BATES PAGES MEDCOM 10841-11640 HAVE BEEN WITHHELD PENDING REVIEW

IDA: MEDCOM

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

24G Dental Wire ~~x1~~ x1
in (L) mandible
24G Dental Wire in (R) mandible x1

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1:1 xylocaine c̄ ep. 1:100,000	12cc	intra-op	INJ	MEG	Dr. [redacted]

b6-2

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

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN [redacted] - b6-2

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)*
Ø

19. ADDITIONAL INFORMATION
Con't #7 by NSG staff. Throat packing on @ 0905 out @ 1030

Surgeon [redacted] Anesthesia [redacted]
b6-2

20. OPERATION(S) PERFORMED

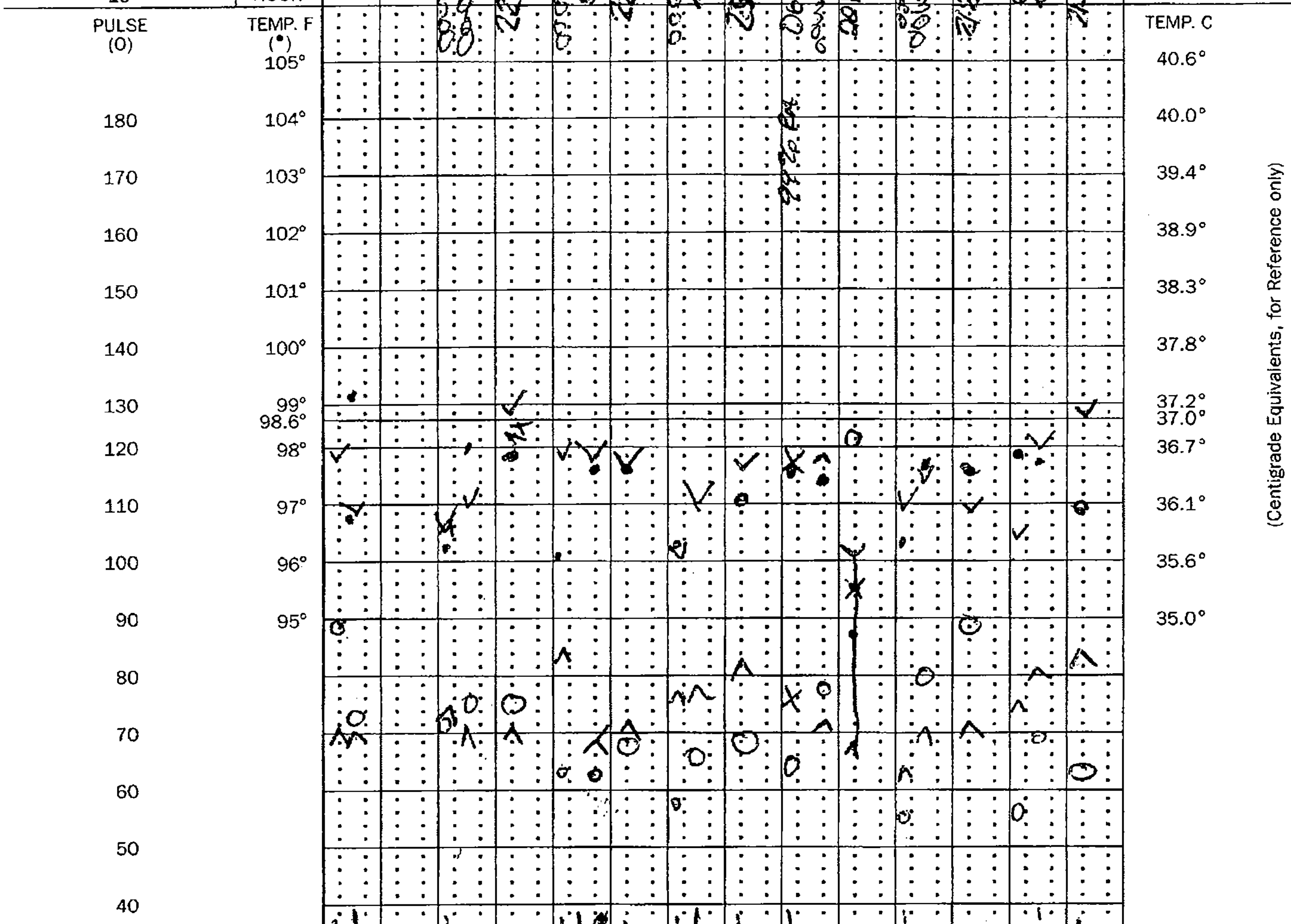
① Closed Reduction of Mandible #1
② Dental Extraction of #2, #12, #15, #18, #19, #29

21. PATIENT TRANSFERRED TO	TIME	METHOD
[redacted]	1100	Intel c̄ O2

22. REGISTERED NUR[redacted] OPT/AD [redacted]

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01
[redacted]
MEDCOM - 11641
b6-2

MEDICAL RECORD	VITAL SIGNS RECORD						
HOSPITAL DAY							
POST- DAY							
MONTH-YEAR / DAY	30 June	1	2	3	4	5	6
19 / HOUR	[illegible]	[illegible] 2235	[illegible]	[illegible]	0630 2012	[illegible]	[illegible]



RESPIRATION RECORD	64	8, [illegible]	64, 4	46	6	4	4, [illegible]
BLOOD PRESSURE	119/66, 108/70	108/74, 110/70, 128/70	118/64, 116/72, 118/68	108/[illegible], 119/78, 116/82	118/76	114/64, 116/70, 108/72	123/[illegible], 126/84
HEIGHT: / WEIGHT →	94%, 100%	95%, 78%	96%, 95%, 97%	90%, 99%	95%	97%	94%, 95%, 96%

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)* | REGISTER NO. | WARD NO. ICW2

EDW [redacted] -bu-4

STANDARD FORM 511 (REV. 7–95) BACK

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	1	2	3	4	5	6	7
POST-DAY							
MONTH-YEAR 003 / DAY	23	24	25	26	27	28	29
HOUR							

PULSE (O) / TEMP. F (•) / TEMP. C

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

	1	2	3	4	5	6	7
	120/80	120/84	130/74	110/80			139/80
		130/78	115/80	114/78	100/0	124/70	

HEIGHT: WEIGHT →

	1	2	3	4	5	6	7
		91%	90%	89%			
			90%	95%			91%

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

EPW

[redacted] - 66 - 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: 16 | 17 | 18 | 19 | 20-21 | 21 | 22

MONTH-YEAR / DAY / 19 / 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°

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] -bl-4

STANDARD FORM 511 (REV. 7-95) BACK

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

DAY

MONTH-YEAR Jul ~~19~~ 2003 | DAY | HOUR

PULSE (O) | TEMP. F (°)

TEMP. C (Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Enter 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.

[redacted] -b6-4

VITAL SIGNS RECORDS

Medical Record

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

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	23	24	25				
POST- DAY							
MONTH-YEAR July / DAY	23	24	25	26	27	28	
~~10~~ 03 / HOUR							

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 16 18 16 16 16 16 16

Record special data only when so ordered

BLOOD PRESSURE: 120/75, 120/80, 98/60, 116/80, 116/78, 116/78, 120/72, 97

HEIGHT: WEIGHT →

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

REGISTER NO.

WARD NO.

EPW

[redacted] -bu-4

VITAL SIGNS RECORDS

Medical Record

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

[redacted] MEDICAL RECORD - ANESTHESIA

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

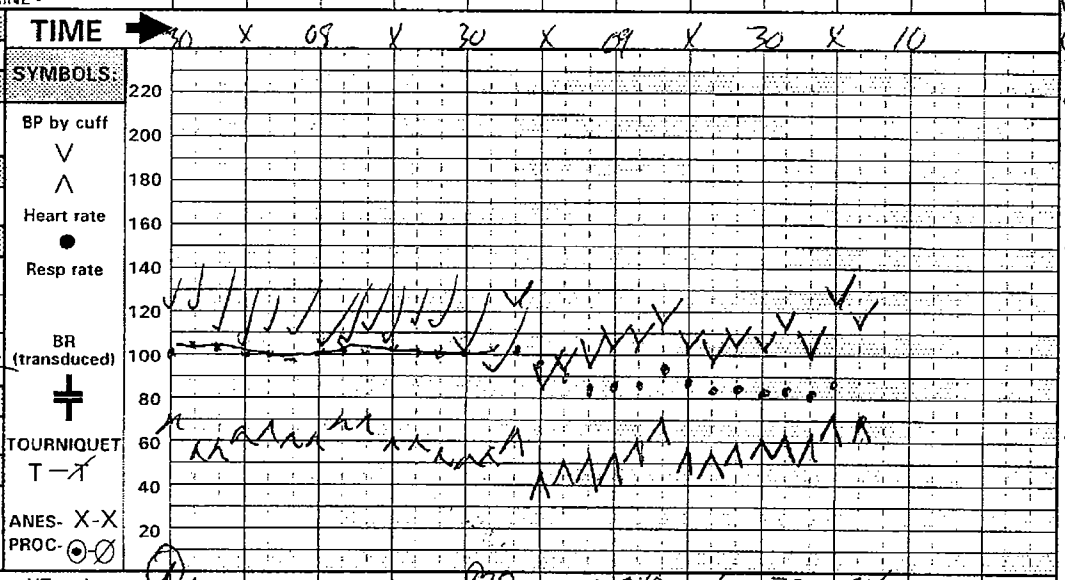
0730 0830

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML; "I" = CONSTANT INFUSION														
DRUG	(Units)													
Versed	mcg	3/2												
Fentanyl	mcg	100				100	50							
Ketamine	mcg		20	20	10 20	20 10								
Propofol	mcg					50	50							
	( )													
Vecuronium	(mg)					10								
VOLAT AGENT	Forane % del					1.2	1.0	1.0	1.3					
	% e.t.													
AIR	L/Min													
N2O	L/Min													
O2	L/Min	4					2	2						
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS														
FLUIDS — LINE site R/S	☐ Warmed	800					800							
LR	☐ Warmed							200						
	☐ Warmed													
	☐ Warmed													
LOSSES — EST BLOOD LOSS							50							
URINE -														

TOTALS	TOTAL EBL
	50
	TOTAL URINE
	Ø

FLUIDS SUMMARY
CRYSTALLOID- 1000
COLLOID- Ø
BLOOD- Ø

PHYS STATUS: 1 2 3 4 5 E
BODY WEIGHT: 90 KG LB
HEMATOCRIT:
INITIAL DATA: BP- 120/70 HR- 100/02
EQUIP CHECK: OK?- Y N
PATIENT RECHECK: OK for PROCEDURE? Y TIME- 0645



VENTIL												
VT - ml						920	850	840	840	730	SV	
f - breaths/min						10	9	7	6	5	10	
Peak inf pres / PEEP						25	23	23	21	21		
MODE - S(pon), A(ssist), C(on)		SV	SV	SV	SV	SV	CV	CV	CV	CV	SV	
MONITORS/ACCESSORIES — BP/Auto Cuff	ET CO2 (torr)					29	27	29	31	35	48	
BP/oth	FIO2 (Frac or %)	1.0	1.0	1.0	1.0	1.0	1.0	70	70	70		
ART line	SpO2 (%)	100	100	100	100	100	100	100	100	100		
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR		
Gas analyzer	TEMP-site L/Ku				36		36					
	N-M Block (T/4)	0/4				4/4	0/4	PT	PT	PT	4/4 SSC technique	
Warming blkt												
Conv warmer												

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

REMARKS
Code drugs with numbers, events with letters
① Induction - [illegible]
② See below
③ Bank's take over case report received
0902 Reglan 10mg
0940 Reversal 5mg neostigmine Rebound 18 mg
0945 spontaneous resp - purposful movement extubated ⊽ nasal suction to Nasopharynx
0948 [illegible] movement titrated at end of case for ↓ HR ⊽ good effect

RECOVERY AT: ICU2
PACU ICU _____ (Specify)
OTHER: awake ⊽ [illegible]
CONDITION: [illegible]
RESP- 12 SpO2- 99
BP- 134/76 HR- 83

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0830	0730	1005
	Ready	Begin	End
PROC	0825	0840	0938

PROCEDURES and CPT Codes: ORIF Fx Mandible

ANESTHETIC TECHNIQUES: Describe block technique under Remarks GNTA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments Nasal RAE 7.0 ⊽ FO Attempt x5. Atraumatic Tube OK

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

SURGEONS: [redacted] -b6-2

[redacted] CRNA

PROCEDURE LOCATION: OR1

DATE: 22 July 05

PAGE 1 OF 1

b6-2 b6-2

Premed c̄ 0.2mg Robinul IV

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "|"=CONSTANT INFUSION		
DRUG	(Units)	
MIDAZ	(mg)	5
FENTANYL	(mcg)	100 50 100
KETAMINE	(mg)	10 20 30
PROPOFOL	(mg)	50 30
	( )	
	( )	
VOLAT AGENT: FORANE	% del	1.5 1.5 0.6 0.4 0.2
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 2 2 2 2
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		

FLUIDS		
LINE site (R) FA	☐ Warmed	LR
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES		
EST BLOOD LOSS		50/50
URINE –		

TOTALS	TOTAL FLUID
5mg	50
250mcg	
	TOTAL URINE
	NA

FLUIDS SUMMARY
CRYSTALLOID – LR 1000
COLLOID –
BLOOD –

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 90 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP 117/68 HR – 62

EQUIP CHECK: (OK) Y N

PATIENT RECHECK: OK to PROCEDURE? TIME – 1051

TIME → 10 45 11 00 15 30 45 12 Noon 15 30 45 1300 15 30

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

220 200 180 160 140 120 100 80 60 40 20

MONITORS / ACCESSORIES / VENT							
VT – ml							
f – breaths/min		16	12	8	10	12	12
Peak inf pres / PEEP							
MODE – S(pon), A(ssist), C(on)		S	S	S	S	S	S
BP/Auto Cuff	ET CO2 (torr)	38	40	42	42	41	46
BP / oth	FIO2 (Frac or %)	>.21	>.21	.78	.78	.78	.98
ART line	SpO2 (%)	100	98	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site						
	N-M Block (T/4)						
Warming blkt							
Conv warmer							

Report to [redacted] CPT

bl2

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

REMARKS — Code drugs with numbers, events with letters

10 40 Pre Op Eval Review
Trans → OR #2
10 50 OR #2 monitors ↑
Pre O2 Fib Opt Awake
Nasal Intub
11 32 Throat Pack in
11 47 4mg c̄ Fran
12 24 Throat Pack out
12 20 Suction Agreed to Extub

RECOVERY AT: PACU ICU 2 (Specify) OTHER
CONDITION: STABLE Room Air
RESP – 16 SpO2 – 95
BP – 125/79 HR – 82

ANES	Start	Room	End
	10 40	10 50	1235
PROC	Ready	Begin	End
	11 15	1130	~~1130~~ 1218

PROCEDURES and CPT Codes: Mouth Alveoplasty, Replaced wire fixation, Soft tissue Repair

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — LA/SURG = 1% Lido c̄ 1:100K Epi — TOTAL

GETA / NASAL RAE

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

Fiber Optic Awake / Sed Nasal Intub / (R) Nare c̄ 7.0 Nasal RAE

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

EPW # [redacted] bl2-4

SURGEONS: [redacted] bl2-2

ANESTHETIST: [redacted] bl2-2

PROCEDURE LOCATION: OR #2 28th CSH

DATE: 11 July 03

PAGE 1 OF

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

☆ U.S. GPO: 1999 – 528-336/10085

PATIENT RECORD

32/M NKDA ASA(2)

Page 1 of 2

MEDICAL RECORD — ANESTHESIA

DRUG	Units	7:30	7:45	8:00	8:15	8:30	8:45	9:00	9:15	9:30	9:45	10:00	10:15	10:30	TOTALS
MIDAZ	(mg)	5													5mg
SUFENTA	(mcg)	10		20				10						5	50 mcg
PROPOFOL	(mg)	200													
LIDO	(mg)	50													
Succ ROC	(mg)	100 50													
VOLAT AGENT FORANE	% del / % e.t.	4	3.5	2.5	2.5	2.5	2.5	2.5	2.5	2.0	2.0	2.0	2.0	1.5	
AIR	L/Min														
N2O	L/Min														
O2	L/Min	2	2	2	2	2	2	2	2	2	2	2	2	2	

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

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

TOTAL RBC: 200

TOTAL URINE: NA

FLUIDS – SUMMARY

CRYSTALLOID – LR 700

COLLOID –

BLOOD –

FLUIDS — LINE site (L) AC 18G ☐ Warmed; LR ☐ Warmed; ☐ Warmed; ☐ Warmed

LOSSES — EST BLOOD LOSS: 100/100 100/100; URINE –

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 90 KG

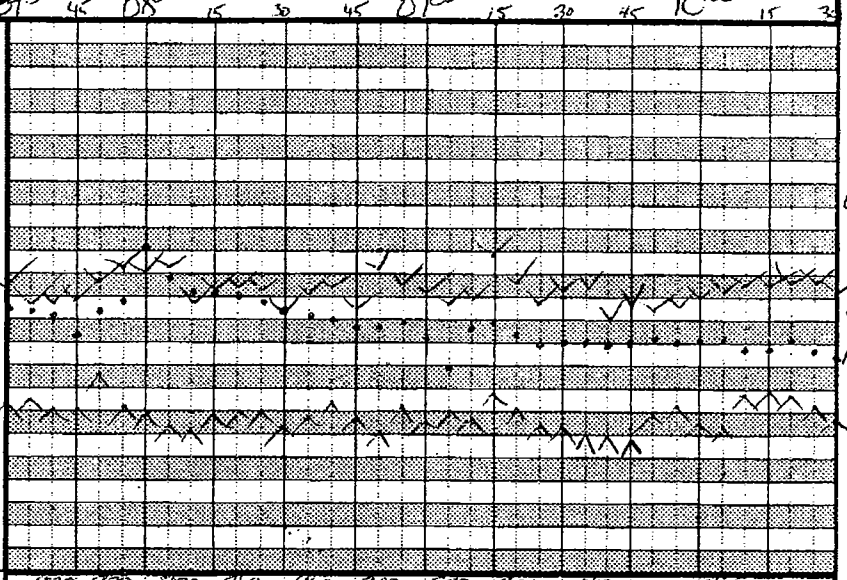
HEMATOCRIT:

INITIAL DATA: BP – 125/74; HR – 87

COMP CHECK: (OK) Y N

PATIENT RECHECK (OK for PROCEDURE?): TIME – 0730

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



	7:30	7:45	8:00	8:15	8:30	8:45	9:00	9:15	9:30	9:45	10:00	10:15	10:30
VT – ml	870	830	870	860	860	860	870	870	870	880	860		
f – breaths/min	16	8	8	8	8	8	8	8	6	6	6	16	12
Peak inf pres / PEEP		30	28	29	29	29	28	29	28	28	28	28	
MODE – S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	C	C	C	C	C	S
BP/Auto Cuff — ET CO2 (torr)		34	40	38	36	33	33	33	35	36	36	37	52
BP / oth — FIO2 (Frac or %)		.79	.77	.77	.77	.76	.76	.76	.76	.75	.75	.74	.74
ART line — SpO2 (%)		100	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES — ECG		SR-T	SR-T	SR-T	SR-T	SR-T	SR-T	SR-T	SR-T	SR	SR	SR	SR
Gas analyzer — TEMP- site	AUA	LABILE											
N-M Block (T/4)		4/4	4/4	4/4	4/4								
Warming blkt													
Conv warmer													

Report to [redacted] SRT

bl-2

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

REMARKS – Code drugs with numbers, events with letters

07:20 Pre Op Eval Rev
→ NO A. 18G IV/(L) AC

07:29 OR #2 monitors ↑
Pre O2 IND/INT/NASAL RAE (R) NAR

08:00 0.2mg Robinul / 10mg Decadron / Re

08:10 Cleocin 900mg / slow IV
Surg Reg Finished 9:

08:16 10mg Reglan

09:39 Break - CPT [redacted], CRNA

10:23 Throat Pks Out
Stomach Suctn/Sure

RECOVERY AT

PACU (ICU) 1 (Specify)

OTHER

CONDITION: STABLE

RESP – 16 SpO2 – 94%

BP – 143/82 HR – 95

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	07:20	07:29	11:10
	Ready	Begin	End
PROC	07:35	08:06	10:30

PROCEDURES and CPT Codes: ORIF MANDIBLE Fx & TEETH Ex X6

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA / NASAL ETT + LA / Surg 1.0% LIDO & 1:100K EPI 12cc @ 0800

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: 170 P COVER EYES & OPSITE DL x 1 / MAC 3 NASAL RAE → (R) NARE → VC, = BBS ⊕, ETCO2 ⊕

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

EPW # [redacted]

Rec in ICU-1

bl-4 Stays in ICU-2

SURGEONS: [redacted] - bl-2

ANESTHETISTS: [redacted] MAJ CRNA

PROCEDURE LOCATION: OR # 2

DATE: 24 JUN 03

PAGE 1 OF 2

MEDICAL RECORD – ANESTHESIA

bl2 WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 11649

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

32/M NKDA ASA(2)

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)
SUFENTA	(mcg) 5
VOLAT AGENT: FORANE	% del / % e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min 8

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

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

FLUIDS		
LINE site (L) AC	☐ Warmed	1R
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES	
EST BLOOD LOSS	
URINE –	

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP – / HR –

EQUIP CHECK: OK? – Y N

PATIENT RECHECK: OK for PROCEDURE? TIME –

TIME → 0730 0800 1100

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

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

VT – ml		
f – breaths/min	10	16
Peak inf pres / PEEP		
MODE – S(pon), A(ssist), C(on)	S	S
BP/Auto Cuff — ET CO2 (torr)	52	48
BP / oth — FIO2 (Frac or %)	.75	.75
ART line — SpO2 (%)	97	98
Steth- PC/ES — ECG	SR	SR
Gas analyzer — TEMP- site	AXILL	
N-M Block (T/4)	4/4	
Warming blkt		
Conv warmer		

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

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

REMARKS – Code drugs with numbers, events with letters

CONT FROM PAGE ONE

1055 Suction
Strong Vents
DEEP EXTUB

SEE Pg ONE

SEE Pg 1

RECOVERY AT: PACU ICU ____ (Specify) OTHER ____

CONDITION:

RESP – SpO2 –

BP – HR –

	Start	Room	End
ANES			
PROC	Ready	Begin	End 1030

PROCEDURES and CPT Codes

SEE PAGE ONE

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

EPW# [redacted] bU-4

Rec in ICU-1

Stays in ICU-2

SURGEONS: [redacted] – bU-2

ANEST[redacted] – bU-4

PROCEDURE LOCATION: OR #2

DATE: 24 Jun 03

PAGE 2 OF 2

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 11650

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Separate/Anesthesia)

Age 32 DAYS MOS (YRS) Sex (✓) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 E
WT: 90 (KG/LB) HT: ? IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: Mandible fx r/p
SURGICAL SERVICE: [redacted] / Oral-Facial Surgeons
NPO SINCE: MN

b6-2

HABITS:
TOBACCO: unknown / yes
ETOH: / no
DRUGS: / yes
Multiple self injected

CURRENT MEDICATIONS: IV stuck
( ) = ordered as premed

( ) Clindamycin 900mg IVq8c - 08/16/24
( )
( )
( )
( )
( )

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

LABORATORY STUDIES:

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

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	unknown
Angina	N	Y	Denies
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	wheezing
Bronchitis/URI	N	Y	Hx smoking
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	Tried to rob taxi
	N	Y	+ hit by driver
Familial HX	N	Y	

ASSESSMENT

PAST SURGICAL/ANESTHETIC
Unknown

PHYSICAL EXAMINATION

BP 117/81 HR 109 R 20 T 99.1
Pain Scale 0-10 _____
HEENT - Teeth unable to assess
Trachea middle
TMJ/Neck FROM
Oropharynx MP4
Nares patent
CHEST: Exp wheezing
CARDIAC: RRR (-) M
EXTREMITIES:
IV Access: 18G (L) AC
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since _____

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

NETA
OK to DC
per Dr [redacted]
b6-2

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.
No interpreter available @ time. Pt. aware he is to go to surgery
The patient/legal guardian seems to understand and agrees. Questions answered.

Signed: [redacted] CRNA/CPT Date: 24 Jun 03 Time: 0010 Hrs

b6-2

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

Signed: _____ Date: _____ Time: _____ Hrs

SEDATION KEY:

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

Patient Identification: (Ward) _____

EPW # [redacted]
b6-4

RECOVER
ICU-1
ICW 2/5PM

* jaw wire [redacted] hut *

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia) Smoker/?drug abuse

Age 32 DAYS MOS (YRS) Sex (X) MALE ( ) FEMALE

ASA Physical State 1 (2) 3 4 5 E
WT: 90 (KG) LB HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE: Repair of soft tissue
SURGICAL SERVICE: ICMES
NPO SINCE: 2400

HABITS:
TOBACCO: (+)
ETOH: 0
DRUGS: ? multiple self inflicted needle sticks

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) N/A
( )
( )
( )
( )
( )

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

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

N/A

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)	? drug abuse
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
24 June - ORIF mandible fx
no comp.

PHYSICAL EXAMINATION
BP 120/80 HR 80 R ____ T ____
Pain Scale 0-10 ____
HEENT - Teeth ____ } jaw wired
Trachea ____
TMJ/Neck FROM
Oropharynx ____ } jaw wired
Nares ____
CHEST: CTA / BOSH
CARDIAC: S1 S2 SR
EXTREMITIES: OK
IV Access: none in place
Ulnar Filling: OK
BACK: OK
OTHER: ____

NPO Since 2400

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

will need awake FO or blind nasal

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: [redacted] -b6-2 Date: 10/7/05 Time: 2030 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

SEDATION KEY:

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

EPW # [redacted] -b6-4
ICW 2

32 YRS MOS (YRS) Sex X MALE (FEMALE

ASA Physical Status: 0
Wt: 90 Ht: X
ALLERGIES: NKDA

Procedure: MANDIBLE ORIF
Surgeon: OMF
Time: 2400

+

MULTIPLE NEEDLE SCARS

PREOPERATIVE
Pertinent Medical/Surgical Review

Cardiovascular:
Hypertension N Y DENIED
Angina N Y
MI N Y
CHF N Y
Other N Y
Pulmonary System:
Asthma N Y
Emphysema N
COPD N Y
Other N Y
Renal System:
Acute/Chronic RF N Y
Gastrointestinal:
Reflux N Y
Hiatal Hernia N Y
PUD/GERD N Y
Endocrine System:
Diabetes N Y
Steroids N Y
Thyroid N Y
Neurological:
Seizures N Y
Neuropathy N Y
Other N Y
Gynecological:
Pregnancy N Y
Other Significant Hx:
N Y
N Y
Familial Hx N Y

PAST SURGICAL HISTORY:
24 JUNE MANDIBLE Fx
Ø COMP

PHYSICAL EXAMINATION
BP
Pain Scale 0-10
HEENT - Teeth: MOUTH WIRED SHUT
Trachea
Tracheostomy
Dentures
Larynx
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES:
IV Access: (L) WRIST 20G
Other Fluids:
BACK:
OTHER:

NPO Since 2400

ANESTHESIA PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ( ) General: Mask / Intubation FIBER OPTIC NASAL

CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/[redacted] and agreed. Questions answered.

[redacted] Date: 22 July 03 Time: 0530 HRS

b4-2

ANESTHESIA EVALUATION AND [redacted] ASU)
( ) PATIENT ANESTHETIC COMPLICATIONS ( ) OTHER

Date: Time: HRS

Patient Identification: (Wrist)

EPW # [redacted]

ICW2 / ICU2

b4-4

SEDATION KEY:

1. MINIMAL (Anxiety ok) 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 response to painful stimulation

2000 (Revised 15 Mar 01 MOD-DOA)

PATIENT RECORD COPY

Previous Edition is Obsolete
GPO 2002 796-08

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: EPW # [redacted] b6-4

NURSING UNIT: ICW#2 | ROOM NO.: | BED NO.: 7

DATE OF ORDER: 23 Jun 03 | TIME OF ORDER: 1647 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Admit to ICW 2 Dr [redacted]
2. Dx: mandible fracture
3. Cond: Stable
4. Vitals: per routine
5. Aller: NKDA
6. Activ: ad lib
7. Nurs: HOB 30°
8. Diet: liquid diet NPO PMN
9. I.V.: LR @ 125cc/hr
10. meds: Clindamycin 900mg IV q 8° / Percocet 1-2 mg PO q 4-6° prn pain

PATIENT IDENTIFICATION: EPW [redacted] b6-4

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 6

DATE OF ORDER [redacted] TIME OF ORDER _____ HOURS b6-2

[redacted] MAJ/DC

230 H°V C7 B W/ LITAN 6 23 03 2330

PATIENT IDENTIFICATION: EPW [redacted] b6-4

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 7

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION: EPW [redacted] b6-4

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 7

DATE OF ORDER | TIME OF ORDER _____ HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW #[redacted] b6-4	24 Jan 03	1200 HOURS	
	Give 3mg MS04 now		
	Give 25mg Phenergan		
	Give Augmentin deb PX now		
	V.O. OK [redacted]		
	Unit dose		
UNIT ICW 2 / ROOM NO. / BED NO. 8	30mg toradol IV [redacted]	[redacted] b6-2	

IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
EPW #[redacted] b6-4		b6-2 HOURS	
UNIT ICW 2 / ROOM NO. / BED NO. 8			

IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
E1		HOURS	
UNIT / ROOM NO. / BED NO.			

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: EPW # [redacted] b6-4

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 8

DATE OF ORDER: 24 Jun 03 | TIME OF ORDER: 1030 HOURS | LIST TIME ORDER NOTED AND SIGN

1. Admit to recovery then ICW 2 Dr [redacted] b6-2
2. Dx: S/P ext of cheek and open reduction of unwanted fracture
3. Cond: Stable
4. Vitals: Per routine ✓

PATIENT IDENTIFICATION: EPW # [redacted] b6-4

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 8

DATE OF ORDER: | TIME OF ORDER: | HOURS

5. Aller: NKDA ✓
6. Activ: Ad lib
7. Nurs: HOB 30°, Yankauer suction to BS ✓
   Δ Left foot dressing changed & Bacitracin on wound.
   Wire cutters to BS @ all times
8. Diet: Clears then blended thru straws die ✓

PATIENT IDENTIFICATION: EPW # [redacted] b6-4

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 8

DATE OF ORDER: | TIME OF ORDER: | HOURS

9. IV: HL when taking PO ✓
10. Meds: Clindamycin 900 mg IV q 8
    Decadron 10 mg IV x 1 dose
    Tylenol #3 1-to 2 tabs crushed PO q 4-6° prn pain
    morphine 2-4 mg IV q 1° prn pain
11. Albuterol Nebs q 6° ℞

PATIENT IDENTIFICATION: EPW # [redacted] b6-4

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 8

DATE OF ORDER: | TIME OF ORDER: | HOURS

Chest PT standard unit dose
incentive spirometry 20 x q 1°

[redacted] b6-2
MAJ/DC

Noted [redacted] 9 June 03
[redacted] 21 June 1230 [redacted] b6-2 b6-2

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 8

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
#[redacted] b6-4 [redacted] b6-4			25 Jun 03 @ 0930 HOURS (1) Selforal care c̄ toothbrush + mouthwash (2) Bacitracin to lips TID [redacted]	1300
NURSING UNIT	ROOM NO.	BED NO.		
			24° / done [redacted] b6-2	b6-2
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
#[redacted] b6-4 [redacted] b6-4			27 Jun 03 @ 2002 HOURS (1) Ensure. I can c̄ meals. (2) Benadryl 25mg IV x [redacted] b6-2 [redacted]	
NURSING UNIT	ROOM NO.	BED NO.		
ICW2		8	24° / done [redacted] b6-2	
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
EPW [redacted] b6-4 [redacted] b6-4			28 Jun 03 1835 HOURS per [redacted] b6-2, MTW DC neb treatments Taken by [redacted]	
NURSING UNIT	ROOM NO.	BED NO.		
ICW2		8	24° / done [redacted]	
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
EPW [redacted] b6-4 [redacted] b6-4			29 Jun 03 @ 0715 HOURS (1) D/C Bedside suction [redacted]	
NURSING UNIT	ROOM NO.	BED NO.		
ICW2	24° / done		[redacted]	

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

b6-2

CLINICAL RECORD - DOCTOR'S ORDERS
For use of this form, see AR 40-66, the proponent agency is OTSG

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

PATIENT IDENTIFICATION: EPW # [redacted] b6-4

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 8

DATE OF ORDER: 1 Jul 03 | TIME OF ORDER: 1825 HOURS | LIST TIME ORDER NOTED AND SIGN

DC clindamycin — noted [redacted]

DC IV [redacted] 1825

per DC [redacted] CPH

Taken by [redacted] - b6-2

PATIENT IDENTIFICATION: EPW # [redacted] b6-4

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 8

DATE OF ORDER: 6 July 03 | TIME OF ORDER: 0216 HOURS

50 mg Benadryl IM now ~~(1) tinnitus~~ and prn QHS for sleep — noted by June 0216

[redacted]

24°/ Jane Elizabeth McNamara [redacted] b6-2

PATIENT IDENTIFICATION: EPW # [redacted] b6-4

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 8

DATE OF ORDER: 7 jul 03 | TIME OF ORDER: @ 1544 HOURS

(1) Please have 20 cc syringe c̄ small tip + 16 g IV catheter c̄ saline + emesis basin @ bedside.

