LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 Oct 03	Assessment performed (see DA4700), pt lying in bed 5 % pain or
0630	discomfort. Will continue to monitor — (b)(6)-2 SGT/LPN
0830	Pt had large formed BM x 1 — (b)(6 SGT/LPN
1000	Pt crying for father - Salaam @ bedside talking to pt. Pt ambulated to back @ 0800 to bathe, now resting in bed. — (b)(6)-2 SGT/LPN

STANDARD FORM 509 (REV. 6/1998) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10 Oct 03	Admission note - 1245 - 15 y/o ♂ received from ICU. Dx: Abd GSW s/p, Gastric Repair, Colon Repair, Liver Cauterization. A&Ox3, Pleural, lungs CTA BILAT, S1-S2 strong and reg (P) BS x4. Steri-stripped incision site from bottom of sternum to symphysis pubis. C.D.I. VSS. Tolerating regular diet. Continues w/ antibiotic therapy. (b)(6)-2 will continue to monitor. SGT, USN
10 Oct 03 2300	Nurses Notes: Assumed care of Pt sitting up in bed. Vitals stable & c/o pain or discomfort. IV antibiotic therapy continues. Pt ambulates s/ complication. Moves all extremities. Urine spontaneously. Order or signs of infection at site of steri strips. will continue to monitor. (b)(6)-2 10/Lan
11 Oct 03	Assessment - 0430. A&Ox3, Pleural, lungs CTA BILAT, S1-S2 strong and reg (P) BS x4. Midline incision steri-stripped C.D.I., c/o 8/10 throbbing pain. Diet & % pain will continue to monitor. (b)(6)-2 SGT, USN
11 Oct 03 17:06	Received care of pt @ HCO. Pt sleeping in bed. Appears comfortable. Breathing easy, unlabored. VS WNL. Per flow

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 OCT 03	Sheet. Will assess when pt. awake. will continue to monitor
1706	(b)(6)-2
1740	Pt awake and alert in bed. PERRLA ⊕ WNL. EOM ⊕ WNL. Skin warm, dry, intact. Buccal mucosa pink/moist. Lungs clear to auscultate (B) throughout. (b)(6)-2 HR regular S1S2 present. Bowel sounds ⊕ x4 quadrants. Abdomen soft. Ø complaints of pain. ML abdominal incision well approximated Steri-strips intact and OTA. Radial pulses (B) ⊕ 2 strength. HL D/C'd from (B) forearm. will continue to monitor
	(b)(6)-2
11 Oct 03 2300	Nurses Notes: Assumed care of pt A+O. Ø c/o pain or complication. Vitals Stable. Able to move all extremities well. Steri strips in place clean dry and intact. Ambulates ī assistance or complication. Ø IV Access Ø IV meds. will continue to monitor
	(b)(6)-2
12 Oct 03 @ 0900	Nursing Notes: pt awake and Alert x3 Perrla in Right Eye Left eye not reactive at all. Mucous membranes moist and intact Lung Sounds CTA with symmetrical rise and fall of the chest. Heart Sounds strong and regular. Bowel Sounds active x4 quad. Ø complaints of Abdominal Pain. Abdominal incision Well approx Steri strips intact. Radial pulses strong/equal with ⊕ strength Will continue to monitor throughout
	(b)(6)-2
12 OCT 03	PT AAO PERRLA 2mm VSS, Lungs CTA 98% on RA, pulses palpable all ext bilat equal/strong, bowel sounds present all 4 quads, voiding via foley, steri strips to abdomen C,D,I, Ø N/V/D, Ø complaints of pain, will continue to monitor
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
12 Oct 03 2315	Nurses Notes: Assumed care of Pt Sleeping but easily aroused. ∅ c/o pain or discomfort. Steri Strips clean dry and intact. VS Stable ∅ IV access. Pt able to move all extremities well. will continue to monitor Status for change (b)(6)-2
13 OCT 03 15:10	Received care of pt @ 14:00. Pt. resting in bed A+O x3. PERRLA⊕ WNL. EOM⊕ WNL. Skin warm, dry, intact. Buccal mucose pink/moist. Lung sounds clear to auscultate (B) throughout. Heart rate regular S1S2 present. Bowel sounds ⊕ x 4 quadrants. Abdomen soft/non-tender. Steri strips to mid-line abdomen intact s/d/s infection. Pt. ambulates to outside latrine ⊖ difficulty. ⊖ complaints of pain (b)(6)-2
Addendum	VS WNL per flowsheet will continue to monitor (b)(6)-2
13 Oct 03 2323	Nurses Notes: Assumed care of Pt A+O ⊖ c/o pain or discomfort. Steri Strips clean dry and intact - Able to move all extremities OK ∅ IV Access. Pt ambulates to Rest Room VOids Spontaneously. will continue to monitor (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. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14 Oct 03 1419	Nurses Notes: Assumed care of Pt AAO x3. Ø c/o pain or discomfort at this time. Vitals Stable. Pt ambulates Ī complication. Steri Strips to abd clean dry and intact Ø odor or signs of infection at site. Ø IV Access Pt voids spontaneously. will continue to monitor status — (b)(6)-2
15 Oct 03 Ø500	Nursing: Observation Pt slept well throughout nite. Ø complaints — (b)(6)-2
15 Oct 03 0845	Nursing Notes: Pt AAO Pearl* ⊥ Ø eye 3mm Ø eye not reactive. mucous membranes moist and intact. Lung sounds CTA with symmetrical rise and fall of the chest. Heart sounds strong and normal. Bowel sounds active x4 quad. Bodies pulses intact strong/equal Ø weakness no complaints of pain. Will continue to monitor throughout the shift. — (b)(6)-2
15 Oct 03 1410	Nurses Notes: Pt stable. Father here to collect boy. Dr. (b)(6)-2 + COL (b)(6)-2 Ī translator at bedside. Plan and previous care discussed Pt left house ambulatory Ī parent in tow — (b)(6)-2 15/a

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
4 Oct 03 1800	Rpt Received, Pt Care Assumed MBC/ CPT/AN
1847	A-Line out, Pressure held, bleeding stopped. EBL >5cc (b)(6)-2
2047	Pt HR + BP ↑ Given MSO4 2mg IV. for Pain (b)(6)-2 CPT/AN
2100	Dr Notified of A-Line loss, Guidance to keep tube Feeding on VIA Dobhoff receival: (b)(6)-2 CPT/AN
2200	Assumed care of patient, client in bed connected to cardiac/resp. monitor, client awake, ⊕ commands, MAE's, lungs CTA, O2 sat on room air is 96%, even, nonlabored respirations, heart rate sinus tachycardia @ 119 BPM. regular sections. Abdomen ⊂̄ midline drsg DAI, [redacted] hypoactive BS to BLQs, none noted to upper Quads. NGT via ⊕ nare to LIS, ⊃ green bile drainage dophoff via ⊕ nare ⊂̄ feeds @ 10cc/hr. Foley ⊂̄ pale yellow urine in bag. small drsg to ⊕ side ⊂̄ mod. amt bloody show on dressing intact. IVF LR infusing via LAC PIV @ 110cc/hr, drsg + site - intact. Medicated per order. (b)(6)-2 CPT/AN
2400	Client asleep in NAD (b)(6)-2 CPT AN
0200	Medicated ⊂̄ 2mg morphine for pain to abdomen [redacted]
0400	IV Antibiotic + Insulin given (b)(6)-2 CPT/AN
0530	IV Imitax 1 (b)(6)-2 CPT/AN
0535	24H° I+O. IV 3195 TF 240 U/O 2720 Balance +235 (b)(6)-2 CPT/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)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5 Oct 03	Assumed care of pt. Report given by
0600	by CPT [redacted], AN. Pt in bed c̄ HOB ↑ 20° angle NGT → LIS, dobhoff c̄ 10cc/hr infusing. (1) AC IV infusing LR @ 110cc/hr, (B) IV saline lock. Foley → gravity will monitor/ [redacted]
0700	Pt in bed, denies pain at present time, appears to be comfortable. Initial assessment complete noted DX 4700 will continue to monitor/ [redacted] SGT USA Quinn
1000	PT in bed T 101.4 Ax 650mg Tylenol given via dobhoff. Will continue to monitor [redacted]
1230	1100 pt OOB ambulate to sink. Am care perform. Pt ambulated > 100ft s̄ difficulty pt denies pain at present time. Pt ↑ in chair. Ø apparent distress noted will continue to monitor/ [redacted] SGT USA Quinn
1430	Pt ↑ chair, ambulated > 200ft s̄ difficult denies pain at present time & distress noted will continue to monitor/ [redacted] SGT USA Quinn
1630	PT BTB @ 1530 resting c̄ HOB 20° angle denies pain at present time. Will continue to monitor/ [redacted] SGT Quinn

STANDARD FORM 600 (REV. 6-97) BACK

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
TOI 30ct03	(See 568)
	15 y/o EPW multiple gunshot wounds
Meds	2 mil Fentanyl (IV 55)
	O.2. non-rebreather (15 L) SpO2 99%
Allergies none	
Pmhx not Applicable	
Pshx not Applicable	
Last meal	
Age 15	
Weight	
POSOX 96%	

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

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

(b)(6)-4

REGISTER NO.	WARD NO.

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

ORIGINAL

558-103

(See instructions on Back of this Sheet)

EMERGENCY CARE AND TREATMENT
(Medical Record)

NSN 7540-00-075-3766

TREATMENT FORM NO. (Stamp) (b)(6)-4

LOG NUMBER

ARRIVAL

DATE			TIME
DAY	MONTH	YR.	
03	10	03	1655

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

CURRENT MEDS. (Include immunization and other data) 0

HISTORY OBTAINED FROM
- [ ] PATIENT
- [X] OTHER (Specify)

ALLERGIES NONE

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)
Gunshot wound to abdomine

SEX male AGE 15

POSSIBLE THIRD PARTY PAYER? [ ] YES [ ] NO

TIME SEEN BY PROVIDER

VITAL SIGNS

TIME	17:00		
BP	139/66		
PULSE	93		
RESP.	40		
TEMP.	96.2 (Ax)		
WT. (Child)	99		

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

ORDERS	INITS.	TIME
X-Ray Abdo & Chest	10	17:10
Type T&C	4	17:15
pt/ptt, CBC	4	17:15
Chem 8	CO	1715

ASSESSMENT/DIAGNOSIS

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)

25 ml of Finnegan at 1655
I.V. #2 started at 1657 5 LR
Unison 30 grams 17:05
10mg MSO4 1715
Ancef 1gm 1710
DSG to (0) protruding Abd / bleeding

PSHX: none

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
To OR

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

TIME OF RELEASE: 1720

(CONTINUE ON SF 507, IF NEEDED)

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

(b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

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

STANDARD FORM 558

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 amb BY anesthesia

2. PATIENT IDENTIFICATION VERIFIED BY (b)(6)-2 AND PROCEDURE CHM

3. DATE 6 Oct 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0757 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc (b)(6)-2 910	RELIEF SCRUB	
ASSIGNED CIRCULATOR	lt (b)(6)-2 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Bump under (R) hip

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

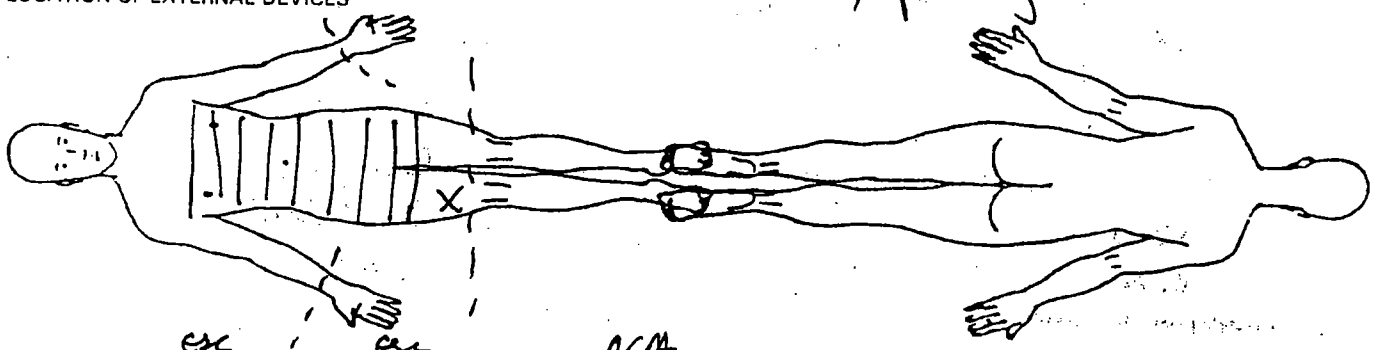
PREP SOLUTION *(Specify)* Hibiclens BY WHOM: (b)(6)-2

SITE: ABD - nipple to groin BY WHOM:

SITE: Down to Bed

COMMENTS: ∅ pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad esc -- Safety Strap esc = = = Tourniquet N/A ///= 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	(b)(6)-2
Needle Sharp	☒ Yes	☐ No	C	C	C		
Instrument	☒ Yes	☐ No	C	C	C		
Other	☒ Yes	☐ No	C	C	C		

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: ~~X~~ 1 cut/coag = 30/30

GROUND PAD: BRAND Valley lab

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 - 7783

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

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 SIGNA

15. X-RAY IN OPER
YES ☒ NO ☐ IF YES, SITE (L) Upper chest

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. Foley	2.	3.
SITE	1. Bladder - placed prior to arrival	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Benzoin
Steri Strips
4 x 8s

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

CPT (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED
I+D ABD wound
(L) Subclavian line placement

21. PATIENT TRANSFERRED TO ICU TIME 1120 METHOD litter

22. REGISTERED NURS (b)(6)-2

REVERSE OF DA FORM 5

MEDCOM - 7784

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

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY

3. DATE 3 OCT 03 TIME PATIENT ARRIVED IN SUITE 1705

4. PATIENT IN ROOM TIME 1705 NUMBER 1 - 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Arabic Speaking Teenager? Emergency

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC Y (b)(6)-2 9ID	RELIEF SCRUB	SSG (b)(6)-2 9ID (1730-1830)
ASSIGNED CIRCULATOR	MAJ (b)(6)-2 AN/66E	RELIEF CIRCULATOR	CPT (b)(6)-2 AN/66E (1830-1930)

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:

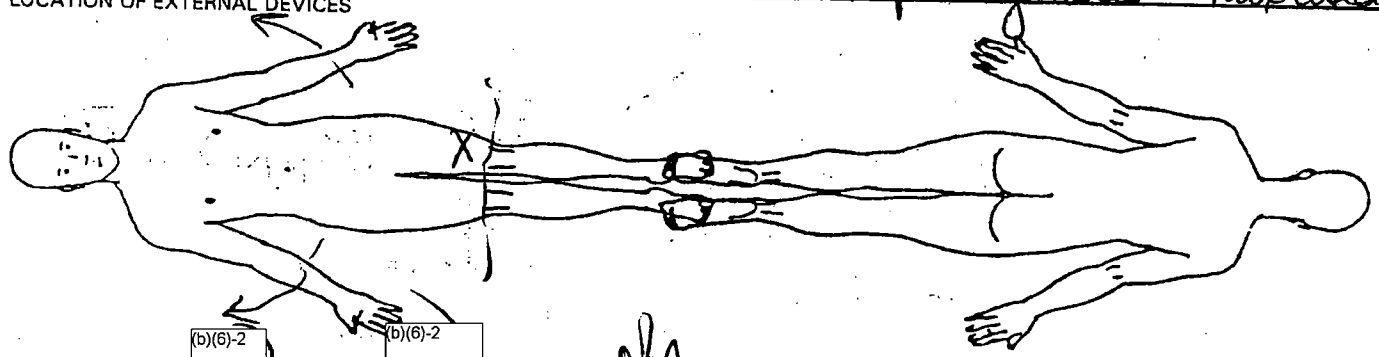
PREP SOLUTION (Specify) Beta / Beta

SITE: Abdomen → BY WHOM (b)(6)-2

SITE: upper thighs including perineal region and Rt BY WHOM:

COMMENTS: no pooling noted. Chux used.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Grou (b)(6)-2 -- Safet (b)(6)-2 NA === Tourniquet

C = Correct I = Incorrect

Initial by (b)(6)-2

10. COUNTS

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

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: Blend 2 Cut 30, Coag 30 → 60

☒ ESU NO: 00442 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

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

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): warm 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. Foley 16FR	2. Easy-Glide Dobhoff Feeding Tube	3. 1/2" Iodoform Gauze
SITE	1. bladder	2. 12FR	3. Posterior flank wound

18. DRESSING/IMMOBILIZATION (Specify) Posterior flank 2X2 Fluffs ABD Pads 4X8 dressing sponges Medipore tape

19. ADDITIONAL INFORMATION

Dr (b)(6)-2

(b)(6)-2

20. OPERATION(S) PERFORMED

Ex Lap, Gastric Repair, Colotomy Repair
Cauterize Liver Laceration

21. PATIENT TRANSFERRED TO ICU TIME 2103 METHOD litter

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

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.01

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

For Use of this form, see AR 40-407: the propone[illegible] is The Office of the Surgeon General.

1. AGE: teenage ?

HEIGHT:

WEIGHT: ?40 kg

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)

☐ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD

REACTION:

3. PREVIOUS SURGERY ☐ NO ☐ YES (Type):

PROPOSED SURGICAL PROCEDURE:

PAIN LEVEL: LOCATION:

0 1 2 3 4 5 6 7 8 9

5. ADDITIONAL INFORMATION: (Previous Surgical and medical History) Skin Condition

Tobacco _____ ppd X _____ yrs. Diabetes Yes No ROM _____
ETOH _____ Implants _____ Glass/Contacts Yes No
Respiratory Disease (Asthma/COPD) Yes No
MEDS: Yes No

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

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

(b)(6)-4

VERIFICATIONS AT HOLDING AREA:

ID/Allergy Band
H&P
NPO Since
~~UHCG/LMP~~ N/A
~~Consent/Blood Transfusion Signed/Witnessed/Dated~~ N/A
Surgical Site/Consent verified by Pt./Anesthesia/Surgeon? Yes No
Contact Precautions
~~Family/Friend.~~ N/A

Dentures Removed
Contacts Removed
Jewelry Removed
Body Pierce Removed

Previous editions are obsolete.

DA FORM 5179, JUN 91

USAPA V1.01

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

10. OR NURSING INTERVENTION COMPLETED / ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

(b)(6)-2 MAJ, AN 3 OCT 03 DATE

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

LEVEL OF CONSCIOUSNESS: A&O Drowsy Sleepy Intubated (Y) (N)

LEVEL OF ACTIVITY: Moves all Extremities (Y) (N) Moves upper Extremities BREATHING EASY:
Transferred to litter with roller due to spinal (Y) (N)

12. (b)(6)-2 ED BY
MAJ, AN
DATE: 3 OCT 03 TIME: 1710

13. POSTOPERATIVE EVALUATION PREPARED
(b)(6)-2 MAJ, AN
DATE: 3 OCT 03 TIME: 2103

REVERSE OF FORM 5179, JUN 91

USAPAV1.0

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY: 1 | 2 | 3

POST- DAY

MONTH-YEAR: 10 Oct | 11 | 12 | 13 | 14 | 15

19 — DAY / HOUR

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

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

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

RESPIRATION RECORD

BLOOD PRESSURE: 107/55 | 108/55 | 111/57 | 103/69 | 109/55 | 104/80 | 104/49 | 80/60 | 107/40 | 101/50 | 95/60 | 104/52 | 105/47 | 104/48

HEIGHT: | WEIGHT ~~Spot~~: 98 | 99 | aa | 99 | 99 | aa | 99 | 99 | 99 | 98 | aa | 99 | 98 | 100

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)*

(b)(6)-4

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

Ward/Section: OR

(b)(6)-2

(b)(6)-4

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

Date: 30Oct03 Time: 1800 Patient #

Test	Result	Ref. Range
GLU		73 - 118 mg/dL
BUN		7 - 22 mg/dL
Creat		0.6 - 1.2 mg/dL
Na		128 - 125 mmol/L
K		3.3 - 4.7 mmol/L
Cl		98 - 108 mmol/L
CO2		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
TK		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 Z iCa++

ph	7.515	7.31 - 7.45
PCO2	304	35 - 45: Art
PO2	425	80 - 105
HCO3	25	22 - 26
TCO2	26	23 - 27
BE	2	(-2) - 3
sO2	100	95 - 100%

Hematology(CBC)

Test	Result	Ref. Range
WBC	12.4	4.8 - 10.8 x 1E3
RBC	4.14	4.7 - 6.1 x 1E6
Hgb	11.5	14 - 18 g/dL (M); 12-16 (I
Hct	35.0	45 - 52% (M); 37 - 47% (I
MCV	84.5	80 - 99 fL
Plt	194	130 - 500 1E3
Lymph%	14.4	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

iCa- 1.14

@ 37°C

Additional Instructions:

Reported By: Date:

MEDCOM - 7790

Ward/Section: ICU

Requesting (b)(6)-2

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

Name: (b)(6)-4

Date: 4 Oct 03

Time: 0500

Patient # (b)(6)-4

Chemistry 7

Test	Result	Ref. Range
GLU	121	73 - 118 mg/dL
BUN	15	7 - 22 mg/dL
Creat	0.7	0.6 - 1.2 mg/dL
Na	137	128 - 125 mmol/L
K	4.4	3.3 - 4.7 mmol/L
Cl	103	98 - 108 mmol/L
tCO2	26	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	9.1	4.8 - 10.8 x 1E3
RBC	3.50	4.7 - 6.1 x 1E6
Hgb	9.9	14 - 18 g/dL (M); 12-16 (F)
Hct	29.0	45 - 52% (M); 37 - 47% (F)
MCV	82.9	80 - 99 fL
Plt	191	130 - 500 1E3
Lymph%	11.8	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 #

0

Ward/Section: ICU

Requesting (b)(6)-2

Name (b)(6)-4

Date: 3 OCT

Time: 2125

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

Patient # (b)(6)-4

Chemistry 7

Test	Result	Ref. Range
GLU	136	73 - 118 mg/dL
BUN	14	7 - 22 mg/dL
Creat	0.6	0.6 - 1.2 mg/dL
Na	135	128 - 125 mmol/L
K	4.3	3.3 - 4.7 mmol/L
Cl	108	98 - 108 mmol/L
tCO2	21	18 - 33 mmol/L

Chemistry 12/LFT

ALB	2.5 *	3.5 - 5.5 g/dL
ALP	217 *	26 - 84 µg/dL
ALT	92 *	10 - 47 µg/dL
AMY	37	14 - 97 µg/dL
AST	131 *	11 - 38 µg/dL
Tbili	0.5	0.2 - 1.6 mg/dL
TP	4.3 *	6.4 - 8.1 g/dL
Ca	8.2	8.0 - 10.3 mg/dL
Chol	47 *	100 - 200 mg/dL
Creat	0.8	0.6 - 1.2 mg/dL
BUN	14	7 - 22 mg/dL
GLU	138 *	73 - 118 mg/dL

Other Chem

Troponin		Negative
GLU Only		73 - 118 mg/dL
CK	830 *	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	15.6 *	4.8 - 10.8 x 1E3
RBC	4.01 *	4.7 - 6.1 x 1E6
Hgb	11.4 *	14 - 18 g/dL (M); 12-16 (F)
Hct	34.1 *	45 - 52% (M); 37 - 47% (F)
MCV	85.0	80 - 99 fL
Plt	278	130 - 500 1E3
Lymph%	20.6	20.5 - 51.1 %

Hematology Manual Diff

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

Coagulation

PT	17.0	9.8 - 13.6 sec
aPTT	41.4	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 03 oct 03

Lab ID #

MEDCOM - 7792

Ward/Section: EMT

Requesting Physician: (b)(6)-2

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

(b)(6)-4

Date: 30 Oct 03

Time: 1655 ~~1830~~

Patient: (b)(6)-4

Chemistry 7

Test	Result	Ref. Range
GLU	136	73 - 118 mg/dL
BUN	19	7 - 22 mg/dL
Creat	0.9	0.6 - 1.2 mg/dL
Na	138	128 - 125 mmol/L
K	3.3	3.3 - 4.7 mmol/L
Cl	107	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%

Hematology (CBC)

Test	Result	Ref. Range
WBC	19.7	4.8 - 10.8 x 1E3
RBC	5.03	4.7 - 6.1 x 1E6
Hgb	14.2	14 - 18 g/dL (M); 12-16 (F)
Hct	42.0	45 - 52% (M); 37 - 47% (F)
MCV	83.4	80 - 99 fL
Plt	306	130 - 500 1E3
Lymph%	20.8	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 03 OCT

Lab ID #

MEDICAL RECORD — ANESTHESIA

DRUG	Units	
Versed	(mg)	2
Fentanyl	(mcg)	50, 50 50 50, 25, 25
Propofol	(mg)	120
Sux / Roc	(mg)	80 / 20, 30
MSO4	(mg)	4, 2, 4
	( )	
VOLAT Agent	% del	.8 1.0 1.0 1.0 1.0 1.0 1.5 .8 .8 .4 1.0
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	2 2 2 2 2 2 2 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	
250	1000
	TOTAL URINE 400

FLUIDS – SUMMARY
CRYSTALLOID–
COLLOID– 1400
BLOOD–

FLUIDS

LINE site	
LR 18g (R) PIV	☐ Warmed
	☐ Warmed
	☐ Warmed
	☐ Warmed

LOSSES: EST BLOOD LOSS; URINE –

REMARKS – Code drugs with numbers, events with letters
0805 (R) subclavian triple lumen placed 22 x 2 ellipse, ultrasound guided injection.

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 45 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP – 116, 58; HR – 91

EQUIP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? yes; TIME – 0800

TIME → 0800 30 0900 30 1000 30 11

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml	500	470	520	510	640	510	480	140	250	240	230	200
f – breaths/min	4	11	11	9	9	7	20	10	11	11	12	13
Peak inf pres / PEEP	28	30	29	30	30	29						
MODE – S(pon), A(assist), C(on)	S/A/C	C	C	C	C	C	SV	SV	SV	SV	SV	SV
ET CO2 (torr)	34	33	32	34	38	38	54	61	58	58	53	50
FIO2 (Frac or %)	.91	.91	.91	.91	.91	.91	.90	.90	.90	.90	.90	.90
SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
TEMP- site	Axillary											
N-M Block (T/4)	4/4	1/4	0/4	0/4	1/4	4/4	2/4	4/4	4/4	4/4		

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

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

RECOVERY AT 1115; PACU (ICU) (Specify); OTHER; CONDITION:; RESP – 10; SpO2 – 96%; BP –; HR – 100

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0745	0757	1120
	Ready	Begin	End
PROC	0815	0846	1100

PROCEDURES and CPT Codes: MGD wound closure / Debridement

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GATA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Pre-ox 5 min, 80 of FiO2, RSI c cricoid, intubated x1 easy, DL x1, MLC3, Grade 1 view, 6.5 ETT placed 22cm @ lip, ⊕ BS ⊕ ETCO2

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

SURG (b)(6)-2; ANES (b)(6)-2

PROCEDURE LOCATION: OR 1; DATE: 6 OCT 03; PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 7794

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

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Fent	(mcg)	50 50,50 50 50
STP	(mg)	200
Sux // Roc	(mg)	80 // 30, 20 20 15 15
	( )	
	( )	
	( )	
VOLAT AGENT	% del	X-1.5 -1.5 -1.5 -1.5 -1.5 -1.5 -1.5 -1.5 -1.5 -1.5
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	X-8 -2 -2 -2 -2 -2 -2 -2 -2 -2 -2

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

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: 1800 Completed 3 Gm Unasyn ! 1 Gm Ancef From EMT

FLUIDS — LINE site: LR; Warmed; Warmed; Warmed; Warmed — 2000 3000 5000

LOSSES — EST BLOOD LOSS: 100; URINE: 100 50/150

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 45 KG / LB

HEMATOCRIT: 19.7/42 4 30C

INITIAL DATA: BP – 132/56 R-24; HR – 108

EQUIP CHECK: OK? – Y N

PATIENT BROWSER: OK for PROCEDURE? Y; TIME – 1840

TIME → 1800 15 30 45 1900 15 30 45 1900 15 30 45

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

220 200 180 160 140 120 100 80 60 40 20

pH – 7.5; PCO2 – 30.4; PO2 – 425; HCO3 – 23; BE – +2; 1115/1/4

I:E = 1:2	VT – ml	800	800	750	750	650	600	610	590	650	650	650	
P Hut	f – breaths/min	8	8	8	8	8	8	8	8	8	8	8	
Peak inf pres / PEEP		24/3	24/3	24/3	24/3	23/3	23/3	23/3	24/3	24/3	24/3	23/3	
MODE – S(pon), A(ssist), C(on)		S/C	C	C	C	C	C	C	C	C	C	C	
BP/Auto Cuff	ET CO2 (torr)	(+)	26	25	24	23	25	26	25	26	27	27	26
BP / oth	FIO2 (Frac or %)	.73	.73	.72	.72	.72	.72	.71	.71	.71	.71	.72	.71
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site (SK)		102.4	102.4	100.4	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6
	N-M Block (T/4)	4/4	4/4	4/4	4/4	4/4	4/4		4/4			4/4	
Warming blkt													
Conv warmer													

Mark with letters & symbols, explain under REMARKS. EVENTS

Position → and Arms (90°) secured on padded armboards.

