PROGRESS NOTES

DATE	
20JUN03 1515	Assumed care of Pt @ 1300 VSS. A+Ox3 (B) LS CTA (D) BS x4. ABD incision c̄ staples OTA CDI. Dry Dsg over d/c SP cath site CDI. Pt ambulates well (D) spontaneous void, adequate volume. Ø c/o pain. (B) AC HL patent. O/W Assessment WNL. will Monitor — (b)(6)-2 [redacted]
2140	Pt. care assumed @ 2100. Pt. sleeping. HR Reg, Lungs CTA, BS (D) x4. midline ABD incision c̄ staples OTA. Drsng to suprapubic area CDI. will cont. to monitor. — (b)(6)-2 [redacted]
20June03 2200	Pt. vitals taken. BP 112/70 P. 94 R. 16 Temp 99.1 — (b)(6)-2 SPC [redacted]
21June03 0740	Assume pt care @ 0500. VSS. pt awake and alert. no c/o pain. HR regular. Lungs CTA throughout. midline incision intact. Dsg CD+I. Dsg to (D) flank CD+I. Abd. BS x4 active. Full ROM to U/E extremities. HL to (L) AC. no s/s (b)(6)-2 redness/infiltration c̄ flush. Will Continue c̄ monitor [redacted]
1600	Dsg Δ done to (D) flank and back. Area free [redacted] of s/s infection. Staples removed (32) dsg applied to closed abd. Sm amt of drainage present. Pt d/c order written, meds to pharmacy and note written, Waiting for MP transport (b)(6)-2 [redacted]
1900	Assumed care of Pt @ 1300. VSS. A+Ox3. Abd incision s/p staple removal CDI, well approximated. Ø s/s of infection. Dressing dry 4x4 @ SP cath d/c site CDI. Ø c/o pain. O/W assessment WNL. with monitor — [redacted] (b)(6)-2

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

PROGRESS NOTES

DATE	
21Jun03 21:33	Assumed c/o pt @ 21:00. Pt. awake and alert. PERRLA(+) LCA(B), BS(+)x4, (+)PPP(B), ML ABD incision well approximated, some redness noted @ staple sights. Dsg @ ↓ of ML ABD inc. CDI. HL(D) AC D/C'd. ∅ complaints. Will cont. to mon — (b)(6)-2 [redacted] DRT/AW
22June03	0700 Assume pt care @ 0700. Pt asleep, no s/s pain or discomfort. VSS. HR reg. Lungs CTA Abd midline incision intact, redness noted. Dsg to ↓ abd CD&I. Dsg to (L) Flank CD&I. Reflex @ BS. Pt waiting for transport to camp. — (b)(6)-2 [redacted] SLWM6
	1000 Dsg Δ done to (L) flank. Sm amt pus to area. Area cleaned c̄ sterile water. New Dsg CD+I. 2x2 placed over ↓ midline incision due to sm. amt drainage. — (b)(6)-2 [redacted] SLWM6
22June03 1420	Assumed pt care @ 1300. VSS. pt awake et alert. lung sounds CTA, abd midline incision ⊕ s/s of infection noted. Drang to (L) flank CDI. 4pts d/c meds in med box. pt awaiting transportation to EPW camp. ⊕ c/o pain voiced @ this time. Will cont to monitor — (b)(6)-2 [redacted] SLWM6
22June03 2130	Pt. vitals taken BP 120/70, P. 88, R. 18, Temp. 99.2 — SC [redacted] (b)(6)-2
22Jun03 2300	Rec'd pt @ 21:00. Pt awake and alert. VSWN. PERRLA(B) LCA(B) BS(B)x4(+) PPP(B). ML ABD incision c̄ staples removed well approx. c̄ 2x2 DSD @ end of incision. ∅ c/o's @ this time will cont. to mon. [redacted] DRT/AW (b)(6)-2

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
23 Jun	Assumed care of pt @ 0500. Pt alert and oriented. VSS. Lungs CTA. Bowel sounds x 4 quads. Pt has 0 c/o pain / discomfort. Pt is awaiting transportation. (b)(6)-2 [redacted] Hlumb, SGT
23 Jun 03 1500	pt. escorted by MP's to [redacted] (b)(2)-2 [redacted] for release discharge & meds & summary [redacted] (b)(6)-2

(Continue on reverse side)

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

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

REGISTER NO.

WARD NO. HCW 2

PROGRESS NOTES
Medical Record

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

558-103

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3781

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL DATE DAY	MONTH	YR.	TIME
11	06	03	1015

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

CURRENT MEDS. (tetanus immunization and other data): NONE

HISTORY OBTAINED FROM: [ ] PATIENT [ ] OTHER (Specify)

ALLERGIES: NKDA

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

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): Pt

SEX: M | AGE: 50

Smoke (yes) EtOH (yes)

POSSIBLE THIRD PARTY PAYER? [ ] YES [ ] NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME	1020		
BP	164/98		
PULSE	115		
RESP.	26		
TEMP.			
WT. (Child)			

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

50 ØSS y/o Pt was shot in the abdomen x 1 day

See HP

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

ORDERS	INITS.	TIME

ASSESSMENT/DIAGNOSIS

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

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

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

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

1 [redacted]

(b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP

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

EMERGENCY CARE AND TREATMENT
Medical Record Copy

MEDCOM - 10444

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	21	22	23	24	25	26	27
POST- DAY							
MONTH-YEAR June 2003 DAY							
19 HOUR	1 3 8	12 3 8	4 8				

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

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

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

RESPIRATION RECORD: 24 | 18 | 18 | 16

BLOOD PRESSURE: 122/80, 110/80 | 116/82 | 122/78, 120/82 | 124/80, 138/116

Record special data only when so ordered

HEIGHT: WEIGHT: SpO2 → 94% | 95% | 95%

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**

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (O) TEMP. F (•)

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

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

(b)(6)-4

EPW# [redacted]

REGISTER NO.

WARD NO. ICW2

VITAL SIGNS RECORDS

Medical Record

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

TWENTY-FOUR HOUR PATIENT IN...E AND OUTPUT WORKSHEET	FROM 2000 ...URS TO _____ HOURS	TOTAL HOURS COVERED	DATE 18 JUN 03

INT

~~URINE~~ Urine Output				Suprapubic ~~INTERMITTENT~~ cath residual					
TIME	TYPE	AMOUNT	ACCUM TOTAL	TIME STARTED	AMOUNT	TYPE (Include Medications)	~~AMOUNT REC'D~~	~~TIME COMPL~~	ACCUM TOTAL
2020	Dark Yellow	700	700	2020	50cc	Dark Yellow			50

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 64 IS OBSOLETE. REPLACES DA FORM 3630 (TEMP) 1 JUL 7.

*U.S.GPO:1998-404-613/30343

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

FROM MN TO MN HOURS | TOTAL HOURS COVERED 24 | DATE 6-19-83

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0800	50cc	Ancef	50cc	0800	50cc

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0700	Amber-colored urine	700cc	700 cc
0930	Amber-colored urine	700cc	1400 cc
1100	Lt yellow urine	410cc	~~8400~~
1400	Dark yellow	400	~~8800~~
1637	" "	550	~~9350~~
2140	" "	400	3160 cc

BLOOD/BLOOD DERIVATIVES

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

Urine Residual ~~OTHER INTAKE~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1100	Lt yellow urine RES	10cc	10 cc
1400	dark yellow	90cc	100 cc
1637	" "	5cc	115 cc

GRAND TOTAL INTAKE

240 " " 60cc 175cc

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

EPW [redacted]

(b)(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792 EDITION OF 1 FEB 64 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL

MEDCOM - 10448

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

TWENTY-FOUR HOUR PATIE… …NTAKE AND OUTPUT WORKSHEET

FRO ____ HOURS TO ____ HOURS	TOTAL HOURS COVERED	DATE

INT…

~~ORAL~~ urine

TIME	TYPE	AMOUNT	ACCUM TOTAL
0400	Park urine	340	340

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE *(Include Medications)*	AMOUNT REC'D	TIME COMPL	ACCUM TOTAL

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS *(Serving levels cc)*

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ TO _____ HOURS | TOTAL HOURS COVERED | DATE

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

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

Output

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0430	Dark Urine	260	260
0915	DK Urine	300	560 cc
1020	DK Urine	300	860 cc
1500	DK Urine	300	1160 cc

BLOOD/BLOOD DERIVATIVES

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

Urine Res. — OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0915	DK Urine	1 cc	1 cc

GRAND TOTAL INTAKE

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM HOURS TO HOURS	TOTAL HOURS COVERED	DATE
	24	21 JUN

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

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

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0400	void x 1		

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

(b)(6)-4

[redacted]

INTAKE EQUIVALENTS (Serving levels cc)

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM M HOURS TO AM HOURS | TOTAL HOURS COVERED 24 | DATE 6-21-98

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0800	Milk	240	240
0800	H2O	240	480
1200	juice	240	520

INTRAVENOUS

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

OUTPUT

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

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0900	30 urine	300cc	300
1130	urine	350cc	650
1700	" "	250cc	800
2300	void x1		

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

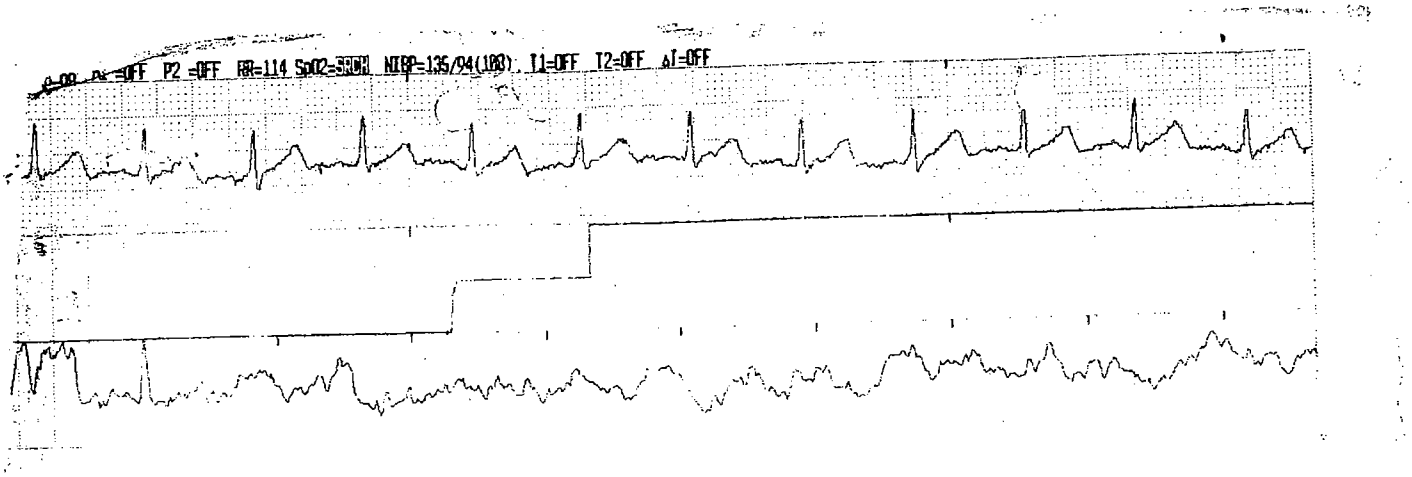
[redacted] (b)(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

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

DD FORM 1 JAN 74 792 EDITION 1 JUL MEDCOM - 10452 REPLACES DA FORM 3630(TEMP)

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



i-STAT 6+

Pt: [redacted] (b)(6)-4

Pt Name: [redacted]

Glu_____340 mg/dL

BUN_____8 mg/dL

Na_____138 mmol/L

K_____5.5 mmol/L

Cl_____110 mmol/L

Hct_____40 %PCV

Hb*_____14 g/dL

*via Hct

Sample Type_: 0748

11JUN03 ~~05:02~~

Oper: 0006781 (b)(6)-2

Physician: [redacted]

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

Ver: [redacted]

TEST(S)		
SPECIMEN TAKEN		
DATE 13 June	TIME 0400	A.M. / P.M.
RESULTS	REQUESTED	(X)
193	GLUCOSE	X
11	UREA N.	X
0.5	CREATININE	X
	URIC ACID	
111	SODIUM	X
4.1	POTASSIUM	X
100	CHLORIDE	X
25	CO_2	X
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
574	CPK	X
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

REMARKS: Chemistry 1

Enter in above space

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

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

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

MD TECH

DATE 13 June

(b)(6)-4

CHEM 1

URGENCY: ☑ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☑ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

CHEMISTRY I
STANDARD FORM 546 (Rev. 8-17)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

546-107

/Section: CMT | REQU: (b)(6)-2 [redacted] | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

, FIRST [redacted] (b)(6)-4 | ME 1010 | SSN/PSEUDO SSN: [redacted] (b)(6)-4

ST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
2		35-45 mmHg (art) 41-51 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
2		23-27 mmol/L (art) 24-29 mmol/L (ven)
3		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
f		(-2) – (+3) mmol/L
ap		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
t		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

[redacted] Chemistry

ST	RESULT	REF. RANGE
nin-1		
of se		

Biochemistry

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

[redacted] Chemistry

TEST	RESULT	REF. RANGE
GLU	271	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	244	39-380 u/l (M) 30-190 u/l (F)
NA^+	134	128-145 mmol/l
K^+	4.9	3.3-4.7 mmol/l
CL^-	107	98-108 mmol/l
tCO_2	16	18-33 mmol/l

Biochemistry

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

Biochemistry

TEST	RESULT	REF. RANGE
ALB	3.0	3.3-5.5 g/dl
ALP	62	26-84 u/l
ALT	61	10-47 u/l
AMY	39	14-97 u/l
AST	79	11-38 u/l
TBIL	0.7	0.2-1.6 mg/dl
GGT	104	5-65 u/l
TP	5.9	6.4-8.1 g/dl

[redacted] Chemistry

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

MARKS:

ORTED BY: (b)(6)-2 [redacted] | DATE: 113ma03 | LAB ID NO.:

(b)(6)-2

Action: 6m5 | REQU[redacted] PHYSICIAN: [redacted] | **LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

FIRST, MI: [redacted] (b)(6)-4 | TIME 1040 | SSN: [redacted] (b)(6)-2

(Hematology) CBC

	RESULT	REF. RANGE
WBC	17.9	4.8-10.8 x 10^3
RBC	4.94	4.7-6.1 x 10^9
Hgb	14.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	44.5	42-52% (M) 37-47% (F)
MCV	90.1	80-94 fl (M) 81-99 fl (F)
Plt	207	130-500 x 10^3 verified
Ly	9.5	20.5-51.1%

(Hematology) Manual Differential

	Mono	
	Eos	
	Baso	
	Imm	
		42-52% (M) 37-47% (F)

Urinalysis

TEST	RESULT	REF. RANGE
Color	Amber	N/A
App	Cloudy	N/A
Glu	2g/L	Negative
Bili	neg	Negative
Ket	mod	Negative
Sp Gr	1.025	N/A
Bld	Large	Negative
pH	5.0	N/A
Prot	1+	Negative
Urob	0.2	0.2-1.0
Nit	neg	Negative
Leuk		Negative
Alb		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

SSA - 4+
Clinitest - 2%
TNTC - RBC
2-4 EPI light mucus

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

RESULT	REF. RANGE
	9.3-13.6 secs
	21-34 secs
	< 20 ug/ml
	< 10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS:

ENTERED BY: Date: Time:

(b)(6)-2 [redacted] 11 Jun 03

---

i-STAT 6+

Pt: [redacted]
Pt Name [redacted]
ID# [redacted]

(b)(6)-4

Glu_____359 mg/dL

BUN_____9 mg/dL

Na_____137 mmol/L

K_____5.0 mmol/L

Cl_____113 mmol/L

Hct_____15 %PCV

Hb*_____5 g/dL

*via Hct

Sample Type_:

11JUN03 0430 ~~02:09~~

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

Physician:_____

Ser# [redacted]
Ver:

-(b)(6)-4

Ward/Section: ICU #1	I[redacted]ESTING PHYSICIAN: VIL[redacted] (b)(6)-2	ORATORY RESULT [redacted] (Subject to the Privacy Act of [redacted]	
LAST, FIRST, MI. EPW # [redacted] -(b)(6)-4	DATE 11 Jun 03	TIME 1800	SSN/PSEUDO SSN:

[redacted]

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF.
WBC	14.6	4.8-10.8 x 10^3	Color		N/A	RPR		Negat
RBC	4.83	4.7-6.1 x 10^9	App		N/A	Mono		Negat
Hgb	13.4	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	[redacted]		
Hct	43.3	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	89.7	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	197 ~~278~~	130-500 x 10^3 verified	SG		N/A	Occ Bld		Neg
Lymph %	14.0	20.5-51.1%	Bld		Negative	H. pylori		Neg
[redacted]			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	[redacted]		
RBC Morph			HCG		Negative			

Spun Hematocrit		42-52% (M) 37-47% (F)	[redacted]			[redacted]
Sed Rate			Cell Count			MUST SUBMIT SF 518 W EVERY UNIT REQUEST
Other			Directigen		Negative	ABO/Rh

[redacted]

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

REMARKS:

REPORTED BY: (b)(6)-2	DATE: 11 Jun 03	LAB ID NO.:

Unit/Section: ICU #1	REQUESTING PHYSICIAN: DR [redacted] (b)(6)-2	LABORATORY RESULT (Subject to the Privacy Act of
LAST, FIRST, MI: EPW # [redacted] (b)(6)-4	DATE: 1 Jun 03	TIME: 0000	SSN/PSEUDO SSN:

Hematology/CBC

TEST	RESULT	REF. RANGE
WBC	13.3	4.8-10.8 x 10^3
RBC	4.67	4.7-6.1 x 10^6
Hgb	13.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	42.1	42-52% (M) 37-47% (F)
MCV	90.2	80-94 fl (M) 81-99 fl (F)
Plt	166	130-500 x 10 verified
Lymph %	10.1	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Myelo		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 EU
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF.
RPR		Nega
Mono		Nega

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 W
EVERY UNIT REQUES

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 [redacted]
REQUESTED

UNIT	TYPE	CROSSMA

REMARKS:

REPORTED BY:	DATE:	LAB ID NO:
(b)(6)-2 [redacted]	1 Jun 03	

Section: ICU #1

REQUESTING PHYSICIAN: DR [redacted] (b)(6)-2

CHEMISTRY RESULT FO
(Subject to the Privacy Act of 19

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

DATE: 12 JUN 08 TIME: 0500

SSN/PSEUDO SSN:

[redacted]

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
	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
	7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg
	35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l	NA^+		128-145 mm
	80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl	K^+		3.3-4.7 mmo
	23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl	CL^-		98-108 mm
	22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl	tCO_2		18-33 mmol
	95-98%	CHOL		100-200 mg/dl	[redacted]		
	(-2) – (+3) mmol/L	CRE		0.6-1.2 mg/dl	TEST	RESULT	REF. RAN
	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	[redacted]			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	265	73-118 mg/dl	AST		11-38 u/l
	38-51% PCV	BUN	9	7-22 mg/dl	TBIL		0.2-1.6 mg
	12-17 g/dl	CRE	0.6	0.6-1.2 mg/dl	GGT		5-65 u/l
[redacted]		CK	811	39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
T RESULT	REF. RANGE	NA^+	125	128-145 mmol/l	[redacted]		
in-1		K^+	4.2	3.3-4.7 mmol/l	TEST	RESULT	REF. RAN
of		CL^-	102	98-108 mmol/l	NA^+		128-145 mm
		tCO_2	23	18-33 mmol/l	K^+		3.3-4.7 mm
					CL^-		98-108 mm
					tCO_2		18-33 mmol

ARKS:

[redacted] (b)(6)-2

Ward/Section	REQUESTING PHYSICIAN	LABORATORY RESULT (Subject to the Privacy Act of
ICU#1	DR [redacted] (b)(6)-2	

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
EPW # [redacted] (b)(6)-4	12 JAN 03	0500	

Hematology/CBC

TEST	RESULT	REF. RANGE
WBC	13.0	4.8-10.8 x 10^3
RBC	4.48	4.7-6.1 x 10^6
Hgb	13.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	40.3	42-52% (M) 37-47% (F)
MCV	89.9	80-94 fl (M) 81-99 fl (F)
Plt	151	130-500 x 10³ verified
Lymph %	10.2	20.5-51.1%

(Hemato-Path) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Seg Neutrophil		42-52% (M) 37-47% (F)	
Vol Bnd			
Other			

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D-dimer		<50 ug/ml
FDP		10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Gbl		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

Blood Bank Unit Cross Match

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

UNIT	TYPE	CROSSMA

Misc. Serology

TEST	RESULT	REF
RPR		Neg.
Mono		Neg.

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: (b)(6)-2 [redacted] DATE: 12 Jan 03 LAB ID NO:

Ward/Section:	RE. STING PHYSICIAN: [redacted] (b)(6)-2	C. MISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. ICU #1	# [redacted] (b)(6)-4	DATE 13 June · TIME 0840 · SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

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

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU	194	73-118 mg/dl
BUN	12	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	454	39-380 u/l (M) 30-190 u/l (F)
NA^+	118	128-145 mmol/l
K^+	3.9	3.3-4.7 mmol/l
CL^-	101	98-108 mmol/l
tCO_2	24	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:	DATE:	LAB ID NO.:
[redacted] (b)(6)-2	13 June 03	

Unit/Section: ICU #	REQUESTING [redacted] (b)(6)-2	LABORATORY RESULT (Subject to the Privacy Act of
LAST, FIRST, MI: Glw # [redacted] -(b)(6)-4	DATE: 13 June 2160	TIME	SSN/PSEUDO SSN:

CBC + Chem 8

Hematology

TEST	RESULT	REF. RANGE
WBC	11.6	4.8-10.8 x 10^3
RBC	3.63	4.7-6.1 x 10^6
Hgb	10.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	33.0	42-52% (M) 37-47% (F)
MCV	90.9	80-94 fl (M) 81-99 fl (F)
Plt	139.	130-500 x 10^3 verified
Lymph %	11.0	20.5-51.1%

Hematology (Manual) Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Other		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		0.2-1.8
Nit		Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF
RPR		Nega
Mono		Nega

Microbiology

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

Microscopic Urinal

Blood Ba

MUST SUBMIT SF 518 EVERY UNIT REQUES

Coagulation Studies

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

Blood Bank Type & Crossmatch

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

UNIT	TYPE	CROSSMA

REMARKS:

REPORTED BY:	DATE:	LAB ID NO:
[redacted] (b)(6)-2	13 June 03	

d/Section: ICU1 | REQU[redacted]NG PHYSICIAN: [redacted] (b)(6)-2 | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

ST, FIRST, MI. EPW [redacted] | DATE 14 June | TIME 0400 | SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC (b)(6)-4

TEST	RESULT	REF. RANGE
WBC	8.6	4.8-10.8 x 10^3
RBC	3.50	4.7-6.1 x 10^9
Hgb	10.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	31.4	42-52% (M) 37-47% (F)
MCV	89.8	80-94 fl (M) 81-99 fl (F)
Plt	163	130-500 x 10^3 verified
Lymph %	15.6	20.5-51.1%

Hematology) Manual Differential

gs		Mono	
nds		Eos	
mph		Baso	
p		Imm	
C mph			

m matocrit		42-52% (M) 37-47% (F)
Rate		
ner		

Coagulation Studies

EST	RESULT	REF. RANGE
		9.8-13.6 secs
TT		21-34 secs
limer		<20 ug/ml
P		<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

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

UNIT	TYPE	CROSSMATCH

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	

:MARKS:

ection: ICU 1

REQUESTING PHYSICIAN: [redacted] (b)(6)-2

CHEMISTRY RESULT FO
(Subject to the Privacy Act of 19

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

DATE	TIME	SSN/PSEUDO SSN
14 June	0400	[redacted] (b)(6)-4

[redacted]

	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
		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
		7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg
		35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l	NA^+		128-145 mm
		80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl	K^+		3.3-4.7 mmo
		23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl	CL^-		98-108 mm
		22-26 mmol/L (art) 23-28 mmol/L (ven)	CA^{++}		8.0-10.3mg/dl	tCO_2		18-33 mmo
		95-98%	CHOL		100-200 mg/dl	[redacted]		
		(-2)-(+3) mmol/L	CRE		0.6-1.2 mg/dl	TEST	RESULT	REF. RAN
		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	[redacted]			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	166	73-118 mg/dl	AST		11-38 u/l
		38-51% PCV	BUN	14	7-22 mg/dl	TBIL		0.2-1.6 mg
		12-17 g/dl	CRE	0.7	0.6-1.2 mg/dl	GGT		5-65 u/l
[redacted]			CK		39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
T	RESULT	REF. RANGE	NA^+	140	128-145 mmol/l	[redacted]		
in-I			K^+	3.8	3.3-4.7 mmol/l	TEST	RESULT	REF. RAN
of			CL^-	100	98-108 mmol/l	NA^+		128-145 mm
			tCO_2	25	18-33 mmol/l	K^+		3.3-4.7 mm
						CL^-		98-108 mm
						tCO_2		18-33 mmol

ARKS:

[redacted] (b)(6)-2

Chem 8 please

[redacted]

LABORATORY RESULT FORM

(Subject to Privacy Act of 1974)

LAST, FIRST, MI	STATUS	DATE	SSN
EPW # [redacted] (b)(6)-4 (b)(6)-2		15 JUN	[redacted] (b)(6)-4

Chemistry (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
PCO_2		35-45 mmHg (art) 41-51 mmHg (ven)
PO_2		80-105 mmHg (art) N/A (ven)
TCO_2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO_3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO_2		95-98%
BEecf		(-2) – (+3) mmol/L
AGap		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

Blood Bank

ABO/Rh		IAT	

Unit	Type	Crossmatch

Misc. Chemistry

CKMB		
Troponin		
DOA		
Alcohol		

Microscopic Urinalysis

Chemistry (Piccolo Analyzer)

TEST	RESULT	REF. RANGE
ALT	28	10-47 U/L
AST	42	11-38 U/L
GGT		5-56 U/L
ALB	2.0	3.3-5.5 g/dl
ALP	69	26-84 U/L
Amylase	81	14-97 U/L
Ca	8.1	8-10.3 mg/dl
Chol	140	<200 mg/dl
Creat	1.0	0.6-1.2 mg/dl
BUN	14	7-22 mg/dl
GLU	166	73-118 mg/dl
Tbili	0.8	0.21.6 mg/dl
TP	6.0	6.4-8.1 g/dl
UA		2.2-6.6 mg/dl (F) 3.6-8.0 mg/dl (M)
Na^+	137	128-145 mmol/L
K^+	3.5	3.3-4.7 mmol/L
Cl^-	101	98-108 mmol/L
$^+CO_2$	27	18-33 mmol/L
CK		39-380 u/L

Urinalysis

TEST	RESULT	REF. RANGE
Gluc		Negative
Bili		Negative
Ketone		Negative
SG		N/A
Blood		Negative
pH		N/A
Protein		Negative
Urob		0.2-1.0
Nitrite		Negative

Hematology

TEST	RESULT	REF. RAN
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
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		130-500 x 10^3 verified
Lymph%		20.5-51.1%
Retic		0.5-1.5% (adu
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Other		
Spun Crit		42-52% 37-47%
Man WBC		4.8-10.8 x
Manual Plt		130-500 x verified

Microbiology

Source	
Gram Stain	
Culture	
KOH/WP	
O&P	
Occ Bld	Malaria
Other	

(b)(6)-2

Ward/Section: 1CW2	REQU[redacted]NG PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 15 Jun	TIME: 0800	SSN/PSEUDO SSN: [redacted] (b)(6)-4

TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE
WBC	7.2	4.8-10.8 x 10³	Color		N/A	RPR		Negative
RBC	3.65	4.7-6.1 x 10⁶	App		N/A	Mono		Negative
Hgb	10.6	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	[illegible]		
Hct	32.4	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	88.7	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
[illegible]	235	130-500 x 10³ verified	SG		N/A	Occ Bld		Negative
[illegible]	18.3	20.5-51.1%	Bld		Negative	H. pylori		Negative
[illegible]			pH		N/A	Micro Parasites		
[illegible]		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
[illegible]		Imm	Leuk		Negative	[illegible]		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	[illegible]			[illegible]		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

TEST	RESULT	REF RANGE	UNIT	TYPE	CROSSMATCH
[illegible]		9.8-13.6 secs			
[illegible]		21-34 secs			
[illegible]		<20 ug/ml			
[illegible]		<10 ug/ml			

REMARKS:

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

(b)(6)-2

MEDCOM - 10466

"Chem 8"

Ward/Section: DCW2

REQUESTING PHYSICIAN:

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

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

DATE: 16Jun04 TIME: 00

SSN/PSEUDO SSN: (b)(6)-4 [redacted]

[illegible]

TEST	RESULT	REF. RANGE
Na	139	138-146 mmol/L
K	3.7	3.5-4.9 mmol/L
Cl	97	98-109 mmol/L
pH	7.394	7.31-7.45
PCO2	47.4	35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2	30	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	29	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf	4	(-2) – (+3) mmol/L
AnGap	16	10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	13	8-26 mg/dl
GLU	173	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	35	38-51% PCV
Hgb	12	12-17 g/dl

[illegible]

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

[illegible]

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

[illegible]

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

[illegible]

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

[illegible]

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

[illegible]

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

DATE: 16Jun03

LAB ID NO.:

ard/Section: ICW2	REQ ING PHYSICIAN:	LA ATORY RESULT FORM (Subject to the Privacy Act of 1974)	
ST, FIRST, MI. # [redacted] (b)(6)-4	DATE 16 Jun	TIME 0200	SSN/PSEUDO SSN: (b)(6)-4 [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	6.7	4.8-10.8 x 10^3
RBC	3.93	4.7-6.1 x 10^9
Hgb	11.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	35.3	42-52% (M) 37-47% (F)
MCV	89.6	80-94 fl (M) 81-99 fl (F)
Plt	295	130-500 x 10^3 verified
Lymph %	25.6	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF RANG
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

EMARKS:

(b)(6)-2 [redacted] 16 Jun 03

MEDICAL RECORD - ANESTHESIA

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

SPECIFY UNITS - MG/MCG/ML, ↑=CONSTANT INFUSION

DRUG	(Units)												
Versed	(mg)	2.5					5						
Glyco	(mg)	.4											
Reglan	(mg)	10											
MSO4	(mg)	.5	5				5						
Anrinal	(mg)	1											
Ancef	(g)	250	250										
VOLAT AGENT	% del												
	Sevo % e.t.	2	- - -	- -	- -	- -	- -	- -	- -				
AIR	L/Min												
N2O	L/Min												
O2	L/Min	5	- - -	- -	- -	- -	- -	- -	- -				

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → [redacted] (b)(6)-2

IV site													
(L) .9NS	☐ Warmed	#1 - -	#2	- - -	- -	- -	- -	#3	- -				
(R) .9NS	☐ Warmed	#2 - -	- -	- -	- -	- -	#3	- -	- -				
PROC	☐ Warmed	#1	#2										
	☐ Warmed												2 units

FLUIDS													
EST BLOOD LOSS													
URINE - Foley				250		600		1200	1400				

TIME →	0400	15	30	45	0500	15	30	45	0600	15	30	45
VT - ml		760	760	750	750	800	800	800				
f - breaths/min		9	9	9	9	10	10	10	12			
Peak inf pres / PEEP		30	30	30	30	24	24	24				
MODE - S(pon), A(ssist), C(on)	S A	C	C	C	C	C	C	C	A A C			
ET CO2 (torr)		47	45	46	45	42	42	45	45			
FIO2 (Fraction or %)		.42	.42	.42	.42	.42	.42	.42				
SpO2 (%)	100	100	100	100	100	100	100	100	100			
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR			
TEMP-site												
N-M Block (T/4)			0/4									
NORCURON	10			2								
Warming blkt												
Forced warmer												

EVENTS (Position) → SUPINE

TOTALS: 2.5 mg, .4 mg, 10 mg, 1 mg, 300 cc

TOTAL ERL: 300

TOTAL URINE: 1400

FLUIDS - SUMMARY

CRYSTALLOID: 4400

COLLOID:

BLOOD: 2 units

REMARKS

Code drugs with numbers, events with letters

Rocephin 2gm IV

cefoxin 900mg IV

Pt reversed @ 0505 → 3mg neo .6mg Glyco

Pre op Estat
Na 137 Cl 99
K+ 5.0 BUN 9
CL 113
HCT 15
HGB 5

RECOVERY AT

PACU ICU _____ (Specify)

OTHER

CONDITION: O2 V mask

BESP: 26 SpO2: 95 Temp 98.3

BP: 125/41 HR: 106

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0400	0411	0600
	Ready	Begin	End
PROC	0420	0440	0555

PATIENT STATUS: 2 3 4 5 (E)

BODY WEIGHT: estimated 90 KG LB

HEMATOCRIT: Hgb 5

VITAL DATA:

TOURNIQUET CHECK: N

TOURNIQUET TEST:

PROCEDURE?

