LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
31May03	0730 Foley c̄ 725 cc clr, yellow urine — 1LT [redacted] AN (b)(6)-2
	0920 MD in to see pt. Drsg A will be done tomorrow.
	(b)(6)-2 1LT [redacted] AN
31May03	1307 pt awake & alert. airway patent, lung sounds CTA abd soft nontender ⊖ distention, BS⊕x4 quads. (R) leg c̄ ext. fix c̄ ace wrap from calf to foot, drsing c̄ several bloody drainage areas. MD aware, previous shift states "MD aware, does not want drsing reenforced, drsing will be A'd 1 June 03. pt able to wiggle toes. (R) leg c̄ FROM ⊕ pulse. BUE c̄ from ⊕ pulses. IV site (R) FA c̄ NS infusing 3 diff. ⊖ S/Sx of infiltration. pt on EPW precautions. (b)(6)-2 leather restraints B/lat. will cont to monitor — [redacted] 91WM6
	foley cath to gravity draining cl. yellow urine ∃ diff. — (b)(6)-2 (b)(6)-2 [redacted] 91WM6
31May03 KOD	Dr. [redacted] c̄ pt A/ing drsing. wound to side of left leg open c̄ muscle exposed packed c̄ gauze, half dollar size, hole to top of leg oozing blood packed c̄ gauze & wrapped c̄ Kerlix (b)(6)-2 drsing. pt tol drsing A well. will cont to monitor — [redacted] 91WM6
31May03 1815	emptied 1200 cc cl yellow urine from foley — [redacted] 91WM6 (b)(6)-2
2100	VSS. Pt. alert. Foley to gravity draining clear yellow urine. Drsng: ext. Fixator to (L) LE intact, clean, dry. Capr refill <3sec. Pulse 2+ c̄ edema +1. ⊕ ROM, ⊕ sensation. HR reg, lungs CTA. BS ⊕ x4, ABD soft, non-distended. Pt (b)(6)-2 NPO p̄ MN tonight. will continue to monitor. — [redacted]
Jun03 0345	UOP CYU 640cc — [redacted] 9MC (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
010513 ~~Aug~~ June 03	Pt is awake. C/o pain; MSO4 max dose already given; pt refuses to allow us to elevate his legs to help ↓ swelling. Airway is intact, breath is even and unlabored, breath sounds clear to all lobes. Abd is soft, nontender, ± distention. BS(+) x 4. Pt is NPO for OR this AM. Pt has FROM to (R) LE and (L) LE. Neurovascularly intact to all extremities. (R) LE has ex fix and ACE; ACE has significant amount of sanguinous drainage. [redacted]
010520 June 03	MSO4 dosage reordered. 2mg MSO4 given IV. Legs elevated above pt heart. Pt is currently sleeping ± c/o pain. [redacted]
010520 June 03	Pt has foley to gravity, draining clear yellow urine. [redacted]
0800	1100 cc UOP via Foley [redacted]
1 June 03 1530	Pt vitals taken BP 122/80, P. 100, R. 16, TEMP. 99.0 [redacted]
1 JUN 03 1340	Assumed care of Pt @ 1300. VSS ± mild low grade temp 99°. A+O x 3. Denies pain @ present time. (L) LE elevated. (R) LE Ex Fix intact, dry lace wrap CDI ± around pins where there is small bloody drainage. (+) sensation, capillary refill <3 sec, mvt of all toes (L) foot. O/W assessment WNL. Will cont to monitor. NPO O/C to OR [redacted]
1 JUNE 03 1595	Author Op Note Pre-Op Dx: Grade III open (R) tib-fib fracture (2) ex fix (L) tibia (3) [illegible]

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

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

REGISTER NO. | WARD NO. EW2

EPW

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Post-Op Dx - same
	Procedure: (1) I+D open (2) left ankle for (2) adjust ext. fix with addition of [redacted] bar (3) DPR fasciotomy
	Surgeon: [redacted] (b)(6)-2
	EBL - <100
	Blood: 1000 LR
	Findings: Fixator loose, Wound clean except several large fragments of devitalized bone removed from tibia. Fasciotomy wound closed with 3-0 nylon very soft compartments
	PLAN: Dressing changes. Repeat I+D in 48 hours. Consider plating of fibula to increase stability. Possibility for BKA with injuries.
	[redacted]
	(b)(6)-2

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all (b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
020540June 03	BLE elevated above heart. Ø edema at this time. IV to Ⓐ hand. Ankles well and [illegible] s/s of infection or inflammation. [redacted]
2 JUN 03	Pt. vitals taken BP 100/56, P. 90, R. 20, Temp 99.0 [redacted]
2 Jun 03	Ⓢ N/A Ⓢ VSS [illegible] [illegible] Ⓐ [illegible] I to [illegible]. [redacted]
2JUN03 1400	Assumed care of Pt @ 1300. VSS, A+O x 3. Urine Cyst spontaneous void, Ex Fix dry intact, small amount of bldy drainage @ lower pin site. ⊕ Sensation, motor toes, cap refill <3sec ⊕ LS. IV [illegible] to see pt. NPO [illegible] for [illegible] in am. O/N assessment WNL. Will monitor [redacted]
2Jun03 2230	Pt care assumed @ 2100. VSS, A+Ox3, ⅓ percocet given for pain @ 11e. Lungsounds CTA, pulses palpable x4, bowel sounds present x4 quadrants. Dressing with ex fix intact, some bloody drainage noted @ lower pins. Pt has ⊕ sensation and can wiggle toes in both feet. NPO past midnight, surgery in AM. Pt resting right now, very cooperative, will continue to monitor. Sp[redacted]
3 Jun 03	Assumed care of pt @ 0500. Pt is awake. Pt is NPO. Pt will be going to OR this am. VSS - P-97, Sats 98%, BP 122/78, R-18 and T-99. Lungs CTA. Bowel sounds x 4 quads. Distal pulses are present. Pt is more comfortable with feet elevated high. Pt has Ø % of pain or discomfort @ this time [redacted] SGT, USMC

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1 June 03	Foley D/C'd @ 1850 — SPC [redacted] GIW
1 June 03 1915	Pt returned from OR. VSS. A&O x 3. Ex Fix Dsg CDI. (L) LE elevated. (+) sensation, capnefil c 3 sec, mvt of toes (L) foot. TOL PO well (+) BS x 4. O/N WNL. Will monitor [redacted]
2140	Pt stable at this time. AAOx3. PERRLA. Lungs clear bilaterally. Abd soft, non-tender, bowel sounds active x4 quads. Ex fix dsg CDI. (L) leg elevated. (+) movement of toes to (L) foot strong pulse & brisk capnefill bilaterally. Tol PO well. Ø complaints at this time — [redacted] CD/AT
02 June 03 0145	Ø Vs replacked. Pt tolerating po well. Ø complaints at this time — [redacted] CD/AT
0430	Pt stable at this time. (L) leg elevated. C/O pain. Percocet ii tabs given. [redacted] CD/AT
0430	Pt T 480cc void to urinal at 2300. 350cc clear yellow urine to urinal @ 0300. Ambulate
0540 June 03	Pt is awake, alert. Airway intact. Breathing is even and unlabored. Lung sounds clear to all fields. BS (+) x 4. Abd is soft, nontender, and ≠ distention. Pt voids spontaneously. Flow to (R) LE and (R) LE. Neurovascularly intact to all extremities. (R) LE has Ex-Fix & ACE wrap, CDI. →

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3Jun03 2030	assumed care @1300 - VSS - IV patent - dsg & ex fix in place & intact to (D) LE - pt. tolerated regular diet - encouraged to T (D) LE and not dangle it over side - through the interpreter pt. told he would return to Surgery in 48-72° for wound washout, wants to go home and not back to EPW camp - [redacted]
2330	Assumed pt care @2100. VSS, A+ox3, percocet ii given for pain stated @ 6 @2130. Lung sounds CTA, pulses palpable x4, bowel sounds present x4 quadrants. Dressing on LE CDI, foot elevated 30°. Pt with (+) sensation and ROM in LLE, able to wiggle toes. Will continue to monitor. Spc [redacted] 91WM6
4 Jun 03 1005	Assumed care of pt @ 0500. Pt is asking for pain meds. Pt asks for pain meds at least 2 hrs. I gave pt ii percocet @ 0630. Pt asked for more pain meds @ 0915. I gave pt Tylenol 650 mg. Pt is now resting quietly with c/o pain or discomfort. VSS - Saks - 98%, P-62, BP 118/72, R-18, T-98.6. Pt has heplock in (R) arm. HL is patent. Pt has ext. fix. on left leg. (L) leg is elevated - [redacted] 91WM6, SGT
4 Jun 03 1300	Pt c/o 3. Pt on (L) chris dsg. Pt in supine position c feet elevated per Pt. (L) c/o PN. @ the time. 110/70 P 73 Resp R 16 (B) CTA. T 98.4 - [redacted] SPC 91W6

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

30 JAN 03
10 AM

Ortho Op Note

Pre-Op Dx: GR256 M open (1) tib-fib fx
Post-Op Dx - same
Procedure: (1) I+D (1) tib-fib fx
(2) Tighten external fixator (1) LLE
Surgeon: [redacted]
ASA - III
PLAN DX - LR 700 cc
Findings - Wound clean. Compartments soft. DPC of medial fracture site clean, not under tension. Ex fixator components loose. These were tightened. Still 2-3 cm shorter soft tissue defect over distal tibia.
PLAN: Repeat I+D in 48-72 hours
continue IV abx.

[redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		SPONSOR'S ID NUMBER
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CPW [redacted] (b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
4 JUN 03 1400	Assumed care of pt @ 1300. VSS. A+Ox3. Ø c/o pain @ present. (L) LE Ext Fix dressing CDI. (+) sensation, cap refill 3 sec, mv toes in (L) LE. (B) LE elevated [redacted] O/W assessment WNL. Will monitor ——— [redacted]
2100	Pt. care assumed @ 2100. Pt. c/o constipation. Dong colace given. HR Reg, lungs CTA, BS (+) X4. Ext. Fix to (L) LE intact. Dsng CDI. (+) sensation, (+) ROM. Cap refill <3 sec. VTA pulse 2° dsng. Will continue to monitor. ——— [redacted] CTAN.
5 Jun 03 0645	Assumed care of pt @ 0500. Pt is sleeping - VSS - 98% - Sat, 68 - P, 118/78 - BP, 97.4 - T, 18 - R. Lungs CTA. Bowel sounds x4 quads. Ext. fix to (L) LE. Pt is NPO. Pt will be going to OR for I+D. Pt will wiggle toes. Pt has Ø c/o pain or discomfort @ this time. ——— [redacted] 86T, 9 WMC
5 JUN 03 0705	Ortho Op Note Pre Op Dx - Open III B (L) Tibia Fx Post Op Dx - Same Procedure: I+D (L) leg Surgeon: [redacted] Anesthesia: [illegible] Blood loss 500 cc [redacted]

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

EPW [redacted] (b)(6)-4

PROGRESS NOTES
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Findings - Wound clean. Closed ~ 50% with 0 prolene retention suture.

Plan - Repeat I+O 72 hours. Attempt delect closure. Consider changing X-fix for LLE.

[redacted]

5 June 03 Assumed care of Pt @ 1300. VSS. 4+0x3. Pain controlled c̄ Tylenol. 1900. (L) LE elevated. Ex Fix Dressing CDI. Pt c/o ↓ appetite. Pt assessed WNL. Will [redacted]

2130: Pt: alert. ABD, soft, non-distended. BS (+) x4. HR Reg. Lungs CTA. (L) LE elevated c̄ ext. Fix; dsng CDI. (+) sensation (+) ROM, Cap refill < 3sec. Will continue to monitor. [redacted]

5 Jun 03 - Assumed care of Pt @ 0500. Pt quiet. 0545 - had morphine @ 0430. VSS. Lungs CTA. Bowel sounds x 4 quads. Pt HL (L) UE - patent. Ext. fix. (L) LE - intact + dry. Pt has cap refill less than 3 sec. Pt can wiggle toes. Ø c/o pain or discomfort @ this time. [redacted] SGT

NOTES	DATE

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

all (b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7 June 03	0520 Assume pt care @ 0500. Pt awake and alert. C/o pain to LLE, 00/11 percocet given for pain. pt encouraged not to bend leg. VSS. HL to ⊕ FA. flushes well no s/s infiltration/redness. Ext. fix and ace wrap to LLE, CDI. ⊕ sensation and ⊕ movement to toes. HR regular. Lungs CTA throughout Abd soft non tender non distended. Bowel sounds x4 active. Radial/pedal pulses palpable. Will continue to keep LLE elevated. and monitor pain. [redacted] 9lumo
7 Jun 03 @ 1900	Pt care assumed @2100. VSS, alert and awake, pt had c/o pain relieved by elevating LLE with blanket. Lung sounds CTA, pulses palpable x4, bowel sounds present x4 quadrants. Pt pulled needle @ IV port out twice, reinforced w/tape, restraints tightened, pt explained to that IV meds are to help him. Pt refused dinner except for milk and cake. Heplock @ LFA flushes well. Dressing with ex fix on LLE CDI, pt has ⊕ sensation, ⊕ ROM on LLE. Pt explained to keep LLE straight, not bent, @ 30° up, frequently bends both legs and has to be re-explained. After assessment, pt had rapid shaking of body, which stopped once attention was given. The MP reported it lasted about 20 seconds with rapid movement of RUE and LUE. VSS stable after episode, assessment w/u. Dr [redacted] notified, will continue to monitor. SPC [redacted] 9lumo
2000	Pt refused solace. SPC [redacted] 9lumo

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
Jun 6 03	
800	Pt CAOx3. ⊘ disorientation - Pt ⊘ sensation - feeles positive ⊖ leg ↑
	V/S 110/70 R 16 (B) CTA T 99.2° P 86 Reg [redacted] S PC 9/10
6 Jun 03	pt. c/o abdominal pain, bloating and no BM -
1615	pt. given I dulcolax suppository PR, will
	monitor results - abdomen soft, round,
	(+) BS x4 quads, tender to touch [redacted]
6 Jun 03	pt. attempted to get OOB when helped pt.
1900	pt. c/o faint and weak, put back in bed, VSS,
	pt. resting very quiet - pt. convinced to get
	on bedside commode to attempt to have BM -
	pt. had normal size BM - bedside bath done
	and peri care and pt. placed back in bed -
	IV patent - no further c/o abdomen pain -
	[redacted] CPMA
2120	Pt care assumed @2100. VSS, alert and awake, c/o
	pain in LLE relieved by 2 percocet. Lung sounds CTA,
	bowel sounds present x4, pulses palpable x4. Pt c/o
	constipation, earlier shift reported bm x2. Abd tender to
	touch. LLE dressing CDI, (+) sensation and ROM.
	Heplock flushed, will continue to monitor. SPC [redacted] PMC

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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WARD NO. ICW2

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

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
8 Nov 03 2030	Multiple given Haldol 5mg IM, Benadryl 2mg IM, and Benzotropine 2.5mg IM, since clearly given extreme agitation on ward, to ensure ward personnel safety. [redacted]
1935	Pt. care assumed @ 1700. Pt. wants to go to BR for BM. Pt. on Bedrest, refuses bedpan. ABD soft, non-tender, non-distended. HR Reg. Lungs CTA. BS ⊕ XY. IV to ⓡUE AL Ext. Fix to ⓛLE intact. ⊕ sensation, ⊕ ROM toes ⓡft ⊂̄ cap refill <3sec. will cont. to monitor. [redacted]
0230	Pt. cont. to be non-compliant, trying to roll out of bed, resisting being restrained, yelling @ times. EMT physians, interpreter consulted. Pt. sedated ⊂̄ 10mg MSO4, 10mg Haldol, 3mg Versed. O_2 Sats 95% HR 88 RR 16. Will continue to monitor. [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
8 June 03	0800 IV in R forearm @ 18g. Spe[redacted]
8 June 03 1040	Ortho Op Note:
	Pre-Op Dx - Open fracture Grade III Tibia Fx
	Post-Op Dx - Same
	Procedure - I+D (L) leg, partial wound closure, splinting (L) leg
	Surgeon: [redacted]
	EBL: nil
	Findings - Able to close wound ≈ 98% but still 1x1 cm area over tibia still open [redacted] PPC
	area of fenestration with slight bleeding drainage. Splint applied to leg to keep the wound fenestration stabilized
	Plan: Pt is getting out his NS. Will D/C CIPRO 500 mg PO BID

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		[redacted] S ID NUMBER
	LAST	FIRST	
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EPW #[redacted] (b)(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 JUN 03 2155 hrs (Cont'd)	(R) anterior forearm Hoplock intact. Lungs CTA, abd ō (+) bowel sounds in all quads - nondistended. Will continue to monitor @ this time. [redacted]
11 JUNE 03	0800 Assumed pt care @ 0500. Pt asleep. Easy to awake for assessment. VSS. no c/o pain. HL placed to (R) wrist by Lt Linch. HR regular. Lungs CTA. BS x 4 active. LLE ex fix and wrap no drainage noted. Pt to OR today. (+) sensation (+) movement to toes of LLE. Will continue to monitor [redacted] 1250 pt returned from recovery of S/P I+D to (L) LE. [redacted]
11 JUN 03	Assumed care of Pt @ 1300. Return from OR/Recovery in [redacted] VSS 4+O3, easily arousable. (L) LE Ex Fix/Drsg CDI. Ø c/o pain (+) BS x 4 (+) CTA. HL IV, tol PO well. Will monitor and assess [redacted]
2200	Pt. resting quietly. Ext. Fixator intact. Cap refill <3sec ō (+) sensation, (+) Rem. VSS. II Percocet given for pain. Will cont. to monitor [redacted]
12 Jun 03	0550: Assumed pt. care @ 0500: Pt. A+Ox3. Lungs CTA pulses palpable x4. (+) sensation and motor function in (L) foot. (+) BS x 4. Ex-Fix ō dsng on (L) leg CDI. c/o pain to (L) leg. Will continue to monitor [redacted]
12 JUNE	1930. Assumed care of Pt @ 1300. VSS A+Ox3 Ex Fix (L) leg CDI ō sm bldy drainage. Pain controlled with ~~IV~~ dyland O/W Assessment w/ II. Will continue [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9 June 03 0930	Assume pt care @ 0500. pt asleep. awakens to touch. VSS. pt up to eat breakfast and drink water. (R) LE ex fix c̄ ace wrap. LLE elevated encourage pt to keep it straight. HR regular. Lungs CTA. BS x4 active. Pulse strong. pt able to wiggle toes of LLE (+) sensation. No c/o pain or discomfort. Haldol 5mg Ativan 2mg and Benadryl 25mg adm. by Lt. [redacted] pt sleeping now. Resp @ 16 bpm. Will continue to monitor — [redacted]
9 June 03 1300	R vitals taken BP 106/68, P. 86, R. 16, Temp 98.7 axillary — [redacted]
10 June 03	800 pt awake sitting up. ex fix to LLE ace bandage ~~and~~ leg coming undone pt continues to bend and move LLE. Assessment WNL. No c/o pain @ this time — [redacted]
10 June 03 1800	Assumed care of Pt @ 1300. VSS x̄ mild temp 99°. Ex Fix Dressing (D) LE CDI. (+) capnefill, sensation, mvt (L) toes. Cns assessment WNL. Will Monitor — [redacted]
10 Jun 03 2155hrs	Assumed care of pt @ 2100hrs. Alert, active in bed. Intermittently sleeping ō observed or verbalized discomfort. (L) tib ex fix noted ō observed drainage around pins or on dress. (L) metatarsal cap refill < 3 secs. warm to touch in all digits. — Cont'd [redacted]

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

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

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[redacted] (b)(6)-4

PROGRESS NOTES
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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	will continue to monitor. SPC [redacted] [illegible]
14 June 03	0600 pt requesting shot for pain. ii percocet adm. will monitor pain level. [redacted] [illegible]
14 June 03	Assumed care of pt @ 0500. Pt asleep. Pt was given ii tabs of percocet for pain. Lung CTA. Bowel sounds x4 quads. Pt has been pulling off his bandage on (L) leg. He has stated that he would like to go home. Pt seems to be relying a lot on pain meds. Pt has 0 % pain or discomfort @ this time. [redacted] LPN, SGT
1900	Assumed care of Pt @ 1300 VSS, A+Ox3. Pain controlled with tylenol. Ex Fix dsg (L) LE wound dsg D/I Ø si/sx infection, now CDI. Ø/W assessment [redacted] will monitor [redacted]
14 Jun 03 2215	Pt awake + alert in bed. VS WNL. PERLA (+) WNL. Skin W+D LE (B). PS (+) x4. (+) PPP (B). Ext. fix (L) ↓ Ext. intact c ACE wrap. Able to move toes and feel sensation. Will cont to mon [redacted] SPC/AN
15 Jun 03	0900 - Pt awake + alert in bed. VSS. Assessment WNL. Ov extremity ext fix intact c wrap. Pt able to move toes + feel sensation. Voicing Ø complaints at this time. Will cont to monitor [redacted]
15 June 03 1300	Pt vitals taken BP 112/68, P-82, R-20 Temp. 98.7 SPC [redacted]
15 Jun 03 1930	assumed care @ 1300 - VSS - dsg A'd, some granulation noted on wound, pin sites cleaned - no % pain @ this time - had BM, ate only milk ed dinner - [redacted]

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 Jun 03 00	Pt care assumed @ 2100. VSS, Alert and awake, pt ~~has received~~ error [redacted] ~~after~~ ~~VSI~~ ~~de~~ ns. has had no complaints this shift. Lung sounds CTA, bowel sounds present x4. Pt had IV out of place in RFA, IV restarted in RFA. Dressing on RLE CDI, pt able to wiggle toes, ⊕ sensation and capillary refill on RLE. No new complaints, will continue to monitor. SPC [redacted] 91WM6
13 Jun 03	0800- Pt sleeping, but easily arousable. Refused breakfast. Drank milk & water. VSS. Lungs CTA, BS ⊕ x4. HL to ® forearm. Dsg to RLE pt able to wiggle toes, ⊕ sensation & cap refill. Voicing no complaints at this time. Will cont. to monitor. — [redacted] JLT RN
13 June 03 1600	Pt vitals taken. BP 120/70, P. 88, R. 16 Temp 98.8 SPC [redacted]
1800	VSS. Assumed care of Pt @ 1300. A+O x3. MD to D/C ex fix dressing, CDI. ⊕ capillary, sensation, mvt of toes. Ø c/o pain. Resting all shift. Ofn assessment WNL. Will Monitor [redacted]
2145	Pt care assumed @ 2100. VSS, pt resting, awaken by verbal stimuli. Lung sounds CTA, bowel sounds present x4, pulses palpable x4. Dressing on LLE CDI, + sensation and ROM, c/o small amount of pain. Hemlock on ®FA flushes well,

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. L CW2

[redacted] (b)(6)-4

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

all (b)(6)-2

LAST NAME #245	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 Jun 03 2230	Pt awake in bed. Eyes 1/2 closed. Appears "groggy". Easy to communicate with. PERRLA. VS WDL. Skin W/D. LCA(B). BS(+) WDL (+) PPP(B). Ext Fix ↓ (L) leg in place. Dsg C/D/I. Ø complaints @ this time. Will cont to mon [redacted] SPC/AN
0811	Tong Ambien given for sleep [redacted] SPC/AN
16 Jun 03	0755 - Pt alert resting comfortable in bed. VSS, lungs CTA, BS(+). Ext fix ↓ (L) leg in place. (+) Sensation cap refill <3 sec. Voicing no complaints. Will cont. to monitor [redacted]
16 June 03 1300	Vitals signs taken. BP 100/60, P-90, R-16 Temp 98.6 SPC [redacted]
2215	Pt. care assumed @ 2100. VSS. Pt. hiding under blanket. Ext. Fix to (L) LE intact. (L) LE cap refill <3 sec. Toes warm. UTA pulse 2° splint. HR Reg, Lungs CTA, ABD soft & Active BS x4. will cont. to monitor. [redacted]
17 Jun 03	0908 - Pt alert VSS, lungs CTA, HR reg, BS(+). Ext fix ↓ (L) leg in place. Dsg CDI. (+) sensation cap refill <3 sec. Able to wiggle toes. Consumed 50% of breakfast. Completed AM care. Voicing Ø complaints at this time. Will cont. to monitor. [redacted]
17 Jun 03 1945	assumed care @ 1300 - VSS - pt. sleeping most of shift - IV patent - ate chicken & dinner tray - dsg D'd, granulation tissue in wound & upper pin sites - no c/o pain, (+) (L) pedal pulse [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

all (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
2330	Pt care assumed @2000. VSS, alert and awake, no complaints at this time. Lung sounds CTA, pulses palpable x4, bowel sounds present x4 quads. Dsg on LLE C̄ ex fix CDI. Pt has ⊕ sensation, pulse, and ROM of LE. Pt states to interpreter he wants to use the bathroom, explained hisigury and healing process, and why he cant ambulate. Pt threw bedpan on the ground, was very aggressive. 2400 meds given, pt now resting. HL @ LFA flushes well, ∅ S/S infiltration. Will continue to monitor. SPC [redacted] 9LW MC
18 June 03	1100 - Pt alert. VSS. Consumed little breakfast
0615 T 98.8	this am. Lung CTA, HR reg, BS⊕, ext fix
P 81	intact to ⊕ leg c̄ DSG CDI. Hrs slept
R 12	this morning ⊽ breakfast. Will cont. to
BP 106/76	monitor [redacted] 2Lt AN
98%	1530. Pt LAOx3. ∅ obvious distress. Pt c/o having to may
	Bowl. Closed dressing. ∅ S/S of infection. Slight
	erythema. Right looked good - Wet to dry dressing unwrapped c̄
	ACE Wrap [redacted] SPC 9LW

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.

EPW [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

all (b)(6)-2

PROGRESS NOTES

DATE	
2200	Pt care assumed @2100. VSS, a&ox3, pt alert and aware, without c/o pain. Lung sounds CTA, bowel sounds present x4 quads, pulses palpable x4. LLE dsg CDI, +ROM, sensation. Pt had HL d/c'd, meds @24 PO. Will continue to monitor. SPC [redacted] 91WM6
20 Jun	Assumed care of pt @ 0000. VSS. Pt has been asleep off and on. Lungs CTA. Bowel sounds x4 quads. Ext. fix. on (L) (L) extremity. Pt can wiggle toes. Cap refill less than 3 sec. Dsg dry and intact. Pt has had no c/o pain/discomfort. Will continue to monitor. [redacted] 91WM6, SPC
20 Sunday 1500	Assumed care of Pts @ 1300. VSS. A+O x3. (P) LS CTA (P) BS x4 (L) LE Ex Fix/Dsg CDI. (P) sensation, cap refill < 3 sec, mvt toes (P) LE, palpable pulses x4. Pt did Personal Hygiene. Q/D Assessment WNL. Ø c/o pain. [redacted]
2130	Pt. care assumed @ 2100. Pt. alert, resting quietly. Ex: Fix to (L) LE intact, dsng CDI. CTA pulse (L) ft. ↓ dsng. Brisk cap refill c (+) ROM toes (L) ft. HR Reg, lungs CTA, ABD soft & BS (+) x4. Will continue to monitor. [redacted]
20 June 03 2200	Pt vitals taken BP 122/80, P. 96, R. 20, temp. 98.6 SPC [redacted]
21 June 03 0600	Pt. laying in bed sleeping w/ Foot of bed @ 15°. External fixator to (L) LE, dressing & ace wrap CDI, cap refill < 3 sec, + ROM in toes, sensation present. Pt. has no apparent complaints @ this time. Assessment completed & no abnormalities noted. Will continue to monitor. [redacted]

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

all (b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	
18 JUN 03 1830	Assumed care of Pt @ 1200. VSS. A+Ox3. ∅ c/o pain. ⓑ LE ex fix CDI, Drsg Δ done, ∅ s/s of infection. OOB → BSC x2. ∅ ambulates WNL. Will cont to monitor. [redacted]
2240	Pt care assumed @ 2100. VSS, A+Ox3, ∅ c/o pain. Lung sounds CTA, pulses palpable x4, bowel sounds present x4 quads. Dsg on lle c̄ ex fix CDI, no drainage noted. Will continue to monitor. SPC [redacted] 9/WMC
19 June 03 0550	Assume pt care @ 0500. Asleep, easy to awake for assessment. No c/o pain @ this time. LLE
0545 T97.8 P92 R22 BP 110/76 97%	ex fix intact c̄ ace wrap. VSS. HR regular. Lungs CTA. ⊕ sensation ⊕ movement cap refill < 3sec below ex-fix. Abd. soft. BS x 4 active. Will continue to monitor. [redacted] 9/WMC
	1245. HL Dc'd. Ativan Δ'd to PO, Benadryl Δ'd to PRN. X-ray consult put in by Dr. [redacted] @ 1240. [redacted] 9/WMC
19 June 03 1500	assumed pt care @ 1300. pt resting quietly easily aroused to verbal stimuli. assessment finds WNL. LLE c̄ ext fix draing CDI. X Ray completed. ∅ c/o pain voiced @ this time. Will cont to monitor — [redacted] 9/WMC
19 June 03 2100	Pt vitals taken BP 112/68, P. 84, R. 20, Temp. 98.6 SPC [redacted]

(Continue on reverse side)

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

REGISTER NO. [redacted]

WARD NO.

