INPA[illegible] TREATMENT RECORD COVER SHEET *(F[illegible] .ate Imprinting)*

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 *(Excluding Items 25 & 26)*

(b)(6)-4

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

ADMITTING OFFICER

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION: RTD

26. DATE OF DISPOSITION: 22JUL02

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

GSW

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW Back.

22Jul CT CHEST
CT ABPC

☐ CHECK IF CONTINUED ON REVERSE

35. TOTAL DAYS THIS FACILITY

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
				2	

36. TOTAL DAYS ALL FACILITIES

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
				2	

SIGNATURE OF ATTENDING MEDICAL OFFICER (b)(6)-2

SIGNATURE OF RAD OR MEDICAL RECORDS OFFICER (b)(6)-2

DA FORM 3647-1, 1 MAY 1979 EDITION O[illegible] USAPA V1.00

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

Afghani male transferred to our facility from Kandahar. Pt c̄ GSW (R) Back, Chest tube placed prior to arrival at fast and some sort of Abd surgery. Chest tube was D/C'd prior to transfer. Pt arrives to our facility c̄ ↑RR and AtoX3. Refer to fast medical note for further info re: care provided prior to arrival to our facility

ALLERGIES:

MEDICATIONS: Mr 304

PAST ILLNESS/PREGNANCY: (R) thigh scar

LAST MEAL: > 48 hr ago

PHYSICAL EXAMINATION

	NORMAL	ABNORMAL
HEENT	✓	
NECK	✓	
CHEST	(R) Chest crepitus ↓ Bl fields	
LUNGS	↑ HR	
HEART		
ABDOMEN	supra umbilical incision c̄ 6 sutures	
RECTAL		
EXTREMETIES	✓	
NEURO	✓	

Pulse ox 92% RA

BACK — suprascapular 3 inches incision c̄ sutures (-) drainage
Infrascapular incision c̄ 4 sutures (-) drainage

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

IMPRESSION: Post 12th R.B Fx
GSW (R) Chest/Back
S/P CT Placed
S/P DPL vs exp lap ?

Chest tube site sutured and intact all areas are tender to p

TREATMENT:
CXR
CTAB
O2
IABS (CBC, electrolytes, coags) U/A
PPD

(b)(6)-2

SIGN | DATE 11/1/02 | 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.

(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

CT Abd
→ intra abd.
pathology
CXR -
type
+ Sorder
HB (+)
at cvrt
Post
12th (R)
R.B Fx
→ Bullet
in muscular
of Back
not in the
intratoracic
area.
→ Lung
base
resolution

AUTHORIZED FOR LOCAL RE

MEDICAL RECORD | **PROGRESS NOTES**

DATE	(b)(3)-1 CSH (FWD) NOTES
22 July 02	Gen Surg Consult
1135	Patient Examined chart, Records CT & CXR
	Reviewed
	S - Patient Transferred For Eval & SW Back
	Sustained 19 July 02 @ Approx 2100hrs Local.
	Treated By Afghan MD & Chest tube R
	Pleural Space & Midline Incision Abdomen
	Transferred to FST For Eval CT Drainage
	minimal & Kindahar & Chest Tube Removed
	Transferred to (b)(3)-1
	O - VSS. A fab Wound medial & Inferior to
	R Scapula. Ecchymosis Around Area & Small
	Incision fmB 2° to chest tube Lungs clear
	Heart - RRR Abdomen ≈ 6-8cm upper midline
	Incision & Sutures In Place. Non tender BLS
	Normal Active
	CT -> No Evidence Intra Abdominal Injury. at
	Level of Incision Does Not Appear Incision was
	Carried into the Abdomen
	A -> No Evidence Intra Abdominal Injury
	P -> Pt as tolerated May Be Transferred when (Bon)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID (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
Prescribed by GSA/ICMR FPMR (41CFR) 101

medically cleared. ~~Chest minimal~~
chest minimal consolidation R-base by CT scan
clinically breathing well.
can follow wounds as an outpatient
(b)(6)-2 LTC MC

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Ian
22 Jun 02	Prev. notes reviewed.
1130	Afghan male c̄ Hx GSW to back - Placement chest tube
	Brought to (b)(3)-1 CSU for evaluation.
	Seen by BMT - see report
	Surgeons - " "
	CT ABDO ⊖
	CT chest consolidation (R) lobe
	Rt op ↓
	Retained (2) pieces to 12th rib
	metal FB posterior to (2) 12th rib
	(P) (A) At this time, surgeons feel no surgery needed Ans
	that pt is stable for tfr to detainee center.
	Detainee center physical done by Dr (b)(6)-2
	@ 1130 ~~HRS~~ (Local) 22 Jun 02 -
	(2) ? consolidation D/W Dr [redacted] with 2-pat.
	B6-2 (b)(6)-2 M

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

28 yr old AFGHAN M.

LAST NAME (b)(6)-4	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7-22-02	electrolytes BPO
0653	CBC
	Coag studies
	vitals: 125/73
	P: 91
	R: 36
	SPO_2: 92
0700	identifying marks:
	occlusive dressing under (R) arm pit
	vertical ~~scar~~ stitch line to mid abdomen
	vertical scar to lateral thigh and buttocks
	tattoo of webbing of (L) thumb and forfinger (moon)
	tattoo on left wrist (5 dots)
	stitches to (R) scapula
	stitches to Lower (R) Scapula
	Scar to (L) scapula
	vertical scar @ (L) shin
	tatoo in Arabic on (R) forearm
0704	3 Lpm O2 via NC
0705	PPD test administered (R) forearm
0730	Labs drawn CBC, lytes T+C
0745	IV LR established (R) FA. KVO Rate.
0810	Pt over for CT of abdomen. Rec IV contrast.
0845	Pt returned.
0850	Pt over to ICU-1 Report given (b)(6)-2 RN

(b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 July 02 2150	(S:) Called to see detainee because he was acting violent. Pt. threw his chest tube bag against the wall + ruptured it. MP's requested assistance in evaluating chest tube and in sedating pt. for transport.
	(O:) Obese male - restrained, fighting restraints.
Initial vitals R - 38 P - 100	Chest: Chest Tube in place. Drainage bag ruptured. CTA(B), BSEB, Wheeze/Crackles.
	(A:) Agitation vs. ? Illicit drug withdrawal. Ruptured CT tube drainage bag.
	(P:) Dr. (b)(6)-2 consulted for advice on sedation regimen. Diazepam - 5mg IM x 1. Haldol - 2mg IM x 1. Benadryl - 50mg IM x 1. After drugs administered pt's vitals noted - R-34, P-94. Will continue to monitor until pt departs for Bagram. CT Tube removed + occlusive dressing applied to wound. (b)(6)-2 M.D. CPT, MC Staff Pediatrician
21 July 02 2150	Consult Tech by Physician on Call. Dr. (b)(6)-2 S/: Concerns c̄ PT's "bizarre behavior". "Allegedly pulled chest tube bag and drained blood-fluid" → (b)(6)-2 OK

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV (b)(6)-2	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.)* (b)(6)-4

REGISTER NO. | WARD NO.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
21 July 02 2150	- Caretaker Reports "Definite fluctuation on PT's behavior" Allegations by interpretation of PT's statements not matching story of events. "PT allegedly stated "He was shot by his brother". Record Review shows "recent sedation & morphine for pain management. Some suspiciousness of "Opium" use (Tract on arms). (b)(6)-2 Vital signs has been consistently stable. PT. was not been hypotensive. - PT. seen "mildly agitated despite 5 g valium IVP. 15-25 mmts prior to this unit intervention. P.E. limited by PT's delirious condition. MSE: unable to assess. A/P: Suspect. Post-Inj. - Post pain management sedation or withdrawal from opium. (P) (1) Haldol 5 g IM. given & 50 g Benadryl inj. to right and left superior gluteal area. respectively. (2) PT. sedated 15-20 post inj. (3) Recommend repeat same dose above if need prior to any evac. (4) Cont Sensory: i.e. glucose, cont LFT's etc. upon arrival to CASH. No other orthopedic problem

STANDARD FORM 600 (REV. 6-97) BACK

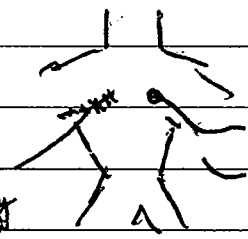
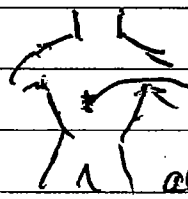
*U.S.GPO:2000-461-707/20309

(b)(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	Pt is >24hr out from CP placement and abd. exploration — pt can be transferred to CSH. He will monitor respiratory status — repeat films, ~~[illegible]~~ Output from CT. Recommend: transfer to CSH – BAGRAM.
	(b)(6)-2 LTC AC (b)(3)-1
21 Jul 02 2140H 2110	Pt seen & reviewed. Agree & his assessment. This pt is stable. S/P GSW yesterday treated & laparotomy/[illegible] chest tube. Rec. transfer to CSH
	(b)(6)-2 CDR. (b)(3)-1
20 Jul 02 2148	Pt. c̄ SpO2 86% lying flat in room air. & Resp distress. 4L O2 FM c̄ ↑SpO2 to 95%. Pt. resting comfortably no complaints
	CXR: (+) scarring (L) lower lobe poss 2° to prior surgery / injury c/w scar (L) posterior chest.
	KUB: (+) Bullet seen in mid-left abdominal field. & free air, & signs of SBO, nl gas pattern
	Abdominal: & signs of bullet in abd. compartment. Suspect retro-peritoneal.
	A/P: Stable S/P GSW to (R) back, c̄ pigtail chest tube (R) chest.
	(1) Vitals q4° (includes SpO2), 2L NC O2
	(2) Unasyn 3gm IV q6h (next dose @ 0300), IVF 80cc/hr LR
	(3) Call MD for SS<P>110, RR>22, SpO2<92%, 60<DBP>90 90<SBP.
	(4) Maintain HOB @ 45-60°
	(5) f/u c̄ C/Med C/Comfort in a
	(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7/20/02	Surgical Consult
2235	Afghani male 24hr s/p GSW entering below (R) scapula c̄ no exit.
115 2/15	Cathed placement of chest tube c̄ allegedly 2L of bloody fluid discharge over
-88↓	24hrs. The Rave had no medical notes on procedures. I believe patient
28	had mini lap. He have not been able to speak to the pt - no interpreter.
/p - 122/68	
PO^2 86	PE: BACK
	
/s - 2130	
p - MD 94/107	old thoracotomy incision — entance wound
r - 32	small chest tube c̄ 100 ml of bloody fluid
BP - 128/76	
SPO^2 - 94	FRONT
	 pt is obese -
/s - 2145	midline incision very comfortable -
p - 85	quiet belly - walking - speaking - we just
R -	abdomen soft - no rebound can't understand him.
BP -	Chest: clear Cor: RSR Pulse 270 - pulse ox > 95% on room air
SPO^2 96	H/H 15/45%
	CXR: underpenetrated - but no mediastinal shift - no gross/Rems for pneumothorax
	Abd: negative exam.
	Imp: (R) chest & abd wound
	Plan: IV - RL @ 125ml/hr Hourly pulse ox M Sat necessary
	Unasyn 3gm IV q 6° H&H q 4°

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

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

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

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 Jul 02	Current meds
20 July 02	
1900 hrs	[S]: Afgan Taliban Commander shot while being captured on 19 July 02 @ approximately 2100 hours local time. Pnt reports through interpreter that he was shot from behind in the back. Pnt seen and treated by local Afgan physician c̄ chest tube placed on (R) side of chest wall. Pnt reports that chest tube bag has been drained once (approximately 2 liters) Pnt states chest bag filled up in 18 hours. No food in last 18 hours. Pnt had antibiotic after surgery ever since!
VITALS	[O]: Afgan Male, INAD, A & Ox 3, well appearing
P-72	HEENT: No blood in mouth
R-30	CHEST: Faint lung sounds on (R) lower chest; chest
B/P 145/90	tube in place anterior axillary line at level of 4th and 5th rib c̄ 100cc of blood in bag.
	ABDOMEN: no bowel sounds, abdomen obese/obtuted ∅ abdomen rigidity, c̄ 3cm vertical midline wound repair c̄ suture in place 2cm above ubilicus ∅ cellulitis/edema c
	BACK: 6cm horizontal wound repair c̄ sutures in place c̄ good wound margins
	EXTREMITIES: Good tone, ∅ wounds / lacerations
	(over)

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.)*

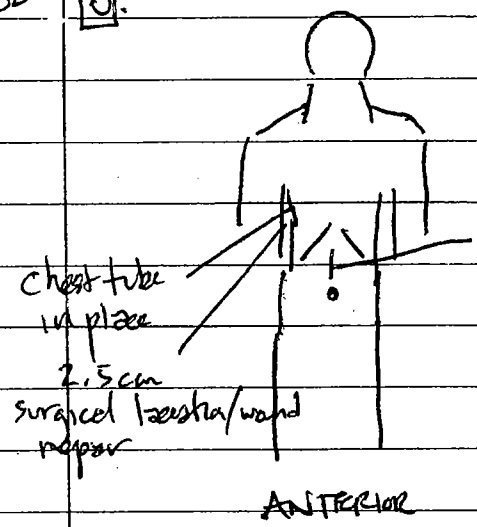
(b)(6)-4

REGISTER NO. | WARD NO.

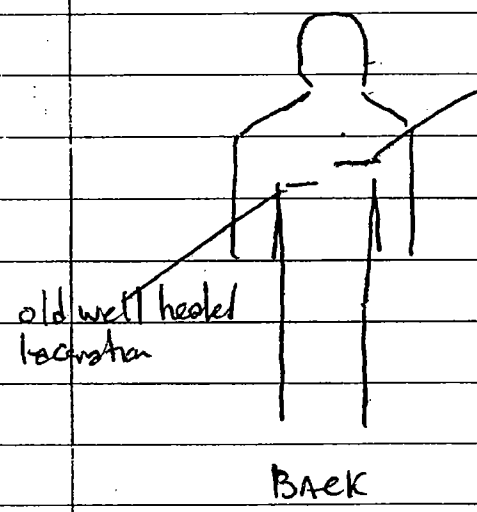
CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 July 02	O:



3cm vertical surgical laceration, wound ⊘ drainage ⊘ cellulitis, sutures in place c̄ good wound margins



6cm linear surgical repair c̄ sutures in place ⊘ drainage ⊘ cellulitis

A: GSW to (R) posterior chest wall
GSW/Laceration to (R) posterior thoracic
GSW/Laceration to abdomen (surgical?)

P: ① IV LR 125 cc/hour ② meds Unasyn 3 gm q̄ 6 hour. Morphine 2 mg titrate to pain q̄ 4-6° hours ③ LABS: H & H ④ CXR, FLAT PLATE ABDOMEN ⑤ Vitals q̄ 2 hours ⑥ re-evaluate in 6 hours. ⑦ Notify Surgeon Dr. (b)(6)-2 if abdomen becomes rigid, ↑ pain, > 40 respirations < 12 ; ↓ BP < 90 systolic < 50 diastolic. ⑧ Dress wounds

per Dr. (b)(6)-2 ESU surgeon

(b)(6)-2

(b)(6)-2

CPT, SPUSA APA

STANDARD FORM 600 (Rev. 6-97), BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*		
2145			
BP 124/72	Intake	output	
P	2155: 250 cc	0	0.5 mL
R 21	2230: 250 cc	0	morphine Inj
SPO2 (86%)	0030 -150 cc	0	@ 0042
0030	0045 905 cc	650 cc	
BP 112/82	0125 420 cc	0	
P 72	100 870 cc	0	
R 24	130 750 cc	100 cc	
SPO2 93%	1616 200 cc	0 cc	
on 2L By mask	1700 450 cc	300 cc	
0725	1800 200 cc	150 cc	
BP 126/68	1845 250 cc	0	
P 100	1927 200 cc	100 cc	
T (99.8)	1108 200 cc	0	
R 40	2030 refused water		
SPO2 88%			
P 103			
BP 140/104			
R 40			
2326			
B/P 142/90	Pulse 103		

(over)

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)*
21 July 2002	Pt. seen 2 days s/p GSW (R) Back, s/p c modified
0325	(R) pleural drainage tube placed, Roughly 45cc output overnight
	SaO2 87% on RA & lying supine. Pt to 95% c 4L FM O2
T: 98.4	Alert, VSS, & distress. Receiving Vicodin 3gm IV q6h x 2
R: 14	doses, Morphine 10mg IV q60min pain.
P: 87	Exam: CT dressing clean, dry + intact, & purulent drainage
0540	Drainage tube patent c (+) flow to drainage bag ~ 45cc
BP 112/76	Pul: CTA (L), (R) base & Breath Sounds, & crackles
P 96	CVR: RRR
R 28	Abd: midline orig-celiotomy incision C/D/I - Abd NT/ND (+) BS
Temp 99.2°	(+) BM (+) flatus
	Ap: s/p GSW (R) chest. Stable
	(1) Continue Vicodin 3gm IV q6hr.
	(2) MSO4 10mg IV q6h
	(3) Continue O2 4L FM in flight.
	(4) Stable no contraindications for flight + transfer.
	(b)(6)-2
21 Jul 02	
0830	Pt resting well as per Guardian. Pertaining to airlift pt is stable for C130 flight
	Eq Baghram
	chest tube out in last 8 hrs = ∅ Pulse Ox 91% RA [redacted] B6-2

STANDARD FORM 600 (REV. 6-97) BACK

*U.S.GPO:2000-461-707/20309

NURSING PROGRESS NOTE

0900 Admitted to ICU #1, 28 yo/m Afghan detainee ♂ S/P GSW (R) Posterior Chest Wall. Awake Alert. Resp easy. Lungs clear bilaterally c̄ decreased sounds in bases. HR 80s-90s. NSR c̄ ectopy. 6cm incision on (R) posterior chest wall, dry, approximated c̄ sutures intact. (R) posteriolateral chest tube site dry, intact. Old well healed incision line present (L) posterior chest wall. Raised nonmovable nodule noted (L) lower posterior chest wall. (−) subcutaneous emphysema. Vertical 8cm incision epigastric area dry, well approximated c̄ sutures intact. Abd Round soft. Nontender. BJ(+)x4, by shackles secured to bed. Handcuffs secured to sidebars bilaterally. Medicated @ 0930 for relief of minimal pain. (b)(6)-2 SP AN

(b)(6)-2

(b)(6)-2

IBC N/C c̄ (guarded to detention cam) ñ IV

NURSING PROGRESS NOTE

FORM 0021

*SEE PROGRESS NOTES:

STAT LABORATORY DATA

Date_____

Time																								
Glucose																								
BUN/CR.																								
Na+																								
K+																								
Cl-																								
HCO_3-																								
WBC																								
Hb/Hct																								
PLT																								
PT/ct																								
PTT/ct																								

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	(b)(6)-2	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.
0930	MSO4 4mg	IV							

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

HT._____
WGT._____
WGT.
YESTERDAY_____
PREVIOUS DAY
INTAKE_____
OUTPUT_____
BSA_____
ALLERGIES_____
ADDRESSOGRAPH

SIGNATURE AND INITIALS NURSE/RESP. THERAPIST	Init.

MEDCOM - 2992

*SEE PROGRESS NOTES:

INTAKE CC/HR

Date _____

INTAKE	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LR				(b)(6)-2	100																			
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds																								
ORAL																								
Hourly Total					100																			
Cumulative Total																								

OUTPUT CC/HR

OUTPUT	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly								550																
Urine Cumulative																								
Emesis/Gastric																								
Stool																								
Output Hourly																								
Output Cumulative																								
Spec. Grav./U.R.																								
Gastric pH																								

TRANSFUSION THERAPY

TYPE	UNIT NO.	TYPE	UNIT NO.	TYPE	UNIT NO.

TOTAL INTAKE

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
ORAL				
IV				
NG				
Bld				

TOTAL OUTPUT

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
URIN				
NG				

*SEE PROGRESS NOTES:

PROCEDURES		OBSERVATIONS	TREATMENTS	
TIME		7 - 4	4 - 12	12 - 8
NEUROLOGICAL		→ SEE CODE →		
Eyes Open	Closed by swelling = C	4		
Verbal Response	ET Tube or Trach = T	5		
Motor Response		6		
Pupils R - react NR - non SR - slow	Size R	3		
	Reaction	R		
	Size L	3		
	Reaction	R		
	Hand Grasp R/L	5 / 5		
Breath Sounds		Clear		
Sputum Character		✓		
Nasal Endotracheal Suctioning Q ____				
Chest PT Q ____				
CDB/IS Q ____				
Vent. ✓'s				
E.T. Tube ⊕ ____				
Cuff ✓/Pr/cc's				
C.T. Strip & Vent Q ____				
C.T. Fluctuates / ___ cm.				
Peripheral Pulses **	U	PS PS		
	L	PS PS		
Circ. Distal to A-Line		✓		
Monitor Alarm On		✓		
PA Line		✓		
CVP/Other		✓		
Art Line		✓		
Peripheral Rsg		✓		
Peripheral		✓		
PT/Family Teaching/Support		✓		

Spontaneous	4
To Speech	3
To Pain	2
None	1
Oriented	5
Confused	4
Inappropriate Words	3
Incompreh. Sounds	2
None	1
Obeys Commands	6
Localize Pain	5
Withdraws to pain	4
Flexion to Pain	3
Extension to Pain	2
None	1

2 3 4 5 6 7 8 9 10

**PULSE CODE

DOPPLER . . . . . D

PALPABLE . . . . . P

STRONG . . . . . S

WEAK . . . . . W

ABSENT . . . . . A

FLEETING . . . . . F

PROCEDURES	OBSERVATIONS	TREATMENTS	
TIME	7 - 4	4 - 12	12 - 8
Bowel Sounds	(+) x4		
ABD Size/Firmness	flat soft		
NG Secure/Proper Pos.	✓		
✓ Patency Q4°	✓		
Aspirate Contin. Feed Q4	✓		
Aspirate Prior to Bolus Feed	✓		
Stool Char./Guaiac	✓		
Urine Color/Character	✓		
Foley Secure/Patent			
External Cath.	✓		
Catheter Care	✓		
Colostomy/Ileostomy Care	✓		
Bath	✓		
Turn & Position Q ____			
Skin Care	✓		
Mouth Care			
Trach / E.T. Care	✓		
ROM	✓		
Dangle	✓		
Restraints Released Q2H	Shoulder Hand cuffs		
OOB to Chair			
Ambulation			
Side Rails ↑			
Drsing. △			
Drsing. △			

ADDRESSOGRAPH

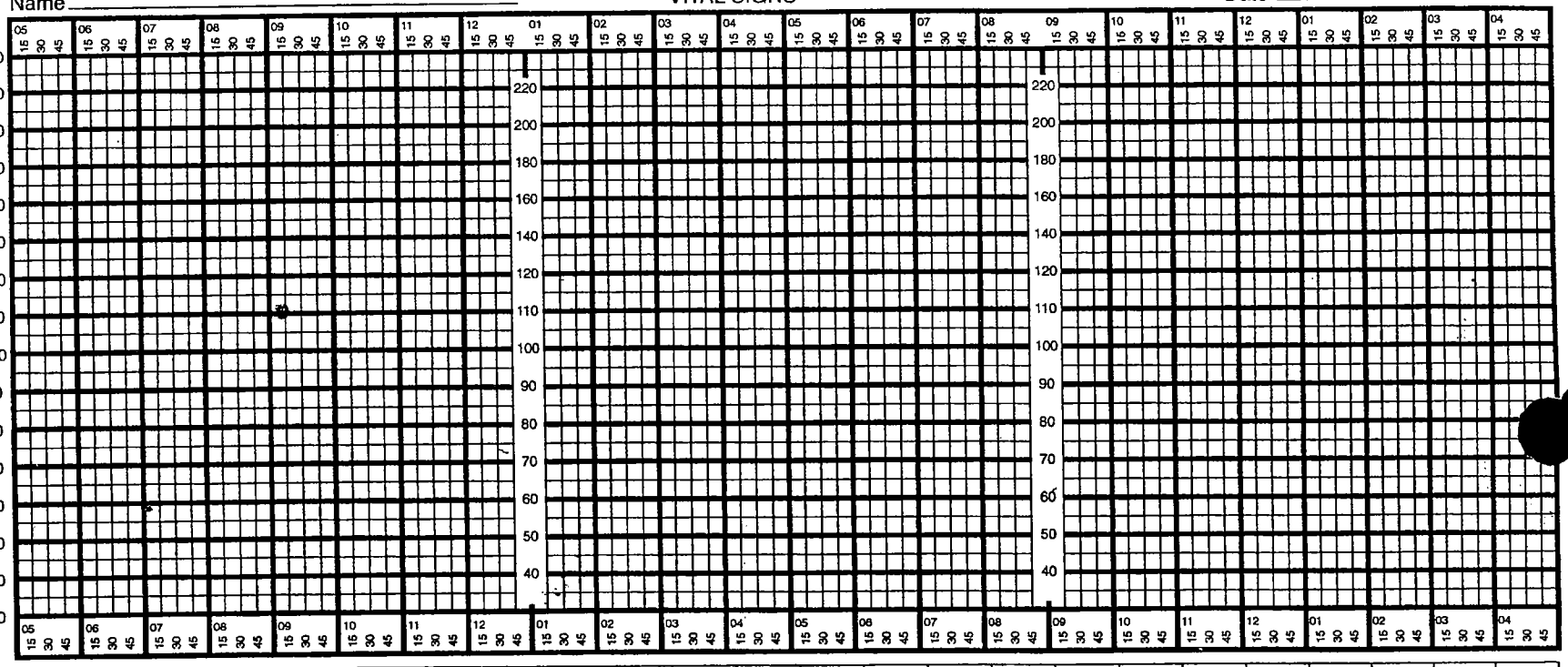
MEDCOM - 2994

*SEE PROGRESS NOTES:

Name _____ VITAL SIGNS Date _____

°F	°C	
105	40.6	240
104	40.0	220
103	39.4	200
102	38.9	180
101	38.3	160
100	37.8	140
99	37.2	120
98.6	37.0	110
98	36.7	100
97	36.1	90
96	35.6	80
95	35.0	70
		60
		50
		40
		30

HR SBP X DBP TEMP •



HEMODYNAMICS

	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR				88		86																		
Rhythm				SR		SR																		
RESP.				22		24																		
CUFF BP				106/73		128/77																		
MAP				93		96																		
PAS/PAD																								
PCW																								
CVP																								
CO/CI																								
SVRI																								

DRUG	UNITS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Zantac	50mg IV Q8H																								

MISCELLANEOUS HOURLY OBSERVATIONS

MEDCOM - 2995

(b)(6)-4

28 yo
Afghan

♂

MISC

SPECIMEN/LAB RPT. NO.

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

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

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE: Dr. (b)(6)-2 / (b)(6)-2

REPORTED BY: MD / TECH

DATE: 7-22-02 0806

LAB ID NO.

REMARKS: COAGS

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED	RESULTS
				PT – 13.3 Ratio 1.1 aPTT – 25.0

557-107

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

(b)(6)-4

28 yo
Afghan

♂

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

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

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

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

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE: Dr (b)(6)-2

REPORTED BY: MD / TECH

DATE: 7-22-02 0844

LAB. ID. NO.

REMARKS: CBC

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED (X)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	PT: CONTROL	PT: PATIENT	PTT: CONTROL	PTT: PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
			RESULTS	4.58	13.4	38.0	83.0	27.1	32.7	7.4											325											

549-107

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

STANDARD FORM 545
545-106

LABORATORY REPORT DISPLAY

TAT System

+

(b)(6)-4

Name:_____

Glu_____93 mg/dL
BUN_____21 mg/dL
Na_____144 mmol/L
K_____3.4 mmol/L
Cl_____109 mmol/L
TCO2_____24 mmol/L
AnGap_____15 mmol/L
Hct_____39 %PCV
Hb*_____13 g/dL
*via Hct'
pH_____7.461
PCO2_____32.5 mmHg
HCO3_____23 mmol/L
BEecf_____-1 mmol/L

Sample Type_:

22JUL02

Oper: (b)(6)-2

(b)(6)-2

Physician:_____

Ser# (b)(6)-4

Ver: (b)(6)-2

PRESSURE MUST BE APPLIED TO ATTACH LABORATORY REPORTS

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

CHEMISTRY I 546-107
STANDARD FORM 546 (Rev. 8-77)
General Services Administration and Interagency Committee on Medical Records, FIRMR (41 CFR) 201-45.505

REMARKS

(b)(6)-2

Enter in above space REQUESTING PHYSICIAN'S SIGNATURE

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REPORTED BY

TECH MD DATE 7-22-02 0844

(b)(3)-1

(b)(6)-4

CHEM I

URGENCY: ROUTINE, TODAY, PRE-OP, STAT

PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM

SPECIMEN SOURCE: BLOOD, OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

PATIENTS MED. RECORD

ALIGN ALL LABORATORY REPORTS ALONG THIS BASE LINE

INSTRUCTIONS: This form may be used to display laboratory reports as a flow sheet to be read as a progressive table. If so, a separate sheet should be used for each type of report form. When assorted report forms are mounted on the display sheet, both test names and results should always be visible.

ENTER IN SPACE BELOW: PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

FORMS DISPLAYED ON THIS SHEET ARE (Check one)

MOUNTED ON STRIPS 1 THROUGH 7	MOUNTED ON STRIPS 1, 3, 5, AND 7
☐ CHEMISTRY I (SF 546)	☐ PARASITOLOGY (SF 552)
☐ CHEMISTRY II (SF 547)	☐ IMMUNOHEMATOLOGY (SF 556)
☐ CHEMISTRY III (SF 548)	☐ ASSORTED FORMS
☐ HEMATOLOGY (SF 549)	☐ OTHER (Specify)
☐ URINALYSIS (SF 550)	**MOUNTED ON STRIPS 1, 4, AND 7**
☐ SEROLOGY (SF 551)	☐ MICROBIOLOGY I (SF 553)
☐ SPINAL FLUID (SF 555)	☐ MICROBIOLOGY II (SF 554)
	☐ MISCELLANEOUS (SF 557)
	☐ ASSORTED FORMS

General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8

LABORATORY REPORT DISPLAY

MEDCOM - 2997

☆ GPO : 1989-0-233-621

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

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

- [x] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

REQUESTING PHYSICIAN *(Print)*

MGT (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

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

VOLUME REQUESTED *(If applicable)*

_____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? ____

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.

TRANSFUSION NO.

PATIENT NO. (b)(6)-4

DONOR

ABO

Rh

RECIPIENT

ABO AB

Rh POS.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NIP	

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

(b)(6)-2

DATE

- [x] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* ON *(Date)*

IDENTIFICATION

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

1st VERIFIER *(Signature)*

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION

TEMP. PULSE BP

DATE OF TRANSFUSION TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN _____ ML

TIME DATE COMPLETED INTERRUPTED

REACTION

- [ ] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER _____

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

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

SIGNATURE OF PERSON NOTING ABOVE

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

(b)(6)-4

28YR

AFGHAN ♂

SEX M

WARD CCT

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

RETURN TO TRANSFUSION SERVICE

MEDCOM - 2998

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
CXR R/o PTX CT ABD	78	M		EMT	
	FILM NO.				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print)		(b)(6)-2		TELEPHONE/PAGE NO.
	SIGNATURE		(b)(6)-2		DATE REQUESTED

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

GSW to (R) chest S/P chest tube removal
r/o pneumothorax (R) side
S/P OPLA vs exp lap

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
(b)(6)-2		

RADIOLOGIC REPORT

CXR
No PTX
Consolidation and/or effusion (L) base
Metal FB LUQ

(b)(6)-2

CT chest - consolidation R base
post op changes (R) thorax with soft tissue emphysema
posterior (R) rib fx 12th
metal FB posterior to (L) 12th rib.

CT Abd - No evidence of pathology in peritoneal cavity.

(b)(6)-2

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
Pt # (b)(6)-4	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION

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

PHYSICIAN ORDER SHEET

DATE	ORDERS	TIME
21 July 02	Adm - ICU 1 (b)(6)-2	
	Dx - GSW (R) Chest (b)(6)-2	
	S/P DPL vs exp. lap	
	Cond'n - Good	
	Vitals - q Shift	
	Allergies - /	
	Diet - NPO	
	IVF - LR at 100 cc/h	
	Abds - MSO4 - 4mg	
	q 6° PRN	
	PAIN	
	- Zantac 50mg	
	IV q 8°	
	- O2 - 2L NC	
	Labs - H/H q	
	Shift	
	Read PPD at 2443 A2 (b)(6)-2	
	Record urine output (b)(6)-2	
	q Shift	
	TB Precaution	
	Surgeon Consult	
	(b)(6)-2 CTAN	
22 July 1300	DISCHARGE TV	
	DETOXIFIN COMM	
	D/C IV	
	D/C R. (b)(6)-2	

WARD	ID: NUMBER	DIAGNOSIS
PATIENT DATA	(b)(6)-4	VERIFICATION

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
(b)(3)-1 (b)(6)-4	7 8: A F	9 10 11 12 13 14 15: (b)(6)-4	(b)(6)-4	16 17:	18: M

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

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34:		35 36: 2 0	37 38 39 40 41 42 43 44 45: 8 0 1 0 0 1 0 0 0

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
Afghan Militay Forces	46:	2150	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49: N / /	50 51 52: X 9 9	53 54 55 56 57 58 59 60 61:

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: T	ICU1	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1 BAGRAM, AFGHANISTAN		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
73 74: Ø /	75 76 77 78 79 80:	81 82 83 84 85 86 87 88: 2 0 0 2 0 7 2 2

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
89 90 91 92: A E A A	93 94 95 96 97 98: (b)(3)-1	99 100 101 102 103 104 105 106: 2 0 0 2 0 7 2 1

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
107 108:	(b)(3)-1 114: (b)(6)-4	115 116 117 118 119 120 121 122: 2 0 0 2 0 7 2 1

FOR LOCAL USE

HOW: Patient suffered a Gunshot wound to the Back
When: 21 July 02 Approximate time unknown
Where: Qandahar Afghanistan

T: 1 Dx: 8760
8750
8742
E9912

Inj: 450

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
	(b)(6)-2

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

ADMISSION AND DISCHARGE INFORMATION

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

1. REPORTING MTF	2. LOCATION (State or Country Code.)
(b)(3)-1 6	7 8
A (b)(6)-4	A F

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	
1 9 7 4 0 1 0 1	2 8 4	X	9	ISLAM

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36	37 38 39 (b)(6)-4
		2 0	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
Afghan Militay Forces	46 Z	2150	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52	53 54 55 56 57 58 59 60 61
N 1 1	X ~~9~~ ~~9~~ K78 ~~K78~~	0 9 3 5 4

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72		N/A
X 1	ICU1	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1 BAGRAM, AFGHANISTAN	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
73 74	75 76 77 78 79 80	81 82 83 84 85 86 87 88
~~D~~ T 05		2 0 0 2 0 7 2 2

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
89 90 91 92	93 94 95 96 97 98	99 100 101 102 103 104 105 106
A E A A	(b)(3)-1	2 0 0 2 0 7 2 1

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
107 108	109 110 111 112 113 114	115 116 117 118 119 120 121 122
A F	(b)(6)-4 (b)(3)-1	2 0 0 2 0 7 2 1

FOR LOCAL USE

HOW: Patient suffered a Gunshot wound to the Back
When: 21 July 02 Approximate time unknown
Where: Qandahar Afghanistan

DX 8761

BC

Trauma 9

Inj 559

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
	(b)(6)-2

AEROMEDICAL EVACUATION PATIENT RECORD

(b)(6)-4

PATIENT IDENTIFICATION

1. NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE U P R	5. GRADE
(b)(6)-4					

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION (1A-5F)	11. ACCEPTING PHYSICIAN	12. CITE/AUTHORITY NO.
28	✓ Male / Female			AMBULATORY / ✓ LITTER		

13. APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FACILITY	16. NUMBER OF ATTENDANTS
	14b. ORIGINATING FACILITY PHONE NUMBER	15b. DESTINATION FACILITY PHONE NUMBER	16a. MEDICAL / 16b. NON MED

17. DIAGNOSIS

S/p GSW (R) chest x4 days

18. BATTLE CASUALTY | DISEASE | NON-BATTLE INJURY

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues. Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	ISSUE		YES	NO	ISSUE
a.			HYPERTENSION	f.			MOTION SICKNESS	k.			AMBULATORY
b.			CARDIAC HX	g.			VISION IMPAIRED	l.			AMBULATORY AID
c.			DIABETES	h.			VOIDING PROBLEMS	m.			SELF-MEDS
d.			RESPIRATORY	i.			BOWEL PROBLEMS	n.			ADEQUATE SUPPLY OF MEDS
e.			EARS/SINUS	j.			SELF-CARE	o.			OTHER

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
21 JUL 02	0830	UNKNOWN

20d. DIET | REG | 3GM NA | CARDIAC | DIABETIC ____ CALS

RENAL ____ Gm prot ____ Gm Na ____ Meq K ____ mg PO4

TUBE ____ TYPE ____ cc/hr, 1/2, 3/4, FULL STRENGTH

PEDIATRIC: AGE ____ OTHER (Specify) ____

TPN: Change to D10 at ____ cc/hr for max of ____ days

TUBE FEEDING ____ at ____ strength at ____ cc/hr

20e. IV/BLOOD LR 125 cc/hr

20f. SPECIAL EQUIPMENT

	TRACTION	ORTHOPEDIC BRACES
SUCTION	IV PUMP	✓ CHEST TUBE/HEIMLICH
NG TUBE	TRACH	RESTRAINTS
STRYKER FRAME	MONITOR	OTHER (Explain in 23)
INCUBATOR	FOLEY	

O2: LITERS: ROUTE:

VENTILATOR SETTINGS

20g. ALTITUDE RESTRICTION:

20h. RECORDS TO ACCOMPANY PATIENT

OUTPATIENT RECORDS	X-RAYS	FINANCIAL
INPATIENT RECORDS	OB RECORDS	OTHER (Specify)
✓ NARRATIVE SUMMARY	DENTAL RECORDS	

20i. MEDICATIONS/TREATMENTS

1. IV LR 125 cc/hr
2. Unasyn 3gm IV q 6 hr
3. Morphine 2mg q4h PRN for pain
4. Vitals q 2h
5. I/O of chest tube
6. Monitor chest tube for patency

21. PRE-FLIGHT VITALS

21a. DATE/TIME	21b. TEMP	21c. ~~PULSE~~ BP	21d. RESP	21e. ~~BP~~ Pulse
22 July 02		142/90		103

22. BRIEF NARRATIVE

At 36h s/p GSW (R) chest tx c laparotomy & chest tube by local physician. Pt now stable c/ complications c/o pain at wound site. Pt stable & clear for C130 flights for transfer.

23. ASSESSMENT/PROGRESS

DATE/TIME	NOTES
22 July 02	Handover → Begum
0830Z	Pt was received under guard
0330L	distal pulse strong & movement of all extremities. Unable to view chest tube due to restraints. Skin pink warm & dry. Respirations @ 35 & Regular. Pulse is Full & Regular. (b)(6)-2
0100Z	upon review of Pt chart CT
0400L	has been DC'd and site covered c occlusive dsg. (b)(6)-2
0130Z	No change in privacy. No
0430L	signs of drug from wound site. Resp normal @ 32 (b)(6)-2
0153Z	16 oz H2O PO
0453L	(b)(6)-2
0215Z	PMS to extremities x4
0515L	P:90 Full & regular R:32 c. Bilateral Rise and Fall of Chest (b)(6)-2
	refill within 2sec (b)(6)-2

(b)(6)-2 OF ATTENDING PHYSICIAN

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

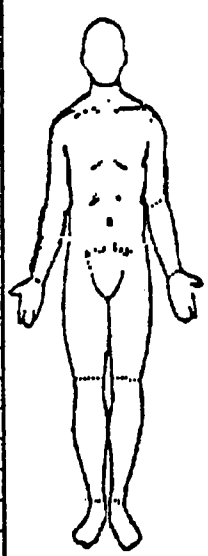
AF FORM 3899, MAR 95

23. **ASSESSMENT/PROGRESS** *(Continued)*

DATE/TIME	NOTES	DATE/TIME	NOTES
0600	Pt Deplaned @ Bagram / [redacted] (b)(6)-2		

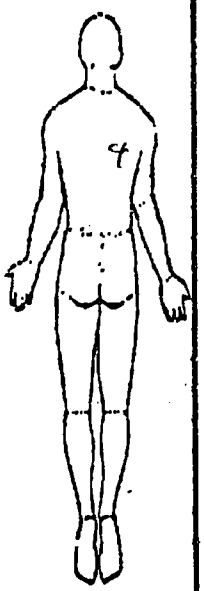
GLASCOW COMA SCALE		DATE/TIME						
		PREFLIGHT	INFLIGHT					POSTFLIGHT
			20 Apr 02					
1. EYE OPENING	SCORE							
SPONTANEOUS	4							
TO SOUND	3							
TO PAIN	2							
NO RESPONSE	1							
2. BEST VERBAL RESPONSE	SCORE							
ORIENTED	5	5	5					
DISORIENTED	4							
INAPPROPRIATE WORDS	3							
INCOMPREHENSIBLE SOUNDS	2							
NONE	1							
2. BEST VERBAL RESPONSE	SCORE							
OBEYS COMMANDS	6	6	6					
RESPONSE TO PAIN								
LOCALIZES	5	5	5					
WITHDRAWS	4							
DECORTICATE	3							
DECEREBRATE	2							
NO RESPONSE	1							
TOTAL = 1 + 2 + 3								

[X] IDENTIFY FINDING BY NUMBER



1 - BURN
2 - CAST/SPLINT
3 - DRESSING
4 - DRAINAGE
5 - ECCHYMOSIS
6 - HEMATOMA
7 - PAIN
8 - PRESSURE AREA
9 - RASH
10 - OTHER

WRITE # FOR FINDING ON DRAWING



INPATIENT TREATMENT RECORD COVER SHEET *(For Plate Imprinting)*

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 *(Excluding Items 25 & 26)*

AFGHAN MALE
EPW

(b)(6)-4

(b)(6)-4

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

ADMITTING OFFICER

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION: 01 - RTD

26. DATE OF DISPOSITION: 20020812

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

GSW

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Multiple GSW
(L) chest
face / eye
leg
arm.

2 AUG BICAT ROYAIN

☐ CHECK IF CONTINUED ON REVERSE

35. TOTAL DAYS THIS FACILITY

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

36. TOTAL DAYS ALL FACILITIES

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

(b)(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(6)-2

DA FORM 3647-1, 1 MAY 1979 EDITION OF 1

USAPA V1.00

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

GSW x? MIW Afghan ♂

VS @ 1900 L: P=155 B/P: 133/45
1910 L: P=111 B/P: 106/63
1925 L: P=123 B/P = 147/65

1000ml LR @ 1845 L

Chest tube → drainage, F/C → drainage minimal output
1u PRBC O neg started @ 1855 L

1935 - #7 Citen IV fluid ⊕ - 1 GMS Kefzol given IV 119/-16 / 51

PHYSICAL EXAMINATION

GSW (R) Anterior chest, (R) back, mid back cervicothoracic junction, GSW (R) thigh, (R) foot, scrotum.
Hand intubated unconscious
Chest CT (L), ⊘ BS (R)
Abd soft NSD ⊘ rigidity - foley in place ⊘ urine ⊘ gross blood, shrapnel scrotum.
Ext. GSW (R) thigh, (R) foot, (R) MC-P joint #2
Neuro - sedated.
To OR STAT for resuscitative thoracotomy

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

(b)(6)-2		DATE	IDENTIFICATION NO.	ORGANIZATION (b)(3)-1
	UAT	27 July 02		

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

(b)(6)-4

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

Afghan male who presents for further eval from the FAST. Pt c̄ GSW (R) Chest; (R) Back; midline Back (R) thigh (R) foot (R) scrotum (L) knee (R) MCP joint #2.

Pt c̄ Air Resuc / Rec Tiffre and BL CT + BR at the FAST

ALLERGIES: unknown

MEDICATIONS: unknown

PAST ILLNESS/PREGNANCY: unknown

LAST MEAL: unknown

Alb 3.2 Alp 72 Alt 31 Ast 95 Amy 104 + Bili 12.

U/A – Blood large

Pt 14.7 INR 1.56 PTT 17.0 Cr 9 Hp 49 Gs 75

WBC 105 / 42 / 20 / 12 / 114 / 9.1

Hct 13.1 / 39.6

PHYSICAL EXAMINATION

NORMAL — Intubated / sedated / Paralyzed — ABNORMAL

HR 95
BP
RR 17
Pulse
Ox
00%

HEENT (L) Periorbital ecchymosis c̄ BL sclera injection
NECK Post neck c̄ wound at midline (cervical region)
CHEST 2 (R) Chest wounds; BL CT; RR; BL BS BL Chest c̄ staples.
LUNGS
HEART
ABDOMEN Soft ND
RECTAL no tone
EXTREMETIES (R) thigh wound (L) knee wound (R) foot wound (R) thigh staples
NEURO Paralyzed
Genitalia (R) scrotal wound laceration (R) Foley in place
BACK – See Post neck (L) upper back wound

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

IMPRESSION: – Multiple GSW Chest, Back, Scrotum, extremities
– S/P BL Chest tube Placement
– hemothorax

TREATMENT: CT Head; Chest; Abdomen + Pelvis

(b)(6)-2

	DATE	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.