TOTALS — TOTAL BIN; TOTAL URINE

FLUIDS – SUMMARY: CRYSTALLOID–; COLLOID–; BLOOD–

REMARKS – Code drugs with numbers, events with letters

1855 pt ID'd & pl of Care reviewed
1900 In Rm Monitors On
1906-1908 RSI c̄ Cricoid pres.
1912 (R) Rad A-line started
2000 Cont Drip
Page #2

RECOVERY AT: PACU ICU (Specify); OTHER; CONDITION: SEE PAGE #2; RESP–; SpO2–; BP–; HR–

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1845	1900	
PROC	Ready	Begin	End
	1910	1925	

PROCEDURES and CPT Codes: Exp. Lap

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Visualized Cords; Intubated c̄ 6.5 ETT to 20cm @ LIP 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: (b)(6)-2; (b)(6)-2; MAJ N, CRNA; MAJ N, CRNA; Nurse Anesthetist

PROCEDURE LOCATION: 1-1

DATE: 30 Oct 03

PAGE 1 OF 2

WAMC FORM 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 7795

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

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Ketorolac (mg)		30
Reostigm (mg)		3
Glycop (mg)		0.8
	( )	
	( )	
	( )	
VOLAT AGENT	Sevo % del / % e.t.	1.0 ~ 1.0 ~ 1.0 %
AIR	L/Min	
N2O	L/Min	
O2	L/Min	~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

FLUIDS		
LINE site	~R	☐ Warmed
		☐ Warmed
		☐ Warmed
		☐ Warmed

LOSSES: EST BLOOD LOSS; URINE –

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: 45 KG / LB

HEMATOCRIT: 14.7 / 44 / 30%

INITIAL DATA: BP – 132/56; R 24; HR – 108

SIGNIF CHECK: OK? – (Y) N

PATIENT READIES: OK for PROCEDURE? Y; TIME – 1800

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

TIME → 1700 / 15 / 30 / 45 / 2100

	1700	15	30	45	2100
VT – ml	650	650	650		
f – breaths/min	8	8	8	26	
Peak inf pres / PEEP	23/4	23/4	25/4		
MODE – S(pon), A(ssist), C(on)	C	C	C	S	
ET CO2 (torr)	26	24	34	49	
FIO2 (Frac or %)	.71	.72	.71	.72	
SpO2 (%)	100	100	100	100	
ECG	SR	SR	SR	SR	
TEMP- site (skin)	98.6	98.6	98.6		
N-M Block (T/4)	1/4		4/4 EST		

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

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

TOTALS — TOTAL FLUID — TOTAL URINE

FLUID SUMMARY: CRYSTALLOID – ; COLLOID – ; BLOOD –

REMARKS – Code drugs with numbers, event with letters: 2000 Cont From Page #1

RECOVERY AT 2105; PACU (ICU) (Specify); OTHER; CONDITION: stable; RESP – 18; SpO2 – 95; BP – 146/70; HR – 96

ANESTHESIA SUMMARY

	Start	Room	End
ANES	1645	1700	2112
	Ready	Begin	End
PROC	1710	1725	2055

PROCEDURES and CPT Codes: EXP. LAP

AKESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: SEE Page #1

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: 30 Oct 03

PAGE 2 OF 2

ANESTHESIA PLAN OF CARE PRE[illegible]EDURAL ASSESSMENT (Sedation/[illegible]thesia)

Age 15 DAYS MOS YRS Sex ☒ MALE ( ) FEMALE

PROPOSED PROCEDURE: Ex Lap
SURGICAL SERVICE: Gen Surg
NPO SINCE: (b)(6)-2

ASA Physical State 1 2 3 4 5 E
WT: N/S KG/LB HT: — IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: Ø
ETOH:
DRUGS:

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

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

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION
BP 131/62 HR 90 R 14 T —
Pain Scale 0-10
HEENT - Teeth intact
Trachea Midline
TMJ/Neck Flow
Oropharynx MPP
Nares Patent
CHEST: CTA
CARDIAC: S/S
EXTREMITIES: Bilat A
IV Access: Ø
Ulnar Filling:
BACK:
OTHER:

NPO Since

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

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

The p[illegible] (b)(6)-2 [illegible]d and agrees. Questions answered.
Signe[illegible] Date: 30 OCT 03 Time: 1630 Hrs

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

Signed: _____ Date: _____ Time: _____ 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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 3 OCT 03 TIME OF ORDER: 1957 HOURS

LIST TIME ORDER NOTED AND SIGN

1. ADMIT TO ICW ((b)(6)-2)
2. CONDITION: STABLE
3. DX: ABDOMINAL GSW S/P GASTRIC REPAIR, COLOTOMY REPAIR, LIVER CAUTERIZATION
4. ACTIVITY: BEDREST
5. NKDA

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

6. CALL MD FOR T>101.5, BP>160, HR>110, UOP<25cc/HR
6. DIET NPO
7. NG @ LIS
8. FOLEY TO GRAVITY
9. ENTERAL FEED 1 Dic/HR PER Dr DOBHOFF

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

10. KUB IN AM
11. UNASYN 3g IV q6H
TORADOL 30 mg IV q6H
MSO4 2-4 mg IV q15' ≤ 20 mg q2°
ZANTAC 50 mg IV ~~FLD~~ q8H
12. O2 VIA NC TITRATE TO >95%
13. MONITOR I/O

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

14. MONITOR A-LINE
15. CBC 2 IN AM
CHEM 8 3

(b)(6)-2

Noted 30ct03

@ 0234 (b)(6)-2 MD, USC

(b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUNE [illegible] WHICH MAY BE USED.

MEDCOM - 7798

1400 LR
450

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
4 Oct 03	1700 HOURS	
Tylenol 650mg via OG/Buff Q4-6° p.r.n. for T > 101.5		
U.O. [(b)(6)-2] [(b)(6)-2]		1700 [(b)(6)-2]
[(b)(6)-2]		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
05 Oct 03	1810 HOURS	noted
(1) TF rate 40 cc/hr		[(b)(6)-2]
(2) My line same clear fluids po		

NURSING UNIT | ROOM NO. | BED NO.

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

MAJ, MC USA
CHIEF, DOS

PATIENT IDENTIFICATION

[(b)(6)-4]

DATE OF ORDER	TIME OF	
06 Oct 03	1110 HOURS	
(1) Resume Premin order		[redacted]
(2) IV fluids LR TKO 75 cc/hr		[redacted]

[(b)(6)-2]

NURSING UNIT | ROOM NO. | BED NO.

[(b)(6)-2]

PATIENT IDENTIFICATION

[(b)(6)-4]

DATE OF ORDER	TIME	
08 Oct 03	0840 HOURS	
(1) DC Foley, NGT		
(2) INCREASE OTF to 65 cc/hr		
(3) Clear liquid diet		
(4) DUL COLAX Supp. 10mg PR NOW		MD

Transcribed [(b)(6)-2] 08 Oct 03

NURSING UNIT | ROOM NO. | BED NO.

[(b)(6)-2]

MAJ, MC USA
DOS

8 Oct 03

DA FORM 1 APR 79 4256 REPLACES EDITION OF ... MAY BE USED.

MEDCOM - 7799

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

Transcribed 9 Oct 03 (b)(6)-2

DATE OF ORDER: 08 OCT 03 TIME OF ORDER: 1400 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Dr (b)(6)-2

(1) Decreased Fluids from 75 cc/hr to 50 cc/hr.

Taken by Gonzalez (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24 8 Oct 03 (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

Noted 9 Oct 03 (b)(6)-2

DATE OF ORDER: 09 Oct 03 TIME OF ORDER: 0920 HOURS

(1) DC DOBHOF Tube

(2) Regular diet - small portion - Well chewed + Supplement w/ Carnation/Ensure - last meal

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

MAJ, MC USA

DOS

NURSING UNIT | ROOM NO. | BED NO.

24 10 Oct 03 (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 10 Oct 03 TIME OF ORDER: 0540 HOURS

(1) May DC TLC

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

[redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER: 10 Oct 03 TIME OF ORDER: 1117 HOURS

Noted (b)(6)-2

Transfer to ICW

Resume previous orders

1115 V.O. Dr (b)(6)-2 (b)(6)-2 (b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 7800

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: 30Oct03 | TIME OF ORDER: 2151 HOURS | LIST TIME ORDER NOTED AND SIGN

IVF LR @ 110 cc/hr

Vo! Dr (b)(6)-2 CPT/AN

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

Noted 30Oct03 @ 2235 (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 30Oct03 | TIME OF ORDER: 2303 HOURS

500cc Bolus LR

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

1 mV @ 150cc/hr

Noted [redacted]

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

LVN

PATIENT IDENTIFICATION

24° Chest ✓ 4Oct03 0215 HOURS

4Oct03 0221

Give Bolus 500cc Na

VO! Dr (b)(6)-2 CPT/AN

(b)(6)-2

4Oct03 @ 0222

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 4Oct03 | TIME OF ORDER: 1300 HOURS

IVF: LR @ 110cc/hr

V.O. Dr (b)(6)-2 (b)(6)-2 MYN (b)(6)-2 1300 MYN

(b)(6)-4

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° 5Oct03 (b)(6)-2 PT AN 0235

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

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
14 OCT 03	1725 HOURS	
① DC IV needs + IV		
② Tylenol #3 - gm 1-2 po q4° prn/pain		
③ Zantac 150mg 1 po BID		

(b)(6)-2

MAJ, MC USA
CHIEF, DOS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	
24° chest / 11 OCT 03 @ 2300	

(b)(6)-2

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 MEDCOM - 7802 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. Oct Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	3	4	5	6	7	8	9	10	11	12	13	14	15	16
30Oct03	(b)(6)-2	Activity Bedrest	06		(b)(6)-2												
			18		(b)(6)-2												
30Oct03		Call MD For T>101.5	06														
		100>SBP>160, 60>HR>110	18														
		UOP<25cc/hr															
30Oct03		Diet NPO	06		(b)(6)-2												
30Oct03		Foley to Gravity	06		(b)(6)-2												
			18														
[redacted]		[redacted] Feed 10cc/hr	06														
5Oct03		[redacted]															
30Oct03		Monitor I+O	06														
			18														
30Oct03		[redacted] I+O	06														
			18														
05Oct03		Activity: OOB as tolerated	06			(b)(6)-2							(b)(6)-2				
			18														
[redacted]																	
9Oct03		Diet Reg Small portion	06									(b)(6)-					
		c carbination/ensure	11								(b)(6)-2						
		each meal	18										(b)(6)-2				

ALLERGIES ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: Abd GSW, S/P Gastric Repair, Colon Repair, Liver Cauterization

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

(b)(6)-4

Age 15

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Oct Yr 03

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
30oct03	(b)(6)-2	Admit to ICU Lowery	30oct03	1957	2100	(b)(6)-2
30oct03		Condition	30oct03	1957	2100	
30oct03		Dx Abdominal GSW, S/P Gastric Repair	30oct03	1957	2100	
		Colotomy Repair, liver cauterization	—	—	—	—
30oct03	(b)(6)-2	KUB in RR	30oct	1957	2214	(b)(6)-2
30oct03		CBC, Chem 8 in AM	30oct	0560	0540	
[illegible]		Resume Previous Orders	[illegible]	[illegible]	[illegible]	
08oct		D/C NGT	08oct03	0900	0900	
08oct	(b)(6)-2	Dulcolax Suppository supp 10mg PR	08oct03	HELD	HELD	
9oct		DC Dulcolax	9oct	0930	0930	(b)(6)-2
10oct		Mag DC TLC	10oct03	—	0600	
10oct	(b)(6)-2	Transfer to ICW	10oct	1117	1130	
10oct		Resume Previous Orders	10oct	1117	1130	
11oct		D/C IV meds and IV	11oct	1740	1740	(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. Oct Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED (3 4 5 6 7 8 9 10 11 12 13 14 15)
30Oct	(b)(6)-2	~~IVF LRC @ 90 cc/hr~~	06	(b)(6)-2 4 Oct 03
		~~IVF 5%~~	18	
30Oct	(b)(6)-2	Unasyn 3gm IV	04	(b)(6)-2 D/C'd 11 Oct 03
		q 6H	10	
			16	
			22	(b)(6)-2 (b)(6)-2
30Oct	(b)(6)-2	Toradol 30mg IV q6H	04	(b)(6)-2 Recurring Below
			10	
			16	
			22	
30Oct	(b)(6)-2	Zantac 50mg IV q8H	06	(b)(6)-2 D/C'd 11 Oct 03
			14	
			22	(b)(6)-2
30Oct	(b)(6)-2	O2 via NC Titrate to	06	(b)(6)-2
		Keep SPO2 > 95%	18	(b)(6)-2
4 Oct 03	(b)(6)-2	IVF: LRC @ 100cc/hr	06	(b)(6)-2 Order D/C
			18	
30Oct	(b)(6)-2	Toradol 30mg IV q6H	04	(b)(6)-2
			10	
			16	
			22	(b)(6)-2 D/C'd 11 Oct 03
6 Oct 03	(b)(6)-2	IVF: LRTRA 25cc/hr	06	(b)(6)-2 D/C'd 08 Oct 03
			18	[redacted]
08 Oct 03		IVF: LRC 50cc/hr	06	(b)(6)-2
			18	D/C'd
11 Oct 03		Zantac 150mg PO	08	(b)(6)-2
		BID	20	(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: Abd Gsw s/p Gastric Repair, Colon Repair Liver Cauterization

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

Age [redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. Oct Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
3 Oct	(b)(6)-2	Bolus 500 cc LR	3 Oct	2300	2310	(b)(6)-2	
4 Oct		Boluses 500 cc LR	3 Oct	0230	0225		
		~~Tylenol~~ PO					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION	TIME/DATE DISPENSED												
3 Oct 03	(b)(6)-2	MSO4 2-4mg IV	D	3 Oct 03	4 Oct 03	4 Oct	4 Oct	4 Oct	4 Oct	5 Oct 03	6 Oct					
		q15° ≤ 20mg q20°	A	2mg	2mg	2mg	2mg	2mg	2mg	2mg	1mg					
			T	2317	0035	0112	0230	1300	2047	0200	0300					
			I	(b)(6)-2												
4 Oct 03	(b)(6)-2	Tylenol 650mg PO	D	4 Oct	5 Oct	5 Oct	6 Oct 03									
		Q4 hours 0-4-6° pm	T	1630	1030	2100	0400									
		for Temp > 101.5	I	(b)(6)-2												
			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		INITIALS	21,3C	INITIALS
NEURO	PUPILS					(R) 2mm Sluggish (L) 5mm Sluggish	
	SENSORIUM					Lethargic, Responses to Voice, Follows Commands	
RESPIRATORY	RESPIRATORY PATTERN					Reg, Even, Unlabored, 24/M, 100% Spec	
	BREATH SOUNDS					CTA - bilat	
	SECRETIONS					⊖ Secretions	
SKIN	COLOR					NFR	
	INTEGRITY						
IV SITE	LOCATION					(R) AC + (R) AC Patent	
	CONDITION					A-Line (R) Rad	
GASTRO	ABDOMEN					Soft, Tender	
	BOWEL SOUNDS					BS - Hyperactive	
						Midline - Abd Dressing D/I, Bloody Drainage	
GU	URINE:					Foley to Gravity	
	COLOR/CLARITY					Yellow Clear	
CARDIOVASCULAR	CARDIAC RHYTHM					SR	
						+2 Pulses UE/LE	
						Capreffill > 3 sec	

LEGEND

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: Oct 3, 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 30 Oct 03 | DX | PAGE | 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																	IV 60
	Temperature																	96
	Pulse																	65
	Respiratory Rate																	8
	SpO2																	100
	O2																	Mask
																		10L/min

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

OUTPUT		HOUR / TOTAL	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
	URINE	sp gr																
		S/A																
	NG	OUTPUT																
		pH																
		GUIAC																
	EMESIS																	
	STOOL																	
	DRAINS																	
	TOTALS																	

(b)(6)-2

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

	22	23	24	01	02	03	04	05	
	140/54	140/61	140/61	127/80	124/67	120/54	115/78	109/49	
	97.3				100.5			97.8	
	71	86	87	107	117	123	115	117	
	9	12	16	16	16	15	18	17	
	100	100	100	100	100	100	100	100	
	24/NP	24/NP	24/NP	24/NP	24/NC	24/NP	24/NP	24/NP	

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

LABORATORY	TIME	2145								
	GLUCOSE	136								
	Na/K	139/3.3								
	Cl/CO_2	108/21								
	BUN/Cr	14/.6								
	WBC/PLATELET	13.0/80								
	Hct/Hgb	11.4/39								

	22	23	24	01	02	03	04	05	8° T
	40	90/190	110/290	150/440	150/590	150/740	150/890	150	1140
			500		600				1000
	OR	5000	LR						5000
	Tube Feed			10	10	10	10	10	50
									7190
	40/40	5/45	40/85	65/150	35/185	100/285	80/365	30/395	395
	4/0	OR	200						200
	EBL	100							100

ACTIVITIES 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	7140	Urine:	985
FF	50		100
	7190		
TOTAL		TOTAL	1085

BALANCE 6105

NURSE'S SIGNATURE (b)(6)-2 INITL (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	0800	INITIALS (b)(6)-2		INITIALS	1800	INITIALS (b)(6)-2
NEURO	PUPILS	(R) Pupils 3mm [illegible]				(R) 3mm PERRLA	
	SENSORIUM	(L) pupils 4mm unreactive				(L) 5mm Sluggish	
		Alert to name, month				A+Ox3 MAEW	
		denies pain at this time					
RESPIRATORY	RESPIRATORY PATTERN	Even and unlabored				Even, Unlabored	
	BREATH SOUNDS	Lungs CTA in upper				CTA à decreased bases	
	SECRETIONS	fields, diminished in				⊖ Cough	
		bases. O2 [illegible] on				⊖ Sputum	
		T Sat 100%. ↓ cough					
		or productive secretions					
SKIN	COLOR	Normal for race.				NFR	
	INTEGRITY						
IV SITE	LOCATION	18G to RAC site				18G (R) AC ⊖ Site Inf	
	CONDITION	S redness or drainage,				18G (L) AC ⊖ Site Inf	
		18G to (L) AC site S				LR @ 100cc/hr	
		redness or drainage. IVF					
		LR @ 100cc/hr					
GASTRO	ABDOMEN	NG to LIS, Dobhoff c	Sound, Dsg intact			NG to LIS, Dobhoff c	
	BOWEL SOUNDS	Improved @ 10cc/hr.	Bowel sounds, improved			Improved @ 10cc/hr	
		Abdominal dressing intact	to lower quadrants			Mid Line Abd Dress CDI	
		c dry blood, (L) ostomy				(R) Flank Dress - CDI	
GU	URINE	Foley to gravity,				Foley to gravity	
	COLOR/CLARITY	Concentrated urine, 40cc/hr				Clear Yellow	
CARDIOVASCULAR	CARDIAC RHYTHM	Sinus tachycardia,				ST	
		PR, Ir, one-08, S1, S2,				+2 Pulses UE/LE Bilat	
		Anxiety, Pleased off				⊖ Edema	
		to all exertions. No				Cap Refill < 3 sec	
		evidence of 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 [illegible] MAN

DEPARTMENT/SERVICE/CLINIC ICU

DATE 4 Oct 2003

PATIENT'S IDEN[illegible] 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 4Oct03 DX PAGE

HOSPITAL DAY

VITAL SIGNS	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
BP Arterial Line	99/46	107/48	107/47	108/47	140/56	138/54	128/58	107/47	117/48	134/47	119/49	119/57	122/55			
BP Cuff	104/49		102/48		128/58	118/54	124/54	118/51	112/52	128/55	122/51			128/62	115/50	108/48
Temperature		99.7	99.8			98.8			100.6	101.5		101.5	100.9	99.5		
Pulse	114	114	112	104	110	107	115		122	117	121	121	115	114	117	119
Respiratory Rate	16	15	14	10	20	20	19		20	17	19	14	13	14	20	23
SpO_2	100	100%	100%	100%	100%	98%	99%		98%	99%	99%	99%	99%	99	96	96
O_2 @	2L/NC	2L NC	2L NC	2L NC	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA

INTAKE	TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21
IVF		125	150	150	150	150	150	150	110		110	110	110	110	110	110	110	110
		120	275	425	575	725	875	1025	1135		1245	1355	1465	1575	1685	1795	1905	2015
Tube feed		10	10	10	10	10	10	10	10		10	10	10	10	10	10	10	10
		10	20	30	40	50	60	70	80		90	100	110	120	130	140	150	160
IVPB																		
TOTALS																		

OUTPUT		HOUR / TOTAL	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
URINE			25/25	40/65	40/105	40/145	60/205	120/325	120/445	100/545	100/645	60/705	90/795	90/885	120/1005		375/1380	
		sp gr																
		S/A																
NG		OUTPUT																
		pH											200					
		GUIAC																
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

22	23	24	01	02	03	04	05
109/47	107/40	109/42	110/32	115/38	117/39	115/36	120/41
99²		99³				99¹	
119	112	116	115	111	123	123	131
14	21	22	19	19	19	18	20
96	96	97%	98%	96	97	96	95
RA	RA	RA	RA	RA	RA	RA	RA

22	23	24	01	02	03	04	05	8° T
110	110	110	110	110	110	110	110	
2325	2435	2545	2655	2765	2875	2985		3195
10	10	10	10	10	10	10	10	
170/50	180	190	200	210	220	230	240	8-10

500/1880	200/1080	175/2265	475/3210

ACUITY LEVEL CLASSIFICATION

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

LABORATORY	TIME	0440								
	GLUCOSE	121								
	Na/K	137/4.1								
	Cl/CO_2	103/26								
	BUN/Cr	15/0.7								
	WBC/PLATELET	9.1/191								
	Hct/Hgb	27.0/9.9								

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

24 HR TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME 0630	INITIALS (b)(6)-2		INITIALS	1900	INITIALS (b)(6)-2
NEURO	PUPILS	(R) pupil 3mm Reactive				(R) pupil 3-4mm brisk	
	SENSORIUM	(L) pupil 5mm				(L) pupil fixed + dilated 6-7mm	
		alert, oriented & able				A+O x3 MAES.	
		to move extremities x4				(+) commands	
		denies pain at this time				denies pain	
RESPIRATORY	RESPIRATORY PATTERN	RR Reg RR 25 S902 96% on RA				easy, non-labored	
	BREATH SOUNDS	LS: CTA IS at bedside				clear bilat.	
	SECRETIONS	Ø cough, o secretion				Ø	
		noted				on room air O2 sat	
						99%	
SKIN	COLOR	normal for race				WNL.	
	INTEGRITY	Abd drsg CDI				midline Abd drsg (+)	
						(R) side drsg O+I	
IV SITE	LOCATION	(L) IV patent infusing				(L) AC PIV	
	CONDITION	LR @ 110cc/hr				drsg + site intact	
		(R) IV Saline locked				LR @ 110 cc/hr	
						infusing	
GASTRO	ABDOMEN	flat, soft non distended				flat, non distended	
	BOWEL SOUNDS	BS ↓ active				(+) hypoactive BS.	
		Duodoff infusing				NGT → JVS → green bile drainage	
		@ 10cc/hr				pyloroff → feeds ↑ 40cc/hr	
GU	URINE:	Foley → gravity				foley → gravity → bag	
	COLOR/CLARITY	drain clear yellow				clear yellow urine	
		urine					
CARDIOVASCULAR	CARDIAC RHYTHM	HR Tachy @ 122 bpm				Sinus tachycardia	
		skin warm dry				ectopy S1 S2 auscultated	
		S1 S2 normal Ø extra sounds				palpable pulses x4	
		(+) peripheral pulses x4				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 (S... (b)(6)-2 SGT 91WM6

DEPARTMENT/SERVICE/CLINIC ICU

DATE 5OCT03

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

DATE 5 Oct 03 DX PAGE

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	122/96	124/110	122/111	119/95	115/59	130/110	117/52	127/83		113/103	109/57	112/67	119/77	101/53	103/66	107/64	113/75
	Temperature	99.5	98.9		101	101	~	99.5	99.2		99.2			99.4	100.8	99.9		101.0
	Pulse	126	119	120	124	128	120	120	113		113	109	121	123	117	115	111	123
	Respiratory Rate	22	13	22	21	22	25	21	22		26	22	24	26	13	24	27	24
		96	97	97%	98%	98%	96%	98	98%		100%	96%	96%	98%	97%	97%	100%	96%
		RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA/D	RA/D

INTAKE	TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21
	IVF	110	110	110	110	110	110	110	110	880	110	110	110	110	110	110	110	110
	TF	110	220	330	440	550	660	770	880		990		1210		1430	1540	1650	1760
	IVPB	10	10	10	10	10	10	10	10	80	90	10	10	10	10	10	10	10
	Diphoff mab/flush		20	30	40	50	60	70	80	80	90	100	110	120	130	140	150	160
						100				100	50		100			90	40	40
						100					150		250			170	210	280
																		60
																		60
	TOTALS																	

OUTPUT		HOUR / TOTAL	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
	URINE		50/50	200/250	125/375	75/450	75/525		225/750		80/830		100/930		220/1150		150/1300	
		sp gr																
		S/A																
	NG	OUTPUT	200															
		pH																
		GUIAC																
	EMESIS																	
	STOOL																	
	DRAINS																	
	TOTALS																	

POST-OP DAY

	22	23	24	01	02	03	04	05	
	106/48	109/62	104/58	106/56	111/70	114/70	116/74	113/56	
		99.4			99.2		100.9		
	119	119	104	103	107	116	125	119	
	20	20	19	18	19	23	23	20	
	96%	95	97	97	96%	95%	96	96	
	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

	22	23	24	01	02	03	04	05	8° T
	110	110	110	110	110	110	110	110	
	1870	1980	1090	1200	1310	1420	1530	1640	1640
	40	40	40	40	40	40	40	40	
	290	330	370	410	450	490	530	570	570
	150						100		
	400						500		500
							100		
							120		120
									2830
		450			440		495	50	
		1755			2195		2670	2720	2720

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME								
	MODE								
	F_IO_2								
	TV								
	RATE								
	PEEP								
	A: pH								
	A: PCO_2								
	A: pO_2								
	B: HCO_3								
	B: 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 HR I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE	OUTPUT
IV		Urine:
po		
TOTAL	2830	TOTAL 2720
BALANCE	+110	

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

INITL (b)(6)-2

MEDCOM - 7815

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 [redacted]	(b)(6)-2	INITIALS		INITIALS
NEURO	PUPILS	(R) 3mm Reactive					
	SENSORIUM	(L) 6mm non-Reactive					
RESPIRATORY	RESPIRATORY PATTERN						
	BREATH SOUNDS						
	SECRETIONS						
SKIN	COLOR						
	INTEGRITY						
IV SITE	LOCATION						
	CONDITION						
GASTRO	ABDOMEN						
	BOWEL SOUNDS						
GU	URINE:						
	COLOR/CLARITY						
CARDIOVASCULAR	CARDIAC RHYTHM						

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; SA - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

(b)(6)-2

CPT Aw

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 6 Oct 03

(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: OR | HOSPITAL DAY

VITAL SIGNS	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
BP Arterial Line																	
BP Cuff	109/61	OR				114/69	115/69			104/57	107/59	97/56	100/60	111/59			
Temperature	99.5					95.6	96.3			97.7	97.7		97.8				
Pulse	104					80	85			90	96	89	94	96			
Respiratory Rate	20					23	12			11	12	14	16	18			
O2 Sat	96%					100%	100%			100	100	100%	100%	100%			
														2L			

Operative Report

INTAKE	06	07	08	09	10	11	12	13	8 T	14	15	16	17	18	19	20	21
LR	110 / 110					75 / 185	75 / 260	75 / 335	335	75 / 410	75 / 475	75 / 550	75	75	75	75 / 850	75 / 925
1 VAB	50 / 50																
Tube feed	40 / 40						40	40	80	40 / 120	40 / 160	40 / 200	40 / 240	40 / 280	40 / 320	40 / 360	40 / 400
Dophoff Aush/meds																	
OR 1400					400 / 1400				1400								
TOTALS																	

OUTPUT		06	07	08	09	10	11	12	13	8 T	14	15	16	17	18	19	20	21
URINE	HOUR	125				400				525	325							600
	TOTAL	125				525					850							1450
	10 gr																	
	S/A																	
NG	OUTPUT					300							100					
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS	RBL					Mod												
TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	22	23	24	01	02	03	04	05
T	98.7							98.6
BP	122/47	117/60	115/59	130/62		114/61	115/61	
P	80	75	81	87	75	82	79	82

INTAKE	22	23	24	01	02	03	04	05	8° T
I	1400		1300		1450		1600	1675	1675
	150						100		350
N	40 / 440	40 / 480	40 / 520	40 / 560	40 / 600	40 / 640	40 / 680	40 / 720	720

OUTPUT	22	23	24	01	02	03	04	05	
O								600	

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 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	1675	Urine:	
PO	400		
IVPB	350		
TOTAL	2050	TOTAL	2080

BALANCE (-) 30

NURSE'S 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

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	INITIALS		INITIALS		INITIALS
		0615	(b)(6)-2				
NEURO	PUPILS	3mm & PERRLA				2mm PERRLA	
	SENSORIUM	alert, awake, follows commands, moves all extremities				alert, smiling, talking moves all ext	
RESPIRATORY	RESPIRATORY PATTERN	even & unlabored				RRR - P: 02 100% OR	
	BREATH SOUNDS	CTA b. laterally				Lungs CTA bilat	
	SECRETIONS	Ø noted				Ø cough	
						(+) IS	
SKIN	COLOR	normal for race				normal	
	INTEGRITY	dsg to midline abd & (R) waist - CDI				Ø skin breakdown	
IV SITE	LOCATION	LSC TLC					
	CONDITION	all lines flushed & patent, LR infusing @ 75cc/h to medial port				(L) subclavian TLC 2 ports patent medial & Ø patent -	
GASTRO	ABDOMEN	soft, nontender					
	BOWEL SOUNDS	(+) x 4 quads, Ø BM, TPS to Dobhoff @ 40cc/h, NG to IS & minimal output				(+) BS - soft - nontender - BM this shift - NG to IS dobhoff blocks PO, tube to gravity	
GU	URINE:	Foley to gravity					
	COLOR/CLARITY	clear, yellow				clear yellow urine	
CARDIOVASCULAR	CARDIAC RHYTHM	NSR, all pulses palpable, Ø edema noted				QS - somewhat pale NSR - all pulses palpable	

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)

PRE (b)(6)-2

SGT/LPN

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 70CT03

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	122/47	107/65	133/45	127/44	151/82	139/86	128/68	135/71			124/80	124/44	133/70	137/79				
Temperature	97°				99.4													
Pulse	95	90	86	84	88	107	103	99			88	102	93	92				
Respiratory Rate	99%	100%	98%	99%	100%	100	100	98			99	100	97	99				

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR	75	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	
IVPB	50				100					50		100						
TF	40	40	40	40	40	40	40	40		40	40	40	40	40	40	40	40	
												1795						
TOTALS																		

OUTPUT

Foley URINE	HOUR	100	100	100	200	250	250	200	150		200	150	100	200	200			
	TOTAL																	
	SP gr													2200				
	S/A																	
NG	OUTPUT													350				
	pH																	
	GUIAC													2550				
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

	22	23	24	01	02	03	04	05
	138/70				138/70			
	98				98			
	92				91			
	16				14			

	22	23	24	01	02	03	04	05	8° T
	125	77	95	98	8	8	10	8	
	40	40	40	40	40	40	40	40	
		700					1,050		3950

— BM

ACUITY LEVEL CLASSIFICATION

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

LABORATORY DATA	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 2250	Urine: 3950		
po 400			
TF 960			
TOTAL 3610	TOTAL 3950		
BALANCE	−340		

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

(b)(6)-2

	TIME	0600	INITIALS		INITIALS		INITIALS
NEURO	PUPILS	Pupils 3mm bilat					
	SENSORIUM	A+O x3, MAE x4.					
		Drawes W/D on					
		Right Hemiparesis at this					
		time					
RESPIRATORY	RESPIRATORY PATTERN	Even + unlabored					
	BREATH SOUNDS	Decreased breath					
	SECRETIONS	sounds on the right,					
		CTA on the left.					
SKIN	COLOR	Ashen on all					
	INTEGRITY	extremities, Multiple					
		bruises throughout					
IV SITE	LOCATION	D FW					
	CONDITION						
GASTRO	ABDOMEN	BS x4 audible.					
	BOWEL SOUNDS	Abdomen tender to					
		palpation on the right					
		N - distended					
GU	URINE:	Foley to gravity, clear					
	COLOR/CLARITY	yellow urine					
CARDIOVASCULAR	CARDIAC RHYTHM	SR w/ occasional PVC, to					
		one-off, P, + S3					
		auscultated. JVD					
		edema 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 (0600 in 6

DEPARTMENT/SERVICE/CLINIC ICU

DATE 7 Oct 03

PATIENT'S I... (When entries give: Name—last, first, middle; g... date, hospital or medical facility)

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 7 Oct 03 DX ARF H-Pylori 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	143/84				116/77									143/91			
Temperature	98				98.3					99.5				99.5			
Pulse	75				70									74			
Respiratory Rate	25				30					34				30			
SpO2	91%				98%					98%				96%			
	RA				RA					RA				RA			

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
po			240 / 240				500 / 740					500 / 1140						
TOTALS																		

OUTPUT

			06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21
URINE	HOUR / TOTAL		650 / 650						1100 / 1750			600 / 2350		300 / 2650					
	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

22	23	24	01	02	03	04	05	8° T

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 DONE	TIME				TURN	TIME				
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE				SUCTION					
	TRACH CARE									
	ROM EXERCISES									

