Ward/Section: ICU	Requestii	(b)(6)-2	LAB TORY RESULT FORM (Subject to the Privacy Act of 1974)
Name: (b)(6)-4	Date: 25 SEPT	Time: 0500	Patient # (b)(6)-4

Chemistry 7

Test	Result	Ref. Range
GLU	99	73 - 118 mg/dL
BUN	15	7 - 22 mg/dL
Creat	1.6	0.6 - 1.2 mg/dL
Na	127	128 - 125 mmol/L
K	4.3	3.3 - 4.7 mmol/L
Cl	105	98 - 108 mmol/L
tCO2	23	18 - 33 mmol/L

Chemistry 12/LFT

Test	Result	Ref. Range
ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Test	Result	Ref. Range
Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative

Micro UA

Blood Gas

Test	Result	Ref. Range
ph		7.31 - 7.45
PCO2		35 - 45: Art
PO2		80 - 105
HCO3		22 - 26
TCO2		23 - 27
BE		(-2) - 3
sO2		95 - 100%

Hematology (CBC)

Test	Result	Ref. Range
WBC	10.5	4.8 - 10.8 x 1E3
RBC	3.46	4.7 - 6.1 x 1E6
Hgb	9.8	14 - 18 g/dL (M); 12-16 (F)
Hct	29.7	45 - 52% (M); 37 - 47% (F)
MCV	86.0	80 - 99 fL
Plt	120	130 - 500 1E3
Lymph%	12.3	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

Test	Result	Ref. Range
PT	14.0	9.8 - 13.6 sec
aPTT	51.3	21 - 34 sec
INR		N/A

MISC

Test	Result	Ref. Range
Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

(b)(6)-2	Date 25	Lab ID #

MEDCOM - 7574

Ward/Section: ICU	Requesting Physician: Dr (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)
LAST, FIRST, MI	25 Sept 03	TIME 1130	SSN/PSEUDO SSN:

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC		4.8-10.8 x 10
RBC		4.7-6.1 x 10
Hgb		14-18g/dl (M) 12-16 g/dl (F)
Hct		45-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10 Verified
Lymph %		20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
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
INR		

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

MET[redacted]7

TEST	RESULT	REF. RANGE
GLU	88	73-118 mg/dl
BUN	16	7-22 mg/dl
CRE	1.5	0.6-1.2 mg/dl
[redacted]		
NA*	141	128-145 mmol/l
K*	3.8	3.3-4.7 mmol/l
CL*	106	98-108 mmol/l
CO2	27	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

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/
BUN		7-22 mg/dl
CA**		8.0-10.3 mg
CHOL		100-200 mg
CRE		0.6-1.2 mg/
GLU		73-118 mg/
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by: (b)(6)-2	DATE: 25 Sept 03	LAB ID NO: (b)(6)-4

Ward/Section:	Requesting Physician:	Laboratory Result Form (Subject to the Privacy Act of 1974)
ICU	(b)(6)-2	

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN:
(b)(6)-4	26Sept03	0400	(b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	8.9	4.8-10.8 x 10
RBC	3.34	4.7-6.1 x 10
Hgb	9.3	14-18g/dl (M) 12-16 g/dl (F)
Hct	28.8	45-52% (M) 37-47% (F)
MCV	86.3	80-94 fl (M) 81-99 fl (F)
Plt	170	130-500 x 10 Verified
Lymph %	14.0	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
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
INR		

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

MET[redacted] 7

TEST	RESULT	REF. RANGE
GLU	96	73-118 mg/dl
BUN	14	7-22 mg/dl
CRE	10	0.6-1.2 mg/dl
[redacted]		
NA*	136	128-145 mmol/l
K*	3.9	3.3-4.7 mmol/l
CL*	108	98-108 mmol/l
CO2	23	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

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

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by:	DATE:	LAB ID NO:

AM-lab

Ward/Section:	Requesting Physician:	Laboratory Result Form (Subject to the Privacy Act of 1974)
ICU	Dr (b)(6)-2	

LAST FIRST MI		TIME	SSN/PSEUDO SSN:
(b)(6)-4	27 Sep 03	0410	

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	7.3	4.8-10.8 x 10
RBC	3.18	4.7-6.1 x 10
Hgb	8.9	14-18g/dl (M) 12-16 g/dl (F)
Hct	27.5	45-52% (M) 37-47% (F)
MCV	86.6	80-94 fl (M) 81-99 fl (F)
Plt	219	130-500 x 10 Verified
Lymph %	26.7	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
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
INR		

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

MET [redacted] 7

TEST	RESULT	REF. RANGE
GLU	89	73-118 mg/dl
BUN	13	7-22 mg/dl
CRE	1.1	0.6-1.2 mg/dl
[redacted]		
NA*	136	128-145 mmol/l
K*	4.1	3.3-4.7 mmol/l
CL*	103	98-108 mmol/l
CO2	24	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

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/
BUN		7-22 mg/dl
CA**		8.0-10.3 mg
CHOL		100-200 mg
CRE		0.6-1.2 mg/
GLU		73-118 mg/
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

CK 3865

Remarks:

Reported by:	DATE:	LAB ID NO:

Ward/Section: FCU	Requesting Physician: Dr (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)

LAST FIRST MI (b)(6)-4	DATE 28 Sept	TIME 0400	SSN/PSEUDO SSN (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	12.5	4.8-10.8 x 10
RBC	4.56	4.7-6.1 x 10
Hgb	12.7	14-18g/dl (M) 12-16 g/dl (F)
Hct	39.2	45-52% (M) 37-47% (F)
MCV	85.9	80-94 fl (M) 81-99 fl (F)
Plt	387	130-500 x 10 Verified
Lymph %	25.8	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
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
INR		

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

MET 8

TEST	RESULT	REF. RANGE
GLU	101	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	1.4	0.6-1.2 mg/dl
[redacted]		
NA*	131	128-145 mmol/l
K*	3.6	3.3-4.7 mmol/l
CL*	101	98-108 mmol/l
CO2	25	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

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/
BUN		7-22 mg/dl
CA**		8.0-10.3 mg
CHOL		100-200 mg
CRE		0.6-1.2 mg/
GLU		73-118 mg/
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results: CK 2149

Remarks:

Reported by:	DATE:	LAB ID NO:

ICU 0500

Ward/Section: ICU

Requestin ca (b)(6)-2

(b)(6)-4

Date: 29 SEPT

Time:

RATORY RESULT FORM

(Subject to the Privacy Act of 1974)

Patient # (b)(6)-4

Chemistry 7		
Test	Result	Ref. Range
GLU	104	73 - 118 mg/dL
BUN	16	7 - 22 mg/dL
Creat	1.6	0.6 - 1.2 mg/dL
Na	142	128 - 125 mmol/L
K	3.3	3.3 - 4.7 mmol/L
Cl	105	98 - 108 mmol/L
tCO2	25	18 - 33 mmol/L

Chemistry 12/LFT		
ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.9 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem		
Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis		
Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leu		Negative
Micro UA		

Blood Gas		
ph		7.31 - 7.45
PCO2		35 - 45: Art
PO2		80 - 105
HCO3		22 - 26
TCO2		23 - 27
BE		(-2) - 3
sO2		95 - 100%

Hematology(CBC)		
Test	Result	Ref. Range
WBC	9.0	4.8 - 10.8 x 1E3
RBC	3.13	4.7 - 6.1 x 1E6
Hgb	8.6	14 - 18 g/dL (M); 12-16 (F)
Hct	27.0	45 - 52% (M); 37 - 47% (F)
MCV	86.4	80 - 99 fL
Plt	311	130 - 500 1E3
Lymph%	30.0	20.5 - 51.1 %

Hematology Manual Diff	
Seg	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation		
PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC		
Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Pedro 0530 29 SEPT

Additional Instructions:

Reported By	Date	Lab ID #

Ward/Station: [redacted]

Requesting Physician:

Laboratory Result Form
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4

DATE 29 SEPT TIME 0930

(b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	9.5	4.8-10.8 x 10
RBC	3.27	4.7-6.1 x 10
Hgb	9.0	14-18g/dl (M) 12-16 g/dl (F)
Hct	28.5	45-52% (M) 37-47% (F)
MCV	87.1	80-94 fl (M) 81-99 fl (F)
Plt	326	130-500 x 10 Verified
Lymph %	28.4	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
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
INR		

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

[redacted]

TEST	RESULT	REF. RANGE
GLU	109	73-118 mg/dl
BUN	15	7-22 mg/dl
CRE	1.1	0.6-1.2 mg/dl
[redacted]		
NA*	142	128-145 mmol/l
K*	3.9	3.3-4.7 mmol/l
CL*	101	98-108 mmol/l
CO2	26	18-33 mmol/l

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

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/
BUN		7-22 mg/dl
CA**		8.0-10.3 mg
CHOL		100-200 mg
CRE		0.6-1.2 mg/
GLU		73-118 mg/
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by: | **DATE:** | **LAB ID NO:**

MD [illegible] 29 Sept

MEDCOM - 7580

Ward/Section:	Requesting Physician:	Laboratory Result Form (Subject to the Privacy Act of 1974)
ICU	Dr (b)(6)-2	

LAST FIRST MI (b)(6)-4 | 30 Sep 03 | TIME 0550 | SSN/PSEUDO SSN:

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	7.3	4.8-10.8 x 10
RBC	3.01	4.7-6.1 x 10
Hgb	8.5	14-18g/dl (M) 12-16 g/dl (F)
Hct	26.0	45-52% (M) 37-47% (F)
MCV	86.5	80-94 fl (M) 81-99 fl (F)
Plt	384	130-500 x 10 Verified
Lymph %	30.1	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
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
INR		

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

MET[redacted] 7

TEST	RESULT	REF. RANGE
GLU	81	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	1.2	0.6-1.2 mg/dl
[redacted]		
NA*	141	128-145 mmol/l
K*	2.9 *	3.3-4.7 mmol/l
CL*	105	98-108 mmol/l
CO2	29	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

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/
BUN		7-22 mg/dl
CA**		8.0-10.3 mg
CHOL		100-200 mg
CRE		0.6-1.2 mg/
GLU		73-118 mg/
TP		6.4-8.1 g/dl

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by: (b)(6)-2 | **DATE:** 30 Sep 03 | **LAB ID NO:**

Ward/Section: ICU	Requesting Physician: Dr. (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)
LAST, FIRST, MI	IE	SSN/PSEUDO SS (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC		4.8-10.8 x 10
RBC		4.7-6.1 x 10
Hgb		14-18g/dl (M) 12-16 g/dl (F)
Hct		45-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10 Verified
Lymph %		20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
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
INR		

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

MET 7

TEST	RESULT	REF. RANGE
GLU	117	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
[redacted]		
NA*	132	128-145 mmol/l
K*	4.3	3.3-4.7 mmol/l
CL*	101	98-108 mmol/l
CO2	22	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

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

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Repo (b)(6)-2	DATE: 3/31	LAB ID NO: 007

ICU

Reques can: (b)(6)-2

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

(b)(6)-4

Date: 1 oct 03

Time: 0500

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

Chemistry 7		
Test	Result	Ref. Range
GLU	102	73 - 118 mg/dL
BUN	8	7 - 22 mg/dL
Creat	0.7	0.6 - 1.2 mg/dL
Na	135	128 - 125 mmol/L
K	3.7	3.3 - 4.7 mmol/L
Cl	99	98 - 108 mmol/L
tCO2	23	18 - 33 mmol/L

Chemistry 12/LFT		
ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem		
Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis		
Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative
Micro UA		

Blood Gas		
ph		7.31 - 7.45
PCO2		35 - 45: Art
PO2		80 - 105
HCO3		22 - 26
TCO2		23 - 27
BE		(-2) - 3
sO2		95 - 100%

Hematolo[redacted]		
Test	Result	Ref. Range
WBC	9.4	4.8 - 10.8 x 1E3
RBC	3.42	4.7 - 6.1 x 1E6
Hgb	9.3	14 - 18 g/dL (M); 12-16 (F)
Hct	29.4	45 - 52% (M); 37 - 47% (F)
MCV	85.8	80 - 99 fL
Plt	557	130 - 500 1E3
Lymph%	26.9	20.5 - 51.1 %

Hematology Manual Diff	
Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation		
PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC		
Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

Reported By	Date	Lab ID #
(b)(6)-2	01 oct 03	

Ward/Section: ICU

Requ[illegible] [illegible]ican: Dr. (b)(6)-2

[illegible]RATORY RESULT FORM
(Subject to the Privacy Act of 1974)

Name:

Date: 9 Oct 23

Time: 1430

Patient # (b)(6)-4

Chemistry 7

Test	Result	Ref. Range
GLU	127	73 - 118 mg/dL
BUN	10	7 - 22 mg/dL
Creat	1.1	0.6 - 1.2 mg/dL
Na	136	128 - 125 mmol/L
K	3.7	3.3 - 4.7 mmol/L
Cl	104	98 - 108 mmol/L
tCO2	23	18 - 33 mmol/L

Chemistry 12/LFT

Test	Result	Ref. Range
ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Test	Result	Ref. Range
Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative

Micro UA

Blood Gas

Test	Result	Ref. Range
ph		7.31 - 7.45
PCO2		35 - 45: Art
PO2		80 - 105
HCO3		22 - 26
TCO2		23 - 27
BE		(-2) - 3
sO2		95 - 100%

Hematology(CBC)

Test	Result	Ref. Range
WBC		4.8 - 10.8 x 1E3
RBC		4.7 - 6.1 x 1E6
Hgb		14 - 18 g/dL (M); 12-16 (F)
Hct		45 - 52% (M); 37 - 47% (F)
MCV		80 - 99 fL
Plt		130 - 500 1E3
Lymph%		20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

Test	Result	Ref. Range
PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC

Test	Result	Ref. Range
Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

(b)(6)-2

Date: 9 Oct

Lab ID #

Ward/Section:	Requesting Physician:	Laboratory Result Form (Subject to the Privacy Act of 1974)
ICU	Dr (b)(6)-2	

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN:
(b)(6)-4	2 Oct 03	0500	

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	13.2	4.8-10.8 x 10
RBC	4.01	4.7-6.1 x 10
Hgb	11.2	14-18g/dl (M) 12-16 g/dl (F)
Hct	34.4	45-52% (M) 37-47% (F)
MCV	85.6	80-94 fl (M) 81-99 fl (F)
Plt	670	130-500 x 10 Verified
Lymph %	25.6	20.5-51.1%

(Hematology) Manual Diff

Segs		
Bands		
Lymph		
Atyp		
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
INR		

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

MET[redacted] 7

TEST	RESULT	REF. RANGE
GLU	130	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	1.1	0.6-1.2 mg/dl
[redacted]		
NA*	137	128-145 mmol/l
K*	3.8	3.3-4.7 mmol/l
CL*	102	98-108 mmol/l
CO2	23	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANGE
PRP		Negative
Mono		Negative

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

Malaria Smear

Results:

Microscopic UA

Results:

Remarks:

Reported by:	(b)(6)-2	DATE: 02 oct 03	LAB ID NO:

ction: ICW | Requ[illegible] by: Dr. (b)(6)-2 | ORATORY RESULT FORM (Subject to the Privacy Act of 1974)

(b)(6)-4 | Date: 3 Sep 2003 | Time: 0635 | Patient #

Chemistry 7

Test	Result	Ref. Range
GLU	[redacted] 160	73 - 118 mg/dL
BUN	17	7 - 22 mg/dL
Creat	1.2	0.6 - 1.2 mg/dL
Na	137	128 - 125 mmol/L
K	3.9	3.3 - 4.7 mmol/L
Cl	104	98 - 108 mmol/L
CO2	28	18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative
Micro UA		

Blood Gas

ph		7.31 - 7.45
PCO2		35 - 45: Art
PO2		80 - 105
HCO3		22 - 26
TCO2		23 - 27
BE		(-2) - 3
sO2		95 - 100%

Hematology(CBC)

Test	Result	Ref. Range
WBC	16.4	4.8 - 10.8 x 1E3
RBC	4.31	4.7 - 6.1 x 1E6
Hgb	12.1	14 - 18 g/dL (M); 12-16 (F)
Hct	36.6	45 - 52% (M); 37 - 47% (F)
MCV	85.1	80 - 99 fL
Plt	812	130 - 500 1E3
Lymph%	22.2	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

(b)(6)-2 | Date: 03 OCT | Lab ID #: 002

on: ICU | R | hysican: Dr (b)(6)-2

ORATORY RESULT FORM

Subject to the Privacy Act of 1974)

(b)(6)-4 | Date: 04 Oct | Time: 0600 | Patient #: (b)(6)-4

Chemistry 7

	Result	Ref. Range
GLU	179 *	73 - 118 mg/dL
BUN	14	7 - 22 mg/dL
Creat	1.2	0.6 - 1.2 mg/dL
Na	138	128 - 145 mmol/L
K	3.7	3.3 - 4.7 mmol/L
Cl	104	98 - 108 mmol/L
CO2	29	18 - 33 mmol/L

Chemistry 12/LFT

ALB		3.5 - 5.5 g/dL
ALP		26 - 84 µg/dL
ALT		10 - 47 µg/dL
AMY		14 - 97 µg/dL
AST		11 - 38 µg/dL
Tbili		0.2 - 1.6 mg/dL
TP		6.4 - 8.1 g/dL
Ca		8.0 - 10.3 mg/dL
Chol		100 - 200 mg/dL
Creat		0.6 - 1.2 mg/dL
BUN		7 - 22 mg/dL
GLU		73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK		39 - 380 µg/L - Male
		30 - 190 µg/L - Female

Urinalysis

Test	Result	Ref.Range
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SGav.		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2 - 1.0
Nit		Negative
Leuk		Negative
Micro UA		

Blood Gas

ph		7.31 - 7.45
PCO2		35 - 45: Art
PO2		80 - 105
HCO3		22 - 26
TCO2		23 - 27
BE		(-2) - 3
sO2		95 - 100%

Hematology(CBC)

Test	Result	Ref. Range
WBC	12.9	4.8 - 10.8 x 1E3
RBC	4.10	4.7 - 6.1 x 1E6
Hgb	11.4	14 - 18 g/dL (M); 12-16 (F)
Hct	35.4	45 - 52% (M); 37 - 47% (F)
MCV	86.2	80 - 99 fL
Plt	775 *	130 - 500 1E3
Lymph%	23.7	20.5 - 51.1 %

Hematology Manual Diff

Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation

PT		9.8 - 13.6 sec
aPTT		21 - 34 sec
INR		N/A

MISC

Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

Reported By (b)(6)-2 | Date 04 Oct 03 | Lab ID #

Versed 1mg IV pre-op
Unasyn 3Gm ↑

EDICAL RECORD - ANESTHESIA

For use o. .orm, see AR 40-66; the proponent agency is ti' .G

DRUG	(Units)												
Fentanyl	(mcg)	50 50		50 100					50	50			50
Versed	(mg)	20											
Sch/Vec	(mg)	100	5			5		5			2		2
	( )									66-2 [redacted]			
	( )												
Labetalol	(mg)			10							10 5		
VOLATILE	% del												
PARALYTIC	% e.t.		.8	1.1	1.0	.7	.8	.8	1.2	1.2	.6	.7	1.0
AIR	L/Min		1	1	1	1	1	1	1	1	1	1	1
N2O	L/Min												
O2	L/Min	8	1	1	1	1	1	1	1	1	1	1	1

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, ↑↓ = CONSTANT INFUSION

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

FLUIDS												
LINE site	☒ Warmed				NS				600			
#1 BG (1) R Leg	☒ Warmed	200			200							
#2 BG (L) hand	☐ Warmed	100			300							350
PRBCs	☐ Warmed				(1)							

LOSSES												
EST BLOOD LOSS				300						400		
URINE -					450				100	550		

TOTALS	TOTAL EBL
400	400
20	
100 / 19	TOTAL URINE
X	700
5	

FLUIDS - SUMMARY
CRYSTALLOID- 400 cc
COLLOID- —
BLOOD- 1 u PRBC

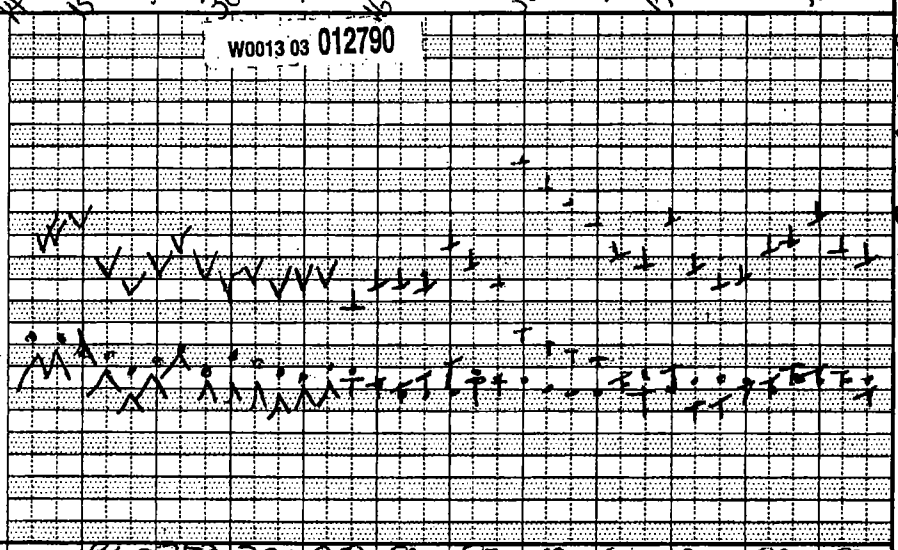
REMARKS
Code drugs with numbers, events with letters
(1) 7 i.d. pre-op in ER.
(2) in OR; pre-c monitors. RSI c̄ cricoid, OGT placed.
15:50 H/H 12.9/39.4
7.35/34/167/19/-6
Ca+ 1.2
16:50 14.7/44.8
7.32/34/325/18/-9
1915 50mEq NaHCO3 IV
(3) OGT to NGT
(4) nasal - passed scoff.

PHYSICAL STATUS: 1 2 3 4 5 (E)
BODY WEIGHT: 75 (KG) LB
HEMATOCRIT: 47.5
INITIAL DATA: BP- 122/83 HR- 87
EQUIP CHECK: OK? (Y) N
PATIENT RECHECK: OK for PROCEDURE? (Y) TIME-

TIME → 1445 1500 30 1600 30 1700 30

SYMBOLS: BP by cuff (Alike); (2) Radial; Heart rate 1525; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-⊙

W0013 03 012790



VENTILATION												
1:2 1:2	VT - ml	660	750	780	960	860	850	890	870	860	890	860
Lime (+)	f - breaths/min	10	11	11	11	11	11	11	11	11	11	11
OGT	Peak inf pres / PEEP	16/3	15/3	18/3	19/3	20/3	21/3	21/4	20/4	20/3	21/3	20/3
	MODE - S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES												
✓ BP/Auto Cuff	✓ ET CO2 (torr)	7	33	33	31	29	31	29	30	29	31	33	31
BP/oth	✓ FIO2 (Frac or %)	.88	.55	.56	.6	.6	.58	.55	.57	.57	.57	.57	.58
✓ ART line	✓ SpO2 (%)	100	99	99	99	100	100	100	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	1° AVB		SR	PVC	SR	SR	SR	SR	SR	SR	SR
✓ Gas analyzer	✓ TEMP-site Skin		98.6		98.6	98.6		98.6	98.6	98.6	98.6	98.6	98.6
	✓ N-M Block (T/4)	0/4	1/4	0/4	1/4	2/4	0/4	2/4	0/4	1/4	2/4	1/4	1/4
Warming blkt		✓											
Cooling blanket													

Mark with letters & symbols, explain under REMARKS — EVENTS / Position → pressure pts padded but <90° on tapped à [illegible]

RECOVERY AT: 1900
PACU (CU) (Specify)
OTHER T2 96.6 [illegible]
CONDITION: Stable
RESP. 20 SpO2-99% O2 FC
BP- 134/87 HR- 105

ANESTHESIA / PROCEDURE TIMES	Start	Room	End
ANES	1445	1450	1930
PROC	Ready	Begin	End
	1500	1514	1900

PROCEDURES and CPT Codes:
ex lap, colectomy I/O (L) colon

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: RSI c̄ cricoid #8.0 ETT / #3 mil @ 21 cm @ ML. ⊕ ETCO2 ⊕ BBS. Intubation by SSG Wide RRT. Atraumatic

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility
(b)(6)-4

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

PROCEDURE LOCATION: OR 1-1
DATE: 9/23/03
PAGE 1 OF 2

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)								TOTALS
Fentanyl (mcg) 400				25	25			500
Vecuronium (mg) 18								22
Neostigmine ( )				<6>				6
glycopyr ( )				<.9>				0.9
( )								—
Esmolol (mg)				20	10		10	30
AGENT % del								
AGENT Isoflurane % e.t.	0.6	0.6	.6	X				
AIR L/Min	1	1	1	X				
N2O L/Min								
O2 L/Min	1	1	2	2	8	8	15 FM	

TOTAL EBL / TOTAL URINE: —

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

FLUIDS

LINE site				
NS ☐ Warmed	700		900	
#18G (L) AC (200) ☐ Warmed				
#16G (L) hand ☐ Warmed	250	Δ to RA 400	———	500
☐ Warmed				

LOSSES

EST BLOOD LOSS 400

URINE - 550 — 100

FLUIDS SUMMARY: CRYSTALLOID- / COLLOID- / BLOOD- See pg 1

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 75 KG/LB

HEMATOCRIT:

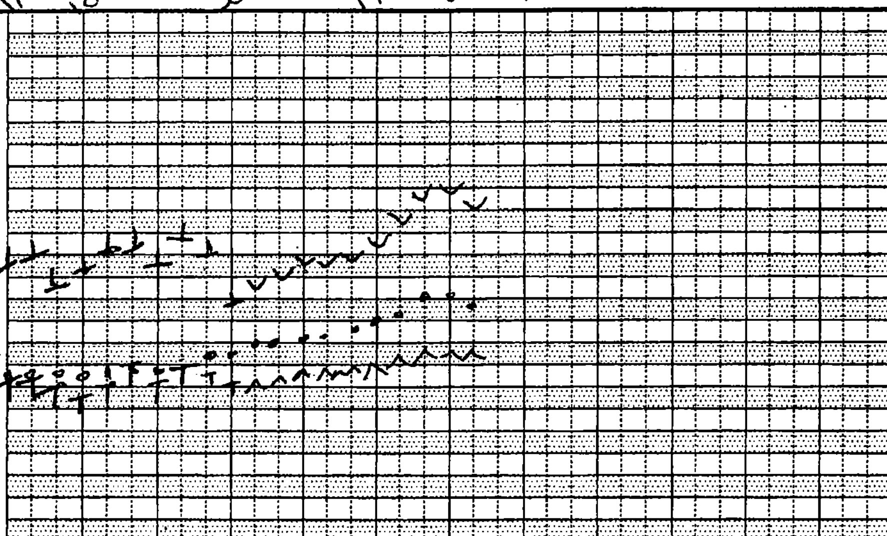
INITIAL DATA: BP- / HR-

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? TIME-

TIME → 1745 1800 0 30 0 1900 15 30

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-⊙



VENTIL.

VT - ml	650	750	750	>400	>400	>250	
f - breaths/min	7	8	8	20	18	24	18
Peak inf pres / PEEP	20/3	19/3	19/3	—	—		
MODE - S(pon), A(ssist), C(on)	C	C	C	A	A	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff ✓	ET CO2 (torr)	36	39	46	53	60	60	NA
BP/oth	FIO2 (Frac or %)	.57	.57	.58	.85	.90	.90	.21
ART line	SpO2 (%)	100	100	100	100	99	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR
Gas analyzer ✓	TEMP-site	98.6	98.6	98.6	98.6	98.6	98.6	98.6 tymp
	N-M Block (T/4)	2/4						
Warming blkt								
Conv warmer								

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

REMARKS

Code drugs with numbers, events with letters

- cont. from pg 1
- 1750 Zofran 4mg IV
- 1830 Report to CPT [redacted]
- 1910 Resp even et reg. TV > 250cc Airway reflexes intact. Opens eyes to verbal stim. oral suction. Extubate c̄ pos. pressure breath. Spont resp resume. Nasal Airway placed (L) nare
- 1920 To ICU via litter. Report to CPT (b)(6)-2. VSS. Pt stable
- 1933 → Lopressor per Dr H

RECOVERY AT: PACU ICU ____ (Specify) OTHER ____

CONDITION: See pg 1 — RESP- SpO2- BP- HR-

ANESTHESIA/PROCEDURE TIMES: ANES Start / Room / End; PROC Ready / Begin / End

PROCEDURES and CPT Codes: ex lap, colectomy, I/D (L) elbow

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — See pg 1

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

(b)(6)-4

SURGEONS: (b)(6)-2

(b)(6)-2 (b)(6)-2 CPT AN CRNA

PROCEDURE LOCATION: OR 1-1

DATE: 23 Sep 03

PAGE 2 OF 2

DA FORM 7389, FEB 1998 — MEDCOM - 7589 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

NEW
A40 ASA III CAD S/P MI 1 hour Ago

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the [illegible]

CONTINUOUS/REPEATED DRUGS #SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION	(Units)															
Versed	(mg)	1														
Fent	(mcg)	100 50	50	50												
STP	(mcg)	200 100														
Sux // Nim	(mg)	100 // 10														
MSO4	(mg)							2 2 2 2								
	( )															
VOLAT AGENT	Sevo % del	X-2.0	-1.7	-1.5	-1.5	-1.0	-0.8	-X								
	% e.t.															
AIR	L/Min															
N2O	L/Min															
O2	L/Min	X-8	-2	2	-2	-2	-2	-2	-8							

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

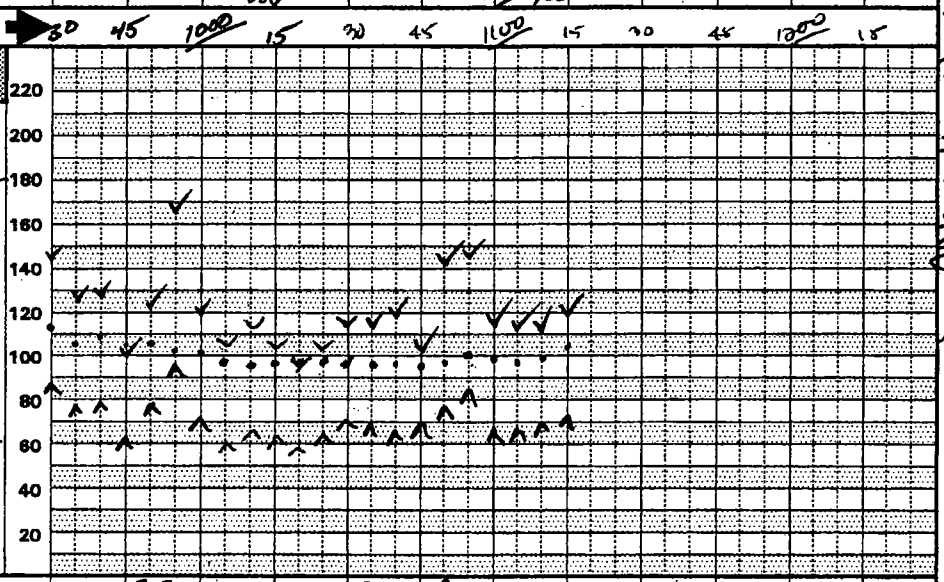
FLUIDS															
LINE site LR	☐ Warmed			100		300			500						
	☐ Warmed														
	☐ Warmed														
	☐ Warmed														
EST BLOOD LOSS															
URINE -				300				100/400							

TOTALS: 1mg, 200mcg, 300mg, 100/10g, 8mg
TOTAL EBL: Min.
TOTAL URINE: 400

FLUIDS - PRIMARY
CRYSTALLOID- LR 500
COLLOID-
BLOOD- X

REMARKS
Code drugs with numbers, events with letters
0900 pt IDD! Plan of Care Revised w/ pt
0925 In Rm Monitors On
0927-0953 Induction / Intubation
1114 pt sys good TV, pt Extubated & pos. gag pos. for suction Oral Airway & Nasal Airway in place

PRE-ANESTHETIC ASSESSMENT
1 2 3 4 5 E
BODY WEIGHT: N75 (KG) LB
HEMATOCRIT: 29.7
INITIAL DATA:
BP- 144 / 88
HR- 112
EQUIP CHECK
OK? - (Y) N
PATIENT RECHECK
OK for PROCEDURE? YES
TIME- 0915



VENTIL									
I:E=1:2	VT - ml		720	750	720	730	800		
	f - breaths/min		10	10	10	10	6	15	
	Peak inf pres / PEEP		23	23	22	22	24		
	MODE - S(pon), A(ssist), C(on)	S/C	C	C	C	C	C	S	
MONITORS/ACCESSORIES									
BP/Auto Cuff	ET CO2 (torr)	(+)	36	33	33	32	37	49	
BP/oth	FIO2 (Frac or %)	.86	.86	.85	.85	.85	.85	.85	
ART line	SpO2 (%)	100	100	100	100	100	100	100	
Steth- PC/ES	ECG	SR	ST	SR	SR	SR	SR	SR	
Gas analyzer	TEMP-site Skin			100.4	100.4	100.4	100.4		
	N-M Block (T/4)	3/4	1/4	0/4		2/4		1/4	
Warming blkt			✓✓						
Cover warmer									

Mark with letters & symbols, explain under REMARKS — EVENTS Position → Arms <90°; secured on padded armboards 0 ← →

RECOVERY AT 1120
PACU ICU _____ (Specify)
OTHER _____
CONDITION: Stable
RESP- 16 SpO2- 97
BP- 113/72 HR- 104

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0901	0925	1130
	Ready	Begin	End
PROC	0935	1010	1115

PROCEDURES and CPT Codes:
I&D / Washout @ elbow! Abcd.