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

PROGRESS NOTES
Medical Record

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PROGRESS NOTES

DATE	
	cont'd. Ø c/o's @ this time. Will cont. to mon. [redacted]
23 Jun 03 0950	Assumed care of pt @ 0500. Pt is sleeping. VSS. Pt is NPO. - On call to OR. Lungs CTA. Bowel sounds x4 quads. Ptet HL in (L) arm @ 0900. Pt has Ø % pain/discomfort. Will continue to monitor. [redacted] SGT
23 Jun 03 2045	assumed care @ 1300 - pt. to OR @ 1500 returned ~ 1930 - (L) LE has ex fix in place, ace wrap, drainage noted on (P) lateral aspect of (L) ankle - IV patent - pt. sleeping easy to arouse but very drowsy - lungs CTA (B) - no BS noted - <2 sec cap refill in (L) toes - pt. given bed bath, mouth care done - DTV @ 2100 [redacted]
2230	Pt. care assumed @ 2100. VSS. Pt. resting quietly, cooperative. LR @ 128 cc/hr. infusing ~ difficulty. Ex-fix to (L) LE intact. Scant amt bloody drainage leaking through dsng, bleeding controlled. HK Rg, Lungs CTA, ABD soft & BS (+) x4. Will cont. to monitor. [redacted]
24 June 03 0530	Assumed pt care @ 0500. Pt asleep now. ∞ II percocet PO adm for pain @ 0515, pt moving around trying to get comfortable. Labs returned WBC↑, temp 100.2°, HR regular. Lungs CTA. BS x4 active. Ex-fix and ace wrap to LLE. (+) sensation (+) movement to toes, red drainage noted and marked. HL to (L) FA (cont)

STANDARD FORM 509 (REV. 7-91) BACK

[redacted]

all (b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	
21 JUN 03 1900	Assumed Care of Pt @ 1300. VSS. Asleep most of shift. TOC Reg Diet well. (L) LE Ex fix/drsg CDI. W→D drsg's on (L) LE, ⊘ s/s of infection. ⊘ c/o pain. ⊘ w/ assess. RN will monitor [redacted]
21 Jun 03 2300	Pt. sleeping easy, to awaken VS WNL. Skin W/D. Perl (+) LCA (+). BS (+) x4. (+) PPP. (L) ext. fix intact. Dsg CDI. Pt. refused dose of Ativan @ this time. Will cont. to mon. [redacted] RRD/AN
22 June 03 0745	Assume pt care @ 0500. pt awake c/o pain to LLE, percocet ½ adm. VSS. HR regular. Lungs CTA. Abd soft BS x 4 active. (L) ext fix and dsg Intact. will cont. to monitor. [redacted] Sturm
22 Jun 03 2020	assumed care @ 1300 - VSS - ate dinner c some assistance - mostly sleeping - dsg Δ'd - pt. attempted BM x 2 s success, abdomen not distended (+) BS x 4 quads (+) pedal pulse (+) 2 in (L) foot - no c/o pain @ this time [redacted] CRAN
22 June 03 2130	Pt vitals taken. BP 124/88, P. 96, R. 20, Temp. 98.0 SPC [redacted]
22 Jun 03 2300	Pt. rec'd @ 21:00 Sleeping in bed. easy to awaken. VS WNL. Perl (+) LCA (+). BS (+) x4. (+) PPP (+). Able to wiggle toes to (L) foot and feel sensation. (+) ex fix intact. Dsgs CDI

(Continue on reverse side)

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

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PROGRESS NOTES
Medical Record

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all (b)(6)-2

PROGRESS NOTES

DATE	
25 June 03	0545 Assume pt care @ 0500. Pt asleep now. ii percocet adm for pain @ 0530. Labs drawn this am WBC ↓ from yesterday but still elevated. Temp 100.6. HR reg Lungs CTA, BS x 4 active. HL to (L) wrist no s/s redness/infiltration c̄ flush. Ex-Fix and ace wrap intact. Drainage marked, (+) sensation (+) movement (+) pulse to (L) foot. Will cont. to monitor. — [redacted] 91WM6
	1245 Dsg Δ and pin care done. Stitches to wounds intact, no drainage noted. Pt c/o pain @ this time. pins cleaned c̄ sterile water and H_2O_2. — [redacted] 91WM6
25 June 03 1530	assumed pt care @ 1300. VSS pt resting c̄ eyes closed, arouses to painful stimuli. lungs CTA, abd soft BS(+). (R)LE c̄ full ROM (+) pulse (L)LE c̄ ext fix dressing CDI (+) pulse. BUE c̄ full ROM (+) pulses. HL to (L) wrist flushes 3 diff. (-) S/Sx of infection. Will cont to monitor. — [redacted] 91WM6 SGT
25 Jun 03 0239	Rec'd pt @ 21:00. Pt. sleeping. easy to awaken. VS WNL according to VS flow sheet. PERRLA (+) WNL LCA (B). BS (+) x4. (+) PPP (B). Minor tremors noted in Pt's (L) hand while holding a cup. C/o pain @ 23:54. ii Percocet given. Will monitor [redacted] DET/AD
26 June 03	Assumed pt care @ 0500. pt asleep easy to awake. VSS. HR regular lungs CTA BS x 4 active. No c/o pain. Encouraged pt to keep (L)LE elevated.
0500 T 98.1 P 110 R 16 BP 116/84 97%	Ex-Fix intact, Dsg CD+I. (+) sensation (+) movement to toes. Will continue to monitor — [redacted] 91WM6

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MEDICAL RECORD	PROGRESS NOTES
DATE 24 June 03	0530 (cont.) no s/s redness/infiltration c̄ flush. will encourage pt to keep LLE straight and elevated. will continue to monitor. [redacted] 91WMC
	0945 temp 99.2°, ↓ from this am. [redacted] 91WMC
24 June 03	1000. MO notified of ↑WBC. IV antibiotic Ancef discontinued, unasyn started. CBC ordered for AM 25 June. [redacted] 91WMC
24 June 03 1430	assumed pt care @ 1300. VSS pt resting c̄ eyes closed, arouses to painful stimuli. lung sounds CTA abd soft round. BS(+) x4 quads. (D) LE c̄ ext fix drawing c̄ old drainage noted, keep putting (L) leg on blanket to keep elevated, pt will not keep ext ↑, keeps moving leg. pt c/o pain given ii percocet @ 1400 per prn orders. will cont to monitor. HL to (L) wrist flushes well c̄ diff of swelling/redness noted [redacted] 91WMC
2300	Pt care assumed @ 2100. VSS, pt resting awoken to painful stimuli. Lungs CTA, + BS x4 quads. LLE with some bloody drainage noted, dsg intact. Pt explained through Nabil to keep his leg straight and elevated so that it can heal, compliant so far on shift. ii Percocet given for pain. HL @ L wrist flushes well, will continue to monitor. [redacted] 91WMC

(Continue on reverse side)

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

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

PROGRESS NOTES
Medical Record

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9// (b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE 1230 26 June 03	Dsg Δ done @ 1000. pins cleaned c̄ STR+H2O2. Stitches intact. Pt ate both breakfast and lunch today. Haldol and Ativan @ 1200. No c/o pain @ this time. — [redacted] SMMC
26 June 03 1615	assumed pt care @ 1300. pt sleeping. VSS. lung sounds CTA, abd soft BS⊕x4 quads. RLE c̄ full rom ⊕ pulse. LLE c̄ ext fix, drsng CDI. pt will not keep leg elevated. HL to ⓛ wrist s̄ s/sx of infection noted. Will cont to monitor — [redacted] 9MMC SGT
26 June 03 2000	drsng Δ'd on ⓛ leg. pins cleaned c̄ H2O2+ STR, ⊖ signs of infection noted, stitches intact. pt tol well. ⊖ c/o pain @ this time. Will cont to monitor — [redacted] 9MMC
2300	Pt care assumed @ 2100. VSS. Pt. IV site reinforced & secured c̄ tape & tubular gauze. HR Reg. Lungs CTA ABD soft c̄ BS⊕ xy. Pt. c/o lower ABD pain c̄ palpation. ⓛ ex-fix intact. Drsng CDI. Attempting to keep ⓛ LE ↑ 2° edema to ⊖ ft, but pt. non-compliant. ⓛ LE c̄ pulse 1+, brisk cap refill, ⊕ sensation, ⊕ ROM. Will cont. to monitor. — [redacted] CTMN
27 Jun 03	0615 - Pt alert OOB to bathroom x1. BM x1. Dsg CDI to ext fix to ⓛ leg. Lungs CTA, BS⊕, HR reg, pulses equal & strong, bilat to ↑ & ↓ extremities, cap refill <3 sec. Will cont to monitor — [redacted] 2L+RN

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

EPW-A [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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PROGRESS NOTES

DATE	
27JUN03 1500	Assumed care of Pt @ 1300 VSS, A+Ox3. Pt resting NO c/o pain. (L) LE Ex Fix/Dsg CDI. (P) palpable pulse, cap refill <3sec (L) foot. O/W assessment WNL. Will monitor [redacted]
27Jun03 2200	Rec'd pt @ 21:00. Pt sleeping awakened c some difficulty. appears lethargic @ this time. VS WNL. According to VS c low sheet. Perrla (+) WNL. Skin W/D. LCA (+). BS (+) x4. (+) PPP (+). Able to move and feel toes to (L) foot. (L) LE ext. fix. intact c ace wrap dsg C/D/I. No complaints this shift with cont to mon [redacted] /AN
28Jun	1100- VSS Pt sleeping but easily awakened. Follows commands, but moves slowly. Lungs CTA, HR reg, BS (+). DSG to ext fix intact. (P) sensation, warm to touch cap refill <3 sec. Will cont to monitor [redacted] 2400 AM

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

all (b)(6)-2

PROGRESS NOTES

DATE	
29 June 03	0845 Assume pt care @ 0500. Pt IV site restarted in (R) hand LR @ 100cc/hr no s/s redness/infiltration. VSS. HR regular Lungs CTA BS x 4 active abd soft. pt hands very shaky. Tolerated clears this am. LLE ex-fix dsg intact. (+) sensation (+) movement to toes. Cap refill < 3sec. Will continue to monitor [redacted] SIWMP
	1050 pt dsg Δ done. pins cleaned. Stitches intact. Sm amt of yellow drainage @ open wound site. Will continue to monitor [redacted] MMP
	1215 pt c/o pain to lower abd and that he cannot void. Pt requested foley through interpreter. MD notified, V.O. Byron Br [redacted] to insert foley cath. He French foley cath was gravity inserted. Draining yellow urine c̄ small amt of sediment present. pt tolerated 240cc of tang and half jello cup. Will continue to monitor [redacted] more
	1225 400cc UOP [redacted] MWMP
	1300 pt had med BM green @ 1100 [redacted] SMMP
1900	Assumed care of Pt @ 1300. VSS. In and out of sleep. Visably shaky, Groggy. (+) BS x 4. (B) LS CTA. Pt tol jello @ dinner spit up soup. Dsg Δ done to (L) LE Ex Fix. Stitches CDI (-) s/s infection, pin care done. (+) sensation, pulse palpable cap refill < 3sec (+) foot. O/the tech informed of splint order for foot drop. O/W WNL. [redacted]

STANDARD FORM 509 (REV. 7-91) BACK
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all (b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	
28 Jun 03	1300 - Talked c [redacted] about Haldol and Ativan. Will write order to make both PRN — [redacted] 2400
28 Jun 03 1715	assumed care @ 1300 - VSS - IV patent, abx given as ordered - lungs CTA (B) - (D) BS x4 quads - pt. had BM this am - pt. attempted to eat dinner but regurgitated each bite he took & each sip he took, will notify physician - no c/o pain - dsg Δd on (D) LE - opens eyes only when talked to and slightly shaken, follows simple commands — [redacted] CHA
28 Jun 03 2130	Dr. [redacted] aware of pt's vomiting c eating & drinking - pt. NPO, clears in AM, LR @ 100cc/hr started - Zofran ordered PRN - unasyn d/c'd — [redacted]
28 Jun 03 22:25	Pt rec'd @ bl. & pt. sleeping, somewhat difficult to awaken. Restraints x2 (D) wrist (P) ankle, skin PWD, PERRLA (B) w/ LCA (B). BS (A) x4. (D) PPP (B). PIV (P) FA patent c 100cc/hr. (D) leg ext fix c ACE wrap CDT. Able to move and feel toes to (D) foot. c complaints, will cont. to mon [redacted] RN/AN

(Continue on reverse side)

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

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WARD NO. 6W

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
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EPW # [redacted] (b)(6)-4

all (b)(6)-2

FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

6 JUN 03 2300: VSS, pt. care assumed @ 2100. HR Reg. lungs CTA, ABD soft ∅ BS XY. Foley to gravity draining cyu. Ex-Fix to (L) LE intact, drsng CDI. Splint applied to (L) ft by orthotec 2° foot drop. Brisk cap refill, ROM, sensation, pulse 2°, will cont. to monitor. [redacted]

30 Jun 03 0930 - Pt alert but moves slowly to commands. Ate jello and one orange for breakfast. Tolerating PO. Joined in c AM care. Foley intact draing yellow urine c some sediments. IV to (R) arm. VSS, lung CTA, HR regular, BS(+). Dsg to (L) leg intact. Will cont to monitor [redacted]

30 Jun 03 assumed care @1300 - VSS - pt. more alert this shift, repeats simple words and seems to understand more today - IV patent - Foley draining yellow urine c whitish sediment QS - Small tremors noted in hands - pt. had BM - ate ½ jello, 15 cc broth, 480cc tang @1730 and has not vomited as of this time - ~~Bm~~ xray done of (L) tib-fib [redacted]

1830

2115 Pt. care assumed @2100. Pt. assisted c mouth care. LR infusing @100cc/hr s difficulty. IV site CDI, s s/s infection. HR Reg., lungs CTA, ABD soft c BS (+) XY. Ex-fix to (L) LE intact c drsng CDI. Brisk cap refill to tes (L) ft. UTA pulse 2° splint, UTA sensation or ROM 2° pt. very drowsy. Will cont. to monitor. [redacted]

EPW [redacted] (b)(6)-4

all (b)(6)-2

MEDICAL RECORD | PROGRESS NOTES | SUBMITTED FOR LOCAL R

DATE	NOTES
1 Jul	Assumed care of pt @ 0500. Pt is asleep. VSS. Lungs CTA. Bowel sounds x 4 quads. Pt has a blank gaze in his eyes. Pt is starting to move around a little more. Pt has ∅ c/o pain / discomfort @ this time. [redacted] SGT
1 Jul 03 1850	assumed care @ 1300 – VSS – no c/o pain @ this time – ate Jello & SL tang for dinner, gagged on first bite of jello but had no trouble after that – LR @ 100 cc/hr infusing into (L) hand IV – dsg intact on (L) LE – Foley draining yellow urine c̄ white sediment – Pt. sleeping mostly, tremors evident when awake, more aware of surroundings – [redacted] CP
1 July 03 @ 2250	Pt awoke to ask to put HOB ↓. Attempted to explain reasoning for keeping HOB elevated, VSS, LCTA (B) + BS x4 qds, IVF infusing s̄ complication. ∅ c/o pain or discomfort noted @ this time. Foley draining clear-yellow urine. Will cont to monitor & support [redacted] minute.

SHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID N (SSN or Other)
	LAST	FIRST	MI	
SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

IDENTIFICATION (For typed or written entries, give: Name - last, first, middle; ID No or SSN, Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO. Ward 2

EPW

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509

all (b)(6)-2

ME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

ATE	NOTES
3 July 03	Assumed pt care @ 0800: Pt. awake. A+O x3 lungs CTA. (+) pulses x4. (+) BS x4. Foley to gravity c̄ clear yellow urine. IV LR infusing @ 100 cc/hr in (R) hand. Ex-fix c̄ ace wrap on (R) leg intact. ADM
0600 97.4	care done. Ø complaints @ this time [redacted]
116	1130: Dsng change complete. Around pin site has dry/gray
20	crust. Dr. [redacted] notified and verbalized that it is
138/80	normal. — [redacted] 91W MG
98%	
3 July 03	assumed pt care @ 1300. pt sleeping, hard to arouse
1500	VSS. lungs CTA, abd soft BS(+) x4 quads. Foley cath to
	gravity intact. IV (L) hand LR @ 100 cc/hr infusing 3 dry
	(R) 5/5x of infiltration. (L) leg c̄ ext fix draing CDI. Ø
	5/5x of distress noted @ this time. Will cont to
	monitor — [redacted] SGT
3 July 03	Emptied 500cc amber color urine from foley. pt resting
2030	quietly. — [redacted] SGT
3 July 03 2305	Received pt resting on bed. VSS, See SF 511.
	Pin/wound care done. Ø c/o pain. LS CTAB,
	HRR, BS(+) abd SNT. IV (L) hand infusing
	LR @ 100 cc/hr. (L) leg w/ drsg c/d/i and
	ex fix. Toes warm, cap refill brisk.
	Will cont to monitor [redacted]
4 July 03	0630 - Pt resting quietly this Am. IV to (R) arm.
	Ace wrap intact to (R) ext fix. VSS, lungs CTA,
	HR regular, BS(+). Voicing Ø complaints at this
	time. Will cont to monitor — [redacted]

all (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1 July 03 2300	Drsg to (L) LE Ad & Pin care done, stitches intact very small amt of yellow fluid noted. [redacted] 91WM
2 Jul 03	Assumed care of pt @ 0000. Pt awake. Pt sat @ bedside and was washed. VSS. Drsg A done to (L) left ext. Pincare done, stiches intact. Lungs CTA, Bowel sounds x 4 quads. Ø c/o pain / discomfort. [redacted] CPN, SGT
2 July 03 1430	Assumed pt care @ 1300. Pt sleeping, rouses to painful stimuli. VSS. Lungs CTA, abd soft BS(+). (L) leg c̄ ext fix & splint, dressing CDI & leg elevated. Ø IV(L) hand infusing, ⊼ diff, (-) s/sx of infiltration. (-) c/o pain voiced @ this time. Will cont to monitor. [redacted] 91WM6 SGT
2 Jul 03 00:03	Rec'd pt @ 21:00. Sleeping. Easy to awaken. Skin W/D. Perl (+) ICA (+). BS (+) x4. (+) PPP (+). Able to move & feel toes to (L) foot. Ex fix in place c̄ ACE wrap dsg CDI. (+) 2 pitting edema to (L) ankle & top of foot. Ø c/o pain. Will cont to mon. [redacted] 21 /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

EPW [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

all (b)(6)-2

FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

5Jul03
1540: 0700: Assumed pt care @ 0500: Pt. awake, A+O x3. lungs
T 98.3 CTA. (+) BS x 4. (+) PERRLA. Pulses x4. (+) sensation in (L) foot.
P-74 IV LR @ 100cc/hr infusing in (L) hand. Ex-Fix + ACE wrap
R-16 of (L) leg CDI. Denies any discomfort @ this time
BP-122/82 Will continue to monitor [redacted]
SpO2 98% 0950: Dsg change complete. Ø signs of infection or foul
odor noted [redacted] gilmb
1300: Assumed care @ 1300. VS: A+O x3 Dsg Δ/pr care done to (L) LE
Ex Fix Ø s/s of infection. (+) sensation, cap refill <3sec,
mvt toes. (L) LE. TOUCH ore Ø c/o pain C/W assessment
WNL. Will Monitor [redacted]
5Jul03 Rec'd pt @ 21:00. Pt. sleeping, easily awakened. PERRLA (+). Skin
2210 W/D. LCA (B). BS (+) x4. (+) PPP (B). FTG in place draining CYU. (L)
↓ ext ex fix in place c̄ ACE wrap dsg. C/D/I. c̄ c/o's @
this time will cont. to mon. [redacted] /AW
6Jul03 Pt. awake & alert in bed c̄ (L) LE ↑ on folded blanket. Pt IV in (L) hand
0700 infiltrated, IV removed. HR Reg. lung sounds clear bilat, bowel sounds
hyporactive x 4 quads. (L) LE dressing to ext. fix CDI, pt. is able to wiggle
(L) digits, cap refill <3sec, (+) sensation. All other assessment findings
WNL. Pt. c̄ complaints @ this time. Will continue to monitor. [redacted]
1000 Foley D/c'd & IV d/c'd per MD order [redacted]

[redacted] Foley to gravity drained draining CYU [redacted]

Date only 09:19

all (b)(6)-2

EDICAL RECORD | PROGRESS NOTES | AUTHORIZED FOR LOC.

DATE	NOTES
4 July 03 1310	Assumed pt care @ 1300. VS, BP: 130/78, P: 80, temp: 97.9, R: 14 O2 sats 98% RA. Pt resting quietly arouses to painful stimuli. lungs CTA, abd soft BS(+) x4. (D) leg c̄ ext. fix drsing CDI. Foley cath intact. (R) leg c̄ full ROM (+) pulse. ↑ left c̄ full ROM (+) pulses. IV (D) hand infusing LR @ 120cc/hr, (D) S/Sx of infiltration. (D) complaints voiced. Will cont to monitor - [redacted] 9wm6
4 July 03 2000	800cc cl yellow urine emptied from foley. (D) c/o pain voiced this shift — [redacted] 9wm6 SGT
4 Jul 03 20:19	Rec'd pt @ 21:00. Awake and alert in bed. VS WNL per flow sheet. LCA (R). BS(+)x4. PIV patent (L) FAC LR @ 100cc/hr infusing. (D) sxs infiltration noted. (L) ext fix in place to ↓ ext. c̄ ace wrap and stabilization cast in place. Able to move and feel toes to (L) foot. toes warm c̄ (+) <3 sec cap refill. (+) PPP (R). Will cont to mon [redacted] /AN
2257	Pin care done. skin @ bottom of pins slightly flaky and laceration intact. Skin color WNL. W→D redsg applied c̄ ace wrap dsg started @ foot & c/o pain @ this time. Will cont to mon [redacted] /AN
0050	c/o abd pain and requesting commode. Commode given c̄ results of BM. Will monitor [redacted] /AN

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

SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509

all (b)(6)-2

DATE	NOTES
7 Jul 03	Assumed pt care @ 2100: Pt. A&Ox3. lungs CTA.
2110	⊕ Equal. ⊕ Pulses. ⊕ BSx4. ext - fix c̄ Ace wrap CDI.
	⊕ sensation in ⊕ toes. Denies any c/o @ this
	time - will continue to monitor — [redacted] 9Jul03.
2150	Pt care complete. ∅ signs of infection or foul
	odor noted. — [redacted] 9Jul03 —
8 Jul 03	0820 - Pt alert lying in bed. VSS, lungs CTA,
	⊕ pulses, ⊕ BS x4. Dsg CDI to ⊕ ext fix.
	Able to move toes, ⊕ sensation. Voices
0640 97.5	no complaints. Will cont to monitor — [redacted]
86	8 July 03 - 1445: assumed pt care @ 1300. pt sleeping
20	VSS. assessment findings WNL. ⊕ leg c̄ ext fix
120/82	dressing CDI, pt able to move toes. ∅ complaints
99%	voiced. Will cont to monitor — [redacted] 9JUL03 SGT
2130.	Pt. care assumed @ 1700. Pt. resting
	quietly. Drng Δbd to ⊕ LE. Pin care done
	c̄ H_2O_2. HR Reg, Lungs CTA, ABD soft c̄ BS
	⊕ sounds will cont. to monitor. — [redacted] CTA
2145	⊕ LE c̄ brisk cap refill, toes warm to touch. Pulse
	2+ — [redacted] 1CTAN
9 July 03	0610 Assume pt care @ 0500. Pt awake and
	alert. VSS. Dsg to LLE c̄ Ex fix intact. C/O.
	no c/o pain. HR reg. Lungs CTA. Abd soft
	tender to palpate BLQ. Will continue to
	monitor — [redacted] 9JUL03

all (b)(6)-2

AUTHORIZED FOR LOCAL REPRO

DICAL RECORD | PROGRESS NOTES

DATE	NOTES
6-JUL 03 1930	Assumed care of Pt @ 1300. VSS. A+Ox3 ⊘c/o pain. TOC PEG DIET @ DINNER ⊘N/V. Pt ctv, voided 350cc dark yellow urine spontaneously. ⊕BS x 4. Dsg change/Pin care done on ⓛLE Ex Fix. ⊘s/s of infection. Able to amb. to BSC c̄ assistance. O/W assessment WNL. Will Monitor — [redacted]
6 JUL 03 2121:51	Assumed c/o pt. @ 21:00. Sleeping easily awakened. VS WNL per flow sheet. Skin WD. PERLA⊕ LCA(B) BS⊕x4 ⊕PPP(B) ⓛ↓ ext ex-fix in place. ACE wrap dsg and splint intact. DSG to pins CDII. Pt able to move and feel toes. Toes warm to touch c̄ <3sec cap refill. ⊘ complaints @ this time. Will cont to mon [redacted] DLT/AW
7 July 03 0600 98.1 74 16 122/86 98%	1100 - Pt alert lying in bed voicing no complaints. VSS, Lungs CTA, BS⊕. Dsg c/d to ⓛ leg. Ext fix intact. Pt able to move toes, ⊕ sensation, warm to touch. Will cont. to monitor — [redacted] DLT/AW
	1900 - Assumed care @ 1300 VSS. A+Ox3 - ⊘c/o pain. Ex FIX ⓛLE CDI DRSG. ⊕sensation, and cap refill <3sec. ⓛFOOT. TOL REG DIET. O/W assessment WNL WILL MON, TOC — [redacted]

IONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID (SSN or Other) [redacted]

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

T'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

EPW [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101-

all (b)(6)-2

NOTES

10 Jul 03 2127 Assumed c. @ 21:00. Awake and alert in bed. Skin color WNL w/ D. PERRLA (+). LCA (B). BS (+) x4. (+) PPP (B). (L) leg ex fix intact. Dsg C ACE wrap C/D/I. C/O pain x 1. II Percocet given. No further complaints voiced. Will cont. to mon —
[redacted] /AN

11 July 03 0805 - Pt alert lying in bed. VSS, lungs CTA, HR regular, BS (+). Dsg intact to (L) ext fix lower extremity. Able to wiggle toes, (+) sensation, warm to touch. Voicing no complaints at this time. Will cont. to monitor —
[redacted] 2Lt AN

0630 97.9
86
16
118/76
98%

11 Jul 03 1237 Author Op Note

Pre Op Dx - Grade III B open (L) tibia fracture
Post Op Dx - Same
Procedure: (1) SQ plating of (L) tibia
(2) removal of ext. fixator (L) tibia
Surgeon - [redacted] / [redacted]

Findings - Tibia not healthy fracture reduced, SQ plate applied, 3 distal screws, 2 proximal screws, in good position

PCAW! Splint, sutures out 1 week, then R/C to [redacted]

all (b)(6)-2

AUTHORIZED FOR LOCAL RE

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
9JUL03	1430 Assumed care of Pt @ 1300. VSS. A+O x 3. Ⓒ c/o pain Ⓑ LS CTA, Ⓑ BS x 4, Ⓛ LE ex fix/DRSG, CDI, Ⓟ palpable pulse sensation, cap refill <3 sec, mvt toes Ⓛ foot. Pt resting comfortably. Ⓒ/N access: O/W assessment WNL. Will Monitor [redacted]
2200	Pt. care assumed @ 2100. VSS. Pt. sleeping but easily arousable. HR Reg, lungs CTA, BS Ⓟ x 4 Ⓛ ex-fix intact, drsng CDI Ⓟ sensation, Ⓟ ROM toes Ⓛ ft. Brisk cap refill. will cont. to monitor. [redacted] /STAN
10July03 0545	Assume care of pt @ 0500. awake and alert. c/o pain to LLE. Dsg clean & dry. Percocet given @ 0510. VSS. LLE ex-fix intact Dsg C&D. HR reg, Lungs CTA. Abd soft. BS x 4 tender to palpate Ⓑ LQ. Ⓟ sensation Ⓟ movement cap refill <3sec to Ⓛ toes. Will continue to monitor. [redacted] /WMP
10July03 1400	assumed pt care @ 1300. pt resting quietly VSS. assessment WNL. Ⓛ LE c̄ ext fix drsng CDI. pt has orders for NPO p̄ MN for OR in am. Ⓒ/O pain voiced. Will cont to monitor [redacted] /WMP

SPONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NO. (SSN or Other)
	LAST	FIRST	MI	
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IDENTIFICATION (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record
STANDARD FORM 509

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

all (b)(6)-2

TE	NOTES
7-12-03 2200	Pt. care assumed @ 2100. Pt. denies pain @ this time. HK Reg, lungs CTA, BS (+) x4. cast to (L) LE CDI's ^. Brisk cap refill c (+) sensation, (+) rom digits (L) ff. HL to (L) AC flushes well c good blood return. Will cont. to monitor. — [redacted]
13 July 03 0715	0510 - Pt alert laying in bed 40 constipation. VSS, lungs CTA, HR regular, BS (+) x4. Pulses equal & strong to upper extremities. Pulse strong to ↓ (R) extremity. Cast to (L) leg, able to wiggle toes, (+) sensation, cool to touch. Will cont to monitor — [redacted] 2444
98.8 82 126/70 98%	1410 - Assumed care of Pts @ 1300. VSS. A+Ox3. Ø c/o pain (L) LE cast CDI. (+) sensation/Cap refill <3sec/mvt (2) toes (R) LS CTA + BS x4. ABD FIRM Ø distention. Pt c/o constipation. O/W Assessment WNL. Will monitor — [redacted]
13 Jul 03 2245	Rec'd c/o pt @ 21:00. Awake and alert in bed. Skin W/D. PERRLH (+) LUQ (B). BS (+) x4 (+) PPP (B). (L) ACE wrap dsg CID/I, (+) sensation (+) ROM to (L) digits. (+) <3 sec cap refill. c/o pain in ABD x1. 8mg Pain. this shift. Ø further ABD complaints. c/o pain x1 (L) ↓ ext. ¢ Percocet given. Will cont. to mon. [redacted] AW
14 July 03	1200 - Pt alert OOB x1 to bathroom. No complaints. Lungs CTA, VSS, BS (+). Cast to (L) extremity. (+) sensation, able to wiggle toes. HL to (L) AC. Will cont to monitor — [redacted] 2444

all (b)(6)-2

AUTHORIZED FOR LOCAL REPR

CAL RECORD | PROGRESS NOTES

TE

NOTES

11JUL/03 1930. ~~Assumed care of Pt @ 1930~~ ERROR. [redacted] Pt returned from OR/ICU#2 via litter @ 1500. VSS. A+O x3. (P)BS x4 (B)LSCTA. Ø dopain. TOL Reg PO DIET, HL d/c'd from (R) AC cathintact/Kinked, new 18G HL PIV started (L) AC. Cast to (L) LE CDI. (P) sensation, cap refill <3sec, mvt of toes in (L) foot. Q/W assessment WNL. Will Monitor [redacted]

2200 Pt. care assumed @ 2100. VSS. IV to (L) AC flushes 1CPM I difficulty, Ø s/s infiltration or infection. HR Reg, Lungs CTA, BS (P) x4. (L) LE cast CDI, ↑ on blanket. (P) sensation, (P) ROM toes, brisk cap refill. will cont. to maniter. [redacted] 1CPM

12JUL/03 0900 - Pt alert lying in bed. VSS, lungs CTA, HR reg, BS (P). Cast to (L) lower limb, (P) sensation, able to wiggle toes, warm to touch. HL in (R) AC infusing antibiotics. Voicing Ø complaints at this time. Will cont to monitor [redacted] 2PM

1545 Assumed care of patient @ 1300 VSS. A+O x3. Cast (L) LE CDI. X-Ray taken of PA/LAT TIB/FIB. Ø c/o pain. (P) sensation, mvt toes, cap refill <3sec (L) foot. HL RG DIET. Q/W Assessment WNL. Will cont to monitor [redacted] 1PM

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

PROGRESS NOTES
Medical Record

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

[redacted] (b)(6)-4

all (b)(6)-2

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CAL RECORD

PROGRESS NOTES

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MJUL03-1400 Assumed care of patient @ 1300. VSS. A+O x3. Ø Clopain. (L) LE CAST CDI. (+) sensation, mvt, cap refill <3sec (L) toes. (L) AC PIV HL patent. (+) BS x 4. O/W assess. WNL. will monitor — [redacted]

2245 Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS (+) x4. HL to (L) AC flush. Ø S/S infection or infiltration. Cast to (L) LE intact c̄ neurochecks WNL - (L) LE ↑ on blanket. Will cont. to monitor. — [redacted] CTA

15Jul Assumed care of pt @ 0500. Pt asleep. VSS. Lungs CTA. Bowel sounds x4 quads. Pt ate all of his breakfast. Ø c/o pain / discomfort. Will continue to monitor — [redacted] SGT, 9140

15July Pt care assumed @ 1300. VSS HR Reglar. Lungs sounds clear bilateral. BS x4. Good Pulse motor function on all extremity. Skin is warm and dry. D/C heplic because of pain and will reinsert new one before end of shift. Cast is dry and intact c̄ no S/S of infection. Will continue to elevate, and monitor pt for level of comfort. SGT [redacted] LPN —

15July 1930 Pt is resting comfortably in bed c̄ no c/o pain. VASSER LPN —

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

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41 CFR) 101

[redacted] (b)(6)-4

all (b)(6) -2

TE	NOTES
15 July 03	2300 Assume pt care @ 2100. Pt asleep easy to awake for assessment. VSS. HR reg. Lungs CTA. Abd soft BS x4. (L) LE ~~cast~~ Splint and ace wrap (+) movement (+) sensation to toes. No c/o pain @ this time. Pt has no PIV site @ this time. [redacted] 9lwmc
16 Jul	Assume care of pt @ 0300. Pt asleep. VSS. Lungs CTA. Bowel sounds x4 quads. Abd. soft and tender. Ext. fix to (R) leg. Pt oob c crutches to Br. Ø c/o pain / discomfort. [redacted] LPN, 86T
1415	Assumed care of Pt @ 1300. VSS. A+O x3. Ø c/o pain (L) LE ~~boot~~ splint/ace wrap CDI. Ambulate on crutches 5 assistance. (+) sensation, cap refill <3 sec, mmt toes (L) foot. ~~HL~~ ERROR. Ø IV access. O/W assessment WNL. Will cont monitor [redacted] ILT4

all(b)(6)-2

AUTHORIZED FOR LOCAL REPRO

CAL RECORD

PROGRESS NOTES

TE

NOTES

16JUL03 Rec'd c/o pt @ 21:00 Awake and alert in bed. Restraints
21:27 x2 (R) wrist and ankle. PERRLA (+) WNL. Skin color WNL.
LCA (B). BS (+) x4. ABD soft and slightly tender to palpation
(R) ↓ quadrant. (L) ↓ ext. c̄ ACE wrap and cast C/D/I (+)
sensation (+) circulation (+) ROM of toes. (+) <3 sec cap refill.
c/o pain to (L) ↓ ext. will cont. to mon. [redacted] 09/Ai

17Jul Assumed care of pt @ 0000. Awake and alert.
VSS. Lungs CTA. Bowel sounds x4 quads. Abd - soft
and tender. Cast to (L) left leg. Cap refill less than
3 sec. Pt can feel sensation in toes. Pt can wiggle
toes. Ø c/o pain/discomfort @ this time. Will continue
to monitor [redacted], LPN, SGT

17July03 Assumed pt care @ 1300. VSS. lungs CTA, abd soft
1415 BS (+). (L) leg c̄ cast (+) movement, (+) sensation. <3 sec cap
refill. (R) leg c̄ full ROM (+) pulse. BUE c̄ full ROM (+) pulses
(+) IV access noted. (+) c/o pain voiced @ this time. Will
cont to monitor [redacted] 9 Wmle

18JUL03 Rec'd c/o pt @ 21:00. Restraints x2 (R) ankle and wrist.
00:22 Sleeping in bed easily awakened. Alert. PERRLA (+) Skin
color WNL. LCA (B). BS (+) x4. ABD soft & tender. (L) ↓ ext.
ACE wrap soft splint C/D/I (+) ROM (+) sensation (+) <3 sec cap

SHIP TO SPONSOR

SPONSOR'S NAME

LAST | FIRST | MI | SPONSOR'S ID (SSN or Other)

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

REGISTER NO | CARD NO

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41CFR) 101

all(b)(6)-2

TE	NOTES
cont'd	refill to 2 digits. & c/o pain @ this time will cont. to mon. [redacted] RT/AN
18 Jul	Assumed care of pt @ 0500. Pt awake and alert. VSS. Lung sounds CTA. Bowel sounds x 4 quads. Ø c/o pain/discomfort [redacted] LPN; SGF
18Jul03 1350	assumed care @ 1300 - VSS - no c/o pain @ this time - cap refill <2 sec in (R) toes pt. can wiggle toes, splint & ace wrap intact - pt. can ambulate c crutches S problem [redacted]
18Jul03 23:24	Rec'd c/o pt. 21:00. VS WNL per flowsheet, sleeping in bed easily awakened. Restraints x2. Skin color WNL. LCA (+). BS (+) x4. (+) PPP (R). (L) ↓ ext. error [redacted] soft splint CADII. (+) sensation (+) ROM (+) <3 sec cap refill to digits. & c/o pain will cont. to mon. [redacted] RT/AN
19 Jul	Assumed care of pt @ 0500. Pt awake and alert. VSS. Lungs CTA. Bowel sounds x 4 quads. Abd soft x tender. Awaiting OR. Receiving ∡ x-ray and cast placement. Left for OR @ 0645. E/T @ 0745. Pt has d/c orders. Will continue to monitor. [redacted] SGT, LPN
19Jul03 1700	assumed care @ 1300 - cast intact on (L) LE, cap refill <2 sec in (L) toes - pt. awaiting transport to EPW camp [redacted]
19Jul03 1900	pt. escorted to helicopter c crutches, trays, meds & personal effects by me for transport to EPW camp [redacted] SGT, LPN

558-104

7540-01-075-378

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 31 May 03 | TIME: 0100

TRANSPORTATION TO FACILITY

SEX: M

AGE: 26

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: Unknown - for kidney inf

ALLERGIES: NKDA

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			

HOW

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW (L) leg / Hx - Kidney infection

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME: 0102

INITIALS: C

VITAL SIGNS

TIME	0105				
BP	127/62				
PULSE	112				
RESP	20				
TEMP	99.6				
WT					

LAB ORDERS

☑ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		CHEM:
BLOOD C&S X			

X-RAY ORDERS

CXR PA & LAT/PORTABLE	C-SPINE
ACUTE ABDOMEN	LS SPINE
SINUS	~~HEAD CT~~
ANKLE R/L	X (L) tib/fib

ORDERS

☑ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 72 HRS

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED TO | WHEN

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)*

EPW

[redacted] (b)(6)-4

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)

038

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER

TEST RESULTS

CBC		SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC			SUP O2	PH	PO2	RESULTS	
H/H			PCO2	SAT	OTHER		
PLT							
PT			U/A	DIP		EKG INTERPRETATION	
APTT	BHCG	ETOH	GLU	MICRO			

PROVIDER HISTORY/PHYSICAL

26 y/o ♂ EPW who was shot after fleeing a weapon on some 82nd AB base troops. pt was shot in (L) LE then operated on @ FST team @ 2100, 30 May 03. pt brought here after fasciotomy & Ex-Fixation on (L) LE. Pt ABOX 3 on ARRIVAL VIA FLA.

