LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19 July 03 1320	assumed pt care @ 1300. pt awake et alert. VSS (L) arm c̄ cast (+) movement, (+) sensation of fingers. (R) ↑ ext c̄ full ROM (+) pulse. (-) IV access, lungs CTA, abd dressing CDI. BS hyperactive. B↓ ext c̄ full ROM (+) pulses. (-) c/o pain/ discomfort voiced @ this time. Will cont to monitor - [redacted] b62 91WML
19 Jul 03 23:04	Rec'd c/o pt @ 21:00. Awake and alert in bed. Restraints x 1 (R) wrist. PERRLA (+) WNL. Skin color WNL WD LCA (B). BS (+) x4 hyperactive. Cast to (L) arm CDI digits (+) ROM (+) <3 sec cap refill. (+) sensation. ML ABD dsg CDI. (+) PPP (B). (-) c/o pain @ this time. Will cont to mon [redacted] b62 SPT/AN
20 Jul 03	0530: Assumed pt. care @ 0500: Pt. A+O x3. VSS. lungs CTA. (+) BS x4. Cast on (L) arm intact. (+) sensation + movement in fingers. Dsg to mid abd CDI. (-) complaints @ this time. [redacted] b62 91WM
20 July 03 1345	assumed pt care @ 1300. VSS (R) arm c̄ cast (+) movement (+) sensation <3 sec cap refill. (R) arm c̄ full ROM (+) pulse. lungs CTA, abd dressing CDI. BS hyperactive. BLE c̄ full ROM (+) pulses. (-) c/o pain voiced @ this time. Will cont to monitor — [redacted] b62 91WML
21 July 03 0200	Pt. asleep in bed. ∅ complaints at this time. HR Reg, lung sounds clear bilat, bowel sounds (+) X4 quads. Pt ∅ IV access. DSG D'd to abdomen, wound ∅ stitches, approximating well. ∅ s/s of infection. Cast to (R) arm, (+) sensation in digits, <3 sec cap refill, full ROM. All other assessment findings WNL. Will continue to monitor [redacted] b62 SPT

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

[redacted] b6-4

1 CW

21July03 0700-Pt alert lying in bed. VSS, lungs CTA, BS ⊕. Will encourage ambulation today. Dsg CDI to medium incision to abd. Voiding ⊘ complaints. Will cont. to monitor [redacted]

21Jul03 1430 pt. instructed on dsg and demonstrated correct technique for dsg Δ - meds, supplies, xrays and dc summary @ bedside - pt. is awaiting transfer to Elwcamp [redacted] b62

21Jul03 1515 pt: wrists cuffed, escorted to helicopter. Rx mp c meds, DC summary & dsg Δ supplies b62 for transport to Elwcamp [redacted]

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] b62 SWM6

(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 # error [redacted] 66-4

ICW2 BED #3

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
19 June 03 1811	GENERAL SURGERY S: Pt awake, alert & responsive Sitting up in chair O: Tm 102.2 (1800) Tc 99.1 P-115 BP 134/87 I/O NGT-400cc IVs - 225-375cc/hr bloody 142 / 105 / 3.9 / 25 7.3 / 11.9 / 37.5 <2 02 AKAR-RRR S (M) (Tachycardic) LUNGS- Bilateral rales Abdomen Rosal - BBS - No distension. Bowel sounds A: POD #1 Exp Lap - Repair enterotomy. Hemodynamically stable P: Continue Antibiotics and NGT - Ambulation - Monitor urine
20 JUN 03 @ 0545	Received report, awake and alert, 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 (R) nares to LIS. O2 via NC @ 2 Pt eyes appear to be yellow (Sclera) in color.

[redacted] MD
MAJ, MC USA
CHIEF, DOS

b6-2

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

(Continue on reverse side)

REGISTER NO.

WARD NO. ICU 2

EPW [redacted]

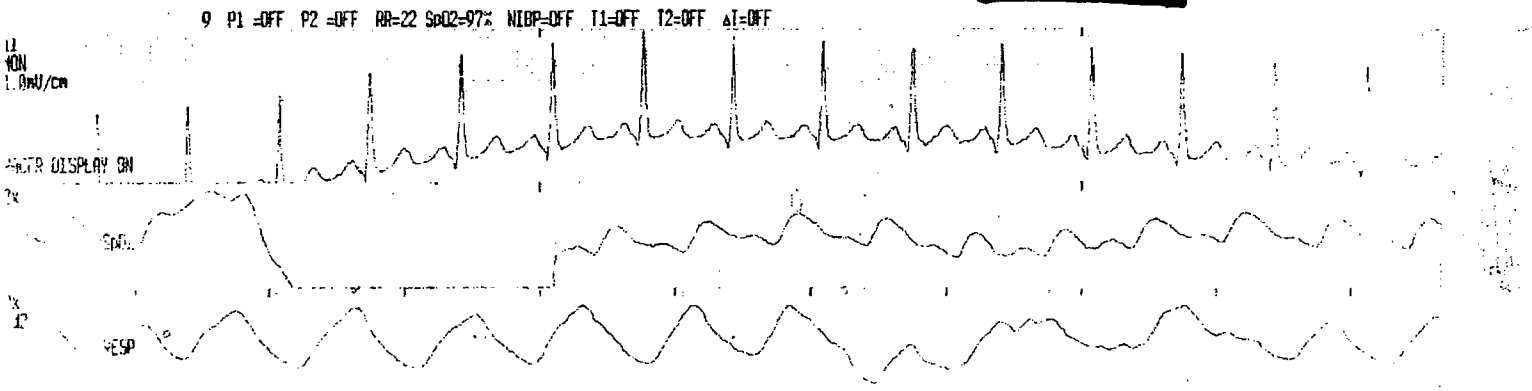
b6-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
20 JUN 03 @0545 (Cont.)	Foley to gravity draining clear amber urine. Sinus 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. Medical 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 Vicodin tx @ this time. — [redacted] b6-2 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] b6-2 SGT 91WM6 —
1235	Returned from OR via stretcher, asleep but arousable. Lungs c̄ bilateral rales. Resp. tx given. O2SATS 99% @ present on 10L via Face Mask. VSS. (L) arm elevated c̄ DRSG C.D.I. (L) arm c̄ (+) 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 till recovered. Pupil equal @ 4 mm and reactive to light. — [redacted] 91WM6 SGT

STANDARD FORM 503 [redacted]
USAPPC V1.00

b6-2

PROGRESS NOTES

DATE

Finding - Hairy vessel loops present closed in 60%.
Plan: Repeat I+D in 2-3 days, Reposition staples that are holding vessel loops.

[redacted] b6-2

[redacted]

23 Jan 03
1200

Gen Surg
S: (+) BM, NO, tolerating diet

O: T 103 Tc 98.9 P 74 BP 132/84 100% RA
(+) BM UO - 7100 cc / 24
Lungs - Bilateral rales CXR - (+) atelectasis
Abdomen - RLQ 5 cm
Wound - drain intact. (+) BS
No peritonitis Sign
(+) drain to splint
A: (1) PPD #5 GSW - Colon (2) ? Ileus ?
P: (1) Continue antibiotics, Pulmonary toilet
(2) Advance Diet

[redacted] b6-2

Comm

10.3 / 8.6 / 57.2 / 331 / 17
125 / 102 / 36 / 24 / 0.3
CPK - Bili 4.9
BUN 2.0
ALP - 65
ALT - 75
AST - 91
Mg - 4.3
K - 3.7

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0205	C/o pain ABD area. MSO4 4mg given IV. Will Monitor [redacted] b6-2
0250	C/o pain ABD. Give Percocet 1 tab po. Will Monitor — SGT [redacted] b6-2
0325	C/o pain in ABD. Give MSO4 3mg IV. Will Monitor SGT [redacted]
0400	Resting in bed @ present time — SGT [redacted]
Jul 03 @ 1545	A+O X3. C/o Pain to Abdomen. medicated c̄ Tylenol 650mg as per order. Lungs CTA bilaterally. Heart S_1S_2. Abdomen c̄ (+) BS X 4 quads. Abd dressing CDI c̄ DSD. Able to move all 4 extremities. LUE c̄ cast (+) NVC. Foley to Gravity draining clear yellow urine. IV: (R) Subclavian infusing NS @ 125cc/hr. Will Continue to monitor and assess. — [redacted] b6-2 SGT 91WM6 —
0820	Ambulated c̄ minimal assist length of Ward X 2. A.M. Care done. Ate only 5% breakfast. Abdominal DESG Changed. Placed back in bed. Ø complaints voiced at this time. — [redacted] b6-2 SGT 91WM6 —
7 July 03 1700	Assumed care of pt @ Day Shift. report given by SGT [redacted] b6-2
1805	Alert & Orient. PERRL @ 2 mm. Eyes: Sclera yellow. Lung sounds clear bil. (R) Subclavian central line c̄ triple

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	lumen DSG CDF. Central line = triple lumen S S/S of infection or infiltration noted. NS @ 50cc/hr via Central line. ABD DSG CDF. BS in all 4 quads. Pedal pulses present bil. Q radial pulse present Q unable to assess dil to cast. Pt can move Q hand fingers. Cap refill <3sec @ fingernail bed. Q Arm/hand cast CDF. Foley to gravity drainage Clear yellow urine in foley bag. Will Monitor [redacted]
1804	Late entry Tylenol 650mg po given for ABD pain. Will Monitor [redacted] b6-2
1905	Pt C/o pain in ABD Percocet II given for pain Will Monitor [redacted] b6-2
2050	Give MS04 4mg IV for ABD pain Will Monitor [redacted] b6-2
2100	ABD DSG bid - 0640 DSG moderate amt. brown & bloody drainage noted on old DSG. ABD = sutures. Sutures approx @ 1 inch apart. Applied 4x4's & ABD pads. Secured = tape. Will Monitor [redacted] b6-2
2225	Pt C/o pain in ABD. Notified Dr. [redacted] of pt pain & meds given. VO. Obtain give Ambien 10mg po x1 dose. Ambien 10mg po given @ 2230. Will Monitor [redacted] b6-2
2400	Pt resting in bed @ present time. Will Monitor [redacted] b6-2
0110	C/o ABD pain MS04 5mg IV given Will Monitor [redacted] b6-2
0239	Tylenol 650mg given for ABD pain Will Monitor [redacted] b6-2

STANDARD FORM 509 (REV. 5/1999) BACK

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

2nd MAR FST

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign e
	Surgery Staff
18 Jun 03 0145	y/o Iraqi national shot by US forces after he was awaken & pointed rifle to point at them. C/o pain (R) flank & groin. PMH – possible HTN & meds. PE – Vitals: 130/68 p 89 96% RA. MS – knows name, doesn't remember incident. HEENT – nl. Chest CTA (B). Heart RRR @ ⓐ. Back: Abd (R) CVA pain – & TTP. c̄ overlying ecchymosis. (R) flank GSW. See drawing of back. There is ecchymosis & swelling of (R) upper outer thigh. The peripheral pulses are nl & trophic & dopplerable. The (R) arm is nl – (L) hand has a wound at posterior elbow & 2x exit wounds of dorsal forearm. ?of ulnar motor intact. (See ortho note) The U/S of abdomen: nl – but poor quality 2° obesity. Pelvis xrays show, no fx, but fragment of bullet down (R) lateral thigh.
V/V (L)/(R)	GSW entry
	D/A: 1 GSW (R) arm c̄ radial fx & skin defect. 2 GSW (R) flank that struck ileal wing & tracked down buttock & lateral thigh. This wound doesn't need much care. He needs evac to CSH hospital to tx R arm c̄ ORIF

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

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

[redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 Jan 03	ORTHO NOTE
	Iraqi national who pointed AK-47 @ US Troops & was
	shot w 5.56. Presents to 2nd ACR FST for eval.
	RE: Hemodynamically Stable
	AOO x3 (per interpreter)
	LUE:
	Shoulder NTTP w Full ROM
	Elbow NTTP w Full Flex/Ext
	TTP @ lateral distal brachium where an
	entrance wound is located.
	Open dorsal wound on forearm w skin and
	SQ w/o tissue loss.
	Distal LT intact, EPL, FPL, intrinsics intact.
	Pulses 2+ DP/PT.
	RLE: Entrance wound on (R) Post. flank.
	Contusions & swelling at (R) Posterior flank/thigh.
	Pain w Hip ROM, ROM w crepitance.
	Distal LT intact. Toe flex/Ext intact/Ankle DP/PF
	intact. Pain prohibited quad flexion/activity.
	Xray - Shrapnel in (R) Buttock/Thigh. No obvious fracture.
	Comminuted (R) Radius Fx.
	Imp: (L) Radius Open Fracture w ST loss.
	(R) Buttock GSW, no obvious Fx or hip involvement
	Plan: Splint LUE w IC NS irrigation.
	Ancef + 6-mont IV
	Evac to CSH for operative tx. [redacted] b6-2
	MAJ, MC ORTHO

STANDARD FORM 600 (REV. 6-97) BACK

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

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MEDICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
28 JAN 03	Progress Note
	S/P Cholecystectomy / closure Pound dehiscence
needs	Cardiopulmonary: mildly tachycardic c stable BP
asx PRN	CXR - wet appearing gastric f pneum
Fortz 2gm q8	sealed green opaque gastric 1lit 29
Gent 5mg/kg dd	F/E/N NPO since day of surg
Unyne drip	c NG tube in place NG not interrupted
Acetam PRN	JP out = 100cc serosanguinous fluid
Tylenol supp	UOP brisk around Lasix Rx.
	Labs B2/95/16 (07) ALT 148 ↑ AST 218 ↑
	4.2/37/0.7 Amy 44 nl TBili 7.1
	GGT 72 (65)
	ID: Pneumonia on Fortz/Gent Wound drainage good well
	30.6/29 (5.9) 81% Seg
	Dx: (1) S/P wound dehiscence s/p S&I leg f primary anterior repair
	(2) Open (L) foot wound
	(3) ↑ TBili to 7.1 / ↑ Transaminases
	(4) pneumonia (WBC ↑ 30) / fever
	Rx: Cont Fortz + Gent
	Monitor LFTs

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
needs	Wadsworth	[redacted]	
SPONSOR'S NAME	SSN/ID NO.	RELA [redacted]	b6-2
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SS[redacted] Date of Birth; Rank/Grade.)		[redacted]	WARD NO.

[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

NSN 7540-00-634-4176 600-108

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

21 JUL 03 Discharge Summary [redacted] b2-2

DOA 18 JUN 03

DOT 21 JUL 03

LTC [redacted] b6-2 MD

MAJ [redacted] b6-2 MD

REASON FOR ADMISSION: GSW to (R) flank.

Hospital Course: After appropriate stabilization in the EMT the patient was taken to the OR for exploratory laparotomy. He was found to have a small Right retroperitoneal hematoma with injury to small bowel requiring primary repair. The Neurovascular structure of the perineum remained intact. Post op course complicated by 1) acalculous cholecystitis c̄ drainable ↑ T Bili and 2) wound dehiscence. The patient was returned to the OR where he underwent a cholecystectomy c̄ cholangiogram. His wound c̄ closed @ the fascia but left open @ skin. His post operative course again was complicated by a prerenal requiring aggressive antibiotic Rx. His wound gradually closed and is now ready for Discharge.

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

[redacted]

b6-4

RECORDS MAINTAINED AT: ▶	(on it)	
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 - 11252

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	(Cont)
	Final diagnosis
	1) GSW flank / small bowel laceration.
	2) acalculus cholecystitis
	3) wound dehiscence
	4) Pneumonia (Hospital required)
	Procedures: GSW to (L) arm ō tetanus Rx
	1) Exlap with primary closure small bowel injury
	2) Cholecystectomy ō cholangiogram
	3) OPC of old wound
	Plan: Transfer to EPW camp
	Cont simple wound dressing
	Cast removal in 2 wks.
	Meds: Percocet PRN [redacted] b6-2
	Tylenol PRN

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 JUN 03 0630	Assumed care of PT. PT lying in bed HOB @ 40°. easily aroused, VS 123/77-101-119-25-97% SpO2 on ~~RA~~ 10 LPM via NRB. Pupils 3mm brisk, PERRLA, sclera are yellow. O.W., Lungs CTA(B), ↓BS in bases but Δ noted from yesterday and pt has better sounds in bases. Equal rise and fall of chest. O2 sats 96-100% on 10 LPM ~~RB~~ mask. CV: S1 S2 present, Sinus Tach rate 120's, (R) central line triple lumen @ 50cc/hr NS infusing, Pulses x 3, Cap refill < 3 sec x4 extremities, ABD Dressing has minimal drainage noted, BS in (4) quadrants, ABD round, FTP, Foley to gravity draining thick clear amber urine about 80cc/hr. PT has weak movement and (+) sensation in all extremities. b6-2 [redacted] SSG Grounds
28 JUN 03 0600	VS 123/77-111-21-101-97% SpO2 on 10 LPM Rebreather Mask. Pt given 650 mg Tylenol PR for ↑ temp. PT Alert, verbal. W.N. monitor for ↓ temp. b6-2 [redacted] SSG Grounds
28 JUN 03 0600	PT will not be going to OR today. b6-2 [redacted] SSG Grounds
28 JUN 03 0900	PT given Lasix 20 mg IV by CRT [redacted] W.N. monitor for effects. PT VS 99-114/68-107-28-100% SpO2 on Rebreather mask. b6-2 [redacted] SSG Grounds
28 JUN 03 1000	PT voided 300 cc amber colored urine, urine was less concentrated than last hr. PT's VS 28-97-113/68-97-100% SpO2 on 10 LPM via Rebreather mask. b6-2 [redacted] SSG 9th MG

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.

#[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

28-JUN-03 PT's p. ? dressing c'd, Brow h damage noted
1015 in mid & of wound, secosanguinous drainage superior
and interior. Retention straps in place clean and
dry, intact. 2 blisters noted on retention straps
1 blister on pt's (L) groin and 1 blisters on PT's
(R) lumbar area of back. wh irrigated and b6-2
Wet to dry dressing applied. — [redacted] SSG
1045 assumed care (Nursing) for patient. Agree c
initial assessment done by SSG [redacted] — [redacted] SGT 9WM6
1100 DR [redacted] b6-2 placing new Subclavian to (R) Triple
Lumen CATH. — [redacted] SGT 9WM6
1100 Placed on 5L VIA NC will Monitor O2 SATS — [redacted] b6-2
1235 (L) Subclavian triple Lumen D/C'd intact. Site Pressure
x 5 minutes. 4x4 Applied. — [redacted] SGT 9WM6
1500 O2 ↓ to 3L VIA NC O2 SATS @ 98% — [redacted] SGT 9WM6
1600 O2 ↓ to 2.5L VIA NC O2 SATS maintained @ 97-98%
Well Continue to monitor. — [redacted] SGT 9WM6
1600 Temp 101.6. Tylenol Supp given as per orders
Well Continue to monitor. — [redacted] SGT 9WM6
28JUN03 1700 Assumed care of Day Shift report given by SGT [redacted] Eyes
are yellow. PERRL @ 2mm. (L) Arm DSG CDI. ABD/Chest DSG CDI.
(L) Subclavian DSG CDI. (R) Subclavian central line = triple lumen
S/S of infection or infiltration noted. MSO4 1mg/hr & NS @
50cc/hr via central line. (R) thigh area small blister noted. (R) posterior
back purple blister noted. (R) Flank area entrance wound healed. No
drainage or active bleeding noted. ABD nondistended. BS noted in all
4 quads. NG tube (R) nare to L15. NG tube placement verified. Lung
sounds clear of lobes ↓ lobes diminished. Foley = clear amber urine
noted in foley bag. Cardio: Trach. [illegible] Radial pulse present bil. (R) radial
pulse [illegible] (L) numbness to [illegible] NKA (L) hand strong [illegible]

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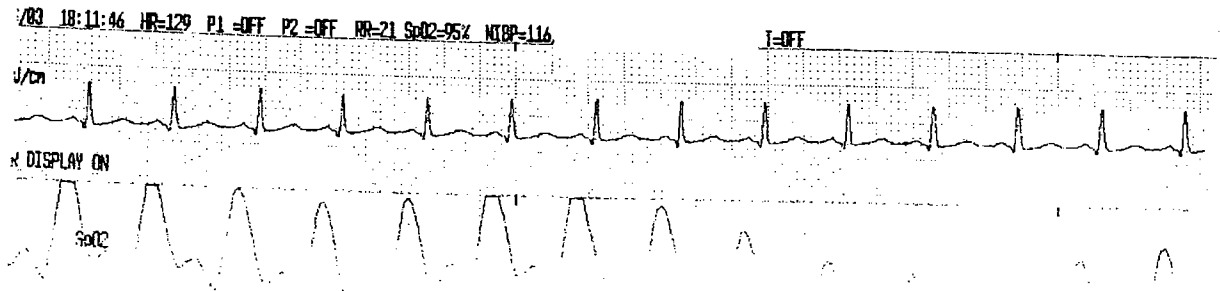
MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
26 June 03 1700 (cont)	(D) hand cap refill < 2 sec @ fingertips bed. Will monitor [redacted]
1800	T 102.5 A. Dr [redacted] notified of temp. No new orders received. MD stated P4 is going back to OR in AM. [redacted]



b6-2

1918	T 101.4 A Will cont. to monitor. [redacted]
2230	T 101.1 A Tylenol 650 mg given RTL for temp. Will monitor b6-2 [redacted]
2235	New order received by Dr [redacted] for Ceftriaxone. Pharm out of Fortaz. b6-2 [redacted]
2300	T 101.5 A Will cont. to monitor b6-2 [redacted]
2400	T 100.2 A. Will cont. to monitor b6-2 [redacted]
0100	T 99.6 A. Will cont. to monitor b6-2 [redacted]

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

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

[redacted]

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

b6-2

0200 T. 99°A. WCN cont. to Monitor — [redacted]

0300 T 99°A WCN Cont. Monitor — b6-2 [redacted]

0400 T 99°A. Pt use IS approx. 10 g use. Used Several times this Shift. b6-2 [redacted]

0430 MS04 3mg given for Mid line pain Will Monitor b6-2 [redacted]

0500 Report Given Informed of pt temps. during Shift. Reported to [redacted] b6-2 [redacted] b6-2

0515 Received Report, Assumed care of PT. VS 117/64-99?-112-16 96% SpO2 on 2LPM via NC, PT Alert on make some needs Known through gestures. Verbal, pupils PERRLA, sclera yellow, Lungs ↓ bases, (C) base more ↓ than right. Upper Lobes Lung CTA (B). equal size & Rise of chest, CV-Sinus Tach Rate 110's-120's, Pulse x 3, cap refill x4 <3secs. (C) triple lumen central line c 50cc NS/IV, ABD soft, TTP, Round, BS x4 quadrants, passes flatus, ∅ BM, Dressing C/D/I, NGT LIS, producing brownish drainage. Foley to gravity draining clear amber urine, Pt has moment and sensation in LLE. [redacted] 556 91-1a6

Progress Note [redacted] b6-2

Patient looks better today

CXR ~~pending~~ (R) lower lobe pneum overall improved

7.1 / 24.7 / 23.1 WBC ↓ Bili ↓ 5.2

Abdomen heal well (+) blisters around retent. suture. c̄ mod edem.

(+) BJ

Plan: - Discuss transfer c̄ staff - 2u PRBC
- 40 OR c̄ am f̄ when out of Bx
- DC NG
- Stand fluids c̄ clear to pm

[redacted] b6-2

29-JUN-03 1030 PT to O.R. for closure at 1hr or (2) am. — [redacted] 556 91-1a6

29-JUN-03 1200 PT returned from O.R. VS 100?-114/65-118-23-95% SpO2 on 2L NC, PT's (2) hand has no sensation or movement. Cap refill <3 sec., PT alert and verbal, no c/o pain. PT able to lift left arm. Will monitor for return of sensation. PT's arm dressing C/D/I.

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stam, 28CSH

LOG NUMBER

ARRIVAL — DATE: DAY 18 MONTH Nov YR. 03 — TIME 0400

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet): [ ] PRIVATE VEHICLE [ ] AMBULANCE [X] OTHER (Specify) MEDEVAC

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): GSW (L) thigh

SEX: M AGE: 33

POSSIBLE THIRD PARTY PAYER? [ ] YES [ ] NO

TIME SEEN BY PROVIDER: 0405

VITAL SIGNS			
TIME	0400	0445	0500
BP	84/32	113/70	128/72
PULSE	109	117	114
RESP.	20	18	20
TEMP.		100°	
WT. (Child)	100/02		80 kg

CATEGORY (See reverse): [ ] EMERGENT [X] URGENT [ ] NON-URGENT

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)

Ø med problems Ø surgeries

⊕ distal pulse (L) Arm

33 y/o ♂ Iraqi who pulled on AK-47 on US troops and demonstrated intent to fire. Seen By MAJ [redacted] the Injured LUE sent here for Surgery. Treated pt c̄ Cent (400) and Ancef 1gm IV. Pt A&O seen By gen Surgery who Discovered a NIFAST Exam and GSW enter (R) Buttock Exit (R) thigh Laterally. Pt Arrived UA Aerovac in Splint CAST.

b6-2

6' WD, WN, NAD, AAOX3

HH NAD, PERRLA, EOMI, PC, TM

L: CTAB, RRR

Abdomen Soft, ND (R) BS ⊕ TTP middle and Exit (R) Exit wound (R) Forearm (R) Expand Bone (R) Extrem wound (R) Buttock.

(A/P) Gen Surgery for to surgery sent pt. to ward then OR.

FAST Exam ED - Negative

b6-2 (CONTINUE ON SF 507, IF NEEDED)

PMH - Ø
PSH - Ø
FH - Ø
meds - Ø
All - NKDA

10.4 / 41.4 / 13.3 / 288

145 | 109 | 15 | 163
3.9 | 21 | 1.0

P 7/P77 - 13/25

T+S - A+

CXR - NAD

pelvis ⊕ shrapnel (R) thigh

ABD NAD

(L) Forearm ⊕ FX (R) Radius (R) Ulna

UA - ⊕ Blood 5-7 RBC

ORDERS / INITS. / TIME

ORDERS	INITS.	TIME
CBC, Chem 12, PTT, PT	[redacted]	0425
UA, T+S, PTT		0425
CXR (L) Arm		0430
pelvis XR		
ABDOMINAL XR		
Shrapnel FV		0429

b6-2

ASSESSMENT/DIAGNOSIS
(L) GSW to (R) thigh w/ US
(L) GSW to (R) buttock.

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: [X] IMPROVED [ ] UNCHANGED [ ] DETERIORATED

TIME OF RELEASE: 0540

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).

EPW # [redacted] b6-4 [redacted] b6-4

[redacted] b6-4

[redacted] b6-4

SI [redacted] 2265

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: 33

HEIGHT:

WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE: s/p GSW
Exploratory Lap & I&D LFA

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition WNL X bruising (L) flank
Tobacco ___ ppd X ___ yrs. Body Piercing Ø Diabetes (Y) (N) ROM WNL X LUE ASA/Motrin w/72 hrs (Y) (N)
ETOH ___ 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)
66-4
[redacted]

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since 0100 ! 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 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. 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: NO 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. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

b6-2 [redacted] /AD 18 Jun 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site ☒ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTA (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 liter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) b6-2 [redacted] /AD

DATE: 18 Jun 03 TIME: 0700

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] /AD

DATE: 18 Jun 03 TIME: b6-2

MEDICAL RECORD

PRE-OPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: Unknown
HEIGHT:
WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE: Wound Exploration

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)

[redacted] b6-4

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

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 b6-2 [redacted] ✓ 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 INTERVENTIONS NOTED.

b6-2 [redacted] AW 25 JUN 03 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

Bovie Site: Clean

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] b6-2

DATE: 25 JUN 03 TIME: 1450

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT/AN

DATE: 25 Jun 03 TIME: b6-2

REVERSE OF FORM 5179, JUN 91

MEDCOM - 11262

USAPA V1.0

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: See chart
WEIGHT:

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
Colep SD LFD

4. PROPOSED SURGICAL PROCEDURE:
SD LFD

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition
Tobacco___ppd X___yrs. Body Piercing Diabetes (Y) (N) ROM
ETOH Implants See chart ~~Respiratory Disease~~ (Asthma/COPD) (Y) (N) ASA/Motrin w/72 hrs (Y) (N)
~~Glasses/Contact (Y) (N)~~ Dentures Hypertension (Y) (N) Herbal Medicines (Y) (N) Anticoagulants (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to: X 1) Surgical Procedure & Operating Room Environment ___2) Separation Anxiety (Child) X 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g.. warm blanket. touch). o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION X Potential for respiratory dysfunction due to: X 1) Positioning X 2) Effects of Anesthesia ___3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase .	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress. o Assist anesthesia during intubation and extubation.
C. INTEGUMENT X Potential impairment of skin integrity due to: X 1) Intraoperative Immobility X 2) ESU Pad Placement X 3) Positional Aids ___4) Prosthesis X 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

EPW #[redacted]
66-4

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

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

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

[redacted] b6-2 29 Jun 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] b6-2
DATE: 29 Jun 03 TIME: 1015

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] b6-2
DATE: 29 Jun 03 TIME: 1147

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: 95 kg

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
Ex lap, Wound Debridement (L) arm

4. PROPOSED SURGICAL PROCEDURE:
DPC

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)
#[redacted] 66-4
ICU-2

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since Midnight ! 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:_____

LEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOME	OR NURSING INTERVENTION
ON: or inadequate tissue perative Mobility oning ng Disease y Devices pthermia	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 ar correctly applied. Offer pillow for under knes. Place and take down legs from stirrups with slow bilateral motion. Check that rings and all body piercing has been removed
USCULAR tential impairment of o: in raoperative Hazards osthesis positioning ransfer pt. to/from OR table Potential discomfort due to: Length of Surgery Positioning 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.. pibws. bath towels. etc.) for positioning.
IAL SENSES Diminished visual perception ing:) Pre-Medicated) W/O Glasses Potential for decreased nication due to: 1) Diminished Hearing 2) Language Barrier Potential injury due to es: 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. Kep 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.
OTHER PATIENT PROBLEMS NEEDS. ntinuation 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

OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

b6-2 [redacted] CPT IAN 6 July 03 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 liner with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT IAN b6-2 DATE: 6 July 03 TIME: 0730

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CPT IAN DATE: 6 July 03 TIME: 0925 b6-2

MEDICAL RECORD — **INTRAOPERATIVE** [redacted]

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 ILT [redacted] b6-2

3. DATE 18 JUN 03 TIME PATIENT ARRIVED IN SUITE 0705

4. PATIENT IN ROOM TIME 0705 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA s/p GSW (R) flank / (L) FA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	ILT [redacted] b6-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt supine on padded OR table. But on padded arm boards <90°. Safety strap across mid-thigh

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

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL DONE BY: ☒ YES ☐ NO Lower Abdomen/pubis

METHOD: ☒ OR ☐ NURSING UNIT ☐ DEPILATORY ☒ RAZOR Dr. [redacted] b6-2 ☐ CLIP

COMMENTS:

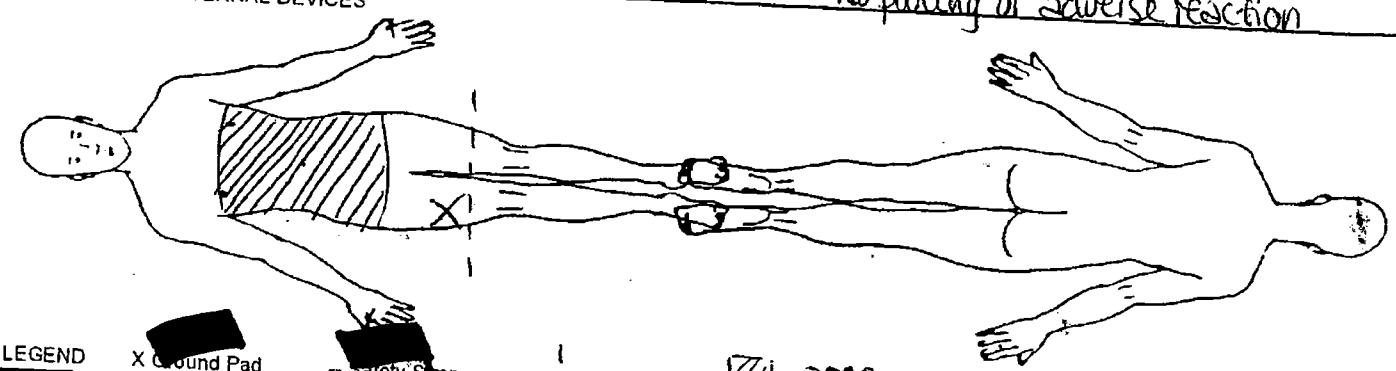
PREP SOLUTION (Specify) Betadine / Betadine b6-2

SITE: Nipple line to pubis BY WHOM: ILT [redacted]

SITE: left arm BY WHOM: MAS [redacted] b6

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] Ground Pad -- [redacted] Safety Strap ||| === Tourniquet ▨ - prep

Initial: SSG [redacted] b6-2 ILT

C = Correct I = Incorrect

10. COUNTS b6-2

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No					
Needle Sharp	☒ Yes ☐ No					
Instrument	☒ Yes ☐ No					
Other	☒ Yes ☐ No					

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

[redacted]

b6-4

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

☒ ESU NO: #1 Cut 40 Coag 40

GROUND PAD: BRAND VL Polyhesive 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
Thrombin Lot R114A552 Exp May 04	Q.S.	intra-op	Topical	MFR: Gentrac	Dr. [redacted]

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S S[redacted] b6-2

15. X-RAY IN[redacted] IF YES, SITE

YES ☐ NO ☐

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Xeroform, 4x8 Abdomen fluffs, kerlix, velcro, splint, ACE on Left Arm

19. ADDITIONAL INFORMATION
WC
Surgeons: Dr. [redacted] b6-2
Dr. [redacted] b6-2
Dr. [redacted] b6-2
Anesthesia: LTC [redacted] b6-2 Anesthesia Type: Gen

Bovie Pad site intact pre-op ✓ post-op ✓ Bovie Settings: Coag/Cut 40/40
Tourniquet Site intact pre-op ____: post-op N/A
Tourniquet Time: Up____ Down____ N/A
Pt arrived in OR c̄ Foley cath.