(b)(6)-4

(b)(6)-4

HA

EPW

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

~~used~~ 0170
valium

MEDICAL RECORD | ABBREVIATED MEDICAL RECORD 0900

INITIAL ASSESSMENT

AIRWAY / BREATHING

- ☐ Patent ☐ Obstructed ☐ Symmetrical
- ☐ Asymmetrical ☐ Unlabored ☐ Labored
- Trachea midline? ☐ Yes ☐ No
- Breath Sounds: Present ☐ Right ☐ Left
  - Clear ☐ Right ☐ Left
  - Decreased ☐ Right ☐ Left
  - Absent ☐ Right ☐ Left
  - Rales/rhonchi ☐ Right ☐ Left
- Crepitus? ☐ Yes ☐ No

IV L Arm 14g.

CIRCULATION

- Skin/mucous: ☐ Pink ☐ Pale
- Membrane color: ☐ Flushed ☐ Jaundiced ☐ Ashen ☐ Cyanotic
- Pulses: ☐ Normal, Site ☐ Bounding, Site ☐ Weak, Site ☐ Absent, Site
- Rate _____ /minute Rhythm _____
- Skin temp: ☐ Warm ☐ Hot ☐ Cool/cold
- Skin moisture: ☐ WNL ☐ Dry ☐ Moist

~~2 Suct~~
2 Pleur-vac
trauma panel
wounds to Dyllic
~~back of~~ + Thigh

DISABILITY

GLASGOW COMA SCALE

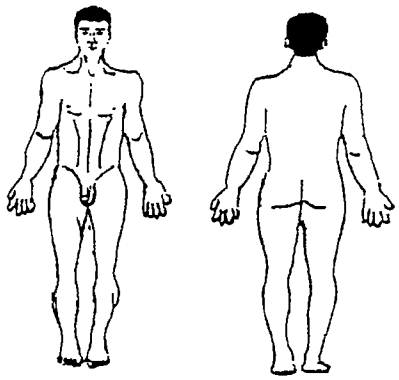
EYE OPENING	SPONTANEOUS	4
	TO VOICE	3
	TO PAIN	2
	NONE	1
VERBAL RESPONSE	ORIENTED	5
	CONFUSED	4
	INAPPROPRIATE WORDS	3
	INCOMPREHENSIBLE WDS	2
	NONE	1
MOTOR RESPONSE	OBEYS COMMANDS	6
	LOCALIZED PAIN	5
	WITHDRAW TO PAIN	4
	FLEXION TO PAIN	3
	EXTENSION TO PAIN	2
	NONE	1

GCS TOTAL:

Pupil Reaction	OS Size	OD Size
☐ Brisk	____ mm	____ mm
☐ Constricted	____ mm	____ mm
☐ Sluggish	____ mm	____ mm
☐ Dilated	____ mm	____ mm
☐ Nonreactive	____ mm	____ mm

2 3 4 5 6 7 8 9

IDENTIFY INJURY SITE BY NUMBER



1. Laceration	6. Open fx	11. Edema
2. Abrasion	7. GSW	12. Amputation
3. Hematoma	8. Stab	13. Avulsion
4. Contusion	9. Burn	14. Pain
5. Deformity	10. Cold	

Head:
~~Nasal tube~~
~~ET tube in place~~

Maxillofacial:

C-spine/neck:

Chest:
~~IV-lateral tubes~~
~~GSW to chest~~

Abdomen

Perineum

Musculoskeletal

Fobell
GSW to
R foot
BP 131/77
P-105
R-18
100% O2
Staples
inside
R thigh
intubated
20mg
of Etomidate
Sag (0900)
VRC
0927 Sme
VRC

SIGNATURE OF PHYSICIAN	DATE	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.

ABBREVIATED MEDICAL RECORD
Standard Form 539

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
PT (b)(6)-4			

DATE	NOTES
28 July 02	Young Afghan male presented c̄ multiple GSW to torso
0845	and extremities. PT arrived via medevac c̄ bilateral chest
	tubes and ET tube in place. PT being bag ventilated. Initial
	vitals on arrival B/P 131/77 P105 R18.
	Dr (b)(6)-2 evaluated PT. PT given 20mg Etomidate and 5mg
	Vec. IV for further sedation and paralyzation.
	- Trauma labs drawn. Confirm ET tube placement by
	- auscultation and Chest x-Ray. 8cm Tube. 26mm at incisors.
	- Pleura Vac System added to each chest tube.
	- Foley Cath already in place. Note 300 cc blood tinged
	and gross blood in tubing. Portable x-Rays series complete.
0907	5mg Vec given 2nd dose. PT on Vent. Setting TV 800 R12 FiO2 100%
0930	PT surgically evaluated by Dr (b)(6)-2 / Dr (b)(6)-2
1000	PT placed on full board c̄ C-collar and head immobilizers
1010	PT placed on Depravan Drip 25mcg/min. Give 1gram Ancef IV.
1025	PT over for complete CT: Head, Chest, Abdomen, Pelvis.
	While in CT. PT received 10mg Vec. IV for paralysis.
1050	PT report given to ICU by Dr (b)(6)-2 PT then transferred
	to ICU. B/P 128/75 P114 R20 O2 SAT 97. (b)(6)-2 RN

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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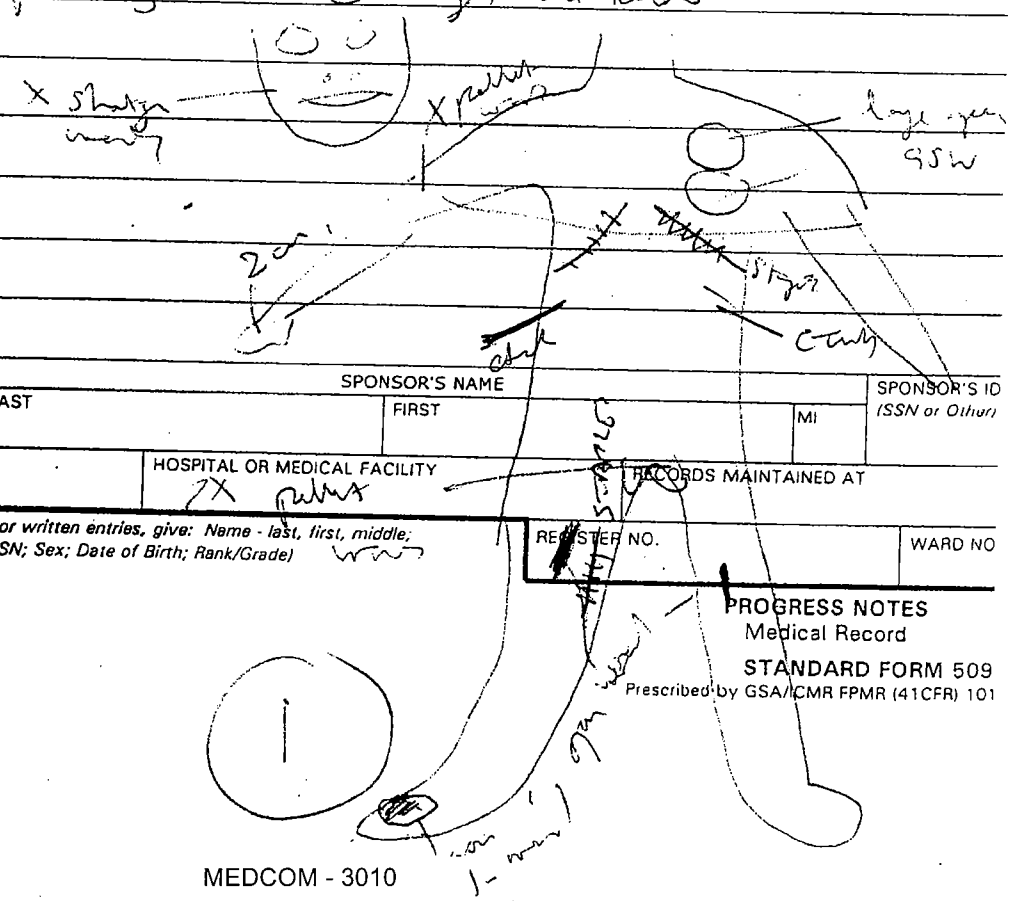
MEDICAL RECORD | ICU | **PROGRESS NOTES**

DATE	NOTES
	H + P
28 Jun 2	CC Multiple GSW
1110L	HPI Teenage Afghan ♂. Multiple GSW
	i° treatment at FST includes bilateral chest tubes
	for ? pneumothorax. Resume thoracotomy B/L, (R) Peritoneal exp
	→ R A @ C5/6 & C7 head, neck, abdo, pelvis
	numerous buckshot shotgun pellets + 2 severe knife-
	wounds on chest & exit over neck + shoulder.
	Bullet pellets in globes
	All unknown — MEDS unknown
	PMH " " — FOB unavailable
	O/E Lab 140 | 105 / 4.2 | 20 — 12 / 114 / 1.1 — INR 1.5 — 10.2 > 13.1 / 34.6 < 53 — PTT 17
	U/A ⊖
	VSS P 101 BP 163/82 RR 98% R 12 (vent)
	Skin pale dry. Eyes ⊖ Eyes see below



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

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

Pt (b)(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Eye exam pt (b)(6)-2 OD
	(L) Severe damage to ant. segment. Severe edema + bleeding
	(R) entry site normal conditions. Ant segment free of blood. Fundus intact.
	Inj (L) eye not straightened.
	PROBLEMS
	S/P BIL THORACOTOMY
	(L) Pneumo Rx Resolved
	BIL CHEST TUBES
	VENTILATION
	. Severe eye injury
	- X wounds — Chest - bullet x 2
	— Knees, feet.
	Platelets 50
	↑ LFT but GGT(N) ∴ c/w muscle damage.
(P)	Vent Mx
	IV Abx
	IV fluids
	Stay w/u
	Follow H+H / platelets
	Pain Mx treatment

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101

2

DATE	NOTES
28 Jun 02	Pt's condition d/w surgeons, LTC (b)(6)-2, CPT (b)(6)-2. Labs
1420	ABG, CT + X rays reviewed
	(P) (1) ortho - OR currently as initial workup
	(2) Resp - stable on vent. if possible D/C ASAP.
	(3) GSU - on Abx
	(4) ophthalmic - D/W LTC (b)(6)-2 / OPHTH to follow.
	Surgical operations not presently available. Upt. behavior that pt not immediately danger to loss vision (P) eye.
	(L) eye no operative repair possible at present
	(b)(6)-2
29 June	Icu
0745	S - stable on mechs. ↓ output of vni
	O - V 97 T max 37.2 pulmonal I 1100 O 415
	Lab 124 / 3.6 | 22 | 17 / 113 / 1.1 11+H 10/29
	O/E pt sedated. (L) pupil undilatable. (R) pupil sluggish
	HS S, S. tachycardic rate ↓ = murmur
	BS OTA
	Wounds - not visualized
A/P	(1) ortho - follow orders Dr (b)(6)-2. AMP + CONT FL
	(2) Resp - plan wean if cxr ok.
	(3) GSU - as (1)
	(4) ophth - IV Abx. Telconsult.
	(5) Hypercoagulation - follow lytes. NS or substitution if req.
29 July 02 11[00] L	Patient tolerated Vent. wean & CPAP x 45 min
	ABG: 7.449/43.6/80/30 96%
	Extubated successfully @ 11[08] to 10L via VM

FPI LEX Printed on Recycled Paper

STANDARD FORM 500 ... BACK

(b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

1350 pm
28 July 02

ORTHO

Skeletally immature ♂ who sustained multiple shrapnel wounds to (R) hands, (L) knee, (R) foot as well as GSW to (L) chest wall + shoulder. Arrived in ER ~~with~~ intubated and paralyzed ∴ no N/V exam possible.

PE: pulses 2+ (B) LE/UE c̄ <3 sec cap refill

2° ortho survey reveals: ∅ crepitus c̄ ROM all joints in (B) UE/LE c̄ exception of (L) shoulder.

Pt is intubated + paralyzed.

Xray: (L) Hand/(R) Hand: Shrapnel in SQ area, ∅ fx

(L) Elbow: shrapnel superficial, ∅ fx

(L) Shoulder: comminuted scapular neck fx c̄ AC disruption and acromial fx

(L) Knee: SQ shrapnel, ∅ EB in joint ∅ free air

(R) Foot: Comminuted Metatarsal fx 3/4/5 c̄ good align. Shrapnel in sinus tarsi area

A/P) Multiple wounds requiring I+D. No possible ORIF c̄ these injuries. S/Ny to (L) arm and splint to (R) LE.

(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

Pt # (b)(6)-4

3

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 3013
509-114

29 Jul 02 ICU E NOTE (CONT)
2013

Labs from earlier: U/A (-) nitrite
micro: many rbc, rare rbc cast

12 / 11.7 / 33.4 / 160 139 / 99 / 3.5 / 13 / 107

A/P (1) Fever: UTI unlikely
Atelectasis possible
doubt wound infection
pt is on gentamycin & ancef
(2) Tachycardia: may be related to fever
doubt pt is volume down
(3) ✓ CXR.
(4) Sx tic Tx & Tylenol

(b)(6)-2

29 Jul 02 CXR: No infiltrate. No atelectasis. B/L chest tubes
2106

(b)(6)-2

30 July 02 S/ Above noted. Patient quite restless last night. Still tachy. Wants to eat.
8 10 L

O/ Tm HR 104 127/67 Sat 94%/D.
Gen: AA in NAD.
Cor: tachy
Lys:
Abd:
Ext: (1) LUE -
Neuro: (1) eye - no reaction

(b)(6)-2

Labs: Hb 10.7 WBC 8.6 plt 116

A/P (1) Mult. injuries: - (1) eye - FB: needs Vitrectomy (for Ophth)
- Bl. re ✓ CXR & consider removal.

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
29 Jul 02 1300	CXR → No Evidence Pneumothorax CT Drainage Decreased Will Get CXR in Am & if OK may remove chest Tubes Pending Further Sug
29 Jul 02 1840	Ian (b)(6)-2 NP c/o tenderness ⊖ ortho - XR ⊖ soft tissue swelling entire L Na Rx ↑ fluids / lasix / Juice as L uni + ↑ Cl Nov Na 139. Bun L 17 → INC 125 ml. follow I + O H + H Hct 32. (b)(6)-2
29 Jul 02 2015	Since extubation, pt has been tachypnic with resp rate 28-32. O_2 Sat has been 92-94%. Also HR has been 121-141. Pt is running a fever at 101.9. Pt is taking shallow breath, states it hurts to take deep breath (he has bilateral chest tubes in). BP has been stable at $\frac{113-153}{55-92}$. Pt has foley Gen: NAD Heart: Tachycardic Lung: Shallow breath, no wheezing, no crackles Abd: ⊕ BS, soft (b)(6)-2 CONT

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID (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
Pt (b)(6)-4		

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101

4

cont'd

Gen: Cor / stable in NAD
Cor:
Chest: B/L CT
Abd: (+) BS
Ext: moves (L) LE

Labs: Lytes - WNL ~~K~~ Na 119
CK 1733 Hb 9.9 Plt 191 WBC 6.8

A/P
(1) Mult. injuries
- eye: await ophthalmologist
- chest: consider D/C (R) CT. cont. abx.
- ext: cont. sling & splint.

(2) ↓ Na+ - suspect fluid retention. Will incr. diuresis.

(b)(6)-2

31 Jul 02 1110 Both chest tubes removed ~~5~~ complication O2 Sat remains @ 96% clinically Good B/S Both Lung Fields will check CXR in AM

(b)(6)-2

1 Aug 02 1002 S/ Neg. report blue-green discharge from posterior wounds & (L) ant. chest wound.

O/ Tm 37.8 VSS 97% on 2L
Gen: resting comfortably in NAD
Cor: reg
Lys: S/P D/C B/L chest tubes c̄ sq. not removed
Abd: (+) BS

(b)(6)-2

cont'd

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
30 July 02 cont'd	- Open (L) upper chest tube:
	- await further recs from surgery
	- (L) UE, s/p debridement, cont - sling.
	- Shrapnel (L) knee:
	- stable.
	- (R) foot & (R) subtalar arthrotomy:
	- cont. splint
	- Disp:
	- needs to be placed for long term medical care. ? where
	(b)(6)-2
31 July 02 830 L	S/ No new problems. Still stable p̄ extubation. Still restless. Currently, resting comfortably.
	O/ Afeb VSS 97% on 4 L →

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.
Pt (b)(6)-4		

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL RE

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1 Aug 02 cont'd	A/P ① Multi. injuries 2° GSW, s/p debridement now c̄ discharge suggestive of pseudomonas: – ↑ abx. – cont. dsg. ↑'l per surgery – cont. sling & split (b)(6)-2 ② ↓ Na+. – resolved, rev'd (135)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID (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

Pt. (b)(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

Pre-Op Note - Ophthalmology

Aug 1 '02 Young Middle Eastern male (unknown age, (15 yrs) race v nationality -) DPW c̄ multiple gunshot v grenade injuries presents c̄ ↓ V.A. OU v fed. chemosis OS. Ho ↓ no V.A. OS and temporal reading OD. Speaks fluent English. No c/o ocular pain. Incident occurred 5 d. ago.

Organic psychosis, anti-psychotics, given Haldol

Exam: VA OD reads medium sized letters on 4x4" sponge pkg

VA 5c OS L.P. but no projection

Lids: Crusting v discharge OU, OS > OD. OS 1-2+ edema

Appears mild, c̄ full ROM.

Pupils OD v 3 mm, reactive.

OS difficult to visualize, 2° large

Conj: OD small area conj. hem. v ↑ to limbus. OS 2-3+ injection hem. v ↑ + edema -

Cornea OD cl.

OS Diffuse, large corneal wound (full thickness).

AC OD appears cl to fundus.

OS uncertain. Corneal wound plugged with entrapped iris.

Patient slope exam:

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

(b)(6)-4

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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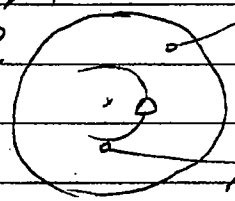
MEDICAL RECORD	PROGRESS NOTES

DATE | NOTES

Cont.

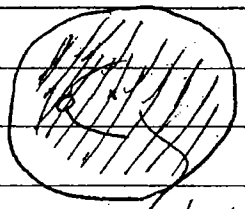
OD



small spot hem.

small white FB in mid-vitreous wh is sl. hazy.

OS



(total vit. hem.

No fundus details seen. One white FB present in mid vit.

CAT scan shows FB's (1 ea) OU - roughly mid vit.

Imp - • Penetrating ocular injury OU c̄ presumed metallic FB's (grenade fragments?).

• Surprisingly little inflammatory reaction OU (almost none OD) - doubt endophthalmitis.

• Exposed uveal tissue OS x 5 d makes sympathetic ophthalmitis a concern.

• Assuming FB's are not copper, will plan to leave in place OU. (no intraocular capsulitis here).

• Pupils have not been dilated, ∴ →

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synechiae may have formed ⓡ.
- IOP unknown but will be determined in O.R. tomorrow.
- No steroids have been used - may have major inflammatory reaction (OS > OD)

Disp: In a.m.: 1) explore OD globe & repair wound(s) in sclera.
2) explore OS globe; repair corneal wound & any other wounds. Enucleate phn.
3) Intravitreal injection of antibiotics & steroids bv.

Remove lens phn.

Problems: 1) No enucleation set available.
2) No intraocular instruments available.
3) No scleral buckling instruments & elements available.
4) No cryosurgery available (also no liquid N_2 & no dry ice)
5) No ophthalmic ultrasound available.

Plan discussed c̄ pt. He understands & has had an opportunity to ask questions. Pt. is febrile (101°) & is growing pseudomonas from surgical wounds. Was having trouble breathing c̄ AB O_2 @ 88 this p.m. More comfortable on O_2.

(b)(6)-2

CPT. USA - MC
Ophthalmology

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Icu
2Aug02	S/P Stay both eyes. No enucleation done.
1855 L	(P) receive pre op orders eye Ancef + Gent IV Fady
	Will D/W Dr (b)(6)-2 (ophthalmology) further Rx (b)(6)-2
	Op Note
2Aug02 1845	Pre-op Dx - Penetrating ocular injuries c̄ retained intra-orbital FB's OU; hyphema + intraocular hemorrhage OS.
	Post-op Dx - Same
	Surgeon - (b)(6)-2
	USAF - MC Col. Ophthalmology -
	Anesthesia - Genl.
	Assistant - Dr.
	Procedure - ~~OD~~ (NO OPERATING MICROSCOPE AVAILABLE)
	OD: Exposure + exploration of 4 orbital quadrants; no post. wounds found.
	Closure of superonasal orbital wound (very small) + 2 mm post to limbus, close to 3 o'c. c̄ 7-0 Vicryl
	Injection of intraorbital antibiotics* +

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.

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PROGRESS NOTES
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stenosis *
- Closure of conjunctiva c̄ 5-0 (!) gut -
Ending pressure 4 mm Hg (Schiotz).
OS: Exploration of all scleral quadrants -
no post. wounds found
Excision of entrapped uveal tissue (iris)
in corneal wounds.
Repair of 2 irregular, necrotic corneal
wounds c̄ 10-0 nylon.
Closure of 1 small superotemporal scleral
wound c̄ 7-0 Vicryl.
No attempt made to remove presumed
ruptured lens, since no phako, cryo-
probe or lens loop available.
No attempt made to remove vit. hem., since
no vitrectomy instrumentation
available.
Intravitreal injection of antibiotics *,
steroids **
Ending pressure unrecordably low (Schiotz).
OU: No attempt made to remove intraocular
foreign body, since no ultrasound,
magnet, vitrectomy equipment or
scleral buckling equipment available.
At end of procedure, Atropine 1% and
Pred Forte and Gentamycin gtts
instilled OU.

Pt. condition - good -
Blood loss - < 5 cc -

(b)(6)-2

* Ceftazidime 1 mg in 0.1 cc (0.1 mg)
Vancomycin 1 mg in 0.1 cc (0.1 mg)
** Dexamethasone 4 mg in 0.1 cc (0.4 mg)

USA - MC Col.
Ophthalmology

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3 Jan 02 P.O. Day #1 note cont.	inferiorly, but hyphema mostly cleared. Pupil - 4 mm. Vit. & fundus not visualized - ? red reflex on first lit. exam.
	Imp: Excellent status OU. Expect recovery of some useful vision OD. Corneal wounds OS may be infected. (C+S pending). Retained intraocular FB's OU. OS may develop R.D. & eventual phthisis unless repair of R.D. can be done + vitrectomy.
	Rxp - Atropine 1% gtt i OU bid. Red Tobr OD gtt i qid. (not OS) Cloxacillin OD gtt i qid " OS q 2 hrs. To be followed by Opt. (b)(6)-2
	(b)(6)-2 CAPT USA-MC

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.

(b)(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

3 Aug 02 Post Op Day #1 - Ophthalmology
No c/o pain or.
OD: VSC can visualize objects on ceiling.
lids - 0 edema
conj - flat, small amt. subconj. hem.
cornea - cl
a.c. formed, deep + cl to trans light
lens - apparently cl to trans light.
vit. - cl. hazy but clearer than pre-op.
fundus - retina flat, disc pink, macula clear
f.f. 2 — white FB in mid-vitreous
OS: VSC "light is brighter than before surgery"
lids - 2+ edema, small amt. discharge.
conj - flat, 3+ subconj. hem., 4-5 mm post. to limbus -
cornea - wound edematous, white-gray, sutures intact.
a.c - formed, deep, small amt. hem. sup. +

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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REGISTER NO.

WARD NO.

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PROGRESS NOTES
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

3 Aug 02 07²⁵ L

S/P Ophtho. procedures - see op. note.
No new problems: Tol. PO. Back wound discharge - still green

O/ Afeb VSS.
Gen: AA in NAD.
Wounds - no Δ.

A/P
1) Mult. GSW c̄ resultant injuries
- cont. abx
- cont. dsg. Δ's.
- cont. splint & splint.

(b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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# (b)(6)-4		

PROGRESS NOTES
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7 AUG 02
Pt resting with. Heat RSR go clear
avait eye level (ns) minor cont to wound
dressings to Back

(b)(6)-2

8 AUG 02 Pt cont to improve. Febrile
wounds on Back clean; cont ō passent
dressing. Transfer when dry dressings only needed.

(b)(6)-2

9 AUG 02
no complaints febrile Hot RSR
Lgs clear cont passent dressing ty.

(b)(6)-2

10 AUG 02. wounds looking much improved ē evidence of
granulation present. Bottle - no drainage.
Cont passent dressing Stage Lgs cont to improve st.

(b)(6)-2

11 AUG 02 wounds cont to clear. no complaints, febrile
staples removed this Am. Hot Lgs stable.
probable detainee center tomorrow

(b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
4 Aug 02 0932	S/ Quiet night. No new problems
	O/ Afeb. VSS
	Exam unchanged
	Plan: – cont. abx
	– cont. dsg. Δ c
	(b)(6)-2
5 AUG, 02	OPTOMETRY:
	PT SEEN FOR F/U ON BILATERAL REPAIR OF PENETRATING INJURIES
	TO GLOBES. RIGHT EYE IS CLEAR AND QUIET WITH NO HYPEMA OR
	SYNECHIA. LEFT EYE HAS SMALL HYPHEMA WITH CENTRAL CORNEAL
	OPACITY FROM PENETRATING INJURY. MEDS: ATROPINE, OCUFLOX,
	BACITRACIN OINTMENT, LASH DEBRIS REMOVAL BID.
	(b)(6)-2 CAPT, OD, NSC

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.

Pt - (b)(6)-4

PROGRESS NOTES
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

12AUG
1000

discharge ~~[illegible]~~ summary

Pt presented c̄ multiple GSW including pellet wounds, shrapnel & gunshot. Sustained penetrating wounds to both eyes no vital structures damaged. Initially presented c̄ bilat chest tubes & intubated from chest wounds (R) & (L) shoulder, shrapnel (L) elbow comminuted fx (R) scapular, anomal fx, shrapnel in: (L) knee, (B) foot comminuted fx. multiple med cleaned, debrided, surgical repair (B) foot, (L) chest wounds, ophth eval for eye wounds, pt extubated 2nd day after admission, drainage for wounds ~~[illegible]~~ Bacitracin cleaned, ophth drops for eyes, healed gradually. wounds repeated to ~~debrident~~ & dressing changes well., reason increasing Back wounds debridement cleaning & granulating, cont. c̄ dressing changes, D/C antibiotics, F/U 1 month for cont. eye tx, no diet dressing A BID,

(b)(6)-2

(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

510-112

NSN 7540-00-634-41

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8/1/02	1°	1345	Arrived as transfer from ICU1 via litter c̄ 2 assist; may assist to transfer to bed. IV LR @ 125cc/hr infusing via flowmeter RUE; foley intact and draining clear yellow urine in bag; DSD intact on bilat shoulders and L ↑ chest; shackled c̄ MP in attendance; excellent use of english; LUE in sling; no ¢ pain at this time. (b)(6)-2 CPT, AN, USAR
1 Aug 02		2130	Lying in bed, eye closed most of this tour. IVF NSS @ 100cc/hr. O2 titrated. Present @ 2L/min. Ro SOX = 99%. Cont. pro pag to monitor VS; 3 lead EKG. Foley cath draining clear amber urine. MP @ bedside. C/O pain x 2 level "8". Medicated as ordered. Sling in place. Drsg intact. Will cont. to observe. (b)(6)-2 MAJ. ANC
2 Aug 02		0800	Alert in bed; lethargic; O2 2LNC; pulse ox >90% c̄ O2; sling on LUE; foley intact and draining clear yellow urine; RUE IV site intact and infusing NSS @ 100 ml/hr via flowmeter; DSD intact over back/LT ↑ chest wounds/PT ↑ rib site; NPO, 2° surgery; no ¢ pain at this time. (b)(6)-2 CPT, AN, USAR

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, mi hospital or medical facility) (b)(6)-2

REGISTER NO.

WARD NO.

(b)(6)-4

NURSING NOTES

Medical Record

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

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
5 Aug 02	0800		(cont) No c/o pain at this time; resp unlabored; minimal bleeding. (b)(6)-2 CPT AN, USN
5 Aug 02	1000		Wound care to B/L ↑ lacy wounds: packing removed, W/D c̄ Dakins solution repacked in sites; LT wound ↑ amount green drainage c̄ min fresh blood. Covered c̄ abd pads, tape; tolerated poorly c̄ ↑ pain; well medicated c̄ pain pills prior to wound care (b)(6)-2 CPT, AN
5 Aug	1900		A&O x3. Pleasant & Cooperative. c̄ back pain. ↑T° 100.4 Tylenol given rest VSS. Vags ⊕ intact (R) F&A. Unable to tolerate sitting. (b)(6)-2 (b)(6)-2 91C03, MC
6 AUG 02			OPTOMETRY: LEFT EYE CONTINUES TO IMPROVE WITH REDUCED ANTERIOR CHAMBER REACTION AND REDUCED HYPOPION. RIGHT EYE IS CLEAR c̄ SEALED PUNCTURE NASALLY. BOTH PUPILS ARE MAXIMALLY DILATED. WILL BEGIN STEROID (PRED FORTE) IN OS TODAY (b)(6)-2 CPT, OD
6 Aug 02	2230		Responds to All Stimuli. Orientated. Medicated for pain. Will cont. to observe. (b)(6)-2 AN

*U.S. GPO: 1989-242-450/02341

NURSING NOTES
Standard Form 510
(Reverse)

CLINICAL RECORD — **NURSING NOTES** (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS (Include medication and treatment when indicated)
8/4/2		1500	Received at transfer from ICU; max assist to transfer from litter to bed; NWB RLE; +Heplock site of RUE D&I; Resting 5 responses; alert during trans-fer 5 40; ~~ace wrap~~ wrapping of RLE D&I; RLE N/D to touch; DSD intact on back and LT ↑ chest wounds; PT demonstrates good to excellent use of English; Staple site wounds of bilat ulcs intact; SS/S drainage; NP in attendance; leg splint on LLE; SS/S trauma to site of DSD on OU; [(b)(6)-2] CPT, AN, OSAR —
[illegible]		2035	A+Ox3. Pt C/O pain/[illegible] - medicated c̄ Percocet @ 20:00. Heplock intact (P) PM. VS WNL - T 100.2° medicated c̄ Tylenol 650mg. V/ass. — [(b)(6)-2] 91W3MC [(b)(6)-2]
5 Aug		0800	alert in bed; RLE drsng D&I; multiple wound sites c̄ staples D&I; PV stool LLE SS/S infection; DSD intact on ↑ LT + RT Back + ↑ LT Chest; very good use of English; voiding QS/day, yellow urine; eye care by CPT [(b)(6)-2] Cont [(b)(6)-2]

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

[(b)(6)-4]

REGISTER NO. [(b)(6)-2]

WARD NO. CPT

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

BOD 9

510-112 NSN 7540-00-634-412

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
7 Aug 02	0830		Pt A&O x3 - Denies c/o pain - Dressings remain intact - Verbalizing c̄ staff when spoken to but does not verbalize (I) for conversation - Only verbalizes to make needs known - USS (b)(6)-2 Sgt, 91W
7 Aug 02	2100		Pt A&O x3 - IVPB given (HL ~~[illegible]~~ for odent) USS. Denies c/o pain. (b)(6)-2
8 Aug 02	1130		Pt A&O x3 - USS - Denies pain but was premedicated prior to dressing D's - Verbalized effectiveness of pain medication p̄ dressing Δ - Small amount of bleeding noted from bilateral back wounds - Moderate amount of Serosanguinous drainage noted on removal dressings - Ø odor noted - Betadine solution applied to W2D - Staples & sutures intact c̄ drainage - (L) arm remains immobilized - Splint intact on (R) lower extremity - Ø ↑ inflammation noted c̄ (L) eye - IV site patent & flushable - (b)(6)-2 Sgt, 91W
AUG 8 2002	1340		OPTOMETRY:
			PT HAS CLEAR ANTERIOR CHAMBER OD c̄ RING OPACITY ON ANTERIOR LENS CAPSULE. OS HAS SMALL HYPOPION c̄ A RESOLVING CORNEAL WOUND (2 SUTURES PRESENT).

(Continue on reverse side) OVER →

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

REGISTER NO.

WARD NO. ICW

(b)(6)-4

Bed #9

NURSING NOTES
Medical Record

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

MEDCOM - 3033

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			INTRAOCULAR PRESSURES WERE 10.2 OD AND 4.0 OS
			(BOTH WELL BELOW NORMAL) CONTINUE TO PRED FORTE
			AND OCUFLOX Q6H OU
			(b)(6)-2 CAPT, OD, MSC.
			OPTOMETRY: ADDED CILOXAN TO MEDS GIVEN Q6H OU
			LEFT EYE HAS RESOLVING CENTRAL PUNCTATE
			OD IS CLEAR, PUPILS REMAIN DILATED OD>OS
			(b)(6)-2 CAPT OD, MSC

U.S. Government Printing Office: 1995 - 404-763/20065 STANDARD FORM 510 (REV. 7-91) BACK

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10Aug02	0800		(cont.) S/S dehiscence; voiding ⊘S clear yellow urine; appetite fair at times; minimal movement in Rt; slings on LUE. ⊘ c/o pain at this time. (b)(6)-2 AN, USAR
10Aug02	0830		Dressing Δ of ↑ back / dotted Δ by M.D. — (b)(6)-2 SP, AN
10Aug02		2300	Pt A+O x3 — Tolerating IV meds — Dressing Δ's done as ordered — (L) arm remains in sling. Pre-medicated c Percocet prior to dressing Δs — Drinking H_2O — Urine clear + yellow — USS — (b)(6)-2 SP, 91WM6
11Aug02	0830		Pt A+O x3 — Ambulated F/A for IVB patent ⊘S/S of infiltration. Flushes easily. Ate 90% breakfast. Vdgs. VSS. (L) arm remains in sling. Drsgs to back dry & intact. Pt requested to get TOOB to chair to get washed & ⊘ Verbalized C/O pain thus far (b)(6)-2 91W3MG (b)(6)-2
11Aug02		1440	(L) flank/chest 14 staples removed ⊘S/S of infection. incision site approximated. (R) flank/chest 13 staples removed site approximated ⊘S/S of infection. 13 staples & 8 stitches removed from abdominal site which edges are approximated ⊘S/S of infection. (L) LE 2 staples removed (R) LE 13 staples & 8 stitches removed edges approximated ⊘S/S of infection to incision site. Drsgs Δ'd to back & shoulder. Patient's W→D drsgs applied. Denies C/O pain — (b)(6)-2 91W3MG (b)(6)-2

510-112

NSN 7540-00-634-41

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8 Aug 02		2135	A&O x3. Pleasant & Cooperative. Ht. (R) hand patent for IV Bacteriostatic. Vdgs. WNL. VSS. & Verbalized c/o pain. [illegible] (b)(6)-2 9 W3MC (b)(6)-2
9 AUG 02			OPTOMETRY: PT HAS CLEAR ANTERIOR CHAMBER OD WITH RING OPACITY (CATARACT) ON ANTERIOR LENS CAPSULE. LEFT HAS SMALL HYPOPION IN INF. ANGLE, CENTRAL CORNEAL OPACITY WITH 2 SUTURES, REDUCED HEME IN ANGLE. POST VITREOUS CLEAR OD, HAZY OS. (b)(6)-2 CAPT, OD, USN
9 Aug 02	0800		Alert in bed; voiding QS clear yellow urine; DSD intact on Rt ↑ back; IV site of RUE D&I; Suture sites over flank/chest intact & good adhesion; receiving opioids through drip per order. Some c/o "Bitter" taste in throat - relayed to MD. (b)(6)-2 PT, AN, USN
9 Aug 02		2225	A&O x3 Pleasant & Cooperative. VSS. Ht (R) FA patent for IV Bacteriostatic DSD & bandaged. Eye gtts given. No verbal c/o pain. Monitor q hour intervals. (b)(6)-2 9 W3MC (b)(6)-2
10 AUG 02	0800		A&O x3 in bed; very good English use; DSD intact on ↑ back/shoulder and LT deltoid incisions over (R) flank/chest staples intact. Cont. (b)(6)-2

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

Continue on reverse side REGISTER NO. WARD

EPW

NURSING NOTES
Medical Record

(b)(6)-4

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

MEDICAL RECORD - NURSING DISCHARGE SUMMARY

For use of this form, see AR 40-407; the proponent agency is OTSG

1. Date/Time: 12 Aug 02

2. Discharge to: ☐ Home Other *(specify)*

3. Mode: ☐ Ambulatory Other *(specify)*

4. Accompanied by:

5. Activity: ☐ Limitations *(specify)*

OOB TO CHAIR With The Assist of ONE. AS TOLERATED.

_____ Patient and/or Significant Other (S.O.) communicates knowledge and understanding of activity limitations.

6. Diet: ☐ No Dietary Restrictions If special, identify

Reg KOSHER

_____ Patient/S.O. communicates understanding of dietary restrictions.

7. Medications: ☐ No Medication Required

Name of Medication	Dosage	Frequency of Medication	Special Instructions
Eye Drops; SEE MEDICATION SHEET.			

_____ Patient and/or S.O. communicates knowledge and understanding of name, dosage, frequency and special instructions.

8. Treatments/Care:

Instructions Given:	Patient/ S.O. observed Demonstrations (Date)	Patient/S.O. Returned Demonstration (Date)
Wound CARE @ (R) & (L) UPPER BACK: WET TO DRY With DAKIN'S SOLUTION. TWICE A day.		

Equipment/Supplies (Specify)

9. Follow-up: You should be seen in _____ clinic in _____ (time period).

(b)(6)-2

_____ Patient/S.O. communicates understanding of follow-up instructions.

10. Patient's Condition (Health Status relative to Nursing Care Plan):

Improved; PT is Partial Care Now.

(b)(6)-2

MAJ ANC

12. Additional Information:

PT is Able: (1) Partial Bath Self (2) Feed Self (3) Speak Clear Concise English

13. Patient Identification:

#

(b)(6)-4

COPY 1 - INPATIENT RECORD COPY

DA FORM 3888-3, JUN 91 REPLACES DA FORM 3888-5, 1 OCT 71, WHICH IS OBSOLETE.

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY (b)(6)-2 / (b)(6)-2 CRNA

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY Anesthesia, Surgeon

3. DATE 28 JUL 02 TIME PATIENT ARRIVED IN SUITE 1354

4. PATIENT IN ROOM TIME 1354 NUMBER (b)(6)-4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Intubated prior to entering O.R.