G: W/D, WD, NAD, A&O3
H: NC/AT, PERRLA, EOMI, (P) TM
N: ⊘ neg
L: CTA (B) ⊘ rales/rhs
C: RRR ⊘ M/R/G
ABD: Soft, NT, NO (B)S, ⊘ rebound.
Ext: ~~[illegible]~~ NVI., (+) Ex-Fix,
Neuro: NL, Normal Exam

(A/P) GSW (L) LE, post-operative - meds / ortho surgeon / EMC

Pt's ID + money ⊂ PAD.

According to interpreter one of the ID cards says the person is Republican Guard / weapons man

CONSULT WITH	TIME	ACTION
Ortho	0730	- will see pt in A.M.
PT	0730	- will see pt in A.M.

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

[redacted]

DIAGNOSIS

(1) GSW ⊂ T.b/F.b FX to (2) Leg.

CODES (b)(6)-2

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 *(Doctor)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)

038

ACUTE CARE WARD/RECOVERY ROOM
FLOW SHEET

ADMIT TIME	PROCEDURE	SURGEON	D/C TIME
3/30/03 2100	Exploration/Ligation + X fix (L) LE Posterior fasciotomy Irrigation / Debridement	(b)(6)-2 [redacted]	2155

Allergies unknown Anesthesia Type (GEN) MAC REGIONAL

Per translator - Denies allergies

	ADMIT	AD+5	AD+10	AD+15	AD+30	AD +45	AD+60	DC
RESP	20	22	20	22	[illegible]	24		
SPO2	95	97	96	98	96	97		
PULSE	123	121	126	123	123	124		
BP	121/57	123/53	108/54	110/49	108/54	104/65		
TEMP								
	2100	2105	2110	2115	2130	2145		

ASSESSMENT:

In OR 5400 cc/NS

3 lap sponges in wound

D=DRESSING

(L) knee to toes X fix in place cap refill < 3 sec toes warm

X= IV SITE

FLUID

NS

RATE 125 cc

T= TUBE

none

O=DRAINS

none

AMT. IN BAG 700 / 600

02 5 **LPM** NC O2 DC'd @ 2141

MEDICATION	DOSE	TIME	ROUTE	OR/RR Total
Msoy	4mg	2118	IV	4
Versed	1mg			3mg
Ancef	1gm	prep		
Gent	80mg	prep		
Fentanyl	in	OR		250mcg
Msoy	4mg	2128	IV	8mg

INTAKE		OUTPUT	
SOURCE	AMT	SOURCE	AMT
NS	125	foley	250
NS	300		
	425		

NAME Iraqi Soldier - [redacted]
SSN
UNIT PPW

(b)(6)-4

NOTES 2100 To RR via litter awake. Color pale pink. See US on front. (L) leg c̄ X fix. Lower portion. Cap refill < 3 sec. 3 lap sponges in ope wound. (only + one wrapped). Combative, thrashing around. Restrained c̄ cravats. Belt wrists. (+) CMS p̄ restrained.

2115 Monitor. Restraints in place at wrist. Cap refill < 3 sec. (L) leg X fix intact. unable to assess sensation. Interpreter unable to get response for sensation to toes.

2130 Still thrashing but calmed slightly. Resp even + unlabored HR Regular. Lungs c̄ slight rhonchi (L) toes warm, cap refill < 3 sec X fix in place. Wrist restraint in use, (+) pulses, cap refill < 3 sec.

2145 To CSH via ground ambulance LSS.

Post-Anesthesia Recovery Score

Criteria	ADM	30 Min	DC
2 Moves all extremities on command	2	2	2
1 Moves 2 extremities on command			
0 Moves 0 extremities on command			
2 Cough, Deep breathe	2	2	2
1 Dyspnea, limited breathing			
0 Apnea			
2 SBP± 20mm Pre Op 117/80 Preop	1	1	1
1 SBP±20-50mm Pre-Op			
0 SBP±50mm Pre-Op			
2 Fully Awake	2	2	2
1 Arousable on call			
0 Not Responsive to verbal stimuli			
2 Normal Skin Color and appearance	1	2	2
1 Pale, dusky, blotchy or jaundice			
0 Cyanotic	/8	/9	/9

Discharge: BP 104/69 HR 24 RR 124 SaO2 97% RA

Signature and Title : [redacted] MA/GW

(b)(6)-2

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 26

HEIGHT: } unknown
WEIGHT:

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

3. PREVIOUS SURGERY [ ] NO [✓] YES (type):
Ex. Fix LLE

4. PROPOSED SURGICAL PROCEDURE:
I&D Ct, Tibia Fix c External Fixation

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition WNL
Tobacco 2 ppd X___yrs. Body Piercing Ø Diabetes (Y) (N) ROM WNL x LLE ASA/Motrin w/72 hrs (Y) (N)
ETOH___ Implants Ø Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Ø Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

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

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

CIV
26 yrs.

[redacted] (b)(6)-4

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

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

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

[redacted] LT/AN (b)(6)-2 1 Jun 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] LT/AN
DATE: 1 Jun 03 TIME: 1400

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) LT [redacted]
DATE: 20030601 TIME: 1550

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 26

HEIGHT:

WEIGHT:

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

3. PREVIOUS SURGERY [ ] NO [✓] YES (type):
I&D, Ex Fix Lt Tibia

4. PROPOSED SURGICAL PROCEDURE:

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition
Tobacco 2 ppd X 11 yrs. Body Piercing Diabetes (Y) (N) ROM ASA/Motrin w/72 hrs (Y) (N)
ETOH Implants Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

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

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

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

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	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.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o. Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ 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 difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated ____ 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ____ 1) Diminished Hearing ✓ 2) Language Barrier F.3. NA 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.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

(b)(6)-2 [redacted] MAJ AN 5 Jun 03 DATE

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

(b)(6)-2 12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] MAJ AN
DATE: 5 Jun 03 TIME: 0820

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] MAJ AN
DATE: 5 Jun 03 TIME:

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: UNKNOWN
HEIGHT:
WEIGHT:

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
See H&P

4. PROPOSED SURGICAL PROCEDURE:
I&D (L) Tibia

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

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

9. PATIENT'S IDENTIFICATION: (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)
EPW #[redacted]
(b)(6)-4

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

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

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

_____ DATE _____

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated
LEVEL OF ACTIVITY [redacted] ☐ Moves All Extremities ☐ Moves Upper Extremities
☐ Transferred to liner with roller due to spinal

SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT (Y) (N)
BREATHING EASY: (Y) (N)

12. PRE[redacted]ALU[redacted]PARED BY (Sign[redacted] CPT/A2
DATE: 8 Jun 03 TIME: 1000

13. POSTOPERATIVE [redacted]ATION [redacted]ARED BY (Signature and Tit[redacted] CPT/A2
DATE: 8 Jun 03 TIME:

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 26

HEIGHT:

WEIGHT: 80 kg

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
I+D (L) Leg + Ext. Fixator Placement

4. PROPOSED SURGICAL PROCEDURE:
ORIF (L) fibula

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition _____
Tobacco ✓ ppd X 22 yrs. Body Piercing _____ Diabetes (Y) (N) ROM limited ASA/Motrin w/72 hrs (Y) (N)
ETOH _____ Implants _____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures _____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

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

9. PATIENT'S IDENTIFICATION: (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)
EPW [redacted] (b)(6)-4.
ICW-2

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ 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 difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: 1) Diminished Hearing ✓ 2) Language Barrier F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from either side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures. Use interpretor as necessary
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

(b)(6)-2 [redacted] MAJ AN 23 June 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature [redacted] CPT IAN
(b)(6)-2 DATE: 23 June 03 TIME: 1100

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] MAJ AN
DATE: 23 June 03 TIME: 1756

(b)(6)-2

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE:

HEIGHT:

WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE: Cast manipulation

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

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

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

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

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCO...	8. ... URSING 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.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o. Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ 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 difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated 2) W/O Glasses F.2. Potential for decreased communication due to: ✓ 1) Diminished Hearing ? ✓ 2) Language Barrier F.3. Potential injury due to dentures: 1) Upper 4) Caps 2) Lower 5) Crowns 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. Ø	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

(b)(6)-2 [redacted]

19 Jul. 03 DATE

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

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

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

(b)(6)-2 12. PREOPERATIVE EVALUATION PREPARED BY (Si[redacted] LTC

[redacted] 19 Jul. 03 [redacted]E: 19 Jul. 03

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

DATE: 19 Jul. 03 TIME: 0652

(b)(6)-2

all (b)(6)-2

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: Anesthesia LITTER BY Anesthesia

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

3. DATE: 1 Jun 03 TIME PATIENT ARRIVED IN SUITE: (CW → OR)

4. PATIENT IN ROOM TIME: 1408 NUMBER: 2-1/2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO P MN, NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (910)	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] (66E) (1500)	RELIEF CIRCULATOR	1LT. [redacted] (66E) (1500 - End)

7. POSITION AND POSITIONAL AIDS (Specify)

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

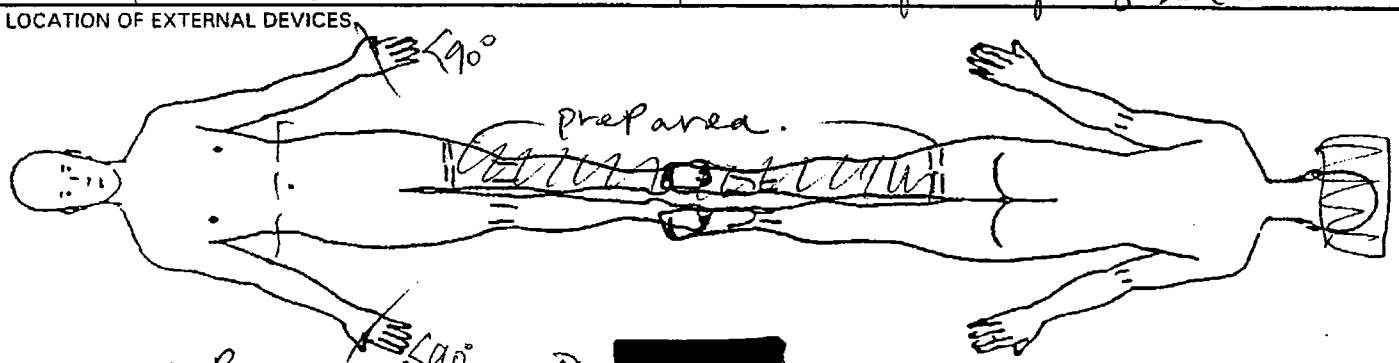
COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL: ☑ YES ☐ NO
DONE BY: ☑ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☑ RAZOR ☐ CLIP
COMMENTS: Q Cuts noted.

PREP SOLUTION (Specify): Betadine Scrub & Paints.
SITE: Lt. leg BY WHOM: CPT. [redacted]
SITE: BY WHOM: Med [redacted] assist
COMMENTS: Q pooling of Sol.

9. LOCATION OF EXTERNAL DEVICES



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

Dr. [redacted]

C = Correct I = Incorrect

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

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

CIV
26 Yrs.
[redacted]
(b)(6)-4

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

☑ ESU NO: Valley Lab #4
GROUND PAD: BRAND 3M.
LOT NO: 2005-10 OT

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Coag 230
Cut 230

MEDCOM - 10100

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

all (b)(6) = 2

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

4920-1-010 X 4
4920-2-140 X 4
4920-2-020 X 2
5029-8-830 X 21 } Hoffman II Stryker Howmedica

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATU[redacted]

15. X-RAY IN OPER[redacted] ROOM YES ☒ NO ☐ IF YES, SITE Lt. leg

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)*
Muffs
Kerlix
ABDS
ACE

19. ADDITIONAL INFORMATION
DA form 5179 Reviewed & nsg care implemented.

Surgeon: [redacted] / [redacted]

Anes: Dr. [redacted] / [redacted] (CRNA)

20. OPERATION(S) PERFORMED

I & D c̄ Lt. Tibia External Fixation.

21. PATIENT TRANSFERRED TO 1542 TIME 1553 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted]

REVERSE OF DA FORM 5179-1, OCT [illegible] USAPA V

MEDCOM - 10101

all (b)(6)-2

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-68, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY Anesthesia
2. PATIENT IDENTIFIED, RECORD [redacted] REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN
3. DATE 3 Jun 03 TIME PATIENT ARRIVED IN SUITE 0945
4. PATIENT IN ROOM TIME 0945 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted], ORT	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] AN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt transferred to OR table, anatomically aligned for surgical procedure, ⊃ pad under head - (B) arms on padded arm boards less 90°

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

COMMENTS:

8. SKIN PREPARATION

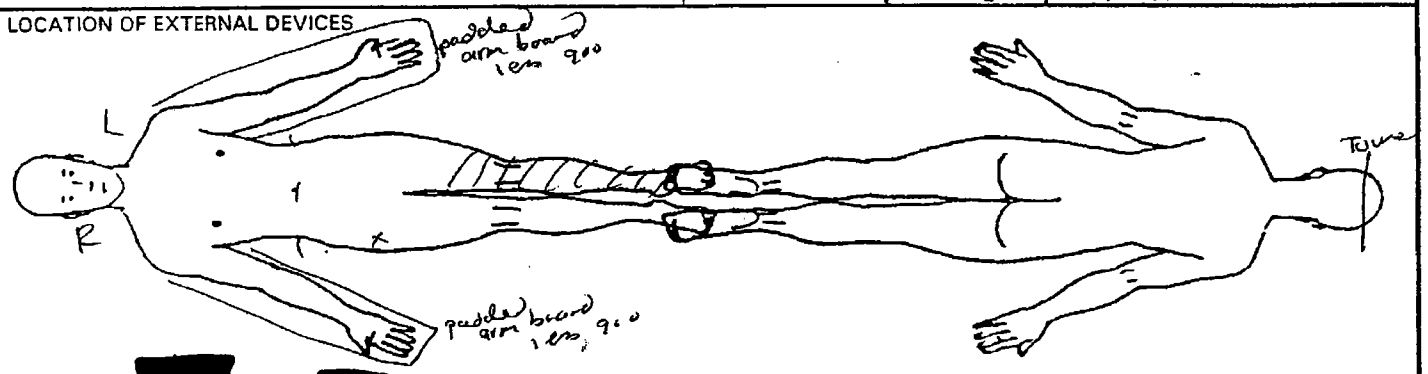
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE (L) Leg BY WHOM: CPT [redacted], AN
SITE: ~~XXX~~ See #9 BY WHOM:

COMMENTS: ⊖ pooling of Solution noted

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS — C = Correct I = Incorrect Initial SPC [redacted] / CPT [redacted]

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

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

EPW [redacted] (b)(6)-4

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

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

☐ ESU NO: [redacted]
GROUND PAD: BRAND _____
LOT NO: _____

☐ BIPOLAR NO: _____

MEDCOM - 10102

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS, SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
ABD pads
ACE

19. ADDITIONAL INFORMATION
Surgeon [redacted] Anesthesia [redacted]

all (b)(6) -2

20. OPERATION(S) PERFORMED
I+D (L) Leg

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU-1	1035	Litter & O2

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

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

all (b)(6)-2

MEDICAL RECORD — **INTRA... 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 CPT [redacted], CPT Fr[redacted]

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

3. DATE 5 Jun 03 TIME PATIENT ARRIVED IN SUITE 0820

4. PATIENT IN ROOM TIME 0820 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

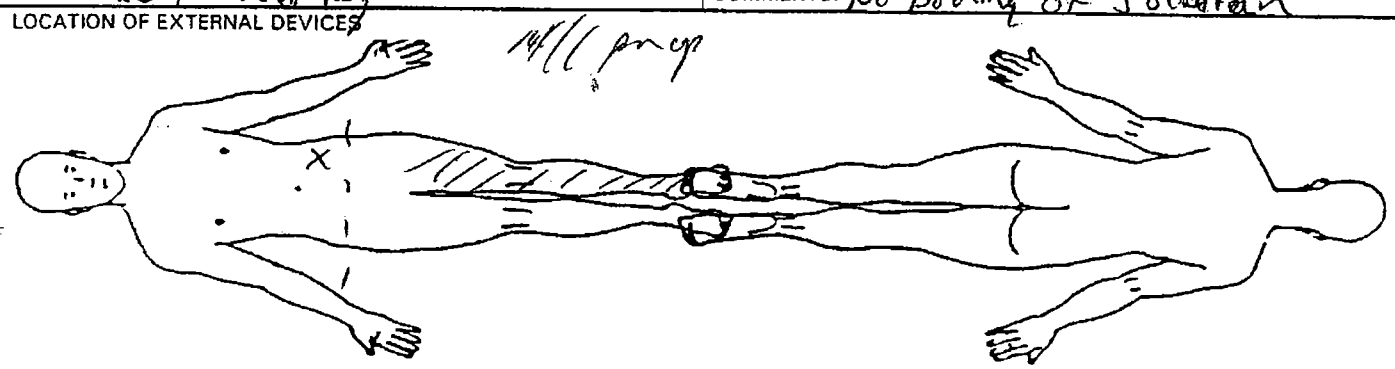
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Povidone Scrub + solution
SITE: Left leg BY WHOM: MAJ [redacted]
SITE: BY WHOM:
COMMENTS: No pooling of solution

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		
Needle Sharp	☑ Yes ☐ No		C	C		
Instrument	☐ Yes ☑ No				SPC [redacted]	MAJ [redacted]
Other	☐ Yes ☑ No				SPC	MAJ

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

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

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

☑ ESU NO: Valleylab #1
GROUND PAD: BRAND Valleylab
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 10104

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): N/S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
Kerlix
ABD
ACE

19. ADDITIONAL INFORMATION

Surgeon Dr [redacted]

Chief CPT [redacted]

all (b)(6)-2

20. OPERATION(S) PERFORMED

I&D Left Tibia

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 2		Litter

22. REGISTERED NURSE SIGNATURE

[redacted] AN S. Jurez

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

all (b)(6) -2

MEDICAL RECORD — **INTRA[illegible]RA[illegible]OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD R[illegible] AND PROCEDURE
VERIFIED BY [redacted]

3. DATE 08 Jun 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME [redacted] NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: UNKNOWN

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted], ORT	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] AN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt transferred to OR table, anatomically aligned for Surgical procedure c (B) arms on padded arm boards less 90°

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

COMMENTS:

8. SKIN PREPARATION

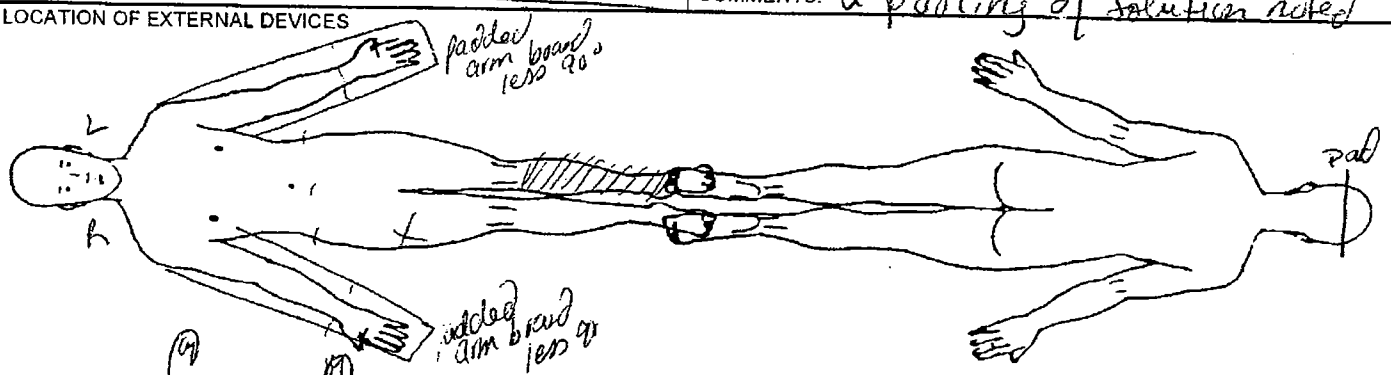
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: (L) Leg BY WHOM: CPT [redacted], AN
SITE: BY WHOM:

COMMENTS: a pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad — Safety Strap === Tourniquet

10. COUNTS

C = Correct I = Incorrect

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

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

EPW # [redacted]

(b)(6)-4

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

NOT used

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

MEDCOM - 10106

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluff
Kerlix
Splint

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: [redacted] [redacted]:

Bovie Pad site intact pre-op_____; post-op_____ Bovie Settings: Coag/Cut Not used
Tourniquet Site intact pre-op _____: post-op_____ Not used
Tourniquet Time: Up____ Down Not used

all (b)(6)-2

20. OPERATION(S) PERFORMED

I+D (L) Leg c̄ closure of wound

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU-2 (RR)	1037	litter c̄ O2

22. REGISTERED NURSE SIGNATURE [redacted] CPT/An

all (b)(6)-2

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

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA LITTER BY ANESTHESIA

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

3. DATE 11 Jun 03 TIME PATIENT ARRIVED IN SUITE 1019

4. PATIENT IN ROOM TIME 1019 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA
NPO PMN

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	ILT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) A. In supine position on padded OR table. BUE on padded armboards <90°.

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

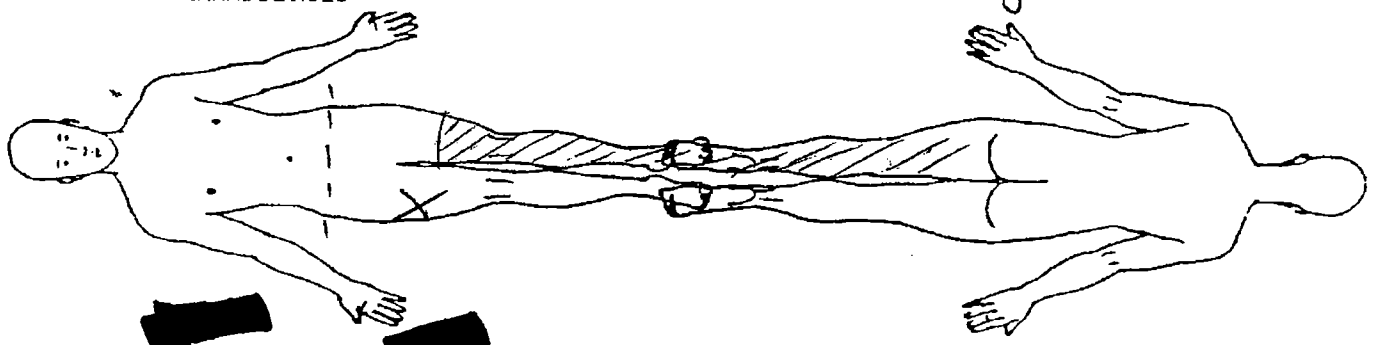
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine/Betadine
SITE: LLE BY WHOM: ILT [redacted]
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



[redacted] [redacted]

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

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

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes	[ ] No				PFC [redacted]	ILT [redacted]
Needle Sharp	[X] Yes	[ ] No					
Instrument	[ ] Yes	[X] No					
Other	[ ] Yes	[X] No					

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

[redacted]

(b)(6)-4

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

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

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

[ ] BIPOLAR NO: _____

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

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

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs, Sten-strips. Kerlix. Kling
Splint. ACE

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: CPT [redacted] Anesthesia Type: Gen

Bovie Pad site intact pre-op ✓; post-op ✓ Bovie Settings: Coag/Cut N/A
Tourniquet Site intact pre-op N/A; post-op
Tourniquet Time: Up____ Down N/A

911(b)(6)-2

DA 5179 from 8 Jun 03 in Chart.

20. OPERATION(S) PERFORMED

IKD LLE

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU2	1123	LITTER C O2

22. REGISTERED NURSE SIGNATURE [redacted]

all(b)(6)-2

MEDICAL RECORD | **INTRAOP** | **CUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

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

3. DATE 23 June 03 TIME PATIENT ARRIVED IN SUITE 1505

4. PATIENT IN ROOM TIME 1505 NUMBER 1-1 | 4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: nkda

6. NURSING PERSONNEL

ASSIGNED SCRUB	Pfc [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Maj [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Bunsip (3 L saline bag) under Lt hip

8. SKIN PREPARATION

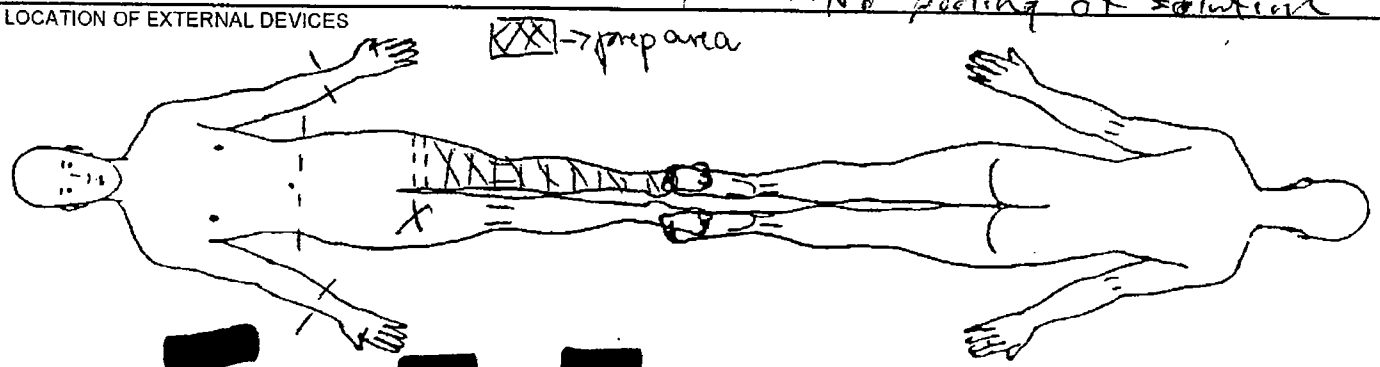
HAIR REMOVAL ☐ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betal Beta
SITE (L) Leg BY WHOM: 1LT [redacted]
SITE: BY WHOM:

COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

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

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

EPW [redacted] (b)(6)-4
ICW-2

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

☒ ESU NO: Valleylab #1
GROUND PAD: BRAND Valleylab
LOT NO: 69652 Exp 200504

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

Synthes 248.08 8 hole DCP plate
Screws: 206.16 X 4 206.14 X2 206.18 X 1 204.18 X 1

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

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)*
Xeroform
Fluffs
Kerlix
Ace

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: CRT [redacted] Anesthesia Type: General

Bovie Pad site intact pre-op ✓; post-op ✓ Bovie Settings: Coag/Cut 30/30 all (b)(6)-2
Tourniquet Site intact pre-op ✓; post-op ✓
Tourniquet Time: Up____ Down____

20. OPERATION(S) PERFORMED
ORIF Left Fibula, Adjustment of Hoffman device

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU-1	1750	Litter c safety straps on

22. REGISTERED NURSE SIGNATURE
[redacted] MAN AN 23 Jun

all (b)(6)-2

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 Anes staff

2. PATIENT IDENTIFIED, REC[redacted] AND PROCEDURE VERIFIED BY [redacted] CPT (AN)

3. DATE 11 July 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 1018 NUMBER 2-1/2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA, NPO p MN

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	SPC [redacted] (1030 – End)
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

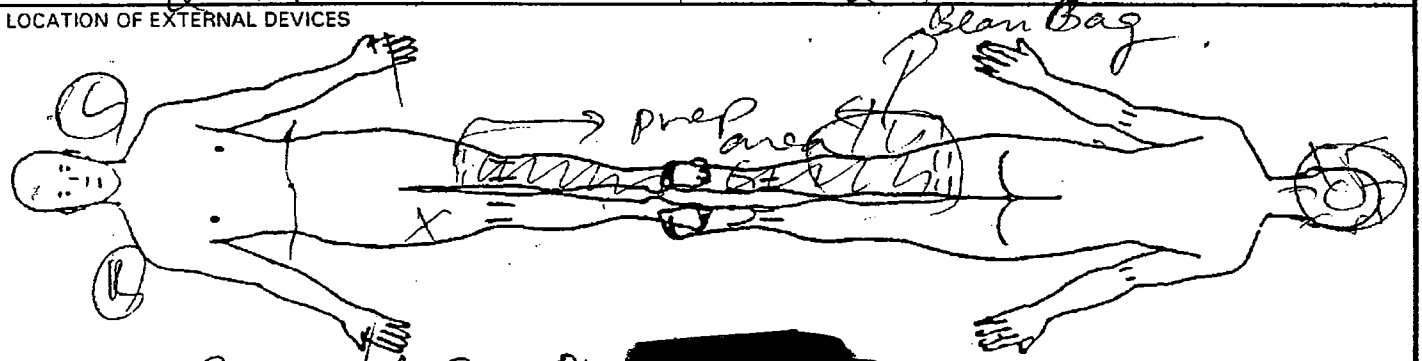
COMMENTS: (R) leg to stirrup. Beanbag to (L) knee. (B) arms to armboard 90°

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine 5/90
SITE: (L) leg BY WHOM: CPT [redacted]
SITE: ~ BY WHOM: ~
COMMENTS: Ø pubic

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

CPT [redacted] (b)(6)-4

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

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

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

☐ BIPOLAR NO: _____

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

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

Synthes" DCP Plate 10 Hole # 226.10 X 1 Lot # 0619101 / ASIF Screw Lot # 0619101 4.5 mm Cortex Screw 30 mm X 1, 50 mm X 1, 42 mm X 2

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S):

0.9% Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

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)

Sluffs, Kerlix, Webril, ABDs, Ace, Splint

19. ADDITIONAL INFORMATION

[redacted]

all (b)(6)-2

20. OPERATION(S) PERFORMED

(L) Tibia Ex Fix Removal and Fixation plate, screws

21. PATIENT TRANSFERRED TO ICU2 TIME See Anes. Record METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] LPN/AN [redacted]

REVERSE OF DA FORM 5179-1, [illegible] USAPA V1.01

all (b)(6)-2

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: Cart BY OR staff	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted]
3. DATE 19 July 2023 TIME PATIENT ARRIVED IN SUITE 0608	4. PATIENT IN ROOM TIME 0609 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	Cpt. [redacted] LTC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Spc [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

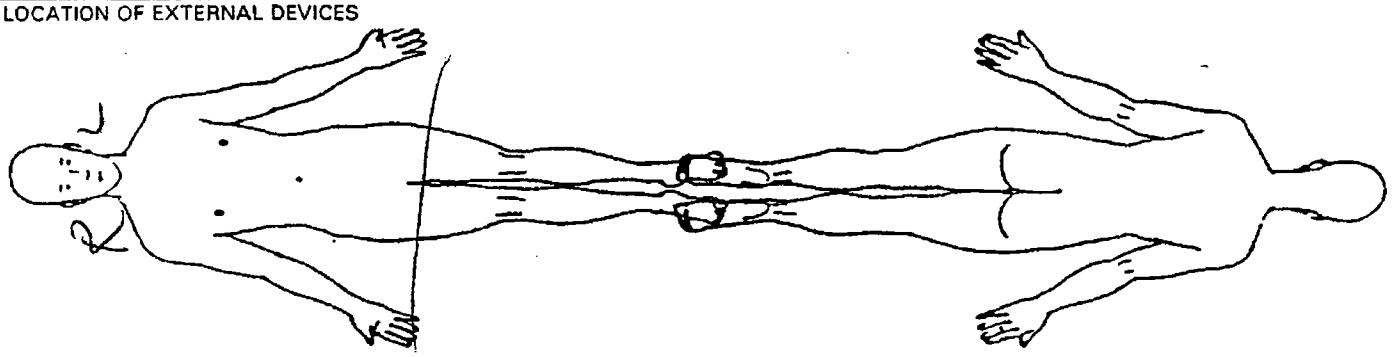
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* NA
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;)*

[redacted] (b)(6)-4

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

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

MEDCOM - 10114

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):

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE (L) leg

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)*
Webril
5" fiberglass casting

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED
Cast Manipulation

all (b)(6)-2

21. PATIENT TRANSFERRED TO ICU | TIME 0652 | METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT

[redacted] -C, AN

EDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY		1	2														
POST-OP DAY																	
MONTH-YEAR	DAY	31 May	1 June														
2003	HOUR	13	08														

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

PULSE (O)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	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: 18 16 16

BLOOD PRESSURE: 130/86 130/78 130/88 130/78

SPO2: 97 98% 97

HEIGHT: WEIGHT → 98

Record special data only when so ordered

Recapol Conti

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

REGISTER NO.

WARD NO. ICW2

STANDARD FORM 511 (REV. 7-95) BACK

[redacted] (b)(6)-4

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY | DAY | DAY | HOUR

Day	1 Jun		2 Jun		3 Jun		4 Jun		5 Jun		6 Jun		7	
Hour	12		0	12	3	2	3	6		12	3	6	9	12

PULSE (0) — TEMP. F (°) — TEMP. C (Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

ICW

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 10117

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Jun 03 DAY 9 10 11 12 13 14 15

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° 98.6° 37.2° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record specially when so ordered

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

REGISTER NO.