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

PROCEDURES and CPT Codes:

Exp lap c placement of suprapubic catheter

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GA EA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

OL x T 8.0 ET Anrinal BS Bilat =

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

SSN # EPW

NAME: [redacted] (b)(6)-4

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

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

PROCEDURE LOCATION: OR #1

DATE: 11 JUN 03

PAGE 1 OF 1

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

(b)(6)-2

[redacted]

CardioSmart

BAGHDAD TEACHING HOSPITAL [redacted] (b)(6)-4

MMMMM

Date of Birth
Height/Weight /
Blood Pressure
Medication

Comments

Measurement Results:

QRS	:		168 ms
QT/QTC	:	228 /	214 ms
PR	:		(166) ms
P	:		(128) ms
RR/PP	:	306 /	305 ms
P/QRS/T	:	0/ -5/	30 degrees
QTD	:		26 ms
Sokolow	:		1.52 mV
MK	:		1

Interpretation:

(b)(6)-4

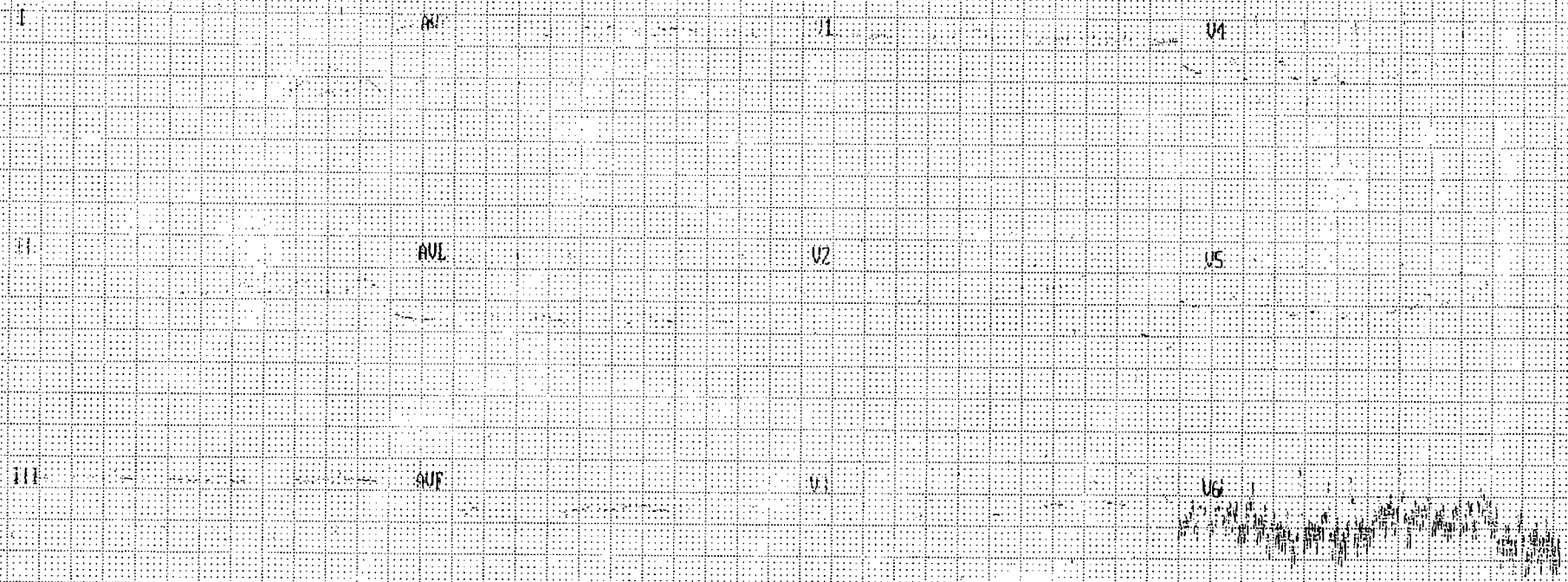
[redacted]

probably acute MI (lateral)
"RSR" pattern
atrial fibrillation
tachycardia
minor left axis deviation
significant ST-segment depression (lateral)
ST-segment elevation (inferior, anterior)
large negative T-wave (lateral)
R/S inversion area between V1 and V2
S waves up to V6
Note ! temporary signal interference

report not confirmed.

ST-Table

Lead	I	II	III	AVR	AVL	AVF	V1	V2	V3	V4	V5	V6
mV	0.13	0.13	0.00	-0.13	0.07	0.06	-0.08	0.20	0.17	0.16	-0.04	-0.24
mV/s	-1.75	-2.00	-0.20	1.85	-0.70	-1.11	2.13	-6.95	-6.45	-5.25	-1.96	-5.11



10.Jun.2003 23:29:13 25mm/s 10mm/mV ABS 50Hz 0.08 35Hz 3.F1 Automatic V4.22 CS-121 (1)

MEDCOM - 10470

Doctor's Orders—Post-OP

[redacted] (b)(6)-2

Nurse Complete	Dr.'s Select	
		DATE: 11 June 2003 TIME: 0625
☐	☑	1. Admit to: ☐ OR ☒ PACU ☐ ICW ☐ Patient Holding
☐	☑	2. Diagnosis: Shrapnel injury ⓛ flank.
☐	☑	3. Condition: ☐ Critical ☒ Guarded ☐ Stable ☐ VSI ☐ SI
☐	☐	4. Allergies: See SF 558
☐	☑	5. Vitals: ☐ Unit SOP ☐ Notify Dr. for SBP < 90 or > 180, ~~DBP~~ < ___ or > ___, HR < 50 or > 140, RR < ___ or > ___, or Temp > ___
☐	☑	6. Activities: ☒ Bed Rest, ☐ BRP, ☐ OOB ASAP w/ assist, ☐ Sit up and dangle when stable ☐ Other:
		7. NRSG:
☐	☑	a. Propaq monitor w/ Pulse-ox
☐	☑	b. O_2 to maintain SAT's above 94%
☐	☐	c. Maintain Vent settings at MODE=_____ Vt=_____ RR=_____ PEEP= FIO$_2$=
☐	☑	d. ☐ Reinforce or ☒ Change dressing for bleed-through X1 then notify Dr.
☐	☑	e. I's & O's
☐	☑	c. Suction NT ETT PRN
☐	☐	d. CT to ☐ H_2O seal or ☐ Suction at ___
☐	☑	8. Diet: ☒ NPO ☐ Clear fluids as tolerated ☐ Other:
☐	☑	9. IV: ☒ NS or ☐ LR TRA 150 cc/hr ☐ DEXTRAN or ☐ Hespan X 500 cc bolus titrated then _____ cc/hr ☐ Albumin 100cc X ____ TRA _____ cc/hr ☐ When tolerating PO fluids, complete current fluid then SL.
☐	☐	10. BLOOD: ☐ T&S or ☐ T&C _____ units ☐ Transfuse ____ units ☐ PRBCs or ☐ Whole Blood
		11. Medications:
☐	☑	a. Tobramycin 300mg IV Q12hrs X ⓔ ☒ Ceftriaxone 750 mg IV
☐	☑	ⓑ Clindamycin 600mg IV g 8o f ☐ PEN G 2 million Units IV
☐	☐	c. Cefazolin 1 gram IV
☐	☐	d. Phenergan 12-25mg Titrate ☐ IV ☐ IM Q4hrs PRN nausea/vomiting
☐	☐	g. Droperidol 1mg ☐ IV ☐ IM X 1 PRN Nausea/Vomiting
☐	☑	h. MSO_4 1-3mg Titrate ☒ IV ☐ IM Q10min PRN Pain
☐	☐	i. Robinul 0.1mg IV X 1
☐	☐	j. Zantac 50 mg ☐ IV or ☐ IM or ☐ 6.25mg/hr infusion
☐	☐	k. Tetanus Immune Globulin
☐	☐	l. Toradol ☐ IV 30mg or ☐ IM 60 mg
☐	☐	m. Maintain sedation/paralysis w/ Rocuronium and MSO_4 PER SOP
☐	☐	12. LABS: a. iSTAT ☐ Glucose ☐ ABG ☐ BMP ☐ CMP
		13. Additional: Foley to ~~urinometer~~ gravity bag
		Signature: LTC [redacted] (b)(6)-2

LOG# PT NAME: PT SSAN# 10JAN03

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

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

DATE OF ORDER: 11 Jun 03 | TIME OF ORDER: 1030 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU
2. Dx - s/p ex lap
3. Condition stable
4. Vitals - per routine
5. Allergies - NKDA
6. Activity - Bedrest - supraprubic foley to gravity

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

NURSING UNIT: ICU I | ROOM NO. [redacted] | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

7. Nursing - notify MO for temp > 101.4, BP > 160/90 or < 90/60; HR > 130 or < 50; RR > 25 or < 10; UOP < 40 cc/hr
8. Diet - NPO

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

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

DATE OF ORDER | TIME OF ORDER _____ HOURS

9. IVF 125 cc/hr LR
10. LABS - P
11. Meds - ~~Cefotetan 2 grams IVPB q 12° or~~
   MSOY - 2-4 mg IVP q 3-4° prn
   ~~Phenergan 25 mg IVP q 4-6° prn~~

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

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

DATE OF ORDER | TIME OF ORDER _____ HOURS

12. O2 supplement to maintain p-ox > 95% [redacted] (b)(6)-2
13. Meds - Ancef - 1 gram IVPB q 8°
   Gentamicin - 400 mg IVPB q day
14. q 6° CBC x 4
   q d Chemistry
   11 JUN 03

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

NURSING UNIT: ICU I | 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	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW # [redacted] (b)(6)-4	12 JUN 03 / 0720 HOURS	
	OK for ~~[illegible]~~ ~~[illegible]~~ swallows	
	to mouth [redacted] (b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.		

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW # [redacted] (b)(6)-4	12 June 03 / 2100 HOURS	
	1) VO - Dr. [redacted] to Rock NG tube to LIS, Water allowed PO. (b)(6)-2	2100 - [redacted] (b)(6)-2
	(b)(6)-2 [redacted]	
NURSING UNIT / ROOM NO. / BED NO.		

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW [redacted] (b)(6)-4	13 JUN 03 / 0125 HOURS	
noted + done 13 June 03 [redacted]	DC NG tube	
	Clear liquid tody	
	Repeat chem 8 + CBC and repeat q AM	
NURSING UNIT / ROOM NO. / BED NO. (b)(6)-2	(b)(6)-2 [redacted]	

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# [redacted] (b)(6)-4 EPW	13 JUN 03 / 1011 HOURS	
[redacted] (b)(6)-2	DC LR	
	D to NS @ 100cc/hr	
	DC Cent	
	start Cipro 400 q IVPB q 12h	
NURSING UNIT / ROOM NO. / BED NO.	14 JUN 03 0840 [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

[redacted] (b)(6)-4

Epid

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 14 JUN 03 TIME OF ORDER: 0835 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Transfer to ward when bed space available
2. Rx s/p GSW to flank
3. Condition stable
4. IVF LR @ ~~[illegible]~~ 75cc/h
5. Diet: Clear liquids only NPO
6. Foley to gravity drainage

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

7. Change Dressings Daily - flank and abdomen
8. Meds:
   - MSO4 2-8mg IVP q 2° prn pain
   - Phenergan 12.5mg IVP q 6° prn nausea
   - Ancef 1gm q 8° IVPB
   - Cipro 400mg IVPB q 12°
9. Bedrest

PATIENT IDENTIFICATION

[redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

10. CBC, chem 8 q AM x3 days
11. Dr. [redacted] (b)(6)-2
12. Need IVP for [redacted] (b)(6)-2 [redacted] OR [illegible] (b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 14 JUN 03 TIME OF ORDER: 1522 HOURS

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

Limited sips of water only

Noted & Done [redacted] (b)(6)-2

(b)(6)-2

[redacted]

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

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 A SIGN
[redacted] (b)(6)-4				15 JUN 03	0706 HOURS	
				Clears now		
					noted [redacted] 15 Jun 0710	
					[redacted] (b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.		(b)(6)-2		
DXP / Ward		[redacted]			24/AN	
PATIENT IDENTIFICATION					TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

DATE OF ORDER: CT JUN 03 | TIME OF ORDER: 1306 | HOURS | LIST TIME ORDER NOTED AND SIGN

① OOB to Chair
② Regular Diet
(b)(6)-2 [redacted]

NURSING UNIT: 2GP | ROOM NO.: done | BED NO.: [redacted] (b)(6)-2

Noted [redacted] (b)(6)-2 2GT/AN

PATIENT IDENTIFICATION: 1A [redacted] (b)(6)-4 (b)(6)-2

DATE OF ORDER: 16 JUN 03 (b)(6)(2) | TIME OF ORDER: 0900 | HOURS | (b)(6)-2

V.O. from Dr. [redacted] to CT [redacted] (b)(6)-2
① Tylenol #3 1-2 tabs po PRN for pain. q4-6°
(b)(6)-2 [redacted] 2G/AN

note [redacted] 1000 6/16

NURSING UNIT: 1CW2 | ROOM NO.: | BED NO.: [redacted]

(b)(6)-2 [redacted]

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

DATE OF ORDER: 16 JUN 03 | TIME OF ORDER: 1153 | HOURS | (b)(6)-2 [redacted]

~~DC Foley~~ ✓
Ambulate c assistance ✓
DC Gneef/IV Cyno ✓
Δ to oral [redacted]
Cyn 500 [redacted]
BID (b)(6)-2
Heplock IV ✓

note tech Kaj 1200 [redacted]

(b)(6)-4

NURSING UNIT: 1CW2 | ROOM NO.: | BED NO.: [redacted]

PATIENT IDENTIFICATION: 24° VS [redacted] (b)(6)-2

DATE OF ORDER: DC Daily labs | TIME OF ORDER: | HOURS | (b)(6)-2

1CT/AN 6/16/03 2330

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

EPW

[redacted] (b)(6)-4

NURSING UNIT: ICW3 | ROOM NO. | BED NO. [redacted]

DATE OF ORDER: 18 JUN 03 | TIME OF ORDER: 1427 HOURS | LIST TIME ORDER NOTED AND SIGN

1 Please keep SP tube clamped

— Check residual urine after each void by opening SP tube and checking volume

— Record on I/O sheet (b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: Noted [redacted] | HOURS (b)(6)-2

6-18-03 2330 VO. from Dr. [redacted] /LP [redacted]

① Clamp SP cath @ night only (b)(6)-2 (b)(6)-2 [redacted] 1CT/AN

(b)(6)-2 [redacted] 24° Vs [redacted] 1CT/AN 6-18-03 2330

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT: 24° Vs | ROOM NO. [redacted] | BED NO. 19 Jun 03

DATE OF ORDER: 19 JUN 03 | TIME OF ORDER: 0707 HOURS

+ Clamp SP tube during day

+ ✓ Post void residual

— Drain at night

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

PATIENT IDENTIFICATION (b)(6)-4

(b)(6)-4

[redacted]

24° Vs [redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

D/C SP tube [redacted] (b)(6)-2

DC staples in [redacted] (b)(6)-2

1CT/AN 6-20-03 22[redacted]

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

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

TIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AN SIGN
# [redacted] (b)(6)-4			21 Jun	0920 HOURS	
			✓ Keflex 500mg ; PO QID		
			✓ OK for tran [redacted] (b)(6)-2		
RSING UNIT	ROOM NO.	BED NO.			
ICW II		[redacted] (b)(6)-2			
TIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
# [redacted] (b)(6)-4			21 Jun 03	21:30 HOURS	
			VO		
			D/C HL x 1 now		
			(b)(6)-2		
			Dr [redacted] [redacted]		
RSING UNIT	ROOM NO.	BED NO.			
ICW 2		[redacted]	24° ✓ done [redacted] (b)(6)-2		
TIENT IDENTIFICATION		(b)(6)-4	DATE OF ORDER	TIME OF ORDER	
				HOURS	
RSING UNIT	ROOM NO.	BED NO.			
TIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
RSING UNIT	ROOM NO.	BED NO.			

noted 21:30 21 Jun 03 [redacted] (b)(6)-2

noted 21 Jun 03 0930 [redacted] (b)(6)-2

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

all (b)(6)-2 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 11	12	13	14	15	16	17	18	19	20	21	22	23	24
11JUNE	[redacted]	Vitals per Routine	05	●	●	●	●										
			17	●	●	●											
11JUNE	[redacted]	ACTIVITY - BEDREST	05	●	●	●	●										
		SUPRAPUBIC FOLEY	17	●	●	●											
		TO GRAVITY															
11JUNE	[redacted]	NOTIFY MD FOR	05	●	●	●	●										
		T>100.4 BP 160/90	17	●	●	●											
		OR <90/58 HR>130															
		OR <50 RR>25 OR<10															
		UOP <40 cc/o															
		(b)(6)-2															
11JUNE	[redacted]	DIET: ~~NPO~~ ~~H_2O~~ [redacted]	05	●	●	●	●										
		~~PO. Clear Liquid~~	17	●	●	●											
		NPO															
11JUNE	[redacted]	CBC Q6 × 4	06	●													
			12 (1)	●													
			18 (2)	●													
			24 (3)	●													
11JUNE	[redacted]	Chemistry Q DAY	04	●	●	●											
		+ CBC Q AM															
12JUNE	[redacted]	Swabs to mouth	05	●	●	●											
			17	●	●												
12JUNE	[redacted]	NG LTS	05	●	●												
			17	●													

Auto DC 5 4th Draw

D/C [redacted]

COND: STABLE

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: S/P EX LAP

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO (b)(6)-2

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

all (b)(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo June Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11JUN03	[redacted]	ADMIT TO ICU #1	11JUNE	—	1145	
11JUNE03	[redacted]	Dx - S/P EXPLOR. LAP	11JUNE	—	NOTED 1150	[redacted]
11JUN03	[redacted]	CONDITION - STABLE	11JUNE	—	NOTED 1158	[redacted]
		~~VITALS PER~~				
13 Jun	[redacted]	CBC + chem 8 Repeat now	13 June 03 @ 0800		done	[redacted]
13 June	[redacted]	D/C NG Tube	done @ 0745		13 June	[redacted]

all (b)(6)-2

(b)(6)-2

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

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 06 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 14	15	16	17	18	19	20	21	22	23	24	25	26	27
14	[redacted] (b)(6)-2	DIET NPO	6	/	[redacted]												
		Lemon Swabs of mouth only	11	/													
			17	[redacted]													
14	[redacted] (b)(6)-2	FOLEY TO GRAVITY DRAINAGE	5	/	[redacted]												
			13	[redacted]													
			21	[redacted]													
14	[redacted] (b)(6)-2	Δ Dress Daily to Flank (b)(6)-2 [redacted]	10	[redacted]													
14	[redacted] (b)(6)-2	ACT [redacted] (b)(6)-2 COB EG Chart	5	/	[redacted]												
			13	[redacted]													
			21	[redacted]													
		CBC, Chem 8 QAM x 3 days	04	/	[redacted]												
15	[redacted] (b)(6)-2	Diet: [redacted] (b)(6)-2 REG	06	/	[redacted]												
			11	/													
			17	/													
16	[redacted] (b)(6)-2	Ambulate C ASSISTANCE	05	/	/	[redacted]											
			13	/	/												
			21	/	/												
16	[redacted] (b)(6)-2	Suprapubic (b)(6)-2 Cath ~~to gravity~~	05	/	/	[redacted]											
			13	/	/												
		Clamped during day	21	/	/												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: D/S/P GSW to FLANK

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

SPCO (b)(6)-4

[redacted]

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

All above (b)(6)-2 line

all above (b)(6)-2 line

(b)(6)-2

DA FORM 4677, 1 OCT 78 USED. USAPA V1.00

all (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
14	[redacted]	TRANSFER TO WARD WHEN BED SPACE AVAILABLE	14		1530	[redacted]
14	[redacted]	COND: STABLE	14		1530	[redacted]
14	[redacted]	Needs IVP today		Done	[redacted]	
21Jun	[redacted]	OK for transfer	21Jun	ASAP		
21Jun	[redacted]	D/C HL x1 now	21Jun	21:30	21:30	[redacted]

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

USAPA V1.00

All redactions (b)(6)-2 except one (b)(6)-4 at bottom

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. Jun Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18	19	20	21	22	
18	[redacted]	Check residual urine	5	/	[redacted]				
		after each void by	13	[redacted]	[redacted]				
		opening SP tube and	21	[redacted]					recurrent
		checking volume							
18	[redacted]	Record urine output	5	/	[redacted]				
		and residuals on	13	[redacted]					DC'd
		I+O sheet	21	[redacted]					20 June 03
									[redacted]
6-18	[redacted]	Clamp SP cath @	22	[redacted]					
		~~night time only~~							D/C
		D							
6-19	[redacted]	Drain SP @ Night	22	/	[redacted]				DC'd 20 June 03 [redacted]
6-19	[redacted]	Clamp SP during days	5	/	[redacted]				
		check post void residual	13	/					DC'd
			21	[redacted]					20 June 03
									[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW to (L) FLANK

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

All redactions (b)(6)-2 except 1 (b)(6)-4 at bottom

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 11	12	13	14	15	16	17	18	19	20	21	22	23	24
11 JUN 03	[redacted]	IVF: LR 125cc/o	05	[redacted]													
			17	[redacted]			D/C 13 June @ 1100										
11 JUNE	[redacted]	MEDS - ANCEF 1gm	04	/	[redacted]												
		IVPB Q 8°	12	[redacted]													
			20	[redacted]													
11 JUNE	[redacted]	GENTAMICIN 400mg	13	[redacted]			D/C 13 June @ 1000										
		IVPB Q DAY															
11 JUNE	[redacted]	O2 to maintain POX	05	[redacted]													
		>95%	17	[redacted]													
13 June	[redacted]	NS @ 100cc/hr	05	/	/	[redacted]											
			17	/	/	[redacted]											
13 June	[redacted]	Cipro 400mg IVPB q 12°	10	/	/	[redacted]											
			22	/	/	[redacted]											

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: S/P EX LAP

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO. _____

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

All: (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 06 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 Jun	[redacted]	MSO4 2-4mg IVP	3mg IVP 11 Jun 1515	3mg IVP 11 Jun 1830	2mg IVP 11 Jun 2210	2mg IVP 11 Jun 0115	3mg IVP 12 Jun 0500	4mg IVP 12 Jun 1100	3mg IVP 12 Jun 1500	3mg IVP 12 Jun 2100	0.5mg IVP 13 Jun 0630	4mg IVP 13 Jun 0630	3mg IVP 13 Jun 1200	3mg IVP 13 Jun [illegible]	4mg IVP 13 Jun 1830	2mg IVP 14 Jun [illegible]
		Q3-4° PRN					12 Jun 2[illegible] 2mg	14 Jun 4mg 1030								
		~~FORTADOL~~														
11 Jun	[redacted]	Phenergan 25mg IV	25mg IVPB 2130													
		Q4-6° PRN														

USAPA V1.00

All: (b)(6)-2 except one (b)(6)-4 at bottom

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	14	15	16	17	18	19	20	21	22	23	24	25	26	27
14	[redacted]	IV Fluid LR @ 75cc/hr	5	/	[redacted]												
			13	[redacted]													
			21	[redacted]													
14	[redacted]	Ancef 1gm Q8° IVPB	04	/	[redacted]												
			12	100 ml													
			20	[redacted]													
14	[redacted]	Cipro 400mg IVPB Q12°	10	100 ml	[redacted]												
			22	[redacted]													
16	[redacted]	HL IV	5	/	/	/	[redacted]										
			13	/	/	[redacted]											
			21	/	/	[redacted]											
16	[redacted]	Cipro 500mg PO BID (c food)	08	/	/	/	[redacted]										
			18	/	/	[redacted]						/					
20 June 03	[redacted]	Keflex 500mg tab PO QID	6	/	/	/	/	/	/	/	[redacted]						
			12	/	/	/	/	/	/	/							
			18	/	/	/	/	/	/	/							
			24	/	/	/	/	/	/	/							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Dx S/P GSW to FLANK

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
14	[redacted]	MSO4 2-8mg IVP	0183 14Jun 4mg	25:31 14Jun	0828 15Jun	15Jun 2000 2mg	15Jun 2137	16Jun 0857								
		Q2° PRN PAIN	[redacted]	4mg	10mg	RDS	2mg	8mg								
							IV	IV								
14	[redacted]	Phenergan 12.5mg IVP														
		Q6° PRN PAIN														
16	[redacted]	Tylenol #3 1-2 tabs	16June 0900	16June 2200	1	17June 1700	1500 17June	3	15	2130 19Jun						
		q-4 tabs PRN pain	[redacted]	[redacted]	1	[redacted]	[redacted]			[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

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0530	INITIALS [redacted]	INITIALS	1700	INITIALS [redacted]
NEURO	PUPILS	reactive	(b)(6)-2		PERRLA, 3cm, (b)(6)-2	
	SENSORIUM	intact follows commands able to communicate pain.			Pt opens eyes & responds when spoken to. able to communicate pain & thirst.	
RESPIRATORY	RESPIRATORY PATTERN	unlabored, even			RR 20-24/bpm, unlabored, LS clear (B) to auscultation, ∅ secretions	
	BREATH SOUNDS	even				
	SECRETIONS	∅				
SKIN	COLOR	NL for race			normal for race	
	INTEGRITY	midline abd drsg (L) flank drsg.			midline abd DRSG. (L) flank DRSG.	
IV SITE	LOCATION	(R) AC			(R) AC patent intact S S/S inf / infiltration	
	CONDITION	patent intact.				
GASTRO	ABDOMEN	NT Soft.			NT, ND, hyperactive BSX 4 quads	
	BOWEL SOUNDS	absent BS				
GU	URINE: COLOR/CLARITY	blood tinged suprapubic catheter in place. draining g.s. —			blood tinged urine - suprapubic catt. in place.	
CARDIOVASCULAR	CARDIAC RHYTHM	S_1S_2 ∅ ectopy —			S_1, S_2, ∅ ectopy. Sinus rythym.	

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC [redacted] (b)(6)-2

DATE 12 JUN 03

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

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Lne																		
BP Cuff		144/97	144/94	142/96		125/91	136/91	144/91		142/95	146/96		135/93	137/93	136/90		139/89	
Temperature						99.5	–	–		–	–		99.2	–	–		99.6	
Pulse		100	101	103	105	107	102	104		99	108		110	110	114		112	
Respiratory Rate		26	26	24	24	24	22	22		20	20		22	22	20		22	
O2 Sats		98%	97%	98%	97%	97%	98%	99%		97%			96%	96%	97%		96%	
O2		2L	2L	2L	2L	2L	2L	2L		2L	2L		1.5L	1.5L	1.5L		1.5L	
pain																		
sitter																		

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR		125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1000
IVPB														50	100			150
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL		225/225	200/425	200/625	250/875	50/975				750/1725		400/2125					
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	134/87	135/88	134/88	132/88	136/91	140/86	149/98	152/104	
	120	124	119	118	114	115	109	109	
	22	22	20	22	24	24	20	24	
	95%	96%	96%	96%	94%	95%	98%	94%	
	1.5L	1.5L	1.5L	1.5L	1.5L	2L	2L	2L	

INTAKE	16	17	18	19	20	21	22	23	8° T
	125	125/250	125/375	125/500	125/625	125/750	125/875	125/1000	1000
							50		50

OUTPUT									
	600/1925	425/3150	125/3275	50/3320	110/3430	115/3545	250/3795	205/4000	4000

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GAS	A: pH									
	A: PCO_2									
	A: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

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

DAILY ACTIVITIES DOCUMENTING	TIME	1800		
	MOUTH CARE	[redacted]		
	BATH	(b)(6)-2		
	SKIN CARE			
	FOLEY CARE			
	TRACH CARE			
	ROM EXERCISES			

TURN	TIME				
SUCTION					

24°I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	3000	Urine:	
po	200		
TOTAL	3200	TOTAL	4000

BALANCE -800

NURSE'S SIGNATURE	INITIALS
[redacted]	
(b)(6)-2s	

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89 (b)(6)-2

INITIAL SHIFT ASSESSMENT

	TIME	0500 INITIALS [redacted]	(b)(6)-2 INITIALS	1700 INITIALS [redacted]
NEURO	PUPILS	Perrla		3cm Perrla, Pt alert
	SENSORIUM	intact. able to		able to vocalize pain,
		communicate pain.		thirst, follows simple
		follows simple commands		commands.
RESPIRATORY	RESPIRATORY PATTERN	unlabored even		Even unlabored.
	BREATH SOUNDS	CTA		Equal rise/fall.
	SECRETIONS	0. No tube to LTS.		clear BS (B).
SKIN	COLOR	Nl for race		NFR, abd & (D) flank
	INTEGRITY	abdominal & (D) flank		DRSG.
		drsg		
IV SITE	LOCATION	(R) AC		(R) ac, patent &
	CONDITION	patent & intact infusing		intact - LR @ 100cc/
		LR 5 difficulty -		hr 5 s/s inf/infil
GASTRO	ABDOMEN	Soft nontender		NT, ND, BS noted
	BOWEL SOUNDS	hyperactive noted -		x 4 quads, hyperactive
GU	URINE:	Supra pubic catheter		Suprapubic Cath.
	COLOR/CLARITY	in place draining tea		in place draining
		colored blood tinged urine		bloody/tea colored urine c
CARDIOVASCULAR	CARDIAC RHYTHM	S1 S2 & Ectopy -		clots.
				S1, S2, Sinus rythm.