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility
(b)(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments DLX Tc 4/MC
Visualized Cords; Intubated & 8.0 ETT to 24cm @ lip, Bilat BS; ETCO2 x5 waves, Eyes taped

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

ANESTHETISTS: (b)(6)-2 MAJ (b)(6)-2 N, CRNA
Nurse Anesthetist

PROCEDURE LOCATION: OR1-1
DATE: 25 SEP 03
PAGE 1 OF

28 Sep 03 | 131 / 3.6 | 101 / 25 | 11 / 1.7 <101

12.5 / 12.7 / 39.5 <38T

MEDICAL RECORD - ANESTHESIA

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

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION																		
DRUG	(Units)																	
Versed	(mg)	2																
Fentanyl	(ug)	50	100	100														
Amidate	(mg)	14	6															
Sch	(mg)	100																
MSO4	(mg)			3	2	3	2											
Rehep	(mg)				4													
VOLATILE AGENT	% del																	
Sevo	% e.t.		1.0	2.3	2.3	1.7	1.0	X										
AIR	L/Min																	
N2O	L/Min																	
O2	L/Min	8	2	1.5	1.5	1.3	1.5	8										

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

FLUIDS																		
LINE site	☐ Warmed																	
LR 1700	☐ Warmed		100		300			400										
	☐ Warmed																	
	☐ Warmed																	
LOSSES	EST BLOOD LOSS																	
	URINE -						125											

TIME → 1130 · 30 · 1200 · 30

1 2 3 4 5 (E)

BODY WEIGHT: 85 (KG) LB

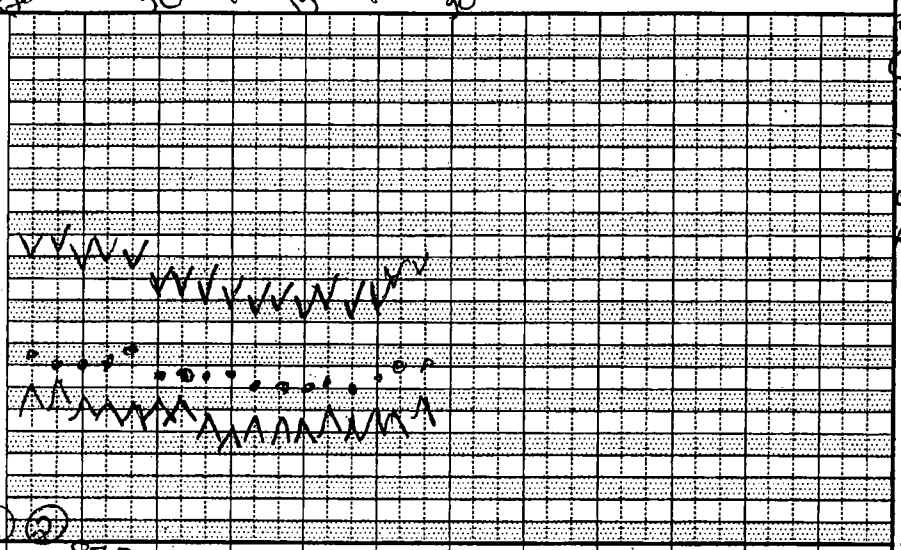
HEMATOCRIT:

INITIAL DATA: BP- 130/70 HR- 83

EQUIP CHECK: OK? (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME- 1200

SYMBOLS: BP by cuff V ∧; Heart rate ●; Resp rate; BR (transduced) ✚; TOURNIQUET T—T; ANES- X-X; PROC- ⊙ ⊘



VITAL								
	VT - ml		870					
	f - breaths/min		19	19	15	15	15	16
	Peak Inf pres / PEEP		21/3					
	MODE - S(pon), A(ssist), C(on)	S	C	S	S	S	S	S
MONITORS/ACCESSORIES	BP/Auto Cuff		ET CO2 (torr)	30	37	39	34	37
	BP/oth RUE		FIO2 (Frac or %)	.9	.91	.9	.9	.91	.9
	ART line		SpO2 (%)	100	100	100	100	100	100
	Stethe- PC/EB		ECG	SR	SR	SR	SR	SR	SR
	Gas analyzer		TEMP-site		98.6	98.6	98.6	98.6
			N-M Block (T/4)		4/4			
	Warming blkt							
	Cover warmer							

Mark with letters & symbols, explain under REMARKS

EVENTS Position → pressure pts padded BUE <90 on armboard on vised a intubation

TOTALS	
TOTAL EBL	UNK
TOTAL URINE	125

FLUIDS SUMMARY: CRYSTALLOID- 400; COLLOID- 0; BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

(1) Pt. from ICU → OR.
(2) Pre-O2 monitors RSI c̄ cricoid until ETT position confirm
(3) Pt. extubated c̄ SV TV > 5cc/kg. SpO2 98%. → ICU via stretcher c̄ O2. T&C under Report given.

RECOVERY AT 1331

PACU / ICU (Specify)

OTHER

CONDITION: Stable

RESP. 14 SpO2- 99 BP- 109/55 HR- 71

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1150	1205	1339
	Ready	Begin	End
PROC	1212	1230	1328

PROCEDURES and CPT Codes: I/D closure abd. wounds

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

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

(b)(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
LLOV 1/1 attempt MAC 4 #8.0 ETT @ 23cm (R) Tlip (+) BBS (+) ETCO2. Atraumatic. Cuff to seal O.

SURGEONS: (b)(6)-2 (b)(6)-2 (b)(6)-2

PROCEDURE LOCATION: OR 1

DATE: 9/28/03

PAGE 1 OF 1

CPT CRNA

PRE-ANESTHESIA AND POST-ANESTHESIA EVALUATION

AGE: 16 HRS DAYS MOS (YRS) SEX: (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: _____ SURGICAL SERVICE: C.S.

ASA PHYSICAL STAUS 1 2 (3) 4 5 E
WEIGHT: 75 (KG/LB) HEIGHT: 68 IN.
ALLERGIES: NKDA

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

CURRENT MEDICATIONS:
([ ]= ordered as premed)
[ ] _____
[ ] _____
[ ] _____
[ ] _____
[ ] _____
[ ] _____

PREMEDICATION:
None Yes (@ _____ Hrs) /OC
_____ ' _____ mg IV IM PO
_____ ' _____ mg IV IM PO
_____ ' _____ mg IV IM PO

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

16.9 > 15.4 / 475 < 281

143	113	21
3.7	21	1.4

PREOPERATIVE ASSESSMENT

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:	Hypertension	N	Y	Echo WNL
	Angina	N	Y	(+) CAD
	MI	N	Y	10 yrs ago (angina)
	CVA	N	Y	
	Other	N	Y	
Pulmonary System:	Asthma	N	Y	
	Bronchitis/URI	N	Y	
	COPD	N	Y	
	Other	N	Y	
Renal System:	Acute/Chronic RF	N	Y	
Gastrointestinal:	Hepatitis	N	Y	
	Hiatal Hernia	N	Y	
	PUD	N	Y	
Endocrine System:	Diabetes	N	(Y)	Pre Interpretes
	Steroids	N	Y	
	Thyroid	N	Y	
Neurological:	Seizures	N	Y	
	Neuropathy	N	Y	
	Other	N	Y	
Gynecological:	Pregnancy	N	Y	
Other Significant Hx:		N	Y	
Familial HX		N	Y	

PAST SURGICAL/ANESTHETIC HISTORY

PHYSICAL EXAMINATION Sat 99% RA
BP 120/83 HR 87 RESP _____
HEENT - Teeth edentulous
Trachea midline
TMJ/Neck MRII FROM
Oropharynx 3+3 MA
Nares _____
CHEST: _____
CARDIAC: SR c 1° AVB
EXTREMITIES: Q WAVES II, III, AVF
IV Access: #18 G IV x 2 (L)(R) A
Ulnar Filling: _____
BACK: _____
OTHER: _____

7.3	44.4	196	22	BE -4

ANESTHETIC PLAN: [ ] Local [ ] MAC - [ ] Regional (Specify): _____ [X] General: Mask Intubation

INFORMED CONSENT/COUNSELLING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.
The patient/legal guardian agrees to understand and agrees. Question (b)(6)-2
Si (b)(6)-2 CRT CPT, AN CRNA DATE: 9/23/93 TIME: 1445 Hrs

CONDITION UPON ARRIVAL TO P.A.R.R. _____
VITAL SIGNS: BP _____ HR _____ RESP _____ SuO_2 _____
RESP STATUS: [ ] Spontaneous [ ] Assisted [ ] Cont'd
MENTAL STATUS: [ ] Awake [ ] Alert [ ] Lethargic [ ] Asleep
[ ] Responsive [ ] Unresponsive Block Level _____
REPORT GIVEN: [ ] Yes [ ] No

POST-ANESTHESIA EVALUATION AND NOTE
[X] NO APPARENT ANESTHETIC COMPLICATIONS [ ] OTHER
(b)(6)-2
DATE: 9/23/93 TIME: 1217 Hrs

PATIENT IDENTIFICATION: (Ward: _____)

(b)(6)-4

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)* _____

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [x] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

REQUESTING PHYSICIAN *(Print)* (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW

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

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER: SEE PREVIOUS

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED: SF 518

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

W0013 03 012790 A

TRANSFUSION NO.

PATIENT NO. (b)(6)-4 [redacted]

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	COMP

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

DONOR	RECIPIENT
ABO A	ABO A
Rh POS	Rh POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 23 SEP 03

REMARKS: EXP 24 SEP 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

(b)(6)-2

AT *(Hour)* 1534 ON *(Date)* 23 SEP 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.

(b)(6)-2 CPT/CPNX

(b)(6)-2 CPT

PRE-TRANSFUSION

TEMP. 99.6 PULSE BP 105/61

DATE OF TRANSFUSION 9/23/03 TIME STARTED 1600

POST-TRANSFUSION DATA

AMOUNT GIVEN 355 ML

TIME/DATE COMPLETED/INTERRUPTED 9/23/03 1650

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
98.6	77	143/60

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.)*
- [x] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

SEX M WARD EMT

(b)(6)-4

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 - 7593

Medical Record Copy

RADIOLOGIC CONSULATION REQUEST

PATIENTS NAME: (b)(6)-4

SSN: #

UNIT: EMT

PROVIDER/ CLINIC: EMT (b)(6)-2

DATE REQUESTED: 23 SEP 03

EXAMINATION REQUESTED:

PCXR

ABD.

(2) elbow

SPECIFIC REASON(S) FOR REQEST:

RADIOLOGIC REPORT:

3x4 Simultaneous Report

Name: (b)(6)-4
Number:
Sex: Male
Date of Birth: 9/23/1939 (64 years)
Height/Weight: 68in / 165lb

Recorded: 9/23/2003 9:17:47 PM
Device: CL 131127

Measurements

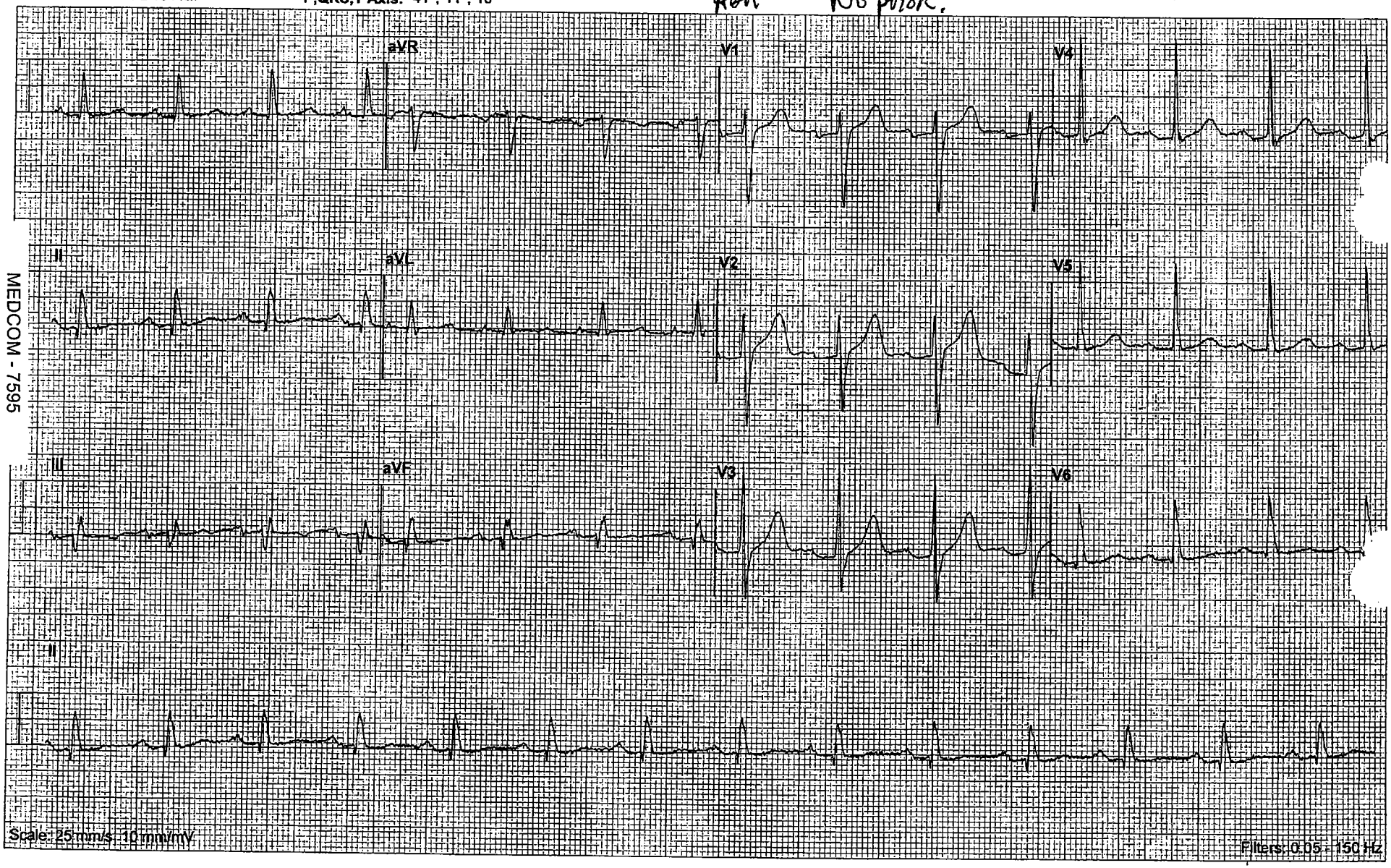
Heart Rate:	83 bpm
P Duration:	142 ms
PR Interval:	218 ms
QRS Duration:	102 ms
QT Interval:	380 ms
QTc Interval:	448 ms
P,QRS,T Axis:	41°, 11°, 10°

Interpretation (Unconfirmed)
Sinus rhythm with 1st degree AV block
~~Inferoposterior infarction cannot be ruled out~~
~~Possible ischemic ST-T changes in posterior leads~~

NSIVCD
NSST-T

Also No prior.

(b)(6)-2 (b)(6)-2, M.C,
LTC MC



MEDCOM - 7595

(Data must be reviewed by a qualified physician)

Confirmed by:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-2

DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
23 Sept 03	1900		
(1) I-Fcu Dx			
(2) Dx SP s/p LAP/Transverse colectomy w/ Bacteremia, I+D - Abdominal wall + (2) abscess wounds			
(3) Cond - Stable, NKDA			
(4) VS q 1°, I+O, monitor, [illegible], Pulse Ox			
(5) Alert - Bedrest only			

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	HOURS	
(6) NPO			
(7) O2 - O2 Face Mask - titrate to Keep Sat ≥ 92%			
(8) IV LR TKA 125 cc/hr			
(9) Unasyn 3 gms IVPB q 6°			02-08-14-20
(10) Morphine 02-6mg IV q 2° Prn pain			
(11) Toradol 15mg IV q 6°			

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	HOURS	
(12) Zantac 50mg IV q 8°			
(13) Upon arrival - CBC, chem 8, FSG			
(14) CBC, chem 8 q AM			
(15) FS blood sugar q 4° → see SSI			
(16) TCDB q 1°, incentive spirometry 10-24/hr			
(17) Call MD for T > 101°, P < 60, > 140, SBP < 100, < 90, UO < 30cc/hr, Sat < 92%			
(18) Foley [illegible]			
(19) NPO [illegible]			

NURSING UNIT | ROOM NO. | BED NO.

24° Chest ✓ 23 Sept 03

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

MAJ, MC, USA
CHIEF DOS

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

MEDCOM - 7596

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 23 Sep 03 TIME OF ORDER: 1930 HOURS

(1) Metoprolol 5 mg IVP x 1 now. May repeat x II doses if needed to keep HR < 100.

(2) Metoprolol 5 mg IVP q 6°.

(b)(6)-2

LIST TIME ORDER NOTED AND SIGN

(b)(6)-2

(b)(6)-2

2400 23 Sept 03 [redacted]

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 23 Sept 03 TIME OF ORDER: 2055 HOURS

(1) NG to LWS

VO! Dr (b)(6)-2 (b)(6)-2

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

Noted 23 Sept 03 @ 2055

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 23 Sept 03 TIME OF ORDER: 2300 HOURS

(1) Give 1000 cc LR Now IV

VO! Dr (b)(6)-2 (b)(6)-2 [redacted]

Noted 23 Sept 03 @ 2300

(b)(6)-2

24 Sept 03 @ 0300

(1) Give 1000 cc Bolus of LR IV Now

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

Noted 24 Sept 03

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

[redacted] DATE OF ORDER: 24 Sept 03 TIME OF O[redacted] HOURS 0515

(1) Give Bolus LR 1000 cc [redacted] Now

VO! Dr (b)(6)-2 (b)(6)-2

Noted 24 Sept 03 @ 0515

MD

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

[redacted] DOS

NURSING UNIT	ROOM NO.	BED NO.

Chart rev'd 26 Sep 03 @ 0600

(b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

23 Sept 03 — 1900

SLIDING SCALE INSULIN

BS — REGULAR INSULIN

≤85 — Ø U and Notify MD

85-149 — 0 U

150-200 — 3 U IV

201-250 — 6 U IV

251-300 — 9 U IV

>300 — 12 U IV + Notify MD

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

21° Chest 23 Sept 03 6/20/40

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 24 SEPT 03 TIME OF ORDER: 0640 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) HESPAN 500 cc IV bolus

Noted 24Sep03 0640

(b)(6)-2 (b)(6)-2 (b)(6)-2 , MD

MAJ, MC USA CHIEF, DOS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 24 Sept 03 TIME OF ORDER: 0710 HOURS

(1) Port CXR for line placement

Noted 24Sep03 (b)(6)-2

(b)(6)-2 , MD

(b)(6)-2 MC USA DOS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 24 Sept 03 TIME OF ORDER: 1710 HOURS

(1) THORAZINE 25 mg IV

(2) Try hand ICE chips

(3) FS BG q 8°.

noted @ 1900 (b)(6)-2 14 AN

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

MAJ, MC USA CHIEF, DOS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 24 Sep 03 TIME OF ORDER: 1900 HOURS

(1) Benadryl 50 mg IV x 1 now. May repeat again x 1 if not effective.

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24 Sep 03 2230

(1) Ambien 5 mg PO x 1 now.

(b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 25 SEPT 03 TIME OF ORDER: 1120 HOURS

LIST TIME ORDER NOTED AND SIGN

(b)(6)-2

1. To ICU - Dr [redacted] b(6)-2
2. DX - SP Wound treatment - Closure Medial Aspect, (L) ELBOW
3. Cont - Stable NKDA
4. VS q 1°, I+O MONITOR, Pulse Ox
5. Ac Tol up in chair QID, Ambulate w/ assistance QID

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: HOURS

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

6. DIET - NPO
7. O2 10L Face Mask - TITRATE TO Resp Sat ≥ 92%
10. UNASYN 3 gm IVPB q 6°
11. MORPHINE 2-6 mg IV q 2° PRN/P
12. TORADOL 15 mg IV q 6°
13. ZANTAC 50 mg IV q 8°

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: HOURS

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

14. FOLEY to gravity
15. CBC, chem 8 q AM
16. FS Blood glucose q 8° - See SSI
17. TCDB q 1°, INCENTIVE SPIROMETRY 10-20x / hour
18. METOPROLOL 5 mg IVP q 6°
19. Blood sugar on arrival

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER: HOURS

NURSING UNIT | ROOM NO. | BED NO.

20. IV LR TKO 125 cc/hr
21. Call MD if T ≥ 101°, P < 60 or ≥ 100, SBP < 100 or ≥ 140, UO < 30 cc/hr, Sat ≤ 92%
22. PHENERGAN 25 mg IV q 4° PRN/Nausea [redacted] MD

(b)(6)-2

MAU, MC USA
CHIEF DOS
[redacted]

(b)(6)-2

24° Blood

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

MEDCOM - 7600

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
25 Sep03	2320 HOURS	
① 5mg Valium IV x1 Now		noted 25 Sep03 2332
② restraints applied as needed.		
V.O D (b)(6)-2 (b)(6)-2	1LT AN	(b)(6)-2
(b)(6)-2		
24 Clock V 26 Sept02 (b)(6)-2		

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.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 25 Sept 03 TIME OF ORDER: 1400 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) HALOPARIDOL 5mg IM now and q 8° PRN / AGITATION

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 25 Sept 03 TIME OF ORDER: 2100 HOURS

(1) Ambien 5mg PO for Sleep X1 [illegible] VO: Dr [illegible]

24° Chart 26 Sept 03 @ 0155 [illegible]

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 26 SEPT 03 TIME OF ORDER: 1155 HOURS

(1) DC ~~Atenolol~~ 5mg IV Lopressor

(2) Atenolol 50mg PO BID

V/O: Dr Hodges / [illegible] CPT, HSC

noted 26 Sept

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

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

(1) Thorazine 25mg IV PRN for hiccups.

noted 1500 26 Sep

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

24° [illegible] 1 IV 26 Sep 03 @ 1900

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF [illegible] E USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 26 Sept 2003 TIME OF ORDER: 1700 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Give Haldol 5mg IM x 1 now

V.O Dr (b)(6)-2 (b)(6)-2 (b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 26 Sept 2003 TIME OF ORDER: 1655 HOURS

(1) D/C IV Fluids

(2) Flush IL Q 8° [redacted]

V.O Dr (b)(6)-2

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 26 Sep 03 TIME OF ORDER: 1715 HOURS

(1) Sedation cocktail:

Lorazepam 2mg IV x 1 now / PO

Haldol 10mg IV x 1 now.

(If no response in 30 mins - double dose)

Benadryl 50mg po x 1 now.

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 26 Sep 03 TIME OF ORDER: 2300 HOURS

1mg versed IV and titrate to reduce agitation as needed.

V.O Dr (b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 27 Sep 03 TIME OF ORDER: 0930 HOURS

LIST TIME ORDER NOTED AND SIGN

1. D/C Thorazine
2. Sedation cocktail when needed:
   Lorazepam 4mg po.
   Haldol 15mg IV.
   Benadryl 50mg po.
   may repeat in 3-4° if not effective.

TRANSCRIBED 9qf CPT 1000 27 Sept 2003

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 27 Sep 03 TIME OF ORDER: 1400 HOURS

1. Δ SS Insulin route to SQ.

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 27 Sept 03 TIME OF ORDER: 1430 HOURS

VO Dr (b)(6)-2

1. RVB
2. TORADOL 30 mg IV x 1 now.

Taken by (b)(6)-2 CPT

Verified (b)(6)-2 1700

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 27 Sept 03 TIME OF ORDER: 1715 HOURS

VO Dr (b)(6)-2

1. Δ Diet to sips 'n chips
2. IVF's LR @ 200 cc/hr while asleep.

V.O. (b)(6)-2 (CPT)

24° 27 Sep @ 2040 (b)(6)-2 CPT

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4				28 Sept 03	0800 HOURS	
			VO	Dr (b)(6)-2		
	(6)-2		1	Vital signs	Q 4°	
				Taken by	(b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.				

0945 28 Sept

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	
(b)(6)-4						
NURSING UNIT	ROOM NO.	BED NO.				

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1984 262-710

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

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
28 Sep 03	1330		
1	To LCU Dr (b)(6)-2		✓
2	Dx - SP (b)(6)-2 VT/DPC Abdm Wnds		✓
3	Cont Stable NKDA		
4	VS q 4°, I&O, Pulse Ox, Monitor		
5	ALL - Up in chair / Ambulate w/ Assistance WBD		
6	DIET - Clear liquids		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	HOURS
7	IV LR TRA 100 cc/hr	
8	SSI - FSBS q 8°	
9	Foley for gravity	
10	UNASYN 3 gm IVPB q 6°	
11	CBC, chem 7 q AM	
12	Duricef 10 mg Sy - TPR	
13	Sedation cocktail PRN	

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	HOURS
✓	LORAZEPAM 4 mg po	
✓	HALDOL 15 mg IV	
✓	BENADRYL 50 mg po	
	MAY REPEAT in 4° IF NOT EFFECTIVE	
14	ATENOLOL 50 mg 1 po BID	
15	TCDB q 1°, Incentive Spiro 10-20x/hr	
16	Notify MD for T > 101°, Pulse > 100, SBP < 100 or > 150, UO < 30 cc/hr	

Verified 1500 (b)(6)-2 28 Sep 03

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	HOURS
	SBP < 90 mm Hg, UO < 30 cc/hr	

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

MAJ MC USA
CHIEF, DOS

NURSING UNIT	ROOM NO.	BED NO.

(b)(6)-2 24° 28 Sep 03 @ 2000

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 28 Sept TIME OF ORDER: 1600 HOURS

LIST TIME ORDER NOTED AND SIGN

V0 DR (b)(6)-2

1. Zantac 50 mg IV q 8°
2. Toradol 15 mg IV q 6°
3. MSO4 2-6 mg IV q 2° prn pain
4. Phenergan 25 mg IV q 4° prn nausea
5. Versed 1 mg IV q titrate to reduce agitation, prn

PATIENT IDENTIFICATION

Verified 28 Sept 03 1800 (b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

DR (b)(6)-2

Addendum

1. Bolus 500cc then 200cc/hr.

(b)(6)-2

PATIENT IDENTIFICATION

Verified (b)(6)-2 28 Sep 1720

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 28 Sept 2003 TIME OF ORDER: 1700 HOURS

V1 DR [redacted] (b)(6)-2

1. Fluts [redacted]

(b)(6)-2

(b)(6)-2

24° V 28Sep03 02008 (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 29 Sep03 1945 HOURS

1. increase Toradol dose to 30 mg q6° for pain
2. hold morphine for now.

V.O.D (b)(6)-2

(b)(6)-2

(b)(6)-2

noted 29Sep03 1945

(b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 29 Sep 03 TIME OF ORDER: 2100 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Tylenol 1000mg po q 6° PRN Pain.

V.O. Dr (b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

2x° V 30Sep0300630

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 30 Sep 03 TIME OF ORDER: 0830 HOURS

(1) D/c Foley.

(2) KCl Liquid ~~20 meq/1~~ (20meq/15ml) 60ml po now + then again in 4°

(3) D/c Toradol.

(4) Repeat chem 7 @ 1500.

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 30 Sept TIME OF ORDER: 0900 HOURS

Change KCL to 40meq KCL in 100cc NSS infuse over 4 hours IV

V.O. Dr

(b)(6)-2

(b)(6)-2

MAJ, MC USA
CHIEF DOS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 30 Sept 03 TIME OF ORDER: 2248 HOURS

(1) Flat + Upright Abd Now

VO: Dr (b)(6)-2 Got

Noted 2330 30 Sept 03

(b)(6)-2

1 Oct 03

24 ✓ 30 Sept 03 @ 0100

DA FORM 1 APR 79 4256 ... L 77, WHICH MAY BE USED.

MEDCOM - 7608

CLINICAL RECORD - DOCTOR'S ORDERS

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

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PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
1 Oct 03	0152 HOURS	

(1) Dc Hangman IV
V.O. Dr (b)(6)-2 (b)(6)-2 (b)(6)-2 (b)(6)-2 (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
1 Oct 03	0155 HOURS

(1) ↓ IV Fluids to TKO...
V.O. Dr (b)(6)-2 (b)(6)-2 (b)(6)-2
Noted 1 Oct 03 @ 0200

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
1 Oct 2003	0930 HOURS

(1) D/c Triple Lumen Catheter
(2) Change Zantac to 150mg po BID
V.O. Dr [redacted] (b)(6)-2 (b)(6)-2 (b)(6)-2 (b)(6)-2
2nd ✓ 2 Oct 03 @ 0245 (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
2 Oct 03	0800 HOURS

D/c Fingersticks and Sliding Scale Insulin
V.O. Dr (b)(6)-2 (b)(6)-2 (b)(6)-2

04 OCT 03 1000

(1) D/c Labs.
Noted 05 Oct 2003 drawn ✓ 2 Oct 2003 1015 (b)(6)-2 (b)(6)-2 (b)(6)-2

DA FORM 1 APR 79 4256 MEDCOM - 7609 1 MAY

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4	20 Oct 2003	1500 HOURS	
	(1) Transfer to ICW		
	(2) Resume previous orders		
	V.O. Dr (b)(6)-2	(b)(6)-2	
(b)(6) [redacted]	(b)(6)-2 [redacted]		
NURSING UNIT			

noted 20 Oct 2003 [redacted]

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
(b)(6)-4	04 Oct 03	1120 HOURS	
	DC to MP entry		
(b)(6)-2	(b)(6)-2 [redacted]		
	(b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.			

noted 4 Oct 2003 [redacted] (b)(6)-2

Y, MD
MAJ MC USA
CHIEF, DOS

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
(b)(6)-4		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 23	24	25
23 Sep 03	(b)(6)-2	VS q1°, I & O, monitor	06	/	(b)(6)-2	
		A-line, Pulse OX	18	[redacted]	(b)(6)-2	
23 Sep 03		Act: Bedrest today	06	/	(b)(6)-2	
			18	[redacted]	(b)(6)-2	
23 Sep 03	(b)(6)-2	NPO	06	/	(b)(6)-2	
24 Sep 03		May have ice chips	18	[redacted]		
23 Sep 03		CBC, chem 8 qAm	05	/		
23 Sep 03		FS blood sugar q4°	04	/	[redacted]	changed to q8°
24 Sep 03		FSG q8°	08	/	(b)(6)-2	
			12	/		changed to q6°
			16	/		
			20	[redacted]		changed to q8°.
			24	[redacted]	(b)(6)-2	
23 Sep 03	(b)(6)-2	TCDB q1°, incentive	06	/	(b)(6)-2	
		Spirometry 10-20/hr	18	[redacted]		
23 Sep 03		Call MD for temp >101°,	06	/	(b)(6)-2	
		P<60 >100, SBP <100 >140,	18	[redacted]	(b)(6)-2	
		UO < 30cc/hr, sat <92%		/	/	/
23 Sep 03	(b)(6)-2	NG to LIS	06	/	(b)(6)-2	
			18	[redacted]		
2						

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: S/P Exp Lap / Transverse colectomy w/ ileostomosis, I&D abdominal wall + (2) Elbow wounds.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Sep Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
23 Sep 03	(b)(6)-2	To ICU D[redacted] b(6)-2	23 Sep 03		1920	(b)(6)-2
23 Sep 03		cond - stable	23 Sep 03		1920	
23 Sep 03		upon arrival - CBC, chem 8 FSG	23 Sep 03		1925	
24 Sep 03	[redacted]	Port-CXR for ln placement	24 Sep 03		0915	
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
25 Sep 03	(b)(6)-2	Restraints applied as needed	Date	25 SEPT												
.....	.....		Time	0100												
.....	.....		Initial	[redacted]	b(6)-2											
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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 Sept Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27	28
25 Sept 03	(b)(6)-2	VS: Q1° I+O, Monitor	06	(b)(6)-2			
		Pulse Ox	18				
25 Sept 03		Act: Up in Chair QID					
25 Sept 03		Ambulate c Assistance	06	(b)(6)-2			
		QID	12	(b)(6)-2			
			18				
			22				
27 Sep 03	(b)(6)-2	Diet: Sips n chips	06		(b)(6)-2		
			11				
			18				
25 Sept 03	(b)(6)-2	O2 10L Free mask: Titrate	06	(b)(6)-2			
		to keep Sat > 92%	18				
25 Sept 03		Foley to Gravity	06				
			18	(b)(6)-2			
25 Sept 03		CBC, Chem 8 Q-AM	05	(b)(6)-2			
		FS Blood Glucose Q8°	04				
		See SSI	12	(b)(6)-2			
25 Sept 03		FS: Blood Glucose Q8°	04				
		See SSI	12	(b)(6)			
			20				
25 Sept 03	(b)(6)-2	TCDB Q1° Incentive Spirometry	06				
		W-20x/hour	18				
25 Sept 03		Call MD for T > 101	06				
		P < 60 or > 100, SBP < 100	18				
		> 140, UO < 30cc/hr					
		Sat < 92%					

Rewritten (b)(6)-2 28 Sept 2003 1000

DUPLICATE See below.