DA 5179 Initiated

20. OPERATION(S) PERFORMED
Exp Lap & I&D LFA

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU2	1105	LITTER c̄ O2

22. REGISTERED NURSE SIGNATUR[redacted] b6-2 [redacted]AN

USAPA V

REVERSE OF DA FORM 5179-1, OCT 87

MEDICAL RECORD

INTRAOPERATIVE CURRENT

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 [redacted] b6-2

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

3. DATE 20 June 03 TIME PATIENT ARRIVED IN SUITE ICU → OR

4. PATIENT IN ROOM TIME 1008 b6-2 NUMBER 21/2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA. NPO ∮ MN.

6. NURSING PERSONNEL

b6-2

ASSIGNED SCRUB	SSG. [redacted] (PID)	RELIEF SCRUB	
	b6-2		
ASSIGNED CIRCULATOR	CPT. [redacted] (b6-5)	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Two arm board used to lt. arm.

8. SKIN PREPARATION

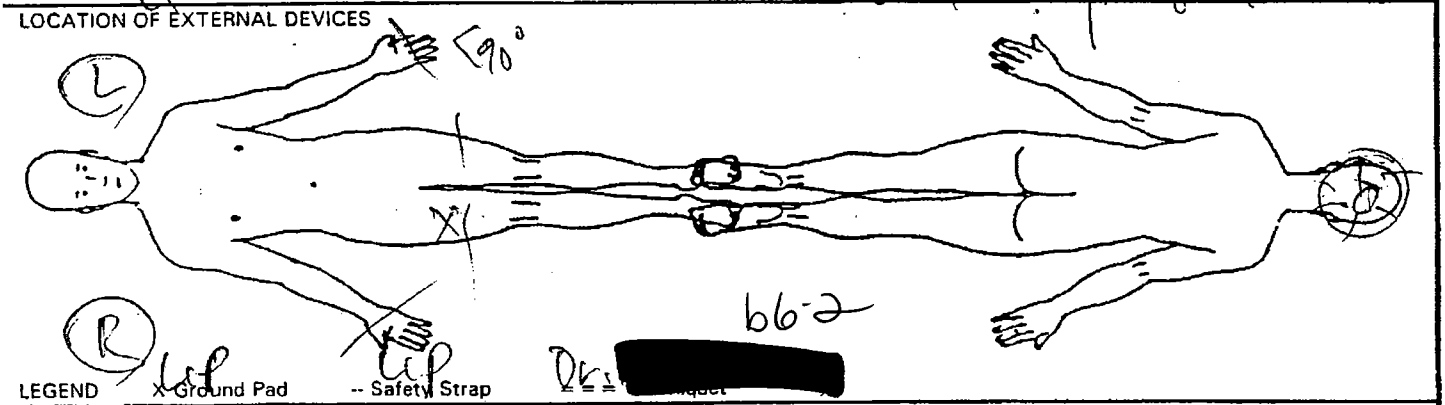
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS: Ø

PREP SOLUTION (Specify) Betadine S/sol b6-2
SITE: Lt. Arm BY WHOM: CPT. [redacted] Anes
SITE: BY WHOM:

COMMENTS: Ø Poolings of sol.

LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap Dr: [redacted]

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No				b6-2	
Needle Sharp	☑ Yes ☐ No		C	C	SSG [redacted]	CPT.
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

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

b6-4

GPW # [redacted]

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

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Coag: 30 Cut: 30

MEDCOM - 11269

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179 (ITEM 1), FEB 82, WHICH IS OBSOLETE USAPA V1.01

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

"Synthes" 3.5mm Cortex 20 of XX
18mm X2

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 [redacted] b6-2

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

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
webril
Kerlix Ace & splint.

19. ADDITIONAL INFORMATION

Dr. [redacted] b6-2
may [redacted]

20. OPERATION(S) PERFORMED

Lt. arm I&D and ORIF.

21. PATIENT TRANSFERRED TO ICU2 TIME 5:00 Area Recovd METHOD Litter

22. REGISTERED NURSE [redacted] /AN

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

b6-2

MEDCOM - 11270

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 b6-2
VIA: Litter BY [redacted] Staff

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

3. DATE 22 June 03 TIME PATIENT ARRIVED IN SUITE 1600 → OR

4. PATIENT IN ROOM b6-2 TIME NUMBER 1-1/3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA, NPO p MN

6. NURSING PERSONNEL

b6-2

ASSIGNED SCRUB	PFC, [redacted] (91D)	RELIEF SCRUB	
	b6-2		
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:

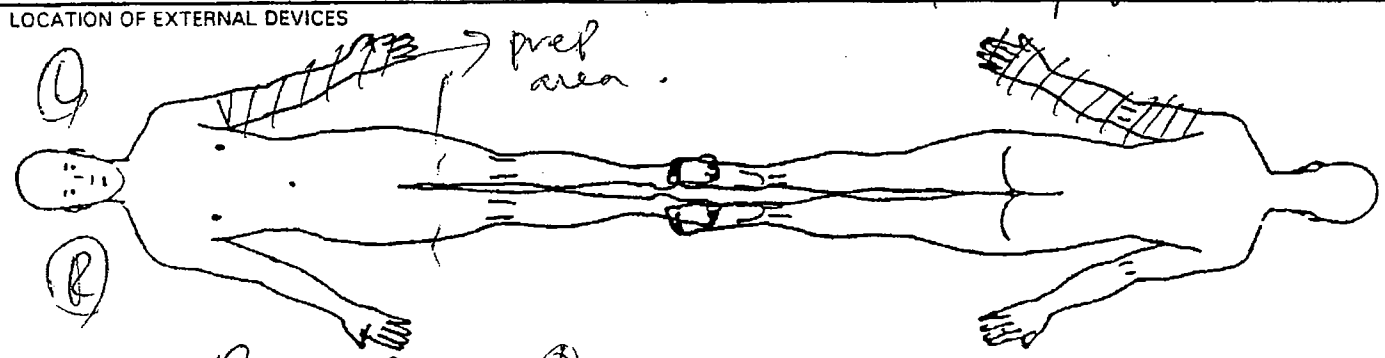
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* Betadine S/Sol
SITE: Lt. arm BY WHOM: CPT. [redacted]
SITE: BY WHOM:
COMMENTS: & Pootings of Sol.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (up) Safety Strap (up) = = = Tourniquet (D)

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB b6-2	CIRCULATOR b6-2
Sponge	☑ Yes	☐ No					
Needle Sharp	☑ Yes	☑ No		C	C	PFC. [redacted]	CPT. [redacted]
Instrument	☐ Yes	☑ No					
Other	☐ Yes	☑ No					

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

b6-4
EPW [redacted]
35yrs.

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

☑ ESU NO: valley lab #1
GROUND PAD: BRAND polyhesive
LOT NO: 54179

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

coag 120 cut 120

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
[redacted] b6-2		

PHYSIC[redacted]

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

YES ☐ NO ☑

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Xeroform
fluffs. Webrils.
Kerlex
Ace. & splint

19. ADDITIONAL INFORMATION

b6-2

Surgeon: Ov[redacted]

20. OPERATION(S) PERFORMED

Lt. arm wd I & D and splint.

21. PATIENT TRANSFERRED TO b6-2 ICU TIME 0[illegible] METHOD Anes. Record

22. REGISTERE[redacted] CPT. AN[redacted]

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

MEDCOM - 11272

MEDICAL RECORD | **INTRAOPERAT[illegible] 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 Anesthesia CPT [redacted]

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

3. DATE 05 Jun 03 TIME PATIENT ARRIVED IN SUITE 1453 b6-2

4. PATIENT IN ROOM TIME 1453 b6-2 NUMBER 2-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] ORT (b6-2)	RELIEF SCRUB	SPC [redacted] (ORT: 910) (b6-2)
ASSIGNED CIRCULATOR	CPT [redacted] AN (b6-2)	RELIEF CIRCULATOR	MAJ [redacted] @ 1700 (b6-2) CPT [redacted] (1910 – End)

7. POSITION AND POSITIONAL AIDS (Specify) Pt transferred to OR table, anatomically aligned for surgical procedure (3) arms on padded arm board less 90°

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

COMMENTS:

8. SKIN PREPARATION

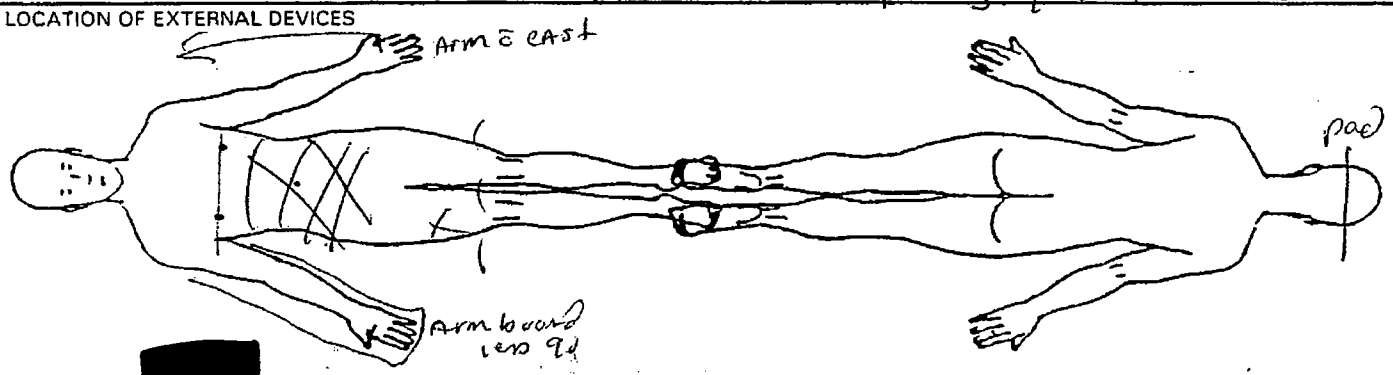
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Betadine/Betadine
SITE: Abd BY WHOM: CPT [redacted] AN (b6-2)
SITE: ** See #19 BY WHOM:

COMMENTS: @ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND [redacted] Ground Pad -- Safety Strap = = = Tourniquet

C = Correct I = Incorrect initial CPT [redacted] PFC [redacted]

10. COUNTS		Initial Other**	First Closing Count	Final Closing Count	SCRUB b6-2	CIRCULATOR b6-2
Sponge	☒ Yes ☐ No	C	C	C	PFC [redacted]	CPT [redacted]
Needle Sharp	☒ Yes ☐ No	C	C	C		
Instrument	☒ Yes ☐ No	C	C	C		
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

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 30/30

☐ ESU NO: #4
GROUND PAD: BRAND Valleylab
LOT NO: 169652 EXP 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S): 0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
Conray 60% for IVC QS	intra-op	Dr. [redacted] b6-2
16Fr Foley inserted the end of case.		Dr [redacted] b6-2

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☑

TYPE/SIZE	1. 16Fr Foley	2. Socked Kerlex	3.
SITE	1. Bladder	2. Abd	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

4X8 fluffs.
TAPE

19. ADDITIONAL INFORMATION

Surgeon
[redacted]
b6-2

Anesthesia
[redacted]
b6-2

20. OPERATION(S) PERFORMED

Wound Exploration - closure
Cholecystectomy, Cholangiogram

21. PATIENT TRANSFERRED TO ICU-2 b6-2 TIME See Anes-Record METHOD Litter [redacted]

22. REGISTERED NURSE SIGNATURE [redacted] CPT/Ar [redacted]

MEDICAL RECORD — **INTRAOPERATI[illegible]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 b6-2 b6-2
VIA: [illegible] BY CPT [redacted] / Dr [redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] b6-2

3. DATE 09 Jan 03 TIME PATIENT ARRIVED IN SUITE 1038

4. PATIENT IN ROOM TIME 1078 NUMBER #1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: 33yo male,

6. NURSING PERSONNEL

b6-2

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
	b6-2		b6-2
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	MAJ [redacted] 1050-1120

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt in supine body alignment, (R) arm as prepped @ <90°

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

COMMENTS:

8. SKIN PREPARATION b6-2

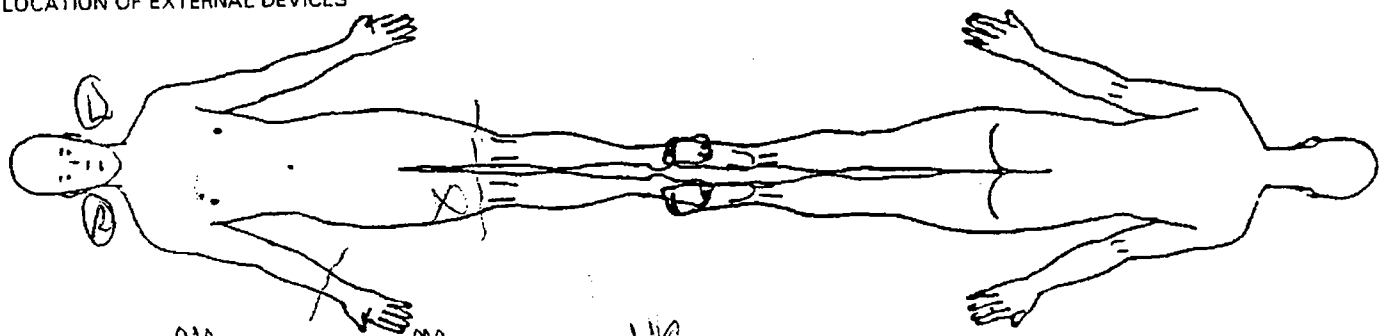
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/paint BY WHOM: CPT [redacted] MAJ [redacted]
SITE: Left arm
SITE: BY WHOM:

COMMENTS: no pain noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (yes) -- Safety Strap (yes) = = = Tourniquet (no)

10. COUNTS — C = Correct I = Incorrect — Initial count - SPC [redacted]

		Other**	First Closing Count	Final Closing Count	SCRUB b6-2	CIRCULATOR b6-2
Sponge	☒ Yes ☐ No	/	C	C		
Needle Sharp	☒ Yes ☐ No				SPC [redacted]	CPT [redacted]
Instrument	☐ Yes ☒ No		/	/		
Other	☐ Yes ☒ No					

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

[redacted]
b6-4

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

☒ ESU NO: 1
GROUND PAD: BRAND Valleylab
LOT NO: 68236

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 11275

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): 0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Xeroform, fluff, webril, splint, webril, ace

19. ADDITIONAL INFORMATION
Surgeon - Hilton
Anesthesia - Dr McMillan
Local block

20. OPERATION(S) PERFORMED
I&D left forearm

21. PATIENT TRANSFERRED TO ICU #2 TIME 1145 METHOD Gurney

22. REGISTERED NURSE SIGNATURE [redacted] b6-2

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

MEDICAL RECORD

INTRAOPERATI[illegible]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 BY Anesthesia VIA Either

2. PATIENT IDENTIFIED, RECORD REVIEWED, AND PROCEDURE VERIFIED BY CPT [redacted] b6-2

3. DATE 6 July 03 TIME PATIENT ARRIVED IN SUITE 0810

4. PATIENT IN ROOM TIME 0810 NUMBER 1-1 12

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

b6-2

ASSIGNED SCRUB	SPC [redacted]	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: proper body alignment maintained, all pressure areas padded, position approved by surgeon + anesthesia

8. SKIN PREPARATION b6-2

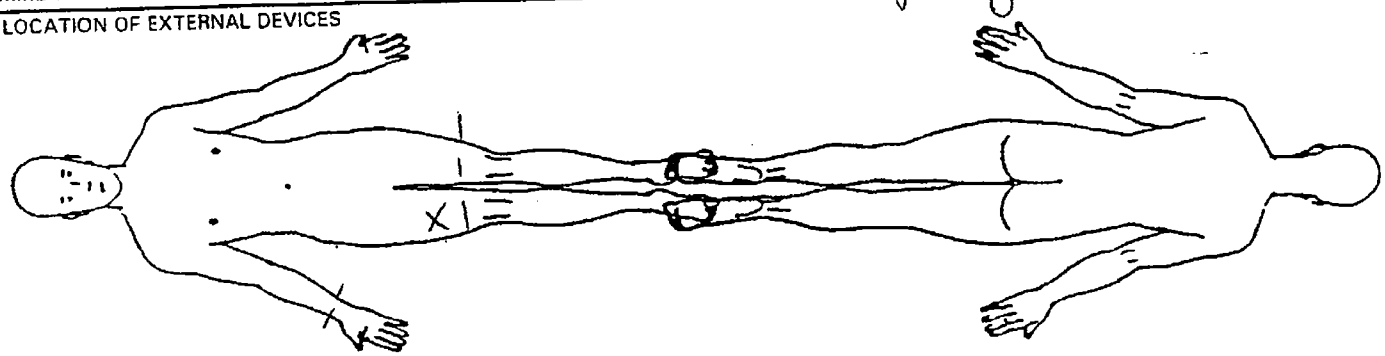
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Beta / Beta BY WHOM: [redacted]
SITE: Abdomen
SITE: #9 BY WHOM:

COMMENTS: no pooling or skin reaction noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad SM -- Safety Strap SM = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB b6-2	CIRCULATOR b6-2
Sponge	☒ Yes ☐ No		C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes ☐ No					
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

#[redacted] b6-4

ICU-2

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

☐ ESU NO:
GROUND PAD: BRAND Valleylab Ram Polyhesive II
LOT NO: 65706 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 11277

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

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
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	16 F FIC		
SITE	Bladder		

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8
Tape

19. ADDITIONAL INFORMATION
Surgeon: [redacted]
Anesthesia: [redacted]
b6-2 all
- FIC in place prior to arrival to OR

20. OPERATION(S) PERFORMED
DPC abdominal wound, Suture removal (L) arm + Cast replacement

21. PATIENT TRANSFERRED TO ICU-2 TIME See DA7389 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT AN

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

b6-2

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	15	16	17	18	19	20	21
POST- DAY							
MONTH-YEAR DAY							
19 HOUR	0 1 2	0 1	1 2	0 1 2	0 1 2	1 2	1

PULSE (O) / TEMP. F (•)

PULSE (O)	TEMP. F (•)
	105°
180	104°
170	103°
160	102°
150	101°
140	100°
130	99° / 98.6°
120	98°
110	97°
100	96°
90	95°
80	
70	
60	
50	
40	

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 12 | 18 | 15 | 18 | 16 | 16 | 16 | 16 | 16 | 16 | 20 | 16 | 16

BLOOD PRESSURE: 115/82, 110/60 | 118/78, 116/60 | 108/78, 114/72 | 124/84, 116/72 | 120/82, 114/62 | 122/72, 118/64, 116/60 | 124/70, 116/70

HEIGHT: | WEIGHT →: 96% | 94% | 95% | 95% 96% | 96% 96% | 98% | 99%

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. CW2

STANDARD FORM 511 (REV. 7-95) BACK

#[redacted]

66.4

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (O) TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)

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

PULSE	TEMP. F
180	104°
170	103°
160	102°
150	101°
140	100°
130	99°
120	98°
110	97°
100	96°
90	95°
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)*

EPW [redacted]

b6-4

REGISTER NO.

WARD NO. ICW2

VITAL SIGNS RECORDS

Medical Record

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

P I&D Recovery 20 Jun 03

Time	05	06	07	08	09	10	~~11~~ 1235	~~12~~ 1245	~~13~~ 1250	~~14~~ 1255	~~15~~ 1300	~~16~~ 1305	~~17~~ 1310	~~18~~ 1315	~~19~~ 1320	~~20~~ 1325	~~21~~ 1330	~~22~~ 1335	23	24
							135/82	126/77	133/76											
BP							/	/	X	132/78	126/76	130/81	128/81	131/76	122/74	129/77	128/78	121/76		
TEMP							/	/	X	X	98.7	X								
HR							120	110	112	110	114	117	117	123	119	116	117	121		
RR							21	22	19	21	22	22	21	22	21	21	22	22		
SAO2							90%	98%	98%	99%	99%	99%	97%	99%	98%	98%	98%	98%		
FIO2									10L	10L	10L	10L	4L	4L	4L	4L	4L	4L		
									FM	FM	FM	FM	NC	NC	NC	NC	NC	NC		
								Bowel Sounds												
INPUT																				
PO																				
IV																				
NGT																		Quiet		
TURN Q 2																				
TOTAL																				
OUTPUT																				
URINE																				
NGT																				
STOOL																				
TOTAL																				
BALANCE																				

MEDCOM - 11281

PT'S NAME: #[redacted] 66-4 ID#: DATE: 20 June 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP INV																								
BP NIBP	144/88	143/89	118/87	141/91	130/88			135/82	124/76	119/70	123/75	127/77	135/74	130/79	133/79	134/86	139/80	130/80	134/81	135/83	139/79	135/70	135/84	138/89
TEMP	99.2A	99.1 (60)	99.0	99.0	99.0			98.5	98.7	98.7	99.9	98.8	100.2A	100.4A	100.4A	100.2A	100A	H	—	99.2A	99.2A	99.2A	99.3	99.6A
HR	101	98	102	107	106			116	114	121	125	124	124	126	123	111	109	118	108	109	112	99	94	101
RR	20	24	18	21	26			24	22	22	24	23	30	34	30	24	21	26	28	24	20	34	24	24
SP02	97	99%	99%	98%	98%			92%	99%	97%	97%	96%	97	95	96	97	98	98	98	98	96	99	98	99
FIO2	2L	2L	2L	2L	2L			10L	10L	4L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L
	NC	NC	NC	NC	NC			VM	FM	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
INPUT																								
PO	Ø	Ø	Ø	—	—	OR	OR						NPO	Ø	Ø	Ø								
IV	125	125	125	125	125			63	62	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
PCA	Ø	Ø	Ø	—	—	—	—	—					Ø											
IVPB	—	50	—	—		Pt in	Pt in			50		100						150						100
SUB TOTAL																								
TOTAL				560								775												1700
OUTPUT																								
URINE	75		100			OR	OR			100		100	75	30	50	50	60	45	45	110	110		120	90
NGT			300									50	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	2
STOOL						Pt in	Pt in																	
SUBTOTAL																								
TOTAL			475							575		725												1837
BALANCE																								

MEDCOM - 11282

PT'S NAME: H[redacted] b6-4 ID#: DATE: 21 June 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	
BP INV																								
BP NIBP	157/87	124/69	146/84	140/86	128/87	134/84	136/81	137/78	135/81	131/82	141/82	137/85	135/85	132/79	132/81	131/75	129/76	129/78	125/82	134/81	129/79	132/81	134/78	
TEMP	99.7 oral	99.1 oral	99.3 oral	99.1 oral	99.5 oral	99.3 oral	99.1	99.1	98.9	98.1 oral	99 oral	98.8 oral	101.2 A	98.7 A	98.5 A	100.1 A	100.1 A	98.8 A	99.3 A	99.2 A	99.2 A		99.0	
HR	111	107	88	96	100	102	98	114	102	91	102	100	102	101	97	94	90	90	91	84	107	83	96	1.4
RR	24	28	24	24	20	24	28	24	26	24	28	29	31	27	35	25	20	20	28	18	21	18	21	30
SP02	97%	95%	94%	95%	97%	97%	98%	98%	97%	100%	100%	98%	100	98	97	99	100	100	98	97	97	96	97	97
FIO2	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L
	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
INPUT																								
PO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	20	30										
IV	125/500	125/625	125/750	125/875	125/1000	125/1125	125/1250	125/1375	125/1500	125/1625	125/1750	125/1875	125	125	125	125	125	125	125	125	125	125	125	125
NGT	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	50	Ø	Ø	300											
TPB		50				180																		
SUB TOTAL																							1250	4010
TOTAL	125/500	175/675	125/825	125/950	125/1075	125/1200	125/1325	125/1450	125/1575	125/1700	125/1825	125/1950											3	
OUTPUT																								
URINE	90	50	75	50	40	150	60	40	100	60	50	50	250		100		100		100		100		45	
NGT	Ø	Ø	Ø	5	Ø	Ø	Ø	Ø	Ø	Ø	25	65	300											
STOOL	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	
SUB TOTAL																							405	
TOTAL	90	140	215	265	305	455	515	555	655	715	790	905	1460										1405	
BALANCE																								

MEDCOM - 11283

PT'S NAME: #[redacted] 66-4 ID#: DATE: 22 Jun 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP INV																								
BP NIBP	125/80	131/80	141/83	134/76	134/79	132/79	134/86	134/84	134/81			125/73	137/80	134/76	139/82	130/75	134/78	123/74	134/78	134/74	132/76	128/75	128/76	130/76
TEMP		99°oral	99°oral	99°oral	99°oral	99°oral	—	99°oral	99°oral			100°	101.3	101 oral	103 A	101 A	102 A	102 A	100 A	99 A	99 A	99 A	99 A	99 A
HR	90	90	75	76	73	81	101	100	96			111	101	102	87	99	116	115	98	78	82	87	73	80
RR	20	23	24	26	22	23	24	26	29			27	32	22	21	30	31	30	29	20	20	19	16	18
SP02	96%	96%	96%	97%	97%	97%	95%	97%	95%			92%	97%	96%	99	96	95	97	96	98	97	99	100	98
FIO2	2l	2l	2l	2l	2l	2l	2l	2l	2l			6l	10l	10l	10	10	10	10	8	10	10	10	10	8
SIO2	NC	NC	NC	NC	NC	NC	NC	NC	NC			MASK	MASK	MASK	Mask	Mask	Mask	Mask	Mask	Mask	Mask	Mask	Mask	Mask
INPUT																								
PO	Ø	Ø	30	360	NPO ~~125~~ Ø	NPO	NPO	NPO	NPO			NPO	60	60	30	60		60						
IV	125	125	175	175	125	125	125	225	125			125	125	125	125	125	125	125	125	125	125	125	125	125
NGT	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø			Ø	Ø											
J.P.												800												
SUB TOTAL	125	125	205	535	125	125	125	225	350			926 ~~925~~	185	185										
TOTAL	125	250	455	990	1115	1240	1365	1590	1940			2865	3050	3175										4635
OUTPUT																								
URINE		200	60	120	60	250	—	300	75			400	375		450		250			300		100		100
NGT		Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø			Ø	Ø											
STOOL		Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø			Ø	Ø											
SUBTOTAL		200	60	120	180	250	—	300	75			400	375											
TOTAL		200	260	380	560	810	810	1110	1185			1585	1960											~~1960~~ 3060
BALANCE																								

In operating Room

In operating Room

MEDCOM - 11284

PT'S NAME: #[redacted] 66-4 ID#: DATE: 23 June 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP INV																								
BP NIBP	132/78	152/80	134/81	125/81	—	129/80	134/85	124/77	134/80	131/55	133/74	134/80	144/83	132/72	134/75	135/63	136/63	139/81	135/80	135/76	133/78	136/83	133/81	143/86
TEMP	99 A	98 oa	98 oa	98 oa	99 oa	98 oa	98 oa	98 oa	98 oa	1	100 o	100 o	101	100 A	98.7 A	98 A	99.4 A	100 A	100 A	98 A		98.7		
HR	86	88	70	75	80	96	74	91	87	81	87	90	97	91	80	69	80	73	72	90	97	85	93	101
RR	21	25	25	24	20	25	18	26	22	28	32	27	24	26	26	24	30	19	16	20	27	28	27	22
SP02	97	98	96	98	99	98	100	97%	98%	100	100	100	97	98	95	97	95	94	94	94	94	95	96	96
FIO2	8L	8L	8L	8L	8L	8L	8L	8L	8L	8L	8L	8L	5L	5L	off	4L	off	off	off	off	RA	RA	RA	RA
SI02	Mask	Mask	Mask	Mask	Mask	Mask	Mask	Mask	Mask	Sem	SFM	SFM	NC	NC		NC								
INPUT																								
PO	Ø	Ø	120	60	Ø	100	—	120	—	—	60	—	120											
IV	125	175	125	125	125	125	225	125	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75
NGT	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø															
SUB TOTAL	125	175	245	185	125 / 310	225	450	245	75	75	135	75	195	75 EA										
TOTAL	125	300	545	730	855	1080	1530	1775	1850	1925	2060	2135	2330											
OUTPUT																								
URINE	60	115	50	125	40	Foley D/C 125	—	—	—	400	—	—	—	400			175		450			600		
NGT	Ø	Ø	Ø	Ø	Ø	Ø	—	—	—								Y Vomit							
STOOL	Ø	Ø	Ø	Ø	Ø	X1 Large Ø	—	—	—															
BTOTAL	60	115	50	125	165	125	0	0	0	400	—	—												
TOTAL	60	175	225	350	515	640	640	640	640	1040	1040	1040												
BALANCE																								

MEDCOM - 11285

PT'S NAME: #[redacted] 66-4 ID#: DATE: 24 June 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP INV																								
BP NIBP	141/85	134/75	145/85	144/96	146/80	140/82	147/83	140/82	131/72	145/84	139/78	134/80	137/83	142/77	132/73	140/75	130/76	131/75	135/80	104/75	138/79	133/76	135/77	133/79
TEMP	98.8	99 aw	98 aw	98.7 aw	98.2 aw	100.3 aw	99.5 aw	99.5 aw	99.6 aw	99.8 aw	99.7 aw	100.2 aw	101.4 A	101.2 A	101.3 A	101.3 A	101.3 A	100.4 A	100.3 A	100.3 A	100.5 A	100.3 A	100 A	99.4 A
HR	90	104	81	74	84	77	78	90	82	73	84	94	98	97	96	95	99	101	88	106	97	106	96	78
RR	25	25	28	29	33	30	30	33	28	24	25	34	32	35	27	30	25	30	26	28	23	28	19	19
SP02	93%	94%	93%	93%	93%	93%	95%	95%	94%	95%	95%	93%	93%	92	92	92	90	92	91	92	92	93	93	92
FIO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT																								
PO	—	—	240	—	240	100	—	300	120	—	60	Ø	Ø			750	750		60					
IV	75	75	75	125	75	175	75	75	75	125	75	75	75	75	75	75	75	75	75	75	75	75	75	75
NGT	—	—	315	—	—	275	—	—	—	—	—	—	—											
SUB TOTAL	75	75	315	125	315	275	75	375	195	125	135	210	75											4655
TOTAL	75	150	465	590	905	1180	1255	1630	1825	1950	2085	2195	2270											
OUTPUT																								
URINE	—	300	—	—	—	375	—	125	325	—	275	—	225	425	375	325	375	775		400	400	375	375	
NGT	—	—	—	—	—	—	x1 (large)	—	x1 (small)	—	—	—	—											
STOOL	—	—	—	—	—	—																		
SUBTOTAL	Ø	300	Ø	0	0	375	—	125	325	Ø	275	Ø	225											6125
TOTAL	Ø	300	300	300	300	675	675	800	1125	1125	1400	1400	1625											
BALANCE																								

MEDCOM - 11286

#[redacted] 66-4 25 June 03

Time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
BP	125/75	141/82	136/67	122/83	139/88		137/84	141/81	118/79	139/86						143/85	121/86	133/79	145/88	130/89
TEMP	99.4A	98.7		99.1		99.2	99.2		99.2	99.4							101.9A	101.5A	101.4A	102A
HR	100	84	82	112	88	78	80	9	73	74						111	110	108	91	118
RR	30	20	24	26	29	26	24	22	28	20						28	28	32	33	30
SAO2	92	98	98	96	96	98	98	100	99	99						93	97	97	99	96
FIO2	RA	2L	2L	RA	RA	2L	2L	2L	2L	2L						8L	8	8L	8L	8L
SOURCE		NC	NC		NC	NC	NC	NC	NC	NC						FM	FM	FM	FM	FM
I/S		10	10	10																
INPUT																				
PO			60	180 240			NPO													
IV		75	75	75	75	75	—	75	75	75						150	150	150	150	150
NGT										50						Ø	Ø	Ø	Ø	Ø
DPB		80					100									100				
TURN Q 2																				
TOTAL										650										1300
OUTPUT																				
URINE		450	375	355	400	—	600	475	—	500						300	300 Foley	140	215	100
NGT																				
STOOL																				
JP																30		20		10
TOTAL										3155										
BALANCE																				

