BATES PAGES MEDCOM 9441-9640 HAVE BEEN PREVIOUSLY RELEASED

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted] b6-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 6 June 03 TIME OF ORDER: 0930 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) ~~2 liters NS over 4 hrs~~

(2) ~~DC Gentamicin & Unasyn~~ [redacted]

~~DC UNASYN~~

(3) ~~Start 3.378 grams Zosyn IVPB - start @ 0900 in AM~~

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 6 June 03 TIME OF ORDER: 0930 HOURS

[redacted] b6-2

(1) 2 liters NSS over 4 hrs

(2) DC Gent

(3) DC UNASYN

(4) Start 3.375 grams Zosyn IVPB Q6°

(5) Hold tube feeds

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

Richard Malyszn MD

Noted @ 1100 [redacted]

b6-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 6 June 03 TIME OF ORDER: 1630 HOURS

↑ IVF to 125 ml°

[redacted] CPT/MC

b6-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b6-4	6 June 03	1915 HOURS	b6-2
	1) VO per Dr. [redacted] to give 1000 cc. Bolus NS, IVBP		
			[redacted] b6-2
NURSING UNIT: ICU 1 / ROOM NO.: / BED NO.: 7			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
[redacted] b6-4	1) 6 June 03	2030 HOURS	
	VO per Dr. [redacted] to run CBC, MetHyte8.		b6-2
	[redacted]		
NURSING UNIT: ICU 1 / ROOM NO.: / BED NO.:	[redacted]		b6-2

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
[redacted] b6-4	1) 6 June 03 [redacted]	[redacted] HOURS	
	VO per Dr. [redacted] to run Troponin - [redacted]		
	[redacted]		b6-2
NURSING UNIT: / ROOM NO.: / BED NO.:			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
4823871	6-6-03	2200 HOURS	
	(1) EKG	2230 Done CB	
	~~(2)~~		
	(2) Transfuse 2 U PRBC now 2330		
	(3) Dopamine C 3 mg/min - 2300 - Done CB		
	(4) 9 IVF to 200 cc/hr - 2200 - Done CB		
NURSING UNIT: / ROOM NO.: / BED NO.:	[redacted]		

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE U[redacted] b6-2

MEDCOM - 9642

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	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
07 June 03	1935 HOURS	
(1) To Icer #1 - Dr. [redacted] b6-2		
(2) SP EXP LAP		
(3) cond - Stallee, NKDA		
(4) VS q 1°, F+O		
(5) ACTIVITY - Bedrest - Elevate HOB 30°		
(6) DIET - NPO		
(7) IV LR TRA 150cc/hour		

NURSING UNIT | ROOM NO. | BED NO.

7 JUN 03 MB 2206

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
(8) FENTANYL ~~MORP~~ gtt IV TITRATE TO EFFECT HOURS		
(9) PROPOFOL gtt IV TITRATE TO EFFECT		
(10) DOPAMINE gtt IV 3mcg/kg/min		
(11) ZOSYN 3.375 grams IVPB q 6°		
(12) NGT to LIS		
(13) FOLEY CATH to gravity		
(14) ZANTAC 50mg IV q 8°		
(15) VENT - SIMV - 850cc, R-12, P-5		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
50% D2 HOURS		
(12) HEPARIN 5000 Units SQ BID		
(17) JP's x2 to bulb suction — Strip q 4°		
Empty q 4° or soon if full/Recharge.		
(18) ABG in 30min		
(19) ABG, CBC, chem 8, LFTS in AM		
(20) Call MD for T7102, P<60 or >100, SBP<100 or >170, UO<30cc/hr		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
SSA <90% HOURS		
[redacted] MAJ, MC USA CHIEF, DOS		b6-2
[redacted]		b6-2

NURSING UNIT | ROOM NO. | BED NO.

24

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	08 June 03	0915 HOURS	
	(1) DAILY CXR		b6-2
	(2) ↓ MIV to 125cc/hrm		
	(3) LASIX 20mg IVP Now please		0930 [redacted]
	(4) ~~KCL 40mEq/100cc NS NPB over 2° via central line~~		1030
b6-4			
NURSING UNIT: ICU #1 / ROOM NO. / BED NO. # [redacted]	[redacted] MD MAJ, MC USA CHIEF, DOS		b6-2

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	08 June 03	1000 HOURS	
	(1) 25% Albumin 100cc IVP		10[redacted]
	Noted @1600	[redacted] MD MAJ, MC USA CHIEF, DOS	b6-2
NURSING UNIT / ROOM NO. / BED NO.	[redacted]		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
# [redacted] b6-4	08 June 03	1619 HOURS	
	(1) LR 500cc BOLUS IV x1		Done
	b6-2		[redacted] b6-2
	[redacted] MD MAJ, MC USA CHIEF, DOS	[redacted]	
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
[redacted] b6-4 b6-2 [redacted]	08 JUNE 03	1920 HOURS	
	(1) DAILY CBC, chem 8, ABG, LFTs		
	b6-2	[redacted] MAJ, MC USA CHIEF, DOS	b6-2
NURSING UNIT / ROOM NO. / BED NO.	2/9 [redacted]		

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# [redacted] b6-4	09 June 03	0845 HOURS	
	(1) KCL 40meq /100cc NS IVPB		0900/done
	over 2° via CENTRAL LINE		
	VERBAL ORDER DR [redacted] b6-2		[redacted]
	[redacted]		
NURSING UNIT: ICU #1 / ROOM NO. / BED NO.: #7	MAJ, MC USA CHIEF, DOS		

noted: [redacted] b6-2 9 June 0900

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
0 [redacted] b6-4	09 June 03	1100 HOURS	
	(1) Mg SO4 4 grams /100 cc D5W IVPB		1230 done
	over 2 hours		
	[redacted] b6-2		
	MAJ, MC USA CHIEF, DOS		
NURSING UNIT / ROOM NO. / BED NO.	[redacted] MD		
	[redacted] MAJ, MC		

noted: [redacted] b6-2 9 June 1100

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
EPW [redacted] b6-4	09 June 03	1305 HOURS	
	(1) DC Propofol 1310 done		
	Versed gtt - Titrate to effect		
	(3) LASIX 20mg IVP 1350 done		
	(4) 25% Albumin 50cc in 500cc D5W IV		
	[redacted], MD 1400 done		
NURSING UNIT / ROOM NO. / BED NO.	MAJ, MC USA CHIEF, DOS		
	[redacted] b6-2		

noted: [redacted] b6-2

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
EPW [redacted] b6-4	[redacted]	[redacted] HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b6-4	10 June 03	1040 HOURS	
	(1) Transfuse 2 UNITS PRBC's 1 VPB over 2°		
	(2) Premed w/ Benddryl 25mg IV Tylenol Supp 650 ¼ PR		1114 [redacted]
	(3) LASIX 20mg IV p̄ Transfusion		
	(4) CBC p̄ Transfusion complete		
NURSING UNIT: ICU#1 / ROOM NO. / BED NO.	[redacted]		

b6-2 Noted 1145 10 June 03 [redacted]

MAJ, MC USA CHIEF, DOS [redacted]

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
# [redacted] b6-4	10 June 03	0900 HOURS	
	Peep 10, Rate 10 SIMV FIO 60% TVu 850 Weaw FIO2 to Keep Sats 794% V.O. WR [redacted]		
NURSING UNIT: ICU#1 / ROOM NO. / BED NO.			

b6-2 Noted 1145 10 June 03 [redacted] b6-2

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
[redacted] b6-4	1245	6/11/03 HOURS	
	Give 40 mEq of KCL IV x1 now. T.O Dr [redacted] /CPTO [redacted] Noted 11 Jun 03		
	b6-2		[redacted] 1/03 1232
NURSING UNIT: ICU#1 / ROOM NO. / BED NO.	[redacted]		

Close [redacted]

MAJ, MC USA CHIEF, DOS

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
[redacted] b6-4	11 June 03	2330 HOURS	
	(1) PROPOFOL gtt. 100 mcg/kg/min		
	(2) VECURONIUM gtt. 0.1mg/kg bolus then 0.1mg/kg/hour		
	(3) Vent - TV-750, P-10, R-14, 100%		
NURSING UNIT / ROOM NO. / BED NO.			

b6-2 Noted 0055 11 Jun 03 [redacted]

[redacted] MC USA DOS [redacted]

b6-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b6-4

Noted 11 JUN 03 @ 0059 b6-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 12 June 03 — TIME OF ORDER: 0047 HOURS — LIST TIME ORDER NOTED AND SIGN

1. CIPRO 400mg IVPB q 12°
2. LASIX 20mg IVP X 1
3. DC PROPOFOL
4. TIT O2 to Keep Sats ≥ 90%

[redacted] MAJ, MC USA [redacted] CHIEF, DOS

b6-2

PATIENT IDENTIFICATION

[redacted]

b6-4

Noted 12 JAN 03 @ 1903 [redacted] cpt/AN

NURSING UNIT	ROOM NO.	BED NO.
		b6-2

DATE OF ORDER: 12 June 03 — TIME OF ORDER: 1835 HOURS

1. VANCOMYCIN 1 gram IVPB, q 12°

b6-2

[redacted]

PATIENT IDENTIFICATION

[redacted]

b6-4

Noted @ 0100 6/13/03 [redacted] cpt/AN

NURSING UNIT	ROOM NO.	BED NO.
		b6-2

DATE OF ORDER: 13 June 03 — TIME OF ORDER: 0100 HOURS

1. Give IV Bolus of 1 Ltr LR Now
2. May Titrate Dapamine gtt ↑ to 5 mg/kg/min to Maintain SBP > 90 + MAP > 60

Dr [redacted] For [redacted] cpt/AN

b6-2

PATIENT IDENTIFICATION

13 10 done

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 13 June 03 — TIME OF ORDER: 1220 HOURS

1. Albuterol Neb 0.5 cc / 0.5 cc NS now hr q 4° + PRN
2. HESPAN 500 cc IVPB ← 1330/done

Noted @ 1430 [redacted]

[redacted]

DA FORM 1 APR 79 4256 REPLAC MEDCOM - 9647 CH MA [redacted]

[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	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW #[redacted] b6-4 b6-2 [redacted] done 1500	13 June 03	1500 HOURS	
	(1) LASIX 20 mg IVP		
	[redacted] MAJ, MC USA CHIEF, DOS		b6-2
NURSING UNIT: ICU-1 / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
Done 13 June 03 1900 b6-2 [redacted]	13 June 03	1900 HOURS	
	(1) LASIX 40mg IVP X1 NOW		
	VO DR [redacted]		CPT/AN
	b6-2		
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
#[redacted] b6-4 b6-2 noted [redacted] 14 June 03 0900	14 June 03	0900 HOURS	
	25% Albumin 100cc / 1L LR		
	to infuse IV over 30 minutes		
	14 June 03		
	b6-2 [redacted]		
NURSING UNIT / ROOM NO. / BED NO.			

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

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

MEDCOM - 9648

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	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
14 JUNE 03	1650		
(1)	Ex/CW/-Dr [redacted]		b6-2
(2)	DX SP EXP CUP/PLACEMENT J tube/Trash		✓
(3)	Cont. guarded NKDA		✓
(4)	I+O VS q 1°, I+O, Monitor, Pulse OX		✓
(5)	IV LR TRA 150 cc/hour		✓
(6)	MORPHINE gtt tit to effect		✓
(7)	Versed gtt tit to effect		✓

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	HOURS	
(8)	DORAMINE gtt 3 mcg/kg/min tit to keep MAP ≥ 70		✓
(9)	ZOSYN 3.375 grams IVPB q 6°		✓
(10)	CIPROFLOXACIN 400 mg IVPB q 12°		✓
(11)	VANCOMYCIN 1 gram IV q 12°		✓
(12)	NGT to LIS		✓
(13)	Foley cath to gravity		✓
(14)	ZANTAC 50 mg IV q 8°		✓

b6-2 noted [redacted] 14 June 03 1730

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	HOURS	
(15)	JP's x 2 to bulb suction, Strip q 4° empty q 4° or sooner if full/Recharge		✓
(16)	HEPARIN 5000 UNITS SQ BID		✓
(17)	JEVITY per J-tube TRA 10 cc/hour		✓
(18)	Flush w/ 10 cc Water q 4°		✓
(18)	VENT - SIMV 700 cc TV, R-15, P-10, 60%		✓
(19)	ABG, CBC, Chem 8, LFT's q AM		✓
(20)	ABG, CBC, Chem 8 Now		✓

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	HOURS	
(21)	call MD for T > 102°, P < 60 or > 110, SRP < 100 or > 165, UO < 30 cc/hour, Sat ≤ 90%		✓
(22)	Turn q 2°		✓
(23)	DAILY CXR [redacted] MAJ, MC		

b6-2 b6-2 [redacted]

16 JUNE 03

NURSING UNIT | ROOM NO. | BED NO.

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

DENTIFICATION

EPW

[redacted] 14JUN03

b6-4

[redacted] 20:45

b6-2

UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 14 June 03 — TIME OF ORDER: 1835 HOURS — LIST TIME ORDER NOTED AND SIGN

1. Bolus IV 1 Liter LR
2. Vecuronium gtt - tit to 2/4 twitch
3. Albuterol Neb 0.5cc/2.5cc NS
   Any + g 4°
   ~~Acid Vecuronium gtt error (RL)~~

[redacted] b6-2 Noted [redacted] 03

DENTIFICATION

EPW [redacted]

b6-4

UNIT	ROOM NO.	BED NO.

DATE OF ORD[redacted] — TIME [redacted]

16 June 03 — 1045 HOURS

1. LASIX 320 mg IVP 1100/dose
2. DNR - No ACLS measures if code
3. ↓ Mentorene IV to 50cc/hr

[redacted] MAJ, MC b6-2

DENTIFICATION

[redacted]

b6-4

UNIT	ROOM NO.	BED NO.

DATE [redacted]ER — TIME OF ORDER

16 June 03 — 1220 HOURS

1. ↑ LASIX gtt to 40mg/hr

Noted

[redacted]

1300 [redacted] b6-2

DENTIFICATION

[redacted]

b6-4

UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 16 Jun 03 — TIME OF ORDER: 1500 HOURS

1. Vecuronium 14mg IVP 1500 [redacted]
   then Vec gtt - tit to 2-4 twitch

b6-2

Noted [redacted]

1700 [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	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
EPW #[redacted] b6-4 14 JUN 03 2045	14 JUNE 03	1914 HOURS	1330/a
	① LASIX 40mg IVP		
	② TV 800, Peep 8		
	[redacted]		b6-2
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
[redacted] b6-4 14 JUN 03 2000	14 JUNE 03	2140 HOURS	
	① LASIX 80mg IVP		
	② ZOSYN Δ to 2.25 grams IVPB Q6°		
	③ CIPRO 400mg Q 24°		
	④ ZANTAC 50mg IVPB Q 24°		
	⑤ VANCOMYCIN [redacted] QOD		
NURSING UNIT / ROOM NO. / BED NO.	b6-2		

PATIENT IDENTIFICATION	DATE OF OR[redacted]		
[redacted] b6-4 Noted 15 June @ 0300 [redacted] b6-2	15 JUN 03	0220 HOURS	
	① Stat Chem 8		
	② Set up for CVP		
	VO Dr [redacted]		
	for [redacted] CRT/AN		
NURSING UNIT / ROOM NO. / BED NO.	b6-2		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
EPW #[redacted] b6-4	15 JUNE 03	0600 HOURS	
	① LASIX 160mg IVP 0630 done		
	② FIO2 80% TV 800 rate 15, peep 12		
	FIO2 80% TV 700, rate 18, peep 12		
	[redacted]		
NURSING UNIT / ROOM NO. / BED NO.	@ 1700	b6-2	

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

MEDCOM - 9651

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION [redacted]

b6-4

DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
15 June 03	1330		
(1) LASIX 160 mg IVP		1330	done
DC [redacted]			
[redacted] MAJ, MC USA CHIEF, DOS			

NURSING UNIT | ROOM NO. | BED NO.

b6-2

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	HOURS
15 Jun 03	1360	
(1) [redacted]		
[redacted]		
[redacted] MD		
[redacted] MC USA CHIEF, DOS		

b6-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b6-4 [redacted]

Noted 16 Jun 03 0210

DATE OF ORDER	TIME OF ORDER	HOURS
16 Jun 03	0210	
(1) Give LASIX 160mg IVP Now		
V/O Dr [redacted]		
For [redacted]		

b6-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

PW [redacted]

b6-4

DATE OF ORDER	TIME OF ORDER	HOURS
16 June 03	0755	
(1) BUN/CREATININE		0830 done
(2) LASIX 160mg IVP now then start		done
LASIX GTT - 20mg/hour		
[redacted] MAJ, MC USA CHIEF, DOS		

b6-2

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 1 APR 79 4256 REPLACES [redacted]

MEDCOM - 9652

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	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# [redacted] b6-4 Noted 6/17/03 @ 1947 [redacted] b6-2	16 Jun 03	1700 HOURS	
	Warfare gtt start @ 20 mcg/g/min & rate to effect		
UNIT / ROOM NO. / BED NO.	[redacted]		b6-2

IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
EPW b6-4 [redacted] Noted 6/17/03 @ 1950 [redacted] b6-2	17 June 03	1939 [redacted] HOURS	
	(1) MAX conc all drgs and NPB's		
	(2) ↓ MIV to 25 cc/hr b6-2		[redacted] MAJ, MC USA CHIEF DOS
UNIT / ROOM NO. / BED NO.	[redacted]		MAJ, MC

IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
EPW [redacted] b6-4	18 June 03	1320 HOURS	
	(1) LASIX 320 mg IVP 1330/ [redacted]		
	(2) MAX concentrate LASIX drgs - w/ increase LASIX gtt to 160 mg/hr		b6-2
	Noted @ 1340/ [redacted]		[redacted] MAJ, MC USA CHIEF DOS
UNIT / ROOM NO. / BED NO.			b6-2

IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	18 Jun 03	1650 HOURS	b6-2
	1966 in 30 minutes U.O. [redacted]		
	[redacted]		
UNIT / ROOM NO. / BED NO.	240 [redacted]		MAJ, MC USA CHIEF DOS b6-2

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

MEDCOM - 9653

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
BPW [redacted] b6-4				15 June 03	0900 HOURS	
			①	DC Department	JH	
					b6-2	
UNIT	ROOM NO.	BED NO.		[redacted] USA DOS		
IDENTIFICATION				DATE OF ORDE[redacted]	TIM[redacted] HOURS	
UNIT	ROOM NO.	BED NO.				
IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS	
UNIT	ROOM NO.	BED NO.				
IDENTIFICATION				DATE OF ORDER	TIME OF ORDER HOURS	
UNIT	ROOM NO.	BED NO.				

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 29	30	31	6/1	2	3
29May03	[redacted]	VS/A/Q 1 x 4	05	[redacted]					
		Mens q 2°	17	[redacted]					
		I/O	05	[redacted]					
			17	[redacted]					
am		Foley to DD	05	[redacted]					
			17	[redacted]					
31May03	[redacted]	NG to LIS	05	[redacted]					
			17	[redacted]					
		Activity: Bedrest	05	[redacted]					
			17	[redacted]					
		Diet NPO	05	[redacted]					
			17	[redacted]					
		Change dressing	08	[redacted]					
		on right buttock	20	[redacted]					
		QD							
		change dressing	08	1620	[redacted]				
		on abdomen		[redacted]					
		Sliding 5/30							
		call if >102,	05	[redacted]	[redacted]				
		P >120, U.O. <	17	[redacted]	[redacted]				
		30/hr							
30may	[redacted]	Cec, lytes, Bun/ce Q Am	04	[redacted]	[redacted]				
30may	[redacted]	CPK q 8° x 4	04	[redacted]	[redacted]	X	X	X	
			15	[redacted]	X	X	X		
			23	[redacted]	X	X	X		
			07	X	X	X	X		
30May	[redacted]	CXR QD while intubated	04	[redacted]					

Rewrite 3 Jun [redacted]

see next page

ALLERGIES: ☐ YES ☐ NO — PRIMARY DIAGNOSIS: 7 DKDC S/P Exp Lap, (R) pancreatectomy, choleci/ectomy, partial hepatectomy

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO — PAGE NO. page 1

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 ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	-----	Condition: Stable				
5/29/02	[redacted]	Change Vent Settings as follows.				
	-----	FIO2 ↓ to 50%, ↑ Resp Rate to 14, VT				
	-----	800 Peep of 5.				
5/29	[redacted]	Repeat Abg in 30 mins	done		1620 Hrs	[redacted]
5-30	[redacted]	CBC, lytes, Bun/Cr now UV	30 may	Done		[redacted]
5/30	[redacted]	ABG in A.M. c̄ labs	31 May	0400	0415	[redacted]
5/30	[redacted]	T&C 2 u PRBC to OR tomorrow.	done	5/30/03	2010	[redacted]
5/31	[redacted]	Vent: PC Rate 14, TVn				
	-----	800 FIO2 50%				
5/31	[redacted]	Admit c/o [redacted] / [redacted]				
5/31	[redacted]	Cond: Serious				

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. May Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6	7	8	9
29 May	[redacted]	Vitals q 1° x4 then	05	[redacted]						
		2°	17	[redacted]						
29 May	[redacted]	I/O	05	[redacted]						
			17	[redacted]						
31 May	[redacted]	Foley to gravity	05	[redacted]						
			17	[redacted]						
31 May	[redacted]	NG to LIS	05	[redacted]						
			17	[redacted]						
31 May	[redacted]	Activity: Bedrest, restraint	05	[redacted]						
			17	[redacted]						
31 May	[redacted]	Change dsg to @ buttock	08	[redacted]						
		BID	20	[redacted]						
31 May	[redacted]	Call T > 102 p > 120	05	[redacted]						
		U.O. < 30 cc/hr	17	[redacted]						
29 May	[redacted]	Dx: GSW Liver, colon, shoulder	05	[redacted]						
		~~Bathing~~	17	[redacted]						
31 May	[redacted]	Diet: NPO (po)	05	[redacted]						
			17	[redacted]						
31 May	[redacted]	CBC, ABG, Lytes, Bun, Ca	04	/ [redacted]						
		CK ~~QAM~~	04	/ [redacted]						
31 May	[redacted]	JP to bulb	05	[redacted] DC'd 3 June 03						
			17	[redacted]						
3 June	[redacted]	Keep HOB @ 30°	05	[redacted]						
			17	[redacted]						
3 June	[redacted]	NT suctioning q 4°	05	[redacted]						
			17	[redacted]						
~~3 June~~	[redacted]	~~CXR CBC Am while Tubes~~	04	/ [redacted]						

ALLERGIES: ☐ YES ☐ NO

? NKDA

PRIMARY DIAGNOSIS: S/P Exp Lap, partial hepatectomy (R) hemicolectomy cholecystectomy.

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

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
3 June	[redacted]	Repeat CBC	done	@ 0740		[redacted]
3 J	[redacted]	Chest & abd X-RAY	done	@ 0900		[redacted]
3 J	[redacted]	PT to see for foot splints to prevent foot drop	> consult put in 3 June 2003			[redacted]
6 June	[redacted]	CBC, Metlyte 8	6 June done	2030	2030	CB

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

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 30	31	6/1	2	3	
30 May	[redacted]	Liver panel now &	04	1200	[redacted]				D/C 2 June
		QAM							
31 May 03	[redacted]	Dx: GSWs liver,	05	/	[redacted]				
		colon, shoulder	17						
31 May 03	[redacted]	VS: ICU Routine	05	/	[redacted]				
		c̄ I&O's	17						
31 May	[redacted]	DCT BR, Restraint	05	/	[redacted]				
		PRN (EPW)	17						
		to Do not							
31 May	[redacted]	Ext Rotate @	05	/					
		PRN	17						
31 May	[redacted]	Do not Ext	05	/	[redacted]				
		Rotate @	17	/	[redacted]				DC'd June
		PRN							
	[redacted]	NPO	05	/	[redacted]				
			17	/	[redacted]				
31 May	[redacted]	Resume previous	05	/	[redacted]				DC'd June
		Vent setting	17	/	[redacted]				
*31 May	[redacted]	CBC, ABG, Nites	04	/	/	[redacted]	/	[redacted]	
		Bun/Cr, CK							
		QAM							
31 May	6	JP to Bulb	05	/	8	[redacted]			
			17	/	[redacted]				
2 June	[redacted]								

b6-2

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: S/P Exploratory lap, (R) hemicolectomy, Cholecystectomy, partial hepatectomy

ADDITIONAL PAGES IN USE: ☑ YES ☐ NO

PAGE NO: 2

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

MEDCOM - 9659

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
b6-2 [redacted]	[redacted]	XR AP (L) shoulder	done	that	[redacted]	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 *(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 3	4	5	6	7	8	9	10	11	12	13	14	15	16
Ø3 June 03	[redacted]	Remove foot splints B/L	05	/	[redacted]												
		ē 2-3° 14	17	[redacted]													
4 Jun 03	[redacted]	Simu 76, FIO2 ~~60%~~ 50%	05	/	[redacted]												
		TV 750, peep sim	17														
		FIO2 60%															
4 Jun	[redacted]	Wean FIO2 to	05	/	[redacted]												
		keep sat > 94%	17														
		Ensure on [redacted]															
4 Jun	[redacted]	JING 60cc Boluses	02	/	/	[redacted]											
		@3° ✓ residual	05	/	/												
		@3° hold bolus	08	/	[redacted]												
		for residual > 90cc	11	/	[redacted]												
			14	/	[redacted]												
			17	/	[redacted]												
			20	/	[redacted]												
			23	/	[redacted]												
4 Jun 03	[redacted]	OXR in AM	04	/	/	done	[redacted]										
5 Jun 03	[redacted]	TF @ 60/hr	12	/	/	[redacted]											
		advance 20cc	17														
		@ 4° to max rate															
		goal of 100cc/hr															
6 Jun 03	[redacted]	✓ residuals @4°	04	/	/	/	[redacted]										
		hold TF for	08	/	/	[redacted]											
		residuals > 100cc	12	/	/	[redacted]											
			16	/	/	[redacted]											
			20	/	/	[redacted]											
			24	/	/	[redacted]											

b6-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Exp Lap, partial, hepatectomy, (R) hemicolectomy, cholecystectomy

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

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 9661

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
5 June	[redacted]	VO per Dr [redacted] to turn down vent	5 June	0345	0345	[redacted]
	-----	Setting from 16 to 14.				
6 Jun	[redacted]	Hold Tube Feed			[illegible]	[redacted]
6 June	[redacted]	CBC, Metlyte 8, Troponin - Dr. [redacted] VO	6 June	2030	2030	[redacted]
6 June	[redacted]	EKG	6 June	2230	2230	[redacted]
6 June	[redacted]	Transfuse 2U PRBC NOW	6 June	2230	2230	[redacted]

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

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. Jun 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
7 JUN Renewed 14 JUN	[redacted]	CONDition: ~~Stable~~ GUARDED	05 / 17	[redacted]
~~7 JUN~~ Renewed	[redacted]	Vitals: Q 1 hr Monitor + Pulse OX	05 / 17	[redacted]
~~7 JUN~~ Renewed 14 JUNE	[redacted]	I+Q q 1°	05 / 17	[redacted]
7 JUN	[redacted]	Activity Bed Rest Elevate HoB 30°	05 / 17	[redacted]
7 JUN	[redacted]	Diet: NPO	05 / 17	[redacted]
~~7 JUN~~ Renewed 14 JUN	[redacted]	NGT TO LIS	05 / 17	[redacted]
~~7 JUN~~ Renewed 14 JUN	[redacted]	Foley Cath to gravity	05 / 17	[redacted]
7 JUN	[redacted]	Vent: SIMV, 850, R 12 P 5, 50% FiO_2	05 / 17	[redacted] Settings Ad 10 June 2003
~~7 JUN~~ Renewed 14 JUN	[redacted]	JP's ~~X2~~ to Bulb Suction, Strip q4° Empty q4° or sooner if Full / Recharge	05 / 17	[redacted]

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: S/P Exp-Lap — Cond: guarded 14 JUN E03 S/P EXP LAP T tube place TRACH