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: Dx: S/P Wound Washout Closure Midline Abdomen 1 Q Q AM Condition Stable

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 1

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Sep Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
25 Sept 03	(b)(6)-2	To I Ou - Dr [redacted] b6-2	25 Sept	1120	1120	(b)(6)-2
25 Sept 03		DX: S/P Wound Washout, Closure Muscle	25 Sept	1120	1120	
25 Sept		Abdomen / (L) ELBow : Cond: Stable	25 Sept	1120	1120	
25 Sept		Blood Sugar On Arrival	25 Sept	1135	Done	
27 Sept		KUB x 1 new / flat & upright	27 Sept	1500	1500	
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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. ____ Yr. ____

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 26	27	28	29
26 Sep03	(b)(6)-2	Flush TL Q8°	06	/	(b)(6)-2		
			14	/	(b)(6)-2	(b)(6)-2	
			22		(b)(6)-2		
26 Sep03		Flush TL Q8° = Heg work.	06	/	/	(b)(6)-2	
			14	/	/		
			22	/	/		

RE WRITTEN BELOW

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: 2

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mo. Sept Yr 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28	29	30	1	2	3
28 Sept	(b)(6)-2	VS: Q4° ≈ PO	06	(b)(6)-2					
			8	(b)(6)-2					
28 Sept	(b)(6)-2	I & O's	06						
			18						
28 Sept	(b)(6)-2	ACTIVITY: Up in	06						
		Chair, ambulate	18						
		≈ assist QID							
28 Sept	(b)(6)-2	DIET: Clear Liquids	06	(b)(6)-2					
			18						
28 Sept	(b)(6)-2	FSBS Q8° - See SS →	06	(b)(6)-2					
		med care plan	14						Dcd 30 Sept 03
			22						
28 Sept	(b)(6)-2	Foley to gravity	06	(b)(6)-2					Dcd 30 Sept 03
			18						
28 Sept	(b)(6)-2	LABS: CBC, Chem 7	05	(b)(6)-2					
		q Am							
28 Sept	(b)(6)-2	TCDB q 1° / incentive	06	(b)(6)-2					
		spirometer 10-20x / hr	18						
28 Sept	(b)(6)-2	Notify MD for: T > 101°,	06						
		P < 60 > 100, SBP [illegible]	18						
		Uop < 30 cc/hr, SaO2 < 92%							
28 Sept	(b)(6)-2	Flush Central L-3L	06	(b)(6)-2	(b)(6)-2				1 Oct 03
		≈ 10cc syringe 3cc 100U	18	[redacted]					
		Heparin							

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: S/P Washout / DC abdomen wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Sept Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
28 Sept	(b)(6)-2	Admit to ICU - Dr (b)(6)-2	28 Sept	1300	1300	(b)(6)-2
28 Sep 03		Dx: s/p washout DPC abdwn	28 sep	—		
28 Sep 03		condition stable NCDA	28 sep	1300	1300	
30 Sept 03		Flat + Upright Abd X-Ray	28 Sept	2330	2300	
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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USAPA V1.00

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 2	3	4	5
20 OCT	(b)(6)-2	VS Q 4° c PO2	06	/	(b)(6)-2		
			14	/			
			22	/			
20 OCT	(b)(6)-2	I + O's	06	/			
			14	/			
			22	O			
20 OCT	(b)(6)-2	Activity: Up in Chair	06	/	(b)(6)-2		
		ambulate c assist QID	12	/			
			18		(b)(6)-2		
			24				
20 OCT	(b)(6)-2	Diet: Clear liquids	06	/	(b)(6)-2		
		Preg	12	/			
			18		(b)(6)-2		
20 OCT	(b)(6)-2	Labs: CBC, Chem 7	05				
		q AM	/				
20 OCT	(b)(6)-2	TCDB q 1° / IS 10 20	06	/			
		times / min.	14	/			
			22	O			
20 OCT	(b)(6)-2	Notify MD for T > 101°	06	/	(b)(6)-2		
		P < 60 > 100 SBP < 100	14	/			
		> 150 UOP < 30 cc, SaO2	22		(b)(6)-2		
		< 92%					

D/C Labs 40 days
Contraceptive

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS: S/P washout/D+C abdomen wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo Oct Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
2OCT	(b)(6)-2	Transfer to ICW: Resume all	2OCT	1800	Done	(b)(6)-2
		previous orders				
4Oct		D/C to MP custody	4 OCT	1706	1706	(b)(6)-2

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

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo. Sep Yr 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23	24	25
23 Sep 03	(b)(6)-2	Sliding Scale insulin	04	/	(b)(6)-2	
		q 4°	FSG	/		
		BS Regular insulin	units	/		
		≤85 Øu + notify MD	08	/		
		85-149 Øu	FSG	/		
		150-200 3u IV	units	/		
		201-250 6u IV	12	/		
		251-300 9u IV	FSG	/		
		>300 12u IV + notify MD	units	/		
			16	/		
			FSG	/		
			units	/		
			20		(b)(6)-2	
			FSG			
			units			
			24			
			FSG			
			units			

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: S/P Exp Lap / Transverse colectomy w/ reanastomosis, I&D abdominal wall to (L) Elbow wound

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 2

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo. ____ *Yr.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23	24	25
23Sep03	(b)(6)-2	IV LR TKO 125cc/hr	06	/	(b)(6)-2	
			18			
23Sep03	(b)(6)-2	Unasyn 3g IVPB	02	/		
		q6°	08	/		
			14		(b)(6)-2	
			20			
23Sep03	(b)(6)-2	O2 10L face mask-	06	/		
		titrate to keep Sat	18	(b)(6)-2		
		≥ 92%		/	/	/
23Sep03	(b)(6)-2	Toradol 15mg IV q6°	06	/	(b)(6)-2	
			12	/	(b)(6)-2	
			18	/		
			24			
23Sep03	(b)(6)-2	Zantac 50mg IV q8°	08	/	(b)(6)-2	
			16	/	(b)(6)-2	
			24			
23Sep03	(b)(6)-2	Metoprolol 5mg IVP	06	/		
		q6°	12	/		
			18	/		
			24			

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: S/P Exp Lap / Transverse colectomy w/ reanastomosis, I&D abdominal wall to ⊿ Elbow wound

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Sep Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
23 Sep 03	(b)(6)-2	Metoprolol 5mg IVP X1 now	23 Sep 03	now	1430	(b)(6)-2
23 Sep 03		May Repeat x II doses if needed				
		to keep HR < 100				
23 Sept	(b)(6)-2	LR 1000 cc Now	23 Sept 03	2300	2300	(b)(6)-2
24 Sept		LR 1000 cc Bolus Now IV	24 Sept 03	0300	0300	
24 Sept		LR 1000 cc Bolus IV Now	24 Sept 03	0515	0515	
24 Sep 03		Hespan 500cc IV bolus	24 Sep 03	0640	0645	
24 Sep 03	(b)(6)-2	Thorazine 25mg IV	24 Sep 03		1730	
24 Sep 03		Benadryl 50mg IV X1 now.	24 Sep 03	now	1930	
		May repeat x1 if not effective	24 Sept 03	prn	2100	
25 Sep 03	(b)(6)-2	Valium 5mg IV X1 now	25 Sep 03	now	0030	
24 Sep 03		Haldol 5mg IM now	24 Sep 03		1400	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
23 Sep 03	(b)(6)-2	Morphine 2-6mg	Date	23 Sept 03	23 Sept 03	23 Sept	23 Sept	24 Sep	24 Sep	24 Sept	25 Sept	25 Sept				
		IV q2° PRN Pain	Time	1930	2145	0135	0400	0930	1130	2100	0100	0300				
			Dose	4mg	4mg	5mg	3mg	2mg	4mg	4mg	4mg	4mg				
			I	(b)(6)-2												

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25	26	27	28	29	30
25Sep03	(b)(6)-2	IV: LR TRA 125cc/hr	06	(b)(6)-2					
			18	(b)(6)-2	DC'd				
25Sep03		Unasyn 3 gram IVPB	02	/	(b)(6)-2				
		Q 6°	08	(b)(6)-2					
			14						
			20						
25Sep03	(b)(6)-2	Toradol 15mg IV Q 6°	06						
			12						
			18	(b)(6)-2					
			24						
25Sep03	(b)(6)-2	O2 10L from Mask - Titrate	06						
		to keep Sat > 92%	18	(b)(6)-2					
25Sep03		Zantac 50mg IV Q8°	08						
			16						
			24						
25Sep03	(b)(6)-2	Metoprolol 5mg IVP Q6°	06	[redacted]					
			12	(b)(6)-2	DC'd 26Sep03 SS				
			18						
			24						
26Sep03	(b)(6)-2	Atenolol 50mg PO BID	10	/	(b)(6)-2				
			22	/					
27Sep03	(b)(6)-2	IVF LR @200 cc/hr	06	/					
		while asleep.	18	/					

Return Her 28 Sept 03

[redacted] 160

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: Dx: S/P Wound ~~Rupture~~ Wound Closure middle Abdomen/Ventral Cond: Stable

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1

PATIENT IDENTIFICATION: (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
25 Sep 03	(b)(6)-2	Haloperidol 5mg IM now	25 Sep	1400	1400	(b)(6)-2
25 Sept 03		Ambien 5mg PO For Sleep x1	25 Sept	2100	2115	
26 Sept		Haldol 5mg IM x1 now	26 Sept	now	now	
26 Sep 03		Lorazepam 2mg IV/PO x1 now	26 Sep 03	~~now~~ 1900	PO dose 1900	
26 Sep 03		Haldol 10mg IV x1 now } if no response in 30 min double dose	26 Sep 03	now	1900	
26 Sep 03		Benadryl 50mg PO/IV x1 now	26 Sep 03	now	IV dose 1900	
26 Sep 03		Lorazepam 2mg PO x1	26 Sep	—	2300	
11		Haldol 10mg IV x1	26 Sep	—	2300	
27 Sept		Tarachol 30mg x1 now	27 Sept	1500	0800	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
25 Sep 03	(b)(6)-2	Morphine 2-6mg	D	25 Sept	25 Sept	25 Sept	26 Sept	26 Sep	26 Sep 03	26 Sep 03	26 Sep 03	27 Sep 2003	27 Sep 03	27 Sep 03		
-----	-----	IV Q2° prn/pain	T	2000	0300	0700	0800	0810	1850	2218	0080	0300	1945	2230		1
-----	-----		I	6mg	4mg	3mg	5mg	5mg	5mg	5mg	5mg	3mg	3mg	4mg		
-----	-----		E	(b)(6)-2												
25 Sep 03	(b)(6)-2	Phenergan 25mg IV	D													
-----	-----	Q4° prn/nausea	T													
-----	-----		I													
-----	-----		E													
25 Sep 03	(b)(6)-2	Haloperidol 5mg IM	D	25 Sept	26 Sep											
-----	-----	q8° PRN/agitation	T	2300	1500											
-----	-----		I	5mg IV	5mg IM											
-----	-----		E		SS											
-----	-----															

(b)(6)-2

28 Sept 1600

Pulmitan

USAPA V1.00

Verify by Initialing

THERAF ; DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. _____ *Yr.* _____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
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Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
26 Sep 03	(b)(6)-2	1mg Versed IV and titrate	27 Sep 03	27 Sept 03	27 Sept 03	27 Sep 03	27 Sep 03									
- - - - -	- - - - -	to reduce agitation as	1mg	1mg IV	1330 1mg IV	1945	2230									
- - - - -	- - - - -	needed.	MC	0830	[redacted]	1mg	1mg									
- - - - -	- - - - -		0030	[redacted]	[redacted]	(b)(6)-2										
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Rewritten 28 Sept 03 1600

(b)(6)-2

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25	26	27	28
	------	Sliding Scale Insulin *	04		(b)(6)-2		
	------	08°	BS		88	82	99
	------		Ins		Ø	Ø	Ø
	------	BS Regular Insulin *	12		(b)(6)-2		
	------	<85 Ø u + notify MD	BS		115	198	140
	------	85-149 Ø u	Ins		Ø	3u	Øu
	------	150-200 3u SQ *	20		(b)(6)-2		
	------	201-250 6u SQ	BS		105	106	91
	------	251-300 9u SQ	Ins		Ø	Ø	Ø
	------	>300 12u SQ + notify MD					

Reviewed 28 Sept 03 1600

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: Dx: S/P wound debridement, closure medial elbow (L) Elbow cubital space

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
24 Sep 03	(b)(6)-2	Thorazine 25mg	DATE	24 Sep		DC'd		27 Sept		2003							
		PRN IV for hiccups	TIME	1500				0945		(b)(6)-2		CPT/RN					
			Initials	(b)(6)-2													
27 Sept	(b)(6)-2	Sedation Cocktail PRN	Date	27 Sep 03	28 Sep 03												
		Lorazepam 4mg PO	Time	2150	0110												
		Haldol 15mg IV	Initials	(b)(6)-2													
		Benadryl 50mg PO															
		may repeat in 3-4"															
		if not effective															

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. Sept Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 28	29	30	1	2	3
28 Sept	(b)(6)-2	IVF: LR @ 200 [redacted] for @ TKO	06	[redacted]					
			18	[redacted]					
28 Sept		Regular Insulin: SS q 8°:	06						
		<85 ØU NHO	FS		106	81	102		
		85-149 ØU	Ins			Ø	Ø		
		150-200 3U SQ	14	[redacted]					
		201-250 6U SC	FS	140	92	114	127		
		251-300 9U SC	Ins	Ø	Ø	Ø	Ø		
		>300 12U SC & NHO	22						
28 Sept	(b)(6)-2	Unasyn 3gm IVPB q 6°	FS		167	111	126		
			Ins	Ø	34	Ø	56		
			02						
			08						
			14	[redacted]					
			20						
28 Sept	(b)(6)-2	~~Dulcolax to my suppository~~							
		ATENOLOL 50 mg ½ po BID	10						
28 Sept	(b)(6)-2	Zantac 50 mg IV q 8°	22						
			08						
28 Sept	(b)(6)-2	Toradol 15 mg IV q 6°	16						
			24						
			06						
			12						
			18	[redacted]					
1/03	(b)(6)-2	Zantac 150 mg po BID	24						
			10	/	/	/			
			22	/	/	/			

(b)(6)-2

(b)(6)-2

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(b)(6)-2

(b)(6)-2

(b)(6)-2

Change 10/1/03

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: S/P WASHOUT DPL Abd wnd

PATIENT IDENTIFICATION:

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. 1

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

6 17 18 19 20

DA FORM 4678, 1 FEB 79

MEDCOM - 7628

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

Mo. 04

Verify by initialing	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		Dulcolax Suppository 10mg x 1	28 Sept	28 Sept	1600	(b)(6)-2
	(b)(6)-2	fleets Enema x 1	28 Sept	1710	2030 ↑ stable	(b)(6)-2
	(b)(6)-2	Bolus 500 cc	28 Sept		1710	
		Toradol 15mg IV (To total 30mg for 1800 dose) @ 29 sep 03	29 Sep		1945	
	(b)(6)-2	40 meq KCl in 1 liter NSS (Nurse #1	30 Sept	1100	1100	(b)(6)-2
		over hours x 2	30 Sept	1500	1500	

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED			
28 Sept	(b)(6)-2	Sedation Cocktail PRN	28 Sept 2200 SL	28 Sept 2300 SL	30 Sept 2130 [redacted]	
		Lorazepam 4mg PO				
		Benadryl 50mg PO				
		Haldol 15 mg IV				
		May repeat in 4° if not effective				
28 Sept	(b)(6)-2	Msay 2-6mg IV q 2°	2:15 Sept 4mg 0230 SL	29 Sep 4mg 0830 OS	1040 OS	4mg 1530 OS
		PRN pain		29 Sep 03 2000 SL	30 Apr 1500	01 Oct 03
28 Sept	(b)(6)-2	Phenergan 25 mg IV				
		q 4° nausea				
28 Sept	(b)(6)-2	VERSED 1mg IV	Date	29 Sep	29 Sep	
		titrate to reduce agitation	Time	0230	0415	
			Dose	1mg	1mg	
		PRN	Initials	[redacted]		

HOLD

b(6)-2

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 29	30	1										
29 Sep 03	(b)(6)-2	Toradol 30mg IV q6°	06	/	(b)(6)-2											
			12	/							D/C'd					
			18	/								30 Sept 03				
			24	(b)(6)-2												
10 Oct 03	(b)(6)-2	Zantac 150mg po BID	6	/	/					Renewed						
			22	/	/							10 Oct 03				

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	S/P Washout DPC Abd wound	PAGE NO. 2

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*					Mo._____ Yr. _____
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
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Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED														
29 Sep 03	(b)(6)-2	Tylenol 1000 mg PO	DATE	29 Sep 03	30 Sep	30 Sep	30 Sept										
- - - - -	- - - - -	q6° PRN Pain	TIME	2100	0800	1400	2016										
- - - - -	- - - - -		Initial	(b)(6)-2													
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USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo. ____ *Yr.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2	3	4	5	6	7	8	9
20CT08	(b)(6)-2	Atenolol 50mg i PO	10	/ (b)(6)-2							
		BID	22	(b)(6)-2							
20CT08	(b)(6)-2	Zantac 150mg PO	10	/ (b)(6)-2							
		BID	22	(b)(6)-2							

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: S/P washout/D&C abdominal wands

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
2OCT	(b)(6)-2	Phenergan 25mg														
- - - - -	- - - - -	IV q 4° PRN														
- - - - -	- - - - -															
2OCT	(b)(6)-2	Tylenol 1000mg PO	20CT 2117	20CT 1000	20CT 1835	20CT 2057	20CT 2150									
- - - - -	- - - - -	q6° prn pain	(b)(6)-2													
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				2	3	4											
2 Oct 03	(b)(6)-2	Atenolol 50mg i po	10	(b)(6)-2													
		BID															
2 Oct 03		Zantac 150mg po BID	10	(b)(6)-2													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Wound DPL ABD wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
28 Sept 03	(b)(6)-2	Phenergan 25mg IV	D													
- - - - -	- - - - -	Q4° prn Nausea	T													
- - - - -	- - - - -		I													
- - - - -	- - - - -		E													
28 Sept 03	(b)(6)-2	Versed 1mg IV titrate	D													
- - - - -	- - - - -	to reduce Agitation	T													
- - - - -	- - - - -	prn	I													
- - - - -	- - - - -		E													
28 Sept 03	(b)(6)-2	Tylenol 1000mg PO	D													
- - - - -	- - - - -	Q6° prn pain	T													
- - - - -	- - - - -		I													
- - - - -	- - - - -		E													
- - - - -	- - - - -															

USAPA V1.00

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INITIALS	MSC	INITIALS (b)(6)-2		INITIALS
NEURO	PUPILS			3mm PERRLA			
	SENSORIUM			Arousable to voice			
				Lethargic			
RESPIRATORY	RESPIRATORY PATTERN			Even			
	BREATH SOUNDS			CTA			
	SECRETIONS			⊖ Secretions			
SKIN	COLOR			NFR			
	INTEGRITY			Midline Abd CDT			
				(L) FA, CDT			
IV SITE	LOCATION			15G (R) FA Patent			
	CONDITION			⊖ S+Sx Infection			
				(L) Rad-A-Line			
GASTRO	ABDOMEN			Soft Tender			
	BOWEL SOUNDS			~~BS Normal~~ [redacted] ⊖ BS			
GU	URINE:			Foley			
	COLOR/CLARITY			Yellow Concentrated			
CARDIOVASCULAR	CARDIAC RHYTHM			SR c̄ 1st Deg AVB			
				1/2 Pulses UE, +1 LE			

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

b(6)-2

(Continue on reverse)

PREPARED BY (Name, grade, and organization) (b)(6)-2 [redacted] CPT/AN

DEPARTMENT/SERVICE/CLINIC ICU

DATE 23 Sept 03

PATIENT (Name—last, first, middle; grade; date; hospital or medical facility) (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

28 Sept 03

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	/	14	15	16	17	18	19	20	21	/
BP Arterial Line															141/76			
BP Cuff															150/87	123/74	109/65	
Temperature															96.8			
Pulse															96	89	91	
Respiratory Rate															22	23	16	
															99	100	99	

(b)(6)-2

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR															100 125	125 250	125 375	375
OR													OR	1400				1400
													IVPB	350				350
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL												OR	700/700		50/750	50/800	780
	sp gr																	
	S/A												(b)(6)-2	400				400
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

	22	23	24	01	02	03	04	05	
V									
I	97/63	100/65	111/66	103/71	100/64	92/55	99/63	80/85	
T	0	97 9		100 4	100 4		100 4		
A	91	94	91	89	96	97	115	105	
L	12	13	12	13	14	15	22	17	
	100	100	100	100	100	100	100	100	
	4L	4L	4L	4L	4L	4L	4L	4L	

	22	23	24	01	02	03	04	05	8° T
75	125 500	125 625	125 750	125 875	125 1000	125 1125	125 1250	125 1375	1375
100									1400
50									350
Stat		1000 1050				1000			2000
									$625
30	1 810	20 830	40 870	30 400	35 435	30 465	40 505	40 545	1045
									400

ACUITY LEVEL CLASSIFICATION

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

LABORATORY	TIME	20	21	04	05
	GLUCOSE	254	105	147	139
	Na/K	131/6.3			130/4.5
	Cl/CO_2	102/18			101/14
	BUN/Cr	17/1.2			18/1.7
	WBC/PLATELET	13.5/255			14.4/207
	Hct/Hgb	45/14.4			49/15.4

ACTIVITIES DONE DAILY / EVERY 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	5125	Urine:	1045
po			400
TOTAL	5125	TOTAL	1445
BALANCE			+3680

NURSE'S SIGNATURE	INITIALS
(b)(6)-2	(b)(6)-2

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0620	INITIALS [redacted]	b(6)-2	INITIALS		INITIALS
NEURO	PUPILS		2mm & PERLA				2mm Perla	
	SENSORIUM		alert, awake, follows commands moves all extremities				awake - oriented? language barrier moves all extremities uncooperative at times	
RESPIRATORY	RESPIRATORY PATTERN		even & unlabored				RRR - shallow	
	BREATH SOUNDS		CTA bilaterally				unlabored - CTA	
	SECRETIONS		Ø noted, on 4L O2 via NC saffing 99-100%				bilat - SaO2 > 95% on 2L NC -	
SKIN	COLOR		normal for race					
	INTEGRITY		dressing to midline abd ~~Ø serous drainage & from NCE~~				No Δ's	
IV SITE	LOCATION		RFA					
	CONDITION		infusing LR @ 125cc/h patent, Ø S/Sx infiltration, infiltration				Triple lumen cath Distal ok medial LR @ 125cc/hr proximal port occluded	
GASTRO	ABDOMEN		round, mod. distended				soft, round and convex	
	BOWEL SOUNDS		absent in all quads NG to LIS, NPO				Ø BS - Dsg CDI NG - one sip cimbien Ø N/V	
GU	URINE:		Foley to gravity				Foley to Gravity	
	COLOR/CLARITY		clear, dark yellow				clear dark yellow	
CARDIOVASCULAR	CARDIAC RHYTHM		NSR, pulses in lower extremities weaker than upper, A-line to Ø read, not reading				UOS > 30 ml/hr NSR - Tachy 100-120's A-line pulled out by patient	

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 (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 24 Sept 03

PA (b)(6)-4 ...me—last; first;

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

24 Sept 03 Exp Lap S/P (GSW)

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
BP Arterial Line						91/54	94/59	91/53	92/55	91/56	91/56	100/61	113/64	121/57	112/55	124/55
BP Cuff	88/53	78/49	91/59	97/57	109/40	112/56	115/55	109/46	109/45	105/52	105/50	132/60	109/46	107/57	110/55	110/60
Temperature				99.8	?											100.4
Pulse	94	93	94	100	101	107	96	96	101	100	107	108	129	108	115	114
Respiratory Rate	18	14	10	20	22	25	22	19	20	20	25	25	22	21	18	20
SPO2	100	100	99	100	99	97	99	98	98	99	98	98	94	98	97	96
	4L	4L	3L	3L	2L	2L	2L	2L	2L	3L	3L	3L	3L	3L	3L	3L

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR	125	125	125	125	125	125	125	125		125	125	125	125	500	125	125	125	
IVPB			150				50			100						100		
TOTALS																		

OUTPUT

Foley URINE	HOUR / TOTAL	40	30	30	30	50	50	50	40	40	50	80	40	40	50	60	60	
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

VITALS	22	23	24	01	02	03	04	05
	92/47	97/49	98/46	pulled out				
					131/73	124/69	133/55	121/61
	103		100°					100°
	110	114	112	110	104	101	96	100
	21	24	20	22	23	22	19	19
	96%	96%	95%	97%	100%	97%	99%	99%

	22	23	24	01	02	03	04	05	8° T
	125	125	125	125	125	125	125	125	
			50						
	100	100	100	100	70	80	80	80	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME										
	MODE										
	F_IO_2										
	TV										
	RATE										
	PEEP										
ARTERIAL ABG	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 H&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	1100	Urine:	
po	Ø		
IVPB	450		
TOTAL	1550	TOTAL	1460

BALANCE (-) 90

NURSE'S SIGNATURE	INITIALS
(b)(6)-2	(b)(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

bles - 2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0685	INITIALS [redacted]	1900	INITIALS [redacted]		INITIALS
NEURO	PUPILS		2mm & PERLA		3mm PERLA			
	SENSORIUM		awake, alert, talking, no interpretor available follows commands moves all extremities		Awake, Alert, Confused? MAE x4 strong, Follows, Commands			
RESPIRATORY	RESPIRATORY PATTERN		even & unlabored		Even + unlabored			
	BREATH SOUNDS		CTA bilaterally		CTA bilaterally			
	SECRETIONS		Ø noted on 4L O2 via NC sating 98-100%		Ø Noted on 4L O2			
SKIN	COLOR		normal for race		NFR			
	INTEGRITY		dsgs to abd wounds CDT,		dressing to Abd - Intact, Clean Reinforced on Sides			
IV SITE	LOCATION		(R) SC TLC infusing		(R) SC TLC infusing			
	CONDITION		LR to medial port, transducing distal port					
GASTRO	ABDOMEN		soft, non-tender		Soft, Tender			
	BOWEL SOUNDS		absent in all quads, NPO for surgery		BS hypo			
GU	URINE: COLOR/CLARITY		Foley to gravity clear, dark yellow/amber		Foley to Gravity, Clear, Dark			
CARDIOVASCULAR	CARDIAC RHYTHM		NSR, all pulses palpable, Ø edema noted.		ST +1 Pulses UE/LE, Bilat Ø Edema Noted			

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

(Continue on reverse)

PREPARED BY (Name, grade, date, hospital or medical facility) (b)(6)-2 SGT/LPN

DEPARTMENT/SERVICE/CLINIC ICU

DATE 25 Sep 03

PATIENT'S (Name—last, first, middle; grade; date; hospital or medical facility) (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
BP Arterial Line																
BP Cuff	139/66	118/64	116/61	113/66			112/69		129/80	98/56	136/53	121/69	138/77	141/76	142/71	131/71
Temperature	98.2													99.7		
Pulse	96	97	100	105			107		97	100	105	104	99	101	108	107
Respiratory Rate	21	23	24	20			17		19	18	19	20	19	22	27	23
O2	4L	4L	6L	6L			8L		6L	5L	5L	4L	4L	4L	4L	4L
	99	96	96	91			100		97	98	97	95	96	95	95	98
CVP	10	12	12	14			9									

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR	125 / 125	125 / 250	125 / 375	125 / 500	250 / 750	500 / 1000	125 / 1125	125 / 1250		125 / 1375	125 / 1500	125 / 1625	125 / 1750	125 / 1875	125 / 2000	125 / 2125	125 / 2250	2850
IVPB			150						150	100 / 250						100 / 350		350
TOTALS																		

OUTPUT

		TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
URINE		HOUR / TOTAL	120 / 120	110 / 230	110 / 340	90 / 430			75 / 505	75 / 580		60 / 640	60 / 700	50 / 750	50 / 800	60 / 860		60 / 920	150 / 1070	250 / 1320
		sp gr					400													400
		S/A																		
NG		OUTPUT																		
		pH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

POST-OP DAY

	22	23	24	01	02	03	04	05
	101/60	103/6L	170/66	163/87	173/60	172/68	170/41	142/71
				99				
	105	101	121	112	101	110	113	109
	24	10	20	21	14	15	16	16
	99	98	93	96	96	94	95	97
	4L	4L	4L	4L	6L	6L	6L	6L

	22	23	24	01	02	03	04	05	8° T
150	125	125	125	125	125	125	125	125	
150	3825	3800	3825	3250	3375	3500	3625	3750	3750
									350
									4100
70	100/2220	100/2220	480/20	150/2270	100/2370	450/2320	200/2320	100/2320	3320
70									400

ACUITY LEVEL CLASSIFICATION

BESPDIABATOREY	TIME										
	MODE										
	F_IO_2										
	TV-- · · ·										
	RATE										
	PEEP										
A	pH										
A	PCO_2										
	pO_2										
B	HCO_3										
	SAT										
G	BASE										

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

ACTIVITIES 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	4100	Urine: 3750
po		
TOTAL		TOTAL
		BALANCE +350

(b)(6)-2

URE

INITIALS

(b)(6)-2

MEDCOM - 7644

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	0615	INITIALS [redacted]	b(6)-2	INITIALS	1830	INITIALS (b)(6)-2
NEURO	PUPILS	3mm & PERRLA				PERRLA	
	SENSORIUM	pt agitated, disoriented, confused, in & out of sleep				very agitated, attempting to get out of bed, pulling at lines, redirected to RCB	
RESPIRATORY	RESPIRATORY PATTERN	even & unlabored				even, some SOB noted on exertion due to agitation on 5L NC	
	BREATH SOUNDS	CTA bilaterally					
	SECRETIONS	⊘ noted, refuses to use IS, snoring resp while asleep					
SKIN	COLOR	normal for race				WNL.	
	INTEGRITY	dressings to abd reinforced, dsg to R arm (ACE wrap)				drsg to abdomen D+I, R arm drsg intact	
IV SITE	LOCATION	(L) SC TLC, medial port				(L) SC TLC, all ports	
	CONDITION	infusing LR @ 125 c/h, distal port connected to transducer line but not transducing, prox port patent & flushed				inplocked, flushed all ports c̄ 10cc NS, no blood return to distal + proximal ports. medial ports c̄ blood return. AI	
GASTRO	ABDOMEN	soft, obtunded				soft c̄ DDS intact	
	BOWEL SOUNDS	(+) in lower quadrants difficult to assess in upper				(+) BS auscultated	
GU	URINE:	Foley to gravity				Foley → gravity	
	COLOR/CLARITY	clear, amber				Clear yellow urine	
CARDIOVASCULAR	CARDIAC RHYTHM	NSR, EKG leads unhooked 2° pt anxiety, all pulses palpable, mild edema noted to UE				regular [redacted] rhythm auscultated S1S2 heard, (+) pulses to all extremities	

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) (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 26 Sept 03

PATIENT IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility) (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

26 Sept 03 (5(a) Abd + Elbow)

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
BP Arterial Line																		
BP Cuff	144/66	145/83	147/80	140/51	91/54	154/86	139/75	134/79		139/78	110/64	111/62	110/60	135/65	112/59	105/57	120/64	
Temperature																		
Pulse	94	102	105	100	92	109	104	105		93	95	94	97	97	85	82	77	
Respiratory Rate	16	19	23	17	16	17	21	23		25	23	21	17	25	20	18	24	
SPO2	96	99	96	93	97	96	96	96		97	96	97	95	96	97	97	98	
	6L	6L	4L	4L	6L	6L	6L	6L		6L	6L	6L	6L	6L	5L	3L	3L	
															NC	NC	NC	

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
IR	125 / 125	125 / 250	125 / 375	125 / 500	125 / 625	125 / 750	125 / 875	125 / 1000	1000	125 / 1125	125 / 1250	125 / 1375	125 / 1500	0	0			1500
PO		500		250						100		50						
IVPB			150			250 / 400		250 / 650						400 / 1050		100 / 1150		1150
TOTALS																		

OUTPUT

	HOUR / TOTAL	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
URINE		100 / 100	125 / 225	125 / 350	150 / 500	150 / 650	200 / 850	200 / 1050	150 / 1200		150 / 1350	150 / 1500	100 / 1600	125 / 1725	125 / 1850		650 / 2500		2500
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

	22	23	24	01	02	03	04	05	
BP	143/70	133/76	124/70	100/57	93/54	115/60	115/63		
HR	95	97	90	81	79	82	97		
RR	22	20	20	19	16	16	14		
O2	3L	3L	3L	3L	3L	3L	3L		
meth	NC	NC	NC	NC	NC	NC	NC		
O2sat	95	97	98	98	98	96%	98		

	22	23	24	01	02	03	04	05	8° T
IV									
po									
UO			50 / 1200		100 / 1300				1300
	50 / 3050				1200 / 4250			100 / 4450	4450

ACUITY LEVEL CLASSIFICATION

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

LABORATORY	TIME	0100								
	GLUCOSE	96								
	Na/K	136 / 3.9								
	Cl/CO_2	104 / 23								
	BUN/Cr	14 / 1.0								
	WBC/PLATELET	8.4 / 170								
	Hct/Hgb	28.8 / 9.3								