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2	91D	RELIEF SCRUB	N/9
	(b)(6)-2	91D		
ASSIGNED CIRCULATOR	(b)(6)-2	RN	RELIEF CIRCULATOR	
	(b)(6)-2	91D		

7. POSITION AND POSITIONAL AIDS (Specify)

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

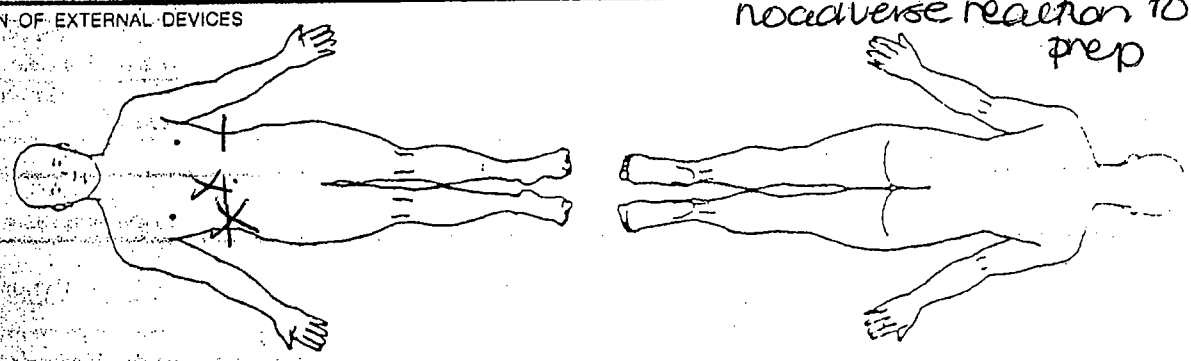
COMMENTS: modified beach chair
Tape strap across forehead + abdomen c̄ towels

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine
SITE: (W) shoulder / BY WHOM: (b)(6)-2 / (b)(6)-2
SITE: Chest bilat legs BY WHOM:
COMMENTS: no pooling of solution / no adverse reaction to prep

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

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

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

(b)(6)-4

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

☒ ESU NO: 001011
GROUND PAD: BRAND Valleylab
LOT NO: 56773 2003/12

☒ ESU NO: 000999
GROUND PAD: BRAND Valleylab
LOT NO: 56773 2003/12

☐ BIPOLAR NO: N/A

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
Cancef	1gm	intra-op	irrigation	(b)(6)-2	Surgeons

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
cancef 1gm / L NSS

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1. N/A	2.	3.
SITE	1. N/A	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)
shoulder - gauze / opsite
legs - gauze / opsite /
foot - Kerlix
(R) hand - gauze / Kerlix

19. ADDITIONAL INFORMATION
bilateral chest tubes + foley inserted prior to entering O.R.

20. OPERATION(S) PERFORMED
debridement of (R) shoulder, chestwall (R) knee, (R) foot (R) subtalar arthrosteny (R) hand

21. PATIENT TRANSFERRED TO ICU TIME 1528 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2, RN ICU

REVERSE OF DA FORM 5179-1, OCT 87

U.S. GPO: 1998-404-813/40449

MEDICAL RECORD | **INTRAOPERA[illegible] OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY (b)(6)-2

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

3. DATE 30July02 TIME PATIENT ARRIVED IN SUITE 1720

4. PATIENT IN ROOM TIME 1720 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 Z 91D N/a	RELIEF SCRUB	N/a
ASSIGNED CIRCULATOR	(b)(6)-2 RN (b)(6)-2 91D	RELIEF CIRCULATOR	a

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: armboards 2nd pillow between legs / arms tape strap across arms / thighs / legs

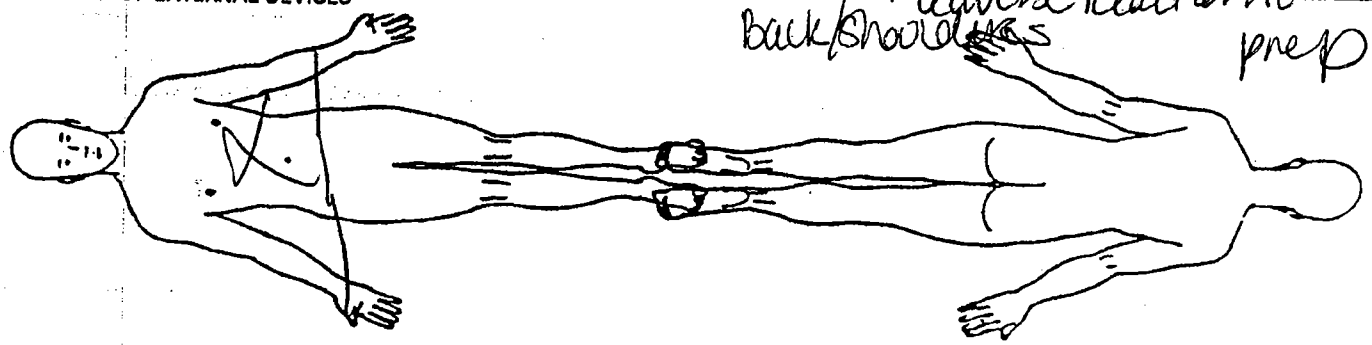
8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine
SITE: (b) lat legs BY WHOM: (b)(6)-2
SITE: (b) shoulder BY WHOM:
COMMENTS: no pooling of solution / no adverse reaction to prep

9. LOCATION OF EXTERNAL DEVICES

Back/Shoulders



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

C = Correct I = Incorrect

10. COUNTS

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	(b)(6)-2 91D	(b)(6)-2 RN
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

(b)(6)-4

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

☒ ESU NO: 001011
GROUND PAD: BRAND valleylab
LOT NO: 567773 / 2003 12

☐ ESU NO:
GROUND PAD: BRAND N/a
LOT NO:

☐ BIPOLAR NO:

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

MEDCOM - 3040

13. PROSTHESIS, IMPLANTS ☐ ☒ NO IF YES NAME: ID NU: F JFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
ancef	1gm	intra-op	irrigation	(b)(6)-2	(b)(6)-2 Surgeon

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

ancef 1gm / 1L NSS

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN (b)(6)-2

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME N/A	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 ☐ (b)(6)-2 8/26/02

TYPE/SIZE	1. ent	2. Kerlix	3.
SITE	1. KC 7-30-02	2. Back	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

xeroform / gauze / Kerlix

Multiple sites

19. ADDITIONAL INFORMATION

N/A

20. OPERATION(S) PERFORMED

debridement bilateral legs, Pectoralis repair, partial closure clavicle shoulder, I+D of shoulder + back

21. PATIENT TRANSFERRED TO Recov TIME 1950 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 RN BSN / LT

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDICAL RECORD — **INTRAOPE : DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA LITTER BY (b)(6)-2

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

3. DATE 2 Aug 02 **TIME PATIENT ARRIVED IN SUITE** 1050

4. PATIENT IN ROOM TIME 1050 **NUMBER** 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 SGT 91D	RELIEF SCRUB	
	(b)(6)-2 SGT 91D		
ASSIGNED CIRCULATOR	(b)(6)-2 CPT 2U	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

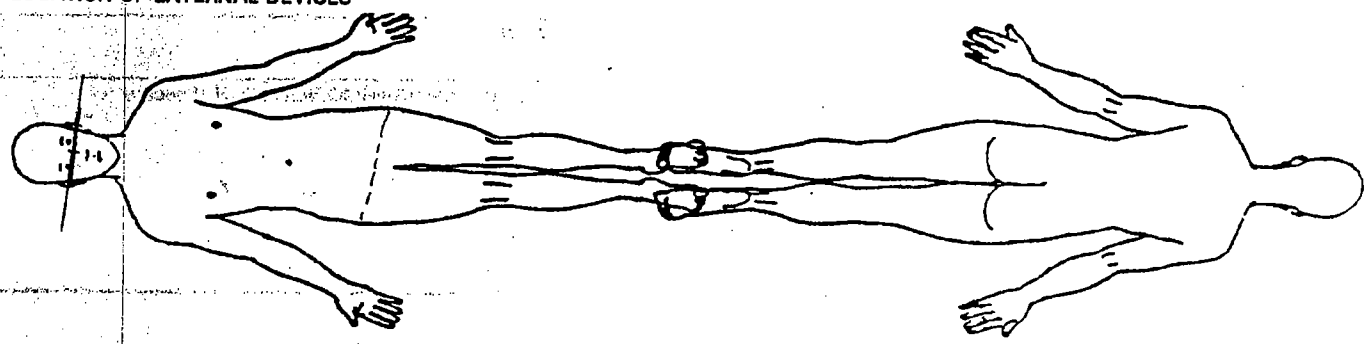
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine
SITE: face BY WHOM: CPT (b)(6)-2
SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap = = = Tourniquet

10. COUNTS C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☒ No				(b)(6)-2 91D	(b)(6)-2 2U
Needle Sharp	☒ Yes	☐ No		C	C	(b)(6)-2 91D	(b)(6)-2 2U
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;)*

(b)(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ ☒ NO IF YES NAME: ID NUM ACTURER

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):

BSS 15ml

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 ② CSM ~~Left~~ Right Eye	NAME ② CSM ~~Left~~ Right Eye.
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Right Eye - 4x4's, 1" Tape over plastic container - Left Eye - 4x4's, 1" Tape over plastic Eye

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

Closure Sclera Wound Right Eye; Injection of Antibiotics and Steroids O.D.; Corneal Wound Repair Left Eye; Exploration of Globe; Closure Sclera Wound O Eye; Injection of Steroids/Antibiotics

21. PATIENT TRANSFERRED TO	TIME	METHOD
PCU		Wheel

22. REGISTERED NURSE SIGNATURE

(b)(6)-2

REVE

USAPA V1.00

MEDICAL RECORD — **INTRAOPER DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY MAJ (b)(6)-2

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

3. DATE 03 AUG 2002 TIME PATIENT ARRIVED IN SUITE 1139

4. PATIENT IN ROOM TIME 1139 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [ ] OTHER (Specify)

COMMENTS: ~~Language~~ SMD 03 AUG 2002 Barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 91D	RELIEF SCRUB	N/A
ASSIGNED CIRCULATOR	(b)(6)-2 91D	RELIEF CIRCULATOR	N/A

7. POSITION AND POSITIONAL AIDS (Specify)

[ ] SUPINE [ ] LITHOTOMY [ ] PRONE [ ] KRASKE LATERAL: [X] LEFT SIDE UP [ ] RIGHT SIDE UP

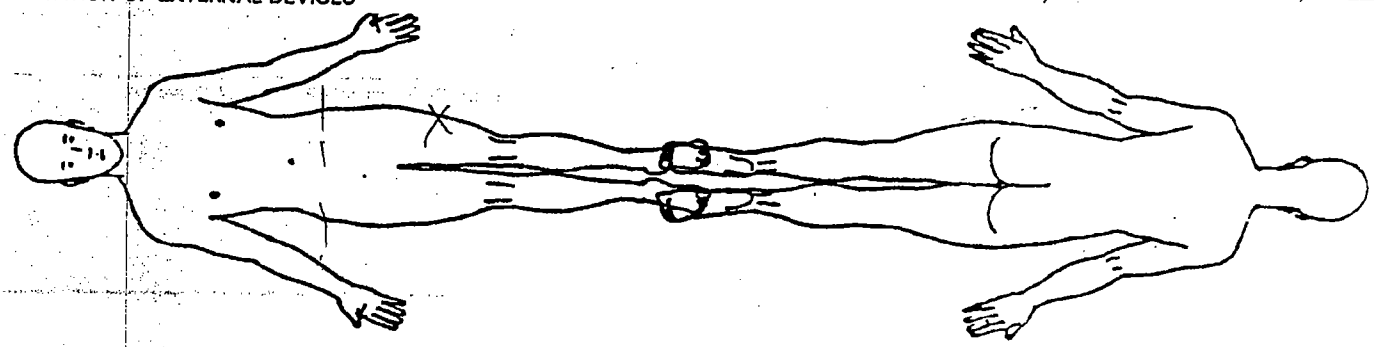
COMMENTS: Axillary Roll, Chest Rolls Front & Back, Pillow Between Legs, Safety Straps Armboard, Axilla, Left Arm

8. SKIN PREPARATION

HAIR REMOVAL [ ] YES [X] NO
DONE BY: [ ] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP
COMMENTS: N/A

PREP SOLUTION (Specify) Betadine Solution
SITE: Upper (2) Quadrant BY WHOM: MAJ (b)(6)-2
SITE: Chest to Back BY WHOM:
COMMENTS: NO POOLING, NO ADVERSE RXN

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad — Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes	[ ] No		C	C	(b)(6)-2 M 91D	(b)(6)-2 91D
Needle Sharp	[X] Yes	[ ] No					
Instrument	[ ] Yes	[X] No					
Other	[ ] Yes	[X] No					

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

(b)(6)-4

AMEPU

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) [X] YES [ ] NO

ESU NO: 00/011
GROUND PAD: BRAND Valley Lab
LOT NO: 56773 / 2003-12

[ ] ESU NO:
GROUND PAD: BRAND
LOT NO:

[ ] BIPOLAR NO:

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

13. PROSTHESIS, IMPLANTS ☐ ☒ NO IF YES NAME: ID NUM. T ACTURER

N/A

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
ANCEF	1gm / L		Irrigation	(b)(6)-2	Surgeon
	N/A				

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

Ancef 1gm/L

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSIC (b)(6)-2

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1. N/A	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Xeroform/gauze/tape

~~Kerlix~~ Tape (b)(6)-2

19. ADDITIONAL INFORMATION

Foley inserted prior to entering OR

GSW Back packed w/3" Kling w/NSS

(b)(6)-2 RN, BSN

20. OPERATION(S) PERFORMED

Irrigation & closure chest GSW

Irrigation Back GSW

21. PATIENT TRANSFERRED TO ICU 1 TIME 1252 METHOD Litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 SrD (b)(6)-2 RN BSN

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

511-117

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	16AUG02	16Aug02	12AUG							
POST- DAY	1700HRS									
MONTH-YEAR / DAY										
19 / HOUR	2000		0900							

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 18 | 18 | 20

BLOOD PRESSURE: 109/48 | 118/81 | 108/72 | 115/74

HEIGHT: | WEIGHT →

SAO2: 90 RA | 100 95 RA

Record special data only when so ordered

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

(b)(6)-4

REGISTER NO.

WARD NO.

Bed 9

AM EPW

VITAL SIGNS RECORDS
Medical Record

STANDARD FORM 511 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	2002									
POST- DAY	8/4	8/5	8/6	8/7/02	8/7	8/8/02	09AUG02			
MONTH-YEAR / DAY										
19 / HOUR	0800	0800	0800	2000	0800	2000	0800	2000	0800	2000

PULSE (0) / TEMP. F (°): 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

PULSE (0): 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 18 | 18 | 18 | 18 | 18 | 18 | 16 | 18 | 18 | 18

BLOOD PRESSURE: 2030 96/64 | 1945 128/84 | 0832 122/86 | 0800 116/76 | 2100 120/76 | 0800 124/86 | 2045 112/74 | 2125 120/68 | 2200 108/68 | 0800 118/74

HEIGHT: | WEIGHT →

Record special data only when so ordered: SpO2 92 2030 RA | SpO2 92 1945 RA | SpO2 96 2100 RA | SpO2 95 2125 RA | SpO2 93 2200 RA

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)* | REGISTER NO. | WARD NO.

STANDARD FORM 511 (REV. 7–91) BACK

*U.S. Government Printing Office: 1992 — 312-071/50030

(b)(6)-4

VS 94°

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST- DAY		8/1/02	8/2/2														
MONTH-YEAR	DAY																
19	HOUR	1400															
PULSE (O)	TEMP. F (°)																TEMP. C
	105°																40.6°
180	104°																40.0°
170	103°																39.4°
160	102°																38.9°
150	101°																38.3°
140	100°																37.8°
130	99°																37.2°
	98.6°																37.0°
120	98°																36.7°
110	97°																36.1°
100	96°																35.6°
90	95°																35.0°
80																	
70																	
60																	
50																	
40																	
RESPIRATION RECORD		24	24														
BLOOD PRESSURE		126/67	116/41														
		2100 119/65															
HEIGHT:	WEIGHT →																
		2100 SPO2-99	2100 SPO2 99%														

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

#

(b)(6)-4

STANDARD FORM 511 (REV. 7-91) BACK

*U.S. Government Printing Office: 1992 — 312-071/50030

(b)(6)-4

RESPIRATORY SUPPORT SYSTEM

Date 28 Jul 02

Time	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
FiO_2							100	100	50		50	40			40		40	~~40~~		40				
Ventilator Model						154	~~A/C~~	~~A/C~~	154		154	154			154		154			154				
PEEP/CPAP, cmH_2O							10	10	10		10	10			10		10			10				
Vent Mode							A/C	A/C	A/C		A/C	A/C			A/C		A/C			A/C				
Volume set, ml•breath^{-1}							450	450	500		530	600			600		600			600				
Rate set•min^{-1}							12	12	14		18	16			16		16			16				
Insp. Flow Rate, l•min^{-1}							—	—	—		—	—			—		—			—				
Pres. Support, cm H_2O							—	—	—		—	—			—		—			—				
Spontaneous Rate							—	—	—		—	—			—		—			—				
Spontaneous TV							—	—	—		—	—			—		—			—				
Tot Min Vent, l•min^{-1}							5.4	5.4	9.0		9.0	9.5			9.5		9.5			9.4				
[redacted] Control cmH_2O							—	—	—		—	—			—		—			—				
Peak Airway Pressure							30	30	30		24	36			34		29			34				
Therapist's Initials							(b)(6)-2																	

BLOOD GAS LABORATORY VALUES

Time Obtained								1217	1317				1709											
Source (A or V)								A	A				A											
pH								7.192	7.379				7.483											
PCO_2 mmHg								72.6	38.9				34.8											
PO_2 mmHg								291	—				137											
tO_{2c} Vol %								30	24				25											
HCO_{3c} mmol/L								28	23				24											
ABE_c mmol/L								0	2				1											
tHb g/dL								—	—				—											
[redacted]b %								—	—				—											
SO_2 %								100	98				99											
Ca ++ mmol/L								—	—				—											
Na + mmol/L								—	—				—											
K + mmol/L								—	—				—											
Cl- mmol/L								—	—				—											
Tonometer PCO_2								—	—				—											
Ton-Art PCO_2								—	—				—											

ON-LINE PARAMETERS

Pulse Oximeter SaO_2												100	100	100			100			100				
Oximeter SvO_2																								

MEDCOM - 3049

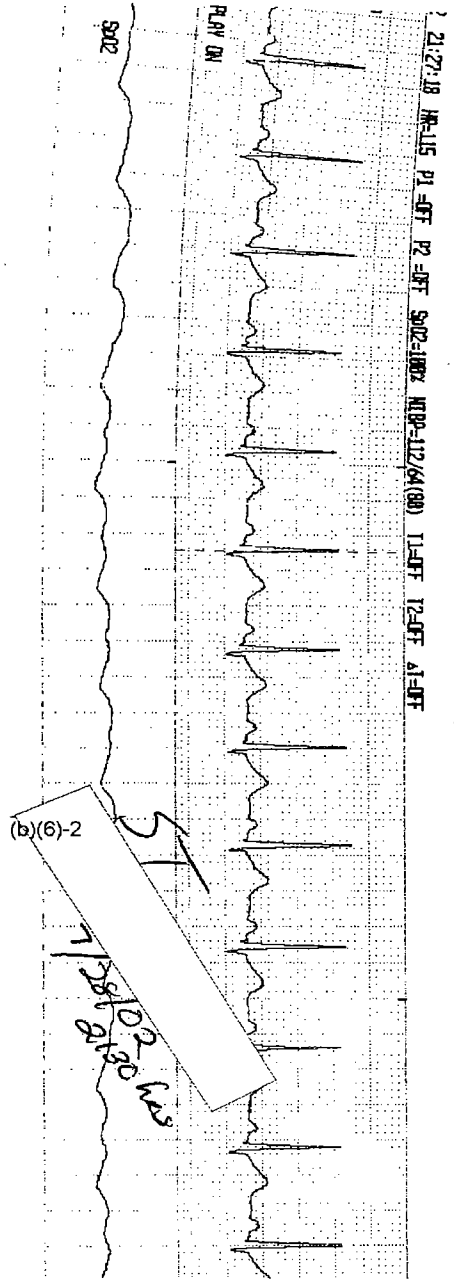
NURSING PROGRESS NOTE

RESPIRATORY PROGRESS NOTE

1200 ABG results indicate excess CO_2 w/ ↓pH. ↑RR18 ↑VT500 ↓FIO2 5
remains 10 PEEP A/C BS clear eq/bil. (b)(6)-2 T
1317 ABG results improved - pt stable RT
1535 pt returned from OR intub. BS clear bil/eq. RT
1615 Dr. (b)(6)-2 order for vent: VT 600 RR 16 10 PEEP 40% S/RT
ABG @ 1700 VR 65 RR16 SAT 100 S/RT
1715 ABG drawn no changes per Dr. (b)(6)-2 S/RT
1900 pt stable, suctioned - no sputum. BS bil/eq. RT
2130 pt stable on vent VR 107 RR 16 SAT100 BS clear /bil RT
2400 pt stable on vent RT

ADDRESSOGRAPH

EKG RHYTHM STRIPS



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i-STAT G3+

Pt: (b)(6)-

Pt Name: AMEPW #(b)(6)-4

TCO2_____25 mmol/L

At 37C

pH_____7.483

PCO2_____32.3 mmHg

PO2_____137 mmHg

HCO3_____24 mmol/L

BEecf_____1 mmol/L

sO2*_____99 %

*calculated

Sample Type_:

28JUL02 17:09

Oper: 5965

Physician: Dr. (b)(6)-2

Ser# 40004

Ver: JAMS043C
CLEW A84

---

*SEE PROGRESS NOTES: (b)(6)-4

INTAKE CC/HR

Date 28 July 07

INTAKE	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LR							100	100	100			100	100	100	100	100	100	100	100	100	100	100	100	100
Nimbex							5	5							5	5	7	7	7	7	7	7	7	OFF
Propofol							3	10							15	15	25	25	25	25	25	25	25	25
meds																								
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds																								
ORAL																								
Hourly Total															120	120	132	132	132	132	132	132	132	132
Cumulative Total															120	240								1300

OUTPUT CC/HR

OUTPUT	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly								425				550					250	20	30	35	65	35	35	30
Urine Cumulative																								
Emesis/Gastric																								
Stool																								
Output Hourly																								
Output Cumulative																	250							500
Spec. Grav./U.R.																								
Gastric pH																								

TRANSFUSION THERAPY

TYPE	UNIT NO.	TYPE	UNIT NO.	TYPE	UNIT NO.

TOTAL INTAKE

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
ORAL				
IV	223			
NG				
Bld				
TOTAL				

TOTAL OUTPUT

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
URIN	550			
NG				
TOTAL				

MEDCOM - 3052

*SEE PROGRESS NOTES: (b)(6)-4

STAT LABORATORY DATA

Date 30 July 03

Time																								
Glucose																								
BUN/CR.																								
Na+																								
K+																								
Cl-																								
HCO_3-																								
WBC																								
Hb/Hct																								
PLT																								
PT/ct																								
PTT/ct																								

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.	TIME	DRUG/DOSE	Route	Init.		DRUG/DOSE	Route	Init.
1210	MSO4 5mg	IV	(b)(6)-2	0430	Fentanyl 50 mcg	IV	(b)(6)-2				
1215	MSO4 5mg	IV									
1245	Fentanyl 50mcg	IV									
1300	Fentanyl 50 mcg	IV									
1730	Fentanyl 50 mcg	IV									
1930	Fentanyl 100 mcg	IV									
2100	Fentanyl 50 mcg	IV									
2200	Fentanyl 50 mcg	IV									
2300	Fentanyl 50 mcg	IV									
2400	Fentanyl 50 mcg	IV									
00	Fentanyl 50 mcg	IV									
0140	Tylenol 650 supp	PR									
0210	50 mcg Fentanyl	IV									

Fentanyl 50-100 mcg Q1° PRN

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

HT.
WGT.
WGT.
YESTERDAY
PREVIOUS DAY
INTAKE
OUTPUT
BSA
ALLERGIES

ADDRESSOGRAPH

(b)(6)-4

SIGNATURE AND INITIALS NURSE/RESP. THERAPIST

	Init.
(b)(6)-2 RN	(b)(6)-

MEDCOM - 3053

*SEE PROGRESS NOTES:

Name (b)(6)-4

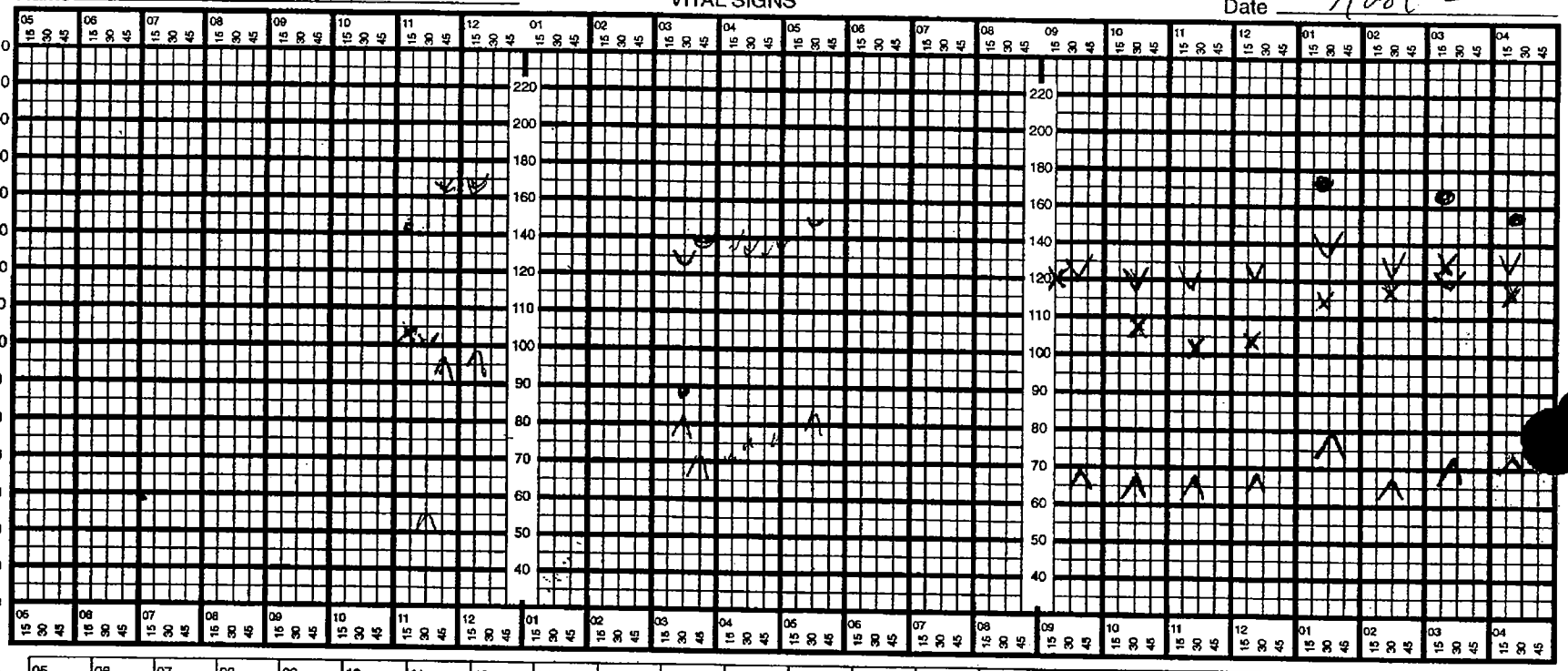
Date 7/28/02

VITAL SIGNS

°F °C

105 40.6 240
104 40.0 220
103 39.4 200
102 38.9 180
101 38.3 160
100 37.8 140
99 37.2 120
98.6 37.0 110
98 36.7 100
97 36.1 90
96 35.6 80
95 35.0 70
60
50
40
30

HR X
SBP
DBP
TEMP •



HEMODYNAMICS

	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR						105	130	108	OR		68	68	90	94			120	107	101	104	114	119	121	117
Rhythm						ST	ST	ST			SR	SR	SR	SR			ST	ST	ST	ST	ST	ST	ST	ST
RESP.						12	18	18			18	18	18	18				18	18	18	18	16	16	16
CUFF BP						136/78	167/96	99/54			158/71	135/77	123/70	148/75			120/69	117/68	108/67	120/69	132/90	120/66	118/71	120/74
MAP							121	69			95						(88)	184	(89)	(89)	(98)	(86)	(88)	(93)
PAS/PAD																								
PCW																								
CVP																								
CO/CI																								
SPO_2 ~~SaRI~~						100	100	99			100	100	100	100			100	100	100	100	100	100	100	100

DRUG UNITS

	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
ANCEF 1GM																								
GENTAMYCIN 400MG IV Q8																								
NEMBEX IV TITRATE/EFFECT							5	5	5 5		5	5	5	5			7							
PROPOFOL IV TITRATE/EFFECT							3 3 3	10	10 10		10	10	10 15	15	15		25							
Tagamet 300mg IV BID																								

(b)(6)-2

(b)(6)-2

MISCELLANEOUS HOURLY OBSERVATIONS

(b)(6)-2

NURSING PROGRESS NOTE

1115 Admitted to ICU #1 Afghan ♂ c/p multiple GSW/missile wounds. Sedated, paralyzed, intubated. (R) pupil reactive. (L) eye damaged/non reactive. HR 80c - TGS NSR. s/p Lung c/lower. Bilateral thoracotomy incisions approximated c̄ staples intact. Bilateral Chest tubes intact → Pleurevac both draining small amt serosanguineous fluid. Subq emphysema present between (R) chest tube & axilla. [illegible] penetrating wound noted posterior thorax approx 6cm [illegible] of Neck. (R) Large open wound present (anterior) chest wall approx 4x8cm packed c̄ gauze. (b)(6)-2 Soft BS present x4. Multiple small missile wounds present (R) hand/face. 2 wounds noted (R) scrotum c̄ swelling noted. Dress → Bilateral knee wounds dry/intact. (R) foot dress dry/intact. 1450 given for tachycardia @ 1210 & 1215 [illegible] c̄ slight relief. Fentanyl given @ 1245 for more complete relief of tachycardia & Propofol ↑ to 10 mcg/kg/min. To OR for multiple wound debridement @ 1315 Returned 1550.

(b)(6)-2

(2030) Assessment complete + noted: monitor intact c̄ alarms on; pt sedated c̄ propofol + nimbex + receiving Fentanyl PRN for pain control; Note (R) nare + ITS c̄ lt green/brown drainage present; ETT secured to vent c̄ settings of AC/16/600/40%/+10 c̄ collar intact; (L) chest wound dressing intact c̄ no active drainage/bleeding; (R) + (L) Thoracotomy incisions c̄ staples intact; (R) + (L) Chest tubes secure to 20cm suction, serosanguinous drainage present in chambers; (R) lateral chest c̄ small amount SQ air noted + marked; Dressing to (R) hand c̄ serosanguinous drainage present; scrotum c̄ 2 small puncture wounds + no present drainage; foley secure, patent c̄ clear yellow urine; (R) Thigh, calf + foot dressings dry/intact; (L) knee dressing dry/intact. CAT

(2100) Pt. awakens fair to communicate + sat up; 50mg Fentanyl for pain; Propofol ↑ 25mg/kg/min; Nimbex ↑ 7mg/hour. CAT

(0100) Urine appears to have sediment (cloudy) in it. CAT (0140) Temp 101° axillary; Tylenol supp. PR x1. CAT (0330) Nimbex off. CAT

NURSING PROGRESS NOTE

FORM 0021

☆U.S. GPO: 1997—508-276

*SEE PROGRESS NOTES:

PROCEDURES		OBSERVATIONS		TREATMENTS
TIME		7 - 4	4 - 12	12 - 8
NEUROLOGICAL		→	SEE CODE	→
Eyes Open	Closed by swelling = C			
Verbal Response	ET Tube or Trach = T			
Motor Response				
Pupils R - react NR - non SR - slow	Size R			
	Reaction			
	Size L			
	Reaction			
	Hand Grasp R/L			
ath Sounds				
Sputum Character				
Nasal Endotracheal Suctioning Q ____				
Chest PT Q ____				
CDB/IS Q ____				
Vent. ✓'s				
E.T. Tube @ ____				
Cuff ✓/Pr/cc's				
C.T. Strip & Vent Q ____				
C.T. Fluctuates / ___ cm.				
ipheral Pulses **	U			
	L			
Circ. Distal to A-Line				
Monitor Alarm On				
PA Line				
CVP/Other				
Art Line				
Peripheral				
Peripheral				
PT/Family Teaching/Support				

(b)(6)-2

Spontaneous	4
To Speech	3
To Pain	2
None	1
Oriented	5
Confused	4
Inappropriate Words	3
Incompreh. Sounds	2
None	1
Obeys Commands	6
Localize Pain	5
Withdraws to pain	4
Flexion to Pain	3
Extension to Pain	2
None	1

2 3 4 5 6 7 8 9 10

**PULSE CODE

DOPPLER . . . . . D

PALPABLE . . . . . P

STRONG . . . . . S

WEAK . . . . . W

ABSENT . . . . . A

FLEETING . . . . . F

PROCEDURES	OBSERVATIONS		TREATMENTS
TIME	7 - 4	4 - 12	12 - 8
Bowel Sounds			
ABD Size/Firmness			
NG Secure/Proper Pos.			
✓ Patency Q4°			
Aspirate Contin. Feed Q4			
Aspirate Prior to Bolus Feed			
Stool Char./Gualac			
Urine Color/Character			
Foley Secure/Patent			
External Cath.			
Catheter Care			
Colostomy/Ileostomy Care			
Bath			
Turn & Position Q ____			
Skin Care			
Mouth Care			
Trach / E.T. Care			
ROM			
Dangle			
Restraints Released Q2H			
OOB to Chair			
Ambulation			
Side Rails ↑			
Drsing. Δ			
Drsing. Δ			

(b)(6)-2

ADDRESSOGRAPH

MEDCOM - 3056

(b)(6)-4

RESPIRATORY SUPPORT SYSTEM

Date 7/29/02

Time	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
FiO_2	40		40		40	30																		
Ventilator Model	754		754		754	754																		
PEEP/CPAP, cmH_2O	10		10		5	5																		
Vent Mode	A/C		A/C		A/C	A/C																		
Volume set, ml•breath^{-1}	600		600		600	600																		
Rate set•min^{-1}	16		16		16	12																		
Insp. Flow Rate, l•min^{-1}	—		—		—	—																		
Pres. Support, cm H_2O	—		—		—	—																		
Spontaneous Rate	0		0		0	6																		
Spontaneous TV	—		—		—	—																		
Tot Min Vent, l•min^{-1}	9.6		9.5		9.5	9.6																		
[illegible]. Control cmH_2O	—		—		—	—																		
Peak Airway Pressure	35		34		29	29																		
Therapist's Initials	(b)(6)-2																							

BLOOD GAS LABORATORY VALUES

Time Obtained			0907																					
Source (A or V)			A																					
pH			7.445																					
PCO_2 mmHg			34.8																					
PO_2 mmHg			150																					
tO_{2c} Vol %			25																					
HCO_{3c} mmol/L			24																					
ABE_c mmol/L			0																					
tHb g/dL			—																					
[illegible]b %			—																					
SO_2 %			99																					
Ca ++ mmol/L			—																					
Na + mmol/L			—																					
K + mmol/L			—																					
Cl- mmol/L			—																					
Tonometer PCO_2			—																					
Ton-Art PCO_2			—																					

ON-LINE PARAMETERS

Pulse Oximeter SaO_2	100		100		100									93				94						
Oximeter SvO_2																								

(b)(6)-4

*SEE PROGRESS NOTES:

INTAKE CC/HR

Date 7/29/02

INTAKE	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LR	125	500	125	125	150	150	500	125	125	125	125	125	125	125	125	125	125	125	125	~~125~~ 500	125	125	125	125
Propofol	25.5	25.5	25.5	25.5	25	25	30	15	5	5	5	—												
MEDS				50															50					
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds																								
ORAL								140																
Hourly Total	150	525	150	200	175	175	530	~~500~~ 1945	130	130	130	125	125	125	125	125	125	125	175	500	125	125	125	125
Cumulative Total	150	1675	825	1025	1100	1275	1805	1945	2075	2205	2335	2460	2585	2710	2835	2960	2385	2510	2685	3185	3310	9435	3560	3685

OUTPUT CC/HR

OUTPUT	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly	30	30	45	60	50	90	200 ~~200~~ 400	1000	230	85	70	70	70	~~65~~	110	70	75	90	80	30	80		180	140
Urine Cumulative																								
(L) CT															80									10
NG Total		200														Call	day	100		100				200
Emesis/Gastric																								
Stool																								
(R) CT															20	~~70~~								10
Output Hourly	30	230	45	60	50	90	400	1000	230	315	70	70	70	65	220	70	75	190	80	130	80		180	~~190~~ 370
Output Cumulative		260	305	365	415	505	905	1905	1135	1450	1520	1590	1660	1725	1945	2015	2090	2280	2960	3090	3170		3350	3740
Spec. Grav./U.R.																								
Gastric pH																								

-65

TRANSFUSION THERAPY

TYPE	UNIT NO.	TYPE	UNIT NO.	TYPE	UNIT NO.

TOTAL INTAKE

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
ORAL				
IV				
NG				
Bld				

TOTAL OUTPUT

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
URIN				
NG				

NURSING PROGRESS NOTE

RESPIRATORY PROGRESS NOTE

0500 pt stable on vent, settings on reverse side of chart, ♡R 117 RR 16 SAT 100 BS clear, ET tube 8.0 26 @ lip (b)(6)-2 /RT

0714 pt stable ABG results good, RT suggest ↓RR & PEEP, will wait for Dr. order BS clear Bil/equal tube placement 26cm @ lip cuff pressure 28 cmH2O (b)(6)-2 /RT

0829 ↓ PEEP to 5 as per Dr. (b)(6)-2 suggestion he's recieving too much O2 (b)(6)- /RT

1055 ABG 30 min CPAP suggests extubation @ 1115 /B6-2

RR 26 ♡R 134 SaO2 96% on 10L SM w/ humid. [redacted] /RT

1430 ♡R 112 RR 28 SaO2 97 BS clear eq./bil 5L SM w/ humid. [redacted] /B6-2

1800 pt stable on 5L humidified O2 ♡R 119 RR 32 SAT 92 BS clear [redacted]

→ TMS/RT

2200 pt stable on 5L humidified O2 ♡R 112 RR 30 SAT 94 BS clear (b)(6)-2 /RT

2330 pt stable on 5L humidified O2 ♡R 102 RR 27 SAT 93 (b)(6)-2 /RT

ADDRESSOGRAPH

AM & PM (b)(6)-4

EKG RHYTHM STRIPS

02 08:28:31 HR=111 P1 =OFF P2 =OFF SpO2=100% NIBP=125/71(89) T1=OFF T2=OFF ΔT=OFF

DISPLAY ON

SpO2

29/02 20:02:40 HR=123 P1 =OFF P2 =OFF SpO2=93% NIBP=113/55(75) T1=OFF T2=OFF ΔT=OFF

AY ON

SpO2

Sinus Tach (b)(6)-2 RN ILT 7/29/02 2000hrs

ADDRESSOGRAPH

Mason #

(b)(6)-4

*SEE PROGRESS NOTES: (b)(6)-4

STAT LABORATORY DATA

Date 1/29/02

Time																								
Glucose																								
BUN/CR.																								
Na+																								
K+																								
Cl-																								
HCO_3-																								
WBC																								
Hb/Hct																								
PLT																								
PT/ct																								
PTT/ct																								

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.	TIME	DRUG/DOSE	Route	Init.		DRUG/DOSE	Route	Init.
0600	50mcg Fentanyl	IV	(b)(6)-2	2115	50mcg Fentanyl	IV	(b)(6)-2				
0715	50mcg Fentanyl	IV		2215	50mcg Fentanyl	IV					
0815	50mcg Fentanyl	IV		2345	50mcg Fentanyl	IV					
0915	50mcg Fentanyl	IV		0140	50mcg Fentanyl	IV					
~~0920~~ 1020	5mg MSO4	IV		0205	Valium 1mg IV	IV					
1030	50mcg Fentanyl	IV									
1035	Lasix 40mg	IV									
1130	50mcg Fentanyl	IV									
1230	50mcg Fentanyl	IV									
1330	50mcg Fentanyl	IV									
15	50mcg Fentanyl	IV									
1720	50mcg Fentanyl	IV									
1830	50mcg Fentanyl	IV									

Fentanyl 50-100mcg Q1° PRN-PAIN

~~Nimbex 7mg IV Q1° D/C 1/29/02~~

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

HT.
WGT.
WGT.
YESTERDAY
PREVIOUS DAY
INTAKE
OUTPUT
BSA
ALLERGIES
ADDRESSOGRAPH

SIGNATURE AND INITIALS NURSE/RESP. THERAPIST

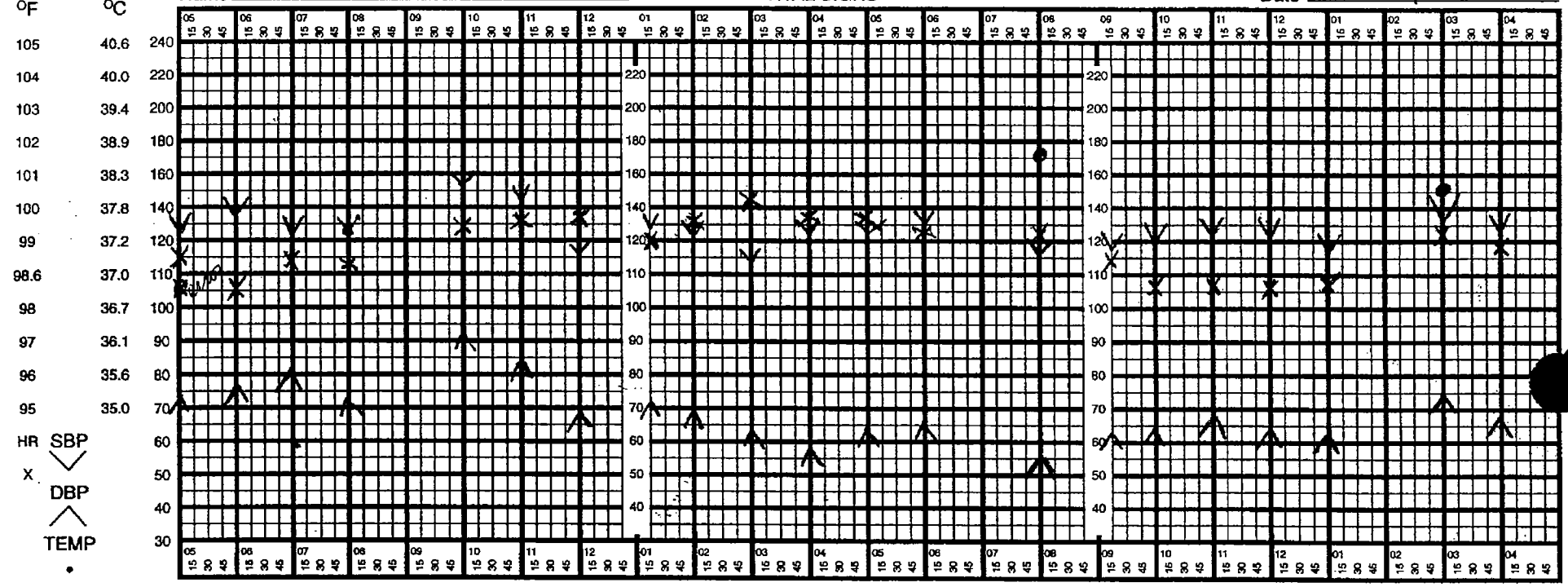
	Init.
(b)(6)-2	(b)(6)-2
(b)(6)-2	

MEDCOM - 3061

*SEE PROGRESS NOTES:

(b)(6)-4

Name _____ VITAL SIGNS Date 7/29/02



HEMODYNAMICS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR	115	105	115	112		130	131	136	120	131	114	136	131	125		121	119	106	107	106	107		121	118
Rhythm	ST	ST	ST	ST		ST	ST	ST	ST	ST	ST	ST	ST	ST		ST	ST	ST	ST	ST	ST		ST	ST
RESP.	16	16	16	16		16	28	32	24	22	32	28	32	28			32	30	28	28	30		35	28
CUFF BP	129/73	139/76	124/81	125/51		153/92	141/83	116/77	121/71	128/69	114/63	124/78	129/63	130/65		113/55	118/62	120/64	123/67	125/63	119/62		130/75	122/67
MAP	(92)	(99)	(95)	89		111	102	85	91	90	80	86	85	94		(73)	(81)	(80)	(77)	(84)	(83)		(98)	(88)
PAS/PAD																								
PCW																								
CVP																								
CO/CI																								
SpO2 ~~SVRI~~	100	100	100	100		100	93	94	94	96		94	92	92		93	94	94	93	95	97		93	92

DRUG	UNITS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Gentamycin 400mg IV Q8																									
Propofol (Titrate)																									
Tagamet 300mg IV BID																									
Ancef 1 Gm Q8																									

MISCELLANEOUS HOURLY OBSERVATIONS

NURSING PROGRESS NOTE

0820 - Cpt. (b)(6)-2 to see patient at (0715) awake; reaching for ETT; 50 mcg Fentanyl for pain control + sedation (b)(6)-2

0800: Pt intubated / sedated. (+) eye opener (-) R & pupils bilateral edema. ETT @ 26cm midline. VFT ↑ to 150 cc/HR. Sat 3 w.o. NS GT to LJS. Bilat CT to 5x, (-) drainage. Foley to gravity c orange urine type urine. Nitroglycerin D/C'd on night shift. Propofol at 25 mg/kg/hr (25 cc). Brisk capillary refill to bilat LE. Lungs c Sens coarse rhonchi bilat. LN chest xray ordered. See Resp notes & vent settings. (b)(6)-2 RT ARC

0920: Pt for CXR. Breathing + reacting c ETT tube. Bolused c 3 cc Propofol for ↑ sedation for X-ray. (b)(6)-2 RT ARC

0925: Propofol bolus effective. RT ARC

0950: Nimbex 7 mg IVP given as per order. RT ARC

1020: Stable weaning initiated. See Resp notes.

1020: Propofol ↑ to 30 mg/kg/min. (b)(6)-2 RT ARC

1115: Propofol weaned to 5 mg/kg/min. Pt extubated. Tolerating FM well. Pt alert enough for interpreter to explain surroundings. Pt acknowledged understanding. Requested food. Foley draining large amts of clear urine. Propofol to be D/C'd & tips bottle completed. (b)(6)-2 RT ARC

1300: Pt verbalizing pain in (R) hand / (L) ankle. Asked if the fam in English. Explain to pt extent of injuries + also explained that he will be medicated for pain frequently. Told pt to take deep breaths + cough. Pt complied c deep breathing. Will continue to monitor frequently. (b)(6)-2 RT ARC

1500: Propofol D/C'd at this time. (b)(6)-2 RT ARC

(2015) Assessment complete + noted: NPO; pt. denies pain; mentor intact c alarms on; C-collar intact; NS to (R) arm + LTS; (L) chest wound dressed c tegaderm, dark brown drainage present; Bilateral CT's to 20cm suction + intact c serosanguinous drainage present in chambers; bilateral thoracotomy incisions c staples intact / no drainage; foley patent + draining; (L) knee dressing dry / intact; (R) leg dressings dry / intact; pt able to move (R) foot on command; Scrotal wounds not draining (b)(6)-2

NURSING PROGRESS NOTE

(2045) PCXR for fam + Rhonchi - CT (2045) Ice Chips c difficulty - CT (2220) C/O (L) elbow pain; 50 mcg Fentanyl CT (0130) Pt. frequently awake, demanding H_2O, explained about NPO, constantly trying to remove (R) arm from sling (b)(6)-2

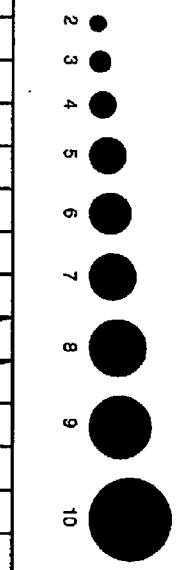
FORM 0021

☆U.S. GPO: 1997—508-278

*SEE PROGRESS NOTES:

PROCEDURES			OBSERVATIONS 7 - 4	OBSERVATIONS 4 - 12	TREATMENTS 12 - 8
TIME					
NEUROLOGICAL			→ SEE CODE →		
Eyes Open	Closed by swelling = C		ET	3	
Verbal Response	ET Tube or Trach = T		ET	5	
Motor Response			3	6	
Pupils R - react NR - non SR - slow		Size R	4	4	
		Reaction	NR	R	
		Size L	6	(b)(6)-2	
		Reaction	N		
		Hand Grasp R/L	— —	T T	
Bath Sounds			Bilat Rhonchi	↓ Bilat Rhonchi	
Sputum Character			—		
Nasal Endotracheal Suctioning Q PRN			PRN		
Chest PT Q ____			—		
CDB/IS Q ____			—		
Vent. ✓'s			PRN		
E.T. Tube @ 26 cm			✓		
Cuff ✓/Pr/cc's			✓		
C.T. Strip & Vent Q ____			—		
C.T. Fluctuates / ___cm.			—		
Peripheral Pulses **		U	+ P	P	
		L	Brisk CR	R=Warm L=P	
Circ. Distal to A-Line			—		
Monitor Alarm On			Yes	(b)(6)-2	
PA Line			—		
CVP/Other			—		
Art Line			—		
Peripheral			(R) Arm	(b)(6)-2	
Peripheral			(L) Arm		
PT/Family Teaching/Support			—		

Spontaneous	4
To Speech	3
To Pain	2
None	1
Oriented	5
Confused	4
Inappropriate Words	3
Incompreh. Sounds	2
None	1
Obeys Commands	6
Localize Pain	5
Withdraws to pain	4
Flexion to Pain	3
Extension to Pain	2
None	1



**PULSE CODE

DOPPLER	D
PALPABLE	P
STRONG	S
WEAK	W
ABSENT	A
FLEETING	F

PROCEDURES	OBSERVATIONS 7 - 4	OBSERVATIONS 4 - 12	TREATMENTS 12 - 8
TIME			
Bowel Sounds	Hypo x4	(+) x4	
ABD Size/Firmness	Soft	Soft	
NG Secure/Proper Pos.	✓	(b)(6)-2	
✓ Patency Q4°	✓		
Aspirate Contin. Feed Q4	—		
Aspirate Prior to Bolus Feed	—		
Stool Char./Guaiac	—		
Urine Color/Character	Orange Juice	Clear Amber	
Foley Secure/Patent	✓	(b)(6)-2	
External Cath.	—		
Catheter Care	✓	(b)(6)-2	
Colostomy/Ileostomy Care	—		
Bath	—		
Turn & Position Q ____	—		
Skin Care	—		
Mouth Care	—		
Trach / E.T. Care	✓		
ROM	—		
Dangle	—		
Restraints Released Q2H	—		
OOB to Chair	—		
Ambulation	—		
Side Rails ↑	—		
Drsing. △	—	CA1	
Drsing. △	—	CA1	

ADDRESSOGRAPH

AMEPW

#(b)(6)-4

MEDCOM - 3064

(b)(6)-4

RESPIRATORY SUPPORT SYSTEM

Date 7/30/02

Time	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
FiO_2																								
Ventilator Model																								
PEEP/CPAP, cmH_2O																								
Vent Mode																								
Volume set, ml•breath^{-1}																								
Rate set•min^{-1}																								
Insp. Flow Rate, l•min^{-1}																								
Pres. Support, cm H_2O																								
Spontaneous Rate																								
Spontaneous TV																								
Tot Min Vent, l•min^{-1}																								
[illegible]. Control cmH_2O																								
[illegible]eak Airway Pressure																								
Therapist's Initials																								

BLOOD GAS LABORATORY VALUES

Time Obtained																								
Source (A or V)																								
pH																								
PCO_2 mmHg																								
PO_2 mmHg																								
tO_{2c} Vol %																								
HCO_{3c} mmol/L																								
ABE_c mmol/L																								
[illegible]Hb g/dL																								
[illegible]o %																								
SO_2 %																								
Ca ++ mmol/L																								
Na + mmol/L																								
K + mmol/L																								
Cl- mmol/L																								
Tonometer PCO_2																								
Ton-Art PCO_2																								

ON-LINE PARAMETERS

Pulse Oximeter SaO_2																96								
Oximeter SvO_2																								

(b)(6)-2

*SEE PROGRESS NOTES:

INTAKE CC/HR

Date 7/30/02

INTAKE	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LR	150	150	150	150	150	150	50	50	300	150	150	150	OR			125								125
MEDS				50	50							50				50			50		50			
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds			25		25	50				25														
ORAL																								
Hourly Total	150	150	150	200	200	200	50	50	300	175	150	200												
Cumulative Total	150	300	450	650	850	1050	1100	1150	1450	1625	1775	1975												

OUTPUT CC/HR

OUTPUT	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly	185	110	120		550	100	100	25	30	120	100	180							300					
Urine Cumulative		295	415		965	865	965	990	1070															
(L) CT								0																
(R) CT								0																
Emesis/Gastric (NG)								800																
Stool																								
Output Hourly																								
Output Cumulative	185	295	415																					
Spec. Grav./U.R.																								
Gastric pH																								

TRANSFUSION THERAPY

TYPE	UNIT NO.	TYPE	UNIT NO.	TYPE	UNIT NO.