(2) xeroform gauze to BS

[redacted] - b6-2

PATIENT IDENTIFICATION: EPW # [redacted] b6-4

NURSING UNIT: ICW 2 | ROOM NO.: | BED NO.: 8

DATE OF ORDER: | TIME OF ORDER: | HOURS

24°/s [redacted] 7-8-03 2230

14 July 2230

V.O. Dr [redacted] - b6-2

(1) 25 mg Zyrtec now

[redacted]

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

24° VS [redacted] 7-15-03 0015

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

U.S. GOVERNMENT PRINTING OFFICE 2001-475-200

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW # [redacted]

b6-4

DATE OF ORDER 10 Jul 03 TIME OF ORDER 1556 HOURS

LIST THE ORDERS NOTED AND SIGN

(1) NPO ~~P~~ MN

(2) Void on call to OR

[redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.

b6-2

24° [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER 11 Jul 03 @ TIME OF ORDER 1223 HOURS

(1) resume previous orders

[redacted] b6-2

24° VS [redacted] 1 ATAN 7-12-03 0053

[redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

12 Jul 03 1600

(1) 2 tablespoons MOM now PO

V.O. [redacted] b6-2

[redacted] b6-2

[redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.

24° VS [redacted] 1 ATAN 7-12-03 2240.

PATIENT IDENTIFICATION

DATE OF ORDER 13 Jul 03 TIME OF ORDER 0713 HOURS

(1) OOB to chair all day

(2) dulcolax supp PRN

[redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.

24° chart ✓ 14 July 03 0830 [redacted]

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO.

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

(1) Okay for [illegible] to drink carnation instant breakfast and ensure 2 cans per meal @ ASMC.

[redacted] b6-2

Noted 0026 16 Jul [redacted]

PATIENT IDENTIFICATION

E/P W [redacted] b6-4

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

DATE OF ORDER: 15 July TIME OF ORDER: 1243 HOURS

(1) ~~Okay to go to ASMC~~

[redacted] b6-2

b6-2

PATIENT IDENTIFICATION

E/P W [redacted] b6-4

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

DATE OF ORDER: 18 July TIME OF ORDER: 2340 HOURS

~~D/C Chest PT~~

D/C incentive spirometry

[redacted]

[redacted] done [redacted] b6-2

Noted 2340 18 Jul [redacted]

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT | ROOM NO. | BED NO. 8

ICW2

DATE OF ORDER: ~~0032~~ 01 Jul TIME OF ORDER: 00:32 HOURS

VO.

Phenergan 12.5-25mg IM x1 now

Dr [redacted] b6-2

Noted 0032 01 Jul [redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

PHYSICIAN SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORDERED IN USE, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

[redacted] b6-4

DATE OF ORDER — TIME OF ORDER

21 Jul 03 @0930

(1) NPO P MN

(2) Void on call to dr [redacted] b6-2

21 Jul 0930

NURSING UNIT: ICW 2 | ROOM NO.: 24 V/S | BED NO.: 8 2100

21 June 03 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER

21 July 03 2346

5 mg phen IV (1) Void dr on

[redacted] b6-4 2265

NURSING UNIT | ROOM NO. | BED NO.

Noted 21 JUL 03 [redacted] 2330

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER

21 July 2330

V.O. b6-2

Dr [redacted] to SPC [redacted] b6-2

Δ 25mg phen to IM

NURSING UNIT | ROOM NO.: 24 V/S | BED NO.: 0200

22 July 03 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER

NURSING UNIT | ROOM NO. | BED NO.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

DATE OF ORDER: 22 Jul 03 TIME OF ORDER: 2 1000 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Resume Previous orders.
2. Phenergan 12.5-25mg IV/IM/PR q4° prn N/V
3. NS @ 125cc/hr until taking PO then D/C IV

22 July 03 1158 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER [redacted] b6-2

1. Toradol 30mg IV q6° prn pain
2. morphine 2-4mg q1° prn pain

[redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.

24° [redacted] AD

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER b6-2

1830 HOURS

EPW

[redacted] b6-4

V.O from Dr [redacted] b6-2

30 mL MOM for abd Cramps.

1Lt Walker [redacted] b6-2 /AN

NURSING UNIT | ROOM NO. | BED NO.

24° [redacted] AD

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

25 Jul 03 2 1648 HOURS b6-2

1. Please D/C Pt to MP custody in AM.
2. Please send Procedural ensure c̄ pt when D/C'd.

[redacted] b6-2

NURSING UNIT | ROOM NO. | BED NO.

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

Green Sheet

the proponent agency is the Office of The Surgeon General.

MD 7 YR 200

RIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24	25	26
7	[redacted]	vitals per routine	05	[redacted]					
	b6-2		13	[redacted]					
			21	[redacted]					
			/						
7	[redacted]	activity: ad lib	05	[redacted]					
	b6-2		13	[redacted]					
			21	[redacted]					
			/						
7	[redacted]	diet: liquid-blend	07	[redacted]					
	b6-2	thin strain & ensure	12	[redacted]					
			17	[redacted]					
			/						
7	[redacted]	wire cutters @	05	[redacted]					
	b6-2	bedside	13	[redacted]					
			21	[redacted]					
			/						
7	[redacted]	have 20cc syringe c	08	[redacted]					
	b6-2	small tip & 16G IV cath c	/						
		saline & emesis basin	/						
		and xeroform gauze to BS	/						
			/						
20 July	[redacted]	Self oral care c ~~toothbrush~~	06	[redacted]					
	b6-2	& bacitracin to lips TID	14	[redacted]					
			22	[redacted]					

662

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: mandible fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIME

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USA

MEDCOM - 11663

Sheet

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*					Mo July Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
July 4	-----	on call to OR - NPO @ MN	July	AM	done	[redacted]	662

Order/ Expir Date		PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
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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. 07 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 7	8	9	10	11	12	13	14	15	16	17	18	19	20	
July	[redacted]	Vitals per routine	05	[redacted]														b6-2
		b6-2	13	[redacted]														
			21	[redacted]														
July	[redacted]	Act ad lib	05	[redacted]														b6-2
		b6-2	13	[redacted]														
			21	[redacted]														
		b6-2																
July	[redacted]	Diet: liquid	06	[redacted]														b6-
		blended thru straw	12	[redacted]														
		Ensure	17	[redacted]														
		b6-2																
July	[redacted]	Wire cutters @	05	[redacted]														b6-
		bedside	13	[redacted]														
			21	[redacted]														
		b6-2																
July	[redacted]	IS 20xs Q1°	05	[redacted]														b6-
			13	[redacted]														
			21	[redacted]														
		b6-2																
7	[redacted]	Please have 20cc syringe	08	[redacted]					[redacted]									b6-2
		small tip and 16G IV cath c		b6-2														
		Saline + Emosis Basin and																
		Xeroform gauze to BS																

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: Mandible fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW

[redacted] b6-1

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*				Mo ____ Yr 2003
Order Date	Clerk Nurse	b6-2 SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10	[redacted]	NPO p MN for OR	11 July	2400	Done	[redacted] b6-2
11	[redacted]	Resume Previous Orders	11	1400	1400	[redacted] b6-2
	-----	b6-2				

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 23	24	25	26	27	28	29	30	1	2	3	4	5	6
23	[redacted]	V. tals per ROUTINE	5	/	[redacted]												
		b6-2	13														
			21														
23	[redacted]	Act: AD LIB	5	/	[redacted]												
		b6-2	13														
			21														
		b6-2															
23	[redacted]	HOB ↑ 30° ē	5	/	[redacted]					b6-2							
		Yankauer suction to	13		[redacted]							D/C					
		BS	21		[redacted]												
		b6-2															
23	[redacted]	Diet: Liquid then	6	/	[redacted]												
		blended thru straw	11	/	[redacted]												
		diet - Ensure ¶ carmels	17		[redacted]												
24 June	[redacted]	wire cutters @ BS	6	/	/	[redacted]											
		b6-2	14														
		b6-2	21														
24	[redacted]	N(L) not draining as	6	/	/	[redacted]											
		needed ē Bacitracin	14														
		on wound	21	/	[redacted]												
24	[redacted]	I S ⓖ 20x's ē/°	6	/	/	[redacted]											
24	[redacted]	b6-2	14														
b6-2			21	/	[redacted]												

b6-2

b6-2

b6-2

b6-2

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: Mandible fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: EPW [redacted] - b6-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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
23	[redacted]	ADMIT ICW#2 i STABLE	23		1700	[redacted]
23	[redacted]	NPO p MIDNIGHT	23	2355		
24	[redacted]	Card: Stable	~~23~~ 24	—	—	[redacted]
b6-2	-----					

	-----					

b6-2

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

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 25	26	27	28	29	30	1	2	3	4	5	6	7	8
25 Jun	[redacted]	Selforal care c	05	/	[redacted]												
bl-2		toothbrush	13	[redacted]													
			21	[redacted]													
25 Jun	[redacted]	Bactrim to lips	05	/	[redacted]												
		TID	13	[redacted]													
			21	[redacted]													

b6-1

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: mandible Cx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] -b6-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 7 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 9	10	11	12	13	14	15	16	17	18	19	20	21	22
25 Jun	[redacted]	Self oral care c	05	[redacted]													
	------	toothbrush	13														
	------		21														
25 Jun	[redacted]	Bacitracin to lips	05														
	------	TID	13														
	------		21														

	------																

b6-2

b6-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: mandible Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b6-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verif y Initiating		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 4 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
21 Jul	[redacted]	OOB to chair all day		Done		[redacted] b6-2
[redacted]	[redacted]	Chair for Pt to drink carnation				
		instant breakfast and ensure 2				
		cans per meal @ ASMC				
21 Jul	[redacted]	On call to OR – NPO p midnight	22 Jul	0001		[redacted] b6-2

b6-2

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

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 7 YR 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 22	23	24	25
22 July	[redacted]	NS @ 125 cc/hr	05	/	[redacted]		
bu-2	------	until taking PO	13	[redacted]		bu-2	
	------	then D/C IV	21	[redacted]			

DC'd 26 July 0730

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Mandible Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

#[redacted] bu-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. 7 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
21Jul	[redacted]	Phenergan 12.5-25mg IM x1 now	21Jul	now	0935	[redacted]
21Jul	[redacted]	Phenergan 25mg IM x1 now	21Jul	now	2330	[redacted]
24Jul	[redacted]	MOM 30cc x1	24Jul		1830	[redacted]
bu-2						

bu-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
[illegible]	[redacted]	bu-2 Percocet 1-2 tabs	7-12 0200	12 July 0730	12 July 1300	13 July 0130	13 July 0400	[illegible]	[illegible]	25 July 0126	25 July 1300					
		P.O. Q4-6° prn pain	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
		Dulcolax supp														
17 July	[redacted]	bu-2 PRN	[illegible]	July 2000	[illegible] 2030	23 July 0900										
		bu-2	[redacted]	[redacted]	[redacted]	0900										
22 July	[redacted]	Toradol 30mg IV Q6° PRN Pain	22 July	7-22 2100	7-23 0935	21-13 [illegible]	24 July 0935									
6a	[redacted]	Benadryl 50mg IM			[redacted]	[redacted]	[redacted]									
		PRN-qHS-sleep														
22 July	[redacted]	bu-2 Phenergan 12.5-25mg IV/IM/PR Q4° PRN	7-22 2500	24 July 1500	24 July 0835	25 July 0835										
			1500 LP/BS	[redacted]	[redacted]	25mg IM										
		bu-2														
22 July	[redacted]	MSO4 2-4mg Q1° PRN Pain														

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 06 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23	24	25	26	27	28	29	30	1	2	3	4	5	6
23	[redacted]	IV: LR @ 125cc/hr	5	/	[redacted]												
bu		HL when taking PO	13	[redacted]													
			21	[redacted]													
23	[redacted]	Clindamycin 900mg	08	/	[redacted]												
bu		IV: Q8°	16	[redacted]													
			24	[redacted]													
24	[redacted]	Decadron 10mg IV	19	/	[redacted]												
bu		X 1 dose															
24 bu	[redacted]	albuterol nebs q6°	6	/	/	[redacted]											
		⊼ chest pt standard	12	/	/	[redacted]											
		unit dose	18	/	/	[redacted]											
			24	[redacted]													

Dc'd 15 Jan 03

Dc'd 28 Jan 03

bu

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: mandible fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: D10094

EPW

[redacted] bu

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
27	[redacted]	Benadryl 25mg ÷ dose IV	27	now	2100	[redacted]
6Jul	[redacted]	Benadryl 50mg IM x1 now	6Jul	now	0224	[redacted]
12	[redacted]	~~30mg IV~~ Two TBS MOM now	12		1630	[redacted]
14	[redacted]	25mg Phenergan IM x1 now	14	2230	2230	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
23	[redacted]	Percocet 1-2 tabs	23Jun 1845	25 June 0830	25 June 1845	25Jun 2120	26Jun 0837	26Jul 1030	26Jun 2200	27 June	27 July 1700	27 2100	28Jun [redacted]	28Jun 0830	28Jun	28Jun 2359
		PO Q4-6° pen pain	BRS ⊕	[redacted]		PO	PO	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	PO
24 June	[redacted]	Tylenol #3 1-2	25 June 2010	25 June 03 1500	26 June 1600	26Jun 0915	[redacted]	1Jul 2300	5 July 0815	6Jun 2000	7 Jul 1630	10 July 1240	11 Jun 1415	15 Jul 1235	
		tabs crushed PO	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
		q 4-6° pen pain													
24 June	[redacted]	MSO4 2-4 mg IV	24Jun 1100	24Jun [redacted]											
		q 1° pen pain	1900	[redacted]											
		~~Benadryl 25mg~~ [redacted]													
23	[redacted]	Percocet 1-2 tabs	23Jun [redacted]	24 Jul [redacted]	25 Jul 0919	25Jul 2330	1 July 1000	4 Jul 03 [redacted]	4 Jul 0904	6 July 1045	7 July [redacted]	7 Jul 2350	[redacted]	12 Jul 1210	[redacted]
		PO Q4-6° PRN PAIN	[redacted]	[redacted]	PO	[redacted]	[redacted]	[redacted]	PO	PO	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
6Jul	[redacted]	Benadryl 50mg IM	6Jul 50mg IM	11Jul 2115 50mg IM	12Jul 0230 IM	14 July 0460 IM									
		PRN q HS. for sleep	[redacted]	[redacted]	[redacted]	[redacted]									

See below

2113 7-11 PO 11 PO

USAPA V1.00

EPW [redacted] bu-4

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)

Nasal

Date: 11 Jul 03
Time In: 1235
Allergies: NKA
Pre-op V/S: 117/68, 62
Procedures: wired mouth

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1000 Colloid
OR Output: UOP 0 EBL 50
Meds/Times: fent 250 versed 5 mg

972

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds History

Time	1235	1240	1245	1250	1200	1215	1230	1245
SaO2	96	95	96	95	95	96	98	97
FiO2	4	4	4	4	RA	L	4L	RA
Methods	V	V	V			3	3	
240								
220								
200								
180								
160								
140	^	^				^		
120			^	^	^			
100							^	
80	V	V	V	V	V	V	V	
60	V							
40								
20								
RR	12	12	14	13	12	12	14	
T	99					99		
Time								
Pain (0-10)								
LOS								

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1135	LR	1000	(R) FA		

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	10	D

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 and Title): [redacted] -bu-2

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 11 Jul 02

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

EPW # [redacted] bu-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1255	?	MSO4 2mg	IV			[redacted]

NEUROVASCULAR

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

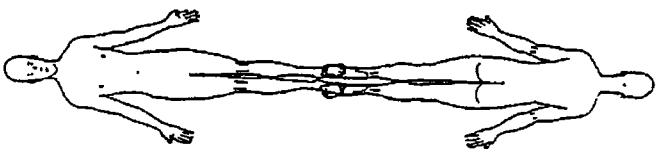
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

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



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1135 = Pt arrived to PACU from OR drowsy but arousable ØNIV Respirations unlabored @ RR 12. IVF LR infusing TKO — [redacted]
1145 - Alert talkative. Requesting to go home and see babies. VSS c/c pain to (R) jaw. Will receive MSO4 — [redacted] b6-2
1255 2mg MSO4 given IVP. RR 19-10 @ SpO2 92-93%. Pt stimulated @ ↑ RR 12 SpO2 95-96%. Will continue to monitor — [redacted] b6-2
1350 - AOX3 ØNIV pain controlled VSS RM Air SpO2 98% No distress noted — [redacted] b6-2

Discharge Criteria:
Date: 11 Jul 03 **Time:** 1355 **PARS:** 10
BP: 108/74 **T:** 97.4 **HR:** 60 **RR:** 12 **Sa02:** 93
Pain Level at D/C (0-10):
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: ICW 2
Report Given To: Lt [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: Cpt [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted] b6-2

[redacted] [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)

Date: 22 Jul 03
Time In: 1000
Allergies: NKDA
Pre-op V/S: 100/70 100
Procedures: SP ORIF Fx mandible
OR Intake: Crystalloid 1000
OR Output: UOP
Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
Colloid
EBL 50
Meds/Times: Tent 250 100 ketamine 5mg 5mg Versed Narcan

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds

History

Time	1000	1005	1010	1015	1020	1025	1030
SaO2	96	99	99	99	98	98	96
FiO2	RA	RA	RA	RA	RA	RA	RA
Methods							
240							
220							
200							
180							
160							
140							
120	^	^	^	^	^	^	^
100							
80	•	•	•	•	•	•	•
60							
40							
20							
RR	11	15	13	11	14	14	15
T	96						97
Time							
Pain (0-10)							
LOS							

Patient teaching done; Wound Care, Pain Management, T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C,	8	10	10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
^ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] - b6-2

DEPARTMENT/SERVICE/CLINIC: ICU #2

DATE: 22 July 03

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

Name - last.

[redacted]

b6-4

☐ HISTORY/PHYSICAL
☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER (Specify)
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1045	8	Toradol	IV	8		[redacted]

NEUROVASCULAR

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

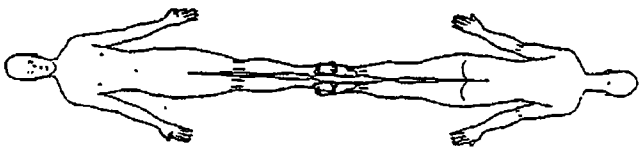
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	None	None	None
30'	"	"	"
60'	"	"	"
D/C	"	"	"



PACU OUTPUT

Time	Source	Color/Appearance	Amount
		[redacted]	

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
		[redacted]	

WAMC OP 173-E

NURSING NOTES

Pt Alert & Verbal. VSS, sats 98-100% on RA. Pt able to follow commands. Pt Jaw wired shut. Cutters @ Bedside. No Drainage Noted. Pt given 0.4mg Narcan upon arrival to floor by CRNA [redacted] c positive results [redacted] 10:45 - Pt c/o pain, ~~30mg MSO4 Given per MD~~ [redacted] 30mg Toradol Given per MD orders. 11:10 Pt VSS 96-100% RA. Awake, Alert, Verbal. Minimal blood draining. [redacted] Lt L b4-2

Discharge Criteria:
Date: 22 Jul 03 **Time:** 11:10 **PARS:** 10
BP: 118/71 **T:** 97.3 **HR:** 74 **RR:** 15 **SaO2:** 96
Pain Level at D/C (0-10):
Intake: [redacted] **Output:** [redacted]
Additional Data: Ø
Transferred To: ICW #2
Report Given To: Lt. [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery R[redacted]OP [redacted]
Charge Nurse Signature: [redacted] b4-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 24 Jun 03 Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block

Time In: 1105

Allergies: NKDA OR Intake: Crystalloid 700 Colloid

Pre-op V/S: 120/74 P-87 OR Output: UOP EBL 200

Procedures: ORIF mandible, tooth extraction (6) Meds/Times:

Drains: Hemovac, NG, [redacted], Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds History

Time	1105	1110	1115	1130	1145	1200
SaO2	95	96	94	98	98	94
FiO2	15	15	10	10	10	10
Methods	NRB	NRB	NRB	NRB	NRB	NRB
240						
220						
200						
180						
160						
140						
120						
100						
80						
60						
40						
20						
RR	16	16	24	14	16	18
T	98.2					

Time								
Pain (0-10)								
LOS								

Patient teaching done: Wound Care, Pain Management, T, C, & DB,. Incentive Spirometer, Comfort Measures

Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1105	LR	300	PAC	[redacted]	700 - 4 L O2

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	1	1	1
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	N	A	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	8	9

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
" = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

PREPARED BY (Signature & Title): [redacted] SSG, LPN

DEPARTMENT/SERVICE/CLINIC: ICU #1

DATE: 24 JUN 03

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

☐ 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

32 NKDA
ORIF mandible
tooth extraction

0810 Cleocin 900 mg IVP
50 mg Sufenta
5 mg - Versed

MEDCOM - 11680

b6-2

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1200	10	MSO4 2mg	IVP	0	E	[redacted]
1200	0	Phenergan	IVP	0		
1246	10/10	Toradol 30g	IV	10/10	—	[redacted]
						b6

NEUROVASCULAR

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

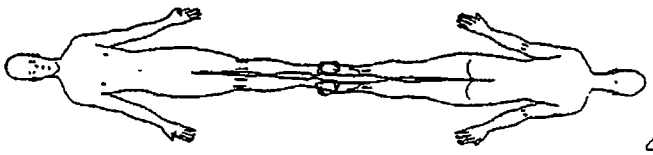
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

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



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1105	NSR	NO	120'

WAMC OP 173-E

NURSING NOTES

Pt to Recovery Area via litter. IV of LR infusing into (L) A.C. O2 @ 10L via NRB and nasal thungal. Pt has dressing to (L) foot. Dressing clean, dry & intact, c/o @ this time. — [redacted] b6-2

1200 c/o pain. Scant amt of vomiting after ed. Gx'd and MSO4 given IVP. Pt HOB ↑ pillow support. SpO2 99% on RA. Pain b6-2 via NRB. Will continue to monitor. — [redacted]

1205 - Report given to SGT [redacted] b6-2

b6-2 [redacted]

1215 Notified Dr [redacted] pt vomiting, unable to wean O2 from placed, on NC @ 4L. Orders received.

1246 Toradol 30g IV for pain / vomiting

1255: Dr [redacted] Notified of pt's condition. Neb Tx given by RT. Pain managed by MSO4 Toradol. SpO2 - 94% - RA. [redacted]

Pt left c/o @ this time — [redacted]

Discharge Criteria:
Date: 24 Jun **Time:** **PARS:**
BP: 127/84 **T:** 98.6 **HR:** 94 **RR:** 16 **Sa02:** 99% [redacted]
Pain Level at D/C (0-10):
Intake: 100 cc **Output:** 0
Additional Data:
Transferred To: ICW #2
Report Given To: SGT [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: SGT [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted]

b6-2

MEDCOM - 11682

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM: [redacted] bu-4

RANK / GRADE

MALE / HOMME: X

FEMALE / FEMME

SSN / NUMÉRO MATRICULE

SPECIALTY CODE / GPM

RELIGION / RELIGION

2. UNIT / UNITÉ: 115 MP BN

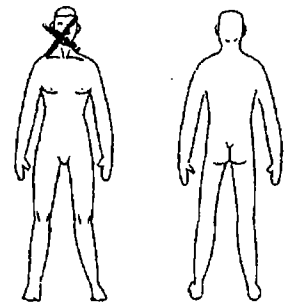
FORCE / ÉLÉMENT: A/T | AF/A | N/M | MC/M

NATIONALITY / NATIONALITÉ: TK/TO

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

3. INJURY / BLESSURE

FRONT / DEVANT | BACK / ARRIÈRE



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

[redacted]

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

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

5. PULSE / POULS: 120 | TIME / HEURE: 14:00

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

7. MORPHINE / MORPHINE: X NO / NON | YES / OUI | DOSE / DOSE | TIME / HEURE | 8. IV / IV | TIME / HEURE

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

6 day old jaw [illegible]

132/48

10. DISPOSITION / DISPOSITION: [illegible]

- RETURNED TO DUTY / RETOUR À L'UNITÉ
- X EVACUATED / EVACUÉ
- DECEASED / DÉCÉDÉ

TIME / HEURE: 1415

[redacted] / UNIT / OFFICIER MÉDICALE / UNITÉ: Bu-2

DATE/DATE (YYMMDD): 03.06.23

DE[redacted]
DEC 91

This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A I I D I	I Z	0 0 1 3 5 9 4	EPW # [redacted] b6-4	EPW	M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
Z Z Z Z Z Z Z Z	2 5 Y	X	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	Z	1647	— b6-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	K 7 8	Z Z Z Z Z

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
—	—	1	YEAR [X] NO

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

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] b2-2	UNK
	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
5 0		Ø 3 Ø 7 2 5

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A B F A		Ø 3 Ø 6 2 3

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

FOR LOCAL USE

mandible fracture

DX	proc.	T.	Im.
80225	7676	9	599
80226	9355		
87372	2309		
87373	245		
E9689			

ADMITTING OFFICER (Sign as required)	SIGNATURE OF PROCESSING CLERK
[redacted] b6-2	[redacted] b6-2

[redacted]

INPATIENT TREATMENT RECORD COVER SH[redacted]

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

1. REGISTER NUMBER: 13595	2. NAME (Last, First, MI): UNK CIV [redacted] - b6-4	3. GRADE: CIV	ADMISSION REMARKS
4. SEX: M / 5. AGE: UNK / 6. RACE: X / 7. RELIGION: MUSLIM / 8. LENGTH OF SVC: — / 9. ETS: —		10. PREVIOUS ADMISSION: NO	
11. FMP: 99 / 12. SSN: 000-00-0334 / 13. ORGANIZATION: —		14. WARD: ICW1	
15. FLYING STATUS: NO / 16. RATING, OSC: [illegible] / 17. DEPT / BR: [illegible] / 18. BRANCH/CORPS: — / 19. UIC/ZIP: —		20. TYPE CASE: NBI	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: DIRECT FROM ER	22. HOURS OF ADMISSION: 1300	23. CLINIC SERVICE: AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —	25. TYPE DISPOSITION: XFER TO CIV HOSP	26. DATE OF DISPOSITION: 1 JUL 2003	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —	27b. TELEPHONE NO.: —	28. DATE OF THIS ADMISSION: 25 JUN 03	ADMITTING OFFICER: b6-2 PR [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b2-2		30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DA[redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

UNK

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: 904.41
904.42
890.1
958.8
736.79
E991.2

Proc: 38.48 86.28
38.49 86.02
83.14 86.04
81.91 86.59

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	7	7

36. Total Days All Facilities

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]				

SIGNATURE OF ATTENDING MEDICAL OFFICER

[redacted]

DA FORM 3647, MAY 79 USAPPC V1.00

b6-2 [redacted] b6-2

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER: 13595	2. NAME (Last, First, MI): EPW Ø [redacted] bu-4			3. GRADE: EPW	ADMISSION REMARKS
4. SEX: M	5. AGE	6. RACE: IRAQI	7. RELIGION: UNKNOWN	8. LENGTH OF SVC: —	9. ETS: —
10. PREVIOUS ADMISSION: NO					
11. FMP: 99	12. SSN: [redacted] 662	13. ORGANIZATION: —		14. WARD: ICU1	
15. FLYING STATUS: —	16. RATING/DSG: K76	17. DEPT./BEN	18. BRANCH/CORPS: —	19. UIC/ZIP	20. TYPE CASE: BI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: DIRECT FROM ER			22. HOURS OF ADMISSION: 2030	23. CLINIC SERVICE: ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —			25. TYPE DISPOSITION	26. DATE OF DISPOSITION	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —			27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION: 23 JUNØ3	ADMITTING OFFICER: bu-2 [redacted] m
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] 62-2				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

M-16 5.56 mm ROUND

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW (R) LEG

8910	PROC	INJURY	T.
90442	3958	1	450
90441	8314		
1D	8604x3		
	9904x2		

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		

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	[redacted]	0 bu-2	[redacted] 0		

SIGNATURE OF ATTENDING MED[redacted] bu-2 [redacted] bu-2

DA FORM 3647, MAY 75 bu-2

USAPPC V1.10

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

~20yo young Iraqi male who suffered a GSW by 5.56 to left thigh on 1300 today - Had 2.5 cm Popliteal Arty defect repaired by RSVG. Reported to have attached a gravel bed non stats in leg by MIG
Received 4u PRBCs, 4L crystalloid, 1U FFP by MIG
1 gm Ancef / Tet at 1330

2.02 > 11.7/37.1 < 209

4.9 / 146/4.1 <

AN?, Meds ?, PMH ?, PSH ?