WARD NO. 6CW2

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

[redacted] (b)(6)-4

NSN 7540-00-634-4124

EDICAL RECORD — VITAL SIGNS RECORD

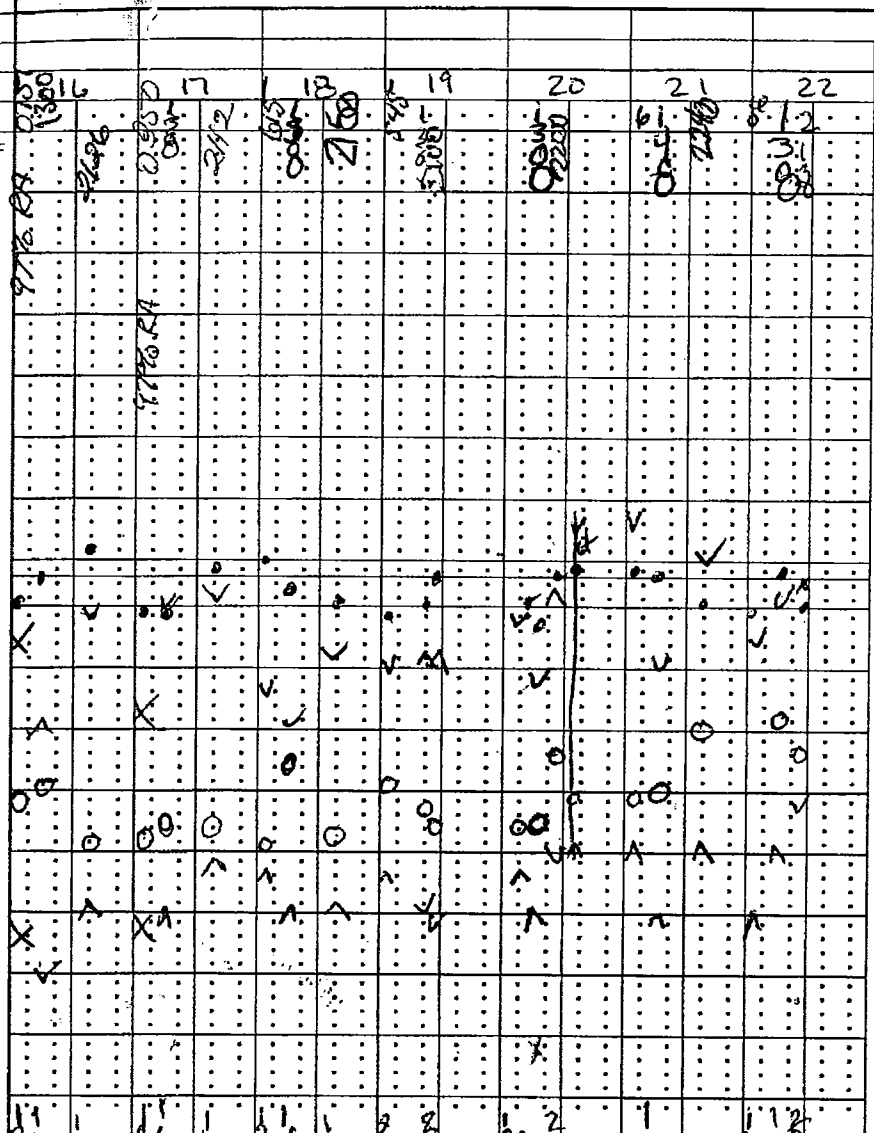
HOSPITAL DAY

POST-OPERATIVE DAY

MONTH-YEAR | DAY | HOUR

19

PULSE (O) | TEMP. F (•) | TEMP. C



RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. CW2

EPW

#[redacted]

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 10119

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 23 Jun, 24, 25, 26, 27, 28, 29, 30, 31

19 | HOUR

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: 5ft3 ~~WEIGHT~~ →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

EPW [redacted] (b)(6)-4

STANDARD FORM 511 (REV. 7-95) BACK

L-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		1 July	2 July	3	4	5	6	7
POST-	DAY							
MONTH-YEAR	DAY							
19	HOUR							

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

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

EPW [redacted] (b)(6)-4

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

19 | HOUR

PULSE (O) | TEMP. F (•)

TEMP. C

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

EPW [redacted] (b)(6)-4

STANDARD FORM 511 (REV. 7-95) BACK

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	15	16	17	18	19	20
POST- DAY						
MONTH-YEAR / DAY						
19 / HOUR	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	

PULSE (O) / TEMP. F (•)

105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

98% 98% 98% 98%

DC'd

Voided

BM

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

REGISTER NO.

WARD NO. ICW2

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

VITAL SIGNS RECORDS

Medical Record

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

CBC
albumin

24 [redacted] LABORATORY RESULT FORM

LAST FIRST MI | STATUS | DATE | SSN 245

[redacted]

TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE
Na		138-146 mmol/L	ALT	26	[redacted]	WBC	10.5	4.8-10.8 x 10³
K		3.5-4.9 mmol/L	AST	44	[redacted]	RBC	3.23	4.7-6.1 x 10⁶
Cl		98-109 mmol/L	GGT		3.56-1.0	Hgb	8.4	14-18 g/dl (M) 12-16 g/dl (F)
pH		7.31-7.45	ALB	3.2	3.5-5.5 g/dl	Hct	26.8	42-52% (M) 37-47% (F)
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)	ALP	66	26-84 U/L	MCV	82.9	80-96 fl (M) 81-99 fl (F)
PO_2		80-105 mmHg (art) N/A (ven)	Amylase	21	14-85 U/L	Plt	398	130-500 x 10³ verified
tCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)	Ca	9.0	8.10-10.2 mg/dl	Lymph%	43.0	20.5-51.1%
HCO_3		23-26 mmol/L (art) 25-28 mmol/L (ven)	Chol	106	200-240 mg/dl	Atypic		0.5-1.5% (adult
sO_2		95-98%	Creat	[redacted]	[redacted]			9.8-13.6 secs
BEecf		(+2) mmol/L	[redacted]	[redacted]	[redacted]			21-34 secs
AGap		10-20 mmol/L	GLU	[redacted]	[redacted]			<20 ug/ml
Ca		1.12-1.32 mmol/L	TBili	0.4	0.1-1.0 mg/dl			<10 ug/ml
BUN		8-26 mg/dl	TP	4.4	6.4-8.3 g/dl			Mono
GLU		70-105 mg/dl	LDH	[redacted]	[redacted]			Eos
Creat		[redacted]	Na	[redacted]	[redacted]			Baso
Hct		37-52% PCV	K	[redacted]	[redacted] mmol/L			Imm
Hgb		12-18 g/dl	Cl	[redacted]	98-106 mmol/L	Morph		
			CO_2		18-31 mmol/L			
ABO/RH			CK		39-330 U/L	Crit		42-52% (M 37-47% (F
Unit	Type	Crossmatch	[redacted]			Man WBC		4.8-10.8 x
			TEST	RESULT	REF RANGE	Manual Plt		130-500 x verified
			Gluc		Negative			
			Bili		Negative			
			Ketones		Negative			
			SG		N/A			
CKMB			Blood		Negative			
Troponin			pH		N/A			
DOA			Protein		Negative			
Toxicol			Urobil		[redacted]			
			Nitrite		Negative			
			HCG		Negative			

Microbiology

Source		
Gram Stain		
Culture		
KOH/WP		
Bld		Malaria

SHADOW P/R

[redacted]

(b)(6)-2

(b)(6)-2

Ward/Section: ICU #2 | REQUESTING PHYSICIAN: [redacted] | [redacted] CHART

LAST, FIRST, MI: [illegible] | DATE: [illegible] | TIME: [illegible] | SSN/PSEUDO SSN: [illegible]

(i-STAT)			(Piccolo) Chemistry			(Piccolo) Metabolic Panel		
TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE
Na		134-146 mmol/l	ALB		3.5-5.0 g/dl	BUN		7-22 mg/dl
K		3.8-5.4 mmol/l	ALP		26-84 U/l	CA		8.0-10.3 mg/dl
Cl		98-109 mmol/l	ALT		10-47 U/l	CRE		0.6-1.2 mg/dl
pH		7.31-7.45	AMY		14-97 U/l	NA		128-145 mmol/l
PCO2		35-45 mmHg (4.7-6.0 kPa)	AST		11-38 U/l	K		3.1-4.7 mmol/l
PO2		80-100 mmHg (10.6-13.3 kPa) NA (ven)	TBIL		0.2-1.4 mg/dl	CL		98-108 mmol/l
TCO2		24-27 mmol/l (25-28 mmol/l (ven))	BUN		7-22 mg/dl	CO2		18-33 mmol/l
HCO3		22-26 mmol/l (23-27 mmol/l (ven))	CA		8.0-10.3 mg/dl			
sO2		NA	CHOL		100-200 mg/dl	(Piccolo) Liver Panel Plus		
BEecf		-2 to +3 mmol/l	CRE		0.6-1.2 mg/dl	TEST	RESULT	REF RANGE
AnGap		10-20 mmol/l	GLU		73-106 mg/dl	ALB		3.5-5.0 g/dl
Ca		1.05-1.32 mmol/l	TP		6.0-8.0 g/dl	ALP		26-84 U/l
BUN		8-20 mg/dl	(Piccolo) Lipid			ALT		10-47 U/l
Gluc		70-105 mg/dl	TEST	RESULT	REF RANGE	AMY		14-97 U/l
Creat		0.6-1.2 mg/dl	GLU	101	73-106 mg/dl	AST		11-38 U/l
Hct		37-49 %	BUN	6	7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hbg		12-16 g/dl	CRE	0.5	0.6-1.2 mg/dl	GGT		5-65 U/l
Misc. Chemistry			CK	316	39-308 U/l (30-135 mU/ml)	TP		6.4-8.1 g/dl
TEST	RESULT	REF RANGE	NA	137	134-146 mmol/l	(Piccolo) Electrolyte		
Amylase		14-97 U/l	K	4.2	3.8-5.4 mmol/l	TEST	RESULT	REF RANGE
Drug of Abuse			CL	99	98-109 mmol/l	NA		128-145 mmol/l
			TCO2	24	18-33 mmol/l	K		3.1-4.7 mmol/l
						CL		98-108 mmol/l
						CO2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] | DATE: 24 Sep 05 | LAB ID NO:

BC all (b)(6)-2

#[redacted] 6-24-05 0350 | ICW#2

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC	19.5	4.8-10.8 x 10^3
RBC	4.39	4.7-6.1 x 10^9
Hgb	11.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	36.5	42-52% (M) 37-47% (F)
MCV	83.1	80-94 fl (M) 81-99 fl (F)
Plt	513	130-500 x 10^3 verified
Lymph %	15.5	20.5-51.1%

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

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

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

CSF		
Cell Count		
Directigen		Negative

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

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

Microscopic Urinalysis

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

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

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

REMARKS:

REPORTED BY:	DATE: 24 Jun 03	LAB ID NO.:

(b)(6)-2 CBC

EPW# [redacted]

EPW# 6.25.08 0345

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC	17.3	4.8-10.8 x 10^3
RBC	4.30	4.7-6.1 x 10^6
Hgb	10.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	36.0	42-52% (M) 37-47% (F)
MCV	83.9	80-94 fl (M) 81-99 fl (F)
Plt	433.	130-500 x 10^3 verified
Lymph %	24.6	20.5-51.1%

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

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

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

CSF		
Cell Count		
Directigen		Negative

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

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

Microscopic Urinalysis

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

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

all (b)(6)-2

Ward Section: [redacted]

ING PHYSICIAN: [redacted]

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

LAST, FIRST, MI: [redacted]

DATE: 6 30 | TIME: 0300 | SSN: [redacted]

(b)(6)-4

(i-STAT)

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

Misc. Chemistry

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

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	100	73-118 mg/dl
BUN	4	7-22 mg/dl
CRE	0.6	0.6-1.2 mg/dl
CK	206	39-380 u/l (M) 30-190 u/l (F)
NA^+	138	128-145 mmol/l
K^+	4.4	3.3-4.7 mmol/l
CL^-	102	98-108 mmol/l
tCO_2	23	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted]

DATE: 29 Jan 07

LAB ID NO.:

...on:	REQUESTING ...GA	CHEMISTRY ...JI ...ORM (Subject to the Privacy Act of 1974)
...ST, MI:	DATE / TIME	SSN/PSEUDO SSN:

(i-STAT)		(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
RESULT	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
	138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
	3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
	98-109 mmol/L	ALT		10-47 u/l	CA^{++}		8.0-10.3 mg/dl
	7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
	35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l	NA^{+}		128-145 mmol/l
	80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl	K^{+}		3.3-4.7 mmol/l
	23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl	CL^{-}		98-108 mmol/l
	22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl	tCO_2		18-33 mmol/l
	95-98%	CHOL		100-200 mg/dl	**(Piccolo) Liver Panel Plus**		
	(-2)--(+3) mmol/L	CRE		0.6-1.2 mg/dl	*TEST*	*RESULT*	*REF. RANGE*
	10-20 mmol/L	GLU		73-118 mg/dl	ALB		3.3-5.5 g/dl
	1.12-1.32 mmol/L	TP		6.4-8.1 g/dl	ALP		26-84 u/l
	8-26 mg/dl	**(Piccolo) Metlyte 8**			ALT		10-47 u/l
	70-105 mg/dl	*TEST*	*RESULT*	*REF. RANGE*	AMY		14-97 u/l
	0.7-1.5 mg/dl	GLU		73-118 mg/dl	AST		11-38 u/l
	38-51% PCV	BUN		7-22 mg/dl	TBIL		0.2-1.6 mg/dl
	12-17 g/dl	CRE		0.6-1.2 mg/dl	GGT		5-65 u/l
Misc. Chemistry		CK		39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
RESULT	*REF. RANGE*	NA^{+}		128-145 mmol/l	**(Piccolo) Electrolyte**		
	Negative	K^{+}		3.3-4.7 mmol/l	*TEST*	*RESULT*	*REF. RANGE*
	Negative	CL^{-}		98-108 mmol/l	NA^{+}		128-145 mmol/l
	Negative	tCO_2		18-33 mmol/l	K^{+}		3.3-4.7 mmol/l
	Negative				CL^{-}		98-108 mmol/l
	Negative				tCO_2		18-33 mmol/l

...KS:

...ED BY:	DATE:	LAB ID NO.:

EPW# [redacted] 7 , 0330 #2

(b)(6)-4

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		150-500 x 10³ verified
Lymph %		20.5-51.1%

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

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

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

CSF		
Cell Count		
Directigen		Negative

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

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

Microscopic Urinalysis

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

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

REMARKS:

REPORTED BY: [redacted] DATE: 12 Jul 03 LAB ID NO.:

(b)(6)-2

(b)(6)-2

Ward/Section: ICW#2

LAST, FIRST, MI: (b)(6)-4 #[redacted]

[redacted]

DATE: 7-12 | TIME: 0330 | SSN-PSEUDO: #[redacted] (b)(6)-4

RESULT FORM

(Subject to the Privacy Act of 1974)

(i-STAT)

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

Misc. Chemistry

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

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		[illegible]