TOTAL INTAKE

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
ORAL				
IV				
NG				
Bld				

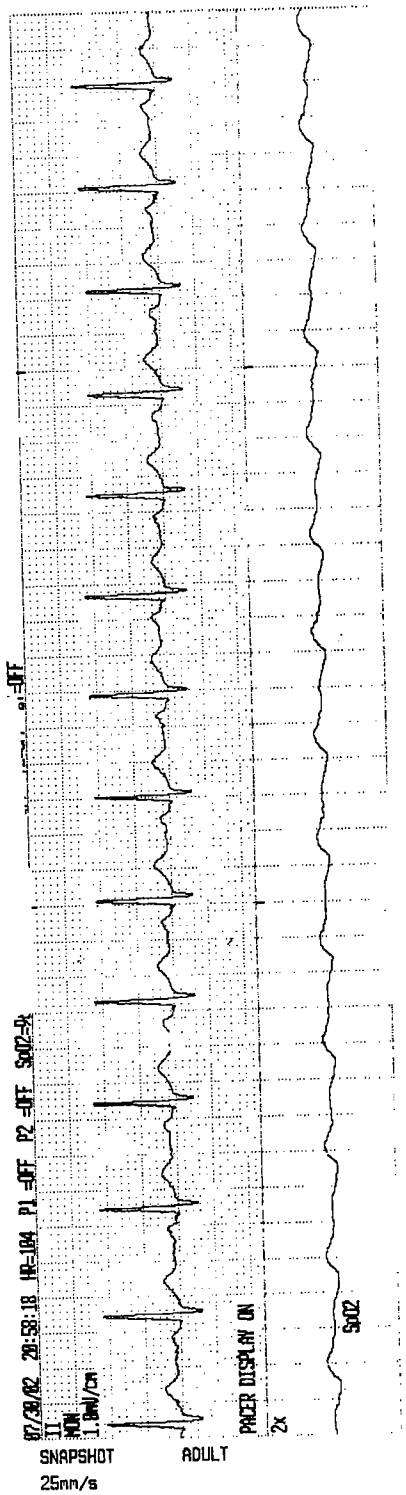
TOTAL OUTPUT

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
URIN				
NG				

NURSING PROGRESS NOTE	RESPIRATORY PROGRESS NOTE
	1330 NC ↓2L no humid. SaO2 97 BS diminished — (b)(6)-2 RT
	2030 NC 5L no humidity ♡R 100 RR 24 SAT 97 BS diminished (b)(6)-2 /RT

ADDRESSOGRAPH

EKG RHYTHM STRIPS



PROTOCOL SYSTEMS, INC.

*SEE PROGRESS NOTES: (b)(6)-4

STAT LABORATORY DATA

Date 1/30/02

Time																								
Glucose																								
BUN/CR.																								
Na+																								
K+																								
Cl-																								
HCO_3-																								
WBC																								
Hb/Hct																								
PLT																								
PT/ct																								
PTT/ct																								

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.
0530	50mcg Fentanyl	IV	(b)(6)-2						
0740	50mcg Fentanyl	IV							
1000	Tylenol 650mg	PO							
1230	Fentanyl 50mcg	IV							
1500	Fentanyl 50mcg	IV							
1800	Fentanyl 50mcg	IV							
1700	Fentanyl 50mcg	IV							
2000	Demerol 12.5mg	IV							
2200	MSO4 5mg	IV							
0010	MSO4 5mg	IV							
0200	Fiorst 50mcg	IV							
0400	Fiorst 50mg	IV							

Fentanyl 50mcg Q1° PRN PAIN
Tylenol 650mg Supp OR Q4-6° PRN

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

HT.
WGT.
WGT.
YESTERDAY
PREVIOUS DAY
INTAKE
OUTPUT
BSA
ALLERGIES

ADDRESSOGRAPH

SIGNATURE AND INITIALS

NURSE/RESP. THERAPIST	Init.
(b)(6)-2	(b)(6)-2
(b)(6)-2	

*SEE PROGRESS NOTES:

Name (b)(6)-4

VITAL SIGNS

Date 7/30/02

°F °C

105 40.6 240
104 40.0 220
103 39.4 200
102 38.9 180
101 38.3 160
100 37.8 140
99 37.2 120
98.6 37.0 110
98 36.7 100
97 36.1 90
96 35.6 80
95 35.0 70
60
50
40
30

HR X SBP DBP TEMP •

HEMODYNAMICS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR	119	110	105	103	105	98	96	92	93	94	98	101				108	105	106	99		103		85	
Rhythm	ST	ST	ST	ST	ST	SR	SR	SR	SR	SR	SR	ST				SR	SR	SR	SR		SR		SR	
RESP.	35	32	26	25	23	18	18	20	20	22	20	26				22	20	16	14					
CUFF BP	140/78	130/76	132/67	127/70	109/68	131/72	116/70	95/62	125/66	130/64	133/66	134/67				132/96	142/72	134/66	132/67		131/61		130/69	
MAP	(98)	(95)	(86)	85	82	91	82	69	85	87	88					105	91	89	95		(94)			
PAS/PAD																								
PCW																								
CVP																								
CO/CI																								
SPO2 ~~SVRI~~	91	96	97	91	96	97	96	96	97	95	95	95				95	98	94	94		94		95	

DRUG	UNITS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Gent	400 mg IV QD					(b)(6)-2																			
Ancef	1 gm IV Q8H													(b)(6)-2						(b)(6)-2					
Tagamet	300 mg IV BID			(b)(6)-2													(b)(6)-2					(b)(6)-2			

MISCELLANEOUS HOURLY OBSERVATIONS

NURSING PROGRESS NOTE

Oxygen Awake Alert Denies pain lungs clear bilaterally HR 90s NSR Sections.
Eyes damaged as previously noted & charted. Bilateral Thoracotomy incisions
well approximated & staples intact. Bilateral chest tubes → pleurovacs
draining scant serosanguineous fluid & air leaks. Left Sclera → (R) lower lid
dry & inflamed. (R) foot warm & good cap refill. Refill intact. Foley draining clear
Amber urine.

Responsive, c/o back pain repositioned PRN,

NURSING PROGRESS NOTE

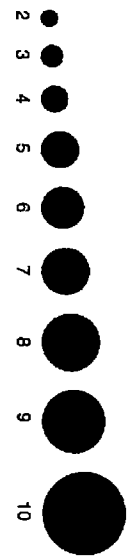
MEDCOM - 3071

☆U.S. GPO: 1997—508-276

*SEE PROGRESS NOTES:

PROCEDURES		OBSERVATIONS	TREATMENTS	
TIME		7 - 4	4 - 12	12 - 8
NEUROLOGICAL		→ SEE CODE →		
Eyes Open	Closed by swelling = C	U		
Verbal Response	ET Tube or Trach = T	S		
Motor Response		G		
Pupils R - react NR - non SR - slow	Size R	S		
	Reaction	R		
	Size L	NR		
	Reaction			
	Hand Grasp R/L	S / S		
[redacted]ath Sounds		Clear		
Sputum Character		clear - white		
Nasal Endotracheal Suctioning Q ____				
Chest PT Q ____		(b)(6)-2		
CDB/IS Q ____				
Vent. ✓'s				
E.T. Tube @ ____				
Cuff ✓/Pr/cc's				
C.T. Strip & Vent Q ____				
C.T. Fluctuates ___/___ cm.				
[redacted]ipheral Pulses **	U	P / P		
	L	P / P		
Circ. Distal to A-Line		(b)(6)-2		
Monitor Alarm On				
PA Line				
CVP/Other		(b)(6)-2		
Art Line				
Peripheral	16ga R/L			
Peripheral	18ga R/L			
PT/Family Teaching/Support				

Spontaneous	4
To Speech	3
To Pain	2
None	1
Oriented	5
Confused	4
Inappropriate Words	3
Incompreh. Sounds	2
None	1
Obeys Commands	6
Localize Pain	5
Withdraws to pain	4
Flexion to Pain	3
Extension to Pain	2
None	1



**PULSE CODE

DOPPLER . . . . . D

PALPABLE . . . . . P

STRONG . . . . . S

WEAK . . . . . W

ABSENT . . . . . A

FLEETING . . . . . F

PROCEDURES	OBSERVATIONS	TREATMENTS	
TIME	7 - 4	4 - 12	12 - 8
Bowel Sounds	(+) x4		
ABD Size/Firmness	Flat (b)(6)-2 Ft		
NG Secure/Proper Pos.			
✓ Patency Q4°			
Aspirate Contin. Feed Q4			
Aspirate Prior to Bolus Feed			
Stool Char./Gualac			
Urine Color/Character	Clear Amber		
Foley Secure/Patent	(b)(6)-2		
External Cath.			
Catheter Care			
Colostomy/Ileostomy Care			
Bath			
Turn & Position Q ____	(b)(6)-2		
Skin Care			
Mouth Care			
Trach / E.T. Care			
ROM			
Dangle			
Restraints Released Q2H			
OOB to Chair			
Ambulation			
Side Rails ↑	(b)(6)-2		
Drsing. △			
Drsing. △			

ADDRESSOGRAPH

MEDCOM - 3072

*SEE PROGRESS NOTES: (b)(6)-4

STAT LABORATORY DATA

Date 11/21/06

Time																								
Glucose																								
BUN/CR.																								
Na+																								
K+																								
Cl-																								
HCO_3-																								
WBC																								
Hb/Hct																								
PLT																								
PT/ct																								
PTT/ct																								

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.	TIME	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.
0730	Fentanyl 50 mcg	IV	(b)(6)-2	0330	Fentanyl 50 mcg	IV	(b)(6)-2			
1000	Furosemide 20 mg	IV		~~0500~~	F					
1045	Fentanyl 50 mcg	IV								
1130	Fentanyl 50 mcg	IV								
1345	Fentanyl 50 mcg	IV								
1545	Fentanyl 50 mcg	IV								
1700	Fentanyl 50 mcg	IV								
1730	Fentanyl 50 mcg	IV								
2100	Fentanyl 50 mcg	IV								
2200	" " "	IV								
2300	" " "	IV								
0030	Fentanyl 50 mcg	IV								
0200	Fentanyl 50 mcg	IV								

Fentanyl 50 mcg Q1° PRN Pain

Tylenol 650 mg Supp PR Q4-6° PRN

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

HT.
WGT.
WGT.
YESTERDAY
PREVIOUS DAY
INTAKE
OUTPUT
BSA
ALLERGIES

ADDRESSOGRAPH

SIGNATURE AND INITIALS

NURSE/RESP. THERAPIST	
(b)(6)-2	(b)(6)-2
(b)(6)-2	RT RNC

MEDCOM - 3073

*SEE PROGRESS NOTES: (b)(6)-4

Name _____ VITAL SIGNS Date 7/31/02

°F °C

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

HR X SBP DBP TEMP •

240 220 200 180 160 140 120 110 100 90 80 70 60 50 40 30

05 06 07 08 09 10 11 12 01 02 03 04 05 06 07 08 09 10 11 12 01 02 03 04

15 30 45

HEMODYNAMICS

	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR	85		75	76	76	85	87	80	87	76	95	100	72			85					81			
Rhythm	SR		SR	SR	SR	SR	SR	SR					SR			SR					SR			
RESP.			18	20	20	20	20	20					20			20					18			
CUFF BP	137/71		144/64	139/80	141/51	139/69	135/74	138/74				135	138/72			144/70					140/72			
MAP			93	96	95	97	97	96					95			96					97			
PAS/PAD																								
PCW																								
CVP																								
CO/CI																								
SPO2 ~~SVRI~~	97		99	97	94	96	97	96	96	95	96	100	96			96					97			

V 5 85 SR 20 144/75 100 100

DRUG UNITS

05 06 07 08 09 10 11 12 01 02 03 04 05 06 07 08 09 10 11 12 01 02 03 04

Gent 400 mg IVQD
Ancef 1gm IVQ8H
~~Tagamet 300 mg IVBID~~
Oxi. Flex Ipratrop QID

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

MISCELLANEOUS HOURLY OBSERVATIONS

NURSING PROGRESS NOTE

06:00 – Pt Slept Part of night – AT Parts During night Pt Restless – Frequently Asks for H_2O.
USS – UO – QS Clear yellow via Foley cath.
Dressing OK. CDI – CT – Drainage minimal.
Serou / Sang Drainage Medicated During night for Pain. [redacted] LT (b)(6)-2 RN

0800 Awake Alert oriented Respeasy. Lungsclear bilaterally, HR 80s-90s NSR Sectoly. (L) shoulder drsg dry intact. Bilateral Thoracotomy incisions well approximated c staples intact. Bilateral chest tubes → Pleurevacs draining scant serosanguineous fluid. HRII off to recovery RBS. (R) leg drsg dry intact. (R) foot warm c good capillary refill. Both Chest tubes Removed by LTC Kelly @ 1100. NG, IV @ 1200.
Staples removed by LTC Kelly @ 1400 → Chair Assistance 1330-1730
Tolerated well. Tolerating liquids well PO. Drsg → Posterior chest wall
Δ Few large amt mostly smelling blue green drainage (R) Posterior shoulder wound 3x4cm x 2.5cm deep. (L) Posterior shoulder wound 3x3cm x 3cm deep. Packing Δ [redacted] covered c dressing.
[redacted] (b)(6)-2 PT AN

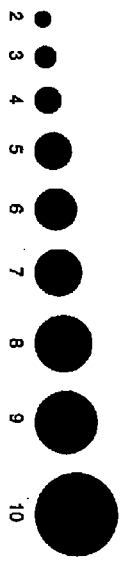
2130 VS 98.4 F – 85 regular – 20 even and nonlabored, lungs clear bilaterally – 144/70. Pulse oximetry 96%. Drsgs to both sides of chest, (L) anterior chest and (R) foot clean and intact. Pedal pulse (+) (R) foot. Urine 800cc in Foley bag, dark yellow, Foley patent. IV (R) arm running 2% 100cc/hr. 2L nasal cannula running. (L) leg cuff nonbinding. (L) foot warm, strong pedal pulse. Given 50 mcg Fentanyl @ 2100 for pain. Drank 1 cup cold water, 1 orange juice. [redacted] (b)(6)-2 RN

NURSING PROGRESS NOTE

*SEE PROGRESS NOTES: (b)(6)-4

PROCEDURES		OBSERVATIONS	TREATMENTS	
TIME		7 - 4	4 - 12	12 - 8
NEUROLOGICAL		→ SEE CODE →		
Eyes Open	Closed by swelling = C	4		
Verbal Response	ET Tube or Trach = T	5		
Motor Response		6		
Pupils R - react NR - non SR - slow	Size R	2		
	Reaction	R		
	Size L	2		
	Reaction	NR		
	Hand Grasp R/L	5		
[redacted]ath Sounds		clear		
Sputum Character		C		
Nasal Endotracheal Suctioning Q ____				
Chest PT Q ____				
CDB/IS Q 4°				
Vent. ✓'s				
E.T. Tube @ ____				
Cuff ✓/Pr/cc's				
C.T. Strip & Vent Q ____				
C.T. Fluctuates / ___ cm.				
[redacted]pheral Pulses **	U	1+ A		
	L	A 1+		
Circ. Distal to A-Line		(b)(6)-2		
Monitor Alarm On				
PA Line				
CVP/Other				
Art Line				
Peripheral				
Peripheral				
PT/Family Teaching/Support				

Spontaneous	4
To Speech	3
To Pain	2
None	1
Oriented	5
Confused	4
Inappropriate Words	3
Incompreh. Sounds	2
None	1
Obeys Commands	6
Localize Pain	5
Withdraws to pain	4
Flexion to Pain	3
Extension to Pain	2
None	1



**PULSE CODE

DOPPLER . . . . . D
PALPABLE . . . . . P
STRONG . . . . . S
WEAK . . . . . W
ABSENT . . . . . A
FLEETING . . . . . F

PROCEDURES	OBSERVATIONS	TREATMENTS	
TIME	7 - 4	4 - 12	12 - 8
Bowel Sounds	(+)x4		
ABD Size/Firmness			
NG Secure/Proper Pos.			
✓ Patency Q4°			
Aspirate Contin. Feed Q4			
Aspirate Prior to Bolus Feed			
Stool Char./Gualac			
Urine Color/Character			
Foley Secure/Patent			
External Cath.			
Catheter Care			
Colostomy/Ileostomy Care			
Bath			
Turn & Position Q ____			
Skin Care			
Mouth Care			
Trach / E.T. Care			
ROM			
Dangle			
Restraints Released Q2H			
OOB to Chair			
Ambulation			
Side Rails ↑			
Drsing. △			
Drsing. △			

ADDRESSOGRAPH

MEDCOM - 3076

*SEE PROGRESS NOTES: (b)(6)-2

INTAKE CC/HR

Date 7/31/02

INTAKE	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LRC 100°	100	100	100	100	100	100	100	100	100	50	50	50	100											
						50							50											
Meds																								
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds					50			50			50													
ORAL					50			50			50													
Hourly Total																								
Cumulative Total																								

OUTPUT CC/HR

OUTPUT	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly	<700				160		140	160				200										1600		
Urine Cumulative																600						2200		
(1) CT	60																							
(2) CT	20																							
Emesis/Gastric(1) C																								
Stool																								
Output Hourly																								
Output Cumulative																								
Spec. Grav./U.R.																								
Gastric pH																								

TRANSFUSION THERAPY

TYPE	UNIT NO.	TYPE	UNIT NO.	TYPE	UNIT NO.

TOTAL INTAKE

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
ORAL				
IV				
NG				
Bld				
TOTAL				

TOTAL OUTPUT

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
URIN				
NG				
TOTAL				

*SEE PROGRESS NOTES:

STAT LABORATORY DATA

Date 1 AUG 02

Time																								
Glucose																								
BUN/CR.																								
Na+																								
K+																								
Cl-																								
HCO_3-																								
WBC																								
Hb/Hct																								
PLT																								
PT/ct																								
PTT/ct																								

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.
0500	Fentanyl 50 mcg	IV	(b)(6)-2						
0700	4 mg MSO4	IV							
0900	Fentanyl 50 mcg	IV							

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

HT.
WGT.
WGT. YESTERDAY
PREVIOUS DAY
INTAKE
OUTPUT
BSA
ALLERGIES

ADDRESSOGRAPH

IV Fentanyl 50 mg q 1° PRN pain
Tylenol 650 mg supp PR q 4-6° PRN

SIGNATURE AND INITIALS NURSE/RESP. THERAPIST

	Init.
(b)(6)-2 1LT ANC	(b)(6)-

(b)(6)-4

MEDCOM - 3078

*SEE PROGRESS NOTES: Name #(b)(6)-4 VITAL SIGNS Date 1 AUG 02

°F °C

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

HR X SBP DBP TEMP •

240 220 200 180 160 140 120 110 100 90 80 70 60 50 40 30

05 06 07 08 09 10 11 12 01 02 03 04 05 06 07 08 09 10 11 12 01 02 03 04

HEMODYNAMICS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR	85			87		85																		
Rhythm	SR			SR		SR																		
RESP.	20			20		20																		
CUFF BP	149/75			130/76		128/64																		
MAP	100			99		85																		
PAS/PAD																								
PCW																								
CVP																								
CO/CI																								
pulse oximetry ~~SVRI~~	100			100		94																		

DRUG	UNITS	05	06	07	08	09	10	11	12	13 01	14 02	15 03	16 04	17 05	06	07	08	09	10	11	12	01	02	03	04
Gent. 400mg IV qD						(b)(6)-2																			
Ancef 1gm IV q 8°																									
				(b)(6)-2		(b)(6)-2																			
Ocoflex 1 gtt OU q2																									

MISCELLANEOUS HOURLY OBSERVATIONS

NURSING PROGRESS NOTE

0800 Awake, Alert. Oriented. Respiratory lungs clear bilaterally. HR 90s, 100s. BSR → SVT secretory. Bilateral Thoracotomy incisions approximated & staples intact. Bilateral anterior shoulder drsg dry & intact. Bilateral posterior shoulder drsg dry & intact. (R) leg drsg dry & intact. (R) foot warm & good capillary refill. OOB → chair for BM. Transferred to ICU 1300.

(b)(6)-2

CPT AR

NURSING PROGRESS NOTE

*SEE PROGRESS NOTES:

PROCEDURES		OBSERVATIONS	TREATMENTS	
TIME		7 - 4	4 - 12	12 - 8
NEUROLOGICAL		→ SEE CODE →		
Eyes Open	Closed by swelling = C	4		
Verbal Response	ET Tube or Trach = T	5		
Motor Response		6		
Pupils R - react NR - non SR - slow	Size R	3		
	Reaction	R		
	Size L	3/R		
	Reaction			
	Hand Grasp R/L	5 / 5		
ath Sounds		clear		
Sputum Character		—		
Nasal Endotracheal Suctioning Q ____		—		
Chest PT Q ____		—		
CDB/IS Q ____		—		
Vent. ✓'s		—		
E.T. Tube @ ____		—		
Cuff ✓/Pr/cc's		—		
C.T. Strip & Vent Q ____				
C.T. Fluctuates / ___ cm.				
ipheral Pulses **	U	NS		
	L	✓		
Circ. Distal to A-Line		(b)(6)-2		
Monitor Alarm On				
PA Line		—		
CVP/Other		—		
Art Line		(b)(6)-2		
Peripheral				
Peripheral		—		
PT/Family Teaching/Support				

Spontaneous	4
To Speech	3
To Pain	2
None	1
Oriented	5
Confused	4
Inappropriate Words	3
Incompreh. Sounds	2
None	1
Obeys Commands	6
Localize Pain	5
Withdraws to pain	4
Flexion to Pain	3
Extension to Pain	2
None	1

2 3 4 5 6 7 8 9 10

**PULSE CODE

DOPPLER - - - - - D

PALPABLE - - - - - P

STRONG - - - - - S

WEAK - - - - - - W

ABSENT - - - - - A

FLEETING F

PROCEDURES	OBSERVATIONS	TREATMENTS	
TIME	7 - 4	4 - 12	12 - 8
Bowel Sounds	+ x4 (b)(6)-2		
ABD Size/Firmness	Flat soft		
NG Secure/Proper Pos.	—		
✓ Patency Q4°	—		
Aspirate Contin. Feed Q4	—		
Aspirate Prior to Bolus Feed	—		
Stool Char./Gualac	—		
Urine Color/Character	clear Amber		
Foley Secure/Patent	—		
External Cath.	—		
Catheter Care	—		
Colostomy/Ileostomy Care	—		
Bath	—		
Turn & Position Q ____	—		
Skin Care	—		
Mouth Care	—		
Trach / E.T. Care	(b)(6)-2		
ROM	—		
Dangle			
Restraints Released Q2H			
OOB to Chair			
Ambulation	—		
Side Rails ↑			
Drsing. △			
Drsing. △			

ADDRESSOGRAPH

(b)(6)-4

MEDCOM - 3081

NURSING PROGRESS NOTE

07'15 - Drsg D to back wounds - repacked + dressed
i wet → dry NSS (b)(6)-2 ILT MC

RESPIRATORY PROGRESS NOTE

ADDRESSOGRAPH

(b)(6)-4

*SEE PROGRESS NOTES:

INTAKE CC/HR

Date 1 AUG 02

INTAKE	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LR	100	100	100	100	100	100	100																	
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds																								
ORAL																								
Hourly Total																								
Cumulative Total																								

OUTPUT CC/HR

OUTPUT	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly		800				800																		
Urine Cumulative		800																						
Emesis/Gastric																								
Stool																								
Output Hourly																								
Output Cumulative																								
Spec. Grav./U.R.																								
Gastric pH																								

MEDCOM - 3083

TRANSFUSION THERAPY

TYPE	UNIT NO.	TYPE	UNIT NO.	TYPE	UNIT NO.

TOTAL INTAKE

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
ORAL				
IV				
NG				
Bld				
TOTAL				

TOTAL OUTPUT

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
URIN				
NG				
TOTAL				

*SEE PROGRESS NOTES:

STAT LABORATORY DATA

Date 8/1/09 UA

Time																								
Glucose																								
BUN/CR.																								
Na+																								
K+																								
Cl-																								
HCO_3-																								
WBC																								
Hb/Hct																								
PLT																								
PT/ct																								
PTT/ct																								

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.
2240	Fentanyl 50mcg	IV	(b)(6)-2						
0100	Fentanyl 50mcg	IV							
0300	Fentanyl 50	IV							
0451	Fentanyl 50	IV							

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

HT.
WGT.
WGT.
YESTERDAY
PREVIOUS DAY
INTAKE
OUTPUT
BSA
ALLERGIES

Advana Diet as tolerated
Ancef 1 Gm IV Q8°
Gentamycin 400 mg IV QD
LR @ 100 cc/HR
Tylenol 650 mg supp PR Q4-6° PRN
Fentanyl 50 mcg IV Q1° PRN pain

SIGNATURE AND INITIALS NURSE/RESP. THERAPIST

	Init.
(b)(6)-2	(b)(6)-2
(b)(6)-2	

AM & PM

ADDRESSOGRAPH #(b)(6)-4

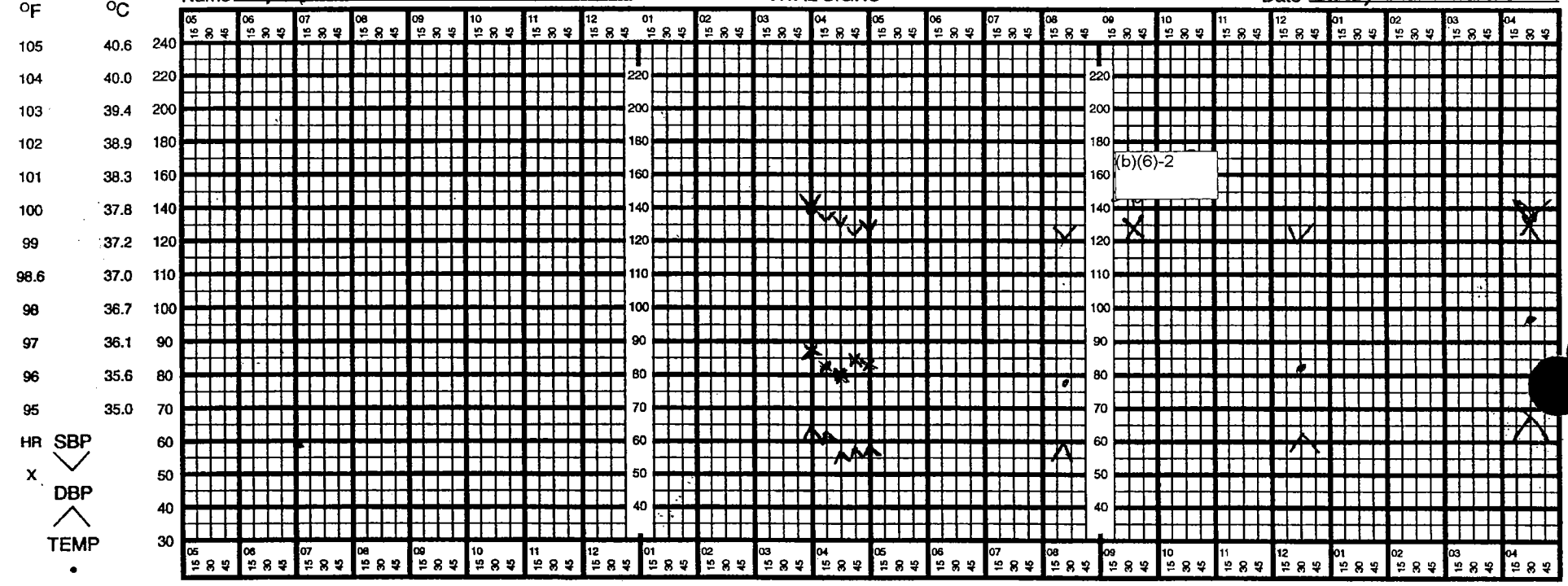
MEDCOM - 3084

*SEE PROGRESS NOTES: (b)(6)-4

Name [redacted]

VITAL SIGNS

Date 2 Aug 02



HEMODYNAMICS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR												88	83		77	77				82				97
Rhythm												SR	SR		SR	SR				SR				SR
RESP.												21	20		20	20				20				20
CUFF BP												140/64	128/58		130/60	120/60				120/60				130/66
MAP																				83				
PAS/PAD																								
PCW																								
temp CVP																	99.4							37
CO/CI																								
SaO2, ~~SVRI~~												100	100		100	100				96%				93%

DRUG	UNITS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Gentamycin	400 mg IV													(b)(6)-2						(b)(6)-2					
QD																									
Ancef 1 Gm IV	@ 8°																								

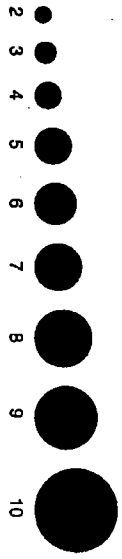
MISCELLANEOUS HOURLY OBSERVATIONS

MEDCOM - 3085

*SEE PROGRESS NOTES:

PROCEDURES		OBSERVATIONS	TREATMENTS	
TIME		7 - 4	4 - 12	12 - 8
NEUROLOGICAL		→	SEE CODE	→
Eyes Open	Closed by swelling = C		E4	
Verbal Response	ET Tube or Trach = T		5	
Motor Response			6	
Pupils R - react NR - non SR - slow	Size R			
	Reaction			
	Size L			
	Reaction			
	Hand Grasp R/L		weak R-opposite	
[redacted]ath Sounds			CTA	
Sputum Character			—	
Nasal Endotracheal Suctioning Q ____			—	
Chest PT Q ____			—	
CDB/IS Q ____			enc	
Vent. ✓'s			—	
E.T. Tube @ ____			—	
Cuff ✓/Pr/cc's			—	
C.T. Strip & Vent Q ____				
C.T. Fluctuates / ___ cm.				
[redacted]pheral Pulses **	U		(+)	
	L		(+)	
Circ. Distal to A-Line			—	
Monitor Alarm On			—	
PA Line			—	
CVP/Other			—	
Art Line			—	
Peripheral			RH [redacted]	Bb-2
Peripheral			—	
PT/Family Teaching/Support			—	

Spontaneous	4
To Speech	3
To Pain	2
None	1
Oriented	5
Confused	4
Inappropriate Words	3
Incompreh. Sounds	2
None	1
Obeys Commands	6
Localize Pain	5
Withdraws to pain	4
Flexion to Pain	3
Extension to Pain	2
None	1



**PULSE CODE

DOPPLER	D
PALPABLE	P
STRONG	S
WEAK	W
ABSENT	A
FLEETING	F

PROCEDURES	OBSERVATIONS	TREATMENTS	
TIME	7 - 4	4 - 12	12 - 8
Bowel Sounds		(+)	
ABD Size/Firmness		SNT	
NG Secure/Proper Pos.		—	
✓ Patency Q4°		—	
Aspirate Contin. Feed Q4		—	
Aspirate Prior to Bolus Feed		—	
Stool Char./Gualac		—	
Urine Color/Character		Cl yellow	
Foley Secure/Patent		(b)(6)-2	
External Cath.		—	
Catheter Care		—	
Colostomy/Ileostomy Care		—	
Bath		—	
Turn & Position Q ____		SCW	
Skin Care		—	
Mouth Care		(b)(6)-2	
Trach / E.T. Care		—	
ROM		SCW	
Dangle		—	
Restraints Released Q2H		—	
OOB to Chair		—	
Ambulation		—	
Side Rails ↑		—	
Drsing. △		D&I	
Drsing. △		—	

ADDRESSOGRAPH

AMEPW (b)(6)-4

MEDCOM - 3086

RESPIRATORY SUPPORT SYSTEM

Date 2Aug 02

Time	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
FiO_2																								
Ventilator Model																								
PEEP/CPAP, cmH_2O																								
Vent Mode																								
Volume set, ml•breath^{-1}																								
Rate set•min^{-1}																								
Insp. Flow Rate, l•min^{-1}																								
Pres. Support, cm H_2O																								
Spontaneous Rate																								
Spontaneous TV																								
Tot Min Vent, l•min^{-1}																								
[redacted]. Control cmH_2O																								
[redacted]eak Airway Pressure																								
Therapist's Initials												(b)(6)-2												

BLOOD GAS LABORATORY VALUES

Time Obtained																			2303					
Source (A or V)																								
pH																								
PCO_2 mmHg																								
PO_2 mmHg																								
tO_{2c} Vol %																								
HCO_{3c} mmol/L																								
ABE_c mmol/L																								
[redacted]Hb g/dL																								
[redacted]b %																								
[redacted]O_2 %																								
Ca ++ mmol/L																								
Na + mmol/L																								
K + mmol/L																								
Cl- mmol/L																								
Tonometer PCO_2																								
Ton-Art PCO_2																								

ON-LINE PARAMETERS

Pulse Oximeter SaO_2												100		100			99		95					
Oximeter SvO_2																								

*SEE PROGRESS NOTES:

INTAKE CC/HR

Date 2 Aug 02

INTAKE	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LR @100															100	100	100	100	100	100	100	100	100	100
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds																								
ORAL																								
Hourly Total																								
Cumulative Total																								

MEDCOM - 3088

OUTPUT CC/HR

OUTPUT	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly											200													
Urine Cumulative																								
Emesis/Gastric																								
Stool																								
Output Hourly																								
Output Cumulative																								
Spec. Grav./U.R.																								
Gastric pH																								

TRANSFUSION THERAPY

TYPE	UNIT NO.	TYPE	UNIT NO.	TYPE	UNIT NO.

TOTAL INTAKE

	5A - 1P	1P - 9P		9P - 5A	24° TOTAL
ORAL					
IV					
NG					
Bld					
TOTAL					

TOTAL OUTPUT

	5A - 1P	1P - 9P		9P - 5A	24° TOTAL
URIN					
NG					
TOTAL					

Pt 106

NURSING PROGRESS NOTE

1600 Admitted to ICU#1 Bed#4 post operatively, O2 10L SM, SaO2 100% LCTA. VSS, T100, Bilat eye DSGs intact (L) upper chest, (R) chest, (L) chest DSGs intact. (L) O-sly inflated Poly drain clear yellow urine. IVF running @ 100cc/Hr, Abd soft, (+) BS. Lips moistened, Pt shuffled to bed. MP oriented. — (b)(6)-2 RN

2000 assumed care — (b)(6)-2 sgn

2200 - DSGS to bilat eyes D&I, awake, alert. IV site RFA leaking Δd to R hand - infusing LR @ 100° - site intact. VSS. Bilat O2 9ot on 1L O2 nc. staples intact mult other incisions. SR on monitor. DSGS D&I to bilat ribs (other) and (L) ↑ collar bone area. (+) capr refill (brisk) to (R) foot, splint intact. sling intact to (L) arm. Foley patent & drng clear yellow urine. — (b)(6)-2 sgn

addendum - ice chips. Given tolerated well — (b)(6)-2 sgn

add 50mg Fentanyl given. N & or c/o (L) shoulder pain area. Green drng - dsg intact — (b)(6)-2 sgn

ADDRESSOGRAPH

AM & PM #(b)(6)-4

RESPIRATORY PROGRESS NOTE

1600 pt brought out of OR on supplemental O2 10L SM ♡R 91 RR 21 SAT 100 BS clear — (b)(6) /RT

1800 pt stable on 4L NC ♡R 81 RR 18 SAT 100 BS clear (b)(6) /RT

2124 pt stable on 4L NC ♡R 88 RR 16 SAT 99 BS clear (b)(6) /RT

2303 pt stable/sleeping 2L ~~nasal~~ NC ♡R 99 RR 28 SAT 94 BS clear (b)(6) /RT

*SEE PROGRESS NOTES:

STAT LABORATORY DATA

Date 3 Aug 02

Time																								
Glucose																								
BUN/CR.																								
Na+																								
K+																								
Cl-																								
HCO_3-																								
WBC																								
Hb/Hct																								
PLT																								
PT/ct																								
PTT/ct																								

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.
0800	Fentanyl 50mg	IV	(b)(6)-2						
1000	Fentanyl 50mcg	IV							
1430	Fentanyl 50mcg	IV							
1600	Tylenol 650mg	PO							
1700	Fentanyl 50mg	IV							
1845	Fentanyl 50mg	IV							
2037	Fentanyl 50mg	IV							
2327	Fentanyl 50mg	IV							
0123	Fentanyl 50mg	IV							
0230	Fentanyl 50mcg	IV							
330	Fentanyl 50mg	IV							

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

HT.
WGT.
WGT.
YESTERDAY
PREVIOUS DAY
INTAKE
OUTPUT
BSA
ALLERGIES
ADDRESSOGRAPH

Advance diet as tol
Ancef 1 gm IV Q8°
Gent 400mg IV QD
LR @ 100°
Tylenol 650mg supp PR Q4-6° prn
Fentanyl 50 mcg IV Q 1° prn pain
Tylenol 650mg PO Q4-6° PRN

SIGNATURE AND INITIALS
NURSE/RESP. THERAPIST

	Init.
(b)(6)-2	(b)(6)-2
(b)(6)-2 LPN	
(b)(6)-2 ILT ANC	
(b)(6)-2	

AM EPW

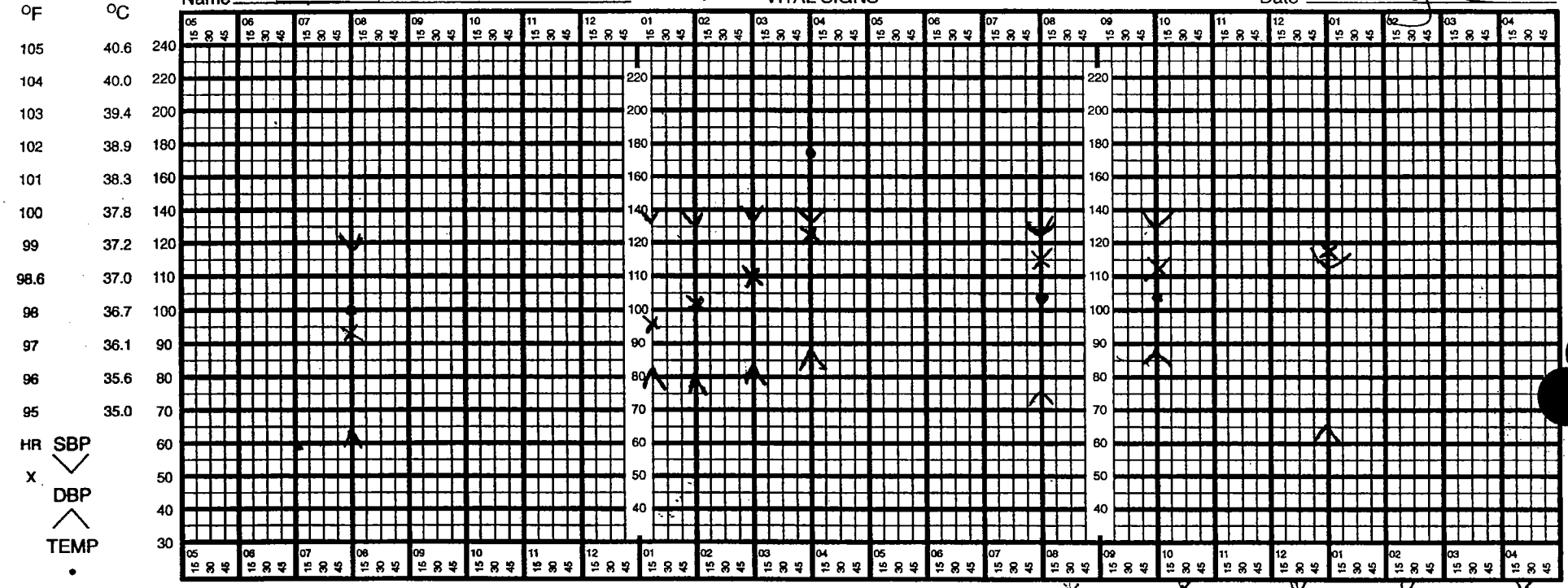
(b)(6)-4

MEDCOM - 3090

*SEE PROGRESS NOTES: Name (b)(6)-4

VITAL SIGNS

Date 3AUG02



HEMODYNAMICS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR				94					97	102	110	126				115		111			119		103	
Rhythm				SR																				
RESP.				23					19	25	15	23				21		18			20		22	
CUFF BP				124/63					138/72	131/80	134/83	135/87				125/75		130/86			112/65		120/71	
MAP																								
PAS/PAD																								
PCW																								
temp ~~CVP~~				36.7								101.8				101.1		101.5					98.7	
CO/CI																								
SaO2 ~~SVRI~~				98% 2 LNC					95%	97%		100%				95%		88%			96		93	

DRUG	UNITS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Gent	40mg IV QD																			(b)(6)-2					
Ancef	1gm IV Q8°				(b)(6)-2								(b)(6)-2								(b)(6)-2				
Pred forte	1 gtt OD QID												(b)(6)-2							(b)(6)-2					
Atropine	1% 1 gtt OU BID															(b)(6)-2		(b)(6)-2							
Occuflox	II gtt OS Q2°																			(b)(6)-2		(b)(6)		(b)(6)-2	
Occuflox	II gtt OD QID												(b)(6)-2												

MISCELLANEOUS HOURLY OBSERVATIONS

MEDCOM - 3091

*SEE PROGRESS NOTES:

PROCEDURES		OBSERVATIONS	TREATMENTS	
TIME		7 - 4	4 - 12	12 - 8
NEUROLOGICAL		→ SEE CODE →		
Eyes Open	Closed by swelling = C	Bilat eye patches	—	
Verbal Response	ET Tube or Trach = T	5		
Motor Response		6		
Pupils R - react NR - non SR - slow	Size R	eye patches		
	Reaction	"		
	Size L	eye patches		
	Reaction	"		
	Hand Grasp R/L	(+) (+)		
Breath Sounds		LCTA		
Sputum Character		—		
Nasal Endotracheal Suctioning Q ____		—		
Chest PT Q ____		—		
CDB/IS Q ____		—		
Vent. ✓'s		—		
E.T. Tube @ ____		—		
Cuff ✓/Pr/cc's		—		
C.T. Strip & Vent Q ____		—		
C.T. Fluctuates / ___ cm.		—		
Peripheral Pulses **	U	P		
	L	P		
Circ. Distal to A-Line		—		
Monitor Alarm On		Yes		
PA Line		—		
CVP/Other		—		
Art Line		—		
Peripheral		(+) HAND		
Peripheral		—		
PT/Family Teaching/Support		—		

Spontaneous	4
To Speech	3
To Pain	2
None	1
Oriented	5
Confused	4
Inappropriate Words	3
Incompreh. Sounds	2
None	1
Obeys Commands	6
Localize Pain	5
Withdraws to pain	4
Flexion to Pain	3
Extension to Pain	2
None	1

2 3 4 5 6 7 8 9 10

**PULSE CODE

DOPPLER . . . . . D
PALPABLE . . . . . P
STRONG . . . . . S
WEAK . . . . . W
ABSENT . . . . . A
FLEETING . . . . . F

PROCEDURES	OBSERVATIONS	TREATMENTS	
TIME	7 - 4	4 - 12	12 - 8
Bowel Sounds	(+) x4		
ABD Size/Firmness	soft		
NG Secure/Proper Pos.	—		
✓ Patency Q4°	—		
Aspirate Contin. Feed Q4	—		
Aspirate Prior to Bolus Feed	—		
Stool Char./Guaiac	—		
Urine Color/Character	Clear Yellow		
Foley Secure/Patent	✓		
External Cath.	—		
Catheter Care	✓		
Colostomy/Ileostomy Care	—		
Bath	—		
Turn & Position Q 4°	✓		
Skin Care	✓		
Mouth Care	✓		
Trach / E.T. Care	—		
ROM	—		
Dangle	—		
Restraints Released Q2H	—		
OOB to Chair	✓		
Ambulation	—		
Side Rails ↑	Shackled		
Drsing. Δ	OSOO		
Drsing. Δ			

ADDRESSOGRAPH

AMEPW # (b)(6)-4

MEDCOM - 3092

*SEE PROGRESS NOTES:

INTAKE CC/HR

Date 3 Aug 02

INTAKE	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LR @ 100																								
LR @ 100	150	100	150																					
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds																								
ORAL																								
Hourly Total																								
Cumulative Total																								

MEDCOM - 3093

OUTPUT CC/HR

OUTPUT	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly	1825													525										
Urine Cumulative																						2000		
Emesis/Gastric																								
Stool																								
Output Hourly																								
Output Cumulative	1825																							
Spec. Grav./U.R.																								
Gastric pH																								

TRANSFUSION THERAPY

TYPE	UNIT NO.	TYPE	UNIT NO.	TYPE	UNIT NO.