7.4/283/119/18/-7/99 15.8/60.7

PHYSICAL EXAMINATION V.S. - P-117 143/91 R 100% 0 Pen

Gen - Thin male on Vent. Paralyzed + sedated.
HEENT - Ø NECK Ø LUNGS - CTA. HEART RRR S(m)
Abdm - Ø MS - No Deformity GU Ø
PV - Left lower ext. Stump Normal - +DP
Monophasic flow PT
+++
+++

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

A: SP Left Popliteal Arty Repair / Fasciotomy

P: To OR for exploration.

b6 -2

[redacted] MAJ M[redacted]

SIG[redacted] OF [redacted]	DATE 23 June 03	IDENTIFICATION NO.	ORGANIZATION
[redacted]'S IDENTIFICAT[redacted] *(Type or print. When entries give Name last, first, middle; [redacted] date; hospital or medical facility)* [redacted] b6-2		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
USAPPC V1.00

[redacted]
b6-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
0500	assessment complete; VSS; — [redacted] b6-2
0730	pt extubated; tolerated procedure well; VSS S.O2 99% RA; call CTM. — [redacted] b6-2
0815	MSO4 2mg IVP for pain summary, THR; "[redacted]"
1200:	V.O. to DC NGT & advance diet as tolerated; pt requesting water, regular, CVD. — [redacted] b6-2
1730	RECEIVED PT FROM DAYSHIFT. VSS. ASSESSMENT COMPLETE (SEE OP375) PT DENIES PAIN. WILL CONTINUE Z PLAN OF CARE — [redacted] CDTN b6-2
2100	PT C/O PAIN 5mg MSO4 IVP GIVEN — [redacted]
2355 w/03 0400	PT C/O PAIN "SEVERE" POST TRANSLATION. 5mg IVP MSO4 GIVEN. WILL CONTINUE MONITOR — [redacted] CDTN b6-2
6/28/03 0800	

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

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

EPW [redacted] b6-4

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
6/25/03	Nursing: GI.
0800	Pt has Partial BS all four Quads. Advanced to Regular Diet this Am, tolerated ~~3~~ c/o ~~of~~ N or Vomiting — [redacted] bu-2
6/25/03	Nursing: Neuro
1000Hrs	Pt c/o of LLE Extremity pain. Level 7 on a Scale of 1-10. Morf 5mg IVP X1 given c positive effect. [redacted] bu-2
6/25/03	Nursing: Neuro
1100Hrs	LE Assessment done q 2° c dorsalis pedis pulse checks c doppler. Dorsalis pedis pulse present and strong via Doppler. Toes are cool c AROM of neither the (L) toes or the LLE. Sensation is present only from mid thigh level up words and absent below the mid thigh down to the toes. A large Blister is present underneath the bulky dsg proximal to the Left ankle. P.O notified. There is no evidence of drainage or hemorrhage noted @ the dressing site. Pt medicated c Morf 5mg IVP X1 @1000hrs c positive effect. Pt was anxious about loosing his LLE and asked if there was pulse present in the Extremity. He was informed that there was pulse via doppler present. Will continue to monitor pt's status — [redacted] bu-2
1745	Received Pt from CPT D. Vess. Assessment (complete (see CP375) Pt Denies pain @ this time. Large Blister noted on (L) inner ankle. Will continue c plan of care — [redacted] bu-2 CPT D
2000	Pt c/o pain (L) leg. 3mg IVP MSO4 given — [redacted] bu-2 CPT D
2315	Pt c/o pain (L) leg. 5mg IVP MSO4 given — [redacted] bu-2 CPT D

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
23 Jun	OP Note
2030	prop Dx: SM (D) Pop Artery Repair
	Vein Repair
	A Comp LE Pain
	procedure washout exploration
	Bypass pulse
	Surgeon Lowen
	Orange
	EBL 200 cc
	QTT
	Follow Adequate Fasciotomy
	(D) DP pulse
	Foot PT pulse
	Plan: Cont Abx / Vasc V's
	Washout Fasciotomy 48-72°
	[redacted] b6-2

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

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

[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE **STANDARD FORM 600** (REV. 5-64)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 11689

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26 June 03	1700 Assumed care @ 1700 - VSS. pt lying in bed c̄ complaint. Assessment done - see DA4700 WAME OP 323 for initial assessment. will continue to monitor. [redacted] CRT/an b6-2
	2345 - Assessment remains the same. Ø changes noted pt assisted c̄ ROM to (R) Lower extremity. VSS. Afebrile. will continue to monitor. [redacted] CRT/an
	0220 flushed heparin lock & in UOP. 100cc Returned. & 30cc of flush - will continue to monitor [redacted] b6-2
27 June 03 0400	
0600	Nursing Neuro. AxOx3. c/o of (R) leg pain more intense on flexion than extention. (R) leg assessed Ø point tenderness or edema or masses found. Passive ROM of RLL done starting from slow gradual flexion and extension to more faster flexion and extension. Pt tolerated the ROM exercise c̄ c/o of mild pain but stayed c̄ the encouragement. Teaching done explaining the importance and rationale of q 1° AROM on RLE while on bed rest to pt. Pt returned demonstrated AROM on the extremity and felt better. Will continue to encourage ROM exercises. (L) LE has pulse present palpable on the dorsalis and top of the foot. LLE Warm, c̄ Small Active Internal rotation motion. Pt at Large ½ Dollar Cover Size Blister still present on the [redacted] left ankle [redacted] b6-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
6/26/03 0547	
6/26/03 0550	Nursing: Beg. Shift note: pt awake and resting. Denies any pain @ this time. Pt is warmer today c̄ palpable but weak dorsalis pedis pulse. Pt also has very little improvement in bottom of the left toes and positive sensation to touch. Pt is happy that circulation, motor and sensory functions are gradually returning. There is about ½ size of a golf ball blister on the proximal respect of (R) ankle will notify MD for further assessment. Will continue to monitor pts status — [redacted] b6-2

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

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

REGISTER NO.

WARD NO.

EPW# [redacted] b6-4
ICU I

PROGRESS NOTES
Medical Record

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6/27	
	Post op Note
6/27/03 1325 PM	Pt Received from OR via litter accompanied by Anesthesia. Pt drowsy from Anesthetics but easily aroused. VS: HR 80 O2 Sat 100% on 10LFM. Resp rate 17, BP 127/71. LFA HL & LR infusing @ TKO increased to keep vein open. 75cc/hr Bulky dsg to LLE d&I. Pedal pulses present bilateral LE. Left warmer than Right. Foley to gravity & clear yellow urine draining. Temp 98.5 [redacted] bl-2
6/27/03 1548	Nursing Note: Pt c/o pain on the (R) LE @ the Surgical Site. LLE assessed pedal pulses present, warm and afebrile. Pt medicated c MSO4 5mg IVPX1. Pain Management is effective. T. Max 99.2. O2 Sat 100% O2 Supplementation weaned down to 2LNC. c/o 98. Will continue to monitor pt's Status [redacted] bl-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERV [redacted]	MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

REGISTER NO.	WARD NO.

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 JUN 03 (0600)	pt A/O; FC; NO SIS or distress; LCTA (B); SAO2 100 on RA; Colon NFR; pt using IS x 3 balls; PIV x 2 to UE (L)/(R); Anxiety, VPB; S1, S2, SR, ∅ ectopy; foley to drainage; urp QS; distal pulses 2+ to all extremities; LLE ⊂ AE wrap; surgical site CDI; no new orders written — [redacted] bu-1
(0800)	Ann: one dose; breakfast 30%; MSO4 1mg for LE pain; hrs has been in; no new orders; care assumed by CPT [redacted]
0815	ASSUMED CARE. AGREE ⊂ ABOVE ASSESSMENT. — bu-2 [redacted]
0920	c/o pain. 1mg MSO4 given IVP — [redacted]
0940	pt asleep. c/o pain relieved @ this time — bu-2 [redacted]
1000	Dr [redacted] @ bedside. Okay to ambulate 50m exercises — bu-2 [redacted]
1100	CBC drawn. — [redacted]
1125	results reviewed by Dr [redacted]
1140	CBC repeated for verification — [redacted]
1215	2nd results of CBC reviewed by Dr [redacted] orders received to give 2 U PRBCs. — bu-2 [redacted]
1230	T&S completed. — [redacted]
1330	1st U PRBC given. 1642328 in O18OC [redacted]

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

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

[redacted] bu-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28Jun03	0500 1st U PRBC's completed, 1642328 [redacted]
	see PRBC's sheet for additional US. [redacted]
	1515 2nd unit PRBC's hung. 5304661 bu-2
	BP 151/66 HR 84 FiO2 100% [redacted]
	1530. Ø RBC noted @ this time. 530466[redacted]
	1700 2nd unit PRBC's completed. Ø RBC [redacted]
	noted. bu-2 [redacted]
	1715 CBC drawn per stick, sent [redacted]
	to lab. bu- [redacted]
1730	Received Pt from Day shift. VSS. Assessment completed (see op 375)
	(L) LE Ace wrapped. Upper (L) thigh staples & well approximated incision.
	Small serosanq drainage noted. Pt. moves extremity well. Pt. NPO
	& MN for I&D in AM bu-2 [redacted] pt. pain
29Jun03 0540	Pt. c/o pn (L) LE, 5mg morphine IVP given. Foley to gravity, draining
	yellow urine. Dressing to (L) LE, CDI. Ø obvious drainage
	LR infusing into (L) AC @ 125cc/hr. IV site (R) upper arm, both [redacted]
	sites CDI, patent. VSS. SpO2 100% RA. Will continue to monitor. bu-
29Jun03 0800	Pt. resting well. (L) LE remains elevated. Ø c/o pn @ this [redacted]
	time. 91[illegible]
29Jun03 1130	Pt. c/o pn (L) LE, 5mg morphine IVP given. Will continue to monitor [redacted] 91[illegible]
29Jun03 1340	Pt. to OR. [redacted] 91[illegible]

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

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

Ø [redacted] bu-4

28 Jun 03

CHRONOLOGICAL RECORD OF MEDICAL CARE
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FIRMR (41 CFR) 201-9.202-1

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 Jun 03 1405	Pt. returns to ICU 1 from O.R. I&D of (D) LE. Temporarily on NC @ 4 lpm until SpO2 increases. (L) AC & (R) upper arm IV sites remain patent. LR infusing @ 100/hr in (L) AC. Ace wrapped around soft cast on (L) extremity. (+) pedal pulses bilaterally. JP drain, intact. Temp. of 99.8, ↑ of Tylenol 3 given ~~point a addition~~ [redacted] b6-2 po. 3 mg MSO4 IVP given for pn [redacted] b6-2 [redacted]
29 Jun 03 1545	SpO2 97% RA. Temp ↓ to 98.8. Pt. resting quietly. Pt. now awakes and c/o pn. 5 mg MSO4 IVP given (1600) Systolic pressure ranging from 173-189. BP currently 176/65 will notify MD of elevated pr. Will continue to monitor closely [redacted] b6-2 [redacted]
29 Jun 03 1600	MD notified of pt systolic pressure. [redacted]
29 Jun 03 1700	Pt. systolic pressure come down. BP 123/38. [redacted]
29 June 03	1730 Assumed care @ 1700. pt sitting up in bed sleeping. ⅁ complaint. VSS. Assessment done. See ICU flow sheet. will continue to monitor. [redacted] CPT/AN b6-2
30 June 03	0001 pt Assessment unchanged from earlier assessment. VSS. will continue to monitor. [redacted] CPT/AN b6-2

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

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

LPW # [redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

26 Mar 03 — General Surgery

0800 — S: Pt ~~[illegible]~~ [illegible]

NPO for lunch not

O: Afebrile - 99 P - 88 R - 15 1002

PT/PTT - 11.5/39 I/O 3044/3500 (-)456

Hgmi stt.

Left lower ext - (+) DP/PT w/ Doppler - hum

good cap refill

A: POD 2 Reverse vein Popliteal bypass (L) LE - w/ 4 compartment fasciotomies

P: (1) Wound of Foreathing bypass

(2) Continue Heparin - Mine done.

[redacted] USA
DOS

b6-2

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)

GPW

[redacted]

b6-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6/26/03	Nursing : Heparin therapy
1020	Heparin drip stopped @ 1020hrs. per H.O orders [redacted] b6-2
6/27/03	Nursing: Preop
1155	Pt taken to OR via gurney accompanied by anesthesia [redacted] b6-2
27 JUNE 03	Brief Op Note
1300	pre-op dx: [illegible]
	post-op dx: [illegible]
	procedure: [illegible]
	surgeon: [redacted] b6-2
	anesthesia: [illegible]
	EBL 100
	fluids 1200
	UOP 325
	complications none
	findings necrotic muscles [illegible] – [illegible]
	in complication.
	[redacted] b6-2

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

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

EIN [redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28 Nov 03	General Surgery
1050	Post S.S. c d/p cow to left popliteal artery
	repaired c PVG by FJT - d/p wound exploration
	& examination of fasciotomies - d/p without &
	debridement of fasciotomies c near complete
	removal of muscles from anterior compartments
	2° necrosis.
	Ht 5'6" - 92 - 16 - 100.2 RA
	looks well - conversing through interpreter
	LE - extremity left foot, difficult to feel
	pulses (+) doppler signals @ 2'/25
	biphasic PT, monophasic DP
	fasciotomies dressed - dry
	wounds (+) high serous drainage
	medial incision angles at L/R (-) exposure
	- able to plantar flex foot, cannot dorsiflex
	can flex & ext @ knee, hip
	IMP/plan: fascia, d/p popliteal artery repair
	leaning off - foot NVI unless fasciotomies are closed
	PT to lower leg via splint - immediately given
	PO oxycodone for analgesia. [redacted] b6-2

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

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

[redacted] b6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 June 03	General Surgery
0810	DX # 6, 6, 2 Dp GSW to perineum, left - RRUQ - penetrating injury repair, L/S laparotomy - transverse lower leg & l/p amputation & debridement anterior compartment 29 anterior muscle.
89 / 27 / 200	
post resuscitation	Alert HR ↓ BP BP 131/57 RR 16 SpO2 100% RA
of 2 units	no IV Dopamine
prep for	Looks well
Hot/C	chest clear BL
	con RR & ⊖
Less	Abd soft flat ⊖ BS
Incis	Ext ⊕ wet dressings intact
No	Extremities warm - left popliteal pulse
Bruising	doppler signal - transmitted DP & PT
Tg	Right present.
	passive & active ROM @ knee/hip / ankle joint
	V. limited dorsiflexion - active.
1100/2000	Doing well
	- to OR today for debridement - ? fasciotomy closure
	- post-op - NC/Foley - DOB - ambulate
	aggressive PT bed active & passive ROM/IC.

[redacted] bu-2

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

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] bu-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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29 Nov 03
1400

Ortho Op Note

Pre-Op Dx - GSW to (L) leg with fracture

Post Op Dx - same

Procedure - I+D (L) leg with IOPL of tibial fracture

Surgeon [redacted] b(6)-2

[redacted] b6-2

CBL - BIV

Findings: Large blood clot in anterior compartment removed. Afterward, wounds clean. Tibial wound closed with 3-0 nylon after placing J.P drain in anterior compartment. Medial wound closed 80% using vessel loop lacing. Splint applied.

PLAN - Repeat I+D in 2-3 days, attempt medial closure

[redacted] b6-2

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 June 07	General Surgery
1710	POD #2, B.3.1 Doing well
	Ambulating & consumes liquids.
	Tol. Regular diet
	AFEB 99.8 BP 124/77 HR 100 RR 14 SpO2 100% RA
	Lungs clear CV: RRR
	Abd: soft, flat
	Ext - [illegible] - pulses [illegible]
	Impr/Plan Doing well
	transfer to ward
	- [illegible] to OR in [illegible] for [illegible]
	& closure of [illegible]
	- transfer to [illegible]
	CBC in am
	[redacted] b6-2

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

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

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

15 JUL 03
1600

Ortho Op Note and Transfer Note:

Pre Op Dx - (1) GSW to (L) leg
(2) Popliteal artery repair with RSVG.
(3) Fasciotomies (L) lower leg

Post Op Dx - same

Procedure - I + D (L) lower leg with closure of fasciotomies

Surgeon - [redacted] 66-2

GBL - MN

Findings - Fasciotomies closed.

GSW to (L) leg, with disruption of popliteal artery 23 JUN 03. Had saphenous interposition nerve graft done, and lower leg fasciotomy. Multiple I + D's done (x3), with closure of fasciating wounds.

PLAN: NWB + GRAM JVP3 Q8 MG 4 72 hrs, needs graft donor site staple removal

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

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[redacted] b6-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	in 3-5 days, attempt with dressing change. Fasciotomy wound sutured out in 7 days.
	Patient also had compartment syndrome with loss of entire (L) anterior compartment. Will need splint and eventual orthotic to treat foot drop.
	[redacted] bu-2
	[redacted] OOL ns

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MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

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

Clinical Summary / op Note

B/P: Fragi ♂ unknown age ≈ 20's

P: Shot in (L) distal thigh = Weapon =

: American M16 Brought to 912 FST

R: Awk & Alrt, on Arrival (L) Ant BK

= Cool, Pulsless

MEDS: T&T 6SW med → lat thigh

Plain film ? lateral cortical disruption (-) Off

PMX: other Trauma w/u (-)

Unknown Blood loss on scene

ASX: Op Note

Pre&Pop Dx as above (+) Venous injury

RX: Proc: (1) medial popliteal exploration

(2) repair of Pop V. laceration

ALG: (3) Harvest of Saph V. R groin

(4) Reversed Saph Interposition graft

SMOKE: to ≈ 2.5 cm Defect (L) pop Art

(5) 4 Compartment fasciotomies (6) (L) knee arthroscopic → negative

EBL - 900cc Fr. Op 800cc

Fluid 4 l Crystaloid 100cc 25% Alb

4 u PRBC

Off

Tm? 37

HCT 30

pH 7.30

=> OR

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

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
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Addl info ② Conclusion of Prox & Dist anastomosis ④ Patent + good pulse in Art distal to repair → foot warm but no pop pulse → fogarty to PT Art c̄ return of clot → NO improvement of Distal pulses NO Doppler Available at FST to ✓ signal

Transfer for pop Care, observation & rescue vs if graft ↓ consider fem → distal BP

MAJ [redacted] b6-2
MAJ [redacted] b6-2
DNVT# [redacted]

AUTHORIZED FOR LOCAL

DICAL RECORD | PROGRESS NOTES

DATE	NOTES
30 Jun 03 @ 1926	Pt c/o popliteal arteay Repair c̄ fasciotomies (L) Leg c̄ washout. VSS, temp 99.0, S1S2 present, lungs CTA, (+) BS x 4 quad, abd soft, (+) peripheral pulses, pt A&O x 3. IV (R) arm, LR 125 cc/hr p̄ MN 30 Jun 03 with cont. to monitor — bu-2 [redacted] 91W
30 Jun 03 @ 2146	JP bulb suction output @ 10 cc. — bu-2 [redacted] 91W
30 Jun 03 @ 2200	- Concur c̄ above assessment [redacted]
1 Jul 03 0840	VSS. Pain @ this time to LE. Airways & desq intact CNS to LE intact. AO (+) 2 pulses to ped extremities c̄ ± 2 sec fee. CR. NPO @ this time and prepared for OR — [redacted] bu-2
1 July 1900	Pt S/P I&D of LE and repair of popliteal artery. Received back from PACU @ 1800. VSS. Bulky dsg to LE c̄ posterior splint C/D/I. (+) circulation, movement and sensation to (L) distal extremity. C/o pain - ¾ T3 given. (D) LE elevated c̄ blanket. PIV to (L) AC blown and DC'd. 18G to (R) hand patent and running LR @ 100cc/°. Foley DC'd. Void @ BS. LCTA (B). BS x 4. (+) appetite. Tolerating Regular diet c̄ difficulty. Will continue to monitor & support. — [redacted] bu-2

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

/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

CIV # [redacted] bu-4

PROGRESS NOTES
Medical Record
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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 Jun 03 0630	Pt. Ace care assumed @ 0600. Pt. awake & sitting up in bed. Ø c/o @ this time. Continues on LR @ 100cc/hr Foley to gravity, draining yellow urine. JP drain intact Ace wrap around stump dest on (L) LE CDI, pedal pulses +2 IV sites (L) AC & (R) upper arm Ø S/S infiltration. Will continue to monitor [redacted]
30 Jun 03 0811	Pt c/o (L) LE pn, 5mg MSO4 IVP given. [redacted]
	b6-2
0909	Pt given 3mg IVP Morphine for (L) leg discomfort. Pulses 2+ toes pink, warm to touch [redacted]
1000	Pt OOB to chair, after 1° c/o pn. Pt. put back in bed given 3mg MSO4 IVP (IVD) Resting quietly @ this time. [redacted]
1400	Pt. had epistaxis, easily controlled c pressure and ice. Ø c/o pn & N/V Temp. 99.9 ¯¯¯ (325) Tylenol given po. Will continue to monitor [redacted]
1500.	Pt c/o pn (L) LE after Physical Therapy (1440) 2mg MSO4 IVP (SQ). Temp has decreased, 98.8. Will continue to monitor [redacted]
1700	Pt. resting quietly @ this time. Will brief oncoming shift [redacted]

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

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

#[redacted] b6-4

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

DATE 30 June

PATIENT ASSESSMENT

E: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Loose / Tight / Diaphoretic / Shiny / Dry

Temperature WNL

Pale / Cyanotic / Jaundiced

Membranes: Moist / Dry / Cracked

eakdown: None Location: Size:

NEUROLOGICAL

ert / Lethargic / Unresponsive GCS:

ed / Disoriented Pupils: PERRLA 3mm

y Movement: Full / Limited / None

CARDIOVASCULAR

- 4): Radials +2 Pedals +2

Refill: Seconds <3 sec Homan's Sign

Venous Distension Edema (L) foot

unds S1S2

PRI: QRS:

Catheter	Central	Arterial	Peripheral 1	Peripheral 2
ns				
			(R) AC	(L) upper arm

Chest Pain

RESPIRATORY

ansion / Symmetrical / Asymmetrical

n / No Distress / SOB / Labored / Use of Access Muscles

Patterns: unlabored, even

roductive / Nonproductive / None

Color / Amount / Consistency / Odor

nage System Gravity: Suction cm:

No Yes Crepitus

of Drainage:

Midline / Deviated (R) / Deviated (L)

way Size: Type: Position:

Sounds	Anterior/Location	Posterior/Location

GASTROINTESTINAL

Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: NC wrap around, soft cast

lamped/Inter. Suction/Cont. Suction/Dependent Drainage

e: Color N/A Character

g: Day No: Strength: Rate: Aspirate:

acter

GENITOURINARY

lor: yellow Character:

ntinent / Incontinent / Catheter

EMOTIONAL / TENDER

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripher
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent /

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): 28 CSH

LOG NUMBER: —

ARRIVAL — DATE: DAY 23, MONTH JUN, YR. 03 — TIME: 1845

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

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): GSW (L) Leg

SEX: M — AGE: 20

POSSIBLE THIRD PARTY PAYER? [ ] YES [ ] NO

TIME SEEN BY PROVIDER: 1845

VITAL SIGNS

TIME	1846		
BP	109/60		
PULSE	105		
RESP.	14		
TEMP.	100.4		
WT. (Child)	80%		

CATEGORY (See reverse)

- [X] EMERGENT
- [ ] URGENT
- [ ] NON-URGENT

ORDERS	INITS.	TIME
(L) leg ERAY	[redacted]	
(ABG) CBC, UA, PTPTT, [illegible]		1853
Electrolyte		1853
I.V (L) ARM NC		1853
Chest X RAY		

ASSESSMENT/DIAGNOSIS: GSW (L) popliteal with graft

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)

20 y/o ♂ s/p GSW to (L) posterior leg while shooting at U.S. troops. PAST from operated on pt, performed a graft of popliteal artery / intubated pt INT, pt (L) ATK's on arrival. pt has received 4000cc NS / 100cc Albumin / 4U PRBC's prior to arrival. [A: Intubated B: good BS C: [illegible]]

G: WD, thin, intubated
H: NC/AT, TMO
N: [illegible] strong
Z: [illegible]
B: [illegible]
Ext: ↓ pulse on (L) foot, FAMT - By Pupils, Drowsy.
(L) leg in CAST s/p surgery

PMH?
PSH: graft

CXR - good ET Tube & pacemaker
(L) knee (R) staples for graft

Pt Arrived ↓
Pt Intubated 8.0
22 at teeth
SIMV 14 700 30%
1000cc U.O.

Pt Arrived with NG Tube, Foley, Ventilator, ET Tube with vent. Pt was on 6th line

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: FCU #1

(A.P.) Admit to FCU / Gen Surg

CONDITION UPON RELEASE

- [X] 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).

SIGNATURE OF PROVIDER AND ID STAMP: [redacted] DE-2

[redacted] (include medications ordered, any limitations and follow-up plans)

[redacted] DE-4

EMERGENCY CARE AND TREATMENT
MEDCOM - 11709 Copy

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

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE:

HEIGHT: See H&P

WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE:
Washout & Debrid LLE Fasciotomy = OPC

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

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

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

#[redacted] be-4

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

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

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

[redacted] bce-2 19 Jun 03 DATE

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

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

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

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

DATE: 19 June 03 TIME:

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] bce-2

DATE: 19 Jun 03 TIME: 1410

MEDCOM - 11711

MEDICAL RECORD

INTRAOPER[redacted]OCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia

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

3. DATE 1 Jul 03 TIME PATIENT ARRIVED IN SUITE 1434

4. PATIENT IN ROOM TIME 1434 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO p MN

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify) Supine on padded OR table. BUE on padded arm boards <90°.

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

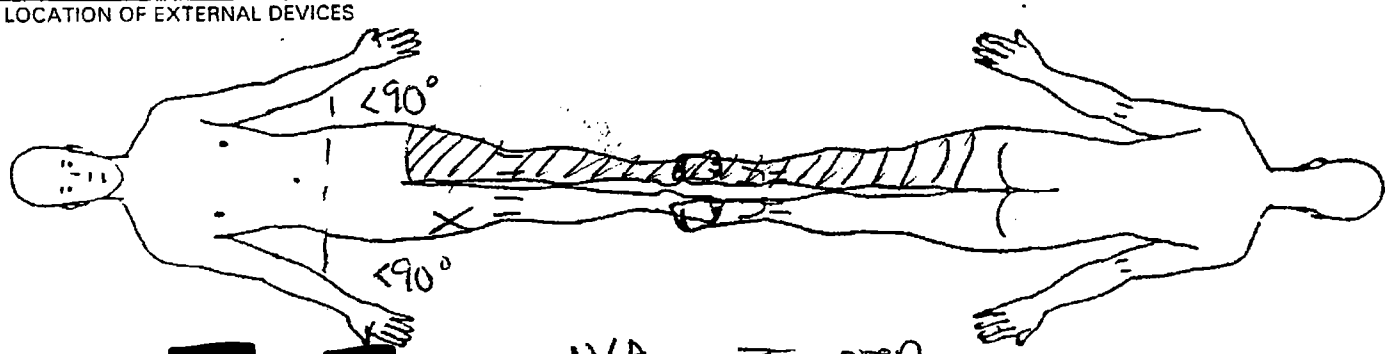
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Beta / Beta
SITE: Left leg BY WHOM: ILT [redacted]
SITE: BY WHOM: b6-2
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] Safety Strap = = = Tourniquet N/A ☒ - prep

Initial: PFC [redacted] ILT b6-2

10. COUNTS

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes	[ ] No	/	C	C	PFC [redacted] b6-2	ILT [redacted] b6-2
Needle Sharp	[X] Yes	[ ] No					
Instrument	[ ] Yes	[X] No	/	/	/		
Other	[ ] Yes	[X] No					

C = Correct I = Incorrect

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

CIV # [redacted] b6-4

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

[X] ESU NO: # 1 Cut 30 Coag 30
GROUND PAD: BRAND VL Polyhesive
LOT NO: H9402 Exp 05-92

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

[ ] BIPOLAR NO:

MEDCOM - 11712

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

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs, Kerlix, webril
Splint, ACE

19. ADDITIONAL INFORMATION
Surgeon Dr. [redacted] b6-2
Anesthesia: MAJ [redacted] b6-2

Pt. arrived in OR c̄ Foley cath & J-P drain

DA 5179 In Chart

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

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	1548	Litter c̄ O2

22. REGISTERED NURSE SIGNATURE
b6-2 [redacted] MAJ

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

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Cart BY CPT [redacted] / Dr [redacted]

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

3. DATE 29 June 2005 TIME PATIENT ARRIVED IN SUITE b6-2 1245 b6

4. PATIENT IN ROOM TIME 1245 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)* Pillow under body elements. Arms on armboards @ <90°. Tourniquet placed on left thigh by Dr [redacted] 1015 U-Drape

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

COMMENTS: Initially tourniquet from prep.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

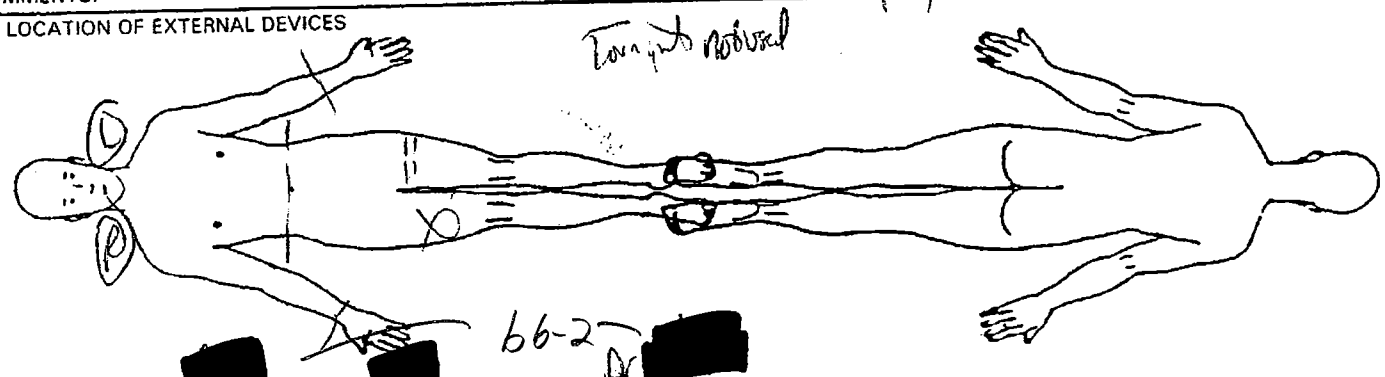
PREP SOLUTION *(Specify)* Betadine scrub/paint

SITE: left leg BY WHOM: CPT [redacted] b6-2

SITE: BY WHOM:

COMMENTS: No patient [illegible]

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

Initial counts SPC [redacted] / CPT [redacted]

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

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

H [redacted] b6-4

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

☒ ESU NO: 1

GROUND PAD: BRAND Valleylab

LOT NO: 65706

☐ 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): Origins

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S [redacted] b6-2

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	10mm JP		
SITE	Left Lower Leg		

18. DRESSING/IMMOBILIZATION *(Specify)*
xeroform, fluffs, bly, webil, oplat, webil, ace

19. ADDITIONAL INFORMATION
Surgeon - Dr [redacted] / Dr [redacted] b6-2
b6-2
Anesthesia - Dr [redacted] b6-2

20. OPERATION(S) PERFORMED
Left lower extremity debridement & wound

21. PATIENT TRANSFERRED TO Ward 1 TIME 1405 METHOD Litter

22. REGISTERED NURSE SIGNATURE b6-2 [redacted]

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

MEDICAL RECORD [redacted]

INTRAOPERAT[redacted]OCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

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

3. DATE 27 June 03 TIME PATIENT ARRIVED IN SUITE 1200

4. PATIENT IN ROOM TIME 1200 ble-2 NUMBER 1-1 | 9

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PfC [redacted] ble-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] ble-2	RELIEF CIRCULATOR	CPT [redacted] ble-2

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt in proper body alignment. Dawson armboards @ <90°. Bump under left hip. Webril between tourniquet & skin.

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

COMMENTS: Tourniquet isolated from prep & 10.15 drape.