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
[illegible]		8.0-10.3 mg/dl
[illegible]		0.6-1.2 mg/dl
[illegible]		128-145 mmol/l
[illegible]		3.3-4.7 mmol/l
[illegible]		98-108 mmol/l
[illegible]		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
[illegible]B		3.3-5.5 g/dl
[illegible]P		26-84 u/l
[illegible]T		10-47 u/l
[illegible]Y		14-97 u/l
[illegible]T		11-38 u/l
[illegible]IL		0.2-1.6 mg/dl
[illegible]T		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
[illegible]		128-145 mmol/l
[illegible]		3.3-4.7 mmol/l
[illegible]		98-108 mmol/l
[illegible]		18-33 mmol/l

```
======= PICCOLO ========
12/07/03          03:27
REFERENCE RANGE:      MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #:        3141AA4
OPER #: [redacted]  DR #: 000
SERIAL #:      0000100697
.......................
GLU   97   73-118   MG/DL
BUN   6*   7-22     MG/DL
CRE   0.6  0.6-1.2  MG/DL
CK    32*  39-380   U/L
NA+   138  128-145  MMOL/L
K+    4.4  3.3-4.7  MMOL/L
CL-   103  98-108   MMOL/L
tCO2  26   18-33    MMOL/L

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

REMARKS:

REPORTED BY: [redacted]

DATE: 12 Jul 03

LAB ID NO.:

(b)(6)-2

(b)(6)-4

ID: [redacted] 12-07-03
WB 03:28

			Patient Limits	
WBC	11.4 H	x10^3/uL	4.5	10.5
RBC	4.36	x10^6/uL	4.00	6.00
Hgb	10.8 L	g/dL	11.0	18.0
Hct	35.6	%	35.0	60.0
MCV	81.6	fL	80.0	99.9
MCH	24.7 L	pg	27.0	31.0
MCHC	30.2 L	g/dL	33.0	37.0
Plt	421.	x10^3/uL	150.	450.
LY%	28.1 *	%	20.5	51.1
LY#	3.2 *	x10^3/uL	1.2	3.4

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 2½ DAYS MOS (YRS) Sex (✓) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 E
WT: 80 (KG/LB) HT: N ? IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: I+D (R) thigh Fx c Ex Fix
SURGICAL SERVICE: ortho
NPO SINCE: 2400

HABITS:
TOBACCO: 2 PPDX 11 yrs
ETOH: Ø
DRUGS: Ø

CURRENT MEDICATIONS:
(✓) = ordered as premed

✓ Ancef 1 g q 6h (LD 1200)
✓ MVI
✓ MSO4 PRN
( )
( )
( )

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

LABORATORY STUDIES:
HB/HCT: ____/____
U/A:
OTHER:
Lab drawn @ 0600

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	GSW LLE
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Tonsectomy / Eval Exam @ EST 30 min

PHYSICAL EXAMINATION 97%
BP 120/70 HR 90 R 16 T 99.8
Pain Scale 0-10
HEENT - Teeth Poor dentition
Trachea Midline
TMJ/Neck FROM
Oropharnyx MP III
Nares Patent
CHEST: CTA (B)
CARDIAC: S1 S2 RRR
EXTREMITIES: 16 g RAC
IV Access: NS TKO / NW
Ulnar Filling:
BACK: Ø
OTHER:

NPO Since 2400

ANESTHETIC PLAN: { } LOCAL { } MAC (✓) Regional (Specify): SAB (✓) 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.

Completed via interpreter.

The patient/legal guardian seems to understand and agrees. Questions answered.

Signed: [redacted] CRT/CRNA Date: 31 May 03 Time: 1525 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
(b)(6)-2

Signed: _____ Date: _____ Time: _____ Hrs

Date of Surgery
1 Jun 03

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.

Patient Identification: (Ward)

EPW
✓ CTV [redacted]
(b)(6)-4

ICW # 2

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Propofol	(mg)	211
Fentanyl	(μg)	(200) 50
Rocuronium	(mg)	160
Sux	(mg)	100
Ancef	(gm)	4 3 3 2 3
	(gm)	
	(gm)	
VOLATILE AGENT: Forane	% del	
	% e.t.	1.4 2.5 2.3 1.0 .7
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 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 ▶

LINE site		
UK	☐ Warmed	— 300 — 600 — 1000
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES	
EST BLOOD LOSS	
URINE –	400

TOTALS	
4/1	
250/0	
1515	

TOTAL FLUID: 1400

TOTAL URINE: 400

FLUIDS – SUMMARY

CRYSTALLOID– 1000

COLLOID– 0

BLOOD– 0

REMARKS– Code drugs with numbers, events with letters

(1) → UR. O2 monitors SAB attempted: Success. I-II Completed.

(2) Sed/evaluated ESV TV>5cc/kg SpO2 > 96% → Rm for recovery. IV patent. Report given.

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 80 KG LB

HEMATOCRIT:

INITIAL DATA: BP – 120/76 HR– 102

EQUIP CHECK: OK? – Y N

PATIENT RECHECK: OK for PROCEDURE? Y TIME– 1416

TIME → 1400 30 1500 30 1600 30

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml	600	480	500	500	650		
f – breaths/min	14	13	10	10	10	16	
Peak inf pres / PEEP	16						
MODE– S(pon), A(ssist), C(on)	S	C	S	S	S	S	S
ET CO2 (torr)	7	5	56	56	50	48	50
FIO2 (Frac or %)	92	92	9	92	92	9	9
SpO2 (%)	100	100	100	100	100	100	100
ECG	SR	SR	SR	SR	SR	SR	SR
TEMP- site							
N-M Block (T/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 → Supine pts padded BUE <90° UE taped.

RECOVERY AT 1551

PACU ICU (Specify)

OTHER

CONDITION awake

RESP– 16 SpO2– 99

BP 133/46 HR– 123

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1400	1415	1537
	Ready	Begin	End
PROC	1430	1453	1540

PROCEDURES and CPT Codes

I/D (L) tibia fx

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

LMA #3 attempt #8.0 ET 22cm (R) lip (+) ETCO2 DBS #2 M.I. Anaemotic Cuff ↑ (by Dr. Perkin)

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

EPW #[redacted]

(b)(6)-4

(b)(6)-2

(b)(6)-2

SURGEON [redacted]

ANESTHETIST [redacted]

PROCEDURE LOCATION OR 10

DATE 01 June 03

PAGE 1 OF 1

RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 10134

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

MEDICAL RECORD — ANESTHESIA

DRUG	Dose	
Versed	(mg)	1.5
Fent	(mcg)	150/100
Lido Prop	(cc)	15
Sux	(mg)	100
	( )	
	( )	
VOLAT AGENT: Forane	% del	2.5 2.5 1.5 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8/2 2 2 4

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

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

TOTALS	
1.5 / 1.0	μ/in
25.0	
	NA

FLUIDS – SUMMARY
CRYSTALLOID – 700
COLLOID – Ø
BLOOD – Ø

FLUIDS
LINE site: 18g (R) hand — ☐ Warmed
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES — EST BLOOD LOSS — URINE –

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 80 KG / LB

HEMATOCRIT:

INITIAL DATA: BP – 133/72 HR – 89

PUMP CHECK: OK? – (Y) N

PATIENT PREPARED: OK for new PROCEDURE? TIME – 0940

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

TIME → 0930 X 1000 X 1030 X 1100 X 1130 X 1200 X 1230

REMARKS – Code drugs with number with letters
(A) Pt in waiting area. ID Vd, NPO Vd, chart reviewed
IV: 18g (R) hand from floor
(B) Pt to OR. monitors placed
(E) I & I

VT – ml		400	400	390	400
f – breaths/min		12	8	10	10
Peak inf pres / PEEP					
MODE – S(pon), A(ssist), C(on)		S/C	S	S	S
BP/Auto Cuff	ET CO2 (torr)	49	55	53	55
BP / oth	FIO2 (Frac or %)	1.0	1.0	1.0	1.0
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP- site skin		99	99	99
	N-M Block (T/4)	0/4	4/4	4/4	4/4
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS (A) (B) (E) — Position (B)

RECOVERY AT: PACU (ICU) #1 (S) — OTHER — CONDITION Stable/SR/T-9 — RESP – 12 — SpO2 – 97 — BP – 115/64 — HR – 84

ANES	Start	Room
	0900	0940
PROC	Ready	Begin
	0945	0955

PROCEDURES and CPT Codes: 1 + D (R) Leg

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: Miller #2 / 8.0 ETT / Grade I view

Preox / Demitro / D Lx1 / VC x1 / tube passed through clear cords, I difficulty, (+) BBS, (+) EtCO2, 30x3, eyes taped, tube taped to teeth @ 24 cm, pressure points Vd + padded

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

#[redacted]

(b)(6)-4

ICW 2

(b)(6)-2

SURGEONS: [redacted] MD

ANESTHETIST: [redacted] M.D.

(b)(6)-2

PROCEDURE LOCATION: OR #2

DATE: 3 June 03

PAGE 1 OF

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 10135

U.S. GPO: 2002-[illegible]

Tobacco

NKDA

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)				TOTALS	TOTAL
Midazolam (iv)		2			2	25
Fentanyl (iv)		<100>	<50>	<50>	200	
Propofol (iv)		50			50	TOTAL
Lidocaine (iv)		30			30	
	( )					Ø
	( )					

VOLAT AGENT				
ISO	% del / % et.	1.2	1.2	1.3 X
AIR	L/Min			
N2O	L/Min			
O2	L/Min	10	2	2 2-8

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

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

FLUIDS – SECONDARY: CRYSTALLOID – 500; COLLOID – Ø; BLOOD – Ø

LINE site: RU (L) FA ☒ Warmed — NS — #1 — ☐ Warmed ☐ Warmed ☐ Warmed

LOSSES: EST BLOOD LOSS; URINE –

PHYSIOTYPE: 1 (2) 3 4 5 E

BODY WEIGHT: 80 (KG) LB

HEIGHT (CM): 26.8

VITAL DATA: BP – 118, 78; HR – 68

DRUG CHECK: OK? – (Y) N

PATIENT ENGINEER: OK for PROCEDURE? JT; TIME – 0700

TIME → 0815 · · 0900 · 30 · 1000

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	—	400	360	370
f – breaths/min	—	10	14	17
Peak inf pres / PEEP	—	—	—	—
MODE – S(pon), A(assist), C(on)	S	S	S	S
ET CO2 (torr)	43	43	37	43
FIO2 (Frac or %)	0.70	0.67	0.66	0.70
SpO2 (%)	100	100	100	100
ECG	SR	SR	SR	SR
TEMP – site AU				
R-M Block (T/4)				

Warming blkt: X | W00 | Blanket → → →; Conv warmer

Mark with letters & symbols, explain under REMARKS. EVENTS (1) (2) (3) (4); Position

REMARKS: Code drugs with number with letters

(1) Pre-operative Counseled for anesthesia.
(2) TOOR, monitor O2 18G PIV (L) FA placed. Induced, eyelid taped
(3) Emergence uneventful To Extra to PACU
(4) Report given.

RECOVERY: PACU (#) 2 0910; CENTER T-95.1A; CONDITION Stable and; RESP – 20 – 98; BP – 131/68 HR – 90

ANESTHESIA: Start 0815; Room 0825 091

PROC: Ready 0830; Begin 0840 090

PROCEDURES and CPT Codes: I + D (L) Lower Extremity

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, Head tilt; Chin lift

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

EPW # [redacted]

(b)(6)-4

JCW (b)(6)-2

(b)(6)-2

SURGEONS: [redacted]

ANESTHETIST: [redacted] CRNA/CPT

PROCEDURE LOCATION 1

DATE 5 Jun 03

PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 10136

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 26 DAYS MOS YRS Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: I+D (L) Leg
SURGICAL SERVICE: Ortho
NPO SINCE: NPO since MN

ASA Physical State 1 (2) 3 4 5 E
WT: 80 (KG/LB) HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: 22 pk yrs
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef 1gm IVPB q 8°
( ) Percocet 1 tab @ 0100
( ) ____
( ) ____
( ) ____
( ) ____

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

LABORATORY STUDIES:
HB/HCT: ____ / ____
U/A: ____
OTHER: ____
10.2 / 26.8 / 8.4 / 398

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	OSD (2) lower leg
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
1 Jun 03 > I+D Gluteal fx
3 Jun 03 >

PHYSICAL EXAMINATION
BP 118/78 HR 68 R 18 T 97.6
Pain Scale 0-10 ____ 98% O_2
HEENT - Teeth intact
Trachea midline
TMJ/Neck FROM
Oropharynx MPZ
Nares patent
CHEST: CTA (B)
CARDIAC: RRR (-) (-)
EXTREMITIES:
IV Access: 18Gr (R) HD
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since MN

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ { ✓ } General: Mask/intubation B/U

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: [redacted] CRNA/CPT Date: 6-05-03 Time: 0744 Hrs

(b)(6)-2

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

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

Mr. [redacted] (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.

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
MIDAZ	(mg)	5
FENT	(mcg)	50 50
ETOMIDATE	(mg)	16 10
KETAMINE	(mg)	
	( )	
SUCC	(mg)	100 60
VOLAT AGENT	% del	
FORANE	% e.t.	3.5 1.0 0.4
AIR	L/Min	
N2O	L/Min	
O2	L/Min	2 1 2

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

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

TOTALS	TOTAL FB
5 mg	MIN
100 mcg	
26 mg	TOTAL URINE
50	Ø
160	

FLUIDS – SUMMARY

CRYSTALLOID– 800 LR

COLLOID–

BLOOD–

FLUIDS

LINE site (R) A BG ☐ Warmed LR

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES: EST BLOOD LOSS

URINE –

FLUID STATUS: 1 2 3 4 5 E

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP – 137/74 HR – 78

SAMP CHECK: (OK?) Y N

PATIENT READY: (OK for PROCEDURE?) TIME – 0924

TIME → 930 45 1000 15 30 45 1100

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml		560	810	810	860
f – breaths/min	10	10	10	8	8
Peak inf pres / PEEP		23	20	22	22
MODE– S(pon), A(ssist), C(on)	S	C	C	C	C
BP/Auto Cuff / ET CO2 (torr)		46	30	36	35
BP / oth / FIO2 (Frac or %)		.82	.81	.88	.88
ART line / SpO2 (%)	100	65 100	100	100	100
Steth- PC/ES / ECG		SR	SR	SR	SR
Gas analyzer / TEMP- site					
N-M Block (T/4)		2/4 0/4	4/4		
Warming blkt					
Conv warmer					

REMARKS – Code drugs with numbers, events with letters

0900 PreOp EVAL-18G IV/A
VERSED 5mg
KETAMINE 25/25mg
920 TRANS → OR#1
monitors ↑
0925 Pre O2 IND/INT X2
OGT → Suct & OFF
0930 Suction
Agreed to Ext

RECOVERY AT: PACU ICU 2 (Specify) OTHER T=95.1/Ax

CONDITION: STABLE

RESP– 16 SpO2– 96

BP– 123/41 HR– 102

	Start	Room	End
ANES	0915	0925	1044
PROC	Ready 0940	Begin 0949	End 1030

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

PROCEDURES and CPT Codes: I&D (L) TIB

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: 8.0 DLX2 ETT → VC & BBS⊕ ETCO2⊕ Secured @ 21cm/LIPS EYES TAPED

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

#[redacted]

(b)(6)-4 ICW2 (b)(6)-2 (b)(6)-2

SURGEONS: [redacted]

ANESTHETIS[redacted]

PROCEDURE LOCATION: OR #1

DATE: 08 Jan 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED Jan 99

MEDCOM - 10138

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 26 DAYS MOS YRS

Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: I & D left leg

SURGICAL SERVICE: ortho

NPO SINCE: 5 MN

S/P GSW

ASA Physical State 1 2 3 4 5 E

WT: 80 KG/LB HT: ____ IN.

ALLERGIES: NKA

HABITS:

TOBACCO: 22 pack yrs

ETOH: ____

DRUGS: ____

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) Anacef

( ) Percocet

( ) ____

( ) ____

( ) ____

( ) ____

PREMEDICATIONS:

None Yes (@ ____ Hrs) /CC

____ . ____ mg IV IM PO

____ . ____ mg IV IM PO

____ . ____ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: ____ / ____

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
	N	Y
Familial HX	N	Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC

1 I & D (L) Tib

3 JUN

5

PHYSICAL EXAMINATION

BP 122/70 HR 84 R 16 T 98.2 99%

Pain Scale 0-10 ____

HEENT - Teeth ✓

Trachea ____

TMJ/Neck Prom

Oropharnyx MO2

Nares ____

CHEST: ATA

CARDIAC: RRR

EXTREMITIES:

IV Access: ____

Ulnar Filling: ____

BACK: ____

OTHER: ____

NPO Since 5 MN

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

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

agitated, discussed c̄ interpreter will give Versed ā . OK

The patient/legal guardian seems to understand and agrees. Questions answered.

Signed: [redacted] Date: 8 JUN 03 Time: 0805 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)

{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

(b)(6)-2

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

[redacted]

(b)(6)-4

ICW2 1328

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.

PCU2

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Versed	( )	2-3
Fentanyl	( )	100-150
Lidocaine	( )	100
Propofol	( )	200
Nimbex	( )	6 2 5/8
Nesp/Rob	( )	
VOLAT AGENT 150	% del % e.t.	X 1.0/.8/1.0/1.5/1.0
AIR	L/Min	X
N2O	L/Min	X
O2	L/Min	8/2/2/2/2/8

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

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

LINE site		
(R) wrist 18g	☐ Warmed	150 250
	☐ Warmed	UCI
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE –

TOTALS	TOTAL GIVEN
5/0	Minimal
250/0	
100	TOTAL URINE
200	
8	Ø
5/8	

FLUIDS – SUMMARY
CRYSTALLOID – 800
COLLOID – Ø
BLOOD – Ø

REMARKS – Code drugs with numbers, events with letters

1010 PT ID, chart reviewed. Assessment per preop form 2400.
1019 [illegible], Monitor
1025 ind/int. (see removal
1105 PT ext. deep
1125 PT TRANSFERRED TO ICU2. RPT TO MAT [redacted]

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP 125/67 HR 63

TEMP CHECK: OK? (Y) N

PATIENT READINESS: OK for PROCEDURE? TIME 1023

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

TIME → 1015 1030 X 1100 X 1130

VT – ml	650	530	460	150	400
f – breaths/min	10	6	6	10	14
Peak inf pres / PEEP	18	18	18		
MODE – S(pon), A(ssist), C(on)	SV –	CV –	CV	AV	SV
ET CO2 (torr)	31	35	39	48	51
FIO2 (Frac or %)	.67	.67	.69	.66	.66
SpO2 (%)	100	100	100	100	100
ECG	SR	SR	SR	SR	SR
TEMP- site	Avail				
N-M Block (T/4)	4/4 –	1/4 –	3/4	4/4	

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

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

RECOVERY AT: PACU ICU 2 (Specify); OTHER
CONDITION: TEMP 95.7
RESP – 16 SpO2 – 100
BP – 127/55 HR – 76

	Start	Room	End
ANES	1010	1019	1130
PROC	Ready 1028	Begin 1037	End 1111

PROCEDURES and CPT Codes: I & D (L)

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL x 1 3 Diff grade II view used MAC 3 – # 7.0 ETT TO 23@ up. BBS. Taped to (R) side. SBB in place

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

[redacted]

(b)(6)-4

all (b)(6)-2

SURGEONS: [redacted]

ANESTHETIST: [redacted] CPT CRNA ANESTHESIA

PROCEDURE LOCATION 1

DATE 11 JUN 03

PAGE 1 OF

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 10140

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

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)	
Lidocaine	(mg)	100
Fentanyl	(mcg)	100-50-50-50 … 100 … 100
Propofol	(mg)	200
Nimbex	(mg)	10
MSO4	(mg)	
Benadryl	(mg)	10 10
VOLAT AGENT 150	% del	50
	% e.t.	x/2/1.5/1.5/1.5/2/2/1.8/1.5/1.0/.6/.6/.8/.6/.6/.6/x/x
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8/3/3/4/4/3/4/4/2/3/3/3/3/3/5/5/2/3/4/8

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

FLUIDS — LINE site: 18g Ⓛ wrist ☐ Warmed — LR – 400 ... 1000 / 1400 — LR

LOSSES — EST BLOOD LOSS / URINE –

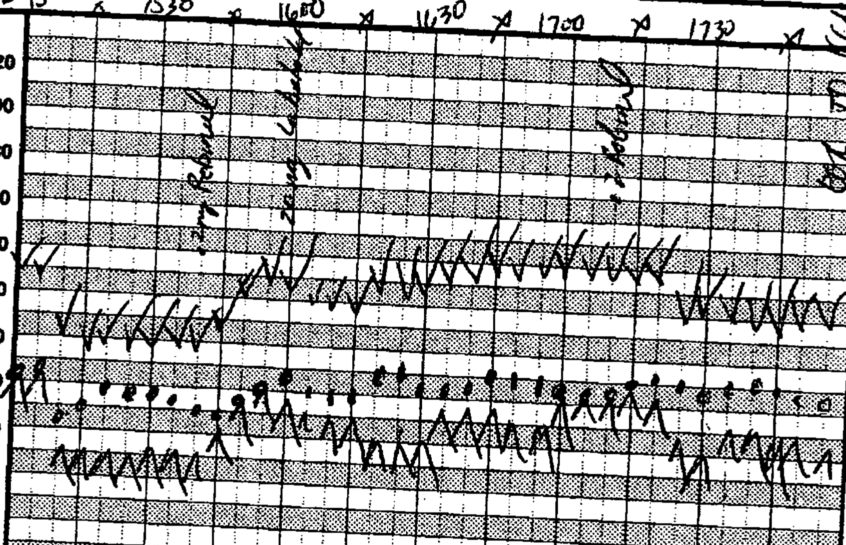
TOTALS	
TOTAL EBL	MIN (50
TOTAL URINE	Ø

FLUIDS – SUMMARY
CRYSTALLOID–
COLLOID– Ø
BLOOD– Ø

PHYS STATUS: 1 ② 3 4 5 E
BODY WEIGHT: 90 KG
HEMATOCRIT:
INITIAL DATA: BP – 132/83, HR – 83
EQUIP CHECK: OK? – Y N
PATIENT RECHECK: OK for PROCEDURE? TIME–

TIME ➡ 1500 x 1530 x 1600 x 1630 x 1700 x 1730 x

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



VT – ml	800	710	720	610	470	440	200	600	610	500	720	150
f – breaths/min	8	8	8	4	10	8	7	5	8			
Peak insp pres / PEEP	18	18	18	13	/	/	/	/	/	10	10	10
MODE – S(pon), A(ssist), C(on)	SV-CV-CV		CV	AV	SV	SV	SV	SV	SV	SV	SV	SV
✓BP/Auto Cuff ✓ET CO2 (torr)	34	30	32	40	51	48	50	49	43	45	49	47
BP / oth ✓FIO2 (Frac or %)	.60	.58	.58	.58	.58	.55	.55	.55	.53	.53	.53	.53
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	Avail											
✓N-M Block (T/4)	4/4-0/4-1/4											
✓ESTETH	HSBS-HSBS-HSBS →											
Warming blkt												
Conv warmer												

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

REMARKS — Code drugs with numbers, events with letters

1450 PT ID, CHART ✓, FORM 2400 COMPLETED.
1500 Rm, O2, monitors
1507 IND / Intubation
1535 Ⓣ up 275 mmHg Ⓛ LEG.
1705 Surgeon request 30 more min Ⓣ time
1710 Ⓣ ↓ 105 min.
1736 PT EXT deep.
1753 OOR TO ICU
1758 RPT TO ICU

RECOVERY AT 1756 — PACU / ICU (Specify) — OTHER
CONDITION: Stable
RESP– 8 SpO2– 97
BP– 152/85 HR– 8[illegible]

ANESTHESIA / PROCEDURE TIME

ANES	Start 1450	Room 1500	End 1800
PROC	Ready 1508	Begin 1537	End 1750

PROCEDURES and CPT Codes: I & D Ⓛ FIBULA

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — Easy vent, DL x1 c̄ 3 MIL, grade II view, #8 ETT to 23 @ LIP, eyes taped, cuff ↑, ⊕ BBS ⊕ ETCO2, DA in ASAP, tube taped to Ⓛ, TDTS

PATIENT IDENTIFICATION — Typed or written entries: Name, Grade/Rate, Medical facility
#[redacted] ICW2 (b)(6)-2
(b)(6)-4

SURGEONS: [redacted]
ANESTHETIST: [redacted] CPT CRNA
(b)(6)-2

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

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED Jan 99
MEDCOM - 10141

ESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

DAYS MOS YRS

Sex ( ) MALE ( ) FEMALE

ED PROCEDURE: ORIF (L) FIBULA
AL SERVICE: ORTHO
NCE:

ASA Physical State 1 (2) 3 4 5 E
WT: 80 KG/LB HT: ___ IN.
ALLERGIES: NKDA

TS:
BACCO: 2 PPD x 11 yrs
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Ancef
( ) MVI
( ) MSO4
( ) Ativan
( )
( )

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

LABORATORY STUDIES:

HB/HCT: ____/____
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)	GSW (L)
	N Y	
Familial HX	N Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC

Fasciotomy
I&D

PHYSICAL EXAMINATION
BP 118/87 HR 96 R ___ T ___
Pain Scale 0-10
HEENT - Teeth Intact
Trachea midline
TMJ/Neck Free
Oropharnyx MPII
Nares
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES: 18g (L) wrist
IV Access:
Ulnar Filling:
BACK: CDI
OTHER:

NPO Since

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

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

The pati[redacted] seems to understand and agrees. Questions answered.
Signed: [redacted] CRNA Date: 23JUN03 Time: 1500 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER
(b)(6)-2

Signed: ___ Date: ___ Time: ___ Hrs

Patient Identification: (Ward)

#[redacted] (b)(6)-4
ICW2 | ICU1

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

S/P GW

ANESTHESIA PLAN OF CARE

6 DAYS MOS YRS

PROCEDURAL ASSESSMENT (Sedation)

Sex (✓) MALE ( ) FEMALE

Smoker

POSED PROCEDURE: (L) tibia plateau

RGICAL SERVICE: ortho

O SINCE:

ASA Physical State 1 (2) 3 4 5 E

WT: 80 KGS HT: ___ IN

ALLERGIES: NKDA

HABITS:

TOBACCO: (+)

ETOH:

DRUGS: —

CURRENT MEDICATIONS:

( )= ordered as prefixed

( ) Cdace

( )

( )

( )

( )

( )

PREMEDICATIONS:

None Yes (@ ___ Hrs) /CC

___ mg IV IM PO

___ mg IV IM PO

___ mg IV IM PO

LABORATORY STUDIES:

HS/HCT: ___/___

U/A:

OTHER:

25 June

10.9/433

173/36

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

Familial HX N Y

ASSESSMENT

PAST SURGICAL/ANESTHETIC

LLE D&D: 30 mg

multiple D&D's

6 complications

PHYSICAL EXAMINATION

BP 94/44 HR 80 R ___ T 98.6

Pain Scale 0-10 ___

HEENT - Teeth: intact

Trachea: midline

TMJ/Neck: FROM

Oropharynx: C1 2, 3/6 TK

Nares: —

CHEST: BBS/CTA

CARDIAC: S/S C

EXTREMITIES:

(L) LE Ex-fix

IV Access: OK - heparin lock

Urine Filling: #18 (R) A/C

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 a discussed with the patient/legal guardian.

The patient/legal gu[redacted] agrees. Questions answered.

Signed: [redacted] Date: 10/Jul/13 Time: 2200 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)

( ) NO APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER

(b)(6)-2

Signed: ___ Date: ___ Time: ___ Hrs

Patient identification: (Ward) ___

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

(b)(6)-4

[redacted] ICW2

MEDICAL RECORD - ANESTHESIA

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

DRUG	(Units)		
Fentanyl	(mcg)	50	50
Versed	(mg)	3/2	
Propofol	(mg)		200
	( )		
	( )		

CONTINUOUS/INTERMITTENT INFUSIONS - SPECIFY UNITS "I" = CONSTANT INFUSION

VOLAT AGENT	Sevo	% del
		% e.t.
AIR		L/Min
N2O		L/Min
O2		L/Min

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

FLUIDS ANESTH.

LINE site #18 (L) ☐ Warmed

☐ Warmed

☐ Warmed

☐ Warmed

LOSSES: EST BLOOD LOSS

URINE -

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT: 35

INITIAL DATA: BP- 126/68 HR- 75

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? ✓ TIME- 0530

TIME: 0530 0700

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

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

VENTIL.

VT - ml	
f - breaths/min	
Peak inf pres / PEEP	13
MODE - S(pon), A(assist), C(on)	SC SC AW
BP/Auto Cuff	ET CO2 (torr) 5
BP/oth	FIO2 (Frac or %) 1.0 1.0 1.0 40
ART line	SpO2 (%) 100 100 100 100
Sleth- PC/ES	ECG Sin Sin SW
Gas analyzer	TEMP-site SR
	N-M Block (T/4) 0/4
Warming blkt	
Conv warmer	

MEDICATIONS/ACCESSORIES

Mark with letters & symbols, explain under REMARKS

EVENTS Position →

PROCEDURES and CPT Codes: Mandible + Cast (L) Fibula

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

#[redacted]

(b)(6)-2

ICU2 | ICU1

ANESTHETIC TECHNIQUES: Describe block technique under Remarks G/A - OAW

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

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

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

TOTALS	TOTAL EBL
100 mcg	
5 mg	min
TOTAL URINE	
	NA

FLUIDS SUMMARY

CRYSTALLOID- LR 300

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

(1) time - monitors

0642 ALBRITTON RELIEF

(b)(6)-2

RECOVERY AT: PACU ICU 1 (Specify)

OTHER

CONDITION: STABLE Room AIR

RESP- 16 SpO2- 100

BP- 105/60 HR- 75

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0530	0700	0700
	Ready	Begin	End
PROC	0615	0620	0650

PROCEDURE LOCATION: OR 2

DATE: 17 Aug 03

PAGE 1 OF 1

Report to [redacted] 0600

FORM 7389, FEB 1998

MEDCOM - 10144

COPY 1 - PATIENT'S MEDICAL RECORD

VERSED mg 5

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
PROPOFOL	(mg)	200
FENTANYL	(µg)	100-150
LIDOCAINE	(mg)	100
SUCCINYLCHOLINE	(mg)	180
NIMBEX	(mg)	16
MSO4	( )	
VOLAT AGENT: SEVO	% del	X/2.5/2.0/2.0/2.0/2.0/2.0/2.0/2.0/2.0/1
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8/2/2/2/2/2/2/2/2/2/2/8

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

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

LINE site	
UR 18g	☐ Warmed
	☐ Warmed
	☐ Warmed
	☐ Warmed

TOTALS	TOTAL FBL
250	50
	TOTAL URINE
10	10

FLUIDS – SUMMARY
CRYSTALLOID 1400
COLLOID – Ø
BLOOD – Ø

LOSSES: EST BLOOD LOSS; URINE –

ASA STATUS: 1 2 3 4 5 E

BODY WEIGHT: 80 KG LB

HEMATOCRIT: 36

VITAL DATA: 111/65; R – 80

EQUIP CHECK: OK? – Y N

PATIENT RECHECK: Ready for PROCEDURE? Y; TIME 1030

TIME → 1030 1100 1130 1200

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

Airway Collapse

VT – ml	650	650	630	640	640	400	380	410
f – breaths/min	6	6	6	6	6	6	6	6
Peak inf pres / PEEP	21	21	21	21	21	25	21	
MODE – S(pon), A(ssist), C(on)	S-C	C	C	C	C	C	C	S
ET CO2 (torr)	40	33	33	33	30	31	40	49
FIO2 (Frac or %)	.75	.75	.75	.75	.75	.75	.75	.75
SpO2 (%)	100	100	100	100	100	100	100	100
ECG	SR	SR	SR	SR	SR	SR	SR	SR
TEMP- site	Avau							
N-M Block (T/4)	4/4-0/4-0/4				1/4-0/4			

☒ 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 → ⊙

REMARKS – Code drugs with numbers, event with letters

1015 PT ID, PREOP FORM 2400 REVIEWED, Ø Δ.
1022 RM, O2, monitors
1049 TOTS
1127 (T) ↑ @ 275 mm mmHg [redacted]
1220 PT C VT > 400 ml + NTC – cont.
1224 OOR TO CCU3
1235 PT TO SPC [redacted]

RECOVERY AT 1226
PAIN (ICU) 2 (Specify)
OTHER
CONDITION:
RESP – 16 SpO2 – 96 RA
BP – 129/71 HR – 83

TIME	Start	Room	End
AREA	1015	1022	1235
PROC	Ready	Begin	End
	1049	1103	1216

PROCEDURES and CPT Codes: (L) TIBIA PLANING

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

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

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL x3 success c̄ 4.0 MAC #8.0 ET in to 21cm @ lip. cuff ↑, ⊕ ETCO2, ⊕ BBS, TAPE TUBE TO ⊕ 5.0cm, inserted #10 OA as BB, eyes taped – TOTS

SURGEON: (b)(6)-2

ANES: (b)(6)-2

PROCEDURE LOCATION 2
DATE 7/11/03
PAGE 1 OF

[redacted] (b)(6)-4

PATIENT RECORD — WAMC OP 376 REVISED 1 Jan 99 — RECORD – ANESTHESIA

☆ U.S. GPO: 1999 – 528-336/10

ESTHESIA PLAN OF CARE / PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

e 26 DAYS MOS (YRS) Sex (X) MALE ( ) ~~FEMALE~~

ASA Physical State 1 (2) 3 4 5 E

POSED PROCEDURE: (L) TIBIA CAST

GICAL SERVICE: ORTHO

WT: 80 (KG/LB) HT: ____ IN.

SINCE: ____

ALLERGIES: NKDA

ITS:

BACCO: SMOKER

ETOH: ____

DRUGS: ____

RENT MEDICATIONS:

ordered as premed

MEDICATIONS:

e Yes (@ ____ Hrs) /CC

__ · ____ mg IV IM PO

__ · ____ mg IV IM PO

__ · ____ mg IV IM PO

ORATORY STUDIES:

12 July HCT: 10.8 / 35.6

ER: ____

DLT 421

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:			
Acuta/Chronic RF	(N)	Y	
Gastrointestinal:			
Hepatitis	(N)	Y	
Hiatal Hernia	(N)	Y	
PUD/GERD	(N)	Y	
Endocrine System:			
Diabetes	(N)	Y	
Steriods	(N)	Y	
Thyroid	(N)	Y	
Neurological:			
Seizures	(N)	Y	
Neuropathy	(N)	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT

PAST SURGICAL/ANESTHETIC

LLE 30 MAY

MULTIPLE I&Ds

Ø COMPLICATIONS

PHYSICAL EXAMINATION

BP ____ HR ____ R ____ T ____

Pain Scale 0-10 ____

HEENT - Teeth ____

Trachea (WNL)

TMJ/Neck 3+

Oropharnyx MPZ

Nares ____

CHEST: CTA

CARDIAC: S1 S2

EXTREMITIES: ____

IV Access: ____

Ulnar Filling: ____

BACK: ____

OTHER: ____

NPO Since PRIOR TO MN

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

ORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to cussed with the patient/legal guardi[redacted] (b)(6)-2

patient/leg[redacted]ns. Questions answered.

ned: [redacted] 19 July 03 Time: 0500 Hrs

T-ANESTHESIA EVALUATION AND NOTE (NON ASU)

NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

ned: ____ Date: ____ Time: ____ Hrs

ent Identification: (Ward) ____

#[redacted] ICW2/ICU.

(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 n necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may be ...

ANESTHESIA PLAN OF CARE PRE-PROCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

PROPOSED PROCEDURE: I&D (L) leg pos. Ext Fix adj
SURGICAL SERVICE: Ortho
NPO SINCE: PMN

ASA Physical State 1 (2) 3 4 5 E
WT: 80 (KG) LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: 2ppd x 11yrs
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

() Ancef 1gm 60
() ____
() ____
() ____
() ____
() ____

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

LABORATORY STUDIES:
HB/HCT: ____ / ____
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	GSW (L) lower leg
	N	Y	
Familial HX	N	Y	

ASSESSMENT

PAST SURGICAL/ANESTHETIC

Ext. Fix/Fusion

PHYSICAL EXAMINATION

BP 126/71 HR 99 R 18 T 101
Pain Scale 0-10 ____
HEENT - Teeth poor
Trachea midline
TMJ/Neck FROM
Oropharnyx MPE
Nares ____
CHEST: CTA
CARDIAC: S.S.
EXTREMITIES:
IV Access: #18g (L) Hand
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.

Signed: ____ Date: ____ Time: ____ Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

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

Patient Identification: (Ward) ____

[redacted] (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

[redacted]

(b)(6)-4

26 y/o ♂ Iraqi EPW

NURSING UNIT	ROOM NO.	BED NO.
ICW		

DATE OF ORDER: 31 May 03 TIME OF ORDER: 0120

Admit to ICW #2

Dx: GSW (L) LE with Ex Fix + Fasciotomy

Conditions: Stable

VS q8h per Routine

AM: NPDA

Meds: 4mg MSO4 Q4-6° prn PAIN

Diet: Regular

LIST TIME ORDER NOTED AND SIGN

Noted 5/31/03 1UT/AN

PATIENT IDENTIFICATION

EPW [redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW		

DATE OF ORDER: TIME OF ORDER:

LABS: CBC, chem 12, Lytes @ 0600

Activity: Bedrest -

Consult: PT For Crutches

Consult: Orthopedic Surgery.

Tylenol 650mg p.o. Q6° prn Temp > 100.4

IV Ancef 1gm Q6°

12.5mg Phenergan IV Q6° prn Nausea + Vom.

(b)(6)-2

PATIENT IDENTIFICATION

EPW [redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW		

DATE OF ORDER: TIME OF ORDER:

IVF @ 75cc/hr NS.

~~Lasix~~ Diuretic p.o. Daily

NPO - MN

5-31-03

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
31 May 03	0300	

[redacted] 1UT/AN 34°V

PATIENT IDENTIFICATION

EPW [redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW		

DATE OF ORDER: TIME OF ORDER:

HOURS

FORM APR 79 4256 REPLACES EDITION OF 1 JUL 7 ... USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

NT IDENTIFICATION

PW (b)(6)-4

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2		12

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
1 Jun 03	0820 HOURS	
MSO4 1-2mg q15min prn pain, for max dose ~~to~~ 16mg in 4 hrs.		[redacted]
V.O. Dr. [redacted]		
all (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

ATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
	HOURS

38

RSING UNIT	ROOM NO.	BED NO.

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

☆ U.S. GOVERNMENT

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW [redacted]

(b)(6)-4

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

DATE OF ORDER: 1 JUNE 03 | TIME OF ORDER: 1550 HOURS | LIST TIME ORDER NOTED AND SIGN

1. TO ICW-2
2. S/P EYE (L) LID
3. CONTINUE STRIKE
4. VS - ROUTINE
5. BED REST
6. D/C FOLEY

PATIENT IDENTIFICATION

EPW [redacted]

(b)(6)-4

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

DATE OF ORDER | TIME OF ORDER: LATE HOURS

7. [illegible] 1 [illegible] EVERY Q [illegible]
8. EV - LR AT 125 [illegible], [illegible] LOCAL WHEN TAKE PO. WHEN
9. TYLENOL 650 mg P.O. Q 4-6 hrs PRN
10. PERCOCET, 1-2 P.O. Q 4-6 hrs PRN
11. MSO4, 2-6 mg EVP Q 2 hrs PRN
12. REGULAR DIET.

PATIENT IDENTIFICATION

EPW [redacted]

(b)(6)-4

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

DATE OF ORDER | TIME OF [redacted] (b)(6)-2

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

EPW [redacted]

(b)(6)-4

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

DATE OF ORDER: JUNE 2, 03 | TIME OF ORDER: 1355 HOURS

1. NPO [illegible]
2. FOR O.R. TOMORROW (b)(6)-2

[redacted]

NURSING UNIT: ICW 2 | ROOM NO.: 24 VS | BED NO.: 2220

2 June 03 [redacted] (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: EPW [redacted] (b)(6)-4

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