TOTAL INTAKE

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
ORAL				
IV				
NG				
Bld				
TOTAL				

TOTAL OUTPUT

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
URIN				
NG				
TOTAL				

NURSING PROGRESS NOTE

0300 dsgs Ad to bilat back c̄ NS W→D. irrigated c̄ NS - & packed, covered c̄ DSD. Large amt of grun/bloody drng - 2 exit wounds c̄ red tissue - foul smelling. Premedicated c̄ Fentanyl 50 mcg. _____ (b)(6)-2 Sgt

0800 Responds to verbal stimuli, Oriented. (L)-(R) shaft DOES DOI. (R) LE dcg c̄ splint intact. (L) arm sling. IVF infusing c̄ difficulty. Foly draing clear yellow urine, shackled to bed. MP present - medicated c̄ 50mg Fentanyl IVP for c/o pain (b)(6)-2 [illegible]

2044 - Stable, dressings on eyes, chest and foot clean and secure, HR is at 107, BP - 125/77 SpO2 - 92, R - 25, T - 100.7. IV line in (R) arm running good. GSW wound on (L) shoulder thru all both sides. GSW to (R) foot, (L) knee wound. Lung sound clear and equal, he has bandages to both eyes can't see out of OD and minimum vision out of OS

RESPIRATORY PROGRESS NOTE

ADDRESSOGRAPH

AMEPW # (b)(6)-4

3Aug02

*SEE PROGRESS NOTES: (b)(6)-2

STAT LABORATORY DATA

Date 7/10/06

Time																								
Glucose																								
BUN/CR.																								
Na+																								
K+																								
Cl-																								
HCO_3-																								
WBC																								
Hb/Hct																								
PLT																								
PT/ct																								
PTT/ct																								

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.
0528	Fentanyl 50 mcg	IV	(b)(6)-2						
0630	Fentanyl 50 mcg	IV							
1015	Fentanyl 50 mcg	IV							
1315	Percocet #1	PO							

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

HT.
WGT.
WGT.
YESTERDAY
PREVIOUS DAY
INTAKE
OUTPUT
BSA
ALLERGIES

Advance diet as tol
AAcef 1gm IV Q8°
Gent 400 mg IV QD
LR @ 100°
Tylenol 650mg supp PR Q4-6° PRN
Fentanyl 50 mcg IV Q1° PRN Pain
Percocet I or II PO Q4-6° PRN

SIGNATURE AND INITIALS NURSE/RESP. THERAPIST

	Init.
(b)(6)-2	(b)(6)-2
(b)(6)-2 ILT ANC	
(b)(6)-2 ILT ANC	

AMEPW

ADDRESSOGRAPH (b)(6)-4

*SEE PROGRESS NOTES: (b)(6)-4

Name _____ VITAL SIGNS Date 4 Aug 02

°F °C

105 40.6 240
104 40.0 220
103 39.4 200
102 38.9 180
101 38.3 160
100 37.8 140
99 37.2 120
98.6 37.0 110
98 36.7 100
97 36.1 90
96 35.6 80
95 35.0 70
60
50
40
30

HR X
SBP ∨
DBP ∧
TEMP •

HEMODYNAMICS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR	89			80																				
Rhythm																								
RESP.	19			28																				
CUFF BP	126/74			122/79																				
MAP																								
PAS/PAD																								
PCW																								
TEMP ~~CVP~~				101°																				
CO/CI																								
SPO2 ~~SVRI~~	94%																							

DRUG	UNITS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Gentamycin	400mg IV qD																								
Ancef	1gm IV q8°				(b)(6)-2																				
Pred Forte	÷ gtt OD																								
Atropine 1%	÷ gtt OU																								
Occuflox	÷ gtt OS Q2																								
Occuflox	÷ gtt OD Q4																								

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

MISCELLANEOUS HOURLY OBSERVATIONS

NURSING PROGRESS NOTE

4 Aug 02 0930: Foley + IVF D/C'd as per MD order. Pt was assisted to BSC - ⊖ Bm. A+O x3. N/O c/o pain this time. Pt pleasant, cooperative. Chest + back DSG's C+D+I. LOA. ⊕ BS x4 VSS. NVO Δ's. (b)(6)-2 ...ith Amy

1100: Bilat Shoulder DSG's d/c'd.

NURSING PROGRESS NOTE

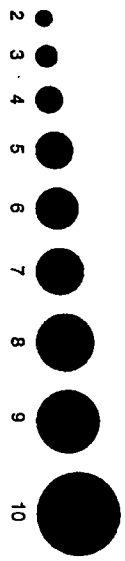
FORM 0021

☆U.S. GPO: 1997—508-276

*SEE PROGRESS NOTES:

PROCEDURES		OBSERVATIONS	TREATMENTS	
TIME		7 - 4	4 - 12	12 - 8
NEUROLOGICAL		→ SEE CODE →		
Eyes Open	Closed by swelling = C	4		
Verbal Response	ET Tube or Trach = T	5		
Motor Response		6		
Pupils R - react NR - non SR - slow	Size R	5		
	Reaction	+		
	Size L	6		
	Reaction	−		
	Hand Grasp R/L	+ / +		
[redacted]ath Sounds		CTA bilat		
Sputum Character		—		
Nasal Endotracheal Suctioning Q ____		—		
Chest PT Q ____		—		
CDB/IS Q ____		—		
Vent. ✓'s		—		
E.T. Tube @ ____		—		
Cuff ✓/Pr/cc's		—		
C.T. Strip & Vent Q ____		—		
C.T. Fluctuates / — cm.		—		
[redacted]ripheral Pulses **	U	P		
	L	L P − R c 50/in + 5N		
Circ. Distal to A-Line		—		
Monitor Alarm On		Yes		
PA Line		—		
CVP/Other		—		
Art Line		—		
Peripheral		R arm		
Peripheral		—		
PT/Family Teaching/Support		—		

Spontaneous	4
To Speech	3
To Pain	2
None	1
Oriented	5
Confused	4
Inappropriate Words	3
Incompreh. Sounds	2
None	1
Obeys Commands	6
Localize Pain	5
Withdraws to pain	4
Flexion to Pain	3
Extension to Pain	2
None	1



**PULSE CODE

DOPPLER	D
PALPABLE	P
STRONG	S
WEAK	W
ABSENT	A
FLEETING	F

PROCEDURES	OBSERVATIONS	TREATMENTS	
TIME	7 - 4	4 - 12	12 - 8
Bowel Sounds	+ x4		
ABD Size/Firmness	Soft		
NG Secure/Proper Pos.	—		
✓ Patency Q4°	—		
Aspirate Contin. Feed Q4	—		
Aspirate Prior to Bolus Feed	—		
Stool Char./Gualac	—		
Urine Color/Character	Clear Yellow		
Foley Secure/Patent	D/C'd 0930		
External Cath.	—		
Catheter Care	—		
Colostomy/Ileostomy Care	—		
Bath	✓		
Turn & Position Q ____	✓		
Skin Care	✓		
Mouth Care	✓		
Trach / E.T. Care	—		
ROM	—		
Dangle	✓		
Restraints Released Q2H	—		
OOB to Chair	✓		
Ambulation	—		
Side Rails ↑	—		
Drsing. Δ	✓		
Drsing. Δ	—		

ADDRESSOGRAPH

AMEPW (b)(6)-4

MEDCOM - 3098

(b)(6)-4

ICU 1

SPECIMEN/LAB RPT.

MISC

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

PATIENT STATUS: ☐ BED ☐ A ☐ OUTPATIENT ☐ ☐ NP ☐ D

SPECIMEN SOURCE (Specify)

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

REQUESTING PHYSICIAN'S SIGNATURE: Dr. (b)(6)-2 (b)(6)-2

REPORTED BY: (b)(6)-2 MD TECH 0725

DATE: 7-31-02

LAB ID NO.

REMARKS: Lytes, BUN, Crea, Glu

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED	RESULTS
		06 48		

Glucose - 96 Cl - 95
BUN - 10 tCO2 - 27
CRE - 0.7
CK - 1733
Na^+ - 119
K^+ - 3.7

PICCOLO
07/30/02 07:14 PM
REFERENCE RANGE: MALE
PATIENT #: (b)(6)-4
METLYTE 8
DISC LOT #: 2261BA4
OPER #: (b)(6)-2 DR #: 000
SERIAL #: (b)(6)-2

GLU	96	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	1733*	39-380	U/L
NA+	119*	128-145	MMOL
K+	3.7	3.3-4.7	MMOL
CL-	95*	98-108	MMOL
tCO2	27	18-33	MMOL

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

(b)(6)-4

ICU 1

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

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

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

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

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE: Dr. (b)(6)-2 (b)(6)-2

REPORTED BY: (b)(6)-2 MD TECH 0725

DATE: 7-31-02

LAB. ID. NO.

REMARKS: CBC HC@0728

549-107

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED (K)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	CONTROL PTT	PATIENT PTT	CONTROL	PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
		06 48																														
	RESULTS			3.49	9.9	29.6	84.8	28.4	33.5	6.1											195				LYPC	= 13.9 L		LYPC	0.9 L			

WBC DIFF AND BLOOD CELL MORPH

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
Prescribed by GSA/ICMR
FIRMR (41-CFR) 201-45.505

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

RESULTS

Gluc - 89
Bun - 12
Na+ - 143
K+ - 3.5
Cl - 103
CO_2 - 25
Creat - 0.8

REMARKS

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE: Dr. (b)(6)-2
REPORTED BY: (b)(6)-2
MD DATE: 7/30/02
TECH: 91Km4

(b)(6)-4

Bun/Cr/Lytes

ICU #1 Bed #5

MISC
URGENCY: ROUTINE; TODAY; PRE-OP; STAT
PATIENT STATUS: BED; AMB; OUTPATIENT; NP; DOM
SPECIMEN SOURCE (Specify): Vein
LAB ID NO.
SPECIMEN/LAB RPT. NO.

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

PATIENT'S MED. RECORD

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

RESULTS	REQUESTED	(X)
3.76	RBC COUNT	L
10.7	HEMOGLOBIN	L
31.5	HEMATOCRIT	L
85.7	MCV	
29.2	MCH	
34.1	MCHC	
8.6	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
156	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
40% 7.8	PT CONTROL	
40 8.7	PT PATIENT	
	PTT CONTROL	
	PTT PATIENT	
	PTT % ACTIVITY	
	PTT RATIO	
	SICKLING TEST	
	LE PREP	

CBC

REMARKS

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING: Dr. (b)(6)-2
REPORTED BY: (b)(6)-2
MD DATE: 7/30/02
TECH: 6Ms

(b)(6)-4

Hy H

ICU #1 Bed #5

MISC
URGENCY: ROUTINE; TODAY; PRE-OP; STAT
PATIENT STATUS: BED; AMB; OUTPATIENT; NP; DOM
SPECIMEN SOURCE: VEIN; CAP; OTHER (Specify)
LAB. ID. NO.
SPECIMEN/LAB RPT. NO.

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
Prescribed by GSA/ICMR
FIRMR (41-CFR) 201-45.505
549-107

PATIENT'S MED. RECORD

(b)(6)-4

ICU #1

MISC
URGENCY: ROUTINE; TODAY; PRE-OP; STAT
PATIENT STATUS: BED; AMB; OUTPATIENT; NP; DOM
SPECIMEN SOURCE (Specify)
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE: (b)(6)-2
REPORTED BY: (b)(6)-2
MD DATE: 7/31/02
TECH: 1235
LAB ID NO.
REMARKS

TEST(S)
SPECIMEN TAKEN
DATE: 31 JUL 02 | TIME A.M. P.M.: 12:15
REQUESTED: Electrolytes
RESULTS

Date
Pt. Name:
90 mg/dL
11 mg/dL
136 mmol/L
3.3 mmol/L
94 mmol/L
29 %PCV
10 g/dL
Hb/Hct
Sample Type:
31JUL02 12:15
Oper: (b)(6)-2
Physician: (b)(6)-2
07
S0430
H A84

MEDCOM - 3100

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

STAT G3+

06

Pt Name: Pt (b)(6)-4

TCO2_____30 mmol/L

At 37C

PH_____7.192

PCO2_____72.6 mmHg

PO2_____291 mmHg

HCO3_____28 mmol/L

BEecf_____0 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

28JUL02 12:17

Oper: 1423

Physician:_____

Ser# 39665

Ver: JAMS043C
CLEW A84

STAT G3+

Pt: (b)(6)-4

Pt Name:_____

TCO2_____24 mmol/L

At 37C

PH_____7.379

PCO2_____38.9 mmHg

PO2_____*** mmHg

HCO3_____23 mmol/L

BEecf_____ mmol/L

sO2*_____** %

*calculated

Sample Type_:

28JUL02 13:17

Oper: 1423

Physician:_____

Ser# 39665

Ver: JAMS043C
CLEW A84

STAT G3+

Pt: 106

Pt Name:_____

TCO2_____25 mmol/L

At 37C

PH_____7.445

PCO2_____34.8 mmHg

PO2_____150 mmHg

HCO3_____24 mmol/L

BEecf_____0 mmol/L

sO2*_____99 %

*calculated

Sample Type_:

29JUL02 07:07

Oper: 1423

Physician:_____

Ser# 40004

Ver: JAMS043C
CLEW A84

STAT G3+

Pt: 106

Pt Name:_____

TCO2_____32 mmol/L

At 37C

PH_____7.449

PCO2_____43.6 mmHg

PO2_____80 mmHg

HCO3_____30 mmol/L

BEecf_____6 mmol/L

sO2*_____96 %

*calculated

Sample Type_:

29JUL02 10:55

Oper: 1423

Physician:_____

Ser# 40004

Ver: JAMS043C
CLEW A84

Pt # (b)(6)-4 ICU #1 BED #5

Chem 7 / BUN/CR
(Istat 6)
Mg ?
Hct

MICRO-BIOLOGY 1

SPECIMEN LAB RPT NO

PATIENT STATUS: ☑ BED ☐ AMB ☐ OUTPT ☐ DOM ☐ NP

INFECTION: ☐ ADMITTED WITH HOSPITAL ACQUIRED ☐ ☐ PRE OPERATIVE POST OPERATIVE ☐ ☐ NON SURGICAL POSTPARTUM ☐ ☐ NEWBORN OTHER (Specify) ☐

PATIENTS MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE: Dr. (b)(6)-2

REPORTED BY: (b)(6)-2 MD 7.29.02 0700 TECH

DATE: 7/29/02

LAB ID NO

CLINICAL INFORMATION (including specimen source): (b)(6)-2

ANTIBACTERIAL THERAPY

SPECIMEN TAKEN: DATE / TIME / A.M. P.M.

EXAMINATION REQUESTED: ☐ SMEAR ☐ CULTURE ☐ SENSITIVITY ☐ COLONY COUNT

REPORT

Glu 113
Bun 15
Cr 1.1
Ca >5000 ×
Na+ 124 ×
K+ 3.6
Cl- 100
tCO2 22

Mg - 10
Hct - 29

553-107

MICROBIOLOGY 1
STANDARD FORM 553 (Rev. 3-77)
Prescribed by GSA/ICMR
FPMR (41-CFR) 201-45.505

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

RESULTS	REQUESTED	(X)
	ROUTINE	
Dk yellow	COLOR	
1.019	SPECIFIC GRAVITY	
0.2	UROBILINOGEN	
Lg	OCCULT BLOOD	
	BILE	
SM	KETONES	
Neg	GLUCOSE	
Trace	PROTEIN	
8.0	pH	
	MICROSCOPIC	
	WBC	
	RBC	
	EPITH CELLS	
	CASTS: WBC	
	CASTS: RBC	
	CASTS: HYALINE	
	CASTS: GRANULAR	
	BACTERIA	
	CRYSTALS	
	MUCUS	
	NITRITE	
	BENCE-JONES PROTEIN	
	HEMOSIDERIN	
	HCG	

UA / Ø micro

REMARKS: MAJ

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

REQUESTING PHYSICIAN'S SIGNATURE: (b)(6)-2

REPORTED BY: (b)(6)-2

MD / TECH: 91304

DATE: 28 Jul 02

LAB. ID NO.

URINALYSIS — URGENCY: ROUTINE, TODAY, PRE-OP, STAT — PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM — SPECIMEN SOURCE: ROUTINE, OTHER (Specify) — SPECIMEN/LAB RPT N

URINALYSIS 550-107
Standard Form 550 (Rev. 4-77)
General Serv. Committee on Med

#

(b)(6)-4

ICU

TEST(S) — SPECIMEN TAKEN — DATE 28 Jul 02 — TIME 1826 A.M. P.M.

RESULTS	REQUESTED	(X)
4.58	RBC COUNT	
14.2	HEMOGLOBIN	X
39.2	HEMATOCRIT	X
85.6	MCV	
31.1	MCH	
36.3	MCHC	
11.5	WBC COUNT	X
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	X
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
207	PLATELET COUNT	X
	RETICULOCYTE COUNT	
	CLOTTING TIME	
13.6	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
#1.6	PT CONTROL	
	PT PATIENT	
	PT % ACTIVITY	
	PT RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS: CBC

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

REQUESTING PHYSICIAN'S SIGNATURE: (b)(6)-2

REPORTED BY: (b)(6)-2

MD / TECH: 7-29-02

DATE

LAB. ID NO.

HEMATOLOGY — URGENCY: ROUTINE, TODAY, PRE-OP, STAT — PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM — SPECIMEN SOURCE: VEIN, CAP, OTHER (Specify)

HEMATOLOGY 549-107
STANDARD FORM 549 (Rev. 7-78)
Prescribed by GSA/ICMR

(b)(6)-4

ICU #1

IENT'S MED. RECORD

Pt. #(b)(6)-4 ICU #1 BED #5

UA / [redacted]

Microscopic

URIN-ALYSIS — URGENCY: ROUTINE, TODAY, PRE-OP, STAT — PATIENT STATUS: BED, AMB., OUTPATIENT, NP, DOM. — SPECIMEN SOURCE: ROUTINE, OTHER (Specify)

SPECIMEN/LA

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

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY: (b)(6)-2

MD / TECH

DATE: 7-29-02

LAB. ID. NO.

REMARKS: Cloudy yellow; = nitrite + bili; micro: M RBCs, R Rec RBC cell cast

RESULTS	REQUESTED	(X)
Cloudy	COLOR	
1.032	SPECIFIC GRAVITY	
5.0	pH	
≥	GLUCOSE	
TR	PROTEIN	
+++	OCCULT BLOOD	
+	KETONES	
	MICROSCOPIC	
	WBC	
	RBC	
	EPI CELLS	
	CASTS: WBC	
	CASTS: RBC	
	CASTS: HYALINE	
	CASTS: GRANULAR	
	BACTERIA	
	CRYSTALS	
	MUCUS	
	BILE	
NEG	URO-BILINOGEN	
	BENCE-JONES PROTEIN	
	HEMOSIDERIN	
	PSP	
	15 MIN.	
	1 HR.	
	HCG	

URINALYSIS — Standard Form 550 (Rev. 4-77) — GSA FPMR 101-11.8

MEDCOM - 3102

(b)(6)-4

EMT

MISC
URGENCY: ☐ ROUTINE ☐ TODAY ☐ ☐ PRE-OP STAT ☒
PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ ☐ NP ☐ DOM
SPECIMEN/LAB RPT. NO.
SPECIMEN SOURCE (Specify)
MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE: MAJ. (b)(6)-2
REPORTED BY: (b)(6)-2
MD: 91KM4 TECH
DATE: 28JUL02
LAB ID NO.

REMARKS: PT / PTT

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED	RESULTS
PT				19.7
INR				1.56
PTT				17.0

557-107 MISCELLANEOUS STANDARD FORM 557 (Rev. 3-77)

(b)(6)-4

EMT

MISC
URGENCY: ☐ ROUTINE ☐ TODAY ☐ ☐ PRE-OP STAT ☒
PATIENT STATUS: ☐ BED ☐ AM ☐ OUTPATIENT ☐ ☐ NP ☐ DO
SPECIMEN/LAB RPT. N
SPECIMEN SOURCE (Specify)

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

REQUESTING PHYSICIAN'S SIGNATURE: MAJ (b)(6)-2
REPORTED BY: (b)(6)-2
MD: 91KM4 TECH
DATE: 28JUL02
LAB ID NO.

REMARKS: ABG'S

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED	RESULTS
			3+	

Pt: (b)(6)-4
Pt Name: _____

TCO2	26 mmol/L	
Ht 37C		
PH	7.435	
PCO2	37.5 mmHg	
PO2	59 mmHg	
HCO3	25 mmol/L	
BEecf	1 mmol/L	
SO2*	91 %	
*calculated		

Sample Type: _____
28JUL02 10:05
Oper: (b)(6)-2
Physician: _____
0007

557-107 MISCELLANEOUS STANDARD FORM 557 (Rev. 3-77)

(b)(6)-4

EMT

MISC
URGENCY: ☐ ROUTINE ☐ TODAY ☐ ☐ PRE-OP STAT ☐
PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ ☐ NP ☐ DOM
SPECIMEN/LAB RPT. NO.
SPECIMEN SOURCE (Specify)
PATIENTS MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE: MAJ (b)(6)-2
MD: 91KM4 TECH
DATE: 28JUL02
LAB ID NO.

REMARKS: Trauma Panel

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED	RESULTS
ALB				3.3
ALP				73
ALT				31
AST				495
Amy				104
Bili				1.3
BUN				13
Creat				1.1
Glucose				114
HGT				9
LIP				44.9
CA+				7.5
Na+				140
K-				4.3
Cl-				105
CO_2-				30

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

MEDCOM - 3103

AM EPW

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

RESULTS	REQUESTED	(X)
3.95	RBC COUNT	X
11.7	HEMOGLOBIN	X
33.4	HEMATOCRIT	X
84.5	MCV	
29.5	MCH	
34.9	MCHC	
12.0	WBC COUNT	X
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
160	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PROTIME CONTROL	
	PROTIME PATIENT	
	PROTIME % ACTIVITY	
	PROTIME RATIO	
	SICKLING TEST	
	LE PREP	

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
Prescribed by GSA/ICMR
FIRMR (41-CFR) 201-45.505
549-107

REMARKS: DR

Enter in above space — PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE: (b)(6)-2
REPORTED BY
MD DATE
TECH
LAB. ID. NO.

1Y 8.8 #1Y 0.8

ICU #1

(b)(6)-4

HEMATOLOGY
URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)
SPECIMEN/LAB RPT. NO.

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

Na	139
K+	3.5
Cl	99
BUN	13
Glu	10.7
Hct	32

ELECTROLYTES W/ BUN + CREAT.

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
557-107

REMARKS: DR

Enter in above space — PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE: (b)(6)-2
REPORTED BY
MD DATE
TECH
LAB ID NO.

ICU #1

(b)(6)-4

MISC
URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DC
SPECIMEN SOURCE (Specify)
SPECIMEN/LAB RPT. NO.

AM EPW

(b)(6)-4

ID. RECORD

#(b)(6)-4

EMT

HEMATOLOGY
URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT
PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)
SPECIMEN/LAB RPT. NO.
LAB. ID. NO.
PATIENT'S MED. RECORD

Enter in above space — PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE: MAJ (b)(6)-2
REPORTED BY: (b)(6)-2
MD
TECH: 91KM4
DATE: 28JU02
REMARKS

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

RESULTS	REQUESTED	(X)
4.63	RBC COUNT	
13.1	HEMOGLOBIN	
39.6	HEMATOCRIT	
85.5	MCV	
28.3	MCH	
33.0	MCHC	
10.3 H	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	74
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
53 L	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PROTIME CONTROL	
	PROTIME PATIENT	
	PROTIME % ACTIVITY	
	PROTIME RATIO	
	SICKLING TEST	
	LE PREP	

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
Prescribed by GSA/ICMR
FIRMR (41-CFR) 201-45.505
549-107

516-108

NSN 7540-00-634-4158

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

S/P GSW

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT
(b)(6)-2	N/A	N/A

ANESTHETIST	ANESTHETIC	TIME BEGAN: 1149
(b)(6)-2	General	TIME ENDED: 1250

CIRCULATING NURSE	SCRUB NURSE	TIME OPERATION BEGAN	TIME OPERATION COMPLETED
(b)(6)-2 9ID	(b)(6)-2 M 9ID	1210	1248

OPERATIVE DIAGNOSES

Chest + back wounds - deep

DRAINS (Kind and number)

Foley inserted prior to entering OR

SPONGE COUNT VERIFIED

+ Sharps / CORRECT

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

N/A

OPERATION PERFORMED

Irrigation & closure chest GSW

Irrigation Back GSW

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)

PROSTHETIC DEVICES (Lot no.)	DATE OF OPERATION

M.n EBL

Ø Complications

SIGNATU (b)(6)-2

DATE 3 Aug 0C

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

REGISTER/I.D. NO.	WARD NO.

(b)(6)-4

AME P.W

FAKAD

OPERATION REPORT
Medical Record

MEDCOM - 3105

STANDARD FORM 516 (REV. 5-83)
Prescribed by GSA and ICMR, FPMR 101-11.806-5

516-108

NSN 7540-00-634-4155

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

S/P OSCW bilateral legs, R Shoulder

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT
(b)(6)-2		

ANESTHETIST	ANESTHETIC	TIME BEGAN: 1050
(b)(6)-2	General	TIME ENDED: 1512

CIRCULATING NURSE	SCRUB NURSE	TIME OPERATION BEGAN	TIME OPERATION COMPLETED
(b)(6)-2 M.D.	(b)(6)-2	1120	1525

OPERATIVE DIAGNOSES

Penetrating Ocular Injury c Retained Intraocular Foreign Bodies, OU and Hyphemia and Vitreous Hemorrhage

DRAINS (Kind and number)	SPONGE COUNT VERIFIED

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

① CSM ~~Left~~ Right Eye (Micro) Sent to

② CSM ~~Left~~ Right Eye (Micro) Sent to

OPERATION PERFORMED

Closure Sclera Wound Right Eye; Injection of Antibiotics and Steroids OD; Corneal Wound Repair Left Eye; Exploration of Globe; Sclera Wound Closure; Injection Antibiotics, Steroids

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)	PROSTHETIC DEVICES (Lot no.)	DATE OF OPERATION

SIGNATURE OF SURGEON	DATE
(b)(6)-2	2 Aug 02

PATIENT'S IDENTIFICATION* (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)	REGISTER/I.D. NO.	WARD NO.
(b)(6)-4		

OPERATION REPORT
Medical Record

STANDARD FORM 516 (REV. 5-83)
Prescribed by GSA and ICMR, FPMR 101-11.806-6

516-108

NSN 7540-00-634-4156

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS
S/P GSW ~ bilateral legs, (L) shoulder debrisment

SURGEON (b)(6)-2 | FIRST ASSISTANT (b)(6)-2 | SECOND ASSISTANT —

ANESTHETIST (b)(6)-2 | ANESTHETIC general | TIME BEGAN: 1723 | TIME ENDED: 1948

CIRCULATING NURSE (b)(6)-2 RN | (b)(6)-2 91D | SCRUB NURSE (b)(6)-2 Z 91D | TIME OPERATION BEGAN 1752 | TIME OPERATION COMPLETED 1930

OPERATIVE DIAGNOSES
Gunshot wounds (L) shoulder, back and both legs
open fracture (R) foot

DRAINS (Kind and number)
Foley + Chest tube inserted prior to entering O.R.

SPONGE COUNT VERIFIED + Sharps correct

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION
N/A

OPERATION PERFORMED
Bilateral debrisment of legs, pectoralis repair, pannel closure of clavical, I+D of shoulder + back

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)

PROSTHETIC DEVICES (Lot no.)

DATE OF OPERATION

I+D (B) legs, (R) foot
2° closure (B) leg wounds
I+D chest, back wounds with packing of wounds
Φ cap
200 EBL

SIGNA (b)(6)-2

DATE 30 July 02

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

REGISTER/I.D. NO.

WARD NO.

(b)(6)-4

OPERATION REPORT
Medical Record

MEDCOM - 3107

STANDARD FORM 516 (REV. 5-83)
Prescribed by GSA and ICMR, FPMR 101-11.806-5

516-108

NSN 7540-00-634-4156

MEDICAL RECORD

OPERATION REPORT

PREOPERATIVE DIAGNOSIS
GSW / Shrapnel (R) shoulder / bi-lat legs

SURGEON (b)(6)-2

FIRST ASSISTANT (b)(6)-2

SECOND ASSISTANT (b)(6)-2

ANESTHETIST (b)(6)-2 / (b)(6)-2

ANESTHETIC General

TIME BEGAN: 1354
TIME ENDED: 1528

CIRCULATING NURSE (b)(6)-2 RN / (b)(6)-2 91D

SCRUB NURSE (b)(6)-2 91D / (b)(6)-2 91D

TIME OPERATION BEGAN 1455

TIME OPERATION COMPLETED 1525

OPERATIVE DIAGNOSES
GSW (L) CW/shoulder
Shrapnel (L) Knee, (R) Foot open Metatarsal fractures, traumatic arthrotomy sulfa joint

DRAINS (Kind and number)
Foley + Chest tubes bilat inserted prior to entering O.R.

SPONGE COUNT VERIFIED
+ Sharps / correct

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION
N/A

OPERATION PERFORMED
debridement (R) shoulder chestwall, (R) Knee (R) Foot + (R) subtaylor arthrotomy (R) hand

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)

PROSTHETIC DEVICES (Lot no.)

DATE OF OPERATION

IAW as above

Ø EBL

Ø Comp

Sling to (L) shoulder

Splint to (R) foot

(b)(6)-2

SIGNATURE (b)(6)-2

DATE 26 July 02

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

REGISTER/I.D. NO.

WARD NO.

(b)(6)-4

OPERATION REPORT
Medical Record

STANDARD FORM 516 (REV. 5-83)
Prescribed by GSA and ICMR, FPMR 101-11.806-8

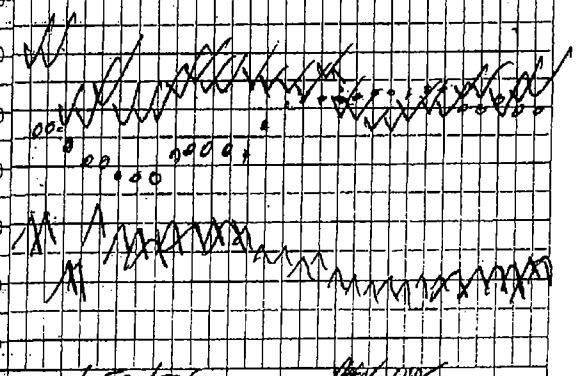
I/II

POSITION / EVENTS	TIME 1045	X	12	X	13	Totals
l/min. O₂	3	2	2	2	2	2
l/min N₂O / Air						
% Sevoflurane / Desflurane ISO	2.8	1.5	1.6	1.7	1.0	
mg PENT / PROPOF (Lidg)	160					
mg DTC / SUCC / MIVACR / ROC/RAP						
mg MSO₄ / mcg ml FENT	3.2					
mg MIDAZ						
Vecuron	8		2			
Morphine			5		5	

Premeds: None
Wt:
Allergies: NKDA

PT ID: (b)(6)-2
☒ Verbal ☐ Armband Signature
ATBX: TIME:
☒ GA. INHA ☐ GA. IV ☐ MAC ☐ Bier Block
☐ Spinal ☐ Epidural ☐ Nerve Block
Airway ☐ Oral ☐ Nasal ☐ Bite Block ☐ Mask ☐ Nasal Cannula
Intubation ☒ Oral ☐ Nasal RAE R L ☐ LMA
☐ Stylette ☐ Cuff Tube Size: 8.0
Blade: Mil 3 x 1 ☐ Cricoid Pres Easy/Difficult
Atramentn

Eyes ☐ Lube/Tearisol ☐ Taped ☐ Laser Protect
Arms Board L R Tucked L R Padded L R



1155 Bradycardia given Atropine .8
1225 Intra Ocular pressure 40mm Hg
1335 · Vecuron 8mg
1345 morphine 5mg

TV/PIP	650/26									
ESL										
Urine										2
IV #1	LR1000 1120									
☒ BP R L / EKG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
ETCO₂			34	37	38	39	39	37	34	35
☐ Tourniq / SpO₂	98	97	97	99	100	100	100	100	100	100
↑ Temp		36	36	36	36	36	36	36	36	36
↓ Resp	O	X	X	O	X	X	X	X	X	X

Procedure: Closure of sclera & retrobulbar injection of antibiotics & steroids

Crystalloids	Colloids	Total EBL
2200	Ø	Urine

Diagnosis: Multiple GSW c projectile injury B/L eye

Anesthesiologist (b)(6)-2	Anesth. Start	Anesth. End	Date
	1050	1545	24 AUG 02
	ASA 1 (2) 3		

	BP	P	R	O₂Sat	Temp
Phase I	135/59	100	16	100	100.9
Phase II					

Surgeon

(b)(3)-1

(b)(3)-1

Patient Identification

(b)(6)-4

Afganistan

ANESTHESIA RECORD

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
	PHYSICAL STATUS 1 2 3 4 5 E		

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER	

Pt known to us

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(ACUTE, ASTHMA, OTHER PATHOLOGY)	BP ..... PULSE ..... ECG (IF PERTINENT)	(CEREBROVASCULAR, POLIO, NEUROLOGICAL)	(ALLERGIES)

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY: E.G. STEROIDS, TRANQUILIZERS

PREOPERATIVE DIAGNOSIS	PREMEDICATION

SIGNATURE OF EVALUATING PHYSICIAN	DATE
	2AUG02

Previous anesthetics chart reviewed pt examined

POSTANESTHETIC VISITS

(b)(6)-2

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1996 - 716-954/53312

Dx of - Multiple GSW - Chest, (R) leg, foot + hand

Postop - Bilat Tube Thorac, GSW (R) leg, (R) foot, (R) hand

Procedure: Bilat Resuscitative Thoracotomy, Chest tubes

(R) pericardial exploration, debridement. Bilat Chest + back wounds, Debride (R) foot wound (GSW)

Team - (b)(6)-2 / (b)(6)-2

EBL 1 l

Fluid 3 units whole blood + 7000 cryo + blood

Drain - Bilat Tube Thoracotomy

Tot Well 10 ml stable bed outbound

I.O. ~~1800cc~~ 2700 cc

(b)(6)-2

(b)(6)-4

27 July 02

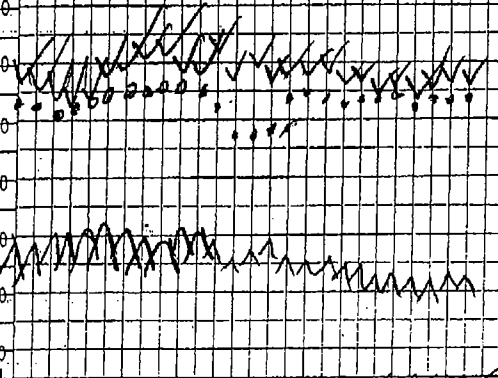
I/II

POSITION / EVENTS	TIME	1315	X	14	X	15	X	Totals
l / min. O₂		2	2	2	2			
l / min N₂O / Air								
% Sevoflurane / Desflurane Iso		1.0-1.5		1.1	1.3			
mg PENT / PROPOF (Lidd)								
mg DTC / SUCC / MIVACR / ROC/RAP								
mg MSO₄ / mcg ml FENT								
mg MIDAZ								
Vecuron		7						
Morphine			5		4			
Robinul/Neostigmine							0.7	

Premeds | Wt | Allergies

PT ID
☐ Verbal ☐ Armband Signature
ATBX: TIME:
☐ GA. INHA ☐ GA IV ☐ MAC ☐ Blor Block
☐ Spinal ☐ Epidural ☐ Nerve Block
Airway ☐ Oral ☐ Nasal ☐ Bite Block ☐ Mask ☐ Nasal Cannula
Intubation ☐ Oral ☐ Nasal RAE R L ☐ LMA
☐ Stylette ☐ Cuff Tube Size:
Blade: ☐ Cricoid Pres. Easy/Difficult

Eyes ☐ Lube/Tearisol ☐ Taped ☐ Laser Protect
Arms Board L R Tucked L R Padded L R



(b)(6)-2

							29/660	35/620	27/680
EBL									
Urine									
IV #1	NS 1000 (2)								
Incision									
☐ BP R L	EKG	SR	SR	SR	SR	SR	SR	SR	SR
	ETCO₂	32	32	32	37	37	37	37	35
☐ Tourniq	SpO₂	98	99	99	100	100	100	100	100
↑	Temp	37.8	37.8	37.8		37.7		38.1	38.1
↓	Resp	⊗	⊗	⊗	⊗	⊗	⊗	⊗	⊗

Procedure

See Page I

Crystalloids | Colloids | Total EBL | Urine

Diagnosis See Page I

Anesthesiologist (b)(6)-2 | Anesth. Start | Anesth. End | Date 2AUG02

ASA 1 2 3

Phase I | BP | P | R | O₂Sat | Temp

Phase II

Surgeon

(b)(3)-1

(b)(3)-1

Patient Identification

(b)(6)-4

Afganistan

ANESTHESIA RECORD

POSITION / EVENTS	1715		18			19			
TIME	X								X
l / min. O_2	2							1	0
l / min N_2O / Air								2	0
% Sevoflurane / Desflurane ISO	2	1	1.5		1.0			1.5	X
mg PENT / PROPOF (Lidc)	100								
mg DTC / SUCC / MIVACR / ROC/RAP	100								
mg MSO. / mcg ml FENT	2		3				3		
mg MIDAZ	1.5								

Totals

Premeds: ~~None~~ Fentanyl 100 mcg

Wt

Allergies: NKDA

PT ID: (b)(6)-2

☒ Verbal ☐ Armband Signature

ATBX: Ancef 1 gm IV 1720

☒ GA. INHA ☐ GA. IV ☐ MAC ☐ Bier Block

☐ Spinal ☐ Epidural ☐ Nerve Block

Airway ☐ Oral ☐ Nasal ☐ Bite Block ☐ Mask ☐ Nasal Cannula

Intubation ☒ Oral ☐ Nasal RAE R L ☐ LMA

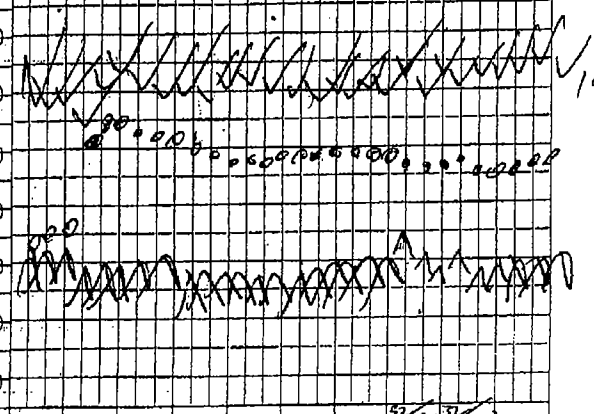
☐ Stylette ☐ Cuff Tube Size: 8.0 Mi/3x1

Blade: ☐ Cricoid Pres Easy/Difficult

Smooth uneventful. N intubation easy

Eyes ☐ Lube/Tearisol ☐ Taped ☐ Laser Protect

Arms Board L R Tucked L R Padded L R



1900 Break Echocardiogram

EBL								53/90	37/90	
Urine										
IV #1										
Incision										
☒ BP R L	EKG	SR	SR	SR	SR	SR	SR	SR	SR	SR
	$ETCO_2$		33	42	36	30	29	29	29	29
☐ Tourniq	SpO_2	100	100	100	100	100	100	100	100	100
↑	Temp		98	99	99	99	98	99	100	100
↓	Resp	O	X	X	X	V	X	X	X	O

Pt successfully breathing well extubated awake and alert exiting to PACU II. Tolerated well. Demerol 12.5 mg IV now.

Procedure: Debridement partial pectoralis repair & closure. Debridement wounds of back. Debridement of foot

Crystalloids	Colloids	Urine
1200	Ø	150

Diagnosis: Multiple GSW (R) chest

Anesthesiologist: (b)(6)-2

Anesth. Start	Anesth. End	Date
1720	1948	30 JUL 02

ASA 1 (2) 3

	BP	P	R	O_2Sat	Temp
Phase I	182/80	140	20	94	
Phase II					

Surgeon: (b)(6)-2

(b)(3)-1

(b)(3)-1

Afganistan

Patient Identification

(b)(6)-4 (EPW)

(b)(6)-4

ANESTHESIA RECORD

MEDCOM - 3113

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
Debridement			Enemy POW

PHYSICAL STATUS: 1 (2) 3 4 5 E

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ..... ABNORMAL AND WHY?	HGB ..... RBC ..... HCT ..... OTHER	

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY) B/L Chest tubes ~~[illegible]~~	BP ..... PULSE ..... ECG (IF PERTINENT) WNL	(CEREBROVASCULAR, POLIO, NEUROLOGICAL) None	(ALLERGIES) NKDA

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY: E.G., STEROIDS, TRANQUILIZERS
No complications Operations x2	Ancef Tgn

PREOPERATIVE DIAGNOSIS	PREMEDICATION
	Fentanyl 100 mcg

SIGNATURE OF EVALUATIN (b)(6)-2

DATE 30JUL

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

*U.S. Government Printing Office: 1998 - 716-994/63312

25 July 02
0545

neuro → paralytics on board

C-V → LSCVS. (B)CT c̄ min. drg at this time - $S_1 S_2$ ST ectopy.
ETT PO 27cm @ lip. RP 2+ x2 LDP 2+ RDP 1+

G-I → (+)BS, abd soft, flat

GU → 16 fr foley c̄ clear, yellow urine

M-S → Paralytics on board

Vent S Resp
Peak 60
Rate 20
TV 920

(b)(6)-2 SSG 91W30MG

---

28 July 02 0600 Dsg Sd to (R) foot by (b)(6)-2 (b)(6)-2 SGT 91W20MG

28 July 02 0635
DSG S

(L)CT → CT intact. Jeroform in place. c̄ dry method. Abd incl place c̄ occlusive dry

ant drg → min drg method. saline packing removed. tissue punch. saline packing replaced. abd replaced c̄ occlusive drg.

Post drg → serosanguinous drg. saline packing replaced. abd occlusive drg

(R)CT → CT intact. Jeroform replaced. min drg for CT. abd occlusive drg

---

(b)(6)-2 SSG 91W30MG

TIME	1400	1430	1500	1530	1600	Totals
POSITION / EVENTS						
l / min. O_2						
l / min N_2O / Air						
% Sevoflurane / Desflurane						
mg PENTT / PROPOF (Lidd)						
mg DTC / SUCC / MIVACR						
mg MSO_4 / mcg/ml FENT						
mg MIDAZ						
Neosynephrine						
Propofol gtt						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
(b)(6)-2						
EBL						
Urine						
IV #1 LR 1 gRA						
Infusion						
BP (R) L						
Tourniq						
Procedure						

EKG	SR	SR	SR	SR	SR
$ETCO_2$	47		36	36	34
SpO_2	98	98	100	100	100
Temp			35.3	36.1	35.2
Resp	9	11	11	11	11

Premeds

Wt

Allergies ? (b)(6)-2

(b)(6)-2

PT ID

☐ Verbal ☐ Armband Signature

ATBX: TIME:

☒ GA. INHA ☐ GA. IV ☐ MAC ☐ Bier Block

☐ Spinal ☐ Epidural ☐ Nerve Block

Airway ☐ Oral ☐ Nasal ☐ Bite Block ☐ Mask

Intubation ☐ Oral ☐ Nasal RAE

☐ Stylette ☐ Cuff Tube Size:

Blade: ☐ Cricoid Pres. Easy/Difficult

Pre existing 8

Eyes ☐ Lube/Tearisol ☒ Taped ☐ Laser Protect

Arms Board (L) (R) Tucked (L) (R) Padded

Transport to OR c̄ ambu + O_2.

