B6-2

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1320	(+)	MSO4 3mg	IVP		E	[redacted]

NEUROVASCULAR

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

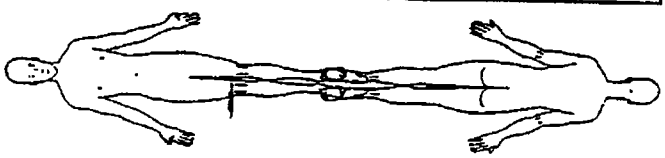
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) Buttocks	Bulky pad	Ø
30'	(R) Buttocks	Bulky pad	Ø
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1140 - Arrived from OR moaning, groaning, and shivering. Language barrier. Respirations even and unlabored. O2 applied via NRBM. SpO2 99-100%. Febrile Temp 103° Anesthesia @ BS. Will cont. to monitor status [redacted]

1150 Pt given Demerol 25mg IVP for shivering Temp 103°. [redacted]

1205 - Pt given Tylenol supp. 650mg PR per Dr [redacted] Reddish welts noted on (R) arm above IV insertion site from upper forearm to AC. Given 50mg Benadryl IM. IVF stopped and IV dcd & present. Will cont. to monitor [redacted]

1250 Sensation Check. Pt c̄ complete sensation LLE down to foot and toes. RLE Ø sensation from above knee down to foot. [redacted] B6-2

1305 Pt had 300cc of water. Will monitor for tolerance of H2O. [redacted]

1400 Alert, able to lift buttocks off bed. VSS. ØNIV. pain controlled. Report given Cpt [redacted] IVF TKO. [redacted] B6-2

Discharge Criteria:
Date: 22 Jun **Time:** 1400 **PARS:**
BP: 102/46 **T:** 100.2 **HR:** 85 **RR:** 19 **Sa02:** 96
Pain Level at D/C (0-10):
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: ICW 2
Report Given To: Cpt [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: _____
Cleared IAW Recovery Room SOP R-2
Charge Nurse Signature: [redacted]

WENTY-FOUR HOUR PATIENT . AKE AND OUTPUT WORKSHEET	FROM HOURS TO HOURS	TOTAL HOURS COVERED	DATE

INT

ORAL

ME	TYPE	AMOUNT	ACCUM TOTAL
00	O.J	80cc	80
500	H2O	120cc	200cc
730	Strawberry Milk	250cc	450cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0115	500	LR @ 75 cc/hr	500	0900	500

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1030	dk urine	800cc	800cc
1530	clear yellow urine	700cc	1500cc

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)

EPW [redacted] B6-4

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 EDI 1 JU MEDCOM - 11042 REPLACES DA FORM 3630(TEMP)

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT IN...E AND OUTPUT WORKSHEET	FROM 4 HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE 16 JUN 03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
2300	H_2O	120	120
2330	H_2O	120	240

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1545	500	LR@75cc/hr	500	2245	500
2300	500	LR@75cc/hr			
2400	50	Ancef	50	0030	550

~~IRRIGATIONS (N/G, Bladder, etc.)~~ URINE OUTPUT

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
2300	32 CYU	320	320

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)

EPW [redacted] B6-4

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 JU

MEDCOM - 11043

*U.S.GPO:1996-404-613/30303

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE 19

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0830	H2O	240	240
0830	Milk	240	480
0830	juice	120	600
1145	juice	120	720
1645	juice	120	840

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1400	500cc	LR 75 cc/hr			

OUTPUT

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
05-13	Cyn x 3		
	quantity sufficient		
~~1400~~	~~C44~~	~~200cc~~	~~200cc~~

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)

ePW [redacted] B6-4

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.GPO:1996-404-613/3

TWENTY-FOUR HOUR PATIE[illegible]ND OUTPUT WORKSHEET

FROM ___ HOURS TO MN HOURS | TOTAL HOURS COVERED 24 | DATE 6-18-93

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0715	Milk	120	120cc
0715	OJ	120	240cc
0715	1½ Waffles		
0930	H_2O	120	360cc

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
	500cc	LR @ 75 cc/hr	500	0400	500

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0800	It yellow urine	600cc	600cc
1500	X̄	600x̄	600x̄cc

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)

#[redacted] B6-4

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 54 IS OBSOLETE. REPLACES DA FORM 3830(TEMP) 1 JUL 72 WHICH MAY BE USED

*U.S.GPO:1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INT... AND OUTPUT WORKSHEET

FROM 14 HOURS TO 24 HOURS | TOTAL HOURS COVERED 10 | DATE 22 Jun 05

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
14	H2O	120	120
17	milk	240	360

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1400	700cc	LRC 75cc/hr			
1800	100	Unasyn	100		

~~MEDICATIONS (IV, [illegible], etc.)~~ OUTPUT

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1600	urine	750cc	750cc

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)

H [redacted] EPW

B6-4

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.GPO.1996-404-613/30343

TWENTY-FOUR HOUR PATIENT INTA AND OUTPUT WORKSHEET

FROM 1 HOURS TO 24 HOURS | TOTAL HOURS COVERED 24 | DATE 6-23-83

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0600	IVMEDS	100	100
0730	Juice /milk	300	400

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1200	100	Uracyn	100	1300	100

OUTPUT — IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0930	Clear Yellow Urine	800	800
1700	" "	600	1400
2330	Cyu	500	1900

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)

EPW# [redacted]

B6-4

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 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72 WHICH MAY BE USED.

*U.S.GPO:1986-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS
TO _____ HOURS

TOTAL HOURS COVERED

DATE 24 Jan 03

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
02	Juice	300	
12	Rehydrill	300	600

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0015	100	D5W	100	0100	100
06	100	D5W	100	0630	200

Urine ~~IRRIGATIONS (N/G, Bladder, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
07	yellow	375	

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B], 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)

CPW [redacted] B6-4

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.GPO:1998-404-613/30343

B6-4

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM [redacted] | RANK / GRADE | MALE / HOMME | FEMALE / FEMME

SSN / NUMÉRO [redacted] | SPECIALTY CODE / GPM | RELIGION / RELIGION

2. UNIT / UNITÉ 1/5th MP

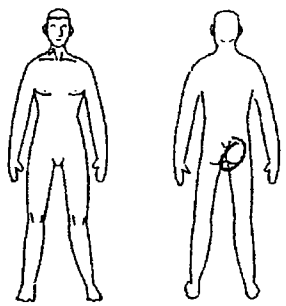
FORCE / ELÉMENT | NATIONALITY / NATIONALITÉ

A/T | AF/A | N/M | MC/M

BC / BC | NBI / BNC | DISEASE / MALADIE | PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT | BACK / ARRIÈRE



- AIRWAY / TRACHÉE
- HEAD / TÊTE
- WOUND / BLESSURE
- NECK/BACK INJURY / BLESSURE AU COU/AU DOS
- BURN / BRÛLURE
- AMPUTATION / AMPUTATION
- STRESS / TENSION
- OTHER (Specify) / AUTRE (Spécifier)

See operative Note and D/C Summary

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

- [X] ALERT / ALERTE
- VERBAL RESPONSE / RÉPONSE VERBALE
- PAIN RESPONSE / RÉPONSE À LA DOULEUR
- UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS | TIME / HEURE

6. TOURNIQUET / GARROT [ ] NO / NON [ ] YES / OUI | TIME / HEURE

7. MORPHINE / MORPHINE [ ] NO / NON [ ] YES / OUI | DOSE / DOSE | TIME / HEURE

8. IV / IV | TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

Please Pt Hold until ambulatory overcrowding here precludes our keeping him Now.

[redacted]

B6-2

10. DISPOSITION / DISPOSITION

- [ ] RETURNED TO DUTY / RETOUR À L'UNITÉ
- [X] EVACUATED / EVACUÉ
- [ ] DECEASED / DÉCÉDÉ

S-81

TIME / HEURE 2036

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ [redacted]

DATE/DATE (YYMMDD) 15JUL05

DD Form 1380 [redacted] U.S. FIELD MEDICAL CARD
DEC 94 [redacted] Form 1380 and DD Form 1380 (TEST), which are obsolete. FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

B6-2

ADMISSION AND CODING INFORMATION

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

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

b6-4

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	27 28 29: 2 7 y	30: Z	31: 9	unk

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	35 36: 9 9	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	46: U	1450	N/A b(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	50 51 52: K 7 9	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
		71: 9	YEAR [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: Ø	ICW2	—
		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b2-2		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: —

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
73 74: 5 Ø		81 82 83 84 85 86: Ø 3 Ø 7 Ø 2

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
87 88 89 90: A B A A		97 98 99 100 101 102: Ø 3 Ø 6 1 6

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
103 104:		111 112 113 114 115 116:

FOR LOCAL USE

Dx: GSW thigh

Inj Trauma 450 1

Dx: 8900 8770 E9912

Pr 8659 9659

[redacted] as required) [redacted] Dr [redacted]

SIGNATURE OF ADMITTING CLERK: [redacted] PFC 9/01B

DA FO[redacted] EDITION OF MAY [redacted] IS OBSOLETE

B6-2 B6-2

B6-4

PATIENT TREATMENT RECORD COVER SHEET

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

NAME (Last, First, MI) [redacted] UNK-CIV

RELIGION X MUSLIM

LENGTH OF SVC ETS —

GRADE CIV

99 [redacted] ORGANIZATION —

PREVIOUS ADMISSION NO

NO — [redacted] BRANCH/CORPS DIC/ZIP —

WARD ICU-1

TYPE CASE

SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION DIRECT FROM ER.

HOURS OF ADMISSION 1735

CLINIC SERVICE WIA.

RELATIONSHIP OF EMERGENCY ADDRESSEE —

TYPE DISPOSITION XFER TO CIV HOSP

DATE OF DISPOSITION ABAA

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —

TELEPHONE NO. —

DATE OF THIS ADMISSION 25 JUN 03

NAME AND [redacted]

DATE OF INTIAL ADMISSION 16 JUN 03

B2-2

DIAGNOSES-OPERATIONS AND SPECIAL PROCEDURES

DX: S/P GSW TO BACK/ PTX (L)

876.0
860.0
807.0
707.0
E991.2

PR. 86.28

Total Days This Facility

ABSENT SICK DAYS	OTHER DAYS	CONV. LV/COOP CARE DAYS	SUPPLEMENTAL CARE DAYS	BED DAYS	TOTAL SICK DAYS
0	0	0	0	9	9

Total Days All Facilities

ABSENT SICK DAYS	OTHER DAYS	CONV. LV/COOP CARE DAYS	SUPPLEMENTAL CARE DAYS	BED DAYS	TOTAL SICK DAYS

SIGNATURE OF ATTENDING M[redacted]

DA FORM [redacted]

B6-2

MEDICAL RECORD

ABBREVIATED MEDICAL RECORD

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

24 yo male involved GSW to left thoracic area c̄ apparent exit wound left back - resuscitated at scene c̄ c/o left chest pain - d/c PB - left - left chest thoracoscopy tube placed in ED.

Pulse	Resp	Temp	Wt	Ht
?	?	?		

CXR - post CT
placement ⊕ shrapnel fragments mediastinum
⊕ chest tube & PTX left

PHYSICAL EXAMINATION

114/53 - 92 - 18 - 98% NRB
Patient: exit penc
neck supple - wound left thoracic - bleeding
Chest: equal BS now s/p CT placement
con RR 5 m/k
RBS left. flat
OT ⊖ wounds

CBC
9.5 > 39.8 < 270
OR 1.025 neg

PROGRESS (Enter date of discharge and final diagnosis)

INT: gsw to left chest - posterior
⊕ PTX - resolved s/p chest tube placement
no apparent neurovascular injury
pcrs OR for washout of wound

[redacted] B6-2

SIGN[redacted]

PATIENT [redacted] | DATE 16 JUN 03 | IDENTIFICATION NO. | ORGANIZATION

For written entries give Name last, first, middle; grade; date; hospital or medical facility)

REGISTER NO. | WARD NO.

[redacted]

B6-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

539-106

MEDICAL RECORD	PROGRESS NOTES	AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
16 June 03	1740 - Received pt from OR. Male chagi EPW c̄ GSW to L upper lobe of lung. Pt. VSS. Pt chest tube to 20cm water suction. Pt has O_2 via NRB @4L. Pt has IV in LAC running LR@125cc/hr. IV in RFA heplocked. Pt is restrained on both arms. Admission Vitals: BP 114/51 T: 101.1 HR: 111 R: 24 O_2: 100%. Pt has not c/o pain and is sleeping [redacted] B6-2
	1830 - Pt c/o pain 6mg MSO4 and ii T3 given. Will continue to monitor [redacted]
	2110 - Pt c/o pain on right side. Talked to Dr. [redacted] B6-2 and he said that it was looked at already and nothing is wrong. Gave pt 6mg MSO4 [redacted]
	0000 - Pt has approx. 200cc of blood drainage from back wound. ~~Pt~~ Reinforced dressing and showed Dr. [redacted] B6 Will continue to monitor. [redacted]
	0130 - Pt has low urine output. IV fluid changed over to other arm. IV in RAC taken out [redacted] B6-2
	0230 - Pt urine output 0. Changed foley, got no urine return. Notified Dr. [redacted]. He ordered 500cc boluss of LR. [redacted]
B6-2	0330 - Pt had some urine output. 30cc [redacted]
	0400 - IV in left FA infiltrated. Placing a new one in R arm. Pt has c/o pain all night in right leg. Doctors are aware [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.	

[redacted] B6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1O)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 June 03	General Surgery
0845	Pt ~~[illegible]~~ GSW to left thorax/back with left back pain
	drainage, (R) PTX - ambulant & assessment of
	wound left chest tube
	pt c/o (R) & (L) chest pain back pain
88 / 34 / 211	T 101.5 HR 88-98 BP 118/60 RR 20's 100% 4 L O2 via
39 hrs	facial mask complaining T/O of 150 hours
MEDS	chest CXR b/c [illegible] (L) base no 90 cal
ABCS	can RLR ↑ (L) / R 135°
MAP	ABS soft NT ↑ MP
Tracheostomy #3	back dressing reinforced - will change when
LR @ 125 cc/h	contaminated
	Plan
~~[illegible]~~ Recieves	PCM: GSW (R) back/chest - PTX, pulmonary
150 cc	- bring fluid well
Colloids	- pulmonary toilet - IS/DPK
100	- no - follow fluid status
1000 AM	- dressing Δ - contaminated on rec
	to remove & repack dressing.
CAR	
Reported	[redacted] Bb-2
Jeffries	
ECG	17 June 03 1210
PTX	Dressing Δ'd c̄ assistance of nursing staff.
	no pressure - drains patent, clear,
	[redacted]

STANDARD FORM 503 [redacted] BACK

USAPA V1.00

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
18 June 03 0910	Pt c̄ c/o pain 8° to GSW m/R VS stable 123/52 68 18 given Tylenol #3 ii P.O. Now To ↓ pain [redacted] 91630
18 June 03 0920	Pt now Asleep ī c/o pain or discomfort. Pain ∅ meds effective at this time. [redacted] 91630
18 June 03 1200	Pt Ambulated x 1 Today c̄ c/o Nausea. given Phenergan 25mg IVP by en. Pt ambulated c̄ unsteady gate c̄ assistance by two staff members. Dressing to mid Back Red tinged / secure in place. Foley to gravity drainage ī Diff ∅ Temp now Asleep [redacted] 91630
18 June 03 1420	General Surgery pm#2 Dip GSW to (L) back – PTX Rising wbc, pmn were compromised, c/o (L) ML. Decr output / [illegible] AFEB HR 60-100 BP 128/64 SACR WEB SUNE looks well chest ↓ BS (L) anteriorly clear on RER (M) wound – clear serous drainage - Keister removed & replaced Penrose Imp/Plan: Rising wbc [redacted] CT – to HO pel cont wound care

B6-2

B6-2

B6-2

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

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

EPW [redacted]

B6-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6/18/03 1420	Nursing: DSG change. Dsg to upper back proximal to (L) shoulder dsg Δ'd by N.O. Packing removed and Sterile Kerlex Roll applied. Pt was premedicated with MSO4 5mg IVP x1 via (R) FAm HL. Pt was later given MSO4 3mg IVP x1 p̄ dsg Δ. Pt tolerated dressing Δ well c̄ medication [redacted]
6/18/03 1730	Nursing: Chest Tube. Chest tube was taken off wall suction and maintained at water seal suction per Dr [redacted] orders. Will continue to monitor pt [redacted] B6-2
18 Jun 03 1750	Rec'd pt drowsy/fatigued, otherwise coherent/calm. HOB ↑ reposition ed for comfort/dinner. PO intake/fld. highly encouraged. Support t.e. Care plan reinforced; meds. act level/rehab/healing, nutrition, D/c planning, pain control/coping; needs reinforcement. see flowsheet for further assessment [redacted] BT/LPN. See note for pain
18 Jun 03 0450	Pt medicated PRN c̄ effect. relief. Repositioned for comfort. Pt/fam encouraged [redacted] Q < CT dsg c̄ D, + I - [redacted] /LPN
19 Jun 03 0900	Pt resting in bed. Chest tube D/C'D by physician. Dressing applied to site. IV of LR to (L) wrist infusing @ 125 cc/hr. Foley to gravity remains intact. Dressing to back c̄ mod amt of drainage. AM care performed, foley care performed. Pt c/o @ this time. Will continue to monitor. [redacted] BT, LPN B6-2
19 Jun 03 1100	Dressing Δ done by physician. 6mg MSO4 given for c/o pain. Pt being transferred to ICU. Will continue to monitor. [redacted] BT, LPN

FORM 509 (REV. 5/1999) BACK
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[redacted] B6-4

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
19 JUN 03	General Surgery
1400	POD #3 - s/p GSW to (L) back - PTX
	chest tube x 3 today & drip
	doing well.
	MBP 130/67 HR 80-90s RR 20 99% RA
	lungs clear
	CO improve
	chest CDI B/L. wounds: clean - serous drainage
	on RA
	at a min output c̄ - x 3 (-) BS on CXR [illegible]
INS/PLAN:	Transfer to ICU
	- cont wound care c̄ dressing x̄ daily - BID
	- CXR in AM
	- [illegible]
	- [illegible] [redacted] B6-2
19Jun03	pt. transferred from ICU [redacted] in stable
1510	condition - VSS, T 101.4, given ~~it~~ Tylenol #3
	tabs for pain & chest tube removal site
	and for fever - dsg on (L) chest CDI, dsg
	on back CDI, entrance wound on neck
	approximated - SL patent in (R) wrist -

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. ICU

EPW # [redacted] B6-4

PROGRESS NOTES
Medical Record

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

USAPA V1.00

66-4

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

DATE	NOTES
19Jun03 Cont.	Foley to gravity, draining clear yellow urine - pt. restrained @ (R) wrist and (L) ankle - lungs CTA (B), (+) BS, (+) 2 pulses in all extremities - pt. ambulated from litter to bed c assistance - used B6-2 IS as instructed [redacted]
19June03 2100	Pt vitals taken. BP 128/60, P. 104, R. 16, temp. 100.8 — SPC [redacted] B6-2
19Jun03 22:15	Assumed care of pt @ 21:00. Pt resting in bed awake + alert. VS WNL. ~~Skin W/D~~ error. X̄ temp. 100.8. temp @ 1500 was 101.4. Skin W+D. LCA (B) + @ bases. BS (+) x4. (+) PPP (B). (L) posterior shoulder dsg C/D/I. DSG to (L) LAT chest wall C/D/I. C/O (L) Post. shoulder pain. ii Tylenol #3 given. Will cont. to mon [redacted] DOT/AO B6-2
22:30 B6-2	O_2 Sat 89%. O_2 @ 2L NC initiated. O_2 Sat 99%. Will cont to mon. [redacted] DOT/AO
20Jun03 0000	Pt vitals taken. BP 124/56, P. 104, [illegible] Temp 100.0 — SPC [redacted] B6-2
20Jun03 0600	Assumed pt care @ 0500: Pt. awake, A+O x 3. temp: 99.8°. lungs ↓ @ bases. BS x 4 - (+) Pulses x 4. Dsng (L) posterior shoulder CDI. Dsng to (L) Lateral chest CDI. HL @ FA patent to flush. SATS 94% RA. Foley to gravity
0540 T 99.8	ē 600 cc dark amber output. Pt. grimaces when moved.
P 82	Will continue to monitor. B6-2 [redacted]
R 16	
BP 118/60	20Jun03 0845 Foley catheter discontinued as ordered. Drain
93%	mod. amt. amber urine. B6-2 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES	AUTHORIZED FOR LOCAL REPRODUCTION
DATE	NOTES	

20 JUNE 03 General Surgery

0900 POD #4 S/P OPN to back (3) & (4) PMB

Chest tube removed yesterday w/ incident.

NO c/o SOB, c/o back-wound pain.

CXR Lungs clear.

Afebrile Afeb 99.8 HR 82 BP 118/60 RR16 RA

B/L Bilat Tm (bil) yesterday

Q8TV Lungs clear.

Q8T Chest w/ (1) tube drain (2) right chest wound tenderness

CXR NAD

Abd Soft NT NS BBS

Wt (2) medial left buttock.

Wound: clean - (2) erythema - early collapse

vitals - cont. dressing Δs

Ins/Out: POD #4 - doing well

Cont. missing Δs c̄ tolerate well / PRN pain

meds for pain.

Ambulate [redacted] B6-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO. PCW2

#[redacted] B6-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 JUN 03	0930 – dressing s'd by M.D. Pt was premedicated for procedure, tolerated well. B6-2 [redacted]
1000 T 99.2	20 JUN 03 Assumed care of Pt @ 1300. A+O x 3. VSS x mild temp.
P96	1600. Ambulate c̄ little assistance x2. Drsg on upper Back CDI. (L) wrist
R20	PIV, HL, patent. (B) LS CTA, (+) BS x 4. Resting comfortably
BP 120/66	O/W Assessment WNL. Will MONITOR [redacted]
93%	1900 → Temp ↓ to 99.5 [redacted] B6-2
	2000 → Drsg Δ w → D completed. Osi/Sx infection [redacted]
20 June 03	Pt vitals taken BP 110/70, P96, R-16, Temp. 99.6
2200	[redacted] B6-2
20 Jun 03	Received Pt @ 21:00. Awake + Alert. Skin W/D. VS WNL. PERLA (+)
23:05	LCTA (B). Diminished @ LD lobe. BS (+) x 4. (+) PPP (B). Drsg to (L) lat.
	Chest wall C/D/I. DSG to ~~Posterior~~ (L) shoulder C/I c̄ mod. amt
	serous drainage. ∅ c/o @ this time will cont. to mon.
B6-2	[redacted] RLT/AW
Attention	[redacted] (L) wrist
20 June 03	Pt vitals taken BP 118/70, P.96, R-16, Temp 99.6
2400	[redacted] B6-2
0145	Pt c/o pain (L) shoulder ~~to~~ 3mg MSO4 given will
	man [redacted] RLT/AW
	B6-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE	
21 June 03	0700 Assumed pt care @ 0500. Pt sitting up asleep - easy to awake. VSS. HR regular. Lungs CTA diminished @ lower (L) lobe. Drsg to (L) side CDI. Drsg to back intact, saturated c̄ clear drainage. pt has cold pack to neck for pain. Abd soft flat BS x4 active. Full ROM U/L extremities. IV in LH to (L) LFA flushes well pnn s/s redness/infiltration. Will continue to monitor [redacted] HO
	B6-2
21 JUNE 03	General Surgery
1100	POD #5 s/p TEP/ventral - large (L) SK around/fan drain. Doing okay. Sore c/o (2) wks ago. Energy under wks PO HR 50-80 BP 112/72 94% RA (L) Hosp (cons good)
	Incision CDI c̄ c̄ c̄ RR wks soft/no warm clean, early closing - collapsing. Chest tube site okay (L) chest
	Impression: POD #5 s/p TEP/ventral pain 2° to pt's personality
	Plan: Doing well - cont. current care no good way for early date would 2° to chest tube but will discuss early in or tomorrow. B6-2 [redacted] MD

(Continue on reverse side)

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

CIV # [redacted] B6-4

REGISTER NO.

WARD NO. CCW2

PROGRESS NOTES
Medical Record

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

[redacted] B6-2

PROGRESS NOTES

DATE	
21 20Jun03 2020	assumed care @1300 - VSS - IV patent - dsg Δ'd as ordered p MSO4 premed - pt. ambulated this shift - NPOP mn o/c to OR in Am, LR@125cc/hr to start @ mn tonight — B6-2 [redacted]
2300	Pt. care assumed @2100, VSS. Pt alert, compliant c̄ care. IVF LR started @ 125 cc/hr. Pt NPOP MN for surgery. HR Reg, lungs c̄ scattered exp wheezes. Drsg to back CDI. ABD soft c̄ BS(+) x4. B6-2 [redacted]
22June03 0600	0600. assume pt care @ 0500. pt asleep, easy to awake. VSS. HR regular, Lungs CTA. LR@ 125cc/hr to (L) FA. Dsg to neck, saturated c̄ yellow drainage. Dsg to (L) side CDI. Abd. soft, flat BS x4 active. No c/o pain @ this time. Waiting to go to OR for partial wound closure. NPO @ this time. [redacted] B6-2
22JUN03 0900	Brief Op Note - Surgery pre-op dx: OSW to left back 16 June 03 post-op dx: same as above procedure: partial closure back wound Surgeon: [redacted] B6-2 assistant: [illegible] ESL: [illegible] fluids: 300 [redacted] B6-2 complications: none to PACU stable

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

PROGRESS NOTES

DATE	
	but refuses pain medication. Pt is now sleeping comfortably. VSS. — [redacted] SGT
	B6-2 91WM6, SGT
23 Nov 03	General Surgery
0015	POD #7, 1 d/p wound dressing & gauze change. Doing fairly well. Didn't sleep well overnight but resting comfortably now.
	AFEB VSS TOL DIET
	CHEST CTA B/L
	CDL RRR
	Skin warm, diaphoretic during exam overnight wound bed clean, drains intact & functional
	EXT (R) LE tenderness - limited 20° to medial from BED.
	Imp/Plan: Doing well
	- continue wound care
	- cont. PO meds
	- drainage/blister to (R) ankle wound when blister ruptures skin. [redacted] SGT
	B6-2 [redacted] B6-2
23 Nov	Pt has decubitus forming Dr. [redacted] said not to do anything until it opens. Right ankle - size of a quarter. — B6-2 [redacted] 91WM6, SGT
23 Jun 03	assumed care @ 1300 - VSS - blister on (R)
1430	ankle remains intact - dsg CD&I on back, no c/o pain @ this time — IV patent - [redacted]
	B6-2

USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE 22June03	1120 pt returned from recovery via litter, s/p partial wound closure. VSS. Dsg to neck CD+I. LR @ 125cc/hr to (L) FA. New orders transferred. Pt has no c/o pain @ this time. Will continue to monito[redacted] B6-2
22 June 03 1400	assumed pt care @ 1300. pt resting c̄ eyes closed aroused to painful stimuli. VSS. lung sounds CTA x̄ L lower lobe slightly diminished. abd soft nontender. BS present. ↓ ↑ ext full ROM strong (+) pulses. wound to (L) ↑ back draining CDI. ↓ (R) wrist infusing LR @ 125cc/hr 5 dry (0) s/sx of infiltration noted (0) c/o pain voiced @ this time. Will cont to monitor B6-2 [redacted] 9 WM6
22 June 03 2130	Pt vitals taken. BP 128/70, P. 92, R. 16, TEMP 100.6 SPO[redacted] B6-2
22Jun03 22:55	Pt. rec'd Awake + alert in bed. VS WNL x̄ temp. 100.6° Will monitor + take again in 1° Skin W/D. PERLA (+) WNL, LCA (B). BS (+) x4. (+) PPP (B). DSG to shoulder C/D/I. W/I cont. to mon. IS encouraged c̄ interpreter's assistance
B6-2	[redacted] 2ET /AW B6-2
23:45	Temp @ 100.8 ii Tylenol 650mg given will mon [redacted] AW
01:11	c/o pain in (L) shoulder + (L) lat chest. 5mg MSO4 given
B6-2	will mon [redacted] 2ET/AW
23 Jun 0930	Assumed care of pt @ 0500. Pt is alert. Pt. ~~will not~~ didn't sleep on night shift. Pt ambulated for 7 minutes. Pt says he has a little pain

(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.

EPW # [redacted] B6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
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MEDICAL RECORD | PROGRESS NOTES

DATE

24 June 03 1500 Assumed pt care @ 1300. pt awake & alert. VSS. HOB ↑90°. lung sounds CTA, abd soft nontender BS⊕. BLE c̄ full rom⊕ pulses, BUE c̄ full rom⊕ pulses. H2 ⓛFA flushes 5 diff, ∅ redness/swelling noted. Drains to L Upper back CDI c̄ suction apparatus intact @ BS. ∅ drainage noted @ this time. ∅% pain voiced. Will cont to monitor — B6-2 [redacted] 9/wmc

24 June 03 1930 Sm amt of bloody drainage noted. drains CDI. suction intact. ∅% pain will cont to monitor — B6-2 [redacted] 9/wmc

24 June 03 2045 emptied 5cc of drainage from suction — B6-2 [redacted] 9/wmc

24 Jun 03 22:21 Rec'd pt @ 21:00. Pt. awake and alert in bed. VS WDL PERRLA⊕ WDL. Skin W/D. LS ⊕ mid lobe c̄ rhonchi + adventitious sounds diminished @ base ⊕ to ⓛ lobe. CTA @ ↑ lobe; mid lobe diminished. BS⊕ x4 ⊕ PPP⊕. DSG ↑ⓛ back C/D/I c̄ J.P drain intact to suction. Draining mod amt. serosanguinous drainage. Pt. enc. to use IS for 10 min 5 diffculty. Able to keep ball @ #5 @ 1800 ml. Will cont. to mon [redacted] 24 /AN

25 June 03 0900 - Pt alert lying in bed. Diminished lung sounds, HR regular, BS⊕, DSG to back CDI connected to suction apparatus. ∅ complaint of pain. DC instruction written. Awaiting transportation. — B6-2 [redacted] (Continue) 24 AN

0800 T 99.0 P 89 R 22 BP 130/74 96%

CIV

EPW [redacted] B6-4

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

REGISTER NO.

WARD NO. ICW2

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
6 23 03 2145	Pt. care assumed @ 2100. VSS. Pt c/o pain to back. T#3 ⅞ given. HL to ⊕ FA - flushed ⊘ S/S infection. HR Reg. Lungs CTA, BS ⊕ XY. Drsng to Back B6-2 CDI. Will cont. to monitor. — [redacted]
24 JUN 03	0630. VSS. NAD noted. Dressing to back dry + intact. Pt awake and alert. ⊘ c/o nausea. Hep lock intact, site ⊖ redness or edema.
0500 T 97.7 P 69 R 16 BP 116/76 97%	BBS CTA ⊕ =. Pulses strong ⊕ =. Resting quietly @ present. — B6-2 [redacted]
	(0830) Pt premedicated ⊜ 5mg in Soy for ⊘ 56 ⊿. as ordered. SL patent, site ⊖ redness or edema. — B6-2 [redacted]
24 JUN 03 0940	General Surgery POD #2 Doing well. ⊘ complaints. APLS VSS Wound: clean, some granulation tissue serous drainage, gauze wicks ⊖ erythema (2) chest tube site - looks good. Gauze to back wound. - wound care applied - Δ dressing in 3 days. - Remove CT tomorrow B6-2 [redacted]

MEDICAL RECORD	PROGRESS NOTES
DATE	
	General Surgery - Transfer Summary
25 JUNE 03	ADM DATE 16 JUNE 03
0815	HPI: 24 yo male sustained GSW to left thoraxis with exit wound left upper back - dyspnea & hemat to left hemith. Left pneumothorax present upon arrival to EMT. Left chest tube placed c̄ resolution of pneumothorax - 200 cc blood. U/S of pericardium revealed no pericardial effusion. Pt c̄ no other injuries. Hct 39.8
PMH	
∅	
PSH	
∅	
NKDS	Hospital course: Patient taken to OR upon admission for debridement & debridement of soft tissue injury 2° to GSW. (+) posterior ribs fx - large tunneling soft tissue tract - packed open chest tube removed on POD #3. ABX d/c'd at that point. Pt continues to do well. Returned to operating room on POD #6 for partial wound closure to hasten healing. POD #8 wound VAC - leaks/to drain/suction - applied to wound. Pt continues to recover c̄ course.
NKDA	
Current Meds	
Tylenol	
Tylenol #3	
ASA - dressing	
B6-2 [redacted]	
- Regular	
Diet	Disposition: Transfer for continued wound care
- IV HL	wounds to heal by 2° intention [redacted]
	B6-2 [redacted]
	MT ME
	General Surgery

(Continue on reverse side)

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

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PROGRESS NOTES
Medical Record

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Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE	
25 June 03 1545	Assumed pt care @ 1300. VSS. Pt awake & alert sitting ↑ in bed, ⊖ c/o pain voiced @ this time. Lung sounds CTA. Abd soft BS⊕x4 quads. ↓ & ↑ full rom ⊕ pulses. HL ⊖ EA flushes 5 diff ⊖ redness or edema noted. Drains to upper left back - CDI c̄ suction apparatus intact. Will cont to monitor — B6-2 [redacted] 91WM6 SGT
25 June 03 2045	Emptied 25 cc reddish brown drainage from suction ⊖ complaints voiced @ this time — B6-2 [redacted] 91WM6 SGT
25 Jun 03 2045	Rec'd pt @ 21:00. Pt. awake and alert. VS WNL according to flow sheet. Skin W/D. PERRLA⊕ WNL. LCA⊖. BS⊕x4 hyperactive. ⊕ PPP⊖. DSG to ⊖ ↑ back C/D/I. ⊖ drainage noted. JP tube intact to intermittent suction @ 40 sec. Error B6-2 ~~⊖ pain~~ ⊖ c/o pain @ this time. Will cont. to mon. Pt amb. c̄ difficulty. c/o Error B6-2 dizziness when he gets up. Will mon [redacted] B6-2
26 June 03 0500	0500 VSS. Stable. Afeb. Drain to back wound to L JS draining small amount of bloody drainage. BBS
0500 T 98.7 P 77 R 20 BP 122/80 97%	CTA & = . BS⊕x4. Pulses strong & = S.L. intact site c̄ redness or edema. Resting quietly @ present c̄ c/o — [redacted] B6-2

(Continue on reverse side)

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

CIV [redacted] B6-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

NSN 7540-00-634-4176

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16 [illegible] 03	General Surgery Brief Op Note
1230	pre op dx: OSW to left [illegible] side, [illegible]
	post op dx: same as above
	procedure: [illegible] exploration & debridement / [illegible]
	surgeon: [redacted] B6-2
	anesthesia: local, [illegible]
	EBL: 50
	fluids: 600 cc 250
	specimen: 0
	findings: large [illegible] soft tissue [illegible]
	(R) right posterior [illegible]
	complications: none
	[redacted] B6-2
	[illegible]

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. ICU

EPW [redacted] B6-4

CIV

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

ALL B6-2 (except last)

MEDICAL RECORD — AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
17 Jun 03 0630	Pt in bed resting. O2 @ 3L via N/C. IV of LR @ 125 cc/hr infusing 3 s/s pt redness or edema. Chest tube to 20 mm H_2O suction. Dressing to back c̄ blood tinged drainage intact. Foley to gravity draining blood tinged urine. 0 c/o @ this time [redacted] SGT, UR B6-2
17 Jun 0735	Pt c/o pain Medicated c̄ 4mg MSO4 [redacted] SGT, UR
17 Jun 1010	Pt c/o pain. Medicated c̄ 4mg MSO4. [redacted] SGT, UR
17 Jun 1230	Physician in to do dressing Δ. Dressing Δ done under conscious sedation. Sedated c̄ 10mg MSO4. VS BP-123/63 P-104 R-25 T-99.2 SPO2-99%. Will continue to monitor. [redacted] SGT, UR
17 Jun 1600	Foley cath D/C'D. pt ×1 c/o pain. Medicated c̄ 2mg MSO4 for c/o pain. [redacted] SGT, UR
17 Jun 1700	Pt c/o pain. Medicated c̄ 4mg MSO4 for pain [redacted] SGT, UR
17 Jun 1800	Rec'd pt. A&O/cooperative. Repositioned for comfort. HOB ↑. PO intake/fluids highly encouraged. CT (L) drg. C.D. & I. - cont. @ 20 cm H_2O Sx. Sats in the upper 90's c̄ 3L NC. (R) back drg. continues c̄ moderate amts. of sang. drainage. Δing chux/reinforcing drg. PRN. Care plan reinforced; I.S. use, Pulm. toilet exercises, foley - need to void, nutrition/healing, act. level, N/C, planning P.T. pain - meds - side effects; needs reinforcement. [redacted] Sgt LPN

for further assessment refer to flowsheet

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.