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME / INITIALS			
	27 Sept	0630 (b)(6)-2			
NEURO	PUPILS	3mm 3mm Reactive			
	SENSORIUM	awake, agitated, ⊕ irritability, bouts intermittent confusion, and ⊕ anxiety. Restraints x 3 to (R) U/L ext. and (L) UE. moves all ext, good sensation, good strength			
RESPIRATORY	RESPIRATORY PATTERN	deep, unlabored			
	BREATH SOUNDS	RR: 18-20 SaO2 99%			
	SECRETIONS	Ø secretions. BS: clear throughout posteriorly. ⊕ SOB, dyspnea on exertion			
SKIN	COLOR	NFR			
	INTEGRITY	⊕ Midline abd incision dry COI. Drg to (R)(L) lateral regions COI			
IV SITE	LOCATION	3-lumen catheter			
	CONDITION	to (L) subclavian Proximal - Ø flush; Ø BR Medial - ⊕ flush; ⊕ BR Distal - ⊕ flush; ⊕ BR			
GASTRO	ABDOMEN	↓ BS UQ Soft, non tender, non distended.			
	BOWEL SOUNDS	Hyperactive (R)(L) LQ Ø BS U R/LQ.			
GU	URINE:	Foley to gravity			
	COLOR/CLARITY	clear yellow			
CARDIOVASCULAR	CARDIAC RHYTHM	BP 135/70 82 NSR S1 S2 present ↑ @ apex, 1+ radial pulses Bilat and 1+ pedal pulses Bilaterally capillary ≤ 3 sec			

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

(b)(6)-2

(b)(6)-2

(Continue on reverse)

ILT A ✓

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 27 Sep 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

TR' MENT

DATE | DX | HOSPITAL DAY

VITALS	TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
	BP Arterial Line																		
	BP Cuff	101/58	135/70	136/74	116/74	142/67	120/73	137/69	129/70		120/74	142/73	111/59	102/44	144/50				
	Temperature	98.6	98.1		97.6				96.9		96.0	96.8		97.4	[redacted]				
	Pulse	82	83	82	85	93	86	83	84		82	81	79	74	73				
	Respiratory Rate	18	19	20	21	11	21	19	20		13	19	22	18	19				
	Oxygen	3L NC	3L	3L	3L	3L	RA	—	3L		3L	3L	—	—	—				
	O2Sat	99%	98%	100%	98%	99%	98%	97%	98%		99%	100%	97%	96%	95%				
			NC	NC	NC	NC	RA	RA	NC		NC	NC	RA	RA	RA				
	FSBS								194								91		
			Ativan 1mg	Versed 1mg 0880	MSO4 3mg	Dramin 4		Tuzadol	Versed 1mg 1330 MSO4 4mg IV		Unasyn	Toradol 30mg IV Kub	Zantac		Tordadol				

INTAKE	TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
	IVPB	Ø	Ø	200 200	Ø 200	Ø 200	Ø 200	Ø 200	Ø 200	200	100 300	Ø 300	100 400	Ø 400	Ø 400	— 400	100 500		500
	PO	Ø	60	60	60	60 120	120	120	120	120	150	150	30 180	Ø 180	Ø 180	30 210			
	IVF												125 Ø 125	125 125	125 125	200 325	200 525	200 725	725
	PO																		
	TOTALS																		

OUTPUT		HOUR / TOTAL	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
	URINE		125 / 125	125 / 250	125 / 375	125 / 500	100 / 600	100 / 700	100 / 800	100 / 900	900	100 / 1000	125 / 1125	125 / 1250	125 / 1375	125 / 1500			725 / 2225	2225
		sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS		Ø	Ø	Ø	Ø									Ø					
	STOOL		Ø	Ø	Ø	Ø								→	Ø					
	DRAINS																			
	TOTALS																			

POST-OP DAY

	22	23	24	01	02	03	04	05	
BP	116/76				140/57				
T	98°				97.8				
HR	88				78				
RR	16				18				
Hyper	R/A				R/A				
O2sat	99%				93%				
							99		

	22	23	24	01	02	03	04	05	8° T
VPO	~~500~~		50		100				
	~~500~~		550		650				650
PO	~~50~~		~~50~~		~~100~~				
	~~210~~		~~260~~		~~360~~				360
vt	~~200~~	~~200~~	~~200~~	~~200~~	~~200~~	~~200~~	~~200~~	~~200~~	
	~~1125~~	~~1125~~	~~1325~~	~~1525~~	~~1725~~	~~1925~~	~~2125~~	~~2325~~	2325
	325				875			125	
	2550				3425			3650	3650

ACUITY LEVEL CLASSIFICATION

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

LABORATORY	TIME	1400							
	GLUCOSE	198							
	Na/K								
	Cl/CO_2								
	BUN/Cr								
	WBC/PLATELET								
	Hct/Hgb								

ACTIVITIES DAILY LIVING	TIME	0930			TURN	TIME			
	MOUTH CARE								
	BATH	(b)(6)-2							
	SKIN CARE								
	FOLEY CARE				SUCTION				
	TRACH CARE								
	ROM EXERCISES								

24 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL	2325	TOTAL	360

NURSE'S SIGNATURE (b)(6)-2 INITIALS

MEDCOM - 7650

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	0620	INITIALS [redacted] (b)(6)-2	INITIALS		INITIALS
NEURO	PUPILS	3mm 3mm Perrl			3mm Perrl	
	SENSORIUM	A&O disoriented, agitated, 2pt restraint x4 place to Bilat WE. Circ ⊕=⊕ pulses, capr refill ≤3sec. Moves all ext. ⊕ strength especially u/e ext. ⊕ sensation. No evidence of pain.			moments of conversation moments of confusion Pt will sleep then awaken intermittently	
RESPIRATORY	RESPIRATORY PATTERN	unlabored, even, deep breaths			RRR - ⊘ cough	
	BREATH SOUNDS	SaO2 93% RA RR 1:20-24 BPM			⊕ cough ⊕ CP	
	SECRETIONS	⊘ secretions. BS clear throughout.			BR B-17	
					O2 NC @ 2L S.O2 99%	
SKIN	COLOR	NER. ⊕ abd midline incision ⊕ ecchymosis				
	INTEGRITY	app i staples. DsCDI, ⊕ ⊘ UQ to ⊕ ⊘ lower lateral			No As	
		Central aspect bullet holes, Dsg x2 abd sym.				
I.V. SITE	LOCATION	CDI		Large areas extending to back		
	CONDITION	3-lumen Central line - to ⊕ subclavian. Dsg ⊘ ul 27 Sept. ADI			Triple lumen	
		Proximal - ⊕ flush ⊕ BR			LR @ 200 cc/hr	
		Medial - ⊕ flush ⊕ BR - LR @ 200 cc/hr			proximal, distal patent	
		distal - ⊕ flush ⊕ BR			flushed c. Heparin	
GASTRO	ABDOMEN	⊕ BS Bilat lower quadrants ⊘ upper quadrants			⊕ BS throughout	
	BOWEL SOUNDS	BS heard. ⊕ abd distention, Pt agitation difficulty assessing abd tenderness.			Passes flatus - small	
					passes stool - soft, ⊕	
					⊕ pain - intermittent	
GU	URINE:	Foley to gravity clear yellow			foley to gravity	
	COLOR/CLARITY				BS dark yellow urine	
CARDIOVASCULAR	CARDIAC RHYTHM	NSR 5152 presents			Stable	
		⊘ dysrhythmia			NSR HR 70's-90's	
		pulses peripheral radial			⊕ radial, pedal pulses	
		Blat = 1+, Cap refill ≤5sec				

LEGEND (b)(6)-2

[illegible] Pressure
[illegible] of Arterial CO_2
[illegible] Expiratory Pressure
SA - Fractional
SAT - Saturation
TRACH - Tracheostomy

(b)(6)-2

(Continue on reverse)

1LT [illegible]

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 28 Sep 03

middle; grade; date; hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS	TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
	BP Arterial Line								133/0										
	BP Cuff	139/84	→	→	→	158/84			100/55		92/50		95/55	120/65	124/75			120/76	
	Temperature	98.6				98.0			99.0				98.6					98.8	
	Pulse	91				83			77		81		75	79	80			81	
	Respiratory Rate	22				14			18		18		18	14	17			17	
	O2 sat	93				97%			99%		97%		96	97	97%			99%	
		RA				RA			NRB		NC		NC	NC	NC			NC	
											4L		2L	2L	2L			2L	
											Return from OR	Sleeping	Sleeping	Bolus				Sleeping	

INTAKE	TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
	LR	200 / 200	200 / 400	200 / 600	200 / 800	200 / 1000	Ø / 1000	OR	OR	1000	200 / 1200	200 / 1400	200 / 1600	500 / 2100	200 / 2300	200	200	200 / 2900	2900
	IVPB	Ø	Ø	200	200	200	Ø	200	200	200	100 / 300	Ø / 300	100 / 400	Ø / 400	Ø / 400	Ø / 400	100 / 500	100	500
	PO	Ø	NPO						NPO	Ø									100
	PO																		
	TOTALS																		

OUTPUT			06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
URINE	HOUR		350	→	1200	→		1200				125	30	30	35	50	50	50	50	
	TOTAL		350	→	1550	→		1750			1750	1875	1905	1935	1970				2070	2170
	sp gr																			
	S/A																			
NG	OUTPUT		N/A											Bolus 200 cc						
	pH																			
	GUIAC																			
EMESIS			Ø				Ø				Ø									
STOOL			Ø				Ø				Ø						Bs 35			
DRAINS			N/A								N/A									
TOTALS																				

POST-OP DAY

	22	23	24	01	02	03	04	05	
				[illegible]				126/80	
				97					
				80				82	
				16				17	
				99%				98%	
				2LL				NC	
								2L	

	22	23	24	01	02	03	04	05	8° T
	200	100	200	300	300	300	300	300	1600
			50		100		100		150
	60	40	40	40					180

	40/200	40/200	40/200	40/200	40/200	40/200	40	40	320

ACUITY LEVEL CLASSIFICATION

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

LABORATORY	TIME	0400									
	GLUCOSE	101									
	Na/K	131/3.6									
	Cl/CO_2	101/25									
	BUN/Cr										
	WBC/PLATELET	12.5									
	Hct/Hgb	39.3/12.7									

ACTIVITY / DIET / DRESSING	TIME				TURN	TIME				
	MOUTH CARE									
	BATH	0800								
	SKIN CARE	0800								
	FOLEY CARE	0800			SUCTION					
	TRACH CARE									
	ROM EXERCISES		AMB							
			1030-1130							

24 I&O TOTALS

wt Yesterday ____ wt Today ____

INTAKE		OUTPUT	
IV	4500	Urine:	2490
~~po~~	650 NPB		
~~TPN~~	100 Po		
TOTAL	3250	TOTAL	2490
BALANCE	+760		

NURSE'S SIGNATURE | INITIALS

(b)(6)-2

CPT

(b)(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0 1130	INITIALS (b)(6)-2		INITIALS	1900	INITIALS (b)(6)-2
NEUROLOGICAL	PUPILS		Reactive equal				PERRL	
	SENSORIUM		Confused agitated				Agitated and confused	
			follows some commands				at times, follows	
			Moves all extremities				some commands.	
			Language barrier					
RESPIRATORY	RESPIRATORY PATTERN		RR even, unlabored				Reg n, non labored.	
	BREATH SOUNDS		LS CTA				Clear bilat	
	SECRETIONS		∅ secretion noted				∅	
			pt snores while				O2 sat 97% on 3L	
			sleeping stay maintain				NC ∴ humidity	
			94% on RA					
SKIN	COLOR		normal for race				WNL	
	INTEGRITY		Abd. incision approximated ∴ staples				mid line abd incision ∴ staples	
			stable redness (L) arm guarding ace				intact. drsg to (R) + (L) Abd Art.	
IV SITE	LOCATION		TLC - central line				(R) ∴ TLC site + dsg	
	CONDITION		Medial port infusing LR 200cc/hr				intact. LR @ 200cc/hr	
			Heparin @ proximal port				via distal port. Prox + medial	
			flush ∴ NS ∴ difficulty				ports heparinized. prox port ∴	
							no blood return flushed + heparinized	
							med. port (+) blood return flushed	
GASTRO	ABDOMEN		Abd soft non distended				Abd. round, slightly distended	
	BOWEL SOUNDS		(+) BS x 4 quad				(+) hyperactive BS x 4 quads.	
			∅ bm this am				refused dinner.	
GU	URINE:		Foley > gravity					
	COLOR/CLARITY		clear dk yellow urine				Foley > gravity	
							clear yellow urine	
CARDIOVASCULAR	CARDIAC RHYTHM		HR NSR HR 80					
			BP 92 normal ∅				NSR ∅ ectopy	
			extra sounds (-)				palpable pulses ∴	
			peripheral pulses x4				difficult radial + pedal	
							pulses	

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

(b)(6)-2

SGT 91WM6

DEPARTMENT/SERVICE/CLINIC ICU

DATE 29 Sept 03

(Continue on reverse)

(... grade, date, hospital or medical facility) ... entries give: Name—last, first,

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS	TIME	06	07	08	09	10	11	12	13	/	14	15	16	17	18	19	20	21	/
	BP Arterial Line																		
	BP Cuff	89/100	/	/	/	98/80	/	/	102/72		/	/	/	112/50	147/67				
	Temperature	98.1				97.9			...					99.4					
	Pulse	83				81			75					74	74				
	Respiratory Rate	20				20			18					18	18				
	SAO2	94				94%			100%					99%	99				
		3L				RA			4L					3L	3L				
									NC					NC	NC				

INTAKE	TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
	ZL	200/200	100/100	200/100	200/800	200/100	100/100	100/100	200/100	1650	100/1800	200/200	200/2200	200/2400	200/2600	200/2800	200/3000	200/3200	3200
	PO					100/150	50/150				100/150		60/300		100/400				
	IVPB			150/150							150/300		50/350				100/400		
	TOTALS																		

OUTPUT		HOUR / TOTAL	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
	URINE		X	X	X	100/100	100/200	X	X	125/	1025	100/125	X	200/325	/	/	750/2075	/	/	
		sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS																			

POST-OP DAY

V	22	23	24	01	02	03	04	05	
I									
T	129/103								
A	97.5								
L	80								
S	18								
	94								
	3L NC								
					Client ambulated				

	22	23	24	01	02	03	04	05	8° T
	250	250	200	200	200	200	200	250	
	3400	3600	3800	4000	4200	4400	4600	4850	480
	100								
	500								500
6PM			50		100				
			450		550				550
									5850
	1100						1300		
	375						445	4475	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME										
	MODE										
	F_IO_2										
	TV										
	RATE										
	PEEP										
ARTERIAL BLOOD GAS	pH										
	PCO_2										
	pO_2										
	HCO_3										
	SAT										
	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	5850	TOTAL	4475

BALANCE 1375

NURSE'S SIGNATURE (b)(6)-2 INITIALS

MEDCOM - 7656

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	0700	INITIALS (b)(6)-2	1900	INITIALS (b)(6)-2		INITIALS
NEURO	PUPILS	Pupils 3mm bilat		3mm PERRA			
	SENSORIUM	Alert and cooperative		A+Ox3 Cooperative			
		Conversing, MAE x 4,		MAE x 4			
		Hair clean					
RESPIRATORY	RESPIRATORY PATTERN	Even and unlabored		Even + Unlabored			
	BREATH SOUNDS	Lungs ⊂ bilateral		CTA ⊂ Bilateral			
	SECRETIONS	Crackles. ∅ Decreased		Basal			
		or productive cough.		⊖ Non-productive Cough			
SKIN	COLOR	Warm, No evidence		NPR			
	INTEGRITY	of skin breakdown		⊖ Skin breakdown			
		1st area to (L) arm					
IV SITE	LOCATION	TLC to (R) subclavian		TLC (R) SubClav			
	CONDITION	Site S redness or					
		drainage. Pressing clots					
		will change today?					
GASTRO	ABDOMEN	BS x 4. Midline		BS x 4 Midline Abd ⊂			
	BOWEL SOUNDS	incision, staples intact		staples ⊖ Redness			
		S redness or drainage					
GU	URINE:	Foley to bedside, clear		Unavailable			
	COLOR/CLARITY	Yellow urine.		Clear Yellow urine			
CARDIOVASCULAR	CARDIAC RHYTHM	SR S ectopy. Pulses		SR			
		2+ to all extremities.		⊖ Edema			
		No edema or JVD.					
		S1 + S2 auscultated					

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) (b)(6)-2 LT AN

DEPARTMENT/SERVICE/CLINIC ICU

DATE 30 Sep 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	/	14	15	16	17	18	19	20	21	/
BP Arterial Line																		
BP Cuff	138/72		117/67							142/74				142/71		138/64		
Temperature	97.1		97.4											97.3				
Pulse	72		67							70				73		73		
Respiratory Rate	18		18							14				16		16		
Oxygen	3L		3L							RA				RA		RA		
O2sat	98%		100%							99%				98%		99		

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR	200/200	200/400	200/600	200/800	200/1000	200/1200	200/1400	200/1600		200/1800	200/2000	200/2200	200/2400	200/2600	200/2800	200/3000	95/3095	
1UPB			150/150															
PO																		
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL	150/150		400/550		1100/1650					300/1950			500/2450				500/2950
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

VITAL SIGNS

	22	23	24	01	02	03	04	05	
				103/65					
				71					
				20					
				98					
				RA					

	22	23	24	01	02	03	04	05	8° T
3025									3025
3650				200/350				500	3650
				small					

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME	
	MODE	
	F_iO_2	
	TV	
	RATE	
	PEEP	
ABG	pH	
	PCO_2	
	pO_2	
	HCO_3	
	SAT	
	BASE	

LABORATORY DATA	TIME	0600
	GLUCOSE	81
	Na/K	141/2.9
	Cl/CO_2	105/29
	BUN/Cr	11/1.2
	WBC/PLATELET	7.3/384
	Hct/Hgb	8.5/26.0
	RBC/mcv	3.01/86.6

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

TURN — TIME

SUCTION

24° I&O TOTALS

wt Yesterday ____ wt Today ____

INTAKE		OUTPUT	
IV	3025	Urine:	3650
po			
TOTAL		TOTAL	

BALANCE −625

NURSE'S SIGNATURE	INITIALS
(b)(6)-2 (b)(6)-2	(b)(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0700	INITIALS [redacted]	0600	INITIALS	18K INITIALS [redacted]
	PUPILS	3mm & PERLA				PERLA
	SENSORIUM	alert, awake, language barrier, follows commands, moves all extremities				A+O x 3 ⊕ commands MAE3
RESPIRATORY	RESPIRATORY PATTERN	even & unlabored				easy non labored
	BREATH SOUNDS	CTA bilaterally				clear bilat
	SECRETIONS	⊘ noted - productive cough occasionally				⊘ no distress or SOB chest on room air O2 sat 98%
SKIN	COLOR	Pink, warm				pink WNL
	INTEGRITY	dsgs to ⊕ sides abd & midline incision c̄ staples, otherwise intact				dsg to ⊕+⊖ abdom c̄ midline approx. staples ⊕ SAT keptclean
IV SITE	LOCATION					
	CONDITION	Heplocked, flushed & patent				flushes easily + patent.
GASTRO	ABDOMEN	soft, non tender				soft c̄ midline staples + dsg x2
	BOWEL SOUNDS	⊕ x4 quads, regular diet				⊕ BS x4 quads. good po intake
GU	URINE:	Voids on own				voids in commode.
	COLOR/CLARITY	clear, yellow				clear yellow
CARDIOVASCULAR	CARDIAC RHYTHM	NSR, all pulses palpable & mod edema noted to hands				NSR - 3 edema ⊕ pulses x 4 extremities

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)

PREPAR (b)(6)-2 SGT/LPN

DEPARTMENT/SERVICE/CLINIC ICU

DATE 1 Oct 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	/	14	15	16	17	18	19	20	21	/
BP Arterial Line																		
BP Cuff	140/59				128/60					136/35		147/84	→					
Temperature	97.5									97.3								
Pulse	71				72					99		75	→					
Respiratory Rate	18				17					20		20	→					
SaO2	91%				92%					97%		98%	→					

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
IVF	Ø				Ø													
IVPB	Ø				Ø													
PO	Ø														300 500			
TOTALS																		

OUTPUT

URINE	HOUR	300				400										500			
	TOTAL					700										700			
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL			200													Small formed Brown			200
DRAINS																			
TOTALS																			

POST-OP DAY

	22	23	24	01	02	03	04	05
BP	131/52				133/70			
Temp	98				98.3			
Pulse	98 86				70			
RR	14				18			
Sat	99%				98%			

	22	23	24	01	02	03	04	05	8° T
	100 600								600
					400 1600				600 1600
									200

ACUITY LEVEL CLASSIFICATION

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

LABORATORY	TIME	0500									
	GLUCOSE	102									
	Na/K	136/87									
	Cl/CO_2	99/23									
	BUN/Cr	8/0.7									
	WBC/PLATELET	9.4/551									
	Hct/Hgb	29.4/9.3									

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	600?	TOTAL	1800

BALANCE 1200

NURSE'S SIGNATURE | INITIALS

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

(b)(6)-2 | LPT/AW

MEDCOM - 7662

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	[redacted] 1662 INITIALS	INITIALS	INITIALS
NEURO	PUPILS	Pupils 3mm bilat. - [illegible]		
	SENSORIUM	[illegible] - Bilateral		
		5 [illegible]		
RESPIRATORY	RESPIRATORY PATTERN	Even & unlabored		
	BREATH SOUNDS	Lungs CTA		
	SECRETIONS	Coughing, clear white		
		sputum		
SKIN	COLOR	Warm		
	INTEGRITY	Normal for Race		
I.V. SITE	LOCATION	[illegible]		
	CONDITION	Site [illegible] redness or		
		drainage		
GASTRO	ABDOMEN	Abdomen Mobile		
	BOWEL SOUNDS	Shape - [illegible] 5		
		redness or drainage		
GU	URINE:	Voiding Per Bedside		
	COLOR/CLARITY	Commode.		
CARDIOVASCULAR	CARDIAC RHYTHM	S1 + S2 - Auscultated		
		Denies chest pain or		
		SOB. Dulses [illegible]		
		to CAD risk factors.		

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)

(b)(6)-2

LT AN

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 2 Oct 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13	/	14	15	16	17	18	19	20	21	/
BP Arterial Line																		
BP Cuff	134/71				132/76					138/69				144/75				
Temperature	97.6				97.9					97.7				96.5				
Pulse	68				69					67				66				
Respiratory Rate	16				18					20				22				
O2 Sat	95%				100%					100%				98%				

INTAKE

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
IVF																		
IVPB																		
PO																		
TOTALS																		

OUTPUT

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

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	22	23	24	01	02	03	04	05	
	22	23	24	01	02	03	04	05	8° T

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
(b)(6)-2	

1. (b)(6)-4

RANK / GRADE

MALE / HOMME

FEMALE / FEMME

SSN / NUMÉRO MATRICULE

SPECIALTY CODE / GPM

RELIGION / RELIGION

2. UNIT / UNITÉ

FORCE / ÉLÉMENT

NATIONALITY / NATIONALITÉ Iraq

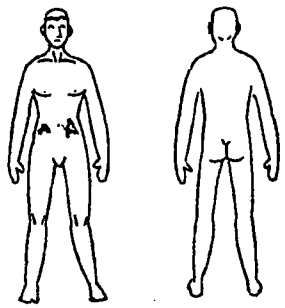
A/T | AF/A | N/M | MC/M

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

3. INJURY / BLESSURE

FRONT / DEVANT

BACK / ARRIÈRE



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

GSW

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

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

5. PULSE / POULS: 80 | TIME / HEURE: 1300

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

7. MORPHINE / MORPHINE: [X] NO / NON [ ] YES / OUI | DOSE / DOSE: 5 mg | TIME / HEURE: 1320

8. IV / IV: L arm | TIME / HEURE: 1310

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

GSW to abdomen dressed entry exit
IV started
Morphine 5 mg IV
Pulse 80 } 1300
RESP 20
BP 147/84

10. DISPOSITION / DISPOSITION | RETURNED TO DUTY / RETOUR À L'UNITÉ | TIME / HEURE

(b)(6)-2

Pa. c. Pr. 25 | DATE/DATE (YYMMDD)

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

Admission a[illegible] Coding Information

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

orting MTF (b)(3)-1	2. MTF Locati[illegible] IZ			
[illegible]egister Number (b)(6)-4	Name (Last, First, MI) (b)(6)-4		4. Pay Grade CIV	5. Sex M
[illegible] DoB (YYYYMMDD)	7. Age at Admission	8. Race X	9. Ethnicity 9	Religion MUSLIM
10. Length of Service	ETS	11. FMP 99	12. Social Security Number (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission 14:05	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICU	Name / Relationship of Emergency Addressee		
		Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted] b(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition HOME	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-10-04		
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-09-23		
27. Location of Occurrence IZ	28. MTF of Initial Admission	29. Date of Initial Admission 2003-09-23		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW ABDOMEN, FRAGMENTATION WOUND LEFT ELBOW

879.2 54.72

Procedure Narrative(s): EX LAP, BOWEL RESECTION AND REPAIR, LEFT ELBOW DEBRIDEMENT

Cause of Injury Narrative: PT RAN A CHECKPOINT WITH A WEAPON IN HIS VEHICLE.

Admit[illegible] (b)(6)-2

Signature o[illegible] (b)(6)-2

Autor[illegible]

MEDCOM - 7667

(b)(3)-1

Country Code.)

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

REGISTER NUMBER (10–15): (b)(6)-2

(Last, First, Middle Initial): (b)(6)-4

4. PAY GRADE (16–17): CIV

5. SEX (18): M

DATE OF BIRTH (YYYYMMDD) (19–26): 1 9

7. AGE AT ADMISSION (27–29):

8. RACE (30): X

9. ETHNIC BACKGROUND (31): 9

RELIGION: MUSLIM

10. LENGTH OF SERVICE (32–34):

ETS:

11. FMP (35–36): 9 9

12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-2

ORGANIZATION (Active Duty Only):

13. MARITAL STATUS (46): Z

HOUR OF ADMISSION: 1405

BRANCH / CORPS:

14. FLYING STATUS (47–49):

15. BENEFICIARY CATEGORY (50–52): K Z 8

16. ZIP CODE OF RESIDENCE (53–61): 0 9 3 2 3 0 0 2 0

17. UNIT LOCATION (State or Country Code) (62–63): I Z

18. MOS (64–70):

19. TRAUMA (71): BC

PREV. ADMISSION: YEAR: ☑ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): 1

WARD: 1C4

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY:

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

21. TYPE OF DISPOSITION (73–74): 0 5 CRO/ EPW

22. MTF TRANSFERRED TO (75–80):

23. DATE OF DISPOSITION (YYYYMMDD) (81–88): 2 0 0 3 1 0 0 4

24. CLINIC SVC - ADMITTING (89–92): A A A A

25. MTF TRANSFERRED FROM (93–98):

26. DATE THIS ADMISSION (YYYYMMDD) (99–106): 2 0 0 3 0 9 2 3

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (107–108): I Z

28. MTF OF INITIAL ADMISSION (109–114):

29. DATE INITIAL ADMISSION (YYYYMMDD) (115–122):

FOR LOCAL USE

Dx: 86350 GSW / ABD, FRAGMENT WOUND (L) ELBOW
88111 EXLAP, BOWEL RESECTION & REPAIR, (L) ELBOW DEBRIDEMENT
E9912 PT RAN V/ POINT O WEAPON IN VEHICLE

ADMITTING OFFICER (Signature, as required): Pr 7762 8345

SIGNATURE OF ADMITTING CLERK:

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

Ins Trauma

(b)(6)-4

MEDCOM - 7668

(b)(3)-1

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4		3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE	7. [illegible]	[illegible]	10. PREVIOUS ADMISSION	
11. FMP	12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN K78	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION			22. HOURS OF ADMISSION 0800	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION	26. DATE OF DISPOSITION 2003 0927		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 20030927		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY				30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

(b)(3)-1

INDIVIDUAL SICK SLIP ☐ ILLNESS ☒ INJURY		DATE 13 OCT 03
LAST NAME-FIRST NAME-MIDDLE INITIAL OF PATIENT (b)(6)-4		ORGANIZATION AND STATION
SERVICE NUMBER/SSN (b)(6)-4	GRADE/RATE	
UNIT COMMANDER'S SECTION		MEDICAL OFFICER'S SECTION
IN LINE OF DUTY		IN LINE OF DUTY
REMARKS		DISPOSITION OF PATIENT ☐ DUTY ☐ QUARTERS ☐ SICK BAY ☐ HOSPITAL ☐ NOT EXAMINED ☒ OTHER (Specify):
		REMARKS (1) WEIGHT BEAR (R) LEG AS TOLERATED (2) DAILY DRESSING CHANGES (3) CAMP PERSONNEL REMOVE SUTURES IN 5-7 DAYS (4) KEFLEX 500mg FOUR TIMES A DAY X 7 DAYS
SIGNATURE OF UNIT COMMANDER		SIGNATURE OF MEDICAL OFFICER (b)(6)-2 (b)(6)-2

DD FORM 689, MAR 80

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

31yo ♂ SUSTAINED INJURIES TO B/L LE AND (L) UE @ ~ 0001 TODAY WHILE ENGAGING US FORCES BY REPORT. 2 ASSOCIATES KILLED. C/O PAIN B/L LE.

PMH: φ PSH: φ NKDA.

PHYSICAL EXAMINATION

HEENT: NC/AT PERRLA, EOMI, SUPPLE
LUNGS: CTA B/L CV: RRR S1 S2 ⊖ m
ABD: SOFT NT/ND ⊕ NABS; PELVIS: STABLE
EXTREM: B/L LE ⊂ DOPPLER DP/PT PULSES, SENSATION INTACT B/L FEET PLANTAR/DORSAL. TOE FLEX/EXT OK. MULTIPLE PUNCTURE WOUNDS ANT MED (L) TIBIA 1.5 cm DIA ENTRANCE WOUND (R) DISTAL MED THIGH; PUNCTURE WOUND DISTAL LAT (L) THIGH. PUNCTURE WOUNDS x 2 (L) UPPER ARM.

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

COMPARTMENTS SOFT B/L LE/THIGHS.
⊖ PAIN ⊂ PASSIVE STRETCH (L) LEG.

A/P ① MULTIPLE FRAGMENTATION WOUNDS
② FLAIL HD, (L) ELBOW ARTHROTOMY, POSSIBLE ANT COMP RELEASE (L) LEG.

XRAY
MULTIPLE SMALL SOFT TISSUE FRAG. (L) LEG, SINGLE FRAGMENTS B/L THIGHS; INTRA ARTICULAR (L) ELBOW FRAC.

(b)(6)-2	(b)(6)-2			
YSICIA	DATE 26 SEP 03	IDENTIFICATION NO.	ORGANIZATION	
ICATION *(For typed or written entries give Name last, first, cal facility)*		REGISTER NO.	WARD NO.	

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
26 Sept 03	0753 - Pt. Arrives
	0757 - Labs Drawn
	0759 - 1000 ml LR Hung.
	0801 - BP: 115/80 M P: 104 O2: 98% ~~BVM~~ (b)(6)-2
	0807 - 5 Mg morphine IV
	0807 - BP: 155/107 P: 76 O2: 100 ~~BVM~~ (b)(6)-2
	0809 - 3 mg Versed IV
	0809 BP: 156/100 P: 81 O2: 100 ~~BVM~~ (b)(6)-2
	0815 BP: 166/82 P: 84 O2 100 ~~BVM~~ (b)(6)-2
	0818 - Foley ~~Secured~~ [redacted] b6-2 Attempted
	0818 - BP: 160/82 P: 86 O2: 100 ~~BVM~~ (b)(6)-2
	0820 - 5 MG Morphine IV
	0821 - BP: 156/105 P: 86 80 O2: 100 ~~BVM~~ (b)(6)-2
	0823 - 350 Gent IV Piggyback
	0824 - Tetanus IM
	0826 - Foley Attempted
	0827 - BP: 154/100 P: 83 O2: 100 ~~BVM~~ (b)(6)-2
	0830 - BP 89/61 P: 82 O2: 100 ~~BVM~~
	0836 - BP 171/84 P: 66 O2: 100 ~~BVM~~
	0838 - Foley Secure
	0842 - BP 129/67 P: 55 O2: 100 ~~BVM~~ (b)(6)-2
	0850 - BP: 121/73 P: 54 O2: 100 ~~BVM~~ (b)(6)-2 : 27

(b)(3)-1 [redacted]	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

(b)(6)-4

REGISTER NO.