DATE OF ORDER: 3 JUN 03 | TIME OF ORDER: 1025 HOURS | LIST TIME ORDER NOTED AND SIGN

1. TO ICU 1 [illegible] PREVIOUS [illegible] ICW 2
2. S/P I+D (L) LEG
3. CONDITION - STABLE
4. VS - ROUTINE
5. R LEGBAR. DILT
6. IV - LR @ 125 CC/HR. DISCONTINUE
7. WHEN TOLERATES P.O. WITH
8. CBC, ALBUMIN IN A.M.
9. RESUME ALL OTHER PREVIOUS ORDERS

(b)(6)-2 [redacted]

Noted [redacted]

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

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

DATE OF ORDER: 4 JUN 03 | TIME OF ORDER: 1600 HOURS

1. NPO AFTER MIDNIGHT

(b)(6)-2 [redacted]

Noted (b)(6)-2 [redacted] Quinnie [illegible] June 1630 (b)(6)-2

6/4 2215 VO Dr. [redacted] / 4 [redacted]

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

24° F's [redacted] LATER 6/5/03 0030.

(b)(6)-2

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

DATE OF ORDER: 100mg Colace PO x 1 now | TIME OF ORDER: HOURS 0730 [redacted]

5 JUN 03 0903

1. RESUME ALL PLANNED ORDERS
2. RESUME DILT
3. IV LR @ 125 CC HEP LOCK WHEN TOLERATE P.O.

4° [redacted] 6/5/03 2100

(b)(6)-2

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

[redacted] (b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

WARD	ROOM NO.	BED NO.
ICW2		8

DATE OF ORDER: 7 JUN 03 — TIME OF ORDER: 1600 HOURS

1. COLACE 100 mg BID
2. DULCOLAX SUP. P.R. PRN
3. DULCOLAX TAB, 1 P.O BID PRN.

[redacted] 1620

(b)(6)-2 noted

PATIENT IDENTIFICATION: EPW (b)(6)-2 [redacted] (b)(6)-4

WARD	ROOM NO.	BED NO.
ICW2		8

DATE OF ORDER: 7 JUN 03 — TIME OF ORDER: 2030 HOURS

1. NPO after midnight
2. D/C morphine
3. AMBIEN 10 mg Q HS PRN
4. TO OR IN AM

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

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

WARD	ROOM NO.	BED NO.
ICW2		8

DATE OF ORDER: 8 JUN 03 — TIME OF ORDER: 0950 HOURS

1. TO ICW 2
2. Resume BUN pharmacy orders
3. IV - LR at 125 cc/hr. D/C IV when tolerating P.O. intake
4. D/C enemas
5. CIPRO - 500 mg BID, P.O.
6. D/C colace.
7. MELOXICAM - 5mg IM BID 1st dose given @ 1058.
8. ATIVAN 2mg IM BID
9. BENADRYL 25mg IM BID

[redacted] 14 AUG [redacted] 03 2230

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

PATIENT IDENTIFICATION: EPW (b)(6)-4 [redacted] 24° VS

WARD	ROOM NO.	BED NO.
ICW2		8

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

FORM 4256 APR 79 — 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	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# [redacted] (b)(6)-4	ICW2			6/9	0130 HOURS (b)(6)-2	
				V.O. From Dr. [redacted] to Lt. [redacted] (b)(6)-2 (1) 2ng African Iny		now
				(b)(6)-2 [redacted]		
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
# [redacted] (b)(6)-4	ICW2			9 Jun 03	0230 HOURS	
				10 mg Tab ARDol		
				10 mg IM MSO4		
				3 mg Vened IV		
				(b)(6)-2	(b)(6)-2	
				[redacted]		
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
EPW [redacted] (b)(6)-4	ICW2		1	10 Jun 03	1900 HOURS	
				NPO p mn		
				to OR in AM	(b)(6)-2	
				[redacted]		
PATIENT IDENTIFICATION	NURSING UNIT	ROOM NO.	BED NO.	DATE OF ORDER	TIME OF ORDER	
(b)(6)-2				13 Jun 03	(b)(6)-2 HOURS	
				(1) W→D dsg Δ on (L) LE wound		(b)(6)-2
				@D (b)(6)-2		
				V.O [redacted]		no
				[redacted]		
				(b)(6)-2		
				[redacted]		

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

GPW [redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 11 JUN 03 — TIME OF ORDER: 1115 HOURS — LIST TIME ORDER NOTED AND SIGN

(b)(6)-2 [redacted]

1. TO ICW 2
2. S/P I+O (b) FIBIN
3. RESUME ALL PREVIOUS ORDERS
4. IV - LR at 100 cc/hr. O/K WITH FULLER P.O. FLUID
5. RESUME DIET

11 Jun 03 1130

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 11 Jun 03 — TIME OF ORDER: 1200 [redacted] HOURS

(b)(6)-2

1. MSO4 4mg IV x1 prn pain
2. May repeat x 2 q 15 min prn pain

[redacted]

(b)(6)-2

[redacted]

(b)(6)-2

PATIENT IDENTIFICATION

EPW [redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2	24/5	250

DATE OF ORDER: 19 JUN 03 — TIME OF ORDER: (b)(6)-2 HOURS

1. ATROPIN 2mg P.O. [redacted] BID
2. BECLOMET 25mg PO [redacted]
3. XIMEDON OP, LEFT EYE (L) [redacted] BID

(b)(6)-2

19 Jun 03 1240

(b)(6)-2

19 JUN 03 [redacted]

PATIENT IDENTIFICATION

EPW [redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW2	24/5	250

DATE OF ORDER: 20 JUN 03 — TIME OF ORDER: 1610 HOURS

(b)(6)-2

noted 20 Jun 03

1. D/C CIPRO

VO. [redacted] / [redacted]

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

[redacted] AW

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

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION (b)(6)-4 # [redacted] EPW (b)(6)-2

NURSING UNIT: ICW2 | ROOM NO.: 24 V [redacted] | BED NO.: [redacted]

DATE OF ORDER: 22 Jun 03 | TIME OF ORDER: 1600 HOURS | LIST TIME ORDER NOTED & SIGN

1. NPO p mn
2. c/c to OR in AM

per Dr [redacted] 1600 (b)(6)-3 [redacted]

[redacted] 24/AN [redacted]

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

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 8

DATE OF ORDER: 23 Jun 03 | TIME OF ORDER: 1750 HOURS (b)(6)-2

1. S/P OK'd to OR
2. Resume all previous orders
3. Resume diet
4. IV ~ LR at 125 cc/hr, Hep lock when taking P.O. med
5. Check & chart NPB q 8 hrs x 72 hrs
6. CBC, electrolytes & IV Abx

24 V [redacted] 1/4 AN 6-23-03 2330

(b)(6)-2 [redacted]

(b)(6)-2

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

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 8

DATE OF ORDER: 24 Jun 03 | TIME OF ORDER: 0000 HOURS (b)(6)-2

1. CBC in AM ✓
2. Unasyn 3.0 gm IV Q6° ✓
3. D/C Ancef ✓

(b)(6)-2 [redacted]

[redacted] given 24 Ancef

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

NURSING UNIT: ICW2 | ROOM NO.: 24 V/S | BED NO.: 8

2300 04 Jun [redacted]

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

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 9

DATE OF ORDER: 6 Jun 03 | TIME OF ORDER: 1000 HOURS | LIST TIME ORDER NOTED AND SIGN

noted [redacted] 0950

✓ D/C Foley

✓ D/C IV

(b)(6)-2

24° / done [redacted]

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

NURSING UNIT: ICW#2 | ROOM NO.: | BED NO.: 9

DATE OF ORDER: [redacted] | TIME OF ORDER: [redacted] 1330 HOURS

NPO p MN

for procedure 11 Jun 03

(b)(6)-2

noted (b)(6)-2 [redacted] 9/10 mine 10 July 03 1400

24° / done [redacted] /AN

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

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 9

DATE OF ORDER: 11 JUNE 03 | TIME OF ORDER: 1330 HOURS

(b)(6)-2 [redacted] 1500

1. RESUME PREVIOUS ORDERS
2. LR 125 cc/hr, HEP LOCK WHEN TOLERATING P.O. WELL
3. REGULAR DIET
4. ADMIT (2) LOC.
5. UP AD LIB, CRUTCHES, NWB on (L)
6. ANCEF, 1 GRAM IVPB Q 8 HRS x 72 hrs
7. CIPROFLOXACIN 500mg P.O. BID.
8. TYLENOL 650mg P.O. Q 4 HRS PRN
9. PERCOCET, 1 tab P.O. Q 4-6 HRS PRN
10. MSO4, 2-6 mg IVPB Q 2 HRS PRN
11. CBC, METABOLIC 8 IN AM.
12. IN AM - AP + LAT (L) TIB/FIB - "ALIGNMENT"

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 9

24° / [redacted] 7 JUN 03 0100 [redacted]

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

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 ORDERS NOTED SIG
EPW [redacted] (b)(6)-2			11 JULY 03	1323 HOURS	
			① MSO4 5-10 mg IVP Q 1 hr PRN. (b)(6)-2 [redacted] For Recovery Only Not TCW	[redacted] (b)(6)-2	
NURSING UNIT: ICW2	ROOM NO.	BED NO. 7			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			11 JULY 03	1605 HOURS	
			① TORADOL 30mg IVP Q 6 hrs x 48 hrs (b)(6)-2 [redacted]		
NURSING UNIT	ROOM NO.	BED NO.			
	24°V	[redacted]	14 JAN 7-12-03 0100		

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
24°V [redacted] (b)(6)-2			14 JAN 7-12-03 2240	HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			15 JULY 03	1600 HOURS	
			① MSO4 30 <43 P.O. B10 PRN [redacted] (b)(6)-2		(b)(6)-2
NURSING UNIT	ROOM NO.	BED NO.			
		24°	Chart ✓ 14 July 03 0830		

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

PATIENT IDENTIFICATION

(b)(6)-4

#[redacted]

DATE OF ORDER 18 Jul 03 TIME OF ORDER 1600 HOURS

(b)(6)-2

NPO p MN [redacted]

(2) O/C to OR 18 Jul 1700

per Dr. [redacted] (b)(6)-2

NURSING UNIT ICW 2 ROOM NO. [redacted] BED NO. 9

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

(b)(6)-2

DATE OF ORDER 19 July 03 TIME OF ORDER 0653 HOURS

(1) Resume previous orders
(2) Mobilize bid
(3) IV-2L at 125 cc/hr, 2 liter total with taking PO water,
(4) Weight bear as tolerated
(5) P.T. consult for crutches

NURSING UNIT ICW 2 ROOM NO. BED NO. 9

PATIENT IDENTIFICATION

#[redacted]

(b)(6)-4

DATE OF ORDER (b)(6)-2 TIME OF ORDER [redacted]

(8) Discharge to GPW camp Pad

(b)(6)-2 [redacted]

NURSING UNIT ICW 2 ROOM NO. BED NO. 9

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT ROOM NO. BED NO.

all (b)(6)-2

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. 5 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 31	01	02
31 May	FW	VS qs	06	[redacted]		
			13	[redacted]		
			21	[redacted]		
31 May	FW	Diet: Regular	06	[redacted]		
			13	[redacted]		
			21	[redacted]		
31 May	FW	Activity: bedrest	06	[redacted]		
			13	[redacted]		
			01	[redacted]		

Recap

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW (L) LE I Ex Fix & Fasciotomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

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

EPW

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

all (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo May Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
31May	[redacted]	Admit to ICW #2	31May		0130	[redacted]
31May	[redacted]	Labs: CBC, chem 12, lytes	31May	0600		
31May	[redacted]	Consult for PT Eval	31May			
31May	[redacted]	Consult orthopedic surgery	31May			

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

USAPA V1.00

all (b)(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 6 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	4	5	6	7	8	9	10	11	12	B	M
1	[redacted]	VS ROUTINE	5	[redacted]													
			13	[redacted]													
			21	[redacted]													
1	[redacted]	ACT: BR	6	[redacted]													
		Elevate (L) LEG	13	[redacted]													
			21	[redacted]													
1	[redacted]	REGULAR DIET	6	[redacted]													
			11	[redacted]													
			17	[redacted]													
~~4~~	[redacted]	~~NPO p MN~~ error															
14	[redacted]	W→D Drsg ΔQD	15	[redacted]													

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
Sp I+D (L) LEG

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO: 1

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

a11(b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo June Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
1	[redacted]	TO ICW-2 : STABLE	1	/	1700	[redacted]
1	[redacted]	D/C Foley	1	NOW	1900	[redacted]
1	[redacted]	DTV	1	0100	Done	
2	[redacted]	NPO p MID	2	2355		[redacted]
2	[redacted]	to OR in AM	3	AM		[redacted]
3	[redacted]	CBC, Albumin	4	0400	0400	[redacted]
4	[redacted]	NPO p MID	4	2355	2355	[redacted]
7	[redacted]	NPO p MD	8	MN	2100	[redacted]
7	[redacted]	TO OR in AM	8	AM	1200	[redacted]
10	[redacted]	NPO p MID	10	2355	2355	[redacted]

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

USAPA V1.00

all (b)(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLA[illegible] For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo: [illegible] Yr. 2005

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 15	16	17	18	19	20	21	22	23	24	25	26	27	28
1	[redacted]	VS Routine	9	[redacted]													
23	[redacted]	VS routine	13	[redacted]													
			21	[redacted]													
1	[redacted]	Act BR Elevate	5	[redacted]													
23	[redacted]	(L) LE	13	[redacted]													
			21	[redacted]													
1	[redacted]	REGULAR DIET	8	[redacted]													
23	[redacted]	regular diet	11	[redacted]													
			17	[redacted]													
14	[redacted]	W-2 D Dsg Δ QD	17	[redacted]										See below			
25	[redacted]	Dsg Δ and pin	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	[redacted]			
		care ½ STR H2O2 BID	22	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	[redacted]			

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: S/P I&D (L) leg

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

all (b)(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 6 Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19	[redacted]	X-Ray AP ~~LAP~~ (L) Tib / Fib	19	today	[illegible]	[illegible]
22	[redacted]	NPO p mn	23	000 /	Done	[redacted]
22	[redacted]	O/C FOOR in Am	23	O/C	1500	[redacted]
23	[redacted]	CBC / methylate 8 in Am	24	024	1330	[redacted]
23	[redacted]	resume all previous orders	23	now	1930	[redacted]
24	[redacted]	CBC in AM	25	AM	0345	[redacted]
29	[redacted]	CBC, MET 8 in AM	30	0400		[redacted]

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

all (b)(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 6 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 29	30	1	2	3	4	5	6	7	8	9	10	11	12
28	[redacted]	Clears-advas	07	[redacted]													
		tol (slowly)	12														
			17														
			/														
23	[redacted]	VS routine	05	[redacted]													
			13														
			21														
			/														
23	[redacted]	activity BR-elevate	05	[redacted]													
		(R)(L) LE	13														
			21														
			/														
23	[redacted]	Dsg D and pin care	10	[redacted]													
		1/2 strength H2O2 BID	22														
29	[redacted]	Foley cath via	05	[redacted]													
		gravity	13														
			21														
		Foley cath via	05														
4 July	[redacted]	gravity	13														
			21														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: SIP T/D (L) leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted] (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

all (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 6 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
28	[redacted]	NPO tonight	28 Jun		Done	[redacted]
29	[redacted]	Insert foley now	29	1150	1200	[redacted]
29	[redacted]	Posterior Splint by ortho tech	29	ASAP	[redacted]	
	-----	CBC, Methyl'8 in Am	30	Am	0300	[redacted]
6 July	[redacted]	D/c foley	6 July	NOW	1000	[redacted]
10	[redacted]	NPO p MN for plate	11 July	2400	done	[redacted]

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

USAPA V1.00

all (b)(6)-2

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. 7 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13	14	15	16	17	18	19	20	21	22	23	24
11	[redacted]	Regular diet	07	/	[redacted]												
			12	/	[redacted]												
			17	[redacted]													
			/														
11	[redacted]	elevate (L) leg	05	/	[redacted]												
11	[redacted]	up ad libc crutches	13	[redacted]													
		NWBO-(L)	21	[redacted]													
			/														
11	[redacted]	NS routine	05	/	[redacted]												
			13	[redacted]													
			2	[redacted]													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EFW-[redacted]

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

all (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 7 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11	[redacted]	CBC, metlyte 8 in AM	12	04		[redacted]
11	[redacted]	APBLAT(L) TIB/FIB - "S/P plating" in AM	12	AM	1400	[redacted]
18	[redacted]	NPO PMN	19	0001	done	[redacted]
18	[redacted]	O/C to OR 18Jul03	19	0/c	0630	[redacted]
19	[redacted]	DC to EPW Camp Now	19		1900	[redacted]

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

all (b)(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 5 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 31	01	02
31 May	[redacted]	IV Ancef 1gm q6°	06	[redacted]		
			12	[redacted]		
			18	[redacted]		
			24	[redacted]		
31 May	[redacted]	IVF @ 75cc/hr NS	05	[redacted]		
			13	[redacted]		
			21	[redacted]		
31 May	[redacted]	MVI (one) PO QD	10	[redacted]		

No Pain

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: GSW RLE c̄ ExFix & Fasciotomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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

EPW

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

all (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 05 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
31 May	[redacted]	Tylenol 650mg PO q6° PRN temp > 100°	[redacted]													
			[redacted]													
31 May	[redacted]	Phenergan 12.5mg PRN q6° nausea & vomiting														
31 May	[redacted]	Meph 4mg q4-6° PRN for pain	31 May 0130 4mg [redacted]	31 May 0230 [redacted]	31 May 0745 4mg CT	31 May 1130 4mg [redacted]	31 May 1400	31 May 2030 [redacted]	1 Jun 0430 4mg [redacted]							
1 Jun	[redacted]	MSO4 1-2mg q15min prn pain, up to 16mg in 4°	6/1/03 0530 2mg IV	6/1/03 0630 2mg IV	6/1/03 0730 2mg IV	6/1/03 0820 2mg										
			[redacted]													

USAPA V1.00

all (b)(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 06 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3	4	5	6	7	8	9	10	11	12	13	14
1	[redacted]	Ancef 1 gram IVPB	06	[redacted]										DC'd			
		Q 8°	12														
			18											8 Jun 03			
			24											[redacted]			
1	[redacted]	IV: LR @ 125 cc/hr	5	[redacted]													
		HL when tol P.O. well	13	[redacted]													
			21	[redacted]													
6	[redacted]	Colace 100 mg	10							[redacted]				DC'd			
		PO BID	22							[redacted]				8 June 03 AS			
8 Jun	[redacted]	LR @ 125 cc/hr	5								[redacted]						
		DC when able to tol	13								[redacted]						
		crate P.O	21								[redacted]						
8 Jun	[redacted]	Cipro 500 mg BID po	06								[redacted]						
			18								[redacted]						
8 Jun	[redacted]	HALDOL 5 mg IM BID	06														
			18								(not)						
8 Jun	[redacted]	Ativan 2 mg IM BID	06														
			18								(not)						
8 Jun	[redacted]	Benadryl 25 mg IM	06								(not)						
		BID	18														

prn

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: S/P I+D (R) LEG

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

all (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. June Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6/4	[redacted]	Colace 100mg PO x 1 now	6/4	2225	2225	[redacted]
6/9	[redacted]	2mg Ativan IM x1 now	6/9	0130	0130	[redacted]
6/9	[redacted]	10mg IM Haldol	6/9	0230	0230	[redacted]
6/9	[redacted]	10mg MSO4 IV	6/9	0230	0230	[redacted]
6/9	[redacted]	3mg Versed IV	6/9	0230	0230	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
1	[redacted]	Tylenol 650 mg PO	6/4 11	4 June 11 1715	7 June 11 1440	11 June 11 1830		12 June 11 1915		13 June 0300 0300 1650						
-----	-----	Q4-6° prn	[redacted]	[redacted]		[redacted]		[redacted]		[redacted]						
-----	-----															
1	[redacted]	Percocet 1-2 PO.	5 June 2000 11	6 June 0030 11	6 June 0430 11	6/2 0840 11 10	6/2 1240 11 10	6/2 1730 11	6/2 2130 11	6/3 0410 11	6/3 2115 11	6/3 0230 11	6/4 0630 11	6/5 0100 11 10	6/6 0100 11 10	6/6 2200 11
-----	-----	Q4-6° prn	[redacted]	[redacted]		[redacted]		[redacted]		[redacted]		[redacted]		[redacted]		[redacted]
-----	-----															
1	[redacted]	MSO4 2-6mg	6/2 1110													
-----	-----	IVP Q2° PRN	2mg IV													
-----	-----															
6	[redacted]	Dulcolax supp PR prn	6 Jun 1615													
-----	-----	- constipation	[redacted]													
6	[redacted]	Dulcolax tab PO														
-----	-----	BID PRN - constipation														

USAPA V1.00

all (b)(6)-2

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	8	9	10	11	12	13	14	15	16	17	18	19	20	21
8 JUN	[redacted]	Haldol 5mg IM	08	/	[redacted]												
		BID	20	[redacted]													
8 JUN	[redacted]	Ativan 2mg IM	08	/	[redacted]												
		BID	20	[redacted]													
8 JUN	[redacted]	Benadryl 25mg	08	/	[redacted]												
		IM BID	20	[redacted]													
10 Jun	[redacted]	Haldol 5 mg IM	12	~~11~~	/	/	[redacted]										
		BID	24	~~23~~	/	/	[redacted]										
10 Jun	[redacted]	Ativan 2mg IV	12	~~11~~	/	/	[redacted]										
		BID	24	~~23~~	/	/	[redacted]										
10 Jun	[redacted]	Benadryl 25mg	12	~~11~~	/	/	[redacted]										
		IV BID	24	~~23~~	/	/	[redacted]										
11 June	[redacted]	IV LR @ 100cc/hr	05	/	/	/	[redacted]										
		HL when tolerating	13	/	/	/	[redacted]										
		PO Well	21	/	/	/	[redacted]										
~~14 June~~	[redacted]	~~Benadryl 25mg PO~~															
19 June	[redacted]	Ativan 2mg PO BID	12	/	/	/	/	/	/	/	/	/	/	/	[redacted]		
			24	/	/	/	/	/	/	/	/	/	/	/			

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: S/P I&D (L) LEG

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO. 8

PATIENT IDENTIFICATION:
EPW # [redacted] (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

all (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 6 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
11	[redacted]	MSO4 4mg IV X 1 PRN PAIN	11	PRN	1205	[redacted]
11	[redacted]	May Repeat x2 q 15 min PRN pain				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
1	[redacted]	Percocet 1-2 tabs	7 Jun 0500	8 Jun [illegible]	[illegible]	[illegible]	[illegible]	1900	18 Jun 2030	[illegible]	24 Jun 0515	30 June	23 Jun	25 Jun 0500	25 Jun 2354	
		PO q 4-6° PRN	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
6/7	[redacted]	Ambien 10mg PO	6 Jun 2100	10 Jun 1020	[illegible]											
		QHS	[redacted]	[redacted]	[redacted]											
19	[redacted]	Benadryl 25mg PO														
		Q6° PRN														

USAPA V1.00

all(b)(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 6 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18	19	20	21	22	23	24	25	26	27	28
5 JUNE	[redacted]	CIPRO 500mg BID PO	06	[redacted]													
			18	[redacted]													
31 MAY	[redacted]	One MVI PO QD	10	[redacted]													
10 June	[redacted]	HALDOL 5mg IM BID	12	/	/	/	/	/	/	/	[redacted]						
			24	/	/	/	/	/	/	/	[redacted]						
19 June	[redacted]	Ativan 2mg PO BID	12	/	/	/	/	/	/	/	[redacted]						
			24	/	/	/	/	/	/	/	[redacted]						
				/													
23	[redacted]	ancef 1gm IVPB 98°&72°	06	—	—	—	—	—	—	—	—	/	[redacted]			X	
			14	—	—	—	—	—	—	—	—	/				X	
			22	—	—	—	—	—	—	—	/	[redacted]	2	3	X	X	X
				/													
23	[redacted]	LR @ 125cc/hr until taking fluid well then SL	06	—	—	—	—	—	—	—	—	/	[redacted]				
			14	—	—	—	—	—	—	—	/	[redacted]					
			22	—	—	—	—	—	—	—	/	[redacted]					
24	[redacted]	Unasyn 3.0gm IV Q6°	06	/	/	/	/	/	/	/	/	/	/	[redacted]			
			12	/	/	/	/	/	/	/	/	/	[redacted]				
			18	/	/	/	/	/	/	/	/	/	[redacted]				
			24	/	/	/	/	/	/	/	/	/	[redacted]				
27	[redacted]	Unasyn 3.0gm IV	03	/	/	/	/	/	/	/	/	/	/	/	/	/	
			09	/	/	/	/	/	/	/	/	/	/	/	/	/	[redacted]
			15	/	/	/	/	/	/	/	/	/	/	/	/	/	[redacted]
			21	/	/	/	/	/	/	/	/	/	/	/	/	/	[redacted]

ALLERGIES: ☐ YES ☐ NO — NKA

PRIMARY DIAGNOSIS: S/P I+D (R) leg

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO — PAGE NO. 3

PATIENT IDENTIFICATION: #[redacted] (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

all (b)(6)-2

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
(a) July	[redacted]	D/C IV	ceasing	NOW	Done	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
28 12	[redacted]	Haldol 5mg IM	D/C'D						29 Jun 03							
		BID PRN														
28 12	[redacted]	Ativan 2mg PO														
		BID PRN														
28	[redacted]	Zofran 4mg IVP														
		q8° prn-nausea														
13 June copied	[redacted]	Percocet 1-2 tabs PO	10 July 11PO	10 July 11PO												
		q 4-6 hr PRN	0510	0158												
13 June copied	[redacted]	Ambien 10mg PO														
		QHS prn														
13 June copied	[redacted]	Benadryl 25mg PO														
		Q6° PRN														

USAPA V1.00

all (b)(6)-2

CLINICAL RECORD

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

Mo. 7 YR 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11	12	13	14	15	16	17	18	19	20	21	22	23	24
28 Jun	[redacted]	¯ multivitamin PO QD	10	/	[redacted]												
30 Jun	[redacted]	Colace 100mg PO BID	10	/	[redacted]												
			22	[redacted]													
11	[redacted]	LRRK Salk - (HC) when taking PO well	05	/	[redacted]												
			13	[redacted]													
			21	[redacted]													
11	[redacted]	ancef 1 gm IVPB 98°172°	08	/	[redacted]			X									
			16	[redacted]				X	X								
			22	[redacted]				X	X								
11	[redacted]	ciprofloxacin 500mg PO BID.	10	/	[redacted]												
			22	[redacted]													
11	[redacted]	TORDOL 30mg IVP Q6° x 48 hrs	4	/	[redacted]			/									
			10	/	[redacted]			/									
			16	[redacted]				/									
			22	[redacted]				/									

DC'd 1330 19 Jul 03

DC'd 19 Jul 03 BS

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P (L) tib plating
S/P (D) fib plating

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW [redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

all (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. 7 Yr. 03
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED														
11/14	[redacted]	MSO4 ~~5-10mg~~ 2-6mg IV PO q2° prn	1500 5mg IV [redacted]														
11/25	[redacted]	Tylenol 650mg PO q4° prn	[redacted]														
11/14	[redacted]	Percocet 1-2 PO 4-6° hrs prn	7-12 023 [redacted]														
H	[redacted]	MoM 30mg PO BID prn	1300 [redacted]														

D/C 10/31/03

[redacted]

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: _____ Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: 1125

Allergies: NKDA OR Intake: Crystalloid _____ Colloid 800

Pre-op V/S: 125/67 83 OR Output: UOP B EBL Min

Procedures: I+D (L) Ulcer Meds/Times: MSO4 1205

5 Versed 250 fent

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

100-120 30-60

Pre Op Meds / History

Time																	
SaO2	100	100	100	99	95												
FIO2	[redacted]																
Methods																	
240																	
220																	
200																	
180																	
160																	
140																	
120	120	129	124														
100																	
80																	
60																	
40																	
20																	
HR	70	72	75	70	78												
RR	20	20	18	15	12												
T	96.4	96.5	97.4	98.7													
Time	1130	1140	1200														
Pain (0-10)																	
LOS																	

(b)(6)-2

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1130	LR	1000/hr	(R) Hand		

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	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	(2)	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	127/55 (2)	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	10	11	

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)

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE

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

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

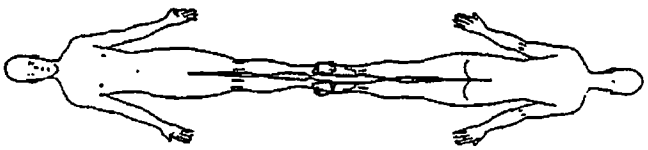
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1200		4 mg MSO4	IV			

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

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

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

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



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Arrived to PACU 2 via wheeled litter accompanied by anesthesia pt arousable IV infusing O2 Sat 100% connected to monitor HR stable, temp 96.9 - wrapped in warm [redacted] blankets (+) pedal pulse (L) leg cap refill <3 sec.

1200 c/o pain pointed to affected limb. MSO4 ordered & given (b)(6)-2

@ 1205 pt appears pain free, no addition c/o pain [redacted] MAS/RN

1230 pt VSS easily arousable, no further c/o pain IV infusing (+) pedal pulse (L) leg to go to ward [redacted] MAS/RN

(b)(6)-2

Discharge Criteria:
Date: Time: PARS:
BP: T: HR: RR: Sa02:
Pain Level at D/C (0-10):
Intake:_____ Output:_____
Additional Data:_____
Transferred To:_____
Report Given To:_____
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: _____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: _____

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: 35 [illegible]
Time In:
Allergies: NKDA
Pre-op V/S:
Procedures:

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

OR Intake: Crystalloid 700 NS Colloid
OR Output: UOP EBL
Meds/Times: 250 mcg fent
propofol
3 ccs
[illegible] 1.5 mg

133/72
89
14-18

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1035	1055	1110
SaO2	97	98	98
FiO2	RA	RA	RA
Methods			
240			
220			
200			
180			
160			
140			
120			
100			
80			
60			
40			
20			
RR			
T			

1035
98.1
82
98.1, 14
97.6F
1055
116/65
84
97%, 18
1100
105/58
42
12
98%.

Time	1050								
Pain (0-10)	[illegible]								
LOS		[illegible]							

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
* = Cuff BP
= Pulse

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

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

PREPA[redacted] (Signature/Title) (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 1

DATE: 3 [illegible] 05

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

H

[redacted] (b)(6)-4
ICU 2.

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete

USAPPC V2.00

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1040		Cangrelor	IVP			TSD

NEUROVASCULAR

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

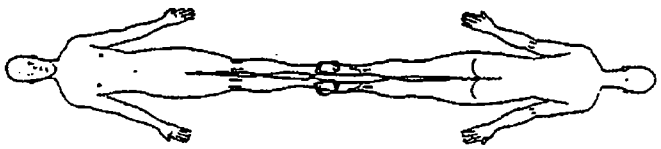
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(D) Groin	ace	c/d/I
30'	(D) Groin	ace	c/d/I
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1040	NSR		

NURSING NOTES

pt arrived pt at approx 1040, pt in no apparent distress on time of arrival. able to move all extremities. No distal pulses accounted appropriate CSTaff
CV NSR 5 ectopy / S1 S2 +2 pulses all extremities
GI hypo BS ⊘ U/D ⊘ BM
GU No void ⊘ foley
pt received Cang at 1040 for [lower leg pain. pain decreased per nonverbal communication

[redacted] (b)(6)-2

Discharge Criteria:
Date: 3 June **Time:** 1120 **PARS:** 10
BP: 136/62 **T:** 97.1 **HR:** 81 **RR:** 15 **SaO2:** 97
Pain Level at D/C (0-10): —
Intake: — **Output:** —
Additional Data:
Transferred To: ICW 2
Report Given To:
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: 1LT [redacted] (b)(6)-2
Cleared IAW Recovery Room SOP 8-3
Charge Nurse Signature: [redacted]

WAMC OP 173-E

(b)(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 05 June 03
Time In: 0910
Allergies: unknown
Pre-op V/S: 118/78 68
Procedures: (L) E 1+D

Anesthesia Type (Circle)): (General) Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 500 Colloid Ø
OR Output: UOP Ø EBL 25
Meds/Times: Ø ABX

80kg
150 fent
2 versed

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds / History

Time	0910	0915	0920	0925	0930	0935	0940
SaO2	98	97	99	98	98	97	99
FiO2	RA	RA	RA	RA	RA	RA	RA
Methods	/	/	/	/	/	/	/
240							
220							
200							
180							
160							
140							
120	V	V	V	V	V	V	V
100					•		
80	•	•	•	•		•	•
60	^	^	^	^	^	^	^
40							
20							
RR	32	22	18	26	25	12	22
T	95	1	98.7		96.8		
Time							
Pain (0-10)							
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0910	NS	500 T	(L) FA	[redacted]	100cc

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
˜ = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 05Jun03

[redacted] (For typed or written [redacted] Name – last, [redacted] middle; grade; date, hospital or medical facility)

(b)(6)-2

EPW [redacted] (b)(6)-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
0915	UTA	Cent 25mcg	IVP	UTA	—	[redacted]
0930	UTA	4mg MSO4	IVP	UTA	—	
1010	UTA	2mg MSO4	IVP	—	—	

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) LE	+	+	+	<3	warm	norm
15'	(L) LE	+	+	+	<3	warm	pink
30'	(L) LE	+	+	+	<3	warm	pink
45'	(L) LE	+	+	+	<3	warm	pink
60'	(L) LE	+	+	+	<3	warm	pink
90'							
D/C							

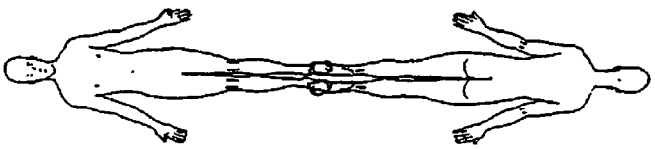
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) LE	ex fix ACE	CDI
30'	(L) LE	ex fix ACE	CDI
60'	(L) LE	ex fix ACE	CDI
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
		[redacted]	
	None		

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Patient recovered on gurney
neuro: awake, moaning, follows commands, medicated c̄ fentanyl and MSO4
resp: lungs clear, sats 98-100% on Room air
CV: HR, B/P stable
GI: abd soft, BS (+), Ø N/V/D
GU: Ø void, Ø distention
Skin: ext fix c̄ ace to (L) LE
~~Respos~~ Report given [redacted]
(b)(6)-2

Discharge Criteria:
Date: 5 June **Time:** 1010 **PARS:** 12
BP: 124/61 **T:** 96.8 **HR:** 79 **RR:** 22 **Sa02:** 98%
Pain Level at D/C (0-10):
Intake: 100 cc **Output:** Ø
Additional Data:
Transferred To: ICW #2
Report Given To: [redacted] (b)(6)-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted] CPT/AN (b)(6)-2
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted] CPT/AN
(b)(6)-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DA

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

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

OTSG APPROVED (Date)

Date: 8 June 03