CPN # [redacted] B6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
17 Jun 03 C.N. → informed	Pt fluids highly encouraged; non-compliant. pt [redacted] offered pt. fluids - unsuccessful void(s). foley inserted [redacted] C.N. and 480cc. cl/yellow urine drained. left in place. will continue to encourage PO intake. - Dinner refused — b(6)-2 [redacted] Sgt/LPN.
18 Jun 03 0400	I. Max of 102.0 (A) - Dr. [redacted] informed: Tylenol order written. I.S. use/fluid intake highly encouraged; non-compliant. Repositioned for comfort - [redacted] Sgt/LPN.
18 Jun 03 0435	Pt. medicated PRN effect. relief. Sits in the upper 90s c 3L NC. CTD currently @ 200cc → sang. drainage. Chux saturated + bed x 3. Ct dsg [redacted] C,D,+I. b(6)-2 [redacted] Sgt/LPN.
18 June 03 0506	EPW # [redacted] ♂ pt now 4 to x 3 ī minimal noted discomfort at 2° to GSW to mid upper Back PTX (L) IV LR @ 125 infusing (L) arm pt now ī erythema or edema site clean/Dry. O2 @ 3L NC O2 sat now 100% skin w/D & Edema. Pupils Reactive. pt responds to hand & Arm Commands & verbal gestures ī diff. Chest tube to 20cm water suction c/D site ī s/s of infection. 210 cc Drainage at this time. red tinged fluid. Am Care Complete, Fcl Care Complete. pt ī mod Drainage to upper back DRS Δ prior to 1200pm Scheduled Cal Now on (R) side minimal Chest pt tolerated this Am. pt mod Asleep. Cont ī present NCP b(6)-2 [redacted] 91C 30

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

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

EPW # [redacted]

b(6)-4

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

NSN 7540-00-634-4176

HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE** | 600-108

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
25 Jun 03 0815	Patient C Surgery POD #9/3 H continues to do well No pain BIL lower extremity. Patient ambulating well. Pain mnt. Patient drainage. VSS T 99.8/99 120/80 HR 80 97% RA Lungs clear. Heart RRR Chest CDI Staples Abd soft, NT, ND Wound - (+) chest sutures removed from proximal & first Back wound dry in place staples x2 Plan: Pt ambulate - wound care - will take shower tomorrow or next day. - may transition to regular diet when tolerating. Continue [redacted] B6-2 [redacted] NAME

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

CIV [redacted]

B6-4

RECORDS MAINTAINED AT:		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

B6-2
MAJ [redacted] B6-2

558-103 [redacted]

[redacted] ...ck of this Sheet,

EMERGENCY CARE AND TREATMENT
(Medical Record)

NSN 7540-01-075-3786

TREATMENT FACILITY (Stamp): B2-2 [redacted] EMT

LOG NUMBER

ARRIVAL			
DATE			TIME
DAY	MONTH	YR.	
16	06	03	1520

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☒ AMBULANCE (Air) ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data): Ø

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): QSW LT BACK # [redacted] B6-4

SEX: M AGE: 24

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME	1530	1548	1606
BP	122/61	114/53	123/63
PULSE	100	92	95
RESP.	20	18	20
TEMP.	—	98	
WT. (Child)	—		

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

1615
122/61
92
1601
22

Pulse 02
1548 - 100%

Chest X-ray CWK 1601

CATEGORY (See reverse)
- ☐ EMERGENT
- ☐ URGENT
- ☐ NON-URGENT b6-2

ORDERS	INITS.	TIME
Morphine	[redacted]	1540
IV NS LT Forearm		1530
Foley cath		1535
UA, CBC, Chem 12		1525
liver Panel		1525
·5 Tetanus		1555

ASSESSMENT/DIAGNOSIS

DISPOSITION (Check all that apply)
- ☐ HOME ☐ FULL DUTY
- QUARTERS: ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
- MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
- REFERRED TO (Indicate clinic)
- ☐ EMERGENCY ☐ TODAY
- ☐ 72 HOURS ☐ ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE
- ☐ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint)
FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

[redacted]

B6-4

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans)

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 24
HEIGHT: } unknown
WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [ ] YES (type): unknown

4. PROPOSED SURGICAL PROCEDURE: S/P GSW Left Chest Emergency case
wash-out - debridement of wound

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition WNL
Tobacco ___ ppd X ___ yrs. Body Piercing Ø Diabetes (Y) (N) ROM WNL ASA/Motrin w/72 hrs (Y) (N)
ETOH Ø Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	Pt. verbalizes any specific anxiety. Pt. Exhibits relaxed body posture.	Allow pt. to verbalize freely. Explain OR environment and answer questions regarding surgery. Offer comfort measures. (e.g.. warm blanket. touch). Explain all nursing procedures before they are done. Remain with pt. whenever possible. Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia ✓ 3) Medical/Smoking History	Pt. will be able to breathe without difficulty during immediate intraoperative phase .	Offer to elevate head of litter or offer pillow. Observe pt. while awaiting surgery for signs of distress. Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids ___ 4) Prosthesis ✓ 5) Pooling of Prep Solutions	Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	Utilize pressure preventing devices on OR table and accessories. Check for proper positioning and support to maintain good body alignment. Pad pressure points. Place ESU ground pad on non compromised skin surface area. Keep prep fluids from pooling.

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

[redacted] BG-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since 1200 ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: Ø

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOM.	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ✓ Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: 1) Length of Surgery ✓ 2) Positioning 3) Arthritis	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt. from either side. ✓ Validate pt.'s understanding of verbal communication. ✓ Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

BG-2 [redacted] 17 AD 16JUN03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT (Y) (N)

LEVEL OF CONSCIOUSNESS: ☐ A&O ☒ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY (Y) (N)

LEVEL OF ACTIVITY: ☒ Moves All Extremities ☐ Moves Upper Extremities ☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] /A

DATE: 16JUN03 TIME: 1600

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title [redacted] 12

DATE: 16JUN03 TIME: 1124 BG-2

BG-2

MEDICAL RECORD — **INTRAOPE[illegible]IVE [illegible]MENT**

For use of this form, see AR 40-66, the proponent age[illegible] [illegible]ne office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA LITTER BY ANESTHESIA

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY. ILT [redacted] B6-2

3. DATE 16 Jun 03 TIME PATIENT ARRIVED IN SUITE 1637

4. PATIENT IN ROOM TIME 1637 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS
☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

COMMENTS: Allergies: NKDA
NPO p 1200 - Anesthesia aware.

6. NURSING PERSONNEL

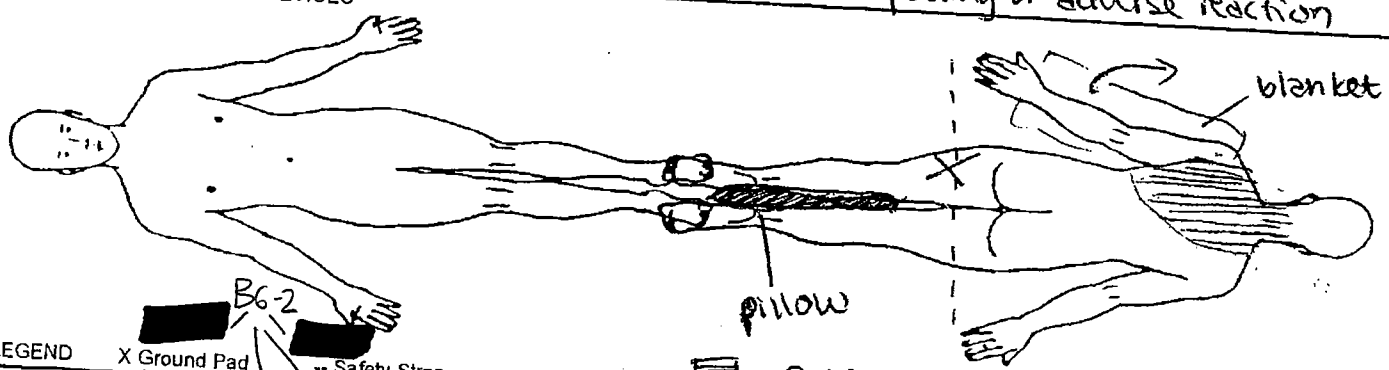
ASSIGNED SCRUB	PFC [redacted] B6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	ILT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt. in lateral position supported by bean bag on padded OR table. RUE on padded arm board - Folded blanket placed between arms Pillow between legs. Normal anatomic body alignment maintained.
☐ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☒ LEFT SIDE UP ☐ RIGHT SIDE UP
COMMENTS:

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

PREP SOLUTION (Specify) Betadine/Betadine
SITE: Upper back/neck BY WHOM: ILT [redacted]
SITE: BY WHOM: B6-2
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



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

INITIAL: PFC [redacted] ILT [redacted] C = Correct I = Incorrect Initial: [redacted]

10. COUNTS

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No		C	C		
Needle Sharp	☒ Yes ☐ No		C	C	[redacted] B6-2	[redacted]
Instrument	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)
[redacted] B6-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO
☒ ESU NO: #4 cut: 30 coag: 30
GROUND PAD: BRAND VL Polyflesive
LOT NO: 10527 Exp 2003-10
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Xylocaine 1% c̄ Epi Lot 210134 Exp 10/04	[redacted] 20cc	INTRA-OP	LOCAL INJ	MFR: [redacted]	DR. [redacted] B6-2

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM 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	

18. DRESSING/IMMOBILIZATION *(Specify)*
Kerlix, 4x8, ABD

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Kerlix packing	2.	3.
SITE	1. upper back	2.	3.

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] B6-2 Anesthesia: [redacted] Anesthesia Type: Gen.

Bovie Pad site intact pre-op ✓; post-op ✓ Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op ____: post-op ____ N/A
Tourniquet Time: Up ____ Down ____ N/A
Pt. arrived in OR c̄ Foley cath and Chest tube.
DA 5179 Initiated

20. OPERATION(S) PERFORMED
Washout & debridement of wound

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 1	1735	LITTER c̄ O2

22. REGISTERED NURSE SIGNATURE [redacted] IT/AN

ALL B6-2 (Except last)

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Amus Staff
TIME PATIENT ARRIVED IN SUITE (CW → OR)

2. PATIENT IDENTIFIED [redacted] VERIFIED [redacted] AND PROCEDURE CPT/AN

3. DATE 22 June 03

4. PATIENT IN ROOM TIME 2152 NUMBER 1-1 / 1

5. PREOPERATIVE EMOTIONAL STATUS
☑ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)

COMMENTS: Allergies: NKDA. NPO p MN.

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] (91D)	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT. [redacted] (66E)	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)
☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☑ LEFT SIDE UP ☑ RIGHT SIDE UP

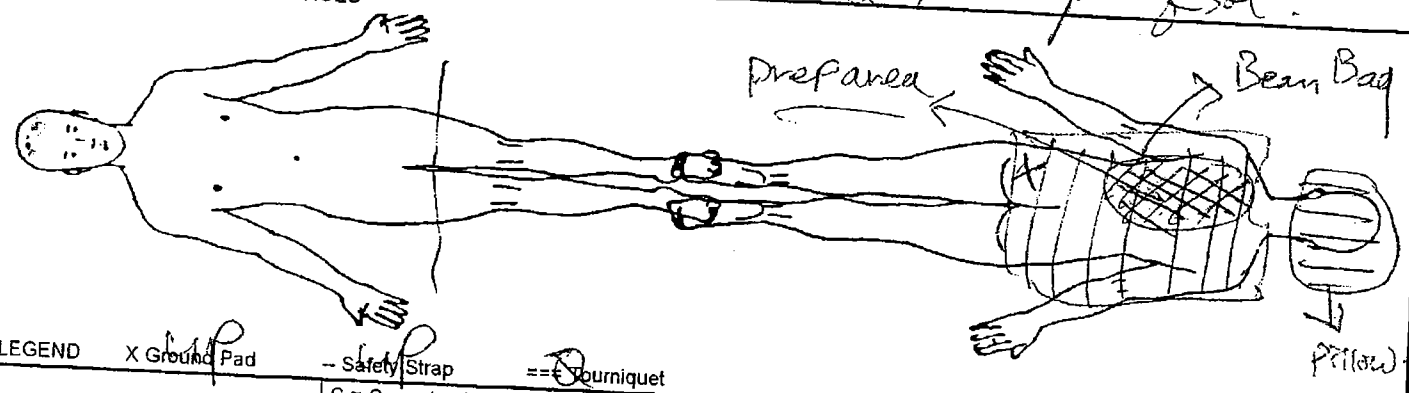
COMMENTS: Bean Bag utilized for lt. side up position. pillow bwn arm supported.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS: ∅

PREP SOLUTION (Specify) Betadine s/sol
SITE: Back BY WHOM: CPT [redacted]
SITE: BY WHOM:
COMMENTS: ∅ pool/swaps of sol.

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	PFC [redacted]	CPT. [redacted]
Needle Sharp	☑ Yes ☐ No	/	/	/	/	/
Instrument	☐ Yes ☑ No	/	/	/	/	/
Other	☐ Yes ☑ No	/	/	/	/	/

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

EPW # [redacted] B6-4
27 yrs.

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

☑ ESU NO: Valleylab #1
GROUND PAD: BRAND Pyrotherapie
LOT NO: 69652.

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:
Coag: 30, Cut: 30

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST) ... OBSOL

MEDCOM - 11078

USAPA V1.01

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

ALL B6-Z

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Xylocaine c̄ epi 1:100,000	10 cc	Intra-op	Injected	Astra	Dr. [redacted]

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% Saline

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted]		

PHYSICIAN [redacted] MD

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☑

TYPE/SIZE	1. Kerlix Roll	2.	3.
SITE	1. Back wd	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

4x8 Kerlix Roll, ABD's & Tape

19. ADDITIONAL INFORMATION

WC

Surgeons: [redacted] Anesthesia: CPT [redacted] (CRNA) Anesthesia Type: I.V Sedation

Bovie Pad site intact pre-op Yes : post-op Yes Bovie Settings: Coag/Cut 30/30

Tourniquet Site intact pre-op ~~0~~ : post-op ~~0~~

Tourniquet Time: Up ~~0~~ Down ~~0~~

20. OPERATION(S) PERFORMED

Back wound I & D and closure.

21. PATIENT TRANSFERRED TO Jail TIME See Anes. Record METHOD Litter.

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN

REVERSE OF DA FORM 5179-1, OCT 8 USAPA V1.01

NKDA

MEDICAL RECORD — ANESTHESIA

DRUG	Dosage					
Glycopyrrolate (mg)	0.2					
Versed (mg)	<2.5>	<2.5>				
Fentanyl (mg)						
Ketamine (mg)	10	10	10	10		
MSO4 (mg)	2-3	2	2	2		
( )						
VOLAT. AGENT % del						
% e.t.						
AIR L/Min						
N2O L/Min						
O2 L/Min	8	8	8	8		

CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "1" = CONSTANT INFUSION

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

TOTALS	TOTAL URINE
.2	Mon
5	
8	
50	
10	Ø

FLUIDS – SUMMARY
CRYSTALLOID – 250
COLLOID – Ø
BLOOD – Ø

FLUIDS: LINE site 18G (UA) ☒ Warmed; ☐ Warmed; ☐ Warmed; ☐ Warmed — 150mL — 250mL

LOSSES: EST BLOOD LOSS; URINE –

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 60 (KG) LB

HEMATOCRIT: 33.8

INITIAL DATA: BP – 130/70; HR – 72

SEMP CHECK: OK? – (Y) N

PATIENT RECORDS: OK for PROCEDURE? [redacted]; TIME – 0730

TIME → 0900 · 30 · 1000 · 30 · 1100

SYMBOLS: BP by cuff (V / Λ); Heart rate (●); Resp rate; BP (transduced); TOURNIQUET T – ↗ B6-2; ANES – X-X; PROC – ⊙ – Ø

220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

VT – ml				
f – breaths/min	27	25	19	24
Peak inf pres / PEEP				
MODE – S(pon), A(ssist), C(on)	S	S	S	S
ET CO2 (torr)		37	30	30
FIO2 (Frac or %)	0.73	0.73	.21	.21
SpO2 (%)	97	100	100	100
ECG	ST	ST	ST	ST
TEMP – site	AVAILABLE			
N-M Block (T/4)				
Fluids c̄ pt	+	+	+	
Warming blkt	X1 Blanket →			
Conv warmer				

BP/Auto Cuff; BP / oth; ART line; Steth – PC/ES; Gas analyzer

REMARKS... Code drugs with numbers, events with letters

(1) Pre-op assessment agree c̄ Jun 16, 2003. Review of Systems.
(2) Room, monitor. O2 SFM, sedated.
(3) SURGEON INJECTED 1% LIDOCAINE c̄ EPI 1:100K 10cc TOTAL.
(4) SURGERY COMPLETE PT DRESSED WELL c̄ SOLUTION. BULKY DSG APPLIED TO BACK.
(5) TO LITTER TO ICU REPORT TO RN. PT LEFT c̄ ATTENDANT

RECOVERY AT 1000
PACU ICU (2) ____ (Specify)
OTHER AUKT 98.7
CONDITION: AWARE STABLE
RESP – 24 SpO2 – 98
BP – 144/69 HR – 110

ANESTHESIA PROCEDURE TIMES

	Start	Room	End
ANES	0855	0905	1005
	Ready	Begin	End
PROC	0910	0930	0952

Mark with letters & symbols, explain under REMARKS — EVENTS (1) (2) (4)
Position → (R) Lateral decubitus

PROCEDURES and CPT Codes: I&D GSW TO BACK

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: MAC c̄ SEDATION AND LOCAL

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: NATURAL

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility
[redacted] B6-4

SURGEONS: [redacted] B6-2

ANESTHETISTS: B6-2 [redacted] CRNA/CPT

PROCEDURE LOCATION: 2

DATE: 22 June 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED Jan 99

MEDCOM - 11080

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

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	Time 1	Time 2	Time 3	Time 4	Time 5	TOTALS
midazolam	(mg)	1	1	.5			2.5
MSO4	(mg)	2	2	2	2	2	10
Ketamine	(mg)	19/20	10/10/10				60
	( )						
	( )						
	( )						
VOLAT AGENT	% del						
	% e.t.						
AIR	L/Min						
N2O	L/Min						
O2	L/Min	6	6	6	6	6	

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

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶ ① ② ③

TOTAL SIZE	50
TOTAL URINE	850

FLUIDS – SUMMARY
CRYSTALLOID– 600
COLLOID– Ø
BLOOD– Ø

LINE site			
LAC	☐ Warmed	RL 900↑	
RFA	☐ Warmed	RL 300↑ – /#2	
	☐ Warmed		
	☐ Warmed		

LOSSES: EST BLOOD LOSS; URINE – Foley ☒ 800-50

PRE-STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: 60 KG LB

HEMATOCRIT: 39.9

INITIAL DATA: BP – 101/43; HR – 98

BLOOD CHECK: OK? – (Y) N

PATIENT READINESS: OK for PROCEDURE? Y; TIME – 1630

TIME → 30 × 17 × 30 × 18 × 30 × 19 × 30

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

220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

	VT – ml				
	f – breaths/min	16	14	14	14
	Peak inf pres / PEEP				
	MODE – S(pon), A(assist), C(on)	S	S	S	S
✓ BP/Auto Cuff	✓ ET-CO2 (torr)				
BP / oth	✓ FIO2 (Frac or %)	>.21	>.21	>.21	>.21
ART line	✓ SpO2 (%)	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR
Gas analyzer	TEMP- site				
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

REMARKS – Code drugs with numbers, events with letters

Pt's chart ✓. OK to proceed.
① To room, SOC monitors, mask O2 applied.
② Local by surgeon 1% xylo c̄ epi 1:100 20 cc total.
③ To recovery stable, O2 6 lpm via mask. Report given.

RECOVERY AT 1735
PACU ICU (Specify)
OTHER 101.1
CONDITION:
RESP – 16 SpO2 – 100
BP – 114/51 HR – 100

ANES	Start	Room	End
	1630	1637	1740
PROC	Ready	Begin	End
	1640	1655	1730

Mark with letters & symbols, explain under REMARKS — EVENTS — Position — RLD c̄ bean bag →

PROCEDURES and CPT Codes: I&D GSW Lt back

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: MAC

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Natural airway c̄ simple mask

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

EPW # [redacted]
" [redacted] B6-4

SURGEONS: [redacted] B6-2
[redacted] MAS/CRNA
[redacted] – ANESTHESIA

PROCEDURE LOCATION 2-1
DATE 6/16/03
PAGE 1 OF 1

WAMC [redacted] REVISED Jan 99

MEDCOM - 11081

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 24 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: I&D GSW Lt back
SURGICAL SERVICE: GS/[redacted]
NPO SINCE: 1200

ASA Physical State 1 2 3 4 5 E
WT: 60 KG/LB HT: ___ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: ___
ETOH: ___
DRUGS: ___

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) ___
( ) ___
( ) ___
( ) ___
( ) ___
( ) ___

PREMEDICATIONS:
None Yes (@ ___ Hrs) /CC
MSO4 . 5 mg IV IM PO 1540
___ . ___ mg IV IM PO
___ . ___ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: 12.1 / 39.9
U/A: nml
OTHER: N/A

136 | 113 | 8 < 141
4.6 | 22 | 0.7

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
Hypertension N Y
Angina N Y
MI N Y
CVA N Y
Other N Y

Pulmonary System:
Asthma N Y
Bronchitis/URI N Y
COPD N Y
Other N Y Lt pneumo (chest tube)

Renal System:
Acute/Chronic RF N Y

Gastrointestinal:
Hepatitis N Y
Hiatal Hernia N Y
PUD/GERD N Y

Endocrine System:
Diabetes N Y
Steriods N Y
Thyroid N Y

Neurological:
Seizures N Y
Neuropathy N Y
Other N Y

Gynecological :
Pregnancy N Y

Other Significant Hx: N Y
N Y

Familial HX N Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC
no PSHx

PHYSICAL EXAMINATION
BP 120/57 HR 96 R 16 T ___ 100%
Pain Scale 0-10 2
HEENT - Teeth ~~[illegible]~~ intact
Trachea M1
TMJ/Neck FROM
Oropharnyx MPI
Nares N/A
CHEST: CTAB
CARDIAC: RRR
EXTREMITIES:
IV Access: 18g LAC, RAC
Ulnar Filling: ___
BACK: See H&P
OTHER: N/A

NPO Since 1200

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

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

The pa[redacted] B6-2 derstand and agrees. Questions answered.
Signed: [redacted] RNA Date: 6/16/03 Time: 1630 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
(X) NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
B6-2
Signed: [redacted] Date: 22 Jun Time: 1920 Hrs

22 June
10.7 / 33.8 - 211 K
0 meds
RRR, Lungs clear
NC Changes LtCW

Patient Identification: (Ward) ICU1

[redacted] B6-4 [redacted]

[redacted] B6-4

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

1-119

MEDICAL RECORD

VITAL SIGNS RECORD

NSN 7540-00-634-4124

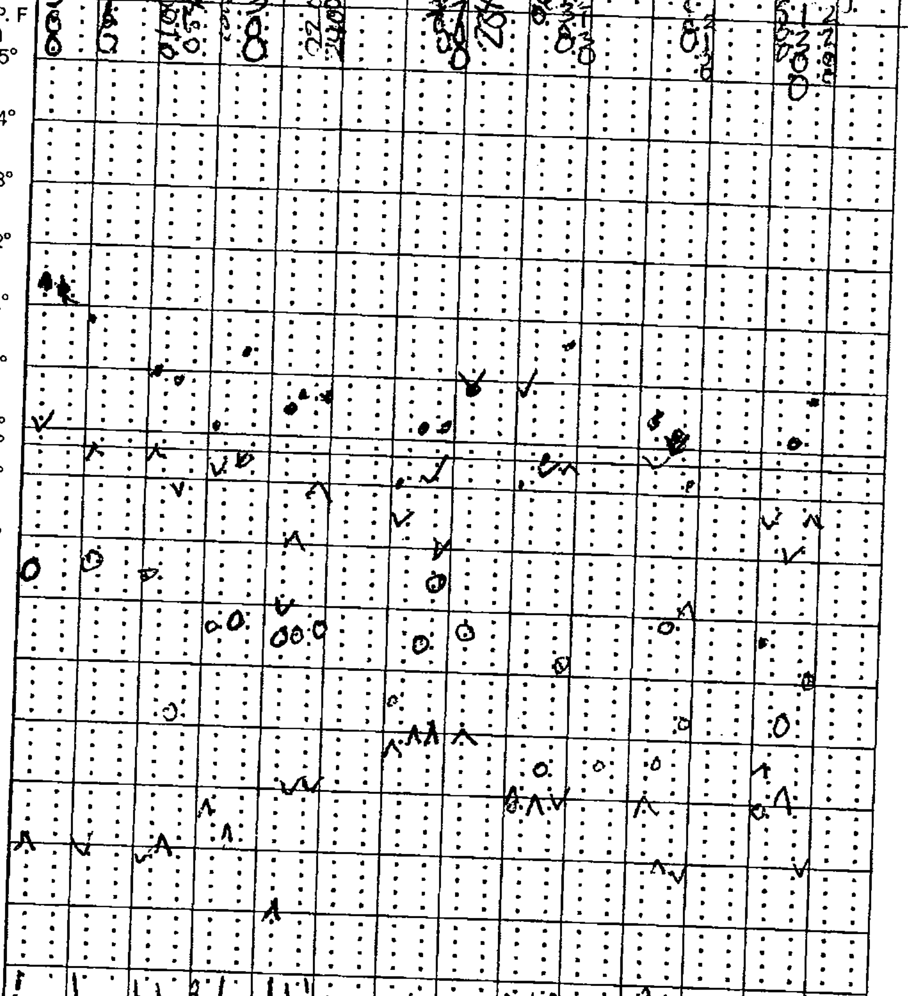
HOSPITAL DAY

POST- op DAY

MONTH-YEAR June 19 2003

	DAY	HOUR
June 2003	19, 20, 20, 21, 22, 23, 24	

PULSE (O) — TEMP. F (•) — TEMP. C



RESPIRATION RECORD

BLOOD PRESSURE

130/60, 118/60, 122/60, 124/60, 100/80, 102/72, 130/80, 134/72, 120/80, 122/70, 110/90, 130/60, 110/70, 110/70

HEIGHT: WEIGHT →

98%, 93%, 94%, 97%, 95%, 97%

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

~~SPW2~~ CIV [redacted] B6-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 11083

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							
MONTH-YEAR / DAY	25	26	27	28	29	30	1
19 / HOUR							

PULSE (O)	TEMP. F (•)	TEMP. C (Centigrade Equivalents, for Reference only)
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

Ward/Section: ICU 1	RE[illegible]TING PHYSICIA[illegible] [redacted] B6-2	[illegible]RATORY RE[illegible]ULT [illegible] (Subject to the Privacy Act of [illegible]

LAST, FIRST, MI. EPW	DATE 17 June	TIME 0330	SSN/PSEUDO SSN: [redacted] B6-4

Hematology/CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. [illegible]
WBC	8.8	4.8-10.8 x 10^3	Color		N/A	RPR		Nega[illegible]
RBC	3.48	4.7-6.1 x 10^9	App		N/A	Mono		Negati[illegible]
Hgb	10.7	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	Microbiology		
Hct	33.8	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	97.1	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	211	130-500 x 10^3 verified	SG		N/A	Occ Bld		N[illegible]
Lymph %	25.8	20.5-51.1%	Bld		Negative	H. pylori		N[illegible]
Hematology/Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp	0	Imm	Leuk		Negative	Microscopic Urine		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	CSF			Blood Bank		
Sed Rate			Cell Count			MUST SUBMIT SF 518 W[illegible] EVERY UNIT REQUEST		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank Unit Crossmatch (ASSIGNED UNITS ONLY)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMA[illegible]
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY: [redacted] B6-2	DATE: 17 June 03	LAB ID NO.:

Ward Section: B6-4 | R. .STING PHYSICIAN:

CHEMISTRY RESULT FO
(Subject to the Privacy Act of 19

LAST, FIRST, M [redacted] | DATE | TIME | SSN-PSEUDO-SSN:

EMT

(i-STAT)

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

Misc. Chemistry

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

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RA
GLU	141	73-118 mg
BUN	9	7-22 mg/dl
CA^{++}		8.0-10.3 mg
CRE	0.7	0.6-1.2 mg
NA^+	136	128-145 mm
K^+	4.6	3.3-4.7 mmol
CL^-	113	98-108 mmo
tCO_2	22	18-33 mmol

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RA
ALB	3.2	3.3-5.5 g/dl
ALP	61	26-84 u/l
ALT	22	10-47 u/l
AMY	94	14-97 u/l
AST	43	11-38 u/l
TBIL	2.2	0.2-1.6 mg/
GGT	60	5-65 u/l
TP	5.2	6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RA
NA		128-145 mm
K		3.3-4.7 mmo
CL		98-108 mmo
tCO_2		18-33 mmol

REMARKS:

REPORTED BY: [redacted] | DATE: | LAB ID NO.:

B6-2

EMT [redacted] B6-4

(Hematology) CBC		
T	RESULT	REF. RANGE
WBC	9.5	4.8-10.8 x 10^3
RBC	4.16	4.7-6.1 x 10^9
Hgb	12.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	39.9	42-52% (M) 37-47% (F)
MCV	96.1	80-94 fl (M) 81-99 fl (F)
PLT	270	130-500 x 10^3 verified
Lymph %	20.2	20.5-51.1%

matology) Manual Differential			
		Mono	
		Eos	
h		Baso	
		Imm	
1			
ocrit		42-52% (M) 37-47% (F)	
ite			

Urinalysis		
TEST	RESULT	REF. RANGE
Color	Yell	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.025	N/A
Bld	Neg	Negative
pH	5.0	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	—	Negative
HCG		Negative

CSF		
Cell Count		
Directigen		Negative

Misc. Serology		
TEST	RESULT	R
RPR		Negative
Mono		Negative

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

Microscopic Urinalysis

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

Coagulation Studies		
r	RESULT	REF. RANGE
PT	12.9	9.8-13.6 secs
PTT	23.5	21-34 secs
er		<20 ug/ml
		<10 ug/ml

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

ARKS:

RTED BY: DATE: LAB ID NO.:

[redacted] B6-4

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] B6-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 16JUN03 TIME OF ORDER 1235 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU-1 - Dr. [redacted]
2. F/C Cxs to [redacted] - PTA
3. [redacted] B6-2
4. Vital signs q1h
5. NPO
6. Monitor: BP, RR, ST

PATIENT IDENTIFICATION

[redacted] B6-2

16JUN03 1900

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

7. Morphine: 2-10 mg. IV q 10 min
   Zofran q 10
   Force to gravity
   CT to 20 cm H2O
8. Meds: Inderal 10 mg q 8°
   Aldomet 1-6 mg IV q 10 PRN
   Tylenol #3 T-II PO q 4 PRN
   Meperidine 25 mg IV q 6 PRN

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

9. Meds: Advance to Regular
10. IVP: CR-D 120 cc q°
11. CSR, CXR in am
12. O2 per nc to keep sats > 95%

[redacted] B6-2 NS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 17JUN03 TIME OF ORDER 0230 HOURS

1. 500 cc NS Bolus Now

[redacted] VODR [redacted]

Noted 17 June 0510 [redacted]

FORM APR 79 **4256** REPLACES EDITION OF 1 JU

MEDCOM - 11088

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW [redacted]

B6-4

NURSING UNIT | ROOM NO. | BED NO.

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

18 JUNE 03 1420

1. upright CXR in AM
2. CT to HD SERV.
3. 5 mg IV MSO4 for dressing changes - DONE

B6-2 [redacted]

[redacted]

PATIENT IDENTIFICATION

EPW [redacted]

B6-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: 3

DATE OF ORDER | TIME OF ORDER | HOURS

18 JUNE 03 1405

1. transfer to ICW
2. fr 68W to back, (+) IV
3. [illegible]
4. NKDA
5. [illegible]
6. [illegible] to keep SpO2 > 92% when at rest [illegible] 1430

[redacted] B6-2

PATIENT IDENTIFICATION

EPW [redacted]

B6-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: 3

DATE OF ORDER | TIME OF ORDER | HOURS

Regular diet

7. DC foley
8. DC IVF
9. [illegible] MSO4 1-5 mg IV q 1h PRN [illegible] 3 times [illegible] PO q 4h PRN
10. upright CXR in AM 20 June 03

PATIENT IDENTIFICATION

EPW [redacted]

B6-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: 3

DATE OF ORDER | TIME OF ORDER | HOURS

[redacted]

B6-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF ...

MEDCOM - 11089 SED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] B6-4

NURSING UNIT: ICW 2 | ROOM NO. | BED NO. [redacted]

DATE OF ORDER: 20 JUNE 03 | TIME OF ORDER: 0905 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) DRESSING DS BID
MD will do AM dressing Δ
KERLIX roll - NAIL wet
to dry - cover c
KERLIX 4x4 & ABD pads.

(2) PHENERGAN c MSO4 5 mg IV
prior to dressing Δs

noted 20 Jun 03 0130

PATIENT IDENTIFICATION

[redacted] B6-4

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

DATE OF ORDER | TIME OF ORDER | HOURS

(3) AMBULATE AD LIB.

[redacted] B6-2 [redacted] and MAY ME

PATIENT IDENTIFICATION

[redacted] B6-4

NURSING UNIT: ICW 2 | ROOM NO. | BED NO. 6

DATE OF ORDER: 20 JUN 03 | TIME OF ORDER: 1600 HOURS

(1) Tylenol #1-#4 325 mg tabs
PO Q4-6° pain Fever
no. Dr. [redacted] B6-2
B6-2 [redacted] B6-2

20 JUN [redacted] AN

PATIENT IDENTIFICATION

[redacted] B6-4

NURSING UNIT: 24° V [redacted] | ROOM NO. | BED NO. 10 AW

DATE OF ORDER: 21 JUNE 03 | TIME OF ORDER: 1120 HOURS

(1) NPO @ MN
(2) IVF: LR @ 125 cc/h to start @ MN.
(3) on call to OR in AM for [illegible] wound closure.

noted [redacted] 1145 21 Jun 03

[redacted] 6 22-03 MN [redacted] B6-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW [redacted] B6-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2		6

DATE OF ORDER: 22 JUNE 03 TIME OF ORDER: 1000 HOURS

1. ADMIT TO PACU → ICW-2 ✓
2. S/P [illegible] closure back wound ✓
3. STABLE ✓
4. NPO ✓
5. VITALS per PACU & ICW CRITERIA ✓
6. ACTIVITY: ADB TID ✓
7. DIET: REGULAR ✓

LIST TIME ORDER NOTED AND SIGN

PATIENT IDENTIFICATION

EPW # [redacted] B6-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

8. IVF: LR @ 125cc/hr [illegible]
9. MEDS: TYLENOL 325mg T-II PO q 4 PRN
   TYLENOL #3 T-II PO q 4 PRN
   MSO4 1-5 mg IV q 1 PRN ✓
   & for dressing ΔS.