8. SKIN PREPARATION

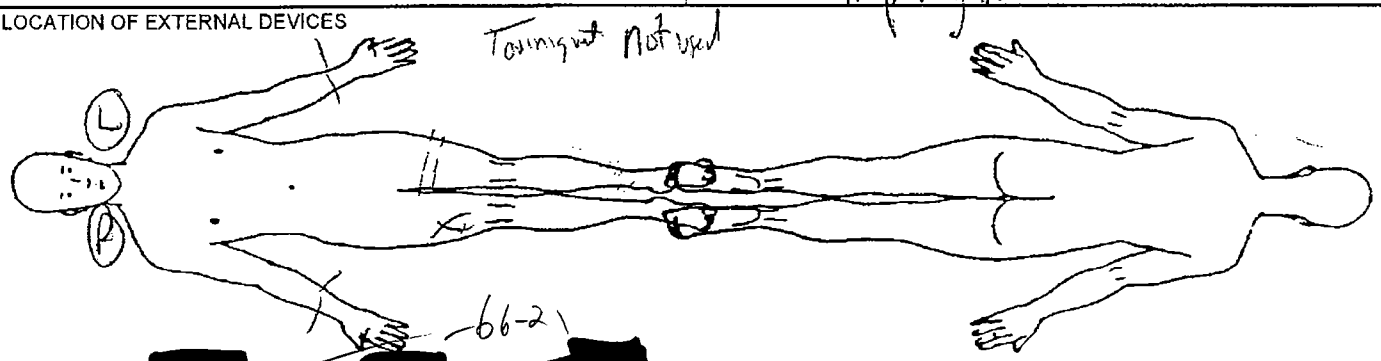
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

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

COMMENTS: No painting method.

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

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

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

EPW # [redacted] bl-4
I CW,

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

☒ ESU NO: #1
GROUND PAD: BRAND Valleylab
LOT NO: 68536

☐ 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
Bacitrac ointment	QS	intra op	topical	[redacted]	[redacted]
				66-2	

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
None

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix

19. ADDITIONAL INFORMATION
WC
Surgeons [redacted] bce-2 Anesthesia: [redacted] bce-2 Anesthesia Type: General

Bovie Pad site intact pre-op CdI; post-op CdI Bovie Settings: Coag/Cut 30/30

20. OPERATION(S) PERFORMED
S&D left leg Fasciotomies

21. PATIENT TRANSFERRED TO ICU #1 TIME DA7389 METHOD Litter & safety strap

22. REGISTERED NURSE SIGNATURE [redacted] CO[redacted]N / [redacted] 09

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

MEDCOM - 11717

bce-2

MEDICAL RECORD [redacted]

INTRAOPERAT[redacted]OCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA [illegible] BY [redacted] b6 b6

2. PATIENT IDENTIFI[redacted] AND PROCEDURE VERIFIED BY [redacted] COMM

3. DATE 23 Jun 03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 1944 [redacted] b6-2 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] 91D B6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E CPT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

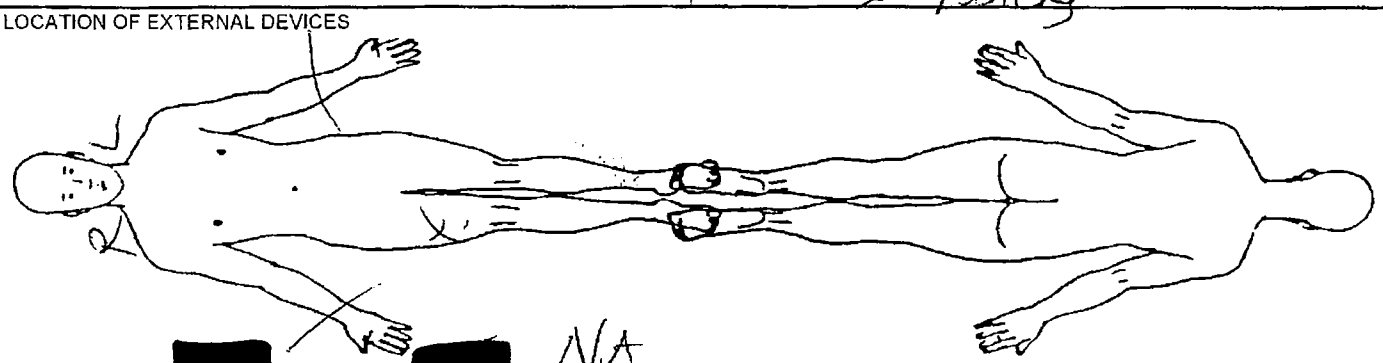
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION *(Specify)* Beta / Beta
SITE: (L) Leg BY WHOM: [illegible]
SITE: circumferentially BY WHOM:
COMMENTS: & pooling

9. LOCATION OF EXTERNAL DEVICES



NA

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

10. COUNTS — C = Correct I = Incorrect [redacted] b6-2

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

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

[redacted] b6-4

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

☑ ESU NO: VL # 20/20
GROUND PAD: BRAND VL Poly
LOT NO: 10525

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] bu-2

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

YES ☐ N[redacted]

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	

18. DRESSING/IMMOBILIZATION *(Specify)* fluffs xeroform Curlex tubigrip ace splint

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Foley 16Fr ER	2.	3.
SITE	1. Bladder	2.	3.

19. ADDITIONAL INFORMATION

WC

Surgeons [redacted] Bu-2 Anesthesia: [redacted] Anesthesia Type: gets

Bovie Pad site intact pre-op CI ; post-op____ Bovie Settings: Coag/Cut 30/30

Tourniquet Site intact pre-op NA : post-op NA

Tourniquet Time: Up NA Down NA

20. OPERATION(S) PERFORMED

(L) Leg Wound Exploration Fasciotomy exp. Dressing Δ

21. PATIENT TRANSFERRED TO ICU TIME 2037 METHOD litter & ambu bag O2 / monitor

22. R[redacted] SIGNATURE [redacted]

bu-2

PART OF MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: ?

HEIGHT: ?

WEIGHT: 60

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

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

4. PROPOSED SURGICAL PROCEDURE:
(L) leg wound exploration

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to: X 1) Surgical Procedure & Operating Room Environment ___2) Separation Anxiety (Child) ___3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures. (e.g., warm blanket, touch). o Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION X Potential for respiratory dysfunction due to: X 1) Positioning X 2) Effects of Anesthesia ___3) Medical/Smoking History	✓ Pt. will be able to breathe without difficulty during immediate intraoperative phase.	o Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress. o Assist anesthesia during intubation and extubation.
C. INTEGUMENT X Potential impairment of skin integrity due to: ___1) Intraoperative Immobility X 2) ESU Pad Placement ___3) Positional Aids ___4) Prosthesis X 5) Pooling of Prep Solutions	✓ Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

#[redacted] ble-4

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

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

10. [redacted] D/ADDITIONAL INTRAOPERATIVE INTERVENTION'S NOTED.

[redacted] bu-2 23 Jun 03 DATE

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

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

LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities

☐ Transferred to litter with roller due to spinal

[redacted] PREPARED BY bu-2 13. POSTOPERATIVE EVALUATION PREPARED BY (S[redacted] bu-2

DATE: [redacted] 23 Jun 03 TIME: 1940 DATE: 23 Jun 03 TIME: 2037

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR: 00 · 01 · 02 · 03 · 04 · 05 · 06 · 07

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

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

RESPIRATION RECORD

Record special data only when so ordered

	00	01	02	03	04	05	06	07
BLOOD PRESSURE BP	116/51	122/65	114/62	118/65			110/62	121/65
PULSE	131	108	104	103	123		157	97
R	17	14	15	13	18		18	16
HEIGHT: WEIGHT →		1						
SpO2	KD	100	100	100	100		100	100
INPUT	125	125	125	125	125		125/50	
OUTPUT	150	150	100	100			200	

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.

[redacted] b4-4.

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 | HOUR

19

PULSE (O) | TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)

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

DAY	30 Jun	1 Jul	1 Jul	2 Jul	3
HOUR			1800	2200	0200
RESPIRATION RECORD			R15	R16	R14
BLOOD PRESSURE	118/55	114/56	124/69	120/70	115/72
	101	55	P109	P89	P80
Temp	99.0	57L	T99.6	T99.2	T98.9
			98%	98%	98%
SpO2	99%		RA	RA	RA

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.

CIV #[redacted] b6-4

VITAL SIGNS RECORDS

Medical Record

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

Date 30 June 03 Bed # 7

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

Time	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
BP	137/59	142/48	148/49	137/42	131/47	142/48	149/50	156/61	162/43	159/47		154/59	153/47	149/41	134/39	119/44	121/46	121/41			124/41			
TEMP		99.1			98.5										99.9	98.9								
HR	97	99	93	107	117	103	108	94	103	115		98	111	108	103	119	111	100			107			
RR	16	17	17	13	19	13	12	16	17	13		16	14	17	20	14	16	14			18			
SAO2	100	100	100	100	99	100	100	100	100	100		100	100	100	99	98	100	100			98			
FIO2	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA			RA			
INPUT																								
PO																								
IV	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100			100			
NGT																								
IVP							50								50									
TURN Q 2																								
TOTAL								850								850								
OUTPUT																								
URINE	150	150	100	100	100	100	125	200	500	325	200	150	175	200	375	500	175	175	125	150	150			
NGT																								
STOOL																								
JP						30													30					
TOTAL								1355								1225								
BALANCE																								
Initials	[redacted]																							

b6-2

MEDCOM - 11724

Master Copy

Ward/Section: ICW #1	[redacted] CIAN: [redacted] b6-2	LABORATORY RESULT FO (Subject to the Privacy Act of 197		
LAST, FIRST, MI: CIV # [redacted] b6-4		DATE: 1 Jul 03	TIME: 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.2	4.8-10.8 x 10^3
RBC	2.38	4.7-6.1 x 10^9
Hgb	6.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	21.6	42-52% (M) 37-47% (F)
MCV	91.0	80-94 fl (M) 81-99 fl (F)
Plt	429	130-500 x 10^3 verified
Lymph %	25.1	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		

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. R
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WI
EVERY UNIT REQUESTE

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 FRESH DAY OF CROSSMATCH OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATC

REMARKS:

REPORTED BY: [redacted] b6-2 | DATE: 01 Jul 03 | LAB ID NO:

bu-4

CIV [redacted] ICW-1 7/1/03 1300 Pre-Op

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	6.5	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	2.80	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	7.7	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	25.4	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	90.6	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	494	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	30.7	20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			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	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
PTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

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

bu-2

Ward/Section: ICU	[redacted] REQUESTING PHYSICIAN: [redacted] b6-2	LABORATORY RESULT F (Subject to the Privacy Act of 1

LAST, FIRST, MI: EFW [redacted] b6-4	DATE: 29 Jun 03	TIME: 0400	SSN/PSEUDO SSN: 000-00-0334

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	8.9	4.8-10.8 x 10^3
RBC	3.00	4.7-6.1 x 10^9
Hgb	8.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.3	42-52% (M) 37-47% (F)
MCV	90.9	80-94 fl (M) 81-99 fl (F)
Plt	282	130-500 x 10^3 verified
Lymph %	27.1	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			

Urinalysis

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

CSF

Cell Count			
Directigen		Negative	

Misc Serology

TEST	RESULT	REF.
RPR		Negati
Mono		Negati

Microbiology

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

Microscopic Urinaly

Blood Bank

MUST SUBMIT SF 518 V
EVERY UNIT REQUEST

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 THE ZR NUMBER OF BLO
REQUESTED)

UNIT	TYPE	CROSSMA

REMARKS:

REPORTED BY: [redacted] b6-2	DATE: 29 Jun 03	LAB ID NO:

ection: ICU1 | REQ[redacted] PHYSICIAN: [redacted] vu-2 | LABORATORY RESULT FORM (Subject to the Privacy A

FIRST, MI: EPID [redacted] vu-4 | DATE: 29JUN03 | TIME: 0021 | SSN PSEUDO SSN: [redacted] vu-4

Hemodilution

(Hematology) CBC			Urinalysis			Misc. Serology		
T	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF
	6.6	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
	1.92	4.7-6.1 x 10^9	App		N/A	Mono		Negative
	5.6	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
	17.4	42-52% (M) 37-47% (F)	Bili		Negative	Source		
	90.9	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
	189	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
%	26.4	20.5-51.1%	Bld		Negative	H. pylori		Negative
matology) Manual Differential			pH		N/A	Micro Parasites		
		Mono	Prot		Negative	Malaria		
		Eos	Urob		0.2-1.0	O & P		
		Baso	Nit		Negative	Other		
		Imm	Leuk		Negative	**Microscopic Urinalysis**		
			HCG		Negative			
crit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
e			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
			Directigen		Negative	ABO/Rh		

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

RKS:

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

ICU#1 [redacted] b6-4

~~ER~~ [redacted]

28Jun03 0570

RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST
WBC 12.5					
RBC 2.67					
7.5					
24.7					
92.2					
255					
20.0					
		pH			
	Mono	Prot			
	Eos	Urob			
	Baso				
	Imm	Leuk			
		Cell Count			MUST SUBMIT SF 519 EVERY UNIT REQUE
		Direct Igen		Negative	ABO/Rh
		MUST SUBMIT SF 519 EVERY UNIT REQUESTED			
RESULT	REF. RANGE	TEST			

[redacted] b6-2

28 Jun 03

ICU 1

EPW # [redacted] b(6)-4

28 Jun 03 1200

RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
6.4				
1.65				
4.8				
15.3				
92.8				
224				
28.7				

			pH		
	Mono		Prot		
	Eos		Urob		
			Leuk		

Cell Count			MUST SUBMIT SF 519 EVERY UNIT REQUESTED
Direct Igen		Negative	ABO/Rh

MUST SUBMIT SF 519 EVERY UNIT REQUESTED

RESULT	REF. RANGE	UNIT	TYPE	CROSSM

[redacted] b6-2

28 Jun 03

Ward/Section: ICU #4	QUESTING PHYSICIAN:		LABORATORY RESULT F (Subject to the Privacy Act of 1
LAST, FIRST, MI. EPW [redacted] bu-4	DATE 27 Jun	TIME 0328	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
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%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count	
Directigen	Negative

Misc. Serology

TEST	RESULT	REF
RPR		Negati
Mono		Negati

Microbiology

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

Microscopic Urinaly

Blood Bank

MUST SUBMIT SF 518 V
EVERY UNIT REQUEST

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	12.0	9.8-13.6 secs
APTT	25.9	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(WITH SUBMIT SF 518 WHEN REQUESTED)

UNIT	TYPE	CROSSMA

REMARKS:

REPORTED BY:	DATE:	LAB ID NO:
[redacted] bu-2	6/27	

*
coag

LAST COPY, RECOPY

Ward/Section: ICU #1	REQU[redacted] PHYSICIAN:	L[redacted]ATORY RESULT FORM (Subject to the Privacy Act of [illegible])
LAST, FIRST, MI: EPW#[redacted] b6-4	DATE: 7/8/2005	TIME: 1109
		SSN/PSEUDO SSN: [redacted] b6-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC	7.1	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	1.91	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	5.6	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	17.5	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	91.4	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	236	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %	25.2	20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			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	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

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

Ward/Section: EMT	RE[redacted] PHYSICIAN: b6-2	LABO[redacted]Y RESULT FORM (Subjec[redacted]ic Privacy Act of 1974)
LAST, FIRST, MI	DATE 23JUN03 / TIME 1845	SSN/PSEUDO SSN: [redacted] b6-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	20.2	4.8-10.8 x 10^3
RBC	4.07	4.7-6.1 x 10^6
Hgb	11.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	37.1	42-52% (M) 37-47% (F)
MCV	91.2	80-94 fl (M) 81-99 fl (F)
Plt	209	130-500 x 10^3 verified
Lymph %	11.6	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	Yel	N/A
App	Clear	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.020	N/A
Bld	~~Lg~~ Mod	Negative
pH	5.0	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	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

5-10 RBCs

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh: O Pos

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	15.8	9.8-13.6 secs
APTT	60.7	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

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

UNIT	TYPE	CROSSMATCH

REMARKS: b6-2

REPORTED BY: [redacted] **DATE:** 23Jun03 **LAB ID NO.:**

Ward/Section: EMT	[redacted]TING PHYSICIAN: [redacted] b6-2	C[redacted]TRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI.	DATE 23 JUN 03	TIME 1845	SSN/PSEUDO SSN: [redacted] b6-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.402	7.31-7.45
PCO2	28.3	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	119	80-105 mmHg (art) N/A (ven)
TCO2	18	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	18	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	99	95-98%
BEecf	-7	(-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	3.0	3.5-5.5 g/dl
ALP	~~[illegible]~~	26-84 u/l
ALT	12	10-47 u/l
AMY	36	14-97 u/l
AST	25	11-38 u/l
TBIL	4.6	0.2-1.6 mg/dl
BUN	7	7-22 mg/dl
CA^{++}	7.5	8.0-10.3mg/dl
CHOL	69	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	130	73-118 mg/dl
TP	4.4	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^+	146	128-145 mmol/l
K^+	4.9	3.3-4.7 mmol/l
CL^-	111	98-108 mmol/l
tCO_2	20	18-33 mmol/l

REMARKS:

REPORTED BY: b6-2 [redacted]	DATE: 23JN03	LAB ID NO.:

Ward/Section: ICU #7	REQUESTING PHYSICIAN:	CHEMISTRY RESULT F (Subject to the Privacy Act of 1

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN
EPW [redacted] b6-4	24 June	0430	

[redacted]

Chem 8
C creat

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

[redacted]

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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]

TEST	RESULT	REF. RANGE
GLU	104	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+	139	128-145 mmol/l
K^+	5.1	3.3-4.7 mmol/l
CL^-	108	98-108 mmol/l
tCO_2	22	18-33 mmol/l

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

[redacted]

TEST	RESULT	REF. P
ALB		3.3-5.5 g
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 m
GGT		5-65 u/l
TP		6.4-8.1 g

[redacted]

TEST	RESULT	REF. R
NA^+		128-145
K^+		3.3-4.7 m
CL^-		98-108 m
tCO_2		18-33 mm

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted] b6-2	24 Jun 03	

Ward/Section: ICU #1 | REQUESTING PHYSICIAN: [redacted] | LABORATORY RESULT (Subject to the Privacy Act of

LAST, FIRST, MI: EPW #[redacted] b6-4 | DATE: 24 June | TIME: 0430 | SSN/PSEUDO SSN:

CBC

Hematology/CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF
WBC	16.3	4.8-10.8 x 10³	Color		N/A	RPR		Nega
RBC	3.53	4.7-6.1 x 10⁶	App		N/A	Mono		Nega
Hgb	10.4	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	31.9	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	90.6	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	172	130-500 x 10³ verified	SG		N/A	Occ Bld		Ne
Lymph %	16.9	20.5-51.1%	Bld		Negative	H. pylori		Ne
(Hematology) Manual Differential			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	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			

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

COAGS

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF518 WITH EVERY UNIT REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMA
PT	15.7	9.8-13.6 secs			
APTT	70.0	21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

b6-2

REPORTED BY: [redacted] | DATE: 24 Jun 03 | LAB ID NO.:

Ward/Section: ICU #1	[redacted]STING PHYSICIAN:	[redacted]BORATORY RESULT (Subject to the Privacy Act of	
LAST, FIRST, MI: EPW# [redacted] b4-4	DATE: 24JUN03	TIME: 1350	SSN/PSEUDO SSN:

(Hematology)			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negat
RBC		4.7-6.1 x 10^6	App		N/A	Mono		Negat
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	Microbiology		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Ne
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		N
(Hematology) Manual Differential			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	Microscopic Urinalysis		
RBC Morph			HCG		Negative			

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

Coagulation Studies			Blood Bank/Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMA
PT	16.7	9.8-13.6 secs			
APTT	45.6	21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY: [redacted] b4-2	DATE: 24JUN03	LAB ID NO.:

KU1

EPW # [redacted] b6-4

[redacted] b6-2

DATE TIME
25Jun03 0940

[redacted] b6-4

RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
		pH		
	Mono	Prot		
	Eos	Urob		
	Baso			

Cell Count		MUST SUBMIT SF 519 EVERY UNIT REQUE
Direction	Negative	ABO/Rh

TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSM
	17.0				
	20.2				

b6-2

[redacted] | DATE

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LABORATORY RESULTS

b6-4

ORST, M [redacted] b6-4 6/25/03 EPW [redacted] ICU I

	RESULT	REF. RANGE			
LUBC					
RBC					
Hgb					
Hct					
MCV					
PLT					
Lymphs					
Mono					
Eos					
Baso					

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

	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT	12.0				
PTT	27.7				

ARKS:

ORTED BY:

PT | PTT | INR

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[redacted] b6-2

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FIRST, MI

EEW [redacted] b6-4

25JUN03 2000

[redacted] b6-2

T	RESULT	REF RANGE	UNIT	TYPE
WBC				
RBC				
Hgb				
Hct				
MCV				
PLT				
Lipemic				
Mono				
Base				

CSF

MUST SUBMIT SF 518 W

EVERY UNIT REQUE

ABO/RH

T	RESULT	REF RANGE	UNIT	TYPE	CROSSMATCH
PT	11.8				
PTT	31.4				

ARKS: [redacted] b6-2

ORTED B [redacted]

AGN 1 [redacted] b6-2

EQW # [redacted] b6-4 HGJWB 0200 [redacted] b6-4

RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT
		Color				
		Appr				
		Bil				
		WBC				
		Bac				
		pH				
Mono		Prot				
Eos		Urob				
Baso						
Iron		Leuk		Negative		
		Cell Count			MUST SUBMIT SF 518 EVERY UNIT REQUE	
		Directigen		Negative	ABO/Rh	

RESULT	REF. RANGE	UNIT	CODE	
11.5				
39.0				

[redacted] b4-2

Last Copy

ICU I

b6-4

EPW # [redacted] b6-4 25Jun03 0800 [redacted]

	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
WBC					
RBC					
Hgb					
Hct					
MCV					
Plt					
Lymph%					
Mono					
Eos					
Baso					

CSF

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUEST

ABO/Rh

	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT	12.6				
PTT	31.0				

ARKS:

ORTED BY: [redacted] 25 June

b6-2

b6-4 [redacted] ICU I 6/26/23 0820 EPN [redacted] b6-4

RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST
		pH			
Mono		Pros			
Eos		Lymph			
		Lactate			

Coll Count			MUST SUBMIT SP 518 EVERY UNIT REQUIRED
Direct Igm		Negative	ABO/Rh

RESULT	REF. RANGE	UNIT	DATE	CLASSIFICATION
11.6				
34.3				

b6-2 [redacted]

26 June

Ward/Section: ICU I	REQU[redacted]G PHYSICIAN:	L[redacted]RATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] b4-4	DATE 6/26/03	TIME 1945	SSN/PSEUDO SSN: [redacted] b6-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
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%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count	
Directigen	Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	10.3	9.8-13.6 secs b6-2
APTT	~~27~~ 24 [redacted]	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WHENEVER A UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b6-4

PATIENT: [redacted] #[redacted] TEST: CBC

ICW #1 1 JULY 2200

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF.
WBC	7.6	4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC	2.72	4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb	7.6	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct	24.6	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	90.6	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
PLT	545	130-500 x 10^3 verified	SG		N/A	Occ Bld		Negat
Lymph %	24.7	20.5-51.1%	Bld		Negative	H. pylori		Negat
(Hematology) Manual Differential			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	**Microscopic Urinalys**		
RBC Morph			HCG		Negative			
Hum Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			MUST SUBMIT SF 518 W EVERY UNIT REQUEST		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOO REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMAT
PT		9.8-13.6 secs			
PTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARK[redacted]

REPORTE[redacted] DATE: LAB ID NO.:

b6-2

TEST(S)

SPECIMEN TAKEN

DATE 23JUN03 TIME A.M. P.M.

REQUESTED

CRT

RESULTS

20.0

REMARKS [redacted] b6-2

REQUESTING PHYSICIAN'S SIGNATURE [redacted] b6-2

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

MUSLIM, IRAQI NATIONAL [redacted] b6-2

TECH

MD DATE

MISC

ROUTINE

TODAY

PRE-OP

STAT

PATIENT STATUS

BED

AMB

OUTPATIENT

NP

DOM

SPECIMEN SOURCE (Specify)

SPECIMEN/LAB RPT. NO.

LAB ID NO.

PATIENT'S MED. RECORD

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505

557-107

i-STAT CG4+

Pt: 0

Pt Name:_____

Lac_____2.92 mmol/L

TCO2_____21 mmol/L

At 7C

pH_____7.286

PCO2_____40.8 mmHg

PO2_____323 mmHg

HCO3_____19 mmol/L

BEecf_____-7 mmol/L

sO2*_____100 %

*calculated

HCT: 30%

Sample Type_:

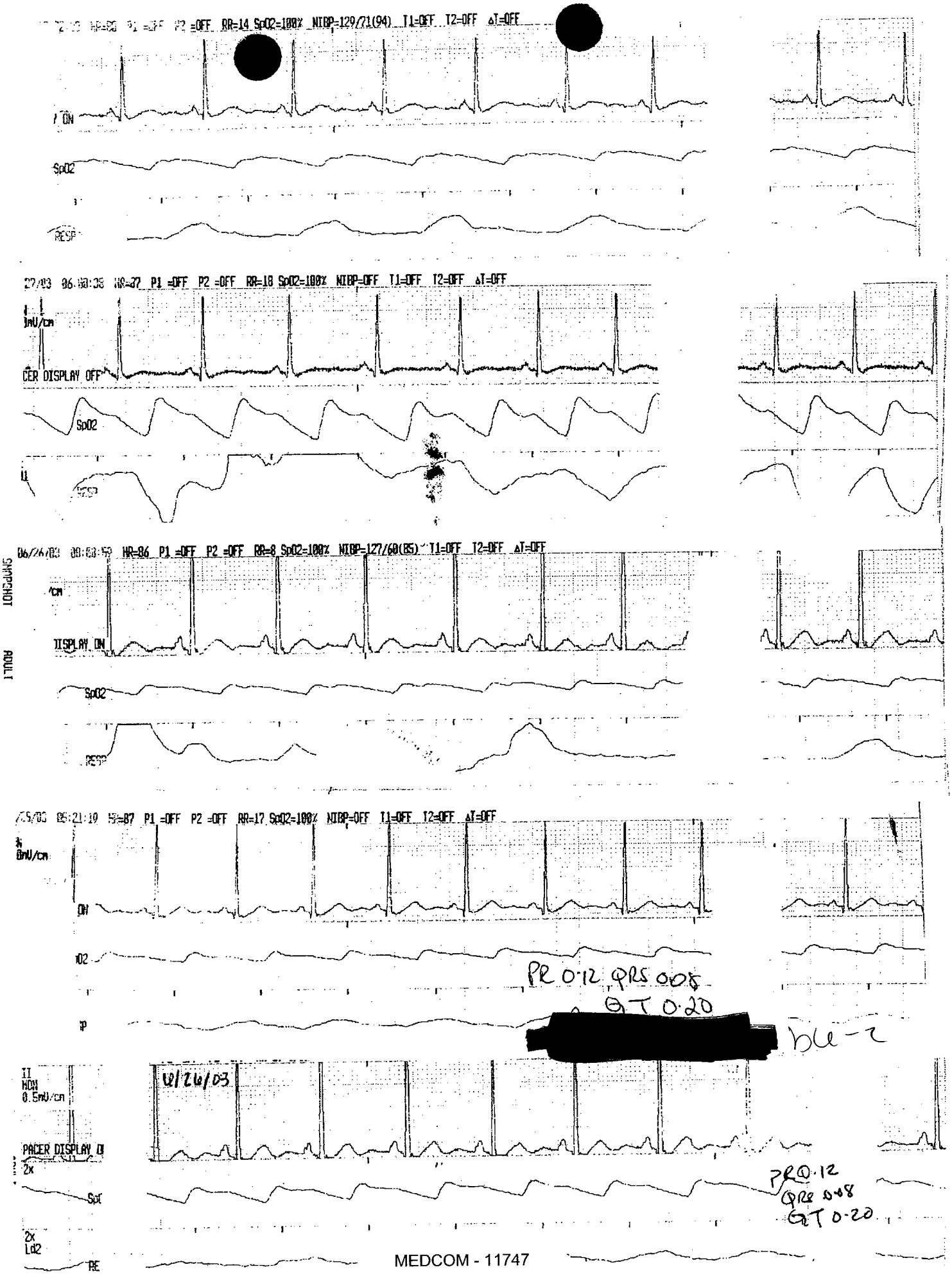
23JUN03 15:56

Oper: #2

Physician:_____

Ser# 40792

Ver: JRM50456


HR=80 P1 =OFF P2 =OFF RR=14 SpO2=100% NIBP=129/71(94) T1=OFF T2=OFF ΔT=OFF
ON
SpO2
RESP
27/03 06:00:36 HR=77 P1 =OFF P2 =OFF RR=18 SpO2=100% NIBP=OFF T1=OFF T2=OFF ΔT=OFF
1mV/cm
CER DISPLAY OFF
SpO2
II
RESP
06/26/03 08:00:59 HR=86 P1 =OFF P2 =OFF RR=8 SpO2=100% NIBP=127/60(85) T1=OFF T2=OFF ΔT=OFF
SNAPSHOT
ADULT
6.25mm
DISPLAY ON
SpO2
RESP
05/21/03 05:21:19 HR=87 P1 =OFF P2 =OFF RR=17 SpO2=100% NIBP=OFF T1=OFF T2=OFF ΔT=OFF
6mV/cm
ON
PR 0.12 QRS 0.08
QT 0.20
[redacted]
II
HDW
0.5mV/cm
01/26/03
PACER DISPLAY
2x
SpO
PR 0.12
QRS 0.08
QT 0.20
2x
Ld2
RE

Page II

Standard Form 517

CLINICAL RECORD — ANESTHESIA

ANESTHETIC(S) 1730 45 15 15 30 45 15 HOUR 30 45 20 25 30 45 50

Zenuran 30

Hep Alm (3000) 3.

Norcuron 10/10

Kefzyol 200

Fortin 8

Tab Chlor 2/4

OXYGEN

CO_2 ABSORP.

ENG SRSA

LEVEL OF ANAL-ANES. 1.0 1.5 1.0 1.0

$ETCO_2$ 30

To Dogwood [redacted] Right Radial

Monitored Blood Pressure

CODE

● PULSE

○ RESP.

V ^ B. P.

X ANES.

Ⓞ OPER.

T TOURN.

220 200 180 160 140 120 100 80 60 40 20

FLUIDS

B BLOOD

N SALINE

G 5% G/W

DX EXPAND.

NUMBERS FOR REMARKS

IV FLUIDS 0.9 Nacl #5 0.9 Nacl #6

POSITION

AGENTS AND TECHNICS

INDUCTION

SATIS.

UNSATIS AND WHY

REMARKS

Contact for Dep Dro(1)

Airway Directly to Dogwood

ENDOTRACHEAL: SIZE BLADE ORO NASO CUFF PACK

REMARKS:

OPERATION PERFORMED Thigh wound exploration Repair of popliteal artery C Renes SVG Repair of popliteal vein Injected by fasciotomy Blue

TOTAL FLUIDS

NAME(S) OF SURGEON(S) [redacted] b6-2

[redacted] b6-2

Signature of Anesthetist.

RECOVERY

REFLEX IN O.R.

EMESIS

ASPIR.

EXCITEMENT

HYPOTENSION

OTHERS

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

[redacted]

REGISTER NO. WARD NO. DATE 28 Jun 03

Page II (2) TWO b6-4

ANESTHESIA

Standard Form 517
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

517-111

ASA II E

Standard Form 517

CLINICAL RECORD — ANESTHESIA

ANESTHETIC(S) / OXYGEN / CO2 ABSORP. / EKG / LEVEL OF ANAL-ANES. / FTCO2 / CODE / FLUIDS / NUMBERS FOR REMARKS / IV FLUIDS / POSITION

INDUCTION

SATIS ✓

UNSATIS AND WHY

REMARKS

Patient checked IV x 2 (L) + (Rt) ROA, arrived from ATLS to X-ray

(1) Rapid sequence induction

(2) Cut down Hickman 20 G

10 57298

10 57301

10 57295

1642038

(4) ABG's + H/H

(5) Surgeon checked to Hickman vein for bypass

(6) ABG #5 Hickman 30

AGENTS AND TECHNICS

Ketamine, Pentothal, Sux, Forane

Level 4 pre for PRC's + IV's

ENDOTRACHEAL: SIZE 8.0 BLADE Mac 4 ORO X NASO ..... CUFF ..... PACK .....