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

b6 2

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

MEDCOM - 9663

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
7JUN	[redacted]	ABG IN 30 MIN	7JUN		Done	[redacted]
7JUN	[redacted]	ABG, CBC, Chem 8, LFT's IN AM	8JUN	0400	[illegible]	A
7JUN	[redacted]	LFTS Now, Blood gas ulA	8JUN	1045		
10JUN	[redacted]	CBC p Transfusion Complete	10JUN	—	1620	[redacted]
14JUN	[redacted]	TO ICU - DR [redacted]	14JUN	—	1653	[redacted]
14JUN	[redacted]	ABG, CBC, Chem 8 now	14JUN	1659	1730	[redacted]

	-----					

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 June Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	7	8	9	10	11	12	13	14	15	16	17	18	19	20
7 JUN	[redacted]	Call MD IF Temp>102	05	[redacted]													
14 June	[redacted]	P<60 >110, SBP<100 & >160	17	[redacted]													
Renewed	[redacted]	UOP<30 cc/HR, Sat<90%	/														
~~8 June~~	[redacted]	Daily CXR	04	/	/	[redacted]											
Renewed 14 JUN	[redacted]		/														
~~8 June~~	[redacted]	Daily CBC, Chem 8, ABG,	04	/	/	[redacted]											
Renewed 14 June	[redacted]	LFT's															
	[redacted]																
10 June	[redacted]	Vent Settings: Peep 10	05	/	/	/	[redacted]										
	[redacted]	Rate 10 SIMV	17	/	/	/	[redacted]										
	[redacted]	FIO2 60% TV~850															
	[redacted]	WEAN FIO2 to keep															
	[redacted]	sats >94%															
11 June	[redacted]	~~FIT O2 to keep Sat>90%~~	05	/	/	/	/	/	[redacted]								
	[redacted]		17	/	/	[redacted]	/	[redacted]									
14 Jun	[redacted]	Turn Pt Q 1-2	05	/	/	/	/	/	/	/	/						
	[redacted]	+ Document positions	17	/	/	/	/	/	/	/	[redacted]						
	[redacted]	Des															
14 JUNE	[redacted]	VENT SETTINGS - SIMV	05	/	/	/	/	/	/	/	/						
	[redacted]	700cc TV, R-15 P-10	17	/	/	/	/	/	/	/	[redacted]						
	[redacted]	60% FIO2															
14 June	[redacted]	TURN Q2° +															
	[redacted]	Document															
	[redacted]																
	[redacted]																
	[redacted]																
	[redacted]																

ALLERGIES: ☐ YES ☑ NO
NKDA

PRIMARY DIAGNOSIS: S/P EXP-LAP Cond Guarded 14 June S/P EXP LAP Trach/J Tube Placement

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

b6-2

CLINICAL RECORD

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

Mo. ____ Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 14	15	16	17	18
14JUN03	[redacted]	I+O	05	/	[redacted]			
			17		[redacted]			
			/					
14JUN03	[redacted]	VS Q 1°, Monitor, Pulse	05	/	[redacted]			
		ox	17		[redacted]			
			/					
14JUN	[redacted]	NG to LIS	05	/	[redacted]			
			17		[redacted]			
			/					
14JUN	[redacted]	Foley catheter To gravity	05	/	[redacted]			
			17		[redacted]			
			/					
14 JUN	[redacted]	JP's x2 To bulb suction	05	/	[redacted]			
		Strip q4° Empty q4° or Sooner	17		[redacted]			
		if Full / Recharge	/					
			/					
14JUN	[redacted]	Jevity per J-Tube TRA	05	/	[redacted]			
		10cc/HR - Flush ē	17		[redacted]			
		10cc H_2O q4°	/					
			/					
14JUN	[redacted]	Vent: SIMV	05	/	[redacted]			
		Rate 15	17		[redacted]			
		T.V. ~~700~~ 800						
		PeeP: ~~10~~ 8						
		Fio2: 60%						
			/					
			/					

ALLERGIES: ☐ YES ☒ NO

NKA

PRIMARY DIAGNOSIS: Dx SP Exp-LAP/Placement J Tube/Trach

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION: Cond. Guarded

[redacted]

EPW

66-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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 14	15	16	17	18	19
14JUN	[redacted]	ABG, CBC, Chem 8	05	[redacted]					
		LFT's QAM	17	[redacted]					
			/						
14JUN	[redacted]	TURN Q2°	05	/ [redacted]					
			17	[redacted]					
			/						
14JUN	[redacted]	Daily CXR	04	[redacted]					
			/						
14JUN	[redacted]	Call MD For T>102°	05	/ [redacted]					
		P<60>110, SBP<100 or >165	17	[redacted]					
		UO <30cc/HR, Sat ≤90%	/						
			/						
15JUN	[redacted]	Monitor CVP	05	/ [redacted]					
			17	[redacted]					
15JUN	[redacted]	FIO2 80, SIMV 18,	05	/ [redacted]					
		TV 700, peep 12cm	17	/ [redacted]					
16JUN03	[redacted]	DNR – no pcls	05	/ [redacted]					
		measures if code	17	/ [redacted]					

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: Dx S/P Exp – LAP/Placement Tube/Trach

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b6-4

EPW

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

b6-2

Verify by Initialing		TH EUTIC DOCUMENTATION C E PLA (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
14JAN	[redacted]	ABG, CBC, Chem 8	14JAN	DONE		[redacted]
15JAN	[redacted]	Stat Chem 8	15JAN03	0235	0235	[redacted]
18JAN	[redacted]	ABG in 30 minutes @ 1700	18JAN	1700		

66.2

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. May Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 29	30	31	6/1	2	
29 May 03	[redacted]	IV LR @ 125/hr	05	/		[redacted]			
			17	[redacted]					
		Versed 2mg/hr	05	/	[redacted]				DC'd 1 June
		IV gtt. titrate	17	[redacted]					
		to sedative effect							
31 May 03	[redacted]	Unasyn 3gm IV Q8°	08	/	[redacted]				
			16	/	[redacted]				
			24	[redacted]					
		Gentamicin 450mg	15	[redacted]					
		IV Q Day							
		(Please have							See New
		pharmacy adjust							Order
		dose based on CR							
		clearance)							
31 May 03	[redacted]	Zantac 50mg IV	08	/	[redacted]				
		Q 8°	16	[redacted]					
			24	[redacted]					
5/29	[redacted]	Start Propofol gtt	05	/					DC'ed
		for sedation	17	KW					
5/30	[redacted]	↑ IVF LR @ 175/hr	05	/	0800 LB				DC'ed
			17	/					
5/30	[redacted]	↓ IVF LR @ 150/hr	05	/	1100 LB				
			17	/	[redacted]				A'd
5/30	[redacted]	↑ IVF LR to 175cc/hr	05	/	/	[redacted]			D/C 2 June
			17	/	[redacted]				

ALLERGIES: ☐ YES ☐ NO — ? NKDA

PRIMARY DIAGNOSIS: S/P Exp. Lap, R hemiolectomy, cholecystectomy, partial hepatectomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

[redacted]

EPW 66-4

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

66-2

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

MEDCOM - 9669

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 May	[redacted]	Bolus LR 500 cc Now	30 May	now	Done	[redacted]
30 May	[redacted]	Bicarb ṫ amp x ṫ now	30 May	now	Done	[redacted]
30 May	[redacted]	Bolus 1 Liter NS	30 May	now	Done	[redacted]
5/30	[redacted]	Bolus 500 cc LR	done	1935	[redacted]	
5/31	[redacted]	Resume Previous Vent Settings:	AC 14 TV 800	5090		

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
5/29/03	[redacted]	MS04 1-10mg IV Q1° PRN pain Tylenol ṫ-ṫ ṫ/pr	5/29 1947 5mg [redacted]	5/30 0830 3mg	5/30 1200 5mg	5/30 1300 5mg	5/30 1530 5mg	5/30 1600 5mg	5/30 2000 5mg						
5/29/03	[redacted]	PO ↓ NG PRN T7102	5/30 1400 650mg [redacted]		5/31 ṫ NG [redacted] 0930										
31 May	[redacted]	MS04 2mg IV Q15 min PRN up to 20mg in 40	5/31 1330 [redacted] 6/1 6mg 2000 2200	5/31 1345 IVP 2mg 2 June 5mg [redacted] 0400	5/31 1400 IVP 2mg 2 June 5mg [redacted] 0700	5/31 1600 2mg IVP 2 June 3mg [redacted] 0900	6/1 2mg 0210	1 June 2mg IVP 0515 2 June IVP [redacted] 1400	1 June 4mg IVP 0930	6-1 2mg IVP [redacted]	6-1 4mg IVP 0930	6-1 2mg IVP 1030	6-1 4mg IVP 1300	6-1 2mg [redacted]	6-1 1400 10mg
31 May	[redacted]	Tylenol 650mg po/pr PRN Q4°	2000 5/31 650mg [redacted]												

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30	31	1	2	
5/30	[redacted]	Dopamine 3mcg/kg/min	05	/	[redacted]	off		P/C
		IV gtt	17	[redacted]	off	off		
5/30	[redacted]	Start Propofol drip	05	/	[redacted]			P/C
5/31		titrate for adequate	17		[redacted]			
	[redacted]	sedation/Effect						
5 May 05	[redacted]	Gentamycin 450mg	15	/	[redacted]			
		IV qd						
2 Jun	[redacted]	↓ IVF to 150cc/hr	05	/	/	/	[redacted]	
			17	/	/	/	[redacted]	
2 June	[redacted]	Metrin 800mg	08	/	/	/	/	
		q 8° via NG	16	/	/	/	/	
			24	/	/	/	1930 [redacted]	

b62

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/p ex lap, (R) hemicolectomy, cholecystectomy, partial hepatectomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

#[redacted] b6-4

EPW

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

MEDCOM - 9671

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 06 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
2 June	[redacted]	PRBC 1 unit	done	2 June @ 0830		[redacted]
2 Jun	[redacted]	20 meq KCl IV Run	hung @ 0800			[redacted]
2 June	[redacted]	MgSO4 ½ gram IV Run	Run over 4 hours			
2 Jun	[redacted]	Lasix 20mg IVP x 1 c blood given @ 0910 3 June 03				[redacted]
2 Jun	[redacted]	D/C daily liver enzymes	done	2 June 03		[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
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USAPA V1.00

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 3	4	5	6	7
2 June	[redacted]	↓ IVF to 150cc/hr LR	05	[redacted]			See below	
			17	[redacted]				
2 June	[redacted]	Morphine 800mg q8° via NG	08	[redacted]				
			16	[redacted]				
			24	[redacted]				
31 May	[redacted]	Gentamycin 450mg IV QD	15	[redacted]				
31 May	[redacted]	Unasyn 3gm IVPB q8°	08	[redacted]				
			16	[redacted]				
			24	[redacted]				
31 May	[redacted]	ZANTAC 50mg IVPB q8°	08	[redacted]				
			16	[redacted]				
			24	[redacted]				
3 June	[redacted]	Ensure (D) or Jevity ↓ NG 60cc bolus q3°, ↓ residual q3°. Hold bolus for residual > 90cc	05	[redacted]				
			17	[redacted]			See green sheet	
4 June 03	[redacted]	MIVF @ 100cc/hr LR	05	[redacted]				
			17	[redacted]				
4 June 03	[redacted]	Versed gtt titrate to effect/sedation	05	[redacted]				
			17	[redacted]				
4 June 03	[redacted]	Dopamine gtt @ 3mg/kg/min	05	[redacted]				
			17	[redacted]				
4 June 03	[redacted]	~~Versed~~ Fentanyl gtt titrate to sedation	05	[redacted]				
			17	[redacted]				
4 June 03	[redacted]	Wean Dopamine to keep MAP > 65	05	[redacted]				
			17	[redacted]				

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Explap. Partial hepatectomy (D) hemicolectomy cholecystectomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION: [redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

b6-2

b6-4

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
3Jun	[redacted]	Haldol 5mg IVP x1 Now	3Jun	1900	1900	[redacted]
4Jun	[redacted]	ACL 40meq in 100cc NS			0800	[redacted]
	-----	over 3°				[redacted]
4Jun	[redacted]	LR 500cc Bolus			0930	[redacted]
	-----	LN NS Bolus / Transfuse				[redacted]
	-----	CVP Now; Main infusion	done			[redacted]
	-----	@100cc/LR ō Bolus				
4Jun	[redacted]	500 cc NS Bolus for ↓ MAP and HR	4June	1900	1900	[redacted]
	-----	140 Now, VO Dr. Bogurst				
4Jun	[redacted]	500 cc NS. Bolus Now VO. Dr [redacted]	4June	2136	2136	[redacted]
5Jun	[redacted]	500 cc Bolus x1 Now	5Jun	0330	0330	[redacted]
6June	[redacted]	500cc Bolus x1 Now (IV) NS	6June	0300	0300	[redacted]
6June	[redacted]	500cc Bolus x1 Now (IV) NS	6June	0400	0400	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
31May	[redacted]	MSO4 2mg IVP q 15min														
-----	-----	PRN up to 20mg in 4°														
-----	-----															
31May	[redacted]	Tylenol 650 mg po/pr	3Jun 0833 po	5June 0120												
-----	-----	PRN 94°	[redacted]													
-----	-----															
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USAPA V1.00

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
6 June	[redacted]	2L NSS OVER 4 HRS		1	1000	[redacted]
		(EACH 500cc)		2	1100	[redacted]
6 June	[redacted]	1000cc NS Bolus NOW		3	1200	[redacted]
6 June	[redacted]			4	1300	
			6 June	1915	1915	[redacted]
6 June		↑ IVF to 200cc per hr.				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													

USAPA V1.00

CLINICAL RECORD

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

Mo. ____ *Yr.* ____

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 6	7	8	9
6JUN03	[redacted]	Start 3.375 grams	06	/	[redacted]		
	[redacted]	Zosyn IVPB q6°	12	[redacted]			
	------		18	[redacted]	/		
	------		24	[redacted]			
6 June	[redacted]	Start Dopamine @	05	/	[redacted]		
	[redacted]	3mcg/kg/min	17	[redacted]	/		
6 June	[redacted]	↑ IVF to 200cc/hr now	05	/	[redacted]		
	[redacted]	(2200 time)	17	[redacted]			
7 June	[redacted]	Start propofol after	05	[redacted]			
	[redacted]	completion of versed	17	/			
	------	VO Dr. [redacted]					

b6-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

[redacted] b6-4

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. 6 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
9 June 03	[redacted]	KCL 40 mEQ /100cc NS IVPB	9 JUNE 03 0830	—	0845	[redacted]
	-----	OVER 2° VIA CENTRAL LINE				
9 June	[redacted]	MgSO4 4gms/100cc D5W IVPB	9 June 03	1100	1200	[redacted]
	-----	OVER 2°				
10 June	[redacted]	KCL 40 mEQ/100cc NS IVPB #1	10 JUNE	0645	0645	[redacted]
	-----	OVER 2° VIA CENTRAL LINE #2	10 JUNE	0845	1080	[redacted]
	-----	X2				
10 June	[redacted]	Transfuse 2 units pRBCs IVPB #	10 JUNE	—	1430	[redacted]
	-----	over 2° #2	10 JUNE	—	1620	[redacted]
10 June	[redacted]	Premedicate ÷ Benadryl 25mg IV	10 June	1115	1115	[redacted]
10 June	[redacted]	Tylenol Supp 650mg ÷ PR	10 June	1130	1130	[redacted]
10 June	[redacted]	LASIX 20mg IV ÷ transfusion	10 June	—	1620	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
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USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 7	8	9	10	11	12	13	14	15	16	17	18	19	20
~~7JUN~~	[redacted]	IV: LR TRA ~~150~~ 125	05	[redacted]													
14JUN Renewed		cc/HR 125	17														
7JUN	[redacted]	Fentanyl gtt IV	05	[redacted]													
		Titrate to Effect	17														
~~7JUN~~	[redacted]	~~Propofol gtt IV~~	05	[redacted]													
		~~Titrate to Effect~~	17														
7JUN	[redacted]	Dopamine gtt IV	05	[redacted]													
14JUN Renewed		3mcg/kg/min tit	17														
		to keep MAP 270															
7JUN	[redacted]	Zosyn 3.375 grams	04 06	[redacted]													
14JUN Renewed		IVPB q6°	10 12	[redacted]													
			16 18	[redacted]													
			22 24	[redacted]													
7JUN	[redacted]	Zantac 50mg IV	06	[redacted]													
14JUN Renewed		q8°	14	[redacted]													
			22	[redacted]													
7JUN	[redacted]	Heparin 5000 units	10	[redacted]													
14JUN Renewed		SQ BID	22	[redacted]													
~~[illegible]~~	[redacted]	~~Versed gtt [illegible]~~		[redacted]													
14JUN03 Renewed		~~to effect~~	17														

ALLERGIES: ☐ YES ☑ NO

NKDA

PRIMARY DIAGNOSIS: Cond: guarded S/P EXP LAP 14 June Trach/J tube placement

S/P Exp - Lap

ADDITIONAL PAGES IN USE: ☑ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

b6-2

b6-4

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. June Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	12	13	14	15	16	17	18	19	20	21	22	23	24	25
11 JUN 03	[redacted]	Propofol gtt @ 100 mcg/kg/min	05	[redacted]	/												
			17	/	/												
11 JUN 03	[redacted]	Vecuronium gtt @ 0.1 mg/	05	[redacted]	[redacted]	[redacted]											
		Kg/hr	17	[redacted]	[redacted]	[redacted]											
~~11 JUN 03~~ Renewed 14 JUN 03	[redacted]	Cipro 400 mg IVPB q12	03	[redacted]	[redacted]	[redacted]											
	[redacted]		15	[redacted]	[redacted]	[redacted]											
~~12 JUN 03~~ Renewed 14 JUN 03	[redacted]	Vancomycin 1gm IVPB 10	07	/	[redacted]	[redacted]											
	[redacted]	q 12°	19	[redacted]	[redacted]	[redacted]											
13 JUN 03	[redacted]	May wean Dopamine	07	/	[redacted]	[redacted]											
	------	↑ 5 mcg/kg/hr to maintain	17	[redacted]	[redacted]	[redacted]											
	------	SBP > 90 + MAP > 60															
13 JUN 03	[redacted]	[redacted] NEB	04	/	/	[redacted]											
	[redacted]	0.5cc / 2.5cc NS	08	/	/	[redacted]											
	------	Now then Q4	12	/	/	[redacted]											
	------	+ PRN	16	/	[redacted]	[redacted]											
	------		20	/	[redacted]	[redacted]											
	------		24	/	[redacted]	[redacted]											
	------																
14 JUN 03	[redacted]	MORPHINE gtt tit	05	/	/	[redacted]											
	------	to effect	17	/	/	[redacted]											
	------																
14 JUN 03	[redacted]	JEVITY per J-tube	04	/	/	/											
	[redacted]	To remain at 100cc/o	08	/	/	/											
	------	flush w/ 100cc H_2O	12	/	/	/											
	------	Q 4°	16	/	/	/											
	------		20	/	/												
	------		24	/	/												

ALLERGIES: ☐ YES ☑ NO — NKDA

PRIMARY DIAGNOSIS: Cont. Guarded S/P EXP LAP 14 JUNE S/P EXP. LAP Trach/J tube placement

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

PATIENT IDENTIFICATION: EPW [redacted] b6-4

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

b6-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 6 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6/11/03	[redacted]	Give ~~last~~ in 40 mEq KCl IV over 2° X1 now	6/11/03	1245	1245	[redacted]
6/11/03	[redacted]	Vecuronium 0.1 mg/Kg Bolus	6/11/03	0001	0001	[redacted]
6/11/03	[redacted]	Lasix 20mg IVP X1	6/11/03	0137	0137	[redacted]
6/13/03	[redacted]	IV Bolus 1Ltr LR Now	6/13/03	0100	0100	[redacted]
6/13/03	[redacted]	Lasix 40mg IVP x1	6/13/03	1900	1900	[redacted]
14 June 03	[redacted]	Albumin 25% 100cc/1L LR				
		to infuse over 30 minutes				
16 June 03	[redacted]	Bolus IV 1Ltr LR	6/14/02	1842	1842	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
13/Jun	[redacted]	[redacted] / Neb	
		0.5cc/2.5cc	
		NS PRN Q4	
		SEE ORDER ON FRONT	

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. JUN Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 14	15	16	17	18
14JUN	[redacted]	IVF LR TKA 150 cc/HR	05		[redacted]			
~~14JUN~~	[redacted]	~~IV NTS 40 50cc/hr~~	~~15~~		[redacted]			
			19					
14JUN	[redacted]	Morphine Drip Titrate to	05		[redacted]			
		Effect	17		[redacted]			
~~14JUN~~	[redacted]	~~Versed Drip Titrate~~	~~05~~		[redacted]			
		~~To Effect~~	~~17~~		[redacted]			
14JUN	[redacted]	Dopamine DRIP 3mcg	05		[redacted]			
		/Kg/MIN. Titrate	17		[redacted]			
		To Keep MAP ≥ 70						
14JUN	[redacted]	ZOSYN 3.375 grams	04					
		IVPB q6°	10					
			16					
			22					
14JUN	[redacted]	CiproFLoxacin 400 mg	03					
		IVPB Q12°	15	[redacted]				
14JUN	[redacted]	VancoMycin 1 gram	10					
		IV Q12°	22	[redacted]				
14JUN	[redacted]	ZANTAC 50 mg IV	06					
		q8°	14					
			22	[redacted]				

ALLERGIES: ☐ YES ☒ NO — NKDA

PRIMARY DIAGNOSIS: Dx S/P Exp-LAP/ Placement J tube/Trach

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO — PAGE NO. 1

PATIENT IDENTIFICATION: [redacted] b6-4

EPW

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

b6-2

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
14JUN	[redacted]	Albuterol NeB 0.5cc/2.5cc NOW	14JUN	NOW		[redacted]
14JUN	[redacted]	LASIX 40 mg IVP	14JUN	NOW		[redacted]
14JUN	[redacted]	BOlus IV 1 Liter LR	14JUN	NOW		[redacted]
14JUN	[redacted]	LASIX 80mg IVP	14JUN	2140 14JUN	2140	[redacted]
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					
	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
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USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 14	15	16	17	18
14JUN	[redacted]	Vecuronium gtt titrate	05	[redacted]				
		to 2/4 Twitches	17	[redacted]				
14 JUN	[redacted]	Albuterol Nebs	04	[redacted]				
		0.5cc/2.5cc NS	08	[redacted]				
		Q4°	12	[redacted]				
			18	[redacted]				
			20	[redacted]				
			22	[redacted]				
14JUN	[redacted]	Heparin 5000 units	10	[redacted]				
		SQ BID	22	[redacted]				
14JUN	[redacted]	ZOSYN Δ18 to 2.25grams	04	[redacted]				
		IVPB Q6°	10	[redacted]				
			16	[redacted]				
			22	[redacted]				
14JUN	[redacted]	Cipro 400 mg 24°	15	[redacted]				
14JUN	[redacted]	ZANTAC 50mg IVPB	06	[redacted]				
		Q24°						
14JUN	[redacted]	VANCOMYCIN 1 gram	22	[redacted]				
		IVPB QOD						

b6-2

ALLERGIES: ☐ YES ☒ NO

NKDA

PRIMARY DIAGNOSIS: DX S/P Exp Lap/Placement J-Tube/Trach

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. 2

PATIENT IDENTIFICATION:

[redacted]

b6-4

EPW

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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. Jun Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15	16	17	18
15 Jun 03	[redacted]	Nitrovan gtt titrate to effect	05	[redacted]			
			17				
16 Jun 03	[redacted]	Lasix gtt - 20mg hour	05	/	[redacted]		
			17	/			
16 Jun 03	[redacted]	Lasix gtt to 20mg/hr	05	/	[redacted]		
			17	/			
16 Jun 03	[redacted]	↓ IMDF to 50cc/hr	05	/	[redacted]		
17 Jun 03	[redacted]	25cc/hr	17	/			
		~~Propofol gtt 100mg~~					
16 Jun 03	[redacted]	Vecuronium gtt	05	/	[redacted]		
		tit between 2-4	17	/			
		twitches					
16 Jun 03	[redacted]	Diprivan gtt	05	/	[redacted]		
		start @ 20mcg/	17	/			
		kg/min titrate					
		to effect					
17 Jun 03	[redacted]	MAX Conc all gtts	05	/	/	/	[redacted]
		+ IVPB's	17	/	/		
18 Jun 03	[redacted]	Lasix gtt to	05	/	/	/	[redacted]
		160mg/hr	17	/	/	/	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: DX

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. 3

PATIENT IDENTIFICATION:

#[redacted] 66-4 EPW

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

MEDCOM - 9684

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
6/16/03	[redacted]	Lasix 160 mg IVP Now	6/16/03	0244	0244	[redacted]
	- - - - -					
	- - - - -					
	- - - - -					
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	- - - - -					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
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USAPA V1.00

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1145 INITIALS [redacted]	66-2 INITIALS	1700 INITIALS DEI
NEURO	PUPILS	Pinpointed & Fixed		2mm, fixed, ØRXN to
	SENSORIUM	withdrals to		light
		painful stimuli only		Sedated c̄ Versed @ 3mg/hr -
				W/D to painful stimuli only,
				Decort post noted intermittently
RESPIRATORY	RESPIRATORY PATTERN	Ventilated SMV 14	TV 700 peep 5, FIO2 @ 40%	SIMV 14, VT 700,
	BREATH SOUNDS	course Rhonchi	throught	Pp5, FiO2 - 40%
	SECRETIONS	(+) thick white.		Clear c̄ slight rales to
			7.5 ETT @ 26 @ lips	upper lobes
				(+) white - mod amt
				mod thick
SKIN	COLOR	NTR		NFR
	INTEGRITY	Intact		CDI, Bloody Drng Rt ear
		Bleeding noted from (R) ear		otherwise intact
IV SITE	LOCATION	(L) AC 18g & (R) Hand 18g		(L) AC 20G - (R) WR 18G
	CONDITION	patent Ø SS of infection		(R) Rad A-line -
				leveled & rezeroed.
				IVs patent SS of
				infection - NS @
				133/hr via PIV
GASTRO	ABDOMEN	Soft		Soft, NT, ND
	BOWEL SOUNDS	(+) BS x4		(+) BS x4
				OGT → LIWS c̄ low amt
GU	URINE:	Clear yellow		Green, Biliary Drng
	COLOR/CLARITY			Clear Amber urine s
				Sediment - UOP ↓
				bolus 1L NS per of [redacted]
CARDIOVASCULAR	CARDIAC RHYTHM	SB 80		SB → NSR, 3 ectopy.
		Ø ectopy noted		(+) 2 Pulses x4, S1 S2

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] b6-2

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 16 MAY 03

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

CIV # [redacted] b6-4

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

DATE | DX | HOSPITAL DAY | PAGE 2

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07	/	08	09	10	11	12	13	14	15	/
	BP Arterial Line	[illegible]																	
	BP Cuff	141/41												141/41	147/74	[illegible]/84	148/76	143/76	
	Temperature	99'												99'					
	Pulse	80												80	53	67	55	53	
	Respiratory Rate	14												14	14	14	14	14	
	SPO_2	99%												99°	100°	100°	100°	100°	
	Source	vent												vent	vent	vent	vent	vent	
	pain																		
	intuition																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
	NS																500	125	626
	IVPB (FLUSH)																3	3	6
	Bolus																		
	TOTALS																		

b6-2 [redacted]

OUTPUT																			
URINE	HOUR / TOTAL	/	/	/	/	/	/	/	/		/	/	/	/	100/100	30/130	30/160	30/190	
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	CSF	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	3	7	10
TOTALS																			

[redacted]

b6-2

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	178/80	188/79	199/80	192/83	149/77	148/77	196/73		
				153/79					
		99.1 (ABD)						99.3	
	52	66	62	56	52	105	53	52	
	14	14	14	14	14	24	14	14	
	100%	100%	100%	100%	97	97	100	100	
	vent	Vent	Vent	Vent	Vent	Vent	Vent	Vent	
	ICP	10	9	6	7	6	6	7	

INTAKE	16	17	18	19	20	21	22	23	8° T
		125	125	175	175	175	175	175	1125
	3	3	3	3	3	3	3	3	21
		1000							1000
								2246	

OUTPUT									
	30/220		70/290	25/315	40/355	35/390	40/430	40/470	470
							220/220		220
	5		30	13	6/64	36/100	5/105	0/105	105