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

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC [redacted] (b)(6)-2

DATE 13 June 03

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

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff	149/98	152/104	149/98	130/98	140/85	141/93	134/86			123/82	124/93		124/86	127/83	127/73		127/78	
Temperature							100°						99.8	–	–		–	
Pulse	110	111	105	104	106	105	102			107	107		103	107	102		104	
Respiratory Rate	20	24	22	20	24	20	20			18	20		20	20	18		22	
SpO2	98%	95%	98%	97%	95%	97%	97%			96%	97%		97%	98%	97%		97%	
	2L	2L	2L	1.5L	1.5L	1.5L	1.5L			1.5L	1.5L		1.5	1.5	1.5		1.5	
gain																		
intervention																		

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR	125	125/250	125/375	125/500	125/625	125/750	125/875	125/1000		125/1125	125/1250	125/1375	100/1475	100/1575	100/1675	100/1775	100/1875	
IVPB					50								200	50				
TOTALS																		

OUTPUT

		TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE		HOUR / TOTAL	175/175	175/350	50/425	300/625	125/750	100/850	200/1050			400/1450	200/1650		200/1850			500/2350		
		sp gr																		
		S/A																		
NG		OUTPUT						100				30								
		pH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	116/77	125/83	127/85	128/87	134/84	129/84	128/78	122/80	
			100.2	100.0		99.6			
	100	107	103	103	95	95	91	90	
	22	20	20	20	20	20	20	20	
	95%	97%	98	97	99	98	98	97	
	1.5	1.5	1.5	1.5	1.5	1.0	1.0	1.0	

Cultured Dr

INTAKE	16	17	18	19	20	21	22	23	8° T
	100/1875	100/1975	100/2075	100/2175	100/2275	100/2375	100/2475	100/2575	2575
						50	200		250

OUTPUT	16	17	18	19	20	21	22	23	
	200/550	300/850	200/1050	100/1150	125/1275	125/1400	200/1600	150/1750	3950

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
	A: pH									
	A: PCO_2									
	A: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

LABORATORY	TIME	0400								
	GLUCOSE	193								
	Na/K	111/4.1								
	Cl/CO_2	100/28								
	BUN/Cr	11/.5								
	WBC/PLATELET									
	Hct/Hgb									
	CPK	544								

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

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	2825	Urine:	
po	175		
TOTAL	3000	TOTAL	3950
BALANCE	950		

NURSE'S SIGNATURE — INITIALS

[redacted] 97

[redacted]

(b)(6)-2

all: (b)(6)-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)* QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0530	INITIALS [redacted]		INITIALS		INITIALS
NEURO	PUPILS	PERRLA					
	SENSORIUM	intact, follows command					
		communicates pain —					
RESPIRATORY	RESPIRATORY PATTERN	even unlabored					
	BREATH SOUNDS	CTA					
	SECRETIONS	Ø —					
SKIN	COLOR	NL for race					
	INTEGRITY	abd + (c) Flank drsg.					
		bruising on arms & upper (L) thigh					
IV SITE	LOCATION	(R) AC					
	CONDITION	patent / intact					
GASTRO	ABDOMEN	staples intact. NT, soft					
	BOWEL SOUNDS	hyperactive.					
GU	URINE:	Blood tinged tea colored					
	COLOR/CLARITY	Suprapubic catheter					
		in place					
CARDIOVASCULAR	CARDIAC RHYTHM	S, S_2 Ø gallops					

LEGEND

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

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted]

DEPARTMENT/SERVICE/CLINIC [redacted]

DATE 4 June 03

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line	117/83																	
BP Cuff	123/83	122/99	125/81	124/86	132/86	134/80	124/82	133/82		140/83	127/82	124/80		132/80	124/75	123/77	127/81	
Temperature							99.4	✓		—	—			—		✓	✓	
Pulse	90	87	93	96	98	96	98	98		95	93	96		92	93	93	94	
Respiratory Rate	20	22	20	24	24	20	20	20		20	20	22		22	20	20	20	
SpO2	97	97	98	97	94	96	97%	97%		99%	98%	99%		95%	96%	96%	97%	
	1L	1L	1L	~~0L~~	~~0L~~	~~0L~~ 2L	1L	1L		1L	1L	1L	1L	.5L			.5L	
pain																		
intervention																		

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR	100	100/200	100/300	100/400	100/500	100/600	100/600	100/700		100/800	100/900	100/1000	100/1100	100/1200	100/1300	100/1400	100/1500	
IVPB				50								50	100					
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL	150/150	150/300	150/450	150/600	300/900							1000/1900					
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	

INTAKE	16	17	18	19	20	21	22	23	8° T
	100/1500								

OUTPUT									
	1000/2900								

ACUITY LEVEL CLASSIFICATION

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

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

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

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	_____	Urine:	_____
po	_____		_____
	_____		_____
TOTAL	_____	TOTAL	_____

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	
(b)(6)-2	

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1200	INITIALS [redacted]	1730	INITIALS [redacted]		INITIALS
NEURO	PUPILS	Appears - drowsy easily aroused, see intact.		pupils 3mm Bilat equal and reactive; drowsy, opens eyes spontaneously;		(b)(6)-2	
RESPIRATORY	RESPIRATORY PATTERN	unlabored, even		BS CTA; unlabored;			
	BREATH SOUNDS	CTA					
	SECRETIONS	Ø					
		NG Tube in place					
SKIN	COLOR	WL for race		Normal for race;			
	INTEGRITY	see progress note		See note for wound assessment;			
I.V. SITE	LOCATION	in R AC		RAC intact;			
	CONDITION	patent + intact		Site normal;			
GASTRO	ABDOMEN	NT, soft		NT, Soft; Bowels			
	BOWEL SOUNDS	hyperactive		Sounds hyperactive;			
GU	URINE: COLOR/CLARITY	Foley draining blood tinged urine —		Foley; Tea colored; hgb quantity Sufficient;			
CARDIOVASCULAR	CARDIAC RHYTHM	Ø ectopy. BP slightly elevated.		ST & ectopy;			

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 2 east

DATE

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

EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

(b)(6)-4

CPW

#[redacted]

DATE	DX													HOSPITAL DAY				
VITAL SIGNS — TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff														138/89	131/86	133/88	131/82	
Temperature														99°	–	–		
Pulse														106	106	107	108	
Respiratory Rate														20	22	20	20	
Sats														95%	94%	98%	96%	
O_2															2L	2L	2L	
pain																		
intervention																		
INTAKE — TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVPB															50	100		
LR															125	125	225	
TOTALS																		
OUTPUT — URINE — HOUR / TOTAL															400		750/1150	
URINE — sp gr																		
URINE — S/A																		
NG — OUTPUT																		
NG — pH																		
NG — GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
			128/84	136/88	142/94	138/94	144/92	142/90	140/98
	130/82		100 8				100 2		
	100°		108	112	106	104	102	107	103
	98		98	98	96	98	98	96	90
	97%		96%	97%	96%	96%	97%	98%	98%
	2L		2L	2L	2L	2L	2L	2L	2L

INTAKE	16	17	18	19	20	21	22	23	8°T
							50		50
	125	125	125	125	125	125	125	125	125 1000

OUTPUT									
			600	300 800	300 1100	300 1400	300 1700	100 1800	275 2075

ACUITY LEVEL CLASSIFICATION

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

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

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

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL	1575	TOTAL	3225

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	
(b)(6)-2	

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (b)(6)-2	2. MTF LOCATION (State or Country Code.)
[redacted]	T Z

3. REGISTER NUMBER (b)(6)-4	NAME (Last, First, Middle Initial) (b)(6)-4	4. PAY GRADE	5. SEX
[redacted]	EPW [redacted]		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	[redacted] 4	Z	9	unk

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	9 9 (b)(6)-4	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS (b)(6)-4
N/A	U	1030	N/A

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	[redacted] (b)(6)-4	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICU	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(6)-2		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
5 0		0 3 0 6 2 1

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A B A A		0 3 0 6 1 1

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

FOR LOCAL USE

DX: S/P Ex Lap

Inj 443 | Trauma 1

Dx: 566.10, 959.11, 868.11, E991.2

Proc: 54.11, 87.73, 87.79, 87.44, 89.52

ADMITTING OFFICER [redacted] (b)(6)-2 | SIGNATURE OF ADMITTING CLERK [redacted] SPC

DA FORM 2085, MAR 80

INPATIENT TREATMENT RECORD CO SHEET

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

1. REGISTER NUMBER [redacted] (b)(6)-4			2. NAME (Last, First, MI) EPW [redacted] (b)(6)-4		3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE [redacted]	6. RACE Z	7. RELIGION unk	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION No
11. FMP 99		12. SSN [redacted] (b)(6)-4		13. ORGANIZATION N/A		14. WARD ICW2
15. FLYING STATUS N/A	16. RATING/ DSG	17. DEPT./ BEN K79	18. BRANCH/CORPS N/A	19. UIC/ZIP		20. TYPE CASE N/A

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER

22. HOURS OF ADMISSION: 2041

23. CLINIC SERVICE:

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —

25. TYPE DISPOSITION: 50

26. DATE OF DISPOSITION: 18 Jul 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —

27b. TELEPHONE NO.: —

28. DATE OF THIS ADMISSION: 11 Jun 03

ADMITTING OFFICER: (b)(6)-2 Dr. [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] (b)(6)-2

30. DATE OF INTIAL ADMISSION:

32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED:

31. SELECTED ADMINISTRATIVE DATA

33. CAUSE OF INJURY

☐ Check if Continued on Reverse

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Mandible Fx

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	39	39

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	39	39

SIGNATURE [redacted] ING MEDICAL OFFICER (b)(6)-2 (b)(6)-2 Dr. [redacted]

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted] (b)(6)-2

DA [redacted]

EDITION OF 1 AUG 76 IS OBSOLETE

USAPPC V1.10

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

(b)(6)-4 [redacted] YOIM EPW presents c̄ trauma to neck and face. Pt has stab wound on upper back that has been sutured. Pt c̄ upper extremity and chest contusions. Pt was attacked (per translator) by a * theif 3 days ago.

PMH: denies
PSH: denies
meds: denies
aller: NKDA

VS: BP 120/60 P96 RR 20 temp 98.5

141	107	15
3.7	23	1.1

<106

10.5 > 9.5 / 30.4 < 261

PHYSICAL EXAMINATION

(B) Periorbital ecchymosis + edema
(L) lower jaw pain and neck pain @ left [redacted] (b)(6)-2 mand angle
Occlusion not repeatable
mandibular ecchymosis
Pt c̄ wounds on his back closed previously +
U.E ecchymosis
Plain films show left [redacted] mandibular angle fracture (b)(6)-2

PROGRESS (Enter date of discharge and final diagnosis)

1) Plan to admit to ICW 2
2) will take to OR in am for closed reduction of mandible fx.

SIGNATURE OF PHYSICIAN | DATE | IDENTIFICATION NO. | ORGANIZATION

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

[redacted] (b)(6)-4

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

539-106

[redacted] (b)(6)-4

MEDICAL RECORD | **PROGRESS NOTES**

AUTHORIZED FOR LOCAL REPRODUCTI

DATE	NOTES
6.11.03 2100	Pt. to ICW #2 from EMT via litter. Pt. stood's tx to cot c̄ min. assist. Locking restraints applied x2. LR @ 120cc/hr. Pt. NPO for surgery in AM. PERRLA, periorbital ecchymosis. Edema to face noted. Ø swelling noted in post. palate. Ø drainage from eyes, ears, or nose. Mult. contusions to arms, back noted. Pt. tender to Palpation. Dsng to middle of back CDI covering stab wound c̄ 1 suture. Pulses 2+ x4 ext. Brisk cap refill. HR Reg, Lungs CTA, but pt. c/o pain c̄ inspiration. ABD soft, nontender c̄ BS⊕ x4. VSS. Will continue to monitor. (b)(6)-2 [redacted]
12 Jun 03	0515: Assumed pt. care @ 0500. Pt. A+O x3. Lungs CTA. Pulses palpable x4. ⊕ BS x4. HOB ↑ 30° c̄ pt laying on ⓡ side. Ø drainage noted from mouth, nose or ears. Dsng on back CDI. IV NS infusing in ⓡ hand c̄ s/s infiltration. Will continue to monitor. (b)(6)-2 [redacted] 9mm
12 Jun 03 2045	Assumed care @ 1300 - VSS - jaw wired shut, wire cutters @ bedside - interp. elec. explained the wires & that the pt. would eat c̄ a straw - IV

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

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

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

[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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES (b)(6)-2
12 Jun cont.	patient - pt. was able to drink broth & jello for dinner. Difficulty [redacted]
12 June 03 (2330hrs)	Assumed care of pt @ 2100hrs. VSS. Jaws remained wired shut c̄ wire cutters present @ the bedside. Suction machine & yankauer available @ the bedside, but not being used @ present. Tolerated 1 can ensure @ 2200hrs via straw. Lungs CTA abd soft, flat c̄ bowel sounds throughout all quads. No c/o pain or discomfort. IV NS @ 120cc/h infusing through (R) forearm. Resting comfortably now. Will continue to monitor during the night. [redacted] CPT/AN (b)(6)-2
12 Jun 03 @0726	Pt sitting in bed. 3 complaints. slurry + arch bars stable.
	VSS AF
	CV RRR
	lungs CTA
	abd soft NT ND (+) BS
	ext ⊕ c/c/c
	A/P mandible fx
	(1) Plan to d/c to mp custody today [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

MEDICAL RECORD

AUTHORIZED FOR LOCAL RE

PROGRESS NOTES

DATE	NOTES
12 jun 03 @1100	OMFS Brief OP NOTE

Pre OP dx: mandible fx [redacted] angle (b)(6)-2
Post op dx: Same
procedure: closed reduction of mandible fx
Surg: [redacted]
Assist: [redacted] (b)(6)-2
Anesth: [redacted]
EBL: min
fluids: 500 cc NS
comp: none
Cond: Stable extubated & transferred
5 event.
[redacted] (b)(6)-2

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

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

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

REGISTER NO. | WARD NO. ICW2

[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

MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCTIO

DATE	NOTES
13 Jun 03	Assumed care of pt @ 0500. Pt is awake looking around. Pts face is still swollen. Lungs CTA. Bowel sounds x 4 quads. Pt's IV has been d/c'd. Pt is now crushed po meds. Pt has no c/o pain/discomfort @ this time. Will continue to monitor. [redacted] (b)(6)-2
1800	Assumed care @ 1300. VSS. 4 x 3 Jaw wired shut. wire cutters @ Bedside. TOL Full liquid Diet well. Ø c/o pain. O/W assessment WNL. Will Monitor [redacted]
2135:	Pt. stable. Jaw wired shut, wire cutters @ B.S out of Pt. reach. Edema noted to face. HR Reg, Lungs CTA ~~X~~ insp. ronchi noted @ UL ant. aw. BS (+) x4. ABD soft. will cont. to monitor. (b)(6)-2 [redacted] / CTA/AN.
14 June 03	0045 Assume pt care @ 0500. Pt awake. no c/o pain. Swelling noted to face around jaw. PERRLA, eyes black/blue (B). Jaw [redacted] (b)(6)-2 wired shut, wire cutters @ bedside VSS. HR regular. Lungs CTA. HOB @ 30°, U/L ext Free ROM. pulses palpable x4. Will continue to monitor. [redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO. ICW 2

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14 June 03 1330	assumed pt care @ 1300. VSS. pt awake & alert. Black & blue eyes bilat, swelling noted to face. jaw wired shut c̄ wire cutters @ bedside. lung sounds CTA, abd round soft nondistended. BS present. full ROM to ext strong ⊕ pulses x 4. pt denies pain @ this time. Will cont to monitor — [redacted] (b)(6)-2 RWM
2210:	HR Reg, Lungs c̄ insp. ronchi bilateral ul anteriorly. BS ⊕ x4. PERRLA. Jaws wired shut, cutters @ BS. Edema ↓ from yesterday. Will cont to monitor. — [redacted] (b)(6)-2
15 June 03 0530	Assumed pt care @ 0500. Pt. awake, A+O x3, with lungs CTA. ⊕ pulses x4 ⊕ BS x4. Jaw wired shut, ∅ signs of difficulty noted. Denies any discomfort @ this time. Wire cutters @ bedside. [redacted] (b)(6)-2
15 Jun 03 1900	assumed care @ 1300 - VSS - pt. tolerated blended thin & strained diet - ambulated x 10 minutes & did personal hygiene @ sink - no c/o pain @ this time — [redacted]
15 Jun 03	Pt doing well s/p closed reduction of mand fx, VSS AF ∅ c/o pain, tolerating PO continue care. [redacted] (b)(6)-2
2240.	VSS. HR Reg, lungs CTA, BS ⊕ x4. Jaws wired shut - wire cutters @ BS. Will continue to monitor. — [redacted] LATA

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16 Jun 03	0800 - Pt alert very cooperative. VSS, lungs CTA HR Reg. Jaws wired shut, cutters at bedside. Some bruising & edema to face. Dsg on backside to small area, CDI. Oral Care done. Voicing no complaints. Will cont. to monitor — [redacted] (b)(6)-2 24 AN
16 Jun 03 @ 0930	OMFS Pt stable s/p CR mand fx doing well VSS AF continue current care
16 June 03 1315	Pt vitals taken BP 110/80, P-82 R-16 Temp 98.8 SPC [redacted] (b)(6)-2
1600	assumed care of Pt @ 1300. VSS, A+O x 3, W/ wire cutters @ bedside. Pt tol DIET. 8 c/o pain. Ambulate w/ assistance. O/W assessment WNL. Will MONITOR — [redacted] (b)(6)-2
2300	Assumed pt care @ 2100. VSS, A+Ox3. Lung sounds CTA, pulses palpable x4, bowel sounds hypoactive. Dsg on back CDI. Oral area is clean, Jaw wired shut with wire cutters @ bedside, no complaints at this time, will continue to monitor. SPC [redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	CMPS PM
17Jun03 @0700	Pt doing well s/p c/k of manual fx. no c/o VSS AF Continue current care (b)(6)-2 [redacted] MMO/SC
17Jun03	1024- Pt alert sitting comfortable in bed. VSS Lungs clear, BS⊕, HR regular. Jaws wired shut c̄ wire cutters at bedside. Voicing ∅ complaints at this time. Will cont. to monitor. (b)(6)-2 [redacted] 2Lt ANC
17Jun03 1320	Pt vitals taken. BP 120/68, P. 76, R. 18 Temp. 98.2 SPO [redacted] (b)(6)-2
17Jun03 1400	assumed pt care @ 1300. VSS. Pt awake & alert assessment findings WNL. Bruising noted around both eyes. BLE & BUE c̄ full ROM strong ⊕ pulses. IV access noted. Jaw wired shut, wire cutters @ bedside. pt c/o pain, ⅋ Tylenol #3 given per prn orders. will cont to monitor (b)(6)-2 [redacted] 9/WNL
2200	Pt. care assumed @ 2100. Pt. alert, c/o being dizzy, denies pain. Pt c/o itching to back. YYY dsng to back removed & skin care provided. Bandaid applied to small open are ⊕ of spine, ~~centra~~ thoracic region. Suture to back now CTA c̄ ∅s/s infection. HR Reg, Lungs CTA, BS⊕ XY. Jaws wired shut, cutters @ BS. will cont. to monitor [redacted] (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	
1145	Assumed care of pt @ 0500. Pt is now awake
18 Jun 03	and alert. Lungs CTA. Bowel sounds x4 quads.
	Cap. refill less than 3 sec. Pt's mouth is wired
	shut. Swelling is gone. Pt. (R) eye has a broken
	blood vessel. Pt has no c/o pain/discomfort @ this
	time. Will continue to monitor. — [redacted] 91WM6
18 June 03	Pt vitals taken. BP 108/60, P. 90, R. 20 (b)(6)-2 Temp. 98.4
1300	— SPC [redacted] (b)(6)-2
18 June 03	assumed pt care @ 1300. VSS. pt awake & alert.
1320	assessment findings WNL. jaw wired shut, wire
	cutters @ bs. (0) complaints voiced @ this time. Will
	cont to monitor — [redacted] 91WM6
2130	Pt care assumed @ 2100 VSS, pt awake and alert w/o complaint (b)(6)-2
	at this time. Lungs CTA, pulses x4, bowel sounds present x4 quads.
	Pt c̄ jaws wired shut + cutters @ bedside. Ø swelling, irritation
	or pain noted, will continue to monitor. SPC [redacted] (b)(6)-2 91WM6
19 June 03	Assume pt care @ 0500. pt asleep, easy to
0600	awake for assessment. VSS. All regular. Lungs CTA
0650 T 97.0	throughout. Abd soft - BS x4 active. Full ROM to
P 56	U/L extremities. Mouth wired shut. Wires intact.
R 14	wire cutters @ bedside. No c/o pain. Will
BP 98/60	Continue to monitor. — [redacted] 91WM6
98%	(b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

[redacted]

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
19 June 03 1345	assumed pt care @ 1300. VSS pt awake & alert HOB ↑ 30°. lung sounds CTA, abd soft nontender BS ⊕, BLE & BUE ⊂̄ full from strong ⊕ pulses. ⊖ IV access noted. pts jaw wired shut, wire cutters @ bedside. ⊖ ⊂̄ broken blood vessels. pt denies pain or discomfort @ this time. Will cont to monitor — [redacted] (b)(6)-2 9 WMC
19 June 03	Pt doing well s/p closed reduction of mandible. continue current care [redacted] (b)(6)-2
20 Jun 03 0800	Pt care assumed @ 2100 - VSS, alert and awake, no c/o pain throughout shift. Lungs CTA, pulses palpable x4, bowel sounds present x4 quads. ⊕ eye ⊂̄ broken blood vessel, no pain noted. Pts jaw wired shut ⊂̄ wire cutters @ bedside. No complaints at this time, will continue to monitor. SPC [redacted] (b)(6)-2 9 WMC
20 Jun 03	0845 - Pt alert OOB x1 VSS, lungs CTA, HR reg, BS⊕, Jaws wired shut ⊂̄ cutters at bedside. Voiding ⊖ complaints. Will cont to monitor [redacted] (b)(6)-2
1430	Assumed care @ 1300. VSS, A+O x3 ⊖ c/o pain jaw wired shut, wire intact. TOL BST Diet. d/w assessment. Will monitor [redacted]
20 Jun 03	Pt doing well s/p closed reduction of mandible. continue current care [redacted] (b)(6)-2
20 June 03 2145	Pt. vitals taken BP 110/70, P. 72, R. 20, Temp. [redacted] (b)(6)-2

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PROGRESS NOTES

DATE	
6.20.03	2200. Pt. VSS, Alert, compliant c̄ care. HR Reg, lungs CTA, BS (+) x4. Jaw wired shut, wire cutters @ BS out of reach of pt. Will cont. to monitor. (b)(6)-2 [redacted] /CT/AN
21Jun03 0915	Pt. asleep in bed easily aroused by verbal stimuli. VSS: BP 99/60, P53, T97.8, Sats 98%. Pt. c̄ any apparent complaints @ this time. All assessment findings WNL. Pt. jaws wired shut, gums c̄ signs of infection, teeth clean. Will continue to monitor. — [redacted] CT/AN (b)(6)-2
21Jun03 @0810	Pt doing well S/P CR of mand fx. 12Jun03 VSS AF & NF Stable. CN DRR lungs CTA (B) Abd Soft NT ND (B) BS eat/ambulated. continue current care. [redacted] (b)(6)-2
1315	Assumed care of Pt @ 1300. VSS. A+O x 3. Jaw wired shut wires intact. TOL BTS diet well. Ø c/o pain. O/W Assessment WNL. Will Monitor. — (b)(6)-2 [redacted]
21Jun03 21:55	Rec'd pt @ 21:00 VS WNL. Pt sleeping easily awakened. PERRLA (+) WNL. Skin W/D LCA (+). BS (+) x4. (+) PPPB. Jaw wires intact. Ø C/O's will mon [redacted] CT/AN (b)(6)-2
22Jun03 0100	Pt. sleeping in bed easily aroused by verbal stimuli. VSS: BP 95/65, P51, Sats 99%, T 98.8. Gums c̄ signs infection. All other assessment findings WNL. Pt. c̄ complaints @ this time. — [redacted] CT/AN (b)(6)-2
22Jun03 @1550	Pt doing well. S/P C/R of mand fx. 12 Jun 03 VSS AF & NF Stable. Continue current care [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	
22 Jun 03 2030	assumed care @1300 - VSS - no c/o pain - tolerating BTB's diet's difficulty - pt. ambulated this shift - [redacted]
2230	Pt. care assumed @ 2100. VSS. Pt given magazine to read. Wires intact, wire cutters @ BS. HR Reg, Lungs CTA, BS (+) x4. Will cont. to monitor. [redacted]
23 June 03	0640 pt care assumed @ 0500. pt asleep, easily awoke for assessment. no c/o pain @ this time. Jaw wired shut. Wire cutters @ BS. Wires intact. Pt ambulates w/ difficulty. Will continue to monitor. (b)(6)-2 [redacted]
23 Jun 03 @ 0835 (b)(6)-2 [redacted]	Pt asleep & arousable c̄ no c/o pain S/P CR wound pt (+) 12 Jun 03. [illegible] Stable pt tolerating blended diet. VSS AF CVRRR lungs CTA (+) abd soft NT ND (+) BS Continue current care. (b)(6)-2 [redacted]
1345	Assumed care of Pt @ 1300. VSS, AOx3. Mouth/Jaw wired shut, w/ wires intact. Ø c/o pain. Tol BTB diet well. Ambulates w/ assistance of W/C. (b)(6)-2 Will Monitor [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO. ICW2

(b)(6)-4

[redacted] EPW

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
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MEDICAL RECORD	PROGRESS NOTES
DATE	
24JUN03 0800	Pt care assumed @ 2100. A+Ox3, no c/o pain. Lungs CTA, pulses palpable x4, bs(+)x4 quads, pulses(+)x4. Jaws wired shut, wire cutters @ bedside. Pt w/o complaints will continue to monitor. (b)(6)-2 [redacted] 9LWMC
24JuneC3 0610	Assume pt care @ 0500. Pt awake and alert. No c/o pain. ~~Mouth~~ [redacted] wired shut, wire cutters @ BS. wires intact. VSS. Lungs CTA, Abd soft BS x4 active. Will continue to monitor. (b)(6)-2 [redacted] 9LWMC
24JunC3 1445	assumed care @1300 - VSS - no c/o pain @ this time - wire cutters @ bedside - ambulated this shift (b)(6)-2 [redacted] CBA
24JunC3 2220	Pt care assumed @ 2100. VSS, alert and awake, no complaints at this time. Lungs CTA, BS(+)x4, pulses(+)x4, wire cutters @ bedside, will continue to monitor. (b)(6)-2 [redacted] 9LWMC
25June 03	0615 Assume pt care @ 0500. Pt awake and alert. Jaw wired shut - wires intact. Wire cutters @ bedside. VSS, Assessment WNL. Will continue to monitor - [redacted] 9LWMC
25JunC3 @0935	Pt doing well S/P CR of mand fx. (b)(6)-2 VSS AF Continue current care (b)(6)-2 [redacted] MAJ/DOC
1430	Assumed care of Pt @ 1300, VSS. A+Ox3. Wires intact Ø c/o pain. O/W assess WNL. Will monitor [redacted] (b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO. 6CW2

CPW

[redacted] (b)(6)-2

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
2300	Pt care assumed @ 2100. VSS, ø pain. Wires intact,
25Jun	assessment WNL. Will continue to monitor [redacted] (b)(6)-2 914 JMG
26 Jun	Assumed care of pt @ 0500. Pt is awake. Pt was mistakenly on the list to leave. May [redacted] had pt brought back. Lungs CTA. Bruised wounds of quads. Pt has had ø % pain or discomfort @ this time. [redacted] (b)(6)-2 LPN-SGT
26Jun03	assumed care of pt. @ 1300 - VSS - wire
1540	cutters @ bedside - ambulated this shift
	no % pain @ this time - bruising on eyes
	fading [redacted] (b)(6)-2 CPT AN
2235	Pt. care assumed @ 2100. VSS. Pt. alert & cooperative
	c̄ care. HR Reg, Lungs CTA, ABD soft c̄ BS ⊕ x4.
	Jaws wired shut. HOB @ 30°. wire cutters @ BS # 8. (b)(6)-2
	Pt. has ø complaints. Will cont. to monitor [redacted] 2LT AN
27Jun03	1100 - Pt alert OOB x1. VSS, lungs CTA, HR Reg,
	BS ⊕. Jaws wired shut c̄ cutters @ bedside.
	HOB 30°. Voiding ø complaints. Will cont.
	to monitor [redacted] (b)(6)-2 2LT AN
1400	Assumed care @ 1300. VSS. A+O. ø c/o pain. Wires
	intact. Upadhb. O/w assess WNL. Will Monitor [redacted] (b)(6)-2
27Jun03	Pt doing well s/p CR. Ofunnel pt.
	continue current care. [redacted] (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	
27 Jun 03 21:40	Pt. rec'd @ 21:00, Awake and alert. PERRLA (+). LCA (B). BS (+) x4 (+) PPP (B). Wires intact. ∅ complaints @ this time. Will cont. to mon. [redacted] (b)(6)-2 2LT/AN
28 Jun	Assumed care of pt @ 0500. Pt is sleeping - VSS. Lungs CTA. Bowel sounds x 4 quads. Pt has ∅ c/o pain/discomfort. Will continue to monitor. [redacted] (b)(6)-2 LPN-SGT
28 Jun 03	OMTS Pt doing well S/P closed reduction of mandible pt 12 Jun 03. VSMF stable continue current care. [redacted] (b)(6)-2
28 Jun 03 1930	assumed care @ 1300 - VSS - no c/o pain @ this time - drinking only C/B, juice & milk for meals, encouraged pt. to drink ensure & dinner, he refused. [redacted] (b)(6)-2 CPL AF
28 Jun 03 21:41	Pt rec'd @ 21:00. Sleeping in bed. ~~Fair~~ easily awakened. Restraints x 2 (B) wrist (L) ankle. Skin PWD. LCA (B). BS (+) x4. (+) PPP (B). wires intact. ∅ c/o pain @ this time. ∅ PIV access. will cont. to mon. [redacted] (b)(6)-2 2LT/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)*

REGISTER NO.