1410 Placed in Semi Fowlers position secured to bed c̄ tape + strap

1425 (R) chest tube to 20 cm suction

A 1355 1530

O 1434 1520

Crystalloids	Colloids	Total EBL
1100		Urine

Diagnosis Multiple GSW B/L chest tubes

	BP	HR	O_2Sat	Temp
Phase I	118/81	66	500 X18 50%	
Phase II				

Patient Identification

Anesthesiologist (b)(6)-2 CRNA

Anesth. Start 1355 Anesth. End 1530 Date 28 Jul 02

ASA 1 2 (3)

(b)(6)-2

Surgeon (b)(6)-2

(b)(3)-1

(b)(3)-1

A MEPW # (b)(6)-4

Afganistan

Page 1

ANESTHESIA RECORD

MEDCOM - 3116

Standard Form 517 1849

1830 **CLINICAL RECORD** ASA IE **ANESTHESIA**

ANESTHETIC(S) — HOUR 19 20 21 22

Forane
Neosynephrin
Scopolamin 0.4 m
Urseal m
Fentanyl m
Norcuron m 10
SAT 99 99 100 100 99 99 99 98 97 97 96
ETCO2 33 34 33 33 33 33 34 34 34 34 34 34
OXYGEN 6 60 60 60 60 60 60 60 60 60 35 35
CO_2 ABSORP.

LEVEL OF ANAL-ANES. O2 4/m C 2

INDUCTION
SATIS.
UNSATIS AND WHY

REMARKS
14 Gr (R) A
18 Gr (D) A
1935 Ancef
G-m # 1 UPB

CODE
● PULSE
○ RESP.
V ^ B. P.
X ANES.
⓪ OPER.
T TOURN.

FLUIDS
B BLOOD
N SALINE
G 5% G/W
DX EXPAND.

NUMBERS FOR REMARKS — Whole Blood #1 #2 #3
Albumin X 50
IV FLUIDS — X 1000/500/5000 / 2000
POSITION — Supine

AGENTS AND TECHNICS
Anesthesia 1849 / 2130
X ⓪ Surgeon 1855 / 2110

1850: Induction
Etomidate 20
Succ 160
Xylocaine 100

ENDOTRACHEAL: SIZE 8.0 BLADE 4 MAC ORO ..... NASO ..... CUFF ..... PACK .....
REMARKS: Direct Visualization, Cords visible (D) ETT (D) Equal
ETC 24 cm @

OPERATION PERFORMED
Bilateral Resuscitative Thoracotomies, (R) Popliteal Exploration, Debridement of Multiple GSWs.

TOTAL FLUIDS: Blood #3, Crystalloid 2000 ml, Albumin 50, Hespan 500 ml

EBL: 1000 ml
U/O: 2700

Trauma #1

RECOVERY
REFLEX IN O.R.
EMESIS
ASPIR.
EXCITEMENT
HYPOTENSION
OTHERS

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

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

(b)(6)-4

REGISTER NO. | WARD NO. | DATE 27 July 02

ANESTHESIA

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR 101-11.806-8 517-109
OCTOBER 1975

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)*

_____ ML

REMARKS:

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

- [x] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED

7-28-02

DATE AND HOUR REQUIRED

7-28-02 930AM

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*

maj. (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

Mult wounds (chest)

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

SIGNATURE OF VERIFIER

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.

TRANSFUSION NO.

PATIENT NO.

#(b)(6)-4

DONOR

RECIPIENT

ABO

ABO B

Rh

Rh POS.

TEST INTERPRETATION

ANTIBODY SCREEN: N/A

CROSSMATCH: N/A

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

(b)(6)-2 911 SM4

[x] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 7-28-02

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* ON *(Date)*

IDENTIFICATION

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

1st VERIFIER *(Signature)*

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION

TEMP. PULSE BP

DATE OF TRANSFUSION TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN _____ ML

TIME DATE COMPLETED INTERRUPTED

REACTION

- [ ] NONE
- [ ] SUSPECTED

If reaction is suspected — IMMEDIATELY:

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

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER _____

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

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

SIGNATURE OF PERSON NOTING ABOVE

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank; rate; hospital number and name of facility.)*

#(b)(6)-4

AFGhani

EMT

male

SEX M

WARD EMT

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

NSN 7540-01-165-7294

519-302

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

Chest

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
14	M		ICU I	

FILM NO.

PREGNANT ☐ YES ☒ NO

(b)(6)-2 Sgm.

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTER (b)(6)-2 SGM

DATE REQUESTED

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

Follow up. Post op

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

RADIOLOGIC REPORT

No significant change

(b)(6)-2

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

(b)(6)-4

(b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 3119

REQUEST/REPORT

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR

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 ... TED AND SIGN

12 AUG 02 1000

1. discharge today
2. OK Genta & Ancef
3. Eye drops as per protocol

(b)(6)-2

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER | TIME OF ORDER

12 AUG 02 _____ HOURS

PT. TO RETURN TO OPTOMETRY ON 10 SEPT FOR REMOVAL OF SUTURES IN LEFT CORNEA.

(b)(6)-2 CAPT, OD, MSC

REMOVAL TO BE DONE AT DETAINEE LOCATION

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

_____ HOURS

URSING UNIT | ROOM NO. | BED NO.

TIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

_____ HOURS

SING UNIT | ROOM NO. | BED NO.

FORM 1 APR 79 **4256** REPLACES EDITION OF 1 JUL 77

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

(b)(6)-4

AM EPW

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

11 AUG 01 (1) remove all staples

(b)(6)-2

NURSING UNT: ICW | ROOM NO. | BED NO.: 9

(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.

FORM APR 79 **4256** REPLACES EDITION OF 1 JUL 77 WHICH

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER | TIME OF ORDER 19:30 HOURS | LIST TIME ORDER NOTED AND SIGN

7 AUG | D/C ATROPINE

CONTINUE C PRED FORTE AND OCUFLOX

QID OU

(b)(6)-2 | CAPT, OD, MSC

(b)(6)-2 | RN

7 AUG 02 2000

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER | TIME OF ORDER 10:00 HOURS

10 AUG

ADD CILOXAN TO DROPS GIVEN

Q6H

(b)(6)-2

(b)(6)-2

(b)(6)-2 | CAPT, OD, MSC

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER HOURS

11 Aug 02 @ D/C Ancef

1520 @ D/C Gentamycin

(b)(6)-2

(b)(6)-2 | 9/10/3/06

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER HOURS

URSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

(b)(6)-4

AM & PM

Bed 9

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 4 Aug 02 | TIME OF ORDER: 1450 HOURS | LIST TIME ORDER NOTED AND SIGN

① Transf To ICW
② DX: multi GSW
③ MEDS: Percocet 1/1-11 PO Q 4-6° PRN
Tylenol 650mg Supp OR PO Q 4-6° PRN
Ancef 1Gm IV Q8° (8A 4P 12m)
Gentamycin 400mg IV QD (11P)
Pred Forte 1 gtt OD QID (5A 11A 5P 11P)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

IV Heplock
Atropine 1% 1 gtt OU bid (9A 9P)
Occuflox II gtt OS Q2° (odd)
Occuflox II gtt OD QID (5A 11A 5P 11P)
④ Diet: As tolerated
⑤ Activity: NWB (R) leg.
⑥ Wet to dry DSG Bs to back wounds & Drains Solution BID. (Bid 1000)

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

CPT, AN

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

PRED FORTE QID OU
SAME TIME AS OTHER EYE MEDS

(b)(6)-2

(b)(6)-2

(b)(6)-2

CPT, MD

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

(b)(6)-4

AM EPW

NURSING UNIT | ROOM NO. | BED NO.

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

3 Aug 02 Admit ICU
S/p I+D
Resume preop orders
except:
1) wet → dry dressing Δ's to back wounds c̄ Dacon's solution bid.
2) Clears liquids, ADAT to Reg
(b)(6)-2 ILT ANC

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

3 Aug 02 1510 V/O from Dr (b)(6)-2 : start D5W Δ's to back wounds in AM 8/4/02.
(b)(6)-2 ILT ANC

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER ____ HOURS

3 Aug 02
1550 ~~V/O from Dr~~ (b)(6)-2
~~1 mg Glucagon Tylenol 650 g PO also~~
(b)(6)-2 ~~ILT ANC~~

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER 1650 ____ HOURS

3 Aug 02
1. Patch + Shield OS 4 hr
Changed daily.
2. Shield OD may be removed (D/C'd) @ 72 hrs post op.
3. Atropine 1% gtt I OU tid
Cyclopl, gtt I-II OD qid
4. Keep eyelids clean and free (cont)

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

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

MEDCOM - 3124

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 3 Aug 02 TIME OF ORDER: 1650 HOURS

LIST TIME ORDER NOTED AND SIGN

Ind I sterile saline
Drops x gentle irrigation —
No pressure on eyelids.
5. Pred Forte, gtt i OD qid.
6. Pt. to be delivered by
Capt. (b)(6)-2
Thank you

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

(b)(6)-2 USA-MC
Ophthalmology
(b)(3)-1

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 3 Aug 02 TIME OF ORDER: 1750 HOURS

Ofloxacin gtt i-ii OS q 2 hr.
No Pred Forte OS.
Thank you

(b)(6)-2 USA-MC
Ophthalmology
(b)(3)-1

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

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

(b)(3)-1
ILT ANC 1837 3 Aug 02

3 Aug 02 D/C Foley
0911 D/C IV Mido → Heparin
(b)(6)-2
ILT ANC 0912 4 Aug 02

4 Aug 02 Percocet 0732 T or Ti PRN q 4-6 hr PRN
(b)(6)-2
ILT ANC
4 Aug 02 1150

NURSING UNIT	ROOM NO.	BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
31 July 02	① Repeat exn 1 Aug 02 11:00	[redacted] B6-2
	(b)(6)-2	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER	
31 JULY	11:45	
1 gtt OCUFLOX OU Q2H		[redacted] B6-2
2 Aug 02 POD #1	(b)(6)-2	
1550L VS q 2 hrs x 2 then 4 hrs		CAT, OD, MS
Advance diet as tolerated		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
Gentamycin 400 mg IV q 8	
Ancef 1 g IV q 8 hrs	
Foley catheter to gravity	
IVF: LR at 100 cc/hr	
Tylenol 650 mg supp PR q 4-6 PRN	
Fentanyl 50 mcg IV q 1 PRN pain	
(b)(6)-2 (b)(6)-2	
LT ANC 8/2/02 1730	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
2 Aug 02	2:16
① Ice chips & sips of water - may advance if tolerated	
(b)(6)-2	

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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PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
30 Jul 02	1300		
Δ IVF to LR @ 150cc/hr			(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	HOURS
30 July 02	Admit ICU	
	s/p I+D	
	LR IV @ 125cc/hr	

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	HOURS
	Ancef 1gm IV q8°	
	Gentamycin 400mg IV qD	
	Tazocin 300mg IV bid	
	MSO4 2-5mg IV q2° prn	
	NPO ~~x~~ ice chips + sips H_2O	
	Chest tubes to CWS	
	NG Tube to CWS	
	Foley to GD	

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	HOURS
	Sling to (L) shoulder	
	NWB (R) LE / (L) UE	
	CXR in AM 7/31	
	CBC, lytes / BUN / Cr / Glu in AM 7/31	
	VS q2° x 4, then q4°	
	Wet → Dry Gauze	
	dressing c's to	
	Both back wounds	

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	HOURS
	Fentanyl 50mcg IV Q1° PRN	
31 Jul	CCB to chair	(b)(6)-2
	D/C Tazocin	(b)(6)-2
31 Jul	Lasix 20mg IVP X1	
	Δ IVF to NS @ 100cc/hr to	
	current bag	
	Re Na+ @ noon	(b)(6)-2

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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PATIENT IDENTIFICATION

#

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

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

29 July 0800 — M MB 570 7mg IV q/h
Lyte/ HH @ 1800
Δ IV to NS @ 1800 [illegible]
29 Jul 02
1340 ① CXR By 0800 30 Jul 02
(b)(6)-2

PATIENT IDENTIFICATION

#

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

29 July 02 1330
X-Ray ⓛ ankle
V/O Dr (b)(6)-2
taken by (b)(6)-2 ILT ANC
29 July 02

29 July 02 1840 HH, Bun, Cr, lyte 0700L 30 Jul 02.

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

29 July 02
1930.
V/O Dr (b)(6)-2 ! may have small cup of ice chips PRN for pleasure.
Taken by (b)(6)-2 ILT ANC

29 Jul 02 1951 (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | HOURS

29 Jul 02 2030
① Tylenol ~~325mg~~ (b)(6)-2
650mg suppository q 4-6° PRN
② [illegible] (b)(6)-2
2140 (b)(6)-2 7/30/02 0230
29 July Valium 1mg IV x1 for Agitation
VO, Dr (b)(6)-2 (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

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

28 Jun 1230 Fentanyl 50 mcg/hr IV Rx

(b)(6)-2

28 Jun 1700 IV Tagamet 300 bid Rx

(b)(6)-2

28 Jun 1600 L. Resume the opt orders

ABG @ 1700 hrs Vent TV 600 A/C 16 40%

get CBC tm Chem.

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

28 Jun 2030 ABG @ 0700 L on 29 Jun 02

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

29 July 02 0530 500cc Fluid bolus then ↑ rate to 125cc/hr.

BUN/CR/Chem 7 this AM Vo. Dr

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

29 Jun 02 0700 ↑ IV to 150 ml/hr

LASIX 40mg IV now

2 Amps Bicarb to 1L NS Done

Bolus 500 cc IVF x1 now

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE 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.

HYSICIAN ORDER SHEET

DATE	ORDERS	TIME
28 Jul 02	Etomidate 20g IV	
	Vecuronium 10g IV	
	TGA AN cap IV	
	Repeat Vecuronium 10m IV	
	Propofol IV drip	
	CBC, electrolyte, Coags	
	U/A	
	CXR	
	ABG	
	CT head, Chest, Abd, Pelvis	(b)(6)-2
	XRAY (R) thigh (R) foot (L) knee	(b)(6)-2
	BL hands	
28 Jul 02	ADMIT ICU	
1100	NPO	
	IV LR - 100 ml/hr	
	Vent IV 450 ml	
	Resp 10	
	A/C 12 BPM	
	FIO2 100%	
	ABG @ 1200 hrs	1200 15%
	Vancomycin 1g q 8 hrs	
	Next dose 1500L	
	Gentamicin 400mg IV q day	
	Nimbex IV	
	titrate to effect	
	begin @ 5 ml/hr	
	CRRT IV	
	titrate to effect	
	begin 20 mcg/min	
	Check pulses distal	
	XR LAT C-Spine / Swimmers view	
	T+O	
	VS q 1hr x 12 hrs then	
	q 2hrs	
	Consult Dr (b)(6)-2 (Done)	
	LAB ~~H+H~~ @ 1600 Local	
	CBC	
28 Jul 02	MSO4 - 10mg IV now (Done)	
	Δ Vent to TV 500 ml / A/C 15 / FIO2 40% / PEEP 10 ABG 1hr	

WARD	ID NUMBER:	DIAGNOSIS
PATIENT DATA	VERIFICATION	
(b)(6)-4		

CLINICAL RECORD

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

Mo.____ Yr.____

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
				14 Aug
14 Aug 22	(b)(6)-2 9103MC	Wet to drydrsg. 4's to back wound & Dakin's solution BID	10	(b)(6)-(2)
			22	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Multi - GSW

ADDITIONAL PAGES IN USE: ☐ YES ☒ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

(b)(6)-4

Am EPW

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 1 OCT 78 4677 EDITION OF 1 DEC 77 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. 08 Yr. 02

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 8/4	8/5
3 Aug	(b)(6)-2	Δ Patch + shield OS QD	1700	D/C	
3 Aug		D/C shield OD p̄ 72° post op	1700	/	/
3 Aug		Keep eyelids c/tAN QD on	1700	(b)(6)-2 1700	
/	/	bid & sterile saline soaks +			
/	/	gentle wiping, NO Pressure			
/	/	on eyelids			

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P multi GS wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

AM EPW (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 1 OCT 78 4677 — EDITION OF 1 DEC 77 MAY BE USED.

2 of 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. 8 Yr. 02

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 6	7	8	9	10	11	12	13	14	15
6Aug02	(b)(6)-2	Pred Forte 1% QID	05	(b)(6)-2									
	-----	OU ([redacted]) - Same	11										
	-----	time as other eye	17										
	-----	mark BOTH EYES	23										

7Aug	-----	PRED FORTE, OCUFLOX OU	8:00	1500	1700								(b)(6)-2
7Aug	(b)(6)-2	PredForte QID OU "right"	5			(b)(6)-2							
	-----		11										
	-----		17										
	-----		23		(b)(6)-2								
7Aug	(b)(6)-2	Ocuflox QID OU	5										
	-----	"11" gtts	11										
	-----		19										
	-----		23		(b)(6)-2								
10Aug02	(b)(6)-2	CILOXAN OU QID	05					(b)(6)-2					
	-----		11										
	-----		17										
	-----		23										
8Aug02	(b)(6)-2	Heplock flush											

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Multi - GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. 2

PATIENT IDENTIFICATION: (b)(6)-4

AM EPW

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 3133

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													
4/1/002	(b)(6)-2		(b)(6)-	8/12 0100												
18 Dec 02	91W3AK01	Percocet T=II PO q 4-6° prn														
4 Dec 02	(b)(6)-2	Tylenol 650 mg Suppsor		0900 12AM												
1 Dec 02	91W3AK01	PO q 4-6° prn	(b)(6)-2													

*U.S. GPO: 1996-454-110/95218

MARS 8/4/02 1 of 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 8/4	8/5	8/4	8/4	8/4	8/4
8/4/2	(b)(6)-2	ANCEF 1 gm IV Q8°	05		(b)(6)-2				
			13						
			21						
8/4/2	(b)(6)-2	GENTAMYCIN 400mg IV QD	23						
8/4/2		PRED FORTE 1 GTT OD	05						
		QID (RIGHT EYE)	11						
			17						
			23						
8/4/2	(b)(6)-2	ATROPINE 1% 1 GTT	09						
		OU BID (BOTH EYES)	21						
8/4/2	(b)(6)-2	OCCUFLOX II GTT OS	07						
		Q2° (ODD HOURS)	09						
		(LEFT EYE)	11						
			13						
			15						
			17						
			19						
			21						
			23						
			01						
			03						
			05						
8/4/2	(b)(6)-2	OCCUFLOX II GTTS OD	05						
		QID (RIGHT EYE)	11						
			17						
			23						
8/4/2	(b)(6)-2	HEPLOCK IV FLUSH							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: MULTI-GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION: (b)(6)-4

AM EPW

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

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

MEDCOM - 3135

WOUND CARE

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. ____ Yr. ____
Order Date	Clerk/ Nurse	~~SINGLE ORDERS, PRE-OPERATIVES~~	Date to be Given	Time to be Given	Time Given	Initials	
8/4/2	(b)(6)-2	WET TO DRY DSG CHANGES TO BACK WOUNDS & BAKINS SOLUTION BID.	10	8/5 (b)(6)-2			
		Transcribed to	12	(b)(6)-2			

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
8/4/2 11 Aug	(b)(6)-2	Percocet 1-2 PO Q4-6° PRN	(b)(6)-2								8/7/2 1300	7 AM 2240	8 AM	8/8/2 1030	8/14/2 2300		
8/4/2 11 Aug	(b)(6)-2	Tylenol 650mg Supps or PO. Q4-6° PRN	(b)(6)-2														
8/7/02	(b)(6)-2 15:10	OCUFLOX, PRED FORTE ATROPINE OU 1gtt	9:10	15:00													

Transcribed to sheet #2

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

1 of 2 MARS

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE (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 8/1	8/2	8/3	8/4
		GENTAMYCIN 400mg IV	23	(b)(6)-2			
		QD					
		ANCEF 1 gm IV Q8°	09	IV	(b)(6)-2		
			17				
			01	(b)(6)-2			
		OCUFLEX 1 GTT OU	09		(b)(6)-2		
		Q2°	11				
			13				
			15				
			17				
			19				
			21				
			23				
			01				
			03				
			05				
			07				
		NSS-IV @ 100cc/HR	08				
			20				
		DRESSING A TO BILAT		IV			
		BACK WOUNDS W/D		8/1 OR			
		GAUZE QD/PRN					

Revised

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(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

PRN

	DATE/TIME											
IV FENTANYL 50mg Q1° PAIN PAIN	8/1	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]				
	1530	2030	2215	1345	(b)(6)-2	(b)(6)-2	(b)(6)-2					
TYLENOL 650mG SUP P.R. Q4-6° PRN												

MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is The Office of The Surgeon General

REPORT TITLE

POST ANESTHESIA CARE UNIT FLOWSHEET

OTSG APPROVED (Date) 17 Jan 80

PROCEDURE: Bilat Resect Thoracotomy, R Pop Cupl, Delay Resect

PHYSICIAN: (b)(6)-2

ANESTHESIA BY: (b)(6)-2

Gen Spinal N[redacted]ry

Local Bier Epidural Other

ALLERGIES: NKA

AIRWAYS: Time DC'D

ETT Nasal Oral Trach

OXYGEN:

Mask Nasal Face Blow-By

Prongs Tent

Liter/min. 5 %

ASA History Gastl Chest

Cardiac Rhythm ST

IV#1 L R Patent Infiltrated

Site L AC Rate 100 Gauge 18

IV#2 R W Patent Infiltrated

Site L R Rate 200 Gauge 18

Time	B/P	P	R	O2SA	Temp	Act	Resp	Circ	LOC	Skin	PAIN	COMMENTS	Neuro-Vascular
PRE-OP	/												
PRE-OP	183/95	155	•										
2200	172/78	120	20				Paralyzed.						
2215	171/98	81	12	81								Vent	
2230	129/91	86	19	99								Bag	
2245	130/86	77	15	99								Bag	
2300	141/80	86	14	84								Vent / paralyzed	
2315	145/86	83	20	91								Vent / paralyzed	
2330	133/77	87	20	92									
2400	138/87	83	20	97								Vent / paralyzed	
0030	159/94	80	20	92								Vent / paralyzed	
0100	169/90	125	20	94									
0130	155/101	110	20	91									
0200	142/95	92	20	91									

VITAL SIGNS | PAR SCORE | OTHER

POST ANESTHESIA RECOVERY SCORE "PARS"

Activity - General Anesthesia
2—Maintain head lift and open eyes
1—Unable to maintain head lift and open eyes
0—Unable to lift head and open eyes

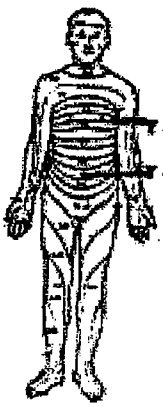
Activity - SAB or Subarachnoid Block
2—Moves all four extremities with control
1—Moves both upper extremities

Respiration
2—Spontaneous respiration; needs no support
1—Limited effort; needs artificial airway or low support
0—Needs ventilation; no spontaneous respiration

Circulation
2—BP 20% preanesthetic level
1—BP 20 - 50% preanesthetic level
0—BP 50% or more preanesthetic level

Level of Consciousness
2—Awake and alert; seldom dozes
1—Awakens when gently stimulated
0—Awakens only when vigorously stimulated

Skin
2—Normal skin color & temperature greater than 95°
1—Skin is pale, blotchy, clammy &/or temperature 95 - 94°
0—Cyanotic &/or temperature less than 95°



DRESSING:	Status	Location
Gauze	old Stain	R+L Chest
Sponge	old Stain	R Foot
Bandaid		
Steri-strips		
Collodian		
Pad-pad		
Coban		
Cotton Balls		
Ace Wrap		

TUBES: Removed Foley NGT

AND Chest Bilat Jackson-Pratt

DRAINS:

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 MAJ AN

DEPARTMENT/SERVICE/CLINIC (b)(3)-1

DATE 27 July 02

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTICS STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

FB NDA OP 132-11a (Revised) 1 Oct 94

INTAKE			OUTPUT		
TIME	TYPE	AMT	TIME	TYPE	AM
OR	Whole Blood	1500	OR	EBL	1000 2500
"	Crystaloid	7000	OR	Urine	2700
"	Albumin	50	~~2330~~ 2330	Urine	3000
"	Heparin	500	2200	Urine	1700
0045	Whole Blood	700			
0249	NS ~~[illegible]~~	1000			
TOTAL			TOTAL		

PACU NURSING NOTES: NURSING CARE PROBLEM NO.'S IDENTIFIED. Refer to PH MDA OP 39

NURSING CARE PROBLEMS: 1. RESP; 2. CIRC; 3. ACT; 4. LOC; 5. TEMP; 6. PAIN; 7. SAFETY; 8. ANXIETY; 9. EDUC; 10. OTHER

2200 Received fm OR. Intubated responding to painful stimuli - attempts for spontaneous resp. Sats dropped into 70's - Ambu bag - Sats 95-100% - placed on Vent A/C TV 100, Rate 12. SAO2 - 70-80's - Settings changed to TV 920 - peak flow of 45, Rate of 19. SAO2 92-95% CO2 26-30 ~~[illegible]~~

2300 Paralyzed - Vecuronium to prevent fighting of vent —

0045 SAO2 dropped into 70's - Additional Vec & MS given

0115 Vent settings adjusted to TV 920 - Rate 20 - Peak Flow 60 SAO2 94-95% — (b)(6)-2 MAT, RN

0345 Reacts to painful stimuli - fighting vent - Vecuronium & Versed given to good effect - SAO2 93-94% — (b)(6)-2 MAT RN

MEDICATION RECEIVED IN PACU/ICU

MEDICATION GIVEN BY:	DRUG	DOSE	ROUTE	TIME	EFFECTIVENESS
(b)(6)-2 MAT,	Versed	1 mg	IV	2315	
(b)(6)-2 MAT, RN	MS	2 mg	IV	2315	
MAT, RN	Narcan	1 mg	IV	2345	
MAT, RN	Narcan	1 mg	IV	0015	
MAT, RN	MS	1 mg	IV	0020	
MAT, RN	Versed	1 mg	IV	0020	

DISPOSITION SUMMARY: Nursing Care Problems No.'s _____ Resolved; No.'s _____ Continue.
Patient was transferred from PACU/ICU recovery room via litter/crib with siderails raised, or held by parent in chair.
Ambulating status: _____ PAR Score _____ Safety Straps _____
Report given to _____ Patient released by Anesthesia _____
Time out _____ Nurses Signature: _____

OR.
MS 2 mg @ 2200
Versed 2 mg @ 2145
Droperidol @ 2140
Lasix 10 mg @ 2230

MED. RECORD-SUPPLEMENTAL MEDICAL

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

OTSG APPROVED (Date)

REPORT TITLE
Clinical Record Doctors Orders

POST OP

(1) Diagnosis: Multiple GSW Bilat. Chest c Hemo-pneumothorax, GSW (R) foot & knee

(2) Procedures: Bilat Emergency Thoracotomy, (R) popliteal Exploration, Debrid. Multiple GSW

(3) Allergies NKDA

(4) Condition: Good (Fair) Poor

(5) Vital Signs Q 5 to 10 minutes until stable then Q 30 minutes

(6) I & O Q-1 hour ~~X~~ 8 hrs

(7) Activity: Bedrest

~~(8) IV Fluids: LR@ 150 cc/hr x 2 liters~~ NS@_____cc/hr x ___liters

9. Blood: Transfuse 1 Units PRBCs if Hgb < 10.

(10) Oxygen: 2 ~~to 5 liters/min via mask~~. Titrate to SAO2 >90%.

(11) Chest Tube: 20 cmH2O ~~Water seal~~ ~~N/A~~ Bilat

(12) Vent settings: SIMV: 12/min., TV: 12cc/kg. 02 Flow to maintain SAO2 >90% PEEP 5c
Peadk Flow 45 liters per minute and adjust as needed.

(13) Extubation criteria :
Pateints spontaneous respiration is 14 to 20 inhalations per minute
Patient is able to cough and breathe.
Pulse oximeter setting must be no less than 92%.
Patient arouses spontaneously and can lift head off bed.
~ 6 hrs.

~~14. NG Tube:~~ LIS Clamped N/A

(15) Medications:
Antibiotics (check one)
✓ Cefazolin Sodium, 1 Gm, IV, q8H due @ 0330
___ Cefoxitin Sodium, 1 to 2 Gms, IV, q6 to 8H
___ Gentamycin Sulfate, ____Mgs q___H

✓ Analgesics:
Morphine Sulfate, 2 to 10 Mgs, IV, q2H prn.
Dopamine 2.5 mg/ml 72 cc + 5 mg Versed in 1.0 L NS @ 200 cc continuous

16. Patient Release:
A. Release form medical evacuation when patient arouses spontaneously, can lift head off bed, when BP is equal to or greater than 100 mm Hg (systloic) and stable, and when there is no evidence of rebleeding.
B. Discontinue chest suction and place Heimlich valve on all chest tubes.
C. Discontinue NG tube suction and ensure that tube is open to air or to straight drainage.

17. HCU 54

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
(b)(6)-2 [signature]	(b)(3)-1	27 Jul 02

PATIENT'S IDENTIFICATION (For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)
(b)(6)-4

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

DA FORM 4700, MAY 78

TWENTY-FOUR HOUR PATIE[redacted]E AND OUTPUT WORKSHEET

FROM [redacted] HOURS TO [redacted] | TOTAL HOURS COVERED | DATE 8-1-02

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1915	WATER/Juice	400	
2200	Juice		
2315	Juice		
	NPO p Midnight		

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1300	1000	LR @ 150	700	1915	
1915	1000	NSS @ 100/hr			
2300	50	Gentamycin 50cc	50	2300	
0200	50	Ancef 1gm IVPB	50	0235	

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

(b)(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630 (TEMP) 1 JUL 72 WHICH MAY BE USED.

*U.S. Government Printing Office: 1994 — 300-727/10425

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1915	1800	—			
2100	1200				

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
GRAND TOTAL OUTPUT			

REMARKS

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

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED.

*U.S. Government Printing Office: 1994 — 300-727/10425

TWENTY-FOUR HOUR PATIEN[redacted]E AND OUTPUT WORKSHEET

FROM 0700 HOURS TO [redacted]	TOTAL HOURS COVERED 0700hr 24°	DATE 2 Aug 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (*Include Medications*)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
		LR @ 150cc/°			

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

(b)(6)-4

INTAKE EQUIVALENTS (*Serving levels cc*)

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 64 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED.

*U.S. Government Printing Office: 1994 — 300-727/10425

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0700					

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
		GRAND TOTAL OUTPUT	

REMARKS

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

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 1 JAN 74 **792**

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED.

*U.S. Government Printing Office: 1994 — 300-727/10425

ADMISSION ...DING INFORMATION

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

1. REPORTING MTF: (b)(3)-1 — A
2. ...ATION (State or Country Code): AF

3. REGISTER NUMBER: (b)(6)-4
NAME (Last, First, Middle Initial): AFGHAN MALE (b)(6)-4 EPW
4. PAY GRADE:
5. SEX: M

6. DATE OF BIRTH (Y Y Y Y M M D D):
7. AGE AT ADMISSION: 18 y
8. RACE: X
9. ETHNIC BACKGROUND: 9
RELIGION: MUSLIM

10. LENGTH OF SERVICE:
ETS:
11. FMP: 99
12. SOCIAL SECURITY NUMBER: (b)(6)-4

ORGANIZATION (Active Duty Only):
13. MARITAL STATUS: M
HOUR OF ADMISSION: 0958
BRANCH / CORPS:

14. FLYING STATUS: N / /
15. BENEFICIARY CATEGORY: K 7 8
16. ZIP CODE OF RESIDENCE: 0 9 3 5 4

17. UNIT LOCATION (State or Country Code): A F
18. MOS:
19. TRAUMA: 9
PREV. ADMISSION: YEAR: [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 0
WARD: ICU1
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1 BAGRAM AF
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

21. TYPE OF DISPOSITION: 0 5
22. MTF TRANSFERRED TO:
23. DATE OF DISPOSITION (Y Y M M D D): 0 2 0 8 1 2

24. CLINIC SVC - ADMITTING: A A A A
25. MTF TRANSFERRED FROM:
26. DATE THIS ADMISSION (Y Y M M D D): 0 2 0 7 2 8

27. LOCATION OF OCCURRENCE (Battle Casualty Only):
28. MTF OF INITIAL ADMISSION: A (b)(3)-1
29. DATE INITIAL ADMISSION (Y Y M M D D): 0 2 0 7 2 8

FOR LOCAL USE

MULTIPLE GSW
X2 CHEST T: 1
1 FEMUR Inj: 450

DX: 8601, 8704, 8900, 8920, 8782, 8840, 7806, 9950, 9913, 37933, E9915
PR: 1229, 1281

ADMITTING OFFICER (Signature as required): (b)(6)-2
SIGNATURE OF ADMITTING CLERK: (b)(6)-2
(b)(6)-2
(b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 7...

1. REPORTING MTF: (b)(3)-1 A

2. ATION: 7 A, 8 F (State or Country Code)

ADMISSIOI D CODING INFORMATION

For use of this form, see AR 40-400; proponent agency is SGO.

3. REGISTER NUMBER: 9 10 11 12 13 14 15 (b)(6)-4

NAME (Last, First, Middle Initial): AFGHAN MALE Detainee (b)(6)-4 EPW

4. PAY GRADE: 16 17

5. SEX: 18 M

6. DATE OF BIRTH (Y Y Y Y M M D D): 19 20 21 22 23 24 25 26 1984 01 01

7. AGE AT ADMISSION: 27 28 29 18 y

8. RACE: 30 X

9. ETHNIC BACK-GROUND: 31 9

RELIGION: MUSLIM

10. LENGTH OF SERVICE: 32 33 34 ~~222~~

ETS

11. FMP: 35 36 ~~99~~ 20

12. SOCIAL SECURITY NUMBER: 37 38 (b)(6)-4 (b)(6)-4

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS: 46 M

HOUR OF ADMISSION: 0958

BRANCH / CORPS

14. FLYING STATUS: 47 48 49 N

15. BENEFICIARY CATEGORY: 50 51 52 K 7 8

16. ZIP CODE OF RESIDENCE: 53 54 55 56 57 58 59 60 61 0 9 3 5 4

17. UNIT LOCATION (State or Country Code): 62 63

18. MOS: 64 65 66 67 68 69 70

19. TRAUMA: 71 9

PREV. ADMISSION: YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 Ø

WARD: ICU 1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

(b)(3)-1 BAGRAM AF

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74 Ø 5

22. MTF TRANSFERRED TO: 75 76 77 78 79 80

23. DATE OF DISPOSITION (Y Y M M D D): 81 82 83 84 85 86 0 2 0 8 1 2

24. CLINIC SVC - ADMITTING: 87 88 89 90 A A A A

25. MTF TRANSFERRED FROM: 91 92 93 94 95 96

26. DATE THIS ADMISSION (Y Y M M D D): 97 98 99 100 101 102 0 2 0 7 2 8

224 009

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 103 104 A F

28. MTF OF INITIAL ADMISSION: 105 106 107 108 109 110 (b)(3)-1

29. DATE INITIAL ADMISSION (Y Y M M D D): 111 112 113 114 115 116 0 2 0 7 2 8

15

FOR LOCAL USE

MULTIPLE GSW BC Trauma Inj
9
~~450~~ 549
XS CHEST 04.8629
FEMUR 82110 PR: 3479
7935 Procedure I guessed at type of repair.

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING OFFICER (b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 79

INPATIENT ... MENT RECORD COVER SHEET *(For Pr... imprinting)*

For use of this form, see AR 40-400; the proponent agency is the Office of The Surgeon General.

PATIENT DATA ITEMS 1 - 30 *(Excluding Items 25 & 26)*

Afghan Male Detainee

(b)(6)-4

Muslim

30Y

LINE	LEGEND
1	REGISTER NO. - NAME - GRADE
2	SEX - AGE - RACE - RELIGION - LENGTH OF SVC - ETS - PREVIOUS ADMISSION
3	FMP - SSN - ORGANIZATION - WARD
4	FLY STAT - RATING/DESG - DEPT/BEN - BRANCH/CORPS - UIC/ZIP - TYPE CASE
5	SOURCE & AUTHORITY FOR ADMISSION - HOUR OF ADMISSION - CLINIC SVC
6	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
7	ADDRESS OF EMERGENCY ADDRESSEE - PHONE NO. - DATE OF THIS ADMISSION
8	NAME & LOCATION OF MEDICAL TREATMENT FACILITY DATE OF INITIAL ADMISSION

ADMISSION REMARKS

ADMITTING OFFICER

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

25. TYPE DISPOSITION: Home ~~DS~~

26. DATE OF DISPOSITION: 20AUG02

31. SELECTED ADMINISTRATIVE DATA

☐ CHECK IF CONTINUED ON REVERSE

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Mult. GSW (R) LE

Debridement Wound Passageway 8-12 8/13 8/14 8/15

1 Aug 02 ~ AKA
3 Aug. Debridement/Revision Stump
8 Aug 02 - Debridement stump (R) Thigh
11 Aug 02 - Debridement (R) Thigh

S/P (R) AKA

☐ CHECK IF CONTINUED ON REVERSE

35. TOTAL DAYS THIS FACILITY

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
				20	

36. TOTAL DAYS ALL FACILITIES

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
				20	

(b)(6)-2

(b)(6)-2

DA FORM 3647-1, 1 MAY 1979 EDITION OF

USAPA V1.00

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
19 Aug 02 0930	Gen Surg S- Less Clo Pain Does well c̄ Haldol O- Less abd Wound clean No new Pus Pockets A -> Wound Improved P- ↓ Pain meds Give Haldol regularly Fr Transfer 20 Aug if Wound Looks good (b)(6)-2
19 AUG 02	Pt afebile, some pain complaints but minimal, resting comfortably, Wound clean dressing changes made that day to IDF tomorrow (b)(6)-2
20 Aug 02 0930	Gen Surg Wound CLEAN No Pus No Fever Transfer to Delaware Center today (b)(6)-2 LTCMC

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16Aug02	GenSurg
0940	Dressing changed under Ketamine Sedation
	& Complications No New Evidence of
	Infection Dressing Remain wet Discharge
	Ketamine 50mgm IV
	Versed 2.5mgm IV
	If unable to Control Urine Will Reinsert
	Foley
	(b)(6)-2 LTCMC
16AUG02	Pt. dressing change well. T 99.2
	Aut BOR Drsp clear BP 132/84 Cont present Tx.
	(b)(6)-2 LTCMC
17 Aug02	GenSurg
0925	Dressing changed Wound Becoming
	more purulent & Pockets of Pus
	Will start BID Dressing change Wet
	To Dry
	(b)(6)-2 LTCMC
18 Aug02	GenSurg
0935	Wound Looks much better 2 Areas
	Remain & ↑ Drainage. Will continue
	BID Dressing changes
	(b)(6)-2 LTCMC

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

(b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

PROGRESS NOTES

DATE	NOTES
10 AUG02	Pt with 3 u PRBC with 24°, tag ↓ but stump seeping ↑ ortho. Hct serv tech, drags are clear, but stump revision ventilator; may need further surgery. (b)(6)-2
11 AUG02	Pt for stump revision & debridement. Low grade temp 100 cont present day. Bands rising. Hct RBC drg clear (b)(6)-2
12 AUG02	[illegible] old female c/o old remarks [illegible] Hct 11.0 Hct 36.1 4.3 < 134/101 Hct RBC drags clear for further surgery - stump revision (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

(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

14 AUG 02 Pt. tol surgery well. Ant RSR drys clear
urinating QS. No ↑ pain presently. Wound culture
enterobact choice & mixed skin flora; G-stain neg.
Cont. present Rx.

(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
6AUG02	Pt became SOB, dyspnea last PM - started on O2 while this AM 101.9 T max 104. CBC impaired, 6,000 Hct 26.6 RBC 2.92 Chest X-ray this AM small (B) pleural effusions no active disease. Heart sounds Lungs Babinski neg. Per CT old. this AM: Cont. to monitor CBC & O2
7AUG02	Pt c̄ sl. temp this AM - 99. less pain Bowels moving well. pulse ox 91% RA. Ant TRR drugs ex. do make replace PRN. CT → no abscess But ↑ inflammation.
10Aug02 1225	Gen Sy S - Clo Bmin stump - unchanged since Admission O - VSS afeb w/o stable Dressing STABLE A → B/P stabalized Hct Improved lytes Neoo Cardiac P → IV N/S Recheck LABS in AM OQ in AM

(b)(6)-2

(b)(6)-2

(b)(6)-2

LTCol

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	NUMBER

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)*

Pt # (b)(6)-4

Bed # 8

REGISTER NO.

WARD NO. ICU

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

3 Aug 02 cont'd

Ext: (R) stump – dsg. soaked.

Plan:
– OR today

(b)(6)-2

4 Aug 02 8PM

S/ Restless. Constantly requesting "injection". Trial of MSO4, Fentanyl, Valium and finally Haldol @ 0730 – Successful

O/ Tm 38.3 HR 102 BP 150/80 93% on 3L
Gen: currently asleep in NAD
No other Δ's

Labs: Hb 6.7 prior to transfusion.

Plan:
– re ✓ H/H

(b)(6)-2

SMAgnew

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

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

REGISTER NO.	WARD NO.

(b)(6)-4

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
	Trauma H&P
1 August	Young Afghan ♂ s/p multiple GSW (R) LE shot during from scene of bombing. Presents hypotensive unable to move (R) LE
	PMH: ∅ PSH: ∅ Meds: ∅
	Allergies: NKDA
	PE WD Afghan ♂ Diaphoretic
	BP 70/palp HR 130 RR 20
	HEENT: NCAT, PERRL, EOMI
	Neck: supple, NT
	Lungs: CTA
	Cardiac: tachycardic
	Abdomen: soft, tender, (+) BS
	Pelvis: stable
	Extremities: tense hematoma (R) inguinal
∅ pulse RLE	ligament to (R) knee, multiple thigh wounds, (R) buttock entry wound. Large wound (R) midfoot c̄ active bleeding
	Neuro: ↓ movement & sensation (R) LE
	Impression: Vascular injury RLE / open midfoot
	Plan: Urgent exploration

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)*

PATIENT #6

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

1 August 02

Op Note

Pre-Op Dx: GSW (R) LE (multiple)

Post-Op Dx: GSW (R) LE (multiple)

Transected (R) SFA

Transected (R) SFV

Open (R) midfoot

Procedure: Exp Celiotomy (Vascular Control)

Exploration of (R) LE vascular tree

Reversed SVG interposition (R) SFA

Ligation (R) SFV

Thrombectomy (R) SFA

~~I & D (R) foot~~

Surgeons: (b)(6)-2 (b)(6)-2

Anesthesia: (b)(6)-2

EBL: 6 l

IVF: 8 whole RBC, 1 PRBC, 10 l IVF, 1 l hetastarch

OR → BAGRAM Critical

*** Important (R) thigh packed for hemostasis due to coagulopathic hemorrhage. Packs will need to be removed when coagulopathy corrected (b)(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
01 Aug 02	ABG: pH 7.36 / PCO2 33.5 / PO2 208 / HCO3 19 / Sat 100%
2220	will ↓ FIO2 to 40% & ↑ rate to 12
	(b)(6)-2 (b)(6)-2
2 Aug 02 0515	S/ PHR p Vent. failure. No other problems.
	O/ VSS
	Vent: SIMV 10 VT 800 FiO2 40%
	Gen: sedated
	Cor: tachy
	Lg: ⊖ wheeze
	Abd: (+) BS
	Ext: S/P (R) AKA
	Labs: K 5-3 Hb
	A/P
	(1) S/P (R) AKA - monitor H/H
	(2) ↓K+, suppl. - resolved
	(3) Vent. support - wean (b)(6)-2
3 Aug 02	S/ Tol. extubation. Febrile.
8AM	O/ Tm 38.6 VSS 93%
	Gen: AA in NAD →

STANDARD FORM 600 (REV. 6-97) BACK

☆ U.S. GPO:1998-432-786/75236

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
01 AUG 02	ADMIT NOTE
2114	Afganee male (appears to be in his 30's), brought to ICU from OR ~~p~~ (R) AKA. Pt is sedated, paralysed and on ventilator. Pt had uncontrolled bleeding of (R) lower ext, which required tourniquet application and amputation. Pt received PRBC while in OR.
	137/91 P78 O_2 Sat 100% Vent Rate 10
	Gen: Sedated, NG & Foley in place
	Heart: single s1, ↓ split s2
	Lung: ⊕ rhonchi, ⊖ wheezing, ⊖ crackles
	Abd: laparotomy incision, non distended, ↓ BS
	Ext: mild clubbing, ⊖ edema
	s/p (R) AKA
	A/P ① s/p (R) AKA
	- morphine for pain
	② On vent
	- sedated ✓ paralysed
	- ✓ ABG
	③ Labs: ✓ CBC, Chem 7 (replace K^+)
	④ Small amt blood, fluid via NG - observe for now

ABG 7.39 | PO2 372 | PCO2 36.7 | 100%

PT/PTT 14.9/34.7/1.32

145, 98, 7 / 2.7 / 182

13.1 / 8.8 / 40.2 / 252

Pr 5.0, Alb 3.2, Alk 43, TBil 1.4, Amy 109, AST 31, ALT 20, GGT 15

HOSPITAL OR MEDICAL FACILITY	STATUS (b)(6)-2	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	R

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.

pt # (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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1 AUG 02	8.0 ET @ 24 cm to lip
	closed abd incis xyphoid to umbilicus stapled
	Airway patent.
	Breathing via 14 RR TV 600 BBS + = clr
138/85	
105	mult GSW RLE. s/p operative repair
15 br/m	↓ pulse R foot. Post R thigh wound. pad applied
CO_2 29	1 u PRBC O- up (1425z) complete
100%	3 (R) thigh total GSW
	(R) sacrificing lower leg
	(R) foot wound packed
	L. medial thigh sharp incision stapled
77/25	~~1 u PRBC up Pres~~ (b)(6)-2
	#2 u PRBC up w/o
	Central line (R) clavicle to LR wide open
	CXR done
	10 mg (b)(6)-2 ~~decreased~~ VEC (1426 z)
	1905hr-14/77 · 115 (P) · 15 (R) · O_2 100% CO_2-34
	40 mEq/g K-IV (pending) hanging (b)(6)-2

RELATIONSHIP TO SPONSOR	(b)(6)-4	SPONSOR'S NAME		SPONSOR'S ISSUE OR SERIAL NO.
	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
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.4

01 AUG

(b)(6)-4

© 2000 T-System, Inc. Circle or check affirmatives, backslash (\) negatives.