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME	1300	1700	2100
	MODE	SIMV	SIMV	SIMV
	F_iO_2	40%	40%	40%
	TV	700	700	700
	RATE	14	14	14
	PEEP	5	5	5
ABG	pH	7.45		
	PCO_2	33.9		
	pO_2	175		
	HCO_3	24		
	SAT	100%		
	BASE			

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

ACTIVITIES OF DAILY LIVING	TIME		1700	
	MOUTH CARE		✓	
	BATH			
	SKIN CARE			
	FOLEY CARE	✓		
	TRACH CARE			
	ROM EXERCISES			

TURN	TIME				
SUCTION					

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	2246	Urine:	470
PO	631		325
TOTAL	2877	TOTAL	755

BALANCE 22

106-2

NURSE'S SIGNATURE [redacted] INITIALS [redacted]

NEUROLOGICAL ASSESSMENT

		HOURS	13	17
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		✓ T
	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
		REACTION	–	Fx
	LEFT	SIZE	2	2
		REACTION	–	Fx
PUPIL SCALE			● 2	● 3 ● 4 ● 5 ● 6 ● 7 mm
ICP				8
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			
Radial	R	#	#
	L	#	#
Redial	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

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1715	INITIALS [redacted]	b6-2	INITIALS		INITIALS
NEURO	PUPILS	PINPOINT (B)					
	SENSORIUM	RESPONDING TO NOXIOUS					
		STIMULI.					
RESPIRATORY	RESPIRATORY PATTERN	EVEN & UNLABORED					
	BREATH SOUNDS	CTA (B) ∑ VENT NO.56					
	SECRETIONS	↓ (B) RALES - SCANT					
		CLEAR SECRETIONS					
		ET 7.5 26@LIP					
SKIN	COLOR	WNL FOR RACE					
	INTEGRITY	Ø S/S BREAKDOWN					
I.V. SITE	LOCATION	(R) RADIAL A-LINE					
	CONDITION	(L) PIV S/L AC					
		(R) FA PIV - NS@1(Pxl)					
		- MSO4@ 4mg/hr					
		- VASODA Fx/in					
GASTRO	ABDOMEN	FIRM, NT [redacted]					
	BOWEL SOUNDS	BS ABSENT					
GU	URINE:	FOLEY DRAINING AMBER					
	COLOR/CLARITY	CLEAR URINE					
CARDIOVASCULAR	CARDIAC RHYTHM	SR/ST Ø ECTOPY					
		Ø JVD. Ø EDEMA					

LEGEND

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

[redacted] b6-2

(Continue on reverse)

PREP[redacted] AN

DEPARTMENT/SERVICE/CLINIC: ICU ~~2 cont~~

DATE: 17 MAY 03

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

Iraqi Civilian b6-4

[redacted]

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

[redacted] 66-4

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	134/77	188/82	162/81	167/84	182/92	158/94	188/84	187/86		155/83	166/86	148/81	150/82	121/77	86/59	85/58	90/62	
BP Cuff	145/74	152/78	143/80	157/76	153/76	146/79	135/72	144/80		149/78	144/81	134/77		131/73	103/62		111/68	
Temperature		97.9 (ax)					99.3 ax				101.4		102.4	103.1	103.5	102.7		
Pulse	52	59	107	66	83	71	76	81	113	113	110	120	124	143	148	144	144	
Respiratory Rate	14	14	26	25	28	26	49	47	16	16	14	14	14	14	19	19	14	
SPO_2	100	100	100	100	100	100	100	100	98	98	98	98	98	98	97	97	98	
Vent/Y or N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
F_iO_2	40%	40%	40%	40%	40%	40%	40%	40%	50%	50%	50	50	50	50	50	50	50	
ICP	8	9	9	6	8	9	10	12	12	12	12	14	14	14	14	14	12	

pain
intervention

INTAKE

TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
9NSC 125/hr	175	175	175	175	175	175	125	125		125	125	125	125	125	125	125	125	
Versed	3	3	3	3	3	3	3	3		5	5	5	5	5	5	5	5	
IVP												50						
Bolus															500	500		
MS4										4	4	4	4	4	4	4	4	

TOTALS

OUTPUT

URINE	HOUR	58	80	80	70	80	90	80	70		150	160	180	60	60	60	50	30
	TOTAL	58	138	218	288	368	658	738	808									
	sp gr																	
	S/A																	
NG	OUTPUT	200			180				300					100/400				
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS	Ventric	33/33	6/39	18/57	12/69	27/96	22/118	16/134	16/150		10/160	11/171	13/184	19/193	25	24	21	20/175
								16	32		42	53	66	85	110	134	155	175

TOTALS

Total 12° shift

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
		140/75	149/76	150/76	158/77	169/79	145/75	139/72	
	101.5 (oc)	99.9							
		121	120	121	119	128	125	125	
		20	18	20	25	22	14	14	
		97	97	100	100	100	99	99	
		Y	Y	Y	Y	Y	Y	Y	
		50	50	45	45	45	45	45	
		11	12	11	12	13	13	12	

INTAKE	16	17	18	19	20	21	22	23	8° T
	125/1375	125/1500	100/1600	100/1700	100/1800	100/1900	100/2000	100/2100	2100
	5/51	5/56	8/64	8/72	8/80	8/88	8/96	8/104	104
		50					50		100
		1000							1000
	4	4/40	4/44	4/48	4/52	4/56	4/60	4/64	64
									3368

OUTPUT									
Urine	30	35/865	100/965	50/1015	150/1165	150/1315	150/1465	200/1665	1665
									600
OC	100/500	100/600							
Drain	13/187	13/200	25/225						225
									2490

300

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME	0700	1500
		MODE	Stem	SIMV
		F_iO_2	40	50
		TV	700	700
		RATE	14	14
		PEEP	5	5
A		pH 1015	7.437	
		PCO_2	36.4	
		pO_2	112	
B		HCO_3	24	
		SAT	98	
G		BASE	∅	

LABORATORY DATA	TIME	0830
	GLUCOSE	
	Na/K	139/3.6
	Cl/CO_2	105
	BUN/Cr	8/1.0
	WBC/PLATELET	6.9/223
	Hct/Hgb	37.1/11.5

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

TURN	TIME			
SUCTION				

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	3368	Urine:	1665
po		OC	600
		CF	225
TOTAL	3368	TOTAL	2490

BALANCE +878

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]
1062	

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
Radial	R L	
Pedal	R L	
	R L	
	R L	
	R L	

LEGEND

++ Normal
+ Weak
- Absent
D Doppler
R Right
L Left

5/29/03

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 b62

INITIAL SHIFT ASSESSMENT

	TIME	1400	INITIALS [redacted]	b6-2	INITIALS	1732 5/29/03	INITIALS [redacted]
NEURO	PUPILS	SEDATED				2mm bilat c̄ sluggish rxn to light; sedated on versed gtt	
	SENSORIUM	VERBAL HTN.				MAE spont.; bilat leather	
		but easily aroused				restraints to wrist d/t EPW	
						status	
RESPIRATORY	RESPIRATORY PATTERN	Mech vent Support				even unlabored	
	BREATH SOUNDS	Sarov 12, Peep 5 FIO2 60%				clear bilat; sats >95%	
	SECRETIONS	VT 800 Lungs course Sat				Ø noted	
		100% ↑ of Secretions.				#8 ETT, 30cm @ lip/tube block, settings	
		Size 8 ETT 23cm @ lip.				as follows: SIMV 14, TV 800, 5 PEEP	
						FIO2 50%; pt overbreathing vent	
SKIN	COLOR	normal for race				Normal for race	
	INTEGRITY	Bulky dsg (L) shoulder, midline				pt c̄ low temp; blankets added	
		Abd incom dsg. (R) line 2x2 dsg.				See progress note re: dsgs	
IV SITE	LOCATION	(L) IJ HL (R) FA HL (R) AC HL				(R) EJ, (L) PIV, (R) PIV, (R) rad Aline	
	CONDITION	(L) R. Aline DXT					
GASTRO	ABDOMEN	large Hyporactive				large, soft, ND	
	BOWEL SOUNDS	Hyporactive				hypoactive BS x4	
						NGT in (R) nare to LWS; small	
GU	URINE:	Clear yellow via foley				and bloody drainage in tubing	
	COLOR/CLARITY	Clear — yellow				foley to gravity draining clear	
						yellow urine	
CARDIOVASCULAR	CARDIAC RHYTHM	SR-Low ST low 100s. Pulses				ST in low 100s – 120s	
		3+ Bilat UE 2+ Bilat LE				1+ pulses in all extremities	
		Slow Cap to torso T-max				BP stable	
		96.8.					

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

PREPARED BY [redacted] b6-2

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 5/29/03

PATIENT'S IDENTIFICATION (Type or print clearly. Include at least three identifiers, if available, such as: Name—last, first, middle; grade; date; hospital or medical facility)

EPW # [redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 5/29/03 | DX | HOSPITAL DAY 1

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07	/	08	09	10	11	12	13	14	15	/
	BP Arterial Line																		
	BP Cuff																137/98	126/87	
	Temperature																96		
	Pulse																85	95	
	Respiratory Rate																33	36	
	Source																vent	vent	
	FiO_2																60	60	
	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															OR 6000	6000 0.125	125 625	
	VERSED																3/3	3/6	
	Gentamycin																		
	TOTALS																		

OUTPUT																			
Ebo URINE EBOL	HOUR / TOTAL	/	/	/	/	/	/	/	/		/	/	/	/	/	900 OR 800	/	/	
	sp gr															900 OR 800			
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY DOS

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	16	17	18	19	20	21	22	23	
		129/90	139/90	140/94	115/73	124/79	109/72	113/78	
	104/71	/	/	/	/	/	/	/	
		94[8]			96[9]				
	96	105	110	116	122	126	123	129	
	17		19	18	24	14	23	22	
	vent	98%	100%	98%	97%	98%	98%		
	50	vent 50%	vent 50%	vent 50%	vent 50%	50% Vent	50% vent	50% vent	

INTAKE	16	17	18	19	20	21	22	23	8° T
	125 / 6375	125	125	125	125	125	125	125	1000
	14/10	4	6	8	8	8	8	8	54
	100								100
BX		50							50
prop				12	24	24	24	24	108
									1312

OUTPUT									
	800/1700	/	125/185	/	125/208	/	125/2175	/	2175

RESPIRATORY DATA										
	TIME	1615	1700	2000						
	MODE	SIMV	SIMV	SIMV						
	F_IO_2	50	50%	50%						
	TV	800	800	800						
	RATE	14	14	14						
	PEEP	5	5	5						
A	pH	7.212		7.293						
A	PCO_2	36.1		33.5						
A	pO_2	169		154						
B	HCO_3	15		16						
B	SAT	99		99%						
G	BASE	-13		-10						

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

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

24° I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE		OUTPUT
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE

NURSE'S SIGNAT[redacted] INITIALS

[redacted]

66-2)

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

b6-2

INITIAL SHIFT ASSESSMENT

	TIME	[redacted]	b6-2	1810 5/30/03
	INITIALS	[redacted]	INITIALS	INITIALS [redacted]
NEURO	PUPILS	Dim pin point sluggish		pinpoint bilat c̄ sluggish
	SENSORIUM	sedated & intubated		rxn to light
		respond to stimuli		remains sedated on versed
				bilat leather wrist restraints
RESPIRATORY	RESPIRATORY PATTERN	Ventilated		
	BREATH SOUNDS	Course Rhonchi ↑		even, unlabored
	SECRETIONS	↓ lowees		CTA bilat
		clear oral secretions		clear oral secretions
		c̄ suction		#8 ETT, 30cm @ bite block
				SIMV 14, PEEP 5, TV 800
SKIN	COLOR	Normal to Race		FIO2 50% ; sats >95%
	INTEGRITY			WNL for race
				see progress note
IV SITE	LOCATION	(R) FA		
	CONDITION	(R) GJ C/D/I		(L) FA, (R) FA, (R) rad Aline
		(L) FA Ø SS infection		
GASTRO	ABDOMEN	Obese soft		
	BOWEL SOUNDS	Bowel sound absent		large soft, NT
		x4		absent BS in all quad.
				NG to LWS (R) nare
GU	URINE:	Foley c̄ carrot		dark bile colored drainage
	COLOR/CLARITY	color urine		foley to gravity c̄ small amt
				of pinkish/orange urine
CARDIOVASCULAR	CARDIAC RHYTHM	ST, Ø ectopy		
		noted		ST 140s, BP stable
		intact pulses x4		1+ pulses bilat

LEGEND

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC ICU 2 unit

DATE 30MAY03

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

EPW # [redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 5/30/03 | DX | HOSPITAL DAY 2

VITAL SIGNS	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line	114/74	113/72	111/72	105/68	97/66	93/60	98/62			133/76	111/66	132/76	123/71	122/77	126/80	106/71	98/62	
BP Cuff																		
Temperature	98						100.4					100.8				102.2		
Pulse	128	128	128	128	127	129	130			129	135	137	139	153	149	148	152	
Respiratory Rate	20	21	19	23	22	21	34			20	16	16	16	16	22	20	18	
O_2 Sats	98%	100%		98%						97%		96%		98%		97%		
O_2 Source	vent 50%	vent 50%	vent 50%	vent 50%	vent 50%	vent 50%	vent 50%			vent	vent	vent	vent	vent	vent	vent	vent	
pain intervention																		

INTAKE	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
MIVF	125	125	125	125	125	125	125	500		175	175	175	175	150	150	150	150	
IVPB	150									150							100	
Versed	8	8	8	8	8	4	3	2		2	3	3	3	3	3	3	4	
Propofol	24	24	24	24	20	9	6	9		9	DC							
Dopamine																		
Bolus																		
PO																		
TOTALS																		

OUTPUT		24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
URINE	HOUR	200		100		100					140	100	60	40	50	50	50	40	
	TOTAL	200		300		400					540	640	700	740	790	840	890	930	
	30 gr																		
	S/A																		
NG	OUTPUT					100					185								
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY 1

VITAL SIGNS	16	17	18	19	20	21	22	23	
	85/51	96/55	107/69	126/72	115/48	90/53	127/69	92/68	
		101							
	146	144	141	136	143	144	142	149	
	14	14	14	14	15	14	14	18	
			97%				96%		
	Vent	Vent	Vent 50%	Vent 50%	Vent 50%	Vent 50%	Vent 50%	50% Vent	

INTAKE	16	17	18	19	20	21	22	23	8° T
	150	150	150	150	175	175	175	175	1300
	50	50							
	4	4	4	4	4	4	4	4	20
						6	6	6	18
					5.6	5.6	5.6	5.6	22.4
				500					500
									1860

OUTPUT									
	30/90	0/90	20/90	30/1010	50/1060	25/1085	150/1235	125/1360	1360
		100							100
									1460

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	1700	2000	2200						
	MODE	SIMV	SIMV	SIMV						
	F_IO_2	50%	50%	50%						
	TV	800	800	800						
	RATE	14	14	14						
	PEEP	5	5	5						
ARTERIAL BLOOD GAS	A: pH									
	A: PCO_2									
	A: pO_2									
	B: HCO_3									
	SAT									
	G: BASE									

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

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

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]

NEUROLOGICAL ASSESSMENT

		HOURS	06
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
		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		
Pedal	R	+
	L	+
Radial	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

OTSG APPROVED (Date)
QA Appr 8 Mar 89 b6-2

INITIAL SHIFT ASSESSMENT

NEURO	TIME	31 May 03	INITIALS [redacted]	b6-2	INITIALS	1729 5/31/03 INITIALS [redacted]
	PUPILS	2mm pinpoint				2mm pinpoint
	SENSORIUM	sedated + intubated				sedated on Propofol gtt
		pt in restraints				not currently c̄ any
						spont. movement
						MSO4 for pain control
RESPIRATORY	RESPIRATORY PATTERN	unlabored, ventilated				even unlabored
	BREATH SOUNDS	CTA bilat				CTA bilat
	SECRETIONS	clear oral secretions				Ø noted
						#8ETT, 30cm @ bite block
						~~SIMV~~ A/C 14, TV 800, PEEP 5,
						FIO_2 50%, sats 94-95%
SKIN	COLOR	NL to race				WNL for race
	INTEGRITY					see progress note
IV SITE	LOCATION	(L) AC				(R) FA, (L) EJ
	CONDITION	(L) wrist				(R) rad. Aline
		(R) wrist (Radial art line)				
GASTRO	ABDOMEN	soft NT ABD dressing				large, ND, soft
	BOWEL SOUNDS	CDI				absent
		very hypoactive				NG to LIWS (R) nare c̄ small
						amt drainage
GU	URINE:	Foley - slightly orange				foley to gravity draining
	COLOR/CLARITY	in color draining to				clear yellow urine
		bag				
CARDIOVASCULAR	CARDIAC RHYTHM	ST Δ Ectopy				ST 120-140s
						stable BP
						afebrile
						1+ pulses

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU Quest

DATE: 31MAY03

PATIENT'S IDENTIFICAT[redacted] typed or written entries give: Name—last, first, middle; grade; da[redacted]spital or medical facility)

EPW# [redacted] b6-4

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

DATE 31 May 03 | DX | 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	124/67	100/57	116/62	96/63	134/60	109/67	97/63			92/77	96/72	90/76				133/82	126/80	
	BP Cuff										/	/	/				/		
	Temperature	101.4				102°		101°			/	/	/				98.8	/	
	Pulse	150	152	147	149	154	156				129	128	132				119	112	
	Respiratory Rate	15	27	27	34	31	33	36			16	17	14				25	14	
	O_2 sats	97%	98%	98%	96%	94%		95%			94%	96%	94%				94%	94%	
	O_2 source	vent 50%	vent 50%	vent 50%	vent 50%	vent 50%	vent 50%	vent 50%			vent 50%	/	/				vent 50%	vent 50%	
	open intubation																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	MIVF	175	175	175	175	175	175	175	175		175	175	175						
	IVPB	150						–			150							100	
	versed	off	—					off	—		—								
	propofol	6	6	6	8	10	10	10	10		10	10					9cc	9cc	
	dopamine	5.6	5.6	5.6	5.6	5.6	5.6	5.6	5.6		5.6	5.6	5.6			off	off	off	
	PO							—			—								
	TOTALS																		

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	URINE		125 / 125	100 / 225	100 / 325	300 / 625	300 / 925	X	250 / 1175			300 / 1475		200 / 1675					450	
		sp gr																		
		S/A																		
	NG	OUTPUT					100													
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS	JP																30		
	TOTALS																			

POST-OP DAY 2

VITAL SIGNS	16	17	18	19	20	21	22	23	
	118/46	102/45	127/68	124/58	128/105	85/53	83/52	92/60	
	98.4				102°		100.7		
	130	134	123	134	129	131	128	121	
	13	14	14	14	14	14	14	14	
	93%	94%			95%	95%	94%	95%	

INTAKE	16	17	18	19	20	21	22	23	8° T
		175	175	175	175	175	175	175	1225
	150								
	9cc	9	9	9	9	9	9	11	74
									1299

OUTPUT									
		550/260		325/300		275/325		125/310	3410
	75								75
JP					30				30
									3505

ACUITY LEVEL CLASSIFICATION

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

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

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

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
PO			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]
[redacted]	
66-20	

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 b6-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1 Jun	INITIALS [redacted]	1700	INITIALS [redacted]		INITIALS
NEURO	PUPILS	2mm pinpoint					
	SENSORIUM	sedated, on vent		sedated, moving head side to side			
RESPIRATORY	RESPIRATORY PATTERN	even, unlabored		even unlabored			
	BREATH SOUNDS	CTA		ronchi in upper lobes			
	SECRETIONS	clear secretions noted #8 ETT, 30cm @ lips bilat TV 800, PEEP 5, FIO2 50%		bilat, diminished in lower lobes FM @ 10L			
SKIN	COLOR	WNL for race		N&R			
	INTEGRITY	bulk dsg to (L) shoulder - abd dsg to abd, dsg to (R) hip		dressing to L shoulder, abd and right hip c/d/i			
IV SITE	LOCATION	(R) Arm, (R) forearm. (D) ET		R Arm, R forearm, LR@ 175cc/hr L EJ sclero lobe sites c/d/i, no s/s infection			
	CONDITION	intact, patent					
GASTRO	ABDOMEN	obese, NT, soft		round, NT, soft			
	BOWEL SOUNDS	hyperactive		absent			
		NG to intermittent suction		NG to LIS			
GU	URINE:	Foley to gravity		Foley to gravity			
	COLOR/CLARITY	dark yellow		yellow			
CARDIOVASCULAR	CARDIAC RHYTHM	ST 130-140's stable BP		S.S. HR 120's - 130's +2 pulses radial & pedal <3 sec cap refill. No edema noted			

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC ICU 2 west

DATE 1 JUN 03

PATIENT'S IDENTIFICA[redacted] For typed or written entries give: Name—last, first, middle; grade; d[redacted]ospital or medical facility)

EPW [redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 6/1/03 DX

HOSPITAL DAY

VITAL SIGNS	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line	165/83	108/58	149/80	119/59	114/65	175/75	119/49	140/49										
BP Cuff										124/64	137/68	106/67	109/64	117/72	104/68		110/67	
Temperature							100.8										100.7	
Pulse	131	121	119	121	112	144	136			127	125	/	140	148	145		133	
Respiratory Rate	32	14	14		14	30	14	14		14	15	24	13	23	29		16	
O_2 sats	94%		94%		94%	93%	99%	98%		96%	/	99%	98%	98%	98%		96%	
O_2 Source	vent 50%	vent 50%	vent 50%	vent 50%	vent 50%	vent 50%	vent 50%	vent 50%		vent 50%	/	vent 50%	T Piece	T Piece	T Piece		[illegible]	
													C 20L O_2 100%	C 10L O_2 50%	C 8L O_2 40%		10L	
pain intensity																		

INTAKE	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	175	175	175	175	175	175	175	175		175	175	175	175	175	175	175	175	
IVPB	150									100							100	
Propofol	11	11	11	11	11	15	15	15		20	18	9	off					
TOTALS																		

OUTPUT																		
URINE	HOUR		275		425		450					700					650	
	TOTAL		275		700		150					1350					1500	
	sp gr																	
	S/A																	
NG	OUTPUT				200													
	pH													500				
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS	JP	30			10						10					10		
TOTALS																		

POST-OP DAY 3/1

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	16	17	18	19	20	21	22	23	
	134/71	102/70	140/73	140/68	134/71	132/71	145/75	148/77	
					~~101.7~~				
					101.7			101.1	
	133	131	150	144	139	156	135	129	
	22	19	22	31	31	22	31	32	
	96%	97	82	96	99	97	97	98	
	FM	FM	PRB		PRB	PRB	PRB	PRB	
	10L	10L	10		10L	10L	10L	10L	
			(Bung Suctioned)						

INTAKE	16	17	18	19	20	21	22	23	8° T
	175	175	175	175	175	175	175	175	
	100								

OUTPUT									
	300 / 2500	225	225	125	125	100	325	325	
								40	

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

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

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

TURN	TIME				

SUCTION					

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]
[redacted]	[redacted]
66-2	

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	2 June	INITIALS [redacted]	b6-2	INITIALS	2 June	INITIALS [redacted] b62
NEURO	PUPILS	3mm pinpoint				1700 - 3mm - pupils	
	SENSORIUM	moving head from side to side; opens eyes.				@ reactive to light or accomadation, Pt. not cognitive, moves from side to side, moans	
RESPIRATORY	RESPIRATORY PATTERN	unlabored				unlabored, bilateral	
	BREATH SOUNDS	rhoch, course				rhonch, tan +	
	SECRETIONS	clear secretions. NG tube in place to Int suction				brownish secretions. NG tube in place c̄ intermittent suction.	
SKIN	COLOR	NL for color				normal for race.	
	INTEGRITY	drsg in place to (L) shoulder ML abd + (R) hip				DRSG in place to (L) shoulder, ABD-midline, (R) hip	
IV SITE	LOCATION	in (L) forearm. A-Line				(L) forearm - A line (R)	
	CONDITION	in (R) wrist. and (L) EJ all patent + intact				wrist ~~and~~ all patent	
GASTRO	ABDOMEN	Soft NT				Soft NT, ND	
	BOWEL SOUNDS	hypoactive				hypoactive BSX 4 quads	
GU	URINE: COLOR/CLARITY	foley to gravity dark urine draining to bag.				foley to gravity dark red urine draining to bag	
CARDIOVASCULAR	CARDIAC RHYTHM	Ø ectopy				S1, S2, slightly tachy 110-120's	

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 2 east

DATE: 2 June 03

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

EPW
[redacted] b6-4

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

MEDCOM - 9707

AMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

#[redacted] 66-4

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	162/84	150/88	116/71	120/72	146/75	143/70	151/86	130/78		115/69	143/91	122/72			182/84			
BP Cuff																		
Temperature	98.8														99.2			
Pulse	128	126	127	126	128	128	129	127		121	131	123			131			
Respiratory Rate	33	32	28	29	40	35	33	28							34			
S_pO_2	96	98	99	97	96	96	97%	99%		99%	94%	99%			96%			
O_2 Method	10L	10L	10L	10L	10L	10L	10L	10L		10L	10L	10L			15L			
	PRB	PRB	PRB	PRB	PRB	PRB	RB	RB		RB	RB	RB			Vent Mask			
pain												Blood transfusion Completed						
intervention																		

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IV LR	175	175	175	175	175	175	175	175	1400	150	150	150	150	150	150	150	150	1200
IV Meds	150																100	
TOTALS																		

OUTPUT

URINE	HOUR / TOTAL	250	250	210	210	100		400		1420		750		1000	1000		900	400	4050
	sp gr																		
	S/A																		
NG	OUTPUT						450									100			
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP				40														
	~~[illegible]~~																		
TOTALS																			

POST-OP DAY

VITAL SIGNS	14	17	18	19	20	21	22	23	
	144/85	177/92	86/52	185/102	154/88	148/89		140/79	
				101.5	100.8	98			
	128	126	125	128	128	120		107	
	38	52	42	27	29	31		36	
	97%	97%	98	98	98	98		98	
	15L	15L	15L	15L	15L	8L		8L	
	venimask	venimask	venimask	venimask	venimask	venimask		venimask	

INTAKE	16	17	18	19	20	21	22	23	8°T
	150	150	15	150	150	150	150	150	1800
	100								

OUTPUT									
		625			600			350	1575
					500				
	20								

ACUITY LEVEL CLASSIFICATION

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

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

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

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE		OUTPUT
IV	4150	Urine:	7045
po			1110
TOTAL		TOTAL	8155

BALANCE ~~-2095~~ -4005

NURSE'S SIGNATURE	INITIALS
[redacted]	
66-2	

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 / bb-2 /

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	3 June	INITIALS [redacted]	Ø3 June	INITIALS [redacted]		INITIALS
NEURO	PUPILS	3mm pinpoint		3mm pin point			
	SENSORIUM	pt moans. Ø follow commands		does it follow commands			
		moves head from side to		moves head side to side			
		side. Ø reactive to light		moans. Ø reaction to light			
RESPIRATORY	RESPIRATORY PATTERN	unlabored. ~~Rh~~		unlabored			
	BREATH SOUNDS	Rhonchi		~~Rhenchi to Upper lobes~~			
	SECRETIONS	clear suction.		~~L L dim~~ Rhonchi B.L			
				all lobes			
SKIN	COLOR	WNL for race		WNL			
	INTEGRITY	Bulky dressing to (L) should		Dressing to (L) shoulder			
		& (R) hip. staples intact to ML		abdomen. & (R) hip dry			
IV SITE	LOCATION	A-line in (L) wrist, periph		& intact. Staples to Abd			
	CONDITION	in (R) forearm and ET		intact Ø drainage.			
		line in (L) side.		A-line in (L) wrist - Periphe			
		all patent & intact. Ø S/SK		in (R) forearm. ET line in			
		of infection.		(L) side all patent Ø S/S			
				of infiltration.			
GASTRO	ABDOMEN	obese - NT, soft.		obese - NT soft			
	BOWEL SOUNDS	very hypoactive BS.		BS hypoactive			
GU	URINE:	draining quantity		quantity sufficient and			
	COLOR/CLARITY	sufficient amount dark		dark Amber in color.			
		in color.					
CARDIOVASCULAR	CARDIAC RHYTHM	$S_1 S_2$ Ø ectopy		NSR			