[redacted] B6-2 [illegible] 22 JUN 03

PATIENT IDENTIFICATION

EPW # [redacted] B6-4

NURSING UNIT	ROOM NO.	BED NO.
	24° ✓ done	

DATE OF ORDER: TIME OF ORDER: HOURS

10. DRESSING ΔS over → dry fluffs & roll, MD pull - to stay 23 JUNE 03 - BID - MD to do AM dressing Δ.
11. UOS ✓ B6-2 [redacted]

PATIENT IDENTIFICATION

CIV EPW # [redacted] B6-4

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

DATE OF ORDER: 23 JUNE 03 TIME OF ORDER: 1015 HOURS

12. HL IV

23 Jun 03 1030

[redacted] B6-2 [redacted]

IVT/AN 6 [illegible] 03 2330

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: ~~EPW~~ CIV [redacted] B6-4

NURSING UNIT: ICW II | ROOM NO.: | BED NO.: 6

DATE OF ORDER: 24 JUNE 03 | TIME OF ORDER: 0935 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) PLEASE PLACE DRAIN TUBING TO ~~MED~~ MED. INTERMITTENT SUCTION 40 SEC ON, MIN TIME OFF MAY DISCONNECT & CLAMP TUBING TO AMBULATE B6-2 [redacted]

Noted [redacted] 24 June 03 0945

(2) DO NOT D DRESSING [redacted]

PATIENT IDENTIFICATION: ~~EPW~~ CIV [redacted] B6-4

NURSING UNIT: ICW II | ROOM NO.: | BED NO.: 6

DATE OF [redacted] ORDER

25 JUNE 03 B6-2 0830 HOURS

(1) PT to TRANSFER TO IRAQI HOSPITAL WHEN TRANSPORTATION BECOMES AVAILABLE

Noted [redacted] 24 June

B6-2 [redacted] B6-2 [redacted]

PATIENT IDENTIFICATION: CIV ~~EPW~~ [redacted] B6-4

NURSING UNIT: ICW II | ROOM NO.: | BED NO.: 6

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION: CIV ~~EPW~~ [redacted] B6-4

NURSING UNIT: ICW II | ROOM NO.: | BED NO.: 6

DATE OF ORDER | TIME OF ORDER | HOURS

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

All B6-2 (Except last)

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. 6 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18	19
16JUN	[redacted]	Vitals: Per ICU	05	/ [redacted]			
			17	[redacted]			
			/				
16JUN	[redacted]	Condition: Stable	05	/ [redacted]			
			17	[redacted]			
			/				
16June	[redacted]	Activity Bedrest	05	/ [redacted]			
			17	[redacted]			
			/				
16June	[redacted]	T's + D's	05	/ [redacted]			
			17	[redacted]			
			/				
16June	[redacted]	Incentive Spirometer	05	/ [redacted]			
			17	[redacted]			
			/				
16June	[redacted]	Foley to Gravity	05	/ [redacted]			
			17	[redacted]			
			/				
16June	[redacted]	CT to -20cm water suction	05	/ [redacted]			
Dcd 18June	[redacted]	Seal	17	[redacted]			
			/				
16June	[redacted]	Diet: Advance to regular	06	/ [redacted]			
			12	/ [redacted]			
			18	GW [redacted]			
			/				
17Jun	[redacted]	Aggressive Pulmonary Toilet	05	/ [redacted]			
			17	/ [redacted]			

Aud Rg

17 Jun 1600 AH

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: S/P GSW to Mid Back PTX L

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: 1

PATIENT IDENTIFICATION:

EPW

[redacted] B6-4

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

A11 B6-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
16 June	[redacted]	Admit to ICU 1	16 June	Now	1710	[redacted]
16 June	[redacted]	S/P GSW to 1st Back	16 June	—	—	[redacted]
16 June	[redacted]	NKDA	16 June	—	—	[redacted]
16 June	[redacted]	CBC, CXR in AM	17 June	0400	0515	[redacted]
17 June	-----	500cc bolus LR	17 June	0230	0230	[redacted]
17 June	-----	1000cc bolus NS	17 June	0500	0520	[redacted]
~~17 Jun~~	[redacted]	~~CXR 0~~ [redacted]				
17 Jun	[redacted]	D/C Foley, pt due to void AHER	17 Jun	2000	[illegible]	[redacted]
	-----	Removal. If <120cc after 4°				
	-----	give 500cc Bolus NS				

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

All B6-2 (except last)

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. 6 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 17	18	19
17 Jun	[redacted]	OOB - may ambulate ☆	05	[redacted]		
		CT on H_2O seal bed	17	[redacted]		
		place back to suction				
		When in bed				
17 Jun	[redacted]	Chest x-ray QAM	05	[redacted]		

Med/D/c'd (Suction) 18 Jun 03 [redacted]

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: S/P GSW to Mid Back, PTX, L

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO — PAGE NO: 2

PATIENT IDENTIFICATION: # [redacted] B6-4

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

All B6-2 (except last)

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. 6 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 19	20	21	22	23	24	25
19	[redacted]	vitals q4°	04	/	[redacted]		X			
			08	/	[redacted]					
21	[redacted]	Δ to QS: N10	12	/	☐	/				
			16	[redacted]						
			20	[redacted]	/					
			24	[redacted]						
			/							
19	[redacted]	O2 per NC to keep	06	/	[redacted]					
		SaO2 >92% - wean as	14	[redacted]						
		tolerated	22	[redacted]						
			/							
19	[redacted]	IS q1° WA	06	/	[redacted]					
			14	[redacted]						
			22	[redacted]						
			/							
19	[redacted]	Diet: regular	07	/	[redacted]					
			12	/	[redacted]					
			17	☐	[redacted]					
20 Jun 03	[redacted]	DSG Δ's BID: MD will do	10	/	[redacted]					
		arm dressing Δ: Kerlex 4x4	20	/	[redacted]					
		wet→dry - cover c̄ Kerlex								
		4x4 & ABD pads. Premedicate								
20 Jun 03	[redacted]	Ambulate AD LIB	06	/	[redacted]					
			14	/	[redacted]					
			22	/	[redacted]					

New orders for Foley cath after morning cleanup [redacted] 22 Jun 03 1100

ALLERGIES: ☐ YES ☒ NO PRIMARY DIAGNOSIS: [redacted] GSW to back / ⊕ PTX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted] B6-4

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

All B6-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 6 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19	[redacted]	transfer to ICW 2	19	now		
19	[redacted]	Stable	19	now	[redacted]	
19	[redacted]	D/C Foley		20 Jun 03	0545	
19	[redacted]	upright CXR in AM	20	AM	0630	
21	[redacted]	NPO - MN	21	2400	2400	
21	[redacted]	ON call to OR in AM for	22	AM		
	-----	partial wound closure				

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

All B6-2 (except last)

CLINICAL RECORD

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

Mo. ____ Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 22	23	24	25	26	27	28	29	30
22	[redacted]	VS Q shift	05	/	[redacted]							
			13									
			21									
22	[redacted]	Activity: OOB TID	05	/	[redacted]							
			13									
			21									
22	[redacted]	Diet: Regular	07	/	[redacted]							
			12									
			18									
22	[redacted]	DSG Δ wet → Dry Kerlex	10	/	[redacted]							
		c NACL, Abd pad to start	22	/								
		23JUN03 BID - MD to do Am dsg										
24JUN03	[redacted]	Please place drain	05	/	/	[redacted]						
		tube to intermittent	13	/	/							
		medium suction	21	/	/							
		40 sec on, min										
		time off. May										
		disconnect and										
		clamp tubing to										
		ambulate										
24JUN03	[redacted]	DO NOT Δ DRESSING	05	/	/	[redacted]						
			13	/	/							
			21	/	/							

DC'd 24JUN03 [redacted]

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: S/P
Partial closure back wound

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

PATIENT IDENTIFICATION:
~~CPW~~ CIV
[redacted]
B6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

All BG-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo June Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
22	[redacted]	Admit to ICW2	22	1000	1050	[redacted]
22	[redacted]	Condition: Stable	22	1000	—	—
22	[redacted]	Labs: O	22	1000	—	—
25	[redacted]	Transfer to Iraqi Hospital when transportation avail				

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

USAPA V1.00

A11 B6-2

Verify by Initialing		HERA IC DOCUMENTATION CARE AN (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													
16 June	[redacted]	MSO4 1-long IV q 1° prn	16 June 6mg 1820 [redacted]	16 June 4mg 1940 [redacted]	16 June 2?6 6mg	16 June 2300 4mg [redacted]	17 June 0130 4mg	17 June 0330 6mg	17 June 0600 4mg	17 June 0730 4mg	17 June 1010 4mg [redacted]	17 June 1210 10mg [redacted]	17 June 1600 2mg [redacted]	17 June 1900 4mg [redacted]	17 June 6mg 1910 [redacted]	17 June 6mg 2030 [redacted]
16 June	[redacted]	Tylenol #3 ÷ - ⅔ tabs Po q 4° prn	16 June ⅔ 1940 [redacted]	16 June ⅔ 2300 [redacted]	17 JUN 1910 [redacted]	17 JUN 2330 [redacted]	18 June 0910 ⅔	18 June								
16 June	[redacted]	Phenergan 20mg IV q 6 prn nausea			Re-ER Hem 17 Jun 03								0510			
16 JUN	[redacted]	Phenergan 25mg IV q 6 hr PRN Nausea	D T F E													
18 JUN	[redacted]	Tylenol 325mg (3) PRN for HA/elev. temp	18 JUN 0100 3 [redacted]													
16 Jun	[redacted]	MSO4 1-6mg IV q 1° PRN	18 JUN 1950 4mg 0110 [redacted]	18 JUN 1950 0400 5mg												

USAPA V1.00

All B6-2 (except last)

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 16	17	18	19
16 June	[redacted]	Ancef 1gm q8	06	/	[redacted]		
			14	/	[redacted]		
			22	[redacted]			
			/	/			
16 June	[redacted]	O2 per NC to keep sats >96%	05	/	[redacted]		
			17	[redacted]			
			/				
16 June	[redacted]	IVF LR@125cc/hr	05	/	[redacted]		
			17	[redacted]			

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: S/P GSW to MID Back, PTX (L)

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO — PAGE NO. 1

PATIENT IDENTIFICATION: (PW) [redacted] B6-4

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

A11 B6-2

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
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Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
16 June	[redacted]	(Re-written) 13 June 03 MSO4 1-6mg IV q 1° prn	13 June 0830 6mg [redacted]	13 June 0130 4mg [redacted]	6/15/03 0130 MSO4 5mg IV [redacted]	6/15 MSO4 3mg IVP [redacted]	6/18 1930 K20 6mg [redacted]	19 Jun 0800 4mg [redacted]								
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USAPA V1.00

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

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

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

NKDA

PRIMARY DIAGNOSIS:

s/p GSW To mid Back, Pt x (L)

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW [redacted]

B6-4

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

All B6-2 (except last)

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. 6 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	22	23	24
19	[redacted]	HL: Flush QS	06	/	[redacted]				
			14	[redacted]					
			22						
21	[redacted]	IVF: LR @ 125cc/hr	06	/	/	/	[redacted]		
		to start @ MN	14	/	/	/			
			22	/	/	[redacted]			

new order written after wound closure 22 June 03 1100

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S1P GSW to back / ⊕ PTX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: EPW [redacted] B6-4

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

A11 B6-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 6 Yr. 03

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
19 22	[redacted]	MSO4 1-5mg IVP q1°	20 Jun 03 2000 0230
		PRN - pain	0900 [redacted]
19 22	[redacted]	Tylenol #3 tabs	19 Jun 2003 0231 0316
		1/1 - 11 tabs PO q4° p/n	11 PO 11 PO 11 PO
20	[redacted]	MSO4 5mg IV prior	21 Jun 2000
		to dressing Δ's	5mg 5mg
20	[redacted]	Tylenol 325mg tabs	20 Jun 1600
		1/1 - 11 PO Q4-6° prn for pain	11

new orders written after closure

USAPA V1.00

All B6-2 (except last)

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. June YR. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 22	23	24	25	26	27
22	[redacted]	IVF: LR @ 125cc/hr	05	[redacted]					
		HL when tol diet	13	[redacted]				D/C	
			21	[redacted]					
23 Jun	[redacted]	HL IV	05	[redacted]					
			13	[redacted]					
			21	[redacted]					

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: S/P Partial closure back wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: ~~EPW~~ CIV

#[redacted]

B6-4

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

A11 B6-2

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**
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Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED														
22	[redacted]	Tylenol 325mg 2/1-00/11	22 Jun 2345 11 PO	25 Jun 07 11													
- - - -	- - - - -	tabs PO q4° PRN	[redacted]	[redacted]													
- - - -	- - - - -																
22	[redacted]	Tylenol #3 2/1-00/11 tabs	22 Jun 2145 00 PO	0-24 0235 2 PO													
- - - -	- - - - -	PO q4° PRN	[redacted]	[redacted]													
- - - -	- - - - -																
22	[redacted]	MsO4 1-5mg IVP	22 Jun 0441	22 Jun 1000	24 Jun 0530	24 Jun 0845	25 Jun 0311										
- - - -	- - - - -	q1° PRN 3 for dsg	5mg IVP	4mg IV	5mg	5mg IVP	5mg IVP										
- - - -	- - - - -		[redacted]														
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USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 22 Jun 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: 0958

Allergies: NKDA OR Intake: Crystalloid 250 Colloid

Pre-op V/S: 136/70 72 OR Output: UOP EBL Minimal

Procedures: I+O GSW Meds/Times:

60kg

UFA

Versed 5
Ketamine 50
MSO4 10

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	0955	1000	1005	1020	1050
SaO2	98	96	98	96	97
FIO2					
Methods	RA	RA	RA	RA	RA
240					
220					
200					
180					
160					
140	^		v	v	
120		^			v
100	•	•	•	•	
80					•
60	v	v	^	^	^
40					
20					
RR	24	18	15	15	19
T	98.0			98.1	
Time	1005	1020			
Pain (0-10)	Ø	Ø			
LOS	AMB	AMB			

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	12	12	12

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

PA[redacted] B6-2

DEPARTMENT/SERVICE/CLINIC: ICU2

DATE: 22 Jun 03

PAT[redacted] entries give: first [redacted] Name – last,

EPW # [redacted] B6-4

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

A11 B6-2

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

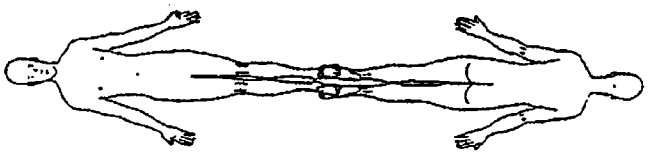
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

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



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

0955 Pt received awake. Resp NSD CTA Bilaterally >96% SaO2 RR 12-20s. CV S1,S2 NSR Ø ECTOPY Pulses 3+ Throughout GI BS(+) GU Spontaneous Ø Void. Skin Intact PIV 20 LFA Wound Bky Dressing Dry and Intact. [redacted] 1050 Report Given to SPC [redacted] VSS. NSD. Transfer to ICW2 via Gurney [redacted]

Discharge Criteria:
Date: [redacted] **Time:** 1050 **PARS:** 12
BP: 117/58 **T:** 98.5 **HR:** 86 **RR:** 19 **SaO2:** 97
Pain Level at D/C (0-10): Ø
Intake: Ø **Output:** Ø
Additional Data:
Transferred To: ICW #2
Report Given To: SPC [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Re[redacted] SOP B-3
Charge Nurse Signatu[redacted]

B6-4

1. LAST NAME	RANK / GRADE	MALE / HOMME ✓
[redacted]		FEMALE / FEMME
SSN / NUMÉRO MATRICULE	SPECIALTY CODE / GPM	RELIGION / RELIGION

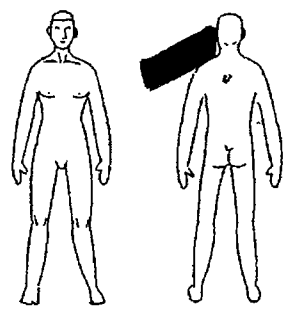
2. UNIT / UNITÉ

FORCE / ÉLEMENT				NATIONALITY / NATIONALITÉ
A/T	AF/A	N/M	MC/M	I.V. [illegible]

	BC / BC		NBI / BNC		DISEASE / MALADIE		PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT — BACK / ARRIERE



	AIRWAY / TRACHÉE
	HEAD / TÊTE
	WOUND / BLESSURE
X	NECK/BACK INJURY / BLESSURE AU COU/AU DOS
	BURN / BRÛLURE
	AMPUTATION / AMPUTATION
	STRESS / TENSION
	OTHER (Specify) / AUTRE (Spécifier)

BP 129/59

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

	ALERT / ALERTE		PAIN RESPONSE / RÉPONSE À LA DOULEUR
	VERBAL RESPONSE / REPONSE VERBALE		UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS	TIME / HEURE	6. TOURNIQUET / GARROT	TIME / HEURE
BC		☐ NO / NON ☐ YES / OUI	1437

7. MORPHINE / MORPHINE	DOSE / DOSE	TIME / HEURE	8. IV / IV	TIME / HEURE
☐ NO / NON ☐ YES / OUI				

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

Stay 3000 mL. M210 GSW
Pain

18 GA (L) AC SC 100 mg
3rd Bag [illegible]

Pt spitting blood

10. DISPOSITION / DISPOSITION			TIME / HEURE
		RETURNED TO DUTY / RETOUR À L'UNITÉ	
	X	EVACUATED / ÉVACUÉ	
		DECEASED / DÉCÉDÉ	

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ	DATE/DATE (YYMMDD)
	[illegible]

DD Form 1380, DEC 91 — *This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.*

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0630 INITIALS JA	INITIALS	INITIALS
NEURO	PUPILS	PERRLA		
	SENSORIUM	Alert & oriented		
RESPIRATORY	RESPIRATORY PATTERN	Eu) unlabored		
	BREATH SOUNDS	B) CTA, (L) diminished		
	SECRETIONS	Breath sounds		
		LT to (D) side		
		to H2O		
SKIN	COLOR	pink w/ pale face		
	INTEGRITY	Intact, surgical		
I.V. SITE	LOCATION	(L) wrist		
	CONDITION	Ps/s (clean)		
		dry dressing		
GASTRO	ABDOMEN	soft, nontender		
	BOWEL SOUNDS	BS x 4 quads		
GU	URINE:	foley to gravity		
	COLOR/CLARITY	dark yellow urine		
CARDIOVASCULAR	CARDIAC RHYTHM	S1 & S2 noted		
		sinus rhythm		
		no ectopy noted		

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

(Continue on reverse)

PREPA[redacted] | DEPARTMENT/SERVICE/CLINIC: ICU 2nd ICU 1 | DATE: 19 Jun 03

B6-2

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

ICU # 1

EPW # [redacted] B6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff			133/64		115/65			130/67			124/74		133/83		124/74			
Temperature	99.9				99.8						99.6				99.8			
Pulse			90		86			97			97		101		108			
Respiratory Rate			16		16			20			20		22		12			
Sat	99		100		99			99			98%		99%		98%			
Source																		
Flow Rate	2L		2L		2L			2L			2L		2L		2L			
pain																		
intervention																		

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR	125	125	125	125	125	125	125	125	1000	125/125	125/250	125/375	125/500	125/625	125/750	125/875		
ampicillin								50	50							50		
PO																		
TOTALS																		

OUTPUT

	HOUR / TOTAL																	
URINE						1200/1200			1200			600/600						
NG	Color																	
	S/A																	
	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

Foley

305 ec max

zero rang

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	

INTAKE	16	17	18	19	20	21	22	23	8°T

OUTPUT									

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
	A: pH									
	A: PCO_2									
	B: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

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

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

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	
BALANCE			

NURSE'S SIGNATURE [redacted]

B6-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

B6-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0620	INITIALS [redacted]	1740	INITIALS [redacted]		INITIALS
NEURO	PUPILS	Peerla 3mm.		Peerla			
	SENSORIUM	full sensation all ext		Alert			
		AROM all Ext. NSOOI		coherent/calm			
		T3 for pain (+) effect					
RESPIRATORY	RESPIRATORY PATTERN	Regular 20 Lung sounds		Even/unlabored			
	BREATH SOUNDS	(R) Bride O2 3L NC cont		(R) CTA (L) ↓ & diminished			
	SECRETIONS	100% Ø Secretions.		R/T - CT			
		(2) flank CT to LCS.					
				(2) CT ⇒ H2O seal			
SKIN	COLOR	Normal for Race		Normal for Race			
	INTEGRITY	Intact (2) flank chest tube		(2) CT + (1) Dressing		back drsg bleeding	
		to low (Bulbous suction.		back drsg intact		reinforced + chux Δ	
I.V. SITE	LOCATION	(2) FA - HU		(2) Quiet		PRN)	
	CONDITION	Site DF I		patent/benign			
GASTRO	ABDOMEN	Soft flat NT		Soft, U-NT			
	BOWEL SOUNDS	(+) x4 quad		(+) x4			
GU	URINE:	Via ~~Hemovac~~ Foley		foley			
	COLOR/CLARITY	to gravity drainage		cl/yel			
		clear yellow urine.					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR on ∞ S1 S2 present		NSR ⇒ ST			
		Peripheral pulse full		S ectopy			
		Strong. Cap refill < 3 sec		S1 S2 only			

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

(Continue on reverse)

PREPARED BY (Signature & Title) B6-2 [redacted] Sgt/LPN

DEPARTMENT/SERVICE/CLINIC ~~ICU~~ 2 East ICU

DATE 18 JUN 83

PATIENT'S [redacted] (When entries give: Name—last, first, middle; grade; date; hospital or medical facility)

ICU #

EPW # [redacted]

B6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff			112/62		110/51	116/59	116/62			115/38	125/52	120/66	121/57	123/64	128/61	128/57	128/57	
Temperature (A)		102.0			99.9		99.1			99.2		99.6		99.6		99.6		
Pulse			118		101	100	80	90		90	68	89	81	86	84	82	83	
Respiratory Rate			16		16	18	16	18		18	18	19	15	18	16	17	19	
Sat			100%		100	100	100	100		100	100	100	100	100	100	100	100	
Source			Mask NC		NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	
Flow Rate			3L		3L	3L	3L	3L		3L	3L	3L	3L	3L	2L	2L	2L	
pain																		
intervention																		

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR	125	125	125	125	125	125	125/125	125/125	725	125	125	125	125	125	125/900	125/1025	125/1150	1,150
Accef							50		50									
PO																		
TOTALS																		

OUTPUT																		
URINE / NG — HOUR / TOTAL					1300 / 1300				1200	700 / 700	800 / 1000	400 / 1400					1800 / 2400	2400
Foley					Emptied													
10 gr																		
SA																		
OUTPUT																		
pH																		
GUIAC																		
EMESIS																		
STOOL																		
CT DRAINS																		
TOTALS																		

B6-2 A11

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	/
	127 col	120 col	~~123~~ 100	~~124~~ 100			121 76		
	99.2					(A)	101.0	T 3 gtt	
	64	86					110		
	18	18					16		
	100	100	100				100		
	NC	NC	NC				NC		
	2L	2L	2L				2L		

INTAKE	16	17	18	19	20	21	22	23	8°T
	125	125	125	125	125	125	125	125	1,000
							50		50

OUTPUT									
	200 / 200	~~200~~ / 400	/	/	/	/	1500 / 1400 emptied	/	1900
		92c							

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GAS	A: pH									
	A: PCO_2									
	A: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

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

ACTIVITIES OF DAILY LIVING	TIME	8	8	8			TURN	TIME				
	MOUTH CARE	✓										
	BATH	✓										
	SKIN CARE	✓										
	FOLEY CARE	✓					SUCTION					
	TRACH CARE	w/ lb										
	ROM EXERCISES											

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE | INITIALS

[redacted]

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

B6-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1630	INITIALS [redacted]	1800	INITIALS [redacted]		INITIALS
NEURO	PUPILS	PERRLA		Pupils			
	SENSORIUM	Alert and oriented		A+O, calm/coherent			
RESPIRATORY	RESPIRATORY PATTERN	Pt. intubated		Ventilated			
	BREATH SOUNDS	BS-clear in		CTA w/ crackles + Dade			
	SECRETIONS	R, BS-coarse in (L). CT to O side - 20 mm suction		R CT → 20 cm suction			
SKIN	COLOR	Normal for race		normal race		back (upper) intact	
	INTEGRITY	Good skin turgor		intact			
IV SITE	LOCATION	(L) wrist		dsg to Dchest C.D.I			
	CONDITION	S/S of redness or swelling		Quiet pt without signs			
GASTRO	ABDOMEN	Soft nontender		soft NT/ND			
	BOWEL SOUNDS	BS x 4 quads		BS x 4			
GU	URINE: COLOR/CLARITY	Foley to gravity drainage bloody tinged urine		void pending			
CARDIOVASCULAR	CARDIAC RHYTHM	S1 S2 noted Sinus rhythm ectopy		ST S2 ectopy S1 S2 only			

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

(Continue on reverse)

B6-2 PREP[redacted] (Title) SGT, USA

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 17 Jun 03

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

EPW #[redacted]

B6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff						118/60	124/70	116/53		117/53	125/66	123/62	131/61	124/61	113/55	123/63	132/63	
Temperature														99.2				
Pulse						93	100	91		87		96	101	107	102	106	105	
Respiratory Rate						14	18	13		11		13	20	20	20	18	19	
Sat r						93%	100%	100%		100%		100%	100%	100%	99%	99%	100%	
source																		
flow																		

INTAKE

TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
NS						1000			1000									100
LR						125	125/50	125/375	375	125	125/375	125/375	125/500	125/625	125/750	125/875	125/1000	1000
Ancef							50		50							50		1050
PO																		
TOTALS									1425									1050

OUTPUT

URINE	HOUR							90						310			250	
	TOTAL								90					400				560
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS									90									560

Pulled

A11 B6-2

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	135/90		116/65				119/57		
			98.6				101.0		
	102		110						
	17		16				18		
	100%		99				100%		
			N/C				NC		
			3L				3L		

INTAKE	16	17	18	19	20	21	22	23	8° T
	125	125	125	125	125	125	125	125	1000
D		30	30	30	30	30	30	30	210

OUTPUT									
				Foley					
				480/480			420/900		900
				Emptied			Emptied		

ACUITY LEVEL CLASSIFICATION

RESPIRATORY THERAPY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
	A: pH									
	A: PCO_2									
	A: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

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

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

24°I&O TOTALS	NURSE'S SIGNATURE	INITIALS
wt Yesterday _____ wt Today _____	[redacted]	
INTAKE: IV _____ po _____ _____ TOTAL _____	OUTPUT: Urine: _____ _____ _____ TOTAL _____	
BALANCE _____		

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INITIALS		INITIALS		INITIALS
NEURO	PUPILS	Perrla sluggish					
	SENSORIUM	4am					
		Alert when spoken to					
RESPIRATORY	RESPIRATORY PATTERN	even unlabored					
	BREATH SOUNDS	CT to L upper lobe					
	SECRETIONS	70cm water suction					
		sounds coarse on left					
		side clear on right					
SKIN	COLOR	NER					
	INTEGRITY	dry, intact					
		dressing on L upper back					
IV SITE	LOCATION	R Forearm duplicated					
	CONDITION	L AC 125cc/hr					
		c/d/i no s/s infection					
GASTRO	ABDOMEN	soft nontender					
	BOWEL SOUNDS	absent					
GU	URINE:	Foley to gravity					
	COLOR/CLARITY	clear yellow					
		urine					
CARDIOVASCULAR	CARDIAC RHYTHM	S1S2 NSR					
		+2 pulses radial +					
		pedal					
		<3 sec cap refill					

B6-2 [redacted] SA

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU Quest

DATE: 16 Jun

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

EPW [redacted] B6-4

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

DATE | DX | HOSPITAL DAY

VITALS SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line																		
	BP Cuff	113/58	124/64	115/53	125/67	111/57	118/60												
	Temperature	•																	
	Pulse	114	95	82	85	80	89												
	Respiratory Rate	99 20	24	17	27	19	27												
		2L 99	100	100	100	100	100												
		NC	2L	2L	2L	2L	2L												
			NC	NC	NC	NC	NC												
	pain																		
	intervention																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	LR @125cc/hr	125/875	125/1000	125/1125	125/1250	125/1375	125/1400												
	Ancef																		
	TOTALS						1360												

OUTPUT		HOUR / TOTAL	50	—	—	30	[redacted]	30 / 50											
	URINE	sp gr																	
		S/A																	
	NG	OUTPUT																	
		pH																	
		GUIAC																	
	EMESIS																		
	STOOL																		
	DRAINS	CT					34/9												
	TOTALS																		

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
		114/51	99/59	111/68	113/54	115/57	114/50	114/68	
		101.1				101.5		101.1	
		111	104	103	99	101	106	110	
		24	18	20	26	14	18	19	
		100%	100%	100	100	100	100	100	
		4L	4L	4L	4L	4L	2L	2L	
		NC	NC	NC	NC	NC	NC	NC	

INTAKE	16	17	18	19	20	21	22	23	8°T
		125	125	125	125	125	125/750		
							50		

OUTPUT									
			100	100/200	100/300	100/400	50/450		

ACUITY LEVEL CLASSIFICATION

RESPIRATORY		TIME									
		MODE									
		F_IO_2									
		TV									
		RATE									
		PEEP									
	A	pH									
		PCO_2									
		pO_2									
	B	HCO_3									
		SAT									
	G	BASE									

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

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

24 I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday	wt Today		
INTAKE	OUTPUT		
IV	Urine:		
po			
TOTAL 2600	TOTAL 560+34		
BALANCE	894		

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF								MTF LOCATION (State or Country Code.)
1	2	3	4	5	6	7	8	
A	1	1	D	1		I	Z	

3. REGISTER NUMBER						
9	10	11	12	13	14	15
B6-4 [redacted]						

NAME (Last, First, Middle Initial): UNK-CIV.

4. PAY GRADE		5. SEX
16	17	18
CIV		M

6. DATE OF BIRTH (Y Y Y Y M M D D)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	
—								2	4	Y	X	9	MUSLIM.

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER								
32	33	34		35	36	37	38	39	40	41	42	43	44	45
—			—	9	9	B6-4 [redacted]								

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	46: U	1735	—

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
—			K	7	B	—								

17. UNIT LOCATION (State or Country Code)		18. MOS							19. TRAUMA	PREV. ADMISSION
62	63	64	65	66	67	68	69	70	71	YEAR ☒ NO
—		—							1	

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: Ø	ICU-1	—

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] BZ-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: —

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (Y Y M M D D)					
73	74	75	76	77	78	79	80	81	82	83	84	85	86
2	6							0	3	0	6	2	5

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (Y Y M M D D)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102
A	B	A	A							0	3	0	6	1	6

27. LOCATION OF OCCURRENCE (Battle Casualty Only)		28. MTF OF INITIAL ADMISSION						29. DATE INITIAL ADMISSION (Y Y M M D D)					
103	104	105	106	107	108	109	110	111	112	113	114	115	116

FOR LOCAL USE

DX: S/P GSW TO BACK / PTX (L)

Dx: 86130 Pr: 8345(9)
E601
E9912

Inj Trauma
450 1

ADMITTING OFFICER (Sign[redacted]

DR [redacted] 4797

SI[redacted]

B6-2

B6-2

DA FORM 2098

INPATIENT TREATMENT RECORD COVER SHEET

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

REGISTER NUMBER: 0013508	2. NAME (Last, First, MI): UNK - EPW			3. GRADE: EPW	ADMISSION REMARKS
4. SEX: M	5. AGE: 33y	6. RACE: X	7. RELIGION: MUSLIM	8. LENGTH OF SVC: –	9. ETS: –
10. PREVIOUS ADMISSION: NO					
11. SSN: 2099 [redacted]	12. ORGANIZATION: –			14. WARD: ICW2	
15. FLYING STATUS: –	16. RATING: DSG –	17. BEN: K78	18. BRANCH/CORPS: B6-4 –	19. UIC/ZIP: –	20. TYPE CASE: WIA.
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: DIRECT FROM ER.				22. HOURS OF ADMISSION: 1610	23. CLINIC SERVICE: AEAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: –			25. TYPE DISPOSITION: DC TO EPW CAMP	26. DATE OF DISPOSITION: 26 JUN 03	
27. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): –			27a. TELEPHONE NO.: –	28. DATE OF THIS ADMISSION: 16 JUN 03.	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] B2-2				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. CAUSE OF INJURY: UNK.

☐ Check if Continued on Reverse

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW TO L DISTAL HUMEROUS

812 40 PR
E991.2 78.12

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
0	0	6	0	10	10

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. [redacted]	f. TOTAL SICK DAYS

SIGNATURE OF ATTENDING MEDICAL OFFICER: DR. [redacted]

DA FORM [illegible]

B6-2

[redacted]

B6-2

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

3½ YO GDW WITH GSW TO (L) DISTAL HUMERUS, OPEN, COMMINUTED FRACTURE

PMH - Ø
PSH - Ø
IND MEDS
NKDA

LAST P.O. - 1100

PHYSICAL EXAMINATION

NAD
HEENT - BT/NL
NECK - SUPPLE
CHEST - BT
EXT - (L) ARM LARGE WOUND OVER LATERAL DISTAL HUMERUS, BONE MISSING, FRAGMENTS NOW APPEARS NAILED

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

XRAYS - COMMINUTED DISTAL HUMERUS FX
(A) OPEN #1 (B) (L) DISTAL HUMERUS FRACTURE
(P) I&D IN OR

[redacted] B6-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	16 JUN 04		

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

REGISTER NO.	WARD NO.

GDW [redacted]
B6-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975 539-106

MEDICAL RECORD	PROGRESS NOTES
DATE	
18 June 03	0740 Assumed pt care @ 0800. Pt awake and alert
	VSS. HL to (R) hand - no s/s redness/infiltration c̄ flush.
640 T99.9	C/O pain to (L) arm. Tylenol #3 $\frac{\text{02}}{\text{11}}$ adm. @ 0720. Ex fix
P99	and ace wrap to (L) arm intact, dry red drainage noted
R18	on dsg around pins. Radial pulse palpable, (+) sensation
BP 124/80	(+) movement cap refill < 3sec to (L) hand. HR regular. Lungs
98%	CTA throughout. Abd. flat, soft BS x4 active. Pt amb.
	to BR $\bar{5}$ difficulty. Waiting for swing and swath from
	PT. Will continue to monitor. [redacted] B6-2 AWMC
	1145 Sling and Swath applied while pt
	awake. Sling and swath for comfort [redacted] B6-2 AWMC
June 03	Pt vitals taken. BP 122/78, P. 76, R. [redacted] Temp. 99.8
320	SPC [redacted] B6-2
June 03	VSS. pt care assumed @ 1300. pt resting quietly easily
1330	aroused to verbal stimuli. Assessment WNL. HL to
	(R) UA (-) redness noted. (L) arm c̄ ext fix wrapped c̄
	ace wrap. good cap refill, pt able to move fingers
	(L) arm also c̄ swing et swath. (-) C/O pain or
	discomfort voiced @ this time. Will cont to monitor
	[redacted] AWMC
	B6-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

EPW # [redacted] b6-4

PROGRESS NOTES

DATE	
6-18-03	
2200	Pt. care assumed @ 2100. Temp 100.4. Pt. c/o pain (L) arm. T3 1/1 given for temp & pain. HR RRS, Lungs CTA, ABD soft & BS (+) X4. Ex Fix to (L) arm intact, dsng CDI. Pt. has (+) sensation, (+) ROM fingers to (L) arm & pulse at & cap refill <3sec. Will cont. to monitor. — BG-2 [redacted]
19 June 03 0700	Pt. awake & alert in bed. VSS. HL in (R) hand s sign of infection. Pt has ext. fixator on (L) humerus. Bright red blood noted & marked on ace wrap.
0615 T98.9 P 84 R 12 BP 100/82 98%	MD came in this AM & had pt. be NPO for OR this AM. Pt says that his pain is very "little". Cap refill on (L) hand ≤ 3 sec. All other assessment findings WNL. Will continue to monitor. — BG-2 [redacted] BLT/AN
	Critical Care Note:
19 JUN 03	Pre-Op Dx - Open (L) humerus fracture Post-Op Dx - same Procedure, I&D/wash OPC (L) arm Surgeon [redacted] EBL - 30 cc BLV: 500 LR Findings - Wound clean, [illegible] Brachialis muscle closed with O-vicryl, pt. skin closed 3-0, Fixator tightened [redacted] BG-2
0800	Pt. to OR via litter. — [redacted]
1100	Pt. back from OR via litter. Tolerated procedure well. VSS. Dressing to (L) humerus CDI. — [redacted]

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

All B6-2 (except last)

MEDICAL RECORD	PROGRESS NOTES
DATE	
19Jun03 2030	assumed care @1300-VSS-IV HLd, tolerating fluids and regular diet-dsg intact on (L) arm, arm slinged while in bed (L) hand swollen, elevated while lying down-no c/o pain this shift-ambulated x3 this shift [redacted] CR
20Jun 0130	Pt care assumed @2100. VSS, alert and awake, no c/o pain. Lung sounds CTA, bs(+)x4, pulses palpable x4 quads. Heplock patent, IV abx infusing. Dsg on LUE c ext fix CDI, (+) sensation, + ROM on LUE. (L) hand swollen, elevated while pt resting. No complaints, will continue to monitor. SPC [redacted] allwm6
20Jun03	0900-Pt alert + awake in bed. Lungs CTA, HRreg, BS(+), Dsg to LUE c ext fix CDI (+) sensation cap refill <3 sec, able to wiggle fingers. Edema noted to extremity. Voiding ø complaints. Will cont. to monitor [redacted]
20Jun03 1800	assumed care @1300-VSS-arm in sling as ordered (L) hand remains swollen, elevated on pillow-IV patent-ambulated this shift-[redacted] medicated for pain c Tylenol #3 ii tabs c good results [redacted]
20Jun03 2015	PT in to see pt. B did PROM c (L) [redacted] hand and elbow [redacted]

(Continue on reverse side)

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

REGISTER NO.