WARD NO. EMT

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

0850 - 1000 ml LR IV #3

0854 - BP: 135/65 P: 94 O2: 100 ~~BVM~~ (b)(6)-2

0859 - BP: 123/77 P: 93 O2: 100 ~~BVM~~

0905 - BP: 127/80 P: 72 O2: 100 RA T: 96.4 TM

VENOUS

pH	7.363
pO_2	29
pCO_2	51.1
HCO_3	29
TCO_2	31
BE	4
O_2	51%

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1200 26 Sept 03	Patient post anesthesia surgery. Wounds and skin cleaned with dilute betadine. Cleansed c antibacterial cleanser, wounds to (R) thigh dressed and (R) LE cleansed c 4x4 applied. Pulses palpable to both lower extremities, posterior tibial c greater sensation to both legs. Noted serous drainage from (R) thigh. Denies discomfort. (b)(6)-2 mgr
1500 26 Sept 03	Patient resting comfortably. Asking for po fluid, instructed patient to remain NPO for surgery. (b)(6)-2 mgr
1600 26 Sept 03	C/o 5/10 pain. Given 4 mg Morphine IVP as per verbal order by Dr. McFadden. Patient resting as present. (b)(6)-2 mgr
1800 26 Sept 03	Patient NPO as ordered for surgery. LR infusing @ 125 cc/hr c̄ intubation. Repeat given to relief. Sterile Dressing to wounds CDI. Vascular for (R) upper thigh with slight bloody drainage noted. Pulses 2++ to both extremities (b)(6)-2 mgr
1815	Pt Cmp Assessment, c/o Pain MSO4 4mg IV Given (b)(6)-2 CPT/AN
2000	2mg MSO4 For Pain Given (b)(6)-2 CPT/AN
2008	4mg MSO4 IV For Pain (b)(6)-2 CPT/AN
27 SEP 03 0200	OP NOTE SURG.: (b)(6)-2 Dx: MULT SUPERFICIAL FRAG WOUNDS B/L LE INTRA ARTIC. (R) ELBOW PROCEDURE: I&D B/L LE, I&D (L) ELBOW FINDINGS: METALLIC FRAG IN OLECRANON FOSSA. OTHER SITES DESCRIBED. COMPLICATIONS: NONE COND: STABLE TO PR. (b)(6)-2 (b)(6)-2 CMT

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
0957 26 Sept 03	Patient is a 31 year old male arrived from ER. SPGSW to (L) lower extremity. Patient describes incident on farm with Americans present, ran away and was shot in (L) leg. Pt's medical history, surgery to (R) leg. Patient denies any allergies. Received gentamicin in ER and tetanus in preparation for surgery. Assessment as follows: Neuro AOx3, pupils sm, brisk, MAE x4, denies discomfort at this time. Received 1cg Morphine in ER for pain. Sensation present to upper lower extremities. Resp: Even and Unlabored, clear on all fields, O2 sats 95% on RA. Abdmen: Flat & distention BS hyperactive x 4 quadrants. GU: Foley to gravity, clear yellow urine, CV: Pulses 2+ to R+L Radial areas, S1 +S2 present, Sinus Bradycardia in 50's. Skin cool to touch. Pulses to R+L Posterior Tibial areas palpable. No evidence of uncontrolled bleeding from (R) lower ext GSW or (L) upper thigh, or (R) Medial Thigh. Plan (1) Check pulses to lower extremities and sensation Q 1°, (2) Medicate for pain and clean all wounds and patient (3) Prepare patient for surgery and keep NPO as ordered. (b)(6)-2 MAJ
26 Sept 03	1045: 131/57 P: 66 RR: 23
	1030: 124/56 P: 59 RR: 12
	1015: 142/70 P: 70 RR: 19
1100	Patient stable awaiting surgery at 1100 (b)(6)-2 MAJ

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			DR'S ID NUMBER
	LAST	FIRST	MI	Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
27Sep03 0355	Received care of pt @ 0320 via litter from ICU recovery P I+D of shrapnel wounds in OR. Pt. awake and alert. Pt. transferred self from litter to bed c̄ moderate difficulty. Required some assistance. PEPPLA (+) WNL. Eom WNL. Buccal mucosa pink/dry. Pt. given H2O. tolerated well. Lung sounds clear b auscultation (B) thru chest. HR regular S1S2 present. Abdomen soft/non-tender x 4 quadrants. Bowel sounds (+) x 4 quadrants. PIV (R) AC TKO infusing @ 100cc/hr. Dressing to (L) arm clean/dry/intact. Dressing to (R) leg clean/dry/intact. Dressing to (L) leg scant amt. dried bloody drainage noted. NVS WNL to all extremities (B) Pedal pulses faint c̄ doppler S.O. complaints of pain @ this time will continue to monitor (b)(6)-2 27 SEP
27 Sep 2003 1340	Nursing - Pt awake, ∅ c/o pain. Interpreter in, pt asking when he will go to surgery. Inform pt. that he had surgery this am. Pt is alert, no recollection of surgery. Lungs CTA, O2 sat 95% on RA. HR 86, reg. IV to (R) ac, ~~TKO~~ NS @ 125, will hk whole bag complete. Abd soft, round, nontender. (+) BS x 4. Pt tolerated reg diet. Drsg to (L) arm CDI. Drsg to (R) leg (thigh) CDI. Drsg to (L) LE c̄ small amt bloody drainage. (B) LE c̄ brisk cap refill & (+) sensation to all toes. Skin warm & dry. (b)(6)-2 AN

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.
(b)(6)-4		

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

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
27 Sep 2003 1420	(Late Entry) 0740 Pt c/o inability to void & pain from full bladder. NO cath, 500 cc of clr orange urine drained. (b)(6)-2
27 Sep 03 20:43	Received care of pt @ 1800. Restraints x 2 (R) wrist/ankle. Pt. sleeping/easily awakened to verbal stimuli. Alert. PERRLA (+) WNL. (+) EOMWNL. Buccal mucosa pink/moist. Lung sounds clear to auscultate (B) throughout. Bowel sounds (+) WNL x 4 quadrants. Abdomen soft/non-tender x 4 quadrants. Dressing to (L) arm c̄ [redacted] moderate amount old blood drainage noted. NV's to (L) hand WNL. ROM to digits. PIV/HL to (R) AC patent/intact. Foley to gravity draining dark amber urine. Dressings to B/L lower extremities clean/dry/intact. NV's WNL (B) feet. Pedal pulses (+) c̄ dopplers. ∅ complaints of pain @ this time. will continue to monitor (b)(6)-2
28 Sep 03	Nursing: Sleep, U.O. Pt slept 4½ 5° tonight U.O. of 400cc dark brown urine (b)(6)-2
28 Sep 2003 0615	Nursing: Pt sleeping, easily aroused c̄ tap to shoulder. ∅ c/o pain. Pt alert. Lung sound coarse ~~+4 O~~ O_2 Sats 92%. Pt given IS, using @ bedside. Encourage pt. to cough, ∅ sputum c̄ cough. HR 82, reg, mild edema (B) LE. IV to (R) ac

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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(b)(6)-4		

PROGRESS NOTES
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
28Sep2003 0915 (cont'd)	Clotted. D/C'd IV & restart leg to (R) wrist on 1st attempt. Pt. tolerated well. IV patent. Abd soft, nontender, (+)BS x4. Pt. turned, repositioned well. Foley to gravity draining clr yellow-orange urine, qs. Drsg to (L) LE c̄ old area of bloody drainage approx 2x3in above elbow. (R) LE c̄ drsg to knee v thigh c̄ CDI. (L) LE c̄ Drsg intact old area of drainage marked, ∅ additional noted. (R) LE c̄ (+) doppler pulse, brisk cap refill, warm, dry. (L) LE c̄ brisk cap refill to all toes, warm, dry —— LT (b)(6)-2
28Sep2003 1325	Nursing: Total UOP 1050 cc of yellow-orange, clear urine in foley. —— LT (b)(6)-2, ANT
28Sep03 1509	Received care of pt. @ 14:00. Pt. awake/alert in bed. Attempted to have BM unsuccessful x1. Pt. ambulated on crutches c̄ much difficulty to commode. Pt. appeared to be in ↑ pain while ambulating. P pt. returned to bed appears to be comfortable PERRLA (+) WNL. EOM (+) WNL. Buccal mucosa pink/moist. Lungs clear to auscultate (B) throughout. Bowel sounds (+) x4 quadrants. Abdomen soft/non-tender & distended. (+) Radial pulses (B) (+) 2 strength. HL to (R) wrist & intact c̄ skin. New IV site initiated x1 attempt c̄ 20G cath. Pt. tolerated well. Flushed easily. Dressing to (R) arm intact c̄ moderate old bloody drainage noted not exceeding border drawn yesterday. Dressings to (B) legs clean/

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

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PROGRESS NOTES
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
Continued 28 Sep 03	dry/intact. NVV's WNL. Tibial pulses palpable (B) ++1 strength. complained of pain x1 ii Percocet given. Will continue to monitor (b)(6)-2 [redacted] 2200/AW
28 Sep 03 2314	Nursing Notes: Assumed care of Pt sleepy but easily aroused. Breathing intact Ø SOB or labored breathing. Foley to gravity clear amber urine noted. Ø Blood in urine. IV fluids infusing Ø S/S of infiltration at site. Dressings clean dry and intact. Ø observed bleeding or drainage noted. Pt able to move all extremities well, will continue to monitor status (b)(6)-2 [redacted] 2315/AW
29 Sep 2003 1200	Nursing: Pt received from ICU post-recovery via stretcher. Pt move self from stretcher to bed c minimal assist. Ø c/o pain @ present. @ Lungs CTA, O2 sats 94%, encourage pt to use IS. HR 74 reg, mild edema (B) LE. Abd soft, round, nontender. ↓ BS x4. HL placed to (D) wrist c NS @ 120. Foley to gravity draining clr, yellow urine. Drsg to (L) elbow & (B) LE CDI. (L) hand cool, +2 radial pulse, brisk cap refill to all fingers. (B) feet cool to touch,

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
29 Sep 2003 1200 Cont'd	brisk cap refill, (+) sensation. ~~Pulses~~ D/P pulses are marked (B) feet. (b)(6)-2
29 Sep 03 15:15	Received care of pt @ 1400. Pt sleeping in bed. Breathing unlabored. Easily awakened to verbal stimuli. Pt Awake/alert. PERRLA (+) WNL. EOM (+) WNL. Buccal mucosa pink/moist. Skin warm/dry/intact. Lung sounds clear to auscultate (B) throughout. Bowel sounds (+) x4 quadrants. Abdomen soft/non-tender. Heartrate reg S1S2 present. HL to (B) forearm patent/intact. Dressing to (D) arm clean/dry/intact. NV ✓'s to (D) Hand WNL. Dressings to (B) lower extremities clean/dry/intact. NV ✓'s to (B) feet WNL. Pt. O2 Sat 92%. @ 14:00 vitals. Pt encouraged to use IS. O2 sat ↑ to 98%. ∅ complaints of pain @ this time. Foley to gravity draining dark, clear yellow urine will continue to monitor (b)(6)-2
29 Sep 03 2257	Nurses Notes: Assumed care of pt sleepy but easily aroused. Breathing intact ∅ S/S of SOB or labored breathing. Vitals stable ∅ complication. ∅ c/o pain or discomfort. IV antibiotic therapy continues IV SL flushes well. dressing to (L) arm clean dry and intact. Pt able to move all extremities well (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

24 Sep 03
1014

BRIEF OPERATIVE REPORT

PRE-OP DIAGNOSIS: BIL LE FRAGMENTATION WOUND, (L) ELBOW INTRA ARTIC. FRAG. WOUND

POST-OP DIAGNOSIS: SAME

PROCEDURE: I+D, DPC

SURGEON: (b)(6)-2 ASSISTANT: Ø

ANESTHESIA: GEN OPERATIVE ANTIBOITIC:

FLUIDS: 400 BLOOD PRODUCT USAGE: Ø

EBL: MIN URINE OUTPUT: Ø

TOURNIQUET TIME: Ø

DRAINS: Ø

SPECIMENS: Ø

FINDINGS: CLEAN WOUNDS → CLOSED

DESCRIPTION OF PROCEDURE: I+D LEGS, LARGE WOUND POST MED (R) THIGH. ALL CLEAN. ELBOW CLEAN. TRICEPS SPLIT RE APPROX C O-VICRYL.

COMPLICATIONS: NONE

CONDITION: STABLE TO RR

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

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO. WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
29 Sep 03	~~Received care of pt @ 14:00. Pt. sleeping. Easily awakened to~~
15:05	~~verbal stimuli. Pt alert. PERLA EOMI. Buccal~~
ENT [redacted]	~~mucosa pink/moist. Skin warm/dry/intact. Lung sounds~~

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30Sep03 0750	Nursing: Pt awake, c/o 11/10 pain. Alert, lungs CTA, continue to encourage IS use. O2 Sats 95% on RA. HR 78, reg. Mild edema (B) LE. IV to (L) fa, patent. Abd soft, nontender (+) BS x4. Pt tolerating reg diet. Foley to gravity, to clear yellow urine. Drsg to (R) LE CDI. Drsg to (B) LE CDI. Drsg to (B) LE to small area old drainage noted. (B) to (B) LE to (+) sensation to all fingers, +2 radial pulse, warm, dry. (B) LE warm, dry, (+) P/P pulse, (+) sensation, ø able to move all toes. — (b)(6)-2
30Sep03 15:56	Received care of pt. @ 14:00. Pt awake/alert in bed. PERRLA (+) WNL EOM (+) WNL. Buccal mucosa pink/moist. Lungs clear to auscultate (B) throughout. HR regular S1S2 present. Bowel sounds (+) x4 quadrants. Abdomen soft/non-tender x4 quadrants. AL to (R) forearm patent/intact. Dressing to (L) arm clean/dry/intact. NVV's WNL to (L) hand. Dressings to (B) legs clean/dry/intact x̄ scant amount bloody drainage to (L) patellar area. Drainage has not exceeded border drawn since yesterday. NVV's WNL (B) feet. (+) Pedal pulses (B) (+)2 strength. Complains of pain x1 ii Percocet given will continue to monitor — (b)(6)-2
30Sep03 23:15	Nurses Notes: Assumed care of pt Sleeping but easily aroused. ø c/o pain at this time. Breathing intact ø SOB or Labored breathing. IV antibiotic Therapy continues. dressing clean, dry and intact. ø complication, ø signs of distress. Will continue to monitor Status — (b)(6)-2

(b)(6)-4

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-300/50618

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
01 Oct 2003 1115	Nursing: Pt ↑ OOB c̄ crutches to ward latrine. Pt able to void, ∅ BM so far. Pt straining to have BM. ∅ SOB, O_2 sats 98% on RA. VBSX4, pt c/o constipation. MOM started. Drsg Δ's done. (L) elbow drsg c̄ sm. amt. sero-sang drainage. Stitches ODT reapplied, 4x4 Kerlix gauze & ace wrap. (R) LE c̄ wound to inner thigh & back of leg. Stitches intact, pt has redness along wound site, c̄ mild inflammation. ∅ active drainage noted. (D) LE c̄ several small wound, stitches intact, ∅ active drainage, 4x4 Kerlix c̄ Kerlix roll & ace wrap applied. —— [redacted]
01 Oct 2003 1400	Late Entry – 1100 – pt has BM of hard formed stool X 1. —— [redacted]
01 OCT 03 16:30	Received care of pt @ 1400. Pt. awake and alert. VS WNL per flow sheet x̄ BP ↑ from baseline pressure Pt ~~complaining~~ Error [redacted] complaining of pain to (R) knee area. II Percocet given. PERRLA (+) EOM (+) WNL. Buccal mucosa pink/moist. Lung sounds clear to auscultate (B) throughout HR regular S1S2 present Bowel sounds (+) x4 quadrants. Abdomen soft/non-tender x 4 quadrants. HL to (R) fore arm (+) erythema (+) tenderness (+) swelling/hardened (+) warm to touch. HL D/C'd new HL IV initiated c̄ 18G catheter x̄ difficulty (+) flush/(+) blood return. ACE wrap dressing to (L) arm clean/dry/intact. (+) NVS WNL to (L) hand. (B) ACE wrap dressings to lower extremities clean/dry/intact. NVS to feet WNL. (L) foot (+) 1 pitting edema noted. ACE wrap bandage loosened and leg elevated c̄ blanket. Will reeval edema throughout shift. & further complaints will continue to monitor

(b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1 Oct 03	Assumed care of Pt. Sleepy but easily aroused. VS stable I.V patent continuing IV therapy. Distal pulses intact, able to wiggle toes capillary refill < 3 seconds. Dressing to left lower extremity clean, dry, and intact. Ø c/o pain. Ambulates with crutch assistance (b)(6)-2 91
	Concur c above assessments (b)(6)-2 LT/AN
02 Oct 2003 1010	Nursing. Pt awake, c/o minimal pain, reports ↑ Pain c̄ ace wraps, remove ace wrap for pt. comfort to (L) thigh & (L) elbow. Loosen ace wrap to (R) thigh Lungs CTA, O2 sat 95% on RA. HR reg, mod edema to (B) LE. Mild edema (B) LE. (+) pulses X4 extremities. Abd soft nontender, (+) BS X4. Ø stools this shift, pt had BM of loose stool last night. Pt ↑ OOB c̄ crutches to ward latrine (R) thigh c̄ ↓ redness @ wound site, antibiotics continue Multiple wounds to (D) LE, stitches intact, minimal drainage present. 4X4 & Kerlix roll applied. (b)(6)-2
2 OCT 02 21:44	Received care of pt @ 1800. pt resting comfortably in bed. Pt up c̄ assist and crutches to commode. Pt. in no apparent distress. Ø complaints of pain. Dressings clean/dry/intact. NV ✓'s WNL to all extremities. Pt sleeping @ this time will cont. to mon. (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.: | WARD NO.:

(b)(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2 Oct 03 2300	Nurses Notes: Assumed care of Pt sleeping but easily aroused. Dressings clean dry and intact. Pt able to move all extremities OK & C/S of distress. Vitals stable. IV SL flushes well. will continue to monitor status (b)(6)-2
3 Oct 2003 0910	Nursing: Pt awake, ∅ c/o pain. Alert, uncp LTA, O2 sat's 97% on RA. HR 74, reg, mild edema BLE. HL to (R) fa dislodged. D/C'd HL, apply warm pack to swollen area. Placed Foley catheter to (R) fa above previous site. Abd soft, nontender (+) BS x4. Stool x 1 today, soft, semi-formed. Ambulated to crutches to ward lanine. Drsg Δ: (L) elbow, ∅ drainage to old drsg, reapply 4x4 & Kerlix. (R) thigh drsg ⊂ small amt. sero-sang drainage, small amt redness around incision site. Reapply 4x4, Kerlix & ace. (L) ⊂ multiple stitch wounds, ∅ drainage, noted. Stitches intact. Reapply 4x4 Kerlix wrap & ace wrap (b)(6)-2
3 OCT 03 1543	Received care of pt @ 1400. Pt awake/alert in bed. PERRLA (+) WNL. EOM (+) WNL. Skin warm/dry/intact. Lungsounds clear to auscultate (B) throughout. Bowelsound (+) x 4 quadrants. Abdomen soft/non-tender x 4 quadrants. Dressing to (L) Elbow clean/dry/intact. (+) NV ✓'s WNL to (L) hand digits. (P) AC IV patent/intact. Dressings to (B) lower extremities clean/dry/intact. NV ✓'s WNL to (B) feet. ∅ complaints of pain @ this time. ∅ edema noted @ this time to (L) lower extremity. Will

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USAPA V1.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
30OCT03 1543 note	continue to monitor — (b)(6)-2 [redacted] OCT/AD
30 Oct 03	Assumed care of Pt @ 2200 sleeping but easily aroused. VS stable distal pulses intact @ c/o pain. dressing clean, dry, intact continues antibiotic therapy ambulates to latrine — (b)(6)-2 [redacted]
	Concur c above assessments — (b)(6)-2 [redacted] 10/A
4 Oct 2003 0725	Nursing: Pt awake, ∅ c/o pain. Lungs CTA, O2 sats 95% on RA, ∅ SOB. HR 76, reg. HL to (R) ac. ∅ edema noted. Abd soft, nontend (+) BS x4, pt tolerating reg diet. ↑ OOB, amb c crutches. Drsg to (L) elbow & (R) thigh are off. Drsg to (D) LE CDE, will change drsg as ordered. (R) thigh wound c small amt. redness present, stitches intact. (L) elbow s ~~drsg~~ active drainage, stitches intact. — (b)(6)-2 [redacted] AD
4 OCT 03 1941	Received care of Pt @ 1400. Pt resting in bed. Ambulated to outside latrine x2 during shift c difficulty or assistance. Pt c complaints of pain. all sutures OTA. Pt awaiting MP's for discharge. will monitor — (b)(6)-2 [redacted] OCT/AD
4 Oct 03 2215	Nurses Note: Assumed care of Pt. Pt has been discharged - awaiting transportation. Stable, conditions c complains. Able to move all extremities c complain. Will continue to monitor status — (b)(6)-2 [redacted] [redacted] 14/A
5 Oct 03 1400	Nursing: Shift Note Pt. awaiting ride. Able to complete ADL's. No change in status. Ambulate to bathroom — (b)(6)-2 [redacted] CPA

STANDARD FORM 600 (REV. 6-97) BACK

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5 Oct 03 2247	Nurses Notes: Assumed care of Pt Sleepy but easily aroused. Denies Pain at this time when asked. V. Sts Stable & S/S of distress. Able to move all extremities: Ambulates c̄ aide of crutches to Rest Room. will continue to monitor Pt. Awaiting transportation to EPW Camp — (b)(6)-2 [redacted] 2/105
6 Oct 03 -	Assessment - Pt Dic. Awaiting transport. VSS, A.M care performed (bed). oob to BR, tolerates. (b)(6)-2 [redacted] Pos. pain. will continue to monitor — 0397 LAN
6 Oct 03 1550	Received care of pt @ 1400. Pt. resting comfortably in bed. Ambulating to outside BR c̄ crutches. MP escort. No complaints @ this time. will continue to monitor VS WNL. per flowsheet — (b)(6)-2 [redacted]
8 Oct 03 2200	Nurses Notes: Assumed care of Pt sleeping but easily aroused. Denies Pain or discomfort at this time. IV ~~Rocef~~ Therapy continues. dressings clean, dry and intact. IV Stable & S/S of infection at sight of HL. Pt will be NPO @ MN for Op Procedure. The Am. will continue to monitor Status — (b)(6)-2 [redacted] 107/LN
[redacted]	b(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
4 OCT 03	NARRATIVE SUMMARY
	DOA: DOD: 4 OCT 03
	ADMIT DX: PENETRATING TRAUMA 26 SEP 03
	(R) PROX THIGH, (L) ELBOW INTRA ARTICULAR,
	BIL LEG SUPERFICIAL WOUNDS
	PROCEDURE I+D OPEN WOUNDS 27 SEP 03,
	DELAYED PRIMARY CLOSURE 29 SEP 03
	HOSPITAL COURSE: UNCOMPLICATED
	I+D, DPC.
	COMPLICATIONS: NONE
	MEDICATIONS: KEFLEX 500mg PO Q.I.D x 7d,
	MOTRIN 800mg PO TID, PERCOCET 1-2 PO, 4-6 H PRN
	DISPOSITION: D/C TO MP CUSTODY. REMOVE
	SUTURES @ DETENTION FACILITY. (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

7 OCT 03
1245B

BRIEF OPERATIVE REPORT

PRE-OP DIAGNOSIS: RIGHT THIGH SEROMA

POST-OP DIAGNOSIS: SAME

PROCEDURE: RIGHT THIGH WOUND I&D

SURGEON: (b)(6)-2 ASSISTANT: Ø

ANESTHESIA: GEN OPERATIVE ANTIBOITIC: ALLERGIES

FLUIDS: 1 L. LR BLOOD PRODUCT USAGE: Ø

EBL: 30 cc URINE OUTPUT: Ø

TOURNIQUET TIME: Ø

DRAINS: Ø

SPECIMENS: Ø

FINDINGS: SEROMA, NO FRANK PUS.

DESCRIPTION OF PROCEDURE: EXTENSIVE TRAUMATIC WOUND AND CONNECTED ENTRANCE/EXIT. LAVAGE 3 L., PACKED OPEN.

COMPLICATIONS: NONE

CONDITION: STABLE TO PR.

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

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7 OCT 03	ASSESSMENT - 0930 - AAO x3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG AND REG, (+) BS x4. 0 % PAIN. IV ANCLE TKO. CONTINUES OOB & CRUTCH ASST. TOLERATES REG DIET. INS & TKO. TO OR THIS A.M. WILL CONTINUE TO MONITOR THROUGHOUT (b)(6)-2 SGT. [illegible]
7 OCT 03	PT AAO PERRLA, Lungs CTA 97% on RA, pulses palpable all ext bilat equal/strong BS present, ø complaints of pain. (b)(6)-2 SGT 91WM6
7 OCT 03	Dressing C,D,I (b)(6)-2 SGT 91WM6
7 OCT 03	I concur c̄ the above assessment (b)(6)-2 CPT [illegible]
22:52 8 OCT 03 0435	Nursing: Shift Note Pt. Somatic early part of shift. c/o arm ack possibly related to IV site on antibotic. Site changed & IV slowed down. Mom given for constipation. Ambulates c̄ crutches to bathroom. Cont. to monitor. (b)(6)-2 CPT [illegible]
8 OCT 03	ASSESSMENT - 0915 - AAO x3, PERRLA, LUNGS CTA BILAT, S1-S2 STRONG AND REG, (+) BS x4. DRESS A/D @ 0900. WOUND "BEEFY RED", ø SIGNS OF INFECTION. PERCOCET FOR PAIN. CONTINUES IV NARCOTICS q 4°. OOB TO BR & CRUTCH ASST. TOLERATES REG DIET. WILL CONTINUE TO MONITOR THROUGHOUT THIS SHIFT. (b)(6)-2 SGT [illegible]
8 OCT 03	PT AAO PERRLA VSS, Lungs CTA SaO2 96% on RA, pulses palpable in all ext bilat equal/strong skin warm/dry, bowel sound present all 4 quad, dressing C,D,I, will continue to monitor. (b)(6)-2 SGT [illegible]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9 Oct 03 0600	Nursing: Observation note Pt. w/o significant changes throughout night. Pt. tolerating IV antibiotic. Cont. to monitor. (b)(6)-2 RN
9 Oct 03 0850	Assessment - AO x3, PERRLA, Lungs CTA Bilat, S1-S2 strong and reg, (+) BS x4. Disc to (R) LE AC'd @ 0845. No signs of infection. "Beefy red" in color. 0% pain. Continues IV antibiotic therapy. OOB to BR c crutch asst. Tolerates reg diet. Ster. strips to (L) US intact. Will continue to monitor throughout. (b)(6)-2 RN
9 Oct 03 15:12	Received care of pt @ 14:00. Pt. resting in bed. Complaining of pain to (R) forearm @ IV site. Forearm (+) edema & pitting (+) hard (+) hot to touch (+) tenderness. IV removed. New IV IV initiated to (L) forearm. PERRLA (+) EOM (+) EOM. Buccal mucosa pink/moist. Skin warm, sweaty, intact. Blanket removed. Pt given sheet. Lung sounds clear to auscultate (B) throughout. Bowel sounds (+) hypoactive x4 quadrants. Abdomen soft/nontender x4 quadrants. (+) Radial pulses (B) (+) strength. ACE wrap to (R) thigh clean, dry, intact. NV's to feet WNL. & further complaints @ this time will continue to monitor. (b)(6)-2 RN
9 Oct 03 2024	Pt premedicated for dressing change c 0.5 ml Percocet. Dressing change performed to (R) thigh. Old dressing c moderate amount yellow/serous drainage. Wound beefy red in color. Well approximated. & s/s infection. Packed c kerlix fluff sponges in NS. 2 4x4s to cover wet dressing. Kerlix wrap and ACE wrap applied. Will monitor. (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10 OCT 03	BRIEF OPERATIVE REPORT
1030	PRE-OP DIAGNOSIS: (R) LEG FASCIOCUTANEOUS WOUND, POST. CLOSURE SEROMA
	POST-OP DIAGNOSIS: SAME
	PROCEDURE: (R) THIGH I&D, DPC
	SURGEON: (b)(6)-2 ASSISTANT:
	ANESTHESIA: GEN OPERATIVE ANTIBOITIC:
	FLUIDS: BLOOD PRODUCT USAGE:
	EBL: 30 cc URINE OUTPUT:
	TOURNIQUET TIME: Ø
	DRAINS: JP, 7 mm x 5 (R) THIGH
	SPECIMENS: Ø
	FINDINGS: NO EVIDENCE INFECTION
	DESCRIPTION OF PROCEDURE:
	IRRIGATION, FRESHEN SKIN EDGES, CLOSE OVER DRAIN
	COMPLICATIONS: Ø (b)(6)-2 (b)(6)-2
	CONDITION: STABLE TO RR

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

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

REGISTER NO. | WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10Oct03 0530	Nursing: Observation Pt. slept well throughout night. Aware of pre-op status. Ø jewelry noted. Continue IV antib w/o difficulty. Continue to monitor (b)(6)-2 CPT RN
10 Oct 2003 1140	Nursing: Pt received from ICU via stretcher, post-op Ø c/o pain. Lung CTA, O2 sats 97% on RA, Ø SOB. HR 68, reg. Abd soft, nontender, (+) BS x4. Ø UOP. DTV by 1630. Drsg to (R) thigh CDI, RLE warm, DN, brisk cap refill. (b)(6)-2 RN
10 OCT 03	PT AAO PERRLA, VSS, JP drain to (R) thigh drained 8cc during shift, Ø complaints of pain, ambulating with crutches, will continue to monitor (b)(6)-2 SGT 9/Wag
11Oct03 0330	Nursing: Sleep Note Pt. slept well throughout night, tolerating PO antibiotics. No signs of distress. VSS Continue to monitor (b)(6)-2 CPT RN
11Oct03 0600	Nursing: Output JP drain of 8cc for this shift. (b)(6)-2 RN
11 OCT 03	ASSESSMENT - 0915 - AAO+3, PERRLA, CONJ CLA BILAT, S1-S2 STRONG AND REG. (+) BS x4. REMOVED JP DRAIN PER DR. (b)(6)-2 ORDER ABSG C.D.I Ø C/O PAIN. O.B. TO BR TOLERATES REG DIET (b)(6)-2 SGT. RN

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1988)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 OCT 03 16:02	Received care of pt. @ 1400. Pt. sleeping in bed. Appears comfortable. Easily awakened to verbal stimuli. Awake and alert in bed. Restraints x2 (R) wrist (R) ankle. (+) PERRLAWR (+) EOM WNL. Buccal mucosa pink/moist. Skin warm, dry, intact. Lungs clear to auscultate (B) throughout. HR regular S1S2 present. Bowel sounds (+) x4 quadrants. (+) radial pulses (B) (+) 2 strength. HL to (R) forearm patent/intact. ACE wrap to (R) thigh clean, dry, intact. NV ✓'s to (R) foot digits WNL. Pt. complained of headache. Tylenol given. & further complaints will continue to monitor. (b)(6)-2 [redacted] SGT AN
Addendum 1750	VS WNL per flowsheet (b)(6)-2 [redacted] SGT AN. HL to (R) forearm D/C'd per Dr. (b)(6)-2 [redacted] (b)(6)-2 [redacted]
14 Oct 03 0150	Nursing: ~~Pt. [redacted]~~ Slept note. Pt. slept 7 hr. tolerating po antibiotic. ∅ complaints this shift (b)(6)-2 [redacted] CPM
12 Oct 2003 0950	Nursing: Pt awake, ∅ c/o pain, alert. Lungs CTA, O2 sat 99% on RA. HR 100, reg, ∅ IV access, ∅ edema noted. Abd soft, nontender, (+) BS x4. Pt ↑ OOB, ambs c crutches to latrine. Drsg to (R) thigh inner thigh D'd. Old drsg c̄ small amt. sero-sang drainage. Stitches intact, small amt bleeding when sutures removed. Replace sutures ✓ 4x4, wrap c̄ Kerlix & ace wrap. IV (b)(6)-2 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	ORTHO NARRATIVE SUMMARY NOTES
13 OCT 03	DOA: 27 SEP 03 DOD: 13 OCT 03
	Dx: LEFT ELBOW INTRA ARTICULAR
	FRAGMENTATION WOUND, BILATERAL
	LOWER EXTREMITY FRAGMENTATION WOUNDS
	PROCEDURES:
	27 SEP 03: (L) ELBOW I+D, BILATERAL
	LOWER EXTREMITY I+D
	29 SEP 03: (L) ELBOW I+D, DPC;
	BIL LE I+D, DPC
	7 OCT 03: (R) THIGH SEROMA I+D.
	10 OCT 03: (R) THIGH I+D, DPC.
	HOSP COURSE: SUSTAINED FRAGMENTATION
	WOUNDS WHEN FIRED ON BY AH 64
	2 ASSOCIATES KILLED. INITIAL I+D
	27 SEP 03. SEROMA C̄ CONTINUED
	THIGH DRAINAGE I+D 7 OCT 03.
	INCISION C̄ MINIMAL DRAINAGE @
	DISCHARGE.