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

bb-2

(Continue on reverse)

PREPARED BY (Signature & Title)
[redacted] 91WM6

DEPARTMENT/SERVICE/CLINIC
ICU 2 east

DATE
3 June 03

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

EPW # [redacted] bb-4

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

MEDCOM - 9710

AMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

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	159/87	164/97	164/90	167/93	127/75	138/85	147/84			119/76	138/71		149/88		134/72		132/76	
BP Cuff																		
Temperature							97.6						98.4					
Pulse	172	124	120	115	112	107	114			109	115		117		121		120	
Respiratory Rate	33	23	35	40	22	31	28			34	28		34		35		37	
Sp O2	98	98	98	97	97	97	95%			99%	98%		98%		97%		97%	
	8L	8L	8L	8L	8L	8L	8L			8L	8L		8L		8L		8L	
	venimask	venimask	venimask	venimask	venimask	venimask	venimask			venimask	venimask		venimask		venimask		venimask	
pain																		
intervention																		

INTAKE																			
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
2V LR	150	150	150	150	150	150	150	150	1200	150	450	150	150	150	150	150	150	2400
2V meds	50	50								100							100	
Ensure TF										60			60	60	60	60		240
TOTALS																		

OUTPUT																			
URINE	HOUR						300												
	TOTAL								800	475/1275				425/1750				1750
	Sp gr																		
	S/A																		
NG	OUTPUT						100												
	Residual												<10			<10			
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP						30								10	JP taken out By [redacted]			
TOTALS																			

b6-2

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
		144/84	148/85	144/85	164/94	132/78	161/99	165/97	
						96			
		119	112	114	128	124	97	119	
		35	40	41	36	33	30	37	
		99%	99	99	97	97	96	97	
		8L	8L	8L	8L	8L	8L	8L	
		Vent mask	Vent mask	Vent mask	Vent mask	Vent mask	Vent mask	Vent mask	

INTAKE	16	17	18	19	20	21	22	23	8° T
	2400/150	2550/150	2700/150	150/2850	150/3000	150/3150	150/3300	150/3450	3450
	100								
		300/60			360/60			60/420	420

OUTPUT	16	17	18	19	20	21	22	23	
	500/850				500/250	200/250		500/345	345

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 bb-2 bb-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0510	INITIALS [redacted]	1700	INITIALS [redacted]	INITIALS
NEURO	PUPILS	pupils [illegible]		2ml. nonreactive to		light bilaterally.
	SENSORIUM	[illegible]		Pt. sedated.		
		& [illegible]		resting quietly.		
		[illegible]				
		[illegible]				
RESPIRATORY	RESPIRATORY PATTERN	[illegible]		unlabored, even		
	BREATH SOUNDS	[illegible]		bilaterally.		
	SECRETIONS	[illegible]		BS clear to.		
		[illegible]		aus. bilaterally.		tidal volume - 750ml
		[illegible]		ET #7 c̄ 24cm @		F1O2 - 50%
		[illegible]		bite block, vent settings - mode SIMV 16, peep 5		
SKIN	COLOR	skin [illegible]		Skin warm & dry, color		nml for race, (L) EJ c̄
	INTEGRITY	color [illegible]		25mm/hr LR, (R) cortis c̄ 75mm LR, (R) A line, staples		
		[illegible]		midline, 3rd spacing		noted.
IV SITE	LOCATION	(R) [illegible]		(L) EJ c̄ 25mm/hr LR (R)		
	CONDITION	[illegible]		cortis c̄ 75ml LR,		
		(L) EJ [illegible]		Dopamine, Fentanyl, versed		
		c̄ [illegible]		running thru (R) cortis, (R)		
		[illegible]		A line, All patent,		
				CDI		
GASTRO	ABDOMEN	ABD soft [illegible]		ABD Distended, Firm,		
	BOWEL SOUNDS	c̄ [illegible]		c̄ hypoactive BS.		
		[illegible]		NG tube in place,		
		secure.		(L) nare.		
GU	URINE:	F/C [illegible]		Foley cath. to gravity.		
	COLOR/CLARITY	c̄ [illegible]		Amber urine,		
		noted.		sufficient amt.		
CARDIOVASCULAR	CARDIAC RHYTHM	S-Tach, noted on		HR 120-135.		
		monitor. HR [illegible]		Sinus tachy, PVC's		
		c̄ occ. PVC's		noted,		
		noted. [illegible]				
		[illegible]				

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

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 4 Jun 03

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

EPW [redacted] bb-4

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

DATE 04 June 03 | 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	121/84	139/82	121/71	123/71	123/76	138/87	130/60	138/71		91/59	91/49	96/66	93/62	109/74	91/72	109/70	90/65
BP Cuff																	
Temperature		98.9 Axa					99.5			D2				99.1			
Pulse	98	121	123	107	113	119	126	199		157	148	158	128	109	134	132	129
Respiratory Rate	35	32	32	31	32	36	27	34		50	27	35	17	16	16	19	18
	8L ventimas	8L ventimas	8L ventimas	8L ventimas	8L ventimas	8L ventimas	8L										
SPaz	97	97	97	97	99	98	97	96		100	96	95	98	99	99	99	98
Mode										Vent							
FIO2								100		80	60	60	60	60	60	60	60
pain																	
intensition																	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IV LR	150	150	150	150	150	150	150	150	1200	100	100	100	100	100	100	100	100	800
IV Zantac	50											50						50
IV Unasyn	50											50						50
~~G TUBB~~										Bolus 500			Bolus 1000					1500
Ensure bolus					60												60	
Dopamine										56.3	56.3	56.3	56.3	56.3	56.3	56.3	56.3	448
Fentanyl										8	8	8	8	8	8	8	8	64
Versed										3	3	3	3	3	3	3	3	24
KT RUN											25	25	25	25				100
water flush																		
TOTALS																		2936

OUTPUT

URINE	HOUR / TOTAL	50/60	50/100		100/200		50/250		100/[illegible]	350				1300/130	200/1500		350/1750	100/1850	1850
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		1850

40 mg/kg/sx

40 mg/kg/sx

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	122/65	94/41	127/83 118/73	173/87	89/62	113/46	101/68	115/74	
					99%				
	145	132	137	158	126	129	130	130	
	31	30	35	24	33	18	22	25	
	99	96	97	100	98	100	100	99	
	100	60	50	50	50	50	50	50	

INTAKE	16	17	18	19	20	21	22	23	8° T
	100	100	100	100	100	100	100	100	800
	50								50
	50								50
	100			500		500			1100
			60			60			120
	56³	56³	56³	56³	45	75	56³	46 2	448.4
	8	8	8	8	8	8	8	8	64
	3	3	3	3	3	3	3	3	18
						56³			
			50			20			70
									2650

OUTPUT	16	17	18	19	20	21	22	23	
	100	75	200 375	200 575					575

Vomited Tylenol Given IV

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
	TIME	0700	1800							
	MODE	PC	SIMV							
	F_IO_2	60%	50%							
	TV	750	750							
	RATE	16	16							
	PEEP	5cm	5							
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										
	bb-2 TIME	NM	1300	0200						
	MOUTH CARE	[redacted]								
	BATH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN	TIME							
SUCTION								

24* I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday	wt Today	[redacted]	
INTAKE	OUTPUT	bb-2	
IV	Urine:		
po			
TOTAL 785	TOTAL 2775		
BALANCE 4410			

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 b6-2

INITIAL SHIFT ASSESSMENT

	TIME	0510	INITIALS [redacted]	b6-2	INITIALS	1700	INITIALS [redacted]
NEURO	PUPILS	Pupils 2-3mm sluggish				Pupils 2-3mm, non	
	SENSORIUM	Pt. light sedated				reactive to light. Pt.	
		on Versed drip				sedated on Versed,	
		Fentanyl. Pt. generally				Fentanyl.	
		calm.					
RESPIRATORY	RESPIRATORY PATTERN	RR unlabored, unlabored				RR increased due to	
	BREATH SOUNDS	LS @ ego w/ vent				RT suctioning. Versed	
	SECRETIONS	w/ [illegible]				was increased (boluses)	
		unlabored. Pt.				Pt. RR now even,	
		[illegible] @				unlabored. Vent settings:	
		[illegible]				SIMV, F_IO_2 65%, TV 750ml	
SKIN	COLOR	Pt. pink, [illegible]				Rate 14 BPM, peep 5.	
	INTEGRITY	on bed, skin HEX				Skin warm & dry, small	
		[illegible]				breakdown noted on sacrum area.	
IV SITE	LOCATION	R SC, [illegible]				R SC cortids & MIVF @	
	CONDITION	MIVF @ [illegible]				100 cc/hr. Fentanyl 8ml/hr.	
		[illegible]				@ FJ & MIVF @ 25cc	
		[illegible]				A line hooked to pressure	
		[illegible]				bag, peripheral R forearm	
		[illegible]				& hooked all patent &	
		[illegible]				S/S inf/infiltration.	
GASTRO	ABDOMEN	[illegible]				Firm, distended;	
	BOWEL SOUNDS	[illegible]				BS hypoactive x4 quad.	
		[illegible]				DRSG to R hip - CDI,	
		[illegible]				NG tube to R nare,	
GU	URINE:	[illegible]				LTS, O brownish tinged	
	COLOR/CLARITY	[illegible]				secretions noted, Foley	
		[illegible]				to gravity, patent &	
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible]				amber urine, HR 120-	
		[illegible]				140 & PVC's noted.	
		[illegible]					
		[illegible]					
		[illegible]					

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

(Continue on reverse)

Strong acute urine

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

DEPARTMENT/SERVICE/CLINIC ICU 2 west

DATE 5 June 03

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

H [redacted] b6-4 5 Jun 03

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITALS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line	117/72	113/75	93/57	92/61	103/64	122/75	118/70	114/70		158/75	121/80	128/70	100/70	104/64	99/64	94/60	90/60	
BP Cuff				57/39	101/68	114/80												
Temperature		101.4			99.6		101.5			101				100				
Pulse	129	128	125	115	111	118	122	114		120	105	120	128	120	126	123	121	
Respiratory Rate	20	18	28	16	17	33	31	29		33	32	24	29	31	32	33	28	
Sp O2	98	99	99	99	99	98	96	98		96	97	98	96	95	96	97	96	
Mode																		
FIO2	50	50	50	50	50	50	50	50		50	50	50	50	50	50	50	50	

SIGNS

pain

intuition

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IV LR	100	100	100	100	100	100	100	100	800	100	100	100	100	100	100	100	100	800
IV Zantac	50								50	50								50
IV Unasyn	50								50	50								50
IVPB TP				500					500								100	100
~~Enrore Solves~~	60			60					120	60	60	60	60	80	80	80	80	320
NG flush	20	20		20					60									
Dopamine	46.9	46.9	46.9	46.9	37.5	37.5	37.5	37.5	337.5	11.5	11.5	11.5	11.5	11.5	[illegible]	[illegible]	[illegible]	56.5
Fentanyl	8	8	8	8	8	8	8	8	64	8	8	8	8	8	8	8	8	64
Versed	2	2	2	2	2	2	2	2	15	2	2	2	2	2	2	2	2	16
Tylenol 20 mL (0.5 Dmg)		20							20									
TOTALS									2016									1556

OUTPUT

URINE	HOUR / TOTAL	150		225 / 975			100 / 1075			1075	48 / 400	47 / 445	47 / 520	125 / 645	150 / 795	45 / 840	100 / 1000	50 / 1050	1050
	10 gr																		

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	100/60	114/76	104/56	78/51	84/49 100/58	107/6	105/62	104/70 102	
	118	114	134	129	128	131	137	141	
	21	21	21	21	22	29	40	42	
	96	97	95	99	97	98	95	95	
	50	50	65	65	50	50	50	50	

INTAKE	16	17	18	19	20	21	22	23	8° T
	100	100	100	150	100	100	100	100	800
	50								50
	50								50
	60	60	60	60	60	60	60	0	180
								20	20
	8	8	8	8	8	8	8	8	64
	2	2	2	2	2	2	2	2	16
								20	20
									1200

OUTPUT	16	17	18	19	20	21	22	23	
	175			325				175	515
	1400								
	held								
		held							

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		4pm	5pm
	TIME	1500	1500
	MODE	SIMV	SIMV
	F_IO_2	50%	65%
	TV	750	750
	RATE	16	14
	PEEP	5	5
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 DAILY DOING	bb-2 TIME	0200	1400
	MOUTH CARE		[redacted]
	BATH		[redacted]
	SKIN CARE		[redacted]
	FOLEY CARE		[redacted]
	TRACH CARE		
	ROM EXERCISES		[redacted]

TURN	TIME							
SUCTION								

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	4773	Urine:	1575
po			1050
			575
TOTAL	4773	TOTAL	3200
BALANCE			1573

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]
bb-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

/ b6-2 \

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHEET ASSESSMENT

	TIME	0510	INITIALS [redacted]		INITIALS	1800	INITIALS [redacted]
NEURO	PUPILS	pupils sluggish 2+				pupils 2 mm - slow to	
	SENSORIUM	light dmt. withdrawal				light accomodation,	
		to painful stimulation				Pt. sedated c̄ Versed	
		carefully sedated				& Fentanyl.	
		on versed / Fentanyl					
RESPIRATORY	RESPIRATORY PATTERN	RR even, unlabored				RR even, unlabored,	
	BREATH SOUNDS	L/S ⊕ coarse crackles				30 bpm, mech vent,	
	SECRETIONS	wheezes, secretions copious				size 7 ett, placed @ 24	
		amt of thick white				@ lip - SIMV, RR 16, VT	
		secretions orally				750, FIO2 50%, Peep 5	
		intubated c̄ ± suction				L/S upper course (B) ↓ diminished	
SKIN	COLOR	pink @ 24-25 cm lower				skin warm & dry,	
	INTEGRITY	lip line. ↓ base ⊕				normal for race ⊕ 3rd	
		diminished. skin intact				spacing noted, ++ edematous,	
IV SITE	LOCATION	pink appearance, intact.				(R) SCC cordis MIVF	
	CONDITION	(R) SCC c̄ cordis, clear				@ 100cc/hr c̄ Fentanyl /	
		skin, cleansed q 8h				Versed IVPB, (R) EJ	
		using sterile technique.				c̄ 25cc MIVF, NS, A line	
		MIVF @ 75cc/hr				on pressure bag 300 mmHg	
		c̄ versed Fentanyl				peripheral IV ⊕ lock, all	
GASTRO	ABDOMEN	PB (R) c̄ catheter				c̄ S/S infiltration, patent	
	BOWEL SOUNDS	infusing MIVF @				CDI - ABD, firm, distended,	
		75cc/hr. (R)				hypoactive BS x 4 q. NG tube	
		5 AM disturbed				in place @ IS.	
GU	URINE:	clear, yellow				Foley to gravity bag >	
	COLOR/CLARITY	c̄ copious amt 2°				50cc/hr. Dark amber	
		to urine retention				urine / very strong scent.	
CARDIOVASCULAR	CARDIAC RHYTHM	monitored, flow				HR 110-120s, ⊘	
		ESR, pulses c̄ Fa				ectopy, some PVCs noted	
		(R) DP 100, HR 110s					
		⊘ ectopy, heart ⊕					
		(R) S3 gallop					

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SA1 - Saturation; TRACH - Tracheostomy

b6-2

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] 91WM6

DEPARTMENT/SERVICE/CLINIC ICU 2 unit

DATE 16 June 03

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

[redacted]

b6-4

☐ 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	103/68	82/56	84/53	91/62	108/69	97/67	104/71	100/68		103/71	105/65	99/65	105/66	98/51	96/62	132/66	143/77	
BP Cuff	99/61	89/55		92/60														
Temperature	102.7	101.4			99.1		99.5							99.8				
Pulse	141	131	121	117	113	113	120	117		119	115	111	110	107	109	106	117	
Respiratory Rate	31	27	18	18	24	26	24	26		25	29	22	22	24	24	20	36	
										95	96	97						
SpO2	94	97	95	98	96	98	96	93		95	96	97	100	100	100	100	92	
F2O2	50	50	50	50	50	50	50	50		50	50	50	50	40%	40%	40%	70%	
pain																		
intermittent																		

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IV LR	100	100	100	100	100	100	100	100	800	100	100	off	off	off	100	100	100	500
IV Zantac	50								50	50				50				100
IV Unasyn	50								50									
IV PB																		
Tube Feeding	0	60	60	60	0	off	off		180	0/0								
Fentanyl	8	8	8	8	8	8	8	8	64	8	8	8	8	8	8	8	8	64
Versed	2	2	2	2	2	2	2	2	16	2	2	2	2	2	2	2	2	16
Tylenol	20																	
NS Bolus				500	500				1000	500	500	500	500	500	2500			3000
Dopamine									2160									2676
TOTALS																		2676

OUTPUT

URINE	HOUR / TOTAL	10	10	10	10	10/50			10/60	60	20	20/40		100/340		100/340	50/390	50/440	440
	10 gr																	
	S/A																	
NG	OUTPUT					300	Residual 300											
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		440

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	100/64	91/60	97/68	88/56	90/57	89/57	91/59	85/55	
					88/51				
				99.7					
	108	121	116	115	106	105	104	99	
	27	25	29	28	22	27	21	23	
	95	96	97	95	96	96	97	98	
	100/50%	50%	50%	50%	50%	50%	50%	50%	

INTAKE	16	17	18	19	20	21	22	23	8°T
	100	125	125	125	125	125	125	125	975
	8	8	8	8	8	8	8	8	64
	2	2	2	2	2	2	2	2	16
				1000					100
								113	113
									2066

OUTPUT	16	17	18	19	20	21	22	23	
	50	50/100	50/150	20/170	55/225	15/240	15/255	30/285	285
							400		400

transfusion 4823871 Exp 9330

ACUITY LEVEL CLASSIFICATION

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

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

ACTIVITIES DAILY LIVING	TIME	0200			TURN	TIME			
	MOUTH CARE								
	BATH	[redacted]							
	SKIN CARE	[redacted]							
	FOLEY CARE	[redacted]			SUCTION				
	TRACH CARE								
	ROM EXERCISES	[redacted]							

24°I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday	wt Today	[redacted]	
INTAKE	OUTPUT		
IV	Urine:		
po			
TOTAL 7406	TOTAL 1685		

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS	1900
EYES OPEN	SPONTANEOUSLY	4	
	TO SPEECH	3	
	TO PAIN	2	
	NO EYE OPENING	1	4
BEST VERBAL RESPONSE	ORIENTED	5	
	CONFUSED	4	
	VERBALIZES	3	
	VOCALIZES	2	
	NO VOCALIZATION	1	1
BEST MOTOR RESPONSE	OBEYS COMMANDS	6	
	LOCALIZES PAIN	5	
	FLEXION WITHDRAWAL	4	
	ABNORMAL FLEXION	3	
	EXTENSION TO PAIN	2	
	NO MOTOR RESPONSE	1	1
LIMB MOVEMENT — ARMS	NORMAL POWER		
	MILD WEAKNESS		
	SEVERE WEAKNESS		
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		1
LIMB MOVEMENT — LEGS	NORMAL POWER		
	MILD WEAKNESS		
	SEVERE WEAKNESS		
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		1
PUPILS — RIGHT	SIZE		2
	REACTION		—
PUPILS — 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		
	R L	
	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

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0510	INITIALS [redacted]	66-2	INITIALS	1700	INITIALS
NEURO	PUPILS	pupils sluggish				Pupils 2mm-slow	
	SENSORIUM	withdrawal to				reaction to light,	
		localize stimulation				No physical reaction to stimuli,	
		sedated on				Pt. Sedated on Propofol	
		[illegible]				Fentanyl. (whites of eyes yellow)	
RESPIRATORY	RESPIRATORY PATTERN	[illegible]				Pt. intubated c̄ #7	
	BREATH SOUNDS	intubated c̄ 7.0 cath				cath, placed @ 24	
	SECRETIONS	placed @ 24-25 cm				CM. Vent Sc Hings	
		[illegible]				SIMV, RR 14, VT 750,	
		[illegible]				FIO2 40% Peep 5	
		Diminished throughout				LS, c̄ suction LIS, thick	
SKIN	COLOR	Gray, thick, tenious				copious amt of secretions.	
	INTEGRITY	copious amt of				Skin, warm dry, yellowish	
		secretion per [illegible]				appearance, (R) SC	
IV SITE	LOCATION	oral, skin cool,				c̄ corticals, triple	
	CONDITION	pale appearance				lumen, MIVF @ 150 cc/hr	
		[illegible] (R) SC				LR, A line to (R) forearm	
		c̄ corticals, dry				hooked to pressure bag	
		[illegible]				@ 300 mmHg.	
		@ 300 cc/hr					
GASTRO	ABDOMEN	~~[illegible]~~				ABD, firm, distended	
	BOWEL SOUNDS	ABD firm, hyp				hypoactive BS x 4 quads	
		active BS x 4 (L)				NGT on (L) nare c̄	
		nare not [illegible]				LIS, thick brown	
GU	URINE:	c̄ [illegible] drainage				secretions noted	
	COLOR/CLARITY	[illegible]				Foley to gravity bag	
		c̄ apple cider color				150-200 cc urine output hr	
CARDIOVASCULAR	CARDIAC RHYTHM	noted in [illegible]				HR 90-100, Ø ectopy,	
		[illegible]				PVC's noted.	
		[illegible] HR 90's					
		Ø ectopy heats					
		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] 66-2

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 7 June 03

PATIENT [redacted]IFICATION (For typed or written entri[redacted] Name—last, first, middle, [redacted]ade; date; hospital or medical facility)

EPW # [redacted] 66-4

☐ 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	98/61	110/61	108/62	106/63	118/62	116/56	101/56			104/63	100/61	99/62	99/62	112/70	104/63	142/75	143/78	
	BP Cuff	~~97/60~~	~~97/59~~			97/60	97/59		112/61										
	Temperature	98.3	97.5		98.1			98.5							99.1				
	Pulse	96	91	91	93	92	93	92	97		95	94	95	93	102	104	102	110	
	Respiratory Rate	17	14	14	16	17	16	16	17		16	16	24	20	21	24	28	26	
	SpO2	98	99	99	97	99	100	99	97		98	99	95	97	95	96	97	98	
	FIO2	50%	50%	50%	50%	50%	50%	50%	50%		40%	40	40	40	40	40	40%	40%	
	pain																		
	intervention																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	2V LR	200	200	200	200	200	200	200	200	1600	200	200	200	200	200	200	200	200	1600
	2V Zantac		50							50									
	2V Zosyn		50			50				100									
	Fentanyl	8	8	8	8	8	8	[illegible]		48	8	8	8	8	8	8	8	8	64
	Versed	2	2	2	2	2	2	[illegible]		12	—	—	—	—					
	Dopamine	11³	11³	11³	11³	11³	11³	11³	11	115	11³	11³	11³	11³	11³	11³	11³	11³	115
	PRBC	478	565							1043									
	NS, flush	200	300							500									
	Propofol						5	5	5	15	5	5	5	5	5	5	5	5	40
	TOTALS									3483									1819

OUTPUT																			
URINE	HOUR / TOTAL	50/50	50/100	125/225	225/350	100/450	150/600		250/850	850	200	200/400	200/600	150/750	175/925	150/1175	375/1550	200/1750	1750
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	② JP																		
TOTALS										951									1750

9
88
27
1

surgery 1830 — 1930 suction

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	163/82	121/84		109/63	114/69	108/74	85/54	86/57	
	116	118		98	100	106	104	102	
	26	24		12	12	14	17	12	
	98	96		98	100	98	99	100	
	40	40		50	50	50	50	50	

INTAKE	16	17	18	19	20	21	22	23	8° T
	200	200		150	150	150	150	150	1150
								50	150
								50	50
	8	8		4	4	4	4	4	36
	11³	11³		11³	11³	11³	11³	11³	79.1
	5	5		9	9	9	9	5	51
									1416
									1416

OUTPUT		300/300	300/600	350/900	75/975	200/1175	250/1425	225/1650	1650
		400						300	700
					surgery				
								120	120
									2170

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
	TIME	1135								
	MODE	SCMV								
	F_IO_2	40%								
	TV	750								
	RATE	12								
	PEEP	5cm								
A	pH									
A	PCO_2									
A	pO_2									
B	HCO_3									
B	SAT									
G	BASE									

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

ACTIVITIES OF DAILY LIVING										
	b6-2 TIME	0300								
	MOUTH CARE									
	BATH	✓ [redacted]								
	SKIN CARE	✓ [redacted]								
	FOLEY CARE	✓ [redacted]								
	TRACH CARE									
	ROM EXERCISES	[redacted]								

TURN	TIME									
SUCTION										

24° I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday	wt Today	[redacted]	
INTAKE	OUTPUT b6-2		
IV	Urine:		
po			
TOTAL 6718	TOTAL ~~6718~~ 5070		
	BALANCE 1648		

NEUROLOGICAL ASSESSMENT

			HOURS	7 gm 0400
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
		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		
	R L	
	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

b6-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0510	INITIALS [redacted]	1719	INITIALS [redacted]		INITIALS
NEURO	PUPILS	2mm sluggish [redacted]		2mm non reactive			
	SENSORIUM	light sedated on		sedated on fresh &			
		drip [illegible]		propofol			
		[illegible]					
		[illegible] when					
RESPIRATORY	RESPIRATORY PATTERN	[illegible]		intubated, clear			
	BREATH SOUNDS	[illegible]		exp. sounds bilat			
	SECRETIONS	[illegible]		vent settings SIMV			
		[illegible]		Peep 5, TV 350			
		[illegible]		Rate 12, O2 60%			
		[illegible]					
SKIN	COLOR	[illegible]		NFR.			
	INTEGRITY	[illegible]		abd. wounds seeping			
				greenish fluid			
IV SITE	LOCATION	[illegible]		1 SC lines & triple			
	CONDITION	[illegible]		lumen, site is c/d/i			
		[illegible]		no s/s infection			
		[illegible]		A line left right arm			
		[illegible]					
GASTRO	ABDOMEN	[illegible]		large round firm			
	BOWEL SOUNDS	[illegible]		no bowel sounds			
		[illegible]		x4 quads 2 JP drains			
		[illegible]		NG & LIS from wound			
GU	URINE:	[illegible]		dark yellow			
	COLOR/CLARITY	[illegible]		foley to gravity			
		[illegible]					
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible]		S.S2			
		[illegible]		+3 edema in hands			
		[illegible]		+ feet, <2 sec cap			
		[illegible]		refill			
		[illegible]					

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

b6-2

PREPARED BY (Signature & Title) [redacted] 91WM6 SPC

DEPARTMENT/SERVICE/CLINIC ICU 2 east

DATE 8 June 03

(Continue on reverse)

PATIENT'S IDENTIFICATION (For typed or written entries [illegible] middle; grade; date; hospital or medical facility) [redacted] rst,

EPW [redacted] b6-4

☐ 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	101/69	101/70	85/54	100/62	87/60	90/70	117/81	93/60	X	92/61	96/63	95/51	100/70	97/68	105/62	107/67	136/74	
BP Cuff																		
Temperature	98.1						99.1					98.4						
Pulse	105	106	102	102	102	103	102	103		101	128	104	101	106	108	110	81	
Respiratory Rate	13	16	12	14	15	15	13	13		15	32	16	12	12	13	14	12	
SpO2	99	100	100	99	99	45	95	98		99	87	99	100	92	100	97	98	
FiO2	50	50	50	50	50%	50%	50%	50		50	70% grid	50	50%	50%	50%	50%	50%	
pain							Sedated on Dipsidon / Fentanyl											
intubation																		

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IV LR	150	150	150	150	150	150	150	150	1200	150	150	150	125	125	125	125	125	1015
IV Zantac	–						50		50					50		50		100
IV Zosyn							50		50									
Fentanyl	4	4	4	4	4	4	4	4	32	4	4	4	4	4	4	4	4	32
Propofol	5	5	5	5	5	5	5	5	40	5	5	5	5	24	24	24	24	116
Dopamine	11³	11³	11³	11³	11³	11³	11³	11³	90⁴	11³	11³	11³	11³	11³	11³	11³	11³	90⁴
K Run												100						100
Albumin												100						100
TOTALS									1502									1713

OUTPUT

URINE	HOUR	225				700		100	50		150	100	200	400	350	500	500	350	
	TOTAL	225				995				1145		250	450	850	1200	1700	2200	2550	2550
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP1					40							30						
	2					25							25						
TOTALS																			[illegible]

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	92/62	103/60	121/67	120/63	118/62	119/62	115/60	113/56	
				98.5					
	97	102	102	100	98	97	99	93	
	12	12	12	12	12	12	12	12	
	94	100	99	100	95	99	99	100	
	50%	50%	60%	60%	60%	60%	60%	60%	

	16	17	18	19	20	21	22	23	8° T
R I	125	125	125	125	125	125	125	125	
intac	50						50		
							50		
	4	4	5	5	5	5	5	5	
	28	28	14⁴	14⁴	14⁴	14⁴	14⁴	14⁴	
	11³	11³	11³	11³	11³	11³	11³	11³	
		500							

OUTPUT									
	200/900	125/325	225	125	125	150	100	100	
P1	30								
2	10								

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
	TIME	05	17							
	MODE	SIMV	SIMV							
	F_iO_2	50%	60%							
	TV	850	850							
	RATE	12	12							
	PEEP	5cm	5							
A	pH									
	PCO_2									
	pO_2									
B	HCO_3									
	SAT									
G	BASE									

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

ACTIVITIES OF DAILY LIVING										
	TIME	1500	66-2							
	MOUTH CARE	[redacted]								
	BATH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN	TIME				
SUCTION					

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE

NURSE'S SIGNATURE	INITIALS
[redacted] 66-2	[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
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0517	INITIALS [redacted]	b6-2	INITIALS		INITIALS
NEURO	PUPILS	2mm sluggish c̄ light				3mm sluggish c̄ light	
	SENSORIUM	SEDATED ON FENT				Pt. Sedated on Fent/	
		+ PROPOFOL Does				versed, Does not	
		not respond to sound				respond to stimuli,	
		or touch					
RESPIRATORY	RESPIRATORY PATTERN	nonlabored RR14				nonlabored, RR16-20,	
	BREATH SOUNDS	intubated 7.0 24 @ teeth				ETT @ 26 @ teeth, #7,	
	SECRETIONS	lung sounds coarse				LS, course diminished	
		diminished Bilat				(B), Vent SIMV, Peep 5,	
		Vent SIMV PEEP 5				TV 850, FIO2 60%	
		TV 850 FIO2 60%				(Left LS - very diminished)	
SKIN	COLOR	NFR				Normal for race, skin	
	INTEGRITY	Skin dry incision to (L)				warm & dry, incision to	
		Shoulder intact Abd drsg seeping				(L) shoulder CDI, ABD weeping	
IV SITE	LOCATION	(L) FA ART Line (R) SC				reinforced c̄ 4x4's, (R)	
	CONDITION	triple lumen, both				A line in place, patent	
		sites CDI Ø s/sx infection				c̄ pressure bag set at 300 mmHg	
		Patent upon flush				(R) SC c̄ triple lumen	
						both sites CDI s̄	
						s/s infection..	
GASTRO	ABDOMEN	Rounded incision to midline				No bs noted, JPx	
	BOWEL SOUNDS	No Bowel Sounds noted				2, incision site	
		JPx2 to incision site				c̄ some weeping.	
		Ø masses on palpation soft				Abd soft, nondistended	
GU	URINE:	foley to gravity				foley to gravity c̄	
	COLOR/CLARITY	dark amber clear				dark amber clear	
CARDIOVASCULAR	CARDIAC RHYTHM	$S_1 S_2$ on Auscultation				S_1, S_2 on auscultation,	
		Rhythm regular				Reg Rate/Rythm,	
		+3 Edema to hands				+3 edema to hands	
		+2 to feet pulses				+2 feet, distal	
		palpable				pulses palpable.	