WARD NO. ICW2

ePW

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
29 June 03	Assumed pt. care @ 0500. Pt. awake. A&O x3.
0700	(+) pulses x4, (+) BS x4. lungs CTA. Denies any discomfort @ this time. Will continue to
0000 T96.1	monitor. (b)(6)-2 [redacted] Slaunt
P57	1500. Assumed care of Pt @ 1300. VSS. A&O x3. Ø c/o pain
R16	wires intact. O/W assess. WNL. Will continue
BP90/60	(b)(6)-2 [redacted]
99%	2300. Pt care assumed @ 2100. VSS. HR Reg, Lungs CTA, ABD soft & BS (+) x4. Jaws wired shut, wire cutters @ BS. Will cont. to monitor. (b)(6)-2 [redacted] LTAN
30 Jun 03	0840 - Pt alert lying in bed. VSS, lungs CTA, HR reg, BS (+). Jaws wired shut & cutters at bedside. Voiing ø complaints. Will cont to monitor [redacted] (b)(6)-2 [illegible]
30 Jun 03	Pt doing well s/p C/Pr, ORIF mandible pt on 12 Jun 03. VSS AF vsnf stable. continue current care. (b)(6)-2 [redacted]
1500	Assumed care of Pt @ 1300. VSS, A&O x3. Wired shut jaw, wires intact. Tol BS & sounds. Ø c/o pain. O/W Assessment WNL. Will cont to monitor [redacted] [illegible]
2125	Pt. care assumed @ 2100. Pt alert & cooperative. (b)(6)-2 HR reg, Lungs CTA, ABD soft & BS (+) x4. Jaws wired shut & wire cutters @ BS #8. Will cont. to monitor. [redacted] (b)(6)-2 [illegible]

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:DICAL RECORD

PROGRESS NOTES

DATE | NOTES

Jul 03 OMFS

Pt S/P CR of wound f/t 12 Jun 03
doing well & C/O tolerating PO
VSS AF
CNRRR
lungs CTA(B)
abd soft NT ND (+)BS
ext ¢ c/c/c
A/P S/P CR of wound f/t.
(1) continue current care. (b)(6)-2 [redacted]

1Jul Assumed care of pt @ 0500. Pt is awake and alert. Lungs CTA. Bowel sounds x 4 quads. Pt has ¢ c/o pain/discomfort. Will continue to monitor. (b)(6)-2 [redacted], 91WM6, SGT

1July03 assumed pt care @1300. pt AAOx3. VSS. lung
1530 sounds CTA, abd soft BS (+) x4 quads. ↓ & ↑ Ext c̄ full
rom (+) pulses. jaw wired shut, wire cutters @ bs. (1)
complaints voiced. Will cont to monitor — (b)(6)-2 [redacted] 91WM6 SGT

1July03 pt awake & alert, VSS, LCTA(B), (+)BS x4 quads.
@2215 abd: soft, ND, NTTP, good peripheral pulses.
wire cutters @ bedside. ¢ complaints
noted. Will cont to monitor — (b)(6)-2 [redacted] 91WM6 SPC

NSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID N (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.

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509

FIRST NAME	MIDDLE INITIAL	ID NUMBER

(b)(6)-2

NOTES

2 jun 03 @0910 OMFS POD #[redacted] (12 jun 03)

Pt doing well s/p CR of mandible fracture
Φ c/o pain. Archbars/IMF stable.
VSS/AF CV RRR lungs CTA(B) abd SOFT NT ND Φ BS
Continue current care

[redacted]

(b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	
2 Jul 0930	Assumed care of pt @ 0500. Pt sleeping. Lungs CTA. Bowel sounds x 4 quads. Pt has had Ø c/o pain/discomfort. Will continue to monitor. (b)(6)-2 [redacted], 91WM6, SGT
1310	Assumed care of Pt @ 1300. VSS. A+O x 3, c/o pain wires on jaw intact. TOL BTS DIET & ENSURE. O/AD Assessment WNL. Will cont to monitor (b)(6)-2 [redacted]
2 Jul 03 2237	Rec'd pt @ 21:00. Pt awake + alert in bed. Skin W/D. PERRLA (+) LCA (B). BS (+) x 4. (+) PPP (B)
3 Jul 03 @ 1020	OMFS POD # [redacted] (b)(6)-2 Pt lying in bed 5 c/o this AM VSS stable. VSS AF CVRRR lungs CTA (B) abd soft NT ND (+) BS A/P S/P CR mand pt doing well (1) continue current care (b)(6)-2 [redacted]
3 Jul	Assumed care of pt @ 0500. VSS. Lungs CTA. Bowel sounds x 4 quads. Ø c/o pain discomfort (b)(6)-2 [redacted], LPN, SGT
3 Jul 03 1400	assumed care @ 1300 - VSS - no c/o pain @ this time - tolerated BTS diet — [redacted] CRNA (b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO. FCW 2

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

PROGRESS NOTES
Medical Record

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

DATE	
3 July 03	2250 Assume pt care @ 2100. pt awake and alert. Wire cutters @ BS. jaw wired shut. wires intact. VSS. HR reg. Lungs CTA. BS x 4 active. pt ambs w difficulty. Pt c/o pain. Will continue to monitor [redacted] (b)(6)-2
4 July 03	
0600 96.5	4 July 03 Team Note
67	S & P at 22. Pain complaints
16	tolerating liquid diet
106/62	O: afebrile + normotensive
97%	
	A/P: S/P wire fracture of mandible fx
	(1) Continue care (b)(6)-2 [redacted] (b)(6)-2
4 July 03	1130 - Pt alert lying in bed. VSS, Lungs CTA, HR regular, BSO. Jaws wired i cutters at bedside. Voiding ∅ complaints. Will cont to monitor [redacted] (b)(6)-2 AN
4 July 03 1345	assumed pt care @ 1300. pt awake et alert. VSS assessment finds WNL. jaw wired shut, wire cutters @ bs. ∅ complaints voiced. Will cont to monitor - [redacted] (b)(6)-2 RWMC

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USAPPC V1.00

MEDICAL RECORD | PROGRESS NOTES | AUTHORIZED FOR LOCAL RE

DATE | NOTES

05Jul03 @0410 Received pt resting on bed. USS all SF 511 for details. Alert, LSCTAB, HRR, BS⊕x4. Wrs cuffed @ BS. Ø c/o pain this shift. Will cont to monitor.
[redacted] USN
(b)(6)-2

5 Jul 03
0550: T 96.8
P 70
R 18
B/P 98/70
SATS: 98%

OMFS PDD# [redacted] (b)(6)-2
STP C/R manual fit 3 c/o
VSMF stable tol liq diet
VSS AF
continue current care
5 Jul 03 @ 0725

[redacted] (b)(6)-2

3 Jul 03 0780 Assumed pt. care @ 0500. Pt asleep. Awake easily on verbal command. A+O x3. lungs CTA. ⊕ Pulses x4. ⊕ BS x4. wire cutters @ bedside. Ø complaints @ this time. [redacted] 9 Jun 6

1330 Assumed care of Pt @ 1300. VSS. A+O x3. JAWS WIRED SHUT. (b)(6)-2 TOL BTS diet ō ENSURE. Ø c/o PAIN. O/W assessment WNL. WILL CONT TO MONITOR
(b)(6)-2 [redacted] USN

05Jul Pt rec'd @ 21:00. Awake and alert in bed. Skin WD. VS 21:31 WNL per flowsheet. PERRLA⊕. LCA⊕. BS⊕x4. Ø c/o pain

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NO (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.

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509

FIRST NAME	MIDDLE INITIAL	ID NUMBER

@ this time wires intact & wire cutters @ bedside. Will cont. tomon. [redacted] RT/AN (b)(6)-2

6 July 03 0525 Assume pt care @ 0500. Pt awake and alert. No c/o pain @ this time. Jaw wired shut. wires intact. wire cutters @ BS. VSS. Assessment WNL will continue to monitor [redacted] (b)(6)-2 SWMP

1330 Assumed care of Pt @ 1300. VSS. A+O×3. Wires intact, cutters @ bedside. - c/o pain. O/W assessment WNL. Will cont to monitor [redacted] (b)(6)-2

6 JUL 03 21:20 Rec'd pt @ 21:00. Awake and alert in bed. VS WNL per flow sheet. Skin W/D. PERRLAO. LCA (B) BS (+) ×4. (+) PPP (B). Jaw wires intact. & c/o pain. Will cont. to mon. [redacted] RT/AN (b)(6)-2

7 July 03

(5) 0722 OMFS POD #[redacted] (b)(6)-2

600 96.5 pt S/P CR of mandible doing well & c/o
63 VSS AF & MF stable
14
100/60 continue current care
97% [redacted] (b)(6)-2

1200 - Pt alert resting in bed. Am care done. Adequate breakfast & lunch intake. Jaws wired shut & cutters @ bedside. Voicing no complaints at this time. Will cont to monitor [redacted] (b)(6)-2 JL+AN

AUTHORIZED FOR LOCAL REPRO

DICAL RECORD

PROGRESS NOTES

DATE	NOTES
7 Jul 03 2010	assumed care @ 1300 – VSS – wire cutters @ bedside – pt. tol. BTS diet – no c/o pain @ this time – (b)(6)-2 [redacted] CRNA
7 Jul 03 2120	Assumed pt. care @ 2100. VSS. Pt. A&O x 3. Lungs CTA (B), (+) BS x4. (+) Pulses x4. wire cutters @ bedside – ∅ complaints – [redacted] 9 Jul 03 (b)(6)-2
8 July 03 @ 0905	OMFS POD [redacted] (b)(6)-2 Pt doing well S/P CR of unand pt. no complaints tolerating PO diet (BTS).
0700 96.5 59 16 108/64 97%	VSS AF Continue current care. (b)(6)-2 [redacted]
	0930 - Pt alert lying in bed. VSS, lungs CTA, BS (+) x4. Jaws wired shut i cutters at bedside. Pulses (+). Voiding ∅ complaints. Will cont to monitor (b)(6)-2 [redacted] 7 Jul 03
2240	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA, BS (+) x4. Jaws wired shut, wire cutters @ B.S. Pt. c/o pain to Jaw motrin crushed & given. Will cont. to monitor. [redacted]

IONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID # (SSN or Other) (b)(6)-2
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) (b)(6)-4 [redacted]

REGISTER NO. | WARD NO. 2W2

EPW

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

TE	NOTES
July 03 0535	Assume pt care @ 0500. Pt awake and alert c/o pain to ⓛ side of jaw. percocet ÷ tab ordered and given @ 0345. No relief. Wire cutters @ BS. VSS. Will talk to MO about ordering PRN pain meds. Will continue to monitor [redacted] 9IWMC (b)(6)-2
9 July 03 @0930	OMFS POD [redacted] (b)(6)-2 Pt doing well s/p CR & mandpro ⓛ clopain OMF stable this place VSS AF continue current care [redacted] (b)(6)-2
9 July 03 1100	pt felt nauseous around 0900. Cool rag placed to forehead. Suction pt to BS. Phenergan ordered for any further N/V. pt resting now. (b)(6)-2 [redacted] 9IWMC
9 July 03 1300	Assumed pt care @ 1300. Pt awake & alert. VSS assessment findings WNL. Jaw wired shut, wire cutters @ bs. ⓛ c/o pain voiced @ this time. Will cont to monitor [redacted] 9IWMC (b)(6)-2

AUTHORIZED FOR LOCAL REPRO

DICAL RECORD

PROGRESS NOTES

DATE | NOTES

7-9-03 2245: Pt care assumed @ 2100 - VSS. HR Reg, lungs CTA, BS ⊕ x4. Jaws wired shut, wire cutters @ bedside. Will cont. to monitor (b)(6)-2 [redacted] (CTA)

10 July 03 0615 Assume care @ 0500. Awake and Alert. No c/o pain. Jaws wired shut. Wire Cutters @ bedside. Assessment WNL. Will continue to monitor [redacted]

0500 96.1 68 14 90/61 97%

OMFS POD # [redacted] (b)(6)-2 (b)(6)-2

Pt doing well s/p closed reduction of mandible fracture. no complaints

VSS AF

Continue current care (b)(6)-2

Plan to D/C wires in 2 wks. [redacted] (b)(6)-2

10 Jul 03 ~~assumed care @ 1300~~ [redacted]

1700 assumed care @1300 - VSS - no c/o pain @ this time - drinking only small amounts of BTS diet - does not want to walk for exercise (b)(6)-2 [redacted] CHRA

2300 Pt care assumed @ 2100. VSS, 94/13, no c/o pain. Pt drinking H_2O, wires intact with cutters @ bedside. Will continue to monitor. [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (b)(6)-2 | SPONSOR'S ID (SSN or Other)

LAST | FIRST | MI

UNIT 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. TCW 2

(b)(6)-4

ERW # [redacted]

PROGRESS NOTES
Medical Record

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

TE	NOTES
11 July 03	OMPS POD [redacted] (b)(6)-2
	pt doing well S/P CR Ophrand pt.
	S c/o this am.
0550 96.1	VSS AF
29	
16	Continue current care,
100/70	Plan to D/C wires in 2 wks. [redacted] (b)(6)-2
98%	
11 Jul	Assumed care of pt @ 0500. Pt asleep. VSS. Pt ambulated for 10 minutes. Lungs CTA. Abd soft and tender. Bowel sounds x4 quads. Ø c/o pain discomfort. Will continue to monitor — [redacted] CPN, SG
1350	Assumed care of Pt @ 1300. VSS. A+O x3. Jaw wires intact. Ø c/o pain. TOL BTS DIET. O/W (b)(6)-2 Assessment WNL. Will Monitor — [redacted]
2325	Pt. care assumed @ 2100. Jaws wired shut, wire cutters @ BS. HR reg, lungs CTA, BS (+) x4. will cont. to monitor — [redacted] LCTAN
2330	Pt. c/o constipation. Pt given SUPP — [redacted] LCTAN
12 Jul	Assumed care of pt @ 0500. Pt is asleep. (b)(6)-2 VSS. Lungs CTA. Bowel sounds x4 quads Ø c/o pain / discomfort @ this time. — (b)(6)-2 [redacted], 91WM6, SGT
1330	Assumed care of Pt @ 1300. VSS. A+O x3. Ø c/o pain. Wires to jaw intact. O/W Assessment WNL. Will Monitor — [redacted] (b)(6)-2

CAL RECORD (b)(6)-2 AUTHORIZED FOR LOCAL REPRO

PROGRESS NOTES

NOTES

12 Jul 03 POD # [redacted]

OMFS

Pt S/P CR of mandible for doing well
5 C/O. pt need to ambulate
more. continue current care
USS AR

[redacted] (b)(6)-2

2115 Pt. care assumed @ 2100. Pt. c/o ø pain @ this time.
Jaws wired shut, wire cutters @ B.S. HR Reg. lungs
CTA, BS ⊕ X4. will cont. to monitor. (b)(6)-2 [redacted] LCTAN,

13 Jul 03 @ 0520 Assumed pt care @ 0500: Pt. A+O x 3. VSS. lungs CTA
⊕ pulses x 4. ⊕ BS x 4. ø complaints. wire cutter
@ bedside. mouth wired shut. [redacted] S/W MG

(b)(6)-2

13 Jul 03 OMFS POD # [redacted] (b)(6)-2

Pt doing well S/P CR of mandible
fracture VSS stable continue
current care. (b)(6)-2 [redacted]

1435 Assumed care of Pt @ 1300. VSS. A+O x 3. Wires intact
TOL B75 diet. ø c/o pain. QW assessment [redacted] (b)(6)-2
will Monitor (b)(6)-2 [redacted]

SHIP TO SPONSOR

SPONSOR'S NAME [redacted]

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.

CPW (b)(6)-4

[redacted]

PROGRESS NOTES
Medical Record

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

TE	NOTES
13JUL03 2358	Rec'd c/o pt @ 21:00. Awake and alert in bed. Restraints x2 (R) ankle (L) wrist. PERRLA (+). Skin W/D. LCTA (B). BS (+) x4. (+) PPP (B) Jaw wires intact & c/os @ this time [redacted] CRT/AD
14JUL03 0530	Pt. awake & alert in bed. HR Regular, Lung sounds clear b/lat, bowel sounds (+) x 4 quads. Wire cutters @ bedside, restraints x2. Gums ⅋ s/s of infection. Pt. ⅋ complaints @ this time. [redacted] (b)(6)-2 (b)(6)-2 CRT/AD
	OMFS POD 4 [redacted] (b)(6)-2
14 Jul 03 @0715	Pt doing well S/P C/R O/ward pt. ⅋ C/O.
	VSS AF
	continue current care
	remove drains 2wks [redacted] (b)(6)-2
14JUL03 1930	assumed care of pt. @1300 - VSS - tol. BTS diet - pt. can be transferred to ASMC C wound closure tray if nutrition can be provided - no c/o pain - pt. ambulated to BR and back only this shift [redacted] (b)(6)-2
2115	Pt. care assumed @ 2100. HR Reg. lungs CTA BS (+) x Jaws wire shut. wire cutters @ foot of bed. HOB @ 30°. Pt. c/o pain will cont. to monitor. [redacted] (b)(6)-2 CRT/AD

MEDICAL RECORD | **PROGRESS NOTES**

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
15 Jul 03 @ 0700	OMFS POD # [redacted] (b)(6)-2 Pt doing well S/P CR of mand fx. Pt c stable OMF c no c/o, VSS AF continue current care
15 Jul	Assumed care of pt @ 0500. VSS. Lungs CTA. Bowel sounds x4 quads. Abd. soft & tender. Pt has d/c orders to ASMC. Awaiting transportation. Suture removal kit readily available to take with him. (b)(6)-2 [redacted], SGT, LPN
15 July 1307	Assumed care of PT. VSS. Lung sounds Ae clear Bilateral. Bowel sounds x4 quads. Abdomen soft + tender. Good Pulse rate function on all quadrants. Skin is warm & Dry. PT has no c/o pain and is resting comfortably in bed. Awaiting transfer to ASMC. Suture removal kit readily available to take with him. Will continue to monitor. SGT (b)(6)-2 [redacted] LPN
15 Jul 03 21:26	Pt. rec'd @ 21:00. Awake and alert in bed. Restraints x 2 (R) wrist (R) ankle. PERRLA (+) WNL. Jaw wires intact. Skin color WNL x skin on neck peeling and c/o itching. offered lotion to apply. Pt denies need for lotion. No further complaints. 20/(B) BS (+) x4. (+) PPPB. Will cont to mon. [redacted] DZT/AW

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

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

REGISTER NO. | WARD NO. 6W2

[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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7/6-03 0800	Pt. care assumed @ 0500. Pt. ↑ to BR's, ambulated. Jaws wired shut, wire cutters @ BS. HR Reg, lungs CTA, BS (+) x4. Pt. tol 80% BTS diet. (b)(6)-2 [redacted] LCTAN
1330	Assumed care of Pt @ 1300. VSS. A+O x3. Jaw wired shut. Ø c/o pain. Tol BTS diet. Ø/w Assessment WNL. Will Monitor (b)(6)-2 [redacted]
16 Jul 03 23:51	Rec'd c/o pt. @ 21:00. Awake and alert in bed. Restraints x2. (R) wrist (R) ankle. PERRLA (+) WNL. Skin color WNL. Jaw wires intact. LCA (B), BS (+) x4. (+) PPP (B). Ø c/o pain or N/V. Will cont. to mon. (b)(6)-2 [redacted] DLT/AN
0650	Pt. care assumed @ 0500. VSS. HR Reg, lungs CTA, BS (+) x4. Jaws wired shut, wire cutters @ B.S. Will cont. to monitor. (b)(6)-2 [redacted] LCTAN
16 Jul 03 1325	assumed care @ 1300 - VSS - wires in place, wire cutters in wound closure kit @ bedside - pt. does not want to ambulate, will encourage again later (b)(6)-2 [redacted] CRTAN
18 Jul 03 00:54	Rec'd c/o pt @ 21:00, VS WNL per flowsheet. Awake and alert in bed. Restraints (R) wrist (R) ankle. PERRLA (+) WNL. LCA (+) (B) BS (+) x4. (+) PPP (B). Skin WNL. Jaw wires intact. Persistantly requesting sleeping meds. [redacted] DLT/AN
0600	Pt. care assumed @ 0500. VSS. Ø pain. Jaws wired shut, wire cutters @ B.S. HR Reg, lungs CTA, BS (+) x4. Will cont. to monitor. (b)(6)-2 [redacted] LCTAN (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

IEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
18 Jul 03 @1211	OMFS POD [redacted] Pt doing very well s/p closed reduction & wired fx. VSS, AF. Plan to remove arch bars + wires in 1wk. (b)(6)-2 [redacted]
1530	Pt d/c'd to ASM c̄ Zofran PO + Xrays. [redacted] (b)(6)-2

IIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

SPONSOR'S ID NUMBER (SSN or Other)

RVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (R
Prescribed by GSA/ICMR FPMR (41CFR) 101-11

558-103

(See Instructions on Back of t.

NSN 7540-01-075-3786

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp) [redacted] (b)(6)-2

LOG NUMBER

ARRIVAL

DATE			TIME
DAY	MONTH	YR.	
11	JUN	03	1815

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
- [ ] PRIVATE VEHICLE
- [ ] AMBULANCE
- [x] OTHER (Specify) AIR EVAC

CURRENT MEDS. (tetanus immunization and other data): none

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

ALLERGIES: NKDA

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

HOME TELE. NO. (Inc. area code)

(b)(6)-4

CHIEF COMPLAINT(S) (Include symptom(s), duration): Neck Face trauma

SEX: M

AGE: [redacted]

POSSIBLE THIRD PARTY PAYER?
- [ ] YES
- [ ] NO

TIME SEEN BY PROVIDER

VITAL SIGNS			
TIME	18:25		
BP	120/65		
PULSE	96		
RESP.	100		
TEMP.	98.5		
WT. (Child)	65 Kg		

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

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

(b)(6)-4

S - [redacted] yo EPW ♂ c/o pt's HAS trauma to neck & FACE HAS stab wound on upper BACK wound HAS Been Sutured Possible Lower mandible FX HAS Blood in (R) Eye Pt HAS CHest PAIN when INHALING contusion to BOTH upper Extremities

Posterior wound was IRRAGATED & BACITRACIN & BANDASED GRASS WAS Also removed & Bandaged

ORDERS	INITS.	TIME
CBC + LS	[redacted]	1845
Chem 12 Lytes		1845
FACIAL Bones		[illegible]
tetnus, 5cc		1900
Ancef 1gram		1900
Morphin 5		[illegible]

ASSESSMENT/DIAGNOSIS
(b)(6)-2
(R) Angle of mandible
Fraser

A - intact
B - intact
C - intact
D -

Pt ambulatory here for trauma to neck & face

Pt. Rollins consulted pt in ER.

is admitted to pt for surgery tomorrow.

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

(b)(6)-2

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

TIME OF RELEASE: 2024

(CONTINUE ON SF 507, IF NEEDED)

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

[redacted] (b)(6)-4

SIGNATURE OF PROVIDER AND ID STAMP
[redacted] (b)(6)-2

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

EMERGENCY CARE AND TREATMENT

MEDCOM - 10533

Medical Record Copy

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

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CAL RECORD | PROGRESS NOTES

NOTES

Discharge/transfer summary

14 jul 03
@1050 Admit Dx: Left mandibular angle fracture

Discharge Dx: Same

D/C condition: Stable

D/C diet: blended thru straw, Carnation instant breakfast, ensure 1-2 cans per meal

D/C meds: OTC Pain meds crushed. Pt should not need pain meds.

Procedures: Pt underwent closed reduction of his left mandibular angle fracture with archbars and wires and maxillo mandibular fixation. * Pt is wired SHUT *

Plan: Pt will need to be returned to the [redacted] (b)(6)-2 on 28 July 03 for eval + removal of archbars and wires.

(b)(6)-2 [redacted] MAJ/DC
[redacted] maxillofacial SX.

MAJOR, DC
ORAL & MAXILLOFACIAL SURGERY

SHIP TO (Provider) | SPONSOR'S NAME | SPONSOR'S SSN
LAST | FIRST
SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT
IDENTIFICATION (Use inverted or other entries: name - last, first, middle; SSN, sex, date of birth, rank, grade) | REGISTER NO | Assoc. No.

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509 REV. 3
Prescribed by GSA ICMR FPMR (41 CFR) 101-11.4

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: [redacted] (b)(6)-4 HEIGHT: } unknown WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [X] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:

Closed reduction of mandible fx.

5. ADDITIONAL INFORMATION: Last PO: [redacted] Medical Hx: Ø Implants: Ø Medications: Clindamycin 900mg IV QD MSO4 1-2mg q 1° PRN
Jewelry removed: yes/no Family waiting: yes/no (b)(6)-2

Multiple bruises and scratches

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	Ø Pt. verbalizes any specific anxiety. Ø Pt. exhibits relaxed body posture.	Ø Allow pt. to verbalize freely. Ø Explain OR environment and answer questions regarding surgery. Ø Offer comfort measures, (e.g., warm blanket, touch) Ø Explain all nursing procedures before they are done. Ø Remain with pt. whenever possible. Ø Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	Ø PT. will be able to breathe without difficulty during immediate intra-operative phase.	Ø Offer to elevate head of litter or offer pillow. Ø Observe pt. while awaiting surgery for signs of distress Ø Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovi e pad; position; fluid shift	Ø PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	Ø Utilize pressure preventing devices on OR table and accessories. Ø Check for proper positioning and support to maintain good body alignment. Ø Pad pressure points. Ø Place ESU ground pad on non compromised skin surface area. Ø 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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	ø Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	ø Check for support stockings or ace wraps. If none, check with doctors. ø Check that safety straps are correctly applied. ø Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ø Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	ø Pt. will be transferred to OR table without difficulty. ø Pt. will not experience unnecessary physical discomfort.	ø Have sufficient people available for transfer. ø Insure proper body alignment. ø Allow patient to lie in position of comfort while waiting for surgery. ø Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	ø Pt. will be made aware of surroundings prior to anesthesia induction. ø Pt. will be transferred safely to OR table. ø Pt. will be able to understand instructions. ø Minimize danger of injury during intraop period.	ø Introduce self. Keep pt. informed as to where he/she is and what is happening. ø Inform pt. in which direction to move and assist if necessary. ø Speak clearly and slowly. ø Address pt. from EITHER side. ø Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. (b)(6)-2	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 COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] 1LT/AN 12 JUN 03 DATE

11. POSTOPERATIVE EVALUATION:

Pt ⊼ s/s of distress

(b)(6)-2

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] 1LT/AN DATE: 12 JUN 03 TIME: 0750	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] 1LT/AN DATE: 12 JUN 03 TIME: 1105

REVERSE OF DA FORM 5179, JUN 91 USAPA V1.01

MEDICAL REC[illegible]	INTI[illegible]E[illegible]TIVE DOCUMENT For use of this form, see AR 4[illegible] [illegible]e proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA LITTER BY ANESTHESIA

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY ILT [redacted] (b)(6)-2

3. DATE 12 JUN 03 TIME PATIENT ARRIVED IN SUITE 0925

4. PATIENT IN ROOM TIME 0925 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA
NPO p MN

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted]	RELIEF CIRCULATOR	

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

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

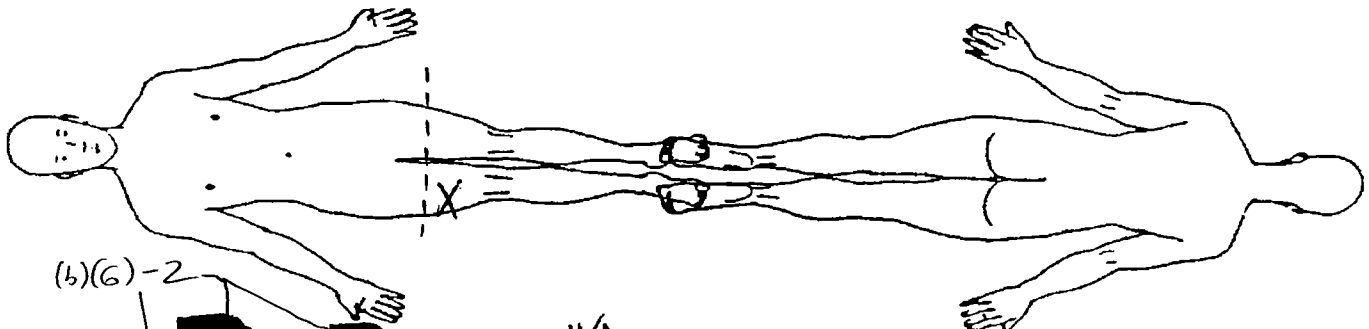
COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Chlorhexidine Gluconate
SITE: Oral cavity BY WHOM: Dr. [redacted] (b)(6)-2
SITE: BY WHOM:
COMMENTS: No adverse reaction noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] – Safety Strap N/A === Tourniquet

INITIAL: SPC [redacted]
ILT

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes [ ] No	/	C	C	SPC [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 [ ] NO

[X] ESU NO: #1 Cut 20 Coag 20
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 68936 Exp 2005-03

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

[ ] BIPOLAR NO:

13. PROSTHESIS, IMPLANTS ☐ ☒ 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
Bacitracin Oint Lot: H637 Exp: Jan-05	Q.S.	intra-op	local application	MFC: [redacted] (b)(6)-3	Dr. [redacted] (b)(6)-2

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*

19. ADDITIONAL INFORMATION
WC
Surgeons: Dr. [redacted] Anesthesia: CPT [redacted] Anesthesia Type: Gen
(b)(6)-2

Bovie Pad site intact pre-op ✓; post-op_____ Bovie Settings: Coag/Cut 20/20
Tourniquet Site intact pre-op _____; post-op N/A
Tourniquet Time: Up____ Down____ N/A

DA 5179 INITIATED

20. OPERATION(S) PERFORMED

Closed reduction of mandible fx.
(b)(6)-2

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU2	1103	LITER c O_2

22. REGISTERED NURSE SIGNATURE [redacted] 1IT/AN

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

MEDCOM - 10538

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

(b)(6)-2

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR June 19 2003

DAY: 11, 12, 13, 14, 15, 16, 17

HOUR

PULSE (O) / TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only): 40.6°, 40.0°, 39.4°, 38.9°, 38.3°, 37.8°, 37.2°, 37.0°, 36.7°, 36.1°, 35.6°, 35.0°

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

TEMP. F: 105°, 104°, 103°, 102°, 101°, 100°, 99°, 98.6°, 98°, 97°, 96°, 95°

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

[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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 18 Jun 19 20 21 22 23 24

19 | HOUR

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

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

(Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. 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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR June 19 2003 | DAY 25 26 27 28 29 30 1

HOUR

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

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

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

RESPIRATION RECORD

BLOOD PRESSURE

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

STANDARD FORM 511 (REV. 7-95) BACK

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Jul 19 | DAY | HOUR

PULSE (0) | TEMP. F (°)

TEMP. C (Centigrade Equivalents, for Reference only)

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

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

	2 Jul			3 Jul			4			5			6			7			8		
Hour	1	9	21	1	9	21	1	9	21	1	9	21	1	9	21	1	9	21	1	9	21
Pulse	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80	80
Temp. F	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6	98.6
Resp.	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
Blood pressure	110/70	104/70	130/70	110/60	110/60	110/60	118/60	120/70	98/70	98/70	102/70	102/70	110/66	112/70	102/72	110/67	118/78	102/68	100/68	112/70	98/80
Height: / Weight →	98%	99%	97%				97%	98%	98%	98%	98%	98%	99%	98%	98%	97%	98%	98%	97%	98%	98%

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

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

REGISTER NO.