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

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13 OCT 03	DISPOSITION:
	D/C TO MP CUSTODY. CONTINUE
	DAILY DRESSING B'S UNTIL DRY.
	REMOVE SUTURES IN 5-7 DAYS.
	BY DETENTION FACILITY PERSONNEL.
	MEDS:
	KEFLEX 500mg PO QID F 7 DAYS.
	(b)(6)-2 (b)(6)-2

STANDARD FORM 509 (REV. 6/1999) BACK

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
12Oct03	PT AAO PERRLA 3mm, VSS, lungs CTA SaO2 98% on RA, pulses palpable all ext bilat equal/strong, bowel sounds present all 4 quad, voiding via lytes, Ø N/V/D, Ø complaints of pain, dressing C,D,I, will continue to monitor. (b)(6)-2 SGT WLWMG
13Oct03 0515	Nursing: Sleep Pt slept well throughout nite. Ambulated x2 to bathroom. Ø complaints (b)(6)-2
13Oct 2003 0845	Nursing: Pt sleeping, easily aroused. Ø C/O pain, pt alert. Lungs CTA, O2 Sat 98% on RA. HR RR reg, Ø edema, Ø IV access. Abd soft, round, nontender, (+) BS x4. Pt ↑ OOB to BR c̄ crutch assist. Drsg Δ to (R) inner thigh. O/O drsg c̄ small amt. sero-sang drainage. Stitches intact, Ø redness, Ø swelling noted. Area distal to stitches c̄ scant amt. serous drainage. Replace xeroform gauze x 4x4 & Kerlix wrap. Ace bandage applied. — LCT (b)(6)-2
14Oct03 0454	Nursing: Sleep Pt. quiet throughout night. Voided x1 this shift. Slept > 6 hours. Continue to monitor (b)(6)-2 CPT
14Oct2003 1040	Nursing: Drsg Δ to (R) thigh. Small amt. sero-sang drainage from site, stitches intact, Ø redness, Ø swelling noted to site. Pt is D/C'd, awaiting MP to return to custody — LCT (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

(See instructions on Back of this Sheet)

NSN 7540-00-978-3766

EMERGENCY CARE AND TREATMENT

(Medical Rec.)

TREATMENT FACILITY OF: (b)(6)-4

LOG NUMBER

ARRIVAL — DATE: DAY 26, MONTH Sept, YR. 03 — TIME: 0801

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

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

HISTORY OBTAINED FROM: [X] 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/Shrapnel (R) (L) legs

SEX: M — AGE: 31

POSSIBLE THIRD PARTY PAYER? [ ] YES [ ] NO

TIME SEEN BY PROVIDER: 0801

VITAL SIGNS			
TIME	0801		
BP	115/80		
PULSE	88		
RESP.	18		
TEMP.	96.9 Tm		
Wt. (Child)	98 LA		

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

ORDERS	INITS.	TIME
5 g Mso4 IV		
5 g Mso4 IV		
3 g Versed IV		
d/ 0.5 Zm		
1 LNS Rous		
1 gm Ancef		

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)

31 y/o ♂ EPW s/p Injury at ≈ 0100. today. not found until 0600. Pt c/o only pain (R) thigh / (L) lower leg (L) upper arm. A&Ox3 ordered. Foley with cath in Fed, 7 g Mso4 7 g given, 400 g Cefoxitin IV

G: WD, WN, NAD, A&Ox3

HEENT: PERRLA, EOMI, no nystagmus, FNSOM

CVS: (R) radial

Resp: CTA

Abd: Soft, NT, NABS.

Neuro: A, nonfocal

Neck: (L) shrapnel, (L) thigh fx, (R) shrapnel, (R) thigh fx

Back: (L) 7th/8th — (R) shrapnel, (L) thoracic — (R) (2) p. ass shrapnel, (R) thigh — (R) shrapnel 1 p. ass, chest — WNL, pelvis, (R) shrapnel in Rectum to

Extr: ~~[illegible]~~ NVI, FABR, (R) 7th 8th/metatarsal

Neuro: A, nonfocal

Neck: (L) shrapnel, (R) thigh fx, (R) shrapnel

Back: (L) 7th/8th — (R) shrapnel, (L) thoracic — (R) (2) p. ass shrapnel, (R) thigh — (R) shrapnel 1 p. ass, chest — WNL, pelvis, (R) shrapnel in Rectum to

(A/P) Amp/Mso4/Cefox/Ancef/d? to OR c̄ pt. FABRs

4.9	15.9	312
	49.3	
130	109	131
4.6	28	1.1

PT/PTT 16.4/34.

UA -

CK-387

LFTs WNL

PMHx: Ø

PSHX: Ø

FMHx: Ø

Smoke Off

Last meal 2400 25 Sep

FAST: (-) (+) Full Bladder

ASSESSMENT/DIAGNOSIS: Fragmentation wounds to (R) thigh, (L) lower leg, (L) upper arm

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: OR - Ortho

CONDITION UPON RELEASE
- [ ] IMPROVED
- [ ] UNCHANGED
- [ ] DETERIORATED

TIME OF RELEASE: 0850

(CONTINUE ON SF 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) OR 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).

(b)(6)-4

SIGNATURE OF PROVIDER: (b)(6)-2

(b)(3)-1

Include medications ordered, duty limitations and follow-up

EMERGENCY CARE AND TREATMENT — Medical Record Copy

STANDARD FORM 558 (Rev. 6-82), Prescribed by GSA and ICMP

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY OR Staff

2. PATIENT VERIFIED BY (b)(6)-2 ND PROCEDURE CPT, AN

3. DATE 27 Sept 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0030 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

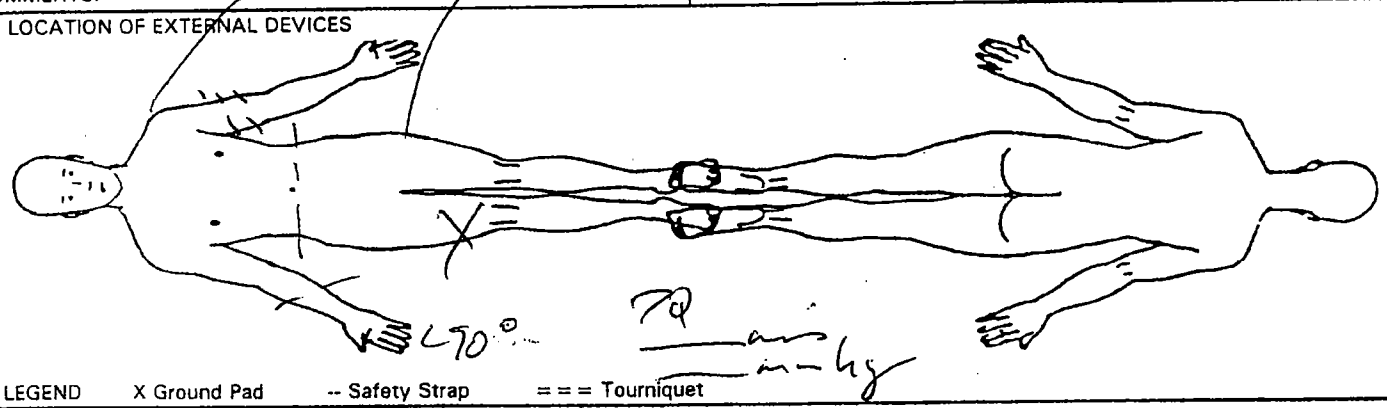
PREP SOLUTION *(Specify)* [redacted]

SITE: L L Leg BY WHOM: (b)(6)-2

SITE: L Arm BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☑ Yes	☐ No	/	/	C		
Needle Sharp	☑ Yes	☐ No	/	/	/		
Instrument	☐ Yes	☑ No	/	/	/		
Other	☐ Yes	☑ No	/	/	/		

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

(b)(6)-4

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

☑ ESU NO: 1-1 30pc

GROUND PAD: BRAND Valley Lab

LOT NO: 698863 2005-03

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

MEDCOM - 7700

13. PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUM 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):

NARC

OTHER ORDERS	TIME	CARRIED OUT BY

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

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. gauze	2.	3.
SITE	B. lt leg wounds	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Dressings
splints
Ace

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

I & D (L) & (R) legs, (L) elbow

21. PATIENT TRANSFERRED TO 7EU TIME 0150 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2

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

MEDCOM - 7701

MEDICAL RECORD

INTRAOPE[redacted]TIV[redacted]CUMENT

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

1. PATIENT TRANSPORTED TO OPERATING R[redacted] (b)(6)-2
VIA litter BY CPT [redacted], CRNA

2. PATIEN[redacted] (b)(6)-2 AND PROCEDURE
VERIFIED B[redacted] MAJ, AN

3. DATE 29 SEP 03 TIME PATIENT ARRIVED IN SUITE 0800

4. PATIENT IN ROOM TIME 0800 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO since MN, per nursing staff. NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] (b)(6)-2 AN/66E CPT [redacted] (b)(6)-2 AN/66E (0815-0830)	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* (B) arms abducted less than 90° or padded armboards.

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

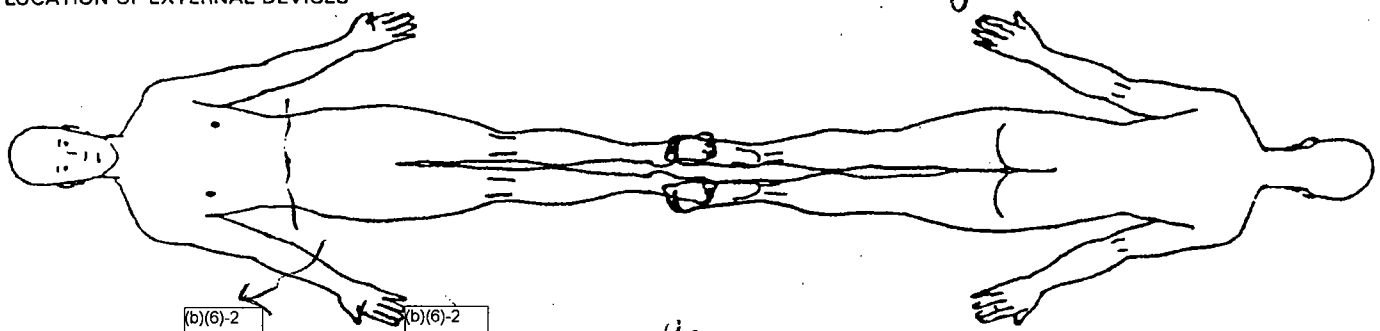
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* ~~Betadine~~ Betadine [redacted] (b)(6)-2 [redacted]
SITE: RLE BY WHOM: [redacted] (b)(6)-2
SITE: LLE BY WHOM: [redacted]
LUE
COMMENTS: No prolingmated. Chux used.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] (b)(6)-2 -- Safety Strap [redacted] (b)(6)-2 = = = Tourniquet N/A

C = Correct I = Incorrect Init by [redacted] (b)(6)-2

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No				[redacted] (b)(6)-2	[redacted] (b)(6)-2
Needle Sharp	☒ Yes ☐ No		C	C		
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

(b)(6)-4 [redacted]

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

☒ ESU NO: 000142 VL FORCE II
GROUND PAD: BRAND VL Polyhesive
LOT NO: 69263 EXP 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

MEDCOM - 7702

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): NSS

OTHER ORDERS	TIME	CARRIED OUT BY

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

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix
Ace Wraps

19. ADDITIONAL INFORMATION

Dr. (b)(6)-2 CPT (b)(6)-2, CRNA

20. OPERATION(S) PERFORMED

D+I, DPC - BLE wounds + LUE wound

21. PATIENT TRANSFERRED TO ICU TIME 1010 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 MAJ, AN

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

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

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

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

3. DATE 7 OCT 03 TIME PATIENT ARRIVED IN SUITE 1102

4. PATIENT IN ROOM TIME 1102 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Alert See previous DA5179. NPO PMN Arabic Speaking.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC (b)(6)-2, 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ (b)(6)-2, AN, 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* (B) arms abducted less than 90° on padded armboards.

☒ 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:

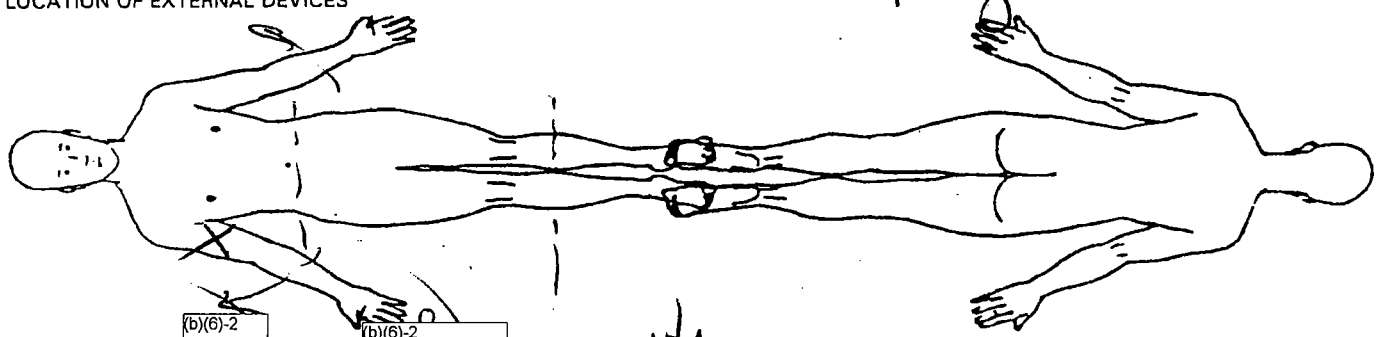
PREP SOLUTION *(Specify)* Betadine & NS

SITE: RLE BY WHOM: (b)(6)-2

SITE: BY WHOM:

COMMENTS: No pooling noted. Chux used.

9. LOCATION OF EXTERNAL DEVICES



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

LEGEND X Ground Pad -- Safety Strap = = = Tourniquet N/A

C = Correct I = Incorrect Init by (b)(6)-2

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

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

(b)(6)-4

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

Setting 30/30

☒ ESU NO: 000142 Valley Lab Force II

GROUND PAD: BRAND VL REM

LOT NO: 69671 EXP 2005-04

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

MEDCOM - 7704

13. PROSTHESIS, IMPLANTS ☐ NO IF YES NAME: ID NUMF AN' CTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): NSS

OTHER ORDERS		TIME	CARRIED OUT BY
	(b)(6)-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.	2.	3.
SITE	1.	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix
Ace Wrap

19. ADDITIONAL INFORMATION

Dr (b)(6)-2 MAJ (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED

D+I, Rt thigh wound

21. PATIENT TRANSFERRED TO ICU TIME 1152 METHOD litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2 MAJ, AN

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

MEDICAL RECORD

INTRAOPE[illegible]TIV[illegible] [illegible]CUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA amb. BY anesthesia

2. PATIENT IDE[illegible] (b)(6)-2 [illegible] AND PROCEDURE
VERIFIED BY [illegible]

3. DATE 10 Oct 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN[illegible]
TIME 0915 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2, 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	SSt (b)(6)-2, 66E	RELIEF CIRCULATOR	Maj (b)(6)-2 (0950-END)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

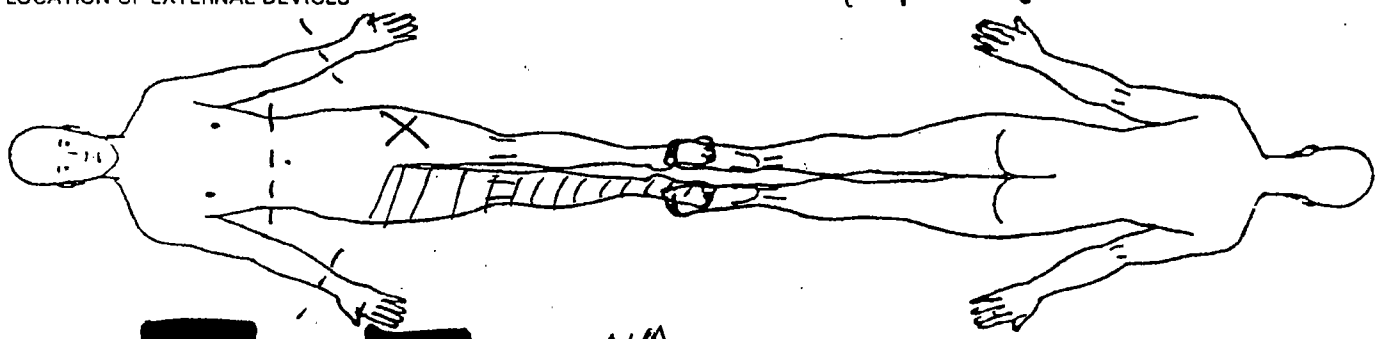
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR
☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Hibiclens
SITE: RLE - Toes to groin BY WHOM: [redacted] (b)(6)-2
SITE: BY WHOM:

COMMENTS: ∅ pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X [redacted] -- Sa[redacted] === N/A Tourniquet /// = prep

10. COUNTS

C = Correct I = Incorrect

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

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

(b)(6)-4

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

☐ ESU NO: #1 cut/coag = 30/30
GROUND PAD: BRAND Valley Lab
LOT NO: 69671 exp 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

MEDCOM - 7706

13. PROSTHESIS, IMPLANTS ☐ NO IF YES NAME: ID NUM MAN CTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
NSS

OTHER ORDERS	TIME	CARRIED OUT BY
(b)(6)-2		
(b)(6)-2		
PHYSICIAN'S SIGNATURE		

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. JP 7mm	2.	3.
SITE	1. (R) Thigh WD	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Xeroform
Fluffs
Kerlix
Ace Wrap

19. ADDITIONAL INFORMATION
Dr (b)(6)-2

May (b)(6)-2, CRNA

20. OPERATION(S) PE
(R) Thigh I+D / DPC

21. PATIENT TRANSFERRED TO ICU TIME 1037 METHOD litter

22. REGISTERED NURSE S (b)(6)-2 USAN (b)(6)-2 MAJ, AN

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ______ TO ______ HOURS COVERED

DATE 28Sep2003

INTAKE

~~ORAL~~ urine

TIME	TYPE	AMOUNT	ACCUM TOTAL
0920	Clr, orange-yellow	750	750
1335	Clr, yellow-orange	300	1050
0245	Clear c/m	1000	2050

INTRAVENOUS

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

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

(b)(6)-4

USAPPC V1.00

MEDCOM - 7708

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 1200 TO _____ HOURS | TOTAL HOURS COVERED | DATE 28 Sep

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1215	Water	250	250

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
IOL	1000	NS	500	1330	500
1330	500	NS			

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ HOURS TO _____ HOURS	TOTAL HOURS COVERED	DATE

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1215	Water	250	250

INTRAVENOUS

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

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

30Sep2003

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
30Sep 1340	~~150~~	~~150~~			
01Oct 0840	300	300			
~~30~~D/C foley					

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

(b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	1	2	3	4	5	6	7
POST-OP DAY	POD 5	1	2	3	4	5	6
MONTH-YEAR / DAY	Sep 27	28	29	30	Oct 1	2	3
2003 / HOUR	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2	0 1 2

PULSE (O) — TEMP. F (°) — TEMP. C

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 5 | 5 | 75 | 3 | 5 | 5

BLOOD PRESSURE: 146/86 | 124/66 | 130/70 | 124/66 | 134/74 | 111/52 | 111/50 | 138/73 | 135/61 | 104/54 | 138/75 | 124/61 | 144/77 | 124/69

120/66 | 126/72 | 131/76 | 134/65 | 124/70 | 120/71 | 124/73 | 123/8 | 136/76 | 136/56

HEIGHT: | WEIGHT → 95% | 95 | 97 | 96% | 98 | 97% | 94% | 94% | 95 | 95 | 97% | 97 | 95%

95 | 95 | 95% | 94 | 93% | 95 | 94% | 93% | 95% | 94% | 94%

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.

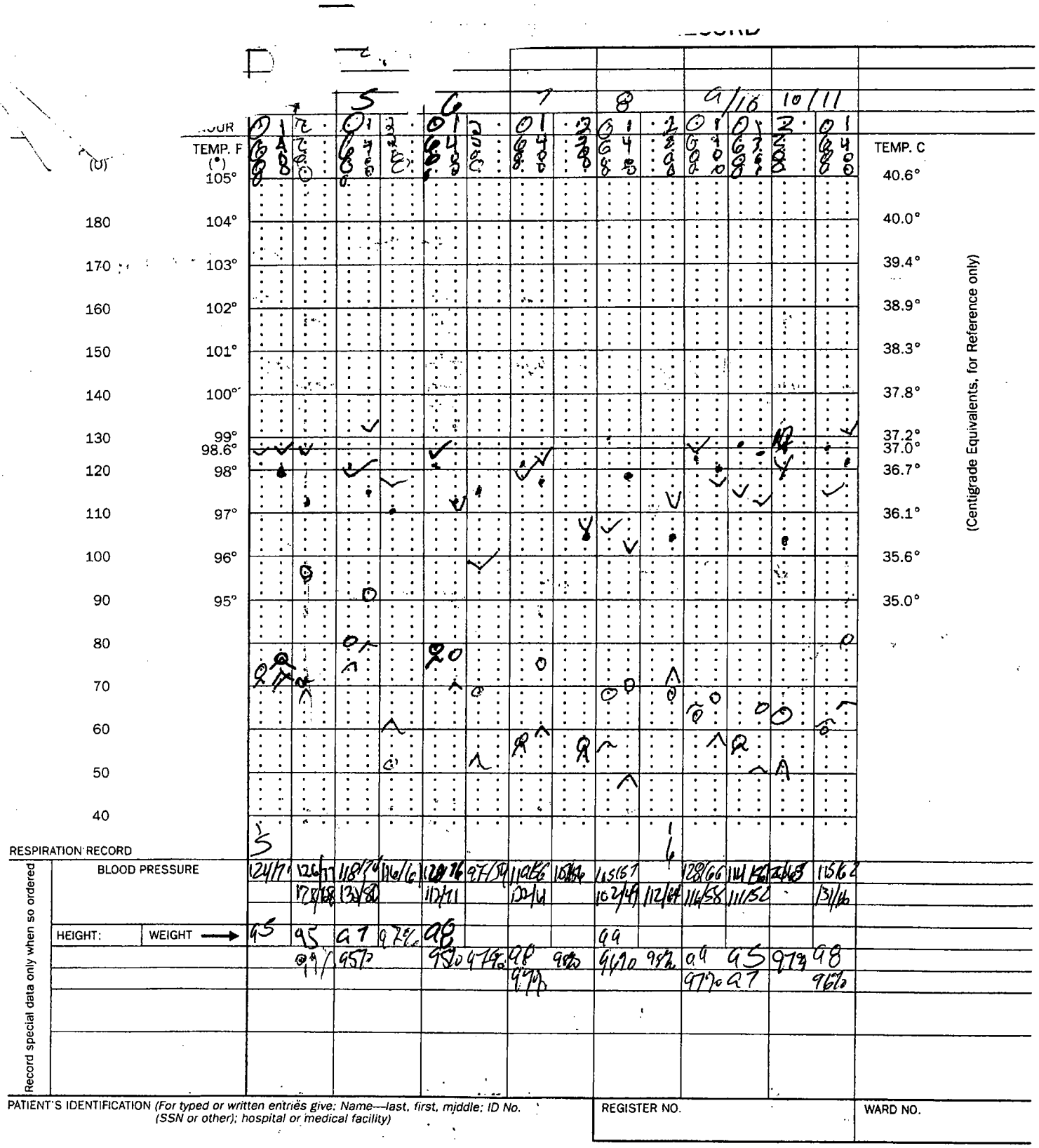
(b)(6)-4

BACK

NSN 7540-00-634-4139

VITAL SIGNS RECORD

MEDCOM - 7712



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.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 7713

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		15														
POST-	DAY															
MONTH-YEAR Oct 80	DAY	17		13		14										
	HOUR	2	01	2	01	0										
PULSE (O) / TEMP. F (•)		2 8 8	04 08 00	2 8 8	04 08 00	0 8 8										

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

(Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

BLOOD PRESSURE		113/62	125/65	123/68	116/64	114/64										
			116/65		130/73											
HEIGHT:	WEIGHT →															
		95%	97	98%	98	97										
			98%		96%											

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

*U.S.GPO:1996-404-763/40069

(b)(6)-4

MEDCOM - 7714

Ward/Section: EMT

Requesting Physician:

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

N (b)(6)-4

Date: 26 SEP 03

Time: 0755

Patient (b)(6)-4

Chemistry 7		
Test	Result	Ref. Range
GLU	131	73 - 118 mg/dL
BUN	7	7 - 22 mg/dL
Creat	1.1	0.6 - 1.2 mg/dL
Na	130	128 - 125 mmol/L
K	4.6	3.3 - 4.7 mmol/L
Cl	100	98 - 108 mmol/L
CO2	28	18 - 33 mmol/L

Chemistry 12/LFT		
ALB	3.6	3.5 - 5.5 g/dL
ALP	91	26 - 84 µg/dL
ALT	24	10 - 47 µg/dL
AMY	52	14 - 97 µg/dL
AST	30	11 - 38 µg/dL
Tbili	1.4	0.2 - 1.6 mg/dL
TP	6.5	6.4 - 8.1 g/dL
Ca	8.9	8.0 - 10.3 mg/dL
Chol	144	100 - 200 mg/dL
Creat	0.9	0.6 - 1.2 mg/dL
BUN	7	7 - 22 mg/dL
GLU	134	73 - 118 mg/dL

Other Chem		
Troponin		Negative
GLU Only		73 - 118 mg/dL
CK	387	39 - 380 µg/L - Male 30 - 190 µg/L - Female

Urinalysis		
Test	Result	Ref.Range
Color	Lt Yellow	N/A
App	SLIGHTLY HAZY	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	NEG	Negative
SGav.	1020	N/A
Bld	LARGE	Negative
pH	5.0	N/A
Prot	NEG	Negative
Urob	0.2	0.2 - 1.0
Nit	NEG	Negative
Leuk	NEG	Negative

Micro UA

WBC - 3-5

RBC - TNTC

EPI - 0-1

Blood Gas		
ph		7.31 - 7.45
PCO2		35 - 45: Art
PO2		80 - 105
HCO3		22 - 26
TCO2		23 - 27
BE		(-2) - 3
sO2		95 - 100%

Hematology(CBC)		
Test	Result	Ref. Range
WBC	14.9	4.8 - 10.8 x 1E3
RBC	5.46	4.7 - 6.1 x 1E6
Hgb	15.9	14 - 18 g/dL (M); 12-16 (I
Hct	49.3	45 - 52% (M); 37 - 47% (I
MCV	90.2	80 - 99 fL
Plt	312	130 - 500 1E3
Lymph%	10.3	20.5 - 51.1 %

Hematology Manual Diff	
Segs	Lymph
Bands	Atyp
Mono	Imm
Eos	RBC Morph
Baso	Plt. Est

Coagulation		
PT	16.4	9.8 - 13.6 sec
aPTT	34.7	21 - 34 sec
INR		N/A

MISC		
Malaria		Negative
Gram Stain		N/A
UA Tox:		Negative
HCG		Negative

Additional Instructions:

Reported By: (b)(6)-2

Date: 2

MEDCOM - 7715

MEDICAL RECORD - ANESTHE[illegible]

For use of this form, see AR 40-66; the proponent agency is th[illegible] [illegible]SG

CONTINUOUS/REPEATED DRUGS AND FLUIDS (SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION)

DRUG	(Units)													
Midazolam	(mg)	2												
Fentanyl	(mcg)	150	50	50										
Propofol	(mg)	160		40										
Succ	(mg)	100												
	( )													
	( )													
VOLATILE AGENT Iso	% del	1.7	1.7	1.7	1.7	1.0	.6 X							
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	6-2	-2-	2	-2-	2	8-15							

ANESTHETIC AGENTS AND DOSAGE

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

FLUIDS

LINE site LR(c) 18g AC	☐ Warmed		300		500			(600)					
	☐ Warmed												
Ancefizin 100cc IVP	☐ Warmed		X		X								
	☐ Warmed												

LOSSES

EST BLOOD LOSS													
URINE -				650				(700)					

TOTALS

	TOTAL EBL
2mg	Min
25mcg	
200mg	TOTAL URINE
100mg	
X	700cc

FLUIDS - SUMMARY

CRYSTALLOID- LR = 600cc

COLLOID-

BLOOD- X

REMARKS

Code drugs with numbers, events with letters

0015 → Preop ~~Auto~~ reviewed. Pt ID on 1 cbt. Place GETA

0028 To OR via litter by 2. Moved safely to bed. Monitors on. Pre O2 pr induction. Eyes taped shut - See Airway note below

0156 Resp event reg. opens eyes TV > 500cc. Airway reflexes intact. MAE. Oral skin sy tubotral & PCS. pressure bandaging

0200 To ICU via litter O2 via NRB FM 15LPM - Report to SFC Love, VSS pt stable

PATIENT STATUS (1 2 3 4 5 E)

BODY WEIGHT: N 90 (KG) LB

HEMATOCRIT: 49.3

INITIAL DATA: BP- 128 185 HR- 81

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y/N TIME- 0020

TIME 0030 0045 0100 0130 0200 30 0300

SYMBOLS: BP by cuff V (P) arm; Heart rate ∧ reg curve; Resp rate ●; BR (transduced) ✚; TOURNIQUET T—T; ANES- X-X; PROC- ⊙-⊙

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

VENTIL

1:E=1:2	VT - ml	960	950	600	>150	>200	>300
	f - breaths/min	18 12	10	7	14	16	20
	Peak inf pres / PEEP	24	24	—	—	—	—
	MODE - S(pon), A(sist), C(on)	S C	C	A	S	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	@ 29	26	30	42	48	—
BP/oth	✓ FIO2 (Frac or %)	.89	.90	.89	.91	.91	.21
ART line	✓ SpO2 (%)	99	99	99	99	99	99
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	SR
Gas analyzer	✓ TEMP-site skin	100.4	100.4	101.4	101.4	[illegible]	98.3 Ax
	✓ N-M Block (T/4)	4/4	4/4	-			
Warming blkt		✓✓					
Conv warmer							

Mark with letters & symbols, explain under REMARKS

EVENTS *Position* → Arms (90° secure on padded armboards O ← → 8

RECOVERY AT 0200

PACU ICU _____ (Specify)

OTHER Stable

CONDITION: 983 Ax.

RESP. 20 SpO2 99 @ 0250

BP- (67/70 HR- 81

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0015	0028	0205
	Ready	Begin	End
PROC	0035	0055	0148

PROCEDURES and CPT Codes:

DAI Multiple shrapnel wounds BLE, LUA

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

(b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* RSI E cricoid pressure 8.0 OETT @ 24cm @ teeth. DL x 1 @ MAC 3 grade Direct view @ stylet; @ 2LO2 sustained; @ BBS = ; (B) sgl Lik block

SURGEONS: (b)(6)-2

ANESTHETISTS: (b)(6)-2 CRT/CRNA

PROCEDURE LOCATION: OR1-1

DATE: 20 SEP 03

PAGE 1 **OF** 1

3Lyo
ASA I
NKDA Array q 5hr @ 0760

MEDICAL RECORD — ANESTHESIA

DRUG	Dosage	
Midazolam	(mg)	2
Ketamine	(mg)	150 50 50
Propofol	(mg)	150 50
Lidocaine	(mg)	150
MSO4	(mg)	5 5 5 5
	( )	
VOLAT AGENT: Sevo	% del	1.5 · 1.7 – 2.0 – 2.0 – 2.0 2.5 – 2.5 – 2.0 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6 – 2 – 2 – 2 – 2 – 2 – 2 – 2 → 9 – 15

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 LR(cc) 20g RA ☒ Warmed — 400 — 200 — 400; ☐ Warmed; ☐ Warmed; ☐ Warmed

LOSSES: EST BLOOD LOSS; URINE – 100 / 100 / 125 / 525

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: N90 KG LB

HEMATOCRIT: 49.3

INITIAL DATA: BP – 139 / 74; HR – 70

BOOB CHECK: OK? – Y N

PATIENT PROMISE: OK for PROCEDURE? Y/N; TIME – 0745

TIME →

SYMBOLS: R arm BP by cuff; V Rig; ^ Adult cuff; Heart rate ●; Resp rate; BP (transduced); TOURNIQUET T – ✓; ANES – X-X; PROC – ⊙ – Ø

I:E = 1:2 VT – ml	800	920	930	900	2300	2150	2300	2400	2500	
⊕ time 1 – breaths/min	16	8	8	8	10	16	15	17	15	16
Peak inf pres / PEEP	22	22	22	22	–					
MODE – S(pon), A(ssist), C(on)	S	C	C	C	A	S	S	S	S	S
✓ BP/Auto Cuff / ✓ ET CO2 (torr)	30	32	31	30	34	45	46	42	–	
BP / oth / ✓ FIO2 (Frac or %)	.89	.89	.89	.88	.87	.82	.86	.56	.21	
ART line / ✓ SpO2 (%)	100	99	99	98	100	99	99	100	99	
Steth – PC/ES / ✓ ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	
Gas analyzer / ✓ TEMP – site Skin		98.6	98.6	98.6	98.6	98.6	98.6	98.6		
✓ N-M Block (T/4)	4/4	0/4								
Warming blkt										
Conv warmer										

Mark with letters & symbols, explain under REMARKS — EVENTS: (R) Arm 90° secured on padded armboard; (L) Arm 90° in field
Position → Supine → → → → → →

TOTALS	
2mg	
250mcg	
200mg	
50mg	
20mg	

TOTAL RM: Min

TOTAL URINE: 825 cc

FLUIDS – SUMMARY: CRYSTALLOID – LR = 400; COLLOID –; BLOOD – X

REMARKS – Code drugs with numbers, events with letters

0745 circuit review
No change since prep done 9/27/03. NPO Adm. 20g IV patent R forearm.
0800 In OR 1-1 via T. Ther. Moves self to bed. Monitors m. Pro2. IV induction. Eyes taped shut. See airway note below
1000 Resp even / Reg. Opens eyes to name. TV > 500. RR 15. O2 Sat. Airway reflex intact. Extubated. Pos. pressure breath. Spont resp resume.
1010 To ICU for recov. VS S. Report to SCT Smith. Pt stable

RECOVERY AT 1010
PACU ICU (Specify)
OTHER T = 96.4
CONDITION: Stable
RESP – 16 SpO2 – 99% O2 RA
BP – 133/77 HR – 80

ANES	Start	Room	End
	0730	0800	1015
PROC	Ready	Begin	End
	0810	0835	1000

PROCEDURES and CPT Codes: I & D & DPC of shrapnel wounds to BLE and LUE

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GEN A. (O2 / Sevo)

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Easy Mask Ventilation. DLX / 2 Miller 3 mg SSG. White RT. 5.0 ETT inserted ersatz. Secured @ 22 cm @ teeth; ⊕ stylet; ⊕ sustained ETCO2; ⊕ BBS = ; ⊕ soft bite

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

(b)(6)-4

SURGEONS: (b)(6)-2

ANESTHETISTS: (b)(6)-2 / CRNA

PROCEDURE LOCATION: OR 1-1

DATE: 29 SEP 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 7717

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

MEDICAL RECORD — ANESTHESIA

DRUG	Units	Dose
Versed	(mg)	2
Fent	(mcg)	150 50
Propofol	(mg)	130
	( )	
	( )	
	( )	
VOLAT AGENT: Iso	% del / % e.t.	X – 1.5 – 1.0
AIR	L/Min	
N2O	L/Min	
O2	L/Min	X-S – 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	CR AS	☐ Warmed
		☐ Warmed
		☐ Warmed
		☐ Warmed

LOSSES	
EST BLOOD LOSS	
URINE –	

TOTALS	
TOTAL IN	
TOTAL URINE	

FLUIDS – SUMMARY	
CRYSTALLOID–	
COLLOID–	
BLOOD–	

REMARKS– Code drugs with numbers, events with letters

1050 pt ID'd & plan of care reviewed w/ pt
1100 In Rm Mon, Zoll On
1105 Induction, LMA placement
1150 SV & good ↑ LMA Removed & pos. pics.