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

b6-2

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] NT

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 9 June 03

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

EPW [redacted] b6-4

- ☐ 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	100/51	101/62	107/59	136/74	137/67	107/60	99/55	125/68		105/6	103/63	101/61	102/60	128/64	113/62	128/64	114/63	
BP Cuff																		
Temperature				98.7				99.5				99.2		98.4				
Pulse	95	91	100	114	116	117	101	98		100	109	102	101	100	103	105	110	
Respiratory Rate	12	12	12	24	24	16	14	14		16	16	12	14	16	13	16	14	
SATS	100	98	100	94	97	96	96	99		100	100	99	99	97	97	99	99	
O_2	60%	60%	60%	60%	60%	60%	60%	60%		70%	70%	70%	60%	60%	60%	60%	60%	
pain						Sedated on propofol												
intervention									+ fentanyl									
INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR	125	125/250	125	125	125	125/750	125	125	1000	125	125/250	125/375	125/500	125/625	125/750	125/875	125/1000	1000
Dopamine	11.3	11.3/[illegible]	11.3	11.3	11.3	113/143	11.3	11.3	90.4	11.3	113/22.6	113/33.9	113/45.2	113/56.5	113/67.8	113/79.1	113/90.4	90.4
Propofol	14.4	14.4/[illegible]	14.4	14.4	14.4	216/103	216	216	136.8	216	288/50.4	288/79.7	288/106.5	288/137.3	288/166.1	Dc'd		166.1
Fentanyl	5	5/10	5/15	5/20	5/25	5/30	5/35	5/40	40	5	5/10	5/15	5/20	5/25	5/30	5/35	20/55	20
Zantac								50	50							50		50
Zosyn					50			50	50			50						50
KCl											50	50						
MgSO4														50	50			100
Albumin																500		500
VERSED																4/8	4/8	8
TOTALS									1367									1984.5
OUTPUT																		
URINE HOUR/TOTAL	100/100	100/200	100/200	50	50/300	100/400	50/450	100/550	550	100/100	50/150	50/200	100/300	100/400	100/500	700/1200	500/1700	1700
URINE sp gr																		
URINE S/A																		
NG OUTPUT						700		250	950			200		200			200	600
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS JP 1				30		20			50				20				7.5	27.5
DRAINS JP 2				10		10			20				7.5				5	12.5
TOTALS									1570									1940

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	16	17	18	19	20	21	22	23	
	112/68	[illegible]	[illegible]	[illegible]	116/69	118/74	120/68	[illegible]	
	104	124	123	121	115	117	105	96	
	16	20	20	21	14	26	12	13	
	97	96	97	97	99	98	100%	100%	
	60%	60%	60%	60%	60%	60%	60%	60%	

RESPIRATORY DATA	TIME	0530	0815	1145	1730					
	MODE	SIMV	SIMV	SIMV	SIMV					
	F_IO_2	60%	70%	60%	60%					
	TV	850	850	850	850					
	RATE	14	12	10	10					
	PEEP	5	10	10	10					
A	pH									
	PCO_2									
	pO_2									
B	HCO_3									
	SAT									
G	BASE									

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

INTAKE	16	17	18	19	20	21	22	23	8° T
	125	125	125	125	125	[illegible]	125	125	875
	11.3	11.3	11.3	11.3	11.3	11.3	off	off	67.8
	20	20	20	20	20	20	20	20	160
	50	~~50~~	~~50~~	~~50~~	~~50~~	~~50~~		50	100
	4	4	4	4	4	4	off	7	31

OUTPUT									
		600/600	125/725	125/950	150/1100	150/1250	150/1400	200/1600	1600
								23	23
								25	25
									1648

ACTIVITIES OF DAILY LIVING	66-2 TIME	1500		
	MOUTH CARE	[redacted]		
	BATH			
	SKIN CARE			
	FOLEY CARE			
	TRACH CARE			
	ROM EXERCISES			

TURN	TIME				
SUCTION					

24° I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE		OUTPUT
IV	2234	Urine:	~~2234~~
po			
TOTAL	2234	TOTAL	1648

BALANCE 589

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]
66-2	

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 / b6-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0530 INITIALS [redacted]	1700 INIT[redacted]	INITIALS
NEURO	PUPILS	Sluggishly reative to	2mm Sluggish, Equal	
	SENSORIUM	light 2mm Pupils	Pt unresponsive	
		equal. Unresponsive	to Painful stim, Sedated	
		to touch, light, sound	Fent / Versed	
		on VERSED		
RESPIRATORY	RESPIRATORY PATTERN	RR 15 Regular	RR 15 Reg	
	BREATH SOUNDS	Lungs COARSE TO	Course Crackes throughout	
	SECRETIONS	AUSCULTATION ↓ IN	Bases Deminishment	
		BASES BILATERALLY	Intubated @ 45%	
		INTUBATED @ 50% FiO_2	Rate 10 Peep 10	
		RATE 10 PEEP 10		
SKIN	COLOR	NFR - (R) Hip packed	(R) Hip Packed, open	
	INTEGRITY	OPEN SKIN @ (L) Heel	Sore (L) Heal, INCISION	
		Incision to shoulder + Abd	(L) Shoulder CDI	
IV SITE	LOCATION	(R) Shoulder SC ō	Trip Lumen Thru	
	CONDITION	triple lumen patent	Cordus (R) Subclavian	
		Op site intact ⊘S/SX	Opsit Intact / A Line	
		INFECTION. ART LINE	(R) FA Opsit CDI	
		Patent to (R) FA		
GASTRO	ABDOMEN	Abd soft Rounded midline	Abd Soft Round, Dist	
	BOWEL SOUNDS	incision Bowel SOUNDS	BS-hypo, NG To,	
		Absent NG tube	LIS / JP x 2 draining	
		draining Bk torn fluid	Serosang	
GU	URINE:	Amber urine draining	Amber Urine VIA	
	COLOR/CLARITY	into foley in adequate	Foley	
		Amts.		
CARDIOVASCULAR	CARDIAC RHYTHM	S. S_2 Regular P 100's	S. S_2, Reg P>100	
		Edema to upper Exts	+2 Edema UE + LE	
		+2 LOWER EXTS +1	Bilat, Cap Refill <3sec	
		Cap Refill < 3 seconds		

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] b6-2

DEPARTMENT/SERVICE/CLINIC: ICU 2 east

DATE: 10 JUN 03

PATIENT'S IDENTIFIC[redacted] For typed or written entries give: Name—last, first, middle; grade; d[redacted]ospital or medical facility)

[redacted] b6-4

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

DATE 6-10-03 | DX | HOSPITAL DAY

VITALS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line	99/60	101/64	102/80	96/60	90/58	90/50	88/54	100/54		97/56	100/58	97/52	100/60	99/57	113/65	102/63	107/64	
BP Cuff	106/57	109/52	135/75	107/54	104/55	96/44	98/54	97/55		96/53	97/53	99/51	103/56	94/50	109/61	104/59	103/59	
Temperature				102.3	101.9					99.8				99.2	99.3	99.4	100.1	
Pulse	102	104	128	121	110	99	98	90		85	88	92	97	89	88	87	91	
Respiratory Rate	14	18	34	26	21	15	14	17		14	14	10	10	10	10	10	10	
O_2 sats	96	96%	96%	95%	96%	96%	97	96		97	98	98	100	100	100	99	98	
O_2 source	60%	60%	60%	60%	60%	60%	60%	50%		50%	50%	65%	65%	60%	55%	45%	45%	

SIGNS

pain: VERSED 9 ++

intervention: + fentanyl

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	125	125	125/375	125/500	500/1000	125/1125	125/1250	125/1375	1375	125	125/250	125/375	125/500	125/625	125/750	125/875	125/1000	1000
IV PB	50				50				50									
Fentanyl	20	20/40	20/60	20/80	20/100	20/120	20/140	20/160	160	20/20	20/40	20/60	20/80	20/100	20/120	20/140	20/160	160
Versed	10	10/60	12/72	12/84	7/91	7/98	7/105	7/103	63	7/7	7/14	7/21	7/28	7/35	7/42	7/49	7/56	56
ZOSYN						50			50			50						50
DOPAMINE								113/113	113	113/113	113/226	113/339	113/452	113/565	113/678	113/791	113/904	904
KCL										25	25	25	25/500					200
ZANTAC								50	50							50		50
Blood																	350	350
TOTALS									1789									1956

OUTPUT

			24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR / TOTAL		100/100	100/200	100/300	40/340	50/390	20/410	50/460	50/510	510	50/50	100/150	50/200	50/250	100/350	150/500	100/600	100/700	700
	sp gr																			
	S/A																			
NG	OUTPUT					100				150	250	25	Ø					100	25	150
	pH																			
	GUIAC																			
EMESIS																				
STOOL																				
DRAINS	JP 2					38			25		63		50				30		40	120
	JP 1					10			7.5		17.5		7.5				5		5	17.5
TOTALS																				988

988

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	103/62	105/62	104/61	104/68	101/60	103/63	108/64	104/63	
	104/57	102/55	110/59	110/69	105/60	103/57	102/50	101/60	
	100.3	100.4	101.2	100.8	100.4	99.8	99.7	99.4	
	90	90	99	98	96	85	88	87	
	10	12	12	10	10	10	10	10	
	98	98	97	96	97	97	96	96	
	45%	45%	45%	45%	45%	45%	45%	45%	

INTAKE	16	17	18	19	20	21	22	23	8°T
I.V.	125/125	125/250	125/375	125/500	100/600	100/700	125/825	125/1000	1000
								50	50
PO	20/20	20/40	10/50	10/60	10/70	10/80	10/90	10/90	90
	7/7	7/14	7/21	7/21	7/28	7/35	7/42	7/49	49
	50							50	50
	11.3/11.3	11.3/22.6	11.3/33.9	11.3/45.2	11.3/56.5	11.3/67.8	11.3/79.1	11.3/91.2	91.2
	1350-1								
									3302

OUTPUT	16	17	18	19	20	21	22	23	
	100/100	300/400	350/750	125/875	125/1000	100/1100	100/1200	50/1250	1250
								100	50
		15	–	–			25		40
		2.5	–	–			0		2.5
									1074

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	0200	0500	1100	1430	1645	1700			
	MODE	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV			
	F_iO_2	60%	50%	60	45	45	45			
	TV	850	800	850	850	800	45			
	RATE	14	14	10	10	10	10			
	PEEP	10	10	10	10	10	10			
ARTERIAL BLOOD GAS	A: pH (0400)	7.50	05:43 7.48		1421 7.42					
	A: PCO_2	43.5	45.0		36.9					
	A: pO_2	102	151		94					
	B: HCO_3	34	34		24					
	B: SAT	98%	99%		97					
	G: BASE	11	11		Ø					

LABORATORY	TIME	0530	0930	1630						
	GLUCOSE	107		120						
	Na/K	141/2.5	143/2.9	144/3.6						
	Cl/CO_2	107/34	104/37	108/34						
	BUN/Cr	27	30	29/.31						
	WBC/PLATELET		12.4/565	6.7/639						
	Hct/Hgb	21/7	24.7/7.8	30.5/9.3						

ACTIVITIES DAILY LIVING										
	bb-2 TIME	1030								
	MOUTH CARE	[redacted]								
	BATH	[redacted]								
	SKIN CARE	[redacted]								
	FOLEY CARE	[redacted]								
	TRACH CARE	[redacted]								
	ROM EXERCISES	[redacted]								

TURN	TIME				

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 /b6-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0530	INITIALS [redacted]	1716	INITIALS [redacted]		INITIALS
NEURO	PUPILS	pupils 3mm sluggish		Pupils 3mm sluggish			
	SENSORIUM	to light + equal. Ø		EQual.	[redacted]	b6-2	
		response to light		~~Withdrawn to Painful~~			
		sound / touch on		stimu. Pt parralized			
		Vecuronium gtt.		And sedated			
RESPIRATORY	RESPIRATORY PATTERN	nonlabored rate 15 on		Nonlabored @ 15			
	BREATH SOUNDS	Simv lungs COARSE		Coarse Crackes thruout			
	SECRETIONS	+ Bilat Sats 98%		Deminished bases			
		FIO2 60%		FIO2 60%			
		(L) FOOT SORE OPEN HEEL COVERED c̄ 4x4		(L) Foot Heel open Dressing CDI			
SKIN	COLOR	NFR - Incision to R shoulder		(L) Shoulder Open			
	INTEGRITY	steristrip CDI, Dressing to (R) Hip CDI, MIDLINE ABD		(R) Hip - Dressing c̄			
		INCISION DRESSING CDI		Sero-Sang Drainage			
IV SITE	LOCATION	(R) Shoulder SC c̄		Midline Abd Dress CDI			
	CONDITION	TRIPLE LUMEN ALL		(R) Sub Clav - Triple			
		PORTS PATENT TO FLUSH		Lumin Ø S/Sx Inf			
		(R) FORARM ART LINE		(R) FA A. Line - Ø			
		PATENT. Ø S/Sx infection		S/S INF			
		@ EITHER location					
GASTRO	ABDOMEN	Rounded soft incision		Soft, Round INCISION			
	BOWEL SOUNDS	midline Bowel		Midline, 2x JP, BS			
		sounds Absent NG		Absent, NG c̄			
		c̄ coffee ground drainage		Coffee ground drainage			
GU	URINE:	foley cath Amber		Foley - Amber Urine			
	COLOR/CLARITY	colored clear urine					
		in Adequate Amts					
CARDIOVASCULAR	CARDIAC RHYTHM	S1S2 NSR Regular		S.S. NSR Pulses			
		pulse Edema to		+2 UE/LE Bila			
		U+LE'S +2 Cap		Cap Refill < 3sec			
		Refill < 3sec Ø JVD					

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] b6-2

DEPARTMENT/SERVICE/CLINIC: ICU 2 east

DATE: 12 June 03

[redacted] For typed or written entries give: Name—last, first, middle; gra[redacted], hospital or medical facility)

[redacted] b6-4

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

DATE 12 Jun 03 | 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	146/67	140/65	141/68	112/67	135/68	118/61	105/51	89/50		90/54	125/76	146/78	142/75	140/71	135/72	143/80	132/76	
	BP Cuff	131/72	124/74	129/75	107/68	102/64	111/68	99/58	87/52		95/51	135/72	129/81	128/91	114/76	123/70	125/75	130/86	
	Temperature	103.1	103.2	102.9	102.3	101.4	101.4	100.4	99.1		99.5	99.4	99.3	100.4	100.1	100.3	100.6	100.8	
	Pulse	130	123	126	114	114	112	104	97		94	88	98	109	110	107	114	110	
	Respiratory Rate	15	15	15	15	15	15	15	15		15	15	15	15	15	15	15	15	
	SpO2	98	98	95	97	98	95	98	98		100	100%	100	100	100	100	100%	100	
	FIO2	100	100	60	60	60	60	60	60		60	60	60	60	60	60	60	60	
	pain		versed + fentanyl																
	intervention				+ vecuronium														

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	IVF	125	125/250	125/375	125/500	125/625	125/750	125/875	125/1000	1000	125/125	125/250	125/375	125/500	125/625	125/750	125/875	125/1000	1000
	Zantac IVPB							50		50									
	Fentanyl	10	10/20	10/30	10/40	10/50	10/60	10/70	10/80	80	10/10	10/20	10/30	10/40	10/50	10/60	10/70	10/80	80
	Versed	9	9/18	9/27	9/36	9/45	9/54	9/63	9/72	72	5/5	5/10	5/15	5/20	5/25	5/30	5/35	5/40	40
	Zosyn IVPB				50					50			50						50
	Dopa	11.3	11.3/22.6	11.3/33.9	11.3/45.2	11.3/56.5	11.3/67.8	11.3/79.1	11.3/90.4	90.4	11.3/18.8	11.3/37.6	11.3/56.4	11.3/67.7	11.3/79.0	11.3/90.3	11.3/101.6	11.3/112.9	112.9
	Propofol	27	27							54									
	Vec	10	10/20	5.4/25.4	5.4/30.8	5.4/36.2	5.4/41.6	5.4/47	5.4/52.4	52.4	5.4/5.4	5.4/10.8	5.4/16.2	5.4/21.6	5.4/27	5.4/32.4	5.4/37.8	5.4/43.2	43.2
	Cipro				200													200	200
	Vanco																		
	TOTALS									1448									1526

OUTPUT																			
Foley URINE	HOUR / TOTAL	100/100	125/225	250/475	330/805	400/1205	100/1305	175/1480	100/1580	1580	100/100	100/200	125/325	100/425	125/550	125/675	125/800	100/900	900
	sp gr																		
	S/A																		
NG	OUTPUT								200	200				200			~~125~~	125 ~~325~~	325
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	Jp1		3					5	2.5	10.5				5				5	10
	Jp2		25					20	10	55				30				10	40
TOTALS										1846									1275

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	129/72	140/74	124/70	116/63	112/58	127/66	97/50	92/47	
	121/81	121/81	125/61	119/64	99/67	117/68	99/55	97/55	
	101°	101.5	102	102.3	102.1	101.4	101.8	102.0	
	115	124	132	128	122	123	117	118	
	15	15	15	15	15	15	15	15	
	100	99	99	100	99	100	100	99	
	60	60	60	60	60	60	60	60	

INTAKE	16	17	18	19	20	21	22	23	8° T
	125/125	125/250	125/325	125/500	125/625	125/750	125/875	125/1000	1000
							50		50
	10/10	10/20	10/30	10/40	10/50	10/60	10/70	10/80	80
	5/5	5/10	5/15	5/20	5/25	5/30	5/35	5/40	40
							50		50
	11.3/11.3	11.3/22.6	11.3/33.9	11.3/45.2	11.3/56.5	11.3/67.8	11.3/79.2	11.3/90.5	90.5
	5.4/5.4	5.4/10.8	5.4/16.2	5.4/21.6	5.4/27	5.4/32.4	5.4/37.8	5.4/43.2	43.2
					200				200
									1553

OUTPUT	16	17	18	19	20	21	22	23	
	150/150	150/300	50/350	50/400	50/450	100/550	50/600	50/650	650
								200	200
						2.5		2.5	5
						2.5		5	7.5
									812

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME	0049	0200	0400	0500	1826				
	MODE	SIMV	SIMV	SIMV	SIMV					
	F_IO_2	100	60	60	60					
	TV	700	700	700	700					
	RATE	15	15	15	15					
	PEEP	10	10	10	10					
ABG	pH	7.428		7.46		7.44				
	PCO_2	43.6		42.7		42.3				
	pO_2	123		64		83				
	HCO_3	28		30		28				
	SAT	98		93		95				
	BASE	4		7		5				

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

ACTIVITIES OF DAILY LIVING	TIME	0227	0800	
	MOUTH CARE	[redacted]		
	BATH	[redacted]		
	SKIN CARE		[redacted]	
	FOLEY CARE	[redacted]	[redacted]	
	TRACH CARE			
	ROM EXERCISES		[redacted]	

TURN	TIME	1900	2200			
SUCTION						

24° I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE	OUTPUT
IV	4517	Urine: 3130
po		725
		133
TOTAL	4517	TOTAL 3988

BALANCE +529

NURSE'S SIGNATURE

[redacted] CPT/AN

[redacted]

66 2

INITIALS

[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
INTENSIVE CARE NURSING FLOW SHEET b6-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0510	INITIALS [redacted]	1730	INITIAL [redacted]		INITIALS
NEURO	PUPILS	[illegible]		2mm; Equal / Reactive			
	SENSORIUM	[illegible]		Pt sedated c̄ Fentanyl			
		[illegible]		and versed; Paralyzed			
		[illegible]		c̄ Vec;			
		[illegible]					
RESPIRATORY	RESPIRATORY PATTERN	[illegible]		RR even/nonlabored;			
	BREATH SOUNDS	[illegible]		Lung Sounds diminished;			
	SECRETIONS	[illegible]		[illegible] Rhonchi to			
		[illegible]		bilat lung fields;			
		[illegible]		ETT @ 24cm - teeth; #7;			
		[illegible]		pt on vent: simv 100/15/60 7/10			
SKIN	COLOR	[illegible]		Color Normal for race;			
	INTEGRITY	[illegible]		warm; incision to mid			
		[illegible]		abd; wound to (L) heel;			
IV SITE	LOCATION	[illegible]		(R) Subclavian TL; patent;			
	CONDITION	[illegible]		Site normal;			
		[illegible]		(R) Radial Aline;			
		[illegible]		Site normal;			
		[illegible]					
GASTRO	ABDOMEN	[illegible]		Abd soft; BS			
	BOWEL SOUNDS	[illegible]		hypoactive; mid abd			
		[illegible]		incision c̄ dry CDI;			
		[illegible]		NGT to LIS;			
GU	URINE:	[illegible]		Pt voiding amber			
	COLOR/CLARITY	[illegible]		colored urine;			
		[illegible]		UOP minimal;			
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible]		Pt running			
		[illegible]		ST in 110s-120s			
		[illegible]		c̄ no ectopy;			
		[illegible]		[redacted] CPT/AN			
		[illegible]					

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

b6-2

(Continue on reverse)

PREPARED BY (S[redacted]

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 13 Jun 03

PATIENT'S IDENTIFICATION (F[redacted]e—last, first, middle; grade; date; h[redacted]al or medical facility)

[redacted] b6-4

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

DATE 6/13/03 | 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	105/61	93/49	111/58	100/52	134/69	118/58	[illegible]	[illegible]		121/61	122/64	105/[illegible]	104/51	100/51	94/49	96/45	105/59	
	BP Cuff	130/70	91/48	105/63	93/50	120/63	105/59	[illegible]	124/[illegible]		124/[illegible]	110/6[illegible]	[illegible]	93/5[illegible]	94/54	93/53	95/46	100/54	
	Temperature	101.7	101.5	99.9	101.3	101.3	101.3	101.4	68		[illegible]	102	[illegible]	102.5	102.3	102.3	102.0	101.5	
	Pulse	123	110	108	110	113	117	104	117		130	140	130	125	123	123	119	120	
	Respiratory Rate	15	15	15	15	15	15	35	31		15	15	15	15	15	15	15	15	
	SPO3	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	98	
	FIO2	60	60	60	60	60	60	60	60		60	60	60	60	60	60	60	60	
	CVP																	20	
	pain																		
	intervention																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	IVF (LR)	125/125	125/250	125/375	125/500	125/625	125/750	125/875	125/1000	1000	125/125	125/250	125/375	125/500	125/625	125/750	125/875	125/1000	1000
	Versed	5/5	5/10	5/15	5/20	5/25	5/30	5/35	5/40	40	5/5	5/10	5/15	5/20	5/25	5/30	5/35	5/40	40
	Fentyl	8/8	8/16	8/24	8/32	8/40	8/48	8/56	8/64	64	8/8	8/16	8/24	8/32	8/40	8/48	8/56	8/64	64
	Dopa	11/11	11/22	11/33	11/44	11/55	11/66	[illegible]	102	102	113/113	113/226	113/339	113/454	113/565	113/678	113/791	904	904
	IVPB Zosyn					50				50			50						50
	IVPB Zantac							50		50							50		50
	IVPB Cipro				200					243								200	200
	IVPB Vec	54/54	54/108	54/162	54/216	54/27	54/324	54/378	54/432	54/486	54/54	54/108	54/162	54/216	27/24	27/27	27/297	27/324	324
	LR Bolus		1000							1000							[illegible]	[illegible]	500
	IVPB Vanc																		
	TOTALS									2549									2027

OUTPUT																			
URINE Foley	HOUR / TOTAL	30/30	30/60	100/160	100/260	30/290	30/340	30/370	40/410	410	60	125/185	40/225	60/285	100/385	40/425	30/455	0/455	455
	sp gr																		
	S/A																		
NG	OUTPUT																	200	200
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP.1								7.5	7.5								10	10
	JP.2								10	10								7.5	7.5
TOTALS										[illegible]									1655

POST-OP DAY

	16	17	18	19	20	21	22	23	
VITAL SIGNS	109/54	110/56	98/52	102/58	107/62	114/65	92/50	100/56	
	86/52	86/57	92/50	92/58	97/61	114/65	89/51	98/55	
	102	12[illegible]	101[3]	100[8]		100[3]	99[7]	98[5]	
	120	123	114	109	112	112	101	93	
	15	13	15	15	15	15	15	16	
	98	98	100	100	100	99	97	99	
	60	60	60	60	60	60	60	60	