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0615	INITIALS (b)(6)-2		INITIALS	1800	INITIALS (b)(6)-2
NEURO	PUPILS		3mm & PERLA				~~PERLA~~ (R) round reactive (L)	
	SENSORIUM		awake, alert, follows commands, moves all extremities				A+OX3 (R) commands, MAE's. verbalizes well & interprehens.	
RESPIRATORY	RESPIRATORY PATTERN		even & unlabored				easy, nonlabored	
	BREATH SOUNDS		CTA bilaterally				CTA bilat.	
	SECRETIONS		Ø noted				Ø, O2 sat 99% on R/A uses incentive spirom up to max 1200 cc/s without difficulty	
SKIN	COLOR		normal for race				WNL	
	INTEGRITY		midline abd incision & steristrips, dsg to (R) abd GSW CDI				(R) side drsg intact + dry midline abd incision & skin clos.	
IV SITE	LOCATION		(R) SC TLC				(R) SC TLC & dsg + site intact. Proximal & LR (R) S	
	CONDITION		Medial port not patent, Distal infusing LR @ 75cc/°				infusing. distal port clamp (R) blood returns, flushes easily medial port unable to flush, clamped @ 0600 return soft clot	
GASTRO	ABDOMEN		soft, nontender				(R) BS x 4 quads	
	BOWEL SOUNDS		(+) x 4 quads, NG to LIS, TFs to Dobhoff @ 40cc/° Ø BM yet				TF @ 65cc/hr via dobhoff thru (R) nare.	
GU	URINE:		Foley to gravity				voids clear yellow urine in urinal	
	COLOR/CLARITY		clear, yellow					
CARDIOVASCULAR	CARDIAC RHYTHM		NSR, all pulses palpable, Ø edema noted				regular to auscultation & Echo. (R) pulses to 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)

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

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 8 Oct 03

PATIENT IDENTIFICATION (If 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	120/68	124/79	130/74				125/66				120/69		116/59			
Temperature	98.3						99.8				98.8		98.4			
Pulse	92	83	89				87				97		76			
Respiratory Rate	16	17	15				18				16		20			
O2 Sat													99%			
Method													R/A			

INTAKE

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
LD	75 / 75	75 / 150	75 / 225	60 / 285	60 / 345	60 / 405	60 / 465	60 / 525	525	50 / 585	60 / 645	60 / 705	60 / 765	60 / 825	60 / 885			885
TF	40 / 40	40 / 80	40 / 120	65 / 185	65 / 250	65 / 315	65 / 380	65 / 445		65 / 510	65 / 575	65 / 640	65 / 705	65 / 770	65 / 835	65 / 900	65 / 965	965
PO														400 / 400				400
LR	75 / 75	75 / 150	75 / 225	75 / 300	75 / 375	75 / 450	75 / 525	75 / 600	600	75 / 675	50 / 725	50 / 775	50 / 825	50 / 875	50 / 925	50 / 975	50 / 1025	1025
IVPB	50 / 50				100 / 150					50 / 200		100 / 300						

TOTALS

OUTPUT

Foley URINE	HOUR	100	100	200		300		300	250		200		200	325		300		
	TOTAL	100	200	400		700		1000	1250		1450		1650	1975		2275		2275
	SG																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL										XT								
DRAINS																		

TOTALS

POST-OP DAY

	22	23	24	01	02	03	04	05	
BP	123/75				118/60				
T	99¹				99°				
HR	90				82				
RR	18				16				
O2Sat	98%				99%				
meds	R/A				R/A				

	22	23	24	01	02	03	04	05	8° T
TF	65 1035	65 700	65 765	65 330	65 895	65 960	65 1025	65 1090	1090
PO									400
LR	50 1075	50 1125	50 1175	50 1225	50 1275	50 1325	50 1375	50 1425	1425
IVPB	150 450						100 550		550
	300 1575	50 3100					500 3700		3465 3700

37.00

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 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-HR TOTALS

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

INITIALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL	3465	TOTAL	3700

BALANCE -235

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 0730	INITIALS (b)(6)-2		INITIALS	1900	INITIALS (b)(6)-2
NEURO	PUPILS	Alert orient				(+) reactive, pink 3m	
	SENSORIUM	able to follow				(+) dilated fixed	
		commands. periods				A+O x 3.	
		of crying for				(+) commands, MAE's	
		family					
RESPIRATORY	RESPIRATORY PATTERN	RR Reg				easy, non labored.	
	BREATH SOUNDS	LS CTA				CTA bilat.	
	SECRETIONS	SaO2 98-99% RA				O2 sat 100% on R/A	
		(-) secretions noted					
SKIN	COLOR	normal for race				WNL	
	INTEGRITY	stress strips intact				(+) side, dry D&I. midline abd.	
		(-) skin breakdown noted				incision c̄ staples intact	
IV SITE	LOCATION	TLC subclavian				(+) SC TLC. Sik removed intact	
	CONDITION	proximal, distal				Proximal port c̄ LR @ 50cc/hr infusing	
		port flushes c̄ difficult				Distal port flushed c̄ good blood	
		medial port (-) flush				return + heparinized. Proximal	
		(-) blood return				port unable to flush	
GASTRO	ABDOMEN	soft, flat, non distended				soft, flat,	
	BOWEL SOUNDS	(+) BS x 4 quads				(+) BS x 4 quads	
		BM loose dark				(-) N/V.	
		brown stool this shift				ate 40% dinner.	
GU	URINE:	Urinates s̄ urinal				voids in urinal.	
	COLOR/CLARITY	clear yellow					
		(-) pain voice					
CARDIOVASCULAR	CARDIAC RHYTHM	HR NSR				NS 2. s̄ ectopy	
		(+) peripheral pulse x 4				S1S2 auscultation	
		skin warm dry				(+) palpable pulses x 4	
		gel cap refill < 3 sec				(-) extremities. (-) hands,	
						thumb, index and middle fingers half	
						missing	

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; SA1 - Saturation; TRACH - Tracheostomy

(Continue on reverse)

(b)(6)-2

CPT An

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 9 Oct 03

(When 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	124/62			128/80										104/42				
Temperature	98.5			99.2										98.5				
Pulse	84			99										80				
Respiratory Rate	16			17										18				
Oxygen	R/A			RA										R/A				
O2 Sat	99%			99%										100%				

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR	50 50	50 100	50 150	50 200	50 250	50 300	50 350	50 400	400	50 450	50 500	50 550	50 600	50 650	50 700	50 750	50 800	
IVPB	50 50				100 150				150	50 200		100 300						
Tube Feeds	65 65	65 130	65 195	65 250					250									250
PO		240 240					240 480								300 780			780
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			200		300		200		100	1100									
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL				Loose MC				8am Loose											
DRAINS																			
TOTALS																			

POST-OP DAY

	22	23	24	01	02	03	04	05
V								
I	98/59				116/60			
T	98.3				97.8			
A	76				80			
L	16				18			
	R/A				R/A			
	98%				100%			

	22	23	24	01	02	03	04	05	8° T
	50	50	50	50	50	50	50	50	
LR	850	900	950	1000	1050	1100	1150	1200	1200
1180	150						100		
	450						450		550
									250
									780
									2780
	500				525				
	1500				2025				2025
									2025

T sinus rhythm

ACUITY LEVEL CLASSIFICATION

VENTILATOR	TIME										
	MODE										
	F_IO_2										
	TV										
	RATE										
	PEEP										
ABG	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 OF DAILY LIVING	TIME										
	MOUTH CARE										
	BATH										
	SKIN CARE										
	FOLEY CARE										
	TRACH CARE										
	ROM EXERCISES										

TURN	TIME										
SUCTION											

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL	2780	TOTAL	2025

BALANCE +755

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0630	INITIALS (b)(6)-2		INITIALS		INITIALS
NEURO	PUPILS		2mm & PERLA					
	SENSORIUM		alert, awake					
			follows commands					
			moves all extremities					
RESPIRATORY	RESPIRATORY PATTERN		even & unlabored					
	BREATH SOUNDS		CTA bilaterally					
	SECRETIONS		Ø noted					
SKIN	COLOR		normal for race					
	INTEGRITY		midline abd sten strip (inc) &					
			(R) waist dsg CDE					
IV SITE	LOCATION		(R) FA PIV infusing					
	CONDITION		LR @ 50cc/° - Ø signs					
			infection or infiltration					
GASTRO	ABDOMEN		soft, non-tender					
	BOWEL SOUNDS		(+) x 4 quads, reg					
			diet					
GU	URINE:		None yet this shift					
	COLOR/CLARITY							
CARDIOVASCULAR	CARDIAC RHYTHM		NSR, all pulses palpable,					
			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)

(b)(6)-2

CPT AN

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 10 Oct 03

(When 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	99/42				110/68													
Temperature	97.5																	
Pulse	70				94													
Respiratory Rate	16				18													
O2 Sat	100%				100%													
Method	RA				RA													

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR	50 / 50				200													
IVPB	50 / 50				100													
PO																		
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL		275			705												
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

Admission and Coding Information

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

1. Reporting MTF (b)(3)-1	2. MTF Location IZ			
3. Register Number (b)(6)-4	Name (Last, First, MI) (b)(6)-4		4. Pay Grade CIV	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission 15	8. Race X	9. Ethnicity 9	Religion MUSLIM
10. Length of Service	ETS	11. FMP 20	12. Social Security Number (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status Z	Hour of Admission 20:30	Branch / Corps: ARMY
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: ICW	Name / Relationship of Emergency Addressee Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted] b(e)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-10-10		
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-10-01		
27. Location of Occurrence IZ	28. MTF of Initial Admission	29. Date of Initial Admission 2003-10-01		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW TO ABDOMEN
879.2

Procedure Narrative(s): EX LAP, GASTRIC REPAIR, COLOSTOMY REPAIR, LIVER LACERATION REPAIR, ABDOMINAL WOUND I&D, SUBCLAV
54.19 44.19 46.43 50.29

Cause of Injury Narrative: PT WAS SHOT WHILE TRYING TO STEAL AMMUNITION

Admitti (b)(6)-2

Signature of Admitting Clerk

MEDCOM - 7833

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.)
(b)(3)-1	

3. REGISTER NUMBER	4. PAY GRADE	5. SEX
(b)(6)-4	CIV	m

(b)(6)-4

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20	[redacted]	X	9	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		20	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	S		

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0		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)
2 6	0 5 8 0	2 0 0 3 1 0 1 0

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
A B A A		2 0 0 3 1 0 1 0

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

FOR LOCAL USE

Pt shot while trying to steal Ammunition
GSW to ABO
879.2

Ex Lap GASTRIC Repair, Colostomy Repair Liver Laceration Repair
Abdominal Wound I+D Subclav
54.19 44.19 46.43 50.29

DX-8792
E9912
Trauma-1
Injury-450
PR-4449
4643
5029

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK

(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	36	X	MUSLIM			NO

11. FMP	12. SSN	13. Organization	14. Ward
99	(b)(6)-4		ICW

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

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	21:10	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-10-22

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-10-09	DR (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] b(6)-2	2003-10-09	

31. Selected Administrative Data

Marital Status: Z DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: INJURED TRYING TO STEAL AMMUNITION

34. Diagnosis / Operations and Special Procedures:

GSW TO RIGHT CHEST

875.0 47.19

EX LAP APPENDECTOMY WOUND DEBRIDEMENT

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 (b)(6)-2 s Officer (b)(6)-2 SG, PAD NCOIC

MEDCOM - 7835

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

See SF 558 -

PHYSICAL EXAMINATION

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

(b)(6)-2, MD

USA

(b)(6)-2

	DATE	IDENTIFICATION NO.	ORGANIZATION
	09DC703		

ritten entries give Name last, first, date; hospital or medical facility)

REGISTER NO.	WARD NO.

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*	
09 OCT 03 (2011)	(S) PT. w/ GUNSHOT WOUNDS TO (L) LATERAL CHEST, AND TO (L) LOWER BACK. INITIATED 2 iv (R) ARM @ AC VEIN – NaCl 0.9%, (L) ARM AC VEIN SAME. PT. SHAKING, (2020) INITIATE FOLEY CATHETER @ (R) UPPER TORSO (NEAR ARMP. PREPPED PLEUR-EVAC (2020), INITIATED O_2 (2020) THROUGH REBREATHER MA	
BP: 118/76 → (2014) (R) ARM	(2015) – 5 mL MORPHINE AT (R) ARM.	(2011) SOME EXIT WOUND SEEN AT BACK OF PT.
BP 138/48 → P: 100 → (2048)	(2020) – 5 mL MORPHINE THROUGH IV (2023) – 5 mL VALIUM THROUGH iv (2028) – 5 mL MORPHINE IV	~~(2030) FOLEY CATH. INSERTED (R) UPPE TORSO.~~
	(2032) – 5 mL MORPHINE IV (2035) – 5 mL MORPHINE IV	(2036) INSERTION OF ~~FOLEY CATH.~~ CHEST TUBE (R) UPPER TORSO. PT. WAS IN VEHICLE UNDER FIRE FROM .50 CAL (PER CPT. (b)(6)-2). (2039) STITCHING OF ~~FOLEY CATH.~~ CHEST TUBE SITE
	(2043) INSPECTED PT'S BACK. (2048) FOLEY CATH. INSERTED & SECURED. (2052) AUSCULTATION OF PT'S LUNGS.	
	PE – Awake. Alert. A – patent ⊕ gag B – trachea midline LCTAB BS = L C – rad pulse 1+/4+ bilat CR ~ 3 secs D – MAE spont and to command GSW (R) lat CW = ant entrance, post exit, Ø air GSW (R) lower lumbar area c hematoma, Ø exit noted	

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)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USAPA V2.00

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Due to medivac, chest tube place (R) mid ax 5th ICS c̄ heimlich valve
	Foley placed - clear yellow urine return
	2 AC IV's
	No Δ with reassessment p̄ CT placement
	Awaiting medivac
	(b)(6)-2
	CPT MC

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD Nursing **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 Oct 03	2110 pt arrived, A & O x 3, 39 y.o. ♂, c/o GSW to (R) chest + (R) lower back, onset tonight. VSS: 136/87, P 109, R 20, temp 100.8
2120	2nd IV started, labs drawn, urine sent from foley placed PTA, (R) chest tube placed PTA attached to Pleurevac ⅤⅤ drainage, O_2 cont. via nonrebreather mask. Ancef 1 gm started IVPB + tetanus 0.5 cc given IM (L) shoulder, 147/84, P 96, RR, ox
2122	X rays of chest + abd started.
2135	Lat. X ray of abd done, BP 121/60, P 95, R 16, ox 3rd + 4th L. ob L.R. started @ 250 cc/hr.
2150	pt waiting for O.R. to do exploratory lap. of abd, BP 121/68, P 95, R 16, ox 99% O_2 dec to 2 L, N.C. Lt (b)(6)-2 RN, ET

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)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD Nursing **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 Oct 03	2110 pt arrived, A/O x 3, 39 y.o. ♂, c/o GSW to (R) chest + (R) lower back, onset tonight. VSS: 136/87, P 109, R 20, temp 100.8
2120	2nd IV started, labs drawn, urine sent from foley placed PTA, (R) chest tube placed PTA attached to Pleurevac 5 drainage, O_2 cont. via nonrebreather mask. Ancef 1 gm started IVPB + tetanus 0.5 cc given IM (L) shoulder, 147/84, P 96, RR, ox
2122	X rays of chest + abd started.
2135	Lat. X ray of abd done. BP 121/60, P 99, R 16, ox 3rd + 4th L. ob L.R. started @ 250 cc/hr.
2150	Pt waiting for O.R. to do exploratory lap. of abd. BP 121/68, P 95, R 16, ox 99% O_2 Sat to 2 L. N.C. Lt (b)(6)-2 RN, ET

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

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

REGISTER NO. | WARD NO.

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9OCT03	BRIEF OPERATIVE REPORT

PRE-OP DIAGNOSIS: GSW to back/retroperitoneum and (R) chest.

POST-OP DIAGNOSIS: " "

PROCEDURE: Ex lap, appendectomy, Wound debridme

SURGEON: (b)(6)-2 ASSISTANT: (b)(6)-2

ANESTHESIA: GETA OPERATIVE ANTIBOITIC: Unasyn 3.0g

FLUIDS: 2600 cc BLOOD PRODUCT USAGE: ϕ

EBL: 200 cc URINE OUTPUT: — 450cc

TOURNIQUET TIME: —

DRAINS: Chest tube

SPECIMENS: appendix

FINDINGS: Wound track from lumbar paraspinal region to retroperitoneum, GSW to (R) chest

DESCRIPTION OF PROCEDURE: Ex lap, ϕ free blood, bowel - WNL, nl liver, spleen, (B) kidney. Wound track debridment from lumbar region, ϕ ureter injury. (R) GSW to chest. - debridement

COMPLICATIONS: ϕ

CONDITION: Stable

(b)(6)-2

LH

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

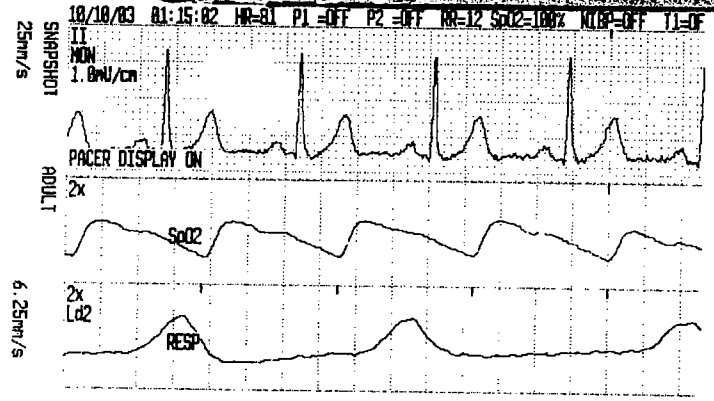
(b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10 Oct 03 @	0050 Pt From OR, Shaking and moaning, Vs T 94.4 - 126 - 127/73 - 24 SPO2 97%, O2 Applied via NC @ 6L/min, Chest Tube Right Chest to Pulmonic @ Continuous 20cm Suction, Bilat UE restraints applied, Foley to bravity, Midline Incission c̄ Dressing CDI Dressing to (R) Flank CDI, Dressing to (R) Chest Tube c̄ Bloody drainage but intact, Patient given MSO4 5mg IVP for Pain Physical assessment Completed and recorded on PCU Flow Sheet. (b)(6)-2
0110	Pt Attempting to Vomit Phenergan 25mg IVP Given. Rhythm Strip HR 86 QRS 0.08 NSR (b)(6)-2



0300	MSO4 3mg Given For Pain. (b)(6)-2
0500	Am Labs Collected, 24° I+O computed IV in 2750 Po 1525 EBL 200 CTout 18 Balance +1007, MSO4 3 mg IVP for Pain, Request for AM C-XRay Submitted (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NO (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

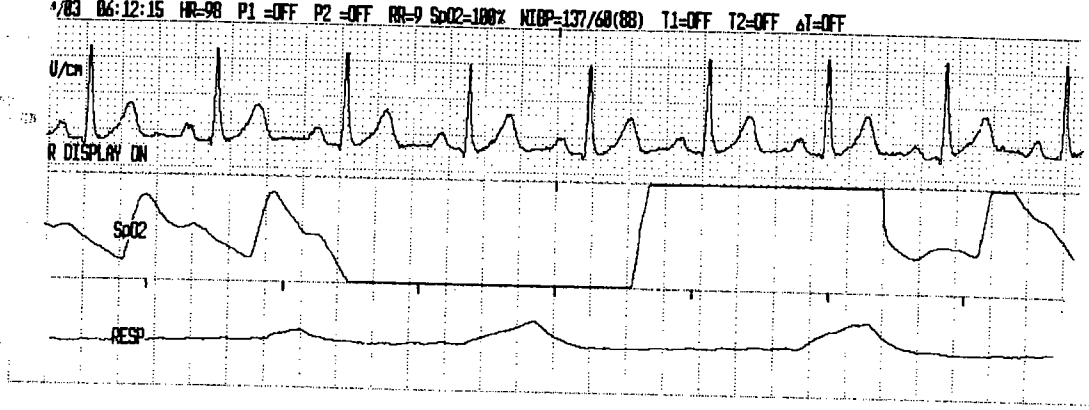
(b)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES



10 Oct 2003 Received report from CPT (b)(6)-2. Patient denies c/o nausea or [illegible] leads. A=O x 3, MAE x 4. Monitor shows SR ~ ectopy with rates in the 90's. O2 at 2 L/min ~ sats 100%. IV infusing via (1) A/C ~ D5 1/2 NS @ 150cc/hr. (1) A/C ~ redness or drainage. 18G Heplock - foley to gravity, clear yellow urine. Chest tube to 20cm suction. Abdomen dressing, midline, slight serous sanguinous drainage at the top of the dressing. (1) flank entrance wound, dressing clean, dry and intact. Plan (1) Encourage use of incentive spirometer, (2) Assist OOB to chair as tolerated, (3) Medicate PIN for pain o (b)(6)-2 [illegible]

0800 Patient assisted OOB to chair. Tolerated activity ~ one episode of nausea. Assisted back to bed in 10 minutes after c/o pain. Medicated ~ 4 mg Morphine. (b)(6)-2 [illegible]

1000 Resting comfortably. O2 sats 87% on RA. Assist 2 1/2 hours using incentive spirometer. Will monitor and encourage use of IS (b)(6)-2 [illegible]

1130 Given 4 mg Morphine IVP x 1 @ 1100. Remains in NSR ~ ectopy. IV infusing as ordered. Will assist OOB to chair (b)(6)-2 [illegible]

1200 C/o nausea, given Phenergan 25 mg IV. Tolerated clear liquid diet ~ emesis. Remains in SR ~ ectopy. (b)(6)-2 [illegible]

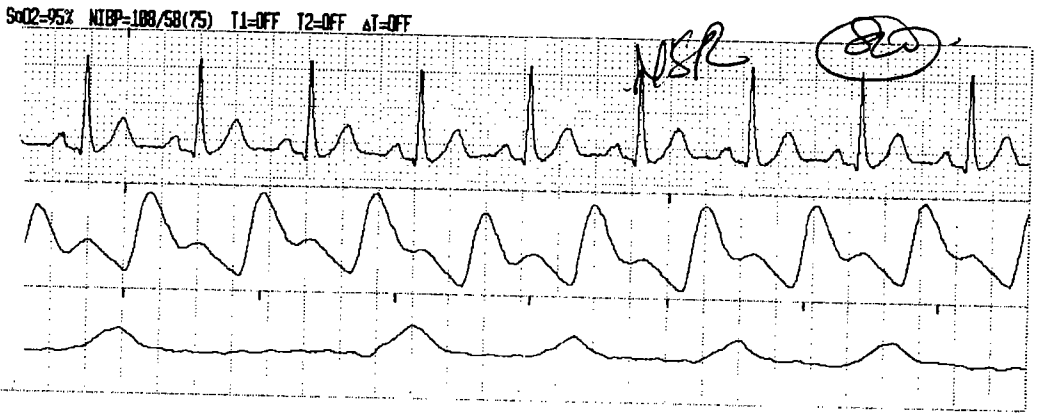
1500 Assisted OOB to chair. Tolerated activity ~ less complaints. Medicated ~

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
10 Oct 03	Morphine 4 mg IVP. Chest tube @ 40 cc serous drainage. Tipped over on the floor, Pleurevac changed to accomodate accurate reading, secured to chest tube and body alignment. Pleurevac taped to the floor to prevent second spillage. Denies pain or discomfort at this time. (b)(6)-2
1800 10 Oct 03	Pt. [illegible] to see NPO ō MN for washouts of the arm of abdominal wounds. Report given to night shift [illegible] (b)(6)-2
10 Oct 03 1800	Report from day shift RN [illegible] (b)(6)-2, client in bed asleep, connected to cardiac/resp monitor, IVF infusing @ 150 cc/hr, (R) chest tube connected to 20 cm H2O suction (b)(6)-2
1900	Assessment done see DA form 4700 medicated for pain to (R) chest and abdomen. (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

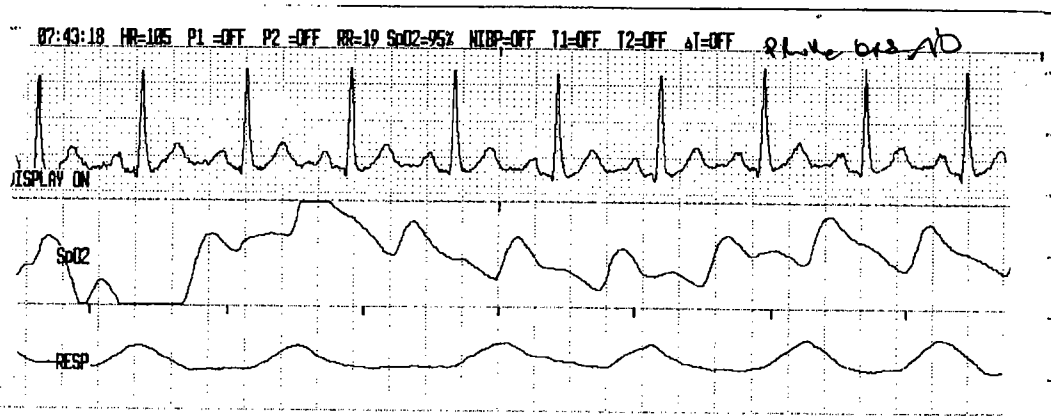
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
(b)(6)-4		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1991)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1)
USAPA V1.0

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

DATE	NOTES
10 Oct 03 1930	Client in bed asleep at this time. — (b)(6)-2 — SSA
2100	Ate 25% of clear liquid dinner, tol well no N/V noted. (b)(6)-2 — CPT Ty
2145	c/o pain to abdomen @ incision site, medicated c̄ 5mg morphine IVP. — (b)(6)-2 — CPT Ty
2215	client asleep in NAD — (b)(6)-2 — CPT Ty
2300	Assessment done, no changes from previous assessment pain free at this time. — (b)(6)-2 — CPT Ty
2400	medicated per order c̄ Unasyn and Zantac IV. — SA.
11 Oct 03 0200	Client asleep in NAD — (b)(6)-2 — CPT Ty
0315	c/o pain at incision site to abdomen, medicated c̄ 5mg morphine IV. — (b)(6)-2 — CPT Ty
0400	Client asleep in NAD. — (b)(6)-2 — CPT Ty
0600	Report given to MAJ (b)(6)-2 — (b)(6)-2 — CPT Ty
0615	CXR done by Radiology, c/o pain to abdomen, medicated c̄ 5mg Morphine IVP for pain. — (b)(6)-2 — CPT Ty



11 Oct 2003	0730 Report received from the previous shift. Patient lying supine in no apparent distress. O5½ NSS infusing @ 150 cc/hr's infusion. CT to 20 cm Suction, total output 90 cc. Foley to gravity

STANDARD FORM 509 (REV. 6/1989) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

11/07/03
1210

BRIEF OPERATIVE REPORT

PRE-OP DIAGNOSIS: OPEN SHRAPNEL WOUNDS

POST-OP DIAGNOSIS: SP I+D Chest/Back wounds

PROCEDURE: I+D SHRAPNEL

SURGEON: Dr. (b)(6)-2 ASSISTANT: SSG (b)(6)-2

ANESTHESIA: GETA CPT STARS OPERATIVE ANTIBOITIC: UNASYN 3 gm

FLUIDS: 700 cc BLOOD PRODUCT USAGE: None

EBL: None URINE OUTPUT: 350 cc

TOURNIQUET TIME: NA

DRAINS: Foley

SPECIMENS: None

FINDINGS: 2 pieces of shrapnel, head clean

DESCRIPTION OF PROCEDURE: Upper and lower b/ Pulse Lavage Closed Lam (R) Back and and one upper in (w/ Mattress Suture 3-0 Nylon. Dry applied. Pt tolerated procedure well - Anesthetized well,

COMPLICATIONS: Ø

CONDITION: STABLE

(b)(6)-2 (b)(6)-2 MD
MAJ, MC USA
CHIEF, DOS

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

DEPART./SERVICE	HOSPITAL OR ME	RDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11 Oct 2003 0730	Draining clear yellow urine. Further assessment as per PA Form 4700, Plan (1) keep NPO p MN for Surgery this AM, (2) Encourage use of Incentive Spirometer (3) Monitor Intake and Output and notify MD of U.O. less than 30cc, chest tube output greater than 100cc/hr. (b)(6)-2 mogan
0930	Given complete bed bath. Dressings & staples intact, drainage to mid abdomen site and (R) chest tube site. NPO as ordered. Awaiting Surgery (b)(6)-2 mogan
1030	To OR via litter. Chest tube to water seal. Foley intact D5 1/2 NSS infusing as ordered. (b)(6)-2 mogan
1140	Returned from OR received 2U Fentanyl, 100mcg Propofol and 7U Crystalloids. Placed leather restraints to keep patient from harming his incisions and chest tube. (b)(6)-2 mogan
1140	VS: B/P HR SaO2
1215	122/70 114 94%
1220	128/78 116 93%
1225	124/68 112 94%
1230	123/69 114 94%
1245	Patient resting comfortably. Chest tube to 20 cm suction. Lungs CTA in all fields. Bowel sounds hypoactive to all quadrants. Foley to gravity, clear yellow urine. Urogen infusing as ordered (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR (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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1315 11 Oct 2003	Patient resting comfortably. Voiding per foley. IV running ~~J~~ infiltration
	No apparent distress noted. (b)(6)-2
1500	assisted OOB to chair. T 101.1°. Encouraged use of
	incentive spirometer & IV. Medicated c 5 mg Morphine IVP (b)(6)-2
1800	Dressings changed to Chest tube, DSD and abdominal dressing
	removed. Resting comfortably. Report given to next shift (b)(6)-2
1900	Pt c stable vital signs T-100.5 @ - HOB 30°
	open abd incision c staples (open to air) ∅ S/Sx of
	infx ∅ dehiscence hypoactive BS x (D) L quadrant
	CT to 20 on suction - Suction canister functioning
	well - small amt of drainage. See Flowsheet
	IV to (R) AC discontinued (L) AC W patent
	infusing D5½NS 150cc/hr - Foley to Gravity
	c clear yellow urine - Pt temp 100.9
	(axx) - Clear liquid meal at bedside - tolerated
	Pt c no C/O pain at this time (b)(6)-2
2100	Incision cleansed c betadine and covered c
	dsg. Pt OOB to chair moves slowly
	c C/O abd pain 2° to incision
	Dr [redacted] stated pt might go to
	OR tomorrow for wound cleaning and
	then CT to water seal ∅ procedure
	5 mg IV MSO4 for pain (b)(6)-2
2300	Pt sleeping - positioned on blanket roll so
	he can lay on side - Temp ↓
	See Flow sheet (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12 Oct 03	0700: Pt oob to chair for AM hygiene. Self-care encouraged and practiced. (+) shampoo, oral care, shave and body wash. Pt denies pain. CT to 20 cm H2O suction intact, (-) evidence of leak. ϕ c/o dyspnea, sob. Pt returned to bed 0945. Resting @ this hr. (b)(6)-2
1110:	Pt continues to rest c/ out complaint or needs.
1215:	Pt OOB TO chair. Consumes ~10% NOON meal. Ref po fluids. Per translator - states he is not hungry, has no appetite. I & O monitoring to cont. VS stable. UOP above NP. CT drainage ~ 5-10 cc/hr. (b)(6)-2
late note	1200: PIV d/c'd accidently per pt. 20g PIV placed to (R) FA, good flush, good blood return. D5½ NS continues (b)(6)-2
1400:	Pt sleeping - denies pain or pounding from environ stimuli. Pt appears sad, disinterested in self-care. Tragian music played x 15 minutes c̄ pt discontinuing earphone use and turning off cassette. Returns to sleep. Will cont to monitor. (b)(6)-2
1500:	Pt resting, awake, ⊘ flat affect. VS Normal, no S/S from previous assessment. (b)(6)-2
1630	Pt c/o Bilateral lower quadrant pain. MSO4 4mg IV administered. Eval pending. (b)(6)-2
1710:	Pt resting w/o complaint. Abd slightly taut, minimally distended tender on palpation. Pt dsg dry intact. Will cont. to monitor. (b)(6)-2
1800:	Report given to NG (b)(6)-2 Pt care transferred. Pt c/o complaint @ this hr. (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
12OCT03	Pt awake, sitting ↑ in bed - quiet - 128/66 P-93 R-12
	S.O2 100% RA IVF: D5½NS 150cc/hr into patent
	18G (L) AC c/s/sx of infx (one day old) abd incision
	c staples intact ∅ bleeding healing well
	Chest tube to (R) side draining minimal amt
	at discharge Plan is to be NPO ↑ midnight
	for cleansing of wound in OR - DC at c section
1400	Pt, able to eat reg meal x1 - pleased well
	informed of NPO status ↑ midnight
	(-)BM (+)flatus hypo-active BS - Pt does c/o
	lower abd pain "not gas" (intermittent
	(b)(6)-2
2200	Chest tube output scant, minimal < 5cc
	still 20 cm Suction - Foley to gravity drainage
	QS dark yellow urine > 100 cc/hr - MSO4 IVP
	for pain
	(b)(6)-2
2400	NPO status - Vital Signs Stable
	See Flow chart
0100	Pt medicated for pain c MSO4
	IVPB Unasyn and Zantac infused
	Pt day well calm, cooperative