WARD NO. EPW

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: ~~9~~ ~~10~~ ~~11~~ ~~12~~

POST- DAY

MONTH-YEAR | DAY: 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16

19 | HOUR

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

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

(Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

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

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (0) | 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

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. ICW

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

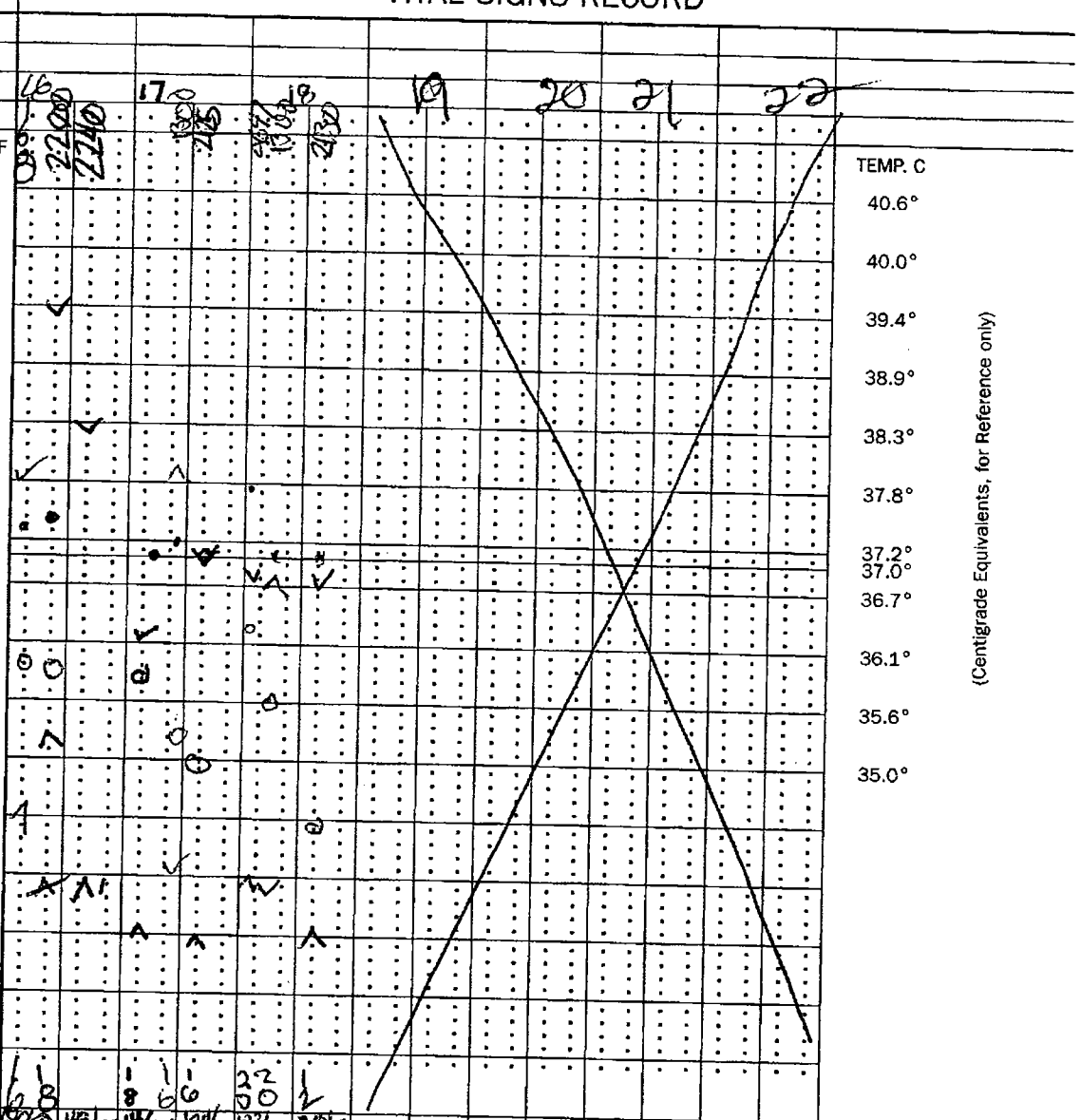
HOSPITAL DAY

POST- DAY

MONTH-YEAR 2/02 | DAY | HOUR

PULSE (0) | 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)

CPW [redacted]

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

Section: EMT

QUESTING PHYSICIAN: [redacted] (b)(6)-2

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

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

DATE	TIME	SSN/PSEUDO SSN:
11 JAN 03	18:29	

(Hematology) CBC

ST	RESULT	REF. RANGE
	10.5	4.8-10.8 x 10^3
	3.34	4.7-6.1 x 10^9
	9.5	14-18 g/dl (M) 12-16 g/dl (F)
	30.4	42-52% (M) 37-47% (F)
	91.2	80-94 fl (M) 81-99 fl (F)
	~~28~~ 261	130-500 x 10^3 verified
h %	18.5	20.5-51.1%

(Hematology) Manual Differential

		Mono	
		Eos	
h		Baso	
		Imm	
h			
ocrit			42-52% (M) 37-47% (F)
ne			

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 [redacted] (b)(6)-4

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

ARKS:

RTED BY: (b)(6)-2 [redacted] DATE: 11 Jan 03 LAB ID NO.:

Ward/Section	TESTING PHYSICIAN:	CHEMISTRY RESULT FORM
EMT	(b)(6)-2	

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN
#[redacted] (b)(6)-4	11 JUN 07	18:29	

(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 (adult) 41-51 mmHg (child)
PO2		80-105 mmHg (adult) N/A (child)
TCO2		23-27 mmol/L (adult) 24-29 mmol/L (child)
HCO3		22-26 mmol/L (adult) 23-28 mmol/L (child)
SO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
iCa		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51%
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	3.1	3.5-5.5 g/dl
ALP	42	26-84 u/l
ALT	30	10-47 u/l
AMY	47	14-97 u/l
AST	66	11-38 u/l
TBIL	0.9	0.2-1.0 mg/dl
BUN	15	7-22 mg/dl
CA	7.9	8.0-10.3mg/dl
CHOL	161	100-200 mg/dl
CRE	1.1	0.6-1.2 mg/dl
GLU	106	73-118 mg/dl
TP	6.1	6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.0 mg/dl
GGT		5-55 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA	141	128-145 mmol/l
K	3.7	3.3-4.7 mmol/l
CL	107	98-108 mmol/l
tCO_2	23	18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
(b)(6)-2 [redacted]	11 Jun 03	

Trauma to neck + face 5 days ago

NKDA

MEDICAL RECORD — ANESTHESIA

DRUG (Units) — CONTINUOUS / REPEATED DRUGS, SPECIFY UNITS – MG / MCG / ML, " ["=CONSTANT INFUSION		TOTALS
Midazolam (mg)	2	2
Fentanyl (mcg)	50 100 25 25 (50?)	250
Propofol (mg)	50 – 50 40	140
Sux (mg)	100	100
( )		
( )		
VOLAT AGENT Sevo % del	2.0 2.0 2.0 2.0 2.0 2.0	
% e.t.		
AIR L/Min		
N2O L/Min		
O2 L/Min	10 2 2 2 2 2 2 10	

To ICU 2

TOTAL EBL: Min

TOTAL URINE: Ø

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

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

FLUIDS — LINE site: 20G (R) H [X] Warmed — LR — #1
[ ] Warmed
[ ] Warmed
[ ] Warmed

LOSSES — EST BLOOD LOSS: Min; URINE – Ø

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 75 (KG)

HEMATOCRIT: 30.4

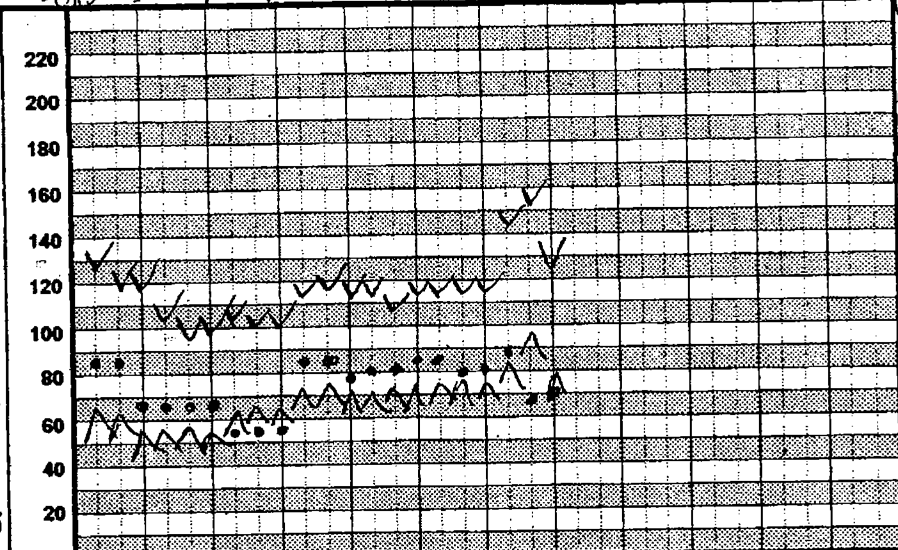
INITIAL DATA: BP – 110/60; HR – 74

EQUIP CHECK: OK? – (Y) N

PATIENT RECHECK: OK for (b)(6)-2 PROCEDURE? [redacted] TIME – 0900

TIME → 915 30 45 1000 . 30 . 1100 . 30 .

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



VT – ml	—	730	730	700	720	720	720	200-300
f – breaths/min	—	10	7	6	5	5	5	10-14
Peak inf pres / PEEP	—	21	21	21	20	20	22	—
MODE – S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	S
ET CO2 (torr)	+	28	27	27	29	30	29	38
FIO2 (Frac or %)	0.78	0.78	0.78	0.78	0.79	0.71	0.92	0.80
SpO2 (%)	100	100	100	100	100	100	100	100
ECG	SR →		SR →				SR	SR
TEMP- site	Available →		95 Ax					
N-M Block (T/4)		4/4 – 0/4		4/4		X		

Monitors: [✓] BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES; Gas analyzer; BS +; head wrapped →; [✓] Warming blkt x1 wool blanket →; Conv warmer

EVENTS (Mark with letters & symbols, explain under REMARKS): (1) (2) (3) (4) (6)
Position: O → Turned 45°

REMARKS– Code drugs with numbers, events with letters
(1) Pre-op assessment + explained anesthe[illegible] + c interpreter explained anesthesia; Oxymetazoline nasal [illegible]
(2) Room monito[rs] O2, Sevo inductio[n] c propofol (R) nar[es] dilated 6.5 + 7.5 NP tube lubricated 5%
(3) Decadron 10mg IV
(4) Zofran 4mg IV; Glycopyrrolate 0.2mg
(5) [illegible] turned bed back to anesthesia
(6) Awake responsive TV 75ml/kg; RR10 BP extubated s complications
(7) TO ICU-2 Report to RN
Throat pack x-0 out; OG passed by surgeon prior to extubation

RECOVERY AT 1105
PACU (ICU) 2 (Specify)
OTHER T-94.4/95.[illegible] Ax
CONDITION: Stable awake
RESP- 20 SpO2- 100
BP- 139/79 HR- 83

ANESTHESIA / PROCEDURE TIME:

	Start	Room	End
ANES	0915	0925	1120

	Ready	Begin	End
PROC	0935	0952	1055

53 min

PROCEDURES and CPT Codes: Closed Reduction of mandible fx

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GNETA, Cricoid pressure

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — DL x1 MAC 3 Grade 1 view; erythematous piece of tissue on epiglottis; Dr. [illegible] to OR observed. 7.5 NPETT c McGills + B[illegible]. Sust. ETCO2 24cm @ nare

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

SURGEONS: [redacted]

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

PROCEDURE LOCATION: 1

DATE: 12 June 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
MAMC OP 376 REVISED 1 Jan 99
MEDCOM - 10548

*U.S. GPO: 2002-729-180/40

(b)(6)-4

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age [redacted] DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: CR Mand Fx
SURGICAL SERVICE: OMFS
NPO SINCE: 2400

Neck/face trauma c̄ rx mand angle fx

ASA Physical State 1 2 3 4 5 E
WT: 65 KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: (X)
ETOH: denies
DRUGS: denies

CURRENT MEDICATIONS:
( ) = ordered as premed

() Clinda IV q8°
() NS 120cc/hr
() MSO4 PRN
()
()
()

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

LABORATORY STUDIES:
HB/HCT: 9.5 / 30.4
U/A:
OTHER:

141 | 107 | 15 / 106
3.7 | 23 | 1.1

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
N Y

Familial HX

ASSESSMENT
PAST SURGICAL/ANESTHETIC
(✓)

* adea but restricted

PHYSICAL EXAMINATION c/ pain
BP 110/60 HR 74 R 18 T ____
Pain Scale 0-10 4
HEENT - Teeth intact
Trachea ML
TMJ/Neck * /FROM
Oropharnyx MP II
Nares Rt better
CHEST: CTAB
CARDIAC: RRR
EXTREMITIES:
IV Access: Rt wrist
Ulnar Filling: N/A
BACK: N/A
OTHER: N/A

NPO Since 2400

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (X) General: Mask Intubation
pt in restraints asleep nasal

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

(b)(6)-2

The patient/[redacted] to understand and agrees. Questions answered.
Signed: [redacted] CRNA Date: 6/12/03 Time: 0715 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ICW2

CIV # [redacted] (EPW)
(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.

(b)(6)-4

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age [redacted] DAYS MOS YRS Sex () MALE () FEMALE

PROPOSED PROCEDURE: Closed Reduction of Mandible Fx
SURGICAL SERVICE: OMFS
NPO SINCE: _____

ASA Physical State 1 2 3 4 5 E
WT: 75 KG/LB HT: _____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: NO
ETOH: qd
DRUGS: qd

CURRENT MEDICATIONS:
() = ordered as premed
() clindamycin 900mg q 8°
()
()
()
()
()

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

LABORATORY STUDIES:
HB/HCT: 9, 30
U/A: _____
OTHER: PT/PTT 26/K
WBC 10.5

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 NA

Other Significant Hx: (N) Y Presented c̄ trauma to neck & face 3D ago
(N) Y
Familial HX (N) Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC
None - unknown

PHYSICAL EXAMINATION
BP 110/60 HR 75 R 18 T 99° F
Pain Scale 0-10 yes
HEENT - Teeth Intact
Trachea Midline
TMJ/Neck Mandible Fx
Oropharnyx _____
Nares _____
CHEST: Clear
CARDIAC: S1, S2
EXTREMITIES: _____
IV Access: 20ga (R) hand
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since MN

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

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

(b)(6)-2

The patient [redacted] understand and agrees. Questions answered.
Signed: [redacted] MD Date: 12 June 03 Time: 0817 Hrs

POST-AN[redacted]ESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) ICW-2

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

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
11 Jun 03	2041 HOURS	(b)(6)-2

1. Admit to ICW 2 Dr [redacted]
2. dx: mandible fx
3. cond: Stable
4. Vitals: Per routine
5. aller: NKDA
6. activ: ad lib

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
		[redacted]

DATE OF ORDER	TIME OF ORDER
	HOURS

7. Nurs: HOBT 30°
8. Diet: NPO
9. IV: NS @ 120cc/hr
10. meds: ~~Amp~~ [redacted] Clindamycin 900mg IV q8° Morphine 1-2mg q1° IV PRN pain
11. on call to OR in AM
12. VOID O'COR

Noted sent 6/11/03 1[redacted]

(b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

ICW #2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
24 VS 6-11-03	2200 [redacted] HOURS

(b)(6)-2

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

12 Jun 03 1058

1. Admit to ICW 2 Dr [redacted] (b)(6)-2
2. Dx: S/P closed reduction mandible fx
3. cond: Stable
4. Vitals: Per routine
5. activ: ad lib
6. Nurs: HOBT 30°

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

ICW #2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER
	HOURS

Yankauer suction to BS

7. Diet: Clears then full liquid Ensure 1 can c meals
8. IV: NS @ 120cc/hr then Heplock when taking PO
9. meds: ~~Amp~~ Morphine 1-2mg IV q1° prn pain Clindamycin 900mg IV q8°
10. Wire cutters to BS @ All times

24° [redacted] D. (b)(6)-2 [redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

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

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

1. D/C IV
2. Pen VK 500mg 1 tab crushed q 6° x 5 days
3. Tylenol #3 1-2 tab crushed q 4-6° pm pain
4. OOB as tolerated [redacted] (b)(6)-2

24° V/S [redacted] ICW 6-13-03 2145 (b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 14 Jun 03 | TIME OF ORDER @ 1020 | HOURS

1. Ensure / CIB 1 can [redacted] (b)(6)-2 c meals

24° V/S 07 [redacted] (b)(6)-2 ICW 6-14-03 2210. (b)(6)-2

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

DATE OF ORDER 15 Jun 03 | TIME OF ORDER 1300 | HOURS

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

D diet to blend thin

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

c T can CIB c meals 1700

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

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

24° V/S [redacted] ICW 6-15-03 2300

PATIENT IDENTIFICATION

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

DATE OF ORDER 16 Jun 03 | TIME OF ORDER @ 0930 | HOURS

1. Okay for OOB to chair & ambulation per MD orders [redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

24° V/S 0045 17 Jun [redacted] (b)(6)-2

24° V/S [redacted] (b)(6)-2 .03 2350.

DA FORM 1 APR 79 4256 REPLACES EDITION [redacted] UL 77, WHICH MAY BE USED.

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

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4 # [redacted]	21 Jun HOURS	
	① D/C Pen VK	
	② D/C tylenol #3	
	[redacted] (b)(6)-2	MAJ/DC
	(b)(6)-2	
	[redacted]	

noted 24 Jun 03 1300 [redacted] (b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
ICW 2	24° / done	[redacted]

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
24° VS [redacted] (b)(6)-2 / LT AN	6-27-03 0001 HOURS	
# [redacted] (b)(6)-4	27 Jun 03 @ 2004	
	① Ensure I can c meals	
	② D/C suture in [redacted]	(b)(6)-02
	Not [redacted]	(b)(6)02
	(b)(6)-2	

NURSING UNIT	ROOM NO.	BED NO.
ICW II		[redacted]

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
24° V [redacted]		
EPW # [redacted] (b)(6)-4	28 Jun 03 @ 0715 HOURS	
	① Phenergan 12.5 mg PO/PR. X1 dose	
	Noted [redacted]	
	(b)(6)-2	

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

PATIENT IDENTIFICATION	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-2		
24° V's [redacted]	LT AN 6-28-03 2300	
EPW (b)(6)-4 [redacted]	7/8/03 2200 HOURS	
	VO. Dr. [redacted] (b)(6)-2 / LT [redacted] (b)(6)-2	
	① 800 mg motrin PO x 1 nurse	
24° V's [redacted] (b)(6)-2	LT AN 7-8-03 2300. [redacted]	LT AN
	7/4/03 2315 [redacted] (b)(6)-2	(b)(6)-2
	VO. Dr [redacted] / LT [redacted]	(b)(6)-2
	① Cessing Tylenol / PO x / now	
	[redacted]	LT AN
	(b)(6)-2	

NURSING UNIT	ROOM NO.	BED NO.
ICW II		[redacted] (b)(6)-4

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

U.S. GOVE

MEDCOM - 10553

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

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

DATE OF ORDER: 7/9/03 | TIME OF ORDER: 0345 HOURS | LIST T ORDE NOTED SIGI

(b)(6)-2

V.O. from Dr. [redacted] / [redacted]

(1) ? Percocet Rx / now

[redacted] / LTAN

(b)(6)-2

PATIENT IDENTIFICATION (b)(6)-4

[redacted] (b)(6)-4

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

DATE OF ORDER: 9 July 03 | TIME OF ORDER: 0610 HOURS

V.O. from Dr. [redacted] / [redacted]

(1) Tylenol 650mg PO x 1 now

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

noted [redacted] while 9 July 03

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

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

DATE OF ORDER: 9 July 03 @ 0930 | TIME OF ORDER: Phenergan ~~12.5-25~~ mg HOURS q4° pm N/V | LTA | PO

(b)(6)-2

noted [redacted] 9 July 03

(b)(6)-2

24°VS [redacted] LTAN 7/10/03 0000

24°VS [redacted] LTAN 7/12/03 2247

24°VS 7-13-03 0001 [redacted] LTAN

(b)(6)-2

PATIENT IDENTIFICATION (b)(6)-4

[redacted] (b)(6)-4

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

DATE OF ORDER: 16 Jul 03 | TIME OF ORDER: @ 0722 HOURS

(1) Okay to give pt Carnation instant breakfast + ensure 2 cans per meal @ ASMC

[redacted]

(b)(6)-2

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

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

PATIENT IDENTIFICATION

#[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
Chand[redacted]		718 03 0850

(b)(6)-2

DATE OF ORDER	TIME OF ORDER	LIST OF NOTIS
7 16 03	0930 HOURS	

(b)(6)-2

VO Dr. [redacted] / CT [redacted]

(1) 30 cc liquid anti-diarrheal PO X 1 now

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

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

[redacted]

(b)(6)-2

DATE OF ORDER	TIME OF ORDER	
LCTAN 18 Jul 03	(b)(6)-2 @ 1244 HOURS	

(1) Okay to go to ASMC

[redacted]

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
	HOURS

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
	HOURS

NURSING UNIT	ROOM NO.	BED NO.

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

U.S. GOVERNMENT PRINTING OFFICE: 2001—478-200

All (b)(6)-2 except for one at bottom

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 11	12	13	14
6/11	[redacted]	Vitals per routine.	5	X	[redacted]		
			13	X			
			21	[redacted]			
6/11	[redacted]	Act. As tolerated	5	X	[redacted]		
			13	X			
			21	[redacted]			
6/11	[redacted]	Nursing: HOB@30°	5	X	[redacted]		
			13	X			
			21	[redacted]			
6/11	[redacted]	Diet: NPO	7	X	[redacted]		
			11	X	[redacted]		
			17	X			

SEE NEW SHEET

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Mandible Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[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

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
6/11	[redacted]	Admit to ICW #2 Dr. [redacted]	6/11	2100	2100	[redacted]
6/11	[redacted]	Cond. Stable.	6/11			[redacted]
6/11	[redacted]	On call to OR				
6/11	[redacted]	Void ON call OR.				

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 except for one at bottom

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. JUNE

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 12	13	14	15	16	17	18	19	20	21	22	23	24	25
6-12	[redacted]	Vitals per routine	5	[redacted]													
			13														
			21														
6-12	[redacted]	Act. Ad lib	5	[redacted]													
			13														
			21														
6-12	[redacted]	Nursing: HOB @ 30°	5	[redacted]													
			13														
			21														
6-12	[redacted]	Diet: Clears then	7	[redacted]													
		Full liquid ~~ensu~~ [redacted]	11														
		I can't meals	17														
6-12	[redacted]	Wire cutters to	5	[redacted]													
		BS @ all times	13														
			21														
6-13	[redacted]	OOB as tolerated	5	[redacted]													
			13														
			21														
15	[redacted]	diet: blend thin &	07	[redacted]													
		strain - C1B + can	12														
		T meals	17														
16 Jun	[redacted]	OOB to chair +	5	[redacted]													
		Ambulate per MP rules	13														
			21														

Δ1 see below

neuritis

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS:
DX: S/P CLOSED REDUCTION MANDIBLE FX

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

PATIENT IDENTIFICATION:
[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

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
6-12	[redacted]	Admit to ICW #2	12	—	—	[redacted]
6-12	[redacted]	DX: S/P closed reduction	12	—	—	[redacted]
		mandible fx				
6-12	[redacted]	Cond: stable	12	—	—	[redacted]
6-27	[redacted]	D/C sutures in Back	27		2030	[redacted]

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

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All (b)(6)-2 except one at bottom

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 26	27	28	29	30	1	2	3	4	5	6	7	8	9
12	[redacted]	Vitals Per Routine	05	[redacted]													
			13														
			21														
12	[redacted]	Act: Ad lib	06	See below 24 Jun 03													
			13														
			21														
12	[redacted]	Nursing: HOB @ 30°	05	[redacted]													
			13														
			21														
12	[redacted]	Wire cutters to bedside @ ALL TIMES	05	[redacted]													
			13														
			21														
15	[redacted]	Diet: BTS c̄ CIB	07	[redacted]													
		+ can Ensure	12														
		c̄ meals	18														
16	[redacted]	OOB to chair and ambulate per MP's rules	05	[redacted]													
			13														
			21														

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
[redacted] S/p closed reduction mandible fx

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

PATIENT IDENTIFICATION:
CPW [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 except one at bottom.

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 10	11	12	13	14	15	16	17	18
12 June	[redacted]	Vitals per Routine	05	[redacted]								
			13									
			21									
12	[redacted]	Nursing HOB @ 30°	05	[redacted]								
			13									
			21									
12	[redacted]	Wire cutters to BS	05	[redacted]								
		@ all times	13									
			21									
15	[redacted]	Diet: BTS to CIB	07	[redacted]								
			12									
			18									
16	[redacted]	OOB to chair and	05	[redacted]								
		amb. per MP's rules	13									
			21									

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: S/p closed reduction mandible fx

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

(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
7/6	[redacted]	Okay to give pt carnation instant breakfast and ensure 2 cans per meal @ASMC	7/6	ASMC		

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11	12	13	14
6/11	[redacted]	NS @ 120 cc/hr	5	X	[redacted]		
			13	X			
			21	[redacted]			
6/11	[redacted]	Clindamycin 900mg IV Q8	08	X	[redacted]		
			16	X			
			24	[redacted]			

711
b)(6)-2

SEE NEW SHEET

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS: Mandible fx	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO. ____

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

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
6-11	[redacted]	Morphine 2mg	6-11 2130	6-11 2300												
		gtIV PRN pain	2130	[redacted]												
		(b)(6)-2														

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo. 06 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	12	13	14	15	16	17	18	19	20	21	22	23	24	25
6-12	[redacted]	IV-NS @ 100cc/hr	5														
		then HL when	13	[redacted]						DCd	[redacted]						
		taking PO	21	[redacted]													
6-12	[redacted]	Clindamycin 900mg	6														
		q 8°	14	[redacted]						DCd 13 June 03				[redacted]			
			22	[redacted]													
6-13	[redacted]	Penicillin 500 mg 1 tab	6			[redacted]											
		crushed q 6° x 5 days	12														
			18														
			24														

All (b)(6)-2

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS:

Dx: S/P closed Reduction Mandable Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

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

A11 (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. June Yr. 2005
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6-12	[redacted]	1 mg Ativan IV x 1 dose	(held)	not given		
6-28	[redacted]	Phenergan 12.5 mg PO/PR. x 1 dose	28	—	0730	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
6-12	[redacted]	Morphine 1-2mg														
		IV q 1° prn pain														
6-13	[redacted]	tylenol #3 1-2 tabs crushed q 4-6° prn pain	6-13 2135 [redacted]	6-14 Sun 1230 [redacted]	6-17 June 1430 [redacted]	6-18 June [redacted]										

D/C Dilaudid 1300 [redacted]

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 6 Yr 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30	31													
6'29	[redacted]	HCIV	5	[redacted]														
			13															
			21															
		(b)(6)-2																

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Jaw fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

all (b)(6) - 2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 7 Yr. 13
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
7/8	[redacted]	800 mg motrin PO, x1 now	7/8.		2000	[redacted]
7/8	[redacted]	650mg Tylenol PO. x1 now	7/8	2318	2318	[redacted]
7/9	[redacted]	Percocet 1 PO x1 now	7/9	0345	0345	[redacted]
7/9	[redacted]	Tylenol 650 mg PO x1 now	7/9	0610	0610	[redacted]
7/6	[redacted]	30cc liquid antidiarrheal PO x1 now	7/6	0950	0950	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
0-29	[redacted]	MSO4 1-2mg IV														
		q 1° PRN pain														
[redacted]	[redacted]	Phenergan 12.5-25	7-13													
		mag IM/PO q4°	[redacted]													
		PRN N/V	0800													

USAPA V1.00

(b)(6)-2 [redacted]

[redacted] (b)(6)-4

(b)(6)-4 [redacted]

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date): ASA / ETOH Hx

Date: 12 June 03 | Anesthesia Type (Circle)): General Spinal Epidural LR IV Sedation Nerve Block | 75kg

Time In: 1111

Allergies: ∅ denies | OR Intake: Crystalloid 500 | Colloid ∅

Pre-op V/S: 110/64 20 74 | OR Output: UOP ∅ | EBL min.

Procedures: Spiral reduct. mandible fx | Meds/Times: Fentanyl 100mcg, Fentanyl 50mcg 1111

Pre-op HCT 30.4

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds | History

Time	11	11	11	12	12	12	12	12	12	12	12	12	12	12	12	12
SaO2		100	100	100	100	97										
FiO2 FM		10	10	10	6	RA										
Methods																
240																
220																
200																
180																
160																
140		A	A	A												
120					A											
100						A										
80		V		V	V	V										
60		O	O	O	O	O										
40																
20																
RR		16	12	14	12	11										
T		94.4	95.8	96.8	96.8	96.8										
Time																
Pain (0-10)		10	9	8	8	sleep										
LOS																

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1220	LR	200	R hand	[redacted]	200
					(b)(6)-2

X-rays: | Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	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] (b)(6)-2 MAJ/AN | DEPARTMENT/SERVICE/CLINIC: ICU 2 | DATE: 12 June 03

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

~~50mcg~~

MEDICATIONS

Allergies: Unknown

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1111	10	50 Fentanyl	IV	↓	(b)(6)-2 [redacted]	
1201	10	MSO4 2mg	IV	↓	[redacted]	

NEUROVASCULAR

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

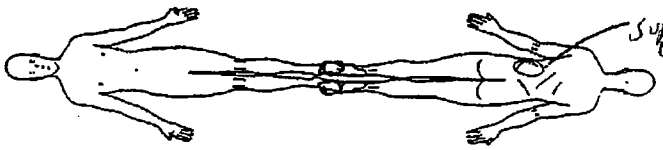
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS - See BACK of Patient

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



Superficial lacerations covered c̄ gauze

PACU OUTPUT

Time	Source	Color/Appearance	Amount
1130	Urine	Clear yellow	600

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1111	SR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

Admit from OR - Stable but in pain + somewhat confused about Jaws wired - interpreter at bedside - [redacted] (b)(6)-4 [redacted] given IV with some less c/o pain + agitation - RACoon eyes (R) > (L) [redacted] (b)(6)-2 hematoma - Some scleral bleeding

1201 continues to c/o pain 10/10 per interpreter: pt noted anxious - 2mg MSO4 IV given [redacted] (b)(6)-2 MMS/RN

Lungs clear - good cough - nurse pad. suction mouth orally Ø - Ø respiratory distress - FM removed - Saturating well with critters at Bedside - Ø nausea - [redacted] (b)(6)-2 MMS/RN

LR continues KVO - (R) hand - site intact Deep breathing exercises done while awake [redacted] (b)(6)-2

Multiple Bruises noted over upper Arms & > R Arm full ROM extremities - Ø c/o pain - transferred to ICW 2 - report given [redacted] (b)(6)-2 MMS/RN

Discharge Criteria:
Date: 12 Sep 12 **Time:** 1203 **PARS:** 12
BP: 114/75 **T:** **HR:** 55 **RR:** 11 **SaO2:** 97
Pain Level at D/C (0-10):
Intake: IV LR 200 **Output:** 600 Urine
Additional Data:
Transferred To: ICW 2
Report Given To: LT
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [redacted] MMS/RN
Cleared IAW Recovery Room SOP B-3 (b)(6) -2
Charge Nurse Signature:

12. REASSESSMENT / REASSESSMENT

DATE / DATE (YYMMDD)	TIME OF ARRIVAL / HEURE D'ARRIVÉE

TIME / HEURE	1650			
BP / PS	132/74			
PULSE / POULS	98			
RESP / RESP	16			

DATE / TIME
DATE / HEURE

13. CLINICAL COMMENTS / DIAGNOSIS
INFORMATION MÉDICALE / DIAGNOSTIQUES

Temp: 101.2°

14. ORDERS / ANTIBIOTICS (Specify) / TETANUS / IV FLUIDS
DIRECTIVES MÉDICALES / ANTIBIOTIQUES (Spécifier) / TÉTANOS / IV FLUIDE

15. PROVIDER / OFFICIER MÉDICALE | DATE/DATE (YYMMDD)

16. DISPOSITION / DISPOSITION
- RETURNED TO DUTY / RETOUR À L'UNITÉ
- EVACUATED / EVACUÉ
- DECEASED / DÉCÉDÉ

TIME / HEURE

17. RELIGIOUS SERVICES / SERVICES RELIGIEUX
- BAPTISM / BAPTISE
- ANOINTING / ONCTION
- CONFESSION / CONFESSION
- PRAYER / PRIÈRE
- COMMUNION / COMMUNION
- OTHER / AUTRE

CHAPLAIN / CHAPELAIN

DD Form 1380, DEC 91 (Back)

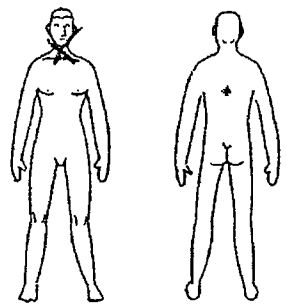
1. LAST NAME, FIRST NAME / NOM ET PRÉNOM: [redacted] (b)(6)-4 | RANK / GRADE | MALE / HOMME | FEMALE / FEMME
SSN: [redacted] | SPECIALTY CODE / GPM | RELIGION / RELIGION

2. UNIT / UNITÉ: 115 MP BN

FORCE / ÉLÉMENT: A/T | AF/A | N/M | MC/M
NATIONALITY / NATIONALITÉ
BC / BC | NBI / BNC | DISEASE / MALADIE | PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT | BACK / ARRIÈRE



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

Neck, Face Trauma
R/O C-Spine
B.L. Inj

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: 120 | TIME / HEURE: 1630 | 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 / PRÉSENTE MÉDICATION / ALLERGIES / ANTIDOTES

110/72 100 20 Sat 77%
C-Spine Retropharyngeal
Fx jaw (R) Alveolar
(b)(6)-4
Wires # [redacted]

10. DISPOSITION / DISPOSITION: 581
- RETURNED TO DUTY / RETOUR À L'UNITÉ
- X EVACUATED / EVACUÉ
- DECEASED / DÉCÉDÉ (b)(6)-2

TIME / HEURE: K40

11. PROVIDER / UNIT / OFFICIER [redacted] | DATE/DATE (YYMMDD): 11JUL03

DD Form 13[redacted] DEC 91 [redacted] previous editions [redacted] DD Form 1380 and DD Form 1380 (7/87), which are obsolete.