OK OK OK OK See flowsheet

MEDCOM - 11287

Date 25 June 03 Bed #

Patient's Name: #[redacted] b6-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP																					129/85	129/84	127/86	129/81
TEMP																					101°A	100°A	100°A	101°A
HR																					125	121	124	125
RR																					26	29	25	27
SAO2																					97	95	96	96
FIO2																					5L	5L	5L	5L
[illegible]																					FM	FM	FM	FM
INPUT																								
PO																								
IV																								
NGT																					150	150	150	150
																					Ø	Ø	Ø	Ø
TURN Q 2																								
TOTAL																								
OUTPUT																								
URINE																					40	100	100	150
NGT																					Ø	Ø	Ø	2
[illegible]OL																								
[illegible]																						2		10
[illegible]AL																								
BALANCE																								448
Initials																								

See other V/S sheet

MEDCOM - 11288

Date 26 June 03 Bed # 5

Patient's Name: [redacted] 66-4 ICU #2

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	133/84	133/85	137/86	137/96	132/86	129/82	139/83	134/84	127/76			124/76	134/81	153/80	120/60	122/72	128/71	134/70	131/78	130/70	125/71	128/73	125/71	118/70
TEMP	101 A	100 oral	101	101	—	100 oral	100 oral	100 oral	100 oral	100 oral				103 A	103 A	101 A	103 A	103 A	103 A	103 A	101 A	101 A	101 A	101 A
HR	124	123	125	117	116	114	98	116	123	114		130	120	133	139	129	131	132	128	142	136	128	101	125
RR	25	24	27	27	28	24	20	23	28	23		30	30	28	26	32	30	29	31	31	21	24	28	19
SAO2	96	95	98	99	100	97	100	99	97	98		94	96	99	94	97	95	100	99	94	94	96	100	96
FIO2	5L	5l	5l	5l	5L	5L	5l	5l	5l	5l		5L	6L	6L	6L	6L	6L	6L	6L	4L	4L	4L	4L	4L
Method	FM	MASK	MASK	MASK	MASK	MASK	MASK	MASK	MASK	MASK		NC	FM	FM	FM	FM	FM	FM	FM	NC	NC	NC	NC	NC
INPUT	150	150																						
PO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO		NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO
IV	150	150	150	150	150	150	150	150	150	150		300	150	150	150	150	150	150	150	150	150	150	150	150
NGT	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	—	—		~~300~~												
IVPB							100	—	—	—		100												
TURN Q 2																								
MS04 gtt															1	1	1	1	1	1	1	1	1	1
									150															
SUBTOTAL	150	150	150	150	150	150	250	150	~~300~~	150		300												
TOTAL	150	300	450	600	750	900	1150	1300	1450	1600		350												3410
OUTPUT																								
URINE		160	140	60	160	80	40	60	80	150		300	100	300	200	60	60	85	70	70	80	70	60	100
[illegible]	—	30	10	—	—	50	—	10	75	75		400	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø
[illegible]OL	Ø	Ø	Ø	Ø	Ø	0	Ø	Ø	0	Ø		Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø
JP	—	5		Ø		15	40	5	—	5		10		Ø		1		1		1		1		10
TOTAL SUB		195	150	60	160	145	185	75	155	230														
BALANCE																								
output TOTAL		195	345	405	565	698	738	813	968	1198		710												1155

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Date 27 June 03 Bed # 56-4

Patient's Name #[redacted]

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP		139/71	139/68	139/90	137/	137/68	138/	141/	137/	132/	127/	128/	128/	129/	135/	135/	134/	132/	133/	130/	130/	132/	117/	118/
TEMP	102	102.3	102.7	102.5	102.5	103.2	103.6	103.6	103.4	103.6	103.3	102.7	102.0	102.6	103.5		103.6	103.1	102.9	102.4	102.4	100.7		99.8
HR		129	128	120	120	117	118	129	115	128	140	138	137	132	128	140	141	136	132	130	131	114	115	130
RR		22	26	26	20	24	26	30	21	28	30	28	36	28	21	36	33	30	36	32	26	23	19	28
SAO2		96	97	96	93	94	96	95	95	97	95	97	98	99	96	96	94	96	97	97	96	98	98	94
FIO2	8	26	4L	4L	4L	4L	4L	4L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L	6L
Method	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	FM	FM	FM	FM	FM	FM	FM	FM	FM
INPUT		NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø
PO NS																								
IV LR	150	150	150	150	150	150	150	150	150	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50
NGT																								50
1504	1	1	1	1	3	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
TURN Q 2																								
IVPB						100				100		100								100	50			
TOTAL	131	782	553	704	658	819	969	1119	1269	1419	1569	1669	1660	1740	1790	1840	1990	2040	2090	2140	2340	2390	2440	2990
OUTPUT																								
URINE	139	155	150	150	200	200	150	200	150	100	900	650	200	300	220	240	250	290	110	220	130	50	50	30
NGT																								
STOOL																								
UP		10		10		5		10		3		3	20	10		5		10		10		5		15
TOTAL	195	320	470	620	870	1075		1045	119	119	2197	285	1365	5301	9581	245		4270		4640				
BALANCE																3820	5070	4160		4510		4700	4750	4785
Initials																								

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28 June 03 Bed #5

EPW # [redacted] 66-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	116/72	116/76	121/70	123/77	114/68	115/60	110/66	110/86	113/66	112/69	114/63	114/68	112/67	116/67	114/62	115/68	113/66	113/65	110/63	110/62	110/61	113/64	111/65	112/68
TEMP	100.1	101.2	101.4	101.2	99.7	99.2	99.4	98.2	99.2	99.2	99.5	101.6	102.4	102.5	101.4	100.4	100.6	101.4	101.4	100.4	99.4	99.4	99.4	99.4
HR	113	119	118	112	107	97	107	103	102	114	110	113	119	139	130	115	114	114	116	121	122	109	112	107
RR	27	25	25	23	28	18	24	22	19	12	18	17	21	21	18	19	17	18	20	20	24	21	17	18
SAO2	98	97	99%	100	100	100	97%	96	100%	98	98%	98%	95%	94	96	97	98	97	97	100	96	97	97	97
FIO2	10L	10L	10L	10L	10L	10L	5L	5L	5L	4L	3L	2.5L	2.5L	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5
							NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
INPUT																								
PO		NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO
IV	50	50	150	100	51	51	51	51	51	51	51	53	51	51	51	51	51	51	51	51	51	51	51	51
NGT						100	100				150													
NPB																								
TURN Q 2																								
																								1512
TOTAL	50	102	253	354	405	351	502	553	604	655	856	909	960											
OUTPUT		100							180	46	40	65	—	100	110	55	60	30	60	65	50	50	80	50
URINE		100	80	60	60	300			450		100	30	—	50	50	50	Ø	50	Ø	Ø	Ø	Ø	Ø	Ø
NGT														[redacted]										
STOOL		5		5		Ø		10		Ø		10		15		15		10		Ø		Ø		4
OP drain																								256
TOTAL																								
BALANCE		~~107~~ 105	~~139~~ 185	250	311	611		621	1251	1297	1437	1542	1542		662									

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29 June 03 EPN# [redacted] 66-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	119/64	112/66	114/72	109/71	121/78	112/66	O	114/65	93/54	93/54	109/60	119/70	118/66	113/65	106/66	104/66	95/63	116/66	121/66	102/61	103/66	115/62	109/65	116/67
TEMP	99A	100	100	100	100	100		100	100	100	100	102	101	100A	99A	99A	99A	98A	100A	100A	101A	100A	99A	99A
HR	112	119	116	117	124	106		118	117	117	121	126	123	123	114	134	121	112	103	110	110	101	111	92
RR	16	19	27	30	23	23		23	19	18	20	24	13	21	19	23	17	30	25	21	19	23	19	20
SAO2	96	100	96	97	96	95		95	95	97	96	96	96	94	97	95	96	95	98	98	98	96	96	96
FIO2	2L	2L	2L	2L	2L	2L		2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L
	NC	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
INPUT																								
PO	NPO	NPO	NPO	NPO	NPO	NPO	OK	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	NPO
IV	51	51	100	50	50	50		45 OK	100	100	150	150	100	101	101	101	101	101	101	101	101	101	101	101
NGT																	500							
						100			10															
TURN Q 2																								
TOTAL	51	102	202	252	302	452	452	902	1012	1112	1262	1412	1512											
OUTPUT																								
URINE	80	100	60	75	90	OK	OK	OK 45	60	60	70	70	60	80	45	45	24	50	70	110	100	50	80	32
NGT	—	—	—	5	—	—	—	—	—	50	—	120	40	50	30	80	Ø	Ø	50	50	Ø	50	50	Ø
STOOL																Med								
JP		5		5		5		5		5	—	8		1		4		Ø		Ø		Ø		10
TOTAL	80	185	265	345	435	440	440	995	1055	1160	1230	1328	1528											2539
BALANCE																								

66-2

[redacted] 3123

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27
+13 10
23/30

30 June 03 EPW-[redacted] 66-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	118/69	120/69	119/67		123/70	122/69	114/66		139/70		111/67		121/68	114/69	120/70	119/69	135/76	122/67	119/70	122/67	115/64	119/67	120/66	114/64
TEMP	99.2 A				98.3									99.2	100.3	100.2	101 A	101.2	101.2	102.2 A	100 A	101.2 A	101 A	99.4 A
HR	96	104	111	119	108	92	91	100	111	103	94		100	101	101	96	109	116	110	114	122	117	111	97
RR	15	17	21	24	20	21	21	18	26	18	12		21	19	19	13	22	21	20	22	25	26	26	24
SAO2	98	98	98	94	96	98	100	97	97	97	99		92	99	99	99	92	95	98	97	96	99	98	99
FIO2	2L	2L	2L	2L	2L	2L	2L	2L	2L		2L		2L	2L	2L	off	off	2L	2L	2L	2L	2L	2L	2L
	NC	NC	NC	NC	NC	NC	NC	NC	NC		NC		NC	NC	NC			NC	NC	NC	NC	NC	NC	NC
INPUT																								
PO																								
IV	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
NGT																				tem				
MSO4	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
TURN Q 2																								
IVPB		50				150												150						2974
			101	101	101	251	101																	
TOTAL	101	151	353	454	555	806	907																	
	101	252																						
OUTPUT																								
URINE	50	55	50	60	60	30	35	70	70	70	100			180	110	150	70		200	200	180	200	200	200
NGT																								
STOOL																								
JP		2		0		8		0		2				3		8		7		8		10		5
TOTAL		57	50	60	60	38	35																	2897
BALANCE	50	107	157	217	277	315	350																	

66-2 [redacted] 2970

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Patient Name 1/1/03 Bed #5 EPN# [redacted] b6-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	122/70	119/70	110/63	105/63	120/67	117/69	115/66	107/66	113/66	114/66	119/64	113/63	107/66	125/57	125/66	126/60	119/58	113/59	114/55	111/65	119/67	118/66	114/72	111/72
TEMP	100.5A	100.5	99.8	99.3	100.6	100.4	101	101	99.8	99.5	99.8	101.0	101.6	100.2A	99.4A	98.8A				100.4			101.0	
HR	100	106	119	111	111	113	102	105	101	98	100	101	100	111	103	95	92	94	93	111	119	114	110	112
RR	27	22	22	23	23	22	24	24	25	24	25	22	22	26	23	25	20	21	24	23	25	21	23	22
SAO2	99	99	99	93	98	98	98	97	99	97	98	97	98	97	96	95	98	100	98	93	93	95	95	94
FIO2	2L	2L	2L	4L	4L	4L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L
Method	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
INPUT																								
PO	100	100						100					100											
IV	101	101	104	101	101	301	250	51	301	101	101	101	101	101	101	101	101	101	101	101	101	101	101	101
NGT																		50	50					
IVPB																								
TURN Q 2																								
TOTAL	101	202	306	407 405	508	709	959	1010	1311	1412	1513	1614	1715	1816	1917	2018	2119	2220	2421	2522	2623	2824	2825	2926
OUTPUT																								
URINE	—	530	250	200	200	250	200	230	220	190	250	200	90	200	110	175	250	130	240	250	200	150	160	200
NGT																								
STOOL																								
JP	—	5	—	—	6	5		5				3	2	0		3		0		2		0		3
TOTAL	0	535	805	1005	1210	1460	1660	1890	2110	2300	2550	2753	2955	3155	3265	3443	3693	3823	4063	4315	4515	4665	4815	5028
BALANCE																								

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02 July 03

[redacted] b6-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	111/68	112/65	111/72	110/65	117/74	109/73	113/73		113/67	113/67	114/73	112/64	111/60	111/64	120/71	115/64	112/68	113/70	105/63	110/70	109/70	109/71	106/61	104/56
TEMP		100.8											98.4	99.4	96.6		99.6		100.4	100	99.8		98.4	98.4
HR	105	112	101	112	107	113	115		107	106	112	103	104	100	114	115	110	104	96	109	111	105	102	101
RR	20	22	23	27	24	15	26		21	20	22	21	20	19	23	24	22	21	19	17	20	19	17	16
SAO2	95	94	98	91	95	95	96		99	97	96	98	98	98	95	95	95	93	97	99	93	95	94	94
FIO2	2L	2L	2L	2L	2L	2L	2L		2L	2L	2L	2L	2L	2L	off	2L	off	off	off	off	off	off	off	off
	NC	NC	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC								
INPUT																								
PO																								
IV	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
NGT																								
MS04	1	1	1	1	1	1	1	2	3	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
TURN Q 2																								
IVPB		50				150				50								100						
TOTAL	101	252	353	454	555	706	807	809	912	1063	1164	1265												2577
OUTPUT																								
URINE		400				575	1160		120	40	400	200	200	200	80	400	400	150	110	160	120	120	45	70
NGT																								
STOOL														0		0		0		3		2		0
JP						100cc	0			5cc														
TOTAL																								
BALANCE		400				985	1145		1265	1310	1710	1910												2970

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Date 3 July 03 b6-4 Bed # 5

Patient's Name #[redacted] EPN

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	100/[illegible]	101/64	106/64	108/64	110/69	105/64	95/64	105/63	107/66	110/60	105/62	110/69	115/72	114/68	110/76	107/76		115/65		105/64		107/62		110/66
TEMP	98.3	98.6					98.8									98.6						98.9		
HR	98	100	100	102	98	107	99	97	111	101	103	105	102	95	102	89		95		87		94		105
RR	17	15	18	20	15	19	17	16	21	18	19	19	22	14	14	15		17		18		17		18
SAO2	94	95	95	95	95	95	97	94	95	93	93	95	95	95	95	95		95		95		96		95
FIO2	off	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		RA		RA		RA		
INPUT																								
PO																								
IV		101	101	101	101	101	101	101	101	101	101	101	100	100	100	100	100	100	100	100	100	100	100	100
NGT																								
IVPB		50				150				50								100	100					
TURN Q 2																								
TOTAL		151	252	353	454	605	706	807	908	1059	1160	1261	1361	1461	1561	1661	1761	1961	2061	2161	2261	2361	2461	2561
OUTPUT																								
URINE	100	200		140	100		200		250		100	140	100	75	50	50	80	80	50	50	50	50	100	100
NGT																								
STOOL																								
JP		205		0		0		0		40cc		0		0		0		0		0		3		0
TOTAL																								
BALANCE	100	302.5		442.5	542.5		142.5		992.5	996.5	1096.5	1236	1336	1411	1461	1511	1590	1670	1720	1770	1820	1873	1973	2073
Initials																								

IN 2561

OUT 2073

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Date 4 JUL 03 b6-4 Bed # 5

Patient's Name: #[redacted]

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP		115/68			109/65						102/60			112/60	111/63	115/69	102/57	112/65	115/63	111/64	108/62	113/63	108/64	111/60
TEMP		98.7			–						98.1			98.4	98.3	97.9	97.4	97.4	98.2	98.3	98.4	96.4	96.3	97.4
HR		95			88						92			98	83	84	92	98	101	92	96	110	97	96
RR		26			16						21			18	16	14	25	17	18	17	18	17	16	17
SAO2		95			96						97			95	96	97	97	97	96	96	90	96	97	96
FIO2		RA			RA						RA			RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
INPUT																								
PO				200										60				60	60					
IV (2L)	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
NGT																								
TURN Q 2																								
TOTAL	100	200	300	500	700	800	900	1000	1100	1200	1300													2660
OUTPUT																								
URINE		300			300						300			160	30	45	30	60	50	70	30	30	50	50
NGT																								
STOOL																								
TOTAL																								1545
BALANCE		300			600						900													
Initials																								

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Patient's Name 5 yrs 03 # [redacted] b6-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	104/60	115/64												120/80										
TEMP	97.4	97.6												98.1										
HR	86	85												99										
RR	15	17												20										
SAO2	96	97												96										
FIO2	RA	RA												RA										
INPUT																								
PO			60	60		100		40			100									NPO				
IV	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
NGT																								
TURN Q 2	100	200																						
TOTAL	100	200	360	520	620	820	920	1060	1160	1260	1460	1560	1660											276
OUTPUT																								
URINE		140	0	0	200	0	0	0	0	0	0	0	0	525	75				300		150		150	
NGT																								
STOOL																								
TOTAL					340								340											15
BALANCE																								
Initials																								

MEDCOM - 11298

Patient's Name: [redacted] b6-4

Time	05	06	07	08	0930	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP		112/82			110/60			111/69					115/82											
TEMP		96.4			97.7								98.7											
HR		84			90			79					100											
RR		24	OR		12			12					16											
SAO2		94			99			95					95											
FIO2		RA			RA			RA					RA											
INPUT																								
PO	NPO	NPO	NPO	NPO																				
IV	100	100	900		63	125	125	125	125				125	125	125	125	125	125	125	125	125	50	50	50
NGT																								
TURN Q 2																								
TOTAL	100	200		1100	1163	→			1663															2345
OUTPUT																								
URINE															900				300		200			200
NGT																								
STOOL																								
TOTAL																								
BALANCE																								
Initials		[redacted]							[redacted]															

662

MEDCOM - 11299

Patient's Name: [redacted] b6-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP		110/62												118/63										
TEMP		98.3												98.4										
HR		64												101										
RR		12												20										
SAO2														97										
FIO2		RA												RA										
														[redacted]	b6-2									
INPUT																								
PO																								
IV	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50	50
NGT																								
TURN Q 2																								
TOTAL											550													1200
OUTPUT																								
URINE											700				450	250		300		225				300
NGT																								
STOOL																								
TOTAL																								
BALANCE																								2a
Initials																								

MEDCOM - 11300

8 July 03 5

Patient's Name: # [redacted] b6-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	—		116/60																					
TEMP			98.1																					
HR			88																					
RR			18																					
SAO2			98																					
FIO2			RA																					
IV T																								
PO								500																
IV	50	50	50	50	50	50	50	50																
NGT			0700	0900																				
MS04 ( )			(4mg)		(3mg)	(7)	(4mg)																	
TURN Q 2	50	50																						
Bladder Test						300																		
Sub total			51.4	50	50	50	50	550																
TOTAL	50	100	151	201	251	301	351	901																
OUTPUT																								
URINE	100	100	100	150	150	—																		
NGT Bladder Test						300																		
STOOL	∅	∅	∅	∅																				
C Tubes	100																							
TOTAL	100	200	300	450	600	900	—	—																
BALANCE				248																				
				~~450~~																				

Initials

MEDCOM - 11301

CMT

CPW # [redacted] b6-4

[redacted] b6-2

18 Jun 03

CPW # [redacted] b6-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/l
K		3.5-5.3 mmol/l
Cl		98-106 mmol/l
pH		7.35-7.45
PCO2		35-45 mmHg
PO2		80-105 mmHg (adult) N/A (neo)
TCO2		23-27 mmol/l (adult) 24-29 mmol/l (neo)
HCO3		22-26 mmol/l (adult) 23-26 mmol/l (neo)
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%
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	3.1	3.5-5.5 g/dl
ALP	84	20-64 u/l
ALT	83	10-47 u/l
AMY	48	14-85 u/l
AST	73	11-38 u/l
TBIL	0.6	0.2-1.0 mg/dl
BUN	15	7-22 mg/dl
CA	7.8	8.0-10.3mg/dl
CHOL	79	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	163	73-118 mg/dl
TP	6.1	6.4-8.1 g/dl

(Piccolo) Metabolic Panel

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
HCO		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118
BUN		7-22
CA		8.0-10.3
CRE		0.6-1.2
NA		128-145
K		3.3-4.7
CL		98-108
HCO_2		18-33

(Piccolo) Liver Panel

TEST	RESULT	REF. RANGE
ALB		3.5-5.5
ALP		20-64
ALT		10-47
AMY		14-85
AST		11-38
TBIL		0.2-1.0
GGT		8-78
TP		6.4-8.1

(Piccolo) Electrolytes

TEST	RESULT	REF. RANGE
NA	145	128-145
K	3.9	3.3-4.7
CL	109	98-108
HCO_2	21	18-33

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
18	Jun 03	

EPW #[redacted] b6-4

[redacted] b6-2

EPW #[redacted] b6-4

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC	10.4	4.8-10.8 x 10^3
RBC	4.47	4.7-6.1 x 10^6
Hgb	13.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	41.8	42-52% (M) 37-47% (F)
MCV	93.6	80-94 fl (M) 81-99 fl (F)
Plt	288	130-500 x 10^3 verified
Lymph %	13.0	20.5-51.1%

(Hematology) Manual Differential			
Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis		
TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.025	N/A
Bld	Large	Negative
pH	6.0	N/A
Prot	neg	Negative
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk		Negative
HCG		Negative

CSF		
Cell Count		
Directigen		Negative

Misc. Serology		
TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

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

Microscopic Urinalysis
2-3 granular casts per LPF 5-7 RBC rare RBC cast Moderate mucus

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

Coagulation Studies		
TEST	RESULT	REF. RANGE
PT	13.3	9.8-13.6 secs
APTT	24.9	21-34 secs
D-dimer		<20 ug/ml
FDP		<10 ug/ml

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
/8	Jm03	

Ward/Section: OR	REQUESTING PHYSICIAN: [redacted] b6-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. # [redacted] b6-4	DATE 18 [illegible]	TIME 0755	SSN/PSEUDO SSN: # [redacted] b6-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.0	4.8-10.8 x 10^3
RBC	3.95	4.7-6.1 x 10^9
Hgb	11.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	37.1	42-52% (M) 37-47% (F)
MCV	93.8	80-94 fl (M) 81-99 fl (F)
Plt	249	130-500 x 10^3 verified
Lymph %	14.3	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 18Jun03	LAB ID NO.:

b6-2

/ard/Section: ICU 2	REQ...TING PHYSICIAN:	LA...RATORY RESULT FORM (Subject to the Privacy Act of 1974)		
AST, FIRST, MI: EPW [redacted] b6-4		DATE 18 June 03	TIME 1140	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
/BC	7.4	4.8-10.8 x 10^3
BC	4.57	4.7-6.1 x 10^9
gb	13.3	14-18 g/dl (M) 12-16 g/dl (F)
ct	43.3	42-52% (M) 37-47% (F)
ICV	94.6	80-94 fl (M) 81-99 fl (F)
lt	248	130-500 x 10^3 verified
ymph %	16.2	20.5-51.1%

(Hematology) Manual Differential

egs		Mono	
ands		Eos	
ymph		Baso	
typ		Imm	
BC lorph			

oun ematocrit		42-52% (M) 37-47% (F)
ed Rate		
ther		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANG
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
T		9.8-13.6 secs
PTT		21-34 secs
dimer		<20 ug/ml
DP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

EMARKS: [redacted]

b6-2

ard/Section: ICU#2 | REQ[redacted]ING PHYSICIAN: [redacted] 66-2 | CH[redacted]ISTRY RESULT FORM (Subject to the Privacy Act of 1974)

ST. FIRST [redacted] 66-4 | DATE 19Jun03 | TIME 0400 | SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
a		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
H		7.31-7.45
CO2		35-45 mmHg (art) 41-51 mmHg (ven)
O2		80-105 mmHg (art) N/A (ven)
CO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
CO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
O2		95-98%
Eecf		(-2) – (+3) mmol/L
nGap		10-20 mmol/L
a		1.12-1.32 mmol/L
UN		8-26 mg/dl
LU		70-105 mg/dl
reat		0.7-1.5 mg/dl
ct		38-51% PCV
gb		12-17 g/dl

Misc. Chemistry

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANG
NA^+	142	128-145 mmol/l
K^+	3.9	3.3-4.7 mmol/l
CL^-	105	98-108 mmol/l
tCO_2	26	18-33 mmol/l

EMARKS:

EPORTED BY: [redacted] **DATE:** 19Jun03 **LAB ID NO.:**

66-2

Ward/Section: ICU #2	REPORTING PHYSICIAN: [redacted] b6-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. # [redacted] b6-4		DATE 19 June 03	TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.3	4.8-10.8 x 10^3
RBC	3.96	4.7-6.1 x 10^9
Hgb	11.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	37.5	42-52% (M) 37-47% (F)
MCV	94.7	80-94 fl (M) 81-99 fl (F)
Plt	202	130-500 x 10^3 verified
Lymph %	22.0	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Hgb/Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

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

UNIT	TYPE	CROSSMATCH

REMARKS: [redacted] b6-2

Ward/Section: ICU #2	RE[redacted]NG PHYSICIAN: [redacted] 66-2	LA[redacted]ATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: #[redacted] 66-4	DATE: 20 June 03	TIME: 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	6.5	4.8-10.8 x 10^3
RBC	3.72	4.7-6.1 x 10^3
Hgb	11.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	35.1	42-52% (M) 37-47% (F)
MCV	94.2	80-94 fl (M) 81-99 fl (F)
Plt	228 verified	130-500 x 10^3
Lymph %	18.9	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 20 Jun 03	LAB ID NO.:

66-2

Ward/Section: ICU 2	REQUESTING PHYSICIAN: [redacted] b6-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. Ep [redacted] b6-4	DATE 29/6	TIME 0430	SSN/PSEUDO SSN:	

(i-STAT)

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

Misc. Chemistry

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+	117	128-145 mmol/l
K^+	4.2	3.3-4.7 mmol/l
CL^-	103	98-108 mmol/l
tCO_2	29	18-33 mmol/l

REMARKS: lytes

REPORTED BY: [redacted]	DATE: 20 Jun 03	LAB ID NO.:

b6-2

ard/Section: ICU #2

REQUESTING PHYSICIAN: [redacted] b6-2

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

AST, FIRST, MI. # [redacted] b6-4

DATE 20 Jun 03 | TIME 0930 | SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	136	138-146 mmol/L
K	3.7	3.5-4.9 mmol/L
Cl	103	98-109 mmol/L
pH	7.381	7.31-7.45
pCO2	45.6	35-45 mmHg (art) 41-51 mmHg (ven)
pO2		80-105 mmHg (art) N/A (ven)
HCO2	28	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	27	22-26 mmol/L (art) 23-28 mmol/L (ven)
SO2		95-98%
BEecf	2	(-2) – (+3) mmol/L
AnnGap	10	10-20 mmol/L
'a		1.12-1.32 mmol/L
BUN	16	8-26 mg/dl
GLU	110	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	31	38-51% PCV
Hgb	11	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
roponin-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	112	73-118 mg/dl
BUN		7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	>5000	39-380 u/l (M) 30-190 u/l (F)
NA^+	118	128-145 mmol/l
K^+	4.2	3.3-4.7 mmol/l
CL^-	104	98-108 mmol/l
tCO_2	100	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

CK = >5000

REPORTED BY: [redacted] | **DATE:** 20 June 03 | **LAB ID NO.:**

b6-2

'ard/Section: ICU 2

UESTING PHYSICIAN: [redacted] b6-2

C - MISTRY RESULT FORI
(Subject to the Privacy Act of 1974)

AST, FIRST, MI: # [redacted] b6-4

DATE	TIME	SSN/PSEUDO SSN:
20JUN03	1330	

(i-STAT)

TEST	RESULT	REF. RANGE
a		138-146 mmol/L
		3.5-4.9 mmol/L
l		98-109 mmol/L
H		7.31-7.45
CO2		35-45 mmHg (art) 41-51 mmHg (ven)
O2		80-105 mmHg (art) N/A (ven)
CO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
CO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
O2		95-98%
Eecf		(-2) – (+3) mmol/L
nGap		10-20 mmol/L
a		1.12-1.32 mmol/L
UN		8-26 mg/dl
LU		70-105 mg/dl
reat		0.7-1.5 mg/dl
let		38-51% PCV
lgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
roponin-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	124	73-118 mg/dl
BUN		7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	75000	39-380 u/l (M) 30-190 u/l (F)
NA^+	119	128-145 mmol/l
K^+	4.5	3.3-4.7 mmol/l
CL^-	104	98-108 mmol/l
tCO_2	32	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANC
ALB	2.1	3.3-5.5 g/dl
ALP	58	26-84 u/l
ALT	27	10-47 u/l
AMY	15	14-97 u/l
AST	127	11-38 u/l
TBIL	4.6	0.2-1.6 mg/dl
GGT	36	5-65 u/l
TP	5.5	6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted]
b6-2

DATE: 20JUN 03

LAB ID NO.:

Ward/Section: ICU #2	R[redacted]STING PHYSICIAN: [redacted] b6-2	C[redacted]MISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: # [redacted] b6-4	DATE: 21 June 08 / TIME: 0400	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+	139	128-145 mmol/l
K^+	3.7	3.3-4.7 mmol/l
CL^-	103	98-108 mmol/l
tCO_2	28	18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b6-2	DATE:	LAB ID NO.:

Ward/Section: ICU#2

REQUESTING PHYSICIAN: [redacted] b6-2

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI: #[redacted] b6-4

DATE: 21 March 03 | TIME: 0400 | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	4.3	4.8-10.8 x 10^3
RBC	2.48	4.7-6.1 x 10^3
Hgb	7.4	14-18 g/dl (M) 12-16 g/dl (F)
HCT	23.5	42-52% (M) 37-47% (F)
MCV	94.7	80-94 fl (M) 81-99 fl (F)
Plt	258	130-500 x 10^3 verified
Lymph %	27.3	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count	
Directigen	Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

Blood Bank Unit Crossmatch
(MUST SUBMIT SF518 FULLY FOR EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 21 Mar 03

LAB ID NO.:

ICU #2 DR [redacted] b6-2

PT# [redacted] b6-4 21 June 03 @ 0635hrs

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	4.8	4.8-10.8 x 10^3
RBC	3.14	4.7-6.1 x 10^6
Hgb	9.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	29.8	42-52% (M) 37-47% (F)
MCV	94.6	80-94 fl (M) 81-99 fl (F)
Plt	252	130-500 x 10^3 verified
Lymph %	21.4	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]

DATE: 6/21/03

LAB ID NO.:

b6-2

[redacted] b6-4 CC#2 22 Aug [redacted] b6-2 0100

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	6.2	4.8-10.8 x 10^3
RBC	2.85	4.7-6.1 x 10^6
Hgb	8.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.1	42-52% (M) 37-47% (F)
MCV	95.0	80-94 fl (M) 81-99 fl (F)
Plt	274	130-500 x 10^3 verified
Lymph %	21.7	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

[redacted] b6-2

'ard/Section: ICU #2

REQUESTING PHYSICIAN: [redacted] b6-2

C. MISTRY RESULT FOR
(Subject to the Privacy Act of 1974)

AST, FIRST, MI: # [redacted] b6-4

DATE: 22 Jun 03 TIME: 0100

SSN/PSEUDO SSN:

(I-STAT)

TEST	RESULT	REF. RANGE
a		138-146 mmol/L
.		3.5-4.9 mmol/L
l		98-109 mmol/L
H		7.31-7.45
CO2		35-45 mmHg (art) 41-51 mmHg (ven)
O2		80-105 mmHg (art) N/A (ven)
CO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
CO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
)2		95-98%
Eecf		(-2) – (+3) mmol/L
nGap		10-20 mmol/L
a		1.12-1.32 mmol/L
UN		8-26 mg/dl
LU		70-105 mg/dl
reat		0.7-1.5 mg/dl
ct		38-51% PCV
gb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
roponin-I		Negative
)rug of buse		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	94	73-118 mg/dl
BUN	16	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK	2946	39-380 u/l (M) 30-190 u/l (F)
NA^+	121	128-145 mmol/l
K^+	3.8	3.3-4.7 mmol/l
CL^-	103	98-108 mmol/l
tCO_2	26	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANC
ALB	1.9	3.3-5.5 g/dl
ALP	58	26-84 u/l
ALT	70	10-47 u/l
AMY	40	14-97 u/l
AST	108	11-38 u/l
TBIL	4.4	0.2-1.6 mg/dl
GGT	39	5-65 u/l
TP	5.4	6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 22 Jun 03

LAB ID NO.:

/ard/Section: ICU #2

RE[redacted]TING PHYSICIAN: [redacted] b6-2

C[illegible]ISTRY RESULT FOR
(Subject to the Privacy Act of 1974)

AST, FIRST M[illegible]: #[redacted] b6-4

DATE: 23 Jun 03 TIME: 0400

SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
la		138-146 mmol/L
.		3.5-4.9 mmol/L
l		98-109 mmol/L
H		7.31-7.45
CO2		35-45 mmHg (art) 41-51 mmHg (ven)
O2		80-105 mmHg (art) N/A (ven)
CO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
ICO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
O2		95-98%
Eecf		(-2) – (+3) mmol/L
nGap		10-20 mmol/L
a		1.12-1.32 mmol/L
UN		8-26 mg/dl
LU		70-105 mg/dl
reat		0.7-1.5 mg/dl
ct		38-51% PCV
lgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
roponin-I		Negative
rug of buse		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	92	73-118 mg/dl
BUN	17	7-22 mg/dl
CRE	0.3	0.6-1.2 mg/dl
CK	1716	39-380 u/l (M) 30-190 u/l (F)
NA^+	125	128-145 mmol/l
K^+	3.6	3.3-4.7 mmol/l
CL^-	105	98-108 mmol/l
tCO_2	24	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANG
ALB	2.0	3.3-5.5 g/dl
ALP	65	26-84 u/l
ALT	75	10-47 u/l
AMY	43	14-97 u/l
AST	91	11-38 u/l
TBIL	4.9	0.2-1.6 mg/dl
GGT	55	5-65 u/l
TP	5.2	6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 23 Jun 03

LAB ID NO.:

ICU#2 [redacted] b6-2

#[redacted] b6-4 23 June 03 0400

(Hematology) CBC

TEST	RESULT	REF RANGE
WBC	10.3	4.8-10.8 x 10³
RBC	2.83	4.2-6.1 x 10⁶
Hgb	8.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.2	42-52% (M) 37-47% (F)
MCV	96.0	80-94 fl (M) 82-99 fl (F)
Plt	331	130-500 x 10³ verified
Lymph %	18.7	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Immu	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF RANGE
PT		9.8-13.6 secs
APTT		21-31 secs
Dimer		20 ng/ml
FDP		10 ng/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

[redacted] b6-2

ICU#2 [redacted] b6-2

[redacted] b6-4 24 June 03 0100

(Hematology) CBC

TEST	RESULT	REF RANGE
WBC	11.7	4.8-10.8 x 10³
RBC	2.96	4.2-6.1 x 10⁶
Hgb	9.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.1	42-52% (M) 37-47% (F)
MCV	95.0	80-94 fl (M) 81-99 fl (F)
Plt	392	150-500 x 10³ verified
Lymph %	17.8	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF RANGE
PT		9.8-13.6 secs
APTT		21-31 secs
Dimer		20 ng/ml
FDP		10 ng/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

[redacted] b6-2

Ward/Section: ICU #2

REQUESTING PHYSICIAN: [redacted] b6-2

CHEMISTRY RESULT FOR (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: # [redacted] b6-4

DATE: 24 June 03

TIME: 0100

SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
pCO2		35-45 mmHg (art) 41-51 mmHg (ven)
pO2		80-105 mmHg (art) N/A (ven)
HCO2		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. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+	137	128-145 mmol/l
K^+	3.3	3.3-4.7 mmol/l
CL^-	103	98-108 mmol/l
tCO_2	27	18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b6-2

DATE:

LAB ID NO.:

MEDCOM - 11320

b6-2

/ard/Section: ICU 2 | RE STING [redacted] | CHEMISTRY RESULT FOR (Subject to the Privacy Act of 1974)

AST. FIRST. MI. C J [redacted] b6-4 | DATE 24 June 03 | TIME 0530 | SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
pCO2		35-45 mmHg (art) 41-51 mmHg (ven)
pO2		80-105 mmHg (art) N/A (ven)
HCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
TEecf		(-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	92	73-118 mg/dl
BUN	14	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK	1392	39-380 u/l (M) 30-190 u/l (F)
NA^+	139	128-145 mmol/l
K^+	3.8	3.3-4.7 mmol/l
CL^-	102	98-108 mmol/l
tCO_2	23	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB	2.2	3.3-5.5 g/dl
ALP	96	26-84 u/l
ALT	91	10-47 u/l
AMY	43	14-97 u/l
AST	107	11-38 u/l
TBIL	5.9 *	0.2-1.6 mg/dl
GGT	120	5-65 u/l
TP	5.4	6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS:

[redacted] b6-2

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

ICU#2 [redacted] b6-2

#[redacted] b6-4 25 Jun 03 0400

(Hematology) CBC

TEST	RESULT	REF RANGE
WBC	19.5	1.8-10.8 x 10³
RBC	2.95	4.7-6.1 x 10⁶
Hgb	8.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.4	42-52% (M) 37-47% (F)
MCV	96.3	80-94 fl (M) 81-99 fl (F)
Plt	433	140-500 x 10³ verified
Lymph %	15.7	20-55 SEG %

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF RANGE
PT		9.8-13.6 secs
APTT		21-31 secs
D dimer		20 ng/ml
FDP		10 ng/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

b6-2

Ward/Section:	RE[redacted]STING PHYSICIAN: b6-2	C[redacted]M'STRY RESULT FORM (Subj[redacted] to the Privacy Act of 1974)
LAST, FIRST, MI: #[redacted] b6-4	DATE: 25 Dec 03 / TIME: 0400	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-[illegible]5 mg/dl
Hct		38-5[illegible]% PCV
Hgb		12-1[illegible] 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. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL	4.0	0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+	140	128-145 mmol/l
K^+	3.5	3.3-4.7 mmol/l
CL^-	104	98-108 mmol/l
tCO_2	23	18-33 mmol/l

REMARKS:

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

b6-2

b6-2

Ward Section: ICU 2

LAST FIRST MI: # [redacted] b6-4

REQUES[redacted]

DATE: 25 Jun 03 TIME: 2000

CHEMISTRY R[illegible]T FORM
(Subject to the Privacy Act of 1974)

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
iCa		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
Urpoum-1		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		8.0-10.3 mg/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) Mellyte 8

TEST	RESULT	REF. RANGE
GLU	103	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK	580	39-380 u/l (M) 30-190 u/l (F)
NA	N.A	128-145 mmol/l
K	4.0	3.3-4.7 mmol/l
CL	99	98-108 mmol/l
tCO_2	27	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 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
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted]

DATE:

LAB ID NO.:

b6-2

#[redacted] b6-4 -- 5 JUN 03 2000 Dr. [redacted] b6-2

-- ECH 2

(Hematology) CBC

TEST	RESULT	REF RANGE
WBC	14.1	4.8-10.8 x 10³
RBC	3.29	4.7-6.1 x 10⁶
Hgb	9.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	31.7	42-52% (M) 37-47% (F)
MCV	96.1	80-94 fl (M) 81-99 fl (F)
Plt	527	140-500 x 10³ verified
Lymph %	10	20-54.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Coagulation Studies

TEST	RESULT	REF RANGE
PT		9.8-13.6 secs
APTT		21-31 secs
D-dimer		20 ug/ml
FDP		10 ug/ml

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch

(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

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

b6-2

26 June 07 Last Copy b6-2

Lab Section: ICU #2

LAST, FIRST, MI [redacted] b6-4

[redacted]

ABO

Sex

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the Privacy Act of 1974

SSN/PSEUDO SSN

0400

CBC/ACHO			Urinalysis			Misc Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	18.8	4.8-10.8 x 10	Color		N/A	RPR		Negative
RBC	3.49	[illegible]	App		[illegible]	Mono		Negative
Hgb	10.4	[illegible]	Gluc		Negative	**Microbiology**		
Hct	33.6	[illegible]	Bili		Negative	Source		
MCV	96.3	[illegible]	Prot		Negative	Gram Stain		
Plt	432	150-500 x [illegible] Verified	SG		N/A	Occ Bld		Negative
Lymph %	13.5	20.5-51.1%	Bld		Negative	H. pylori		Negative
Manual Differential			pH		[illegible]	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	[illegible]		[illegible]	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	[illegible]		Negative	**Hematologic Urinalysis**		
RBC Morph			[illegible]		[illegible]			

Spun Hematocrit		[illegible]	**CSF**		**Blood Bank**
Sed Rate			Cell		MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED
Other			Directigen	Negative	ABO/Rh

Coag Studies			**Blood Bank Transfusion**			
			[illegible] SCHEDULE [illegible] UNIT OF BLOOD (REQUESTED)			
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH	
PT		9.8-13.6 secs				
APTT		21-34 sec				
D dimer		<226 ng/ml				
FDP		<10 ug/ml				

REMARKS:

REPORTED BY: DATE: TEAR DOWN:

b6-4 b6-2

~~TCU#2~~ : ~~H~~[redacted] 2le flume 03 0400 [redacted]

REQUESTING

CLAN:

CHEMISTRY [illegible] FORM

(Subject to the Privacy Act of 1974)

SSN/PSEUDO SSN

DATE

TIME

(i-STAT)

TEST	RESULT	REF RANGE
Na		135-145 mmol/L
K		3.5-5.1 mmol/L
Cl		95-108 mmol/L
pH		[illegible]
pCO2		35-45 mmHg (7.35-7.45) 41-51 mmHg (7.35-7.45) 30-40 mmHg (7.35-7.45) [illegible]
pO2		[illegible] mmHg (arterial) [illegible] mmHg (venous)
TCO2		[illegible] mmol/L (arterial) [illegible] mmol/L (venous)
HCO3		[illegible] mmol/L (arterial) [illegible] mmol/L (venous)
sO2		[illegible] %
BE		[illegible] mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		[illegible] mg/dl
Gluc		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		[illegible] g/dl

Misc. Chemistry

	RESULT	REF RANGE
Troponin I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF RANGE
ALB		3.8-5.5 g/dl
ALP		26-85 U/L
ALT		10-47 U/L
AMY		11-97 U/L
AST		11-38 U/L
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA		8.0-10.5 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		70-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF RANGE
GLU	103	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK	917	59-380 U/L (M) 30-190 U/L (F)
NA	129	128-145 mmol/L
K	4.3	3.3-5.1 mmol/L
CL	101	98-108 mmol/L
HCO3	25	18-33 mmol/L

(Piccolo) Metabolic Panel

TEST	RESULT	REF RANGE
GLU		70-115 mg/dl
BUN		7-22 mg/dl
CA		8.0-10.5 mg/dl
CRE		0.6-1.2 mg/dl
NA		128-145 mmol/L
K		3.3-5.1 mmol/L
CL		98-108 mmol/L
HCO3		18-33 mmol/L

(Piccolo) Liver Panel Plus

TEST	RESULT	REF RANGE
ALB	2.0	3.8-5.5 g/dl
ALP	110	26-85 U/L
ALT	120	10-47 U/L
AMY	55	11-97 U/L
AST	123	11-38 U/L
TBIL	4.1	0.2-1.6 mg/dl
GGT	93	5-65 U/L
TP	55	6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF RANGE
NA		128-145 mmol/L
K		3.3-5.1 mmol/L
CL		98-108 mmol/L
HCO3		18-33 mmol/L

REMARKS:

ORDERED BY: [redacted]

DATE:

LAB ID NO.:

b6-2

Last Copy

27 June 03
0480

Ward/Section: ICU#2

LAST, FIRST, MI

RY RESULT FORM
[illegible] to the Privacy Act of 1974
[redacted] PSEUDO SSN: b6-2

CBC			Urinalysis			Micro/Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	20.1	4.8-10.8 x 10³	Color		N/A	RPR		Negative
RBC	3.05	[illegible]	pH		N/A	Mono		Negative
Hgb	9.1	[illegible]	[illegible]		Negative	**Microbiology**		
Hct	29.9	[illegible]	Blood		Negative	Source		
MCV	98.3	80-[illegible]	[illegible]		Negative	Gram Stain		
Plt	485	130-[illegible] verified	SG		N/A	Occ Bld		Negative
Lymph %	10.6	20.5-51.1%	Bld		Negative	H. pylori		[illegible]
Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	[illegible]		[illegible]	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	[illegible]		Negative	**Microscopic Urinalysis**		
RBC Morph			[illegible]		[illegible]			

			CSF			Blood Bank	
Spun Hematocrit		[illegible]	[illegible]			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Sed Rate			[illegible]				
Other			Directigen		Negative	ABO/Rh	

Coagulation Studies			**Blood Bank/Unit Crossmatch** (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)			
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH	
PT		9.8-13.0 secs				
APTT		21-[illegible]				
D dimer		<20 [illegible]				
FDP		<10 [illegible]				

REMARKS:

REPORTED BY: DATE: LAB ID NO:

[redacted]

27 Jun 03

b6-2

#[redacted] b6-4 2nd Times

ICU #2 0430 [redacted] b6-2

(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
iCa		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	105	73-118 mg/dl
BUN	14	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	2497	39-380 u/l (M) 30-190 u/l (F)
NA^+	138	128-145 mmol/l
K^+	4.2	3.3-4.7 mmol/l
CL^-	103	98-108 mmol/l
tCO_2	25	18-33 mmol/l

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

(Piccolo) Liver Panel Plus		
TEST	RESULT	REF. RAN
ALB	1.7	3.3-5.5 g/dl
ALP	89	26-84 u/l
ALT	85	10-47 u/l
AMY	38	14-97 u/l
AST	114	11-38 u/l
TBIL	4.9	0.2-1.6 mg/dl
GGT	69	5-65 u/l
TP	5.3	6.4-8.1 g/dl

(Piccolo) Electrolyte		
TEST	RESULT	REF. RAN
NA^+		128-145 mmo
K^+		3.3-4.7 mmol/
CL^-		98-108 mmol/
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	23 JAN 03	

b6-2

Ward/Section: ICU #2

LAST, FIRST, MI: EPW # [redacted] b6-4

STING PHYSICIAN: Dr. [redacted] b6-2

DATE: 28 June 03 TIME: 0400

LABORATORY RESULT FORM

...ect to the Privacy Act of ...

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	30.6	4.8-10.8 x 10^3
RBC	2.98	4.7-6.1 x 10^9
Hgb	9.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	29.2	42-52% (M) 37-47% (F)
MCV	97.9	80-94 fl (M) 81-99 fl (F)
Plt	529	130-500 x 10^3 verified
Lymph %	8.7	20.5-51.1%

(Hematology) Manual Differential

Segs	81	Mono	7
Bands	2	Eos	
Lymph	9	Baso	
Atyp		Imm	1
RBC Morph	Sphere		
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 28 Jun 03

LAB ID NO.:

ICU #2 r 1 ~ June 03 @ 0400

EPW # [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
iCa		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	107	73-118 mg/dl
BUN	16	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	1376	39-380 u/l (M) 30-190 u/l (F)
NA^+	132	128-145 mmol/l
K^+	4.2	3.3-4.7 mmol/l
CL^-	95	98-108 mmol/l
tCO_2	31	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RAN
ALB	1.8	3.3-5.5 g/dl
ALP	99	26-84 u/l
ALT	148	10-47 u/l
AMY	44	14-97 u/l
AST	218	11-38 u/l
TBIL	7.1	0.2-1.6 mg/dl
GGT	72	5-65 u/l
TP	6.0	6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS:

Chem 8, liver panel

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	28 Dec 03	

b6-2

b6-2

ection: ICU #2 | REQUES[redacted] PHYSICIAN: | LABO[redacted]TORY RESULT FORM (Subject to the Privacy A[redacted]

FIRST, MI. #[redacted] b6-4 | DATE 29 Mar 03 | TIME | SSN/PSEUDO SSN

(Hematology) CBC			Urinalysis			Misc. Serology		
T	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF
WBC	24.7	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	2.35	4.7-6.1 x 10^9	App		N/A	Mono		Negative
HGB	7.1	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
HCT	23.1	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	98.1	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
PLT	611	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
[illegible]%	9.3	20.5-51.1%	Bld		Negative	H. pylori		Negative
[illegible]matology) Manual Differential			pH		N/A	Micro Parasites		
Seg	83	Mono 3	Prot		Negative	Malaria		
Band	4	Eos 3	Urob		0.2-1.0	O & P		
Lymph	7	Baso	Nit		Negative	Other		
		Imm	Leuk		Negative	**Microscopic Urinalysis**		
			HCG		Negative			
[illegible]crit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
[illegible]e			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
platelets increased			Directigen		Negative	ABO/Rh		

Coagulation Studies			**Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)**		
	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
		9.8-13.6 secs			
		21-34 secs			
[illegible]r		<20 ug/ml			
		<10 ug/ml			

[illegible]RKS:

[illegible]RTED BY: [redacted] DATE: 29 Mar 03 LAB ID NO.:

b6-2

ICU#2 [redacted] b6-2

[redacted]

b6-4 [redacted] 29 Jan 03

(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%
BFecf		(-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	98	73-118 mg/dl
BUN	5	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK	430	39-380 u/l (M) 30-190 u/l (F)
NA^+	125	128-145 mmol/l
K^+	4.2	3.3-4.7 mmol/l
CL^-	97	98-108 mmol/l
HCO_2	30	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RAN
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/d
CRE		0.6-1.2 mg/dl
NA^+		128-145 mme
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol
HCO_3		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RAN
ALB	1.8	3.3-5.5 g/dl
ALP	97	26-84 u/l
ALT	167	10-47 u/l
AMY	39	14-97 u/l
AST	174	11-38 u/l
TBIL	5.2	0.2-1.6 mg/dl
GGT	59	5-65 u/l
TP	5.9	6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RAN
NA		128-145 mmo
K		3.3-4.7 mmol
CL		98-108 mmol
HCO_3		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	29Jan03	

b6-2

Ward/Section: T CU #2

[redacted]TING PHYSICIAN: [redacted] b6-2

L[redacted]ATORY RESULT FORM
(C[redacted]ect o the Privacy Act of 1[redacted]

LAST/FIRST MI: #[redacted] b6-4

DATE: 30 June 03 TIME: 0408

SSN/PSEUDO SSN

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	15.9	4.8-10.8 x 10^3
RBC	2.42	4.7-6.1 x 10^9
Hgb	7.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	23.2	42-52% (M) 37-47% (F)
MCV	96.1	80-94 fl (M) 81-99 fl (F)
Plt	607	130-500 x 10^3 verified
Lymph %	14.0	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] **DATE:** 30 Jun 03 **LAB ID NO.:**

b6-2

~~ICU~~ [redacted] b6-2

~~#~~ [redacted] b6-4 30 June 03 0400

(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	96	73-118 mg/dl
BUN	18	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
CK	268	39-380 u/l (M) 30-190 u/l (F)
NA+	136	128-145 mmol/l
K+	4.5	3.3-4.7 mmol/l
CL-	97	98-108 mmol/l
tCO_2	24	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RAN
ALB	1.8	3.3-5.5 g/dl
ALP	114	26-84 u/l
ALT	152	10-47 u/l
AMY	31	14-97 u/l
AST	153	11-38 u/l
TBIL	3.7	0.2-1.6 mg/dl
GGT	71	5-65 u/l
TP	6.0	6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 30 Jun 03

LAB ID NO.:

Ward/Section: ICU

REQUE[redacted]G PHYSICIAN: b6-2

LAB[redacted]TORY RESULT FORM (Sub[redacted] to the Privacy Ac[redacted])

LAST, FIRST, MI. [redacted] b6-4

DATE 1-Jul-03 | TIME 14/15 | SSN/PSEUDO SSN: [redacted] b6-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	18.4	4.8-10.8 x 10^3
RBC	3.38	4.7-6.1 x 10^9
Hgb	9.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	31.7	42-52% (M) 37-47% (F)
MCV	94.0	80-94 fl (M) 81-99 fl (F)
Plt	723	130-500 x 10^3 verified
Lymph %	13.9	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] **DATE:** 15Jul 03 **LAB ID NO.:**

b6-2

Ward/Section:	REQUE[redacted]	PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act)
LAST, FIRST: [redacted]	[redacted]	DATE:	TIME: 0400

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	14.8	4.8-10.8 x 10^3
RBC	2.32	4.7-6.1 x 10^9
Hgb	6.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	22.3	42-52% (M) 37-47% (F)
MCV	95.9	80-94 fl (M) 81-99 fl (F)
Plt	735.	130-500 x 10^3 verified
Lymph %	25.5	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF.
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

ICU #2 [redacted] b6-2

[redacted] b6-4 1 July 0400

(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
iCa		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	95	73-118 mg/dl
BUN	13	7-22 mg/dl
CRE	0.6	0.6-1.2 mg/dl
CK	164	39-380 u/l (M) 30-190 u/l (F)
NA^+	127	128-145 mmol/l
K^+	4.8	3.3-4.7 mmol/l
CL^-	95	98-108 mmol/l
tCO_2	26	18-33 mmol/l

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

(Piccolo) Liver Panel Plus		
TEST	RESULT	REF. RAN
ALB	1.8	3.3-5.5 g/dl
ALP	140	26-84 u/l
ALT	131	10-47 u/l
AMY	39	14-97 u/l
AST	136	11-38 u/l
TBIL	2.9	0.2-1.6 mg/dl
GGT	90	5-65 u/l
TP	6.4	6.4-8.1 g/dl

(Piccolo) Electrolyte		
TEST	RESULT	REF. RAN
NA^+		128-145 mmo
K^+		3.3-4.7 mmol/
CL^-		98-108 mmol/
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	1 July 03	

b6-2

Ward/Section: ICU #2	REC	PHYSICIAN: Dr. [redacted] b6-2	LAB ATORY RESULT FORM (Subject to the Privacy Act)
LAST, FIRST, MI: # [redacted] b6-4		DATE: 02 July 03	TIME: 0400	SSN/PSEUDO SSN

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	14.2	4.8-10.8 x 10^3
RBC	3.41	4.7-6.1 x 10^9
Hgb	10.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	32.1 ~~30.2~~	42-52% (M) 37-47% (F)
MCV	94.0 ~~32.7~~	80-94 fl (M) 81-99 fl (F)
Plt	166	130-500 x 10^3 verified
Lymph %	14.8	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF.
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	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b6-2 | DATE: 02 Jul | LAB ID NO.:

#[redacted] b6-4 02 July 03 @ 0400 ICU#2

Dr. [redacted] b6-2

(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
iCa		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	102	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
CK	127	39-380 u/l (M) 30-190 u/l (F)
NA+	123	128-145 mmol/l
K+	5.7	3.3-4.7 mmol/l
CL-	94	98-108 mmol/l
HCO_2	25	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RAN
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA		8.0-10.3 mg/d
CRE		0.6-1.2 mg/dl
NA		128-145 mmo
K		3.3-4.7 mmol/l
CL		98-108 mmol
HCO_3		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RAN
ALB	2.2	3.3-5.5 g/dl
ALP	185	26-84 u/l
ALT	161	10-47 u/l
AMY	40	14-97 u/l
AST	158	11-38 u/l
TBIL	3.3	0.2-1.6 mg/dl
GGT	121	5-65 u/l
TP	7.2	6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RAN
NA		128-145 mmo
K		3.3-4.7 mmol
CL		98-108 mmol
HCO_3		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b6-2

DATE:

LAB ID NO.:

ICU #2 [redacted] b6-2

[redacted] b6-4 3 July 03 0400

(i-STAT)

TEST	RESULT	REF RANGE
Na		[illegible] mmol/l
K		[illegible] mmol/l
Cl		[illegible] mmol/l
iCa		[illegible] mmol/l
TCO2		[illegible] mmol/l
iCO2		[illegible] mmol/l
HCO3		[illegible] mmol/l
CO2		[illegible] mmol/l
Hct		[illegible]
AnGap		[illegible] mmol/l
pH		[illegible] mmol/l
BUN		8-26 mg/dl
pCO2		[illegible] mmHg
pO2		[illegible] mmHg
Glucose		[illegible] mg/dl
Hct		[illegible]
Hgb		[illegible] 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		[illegible] g/dl
ALP		[illegible] u/l
ALT		[illegible] u/l
AMY		[illegible] u/l
AST		[illegible] u/l
TBIL		[illegible] mg/dl
BUN		[illegible] mg/dl
CA		8.0-10.2 mg/dl
CHOL		[illegible] mg/dl
CRE		0.6-1.2 mg/dl
GLU		[illegible] mg/dl
TP		[illegible] g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF RANGE
GLU	113	[illegible] mg/dl
BUN	12	[illegible] mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	92	30-350 u/l (M) 30-190 u/l (F)
NA	132	128-145 mmol/l
K	4.6	[illegible] mmol/l
CL	95	98-108 mmol/l
tCO2	26	[illegible] mmol/l

(Piccolo) Metabolic

TEST	RESULT	REF
GLU		
BUN		
CA		
CRE		
NA		
K		
CL		
tCO2		

(Piccolo) Liver Panel

TEST	RESULT	REF
ALB	2.2	
ALP	295	
ALT	210	
AMY	37	
AST	224	
TBIL	2.7	
GGT		
TP	7.1	

(Piccolo) Electrolytes

TEST	RESULT	REF
NA		
K		
CL		
tCO2		

REMARKS:

REPORTED [redacted]

DATE: 03 JUL 03

LAB ID NO.:

b6-2

Last Copy

tion: ICU#2

RST, MI [redacted] b6-4 [redacted] b6-2

LABOR... RESULT FORM
Subject to the Privacy Act of 1974

DATE: 3 Jul 03 0400

SSN/PSEUDO SSN:

CBC

	RESULT	REF. RANGE
WBC	11.5	4.8-10.8 x 10³
RBC	3.42	4.7-6.1 x 10⁶
Hgb	10.0	14-18 g/dl (M) 12-16 g/dl (F)
HCT	32.1	42-52% (M) 37-47% (F)
MCV	93.9	80-94 fl (M) 81-99 fl (F)
PLT	769	130-400 x 10³ verified
Lymph	20.4	20.5-51.1%

Manual Differential

	Mono
	Eos
	Baso
	Imm

rit		42-52% (M) 37-47% (F)

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Uro		1-2 E.U.
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

Cell			
Count			
Directigen		Negative	

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation

RESULT	REF. RANGE
	9.8-13.6 secs
	21-34 secs
	<20 ug/ml
	<10 ug/ml

Blood Bank Unit Crossmatch
MUST SUBMIT SF 518 WITH EACH UNIT OF BLOOD REQUESTED

UNIT	TYPE	CROSSMATCH

RKS:

TED BY: [redacted] DATE: 03 Jul 03 LAB ID NO.:

b6-2

MEDCOM - 11342

[redacted] b6-4/6 Dr. [redacted] b6-2 4 JUL 03 0430

ICU 2

(i-STAT)

TEST	RESULT	REF RANGE
Na		135-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-107 mmol/L
pH		7.35-7.45
pCO2		35-45 mmHg (arterial) 41-51 mmHg (venous)
pO2		80-105 mmHg (arterial) 35-45 (venous)
HCO2		23-27 mmol/L (arterial) 24-28 mmol/L (venous)
HCO3		22-26 mmol/L (arterial) 23-28 mmol/L (venous)
TCO2		23-28 mmol/L (arterial) 24-29 mmol/L (venous)
BE(ecf)		-2.0 (-3.0) mmol/L
BE(ecf)		1.0-2.0 mmol/L
sO2		95-97%
Hct		0.39-0.41
Glucose		4.1-5.9 mmol/L
BUN		3.5-8.2 mmol/L
Crea		44-132 mmol/L
Ca++		1.12-1.32 mmol/L
Lac		0.5-2.0 mmol/L
Hct		35-45% PCV
Hgb		12-15 g/dl

Misc. Chemistry

TEST	RESULT	REF RANGE
Ketones		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF RANGE
ALB	2.2	3.5-5.5 g/dl
ALP	234	26-84 U/L
ALT	175	10-47 U/L
AMY	39	11-85 U/L
AST	140	11-38 U/L
TBIL	1.9	0.2-1.6 mg/dl
BUN	17	7-22 mg/dl
CA	9.0	8.0-10.3 mg/dl
CHOL	180	100-200 mg/dl
CRE	1.1	0.6-1.2 mg/dl
GLU	118	70-115 mg/dl
TP	7.4	6.4-8.1 g/dl

(Piccolo) Metabolic

TEST	RESULT	REF
GLU		
BUN		
CA		
CRE		
NA		
K		
CL		
TCO		

(Piccolo) Liver Panel

TEST	RESULT	REF
ALB	~~2.2~~	
ALP	~~234~~	
ALT		
AMY		
AST		
TBIL		
GGT		
TP		

(Piccolo) Mellyte 8

TEST	RESULT	REF RANGE
GLU	108	70-115 mg/dl
BUN	16	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	75	30-380 u/L (M) 30-190 u/L (F)
NA	130	128-145 mmol/L
K	4.5	3.3-5.0 mmol/L
CL	97	98-106 mmol/L
HCO_3	25	19-33 mmol/L

(Piccolo) Electroly

TEST	RESULT	REF
NA		
K		
CL		
TCO		

REMARKS:

REPORTED BY: [redacted]

DATE: 4 Jul 03

LAB ID NO.:

b6-2

Ward/Section: ICU 2	REQ[illegible] Dr [redacted] 66-2	LA[illegible]RATORY RESULT FORM (Subject to the Privacy Act)
LAST, FIRST, M[illegible] # [redacted] 66-4	DATE 4 Mar 03 / TIME 0430	SSN/PSEUDO SSN

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	10.3	4.8-10.8 x 10^3
RBC	3.56	4.7-6.1 x 10^9
Hgb	10.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	33.6	42-52% (M) 37-47% (F)
MCV	94.3	80-94 fl (M) 81-99 fl (F)
Plt	796	130-500 x 10^3 verified
Lymph %	19.2	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

[redacted] b6-2

#[redacted] b6-4 2 July 03 0400

(i-STAT)

TEST	RESULT	REF RANGE
Na		135-146 mmol/l
K		3.5-4.6 mmol/l
Cl		96-108 mmol/l
pH		7.35-7.45
pCO2		35-45 mmHg (art) 41-51 mmHg (ven)
pO2		80-105 mmHg (art) 35-48 mmHg (ven)
HCO2		23-27 mmol/l (art) 24-30 mmol/l (ven)
HCO3		22-26 mmol/l (art) 23-28 mmol/l (ven)
sO2		95-98%
BEecf		-2.0 to +3.0 mmol/l
AnGap		10-20 mmol/l
iCa		1.12-1.32 mmol/l
BUN		8-26 mg/dl
Glu		70-105 mg/dl
Crea		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12.9-17.3 g/dl

Misc. Chemistry

TEST	RESULT	REF RANGE
Bilirubin-U		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF RANGE
ALB	2.2	3.5-5.5 g/dl
ALP	211	26-84 u/l
ALT	149	10-47 u/l
AMY	37	14-85 u/l
AST	116	11-38 u/l
TBil	2.0	0.2-1.6 mg/dl
BUN	15	7-22 mg/dl
CA	8.8	8.0-10.3 mg/dl
CHOL	196	100-300 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	107	73-118 mg/dl
TP	7.1	6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF RANGE
GLU	103	73-118 mg/dl
BUN	15	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
CK	69	30-380 u/l (M) 30-190 u/l (F)
NA	132	128-135 mmol/l
K	4.1	3.3-4.7 mmol/l
CL	97	98-108 mmol/l
HCO_3	31	18-33 mmol/l

(Piccolo) Metabolic

TEST	RESULT	REF
GLU		
BUN		
CA		
CRE		
NA		
K		
CL		
HCO_3		

(Piccolo) Liver Panel

TEST	RESULT	REF
ALB		
ALP		
ALT		
AMY		
AST		
TBil		
GGT		
TP		

(Piccolo) Electrolytes

TEST	RESULT	REF
NA		
K		
CL		
HCO_3		

REMARKS:

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

b6-2 03 Jul 03

.2

[redacted] 66-4 [redacted]

PHYSICIAN: 66-2

LAB ATC ESULT FORM
(Subject to t
Privacy Act

DATE 5 July 03 | TIME 0408 | SSN/PSEUDO SSN

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	10.1	4.8-10.8 x 10^3
RBC	3.45	4.7-6.1 x 10^9
Hgb	10.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	32.5	42-52% (M) 37-47% (F)
MCV	94.2	80-94 fl (M) 81-99 fl (F)
Plt	827	130-500 x 10^3 verified
Lymph %	21.2	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] **DATE:** 5 July **LAB ID NO.:**

66-2

DCM 2 [redacted] b6-2

[redacted] b6-4 0400 6 Aug 03

(i-STAT)

TEST	RESULT	REF RANGE
Na	133	138-146 mmol/L
K	4.1	3.5-5.0 mmol/L
Cl	99	98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (arty) 41-51 mmHg (ven)
PO2		80-100 mmHg (arty) 35-48 mmHg (ven)
TCO2	31	23-27 mmol/L (arty) 24-29 mmol/L (ven) 22-26 mmol/L (arty) 23-28 mmol/L (ven)
HCO3		
sO2		95-98%
BEecf		-2.0 to +3.0 mmol/L
Anion gap		10-20 mmol/L
iCa		1.12-1.32 mmol/L
BUN	15	8-26 mg/dl
GLU	97	70-105 mg/dl
Crea		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12.9-17.3 g/dl