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 90 KG / LB

HEMATOCRIT:

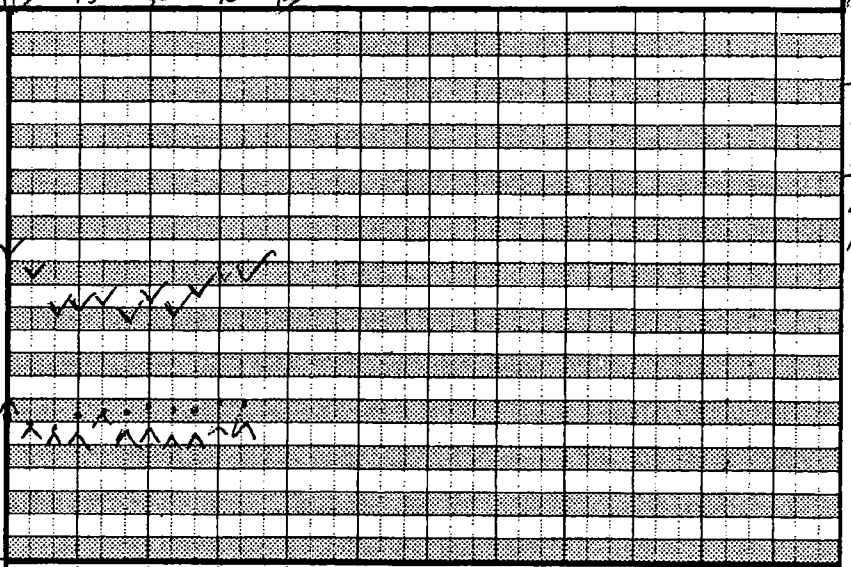
INITIAL DATA: BP – 134/ R-M; HR – 62

COMP CHECK: OK? – Y N

PATIENT READINESS: OK for PROCEDURE? Y; TIME – 1100

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

TIME → 00 15 30 45 120



VITALS	00	15	30	45
VT – ml				
f – breaths/min		10	8	14
Peak inf pres / PEEP				
MODE – S(pon), A(ssist), C(on)	S	S	S	S
BP/Auto Cuff / ET CO2 (torr)	(+)	59	59	(+)
BP / oth / FIO2 (Frac or %)	.41	.41	.41	.41
ART line / SpO2 (%)	100	100	99	99
Steth- PC/ES / ECG	SR	SR	SR	SR
Gas analyzer / TEMP- site				
N-M Block (T/4)				
Warming blkt				
Conv warmer				

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

RECOVERY AT: PACU (ICU) _____ (Specify); OTHER _____; CONDITION: Stable; RESP – 12; SpO2 – 98; BP – 114/62; HR – 74

ANESTHESIA & PROCEDURE TIMES	Start	Room	End
ANES	1050	1100	1200
	Ready	Begin	End
PROC	1105	1125	1145

PROCEDURES and CPT Codes: I&D (R) thigh wound infection

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: G.A.

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: #5 LMA X 1; B/L BS; ETCO2 X5 waves; E/VOS taped

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility: (b)(6)-4

SURGEONS: (b)(6)-2

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

Nurse Anesthetist

PROCEDURE LOCATION: 1-1

DATE: 7 Oct 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED
1 Jan 99

PATIENT RECORD

MEDCOM - 7718

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

MEDICAL RECORD — ANESTHESIA

DRUGS	(Units)	
Versed	(mg)	3
Fentanyl	(mcg)	100, 50, 50 50
Propofol	(mg)	200/100
Tofodal	(mg)	30
	( )	
	( )	
VOLAT AGENT: Iso	% del / % e.t.	X–1.0–1.0–1.0–0.8–X
AIR	L/Min	
N2O	L/Min	
O2	L/Min	X–8–2–2–2–2–8

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

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

TOTALS	
3 mg	
250 mcg	
300 mg	
30 mg	

TOTAL FLUID: Min

TOTAL URINE: Ø

FLUIDS – SUMMARY

CRYSTALLOID– 600

COLLOID– Ø

BLOOD– Ø

FLUIDS		
LINE site	NS	☐ Warmed
		☐ Warmed
		☐ Warmed
		☐ Warmed

500

LOSSES	
EST BLOOD LOSS	
TIME	15 30 45 1000 15
URINE–	

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 90 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP – 137/76 R-18; HR– 68

BLOOD CHECK: OK?– (Y) N

PATIENT CHECK: OK for PROCEDURE? Y; TIME– 0915

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

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml						
f – breaths/min	15	8	9	11	14	
Peak inf pres / PEEP						
MODE– S(pon), A(ssist), C(on)	S	S	S	S	S	S
BP/Auto Cuff / ET CO2 (torr)	(+)	46	49	49	44	45
BP / oth / FIO2 (Frac or %)	.91	.91	.91	.91	.90	.92
ART line / SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES / ECG	SB	SB	SB	SB	SB	SB
Gas analyzer / TEMP- site						
N-M Block (T/4)						
Warming blkt						
Conv warmer						

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

REMARKS – Code drugs with numbers, events with letters

0905 pt ID'd & chart Reviewed

0915 IV Rx Mon, 7 ESS On

0919–0923 Induction c #4 LMA placement

RECOVERY AT 1040

PACU / ICU (Specify)

OTHER

CONDITION: Stable

RESP– 15 SpO2– 98

BP– 110/56 HR– 54

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0905	0915	1045
	Ready	Begin	End
PROC	0925	0940	1030

PROCEDURES and CPT Codes

DPC of (R) Thigh Wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments LMA #4 X 2

Bilat BS & ETCO2 X 5 waves, Eyes taped

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

(b)(6)-4

SURGEONS: (b)(6)-2

ANESTHETISTS: MAJ (b)(6)-2 AN, CRNA

Nurse Anesthetist

PROCEDURE LOCATION 1-1

DATE 10 Oct 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 7719

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

ANESTHESIA PLAN OF CARE **CEDURAL ASSESSMENT (Sedation ... ia)**

Age 31 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

ASA Physical State 1 2 3 4 5 E
WT: 190 KG/LB HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: I&D Multiple Sites
SURGICAL SERVICE: ENT
NPO SINCE: 2100

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

CURRENT MEDICATIONS:
( ) = ordered as premed

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

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

LABORATORY STUDIES:

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

14.9 / 15.9 / 49.3 (312
130
4.6

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	r/o
Steriods	N	Y	
Thyroid	N	Y	Uninterpreted
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	Multiple
Other Significant Hx:			
	N	Y	Sinusitis
	N	Y	Hearing - B/L
Familial HX	N	Y	Lue

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 129/67 HR 67 R ____ T ____
Pain Scale 0-10 ____
HEENT - Teeth intact / poor
Trachea deviated on
TMJ/Neck normal limits
Oropharynx Rom
Nares 3+B MH
CHEST: CTA (B)
CARDIAC: S1 S2
EXTREMITIES:
IV Access: 14G (R) AC
Ulnar Filling: 18G (L) AC
BACK: ____
OTHER: ____

NPO Since 2100

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 p(b)(6)-2 derstand and agrees. Questions answered.
Signe(b)(6)-2 Date: 9/21/03 Time: 0830 Hrs

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

Signed(b)(6)-2 Date: 9/21/03 Time: 1000 Hrs

Patient Identification: (Ward) ____

(b)(6)-4

SEDATION KEY:

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 26 ~~27~~ Sept TIME OF ORDER: 1630 HOURS

LIST TIME ORDER NOTED AND SIGN

1. MSO4 2-8 mg q 2 hrs prn Pain not to exceed 20 mg prior to Surg. (b)(6)-2 (b)(6)-2 (b)(6)-2 MAT/CRNA

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 26 Sept 03 TIME OF ORDER: 1600 HOURS

LR @ 125 c/h

V.O. On (b)(6)-2 (b)(6)-2 (b)(6)-2 1600

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 27 September 03 TIME OF ORDER: 0145 HOURS

1. Admit PR → ICW
2. Dx: Multiple B/L LE fragment wounds ⓛ elbow intra articular fragment. S/P I+D
3. Cond Stable
4. Vitals Q. routine
5. Angel T, IV q 8 H

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: TIME OF ORDER:

6. MSO4 2-4 mg q 15' ≤ 20 mg q 20 HOURS
7. Percocet 1-2 PO q 4-6 H for Pain
8. IVF: NS @ 100 cc/HR Heplock when TOL PO
9. Pain Restraints; UP AD LIB
10. Diet Reg.
11. Colace 1 PO BID

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

NURSING UNIT | ROOM NO. | BED NO.

24° / Cond (b)(6)-2 ATT/AN

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 29 Sep — TIME OF ORDER: 1130 HOURS — LIST TIME ORDER NOTED AND SIGN

(1) Foley to Gravity

VO: Dr. (b)(6)-2 / 10 (b)(6)-2 AN

NURSING UNIT: 28 Sep 03 — ROOM NO.: 0600 — BED NO.: (b)(6)-2

CPT AN

PATIENT IDENTIFICATION

DATE OF ORDER: 28 Sep 03 — TIME OF ORDER: 1743 HOURS

added 29 Sep 03 0500 (b)(6)-2

(1) NPO p MIDNIGHT

(2) TO OR FOR REPEAT I&D, DPC

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

NURSING UNIT — ROOM NO. — BED NO.

24° chart ✓ 29 Sep 03 0550 (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 29 Sep 03 — TIME OF ORDER: 1012 HOURS

(1) ADMIT PR → ICW

(2) Dx: FRAGMENTATION WOUNDS BIL LE, (L) ELBOW S/P I&D / DPC

(3) COND: STABLE

(4) VITALS q ROUTINE

(5) ACT: UP AD LIB, EPW RESTRAINT

(6) NKA

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

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER

(7) ANCEF T q 1V q 8 HOURS

(8) IVF: NS @ 120 cc HR / HEPLOCK WHEN TOL PO

(9) DIET REG

(10) MSO4 2-4mg IV q 15° ≤ 20mg q 2° PERCOCET T 1-2 PO q 4-6H PRN BENADRYL 25-50mg PO q 6H PRN COLACE T PO BID

NURSING UNIT — ROOM NO. — BED NO.

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

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

MEDCOM - 7722

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-2

DATE OF ORDER 1 Oct 2003 TIME OF ORDER 0800 HOURS — LIST TIME ORDER NOTED AND SIGN

(1) D/C Foley

(2) MOM 100cc PO Q2° until BM.

VO: Dr. (b)(6)-2 / LT (b)(6)-2 AN

Speed 1LT 2 Oct 03 @ 0200

NURSING UNIT | ROOM NO. | BED NO.

24° chart ✓ 2 Oct 03 @ 1500 [redacted] TLE

PATIENT IDENTIFICATION

DATE OF ORDER [redacted] /A

4 Oct 03 0825 HOURS

(1) Discharge to MP custody

(2) Opsite to lacerations/ incision sites.

(3) Remove sutures & steri strip wounds x groin and elbow.

(4) Keflex 500mg PO QID

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

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

24° chart ✓ 5 Oct 03 @ 0300 (b)(6)-2 /A

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER TIME OF ORDER HOURS

(1)

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
6 OCT 03	1917 HOURS	
1 ADMIT ICW		
2 Dx: SOFT TISSUE		
FRAGMENTATION WOUNDS,		
CONTINUED DRAINAGE		
3 COND: STABLE		
4 VITALS: Q ROUTINE		
5 ACTIVITY: WBAT, EPW		

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

Noted 6 OCT 03 1936

PATIENT IDENTIF

DATE OF ORDER	TIME OF ORDER	
RESTRAINTS	HOURS	
1 NKDA		
2 DIET: NPO P MIDNIGHT		
3 IVF: TKO		
4 PERCOCET 1-2 PO q 4-6H		
PRN PAIN		
IBUPROFEN 800 mg PO TID PRN		
BENADRYL 25-50 mg PO q 6H PRN		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
10 TO OR IN AM.	HOURS	
11 ANCEF 1g IV q 8H		
~~01-12-00~~	(b)(6)-2	
6-14-22	MAY	
24' chart ✓ 6 Oct 03 @ 2350 (b)(6)-2		14

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.

MEDCOM - 7724

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7 OCT 03 TIME OF ORDER 1155 HOURS | LIST TIME ORDER NOTED AND SIGN

1. ADMIT PR → ICW
2. DX: (R) THIGH SEROMA
3. COND: STABLE
4. VITALS: Q ROUTINE
5. ACT: WBAT, EPW RESPIRATORY
6. DIET: REG
7. IVF NS @ 110 cc/HR HEPARIN

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

WATER TOL PO HOURS

8. NAFCILLIN 2g IV q 4°
9. MSO4 2-4mg q 15' ≤ 20mg q 2°
10. PERCOCET 1 PO q 4-6H PRN
BENADRYL 25-50g PO q 6° PRN
COLACE 1 PO BID
MOM 60cc PO q 2° PRN CONSTIP.
11. WET TO DRY

(b)(6)-2 noted 7 OCT 03 1320

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

DRESSING Δ'S BID HOURS

(R) THIGH

12. REMOVE SUTURES / STERI STRIP (L) EUROON

(b)(6)-2

MAJ

CPT AN 240 7 OCT 03 2300

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

9 OCT 03 2058 HOURS

1. NPO P [redacted]
2. TO OR IN AM

Note (b)(6)-2 SGT [illegible]

(b)(6)-2

MAJ

CPT AN 10 OCT 03 0800

DA FORM 1 APR 79 4250 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 10 OCT 03 TIME OF ORDER: 1030 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) ADMIT: RR → ICW

CONTINUE ORDERS DATED 7 OCT 03

DSG D's QD.

NP DRAIN.

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 10 OCT 03 TIME OF ORDER: 1730 HOURS

(1) MOM 30cc po now then repeat if no result in 1 hour

(2) MOM 30cc po q6° prn

(b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 10 OCT 03 TIME OF ORDER: 1806 HOURS

V.O.

(1) D/C Nafcillin

(2) Begin Keflex 500mg PO QID

Dr. (b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11 OCT 03 TIME OF ORDER: 1609 HOURS

V.O.

Tylenol 325mg 1-2 PO q4-6° PRN pain

Dr. (b)(6)-2

(b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
				13 OCT 03	0945 HOURS	
			(1)	D/C TO WP CUSTODY		
			(2)	REMOVE SUTURES		
				IN 5-7 DAYS		
			(3)	DAILY DRESSING CHANGES		
			(4)	CONTINUE VERFLEX 500mg		
NURSING UNIT	ROOM NO.	BED NO.		PO QID F 7d.		
				(b)(6)-2		
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF O	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED												
				27	28	29	1	2	[redacted]							
27	(b)(6)-2	Vitals q Routine	6	(b)(6)-2												
29 Sep			14													
			22													
27	(b)(6)-2	Regular diet	7	(b)(6)-2												
29 Sep		Regular diet	12													
			17													
27	(b)(6)-2	Elbow Restraints.	6	(b)(6)-2												
		up ad lib	10													
27	(b)(6)-2	Activities: up ad lib	6	(b)(6)-2												
			18													
29 Sep	(b)(6)-2	Foley to Gravity	06	(b)(6)-2												
			14													
29 Sep	(b)(6)-2	Act: up ad lib	06	/	/	(b)(6)-2										
			14	/	/											
			22	/	/											

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS: (L) elbow intra articular wound
Multiple B/L LE Frag wound.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: S/P I+D

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 9 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
27	(b)(6)-2	Admit RR → ICW				
27		Condition: Stable				
	---	NPO P MN for Repeat I+D				
	---	DPC				
29Sep	(b)(6)-2	——— S/P I+D ———				
29Sep		Admit ICW			1120	(b)(6)-2
29Sep		Condition: stable			1120	
6 Oct	(b)(6)-2	D/C foley			0830	
6 Oct		DIV by 1400	4 Oct	1400	1400	
4 Oct		D/C to MP custody	4 Oct			
4 Oct		Opsite to laceration incision site	4 Oct		0920	(b)(6)-2
4 Oct		Remove sutures & skin staples wound	4 Oct		0920	
	---	R groin & elbow				

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 6	7	8	9	10								
6 OCT	(b)(6)-2	Vitals q Routine	06	/	(b)(6)-2											
			14	(b)(6)-2												
			22													
		~~Vitals q Routine~~	06	/	(b)(6)-2											
6 OCT	(b)(6)-2	Activity: WBAT, EPW	14	(b)(6)-2												
		restraints	22													
6 OCT	(b)(6)-2	Diet: NPO p Mid	06	/	(b)(6)-2											
		night	14													
			22	(b)(6)-2												

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

Soft tissue fragmentation wounds continued drainage

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6OCT	(b)(6)-2	Admit ICW Cond: Stable	6OCT	1915	1915	(b)(6)-2
6OCT		To OR in AM	6OCT			

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. ____ Yr. 2003

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING: ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 07	08	09	10	11	12	13	14
7 Oct	(b)(6)-2	Vitals Q Routine	06	(b)(6)-2							See below
			14								
			22								
7 Oct	(b)(6)-2	Act. UBAT, SPIRO Resistance	06	(b)(6)-2							
			08								
7 Oct	(b)(6)-2	Fresh Dsg	06	(b)(6)-2							→ DC
			12								
			18								
7 Oct	(b)(6)-2	Wet to Dry Dsg A's BID (R) THIGH	10	(b)(6)-2							
			20								
			22								
~~7 Oct~~	(b)(6)-2	~~Remove sutures~~ 7R									
9 Oct	(b)(6)-2	NPO ~~after MN~~ Reg Diet	06								
			12								
			18								
8 Oct	(b)(6)-2	Drsg Δ QD	08								
10 Oct		JP Drain	06								
			14								
			22								
13 Oct		VS QD	06								10

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS:

(R) THIGH SEROMA

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

USAP

EDITION OF 1 DEC 77 MAY BE USED.

DA FORM 4077, 1 OCT 78 MEDCOM - 7732

Verity 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	
7 Oct	(b)(6)-2	Admit to IOW	7 Oct	1155	1310	(b)(6)-2	
7 Oct		Dx (R) thigh seroma	7 Oct	1155	1310		
7 Oct		Cond stable	7 Oct	1155	1310		
7 Oct		Remove sutures / steri strip (L) elbow	7 Oct	1155	1310		
11 Oct		Continue orders dated 7 Oct					

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

USAPA V1.00

Verify by Initialing	THE DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. _____ Yr. _____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
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Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION	TIME/DATE DISPENSED													
26 Sept 07	(b)(6)-2	MSU 4 d-8mg Q-2hrs	D	26 Sept	26 Sept	26 Sept	26 Sept										
- - - - -	- - - - -	prn Qwk Not to	T	1400 4mg	1815 4mg	2000 4mg	2300 4mg										
- - - - -	- - - - -	exceed 20mg en or to	I	(b)(6)-2													
- - - - -	- - - - -	Surgery	E	(+)													
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USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
				26	27												
26 Sep 03	(b)(6)-2	LR @ 125 4hr	01	(b)(6)-2													
			18														
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ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

CLINICAL RECORD

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

Mo. 9 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
				27 28 29 30 1 2 3 4 5
27	(b)(6)-2	Ancef 1g IV	08	(b)(6)-2
29Sep		q 8°	16	
			24	D/C'd
27	(b)(6)-2	IV NS @ 100cc/hr	6	(b)(6)-2
		HL when tol PO	14	
			22	
27	(b)(6)-2	Colace 1 PO BID	10	(b)(6)-2
			22	
29Sep	(b)(6)-2	~~IVF NS @ 120 cc/hr~~	06	/ / (b)(6)-2
		Heplock when tol PO	14	/ / D'CD
			22	/ /
01 Oct	(b)(6)-2	MOM 60cc PO Q2°	02	/ — / /
		until BM	04	/ — / /
			06	/ — / /
			08	/ — (b)(6)-2
			10	/ — /
			12	/ — /
			14	/ — / —
			16	/ — / —
			18	— / —
			20	— / /
			22	— / /
			24	— / /

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
Multiple B/L LE fragment wounds
(L) Elbow intra articular wound
s/p: I+D

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

PATIENT IDENTIFICATION:
(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. 9 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
27 2980	(b)(6)-2	MSO4 2-4mg q 15' ≤ 20mg q2d													
27 2980	(b)(6)-2	Percocet 1-11 PO q 4-6° PRN Pain	1140	2140	1539	0016			1562	2183	1544	0341			
			(b)(6)-2												
2980	(b)(6)-2	Benadryl 25-50mg PO q 6-4 PRN													

MEDCOM - 7737

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.

Month Oct Yr. 2005

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 04	5	6
4 Oct 2005	(b)(6)-2	Kelflex 500mg PO QID	06	(b)(6)-2		
			12	(b)(6)-2		
			18	(b)(6)-2		
			24			

D/C'd

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: ⊖ elbow intraarterial wound multiple B/L LE frag wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 6	7	8	9	10
6 OCT	(b)(6)-2	IVF: TKO NS	06		(b)(6)-2			
			14	(b)(6)-2				
			22					
6 OCT	(b)(6)-2	Ancef 1 gm IV q 8H	04					
			12					
			20	(b)(6)-2				
6 OCT	(b)(6)-2	Ancef 1 gm IV q 8H	08		16			
			16					
			24	(b)(6)-2				

Δ'd See below 6 OCT 03

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

Soft tissue fragmentation wound
Continued drainage

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo._____ Yr._____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
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Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
6OCT	(b)(6)-2	Percocet I-II PO	1930 6OCT PO (b)(6)-2													
- - - - -	- - - - -	q4-6H PRN														
- - - - -	- - - - -	Pain														
6OCT	(b)(6)-2	Ibuprofin 800mg														
- - - - -	- - - - -	PO TID PRN														
6OCT	(b)(6)-2	Benadryl 25-50mg														
- - - - -	- - - - -	PO q6H PRN														
- - - - -	- - - - -															
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- - - - -	- - - - -															
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- - - - -	- - - - -															
- - - - -	- - - - -															

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo. ____ Yr. ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 07	08	09	10	11	12	13	14
7 Oct	(b)(6)-2	IVF NS @ 110cc/hr	06	(b)(6)-2							
		Heparin when PO Tol	18								
	(b)(6)-2										
7 Oct		Nafcillin 2g IV q 4°	00								
			4								
			8								
			12								
			16								
			20								
			24								
7 Oct	(b)(6)-2	Colace 1 PO BID	08								
			20								
~~7 Oct~~	(b)(6)-2	~~Mom 1 Oct~~									
10 Oct	(b)(6)-2	(b)(6)-2	06								
			14								
			22								
10 Oct	(b)(6)-2	Keflex 500mg PO QID	08								
			14								
			20								
			02								

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

(R) Thigh Sarcoma

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 7741

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
7 Oct	(b)(6)-2	MSO4 2-4mg q 15'														
- - - -	- - - - -	< 20mg q 2° PRN														
- - - -	- - - - -															
7 Oct	(b)(6)-2	Percocet 1-2 PO q 4-6	8 Oct 0835	8 Oct 2139	9 Oct 1025	10 Oct 2125										
- - - -	- - - - -	PRN														
- - - -	- - - - -															
7 Oct	(b)(6)-2	Benadryl 25-50mg PO														
- - - -	- - - - -	q 6° PRN														
- - - -	- - - - -															
7 Oct	(b)(6)-2	MOM 60cc PO	8 Oct 2100													
- - - -	- - - - -	q 2° PRN constipation														
11 Oct	(b)(6)-2	Tylenol 325mg 1-2 PO	11 Oct 1611													
- - - -	- - - - -	q 4-6° PRN pain	(b)(6)-2													

USAPA V1.00

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0957	INITIALS (b)(6)-2		INITIALS		INITIALS
NEURO	PUPILS	Pupils 3mm with					
	SENSORIUM	MAE x4. A&O x3 drowsy					
		cell greeted appropriately					
		denies pain as this time					
RESPIRATORY	RESPIRATORY PATTERN	Lungs CTA in all fields					
	BREATH SOUNDS	Rate regular, no					
	SECRETIONS	evidence of dyspnea					
		& productive cough.					
		O2 sat 95% on RA					
SKIN	COLOR	Pink, warm, dry					
	INTEGRITY	(b) lower ext. (b) upper thigh					
		(b) medial thigh.					
IV SITE	LOCATION	14G to (b) AC. Site					
	CONDITION	redness on drawing left					
		to (b) AC. Site redness					
		on drawing. Both IVs					
		CLR Ulcerg @ 125 ml/hr					
GASTRO	ABDOMEN	BS x4, hyperactive.					
	BOWEL SOUNDS	No Distention noted.					
GU	URINE:	Foley to gravity, clear					
	COLOR/CLARITY	yellow urine.					
CARDIOVASCULAR	CARDIAC RHYTHM	SR S rhythm, S1 S2					
		Pulses 2+ to all					
		extremities. No murmur					
		or edema.					

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) (b)(6)-2 MAGN

DEPARTMENT/SERVICE/CLINIC ICU

DATE 26 Sept 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
BP Arterial Line																		
BP Cuff						102/49	133/60	139/67		139/60	139/71	139/65	139/68	136/60	134/60	135/65	130/60	
Temperature						98.2						99.4						
Pulse						64	57	68	89	61	86	91	91	75	74	68	68	
Respiratory Rate						9	20	24	14	16	11	20	26	15	16	17	18	
SaO2						95%	97%	96%	95%	97%	95%	94%	96%	96	96	97	97	

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR								125/125		125/250	125/375	125/500	125/625	125/875	125/925	125/1050	125/1175	
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL								1000/1000		100/100	100/200	100/300	100/400		150/550		350/1900	1900
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

VITALS	22	23	24	01	02	03	04	05	
	4/78								
	76								
	26								
	46								

	22	23	24	01	02	03	04	05	8° T
1175	135 1300								
1900									

ACUITY LEVEL CLASSIFICATION

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

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

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

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: ASA IE

Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 27 Sep 03 Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block ISO.

Time In: 0200

Allergies: NKA OR Intake: Crystalloid 600 ml Colloid

Pre-op V/S: 123/93 HR 81 OR Output: UOP 700 EBL 0

Procedures: I&D BLE + (1) OEA Meds/Times: 1gm Ancef @ 0030, 2mg Versed, 250mg Lev. 200mg Propofol, 100mg Suc.

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

Pre Op Meds History

Time	0200	0205	0210	0215	0230	0245	0300
SaO2	60	80	98		97	95	94
FiO2							
Methods							
240							
220							
200							
180							
160							
140							
120							
100							
80							
60							
40							
20							
RR	25	22	20	24	15	14	15
T	98						

Time							
Pain (0-10)							
LOS							

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

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0200	LR	begin OR	RAC	SL	200

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	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	2		
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	6	9	9

Codes

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

V/S
X = A-line BP
˚ = Cuff BP
= Pulse

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

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

PREPARED BY (b)(6)-2 ICT HN

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 27 Sep 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

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

USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

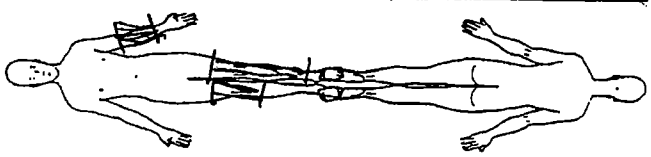
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Elbow, BLE	gauze & bandage	0
30'	"	"	0
60'	"	"	0
D/C	"	"	0



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

0200 - Client received from OR on litter accompanied by OR staff. connected to monitor. IVF LR infusing via (R) AC PIV. Dsg to BLE and (L) elbow D+I. Client very sleepy but open eyes to to tactile stimulus. — [redacted]

0210 client on NRB mask @10 L/min O2

0220 changed oxygen to 4L via NC O2 sat 97%. — [redacted] 1LT Am

0235 [redacted] Oxygen decreased to 2L NC O2 sat 96%, client remains sleepy able to move BLE minimally and moves upper extremities well. (P) commands at this time — [redacted]

0250 Oxygen D'cd @ this time O2 Sat 95% will monitor — [redacted] 1LT Am

0310 O2 Sat 95% on R/A — [redacted]

0315 BP 128/57, HR 74, RR 14, O2 sat 94% on Room air. — [redacted]

0320 Report given to LT [redacted] ICW — [redacted]

0325 Transported via litter & assistance to ICW. — [redacted] 1LT Am

Discharge Criteria:
Date: 27 Sep 03 **Time:** 0315 **PARS:**
BP: 128/57 **T:** 98.3 **HR:** 74 **RR:** 14 **Sa02:** 94%
Pain Level at D/C (0-10): 0/10
Intake: 200 **Output:** 0
Additional Data:
Transferred To: ICW
Report Given To: LT [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted] 1LT Am
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: 29 Sept 03
Time In: 1010
Allergies: NKDA
Pre-op V/S: 137/74 70
Procedures: ICD DPC

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400cc LR Colloid
OR Output: UOP 825 EBL ~~825~~ min
Meds/Times: Ancef 0745 MSO4 2mg Versed 250 mcg 2mg propofol 200mg Zofran 50mg

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1010	1025	1040	1050	1100	1110
SaO2	99	95	96	98	97	
FiO2	100	60	0	21		
Methods	NRB	NRB	NC 2L	RA	RA	
240						
220						
200						
180						
160						
140						
120	V	V	V	V	V	
100						
80	^	^	^	^	^	
60						
40						
20						
RR	17	19	11	19	10	
T	96.9		97	97.4		
Time			1045			
Pain (0-10)			0			
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1010	LR	500	(R) wrist	(b)(6)-2	

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	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)

(b)(6)-2 Signature SGT 91W MC

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 29 Sept 03

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

Name – last,

(b)(6)-4

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

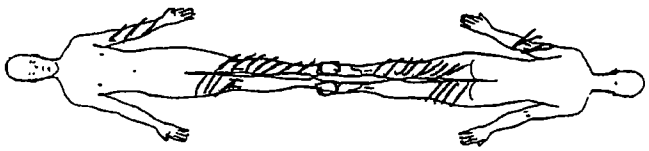
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) above leg splint	Gauze & ace	⊘
30'	" "	" "	⊘
60'	" "	" "	⊘
D/C			⊘



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1010 31 YO ♂ epw transfer via litter to ICU s/p ICD; DC. Pt NRB SaO2 100% arousable ō verbal stimuli. Pt has drsg to (L) arm (L) leg, (R) thigh, gauze & ace wrapping. Foley → gravity draining clear yellow urine. Pt c/o pain 6/10 ⅂ percocet give po. @ 1050 ī gd effect. O2 removed pt remain > 95% SaO2. 1100 pt awake able to take po fluid NAD | (b)(6)-2 SGT P

1100 Report given to SGT (b)(6)-2 pt ready for transfer cell | (b)(6)-2 SGT Quan

Discharge Criteria:
Date: 09 Sept **Time:** 1110 **PARS:** 12
BP: 122/69 **T:** 97.4 **HR:** 85 **RR:** 11 **Sa02:** 99%
Pain Level at D/C (0-10):
Intake: Ø **Output:**
Additional Data:
Transferred To: ICU
Report Given To: SGT (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: (b)(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL ...