	16	17	18	19	20	21	22	23	8° T
INTAKE	125/125	125/[illegible]	125/325	125/450	125/575	125/700	125/825	125/950	950
	5/5	5/10	5/15	5/20	5/25	5/30	5/35	5/40	40
	8/8	8/16	8/24	8/32	8/40	8/48	16/64	16/80	80
	113/113	113/226	113/339	113/442	113/555	113/668	113/781	113/894	894
							50		50
							50		50
	27/27	27/4	27/6.7	27/9.4	27/12.1	27/14.8	27/17.5	27/20.2	20[2]
	500CR							1000	1000
							250		250
									2529.8

	16	17	18	19	20	21	22	23	8° T
OUTPUT	30/30	60/90	30/120	Ø/120	30/150	30/180	25/205	Ø/205	205
								200	200
							7		7
							8		8

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA			
		TIME	0324
		MODE	SIMV
		F_IO_2	60
		TV	700
		RATE	15
		PEEP	10
	A	pH	7.48
	A	PCO_2	43
	A	pO_2	91
	B	HCO_3	31
	B	SAT	97
	G	BASE	8

LABORATORY DATA		
	TIME	0330
	GLUCOSE	142
	Na/K	132/3.3
	Cl/CO_2	105/28
	BUN/Cr	26/1.9
	WBC/PLATELET	17.1/6.41
	Hct/Hgb	28.9/8.9
	RBC / Lymph	3.33/62

ACTIVITIES OF DAILY LIVING			
	b6-2 TIME	2400	09
	MOUTH CARE	[redacted]	
	BATH		
	SKIN CARE		
	FOLEY CARE		
	TRACH CARE		
	ROM EXERCISES		

TURN	TIME

SUCTION

24° I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE	OUTPUT
IV		Urine:
po		
TOTAL	4556.8 JLF	JLF 1092.5
BALANCE		3464.3

NURSE'S SIGNATURE [redacted] INITIALS [redacted]

b6-2

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 b6-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0530	INITIALS [redacted]	1730	INITIALS [redacted]		INITIALS
NEURO	PUPILS	2mm + Sluggish		2mm Sluggish			
	SENSORIUM	to light pupils		EOMI			
		equal & Response		Paralyzed + Sedated			
		to light touch, noise					
		on vec gtt.					
RESPIRATORY	RESPIRATORY PATTERN	15 nonlabored on		15 Nonlabored			
	BREATH SOUNDS	SIMV. F_IO_2 60% BS		SIMV F_IO_2 100			
	SECRETIONS	COARSE + ↓ in Lower		Fine Crackles thru out			
		Lobes R>L. Tube		Diminished bases			
		@ 26 @ LIPS secured		New # Trach			
		c̄ tape. Sats 97%					
SKIN	COLOR	NFR-(R) Shoulder incision		(R) Shoulder incision			
	INTEGRITY	(R) hip c̄ dressing Abd		open to Air			
		midline incision c̄ old drainage		Midline Abd Dress			
IV SITE	LOCATION	(R) shoulder SC triple		CDI, J-Tube			
	CONDITION	lumen patent in all		Dress CDI, 10cc			
		ports (R) FA ARTLINE		open ARFA Foley			
		Patent ∅ S/Sx		Open (L) Femoral dressing CDI			
		infection @ either		(R) A-Line + (R) SC			
		site		Triple lumen thru Cath. ∅ S/Sx Inf			
GASTRO	ABDOMEN	Rounded soft		Rounded Soft			
	BOWEL SOUNDS	BS Absent in all		BS Absent			
		4 Quads midline		Midline Abd Incision			
		incision c̄ 4x4s wet-dry		Dressing CDI			
GU	URINE:	Foley Cath		Foley			
	COLOR/CLARITY	uop 15-30cc/o clear					
		Amber in color					
CARDIOVASCULAR	CARDIAC RHYTHM	S, S2 NSR BP 106/44		S, S2 NSR			
		P 100 +3 edema		+3 edema Dependent			
		to hands + feet		UE + LE			
		Cap Refill <3 sec		Cap Refill <3 sec			
		∅ JVD					

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

b6-2

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] LT AN

DEPARTMENT/SERVICE/CLINIC ICU 2 unit

DATE 14 JUNE 03

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

EPW [redacted]

b6-4

☐ 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	129/79	125/70	112/67	117/66	118/69	111/65	105/59	110/68		110/70	108/64	96/59	111/66	110/66	90/58			
BP Cuff	117/68	112/69	112/69	103/64	108/67	99/69	99/58	104/66		110/65	103/64	98/55	106/64	107/62	103/54			
Temperature	97.6	97.2	97.1		97.5	97.3	97.3	97.1		97.0	97.2	97.2	97.0	97.4	97.7		9	
Pulse	92	95	92	92	98	101	99	94		94	96	94	94	97	101			
Respiratory Rate	15	15	15	15	15	15	15	15		15	15	15	15	15	15			
Sats	99%	99%	99%	99%	99%	97	97	98		99	99	99	98	98	100			
O_2	60%	60	60	60%	60	60	60	60		60	60	60	60	60	60			

pain
intervention

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF (LR)	125	125/250	125/375	125/500	125/625	125/750	125/875	125/1000	1000	125/125	125/250	125/375	125/500	125/625	125/900			900
Versed	5	5/10	5/15	5/20	5/25	5/30	5/35	5/40	40	5/5	5/10	5/15	5/20	5/25	5/30			30
Fentanyl	16	16/32	16/48	16/64	16/80	16/96	16/112	16/128	128	16/16	16/32	16/48	16/64	16/80	16/96			96
Dopa	11.3	11.3/22.6	11.3/33.9	11.3/45.2	11.3/56.5	11.3/67.8	11.3/79.1	11.3/90.4	90.4	11.3/11.3	11.3/22.6	11.3/33.9	11.3/45.2	11.3/56.5	11.3/67.8			67.8
IVPB Zosyn					50				50			50						50
IVPB Zantac							50		50									
IVPB Cipro				250	~~250~~	500			300									
IVPB Vec	2.7	2.7/5.4	2.7/8.1	2.7/10.8	2.7/13.5	2.7/16.2	2.7/18.9	2.7/21.6	21.6	2.7/2.7	2.7/5.4	2.7/8.1	2.7/10.8	2.7/13.5	2.7/16.2			16.9
IVPB Vanc												250						250
~~LR Bolus A~~	Bumin 25% in LR											1000 →						1000
TOTALS									1680									2416.8

OUTPUT

		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE Foley	HOUR / TOTAL	50/50	75/125	15/140	20/160	20/180	0/180	30/210	30/240	240	30/30	30/60	30/90	35/125	30/155	30/185			185
	sp gr																		
	S/A																		
NG	OUTPUT								100	100					100				100
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP #1								7.5	7.5									
	JP #2								7.5	7.5									
TOTALS										354									

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	132/72		114/60	116/103	106/64	112/61	115/65	114/63	
	1			109/54	109/54		91/65	115/65	
	96.3		98.0	97.7	99.4	97.4	97.3	97.5	
	112		124	125	128	117	120	115	
	15		15	5	15	15	18	18	
	95%		96%	99	97	96	97	96	
			100%	90%	90	90	90	90	

INTAKE	16	17	18	19	20	21	22	23	8° T
			125 / 125	125 / 250	125 / 375	125 / 500	125 / 625	125 / 750	750
			5 / 5	5 / 10	5 / 15	5 / 20	5 / 25	5 / 30	30
			2.7 / 3.7	2.7 / 5.4	2.7 / 8.1	2.7 / 10.8	2.7 / 13.5	2.7 / 16.2	16.2
			11.3 / 11.3	13 / 22.6	11.3 / 33.9	11.3 / 45.2	15 / 60.2	15 / 75.2	75.2
	500								500
	2300								2300
								10	10
				1000					1000
	Tube				10			4	681.4

OUTPUT		2.5	5 / 7.5	12 / 19.5	12 / 31.5	20 / 51.5	12 / 63.5	50 / 113.5	113.5
									20
									100
									500
		32		12	5	5		12.5	76.5
		40		17.5	10	7.5		10	75
									385

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME	0410	1700	2130	2230
	MODE	SIMV	SIMV		SIMV
	F_iO_2	60	100		90
	TV	700	700		700
	RATE	15	15		18
	PEEP	10	10		10
ABG	pH	7.47	7.37	7.45	7.43
	PCO_2	37.7	46.5	40.3	34.7
	pO_2	98	73	54	61
	HCO_3	28	27	28	23
	SAT	98	94	92	93
	BASE	4	2	4	-2

LABORATORY DATA	TIME	0400	1710	2130
	GLUCOSE	139	114	143
	Na/K	136 / 3.5	129 / 3.8	134 / 4.1
	Cl/CO_2	104 / 25	103 / 24	104 / 23
	BUN/Cr	35 / 2.9	39 / 3.2	40 / 3.3
	WBC/PLATELET	19.4 / 348	19.7 / 276	
	Hct/Hgb	8.7 / 28.3	8.0 / 26.9	

ACTIVITIES OF DAILY LIVING	b6-2 TIME	2400	0800	1800
	MOUTH CARE	[redacted]	[redacted]	[redacted]
	BATH		[redacted]	
	SKIN CARE		[redacted]	
	FOLEY CARE		[redacted]	
	TRACH CARE		[redacted]	
	ROM EXERCISES		[redacted]	

TURN	TIME		
	1800	2000	2200

SUCTION	
	1800

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	8778.2	Urine:	558.5
po		EBL	100
		NG	700
TOTAL	8778.2	TOTAL	1525

BALANCE + 7253.2

JP's 1665

NURSE'S SIGNATURE [redacted] CRT/AN

b6-2

INITIALS [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

INTENSIVE CARE NURSING FLOW SHEET /b6-2\

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0510	INITIALS [redacted]	1700	IN [redacted]		INITIALS
NEURO	PUPILS		pupils 2mm sluggish		pupils 2mm Sluggish			
	SENSORIUM		to light, sedated		⊖ Response Painful			
			on MSO4 IV continuous		Stimuli / Sedated			
			gtt, ⊖ withdrawal					
			⊖ localize pain.					
RESPIRATORY	RESPIRATORY PATTERN		RR even & unlabored		Res unlabored			
	BREATH SOUNDS		Midline, clear to		Fine Crackles Throughout			
	SECRETIONS		#8 Silicone obturator		Diminished &			
			@ bedside. NGS		#8 Trach secured			
			secure, connected to		by Stitches			
			vent, no drainage					
SKIN	COLOR		warm, pink ⊖ diminished		(L) Heel open			
	INTEGRITY		BK moist, skin		Bandage CDI, Coccyx			
			intact, Braden on,		Decub & Duoderm on			
IV SITE	LOCATION		(R) SC-Cordis @ triple		(R) SC-Cordis @ triple			
	CONDITION		lumen, dsg CDI, IV not		Lumen ⊖ S/Sx Infection			
			infused, cap lock, wall					
GASTRO	ABDOMEN		BS ⊖ ⊖ BS noted x4		Abd Round, Distended			
	BOWEL SOUNDS		(R) JP x2 Tube, TF @		Midline - Abd Dressing CDI			
			10 cc/hr, (R) mid abd		JP x2, Tube Feed			
			⊖ BRPS, ⊖ sensorium		@ 10 cc/hr			
GU	URINE:		drainage, midline		Foley Anchor			
	COLOR/CLARITY		ABD dsg CDI, F/C					
			⊖ BSB, urine clear					
CARDIOVASCULAR	CARDIAC RHYTHM		NSR noted, S-Trach		SinS2, S-Trach			
			⊖ CC, PVCs present		⊖ CC - PVC			
			BP 105-120/50 ⊖		Cap Refill <3 sec			
	b6-2		[redacted] 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

b6-2

(Continue on reverse)

PREPARED BY (Signature) [redacted] RN

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 15/Jun 03

PATIENT'S IDENTIFICATION (For unidentified patients give: Name—last, first, middle; grade; date [redacted] medical facility)

EPW # [redacted] b6-4

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

DATE 16 Jun 03 | 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	110/61	109/63	89/43	109/59	130/63	90/47	111/57	121/56		112/60	114/59	110/61	109/51	105/61	119/65	118/63	90/48	
	BP Cuff		104/61	82/43	105/51														
	Temperature	97.8	97.6	99.0	98.1	98.2	98.1							98.5					
	Pulse	112	114	109	105	111	102	105	112		116	110	108	109	120	121	119	106	
	Respiratory Rate	16	18	18	18	19	18	18	20		18	18	18	18	18	18	18	19	
	FIO2	90	90	90	90	90	90	90	80		80	80	80	80	75	75	75	75	
	SpO2	98	100	98	99	98	99	98	100		100	100	100	99	94	92	96	98	
	CVP			23	20	25	21	18	22		23	20	21	22	22	21	23	19	
	[illegible]																		
	[illegible]																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	IVF (LR)	125/125	125/260	125/375	125/500	125/625	125/750	125/875	125/1000	875	125/125	125/250	125/375	125/500	125/625	125/750	125/875	125/1000	1000
	Versed	5/5	5/10	5/15	5/20	5/25	5/30	5/35	5/40	40	5/5	5/10	5/15	5/20	5/25	5/30	5/35	5/40	40
	MSO4	2/2	2/4	2/6	2/8	2/10	2/12	2/14	2/16	16	2/2	2/4	2/6	2/8	2/10	2/12	2/14	2/16	16
	Dopa	15/15	15/30	19/49	19/68	19/87	19/106	19/125	19/144	145	19/19	19/38	19/57	19/76	19/95	19/114	19/133	19/152	153
	IVPB Zosyn																		
	IVPB Zantac							50		50									
	IVPB Cipro																	100	100
	Vec	3/3	3/6	3/9	3/12	3/15	3/18	3/21	3/24	24	3/3	3/6	3/9	3/12	3/15	3/18	3/21	3/24	24
	IVPB Vanc																		
	Tube Feed	10/10	10/20	10/30	10/40	10/50	10/60	10/70	10/80	70	10/10	10/20	10/30	10/40	10/50	10/60	10/70	10/80	80
	TOTALS									1229									1346

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	URINE		75/75	25/100	20/120	27/147	33/180	20/200	10/210	40/250	250	100	100/100	50/150	75/225	50/275	50/325	50/375	10/385	500
		sp gr																		
		S/A																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS	JP1		10			27				37	20			30				50	
		JP2		10			13				23	10			15				25	
	TOTALS																			

Urgent urology

Urgent urology

7.35 - 7.4

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	128/73	114/63	110/62	122/73	104/60	95/55	119/69	94/51	
			99.0	98.0	97.8	97.5	97	97.6	
	133	120	121	119	114	112	117	114	
	18	19	19	18	20	19	20	21	
	90	90	90	90	90	90	90	90	
	97	97	96	96	95	94	97	96	
	18			27	17	20	21	23	

INTAKE	16	17	18	19	20	21	22	23	8° T
	125/125	125/250	150/400	150/550	150/700	150/850	150/1000	150/1150	1150
			Pop		8/8	5/12	5/17	5/23	23
	2/2	2/4	2/6	2/8	2/10	2/12	2/14	2/16	16
	19/19	19/38	19/57	19/76	19/95	19/114	19/133	19/152	150
			50						
	off	off							
	10/10	10/20	10/30	10/40	10/50	10/60	10/70	10/70	70
									1409

OUTPUT	16	17	18	19	20	21	22	23	
	110/110	200/310	36/346	50/396	90/486	34/520	30/550	30/580	580
								30	300
	20							30	50
	10							15	25

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME	0350	0400		
		MODE	SIMV	SIMV		
		F_iO_2	90	80		
		TV	700	700		
		RATE	18	18		
		PEEP	12	12	1200	1600
	A	pH	7.46		7.391	7.40
	A	PCO_2	36.9		40.4	41
	A	pO_2	97		75	65
	B	HCO_3	26		24	26
	B	SAT	98		99	97
	G	BASE	2		1	1

LABORATORY DATA	TIME	0235	0400							
	GLUCOSE	146	145							
	Na/K	139/3.9	139/3.9							
	Cl/CO_2	102/23	102/25							
	BUN/Cr	39/3.7	43/3.9							
	WBC/PLATELET		8.3/243							
	Hct/Hgb		8.3/26							
	Alb		1.1							

ACTIVITIES OF DAILY LIVING	66-2 TIME	04	02	18
	MOUTH CARE	[redacted]		
	BATH	[redacted]		
	SKIN CARE	[redacted]		
	FOLEY CARE	[redacted]		
	TRACH CARE			
	ROM EXERCISES	[redacted]		

TURN	TIME	2400	0200	0400	1400	2000
		2200				
SUCTION		2400				

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	4028	Urine:	1333
po		NG	300
		JP	210
TOTAL	4028	TOTAL	1843

BALANCE +2185

NURSE'S SIGNATURE | INITIALS

[redacted]

66-2

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 / b6-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0505	INITIALS [redacted]	1730	INITIAL [redacted]		INITIALS
NEURO	PUPILS		pupils 2mm Sluggish		2mm (B) Round Sluggish			
	SENSORIUM		Sedated on Ventilator		Sclera Jaundiced			
			(B) Dangle Pt. pupils		Sedated. W/D From			
			2mg. Versed Continuous IV		Ravenel Stimuli			
			Reactive Stimulation		Does not Follow Commands			
RESPIRATORY	RESPIRATORY PATTERN		RR given at ventilator		Even & Unlabored			
	BREATH SOUNDS		LS coarse, phonchi		Coarse LS ↑ ↓ (B) Bases			
	SECRETIONS		↑ expiratory wheezing (B) bases		Trach #8 Midline Tip			
			midline, Trach #8		Vent Scant Thick			
			8.0 shiley connected to		Secretions			
			vent. ↑ setting noted.					
SKIN	COLOR		Skin pale. Cool to touch		Pale Cool to Touch			
	INTEGRITY		blisters noted (B) SC.		Stage II to Coccyx			
			↑ coccyx 3x3 ↑ dressing					
IV SITE	LOCATION		Dry, no redness, tender		(R) SC Cordis ↑ 3LC			
	CONDITION		blood ptn.		Dsg CDT			
					Patent			
GASTRO	ABDOMEN		Abd soft ↑ (B) BS x4		Abd Round Firm			
	BOWEL SOUNDS		x5 min. midline Abd		Midline Dsg Wet/Dry			
			dressing ↑ x2 JP (B)		JP x2 drain small amt			
			drainage from dressing ↑		Sero Sang. J tube L UQ ↑ TF @ 10cc/hr			
GU	URINE:		Foley patent in place		Foley drainage - Scant			
	COLOR/CLARITY		(D) Port ↑ tube connected		Amber Urine			
			to Kinetic in place					
CARDIOVASCULAR	CARDIAC RHYTHM		well. HR S-Rhythm		SR/ST ↑ occ. PVC's			
			@ 105-120s ↑ occ PVCs		Ctgn Edema			
			present. ↑ edema noted		(+) JVD			
			Pulses noted. Cap refill		(+) PP			
			<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

b6-2

(Continue on reverse)

PREP[redacted] CRT/RN

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 6/16/03

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

EPW # [redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 6/16/03 | DX | HOSPITAL DAY

VITAL SIGNS	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line	96/52	96/50	111/61	91/46	126/66	100/48	111/61	95/47		94/46	117/64	106/57	100/53	100/47	104/50	106/50	90/54	
BP Cuff		99/41	94/50	91/50														
Temperature	97.3	97.2	97.1	97.0	97.1	96.8	96.9					98.1					98.2	
Pulse	112	99	106	101	107	102	97	104		72	105	111	115	114	110	111	115	
Respiratory Rate	22	24	20	21	24	18	18	24		19	21	20	23	21	20	19	14	
SpO2	93	92	95	95	92	95	96	97		93	94	95	93	94	94	94	92	
CVP	24	16	18	23	20	23	23	24		22	20	20	21	21				
open intubation																		

INTAKE	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF (LR)	150/150	150/300	150/450	150/600	150/750	150/1000	150/150	150/300	1300	150	150/300	150/150	150/300	150/450	150/600	150/750	150/900	1000
Dopamine	119/9	19/38	19/57	19/76	19/95	19/114	19/133	19/152	252	19	19/38	19/57	19/76	19/95	19/114	19/133	19/152	252
MSO4	5/5	5/10	5/15	5/20	5/25	5/30	5/35	5/40	40	5	5/10	5/15	5/20	5/25	5/30	5/35	5/40	40
Propofol	5/5	5/10	5/15	5/20	5/25	5/30	5/35	5/40	40	5	5/10	5/15	5/20	5/25	5/30	5/35	5/40	40
~~IVPB Vanc~~ Levaquin	250/X	250/X										250	250	250	250	250	250	1500
" Cipro																		
" Zosyn																		
" Zantac							50		50								100	100
Flush							10					10				10		20
Tube Feed	10/10	10/20	10/30	10/40	10/50	10/60	10/70	10/80	80	10	10	10/30	10/40	10/50	10/60	10/70	10/80	80
TOTALS									1762									1592

OUTPUT		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	
URINE	HOUR	16	15	34	37	34	21	22	50	214	15	22	24	50	35	50	26	15	226
	TOTAL	16	21	55	87	121	142	164	214			22	61	111	146	196	221	236	
	sp gr																		3.5
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP1				20				20	40					25				25
	JP2				10				5	15					10				10
TOTALS										269									271

Urine/Void 300 cc

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	94/50	98/50	89/50	96/51	94/50	98/53	94/50	91/55	
				98.4					
	112	113	107	103	101	96	94	91	
	24	30	25	24	24	24	34	24	
	94	94	98	92	92	96	91	92	

INTAKE	16	17	18	19	20	21	22	23	8°T
	150/40	50/2600	50/2850	50/2600	50/2850	50/2720	50/2850	50/2850	2850
	90/[illegible]	19/842	18/873	18.2/918	18.3/1104	18.2/1181	18.2/1148	167	167
	5/85	2/80	2/88	2/91	2/93	2/95	2/97	2/99	99
	5/85	5/90	16.2/1286	16.2/1224	16.2/1386	16.2/1548	16.2/1711	16.2/1872	187
	40/800	40/240	40/280	40/320	80/400	80/480	80/560	80/640	640
	20/100					Vanc 140/350			350
	50/150								
	Vol 3/3	3/6	3/9	3/12	3/15	3/18	3/21		21
	10/90	10/100	10/110	10/120	10/130	10/140	10/150	10/160	160
									4424

OUTPUT	16	17	18	19	20	21	22	23	
	24/[illegible]	30/55	5/90	[illegible]/157	5/162	24/186	18/204	26/230	230
									680
	20							20	105
	5							5	35

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA					
	TIME	0346		1430	
	MODE	SIMV		SIMV	
	F_IO_2	70		80	
	TV	700		750	
	RATE	18		24	
	PEEP	12		14	
ABG	pH	7.414	7.38	7.38	
	PCO_2	40.1	46.8	40.7	
	pO_2	55	59	69	
	HCO_3	26	25	24	
	SAT	90	88	90	
	BASE	1	-1	1	

LABORATORY DATA					
	TIME	04	1500	1910	
	GLUCOSE	114			
	Na/K	137/4.5			
	Cl/CO_2	102/24			
	BUN/Cr	49/—			
	WBC/PLATELET	11.7/140			
	Hct/Hgb	7.4/23.9			
	Alb	1.0	TBil	8.5	
	Amy	131			
	AST	55			

ACTIVITIES DAILY LIVING				
bb-2	TIME	0001		
	MOUTH CARE			
	BATH	[redacted]		
	SKIN CARE	[redacted]		
	FOLEY CARE			
	TRACH CARE			
	ROM EXERCISES			

TURN	TIME			
	0001	0200	0400	
SUCTION	2330	0400		

24°I&O TOTALS

wt Yesterday ____ wt Today ____

	INTAKE		OUTPUT
IV	4424	Urine:	680
po			140
TOTAL	4424	TOTAL	820

BALANCE: 3604

NURSE'S SIGNATURE	INITIALS
[redacted] CRT/[illegible]	[redacted]
bb-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

b6-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	1600	INITIALS [redacted]	1730	IN[redacted]		INITIALS
NEURO	PUPILS	Sedated, Prop [redacted]		Sedated, No response			
	SENSORIUM	rec 3mm/hr, [redacted] 2mm/hr		to Painful Stimulus			
		Pt is paralyzed.		Pupils 2mm sluggish			
RESPIRATORY	RESPIRATORY PATTERN	Mech Vent Support SIMV		Mech Vent - SIMV RR 24			
	BREATH SOUNDS	24, peep 14 Fio2 50%		Peep 14 FIO2 90% TV			
	SECRETIONS	VT 750. Pt is not		Breath Sounds Coarse			
		breathing above the vent which		Crackles from # 8 Shiley			
		is via Size #8 Shiley Trach.		trach			
		Secretion thick dark yellow					
SKIN	COLOR	sats 90-93%.		Open Heart - (L) Foot			
	INTEGRITY	Sclera Sandy red, moist		Wound (R) Hip. Dressing CDI			
		dry Bulky + dark yellow		Midline Wound Dressing CDI			
		Saturation, Blanch pink		(R) SC Triple Lumen thru Cordis			
IV SITE	LOCATION	Also Bulky 4x4 + dark		(R) Rad A-Line O S/Sy IAF.			
	CONDITION	yellow saturation					
		(R) SC Cordis + the dark					
		(R) Radial a line line					
		one dry & intact					
GASTRO	ABDOMEN	large form BS (+)		Abd, Round, Distended			
	BOWEL SOUNDS	NG to (R) nare to LIS		firm (+) BS			
		TF Jenny @ 10ml/hr.		NG to LIS			
				TF @ 10ml/hr			
GU	URINE:	via foley dark yellow		Foley dark Yellow			
	COLOR/CLARITY			UAND			
CARDIOVASCULAR	CARDIAC RHYTHM	NSR 80s - 90s Ectopics		NSR - 100 + Freq PVC			
		BP 90/50 CVP 24		CVP 18-24			
		S1 S2 Present.		S1 S2 present			

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

b6-2

(Continue on reverse)

PREPARED BY (Signature [redacted] CPT, [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU Surg / ICU-T

DATE: [redacted] 03

[redacted] entries give: Name—last, first, middle; grade; da[redacted] or medical facility)

[redacted] b6-4

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

DATE 17 JUN 03 | DX CSW | HOSPITAL DAY | PAGE 2 OF

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
	BP Arterial Line	107	114	108	103	114	91	104	98		104	92	116	92	101	101	100	118
	BP Cuff	59	65	59	59	71	53	62	58		62	53	61	58	44	52	47	71
	Temperature																96.5	
	Pulse	92	89	87	87	95	89	91	87		44	92	95	94	97	96	99	100
	Respiratory Rate	24	24	24	24	23	21	24	24		24	24	24	24	24	24	26	24
	SpO2	93	92	94	92	93	93	97	93		94	93	92	94	92	96	93	93
	CVP	23	25	25	25	26	26	22	24		23	23	23	23	23	23	23	23
	pain	560	→															
	intervention	0	→															

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	LR	50	50/100	50/150	50/200	50/250	50/300	50/350	50/400	400	50/0	50/100	50/150	50/200	50/250	50/300	50/350	50/400	400
	LASIX	80	80/160	80/240	80/320	80/400	80/480	80/560	80/640	80/740	80/0	80/160	80/240	80/320	80/400	80/480	80/560	80/640	640
	DOPAMINE	18.8	18.8/37.6	18.8/56.4	18.8/73.2	18.8/94	18.8/112.8	18.8/131.6	18.8/150.4	130.8	18.8/0	18.8/24.6	18.8/56.4	18.8/73.2	18.8/92.0	18.8/110.8	18.8/129.6	18.8/145.4	145.4
	PROPOFOL	13.5	13.5/27	13.5/40.5	13.5/54	13.5/67.5	13.5/81	13.5/94.5	13.5/108	13.5/131.5	13.5/0	13.5/27	13.5/40.5	13.5/54	13.5/67.5	13.5/81	13.5/94.5	13.5/108.0	108
	MSO4	2	2/4	2/6	2/8	2/10	2/12	2/14	2/16	2/18	2/0	2/4	2/6	2/8	2/10	2/12	2/14	2/16	16
	VEC	3	3/6	3/9	3/12	3/15	3/18	3/21	3/24	3/27	3/0	3/6	3/9	3/12	3/15	3/18	3/21	3/24	24
	IVPB					50/50				1579	50		50/0	50/100				200/400	1603
											1492.6								
	TF	10	10/20	10/30	10/40	10/50	10/60	10/70	10/80	10/90	1492.6	10/0	10/20	10/30	10/40	10/50	10/60	10/70	70
	TOTALS																		