Misc. Chemistry

TEST	RESULT	REF RANGE
Dipstick		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF RANGE
ALB	2.4	3.5-5.5 g/dl
ALP	383	26-84 u/l
ALT	596	10-47 u/l
AMY	29	14-97 u/l
AST	810	11-38 u/l
TBR	2.8	0.2-1.6 mg/dl
BUN	14	7-22 mg/dl
CA	9.3	8.0-10.5 mg/dl
CHOL	155	100-200 mg/dl
CRE	1.1	0.6-1.2 mg/dl
GLU	102	73-118 mg/dl
TP	7.1	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
TCO2		18-33 mmol/L

(Piccolo) Metabolic Panel

TEST	RESULT	REF RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA		8.0-10.5 mg/dl
CRE		0.6-1.2 mg/dl
NA		128-145 mmol/L
K		3.3-4.7 mmol/L
CL		98-108 mmol/L
TCO2		18-33 mmol/L

(Piccolo) Liver Panel Plus

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
TBR		0.2-1.6 mg/dl
GGT		5-85 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF RANGE
NA		128-145 mmol/L
K		3.3-4.7 mmol/L
CL		98-108 mmol/L
TCO2		18-33 mmol/L

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 6 Aug 03

LAB ID NO.:

Ward/Section: ICU 2 | REQ[redacted] DIVISION: 66-2 | LA[redacted]TORY RESULT FORM (Subject to the Privacy Act)

LAST, F[redacted] #[redacted] 66-4 [redacted] | DATE 6 Aug 03 | TIME 0400 | SSN/PSEUDO SSN

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	8.0	4.8-10.8 x 10^3
RBC	3.24	4.7-6.1 x 10^9
Hgb	9.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	30.6	42-52% (M) 37-47% (F)
MCV	94.4	80-94 fl (M) 81-99 fl (F)
Plt	769	130-500 x 10^3 verified
Lymph %	27.0	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF.
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

Last Copy

ICU 2

[redacted] b6-2

RST, M [redacted] b6-4

7/26/03 0400

Hematology/CBC			Urinalysis			Misc. Serology		
RESULT			TEST	RESULT	REF RANGE	TEST	RESULT	REF
8.2								
3.29								
9.5						Microbiology		
31.0								
94.4								
695								
20.4								
Manual Differential								
	Mono							
	Eo							
	Baso							
						Microscopic Urinalysis		

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

Special Studies			Blood Bank Unit Transfusion		
			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
RESULT	REF RANGE	UNIT	TYPE	CROSSMATCH	

RKS:

TED BY: [redacted] b6-2

ICU 2 [redacted] b6-2

#[redacted] b6-4 7 July 03 0400

(i-STAT)

TEST	RESULT	REF RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		96-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmol/L (art) 41-51 mmol/L (ven)
PO2		80-105 mmol/L (art) 25-40 mmol/L (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-99%
BE(ecf)		(-2)-(+3) mmol/L
AnGap		10-20 mmol/L
iCa		1.12-1.32 mmol/L
BUN		5-26 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
Dogoman I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF RANGE
ALB	2.3	3.5-5.5 g/dl
ALP	344	20-64 u/l
ALT	523	10-42 u/l
AMY	32	11-92 u/l
AST	330	11-38 u/l
TBIL	1.8	0.2-1.6 mg/dl
BUN	13	7-22 mg/dl
CA	8.7	8.0-10.5 mg/dl
CHOL	136	100-200 mg/dl
CRE	0.9	0.6-1.2 mg/dl
GLU	112	73-118 mg/dl
TP	6.8	6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF RANGE
GLU	110	73-118 mg/dl
BUN	13	7-22 mg/dl
CRE		0.6-1.5 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA	133	128-145 mmol/L
K	4.2	3.5-4.7 mmol/L
CL	99	98-108 mmol/L
HCO_3		18-33 mmol/L

(Piccolo) Metabolic Panel

TEST	RESULT	REF RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA		8.0-10.5 mg/dl
CRE		0.6-1.2 mg/dl
NA		128-145 mmol/L
K		3.5-5.1 mmol/L
CL		98-108 mmol/L
HCO_3		18-33 mmol/L

(Piccolo) Liver Panel Plus

TEST	RESULT	REF RANGE
ALB		3.5-5.5 g/dl
ALP		20-64 u/l
ALT		10-42 u/l
AMY		11-92 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		7-55 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF RANGE
NA		128-145 mmol/L
K		3.5-5.1 mmol/L
CL		98-108 mmol/L
HCO_3		18-33 mmol/L

REMARKS:

REPORTED BY: [redacted]

DATE: 7 Jul 03

LAB ID NO.:

b6-2

Pinx1 TX@ISI
I.E NKMA

MEDICAL RECORD — ANESTHESIA

DRUGS	Units	07	08	09
Sufenta	(mcg)	10 10	10 10	
Propofol	(mg)	150		
Midazolam	(mg)	8	2 2 2 2 4	
Morphine	(mg)			
Anzer	(gm)	1	3/3	
	( )			
VOLAT AGENT FOR	% del	X1 — .8 — 1 — 1.5 — 1.5 — 1.5 — 2 — 1.5 — 1.5 — 1.2 — 1.2		
	% et.			
AIR	L/Min			
N2O	L/Min			
O2	L/Min	6 — 2 — 2 — 2 — 2 — 2 — 2 — 2 — 2 — 2		

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

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

FLUIDS		
LINE site R foot 18	☐ Warmed	(1000) — 200 — 350 — 400 — 450 — 700 — 800 — 900
OR	☐ Warmed	
L Subclav Triflum	☐ Warmed	
(Flush in NICU)	☐ Warmed	X 200 350 — 500 — 1000 — 1200 — 1500 —

LOSSES	
EST BLOOD LOSS	200
URINE –	750

TOTALS	
TOTAL FLUID	2150
TOTAL URINE	300

FLUIDS – SUMMARY
CRYSTALLOID – 7.0 CR
COLLOID – 0
BLOOD – 4

REMARKS – Code drugs with numbers, events with letters

Prep, pt # Δ to 311, New T&S ⅡⅠ & CB c sent as #311 @ 0300.
0700 OR, O2, mask still RSI & crowd L subcl Triflum for Dr [redacted] prep/drape
18Fr OGT R Nares placement confirmed by Surg
66-2

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 95 KG LB

HEMATOCRIT: 41.8

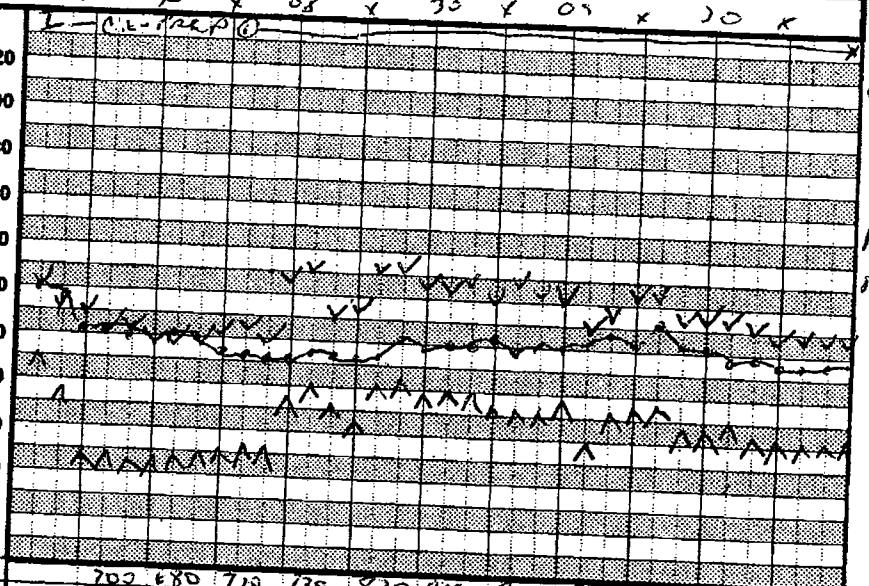
INITIAL DATA: BP – 120 / 94 HR – 120

EQUIP CHECK: OK? – Y N

PATIENT WRISTBAND: OK for PROCEDURE? Y/N TIME – 0700

TIME → 0715 30 08 30 09 30 10

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



	07	08	09	10
VT – ml	700	680	710	770
f – breaths/min	10	10	10	10
Peak inf pres / PEEP	28	24	26	25
MODE – S(pon), A(ssist), C(on)	S C	C	C	C
ET CO2 (torr)	40	40	38	39
FIO2 (Frac or %)	.7	.7	.7	.7
SpO2 (%)	100	100	100	100
ECG	ST	ST	SR	SR
TEMP – site R			37	37.4
N-M Block (T/4)	40	0	2	1

	11	12	13	14	15	16	17	18	19	20
VT – ml	820	820	710	870	880	770				
f – breaths/min	9	9	9	8	8	7	13			
Peak inf pres / PEEP	30	30	29	27	25	26				
MODE – S(pon), A(ssist), C(on)	C	C	C	C	C	C	S			
ET CO2 (torr)	37	36	35	34	36	39	48			
FIO2 (Frac or %)	.7	.7	.7	.7	.7	.7	.7			
SpO2 (%)	100	100	100	100	100	100	100			
ECG	SR	SR	SR	ST	ST	SR	SR			
TEMP – site R	37.8	37.7		36.1	35.9	36.0	36.2			
N-M Block (T/4)	3	3	2	4	2	1	+TOF			

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

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

RECOVERY AT: PACU ICU _____ (Specify) OTHER _____
CONDITION:
RESP – SpO2 –
BP – HR –

ANESTHETIC PROCEDURE TIMES

	Start	Room	End
ANES	0655	0705	1110
PROC	Ready	Begin	End
	0730	0744	1050

PROCEDURES and CPT Codes
D Ex ANAP repair of Soft Tissue Excisions, repair hernia in peritoneum
D I&D L Forearm Deep Complex Facility

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GA, pnox, RSI & crowd, Gd I nerve, ¼-trans, BS=3

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
+ETT 6.5, eyes taped, tube @ 24 cm, OGT, 6.5/3

PATIENT IDENTIFICATION – Typed or written entry: Name, Grade/Rate, Medical facility
[redacted] [redacted] ICW #2
66-4 66-4

[redacted] 66-2
ANESTHESIOLOGISTS: [redacted] 66-2
[redacted] L RECORD – ANESTHESIA 66-2

PROCEDURE LOCATION: OR 1
DATE: 18 JAN 03
PAGE 1 OF

CPT / ANAMNAOP 376 REVISED Jan 99
MEDCOM - 11351

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

i NASYN

MEDICAL RECORD — ANESTHESIA

DRUG	(Mg/Mcg)
SUF (50)	(mcg)
MSO4 (10)	(mg)
NIMBEX	(mg)
VOLAT AGENT FOR	% del
	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min 2 — 6

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

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶ xi 1/4 mg 3 - NIBBX

LINE site		
R leg IV	☐ Warmed	(900)
L SC	☐ Warmed	(1600)
	☐ Warmed	
	☐ Warmed	

LOSSES	
EST BLOOD LOSS	(200)
URINE –	(200)

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

BODY WEIGHT: 95 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP – / HR–

EQUIP CHECK: OK? – Y N

PATIENT READINESS: OK for PROCEDURE? TIME–

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

TIME → 1000 x 30 x 11

VT – ml		
f – breaths/min	12	12	15
Peak inf pres / PEEP		
MODE– S(pon), A(ssist), C(on)	S	S	S
BP/Auto Cuff	ET CO2 (torr)	51	52	54
BP / oth	FIO2 (Frac or %)	.7	.7	.7
ART line	SpO2 (%)	100	100	100
Steth- PC/ES	ECG	ST	ST	SR
Gas analyzer	TEMP- site	36	36.3	36.7
	N-M Block (T/4)	4/4 +TRT		4/4
Warming blkt				
Conv warmer				

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 2 1

TOTALS — TOTAL BP — TOTAL URINE

FLUIDS – SUMMARY: CRYSTALLOID– COLLOID– BLOOD–

REMARKS– Code drugs with numbers, events with letters

See pg 1
0945 (E) Ann Phys
Dr [redacted] in
1000 CPT [redacted] Brock b62
Splint on OR/OP
Sustain SV
extubated awake
to PACU NPA
in Place

RECOVERY AT 1105
PACU (ICU) #2 (Specify)
OTHER
CONDITION:
RESP– SpO2– 96%
BP– 157/73 HR– 120

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES			
PROC	Ready	Begin	End
			1000

PROCEDURES and CPT Codes: See pg 1

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

#[redacted]
b6-4

SURGEON: [redacted] b6-2
ANESTHETISTS: [redacted]

PROCEDURE LOCATION OR 1
DATE 15 JUN 03
PAGE 1 OF 1

[redacted] RECORD – ANESTHESIA

OPT / ANAMNAP 376 REVISED Jan 99

MEDCOM - 11352

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

MEDICAL RECORD — ANESTHESIA

DRUG	(Dose)
Fentanyl	(5)
Propofol	(150 50 50)
Succ	(100)
Lidocaine	(80)
	( )
	( )
HALAT AGENT: Forane	% del 2 – 2.5 – 2.0 2.0
	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min (3 – 3 – 3 – 3 – 2)

CONTINUOUS I.V. – SPECIFY UNITS – MG / ML "I" = CONSTANT INFUSION

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS ▶ 1135 – 30mg Toradol IV

LINE site		
LLE	☐ Warmed	(200) LRs 700
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE – 100 (50) 50

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

BODY WEIGHT: 95 KG LB

HEMATOCRIT:

INITIAL DATA: BP – 149, 84; HR – 104

TEMP CHECK: OK? – (Y) N

PATIENT WRISTBAND: OK for PROCEDURE? Yes; TIME – Now

TIME → 1000 × 30 × 1100 15 30 45 1200 15 30 45

SYMBOLS: BP by cuff (V); 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	400	500	400		350	400	410	
f – breaths/min	10	9	12	12	13	12	13	
Peak inf pres / PEEP	25							
MODE– S(pon), A(ssist), C(on)	S	C	A/S	S	S	S	S	S
BP/Auto Cuff / ET CO2 (torr)	48	50	60	57	57	55	55	55
BP / oth / FIO2 (Frac or %)	.63	.63	.63	.63	.63	.63	.62	.62
ART line / SpO2 (%)	100	100	99	99	99	98	99	99
Steth- PC/ES / ECG	ST	ST	ST	ST	ST	ST	ST	ST
Gas analyzer / TEMP- site								
N-M Block (T/4)								
Warming blkt								
Conv warmer								

TOTALS: TOTAL EST. BLOOD LOSS – min; TOTAL URINE – 50

FLUIDS – SUMMARY: CRYSTALLOID – 1000; COLLOID – ~~0~~; BLOOD – ~~0~~

REMARKS – Code drugs with numbers, events with letters

OR pre
uniforcal

pre-op
4mg ms in pre
ICU

RECOVERY AT: ICU #2
PACU ICU ____ (Specify)
OTHER ____
CONDITION: 94% FM
RESP – 24 SpO2 –
BP – 135/82 HR – 119

	Start	Room	End
ANES	0945	1008	1235
PROC	Ready	Begin	End
	1020	1040	1220

Mark with letters & symbols, explain under REMARKS — EVENTS; Position → Supine

PROCEDURES and CPT Codes: I & D

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility: EPW # [redacted] b6-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: eyes taped

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: SIVI, DVOS x1, atraumatic, cuff, BS = RS tape, tube

SURGEONS: b6-2 [redacted]

ANESTHETISTS: b6-2 [redacted] MAJ CRNA

PROCEDURE LOCATION: OR #2

DATE: 30 Jan 93

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED Jan 99

MEDCOM - 11353

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

Obesity

NKDA

MEDICAL RECORD — ANESTHESIA

DRUG	Dosage
Fentanyl	(MCG)
Lidocaine	(MG)
Diprivan	(MG)
Succs	(MG)
Cisatracurium	
Neostigmine/Glycopyrrolate	
Iso/½ del	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min

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

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

(MCG)	<200> <200> / MgSO4 <4> 1
(MG)	50
(MG)	<400> <100>
(MG)	100
	10
	4/0.6
	1.0 1.0 1.2 1.2 X
	10 2 2 2 2 10 X

TOTALS	
200/5	
50	
500	
100	
10	
4/0.6	

TOTAL BLD: MIW

TOTAL URINE: 300

FLUIDS – SUMMARY

CRYSTALLOID – 800

COLLOID – Ø

BLOOD – Ø

FLUIDS

LINE site: L SC triple ☐ Warmed — 1LR — 800

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES: EST BLOOD LOSS

URINE – 300

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 95 KG LB

HEMATOCRIT: 22.1

INITIAL DATA: BP – 148/87 HR – 93

COMP CHECK: OK? – (Y) N

PATIENT READINESS: OK for PROCEDURE? Y TIME – 1330

TIME → 1400 15 30 45 1500 15 30 1600

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml	750	750	750	560	600		
f – breaths/min	12	12	24	28	28		
Peak inf pres / PEEP	30	30	22				
MODE – S(pon), A(ssist), C(on)	S	C	C	C	S	S	S
ET CO2 (torr)	45	53	54	40	43		
FIO2 (Frac or %)	0.74	0.74	0.74	0.74	0.74		
SpO2 (%)	92	88	95	96	98		
ECG	SR	ST	SR	ST	S	T	ST
TEMP – site	axillary						
N-M Block (T/4)	4/4	—	4/4				

Warming blkt: x1 blanket →

Conv warmer

Mark with letters & symbols, explain under REMARKS

EVENTS (1) (2) (3) (4) (5) (6)

Position → on turned 45°

REMARKS – Code drugs with numbers, events with letters

(1) Pre-op assessment to stretcher; O2 NC
(2) To OR, room, monitors, O2; induced, cricoid pressure. See airway management
(3) Wheezing, albuterol 8 puffs, Solu-Medrol 0.25mg SQ (R shoulder)
(4) 4/4, reversed, TV > 4mL/kg; RR > 8 & < 30 BPM; suctioned OETT for scant secretions; O2 saturation, albuterol 8 puffs, responsive, extubated & conscious
(5) Transported to ICU-2 c̄ SaO2 monitor, 4 O2 on c̄ SFM
(6) ICU-2 moved himself to bed, report to RN; pt left attended SaO2 94% c̄ SFM 10 LPM

RECOVERY AT 1515

PACU (ICU 2) (Specify)

OTHER T-100.7

CONDITION: awake, c̄ stimulation

RESP – 32 SpO2 – 93 Stable

BP – 112/80 HR – 117

ANESTHESIA PROVIDER TIMES

	Start	Room	End
ANES	1345	1400	1530
PROC	Ready	Begin	End
	1425	1430	1455

PROCEDURES and CPT Codes

I&D (L) arm + casting

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

EPN #[redacted]

b6-4

AN ESTHETIC TECHNIQUES: Describe block technique under Remarks

b6-2 GETA

b6-2 Cricoid pressure

AIRWAY MANAGEMENT – intubation route, blade, technique, comments

DL x1 CPT [redacted] DL x1 CPT [redacted] MAC 4; HOB lowered, Grade 1 view, tube pulled out, stylette; DL MAC 4 8.0 OETT [redacted] @ teeth 10mL cuff

SURGEONS: [redacted] + BBS & suct ETCO2

b6-2 [redacted] CRNA

[redacted] CPT [redacted] – ANESTHESIA

PROCEDURE LOCATION 7

DATE 22 Jun 03

PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 11354

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

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND ADJUVANTS		
DRUGS	(Units)	
Lidocaine	(mg)	60
Versed	(mg)	10-20-10 — 5
Fentanyl	(µg)	100 100
	( )	
Robinul	(mg)	2/2/2/2
Neostigmine	(mg)	1-1-1-1
VOLAT AGENT 1.50	% del	1/1/1/1/1/1/1/1/1/1
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	2/2/2/2/2/2/2/2

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

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

FLUIDS		
LINE site	☐ Warmed	
(L) Subclavian	☐ Warmed	422 — 800/800 — 423
	☐ Warmed	
	☐ Warmed	

LOSSES		
EST BLOOD LOSS		50/150
URINE –		

TOTALS	
TOTAL IN	
TOTAL URINE	
FLUIDS – SUMMARY	
CRYSTALLOID–	
COLLOID–	
BLOOD–	

REMARKS–

Code drugs with numbers, events with letters

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / B

HEMATOCRIT:

INITIAL DATA: BP – HR–

DONOR CHECK: OK? – Y N

PATIENT IDENTIFICATION: OK for PROCEDURE? TIME–

TIME → 1500 1530 1900 1930

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml	760	750	740	700	790	920
f – breaths/min	10	10	10	10	10	10
Peak inf pres / PEEP	23	26	22	26	24	✓
MODE– S(pon), A(ssist), C(on)	10	C	C	C	C	SV
☒ BP/Auto Cuff / ☒ ET CO2 (torr)	37	36	50	43	46	47
BP / oth / ☒ FIO2 (Frac or %)	.6	.65	.66	.66	.66	.66
ART line / ☒ SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES / ☒ ECG	SR	SR	SR	SR	SR	SR
☒ Gas analyzer / ☒ TEMP- site						
☒ N-M Block (T/4)	2-2/4-1/4	-1/4	-1/4	-2/4	-2/4	-4/4
Warming blkt						
Conv warmer						

Mark with letters & symbols, explain under REMARKS

EVENTS Position →

RECOVERY AT: PACU ICU _____ (Specify) OTHER _____

CONDITION: RESP– SpO2– BP– HR–

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: 4UA / cholecystectomy

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

[redacted] 66-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

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

PAGE ONE

SURGEONS: [redacted]

ANESTHETISTS: [redacted] 66-2

PROCEDURE LOCATION: OR

DATE: 25 JUN 03

PAGE 2 OF 2

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 11355

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

MEDICAL RECORD — ANESTHESIA

DRUG	(mg/kg)	
PROPOFOL	(mg)	200
FENTANYL	(mcg)	100 (50) [MSO4-10] (10 MSO4)
VERSED	(mg)	2.5
LIDOCAINE	(mg)	100
SUCCINYLCHOLINE	(mg)	100
Vecuronium	(mg)	7-3-1-1—2-1—1-1-1 [Vecuronium-10-5-5-10-5]—5
VOLAT AGENT	1.50 % del	2/2/2/1.5/1.5/1.5/1.5/1.25/1.0/1.0/0.8/0.8/0.8/0.8/1/1/1/1/1/1
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	2/2/3/3/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2

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

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

TOTALS	
TOTAL IN	250
TOTAL URINE	1000

FLUIDS – SUMMARY	
CRYSTALLOID	900
COLLOID	500
BLOOD	Ø

FLUIDS		
LINE site	☐ Warmed	(400 ml) 400/400 400/400 300/300
(L) SUBCLAVIAN	☐ Warmed	NS — 1 L 1 L
	☐ Warmed	200/200
	☐ Warmed	HESP — 500/500
LOSSES: EST BLOOD LOSS		100 100/100
URINE –		

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 95 (KG / LB)

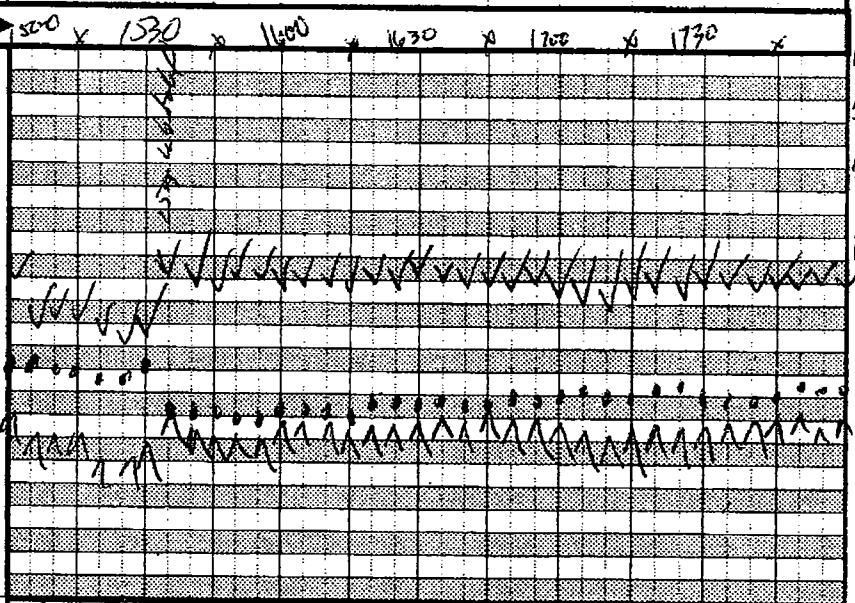
HEMATOCRIT: 28

INITIAL DATA: BP – (100) 142, 81; HR – 91

COMP CHECK: OK? – (Y) N

PATIENT READINESS: OK for PROCEDURE? Y; TIME – 1455

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



	1500	1530	1600	1630	1700	1730						
VT – ml	840	710	700	740	770	770	670	700	690	690	650	680
f – breaths/min	8	10	12	12	12	12	10	12	12	12	12	10
Peak inf pres / PEEP	28	28	29	28	29	28	25	27	29	26	29	29
MODE – S(pon), A(ssist), C(on)	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV
ET CO2 (torr)	40	39	40	32	33	32	34	36	36	36	33	36
FIO2 (Frac or %)	.70	.70	.69	.68	.68	.68	.68	.68	.68	.68	.68	.68
SpO2 (%)	100	99	99	100	100	100	100	100	100	100	100	100
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
TEMP- site	Axill						102°					
N-M Block (T/4)	1/4	1/4	1/4	0/4	1/4	1/4	2/4	0/4	1/4	1/4	1/4	1/4

MONITORS: BP/Auto Cuff; BP / oth; ART line; Steth – PC/ES; Gas analyzer; Warming blkt; Conv warmer

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

REMARKS – Code drugs with numbers, events with letters

1445 PT ID, Ø Δ FROM PREOP FORM 2400
1453 RM, O2, monitors
1500 induction/intubation (see vecuronium)
1511 surgeon request relaxation
1550 NGT Requested b62 By DR. [redacted] – placed x2 attempts in (R) nares
1630 surgeons notified of Temp OCT 102° axill
1928 PT RTC & VT > 4ml/kg – SEN ext – SEN
1936 OOR TO ICU
1945 RPT TO SGT [redacted] b62

RECOVERY AT 1945

PACU ICU (Specify) OTHER

CONDITION: Stable

RESP – 22 SpO2 – 94

BP – 147/67 HR – 106

ANESTHETIC PROCEDURE TIMES

	Start	Room	End
ANES	1445	1453	1750
	Ready	Begin	End
PROC	1503	1507	1930

PROCEDURES and CPT Codes: EUA / cholecystectomy

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Eyes TAPED, easy vent DL x1, I 3 MAC, grade I, TUBE TO 23@ TEETH, @ETCO2, @BBS, TAPE TO @ SIDE, OA IN AS BB – TOTS

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility: [redacted] b64

SURGEONS: [redacted] b62

ANESTHESIOLOGIST: [redacted] CRNA

PROCEDURE LOCATION: OR

DATE: 25 JUL 03

PAGE / OF

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 11356

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

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)					
midazolam	(mg)	2	1	2		versed
fentanyl	(cc)	2	0.5	1	.5	.5 fentanyl
gentamicin	(mg)	345mg				

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

VOLAT AGENT: % del / % e.t.

AIR L/Min

N2O L/Min

O2 L/Min — 2-2-2-2-2-2-2-2

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

TOTALS	
5mg	
4.5cc	

TOTAL BIL: Minimal

TOTAL URINE: 430 ml

FLUIDS – SUMMARY

CRYSTALLOID – 400 ml

COLLOID – ∅

BLOOD – ∅

FLUIDS

LINE site: NS — Warmed — 300 — 400

Warmed

Warmed

Warmed

LOSSES: EST BLOOD LOSS

URINE – 400 — 430

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 90 KG LB

HEMATOCRIT: —

INITIAL DATA: BP – 110/65 HR – 109

BONIP CHECK: OK? – Y N

PATIENT REMARKS: OK for PROCEDURE? Y TIME – 1025

TIME → 1015 30 X 1100 X 30 X 1200

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml	SV	SV	SV	SV	SV
f – breaths/min	20	20	20	24	20
Peak inf pres / PEEP					
MODE – S(pon), A(ssist), C(on)	S	S	S	S	S
BP/Auto Cuff	ET CO2 (torr)	+	+	+	+
BP / oth	FIO2 (Frac or %)	>.21	>.21	>.21	>.21
ART line	SpO2 (%)	98	97	98	97
Steth- PC/ES	ECG	ST	ST	ST	ST
Gas analyzer	TEMP- site	Available			
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

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

REMARKS – Code drugs with numbers, events with letters

Pt ID'd – chart reviewed. To OR for procedure.

(L) ICB – 4" 21ga stimuplex needle used. One pass – biceps & brachioradialis stim ↓ to 0.4 mA – 40ml of 50/50 mixture of 2% lidocaine : 0.5% bupi + epi, MARCAINE given incrementally & repeated negative aspiration – ∅ Δ in HR. In @ 1041

Block in @ 1041 – appears adequate @ 1056.

Pt did well – to ICU #2 for recovery – report given.

RECOVERY AT: PACU ICU #2 (Specify)

OTHER

CONDITION: Stable, Awake

RESP – 22 SpO2 – 98%

BP – 115/70 HR – 120

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1015	1025	1150
	Ready	Begin	End
PROC	1056	1105	1142

PROCEDURES and CPT Codes: Debridement and Irrigation of Left Forearm Wound; Closure of Wound & Splinting

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: Left Infraclavicular Block 2% lidocaine / 0.5% bupivacaine c̄ 1:200,000 epi

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Natural – O2 by Nasal Cannula

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

EPW [redacted] b64

ICU #2

SURGEONS: [redacted] b62

ANESTHETI[redacted] MD.

PROCEDURE LOCATION: 1

DATE: 29 JUN 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 11357

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

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS		
DRUG	Dose	
Versed	(mg)	2
Fent	(µg)	150 50
Lidocaine mg	(mg)	25
Roc	(mg)	50
STP	(µg)	300
	( )	
VOLAT AGENT: Forane	% del	1.5 1.2 1.0 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 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

FLUIDS		
LINE site LR	☐ Warmed	500 900
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	
LOSSES: EST BLOOD LOSS		
URINE –		150 250

TOTALS	
TOTAL FLUID	Min
TOTAL URINE	250

FLUIDS – PRIMARY
CRYSTALLOID– 900
COLLOID– Ø
BLOOD– Ø

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 95 (KG) LB

HEMATOCRIT: 30.6

INITIAL DATA: BP – 123 / 80 HR– 97

TOURNIQUET CHECK: OK? – Y N

PATIENT RECHECK: OK for PROCEDURE? TIME–

TIME → 7 30 8 09 8 30 8 10 8 30 8 11

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

220 200 180 160 140 120 100 80 60 40 20

VITALS					
VT – ml		810	750	760	54
f – breaths/min	10	8	8	8	12
Peak inf pres / PEEP		28	25	23	
MODE– S(pon), A(ssist), C(on)	S-C	C	C	C	
BP/Auto Cuff — ET CO2 (torr)		36	31	36	34 40
BP / oth — FIO2 (Frac or %)		.90	.91	.89	.88 .80
ART line — SpO2 (%)		100	100	100	100 100
Steth- PC/ES — ECG		SR	SR	SR	SR
Gas analyzer — TEMP- site Skin		35.6		36.5	35.7
N-M Block (T/4)		0/4		4/4	
Warming blkt					
Conv warmer					

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

REMARKS – Code drugs with numbers, events with letters

0810 PAT D/C'd – in OR monitors applied
0815 I & I ⊕ Bilat BS ⊕ ETCO2

0915 spont Resp ⊕ Swallow purposful movement. Oral suction & extubated. Sat 99

0920 pt stable responsive to Ice on RA Report given

RECOVERY AT 0924
PACU ICU 2 (Specify)
OTHER 797.1
CONDITION: favorable
RESP– 23 SpO2– 96%
BP– 109/64 HR– 108

ANESTHESIA & PROCEDURE TIMES

	Start	Room	End
ANES	0730	0810	0925
	Ready	Begin	End
PROC	0820	0825	0915

PROCEDURES and CPT Codes
Cast & suture removal @ arm
Closure Abd

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation, route, blade, technique, comments #8 ETT placed one attempt 2 miller blade grade 2 view secured 24 cm lips ⊕ ETCO2 ⊕ Bilat BS

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

SURGEONS: [redacted] b62

PROCEDURE LOCATION 23 HCSU

6Jul/03

ENT [redacted] b64

[redacted] b62

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age ~~33~~ DAYS MOS (YRS) Ex lap Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: I&D Lt arm (GSW)
SURGICAL SERVICE: ortho GSW Rt flank *
NPO SINCE: 2000

ASA Physical State (1) 2 3 4 5 (E)
WT: 95 (KG) LB HT: ____ IN.
ALLERGIES: NKDA

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

CURRENT MEDICATIONS:
( ) = ordered as premed
() Gent } Rec'd @ 2ACRFST
() Ancef }
( )
( )
( )
( )
( )

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

LABORATORY STUDIES:
HB/HCT: 13.3, 41.8
U/A:
OTHER:
PT/PTT 13.3/24.9

145 | 109 | 15 / 163
3.9 | 21 | 1.0

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 Foley cath
Gastrointestinal:
Hepatitis N Y
Hiatal Hernia N Y
PUD/GERD N Y
Endocrine System:
Diabetes N Y
Steriods N Y
Thyroid N Y
Neurological:
Seizures N Y
Neuropathy N Y
Other N Y
Gynecological :
Pregnancy N Y
Other Significant Hx:
N Y
N Y
Familial HX N Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC
(Ø)

PHYSICAL EXAMINATION
BP 134/80 HR 110 R 18 T 100.8
Pain Scale 0-10 2
HEENT - Teeth MP II
Trachea
TMJ/Neck
Oropharnyx
Nares
CHEST: CTAB
CARDIAC: RRR
EXTREMITIES:
IV Access: X2
Ulnar Filling: N/A
BACK: N/A
OTHER: N/A

NPO Since 2000

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

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

The patient/legal guardian [redacted] understand and agrees. Questions answered. b62
Signed: [redacted] MAN, CRNA Date: 6/18/03 Time: 0615 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient identification: (Ward) ICW 2

EPW # [redacted] b64 Dx # [redacted] b64 ICW #2 per PAD I & Band [redacted] b62 [redacted] CPT/AN CRNA 203-50-8384

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.

