	117	100-200	MG/DL
CRE	1.1	0.6-1.2	MG/DL
GLU	111	73-118	MG/DL
TP	7.0	6.4-8.1	G/DL

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

[redacted] (b)(6)-4 09-10-03
15:17

			Patient Limits	
WBC	16.5 H	x10^3/uL	4.5	10.5
RBC	5.04	x10^6/uL	4.00	6.00
Hgb	13.5	g/dL	11.0	18.0
Hct	48.7	%	35.0	60.0
MCV	96.6	fL	80.0	99.9
MCH	29.1	pg	27.0	31.0
MCHC	31.0 L	g/dL	33.0	37.0
Plt	511. H	x10^3/uL	150.	450.
LY%	23.5 *	%	20.5	51.1
LY#	2.7 *	x10^3/uL	1.2	3.4

(b)(6)-4

[redacted] 02-10-03
15:30

			Patient Limits	
WBC	16.1 H	x10^3/uL	4.5	10.5
RBC	5.11	x10^6/uL	4.00	6.00
Hgb	15.0	g/dL	11.0	18.0
Hct	47.2	%	35.0	60.0
MCV	92.3	fL	80.0	99.9
MCH	29.3	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	239.	x10^3/uL	150.	450.
LY%	16.4 *L	%	20.5	51.1
LY#	2.6 *	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/02/03 01:54 AM

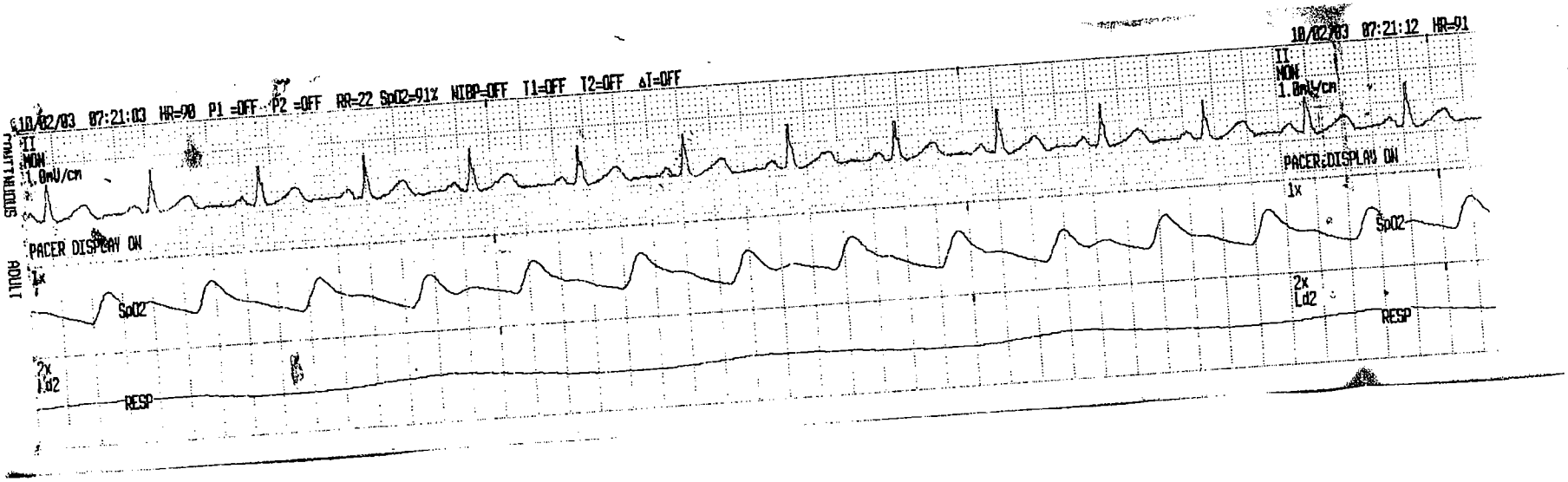
Patient ID [redacted] (b)(6)-4
Test Name :PT
Test Result:= 14.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.26
Sample Type:citrated wh. blood
Test Date :10/02/03
Test Time :01:52 AM
Card Lot :040302
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 10/02/03 01:56 AM

Patient ID [redacted] (b)(6)-4
Test Name [redacted] (b)(6)-4
Test Result:= 26.6 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :10/02/03
Test Time :01:54 AM
Card Lot :100208
Operator [redacted] (b)(6)-2

[redacted] (b)(6)-4 04-10-03
WB 20:18

			Patient Limits	
WBC	12.8 H	x10^3/uL	4.5	10.5
RBC	4.17	x10^6/uL	4.00	6.00
Hgb	12.4	g/dL	11.0	18.0
Hct	38.8	%	35.0	60.0
MCV	92.9	fL	80.0	99.9
MCH	29.7	pg	27.0	31.0
MCHC	32.0 L	g/dL	33.0	37.0
Plt	246.	x10^3/uL	150.	450.
LY%	16.2 *L	%	20.5	51.1
LY#	2.1 *	x10^3/uL	1.2	3.4



ADULT
PROMPT MALFUNCTIONS

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 10/2/03 TIME OF ORDER _____ HOURS

LIST TIME ORDER NOTED AND SIGN

1) Wean O2 to NC sat > 92%
2) CT to wash [illegible]
3) Albuterol neb 2.5 [illegible] / 3.0 [illegible] Co Q 40
4) [illegible]
5) [illegible] today
6) [illegible] as tolerated

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER [redacted] OF ORDER [redacted] HOURS

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 10/2/03 TIME OF ORDER _____ HOURS

1) [illegible]
2) [illegible] 2W [illegible]
3) CT chest w/o IV contrast [illegible] return [illegible] VS [illegible]

[redacted] (b)(6)-7

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER [redacted] TIME OF ORDER [redacted] HOURS

[redacted] (b)(6)-2

020CT03 2315

① Nonrebreather mask now

② ABG now (b)(6)-2 (b)(6)-2

V.O. Dr [redacted] / ILT [redacted], AN

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

Voted 020ct03 2320 [redacted]

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

DATE OF ORDER: 2 Oct 03 TIME OF ORDER: 2359 HOURS

1. Tagamet 300mg IVPB q6°

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

NURSING UNIT: 24° Chart Check ROOM NO. BED NO. (b)(6)-2 Mark Fraley LT/AN 030ct03 0530

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

DATE OF ORDER: 3 Oct 03 TIME OF ORDER: HOURS

1) Hyperventilate prior to bath.
Cough deep breath q1°
2) ATS exercise q2°
3) Incentive Spirometer 5x q1° while awake

[redacted] (b)(6)-2

NURSING UNIT ROOM NO. BED NO.

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 03 Oct [redacted] TIME OF ORDER: 1400 HOURS

V.O. [redacted]
Wean off NR to NC 2-4L to keep O2 sat ≥92%

24° chart (b)(6)-2 [redacted] 4 Oct 0100 [redacted] Maj/AN

(b)(6)-2

NURSING UNIT ROOM NO. BED NO.