SCW2

EPW [redacted]

B6-4

PROGRESS NOTES
Medical Record

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

F111 B6-2

PROGRESS NOTES

DATE	
2215	Pt care assumed @ 2100. VSS, alert and awake w/o complaints at this time. Lung sounds CTA, pulses palpable x4, bowel sounds present x 4 quadrants, LUE dsg CDI, ⊕ sensation and eom ⊘ c/o pain. HL flushes well, will continue to monitor. SPC [redacted] 91L M6
21 Jun 03	0742 - Pt. alert + awake lying in bed voicing no complaints at this time. Lungs CTA, pulses palpable x4, BS⊕, HR reg. Dsg CDI to LUE, ⊕ sensation, cap refill <3 sec, able to move fingers. ⊕ hand remains swollen. HL patent in ⊕ hand. Will cont. to monitor. [redacted]
21 June 03 1430	assumed pt care @ 1300. pt resting c̄ eyes closed. assessment findings WNL. LUE c̄ ext fix drsing CDI c̄ swing et Swath. BLE c̄ full ROM ⊕ pulses RUE c̄ full ROM ⊕ pulse. HL PCTA ⊘ redness or edema noted. ⊘ c/o pain voiced @ this time. Will cont to monitor [redacted] 91WM6
2120	Pt care assumed @ 2100. VSS, alert and aware without c/o pain. Lung sounds CTA, pulses palpable x4, bowel sounds present x4 quads. HL @ RAC flushes well. LUE dsg CDI, no c/o pain, ⊕ sensation and capreffill. ⊕ hand edematous, elevated and pt instructed to wiggle fingers to help decrease edema. No c/o at this time, will continue to monitor. SPC [redacted] 91L M6
0315	4mg MSO4 given for pain in LUE. Will continue
22 Jun 03	to monitor. Spc [redacted] 91L M6

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

All B6-2 (except last)

MEDICAL RECORD	PROGRESS NOTES
DATE 22 June 03 0700	Pt. sleeping in bed easily aroused by verbal stimuli. HL to (R) hand 3 s/s infection. Dressing to (L) humerus CDI, cap refill <3sec, fingers ± full ROM, sensation present in all digits. Pt. is been NPO since MN, on call for OR. Pt. has no apparent complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted]
1430	Assumed care of Pt @ 1300. VSS. AO x 3. ± pulses (B) UE. (L) UE Ex Fix/drsg CDI. Ø c/o pain. (+) 1 Edema (L) hand. (+) sensation, cap refill <3sec, mvt of fingers (L) UE. (R) Hand PIV, HL, flushes well. Ambs ± assistance to BR O/A assessment WNL. Will Monitor [redacted]
2120	Pt. care assumed @ 2100. VSS. ROM performed to (L) hand. Swing/swath removed for shrep. (L) Ex-fix intact. Mild edema noted to (L) hand. Brisk cap refill ± pulse 2+, (+) sensation. HR Reg, lungs CTA, ABD soft ± BS (+) X4. Will cont. to monitor. [redacted]
23 Jun 03 0900	Pt. sleeping in bed easily aroused by verbal stimuli. Dressing on (L) humerus CDI, cap refill <3sec, sensation present, (+) ROM, brachial pulse weak but present. HL in (R) hand 3 s/s infection. All other assessment findings WNL. Pt. has no complaints @ this time. Will continue to monitor. [redacted]
1350	Assumed care of Pt @ 1300. VSS. AO x 3. Ø c/o pain. (+) UE Ex Fix/drsg CDI. Sling applied. (+) sensation, mvt of grip, palpable pulse, cap refill <3sec. (L) hand. (+) 1 Edema (L) hand. Ambulate ± assistance. (R) hand PIV patent O/A assessment WNL. Will Monitor [redacted]

(Continue on reverse side)

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

EPW

[redacted] B6-4

REGISTER NO.

WARD NO. ICW2

PROGRESS NOTES
Medical Record

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

All B6-2

PROGRESS NOTES

DATE	
0100 24Jun03	Pt care assumed @2100. VSS, a+ox3, ∞ T3 given for pain in LUE. Lung sounds CTA, pulses palpable x4, bs⊕x4 quads. Dsg on LUE CDI, ⊕ sensation, ⊕ ROM. Edema has decreased in (L) hand. HL flushes well, will continue to monitor. SPC [redacted] 91WM6
24Jun03	0820 - Pt alert. OOB x1, VSS, lungs CTA, HR reg, BS⊕, Ext fix & Ace wrap to (L) arm. ⊕ sensation cap refill <3 sec, warm to touch. No drainage noticed. Some bruising to upper back of arm. Voicing Ø complaints. Will cont. to monitor - [redacted] 2Lt AN
24Jun03	0900 pin sites/wound clean + Dry pin sites/ H2O2 1/2 sol BID DSOAS / Pin Care
	[redacted]
24Jun	1025 - Dsg s/d to (R) arm. Clean [redacted] H_2O_2 1/2 strength. Dsg reapplied CDI. - [redacted] 2LT AN
24Jun03 1420	assumed care @1300, VSS, dsg intact on (L) arm, sling in place - pt. doing ROM @ wrist & elbow, no c/o pain @ this time, ⊕ 2 pulse in (L) arm - pt. ambulating to BR is difficult - [redacted] CB, A

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

All BG-2 (except last)

MEDICAL RECORD	PROGRESS NOTES
DATE	
24Jun03 2200	Pt care assumed @2100. VSS, alert and awake, c/o small amount of pain in LUE. lung sounds CTA, pulses palpable x4, BS(+)x4. Dsg on LUE CDI, (+)pulse and sensation. Dsg Δ to be done @2300. HL flushes well, will continue to monitor. [redacted] 9LWMG
24Jun03 23:11	C/o pain w/ Tylenol #3's given will mon [redacted] DEW/AD
25Jun03 0100	Dsg Δ done, bloody drainage and serous drainage noted. Pungent odor noted, will continue to monitor. [redacted] 9LWMG
25June03	0520 Assume pt care @ 0500. Pt awake and alert. pt c/o pain to RUE. VSS. HR reg. lungs CTA. BS x4 active. pt ambulates w/ difficulty. LUE ex/flex and ace wrap CD&I. (+) sensation (+) movement to (R) hand. PO Tylenol #3 adm for pain. Will cont to monitor. [redacted] 9LWMG
	0520 HL to (R) hand no s/s redness/infiltration c̄ flush [redacted]
	1050 Dsg Δ @ 1000. pins cleared c̄ H_2O_2 and sterile water. Red drainage noted to lower pin. Wire Continue to monitor [redacted] 9LWMG

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] BG-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE

[illegible] Transw/ DLC NOI

[illegible]

Traff EPW c̄ GSW @ Am

Pt supracondylar Dist th

Underwent Bx fx, IAD & DPC

@ Am [illegible]

WCMA & Pt Pins [illegible]

Pt Alignment Good

Plan) Ex fix 6-8 weeks from LAC

For TMO

Pt Dec

Pincare Hydrocodone 1/2 [redacted]

Tylenol [illegible] B6-2

1515 PT NOTE

HX: ROM @ E|W|H

T/M: PNT ALERT. GMM ~ 3/5. PNT DENY LOSS|↓ SENSATION TO AREA. PNT MINIMAL AROM.

PNT ~ 5°-85° ELBW FLEX|EXT, ~ 60° WRIST FLEX, ~ 5° WRIST EXT, ALL AROM. FPROM.

AROM DIP, PIP, MCP WNL. PNT ABLE COMPLETE HEP'S E VISUAL DEMONSTRATION. HEP'S:

@ E|W|H FLEX|EXT, PRO|SUP, UD|RD, PIP, DIP, MCP X 10 REPS EACH. PNT DENIED ↑ PAIN

C̄ RX.

DX: ROM

I: SAME

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

All B6-2 (except last)

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 JUN 03 1700	Pt admitted from EMT @ 1615. via [illegible] VSS x mild temp. A+Ox3. D/C'd (L) hand IV cath intact. New IV started (L) FA, patent LR @ 100cc/hr. (L) UE Dressing saturated - new blood, re-enforced, wound bled through. Cap refill < 3sec, (+) sensation (L) UE. Awaiting OR. D/W assess w/ RN will monitor [redacted]
10 JUN 03 1945	Office Op Note: Pre-Op Dx: Open Grade III (L) distal forearm fracture. Post-Op Dx: [redacted] Procedure: I+D (L) distal forearm with reduction of external fixation. Surgeon: [redacted] Anesthesia: MAC. Findings: Moderately comminuted intra-articular distal forearm fracture. Wound clean. x-fix applied, good position [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE [redacted]	S 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.

EPW [redacted] B6-4

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

A11 B6-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Jun 03 0300	Pt care assumed @ 2100. VSS, pt resting awoken by verbal stimuli w/o c/o pain. Lung sounds CTA, pulses palpable x4. IV @ RFA heplocked, heplock flushes well. Dressing to LUE saturated c̄ copious amounts of blood. LUE → D dsg Δ, [redacted] 4mg MSO4 given during dressing Δ. Wound is red, very bloody. Pt has swing and sweat due when he awakens. Very cooperative, will continue to monitor. SPC [redacted] 91LM6
17 Jun 03 1100	Assumed care of pt @ 0500. Pt is asleep. VSS. Lungs CTA. Bowel sounds x4 quads. HL (R) arm - patent. Pt has ext. fix (L) arm. Dry and intact. Pt ~~give~~ can wiggle fingers. Pt has ø c/o pain/discomfort @ this time. [redacted] 91WM6, SGT
17 June 03 1330	Pt. vitals taken BP 112/68, P. 76, R. 16, Temp 97.6 [redacted]
17 June 03 1350	Assumed pt care @ 1300. pt awake & alert. VSS. Assessment WNL. RUE c̄ ext fix. drsng CDI. pt able to wiggle fingers, good cap refill. HL to (R) hand Δ s/sx of infection noted. Δ c/o pain or discomfort noted @ this time. Will cont to monitor. [redacted] 91WM6
2300	Pt. care assumed @ 2100. VSS. AK Reg, Lungs CTA, BS (+) x4. Ex Fix to (L) UE intact. Ace wrap CDT. Drsng underneath Ace wrap is saturated around pin sites. Pulses 2+ in (L) radial artery c̄ brisk cap refill. Will cont to monitor. [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

NSN 7540-00-634-4176

600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Transfer Summary
26 July 03	53yo Iraqi EPW
	GSW Fx Supra Condylar Distal Humerus
	Underwent I&D, External Fixation and repeat washouts & Delayed primary closure of wound
	Pin sites clean & dry
	Lateral Arm wound clean & dry
	Stable for Transfer to Iraqi Hospital.
	Plan) Pin Care ½ strength H_2O_2 BID
	Ancef 1 gm IV Q8° x 48°
	then Keflex 250 QID x 10 days
	Tylox prn pain
	Remain ex fix 1-15 Aug
	and change to Long Arm Cast

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT: [redacted] B6-2

PATIENT'S NAME *(Last, First, Middle initial)* [redacted] SEX

RELATIONSHIP TO SPONSOR [redacted] RANK/GRADE

SPONSOR'S NAME ORGANIZATION

DEPART./SERVICE | SSN/IDENTIFICATION NO. | DATE OF BIRTH

All BG-2 (except last)

NSN 7540-00-634-4178

600-108

HEALTH RECORD Progress ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~ Note

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
25 JUN 03	1430 Assumed care of Pt @ 1300. VSS. A+O x3. Ex F, IV/Drsg (L) UE c̄ Dried Bloody drainage, intact, (L) hand (+) Edema, (+) pulse, tmt, warm, cap refill <3 sec. Pt c/o pain. Cont. PT. c/w assess. WNL. Will monitor [redacted]
2330	Pt care assumed @ 2100. VSS, AOX3, c̄ T3 given for pain. Lungs CTA, pulses palpable x4, b/t x4 quads. Dsg to LUE Δ'd. Wound had bloody and serous drainage noted at lower pins site. Pt c/o pain during dressing Δ (+) ROM, pt able to wiggle fingers on LUE. No complaints at this time, will continue to monitor. [redacted] assume
26 Jun 03	Assumed care of pt @ 0500. VSS. Pt is being ward to an Baqi hospital this am. Pt has a 3 day supply of dsg changes. Pt has 0 % pain/ discomfort @ this time. [redacted], LPN, 86F

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

EPW

[redacted]

BG-4

RECORDS MAINTAINED AT:		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 11137

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
25 JUN 03	PT NOTE (CON'T)
	G: 1 PNT STRENGTH DEL/W/H TO ~ 3+/5 X 2 wks.
	SPC [redacted]
	SILVIONA PT TECH

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

558-103

(See Instructions on Back of this Sheet) B2-2

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Specify) [redacted]

LOG NUMBER

ARRIVAL			
DATE			TIME
DAY	MONTH	YR.	
16	JUN	03	1520

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): ☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (Include immunization and other data): denies

HISTORY OBTAINED FROM: ☒ PATIENT ☐ OTHER (Specify) thru transla

ALLERGIES: NKDA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW left upper

SEX: M AGE: 33

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME	1520	1545	
BP	138/74	117/77	
PULSE	85	95	
RESP.	14	16	
TEMP.	100'		
WT. (Child)			

CATEGORY (See reverse)
- ☐ EMERGENT
- ☒ URGENT
- ☐ NON-URGENT

ORDERS	INITS.	TIME
IV. WR	[redacted]	1530
CBC/Met 8		
Ancef + gm	[redacted]	1540
MSO4 5mg	[redacted]	1533

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

S: GSW to left upper arm bleeding controlled c pressure dressing. No other complaints. Good PMS distal to injury.

O: B6-2 [redacted]

Via interpreter = stealing & got shot.
no other complaints.

PMHX Ø
PSHX Ø

(O) VAD
Lungs = CTA (B) Sounds
ABD = BS
(L) upper arm = Lateral open laceration
distal pulse = Intact.
Sensation = Intact.
deformity humerus.

x-rays humerus (L)
Fx complete

ASSESSMENT/DIAGNOSIS: Open Fx humerus GSW

DISPOSITION (Check all that apply)
- ☐ HOME ☐ FULL DUTY
- QUARTERS: ☐ 24 Hrs. ☐ 48 Hrs. ☐ 72 Hrs.
- MODIFIED DUTY UNTIL: DAY / MONTH / YEAR
- REFERRED TO (Indicate clinic)
- ☐ EMERGENCY ☐ TODAY
- ☐ 72 HOURS ☐ ROUTINE
- ADMIT. TO HOSP. UNIT/SERVICE: Ortho / 6W2

CONDITION UPON RELEASE
- ☐ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE:

B6-2

(CONTINUE ON SF 507, IF NEEDED) [redacted] MAJ, MC [redacted] FAMILY PRACTICE

PATIENT'S IDENTIFICATION (Mechanical imprint) FOR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

SIGNATURE OF PROVIDER AND ID STAMP

INSTRUCTIONS TO PATIENT (Include medication [redacted] any limitations and follow-up plans)

#[redacted] B6-4

EMERGENCY CARE AND TREATMENT

MEDCOM - 11139 py

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 33

HEIGHT:

WEIGHT:

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY ☒ NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
I+D (L) arm GSW, Possible Ex-Fix (L) Humerus

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco____ppd X___yrs. Body Piercing_____ Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH_____ Implants_____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures_____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	Pt. verbalizes any specific anxiety. Pt. Exhibits relaxed body posture.	Allow pt. to verbalize freely. Explain OR environment and answer questions regarding surgery. Offer comfort measures. (e.g.. warm blanket. touch). Explain all nursing procedures before they are done. Remain with pt. whenever possible. Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia 3) Medical/Smoking History	Pt. will be able to breathe without difficulty during immediate intraoperative phase .	Offer to elevate head of litter or offer pillow. Observe pt. while awaiting surgery for signs of distress. Assist anesthesia during intubation and extubation.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids 4) Prosthesis ✓ 5) Pooling of Prep Solutions	Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	Utilize pressure preventing devices on OR table and accessories. Check for proper positioning and support to maintain good body alignment. Pad pressure points. Place ESU ground pad on non compromised skin surface area. Keep prep fluids from pooling.

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

EPW [redacted] B6-4
ICW2

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since 11am ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: 0

A11 B6-2

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. ✓ Place and take down legs from stirrups with slow bilateral motion. ✓ Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning 3) Arthritis	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. ✓ Potential for decreased communication due to. 1) Diminished Hearing ✓ 2) Language Barrier F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period.	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt. from either side. ✓ Validate pt.'s understanding of verbal communication. ✓ Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] CPT/AN 16 June 03 DATE

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☑ Sleepy ☐ Intubated
LEVEL OF ACTIVITY: ☑ Moves All Extremities ☐ Moves Upper Extremities
☑ Transferred to litter ~~with roller due to spinal~~ by OR staff
SKIN INTEGRITY: Bovie Pad Site: ☑ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT: (Y) (N)
BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] PT/AN
DATE: 16 June 03 TIME: 1730

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] MAJ AN
DATE: 16 June 03 TIME: 1949

REVERSE OF FORM 5179, JUN 91 USAPA V1.0

MEDICAL RECORD | **INTRAOPERATI OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] B6-2

3. DATE 19 June 03 TIME PATIENT ARRIVED IN SUITE 0925

4. PATIENT IN ROOM [redacted] TIME 0925 NUMBER 2-1 12

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: nkda

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] B6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] B6-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: correct body alignment maintained, 2 armboards utilized for left arm, position approved by surgeon + anesthesia

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

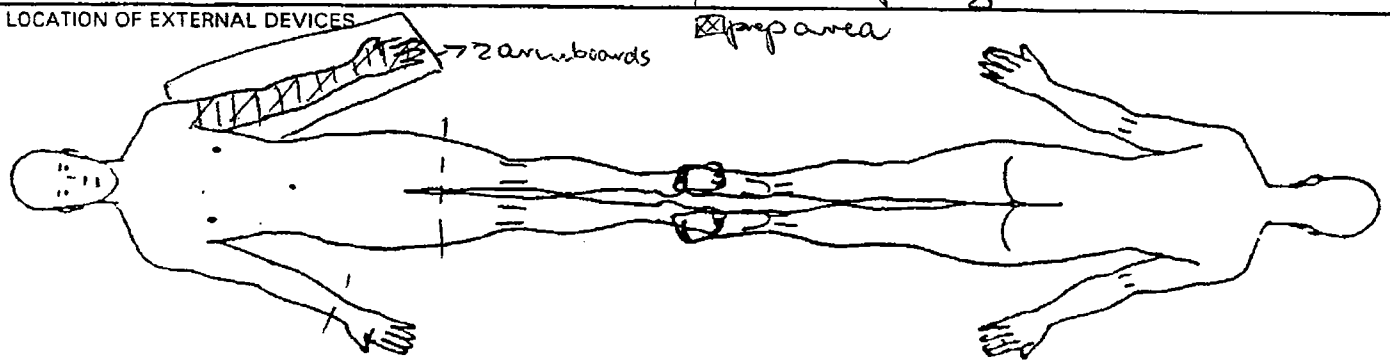
PREP SOLUTION *(Specify)* Beta / Beta

SITE: (1) arm BY WHOM: [redacted] B6-2

SITE: BY WHOM: CPT [redacted]

COMMENTS: no peeling or skin reaction noted

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 B6-2	CIRCULATOR B6-2
Sponge	☒ Yes ☐ No				[redacted]	[redacted]
Needle Sharp	☒ Yes ☐ No		C	C		
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

EPW # [redacted] B6-4

ICW-2

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

☐ ESU NO: _____

GROUND PAD: BRAND _____

LOT NO: _____

☐ ESU NO: _____

GROUND PAD: BRAND _____

LOT NO: _____

☐ BIPOLAR NO: _____

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
None

OTHER ORDERS	TIME	CARRIED OUT BY
none		
[redacted]		

PHYSICIAN'S SIGNATURE [redacted] B6-2

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
Airway

19. ADDITIONAL INFORMATION
Surgeon: [redacted] B6-2
Anesthesia: [redacted]

20. OPERATION(S) PERFORMED
I+D (L) Arm, wound closure

21. PATIENT TRANSFERRED TO
ICU-2

TIME See DA7389

METHOD
Litter & Safety [redacted]

22. REGISTERED NURSE SIGNATURE
[redacted] CPT IAN

All BG-2 (except last)

MEDICAL RECORD — **INTRAOPERA[illegible] DCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anes. Staff

2. PATIENT IDE[redacted]ED AND PROCEDURE VERIFIED BY [redacted] CPT. AN

3. DATE 16 Jun 03 TIME PATIENT ARRIVED IN SUITE ICW → OR

4. PATIENT IN ROOM TIME 1800 NUMBER 2-1 / 3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC. [redacted] 91D)	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT. [redacted] (66E)	RELIEF CIRCULATOR	ILT [redacted] CPT [redacted] MAJ [redacted] @ 0720

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Two arm board utilized to Lt. arm.

8. SKIN PREPARATION

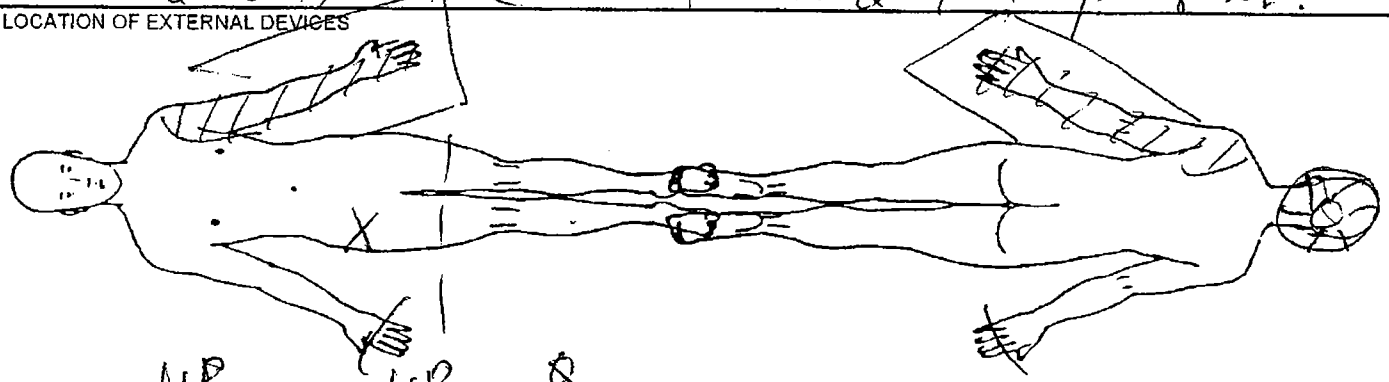
HAIR REMOVAL ☑ YES ☐ NO
DONE BY: ☑ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☑ RAZOR ☐ CLIP

COMMENTS: ⊗ Cuts noted

PREP SOLUTION *(Specify)* Betadine Sol. Sol
SITE: Lt. arm BY WHOM: CPT. [redacted] AN
SITE: ~ BY WHOM: ~

COMMENTS: ⊗ pooling of sol.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (AP) -- Safety Strap (LP) === Tourniquet (⊗)

C = Correct I = Incorrect

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

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

EPW. [redacted] BG-4
33 yrs.

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

☑ ESU NO: Valley Lab #4
GROUND PAD: BRAND Polyhesive II
LOT NO: 69652

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Cont 0009 130 Cut: 30

A11 B6-2

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☑ NO ☐ IF YES, SITE (Lt) arm

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs Xeroform around pins
Kerlix
Ace

19. ADDITIONAL INFORMATION

WC

Surgeons: [redacted] Anesthesia: CPT. [redacted] Anesthesia Type: Gen

Bovie Pad site intact pre-op Yes; post-op Yes Bovie Settings: Coag/Cut 30/30

20. OPERATION(S) PERFORMED

Lt. arm I & D, Hoffman Ex fix to humerus, LT

21. PATIENT TRANSFERRED TO ICU² TIME 1945 METHOD Litter/OR

22. P[redacted]E [redacted] PT/AN / [redacted] MA/AN

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 11145 USAPA V1.01

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY: 23 | 24 | 25 | 26 | 27 | 28 | 29

MONTH-YEAR June DAY

19 HOUR

PULSE (O) — TEMP. F (°) — TEMP. C (Centigrade Equivalents, for Reference only)

PULSE (O)	TEMP. F (°)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99° / 98.6°	37.2° / 37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

RESPIRATION RECORD

BLOOD PRESSURE: 130/90 | 130/80 | 120/80 | 120/80 | 110/72 | 120/80 | 130/80 | 110/70

HEIGHT: WEIGHT →

O2 Sats →: 97% | 98% | 99% | 98%

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7–95) BACK

EPW #[redacted] B6-4

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY: 1

POST- DAY

MONTH-YEAR: June 2003 — DAY: 16, 17, 18, 19, 20, 21, 22

HOUR

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)

180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT

Record special data only when so ordered

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

REGISTER NO.

WARD NO. IC W2

EPW# [redacted] B6-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.20

Ward/Section: E MT

REQUESTING PHYSICIAN: [redacted] B6-2

LAST, FIRST, MI: B6-4 [redacted]

DATE: 16 Jun 2005

TIME: 1530

CHEMISTRY RESULT
(Subject to the Privacy Act of

SSN/PSEUDO SSN: [redacted] B6-4

(i-STAT)

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

Misc. Chemistry

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

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	150	73-118 mg/dl
BUN	21	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
~~CK~~		39-380 u/l (M) 30-190 u/l (F)
NA^+	135	128-145 mmol/l
K^+	4.1	3.3-4.7 mmol/l
CL^-	106	98-108 mmol/l
tCO_2	22	18-33 mmol/l

(Piccolo) Metabolic Pa

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

(Piccolo) Liver Panel P

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

(Piccolo) Electrolyte

TEST	RESULT	REF.
NA^+		128-145
K^-		3.3-4.7 r
CL^-		98-108 r
tCO_2		18-33 m

REMARKS: No CK

REPORTED BY:

DATE:

LAB ID NO.:

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
versed	(mg)	2.5
MSO4	(mg)	4 2
Propofol	(mg)	150
	( )	
	( )	
	( )	
VOLATILE AGENT	% del	1.5 1.0 1.5 1.0 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6 — 2 — 2 — 2 — 6

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

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶ (1) (2) (3) (4)

LINE site		
18g RH	☐ Warmed	NS ——— 400
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE –

TOTALS	
2.5	
6	min
	TOTAL URINE
	Ø

FLUIDS – SUMMARY
CRYSTALLOID– 500
COLLOID– Ø
BLOOD– Ø

ASA STATUS: 1 2 3 4 5 E

BODY WEIGHT: 60 KG / LB

HEMATOCRIT: —

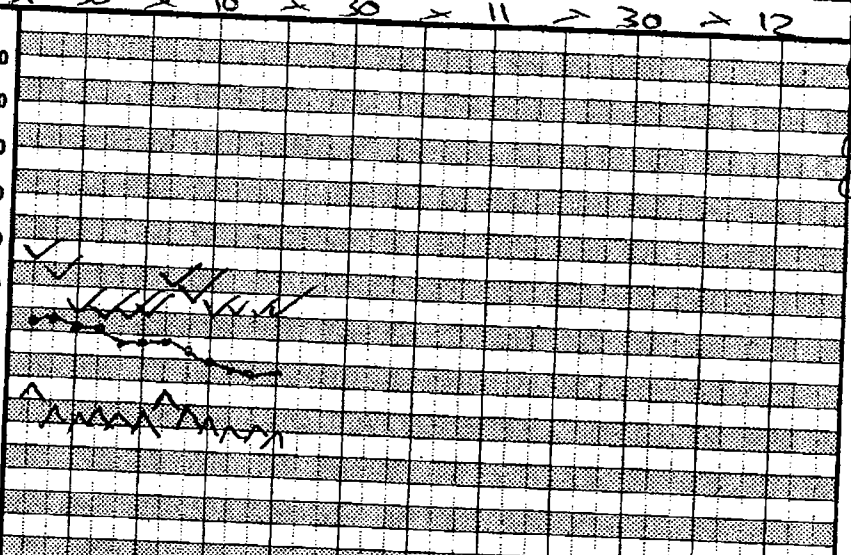
INITIAL DATA: BP – 133/78; HR – 102

EQUIP CHECK: OK? Y N

PATIENT READINESS: OK for PROCEDURE? ✓; TIME – 0910

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

TIME → 30 10 30 11 30 12



VT – ml	450	200	450	380	420
f – breaths/min	18	12	10	10	10
Peak inf pres / PEEP	—	—	—	—	—
MODE– S(pon), A(ssist), C(on)	S	S	S	S	S
✓ ET CO2 (torr)	50	50	50	47	44
✓ FIO2 (Frac or %)	0.7	0.7	0.7	0.7	0.7
✓ SpO2 (%)	100	100	100	100	100
✓ ECG	SR	SR	SR	SR	SR
TEMP- site axill					
N-M Block (T/4)					

✓ BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES; Gas analyzer; Warming blkt; Conv warmer

REMARKS – Code drugs with numbers, events with letters

Pt & chart ✓. OK to proceed.
(1) To room, SOC monitors, prel
(2) Smooth IV ind LMA insertion
(3) Zofran 4mg IV.
(4) Responsive LMA removed & diff. To recovery stabl Report given.

RECOVERY AT: PACU (ICU) (Specify); OTHER T – 96°

CONDITION: RESP – 19; SpO2 – 100; BP – 130/84; HR – 77

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0910	0920	1025
	Ready	Begin	End
PROC	0925	0945	1015

EVENTS — Mark with letters & symbols, explain under REMARKS — Position — 0 — 1 →

PROCEDURES and CPT Codes
① I&D Lt upper arm GSW
② DPC of same

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GLMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Eyes taped, #4 LMA placed w/ trauma, ⊕ ETCO2 BSEB. Secured soft bite block & tape.

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility
B6-4
EPW #[redacted]
35 yo ♂
ICW 2

SURGEONS: [redacted] B6-2

ANESTHETISTS: [redacted] RNA

PROCEDURE LOCATION: Z-1

DATE: 6/19/03

PAGE 1 OF 1

B6-2

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED ~~Jan 99~~

MEDCOM - 11149

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

ESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

35 DAYS MOS YRS

Sex (X) MALE ( ) FEMALE

ASA Physical State 1 2 3 4 5 E

WT: 60 KG/LB HT: ____ IN.

ALLERGIES: NKDA

PROPOSED PROCEDURE: I&D Lt Arm

SURGICAL SERVICE: [redacted] B6-2

TIME SINCE: 2400

S/P GSW

NTS:

TOBACCO: ____

ETOH: ∅

DRUGS: ____

CURRENT MEDICATIONS:

ordered as premed

∅

MEDICATIONS:

e Yes (@ ____ Hrs) /CC

____ mg IV IM PO

____ mg IV IM PO

____ mg IV IM PO

LABORATORY STUDIES:

HCT: ∅ /

IER: ____

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

Since prior OR

ASSESSMENT

PAST SURGICAL/ANESTHETIC

I&D, ex fix 6/16

PHYSICAL EXAMINATION

BP 122/82 HR 84 R 16 T 118

Pain Scale 0-10 2

HEENT - Teeth intact

Trachea ML

TMJ/Neck FROM

Oropharnyx MPZ

Nares N/A

CHEST: CTAB

CARDIAC: RRR

EXTREMITIES:

IV Access: 18g RH

Ulnar Filling: N/A

BACK: N/A

OTHER: N/A

NPO Since 2400

ESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (X) General: Mask/Intubation vs. LMA

brief re-counselling via interpreter

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

[redacted] nd and agrees. Questions answered.

B6-2 [redacted] CRNA Date: 6/19/03 Time: 0715 Hrs

[redacted] E (NON ASU) ATIONS { } OTHER

ned: ____ Date: ____ Time: ____ Hrs

ent Identification: (Ward) ICW2

Shot 16 June while stealing ammo

EPW # [redacted]

B6-4

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is n necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

B6-2 MAJ [redacted] - 8 mg MSO4 signed over to in ICU 2
NKDA

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML. "( )"=CONSTANT INFUSION

DRUGS	Units		TOTALS
Midazolam	(mg)	2.5	2.5
MSO4	(mg)	1 1 3 1 2 2 1 1	12
Ketamine	(mg)	80	80
Sux	(mg)	80	80
	( )		
	( )		
INHALATIONAL AGENT: ISO	% del / % e.t.	1.2 1.5 1.3 1.3 1.2X	
AIR	L/Min		
N2O	L/Min		
O2	L/Min	10 2 2 2 2 2 10	

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

TOTAL EBL: 100
TOTAL URINE: Ø

FLUIDS — SUMMARY
CRYSTALLOID– 900
COLLOID– Ø
BLOOD– Ø

FLUIDS
LINE site 18 (R) HD ☐ Warmed — #1 → 500 #2
Ancef 1gm ☐ Warmed — IVPB →
☐ Warmed
☐ Warmed

LOSSES
EST BLOOD LOSS — 100
URINE —

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

BODY WEIGHT: 60 (KG) LB

HEMATOCRIT: —

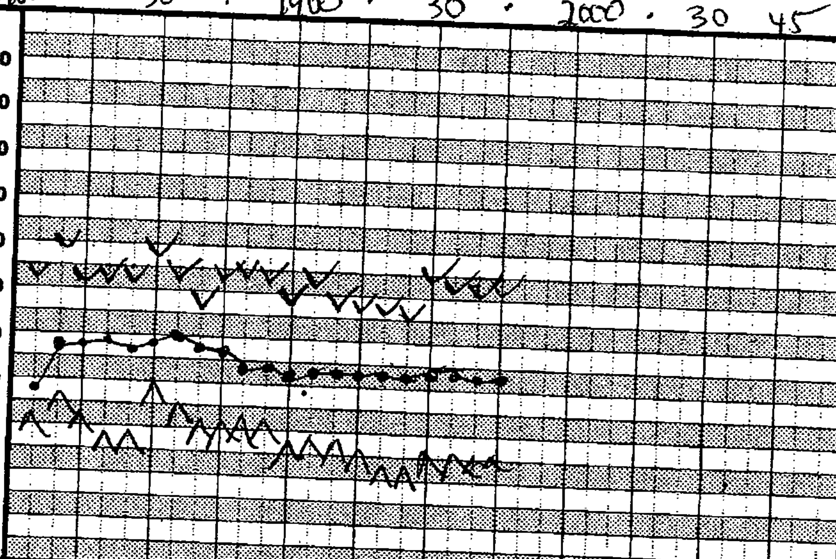
INITIAL DATA:
BP – 117/72
HR– 95

EQUIP CHECK
OK?– (Y) N

PATIENT IDENTIFIED OK for PROCEDURE? [initials]
TIME– 1740

TIME → 1800 · 30 · 1900 · 30 · 2000 · 30 45

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



REMARKS — Code drugs with numbers, events with letters

(1) Pre-op review & assessment.
(2) Room, monitors, 100% O2, cricoid, induced, eyelids taped; OG placed
(3) Reglan 10mg IV, Glycopyrrolate 0.2
(4) TV > 4mL/kg, RR > 8 & < 30 BPM, OP suctioned. Responsive, Extubated without complications
(5) To Litter & to ICU-2. Report to RN.
BP 129/71

VENTILATION

VT – ml	—	710	710	710	180-200	350	350	
f – breaths/min	—	8	8	6	16	12	12	
Peak inf pres / PEEP	—	15	16	16				
MODE– S(pon), A(ssist), C(on)	S-C	C	C	C	S	S	S	

MONITORS / ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	+ 33	34	34	45	48	49	
BP / oth	FIO2 (Frac or %)	0.51 0.51	0.47	0.46	0.47	0.50	0.50	
ART line	SpO2 (%)	97 100 100	100	100	100	100	100	
Steth- PC/ES	ECG	SR-ST	→	ST	ST	SR	SR	
Gas analyzer	TEMP- site Ax	→ Buccal - 100.1						
	N-M Block (T/4)		4/4					
	BS	+		+				
Warming blkt	Blanket x	→	→	→				
Conv warmer								

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

RECOVERY AT 1948
PACU (ICU) 2 (Specify)
OTHER T-97.6.
CONDITION: Stable, Responsive
RESP– 20 SpO2– 100
BP– 143/78 HR– 102

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1755	1800	1952
	Ready	Begin	End
PROC	1810	1829	1935

PROCEDURES and CPT Codes
I & D (L) arm - humerus & external fixation

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA
RSI c cricoid
8.0 OETT - stylette

AIRWAY MANAGEMENT: intubation route, blade, technique, comments
DL x1 Miller 2 grade 1 view 22cm @ lip, stylette removed, 9ml air in cuff, +BBS, sust ETCO2

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

EPW # [redacted]   ICU #2
B6-4   66 min

SURGEONS [redacted] B6-2
[redacted] CRNA/CPT
[redacted]CORD – ANESTHESIA
[redacted]C OP 376 REVISED
B6-2 MEDCOM - 11151 1 Jan 99

PROCEDURE LOCATION 2
DATE 16 Jan 03
PAGE 1 OF 1

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

PROPOSED PROCEDURE: I+D (L) humerus
SURGICAL SERVICE: ORTHO
NPO SINCE: 1100

ASA Physical State 1 2 3 4 5 E
WT: 60 KG/LB HT: ? IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: denies
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Ancef 1gm @ 1540
( )
( )
( )
( )
( )

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

LABORATORY STUDIES:

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

135 | 106 | 21
4.1 | 22 | 0.8 | 150

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			(✗ EMT record)
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	N/A
Other Significant Hx:	N	Y	GSW → (L) distal humerus
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION
BP 117/72 HR 95 R 16 T 100.1
Pain Scale 0-10
HEENT - Teeth intact
Trachea midline
TMJ/Neck Normal / FROM
Oropharynx MP2
Nares patent
CHEST: CTA (B)
CARDIAC: RRR (-) R
EXTREMITIES:
IV Access: 18G (R) hand
Ulnar Filling:
BACK:
OTHER:

Stealing + was elicit by pt. (stealing ammo) NPO Since 1100

Pt. speaks no English, interpreter unavailable, discussed c̄ sign-language pt will have general anesthesia.