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
13 0603 Nursing			

DATE	NOTES
0400	Pt sleeping, DS½NS @ 150 cc/hr. Pt still NPO. No Labs drawn. This am will continue to monitor — (b)(6)-2
0610	Received report, assumed care. Pt asleep awakens spontaneously to external stimuli ox3, ∅ complaints - denies pain. VS WNL - ∅ labs. D5½NS infusing to (R) FA PIV @ 150 cc/hr. O2 per RA, Foley to gravity, clear yellow. (2) internal chest tubes to pleurovac 20 cm H2O suction & minimal op. All VS, physical assessment noted on da Form 4700. Plan: Pt remains NPO for I&D in am, continue NPO status prep for OR. Cont q1° monitoring cardiac, resp status - monitor dr for leaks and op. Monitor wounds for drainage. Provide comfort measures promoting ↓ pain sensation. Provide stimulation to ↓ pot. for depression. Encourage self-care — (b)(6)-2
0700	AM hygiene performed per pt c̄ encouragement. Pt appears sad, (+) flat affect, performs ADLs only c̄ prodding. Denies pain. IVF's cont infusing 150cc/hr. (4) CT to suction ∅ leaking. ∅ Resp distress/difficulties. — (b)(6)-2
0810	Pt Escorted to OR per OR STAFF x2. Pt supine on stretcher. CT suction off - Foley to gravity. IVF's s̄l'd. Chart transferred c̄ pt. — (b)(6)-2
0945	Pt returns to ICU awake, alert on stretcher accompanied by OR staff x2 and Dr (b)(6)-2. O2 per RA SaO2 94-95% RR 15 Brm. Pt agitated, slightly aggressive, swinging arms, pushing staff away. Pt calmed per info provided by interpreter. CXR ordered pending. CT headbed to 20 cm H2O suction. D5½NS placed @ 150 cc/hr to (2) PIVs. Δ'd to LR @ 75 cc/hr. O2 placed s/p CXR ∴ evidence of pneumothorax
1045	Pt sleeping quietly. No evidence distress or discomfort. O2 @ 2L as per original order per Dr [redacted] SaO2 @ 100%

VS:
100/49 88
13 94%
T: 97.6

b(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
130ct03	OP NOTE
0535	PRE-OP DX - OPEN SHARPNEL WOUNDS
	POST-OP DX - SP DPC
	PROCEDURE - WASHOUT chest Wounds + DPC
	SURGEON - Dr. (b)(6)-2 Anth (b)(6)-2
	FINDINGS - Wounds clean -
	DESCRIPTION - GETA - Pt in (L) lat Decubitus, the prepped w/ Betadine - had the injected w/ 1% LNS. Extended ellipse the chest muscle flap w/ using 3-0 PDS. Wound edges approx w/ interrupted horizontal subdermal sutures 3-0 PDS. Skin the approx. w/ 2 Running Horizontal Mattress Sutures of 3-0 Nylon. Dry applied. Tol procedure. Awake/extubated + transported to ICU in stable cond. Antibs - UNASYN 3 gm IV Fluid 500cc LR UO - 50cc Drs & cxg ∅
	(b)(6)-2 (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)*

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
13 Oct 03 1045	(Nursing) (cont.) RR 12. HOB @ 45° CT to suction 20 cm ~ minimal OP - serosanguinous drainage. All dressings to abd, thoracic region intact, dry - no evidence of drainage. BS clear upper lobes diminished (R) m/L lobe (L) L lobe. ∅ crepitus, ∅ stridor, tracheal deviation, accessory muscle use, nasal flaring. Chest wall movement symmetrical, breathing unlabored. Pt remains (crib) quiet c out needs (+) Carnation instant drink, consumed ~200 cc ~/oOT c/o N/V/abd pain (b)(6)-2
1145:	No Δ's from previous assessment.
1230:	PT OOB, ambulatory. (+) UOP in ward BR. ∅ BM. Pt consumed <5% Noon meal. (+) 100 cc PO Carnation Instant Breakfast. Pt states No appetite, denies abd pain.
1315:	Pt returns to bed requesting sleep. States he has trouble to sleep overnight and is very tired. O2 placed per NC @ 2L IVF continued. CT to suction. W. Ilmonitor (b)(6)-2
1400:	Pt sleeping VS stable
1530:	Pt cont. sleeping. No Δ's from previous assessment.
1615:	Pt OOB ambulating around ward and outside. 300 cc clear yellow UOP per ward commode. Pt to chair, reading. Consumed ~100 cc Sprite c/ate/a w/N. Back to bed @ (b)(6)-2
1730	

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. ICU

(b)(6)-4

13 OCT 03

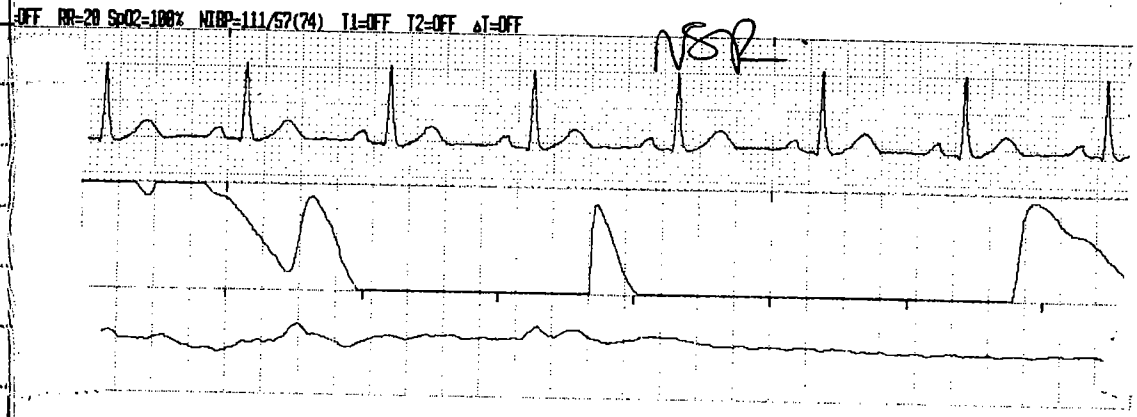
PROGRESS NOTES
Medical Record

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

(b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(Nursing cont.)
13 OCT 03	1800: Pt consumed a 140 cc TEA c̄ ½ cookie. Motrin 600 mg PO and Unasyn 1gm IV administered @ this time. Pt resting c/o at complaints. VS stable. Report given at oncoming shift. Pt care transferred. (b)(6)-2
13 Oct 03 1800	Report from day shift, client in bed, connected to cardiac/resp monitor, LR infusing @ 75 cc/hr via (L) wrist PIV, chest tube connected to 20 cm H2O suction, gentle bubbling noted in chamber. (b)(6)-2 CPT [illegible]
1900	Complete assessment done, see DA form 4700. Sutures to mid back intact, no drainage noted at site. (R) chest tube drsg D+I. Midline abdominal dressing D+I. [illegible]
2100	Client asleep in NAD. (b)(6)-2 CPT [illegible]
2200	Client ate orange and drank can of soda. NO N/V noted. (b)(6)-2 CPT [illegible]



2230	c/o pain, medicated c̄ II percocet tabs. (b)(6)-2 CPT [illegible]
2300	Client asleep at this time in NAD (b)(6)-2 CPT [illegible]
14 OCT 03 0100	Client remain asleep in NAD. (b)(6)-2 CPT [illegible]
0300	Client in bed asleep in NAD, VSS (b)(6)-2 CPT [illegible]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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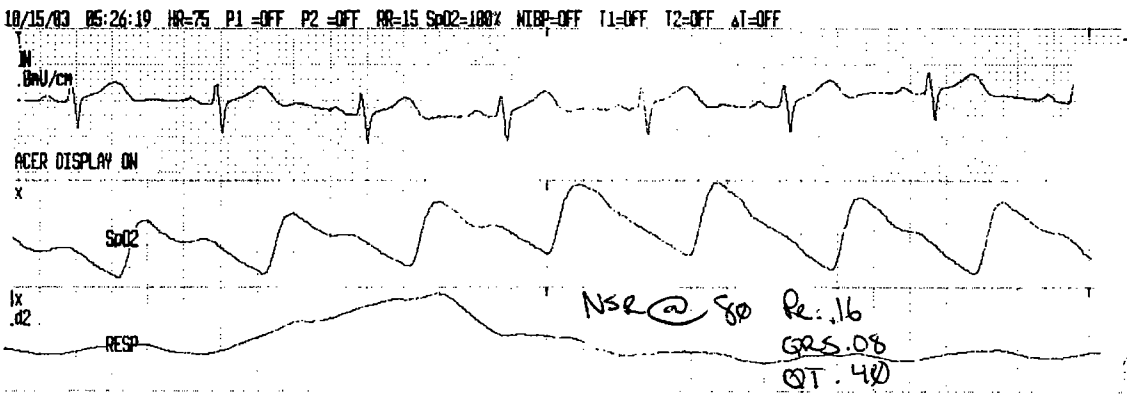
MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14Oct03	Pt resting comfortably in bed. 50mcg Fentanyl
1600	given by MAJ (b)(6)-2 during dsg Δ. Will continue to
	monitor. (b)(6)-2 [redacted]
1820	Received Pt from Dayshift. VSS. Assessment Completed (Secondary 37
	Pt. Denies pain. Will continue to plan of care (b)(6)-2
2000	Pt c/o of abdominal pain. 650mg Tylenol PO Given [redacted]



15Oct03	Pt. Sleeping quietly. VSS. Q Compliance @ this time.
0543	Will continue to monitor (b)(6)-2 [redacted]
0700	Assumed Care of pt. Pt awake eating breakfast. CT → suction VSS noted on DA 0700. Pt stable [redacted] at this time/ [redacted] SGT 9mm

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

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0900	0800 Pt ambulated am care done at
15Oct03	sink. Pt sitting in chair CT → suction
	0843 pt ambulated to X-RAY Q disstress
	noted will monitor/ [redacted] (b)(6)-2 SGT
0930	Pt back from XRay in chair CT → suction
	LS 1200cc/sec x 10. Intial assessment complete
	noted on DA 4700 will monitor/ [redacted] (b)(6)-2 SGT
1130	PT BTB CT → suction meds administered
	as ordered, Pt denies pain appears
	comfortable will monitor/ [redacted] (b)(6)-2 SGT
1330	Dr [redacted] at bedside. CPT [redacted] (b)(6)-2
	[redacted] administer 50mcg Fent per order
	Chest tube was pulled out. Pt tolerate
	procedure well. Gauze c xeroform on site
	c tape. VS 5 procedure 108/52, 76, 11, SAO2 100% 2LO2 NC
	Q SOB, Q disstress ~~noted~~ will monitor
	[redacted] (b)(6)-2 SGT
1630	Pt OOB ambulated to XRay 5 difficulty, Q SOB Q distress
	LS CTA + (R) Base will MONITOR/ [redacted] (b)(6)-2 SGT
15 OCT 03	HHN Tx given c 0.5 Alb/2.5 NS. BBS for clear + to bases.
1700	HR 78-91. O2 SAT on 4L/min NC 100%. RR 20. Pt
Resp Therapy	c strong productive cough for small amount thin clear
	secretions. P Tx BBS for unchanged. NAR [redacted] (b)(6)-2 CRT
1800	Pt stable 1800 Unasyn administered Q acute
	distress noted Report given to SGT [redacted] (b)(6)-2 VSS [redacted]
	[redacted] (b)(6)-2 given SGT

STANDARD FORM 600 (REV. 6-97) BACK

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
14 Oct 03 0530	Blood drawn from (R) AC site and sent to lab, no hematoma noted. Medicated per order. [redacted] (b)(6)-2 CPT
0630	Report received from CPT [redacted] (b)(6)-2, pt lying in bed 5 complaints, CXR done, assessment performed (see DA 4700), pt on 2L O_2 via NC satting 100%, lungs clear to auscultation, ē diminished (R) base. Chest tube to 20cm H_2O suction draining small amt serosanguinous fluid. Will continue to monitor for Δs [redacted] (b)(6)-2 SGT/LPN
0830	Pt ambulated to back to bathe ē difficulty. Pt had large, formed BM x1, ate very little of breakfast. Reconnected to monitor, resting comfortably [redacted] (b)(6)-2 SGT/LPN
0835	Xray shown to MD, chest tube now to waterseal, will order new CXR in 4hrs to determine if CT can be pulled. [redacted] (b)(6)-2 SGT/LPN
1030	Pt resting comfortably in bed ē complaints [redacted] (b)(6)-2 SGT/LPN
1230	Pt ate some of lunch. Still Ø complaints [redacted] (b)(6)-2 SGT/LPN
1400	Pt ambulated to Xray - Dr [redacted] (b)(6)-2 in to Δ dsg (chest tube placement in question), CT back to 20cm H_2O suction, ē pt on O_2 via NC @ 2lpm. Will monitor [redacted] (b)(6)-2 SGT/LPN

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)(1)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
140403	GEN DRUG SURG
1515	S: Pt. denies pain, tolerating. No N.V. for chest. Ambulates w/ assistance. Tol regular diet.
	O: Alert, VS stable. CVR
	S.L.S. 18.2/164 134/105/1.0 10% PTX w/ Surgical tube
	31.7 3.7/25 94 at chest well w/ (R)
	Pre medicated pt w/ 50 µg FENTANYL -
	Removed (R) chest tube during the prepped
	w/ Betadine and sterilely administered tube x 2 cm.
	Applied sterile dressing and secured tube / Bradyp.
	No comp.
	A: POD# 5/3 1#1 GSW stomach
	P: ① Placed CT back on Suction
	② CVR terminated

(b)(6)-2

(b)(6)-2 , MD
MAJ, MC USA
CHIEF, DOS

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.0

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MEDICAL RECORD	PROGRESS N

DATE	NOTES
15 OCT 03 1800	Report recieved - Pt. stable, NAD, Vital Signs Stable 122/66 P-83 R-12 SpO2 99% on 2L NC - Pt sitting up in bed - Dsg. to old CT site bolky, CD & I Ø old discharge - abd incision c̄ staples - open to air well approx, Ø dehiscence, ØS/Sx of infx - Pt using urinal at bedside ØS clear yellow urine will continue to monitor — (b)(6)-2 [redacted]
2100	Pt sleeping, Ø complaints — (b)(6)-2 [redacted]
2200	Pt c/o pain at IV site Ø evidence of infiltration patient will monitor — (b)(6)-2 [redacted]
2300	2 percocet for pain/sleep, VSS, Sa flow sheet, afebrile — (b)(6)-2 [redacted]
16 Oct 03 @ 0200	Pt lying in bed eyes closed, resp even and unlabored. Ø S/Sx of distress. Will cont' to monitor — (b)(6)-2 [redacted]
16 Oct 03 @ 0545	Labs drawn @ 0500. CXR request sent to rad. pt has Ø C/o @ this time. (b)(6)-2 [redacted]
0600	assume care of pt Report [redacted] receive by SGT (b)(6)-2 pt appears to be sleeping. NAD note at this time 0600 med administr by offcoine shift will monitor / — (b)(6)-2 [redacted] SGT

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. 5/199
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 OCT 03	HHN Tx given c̄ 0.5 Alb/2.5 NSS, BBS for Clear. RR 14 ∅
0615	evidence of distress. O2 SAT on 2L/min NC 99% HR 71-80
Resp Therapy	PTx BBS clear, NAR (b)(6)-2 CRT
0830	Pt OOB ambulate to sink am care performed. Initial assessment complete noted on DA4700 NAD noted will monitor b(6)-2 (b)(6)-2 SGT
1030	MD Dr [redacted] in to see pt. transfer orders written. Report given to SGT [redacted] Pt ready for transfer. VSS NAD b(6)-2 (b)(6)-2 SGT

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
16OCT03 1145	ADMISSION - 39 y/o ♂, ICAOI EPW RECEIVED FROM ISU. DX: S/P RSW TO CHEST, FLANK. A&O x3, PERRLA, SKIN NORMAL COLOR, DRY, INTACT, MUCOUS MEMBRANES PINK, MOIST, INTACT. LUNGS CTA BILAT SYMMETRICAL RISE AND FALL IN CHEST. S_1-S_2 STRONG AND REG, PULSES PALPABLE RADIAL, BRACHIAL BILAT, CAP REFILL <3. (+) BS x4. MIDLINE INCISION CLOSED W/ STAPLES, C.D.I. DRSG TO (R) FLANK C.D.I. PT CONTINUES IV ANTIBIOTIC THERAPY UNASYN 3gm IVPB q6°. IVHL TO (R) WRIST. Ø % PAIN, Ø % SHORTNESS OF BREATH. ALTHOUGH NO ORDERS STATED, SSG [redacted] RT WILL CONTINUE PT NEB TREATMENTS. WILL CONTINUE TO MONITOR STAT.
16OCT03 1200	HHN Tx given c̄ 0.5 Albuterol/2.5 NS. BBS for clear ½ to bases. HR 82-87. RR 16 & stable. O2SAT on R.A. 97%
Resp therapy	NAP [redacted] CRT
16Oct03 1920	HHN Tx given c̄ 0.5 Alb/2.5 NS BBS CTA ↓LRL>LLL No adverse affects [redacted] RT
16Oct03 2200	Nurses Notes: Assumed care of [redacted] Ø c/o pain or discomfort. Vitals Stable IV SL flushes well. IV antibiotic unasyn Therap Continues. Middline Staples Clean dry and intact. Dressing to (R) flank clean dry and intact. Will continue to monitor Stat [redacted]

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
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

16 OCT 03 GENERAL SURGERY SVC

1015 S: No Shortness of Breath, N, V.
Tolerating Regular diet
O: Afebrile, VS stable
114/60 T-98 P-75 R-15
CVA – No P+T – Staples drainless flush. No infiltrate
GEN – Lungs – CTA. Drains still intact –

A: POD # 7/5/3 – Doing well
P: ① Transfer to IEW today
② Continue UNASYN x 72°

(b)(6)-2

(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.

(b)(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17 Oct 1244	Pt given Nb @ prescribed dose. No adverse reactions. BBS CTA + Lowbly (b)(6)-2 [redacted] RT
17 Oct 0600	Nursing: Shift / Sleep: Pt cont. IV antibiotic. RT in to assess resp. + given tx. No signs of resp distress. Pt c̄ unlabored, even resp. Pt slept ≥ 6 hrs this shift. (b)(6)-2 Continue to assess. CPTA
17 Oct 03 1045	Nursing: Pt AAO Perrla 3mm. Mucus membranes moist and intact. Lungs CTA with symmetrical rise. Heart sounds strong and normal. Bowel sounds active x4 quad. Cap refill <3sec. Radial pulses bilat and equal / strong. TCDB treatment done with incentive spirometer done. SpO2 >95%. No signs of labored breathing. Pt sleeping comfortably c̄ no complaints of pain. Will continue to monitor throughout (b)(6)-2 [redacted]
1310	HHN Tx given c̄ 0.5 Alb / 2.5 NS. BBS for clear. [redacted]
17 OCT 03	O2 SAT on R.A. 98%. HR 96-92. No c/o SOB, difficulty. (b)(6)-2 CRT
Resp Therapy	NAR
17 Oct 03 1450	Nurses Notes: Assumed care of Pt AAO ∅ c/o pain or discomfort. Vitals stable. Staples at midline clean dry and intact. dressing to (R) chest wall clean dry and intact. IV antibiotic therapy continues. Hands spontaneously. Will continue to monitor [redacted] (b)(6)-2

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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MEDICAL RECORD

PROGRESS NOTES

DATE	NOTES
7 Oct 1930	Nurses Notes! Dressing changes completed on chest wall. Sutures in place ∅ bleeding or foul odor ∅ signs of infection at site. Abrasion noted on (R) scapula Red non bleeding ∅ swelling. will continue to monitor. Via interpreter Pt was told to keep off that side of his back - Pt verbalized through interpreter that he will comply (b)(6)-2 LT/AN
8 Oct 03 0530	Nursing: Shift Note/Sleep Pt. slept most of shift side-lying most of night. ¹⁄₀ being cold when he sleeps. Encouraged to ↑ ambulation + h2o intake this shift a.m. Resp. therapy assessed + gave tx. ∅ changes in drog. or suture lines. Cont. to monitor (b)(6)-2 CPT AN
8 Oct 03 0532	Nursing: U.O. Pt. had no output this shift. Plan to ↑ intake. Strict I+O. ↑ ambulation. Assess for depressive sx. (b)(6)-2 PTA
18 OCT 03 0620 Resp Therapy	HHN Tx given c 0.5 Alb/2.5 NS BBS for clear. RR 12. ∅ ¹⁄₀ SOB. HR 86-89 O2SAT on R.A 98%. NAR (b)(6)-2 CAT

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	

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

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18 oct 1100	Nursing: Pt AFO gorda X3mm. mucosa membranes moist and intact. Lungs CTA c̄ symmetrical rise and fall of the chest. Heart Sounds strong and normal. Bowel sounds active X4 quad. Mid line staples intact. Bilat Radial Pulses strong/equal. Ø complaints of pain. will continue to monitor throughout. [redacted] (b)(6)-2
18 oct 1450	Nurses Notes: Assumed care of Pt AFO Vital (b)(6)-2 Stable dressing to (R) chest clean dry and intact. Ø foul odor or drainage noted. midline staple clear dry and intact. Ø redness or swelling noted in area. IV antibiotic therapy continues. Pt Ambulates to bathroom ad. will continue to monitor status [redacted] (b)(6)-2 101
1955	Changed dressing to (R) chest + back. Ø blood on dressing. Abrasion to scapula. appears dry Pt admits ↓ pain when touched. will continue to monitor area. Advise Pt through interpreter to keep upright. Use incentive spirometer and keep off affected side. Pt verbalize understanding [redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	REGISTER NO.	WARD NO.

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
19 OCT 03 @ 0635	Assumed care of pt @ 2200. Asst WNL; VSS; please all SF Form 511. Staples to Chest & midline C.D.I. O_2 Sat = 98%, PT denies c/o pain. Communicated c assist. from pt next to him. PT slept throughout most of the night. ABX given as ordered. Please see DA 4078. (b)(6)-2 2LT/AN
19 OCT 03 1015	- Assessment - AAO x3, PERRLA, Lungs CTA BILAT, S_1-S_2 strong and reg, (+) BS x4. Midline incision site clean, dry, intact. Drsg to (R) flank C.D.I. Ø c/o pain. Continues IV antibiotics, OOB to BR. Tolerates reg diet. (b)(6)-2 Will continue to monitor throughout. SGT/AN
19 Oct 03 1419	Nurses Notes: Assumed care of Pt AAO Ø c/o pain or discomfort vitals stable staples to midline clean dry and intact Ø swelling or odor dressing to (R) flank clean dry and intact. Pt to perform self care today. Void spontaneously. Encourage increase PO fluids. IV antibiotics continue will continue to monitor status (b)(6)-2 Cole
2005	Dressing change completed. Sutures in place. Abdomen looking better SNM & c/o pain (b)(6)-2 Vaughn

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20OCT03 @0330.	Assumed care of pt @ 2200. Asst. WNL; including BS x 4; ABD soft, nontender; lungs CTA (B). Staples midline of chest = C,D,I. PT conts. to deny c/o pain. Communication/translation assist. per roommate. PT sleeping currently. Ø c/o N, V, DOR any other unusual sx. DRSG to (R) flank = C,D,I. VS q 6° noted & stable; please see SF Form 511. ABX IV cont. Please see DA 4678. PT c̄ blanket over head most of night. Appears sleepy; sad but cooperative. Not very talkative per roommate. Will cont. to monitor (b)(6)-2 SLT/AN
20OCT03 11 25	- ASSESSMENT- A&O x3, PERRLA, LUNGS CTA BILAT, S1 S2 STRONG + REG, (B) BS x4. Ø c/o PAIN. CONTINUES IV ANTIBIOTICS, CONTINUES TCDB EXERCISES c̄ INCENTIVE SPIROMETER. OOB TO BR. TOLERATES MEAL DIET. WILL CONTINUE TO MONITOR THROUGHOUT (b)(6)-2 SGT/LAR
20 Oct 03 1455	Nurses Notes: Assumed care of Pt A&O Ø c/o pain or discomfort. Staples at midline CDI and dressing to (R) chest clean dry and intact. Pt practices c̄ IS. at bedside ↓ BS to (R) lung. Nonproductive cough c̄ use of incentive spirometer. Pt ambulates to Rest Room SR. will continue to monitor (b)(6)-2
21OCT03 @ 0500.	Assumed care of pt @ 2200. Asst. WNL; VSS; please see SF Form 511. PT S c/o pain. Staples midline chest = C,D,I. To clarify Unasyn ABX order in AM. PT A+O x3. BS x 4 Lungs CTA PT S further compliance. Will cont. to monitor. (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.0C

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

Department of the Army

[redacted] b(2)-2

NARRATIVE SUMMARY

DIAGNOSIS: GSW to (R) chest

PROCEDURES: 10 OCT 03 – EXP LAP, – APPENDECTOMY, WOUND DEBRIDEMENT

HISTORY OF PRESENT ILLNESS: DOA- 10 OCT 03 DODC- 22 OCT 03

36yo IRAQI male who was shot by US forces on 10 OCT 03. He presented on TIKRIT w/ a Right chest thoracostomy tube w/ shrapnel wounds from 50 cal in (R) chest and (R) lower back.

(b)(3)-1

HOSPITAL COURSE: Evaluation in EMT revealed shrapnel in retroperitoneum & abdomen so an exploratory laparotomy was performed. No intraabdominal injury was seen. A massive penetrating (R) sided retroperitoneal hematoma was explored. Finally – no injury to (R) iliac A/V or ureter. PSOAS Hematoma seen.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		(b)(6)-2	SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST		
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY			
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

875.0
47.19

PROGRESS NOTES
Medical Record

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

MEDCOM - 7868

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	HOSPITAL COURSE (CONTINUED): Multiple adherent fecaliths were seen in Appendix, so an incidental appendectomy was performed. Pt was taken back to the OR twice for wound washout and DPC – Chest tubes removed on POD # 6. Staples and Foley removed POD #2. 2/02/07 03. Pt was kept in UMMC 5W 3 for IVAB abx stay. Tolerating regular diet, daily normal bowel function and ambulating without assistance.
	DISPOSITION: DC to MP on thursday 22 02 07.
	RECOMMENDATIONS: F/U PRN for problems
	MEDICATIONS: PROTRIN 800mg – 1 po TID w/ food.
	TYLENOL #3 – 1-2 po q 4° PRN/PRN
	COLACE 100mg – 1 po BID
	(b)(6)-2 (b)(6)-2 MD JOHN M [illegible] MAJ, MC USA CHIEF, DDS (b)(6)-2

09 (REV. 5/1999) BACK
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
22 Oct 03	Nurses Notes: Assumed care of Pt AT 0 Vitals
1419	Stable. Pt had Ø c/o pain or discomfort. Ø
	I.V Access. Pt uses incentive Spirometer Ø
	coughing today. Pt ambulates to Restroom
	Ø complication. will continue to monitor Status
	(b)(6)-2 Emica 10/A
1730	Pt c/o pain c̄ inspiration in (L) Thoratic
	region. gave Pt MOM c̄ have Pt ambulate
	for 20 minutes. will continue to monitor
	for changes (b)(6)-2 Emica 10/A
1900	Pt Asleep Ø c/o (b)(6)-2 Emica 20
23 Oct 03	Assumed Care of pt @ 2200. TISST. WNL; VS;
	please see SF 511. PT denies c/o pain. Steri
	Strips in place = C.D.I to incisions. PT currently
	Sleeping. Ø further complaints - awaiting DC
	to MPs (b)(6)-2 2CT/AN

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21OCT03 1100	- ASSESSMENT - A&Ox3, PERRLA, LUNGS CLEAR, S1-S2 STRONG AND REG, (+) BS x4. MIDLINE INCISIONS / BRUISE TO (R) FLANK C.D.I. COR TO BR. Ø % PAIN. TOLERATES REG DIET. WILL CONTINUE TO MONITOR THROUGHOUT — (b)(6)-2 "SGT"
21OCT03 1515	Nurses Notes: Assumed care of pt A&O. Denies pain or discomfort at this time. Staples to midline clean dry and intact. Bruise to (R) flank healing dry ~~5~~ Ø open area or bleeding. Suture to (R) chest and flank in place, clean dry and intact Ø odor or signs of infection. Pt using incentive spirometer & coughing occasionally non productive cough. Pt able to ambulate ~~5~~ difficulty or complaints to rest room under spontaneously. will continue to monitor status — (b)(6)-2 EMT CRK
2015	staples removed. wound dry, clean and intact Ø drainage or bleeding. Pt denies pain or tenderness to medline. will continue to monitor — (b)(6)-2
22OCT03 @0245	Assumed care of pt @ 2200. ASST. WNL; VSS; please see SF511. PT ~~5~~ c/o pain. ~~Staples~~ steri-strips midline of chest - C.D.I steristrips in place as well as wound to (R) flank. PT ↑ ambulating ~~5~~ difficulty. Incisions ~~5~~ S/Sx of infection / ~~infiltration~~ error. Will cont. to monitor. PT denies any further complaints / issues. — (b)(6)-2 SGT/N

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
22 Oct 03	Nurses Notes! Assumed care of Pt AT0 Vitals
1419	Stable. Pt had Ø c/o pain or discomfort. 4
	I.V Access. Pt uses Incentive Spirometer Ø
	Coughing today. Pt ambulates to Restroom
	S Complication. will continue to monitor Status
	(b)(6)-2 Emica 10/A
1730	Pt c/o pain E inspiration in (L) Thoracic
	region. gave Pt MOM E have Pt ambulate
	for 20 minutes. will continue to monitor
	for changes (b)(6)-2 G 10/A
1900	Pt Asleep Ø c/o (b)(6)-2 W
230903	Assumed Care of pt @ 2200. Asst. WNL; VS:
	please see SF 511. Pt denies c/o pain. Steri
	Strips in place = C,D,I to incisions. Pt currently
	Sleeping. Ø further complaints - awaiting dc
	to MPs (b)(6)-2 2U/SN

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; (b)(6)-4 e or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.		WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1989)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

ST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21OCT03 1100	ASSESSMENT - A&Ox3, PERRLA, LUNGS CLEAR, S_1-S_2 STRONG AND REG, (+) BS x4. MIDLINE INCISIONS / DRSG TO (R) FLANK C/D/I. OOB TO BR. 8% PAIN. TOLERATES REG DIET. WILL CONTINUE TO MONITOR TURNOVER — (b)(6)-2 SGT USA
21OCT03 1515	Nurses Notes: Assumed care of Pt A&O. Denies pain or discomfort at this time. Staples to midline clean dry and intact. Bruise to (R) flank healing dry & ∅ open area or bleeding. Sutures to (R) chest and flank in place, clean dry and intact ∅ odor or signs of infection. Pt using incentive spirometer & coughing occasionally non productive cough. Pt able to ambulate & difficulty or complaints to rest room urinates spontaneously. will continue to monitor status — (b)(6)-2 SGT USA
2015	staple removed. wound dry, clean and intact ∅ drainage or bleeding. Pt denies pain or tenderness to medline. will continue to monitor — (b)(6)-2 SGT USA
22OCT03 @0245.	Assumed care of pt @ 2200. ASST WNL; VSS; please see SF511. PT ↑ c/o pain. ~~Staples~~ Steri-strips midline of chest - C.D.I. steristrips in place as well as wound to (R) flank. PT ↑ ambulating ↑ difficulty. Incisions ↑ S/SX of infection / ~~inflammation~~ erythema. Will cont. to monitor. PT denies any further complaints / issues. — (b)(6)-2 SGT USA

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

558-103

(See instructions on Back of this Sheet)

NSN 7540-00-075-3766

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL

DATE			TIME
DAY	MONTH	YR.	
9	Oct	03	2110

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

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

HISTORY OBTAINED FROM
☒ PATIENT ☐ OTHER (Specify)

ALLERGIES
Ø 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

SEX: M AGE: 39

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: on Arrival

VITAL SIGNS

TIME	2110	2120	
BP	135/87	177/84	
PULSE	104	103	
RESP.	20	16	
TEMP.	100.8 (R)		
WT. (Child)	71 kg	100%	LnRA

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

ORDERS

	INITS.	TIME
Ancefi gm IM	[redacted]	2120
Id 0.5cc IM	[redacted]	2120
CBC, PT, PTT		
UA, HCG		
chem 12, Lytes		
CXR, KUB, plain		

ASSESSMENT/DIAGNOSIS
GSW (R) chest
(R) flank.