PATIENT IDENTIFICATION

Noted [redacted] (b)(6)-2 5 Oct 1900

DATE OF ORDER: 4 Oct 03 TIME OF ORDER: HOURS

PA/Lat CXR in 4° to r/o pneumo

(b)(6)-2 [redacted]

NURSING UNIT ROOM NO. BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 4 Oct 03 TIME OF ORDER: 2020 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Blood Cx / CBC now. 1935
2. Tylenol 650mg po q4° PRN 1935
3. q4° VS.
4. D/C IVF per Oncol (b)(6)-2 [redacted] 1940

(b)(6)-2

[redacted]

(b)(6)-2

PATIENT IDENTIFICATION

0200 SOA [redacted]

(b)(6)-2

DATE OF ORDER: 04 OCT 03 TIME OF ORDER: 2320 [redacted] HOURS

1) Transfer to ZCU
2) Dx S/P GCW to Chest
3) Vitals Q4° with Sat check
4) Activity OOB Ambulatory
5) Diet Regular
6) IV heparin

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: HOURS

7) Incentive Spirometry 5x Q1° while awake
8) Albuterol 2.5/3.0cc Neb Q6° for 72°
9) MEDS
Percocet 1-2 Tab PO Q4° PRN
Levofloxacin 500mg PO QD
10) PA/lat CXR QAM

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: HOURS

11) Critical no Systolic, SBP>180 cy q2
Sat <90%
12) 4L NC.

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

[redacted] 5ZCU 2300

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

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4 E# [redacted]				8 Oct 03	_____ HOURS	
				1) D/C to EPW Camp		
(b)(6)-2 Noted [redacted]				[redacted] (b)(6)-2		
NURSING UNIT	RO[redacted]	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER _____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6
03 Oct	[redacted]	Incentive spirometry	06	/	[redacted]		
(b)(6)-2		5X q 1° while	18	[redacted]			
		awake	X				
			X				
03 Oct	[redacted]	Wean off NR	06				
(b)(6)-2		to 2-4L NC to	18	[redacted]		Repeat order	
		maintain O2 sat	X				
		≥ 92%	X				
3 Oct	[redacted]	NI switching q8°	06				
(b)(6)-2			18	[redacted]		DC'd 4 Oct 03	
			/				
04 OCT 03	[redacted]	VS Q4°	06	/	[redacted]		
(b)(6)-2			18	[redacted]			

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: DOA 02 Oct 03
3 PGSW to chest & back

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO: 2

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

(b)(6)-2

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — 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 5	6	7	8
05OCT (b)(6)-2	[redacted]	IV heplock	06	[redacted]	NO IV		
			18	[redacted]	6 Oct 03 @ 1000		
		(b)(6)-2					
05OCT (b)(6)-2	[redacted]	Albuterol [redacted] 2.5/3.0 cc Neb q 6° for 72°	06	[redacted]			
			12	[redacted]			
			18	[redacted]			
			2[redacted]	[redacted]			
05OCT (b)(6)-2	[redacted]	Levoflaxen 500mg PO qd	10	[redacted]			
05 Oct (b)(6)-2	[redacted]	4l NC (wean off O2)	06	[redacted]			
			18	[redacted]			
			18	[redacted]			
			20	[redacted]			
(b)(6)-2	[redacted]						
(b)(6)-2 05OCT [redacted] 8 Oct	[redacted]	Percocet 5-325 tabs PO q4-6° PRN	D/[illegible]	600	700		
			D/[illegible]	200	200		
			[illegible]	2	2		
			[illegible]	[redacted]			

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW to Chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

(b)(6)-2

1. Reporting MTF (b)(2)-2 [redacted]	2. MTF L[illegible]n IZ	Admissio[illegible]d Coding Information For use of this form, see AR 40-400; the proponent agency is OTSG	
3. Register Number [redacted] (b)(6)-4	Name (Last, First, MI) (b)(6)-4 [redacted]	4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD) 1977-01-01	7. Age at Admission 26Y	8. Race X	9. Ethnicity 9	Religion ISLAMIC
10. Length of Service	ETS	11. FMP 20	12. Social Security Number [redacted] (b)(6)-4
Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES	16. Zip Code of Residence:	
17. Unit Location IZ	18. MOS	19. Trauma DIS	Prev. Admission NO
20. Source of Admission Direct from ER	Ward: ICU1	Name / Relationship of Emergency Addressee Address of Emergency Addressee	
Name and Location of Medical Treatment Facility: 0580 - 28th CSH - Iraq; No Install Provided		Telephone Number of Emergency Addressee	
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-10-08	
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-10-02	
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-10-02	

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW TO THE ~~ABDOMEN~~ Chest
Hemothorax
Pulmonary contusion

Procedure Narrative(s):

Cause of Injury Narrative:

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

9	10	11	12	13	14	15

4. PAY GRADE: 16 17

5. SEX: 18

6. DATE OF BIRTH (YYYYMMDD): 19 20 21 22 23 24 25 26

7. AGE AT ADMISSION: 27 28 29

8. RACE: 30

9. ETHNIC BACK-GROUND: 31

RELIGION

10. LENGTH OF SERVICE: 32 33 34

ETS

11. FMP: 35 36

12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS: 46

HOUR OF ADMISSION

BRANCH / CORPS

14. FLYING STATUS: 47 48 49

15. BENEFICIARY CATEGORY: 50 51 52

16. ZIP CODE OF RESIDENCE: 53 54 55 56 57 58 59 60 61

17. UNIT LOCATION (State or Country Code): 62 63

18. MOS: 64 65 66 67 68 69 70

19. TRAUMA: 71

PREV. ADMISSION YEAR

☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72

WARD

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74

22. MTF TRANSFERRED TO: 75 76 77 78 79 80

23. DATE OF DISPOSITION (YYMMDD): 81 82 83 84 85 86

24. CLINIC SVC - ADMITTING: 87 88 89 90

25. MTF TRANSFERRED FROM: 91 92 93 94 95 96

26. DATE THIS ADMISSION (YYMMDD): 97 98 99 100 101 102

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 103 104

28. MTF OF INITIAL ADMISSION: 105 106 107 108 109 110

29. DATE INITIAL ADMISSION (YYMMDD): 111 112 113 114 115 116

FOR LOCAL USE

Dx 86131
8603
E9912

Pr: 3404
9394

Inj Trauma
450 1

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 89

EDITION OF MAY 79 IS OBSOLETE

USAPPC V1.00

CLINICAL RECORD

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

Mo. ____ Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	4	5	6	7	8
2Oct	[redacted]	Chest tube to suction	08	[redacted]							
			18	[redacted]							
2Oct	[redacted]	Routine VS 1 & O	06	[redacted]							
			18	[redacted]							
2Oct	[redacted]	PCXR @ 0400 qAM	04	[redacted]							
2Oct	[redacted]	NPO	06	[redacted]							
			18								
2Oct	[redacted]	Incentive Spirometer q 2hrs	06	[redacted]							
		while awake	18	[redacted]							
2Oct	[redacted]	wean O_2 to NC SAT >92	06	[redacted]							
			18	[redacted]							
2Oct	[redacted]	up in chair	06								
			18	[redacted]							
2Oct	[redacted]	Clear liquid diet	06	[redacted]							
		AAT Regular	18	[redacted]							
2Oct	[redacted]	Place foley cath	06	[redacted]							
2 Oct	[redacted]	foley care q S	18	[redacted]							
			X								
3Oct03	[redacted]	Hygiene and pulmo	06	[redacted]							
	[redacted]	vary toilet q 1°	18	[redacted]							
3Oct03	[redacted]	Cough + deep breath	06	[redacted]							
			18	[redacted]							