Time In: 1043
Allergies: NKDA
Pre-op V/S: WNL
Procedures: R (b) leg

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block

OR Intake: Crystalloid 800 LR Colloid
OR Output: UOP Ø EBL Min
Meds/Times:

Versed 2mg
100mg Fent
Etomidate 20mg
Ketamine 30

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1043	1055	1105	1115	1125	1135	1145	1155	1205	1215	1230	1245	1315	1345
SaO2	96	98	99	99	99	99	99	99	99	99	99	99	99	100
FiO2														
Methods														
240														
220														
200														
180														
160														
140		A												
120	A		A	A			A	A	A	A				
100	•	•			A	A		•			A	A	A	
80		•	•	•	•	•	•		•	•	•	•	•	•
60		V	V					V	V	V	V			
40	V	V			V	V	V					V	V	V
20														
RR	32	28	23	20	19	20	20	20	14	14	15	14	13	
T	98.1					99.1				98.1			98.5	
Time														
Pain (0-10)														
LOS														

Pacu Intake (b)(6)-2

Time	Solution	Amount	Site	By	Infused
1043	NS		R FA	[redacted]	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	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	1	1	2
Circulation (~~Peds <6 years~~) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	9	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

PREPARED BY (Signature & Title) [redacted] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU/ICU

DATE: 8 June 03

(Continue on reverse)

PA[redacted]TION (For typed or written entries give: first [redacted]ate; hospital or medical facility)

Name – last,

[redacted] (b)(6)-4

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

all (b)(6) 2

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1045	UTA	2mg MoSy	IV	/		[redacted]
1055	/	5mg Droldol	IM	/	/	
1104	UTA	2mg MoSy	IV	/	/	
1127	/	2mg MoSy	IV	/	/	

NEUROVASCULAR

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

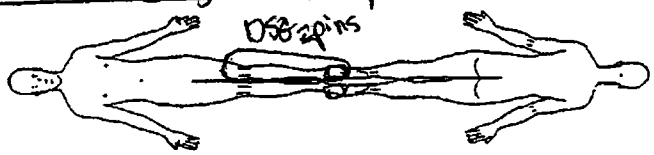
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

	Time	Location	Type	Drainage
Adm	1043	(L) leg	ace & pins	Ø
30'	1113	(L) leg	ace & pins	Ø
60'	1143	(L) leg	ace & pins	Ø
D/C	1146	(L) leg	ace & pins	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

1043 Amited from surgery to PACU/ICU for recovery. (R) IV NS (R) inner FA 3 S/S of infection or infiltration. (L) leg DSG & pins on outside of leg. CDI. Upset @ present time. Interpreter came by to talk to him. Will monitor Sgt [redacted]
1115 Resting in bed @ present time. Not upset @ present time. [redacted]
1130 Tries to sit up @ V's. Rai[redacted] (L) leg off of bed @ V's. Will monitor. See Meds @ [redacted] LPN
1146 Transported to ICW II. Report given to Sgt [redacted]

Discharge Criteria:
Date: 6/8 **Time:** 1747 **PARS:** 12
BP: 102/49 **T:** 97.5 **HR:** 91 **RR:** 16 **Sa02:** 100
Pain Level at D/C (0-10):
Intake: 300 **Output:** Ø
Additional Data: Ø
Transferred To: ICW II
Report Given To: Sgt [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: Sgt [redacted] LPN & CPT [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted] CPT [redacted]

WAMC OP 173-E

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: 23 June 03
Time In: 1800
Allergies: NKDA
Pre-op V/S: 132/83 HR83
Procedures: Left Ovit
Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1800 Colloid Ø
OR Output: UOP Ø EBL 50
Meds/Times: 250 Fentanyl, 300 Lidocaine, 20 MSO4, 50 Glycopyrrolate, 250 propofol, 10 Nimbex, 14 Robinul

Drains: Hemovac, NG, JP, T-tube, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds History

Time	1800	1810	1820	1830	1840	1850
SaO2	97	100	100	97	98	94
FiO2	2L	2L	2L	10L	10L	Ø
Methods						
240						
220						
200						
180						
160	✓					
140		✓			✓	✓
120			✓	✓	✓	
100		∧				
80	∧		∧			
60				∧	∧	
40			∧			
20						
RR	18	16	18	25	20	19
T	96.7		98.7			98.1
Time	1800					
Pain (0-10)						
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	2	
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	8	

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): [redacted] Spc
DEPARTMENT/SERVICE/CLINIC: ICU 1
DATE: 23 June 03

(b)(6)-2 PATIENT'S IDENTIFICATION (For typed or written entries give: first, middle; grade; date; hospital or medical facility)
Name – last,
EPW [redacted] (b)(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

all (b)(6)-2

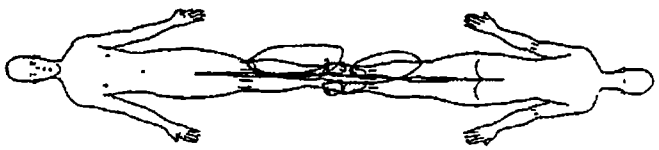
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

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

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

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

DRESSINGS			
Time	Location	Type	Drainage
Adm	LLE	Ace wrap	ex fix
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1805	80's	no	no

WAMC OP 173-E

NURSING NOTES

1800 Pt. arrived via stretcher, report given by CRNA. Pt's vitals 147/80 HR85, R 16, Spo2 98% @ 2L via NC, VSS, pt. arousable upon physical/verbal stimulie, Will continue to monitor. [redacted]

Discharge Criteria:
Date: Time: PARS:
BP: T: HR: RR: Sa02:
Pain Level at D/C (0-10):
Intake: Output:
Additional Data:
Transferred To: ICW 2
Report Given To: Cpt. [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: ICU Spc [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted]

Jeyo 10g(R) ASA #2

90 Kg

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: 11 July 03
Time In: 1205
Allergies: NKA
Pre-op V/S: 111/65 80
Procedures: Ortho plate

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1400 Colloid
OR Output: UOP 0 EBL 50
Meds/Times:

250 Fent
5 Versed
10 MSO4

Drains: Hemovac, NG, JP, T tube, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time																
SaO2	96	100	100	100	100	99	99	100								
FiO2	RA	4L	4L	4L	4L	RA	RA	RA								
Methods																
240																
220																
200																
180																
160																
140																
120																
100																
80																
60																
40																
20																
RR	11	18	12	12	20	20	18	16								
T	99							98								
Time																
Pain (0-10)																
LOS																

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	—	—	—
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	10	10

Codes

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

V/S
X = A-line BP
^ = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

(b)(6)-2 PR[redacted]BY (Signature & Ti[redacted] LPN

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 11 July 03

[redacted]'S IDENTIFICATION (For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

[redacted] (b)(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete

USAPPC V2.00

all (b)(6)-2

MEDICATIONS

Allergies: NKA

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1250	5/10	MSO4 4mg	IV	3	E	SEL
1300	5/10	MSO4 2mg	IV	5	I	SEL
1329	5/10	MSO4 4mg	IV	5	E	SEL

NEUROVASCULAR

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

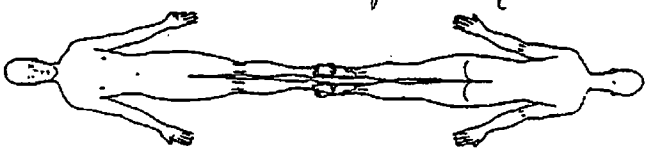
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	LLE	Ace & Splint	Ø
30'	LLE	Ace & Splint	Ø
60'	LLE	Ace & Splint	Ø
D/C	LLE	Ace & Splint	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt recieved from Surgery 12:20. VSS. Sats 96-100 on RA. Pt alert. Able to Cough & Deep Breath. Drsg to LLE C/D/I. Pt able to move toes to LLE, Cap Refill brisk <3 sec. Extremity warm to touch [redacted] Touch. + Sensation. Pt C/O pain 2mg MSO4 given per MD orders. [redacted] 1330. Pt C/O pain 5/10. 4mg MSO4 given per MD orders. Pt still C/O pain 5/10 [redacted] LPN

Discharge Criteria:
Date: 13 July 09 Time: 1414 PARS: 10
BP: 131/69 T: 98 HR: 83 RR: 16 Sa02: 97
Pain Level at D/C (0-10):
Intake: Ø Output: Ø
Additional Data: Ø
Transferred To: ICW #2
Report Given To: Lt [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SPC [redacted]
Cleared IAW Recovery Room SOP: B.3
Charge Nurse Signature: [redacted] maj/RN

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 18 July 03
Time In: 0700
Allergies: NKDA
Pre-op V/S: 122/68
Procedures:

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 600 Colloid
OR Output: UOP EBL
Meds/Times: 100 Fent. 5mg Versed

Drains: Hemovac, NG, JP, T-tube, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds / History

Time	0700	0705	0710	0725
SaO2	100	99	99	100
FiO2				
Methods	RA	RA	RA	RA
240				
220				
200				
180				
160				
140				
120				↓
100		↓	↓	
80	↓	•	•	•
60	^	^	^	^
40				
20				
RR	8	6	6	4
T	98			
Time				
Pain (0-10)				
LOS				

Pacu Intake

Time	Solution	Amount	Site	By	Infused
0700	LR	600	L wrist	OL	400

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

Codes

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

V/S
X = A-line BP
" = Cuff BP
= Pulse

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

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

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

PREPARED BY (Signature & Grade): [redacted] 66-2

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 18 July 03

(Continue on reverse)

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

[redacted] (b)(6)-4

80 KG

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

Fiberoptic Bronch.

all (b)(6)-2

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(D) leg	F	+	P	B	W	PK
15'	(D) leg	F	+	P	B	W	PK
30'							
45'							
60'							
90'							
D/C	(D) leg	F	+	P	B	W	PK

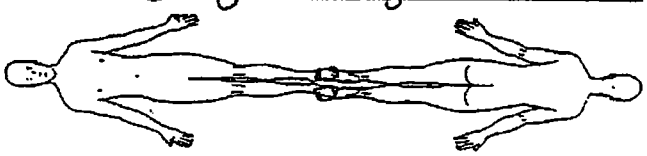
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(D) leg	Short leg cast	∅
30'			
60'			
D/C	(D) leg	Short leg cast	∅



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0700	NSR	∅	∅

WAMC OP 173-E

NURSING NOTES

- Pt to ICU #1 for recovery from OR. IVF LR infusing into (D) wrist. ∅ S/S of redness OR swelling to site. Site is patent + intact. Short leg cast to (D) leg. Pt has brisk cap. refill, skin is warm to touch. ∅ c/o pain. Will continue to monitor + assess. VSS [redacted]
- 0730 - Pt to ICU #2 [redacted]

Discharge Criteria:
Date: **Time:** **PARS:**
BP: 120/62 **T:** 96.5 **HR:** 73 **RR:** 18 **Sa02:** 99% - RA
Pain Level at D/C (0-10): ∅
Intake: 50 **Output:** ∅
Additional Data:
Transferred To: ICU #2 [redacted]
Report Given To: [redacted]
Transferred Via: W/C [redacted] Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Ro [redacted]
Charge Nurse Signature: [redacted]

all(b)(6)-2

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM: ~~[illegible]~~ Detainee

RANK / GRADE: —

✓ MALE / HOMME
FEMALE / FEMME

SSN / NUMERO MATRICULE: [redacted]

SPECIALTY CODE / GPM:

RELIGION / RELIGION:

2. UNIT / UNITE:

FORCE / ÉLÉMENT: A/T | AF/A | N/M | M/M

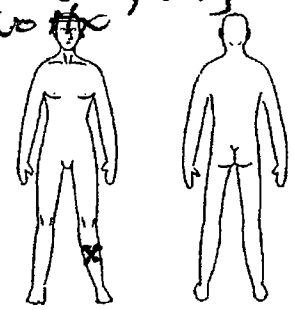
NATIONALITY / NATIONALITÉ: UNK

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

3. INJURY / BLESSURE

FRONT / DEVANT — BACK / ARRIÈRE

S/P GSW (L) Leg
for emerg Surg
No NBC



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

Ancef 1gm
Gent 80mg } IV
Fent 50 µg
Versed 2mg
PIVX2

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

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

5. PULSE / POULS | TIME / HEURE

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

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

8. IV / IV | TIME / HEURE

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

IND Pentothal 300 Sux 180 Fent 2
GETA RSI ā Cricoid press. DVL x 1
7.0 OETT TO 24 cm ⊕ BBS ⊕ ETCO2
BP 80's p̄ induct Ephedrine 15 mg
& PUSH IV. FLUIDS.
WOUND - 4 LAP (SINGLE) IN WOUND

10. DISPOSITION / DISPOSITION: TO PACU

RETURNED TO DUTY / RETOUR À L'UNITÉ
EVACUATED / EVACUÉ
DECEASED / DÉCÉDÉ

TIME / HEURE

11. PROVIDER / UNITED STATES / UNITÉ: [redacted] Mobile AW CRNA

DATE/DATE (YYMMDD): 03 05 30

DD Form 1380, DEC 91

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

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

☆U.S. GPO: 1995-402-147

all (b)(6)-2

ADMISSION AND CODING INFORMATION

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

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

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

NAME (Last, First, Middle Initial): EPW [redacted] b6-4

4. PAY GRADE		5. SEX
16	17	18
		M

6. DATE OF BIRTH (YYYYMMDD)							
19	20	21	22	23	24	25	26

7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACKGROUND	
27	28	29	30	31	
2	6	4	Z	9	

RELIGION: unk

10. LENGTH OF SERVICE			ETS
32	33	34	
			N/A

11. FMP	
35	36
9	9

12. SOCIAL SECURITY NUMBER								
37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION (Active Duty Only): N/A

13. MARITAL STATUS: 46

HOUR OF ADMISSION: 0120

BRANCH / CORPS: N/A b6-4

14. FLYING STATUS		
47	48	49

15. BENEFICIARY CA1		
50	51	52
K	7	9

Transferred to EPW camp Did not die

16. ZIP CODE OF RESIDENCE								
53	54	55	56	57	58	59	60	61

17. UNIT LOCATION (State or Country Code)	
62	63

18. MOS			
64	65	66	6

TRAUMA

PREV. ADMISSION: YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION
72
Ø

W/ RELATIONSHIP OF EMERGENCY ADDRESSEE

ESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] (b)(2)-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	
73	74
~~5~~	Ø

22. MTF TRANSFERRED TO					
75	76	77	78	79	80

23. DATE OF DISPOSITION (YYMMDD)					
81	82	83	84	85	86
Ø	3	Ø	7	1	9

24. CLINIC SVC - ADMITTING			
87	88	89	90
A	E	A	A

25. MTF TRANSFERRED FROM					
91	92	93	94	95	96

26. DATE THIS ADMISSION (YYMMDD)					
97	98	99	100	101	102
Ø	3	Ø	5	3	1

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	
103	104

28. MTF OF INITIAL ADMISSION					
105	106	107	108	109	110

29. DATE INITIAL ADMISSION (YYMMDD)					
111	112	113	114	115	116

FOR LOCAL USE

Dx: GSW (L) leg with Ex fix + fasciotomy

Dx: 8911 P8628
E 9992 ~~E916~~ 7817
~~S2392~~ 8314

Trauma 1 Inpt 450

ADMITTING OFFICER (Signature): [redacted]

SIGNATURE OF ADMITTING CLERK: [redacted]

DA FORM 2085, MAR 80 SRC, 9/6/16

(b)(6)-2

INPATIENT TREATMENT RECORD COVER SHEET

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

1. PATIENT NUMBER [redacted]	2. NAME (Last, First, MI) EPW [redacted] (b)(6)-2		3. GRADE N/A
4. AGE	5. SEX	6. RACE	7. RELIGION
M	X	(b)(6)-4	
8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION No	
11. AGE 99	12. SEX [redacted]	13. ORGANIZATION N/A	14. WARD ICU2
15. MILITARY STATUS N/A	16. RATING DEN	17. DEPT DEN	18. MEDICAL CODES N/A
19. DIEZIP	20. TOTAL CASE N/A		
21. MODE OF ADMISSION Direct from ER	22. HOUR OF ADMISSION 0725	23. CLINIC SERVICE ABFA	
24. MANNER OF EMERGENCY ADMISSION	25. TYPE DISPOSITION 50	26. DATE OF DISPOSITION 9 Jun 03	
27. ADDRESS OF EMERGENCY ADMISSION (Include ZIP Code)	27b. TELEPHONE NO	28. DATE OF THIS ADMISSION 4 Jun 03	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]		30. DATE OF INITIAL ADMISSION	

ADMISSION REMARKS

ADMITTING DEPT. (b)(6)-2

Do [redacted]

31. DETAILED ADMINISTRATIVE DATA

(b)(2)-2

32. DATE OF WRITTEN NOTIFICATION COMPLETION OR TRANSFER

Usual Continued on Reverse

33. CAUSE OF DEATH

34. DIAGNOSES, INJURIES AND OPERATIONS

GSW to face + (L) shoulder

35. Total Days This Facility

a. ACUTE SICK DAYS	b. OTHER DAYS	c. CONV LVCHOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	6	6

36. Total Days All Facilities

a. ACUTE SICK DAYS	b. OTHER DAYS	c. CONV LVCHOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	[redacted] Ø	Ø	6	6

SIGNATURE OF ATTENDING MEDICAL OFFICER [redacted]

SIGNATURE OF PATIENT MEDICAL RECORDS OFFICER

DA FORM 3647, MAY 79 EDITION OF 1 AUG 76 IS OBSOLETE USAPEC V1.00

(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

4 June 03 @ 1041

OMFS Brief OP NOTE

Pre OP dx: GSW to face
Postop dx: Same
procedure: I&D of facial & scalp wounds, left of teeth # 3-5, 13, 15 29, 30
Surg: [redacted] (b)(6)-2
Assist: [redacted] (b)(6)-2
Anesth: NSETA
EBL: 200cc
U/O: 350cc
fluids: 1LR NS
Specimens: teeth # 3-5, 13, 15, 29, 30
Comp: None
Cond: Stable, remained intubated for airway control and transferred to recovery (ICU)

[redacted]
(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.

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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all (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
1040 4 June 03	Arrived to ICU #2 ~~p~~ Surgery. Pupils - sluggish @ 2mm. Pt Sedated. ~~Drowsy~~ Alert ~~FA~~ Refer to DA 4700 for assessment. Bruise to (L) eye blue in color. Edema noted to face area around jaw area from surgically procedure done. (R) deltoid area CDI. Facial DSG covering top of head, across jaws & chin. Small amt drainage noted around (L) ear area. Abrasion (L) knee. Versed @ 5mg/hr, Fent @ 10cc/hr & NS @ 120cc/hr. Will monitor. Pt guarded. No further A's in status noted. Sgt [redacted] 2PM
1800	Nursing: Assumed care 1700. See critical care flow sheet for assessment. Pt lying in bed, HOB ↑. NS infusing @ 120, Versed drip @ 5mg/hr, Fentanyl @ 50mcg/hr. Pt Guarded by MP. Will continue to monitor closely [redacted] MAA
0500	Uneventful night. Pt Remained stable. No Δ's in assessment. AM care done, morning ABG showed mild Alkalosis w/ pH 7.46, PCO2 38.1 HCO3 27. PO2 184. CBC + chem to lab. CXR pending. Report provided to oncoming nurse [redacted] MAA
June 5, 2003	Assumed care @ 0500 ~~p~~ report from night shift. See critical care assessment sheet for assessment. HOB @ 30°. Pt guarded by MP. NS @ 120 cc/hr. Fent @ 10 cc/hr. Versed @ 5 cc/hr. Will monitor closely. Sgt [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

all (b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5JUN03 0630	pt remain on vent @ following setting SIMV, TV 700, RR 14 FIO2 40% peep 5 cm H2O, P.O. 100, last ABG @ 0500 hrs. P.O2 184 suggested FIO2 titrated to maintain O2 sat > 95%. Alarm set and functioning well — [redacted] CRT
1447	Pt having pain. Trying to sit up in bed & getting upset. Adjusted sedation Versed 5mg/pump to 7mg/hr. Gave pt 25mg bolus IVP of Fent. for pain & increased Fent drip 50mcg/hr to 75mcg/hr to protect pt airway & the pain. Will monitor effectiveness & titrate as needed. — Sgt [redacted] USAF
05Jun03 1530	Patient agitated earlier this am approx 0730. Bolused c̄ 3mg versed per IV. Patient calmer p̄ bolus. [redacted] CRT USAF
1540	Pt ~~calm~~ resting in bed p̄ bolus of Fent. Will monitor pt closely. SpO2 @ 100%. R 14. HR 99. — Sgt [redacted] USAF
1557	Pt woke up agitated, ↑ Fent 100mcg/hr to protect airway & the pain. Will monitor effectiveness & titrate as needed. — Sgt [redacted] USAF
1620	Pt agitated moving around in bed. Versed ↑ 10mg/hr due to agitation. Will monitor closely. Sgt [redacted] USAF
1650	Pt resting in bed @ present time. Will monitor closely. Pt guarded by MP. — Sgt [redacted] USAF
1700	Pt resting in bed. Reported to night shift. Sgt [redacted] USAF
	Nursing: Assumed care 1700. See critical care flow sheet for assessment. HOB ↑, versed @ 10mg/hr, Fent @ 100mcg/hr & NS @ 120cc/hr. Pt guarded by MP. Will continue to monitor — [redacted] USAF
2200	Pt has been agitated off & on x 1°, received versed bolus of 3mg each time. Versed ↑ 12mg/hr. Will monitor — [redacted] USAF

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

5 Jun 03

@ 0835 OMFS

Pt intubated in bed sedated. head dressing in placed c̄ no active bleeding noted. dried blood noted on dressing.

VS: BP 128/89 T 99A P 78 R vent.

vent. SIMV 14 TV 700 FIO2 40% Peep 5

ABG: 7.46 / 38.1 / 184 / 27

CV: RRR

lungs CTA (B)

Abd. soft NTND (+) BS

ext: re strained

A/P S/P GSW to face

(1) Plan for OR in Am

(2) Titrate FIO2 to O2 sats.

(b)(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6 Jun 03 @ 0930	OMFS Brief OP NOTE
	Pre op dx: GSW to face
	Post op dx: Same
	Procedure: I&D & closure of wounds
	Surg: [redacted] (b)(6)-2
	Assist: [redacted] (b)(6)-2
	Anesth: NETA
	EBL: minimal
	U/O: 250cc
	fluids: 900cc NS
	comp: none.
	finding: palatal hole / communication left to granulate in
	Cond: Stable, extubated & transferred to recovery on mask O2.
	[redacted]
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES
DATE	
5 June 03 2335	PT agitated, moving about. Versed 3mg bolus given. Fent ↑ 150mcg/hr, versed ↑ 15mg/hr. VSS. Will monitor — [redacted]
6 June 0430	PT resting more comfortably, No agitation past few hours. Versed ↓ 10mg/hr. Temp ↑ 101.6. Tylenol 650mg PR given. NS @ 120cc/hr, UOP good. PT O/C to OR this am. Will continue to monitor — [redacted]
0500	~~Assumed~~ error Assumed Care of report from night shift nurse. See Critical Care Sheet for assessment. T 101.8 A Tylenol was given @ 0430 on night shift. Will Monitor Temp closely since it has only been 30 min of Tylenol given. Versed @ 10mg/hr, NS @ 120cc/hr, Fent @ 100mcg/hr. Pt resting comfortably, No agitation @ present time. Will Monitor closely. Pt guarded by MP. Pt on call to OR this AM. (R) nare @ 21cm vent ETT. error Blue bruise noted ↓ (L) eye. Face/head DSG No active bleeding noted. Mod amt of old drainage noted on DSG. (L) Deltoid DSG C/D/I. Hobb @ 30° — Sgt [redacted]
6/6/03	Pt continues on mechanical ventilation size 7.5 ETT. Placed 27 cm @ nare ~~parameters~~ set SIMV RR 14 VT 700 PEEP 5 FIO2 30% SPO2 98% BBS coarse Pt suctioned in AM By Nurse removed thick yellow secretion Pt going to OR in AM [redacted] RT
0730	Chest X-ray done. Going to Surgery. Informed Surgical Staff of pt. (above stats & temp), ABG's done. [redacted] Tylenol 650 mg PTL given. T. 103.4 — Sgt [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

#[redacted]

PROGRESS NOTES
Medical Record

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

all (b)(6)-2

PROGRESS NOTES

DATE	
6 June 03	1025 Pt admitted to Surgery by litter. See assessment Critical Sheet & PACU Flow Sheet assessment sheet. — Sgt [redacted] 2Pm
1230	Pt was admitted c FM@ 15L/min. ↓ O2 to 8L/min. Pt put Venti-Mask @ 35% 8L/min. Nasal trumpet intact @ nare. Pt resting at present time. NSR c ectopy noted on Cardiac Monitor. Tylenol 650 mg RTL given for temp 101.3A. Will Monitor. — Sgt [redacted] 2Pm
1305	Temp ↓ 100.5A Will continue to monitor closely. Pt guarded by MP. Pt resting in bed @ present time. SPO2 97%. Will monitor — Sgt [redacted] 2Pm
1605	T. 101.2 A Tylenol 650 mg RTL given. Will Monitor. Pt guarded by MP. HOB ↑ @ 30°. — Sgt [redacted] 2Pm
1700	T 99.7 A. HOB ↑ @ 30° Report given to night shift nurse. MP guarded Pt. — Sgt [redacted] 2Pm
6 JUN 03 1730	Assumed care of pt. Pt in bed, asleep, NAD, HOB ↑ 30°, arousable to touch, responds to simple commands. See DA 4700 for assessment. — [redacted] SSG Simms
6 JUN 03 2000	Pt sitting up in bed, coughing up bloody/yellow sputum. VS 122/75-101-20-100-96% SpO2 on RA c nasal trumpet. Pt arousable to speech. Pt foley d/c'd. 100 cc clear yellow urine in bag, 5cc water in foley's balloon. — [redacted] SSG Simms
6 JUN 03 2100	Pt ~~voided~~ vomited, brownish green stomach contents, about 200 cc's. Pt given Phenergan 12.5 mg IVP. Will monitor for effectiveness. — [redacted] SSG Simms
6 JUN 03 2115	Pt voids 300 cc clear yellow urine. — [redacted] SSG Simms.
6 JUN 03 2245	Pt vomits 20 cc brownish fluid. Pt given 12.5 mg ~~extra~~ phenergan IVP. Will monitor for effectiveness. — [redacted] SSG Simms

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

all (b)(6)-2

LAST NAME	NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7 June 03	Pt pulled packing out of roof of mouth while dating Pt. @0740. Will Monitor pt closely. Pt guarded by MP. HOB 1@30°. — Sgt [redacted] Sgt
1700	Report to night shift. Pt guarded by MP. HOB @30°. NS@120cc/hr. — Sgt [redacted] Sgt
7-JUN-03 1730	PT awake in bed, speaking Arabic, no interpreter present. VSS NAD. See DA 4700 (7-JUN-03) for assessment. — [redacted] SSG Guards
7-JUN-03 1830	PT mouth irrigated w NS & suction. PO tolerated some. VSS. — [redacted] SSG Guards
8 June 03	0500 Assumed care of pt w/ report from night shift. See Critical Care assessment sheet. ~~Top~~ Roof of mouth sore yellow & red skin noted. (R) mouth area sutures CDI. HOB @30°. Guarded by MP. Will Monitor — Sgt [redacted] Sgt
0815	New Orders to transfer pt. Report given ICW II staff. Pt awaiting transport. — Sgt [redacted] Sgt
0820	Transported pt to ICW II. — Sgt [redacted] Sgt

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

[redacted] (b)(6)-4

MEDCOM - 10203

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all (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
7 June 03	0500 Assumed care of pt p report from night shift. See Critical care sheet for assessment. IV D FA NS @ 120cc/hr. No S/S of infection or infiltration noted. HOB @ 30°. Pt awarded by MP, Will continue to monitor. — Sgt [redacted] USA
7 Jun 03 @ 0717	OMFS progress note pt lying in bed ~~restrained~~ Restrained [redacted] and not cooperative to exam. VSS T_m 100.2 T_c 99.3 CV: RRR Lungs: (B) Rhonchi ↓ BS on (R) Abd: soft NT ND (+) BS Ext: restrained A/P S/P GSW to face ⊂ wounds closed and palatal wound still open (1) Albuterol neb [redacted]
7 Jun 03 @ 1730 hrs	One time neb tx ordered ⊂ 0.5cc ALL/3cc NSS x dyspnea of noise, b/s mild shortness of breath (L) side, HR 86-87, RR 20 P.O. on RA 96% C.S. pty clear bi-lat - tube NPC - 2CM

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

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

PROGRESS NOTES
Medical Record

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

8jun03 @ 0723 Pt lying in bed 3 complaints. facial wounds closed 1° T no s/s of infx no active bleeding noted.
Palatal wounds open T no s/s of infx.
VSS AF
CV: RRR
Lung: CTA (B)
abd: soft NT ND (+) BS
ext: restrained no c/c/e
A/P S/P GSW to face
(1) transfer to floor

(b)(6)-2

[redacted]

9jun03 @ 1022 Pt in bed restrained. facial wounds closed 1° T no s/s of infx. no c/o pain. palatal wound open and healing.
Plan to D/C to MP custody and f/u in 2 wks.

[redacted] (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)

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

REGISTER NO.

WARD NO. ICW2

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
8 June 03 1045	Pt transferred from ICU#2 to ward. Amb. ⊼ difficulty. dx: S/p GSW face and (R) shoulder. Stitches to (R) side of head intact. To (R) shoulder intact. (L) and (R) side of face stitches intact. Mouth care done in ICU#2. no S/S infection @ any site. Suction @ BS. Pt HOB 30° elevated. Pt awake moving around. Restraints on wrist Bilat. VSS. HR regular. Lungs CTA throughout. Bowel sounds active x4. Pulses palpable, strong x4. HL placed in (R) hand by MAT HOWELL. Flushes, NO S/S REDNESS/INFILTRATION. Pt c/o pain to mouth. Will continue to monitor. — [redacted] SMUMP
	1600 Mouth irrigated ⊼ NS and suction. Cleaned with Lemon Glycerine swabsticks. ~~site~~ Gums and tongue free of s/s infection. Bacitracin applied to wounds — [redacted] SMUMP
2230	Assumed care of PT @ 1700. Pt. Alert. Pt. voiding ⊼S. Mouth care done & applied bacitracin to wounds. Stitches to wound CTA ⊼ s/s infection. HOB @ 30°. Suction @ BS. Pt. tol. soft diet. HR Reg. lungs CTA BS (+) x4. Will continue to monitor — [redacted] CWM

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)*

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

REGISTER NO.

WARD NO. ICU#2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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all(b)(6) - 2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9 Jun 03	0600 Pt A-O×3. HR regular, BS present ×4, lungs CTA, pulses equal bilat to ↑ & ↓ extremities. VSS. Staples intact to (D) side of scalp. Ø Signs of redness. HL to (R) hand. Will continue to monitor ——— [redacted] 2Lt AN
9 Jun 03	1212 Pt did well this morning shift. Very pleasant + cooperative. Supplies ready for releasing to MP custody ≈ instructions. Will care to monitor ——— [redacted] 2Lt AN
9 Jun 03 1630	assumed care @ 1300 - VSS - IV patent - mouthcare & wound irrigation done as ordered - packed with sutures & staples - pt. has Sx orders to return to EPW camp [redacted]

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

Transfer Summary

9 Jun 03 @ 0852 Grade EPW S/P GSW to Face & left Shoulder. Pt underwent vl&D x2 c̄ closure of left Shoulder wounds and facial wounds. Pt has facial sutures on (R) cheek, (L) cheek & (L) ear. Pt also has staples in (L) parietal area and left shoulder sutures.

Pt has left maxillary defect c̄ an open palatal wound that will need irrigation c̄ NS TID. Pt will need his sutures removed in 3-4 days and his staples removed in 7 days.

b6-2 * Pt will need f/u @ the CSH c̄ Dr [redacted] in 2 wks. for eval of palatal wound.

Rx: Augmentin
Afrin nasal spray
Tylenol #3

b6-2

NO SMOKING! [redacted]

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.

EPW # [redacted] b6-4

PROGRESS NOTES
Medical Record

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

all (b)(6)-2

LAW/ [redacted] / [redacted]

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted]

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL: DATE (Day, Month, Year) 4 June 05 | TIME 0543

TRANSPORTATION TO FACILITY: Air

SEX | AGE: M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			
MEDICAL HISTORY OBTAINED FROM			

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN (Date)
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			
HOW			

EMERGENCY ROOM VISIT: DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS: DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW to face & (L) shoulder

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 0543

INITIALS: [redacted]

VITAL SIGNS

TIME	0543	0556	0626	0636	
BP	143/54	143/82	130/70	119/67	
PULSE	109	107	87	67	
RESP	28	27	21	18	
TEMP		98.3 (A)			
WT	68 kg				

LAB ORDERS

X CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	X UA MSCC/CATH		CHEM:
BLOOD C&S X			
X Met Type 8			
X Type + Screen			

X-RAY ORDERS

X CXR PA & LAT/PORTABLE		C-SPINE
	ACUTE ABDOMEN	LS SPINE
	SINUS	HEAD CT
	ANKLE R/L	X L Shoulder
		X Skull

ORDERS

☒ PULSE OX 97, 98, 98 ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0551	Foley	[redacted]	[redacted]	0558	Saline lock [redacted]
0551	Fetanol 100 mcg			0552	
0556	Fetanol 50 mcg			0556	
0605	Tetanus		LAW	0605	

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

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)*

[redacted] (b)(6)-4

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

epw

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER

TEST RESULTS

CBC		SMAC					
WBC 13.9		134	101	7	108		
H/H 13/41		4.1	23	1.1			
PLT 301							
PT							
APTT	BHCG	ETOH	GLU				

ABG/PULSE OX		
SUP O2	PH	PO2
PCO2	SAT	OTHER
U/A: DIP trace Bld nl		
MICRO 1,015/7.0		

RADIOLOGY — Check if read by radiologist ☐

RESULTS
AP CXR = Ø pneumothorax; nl
Humerus = Ø Frag Ø Fx
Skull = ? No Fx

EKG INTERPRETATION

PROVIDER HISTORY/PHYSICAL

30 ish Iraqi EPW ♂ was laying mines last night, caught by US MP shot twice; once in (L) upper lateral arm. once in face. Fx ≈ 2100 @ AID
Station ≈ Ancef + gm @ 0428. & Dressed.

(2) ABD No interpreter around. responsed to commands by open mouth & pain.
HEADNT = (L) Lateral laceration to scalp Temporal area.
eyes = (L) chemosis / orbital edema & Lid ecchymoses. sound / PERRLA:
Nose = nl
Mouth = upper hard palate entrance wound; mild bleeding.
moves jaw.
Face = (L) Lateral cheek laceration to oral cavity.
lungs = CTA (B) ⊘ = RRR ≈ (m) ABD = NDNT NABS well healed scars across chest ABD.
rectal = guaiac neg gen = nl circ. ♂ Back = Ø injuries.
(L) Deltoid area = Laceration.

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP [redacted] / [redacted] all (b)(6)-2

DIAGNOSIS
Facial GSW / (L) Deltoid laceration.

CODES

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

EPW / [redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

ICU-2

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 30's
HEIGHT: ≈ 5'8"
WEIGHT: ≈ 70 lbs

2. KNOWN ALLERGIC SENSITIVITIES (e.g.. Iodine, Tape, Medication)
☐ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION: no allergies listed in chart.

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

4. PROPOSED SURGICAL PROCEDURE:
I+D Gunshot wound to face.

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition Dirt encrusted, stinky
Tobacco smoker ppd x ___ yrs. Body Piercing N.A. Diabetes (Y) (N) unk ROM X 3 ASA/Motrin w/72 hrs (Y) (N)
ETOH unknown Implants unknown Respiratory Disease (Asthma/COPD) (Y) (N) unk Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures N.A. Hypertension (Y) (N) unk Herbal Medicines (Y) (N) MEDS: Ancef 040(

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

9. PATIENT'S IDENTIFICATION: (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)
EP W [redacted] (b)(6)-4
[redacted] (b)(2)-2

b6-2

VERIFICATIONS AT HOLDING AREA:
[redacted]D/Allergy Band [redacted]entures Removed
[redacted]H & P [redacted]ntacts Removed
! NPO Since UNK [redacted]ewelry Removed
! ~~UHCG/LMP~~ [redacted]ody Pierce Removed
[redacted]onsent/Blood Transfusion Signed/Witnessed/Dated
[redacted]/Surgical Site/Consent verified by [redacted]./Anesthesia/Surgeon