* Exit wound r/ buttock & thigh

(ICU 2 Recov J 2)

ESTHESIA PLAN OF CARE PR[redacted]OCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

ASA Physical State 1 (2) 3 4 5 E
WT: 95 KG/LB HT: ____ IN.
ALLERGIES: NKDA

POSED PROCEDURE: I&D (L) Arm
GICAL SERVICE: Ortho
SINCE: mid

ITS:
BACCO: (+)
ETOH: (+)
DRUGS: —

RENT MEDICATIONS:
ordered as premed
LR @ 125 cc/hr
Unasyn 3gm q6 IVPB (2 doses)
Zantac IV 50mg q8
Toradol 30mg IV q6
MSO4 > prn
Phenergan > prn

MEDICATIONS:
e Yes (@ ____ Hrs) /CC
___. ____ mg IV IM PO
___. ____ mg IV IM PO
___. ____ mg IV IM PO

ORATORY STUDIES:

HCT: ____/____
IER: ____

20 Jun
6.5 | 11.2 | 228
35.1
117 | 103 | -
4.2 | 29 | -

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			See Anesthesia Record 6/18/03
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	Foley Cath
Gastrointestinal:			
Hepatitis	N	Y	NGT to LIS
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 (R) Flank (L) Femur
	N	Y	on 17 June 03
Familial HX	N	Y	

ASSESSMENT

PAST SURGICAL/ANESTHETIC
Ex lap - Gsw 17 Jun 03
Ø complications

PHYSICAL EXAMINATION

BP 89/49 HR 98 R 20 T 99 °C
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea MPII
TMJ/Neck 3FB TMD
Oropharnyx ____
Nares ____
CHEST: CTABS
CARDIAC: RRR
EXTREMITIES:
IV Access: (L) SCL
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since mid

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

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

b62
patient/le[redacted]ems to understand and agree. Questions answered.
ned: [redacted] CRT CRNA [redacted] Date: 20 Jun 03 Time: 0715 Hrs

T-ANESTHESIA EVALUATION AND NOTE (NON ASU)
NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
b62
[redacted] RNA
ned: [redacted] ate: 22 Jun Time: 2000 Hrs

22 Jun 03
121 | 103 | 94
3.8 | 26 | 16
1.5
8.5
27.1
27K

ent Identification: (Ward) b64

EPW # [redacted]

ICU 2

AM chg by OTC
NG - out
O2 2L N/C - 95% SaO2
Lungs clear RRR
ITC

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

PROPOSED PROCEDURE: Exp lap
SURGICAL SERVICE: G.S.
NPO SINCE: Ate @ 0730 Full Breakfast

ASA Physical State 1 2 3 4 5 E
WT: 95 KG LB HT: ____ IN.
ALLERGIES: NKDA

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

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Zantac 50cc
( ) Unasyn 3Gm
( ) NS@ prn
( ) Phenergan
( ) NS @ 75cc/hr
( ) Toradol 30mg

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

LABORATORY STUDIES:
HB/HCT: 8.9 / 28.4
U/A:
OTHER: 433
WBC 11.5 TBIL 4 (w 5.4)

140 | 104 | 92
3.5 | 23 | 14 0.8

24 June

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension N Y
- Angina N Y
- MI N Y
- CVA N Y
- Other N (Y) Occ. unifocal PVC

Pulmonary System:
- Asthma N Y
- Bronchitis/URI N Y
- COPD N Y
- Other N Y

Renal System:
- Acute/Chronic RF N Y Fulvicin

Gastrointestinal:
- Hepatitis N (Y) Cholera Jaundice
- 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

Gynaecological:
- Pregnancy N Y NA

Other Significant Hx:
- N (Y) GSW (R) Flank
- N Y (L) Forearm

Familial HX N Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC
Ex-lap GA
(L) arm 5 comp

Sul2 NC LL 96%

PHYSICAL EXAMINATION
BP 139/88 HR 86 R 21 T 99 2
Pain Scale 0-10
HEENT - Teeth poor / dentures
Trachea midline
TMJ/Neck 3FB
Oropharnyx MPII
Nares
CHEST:
CARDIAC: S1S2 S (m)
EXTREMITIES: NS @ 75cc/hr
IV Access: (R) Subclavian
Ulnar Filling:
BACK:
OTHER:

NPO Since Ate Full Breakfast @ 0730

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ____ GETA ( ) 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 patient/legal guardian seems to understand and agrees. Questions answered. Translator present / Pt understands

Signed: ____ Date: 25 June Time: 1000 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Reviewed chart 27 Jun 03

O2 Sat 96% on O2 6L N/C
T 103.6 - tylenol DR b62
WBC 20.1 9.1 / 29.9 Hct 48% Sinem. [redacted] b62
Lung Rhonchi [redacted]
138 | 103 | 105
4.7 | 25 | 14 / 1.7
Ulcer

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

Patient Identification: (Ward) ____

b64

[redacted]

ICU 2

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/AS [illegible])

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

PROPOSED PROCEDURE: I&D (L) Arm
SURGICAL SERVICE: Orthe
NPO SINCE: mid

ASA Physical State 1 (2) 3 4 5 E
WT: 95 (KG/LB) HT: ___ IN.
ALLERGIES: NKDA

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

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) NS @ 50cc/hr
( ) Zantac 50mg
( ) ~~Unasyn 3 Gm~~ Fortaz 1 Gm
( ) ~~Morphine~~
( ) Phenergan } prn
( ) Tylenol
Tylenol prn

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

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

25 June
30 | 9.0 / 29.2 | 529
132 | 95 | 16 / 4.2 | 3 | 0.7 | 107

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	See Anesthesia Pre-op Eval 27 June 03
Angina	N	Y	
MI	N	Y	(+) Pneumonia – Resolved
CVA	N	Y	
Other	N	Y	CXR 28 June – (L) side effusion
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	Foley Cath
Gastrointestinal:			
Hepatitis	N	Y	NG Tube (R) nare
Hiatal Hernia	N	Y	Sclera Jaundice
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	NA
Other Significant Hx:	N	(Y)	GSW (R) Flank,
	N	Y	(L) Forearm
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ex lap x2 > 5 camp
(L) Arm

121 PHYSICAL EXAMINATION
BP 80 HR 105 R ___ T 101 2 100%
Pain Scale 0-10 ___
HEENT - Teeth Poor Dentition
Trachea midline
TMJ/Neck 3 FB
Oropharynx MP II
Nares
CHEST: (+) BBS – CTA – Auscul (+) rhonchi in bases
CARDIAC: RRR
EXTREMITIES:
IV Access: (L) SCL
Ulnar Filling:
BACK:
OTHER: O2 @ 10L via Partial Non-rebreather

NPO Since mid

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

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

The patient [redacted] b62 [redacted] to understand and agrees. Questions answered.
Signed: [redacted] /CPT [redacted] Date: 28 Jun 03 Time: ___ Hrs

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

Signed: ___ Date: ___ Time: ___ Hrs

Patient Identification: (Ward) ___

EPW # [redacted] b64

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

HESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthe

33 DAYS MOS YRS Sex ( ) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 E
WT: 95 KG/LB HT: ____ IN.
ALLERGIES: NKDA

ED PROCEDURE: Delayed PPC
L SERVICE: Ortho
CE: MN

CO: (+)
TOH: (+)
GS: (-)

F MEDICATIONS:
ned as premed

Cipro 10/22 500mg
Nystatin
Colace
MSO4 (0315 5mg)
Percocet
Albuterol

CATIONS:
1@ _____ Hrs) /CC
_____ mg IV IM PO
_____ mg IV IM PO
_____ mg IV IM PO

TORY STUDIES:

133/4.1 | 99/31 | 14/1.1 < 97
8.0 > 9.3/30.6 < 769

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension N Y See Pre-op 3D Tune
- Angina N Y
- MI N Y
- CVA N Y
- Other N Y

Pulmonary System:
- Asthma N Y (+) pneumonia Pseudomonas
- Bronchitis/URI N Y
- COPD N Y
- Other N (Y)

Renal System:
- Acute/Chronic RF N Y foley

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 NA

Other Significant Hx:
- N Y
- N Y

Familial HX N Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC
Ex Lap/GSW & debridement

PHYSICAL EXAMINATION

BP 112/62 HR 84 R 24 T 96.4 Sat 99% RA
Pain Scale 0-10 ____
HEENT - Teeth Poor dentition
Trachea midline
TMJ/Neck 3FB, TM3FB
Oropharnyx ____
Nares ____
CHEST: RRR
CARDIAC: CTA
EXTREMITIES
IV Access: IV LR
Ulner Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

ETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ____ ~~General~~ Mask Intubation

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

b62

t/legal [redacted] understand and agree. Questions answered.
[redacted] Date: 7/6/03 Time: 0735 Hrs

ESTHESIA EVALUATION AND NOTE (NON ASU)
PARENT ANESTHETIC COMPLICATIONS ( ) OTHER

_____ Date: _____ Time: _____ Hrs

entification: (Ward) ICU2 ICU2

[redacted] b64

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

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 1-Jul-03

DATE AND HOUR REQUIRED: 0702 1Jul03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: [redacted] b62

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P EXCAP I+D GAIN

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

SIGNATURE OF VERIFIER: See ITD

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: 1642060

TRANSFUSION NO.

PATIENT NO.

DONOR: ABO A; Rh positive

RECIPIENT: ABO A; Rh positive

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Compatible

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: EXP / DATE 02 JUL 03

PREVIOUS RECORD CHECK: [x] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] b62

DATE 1 JUL 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted] b62

AT *(Hour)* 0955 ON *(Date)* 1 JUL 03

IDENTIFICATION

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

1st VERIFIER *(Signature)*: b62 [redacted] 996 9/11/16

2nd VERIFIER *(Signature)*: b62 [redacted] SP/AN

PRE-TRANSFUSION

TEMP. 100.6 PULSE 104 BP 120/67

DATE OF TRANSFUSION: 1-Jul-03

TIME STARTED: 1000

POST-TRANSFUSION DATA

AMOUNT GIVEN: 450 ML

TIME/DATE COMPLETED/INTERRUPTED: 12:00 / 1 July 03

REACTION: [x] NONE [ ] SUSPECTED

TEMPERATURE: 101.0 PULSE: 104 BLOOD PRESSURE: 107/66

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

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

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

SIGNATURE OF PERSON NOTING ABOVE: b62 [redacted]

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

[redacted] b64

SEX: MALE

WARD: ICU #2

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 11364

Return to Transfusion Service

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 0902 1-Jul-03

DATE AND HOUR REQUIRED: 0902 1 Jul 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: [redacted] b62

DIAGNOSIS OR OPERATIVE PROCEDURE: SIP ex-lap, I+D abd

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

SIGNATURE OF VERIFIER: See JTS

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: 005129

TRANSFUSION NO.: b6-4

PATIENT NO.: [redacted]

DONOR: ABO A; Rh positive

RECIPIENT: ABO A; Rh positive

TEST INTERPRETATION

ANTIBODY SCREEN: N/A

CROSSMATCH: Compatible

PREVIOUS RECORD CHECK: [x] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] b6-2

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 1 JAN 03

REMARKS: EXP DATE 02 JUL 03

SECTION III – RECORD OF TRANSFUSION

[redacted] ON DATA b62

[redacted]

AT (Hour) [redacted] 200 ON (Date) 1 Jul 2003

IDENTI[redacted]

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

1st VERIFIER *(Signature)*: [redacted] b62 9/1 9/1 9/1 b6

2nd VERIFIER *(Signature)*: [redacted] b62

PRE-TRANSFUSION

TEMP. 100.7 PULSE 99 BP 140/82

DATE OF TRANSFUSION: 1-Jul-03

TIME STARTED: 1710

POST-TRANSFUSION DATA

AMOUNT GIVEN: 450 ML

TIME/DATE COMPLETED/INTERRUPTED: 1900/1-Jul-03

REACTION: [x] NONE [ ] SUSPECTED

TEMPERATURE

PULSE: 96

BLOOD PRESSURE: 109/65

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

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

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

SIGNATURE OF PERSON NOTING ABOVE: b62 [redacted]

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

Elw [redacted] b64

SEX: MALE

WARD: ICU #2

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 11365

Return to Transfusion Service

*U.S. GPO: 1992-316-809/60175

NSN 7540-01-166-7284

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
Cholangiogram			[redacted]	OR	
	FILM NO. 66-4				PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) Dr [redacted] b62				TELEPHONE/PAGE NO.
	SIGNATURE [redacted] MAJ AN b62				DATE REQUESTED 25 Jun 03

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

Hx of Exp lap for GSW to abdomen,

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)
25 Jun 03		

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)	LOCATION OF MEDICAL RECORDS
EPW # [redacted] b64	LOCATION OF RADIOLOGIC FACILITY

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

OP NOTE

18 June 03 1000

PRE-OP DX - GSW (R) Flank / (L) Forearm w/ Retained FB

POST-OP DX - SB Perforations / Right Psoas / Iliacus injury

PROCEDURE - (1) OLP LAP - Repair Enterotomy - Retroperitoneal Hp.

(2) Excision Left forearm FB - I+D

SURGEONS - Dr. [redacted] / Dr. [redacted] b62

Time Ø FINDINGS - Retroperitoneal hematoma - Muscle injury RIGHT iliacus / Psoas / Small Bowel perforation

DESCRIPTION - 65M - Abdomen prepped / Draped. Midline incision Xiphoid Sternum → Pubis - Entry into peritoneal cavity. Small bowel extrusion seen with gut. Wound edges trimmed to bleeding tissue and 2 layer closure performed - Vicryl 3-0 Running followed by 3-0 Silk Lembert. Small bowel run → No other injury - Colon, Liver, Spleen, Rectum, Stomach - WNL - Hematoma seen lateral to cecum. Peritoneum opened and small Hematoma found. Hole seen in Psoas and 2 cm area of injury to iliacus. Aorta & IVC WNL. Wound irrigated and bleeding controlled w/ Thrombin soaked gelfoam. Abdomen irrigated w/ 5L NS / Saline. Abdomen closed w/ 2 running sutures #1 Looped Maxon, Subcuts irrigated. Wound edges approx w/ interrupted sutures Vicryl Subdermal 3-0 Vicryl. Skin closed w/ Staples / Xeroform / Dressing.

cont'd

CHIEF, MED RECORDS NOT WORKING 662

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

EPW [redacted] b64

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
	Certified
	IV entry - Anesf, gas, UNASYN IV fluid - 2500 cc LR
	UO - 250 cc EBL 200 cc Immo Foley, NGT
	Cup β
	Pt transported for ICU w/ extubation. b6-2 [redacted] MD
	MAJ MC USA CHIEF DOS
	[redacted]
18 JUL 03	Order Op Note
1850	Pre-Op Dx - GSW (L) forearm with grade III + distal radius fx
	Post-Op Dx - Same
	Procedure - (1) I + D (L) forearm
	(2) (L) forearm dorsal compartment fasciotomy
	Surgeon - [redacted] b6-2
	EBL - 200 cc
	Blood - 65 PRBC
	Findings - Very large skin defect over dorsum of forearm with dead 1 cm skin bridge, measuring ≈ 8 x 15 cm. Skin bridge esp[illegible] Dorsal fasciotomy done [illegible] wound. Radius fracture [illegible] open with muscle after [illegible] Splint applied
	Plan - Repeat I + D 20 or 21 Jul
	Cc: Dist pulse via x-ray [redacted]

STANDARD FORM [redacted] BACK

USAPA V1.00

b6-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW # [redacted]

b64

NURSING UNIT: 1CW2 | ROOM NO.: | BED NO.: 3

DATE OF ORDER: 18 June 03 | TIME OF ORDER: 0545 HOURS | LIST TIME ORDER NOTED AND SIGN

Admit 7CW #2 ✓

Dx: GSW to (L) ARM ✓

@ GSW to (R) FLANK ✓

Condition: guarded ✓

Vitals: per Routine ✓

Allergies: NKDA ✓

Meds: Ancef 1g IV Q 12° prn pain ✓

PATIENT IDENTIFICATION

EPW # [redacted]

b64

NURSING UNIT: 1CW2 | ROOM NO.: | BED NO.: 3

DATE OF ORDER | TIME OF ORDER

Ignore Ancef Q6° next dose 0830 ✓ HOURS

IVF: NS @ 125 cc/hr

Diet: NPO ✓

Activity: Bedrest with GUARD ✓

Plan: to OR for surgery Dr [redacted]

b62 [redacted] 2 [illegible]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

MEDCOM - 11369

DA 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 # [redacted]

b64

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 18 June 03 TIME OF ORDER 0950 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU 2 - Dr. [redacted]
2. Dx - SP GSW LAP / HO (L) Forearm
3. Cond - Stable NKDA
4. VS q 1°, I+O, MONITOR
5. Act - BEDREST
6. Diet - NPO
7. IVLR TRA 125cc/hour

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

8. UNASYN 3 grams IVPB q 6°
9. NGT to LIS
10. FOLEY CATH to Urinalysis
11. Elevate Left Arm on Pillow
12. MORPHINE SULFATE 2-4mg IV q 3° PRN PAIN
13. ZANTAC 50mg IV q 8°
14. TORADOL 30mg IV q 6°
15. PHENERGAN 25mg IV q 4° PRN / NAUSEA

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

16. TCDB q 1°, INCENTIVE SPIROMETRY 10-20x per hour
17. CBC, chem Lyte now then q AM
18. Call MD if T > 101°, P < 60/or > 110, SBP < 100 or > 165, UO < 30cc/hr
19. Tylenol [redacted] MD PRN T > 101

MAJ, MC USA
DOS

Noted Sgt [redacted]

PATIENT IDENTIFICATION

@0014 21° Chart Orders noted Sgt [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

19 Jun 03 0710

1. Dilaudid Nebs 0.5cc / 2.5cc NS nebulizer q 6°

[redacted] 0200 / 20 / 19 Jun 03

[redacted]

24°C @ 2300. Orders noted Sgt [redacted]

b6-2

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

MEDICAL RECORD	PROGRESS NOTES

DATE

20 June 03

0900

GENERAL SURG SVC

S: Ax C/O – Pt Doing + alert

Ambulating w/ crutch – No Complaints

O: Tm 101.8 Tc 99 P- 108 130/88

NS – 75-100cc/hr NGT 300

6.5 / 11.2 / 228 / 35.1 117 / 103 / 4.2 / 29

HEART – RRR S (M) LUNGS – CTA.

Abdomen – Bowel – Drains intact Sent BS.

No gross.

A: POD #20 DCP LAP – still gross Hematuria –

Hemodynamically stable

P: ① Plan wound washout of Left forearm by Ortho Svc

② Abdominal CT Scan today to assess Right 4th trunk.

③ Repeat chem –

b62

[redacted] ML

[redacted] MD, MC USA

[redacted] MEF, DOS

(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] b64

PROGRESS NOTES
Medical Record

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

USAPPC V1.00

PROGRESS NOTES

DATE	
20JUN 03 1210	Attn Op Note Pre-Op Dx - Open (L) radius fracture Post Op Dx - Same Procedure: I+D (L) forearm with ORIF (L) DISTAL RADIUS Surgeon: [redacted] b62 Anesthesia: GA Findings: Wound clean. Dissection proximal of distal radius. Lagging in place using 2 3.5 mm cortical lag screws. Anatomic reduction on Radiographs. Used vessel loops to diminish soft tissue wound. [redacted] b62

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

.INICAL RECORD - DOCTOR'S ORDERS

For us.. this form, see AR 40-66, the proponent agency is OTSG

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

TIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
#[redacted] b64			20 June 03	0900 HOURS	
			① METLYTE 8 mor		
					Noted @ 0915hrs 20 June 03 [redacted]
			b62		
..RSING UNIT	ROOM NO.	BED NO.	[redacted]		b62
ICU #2		5			
			24 Jun 03 @ 0125 orders noted [redacted]	MC USA CHIEF, DOS	

TIENT IDENTIFICATION			DATE OF ORDER	TIME OF [redacted]	
#[redacted] b64				HOURS b62	
..RSING UNIT	ROOM NO.	BED NO.			
ICU #2		5			

TIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
..RSING UNIT	ROOM NO.	BED NO.			

TIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
[redacted] b64				HOURS	
..RSING UNIT	ROOM NO.	BED NO.			

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD EM 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
664 GPW [redacted]	20 JUN 03	1220 HOURS	
	① RESUME PRIMOVE ORDERS [redacted]		
	② S/P I+D (L) ARM W/ TI ORIF OF RADIUS [redacted]		
	③ CONTINUE - STABLE		
	④ ELEVATE (L) ARM [redacted]		
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.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

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

EDICAL RECORD | PROGRESS NOTES

DATE

[illegible] General Surgery SVC

1735 S: Pt resting with - and in bunny - No BM yet

O: T max 99.5 T c 98.4 (Axilla) 135/85 P-102 91

UO - 50 cc/hr

CT Sm Flow -

4.8 9.3 / 29.8 <252 135 / 3.7 103 / 3.8 <

NL GU system - No leak

Lungs CTA Heart - RRR S(M)

Abdn - Flat (+) BS NGT - 300 cc / 29°

No distention.

(L) SCT - in bunny

A: POD #3 LAP for appendicitis - NL CT Sm

Exit pm office

P: (1) DC I NGT (2) Clear liquids today

(3) will repeat CF4's in am (4) Antibiotics for

further am care

b62

[redacted] MD

MAJ, MC USA
CHIEF, DOS

22 Nov 2003 Author Op Note

1500 Pre-Op Dx - GSW (L) forearm

Post-Op Dx - Same

Procedure - TKO (L) forearm

Surgeon [redacted]

b62

Blood - 600 Lr

(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

EDW [redacted]

b64

PROGRESS NOTES
Medical Record

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

TIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW [redacted] b64			21 JUN 03	1735 HOURS	
			(1) NGT DC'd		
			(2) Diet - advance to clear liquids		
			(3) LFTs in am b6-2 [redacted]		MD
			METLYTES [redacted]	MAJ, MC USA CHIEF, DOS	
IRSING UNIT	ROOM NO.	BED NO.	CBC [redacted]		
			21 JUN 03 Orders Noted [redacted]		

TIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			22 JUN 03	0900 HOURS	
			NPO for w/short (1)		[redacted] b6-2
			Foley Am		
IRSING UNIT	ROOM NO.	BED NO.	[redacted]		

TIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
EPW [redacted] b64			22 June 03	0930 HOURS	
			(1) Change IV to NS TKA 125cc/hr		[redacted]
					b6-2
			[redacted] MD		
IRSING UNIT	ROOM NO.	BED NO.	MAJ, MC USA CHIEF, DOS		[redacted]

TIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			22 JUN 03	1457 HOURS	
			(1) NGTUBE & PHENOLS ORDERED		
			(2) ADVANCE TO CLEAR LIQUIDS		
			(3) LFT's, METLYTE & CBC in AM		
[redacted] b64					b6-2
IRSING UNIT	ROOM NO.	BED NO.	[redacted]		[redacted] 22 JUN 03 1735

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

24° ✓ 23 JUNE 03 @ 0250 MZ

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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 / HOURS	LIST TIME ORDER NOTED AND SIGN
#[redacted] b64			22 June 03 1615 HOURS Δ Albuterol neb tx (0.5cc/2.5cc NS) to q4° c̄ nasal suctioning and chest PT V.O. DR [redacted]	22 Jun 03 b6-2 [redacted] 1743
NURSING UNIT: ICU #2	ROOM NO.	BED NO.: 7	[redacted] b6-2	
PATIENT IDENTIFICATION			DATE / TIME / HOURS	
#[redacted] b64			22 Jun 03 2240 HOURS ~~Acte~~ Δ chest PT to q2° (gym) / WYNN, m Noted [redacted] @2247 b6-2 23 June 03 @ 2440 chart check — Sgt [redacted]	
NURSING UNIT	ROOM NO.	BED NO.	24° chart ✓ 23 June 03 @ 0853 mz	
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER / HOURS	
EPW [redacted] b64			23 June 03 0940 HOURS ① DC Foley cath ② CXR PA & LAT [redacted] b6-2	Noted @ 1010h 23 JUN 03 [redacted] b6-2
NURSING UNIT	ROOM NO.	BED NO.	[redacted]	
PATIENT IDENTIFICATION			DATE / TIME / HOURS	
EPW [redacted] b64			23 June 03 12[redacted] HOURS ① Advance to Regular diet ② Ambulate w/ assistance & IV ③ Physical therapy to assist w/ ambulation ④ ↓ MW to 75cc/hr	Noted @ 1226h 23 Jun 03 [redacted] b6-2
[redacted] b6-4				
NURSING UNIT	ROOM NO.	BED NO.	[redacted]	b6-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY B[redacted]

24° chart ✓ @ 2342 2[redacted] 23 June 03 Sgt [redacted] EPW

b6-2

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

TIENT IDENTIFICATION

#[redacted] b6-4

DATE OF ORDER: 24 June 03 TIME OF ORDER: 1100 hrs HOURS

LIST TIME ORDER NOTED AND SIGN

(1) △ Albuterol Neb Tx's To (0.5cc/2.5cc NS) q6° with Chest PT

b6-2

V.O. Dr. [redacted] CPT/MC [redacted] MD

MAJ, MC USA

CHIEF, DOS

IRSING UNIT	ROOM NO.	BED NO.
ICU #2		5

TIENT IDENTIFICATION

#[redacted] b6-4

DATE OF ORDER: 24 June 03 TIME OF ORDER: 1818 HOURS

(1) Tylenol 650 mg po q 4° Pain

(2) CT Tech

(3) MS 5 mg x 01 given [redacted] MD b6-2

b6-2 [redacted] MAJ, MC USA CHIEF DOS

IRSING UNIT	ROOM NO.	BED NO.

Noted @ 183[redacted] noted [redacted] b6-2

TIENT IDENTIFICATION

[redacted] b6-4

DATE OF ORDER: 240cc @ 2450 Orders noted [redacted] TIME OF ORDER: 25 June 03 0925 HOURS

(1) NPO

(2) OR tech for wound eval, O

b6-2 [redacted] MD

[redacted] MAJ, MC USA CHIEF, DOS

[redacted] b6-2 [redacted] 0925

IRSING UNIT	ROOM NO.	BED NO.

TIENT IDENTIFICATION

[redacted] b6-4

DA[redacted] ORDER HOURS

[redacted]	ROOM NO.	BED NO.

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CLINICAL RECORD - DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION

#[redacted] b6-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
25 Jun 83	1030 HOURS	
1. Type & Screen 2 UPRBC For LGR		b6-2 [redacted] 9/10/86 [redacted]
	b6-2 [redacted] MAJ, CRNA	

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.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

b6-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

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MEDICAL RECORD	PROGRESS NOTES

DATE

28 Jan 03 GEN. Surgery

0848 S: Pt [illegible] in [illegible] opened yesterday w/ Sac DC
[illegible] complaints of abdom pain, ⊖ BM
O: Afebrile, VS [illegible]

CT scan [illegible] ? Fecal [illegible]

A: POD 7 Exp Lap — Fecal Dehiscence

P: UR today for usual explanation —
also examined [illegible].

b6-2

[redacted] MD
MAJ, MC USA
CHIEF, DOS

(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.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
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CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION

EPW # [redacted] b6-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 25 Jun 03 TIME OF ORDER: 1830 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU 2
2. S/P Ex lap wound exploration
3. Condition stable
4. VS q 1hr including pulse ox + UO
5. Call MD for UO < 30cc, HR > 120 < 50, SBP > 160 < 90, DBP > 90 < 60, RR > 30 < 10, T > 100.4

b6-2 Noted [redacted] 1830

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

6. Activity BR
7. All NKDA
8. Diet NPO
9. IVF LR @ 150 cc/hr
10. Foley to Gravity, NGT to LIS
11. MSO4 1-4 mg IV q 1hr prn pain
12. Unasyn 3 gm IV q 6 hrs. First dose 6 hrs P last dose.

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

13. IS 10 x q hr while awake, TCDBs 1°
14. CBC Chem 8 Liver panel QAM
15. JP to bulb suction
16. Record JP output Q2 hrs + Strip
17. Phenergan 25 mg IV q 4-6 hrs prn nausea
18. Gen Surg Dr [redacted] [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: [redacted] HOURS

19. Tylenol Supp 650mg PR q 4° PM / T > 101.0
20. CBC, chem 8 now

MAJ MC USA

b6-2

[redacted] MD

MAJ, MC USA
CHIEF, DOS

NURSING UNIT | ROOM NO. | BED NO.

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PROGRESS NOTES

DATE	
25 June 03 1945	OP NOTE PRE-OP DX – FASCIAL DEHISCENCE POST-OP DX – FASCIAL DEHISCENCE, Cholelithiasis chronic PROCEDURE – Cholecystectomy / Fascial repair SURGEON – Dr. [redacted] ASSIST – Dr. [redacted] b6-2 FINDINGS – Tense GB, mild cholelithiasis – sludge, Fascial Dehiscence Trimo Set 8. Description – GETA – Fascial suture pulled through wound portion of incision ~~separation~~ coupled for Urinalysis. Chest opened – GB inspected – Sl erythema tense, Dense thick cholecystitis profound; Cholecystogram used for identify Common Bile Duct. GB resected – cystic duct ligated w/ 2-0 Silk / Hemoclip. Small amount of Bile leaking from Needle stick in common duct this was closed w/ 3 interrupted sutures of 3-0 Maxon. JP drain placed over CBD + brought out through RUQ. Retention suture placed w/ interrupted #2 Nylon. Fascia approximated w/ Bogota of 8 sutures w/ 2-0 Prolene. JP secured w/ 3-0 Nylon. Undermined approx w/ Vertical Subdermal sutures 3-0 Chromic. Bolster placed on Retention + Fascia. Chest packed w/ RS soaked gauze + towel. Pt tol well was extubated + transported to PACU in Stable condition. Antibiotics – Unasyn, IV Fluids in – LR 900 Hepm – 500cc GBL – 250cc 4G – 1000cc Drains – Foley, NGT, JP. b6-2 [redacted] MD [redacted] MAJ, MC USA [redacted] CHIEF, DOS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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TIENT IDENTIFICATION

[redacted] b64

DATE OF ORDER 25 JUNE 03 TIME OF ORDER 2330 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Albuterol Neb 0.5 cc/2.5 cc NS w/ CP - q 6°
2. CVR ~~m~~ AM

b6-2

IRSING UNIT | ROOM NO | BED NO.

[redacted]

TIENT IDENTIFICATION

[redacted] b64

Noted by [redacted] Verified [redacted]

24 cc @ 0035 Orders noted [redacted]

26 June 03 0700 b6-2

1. TORADOL 30mg IV q 6°
2. ZANTAC 50mg IV q 8° 6-14-22 Noted @ 0710
3. PHENERGAN 25mg IV MIV [redacted] b6-2

IRSING UNIT | ROOM NO | BED NO.

ICU #2 | | 5

[redacted] b6-2

TIENT IDENTIFICATION

[redacted] b6-4

DATE OF OR[redacted]

26 JUNE 03 1795 [redacted] HOURS

1. MORPHINE gtt - 1mg/hour
2. ATIVAN 2mg IV Immediately q 6° PRN/ANXIETY
3. Dressing change daily w/ NS wet to dry.

IRSING UNIT | ROOM NO | BED NO.

[redacted] MD b6-2

MAJ, MC USA
CHIEF, DOS

TIENT IDENTIFICATION

DATE OF ORDER [redacted] TIME OF ORDER HOURS

24 cc @ 2255 26 June 03 Orders noted [redacted]

[redacted] b6-4

IRSING UNIT | ROOM NO. | BED NO.