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p GSW (R) chest/back = hemothorax

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 1

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

(b)(6)-2 all.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
02OCT03	[redacted]	Admit ICU	02OCT03		0535	[redacted]
	-----	Stable	02OCT03		0535	[redacted]
20ct	[redacted]	CBC q 4° X3 start @ 0600	20ct	0600	0545	[redacted]
20ct	[redacted]	CT chest with contrast	↓	1000	Not Done	[redacted]
	-----		↓	1400	1520	[redacted]
20ct	[redacted]	CT chest & contrast	20ct	TODAY		
20ct	[redacted]	ABG Now	20ct	Now	2315	[redacted]
020ct	[redacted]	↑ in chair today	020ct			
020ct	[redacted]	Dr [redacted] is attending	020ct			
04OCT	[redacted]	Blood C/ CBC now	04OCT	NOW	1935	[redacted]
04OCT	[redacted]	PA/lat CXR in 4° to R/o pneumonia	04OCT			

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	8
5OCT	[redacted]	USq 4° with Sat	06	[redacted]			
		Check	18	[redacted]			
5OCT	[redacted]	Act OOB amb	06	[redacted]			
			18	[redacted]			
5OCT	[redacted]	Diet Regular	06	[redacted]			
			18	[redacted]			
5OCT	[redacted]	Incentive Spirometer	06	[redacted]			
		5x q1° while	18	[redacted]			
		awake	/				
0CT05	[redacted]	PA/LAT CXR	05	/ [redacted]			
		qam	/				
05OCT	[redacted]	4L NC	06	[redacted]			
			18	[redacted]			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW to Chest

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Oct Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10/5	[redacted]	Transfer to ICW				
08 OCT 03	[redacted]	D/C to EPW camp				

(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
	[redacted]	Contact MD T >101.8														
		SBP > 180														
		Sat < 90%														

(b)(6)-2

CLINICAL RECORD

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

Mo.____ Yr. ____

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2	3	4	5	6	7	8	9	10
b)(b)-2 20ct	[redacted]	IVF: LR @ 75cc/hr	08	[redacted]								
			16	[redacted]								
b)(b)-2 20ct	[redacted]	Ancef 1g IVPB q 8°	08	[redacted]								
			16	[redacted]								
			24	[redacted]								
		MSO4		error								
(b)(b)-2 20ct	[redacted]	Zantac 50mg IV Q8°	00	[redacted]								
			14	[redacted] DC'd Replaced by								
			24	Tagamet [redacted]								
(b)(b)-2 20ct	[redacted]	Albuterol Neb 2.5cc/3.0	06	[redacted]								
		cc Q4h	10	[redacted]								
			14	[redacted]								
			18	[redacted]								
			22	[redacted]								
			02	[redacted]								
20ct03		10L NR Mask	06	[redacted] DC'd								
			18	[redacted]								
b)(b)-2 20ct03	[redacted]	Tagamet 300mg IVPB	06	[redacted]								
		q 8°	12	[redacted]								
			18	[redacted]								
			24	[redacted]								

b)(b)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/p GSW @ chest/back = hemothorax

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. ____ Yr. ____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
(b)(6)-2 2Oct	[redacted]	Lasix 20mg IV	2Oct	1630	1630	[redacted] (b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
(b)(6)-2 2Oct	[redacted]	MSO4 2-4mg IVP	D	2Oct 0600	2Oct 0700	2Oct 0830	2Oct 1100	2Oct 1530	2Oct 1630	2Oct 1730	2Oct 2045	2Oct 2300	3Oct 0004	3Oct 0155	4Oct 0700	4Oct 1130	
		q 30 min PRN pain	T	0507 4mg	4mg	3mg	3mg	4mg	3mg	3mg	iV	[redacted]					
			I	[redacted]													
				3Oct 1400	3Oct 1930	3Oct 2000	3Oct 2330	4Oct 0100	4Oct 0220								
				3mg IV	3mg	4mg	3mg	4mg	4mg								
(b)(6)-2 04OCT03	[redacted]	Tylenol 650mg po Q4° pm	D	04Oct	[redacted]												
			T	1925													
			I	[redacted]													

(b)(6)-2

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

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

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

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0240	INTILA [redacted]	(b)(6)-2	INTILAS		INTILAS
	PUPLIS	3mm PERRLA					
	SENSORIUM	Able to speak some English + express needs					
RESPIRATORY	RESPIRATION PATTERN	Equal chest rise, Tachypnea RR 30s, BS clear @ LL					
	BREATH SOUNDS	diminished @ Lobe + RLL					
	SECRETIONS	0 secretions noted @ this time					
SKIN	COLOR	WNL for race. Chest tube to continuous suction @ Mark Drg C.D.I					
	INTEGRITY						
IV SITE	LOCATION	PIV @ AC + @ AC ENS					
	CONDITION	@ KVO. 0 S/S of infection Patent.					
GASTRO	ABDOMEN	soft, nontender					
	BOWEL SOUNDS	(+) normal in all 4 quad.					
GU	URINE	urinal, dark yellow urine					
	COLOR/CLARITY						
CARDIOVASCULAR	CARDIACRHYTHM	SR c 0 S/S of ectopy HR 80s + 2 palpable pulses + ≥3sec cap refill in all ext.					

LEGEND

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

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CINC 1441

DATE 02 OCT 03

PATIENT'S INDICATIONS *(For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)*

(b)(6)-4 [redacted]

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

0248 → 02

DATE	DX	03	04	05	~~06~~														HOSPITAL DAY
VITAL SIGNS TIME	~~24~~	~~01~~	~~02~~	03	04	05	06	07		08	09	10	11	12	13	14	15		
BP Arterial line	129																		
BP Cuff	60	127/69	104/61	124/72															
Temperature	99.2	99.2		98.4															
Pulse	80	88	73	78															
Respiratory Rate	32	30	26	31															
SpO2	100	96	99	100															
Source	NRB	NC	NRB	NRB															

INTAKE TIME	~~24~~	~~01~~	~~02~~	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	02	03	04	05	~~06~~													
IVF (UR)	75	75	75	75					300									
IVPB									0									
TOTALS									300									

OUTPUT																		
URINE	HOUR / TOTAL	~~650~~ 650							~~650~~									
	SP gr																	
	S/A																	
~~NG~~	OUTPUT																	
	PH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS	~~Chest tube~~	23			73				96									
TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

14	17	18	19	20	21	22	23

INTAKE

14	17	18	19	20	21	22	23	8°T

OUTPUT

RESPIRATORY DATA

TIME										
MODE										
F_IO_2										
TV										
RATE										
PEEP										
A: pH										
A: PCO_2										
B: pO_2										
B: HCO_3										
G: SAT										
G: BASE										

LABORATORY DATA

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

ACTIVITIES DAILY LIVING

TIME										
MOUTH CARE										
BATCH										
SKIN CARE										
FOLEY CARE										
TRACH CARE										
ROM EXERCISES										