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

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

The pa[redacted]nd and agrees. Questions answered:
B6-2 Signed: [redacted] RNA/CP Date: 6/16/03 Time: 1723 Hrs

POST-AN[redacted] (NOW ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

EPW # [redacted] B6-4

SEDATION KEY:

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: EPW [redacted] B6-4

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 13

DATE OF ORDER: 16 JUN 03 | TIME OF ORDER: 1610 HOURS | LIST TIME ORDER NOTED AND SIGN

1. TO ICW-2
2. OPW (L) NUMBNESS [redacted]
3. CONTINUE - STABLE
4. VS - MONITOR
5. BLOOD WORK B6-2 [redacted]
6. NPO

PATIENT IDENTIFICATION: EPW [redacted] B6-4

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 13

DATE OF ORDER: | TIME OF ORDER: HOURS

7. PRE-OP FOR OR TODAY
8. MSO4 2-6 mg IVP Q 2 HRS PRN
9. ANCEF 1 GRAM IVPB Q 8 HRS
10. IV LR AT 100 cc/HR

B6-2 [redacted]

PATIENT IDENTIFICATION: EPW [redacted] B6-4

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 13

DATE OF ORDER: 16 JUN 03 | TIME OF ORDER: 1930 HOURS

1. RESUME PREVIOUS ORDERS
2. S/P X-RAY (L) NUMBNESS
3. IV LR AT 100 cc/HR, HEP LOCK WHEN TOLERATE P.O. WELL
4. REGULAR DIET
5. ANCEF 1 GRAM IVPB Q 8 HRS

PATIENT IDENTIFICATION: EPW [redacted] B6-4

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

DATE OF ORDER: | TIME OF ORDER: HOURS

6. TYLENOL 650 mg P.O Q 4 HRS PRN
7. TYLENOL #3 1-2 P.O. Q 4 HRS PRN
8. MSO4 2-6 mg IVP Q 2 HRS
9. SLING AND SWATH TO (L) ARM WHEN AWAKE
10. ~~ANCEF 1 GRAM IVPB~~ [redacted]

NURSING UNIT: 24 VS [redacted] | ROOM NO.: | BED NO.: [redacted] B6-2

6. 16 0300 [redacted]

DA FORM 1 APR 79 4256 24 VS REPLACES [redacted] 77. WHICH MAY BE USED. 6-28-03 2300

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] B6-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO.

DATE OF ORDER: 19 JUN 03 TIME OF ORDER: 0631 HOURS

LIST TIME ORDER NOTED AND SIGN

1. NPO
2. TO OR [redacted] B6-2 [redacted] B6-2 [redacted] B6-2 [redacted] 0655

PATIENT IDENTIFICATION

[redacted] B6-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO.: 13

DATE OF ORDER: 19 JUN 03 TIME OF ORDER: 1015 HOURS

1. RESUME PRE-OP ORDERS
2. S/P I-D, DPL (1) BOTH
3. VS - NORMAL
4. RESUME DIET
5. IV - 22 @ 100 CC/HR 2/100 2D02 WITH TOLOR K, KCL WITH
6. GIVE 1 GM IMPB PO STAT & 72 HOURS
7. CONSULT PT. TO BISON [redacted] ELBOW RDA BLEEDING PLEASE OVER [redacted] B6-2 — [redacted] 19 JUN 03

PATIENT IDENTIFICATION

EPW [redacted] B6-4

NURSING UNIT: ICW2 | ROOM NO.: 24 V/S | BED NO.: 13 0200 20 Jun 03 [redacted]

DATE OF ORDER: [redacted] TIME OF ORDER: 24 JUN 03 1000 HOURS

DSGD & PIN CARE 1/2 STR H2O2 BID 24 Jun 1025

PATIENT IDENTIFICATION

EPW [redacted] B6-4

NURSING UNIT: ICW2 | ROOM NO.: 24 V/S | BED NO.: 13 2200 24 JUN 03 [redacted] B6-2 [redacted] [redacted] JUN

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 72 [redacted] E USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] B6-4				25 Jun 07	2200 HOURS	
				Ok to D/C to Iraqi Hospital		[redacted]
				B6-2 — [redacted]		
NURSING UNIT	ROOM NO.	BED NO.				
	24V/S	2330	25	Jun [redacted]		[redacted] -B6-2
PATIENT IDENTIFICATION				DATE OF ORDER [redacted]	T [redacted] 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.				

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

TIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AN SIGN
EPW [redacted] B6-4			26 Nov	11 00 HOURS	B6-2 [redacted]
			OC NO D/C arrangements made		
			B6-2 [redacted]		
RSING UNIT	ROOM NO.	BED NO.			
ICW2		13			

TIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
epw [redacted] B6-4				HOURS	
RSING UNIT	ROOM NO.	BED NO.			
ICW2		13			

TIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
epw [redacted] B6-4				HOURS	
RSING UNIT	ROOM NO.	BED NO.			
ICW2		13			

TIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
epw [redacted] B6-4				HOURS	
RSING UNIT	ROOM NO.	BED NO.			
ICW2		13			

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 2001-479-200

ADMISSION A... CODING INFORMATION

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

1. REPORTING MTF	2. ...TF LOCATION (State or Country Code.)
A I I D I	I Z

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
b6-4 [redacted]	UNK - EPW	EPW	M

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

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	U	1610	— B6-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	K78	—

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
—	—	1	YEAR [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICW2	—

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] B2-2	—

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
—

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
Ø5		030626

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AEAA		030616

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

FOR LOCAL USE

DX: GSW TO (L) Distal humerous

Dx: 81251
E9912

Pr: 7961
8659
7812

Inj Trauma
443 1

ADMITTING OFF[redacted]

SIG[redacted]

DR. [redacted]

DA FORM [redacted] MAR 88 [redacted]

MEDCOM - 11157

B6-2

All B6-2 (except last)

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. 0 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18
16	[redacted]	VS-routine	06	✓		
			14	[redacted]		
			22			
			1			
16	[redacted]	Bedrest	06			
			14			
			22			
			1			
16	[redacted]	NPO	07			
			11			
			17			

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: s/p ex fix open (L) humerous fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted]

B6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

A11 B6-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo 6 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
16	[redacted]	admit to ICW2	16		1630	[redacted]	
16	[redacted]	condition - stable	done			[redacted]	
16	[redacted]	D/C to OR	16				

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

USAPA V1.00

All B6-4-4

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. 6 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 16	17	18	19	20	21	22	23	24	25	26	27	28	29
16Jun	[redacted]	IV LR@100cc/hr	5	/	[redacted]												
		HL when tolerating PO	13	/													
			21	/													
16Jun	[redacted]	Ancef 1 gram IVPB	8	/	[redacted]												
		Q8 hrs	16	/													
			24	[redacted]													
19June03	[redacted]	Ancef 1 Gram IVPB	8	/	/	/	/	[redacted]			/	/	—	—	—	—	—
		q8° x 72 hours	16	/	/	/	/				/	/	—	—	—	—	—
			24	/	/	/	/				/	/	—	—	—	—	—

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: S/P ex fix @ humerus

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: EPW # [redacted] B6-4

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

A11 B6-2

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. 6 Yr. 03

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													
16 Jun	[redacted]	MSO4 2-6mg	17 Jun	21 Jun	25 Jun											
		IVP q6hrs	4mg	4mg	4mg											
16 Jun	[redacted]	T3 ½-1½ PO	17 Jun 1420	2020	10	18 Jun	20 Jun	20 Jun 1800	23 Jun 6000	24 Jun	24 Jun 2310	25 Jun 1010	25 Jun 6000			
		Q4-6hrs prn														
16 Jun	[redacted]	Tylenol 650mg Q4hrs														
		prn														

USAPA V1.00

All B6-2 (except last)

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 6 Yr 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 16	17	18
16	[redacted]	LR @ 100cc/hr	06	✓		
			14	[redacted]		
			22	[redacted]		
16	[redacted]	ancef 1gm IVPB q8°	08	✓		
			16	[redacted]		
			24	[redacted]		

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: open (L) humerus s/p ORIF

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: EPW [redacted] B6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. 6 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
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	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -	B6-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
46 19	[redacted]	MSO_4 2-8 mg IVP q2°														
- - - -	- - - - -	pcn - pain														
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
- - - -	- - - - -															
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- - - -	- - - - -															

USAPA V1.00

All B6-2 (except last)

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. 6 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18	19	20	21	22	23	24	25	26	27	28	29
16 Jun	[redacted]	Regular Diet	5	/	[redacted]												
			11	/	[redacted]												
			17	/	[redacted]												
16	[redacted]	VS: ROUTINE	05	/	[redacted]												
			13	/	[redacted]												
			21	/	[redacted]												
16	[redacted]	Sling and swath to (L) Arm when awake	05	/	/	[redacted]											
			13	/	/	[redacted]											
			21	/	/	[redacted]											
16	[redacted]	Act: BED REST	05	/	/	[redacted]											
			13	/	/	[redacted]											
			21	/	/	[redacted]											
19	[redacted]	NPO on call to OR	05	/	/	/	[redacted]										
			13	/	/	/											
			21	/	/	/											
19 Jun 03	[redacted]	Regular diet	6	/	/	/	[redacted]										
			11	/	/	/	[redacted]										
			17	/	/	/	[redacted]										
24 Jun	[redacted]	Dsg Δ + Pincare ½ str H_2O_2 BID	10	/	/	/	/	/	/	/	/	[redacted]					
			22	/	/	/	/	/	/	/	/	[redacted]					

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: S/p ex fix (L) humerus

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION

EPW # [redacted]

B6-4

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

All B6-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo June Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
16Jun	[redacted]	Resume Previous Orders	16	—		[redacted]	
~~16Jun~~	[redacted]	~~Singoul Swathe to Dorm when awake~~	~~16Jun~~			See front	
19JunB	[redacted]	Consult PT to begin elbow ROM	19JunB	Done		[redacted]	
	-----	passive only.					
25	[redacted]	OK to D/C when arrangements made	when avail.				
25	[redacted]	OK to D/C to Iraqi Hospital					

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

33yo
EPW
Hemovac
m16
I+D
D Amp
Ext Fix

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date): 60 kg

Date: 16 JUN 03
Time In:
Allergies: Ø
Pre-op V/S: 117/72 95P
Procedures: I+D ⓒ Hemovac fx External fixation

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 900 Colloid
OR Output: UOP Ø EBL 100
Meds/Times: Cen 2.5 Versed / 12 mg MSO4 / 80 ketamine

Anclf 1800
Regian 1830

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History 6/40 24 ulcer

Time	1950	1955	2000	2005	2015	2030	2045
SaO2	100	100	100	100	100	100	97
FiO2 FM	10	10	10	10	10	10	Ø
Methods							
240							
220							
200							
180							
160							
140							
120	A	A	A		A		
100							
80	O	O	O	Ø A	O		
60	V	Ø			A		
40							
20							
RR	12	12	12	12	11		
T	97.6	98.8	98.6				
Time							
Pain (0-10)							
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	Ø	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1.5	1.5	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	.5	.5	1.5
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	10	11.5

Codes

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

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

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

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

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

PREPARED BY (Signature & Ti [redacted] (Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 16 JUN 03

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

B6-2

EPW

[redacted]

B6-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(D)		N/A	✓	<2sec	✓	✓
15'	~~L Arm~~			✓	<2sec	✓	✓
30'	~~R Arm~~		✓	✓	<2sec	✓	✓
45'							
60'							
90'							
D/C							

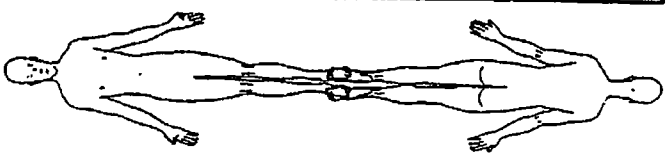
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(D) Arm ex-fix	kerlex/Ace	Ø
30'	(D) Arm ex-fix	~	around ulcer physiotherapy
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
N/A			

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
	SR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

From OR to ICU for recovery - stable vital signs - sleeping off - on - reminded not to pull of O2 mask - Resting quietly - no acute distress - [redacted] mas/mw
Report given to ICW 2 - pt stable - denies pain - CRT + color good
Sign. left Arm - [redacted] mas/mw
7.5mg morphine signed over to ICW [redacted] mas/mw

Discharge Criteria: meet
Date: 16JUN **Time:** 2049 **PARS:** 11/5
BP: 126/66 **T:** 98.4 **HR:** 85 **RR:** 12 **Sa02:** 97 RA
Pain Level at D/C (0-10): Ø
Intake: 100 **Output:** Ø
Additional Data:
Transferred To: ICW #2
Report Given To: [redacted] B6-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: CPT [redacted] B6-2
Cleared IAW Recovery Room [redacted]
Charge Nurse Signature: [redacted] CPT

B6-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

DTSG APPROVED (Date)

Date: 19 JUN 03
Time In: 1020
Allergies: NKDA
Pre-op V/S: 133/78, 102
Procedures:

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block LMA
OR Intake: Crystalloid 500 Colloid Ø
OR Output: UOP Ø EBL min
Meds/Times: versed 2.5mg/MSO4 6mg

AMA I

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds: History

Time	1020	1025	1030	1040	1115	1145
SaO2	100	99	100	100	99	99
FIO2	100	NC	3L	2L	RA	RA
Methods	UP	[illegible]	[illegible]	NC	/	/
240						
220						
200						
180						
160						
140	V	V	V	V	V	V
120						
100						
80	^	^	^	^	^	^
60						
40						
20						
RR	10	9	20	16	23	20
T	96		95	96	97	97
Time	1045					
Pain (0-10)	Ø					
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	11	12

Codes

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

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

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

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

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

(Continue on reverse)

B6-2 [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 19 JUN 03

Name – last, [redacted] or medical facility)

#[redacted] B6-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

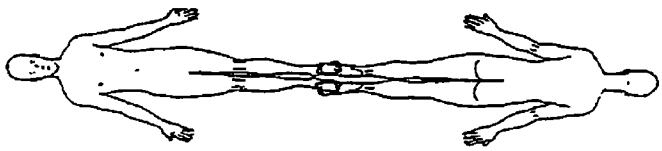
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

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



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES 1050 19 JUNE 03

Nemo sedated follows commands. Pupils Round equal Reactive. Resp CTA Ø distress NRB IDL SaO2 100%. Titrate ↓ TO 2L NC SaO2 100%. CV S1, S2 present NSR Ø ectopy Pulses 3+ Throughout. GI BS Hypoactive Abd SNT GU. Spontaneous. Skin Intact. LUE ex fix ⊕ Pulse Cap Refill ≤3 sec able to wiggle fingers. Pt calm and cooperative Ø pain at 7 this time [redacted] Nemo 1145 Alert. Resp CTA SaO2 > 98% RA. CV S1, S2 ⊕ Pulses 2+ - 3+ Throughout. GI BS Hypoactive x 4 GU Spontaneous. Pt transfer to ICW 2. Report Given to ICT [redacted]

Discharge Criteria:
Date: 19 JUN 03 Time: 1145 PARS: 12
BP: 136/83 T: 97.6 HR: RR: 20 Sa02: 99%
Pain Level at D/C (0-10): Ø
Intake: Ø Output: Ø
Additional Data:
Transferred To: ICW 2
Report Given To: ICT [redacted] B6-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Re[redacted] B6-2
Charge Nurse Signature: [redacted]

BG-4

1. LAST NAME, FIRST NAME / NOM, PRÉNOM: [redacted]

RANK / GRADE

MALE / HOMME ✓

FEMALE / FEMME

SSN / NUMERO MATRICULE

SPECIALTY CODE / GPM

RELIGION / RELIGION

2. UNIT / UNITÉ

FORCE / ELÉMENT

NATIONALITY / NATIONALITÉ

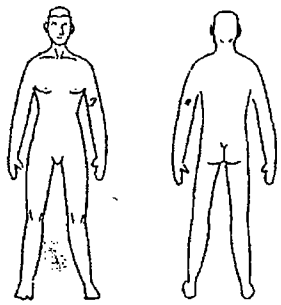
A/T | AF/A | N/M | MC/M

BC / BC | NBI / BNC | DISEASE / MALADIE | PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT

BACK / ARRIÈRE



- AIRWAY / TRACHÉE
- HEAD / TÊTE
- WOUND / BLESSURE
- NECK/BACK INJURY / BLESSURE AU COU/AU DOS
- BURN / BRÛLURE
- AMPUTATION / AMPUTATION
- STRESS / TENSION
- OTHER (Specify) / AUTRE (Spécifier)

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

- ✓ ALERT / ALERTE
- VERBAL RESPONSE / REPONSE VERBALE
- PAIN RESPONSE / RÉPONSE À LA DOULEUR
- UNRESPONSIVE / SANS REPONSE

5. PULSE / POULS | TIME / HEURE

6. TOURNIQUET / GARROT: NO / NON | YES / OUI | TIME / HEURE

7. MORPHINE / MORPHINE: NO / NON | YES / OUI | DOSE / DOSE | TIME / HEURE

8. IV / IV | TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

10. DISPOSITION / DISPOSITION

- RETURNED TO DUTY / RETOUR À L'UNITÉ
- EVACUATED / EVACUÉ
- DECEASED / DÉCÉDÉ

TIME / HEURE

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ

DATE/DATE (YYMMDD)

DD Form 1380, DEC 91

This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

INPATIENT TREATMENT RECORD COVER SHEET

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

B6-4

1. [redacted]	2. NAME (Last, First, MI) EPW [redacted] B6-4					3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE 35y	6. RACE Z	7. RELIGION unk	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION No	
11. FMP 99	12. SSN B6-4 [redacted]			13. ORGANIZATION N/A		14. WARD ICW2	
15. FLYING STATUS N/A	16. RATING/DSG	17. DEPT/BEN K78		18. BRANCH/CORPS N/A	19. UIC/ZIP	20. TYPE CASE N/A	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER	22. HOURS OF ADMISSION	23. CLINIC SERVICE: ABAA
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —	25. TYPE DISPOSITION: 05	26. DATE OF DISPOSITION: ~~6 Jul 03~~ 21 Jul 03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —	27b. TELEPHONE NO.: —	28. DATE OF THIS ADMISSION: 18 Jun 03
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] B2-2		30. DATE OF INTIAL ADMISSION

ADMITTING OFFICER: B6-2 [redacted]

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (L) arm
GSW (R) flank

Complication: Wound dehiscences

procedures
1. Exploratory laparotomy
2. Repair SB enterotomy
3. Exploratory laparotomy
4. Cholecystectomy
5. Closure of wound dehiscence
6. DPC old wound
7. I/D fx arm fx
8. ORIF (L) fx arm

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
0	0	0	0	20	20

36. Total Days All Facilites					
a. ABSENT SICK DAYS [redacted]	b. OTHER DAYS [redacted]	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
		0	0	20	20

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER: [redacted] B6-2

DA FOR [redacted] B6-2 PREVIOUS EDITIONS ARE OBSOLETE

MEDCOM - 11171

USAPPC V1.10

28th

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

33y.o Male Iraqi who brandished an AK-47 toward US soldiers who then fired. The pt received a left femur GSW w/ fracture and (R) flank GSW. C/O of diffuse abdominal pain. No LOC, weakness of extr.

NKDA

Tet ? ETOH ? | Meds ? | PMH ? | PSH ?

PHYSICAL EXAMINATION

ROS-
VS

Gen- Well-fed Male in AD. A&O x 3. HEENT- Head & neck ⊘ THROAT ⊘ LUNGS- CTA. ⊘ BS. HEART- RRR ⊖ (h) Abdomen- Rounded ⊕ BS, ⊕ guarding diffusely. ⊕ TTP. Back- GSW entrance (R) exterior spinal - Hematoma flank & (R) flank. MS- DEFL femur in splint. NV intact Neuro intact

PROGRESS (Enter date of discharge and final diagnosis)

A: GSW (R) Flank/(L) femur

P: OR for ex lap + fixation LLD Left Femur.

B6-2

[redacted] MD

	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	18 JUNE 03		

or written entries give Name last, first, e: date; hospital or medical facility)

REGISTER NO.	WARD NO.

EPW [redacted]

B6-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975 539-106

All B6-2 (except last)

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
18 June 03 1300	P - 130 MD notified T 100.9 MD aware no new orders. SGT [redacted] RN
18 Jun 03 1600	PT's T - 102.9 (Axe), PT AOX3, sweating. Dr. [redacted] notified and pt given orders for Tylenol 650mg PR. PT tolerated suppository. PT refused use of IS. Interpreter explained reason for use of IS and consequences of not using it. Will monitor for ↓ Temp. [redacted]
18 June 03 1717	Assumed pt care p day shift report. See critical care assessment sheet. LR @ 125 cc/hr via triple lumen, (R) nare nasal airway intact. NG tube to low intermittent suction, (R) hip & groin area has purple bruise noted. (L) Arm ≈ DSG CDI. Arm ↑ on pillow. Will monitor. Sgt [redacted]
1800	(R) hip DSG - Bloody drainage noted on DSG. DSG taken off. Small pin point area noted. No active bleeding noted. Will Monitor. Sgt [redacted]
1933	Pt coughed up min. amt sputum. SPO2 ↓ 88% 9L min O2 per face mask applied. Will Monitor. Sgt [redacted]
2218	Face mask taken off. SPO2 ↓ 90's. O2 @ 2L NC. SPO2 @ 95%. Will Monitor. Sgt [redacted]

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

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

REGISTER NO. | WARD NO.

EPW [redacted]

B6-4

MEDCOM - 11173

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD | PROGRESS NOTES

DATE

18 June 03 0600 pt transferred to ICW2 via stretcher from EMT — waiting to go to OR. Condition Stable. Vitals Stable — [redacted] SWM6

B6-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

EPW # [redacted]

b6-4

ICW2 BED #3

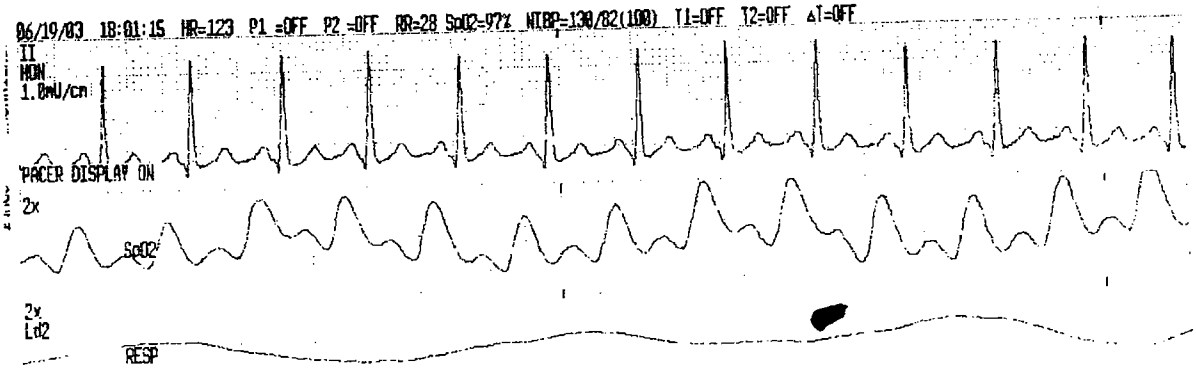
PROGRESS NOTES
Medical Record

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

All B6-2 (except last)

MEDICAL RECORD | PROGRESS NOTES

DATE	
19 June 03 1700	Assumed pt care p day shift report. See critical care assessment. O2@2L per NC. NG tube to inter. suction. Resting in bed a present time. Will Monitor. — Sgt [redacted]



1816	T. 101A Tylenol 650mg PR given. Will Monitor. — Sgt [redacted]
1905	T 100.4A. Will Monitor. Pt resting. (D) Arm deviated on blanket. — Sgt [redacted]
2131	2mg MSO4 IVP given for pain. Will Monitor — Sgt [redacted]
2200	Resting in bed. No c/o pain @ present time. Will Monitor — Sgt [redacted]
2445	MSO4 4mg given for pain. Will Monitor — Sgt [redacted]
0145	Resting in bed. Will Monitor — Sgt [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

#[redacted]

B6-4

MEDICAL RECORD | PROGRESS NOTES

DATE

19 June 03 1811

General Surgery

S: Pt awake, alert & responsive

Sitting up in chair Tody

O: Tm 102.2 (1800) Tc 99.1 P-115 BP 134/87

NGT - 400cc

I/O

IV - 25-37cc/hr

142/110 3.9/25 7.3 11.9/37.5 02

bloody

ABRT - RRRS (M) (Tachycardic)

LUNGS - Bibasilar rales Mix in well.

Abdomen - Bowel - ⊖BS - No distension. Any

tender

A: POD #1 Exp Lap - Repair thoracotomy. Stable hemodynamically

P: Continue Antibiotics and NGT - Ambulation - Monitor urine

B6-2

[redacted] MD
[redacted] MC USA
[redacted] F, DOS

20 JUN 03 @ 0545

Received report. Awake [redacted] and alert. [redacted] follows commands c̄ encouragement. Lungs c̄ rales bilaterally ↑↓. Pulmonary toilet complete. Still has difficulty with coughing. Use of incentive spirometer done. Abdomen: ⊖ bowel sounds x 4 Quads NG tube to ⊕ drainage to LIS. O2 via NC @ 2 Pt eyes appear to be yellow (Sclera) in Color.

(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 2

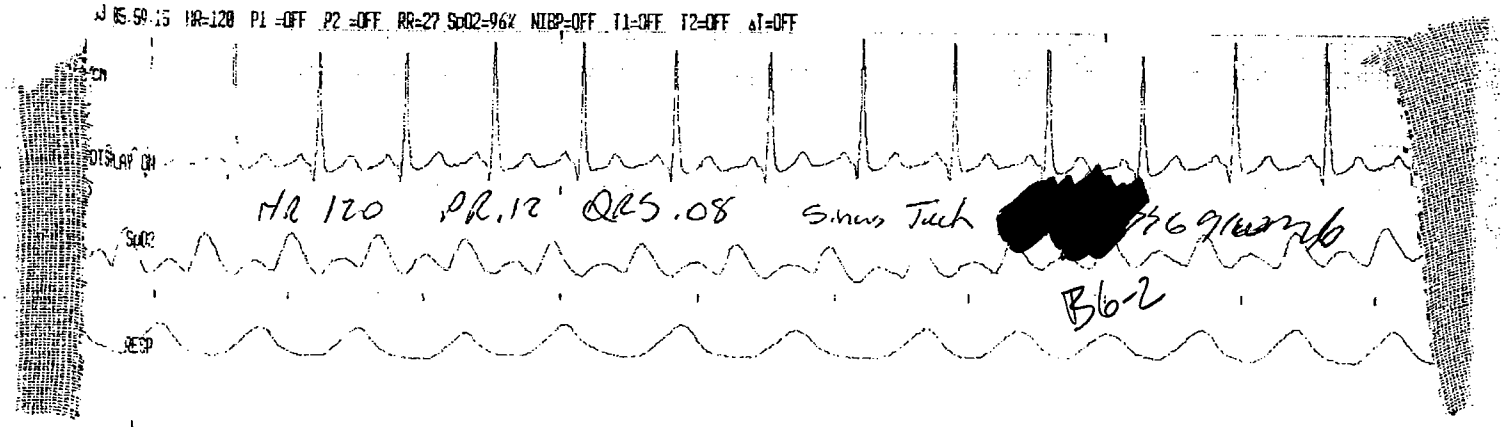
EPW [redacted]

B6-4

PROGRESS NOTES
Medical Record

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

FIRST NAME	MIDDLE INITIAL	ID NUMBER



19-Jun-03 05:30 Assumed care of Pt. Pt asleep, easily arousable to verbal stimuli, Pt is alert, verbal, able to convey needs c̄ help of interpreter. VS 100⁴-121-133/87-17-95% SpO2 on 2LPM O2 via NC. Pt assessment on DA form 4700 dated 19 Jun 03. Pt has (B) ↓ lung sounds at the bases. Will consult c̄ MD about NEB TX's or Chest PT. Pt refuses to use I.S. Will continue to monitor. — [redacted] B6-2

19-Jun-03 0700 Pt ↑ OOB to chair. Pt had medium assistance c̄ sitting up but was doing most of the work. VS 138/80-100³-127-26-96% on 2LPM NC [redacted]

9 Jun 03 0804 Neb tx given to pt. .5cc Alb/2.5cc NS BS Diminished HR 130 RR 45 SpO2 96 Post Tx No change to BS HR 130 RR 30 SpO2 98 — [redacted] B6-2

19 Jun 03 1400 PT's T 101.8(Ax). PT HR 130's-140. PT's lungs ↓ bases (B), (L) base clearer. Pt given 650 mg Tylenol PR. Will monitor for ↓ Temp [redacted]

19 Jun 1130 RT Neb tx given to pt .5cc Alb/2.5cc NS BS coarse Diminished in bases HR 140 RR 44 SpO2 95% post tx HR 137 RR 37 SpO2 97% BS No change — [redacted] B6-2

19-Jun-03 1627 Pt VS 100⁶-126-26-130/76-96% 2LO2 on RA 2LPM NC. Pt alert, verbal cooperative, ↑ OOB to chair x 2 today. Medicated for pain p̄ transfer to chair @ 1200. Lungs ↓ BS @ bases (B). Pt still refuses to use IS or TCDB. Pt continues nebs & PT. — [redacted] B6-2

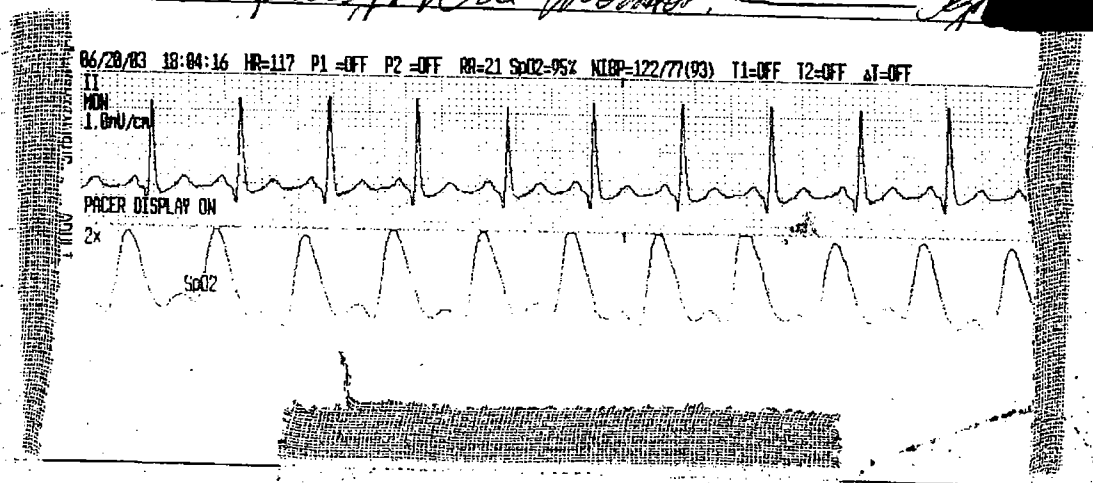
[redacted]

B6-4

B6-2 A11

PROGRESS NOTES

DATE	
20 June 03 1700	Cont. @ surgical beds. (L) Arm: DSG CDI. Chest/ABD DSG CDI. O2 @2L per NC. NG tube to low intermittent suction. NG tube to (R) nare. NG tube placement verified. LR @ 125 cc/hr via central line triple lumen. Foley patent draining clear amber urine to bedside drainage bag. Will monitor. — Sgt [redacted]



~~1908~~	
1908	MSO4 2mg given for pain. Will monitor. Sgt [redacted]
2008	Pt resting in bed @ present time. Sgt [redacted]
2345	Transported to CT per letter. Sgt [redacted]
2425	Pt transported back to ICU #2 from CT. MSO4 2mg given for pain. Will monitor. — Sgt [redacted]
1 June 03 0114	Pt resting @ present time. Will monitor. Sgt [redacted]
21 June 03 (0710hrs)	Assumed care of patient @ 0500hrs. Morning assessment is as follows: (Neuro): Alert & active in bed. Moves (B) LE's and (R) arm ≈ noted problems. Has limited ROM to (L) arm D/T (L) arm splint (dressing C,D,I). Capillary refill (L) hand < 3 secs; same for (R). No gestured or verbalized pain @ time of assessment. (HEENT): PERRLA ≈ pupils 3mm, brisk response. Neck supple. ~~Mouth~~ oral cavity WNL. (CV): Remains tachycardic (range: 104-120 depending on activity). No noted abnormalities. (L) subclavian triple lumen central line patent (dressing Δ tomorrow). (Resp): Lungs CTA ≈ some diminished breath sounds (B) lower lobes [redacted]

STANDARD FORM 509

All B6-2 (except last

MEDICAL RECORD	PROGRESS NOTES
DATE	
20 Jun 03 @ 1335	NG tube Placement Checked, not in place. NG tube advance 10cm. Placement checked c̄ 30cc Air. ⊕ gurgle tube taped in place. LABS: drawn MET 8 and liver panel. CT Abdomen pending. VSS. Will Continue to monitor. — [redacted] SGT 9/UMC —
1350	Awake c̄ occasional drowsiness, able to cough up sputum. follows commands & verbalizes need [redacted] SGT 9/UMC
1430	Request Water and something to eat. Status still NPO VSS. — [redacted] SGT 9/UMC
1445	LAB Result from Met 8 + LFT given to DR [redacted] & new orders — [redacted] SGT 9/UMC
1620	Stable. VSS. & complaints of Pain I+O's recorded. — [redacted] SGT 9/UMC —
1700	Assumed care of pt @ report from Day Shift. Eyes: PERRL @ 2mm. Verbal (+), alert, moves med Extrem. Resp: = chest & fall of chest bil. lung sounds clear ↑ & ↓ diminished. No secretions noted @ present time. Skin warm & dry to touch. Color appropriate for race. ® hip/thigh/groin area has purple bruise noted. ® on hip posterior has small entrance wound noted. No active bleeding noted. ® subclavian area central line triple lumen patent ∃ S/S of infection or infiltration noted. ABD soft non distended. ⊖ BS in all 4 quads. Cardiac: Tachycardic 120's @ present time. Pedal pulse present bil. ® Radial pulse present. ® unable to assess due to ISS. ® Fingers Rt Arm move. Cap. [redacted] <2sec.

(continue on reverse side)

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

EPW [redacted]

B6-4

REGISTER NO.