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

ADMISSION AND CODING INFORMATION

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

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

(b)(6)-4

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	[redacted] 4	Z	9	unk

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	2041	N/A

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

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

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

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(6)-2

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
5 Ø		Ø 3 Ø 7 1 8

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A A		Ø 3 Ø 6 1 1

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

FOR LOCAL USE

Dx: Mandible fx

DX: 80220

Px: 7675

ADMITTING [redacted]

SIGNATURE OF ADMITTING CLERK [redacted] SPC 9/6/10

(b)(6)-2

DA FORM [illegible] MAR 80

(b)(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) [redacted] (b)(6)-4			3. GRADE FGN	ADMISSION REMARKS
M	6. RACE Z	M	Z	ETS	10. PREVIOUS ADMISSION
11. FMP 99	12. SSN [redacted]	13. ORGANIZATION —			14. WARD ICU1
15. FLYING STATUS —	16. DSG -	BEN [redacted]	18. BRANCH/CORPS (b)(6)-4	19. UIC/ZIP	20. TYPE CASE NBI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION P - Direct from ER-			22. HOURS OF ADMISSION	23. CLINIC SERVICE ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE		25. TYPE DISPOSITION CRO		26. DATE OF DISPOSITION 11-June-03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)		27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 11-June-03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(6)-2				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

~~SIP~~ GSW to abdomen

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

SIP GSW to abdomen
(R) radius Fracture
(L) leg shyenil

Dx:
879.2
813.81
891.0
864.00
E991.2

Px:
45.62
45.79
86.28
99.29
87.44

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	1	1

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

DA FORM 3647, MAY 79 [redacted]EDCOM - 10573 USAPPC V1.10

HOSPITAL REPORT OF DEATH

FOR USE OF THIS FORM, SEE AR 40-2; THE PROPONENT AGENCY IS OFFICE OF THE SURGEON GENERAL.

NAME AND LOCATION OF HOSPITAL

Instructions - Medical Officer in attendance will:

Prepare, in one copy only, Items 1 through 10 and sign Item 11. Print or type entries.

Send form, without delay to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

SECTION A - ATTENDING MEDICAL OFFICER'S REPORT

PERSONAL DATA

1. PATIENT DATA *(Patient's ward plate will be used to imprint identifying data if available)*

Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number

2. TIME OF DEATH *(Hour-day-month-year)*: 2125 11 06 03

3. MEDICAL EXAMINER/ CORONER'S CASE ☐ YES ☐ NO

4. RELIGION: MUSLIM

5. CHAPLAIN NOTIFIED ☐ YES ☐ NO

6. NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH

CAUSE OF DEATH

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death)*	DUE TO *(for as a consequence of)* ventilatory failure	10 min
7b. ANTECEDENT CAUSES *(Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last)*	DUE TO *(for as a consequence of)* (1) multiple trauma	
	(2)	
8. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT	a.	
	b. (b)(6)-2	

9. DATE	10. TYPED OR PRINTED NAME AND GRADE OF MEDICAL OFFICER IN ATTENDANCE	11. [redacted] OFFICER IN ATTENDANCE
11 June 03	[redacted], MAJ, MC	[redacted]

SECTION B - ADMINISTRATIVE [redacted]

TYPE OF ACTION	HOUR	DAY	MO[redacted]	YEAR	INITIALS OF RESPONSIBLE OFFICER
12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON					
13. POST ADJUTANT GENERAL NOTIFIED					
14. IMMEDIATE CO OF DECEASED NOTIFIED					
15. INFORMATION OFFICE NOTIFIED					
16. POST MORTUARY OFFICER NOTIFIED					
17. RED CROSS NOTIFIED					
18. OTHER *(Specify)*					
19.					

SECTION C - RECORD OF AUTOPSY

20. AUTOPSY PERFORMED *(If yes, give date and place)* ☐ YES ☐ NO

21. AUTOPSY ORDERED BY *(Signature)*

22. PROVISIONAL PATHOLOGICAL FINDINGS

23. DATE	24. TYPED NAME AND GRADE OF PHYSICIAN PERFORMING AUTOPSY	25. SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY
26. DATE	27. TYPED NAME AND GRADE OF REGISTRAR	28. SIGNATURE OF REGISTRAR

DA FORM 3894, OCT 72 REPLACES DA FORM 8-257, 1 JAN 61, WHICH WILL BE USED. USAPPC V2.00

All (b)(6)-2

CERTIFICATE OF DEATH *(OVERSEAS)*
Acte de décès *(D'Outre-Mer)*

NAME OF DECEASED *(Last, First, Middle)* Nom du décédé (Nom et prénoms)	GRADE Grade	BRANCH OF SERVICE Arme	SOCIAL SECURITY NUMBER Numéro de l'Assurance Sociale
ORGANIZATION Organisation	NATION *(e.g., United States)* Pays	DATE OF BIRTH Date de naissance	SEX Sexe ☐ MALE Masculin ☐ FEMALE Féminin

RACE Race	MARITAL STATUS État Civil		RELIGION Culte	
☐ CAUCASOID Caucasique	☐ SINGLE Célibataire	☐ DIVORCED Divorcé	☐ PROTESTANT Protestant	☐ OTHER *(Specify)* Autre *(Spécifier)*
☐ NEGROID Négroïde	☐ MARRIED Marié	☐ SEPARATED Séparé	☐ CATHOLIC Catholique	
✓ OTHER (Specify) Autre *(Spécifier)*	☐ WIDOWED Veuf		☐ JEWISH Juif	

NAME OF NEXT OF KIN Nom du plus proche parent	RELATIONSHIP TO DECEASED Parenté du décédé avec le susdit
STREET ADDRESS Domicilié à (Rue)	CITY OF TOWN AND STATE *(Include ZIP Code)* Ville (Code postal compris)

MEDICAL STATEMENT Déclaration médicale

CAUSE OF DEATH *(Enter only one cause per line)* Cause du décès (N'indiquer qu'une cause par ligne)			INTERVAL BETWEEN ONSET AND DEATH Intervalle entre l'attaque et le décès
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH[1] Maladie ou condition directement responsable de la mort[1]		ventilatory failure	10 min
ANTECEDENT CAUSES Symptômes précurseurs de la mort.	MORBID CONDITION, IF ANY, LEADING TO PRIMARY CAUSE Condition morbide, s'il y a lieu, menant à la cause primaire	multiple trauma	
	UNDERLYING CAUSE, IF ANY, GIVING RISE TO PRIMARY CAUSE Raison fondamentale, s'il y a lieu, ayant suscité la cause primaire		
OTHER SIGNIFICANT CONDITIONS[2] Autres conditions significatives[2]			

MODE OF DEATH Condition de décès	AUTOPSY PERFORMED Autopsie effectuée ☐ YES Oui ✓ NO Non		CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES Circonstances de la mort suscitées par des causes extérieures
☐ NATURAL Mort naturelle	MAJOR FINDINGS OF AUTOPSY Conclusions principales de l'autopsie		
☐ ACCIDENT Mort accidentelle			
☐ SUICIDE Suicide	NAME OF PATHOLOGIST Nom du pathologiste		
● HOMICIDE Homicide	SIGNATURE Signature	DATE Date	AVIATION ACCIDENT Accident à Avion ☐ YES Oui ☐ NO Non
DATE OF DEATH *(Hour, day, month, year)* Date de décès *(l'heure, le jour, le mois, l'année)*	PLACE OF DEATH Lieu de décès		

I HAVE VEIWED THE REMAINS OF THE DECEASED AND DEATH OCCURRED AT THE TIME INDICATED AND FROM THE CAUSES AS STATED ABOVE.
[redacted] les restes mortels du défunt et je conclus que le décès est survenu à l'heure indiquée et à, la suite des causes énumérées ci dessus

NAME OF [redacted] médicin militaire ou du médicin sanitaire	[redacted]	TITLE OR DEGREE Titre ou diplômé MD
GRADE [redacted] Grade O4	INSTALLATION OR ADDRESS Installation [redacted]	
DATE Date 11 JUN 03	SIGNA[redacted]	

[1] *State disease, injury or complication which caus[redacted] but not mode of [redacted] failure, etc.*
[2] *State conditions contributing to the death, but not related to the disease or c[redacted] causing death.*
[1] *Préciser la nature de la maladie, de la blessure ou de la complication qui [redacted] contribué à la mort, mais non la manière de mourir, telle qu'un arrêt du co[redacted] etc.*
[2] *Préiser la condition qui a contribué à la mort, mais n'ayant aucun ra[redacted] la maladie ou à la condition qui a provoqué la mort.*

DD FORM 2064, APR 1977 REPLACES DA FO[redacted], 1 JAN 1972 AND DA FORM 3565-R(PAS), 26 SEP 1975, [redacted]ARE OBSOLETE. USAPA V1.00

MEDICAL RECORD

UTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1st 1315	heart - S1 S2 S m/r/g
BP 137/92	- lungs - CTA
P- 129	- Abd - distended + TTP
R- 20	
	- multiple GSW to Abd
1330	
1345(?)	- GSW: A+O x3
	~~Impl: Acute Abd~~
	Plan: O2 @ 10L
1437	② IV. c̄ pressure bag x2L
BP 86/64	③ evac to [redacted] + (b)(6)-2
P 152	④ Reinforce bandages
R: 28	⑤ further eval (chest)
	[redacted]
	~~PT admitted to 501st~~ AID Station
~~1445~~	
~~1500~~	(b)(6)-2
~~1500~~	
@	

HOSPITAL OR MEDICAL FACILITY

SPONSOR'S NAME	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
	SSN/IR. 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.)

Iraqui Man

REGISTER NO.	WARD NO.

1st name: [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

USAPA V2.0

[redacted] (b)(6)-4

(b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

[redacted] 4 fold ♂ PT 1345 PT admitted to [redacted]

med ∅
allg ∅
LO Intake 10 June evening
Scars – tortured.

1345		1406	
BP	97/64	BP	126/56
r	26	r	24
p	160	p	132

entry on (L) calf (R) forearm → exit + entry
(L) upper quadrant
(R) upper quadrant – no exit wound

1400 rectal no blood
1407 urine no gross Blood
IV's
Sodium chloride (L) arm 1400, Sodium chloride (L) arm 1410
1407 16' French Foley inserted yellow urine [redacted] | 15 [redacted]
1408 5 milligrams of morphine give [redacted]
(b)(6)-2

1415
BP 105/62
r 38
p 132
1420
BP 101/60
r 38
p 135

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry) DATE

MEDICAL RECORD

DATE

CHRONOLOGICAL RECORD OF MEDICAL CARE

AUTHORIZED FOR LOCAL REPRODUCTION

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

(b)(6)-4

Home 03 1430

[redacted] yo Iraqi national brought by 310 ambulance involved in Iraqi vs. Iraqi gang-related event. Sustained multiple gunshot wounds to chest, abdomen + extremities

Last ate - 1030 meds Ø NKDA.

O: alert, awake GCS 15
HEENT benign CV RRR tachy Ø hm
lungs CTA (B) c̄ symm BS GSW (L) chest - rib 5 Ø exit.
Abdomen mildly tense tender mid-right upper quads, ØBS GSW mid abd entry c̄ exit RUQ, bleeding profusely.
2+ fem pulses GSW (L) flat buttock - mid trochanter level ~~exit~~ ?exit (L) calf.
Ext ⊕ radial/DP pulses GSW entry + exit (R) forearm. tattoo (L) bicep healed GSW scar (L) ant. thigh.

Imp multiple GSW c̄ ?involvement of liver

Plan IV x 2 NS full, blood when available Xray - chest and pelvis. Initial HCT ≥6 to OR for stabilization then transport to CSH. Surgeon actively involved from start.

(b)(6)-2

[redacted] MD

MAJ, USA, MC
STAFF PEDIATRICIAN, LRMC

SPITAL OR MEDICAL FACILITY

NSOR'S NAME | STATUS | DEPART./SERVICE

SSN/ID NO. | RELATIONSHIP TO SPONSOR | RECORD MAINTAINED AT

IENT'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.

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

USAPA V2.00

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
11 June 03 1720	Op Note Dx: Multiple GSW, thoracoabdominal + (L) lower extremity Procedure: #1 Laparotomy, small bowel resection, (R) colectomy #2 Debridement wnds. (L) thigh, leg x 2 [redacted] / [redacted] GET (b)(6)-2 EBL: 300 cc. Fluids: 8500 crystalloid, 2 units blood + 500 Dextran Drains: ϕ Complications: ϕ Findings: multiple thru + thru GSW of distal small bowel + mesentery, (+) GSW of ascending colon (T) + (R) mid-transverse colon (T). Given hypotension + diameter of each lesion, none were amenable to 1° repair. Resected terminal 24-30" of ileum, + additional 8" terminal ileum resected in continuity c (R) colon to mid-transverse colon. Latter left closed, intraperitoneal, + marked w/a Nylon suture. Distal stayed end of ileum brought out to RLQ abdominal wall => NOT MATURED !! LTC [redacted]

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

SPONSOR'S ID NO. (SSN or Other): [redacted] (b)(6)-2

PART, 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.

→ over

LOG #:
SSAN #:
NAME:

PROGRESS NOTES
Medical Record

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

USAPA V1.00

Significant negatives:

No injury to spleen, rectum, descending colon (did not mobilize splenic flexure), retroperitoneum, pelvic structures.

Note: "graze" injury to anterior aspect (R) lobe of liver, just anterior to gallbladder fundus.

* Total of ≈ 8-10 enterotomies in distal ileum. *

NSN 7540-00-634-4176

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
6/11/03 1700	BP 114/70 P110 T96.4 Vent setting TV 800 BPM 10 SAO2 100%. S/P laps 2° GSW to abd. Pt has 4 wound ground, dressing to (R) flank, reinforced 2° blood through. Tube drainage dressing are present, dry & intact. Pupils are 2mm sluggish. Lungs are clear & have sounds are decreased. Plan is to monitor until air transport can be arranged.
6/11/03 1730	BP 88/46 P123 SAO2 94 DR [redacted] notified & order for 250cc LR bolus given. [redacted]
1740	111/56 P122 SAO2 100%. Bolus complete, lodent pulses are palpable. Wound cleaned. -Pt [redacted]
1745	BP 119/67 P119 SAO2 100% [redacted]
1750	MS 5mg SIVP & Versed 5mg SIVP for agitation given. BP 94/64 P120 SAO2 100% Medic 56 here to transport to LZ [redacted]

(b)(6)-2

HOSPITAL OR MEDICAL FACILITY

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

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; [redacted] EPW

REGISTER NO. | WARD NO.

(b)(6)-4

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

ICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
(b)(6)-2 MAR 03 [redacted] 2130	Rec'd pt sedated/intubated from E.R. via Litter. @ approx 2130 hrs orders written. HR ↓ 30's. Physician currently @ the bedside discussing plan. Satz ↓ being pt currently. HR on arrival in the 80's - Never was able to pick Satz. HR ↓ 40 → 30's @ 2134-2135. Dr [redacted] called the bedside. Debriefed by staff. CHN pt ↓ to Asystole. See pt MD note for further assessment ↓ - Post Mortem Care done/Linen D/C'd & pt transp to Morgue @ 2216 hrs. [redacted] Sgt/LPN (b)(6)-2

(b)(6)-2

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

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

MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRODUCT

DATE	NOTES
11 JUN 03	Death Note
2130	Called to see pt for bradycardia. Initial strip showed junctional escape rhythm. When I arrived at the bedside pt was in sinus bradycardia to 20's. BP could not be obtained. On evaluating the patient, I noticed his chest was not moving. Troubleshooting the vent showed that it was ~~not~~ turned on. Pt was pronounced @ 2125 but not delivering breaths. On retrospect, it appears as if the lines may have been disconnected. [redacted] (b)(6)-2

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

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

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

PROGRESS NOTES
Medical Record

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

558-103

(See Instructions on Back of this Sheet)

EMERGENCY CARE AND TREATMENT
(Medical Record)

NSN 7540-01-075-3786

TREATMENT FACILITY (Stamp)

LOG NUMBER

ARRIVAL DATE DAY	MONTH	YR.	TIME
11	June	72	1905

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

CURRENT MEDS. (tetanus immunization and other data)

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES

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

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration) PX 110%

GSW to ABD / Lower Ext

SEX: M AGE:

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 1905

VITAL SIGNS			
TIME	1910		
BP	~~82/45~~	97/58	96/30
PULSE	139	133	135
RESP.	Vent.	14	vent
TEMP.	98°		
WT. (Child)			

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

5 EPW shot By other Injgs. Operated on @ FAST room., 8500 crystalloid, 2 units PRBC, 500 cc dextran.

CATEGORY (See reverse)
- ✓ EMERGENT
- URGENT
- NON-URGENT (b)(6)-2

~~5 EPW stc~~

A: Intubated
B: (B) Breath Sounds = Equal Bilaterally
C: HR-130-140, BP-58%
D: Intubated / Sedated
E: NMB Foley in place & urine in Foley Bag.

#1: 6.4 / 11.6 / 38.0 / 190

#2: 6.4 / 12.2 / 39.1 / 190

~~199 / 111 / 9 / 100~~
~~4.4 / 19~~

7.21/44/132/18.

ABG #2
7.27/45/130/21

ORDERS	INITS.	TIME
25 Versed x IV	[redacted]	1920
CBC, Lytes, UA		
ABG 60%		
1020 out		
3mg versed IV		2000
10mg Versed IV		

ASSESSMENT/DIAGNOSIS
(a) GSW to ABD s/p surgery
(2) Shrapnel @ lower leg
(b) @ Abdis Fx open.

DISPOSITION (Check all that apply)
- HOME
- FULL DUTY

QUARTERS: 24 Hrs. 48 Hrs. 72 Hrs.

MODIFIED DUTY UNTIL: DAY MONTH YEAR

REFERRED TO (Indicate clinic)

- EMERGENCY
- TODAY
- 72 HOURS
- ROUTINE

ADMIT. TO HOSP. UNIT/SERVICE

General surgery service pt. wounds bilat admitted to ICU #2 should until surgery.

NPO

CONDITION UPON RELEASE
- ☒ IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

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

CU1 [redacted] (b)(6)-4

EPW

SIGNATURE OF PROVIDER AND ID STAMP: [redacted] 2265

INSTRUCTIONS TO PATIENT (Include medications ordered, any limitations and follow-up plans) (b)(6)-2

EMERGENCY CARE AND TREATMENT

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

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

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

11/Jan03 [redacted] (b)(6)-2

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	6.4	4.8-10.8 x 10^3
RBC	4.21	4.7-6.1 x 10^6
Hgb	12.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	39.1	42-52% (M) 37-47% (F)
MCV	92.7	80-94 fl (M) 81-99 fl (F)
Plt	190	130-500 x 10^3 verified
Lymph %	16.1	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
Appr		N/A
Gluc		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leu		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Blood Bank Type & Crossmatch

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

UNIT	TYPE	CROSSMATCH

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	

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]

DATE: 11 Jan 03

LAB ID NO.:

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

Ward/Section: Gm1	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: GPW [redacted] (b)(6)-4	DATE: 11 Jan 03 / TIME: 1325	SSN/PSEUDO SSN: # [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.1	4.8-10.8 x 10^3
RBC	4.07	4.7-6.1 x 10^6
Hgb	11.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	38.0	42-52% (M) 37-47% (F)
MCV	93.3	80-94 fl (M) 81-99 fl (F)
Plt	176	130-500 x 10^3 verified
Lymph %	16.6	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			

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

Miscellaneous

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 Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS: ~~ABG (b)(6)-2~~

REPORTED BY: [redacted]	DATE: 11 Jan 03	LAB ID NO.:

Ward/Section: PMT

ORDERING PHYSICIAN: [redacted] (b)(6)-2

[redacted] LABORATORY RESULT FORM

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

DATE: 11Mar03 | TIME: 1928 | SSN/PSEUDO 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	7.211	7.31-7.45
PCO2	44.1	35-45 mmHg (arte) 41-51 mmHg (ven)
PO2	132	80-105 mmHg (arte) N/A (ven)
TCO2		23-27 mmol/L (arte) 24-29 mmol/L (ven)
HCO3	18	22-26 mmol/L (arte) 23-28 mmol/L (ven)
sO2	98	95-98%
BEecf	-10	(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51%
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		19-47 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) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		[illegible]
CRE		[illegible]
NA+		128-144 mmol/l
K+		[illegible]
CL-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		19-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-55 u/l
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA+	149	128-144 mmol/l
K+	4.4	3.3-4.7 mmol/l
CL-	111	[illegible]
tCO_2	19	[illegible]

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]

DATE: 11Mar03

LAB ID NO.:

MEDICAL RECORD - ANESTHESIA

form, see AR 40-66; the proponent agency is the DTSL

SPECIFY UNITS - MG/MCG/ML, "*"=CONSTANT INFUSION

DRUG	(Units)											
VECURON (mg)		2.5								2.5		
ADRIAMYCIN (mg)		.2										
MSO4 (mg)		5	10									
STP (mg)		250	200							5	5	
NORCURON (mg)		10		2			3	3	2			
INVASYNE (L)		1										
VOLAT. AGENT	SOVO % vol		2.5	—	—	—	—	—	—	—	—	—
	% e.t.											
AIR	L/Min											
N2O	L/Min											
O2	L/Min	5	—	—	—	—	—	—	—	—	—	—

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

IV site Dextran 10% LR (R) ☐ Warmed

LR (L) ☐ Warmed

.9 (L) ☐ Warmed

PRBC ☐ Warmed

EST BLOOD LOSS

URINE - FOLEY

TIME → 1445 30 1500 30 1600 30 1700

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

228 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

VT - ml		800	850	850	860	850	850	850	860	860	860
f - breaths/min	20	10	10	10	10	10	10	10	10	10	10
Peak inf pres / PEEP		22	20	22	20	22	22	22	22	22	22
MODE - S(pon), A(assist), C(ass)	S A	C	C	C	C	C	C	C	C	C	C
ET CO2 (torr)		38	38	38	37	35	35	31	36	36	36
FIO2 (Frac or %)		44	45	44	46	44	44	44	44	44	46
SpO2 (%)	96	98	98	97	96	98	98	98	98	98	98
ECG	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST	ST
TEMP-site											
N-M Block (T/4)		0/4				4/4					

Warming blkt

BPV Warmer

Letters & symbols for REMARKS

EVENTS / Position → SUPINE

TOTALS: 5 ml, .2, 25 ml, 500 ml, 20 ml, 1 ml

TOTAL EBL: 800

TOTAL URINE: 1000

FLUID SUMMARY: CRYSTALLOID- 5800; COLLOID- 500; BLOOD- 2 units

REMARKS: Code drugs with numbers, events with letters

5304271

W0204 03 001157 2

Rocephin 2gm IV
Cleocin 900mg IV
@ 1420

pt taken to
ICU intubated
VSS report Dr

BIO ISTAT
HGB 12
HCT 34

RECOVERY AT: PACU ICU ____ (Specify) OTHER ____

CONDITION: RESP- SpO2- BP- HR-

ANESTHESIA/PROCEDURE TIMES

	Start	Room	End
ANES	1400	1420	1715
PROC	Ready	Begin	End
	1425	1435	1700

PROCEDURES and CPT Codes: Exp LAP

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

#

U# EPW

E:

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

GA ET

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

7.0 ET Atraumatic DL x 1 BS bilat = ⊕ ET CO2

SURGEONS: [redacted] ← (b)(6)-2

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: OR #1

DATE: 11 JUN 03

PAGE 1 OF 1

Doctor's Orders—Post-OP 126th OP 4256

Nurse Complete	Dr.'s Select	DATE: TIME:
☐	☒	1. Admit to: ☐ OR ☑ PACU ☐ ICW ☐ Patient Holding
☐	☒	2. Diagnosis: Multiple GSW, torso, (L) lower extremity
☐	☒	3. Condition: ☑ Critical ☐ Guarded ☐ Stable ☐ VSI ☐ SI
☐	☐	4. Allergies: See SF 558
☐	☒	5. Vitals: ☐ Unit SOP ☑ Notify Dr. for SBP < 90 or > 170, DBP < ___ or > ___, HR < 50 or > 140, RR < ___ or > ___, or Temp > ___
☐	☒	6. Activities: ☑ Bed Rest, ☐ BRP, ☐ OOB ASAP w/ assist, ☐ Sit up and dangle when stable ☐ Other:
		7. NRSG:
☐	☒	a. Propaq monitor w/ Pulse-ox
☐	☒	b. O_2 to maintain SAT's above 94%
☐	☒	c. Maintain Vent settings at MODE=___ Vt= 800 RR= 10 PEEP= 5 FIO_2= 100
☐	☒	d. ☐ Reinforce or ☑ Change dressing for bleed-through X1 then notify Dr.
☐	☒	e. I's & O's
☐	☒	c. Suction NT ETT PRN
☐	☐	d. CT to ☐ H_2O seal or ☐ Suction at ___
☐	☒	8. Diet: ☒ NPO ☐ Clear fluids as tolerated ☐ Other: NGT to LCS
☐	☑	9. IV: ☐ NS or ☑ LR TRA 150 cc/hr ☐ DEXTRAN or ☐ Hespan X 500 cc bolus titrated then ___ cc/hr ☐ Albumin 100cc X ___ TRA ___ cc/hr ☐ When tolerating PO fluids, complete current fluid then SL.
☐	☐	10. BLOOD: ☐ T&S or ☐ T&C ___ units ☐ Transfuse ___ units ☐ PRBCs or ☐ Whole Blood
		11. Medications:
☐	☒	a. Tobramycin 300mg IV Q12hrs X ; e ☑ Ceftriaxone 750 mg IV q 12hrs.
☐	☒	b. Clindamycin 600mg IV q 8° ; f ☐ PEN G 2 million Units IV
☐	☐	c. Cefazolin 1 gram IV
☐	☒	d. Phenergan 12-25mg Titrate ☐ IV ☐ IM Q4hrs PRN nausea/vomiting
☐	☐	g. Droperidol 1mg ☐ IV ☐ IM X 1 PRN Nausea/Vomiting
☐	☑	h. MSO_4 1-3mg Titrate ☑ IV ☐ IM Q10min PRN Pain
☐	☐	i. Robinul 0.1mg IV X 1
☐	☐	j. Zantac 50 mg ☐ IV or ☐ IM or ☐ 6.25mg/hr infusion
☐	☐	k. Tetanus Immune Globulin
☐	☐	l. Toradol ☐ IV 30mg or ☐ IM 60 mg
☐	☐	m. Maintain sedation/paralysis w/ Rocuronium and MSO_4 PER SOP
☐	☐	12. LABS: a. iSTAT ☐ Glucose ☐ ABG ☐ BMP ☐ CMP
		13. Additional:
		Foley to gravity bag.
		***Note to receiving facility: RLQ dressing covers a non-matured stapled end of ileum ***
		Signature: LTC [redacted]

LOG# PT NAME: (b)(6)-2 PT SSAN# 10JAN03

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	ROOM NO.	BED NO.