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

S: 39 y.o. ♂ c/o GSW to (R) chest + (R) lower back, onset tonight, A/Ox3, foley

39 y/o ♂ c/o GSW to (R) chest and (R) flank, CT @ BAT, foley / 25mg MSO4 IV
Sy Man IV. Pt Armed UNA Alerted
AAOx3

AMA - Ø
PSH - Ø
Fu - ?
LAST meal - 1900
FST (-)

G: WD, WN, NAD AAOx3
H-NCAT, PERRL, EOM, O/P (-)
(+) ecchymosis @ J'W
N: Ø meningismus, Ø JVD/Ø stridor
L: CTA (-) crackles CT on (R)
B: Hr 104, Ø M/R/G
Ext: Ø c/c/e
MAE: (+) (R) flank Entrance wound (1)

DISPOSITION (Check all that apply)

HOME	FULL DUTY

QUARTERS: 24 Hrs. | 48 Hrs. | 72 Hrs.

MODIFIED DUTY UNTIL:

DAY	MONTH	YEAR

REFERRED TO (Indicate clinic)

EMERGENCY	TODAY
72 HOURS	ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

CONDITION UPON RELEASE

IMPROVED	UNCHANGED
DETERIORATED	

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

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

(b)(6)-2

MP 002726

(Plan) (Include medications ordered, any limitations and follow-up)

(b)(6)-4

EMERGENCY CARE AND TREATMENT
Medical Record Copy

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

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

(b)(6)-2

/ ADDITIONAL INTRAOPERATIVE INTERVENTIONS NOTED.

MAJ, AN 11 OCT 03 DATE

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

LEVEL OF CONSCIOUSNESS: A&O Drowsy Sleepy Intubated

LEVEL OF ACTIVITY: Moves all Extremities (Y) (N) Moves upper Extremities Transferred to litter with roller due to spinal

BREATHING EASY: (Y) (N)

12. PREOPERATIVE EVALUATION PREPARED BY (b)(6)-2 MAJ, AN

DATE: 11 OCT 03 TIME: 1030

POSTOPERATIVE EVALUATION PREPARED (b)(6)-2 MAJ, A

DATE: 11 OCT 03 TIME: 1202

USAPAV1.0

REVERSE OF FORM 5179, JUN

MEDCOM - 7875

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

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

1. PATIENT TRANSPORTED TO OPERATIN[illegible] OOM VIA litter BY OR Staff
2. PATIENT IDE[illegible] VERIFIED BY [illegible] (b)(6)-2 PROCEDURE CPT, R
3. DATE 9 Oct 03 TIME PATIENT ARRIVED IN SUITE
4. PATIENT IN ROOM TIME 1015 NUMBER 1-1

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	CPT (b)(6)-2 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

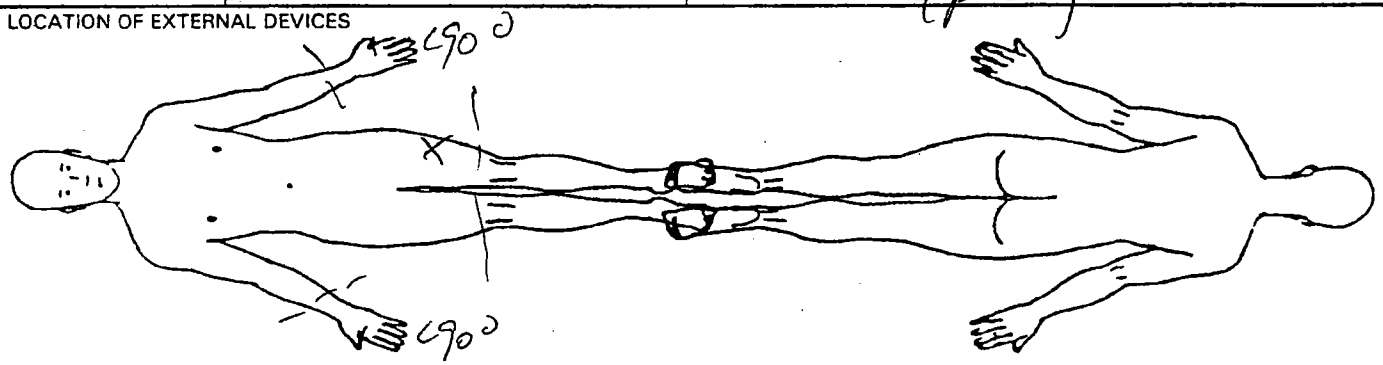
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* [redacted]
SITE: Nipple to groin BY WHOM: [redacted]
SITE: BY WHOM: (b)(6)-2
COMMENTS: Ø problems

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No		C	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☑ Yes ☐ No		C	C		
Instrument	☑ Yes ☐ No		C	C		
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 30/70
GROUND PAD: BRAND Valle Lab
LOT NO: 69671 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

ESU pad site clean prep - ok

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

MEDCOM - 7876

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S): NACL

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	NAME

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

	1.	2.	3.
TYPE/SIZE	16A Foley	Chest tube	Supra pubic
SITE	Bladder	(R) pleural space	(R) back towards

18. DRESSING/IMMOBILIZATION *(Specify)*

4x8 Cover All
abd pads

19. ADDITIONAL INFORMATION

Dr (b)(6)-2

Foley draining clear yellow urine from SR.
Chest pleural suac connected suction post intubation.

20. OPERATION(S) PERFORMED

facial laceration repair
Exploratory laparotomy / Appendectomy
I&D back GSW

21. PATIENT TRANSFERRED TO TCU TIME 0030 METHOD litter

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

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

MEDCOM - 7877

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

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

1. PATIENT TRANSPORTED TO OPERATIN[illegible]OM (b)(6)-2 VIA Litter BY CPT (b)(6)-2 CRNA

2. PATIENT IDENTIF[illegible] RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2

3. DATE 11 OCT 03 TIME PATIENT ARRIVED IN SUITE 1042

4. PATIENT IN ROOM TIME 1042 NUMBER 1 - 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Alert. Arabic speaking. Nurses confirmed NPO status.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)* Beanbag deflated. Axillary roll under Lt axilla. Pillow between legs + arms. Egg-crate under left dependent leg.

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

COMMENTS: Egg-crate between feet. Left leg bent. Right leg straight, (B) arms extended in front of body. Lt dependent arm resting on padded armboards

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

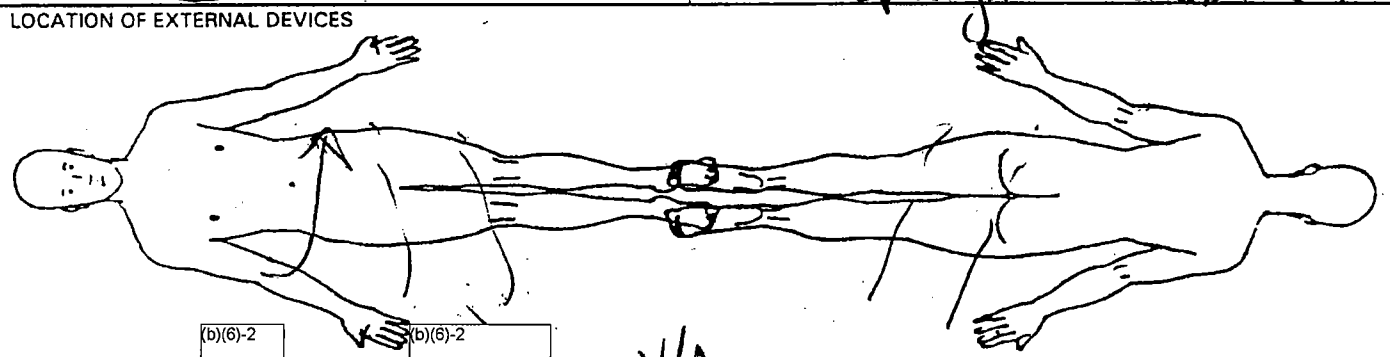
PREP SOLUTION *(Specify)* Beta/Beta

SITE: Rt lateral chest/flank BY WHOM: (b)(6)-2

SITE: back. BY WHOM:

COMMENTS: No pooling noted. Chux used.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Grou[illegible] (b)(6)-2 -- Safety Strap (b)(6)-2 = = = Tourniquet N/A

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCR[illegible] (b)(6)-2	CIRCULATOR (b)(6)-2
Sponge	☒ Yes ☐ No		C	C		
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

30/30

☒ ESU NO: VL FORCE IT 000442

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATU

(b)(6)-2

15. X-RAY IN OPERAT IF YES, SITE

YES ☐ N

16. TORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Xeroform
Petrolatum Gauze
Fluff
4X8 dressing sponges
Coverall

19. ADDITIONAL INFORMATION

RN

(b)(6)-2

20. OPERATION(S) PERFORMED

DPC + D+I - back wound
D+I, R+ flank / chest wound

21. PATIENT TRANSFERRED TO CU TIME 1202 METHOD Litter

22. REGISTERED NURSE SIGNATURE

(b)(6)-2

, MAJ, AN

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

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

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

1. PATIENT TRANSPORTED TO OPERATI[illegible] ROOM VIA litter BY CPT (b)(6)-2 CRNA

2. PATIENT IDENTI[illegible] RECORD REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 MAJ, AN

3. DATE 13 OCT 03 TIME PATIENT ARRIVED IN SUITE 0815

4. PATIENT IN ROOM TIME 0815 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO status verified by ICU staff See DA5179, dated OCT 03 for assessment data

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC (b)(6)-2 9 MD	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ (b)(6)-2 AN/610E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Bean bag deflated & patient placed on left side. Axillary roll under left axilla, lt arm extended in front resting on padded armboard. Pillow between arms, right arm resting extended on pillow. Leg-crate pillow for head. Rt dependent leg lient ~~rested~~ on leg crate & Rt leg straight resting on pillow b/w legs. Leg-crate bolsters under Rt foot/ankle.

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

COMMENTS:

8. SKIN PREPARATION

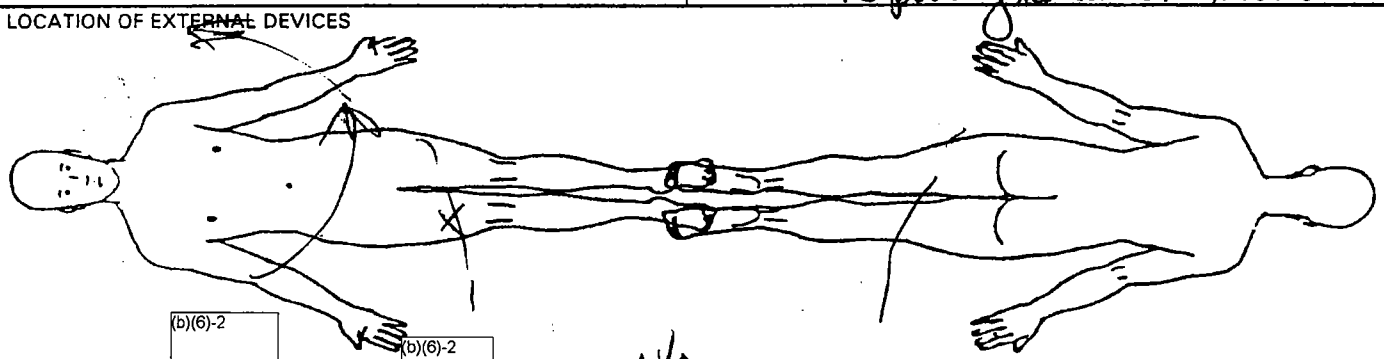
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine
SITE: Rt Chest + flank BY WHOM (b)(6)-2
SITE: Wall BY WHOM

COMMENTS: No pooling noted. Chux used.

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (b)(6)-2 -- Safety Strap (b)(6)-2 = = = 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		3	3		
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: 000442 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 - 7880

13. PROSTHESIS, IMPLANTS ☐ YE ☒ NO IF YES NAME: ID NUMBEF UFACTURER

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 warm

OTHER ORDERS	TIME	CARRIED OUT BY

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

15. X-RAY IN OPERATIN IF YES, SITE
YES ☐ NO

16. RY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Xeroform
4 X 8 dressing sponges
Covers, OS

19. ADDITIONAL INFORMATION
Dr. (b)(6)-2
CPT (b)(6)-2, CRNA

20. OPERATION(S) PERFORMED
I+D Rt chest wound + DPC

21. PATIENT TRANSFERRED TO ICU TIME 0935 METHOD litter

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

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

.19

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY				6			7																	
POST- DAY				3			4																	
MONTH-YEAR OCT	DAY			16			17			18			19			20			21					
2003	HOUR	11	12	·	01	1	·	0600	1	1	2	0	1	1	2	0	1	2	0	1	1	2	0	1	1	·
PULSE (0)	TEMP. F (°)	84	82		82	80			84	80	84	86	84	84	84	86	84	84	86	82	84	84	86	84	84	
	105°																									
180	104°																									
170	103°																									
160	102°																									
150	101°																									
140	100°																									
130	99°																									
	98.6°																									
120	98°																									
110	97°																									
100	96°																									
90	95°																									
80																										
70																										
60																										
50																										
40																										
RESPIRATION RECORD		16			34	4	4		3	5	16	5	16		16	5	7		16	6		16				
BLOOD PRESSURE		124/67	120/66		132/62	124/63		116/68		128/69	124/60		110/60		115/64		116/50		126/62		110/54	103/48			
					116/61			126/66		110/65	108/59		106/55		118/62		113/61		118/56		103/54	110/52			
																						118/63			
HEIGHT:	WEIGHT →																								
		99%	98%		98	97%		97%		66	98%		97%		98%		98%		98%						
					98			68		98	99%		98%		97%		95%		99%		99%	99%		98	
																					99%	95%			

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

(Centigrade Equivalents, for Reference only)

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)*

(b)(6)-4

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	
POST- DAY	
MONTH-YEAR	DAY 23
19	HOUR

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

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE 105/68

HEIGHT: WEIGHT → 180 lb

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

Ward/Section: ICU | R | Physician: (b)(6)-2

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

Name: (b)(6)-4 | Date: 9 Oct 03 | Time: | Patient # (b)(6)-4

Chemistry 7

Test	Result	Ref. Range
GLU	151 *	73 - 118 mg/dL
BUN	15	7 - 22 mg/dL
Creat	1.4	0.6 - 1.2 mg/dL
Na	141	128 - 145 mmol/L
K	4.4	3.3 - 4.7 mmol/L
Cl	105	98 - 108 mmol/L
tCO2	27	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	15.3	4.8 - 10.8 x 1E3
RBC	3.95	4.7 - 6.1 x 1E6
Hgb	12.7	14 - 18 g/dL (M); 12-16 (F)
Hct	39.8	45 - 52% (M); 37 - 47% (F)
MCV	100.8	80 - 99 fL
Plt	138	130 - 500 1E3
Lymph%	5.3	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 10 Oct 03 | Lab ID #

ENT

(b)(6)-2

ect to the Privacy Act of 1974)

Name: EPW

Date: 9 Oct 03

Time: 2115

(b)(6)-4

Chemistry 7		
Test	Result	Ref. Range
GLU	127	73 - 118 mg/dL
BUN	16	7 - 22 mg/dL
Creat	1.2	0.6 - 1.2 mg/dL
Na	142	128 - 145 mmol/L
K	4.6	3.3 - 4.7 mmol/L
Cl	105	98 - 108 mmol/L
TCO2	24	18 - 33 mmol/L

Chemistry 12/LFT		
ALB	3.7	3.5 - 5.5 g/dL
ALP	69	26 - 84 µg/dL
ALT	13	10 - 47 µg/dL
AMY	28	14 - 97 µg/dL
AST	28	11 - 38 µg/dL
Tbili	0.7	0.2 - 1.6 mg/dL
TP	7.3	6.4 - 8.1 g/dL
Ca	7.8	8.0 - 10.3 mg/dL
Chol	124	100 - 200 mg/dL
Creat	1.3	0.6 - 1.2 mg/dL
BUN	15	7 - 22 mg/dL
GLU	130	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	Dk Yellow	N/A
App	Clear	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	NEG	Negative
SGav.	1.030	N/A
Bld	MOD	Negative
pH	5.0	N/A
Prot	Small	Negative
Urob	0.2	0.2 - 1.0
Nit	NEG	Negative
Leuk	NEG	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	21.4	4.8 - 10.8 x 1E3
RBC	3.96	4.7 - 6.1 x 1E6
Hgb	13.0	14 - 18 g/dL (M); 12-16 (
Hct	40.3	45 - 52% (M); 37 - 47% (
MCV	101.8	80 - 99 fL
Plt	139	130 - 500 1E3
Lymph%	6.9	20.5 - 51.1 %

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

Coagulation		
PT	13.1	9.8 - 13.6 sec
aPTT	30.2	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 09 oct 03	Lab ID #

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	14 Oct 03	0530	(b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	5.6	4.8-10.8 x 10
RBC	3.17	4.7-6.1 x 10
Hgb	10.2	14-18g/dl (M) 12-16 g/dl (F)
Hct	31.7	45-52% (M) 37-47% (F)
MCV	100.0	80-94 fl (M) 81-99 fl (F)
Plt	164	130-500 x 10 Verified
Lymph %	27.7	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 7

TEST	RESULT	REF. RANGE
GLU	94	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
[redacted]		
NA*	134	128-145 mmol/l
K*	3.7	3.3-4.7 mmol/l
CL*	105	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/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:

CK 290

Remarks:

Reported by:	(b)(6)-2	DATE: 14 oct 03	LAB ID NO:

Ward/Section: ICU	Requesting Physician: (b)(6)-2	Laboratory Result Form (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI (b)(6)-4	DATE 15 OCT 03	TIME 0500	SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF.RANGE
WBC	6.1	4.8-10.8 x 10
RBC	2.84	4.7-6.1 x 10
Hgb	9.3	14-18g/dl (M) 12-16 g/dl (F)
Hct	28.6	45-52% (M) 37-47% (F)
MCV	100.8	80-94 fl (M) 81-99 fl (F)
Plt	147	130-500 x 10 Verified
Lymph %	12.0	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 7

TEST	RESULT	REF. RANGE
GLU	81	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
[redacted]		
NA*	133	128-145 mmol/l
K*	3.6	3.3-4.7 mmol/l
CL*	106	98-108 mmol/l
CO2	23	18-33 mmol/l

Misc. Serology

TEST	RESULT	REF RANG
PRP		Negative
Mono		Negative

Chemistry 12

Test	Result	Ref. Rang
ALB		3.5-5.5 g/d
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 m
CHOL		100-200 m
CRE		0.6-1.2 mg
GLU		73-118 mg
TP		6.4-8.1 g/d

MISC

Results:

Microscopic UA

Results:

Remarks:

Repo (b)(6)-2	DATE: 15 OCT	LAB ID NO: (b)(6)-4

Met 8 / CBC

Ward/Section: ICU

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

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

Name: (b)(6)-4

Date: 16 Oct 03

Time: 0500

Patient #

Chemistry 7

Test	Result	Ref. Range
GLU	94	73 - 118 mg/dL
BUN	11	7 - 22 mg/dL
Creat	0.9	0.6 - 1.2 mg/dL
Na	139	128 - 125 mmol/L
K	3.5	3.3 - 4.7 mmol/L
Cl	102	98 - 108 mmol/L
tCO2	25	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	92	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	6.5	4.8 - 10.8 x 1E3
RBC	3.40	4.7 - 6.1 x 1E6
Hgb	10.9	14 - 18 g/dL (M); 12-16 (
Hct	34.1	45 - 52% (M); 37 - 47% (
MCV	100.3	80 - 99 fL
Plt	163	130 - 500 1E3
Lymph%	18.9	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:

Reported By: (b)(6)-2

Date: 16 Oct 03

Lab ID #

MEDICAL RECORD — ANESTHESIA

DRUG	(Route)	
Fentanyl	(iv)	50 / 100 / 150 / 100 / 150
Versed	(iv)	2.0
Succ / Vec	(iv)	100 / 4 2 4
Neostig / Robinul	(iv)	4/0.4
	( )	
	( )	
ISOLAT AGENT 150	% del	2.0 2.5 1.5 2.0 1.5 1.5 1.5 — 8
	% et.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 2 2 2 2 2 7 — 8

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

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

FLUIDS		
LINE site	☐ Warmed	
LR 18g	☐ Warmed	1500 / 2400
	☐ Warmed	
	☐ Warmed	

LOSSES	
EST BLOOD LOSS	
URINE –	

TOTALS	TOTAL INF.
500	2.00
	TOTAL URINE
	450

FLUIDS – SUMMARY
CRYSTALLOID– 2000
COLLOID– Ø
BLOOD– Ø

REMARKS–
Code drugs with numbers, events with letters
2230 T, 2 AUMA IN PICU
2400 UNK SYM 3 Cam
NPB

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: 71 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP – 131 / 75 HR– 106

BLOOD CHECK: OK?– (Y) N

PATIENT READINESS: OK for PROCEDURE? TIME– 2020

TIME → 1815 30 23⁰⁰ 30 24⁰⁰ 30 01⁰⁰

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml		700	490	550	230	230	130	240	360
f – breaths/min		10	7	8	9	9	9	10	12
Peak inf pres / PEEP		16	13	16					
MODE– S(pon), A(assist), C(on)		S/C	C	C	C	SV	SV	CV	SV	SV
BP/Auto Cuff	ET CO2 (torr)	48	31	39	37	33	38	37	43	38
BP / oth	FIO2 (Frac or %)	90	90	90	89	90	90	120	90	90
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site	IV / Liquid								
	N-M Block (T/4)	4/4	0/4	2/4	2/4	2/4	4/4	4/4	4/4	4/4
Warming blkt										
Conv warmer										

RECOVERY AT 0040
PACU ICU_____ (Specify)
OTHER_____
CONDITION:
RESP– 12 SpO2– 97%
BP– HR– 102

ANES	Start	Room	End
	2200	2241	2045
PROC	Ready	Begin	End
	2225	2240	0030

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

PROCEDURES and CPT Codes
Rx - leg

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Pre-ox 5min 90% FIO2, RSI c Cricoid Pressure, 12 x 2 MAC 2, Grade I, min 8.0 ITT Placed 24cm @ lip = (+) ETCO2.

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

SURGEON: (b)(6)-2
A (b)(6)-2

PROCEDURE LOCATION 1 - 1
DATE 9 OCT 05
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 7889

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

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

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 10 OCT 03 TIME OF ORDER: 0001 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Admit ICU -
2. Dx: S/P Ex lap, (R) GSW chest
3. Cond - SI
4. Act - in chair TID
5. Allergy - NKDA
6. VS per routine, Pulse Ox
7. Diet - Clear liquids

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

8. IV: D5 1/2 NS @ 150 cc/hr
9. Foley to gravity
10. Chest tube to 20 cm H_2O suction pressure
11. Strict I's and O's
12. IS q 1 hour while awake
13. Meds: MSO_4 4-8 mg IVSP q 1° prn pain
    Zantac 50 mg IV TID 08, 16, 24

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

Unasyn 3.0 gm IV q 6° 06, 12, 18, 24
Phenergan 25 mg IVSP q 8° prn nausea
14. CBC, Chem 7 in AM
15. CXR in AM
16. CXR NW

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

NURSING UNIT | ROOM NO. | BED NO.

24° V 11 Oct 03 @ 050 (b)(6)-2 CPT AV LTC/MC

PATIENT IDENTIFICATION

DATE OF ORDER | HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DATE OF ORDER 11 02 03 TIME OF ORDER 1210 HOURS

LIST TIME ORDER NOTED AND SIGN

(b)(6)-2

(1) To Icu - Dr. (b)(6)-2

(2) SP I+D chest/Back Wounds

(3) Resume all pre-op orders.

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

(b)(6)-2

MAJ, MC USA
CHIEF, DOS

PATIENT IDENTIFICATION

(b)(6)-4

DAT

11 4 03 1600 HOURS

Tylenol 650 mg PO Q4-6° PRN for Temp > 101.5

V.O. Dr Downey (Gary Wallace, MD)

(b)(6)-2

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER 12 Oct 03 TIME OF ORDER 1200 HOURS

Ver. P. 12 Oct 1430 H

(b)(6)-2

VO Dr (b)(6)-2

(1) Regular diet

(2) NPO @ MN

Sign by Colon Surgery

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DA ORDER

HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 13 Oct 03 TIME OF ORDER: 0935 HOURS

LIST TIME ORDER NOTED AND SIGN

1. To ICU - Dr. (b)(6)-2
2. Dx - SP DPC chest wound
3. and allergies NKDA
4. VS q 1°, I+O, monitor, Pulse Ox
5. Act - up in chair QID
6. DIET - Regular
7. IV LR TKO 75 cc/hour

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

8. Chest tube to 20 cm H2O suction.
9. CXR now.
10. UNASYN 3 gm IVPB q 6°
11. TCDB q 1° INCENTIVE SPIROMETRY 10-20 x/hour
12. MORPHINE 2-8 mg IV q 2° pm/pm
13. PERCOCET - 1-2 po q 4° pm/pm

1000 dm

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

14. MOTRIN 600 mg 1 po q 6° w/ food
15. ZANTAC 150 mg 1 po BID
16. CXR in AM
17. CBC, chem 8 q AM
18. NOTIFY MD for T > 101°, P < 60 or > 110, SBP < 100 or > 150, RR or UO in 6 hours, Sat < 92%

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF O

(b)(6)-2

MAJ, MC USA
CHIEF, DOS

13 Oct 03 1300

VO Dr [redacted] b(6)-2

1. Ambulate QID in ward

Taken by [redacted]

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

transcribed CPT 13 Oct 03 1210

NURSING UNIT | ROOM NO. | BED NO.

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

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: 13 Oct 03 TIME OF ORDER: 1000 HOURS

LIST TIME ORDER NOTED AND SIGN

VO Dr [redacted] b(6)-2

(1) O2 per NC @ 2L

Verified (b)(6)-2 1310 13 OCT 03.

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

MAJ, MC USA CHIEF, DOS

NURSING UNIT | ROOM NO. | BED NO.

24hr 13 Oct 03 @ 0700 (b)(6)-2

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER: 15 Oct 03 TIME OF ORDER: 0030 HOURS

(1) VO Per Dr (b)(6)-2 — CXR qAM

Noted

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

MAJ, MC USA CHIEF, DOS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 15 OCT 03 TIME OF ORDER: 1315 HOURS

Verified 15 OCT 03 1325 (b)(6)-2

VO Dr [redacted]

(1) Fentanyl 50mcg IV x 1 now

(2) CXR x 1 @ 1600

[redacted] MD

MAJ, MC USA CHIEF, DOS

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER: 15 Oct 03 TIME OF ORDER: 1645 HOURS

(1) Albuterol 0.5cc / 3cc NS Neb

Noted Doctor [redacted] b(6)-2

(b)(6)-2 MD

MAJ, MC USA CHIEF, DOS

NURSING UNIT | ROOM NO. | BED NO.