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
#[redacted] b6-4	CXR q AM x 3 [redacted]	b6-2 [redacted]
NURSING UNIT: ICU #2 / ROOM NO: / BED NO: 5		556 Scrub b6-2

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER / HOURS	
#[redacted] b6-4	27 Jun 03 1348 1. Lasix 20mg IV x1 – Done 1400 2. Fortaz 2gm IVPB q8° 6 1400 [redacted] 3. Gentamycin 5mg/kg NPB qd. 1400 [redacted] 4. IKO NS – Done [redacted] MAJ, MC FAMILY PRACTICE 5. D/C Urasyn. Done	b6-2
NURSING UNIT: 27 Jun 1400 / ROOM NO: / BED NO:		

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER / HOURS	
#[redacted] b6-4	1730 27 Jun 03 Lasix 20mg IV x1 @ 2000 [redacted] b6-2	NOTED 27 June 03 1830 [redacted]
NURSING UNIT: / ROOM NO: / BED NO:	24 ✓ chart 28 June 03 @ 0038 [redacted]	b6-2

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER / HOURS	
#[redacted] b6-4	28 Jun 03 0845 1. Fortaz 2gm IV now b6-2	Noted @ 0817 28 Jun 03 [redacted] b6-2
[redacted] b6-4	[redacted]	
NURSING UNIT: ICU #2 / ROOM NO: / BED NO: 5		

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

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CLINICAL RECORD - DOCTOR'S ORDERS

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PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
[redacted] b6-4			28 Jun 03 2235 Ceftotan 1 gm @ 12° IV [redacted] @2240 b6-2 24°C noted @ 2313 28 June 03 Orders noted	
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER / HOURS	
			29 Jun 03 1145 ① Resume previous orders [redacted] b6-2 ② LR at 100 cc/hr. [redacted] 1145 29 Jun 03	
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER / HOURS	
[redacted] b6-4			29 Jun 03 215 1. 500 cc LR Bolus [redacted] b6-2 Noted [redacted] 24°C @ 2220 29 June 03 Orders noted [redacted] [redacted] b6-2	
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER / HOURS	
[redacted] b6-4				

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

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AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22 Nov 03	Clinical Op Note
	Pre-Op Dx - Open (L) radius fracture
	Post-Op Dx - Same
	Procedure - I+D of (L) forearm with wound closure DPC
	Surgeon: [redacted] b6-2
	Anes - MIN
	Findings - Wound clean remainder closed via DPL using 3-0 nylon
	[redacted] b6-2

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

CLINICAL RECORD - DOCTOR'S ORDERS

[redacted] b6-4

30 JUN 03 0713

CXR q AM x 3 days (PA/Lat)

Remove NG tube

Start clear liquids

003 T[redacted] b6-2 30 Jun 03 [redacted] b6-2

Combitate with [redacted] 0945

assistance

Incentive Spirometer

10x q h.

b6-2

24°C 30 June 03 @ 2430 Orders noted [redacted]

[redacted] b6-4

1 Jul 03 0910

Advance to Regular Diet

Ensure shake twice daily

b6-2

Transfuse 2 u PRBC slowly over 6 hrs

Preheat [redacted]

Meal 650 [redacted]

Benny [redacted] b6-2

1245

Nystatin swish & spit BID

b6-2

24°C @ 2328 2 July 03 Orders noted [redacted]

b6-2

[redacted]

[redacted]

4258

MEDICAL RECORD - DOCTOR'S ORDERS

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

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

'IENT IDENTIFICATION

[redacted] b6-4

ISING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 3 JUL 03 TIME OF ORDER 1554 HOURS

LIST TIME ORDER NOTED AND SIGN

DC Inadol ✓
DC Gent ✓
DC Cefotet ✓
DC Continue MSO4 drip ✓
DC Albuterol Nebulizer ✓
Start Ciprofloxacin 500 BID ✓
MSO4 2-6 mg IVP q 1 hr PRN ✓

Noted 3 Jul 03 @1610 b6-2 [redacted]

IENT IDENTIFICATION

SING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

Percocet 1-2 tablets PO q 4° PRN ✓
Albuterol MDI 2 puff PRN q 4° PRN ✓
DC Chest PT ✓
Ambulate ad lib tolerated ✓

[redacted] b6-2

IENT IDENTIFICATION

[redacted] b6-4

SING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 4 July TIME OF ORDER HOURS

Ambien 10 mg Start ½ tab then ½ total PO PRN Insomnia

Noted [redacted] b6-2

2400 @ 0230 4 July 03 Orders noted [redacted]

3 July 03

b6-2

ENT IDENTIFICATION

SING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

CLINICAL RECORD - DOCTOR'S ORDERS

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

NT IDENTIFICATION

[redacted] b6-4

DATE OF ORDER: 5 JUL 03 TIME OF ORDER: 0836 HOURS

- NPO after midnight ✓
- Rx Zaxe b6-2
- DC Foly [redacted]

LIST TIME ORDER NOTED & SIGN: noted 0900 [redacted] b6-2

NG UNIT | ROOM NO. | BED NO.

NT IDENTIFICATION

DATE OF ORDER: 5 JUL 03 TIME OF ORDER: 1812 HOURS

- Colace (OT) BID
- Replace Foly
- Noted Sig [redacted] b6-2

NG UNIT | ROOM NO. | BED NO.

NT IDENTIFICATION

DATE OF ORDER: 5 JUL 03 TIME OF ORDER: 2030 HOURS

NPO after midnight

[redacted] b6-2

Noted Sig [redacted] b6-2

5 July 03 24 hr @ 2155 orders noted Sig [redacted]

NG UNIT | ROOM NO. | BED NO.

NT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

NG UNIT | ROOM NO. | BED NO.

CLINICAL RECORD

[redacted] b6-4

DATE OF ORDER 5 JUL 03 TIME OF ORDER 0936

- Return to Ward
- (1) Dx s/p GSW to flank ✓
- (2) Condition Stable ✓
- (3) Diet Advance to Regular ✓
- (4) IVF NS @ 125 cc/h - ✓
  50 c/h when tolerating PO ✓
- (5) Labs CBC / Chem 8 / CPT on Monday AM ✓
- (6) Ambulate with assistance ✓
- (7) Dressing changes BID ✓
- (8) CXR in AM Monday ✓
- (9) - MSO4 q 2-4 g IVP q 2° ✓
  - Percocet 1-2 tabs PO q 4° PRN ✓
  - Tylenol 650 g PO q 4° PRN ✓
- (10) Foley to gravity drainage ✓
- (12) Incentive Spirometer 10x q h while awake ✓
- Dr [redacted] b6-2

Noted 6 Jul 03 @ 1000 SGT [redacted] b6-2

[redacted] b6-4

[redacted] b6-4

[redacted] b6-4

DATE OF ORDER TIME OF ORDER

- Cyprofloxacin 500 g PO BID ✓
- Hytrin 5 g PO q HS ✓
- Colace 100 g PO BID ✓

DATE OF ORDER TIME OF ORDER

NKDA [redacted] b6-2

24°C @ 2025 5 July 03 Orders noted SGT [redacted] b6-2

7 July 03 10 mg Ambien PX1 dose V.O. SGT [redacted] b6-2

24°C @ 0029 8 July 03 Orders noted SGT [redacted] b6-2

DA FORM 4256

[redacted] b64

JK B 0945

Please keep patient until full and pull cycle

Transfer to ward after test

Dx: S/P OSW to abd

Activity Ambulate c̄ assistance PRN

Diet Regular

Meds

[redacted] b64

(1) MSO4 2-4g IVP q 2° PRN pain

(2) phenergan 12.5g IV or 25g PO q 6° PRN nausea

(3) Ciprofloxacin 500g PO BID

[redacted] b64

(4) Hytrin 5g PO q HS

(5) Colace 100g PO BID

(6) Percocet 1-2 PO q 4° PRN

DC central line before transfer

[redacted] b64

Dressing changes BID

Keep OR/arm elevated while in bed

MEDA b62 b62

Dr [redacted]

VS q 8° b62 [redacted]

notify Dr [redacted]

T > 101.5

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

CPW [redacted] b64

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 4

DATE OF ORDER: 12 JUL 03 | TIME OF ORDER: 1608 HOURS | LIST T ORDE NOTED SIGN

RAN 20g RO QQH HS

b62 [redacted]

b62 [redacted]

noted [redacted] b62

9MWM6 12July03 1614

PATIENT IDENTIFICATION

24°VS [redacted]

EPW [redacted] b64

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 4

DATE OF ORDER: 15 JULY 03 | TIME OF ORDER: 1613 HOURS

① DP + LZP ② WMSR ~ S/A OR 75.

b62 [redacted]

noted [redacted]

9MWM6 15 July 03 1634

PATIENT IDENTIFICATION

EPW [redacted] b64

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 4

DATE OF ORDER: 16 July 03 | TIME OF ORDER: 2415 HOURS

① V.O. Dr. [redacted] b62 25mg Benadryl P.O. now for itching

b62 [redacted] 9MWM6

b62 noted [redacted] 2420 16 July 03

24V [redacted] 16 July 03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

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

PATIENT IDENTIFICATION

[redacted] b64

DATE OF ORDER 16 July 03 TIME OF ORDER 2245 HOURS

Benadryl 25mg i po q 6° PRN pruritis [redacted] b62 noted [redacted] 2255 16July03

[redacted] b62 [redacted] b62

NURSING UNIT 1CW2 ROOM NO. BED NO. 4 2W

[redacted] 17July03

PATIENT IDENTIFICATION

[redacted] b64

DATE OF ORDER 17 July 03 TIME OF ORDER HOURS

Tylenol 325mg ii po q 4-6° PRN pain instead of Percocet [redacted] b62 noted 17July 2300

b62 [redacted]

NURSING UNIT ROOM NO. BED NO. 2W

b62 [redacted] 18July03

PATIENT IDENTIFICATION

[redacted] b64

DATE OF ORDER 21 JUL 03 TIME OF ORDER HOURS

Teach patient to Change own dressing. Transfer to 2PW camp after final evaluation by ortho [redacted] b62 noted [redacted] 21July03 0935

NURSING UNIT 1CW2 ROOM NO. BED NO.

[redacted] b62

PATIENT IDENTIFICATION DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT ROOM NO. BED NO.

DD FORM 1 JUL 79 4275 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED

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. Jun 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 Jun	------	Chest PT q 2°	02	/	[redacted]				
	------		04	/					
	------		06	/					
	------		08	/					
	------		10	/					
	------		12	/					
	------		14	/					
	------		16	/					
	------		18	/					
	------		20	/					
	------		22	[redacted]					
	662		24	[redacted]					
23 Jun 03	[redacted]	↓ MAINTENANCE IV (NS) @ 75cc/h	05	/	[redacted]				
	662		17	/					
24 Jun 03	[redacted]	Δ ALBUTEROL NEB TX TO (0.5cc/2.5cc NS)	08	/	/	/	[redacted]		
	------	q 6° & Chest PT	14	/	/	/			
	------		20	/	/	[redacted]			
	------		02	/	/				

	------								

662 662 662 662

Changed 24 Jun 03

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

S/P Exp Lap (GSW) / I & D (L) Forearm

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW # [redacted]

564

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

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*

DATE COMPLETED: 18 19 20 21 22 23 24 25 26 27 28

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
18 JUN	[redacted]	VS AND I&O Q 1°	05 / 17	[redacted]
18 JUN	[redacted]	ACT: BEDREST	05 / 17	[redacted] Δ'd 23 JUN
18 JUN	[redacted]	DIET: NPO	05 / 17	[redacted] Δ'd
18 JUN	[redacted]	NGT TO LIS	05 / 17	[redacted] DC'd
18 JUN	[redacted]	FOLEY CATH TO URINATE	05 / 17	[redacted] D/C'd
18 JUN	[redacted]	ELEVATE (L) ARM ON PILLOW.	05 / 17	[redacted]
18 JUN	[redacted]	TCDB Q 1°, IS 10-20 PER HOUR.	05 / 17	[redacted]
18 JUN	[redacted]	CBC, CHEMLYTE NOW THEN QAM.	05 / 17	[redacted]
18 JUN	[redacted]	CALL MD FOR T > 101 P < 60 OR > 110, SBP < 100 OR > 165 U.O. < 30 cc/HR.	05 / 17	[redacted]
21 June 03	[redacted]	Diet advance to clear liq.	05 / 17	[redacted] D/C'd 22 Jun 03
22 June 03	[redacted]	DIET: NPO (for washout (L) FOREARM)	05 / 17	[redacted] Δ'd
22 Jun	[redacted]	Advance to clear liquids	05 / 17	[redacted] Δ'd 23 Jun 03

all 66-2

all 66

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P EXLAP GSW / I&D (L) FA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ______

PATIENT IDENTIFICATION:

EPW # [redacted] 66-4

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

MEDCOM - 11395

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
18 Jun	[redacted]	ADMIT TO ICU #2 LOWRY/ALBERTSON				
	[redacted]	DX S/P EXP LAP GSW / I&D ⓛ FA				
		COND: STABLE				
20 Jun	[redacted]	Metlyte 8 now	20 Jun	Now	0925	[redacted]
20 Jun	[redacted]	Resume Previous orders, Condition Stable			1030	[redacted]
21 June	[redacted]	NGT DC'd	21 June 03	1735	1735	[redacted]
21 June 03	[redacted]	LFT, Metlyte 8, CBC in AM	22 June 03	0100	0100	[redacted]
22 Jun	[redacted]	LFT, Metlyte 8, CBC in AM	23 Jun	0400	done	[redacted]
22 Jun	[redacted]	Resume all previous orders	22 Jun	now		[redacted]
23 Jun	[redacted]	CXR PA & LAT	23 Jun	today	1100	[redacted]
23 Jun	[redacted]	D/C Foley Cath	23 Jun	today	1015	[redacted]
24 June	[redacted]	CT today	24 June 03	today	2100	[redacted]
25 June 03	[redacted]	T&S for 2u PRBC	25 June 03	now	1045	[redacted]

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

USAPA V1.00

CLINICAL RECORD

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

Mo/Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18
18	[redacted] b6-2	Vitals: per routine	05	[redacted] b6-2
			13	
			21	
	[redacted] b6-2			
18		Diet: NPO	07	[redacted]
			12	[redacted] b6-2
			18	
	b6-2			
18	[redacted]	Act: Bedrest c guard	05	[redacted] b6-2
			13	
			21	

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
GSW (L) ARM, GSW (R) FLANK

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

PATIENT IDENTIFICATION:
EPW # error [redacted] [redacted] b6-4
[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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo June Yr 2003
Order Date	Clerk Nurse	b6-2 SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
18	[redacted]	Admit to ICW2	18	today	0600	[redacted]
18	[redacted]	Condition: Guarded	18	—	—	[redacted]
	-----	b6-2				

	-----					

b6-2

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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

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

Mo. 6 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27	28	29	30	1 Jul	2	3	4	5	6	7	8
25 JUN	[redacted]	VS q 1 hr including	05	/	[redacted]												
		pulse ox & I&O	17	[redacted]													
25 JUN	[redacted]	Activity BR	05	/	[redacted]												
			17	[redacted]													
25	[redacted]	Diet NPO	05	/	[redacted]												
			17	[redacted]													
25	[redacted]	Foley to gravity	05	/	[redacted]												
		NGT to LIS	17	[redacted]													
25	[redacted]	IS 10 x qhr	05	/	[redacted]												
		while awake,	17	[redacted]													
		TCDB q 1°															
25	[redacted]	CBC, Chem 8,	05	/	[redacted]												
		Liver panel q am		[redacted]													
25	[redacted]	JP to bulb	05	/	[redacted]												
		suction	17	[redacted]													
25	[redacted]	Record JP output	05	/	[redacted]												
		q 2 hrs & strip	17	[redacted]													
25 Jun	[redacted]	Call MD for UO <30cc	05	/	[redacted]												
		HR >120 <50 SBP >	17	[redacted]													
		160 <90 DBP >90 <60															
		RR >30 <10 T >100.4															
26 June	[redacted]	D5G Δ dly W/D NS	10	/	[redacted]												
26 June	[redacted]	CXR qAM x 3 days	04	/	/	/	[redacted]										
30 Jun	[redacted]	CXR qAM x 3 day (PA & lat)	04	/	/	/	/	/	[redacted]								
30 Jun	[redacted]	Diet: clear liquid	06	/	/	/	/	/	[redacted]								
			11	/	/	/	/	/		/							
			17	/	/	/	/	/	[redacted]	/							

b6-2

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: S/P Ex lap w/ wound exploration

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

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
25 JUN	[redacted]	Admit to ICU #2	25 Jun	1945	1945	[redacted]
25 JUN	[redacted]	condition stable b6-2	25 June 03	1945	1945	[redacted]
25 JUN	[redacted]	Gen Surg Dr. [redacted]	25 June 03	1945	1945	[redacted]
25 JUN	[redacted]	CBC, Chem 8 now [redacted]	25 June 03	2000	2000	[redacted]
25 June	[redacted]	CXR in AM	26 June		done	[redacted]

	-----					

b6-2

b6-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
25 JUN	[redacted]	Call MD for														
-----	-----	UO < 30cc, HR > 120														
-----	-----	< 50; SBP > 160 < 90														
-----	-----	DBP > 90 < 60;														
-----	-----	RR > 30 < 10														
-----	-----	T > 100.4														
-----	-----															
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b6-2

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 6 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	July 30	1	2	3	4	5	6	7						
30Jun	[redacted]	CXR qAM x 3days	04	/	[redacted]												
		(PA/Lat) in XR	/														
30Jun	[redacted]	OOB TID (ambulate	05	/	[redacted]												
		w/ assistance)	17	[redacted]													
25JUN03	[redacted]	I/S Q1° c̄ SPO and HOB	05	/	[redacted]												
5Jul03	[redacted]	VS Q Shift	17	/	[redacted]												
25JUN03	[redacted]	Foley to Gravity	05	/	[redacted]												
			17	/	[redacted]												
25JUN03	[redacted]	IS q1° x10 while awake	05	/	[redacted]												
		FCDB Q1°	17	/	[redacted]												
25JUN03	[redacted]	CBC, Chem 8, LFT qAM	04	/	[redacted]												
25JUN03	[redacted]	JP to bulb suction	05	/	[redacted]												
	[redacted]		17	/	[redacted]												
25JUN03	[redacted]	Record JP output Q2 hrs	05	/	[redacted]												
		and strip	17	/	[redacted]												
25JUN03	[redacted]	Call MD for UOP<30cc/hr	05	/	[redacted]												
		HR >120 or <50, SBP >200 <90;	17	/	[redacted]												
		ABP >90<60, RR >30<10, T >100.4															
25JUN03	[redacted]	ABD dressing Δ QD, wet today	10	/	[redacted]												
1Jul03	[redacted]	Regular diet c̄ Ensure	05	/	[redacted]												
		shakes twice daily	17	/	[redacted]												
3Jul03	[redacted]	Ambulate as tolerated	05	/	/	/	[redacted]										
			17	/	/	/	[redacted]										
5Jul03	[redacted]	NPO p MN	05	/	/	/	/	/	[redacted]								
			17	/	/	/	/	/	[redacted]								

Dtd 4Jul03 0935 [redacted]

Dtd 4Jul03 0935 [redacted]

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: SIP Exp Lap; wound exploration

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

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

b6-4

b6-4

b6-4

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
1Jul 03	[redacted]	Infuse 2 units PRBC slowly over 6°	1-Jul-03	NOW	1000	[redacted]
5Jul03	[redacted]	NPO P̄ Midnight	6Jul03	0000		
5Jul03	[redacted]	D/C Foley			0900	[redacted]

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 6	7	8	9	10	11	12	13	14	15	16	17	18	19
6Jul03	[redacted]	Diet: Advance to regular	07	[redacted]													
			11														
			17														
6Jul03	[redacted]	Ambulate with Assist.	05														
			17														
6Jul03	[redacted]	Dressing Change BID	10														
			22														
6Jul03	[redacted]	Foley to Gravity	05														
		drainage	17														
6Jul03	[redacted]	Incentive Spirometer	05														
		10x qh while awake	17														
6Jul03	[redacted]	Vital Signs q Shift	05														
			17														

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: S/P GSW to (R) flank

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

b6-4

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo July Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6JUL03	[redacted]	Condition STABLE / return to WARD				
6JUL03	[redacted]	CXR in A.M (Monday)	7JUL	0400	Done	
6JUL03	[redacted]	LABS: CBC / Chem8 / LFT	7JUL	0400		

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

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mdumey r. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18
18	[redacted]	IVF: NS @ 125cc/hr	05	[redacted] b6-2
	b6-2		13	
			21	
	b6-2			
18	[redacted]	Ancef 1gm 8hr	4	/
		IVPB	10	[redacted] b6-2
			16	
			22	

ALLERGIES: ☐ YES ☒ NO

KNDA

PRIMARY DIAGNOSIS: GSW to (L) ARM, GSW to (R) Flank

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW # [redacted] b6-4

ICW2

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo._____ Yr. _____
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
	- - - - -					
	- - - - -					
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	- - - - -					
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	- - - - -					
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Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
18	[redacted]	4 mg MSO4 IVP														
	0600	Q 2° PRN for pain														
- - - - -	- - - - -															
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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. 6 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19	20	21	22	23	24	25	26
18 JUN	[redacted]	IV LR @ 125 cc/HR	05	[redacted]						Fluid D'C 22 Jun 03		
			17	[redacted]								
18 JUN	[redacted]	MNOSYN 3 GRAMS	04	[redacted]								
		IVPB Q 6°	10	[redacted]								
			16	[redacted]								
			22	[redacted]								
18 JUN	[redacted]	ZANTAC IV 50MG	08	[redacted]								
		Q 8° 14	14	[redacted]								
			22	[redacted]								
18 JUN	[redacted]	TORADOL 30MG IV	04	[redacted]								
		Q 6°	10	[redacted]								
			16	[redacted]								
			22	[redacted]								
~~18 Jun~~	~~[redacted]~~	~~PHENERGAN 25MG IV~~										
		~~Q~~										
17 JUN 03	[redacted]	Albuterol NEB Tx - 0.5cc/	06	[redacted]								
		2.5cc NS, Now then Q6°	12	[redacted]								
			18	[redacted]								
			24	[redacted]								
22 Jun 03	[redacted]	IV NS @ 125cc/hr	05	[redacted]								
			17	[redacted]								
22 Jun	[redacted]	Albuterol neb Tx	04	[redacted]								
		to (0.5cc/2.5cc NS)	08	[redacted]								
		q 4° c̄ nasal suctioning	12	[redacted]								
		~~and chest PT~~	16	[redacted]								
		Chest PT D'd only	20	[redacted]								
			24	[redacted]								

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P exlap GSW / JID (L) FA

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

b6-2 b6-2 b6-2 b6-2 b6-2 b6-2

CLINICAL RECORD

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

Mo. 6 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19	20	21	22	23	24	25	26
18 JUN	[redacted]	IV LR @ 125 cc/HR	05	[redacted]						Flud D'C 22 Jun 03		
			17									
18 JUN	[redacted]	UNASYN 3 GRAMS	04									
		IVPB Q 6°	10									
			16									
			22									
18 JUN	[redacted]	ZANTAC IV 50MG	06									
		Q 8°	14									
			22									
18 JUN	[redacted]	TORADOL 30MG IV	04									
		Q 6°	10									
			16									
			22									
~~18 JUN~~	[redacted]	~~PHENERGAN 25MG IV~~										
		~~Q~~										
17 JUN 03	[redacted]	Albuterol NEB Tx - 0.5cc/	06		[redacted]							
		2.5cc NS, Now then Q6°	12									
			18									
			24									
22 JUN 03	[redacted]	IV NS @ 125cc/h	05					[redacted]				
			17									
22 Jun	[redacted]	Albuterol neb Tx	04									
		to (0.5cc/2.5cc NS)	08									
		q 4° c̄ nasal suctioning	12									
		~~and chest PT A'd~~	16									
		Chest PT A'd Only	20									
			24									

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P exp GSW / JID (L) FA

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

b6-2

b6-2

b6-2

b6-2

all 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
24 June	[redacted]	MS04 5mg X1 dose	24 June 03 ~~1800~~	1800	1800	[redacted]

all b6-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
18 June	[redacted]	MORPHINE SULFATE	18 June 4mg		19 June 3mg 0255	19 June 0300 3mg		19 June 0800	19 June 1200	19 June 2131 2mg		20 June 03 4mg 2443	20 June 0950 4mg 1110	20 June 1402 2mg	21 June 1000 4mg	21 June 1330 2mg
	[redacted]	2-4MG IV Q 3° PRN PAIN	1730													
18 June	[redacted]	PHENERGAN 25 MG	18 June 23													
		IV Q 4° PRN/IM [illegible]	25mg 1330													
18 June	[redacted]	Tylenol 650mg PR Q 4°	1600	1100	19 June 1846	21 June 1546		22 June 650mg	22 June 650mg	23 June 650mg	24 June 650mg					
		PRN Temp >101	18 June		PR											
18 June	[redacted]	Morphine 2-4mg IV	21 June 3mg 2143	0935 4mg	22 June 2005 3mg		22 June 1450 2mg	23 June 2118 2mg	23 June 1630 5mg	24 June 2100 2mg		25 June 0155				
		Q 3° prn pain														
24 June	[redacted]	Tylenol 650mg po q	25 June 03 0120 650mg													
		4° prn														

all b6-2

all b6-2

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all b6-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. JUN Yr. 03

Verify by Initialing						
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
26 Jun	[redacted]	PHENERGAN 25mg IV NOW	26 Jun	NOW	0730	[redacted]
26 June	[redacted]	Ativan 2mg IV now	26 June	NOW	1800	[redacted]
27 June	[redacted]	Lasix 20mg IV ÷ @ 2000	27 June	20	20	[redacted]

all b6-2

all b6-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
25 Jun	[redacted]	MSO4 1-4mg IV q 1hr prn pain	25 June 03 2016 2mg [redacted]; 25 June 03 2033 2mg [redacted]; 25 June 03 2115 4mg IV [redacted]; 25 June 03 2301 4mg IV [redacted]; 26 June 0011 4mg IV [redacted]; 26 June 0013 4mg IV [redacted]; 26 June 0205 4mg IV [redacted]; 26 June 0454 4mg IV [redacted]; 26 June 0845 4mg IV [redacted]; 26 June 0445 4mg IV [redacted] → 26 Jun 0600 4mg [redacted]
25 Jun	[redacted]	Phenergan 25mg IV q 4-6 hrs prn nausea	26 Jun 1796 4mg; 26 Jun 1621
25 Jun	[redacted]	Tylenol Supp. 650mg pr q 4° prn / T > 101	25 June 03 1950 650mg [redacted]; 25 June 03 2330 650mg [redacted]; 26 June 0405 650 [redacted]; 26 June 1631 650mg [redacted]; 26 June 2235 650mg [redacted]; 26 June 0311 [redacted]; 27 Jun 0330 650 [redacted]; 27 June 03 1900 650 [redacted]; 27 June 03 650 [redacted]; 27 June 03 650 PR [redacted]
25 Jun	[redacted]	MSO4 1-4mg IV q 1° prn PAIN	25 June 03 @0335 3mg IV [redacted]; 25 June 03 3mg IV [redacted]; 27 Jun 03 4mg [redacted]; 27 June 03 4mg 1903 [redacted]; 28 June 03 0357 4mg [redacted]
26 June	[redacted]	Ativan 2mg IV q 6° prn / anxiety	

all b6-2

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. Jun Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	27	28	29	30										
27 Jun 03	[redacted]	IV NSS 50cc/hr	05	[redacted]													
			17	[redacted]													
27 Jun	[redacted]	Albuterol neb .5cc/2.5cc	06	[redacted]													
		NS & CPT q 6°	12	[redacted]													
			18	[redacted]													
			24	[redacted]													
27 Jun	[redacted]	Toradol 30mg IV	06	[redacted]													
		q 6°	12	[redacted]													
			18	[redacted]													
			24	[redacted]													
27 Jun		Zantac 50mg IV q8°	06	[redacted]													
			14	[redacted]													
			22	[redacted]													
27 Jun	[redacted]	Morphine gtts	05	[redacted]													
		1mg/hr	17	[redacted]													
27 Jun	[redacted]	FORTAZ 2gm IVPB	06	[redacted]													
		q 8°	14	[redacted]													
			22	[redacted]													
27 Jun	[redacted]	Gentamycin 5mg/kg	10	[redacted]													
		IVPB qd	10	[redacted]													
28 June	[redacted]	Ceftotaxi 1gm q12°	10	[redacted]													
		IV	22	[redacted]													
27 June		Zantac 50mg IV q8°	06	[redacted]													
			14														
			22														

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27-Jun-03 — Renitha [redacted] 29-Jun-03 — Renitha [redacted] 29-Jun-03 — Renitha [redacted] 29-Jun-03

Aid due to pharmacy out of Med entered below — Aid due to pharmacy out of Med

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: S/P Ex lap wound exp.