OUTPUT																			
URINE	HOUR / TOTAL	32/32	40/72	30/102	35/137	25/162	42/204	30/234	30/264	60/324	60/0	50/110	40/150	50/200	40/240	40/280	50/330	46/376	376
	sp gr									264									
	S/A																		
NG	OUTPUT																		
	pH																		376
	GUIAC																		
EMESIS										310									
STOOL																			
DRAINS	JP#1								40	40									
	JP#2								10	10									
TOTALS																			

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
		105/57	100/51	102/63	92/58	97/53	96/48	99/43	
				116/67	99/47	93/99			
		97.7	97.7	96.5		97.0			
		108	107	109	108	106	106	106	
		91%	95	95	90	94	94	95	
		24	24	24	24	24	24	24	
		23	26	25	30	30	22	26	

INTAKE	16	17	18	19	20	21	22	23	8°T
	50/0	50/100	50/150	50/200	25/225	25/250	25/275	25/300	300
	80/0	80/160	80/240	80/320	80/400	80/480	80/560	80/640	640
	18.8/0	19/39	19/57	19/76	19/95	19/114	19/133	19/152	152
	13.5/0	13.5/27	13.5/40.6	13.5/54.0	13.5/67.5	13.5/81.0	13.5/94.5	13.5/108	108
	2/0	2/4	2/6	2/8	2/10	2/12	2/14	2/16	16
	3/0	3/6	3/9	3/12	3/15	3/18	3/16	3/20	20
	50/0								
	10/10	10/20	10/30	10/40	10/50	10/60	10/70	10/80	80
									1316

OUTPUT	16	17	18	19	20	21	22	23	8°T
	40/0		46/86	23/109	35/144	21/165	26/190	33/223	223
								250	250
									936
						13			13
						7			7

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
	TIME	0340	0729	1646						
	MODE	SIMV	SIMV	SIMV						
	F_iO_2	80	80	100						
	TV	750	750	750						
	RATE	24	24	24						
	PEEP	14	14	14						
ABG	pH	7.42	7.48	7.34						
	PCO_2	34	35.6	41						
	pO_2	51	57	50						
	HCO_3	22	22	22						
	SAT	87	90	85						
	BASE	-2	-2	4						

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

ACTIVITIES OF DAILY LIVING	66-2 TIME	1900	2200
	MOUTH CARE	[redacted]	
	BATH		
	SKIN CARE	[redacted]	
	FOLEY CARE		
	TRACH CARE	[redacted]	
	ROM EXERCISES		

TURN	TIME				
	1800	200			
SUCTION					

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	4411	Urine:	863
PO		NG	930
		JP	70
TOTAL	4411	TOTAL	1869

BALANCE _____

NURSE'S SIGNATURE

[redacted] CPCP

[redacted] CPT/AN

66-2

INITIALS

[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

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0610	INITIALS [redacted]	06-2	INITIALS		INITIALS
NEURO	PUPILS	2mm Sluggish to light				2mm NRL - scleredema,	
	SENSORIUM	Sedated & paralyzed				jaundiced whites of eyes,	
		on MS04, Dilaudid,				pt. sedated c̄ propofol,	
		Vecuronium, intubated				MS04, ~~Dilaudid~~ Vecuronium,	
		to localize, on ice					
RESPIRATORY	RESPIRATORY PATTERN	RR even & unlabored				RR even & unlabored	
	BREATH SOUNDS	LS (B) diminished.				LS (B) diminished,	
	SECRETIONS	midline trach c̄				midline trach #8,	
		#8 Shiley connected				vent settings SIMV,	
		to vent c̄ settings				100 FiO2, TV 700, 29,	
		noted on back				Peep 18, SpO2 85-87%	
SKIN	COLOR	skin warm pink				skin warm/dry, edematous	
	INTEGRITY	warm/dry, +1				overall, pitting edema	
		RUE PIV noted				noted.	
IV SITE	LOCATION	(R) SCV c̄ cordis,				(R) SCV x 3L cordis, 5	
	CONDITION	site well c̄ dressing				s/s infect, (R) radial	
		on (R) radial Aline				A-line, CDI c̄ s/s	
		c̄ WNL				infect	
GASTRO	ABDOMEN	midline abd dress				midline ABD DRSG,	
	BOWEL SOUNDS	CDI c̄ JP drain				CDI, BS diminished	
		to bulb x 3				x 4 quads.	
		(R) quad. c̄ TPN					
GU	URINE:	Foley F/C to				F/C to gravity bag	
	COLOR/CLARITY	bag c̄ amber				c̄ low output, 10-15ml/hr,	
		UOP				dark amber.	
CARDIOVASCULAR	CARDIAC RHYTHM	Sinus rhythm on				Sinus Rythym - ST	
		monitor c̄ HR				monitor HR 0 110-	
		110-115 when				120	
		continue to					
		monitor. Pt.					

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O2; 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 [redacted] b6-2 cpt AW

DEPARTMENT/SERVICE/CLINIC: ICU 2nd

DATE: 6/18/03

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

EPW # [redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 6/18/03 | 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	94/54	100/03	99/59	81/45	93/46	93/46	[illegible]	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	
	BP Cuff											40	51	51	54	52	53	53	
	Temperature	97.8	98.1	98.1	98.6	98.2		98.7					98.4						
	Pulse	108	114	115	110	109	112	111	121		121	117	110	114	119	121	119	120	
	Respiratory Rate	24	24	24	24	24	24	20	21		22	24	23	24	24	24	25	24	
	CVP	25	30	30	26	23	27	26	23		23	24	24	23	24	20	24	23	
	SPO2	96	93	92	97	96	96	96	89		89	89	88	89	88	89	84	85	
	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	25	25/50	25/75	25/100	25/125	25/150	[illegible]	[illegible]	200	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	200
	Dopa	19	19/38	19/57	19/76	19/95	19/114	[illegible]	[illegible]	152	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	292
	MSO4	2	2/4	2/6	2/8	2/10	2/12	2/14	2/16	16	2	2/4	2/6	2/8	[illegible]	[illegible]	[illegible]	[illegible]	16
	Propofol	14	14/28	14/42	14/56	14/70	14/84	[illegible]	[illegible]	[illegible]	14	14/28	14/42	14/56	[illegible]	[illegible]	[illegible]	[illegible]	112
	Vec	3	3/6	3/9	3/12	3/15	3/18	[illegible]	[illegible]	24	3	3/6	3/9	3/12	3/15	3/18	3/21	3/24	24
	Lasix	80	80/160	80/240	80/320	80/400	80/480	80/960	80/1040	1040	80	80/160	80/240	80/320	80/400	80/480	160/560	160/720	720
	IVPB																	120	100
	Tube Feed	10	10/20	10/30	10/40	10/50	10/60	10/70	10/80	80	10	10/20	10/30	10/40	10/50	10/60	10/70	10/80	80
	TOTALS									1624									1544

OUTPUT																			
URINE	HOUR / TOTAL	30	23/53	25/78	17/95	19/114	23/137	15/152	12/174	174	12	30/42	30/92	60/152	16/168	15/183	15/148	20/218	218
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP1							10		10			15				10		25
	JP2							5		5			10				12		32
TOTALS																			262

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	84/53	100/57	96/57	84/54	93/56	84/49	104/64	102/60	
	48		99.6						
	114	117	117	114	112	109	110	103	
	25	24	29	25	26	25	25	25	
	22	25	27	31	24	25	24	26	
	84	86	86	91	85	90	90	86	

INTAKE	16	17	18	19	20	21	22	23	8° T
	25/25	25/50	25/75	25/100	25/125	25/150	25/175	25/200	200
	47	47/94	28.1/122.1	28.1/150.2	28.1/178.2	28.1/206.3	28.1/234.4	28.1/262.5	262.5
	2	2/4	2/6	2/8	2/10	2/12	2/14	2/16	16
	14	14/28	13.5/41.5	13.5/55	13.5/68.5	13.5/82.0	13.5/95.5	13.5/109.0	109
	3	6	6/12	6/18	6/18	6/24	6/30	6/36	36
	16	16/32	16/48	16/64	16/80	16/96	16/112	16/128	128
							50	250	300
	10/10	10/30	10/30	10/40	10/40	10/50	10/60	10/70	70
									1230 ~~930~~

OUTPUT	16	17	18	19	20	21	22	23	
	34	10/44	2/46	1/47	1/48	41/89	15/104	35/139	139
								10	10
								20	20
									169

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
	TIME	0200	1500	1650	1720					
	MODE	SIMV	SIMV	SIMV	SIMV					
	F_iO_2	100	100	100	100					
	TV	750	750	700	700					
	RATE	24	25	29	29					
	PEEP	14	14	18	18					
A	pH	7.35			7.362					
A	PCO_2	39			38.4					
B	pO_2	58			49					
B	HCO_3	22			19					
G	SAT	87			80					
G	BASE	-4			-7					

LABORATORY DATA										
	TIME	0400								
	GLUCOSE	84								
	Na/K	139/4.6								
	Cl/CO_2	99/23								
	BUN/Cr	63/6.7								
	WBC/PLATELET	8.5/97								
	Hct/Hgb	22.5/7.2								

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

TURN	TIME				
	2400	0200	0400		
SUCTION	0230				

24° I&O TOTALS

wt Yesterday _____ wt Today _____

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

BALANCE _____

NURSE'S SIGNATURE | INITIALS

[redacted]

b(6)

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	0510	INITIALS [redacted]	b(6)-2	INITIALS		INITIALS
NEURO	PUPILS	pupils fixed or					
	SENSORIUM	dilated. ø responds					
		to localize stimulation					
		follows ø commands					
RESPIRATORY	RESPIRATORY PATTERN	[illegible] unlabored					
	BREATH SOUNDS	NSB coarse rhonchi					
	SECRETIONS	noted. midline					
		trach connect to					
		vent. see [illegible]					
		sheet [illegible]					
SKIN	COLOR	[illegible]					
	INTEGRITY	[illegible]					
		noted skin					
IV SITE	LOCATION	[illegible]					
	CONDITION	[illegible]					
		[illegible]					
		[illegible]					
		[illegible]					
		[illegible]					
GASTRO	ABDOMEN	[illegible]					
	BOWEL SOUNDS	[illegible] noted					
		[illegible]					
		[illegible]					
GU	URINE:	noted [illegible]					
	COLOR/CLARITY	[illegible]					
		[illegible]					
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible]					
		[illegible]					
		[illegible]					
		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] b(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 19 June 03

PATI[redacted] (For typed or written entr[redacted] 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 6/19/03 | 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	97/58	99/60	110/68	79/47	65/42	65/40	99/44	91/45										
	BP Cuff						91/70												
	Temperature																		
	Pulse	105	103	101	101	93	92	95	99										
	Respiratory Rate	25	25	25	25	25	25	24	25										
	CVP	24	26	24	28	27	25	8	12										
	SpO2	88	87	79	65	69	74	70	77										
	pain																		
	intubation																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	LR	25	25/50	25/75	25/100	25/125	25/150	25/175	25/200	150	25/175	25/200							
	Dopamine	28.1	28.1/56.2	28.1/84.3	28.1/110.4	28.1/138.5	28.1/167	28.1/195.1	28.1/223.2	223	28.1/251.3	28.1/279.4							
	MS04	2	2/4	2/6	2/8	2/10	2/12	2/14	2/16	16	2/18	2/20							
	Propofol	13.5	13.5/27	13.5/30.5	13.5/44	13.5/57.5	13.5/71	13.5/84.5	13.5/98	98	13.5/111.5	13.5/125							
	Vec	6	6/12	6/18	6/24	6/30	6/36	6/42	6/48	48	6/54	6/60							
	Basic	16	16/32	16/48	16/64	16/80	16/96	16/112	16/128	128	16/144	16/160							
	IVPB										50								
	TOTALS									812									

OUTPUT		HOUR / TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	
	URINE		36/36	40/76	40/116	40/156	5/161	5/166	5/171	5/176	176									
		sp gr																		
		S/A																		
	NG	OUTPUT						1000			1000									
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS	JP1																		
		JP2																		
	TOTALS										1176									

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	

INTAKE	16	17	18	19	20	21	22	23	8°T

OUTPUT									

ACUITY LEVEL CLASSIFICATION

RESPIRATORY										
	TIME	0030	0330							
	MODE	SIMV								
	F_IO_2	100								
	TV	760								
	RATE	25								
	PEEP	18								
ABG A	pH		7.228							
ABG A	PCO_2		47.8							
ABG B	pO_2		39							
ABG B	HCO_3		20							
ABG B	SAT		62%							
ABG G	BASE		-8							

LABORATORY										
	TIME	0400								
	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	NURSE'S SIGNATURE	INITIALS
wt Yesterday _____ wt Today _____	[redacted]	[redacted]
INTAKE / OUTPUT	6/68-2	
IV _____ Urine: _____		
po _____ _____		
_____ _____		
TOTAL _____ TOTAL _____		
BALANCE _____		

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0530	INITIALS [redacted]	b(6)-2	INITIALS		INITIALS
NEURO	PUPILS	PUPILS SIZE & RE					
	SENSORIUM	ALERT, ORIENTED					
		GOOD ORIENTATION					
		SPEECH & COMMUNICATION					
RESPIRATORY	RESPIRATORY PATTERN	REGULAR, UNLABORED					
	BREATH SOUNDS	LUNGS CLEAR, BILATERAL					
	SECRETIONS	NONE, MINIMAL					
		CLEAR, COMFORT					
		WHITE, SEC. MOUTH					
		GREAT SEC. SUCTIONING					
SKIN	COLOR	DUSKY, COMFORT					
	INTEGRITY	INTACT, DRY					
		MOIST, SKIN					
IV SITE	LOCATION	RIGHT FEMORAL TUNNEL					
	CONDITION	REDNESS, TENDER					
		SWELLING, TENDER					
		TUNNEL, DRY					
		DRESSING INTACT					
		INFUSION INTACT					
GASTRO	ABDOMEN	SOFT, SOFT, NT					
	BOWEL SOUNDS	GOOD, ACTIVE					
		SOFT, DISTENDED					
		SEMI-FORM, DARK BROWN					
GU	URINE:	CLEAR, DARK YELLOW					
	COLOR/CLARITY	1 FOLEY					
		FOLEY, OTHER OUTPUT					
CARDIOVASCULAR	CARDIAC RHYTHM	NORMAL SR					
		ASTOLIC, TONE					
		PRESENT, OTHER					
		NORMAL					

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; SVA - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC ICU 2 unit

DATE 19 June 03

PATIENT IDENTIFICATION (Type or typed or written entries [redacted] 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 6/19/03 | 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	97/58	99/60	110/68	79/47	65/42	65/40	73/44	71/45										
	BP Cuff						97/6												
	Temperature																		
	Pulse	105	103	101	101	93	92	93	89										
	Respiratory Rate	25	25	25	25	25	25	24	25										
	CVP	24	26	24	28	27	25	[illegible]	[illegible]										
	SpO_2	88	87	79	65	69	71	70	77										
	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	25	25/50	25/75	25/100	25/125	25/150	[illegible]	25	150	25	25/50							
	Dopamine	28.1	28.1/56.2	28.1/84.3	28.1/110.4	28.1/138.5	28.1/167	[illegible]	[illegible]	233	[illegible]	[illegible]							
	MS04	2	2/4	2/6	2/8	2/10	2/12	[illegible]	[illegible]	16	2	[illegible]							
	Propofol	13.5	13.5/17	13.5/30.5	13.5/44	13.5/57.5	13.5/71	13.5/84	13.5/98	98	13.5	13.5/27							
	Vec	6	6/12	6/18	6/24	6/30	6/36	6/42	6/48	48	6	6/12							
	Lasix	16	16/32	16/48	16/64	16/80	16/96	16/112	16/128	128	16	16/32							
	IVPB										50								
	TOTALS									672									

OUTPUT																			
URINE	HOUR / TOTAL	36/36	40/76	40/116	40/156	5/161	5/16[illegible]	8/169	8/177	177									
	sp gr																		
	S/A																		
NG	OUTPUT						1000			1000									
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP1																		
	JP2																		
TOTALS																			

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	/

INTAKE	16	17	18	19	20	21	22	23	8° T

OUTPUT	/	/	/	/	/	/	/	/	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
	TIME	0030	0330							
	MODE	SIMV								
	F_IO_2	100								
	TV	760								
	RATE	25								
	PEEP	18								
ABG	pH		7.228							
	PCO_2		478							
	pO_2		39							
	HCO_3		20							
	SAT		62%							
	BASE		-8							

LABORATORY DATA										
	TIME	0400								
	GLUCOSE									
	Na/K	/	/	/	/	/	/	/	/	/
	Cl/CO_2	/	/	/	/	/	/	/	/	/
	BUN/Cr	/	/	/	/	/	/	/	/	/
	WBC/PLATELET	/	/	/	/	/	/	/	/	/
	Hct/Hgb	/	/	/	/	/	/	/	/	/

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

TURN	TIME				

SUCTION					

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

NURSE'S SIGNATURE | INITIALS

[redacted]

60 2

MEDCOM - 9762

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A A A D A	I Z	0 0 1 3 2 7 3	EPW # [redacted] b(6)-4		M

b(6)-4

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	2 4 Y	Z	9	

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

b(6) 4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	U	1145	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 9 Enemy Prisoner of War	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø Direct from ER	ICW 1	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] b(2)-2	

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
7 0 RETURN TO EPW CAMP		0 3 0 6 1 9

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A A A A Internal Med.		0 3 0 6 1 0

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: S/P EXP-LAP / Placement J Tube / Trach

DX	DX	PROC		I	J
879.2	5768	311	9655		
9974	E87688	5123		1	450
5678	586	5022			
5185	E9339	4573			
0389		9672			
		966			

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
[redacted]	[redacted] SPC b(6)-2

DA FORM 2085, MAR 90 [redacted] EDITION OF MAY 75 IS OBSOLETE

b(6)-2

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.)
1	2	3	4	5	6	7	8	
A	1	1	D	1		I	Z	

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15		16	17	18
0	0	1	3	2	7	3	EPW [redacted] b(6)-4			M

b(6)-4

6. DATE OF BIRTH (Y Y Y Y M M D D)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31 BACK-GROUND	
											X	9	MUS

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER								
32	33	34		35	36	37	38	39	40	41	42	43	44	45
—				9	9	[redacted]								

b(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	46: 2	1535	

14. FLYING STATUS			15. BENEFICIARY CATEGORY			16. ZIP CODE OF RESIDENCE								
47	48	49	50	51	52	53	54	55	56	57	58	59	60	61
—			K	7	8									

17. UNIT LOCATION (State or Country Code)		18. MOS							19. TRAUMA	PREV. ADMISSION	
62	63	64	65	66	67	68	69	70	71	YEAR	X NO
—											

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: Ø	ICU 1	UNIT
		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNIT
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: [redacted] b(2)-2		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNIT

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (Y Y M M D D)					
73	74	75	76	77	78	79	80	81	82	83	84	85	86
								0	3	0	6	1	4

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (Y Y M M D D)					
87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102
A	B	A	A							0	3	0	5	2	9

27. LOCATION OF OCCURRENCE (Battle Casualty Only)		28. MTF OF INITIAL ADMISSION						29. DATE INITIAL ADMISSION (Y Y M M D D)					
103	104	105	106	107	108	109	110	111	112	113	114	115	116

FOR LOCAL USE

DX: S/P EXP - LAP

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
[redacted] b(6)-2	[redacted] b(6)-2

DA FORM 2985, MAR 90

MEDCOM - 9764

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER 0013285 b(6)-4			2. NAME (Last, First, MI) UNK - IRAQI EPW# [redacted] b(6)-4			3. GRADE EPW	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 [redacted]		13. ORGANIZATION b(6)-4		14. WARD ICU-1	
15. FLYING STATUS NO	16. RATING/ DSG	17. DEPT./ BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP		20. TYPE CASE WIA	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION 1211	23. CLINIC SERVICE		[redacted]
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —			25. TYPE DISPOSITION DK TO CAMP		26. DATE OF DISPOSITION 14 July 2003		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —			27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 30 MAY 2003		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2					30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: ~~S/P WOUND CLOSURE~~

1. S/P GSW to back/pelvis requiring urinary diversion
2. Urinary diversion
3. Open suprapubic wound
4. Small bowel obstruction - resolved
5. UTI resolved

Procedures: flap wound closure

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	45	45

36. Total Days All Facilites

[redacted]	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
[redacted]	0	0	0	45	45

SIGNAT[redacted]FICER b(6)-2 [redacted] PAD OR MEDICAL RECORDS OFFICER [redacted] b(6)-2

DR[redacted]

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER 0013285 b(6)-4	2. NAME (Last, First, MI) EPW [redacted] b(6)-4					3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 21	6. RACE	7. RELIGION	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION	
11. FMP 99	12. SSN [redacted] b(6)-4		13. ORGANIZATION			14. WARD ICU1	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT/ BEN K78	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: direct from ER				22. HOURS OF ADMISSION 0023	23. CLINIC SERVICE		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION 50		26. DATE OF DISPOSITION 22 JUN 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 30MAY03		ADMITTING OFFICER [redacted] b(6)-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY					30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

~~s/p (R) Nephrectomy, Ileal Conduit~~

Dx: GSW to back/abd.

Procedure: Suprapubic random flap hand closure.

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	23	23

36. Total Days All Facilites

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

S[redacted]EDICAL OFFICER [redacted] b(6)-2 SIGNATURE OF [redacted]MEDICAL RECORDS OFFICER [redacted] b(6)-2

DA FORM 3647, MAY 76 EDITION OF 1 AUG 76 IS OBSOLETE USAPPC V1.10

MEDCOM - 9766

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

21 year old Iraqi male (EPW) s/p pelvic GSW in ~~Apr 03~~ Mar 22
c̄ injury to Right ureteral injury and pelvic vasculature.
Had (B) PCN, pubiectomy, coral venous cyclex ligation, (R) [redacted]
nephrectomy and diuretic ileal loop urinary ~~[illegible]~~
here for care of large pubic defect anteriorly.

PMHx - unknown
PSH - see above

percutaneous nephrostomy X 2
May 03
(R) ARM

PHYSICAL EXAMINATION

thin Iraqi male
lungs clear Hrt RRR (-) m
abdomen see diagram
soft tender over wound / missing pubic bone
nl penis, testicle tt
Cut nl
Back (+) granulating Exact wind

PROGRESS (Enter date of discharge and final diagnosis)

Dg. s/p pelvic GSW
Plan: TRAM

9.4
8.4 > 29.5 < 476
136 | 100 | 9 < 107
4.4 | 26 | 0.5

[redacted] b(6)-2

DATE	IDENTIFICATION NO.	ORGANIZATION

PAT[redacted]N (For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.	WARD NO.

[redacted] b(6)-4

ca

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

MEDCOM - 9767

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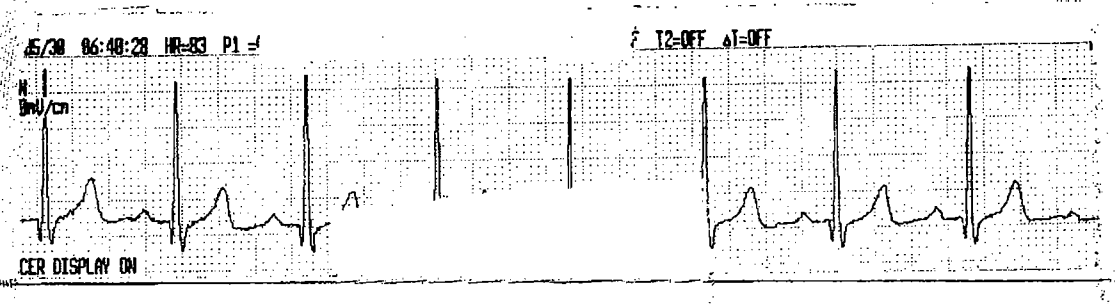
MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 May 03 2400	Admited from EMT via gurney. VSS. Alert x 3. ∅ IV fluids has ostomy bag sd. drainy straw clonl urine Abd. wound lower ~~Abd~~ Abd. draing small amt of bloody drainage. wound packed c̄ 4x4 moist c̄ NS. coved c̄ 4x4 and ABD pads. Restraints applied to upper extremities. guard posted next to bed. — b(6)-2 [redacted]
0100	PT Resting quiety c̄ eyes closed. ostomy drainig ~~clos~~ straw colored urine. Restraints to upper extremities in place and secure. — Sgt [redacted] b(6)-2
0240	Pt had extremely large BM - soft/Brown semi-formed. Given 1mg Ativan PO for anxiety. Pt has bloody Drng from Penile urethra/meatus - Covering LPN/Charge Nurse aware — b(6)-2 [redacted] CPT, AN
0400	CBC and chem 8 drawn. b(6)-2 [redacted]
5/30/03 0545	

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(6)-4

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30 May 03	Nutrition Note
S:	Nursing reports pt c̄ good appetite.
O:	21 y/o Iraqi male Dx: S/P Nephrectomy, Ileal conduit
	Diet: Regular WT: estimated 120 #
A:	Malnourished Iraqi male @ nutritional risk 2° to injuries/surgery. Pt was given a nutritional supplement and consumed it within 30 seconds. I anticipate pt will take adequate PO intake if supplemented.
P:	1) Regular Diet
	2) Will provide carnation Instant Breakfast TID to supplement PO intake.
	[redacted] MAJ, SP RD/LDI
	b(6)-2
30 MAY 03	Nursing: End of Shift Note
1645	Pt is AXOX3. prefers to raise hips up for access to changing Pad in his buttocks than turning from side to side. C/O of pain at the (R) LQ after reenforcement of dsg. MSO4 3mg IVP X'lvers effective for pain control. Pt on RA, regular breathing c̄ Resp Rate c̄ in normal limits. NSR c̄ Ectopics BP WNL. Peripheral pulses palpable 3+/2+ Bilat UE/LE. Ileal conduit draining clear yellow urine. A modified drainage Collection tubing

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

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REGISTER NO.	WARD NO.