[redacted] NO. ICU 2

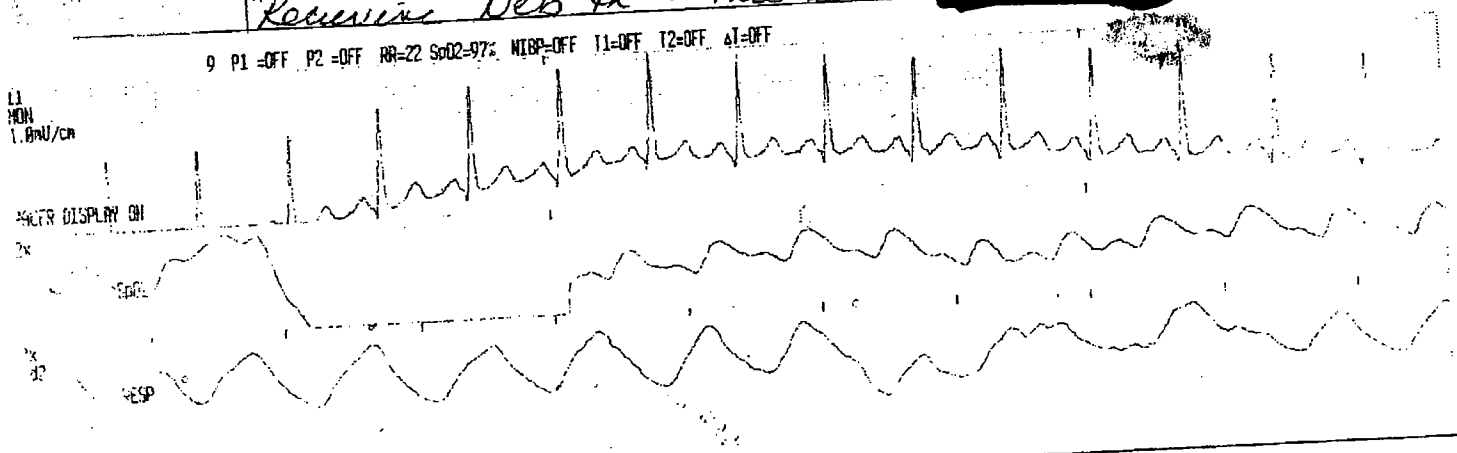
PROGRESS NOTES
Medical Record

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

A11 B6-2

PROGRESS NOTES

DATE	
20 JUN 03 @0545 (Cont.)	Foley to gravity draining clear amber urine. Serius Tachycardia @ 109. VS Normal for patient. afebrile. Skin color normal, warm & dry, has large bruise to (R) thigh. Abdominal drsg CDI. IV- Triple lumen (L) Subclavian flushed @ 3 port & heparinized all 3 ports patent. Medial port c̄ IVF of LR @125cc/hr infusing via pump c̄ difficulty. Ø Complaints of pain. Will Continue to monitor for Δ's in condition. Receiving Neb tx @ this time [redacted] SGT 91WM6



0950	C/o Pain, medicated c̄ toradol 30mg + 4mg MSO4. LAB: Chem8 obtained and sent to lab. OR here will go for I+d of (L) arm. IV Site intact. NGT Clamped. [redacted] SGT 91WM6
1235	Returned from OR via stretcher, asleep but arousable. Lungs c̄ bilateral rales. Resp. tx given. O2 SAts 99% @ present on 10L via Face Mask. VSS. (L) arm elevated c̄ DRSG CDI. (L) arm c̄ (P) NVC. IVF: Continue on LR @125cc/hr via (L) subclavian triple lumen. (-) Bowel Sounds. NG Tube place on LIS. Foley bag to gravity c̄ clear amber urine. Will Continue to monitor q 5 minutes [redacted] till recovered. Pupil equal @ 4 mm and reactive to light.

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

AUTHORIZED FOR LOCAL REPRODUCT

AL RECORD | PROGRESS NOTES

NOTES

Progress Note

Patient is speech cogent

- On NC w/ O2 sat 99%

CXR (+) f (R) LL pneumo w/ (R) effusion

- Drain output 22 cc today

now on clear.

- wound intact, staples intact

pendent

- Tmax 101.3 now 99.8

Abx Cent / Cefotetan

Dx: (1) S/P washout / closed

(2) Hct 22.3

(3) T Bili 2.9

(4) S/P CBD to fistula w/ SB anast and 1° closure

(5) S/P wound dehiscence

(6) (+) RLL pneumo

Plan transfuse 2 u PRBC / Rehydrate

Con't IV ABX

Con't PT [redacted] B6-2

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

RVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] B6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5/15
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)

B6-2 All (except last)

MEDICAL RECORD	PROGRESS NOTES
DATE	
18 JUN 03 2045	RT note: Pt awake HR-117, RR-30, POX-97 on 3LNC. UD Alb given via HHN. Pt uncomfortable HR-128, RR. 33, Pox 97 on 3LNC. Pt tol well. Lungs BS c̄ slight wheeze on (R) Lower + ↓ on (L) Lower. Will continue to monitor — SC [redacted] 91V2Ø
18 JUN 03 0015	Rt note: Pt awake. HR 117, RR-28, Pox 99 on 3LNC. UD Alb given via HH[redacted] aerosol mask. Post tx HR-113, RR-36 Pox-99% on 3LNC. Pt uncomfortable. BS no changes. Will continue to monitor — Sgt [redacted] 91V2Ø
20 Jun 03 0554	UD Alb tx given HR 111 RR 20 spo2 97 BS Diminished [redacted] Rhonci on insp. Post tx HR 103 RR 21 SPO2 98 BS No changes. [redacted]
20 June 1238	UD Alb tx given HR 116 RR 20 spo2 93% BS Diminished HR 112 RR 21 SPO2 98% — Sgt [redacted] RT
20 JUN 03 1810	UD Alb given. HR 120, RR 27, POX 96% on 2LNC. BS slight rhonchi. Post tx HR-131, RR-34, SPO2-97, BS unchanged. Pt not comfortable c̄ tx — Sgt [redacted] 91V2Ø CRT
21 JUN 03 0015	UD Alb given. Pre HR-112, RR-26, SPO2 96 on 2LNC. Pt just return from CT. Post HR-117, RR-32, SPO2 - 99. lungs - diminished. Pt breathing even + unlabored — Sgt [redacted] 91V2Ø
21 Jun 03 1126	UD Alb tx given HR 102 RR 20 SPO2 98% 2L NC Post tx HR 109 RR 25 SPO2 99% BS Diminishe [redacted]
21 JUN 03 1830	Pre tx - HR-94, RR-29, SPO2 - 98% on 3LNC. Alb UD neb given Post tx HR-96, RR 32, SPO2 98% on 2LNC. Pt tol well - Sgt [redacted] BS - diminished otherwise clear — [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted]

B64

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
200	HR 123 RR 25 SPO2 95% BS Clear
Jun 03	NT Suction Done minimal amount of secretions
	Removed — Sgt [redacted] RT
Jun 03	Pt eval HR 88 BP 112/60 RR 22 BS clear pt B6-2
0035	Sounds clear pt sleeping NT Suction Not Done
	will Re-evaluate Next 4L 0400 — Sgt [redacted] RT
0 Jun 03	UD Alb Tx given HR 93 RR 13 SPO2 94% BS Diminished
1745	in bases Post tx HR 117 RR 19 SPO2 99% BS Clear Diminished
	in bases — Sgt [redacted] B6-2
30 Jun	UD Alb Tx Given HR 110 RR 21 SPO2 96 BS Clear
0356	Post TX HR 121 RR 21 SPO2 97% on 2L NC BS No
	change CPT Done — SGT [redacted] KT
	UD Alb Tx Given HR 105 RR 29 SPO2 98% on 2L NC B6-2
	BS clear + Diminished CPT [redacted] Post tx HR 102 RR 25
	SPO2 99% — [redacted] B6-2

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

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

B6-4

PROGRESS NOTES
Medical Record

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

B6-2 All (except list)

PROGRESS NOTES

DATE	
22 JUN 03 0015	Pre tx: HR 86, RR-20, POX 98% on 2L NC. Pt fighting c̄ neb/ aerosol mask. UD Alb neb given. Post tx - HR-110, RR-23, SPO_2-97% on 2L NC, BS ↓↓ @ base. Ø cough. — Sgt [redacted] 1020
25 Jun 03 1800 RT	Pt in OR Tx or CPT Not Done. — Sgt [redacted] RT
25 Jun 03 2348	UD Alb tx given to pt HR 114 RR 30 SpO2 97% Bs Course Rhonci Diminished in Bases Post tx Bs improved HR 125 RR 38 SpO2 98% Chest pt done Pt didnot cough c/o pain CPT [redacted] — Sgt [redacted] RT
26 JUN 03 2000	Pre tx HR 134, RR-30, SPO_2 99 on 15L NRB. UD Alb neb given @ 10LPM. Nurse doing abd dressing Δ's. Post tx HR-132, RR 34, SPO_2 on 6L NRB 95%. BS CTA c̄ ↓ at bases. CPT done. Pt c/o pain CPT Stopped — Sgt [redacted] 1120

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

[redacted] B6-4

A11 B6-2

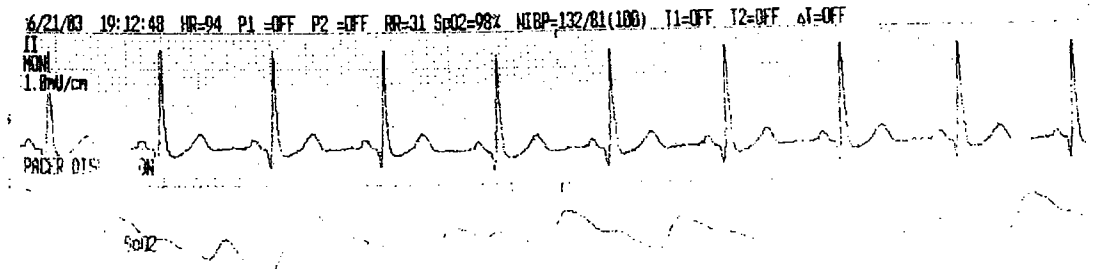
PROGRESS NOTES

DATE	
21 Jun 03 (Cont'd)	(Resp): Pt range 24-28 rpm. ∅ noted respiratory difficulties. Continues on q6° nebulizer tx's, as well as IS 10-20 reps q1°. (GU): Hyperactive Bowel noted throughout. Abdomen soft, nontender, non-distended. Foley cath to gravity drain (UO avg 60cc/hr) Urine amber color. (Lines): IV LR @ 125cc/hr. NG to LIS (∅ output @ present). O_2 @ 2L NC. (LABS): CBC ∅ lytes drawn this A.m. = NA: 139, K+ 3.7, CL: 103, CBC: WBC 4.3 H&H 7.4 & 23.5 (↓ from 11.2 & 35.1 yesterday). Repeat CBC @ 0400hrs H&H 9.3/29.8 Will continue present course of care. [redacted]
21 Jun 03 (1600hrs)	Pt verbalizing abdominal discomfort. Abd incision intact ∅ reinforced dsg. Pt's Abdomen remains soft, non-distended, semi-tender to palpatations. Bowel sounds remain hyperactive in all quads. N/G to LIS. ∅ output. Given MSO4 4mg IVP for discomfort. [redacted]
21 Jun 03 (1600hrs)	Pt OOB to chair x1, tolerated x 30 mins, as well as taking 6-10 steps ∅ some assist. N/G tube to LIS now putting out grumish drainage (>90cc). No further c/o abd pain during this shift (0s-17). [redacted]
1700	Assumed pt care @ dayshift report given. [redacted]
1735	Dr. [redacted] D/C'd N/G tube. New orders noted. Pt given [redacted] 3mg @ 1730 for ABD pain. Will monitor. Eyes - PERRL @ 3mm Alert & Verbal. Resp: = & bil fall of chest. Clear ↑ lobes bilaterally. ↓ lobes diminished noted bil. Skin: appropriate for race. (L) Arm DSG CDI. ABD/Chest DSG CDI. (R) hip/groin/flank area has purple bruise noted. (R) posterior flank area has surgical wound small in size. No active bleeding noted. (L) subclavian central line ∅ triple lumen ∅ S/S of infection or infiltration noted. LR @ 125cc/hr via central line. ABD: soft nondistended (+) BS noted. Foley clear amber urine noted to bedside urine bag. Cardiac: [redacted] Sinus Tachy. Pedal pulses present bil. (R) radial pulse present. (L) unable to assess due to dsg. (L) hand fingers pt can move. Cap refill <2 sec @ fingers. [redacted]

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

All B6-2 (except last)

MEDICAL RECORD	PROGRESS NOTES
DATE 21 June 03 1700 cont	hand, (R) Arm ↑ on blanket. Will Monitor. Sgt [redacted]



1800	Tylenol 650mg given for temp 101 A. Will Monitor. Sgt [redacted]
1800	T 98.9 A Will Monitor — Sgt [redacted]
2145	Pt C/o pain in ABD. MS04 3mg given IV. Will Monitor. Sgt [redacted]
2345	Resting in bed. Will Monitor — Sgt [redacted]
0200	
22 June 03 (0830 hrs)	Assumed care of patient @ 0500hrs. (Neuro): alert & active in bed. Rom noted in all extremities. Brisk capillary refill & bounding pulses noted (unable to palpate (L) UE ⁰/₁₁ bulky ace wrap dressing). (R) hand c̄ moderate (1+) edema. Pupils EERLA; 3mm, brisk (B) Sclera jaundice color. (CV) RRR s̄ (m) HR slight tachy @ high of 102 bpm, otherwise rate avg. 85 bpm. BP systolic 125-141. (Lungs) CTA in all fields. Productive cough; sputum clear. SaO_2 96% @ 2l NC. I.S. q 1-2° @ 10-20 reps @ difficulty breathing. (GI): abd. soft, non-distended c̄ hyperactive bowel sounds in all quad. (+) flatulence verbalized by patient. ⊘ BM. Tolerating clear liquid diet s̄ nausea/vomiting. — Contd [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO. [redacted]

#[redacted]

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
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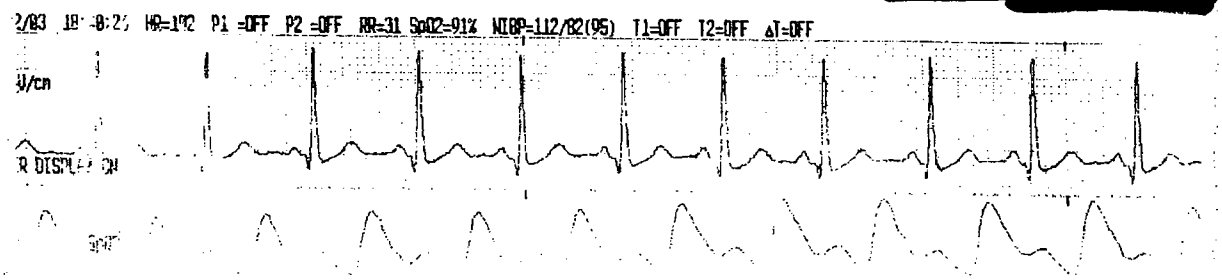
PROGRESS NOTES

DATE	
22 June 03 1740 (Cont.)	Scrotal yellow in color. (D) Arm DSG CDI. Chest → ABD ⊏ staples CDI ⊐ S/S of infection noted. (R) hip/groin/thigh area has purple bruise. (R) posterior flank area has small entrance wound. No drainage or active bleeding noted. (L) Subclavian central line ⊏ triple lumen DSG CDI. No S/S of infection or infiltration noted. NS @ 125 cc/hr via central line. Foley to gravity ⊏ clear amber urine dark in color noted. ABD soft nondistend. hyperactive BS noted in all 4 quads. Cardiac: NSR @ present time. O2 @ 10L/Min per High Flow Face Mask. Pedal pulse present bil feet. (R) radial pulse present. (L) unable to assess due to bulky DSG. (R) hand & fingers can move & cap refill < 2 sec @ fingernail bed (L). (L) Arm ↑ on blanket. Will monitor. Sgt [redacted] B6-2



1900	T. 103A ice ~~off~~ packs applied under arms & groin area. Pt had tylenol @ 1700. Pt vomited 15 several times approx @ 8-10 x's. Will monitor. Sgt [redacted] B6-2
2000	T 101.7A ice packs in place @ under bil arms & groin area. Will monitor. RT give RT Tx. pt upset ⊐ Tx stated pain in own language. MSO4 given @ 2005. Will

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All B6-2 (except last)

MEDICAL RECORD — PROGRESS NOTES

DATE	
22 Jun 03 ~~0721~~ 1921	Pt on Non Rebreather 10 LPM SpO2 100% HR 107 RR 34 BS Diminished UD Alb tx given BS improved HR 107 RR 30 SpO2 98% on 8 LPM Simple mask CPT Done on pt NT Suction Done Pt Placed Back on Non Rebreather will switch back once pt Sat ↑ above 98% — Sgt [redacted] RT SGT
22 Jun 03 1030	Chest PT Done on pt HR 100 RR 32 SpO2 96% Chest PT Done 5 min pt c/o pain pt placed on Simple mask 8 LPM SpO2 97% — [redacted] RT
22 Jun 03 0017	UD Alb tx HR 97 RR 20 SpO2 95% BS Diminished Chest Pt. Done on pt. pt cough a little NT Suction Done Pt coughed RR 36 HR 105 SpO2 96% BS improved still diminished in Bases — SGT [redacted] RT
22 JUN 03 0405	pt on SM @ 10 LPM sats 99%. Pre tx HR-88, RR-23, BS - CTA c ↓ at bases, CPT perform c mod. compliance. Post HR-100, RR-25, SpO2 95%. Deep suctioned 3cc dark yellow thick phlem. Pt coughed up 5cc dark yellow/gran thick phlem p̄ deep suction. HR-83, SpO2 95 on 10L SM. Will continue to monitor. BS diminished — Sgt [redacted] 91V2p
22 Jun 03 0800	Pt on SM @ 7 Lpm sats 98% Pre tx HR: 74 RR: 21 SpO2 98%. BS are CTA but greatly ↓ on bases. Pt seems to tolerate CPT a little better. Deep suction performed Pt dislikes. Post tx vitals HR: 85 RR: 21 BS: unchanged SpO2: 99% Will continue to monitor

(Continue on reverse side)

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

REGISTER NO. | WARD NO. [redacted]

Pt [redacted]

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DATE

22 Jun 03 (Cont'd) (GU): Foley cath to gravity drainage; dark amber urine. U/O ~ 60-80 cc/hr. (Lytes). Ecchymosis noted to lower trunk, (R) flank regions. ∅ skin breakdown. Open (R) flank/post wound noted (minimal). (Lines): (L) SC Triple lumen central line patent (IV LR @ 125 cc/hr patent). (Plan): c̄ Patient now NPO & scheduled for 1400 (L) arm I&D. Will continue clear liquid diet c̄ I&D and probably D/C foley cath in the a.m. [redacted] T/A

22 Jun 03 (0935hrs) Patient c/o abd pain. Abdomen remains soft, flat c̄ (R) flank/flankdrain. BS hyperactive. Maintained NPO for I&D this afternoon. Given 4 mg MSO4 IVP for abd discomfort. Will re-evaluate within 30 min. [redacted] T/A

22 Jun 03 (1300hrs) Addendum: Dr [redacted] (General Surgery) placed pt. on NPO status for washout of (L) forearm. IV received update of this case thru hospital translator. Also, IV fluid LR ↓'d to KVO @ 125 cc/hr D/T. Am lytes result: Na+ 121 (ordered by Dr [redacted]). [redacted] T/A

22 Jun 03 (1515hrs) Talked c̄ Dr [redacted] regarding pt's poor pulmonary toilet. ↑ secretions, copious, thick white sputum. SaO2 @ 91-92% on 2-4L O2 via NC. Given verbal order to ↑ neb tx's to q4° c̄ nasal suctioning & chest PT. [redacted] CM/A

22 Jun 03 (1630hrs) Temp 101° ax. VSS otherwise unremarkable. Encouraging po fluids & cool wash cloth to wipe down pt. IS x 20 reps performed. Air conditioning unit down. 4T generator down. Will monitor & consider giving Tylenol supp as ordered. [redacted] A

22 Jun 03 (1700hrs) Temp 102° ax. VSS otherwise unremarkable. Given Tylenol supp 650 mg PR. Given 400 cc H2O po & cool cloth. IS x 20 reps done. O2 @ 10L non-rebreather. [redacted] CM/A

22 Jun 03 (1730) Temp now 101.2° p̄ Tylenol intervention. Air conditioning now on. Continue to monitor. [redacted] CM/A

23 June 03 1740 Assumed care of pt p̄ day shift report. exp: PEPH @ 2mon old. Alert can make commands, smile, know some english. Resp: clear L lobes bil ↓ lobes diminished bil. = rise & fall of chest bil

(Continue on reverse side)

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

EPW # [redacted]

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All B6-2 (except last

PROGRESS NOTES

DATE	
23 June 03 1930	Pt note: U/D Alb/CPT given at this time Pre tx HR: 84 RR: 28 SpO_2 93% on 6L O2 BBS CTA slightly ↓. Pt tolerated CPT well, Coughed up minimal amount white semi-thick secretions. Post tx HR: 83 RR: 32 SpO_2: 98 BS: no change Will continue to monitor pt's resp status — [redacted] RCT
23 JUN 03 2020	Pt awake. BS CTA c̄ diminished. Pre tx HR - 80, RR - 26, SpO_2 99 UD Alb neb given. CPT done & cough up 3cc [redacted] yellow thick. Post tx - HR 76, RR - 27, SpO_2 99% on 4LNC. no Δ's in BS — Sgt [redacted] 91V20
23 Jun 03 0001	UD Alb tx given HR 94 RR 20 SPO2 94% on RA. Bs Diminished in Bases Post tx HR 1001 BP 135/86 RR 24 SPO2 95% NO Δ Bs Chept PT Done [redacted] RT Sgt Pt c/o Pain —
24 JUN 03 0400	UD Alb given. Pre tx HR 88, RR. 28, SpO_2 93 on RA BS diminish otherwise CTA. Post tx HR - 93, RR 33, SpO_2 93 CPT done pt c/o pain, CPT stopped - Spoke c̄ nurse about pain control & necessity of CPT for Pt - lungs CTA c̄ diminish @ base. SPO2 94 @ RA — Sgt [redacted]
21 June 03	pt. given UD AIR via face mask @ 8Lpm x15 min [redacted] RR 34-34 P 77-88 O2SAT 95% on RA BBS c̄ CTA p̄ NO Δ pt has productive cough c̄ yellowish thick sputum — [redacted]
24 JUN 03 1820	Pre tx HR 90, RR 32, SpO_2 93 on RA. BS CTA otherwise diminished. UD Alb neb given. HR - 105, RR - 31, 91% on RA. CPT done. BS no Δ's ∅ cough — Sgt [redacted] 91V20
25 JUN 03 0040	Pre tx HR 100, RR 26, SpO_2 93% on RA. BS CTA c̄ ↓ @ bases. UD Alb neb given c̄ CPT. Pt c/o pain c̄ CPT. HR - 110, RR - 30, SpO_2 93% on RA — Sgt [redacted]

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Pt. [redacted] B6-4

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PROGRESS NOTES

DATE	
23 Jun 03 (Cont'd)	(GU): Foley cath D/C'd @ 1025 hrs. Will monitor for spontaneous void into urinal. Tolerating po liquids very well. ⊘ nausea/⊘ vomiting. ⊕ flatulence. (Lines): patent ⓛ SC triple lumen central line → IVPS @ 125cc/hr. (Plan): Continue c̄ aggressive resp. therapy. Monitor v/s ⊽ foley cath D/C. CXR PA LAT Mon. Lite tabs: Na+: 125 [redacted] H&H: 8/27 T. bilirubin: 4.9
1430 23 Jun 03	PT voided on floor about 200cc and in urinal 200cc dark amber urine. PT sitting in chair. Given [redacted] 50g IV for c/o pain in ABD. [redacted] 46 grams
1500 23 Jun 03	PT ↑ OOB to walk c̄ PT's help. PT walked about 50 yds. ⊘ c/o pain, dyspnea. PT VS 114-29-133/75 100% SpO2 on 8 LPM via single face mask. PT displayed some weakness while ambulating but did 90% of the work. [redacted] 56 grams
23 Jun 03 1630	PT's Temp 101° (ax). PT c/o being hot. PT given Tylenol 650 mg po. W/I monitor for ↓ temp. [redacted] grams
23 Jun 03 1700	Assumed care of pt ⊽ day shift report. eyes: PERRL @ 4mm. Scalp are intact bil. Alert, verbal, makes commands. Drowsy, knows some English. Resp: even rise & fall of chest bil. ↑ lobes clear. ↓ lobes diminished. Skin: warm & dry to touch. (R) Flank area small entrance wound noted. No active bleeding noted. ~~Drainage~~ No drainage noted. (L) Arm DSG CDI. Chest/ABD incision c̄ staples CDI c̄ S/S of infection noted. (R) hip/Flank area has purple bruise noted. (L) Sub-clavian central line c̄ triple lumen DSG CDI c̄ S/S of infection or infiltration noted. NS @ 75 cc/hr via central line. O2 @ 5L/min per NC. ABD soft nondistended. BS present in all 4 quads hyporactive. PT voids spont. urine dark amber. Cardiac: NSR c̄ occ PVC's noted. Pedal pulses present bil. (R) radial pulse

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EDICAL RECORD | PROGRESS NOTES

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2000 (Cont.) Monitor pt. O2 @ 10L/min per High Flow Face Mask. Sgt [redacted]

22 June 03

2050 T. 102.3 A Tylenol 650 mg RTC given. Ice packs in place @ groin area & under arms bil. Will monitor. No c/o pain @ present time. — Sgt [redacted]

2155 T 102 A Ice pack applied behind neck. Will monitor. — Sgt [redacted]

2225 Dr. [redacted] notified of Temp. MD came & assessed pt. New orders written @ 2245. Will monitor pt. Sgt [redacted]

2255 RT ↓ O2 to 8L/Min per High Flow Face Mask. O2 Sat [redacted]. Will monitor pt — Sgt [redacted]

2415 T 99.8 A. RT done Chest PT & suction c̄ [redacted] Albuterol Neb Tx. Face Mask c̄ O2 @ 10L/Min per [redacted] SpO2 @ 95%. Will Monitor. — Sgt [redacted]

23 June 03 0430 RT p̄ Chest PT, Albuterol Neb Tx & Nasal Suctioning ↓ O2 @ 8L/Min per face mask. IS used also. Will Monitor. Sgt [redacted]

23 June 03 (1040hrs) Assumed care of pt @ 0800hrs. (Neuro): alert, oriented & active in bed. PERRLA 3-4mm neck supple. oral cavity clear; mucous membranes moist. (CV): RRR c̄ (m) rate: 75-80 bpm strong pulses all extremities (+) hand bulky ace wrap dressing). (Resp): Lungs CTA, ↓ diminished breath sounds lower lobes, but ↑ air movement upper & mid lobes. Resp rate: 21-25 rpm. S_AO_2 @ 98% c̄ 8L O_2 via mask. Continues on q 4 neb tx c̄ nasal suctioning & chest PT. (q 2°) (+) greenish/yellow sputum production. I.S. q (-2° x 10-20 repetitions. (GU): ↑ bowel sounds in all quads. (+) bowel movement this am (soft, brown). ↑ U/O in foley (75-100 cc/hr) Continued —

(Continue on reverse side)

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

REGISTER NO.

WARD [redacted]

PROGRESS NOTES
Medical Record

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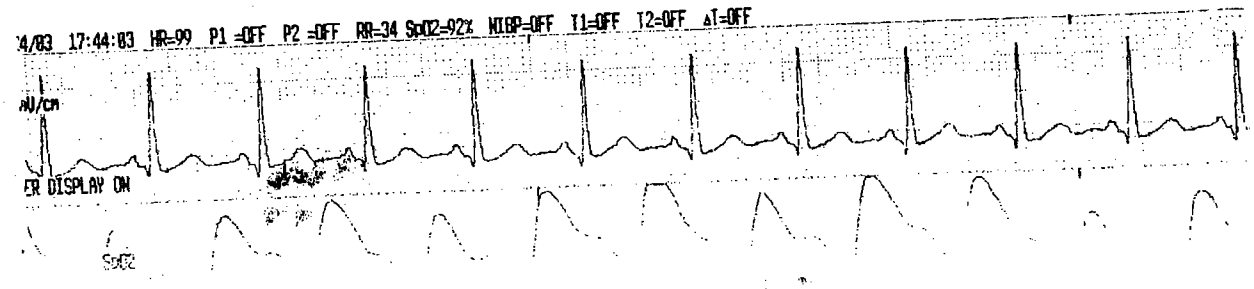
[redacted] of infiltration noted. NS @ 75cc/hr via central line. ABD soft non distended. hyperactive BS noted in all 4 quads. Pt voids spontaneously clear amber urine. NSR noted @ present time. D Arm ↑ on blanket. Will Monitor — Sig [redacted]



1800 Dr [redacted] Ad ABD DSG mod. amt of bloody drainage noted on old DSG. ABD @ 5cm open. No sutures noted in area. Packed w Sugar Sponges. Applied ABD pad, Secured w tape. MSO4 5mg given IV x1 dose per MD order — Sig [redacted]

1818 New Orders noted per Dr [redacted] CT today. Pt instructed for CT. Will Monitor — Sig [redacted]

1918 CT personnel brought contrast for pt to drink for CT. [redacted]

2100 Pt taken to CT per litter. MSO4 given 2mg IV per Mars. Will Monitor — Sig [redacted]

2120 Pt transfer back ICU #2 per litter. Pt transferred to bed. D Arm ↑ on blanket. Will Monitor Sig [redacted]

0120 Tylenol 650mg PO given for temp. Will Monitor Sig [redacted]

0300 T 100 A Will Monitor. Sig [redacted]

0400 T 99.6 A Will cont. to Monitor Sig [redacted]

0455 MSO4 3mg IV for ABD pain. Will Monitor Sig [redacted]

EDICAL RECORD | PROGRESS NOTES

DATE

~~24 June~~

24 June 03 (1635hrs) Addendum: c/o ↑ abd pain. Abd soft, flat ⊼ for 1" area just above the umbilicus. Noted erythema around umbilical region. Temp now 100°F. During 1600 physician rounds general surgeon observed incisional area, removed staples above umbilical region → ~50cc light brown ~~[illegible]~~ [redacted] serosanguinous drainage ~~[illegible]~~ poured from opened 1/2" incisional area. Reinforced c̄ sterile spongy gauze, and abd dressing. Dr. [redacted] to come & evaluate 4x2" opened wound area. Patient given [redacted] Morphine IVP for abd discomfort. Will monitor wound, temp & pain for now. [redacted] B6-2

1810 PT NOTE

HX: AMBUL

T/M: PNT ALERT. c/o ABDOMINAL PAIN. PNT DISPLAY GOOD STRENGTH (R) UE; (R) LE ↓ STRENGTH (L) LE. (L) UE CASTED. PNT AMBUL 4 LAPS ICUZ AREA c̄ ~ 5 MIN REST p̄ 2 LAPS. PNT DISPLAYED SLIGHT DRAG/MINIMAL DF ~~of~~ (R) FOOT. PNT ASS'D BY RN; PT TECH. PNT AMBUL TID.

DX: AMBUL.

I: SAME

G: AMBUL PNT 8-10 LAPS ICUZ AREA ~~TID x 2 WKS~~ [redacted]; 20 DF/PF REPS (L) FEET X 2 WKS.

SPC [redacted] B6-2

SIGNING PT TECH

1700 (out of order) Assumed care of pt p̄ day shift report given. [redacted]
24 June 03 yellow. PERRL @ 2mm. Resp: lungs rhonchi & fall by chest bil. Clear ↑ lobes ↓ lobes diminished noted bil. (R) Arm DSG CDI. Chest/ABD [redacted] ↑ incision c̄ staples CDI ABD DSG CDI. ↓ ABD c̄ staples CDI. (R) flank/hip area has purple bruise noted. (R) flank area above bruise has entrance wound. No drainage or active bleeding noted. (L) subclavian area central line DSG CDI. Central line c̄ ↑ port lumen ≡ 3/5 of infusion B6-2

(Continue on reverse side)

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

#[redacted] B6-4

PROGRESS NOTES
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PROGRESS NOTES

DATE

get out of bed and sit in ~~side~~ bed side chair c̄ void, improved mobility, coordination, ⊕ ↑ cooperative w/ coughing and performing ~~DB~~ exercises. pm
0200 pt awake, c̄ DB / IS x10 able to elevate all 3 chamber markers, ⊕ cough c̄ productive sputum, beige, ↓ clear — breath sounds ctA / ⊕ bases. [redacted]
@400 c/o of abdominal pain @ incision site 2nd PMS given, VS stable, afebrile, resting comfortably [redacted] B6-2

June 03 (0900 hrs) Assumed care of pt @ 0600hrs. (Neuro): alert, oriented and active in bed. ⊕ movement of all extremities c̄ limit to ⊕ arm b/t bulky dressing/splint. Capillary refills < secs c̄ strong pulses noted throughout. (HEENT): PERRLA @ 3mm (brisk). Neck supple → oral cavity c̄ moist mucous membranes; unremarkable. Tolerating regular diet c̄ nausea/vomiting. Nares patent (⊕ congestion). (CV): RHythm c̄ ⓜ rate avg 87 bpm; unremarkable. (Lungs): CTA upper and mid lobes; diminished breath sounds lower lobes, but moving air much better today. Overall air quality movement ↑ throughout. ⊕ yellowish sputum production (spontaneous). SaO_2 @ 95% on RA. Neb tx c̄ chest PT q4' & q2' respectively. (GI): ⊕ bowel sounds in quads. ↑ motility in last 24hr. Abd. soft, flat, non-distended c̄ ⊕ flatulence. Tolerating ORS to chair several times to void in urinal (avg 300cc q 4hr). (Ortho): Ecchymosis remains around flank, buttock region. Abd midline incision c̄ staples C, D, I. Lines: ⊕ SC Triple lumen central line patent c̄ IV NS @ 75cc/hr. (other): ambulating well c̄ asst from P.T. Understands importance to ambulate for ↑ strength & ↑ pulmonary toilet. (LABS): Tbili ↑: 5.9 (4.4 yesterday) Na+ 137 (Plan): Consult c̄ Dr [redacted] regarding Tbili level (? ↑ fluid IV); D/C order for Toradol, ↓ Neb tx & Chest PT to q 6hr. Window for skin fl[redacted] Lovenox — CK/AL

[redacted]

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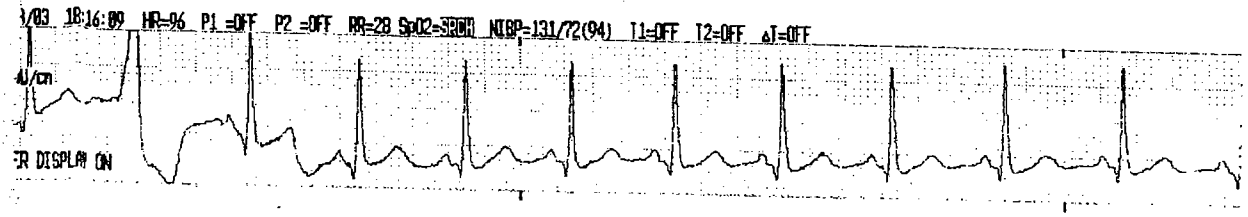
EDICAL RECORD | PROGRESS NOTES

DATE

23 June 03 present. ⓡ radial unable to assess due to bulky dressing
1700 ⓛ hand/Arm. ⓛ pt can move fingers. Cap refill < 2
cont. sec @ dominant bed on ⓛ. Will monitor. Sgt [redacted] B6-2
1830 Ambulated pt. Pt cough up small amt sputum. Ambulated back to chair. SPO2 @ 95%. O2 off @ present. Will monitor SPO2. Pt used IS 10-15 x's. Pt breath deep also. Sgt [redacted]
1950 SPO2 ↓ 89. O2 @ 4L/NC reapplied. SPO2 ↑ 97%. Will monitor. Sgt [redacted] B6-2



002

2118 Pt up to BSC. had small BM. After Ambulate back to chair pt. c/o chest/ABD pain. MSO4 2mg given @ 2118. O2 taken off. SPO2 @ 95%. Will monitor. After pt put back in bed pt used IS approx 10 x's. Will monitor. ⓛ Arm elevated on pillow. Sgt [redacted] B6-2
2400 pt c/o pain to perineal area ⊕ dry using urinal while in bed. pt assisted ⊕

(Continued on reverse side)

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

EPW [redacted]

REGISTER NO. | WARD NO.

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PROGRESS NOTES
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Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1

ICAL RECORD

AUTHORIZED FOR LOCAL REPR

PROGRESS NOTES

DATE	NOTES
25 MAY 03 0530	ASSUMED CARE OF PATIENT THIS AM @ 0500. NEURO ALERT AND ORIENTED RESPONDS APPROPRIATELY. PUPILS 3MM BRISK. CV S1,S2 (+) PULSES PALPABLE THROUGHOUT 2+-3+ RUE AND BLE LUE C̄ BULKY DRESSING LCTA PULSES CAP REFILL BRISK, HR 75 BPM NSR Ø ECTOPY @ THIS TIME. RESP CTA TO BILATERAL LUNGS C̄ ↓ AIR MOVEMENT IN THE BASES BILATERALLY. NAD PT ABLE TO ELEVATE 2-3 BALLS ON THE INCENTIVE SPIROMETRY C/OUT DIFFICULTY. CURRENTLY RR 20 C̄ SaO2 97 ON 2L VIA NC, UPON RECEIPT OF PT THIS AM SaO2 @ 89% VIA 2 PULSE OX SOURCES THEN PT PLACED ON 2L TO ↑ SaO2 WILL CONTINUE TO ASSESS AND WEAN OFF O2. GI ABD SOFT SLIGHTLY DISTENDED C̄ TENDERNESS TO (R) SIDE EVIDENCED BY PT REMARKS OF PAIN ACCOMPANIED BY GRIMACING. BS X4 QUADRANTS. PT ON REG DIET, WILL ASSESS TOLERATION THROUGHOUT THE SHIFT. GU PT VOIDING SPONTANEOUSLY TO URINAL C̄/OUT DIFFICULTY. PT C̄ 450CC OF URINE THIS DARK YELLOW (↓ IN DARKNESS FROM YESTERDAY) CLEAR, Ø SEDIMENT. SKIN INTACT. PT C̄ MIDLINE INCISION TO ABDOMEN, ONE APPROXIMATELY 2" AREA OPEN C̄ PACKING. SEROUS FLUID FOUND ON DRESSING @ LOWER ASPECT OF OPEN AREA, OTHERWISE STAPLES IN PLACE WELL APPROXIMATED. DSG INTACT. LUE C̄ BULKY DRESSING AND SOFT CAST IN PLACE CAP REFILL WNL. LINES TLC (+) SUBCLAVIAN C̄ NS @ 75CC/HR. WILL CONTINUE TO MONITOR PATIENT FOR CHANGES IN STATUS. [redacted]

HIP TO SPONSOR	LAST	SPONSOR'S NAME FIRST	MI	SPONSOR'S ID NUM. (SSN or Other)
	B6-2			
ERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO. | WARD NO.