REMARKS: Rapid sequence ATR intubation BS=BL pre, post position

OPERATION PERFORMED: Thigh wound exploration + repair of popliteal artery & repair SVG. Repair of popliteal vein (6) Leg fasciotomy

TOTAL FLUIDS: PRC – 4 units; 0.9 Nacl 9,000; ERL – 900; Albumin – 100 cc; Poly – 800

NAME(S) OF SURGEON(S): [redacted] b6-2 b6-2 b6-2 [redacted]

Signature of Anesthetist: [redacted]

RECOVERY: REFLEX IN O.R. ..... EMESIS ..... ASPIR. ..... EXCITEMENT ..... HYPOTENSION ..... OTHERS .....

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

[redacted] b6-4

REGISTER NO. | WARD NO. | DATE 23 Nov 03

ANESTHESIA

Standard Form 517
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

517-111

PAGE I (one)

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT (LBS.)	SPECIAL INFORMATION
GSW to LEFT Knee	18		PATIENT DOES NOT SPEAK ENGLIG - NPO - 8 00/12 Interpreter

PHYSICAL STATUS: 1 2 3 4 5 6 7

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL ABNORMAL AND WHY?	HGB ____ RBC ____ HCT ____ OTHER	

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY) Smoker Ø Bronco Ø TB Ø	BP ____ PULSE ____ ECG (IF PERTINENT) Cardiac Ø	(CEREBROVASCULAR, POLIO, NEUROLOGICAL) Loc Ø	(ALLERGIES) Ø Darkness

PREVIOUS ANESTHETICS AND COMPLICATIONS	PRESENT DRUG THERAPY; E.G., STEROIDS, TRANQUILIZERS

PREOPERATIVE DIAGNOSIS	PREMEDICATION
PATIENT TOLD Through Interpreter. Concerning Anesthesia Complication	

SIGNATURE OF EXAMINING PHYSICIAN: [redacted] DATE: 03 Jun 03

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

DU-2

*U.S. Government Printing Office: 1994 — 300-892/10029

[redacted]ncef 1gm IVPB [redacted] ward c patient

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
versed	(mg)	2
fentanyl	(ug)	50/25/25/25
propofol	(mg)	100
	( )	
	( )	
	( )	
MSO4	( )	
VOLAT AGENT — Iso	% del	1.5 1.5/1.5/1.0/1.0/1.4/1.4
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	6—3/4/4/4/5/8

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

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: (1) (2) (3) (4) (5) (6)

TOTALS	
2	
125	
10	

TOTAL EST. BL: 60

TOTAL URINE: Foley DC'd 30

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

FLUIDS		
LINE site 18g LAC	☐ Warmed	RL500 — 500
	☐ Warmed	22LR
	☐ Warmed	
	☐ Warmed	

LOSSES	
EST BLOOD LOSS	60
URINE –	300

REMARKS – Code drugs with numbers, events with letters

Pt's chart v. OK to proceed.
(1) To room via little 30cm mon 5 applied pre O2.
(2) Smooth IV induction
(3) Phenergan 12.5 mg IV.
(4) Relief by CRT [redacted]
(5) EOR to ICU bed-2
(6) Rpt to SSG [redacted]

PHYS. STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG / LB

HEMATOCRIT: 27.3

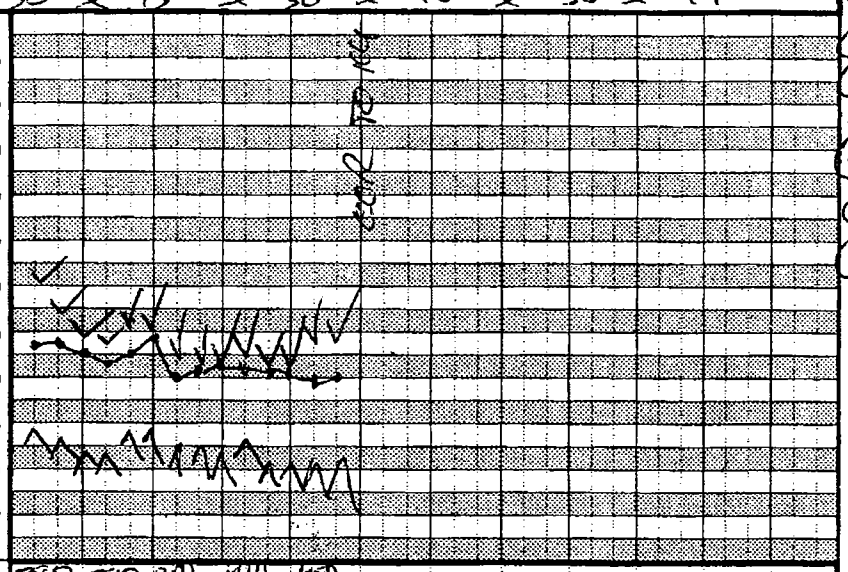
INITIAL DATA: BP – 124/50; HR – 94

CONSENT CHECK: OK? – (Y) N

PATIENT RECORDS: OK for PROCEDURE? ✓ TIME – 1345

TIME → 30 × 15 × 30 × 16 × 30 × 17

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



VT – ml		350	350	350	400	450
f – breaths/min		17	16	17	16	17
Peak inf pres / PEEP						
MODE– S(pon), A(ssist), C(on)		S	S	S	S	S
BP/Auto Cuff	✓ ETCO2 (torr)	37	36	37	37	41
BP / oth	✓ FIO2 (Frac or %)	0.75	0.75	.75	.76	.76
ART line	✓ SpO2 (%)	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site	available				
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

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

RECOVERY AT 1550
PACU (ICU) (Specify)
OTHER
CONDITION: STABLE
RESP– 20 SpO2– 100
BP– 118/67 HR– 88

	Start	Room	End
ANES	1425	1434	1600
PROC	Ready 1440	Begin 1453	End 1539

PROCEDURES and CPT Codes: I&D L leg

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GM

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Eyes taped, 9cm OA placed, easy mask

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

CIV # [redacted] bed-4 IOW1
20 yo ♂

SURGEONS: [redacted] bed-2
ANESTHE[redacted] bed-2 MAJ, CRNA

PROCEDURE LOCATION: 1-1
DATE: 7/1/03
PAGE 1 OF 1

[redacted] RECORD – ANESTHESIA REVISED 99

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

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS SPECIFY UNITS – MG / MCG / ML, "I" = CONSTANT INFUSION		
DRUG	(Bolus)	
fentanyl	(mcg)	50 50 50 50 50
propofol	(mg)	150 30
	( )	
	( )	
	( )	
	( )	
VOLAT AGENT	ISO % del / % e.t.	2.0 – 2.0 – 1.5 – 1.5 – 1.0 – 0.0
AIR	L/Min	
N2O	L/Min	
O2	L/Min	2 – 2 – 2 – 2 – 2 – 3 – 4
SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS		

FLUIDS		
LINE site		
LR 18 ga (2)	☐ Warmed	
	☐ Warmed	100 – 200 – 250
	☐ Warmed	
	☐ Warmed	

LOSSES		
EST BLOOD LOSS		* – 50
URINE –		200 – 225

TOTALS	
TOTAL FLUID	50
TOTAL URINE	225

FLUIDS – SUMMARY	
CRYSTALLOID–	250
COLLOID–	NONE
BLOOD–	NONE

REMARKS– Code drugs with numbers, events with letters

Pt ID'd. Chart reviewed. NPO since MN.

To OR – monitor on – smooth IV induction.

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 65 (KG) LB

HEMATOCRIT: 27

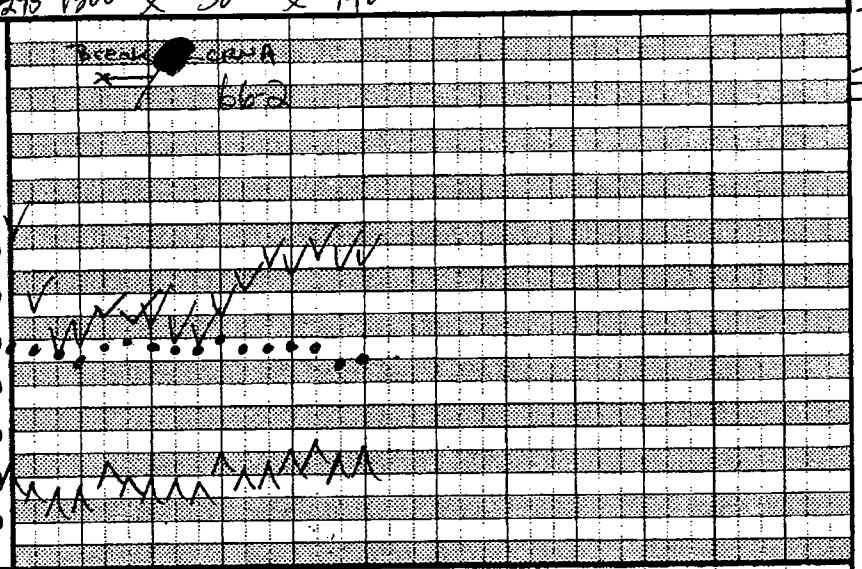
INITIAL DATA: BP 124/80 HR– 101

EQUIP CHECK: OK?– (Y) N

PATIENT ID CHECK: OK for PROCEDURE? Y TIME– 1240

TIME → 1245 1300 X 30 X 1400

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



	VT – ml	380	310	310	480	440
	f – breaths/min	15	12	22	9	12
	Peak inf pres / PEEP					
	MODE– S(pon), A(ssist), C(on)	S	S	S	S	S
BP/Auto Cuff (X)	ET CO2 (torr)	47	50	50	52	48
BP / oth (X)	FIO2 (Frac or %)	.81	.82	.8	.8	.8
ART line (X)	SpO2 (%)	100	99	100	99	100
Steth- PC/ES (X)	ECG	SR	SR	SR	SR	SR
Gas analyzer	TEMP- site	Available				
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

RECOVERY AT	ICU
PACU (ICU) I (Specify)	
OTHER	
CONDITION:	SaO_2 3L NC
RESP– 9-12	SpO_2– 100
BP 123/75	HR– 110

ANESTHESIA & PROCEDURE TIMES	Start	Room	End
ANES	1230	1240	1415
PROC	Ready 1248	Begin 1300	End 1400

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

PROCEDURES and CPT Codes: I&D LLE

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GA – Eyes taped, arms padded & secured

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: LMA #4. Easily placed bu-2

PATIENT IDENTIFICATION– Typed or written entries: Name, Grade/Rate, Medical facility: EPW [redacted] ICU #1 bu-4

SURGEONS: [redacted]

ANESTH [redacted]

PROCEDURE LOCATION: 1

DATE: 29 JUN 03

PAGE 1 OF 1

bu-2

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)	
Fentanyl	(µg)	2 1 . 3 . 5 1
Propofol	(mg)	150 50 10 10
Sufx	(mg)	60
Lidocaine	(mg)	20
	( )	
Neo-Syn	(mg)	20 20
VOLAT AGENT Forane	% del	.5 — 1 — 1.25 — 2
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8 — 2 — 2 — 2 — 2

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

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

FLUIDS — LINE site LA 1 ☐ Warmed — 9a — 1000 bl
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES — EST BLOOD LOSS — 50 — 50/100
URINE – 325

TOTALS	
5cc	100
TOTAL URINE	325

FLUIDS – SUMMARY
CRYSTALLOID– 1200
COLLOID– 0
BLOOD– 0

REMARKS – Code drugs with numbers, events with letters

* VERSED 2.5 @ 11
Reglan 10 @ 11

PHYS STATUS: 1 / 2 3 4 5 E

BODY WEIGHT: 60 KG / LB

HEMATOCRIT: 10/31

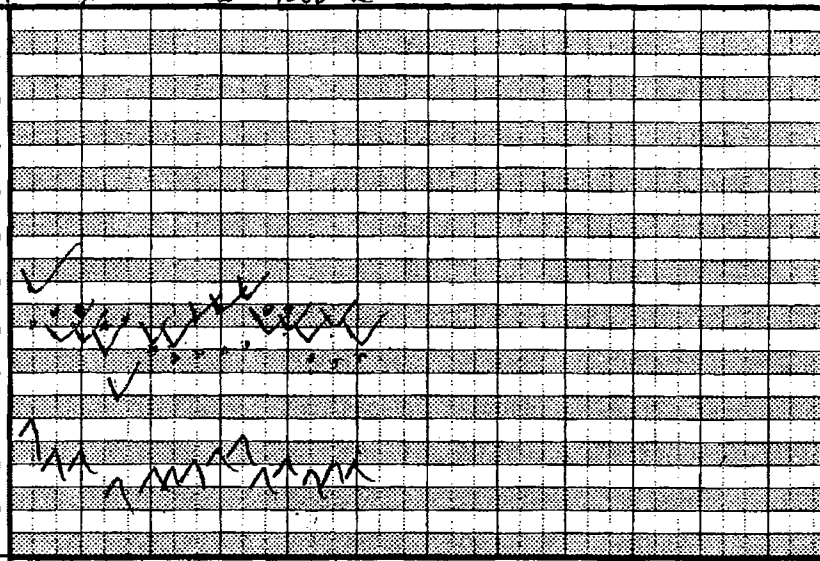
INITIAL DATA: BP– 130/58 HR– 81

EQUIP CHECK: OK?– Y N

PATIENT REVIEWED: OK for PROCEDURE Y/N TIME– 1200

TIME → 1200 x 30 x 1300 x

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



MONITORS / ACCESSORIES						
	VT – ml	610	620	640	300	640
	f – breaths/min	12	8	8	12	10
	Peak inf pres / PEEP	18	16	16		16
	MODE– S(pon), A(ssist), C(on)	S C	C	C	S	C C
BP/Auto Cuff	ET CO2 (torr)	38	30	32	50	54
BP / oth	FIO2 (Frac or %)	.90	.91	.91	.91	.91
ART line	SpO2 (%)	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	SR	SR	ST
Gas analyzer	TEMP- site					
	N-M Block (T/4)	4/4				
Warming Mkt	warm Tow					
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 0 1

RECOVERY AT 1320 PACU ICU #1 (Specify) OTHER
CONDITION: 100 10
RESP– 12 SpO2–
BP– 109/73 HR– 104

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1750	1200	1330
PROC	Ready	Begin	End
	1208	1225	1315

PROCEDURES and CPT Codes: I&D (W) hip

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA — Eyes taped

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: SIV1, DVLX1, atraumatic, Cuff T, BS=BS, tube taped

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

SURGEON [redacted] bu-2

ANESTH [redacted] MAJ CRNA bu-2

PROCEDURE LOCATION

DATE 27 Jun 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 11753

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

[redacted] [redacted]

STHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

ASA Physical State 1 (2) 3 4 5 E
WT: ~70 KG/LB HT: ____ IN.
ALLERGIES: NKDA

OSED PROCEDURE: I&D (R) leg
ICAL SERVICE:
INCE: P M

S:
ACCO:
ETOH:
RUGS:

ENT MEDICATIONS:
dered as premed
Ancef 1Gm

EDICATIONS:
Yes (@ ____ Hrs) /CC
.. ____ mg IV IM PO
.. ____ mg IV IM PO
.. ____ mg IV IM PO

RATORY STUDIES:
T: 8.6, 27.3 (P) supplies
R: P
WBC 8.4
PLT 282
prior to 8/27 Hc was 51%

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension N Y
- Angina N Y
- MI N Y
- CVA N Y
- Other N Y

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

Renal System:
- Acute/Chronic RF N Y Foley

Gastrointestinal:
- Hepatitis N Y
- Hiatal Hernia N Y
- PUD/GERD N Y

Endocrine System:
- Diabetes N Y
- Steriods N Y
- Thyroid N Y

Neurological:
- Seizures N Y
- Neuropathy N Y
- Other N Y

Gynecological :
- Pregnancy N Y NA

Other Significant Hx:
- N Y
- N Y
- Familial HX N (Y) S/P I&D LLE ~ Fasciotomy

unknown

ASSESSMENT
PAST SURGICAL/ANESTHETIC
I&D (LLE ~ Fasciotomy Exploration)

PHYSICAL EXAMINATION
BP 124/78 HR 101 R 18 T 98.9
Pain Scale 0-10 ____
HEENT - Teeth intact
Trachea midline
TMJ/Neck 2/2 FB
Oropharnyx II
Nares
CHEST: CTA (distant
CARDIAC: S1 S2 ~ SM
EXTREMITIES:
IV Access: (L) 20G
Ulnar Filling: (R) T Arm 20G
BACK:
OTHER:
SaO2 100% RA

NPO Since P MN

(+) Pt (D) IV (old)

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

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

tient/legal guardian seems to understand and agrees. Questions answered.

: ____ Date: ____ Time: ____ Hrs

ANESTHESIA EVALUATION AND NOTE (NON ASU)
APPARENT ANESTHETIC COMPLICATIONS { } OTHER

: ____ Date: ____ Time: ____ Hrs

1 July 03
Reviewed
No Dess
m II - 2.5FB

t Identification: (Ward) ____

Gen.

~~EPW~~ CW # [redacted] (ICU1 - ICU2) [redacted] Lt

ble-4 b6-2

WBC 7.2 hgb 6.8 hct 21.6 429K

Screen 4 units

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 no necessary.
3. DEEP SEDATION/ANALGESIA. Patient responds purposefully following repeated or painful stimulation. Airway assistance may

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

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

ASA Physical State 1 (2) 3 4 5 E
WT: ~60 KG/LB HT: ____ IN.
ALLERGIES: NKDA

PROPOSED PROCEDURE (R) leg wash-out / partial wound closure
SURGICAL SERVICE: Ortho
NPO SINCE: ↑ MN

HABITS:
TOBACCO: Unknown
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered (25,000 / 500) - 12 u/hr
( ) heparin drip 600u/hr
( ) Ancef 1Gm q8°
( ) Lc @ 75cc/hr
( )
( )
( )

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

LABORATORY STUDIES: 24 Jun
HB/HCT: 10 / 31
U/A:
OTHER:
PT/PTT: 11.5/39
26 Jun
24 Jun :
16.3 WBC 172K PLTS
10.4 Hb 139 | 108 | 11
31.9 Hct 5.1 | 22 | 0.7 | 104

PRE-OPERATIVE
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 Nil
Other Significant Hx:
N Y
N Y
Familial HX N (Y) S/p GSW (R) Leg

Unknown

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Explor / Repair (L) popl

PHYSICAL EXAMINATION
BP 110/56 HR 88 R 16 T 99 SaO2 RA 100%
Pain Scale 0-10
HEENT - Teeth Rough molars
Trachea Mid line
TMJ/Neck 2½-3FB
Oropharynx C
Nares
CHEST: CTA (distant)
CARDIAC: S1 S2 ≅ (m)
EXTREMITIES: #20G (R) Tarm / #18G (L) Arm
IV Access:
Ulnar Filling: (R) fast warm (L) palat pulse
BACK: Open (L) cap refill
OTHER: Foley

NPO Since ↑ MN

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ____ ( ) General: Mask intubation GETA

Interpreter not Avail / Chart Reviewed

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

The patient/[redacted] -66-2 [redacted]erstand and agrees. Questions answered.
Signed: [redacted] MAJ, CRNA Date: 26 Jun 93 Time: 1630 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

EPW [redacted] (ICU #1 / FCU #1)
bu-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

MEDICAL RECORD — ANESTHESIA

DRUG	Units	
Versed	(mg)	3
Nimbex	(mg)	14
Fentanyl	(mcg)	100 50 50
	( )	
	( )	
	( )	
VOLAT AGENT: ISO	% del / % e.t.	1.0/1.5/1.0/1.0/1.0/0.4
AIR	L/Min	
N2O	L/Min	
O2	L/Min	2/2 1 1 1 2 2

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

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

Versed

TOTALS	
3mg	
14mg	
200mg	

TOTAL BLD: Minimal

TOTAL URINE: 200ml

FLUIDS – SUMMARY

CRYSTALLOID – 700ml

COLLOID – Ø

BLOOD – Ø

FLUIDS		
LINE site: NS	☐ Warmed	150 / 600-700
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES		
EST BLOOD LOSS		Ø
URINE –		125 / 200

PHYS STATUS: 1 2 3 4 5 (E)

BODY WEIGHT: 60 (KG) LB

HEMATOCRIT: 37

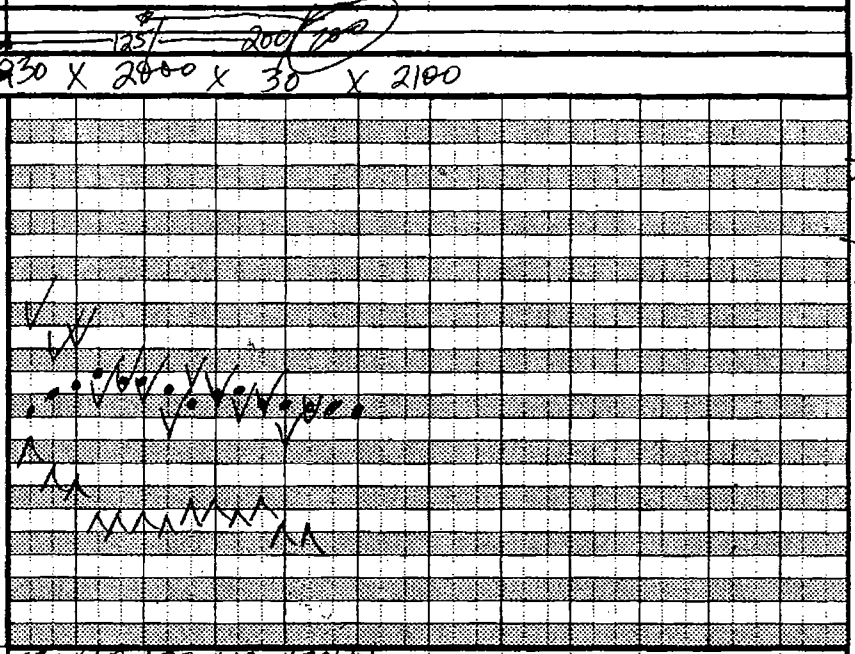
INITIAL DATA: BP 140/91 HR – 102

COMP CHECK: OK? – (Y) N

PATIENT READINESS: OK for PROCEDURE? Y TIME – 1940

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

TIME → 1930 X 2000 X 30 X 2100



VT – ml	720	660	620	610	670	HV
f – breaths/min	10	8	8	8	8	
Peak inf pres / PEEP	22	20	20	21	22	
MODE – S(pon), A(ssist), C(on)	C	C	C	C	C	C

BP/Auto Cuff	ET CO2 (torr)	27	32	33	33	33	4
BP / oth	FIO2 (Frac or %)	.6	.6	.6	.6	.5	1.0
ART line	SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP- site Skin	38	38	38	38	38	
	N-M Block (T/4)			0/4	0/4	0/4	
Warming blkt							
Conv warmer							

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

REMARKS – Code drugs with numbers, events with letters

Pt ID'd in EMT. Already intubated. Bilateral breath sounds ∅. VSS.

To OR – monitors on – pt stable

To ICU #1 in stable condition – report given – pt put on vent there – equal BS (B).

RECOVERY AT: PACU / ICU #1 (Specify)

OTHER

CONDITION: stable, intubated

RESP – 8 SpO2 – 100%

BP – 117/77 HR – 86

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1935	1944	2050
PROC	Ready 1949	Begin 1950 2010	End 2032

PROCEDURES and CPT Codes: I & D Left Leg

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA – ETT

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Pt intubated w/ 8.0 ETT – 22cm @ lips equal breath sounds. ETT & eyes taped

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

[redacted] ICU #1

b(6)-4

SURGEONS: [redacted] b(6)-2

ANESTHE[redacted]

PROCEDURE LOCATION: OR 1

DATE: 23 JUN 03

PAGE 1 OF 1

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 11756

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 20 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

ASA Physical State (1) 2 3 4 5 (E)
WT: ~60 (KG)/LB HT: ____ IN.
ALLERGIES: unknown

PROPOSED PROCEDURE: Exploration / possible histotomy completion S/P GSW (L) LEG
SURGICAL SERVICE: ____
NPO SINCE: unknown

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: ~10 / 32.8
U/A: ____
OTHER: ____

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
unknown

PHYSICAL EXAMINATION
BP ____ HR ____ R ____ T ____
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea ____
TMJ/Neck ____
Oropharynx ____
Nares ____
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES:
IV Access: 18g x2 (L) UE
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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

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

The patient/leg[redacted] understand and agrees. Questions answered. b(u)-2
Signed: [redacted] CRNA Date: 23 JUN 03 Time: 1930 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

[redacted] b(u)-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.

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1 unit ML

REMARKS:

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

- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 28 JUN 03

DATE AND HOUR REQUIRED 28 JUN 03 ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* Dr [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE S/P (L) Leg Fasciotomy

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

SIGNATURE OF VERIFIER

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 1642329

TRANSFUSION NO.

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

DONOR

ABO O

Rh POS

RECIPIENT

ABO O

Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN: NA

CROSSMATCH: Compat

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK:

[ ] RECORD [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted] b(6)-2

DATE 28 JUN 03

REMARKS: EXP 02 JUL 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] b(6)-2

[redacted] 1520 ON *(Date)* 28 JUN 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Sig[redacted]* [redacted] b(6)-2

2nd VERIFIER *(Sig[redacted]* [redacted] b(6)-4

PRE-TRANSFUSION

TEMP. 99.2 PULSE 118/64 BP 114/74

DATE OF TRANSFUSION 28 JUN 03 TIME STARTED 1330

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED 1510 28 JUN 03

REACTION [X] NONE [ ] SUSPECTED

TEMPERATURE 100 PULSE 100 BLOOD PRESSURE 169/62

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN

[ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

[X] NO [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE [redacted] b(6)-2

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, [redacted]e; grade; rank: [redacted]

SEX M WARD CU #1

EPW # [redacted] b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

PRINTED ON RECYCLED PAPER

MEDCOM - 11758

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

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

DATE REQUESTED: 28 JUN 03

DATE AND HOUR REQUIRED: 28 JUN 03 ASAP

REQUESTING PHYSICIAN *(Print)*: Dr. [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P (L) leg Fasciotomy

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

VOLUME REQUESTED *(If applicable)*: 1 unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: 5304661

TRANSFUSION NO.: b(6)-4

PATIENT NO.: [redacted]

TEST INTERPRETATION

ANTIBODY SCREEN: NA

CROSSMATCH: Comp

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

SIGNATURE OF PERSON PERFORMING TEST: [redacted] b(6)-2

DONOR
ABO: O
Rh: POS

RECIPIENT
ABO: O
Rh: POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 28 JUN 03

REMARKS: EXP 02 JUL 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted] b(6)-2

AT *(Hour)*: 1440 ON *(Date)*: 28 JUN 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient [redacted] same person named on this Blood Component Transfusion Form and on the patie[redacted]tification tag.

1st [redacted] b(6)-2

2nd [redacted] b(6)-2

PRE-TRANSFUSION

TEMP.: 99 PULSE: 89 BP: 187/66

DATE OF TRANSFUSION: 28 JUN 03 TIME STARTED: 1515

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1U ML

TIME/DATE COMPLETED/INTERRUPTED: 28 JUN 03 1700

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE: 99.8 PULSE: 117 BLOOD PRESSURE: 186/62

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [x] NO
- [ ] YES *(Specify)*

b(6)-2

SIGNATURE OF PERSO[redacted] RN

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, firs[redacted]dle; grade; rank; rate; hospital or medical facilit[redacted]

SEX: M WARD: ICU #1

EPW # [redacted] b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 11759

Medical Record Copy

518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1 unit ML

REMARKS:

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

- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 23 JUN 03

DATE AND HOUR REQUIRED 23 JUN 03 NOW

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE s/p (illegible) Transfusion

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

SIGNATURE OF VERIFIER

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. 5304661

TRANSFUSION NO. 66-4

PATIENT NO. [redacted]

DONOR

ABO O

Rh POS

RECIPIENT

ABO O

Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN N/A

CROSSMATCH Comp

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: EXP 02 JUL 03

PREVIOUS RECORD CHECK:

[ ] RECORD [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted] b(6)-2

DATE 23 JUN 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] b(6)-2

AT *(Hour)* 1440 ON *(Date)* 23 JUN 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patie[redacted]ntification tag.

1st VERI[redacted] b(6)-2

2nd VERIFIER *(Signature)* b(6)-2 [redacted]

PRE-TRANSFUSION

TEMP. 97.9 PULSE 84 BP 151/66

DATE OF TRANSFUSION 23 JUN 03 TIME STARTED 1515

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 ML

TIME/DATE COMPLETED/INTERRUPTED 23 JUN 03 1700

REACTION [X] NONE [ ] SUSPECTED

TEMPERATURE 97.5 PULSE 77 BLOOD PRESSURE 136/62

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN

[ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

[X] NO [ ] YES *(Specify)* b(6)-2

SIGNATURE OF PERSON NOTING ABOVE [redacted]

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

EPN# [redacted] b(6)-4

SEX M

WARD ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 11760

Return to Transfusion Service

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: 1 JULY 03 TIME OF ORDER: 1540 HOURS

LIST TIME ORDER NOTED AND SIGN

1. RESUME PRIMARY DIET [redacted]
2. RESUME DIET
3. IV - LR AT ~~125~~ 100 CC/HR, b6-2
   MED LEGAL WITH TAKING P.O. [redacted]
4. D/C FOLEY.
5. EVAC TO CIVILIAN HOSPITAL 2 [redacted]

PATIENT IDENTIFICATION

24 YO OTHER MALE

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER HOURS

6. GOC AT 2100 TODAY
7. 7-1-03 0000.

b(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IDENTIFICATION

[redacted]

b(6)-4

UNIT	ROOM NO.	BED NO.