TURN SUCTION

TIME										

24*180 TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

TOTAL 3000

OUTPUT

Urine: _____

TOTAL 746

-446

NURSE'S SIGNATURE [redacted] INITIALS

(b)(6)-2

(b)(6)-2

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

			INITIAS		INITIAS		INITIAS
NEURO	0615 TIME	[illegible]					
	PUPLIS	PERL 3 mm bilat				PERRL 3mm	
	SENSORIUM	AAO.				AAOX3	
		Active ROM to				Active ROM to	
		All EXTREMITIES				X4 extremities	
RESPIRATORY	RESPIRATION PATTERN	15-27 Reg.				Clear & diminished	
	BREATH SOUNDS	Clear & Diminished (R) base				bases	
	SECRETIONS	Ø				4L NC SpO2 @ 95%	
		Sat 92-100% on 10L				chest tube to (R)	
		NRB. Mask.				chest wall drainage	
		chest tube to (R) chest wall				sanguinous fluid	
SKIN	COLOR	Normal				NPR BSW to (R)	
	INTEGRITY	Intact except for				side back & chest	
		BSW (R) side/back to chest				tube.	
IV SITE	LOCATION	(L) hand				(L) AC & LR @ 75cc/hr.	
	CONDITION	Patent. LR 75h				(R) side H/L to (R)	
		(R) left AC				AC (+) Flush Ø	
						S/S of infection	
						Redness	
GASTRO	ABDOMEN	Nontender, Soft to touch				Soft, round	
	BOWEL SOUNDS	(+)				nontender. (+)	
						BS X4 quad	
GU	URINE	Uses urinal				Foley draining	
	COLOR/CLARITY	Not seen				to gravity clear	
						yellow	
CARDIOVASCULAR	CARDIACRHYTHM	SR. HR 80's All				S1, S2 (+) pulses	
		peripheral pulses (+)				X4 good	
		BP 132 (-) JVD or edema					
		(-) chest pain.					

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

(Continue on reverse)

[redacted] (b)(6)-2 | DEPARTMENT/SERVICE/CINC ICU | DATE 02 OCT 03

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

(b)(6)-4 [redacted]

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
BP Arterial line																		
BP Cuff	116/60	118/70	123/77	117/67	113/60	118/67	116/67	113/78		136/78	123/64	121/66	121/73	119/64	114/67	119/69	124/76	
Temperature	98.3				98.2					98.4				100.1				
Pulse	71	90	95	82	80	81	107	83		93	98	85	83	87	97	92	114	
Respiratory Rate	21	23	22	18	18	17	19	19		22	24	20	20	20	25	26	34	
O2sats	100	100	100	97	96	97	96	98		99	97	94	95	94	95	95	94	
Source	NRB	NRB	NRB	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	
		10L	10L	4L	4L	4L	4L	4L		4L	4L	4L	4L	4L	4L	4L	4L	

INTAKE

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
IVF	75	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	
IVPB			100									100						
PO							240	240		240			500	100 / 200				
TOTALS	75	75	175	75	75	75	315	315		315	75	175	575					

OUTPUT

URINE	HOUR / TOTAL											500 / 500						
	SP gr																	
	S/A																	
NG	OUTPUT																	
	PH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS	CT													130				
TOTALS																		

POST-OP DAY

VITAL SIGNS									
	22	23	24	01	02	03	04	05	
	129/62	125/69	118/69	131/61	124/71	123/59	129/71	111/68	
	101.5	101.4		100.8					
	101	106	96	87	90	88	92	100	
	31	26	31	23	40	23	30	36	
	97	95	97	100	96	95	96	99	
	NC	NC	NR	NR	NR	NC	NR	NC	
	4L	10	10	10	10	10	10	10	

INTAKE	14	17	18	19	20	21	22	23	8°T
	75	75	75	75	75	75	75	75	
		180							

OUTPUT									

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
	TIME		0800	2330						
	MODE		NRB	PRB						
	F_IO_2		10L	70						
	TV			—						
	RATE			28						
	PEEP			—						
ABG	A	pH		7.38						
		PCO_2		42						
	B	pO_2		76						
		HCO_3		25						
		SAT		93						
	G	BASE		0						

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

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

TURN	TIME					
SUCTION						

24 HR TOTALS

WT Yesterday _____ wt Today _____

INTAKE

IV _____

Po _____

OUTPUT

Urine: _____

TOTAL _____

BALANCE

NURSE'S SIGNATURE | INITIALS

MEDCOM - 20813

Patients Name: [redacted] (b)(6)-4 Date: 4OCT05

ITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
.ine																										
P	108/64	121/54	117/59		127/63	134/75	125/66					110/49		123/51	106/51	118/59		134/63				104/62				
MP	99.0								100.0					101.1	100.4	100.0		99.7				99.2				
	103	86	99	106	87	128	117	110	107		110	97		107	110	114		105				92				
	(45)	(80)	30	22	27	27	25	29				24		23	32	36		25				31				
)2	96	96	96	98	98	98	91	96	95		94	95		95%	95%	91%		94%				93%				
)2	FM		FM	NC	NC	NC	NC	NC	NC		NC	NC		NC	NC	NC		NC				NC				
urce	9	6L	6L	7L	4L	4L	4L	4L	4L		4L	4L		3L	4L	4L		4L				4L				
P	82	83	83		85	96	86	0			0	75		90	75	83		90				79				
															Gauze + tape @ 1900											

KE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
	75	75	75	75	75	75	75	75	75	DC	DC		~~825~~													0
			50										500			900				1000						1500
														1200				3600				1800				6600
				240																						
										DC IV																
Total													875 ~~825~~													8100

TPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
NE			1700						200				1900	600								600				2100
OL																										
IN									Jerky Beef																	
Total													1900													2100

Total in: 1685 total out: 2100 (-415)

MEDCOM - 20814

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0800 Initals [redacted] (b)(6)-2	Time: 1800 Initals [redacted] (b)(6)-2
NEURO	Pupils	PERRLA	PERRLA 3mm brisk
	Sensorium	alert + oriented	alert, able to follow commands
	LOC / GCS	Verbalize needs	+ express needs
CARDIAC	Cardiac Rhythm	SR, 100↓ S1 S2	SR HR100s S1S2, Ø ectopy
	PRI: / QRS:	Ø ectopy	noted. +2 palpable
	Pulse Strength	++ radial + pedal	pulses in all ext. cap refill
	Cap Refil / JVD	<3 seconds	<3sec in all ext. Ø edema
	Edema	Ø	noted. Denies chest pain but
	Chest Pain	denies ✗ chest tube	c/o tenderness on (R) side chest
	(non cardiac)	site + pain R/t tender	+ side
RESP	Respiratory Pattern	RRR, shallow breathing	tachypnea RR30s, shallow
	Breath Sounds	CTA ↓ BS (R) side	breathing. ↓ BS (B) ↓ lobes
	Secretions	↓ air exchange	Ø secretions noted @ this time
	Cough	throughout	IS q 1°
		C+DB, IS	
SKIN	Color	WNL	WNL for race. Drsg (R) chest
	Integrity	GSW entry site back	+ Plant C, D, I
	Backside	exit (R) side below	
		the nipple CT (R) MA side	
IV	Access Devices	(R) IV (L) AC D+I	(R) AC ≈ Ø s/s of infection
	Location	(L) PIV LR @ 75 + IVPB	H.L. patent.
	Condition	patent (R) AC	
GI	Abdomen	Bilateral BS	Distended, tender (R) side
	Bowel Sounds	active	(+) BS small quad
	Stoma/Ostomy	Ø	
GU	Device	foley to gravity	urinal, dark amber
	Color / Clarity	clear amber	urine ≈ Ø sediment