24hr 16 Oct 03 @ 0430 (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 15 Oct 03 TIME OF ORDER 1711 HOURS

LIST TIME ORDER NOTED AND SIGN

1 Vital Signs to Q4°

V.O. Dr (b)(6)-2 (b)(6)-2 (b)(6)-2 1711

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

MAJ, MC USA
CHIEF, DOS

24° V 16 Oct03 @ 0430 (b)(6)-2 CPT AN

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 20 OCT03 1130 HOURS

1 DC Unasyn IV.

V/O (b)(6)-2 (b)(6)-2

(b)(6)-2 CPT, MSC

(b)(6)-2 MD

MAJ, MC USA
CHIEF, DOS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

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

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: 16 OCT 03 TIME OF ORDER: 0950 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Transfer to ICW - DR (b)(6)-2
2. DX - SP GSW to chest/Flank
3. Cond - Stable
4. NKDA
5. VS q 6°
6. ACTIVITY - up in chair QID, AMBULATE WITH ASSISTANCE QID

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

7. DIET - REGULAR
8. HEP LOCK IV
9. UNASYN 3 grams IVPB q 6°
10. PERCOCET GIVE 1-2 po q 4° PRN/PAIN
11. COLACE 100mg - 1 po BID
12. MOTRIN 600mg - 1 po q 6° w/food PRN/PAIN
13. ZANTAC 150mg 1 po BID

noted (b)(6)-2 16 OCT 03 1100

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

14. PRENATAL VIT - 1 po q AM start today
15. TCDB q 1°, INCENTIVE SPIROMETRY 10-20 q 1 hr
16. CXR tomorrow AM
17. NOTIFY MD for T>101°, P<60 or >110, SBP<100 or >160

(b)(6)-2 CPT AND 3/8 OCT 03 24 (b)(6)-2 MAJ. MC USA CHIEF, DOS

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 21 OCT 03 TIME OF ORDER: 2300 HOURS

1. DC tomorrow to MP custody

24 Chart Check (b)(6)-2 (b)(6)-2 RET/AN 22 OCT 03 @0245

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

MEDCOM - 7895

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED: 9	10	11	12	13	14	15	16						
[redacted]				(b)(6)-2 [redacted]													
10 Oct 03	S...	VS per routine: q 4	06	(b)(6)-2 [redacted]					Rewritten								
		Pulse Ox	18	(b)(6) [redacted]													
10 Oct 03	SI	Diet: clear liquids	06	/ (b)(6)-2 [redacted]					D/C'd		(b)(6)-2 [redacted]						
			18	(b)(6)-2 [redacted]													
10 Oct	SI	Foley to gravity	06	(b)(6)-2 [redacted]					D/C'd		(b)(6)-2 [redacted]			OR 1900			
			18	(b)(6)-2 [redacted]										13 Oct 03			
10 Oct 03	S...	Chest tube to 20cm H_2O	06	/ (b)(6)-2 [redacted]													
		pressure suction	18	(b)(6)-2 [redacted]					O								
[redacted] (b)(6)-2																	

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: S/P Ex lap, (R) GSW chest

13 OCT 03 DX: S/P DPC Chest WND COND: STABLE

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

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

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Oct Yr 03

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10 Oct 03	(b)(6)-2	Admit to ICU	10 OCT 03		0100	(b)(6)-2
10 Oct 03		Condition: SI	10 Oct 03		0100	
10 Oct 03		CBC, Chem 7 in Am	10 Oct 03		0500	
10 Oct 03		CXR now	10 Oct 03		0105	
10 Oct 03		CXR in Am	10 Oct 03	0600	130	
11 Octobr		Transfer to ICU	11 Octobr	1210	1210	
11 Octobr		S/P I+D Chest/Back Wounds	11 Octobr	1210	1210	
11 Octobr		Resume all pre-op orders	11 Oct	1210	1210	
12 Oct		NPO midnight	12 Oct	2400	Due	
13 Oct		CBC, Chem 8 in Am	14 OCT 03	0500	Order Rescheduled on Rescheduling SIXG	
13 Oct		CXR in Am	14 OCT 03	0500	Due	(b)(6)-2
13 Oct		CXR X 1 now	13 OCT 03	1000	1000	
15 Oct		CXR X 1 @ 1600	15 OCT 03	1600	Due	
	.....					
	.....					
	.....					
	.....					

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 16	17	18	19	20	21	23
16 Oct	(b)(6)-2	VS q 6°	06	(b)(6)-2						
			12							
			18							
			24							
	(b)(6)-2									
16 Oct		ACTIVITY OOB IN CHAIR	06	(b)(6)-2						
		QID, AMBULATE Z ASST QID	12							
			18							
			22							
16 Oct	(b)(6)	DIET: REG	06	(b)(6)-2						
			12							
			18							
16 Oct	(b)(6)-2	TCDB q1°, INCENTIVE	06	(b)(6)-2						
		SPIROMETER 10-20 q1°	14							
			22							
16 Oct	(b)(6)-2	NOTIFY MD FOR T > 101°,	06	(b)(6)-2						
		P < 60 > 110 SBP < 100 > 160	14							
			22							

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	S/P GSW TO CHEST / FLANK	PAGE NO: ____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

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
16Oct	(b)(6)-2	TRANSFER TO ICW — D.R. (b)(6)-2	16Oct	0950	1050	(b)(6)-2
16Oct		S/P GSW to CHEST/PLATIC	16Oct	0950	1050	
16Oct		Comp: stable	16Oct	0950	1050	
16Oct		CXR Tomorrow A.m	17Oct	A.M.		
10/22/03		DC tomorrow to MP custody	22OCT03			

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED (9, 10, 11, 12 noon, 14, 15, 16)
10 Oct 03	[redacted]	IV: D5½NS @150 cc/hr	06	/
b(6)-2			18	[redacted]
10 Oct 03	[redacted]	Zantac 50mg IV TID	08	/
			16	/
			24	0115 [redacted]
10 Oct 03	[redacted]	[redacted]	06	[redacted]
[redacted]			12	[redacted]
[redacted]			18	[redacted]
[redacted]			24	[redacted]
[redacted]			06	[redacted]
[redacted]			12	[redacted]
[redacted]			18	[redacted]
[redacted]			24	[redacted]
[redacted]			06	[redacted]
[redacted]			12	[redacted]
[redacted]			18	[redacted]
[redacted]			24	[redacted]
[redacted]		IVFS LR @ 75 cc/hr	06	[redacted]
[redacted]			18	[redacted]
13 OCT 03	[redacted]	CBC, chem 8 qam	05	/ / / / / Reinitiated
13 OCT 03	[redacted]	Albuterol neb 2.5 in 3cc NS	06	/ / / / / / /
		NSB q 6°	12	/ / / / / / /
			18	/ / / / / / /
			24	/ / / / / / /

(b)(6)-2

DC'd 13 OCT 03 1000 [redacted]

DC'd 13 OCT 03 1000 AM [redacted]

[redacted] DC'd 13 OCT 03

ALLERGIES: ☐ YES ☒ NO

NKDA.

PRIMARY DIAGNOSIS: 13 OCT 03 DX: DAC chest HAVP

S/P Ex Lap, (R) Chest GSW

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

26

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Oct Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
15Oct	(b)(6)-2	T Albuterol .5cc / 3cc NS NOSD	15Oct	17Oct	1700	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
10 Oct 03	(b)(6)-2	MSO4 4-8mg IVSP	Date	10 Oct	10 Oct	10 Oct	10 Oct	10 Oct	10 Oct	10 Oct 03	10 Oct 03	11 Oct 03	11 Oct 03	11 Oct 03	11 Oct	12 Oct
		q1° PRN pain	Time	0000	0300	0700	0900	1100	1500	1900	2145	0315	0655	1517	2100	0900
			DOSE	4mg	3mg	4mg	4mg	4mg	4mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg
			Initial	(b)(6)-2												
10 Oct 03	(b)(6)-2	Phenergan 25mg	DATE	10 Oct	10 Oct											
		IVSP q8 PRN nausea	TIME	0115												
			Initial	(b)(6)-2												
10 Oct 03	(b)(6)-2	[redacted]	D	[redacted]												
			I	(b)(6)-2												
			K													
		MSO4 4-8mg IVSP	Date		10 Oct	10 Oct	10 Oct									
			1615	IM	5mg		0200	0400								
		q1° PRN pain	(b)(6)-2		2100	0000		5mg SC								

USAPA V1.00

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

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

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

NKDA

PRIMARY DIAGNOSIS:

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

(b)(6)-4

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. OCT Yr. 03
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
15 OCT	(b)(6)-2	Fentanyl 50 mcg IV +1 now	15 OCT	1315	1315	(b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
16 OCT	(b)(6)-2	[redacted]														

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo. ____ *Yr.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 16	17	18	19	20	21	22	23
16 Oct	(b)(6)-2	HL IV	06	(b)(6)-2							
			14	(b)(6)-2							
			22								
16 Oct	(b)(6)-2	Unasyn 3gm IVPB q6°	06	(b)(6)-2							
			12	(b)(6)-2							
			18								
			24								
16 Oct	(b)(6)-2	Colace 100mg 1 PO QD	10	(b)(6)-2					(b)(6)-2		
16 Oct	(b)(6)-2	Zantac 150mg 1 PO BID	08	(b)(6)-2					(b)(6)-2		
			20								
16 Oct	(b)(6)-2	Prenatal Vit 1 PO q Am	08	(b)(6)-2					(b)(6)-2		

D/C'd (b)(6)-2

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS: S/p CSW TO CHEST/FLANK

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													
11600	(b)(6)-2	Percocet 1-2 q 4°														
- - - - -	- - - - -	PRN / PAIN														
- - - - -	- - - - -															
11600	(b)(6)-2	Motrin 600mg 1 po q 6°														
- - - - -	- - - - -	with food PRN / PAIN														
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

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		INITIALS		INITIALS
NEURO	PUPILS					0050	(b)(6)-2
	SENSORIUM					3mm PERRLA	
						A&Ox2, Uncooperative	
RESPIRATORY	RESPIRATORY PATTERN					Even, Unlabored	
	BREATH SOUNDS					CTA, Diminished	
	SECRETIONS					⊖ Secretions / ⊖ Cough	
						O2 @ 6L/NC Sp02 100%	
SKIN	COLOR					NFR	
	INTEGRITY					Intact	
IV SITE	LOCATION					(R) AC SL	
	CONDITION					(L) AC ⊂ D5½@150	
						Midline Mod Drainage	
						CDI, (R) Flank Drainage	
						CDI, (R) Chest Tube ⊖	
						Draining Bloody Drain	
GASTRO	ABDOMEN					Soft, Tender to Pal	
	BOWEL SOUNDS					hypo X4	
GU	URINE:					Foley to Gravity	
	COLOR/CLARITY					Yellow Clear	
CARDIOVASCULAR	CARDIAC RHYTHM					NSR-ST	
						PR .16 QRS .08	
						+2 Pulses UE/LE Bilat	

LEGEND

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 9 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

9Oct03 GSW ~~#~~ Flank S/P L1 + Exp Lap

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																		
Temperature																		
Pulse																		
Respiratory Rate																		

INTAKE

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

OUTPUT

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

(b)(6)-4

9/24/03

POST-OP DAY

	22	23	24	01	02	03	04	05	
VITALS									
				87/73	146/85	135/80	103/81	137/51	
				99A		97 6			
				126	85	100	85	85	
				20	13	11	8	4	
				99%	100%	97	100	100	
				RA	6L/NC	6L/NP	RA	4L/NC	

	22	23	24	01	02	03	04	05	8° T
D5½				150	150 300	150 150	150 100	150 150	750
								OR	2000
IVP				50	50				
				69/150	200/150	50/100	225/115		1125
							OR 4/0		450
							EBL		200
CT				14	0/14	0/14	4/18	0/18	18

ACUITY LEVEL CLASSIFICATION

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

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

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

24 H I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	750	Urine:	1525
OR	2000	EBL	200
		CT	18
TOTAL	2750	TOTAL	1743

BALANCE 1007

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS (b)(6)-2		INITIALS	1900	INITIALS (b)(6)-2
NEURO	PUPILS	Pupils 3mm brisk - drops 3				PERRL	
	SENSORIUM	MAE x4 - c/o pain to				A+O x3.	
		incision site. Hand				MAE's.	
		grips equal strength				medicated c̄ morphine for	
						c/o pain.	
RESPIRATORY	RESPIRATORY PATTERN	Even + unlabored.				even, nonlabored.	
	BREATH SOUNDS	Lungs CTA, diminished				(R) base diminished	
	SECRETIONS	breath sounds to (R)				chest tube to (R) chest c̄	
		base. Chest tube to				recent thoracotomy. no	
		20cm suction. Minimal				air leak noted, drsg x2	
		drainage.				to (R) chest	
SKIN	COLOR	Dressings to abdomen,				WNL.	
	INTEGRITY	(R) flank. Abrasions				Drsg to back and abdomen	
		noted to (R) arm				c̄ small amt drainage, intact	
IV SITE	LOCATION	18G to (L) AC, D5½NS				DAC PIV c̄	(R) AC 18G left
	CONDITION	@ 150 c/hr, (R) AC 18G				D5½NS @ 150 c/hr	patent, dry
		Heplock. Sites c̄				infusing, site	+ site intact
		redness or infiltration				+ drsg intact	
						+ patent	
GASTRO	ABDOMEN	Median incision				Soft, flat c̄ midline	
	BOWEL SOUNDS	Covered c̄ 4x4's				drsg. (A) hyperactive	
		drainage, dressing clean				BS auscultated.	
		intact abdomen.					
GU	URINE:	Foley to gravity, clear				Foley → gravity → bag	
	COLOR/CLARITY	yellow urine.				clear yellow	
CARDIOVASCULAR	CARDIAC RHYTHM	SR c̄ occ PVC. 20				NSR c̄ ectopy.	
		ORS. 10. Pulses				pulses palpable	
		to all extremities				to all extremities	
		no 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)

PR (b)(6)-2 | CPT/AN | DEPARTMENT/SERVICE/CLINIC: ICU | DATE: 10 Oct 03

PATIENT IDENTIFICATION (If 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

(b)(6)-4

10 Oct 65w r/ank s/p (R) CT + exp Lap

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	150/44	112/50	135/68	112/66	131/65	124/64	118/65	135/53		134/71	133/63	127/66	118/67	124/67	108/58	128/66	126/69	
	Temperature		98.4			100.0			100.1			100.5		100.6		99.7			
	Pulse	90	92	106	92	91	97	84	93		91	93	90	90	91	90	95	99	
	Respiratory Rate	8	13	16	11	10	12	14	11		18	11	11	13	18	16	12	20	
	SPO^2	100%	100%	96%	98%	95%	97%	95%	95%		96%	95%	96%	97%	95%	95%	95%	96%	
	O_2	NC2L	NC2L	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	R/A	R/A	R/A	

INTAKE	TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
	D5 ½ NS	150	150 300	150 450	150 600	150 750	150 900	150 1050	150 1200	200	150 1350	150 1500	150 1650	150 1750	150 1900	150 2050	150 2200	150 2350	
	IVP	100		50 150				100 250		200			50 300		100 400				
	PO							100 110		110						250 360			
	TOTALS									1550									

OUTPUT		HOUR / TOTAL																	
	URINE			200 200	200 400	200 600	200 800	100 900	100 1000	100 1100		150 1250	50 1300	200 1500	150 1650	150 1800	450 2250		225 2475
		SP GR																	
		S/A																	
	NG	OUTPUT																	
		pH																	
		GUIAC																	
	EMESIS																		
	STOOL																		
	DRAINS	CT/R	25	25							940								
		Suction	700	700							1500						5		34
	TOTALS																		

10 Oct 03

POST-OP DAY

	22	23	24	01	02	03	04	05
BP	117/68	117/67	124/71	119/61	132/78	122/63	126/68	122/66
Temp		98.9				99.4		
HR	98	95	94	94	100	94	100	101
RR	14	12	16	15	24	18	14	16
O2 sat	96	95	95	95%	94%	96%	94	95
O_2	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

	22	23	24	01	02	03	04	05	8° T
	150	150	150	150	150	150	150	150	
	2500	2600	2800	2950	3100	3250	3400	3550	3550
			150						550
			550						360
									4460
	225 / 2200		300 / 3000		400 / 3400		600 / 4000		4000
T	10/44		15/59			39/99	14/100		100

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	0430									
	GLUCOSE	151									
	Na/K	141 / 4.4									
	Cl/CO_2	102 / 27									
	BUN/Cr	15 / 1.4									
	WBC/PLATELET	15.5 / 158									
	Hct/Hgb	39.5 / 12.7									

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

24 H I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL	4460	TOTAL	4100
BALANCE	+360		

NURSE SIGNATURE (b)(6)-2 | INITIALS (b)(6)-2

(b)(6)-2

MEDCOM - 7911

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

(b)(6)-2

		TIME	0600	INITIALS		INITIALS	(b)(6)-2
NEURO	PUPILS		Pupils 3mm bilat				Perrl - 3mm
	SENSORIUM		MAE x4. Amb I.				Pt alert, quiet
			c/o pain at incision				able to move all ext
			site. Medicated prn c				
			morphine.				
RESPIRATORY	RESPIRATORY PATTERN		Even + unlabored.				RRR - suction off
	BREATH SOUNDS		Lungs CTA on (L) side,				lung assessment clear
	SECRETIONS		diminished on (R) lower				(L) side - shallow
			lobe - Coughing up				breaths ⊘ cough
			clear tinged secretions				
			CTA (R) lower lobe, decr breath				
SKIN	COLOR		Normal for race. Slight				normal for race
	INTEGRITY		bloody drainage to mid				
			abdominal site, (R) chest tube				
IV SITE	LOCATION		18G to (L) AC, D5W/NS				D/C (R) AC IV
	CONDITION		@ 150cc/hr, 18G to				(L) AC D5/2NS 150cc/hr
			(R) AC, Both sites				c IVPB
			redness or drainage.				
GASTRO	ABDOMEN		BS x4 Quadrants.				hypo-active BS,
	BOWEL SOUNDS		mildly distended. Incision				(R) lower quadrant
			c bloody drainage at the				⊘ BM
			top.				
GU	URINE:		Foley to gravity, clear				foley to Gravity
	COLOR/CLARITY		yellow urine.				
CARDIOVASCULAR	CARDIAC RHYTHM		Sinus Tachycardia, PR ↓				NSR - HR 100's
			ons. IV. Pulses 2+ to				(R) cap refill ⊘
			and extremities. Cap refill				pulses
			brisk. No edema or clubbing.				

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

CPT AHY

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 11 OCT 03

(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	124/71	129/71	109/70	132/79	132/79	–	132/70	115/68		113/69	119/70	116/70	125/70	120/71	100/62	110/62	134/79	
Temperature	99.4			100.5			100.3				101.5		101.2		100.5		100.3	
Pulse	106	105	105	110	110	OR	114	109		102	103	104	99	105	101	100	102	
Respiratory Rate	15	18	17	18	18		11	18		18	17	15	15	16	17	16	15	
Oxygen	RA	RA	RA	RA	RA		RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	
O2 Sat	98%	98%	98%	95%	96%		95%	95%		98%	98%	98%	97%	99%	98%	98%	98%	

Slowing Energy

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
D5 1/2 NS	150 / 150	150 / 300	150 / 450	150 / 600	150 / 750	700 / 1450	150 / 1600	150 / 1750	1750	150 / 1900	150 / 2050	150 / 2200	150 / 2350	150 / 2500	150	150	150	
IVPB	100 / 100		50 / 50				100 / 200		200			50 / 300		100 / 400				
PO																		
TOTALS									2000									

OUTPUT

URINE	HOUR / TOTAL	150 / 150	75 / 225	75 / 300	150 / 450	150 / 600	350 / 950	–	200 / 1150		100 / 1050	100 / 1300	100 / 1400	100 / 1500	100 / 1600	75	75	100	1250
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	RT CHEST TUBE	10 / 10			–		40						10				5	55
	Total Chest Tube Output				80		120						130				135	135
TOTALS																		

POST-OP DAY

	22	23	24	01	02	03	04	05	
	135/79	125/66	128/64	106/70	123/66	124/69	128/70		
T	100.2	99.2	—						
A	100	100	98	92	89	87	86		
L	16	13	10	14	10	10	11		
	RA	RA	RA	RA	RA	RA	RA		
	98.0	97.0	97.6	99.1	98.6	99.0	98.4		

	22	23	24	01	02	03	04	05	8° T
	150	150	150	150	150	150	150	150	1150
			150						150
	125	125	125	100	100	100	100	100	2850
				10Ø				10	
				145				155	155

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME										
	MODE										
	F_iO_2										
	TV										
	RATE										
	PEEP										
ABG	A: pH										
	A: PCO_2										
	A: 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 HR I&O TOTALS	NURSE'S SIGNATURE	INITIALS
wt Yesterday ____ wt Today ____	(b)(6)-2 CPT AN	(b)(6)-2

	INTAKE	OUTPUT
IV		Urine:
po		
TOTAL	4300	TOTAL 3005
BALANCE	1295	

MEDCOM - 7914

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	INITIALS		INITIALS		INITIALS
NEURO	PUPILS	0630	(b)(6)-2			awake, trying to keep	
	SENSORIUM	awake, moaning				aware of surroundings	
		(a) in bed, follows				moves all extremities	
		command language					
		barrier					
RESPIRATORY	RESPIRATORY PATTERN	RR Reg RR 14 SpO2 100%				Deb – even unlabored	
	BREATH SOUNDS	LS: CTA ↓ bases				Lungs CTA – ↓ bases	
	SECRETIONS	CT (R) side intact				Ds None	
		& secretions					
SKIN	COLOR	normal for race				normal – incision	
	INTEGRITY	Abd. incision – stable				well approx – no discharge	
		dressing (R) lower abd CDE				↑ SS/S of infection	
IV SITE	LOCATION	18g IV (D) forearm					
	CONDITION	↑ S/S infiltration				18g IV (D) FA	
		infusing D5 1/2 NS				D5 1/2 NS 150 cc/hr	
		@ 150cc/hr					
GASTRO	ABDOMEN	Abd soft, non distended				Abd soft – non tender	
	BOWEL SOUNDS	abd incision				(+) BS hyperactive	
		(+) BS XCL quads				NPO ? undigested food	
GU	URINE:	Foley ↓ gravity				Foley to gravity	
	COLOR/CLARITY	drainage clear yellow				CPS dark yellow	
		urine				urine	
CARDIOVASCULAR	CARDIAC RHYTHM	HR ~~[illegible]~~ 91				HR 80-100s	
		S1 S2 normal				NSR S1 S2	
		(+) peripheral pulses				(+) peripheral pulses	
		bil					

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

SGT 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 12OCT03

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	129/71	120/64	125/71	132/64	124/68	122/18	137/67	109/53		132/62	148/70	125/69	113/56	130/72	[illegible]	121/57	124/64	
Temperature	98.4					97.9						98.2		98.9		98°		
Pulse	90	88	91	92	87	84	92	96		92	85	86	85	93	89	90	99	
Respiratory Rate	10	10	16	17	17	10	13	12		17	19	22	11	14	13	10	8	
P.O.	98%	100%	100%	100%	97%	100%	99%	100%		99%	100%	98%	99%	100%	99%	100%	99%	
Source	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	

Zantac
Personal Hygiene
Unazyn
Zantac
Nsg Hygiene

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
IVF	150 / 150	150 / 300	150 / 450	150 / 600	150 / 750	150 / 900	150 / 1050	150 / 1200	1200	150 / 1350	150 / 1500	150 / 1650	150 / 1800	150 / 1950	150 / 2000	150 / 2150	150	
IVPB	100 / 100	100 / 100	50 / 150	0 / 150	0 / 150	0 / 150	100 / 250	0 / 250	250	0 / 250	0 / 250	50 / 300	0 / 300	100 / 400				
PO	100 / 100	100 / 100	100 / 100	100 / 100	0 / 100	0 / 100	0 / 100	0 / 100	100	120 / 220	0 / 220	0 / 220	0 / 220	100 / 320				
													220					
TOTALS																		

OUTPUT

Foley URINE	HOUR	100	200	250	250	250	250	300	250	200	200	200	200	225	125	150	150	
	TOTAL	100	300	550	800	1050	1300	1600	1850	2050	2250	2450	2700	2925				
	SP GR												2700					
	S/A																	
NG	OUTPUT																	
	PH																	
	GUIAC																	
EMESIS																		
STOOL																		
CT DRAINS		→	36cc	15/50	15/67	4/71	10/81	7/88	8/96	5/93	0/93	10/103	5/108	0/108				
													2603					
TOTALS																		

POST-OP DAY

	22	23	24	01	02	03	04	05	
	121/57	124/72	113/62	124/64	124/72	121/57	124/80	120/66	
			98				93		
	82	90	85	86	88	91	82	90	
	13	12	9	8	11	12	20	18	
	99%	100%	100%	100%	100%	100%	100%	100%	
	RA	RA	RA	RA	RA	RA	RA	RA	

	22	23	24	01	02	03	04	05	8° T
	150	150	150	150	150	150	150	150	3350
			150						
			NPO						
	200	200	200	200	150	150	175	150	4775
								10/110	118

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	TIME										
	MODE										
	F_IO_2										
	TV										
	RATE										
	PEEP										
ARTERIAL BLOOD GASES	A: pH										
	A: PCO_2										
	A: 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	0900				TIME				
	MOUTH CARE	KW			TURN					
	BATH	KW								
	SKIN CARE	KW								
	FOLEY CARE	KW			SUCTION					
	TRACH CARE	/								
	ROM EXERCISES	/								

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	3350	Urine:	
po	320	CT	118
IVPB	550		
TOTAL	4220	TOTAL	4893
BALANCE	+673		

NURSE'S SIGNATURE | INITIALS

(b)(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0630	INITIALS (b)(6)-2	1618	INITIALS (b)(6)-2		INITIALS
NEURO	PUPILS	2mm & PERLA		2mm (R) PERRLA			
	SENSORIUM	alert, awake, follows commands, moves all extremities		AAOX3 MAE x4 Follows All Commands			
RESPIRATORY	RESPIRATORY PATTERN	even & unlabored		Even & Unlabored			
	BREATH SOUNDS	CTA diminished (R) ↓		CTA, Slightly ↓ (R) LL			
	SECRETIONS	Ø noted, (R) chest tube @ 20cm H2O suction & minimal serosanguinous drainage		CT (R) to 20cm H2O Serosanc Drainage Dsg CDI			
SKIN	COLOR	normal for race		WNL For Race			
	INTEGRITY	dsg to CT, upper side exit wound & midline abd all CDI		Exit Wound & Midline Abd CDI			
IV SITE	LOCATION	(L) wrist infusing		(R) wrist PIV & LR @			
	CONDITION	LR @ 75cc/h, Ø signs infiltration or infection		75cc/hr Ø S/S Infiltration/Infection			
GASTRO	ABDOMEN	soft, mildly distended		Soft, NT BS x4			
	BOWEL SOUNDS	Ø x4 quads, reg diet very little appetite		Ø c/o N/V/D			
GU	URINE: COLOR/CLARITY	None yet this shift		Voids per urinal Denies Difficulty			
CARDIOVASCULAR	CARDIAC RHYTHM	NSR, all pulses palpable, Ø edema noted		NSR & Ectopy PP (+) x4 Ø Edema Cap refill < 3sec			

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

CPT AN

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 13 Oct 03

(When classification of type of each 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	120/62	100/62	136/61	119/64	135/61	104/61	104/61	124/66		111/60	117/55	120/61	122/74	124/70	130/67	125/54	134/63	
Temperature	97													97.6				
Pulse	74	70	79	78	74	74	71	74		76	72	68	67	69	75	65	72	
Respiratory Rate	12	8	10	9	13	12	13	16		14	15	16	15	10	16	8	15	
Oxygen	2L nc	2L	2L	2L	2L	RA	RA	RA		RL	2L	2L	2L	2L	2L	2L	2L	
O2 sat	100%	100	100	100	100	97	99	100		100	99	100	100	100	98	100	100	

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR	75 / 75	75 / 150	75 / 225	75 / 300	75 / 375	75 / 450	75 / 525	75 / 600	600	75 / 75	75 / 150	75 / 225	75 / 300	75 / 375	75 / 450	75 / 525	75 / 600	600
IVPB	100 / 100						100 / 200		200					150 / 150				150
PO														30 / 30				50
TOTALS									800									800

OUTPUT

			06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
URINE	HOUR / TOTAL			400 / 400							400				800 / 800			250 / 1050		
	SP GR																			
	S/A																			
NG	OUTPUT																			
	pH																			
	GUIAC																			
EMESIS																				
STOOL				XT																
DRAINS																				
TOTALS										400										1050

POST-OP DAY

	22	23	24	01	02	03	04	05
	119/58	116/61	130/60	137/65	127/53	126/55	124/60	130/64
	71	78	71	69	64	62	71	72
	12	15	14	8	8	11	9	19
	2L	2L	2L	2L	2L	2L	2L	2L
	100	100	100	100	100	100	100	100

	22	23	24	01	02	03	04	05	8° T
	75	75/150	75/225	75/300	75/375	75/450	75/525	75/600	600
					100/100				100
	50/50		50/100						100
									800
						425/425			425

ACUITY LEVEL CLASSIFICATION

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

LABORATORY	TIME	0530								
	GLUCOSE	94								
	Na/K	134/3.7								
	Cl/CO_2	105/25								
	BUN/Cr	8/1.0								
	WBC/PLATELET	5.6/164								
	Hct/Hgb	37/10.2								

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	2250	Urine:	1875
PO	150	CT	70
TOTAL	2400	TOTAL	1945
BALANCE	455		

NURSE'S SIGNATURE

(b)(6)-2

(b)(6)-2

MEDCOM - 7920

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 (b)(6)-2		INITIALS	1900	INITIALS (b)(6)-2
NEURO	PUPILS	2mm 2mm Reactive				PERRL	
	SENSORIUM	AAO x3, responds appropriately				A+O X3	
		to commands, single question				MAE 5	
		⊕ movement, sensation to all				⊕ commands	
		extremities.				⊖ pain	
RESPIRATORY	RESPIRATORY PATTERN	Non labored, movement		chest wall to warm		easy non labored	
	BREATH SOUNDS	symmetrical. BS clear		suction ī minimal		diminished RLL	
	SECRETIONS	throughout, diminished ⊕		sensanguinous op.		⊖ secretions.	
		base. ⊘ cough ⊘ secretions.				2LNC → O2sat 100%.	
		100% SaO2 RA RR 14-15				use incentive spirometer	
		BPM. ⊘ dyspnea, sob. ⊕ CT to ⊕ lateral				well.	
SKIN	COLOR NPR	NPR, warm, dry. ⊕ midline incision, dsg OI ⊕ CT to ⊕ side				WNL	
	INTEGRITY	INTACT, ī ⊕ evidence of minimal				see note for drays.	
		Bruising Rt PIV stick.					
IV SITE	LOCATION	20 g PIV, CDI placed				⊕ wrist PIV.	
	CONDITION	12 OCT 03 infusing				site + dsg intact.	
		D5½NS @ 150 cc/hr to				LR @ 75 cc/hr	
		⊕ FA. ⊘ evidence infection,				infusing, site patent.	
		infiltration.					
GASTRO	ABDOMEN	TAWT, minimally distended.				slightly distended.	
	BOWEL SOUNDS	tender on palpation to Rlat.				⊕ BS x4 quads.	
		LQ. ⊕ BS x4q. ⊖ Flatulence				appetite good, refused	
		(pt. denies), ⊖ N, ⊖ V. Pt NPO on call to OR				dinner.	
GU	URINE:	⊘				voids in urinal	
	COLOR/CLARITY						
CARDIOVASCULAR	CARDIAC RHYTHM	NSR, VS stable WNL				NSR ī ectopy.	
		⊘ cough, cyanosis, edema				palpable pulses	
		pulses 2+ Pedal/radial				to all extremities.	
		bilaterally cap refill				good cap refill.	
		≤ 3 sec.					