DATE OF ORDER: 11 Jun 03 — TIME OF ORDER: 1630 — HOURS — LIST TIME ORDER NOTED AND SIGN

1. Admit to ICW #1
2. DX: GSW to AB Forearm S/P Exp. Lap
   ② R RADIUS Fracture
   ③ L Leg Shattered
3. Condition: Critical
4. Vitals: per Routine
5. Allergies: NKDA

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: D.ET: NPO — TIME OF ORDER — HOURS

6. Meds: ① 350 mg gentamycin IV Q24° 0500 ~~morning~~
   ② 1 gm Ancef IV Q6° next dose @ midnight
   ③ 4 mg MSO4 IV Q 4° PRN pain
   ④ 2 mg Versed Q 2° PRN pain
   ⑤ 650 mg tylenol PR Q6° PRN fever
Activity: Bedrest
Nursing monitor I+O's

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

IVF: 100 cc/hr LR
Oxygen to keep SATS ≥ 92%
QA.M: CBC, Chem 7, CXR
CAN Surgery for additional orders
(b)(6)-2
[redacted] MD

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

DRM 4256 APR 79 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)* QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	21:30	INITIALS (b)(6)-2	INITIALS		INITIALS
NEURO	PUPILS	Fixed/dilated	7mm			
	SENSORIUM	sedated				
		intubated				
RESPIRATORY	RESPIRATORY PATTERN	intubated				
	BREATH SOUNDS	clear to Ausc/Coarse				
	SECRETIONS	prated.				
SKIN	COLOR	pale				
	INTEGRITY	intact/dressed				
IV SITE	LOCATION	to AMD/leg/left	RUE	RUE		
	CONDITION	(R) AC	patent/benign			
GASTRO	ABDOMEN	Soft NT/ND				
	BOWEL SOUNDS	( )				
GU	URINE:	cl/yell				
	COLOR/CLARITY	foley/patent				
CARDIOVASCULAR	CARDIAC RHYTHM	sinus (R)				
		first (R) waves.				
		present.				
		difficult to				
		assess due to transfer fluid. process				

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

(b)(6)-2

(Continue on reverse)

PREPARED BY: [redacted] / LPN

DEPARTMENT/SERVICE/CLINIC: [redacted]

DATE: 11 Jan 03

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

NEUROLOGICAL ASSESSMENT

		HOURS	930
COMA SCALE	EYES OPEN	SPONTANEOUSLY 4	
		TO SPEECH 3	
		TO PAIN 2	
		NO EYE OPENING 1	✓
	BEST VERBAL RESPONSE	ORIENTED 5	
		CONFUSED 4	
		VERBALIZES 3	
		VOCALIZES 2	
		NO VOCALIZATION 1	✓
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6	
		LOCALIZES PAIN 5	
		FLEXION WITHDRAWAL 4	
		ABNORMAL FLEXION 3	
		EXTENSION TO PAIN 2	
		NO MOTOR RESPONSE 1	✓ Sedated
LIMB MOVEMENT	ARMS	NORMAL POWER	
		MILD WEAKNESS	
		SEVERE WEAKNESS	
		ABNORMAL FLEXION	
		ABNORMAL EXTENSION	
		NO RESPONSE	✓ Sedated
	LEGS	NORMAL POWER	
		MILD WEAKNESS	
		SEVERE WEAKNESS	
		ABNORMAL FLEXION	
		ABNORMAL EXTENSION	
		NO RESPONSE	✓
PUPILS	RIGHT	SIZE	7mm
		REACTION	–
	LEFT	SIZE	7mm
		REACTION	–
PUPIL SCALE			● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm
ICP			
CEREBRAL PERFUSION PRESSURE			

LEGEND

- C Closed by swelling
- T Trach/Endo
- S Slurring
- D Dysphasia
- R Receptive
- E Expressive
- R Right
- L Left
- Record separately if there is a difference between the two sides.
- ++ Brisk
- + Slow
- – No Response
- + Intact
- – Abnormal

VASCULAR ASSESSMENT

		HOURS	1630
Pad/Ulnar	R		+
	L		+
Femoral	R		+
	L		+
Pedal	R		+
	L		+
	R		
	L		
	R		
	L		

LEGEND

- ++ Normal
- + Weak
- – Absent
- D Doppler
- R Right
- L Left

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 0 1	1 2	[redacted]	[redacted] (b)(6)-4	FGN	M M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
[redacted] (b)(6)-4	[redacted]	X	9	M

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
2 2 2 (b)(6)-4		1 1 (b)(6)-4	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	—	(b)(6)-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
1 1 1	[redacted] (b)(6)-4	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	NO
		9	03	X

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICU I	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] (b)(6)-2	

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
0 5		0 3 0 6 1 1

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A B A A		0 3 0 6 1 1

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
		0 3 0 6 1 1

FOR LOCAL USE

S/P GSW to abdomen
(R) radius Fracture
(L) leg shyent-

T: 9
Inj: 569

Dx: 86339
86399
86351
86352
51881
88100
8940
E9912

PR. 4562
4579
8628

Death: #5

ADMITTING OFFICER (Signature, as required) [redacted] (b)(6)-2

SIGNATURE OF ADMITTING CLERK [redacted]

FORM 3985 MAR 89

(b)(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]	2. NAME (Last, First, MI) EPW # [redacted] (b)(6)-4			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE —	7. RELIGION —	8. LENGTH OF SVC —	9. ETS —
10. PREVIOUS ADMISSION NO.					
11. EMP 99	12. SSN [redacted] (b)(6)-4	13. ORGANIZATION —		14. WARD ICU #1	
15. FLYING STATUS NO	16. RATING/ DSG —	17. DEPT./ BEN —	18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct from ER			22. HOURS OF ADMISSION 0230	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK		25. TYPE DISPOSITION 05		26. DATE OF DISPOSITION 23 June 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK		27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 13 June 03	ADMITTING OFFICER [redacted] (b)(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(6)-2				30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW to chest

Dx: 862.39, 901.41, 861.03, 861.30, 518.0, 512.0, E991.2

Rx: 37.12, 38.04, 38.05, 96.71, 99.29, 34.88, 34.04, 89.52, 87.44, 93.94 (x17)

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	10	10

36. Total Days All Facilites

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

DR. [redacted] ← (b)(6)-2 → [redacted] MEDICAL RECORDS OFFICER

DA FORM [redacted] AY 79 EDITION OF 1 AU[redacted]ETE USAPPC V1.10

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

MALE EPW BROUGHT TO ED RECEIVING CPR FOR UNCERTAIN PERIOD OF TIME. PT TREATED FOR LEFT TENSION PNEUMOTHORAX IN ED C̄ IMMEDIATE IMPROVEMENT.

UNKNOWN MEDICAL HISTORY

PHYSICAL EXAMINATION

VS: HR 101 O2SAT 44% BAG VENTILATION (INTUBATED)
RR 37 BP 155/102

HE: GENERAL: NON RESPONSIVE TO PAINFUL STIMULI
H: NC
E: 3 → 6 mm REACTIVE
E: ∅ HEMOTYMPANUM
N: ∅ EPISTAXIS
T: CLEAR
LYM: TRACHEOSTOMY → CHEST:
LUNGS: B/L BS
ABD: SOFT, NT, ND ∅ BS
RECTAL: ∅ BLOOD ⊕ TONE

NEURO: UNRESPONSIVE
EXT:

FAST: ? PERICARDIAL FLUID
CXR: LEFT PTX C̄ RETAINED ROUND LEFT CHEST

PROGRESS (Enter date of discharge and final diagnosis)

Imp: GSW TO CHEST
POSSIBLE ISCHEMIC BRAIN INJURY
PLAN: PERICARDIAL WINDOW POSSIBLE STERNOTOMY/THORACOTOMY

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	13JUN03		

PATIENT [redacted]IFICATION (For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)

(b)(6)-2

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

(b)(6)-2 [redacted]

AUTHORIZED FOR LOCAL REPRODUC

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
13 Jun 03 0900	Pt sedated c̄ diprivan @ 50mcg/kg/min. vent SIMV RR 14 TV 750 FIO2 60% PS. Coarse @ breath sounds. Thick tannish secretions orally. Palpable pulses @. Abd soft, NP c̄ absent bowel sounds NGT (R) nare LIS. foley cath to BSO c̄ clear yellow urine. CT to (L) CW to 20cm suction c̄ bloody drainage. VS @ present No distress noted — (b)(6)-2 [redacted] EPW
13 Jun 03 1240	↓ FIO2 40% PS Pt c̄ RR 20, 98% HRT 130-136. BP 128/70. Pt c̄ continuous movement LEs. Rec'd MSO4 2mg IVP @ 1200. Wheezing to (L) upper lobe. Albuterol neb given per RT — [redacted] EPW
13 Jun 03 1251	Neb tx given. 5cc Alb c̄ 2.5 NS BS coarse c̄ wheezing (b)(6)-2 SpO2 99 Post Tx BS slight improvement SpO2 99% [redacted]
1345	Pt sedated c̄ diprivan slowly weaning to off. IVF LR infusing @ 100cc/hr. CT to 20cm suction. SpO2 97-100%. Interpreter @ BS explaining plan of care of extubate. Pt denies pain @ present. Will cont. to monitor — (b)(6)-2 [redacted] EPW
13 Jun 03 1350	Pt extubated. Non rebreather applied @ 15L. SpO2 97-98%. Suctioned orally c̄ minimal amount of secretions. Awake talkative. Diprivan weaned to off. Cont. c̄ antibiotic therapy. Temp elevated to 102 discussed c̄ Dr [redacted] no orders given @ present. — [redacted]
1420	Tylenol 650mg per NGT given for temp elevation. (b)(6)-2 O2 via nonrebreather @ 10L. No respiratory distress noted. Pt c̄ ↓ BS to lower lobes. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR NUMBER (SSN or Other) (b)(6)-2
	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.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MI	INITIAL	ID NUMBER

DATE	NOTES
13 Jun 03 1420	cont'd. HOBT. Pt denies difficulty breathing. Attempting to encourage deep breathing and coughing c̄ little cooperation from patient. HR 130's. Dr [redacted] aware. Will cont. to monitor – [redacted]
13 Jun 03 1600	Pt continues c̄ HR 130's. SpO2 98% HC NC. R33. ~~denies pain~~ c̄ [redacted] (b)(6)-2 (b)(6)-2 (b)(6)-2 MSO4 2mg IVP given. LR cont. c̄ 100cc/hr. JP drain to bulb suction. CT remains to suction. NGT removed per Dr. [redacted] (b)(6)-2 foley remains to gravity drainage. Pt refusing to deep breath. Breath sounds ↓ @ to mid and lower lobes. Notified Dr [redacted] (b)(6)-2 No orders c̄ present [redacted] (b)(6)-2
1650	Notified Dr [redacted] (b)(6)-2 of ↓breath sounds. Order given to continue to encourage deep breathing and incentive spirometer use. Pt refusing to deep breath and cough. Will cont. to monitor status – [redacted] (b)(6)-2
1730	Received pt @ 1700 resting in bed w/o c/o @ this time. (N) Alert, oriented, on 3mm buck, ufc + moves spontaneous. Is able to interact somewhat c̄ conversation. Language barrier inhibits proper communication. (Resp) Intubated today w/o complications. HC SL c̄ SpO2 ~97%, encouraging ICS, + deep breathing, pt uncooperative c̄ procedures of deep breathing + ICS. CT to (D) chest wall to 20cm H2O cont suction, draining minimal amts. 5-30 q4°. Diminished BS to (D) chestwall. Wheezing noted to (D) chest wall (BS). (CV) ST HR 130's, ± pulses throughout, c̄ CR <3secs. (GI/GU) SNTND ~~BS x4~~ hypoactive. ⊕BM. Foley c̄ CYU ~70cc/HR. Foley care done. NPO, sips of H2O plus NGT PIC today. (Integ) incision to sternum, dressed, clean, JP to incision drain q4° c̄ ~60cc q4°, sanguinous. Otherwise intact. (Lines) (D) EJ 18g c̄ (D) AC 18g – patent. LR @ 100cc/HR. POC: ABX therapy, ICS, TCDB, Pn mgmt. (b)(6)-2 ILT [redacted] AN

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

(b)(6)-4 2035 470 131 2636 2601 19 #[redacted]

2880 -1387 1493

MEDCOM - 10597

AUTHORIZED FOR LOCAL REPRODUCT

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
13 JAN 03	SURGERY OP NOTE
	PREOP DX: GSW TO MEDIASTINUM & LEFT CHEST C TAMPONADE PTX & HYPOTENSION
	POST-OP DX: GSW THROUGH MANUBRIUM C INJURY OF PERI-PULMONARY ARTERY TISSUE & PRECARDIAL TISSUES C PERICARDIAL HEMATOMA & LEFT LUNG INJURY
	PROC: PERICARDIAL WINDOW, MEDIAN STERNOTOMY & C PERICARDIOTOMY & GREAT VESSEL EXPLORATION
	SURGEON: [redacted] (b)(6)-2
	EBL: 400 cc
	UO: 1500 cc
	COMPLICATIONS: Ø
	DRAINS: LEFT CHEST TUBE / MEDIASTINAL & JP FOLEY/NG
	CONDITION: STABLE / INTUBATED / MENTAL STATUS UNKNOWN
	ASA: ANY BF 1gm ON CALL TO OR
	[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.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14 JUN 03 1000	PROGRESS NOTE PD#1 PERICARDIAL WINDOW / MEDIAN STERNOTOMY / PERICARDIOSTOMY
	PT AWAKE ALERT & ORIENTATED - APPROPRIATE PAIN
	CVR: TACHYCARDIC HR 120s CVR: Volume loss B/L
	LUNGS: BLNC SATS 97% LEFT UPPER LOBE RALES CLL ↓ L
	ABD: SOFT, NT, ND
	Board: 48 T/O 2617/2635
	Home: 6.5 9.5 30.7 222 CT = 70 INST 5°
	IP = 10cc LAST 4°
	ID: TL 99.6 Tm 102.8
	Imp: POD#1
	ATB/SEPSIS
	Plan: DC IP
	ADVANCE DIET
	AMBULATE & ASSISTANCE
	IS
	RT TO MOVE COUGHING
	CT TO WATER SEAL
	[redacted]
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

AUTHORIZED FOR LOCAL REPROD

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 JUN 03 0124	RT note: Pt awake. ⊕ wheezing exp. Noticed O_2 disconnect at 5-in-1. SpO_2 88 reconnect SpO_2 98 within 2 minutes. Alb UD neb given. HR. 124, RR 22., Pox 97-98%. Pt tol tx well. ⊖ cough. Place pt back on NC @ 4(pm) POX 97% will continue to monitor ——— Sgt [redacted] (b)(6)-2 91U2Φ
14Jun03 0130	Call centry. for 0030 14Jun03. Pt on 4LNC c̄ difficulty breathing, + wheezing throughout, desatting cont: after FM @ 15L placed x 3-5min, and ↑ RR. Dr. [redacted] (b)(6)-2 notified, ordered Albuterol neb tx x1 now to maintain SPO2 ≥91%. Pt cont. to have wheezing throughout, but ↓ p̄ albuterol tx. LLL diminished c̄ wheezing noted. Pt placed on 2LNC c̄ SPO2 ~98%. RR 16, and unlabored. When using ICS is now able to drung 1 ball 1/2-3/4 way up. Pn mngmt by MSO4 IVP 1-4mg q1°. Pt appears more comfortable. ——— 1LT [redacted] AN (b)(6)-2
0430	Pt resting in bed throughout night c̄ Φ1-2° pn mgmt c̄ MSO4 IVP 2-4mg each IVP. U/O ~70cc c̄ golden yellow in color, A Δ from oncoming shift from cyu. Periodically, prn, Δ NC to SM when SPO2 < 91% w/o ↑ c̄ COB. Wheezing throughout RΣL,

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

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

PROGRESS NOTES
Medical Record

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LAST NAME	NAME	MI	ID NUMBER

DATE	NOTES
cont.	Diminished to Bases L>R. Neb tx x1. Pt also untied restraints on (R) hand. Supp + ICS throughout p.m. Cont to monitor (b)(6)-2 [redacted]
14 Jun 03 0700	Pt asleep at intervals. Easily arouses appropriate in responses. Cooperative. O2 via NC @ 4 L c̄ SaO2 98-99%. Respirations unlabored c̄ wheezing noted to (R) and (L) lobes. Diminished breath sounds in bases. Incentive spirometer use and importance explained to patient by the interpreter. Pt continues to not deep breathe despite encouragement. CT to 20cm suction. Midline dressing to sternal area c̄ staples CDI. Abdomen round NT, ND c̄ absent bowel sounds to upper quads and LLQ. Hypoactive to RLQ. Palpable pulses (B) (R) EJ JVC'd due to infiltration. Cap refill c̄ 3secs. Foley cath BSD c̄ dark yellow urine. CT c̄ serosanguinous drainage. No distress noted (b)(6)-2 [redacted]
14 Jun 03 1000	Pt c̄ (B) wheezing to upper lobes and crackles. Incentive spirometer in use c̄ splinting of incisions. JP drain removed by [redacted] (b)(6)-2 Albuterol neb given per RT. CT to water seal. IVF LR @ 50/hr NT suctioned c̄ thick yellow secretions. Pt reluctant to cough. Interpreter c̄ BS explaining procedure. CXR done and seen by MD. (b)(6)-2 Cont. c̄ diminished breath sounds to bases. No distress noted. [redacted]
14 Jun 03 1200	Pt c̄ incentive spirometer in use. Coughing nonproductively. Pt sitting up in bed along the side. HR ↑ 159 and ↑ dizziness. Pt c̄ unsteady head motion. Placed in supine position. CT to H2O Seal. IVF cont. to infuse. Will cont. to monitor (b)(6)-2 [redacted]
14 Jun 03 1600	Pt resting in bed c̄ HR 130-140's. SpO2 95-99%. IVF cont. to infuse. Pt CDB c̄ incentive spirometer in use. Nonproductive. Consulted on [redacted] (b)(6)-2 regarding HR. IVF 50-100/hr. concentrated. Cont. c̄ wheezing and ↓ bases (breath sounds) (b)(6)-2 [redacted]

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MEDICAL RECORD | **PROGRESS NOTES** | AUTHORIZED FOR LOCAL REPRO

DATE	NOTES
14Jan03 1250 Resp Therapy	Neb tx given .5cc Alb & 2.5cc NS Bs Coarse exp & insp wheezing Diminished in Bases HR 132 BP 114/66 RR 26 SpO2 96 BS No Δ after tx ~~No~~ NT suction done removed less than 1cc of secretions pt did not cough [redacted] RT SGT (b)(6)-2

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

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

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

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

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 Jun	1800 pt. given ND AIB via face mask @ 8LPM
	P 118 - 119
	RR 24 - 19
	BBS - coarse throughout p̄ NO Δ
15 Jun	0000 pt tx given by nurse.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
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[redacted] (b)(6)-4

REGISTER NO.	WARD NO.

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1000 RT 14 Jun 03	Neb tx Given to pt .5cc Alb c̄ 2.5cc NS BS insp & exp wheezing in upper lobes diminished in lower lobes SpO2 97% HR 125 BP 119/73 RR 33 Post Tx BS NO Δ SpO2 97% NT suction Done on pt removed about 2cc secretions pt Did not cough SpO2 99% (b)(6)-2 [redacted]
1603 RT 6/14/03	Neb tx given to pt .5cc Alb c̄ 2.5cc NS BS coarse diminish in lower lobes HR 147 BP 111/60 SpO2 97 Post Tx BS Diminished HR 145 BP 111/60 RR 32 SpO2 97. ~~Pt not N~~ Did Not Do NT suction pt did IS and coughed (b)(6)-2 [redacted]
14 Jun 03 1620	Pt evaluated by anesthesia and (b)(6)-2 [redacted] for ↑ HR 145 RR 32. HR ↓ p̄ coughing and any movement to 140's. Order given to give 1L of fld. Tolerating PO intake well. Pt continues to use incentive spirometer c̄ gradual progression of use. Will continue to monitor (b)(6)-2 [redacted]
15 Jun 03 0430	CPT, FCS, c̄ CDB throughout p.m. ~~Took~~ @ VS shut-off frequency. MSO4 4mg IVP Q1° for pn c̄ activity. U/O ~70cc golden yellow urine. P.M care done. CT dressing reinforced. Report given to CPT (b)(6)-2 [redacted]. NT [redacted]
15 Jun 03 0600	Pt resting in bed. Awakened and encouraged to use IS. Easily arouses. Respirations unlabored intermittent CDB. Instructed on splinting wounds. SpO2 95-99% (b)(6)-2 [redacted]

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.

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

PROGRESS NOTES
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LAST NAME	F.NAME	MIL	INITIAL	ID NUMBER

DATE	NOTES
15 Jun 03 0600 Cont	td Da via NC @ 3L. CT to (L) CW to water seal minimal amt serosanguinous fld. Breath sounds clear to upper lobes, diminished in bases. Medicated sporadically for c/o pain. Palpable pulses (2). Abd sound NO, NT c̄ hypoactive bowel sounds. Tolerating clear liquid diet s̄ complications. Foley cath to BSO c̄ dark yellow urine. IVF LR infusing @ 50cc/hr. Continues ~~and~~ c̄ antibiotic therapy. Pt instructed on importance of IS and coughing c̄ the assistance of the interpreter. Will continue to monitor status - [redacted] (b)(6)-2 CFAN
15 Jun 03 1600	Pt up to ambulate in AM. Tolerated fairly. c/o feeling dizzy and noted an unsteady gait p̄ ambulating 5 mins. Starting to use IS productively. Coughing intermittently nonproductively. Up @ BS x1 today and tolerated well. IVF LR continue @ 50/hr. Fentanyl patch applied @ 1250 50mcg. to (L) side of back. Pain meds MSO4 administered throughout the day. VSS. Febrile to max 101. Give Tylenol 650mg PO @ 1200. No further changes. [redacted] (b)(6)-2 CFAN
15 JUN 03 1220	Pt c/o pain around incision area on the chest. Medicated with 2mg MSO4 IVP. [redacted] (b)(6)-2
15 Jun 03 1730	Medline dressing to sternal area CDI. Drains to CT and CDI. Will keep monitoring for any changes. [redacted] (b)(6)2
15 Jun 03 1800	Pt encouraged to deep breath and cough. Been incentive spirometry 10x while awake. [redacted]
15 JUN 03 1930	Pt up and ambulating well with minimal assistance. [redacted] (b)(6)2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15 Jun 03	Surgery Progress Note BPW [redacted] (b)(6)-2 Pericardiotomy & (L) Tube Thoracostomy Doing well tolerating PO, Ambulating ō assistance & ō better Pulmonary Hygiene. GIS: Awake, Alert, Follows commands Lungs: improved ↓ BS B/L CAR: (+) volume loss CV: Tachycardic HR 117 RR 22 94% RA Abd: soft, NT, ND (+) BS ID: Tmax 101.8 Tc 99° I/O 2847/1290 < T = 72 Imp: Improving Plan: Advance Diet cont current plan (b)(6)-2 [redacted] ✓ Labs & CXR in AM DC CT tomorrow

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

WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 JUN 03	Surgery Progress Note (b)(6)-4 [redacted] 90 male [redacted] (b)(6)-2 doing well, tolerating PO, ambulating but c̄ poor pulmonary hygiene. CNS: awake, alert, oriented CVS: HR 122 BP 136/86 Lungs: ↓↓ B/L BS I/O 1760/1852 Abd: soft, NT, ND @ BS CPK: ØPITY Ext: improving Plan: DC chest tubes cont pulmonary work [redacted] (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16 Jun 03 0600	Pt received resting in bed smiling. O_2 on via N/C @4L. See DA 4700 for initial assessment. Art care performed and CXR obtained. Will continue to monitor (b)(6)-2 [redacted] CPT/AN
0900	Chest tube pulled by Dr (b)(6)-2 [redacted], occlusive dressg applied c̄ petroleum gauze. Foley D/C'd per physicians orders. No further problems noted @ present time, will continue to monitor [redacted] CPT/AN
1100	CXR taken. results pending (b)(6)-2 [redacted] CPT/AN
1300	Pt c̄ complaints of difficulty urinating. In + out catheter performed c̄ output of 900cc noted. Pt currently comfortable, will continue to monitor (b)(6)-2 [redacted] CPT/AN
1500	Pt given tylenol 650mg for temp of 100.7. Encouraged use of incentive spirometer. Pt up to bedside and sat up in chair. (b)(6)-2 Currently resting in bed, will continue to monitor [redacted] CPT/AN
1700	Pt currently lying in bed, temp currently 99.7. Continues use of incentive spirometer & encourages coughing & deep breathing. Report given to oncoming shift (b)(6)-2 [redacted] CPT/AN
1800	up in bed - dangling feet for dinner - ate one cookie, few pieces of fruit - a few teaspoons to vegetables + milk. tolerated well - oxygen off - Sat 95% - Incentive spirometer x 10 - 2 balls up - Encouraging to take deep breaths (b)(6)-2 [redacted] MAS/AN
1830	Ambulated to commode and g tent - flatus c̄ small watery stool - tolerated well - Some initial nausea upon return to bedside - then went away c̄ sitting up in chair - (b)(6)-2 [redacted] MAS

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REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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All (b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 June 03 1900	up in chair x1 hour & oxygen O2 sat >85 - tol. well - talking to interpreter & mp guard about his situation - Back to bed O2 sat ↓ 88 - 2L s/c on in sat 99% [redacted] (b)(6)-2
16 June 03 2230	Pt. sitting up in bed ⅁ c/o. O2 on 4L NC sats ranging 98-100%. Encouraged use of IS. — [redacted]
17 June 03 0825	Pt. in agitated state. Woke up & started to disconnect his EKG leads & IV. Pt. calmed down, leads re-connected & IV re-attached. Will cont. to monitor. — [redacted]
17 June 03 0400	Albuterol neb tx given. Pox cont. to range between 96-100%. ō 4L O2 NC. ∅ signs resp. distress throughout the night. Pulmonary toilet & IS used. Pt. currently sitting up in bed eating crackers. Will cont. to monitor. — [redacted]
7 Jun 03 0000	Pt appears to be resting comfortably ⅁ s/s of pain or discomfort. VSS, NAD HOB ↑ 30° [redacted] SSG 9/W/M6
17 Jun 0700	↓ O2 to 2LPM SAO2 95% RR 16 unlabored pt more awake ⅁ Active [redacted] SSG 9/W/M6
7 Jun 0800	Pt sitting up in bed ⅁ O2 SAO2 95% RA Pt sitting in bed ⅁ very active [redacted] SSG 9/W/M6
7 Jun 03	2130 PT recieves 650mg tylenol for fever of 101.6 — [redacted]

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Both (b)(6)-2

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 Jun 03	Neb tx given to pt BS Clear Diminished in lower lobes
0826	HR 107 BP 140/89 RR 21 SpO2 93 Post tx HR 111 RR 26 SpO2 95
	BS Diminished in lower lobes [redacted]
17 Jun 03	Neb tx given .5cc Alb / 2.5cc NS BS Diminished ~~Rth Lob~~
1151	thorac on insp HR 110 RR 20 SpO2 95 pt tx HR 107
	RR 22 SpO2 BS No change [redacted]

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All (b)(6)-2 except one at bottom

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15Jun03	Pt ~~gas~~ neb tx ē .5cc Alb/2.5cc NS x dur of meds HR 115-118 P.O. on 4LPM bi3. ↓ in lower ↑ LUL, pt not ~~taking~~ deep breath, ~~nyscent~~ lung expansion therapy ~~nyscent~~, I.S. instructed but pt effort poor? Language problem, will return tx instruct again, ~~listen to~~ well [redacted] CRT
15Jun03	Neb tx given. .5cc Alb/2.5cc NS HR 110 RR 29 SpO2 96 BS Diminishe in ~~two~~ LLobes Rhonci on insp. Post Tx HR 127 RR 29 SpO2 97 BS Rhonci insp & exp Diminishe lower lobe [redacted]
16Jun03 0800	Neb tx given .5cc Alb/2.5cc NS. BS Rhonci on insp Diminished lower lobes HR 123 BP 133/81 RR 27 SpO2 78 % Post Tx HR 125 BP 133/81 RR 24 SpO2 97% BS Rhonci upon inspiration Diminished Lower lobes [redacted]
16Jun03 1229	Neb tx given .5cc/2.5cc NS BS Diminished in base HR 123 BP 141 RR 20 SpO2 95 Post Tx 134 BP 141/79 RR 31 SpO2 93 [redacted] RT 307
16Jun03 1604	Neb tx given .5cc/2.5cc NS BS Diminished HR 102 BP 123/69 SpO2 90% Post Tx HR 113 BP 123/69 RR 25 SpO2 91 Pt placed on NC @ 4lpM BS Diminished pt SpO2 98% [redacted]

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

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REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	
17 Jun 03	1250- Pt received from ICU via ambulatory. BP 112/78 P 110 T 99.8 Resp 22. Staples to midline chest intact ∅ S/S of infx. Dsg to CT site CDI. HL to (L) hand. Upper airway noise heard, Diminished in bases. HR reg, BS(+) x4. Pulses strong + equal bilat to upper & lower ext. Cap refill <3 sec. Skin (b)(6)-2 warm & dry to touch — [redacted] 2nd AN
17 Jun 03 1900	assumed care @ 1300 - VSS - (R) BS - (R) lung, upper lobe ⊂ rales noted, (L) CTA - staples intact on chest & abdomen, dsg on (R) chest covering CT site, CDI - IV patent - pt. ambulated x2 this shift - encouraging C&DB q1° - ate small amount of chicken for dinner (b)(6)-2 [redacted] CM
2130	Pt care assumed @ 2100. T @ 101° @ 2100, @ 2230 temp @ 98.6. Lungs have rales heard in (R) lung, upper lobe on inspiration, (L) lung CTA. Abd ⊂ staples OTA CDI, ∅ S/S infection. IV heplocked, flushes well. IS encouraged on pt. Pulses palpable x4, bowel sounds present x4 (b)(6)-2 quads. Pt without complaints, continue to monitor. SPC [redacted] 9 Jun 03
18 Jun 03 0600	Pt. awake & alert in bed. VSS: BP 104/68, Sats 94%, P98, temp 99.4. Incision is midsternal, 12 inches long, well approximated, no signs of infection. Dsg on (L) side of chest CDI. Heplock in (L) hand ⊂ S/S of infection. Pt has

(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. ICW2

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

PROGRESS NOTES
Medical Record

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All (b)(6)-2

PROGRESS NOTES

DATE	
18 June 03 0600	no complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] 2LT(AN)
0700	New IV placed in (R) hand. [redacted]
18JUN03 1430	Assumed care of Pt @ 1300. VSS x mild temp. A+Ox3. Staples CTA CDI mid sternal line. (L) chestwall drsg CDI. (+) BS x 4, palpable pulses x 4. (R) LS ↓ Rhonchi. (L) LS CTA. Pt encourage Deep Breath and cough (+) IS. O/W Assessment WNL will Monitor [redacted]
18Jun03 01:20	Pt received awake + alert in bed. VS WNL according to flow sheet. PERRLA (+) WNL. Skin W/D. Lung sounds ↓ @ base (B) A+P. (L) lung C (+) crackles. (+) BS x4. ML ABD incision well approximated C staples intact. ⊗ sxs infection. Drsg to (L) lateral chestwall CLD/I D/C last 16 Jun 03. (+) PPP (B). Cap refil <3 sec. Pt instructed to use incentive spirometer for 10 min. Was able to hold ball @ 2200 mL. Pt. C+DB C (+) Productive cough (+) viscous mucous whitish in color, C/O pain in general chest area ↑ Tylenol #3's given. Will cont. to mon [redacted]
19Jun	Assumed care of pt @ 0800. Pt has C/O gas. MD said it was normal. Lungs sounds are congested. Pt has take 3 big breaths with deep coughs. Pt has ambulate twice. Pt was given T-3 @ 0800. Pt has ate all his breakfast and lunch [redacted]
19JUN03 1450	Assumed care of Pt @ 1300. VSS x pulse was 121 ↑ pt ambulated recheched @1445 P: 100. A+Ox3. Drsg (L) Chest Wall CDI, mid sternal incision staples CTA CDI. (B) LS insp/exp wheezing ↓'d @ bases. (+) IS, (+) deep breath + cough, ambulation @ 4° ↓ assistance. (+) BS x 4. (+) palpable pulses x 4 (⊗) edema. (+) cap refil <3 sec (B) LE. O/W Assessment WNL. Will Monitor [redacted]

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MEDICAL RECORD	PROGRESS NOTES
DATE	
18 JUN 03	SURGERY PROGRESS NOTES (b)(6)-4 PT [redacted] IMPROVING BUT STILL Ø MILD TACHYCARDIA, ABDOMINAL IMPROVING PULMONARY HYGIENE VSS / APOB CVS: HR 100 130/60 LUNGS: ↓↓ BBASES C/W CTA ABD: SOFT, NTND Ø BS EXT: STABLE (b)(6)-2 PLAN: CONT PULMONARY HYGIENE [redacted]
19 JUN 03	SURGERY PROGRESS NOTES PT POD #6 STABLE VSS / APOB HR 110-120 LUNGS: HONKING COUGH LUNGS: ↓↓ ON LEFT CVS: IMPROVING TACHYCARDIA EXT STABLE (b)(6)-2 PLAN: CONT CURRENT TX [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.