18

Prototype

EMERGENCY PHYSICIAN RECORD
Multiple Trauma (5)

TIME SEEN:_____ ROOM:_____ __ EMS arrival

HISTORIAN: __patient __spouse __paramedics

__HX / X EXAM LIMITED BY: Intubation

HPI **chief complaint:** Injury to: (R) L E

occurred:
__just PTA
X today
__yesterday
days PTA

where:
__home __school
__neighbor's __city park
__work __street

context: Afghan male s/p exp. lap. spp grafting (R) femoral artery c̄ reverse (L) saphenous vein. Pt required above procedure 2ry GSW/shrapnel

location of pain/injuries:
head face mouth
neck chest abdomen
back upper mid- lower
radiating to R / L thigh / leg

–right–		–left–	
shldr	hip	shldr	hip
arm	thigh	arm	thigh
elbow	knee	elbow	knee
f-arm	leg	f-arm	leg
wrist	ankle	wrist	ankle
hand	foot	hand	foot

severity of pain:
mild
moderate
severe

associated symptoms:
__lost consciousness / dazed
duration:
remembers:
impact coming to hospital
__seizure

ROS ☐ all systems neg except as marked
__loss feeling/power arms/legs
__headache
__double vision/hearing loss
__trouble breathing/ chest pain
__nausea/vomiting
__loss of bladder function
__skin laceration
__recent fever/illness

Unable to obtain

SOCIAL HISTORY __recent ETOH __smoker __drug abuse
UNK.

PAST HISTORY __negative

UNK

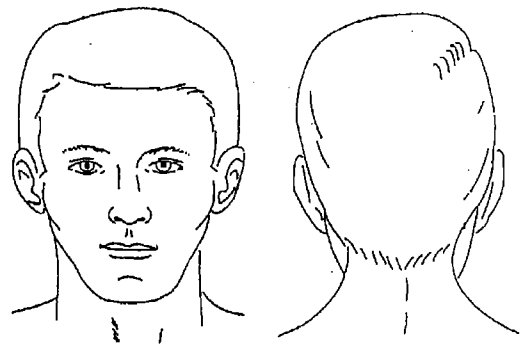
Meds- __none / __see nurses note UNK
Allergies- __NKDA / __see nurses note UNK

☐ Nurses note reviewed ☐ Tetanus immun. UTD ☐ Vital signs reviewed

PHYSICAL EXAM __Alert __Lethargic __Anxious Intubated
Distress- __NAD __mild __moderate __severe
Other- __c-collar (PTA / in ED) __back-board __IV __splint

HEAD
✓ no evidence of trauma
__see diagram
__Battle's sign / Raccoon Eyes

NECK
__non-tender
__painless ROM
✓ trachea midline
__see diagram
__vertebral point-tenderness
__muscle spasm / decreased ROM
__pain on movement of neck



EYES
__PERRL
__EOMI
__unequal pupils R-____mm L-____mm
__EOM entrapment / palsy
__subconjunctival hemorrhage
Pinpoint pupils

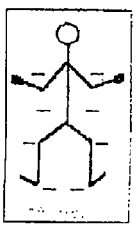
ENT
✓ nml external inspection
✓ no dental injury
__hemotympanum
__TM obscured by wax
__clotted nasal blood
__dental injury / malocclusion

RESP & CVS
__chest non-tender
✓ breath sounds nml
__heart sounds nml
__see diagram (on reverse)
__decreased breath sounds
__wheezing / rales
__splinting / paradoxical movements
↑ HR

ABDOMEN
__non-tender
__no organomegaly
__see diagram (on reverse)
__tenderness / guarding / rebound
__mass / organomegaly
midline scar s/p exp. lap.

GENITAL / RECTAL
__nml genital exam
__nml vaginal exam
__nml rectal exam
__heme negative stool
__perineal hematoma
__blood at urethral meatus
__decreased rectal tone
(R) groin hematoma.

NEURO / PSYCH
__oriented x3
__mood & affect
__CN'S nml as tested
__sensation & motor nml
__confusion / disorientation
__EOM palsy / anisocoria
__facial asymmetry
__unsteady / ataxic gait
__sensory / motor deficit



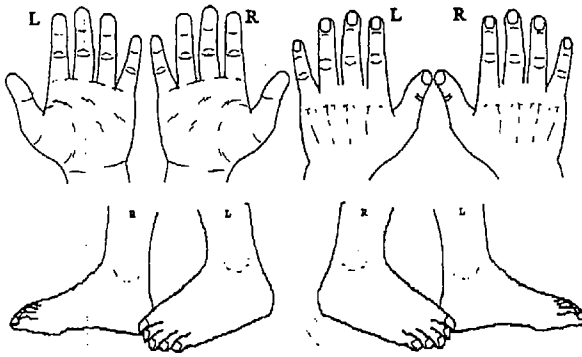
Intubated - moved UE spontaneously

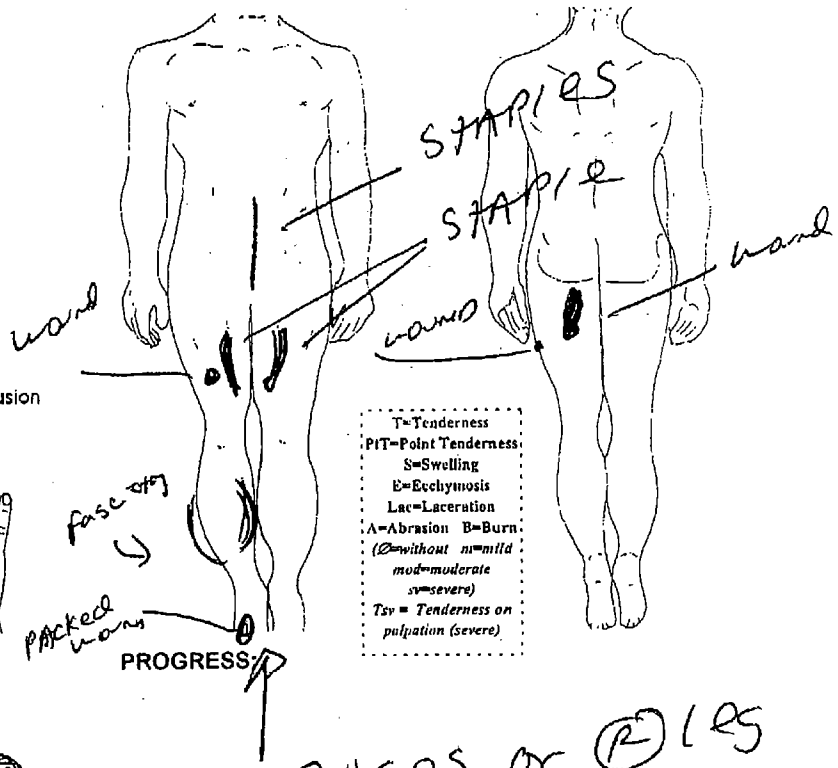
SKIN
__intact
__warm, dry
__see diagram
__crepitus / diaphoresis

BACK
__no CVA tenderness
__no vertebral tenderness
__see diagram
__vertebral point-tenderness
__CVA tenderness
__muscle spasm / limited ROM
(—) wounds

EXTREMITIES
__atraumatic
__pelvis stable
__hips non-tender
__no pedal edema
__nml ROM
__see diagram
__bony point-tenderness
__painful / unable to bear weight
__pulse deficit

Joint Exam:
__limited ROM / ligaments laxity / joint effusion





NO PULSES on (R) LEG
Collaterals (R) leg
Cold leg.

XRAYS ☐Interp. by me ☐Reviewed by me ☐Discsd w/radiologist

C-Spine D-Spine LS-Spine
__nml / NAD
__no fracture
__nml alignment
__soft tissues nml
__reversal / straightening of cerv. lordosis
__DJD / spondylosis / spurring

CXR
__nml / NAD
__no infiltrates
__nml heart size
__nml mediastinum
__rib fracture
__infiltrate / atelectasis

ET tube in good position (-) Ptx.

OTHER ☐See separate report

__Discussed with Dr.
will see patient in: office / ED / hospital
__Counseled patient / family regarding:
lab results diagnosis need for follow-up
__Rx given __Admit orders written
__CRIT CARE- *30-74 min* *75-104 min* _____ *min*
__Prior records ordered
__Additional history from:
family caretaker paramedics

CLINICAL IMPRESSION:

contusion

head		wrist	R / L
face		hand	R / L
chest		hip	R / L
abdomen		thigh	R / L
back		knee	R / L
shoulder	R / L	leg	R / L
arm	R / L	ankle	R / L
elbow	R / L	foot	R / L
forearm	R / L		

sprain / strain
neck dorsal lumbar

concussion
with LOC w/o LOC

laceration

- multiple GSW/shrapnel wounds
- S/P ex lap laparotomy
- S/P repair Femoral Artery lac via Graft
- Coagulopathy

Wound Description/Repair
length_____**cm** **location**_____
__superficial __SQ __muscle __linear __^stellate __^irregular
__clean __contaminated *moderately / *heavily*
distal NVT: __neuro & vascular status intact __no tendon injury
anesthesia: __local __digital block _____cc
__lidoc 1% 2% epi / bicarb __marcaine .25% .5% __LET
prep:
__Shur-Clens / Betadine / Hibiclens
__irrigated /washed w/saline **extensively*
__explored
__^debrided / undermined **extensively*
__foreign material removed *minimal moderate ^extensive*
repair: *Wound closed with: wound adhesive / steri-strips*
SKIN- #_____ _____-0 nylon / prolene / staples
*SUBCU- #_____ _____-0 vicryl / chromic
*may indicate intermediate repair ^may indicate intermediate or complex repair

DISPOSITION- ☐ home ☐ admitted ☐ transferred
CONDITION- ☐ unchanged ☐ improved ☐ stable

TO OR

PHYSICIAN SIGNATURE- (b)(6)-2
(b)(6)-2

2.7

510-112 NSN 7540-00-634-412

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4Aug02		1645	Pt transferred from ICU I via litter. USS- Pox 85% on RA - O2 on @ 2L Pox 93% - c/o pain "all over" & medicated as ordered - F/c patent & draining clear yellow urine - Foley @ bedside - Pt shackled to bed c (L) wrist + (L) ankle attached to bedframe — (b)(6)-2 [redacted] RN
4AUG02		2030	Pt is bed resting A&x3 speaks (broken english - understands) commands. temp 102.4 fluids encouraged, tylenol 650mg administered. Foley draining clear yellow urine to gravity. Pt complains of generalized body pain. "Very pain fine" will administer Fentanyl as prescribed — (b)(6)-2 [redacted] RN
4AUG02		2230	(b)(6)-2 Pt. asleep no further S/S of discomfort Foley draining to gravity. IV infusing LR @ 125 ~~5~~ difficulty. antibiotic IV tolerated. Npo ~~p~~ MN for OR Sx. Sound @ bedside. (L) arm + (L) ankle shackled to bed (b)(6)-2 [redacted] RN
5Aug02		0240	Fentanyl given c/o "fine pain" will continue to monitor. (b)(6)-2 [redacted] RN
5Aug02	0700		Urine output 1900 for the Night evening shift (12hrs) clear amber urine. IV site intact No S/S of difficulty (b)(6)-2 [redacted] RN

(Continue on reverse side)

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

REGISTER NO.

WARD NO. ICU

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

Bed # 8

NURSING NOTES

Medical Record

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

MEDCOM - 3162

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8/5/02	0800		A+O x 3; min english use; foley intact and draining clear yellow urine; central line of (R) clavicle D&I and infusing LR @200 @ HR; DSD on (R) AKA intact ~ S/S hemorrhage. (b)(6)-2 CPT, AN, USA
5 Aug 02			
5 Aug 02		2050	C/O "S.O.B." Slight wheezing on Expiration. TEMP. 103.8 - 98-20. DR. NOTIFIED C/O INCISIONAL PAIN". UNABLE TO DETERMINE PAIN level. IV SITE @ (L) FOREARM INFILTRATED & D/C'd. X-RAY (CS) DONE AS ORDERED. RESPIRATION 20 NON labored. Will Medicate AS ordered. (b)(6)-2 SMC
8/6/02	0800		A+O x 3; lethargic; min. english use; DSD intact on (R) AKA; foley intact draining clear yellow urine; (R) clavicle central line intact c̄ bifocals; constant c/o pain; SPO2 95% on O2 2L/M; MPin attendance; Pt shackled to bed ~ S/S trauma to shackled foot. (b)(6)-2 CPT, AN
8/6/02	1210		Pt medicated with 50mg Demerol for pain. (b)(6)-2 RN
6 Aug 02		2235	A+O. minimal English use. C/O pain. T°↑ 102 Tylenol given. SPO2 90/RA. Central line intact for IVPB. Remains shackled to bed (R) wrist + (L) ankle. Foley intact draining lg and yellow urine. Both given (b)(6)-2 ST

*U.S. Government Printing Office: 1995 - 404-763/20085

510-112

NSN 7540-00-634-412

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
7 Aug 02	0830		Pt resting in bed. R-26 T99.6-82-136/80 c/o pain. Central line flushed & NSS. Demerol admin per physician order. Appetite poor. Fluids encouraged pt drank 1 box apple juice. Foley draining clear amber urine. AM personal hygiene care given. Turned & Repositioned. (b)(6)-2
7 Aug 02	0940		pt asleep on reassess. No discomfort noted. (b)(6)-2 RN
7 Aug 02	1030		on interview with assist from interpreter pt stated he is nauseu, refuses to eat requests IV medication. Communication shared c physician. Phenergan 12.5 administered (b)(6)-2 RN
7 Aug 02	1200		pt able to eat two apples tolerated w/o N/V.
7 Aug 02	1430		Pt c/o pain. medicated with demerol 25mg (b)(6)-2 RN
7 Aug 02	1725		Reassess pain pt stated "able to rest". will continue to monitor. (b)(6)-2 RN
8 Aug 02	0900		Pt AOx3 ambulating needs. Appetite fair ate 4/8 of meal. ~~Voids~~ Foley to gravity clear amber urine. BMx1 Soft brown stool. AM care given. T↑ 101 (Continue on reverse side) PRN admin. (b)(6)-2

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

REGISTER NO.

WARD NO.

(b)(6)-4

Amputee

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.20

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8 Aug 02	1000		T 100.6 pt resting in bed NPO for OR. (b)(6)-2
8 Aug 02	1300		Valadol held NPO for OR (b)(6)-2
8 Aug 02	1530	—	pt returned from OR via litter. 2L O2 via NC 96%. P 130 BP 124/85-94-28. Will continue to monitor. Demerol 25mg IV given for pain. LR @ 200cc/° to central line infusing S difficulty. (b)(6)-2
8 Aug 02	1545		118/86 - 136 - 94% - 24
8 Aug 02	1630	—	129/85 - 124 - 94% - 26 : c/o pain Valadol PRN given Pulse ox 99% 2L NC O2. Will continue to monitor & [illegible]
8 Aug 02	1700		Urine output 100cc clear yellow urine fluids encouraged PO (b)(6)-2
8 Aug 02	1730		PT drinks water, refuses to eat dinner. c/o of pain 125/81 - 121 - 26 - 98%. (b)(6)-2
8 Aug 02	1800		VS 122/80 - 121 - 24 - 98% PT resting in bed c O2 applied via NC. Pulse ox 98%. Foley patent draining clear yellow urine 120cc this hour. (b)(6)-2
8 Aug 02	1900	—	Pt c/o pain - demerol 25mg admin. Side rails reinforced. (b)(6)-2
8 Aug 02		2115	A&Ox3 Urine Output maintained (foley) documented. IV Subclavian LR infusing @ 200cc/° [illegible] Antibiotics given. Complaints of thirst. Sleeping for long intervals. T 101.9° Tylenol 2 tabs given. Drowsy [illegible] Verbalized c/o pain. (b)(6)-2
9 Aug 02	0800		alert & oriented; kept NPO for surgery. [illegible] use — interpreter brought for F/S. Cont (b)(6)-2

510-112 NSN 7540-00-634-412

MEDICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
9Aug02	0800		(cont) Central line (R) subclavian intact s/s infection; resp unlabored on RA; foley intact and draining clear amber urine QS; constant c/o wanting something to sleep and wanting something to eat or drink despite I/S by interpreter; DSD intact on (R) AKA; DV LR @ 200 cc/hr via central line. [redacted] CPT, AN USAR
9Aug02	1730		Pt received from OR. S ANC on floor; Ø PRBC available on ward; report given to 9W S full comprehension; staff nurse not notified; pt BP ↓ 80/4; ii units PRBC brought up and given by MAJOR [redacted]; ICU nurse, Dr [redacted] staff assessed / Tx pt; returned to USS and S s/s distress; LR @ 150 cc/hr infusing via flowmeter; Ø resp. distress. Foley intact and draining clear yellow urine; DSD intact on (R) AKA. [redacted] CPT, AN
9Aug02		2210	AOX3 VS remain t. Subclavian intact. Hydrous LR @ 150 cc/hr. Antibiotic IVPB's given. Monitored VS. O2 via NRB. Medicated for pain by Maj [redacted] continues to c/o pain. Foley intact. [redacted] 9W3114

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.20

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10 Aug 02	0800		Pt alert in bed; nfm attendance; minimal English use; (R) SC central line intact and LR infusing @ 200cc/HR; H&H <28% @ 27 and 1 unit PRBC #462601 infused per protocol s reaction starting @ 0815; foley draining clear yellow urine but appears to be leaking around urethra; Pt c/o constant pain and requesting pain med every hour; BSA intact on (R) AKA; O2 rebreather @ 2L; ~~Medic~~ [redacted] CPT, TN, USAR
10 Aug 02	0945		Blood completely infused s incident [redacted] CPT, TN
10 Aug 02	1500		Pt assessed → 99.7 (F) Temp; c/o Pain @ (R) stump; (P) rate 120; Diaphoretic; Pt given Tylenol & Demerol PRN, will monitor for effectiveness. [redacted] / [redacted] 1LT BSN/USA
10 AUG 02		2230	145/67-20-116-100°. IV infusing to central line. Anxiety therapy cont. urine output clear yellow 400cc draining to gravity via foley. Skin dry (R) amputated stump resting on chucks pads to cover drainage. Tylenol admin ↑ temp. PO fluids encouraged. [redacted] RN
10 AUG 02		0040	Clear yellow urine 200cc draining to gravity via foley cath. Demerol given for pain. Turned & repositioned. IV NSS infusing ∅ difficulties noted. [redacted] RN

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

510 (REV. 7-91) BAC

510-112 NSN 7540-00-634-412

MEDICAL RECORD — NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11 AUG 02	0800		Pt resting in bed. NPO status OR this AM urine output per Night 1500 clear yellow urine. (R) stump draining. Placed on pads. Antibiotic therapy cont. NSS @ 200cc infusing to central line. VS. 174/91 - 124 - 24. — (b)(6)-2 RN
11 AUG 02		2030	Pt assessed. Vs obtained as needed. O2 2L via nasal 98% - 101-126-24 146/86 Skin warm dry. NSS infusing @ 200cc to central line. Foley draining clear yellow urine. Tylenol admin per temp. (R) stump drain pads placed general pt to absorb moisture. PO fluids encouraged. — (b)(6)-2 RN

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

Bed #8

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.2(

510-112

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
12 Aug 02		1700	RETURNED FROM O.R. DRSG DRY & INTACT. RESP. 22 REGULAR, PULSE 98 @ RA. VOIDING VIA FOLEY CATH. 400ML. PRO-PAG. APPLIED. 1VF INFUSING NSS @ 125cc/hr VIA INTERNAL JUGULAR. WILL CONT. TO OBSERVE. (b)(6)-2 mg ANC
12 AUG 02		[illegible]	PT in bed resting. VSS 124/77-135-99-96 pulse ox RA. I.J. (R) side clean intact infusing NSS @ 125cc. Foley cath draining clear yellow urine. Tylenol 500mg given for rest. Evening SHCT provided. (b)(6)-2 RN
13 Aug 02		1450	118-124/71-98.7-97% pulse ox 02 mask 2L. Returned from OR. LR infusing (R) I.J. pt c/o pain demerol given as per physician order. Dressing dry & intact. (b)(6)-2 RN
13 AUG 02		1510	Morphine 5mg administered per physician order. Drsg dry & intact. (b)(6)-2 RN
13 AUG 02			123-123/84-24-97 P ox 95% 2L mask. Bleeding Drsg dry & intact. Foley draining to gravity c/o pain. Toradol administered. (b)(6)-2 RN
13 Aug 02		2300	Pt voided <30cc ⅕ c/o; SP stable, afebrile, ⅕ distension; will continue to monitor. (b)(6)-2 CPT/AN
13 Aug 02		2400	Sh. cath for ≈100cc clear yellow urine; ⅕ distension; ⅕ c/o pain. (b)(6)-2 CPT/AN

(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 (b)(6)-2

WARD NO.

NURSING NOTES
Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14 Aug 02	0400		Voided 600 cc clear amber urine. (b)(6)-2 [redacted] PT, RN
14 Aug 02	1130		A+O x3 Speaks very little English. Vdgs IV NS Infusing @ 125cc/hr via RD. patent w/ S/S of infiltration or infection @ site. VSS. C/o (verbalized) mild cramping. Remains NPO for OR. (b)(6)-2 [redacted] 91W3MG (b)(6)-2 [redacted]
14 Aug 02		1625	Pt returned from OR. VSS 99°-102-20 13/72. Verbalized c/o pain while on litter. Transferred to bed. Svr IV intact infusing, 125cc/hr (b)(6)-2 [redacted] 91W3MG (b)(6)-2 [redacted]
14 Aug		2110	Pt resting in bed c/o "fire pain" Medad admin. VS 117-124/68-101.4-26 Pulse ox 97% on RA. Tylenol admin for temp. Po fluids encouraged. (R) stump draining. Reinforced dx applied moisture absorbing pad around stump. Amber colored urine 200cc voided into urinal - Catheter
15 AUG	0600		Tylenol given for "fire pain" as described by pt. (b)(6)-2 [redacted]
15 AUG 02	0645		Pt states injection "no good, another injection". IV Demerol 25mg given for pain of (R) stump. (b)(6)-2 [redacted]
15 Aug 02	1035		A+O x3 Speaking very little English. Requesting H2O. Remains NPO for OR. IV LR @ present rate. Thru bag resume NS @ 125cc/hr via RD. T 100° VSS. Remain c/o pain. (R) stump continues to drain lg amt. of serous serosanguinous. Vdgs urine yellow amber in color (b)(6)-2 [redacted] 91W3MG (b)(6)-2 [redacted]
15 Aug 02		1530	Pt returned from OR. Alert. IV infusing c/o extreme pain. 99-[illegible]-24 131/76 SPO2 100% (b)(6)-2 [redacted] 91W3MG (b)(6)-2 [redacted]

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

STANDARD FORM 510

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14 Aug 02		1500	46 staples removed from abd incision approximated. No S/S of infection to site. (b)(6)-2 [illegible]
8/15/02		1930	Alert in bed; minimal ambulation; use of DSD intact on (R) AKA; voided ≈ 500 cc clear yellow urine; Temp 102.2 and Tx c̄ Tylenol as per order; n/p in attendance; Haldol given as per order 2° insomnia; takes analgesic IV non-timely c̄ c/o sleeplessness. (b)(6)-2 [illegible]
16 Aug 02		2130	Pt A&O c̄ use of little English – Pt voiding clear yellow urine c̄ difficulty – Dressing intact on (R) AKA – Moderate amount of serous drainage noted on dressing & Dressing reinforced – IV patent + infusing NS @ 125 cc/hr – Taking in po fluids – c/o (R) AKA pain + Medicated c̄ Demerol also c/o nausea + medicated c̄ Phenergan – Pt agitated + c̄ effects of Demerol noted hour then medicated c̄ Haldol as ordered – (b)(6)-2 [illegible]
17 Aug 02	0630		Ø BM this shift – Medicated for pain throughout night – Eating breakfast c̄ much staff encouragement (b)(6)-2 [illegible]
18 Aug 02		0800	Responds to all stimuli. DRSG TO RLE saturation c̄ ODOR OF URINE. INCONTINENT of Lg Loose BM. VS: WNL. IVF infusing well into RIJ @ 125/hr NS. (b)(6)-2 [illegible]

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14 Aug 02		1500	46 staples removed from abd incision [illegible] No S/S of infection to site. [redacted] [illegible]
8/15/02		1930	Alert & oriented; minimal English use; DSD intact on (R) AKA; voided ≈ 500 cc clear yellow urine; Temp 102.2 and Tx c Tylenol as per order; n/p in attendance; Haldol given as per order 2° insomnia; takes analgesic IV non-timely c c/o sleeplessness. [redacted] [illegible] PT, AN, ISAR
16 Aug 02		2130	Pt A+O c use of little English - Pt voiding clear yellow urine c difficulty - Dressing intact on (R) AKA - Moderate amount of serous drainage noted on dressing. Dressing reinforced - IV patent + infusing NS @ 125 cc/hr - Taking in po fluids - c/o (R) AKA pain + medicated c Demerol also c/o nausea + medicated c Phenergan - Pt agitated + c effects of Demerol noted hours after medicated c Haldol as ordered - [redacted] Sgt. [illegible]
17 Aug 02	0630		Ø BM this shift - Medicated for pain throughout night - Eating breakfast c much staff encouragement [redacted] Sgt. [illegible]
18 Aug 02		0800	Responds to all stimuli. DRSG. TO RLE saturation c ODOR OF URINE. INCONTINENT of lg loose BM. VS: WNL. IVF infusing well into RIJ @ 125/hr NS.

*U.S. Government Printing Office: 1995 - 404-783/20065

[redacted] [redacted] (REV. 7-91) BACK

[redacted]

MEDCOM - 3172

510-112

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
16 Aug 02	0730		Responds To All Stimuli. Follow Simple Command. NPO MAINTAINED. Voiding Via Urinal @ S. Pulsox. 99% R/A. IVF Infusing Well LR into RIJ @ 125cc/hr. NO Over Complications @ This Time, (b)(6)-2 [redacted] [illegible]
16 Aug 02		1830	Pt Alert responsive. IV NSS 125cc infusing RIJ. Refused dinner. Drank Ensure. Voiding clear yellow urine in bottle. Turned and repositioned ——— (b)(6)-2 [redacted] RN

(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.

NURSING NOTES

Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
19 Aug 02	0745		Alert while eating breakfast but hard to arose for VS. VSS. IV SL infusing @ 125cc/hr right AD. Voids urine urinal. Verbalizes no pain — (b)(6)-2 [redacted]
8/19/02	2000		Pt resting on bed; gestures to avoid central line to be removed; relates sits out of way and gestures to pt not to remove or dislodge line in any manner; shakes head to indicate agreement/understanding; (R) AKA site moist c̄ dressings and intact; Some english use as he desires; voiding QS clear yellow urine QS; VSS; NP in attendance. (b)(6)-2 [redacted] CPTAN
8/20/02	0800		98.1 - 74 - 118/82 - 18 Pt Alert oriented, resting in bed. Does not speak english. Communicates through gestures & signs. Follows simple commands with guidance. PO intake 75% tolerated ∅ N/V/D. Voids dark yellow urine in bottle. Assist of 1 turned & repositioned (R) AKA moist dressing applied. (b)(6)-2 [redacted]

MEDICAL RECORD - NURSING DISCHARGE SUMMARY

For use of this form, see AR 40-407; the proponent agency is OTSG

1. Date/Time: 20 Aug. 2002

2. Discharge to: ☐ Home Other (specify) DETAINEE CENTER

3. Mode: ☐ Ambulatory Other (specify)

4. Accompanied by:

5. Activity: ☐ Limitations (specify) Bed Rest

_____ Patient and/or Significant Other (S.O.) communicates knowledge and understanding of activity limitations.

6. Diet: ☑ No Dietary Restrictions If special, identify Regular

_____ Patient/S.O. communicates understanding of dietary restrictions.

7. Medications: ☐ No Medication Required

Name of Medication	Dosage	Frequency of Medication	Special Instructions
- Hal Dol 2mg, PO Daily			
- MOTRIN 800mg, PO 3x Daily			
- DAKIN'S SOLUTION FOR DRSG Change Daily			

_____ Patient and/or S.O. communicates knowledge and understanding of name, dosage, frequency and special instructions.

8. Treatments/Care:

Instructions Given:	Patient/ S.O. observed Demonstrations (Date)	Patient/S.O. Returned Demonstration (Date)
NONE		

Equipment/Supplies (Specify)

9. Follow-up: You should be seen in _____ clinic in _____ (time period).

None

_____ Patient/S.O. communicates understanding of follow-up instructions.

10. Patient's Condition (Health Status relative to Nursing Care Plan):

improved

11. Signature (Registered (b)(6)-2 (b)(6)-2 May ANC

12. Additional Information:

13. Patient Identification: # (b)(6)-4

COPY 1 - INPATIENT RECORD COPY

DA FORM 3888-3, JUN 91 REPLACES DA FORM 3888-5 (TEST), AUG 85 WHICH IS OBSOLETE

MEDCOM - 3175

(b)(3)-1

BAGRAM AFGHANISTAN DISCHARGE SUMMARY

Date:
Name:
Grade:

Summary Of Injuries:

1
2
3
4
5

Operating Procedures:

Date:

	Findings:	Treatment
1AUG	1 uncontrol Bldg (B) thigh GSW	1 AKA (B) leg
3AUG	2 dead muscle (B) femur	2 debride up to G. trochanter
5"	3 debrid - wound closure	3
	4	4
	5	5
	6	6
	7	7
	8	8
	9	9

Discharge Meds:

Other Diagnosis & Condition(s):

Recommendations:

Signature/Title

(b)(3)-1 BAGRAM AFGHANISTAN DISCHARGE SUMMARY

Date:20 August, 2002
Name: #(b)(6)-4
Grade:
Unit:

Summary Of Injuries:

1. MULTGIPLE GUNSHOT WOUND TO RLE
2. S/P RIGHT AKA
3.
4.
5.

Operating Procedures: WOUND DEBRIDEMENT (9 aug, 11 aug, 13 aug),
REVISION OF STUMP (1 aug 3 aug 5 aug , 8 aug) &
DRESSING CHANGES(14 aug, 15 aug, 16 aug)

Date:

Findings:		Treatment
1	UNCONTROLLED BLEEDING	
2	RIGHT THIGH, SECONDARY TO GSW	1. AKA RLE
	NECROTIC MUSCLE RIGHT THIGH	2.
4		4
5		5
6		6
7		7

Discharge Meds:
HALDOL 2MG, PO, DAILY
DAKIN'S SOLUTION FOR DAILY DRSG CHANGE
BOTRIM 800MG,PO 3 TIMES DAILY

Other diagnosis & Condition(s): NONE

RECOMMENDATIONS: DAILY DRSG CHANGES WSITH DAKIN'S SOLUTION

Signature/Name (b)(6)-2 LTC, MC
(b)(6)-2

MEDICAL RECORD | **INTRAOPERAT. DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA witter BY witter

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY

3. DATE 15 Aug 02 TIME PATIENT ARRIVED IN SUITE 1500

4. PATIENT IN ROOM TIME 1500 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 91D	RELIEF SCRUB	a
ASSIGNED CIRCULATOR	(b)(6)-2 RN	RELIEF CIRCULATOR	a

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: armboards

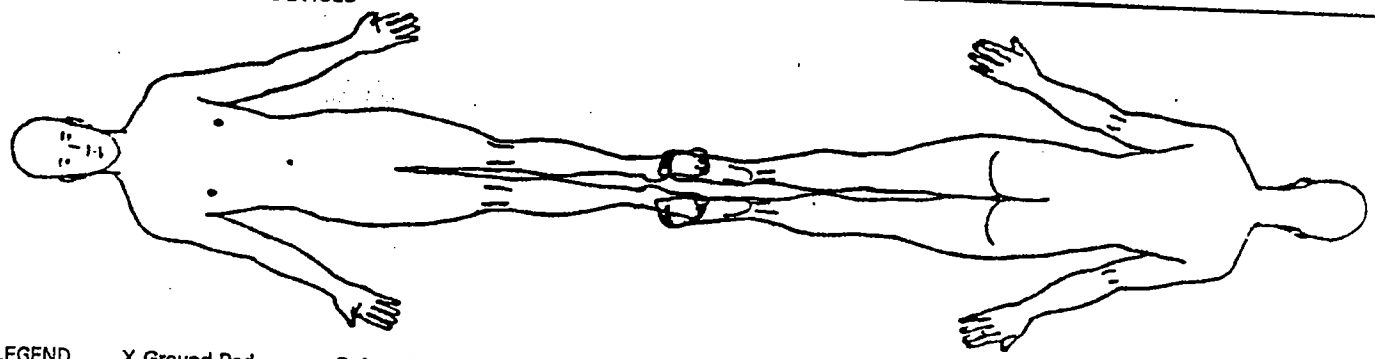
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* a
SITE: BY WHOM:
SITE: BY WHOM:
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No					
Needle Sharp	☐ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

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

(b)(6)-4

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

☐ ESU NO: a
GROUND PAD: BRAND
LOT NO:

☐ ESU NO: a
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ YE ☑ NO IF YES NAME: ID NUMBE ANUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

WOUND IRRIGATION ☐ YES ☑ NO, TYPE(S):

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE (b)(6)-2 LTC MC

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

TYPE/SIZE	1. N/A	2.	3.
SITE	1. N/A	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Gauze/Kerlix

19. ADDITIONAL INFORMATION
N/A

20. OPERATION(S) PERFORMED
Debridement Wound

21. PATIENT TRANSFERRED TO ICW TIME 1525 METHOD WITHER

22. REGISTERED NURSE SIGNATURE (b)(6)-2 RN BSN 1LT

REVERSE OF DA FORM 5179-1, OCT 8. MEDCOM - 3179 USAPA V1.00

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY (b)(6)-2

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

3. DATE 14 Aug 02 TIME PATIENT ARRIVED IN SUITE 1525

4. PATIENT IN ROOM TIME 1525 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 AID	RELIEF SCRUB	u
ASSIGNED CIRCULATOR	(b)(6)-2 RN	RELIEF CIRCULATOR	G

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: armboards

8. SKIN PREPARATION

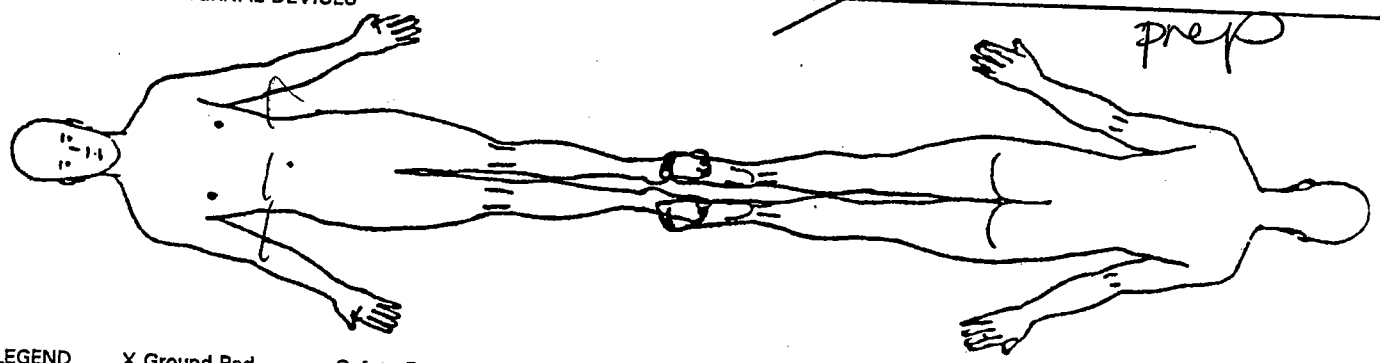
HAIR REMOVAL DONE BY: ☐ YES ☒ NO ☐ OR ☒ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine (b)(6)-2
SITE: R Stump BY WHOM: (b)(6)-2
SITE: BY WHOM:

COMMENTS: No adverse reaction to prep

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap ≈ = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☒ No					
Needle Sharp	☐ Yes	☒ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

(b)(6)-4

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

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____

☐ BIPOLAR NO: _____

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

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

(b)(6)-2

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Staps/Kerlix

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

Dsg Δ

21. PATIENT TRANSFERRED TO | TIME | METHOD litter

22. REGISTERED NURSE SIGNATURE RNBSN ILT

(b)(6)-2

MEDICAL RECORD | **INTRAOPERAT. DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY (b)(6)-2

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

3. DATE 13 August TIME PATIENT ARRIVED IN SUITE 1335

4. PATIENT IN ROOM
TIME 1335 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2	RN	RELIEF SCRUB	
ASSIGNED CIRCULATOR	(b)(6)-2	RN	RELIEF CIRCULATOR	
	(b)(6)-2	RN		

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

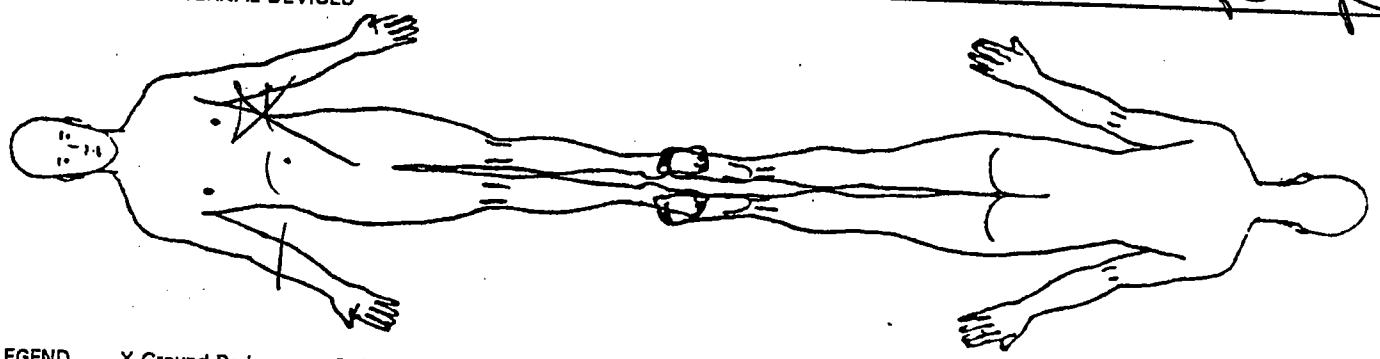
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine
SITE: R Arm BY WHOM (b)(6)-2
SITE: BY WHOM:

COMMENTS: no adverse reaction to prep

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No		C	C	(b)(6)-2	(b)(6)-2 RN
Needle Sharp	☑ Yes	☐ No		C	C		
Instrument	☐ Yes	☑ No					
Other	☐ Yes	☑ No					

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

(b)(6)-4

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

☑ ESU NO: 0101
GROUND PAD: BRAND Valley LAB
LOT NO: 58204 / 2004 02

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGN (b)(6)-2 LTC MC

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
gauze/Kerlix

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED
I+D of (R) AKA

21. PATIENT TRANSFERRED TO ICW TIME 1412 METHOD LITTER

22. REGISTERED NURSE SIGNATURE (b)(6)-2 RN BSN ILT

USAPA V1.00

REVERSE OF DA FORM 5179-1, OCT 8.

MEDCOM - 3183

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA LITTER BY (b)(6)-2

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

3. DATE 12Aug02 TIME PATIENT ARRIVED IN SUITE 1620

4. PATIENT IN ROOM TIME 1620 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 91D (b)(6)-2	RELIEF SCRUB	N
ASSIGNED CIRCULATOR	(b)(6)-2 RN (b)(6)-2 91D	RELIEF CIRCULATOR	A

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: armboards

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

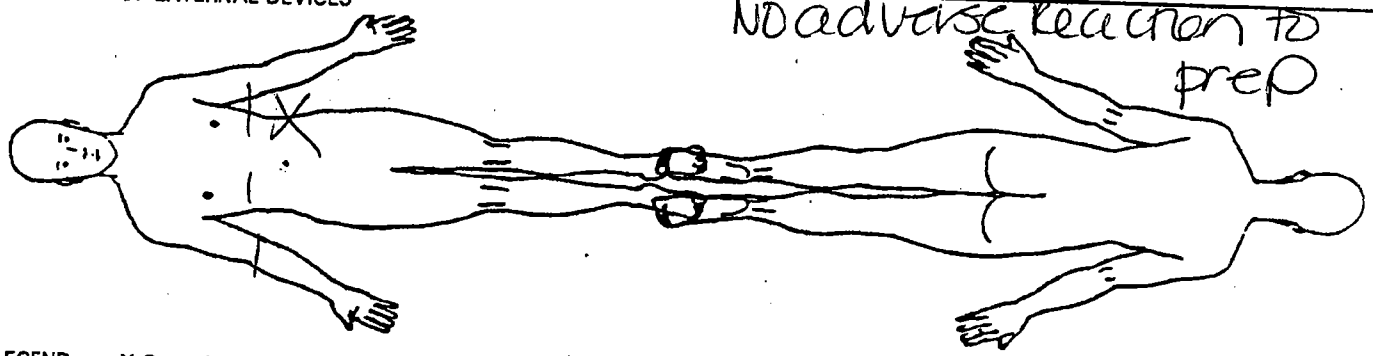
PREP SOLUTION *(Specify)* Betadine

SITE: (R) AKA BY WHOM: (b)(6)-2

SITE: BY WHOM:

COMMENTS: No pooling of solution / No adverse reaction to prep

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☒ No		C	C	(b)(6)-2 91D	(b)(6)-2 RN
Needle Sharp	☒ Yes	☒ No					
Instrument	☐ Yes	☒ No			N		
Other	☐ Yes	☒ No			A		

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

(b)(6)-4

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

☒ ESU NO: 01011

GROUND PAD: BRAND Valleylab

LOT NO: 58309 / 2004-02

☐ ESU NO:

GROUND PAD: BRAND

LOT NO.