DATE OF ORDER 30 MAR 03 TIME OF ORDER 1230 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) TRANSFER TO ICW-1

(2) S/P OSW to left leg
d/p RNV6 applicant [illegible]
c̄ /[illegible] left leg & [illegible]

(3) FREELE

(4) NPO

(5) VITAL q 4°

IDENTIFICATION

UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

(6) ACTIVITY: OOB to chair / ambulate c̄ crutches

(7) DIET: REGULAR c̄ NPO ā MN on 30 MAR - going to OR ā 1 hrs. for [illegible] & [illegible] closure

(8) INF: HL BUT [illegible] @ MN c̄

IDENTIFICATION

UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

LRC 125 cc/h

(9) LABS: CBC in AM 1 DAY 03

(10) MEDS: MEPERIDINE 50 mg IV q 3° PRN
MSO4 1-6 mg IV q 1° PRN
TRAMADOL #3 1-TT PRN po q 4°
BENADRYL 25 mg po q 6° PRN

(11) TP to BURN [illegible]

IDENTIFICATION

UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER

[redacted] b(6)-2 HOURS

[redacted] MD

2300 30 MAR 03 [redacted]

b6-2

[redacted]

b6-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 29 JUN 03 TIME OF ORDER: 1400 HOURS

LIST TIME ORDER NOTED AND SIGN

66-2

(1) RESUME PREVIOUS ORDERS [redacted]

(2) IV - LR @ 100 CC/HR. [redacted] WITH 6-10 [illegible]

(3) JP DRAIN - (L) LEG. EMPTY [illegible] AND RECORD DRAIN Q SHIFT

(4) CZ [illegible] (L) LEG [redacted]

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 30 JUN 03 TIME OF OR[redacted] b(6)-2

(1) Give Tylenol 325 mg Now, then 650 mg PO Q4-6° prn fever/discomfort [redacted] MD

66-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: [illegible] TIME OF ORDER: 1630 HOURS

NPO pm

[illegible] 1 July 03

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER _____ HOURS

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

CLINICAL RECORD — DOCTOR'S ORDERS

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

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
# [redacted] b(4)-4			28 JUNE 03 1100 HOURS	
			(1) REG DIET ADV, NPO @ MN.	
			(2) CBC NOW	
			(3) D/C PT/PTT	
			(4) ELEVATE LEFT LOWER EXTREMITY	
			(5) PROTECT AREAS FROM PRESSURE	
			(6) PHYSICAL THERAPY BY MOBILIZE TO LEFT LOWER EXTREMITY	
NURSING UNIT	ROOM NO	BED NO.		
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
			HOURS	
			(7) TURN UP TO U.O. > 30 cc/hr	
			ADV DIET AS TOL - DIET @ 00 > 30 cc/hr	
			(8) CVP to 125 cc/hr @ MN	
NURSING UNIT	ROOM NO	BED NO.	[redacted] b(4)-2	
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
			28 JUN 03 1250 HOURS	
			H/H S 9GR, 2U PRBC'S, Q4HC EACH OVER 20	
			CBC @ COMPLETION	
			V.O. DR SPENCE [illegible]	
NURSING UNIT	ROOM NO.	BED NO.	[redacted] b(4)-2	
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
			28 JUNE 03 1845 HOURS	
			(1) CBC NOW STAT	
NURSING UNIT	ROOM NO.	BED NO.		

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 1648 TIME OF ORDER: 6/26/03 HOURS | LIST TIME ORDER NOTED AND SIGN

1) Change Coags to q 4m · V.O.
Dr [redacted] / notified CT Surgeon

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

[redacted] MAJ, MC USA CHIEF, DOS

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

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

DATE OF ORDER: 27 JUN 03 TIME OF ORDER: 1305 HOURS

1) MOVE TO ICU S/P [illegible]
[illegible]
2) STABLE - [illegible]
3) NPO
4) OOB to chair
5) DIET [illegible]
6) IVF: CR @ 125 cc/hr HC [illegible]

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

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

DATE OF ORDER | TIME OF ORDER HOURS

7) Nursing: [illegible] T > 101.5, HR > 110 < 60
BP < 30 cc/hr
8) [illegible] q 4m IVP 8°
MSO4 1-6 mg IV q 1° PRN
Percocet #3 T-[illegible] q 4° PRN
Benadryl 25 mg PO q 6° PRN

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

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

DATE OF ORDER | TIME OF ORDER HOURS

9) CBC in am
10) AC PT/PTT

[redacted] b(6)-2

[redacted] MD

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

ICU

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 23 June 03 TIME OF ORDER: 2030 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Transfer to ICU Dr. [redacted] b6-2
2. Do SP exploration left pop artery repair / fasciotomies
3. Cond - fair NKDA
4. VS q 1°, I+O, Vasc check q 2°, Pulses at monitor
5. ACT - BEDREST
6. NPO

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

7. IV LR TRA 100 cc/hour
8. ANCEF 1 gram IVPB q 8°
9. MORPHINE SULFATE 2-10 mg IVP q 2° PRN
10. PROPOFOL gtt - 25 mcg/kg/hour TIT to effect
11. NGT to LIS
12. FOLEY CATH to gravity
13. HEPARIN gtt - to infuse at 600 Units/hour

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

14. VENT - SIMV - TV-600cc, R-8, PEEP-5 FIO2 - 40
15. CBC, chem 8 w/ CREAT, ABG in AM
16. ABG in 30 minutes
17. call MD for T > 101°, P < 60 or > 110, SBP < 100 or > 165, UO < 30 cc/hr

b(6)-2

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE [redacted] b(6)-2

23 June 03

1. [redacted]
2. [redacted] 75 cc/hr

b(6)-2

[redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHI[redacted]BE USE[redacted]

b(6)-2

6/25/03 0930

MEDCOM - 11766

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

Unknown Iraqi Prisoner

NURSING UNIT | ROOM NO. | BED NO.

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

→ ACW; Transfer →
CSH @ Dar Wood
cont quardial
BR - on Vent
Vitals per Transport
Vent
600cc X 12 BPM X 40% X 5 PEEP

PATIENT IDENTIFICATION

? DATE

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

NS Moist Dry PSSC
to fascicotomy
DSD to groin & med knee

b(6)-2

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

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

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"USE ONLY I NO CARBON PAPER REQUIRED"

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 27	28	29	30
27 Jun	[redacted]	VS PER ICU Protocol	05	/	[redacted]		
b(6)-2			17	[redacted]			
27 Jun	[redacted]	DOB TO CHAIR	05	/	[redacted]		
b(6)-2			17	[redacted]			
27 Jun	[redacted]	DIET: REGULAR	08	/	[redacted]		
b(6)-2			12	/	[redacted]		
			18	[redacted]			
27 Jun 03	[redacted]	Call MO T > 101.5 HR	05	/	[redacted]		
b(6)-2	[redacted]	110 < 160 u/o < 30cc/h	17	[redacted]			
		180, Foley to Gravity					
b(6)-2							
27 Jun	[redacted]	Foley to Gravity	05	/			
			17				
27 Jun	[redacted]	I and O	05	/	[redacted]		
b(6)-2			17	[redacted]			
28 Jun	[redacted]	Regular diet, now but	05		[redacted]		
b(6)-2		NPO @ MN (28 Jun)	11		[redacted]		
			17		[redacted]		
28 Jun	[redacted]	Elevate (L) lower extremity	05		[redacted]		
b(6)-2			17		[redacted]		

B(6)-2

B(6)-2

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P washout/debridement LLE x fasciotomy

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 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
28Jun	[redacted]	Admit to ICU s/p Washout / Debridement				
	-----	Left Lower Extremity / FASIOTOMY				
6/27	[redacted]	CBC in Am	6/28	0400		
28Jun	[redacted]	CBC NOW	28Jun	done		[redacted]
28Jun	[redacted]	T&S 10r 2u PRBC's, GIVE each	28Jun		① 1330	[redacted]
	-----	over 2°	28Jun		② 1500	[redacted]
28Jun	[redacted]	CBC p completion of transfusion	28Jun		1715	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
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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/ Number	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 23	24	25	26	27	28
23	[redacted]	V/S q1° pulsox	05	/	[redacted]				
	[redacted]	monitor, I+O.	17	/					
23	[redacted]	Vasc. V/S q2°	05	/					
	[redacted]		17	/					
23	[redacted]	Act. Bedrest	05	/					
	[redacted]		17	/					
23	[redacted]	NPO	05	/			Δed 6/25/03 0530 [redacted]		
	[redacted]		17	/					
23	[redacted]	NGT to LTS	05	/			Δed 6/26/03 0730 [redacted]		
	[redacted]		17	/					
23	[redacted]	Foley to Gravity	05	/					
	[redacted]		17	/					
23	[redacted]	A/PH q6°	4	/	[redacted]				
	[redacted]		20	/	[redacted]		Rewritten for 6/25/03 0555		
	[redacted]		02	/	[redacted]				
	[redacted]		08	/					
	[redacted]		/						
6/23/03	[redacted]	PT/PTT q6°	02	/	/ [redacted]				
	[redacted]		08	/	[redacted]		Δed 6/26/03 1630 [redacted]		
	[redacted]		14	/	[redacted]				
	[redacted]		20	/	[redacted]				
	[redacted]		/						
6/26/03	[redacted]	Diet Regular	08	—	[redacted]				
	[redacted]		12	—	[redacted]				
	[redacted]		18	—	[redacted]				
	[redacted]	Δ coags (PT/PTT) to q AM	04	—					
	[redacted]								

b(6)-2

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
S/P expl. (2) pop artery repair ? laxiotomies

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Jun Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
23	[redacted]	Trans to ICU / Cond. Fair	23 Jun		2100	[redacted]
23	[redacted]	CBC, Chem 8 w/ Creat, ABGs in	24 Jun	done		[redacted]
	-----	A.M., Cargo			0430	[redacted]
23	[redacted]	ABG in 30 min.	23 Jun	2130	2130	[redacted]
	-----	Cond. fair				

	-----					

b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
23	[redacted]	Call M.D. T 710°														
-----	-----	P < 60 / 110, SBP < 100														
-----	-----	7165, UO < 30 cc/°														
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b(6)-2

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b(6)-2 A11

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 28	29	30	1	2	3	4	5
28 Jun	[redacted]	Physical Therapy BID	05	[redacted]							
		Nursing to (L) lower extremity	17	[redacted]							
28 Jun	[redacted]	Protect Heels From	05	[redacted]							
		Necrosis	17	[redacted]							
6·29	[redacted]	JP drain (L) leg, empty &	05	/ / [redacted]							
		record drain q shift	17	/ [redacted]							
6·29	[redacted]	Elevate (L) leg.	05	/ / [redacted]							
			17	/ [redacted]							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/p Wound LLE Fasciotomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: 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

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
30 Jun	[redacted]	NPO p mn [illegible] 1 Jul 03				
b(6)-2	-----					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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b(6)-2 [redacted]

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 30		1	2
30	[redacted]	VS: Q4	02	/	/	/	[redacted]
			06	/	[redacted]	/	[redacted]
			10	/		/	
			14	/		/	
			18	[redacted]		[redacted]	
			22			[redacted]	
30	[redacted]	OOB to chair, AMB	5	/	O	/	
		c crutches	17	[redacted]	/	/	
30	[redacted]	DIET: Regular	5	/	[redacted]		
		NPO p MN on ~~30 JUL~~ 1 JUL	17	[redacted]			
30	[redacted]	JP to bulb suction	5	/	[redacted]	D/C'd	
			17	[redacted]			
1	[redacted]	DIET: regular	5	/	/	/	
			17	/	/	[redacted]	

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: Popliteal Artery Repair c Fasciotomies Dug c washout

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

PATIENT IDENTIFICATION:

CIV # [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

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
30	[redacted]	Tx to ICW #1, stable	30 Jun	1915		
30	[redacted]	NPO p̄ MN on ~~30 Jun~~ 1 Jul	1 Jul	0001		
30	[redacted]	TO OR ~~30 Jun~~ 1 Jul for washout	1 July	AM		
30	[redacted]	CBC in AM	1 Jul	0400		
1	[redacted]	D/C Foley	Done			[redacted] b(6)-2
1	[redacted]	Evac to civilian hospital	2 Jul			
1	[redacted]	CBC @ 2100	1 Jul	2100	2130	[redacted] b(6)-2

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

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 27	28	29	30	1								
27 Jun	[redacted]	IVF: LR @ 125 cc/hr	05	/	[redacted]											
b(6)-2		Heplock when tolerating	17	[redacted]	b(6)-2			A	D							
		P.O.														
	[redacted]															
27 Jun	[redacted]	Mich 1gm IV q8°	06	[redacted]												
b(6)-2			14	[redacted]					b(6)-2							
			22	[redacted]												
	[redacted]															
28 Jun	[redacted]	Titrate IVF to U.O 7	05	/	[redacted]			b(6)-2								
b(6)-2		30 cc/hr MAY H/L	17	/	[redacted]											
		if tolerating diet														
	[redacted]						b(6)-2									
28 Jun	[redacted]	IVF to 125 cc/hr after	05	/	[redacted]			D/C 6.29 TB								
b(6)-2		MN	17	/	[redacted]											
6.29	[redacted]	LR @ 100 cc/hr, HL when	05	/	/	/	[redacted]									
b(6)-2		taking PO well	17	/	/	[redacted]		b(6)-2								

ALLERGIES: ☐ YES ☐ NO
MKDA

PRIMARY DIAGNOSIS: S/P Wound LLE/Fasciotomy. Pr Washout/Debridement

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

PATIENT IDENTIFICATION:
EPW [redacted] [redacted]
b(6)-4 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
30 Jun	[redacted]	Give Tylenol 325 III now	30 Jun	1400	1400	[redacted] b(4)-2
b(4)-2						

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
27 Jun	[redacted]	MSO4 1-6 MG IV	1800 4mg IVP	0130 5mg IVP	0500 6mg IVP	0800 6mg IVP	1300 6mg IVP	1845 5mg IVP	2155 5mg IVP	30 Jun 0130 5mg IVP	0530 5mg IVP	0629 1130 [redacted]	1430 [redacted]	0629 1600 5mg	1900 5mg IVP	2320 30 Jun 6mg IVP
u-2		Q1° PRN	[redacted]													
27 Jun	[redacted]	Tylenol #3 T-II	0629 1130 TABS	71 0611 2	1300 1800 II											
b4-2		TABS PO Q4° PRN														
27 Jun	[redacted]	BENADRYL 25mg PO														
b4-2		Q6° PRN														
27 Jun	[redacted]	MSO4 1-6mg IV	30 Jun 0610 5mg IVP	30 Jun 900 [redacted] 5mg IVP	30 Jun 1110 [redacted] 5mg IVP	30 Jun 1535 [redacted] 2ND	1500 0610 3mg	1300 1830 6mg	1300 2010 IVP							
b(4)-2		Q1° prn														
30 Jun	[redacted]	Tylenol ~~325 III~~ CE 650mg	30 Jun 1400 II													
b(4)-2		po Q4-6° prn														

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[redacted] [redacted]

[redacted] b(6)-2 A11 [redacted]

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 30	1	2	3
30	[redacted]	LR @125 cc/hr	5	/	[redacted]		
		5 MN 30 JUN	17	[redacted]			
30	[redacted]	Ancef + gm IV Q8°	6	/	[redacted]		
			14	/	[redacted]		
			22		[redacted]		
1	[redacted]	LR @ 100 cc/hr	5	/	/		
		HL when tol p.o.	17	/	[redacted]		

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
Popliteal artery Repair c̄ Fasciotomies
Ⓓ leg c̄ washout

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

PATIENT IDENTIFICATION:
CIV # [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													
30	[redacted]	Tylenol #3 1-11 tabs PO Q4°	1300 2100 11	2300 0500 11												
			[redacted]	[redacted]												
(6)2 30	[redacted]	Benadryl 25mg PO Q6° PRN														
30	[redacted]	MSO4 1-6mg IV Q1° PRN	5mg 2000 30min	0200 5mg	2300 0400 [redacted]											
(6)2			[redacted]	[redacted]	[redacted]											

USAPA V1.00

[redacted] [redacted]

b(6)-2
ATI

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. JAN. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23	24	25	26	27
23 Jan	[redacted]	IV LR 100cc/°	05	/	[redacted]			Xed 6/25/03 [redacted]
			17	/	[redacted]			
23	[redacted]	Ancef 1gm IVPBq 8° -	06	/	[redacted]			Rewritten 6/26/03 ATI [redacted]
			14	/				
[redacted] 23	[redacted]	Propofol gtt - 25 mcg	22	[redacted]				
23	[redacted]	Propofol gtt - 25 mcg/	05	/	[redacted]		D/C° 24 Jan 03	[redacted]
		kg/hr TIT to effect.	17	/				
23	[redacted]	Heparin gtt - to inf.	05	/	[redacted]			
		@ 600 units/°	17	/				
23	[redacted]	Vent - SIMV TV 600cc	05	/	[redacted]		24 Jan 03	[redacted]
		R-8, Peep 5, FIO2 40	17	/				
6/25	[redacted]	Change IVF to 75cc/hr	05	→	[redacted]			
			17	→	[redacted]			
6/23	[redacted]	Ancef 1gm IVPB 98°	06	→	[redacted]			
			14	→				
			22	→	[redacted]			

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
s/p Explor/repair ⓡ pop. fasciotomies

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

D(b) - 2 T11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Jun 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													
23	[redacted]	MSO4 2-10mg	0645	0815	1100	0900	6/25	6/25 1600	6/25 2000	6/25	6/26 0200	1040	6/26	4/26	6/27	6/27
.....	.....	IVq2° PRN	2mg	2mg	5mg	5mg		mg	5mg	5mg	5mg	5mg	4	2300		15 35
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															

D(b)-2

USAPA V1.00

28 Jun 03

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

NURSING SERVICE PERSONNEL TIME SCHEDULE

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

DATES (*Inclusive*) OF PERIOD COVERED

TITLE	LAST NAME	DUTY	SUN.	MON.	TUE.	WED.	THURS.	FRI.	SAT.
			HR	BD	FLOR	SHR2	T	RA	
1st Unit	1642328								
1330	1642328	1st Unit	117	118/68	RA	100	99	16	
Leg cuff 1340	" "	" "		168/60	RA	100	99	17	
1400	" "	" "	110	166/61	RA	100		15	
1415	" "	" "	102	168/61	RA	99	99	18	
1430	" "	" "	97	168/63	RA	100		20	
1445	" "	" "	95	168/65	RA	100		17	
1500	" "	" "	95	168/59	RA	100	99	14	
1510	" "	" "	99	167/71	RA	100		16	
~~1520~~	" "	" "	100	169/62	RA	100	100	15	
1515	5304661	Surg	89	164/66	RA	100	99	14	
1530	" "		88	166/62	RA	100	100	10	
1545	" "	Surg	87	166/65	RA	100		15	
1600	" "	" "	93	166/67	RA	100		14	
1615	" "	" "	105	160/74	RA	100		17	
1630			105	160/60	RA	100		21	
1645	" "	" "	93	169/59	RA	100		15	
1700	" "	" "	117	166/62	RA	100	99	23	

SIGNATURE OF HEAD NURSE

WARD

INSTRUCTIONS

List professional personnel first and then nonprofessional.

In column under "title" enter title, e.g., Maj., Capt., Lt., Sgt., Pvt., Mr., Mrs., Miss.

Entries for "Duty" and for "Off-Duty Status" will be symbolized as follows:

"Duty" symbols

- **HN** - Head nurse
- **ASST. HN** - Asst. head nurse
- **GEN. DUTY** - General duty
- **CL. T** - Clinical technician
- **WM** - Ward master

"Off-Duty Status" symbols

- **DO** - Day Off
- **LV** - Leave
- **SK** - Sick leave
- **HT** - Holiday time

DA FORM 3872, JUN 72 REPLACES DA FORM 8-93, 1 JAN 54, WHICH WILL BE USED. USAPPC V1.00

[redacted] b(6)-4

28 Jun 03 Transfusion Sheet.

MEDCOM - 11782

PAGE

DX | HOSPITAL DAY

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
terial Line																	
aff																	
perature																	
Pulse																	
ratory Rate																	
Resp			Room Air														
Transition																	

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15
MTF PO																	

ALS

	HOUR / TOTAL																
IE	50 gr																
	S/A																
	OUTPUT																
	pH																
	GUIAC																
IS																	
L																	

[redacted] b(a)-4

ACUITY LEVEL CLASSIFICATION

	17	18	19	20	21	22	23	
	148/64	142/66	148/75	173/76	162/64	158/58		
	112	103	104	111	98	132		
	19	15	24	13	14	15		
	100	100	100	100	100	100		
	RA	RA	RA	RA	RA	RA		

	17	18	19	20	21	22	23	8° T
	Ø	Ø					→	Ø
	50							
						50		
	300/3380	300/3380	300/3380	300/3380	300/3380	100/3380	100/3380	3380

3380

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

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

ACTIVITIES OF DAILY LIVING	TIME				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 _____

NURSE'S SIGNATURE [redacted]

b(6)-2

b(6)-2

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	6/26/03	INITIALS [redacted]	b(6) - 2	INITIALS		INITIALS
	PUPILS	Pierla 3mm.		Perrla 3mm reactive			
	SENSORIUM	A&O x3. A&Om All Ext		A&O x3 MAE x 4 just			
		W LLE but has regained		wiggles toes on Left side			
		full sensation and MVt.					
		Denies any pain @ this time					
RESPIRATORY	RESPIRATORY PATTERN	Room AIR Regular Shallow		Lungs clear bilat			
	BREATH SOUNDS	in 10s Sat 100%.		on RA c̄ SATS @ 100%			
	SECRETIONS	Ø Secretions		Ø secretions noted			
SKIN	COLOR	Normal for Race		Normal for Race			
	INTEGRITY	Dry and intact except		(L) leg splint + dsg			
		LLE has Bulky Dressing		in place.			
IV SITE	LOCATION	tennis Ball size Bulge.		(R) bicep and (D)			
	CONDITION	(L) FA PIV + (R) Bicep.		Forearm on Heparin			
		Both. Dry and Intact		@ 600cc/hr. and			
				(LR) @ 75cc/hr			
GASTRO	ABDOMEN	Flat NT. Ø Masses		Flat BS (+) x4 quads			
	BOWEL SOUNDS	(+) BS X4 hyperactive.		Pt. tol. Reg diet			
				well			
GU	URINE:	foley to gravity		foley to gravity			
	COLOR/CLARITY	Clear yellow		clear yellow			
				UOS > 30cc/hr			
CARDIOVASCULAR	CARDIAC RHYTHM	NSR c̄ Ectopy. palpable		90's SR			
		strong Bilat UE Peripheral		Ø edema to upper			
		pulses. Bilat LE present		(1) Lower ext. 2+ edema			
		RLE strong pedal (2) weaker		S1 S2 present. 2+ pulses			
		but now pulses doppler.		in 4 distal extremities.			

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

(Continue on reverse)

PREP[redacted] & Title) b(6) - 2
[redacted] CPT, [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU 2 West

DATE: 26 Jun 03

PA[redacted] 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 26 JUN 03 | DX 518 (L) LE PORLITEAL REPAIR | HOSPITAL DAY 3

VITAL SIGNS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff	123/54	121/59	119/56	122/55	124/55	114/50	117/52	117/57		127/60	112/54	124/58	117/52	118/54	115/56	130/69	115/53	
Temperature			99.1															
Pulse	91	84	83	86	78	80	86	78		86	78	76	85	80	75	73	85	
Respiratory Rate	14	14	16	15	17	14	14	17	14	14	16	12	17	12	16	18	21	
SATS	100	100	100	100	98	100	100	100	100	100	100	98	98	100	100	100	100	
O2	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	
open intuition																		

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR	75	75/150	75/225	75/300	75/375	75/450	75/525	75/600	75/675	75/750	75/825	75/900	75/975	75/1050	75/1125	75/1200	75/1275	600
HEPARIN	12	12/24	12/36	12/48	12/60	12/72	12/84	12/96	12/108	12/120	12/132	12/144	12/156	12/168	12/180	12/192	108	108
IVPB																		
PO							200/200		200		100/300				200/500		100	500

OUTPUT																			
TOTALS																			
URINE	HOUR / TOTAL	175/175	175/350	100/450	50/500	50/550	275/825	200/1025	200/1225	1225	200/1400	200/1600	200/1800	200/2000	200/2200	100/2300	100/2400	100/2500	2500
	SG																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS

16	17	18	19	20	21	22	23	
110/56	122/57	123/55	126/73	119/51	119/49	128/67	116/51	
			99.3					
88	88	97	104	94	91	83	85	
16	16	20	18	14	19	13	12	
100	100	100	100	100	100	100	100	
RA	RA	RA	RA	RA	RA	RA	RA	

INTAKE

16	17	18	19	20	21	22	23	8° T
75/75	75	75	75	75	75	75	75	
12/12	12	12	12	12	12	12	12	
						50		

OUTPUT

100/100	100/200	200/400	200/600	200/800	200/1000	150/1150	150/1300	1300

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

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

LABORATORY DATA

TIME	0800	
GLUCOSE		
Na/K		
Cl/CO_2		
BUN/Cr		
WBC/PLATELET		
Hct/Hgb		
PT	11.5	11.6
PTT	39	34.3

ACTIVITIES OF DAILY LIVING

TIME	0800
MOUTH CARE	self
BATH	self
SKIN CARE	self
FOLEY CARE	self
TRACH CARE	
ROM EXERCISES	self

TURN	TIME
SUCTION	

24° I&O TOTALS

wt Yesterday ________ wt Today ________

INTAKE	OUTPUT
IV ______	Urine: ______
po ______	______
______	______
TOTAL ______	TOTAL ______

BALANCE ________

NURSE'S SIGNATURE	INITIALS
[redacted]	NS
[redacted]	C8k
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.

OTSG APPROVED (Date) QA Appr 8 Mar 89

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET b(4)2

INITIAL SHIFT ASSESSMENT

	TIME	6/25/13 0900	INITIAL [redacted]	1745	INITIAL [redacted]	INITIALS
NEURO	PUPILS	Perrl 3mm		3mm (B) PERRLA		
	SENSORIUM	AOX3 Ad Extremities		A+OX3		
		denies any pain		DENIES PAIN		
				MAE WELL		
RESPIRATORY	RESPIRATORY PATTERN	RA Sat 98-100%		EVEN & UNLABORED		
	BREATH SOUNDS	(C) Bilat all Lungfields		CTA		
	SECRETIONS	∅		∅		
		Resp rate in the 20s.				
SKIN	COLOR	warm dry.		WARM DRY		
	INTEGRITY	(L) LE Bulla, dsg reinforced		(D) LE ACE WRAPPED LARGE		
		T ace wrap. T		BLISTER (L) INSIDE ANKLE		
IV SITE	LOCATION	(R) Bicep, (L) wrist PIV		(R) BICEP		
	CONDITION	Site's DTI.		(L) WRIST		
				PATENT CDI		
GASTRO	ABDOMEN	Soft NT (+) BS		SOFT, NT		
	BOWEL SOUNDS	(+) X4		BS X4		
				GOOD APPETITE		
GU	URINE:	Foley. clear yellow		FOLEY DRAINING CLEAR YELLOW URINE		
	COLOR/CLARITY					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR, BP 120/60		NSR		
		Bilat strong fem pulse		DECREASED, 2+		
		left BLE. LLE Doppler		SLIGHT EDEMA (L) LE		
		cap refill < 3 sec		CAP REFILL < 3 SEC		

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

(Continue on reverse)

PREPARED [redacted] b(4)-2 DEPARTMENT/SERVICE/CLINIC ICU Quest ICUT DATE 6/25/03

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

DATE 25 Jun 08 | DX | HOSPITAL DAY 2

VITALS SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line																		
	BP Cuff	119/71	126/67	124/67	129/65	129/65	155/68	167/69	145/62		125/63	126/63	125/58	124/55	120/56	122/56	121/53	125/54	
	Temperature	98		98.8					98.8				98.6					100.3	
	Pulse	85	87	86	92	103	93	100	92		88	90	92	93	104	92	106	88	
	Respiratory Rate	24	19	19	19	18	16	17	17		22	18	17	16	18	16	18	16	
	SATS	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	
	Room						RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	
	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	100/500	100/300	100/100	100/500	100/100	100/500	100/500	800	100	100/500	75/525	75/350	75/420	75/500	75/575	75/600	450
	HEPARIN	12	12/24	12/36	12/48	12/60	12/72	12/84	12/96	96	12/6	12/24	12/36	12/48	12/60	12/72	12/84	12/96	96
	IVPB										50							50	100
	PO										200/200				100/500		150/450		450
	TOTALS																		1226

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	
	URINE		50/50	150/200	150/350	50/400	200/600	100/700	100/800	100/900	900	100/100	100/200	100/400	100/500	100/600	150/750	150/900	100/1000	1000
		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	
	128/60	101/53	130/64	122/61	135/71	117/66	125/64	135/61	
			99						
	97	98	105	110	95	89	85	94	
	21	17	20	19	19	17	15	16	
	100	100	100	100	100	100	100	100	
	RA	RA	RA	RA	RA	RA	RA	RA	
		Ø	Ø	Ø	5/10	Ø	Ø	7/10	
		Ø	Ø	Ø	MgSO4	Ø	Ø	MgSO4	

INTAKE	16	17	18	19	20	21	22	23	8° T
	75/75	75/150	75/215	75/300	75/375	75/450	75/525	75/600	600
	12/10	12/24	12/36	12/48	12/60	12/72	12/84	12/96	96
							1500		1500
	250							100	500
									3644

OUTPUT									
	200/200	125/325	125/450	250/700	200/900	200/1100	350/1450	150/1600	1600
									4900

ACUITY LEVEL CLASSIFICATION

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

LABORATORY DATA	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									
	PT/PTT	17/30.2	12/27	11.5/31.4						

ACTIVITIES OF DAILY LIVING	TIME									
	MOUTH CARE	0800 Self								
	BATH	Self								
	SKIN CARE	Aid								
	FOLEY CARE	Aid								
	TRACH CARE									
	ROM EXERCISES	Aam								

TURN / SUCTION	TIME					
TURN						
SUCTION						

24 H I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	2244	Urine:	3500
po	800		
TOTAL	3044	TOTAL	3500
BALANCE			-456

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]
b(4)-2	

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS
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
LIMB MOVEMENT: ARMS	NORMAL POWER	
	MILD WEAKNESS	
	SEVERE WEAKNESS	
	ABNORMAL FLEXION	
	ABNORMAL EXTENSION	
	NO RESPONSE	
LIMB MOVEMENT: LEGS	NORMAL POWER	
	MILD WEAKNESS	
	SEVERE WEAKNESS	
	ABNORMAL FLEXION	
	ABNORMAL EXTENSION	
	NO RESPONSE	
PUPILS: RIGHT	SIZE	
	REACTION	
PUPILS: LEFT	SIZE	
	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		05	06	07	08	09	10	11	12	13	14	15	16	17
② LE	R	T	T	T	T	T	T	T	T	T	T	T	T	T
	L	D	D	D	D	D	D	D	D	D	D	D	D	D
	R													
	L													
	R													
	L													
	R													
	L													
	R													
	L													

LEGEND

++ Normal
+ Weak
- Absent

D Doppler

R Right
L Left

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

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

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

INITIAL SHIFT ASSESSMENT

	TIME	0200 INITIALS [redacted]	05 INITIAL [redacted]	1730 INITIALS [redacted]
NEURO	PUPILS	PERRL 2mm	2mm + (3)	3mm (B) PERRL
	SENSORIUM	Pt sedated on propofol	Sedated / intub	A&O3
		@ 45mcg/kg/min. Pt	titrated to maintain	Responsive per EPW
		moves uppers on	vent "bucking"	Protocol. Follows
		occasion		commands
RESPIRATORY	RESPIRATORY PATTERN	SIMV 10 TV 600 FIO2	even, unlabored	Even, unlabored
	BREATH SOUNDS	30% peep 5. #8 ETT	Intub @ 22cm	CTA (B)
	SECRETIONS	@ 22cm @ 1/D min.	@ teeth; no	⊘ secretions
		secretions. Lungs	vent A's	on RA
		CTA bilat.		
SKIN	COLOR	Dsg to (R) Fem and	NFR	NFR
	INTEGRITY	Lg dsg to (L) Lower	Bulky dsg to	(L) LE ACE wrapped
		extremity	LLE	Bulky Dsg CDI
IV SITE	LOCATION	(R) forearm 18g ⊂ LR	(R) FA CDI	(R) FA
	CONDITION	@ 100cc/hr and propofol	(L) A/C CDF	(L) AC - Heparin at 1/3
		(B) AC 16g ⊂ heparin		
		running @ 1000un/hr		Patent ⊘ S/S infection
		all sites from S/S of		infiltration
		infection.		
GASTRO	ABDOMEN	BS (+) x 4 quads hypoactive	(+), flat ND	Flat, firm, NT
	BOWEL SOUNDS	flat, nontender.	(+) x4 quads	BS x4
		NGT to (R) nare to LIS	NGT L4S	⊘ N/V
		NPO.		
GU	URINE:	foley to gravity ⊂	Foley	Foley draining
	COLOR/CLARITY	amber colored	amber/yellow	yellow ⊂ sediment
		urine >30cc/hr		QS
CARDIOVASCULAR	CARDIAC RHYTHM	SR-ST 90's-110's	ST.	SR ⊘ ectopy
		Afebrile ⊂ Tmax 98.3		Edema to (L) LE
		⊘ edema noted.		+P Dorsal Contralateral
		see vascular assess-		CAP refill <3sec
		ment on back.		