#[redacted]

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PROGRESS NOTES
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STANDARD FORM 509 (REV

Prescribed by OSA/OMB FPMR (41CFR) 101-11.9

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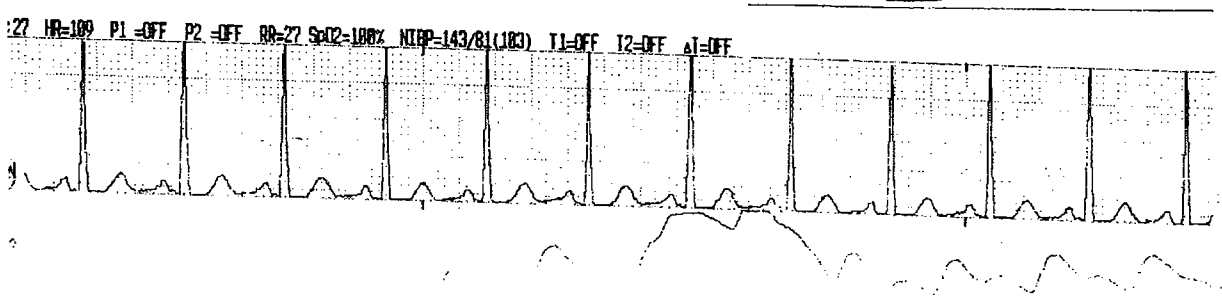
PROGRESS NOTES

DATE	
1950 (cont) 25 June 03	Pedal pulse present bil. (R) radial pulse present. (D) unable to assess ~~left~~ due to IV BS on (L) Arm/hand. (D) pt can move fingers. Cap refill <2 sec @ fingernail bed on (D) hand. BS present in all 4 quads. cardiac: NSR noted @ present time. Will monitor — Sgt [redacted] B6-2
2000	JP tube drained 30cc bloody drainage noted. Sgt [redacted]



2330	Light amt bloody drainage noted on Midline BS. Will monitor. — Sgt [redacted]
2301	MSO4 given 4mg IV for Midline pain. Will monitor — Sgt [redacted]
2330	Tylenol 650 mg PR given T 101.9 A Will monitor Sgt [redacted]
0018	MSO4 4mg given IV for Midline pain. Will monitor — Sgt [redacted]
2330	(late entry) Dr [redacted] notified @ 2 RC >30 minutes. New order noted. Will monitor Sgt [redacted]
0113	MSO4 4mg given IV for Midline pain. T 101.3 A Will monitor. — Sgt [redacted]
0135	Pt resting in bed — Sgt [redacted]

A11 B6-2

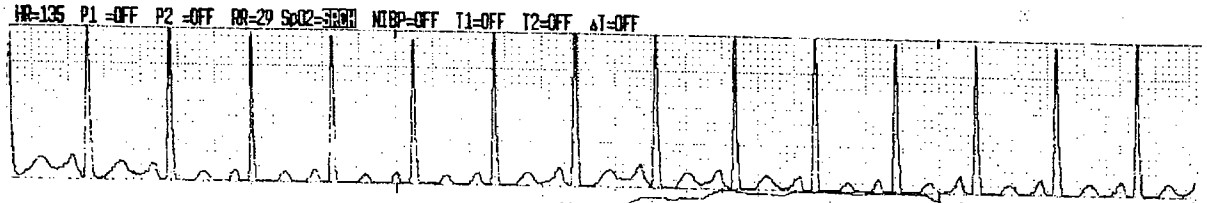
LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0745	PT UP TO CHAIR FOR 45 MINUTES THEN WALKED APPROXIMATELY 40 FEET C̄ MINIMAL ASSIST. PT TAKES SHORT STEPS AND LEANS SLIGHTLY FORWARD. PT TOLERATED WALK AND THEN RETURNED TO BED P̄ WALK. WILL CONTINUE TO MONITOR VSS AND [redacted] PLAN.
0850	LABS RESULTS BILI ↓ FROM YESTERDAY 5.9 TO 4.[redacted] TODAY. DR. [redacted] INFORMED. CONTINUE TO MONITOR. [redacted] PLAN
0900	REPORT GIVEN TO SSG [redacted] VSS. PT IN BED RESTING @ THIS TIME. Ø PAIN. [redacted]
25JUN03 0900	Assumed care of [redacted] PT alert, verbal, eyes PERRLA, sclera yellow 4mm brisk, VS 98.8 - 139/88 - 88 - 20 - 96% S/O2 on 2LPM via NC. Lungs CTA(B) C̄ ↓ sounds in (B) bases. PT has productive cough equal rise and fall of chest. IS q° in use, PT can elevate 2½ balls, CV - S1S2 present, NSR, Pulses ×3, cap ref. <1 sec ×4 (C) subclavian triple lumen cath C̄ 75cc/hr NACL IV, ABD sound soft C̄ midline TTP, staples intact, dressing to ABD clot. BS ×4 quadrant diminished 400 cc amber clear urine. Movement & sensation ×4 extremities WNL mobility. [redacted] SSG Gamble
25JUN03 0935	PT's TOS drain, pt. prepared to go to O.R. Interpreter explained procedure to pt. PT used IS, elevated 2½ balls [redacted]
25JUN03 1400	PT to O.R. [redacted] SSG Gamble
1945 (25 JUN03) 1950	Returned from OR via ~~stretcher~~ litter. See recovery sheet. S/S [redacted] PERRL @ 1mm, eyes are yellow. Lungs: BS sonorous noted bil. O2 @ 8L/min high flow face mask. Midline DSG CDI C̄ JP to bulb suction (R) Arm DSG CDI, (L) nare nasal airway. (R) nare NGT to L-I.S. Central line C̄ triple lumen S/S/S & infiltration or infiltration noted. LR @ 150 cc/hr via central line, Foley to gravity C̄ clear amber urine in foley bag.

A11 B6-2

PROGRESS NOTES

DATE	
26 Aug (cont) 1700	Via triple lumen. Pedal pulses present bil. (R) radial pulse present. (L) unable to assess due to Bulky DSG. (L) hand fingers pt can move. <2 sec cap refill @ (L) finger nail bed. Will Monitor. Sgt [redacted]



1745	Maj [redacted] notified @ Midline DSG drainage, ↑ HR, pain management & anxiet pt hold on Day Shift. New orders noted. Sgt [redacted]
1831	650mg given for ↑ Temp 103.9A. Will Monitor Sgt [redacted]
1900	T 102.3A. Will Monitor cont. Sgt [redacted]
2000	Midline DSG ΔU - old DSG large amt bloodmid & bloody drainage noted. Midline open c̄ ~~[illegible]~~ retention ~~[illegible]~~ suture bands. Packed c̄ NS wet → Dry DSG applied. Covered c̄ ABD pads. Secured c̄ tape. MD notified (Dr. [redacted]) of T 103.9 earlier & last temp was 102.3A. No new orders noted. Will Monitor. Temp taken @2005 101.9A. Will Monitor Sgt [redacted]
2105	T 102.3A Applied cool wash cloth to head. Will Monitor Sgt [redacted]

All B6-2 (except last)

MEDICAL RECORD	PROGRESS NOTES
DATE	
26 Jun 03 (Cont'd)	(GU): Abd soft; ⊕ tenderness to palpation throughout. C/o of constant abd pain → specifically the midline (Incisional) region. Foley cath to gravity drainage; ↓ 120-130cc/hr (Integ): unremarkable from previous assessments. (Lines): Triple lumen central line ⊕ SC → all ports patent → IVF LR @ 150cc/hr. Continue on Abx therapy. NG to LIS collecting guaiac/brown gastric content. (Plan): Pain control → phenergan 25mg IV x 1, start Zantac 50mg IV q 8 and toradol 30mg IV q 6". MSO4 4mg IV given @ 0600 for verbalized abd pain. Will continue to monitor throughout the shift. [redacted]
26/6/03 600	pt c/o nausea checked ex LI [redacted] phenergan. pt discontinued complaint. [redacted] MAY/RN
26/6/03 1776	pt c/o pain painting to abd, ~~no~~ medicated ā 4mg MSO4 IVP. pt thumbs up p̄ 5 min. prior @ 1600 tried NC @ 5L ā success pulse ox dropped to 90% rebreather placed @ 5L. [redacted] MAS/RN
26 June 03 1700	Assumed care of pt p̄ daylight report given. eye are yellow. (R) Have NGT LIS. (C) Have nasal airway. O2 @ 5L/Min per high flow Face Mask (D) Arm DSG C/D/I. ABD DSG large amount bruised drainage noted on DSG. Foley = ~~clear amber urine in foley bag~~ dark amber urine in foley bag. Lung sounds clear ↑ lobes bil. ↓ lobes diminished noted bil. ABD soft nondistended. BS present in all 4 quads hypoactive. Midline DSG large amount bruised drainage noted. JP to bulb suction. NSR noted sections @ present time. (D) Subclavian triple lumen central line ⊕ S/S of infection (redness or infiltration) noted. LR @ 150cc/hr [redacted]

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

REGISTER NO. | WARD NO.

EPW #[redacted]

B6-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. [redacted])
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-45.505
509-111

All B6-2

MEDICAL RECORD	PROGRESS NOTES
DATE	
0255 26 June 03	MSO4 4mg IV given for Midline pain Sgt [redacted]
0310	Pt resting in bed @ present time — Sgt [redacted]
0400	CBC, Met 8 & liver panel drawn via central line & taken to lab. — Sgt [redacted]
0345	(Late entry) MSO4 4mg given IV for Midline pain. Will monitor — Sgt [redacted]
0405	T 101.3 A. Tylenol 650mg PR given. Will monitor — Sgt [redacted]
0430	Pt resting in bed @ present time. Will continue monitor — Sgt [redacted]
0445	MSO4 4mg IV given for Midline pain Sgt [redacted]
0455	T. 101.4 Will monitor — Sgt [redacted]
26 June 03 (0645hrs)	Assumed care of patient @ 0500hrs. (Neuro): Alert & semi-active on bedrest. (+) ROM all extremities, although limited 2ºH ↑ abd pain to which pt verbalizes and demonstrates guarding to mid-abd region. Strong pulses & capillary refill < 3 secs in extremities. (HEENT): PERRLA, brisk response to light, pupils @ 2-3mm c̄ jaundice sclera. Moves patient c̄ NG in (R) nostril & nasal tumpel in (L). Oral cavity c̄ semi-moist mucous membranes. Neck is supple. (CV): tachy (120bpm); rhythm unremarkable c̄ (m). Color of skin normal for nationality although (+) jaundice to trunk. (Lungs): Rhonchi noted upper & mid-lobes; ∅ wheezes. Moving air well during inspiratory. SaO_2 95-96% on $5LO_2$ via mask non-rebreather. Continues on 96° neb tx's c̄ chest pt. (GU): Abd c̄ midline abd dressing; (+) & abd serosanguinous drainage noted → will monitor for ↑. JP×1 to bulb suctioning placed in mid-abd incisional area → draining minimal bloody drainage. Bowel sound hyperactive upper quads; very minimal in the lower quads. (Continue on reverse side) (+) flatulence noted — (continued) [redacted]

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

REGISTER NO. | WARD [redacted]

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

PROGRESS NOTES

DATE	
27 JAN 03	Progress Notes
	POD#1 s/p fascial dehiscence closure and chlorphetg
	T↑ 103 @ 1800 yesterday pm
IPort 1000	Wound now PO2
X 8hr	WBC↑
	Tachycardic P 120-130 BP 139/90
	Lungs 2L O2 96% O2 sat
	wound intact - perfect BVD
	Arm → to OR for dialysis access
	App (1) s/p wound dehiscence
	(2) s/p chlorphed
	(3) febrile ō ↑ WBC
	(4) (R) arm wound
	(5) ↑ Bilirubin 4.9
	— to OR for wound washout
	— CXR this am
	— Cont unasyn

20.1 / 9.1 / 29.9 (485

138	103	14 (105
4.2	25	0.7

CK 2497
AST 114 (38)
ALT 85 (47)
TBil 4.9
GGT 69
Amy nl

BG-2

[redacted]

27 Jan 03 1400	Asked to see pt. regarding Temp 101 / Sat 95% on 6L / CXR = (L) side effusion. (R) infiltrate ō looking "wet" lungs wheezy poor inspiratory effort.
NS TKO	(1) Pneumonia ; likely hosp. acquired, including Pseudomonas.
MEQ Inj Ceftaz	(1) ↑ Unasyn. start Fortaz 1 gm q8 / start 5mg/kg/day & Lasix 20g X 1.
Zantac 50g q6	ō 1st Lasix voided off >2 liters in 3 hours. — [illegible] TKO W
Phenergan	
Tordol	
~~Tylenol~~ PR	Central line Δ; old one 10 days old; despite fever ↓; will Δ subclavian.
28 Jan 03 1130	Sterile prep. / fascial closure; good flash 16cm 7Fr triple Lumen; easy drawing back, CXR = of line secured. BS (B) clear. [redacted]

STANDARD FORM 509 (REV [illegible]) BACK
USAPPC V1.00

BG-2

All B6-2 (except last)

MEDICAL RECORD	PROGRESS NOTES
DATE 2115 26 Jan 03	Dr [redacted] notified of ↑ temp. No new orders received. Will monitor — Sgt [redacted]
2235	T 103.4. Tylenol 650mg given RTC for temp. Will monitor — Sgt [redacted]
2340	RT ∆ O2 4 L/Min per NC. SPO2 @ 95%. Will monitor. — Sgt [redacted]
0211	Tylenol 650mg given RTC for T 101.5. Will monitor — Sgt [redacted]
0300	T. 101.4A. Will cont to monitor Sgt [redacted]
0335	C/O pain. Give MSO4 3mg IV for pain. Will monitor. — Sgt [redacted]
0400	Resting in bed @ present time Sgt [redacted]
0430	Unable to draw labs from central line from medial line & distal line. Both lines flush. Reported this to SSG [redacted] (day shift) — Sgt [redacted]
0530	Assumed care of Pt. Pt alert, verbal, HOB [redacted] 40, eyes-PERRA 3-4 mm brisk, sclera yellow, Equal rise & fall of chest, lungs CTAB ⓒ ↓ BS in ⓑ bases, SpO2 ~~92~~ 97% on 4 L/m NC, Nasal tramp in ⓒ more ⓒ, S1S2 present, Sinus Tach Rate 120's, pulses x 3, cap ref. <3 sec in 4 extremities, ⓒ central line, site clean, ⊘ s/s infection, LR @ 150 ml/hr and NS 0.9% @ 10 ml/hr, ABD round ⊂ medial ⊂ lap dressing intact drainage noted but not soaked, drainage is yellow-brown, Jp drain seroserguinous fluid about 5.0 ml/hr, ↓BS x 4 quadrants, Foley to gravity - amber, clear urine, movement & sensation in ⓒ UE. T 103.5, given Tylenol 650mg PR. [redacted] SSG grunts

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] B6-4

PROGRESS NOTES
Medical Record

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

A11 B6-2

PROGRESS NOTES

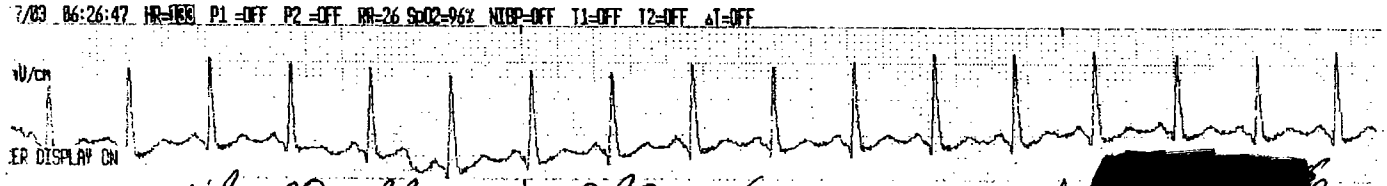
DATE	
27 June 03 1840	Received pt. @ 1700. Nursing assessment done. Neuro: A+O x3. Pupils equal @ 2mm, sluggish. Sclera jaundiced. Resp.: lungs coarse throughout, diminished @ the bases. SpO2 97% c̄ 6L O2 via NC. Nasal trumpet in (R) nare. Albuterol neb tx c̄ CPT Q 6°. CV: ST c̄ ∅ ectopy. HR 120s. 2+ pulses x 3 ext. Unable to assess (L) UE due to splint. Cap refill brisk x 4. GI: unable to assess BS due to large dressing over abd. NGT to LIS (R) nare c̄ mucous clear/white. NPO. GU: Foley cath. to gravity drainage c̄ thick dark amber colored urine. Voiding 200-300cc/hr. Skin: large bulky dressing to abd c/d/i. Aid this Am. JP to bulb suction from abd. wound c̄ 10cc serous drainage last hour. (L) UE splinted c̄ ACE wrap. (+) csm to (L) hand. (R) UE ↑ on blanket. Lines: Triple lumen cath. to (L) SC intact. NS @ TKO + MSO4 drip @ 1cc/hr infusing into 2 ports. Distal port clamped - not in use. — [redacted] 1ST/Am
27 June 03 1900	T 103.5. Tylenol 650 mg PR given. Pt. c/o abd. pain. 4mg MSO4 IVP given. Pt. resting @ this time. — [redacted] 1st/Am
27 June 03 2000	Lasix 20mg IVP given. SpO2 ↓ to 85% 6L NC. Encouraged pt. to deep breath. SpO2 went up to 88% c̄ deep breaths. Face mask put on c̄ 10L O2. SpO2 now 94% c̄ 6L O2 via FM. Will cont. to monitor. — [redacted] 1st/Am
27 June 03 2115	T 103.8. Pt. given bed bath c̄ cold water + "ice bath" c̄ cold compress on forehead. — [redacted] 1st/Am
28 June 03 0450	Pt. able to sleep through most of the night. Woke up @ 0400 c̄ coughing spell. Coughed up white sputum which was suctioned c̄ Yankeair. Am labs drawn from distal port of TLC c̄ difficulty. All 3 lumens able to flush easily. Thrush noted in mouth c̄ suctioning. UOP ↓ to 30cc last hour. ∅ other Δ's. — [redacted] 1st/Am

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

All B6-2 (except last)

MEDICAL RECORD	PROGRESS NOTES
DATE	
27 June 03 0600	RT note: Administered one ug albuterol HHN to Pt & on 2L NC @ this time saturating 96%. HR 122 BP 199/77 RR 28. BBS are CTA but diminished bilaterally on the Lower Lobes. Performed CPT to both lungs. Apical middle & Lower lobes on R & upper & Lower lobes on L. ⊖ sputum production. Semi-strong cough but still non-productive. Post tx: HR 117 RR 32 SpO2 100 on 2L for tx. BBS: Diminished BLL. Will continue to [redacted] NOTIFIED [illegible]

7/03 06:26:47 HR=130 P1 =OFF P2 =OFF RR=26 SpO2=96% NIBP=OFF T1=OFF T2=OFF ΔT=OFF



HR 130 PR .12 QRS .06 Sinus Tach [redacted]

27 Jun 03 1000	Pt ↑ T 103°. TCE applied, Pt given 650 mg Tylenol PR. Pt's ABD wet ⇒ Dry dressing. Dry site retention straps intact. Serosanguinous drainage noted. Ø S/S [illegible] noted. Pt tolerated procedure. [redacted]
27 Jun 03 (1315 hrs)	Temperature currently 103° ax. ⊖ response to cooling measures (ice, tylenol supp). Dr [redacted] who is to perform the pt's wash out of L forearm, has been informed of his most recent condition & re-evaluate. [redacted]
27 June 03 1400	New orders Fortaz 2gm IVPB q 8, Gentamicin 5mg/kg IVPB qd – Orders given @ 1345 – meds incompatible Gent given @ 1400 Fortaz given @ 1600 SGT [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

[redacted]

B6-4

All B6-2 (except last)

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
27 Jun 03 1800	UD Alb tx given HR 126 RR 28 SpO2 95% BS (+) coarse (+) Rhonci Diminished bases Post tx HR 128 RR 32 SpO2 98% BS No change CPT Done Pt coughed throughout Pt c/o pain CPT Stopped — SGT [redacted]
28 June 03	UD Alb tx given HR 133 RR 32 SpO2 98% partial rebreather loc BS Diminished chest PT Done Pt coughed throughout Post Tx HR 132 RR 36 SpO2 97% BS coarse Diminished in Bases — SgT [redacted]
28 Jun 03 1800	RT Note: UD Alb tx given HR 127 RR 21 SpO2 95% BS Diminished Post Tx HR 131 RR 20 SpO2 98% BS No Change — Chest pt Done Pt able to cough up some secretions SGT [redacted]
29 June 0020	UD Alb tx given BS clear HR 112 RR 14 SpO2 96% on 2L NC Post Tx BS No change HR 115 RR 14 CPT Done — SGT [redacted]
29 Jun 1800	UD Alb tx given HR 125 RR 22 SpO2 96 BS clear Diminished RLL Post Tx HR 127 RR 23 SpO2 97% on 2L NC CPT Done — SGT [redacted]
30 Jun 0025	UD Alb tx given BS clear HR 100 RR 20 SpO2 98% on 2L NC Post Tx BS clear HR 114 RR 28 SpO2 99% CPT Done — SGT [redacted] RT SGT

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO

[redacted]

B6-4

PROGRESS NOTES
Medical Record

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

All B6-2 (except last)

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29 June 03 1630	PT VS 102°F 119/70-126-24-96% SpO2 on 4 LPM NC. PT given 650 mg Tylenol PR for ↑ temp. PT's lung sounds at bases have improved, but diminished sounds still noted. PT has (+) productive cough w/ green sputum. PT ambulating, alert, [redacted]
1635 9 Jun 03	PT alert, can move fingers and has sensation in (L) hand. Cap refill <3. [redacted] SSG [redacted]
29 June 03 1700	Assumed care of Day Shift. Report given by [redacted]. Eyes are yellow bil. PERRL @ 2mm. NGT to LIS. NG in (R) Nare. (R) Sub-Clavian triple lumen central line S S/S of infection or infiltration noted. (L) Arm DSG CDI. Midline DSG CDI. (R) Flank area entrance wound healed. No active bleeding or drainage noted. (R) thigh anterior small blister noted. IV @ 100 cc/hr & MS04 1 mg/hr in central line. Central line DSG CDI. O2 @ 4 LPM per NC. Lung sounds clear bil. BS present in all 4 quads. ABD soft nondistended. Foley w/ clear amber urine in foley bag. (L) Arm ↑ on blanket. Cardiac: Sinus Tachy 130's @ present time. Pedal pulse present bil. (L) radial unable to assess due to [redacted] on more fingers on (L) Cap refill <3 sec. (R) radial pulse present. Sig [redacted]
	JP to bulb suction. JP ↑ ABD. Will monitor pt. for temps. [redacted]

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

FT [redacted]

B6-4

PROGRESS NOTES
Medical Record

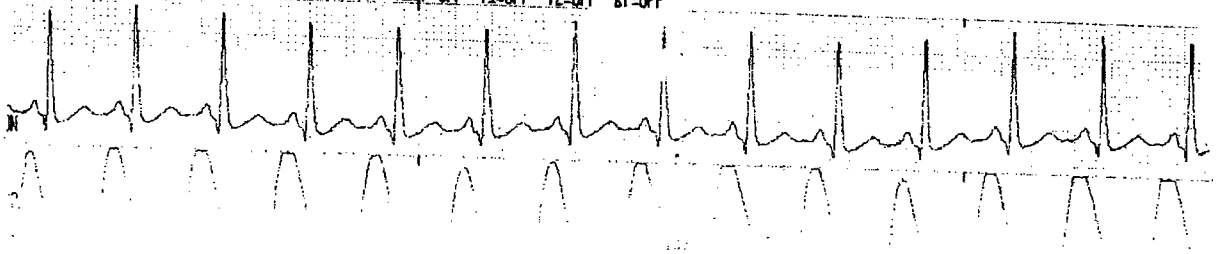
STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

A11 B6-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE | NOTES

56 HR=123 P1 =OFF P2 =OFF RR=26 SpO2=100% NIBP=OFF T1=OFF T2=OFF ΔT=OFF



1800 T 100°A. Will cont. to monitor — Sp[redacted]
1900 T 99°A. Will cont. to monitor — Sp[redacted]
1945 Assisted up to chair. pt @ 5 min ~~stated~~ error pt had to sit on BSC. ~~Sp~~ Med. Asst BM. pt A cleared himself. Assisted back to chair. — Sp[redacted]
2000 Pt used TS approx 10 X's while sitting in chair. Will cont. to monitor. ⊕ Arm T on blanket. Sp[redacted]
2100 24 cc urine output noted. ~~Will~~ Dr. [redacted] notified of urine output. New order recieved @ 2115. Bolus 500 cc LR started @ 2120 per MD order. Will monitor Sp[redacted]
2200 pt 500cc Bolus LR. Urine output 500cc dark amber urine noted. Will monitor — Sp[redacted]
2300 700cc dark amber urine noted. Will cont. to monitor. — Sp[redacted]
2400 1100cc dark amber urine noted. Will cont. to monitor Sp[redacted]
0100 T 101°A Tylenol 650 mg PTC given for T temp. Will monitor. — Sp[redacted]
0200 T 100.4A Will cont. to monitor — Sp[redacted]
0245 Nubain 8mg IV given for incisional pain. Will monitor Sp[redacted]

STANDARD FORM 509

USAPA V1.00

All B6-2 (except last)

AL RECORD

AUTHORIZED FOR LOCAL REPRODUCT

PROGRESS NOTES

30 June 03 2100 Pt Restless 2mg Ativan given IV Will Monitor Sy[redacted]
2200 Tylenol 650mg PTL given T 101.4 A Will Monitor Sy[redacted]
2300 T 101.6 A Will cont to Monitor Sy[redacted]
2000 late entry O2 taken off SpO2 @ 99% Will Monitor Sy[redacted]
2300 late entry O2 reapplied SpO2 v 88% O2 @ 2L per Mo Sy[redacted]
2400 T. 102.2 A Dr. [redacted] notified of Pt temp. No new orders received. Sy[redacted]
0100 T 100.4 A Will cont. to Monitor Sy[redacted]
0200 T 101.2 A Tylenol 650 mg given PTL Sy[redacted]
0300 T 101.3 A Will cont. to Monitor Sy[redacted]
0400 T 99.7 A Will Monitor Sy[redacted]

1 July 03 - Nursing assessment - Pt is Alo x 3, VSS, HR- 101, BP- 122/78, RR 22, T. 100.
0550 SpO2 99%. Pupils Perrla @ 2-3 mm. Pt lung sounds clear c̄ diminished bases, breathing shallow @ 22 Respirations/min. Skin color normal for race, warm, dry. + BS x 4 quadrants, hypoactive. Drsg to abdomen c̄ small amount of drainage. Drsg to be Δ'd later in shift. Pt c̄ foley in place draining yellow urine. 500 cc upo this am. Pt cardiac rhythm sinus tach @ 101, S_1, S_2 present. Pt c̄ (R) central line infusing LR @ 100cc. Pt c̄ Ace wrap & splint to LUE. Neuromuscular checks WNL. [redacted] LPN
(Shift) 0800 Pt ↑ on B standing and walking for 10 minutes while getting X-RAY [redacted] 556 flowers

IF TO SPONSOR

SPONSOR'S NAME

LAST | FIRST | MI | SSN or Other NUMBER

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

REGISTER NO | WARD NO

#[redacted]

B6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-15)

A11 B6-2

1-JUL-03 ~~PT started~~
0940 PT given premedication of 2u PRBC's, PO Tylenol and Benadryl 50 mg PO for

1000. PT 1st unit PRBC started. VS 120/67-100.6-111-22-98% RPM O2 via NC. PT alert and verbal, NAD. Will monitor for reactions

1642060

1015 PT VS 114-100.5-20-114/67-98% SpO2 on 4L via NC - [redacted] 556 9 mins
030 PT VS 107/64-100.9-21-104-98% SpO2 on 4L via NC - [redacted] 556 9 mins
045 PT VS 114/76 - 100.9 - 21 - 107 - 97% SpO2 on 4L via NC - [redacted] 556 9 mins
100 PT VS 112/66 - 101.0 - 24 - 102 - 98% SpO2 on 4L via NC - [redacted] 556 9 mins
200 PT's VS 107/66-100.7-22-97-98% SpO2 on 2L via NC, PT's 1st unit PRBC complete, PT alert and verbal, ate 10% of ready diet. PT sleeping. no reactions noted [redacted]

240 PT's 2nd unit PRBC started # 008129, VS 100.7-22-113/67-101-98% SpO2 on 2L via NC. Will monitor for reactions. [redacted] 556 9 mins
215 PT VS 108/62-100.5-23-99-98% SpO2 on 2L via NC - [redacted] 556 9 mins
230 PT VS 107/64-100.5-21-103-98% SpO2 on 2L via NC - [redacted] 556 9 mins
245 PT VS 110/64 - 100.4 - 24 - 99 - 99% SpO2 on 2L via NC - [redacted] 556 9 mins
300 PT VS 106/63 - 100.5 - 22 - 97 - 99% SpO2 on 2L via NC, Ø reactions noted, PT started on Nystatin swish & spit for hairy tongue

1400 - Pt VS - 113/66 - 99.8 - 25 - 101 - 99% SpO2 2LPM NC - [redacted] 2LPM

Pt c/o Pain, 2mg MSO4 Given - [redacted] 2LPM

1405 - 2nd unit PRBC complete. PT alert, [redacted] NAD, [redacted] 556 9 mins
1505 - PT's Hgb 9.6 Hct 31.7 [redacted] infusion, [redacted] 556 9 mins

All B6-2 (except last)

AUTHORIZED FOR LOCAL REPRODUCT

AL RECORD | PROGRESS NOTES

30 Jun 03 Pt resting in bed. No c/o pain @ present time. Will
0300 cont. to monitor. Sig [redacted]
0400 T 99.4 Will cont. to monitor Sig [redacted]

[redacted] Note

31 Jun 03 Day better details on: Cefotetan | Gent
WBC ↓ 15
Tbili ↓ 3.7
Tmax 100.9
PE: Ct L BS
poor pulmy effort
Ex: Improved
O — R xrg f PALPAT
— No out
— clear tract
— if Bilirubin not ↓ agn DC w/ MD

[redacted]

30 Jun 03 0600 Pt asleep @ intervals but easily ar[redacted] O2 - 4L NC Respirations even and unlabored. Diminished (B) breath sounds but CTA. Palpable pulses. Capnefill ≤ 3secs. NGT to (L) nare LIS ō gastric contents expelled. Absent bowel sounds. foley cath ō amber urine. splint (L) UA. Abdominal Drsg CDI. LR @ 100/hr MSO4 1mg/hr — [redacted]

HIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
RVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
ENTIFICATION: (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 5/19
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)

[redacted]

B6-4

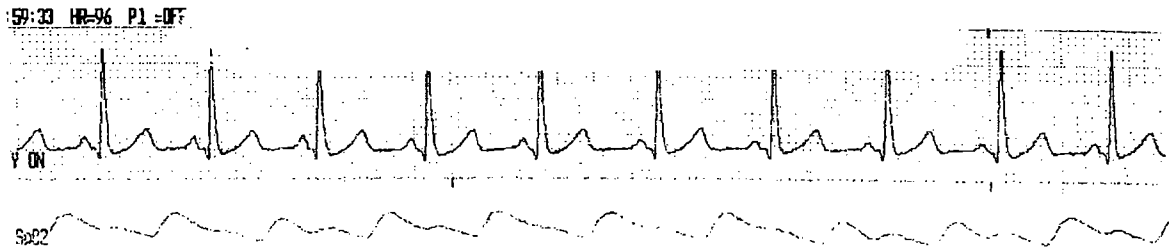
A11 B6-2

cont'd.
30 Jun 03 0600 — JP drain to Abd area to bulb suction scant amt of drainage VSS. (R) SC Triple lumen cath ~ s/s infection. Cont. c̄ antibiotic and neb treatments. Will cont. to monitor status — [redacted] CPT

30 Jun 03 0800 NGT removed per MD order. I/S in use. Pt c̄ forceful cough, Productive. Tolerated clear liquid diet — [redacted] CPT

30 Jun 03 0600 late entry - Pt c̄ jaundice to sclera — [redacted] CPT
Accurate care ~ Day shift report given.

30 June 03 1700 Alert, pt knows some English. Eyes are yellow. PERRL @ 2mm O2 @ 2L per NC. (L) Arm DSG CDI. Midline DSG CDI. (R) anterior thigh area c̄ small blister noted. Foley to gravity c̄ dark amber urine noted. Lung sounds clear ↑ lobes. ↓ lobes diminished. BS ⊖ in all quads. JP bulb to suction on ABD. ABD soft nondistended. (R) subclavian central line c̄ triple lumen ⊘ S/S of infection or infiltrate. Central line DSG CDI. NS @ 100cc/hr & MSO4 1mg/hr via central line. Pedal pulses present bil. (R) radial pulse present. (L) radial unable to access due to DSG. (L) hand pt can move fingers. Cap refill < 3 sec @ finger nail bed on (L). Will monitor. (L) Arm ↑ on blanket. — [redacted]
NSR ~ ectopy noted @ present time — [redacted]



2000 DSG Δ Midline - old DSG large amt of brown & bloody drainage noted on old DSG. Blister noted (R) middle beside Midline wound. Wound c̄ retention bands & sutures by retention bands. Applied wet → dry c̄ NS dressing. Covered c̄ ABD pads. Secured c̄ tape. Pt c/o pain gave MSO4 4mg @ 2030. Will Monitor. — [redacted]

All B6-2 (except last)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30 June 03	0600 Pt. given UDAIB via Aerosol mask c̄ neb machine x 15 min
	P 100 RR 19 100% SAT @ 2L NC
	BBS c̄ CTA p̄ NO Δ CPT x 5 min bilat [redacted] CPT
2 JUL 03	Pt resting but awake to noise. Pre tx: HR 109, RR-26, BS - CTA c̄ ↓↓ @ bases. SPO2 98% on 2L NC. UD AIB neb given. Post HR-106 RR-24, SPO2 97% on 1L NC. CPT done stopped c̄ pain CPT 2 mins each side. —— Sgt [redacted] 91V2B
2 JUL 03	Pre tx HR 110, RR-23, SPO2 95% on RA. UD AIB neb given. Post tx HR 106, RR 21, SPO2 94. BS CTA c̄ slight ↓↓ at bases. CPT done 2 min each side. c̄ cough —— Sgt [redacted] 91V2B
3 July	0600 Pt. given UD AIB via face mask c̄ compressor x 5 min
	P 101-101 RR 19-21 SAT 96% on RA
	BBs c̄ CTA p̄ NO Δ pt. has non productive cough.
	Note placed in record asking Dr. review CPT & Tx. RRR CPT [redacted]

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[redacted] B6-4

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CAL RECORD | PROGRESS NOTES

.TE	NOTES
2 JUL03 @0630	Recieved report. A+O. Ø Complaints of pain or discomfort @ this time. Heart rate Sinus Tachy @118. S1 S2 Present. Lungs breath sounds diminished at the bases (bilaterally) ⊕ Productive cough. Continues on neb tx Q6° c̄ Pulmonary Toliet. Abd soft and tender. Incision site Clean & no S/S of infection. Wet to dry dressing applied. Foley to Gravity draining clear yellow urine. ⒹUE c̄ Splint, unable to check pulse, can wiggle fingers and has good (Brisk) cap refill. Otherwise neurovascular intact. IV ⓡ subclavian triple lumen flushed + Patent. Infusing LR @100cc/hr and Morphine Drip at 1mg/hr. JP Bulb to suction c̄ minimal Serosanguious drainage. Will Continue to monitor for Changes.
B6-2	[redacted] SGT 91WM6
0730	Refused Breakfast. [redacted] SGT 91WM6 B6-2
1130	Taken to xray for PA/LAT. Walked from Xray back to unit. Placed back in bed after episode of being diaphoretic and hypotensive BP 106/65 HR TAchy @119. Medicated for Pain Feet raised and head down in bed. Will

SHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBE (SSN or Other)
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PROGRESS NOTES
Medical Record

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#[redacted]

B6-4

A11 B6-2

DATE	NOTES
1130 (Cont)	Continue to monitor. — [redacted] SGT 9/UM6
2 Jul 03	
1320	Not Diaphoretic, BP Stable @ 113/67 P 106. Resting c̄ no complaints of pain or discomfort. Refused Lunch and Carnation instant breakfast. Will Continue to monitor and inform M.D of Caloric intake — [redacted] 9/UM6 SGT
1500	Stable, Ø complaints of pain or discomfort VSS. Sips of Water & Juice tolerated [redacted] 9/UM6 SGT
1700	Accepted Care ⊽ daysh̄ift report given by Sgt [redacted],
2 July 03	eyes are yellow. PERRL @ 2mm. O2 @ 2L per NC, equal rise & fall of chest, lung sounds clear bil. BS (+) in all 4 quads. Midline DSG small amt yellow drainage noted on DSG. Will Monitor. (L) Arm DSG CDI. JP bulb to suction. JP intact to ↑ ABD. Foley to gravity clear amber urine noted in foley bag. LR @ 100 cc/hr & MSO4 1mg/hr via central line. Central line DSG CDI. Central line c̄ triple lumen. SS/SQ infection or infiltration noted. Pedal pulses present bil. (R) radial pulse (+). (L) radial unable to assess due to DSG. (L) hand fingers pt can move, cap refill < 3 sec @ fingernail bed on (L). Sinus Tach @ 103 @ present time. Will Monitor — [redacted]
1900	Used IS approx @ 10 x's SpO2 @ 95%. [redacted]
1920	RT took o2 off. SpO2 @ 95% Will Monitor [redacted]
1924	RT reapplied O2 @ 1L min per NC. SpO2 @ 94% [redacted]
2139	MSO4 4mg given per Mike pain — [redacted]

STANDARD FO[redacted]

A11 B6-2

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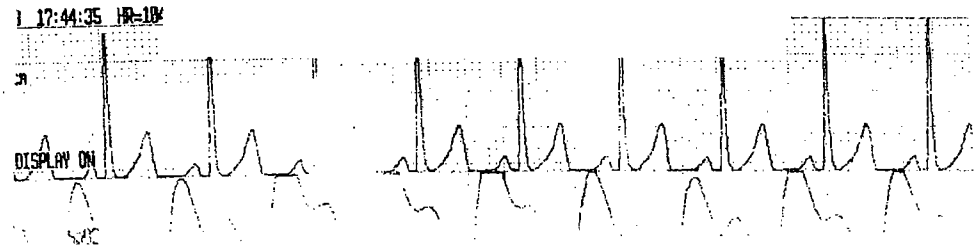
MEDICAL RECORD | **PROGRESS NOTES**

DATE

July 03
1744



2140 O2 off SpO2 @ 95%. Will monitor — Sgt [redacted]

2230 Resting in bed. No c/o pain @ present time. Will monitor. — Sgt [redacted]

2120 late entry O2 taken off. SpO2 @ 95% Will monitor

2300 SpO2 @ 98% Will cont. to monitor Sgt [redacted]

2351 MSO4 3mg given IV for Midline pain. Will monitor [redacted]

0050 MSO4 3mg given IV for Midline pain. Will monitor [redacted]

0180 Resting in bed. — Sgt [redacted]

0255 C/o Midline pain MSO4 4mg given IV. Will monitor — Sgt [redacted]

3Jul03 @ 0540 Recieved report. A&O. Heart rate Sinus Tachy @ 100 S1S2. Lungs CTA bilaterally ⊕ productive cough. Uses i centive spirometer. Resp Fx @ 26°. Abdomen soft and

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PROGRESS NOTES
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A11 B6-2

DATE	NOTES
3 Jul 03 0540 (BOTT)	tender. (+) BS x 4 Quads. Abdominal drsg A'd, CDI (wet to dry). Foley to gravity draining clear yellow urine. JP to bulb suction (L) UE c̄ splint, unable to check pulse. (B) Cap refill, able to wiggle finger. Other exterem·ties Neuro vascularly intact. (R) Subclavian triple lumen flushed & Patent. IV infusing LR @ 100 cc/hr and a morphine drip of 1cc/hr c̄ S/S of infection or infiltration. Will Continue to monitor for any Changes. — [redacted] SGT 91WM6
3 Jul 03 @ 0830	OOB to Chair, ate 25% breakfast. A.M. Care done. C/o Abdominal Pain, Medicated with 3mg MSO4 Will Monitor effect — [redacted] SGT 91WM6
0920	Requested to go back to bed stated he was dizzy. Skin Diaphoretic. Placed back in bed VSS. Pain med effective — Helen [redacted] SGT 91WM6
1130	∅ Complaints of Pain or discomfort. Resting temp 98.8 Will Continue to monitor. — [redacted] SGT 91WM6 —
1500	CXR Complete. C/o Pain medicated c̄ 3mg MSO4 @ 1455. Will Monitor effect. Placed back in bed — [redacted] SGT 91WM6 —

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A11 B6-2

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
3 July 03	0630 Pt. 311 is CTA c̄ cough. please reeval for CPT and/or Tx. His last order was written on 25 June 03. Thank you SGT [redacted] RN/RR CRT
3 JUL 03	Progress Note Patient cont to improve daily on current IV ABx regn afebrile & WBC to 11.5 cleared gomely, mucly. Pain control excellent c̄ IV MSO4 + Toradol Plan: Δ to oral med DC Toradol | IV MSO4 start permit 2 mg q 6 MSO4 PRN. Δ to oral Zantac Δ to PO Cipro & ABx course [redacted] CXR RML pneum persists as plate like atelec
3 JUL 03 2000	Received report from offgoing nurse. Alert 4AO. MAE x4. PERL @ 3mm brisk. (CV) Sinus tach 100's. (+) S/S2 PPP. Unable to assess pulse on (R) UE due to splint on it. Afebrile. (RESP) (B) CTA. (+) productive cough. Room air O2SATS 95%. Equal chest expansion. [redacted]

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

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A11 B6-2

DATE	NOTES
3 Jul 2000	(GI) Abdomen round, tender to touch. Active BS x 4 quadrants. On regular diet tolerating well. (GU) Foley to gravity (positional) draining adequate amount of clear yellow urine. (SKIN) W/D. Midline abdominal wound with dressing intact. (L) arm with splint. JP to bulb suction. (LINES) (R) subclavian triple lumen catheter with LR @ 100 cc/hr. Will keep monitoring for any changes [redacted]
4 Jul 03 @0535	Recieved report. Awake and A+O X 3. Ø Complaints of pain or discomfort at this time. Heart $S_1 S_2$ Present. HR @ 97 bpm. Lungs clear to ascultation bilaterally. Cough + deep breathing encouraged. Abdomen c̄ LG belly dressing. Changed with wet to dry DSD. (+) Bowel Sounds x 4 Quads. Soft and tender to touch. Foley to gravity draining clear yellow urine. LUE with Splint. Splint intact and wrapped c̄ ace wrap. (+) Neuro vascular check to all 4 extremities. (R) SC triple lumen cath infusing LR @ 100 cc/hr s̄ difficulty. Site c̄ no S/S of infection. Able to flush all (3) ports. JP drain to abdomen c̄ minimal drainage. Will Continue to monitor for changes — [redacted] SGT Plumb
0610	Pharmacy out of Zantac, med not given need notify M.D. — [redacted] SGT Plumb
0915	JP bulb DC'd intact by DR [redacted] — [redacted] SGT Plumb

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1900	No c/o pain @ present time. Will monitor Sgt [redacted]
2000	MSO4 3mg IV given Midline pain. Will monitor [redacted]
	FS used several times approx @ 10 x's. Sgt [redacted]
2255	Percocet II given for Midline pain Will monitor Sgt [redacted]
0305	Percocet II given for Midline pain. Will monitor Sgt [redacted]
0400	Resting in bed @ present time. Will monitor Sgt [redacted]
5 JUL 03 @0700	Recieved Report. A+O x 3. c/o of wanting to go home or to Iraqi hospital, advised c̄ help of translator. that pt. Status is EPW and upon discharge will be released to NP's. Verbalized understanding. Ø Complaints of pain or discomfort @ this time. Heart S1S2 HR @ 80 bpm. Lungs CTA + equal bilaterally. Abdomen soft and tender c̄ (+) BS x 4 Quads. Abd drsG CDI. Foley to gravity draining clear yellow urine. Neurovascularity intact x 4 extremity's. Soft splint to (L) Arm intact c̄ NO constrictions, ACE wrap CDI. IV: (R) Subclavian flushed + Patent. infusing LR @ 100 cc/hr s̄ difficulty Will Continue to monitor for changes. [redacted] SGT 91WM6
1000	A.M. Care done. Ambulated and OOB x 1 hours. doing Very well c̄ minimal assist. VS Changed to Q Shift Foley DC'd @ 0900. D TV by 1500. Zantac DC'd and will be NPO p̄ midnight. Abd. drsG Δ'd Site s̄ s/s of infection, (+) Red granulating tissue. Medicated for Pain c̄ MSO4 As per order. [redacted] SGT 91WM6

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A11 B6-2

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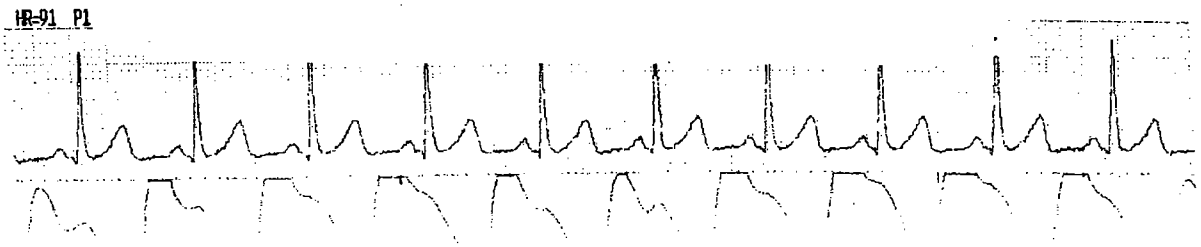
MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
03Jul03	A.M. Care, OOB to Chair then ambulated to
@0945	Nurses station and back —
1700	Assumed care of Day Shift report given. Sgt [redacted]
1800	Alert, Verbal. PERRL @ 3mm. eyes: Sclera yellow. Central line c̄ triple lumen DSG CDI. LR @ 100cc/hr via central line. Midline DSG CDI. (L) Arm DSG CDI. (L) Arm ↑ on blanket. Foley to gravity c̄ dark amber urine noted in foley bag. Pedal pulse present bil. Radial (R) present Dorsalis to assess on (L) due to DSG. (R) hand finger pt can move. Cap refill < 3 sec @ fingernail bed on (L). C/o Midline pain. Give Percocet 1 po. Will monitor. NSR noted s̄ ectopy. Will monitor — [redacted] Lung Sounds Clear ↑ lobes ↓ lobes diminished. IPS present in all 4 quads. — [redacted]

HR-91 P1



RELATION

LAST	FIRST	MI	(SSN or Other)

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All B6-2 (except last)

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5JUL03 @ 1600	Patient unable to void P Foley DC'd @ 0900. Patient was DTV by 1500. DR [redacted] notified of inability. Bladder not distended. Stated to wait a few more hours. Then attempt again. If no void notify MD. — [redacted] SGT [redacted]
1700	Assumed Care of Day Shift report given by SGT [redacted] Pt tries to void & sitting on BSC. Will monitor [redacted]
1800	Pt can't void & can't have BM. Pt having pain when try to void. Dr [redacted] notified recieved new orders for Colace PO BID & Replace foley. Orders recad @ 1815. ~~left~~ Pt assisted back to bed. 16F Foley using Sterile Tech. reapplied. 525cc dark amber urine return noted on foley bag @ 1820. PERRL @ 2mm ens: scleral yellow noted. Central line DSG CDI. LR @ 100cc/hr via central line c triple lumen 5 s/s of infection or infiltration noted. lung sounds clear bil. ABD DSG CDI. BS present in all 4 quads. (L) Arm DSG CDI. Pedal pulses present bil. (R) Radial pulse present. (L) unable to assess due to DSG. Pt can move fingers on (L). Cap refill < 3 sec @ finger nail beds on (L). Pt c/o pain Percocet was given @ 1805 ens. Will monitor — SGT [redacted]
2145	C/o ABD pain. Given Ulsol 6mg IV. Will monitor SGT [redacted]

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

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[redacted]

B6-4

PROGRESS NOTES
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USAPA V1.00

A11 B6-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2315	ii Percocet given for ABD pain Will monitor [redacted]
0005	Resting in Bed @ present time. Will monitor [redacted]
0030	C/O ABD pain. Give 5mg MSO4 IV. [redacted]
0145	C/O ABD pain. Give 5mg MSO4 IV. Will monitor [redacted]
0215	Resting in Bed @ present time — [redacted]
0315	C/O ABD pain. Give 5mg MSO4 IV. Will monitor [redacted]
0400	Resting in bed @ present time — [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0722 6 JUL 03	Neuro. pt. Alert oriented PERRLA 3mm reactive sclera yellow in coloration CV: ST ± ectopy, S1 S2 auscultated no murmurs — Resp. sats 94% RA clear breathing deep intervals clear — RENAL UA GU: voiding on call for surgery. GI: F/L & growth, clear amber yellow urine. Skin: (L) arm ace dress — & mid low abdo. [redacted]
0730 6 JUL 03	pt. C/O pain on 1-10 scale DRAG expressed 6 level MSO4 ordered 2-6 IVP q. 1° because of and level pain expressed gave 3mg dose to discuss w/ Dr. [redacted] anesthesiologist post surgical review — [redacted]
0740	MSO4 had positive effect & C/O pain resting comfortably — [redacted]
6 JUL 03	Brief op Note Procedure: DPC ML old incision Cast (L) arm Dr [redacted] / Dr [redacted] GETA EBL min wound closed successfully. [redacted]

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

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All B6-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6 Jul 03 @ 0930	Recieved from OR. See PACU note DA Form 4700 - [redacted] SGT [redacted]
1230	Resting, Ø complaints of pain or discomfort. VSS, Afebrile. Will continue to monitor and access for pain. - [redacted] SGT [redacted]
1700	Assumed care of pt @ change of shift report given by SGT [redacted]. A&O, Verbal, PERRL @ 2mm. Scrotal yellow. (R) subclavian central line DSG CDI. Central line SS/S of infection or infiltration noted. NS @ 125 cc/hr via CL. (L) Arm DSG CDI. ABD DSG bruised drainage moderate noted on DSG. Lung sounds clear bil. BS present in all 4 quads. Foley cath to gravity - dark amber urine noted in foley bag. Pedal pulse present bil. (R) radial pulse Ø present. (L) unable to access due to DSG. Pt can move (L) hand fingers. Cap refill <3sec. on fingernail beds. (L) Arm ↑ on blanket. Refused to use I.S. Will monitor — SGT [redacted]
1920	MS04 4mg IV given for ABD pain. Will monitor SGT [redacted]
2000	~~After~~ Medline VSS. A'd - of DSG moderate bloody drainage noted on DSG. Wound - Sutures. Applied 4x4's & ABD pads. Secured - tape. A'd Central line DSG - Cleaned - betadine. Applied new op-site DSG. Pt tol. well. No C/O pain @ present time. Will monitor SGT [redacted]
2030	Percocet II Given for ABD pain. Will monitor SGT [redacted]
2325	MS04 4mg given for ABD pain. Will monitor SGT [redacted]
2300	Resting in bed @ present time. Will monitor SGT [redacted]
0000	MS04 3mg IV given for ABD pain. Will monitor SGT [redacted]
0115	C/O ABD pain. Give MS04 3mg IV. Will monitor — SGT [redacted]

STANDARD FORM [redacted] BACK

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01 July 03 Pt. care t[redacted] to me @ 1800. Pt. [redacted] pils equal &
1800 reactive @ 3mm. ↑ RR 20s - sometimes 30s. Pt. takes short, shallow breaths.
Encouraged him to take slower more deliberate breaths. SpO2 2L O2 via NC 97%.
Lungs CTA throughout but difficult to assess due to pt. not taking deep breaths.
ST ō ∅ ectopy. ⊕ pulses x 3 extremeties. Unable to palpate error ⊕ hand because of
splint & ACE wrap. Cap refill brisk x 4. Abd. soft, non-tender. ⊕ BS ⊕ LQ, otherwise
hypoactive. Foley cath. to gravity drainage ō dark yellow urine. Midline abd. incision ō
dressing C/D/I. ⊕ SC central line TLC. infusing ⊼ difficulty. — [redacted] ICT/Am — B6-2

01 July 03 Pt. c/o pain in abd. Medicated ō 2mg MSO4 IVP — [redacted] ICT/Am
2100

01 July 03 Pt. cont. to c/o pain. Medicated ō Ativan 2mg PO. Will cont. to
2230 monitor. — [redacted] ICT/Am

02 July 03 Pt. able to sleep through the night ō minimal c/o B6-2
0445 abd. pain. ~~Pain~~ error Pox maintained 92-95% 2L O2 via NC.
T max. 101.°. VSS. ∅ other Δ's — [redacted] ICT/Am

B6-2

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AL RECORD | PROGRESS NOTES

E | NOTES

1-Jul-03 1700 Pt ↑'d T 101.2. Pt given 650mg Tylenol P.O. Pt Alert verbal, NAD, will monitor for ↓ Temp [redacted] 96 9 from 6

1700 Assumed Care of pt. Pt Daytime report given [redacted] per SSG [redacted] B6-2

Eyes are yellow bil. PERRL @ 2mm. (R) Subclavian central line D&S CDI. Central line = triple lumen 3/15 ok infection or infiltration. NS @ 100 cc/hr & Nexium 40mg/hr via central line. O2 @ 2L per NC. Mid line D&S CDI. (L) Arm D&S CDI. Lung Sounds Clear bil. BS (+) (R) quads ↑ ↓ (L) quads ↑ ↓ (−). Foley patency = clear yellow/amber color urine in foley bag. Pedal pulses present bil. (R) radial pulse (+) (L) Unable to assess due to Bulky D&S. (L) hand pt can move fingers. Cap refill < 3 sec @ fingernail beds on (L) hand. NSR 5 ectopy noted @ present time. Will monitor pt. (L) Arm ↑ on blanket. [redacted]

HR=101 P1 =OFF P2 =OFF RR=

B6-2

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REGISTER NO	WARD NO.

[redacted]

B6-4

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0700 Tue 03	pt expressed pain in abd. at the level 9 when shown chart. gave [redacted] 4mg MSO4 due to expression of upper level on pain scale [redacted] 91WM6
0710 Tue 03	effective relief of pain expressed by pt. Abd covered x3 [redacted] 4mm 50° MSO4 prn as need for pain CV: SR ± extrasys & pmd pulses 2/2 upon auscultation RL lung bilat clear. GU: bowels sounds present. midline abd dressing clean dry intact. GI: oriented x3 FIC Generally: Eyes scleral yellowish in color. Skin NFR Diet Reg. - Ambulate ad comfort - Drg △ BID IS q1° US q Shift [redacted] 9WM6
8 Tue 03 0930	pt C/o pain on scale 1-10 c/o 7 level. gave 3mg MSO4 [redacted] effective relief of pain for pt's [redacted] 91WM6
8 Tue 03 0959	Communicated to pt via translator pt's question: "Why can't I leave today?" I explained Dr's decision in this regard and told pt he would have to speak to pt's Dr. for the questions. Three things I need him to do today 1) eat 2) ↑ to ambulate and 3) participate in self care. This can go a long way to help him in future when transferred to home [redacted] 91WM6
8 Tue 03 1030	bladder test completed as directed by Dr [redacted] 300 cc in NS [redacted] 9WM6 I & O after void bladder residual and [redacted] 91WM6
8 Tue 03 1100	pt C/o pain 1-10 scale 9. gave 4mg MSO4 [redacted]

SPONSOR'S NAME: LAST | FIRST | MI

SPONSOR'S ID NUMBER (SSN or Other)

RELATIONSHIP TO SPONSOR

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

IC [redacted]

B6-4

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
0400	C/o ABD pain. MS 4 4mg IV given Will [illegible] [redacted]

B6-2

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.

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B6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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DICAL RECORD | PROGRESS NOTES

DATE	NOTES
8 July 03 1345	Assumed pt care @ 1300. pt transfered from ICU 2 @ 1245 in stable condition. pt awake & alert. VSS. lungs CTA, abd c̄ midline abd drain CDI. BS(+) (D) arm c̄ cast (+) sensation (+) movement <3 secs cap refill. (R) arm c̄ full ROM (+) pulse. (D) IV access noted. Bilat c̄ full ROM (+) pulses. pt denies pain/discomfort @ this time. Will cont to monitor — [redacted] Plum 367
8 July 03 21:53	Assumed c/o pt @ 21:00. Awake & alert in bed. VS WNL per flow sheet. Skin WD. PERRLA (+). LCA (B). BS (+) x4. ML ABD Dsg C/D/I. Cast to (L) arm C/D/I. able to move and feel fingers. <3 sec cap refill and warm to touch. c/o pain @ this time. Will cont. to mon. [redacted] DLT/AW
	ML ABD dsg ~~to~~ error prod 98 D'd. old dsg c̄ yellow + bloody drainage (scant amt). Kerlix applied DSD. Sutures intact. Skin between sutures healing not all of incision is approximated. c/o pain @ this time will cont. to mon [redacted] DLT/AW
0400	C/o pain x1 ii Percocet given [redacted] DLT/AW
9 July 03 0530	Pt. awake & alert c̄ HOB @ 30°. HR reg, lung sounds clear bilat. VSS. Dressing to abd & (R) clavicle CDI. (L) arm cast ↑ c̄ blanket

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

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

REGISTER NO. | WARD NO.

EPW [redacted] B6-4

PROGRESS NOTES
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DATE	NOTES
9 July 03 0530	rolled underneath. Digits on (L) arm c̄ (+) sensation, full ROM & cap refill <3sec. All other assessment findings WNL. Pt. c̄ complaints @ this time. Will continue to monitor. [redacted] /AN
0930	Dressing Δ'd to Abdomen. Incision not well approximated c̄ s/s of infection. Dr. [redacted] in to see status of wound, so he is aware. [redacted]
1425	Assumed care of Pt @ 1300. VSS. A+O x3. (O) LS CTA. (L) UE cast CDI (+) mvt of fingers, cap refill <3sec, sensation (L) hand. Old Central Line Dsg CDI. ABD Dsg CDI. (+) BS x4. Ø c/o pain. Ambulate c̄ assistance to void w/ (+) BM @ Bathroom. O/W Assessment WNL. Will monitor [redacted]
9 Jul 03 21:40	Rec'd c/o pt. @ 21:00. Awake and Alert in bed. Weeping, interpreter spoke with pt. seems to have calmed him down some. 21:52 Pt. is weeping. PERRLA (+). LCA (B). BS (+) LLQ hypoactive (+) PPP (B). (L) arm cast intact. Fingers warm to touch <3sec. cap refill. Able to move and feel fingers. ML ABD dsg C/D II. Dsg to old central line dsg C/D II. c/o pain @ this time. Will cont. to mon [redacted] /AN
0001	Pt c/o ABD pain @ ML incision ii Percocet given will mon [redacted] /AN

All B6-2 (except last)

MEDICAL RECORD	PROGRESS NOTES
DATE	
10 July 03 0800	Pt. VSS. HR Reg, lungs sounds clear bilat, Dressing to ABD CDI. (L) arm in cast ↑ c̄ rolled up blanket, full ROM in digits, sensation (+), cap refill <3sec. Pt. finally urinated 375cc slightly dark clear urina after 4 attempts. Pt ~~S+L~~ IV access. Pt's complaints @ this time. Will continue
0800 97.5 P 96 BP 116/84 Sats 95%	to monitor all other assessment findings WNL. — [redacted] 2L7/AN
1030	Pt. ABD dressing Δ'd. Wound not approximating well c̄ scant amt. of yellowish ~~&~~ bloody drainage. No S/S of infection noted. — [redacted]
10 July 03 1330	Pt care assumed @ 1300. pt awake et alert. VSS. lungs CTA, Abd drsing CDI. (R) ext c̄ full ROM (+) pulses. (R) arm c̄ cast (+) sensation, < 3 sec. cap refill. (R) arm c̄ full ROM (+) pulse. (D) IV access noted. (D) complaints voiced @ this time. Will cont to monitor — [redacted] 9 WMC
10 July 03 2000-2400	Rec'd c/o pt @ 21:00 Awake and alert in bed. Restraints x2 (R) wrist (L) ankle. PERRLA (+) WNL. Skin W/D. M2 ABD inc DSD C/D/I. JCA (B). BS (+) x4. (+) PPP (B). (L) arm cast C/D/I. Pt able to move and feel fingers c̄ difficulty. Fingers warm ~~to toe~~ touch c̄ < 3sec cap refill. c/o pain @ this time. will cont. to mon. [redacted]
23:38	Dsg Δ'd. Old dsg c̄ scant amt. yellow/greenish drainage c̄ odor noted. Skin between sutures ~~SA~~ approximated. Skin healing.. DSD applied C/D/I. Will mon. [redacted]
0800	c/o pain ~~11~~ Percocet given will cont. to mon [redacted]

(Continue on reverse side)

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

REGISTER NO. [redacted]

NAME NO. ICW 2

PROGRESS NOTES
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PROGRESS NOTES

DATE	
11 Jul 03 0540	Assumed pt. care @ 0500. Pt. resting, awakened easily. A+Ox3. Lungs CTA. (+) pulses x4! Abpo active BSx4. Abdomen abd CDI. Cast on (L) arm CDI. (+) Sensation + movement in (L) fingers. C/o pain to abd. Will continue to monitor — [redacted] 9/wm6
11 Jul 03 1320	assumed pt care @ 1300. pt awake & alert. VSS. pt c/o pain, 7/10 ~~[illegible]~~ percocet given. lungs CTA, abd drsing CDI. BS hypoactive. ~~[illegible]~~ & Vent c̄ full ROM (+) pulse. (R) arm c̄ (+) pulse. (L) arm c̄ cast (+) movement < 3 sec cap refill. Will cont to monitor — [redacted]
11 Jul 03 22:30	Rec'd c/o pt. @ 21:00. Pt. awake and alert in bed. VS WNL per flow sheet. Restraints x2 to (R) wrist (L) ankle. Skin W/D. PERRLA (+) WNL. ICA (B) BS (+) x4. (+) PPP (B). ML ABD DSD CDI. Cast to (L) arm CDI. able to move and feel fingers. fingers warm to touch c̄ < 3 sec cap refill. C/o pain x1 7/10 Percocet given. Will cont. to mon. [redacted]
12 July 03	0540 Assume pt care @ 0500. pt asleep easy to awake. No PIV site. pt c/o pain to abd. VSS. HR reg. lungs CTA. BS x4 Abd midline drsg CD+I. Cast to LUE CD+I. (+) movement (+) sensation to fingers. pt ambulates w/ difficulty will continue to monitor. — [redacted] 9/wm6
12 July 03 1320	assumed pt care @ 1300. VSS. pt awake & alert. lungs CTA abd drsing CDI, BS (+) x4. Vent c̄ full ROM (+) pulses (R) arm c̄ cast (+) movement, < 3 sec. cap refill. (R) arm c̄ full ROM (+) pulse. (L) c/o pain voiced @ this time. Will cont to monitor — [redacted] 9/wm6 —

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TE	NOTES
12 JUL 03 2230	Rec'd c/o pt @ 21:00. Awake and Alert in bed. Restraints to (R) wrist (L) ankle. Skin W/D. PERRHAW. LCA (R). BS (+) x4. M2 ABD DSD C/D/I. Add dsg scant amt drainage noted. [redacted] wound healing and [redacted] scabbing over. Sutures intact. New Dsg C/D/I. Cast to (L) arm C/D/I. Able to move fingers and feel fingers. Warm to touch c̄ <3 sec cap refill. C/o pain x1 ii Percocet given. Will cont. to mon [redacted]
13 July 03	0700 Assume pt care @ 0500. Awake and Alert. Amb to BR c/o abd pain ii percocet given as ordered. Abd dsg CD+I. LUE cast CD+I.
0540 97.4 89 16 116/80 96/0	VSS. HR reg. Lungs CTA. Abd tender to palpate. BS x4. BM this am, voiding s̄ difficulty. (+) movement (+) sensation to fingers of (L) hand. Will continue to monitor. [redacted] 91WMC
1030	Dsg Δ done. Wound scabbing over, no drainage noted. 4x4's placed - will continue to mon [redacted]
13 July 03 1420	assumed pt care @ 1300. pt ↑ ambulating. VSS. lungs CTA, abd dressing CDI. BS (+) x4. ↓ ext c̄ full ROM (+) pulses. (N) arm c̄ cast (+) movement (+) sensation (R) arm c̄ full ROM (+) pulse. (+) c/o pain voiced @ this time. Will cont to monitor. [redacted] 91WMC
2230:	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS (+) x4. ABD soft c̄ MC dressing CDI. MC incision is beefered, s̄ drainage. Cast to (L) UE CDI. Pt. assisted c̄ ID. Neurovascular checks to (L) hand WNL. (+) IV access. Will cont. to monitor. [redacted] 1CTAN.

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14 July 03 Assumed care of pt @ 0500. Pt asleep. VSS. (L) arm in cast - elevated. + sensations. Neg A done @ 1000 hrs. Stitches intact.

0530 96.7 61 16 104/80 95% Neg dry and intact. COB to BR twice. Ø c/o pain / discomfort @ this time. Will continue to monitor. — [redacted], SGT, USMC

1330 Assumed care of Pt @ 1300. VSS - A+O x 3. Ø complaints. (B) LS CTA (F) BS x4. (L) UE cast CDI, (F) sensation, cap refill < 3 sec, pat mvt of (L) hand. ABD drng CDI. O/W assessment WNL Ø IV Access. Will monitor — [redacted]

2235 Assume pt care @ 2100. Pt awake and alert. Abd drg Δ done, sm amt of drainage from bottom of wound. Stitches intact. New DSG CD+I. Cast to LUE intact (+) movement (+) sensation to fingers. VSS. HR reg. Lungs CTA. Abd tender to palpate. BS x4. Amb w/ difficulty. Will continue to monitor. ½ percocet for pain @ 2230. — [redacted], USMC

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DATE	NOTES
15 July 03	0945 - Pt alert lying in bed. VSS, lungs CTA, HR regular, BS(+). Dsg Δd to abd. Incision closed c̄ no s/s of infx. Cast to (L) arm, (+) sensation, able to wiggle fingers, warm to touch. Grade Percocet x1 this Am for pain. Will cont to monitor.
15 July 03 1345	Assumed pt care @ 1300. VSS, lungs CTA, abd soft BS(+)x4. ↓ ext c̄ full ROM (+) pulses. (R) arm c̄ cast. (+) movement, (+) sensation to fingers. (R) arm c̄ full ROM (+) pulse. (D) IV access noted. (D) c/o pain voiced @ this time. Will cont to monitor — [redacted] Blumke
15 July 03 2200	Assume pt care @ 2100. Pt Awake and Alert. No PIV site. VSS. HR reg. Lungs CTA. Abd Soft tender to palpate Midline incision sm amt of drainage to abd dsg. Stitches intact. New DSG CD+I. Cast to (L) UE CD+I (+) sensation @ movement to fingers. Pt amb c̄ difficulty. Will cont to mon. — [redacted] Blumke
2420	Pt c/o itching to wound site. 25mg Benadryl PO ordered x1 — [redacted] Blumke

ONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUM (SSN or Other)

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PROGRESS NOTES
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A11 B6-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 July 03	0900 - VSS, pt alert ambulating X1 this AM. Lungs CTA, HR regular, BS(+). Cast to (L) arm, (+) sensation, able to wiggle fingers. Dsg Dd to midline incision to abd. Three small open areas noted. Voiding w/ complaints. Will cont. to monitor — [redacted] DLHAN
16 July 03 1320	Assumed pt care @1300. pt awake et alert. VSS. lungs CTA abd soft midline incision, dressing CDI BS(+). (L) arm c̄ cast (+) movement (+) sensation. (R) arm c̄ full ROM (+) pulse. BLE c̄ full ROM (+) pulses. (1) IV access noted. (1) c/o pain voiced @ this time. Will cont to monitor — [redacted] gwume
16 July 03 2255	Assume pt care @ 2100. Awake and Alert. c/o pain to midline abd incision ⁻ percocet adm PO. VSS. Dsg Δ done site free of infection. Sm amt of brown drainage noted to bottom of incision. Benadryl 25mg PO given for itching. (L) arm cast (+) movement (+) sensation to fingers. Will cont to monitor — [redacted] Glumk
0330	650 mg Tylenol for pain — [redacted] gwume
17 July 03 0558	Assumed pt. care @ 0500. Pt. A to x3. Lungs CTA. (+) pulses x4. No bowel sounds heard @ this time. Pressing to mid abd. CDI. c/o pain to site. Cast on (L) arm CDI, (+) sensation + movement to (L) fingers. Will continue to monitor — [redacted] gwume

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PROGRESS NOTES

DATE	NOTES
17 July 03 1330	Assumed pt care @ 1300. VSS, pt awake & alert. lungs CTA, abd soft during CDI. hyporactive BS noted. ↑ ext c̄ full ROM ⊕ pulses. ⊕ arm c̄ cast, ⊕ sensation, ⊕ movement, <3 sec cap refill. ⊕ ↑ ext c̄ full ROM ⊕ pulse. ⊕ IV access noted. ∅ c/o pain voiced @ this time. Will cont to monitor - [redacted] 91WM6
17 July 03 2345	Assume pt care @ 2100. pt awake and alert. VSS. Abd midline incision site free of infection new dsg CD+I. c/o pain @ site. ⅐ Infusol @ 2200. pt amb ⅋ difficulty 25mg Benadryl PO for itching @ incision site. ⊕ UE cast ⊕ movement ⊕ sensation to fingers cap refill <3 sec. Will cont. to mon. [redacted] 91WM6
18 Jul 03	0530: Assumed pt. care @ 0500: Pt. asleep. Awakened easily. A+O x3. lungs CTA. ⊕ pulses x4. Hypo active BS x4. Cast on ⊕ arm. CDI. ⊕ sensation and movement in ⊕ fingers. Drsg to mid abd CDI. c/o pain to mid abd. will continue to monitor. [redacted] 91WM6

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

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PROGRESS NOTES
Medical Record

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A11 B6-2

FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 July 03 1335	assumed pt care @ 1300. pt resting quietly easily aroused to verbal stimuli. VSS. Lungs CTA, abd drsng CDI, BS hypoactive. BLE ~~& BUE~~ [redacted] c̄ full ROM ⊕ pulses. ⓡ upper ext c̄ full ROM ⊕ pulse. ⓛ arm c̄ cast ⊕ movement, ⊕ sensation. ⓓ IV access noted. ⓓ c/o pain voiced. Will cont to monitor — [redacted] 9WMC
17 July 03	Dressing change done. Small amt dried blood on old dressing. Ø obvious drainage, Ø swelling, Ø foul odor, Ø pain to pt during change — Sgt [redacted]
19 July 03 0030	Pt. awake & alert in bed c/o pain, ⊕ tylenol given @ 2300. HR Reg, Lung sounds clear bilat, bowel sounds (+) x 2 quads. Cast to ⓛ arm, (+) sensation in digits, < 3 sec cap refill, full ROM in digits. DSG to ABD Δ'd, wound slowly approximating, scant amt of red tinged fluid. No IV access. Pt. continues to c/o pain, will medicate in appropriate time span. All other assessment findings WNL. Will continue to monitor. — [redacted] LT/AW
0530 19 July	Pt care assumed @ 0500, VSS, pt awake and alert c̄ c/o abdominal pain. Pt ambulated c̄ difficulty. Lung sounds CTA, pulses palpable x3 (not palpable on lt), bs ⊕. LUE c̄ cast CDI, pt c̄ ⊕ sensation and capillary refill, rom. Abd dsg's CDI, dsg Δ to be done @ 1000. No pain meds given, percocet was given @ 0315. Will continue to monitor. — [redacted] 9WMC
0915	Dressing Δ done, wound open but closing, no drainage or s/s infection. Will continue to monitor. [redacted] 9WMC