☐ BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

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

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE (b)(6)-2 LTCMC

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1. N/A	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
gauze / laps / Kerlix / ~~peg~~ stockinette

19. ADDITIONAL INFORMATION
foley inserted prior to entering O.R.

20. OPERATION(S) PERFORMED
debridement / irrigation (R) AKA

21. PATIENT TRANSFERRED TO ICU TIME 1700 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 RNBSN ILT

REVERSE OF DA FORM 5179-1, OCT 87

MEDCOM - 3185

USAPA V1.00

MEDICAL RECORD — **INTRAOPER[illegible]OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM (b)(6)-2
VIA LITTER BY (b)(6)-2

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

3. DATE 11 Aug 02 TIME PATIENT ARRIVED IN SUITE 1107

4. PATIENT IN ROOM TIME 1107 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 RN	RELIEF SCRUB	
ASSIGNED CIRCULATOR	(b)(6)-2 RN (b)(6)-2 RN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

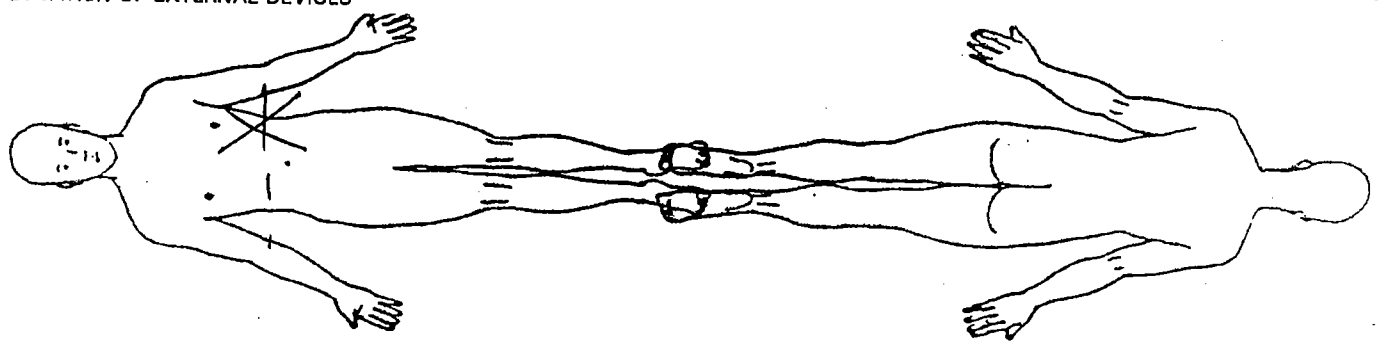
COMMENTS: armboards

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine
SITE: (R) AKA BY WHOM: (b)(6)-2
SITE: BY WHOM:
COMMENTS: No adverse Reaction to prep

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No				(b)(6)-2 RN	(b)(6)-2 RN
Needle Sharp	☐ Yes	☐ No		C	C		
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

(b)(6)-4

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

☒ ESU NO: 01011
GROUND PAD: BRAND Valleylab
LOT NO: 583091 2004/02

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE (b)(6)-2 LTCMS

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
gauze/laps/Kerlix/pkg

19. ADDITIONAL INFORMATION
foley inserted prior to entering O.R.

20. OPERATION(S) PERFORMED
debridement/drainage (R) AKA

21. PATIENT TRANSFERRED TO LAU TIME 1600 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 RN BSN ILT

USAPA V1.00

MEDICAL RECORD — **INTRAOPERA OCUMENT**

For use of this form, see AR 40-407, the propon gency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY (b)(6)-2

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

3. DATE 9aug02 TIME PATIENT ARRIVED IN SUITE 1615

4. PATIENT IN ROOM TIME 1615 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2	91D	RELIEF SCRUB	N/a
ASSIGNED CIRCULATOR	(b)(6)-2	RN	RELIEF CIRCULATOR	
	(b)(6)-2	91D		

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

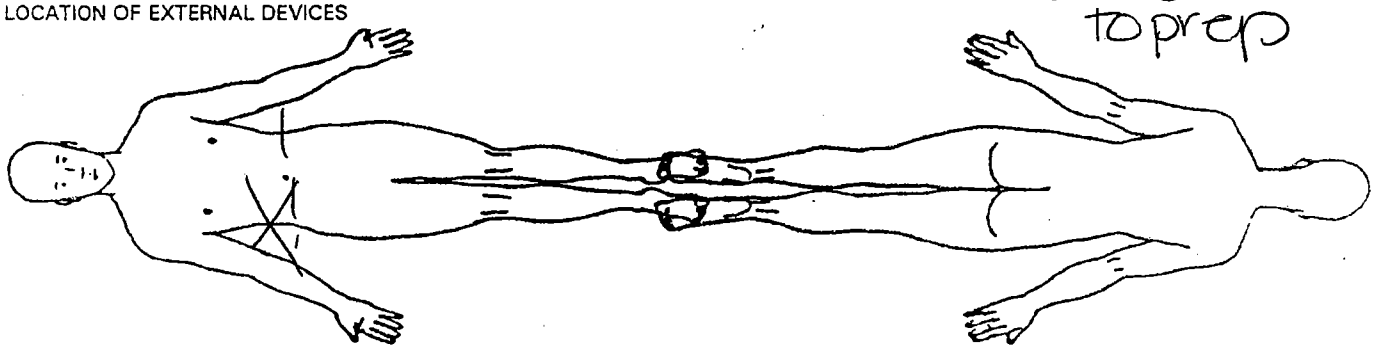
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* Betadine
SITE: (R) AKA BY WHOM: (b)(6)-2
SITE: BY WHOM:
COMMENTS: No pooling of sol / No adverse reaction to prep

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	(b)(6)-2 91D	(b)(6)-2 RN
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

(b)(6)-4

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

☒ ESU NO: Valleylab / 01011
GROUND PAD: BRAND 58309/2004-2
LOT NO: N/a

☐ 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 ☐ Y ☒ NO IF YES NAME: ID NUMBER; FACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

NSS

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNAT (b)(6)-2 LTC MC

15. X-RAY IN OPERA IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1. N/A	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

gauze / Kerlix / peg

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

debridement

21. PATIENT TRANSFERRED TO ICW TIME 1740 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 RN BSN ILT

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDICAL RECORD | **INTRAOPERA /CUMENT**

For use of this form, see AR 40-407, the prope . agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY (b)(6)-2

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

3. DATE 8 August TIME PATIENT ARRIVED IN SUITE 1402

4. PATIENT IN ROOM
TIME 1402 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Sedated / language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 RN	RELIEF SCRUB	N/A
ASSIGNED CIRCULATOR	(b)(6)-2 RN	RELIEF CIRCULATOR	N/A

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

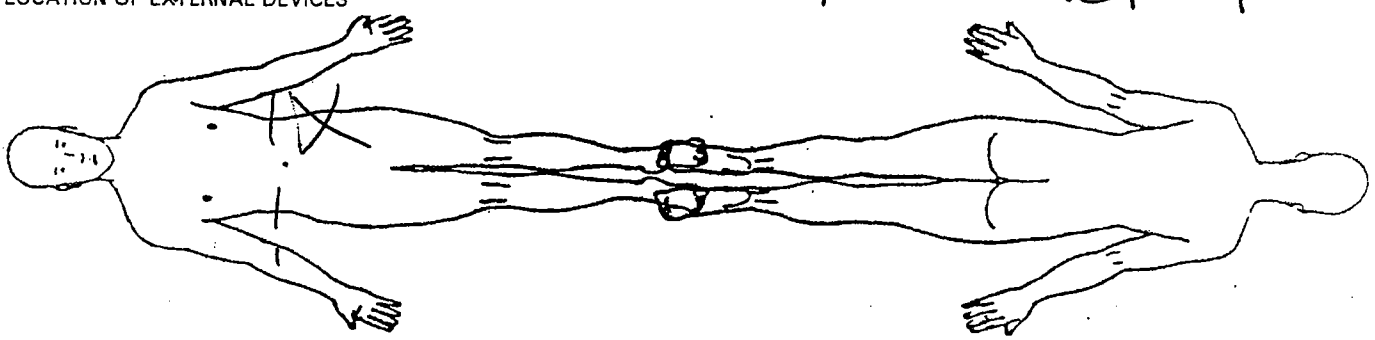
COMMENTS: N/A

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine
SITE: R thigh BY WHOM:
SITE: BY WHOM:
COMMENTS: no pooling / no adverse reaction to prep

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB		CIRCULATOR	
Sponge	☒ Yes	☐ No				(b)(6)-2	RN	(b)(6)-2	RN
Needle Sharp	☒ Yes	☐ No		C	C				
Instrument	☐ Yes	☒ No							
Other	☐ Yes	☒ No							

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

(b)(6)-4

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

☒ ESU NO: 01011
GROUND PAD: BRAND Valleylab
LOT NO: 58304 / 2004 / 2

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

13. PROSTHESIS, IMPLANTS ☐ ☑ NO IF YES NAME: ID NUM M CTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE (b)(6)-2 LTCMC

15. X-RAY IN OPERATING ROOM YES ☐ NO ☒ (b)(6)-2 IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☒ NO ☒	NAME Gram stain/ Culture	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Gauze / Kerlix / peg

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
SITE	1.	2.	3.

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED
I+d (R) AKA

21. PATIENT TRANSFERRED TO FC TIME 1530 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 RN BSN ILT

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDICAL RECORD | **INTRAOPERA[illegible]OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY (b)(6)-2

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

3. DATE 8-5-02 TIME PATIENT ARRIVED IN SUITE 0935

4. PATIENT IN ROOM TIME 0935 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 aid	RELIEF SCRUB	N/A
ASSIGNED CIRCULATOR	(b)(6)-2 RN	RELIEF CIRCULATOR	N/A

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

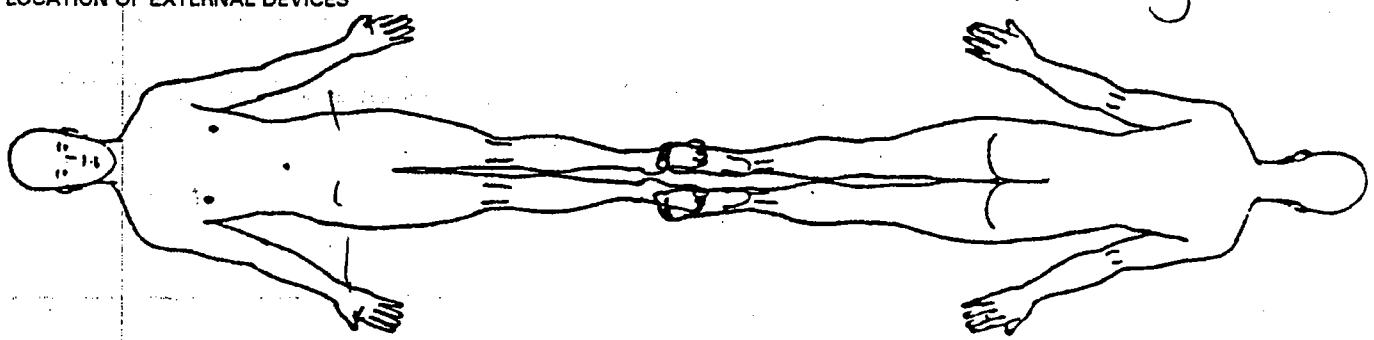
COMMENTS: arm boards

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* betadine
SITE: R leg BY WHOM: (b)(6)-2
SITE: BY WHOM:
COMMENTS: No adverse to prep/ No pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap = = = Tourniquet

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	(b)(6)-2 aid	(b)(6)-2 RN
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

(b)(6)-4

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

☐ ESU NO: N/A
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

13. PROSTHESIS, IMPLANTS ☐ ☒ NO IF YES NAME: ID NUM :ACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Cancef	1gm	intraop	irrigation	(b)(6)-2	Surgeon
N/a					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
Cancef 1gm/1L LR

OTHER ORDERS	TIME	CARRIED OUT BY
N/a		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1. N/a	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
xeroform/gauze/kerlix/tape

19. ADDITIONAL INFORMATION
foley inserted prior to entering O.R.

20. OPERATION(S) PERFORMED
debrisment/wound closure @ leg

21. PATIENT TRANSFERRED TO ICW TIME 1116 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 RN BSN ICU

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDCOM - 3193

MEDICAL RECORD | **INTRAOPE[illegible]E DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY (b)(6)-2

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

3. DATE 30 aug 02 TIME PATIENT ARRIVED IN SUITE 1155

4. PATIENT IN ROOM TIME 1155 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: language barrier

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2	91D	RELIEF SCRUB	
	(b)(6)-2	91D		
ASSIGNED CIRCULATOR	(b)(6)-2	RN	RELIEF CIRCULATOR	
	(b)(6)-2	91D		

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

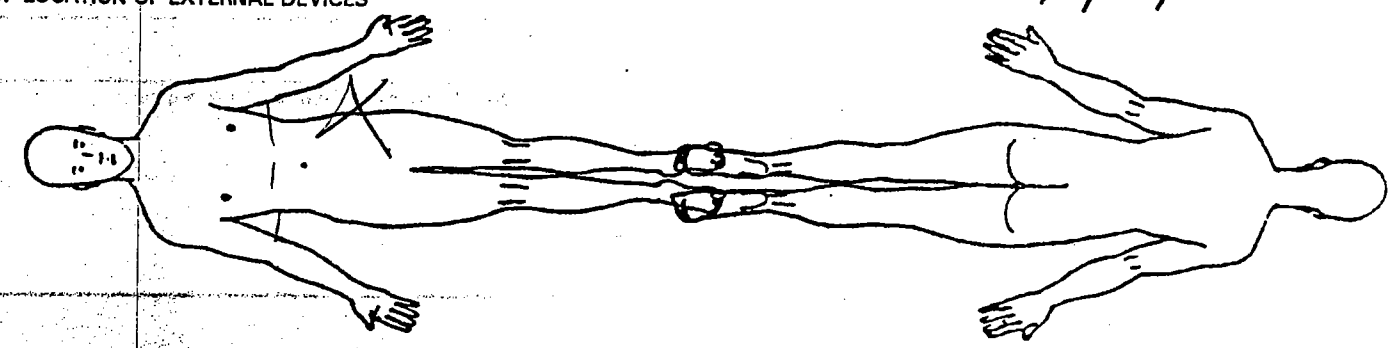
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine
SITE: L leg BY WHOM: (b)(6)-2
SITE: BY WHOM:
COMMENTS: No pooling / no adverse reaction to prep

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No				(b)(6)-2 91D	(b)(6)-2 RN
Needle Sharp	☒ Yes	☐ No		C	C		
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

(b)(6)-4

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

☒ ESU NO: 000999
GROUND PAD: BRAND Valleylab
LOT NO: 58309 / 2004-02

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
ancef	1gm	intra-op	irrigation	(b)(6)-2	(b)(6)-2
n/a					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
ancef / ILNSS

OTHER ORDERS	TIME	CARRIED OUT BY
n/a		

PHYSICIAN'S SIGNATURE (b)(6)-2 LTC MC

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 n/a	

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1. n/a	2.	3.
SITE	1. n/a	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
xeroform / gauze / Kerlix / Coban / ABDs

19. ADDITIONAL INFORMATION
Foley inserted prior to entering O.R.

20. OPERATION(S) PERFORMED
Modification of AKA

21. PATIENT TRANSFERRED TO PACU TIME 1235 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 RN BSN / CI

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDICAL RECORD — **INTRAOPERA DOCUMENT**

For use of this form, see AR 40-407, the prop .. agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY (b)(6)-2 (b)(6)-2

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

3. DATE 10 Aug 02 TIME PATIENT ARRIVED IN SUITE 1917

4. PATIENT IN ROOM TIME 1917 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: intubated

6. NURSING PERSONNEL

ASSIGNED SCRUB	(b)(6)-2 91D	RELIEF SCRUB	N/A
	(b)(6)-2 91D		
ASSIGNED CIRCULATOR	(b)(6)-2 RN	RELIEF CIRCULATOR	N/A
	(b)(6)-2 RN		

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

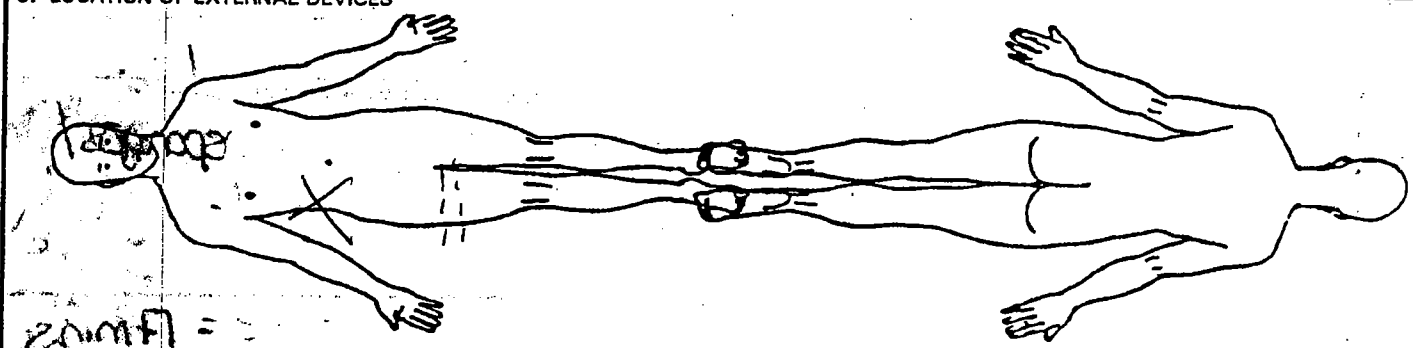
COMMENTS: N/A

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine
SITE: (W) leg BY WHOM: (b)(6)-2
SITE: BY WHOM:
COMMENTS: N/A

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad – Safety Strap = = = Tourniquet

10. COUNTS — C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	(b)(6)-2	(b)(6)-2 RN
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

(b)(6)-4

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

☒ ESU NO: 000999
GROUND PAD: BRAND Valleylab
LOT NO: 562273 / 2003/12

☐ ESU NO:
GROUND PAD: BRAND N/A
LOT NO: N/A

☐ BIPOLAR NO:

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

13. PROSTHESIS, IMPLANTS [ ] ☒ NO IF YES NAME: ID NU NUFACTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Ancef	1gm	mna-p	irrigation	(b)(6)-2	(b)(6)-2

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

OTHER ORDERS	TIME	CARRIED OUT BY
N/a		

PHYSICIAN'S SIGN (b)(6)-2 LTC n c

15. X-RAY IN OPER YES ☐ NO ☐ IF YES, SITE N/A

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☒ NO ☐	NAME (R) leg	NAME N/A
FROZEN SECTION (FS) YES ☐ NO ☒	NAME N/a	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME N/a	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	12 Lap sponges	2.	3.
SITE	(R) thigh	2.	3.

18. DRESSING/IMMOBILIZATION (Specify)
(R) thigh = 2 lap sponges / Kerlix / PEB

19. ADDITIONAL INFORMATION
(R) leg tourniquet ~ start 1916 down 1934 Total time = 17 mins
foley inserted prior to entering O.R.

20. OPERATION(S) PERFORMED
A.K.A

21. PATIENT TRANSFERRED TO ICU TIME 2040 METHOD Litter

(b)(6)-2 RN, BSN, LT

REVERSE OF DA FORM 3179-1, OCT 87 USAPA V1.00

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: Aug 4 | 25AUG02 | 26Aug02 | 4Aug | Aug 8 | Aug 8 | Aug 8.02

19 | HOUR: 2000 2130 0800 2 0830 2 0800 1330 1515 1600 1615 1630 1700 1730 1800 2 0

PULSE (0) | TEMP. F (°) | TEMP. C

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

180 170 160 150 140 130 120 110 100 90 80 70 60 50 40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 24 | 20 | 2 8 | 2 8 | 2 6 | 2 6 | 2 6 | 28 26 | 26 | 24 | 24 24

BLOOD PRESSURE: 156/80 | 136/74 2000 130/78 | 2000 130/82 | 136/80 2045 130/72 | 0800 134/80 | 129/85 | 122/80 2045 130/[illegible] (b)(6)-

HEIGHT: | WEIGHT →

0800 124/85 118/86 | 114/68 1700 124/87

1615 129/94 1630 129/85

5P02 82 2000 | 5P02 90 | 5P02 90 2045 RA

5P02 2045 99

Pulse ox 94% 2d 1615 99% 2d

(b)(6)-2

Record special data only when so ordered

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

Pt # (b)(6)-4

Bed #8

REGISTER NO.

WARD NO. ICW

STANDARD FORM 511 (REV. 7-91) BACK

*U.S. Government Printing Office: 1992 — 312-071/50030

511-117 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY: 09 Aug 02 | 10 Aug 02 | 10 Aug | 11 Aug | 12 Aug | 13 Aug | 14 Aug

19 HOUR: 0800 | 2 | 4 | 5 | 3PM | 8 | 2 | 0800 | 0960 2000 | 1300 2000 | 8 | 2000

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 24 | 8 | 22 | 24 | 20 2 | 2 2 | 4 | 22 | 24 24 | 2 2 8 2

BLOOD PRESSURE: 134/74 | 2145 130/68 | 137/84 | 141/86 | 145/67 | 0840 142/88 | 138/58 | 124/71 128/84 | 1020 132/72 | 124/68

HEIGHT: WEIGHT →

Record special data only when so ordered: 124/77 | 5pt blood sheet | 5L O2 NRB | 5L O2 NRB | 0840 96/RA | 96% RA | 2L O2 Mask 97% | 5L O2 94/RA 1020 | 97% RA

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

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS
Medical Record

STANDARD FORM 511 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

511-117 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 15 Aug | 16 Aug | 17 Aug | 18 Aug | 19 Aug

19 | HOUR

PULSE (O) | TEMP. F (°) | TEMP. C (Centigrade Equivalents, for Reference only)

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

180 170 160 150 140 130 120 110 100 90 80 70 60 50 40

RESPIRATION RECORD

BLOOD PRESSURE: 1030 136/82 | 1600 134/72 | 136/84 | 125/72 2030 118/80 | 0900 132/80 | 0745 134/80 | 2000 118/80 | 2000 120/82

HEIGHT: | WEIGHT →

132/84

122/72 2030 130/84

SPO2 94 1600 RA | SPO2 100 1100 RA | SPO2 98 0900 RA | SPO2 98 0745 RA

Record special data only when so ordered

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) | REGISTER NO. | WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS
Medical Record

STANDARD FORM 511 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

FLOWSHEET FOR VITAL SIGNS AND OTHER PARAMETERS

For use of this form, see AR 40-407; the proponent agency is the OTSG

WARD: ICW

This form may be used for more than one day be drawing a heavy line and adding date. Insert column headings as required.

DATE: 11 Aug 02

11 Aug 02 PATIENT'S NAME	STAT						
UNIT # 1	0915	0930	1000	1030	1100	1130	
# (b)(6)-4 T	100.1	99.6	99.9	99.8			
P	110	116	108	104			
R	20	20	20	20			
B/P	147/84	145/83	140/82	142/82			
UNIT #2				1035	1105	1135	
# (b)(6)-4 T				99.6	99.2		
P				110	110	110	
R				20	20	(b)(6)-2	
B/P				140/72	129/78		

DA FORM 3950, JUN 91 Previous editions are obsolete. *U.S. GPO: 1995-386-733/03913

MEDCOM - 3201

*SEE PROGRESS NOTES:

INTAKE CC/HR

Date 4 AUG 02

INTAKE	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LR				125	125	125	125	125																
meds					50																			
Blood Products																								
PRBC																								
Tube Feedings																								
NG/Meds																								
ORAL																								
Hourly Total		850																						
Cumulative Total		1700																						

OUTPUT CC/HR

OUTPUT	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly				550				600																
Urine Cumulative																								
Emesis/Gastric																								
Stool																								
Output Hourly																								
Output Cumulative																								
Spec. Grav./U.R.																								
Gastric pH																								

TRANSFUSION THERAPY

TYPE	UNIT NO.	TYPE	UNIT NO.	TYPE	UNIT NO.

TOTAL INTAKE

	5A - 1P	1P - 9P		9P - 5A	24° TOTAL
ORAL					
IV	675				
NG					
Bld					
TOTAL					

TOTAL OUTPUT

	5A - 1P	1P - 9P		9P - 5A	24° TOTAL
URIN	1150				
NG					
TOTAL					

MEDCOM - 3202

*SEE PROGRESS NOTES:

STAT LABORATORY DATA

Date 4 AUG 02

Time																								
Glucose																								
BUN/CR.																								
Na+																								
K+																								
Cl-																								
HCO_3-																								
WBC																								
Hb/Hct																								
PLT																								
PT/ct																								
PTT/ct																								

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.
0730	Haldol 2.5 mg	IM	(b)(6)-2						
0900	Acetaminophen 650 mg	PO							
0930	Demerol 25 mg	IV							
1030	Fentanyl 50 mcg	IV							
1800	Fentanyl 50 mcg	IV							
1500	Fentanyl 50 mcg	IV							

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

HT.
WGT.
WGT.
YESTERDAY
PREVIOUS DAY
INTAKE
OUTPUT
BSA
ALLERGIES
ADDRESSOGRAPH

Tylenol 325 mg 2 650 PO q 6° PRN Fever
Fentanyl 50 mcg IV q 2° PRN pain
Demerol 25 mg IV q 6° PRN Pain
//

SIGNATURE AND INITIALS NURSE/RESP. THERAPIST	Init.
(b)(6)-2 ILT ANC	(b)(6)-2
(b)(6)-2	

Pt (b)(6)-4

*SEE PROGRESS NOTES: Name PT # (b)(6)-4 VITAL SIGNS Date 4 AUG 02

°F °C

105 40.6 240
104 40.0 220
103 39.4 200
102 38.9 180
101 38.3 160
100 37.8 140
99 37.2 120
98.6 37.0 110
98 36.7 100
97 36.1 90
96 35.6 80
95 35.0 70
60
50
40
30

HR X SBP DBP TEMP •

05 06 07 08 09 10 11 12 01 02 03 04 05 06 07 08 09 10 11 12 01 02 03 04

HEMODYNAMICS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR		104	108	105				108																
Rhythm			ST	ST				ST																
RESP.			20	26				24																
CUFF BP		157/77	140/80	138/74				138/71																
MAP			87	87				80																
PAS/PAD																								
PCW																								
CVP																								
CO/CI																								
SVRI		95	93	90				98																

DRUG	UNITS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
AnceF 1gm IV q8																									
Gentamycin 500mg IV q8																									

(b)(6)-2

MISCELLANEOUS HOURLY OBSERVATIONS

NURSING PROGRESS NOTE

0800 Awake Alert. Resp easy. Skin warm Dry. Lungs clear. ABD soft. Nontender. BBS (2) Strong drsg intact. (1) Leg incision dry well approximated. 5 staples intact. RA incision approximated. 5 staples intact. VSS AVC 0900.

(b)(6)-2

(b)(6)

TFAN

NURSING PROGRESS NOTE

FORM 0021

☆U.S. GPO: 1997—508-276

*SEE PROGRESS NOTES:

PROCEDURES		OBSERVATIONS	TREATMENTS	
TIME		7 - 4	4 - 12	12 - 8
NEUROLOGICAL		→ SEE CODE →		
Eyes Open (Closed by swelling = C)		4		
Verbal Response (ET Tube or Trach = T)		5		
Motor Response		6		
Pupils R - react NR - non SR - slow	Size R	R		
	Reaction	R		
	Size L	R		
	Reaction	R		
	Hand Grasp R/L	5 / 5		
Breath Sounds		clear		
Sputum Character		–		
Nasal Endotracheal Suctioning Q ____		–		
Chest PT Q ____		–		
CDB/IS Q 1-2		✓		
Vent. ✓'s		✓		
E.T. Tube @ ____		–		
Cuff ✓/Pr/cc's		–		
C.T. Strip & Vent Q ____		–		
C.T. Fluctuates / ___ cm.		–		
Peripheral Pulses **	U	R R		
	L	R R		
Circ. Distal to A-Line		✓		
Monitor Alarm On		✓		
PA Line		✓		
CVP/Other		✓		
Art Line		✓		
Peripheral		–		
Peripheral		✓		
PT/Family Teaching/Support		✓		

Spontaneous	4
To Speech	3
To Pain	2
None	1
Oriented	5
Confused	4
Inappropriate Words	3
Incompreh. Sounds	2
None	1
Obeys Commands	6
Localize Pain	5
Withdraws to pain	4
Flexion to Pain	3
Extension to Pain	2
None	1

2 3 4 5 6 7 8 9 10

**PULSE CODE

DOPPLER . . . . . D

PALPABLE . . . . . P

STRONG . . . . . S

WEAK . . . . . W

ABSENT . . . . . A

PROCEDURES	OBSERVATIONS	TREATMENTS	
TIME	7 - 4	4 - 12	12 - 8
Bowel Sounds	(+)x4		
ABD Size/Firmness	Flat/soft		
NG Secure/Proper Pos.	N/C ogue		
✓ Patency Q4°	✓		
Aspirate Contin. Feed Q4	–		
Aspirate Prior to Bolus Feed	✓		
Stool Char./Gualac	–		
Urine Color/Character	clear		
Foley Secure/Patent	✓		
External Cath.	✓		
Catheter Care	✓		
Colostomy/Ileostomy Care	–		
Bath	–		
Turn & Position Q 2	✓		
Skin Care	✓		
Mouth Care	✓		
Trach / E.T. Care	✓		
ROM	✓		
Dangle	–		
Restraints Released Q2H	Shackles		
OOB to Chair	–		
Ambulation	–		
Side Rails ↑	–		
Drsing. Δ	NR		
Drsing. Δ			

ADDRESSOGRAPH

PT # (b)(6)-4

MEDCOM - 3206

*SEE PROGRESS NOTES:

STAT LABORATORY DATA

Date 8/5/09

Time				1715																				
Glucose																								
BUN/CR.																								
Na+																								
K+																								
Cl-																								
HCO_3-																								
WBC				9.01																				
Hb/Hct				9.7																				
PLT				141																				
PT/ct																								
PTT/ct																								

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.	TIME	DRUG/DOSE	Route	Init.		DRUG/DOSE	Route	Init.
07:00	Tylenol 650mg	PO	(b)(6)-2	03:30	Fentanyl 50mcg	IV	(b)(6)-2				
0900	Fentanyl 50mcg	IV		05:30	Fentanyl 50 mcg	IV					
1430	Fentanyl 50mcg	IV									
1515	Demerol 25mg	IV									
1500	Tylenol 650mg	NG									
1630	Fentanyl 50mcg	IV									
1930	Fentanyl 50mcg	IV									
2120	Fentanyl 50mcg	IV									
2200	Demerol 25mg	IV									
2350	Fentanyl 50mcg	IV									
2330	Ativan 50 mg	IV									
0130	Fentanyl 50 mcg	IV									
0200	Demerol 25mg	IV									

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

HT.
WGT.
WGT.
YESTERDAY
PREVIOUS DAY
INTAKE
OUTPUT
BSA
ALLERGIES

ADDRESSOGRAPH

~~MASOY 2.5mg Q1 PRN~~

TYLENOL 325mg x II oral

Fentanyl 50mcg IV Q2° PRN

Demerol 25mg ~~IV Q4° PRN~~ IV Q 4° PRN pain

SIGNATURE AND INITIALS

NURSE/RESP. THERAPIST	Init.
(b)(6)-2	(b)(6)-2
(b)(6)-2	

(b)(6)-4

*SEE PROGRESS NOTES: Name (b)(6)-4

VITAL SIGNS

Date 8/3/02

°F °C

105 40.6 240
104 40.0 220
103 39.4 200
102 38.9 180
101 38.3 160
100 37.8 140
99 37.2 120
98.6 37.0 110
98 36.7 100
97 36.1 90
96 35.6 80
95 35.0 70
60
50
40
30

HR SBP
X
DBP
TEMP
•

HEMODYNAMICS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
HR		122	109			80	115 121		122	121		115					114			108		104		107
Rhythm		ST	ST			ST	ST ST		ST	ST		ST												
RESP.		25	24			20	20 20		20	22		22					18			18		18		
CUFF BP		125/66	124/68			107/52	135/67		144/72	138/67		134/66					149/71			149/73		148/74		150/74
MAP			80				87		96			86												
PAS/PAD																								
PCW																								
~~TEMP~~ ~~CVP~~		36.6	11						3	3							100.7							
CO/CI																								
SVRI		962				95			91			96					91			98		96		96

DRUG	UNITS	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Heparin Gtt in 500																									
Cefotaxime 500 mg IV (b)																									

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

MISCELLANEOUS HOURLY OBSERVATIONS

NURSING PROGRESS NOTE

Awake Alert oriented. Resp easy, Lungs clear, HR 110s-130 sinus tach ~ ectopy. AR incisional dry well approximated ~ staples intact (L) leg incisions dry well approximated ~ staples intact (R) stump, drsg intact ~ large amt serosanguineous drainage. To OR for Revision Debridement of (R) stump. Dr Cavella advised at H/H @ 1730. PRBCs transfusion initiated

(b)(6)-2

21:30 - VS 100.7 F - 114 regular - 18 even and shallowed. lungs clear bilaterally - 149/71. Pulse oximetry 98%. Drsgs ⊃ (R) stump + abd clean and intact. TERL alert. IV site (L) arm + (R) shoulder patent. 1 unit blood running. NSS running 100 cc/hr. O_2 4 L via nasal cannula. NG tube in place. Foley cath patent draining yellow urine.

(b)(6)-2 ILT ANC

03:30 - 2 units O+ blood given, H+H @ 0400

06:00 - 3rd unit blood given - H+H 21/7

(b)(6)-2 ILT ANC

NURSING PROGRESS NOTE

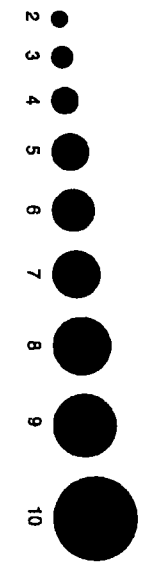
FORM 0021

☆U.S. GPO: 1997—508-276

*SEE PROGRESS NOTES:

PROCEDURES		OBSERVATIONS	TREATMENTS	
TIME		7 - 4	4 - 12	12 - 8
NEUROLOGICAL		→ SEE CODE →		
Eyes Open	Closed by swelling = C	4		
Verbal Response	ET Tube or Trach = T	5		
Motor Response		6		
Pupils R - react NR - non SR - slow	Size R	3		
	Reaction	R		
	Size L	3		
	Reaction	R		
	Hand Grasp R/L	5 / 5		
Breath Sounds		clear		
Sputum Character		\		
Nasal Endotracheal Suctioning Q ____		\		
Chest PT Q ____		\		
CDB/IS Q ____		\		
Vent. ✓'s		\		
E.T. Tube @ ____		\		
Cuff ✓/Pr/cc's		\		
C.T. Strip & Vent Q ____		\		
C.T. Fluctuates / ___ cm.		\		
Peripheral Pulses **	U	PS PS		
	L	PS PS		
Circ. Distal to A-Line		✓		
Monitor Alarm On		✓		
PA Line		✓		
CVP/Other		✓		
Art Line		\		
Peripheral		✓		
Peripheral		✓		
PT/Family Teaching/Support		✓		

Spontaneous	4
To Speech	3
To Pain	2
None	1
Oriented	5
Confused	4
Inappropriate Words	3
Incompreh. Sounds	2
None	1
Obeys Commands	6
Localize Pain	5
Withdraws to pain	4
Flexion to Pain	3
Extension to Pain	2
None	1



**PULSE CODE

DOPPLER . . . . . D

PALPABLE . . . . . P

STRONG . . . . . S

WEAK . . . . . W

ABSENT . . . . . A

FLEETING . . . . . F

PROCEDURES	OBSERVATIONS	TREATMENTS	
TIME	7 - 4	4 - 12	12 - 8
Bowel Sounds	(+) x 4		
ABD Size/Firmness	flat soft		
NG Secure/Proper Pos.	✓		
✓ Patency Q4°	✓		
Aspirate Contin. Feed Q4	\		
Aspirate Prior to Bolus Feed	\		
Stool Char./Gualac	\		
Urine Color/Character	clear Amber		
Foley Secure/Patent	✓		
External Cath.	✓		
Catheter Care	✓		
Colostomy/Ileostomy Care	\		
Bath	\		
Turn & Position Q 2	✓		
Skin Care	✓		
Mouth Care	\		
Trach / E.T. Care	✓		
ROM	✓		
Dangle	\		
Restraints Released Q2H	shackles		
OOB to Chair	\		
Ambulation	\		
Side Rails ↑	✓		
Drsing. △	NJK		
Drsing. △			

ADDRESSOGRAPH

MEDCOM - 3210

*SEE PROGRESS NOTES: 127

INTAKE CC/HR

Date 8-3-02

INTAKE	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
LRC 125		250	125	125	125	125	125	125		125	100	100	100	125										
JU meds				50	100								50											
Blood Products																								
PRBC														500										
Tube Feedings																								
NG/Meds																								
ORAL																								
Hourly Total																								
Cumulative Total																								

OUTPUT CC/HR

OUTPUT	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
Urine Hourly		300			100		120					350	120											
Urine Cumulative																						350		
NG -	CLAMPED																							
Emesis/Gastric																								
Stool																								
Output Hourly																								
Output Cumulative																								
Spec. Grav./U.R.																								
Gastric pH																								

TRANSFUSION THERAPY

TYPE	UNIT NO.	TYPE	UNIT NO.	TYPE	UNIT NO.
PRBC	(b)(6)-4				

TOTAL INTAKE

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
ORAL				
IV	1025			
NG				
Bld				

TOTAL OUTPUT

	5A - 1P	1P - 9P	9P - 5A	24° TOTAL
URIN	1020			
NG				

Elvis 50.

NURSING PROGRESS NOTE

07:00 - Pt Restless, c/o Pain all night medicated Several times c MSO4 - @ thigh Continued to ooze Sero/Sang fluid. DRESSING Δ @ HD Reinforced. Urine output @ S clear Yellow-amber @ Start of tour 23:00

RESPIRATORY PROGRESS NOTE

~~pt b~~

0830 pt BS clear/dim. SaO2 93 on 3L NC HR 123 RR

1700 pt stable on 3L NC humid. HR 136 RR 20 SAT 95

BS clear/dim — (b)(6)-2 /RT

ADDRESSOGRAPH

(b)(6)-4

*SEE PROGRESS NOTES: (b)(6)-4

STAT LABORATORY DATA

Date ∞ Aug 06

Time																							
Glucose																							
BUN/CR.																							
Na+																							
K+																							
Cl-																							
HCO_3-																							
WBC																							
Hb/Hct																							
PLT																							
PT/ct																							
PTT/ct																							

ONE-TIME / PRN MEDICATIONS

TIME	DRUG/DOSE	Route	Init.	TIME	DRUG/DOSE	Route	Init.	DRUG/DOSE	Route	Init.
05:00	MSO4 2mg	IV	(b)(6)-2	03:45	MSO4 5mg	IV	(b)(6)-2			
0800	MSO4 2mg	IV								
0945	MSO4 5mg	IV								
1130	MSO4 5mg	IV								
1230	MSO4 3mg	IV								
1300	Acetaminophen 650mg	PO								
1445	MSO4 5mg	IV								
1600	MSO4 5mg	IV								
1700	MSO4 5mg	IV								
20:30	MSO4 5mg	IV								
22:00	MSO4 5mg	IV								
00:00	MSO4 5mg	IV								
02:00	MSO4 5mg	IV								

ISOENZYMES

DATE				
TIME				
CPK				
MBU				
MB%				
LDH				

HT. _____
WGT. _____
WGT.
YESTERDAY _____
PREVIOUS DAY
INTAKE _____
OUTPUT _____
BSA _____
ALLERGIES _____
ADDRESSOGRAPH

Propofol 5-50 mcg / kg / min
Titrate
MSO4 2-5 mg Q1° PRN
LR @ 125 cc/Hour

SIGNATURE AND INITIALS NURSE/RESP. THERAPIST

	Init.
(b)(6)-2	(b)(6)-2

NURSING PROGRESS NOTE

0800 Awake Alert. Extubated to Simple Facemask @ 5 Lpm.
Resp easy Lungs clear bilaterally. & sounds (L) base HR 140s
ST's octrigy. ABD soft Flat. NGT draining dk green-Brown bilious fluid.
Midline incision clean well approximated staples intact (R) Jackson
drg approximated staples intact. (R) Stump drsg intact &
loose dry serosanguineous drainage. Receiving 1L50ml 0.9 - Sal
IV for pump. PRBCs transfused as per Dr [b)(6)-2] [b)(6)-2]
advised of T temp [b)(6)-2] CPTAN
21:30 - Pt @ 20:30 c/o Throbbing Pain in (R) LE.
Pt Medicated c̄ 5mg MSO4 @ LE. Parts of Dressing
Saturated c̄ Sang Fluid. Does not appear to be
actively Bleeding. BS Bilateral Diminished O2 Sat
97% on 3 LPM N/C - Pt (R) UE (L) LE. Cuffed
to Bed. MP x II close By Bed. midline ABD
Incision c̄ Staples CDI - no Drainage - (L) LE mid thigh
medial aspect Incision c̄ Staples CDI - 1Lt [b)(6)-2] RN
0100 - Pt (L) UE - Released from Cuff By
MP. to Exercise Arm - No Problem Occured
VSS - Medicated for Pain Pt tolerating PO
Intake. [b)(6)-2]

NURSING PROGRESS NOTE

NURSING PROGRESS NOTE

RESPIRATORY PROGRESS NOTE

0500 pt stable on vent/current settings per Dr. order: RR 10
VT 750 FIO_2 ↓40% weaning protocol started ETT 8.0
26@ lip (approx.) ♡R 135 RR 12 SAT 100 BS clear/dim (b)(6)-2 RT
0530 due to weaning switched to SIMV per Dr. B ——— (b)(6)-2 RT
0630 Rate ↓8, FIO_2 ↓35% → NTB
0735 weaning protocol MODE to CPAP ABG 30 min. (b)(6)-2 RT
0820 pt extubated, placed on cool mist @ 5L SaO2 100.
RR 28 ♡R 145 BS clear/dim ——— (b)(6)-2 RT
1600 pt stable on supplemental O2 humidified 3L NC ♡ 146
RR 30 SAT 97 BS clear/diminished ——— (b)(6)-2 RT
1800 pt stable on 3L NC ♡R 136 RR 28 SAT 99 BS clear/dim (b)(6) RT
2127 pt stable on 3L NC humidified ♡R 133 RR 23 SAT 98 clear/dim (b)(6) RT
2310 pt stable/sleeping 2.5L NC humid ♡R 117 RR 25 SAT 94 BS clear/dim (b)(6)-2 RT

ADDRESSOGRAPH

PT NUMBER (b)(6)-4

RESPIRATORY SUPPORT SYSTEM

Date 2 Aug 02

Time	05	06	07	08	09	10	11	12	01	02	03	04	05	06	07	08	09	10	11	12	01	02	03	04
FiO_2	40	40	31	30%																				
Ventilator Model	754	754																						
PEEP/CPAP, cmH_2O	0	0																						
Vent Mode	AC	SIMV		CPAP																				
Volume set, ml•breath^{-1}	750	750																						
Rate set•min^{-1}	10	10	8																					
Insp. Flow Rate, l•min^{-1}	—	—																						
Pres. Support, cm H_2O	—	—																						
Spontaneous Rate	2	2																						
Spontaneous TV	—	—																						
Tot Min Vent, l•min^{-1}	8.9	9.0																						
Pres. Control cmH_2O	—	—																						
Peak Airway Pressure	20	19																						
Therapist's Initials	(b)(6)-2											(b)(6)-2		(b)(6)-2			(b)(6)-2		(b)(6)-2					

BLOOD GAS LABORATORY VALUES

Time Obtained																	2128		2309					
Source (A or V)																								
pH																								
PCO_2 mmHg																								
PO_2 mmHg																								
tO_{2c} Vol %																								
HCO_{3c} mmol/L																								
ABE_c mmol/L																								
tHb g/dL																								
O_2Hb %																								
SO_2 %																								
Ca ++ mmol/L																								
Na + mmol/L																								
K + mmol/L																								
Cl- mmol/L																								
Tonometer PCO_2																								
Ton-Art PCO_2																								

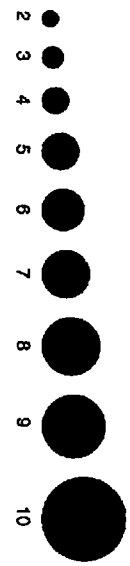
ON-LINE PARAMETERS

Pulse Oximeter SaO_2	100	100	100		100							97		99			98		95					
Oximeter SvO_2	—	—	—		—							—		—			—		—					

*SEE PROGRESS NOTES:

PROCEDURES		OBSERVATIONS	TREATMENTS	
TIME		7 - 4	4 - 12	12 - 8
NEUROLOGICAL		→ SEE CODE →		
Eyes Open	Closed by swelling = C	4		
Verbal Response	ET Tube or Trach = T	5		
Motor Response		6		
Pupils R - react NR - non SR - slow	Size R	3		
	Reaction	R		
	Size L	3		
	Reaction	R		
	Hand Grasp R/L	S / S		
Breath Sounds		Clear		
Sputum Character		C		
Nasal Endotracheal Suctioning Q ____				
Chest PT Q ____				
CDB/IS Q E2c				
Vent. ✓'s				
E.T. Tube @ ____				
Cuff ✓/Pr/cc's				
C.T. Strip & Vent Q ____				
C.T. Fluctuates / ___ cm.				
Peripheral Pulses **	U	(b)(6)-2		
	L			
Circ. Distal to A-Line		(b)(6)-2		
Monitor Alarm On				
PA Line				
CVP/Other R SC				
Art Line				
Peripheral				
Peripheral				
PT/Family Teaching/Support				

Spontaneous	4
To Speech	3
To Pain	2
None	1
Oriented	5
Confused	4
Inappropriate Words	3
Incompreh. Sounds	2
None	1
Obeys Commands	6
Localize Pain	5
Withdraws to pain	4
Flexion to Pain	3
Extension to Pain	2
None	1



**PULSE CODE

DOPPLER . . . . . D

PALPABLE . . . . . P

STRONG . . . . . S

WEAK . . . . . W

ABSENT . . . . . A

PROCEDURES	OBSERVATIONS	TREATMENTS	
TIME	7 - 4	4 - 12	12 - 8
Bowel Sounds	(b)(6)-2		
ABD Size/Firmness	Distended		
NG Secure/Proper Pos.	(b)(6)-2		
✓ Patency Q4°			
Aspirate Contin. Feed Q4			
Aspirate Prior to Bolus Feed			
Stool Char./Gualac			
Urine Color/Character	Yellow amber		
Foley Secure/Patent	(b)(6)-2		
External Cath.			
Catheter Care			
Colostomy/Ileostomy Care			
Bath			
Turn & Position Q ____	(b)(6)-2		
Skin Care			
Mouth Care			
Trach / E.T. Care			
ROM			
Dangle			
Restraints Released Q2H	Shackles		
OOB to Chair			
Ambulation			
Side Rails ↑	(b)(6)-2		
Drsing. △			
Drsing. △			

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