LEGEND: Cr - ; F_IO_2 - ; HCO - ; 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

ICU

(Continue on reverse)

(b)(6)-2 ...re & Title)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 13 Oct 03

...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

☐ TREA... NT

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	104/53	131/69			113/55	132/73	119/68	120/70		125/67	135/66	131/65	130/60	121/71	118/62	111/57	107/49	
	Temperature	97°				97.5	/								98.5				
	Pulse	80	72			77	85	89	98		89	83	85	88	77	72	82	71	
	Respiratory Rate	9	7			11	13	16	16		14	16	15	16	12	12	20	12	
		100%	100%			95%	99%	100%	99%		98%	100%	100%	100%	100%	100%	100%	99%	
		RA	RA			RA	RA	RA	NC		NC	NC	NC	RA	NC	NC	NC	NC	
								2L	2L		2L	2L	2L	–	2L	2L	2L	2L	
SIGNS		Urinary		OK	OK			Pulmonate Urinary	Urinary 600cc				OOB - Ambulating		Urinary 600cc				

INTAKE	TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
	IV	150 / 150	150 / 300	150 / 450		75 / 525	75 / 600	75 / 675	75 / 675	675	75 / 750	75 / 825	75 / 900	75 / 975	75 / 1050	75 / 1050	75 / 1125	75 / 1200	1200
	IVPB	100 / 100	100 / 100	50 / 150		/	/	100 / 250	0 / 250	250	0 / 250	0 / 250	0 / 250	0 / 250	100 / 350				350
	PO	N	0	0		0	200 / 200	0 / 200	100 / 300	300	0 / 300	0 / 300	0 / 300	0 / 300	240 / 540				540
	TOTALS																		

OUTPUT		HOUR / TOTAL	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
	Foley		100 / 100		425 / 425	50 / 475		50 / 525	0 / 525	300 / 825	825	0 / 825	0 / 825	300 / 1125	0 / 1125	0 / 1125		125 / 1250		1250
	URINE	sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	CT 175		0 / 0	5 / 5				25 / 30	5 / 35			18 / 48	–	–	10 / 58					
	DRAINS																			
	TOTALS																			

Foley D/C'd 0/2

POST-OP DAY

	22	23	24	01	02	03	04	05	
BP	126/60	123/64	104/49	127/64	120/69	121/63	125/70	121/67	
T	99°								
HR	73	72	71	72	77	72	76	70	
RR	12	18	13	12	14	12	14	12	
Sats	100%	100%	100%	100%	100%	100%	100%	100%	
O_2	2L	2L	2L	2L	2L	2L	2L	2L	
	NC	NC	NC	NC	NC	NC	NC	NC	

	22	23	24	01	02	03	04	05	8° T
LR	75 / 1275	75 / 1350	75 / 1425	75 / 1500	75 / 1575	75 / 1650	75 / 1725	75 / 1800	1800
IVPD	0 / 350		100 / 450						450
PO	300 / 840		100 / 940						940
	175 / 1325								3190 / 1325
CT	5 / 63		10 / 13				35 / 108		108
									1433

ACUITY LEVEL CLASSIFICATION

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

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

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

24 H I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL	3190	TOTAL	1433

BALANCE 2757

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

INITIALS

MEDCOM - 7923

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	0800	INITIALS (b)(6)-2		INITIALS		INITIALS (b)(6)-2
NEURO	PUPILS						
	SENSORIUM	Alert + Oriented X3 follows commands denies pain at this time				alert and oriented calm, cooperative follows command	
RESPIRATORY	RESPIRATORY PATTERN	RR 18 Reg Non labored				RRL - Lungs CTA	
	BREATH SOUNDS	LS: CTA ↓ (R) base				↓ RLL - X-ray	
	SECRETIONS	Chest tube 20 cm H2O to suction serosang drainage Drsg: CDI. IS 1200cc/sec x 10 ∅ distress				done @ 1700 ∅ CT - dsg CDI	
SKIN	COLOR	Normal for Race				normal for race	
	INTEGRITY	DRSG (R) Chest				∅ Δ's	
IV SITE	LOCATION	Rt (L) wrist					
	CONDITION	infusing LR @ 75cc/hr ∅ s/s infiltration				N. Δ's - ∅ s/sx of infx - ∅ infiltration LR @ 75 c/hr	
GASTRO	ABDOMEN	Soft, flat, nondistended				tolerated regular diet	
	BOWEL SOUNDS	(+) BS x4 quads				+BS ∅BM this shift	
GU	URINE: COLOR/CLARITY	Void ⊃ urinal/commode ∅ pain ∅ difficulty voided				urinal at bedside ∅S clear yellow urine	
CARDIOVASCULAR	CARDIAC RHYTHM	HR Reg HR BS S1 S2 normal ∅ extrasounds (+) peripheral pulses x4				NSR S1 S2 (+) peripheral 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

(Continue on reverse)

CPT, N

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 15 OCT 03

(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	101/57	121/67	129/63	139/63		113/73	114/63	102/60		100/46	117/59	118/63	/	125/57				
Temperature	97.1						97.8					97.5						
Pulse	65	72	88	87		89	77	73		77	72	83		85				
Respiratory Rate	8	9	18	16		12	15	14		13	9	13		12				
O2	2L	2L	2L	2L		2L	100%	100		100%	100%	97%		100				
SATS	100	100%	98%	99%		100%	2L	2L		2L	2L	2L		2L				

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
LR	25 / 25	25 / 150	25 / 225	25 / 300	25 / 325	25 / 425	25 / 500	25 / 575	575	25 / 625	25 / 725	25 / 800	25 / 875	25 / 950	25 / 1025	25 / 1100	25 / 1175	
IVPB	100 / 100	100 / 0	/				100 / 100		300									
Po		240 / 240																
TOTALS																		

OUTPUT

		TIME	06	07	08	09	10	11	12	13	/	14	15	16	17	18	19	20	21	/
URINE		HOUR / TOTAL	0 / 0	0 / 0	0 / 0	200 / 200								300 / 500					400 / 900	
		sp gr																		
		S/A																		
NG		OUTPUT																		
		pH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS		CT	20 / 5 / 25			5 / 30								CT d/c'd						
TOTALS																				

POST-OP DAY

	22	23	24	01	02	03	04	05
	122/68				121/70			
T	97.5				98.2			
	88				71			
	12				16			
	99%				99%			
	RA.				RA			

22	23	24	01	02	03	04	05	8° T
75	75	75 / 1400	75	75	75	75	75	
								1775
							600 / 150	
								1500

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	133 / 3.6									
	Cl/CO_2	106 / 23									
	BUN/Cr	11 / 0.6									
	WBC/PLATELET	6.1 / 87									
	Hct/Hgb	28.6 / 9.3									

ACTIVITIES DONE DAILY	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	1775	Urine:	1500
po			
TOTAL		TOTAL	
		BALANCE	275

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

INITIALS (b)(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0700	INITIALS (b)(6)-2		INITIALS		INITIALS
NEURO	PUPILS						
	SENSORIUM	alert oriented follows commands					
RESPIRATORY	RESPIRATORY PATTERN	RRR even ↑↓ chest					
	BREATH SOUNDS	LS: CTA					
	SECRETIONS	Neb tx per RT ∅ secretions 2L O2 NC Sto2 99% DRSG (R) chest CDI					
SKIN	COLOR	normal for Race					
	INTEGRITY	gd. ∅ breakdown noted					
IV SITE	LOCATION	18g (R) forearm					
	CONDITION	gd. ∅ S/S infiltration 2 LR infusions 75cc/hr ∅ difficulty					
GASTRO	ABDOMEN	soft flat nondistended					
	BOWEL SOUNDS	+ BS x 4 incision c̄ staples CDI ∅ redness					
GU	URINE: COLOR/CLARITY	per urinal clear ∅ complaints					
CARDIOVASCULAR	CARDIAC RHYTHM	HR NSR S1 S2 Reg Norm ∅ extra sounds ∅ murmur noted (+) peripheral 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

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 RN

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 16 Oct 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

DATE 15 Oct 03 | DX S/P Ex Lap, (R) Chest GSW | 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	114/60				112/61													
Temperature	98.1				98.1													
Pulse	75				81													
Respiratory Rate	15				18													
SpO2	100%				99%													
	2LNC				RA													

INTAKE

TIME	06	07	08	09	10	11	12	13	8° T	14	15	16	17	18	19	20	21	8° T
IVF	75	75 150	75 225															
Unasyn	100																	
PO		240																
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL	225																	
	Sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

22	23	24	01	02	03	04	05

22	23	24	01	02	03	04	05	8° T

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	94									
	Na/K	139/3.5									
	Cl/CO_2	102/25									
	BUN/Cr	11/0.9									
	WBC/PLATELET	6.5/163									
	Hct/Hgb	34.1/10.9									
	CK	92									

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

24 HR I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday	wt Today		
INTAKE	OUTPUT		
IV	Urine:		
po			
TOTAL	TOTAL		
BALANCE			

ADMISSION AN[illegible]DING INFORMATION

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

1. REPORTING MTF	2. M[illegible]TION (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 BACKGROUND	RELIGION
[redacted]	36	X	9	muslim

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		9 9 30	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z		

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 8 EPW	0 9 3 2 3 0 0 0 0

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
1	ICW	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)
0 1		2 0 0 3 1 0 2 2

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
A B A A		2 0 0 3 1 0 0 9

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

FOR LOCAL USE

GSW to (R) Chest

Dx: 86239
8761
E9912

Pr: 8345
9394
4719

Chg Trauma
450 1

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

(b)(6)-4

Admission and Bedding Information

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

1. Reporting MTF (b)(3)-1	2. MTF Location IZ			
3. Register Number (b)(6)-4	Name (Last, First, MI) (b)(6)-4		4. Pay Grade CIV	5. Sex M
6. DoB (YYYYMMDD) [redacted]	7. Age at Admission 36	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 21:10	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: ICW	Name / Relationship of Emergency Addressee		
Name and Location of Medical Treatment Facility: [redacted] b(2)-2		Address of Emergency Addressee		
		Telephone Number of Emergency Addressee		
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-10-22		
24. Clinic Svc - Admitting ABA - GENERAL SURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-10-09		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-10-09		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW TO RIGHT CHEST

875.0 47.19

Procedure Narrative(s): EX LAP APPENDECTOMY WOUND DEBRIDEMENT

Cause of Injury Narrative: INJURED TRYING TO STEAL AMMUNITION

Admitting Officer (Signature is required) (b)(6)-2

Signature (b)(6)-2

Automated Facsimile - DA FORM 2985, MAR 2000

28-

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	FGN	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M		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			BC

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	10:30	AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	HOME	2003-11-27

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-20	DR (b)(6)-2

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
(b)(2)-2	2003-11-20	

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury: GSW as a result of conflict with US forces

34. Diagnosis / Operations and Special Procedures:

L humerous fracture

812.12

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

Signature of Attending Medical Officer (b)(6)-2 MAJ, MC

(b)(6)-2

Signa (b)(6)-2

(b)(6)-2 SSG, PAD NCOIC

Automated Facsimile - DA FORM 3647, May 79

MEDCOM - 7932

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

25 YO IRAQI MALE EPW GSW (L) SHOULDER 24° AGO.
BROUGHT TO (b)(2)-2 TODAY IN COAPTATION SPLINT.
NO OTHER INJURIES.

PMH	PSH	MEDS	NKDA
UNK	UNK	Ø	

HEENT: NCAT SUPPLE
LUNGS: CTA BL, CV: RRR w/ S1 S2 Ø
ABD: SOFT NT/ND, ~~Ø~~ PELVIS STABLE

PHYSICAL EXAMINATION

EXTREMS: w/ > (L) UE MULTIPLE SMALL WOUNDS OVERLYING SHOULDER @ DISTAL 1/3 OF DELTOID. MARKED EDEMA. 2+ RAD PULSE. INTACT WRIST FLEX/EXT, FINGER FLEX/EXT/ABD/ADD.

XRAY
COMMINUTED FX PROXIMAL 1/3 HUMERUS. HUM HEAD LOCATED, INTACT TO SURGICAL NECK ONLY

(AP) (1) OPEN, NN INTACT
GS FX (L) PROX HUMERUS.
(2) TO OR FOR IND, RAN FX FIX

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

(b)(6)-2

(b)(6)-2	NAME OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION
	[illegible]	20 NOV 03		

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23 NOV 03 1555	– ASSESSMENT – ABCD, PERRLA, LUNGS CTA BILAT, S1 S2 STRONG AND REG, (+) BS x4. ABLE TO (B)UE ACT C.O.E, SPLINT C.O.F. ARM IN SLING AND COMPLAINS OF C/O PAIN. CONTINUES W/ ANTIBIOTICS. OBS TO BE TOLERATED PER DIET. WILL CONTINUE TO MONITOR THROUGHOUT — (b)(6)-2
23 NOV 03 2049	Assessment: Assumed care of Pt Asleep but easily aroused Vitals Stable, dressing to (B)UE clean dry and intact. IV SL flushes well Ø s/s of infection at IV site. Ø C/O pain or discomfort IV Antibiotic Therapy Continues. WILL continue to monitor status — (b)(6)-2 [illegible]
24 NOV 03 1215	Nursing: Shift note Pt bright & alert Speech clear. VSS, eating & hydrating well. tolerating ambulating to sling. Continues W therapy/antibiotics (+) B.S, interpreter to check if BM lately. Voiding w/o difficulty. Continue to monitor — (b)(6)-2 [illegible]
1500	Pt c/o pain TT percocets given will monitor & report appropriately — (b)(6)-2 [illegible]
2200	Pt c/o pain TT percocets given will monitor and report appropriately — (b)(6)-2 [illegible]

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

ST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25NOV03 @0130.	Nursing Shift Note: Assumed care of pt @ 2400. Asst. VSS; WNL; please see SF Form 511. PT currently ↓ c/o pain. DRSG C,D,I to (L) shoulder/arm. PT currently sleeping. Ambulates w/o assistance c̄ MP. Will cont. to monitor. (b)(6)-2 [redacted] 21/MN
25NOV03 1115	Nursing: Shift Note. Pt. bright & alert. Speech clear in native tongue. Able to use gestures to assist in communication. Continues IV antibiotics, infusing w/o difficulty, tolerating regular diet. Voiding w/o difficulty. BM last p.m. reports regular. (L) arm site c̄ dried drainage on ace wrap. Dressing change today. Continue to monitor. (b)(6)-2 [redacted] CPT/RN
25NOV03 @2330	Nursing Shift Note: Assumed care of pt @ 1800. Asst. WNL; VSS; please see SF 511. PT c/o pain to (L) shoulder & arm. Medicated c̄ two percocet @ 2230. IV ABX cont. SL in (R) FA c̄ pos flush ↓ S/Sx of infection/infiltration. Limited English spoken by pt. DRSG c̄ dried drainage noted. Ø active bleeding noted. Will cont. to monitor. (b)(6)-2 [redacted]
26NOV 03@ 2200.	Nursing Shift Note: Assumed care of pt @ 1800. Asst. WNL, VSS; please see SF Form 511. PT medicated c̄ two percoc @ 2100 for c/o pain to (L) shoulder/ARM. IV & IV ABX d/c per v.o. from Dr. (b)(6)-2 [redacted] Assisted PT c̄ hand washing. Will cont. to monitor. Previous shift reported PT may be d/c to MP's in AM. (b)(6)-2 [redacted] 21/MN

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
	NARRATIVE SUMMARY
27 NOV 03	DOA: 20 NOV 03 DOD: 27 NOV 03
	Dx: (L) HUMERUS COMMINUTED
	GUNSHOT FRACTURE
	PROCEDURES: NONE
	Hx: 21 yo ♂ SHOT BY US
	FORCES UNDER UNCLEAR CIRCUMSTANCES,
	EPW STATUS. COMMINUTED
	PROXIMAL HUMERUS FRACTURE.
	COAPTATION SPLINT. PROPHYLACTIC
	ANTIBIOTICS. NO EVIDENCE INFECTION,
	CONTINUE COAPTATION SPLINT x 3
	WEEKS C COUNTER AND CUFF (NO SLING).
	CONDITION: STABLE
	DISPOSITION: D/C TO MP CUSTODY
	FIU (b)(2)-2 3 WEEKS.
	MEDS: PERCOCET 1 TT PO 4-6H PRN
	(b)(6)-2 (b)(6)-2
	[redacted] MAJ

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 NOV 03	A: patent, protected, c-spine protected
TIME 1745	B: even, unlabored, BS bilat CTA
	C: S1S2, pulses equal bilat 2+ all ext
B/P- 122/84	D: PERRLA, moves all ext.
~~Temp-~~	E: (0) arm (+) bleeding from single entrance &
Resp- 22	exit wound from apparent GSW
Pulse- 118	Iraqi national s/p GSW (L) arm, no other injuries
O2 Sat- 100	20
Allergy-	H- Ø hemorrhage
Meds- 6mg MS 1745 1gm Ceftriaxone IM 1805	E- PERRLA
PMHX-	E- Ø otorrhea
	N- Ø ~~septal hematoma~~
PSHX-	T- WNL
PFHX-	Ext: Single 1/2cm hole medial aspect c 1/2cm exit post
Tobb-	(+) crepitus humerus.
Ethol-	- set
Supp-	pulses 2+
10mg MS given	A/P (1) GSW (L) arm
1gm ancef	- set SYS
1000cc LR given	Evac to jail then hospital in am.
	ILT (b)(6)-2
	LLTR NS (R) IV

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.

Name (b)(6)-4
S.S.#
DOB/Sex Male
Unit Iraqi EPW
Rank/Grade

(b)(6)-4

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

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 NOV 03 @0055.	Nursing Shift Note: Assumed care of pt @ 1800.— Asst. WNL; including BS x4; ABD Soft, flat & nontender. Lungs ± wheezing upon inhalation + occasionally upon exhalation. O_2 Sat = 98%. VSS; please see SF Form 511. IV SL per order. IV ABX started @2200. HOB ↑ ≥45°. DRSG to (L) Arm partially saturated @ armpit area. DRSG reinforced. Foley draining clear, yellow urine ≥30cc/hr. MP present as guard. Restraints x two in place. Will cont. to monitor. — (b)(6)-2 2LT/AN.
21 NOV 03 @0545. Cont.	Cont. from above. 450cc of dark, foul smelling urine drained from foley. CBC done + ~~sent~~ to be (b)(6)-2 sent to lab @ 0600. — (b)(6)-2 2LT/AN
21 NOV 03 1440	Assessment - Afebrile, pain, denies CP & SOB, S-S2 sinus rhythm, (+) BS x4, P: spontaneous C&U. C.D.I. Given incentive spirometer. A.m. care performed. Foley to gravity D/C'd. Urinated 150 cc during via urinal. Tolerated pain med. (b)(6)-2 [redacted] Good to go. Will continue to monitor. — SGT

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

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

REGISTER NO. | **WARD NO.**

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 NOV 03 1917	Assessment Notes: Assumed care of Pt Asleep but easily aroused. Tolerated regular diet Vitals Stable Pt ambulated to outdoor Rest room tolerated it well. IV Ancef therapy continues. (L) hand in braces will continue to monitor status for changes — (b)(6)-2 07/a
22 NOV 03 11:45	Nursing: Shift Note Pt. bright + alert speech clear in native tongue. Eating + hydrating well. tolerating regular diet. Pt changed out of sling for short period of time. Pt rewrap neck sling. Plan to allow slight mt. x3 weeks & reevaluate per physician. Pt. voiding w/o difficulty. Eating + hydrating well. Continues IV antibiotics. Able to have AROM in (L) fingers assistive in feeding. ō fine + gross skills (b)(6)-2 07/a
22 NOV 03 @2215.	Nursing Shift Note: Assumed care of pt @ 1800. Asst. WNL, VSS; please see SF Form 57. DRSG to (L) Arm + shoulder c̄ clean, old bloody drainage, SL d/cd d/t pain + swelling + redness @ site. New 18 gauge IV/SL started in (R) hand IV/ABX cont. PT understands/speaks limited English. Medicated c̄ two percocet @ 2130 for c/o pain + (L) Arm. Will cont. to monitor. PT ambulating to/from latrine c̄ MP ≡ assistance — (b)(6)-2 2LT/AN

STANDARD FORM 600 (REV. 6-97) BACK

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

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL DATE DAY	MONTH	YR.	TIME
20	11	03	1015

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

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

HISTORY OBTAINED FROM: ☐ PATIENT ☒ OTHER (Specify) interpret

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)

SEX: 25 AGE: M

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME	9025	1025	1100
BP	135/80	128/86	136/94
PULSE	115	85	92
RESP.	18	16	16
TEMP.	98.7		
WT. (Child)			

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

ORDERS	INITS.	TIME
3mg MSO4	[redacted]	1025
7mg MSO4	[redacted]	1028
CBC		
chem 7, UA	[redacted]	1020
T&S		
ANCEF 1gm IV	[redacted]	1100
TETANUS 1CCS	[redacted]	

ASSESSMENT/DIAGNOSIS: GSW, (L) LE c COMMINUTED PROX HUMERUS FX

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

CONDITION UPON RELEASE
- ☐ IMPROVED ☐ UNCHANGED
- ☐ DETERIORATED

TIME OF RELEASE:

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

S: pt is an EPW who ambulated into ER c̄ MP escort c̄ (L) arm in splint & pt c/o "I haven't gone to B/A in 2 days" per interpreter pt is s/p GSW to (L) ARM > 24° ago. ~~pt holding bla~~

(b)(6)-2

O: pt in distress, holding bladder

CHEST: CTA (B)

CARD: TACHYCARDIC, REG RHYTHM

ABD: NON DISTENDED, NONTENDER

EX: PROXIMAL (L) LE SWELLING c̄ POST. WOUND, ANTEROMEDIAL WOUND PALPABLE RADIAL PULSE.

NEURO: INTACT ULNAR, RADIAL, MEDIAL DISTRIBUTIONS X-RAY: COMMINUTED PROX FX.

A/P COMMINUTED PROXIMAL HUMERUS FX

-TO O.R. FOR I&D, EX. FIX

(CONTINUE ON SF 507, IF NEEDED)

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

(b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

(b)(6)-2

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

NA

* NURSE'S NOTE *

@1015 - pt ambula 1 into EMT c̄ /p GSW to (L) UE >24° ago. pt escorted c̄ MP & MP states EPW status x 1 day p̄ firefight. pt arrived in distress holding bladder c̄ (L) arm in sling. Interpreter states, "he hasn't gone to the BR x 2 days. pt placed on litter c̄ (+) bladder distention. VS = 130/82, 115, 18, 98.9(o), & 100% RA. (+) radial pulse, pt able to wiggle fingers

@1025 - foley placed in patient, c̄ foley draing yellow, cloudy, urine. 14g in (R) AC patent, 1LTNS ↑ & labs sent ~~to~~ [redacted]

@1035 - foley clamp @ 1000 cc, pt sling removed p̄ 7mg MSO4 given @ 1028. VS - ~~128/48~~ 123/86, 85 16, and 100% RA. [redacted]

@1040 - pt brought to x-ray, stable, foley unclamped, foley contining to drain (+) sediment urine. 1800cc drained so far. pt relaxed, NAD. [redacted]

@1200 - pt back from x-ray, 3mg MSO4 given to pt in x-ray dig movement. VS - 136/94 87, 16, 100% RA. Anti IGM Ruing in 50cc fluid. Td given to (R) deltoid muscle, [redacted]

@1106 - 400mg Gentamycin ordered from pharmacy pt c̄ (+) humerus fx, prepping for OR. NKDA, Last meal - 2 days ago. [redacted]

@1120 - 400mg Gent... pt lying in bed relaxed NAD ...

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT For use of this form, see AR 40-407, the proponent s the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY DR SUM

2. PATIENT IDENTIFIED, CHART REVIEWED AND PROCEDURE VERIFIED BY (b)(6)-2 CMA

3. DATE 20 NOV 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 1550 NUMBER 1-1 #3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: spoke c̄ interp earlier to explain procedures

6. NURSING PERSONNEL

ASSIGNED SCRUB	DPC (b)(6)-2 RCD	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CM (b)(6)-2 66S	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

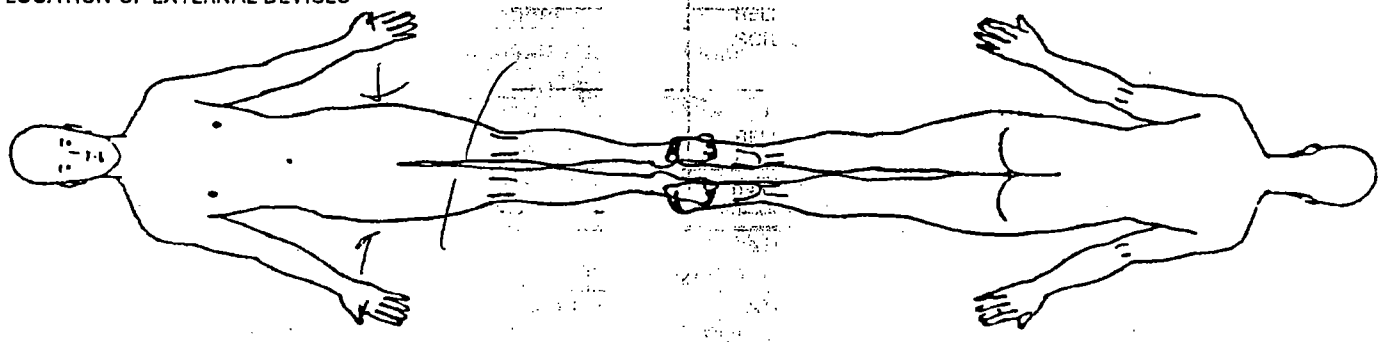
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)*
SITE: BY WHOM:
SITE: 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	CIRCULATOR
Sponge	☐ Yes	☐ No					
Needle Sharp	☐ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

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

(b)(6)-4

21 yo Male

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

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

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):

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)*

Casting
ulnar
ACE knix

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED

Dressing change - (L) humerous

21. PATIENT TRANSFERRED TO Recov TIME 1625 METHOD Litter

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

(b)(6)-2

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 7943 USAPA V1.00

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY	1	2	3	4	5		
MONTH-YEAR / DAY	20	21	22	23	24	25	26
19 / HOUR							

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

(Centigrade Equivalents, for Reference only)

	20	21	22	23	24	25	26
RESPIRATION RECORD	18	18, 16	16	16	18	16	16
BLOOD PRESSURE	131/70	120/72, 124/61	118/68, 117/60	133/76, 113/66	121/75, 118/70	124/65, 112/62	116/78, 119/64
HEIGHT: WEIGHT →	98%	98%, 96%	98%, 98%	97, 97%	98, 98%	98, 98%	98, 98%

Record special data only when so ordered

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

(b)(6)-4

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																
POST- DAY																
MONTH-YEAR	DAY	27														
19	HOUR	0														
PULSE (O)	TEMP. F (°)	6 8 0														TEMP. C
	105°															40.6°
180	104°															40.0°
170	103°															39.4°
160	102°															38.9°
150	101°															38.3°
140	100°															37.8°
130	99°															37.2°
	98.6°	*														37.0°
120	98°															36.7°
110	97°															36.1°
100	96°															35.6°
90	95°															35.0°
80																
70		*														
60																
50																
40																
RESPIRATION RECORD		16														
BLOOD PRESSURE		124/71														
HEIGHT:	WEIGHT →															
		98														

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; 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

Ward/Section: ICW

Requesting Physician: (b)(6)-2

LABORATORY RESULT FORM

(Subject to the Privacy Act of 1974)

Name: (b)(6)-4

Date: 21 NOV 03

Time:

Patient # (b)(6)-4

Chemistry 7

Test	Result	Ref. Range
GLU		73 - 118 mg/dL
BUN		7 - 22 mg/dL
Creat		0.6 - 1.2 mg/dL
Na		128 - 125 mmol/L
K		3.3 - 4.7 mmol/L
Cl		98 - 108 mmol/L
tCO2		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		
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymp		

ID: (b)(6)-4
WB

21-11-03
06:22

			Patient Limits		
WBC	10.4	x10^3/uL	4.5	10.5	
RBC	3.92 L	x10^6/uL	4.00	6.00	(F)
Hgb	11.7	g/dL	11.0	18.0	
Hct	35.2	%	35.0	60.0	(F)
MCV	89.7	fL	80.0	100.0	
MCH	29.8	pg	27.0	31.0	
MCHC	33.2	g/dL	33.0	37.0	
Plt	253.	x10^3/uL	150.	450.	
LY%	19.4 *L	%	20.5	51.1	
LY#	2.0 *	x10^3/uL	1.2	3.4	

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 21 NOV 03

Lab ID #

Ward/Section:	Requesting Physican:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

Name: (b)(6)-4	Date: 20 NOV 03	Time: 1020	Patient # (b)(6)-4

Chemistry

======= PICCOLO =======
11/20/03 10:30
REFERENCE RANGE: MALE
PATIENT #: (b)(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: (b)(6)-4

GLU	109	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	1250*	39-380	U/L
NA+	137	128-145	MMOL
K+	4.7	3.3-4.7	MMOL
CL-	103	98-108	MMOL
tCO2	24	18-33	MMOL

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

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	Yellow	N/A
App	Clear	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	TRACE	Negative
SGav.	1.030	N/A
Bld	TRACE	Negative
pH	6.0	N/A
Prot	TR	Negative
Urob	0.2	0.2 - 1.0
Nit	NEG	Negative
Leuk	N/A	Negative

Micro UA
0-1 RBC
Amorphous sediment (MOD)

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
W		
R		
H		-16 (F)
H		7% (F)
M		
Pl		
L		

ID: (b)(6)-4 20-11-03
WB 10:28
Patient Limits

WBC	12.4 H	x10^3/uL	4.5	10.5
RBC	4.67	x10^6/uL	4.00	6.00
Hgb	13.7	g/dL	11.0	18.0
Hct	41.7	%	35.0	60.0
MCV	89.3	fL	80.0	100.0
MCH	29.3	pg	27.0	31.0
MCHC	32.9 L	g/dL	33.0	37.0
Plt	326.	x10^3/uL	150.	450.
LY%	20.0	%L %	20.5	51.1
LY#	2.5	* x10^3/uL	1.2	3.4

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

Type & Screen

Additional Instructions:

Reported By	Date	Lab ID #
(b)(6)-2	20 NOV 03	(b)(2)-2

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	
VCC	(mg)	0.5
fentanyl	(ug)	50
STP	(mg)	50
Versed	(mg)	2.5
	( )	
	( )	
VOLAT AGENT	% del	
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8

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

FLUIDS

LINE site		
N5	☐ Warmed	300
	☐ Warmed	
	☐ Warmed	
open 400mg	☐ Warmed	100

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

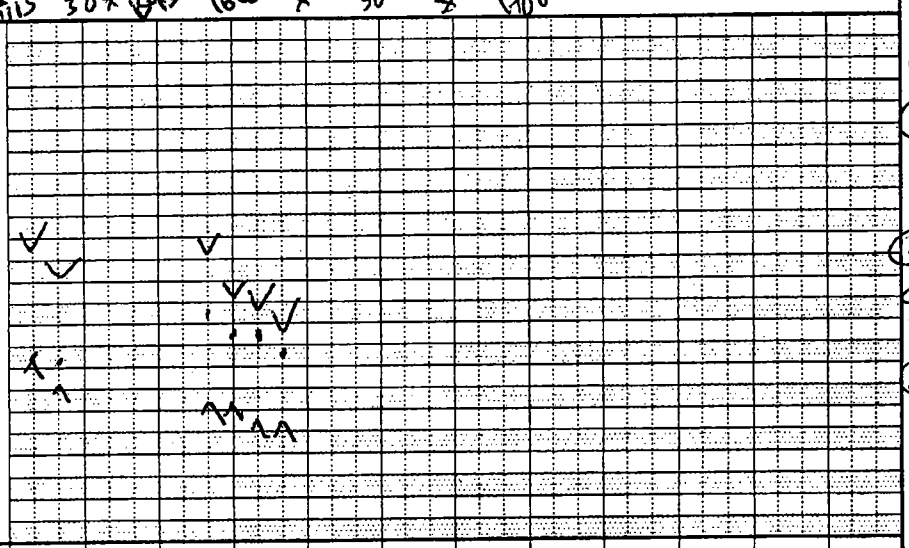
INITIAL DATA: BP- ___/___ HR-

EQUIP CHECK: OK? - Y N

PATIENT RECHECK: OK for PROCEDURE? TIME-

TIME 1115 30 X 1545 1600 X 30 X 1700

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



VENTIL

VT - ml	
f - breaths/min	
Peak inf pres / PEEP	
MODE - S(pon), A(ssist), C(on)	S S S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	(+)
BP/oth	FIO2 (Frac or %)	21 21 21
ART line	SpO2 (%)	100 97 97
Steth- PC/ES	ECG	SR SR SR
Gas analyzer	TEMP-site	available
	N-M Block (T/4)	
Warming blkt		
Conv warmer		

Mark with letters & symbols, explain under REMARKS — EVENTS Position: 1 a 2 3

TOTALS | **TOTAL EBL** | **TOTAL URINE**

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

REMARKS

Code drugs with numbers, events with letters

pt ID ✓ in EMT. Q1A. P.A. & translator. Chart reviewed

1 to OR - Δ plan - to ICU

2 to OR for dressing Δ. monitors / O2.