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC: ICU3, 28th Combat Support Hospital

DATE: 4 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

ICU1

Patients Name:

Date: 3 OCT 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	126/64	120/66	129/68	124/75	122/66	116/61	133/72	116/60	119/72	115/62	124/61	114/60		118/60	130/60	122/55	137/94	133/63	121/61	122/63	131/63	124/59	124/58	120/60	121/50	
TEMP	100.6					100.6			100.6																	
HR	85	92	91	99	95	83	86	86	92	87	92	92		119	92	96	101	104	97	97	99	98	107	98	98	
RR	28	23	26	30	22	21	35	22	51	21	51	27		30	32	30	38	40	28	26	32	30	35	24	42	
SaO2	96	92	93	92	96	98	94	96	96	87	96	97		93	91	94	95	92	93	90	93	90	93	96	94	
FiO2	NR	NR	NR	NR	NR	NR	NR	NR	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	NC	N	SM	SM	
Source	FM		92		96	100%	97	96	96																	
MAP	88																									
FiO2									4L	4L	4L	4L		4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	6L	6L	

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF	75	75	75	75	75	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	75	75	75	75	
IVPB																										
NGT																										
PO								150				150														
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05
URINE	50					200 450						600	850	850											
NGT																									
STOOL																									
DRAIN																									
CT	100											100													
Total																									

MEDCOM - 20816

ICAL RECORD-SUPPLEMENTAL MED DATA

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

OTSG APPROVED (Date) QA Appr 8 Mar 89

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

SHIFT ASSESSMENT

		TIME: 0700 INITIAL [redacted] (b)(6)-2	TIME: INITIALS:
NEURO	PUPILS	PERRLA	PERRL
	SENSORIUM	Awake	A+O x 3
	EXTREMITY MOVEMENT	(+) strong all extremities	Move x4 extremities
	SEDATION	MSO4 4mg @ this time	MSO4 4mg q 30 min PRN
	PAIN CONTROL	well controlled	
RESP	RESPIRATORY PATTERN	UL Bilateral BS	[redacted]
	BREATH SOUNDS	HL (R) ↓ BS (R) chest tube	Slightly labored
	SECRETIONS	none	BS (+) LL dim
	O2 SOURCE/FLOW/SAO2	NR FM	LL
	VENTILATOR SETTINGS	—	
CVS	CARDIAC RHYTHM	SR 91	S1 S2
	CAPILLARY REFILL	< 3 seconds	< 3 sec
	PULSES	Radial + pedal pulses (+)	(+) Pulses x 4 extremities
	EDEMA	(−)	
GI	ABDOMEN	Hyperactive BS	(+) BS x4 quad
	BOWEL SOUNDS	soft none tender	soft round nontender
	BOWEL MOVEMENT	Ø	
	NGT/OGT	Ø	
	TUBE FEDDINGS	Ø	
	DRAINS	Ø	
GU	VOIDING	foley to gravity	Foley to gravity
	COLOR/CLARITY	clear brownish yellow	dark yellow clear
SKIN	COLOR	WNL for race	WNL for race
	INTEGRITY	(R) mid axillary CT site GSW (R) upper back entry wound (R) chest exit wound	CT to (R) chest wall
ACCESS	#1 TYPE/LOCATION/SIZE	# 18	18G to (R) AC ⊂ LR
	DRESSING CONDITION	(R) arm	@ 75cc/hr
	IV FLUID/RATE	LR @ 75 cc/hr	
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Name & Title) [redacted] (b)(6)-2 Maj/AN

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 ICU #1 [redacted]

DATE 03 Oct 02

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

NAME: [redacted] (b)(6)-4 RANK: AGE:

UNIT: [redacted] GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

MEDICAL RECORD SUPPLEMENT

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

OTSG APPROVED (Date) QA APPR 08MAR8

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

INITIAL SHIFT ASSESSMENT

		Time: 0800 Initials [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	PERRLA	
	Sensorium	Alert + Oriented	
	LOC / GCS	Verbalizes needs	
CARDIAC	Cardiac Rhythm	$S_1 S_2$ NSR ↑90 - SR ↓100	
	PRI: / QRS:		
	Pulse Strength	++ radial + pedal	
	Cap Refil / JVD	< 3 seconds	
	Edema	Ø	
	Chest Pain	Ø	
RESP	Respiratory Pattern	BBS, CTA	
	Breath Sounds	↓ BS throughout lower lobe	
	Secretions	(R) side diminished from	
	Cough	mid + lower lobe 2° pneumo	
		C + DB for lung expansion	
SKIN	Color	WNL	
	Integrity	Back entry site CSW +	
	Backside	(R) chest cyst wound, (R) Mid	
		axillary CT site dressing	
IV	Access Devices	(R) AC HL for antibiotic	
	Location		
	Condition	D + I	
GI	Abdomen	BBS soft non tender	
	Bowel Sounds		
	Stoma/Ostomy	Ø	
GU	Device	voiding spontaneously	
	Color / Clarity	g SU clear yellow urine	

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 ICU [redacted]

DATE 05OCT03

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

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78 USAPPC V2.00

ICUS Patients Name: [redacted] (b)(6)-4 Date: 05OCT03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	118/69	118/58			128/65																					
TEMP	99.4	98.8																								
HR	90	102			95																					
RR	14	17			22																					
SaO2	94%	92			95																					
FiO2	4L	4L			4L																					
Source	NC	NC			NC																					
MAP	85				84																					

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
VF																										
VPB	100																									
NGT																										
O																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
RINE																										
GT																										
TOOL																										
RAIN																										
Total																										

MEDCOM - 20819

INPATIENT TRIAGE AND CONTROL

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

1. REGISTRATION NUMBER	2. NAME (Last, First, MI)	3. SERVICE	ADMISSION REMARKS
[redacted] (b)(6)-4	UNK EPW# [redacted] (b)(6)-4	NA	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. STG	10. PREVIOUS ADMISSION
M	26	UNK	UNK	NA	NA	NO

11. PMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted]	(b)(6)-4 NA	ICW I

15. RATING STATUS	16. RATING DGG	17. DEPT. BEN	18. BRANCH/CORPS	19. CIC/ZIP	20. TYPE CASE
NA		NA	NA		NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from Emt	1340	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	24	10/5/03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	10/3/03	(b)(6)-2 Dr [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED
[redacted] (b)(2)-2	10/3/03	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: NASAL FX. 802.0 E886.0

21.71

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. PTD DAYS	f. TOTAL SICK DAYS
0	0	0	0	3	3

36. Total Days All Facilities

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. PTD DAYS	f. TOTAL SICK DAYS
0	0	0	0	3	3

[redacted] (b)(6)-2 (b)(6)-2 SIGNATURE OF CHIEF OF MEDICAL [illegible] OFFICER (b)(6)-2

Dr. [redacted] FOUR [redacted]

DD FORM [illegible]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

26 yo dm EPW playing soccer fell down & broke his nose. Pt c̄ nasal deviation to the pt's left. no septal hematoma

PMH: Ø
PSH: Ø
aller: NKDA
meds: Ø

PHYSICAL EXAMINATION

WDWN 26 yo Im in NAD
NC - PERRL, EOMI
unilateral ecchymosis present
nasal bones deviated to pts left.
Ø septal hematoma. dried blood around nares.
mast smand stable.
Pt missing tooth #9 fell out during fall

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

A/P 26 yo dm EPW c̄ nasal fx.
(1) admit
(2) to OR for SX.