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

(Continue on reverse)

b(6)-2

PREPARED BY (S[redacted]) CPT/AN

DEPARTMENT/SERVICE/CLINIC: ICU 2 west

DATE: 24 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 24 June 03 | DX s/p explore (L) pop Artery Repair | HOSPITAL DAY 1

VITALS																		
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line	138	126	129	126	116	122	116	121	132	132	126	131	134	132	127	137	134	
BP Cuff	82	79	77	86	70	78	71	72	82	81	76	79	78	78	75	73	79	
Temperature	98.8	98.7	98.3		98.8													
Pulse	116	107	104	128	113	116	124	123	118	118	114	112	101	119	97	96	101	87
Respiratory Rate	20	15	15	22	15	18	16	15	20	20	22	20	19	14	22	18	18	20
SAT	100%	100%	100%	100%	100%	100%	100	100	100	100	100	100	100	100	100	100	100	100
O2 %	30%	30%	30%	30%	30%	30%	30%	30%	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA

SIGNS

pain
sedation

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	100	100	100	100	100	100	800	100	100	100	100	100	100	100	100	800
Heparin	12	12	12	12	12	12	12	12	96	12	12	12	12	12	12	12	12	96
Propofol	15.6	17.6	17.6	17.6	21.5	21.5	27.3	27.3	155.4									
Ativ								50	50							50		50
														water 500		water 300		
PO																		800
TOTALS									994									

OUTPUT																			
URINE	HOUR / TOTAL	100 / 100		50 / 150		50 / 200		150 / 350	50 / 400	400	10 / 10	30 / 40	50 / 90	40 / 130	25 / 155	90 / 245	60 / 305	100 / 405	405
	sp gr																		
	S/A																		
NG	OUTPUT					500	→			500									
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS										900									405

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
		137/78	138/76	130/64	131/70	130/69	127/68		
			98%						
	87	90	92	91	98	87	85	90	
	20	24	14	20	19	19	16	19	
	100	100	100	100	100	100	100	100	
	RA	RA	RA	RA	RA	RA	RA	RA	

INTAKE	16	17	18	19	20	21	22	23	8°T
	100	100/200	100/300	100/400	100/500	100/600	100/700	100/800	800
	12	12/24	12/36	12/48	12/60	12/72	12/84	12/96	96
							50		50
						250			
									3888

OUTPUT									
	100/100	50/150	150/300	150/450	150/600	150/750	150/900	50/950	800
									1605

ACUITY LEVEL CLASSIFICATION

RESPIRATORY		TIME	0001	0430
		MODE	SIMV	SIMV
		F_iO_2	30	30%
		TV	600	600
		RATE	10	10
		PEEP	5	5
	A	pH		7.35
	A	PCO_2		39.5
	A	pO_2		101
	B	HCO_3		22
	B	SAT		98%
	G	BASE		-4

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

ACTIVITIES DAILY LIVING	TIME				TURN	TIME			
	MOUTH CARE								
	BATH	200							
	SKIN CARE	200							
	FOLEY CARE				SUCTION				
	TRACH CARE								
	ROM EXERCISES								

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	3638	Urine:	1605
PO	250		
TOTAL	3888	TOTAL	1605
		BALANCE	+2285

NURSE'S SIGNATURE | INITIALS

[redacted]

b(6)-2

NEUROLOGICAL ASSESSMENT

		HOURS	24	02	05
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			
LIMB MOVEMENT	ARMS	NORMAL POWER			
		MILD WEAKNESS			
		SEVERE WEAKNESS	✓	✓	
		ABNORMAL FLEXION			
		ABNORMAL EXTENSION			
		NO RESPONSE			
	LEGS	NORMAL POWER			
		MILD WEAKNESS			
		SEVERE WEAKNESS	✓	✓	
		ABNORMAL FLEXION			
		ABNORMAL EXTENSION			
		NO RESPONSE			
PUPILS	RIGHT	SIZE	2	2	2
		REACTION	+	+	+
	LEFT	SIZE	2	2	2
		REACTION	+	+	+
PUPIL SCALE			● 2	● 3	● 4 ● 5 ● 6 ● 7 mm
ICP					
CEREBRAL PERFUSION PRESSURE					

SEDATED / Intubated

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		24	02	05	06	08	10	12	14	16
uppers	R	++	+	++	++	++	++	++		
	L	++	++	++	++	++	++	++		
Lowers	R	+	+	+	+	+	+	+		
	L	D	D	D	D	D	D	D		
	R									
	L									
	R									
	L									
	R									
	L									

LEGEND

+ + Normal
+ Weak
- Absent
D Doppler
R Right
L Left

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	2000	INITIALS [redacted]	b(6)-2	INITIALS		INITIALS
NEURO	PUPILS	2mm + reactive					
	SENSORIUM	Sedated on Propofol @					
		30mg/kg/min. moves					
		upper extremities					
		on occasion					
RESPIRATORY	RESPIRATORY PATTERN	SDMV 10 TV 600 FIO2					
	BREATH SOUNDS	30% peep 5. #8 ETT					
	SECRETIONS	@ 22cm @ teeth. min					
		secretions. lungs					
		CTA bilat					
SKIN	COLOR	Normal for Race					
	INTEGRITY	~~intact~~ (R) Lower ext.					
		deg 2nd (R) Fem deg					
IV SITE	LOCATION	(L) FA c̄ propofol 2nd					
	CONDITION	LR @ 100cc/hr (R) AC					
		16g c̄ heprin @ 600u					
		an hour.					
GASTRO	ABDOMEN	(+) BS x 4 quads					
	BOWEL SOUNDS	hypoactive					
		NPO - NGT to (R) nare					
		LIS					
GU	URINE:	Foley to gravity					
	COLOR/CLARITY	draining @ S > 30cc/hr					
		of Amber/yellow urine					
CARDIOVASCULAR	CARDIAC RHYTHM	S1 S2 present					
		Rate 80-90's SR					
		distal pulses see					
		vascular assessment					
		on back. Ø edema noted					

LEGEND

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC ICU 2 west

DATE 23 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																		
Temperature																		
Pulse																		
Respiratory Rate																		
SAT																		
pain																		
sitrosition																		

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR																		
Heprin																		
Propofol																		
TOTALS																		

OUTPUT																		
URINE	HOUR / TOTAL																	
	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	
						130	131/45	119	
				B/P		86		80	
				P		88	98.1	98.3	
				T	(A)	96.5	91	107	
						100%	14	16	
							100%	100%	
							Sed	Sed	

INTAKE	16	17	18	19	20	21	22	23	8°T
						100	100	100	300
						12	12	12	36
						11.7	11.7	15.6	39

OUTPUT									
							150/150		150

ACUITY LEVEL CLASSIFICATION

RESPIRATORY			
	TIME		22/00
	MODE		SIMV
	F_iO_2		30%
	TV		600
	RATE		10
	PEEP		5
ARTERIAL GASES	A	pH	7.28
		PCO_2	41.1
		pO_2	134
	B	HCO_3	19
		SAT	99
	G	BASE	-7

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

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

24 I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday	wt Today	[redacted]	[redacted]
INTAKE	OUTPUT	b(6)-2	b(6)-2
IV	Urine:		
PO			
TOTAL	TOTAL		

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS	20
EYES OPEN	SPONTANEOUSLY	4	
	TO SPEECH	3	
	TO PAIN	2	✓
	NO EYE OPENING	1	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	

LIMB MOVEMENT		
ARMS	NORMAL POWER	
	MILD WEAKNESS	
	SEVERE WEAKNESS	
	ABNORMAL FLEXION	
	ABNORMAL EXTENSION	
	NO RESPONSE	
LEGS	NORMAL POWER	
	MILD WEAKNESS	
	SEVERE WEAKNESS	
	ABNORMAL FLEXION	
	ABNORMAL EXTENSION	
	NO RESPONSE	

PUPILS		
RIGHT	SIZE	2
	REACTION	+
LEFT	SIZE	2
	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	20	22
Upper	R		++	
	L		++	
Lower	R		++	
	L		4D	
	R			
	L			
	R			
	L			
	R			
	L			

LEGEND

+ + Normal
+ Weak
- Absent
D Doppler
R Right
L Left

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	6/26/03	INITIALS		INITIALS	1730	INITIALS
NEURO	PUPILS	Peerla 3mm		Peerla 3mm		3mm Peerla	[redacted]
	SENSORIUM	AXOX3. AROM Bilatfue		A+Ox3		AOOX3	
		+ RLE c/o pain. 1/6				MAE. INGL	
		Small mvt (D) Drink Intake				FOLLOWS ALL [redacted]	
		Rotation (B) Toes (B) Pulse Pedal.					
RESPIRATORY	RESPIRATORY PATTERN	Regular Shallow. 105.		even unlabored		EVEN + UNLABORED	
	BREATH SOUNDS	Sat 99-100% on RA.		CTA-B		CTA (B)	
	SECRETIONS	Ø				Ø	
SKIN	COLOR	Normal for race		NFR		WNL	
	INTEGRITY	(B) groin staples (X) Stable		dry intact, insect		(L) & WRAPPED	
		Dry 4x4 applied.		bites all over arms			
	~~LOCATION~~ Skin.	LE Bulky dry. D+I (C)		LEJ hep lock		(L) EA E LE (Q) 12 Sec	
	~~CONDITION~~	large ½ both or excent					
		non size Blister product				Ø S/S INFECTION/	
		Double. skin warm				INFILTRATION	
		and dry.					
	IV Site/Location	Hep lock (B) Groin + LFA D+I.				RATGW	
ELIMINATION	ABDOMEN	Flat NT (+) BS		round, nontender		~~Round~~, NT, FLAT	
	BOWEL SOUNDS	X4 quads		+BS x4 qdo		BS x4	
						GOOD APPETITE	
	URINE:	Clear yellow via		voiding via		Foley Drainage	
	COLOR/CLARITY	foley to gravity.		urine		YELLOW URINE	
		foley care done				GS	
CARDIAC	CARDIAC RHYTHM	NSR in the 80s.		S.S2		NSR Ø ECTOPY	
		Palpable pedal pulses		heady		2+ JUD	
		LE-Peripheral pulses		+2 pulses		Ø EDEMA	
		Strong + full Bilat UE.		2+ cap refill		CAP REFILL < 3 SEC	
		Cap refill < 3 secs				(+) RP	

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	DATE
	ICU 2 west	

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

662

DX | HOSPITAL DAY

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
rterial Line	116/	118/	110/	98/	110/	110	122/82	D/79		130/55	86/58					D	
uff	51	49	49	48	55	57	↑			↑	↑					120/71	126/70
perature			97.8												98.2		
e	78	81	90	71	75	77	83	81		78	87		OR	OR	82	83	83
iratory Rate	16	15	16	13	13	15	26	26		14	11				17	14	14
SAT	100	100	100	100	100	100	100	100		100	100				100	100	100
Jonyl						RA	RA	RA		RA	RA				101 [redacted]	61 [redacted]	

66-2

TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15
LR	75	75	75	75	75	75	75/225	75/600	600	75	75/150	75/225			75/300	25/375	25/450
Heparin	12	12	12	12	12	12/72	12/84	12/96	96	12/12	12/24	12/36		off	12/48	12/60	
IVPB							50		50							50/100	50

ALS

	HOUR / TOTAL	200/200	100/300	100/400	250/650	100/750	100/850	100/950	100/1050	100	100/100	100/200	100/300	100/400		200/100	325/425	
VE	BP SP																	
	S/A																	
	OUTPUT																	
	pH																	
	GUIAC																	
IS																		
L																		
IIC																		

PA

ACUITY LEVEL CLASSIFICATION

16	17	18	19	20	21	22	23	
126/71	129/63	100/79	116/65	123/74	125/74	125/66	121/64	
		100						
83	52	145	119	112	121	121	113	
13		20	13	15	15	19	20	
100	99	99	100	100	100	100	100	
6L		RA	RA	RA	RA	RA	RA	
NC								

	17	18	19	20	21	22	23	8° T
125/125	0	125/250	125/375	50/125/500	125/625	125/750	125/875	875
				200				200
								675
		350/350	50/400	100/500	150/650	50/700	100/800	800

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

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

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

24 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE

IV _____

PO

OUTPUT

Urine: _____

NURSE'S SIGNATURE

[redacted]

b6-2

b(6)-2

PAGE

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

PORT TITLE

NTENSIVE CARE NURSING FLOW SHEET

b(4)-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

TIME	0815	INITIALS [redacted]	1730	INITIALS [redacted]		INITIALS
PUPILS	PERRLA, 3mm		Perrl 3mm		b(4)-2	
SENSORIUM	A/Ox3, follows		A+Ox3 follows			
	commands		commands MAE			
			toes move on			
			(L) foot splint			
RESPIRATORY PATTERN	even, unlabored		place			
BREATH SOUNDS	CTA(B)		CTA bilat.			
SECRETIONS	Ø		Ø secretions			
			RA & sats @ 99%			
COLOR	NFP		normal for Race			
INTEGRITY	warm & dry		warm & dry. new			
			dressing to (L) leg			
LOCATION	(L) AC, (R) upper arm		(L) AC (R) bicep			
CONDITION	CDI, patent		Ø s/s of infections			
			all flush well.			
			LR @ 100cc/hr			
ABDOMEN	soft NB/NT		Soft Flat and			
BOWEL SOUNDS	X4		non tender.			
			BS (+) x 4 quads			
URINE:	Foley to gravity		foley to gravity			
COLOR/CLARITY	yellow		draining clear			
			yellow urine			
CARDIAC RHYTHM	NSR		SR-ST Rate			
	S1S2		90's -100's			
			S1 S2 present			
			2+ pulses x 4 ext.			
			Ø edema noted.			

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; [redacted] PT/INR; b(4)-2; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; SVA - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

ARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU Quest

DATE: 29 Jan 03

T'S IDENTIFICATION (For typed or written entries give: Name—last, first, e; grade; date; hospital or medical facility)

EPW #[redacted] b(4)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specif

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	139	139	131/	133	161/	131/	144/	160		127	124	131/	137/	138/		113/	186/	
	BP Cuff	45	43	41	46	56	55	46	57		47	50	49	55	55		56	11	
	Temperature											98.9					99.8	98.8	
	Pulse	115	115	88	89	96	96	90	102		108	101	100	107			113	115	
	Respiratory Rate	33	17	16	17	10	13	16	15		11	18	13	16			12		
	SATS	100	96	100	100	100	100	100	100		100	100	100	100			100	98	
																	NC	RA	
	pain	0	0	0	0	0	0												
	intervention	0	0	0	0	0	0												

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	LR	125	125/50	125/375	125/500	125/625	125/750	125/875	125/950	950	125	125/875	125/750	125/500	125/375		125/125	125/0	825
	IVPB							50		50							50		50
	PO																		
	TOTALS									1000									875

OUTPUT		HOUR / TOTAL	300/300	300/600	100/700	100/800	100/900	100/1000	125/1125		1125	525/525		375/900	200/1100				1100
	URINE	sp gr																	
		S/A																	
	NG	OUTPUT																	
		pH																	
		GUIAC																	
	EMESIS																		
	STOOL																		
	DRAINS	JP																	
	TOTALS																		1100

OP DAY

	16	17	18	19	20	21	22	23	
B/P	112/62	128/38	126/39	137/41	128/36	146/47	136/48	107/30	
Temp			99.3					99.1	
Pulse	94	97	100	107	104	96	99	97	
RR	12	13	10	20	16	16	17	15	
SAT	97	100	100	100	100	100	100	100	
mode	RA	RA	RA	RA	RA	RA	RA	RA	
Pain									

	16	17	18	19	20	21	22	23	8° T
LR	100	100/100	100	100	100	100	100	100	800
IVPB							50		50
PO									
									850
urine	130/100	100/275	200/425	175/600	250/850	250/1100	200/1300	200/1500	1500
JP			50						1500

ACUITY LEVEL CLASSIFICATION

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

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

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

24 HRS I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

NURSE'S SIGNATURE

[redacted]

b(6)-2

PAGE

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

PORT TITLE

NTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

TIME	0800	INITIALS [redacted]	1730	INITIALS [redacted]	b(6)-2	INITIALS
PUPILS	b(6)-2		3mm (R) Reactive			
SENSORIUM			A&OX3			
			Follows All Commands			
			Denies Pain			
RESPIRATORY PATTERN			Even & Unlabored			
BREATH SOUNDS			CTA			
SECRETIONS			Ø			
COLOR			WNL For Race			
INTEGRITY			See Nsg Note			
LOCATION			(R) Brch PIV			
CONDITION			(L) FA PIV			
			Patent Ø Infection/Infiltration			
ABDOMEN			Soft, NT			
BOWEL SOUNDS			BS X4			
	b(6)-2		Ø N/V/D			
URINE:			Foley Draining			
COLOR/CLARITY			Cly Urine			
			Ø S			
CARDIAC RHYTHM			SR/ST S, S1			
			Ø JVD, Edema, Erythema			
			Cap Refill < 3sec			
			(+) PP			

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)

ARED BY (Signature [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU 2nd

DATE: [redacted]

T'S IDENTIFICAT[redacted]yped or written entries give: Name—last, first, e; grade; da[redacted]l or medical facility)

[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specif.)

MEDICAL RECORD –SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of the Surgeon General

912th Medical Detachment (FS)

TRAUMA FLOWSHEET | OTSG APPROVED *(Date)*

INITIAL ASSESSMENT | ☒ IMMEDIATE ☐ DELAYED ☐ MINIMAL

Date: 23 JUN Arrival Time: 1331 Sex: (M) F Age: _____ Wt: _____

Allergies: _____ Tetanus Status: UTD Unknown

LMP: Last Meal: UNK

Chief Complaint: 2 GSW (L) Leg

PMH: Medications: UNK

Treatments PTA: IV, Field DSG

VITAL SIGNS: BP: 118/71 P: 85 RR: 18 TEMP: 97 SAO2: 100

CHEST
TRAUMA (YES) ☐ NO
PAIN (YES) ☐ NO
SOB YES (NO)
LUNG SOUNDS R L
☐ ☐ CLEAR
☐ ☐ WHEEZES
☐ ☐ DECRESED
☐ ☐ ABSENT

SKIN
☒ WARM
☒ DRY
☐ PALE
☐ DUSKY
☐ MOIST

ABDOMEN
☒ SOFT
☐ DISTENDED
☐ TENDER
BOWEL SOUNDS YES ☐ NO
GULATEST ☐ POS ☐ NEG

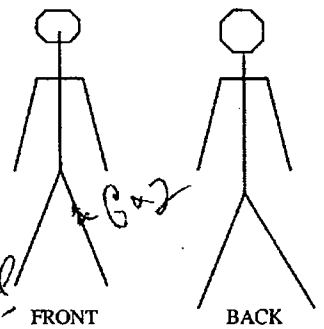
NEURO ☒ ☐
PERRL YES NO R_____mm L_____mm
GLASGOW SCORE 15
PUPIL SIZES 2 · 3 • 4 • 5 • 6 • 7 • 8 • 9

1. EYE OPENING		2. VERBAL REPONSE		3. MOTOR REPONSE	
Spontaneous	4	Oriented	5	Obedient	6
To Voices	3	Confused	4	Prostrated	5
To Pain	2	Inappropriate	3	Withdrawal	4
None	1	Incomprehensible	2	Flextion	3
None	1			Extension	2
				None	1

EXTREMITIES (-) L pedal
☐ DISTAL PULSES
☐ RT X2 LTX2
☐ MOVESEXTREMITIES X4
☐ NO EDEMA
☐ NO DEFORMITIES

EXCEPTIONS TO ABOVE PARAMETERS: SPLINTS

TREATMENTS:
02: LPM NC MASK ORAL AIRWAY
ETT # MM ☐ ☐ NASAL AIRWAY
MONITOR ☐ Y ☐ N EKG ☐ Y ☐ N
NG TUBE #
FOLEY: # DPL ☐ POS ☐ NEG
CHEST TUBE ☐ R ☐ L CM H2O



A= Abrasion
AP=Amputation
AV=Aversion
B=Burn
C=Contusion
D=Deformity
E=Extension
CF=Open Fracture
CF=Closed Fracture
G=GSW
L=Laceration
PW=Puncture Wound
S=Stab Wound
O=Other

Additional Interventions/Assessments: (-) foot dusky cold (-) Pedal Pulse, (-) Extremity NKM - BT Exam HSO

PATIENT'S IDENTIFICATION *For typed or written entries give: Name-last; first; middle; grade; date; hospital or medical facility)*
Patient/Soldier's Name: [redacted] b(6)-2
Rank: Icm, C.v.
SSN: ___/___/___ DOB: ___/___/___

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 4700

ONGOING ASSESSMENT/INTERVENTIONS

TRAUMA FLOWSHEET

IV SOLTIONS/SITES

TIME	SITE/SIZE	IV FLUIDS/BLOOD	AMOUNT INFUSED		OUTPUT
	18(R)AC	LR	1000		CHEST TUBE:
PTA	18(L) FA	NACL	1000		EMESIS:
		LR			NG TUBE:
					URINE:
					EBL:
					OTHER:

TOTAL IN:_____ OUTPUT: _____

NURSING NOTES

TIME	B/P	P	RR	O2 SAT	NURSING ASSESSMENT
1345	121/73		18	100	

Additional Interventions/Assessments _____

TIME	MEDICATION	GIVEN BY:
1339	1G ANCEF	[redacted]
1341	Tetanus LOT U0975AA EXP 25NOV09	
PTA	10mg MSO4	

b(6)-2
Ant

PLAN: ☒ **To OR at** _____ ☐ **To ICU/Post-op at** _____ ☐

Belongings with Patient TO include:_____

PRIMARY NURSE: [redacted] **PRIMARY MEDIC:** [redacted]

ANESTHESIA: [redacted] **MD/SURGEON:** [redacted]

OTHER: _____ PAD COSTIGAN

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 1-Jul-03
Time In: 1545
Allergies: NKA
Pre-op V/S: 124/55 94
Procedures: I+D (C) LEG

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 2000 Colloid
OR Output: UOP 300 EBL 60
Meds/Times: 2 versed 125 Fent 10 Mso4

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds History

Time	1545	1600	1615	1630	1700	1715
SaO2	99	100	100	99	99	100
FiO2	RA	RA	RA	RA	RA	RA
Methods						
240						
220						
200						
180						
160						
140						
120	✓	✓	✓	✓	✓	✓
100						0
80	0	0	0	0	0	
60	A	A	A	A	A	A
40						
20						
RR	10	14	14	12	18	16
T	97	97	97	97	98	98
Time			1630	1730		
Pain (0-10)			2/10	2/10		
LOS						

Patient teaching done: Wound Care, Pain Management.
T, C, & DB,. Incentive Spirometer. Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	1	1	1
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	9	10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
˙ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

PREPARED BY (Sig): SSG [redacted] b(4)-2

DEPARTMENT/SERVICE/CLINIC: ICU 2

DATE: 1-Jul-02

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

CIV
[redacted] b(4)-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

Civ # [redacted] b(4)-4

PATIENT'S CLEARANCE RECORD

For use of this form, see AR 40-2; the proponent agency is OTSG

DATE OF DISCHARGE	TIME OF DISCHARGE
2 July	0630

SIGNATURE OF WARD OFFICER [redacted] b(4)-2 2-7 Hr

PATIENT'S IDENTIFICATION

ACTIVITY CLEARANCE

(The final activity with which the patient must clear will be the disposition office.)

Military	INITIALS*	Non-military	INITIALS*
1. Patient's Trust Fund		1. Patient's Trust Fund	
2. Medical Services Account Officer		2. Medical Services Account Officer	
3. Clothing and Baggage		3. Clothing and Baggage	
4. Medical Holding Unit		4. Postal Service	
a. Supply		5. Change of Address	
b. Pay Section		6. Other *(Specify)*	
c. Service Records		7.	
d. Insurance and Allotments		8.	
5. Postal Service		9.	
6. Change of Address		10.	
7. Other *(Specify)*		11.	
8.		12.	
9.		13.	

REMARKS

DATE	SIGNATURE OF PATIENT ADMINISTRATOR

* INITIALS OF PERSON AUTHORIZING CLEARANCE.

DA FORM 4029, MAR 73 REPLACES DA FORM 8-258, 1 DEC 59, WHICH WILL BE USED USAPPC V1.00

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	0 0 1 3 5 9 5	EPW [redacted] b(4)-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
		X	9	UNKNOWN

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
—	—	9 9	[redacted] b6-2

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	U	2030	—

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	K 7 6	0 0 0 0 0 0 0 0 0

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICU 1	—

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] b2-2	—

	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
	—

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A B A A		0 3 0 6 2 3

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

FOR LOCAL USE

DX: GSW (L) LEG

[redacted] b(4)-2

A[redacted]ed) [redacted] b(4)-2

[redacted] MAJ, MC b(4)-2 [redacted] SPC (P), PAD CLERK

DA FORM 2966, MAR 80 EDITION OF 1 JAN 80 IS OBSOLETE

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 L R D L	I E	0 0 1 3 5 9 5	UNK CIV [redacted] b(6)-4	CIV	M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
	U U K	X	9	MUSLIM

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	U	1300	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 6	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICU 1	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] b2-2		

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
2 6		0 3 0 ~~0~~ 0 1

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
4 E A A		0 3 0 6 2 5

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

FOR LOCAL USE

DX: POPLITEAL ARTERY REPAIR
c̄ FASCIOTOMIES (L) LEG c̄ WASHOUT

ADMITTING OFFICER (Signature, [redacted] b(4)-2

SIGNATURE OF ADMIT[redacted] b(4)-2

DR [redacted]

DA FORM 2085, MAR [redacted]

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER: 13598	2. NAME (Last, First, MI): SPW# [redacted] b(4)-4			3. GRADE: NO	ADMISSION REMARKS
4. SEX: M	5. AGE: 39	6. RACE: X	7. RELIGION: Muslim	8. LENGTH OF SVC: unk	9. ETS: unk
10. PREVIOUS ADMISSION: NO	11. FMP: 99	12. SSN: [redacted]	13. ORGANIZATION: unk	14. WARD: ICU	
15. FLYING STATUS: NO	16. RATING/DSG	17. DEPT/BEN: K-18	18. BRANCH/CORPS: unk	19. UIC/ZIP: unk	20. TYPE CASE: Surgery
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Ø			22. HOURS OF ADMISSION: 0300	23. CLINIC SERVICE: ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —		25. TYPE DISPOSITION: 21		26. DATE OF DISPOSITION: 030701	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —		27b. TELEPHONE NO.: unk		28. DATE OF THIS ADMISSION: 030624	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b2-2				30. DATE OF INTIAL ADMISSION: 030624	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 (R) chest

Proc 8401

875.1
860.5
886.1
486
458.9
7885
799.0
780.6
E991.2

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	7	7

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	7	7

SIGNATURE OF ATTENDING MEDICAL OFFICER: [redacted] b(4)-2

[redacted] COM - 11813 [redacted] FICER: [redacted] b(4)-2

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

~ 35yo Iraqi male brought to [redacted] 62-2 w/ GSW to Right chest. Right chest tube placed at 12x BAS. Reported to be an innocent bystander caught in crossfire.

UA 561020

53.6 / 13.0 / 40.3 (433 / Prot 300

All? Meds ? PMH ? PSH ?

150 / 102 / 4.5 / 23 / 0.9 / 148 / 10

H/H - 11.7/35.7

ABG - 7.357/39.8/142/22/-3/99% Cg - 13.0/23.9

PHYSICAL EXAMINATION VS 144/85 P-103 R-35 100% Ful

GEN WD WN Iraqi Male in AD, Awake, alert

HEENT Ø NECK Ø LUNGS - Decreased BS Bilat

HEART - RRR S (m)

Abdomen - Flat Nondistended, ↓ BS

MS - Left 2ND Digit - traumatic Amputation.

L4R 8mm from thoracic R-3L w/ Bullet F in Left chest.

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

A: GSW chest / Right 2nd Finger

P: Admit → CT scan of chest / Abdomen

b(6)-2 [redacted], MD

[redacted] MAJ/MC

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	27 June 03		

[redacted] d or written entries give Name last, first, 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
USAPPC V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
6/24/03@	1700 Pt Recieved, initial Assessment Completed + Recorded on ICU Flow sheet, [redacted] CPT/AN b(6)-2
6/24/03@	1936 Pt Reoriented, Awake Fighting Vent, 5mg MSO4 Given b(6)-2 [redacted] CPT/AN
6/24/03@	2305 24° I+O IV in 2197 b(6)-2 4/o 1662 NG out 50 CT out 218 Balance +217 [redacted] CPT/AN
6/24/03@	2400 Q4° CBC drawn, (L) Chest Tube dressing Saturated c̄ Blood, (L)+(R) Chest Tube Dressing b(6)-2 Δed, Foley Care, Skin Care Completed [redacted] CPT/AN
6/25/03@	0220 Pt given Additional 5mg MSO4 For Lepin Change, Pt Rulled For Change b(6)-2 [redacted] CPT/AN
6/25/03@	0355 ABG + AM Labs drawn ABG 7.474 Pco2 35.5 Po2 80 HCO3 26 Base Deficit 2 SpO2 96% [redacted] CPT/AN
	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.

EPW # [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

b(4)-4 Cont

[redacted] 4 Chest Tube placed (R) side by [redacted] b(4)-2

[redacted]

b(4)-2

0500 P 102 SAT 100% BP 94/44

~~Chest tube~~ 0640 89/41/76 100%

0650 96/57 84 100%

0700 urine output 1200cc yellow/clear urine

0545 urine output 1200 cc yellow/clear urine

0558 chest tube on left taken out

0600	112/36 (130)	85 (P)	100% SAT
0605	113/36	87	100%
0630	88/43	82	100%
0635	99/43	80	100%

0615 1400 out 4000 in

#1 30

#2 7

#3 750

NG 210

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

MEDCOM - 11816

U.S. Government Printing Office: 1996 - 404-763/40001

STANDARD FORM 600 BACK (REV. 5-84)

NSN 7540-00-634-4178

600-108

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24 June 03	CXR by SSG [redacted] b6-4 0345. b(6)-2 [redacted] LTC, aw
0345	0350 450cc urine from foley. b(6)-2 [redacted] LTC, aw
0352	100/60 - 97 - 32 - 100% O2 sat. Rt chest tube placed by Dr [redacted] 0405 0410 b6-4
	Rt chest tube ~~pulled~~ [redacted] b6-4 no drainage in pleurovac
(0355)	attempted NG tubed 16 French ~~placed~~ by SSG [redacted] LT [redacted] b6-4
0358	100/60 105 - O2 sat 100%
0403	#4 NS 1000cc bolus. [redacted] b(6)-2 LTC, aw
0409	Oral pharyseal tube placed by LT [redacted] Placement checked by SGT [redacted]
0410	144/85 - 101 - 100% O2 sat. b(6)-2 [redacted]
0412	#5 NS bolus. [redacted] b(6)-2
0415	[redacted] MJ O4 [redacted]
0415	144/85 - 103 - 35 - 100% O2 SST b(6)-2
0418	10 mg vec IV JP
~~0416~~	~~Rt chest tube originally out in prior to arrival removed by Dr.~~
	[redacted] [redacted] LTC, aw b(6)-2
15.0 / 4.5 | 102 / 23 | 10 / 0.9	0420 148 PT/PTT ordered [redacted] LTC, aw
	0424 CBC ordered by Dr [redacted] b(6)-2 [redacted]
336 | 13.0 / 40.3	433 0535 LPn, Venous [redacted]
	0538 vent [redacted] SPO2 [illegible] vent
	0540 VS BP 141/66 P 94
	from CT [redacted] b(6)-2
	0540 vent 40% PEEP 4 V.I. Resp. 12
	0550 CT output (1) 120 (2) 270 (3) 312

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

EPW [redacted]

b(6)-4

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)* EPW [redacted]

SEX

RELATIONSHIP TO SPONSOR

STATUS

RANK/GRADE

SPONSOR'S NAME

ORGANIZATION

DEPART./SERVICE

SSN/IDENTIFICATION NO.