3 to FCU for recovery.

RECOVERY AT: PACU ICU (Specify) ; OTHER FC

CONDITION: stable

RESP. 12 SpO2- BP- 104/52 HR- 91

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1515	1555	1630
	Ready	Begin	End
PROC	1600	1605	1613

PROCEDURES and CPT Codes:

ANESTHETIC TECHNIQUES: Describe block technique under Remarks MAC

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

(b)(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments nasal cannula

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

CPT CRNA

PROCEDURE LOCATION: OR

DATE: 20 NOV 03

PAGE 1 OF

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Analgesia)

Age 25 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

ASA Physical State 1 2 3 4 5 E
WT: 140 KG/LB HT: 68" IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: I&D - Ex Fix
SURGICAL SERVICE: ortho
NPO SINCE: x 2 days

HABITS:
TOBACCO: 7 cigs/day x 5 yrs
ETOH: Ø
DRUGS: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) gent 400 mg
( ) - [illegible]
( ) ancef in cmt
( )
( )
( )

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

LABORATORY STUDIES:
HB/HCT: 13.7 / 41.7
U/A:
OTHER:

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	comminuted
	N	Y	prox humerus fx
Familial HX	N	Y	24° ago
			GSW

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION
BP 136/94 HR 115 R 18 T 98.9
Pain Scale 0-10 _____
HEENT - Teeth _____
Trachea _____
TMJ/Neck _____
Oropharnyx _____
Nares _____
CHEST: _____
CARDIAC: _____
EXTREMITIES: _____
IV Access: _____
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since x 2 days

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

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

The patient [redacted] understand and agrees. Questions answered.
Signed: [redacted] CRT CRNA Date: 20 NOV 03 Time: 1100 Hrs

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

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) _____

[redacted]

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 20 NOV 03 TIME OF ORDER: 1623 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit ICW

Dx: (L) Humerus GSW

Cond: Stable

Vitals: Q Routine

Activity: up ad lib, HOB @ 45°

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: NOW TIME OF ORDER: HOURS

Diet: Reg

IVF: NS @ 110 cc/HR until tol PO

Ancef 1g IV q 8°

Gentamicin 400mg IV q 8

MSO4 2-4mg IV q 15' ≤ 20mg q 2°

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

Percocet 1-2 PO q 4-6 H PRN Pain

CBC in AM

(b)(6)-2

Chart Check

(b)(6)-2

24/PM

20NOV03 @ 2030

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 21 NOV 03 TIME OF ORDER: 1200 HOURS

V.O.

DIC Foley

notify MD if ↓ U.O.P. by 6 hours

Dr. (b)(6)-2

(b)(6)-2

24° Chart 21 NOV 03 @ 2347

(b)(6)-2

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

MEDCOM - 7950

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: 26NOV03 TIME OF ORDER: 1900 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) D/C IV + IV ABX (Ancef + Gent). Thanks. V.O. per. D.A. (b)(6)-2 (b)(6)-2 24/MN

24 Chart Check 26NOV03 (b)(6)-2 24/MN @ 2150

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 27NOV03 TIME OF ORDER: 27NOV03 HOURS

(1) D/C TO WP CUSTODY

(b)(6)-2

MA

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

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

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

Mo. ____ Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 20	21	22	23	24	25	26	27
20NOV03	(b)(6)-2	Vitals Q Routine	06	(b)(6)-2							(b)(6)-2
			18								
20NOV03	(b)(6)-2	Activity: UP Ad Lib,	06								
		HOB @ 45°	18								
20NOV03	(b)(6)-2	Diet Reg	08								
			12								
			18								

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

DX: (L) Humerus GSW FX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL, CIRCLE ACTION TIMES

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
20 NOV 03	(b)(6)-2	Admit to ICW: COND: Stable	20 NOV 03	1630	1630	
20 NOV 03		CBC in AM	21 NOV 03	0600	0600	(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.____ Yr.____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 20	21	22	23	24	25	26							
20NOV03	(b)(6)-2	IVF: NSC 110 cc/hr	06	(b)(6)-2							(b)(6)-2						
		until TOL PO	18														
20NOV03	(b)(6)-2	Ancef 1g IV q 8°	06	(b)(6)-2													
			14														
			22														
20NOV03	(b)(6)-2	Gentamycin 400mg	12	(b)(6)-2													
		IV QD															

D/C'd

D/C'd

D/C'd

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
NKDA	DX: (L) Humerus GSW/FX	PAGE NO. _____

PATIENT IDENTIFICATION:

DISPENSING TIMES

Verify By Initialing

(MEDICATIONS) Mo._____ Yr._____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
- - - - -	(b)(6)-2	~~MSO4 2-4mg~~	See below
- - - - -	- - - - -	~~IV ≤ 20mg q~~	
- - - - -	- - - - -	~~2°~~	
- - - - -	- - - - -		
20 NOV 03	(b)(6)-2	MSO4 2-4mg	21 NOV 4mg TL 0630
- - - - -		IV q 15' ≤20mg	
- - - - -	- - - - -	q 2°	
- - - - -	- - - - -		
20 NOV 03	(b)(6)-2	Percocet T-II PO	2130 22 NOV 03 TL (b)(6)-2 (b)(6)-2 (b)(6)-2 25 NOV 03 TL 1130 (b)(6)-2 25 NOV 03 TL (1100) 1130 20 NOV 03 TL (b)(6)-2
- - - - -	- - - - -	q 4-6 H PRN Pain	
- - - - -	- - - - -		
- - - - -	- - - - -		
- - - - -	- - - - -		

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 20 Nov 03
Time: 1630
Allergies: NKDA
Pre-op V/S: _____
Procedures: Drain & I&D FV Schatzker Pentothal / Versed

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

OR Intake: Crystalloid 500 NSS Colloid ~~500 NSS~~
OR Output: UOP Ø EBL (Min)
Meds/Times: _____

Ancef & Gent ER

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

Pre Op Meds / History

Time	1630	1635	1640	1645	1700	1715
SaO2						
FiO2						
Methods						
240						
220						
200						
180						
160						
140						
120	✓	✓	✓	✓	✓	✓
100			✓			
80						
60		✓	✓	✓	✓	✓
40						
20						
RR	19	9	15	21	18	
T	98	98				
Time	1630			1700		
Pain (0-10)	0			0		
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1700	NSS	300	18G LAC	(b)(6)-2	500

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	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	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	1	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.	8	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 BY (Signature & Title): (b)(6)-2 MAJ

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 20 Nov 03

PATIENT'S IDENTIFICATION (For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General. Name — last, first, middle; grade; date; hospital or medical facility)

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	L Arm	+	+			Cool	Pink
15'	L Arm	+	+		+	Cool	Pink
30'	L Arm	+	+		+	Cool	Pink
45'							
60'							
90'							
D/C	L Arm	+	+	+	+	Warm	Pink

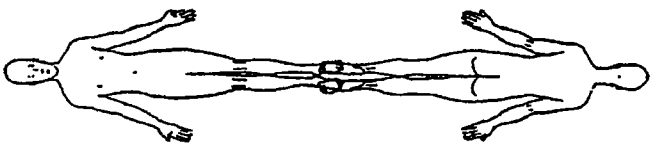
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	L Arm Arch Wrap	Shoulder	Bloody
30'	L Arm Abd Wrap	Shoulder	Small Amt
60'			
D/C	(L) Arm	Shoulder	Small Amount



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1715	Foley	400cc Amber Urine	400cc

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1700	SR	Ø	Ø

NURSING NOTES

1700 Arrived from OR S/P (L) Shoulder Scope & Exploration was performed due to multiple fragments noticed. Arch Wrap & Small amount of bloody drainage to (L) Arm. Cap Refill brisk, Pulses [illegible] (b)(6)-2

1645 O2 [illegible] NS. Nasal Trumpet Applied [illegible] (b)(6)-2

(700): [illegible] (b)(6)-2

Discharge Criteria:
Date: 20 Nov 03 **Time:** **PARS:**
BP: 136 **T:** 98 **HR:** 67 **RR:** 13 **SpO2:**
Pain Level at D/C (0-10):
Intake: 800 **Output:** 400
Additional Data: Ø
Transferred To: ICW
Report Given To: [illegible] (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

WAMC OP 173-E

Admission and Coding Information

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

1. Reporting MTF (b)(2)-2	2. MTF Location IZ			
3. Register Number (b)(6)-4	Name (Last, First, MI) (b)(6)-4		4. Pay Grade FGN	5. Sex M
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race X	9. Ethnicity 9	Religion MUSLIM
10. Length of Service	ETS	11. FMP 20	12. Social Security Number (b)(6)-4	
Organization (Active Duty Only)		13. Marital Status	Hour of Admission 10:30	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: ICW	Name / Relationship of Emergency Addressee Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: (b)(2)-2		Telephone Number of Emergency Addressee		
21. Type of Disposition HOME	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-11-27		
24. Clinic Svc - Admitting AEA - ORTHOPEDICS	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-11-20		
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of initial Admission 2003-11-20		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: L humerous fracture
812.12

Procedure Narrative(s):

DX 81212
78820
E9912

Cause of Injury Narrative: GSW as a result of conflict with US forces Trauma 1 Inj 450

(b)(6)-2

Admitting Officer (Signature, as required) DR (b)(6)-2	Signature of Admitting Clerk

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(2)-2	I Z	(b)(6)-4	(b)(6)-4 EPW	F6N	

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9	27 28 29	30: X	31: 9	MUSLIM

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34		35 36: 2 0	37 38 39 40 41 42 43 44 45: (b)(6)-4

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

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49	50 51 52: K 7 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: O		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: 0 5	75 76 77 78 79 80	81 82 83 84 85 86 87 88: 2 0 0 3 1 1 2 7

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

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

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

IN... ENT TREATMENT RECORD COVER S

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 EPW	ADMISSION REMARKS
4. SEX M	5. AGE 30Y	6. RACE IRAQI	7. RELIGION MUSLIM	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION	
11. FMP 9820		12. SSN (b)(6)-4		13. ORGANIZATION —		14. WARD ICW 1	
15. FLYING STATUS —	16. RATING/ DSG	17. DEPT./ BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE WIA	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION DIRECT FROM ER				22. HOURS OF ADMISSION 1245	23. CLINIC SERVICE ABAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —			25. TYPE DISPOSITION (b)(2)-2		26. DATE OF DISPOSITION 10 APR 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —			27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 10APR 03	ADMITTING OFFICER (b)(6)-2 MAJ	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(2)-2					30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

N/A

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW ⓛ Lung

861.30

789.00

E991.2

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
Ø	Ø	Ø	Ø	1	1

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

DA FORM 3... EDITION ...

MEDCOM - 7960

FROM (Medical treatment facility)
ORIGINE (Unité médicale)
(b)(2)-2

NAME (Last–first–middle initial)
NOM (Nom de famille–premier prénom–initiale deuxième prénom)
EPW 1

SERVICE NUMBER / NUMÉRO MATRICULE	RANK/RATING/GRADE / GRADE	CATEGORY OF PERSONNEL (Service or employer and nationality) / CATÉGORIE DE PERSONNEL (Service ou employeur et nationalité)
N/A	N/A	EPW

DIAGNOSIS / DIAGNOSTIC
GSW (L) LUNG

CLASS–CLASSE		DISEASE / MALADIE	BATTLE CASUALTY / BLESSÉ AU COMBAT	INJURY / BLESSURE
1A	2A			
1B	2B			
1C				
3	4			

VSI / TRES GRAV. MAL.
☐ Yes / Oui ☒ No / Non

CABIN OR COMPARTMENT NO. / NO. CABINE OU COMPARTIMENT

BUNK NUMBER / NUMÉRO COUCHETTE

BAGGAGE TAG NUMBER(S) / NUMÉROS ÉTIQUETTES BAGAGE
(b)(6)-4

DESTINATION / DESTINATION
212

SHIP/AC (Number/type) / NAVIRE/AVION (Matricule/type)

TREATMENT RECOMMENDED EN ROUTE (If no treatment is required a notation to this effect is made) / TRAITEMENT RECOMMANDÉ EN ROUTE (Indiquer si aucun traitement n'est nécessaire)
Chest tube drainage

SIGNATURE OF / SIGNATURE DU
(b)(6)-2

DATE / DATE
10 APR 03

REGULAR DIET / RÉGIME NORMAL

SPECIAL DIET (Describe) / RÉGIME SPÉCIAL (Description)
NPO

SHIP'S RECORD OFFICE TAB – FICHE POUR ARCHIVES TRANSPORTS

FROM (Medical treatment facility)
ORIGINE (Unité médicale)
(b)(2)-2

NAME (Last–first–middle initial)
NOM (Nom de famille–premier prénom–initiale deuxième prénom)
EPW1

SERVICE NUMBER / NUMÉRO MATRICULE	RANK/RATING/GRADE / GRADE	CATEGORY OF PERSONNEL / CATÉGORIE DE PERSONNEL
N/A	N/A	EPW

BAGGAGE TAG NUMBER(S) / NUMÉROS ÉTIQUETTES BAGAGE
(b)(6)-4

DATE OF SHIPMENT / DATE DÉPART
10 APR 03

DESTINATION / DESTINATION
(b)(2)-2

ARRIVAL DATE / DATE ARRIVÉE
10 APR 03

EMBARKATION TAB – FICHE D'EMBARQUEMENT

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)(2)-2	I Z	(b)(6)-4	(b)(6)-4 EPW	1 EPW	M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
[redacted]	30Y	X	9	MUSLIM

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
—	—	99	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	M	1245	—

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

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 6 (b)(2)-2	ICU1	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(2)-2		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: 2 1 (b)(2)-2	75 76 77 78 79 80: A Ø 3 K 1	81 82 83 84 85 86: Ø 3 Ø 4 1 Ø

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
87 88 89 90: A B A A	91 92 93 94 95 96:	97 98 99 100 101 102: Ø 3 Ø 4 1 Ø

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

FOR LOCAL USE

DX: GSW THORAX – 875.0

ACUTE ABDOMINAL PAIN

86130 T INJURY
78900 1 450
E9229.

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
MAJ (b)(6)-2	(b)(6)-2 PFC, 91G10

(b)(6)-4

MEDCOM - 7962

ENT TREATMENT RECORD COVE

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4	EPW	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	21Y	UNK	MUSLIM	—	—	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	(b)(6)-4	—	ICW-1

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—	—	K78	—	—	TBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	1247	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	21	030410

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	030410	Maj (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	030410	

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

Crossfire during Battle.

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

1. S/P Rt Mandibular Fx — 802.30
2. Lt Fibular Fx — 823.91
3. GSW to #1, #2 — E991.2

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

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

SIGNATU (b)(6)-2 M.C. MAJ(P) MC

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

DA FORM [illegible] EDITION [illegible] IS OBSOLETE

USAPPC V1.10

FROM *(Medical treatment facility)*
ORIGINE *(Installation de traitement médical)*
(b)(3)-1

NAME *(Last–first–middle initial)*
NOM *(Nom de famille–premier prénom–initiale deuxième prénom)*
EPW 2

SERVICE NUMBER / NUMÉRO MATRICULE	RANK/RATING/GRADE / GRADE	CATEGORY OF PERSONNEL *(Service or employer and nationality)* / CATÉGORIE DE PERSONNEL *(Service ou employeur et nationalité)*
N/A	N/A	EPW

DIAGNOSIS / DIAGNOSTIC
1. Rt mandibular Fx > S/P GSW
2. Lt Fibular Fx

CLASS–CLASSE		DISEASE / MALADIE	BATTLE CASUALTY / BLESSÉ AU COMBAT	INJURY / BLESSURE
1A	2A			
1B	2B			
1C				
3	4			

VSI / TRÈS GRAV. MAL.
☐ Yes / Oui ☒ No / Non

CABIN OR COMPARTMENT NO. / NO. CABINE OU COMPARTIMENT

BUNK NUMBER / NUMÉRO COUCHETTE

BAGGAGE TAG NUMBER(S) / NUMÉROS ÉTIQUETTES BAGAGES [redacted]

DESTINATION / DESTINATION (b)(3)-1

SHIP/AC *(Number/type)* / **NAVIRE/AVION** *(Matricule/type)*

TREATMENT RECOMMENDED EN ROUTE *(If no treatment is required a notation to this effect is made)*
TRAITEMENT RECOMMANDÉ EN ROUTE *(Indiquer si aucun traitement n'est nécessaire)*
Monitor airway

SIGNATURE OF MEDICAL OFFICER / SIGNATURE DU MÉDECIN (b)(6)-2 (b)(6)-2, M.C. MAJ MC

DATE / DATE 10 APR 03

REGULAR DIET / RÉGIME NORMAL

SPECIAL DIET *(Describe)* / **RÉGIME SPÉCIAL** *(Description)*
Liquids

SHIP'S RECORD OFFICE TAB – FICHE POUR ARCHIVES TRANSPORTS

FROM *(Medical treatment facility)*
ORIGINE *(Installation de traitement médical)*
(b)(3)-1

NAME *(Last–first–middle initial)*
NOM *(Nom de famille–premier prénom–initiale deuxième prénom)*
EPW 2

SERVICE NUMBER / NUMÉRO MATRICULE	RANK/RATING/GRADE / GRADE	CATEGORY OF PERSONNEL / CATÉGORIE DE PERSONNEL
N/A	N/A	EPW

BAGGAGE TAG NUMBER(S) / NUMÉROS ÉTIQUETTES BAGAGES [redacted]

DATE OF SHIPMENT / DATE DÉPART 10 APR 03

DESTINATION / DESTINATION (b)(3)-1

ARRIVAL DATE / DATE ARRIVÉE 10 APR 03

EMBARKATION TAB – FICHE D'EMBARQUEMENT

ADMISSION AND CODING INFORMATION

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

(b)(6)-4

1. REPORTING MTF	(b)(3)-1
2. LOCATION (State or Country Code.)	
3. REGISTER NUMBER	(b)(6)-4
NAME (Last, First, Middle Initial)	EPW (b)(6)-4
4. PAY GRADE	EPW
5. SEX	M
6. DATE OF BIRTH (Y Y Y Y M M D D)	[redacted]
7. AGE AT ADMISSION	21Y
8. RACE	X
9. ETHNIC BACKGROUND	9
RELIGION	MUSLIM
10. LENGTH OF SERVICE	—
ETS	—
11. FMP	99 80
12. SOCIAL SECURITY NUMBER	(b)(6)-4
ORGANIZATION (Active Duty Only)	—
13. MARITAL STATUS	S
HOUR OF ADMISSION	1247
BRANCH / CORPS	—
14. FLYING STATUS	—
15. BENEFICIARY CATEGORY	K 7 8
16. ZIP CODE OF RESIDENCE	
17. UNIT LOCATION (State or Country Code)	—
18. MOS	—
19. TRAUMA	Ø
PREV. ADMISSION	YEAR [X] NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	Ø
WARD	ICU 1
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	—
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	—
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	(b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE	—
21. TYPE OF DISPOSITION	21
22. MTF TRANSFERRED TO	(b)(3)-1
23. DATE OF DISPOSITION (Y Y M M D D)	Ø3 Ø4 1Ø
24. CLINIC SVC - ADMITTING	A B A A
25. MTF TRANSFERRED FROM	
26. DATE THIS ADMISSION (Y Y M M D D)	Ø3 Ø4 1Ø
27. LOCATION OF OCCURRENCE (Battle Casualty Only)	
28. MTF OF INITIAL ADMISSION	
29. DATE INITIAL ADMISSION (Y Y M M D D)	

FOR LOCAL USE

DX: DUAL FX (R) MANDIBLE – 802.20
GSW (L) LEG – 891.0

DX I Trauma
80220 450 1
82381

ADMITTING OFFICER (Signature, as required) (b)(6)-2 MAJ (b)(6)-2

SIGNATURE OF ADMITTING CLERK (b)(6)-2 PFC, 91G10

DA FORM 2085 MAR 80

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 Z	7. RELIGION —	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION NO	
11. FMP 99		12. SSN (b)(6)-4		13. ORGANIZATION N/A		14. WARD ICU1	
15. FLYING STATUS —	16. RATING/ DSG —	17. DEPT./ BEN 1178	18. BRANCH/CORPS —	19 UIC/ZIP —		20. TYPE CASE NBI	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION 0001	23. CLINIC SERVICE AEAA		
24. NAME RELATIONSHIP OF EMERGENCY ADDRESSEE UNK				25. TYPE DISPOSITION 24	26. DATE OF DISPOSITION 030415		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK				27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 030412		ADMITTING OFFICER
(b)(3)-1					30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: S/P Shrapnel wound face/elbow

873.40
881.01
E991.9

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
Ø	Ø	Ø	Ø	13	13

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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6): (b)(6)-4
2. MTF LOCATION (7–8) (State or Country Code.)
3. REGISTER NUMBER (9–15): [redacted]
NAME (Last, First, Middle Initial): (b)(6)-4
4. PAY GRADE (16–17): —
5. SEX (18): M
6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26):
7. AGE AT ADMISSION (27–29): —
(30): Z
9. ETHNIC BACKGROUND (31): 9
RELIGION: —
10. LENGTH OF SERVICE (32–34): —
ETS: N/A
11. FMP (35–36): 9 9
12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4
ORGANIZATION (Active Duty Only): —
13. MARITAL STATUS (46): Z
HOUR OF ADMISSION: 0001
BRANCH / CORPS: —
14. FLYING STATUS (47–49): —
15. BENEFICIARY CATEGORY (50–52): K7B
16. ZIP CODE OF RESIDENCE (53–61):
17. UNIT LOCATION (State or Country Code) (62–63): —
18. MOS (64–70):
19. TRAUMA (71): 9
PREV. ADMISSION: YEAR; [X] NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): O
WARD: ICU 1
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK
(b)(3)-1 [redacted]
21. TYPE OF DISPOSITION (73–74): 24
22. MTF TRANSFERRED TO (75–80):
23. DATE OF DISPOSITION (Y Y Y Y M M D D) (81–88): 20030415
24. CLINIC SVC - ADMITTING (89–92): AEAA
25. MTF TRANSFERRED FROM (93–98):
26. DATE THIS ADMISSION (Y Y Y Y M M D D) (99–106): 20030412
27. LOCATION OF OCCURRENCE (Battle Casualty Only) (107–108):
28. MTF OF INITIAL ADMISSION (109–114):
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D) (115–122):

FOR LOCAL USE

DX: S/P shrapnel wound face/elbow

DX-87340
88101
E9919

Trauma -1
Injury -449

ADMITTING OFFICER (Signature, as required): (b)(6)-2

SIGNATURE OF ADMITTING CLERK: (b)(6)-2

PATIENT 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 (b)(6)-4			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE UNK	6. RACE X	7. RELIGION —	8. LENGTH OF SVC —	9. ETS —
10. PREVIOUS ADMISSION NO	11. FMP 99 AD	12. SSN (b)(6)-4	13. ORGANIZATION —	14. WARD ICW-2	
15. FLYING STATUS NO	16. RATING/DSG	17. DEPT./BEN K	18. BRANCH/CORPS —	19. UIC/ZIP	20. TYPE CASE DNBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER

22. HOURS OF ADMISSION: 1707

23. CLINIC SERVICE: ABRA.

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —

25. TYPE DISPOSITION: D/C Home.

26. DATE OF DISPOSITION: 16 APR 2003

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —

27b. TELEPHONE NO.: —

28. DATE OF THIS ADMISSION: 14 APR 2003

ADMITTING OFFICER: Dr (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(2)-2

30. DATE OF INTIAL ADMISSION: 030416

32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

UNK

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Traumatic destruction of globe of eye — 871.2
GSW to face — 873.1
GSW to back — 873.59
1+D GSW's, multiple — 874.9
GSW, hand (L) — 880.10
(L) hand repair — 883.1
86.05 — 880.13
80.22 — 882.1
96.59 — 882.2
876.1
E991.9

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
Ø	Ø	Ø	Ø	2	2

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: (b)(6)-2 (b)(6)-2 SIGNATURE OF RAP OR MEDICAL OFFICER: (b)(6)-2

DA FORM 3647 EDITION OF 1 AUG 1968 IS OBSOLETE USAPPC V1.00

MEDICAL RECORD	PROGRESS NOTES

DATE

16 April 03 1823

H+P

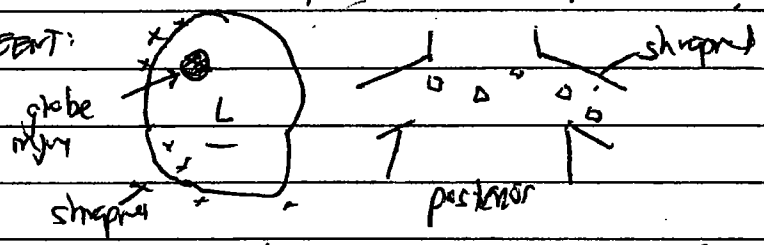
Approximately 25-30 yo. Iraqi citizen involved in shrapnel injury from bomb blast - sustaining shrapnel injuries to (L) dorsum of hand w/ exposed tendon (no bony injury obvious), soft tissue shrapnel to cape of shoulder (R) + (L), superficial shrapnel to scalp and face, also (R) globe injury w/ probable destruction of globe

Tobacco - unknown

NKDA

Air Evac - seen in ED - given 1gm Ancef 10mg MSO4 and then transfer to ICU #4 - bed 4. C-spine/skull/(R) shoulder/CXR done - CS, Seen by Dr. (b)(6)-2 (b)(6)-2 for pre-op assessment.

Exam. WN/WD Iraqi male NAD, MAE, no obvious neuro deficit

HEENT: 

No obvious oral injury.

Teeth intact, tongue midline

24 | 149 | 32 | 48

CN - can't assess EOM 2° injury (L) eye - WNL
V, VII → XII WNL

Lung: CTA (B) ∅ adventitious sounds, trachea midline

Card: RRR Nl 1/2 ∅3/4 ∅ m/r/s

Abdo: Soft, NT ND ∅ HSM felt.

GU: Nl ♂ genitalia, ? feces over pubic - ∅ bony pain pelvis stable.

Ext: (L) hand - exposed tendon over (L) 4th fingers metacarpal.

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
	A/P #1. Globe injury - Plan is to wash/irrigate until clean then dress w/ Eantan ophthalmic and patch. - switch to bacitracin p 2-3 d if remains uninfected.
	#2. (L) hand/shrapnel - → OR for debridement/cleaning of wounds
	#3. Head/facial shrapnel - clean + dress. BID.
	#4. ↑ WBC - likely 2° dehydration/stress demargination would re✓ post op. No sx/sign of underlying infxn.
	(b)(6)-2
	MAJ MC
	ONSET OF LOSS
16 Jan 03 2125	PLT-OP TOX - MULTIPLE LACERATED WOUNDS TO BELOW (2) LACERATION (L) HAND
	POST-OP TOX - STABLE
	PLACEMENT WOUNDS I+D, REPAIR (L) EDC FLOW
	SUPPORT - ALBUTEROL
	CBC - NORM
	FINDINGS - MULTIPLE LACERATED WOUNDS OF BELOW ELBOW SQ & IL DEBRIDEMENT. LACERATION DISTAL (L) WRIST WITH SQ MATT, AND FLEXORS 2nd TENDS. LACERATION EDC FLOW, MISSING VOL 5.0 HOLDS.
	PLAN - ABX. PLASTIC CONSULT (b)(6)-2

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
2130 ~~0930~~ (b)(6)-2	Pt arrived to ICU#1 via litter c̄ OR staff
	drowsy but arousable c̄ touch and voice VSS
16 APR 03	131/71 P-88 T- R-20 PO 99% on RA Dsg to back
	slightly blood tinged ø gross bleeding Dsg to (L) hand CDI
	Pt c̄ superficial schrapnel wounds to face and ears
	slight oozing Pt c̄ LR infusing @ 125 cc/hr into (L)
	hand IV cath (18 G) Eye Patch to (R) eye CDI
	ophthalmic ointment applied prior to bandage and Eye Shield
	Tetanus .5 given prior to surgery - will continue
	to monitor patient — (b)(6)-2 SGT LPN
2300	Pt OOB to use urinal - 100 cc clear yellow urine
	Pt slightly agitated/scared about where he is at (b)(6)-2 (b)(6)-2
	No request for pain meds - informed by interpreter
	that if he needs meds for pain to ask staff
	Pt not taking P.O. at this time - (b)(6)-2 SGT LPN
2330	Eye Shield DSG Δ'd x1 due to sanguinous discharge
	2400 Ancef not given - Pt had 1 Gm prior to (2000 hrs surgery)
	2400 dose can be used at 0800 — (b)(6)-2 SGT LPN
0300	Pt OOB x3 to urinate 300 cc clear yellow urine
	Pt Dsg's CDI - no request of pain meds
	Pt sleeping all night - no P.O. intake
	Vital Signs stable - no ICU flowsheet to
	document - will try to borrow from ICU#2

(Continue on reverse side)

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

(b)(6)-4

Bed # 4
ICU#1

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

(b)(6)-4

PROGRESS NOTES

DATE	
17 APR	2mg IV MSO4 for pain to (D) hand PSI CDI — (b)(6)-2 [redacted] SGT [illegible]
17 APR 0700	Nursing Assment Neuro: A&O X3 (+) Rom all extremes ↓ LUE. Resp: Intact on RA. Cardio BP 140/71. HR 72. (R) Hand HL T LR (C) 12 Cafter. GI: Soft NT BS (+) X 4 Quads eat small amount Breakfast. Gu: urinal. Skin (R) shoulder to Bulky dry small amount of serous pain drainage around the neck (D) hand Bulky dry (+) AROM fingers. Pt c/o pain well medicate as ordered. Afebrile (b)(6)-2 [redacted]
0930	Pt stated he had pain in head & hand. 2 percocet were administered. — (b)(6)-2 [redacted] SGT/LPN
1300	Pt ate 100% of an MRE & Kool Aid. IV d/c'd because it was no longer patent. — (b)(6)-2 [redacted] LPN

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

NSN 7540-01-075-3786

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

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS			ARRIVAL: DATE *(Day, Month, Year)*	TIME
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY	

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

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

CHIEF COMPLAINT

CATEGORY OF TREATMENT		VITAL SIGNS					
☒ EMERGENT	TIME	TIME					
		BP					
☐ URGENT		PULSE					
	INITIALS	RESP					
☐ NON-URGENT		TEMP					
		WT					

LAB ORDERS						X-RAY ORDERS		
☒	CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT		☒	CXR PA & LAT/PORTABLE	☒ C-SPINE
	URINE C&S	UA MSCC/CATH		CHEM:			ACUTE ABDOMEN	LS SPINE
	BLOOD C&S X						SINUS	HEAD CT
							ANKLE R/L	shoulder
								skull.

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1730	Ancef 1gm				
1730	morphine 10 mg				
1730	LR				

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

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶	TO	WHEN
☐ IMPROVED ☐ UNCHANGED				
☐ DETERIORATED	TIME OF RELEASE	I have received and understand these instructions.		
		PATIENT'S SIGNATURE		

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

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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