! Contact Precautions (Y) (N) unk
! Family/Friend: None

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0
MEDCOM - 10211

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards N/A 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 difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated N/A 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: ✓ 1) Diminished Hearing ✓ 2) Language Barrier F.3. N/A 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.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. laying mines last noc, shot by MP's, GSW to face, laceration (L) arm/shoulder.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

_____ DATE

11. POSTOPERATIVE EVALUATION:
LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☒ Intubated
LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities
☒ Transferred to litter with roller due to spinal intub

SKIN INTEGRITY: Bovie Pad Site: ☒ Clean and Dry ☐ Red ☐ N/A
DRESSING DRY & INTACT: (Y) (N)
BREATHING EASY: (Y) (N) Intubated

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] Maj/AN (b)(6)-2
DATE: 04 Jun 03 TIME: 0745

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] (b)(6)-2
DATE: 04 Jun 03 TIME: 1030

(b)(6)-4

all (b)(6)-2

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE:
HEIGHT: See previous H&P
WEIGHT:

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

3. PREVIOUS SURGERY [ ] NO ☒ YES (type):
See H&P

4. PROPOSED SURGICAL PROCEDURE:
I & D + Closure of Wounds

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition____
Tobacco____ppd X___yrs. Body Piercing [redacted]es.(Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH_____ Implants [redacted] Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures [redacted] Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: _____1) Surgical Procedure & Operating Room Environment _____2) Separation Anxiety ~~(Child)~~ _____3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture. History unknown	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g., warm blanket, touch). o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION ✓ Potential for respiratory dysfunction due to: _____1) Positioning _____2) Effects of Anesthesia _____3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase .	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress. o Assist anesthesia during intubation ~~and extubation~~.
C. INTEGUMENT ✓ Potential impairment of skin integrity due to: _____1) Intraoperative Immobility _____2) ESU Pad Placement _____3) Positional Aids _____4) Prosthesis _____5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	o Utilize pressure preventing devices on ~~OR~~ table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

9. PATIENT'S IDENTIFICATION: (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)
[redacted] EPW
(b)(6)-4

VERIFICATIONS AT HOLDING AREA:
[redacted]D/Allergy Band [redacted]entures Removed
[redacted]H & P [redacted]ontacts Removed
! NPO Since [redacted] [redacted]welry Removed
! ~~UHCG/LMP~~ [redacted]ody Pierce Removed
[redacted]Consent/Blood Tra[redacted]fusion
[redacted]gned/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:_____

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION _____ 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.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. ~~o Place and take down legs from stirrups with slow bilateral motion.~~ o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. _____ 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 difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. _____ Diminished visual perception due to being: _____1) Pre-Medicated _____2) W/O Glasses F.2. _____ Potential for decreased communication due to. _____1) Diminished Hearing _____2) Language Barrier F.3. _____ Potential injury due to dentures: _____1) Upper _____4) Caps _____2) Lower _____5) Crowns _____3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from Left side o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

_____ DATE

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

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

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

(b)(6)-2

12. PREOPERA[redacted]IATI[redacted]REPARED BY (Signature and Ti[redacted] UPT/AR

13. POSTOPERATIV[redacted]LUATION[redacted]RED BY (Signature and Title[redacted] UPT/AR

(b)(6)-2

DATE: 6 Jun 03 TIME: 0855 DATE: 6 Jun 03 TIME: 1030

REVERSE OF FORM 5179, JUN 91 [redacted] MEDCOM - 10214 USAPA V1.0

(b)(6)-4

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

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

3. DATE 04 Jun 03 TIME PATIENT ARRIVED IN SUITE 0815

4. PATIENT IN R[redacted] TIME 0815 NUMBER 1-1 (b)(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt awake, language barrier, unable to determine what pt is saying.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted], ORT (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted], AN (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt transferred to OR table, anatomically for surgical procedure c̄ padding under head, (R) arm tucked @ side. (L) arm on padded arm board less 90°

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Betn/Beta

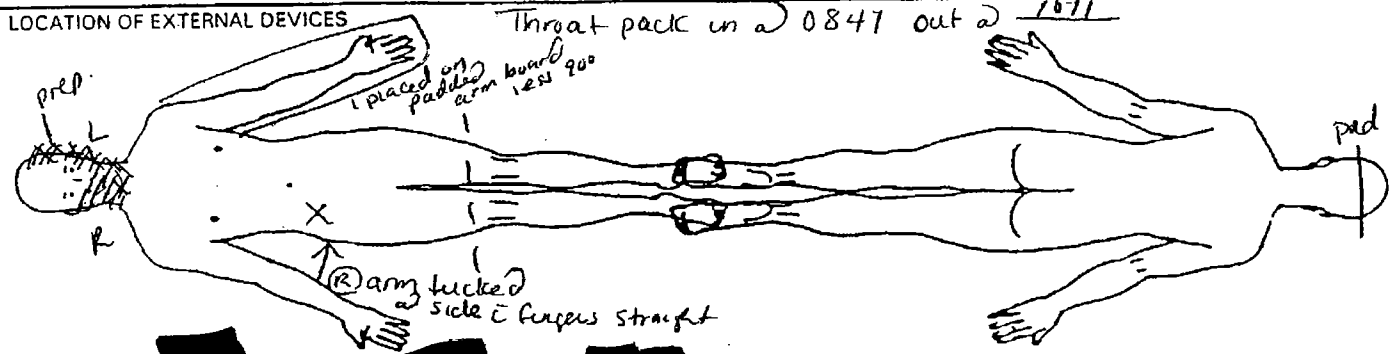
SITE: FACE/(L) Side Head BY WHOM: CPT [redacted] AN

SITE: BY WHOM:

~~XX~~ See #9

COMMENTS: @ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES Throat pack in @ 0841 out @ 1011



LEGEND X Ground Pad -- Safety [redacted] = = = [redacted]urniquet

C = Correct I = Incorrect , initial SPC [redacted] / CPT [redacted] - Throat Pack

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;)

EPW [redacted] (b)(6)-4

[redacted] (b)(2)-2

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☒ NO 25/25

☒ ESU NO: #1

GROUND PAD: BRAND Valley lab (Polyhesive)

LOT NO: #10527 Exp 2003-10

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1 OCT 87 REPLACES DA FORM 5179-1, 1 FEB 72, WHICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1. 2x2 x 4	2.	3.
SITE	1. facial laceration	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
2x2

19. ADDITIONAL INFORMATION
Pt came to OR from EMT c̄ Foley in place

Surgeon
Dr. [redacted]
(b)(6)-2

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

20. OPERATION(S) PERFORMED
I+D GSW to face + removal of (b) teeth
(laceration to face)
(b)(6)-2 (b)(6)-2

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU-2 (RR)	103[redacted]	litter c̄ O2

22. REGISTERED NURSE SIGNATURE
[redacted] MC/AN/[redacted] CRNA
[redacted]

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

04 June 03

04 June 03

MEDCOM - 10216

all (b)(6) -2

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 [redacted] VIA litter BY Anesthesia

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

3. DATE 06 Jun 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pt transferred to OR intubated

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted], ORT	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted], AN	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt transferred to OR table, anatomically aligned for surgical procedure. (B) arms 2 Pt side

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

COMMENTS:

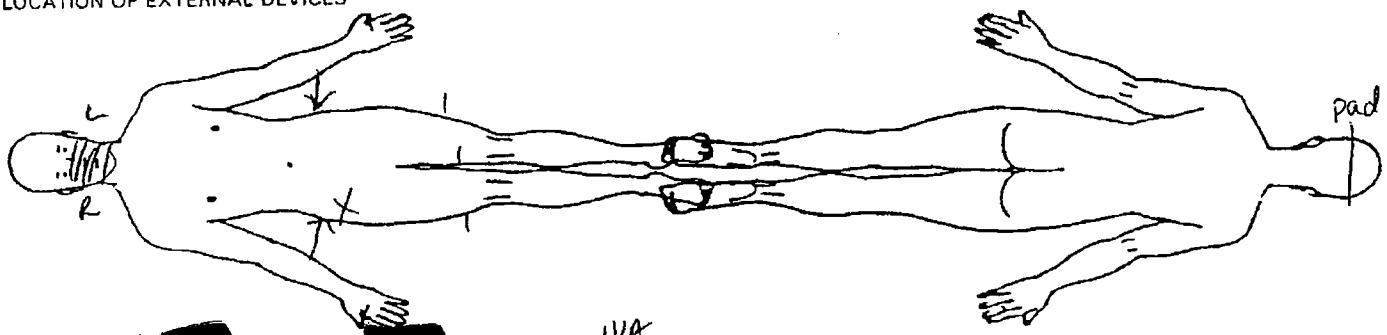
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION (Specify) Betadine/Betadine
SITE: FACE BY WHOM: CPT [redacted], AN
SITE: BY WHOM:
COMMENTS: ## See 0 pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

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

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

[redacted] EPW

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☐ NO 25/25

☒ ESU NO: #4
GROUND PAD: BRAND Valley lab
LOT NO: 54179 Exp 2003-08

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

Bovie not used during case

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):

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
~~Fluffs~~ [redacted] (b)(6)-2
~~Kerlix~~
NO AG

19. ADDITIONAL INFORMATION
Pt came to OR intubated and c̄ Foley in place. Escorted by MP.

20. OPERATION(S) PERFORMED
I+D and closure of facial wounds

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU-2	1020	litter c̄ O2

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN

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

(b)(6)-2

MEDCOM - 10218

[redacted] b6-4

27cm @ nares
7.5 ETT

RT Vent Flow Sheet

4June 1030	SIMV	14	700	50	5	23	1.2	0	—	70	100	139/92	7.5	MET	
4June 1220	SIMV	14	700	40	5	23	1.2	0	—	75	100	127/88	7.5	MET	
4JUN 1400	SIMV	14	700	40	5	22	1.2	0	—	80	100	132/89	7.5	MET	
4Jun 1600	SIMV	14	700	40	5	22	1.2	0	—	91	100	131/83	7.5	MET	
4Jun 1800	SIMV	14	700	40	5	27	1.2	0	—	80	100	128/76	7.5	MET	
4Jun 2000	SIMV	14	700	40	5	27	1.2	0	—	78	100	124/79	7.5	MET	
4Jun 2200	SIMV	14	700	40	5	28	1.2	0	—	86	100	134/87	7.5	MET	
5Jun 0000	SIMV	14	700	40	5	29	1.2	0	—	86	100	134/82	7.5	MET	
5Jun 0200	SIMV	14	700	40	5	28	1.2	0	—		100	134/86	7.5	MET	
5JUN 0600	SIMV	14	700	40	5	27	1.2	0	—	74	100	130/82	7.5	—	
5JUN 0800	SIMV	14	700	40	5	26	1.2	0	—	80	100	128/69	7.5	MET	
5Jun 1000	SIMV	14	700	35	5	28	1.2	0	—	76	100	117/73	7.5	—	
Jun 1225	SIMV	14	700	30	5	26	1.2	8	—	92		116/72	7.5	—	
JUN 1400	SIMV	14	700	30	5	26	1.2	4	—	78	100	116/71	7.5	—	
5Jun 1610	SIMV	14	700	30	5	24	1.2	0	—	82	100	109/69	7.5	—	
5Jun 1830	SIMV	14	700	30	5	25	1.2	6	—	95	100	115/65	7.5	—	
5Jun 2000	SIMV	14	700	30	5	28	1.2	8	—	88	90	102/61	7.5	MET	
5Jun 2200	SIMV	14	700	30	5	30	1.2	1	—	83	100	110/61	7.5	MET	
6Jun 0000	SIMV	14	700	30	5	32	1.2	1	—	81	100	103/59	7.5	MET	
6Jun 0200	SIMV	14	700	30	5	31	1.2	0	—	80	100	106/66	7.5	MET	
6Jun 0400	SIMV	14	700	30	5	35	1.2	0	—	70	100	110/63	7.5	MET	
6Jun 0715	SIMV	14	700	100	5	31	1.2	0	—	72	100	110/62	7.5	MET	
						40	1.2	13	—	142	96	131/88	7.5	MET	

[redacted] b6-2

[redacted] b6-4

[redacted]

MEDCOM - 10219

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY									
POST- DAY									
MONTH-YEAR Jun/03	DAY	8	9	10	11				
19	HOUR	2100	0800						

PULSE (0)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99° / 98.6°	37.2° / 37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 16 16 16 | 16 16

Record special data only when so ordered

BLOOD PRESSURE: 120/68, 112/68

HEIGHT: WEIGHT →

SpO2: 98% | 96%

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

REGISTER NO.

WARD NO. ICW2

EPW FF [redacted] 06-4

GSW to face

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 10220

Transfusion: EMT bb-4

REQUESTING PHYSICIAN: MJ. [redacted] bb-2

HEMISTRY RESULT
(Subject to the Privacy Act)

[redacted] CIV

DATE	TIME	SSN/PSEUDO
4 Jun	0551	[redacted]

bb-4

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
pCO2		35-45 mmHg (art) 41-51 mmHg (ven)
pO2		80-105 mmHg (art) N/A (ven)
HCO3		23-27 mmol/L (art) 24-29 mmol/L (ven)
BE		22-26 mmol/L (art) 23-28 mmol/L (ven)
SaO2		95-98%
Base Def		(-2) – (+3) mmol/L
Lactate		10-20 mmol/L
Ionized Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Cr		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

TEST	RESULT	REF. RANGE
Na+		128-145 mmol/L
K+		3.3-4.7 mmol/l
Cl-		98-108 mmol/l
tCO2		18-33 mmol/l

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		0.2-1.0 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

TEST	RESULT	REF. RANGE
GLU	108	73-118 mg/dl
BUN	7	7-22 mg/dl
CRE	1.1	0.6-1.2 mg/dl
CK	1076	39-380 u/l (M) 30-190 u/l (F)
NA+	134	128-145 mmol/l
K+	4.1	3.3-4.7 mmol/l
CL-	101	98-108 mmol/l
tCO2	23	18-33 mmol/l

TEST	RESULT	REF. RANGE
GLU		73-118
BUN		7-22
CA++		8.0-10.3
tCO2		18-33 mmol/l

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		0.2-1.0 mg/dl
CGT		
TP		6.4-8.1 g/dl

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

Rel [redacted] bb-2

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

[redacted] bb-4

b6-2

Ward/Section: ENT

REQUESTING PHYSICIAN: MAJ [redacted]

LABORATORY RESULT FORM (Subject to the Privacy Act)

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

DATE: 4 Jan

TIME: 0551

SSN/PSEUDO: [redacted] b6-4

TEST	RESULT	REF. RANGE
WBC	13.9	4.8-10.8 x 10³
RBC	4.40	4.7-6.1 x 10⁶
Hgb	13.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	41.5	42-52% (M) 37-47% (F)
MCV	94.3	86-94 fl (M) 81-99 fl (F)
Platelet	301	130-500 x 10³ verified
Lymph %	17.1	20.5-51.1%

Manual Differential		
Seg		Mono
Band		Eos
Lymph		Baso
		Other
Morph		

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

Urinalysis	
Color	Straw
Appearance	clr
Glucose	neg
Bilirubin	neg
Ketones	neg
Sp Gr	1.015
Blood	~~neg~~ trace
pH	7.0
Protein	neg
Urobilinogen	neg
Nitrite	neg
Leukocytes	✓
HCG	✓

Cell Count	
Direct Coagen	

Coagulation			
TEST	RESULT	REF. RANGE	UNIT
PT		9.8-13.6 secs	
PTT		21-34 secs	
D Dimer		<200 ug/ml	
Fibrinogen		410 ug/ml	

Serology	
TEST	RESULT
RPR	
Widal	

Microbiology	
Source	
Gram Stain	
Culture	
H. pylori	
Micro Parasites	
Malaria	
O & P	
Other	

Microscopic Urinalysis	
~~WBC 2-0~~	RBC 0-2
	0-2 WBC

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

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

REMARKS:

REPORTED BY: Date/Time: NO.:

#[redacted] b6-4

last copy

Ward/Section		REQUESTING PHYSICIAN		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST		DATE	TIME	SSN/PSEUDO SSN:		
[redacted]						
				(Plasma) Alkalinine Phosphatase		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/l	ALB		3.5-5.5 g/dl	GLU	142	73-118 mg/dl
K		3.4-4.9 mmol/l	ALP		26-84 u/l	BUN	4	7-22 mg/dl
Cl		98-109 mmol/l	ALT		10-47 u/l	CA	7.7	8.0-10.3 mg/dl
pH		7.31-7.45	AMY		14-97 u/l	CRE	0.8	0.6-1.2 mg/dl
PCO2		35-45 mmHg (arterial) 41-51 mmHg (venous)	AST		11-38 u/l	NA	139	128-145 mmol/l
PO2		80-105 mmHg (arterial) NA (venous)	TBIL		0.2-1.6 mg/dl	K	3.9	3.3-4.7 mmol/l
TCO2		21-31 mmol/l (arterial) 23-30 mmol/l (venous)	BUN		7-22 mg/dl	CL	108	98-108 mmol/l
HCO3		22-26 mmol/l (arterial) 23-28 mmol/l (venous)	CA		8.0-10.3 mg/dl	CO2	22	18-33 mmol/l
sO2		95-98%	CHOL		100-200 mg/dl			
BEecf		(-2)-(+3) mmol/L	CRE		0.6-1.2 mg/dl	(Plasma) Liver Profile		
AnGap		8-20 mmol/l	GLU		73-118 mg/dl	TEST	RESULT	REF. RANGE
Ca		1.12-1.32 mmol/l	TP		6.4-8.1 g/dl	ALB		3.3-5.5 g/dl
BUN		7-26 mg/dl	[redacted]			ALP		26-84 u/l
GLU		70-105 mg/dl				ALT		10-47 u/l
			TEST	RESULT	REF. RANGE	AMY		14-97 u/l
Creat		0.6-1.2 mg/dl	GLU		73-118 mg/dl	AST		11-38 u/l
Hct		35-47 %	BUN		7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb		12-16 g/dl	CRE		0.6-1.2 mg/dl	SG		5-65 u/l
[redacted]			CK		19-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
TEST	RESULT	REF. RANGE	NA		128-145 mmol/l	(Plasma) Electrolyte		
Troponin			K		3.3-4.7 mmol/l	TEST	RESULT	REF. RANGE
Drug of Abuse			CL		98-108 mmol/l	NA		128-145 mmol/l
			HCO_3		18-33 mmol/l	K		3.3-4.7 mmol/l
						CL		98-108 mmol/l
						HCO_3		18-33 mmol/l
REMARKS								
REPORT [illegible]		DATE		LAB ID NO.				

Last Copy

Ward/Section: ICU#2 b6-1 REQUESTING PHYSICIAN: Dr. [redacted] b6-2

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

LAST, FIRST, MI: [redacted] ABGs

DATE | TIME | SSN/PSEUDO SSN:

CBC			Urinalysis			Misc Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	11.7	4.8-10.8 x 10³	Color		N/A	RPR		Negative
RBC	4.23	4.7-6.1 x 10⁶	App		N/A	Mono		Negative
Hgb	12.5	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	40.2	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	95.1	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	226	130-500 x 10³ verified	SG		N/A	Occ Bld		Negative
Lymph%	[illegible]	20.5-51.1%	Bld		Negative	H. pylori		Negative
Diff			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Myelo		Imm	Leuk		Negative	**Manual Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

Blood Bank / Coagulation

Blood Products

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

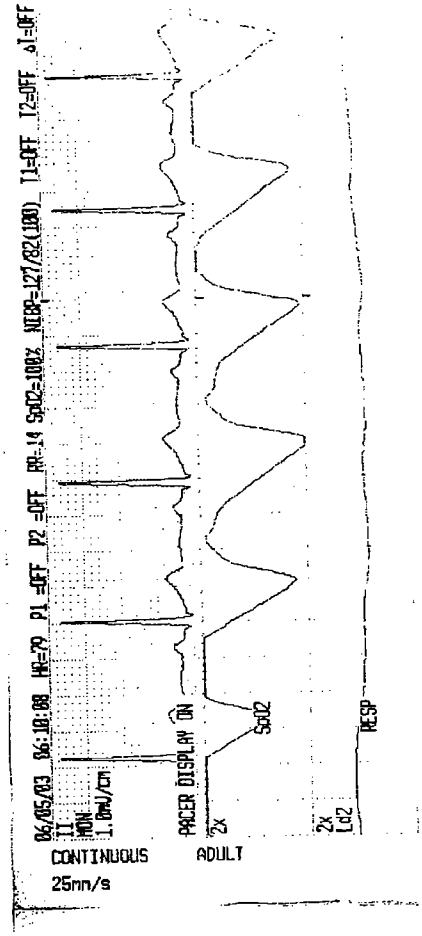
REMARKS:

REPORTED BY: [redacted] DATE: 4 June 03 LAB ID NO.:

[redacted] b6-4

[redacted]#

66-4



PROTOCOL SYSTEMS, INC.

APNEA TICKET (RP) 06/05/03

TIME H:MIN:S	HR/PR BPM	SpO2 %
LAST BREATH:		
03:22:39	85	100
RESUMED BREATHING:		
03:23:00	82	100

ELAPSED TIME:
00:00:21

ADULT

PROTOCOL SYSTEMS, INC.

b6-2

Ward/Section: ICU2	REQUESTING PHYSICIAN: DR [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: EPW [redacted] b6-4	DATE: 6/9	TIME: 0415	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	8.2	4.8-10.8 x 10^3
RBC	5.13	4.7-6.1 x 10^9
Hgb	15.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	48.5	42-52% (M) 37-47% (F)
MCV	94.4	80-94 fl (M) 81-99 fl (F)
Plt	180	130-500 x 10^3 verified
Lymph %	14.2	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: b6-2

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

[redacted] b6-4

ANCU 0430

MEDICAL RECORD — ANESTHESIA

DRUGS	Units	0900	30	1000	30	1100
Versed	( )	3				
Penlyte	( )	100 50 100 100		100	50	
propofol	( )	100				
Sux / Zemu	( )	80 50			40	
	( )					
	( )					
VOLAT AGENT	Forane % del	1.25 1.5	1.5 1.5	1.5 1.5	1.0	SX
	% e.t.					
AIR	L/Min					
N2O	L/Min					
O2	L/Min	10 2	2 2	2 2	2	2X

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

ANESTHETIC AGENTS AND DRUGS

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

FLUIDS		
LINE site	NS	☐ Warmed
		☐ Warmed
		☐ Warmed
		☐ Warmed

LOSSES		
EST BLOOD LOSS		200
URINE –	300	70/350

TOTALS	
TOTAL IN	200
TOTAL URINE	350

FLUIDS – SUMMARY

CRYSTALLOID – NS 1000

COLLOID –

BLOOD –

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

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 41

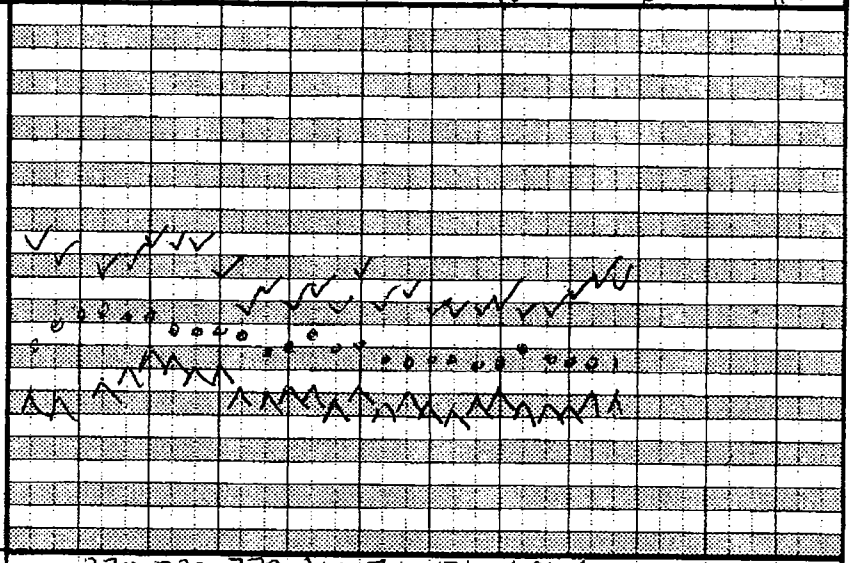
INITIAL DATA: BP – 149/80 HR – 80

CONF CHECK: OK? – (Y) N

PATIENT CHECK: OK for PROCEDURE? ✓ TIME – 0700

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

TIME → 0830 0900 30 1000 30 1100



VITALS	0830	0900	30	1000	30	1100	30	1100
VT – ml	770	770	770	760	740	760	690	690
f – breaths/min	9	9	7	7	7	7	7	7
Peak inf pres / PEEP	16	16	17	17	17	17	17	17
MODE – S(pon), A(ssist), C(on)	CV	CV	CV	CV	CV	CV	CV	CV
ET CO2 (torr)	+	31	31	31	31	32	30	32	32
FIO2 (Frac or %)	1.0	.72	.72	.72	.72	.72	.72	.72	.72
SpO2 (%)	100	100	100	100	100	100	100	100	100
ECG	ST	ST	ST	SR	SR	SR	SR	SR	SR
TEMP- site	Axillary								
N-M Block (T/4)	0/4								

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

REMARKS – Code drugs with numbers, events with letters

PT ID Chart Reviewed
0800 Robinul 0.3 mg IV
Afrin nasal spray
0815 Enter room monitors on
1040 Deadron 10 mg
0820 Smooth Induction
Intubation
OG passed sx, removed
0850 Throat PACK
1010 Throat PACK out

Transported to ECU 2 Ventilate c 100% O2 via ETT. SaO2 100%

RECOVERY AT 1025

PACU (ICU) 2 (Specify)

OTHER

CONDITION: Stable

RESP – 16 SpO2 – 100%

BP – 147/95 HR – 76

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0745	0815	1040
PROC	Ready	Begin	End
	0834	0843	1025

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

PROCEDURES and CPT Codes: I+D GSW-Face - tooth Removal Palate Repair

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA - 2 mm 7.5 Nasal Rae; Afrin bilateral nares; Nasal Phenyl airway 32 FR Rt nare

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Direct - Rt nare; Cords visualized ~~ultrasonic CBAS~~ = ETT passed atraumatic CBAS = ETT 7.5 x 6 ETT secured left tape

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

CPW [redacted]

bb-4

ICU 2

SURGEONS: bb-2

[redacted] ATCARB

PROCEDURE LOCATION	1
DATE	4 Jun 03
PAGE	1 OF

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 10227

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

MEDICAL RECORD — ANESTHESIA

DRUG	Units	
Propofol	( )	55, 10, 10
Fentanyl	(mcg)	50 (Fent in Pr. ICU)
	( )	
	( )	
	( )	
M504	(mg)	3
VOLAT AGENT Forane	% del	.8 – 1.0 1.5 – 1.5 – 1.5 1.5 1.5 .4
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 – 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

FLUIDS		
LINE site LL1	☐ Warmed	400 – 500 – 600 – 700 – 900 LL2
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	
LOSSES	EST BLOOD LOSS	
	URINE –	100 – 250 –

TOTALS	
	Min
TOTAL URINE	250
4	

FLUIDS – SUMMARY
CRYSTALLOID – 1000
COLLOID – 0
BLOOD – 0

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

BODY WEIGHT: 70 KG LB

HEMATOCRIT: 15/48

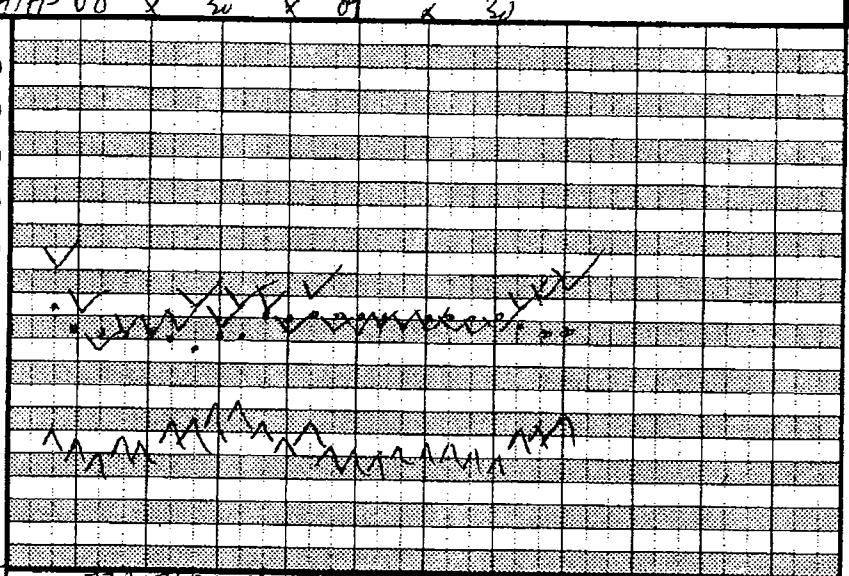
INITIAL DATA: BP 140, 80 HR – 120

SCHIP CHECK: OK? – Y N

PATIENT RECORDS: OK for PROCEDURE? Y TIME – 0745

TIME → 0745 08 x 30 x 09 x 30

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



VENTILATION							
VT – ml		770	760	230	270	310	410
f – breaths/min		14	10	10	10	12	12
Peak inf pres / PEEP			29	24			
MODE – S(pon), A(ssist), C(on)		C	C	C	S	S	S

MONITORS							
BP/Auto Cuff	ET CO2 (torr)	38	30	28	54	52	53	58
BP / oth	FIO2 (Frac or %)	.73	.73	.73	.74	.73	.73	.73
ART line	SpO2 (%)	100	100	100	98	99	99	99
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP- site							
	N-M Block (T/4)							
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS: APPP Arms L 90 — Position: ⊙

REMARKS – Code drugs with numbers, events with letters

Mr. op in ICU
50 mcg Fentanyl
3 mg Versed
(ICU meds)
10 mg Reglan
50 mg Zantac
IV @ anticubital red → Dcd.
1 mg Romazicon
80 mg Narcan
suction copious amts thick yellow secretion

RECOVERY AT ICU #2
PACU ICU 1025 (Specify)
OTHER
CONDITION: Alert and ta
RESP – 20 SpO2 – 98% RA
BP – 141/84 HR – 130

ANESTHESIA / PROCEDURE TIMES	Start	Room	End
ANES	0735	0755	1045
PROC	Ready	Begin	End
	0805	0815	0930

PROCEDURES and CPT Codes: I+D Facial wound c closure

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: Pt. arrived to OR c NETT in place, BS = BS – exp wheezes (prominent) SpO2 100%

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: b6-2

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

EPW # [redacted] (ICU #2)

b6-4

SURGEONS: [redacted]

ANESTHETISTS: [redacted] MAT QA

PROCEDURE LOCATION #2

DATE 6 Jun 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 10228

*U.S. GPO: 2002-729-160/40137

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 30 **DAYS MOS YRS** **Sex** (X) **MALE** ( ) **FEMALE**

ASA Physical State 1 (2) 3 4 5 (E)
WT: 70 KG/LB HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: facial GSW, Scalp wound Lt arm
SURGICAL SERVICE: ORAL
NPO SINCE: don't know - no eryth

HABITS:
TOBACCO: X/D
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Fentanyl 100ug
( ) " 50ug
( ) Ativan - 0400
( ) ____
( ) ____
( ) ____

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

LABORATORY STUDIES:
HB/HCT: 13.1 / 41 36
U/A: ____
OTHER: 134 | 101 | 7 (108
4.1 | 23 | 1.1

Hx - shot left upper lateral arm + face by m.p
Scalp laceration

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

unobtainable

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 194/67 HR 67 R 18 T ____
Pain Scale 0-10 ____ Blk
HEENT - Teeth intact
Trachea midline
TMJ/Neck 2 FB
Oropharnyx ____
Nares Shattered - fent
CHEST: missing - lung clear
CARDIAC: RRRSM
EXTREMITIES: Laceration Lt arm
IV Access: 16 g Lt Arm
Ulnar Filling: Hep Lock 14 g Rt
BACK: ____
OTHER: ____

NPO Since ____

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

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

The pati[redacted] and agrees. Questions answered.
Signed: [redacted] Date: 07-43 Time: ____ Hrs
b6-2

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

EPW # [redacted] b6-4 ICU2

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.

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 30 **DAYS MOS YRS** **Sex** (X) **MALE** ( ) **FEMALE**

PROPOSED PROCEDURE: I+D Face wound & closure
SURGICAL SERVICE: OS
NPO SINCE: NPO (pt. on vent)

ASA Physical State 1 (2) 3 4 5 E
WT: 70 KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: ____
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Fent
( ) Ancef
( ) Versed
( ) ____
( ) ____
( ) ____

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

LABORATORY STUDIES:
HB/HCT: 15 / 48
U/A: ____
OTHER: ____
180 PLT
8.2 WBC

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

unknown

ASSESSMENT
PAST SURGICAL/ANESTHETIC
____
____
____
____
____
____

30% SaO2 10

PHYSICAL EXAMINATION
BP 95/53 HR 95 R 14 T 101.6
Pain Scale 0-10 ____
HEENT - Teeth Broken out
Trachea ____
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: ____
Ulnar Filling: ____
BACK: ____
OTHER: SIMV 14 PEP 35
FiO2 30
TV 700

NPO Since PEEP 5

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ ( ) General: Mask Intubation
ETT
[redacted] MAT CDUA

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

bb-2

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: ____ **Date:** 6 Jan 03 **Time:** 0700 **Hrs**

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

Signed: ____ **Date:** ____ **Time:** ____ **Hrs**

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.

Patient Identification: (Ward) ____

[redacted] (ICU #2) bb-4

EPW

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
EDW [redacted] b6-4			4 Jun 03	0725 HOURS	[redacted]
			Admit to ICU		
			Dx: GSW to Face + Left shoulder		
			Vital signs: stable		b6-2
			VS: per routine		
NURSING UNIT	ROOM NO.	BED NO.	All: NKDA		
			Meds: Ancef 1 gm IV Q 8°		
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
			Morphine IV Q 4° PRN pain		
			Diet: NPO		
			IVF: 75 cc/hr LR		
			Activity: Bedrest/Restraint/Guarded		
NURSING UNIT	ROOM NO.	BED NO.	Plan: to OR Per Dr. [redacted] today		
PATIENT IDENTIFICATION			DATE OF [redacted]	TIME OF ORDER	
			[redacted] b6-2	HOURS	2265
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 4 June 03 TIME OF ORDER: 1045 HOURS

LIST TIME ORDER NOTED AND SIGN: b6-2

1. Admit to ICU 2 Dr. [redacted]
2. Dx: S/P GSW to face
3. Cond: Stable
4. Vitals: Per routine
5. Allergy: NKDA
6. Activity: Bed rest

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

7. Nurs: HOB ↑ 30° Yankauer suction to BS; foley to gravity
8. Diet: NPO
9. IV: NS @ 120cc/hr
10. Meds: Zantac 50mg IV BID, fentanyl drip to sedation, versed drip to sedation

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Tylenol ~~650 mg~~ PR q T>100, Ancef 1gm IV q 8°

11. Labs: ABG & CBC now & in AM
12. CXR in AM
13. Vent TV 700 SIMV 14 PEEP 10 FiO2 40%
14. PRN Vecuronium 5mg IV q 1° [redacted]

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER [redacted] TIME OF ORDER b6-2 HOURS MAJ/D

5 Jun 03 0833

1. On call to OR IN AM
2. titrate FiO2 to O2 Sats >

[redacted] on 5 June 03 @ 0840 b6-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted] b6-4

DATE OF ORDER: 6 Jun 03 TIME OF ORDER: 1010 HOURS

LIST TIME ORDER NOTED AND SIGN: b6-2

(1) Admit to ICU 2 Dr [redacted]
(2) Dx: S/P wound closure
(3) cond: Stable
(4) Vitals: Per routine
(5) aller: NKDA
(6) activ: Bed rest

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

(7) Nurs: HOB ≥ 30° HOURS
Yankauer suction PRN
D/C foley
Oral care BID
Bacitracin to wounds TID
(8) Diet clears
(9) IV: NS @ 120cc/hr
(10) meds: ancef 1 gm IV q 8°

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

Morphine 2-4 mg HOURS q 1° IV prn pain
Tylenol 650 mg PR/PO q 4° prn T;
(11) Albuterol NEB x1, tx done
Noted [redacted] MAJ/DE
@1246 [redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.

7 Jun 03 @ 0716
(1) Phenergan 12.5 mg IV q 4° prn N/V

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

(2) Albuterol NEB x1 HO [redacted]
Noted [redacted] b6-2

[redacted] b6-4

7 Jun 03 @ 1259
(1) afrin nasal spray 2 sprays q nostril BID
(2) Soft diet
(3) NS irrigation TID b6-2

NURSING UNIT | ROOM NO. | BED NO.

Noted [redacted] @ 1258 7 June 03

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 7[redacted] USED

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW #[redacted] b6-4

ICW2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7 Jun 03 TIME OF ORDER 0725 HOURS | LIST TIME ORDER NOTED AND SIGN

1. transfer to the floor
2. Dx S/P GSW to face
3. Cond Stable
4. Vitals per routine
5. Aller: NKDA
6. Activ: restrained Bed rest

PATIENT IDENTIFICATION

EPW #[redacted] noted 6 Jun 03 0930 [redacted] b6-2 b6-4

ICW2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

7. NURS: HOB ↑ 30° HOURS
   - Yankauer suction to BS
   - irrigate palatal wound TID
   - oral care QD
   - Bacitracin to wounds TID
8. Diet: Soft non chew
9. IV: Heplock IV
10. Meds: Ancef 1gm IV q 8°
    - Tylenol #3 HOURS 1-2 tab pog PRN pain
    - phenergan 12.5mg IV q 4° PRN N/V
    - Afrin nasal spray 2 sprays q nostril BID

b6-2 [redacted] b6-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. 24°U5 | BED NO. [redacted]

[redacted] 6/8/03 [redacted]

PATIENT IDENTIFICATION

[redacted]

EPW b6-4

DATE OF ORDER 9 Jun 03 TIME OF ORDER 1025 HOURS

1. OKAY to D/C to MP custody

[redacted] b6-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

ICW2

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. 6 Yr. 03 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4	5	6	7	8	9	10	11	12
4 JUN 03	[redacted]	Diet NPO	05	[redacted]								
			17	[redacted]								
4 JUN 03	[redacted]	Act. Bedrest / restraints	05	[redacted]								
		guarded	17	[redacted]								
4 JUN 03	[redacted]	VS per routine	05	[redacted]								
			17	[redacted]								
4 JUN 03	[redacted]	Bed rest	05	[redacted]								
			17	[redacted]								
4 JUN 03	[redacted]	HOB ↑ 30°	05	[redacted]								
		Yankauer Suction	17	[redacted]								
		to PS, Foley to										
		gravity.										
4 JUN 03	[redacted]	Vent TV 700 SIMV 14	05	[redacted]								
		FiO2 ~~50%~~ 30% PS	17	[redacted]								

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

GSW to Face ~~(L)~~ error Shoulder

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

error [redacted]

66-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo 6 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
4 June 03	[redacted]	Admit to ICU #2	4 June 03	1040	1040	[redacted]	
4 June 03	[redacted]	Condition Stable	4 June 03	1040	1040	[redacted]	
4 June 03	[redacted]	ABG's & CBC NOW	4 June	1205	1205	[redacted]	
4 June 03	[redacted]	ABG's & CBC in AM (05 June)	5 June 03	0400	Done	[redacted]	
4 June 03	[redacted]	CXR in AM (05 June)	5 June 03	0500	Ordered 0445 0700	[redacted]	
5 June 03	[redacted]	On call to OR in AM	5 June 03				

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 ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 6	7	8	9	10	11								
6June03	[redacted]	VS per routine	05	[redacted]													
			17														
6June03	[redacted]	Bedrest	05	[redacted]													
			17														
6June03	[redacted]	HOB↑@ 30°	05	[redacted]													
			17														
6June03	[redacted]	Yankauer suction to	05	[redacted]													
		BS	17														
6June03	[redacted]	Oral care BID	10	[redacted]													
			22														
6June03	[redacted]	Diet clear DCtd	05	[redacted]													
			17														
7June03	[redacted]	Soft diet	05	✓	[redacted]												
			17	✓													

Δ See below

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: S/P Wound closure

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: #[redacted] L-6-4 [redacted] 31 y.o.

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ *Yr* 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
6June03	[redacted]	Condition Stable	6June03	1130	1130	[redacted]
6June03	[redacted]	Admit to ICU 2	6June03	1130	1130	[redacted]
6June03	[redacted]	DC Foley	6June03 NOW	1903		[redacted]

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 6 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 8	9	10	11
6JUN03	[redacted]	Vitals per routine	6	/	[redacted]		
			14	[redacted]			
			22	[redacted]			
6JUN03	[redacted]	Activity: restrained bed rest	6	/	[redacted]		
			14	[redacted]			
			22	[redacted]			
6JUN03	[redacted]	NSG: HOB ↑ 30°	6	/	[redacted]		
			14	[redacted]			
			22	[redacted]			
6JUN03	[redacted]	NSG: Yan Kauer suction to BS	6	/	[redacted]		
			14	[redacted]			
			22	[redacted]			
6JUN03	[redacted]	Irrigate palatal wound TID	6	/	[redacted]		
			14	[redacted]			
			22	[redacted]			
6JUN03	[redacted]	Oral care QD	10	/	[redacted]		
6JUN03	[redacted]	Bacitracin to wounds TID	6	/	[redacted]		
			14	[redacted]			
			22	[redacted]			
6JUN03	[redacted]	Diet: soft non chew	07	/	[redacted]		
			11	[redacted]			
			17	[redacted]			

ALLERGIES: [ ] YES [X] NO

NKDA

PRIMARY DIAGNOSIS: GSW to face

ADDITIONAL PAGES IN USE: [ ] YES [ ] NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW # [redacted] bc-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 6 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8Jun03	[redacted]	transfer to the ICW				[redacted]
8Jun03	[redacted]	Dx S/P GSW to face, condition stable				[redacted]
8Jun03	[redacted]	Allergies: NKDA				[redacted]
9	[redacted]	OK to dc to MP custody	9	now		

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

USAPA V1.00