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

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	
19 June 03 1930	Pt c/o pain in chest. Pulse: 123 O_2 SATS: 87% diaphoretic, pt had same c/o pain x 2 days. Pt put on O_2 ~~SATS~~ @ 2L O_2 SATS 96%, wean from O_2 now SATS 93% on RA. Venous ABG Drawn, CSD MO notified. No new order. Cont. LS, Deep breath + cough. Will monitor (b)(6)-2 [redacted]
19 June 03 2100	Pt. vitals taken BP 108/60, P. 106, R. 16, Temp. 98.8 SPC [redacted] (b)(6)-2
19 Jun 03 22:40	Assumed care of pt @ 21:00. Pt awake resting in bed and alert. VS WDL. LS (B) wheezing. more severe (R) side. thorax BS (+) x4. Dsg C/D/I. (+) PPPB. HL (P) Hand patent. Will cont. to mon. (b)(6)-2 [redacted] DZT/AD
23:20	Pt ↑ to amb on ward. c/o pain @ this time. ii Tylenol #3's given Will monitor [redacted] DZT/AD
20 June 03 0550 T 99.6 P 112 R 18 BP 116/72 92%	Assumed pt care @ 0500: Pt. awake, A+O x 3. Lung inspiratory wheezing heard in (R) + (L) upper bases. (+) pulses x4. Hypo active BS x4. Sats: 89% RA. HL (R) EA patent to flush. c/o tightness in chest. O_2 2L NC administered c̄ some relief. Will continue to monitor. [redacted] (b)(6)-2 9 ward

(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

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

PROGRESS NOTES

DATE	
20 June 03 1410	assumed pt care @ 1300. pt sitting ↑ in bed awake & alert. VSS. O2 sats @ 94% on RA. lung sounds ↑ [redacted] lobes c̄ wheezing noted. abd c̄ midline incision c̄ staples OTA ⊖ s/sx of infection noted. ↓ & ↑ ext c̄ full ROM strong ⊕ pulses. HL ⓡ wrist flushes c̄ diff. ⊖ signs of infection noted. pt encouraged to use IS. pt voided 350cc dark golden urine. Will cont to monitor. [redacted] 91WM6 S6T
2130	Pt. care assumed @ 2100. Pt. alert & compliant. Pt. ambulated length of ward x 10. Pt. using IS c̄ frequent coaching. HR Keg. Ensp wheezes noted throughout lobes. ABD c̄ BS ⊕ x4, soft. midline incision to chest c̄ staples OTA, c̄ s/s infection. Will cont. to monitor. [redacted] 91WM6
20 June 03 2200	Pt vitals taken BP 120/82, P. 116, R. 16, Temp. 100.3
21 June 03 0630	Pt. awake & alert in bed. VSS: BP 134/80, sats 93%, T99.5, P109. 14 inch midsternal incision & 4 inch incision on ⓛ side both well approximated c̄ s/s of infection. Heplaked in ⓡ FA, flushed well c̄ 3cc NS c̄ s/s infection or infiltration. Breath sounds clear bilat. Bowel sounds (+) all 4 quads. All other assessments WNL. Pt. has no apparent complaints @ this time. Will continue to monitor. [redacted] 2LT(AN)
1000	

STANDARD FORM 509 (REV. 7-91) BACK
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NSN 7540-00-634-4176

600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 JUN 03	Surgery STABLE VSS / AFEB mild tachycardia Lungs: CTA Card: RRR CVC: B/L pleural effusions Resp: improving Plan: manage pleural effusion [redacted] (b)(6)2
21 JUN 03 1400	Assumed care of Pt @ 1300. VSS x pt tachy HR's (B) LS ↓'d @ bases, (L) side CTA (R) side coarse insp. wheezes. (+) BS x 4. Palpable pulse x 4. (+) IS use, Deep breath and cough. Ambulate w/ assistance (Ø) c/o pain. MID STERNAL incision c̄ staples OTA CDI. O/W assessment WNL. Will monitor [redacted] (b)(6)-2
21 JUN 03 2145	Assumed C/O pt @ 2100. Pt. Awake and alert in bed. VS WNL x̄ temp. ↑ 100.8 ℞ tylenol given ↓ temp to 99.2 @ 23:30. Skin W/D. PERRLA (+). LS Rhonchi mid (R) [redacted] (b)(6)-2 ant. lobe and diminished @ base. (L) lung CTA x̄ @ base diminished. Encouraged to C+DB for 10 min c̄ difficulty. Pt used IS for 10 min and achieved level 4. BS (+) x 4. MLABD incision intact c̄ staples minimal erythema. Sutures to (L) lat. chest intact c̄ min. erythema (+) PPP (B). Ø c/o's @ this time will cont. to mon [redacted] (b)(6)-2

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

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

RECORDS MAINTAINED AT: ▶

PATIENT'S NAME *(Last, First, Middle initial)* | SEX

RELATIONSHIP TO SPONSOR | STATUS | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION

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

MEDCOM - 10617 DF MEDICAL CARE

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23:30	LCA(B) diminished @ bases will cont to mon
(b)(6)-2	[redacted] /AN
22 June 03	Assume pt care @ 0300. Pt sitting up, awake.
0700	VSS. HR regular. Lungs CTA, diminished @ bases. pt encouraged to cough and use IS. Tylenol #3 PO adm. for pain. pt amb to BR. Abd soft - BS x 4 active - midline incision intact no s/s redness/ infection. HL to (R) hand, no s/s redness infiltration c flast will continue to monitor. (b)(6)-2 [redacted] S/K MA
1000	pt ambulated and OOB to chair. Use of IS and encouraged to cough. (b)(6)-2 [redacted] S/K MA
22 June 03	Pt vitals taken BP 120/88, P. 116, R. 18, Temp. 98.6
2145	SPO [redacted] (b)(6)-2

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22 June 03 1110	General Surgery (b)(6)-2 [redacted] s/p Mediastinotomy, pericardiotomy - 2° GSW lung wedge. 20 complaint x stating denies chest pain T 100.8 HR 100-115 BP 130/80 94% RA Cooled office - admit to CCU chest CXR x 1 R/C basal pneumonitis CXR trachea ⊥ (+) NAD sit up assess: Stable Ochiai (+) staple line, mild erythema, drainage suspect infection
1100/1200	Bring back office - staples / sutures removed - R/C effusions - expect resolution over time - d/c home. (b)(6)-2 [redacted]
22 Jun 03 2030	assumed care @ 1300 - VSS [redacted] - a s. on intact + upper lobes in (B) lungs c̄ ↓ Breath sounds - (+) BS - tolerated regular diet - IS used 9 l°, ambulated this shift [redacted] (b)(6)-2

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

[redacted]

EPW (b)(6)-4

RECORDS MAINTAINED AT: [redacted] (b)(6)-2

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

MEDCOM - 10619 OF MEDICAL CARE [redacted] (b)(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22 Jun 03 21:57	Pt. awake + Alert in bed. VS WNL. Skin PWD. PERRLA (+) LCA (B). BS (+) x4 (+) PPP (B). M.L. ABD incision well approx. c/o pain @ this time. Enc. [redacted] (b)(6)-2 Enc. to walk. Pt walk w difficulty. Enc IS. Will cont to mon [redacted]
0345	Pt. awake c/o muscle pain (R) chest. Palpated chest muscle was cramping. Auscultated (R) lobe (+) Rhonchi. Pt enc to C+DB and use IS. Will mon [redacted] (b)(6)-2
23 June 03 0630	Assume pt care @ 0500. Pt awake and alert sitting up in bed. C/o chest pain (B). VSS, Lungs CTA. Abd soft. Midline insicion intact. BS x4 active. Pt ambulates well. Pt encouraged to use IS. Will Continue to monitor. HL to (R) hand no s/s redness/infiltration c̄ flush [redacted] (b)(6)-2
	1130 HL Discontinued [redacted]
23 Jun 03	Evening pt stable VS Lungs: CTA Will OC [redacted] (b)(6)-2
23 Jun 03 1515	pt. escorted to [redacted] (b)(2)-2 for release/discharge by mp's [redacted] (b)(6)-2

*U.S. Government Printing Office: 1996 - 404-763/40001

STANDARD FORM 600 BACK (REV. 5-84)

558-103

(See Instructions on Back of this Sheet)

NSN 7540-01-075-3781

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): [redacted] (b)(6)-2

LOG NUMBER

ARRIVAL — DATE: DAY 13 / MONTH 6 / YR. 03 — TIME: 0230

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

CURRENT MEDS. (Tetanus immunization and other data)

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES: 1

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

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration): GSW to Chest

SEX: M

AGE:

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: On Arrival

VITAL SIGNS			
TIME	0234	0245	0310
BP		170/10	150/102
PULSE	139	125	101
RESP.	33	37	37
TEMP.			
WT. (Child)	40	95	90

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

ORDERS	INITS.	TIME
CBC MPTO PTT		0245
T&S		0245
U/A (b)(6)-2		0300
morphine 2mg [redacted]	2ms	0305
Ancef 1gm [redacted]	1g	0305
Dramamine	100	

ASSESSMENT/DIAGNOSIS: GSW to chest

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

0230 pt via litter.
CPR in progress
Eyes fixed dilated
O2 bagging by RT — chest tube #1 placed @ 0233
Chest tube kit - ~~tube~~ placed 0233
CPR continues ~~2 Amps~~ 2 Amps Narcan
Foley 0250
NG tube
ET 26 at lip
Chest tube 0310 #2

Male Iraqi EPW Arrived via helicopter after being shot by US troops? Pt received CPR from arrival thru start of flight. Intubated immediately. Pt arrived c̄ no BP/Ø spontaneous respiration and fixed dilated pupils. A: ET tube in place/NG tube in place. B: ↓ BS on (L) (no needle out of 2nd intercostal space) Extremities warm and clear. C: pt c̄ no or faint pulse. D: GCS=3. E: Naked c̄ (1) IV. U/S shows (+) pericardial effusion. FAST Exam (−).

0320	
BP	194/101
HR	89
RESP	29
SpO2	98

[redacted] (b)(6)-2

Orders
tetnus .5cc 0310
Etomidate 20mg 0310

Surgeon to see pt. placed good chest tube.

29	14 / 48	293

UA - WNL

O +

13.2/31.6/87 P77

138	110	14	273
4.1	18	0.9	

CXR - chest tube in tow/post good ET tube placement good NG tube placement & stay

2 CXR
(+) Both lungs in good place
good ET tube placement & stay

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

CONDITION UPON RELEASE
- ✓ IMPROVED
- UNCHANGED
- DETERIORATED

TIME OF RELEASE:

(CONTINUE ON SF 507, IF NEEDED)

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

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

SIGNATURE OF PROVIDER AND ID STAMP: [redacted] 14WD 226 (b)(6)-2

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

Ø Exit wound found. BACK of Trauma noted. Rectal Exam (−), Foley placed good return. Pupils Begin more reactive during resuscitation pt c̄ return of pulse c̄ CXR.

EMERGENCY CARE AND TREATMENT

MEDCOM - 10621

Copy

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

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

8.5 ETT
25cm @ lip

VENT FLOW SHEET

pH pCO2 pO2 HCO3 BE SaO2

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	I/E TIME	Spont RATE	PLATEAU	HR	SO2	BP	ET	CUFF	INITIAL
6/13/03	0700	simv	14	750	60	5	31	1:2	0	—	96	100		8.5	mut	[redacted]
6/13	0830	simv	14	750	60	5	38	1:2	16	—	123	100	119/78	8.5	mut	
6/13	1003	simv	14	750	60	5	32	1:2	0	—	114	100	111/63	8.5	mut	
6/13	1225	simv	14	750	60	5	36	1:2	5	—	129	100		8.5	mut	
6/13	1235	simv	+8	750	+40											
6/13	1345	Pt	extubated		Placed on		non Rebreather			10L PM						

(b)(6)-2

MEDCOM - 10622

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): Unk 3. PREVIOUS SURGERY [ ] NO [ ] YES (type): Unknown

4. PROPOSED SURGICAL PROCEDURE:

Pericardial window, poss median sternotomy

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications:
Jewelry removed: yes/no Family waiting: yes/no

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	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.
B. AERATION ___ Potential for respiratory dysfunction due to sedation; positioning; injury Smoking Hx?	o PT. will be able to breathe without difficulty during immediate intra-operative 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 integuity due to bovie pad; position; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ____ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	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 have been removed.
E. NEUROMUSCULAR CONTROL E.1. ____Potential impairment of mobility due to sedation; pain; injury E.2. ____Potential discomfort due to injury; pain	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, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures. N/A	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. (b)(6)2	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 COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] MAJ AN 13 Jun 03 DATE

11. POSTOPERATIVE EVALUATION:

Pt intubated, breathing c̄ assistance of ventilator. Dressings dry & intact. Chest tube & foley cath patent & draining.

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
(b)(6)-2 [redacted] MAJ AN DATE: 13 Jun 03 TIME: 0415	DATE: 13 Jun 03 TIME: 0698

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

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

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY ER personnel

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

3. DATE 13 Jun 03 TIME PATIENT ARRIVED IN SUITE 0415

4. PATIENT IN ROOM TIME 0415 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: Intubated

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] MAJ [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

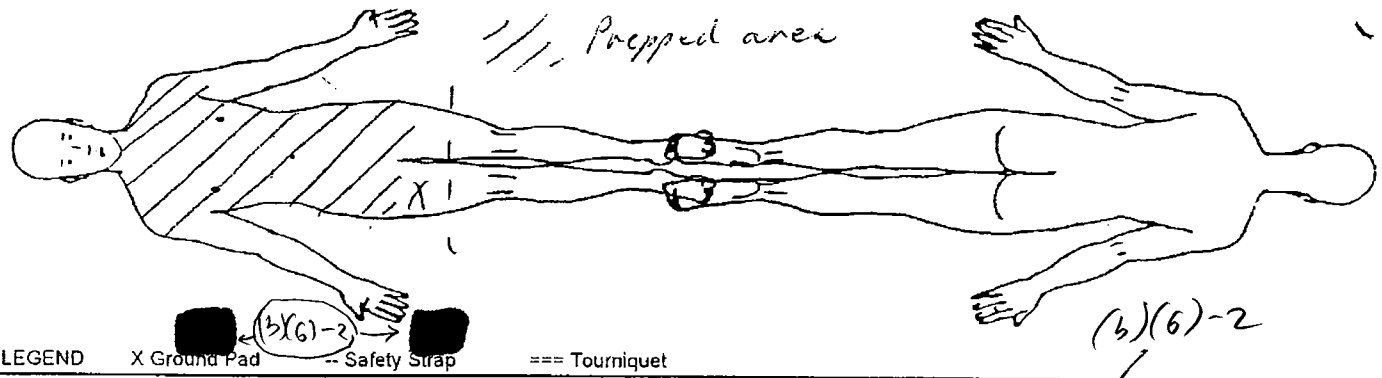
COMMENTS: Both arms on padded armboards, at angle < 90°

8. SKIN PREPARATION

HAIR REMOVAL ☑ YES ☐ NO
DONE BY: ☑ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☑ RAZOR ☐ CLIP
COMMENTS: Chest by Dr Nesser

PREP SOLUTION (Specify) Povidone scrub & solution
SITE: Chest BY WHOM: MAJ [redacted]
SITE: BY WHOM: (b)(6)-2
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] SPC [redacted]	MAJ [redacted] MAJ
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: Valleylab #1
GROUND PAD: BRAND Valleylab
LOT NO: [redacted] Exp 2005-03
(b)(6)-4

☐ 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): N.S.

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. 10mm Jackson Pratt	2.	3.
SITE	1. Lt upper abdomen	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

4x8's
Silk Tape

19. ADDITIONAL INFORMATION

WC

Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: GETA

(b)(6)-2

Bovie Pad site intact pre-op Cal ; post-op _____ Bovie Settings: Coag/Cut 30/30 to 40/40

Tourniquet ~~Site intact pre-op~~ ~~N/A~~ ; post-op N/A

Tourniquet Time: Up N/A Down N/A

20. OPERATION(S) PERFORMED

Pericardial window, Median sternotomy,

21. PATIENT TRANSFERRED TO ICU 2 (b)(6)-2 TIME See SF 517 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ AN 13 Jun 03

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.01

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR June 2003 | DAY | HOUR

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° 37.2°
98.6° 37.0°
120 98° 36.7°
110 97° 36.1°
100 96° 35.6°
90 95° 35.0°
80
70
60
50
40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

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

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

Ward/Section: ICU 2	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. # [redacted] (b)(6)-4		DATE 03Jun03	TIME 0810	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	15.2	4.8-10.8 x 10^3
RBC	5.84	4.7-6.1 x 10^9
Hgb	14.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct 48.4	~~82.9~~	42-52% (M) 37-47% (F)
MCV	82.9	80-94 fl (M) 81-99 fl (F)
Plt	336.	130-500 x 10^3 verified
Lymph %	20.3	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

i STAT G3: 13Jun03 0745

Pt: [redacted]

Pt Name:_____

TCO2_____24 mmol/L

At 37°

pH_____7.040

PCO2_____[illegible] mmHg

PO2_____[illegible] mmHg

HCO3_____23 mmol/L

BEecf_____ 3 mmol/L

sO2%_____100 %

Xcalculated

Sample Type_:

10JUN03 00:05

Oper: [redacted] (b)(6)-4

Physician:_____

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

Ver: [redacted]

---

i STAT G3: [illegible]

Pt: [redacted]

Pt Name:_____

TCO2_____27 [illegible]

At 37C

pH_____7.040

PCO2_____45.0 mmHg

PO2_____111

HCO3_____26 mmol/L

BEecf_____1 mmol/L

sO2%_____98 %

Xcalculated

Sample Type_:

10JUN03 10:14

Per: 000041

Physician:_____

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

Ver: [redacted]

---

i STAT G3W

Pt: [redacted]

Pt Name:_____

TCO2_____[illegible] mmol/L

At 37C

pH_____[illegible]

PCO2_____[illegible] mmHg

PO2_____[illegible] mmHg

HCO3_____[illegible] mmol/L

BEecf_____[illegible] mmol/L

sO2%_____[illegible] %

Xcalculated

Sample Type_:

10JUN03 14:46

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: [redacted]

Section: EMT | RE[redacted]NG PHYSIC[redacted]AN: (b)(6)-2 | LORATORY RESULT FORM (Subject to the Privacy Act of 1974)

FIRST, MI: #[redacted] (b)(6)-4 | DATE: 26JUN07 | TIME | SSN/PSEUDO SSN: #[redacted] (b)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
ST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	29.2	4.8-10.8 x 10^3	Color	Yellow	N/A	RPR		Negative
RBC	5.82	4.7-6.1 x 10^9	App	Clear	N/A	Mono		Negative
Hgb	14.4	14-18 g/dl (M) 12-16 g/dl (F)	Glu	neg	Negative	**Microbiology**		
Hct	48.0	42-52% (M) 37-47% (F)	Bili	neg	Negative	Source		
MCV	82.4	80-94 fl (M) 81-99 fl (F)	Ket	neg	Negative	Gram Stain		
PLT ~~MCHC~~	363	130-500 x 10^3 verified	SG	1.030	N/A	Occ Bld		Negative
CH 6-	n %	20.5-51.1%	Bld	neg	Negative	H. pylori		Negative
-4 % 23.7	(Hematology) Manual Differential		pH	6.0	N/A	Micro Parasites		
lymph	16	Mono 14	Prot	3+	Negative	Malaria		
band	30	Eos 1	Urob	neg	0.2-1.0	O & P		
seg	42	Baso	Nit	neg	Negative	Other		
mono	14	Imm	Leuk		Negative	**Microscopic Urinalysis**		
	1+		HCG		Negative	SSA -4+		
ocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
ite			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
			Directigen		Negative	ABO/Rh	(b)(6)-4 [redacted]	

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
r	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT	13.2	9.8-13.6 secs			
PTT	31.6	21-34 secs			
er		<20 ug/ml			
		<10 ug/ml			

ARKS:

RTED BY: Iraqi Civilian [redacted] -(b)(6)-4 [redacted] -(b)(6)-2 | DATE: | LAB ID NO.:

ard Section: GMT

STING PHYSICIAN: [redacted] (b)(6)-2

CHEMISTRY RESULT FORM

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

DATE: 17 JUN 03 | TIME:

SSN/PSEUDO SSN: #[redacted] (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 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	273	73-118 mg/dl
BUN	14	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	118	39-380 u/l (M) 30-190 u/l (F)
NA+	138	128-145 mmol/l
K+	4.1	3.3-4.7 mmol/l
CL-	110	98-108 mmol/l
tCO_2	18	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF RANGE
GLU		[illegible]
BUN		[illegible]
CA++		[illegible]
CRE		[illegible]
NA+		128-145 mmol/l
K+		[illegible]
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: (b)(6)-2 [redacted]

DATE: 13 Jun 03

LAB ID NO.:

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

Next
Cok
Pilots

Ward/Section

LAST, FIRST, M

DATE

HEMIST

Subject

[redacted]							
Na			ALB			GLU	
K			TP			BUN	
Cl						CA	
pH			M			CRE	
PCO2						NA	
PO2			BIL			K	
TCO2			BUN				
HCO3						CL	
sO2			HOL				
BEecf			CRE				
AnGap			GLU				
Ca						B	
BUN						P	
GLU						MY	
Creat							
Bil						BIL	
Hgb			ORE			SGOT	
[redacted]							
Troponin-I							
Drug of Abuse			CL			NA	
			TCO			K	
						CL	
						CO	

REMARKS

REPORTED BY

DATE

LAB ID NO.

1-STAT 227+

Pt: [redacted] (b)(6)-4

Pt Name: _____

Na_____143 mmol/L

K_____3.8 mmol/L

TCO2_____21 mmol/L

iCa_____1.09 mmol/L

Hct_____40 %PCV

Hb*_____14 g/dL

*via Hct

@ 37C

pH_____7.029

PCO2_____37.8 mmHg

PO2_____324 mmHg

_____20 mmol/L

BEecf_____-6 mmol/L

sO2*_____100 %

*calculated

Sample Type:

10JUN03 04:58

Oper: [redacted] (b)(6)-4

Physician: _____

Ser# [redacted]

Ver: [redacted]

---

rd/Section: ICU 2

K ESTING PHYSICIAN: [redacted] (b)(6)-2

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

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

DATE: 13Jun03

TIME: 0810

SSN/PSEUDO SSN:

(i-STAT)

EST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
O2		35-45 mmHg (art) 41-51 mmHg (ven)
2		80-105 mmHg (art) N/A (ven)
O2		23-27 mmol/L (art) 24-29 mmol/L (ven)
O3		22-26 mmol/l (art) 23-28 mmol/L (ven)
2		95-98%
ect		(-2) – (+3) mmol/L
Gap		10-20 mmol/L
		1.12-1.32 mmol/L
JN		8-26 mg/dl
.U		70-105 mg/dl
eat		0.7-1.5 mg/dl
t		38-51% PCV
b		12-17 g/dl

Misc. Chemistry

EST	RESULT	REF. RANGE
ponin-I		Negative
ug of use		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	3.6	3.5-5.5 g/dl
ALP	68	26-84 u/l
ALT	134	10-47 u/l
AMY	557	14-97 u/l
AST	124	11-38 u/l
TBIL	0.8	0.2-1.6 mg/dl
BUN	12	7-22 mg/dl
CA^{++}	8.2	8.0-10.3mg/dl
CHOL	229	100-200 mg/dl
CRE	1.3	0.6-1.2 mg/dl
GLU	150	73-118 mg/dl
TP	7.0	6.4-8.1 g/dl

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU	150	73-118 mg/dl
BUN	12	7-22 mg/dl
CA^{++}	8.2	8.0-10.3 mg/dl
CRE	1.3	0.6-1.2 mg/dl
NA^+	146	128-145 mmol/l
K^+	3.4	3.3-4.7 mmol/l
CL^-	109	98-108 mmol/l
tCO_2	24	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

EMARKS:

EPORTED BY:

DATE:

LAB ID NO.:

rd/Section: ICU 2

R. ESTING PHYSICIAN: [redacted] (b)(6) -2

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

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

DATE: 14/6 | TIME: 0400 | SSN/PSEUDO SSN:

(i-STAT)

EST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
O2		35-45 mmHg (art) 31-51 mmHg (ven)
2		80-105 mmHg(art) N/A (ven)
O2		23-27 mmol/L (art) 24-29 mmol/L (ven)
O3		22-26 mmol/L (art) 23-28 mmol/L (ven)
2		95-98%
ecf		(-2) – (+3) mmol/L
Gap		10-20 mmol/L
		1.12-1.32 mmol/L
JN		8-26 mg/dl
.U		70-105 mg/dl
cat		0.7-1.5 mg/dl
t		38-51% PCV
b		12-17 g/dl

Misc. Chemistry

EST	RESULT	REF. RANGE
ponin-I		Negative
ug of use		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	1.9	3.5-5.5 g/dl
ALP	39	26-84 u/l
ALT	44	10-47 u/l
AMY	173	14-97 u/l
AST	35	11-38 u/l
TBIL	0.7	0.2-1.6 mg/dl
BUN	6	7-22 mg/dl
CA^{++}	7.4	8.0-10.3mg/dl
CHOL	120	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	98	73-118 mg/dl
TP	3.9	6.4-8.1 g/dl

(Piccolo) ~~Metlyte 8~~

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{++}	138	128-145 mmol/l
K^+	4.3	3.3-4.7 mmol/l
CL^-	100	98-108 mmol/l
tCO_2	20	18-33 mmol/l

EMARKS: Met ~~8~~ 12 & Electrolyte

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

Ward/Section: ICU 2

TESTING PHYSICIAN: [redacted] (b)(6)-2

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

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

DATE: 14/6 | TIME: 0400 | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	6.5	4.8-10.8 x 10^3
RBC	3.78	4.7-6.1 x 10^6
Hgb	9.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	30.7	42-52% (M) 37-47% (F)
MCV	81.2	80-94 fl (M) 81-99 fl (F)
Plt	222	130-500 x 10^3 verified
Lymph %	26.4	20.5-51.1%

(Hematology) Manual Differential

egs		Mono	
ands		Eos	
ymph		Baso	
typ		Imm	
BC lorph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

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

(b)(6)-2 [redacted] 145Hn v3

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)	
STP	(mg)	125
Fentanyl	(mcg)	100 100/50/100 50/100
Midaz	(mg)	2 3
Rocuronium	(mg)	30 20 50
	( )	
	( )	
VOLAT AGENT: Forane	% del	2.0 2.5 2.0 1.0 0.5 0.1 .5 .5 .5 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	

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

FLUIDS — LINE site L Arm (R) EJ — Warmed: 1000 / 1500 / 1000

LOSSES — EST BLOOD LOSS; URINE – 1000 / 1400 / 1550

TOTALS	
125/375	TOTAL SOL 1000
500/Ø	
5/Ø	TOTAL URINE 1500

FLUIDS – SUMMARY: CRYSTALLOID– 2500; COLLOID– Ø; BLOOD– Ø

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: 90 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP – 159/97; HR– 105

GROUP CHECK: OK?– (Y) N

PATIENT RECHECK: OK for [redacted] PROCEDURE? (b)(6)-2 TIME– 0420

TIME → 0430 0500 0530 0600 0630 0700

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml	750	760	860	900	870	770	710	620	650
f – breaths/min	10	10	10	10	10	10	10	10	10
Peak inf pres / PEEP	25	25	25	25	24	25	25	25	25
MODE– S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	C
ET CO2 (torr)	28	27	26	25	23	23	25	27	27
FIO2 (Frac or %)	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
SpO2 (%)	100	100	100	100	100	100	100	100	100
ECG	ST	ST	ST	ST	ST	SR	SR	SR	SR
TEMP- site oral		96°							
N-M Block (T/4)	0/4	0/4	2/4	0/4	0/4	1/4	4/4	4/4	0/4

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

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

REMARKS– Code drugs with numbers, events with letters

(A) Pt in waiting area ID'd, Pt previous intubated, NG Tube in place (L) forearm (R) EJ IV.

(B) Pt to OR, monitor placed

(C) A-line placed Temp. 96°

0500 ABG/lytes/HCT 7.329/37.8/324/20/– 143/3.2/21 14/40

(D) chest open @ 050

(E) All fluids warmed (3l LR given in BMT)

RECOVERY AT 0650; PACU ICU #2 (Specify); OTHER; CONDITION: Stable/CV/ou; RESP– Ket; SpO2– 100; BP– 161/95; HR– 91

ANESTHESIA PROCEDURE TIME

	Start	Room	End
ANES	0400	0420	0700
	Ready	Begin	End
PROC	0425	0440	0640

PROCEDURES and CPT Codes: Pericardial window (+) / sternotomy /

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: ETT in place. (+) = BIS / GETA (b)(6)-2

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

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

Recovery in ICU (b)(6)-2 (b)(6)-2

SURGEONS: [redacted]

ANESTHETIST: [redacted] M.D. [redacted] (b)(6)-2 LTC, MC

PROCEDURE LOCATION: OR #1

DATE: 13 June 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 10639

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

PROPOSED PROCEDURE: PERICARDIAL WINDOW
SURGICAL SERVICE: GEN GUN SHOT WD TO CHEST
NPO SINCE: _____

ASA Physical State 1 2 (3) 4 5 (E)
WT: ≈ 70 KG/LB HT: 70 IN.
ALLERGIES: ?

HABITS:
TOBACCO: _____
ETOH: _____
DRUGS: _____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) _____
( ) _____
( ) _____
( ) _____
( ) _____
( ) _____

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

LABORATORY STUDIES:
HB/HCT: 14 / 48
U/A: _____
OTHER: _____

X MATCHED
O+
4 UNITS

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW NOT CONSCIOUS

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	GUN SHOT WD / MID CHEST
Bronchitis/URI	N	Y	CHEST TUBES X 2
COPD	N	Y	INTUBATED IN EMT
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	
Gastrointestinal:			
Hepatitis	N	Y	NGT
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
_____

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 _____
HEENT - Teeth _____
Trachea _____
TMJ/Neck _____
Oropharnyx _____
Nares _____
CHEST: INTUBATED & BBS = & CRACKLES
CARDIAC: SR 100's
EXTREMITIES:
IV Access: (R) EJ / (L) AC
+ Ulnar Filling: 18G / 18G
BACK: _____
OTHER: _____

NPO Since _____

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

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

The 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

Patient Identification: (Ward) _____

EPW # [redacted] (b)(6)-4 RECOVERY IN ICU-2

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.