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: 7 Oct 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: 1200

Allergies: NKDA OR Intake: Crystalloid 400 Colloid Ø

Pre-op V/S: BP=18 (m:62) OR Output: UOP Ø EBL Ø

Procedures: Meds/Times:

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1200	1200	1215	1230	1245	1300
SaO2	100	100	100	97	99	100
FiO2	NC	NC	NC	RA	RA	RA
Methods						
240						
220						
200						
180						
160						
140						
120			✓			
100	✓	✓		✓	✓	✓
80						
60			O			
40	✓	✓	✓	A	V	✓
20				O	D	
RR	14	20	13	13	10	17
T	96					97
Time	1200					
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
1200	NSS	1000		200	1200

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

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

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

PREPARED BY *(Signature & Title)* (b)(6)-2

DEPARTMENT/SERVICE/CLINIC ICU

DATE 7 Oct 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: first, middle; grade; date; hospital or medical facility)* *Name — last,* (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

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

USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1210	8/10	Morphine 4mg	IV	8	(b)(6)-2	(b)(6)-2

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) Thigh	Full	+	+	Brisk	Cool	PK
15'	(R) Thigh	Full	+	+	Brisk	Cool	PK
30'							
45'							
60'							
90'							
D/C							

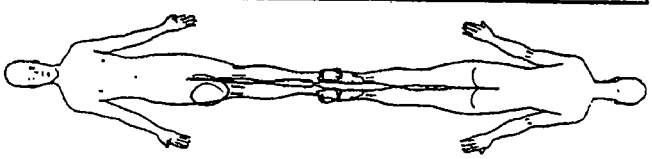
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) Thigh	Ace Wrap	(–)
30'	(R) Thigh	Ace	(–)
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
		Ø	

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1210	SR	(–)	Yes

WAMC OP 173-E

NURSING NOTES

1210 Patient received from Recovery Room
Placed on 1L O2, NRB c O2 Sat 100%, drugs
DPA on call fields. A+O x 3, Sleep Commodo
MAE x 4. Abdomen distention. BS x 4 Quadrants
Places 20 to (R) lower leg. [redacted]
1215 c/o 8/10 pain. Medicated c Morphine
IVP 4mg. IV bag changed c NSS infusing @
KVO rate. Denies discomfort after medication
given. Well monitored. (b)(6)-2 RN
1310 Denies Discomfort. 94% on RA
IV infusing @ KVO. Report given to
ICU [redacted] to ICU Nurse (b)(6)-2

Discharge Criteria:
Date: 7 Oct 13 **Time:** 1300 **PARS:** ~~8~~ 12
BP: 114/57 **T:** 97.8 **HR:** 61 **RR:** 13 **Sa02:**
Pain Level at D/C (0-10):
Intake: 1210 **Output:** Ø
Additional Data: Ø
Transferred To: ICU
Report Given To: ICU (b)(6)-2
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: (b)(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 10 Oct 03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block ASA-1

Time In: 1045

Allergies: OR Intake: Crystalloid 600 ml Colloid

Pre-op V/S: 137/76 68 18 OR Output: UOP 0 EBL minimal

Procedures: B Thyroidectomy Meds/Times: Versed 3mg

Closure Fentanyl 150 mcg

Pre Op Meds History Tarodol 30-mg

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

Time	1045	1055	1105	1100	1115	1130
SaO2	99	97	97	96	96	98
FiO2	(b)(6)-2					
Methods						
240						
220						
200						
180						
160						
140						
120						
	110	110	115			
100				107	110	
80						
60						61
	50	51	46	55	56	
40		29				
20						
	46	49	57	44	55	
RR	15	11	12	14	19	
T	96	96	96	96	98	
Time						
Pain (0-10)						
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	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.	11	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)

PREPARED (b)(6)-2 LPN/LVN DEPARTMENT/SERVICE/CLINIC ICU DATE 10 Oct 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 76 WRAMC OP 175-L (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete

USAPPC V2.00

MEDICATIONS

Allergies:

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

NEUROVASCULAR

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

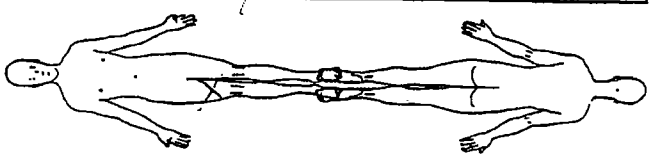
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

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



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1045: Pt admitted to PACU - ICU for recovery. Pt supine, on stretcher accompanied by OR staff x2. Pt drowsy on admission, responds to verbal stimuli, Oriented x 3, O2 per RA SaO2 @ 99% RR - 14BPM. Ø distress noted. NS infusing to (L) wrist 18g Ø evidence infection, infiltration - RR TKO. LS clear throughout, Ø cough, dyspnea, SOB. (R) NSR BP 110/50's HR 41-50's. Ø dependent edema, 1+ pulses bilat pedal, 2+ bilat radial, cap refill < 3 sec toes R/L feet (+) BS x4Q, (-) ABD distention, (-) Abd tenderness, Ø Foley - Ø UOP while on ward. (+) drg to (R) thigh. (+) JP drain, Ø op. (-) drainage to drg (+) CDI. Pt moves all toes, legs (+) sensation throughout. No [illegible]

(b)(6)-2

Discharge Criteria:
Date: 10 Oct 13 **Time:** **PARS:** 12
BP: **T:** **HR:** **RR:** **Sa02:** 99%
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data:
Transferred To: ICU
Report Given To: JT (b)(6)-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: (b)(6)-2
Cleared IAW Recover[illegible]
Charge Nurse Signature (b)(6)-2

Admission Coding Information

For use of this form, [illegible]-400; the proponent agency is OTSG

1. Reporting MTF (b)(3)-1	2. MTF Loc[illegible] IZ			
3. Register Number (b)(6)-4	Name (Last, First, MI) (b)(6)-4		4. Pay Grade CIV	5. Sex M
6. DoB (YYYYMMDD) 1971-07-01	7. Age at Admission 32Y	8. Race Z	9. Ethnicity Z	Religion MUSLIM
10. Length of Service	ETS	11. FMP 99	12. Social Security Number (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status M	Hour of Admission 08:01	Branch / Corps:
14. Flying Status	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES		16. Zip Code of Residence:	
17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission NO	
20. Source of Admission Direct from ER	Ward: ICU	Name / Relationship of Emergency Addressee		
		Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: (b)(3)-1		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-10-13		
24. Clinic Svc - Admitting AEA - ORTHOPEDICS	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-09-27		
27. Location of Occurrence IZ	28. MTF of Initial Admission	29. Date of Initial Admission 2003-09-27		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: LEFT ELBOW INTRA ARTICULAR FRAGMENTATION WOUND, BILATERAL LOWER EXTREMITY FRAGMENTATION WOUNDS

881.11 894.0

Procedure Narrative(s): LEFT ELBOW IRRIGATION AND DEBRIDEMENT, BILATERAL LOWER EXTREMITY IRRIGATION AND DEBRIDEMENT

86.28 79.66

Cause of Injury Narrative: FIRED ON BY AH-60.

(b)(6)-2

Admitting Officer (Signature, as require

DR (b)(6)-2

Signature of Admitting Clerk

12. REASSESSMENT / RÉASSESSMENT

DATE / DATE (YYMMDD)	TIME / HEURE			
030926				
TIME / HEURE	0630	0700		
BP / PS	146/94	$0 BY PMD		
PULSE / POULS	74	74		
RESP / RESP	94% RA	16		

DATE / TIME
DATE / HEURE

13. CLINICAL COMMENTS / DIAGNOSIS
INFORMATION MÉDICALE / DIAGNOSTIQUES

Fx TIB-FIB (L)
GSW POSTERIOR (R) THIGH
3x SHRAPNEL WOUNDS TO (L) LOWER LEG
? SHRAPNEL POST (L) ELBOW

14. ORDERS / ANTIBIOTICS (Specify) / TETANUS / IV FLUIDS
DIRECTIVES MÉDICALES / ANTIBIOTIQUES (Spécifier) / TÉTANOS / IV FLUIDE

CIRC. COMPROMISE (L) LEG
GOOD NV (R) LEG
TX
- ALL WOUNDS DRESSED
- IV LR 14g (R) AC 1000cc
  BOLUS THEN TKO
- SPLINTED (L) LEG AND (L) ARM
- MORPHINE 5mg IVP @ 0645
- FOLEY ATTEMPTED
- MORPHINE 2mg IVP @ 0715

15. PROVIDER / [redacted] CPT [redacted] b(6)-2 — DATE/DATE (YYMMDD) 030926

16. DISPOSITION / DISPOSITION — TIME / HEURE
- [ ] RETURNED TO DUTY / RETOUR À L'UNITÉ
- [X] EVACUATED / EVACUÉ CSH VIA GND
- [ ] DECEASED / DÉCÉDÉ

17. RELIGIOUS SERVICES / SERVICES RELIGIEUX
- [ ] BAPTISM / BAPTISÉ
- [ ] ANOINTING / ONCTION
- [ ] CONFESSION / CONFESSION
- [ ] PRAYER / PRIÈRE
- [ ] COMMUNION / COMMUNION
- [ ] OTHER / AUTRE

CHAPLAIN / CHAPELAIN

DD Form 1380, DEC 91 (Back)

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM — RANK / GRADE [redacted] E-PU — MALE / HOMME [X] — FEMALE / FEMME [ ]

SSN / NUMÉRO MATRICULE — SPECIALTY CODE / GP[redacted] — RELIGION / RELIGION

2. UNIT / UNITÉ Guillian EPW

FORCE / ÉLÉMENT — NATIONALITY / NATIONALITÉ

A/T	A/FA	N/M	MC/M
[X]			

BC / BC	NBI / BNC	DISEASE / MALADIE	PSYCH / PSYCH
[X]			

3. INJURY / BLESSURE

FRONT / DEVANT — BACK / ARRIÈRE

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

GSW / SHRAPNEL TO (B) LEGS

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE
- [X] ALERT / ALERTE
- [ ] VERBAL RESPONSE / RÉPONSE VERBALE
- [ ] PAIN RESPONSE / RÉPONSE À LA DOULEUR
- [ ] UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS	TIME / HEURE	6. TOURNIQUET / GARROT	TIME / HEURE
76	0615	[X] NO / NON [ ] YES / OUI	

7. MORPHINE / MORPHINE	DOSE / DOSE	TIME / HEURE	8. IV / IV	TIME / HEURE
[ ] NO / NON [X] YES / OUI	5 MG	0645	LR 14g	0630

9. [redacted]ENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
[redacted]ENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES (R) AC

10. DISPOSITION / DISPOSITION — TIME / HEURE
- [ ] RETURNED TO DUTY / RETOUR À L'UNITÉ
- [X] EVACUATED / EVACUÉ CSH VIA GND
- [ ] DECEASED / DÉCÉDÉ

11. [redacted]UNITÉ (b)(3)-1 CPT (b)(6)-2 PA — DATE/DATE (YYMMDD) 030926

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

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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(3)-1		(b)(6)-4	(b)(6)-4	CIV	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 19710701	27 28 29: 32Y	30	31	Muslim

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 99	37 38 39 40 41 42 43 44 45: (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46	0800	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52: 1C7 8 — POW/INT	53 54 55 56 57 58 59 60 61: 0 9 3 2 3 0 0 0 0

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	1C4	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
73 74	75 76 77 78 79 80	81 82 83 84 85 86 87 88: 20030927

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
89 90 91 92: DEA — ortho	93 94 95 96 97 98	99 100 101 102 103 104 105 106: 20030927

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
107 108: I Z	109 110 111 112 113 114	115 116 117 118 119 120 121 122

FOR LOCAL USE

(L) Elbow intra articular fragmentation wound

Bil lower ext fragmentation wounds

~~881.11~~ ~~894.0~~

(A) Elbow irrigation & debridement, Bil lower extremity irrigation + debridement ~~88.28~~ ~~79.66~~

ADMITTING OFFICER (Signature as required)	SIGNATURE OF ADMITTING CLERK
b(6)-4 [redacted] b(6)-2	Dx 8901 88111 E9919 Dx 8345 S082

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

MEDCOM - 7756

(b)(3)-1

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name	3. Grade	Admission Remarks
(b)(6)-4	(b)(6)-4	CIV	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	15	X	MUSLIM			NO

11. FMP	12. SSN	13. Organization	14. Ward
20	(b)(6)-4		ICW

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	20:30	ABA - GENERAL SURGERY

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

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-01	DR (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
(b)(3)-1	2003-10-01	

31. Selected Administrative Data

Marital Status: Z DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: PT WAS SHOT WHILE TRYING TO STEAL AMMUNITION

34. Diagnosis / Operations and Special Procedures:

GSW TO ABDOMEN

879.2

EX LAP, GASTRIC REPAIR, COLOSTOMY REPAIR, LIVER LACERATION REPAIR, ABDOMINAL WOUND I&D, SUBCLAV

54.19 44.19 46.43 50.29

35. Total Days This Facility

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

35. Total Days This Facility

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

Sig (b)(6)-2 MAJ,MC

Signature of PAD or Medical Records Officer

MEDCOM - 7757

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

14yo IRAQI MALE SUSTAINED
GSW 3 OCT 03.

PMH / UNK PSH / UNK MEDS / ALLERGY UNK

HEENT: NC/AT, SUPPLE, PERRL & EOMS
LUNGS: CTA B/L
CV: RR nl $S_1 S_2$ ⊖

PHYSICAL EXAMINATION

ABD: APPARENT (R) FLANK ENTRANCE WOUND
E EPIGASTRIC ASPIT, PROLAPSED STOMACH.
NO PULSATILE BLEEDING
PELVIS: STABLE.
EXTREM: NO PENETRATING TRAUMA, nl
CONTOUR / PULSES B/L UE/LE

XRAY
⊖ FOREIGN BODY, RETROPERITONEAL WIDENING

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

(AP) (1) ABD GSW
(2) TO OR FOR EX LAP

(b)(6)-2

3 OCT 03

	DATE	IDENTIFICATION NO.	ORGANIZATION

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

(b)(6)-4

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.606
OCTOBER 1975
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3 OCT 03 2055	BRIEF OPERATIVE REPORT

PRE-OP DIAGNOSIS: ABDOMINAL GSW

POST-OP DIAGNOSIS: SAME

PROCEDURE: EX LAP, GASTRIC ~~REPA~~ REPAIR, COLOTOMY REPAIR, LIVER LACERATION, RECTUS MUSCLE DEBRIDE

SURGEON: (b)(6)-2

ASSISTANT: (b)(6)-2

ANESTHESIA: GEN

OPERATIVE ANTIBIOTIC: ANCEF 1g (1800) UNASYN 3g

FLUIDS: 5000 cc LR

BLOOD PRODUCT USAGE: Ø

EBL: 100 cc

URINE OUTPUT: 200

TOURNIQUET TIME: Ø

DRAINS: Ø

SPECIMENS: Ø

FINDINGS: GASTRIC WALL DEFECT REPAIRED, COLOTOMY REPAIRED, LIVER LAC. CAUTERIZED

DESCRIPTION OF PROCEDURE:

EXPLORATORY LAPAROTOMY C̄ ABOVE FINDINGS. DEBRIDEMENT DEVITALIZED RECTUS

COMPLICATIONS: NONE

CONDITION: STABLE

(b)(6)-2 MD

MAJ, MC USA
CHIEF, DOS

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

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

REGISTER NO. | WARD NO.

[redacted]

b(6)-4

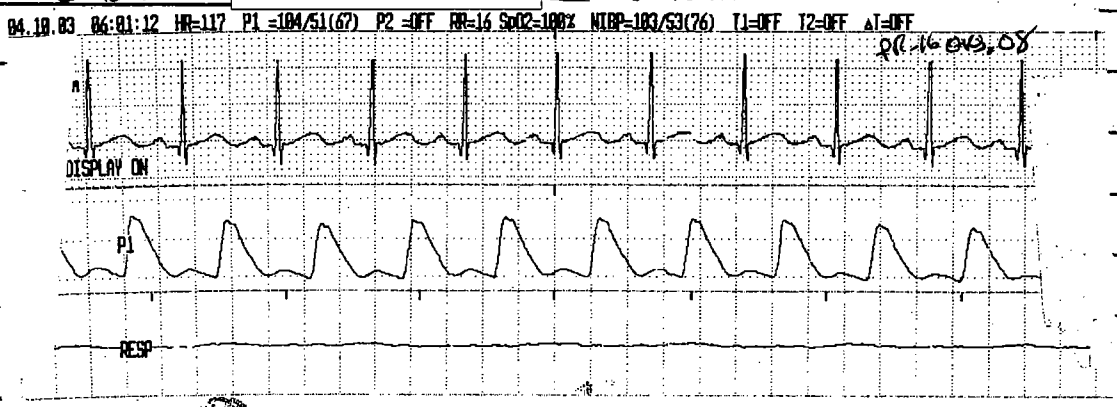
PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30Oct03	Pt From OR, Rpt From CRNA Pt VS WNL's, Pt on O2
2110	via NRBMask @ 10L/min, Pt Lines (R) Rad, PIV (L) AC &
	LR @ TKO, Foley to Gravity, PIV 18gage (L) AC SL, NG
	to LIS, Dobhoff Feed tube to duodenal, Physical assessment
	Completed, Pt Lethargic but arousable to voice, Dressing
	Mid Line Abd Intact & some bloody drainage (b)(6)-2 CPT/AN
2120	Pt noted to have Dressing (R) Flank OSI, (L) Pupil 5cm
	Sluggish, (R) Pupil 2mm Sluggish. Pt Missing parts of (L) thigh
	and 2nd Finger of (L) hand (b)(6)-2 CPT/AN
2220	Pt Labs shown to Dr, Δ on IVF Rate Recieved (b)(6)-2 CPT/AN
2300	4/0 5cc, Dr Notified Orders for 500cc Bolus Received (b)(6)-2
30Oct03 0030	Tube Feed started @ 10cc/hr (b)(6)-2 CPT/AN
0200	Pt Contracted About HR ≥110 + 4/0 35, Orders Received CPT/AN
0441	AM Labs Collected, (b)(6)-2 CPT/AN
0500	24° I+O Iv 7190 4/O 585 EBL100 Balance
	+ 6505 (b)(6)-2 CPT/AN



RELATIONSHIP TO SPONSOR

DEPART./SERVICE

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

REGISTER NO.

WARD NO.

(b)(6)-4

Age 15

PROGRESS NOTES
Medical Record

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

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
4/04/2003 0700	Received report from the previous shift - Patient lying supine. Alert to name, unable to assess ability to follow commands due to language barrier as present. Pupils unequal (L) 5mm dilated, unresponsive (R) 3mm brisk. Abdominal flap, midline dressing noted to bloody drainage throughout, noted seeping under bandage. N/G to low intermittent suction c̄ blood tinged drainage. IV's to (R) + (L) A/C 18 Gauge. (L) A/C c̄ LR @ 150cc/hr. R(A/C) c̄ heparin, flushed, site c̄ drainage. Foley to gravity draining concentrated yellow urine. Monitor shows Sinus tachycardia c̄ rate 100-110's. Plan (1) Medicate for pain as needed p.r.n (2) Monitor urine outputs and bolus for output less than 25 cc, (3) Encourage use of Incentive Spirometer to maintain adequate perfusion. (b)(6)-2
0900	Patient resting comfortably. No complaints of pain at this time. LR infusing c̄ infiltration. Remains in Sinus tachycardia c̄ ectopy. N/G remains to LIS. (b)(6)-2
1000	Patient given complete bath and dressing changed to (L) AC and (R) A/C. IV sites, No other apparent injuries noted, Dr [redacted] on the units. Informed me that pupil status was not a new finding. (b)(6)-2
1300	IV rate decreased to 110cc/hr, urine output adequate > 120cc/hr. Using Incentive Spirometer q 1°. (b)(6)-2
1500	Temp 100.5 Assisted OWB to chair patient tolerated terra activity for 30 minutes, assisted back to bed c̄ difficulty (b)(6)-2
1630	Temp 101.5, reported to Dr. [redacted] Given Tylenol 650 1/a dulcolax tell. (b)(6)-2
1800	Temp 100.5, Pressing charge done by Coleman @ 1600. Encouraged IS Report given to CPT [redacted] (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
05Oct03	1730 Pt OOB ambulate outside
1745	> 100ft w difficulty. Pt → chair denies pain at this time. T 100.8 Ax. D/C'd PIV AC (L) side. Dubhoff infusing feedings @ 10cc/hr, pt tolerates well. NGT → LIS c̄ 200cc/hr of brown/green fluid this shift (R) PIV infusing LR @ 110cc/hr & s/s of redness or infiltration. foley → gravity draining clear yellow urine adequate amount per hour. > 40cc/hr. Pt denied pain this shift. & pain medication need. ↓ active bowel sounds this shift. Will report to incoming shift / [redacted] (b)(6)-2 [redacted] (b)(6)-2
1800	Report from SGT [redacted] (b)(6)-2 client up in chair playing with toys, connected to cardiac/resp monitor, IVS LR @ 110cc/hr infusing via (L) AC PIV. - NGT → LIS via (L) nare → green bile drainage. Dobhoff to feed @ 10cc/hr via (R) nare. Foley patent and draining clear yellow urine. Abd dressing D+I. (R) side clear D+I. [redacted] (b)(6)-2 CPT Hv
1900	Assessment done see DD form 4700, client back to bed c̄ assistance. [redacted] (b)(6)-2 CPT Hv

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5 Oct 03 1900	tube feeds ↑ 40cc/hr @ this time per Dr [redacted] (b)(6)-2
	RR=29 SpO2=98% NIBP=OFF T1=OFF T2=OFF ΔT=OFF 87 Sinus tachycardia
2100	temp 101°, medicated c̄ 650 mg tylenol via dolphoff, tolerated well. (b)(6)-2 CPT Av
2300	temp ↓ 99.4, client asleep in NAD - (b)(6)-2 CPT Av
2400	Client asleep, no change in status, VSS. (b)(6)-2 CPT Av
6 Oct 03 0200	temp 99.2, VSS, no changes in assessment (b)(6)-2 CPT Av
0400	temp ↑ 100.9, medicated c̄ 650 mg tylenol ↓ Dolphoff, tol well. tube feeds continue @ 40cc/hr, LR @ 110 cc/hr. - (b)(6)-2
0600	Medicated per order, VSS. temp ↓ 99.5 axillary, report given to SGT (b)(6)-2 (b)(6)-2 CPT Av

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
06DEC03 1110	BRIEF OPERATIVE REPORT

PRE-OP DIAGNOSIS: OPEN WOUNDS

POST-OP DIAGNOSIS: Same

PROCEDURE: I&D Abdomen Wounds / DPC

SURGEON: (b)(6)-2 ASSISTANT: SPC (b)(6)-2

ANESTHESIA: GETA OPERATIVE ANTIBOITIC: Unasyn

FLUIDS: 1400 cc LR BLOOD PRODUCT USAGE: None

EBL: Min URINE OUTPUT: 450 cc

TOURNIQUET TIME: NA

DRAINS: Foley, NGT, Dobhoff

SPECIMENS: NA

FINDINGS: Wounds clean p HIBICLENS wash —

DESCRIPTION OF PROCEDURE: Undermined wound edges - Trimmed exits wound and wound interwoven wounds irrigated w/ NS. Skin edges approximated w/ Vertical Subdermal sutures 3-0 Vicryl, Length of wound closed w/ Thumb sutures w/ 4-0 Nurylon/Steri Strips; Exit wound closed w/ Penrose H Mattress 4-0 Nylon

COMPLICATIONS: 0

CONDITION: STABLE

(b)(6)-2

(b)(6)-2

RELATIONSHIP TO SPONSOR | LAST | 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)*

(b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	b(a) -2 NOTES
6 Oct 03 Late entry	0600 Assumed care of pt received report from Cpt [redacted] PT in bed appear comfortable. PIV infusing LR @ 110cc/hr, Dobhoff infusing 40cc/hr, NGT → LIS draining green brown liquid. Ø complaints of pain. 0700 Pt OOB ambulate @ hospital 7 100 ft, ↓ difficulty. Initial Assessment complete noted on DA 4700. / [redacted] (b)(6)-2 SGT USA name
Late entry 0800	Pt ambulated to OR 1100, pt return from OR via litter pt transfer to bed monitor on. VS 116/69 80-23 SAO2 88 4L O2 via NC applied ↑ SAO2 99-100%. T 95.9 pt c̄ covers on. T 96.9 TLC ② subclavian all ports flushed c̄ NS c̄ gd blood return. Medial port infusing LR @ 75cc/hr. pt resting comfortably Ø distress at this time will continue to monitor / [redacted] (b)(6)-2 SGT USA name
1500	Pt awake alert VSS, afebrile pt watching TV at present time. In bed c̄ HOB ↑ 30° angle. Ø distress noted will monitor / [redacted] (b)(6)-2 SGT USA name

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
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Q PW [redacted] b(a)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0403 1820	Pt in bed c HOB 30° angle. Dobhoff infusing @ 40cc/hr, NGT → LIS brown green drain TLC subclavian all ports flush ⊼ difficulty Medial port infusing LR @ 75cc/hr. Foley → gravity D/C'd in am per order of Dr (b)(6)-2 & Dr (b)(6)-2. Pt denies pain at present time. Will continue (b)(6)-2 to monitor. Report given to SGT [redacted] (b)(6)-2 SGT [illegible]
2000	Pt. alert, smiling and cooperative – VSS – LR at 75 cc/hr into triple lumen cath – medial port infusing fluid – NGT LIS suction – putting out minimal amt green fluid – Dobhoff tube feed 40cc/hr ⊼ difficulty – Pt. does tolerate sips of H_2O and warm soup – Lungs CTA bilat abd dsg midline c̄D and intact ∅ blood noted (b)(6)-2 [illegible]
2200	Pt OOB ambulating – walking, moving tolerating soup – Foley to gravity draining clear yellow urine – 1 mg MSO4 for pain – sleep (b)(6)-2 [illegible]
0300	Pt sleeping, VSS no complaints – (b)(6)-2
0600	Vital Signs stable – no complaints – (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7 Oct 03 1530	Nutrition Note
	Estimated needs for tube feeding based on current wt and GSW: Current WT: 62# (Today) Age: 13
	~ 2000 kcal (55 kcal/kg x 1.3 SF)
	~ 56-84 gms protein (2-3 gms/kg
	Using Relative, Goal Rate for feeding is 65 cc/h to provide 2000 kcal
	104 gms protein (3.7 gms/kg)
	Pt tolerating 40 cc/h, rate can be increased more if PO intake is not initiated
	(b)(6)-2 (b)(6)-2 MAJ, SP BN/RD
08 OCT 03	Surgery
0848	S: No Nausea, Vomit, Hungry
	O: Afebrile VS wnl
	Abdomen Flat (+) BS Dressing removed - Incision clean + dry
	A: POD 8 s/p LMP
	P: (1) Plan DC Early + NGT in am.
	(2) Bulk + TF tomorrow
	(b)(6)-2 (b)(6)-2 MD MAJ, MC USA CHIEF, DOS

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

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(b)(6)-4

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LAST NAME	NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08OCT03	General Surgery
0845	S: [illegible] pain; No N, V; No Bowel movement yet
	O: Afebrile, VS [illegible]
	LUNGS: CTA HEART: RRR S1 S2
	ABDOMEN: Flat, +BS No TTP.
	A: POD 5 exp lap - Drainage well
	P: ① DC NGT, Foley
	② Clear fluids po
	③ ↑ TF ~ 65 cc/h

(b)(6)-2 MB
MAJ, MC USA
CHIEF, DGS

(b)(6)-2

(b)(6)-2
ACTING LANE
SURGEON

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2200	2200 - Pt - 5 c/o pain - tolerating PO
7 OCT 03	afebrile - Tube feeds 40 cc/hr via
	dobhoff - No BM This shift
	Triple lumen central line - one port
	non-patent medial port - will not flush
0100	Foley to Gravity pulling out. QS clear
	yellow urine - NGT LIS 650 cc total
	light green discharge for 7 OCT 03
	Pt - 5 complaints (b)(6)-2
0300	Pt - Sleeping - no complaints VS 02
	99%, RA (b)(6)-2
0600	Pt sitting up in bed - no complaints
	afebrile Temp 96.7 (+) - VS Stable
	(b)(6)-2
0630	Pt lying in bed, report received from SGT [redacted] assessment
	performed (see DA4700), pt 5 % pain or discomfort
	(b)(6)-2 SGT/LPN
0830	Pt ambulated to back to wash up - emptied 200cc urine
	from Foley - pt sat up in chair for a few minutes. now
	resting comfortably in bed (b)(6)-2 SGT/LPN
1030	Pt up ambulating around ward - drank a juice - Foley &
	NG tube dc'd - so far Ø % nausea (b)(6)-2 SGT/LPN
1230	Pt drank sprite & ate jello 5 % nausea - lying comfortably
	in bed (b)(6)-2 SGT/LPN
1430	IVF ↓'d to 50cc/° - pt voided x4 since Foley was dc'd.
	Pt also had large, soft, formed BM x ÷
	(b)(6)-2 SGT/LPN

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
70CT03 0700	Pt ambulated to back to bathe-linens Ad, assessment performed (see DA4700), pt ambulated outside c̄ assistance. Will monitor. (b)(6)-2 SGT/U
0900	Pt sitting up in chair 5 c/o pain or discomfort. Connected to monitor & suction & TF & IVF infusing. (b)(6)-2 SGT/U
1100	Pt resting comfortably in bed 5 c/o pain. (b)(6)-2 SGT/U
1300	Dressing removed from abd wound (Ø drainage) - pt cried telling interpretor that he missed his family and wants to go home. Now sitting up in bed watching TV 5 complaints (b)(6)-2 SGT/U
1500	Pt crying again about wanting to see father. Staff @ bedside to comfort pt, pt OOB ambulating around hospital (b)(6)-2 SGT/U
1700	Pt sitting up in bed 5 c/o pain or discomfort - Dr [redacted] explained @ rounds that NG tube & Foley will be taken out tomorrow. (b)(6)-2 SGT/U
2000	Pt OOB ambulatory c̄ minimal assist - abd incision c̄ steri-strips well approx Ø S/Sx of infx

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REGISTER NO. | WARD NO.

(b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES

DATE	b(6)-2 NOTES
8 OCT 03 1800	Report from SGT [redacted] client in bed playing I Toys, assessment done see on form 4200 denies pain at this time (b)(6)-2 CPT A
2000	client in bed resting quietly at this time (b)(6)-2 CPT A
2200	no changes in assessment, VSS. medicated per order position for comfort (b)(6)-2 CPT AN
2400	client asleep in NAD. (b)(6)-2 CPT AN
9 OCT 03 0200	No changes in assessment, VSS (b)(6)-2 CPT AN
0400	medicated per order (b)(6)-2 CPT A
0600	Assumed care of pt, report given by
b(6)-2	CPT [redacted] AN pt in bed sleeping TLC infusing lr @ 50cc/hr. Dubhoff infusion @ 65cc/hr HOB ^ 30° angle. NAD at this time will continue to monitor/ (b)(6)-2 SGT USA QUINN
0730	pt OOB ambulated to commode, pt had med loose dark stool. AM care done at since. Initial assessment complete noted on DA 4700. NAD noted at this time will monitor/ (b)(6)-2

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
09027 03	GEN Surg
0520	SL NC N, V, ⊕ BM x 2
	Diet - Clear tolerated
	O2 Afebrile, VS notes
	Abd - Flat ⊕ BS - soft
	NT + TP. Incis clean + dry
	A & PCD + 6 - Drg well.
	P.O. D2 Delivery
	② Advance & Regular Diet
	(b)(6)-2 (b)(6)-2 MD MAJ, MC USA CHIEF, DOS
90ct03	DC'd Abbott pt tolerated well pt awake
0930	c period of crying to go home. Will continue to
	monitor (b)(6)-2 SGT USA 91WM6
1200	Pt ate a gd lunch 1/2 sandwich, 240 of carnation
	instant breakfast. pt tolerated well ∅ nausea
	∅ vomiting (b)(6)-2 SGT USA 91WM6
Late Entry	1400 Meds administer as ordered. Pt OOB
	ambulate @ ward sitting in chair watching
	movies. ∅ complaints of nausea, or pain
	1800 Report given to CPT (b)(6)-2 AN,
	Pt Stable (b)(6)-2 SGT 91WM6

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
~~8 Oct 03~~	b(6)-2
9 Oct 03 1800	Report from SGT [redacted], client in bed awake, coloring in book. LR infusing via D&C TLC @ 50cc/hr. — [redacted] CPT
1900	Assessment done see ~~DA~~ form 4700 for assessment. b(6)-2 ate 40% dinner ~~5~~ N/V. — (b)(6)-2
1930	client OOB watching movie c̄ staff, laughing, in good spirits — S
2200	VSS, medicated per order, no changes ~~in~~ ~~pt~~ from previous assessment. — (b)(6)-2
2215	OOB to commode, small loose BM and urinated c̄ assist. Back to bed — (b)(6)-2 CPT
2400	client asleep in NAD. — (b)(6)-2
10 Oct 03 0200	VSS, no changes — (b)(6)-2
0400	medicated per order, client asleep at this time — (b)(6)-2
0500	client asleep. b(6)-2 — (b)(6)-2 CPT
0540	Verbal orders from Dr [redacted] to D/C TLC. — (b)(6)-2 CPT
0600	20 G PIV placed in (R) forearm, LR @ 50cc/hr connected and infusing via site. TLC to (L) SC discontinued, sutures removed, catheter removed c̄ tip intact, pressure held to site until all bleeding stopped, no hematoma noted, client tolerated procedure well. Report given to SGT [redacted] client in bed quiet, VSS. — (b)(6)-2 b(6)-2 CPT AN.

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

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(b)(6)-4

PROGRESS NOTES
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