(b)(6)-2

SI [redacted]	DATE 03 OCT 03	IDENTIFICATION NO.	ORGANIZATION

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

[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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
04 OCT 03 cont	ii Percocet administered, Yankour suction @ bedside. Pt 2 point restraints. Will continue to monitor. [redacted] 91WM6 (b)(6)-2 (b)(6)(b) I concur c̄ above assessment. [redacted] (b)(6)-2
4 OCT. 03 1945	Pt A+Ox3, VSS, LS CTA (B), (+)BS x4, Pt tol PO well, voiding ī difficulty, HOB ↑ 30°, pain controlled c̄ percs, steristrips on nose CDI, ø s/sx of poor circulation or skin breakdown on pts of restraint. [redacted] 91W (b)(6)-2 [redacted]
Sat 03 @ 1700	Received pt resting in bed, VSS, tol PO chs, wet adm to reg. Sigs, A+Ox3, ii percocets for pain this shift. Dry to Nose, intact. Suction @ BS. Restraints per RPW pain protocol, ø breakdown noted, ø other remarkable assessments. HOB ↑, ø resp distress noted [redacted] (b)(6)-2
5 OCT 03	2130 = VSS, ø c/o pain @ present time, packed PEG's to (B) nares intact, ø active drainage assessed @ present time, HOB ↑ 30°, IV HL to (R) FA flushed & patent. Continuing IV ancef around the clock, Suction @ BS, X2 restraints c̄ ⊖ skin breakdown, POC = Pain Mgt & palliative care. Will continue to monitor for acute Δ's throughout shift. (b)(6)-2 [redacted] CT/AR
6 OCT 03 @ 1100	Pt D/C w/ meds to MP custody, amb-step and IV d/c. [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

PROGRESS NOTES

DATE	NOTES
3 Oct	Pt brought from EMT to ICW #1, pt has nasal fx head to OR Oct 4, VSS, pt A+OX3, pt c/o pain in (L) knee from old gunshot wound. PERRLA, pulse regular and rate within range for age. swelling around upper nasal region, respiration normal (b)(6)-2 lungs clear bi-laterally, depth is regular & cough, abd soft non-distended, no problems chewing/swallowing voiding & difficult after urine, skin warm/dry no breakdown, circulation intact restraints x2 in place [redacted] (1735) I concur c above assessment [redacted]
3 OCT 03 1145	Pt A+OX3, VSS, LS CTA (B), (+) BS x4, abd soft flat non tender, HOB↑ 30°, pt medicated for pain c̄ 2 percs, swelling noted (L) side of nose, able to breath through (R) nostril, IV (R) FA intact infusing NS @ 125cc/h ø s/sx of infex or infiltration, voiding c̄ diff, ø s/sx of poor circulation or skin break ↓ on pts of restraint. [redacted]
OCT 03 1130	Pt A&O LS CTA (B). [redacted] P/O Nasal repair. S, S2 present (+) BS x4 quads. Liquid Diet. [redacted] Tol PO well. c/o pain

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

PATIENT 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)-2		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b
USAPA V

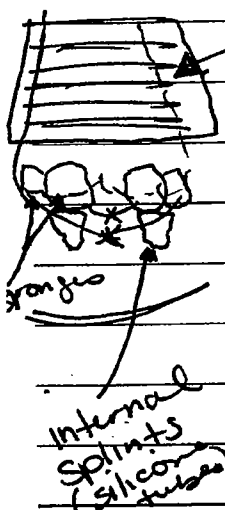
AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

Discharge Summary

05 OCT 03 @ 0915 — 26 yo xem EPW S/P closed reduction of nasal fracture on 04 OCT 03. Pt tolerated procedure well.

D/C cond: stable
D/C Diet: regular
D/C meds: Percocet 1-2 tab po q 4-6° pm pain
Augmentin 1 tab po BID
Afrin 1-2 sprays per nostril BID x 3 days (when nasal packing removed)



Plan
① Please remove internal silicone splints and 4 sponges (2 each nostril) on 07 OCT 03 tuesday.
② Please remove external nasal splint on 11 OCT 03 and remind pt - NO Pressure to nose

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

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

[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	For 4-6 weeks.
	③ use afrin spray x 3 days once nasal packing removed.
	(b)(6)-2 [redacted] MAJ/DC
	cc: OMFS.

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

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING
VIA litter BY anesthesia

2. PATIENT IDENTIFIED AND REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN (b)(6)-2

3. DATE 4OCT03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 0800 NUMBER 2-1 (1)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:
PA & english speaker. No translator available

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

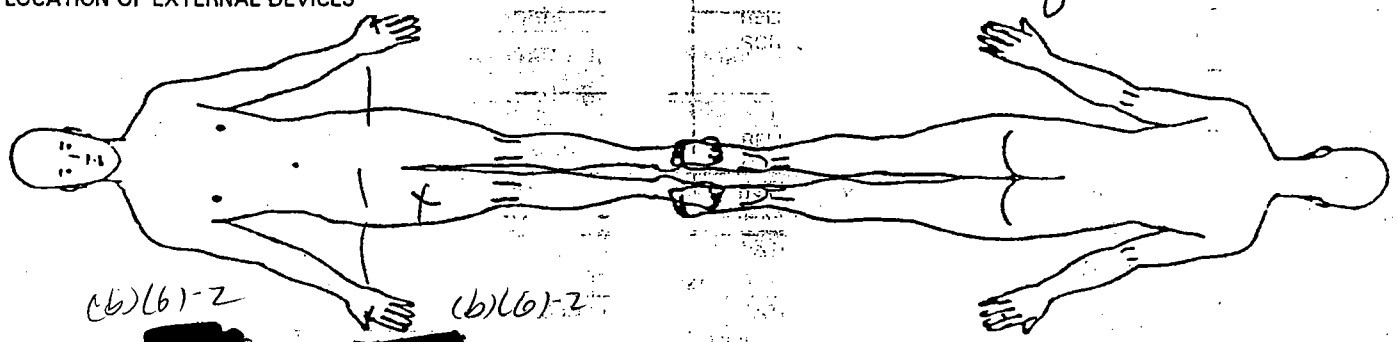
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Beta
SITE: Face BY WHOM: CPT [redacted] (b)(6)-2
SITE: — BY WHOM: —

COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



LEGEND [redacted] Pad — [redacted] p === 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	[redacted]	[redacted]
Needle Sharp	☐ Yes	☐ No	C	/	C	PFC	CPT
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;)*

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

(b)(2)-2
[redacted]
4OCT03

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

☐ ESU NO: CUT Valleylab [redacted] (b)(6)-4
GROUND PAD: BRAND Valleylab E7507
LOT NO [redacted] 2005-02 (b)(6)-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, IMPLANTS ☐ IF YES NAME: ID NUMBE[illegible] URER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Xylocaine ā epi (1:100)	10cc	intraop	inject	[redacted] (b)(6)-2	DR [redacted] (b)(6)-2
Genasal Nasal Spray	QS	intraop	topical	[redacted] (b)(6)-2	DR [redacted] (b)(6)-2
Bacitracin ontment	QS	intraop	topical	[redacted] (b)(6)-2	DR [redacted] (b)(6)

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY

[redacted] NATURE

[redacted] (b)(6)-2

[redacted] 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 (b)(6)-2	

17. TUBES, DRAINS/PACKING YES ☒ NO ☒

TYPE/SIZE	1. Merocel Sinus Pack	2.	3.
SITE	1 (L) + (R) Nostrils	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

- EXTERNAL NASAL SPLINT
- 2x2

19. ADDITIONAL INFORMATION

Splint → PEEL

68L1182 E F520

20. OPERATION(S) PERFORMED

Closed reduction of nasal Fracture.