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

PATIENT IDENTIFICATION: EPW # [redacted] 664

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. June Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
27 Jun	[redacted]	Lasix 20mg IV x 1 now	27 June	1345	1400	[redacted]	all 66-2
27 Jun	[redacted]	Fortaz given @ 1600	27 June	1345	1600	[redacted]	
28 Jun	[redacted]	Lasix 20mg IV now	28 Jun	now	0855	[redacted]	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
27 Jun	[redacted]	MSO4 1-4mg	27 Jun 1400 4mg	27 Jun 1900 2mg	28 Jun 1610 2mg	28 Jun 1730 4mg	28 June 0430 3mg									
-----	-----	IV q 1 hr	[redacted]	[redacted]	[redacted]	[redacted]										
-----	-----	PRN PAIN														
27 Jun	[redacted]	phenergan 25mg														
-----	-----	IV q 4-6 PRN														
-----	-----	nausea														
27 Jun	[redacted]	Tylenol supp 650mg	27 Jun 650mg PR 1400		28 Jun 1610 650mg PR	28 June 2335 650mg RTV										
-----	-----	PR q 4° PRN T >101	[redacted]		[redacted]	[redacted]										
-----	-----	Ativan 2mg														
27 Jun	[redacted]	IV q 6° PRN														
-----	-----	anxiety														
-----	-----															
-----	-----															

Rebecca [redacted] 27-Jun-03

all 66-2

USAPA V1.00

CLINICAL RECORD

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

Mo. 06 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 29	30	1	2	3									
29-JUN-03	[redacted]	IV LR @ 100cc/hr	05	[redacted]													
			17	[redacted]													
28-JUN-03	[redacted]	Cefotaxim 1/1 gm Q12° IV	10	/	[redacted]				D/C 3JUL03								
			22	[redacted]					[redacted] SGT Plume								
27-JUN-03		Gentamycin 5mg/kg IVPB QD	10	/	[redacted]				D/C 3JUL03								
26-JUN-03	[redacted]	MSO4 gtt 1mg/hr	5	[redacted]			Rel[redacted]		[redacted] SGT Plume								
			17	[redacted]													
26-JUN-03	[redacted]	Zantac 50mg IV Q8°	06	/	[redacted]												
			14	[redacted]													
			22	[redacted]													
26-JUN-03	[redacted]	Tordol 30mg IV Q6°	6	/	[redacted]												
			12	/	[redacted]				D/C 3JUL03								
			18	[redacted]					[redacted] SGT Plume								
			24	[redacted]													
25-JUN-03	[redacted]	Albuterol neb 0.5cc/125cc	6	/	[redacted]												
		NS ē CPT Q6°	12	/	[redacted]				D/C 3JUL03								
			18	[redacted]					[redacted] SGT Plume								
			24	[redacted]													
26-JUN-03	[redacted]	MSO4 gtt 1mg/hr	05	[redacted]					D/C 3JUL03								
			17	[redacted]					[redacted] SGT Plume								
1-JUL-03	[redacted]	Nystatin Swish & Spit 4ml QID	10	/	/	[redacted]											
			22	/	/	[redacted]											

b6-2 b6-2 b6-2 b6-2 b6-2 b6-2

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P ER CAP/GSW/ Wx debridement and closure

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

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
22 June	[redacted]	LR 500cc Bolus	22 June	Now	2230	[redacted]
1 July 03	[redacted]	Penicillin c̄ Tylenol 650mg P.O. and Bactrim 5mg/kg	1 July	Now	0930	[redacted]
30 Jul 03	[redacted]	D/C Torado l				
30 Jul 03	[redacted]	D/C Gent				
30 Jul 03	[redacted]	D/C Cefotetan		1610		
30 Jul 03	[redacted]	D/C Continous MSO4 drip			[redacted]	
30 Jul 03	[redacted]	D/C Abuterol Nebulizer				
30 Jul 03	[redacted]	D/C Chest PT				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
26 June 03	[redacted]	Ativan 2mg Q6° PRN Anxiety	Date/Time	26 June 03 2230	27 June 03 0230											
-----	-----		Dose/Int.	[redacted]	2mg	[redacted]										
26 June 03	[redacted]	Phenergan 25mg IV Q4h	Date/Time													
-----	-----	PRN Nausea	Dose/Int													
25 June 03	[redacted]	Tylenol supp. 650mg PR Q	Date/Time	25 June 03 1630	30 June 03 0115	30 June 03 [redacted]	1 July 03 0650 RTU									
-----	-----	4° PRN / T>101	Dose/Int	650mg	[redacted]	[redacted]	[redacted]									
25 June	[redacted]	MSO4 1-4mg IV Q1°	Date/Time	25 June 03 2000	30 June 03 0945	30 June 03 1055	30 June 03 1602	30 June 03 1935	30 June 03 [redacted]	1 July 03 1400	1 July 03 1830	1 July 03 2200				
-----	-----	PRN Pain	Dose/Int	4mg	[redacted]	[redacted]	3mg	[redacted]	[redacted]	2mg	[redacted]	4mg				
-----	-----		23 June 03	23 June 03 2mg	23 June 03 2mg	23 June 03 2mg	23 July 03 2mg	30 July 03 0955 3mg	30 July 03 0955 4mg	30 July 03 1830 3mg	30 July 03 1455 3mg					
-----	-----		1130	1360	1540	4mg	2mg	[redacted]	[redacted]	[redacted]	[redacted]					
-----	-----		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]									
-----	-----															
-----	-----															
-----	-----															

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. 07 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5	6	7	8	9	10	11	12	13	14	15	16
29JUN03	[redacted]	IV LR @ 100cc/hr	05	[redacted]													
			17	[redacted]													
30JUN03	[redacted]	Ciprofloxacin 500mg	10	/	[redacted]												
		PO BID	22	[redacted]													
26JUN03	[redacted]	Zantac 50mg IV Q8°	06	/	[redacted]												
			14	/	[redacted]		D/C 5JUL03										
			22	[redacted]			@ 0900				[redacted]						
1JUL03	[redacted]	Nystatin Swish + Spit	10	/	[redacted]												
		4ml BID	22	[redacted]													
5JUL03	[redacted]	Colace 100mg po	10	/	/	/											
		BID	22	/	/	[redacted]											

b6-2 b6-2 b6-2 b6-2

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: S/P Ex LAP/GSW/wound debridement and Closure

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

PATIENT IDENTIFICATION:

#[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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo._____ Yr._____
Order Date	Clerk/ Nurse	b6-2 SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
4 July	[redacted]	Ambien ½ tab 5mg	4 July 03	2215	2118	[redacted]	b6-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
3 Jul 03	[redacted]	MSO4 2-6mg IVP	3 Jul 03 4mg 1600	3 Jul 4mg 2100	4 Jul 2mg 0200	4 Jul 03 3mg 1000	4 Jul 0000 0200 IVP	5 Jul 03 4mg IVP 1015	5 July 6mg	5 July 03 5mg IVP	6 July 6mg	6 July 03 5mg IVP	6 July 03 5mg IVP	6/7/03 0130	
		Q1° PRN Pain	[redacted]				[redacted]		2145	[redacted] 0030		0145 [redacted]	0345 [redacted]	(7)	
3 Jul 03	[redacted]	Percocet I-II tabs	3 Jul 03 1640 I PO	3 Jul 2100 II PO	4 Jul II PO 0500	4 Jul II PO 1030	4 July II 1500	4 July 2050 II	5 July II 0305	5 Jul 03 0710 II	5 Jul 03 1400 II	5 July 03 1900 II	5 July 03 2015 II		
		PO Q 4° PRN Pain	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		
3 Jul 03	[redacted]	Albuterol MDI													
		2 Puff Q4° PRN													
4 July	[redacted]	Ambien 10mg I													
		po prn Insomnia													

b6-2

b6-2

b6-2

USAPA V1.00

b6-2 b6-2 b6-2

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 06	07	08	09	10	11	12	13	14	15	16	17	18	19
6Jul03	[redacted]	IVF: NS @ 125cc/hr ↓	05	[redacted]													
		50 cc/hr when tolerating PO	17	[redacted]													
6Jul03	[redacted]	Ciproflaxin 500mg PO BID	10	[redacted]													
			22	[redacted]													
6Jul03	[redacted]	Colace 100mg PO BID	10	[redacted]													
			22	[redacted]													
6Jul03	[redacted]	Hytrin 5mg PO QHS	22	[redacted]													

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
S/P GSW to (R) flank

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

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
7July03	[redacted]	Ambien 10mg X1 dose	7July03	2230	2230	[redacted] b6-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
6Jul03	[redacted]	MSO4 2-4mg IVP Q2°	6Jul03 1040 2mg IV [redacted]	6Jul03 1530 4mg IV [redacted]	6July03 1920 4mg IV [redacted]	6July03 2325 4mg [redacted]	7July03 0000 [redacted]	7July03 0045 3mg IV [redacted]	7July03 0400 4mg IV 0205 [redacted]	7July03 0820 4mg IV [redacted]	7Jul 0720 3mg IVP [redacted]	7Jul 1450 3mg IVP [redacted]			
6Jul03	[redacted]	Percocet 1-2 Tabs PO Q4° PRN	6Jul03 1050 2Tab PO [redacted]	6Jul03 1550 2Tab PO [redacted]	6July03 2039 2Tab [redacted]	7July03 0250 [redacted]	7Jul 0640 [redacted]	7Jul03 1240 [redacted]	7July03 1925 [redacted]						
6Jul03	[redacted]	Tylenol 650mg PO Q4° PRN	7Jul03 0525 650mg PO [redacted]	7Jul 1115 650 mg PO [redacted]	7July03 1804 [redacted]	7July03 2039 [redacted]									
6July03	[redacted]	MSO4 2-4mg IVP Q2°	7July03 2050 4mg IV [redacted]	7July03 0110 3mg IV [redacted]	7July03 0400 4mg IV [redacted]		0703 8Jul03 IV 4mg [redacted]	0903 8Jul03 IV 3 [redacted]	1100 8Jul03 IV 4mg [redacted]						

b6-2

b6-2

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 23	24	25										
23 Jul 03	[redacted]	ADVANCE TO REGULAR DIET	05	[redacted]												
			17	[redacted]												
23 Jul	[redacted]	AMBULATE c̄ ASSISTANCE QID	04	[redacted]												
		(PHYSICAL THERAPY TO ASSIST c̄	10	[redacted]												
		AMBULATION)	16	[redacted]												
			22	[redacted]												
25 JUN 03	[redacted]	NPO	07	/	/	[redacted]										
			12	/	/	[redacted]										
			17	/	/											

b6-2 b6-2 b6-2 b6-2 b6-2

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
S/P EXP LAP GSW / I&D (L) FOREARM

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

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

the proponent agency is the Office of The Surgeon General. MO. YR 2003

RIFY BY INITIALING			INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION													
ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED												
				22	23	24										
20July	[redacted] b6-2	Activity: Ambulate c assistance TID	6													
			13													
			21													
20July	[redacted] b6-2	Regular Diet	6													
			12													
			17													
20July	[redacted] b6-2	Dring A's BID	10													
			22													
20July	[redacted] b6-2	Keep R arm ↑'d while in bed	5													
			17													
20July	[redacted] b6-2	VS q 8	6													
			13													
			21													
20July	[redacted] b6-2	Notify Dr Gesauer if T > 101.5	5													
			17													

[redacted] b6-2

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: S/P GSW to abd (R) arm c cast

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

#[redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIME

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

Date	Nurse		be Given	be Given		

b6-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED															
17	[redacted]	Tylenol 325mg ii PO q 4-6° PRN pain instead of percocet	17 July 2200 [redacted]	18 July 2300 ii PO [redacted]	19 July 0100 ii PO [redacted]							[redacted]						
			b6-2															

b6-2

USAPA V1.00

all b6-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. t Yr. 03
Order Date	Clerk/ Nurse	b6-2 SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
16	[redacted]	25mg Benadryl PO now for itching	16 July	Now	2420	[redacted]	b6-2

b6-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
8 July 03	[redacted]	MSO4 2-4 mg IVP	T/D I	1100 07 July	0320	2100	Error [redacted]									
	b6-2	q 20 p.r.n. pain	M E	[redacted]												
8 July 03	[redacted]	Phenergan 12.5 mg IV	T I													
		12.5 mg or 25 mg PO.	M E													
		q 6° p.r.n. nausea														
8 July 03	[redacted] b6-2	Percocet 1-2 PO q 4°	T I	1130 8 July	0300	0400	0310	1500	1030	0520	1030	1130	0311	0745	0100	
		p.r.n.	M E	[redacted]												
8 July 03	[redacted] b6-2	Percocet 1-2 PO q 4°	13 July	1330	0100	0348										
copied		PRN	[redacted]													
8 July	[redacted] b6-2	Percocet 1-2 PO q 4° PRN	17 July	17 July 2006	17 July 0900	18 July 0400	18 July 0915	18 July	19 July 0310	19 July 0800						
			[redacted]													
16	[redacted] b6-2	Benadryl 25mg PO q 4° PRN pruritis	16 July 2280	17 July 0355	17 July 2345	17 July 0420	20 July 0945									
			[redacted]													

all b6-2

all b6-2

USAPA V1.00

b6-2

TRANSFER TO WARD [illegible] 5 [illegible]

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. 7 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 8	9	10	11	12	13	14	15	16	17	18	19	20	21
8JUL03	[redacted]	Ciprofloxacin 500mg	10	[redacted]													
		PO BID	22														
8JUL03	[redacted]	Hyfrin 5mg PO HS	22														
8JUL03	[redacted]	Celebrex 100mg PO BID	10														
			22														
12JUL03	[redacted]	Paxil 20mg po q HS	22	/	/	/	/	[redacted]									
60																	

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
SP GSW to abd

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

PATIENT IDENTIFICATION:
[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

b6-2

b6-4

all b6-2

b6-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo January Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8 Jan	[redacted]	O/G Test done 300 / 300 + 300	on O/G 8 Jan	1030	1030	[redacted]
8 Jul	[redacted]	D/C central line before transfer	8 Jul	[illegible]	0115	[redacted]
15 Jul	[redacted]	AP & LAT (L) wrist	15 Jul	today	1700	[redacted]
21 Jul	[redacted]	Teach pt to D OWN dsg. Transfer to	21 July	asap		
—	—	EPW camp after final eval by OR				

b6-2

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

USAPA V1.00

TRANSFER FROM WARD ORDERS 8JUL03

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. July Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	8	9	10	11	12	13	14	15	16	17	18	A	20	21
8JUL03	[redacted]	Activity: Ambulate	06	/	[redacted]												
		ĉ assistance TID	13	/													
		21	18	[redacted]													
8JUL03	[redacted]	Diet Regular	08	/													
			12	/													
			18														
8JUL03	[redacted]	Dressing Changes BID	10	[redacted]													
			22														
8JUL03	[redacted]	Keep (R) arm elevated	05														
		while in bed.	17														
8JUL03	[redacted]	VS q8:	06	/													
			14														
			22														
8JUL03	[redacted]	Notify Dr Torun if	05	/													
		T > 101.5°F	17														

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: 27
SIP GSW to ABD.

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

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

AL RECORD-SUPPLEMENTAL MEDICAL DATA

For use: ... 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: 25 June 03
Time In: 1945
Allergies: [illegible]
Pre-op V/S: 145 91
Procedures: Colectomy S/P Wound exploration

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

OR Intake: Crystalloid LR 900 Colloid
OR Output: UOP 1000 EBL 250
Meds/Times:

500 Heparin 20 1654 25 versed 45 Fent

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1945	1950	1955	2000	2005	2010	2015	2020	2025	2030	2035	2040	2045	2050
SaO2	94	97	97	100	95	96	95	95	97	97	99	100	99	99
FiO2	6	6	6	6	6	6	6	6	6	6	6	6	6	6
Methods	[redacted]													
240														
220														
200														
180														
160														
140	A	A	A	A	A	A	A	A	A	A	A	A	A	A
120														
100														
80	V	V	V	V	V	V	V	V	V	V	V	V	V	V
60														
40														
20														
RR	29	30	28	25	32	30	28	32	28	28	22	22	25	28
T	A													

b6-2

Time												
Pain (0-10)												
LOS												

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	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	1	1	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	5	8	10

Codes:
AIRWAY: A = Ambu; BB = Blow-by; M = Mask; FT = Face Tent; RA = RoomAir; NC = Nasal Cannula
V/S: X = A-line BP; " = Cuff BP; = Pulse
TEMP: S = Skin; O = Oral; A = Axillary; T = Tympanic; R = Rectal
LOS: C = Cervical; T = Thoracic; L = Lumbar; S = Sacral

PREPARED BY (Sig [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU#2/PACU

DATE: 25 June 03

b6-2

PATIENT'S ID [redacted] For typed or written entries give: first, middle; grade; date; hospital or medical facility) Name — last,

[redacted] b6-4

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

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

USAPPC V2.00

b6-2

MEDICATIONS

Allergies: NKDA

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1950	\	Tylenol 650mg	PR	\		[redacted]
2010	\	MS04 2mg	IV	\	E	[redacted]
2035	\	MS04 2mg	IV			[redacted]

NEUROVASCULAR

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

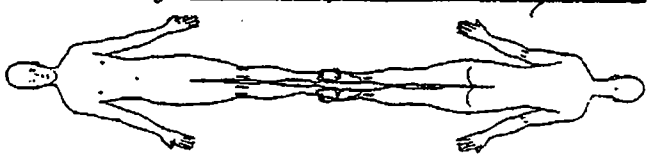
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1945	ABD/Chest	Midline	Ø
30' 2015	Midline	Midline	Ø
60' 2045	Midline	Midline	Ø
D/C 2050	Midline	Midline	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	~~Rhythm Strip Run?~~

WAMC OP 173-E

NURSING NOTES

1945 Admitted to ICU #2 from OR. Ambulatory to stretcher. IV @150cc/hr via central line. Central line DSG CDI. Central line = triple lumen S/S of infection or infiltration. Midline DSG CDI. (L) ARM DSG CDI. Foley to gravity = clear amber urine in foley bag. JP to bulb suction. (L) Nare nasal airway. (R) nare NG tube to low intermittent suction. PERRL @ 1mm eyes are jaundice. Pedal pulse present bil. R radial pulse (+). (L) unable to assess to DSG. (L) fingers can move. Cap refill < 2 sec @ fingernail bed on (L) hand. O2 @ 8L/min Face Mask (hidden) S: [redacted]

2000 JP tube 30cc bloody drainage emptied. 300cc output of foley. NOT to L/S. Ø drainage noted. Sig: [redacted]

b6-2

Discharge Criteria:
Date: 25 Aug 05 Time: 2100 PARS: 10
BP: 126/76 T: 101.9 HR: 110 RR: 28 Sa02: 97%
Pain Level at D/C (0-10):
Intake: @200 cc Output: 300cc
Additional Data:
Transferred To: ICU#2
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 6 Jul 03
Time in: 0930
Allergies: None
Pre-op V/S: 123/80 97
Procedures: Wound Closure + (L) Arm CAST

Anesthesia Type (Circle): General Spinal Epidural
IV Sedation Nerve Block
OR Intake: Crystalloid 900 Colloid
OR Output: UOP 250 EBL minimal
Meds/Times: 2mg Versed, 200 Fent, 300 Sodium Pentothal

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

Pre Op Meds

History

Time	0930	0935	0940	0945	0950	0955	1000	1005	1010	1015	1020	1025	1030
SaO2	94	99	99	97	99	99	98	97	98	94	98	95	99
FiO2	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L
Methods	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
240													
220													
200													
180													
160													
140													
120	^		^						^		^		
				^	^	^	^	^		^		^	^
100	•	^											
		•	•	•	•	•	•	•	•	•	•	•	•
80													
			✓						✓	✓	✓	✓	
60		✓		✓	✓	✓	✓	✓					✓
	✓												
40													
20													
RR	14	16	10	10	17	15	15	12	11	22	20	12	12
T	97												97
Time													
Pain (0-10)													
LOS													

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	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	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.	10	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)

b6-2 PREPARED BY (Signature & Title): [redacted] SGT 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 6 Jul 03

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

EPW [redacted] b6-4.

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

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

USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

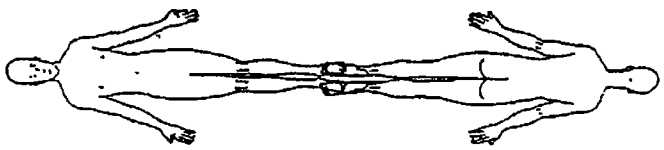
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	ABD	DSD	Shadow
30'	ABD	DSD	Shadow x2
60'	ABD	DSD	Shadow x2
D/C	AB	DSD	Shadow x2



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

0930 Recieved from OR via litter. Asleep heavily sedated but arousable. Monitors placed O_2 2L via NC to maintain SATs. HR Rate Tachy @ 108. Lungs clear bilaterally. Abd. ī DSD dressing ī shadow marked & timed. hypo active bowel sounds x4 quads. Able to move 4 ext. New cast to (L) UE. (-) restrictions able to wiggle fingers. Foley to gravity ī clear yellow urine. IV NS @ 125cc/hr into (R) Subclavian triple lumen. Will continue to monitor. [redacted] SGT 9/[illegible] b6-2
1000 Awake, A+O x3. Ø Complaints b6-2
Condition Stable. VSS. Afebrile. [redacted]
1030 A+O x3. D/c from recovery Status. Ø Complaints voiced. O_2 @ 2L NC removed. Will Continue b6-2
to monitor as ICU Patient. [redacted]

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **SaO2:**
Pain Level at D/C (0-10):
Intake:_____ **Output:**_____
Additional Data:_____
Transferred To:_____
Report Given To:_____
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:_____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:_____

Post-Anesthesia Care Unit (PACU) Flow Sheet

Date: 22 Jun 03
Time In: 1515
Allergies: NKDA
Pre-op V/S: 93 148/87
Procedures: (2) Foreskin Washout

Anesthesia Type (Circle): General Spinal Epidural
IV Sedation Nerve Block
OR Intake: Crystalloid 800 Colloid 0
OR Output: UOP 300 EBL nil
Meds/Times:

2 Ung Fentanyl
5mg MSO4 (1500)
500 Sodium Pentothal

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History ASA II (Obesity)

Time	1515	1520	1525	1530	1535	1540	1545	1550	1555	1600
SaO2	98	97	97	97	96	93	92	91	92	
FiO2	100	100	100	100	100	100	100	40	30	
Methods										
240										
220										
200										
180										
160										
140										
120										
100										
80										
60										
40										
20										
RR	37	26	32	31	29	28	27	29	27	
T	100					100		100	100	

Time	1515	1530	1600
Pain (0-10)	0/10	0/10	0/10
LOS			

Patient teaching done; Wound Care, Pain Management,
T, C, & D8, Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1600	RLD	300	ORL	[redacted]	—
					66-2

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	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	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	8	9

Codes

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

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

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

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

66-2 P[redacted]RY (Signature & Title) [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 22 Jun 03

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

[redacted] 66-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete
USAPPC V2.00

.25cg Terbutaline
Neb TX x4

all 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	(L) forearm	+	+	N/A	B	W	PK
15'	"	+	+		B	W	PK
30'	"	+	+		B	W	PK
45'	"	+	+		B	W	PK
60'	"	+	+		B	W	PK
90'							
D/C	"	+	+		B	W	PK

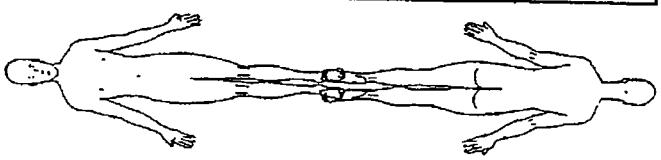
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm 1515	(L) Forearm	Ace wrap (Bulky)	-
30' 1530	" "	" " "	-
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1615	Foley Cath	dk amber urine	100cc

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1515	Tachy (118)	-	
1530	Tachy (100)	-	

NURSING NOTES

(1525 hrs) Patient arrived back from O.R. via litter. S/P I&D (L) forearm. SaO2 93% on 10L O2 via mask. (L) forearm c̄ bulky ace wrap dressing (C, D, I). Drowsy, but responds to mild stimuli & verbal commands. Initial PAR Score → 8. Central line SC Triple lumen patent c̄ IVNS @ 125cc/hr. Lungs c̄ Coarse breath sounds; c̄ wheeze. Abd remains soft, flat non-distended c̄ hyp-bowel sounds (+) flatulence. Foley cath to gravity drainage (dark amber urine). HR 118 (tachy) c̄ (-). Temp 100.3 ax. Will continue to recover post I&D intervention. [redacted] (1630 hrs) Pt more alert, although drowsy. Responds to all commands. PERRLA. No remarkable Δ's except for ↑ in secretions, to include nasal secretions & chest. Pt currently on 10L O2 via mask (non rebreather) → P.T. to re-evaluate @ 2000 hrs → Final PAR score 9

[redacted]

b6-2

Discharge Criteria:
Date: 22 Jun 03 Time: 1630 PARS: 9
BP: 131/72 T: 100.9 HR: 118 RR: 29 SaO2: 93%
Pain Level at D/C (0-10): 0/10
Intake: 30cc Output: 400cc
Additional Data: N/A
Transferred To: PCU #2
Report Given To: N/A
Transferred Via: W/C Litter Gurney Ambulance N/A
Transferred By: [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: **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

Date: 18 June 03
Time In: 1115
Allergies: NKDA
Pre-op V/S: 98/70 110
Procedures: Ex-lap; I+D (L) axm

Anesthesia Type (Circle): General Spinal Epidural ~~IV Sedation~~ Nerve Block
OR Intake: Crystalloid: 3L Colloid
OR Output: UOP 300cc EBL 250cc
Meds/Times: Sufenta 50mg, morphine 10, Unicem 3gm, Ancef 1gm, LR, Toradol

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

Airway: ~~Airway~~, Nasal, Oral, ETT, Trach, Other

Pre Op Meds History

Time	1115	1120	1125	1130	1135	1140	1145	1230	1235	1240
SaO2										
FiO2										
Methods										
240										
220										
200										
180										
160										
140										
120										
100										
80										
60										
40										
20										
RR	27	26	32	33	27			33		
T	98.6		98.4		100.5					
Time	1210									
Pain (0-10)										
LOS										

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	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 (0) Not responsive to stimuli	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)

PREPARED BY *(Signature & Title)* SGT [redacted] b6-2

DEPARTMENT/SERVICE/CLINIC: TCU 2

DATE: 18 June 03

PATIENT'S IDENTIFICATION *(If typed or written, 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

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	0053	INITIALS [redacted]	1737	INITIALS [redacted]		INITIALS
NEURO	PUPILS	3mm Brisk, PERRLA		PERRLA @ 2mm		b6-2	
	SENSORIUM	Alert, verbal b6-2		Alert, verbal			
RESPIRATORY	RESPIRATORY PATTERN	Equal rise & fall at chest		= rise & fall bilat			
	BREATH SOUNDS	Clear @ lobes (B)		clear bil upper lobes			
	SECRETIONS	↓ at bases (B), Occasional cough		diminished ↓ lobes bil			
				No secretions noted			
				@ present time.			
SKIN	COLOR	Normal for race		appropriate for race			
	INTEGRITY	Warm, dry		↓ warm & dry (L) Arm			
		(R) Flank intrance WK		DSG = Acc CDI. Chest → ABD			
I.V. SITE	LOCATION	(L) central line, triple lumen		DSG CDI. (R) hip & groin			
	CONDITION	C/DIS, 125cc/hr LR		area purple bruise noted			
				(R) posterior ↑ (R) buttock small			
				entrance wound. No active			
				bleeding noted. (L) central			
				line triple lumen CDI.			
GASTRO	ABDOMEN	Medial ex CAP site C/DIS		LR @ 125cc/hr via triple			
	BOWEL SOUNDS	↓ BS x 4 quadrants,		lumen. ABD soft, non-			
		soft round, ⊘ TTP		distended, hyperactive BS			
		NGT to LIS		in all 4 quadrants.			
GU	URINE:	Foley to gravity		Foley cath c dark am-			
	COLOR/CLARITY	Dark amber color		ber urine in foley bag.			
CARDIOVASCULAR	CARDIAC RHYTHM	Sinus Tachy 120's		Sinus Tachy, HR 100's			
		S1 S2 present		Pedal pulses present bil.			
		⊘ central line c 125cc/hr		Radial pulse present (R) (L)			
		LR		unable to assess due to DSG.			
				Cap refill < 2 sec (R) hand. (R) hand			
				cool above fingers			

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 2 unit

DATE: 19 June 03

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

FT [redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE	DE 05	06	07	08	09	10	11	12		13	14	15	16	HOSPITAL DAY 17	18	19	20	
VITALS SIGNS																		
TIME	~~24~~	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff	134/84	137/97	124/90	117/78	157/87	136/82	137/92	125/84		125/84	128/75	122/76	117/80	127/75	135/82	143/87	132/85	
Temperature	100.2 A	100.1	100.3	100.3	100.3		101.8	101.5		101.1	100.9	100.5	100.6	100.7	101 A	100.4 A	100.1 A	
Pulse	123	122	127	138	129	136	136	142		141	129	130	126	129	122	123	119	
Respiratory Rate	27	27	26	31	24	30	24	31		29	30	28	26	30	27	26	25	
SPO2	99	96	96	92	99	96	97	97		98	96	97	96	95	97	99	99	
O2	2L	2L	2L	2L	2L	2L	2L	2L		2L	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		125	125	125	125	125	125	125	125	
IVPB	~~100~~	50				100							50	100				
TOTALS	125	300	425	550	675	900	1025	1150		1275	1400	1525	1650	1775	1890	1915	2030	
OUTPUT																		
URINE Foley — HOUR / TOTAL	30	60/90	30/120	30/150	30/180	30/210	150/360	100/460		80/540	80/620	80/700	55/755	55/810	100/910	100/1010	75/1085	
URINE — SP GR																		
URINE — S/A																		
NG — OUTPUT																		
NG — pH																		
NG — GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY	21	22	23	24	01	02	03	04
VITAL SIGNS	16	17	18	19	20	21	22	23
	130/90	134/91	142/89	135/85	139/90	140/83	133/83	143/91
	100A	99A	99A	99A	98A	99A	99A	99A
	120	120	110	108	109	111	108	109
	26	27	25	24	21	22	22	26
	99	98	98	98	97	98	97	97
	2L	2L	2L	2L	2L	2L	2L	2L
INTAKE	16	17	18	19	20	21	22	23
	125	125	125	125	125	125	125	125
		150						100
	2155	2230	2355	2480	2605	2730	2855	3080
OUTPUT	125/1110	100/1210	100/1310	125/1435	75/1510	100/1610	75/1685	50/1735

8°T

ACUITY LEVEL CLASSIFICATION

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

LABORATORY DATA	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

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]
b62	b62

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	1115 b6-2 [redacted]	1717 INITIALS [redacted]	b6-2 INITIALS
NEURO	PUPILS	b6	Sluggish @ 2mm	
	SENSORIUM	aroused to verbal stimuli pupils sluggish.	aroused to tactile stimuli	
RESPIRATORY	RESPIRATORY PATTERN	even unlabored	even & unlabored	
	BREATH SOUNDS	CTA	Clear bilateral coarse b/lat	
	SECRETIONS	thick, oral white, blood tinged	No secretions noted @ present time	
SKIN	COLOR	Pink, warm to touch good turgor	warm to touch. Color appropriate for race. Chest & ABD DSG	
	INTEGRITY			
IV SITE	LOCATION	(R) Central	CDI (L) Arm free DSG	
	CONDITION	Patent triple lumen patent	CDI. (R) central line triple lumen patent & intact.	
GASTRO	ABDOMEN	BS hypoactive	BS hypoactive X4	
	BOWEL SOUNDS	X4. ABD DSG CDI		
GU	URINE:	Foley	Foley c̄ Clear amber urine.	
	COLOR/CLARITY	amber/clear		
CARDIOVASCULAR	CARDIAC RHYTHM	Sinus tach	Sinus tachy. Pedal pulses present bil. (R) radial pulse present (L) radial unable to access due to DSG.	

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

b6-2

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU 2 east

DATE: 17 JUN 03

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

~~000-00-0309~~

EPW [redacted] b6-4

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

DATE 17JUL03 DX GSW to face HOSPITAL DAY 1

VITAL SIGNS																			
TIME	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19
BP Arterial Line										188								
BP Cuff										133/50	130/84	141/82	120/82			119/70	116/76	121/79
Temperature										98.6	/	100.5	100	9	100.9	102.3	100.8 A	100.6 A
Pulse										138	128	131	140	140	144	143	131	128
Respiratory Rate										27	33	27	30	32	26	28	28	24
SaO2										100	100	100	96	98	93	93	96	95
[illegible]										102	102	102	RA	RA	RA	RA	RA	RA

INTAKE																			
TIME	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19
LR																125	125	125
14VAD IVBB																100		
TOTALS																225	350	475

OUTPUT																			
URINE (Foley) HOUR / TOTAL										100/100	350/450	100/550			400	400		100
URINE sp gr																			
URINE S/A										0									
NG OUTPUT																			
NG pH																			
NG GUIAC																			
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY N/A

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	20	21	22	23	24	01	02	03	04
	134/80	135/80	132/92	132/90	135/91	132/86	131/91	128/83	129/87
		98.5	99.7 A	99.8 A	99.2 A	99.2 A	99.1 A	99.9 A	99.7 A
	116	117	121	115	118	114	116	116	117
	21	26	34	20	24	21	25	24	26
		98	98	98	98	98	97	98	98
	9L	9L	2L	2L	2L	2L	2L	2L	2L

INTAKE	20	21	22	23	24	01	02	03	04
	125	125	125	125	125	125	125	125	125
			150						100
	125	125							
	600	125							

OUTPUT									
		100		100		100	25	30	55

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 OF DAILY LIVING	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	INITIALS
[redacted]	
b6-2	

EPW [redacted] 66-4

ICU 2

MIS

URGENCY	PATIENT STATUS
☐ ROUTINE	☐ BED ☐ AMB
TODAY ☐	OUTPATIENT ☐
☐ PRE-OP	☐ NP ☐ DOM
STAT ☐	SPECIMEN SOURCE (Specify)

SPECIMEN/LAB RPT. NO

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY [redacted] MD CH

DATE 18 Jun 93

LAB ID NO.

REMARKS Chem 8

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. / P.M.	REQUESTED	RESULTS
Glu				129
BUN				11
CRE				0.8
CK				4233
Na				132
K				4.4
Cl				110
HCO2				23

557-107

MISCELLANEOUS

STANDARD FORM 557 (Rev. 3-77) Prescribed by GSA/FPMR FPMR (41 CFR) 101-45.505

MEDCOM - 11439

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: NURSING FLOWSHEET - AMBULATORY SURGERY UNIT

OTSG APPROVED (Date): Q1 - 24 Oct 91

ADMISSION:

DATE: 01 25 TIME: 18 JUN 03 PROCEDURE: GSW (L) ARM

GSW (R) REAR KIDNEY AREA

2d ACR

TRANSPORTATION ESCORT: [ ] N/A [/] YES ____ NAME:

ID BAND VERIFIED: [ ] YES [ ] NO (EXPLAIN)

HOSPITAL CARD VERIFIED: [ ] YES [ ] NO (EXPLAIN)

NPO since _____

HOLDING AREA

VITAL SIGNS: [ ] B/P 130/68 121/73 [ ] HR 89 98 [ ] RR _____ [ ] T _____ 96% 135/69 103 144/72 108 135/69

INITIAL ("0" is nonapplicable)
VERIFIED/ON CHART

PERMIT _____
H&P _____
CBC _____
UA _____
ECG _____
XRAY _____
OTHER _____

CONTACT/GLASSES REMOVED _____
ID BAND VERIFIED/ATTACHED _____
DENTURES REMOVED _____
JEWELRY/HAIRPINS REMOVED _____
VOIDED @ _____
VALUABLES _____

PREOPERATIVE MEDICATION/DOCTOR'S ORDERS	ROUTE	SITE	TIME	SIGNATURE
1L LR		(R) AC		[redacted] b6-2
5mg MORAPHINE (R) AC IV				
FOLEY				
400 mg GENT				
1g CEFAZOLIN				

IV THERAPY	SOLUTION	VOLUME	RATE	GAUGE	SITE	SIGNATURE
3L	NS			18g	(R) AC	[redacted] b6-2

TRANSFERRED TO:
[ ] OR
[ ] OTHER _____

TRANSPORTED BY:
[ ] AMBULATORY
[ ] WHEELCHAIR
[ ] CARRIED BY _____
[ ] GURNEY
[ ] SIDE RAILS
[ ] SAFETY STRAPS

(Continue on reverse)

PREPARED BY [redacted] b6-2 | DEPARTMENT/SERVICE/CLINIC | DATE

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

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

MEDCOM - 11440

DA FORM 4700, MAY 78 WAMC OP 425, 1 Dec 91 (MCXC NU)