DATE OF BIRTH

MEDCOM - 11817

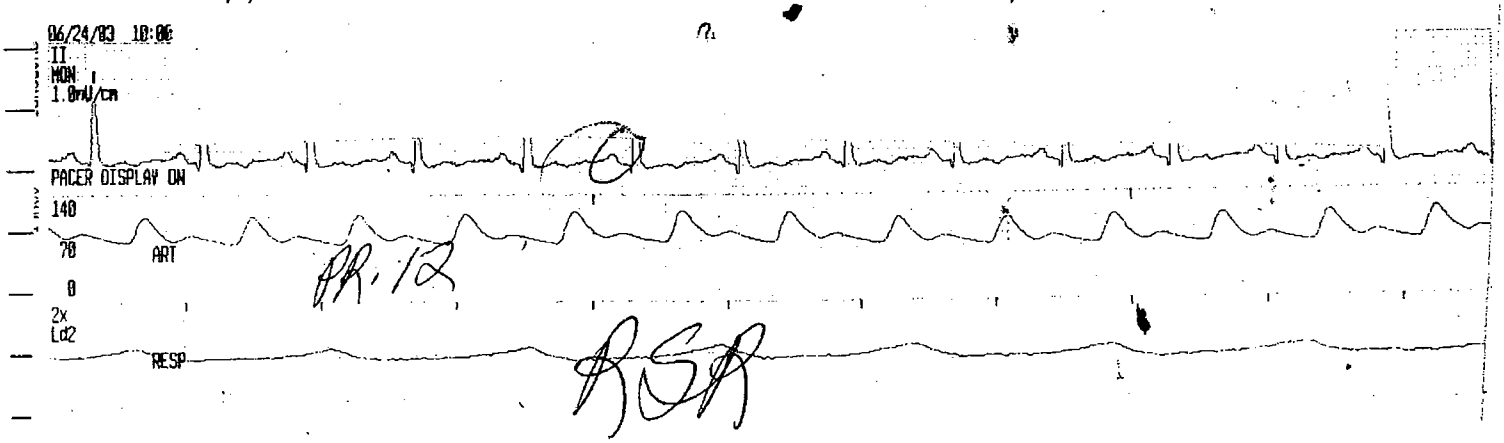
OF MEDICAL CARE

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24Jun03	[redacted]



24Jun03	[redacted]

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

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

[redacted] b(6)-4

24Jun03

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24 Jan 03	0830 Received from OR on summary. Report given by Anesthesist [redacted] 93.1 Warmers applied. See TIU-4. [redacted] Surgeon for initial assessment. [redacted] 0835 T 93.2, SBP 144/88, HR 86, RR 16 [redacted] 0840 HR 88, SBP 146/77, RR 14, SpO2 100%. Remains incst sedated. [redacted] T 93.5, BP 90, RR 14, Prep Scm, TU 800 [redacted] 0900 PCR taken. ABG drawn. Versed given @ 4mg/hr. Respiration noted [redacted] 0905 R hand elevated. Oral airway removed. [redacted] 0920 PCR & ABG's results viewed by Dr [redacted] & new orders received. 0940 update given to Dr [redacted] on consult. Amt of [illegible] fed blood in OR. Orders received. [redacted] 0955 OST removed. Remove [illegible] Remove [illegible] [redacted]

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

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

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

[redacted]

b(4)-4

24/Jan/03

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

PROGRESS NOTES

DATE	
24 Jan 0330	Ortho consult EPW vs Civilian Caught in crossfire Multiple GSW / Frag Inj Orthopedics (R) Index Finger Middle phalanx Dorsal Ray Amputation Digit A) RIF P2 GSW Fx P) Wound Exploration and Pub DIPJ Amputation level [redacted] b(a)-2
24 Jan 0730	Ortho Operative prep Dos (R) IF P2 Bl[redacted] Procedure Amputation P1 Level Surgeon [redacted] ERL: mon TQ: 2 3am Findings: Blast P2 shattered to PIPJ c P1 Pub Condyle Involved P1 Phalangeal Neck Amp c Closure Good Skin / Soft tissue to this level PO PAU Stable [redacted] b(a)-2

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

[redacted] b(a)-4

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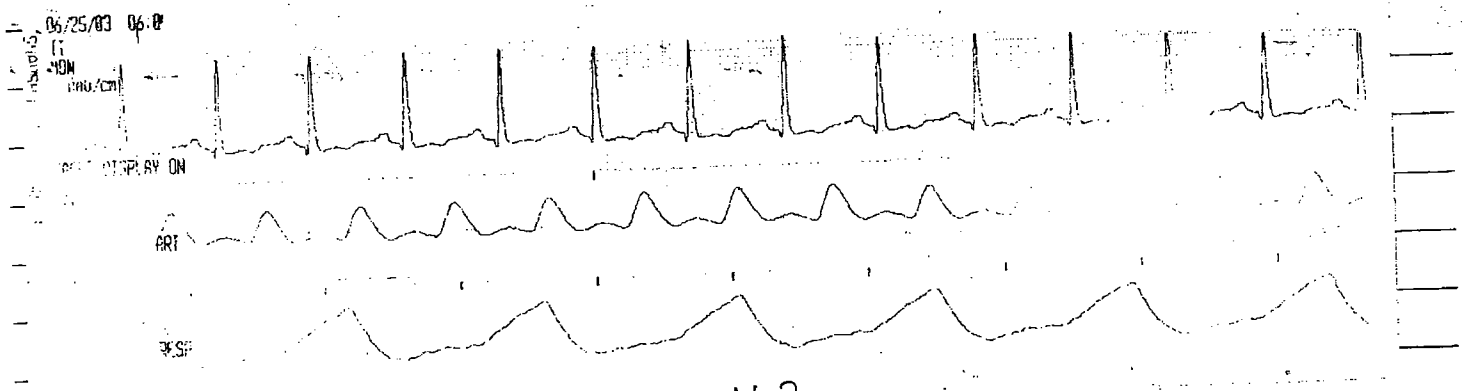
MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
6/25/03	0500 assumed care. Report given by night shift. Initial assessment on DA Form 4700, WRMC OP 375 — [redacted] b(6)-2



6/25/03	0740 Dr [redacted] b6-2 @ bedside. Labs reviewed. 4 new orders @ this time [redacted] b(6)-2 b6-2
	0850 Dr [redacted] @ bedside. 7 my verbal given labs, urinary prophylaxis given. J.P. Central line set up page [redacted] 0900 CVL completed by Dr [redacted] orders received. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	[redacted] (or Other) b(6)-2
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex, Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.	

#[redacted] b(6)-4

25/JUN 03

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

25 June 03 0500

Combat Surg SV2

51 Pt [illegible] / Selected

Pt had left lower collapse lung mpts –

O)

BIS) 9.7 / 30.4 227 — 139 / 105 / 31 / 27 — 8 / 0.8 / 113

789
32.7
71
25
2
9%

CVR –

Lungs –

Abdomen –

402.02

A & HD 3 – GSW – Chest

JP

b(6)-2

[redacted] b(6)-2

MAJ, MC USA
CHIEF, DOS

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

SPW

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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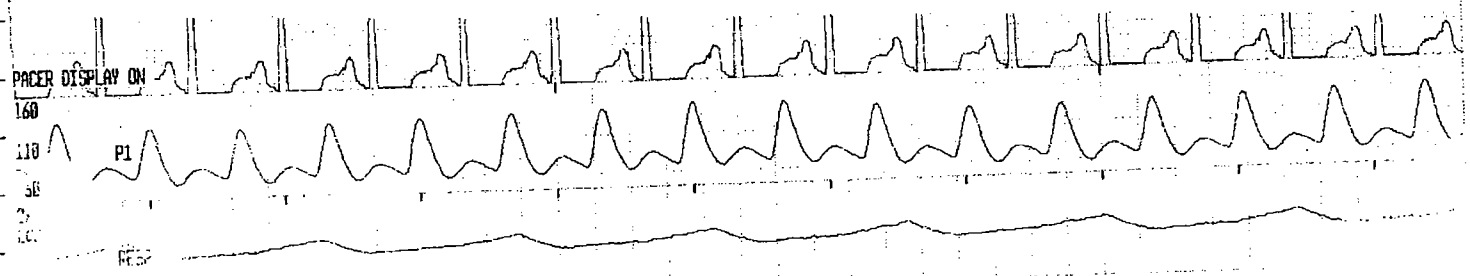
MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
6/26/03	0515 Notified Dr [redacted] @ CW [redacted] b(6)-2 sunken. PCXR taken [redacted] 0520 5mg Vecuronium given IVP. [redacted] b(6)-2 3mg Versed given IVP. Dr [redacted] b(6)-2 @ bedside. PCXR reviewed. Respiratory @ bedside. Sat deep suctioning [redacted] b(6)-2

N.B



6/26/03	0530 RT giving mucomyst treatment. Thick brown clots removed. Oral care given as well. [redacted] b(6)-2 0600 PCXR taken. [redacted] b(6)-2 0645 X-ray reviewed by Dr [redacted] Blood labs results. [redacted] b(6)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR (SSN or [redacted] b(6)-2

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

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

PROGRESS NOTES
Medical Record

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

[redacted] b(6)-4

[redacted] b(4)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

DATE	NOTES
26June03 0001	pt given 975 mg tylenol for Temp of 101.1 will continue to monitor. [redacted] CPT/AN
27June03	0500 Resumed care, report given by CPT [redacted] b(4)-2 initial assessment by DA Form 4700, WAMC OP 375 [redacted] b(4)-2

27June03	0700 Update given to DR [redacted] b(4)-2 on absence of signs, orders received.
b(4)-2	OSF labs results back, notified [redacted]
	0930 Pt at dressing A&D [redacted]
	C&D, [redacted] b(4)-2
b(4)-2	0940 DR [redacted] present. orders received
	4 deep 5cm, left drain sent [redacted]
	1030 X2 attempt to place Doppler, [redacted]
	success. Resp therapy @ bedside, life
	block A&D out, placed @ 26cm [redacted]
	1345 lab results received [redacted]
b(4)-2	1400 DR [redacted] @ bedside, X2 attempts
	block doppler, [redacted] success [redacted]

STANDARD FORM 509 (REV... BACK

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

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
6/26/03	0700 CPK 1746, RKG [redacted] b(4)-2
	0710 d FiO2 @ 80% per [redacted] b(4)-2 [redacted] SpO2 98%.
	1000 ABG results reviewed by DR [redacted] b(4)-2
	1310 FiO2 60%. deep suct. clear secretion per ETT. [redacted]
	1330 USS. ∅ distress noted at this time. [redacted] b(4)-2
	1530 Updating noted in R pleural vac & venting. PCXR taken [redacted]
	1600 PCXR & ABG reviewed by DR [redacted] b(4)-2
b(4)-2	[redacted] orders received [redacted]
	1650 [redacted] updated on pts status, orders received [redacted] b(4)-2
	1710 ETT advanced by RCP Tech. post-tech x-ray done. See PCXR [redacted]
	1730 report given to CPT [redacted] b(4)-2 [redacted] b(4)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(4)-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

26/June 03

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26 June 03	Assumed care @ 1200 hrs. HR ↑ 140 temp 102.8. MD notified. ABX ↑d. Assessment done see DA4700 b(4)-2 WAMC OP 325. will continue to monitor. [redacted] CPT/AN
27 June 03	0001 pt received newly order ABX earlier and temp is down to 102.° HR ↓ BP ↑ well VSS. Pt resting well. continues on propofol @ 60 mcg/kg/min. UOP ↓ to Approx 30 cc/hr MD aware. Remainder of assessment unchanged. will continue to monitor. [redacted] CPT/AN b(4)-2
27 Jun 03	Surgery. HD #4 GSW chest Transmedra stable No complaints ABG 7.53/32/126/27 VSS. ABS #4 997 CT @ left 9.9/28.0 240 Chest CSOA A/P Doing well wean as exhibited [redacted] b(4)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

b(4)-2

6/27/03 1450 Vessel off @ 600 cc/hr started. [redacted]
1500 [redacted] @ 300 cc/hr OR IV Bolus [redacted]
1530 [redacted] vessel off. OR's @ [redacted]
bedside orders received. [redacted]
This been therapy @ bedside. Pond [redacted]
b(4)-2 [redacted] [redacted] b(4)-2
on [redacted] @ 100/min. SpO2 99% [redacted]
[redacted] b(4)-2
1730 [redacted] [redacted]
[redacted]
1730 [redacted] [redacted]
[redacted]

b(4)-2

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

[redacted] b(4)-4

6/27/03

PROGRESS NOTES
Medical Record

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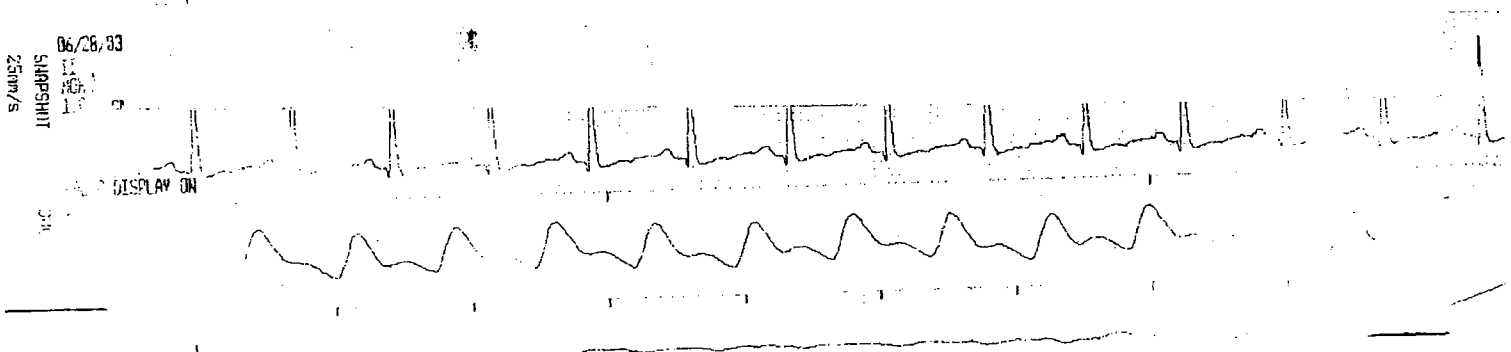
MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
6/28/03	0500 Assumed care. Report given initial assessment on DA Form [redacted] WRMC OP 375. b(6)-2



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

6/28/03 0740 Dr [redacted] @ bedside, update given. @ orders @ this time [redacted] 0800 pm labs drawn per [redacted] sent to lab. [redacted] 0830, 12.5mg phenergan given IM b(6)-2 [redacted] nausea. I.V. [redacted] 0900 pt denies any nausea. Urinary b(6)-2 [redacted] b(6)-2 [redacted] 1030 BCT pulled by Dr [redacted] Gauze applied [redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(6)-4

28 Jun 03

PROGRESS NOTES
Medical Record

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

[redacted] b(4)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

DATE	NOTES
6/28/03	1100 PCXR completed, reviewed by Dr [redacted] b(4)-2 & new orders b(4)-2 [redacted] reviewed b(4)-2 [redacted]
	1140 1st RT Run hung @ 50cc/hr Insulin [redacted] b(4)-2
	1150 Consultor @ bedside, encouraged given sox pt to cough & deep breath, verbalize agreement [redacted] b(4)-2
	1300 labs completed, K 3.9, [redacted]
	1500 VSS SpO2 98% & discharge noted [redacted]
	1630 VSS, & discharge noted [redacted]
	1700 pt OOB to chair, tolerated well, remains on RTO @ 4L/min via NC. b(4)-2 [redacted]
1745	Received Pt from Dayshift VSS - Assessment completed (see OP 38S) pt in chair. Requests to return to bed. Ambulation Minimal Assist. b(4)-2 [redacted] pt. tolerated well
29 JUN 03	Pt T: 101° SATS 88% P: 140-150s. Dr [redacted] NOTIFIED [redacted]
0300	Taken. TT Tylenol PO given [redacted]

b(4)-2

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

[redacted] b(4)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*	
28 Jun 03	Surgery HD#5 GSW to Chest	
LR 125	Extubated yesterday & complication Doing	9.0 / 28 / 319
Fortaz D3	Tm 100.7 HR 110-120 BP 120-139/70s	13.8 / 99 / 144 / 6 / 2.9 / 0.8
Gent D3	UO 7,850 cc/hr	
MSO4 PRN	Chest ↓ BS (L)	Alb 2.3
Tylenol	Mid (R) BS ND NT	Alk 62
	Ext Resp.	Amy 32
	wounds c/d/i	AST 190
		TB 1.3
		GGT 64
		TP 6.9
	A/P Doing well need Better pain ctrl	11.7/282
	D/c (R) CT.	
	Ambulate w/ chair.	CXR - Low Lung Vol
		(R) Clr
		(L) Retrocardiac Density
	[redacted]	b(6)-2
29 Jun 03	Desat plus Am CXR shows ↓	
Fortaz D4	(L) lung collapse.	
Gent D4	Tm 104 HR 130 RR 25-30 110/57 UO 100-200 cc/hr	
LR 50	Chest ↓ BS on (L) lower chest ⊼ Bronchial sounds	
	Abd ND Ext wgs	
	7.0 / 28 / 308 139 / 98 / 117 / 8 / 3.4 / 28 / 0.7	
	A/P Pneumonia vs collapse cont Ambulate	b(6)-2
	NT Suction Neb.	[redacted]

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

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

[redacted] 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

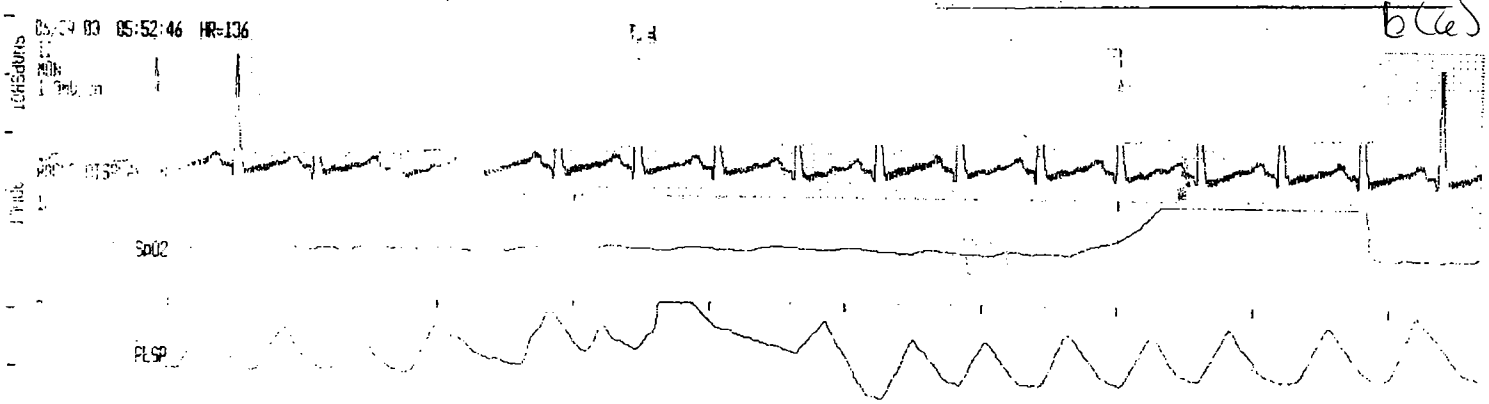
[redacted] b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
29 Jun 03/0500	Assumed care. Report given by CPT [redacted] of noted c̄ SOB. Resp Thar called for neb tx ment. NCXR completed reviewed by DR [redacted] b(6)-2 b(6)-2 [redacted] b(6)-2
	0515 Neb tx ment given by RT, Remains on 10L/min via AC FM. b(6)-2 [redacted]
	0530 AM labs repeated for verification of PEFR 90 BL/min. SpO2 97% - 98% [redacted]

b(6)-2



b(6)-2

29 Jun 03/	0715 Neb tx ment given per RT. [redacted]
	0800 DR [redacted] @ bedside. Orders received. [redacted]
	0830. CT to Hq per DR orders [redacted]

b(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S I (SSN or Oth [redacted]
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[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
29 Jun 03	0900 OOB to chair. Tolerated well. [redacted] b(6)-2
	Chest PT given.
	1030 RLW back to bed per patient request. [redacted]
	1110 Drap Sx'd by Resp. Therapy [redacted] b(6)-2
	copious amt of thick white per b(6)-2
	Nurse suctioning. [redacted]
	1830 used IS x 7, 5 difficulty. [redacted] b(6)-2
	1420 ABG drawn per stick. [redacted]
	1500 DCR taken, notified Dr. [redacted] b(6)-2
	of ABG results. [redacted]
	1530 see chart for ABG results. [redacted]
	1600 OOB to chair, tolerated well. [redacted]
	SpO2 93% - 94% [redacted]
	1700 VSS. ∅ distress noted. [redacted]
	1710 RLW back to bed, update, [redacted] b(6)-2
	given to Dr's ∅ orders received. [redacted]
	b(6)-2

[redacted] b(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
29 Jun 03 0530	Pt note: Administered 1 HHN tx of .5cc alb/NS 2.5cc. Pre tx HR: 138 RR: 28 SPO2: 88% on 10 lpm simple mask. BBS ↓↓ in BLL. Pt follows commands & is in no distress at this time. Pt is AA+3. Post tx HR: 141 RR: [illegible] SPO2: 96% on 6L BS: unchanged. Will continue to monitor resp. status. — [redacted] CRT/91120 b(6)-2
29 Jun 03 1100	Pt note: Administered 1 HHN tx of .5cc alb/NS 2.5cc. Pre tx HR 114 RR: 25 SPO2 96% on 6L simple mask. BBS are CTA. CPT administered. NT suctioning performed. Suctioned 3-5cc of semi-thick white sputum. Pt did not tolerate suctioning well at all very violent. Will continue to monitor pt's resp. status. Post tx HR: 115 RR: 30 SPO2 96% — [redacted] CRT/91120 b(6)-2
30 JUN 03	Pt reintubated 1330.
30 JUN 03 2010	Pre tx: HR 140, RR 14, SPO2 100% on 60%. BS slight coarse. W (L) > (R). UD Alb neb given. Post tx HR 144, RR 14, SPO2 100%. BS unchanged. Note BP @ 70/43 - nurses start 16ga IV (R) FA. Bolus 2 liters fluid. Sx <2cc whitish thick discha Pt has 100.9° A Temp. — Sgt [redacted] 91IV 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.

Pt [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

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 June 03	1730 Assumed care @ 1200 VSS. pt lying in bed ō feet and HOB elevated. Assessment done. see ICU Assessment sheet.
	Dopa attempted to ↓ dropped to 8 mcg/kg/min pt B/P ↓ to 90's systolic and MAPS to 60-62 restarted @ 10 mcg/kg/min. 1800 VS UOP ↓ to 20cc. placed urinometer and foley tubing to track UOP more
b(4)-2	closely. will continue to monitor. [redacted] CPT/AN
	2040 Dopa ↓ to 8 mcg/kg/min. pt ō ↓ UOP MD notified. pt given 2L bolus 1 LR and 1 N.S. 16g Angio started in (R) wrist for blused fluids.
2145	W0017 03 000205 blood unit #1 started [redacted] CPT/AN b(4)-2
2210 b(4)-2	2771580 blood unit #2 started [redacted] CPT/AN
2215	Dopa ↓ to 3 mcg/kg/min. MAP 74 [redacted] CPT/AN
0100	pt Received several doses of Lasix for ↓ UOP see white sheet for doses and times. will continue to monitor. [redacted] CPT/AN b(4)-2
0400	B/P ↓ to sys 90 ō ↓ UOP. gave 500cc bolus of LR. 160mg Lasix given per MD order. b(4)-2
	VSS. will continue to monitor. [redacted] CPT/AN
0500	Report given to CPT [redacted]. [redacted] CPT/AN
	b(4)-2 b(4)-2

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

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

EPW [redacted] b(4)-4

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
6/30/03	0500 Assumed care. Report given. b(4)-2 See ICU-7 flowsheet. [redacted] 0615 Ambulated to bed. [redacted] (R) & (L) cut. (R) hand dsg [redacted] b(4)-2
b(4)-2	0730 Dr. [redacted] @ bedside. b(4)-2 [redacted] 0900 Tube feeding ensure started @ 10cc/hr by Dr. [redacted] placed by Dr. [redacted] 0930 Gatorade @ bedside. Encouraged pt to cough & deep b(4)-2 pt complies. Explained reason why he is not performing. [redacted] b(4)-2 1000 pt tolerating TF ing of ensure @ 10cc/hr. [redacted] b(4)-2 1230 pt c/o 10/10 pain. 5 dose [redacted] 1300 pt diaphoretic, P 88 130's-140's, b(4)-2 RR 50's, SpO2 80's. nebulized. Dr. [redacted] 1330 pt intubated c 8.5 cuff placed @ 23cm lower lip line. Pt sent by anesthesiologist, Dr. [redacted] & Dr. [redacted] b(4)-2 b(4)-2 [redacted] @ bedside. [redacted] 1300 ABR taken. Temp 105.5 [redacted]

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] b(4)-4

30 Jun 03

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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b(4) - 2 A1

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6/30/03 1340	ERROR Erroneously given Dr. [redacted] bags placed under right arm pit along with [redacted] 1430 phone placed by Maj. [redacted] 1500 Dr [redacted] @ bedside [redacted] 1500 given on Tuesday, 6 nurses off. Dr [redacted] @ bedside. Orders received to place on Dopamine @ 3mcg/kg/min [redacted] 1600 placed on bed w/ mattress, Dr's @ bedside, update given. Orders received of Fuz 50%, [redacted] 1800 Report given to new [redacted] SHIFT. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 Jun 03	Event Note
1320	Pt Doing well this Am Ate Lunch then
	became suddenly short of Breath. (food not
	good enough to take his breath Away) c̄ Associated
	Tachycardia to 130-150 placed on 15 L NR
	mask @ and SAT of 88% Abg - 7.59/30/45/89%
	ECG - Sinus TACH, CXR low lung Volume
	but no D't from Am. No Lobar/Lung collapse.
	No improvement with NT suction. Pt
	semi urgently intubated by Anesthesia
	DDx: worsening Pneumonia vs PE.
	Plan. Vent RAT 14/750/8/100%
	Abx. Cipro 400 BID
	Anticoag. Lovenox 100 sq BID
	Echo
	[redacted] b(6)-2
	[redacted] MD Res.
30 Jun 03 1320	Consulted by surgery for emergent intubation of
	pt c̄ pending respiratory failure. Exam/vitals
	as above. Suction ✓. Pre O2 x 5 mins 100% via ambu.
	Induced 10mg versed, 250ug fentanyl, 120mg SUX.
	DL x 1 c̄ 2 miller b 8.5 ETT placed c̄ trauma. (over)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE [redacted]	AINED AT CRNA
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR b(6)-2 [redacted]	b(6)-2

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

[redacted] b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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FIRMR (41 CFR) 201-9.202-1

30 Jun 03 (cont) Breath sounds equal $\bar{p}$ intubation
1320 SpO2 $\bar{c}$ prompt improvement to 98%.
Relaxed $\bar{c}$ 10mg vecuronium on return of spontaneous ventilation. ETT secured 23cm @ teeth by RT. Vent settings per surgery. Care returned to ICU staff.

[redacted] MAJ, CRNA

b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
1U F	30 Jun 03
Forbaz	Surgery
Grent	Agressive Pulm toilet yesterday.
	Tm 102° / 101' 96-120 NR BP 122/74
	I/O 75-225cc/hr
	UT >100cc
	Gen Chest - Improved BS @ (L)
	Base
	CXR - improved Aeration of (L) Base
	Alp Transmediastinal GSW c (L) lobe
	collapse & pneumonia, on Forbaz / Gentam
	Cont Agressive pulm toilet Neeb
	DHT today.
	[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.

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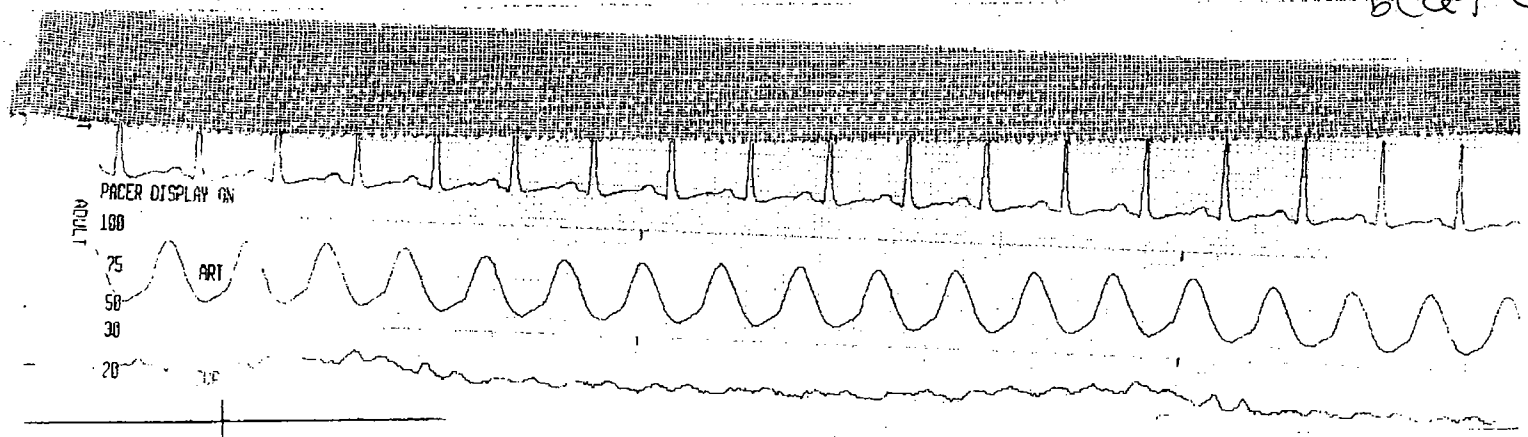
MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
July 03	0500 Assumed care. Report given. Initial assessment on DA Form 4700, see TCU-2 Flowsheet for continuous VS — [redacted] b(6)-2



July 03	0515 remains on Dopamine @ 3 mcg/kg/min, Vecuronium @ 0.8 mcg/kg/min, Versed @ 3cc/hr, Fentanyl 50mcg/hr. LR @ 125cc/hr. NS @ 0 min rate. Dry dk red blood noted to H2O seal, 1 b(6)-2 [redacted] 0630 dressing applied to R hand. R forearm & R LE site intact — [redacted] 0750 Flush Saline 30cc Sterile Water, 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. TCU-2

[redacted] b(6)-4

10/ul 03

PROGRESS NOTES
Medical Record

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