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU3 (b)(6)-2	0900	litter

22. REGISTERED NURSE SIGNATU[redacted] CPT/AN

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																
POST- DAY																
MONTH-YEAR Oct	DAY	3 Oct		4 Oct		5 Oct										
2003	HOUR	1430	18		20	09	2100									

PULSE (0)	TEMP. F (°)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

		103/47		1 4		1 8		6								
Record special data only when so ordered	BLOOD PRESSURE	62	103/49	108/62	108/61	125/63	112/66									
			67	73	71											
			97.8	99.4	98.8											
	HEIGHT: WEIGHT →		98%	98%	98%		D2 98% 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 — ANESTHESIA

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

DRUG	(Units)	
Fentanyl	(mcg)	150 / 100
Lidocaine	(mg)	100
Propofol	(mg)	150
Sch	(mg)	100
Zofran	(mg)	25
	( )	
VOLAT AGENT: ISO	% del	2.0
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	10 – 2 – 2 – 10

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

FLUIDS

LINE size		
18g (R)	☐ Warmed	NS (1000) ——— 400
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE – Not measured

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 75 KG / LB

HEMATOCRIT:

INITIAL DATA: BP – 126/68; HR – 78

EQUIP CHECK: OK? – Y N

PATIENT RECHECK: OK for PROCEDURE – Okay; TIME – 0745

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

TIME: 0730 15 30 45 0900

MONITORS / ACCESSORIES

		0730	0800	0900	
	VT – ml	–	600	400	600
	f – breaths/min	20	12	8	12
	Peak inf pres / PEEP	–	15	18	–
	MODE – S(pon), A(ssist), C(on)	S	S	C	S
✗ BP/Auto Cuff	✗ ET CO2 (torr)	(+)	36	36	36
✗ BP / oth	✗ FIO2 (Frac or %)	.91	.91	.91	.91
✗ ART line	✗ SpO2 (%)	100	100	100	100
✗ Steth- PC/ES	✗ ECG	SR	SR	SR	SR
✗ Gas analyzer	✗ TEMP- site				
	✗ N-M Block (T/4)	4/4		4/4 twitch	
	Warming blkt				
	Conv warmer				

Mark with letters & symbols, explain under REMARKS — EVENTS: Position — TT 90°

TOTALS: TOTAL FLUID 250 mls; TOTAL URINE Ø

FLUIDS - SUMMARY: CRYSTALLOID – 400; COLLOID – Ø; BLOOD – Ø

REMARKS – Code drugs with numbers, events with letters

0745 Pt. in ICW, To OR via litter. 0900 In room. (+) monitors, (+) O2, Sev. IV, induction, PP gaveled. 0815 10cc 1% Lido c 1:100k Epi injected by surgeon. 0845 Pt reversed c Neostigmine (+) 2cc Robinul. 0853 40mg Narcan, Pt SXW x 2. 0855 Pt awake, extubated, follows commands, moves self to litter, To PACU stable.

RECOVERY AT 0900: PACU / ICU ____ (Specify); OTHER ____; CONDITION: Stable/Awake; RESP – ; SpO2 – 96%; BP – ; HR –

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0745	0800	0905
PROC	Ready	Begin	End
	0840	0823	0852

PROCEDURES and CPT Codes: CR Nasal Bone Fx

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comment — NL x T attempt, Grade I view, #8 ETT, MAC (+) BBS (+) ETCO2 Secured @ 23 lip. Soft tissue block, Atraumatic

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

[redacted] (b)(6)-4

SURGEONS: [redacted] (b)(6)-2; [redacted] CPT Ohwa (b)(6)-2

PROCEDURE LOCATION: OR 2

DATE: 4 Oct 03

PAGE 1 OF 1

WRAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 26 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

ASA Physical State 1 2 3 4 5 E
WT: 75 KG/LB HT: ___ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: CR Nasal/Bone Fx
SURGICAL SERVICE: OMFS
NPO SINCE: Mid

HABITS:
TOBACCO: (+)
ETOH: ___
DRUGS: ___

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) NS @ 125cc/hr
( ) Ancef 1gm
( ) ___
( ) ___
( ) ___
( ) ___

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

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	W/A
Other Significant Hx:	N	Y	Playing Soccer - fall down
	N	Y	Nasal deviation to Left.
Familial HX	N	Y	No Hematoma

ASSESSMENT
PAST SURGICAL/ANESTHETIC
(Ø)

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 ___
HEENT - Teeth ___
Trachea ___
TMJ/Neck ___
Oropharnyx MPII
Nares ___
CHEST: ___
CARDIAC: ___
EXTREMITIES:
IV Access: 18g (R)
Ulnar Filling: ___
BACK: ___
OTHER: ___

NPO Since Mid

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

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the [redacted]gal guardian. (b)(6)-2

The patie[redacted]eems to understand and agrees. Questions answered.
Signed: [redacted] CPT CHMA Date: 4 Oct 03 Time: 0730 Hrs

POST-ANE[redacted]D NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ___ Date: ___ Time: ___ Hrs

Patient Identification: (Ward) ICW 1 9B

#[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.

AUTHORIZED FOR LOCAL REPRODUCTION

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

Admission Note

03 OCT 03 @1845 — 26 years EPW s/p playing soccer + fell + sustained nasal fx. admitted for CR of nasal fx.

(b)(6)-2 [redacted]

04 OCT 03 @ 0845 — OMFS Brief OP NOTE

Pre OP dx: nasal fx
Post OP dx: Same
Procedure: closed reduction of nasal fx.
Surgeon: [redacted] (b)(6)-2
Assist: [redacted] (b)(6)-2
Anesth: GETA
EBL: minimal
fluids: 400cc LR
comp: 0
cond: Stable, extubated and transferred to recovery Serent

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5OCT03	OMS POD #1
@ 0910	Pt doing well s/p closed reduction of nasal fracture ⌀ c/o Pain. no active bleeding noted.
	VSS AF
	will D/C to camp today
	[redacted] (b)(6)-2
	[redacted]

STANDARD FORM 600 (REV. 6-97) BACK

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

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

EPW

[redacted]

(b)(6)-4

NURSING UNIT: ICW1 | ROOM NO. | BED NO.

DATE OF ORDER / TIME OF ORDER / HOURS / LIST TIME ORDER NOTED AND SIGN

03 OCT 03 @ 1340

1. Admit to ICW1 - Dr [redacted] (b)(6)-2
2. Dx: Nasal fx
3. Cond: Stable
4. Vitals: Per routine
5. Aller: NKDA
6. Activ: Ad lib
7. Nurs: HOB T 30°

PATIENT IDENTIFICATION

8. Diet: Regular
   * NPO P MN *
9. IV: NS @ 125cc/hr @ MN
10. meds: Percocet 1-2 tab po q 4° pm pain
11. On call to OR in AM
12. VOID on call to OR in AM
13. Ancef 1gm IV q 8°

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

EPW

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER / TIME OF ORDER / HOURS

04 OCT 03 @ 0845

1. Admit PACU then ICW2 - Dr [redacted]
2. Dx: S/P CR nasal fx
3. Cond: Stable
4. Vitals: Per routine
5. Aller: NKDA
6. Activ: Ad lib
7. Nurs: HOBT 30°

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2 Noted [redacted] 04 OCT 03 1000

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER / TIME OF ORDER / HOURS

Yankauer suction to BS

Δ drip sponge PRN

8. Diet: clears then Regular diet as tolerated
9. IV: HLIV when taking PO
10. meds: Percocet 1-2 tab po q 4° pm po
    Ancef 1gm IV q 8°
    toradol 30mg IV q 6° pm pain

(b)(6)-2 [redacted]

DA FORM 1 APR 79 4256 REPL ... WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
				05 OCT 03 @ 0910 HOURS	
#[redacted] (b)(6)-4					
			1	D/c IV (b)(6)-2	[redacted]
			2	D/c meds	1026
			3	D/c to MP custody.	5 OCT 03
NURSING UNIT	ROOM NO.	BED NO.		(b)(6)-2 [redacted]	

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
			_____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.		

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
			_____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.		

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
			_____ HOURS	
NURSING UNIT	ROOM NO.	BED NO.		

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6	7	8							
10/3	[redacted]	Vitals per Routine	06	[redacted]												
			18	[redacted]												
10/3	[redacted]	Activity: ad lib	06	[redacted]												
			18	[redacted]												
10/3	[redacted]	HOB ↑ 30°	06	[redacted]												
			18	[redacted]												
10/3	[redacted]	Diet: Regular	06	[redacted]												
			18	[redacted]												
04 OCT 03	[redacted]	Vitals: per routine	06	[redacted]												
			18	[redacted]												
04	[redacted]	Activ.: ad lib	06	[redacted]												
			18	[redacted]												
04	[redacted]	Nurs: HOB ↑ 30°	06	[redacted]												
			18	[redacted]												
04	[redacted]	Yankauer suction to	06	[redacted]												
		BS	18	[redacted]												
04	[redacted]	Diet: clears then	06	[redacted]												
		reg diet as tolerated	18	[redacted]												

Pre op

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: S/p CR nasal fx
Nasal Fx

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

(b)(6)-2 all

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	
10/03	[redacted]	Admit to ICW 1-Dr [redacted]	10/3	—	—	[redacted]	
10/3	[redacted]	Condition, Stable.	10/3	—	—	[redacted]	
10/3	[redacted]	NPO p MN	10/3	2400	—	[redacted]	
10/3	[redacted]	On call to OR in Am	10/4	—	—	[redacted]	
10/3	[redacted]	Void on call to OR in Am	10/4	—	—	[redacted]	
04 OCT03	[redacted]	Admit PACU then ICW2-Dr [redacted]	04 OCT03	—	—	[redacted]	
04	[redacted]	Cond.-stable	04	—	—	[redacted]	
05	[redacted]	D/C to MP custody	05	—	—	[redacted]	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
24 OCT03	[redacted]	Sdnp sponge prn														
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															
----	----															

USAPA V1.00

CLINICAL RECORD

THE[illegible]UTIC DOCUMENTATION CARE PLAN (M[illegible]CATIONS)

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 3	4	5	6	7
10/3	[redacted]	IV: NS @ 125cc	08	/				
			18					
			06	[redacted]				
10/3	[redacted]	Ancef 1gm IV	06	/	Spec. op			
		Q8°	14					
			22	[redacted]				
04 OCT 03	[redacted]	IV: HL IV when taking	06	/	[redacted]			
		Po	18	/	[redacted]			
04	[redacted]	Ancef 1gm IV q 8°	06	/	[redacted]			
			14	/	[redacted]			
			22	/	[redacted]			

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: s/p CR nasal fx

Nasal Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW #[redacted]

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.00

(b)(6)-2 all

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. OCT Yr. 03

Verify by Initialing: Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
10/3	[redacted]	NS @ 125 cc° @ MN	10/3	2400	—	[redacted]
5 Oct	[redacted]	D/C IV				
5 Oct	[redacted]	D/C meds				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED															
10/3 Exp 10/6	[redacted]	Percocet 1-2 tab po q 4° pen pain	Date 30 Oct; Time 1940; Dose 11; Init 11 [redacted] — pre-op															
04 Oct 03	[redacted]	Percocet 1-2 tab po q 4° prn pain	D/T	4 Oct 0050	4 Oct 0400	4 Oct 0800	5 Oct 2000	5 Oct 0800	5 Oct 1400									
			D/I	[redacted]														
04 Oct 03	[redacted]	Toradol 30mg IV q 6° prn pain	D/T															
			D/I															

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: 4 OCT 03
Time In: 1400
Allergies: NKA
Pre-op V/S: 126/68 78
Procedures: Closed Reduction Nasal bone Fx

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid
OR Output: UOP EBL
Meds/Times: Fentanyl, Narcan

Local lidocaine c̄ EPI

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

Pre Op Meds History

Time	1400	1405	1410	1425
SaO2	99	99	96	97
FIO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120	V	V	V	V
100				
80				
60	^	^	^	^
40				
20				
RR	15	19	22	22
T	98.2			

Time									
Pain (0-10)									
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1400	NS	400	(R) FA	OR	400

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	1	1
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	N/A		
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 = Axillar[redacted]
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)

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

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 4 OCT 03

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

EPIC # [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							

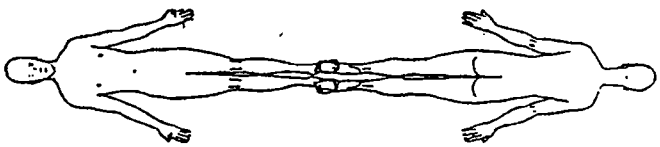
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	NOSE	Nasal brace C	Ø
30'		drip pad	
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0900	SR	Ø	Ø

NURSING NOTES

Pt to recovery room from OR s/p closed reduction nasal bone fx. IV of NS infusing into (R) arm s/s of redness OR swelling to site. Nasal brace C drip pad intact Ø drainage. VSS. Ø c/o @ this time. Will continue to monitor & ASSESS. - [redacted] (b)(6)-2 LAW
- TO ICW #1 via litter [redacted] (b)(6)-2

Discharge Criteria:
Date: 4 OCT **Time:** 0930 **PARS:** 9
BP: 109/52 **T:** 96.2 **HR:** 50 **RR:** 12 **Sa02:** 96 - RA
Pain Level at D/C (0-10):
Intake: 50 **Output:** Ø
Additional Data:
Transferred To: ICW #[redacted]
Report Given To: SPC [redacted] (b)(6)-2
Transferred Via: W/C [redacted] Ambulance
Transferred By: [redacted] (b)(6)-2
Cleared IAW Recovery B[redacted]
Charge Nurse Signature [redacted] (b)(6)-2

WAMC OP 173-E