EPW [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Nursing note. End of shift continuation.
1645	and bag was effective in initiating a continuous drainage
5/30/03	collection. the Stoma is pink and moist Ø bleeding noted
	Wound is pink and moist both mid line abdominal and
	pubic packing. Posterior mid coccyx wound has potending
	tunnels one 1/4 coin size and the other on the proximal
	upper right while facing the wound has less than 1 dime coin
	size. Pt is eating 95% of all meals and appears to have
	good appeb appetite for the feeding given to him including
	ensure drinks. Will continue to monitor pt's status [redacted]
1745	PT sitting up Alert x3. Apetite is good Ate 80% of dinner TRAY. b(6)-2
	drank all of ensure 240 - milk - 240ml - 100ml h2o. Ileostomy
	draining clear urine 100ml @ present. Abd dressings intact
	c̄ small amt of bloody drainage noted soaked through USS.
	Lungs CTA Bil BS ⊕ all quads. offers Ø c/o pain or discomfort
	@ this time. Resting quietly. Restraints are secure to b(6)-2
	upper extremities. ——— SGT [redacted]
1940	Percocet ⅡPO given for c/o Abd pain. will monitor. SGT [redacted]
2200	Abd. dressings Δ'd wet to dry c̄ Kerlex supergauze. moderate
	Amount of serosangous bloody drainage noted. Ø foul odor. Ø S/S
	of infection. Dressing to [redacted] Lower Ø back Δ'd c̄ moderate amt
	of bloody drainage. Ø S/S of infection. Ileostomy draining clear
	yellow urine 100ml in bag. Ø further c/o pain or discomfort. linen
	Δ'd to bed, pt given clean gown. Resting quietly @ present c̄
	Restraints secured to UE. ——— SGT [redacted] b(6)-2
0300	Resting quietly c̄ eyes closed. Restraints to UE in place b(6)-2
	and secure. ileostomy draining clear yellow urine. SGT [redacted]

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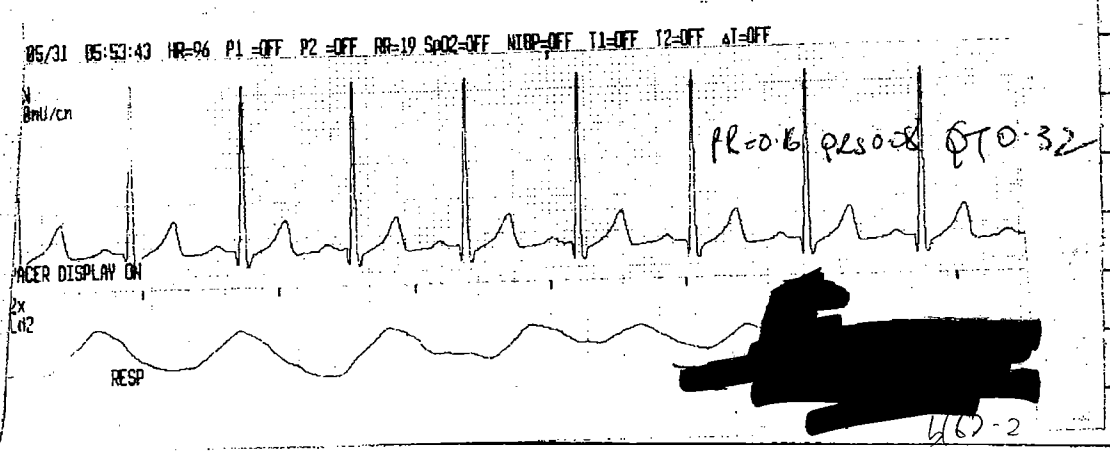
LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30May03 0430	PT is Resting quietly c̄ Eyes closed. ileostomy is draining clear yellow urine. Restraints to UE in place and secure. S at [redacted] b(6)-2
5/31/03 0500	 [redacted] b(6)-2
5/31/03	Nursing: Dsg Δ Pt's dsg change to pelvic area using sterile technique wet to dry super sponge applied to the pubectomy site and the midline abd incision and mid lower back wounds were both closed c̄ sterile gauze. Dr [redacted] applied silver nitrate application to the lower back wounds. One 1/4 coin size and the other a dime (coin size) and the mid line abd site as well. Upon application of silver nitrate wound site changed from pink to light ash a greenish color. The pubectomy site was reddish and moist c̄ moderate bleeding of sero sanguineous fluid. The other two sites the abdominal and the posterior back wounds were dry and intact. Pt Tolerated procedure b(6)-2
5/31	Nursing: Activity [redacted] b(6)-2 Pt OOB to bedside chair X 4°. Pt ~~[illegible]~~ ate Sitting up ~~[illegible]~~ in a chair

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

Nursing Note

DATE	NOTES
030/03	confusion. Ambulate Pt progressed well c̄ self feeding c̄ Restraints time ~~and~~ for pelvic Xray A/P done. Ileocecal valve functioning well c̄ clear yellow urine output. dsg change x 2 2° leaks around the Urostomy Appliance A new appliance applied c̄ confusion during change. drainage tube connect to a foley bag. Pt is ambulate Will continue to monitor Pt. Status — [redacted] b(6)-2
3 May 03	PT Ate 50% of supper, drank 120ml of h2o. VSS, Alt x3.
1825	Abd dressings small amt of bloody drainage noted, dressing to Left low back is dry and intact. ileostomy draining clear yellow urine. offers no c/o @ present time. Restraint to UE in place and secure. — SGT [redacted] b(6)-2
1900	½ Percocet given PO for c/o Abd pain. — SGT [redacted]
2033	morphine 2mg IV given for c/o Abd wound pain. Large amts of bloody drainage from pubic wound & large clots cleaned out of wound. wound running midline chest to pubus, small amount of bleeding noted. silver nitrate applied to wound. dressings Δ'd to both sites, Pubic area packed c̄ 4x4 soaked c̄ NS and covered dry dsg. upper midline wound covered c̄ dry dsg. both cover c̄ Abd Pads. — (cont)

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	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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E PW [redacted] b(6)-4		

PROGRESS NOTES
Medical Record

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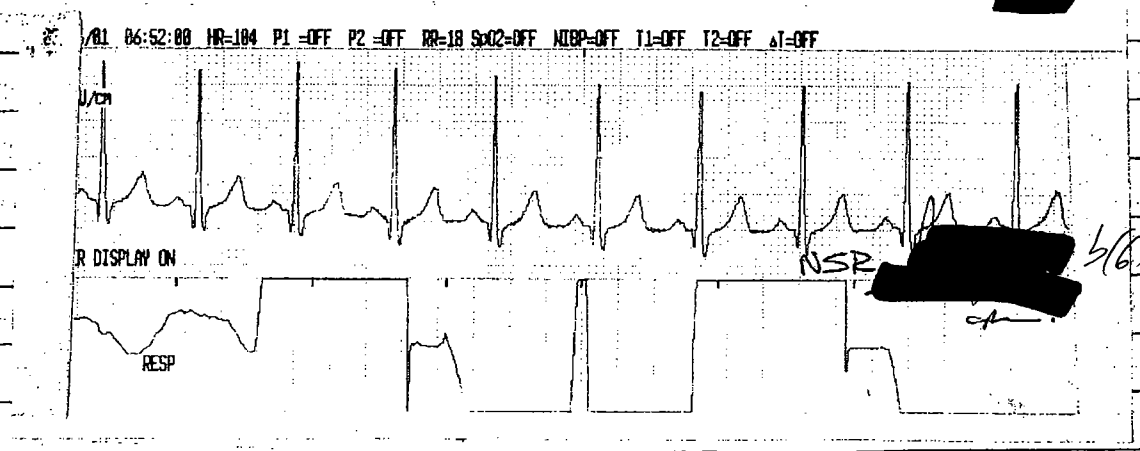
MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
31 May 03	(cont) iliostomy is draining clear yellow urine. Ø leakage
2033	notal. Ø c/o pain or discomfort @ preset. Restraints b(6)-2
	To UE in place and secure. — Sat [redacted]
0230	Taken to X-RAY for AP Pevis via gurney X-RAY obtained.
	Sat [redacted] b(6)-2
6/1/03	
6/1/03	Nursing: End of shift note
1650H	No neuro Δs, Resp unremarkable. NSR. ē Ectopy. palpable
	peripheral pulses. Eats a lot of food requiring snacks in between
	heavy meals. Indiscriminate about food. Dsg change done to
	lower back and mid line abdominal incision. Silver nitrate applied
	using silver nitrate Q-tips. Pt c/o of discomfort from the
	application of silver nitrate but claims pain disappeared soon
	as application ended. The lower back and mid abdominal wounds

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REGISTER NO.	WARD NO.

E PW [redacted] b(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6/1/03	continuation Nsg note ;
1670 Hr	both appear slightly smaller in size c̄ change in color from beefy red to ashy color. The ashy color is more pronounced as soon as Silver Nitrate is applied. There is small amounts of slow droplet of clear drainage noticed in the area proximal to the lower back injury H.O rotated. The unbeating site is without Δs clear moist and wet ~~to~~ dressing applied. pt tolerated dsg Δ better today. [redacted] b(6)-2
6-1-03	Ate 90% of supper drank 2 ucal ensure. Abt x3 USS.
2130	ileostomy draining cloudy urine c̄ mucus shreds fm stoma white in color mod. amt. wound to midline chest to umbicus pink in color c̄ ø drainage or s/s of infection. silvidine sticks used on wound. dry drsg applied. Wound to pubus dark red c̄ large amt of bleeding. several large blood clots taken out of wound. ø drainage or s/s of infection. Replacked c̄ wet gauze soaked in NS and cover c̄ dry dressing and Abd pad. ileostomy waffer Δ'd, stoma is pink s̄ foul drainage draining cloudy urine c̄ mucus streads mod amts. Area around stoma cleaned. wound on (L) lower back is Redish pink c̄ mod amt of bloody drainage ø foul smell or s/s of infection noted. wet to dry NS soaked dressing applied. M.S04 2mg IV given for Abd pain @ 2000, Percocet II Po given 1800 for Abd wound pain. sitting up in bed with restraints off @ present eating. MP @ bedside guarding pt. and monitoring closely ~~with~~ while restraints are off. —
	Sat [redacted]

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b(6)-2

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
6-2-03	Percocet II Po given for c/o Abd. pain. — SGT [redacted]
0130	b(6)-2
6-2-03	Resting quietly eyes closed. Ø further c/o Abd pain.
6-2-03 0200	[redacted]
0430	Ø further Ø c/o pain or discomfort. ileostomy draining clear
6-2-03	yellow urine good output present. Restraints to UE in place
	and secure. — SGT [redacted] b(6)-2

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REGISTER NO. | WARD NO.

E Pw - [redacted] b(6)-4

PROGRESS NOTES
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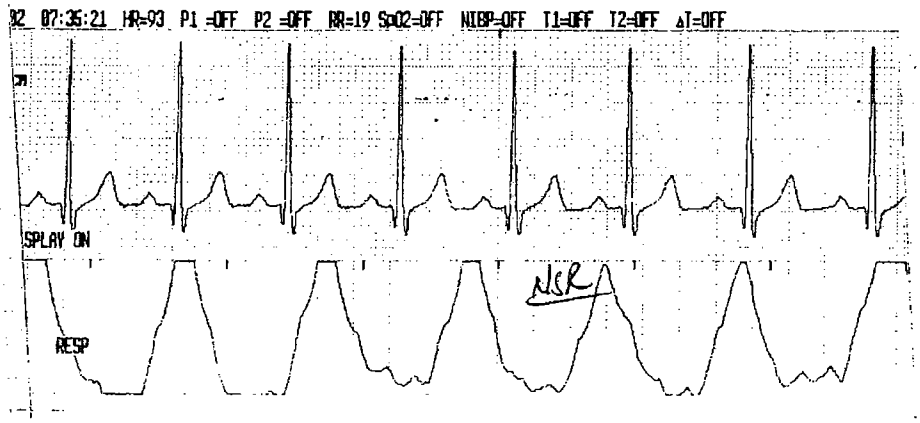
LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6/2/03 0600	
	Nursing: End of shift note
6/2/03 1550	Pt had uneventful day. Remains on RA. Sat 98-100%, Feel ARom all extremities c̄ difficulty c̄ full weight bearing on Bet LE OOB to BSC with assistance for less than 30 minutes. NSR s̄ Ectopy denies any cp. Replace LUE dry and intact. Mid Lower back ~~[illegible]~~ moderate amount of drainage serosanguineous colored. Silver nitrate applied and Curlex reinforced ~~[illegible]~~ by Super sponge in the top applied. The Mid abdominal surgical site appeared flattened and spread. H.O notified, wet dressing c̄ Super sponge applied. The pelvic wound was cleaned c̄ Saline Soaks moist Super gauze applied reinforced c̄ Curlex and tape. H.O was present to evaluate the wound. Save pt percocet 2 po @ 0900 way effective. Attempted to move bowel but unsuccessful x1 well continue to monitor ~~[illegible]~~'s status [redacted] b(6)-2

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

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

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
02 June 03 2200	PT. Ate 1000 at supper drank 600 ml total. ileostomy draining clear yellow urine 300 ml out unit @ present. NS is Amt x3 Percoat π PO given @ 1800 for c/o Abd wound pain. drsg 5 to midline chest SD moderate amt of dark green drainage noted. wet to dry drsg applied. Wound to pubus had several dark red blood clots when removing packing, large amt of blood soaked onto drsg. Replacked c̄ wet gauze soaked in NS and covered c̄ dry sponge and Abd pad. wound to (L) lower back had moderate Amt of gray-green non-foul smelling drainage. ~~NS wet to dry drsg Reapplied.~~ wound is pink-red in color c̄ s/s of infection. Wet to dry soaked c̄ NS Re-Applied. hep to (R) forearm is patent c̄ s/s of infiltration. Restraints to UE in place and are secure. PT is sitting up in bed @ present quietly. offers ø c/o pain OR discomfort. — SGT [redacted] 6(6)-2
0500	PT Rested quietly all noon Percoat given π PO for c/o Abd wound pain @ 0130. ileostomy drain clear yellow urine 850 ml @ present. Restraints to UE in place and secure. — SGT [redacted] 6(6)-2

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

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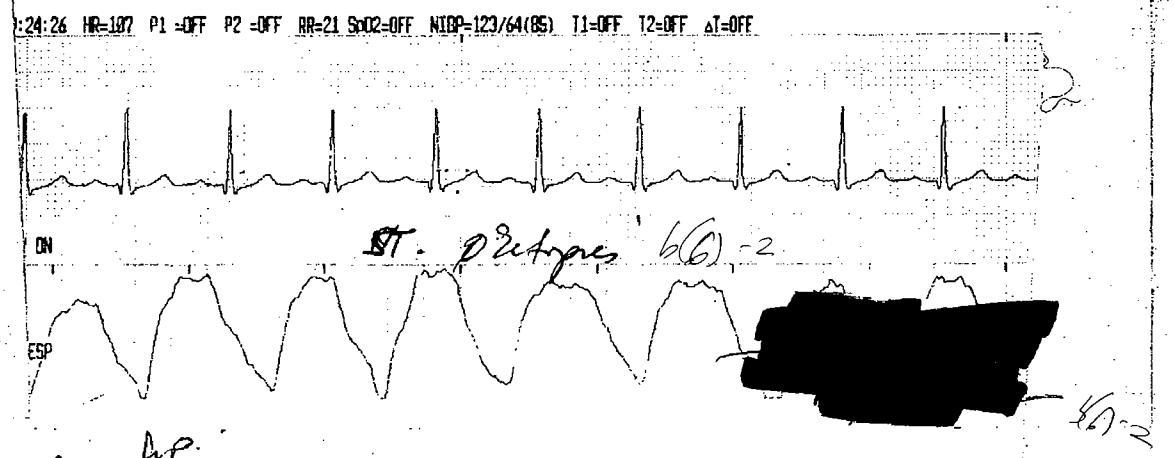
PROGRESS NOTES

DATE

6/3/03



ST. Pretypes b(6)-2

[redacted] b(6)-2

6/3/03 Nursing: IVP.

0700 Explained to pt the plan to perform IVP to rule out bladder perforation via the Arabic Interpreter. Pt verbalized understanding. [redacted] b(6)-2

6/3/03 Nursing IVP.

12 noon Pt left for IVP via litter assisted by RN. Pt axo X3. Assisted pt 00 to litter to Radiology table where IVP was performed over 2°. Pt was guarded by MP presence during, and when finished and transported by to ICU. Films accompanied pt to the unit and stored in pt's flow folder. [redacted] b(6)-2

6/3/03 Nursing Dsg Δ

0745 Dsg Δ done using sterile Technique. LB. dsg had silver nitrate swabs. Applied alt c/o of pain @ the site during application but pain subsided c̄ discontinuation of application of silver nitrate. Wounds show very slight improvement from yesterday as far as swelling during the tissues. Drainage from the SD is minimal but still visible. The mid-line abd. wound is clean pink and most somewhat flattened. Wet to dry sterile dsg. Applied reinforced c̄ Abd pad and Montgomery strap. The subectomy wound is clean pink and

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Continued

MEDICAL RECORD | Nsg Note | PROGRESS NOTES

DATE	
6/3/03	Dsg Δ. continuation
1745	moist. Very minimal bleeding today. wet Super Sponges
	applied by parking pt tolerated procedure &
	will continue to monitor for S Stalg [redacted] b(6)-2
6/03/03	Rec'd pt A+O×3 H+B ↑ in NAD. Dsg Δs done; tol well.
1830	Abd - wnd beefy red - ∅ s/s of infx. noted. suprapubic wnd
	deep/clean. lower back dsg → wnds beefy red/clean -
	stained from Silv. nit. sticks - granulating / healing well → ∅ s/s
	of infx. noted. Prescribed dsgs applied. Urostomy intact
	draining cl/yellow urine → Q.S. Care plan reinforced; dsg Δs,
	pain control, meds-side effects, act level, diet, coping/rehab,
	positioning; voiced/expressed understanding. VSS/Afeb. See
	flowsheet [redacted] b(6)-2 [illegible] assessment. [redacted] Sgt/LPN b(6)-2
0500	Pt slept throughout entire shift following dsg. Δ.
June 04 03	1 large BM → scant bleeding to abd. dsg. as a
	result from straining. dsgs intact. VSS/Afeb. refused
	Dinner tray yesterday night. PO intake highly encouraged
	[redacted] Sgt/LPN b(6)-2
4 June 03 @ 0600.	assumed care of patient. ∅ distress noted - pt sleeping
	comfortably. ∅ complaints at this time. will continue
	to monitor and change dressings. [redacted] b(6)-2
4 June 03 @ 1030	pt tolerated req. diet. ∅ complaints will continue to monitor [redacted] b(6)-2
4 June 03 @ 1230	Dsg Δ done under sterile technique. Abdomen - red - ∅ s/s of
	infection w to D placed abd pad placed on top. Suprapubic

(Continue on reverse side)

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	cont'd
4 June 1230	deep hole - red - Ø S/SX of infection - W to D placed in hole & on top. Abd pad placed - taped down. Pt tolerated well. lower back - site cleaned appears to be healing - Silver nitro stick used. dsg replaced. Ø S/SX of infection. Urostomy intact drain clear yellow urine. pain medication 5mg MSO4 was given before dsgs were changed. Afebrile. tolerating fo Fluids. will continue to monitor. [redacted] b(6)-2
4 June 1345	½ percocet given for pain. will monitor effectiveness [redacted] b(6)-2
4 June 1700	report given to night shift. Pt on Bedside commode. [redacted] SP/ b(6)-2
04 Jun 03 1840	Rec'd Ato x3 - OOB → BSC - 1 large BM → c̄ sang. drainage to lower abd hole as result from BM/straining. Dsg Δ's done Mid-Abd/lower hole beefy red. lower back cords closing in c̄ Silv. nit. sticks - Ø S/S of infx. noted. Tol. well. Tol. dinner well. Pointake highly encouraged. Can plan reinforced, dsg Δ, coping, pain management, meds act. level/positioning; voiced understanding. Max. Emotional Support/Reassurance provided. VSS/Afeb. see flowsheet for further assessment b(6)-2 [redacted] Sgt/LPN.
05 June - 0700	Assessment done. pt calm. no complaints @ this time. [redacted] b(6)-2

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EDW - [redacted] b(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
05 June @1030	Drsg change done to mid abdomen and lower back. Both sites red. - wet to dry drsg done under sterile techniques. abd pads placed on top. Lower back laced c̄ silver nitrate sticks, and drsg replaced. Ø S/Sx of infection. Ø clots noted from abdominal wound. pt tolerated drsgs well. pre-medicated with 5mg MSO4. pt feeding and drinking [redacted] well. afebrile will continue to monitor. [redacted] 1/6-2
05 June 04 1920	Rec'd Pt Ato x3 coherent. OOB → BSC - ØBM: ~~drsg~~ wnds. Continue to bleed (lower abd) as pt. strains or gets up. drsg Δ done; tol well. lower abd hole/mid abd + lower back wnds. Beefy red - Ø S/S of infx. noted. Urostomy bag intact/secured draining cl/yellow urine c̄ sediment. Pt PO intake remains ↑. tol. all food/MRE's. Care plan reinforced; meds, wnds/healing. coping pain control. Act. level, Rom exercises; voiced understanding. VSS/Afeb. [redacted] Sgt/LPN. 1/6-2
6 June 1030	pt ↑ to BSC. Bed linen changed. pt urostomy bag was unsealed. pt very agitated. site cleaned new bag placed. unable to fit new bag properly. tape placed around bag and Chux on outside. drsg change done. area red. Ø S/Sx of infection wet to dry done. pt tolerated fairly well. pre medicated with 5mg MSO4. tape changed over IV Saline Lock. pt became very agitated. started hitting his head. taped area and decided not restick for another IV site. drsg on lower back changed + retaped. laced c̄ silver nitrate. pt ate and went to sleep. will continue to monitor - [illegible]

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
6 June 03	- 1400 urostomy bag changed. Ø leaking noted. Heplock taken out, catheter intact. IV site in (R) forearm restarted c̄ 20g. flushed. pt given MSO4 5mg. - Site patent & intact. will continue to monitor. ajchrile. VSS. [redacted] b(6)-2
6 June 03	- 1620 Foley Bag emptied. UO = 550. Quantity sufficient. much wasted when ostomy bag was leaking earlier in the day. [redacted] b(6)-2
06 June 03 1830	Rec'd pt AAO X 3/calm. Tol dinner well. Dsgs's done; tol well. Mid Abd, lower abd hole/lower back wnds → closing in. ~~Abd~~ All wnds beefy red - Ø S/S of infx. noted. Urostomy bag intact/sealed/secured. Ø leaks present. Care plan reinforced; coping, healing, patience, dsgs's, meds side effects, act. level, independence; needs reinforcement. Max. Emotional Support provided. VSS/Afeb. - [redacted] b(6)-2 Sgt/LPN
07 June 03 0235	Pt currently sleeping in NAD. Medicated PRN c̄ effect. relief. OOB → BSC X2 c̄ small BM for this shift. Eating D. fac. food/MREs; tol. well. b(6)-2 [redacted] Sgt/LPN
7 Jun 03	Pt ↑ in bed. Tolerated A.M. meal well. Performed ~~0940~~ 0950 A.M. Care c̄ Assistance. Dressing Δ done to abdominal and pubic Area. Cleaned Area c̄ Normal saline & packed wound. Medicated c̄ 5mg MSO4 for c/o pain, also Con't

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[redacted] b(6)-4

EPW

MEDCOM - 9782

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
Con't			

DATE	NOTES
	Con't
7 Jun 03	Medicated c̄ ii Percocet TABS. VSS. ∅ other changes noted @ this time. Will continue to monitor [redacted] SGT, LPN b(6)
7 Jun 03 1315	Pt c/o pain. Medicated c̄ ii Percocet tabs. VS. BP - 118/67 P - 82 R - 22 T - 97.4. Will continue to monitor. — [redacted] SGT LPN b(6)2
7 Jun 03 1700	Dressing Δ done per MD order. Abd tissue dressed c̄ silver nitrate & dry dressing. Pelvic area continues to be dressed c̄ wet to dry dressing. ∅ c/o @ this time — [redacted] SGT, LPN b(6)-2
07 June 03 1700	Rec'd pt resting in NAD. dsgd Abd/lower back intact. Care plan reinforced, act level diet coping, pain control meds side effects. dsg Δ's/Δ's explained, voiced understanding. Tol po well ∅ complaints voiced. see flowsheet for assessment. [redacted] SGT/LPN — b(6)-2
07 June 03 1930	PT is Alert x3, MSO4 IV 2mg given for c/o Abd pain 1845 w/ s effects. dsg to lower back ⊔D, mod. Amt of dark green bloody drainage noted ⊔ foul smell. Wound has some Redness but ∅ inflamation, tissue is pink. Ileostomy drainage clear yellow urine. lungs CTABIL, BS ⊕ ⊔ quads. Resting quietly c̄ eyes closed. Restraints to UE in place and secure. — Sgt [redacted] b(6)-2
07 June 03 2215	c/o Abd pain & itching MSO4 2mg IV and 25mg Benadryl given. — Sgt [redacted] b(6)-2
07 June 03 0020	Resting quietly c̄ eyes closed. ∅ further c/o pain or discomfort — Sgt [redacted] b(6)-2
0400	PT Rested quietly all noc. ∅ c/o pain or discomfort. Ileostomy drainage clear yellow urine is patent. Output / Income. Restraints to UE in place and secure — Sgt [redacted] b(6)-2

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 June 03 @ 1000	assessment done. Pt to BSC - large Bowel movement. pt washed off. drsg changed. packed wound after irrigation. abd pad placed & taped down. Silver nitrate stick to midline abd - gauge placed & taped. Silver nitrate to lower back. pt tolerated well. premedicated c̄ MSO4. mod clot noted when removing previous drsg. easily dissolved in hand. will continue to monitor VSS. afebrile. [redacted] b(6)-2
8 June 03 1750	Percocet ii Po given for c/o Abd. wound pain. drsgs intact to Abd. and (R) lower back. Ate 80% of supper TRAY drank 500ml h2o. Ileostomy bag intact draining clear yellow urine. 300ml drained from foley bag. Restraints to UE in place and secure. SGT [redacted] b(6)-2
2000 08 June 03	Abd dressing Δ'd small clot irrigated out of wound c̄ WS c̄ mod ∞ Amt of bloody drainage to packing and cover dressing. chest dressing moderate amt of dark green & foul smelling thick drainage. (R) Lower back had small amt of bloody drainage to cover drsg. MSO4 given IV 2 mg for c/o pain. Restraints to UE in place and secure. SGT [redacted] b(6)-2
2145 ~~2145~~	Percocet ii Po given for c/o Abd pain - SGT [redacted] 9/6/20
08 June 03 0400 8 June 03	MZO2 given for c/o Abd pain. SGT [redacted] b(6)-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	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 June @ 0530	pt resting @ this time. tolerating reg diet & po fluids. assessment done. see OP 375 for further data. [redacted] b(6)-2
	Progress Note
9 Jun 03	Will take patient to OR tomorrow to graft lower ded to reduce grease and allow better granulation of the pelvic wound [redacted] b(6)-2
9 June 03 @ 1130	pt complaining of pain. Medicated c̄ 5mg MSO4. changed dressing @ this time. Wound Beefy red. ∅ S/SX of infection. Silver nitrate applied to midline incision. opening packed c̄ gauze sponge. silver nitrate applied to lower back. pt tolerated well. ∅ feeding after midnight for surgery tomorrow. will get interpretor to facilitate communication c̄ pt. [redacted] b(6)-2
9 June 03 1930	Evacuated PT from ward to Sacr lacertum. MSO4 10 2mg given for c/o pain. Ileostomy in place drainage clear yellow urine. Restraints to UE in place and secure. - satisfactory. b(6)-2
10 9 Jun 03 0715	Pt c/o pain. Medicated c̄ 4mg MSO4 for c/o pain. [redacted] b(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
10 June 03 1830	VSS Alert x3. Abd drsg and Lower @ back intact. ileostomy draining clear yellow urine. Percocet ⅡPO given @ 12 w for c/o Abd pain. Restraints to UE in place and secure — SGT [redacted] b(6)-2
11 June 03 2200	Drsg to Abd and lower back Δd wet to dry drsgs Reapplied. Large amt of bloody drainage from lower Abd wound noted. @ lower back had small amt of bloody drainage noted. MSO4 given 2 mg IV given for c/o Abd pain @ 2000. Restraints to UE in place and secure — SGT [redacted] b(6)-2
0200 11 June 03	MSO4 ½ mg IV given for c/o Abd. pain. ileostomy draining clear yellow urine. Restraints to UE in place and secure. — SGT [redacted] b(6)-2
0430 11 June 03	Percocet ⅡPO given for c/o Abd pain. — SGT [redacted] b(6)-2
11 Jun 03 1100	Pt ↑ in bed. AM care done. Tolerated A-M meal well. Pt c/o pain. Medicated c̄ 2mg MSO4. ∅ changes noted. Will continue to monitor. [redacted] SGT, [illegible] b(6)-2
	Progress Note
	afebrile today
	Dry well
	plan — Skin graft in [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.

EPW # [redacted] b(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 Jul 03	Alert x3 VSS Msoy IV 4mg given for c/o Abd pain. Abd dressing and
1750	dsgs to ⊕ lower back intact. ileostomy draining clear yellow urine
	zool at present. Ate 60% of supper drank 50cm of h2o. Restraints
	in place to UE an secure. —— b(6)-2 SGT [redacted]
1850	Received report from Sgt [redacted] Pt. stable, eating
	in bed. Will continue to monitor — [redacted]
2000	Changed Pt. DRSG to ABD c̄ wet to dry, DRSG Δ to back,
	complete. Both clean dry and intact s̄ s/s infection.
	Pt not medicated prior to DRSG Δ, handled well s̄
	complaint of pain. —— [redacted]
	b(6)-2
12 JUN 03	Brief Op Note
	Procedure: Closure Suprapubic wound
	Surg Dr [redacted] b(6)-2
	GETA
	SBL 200
	Fluids:
	Abx Anal Lgn IVPB
	Findings: adequate skin flap for direct cover
	Cylinder ∅
	[redacted] b(6)-2
12 June 03	End of Shift: Nursing Note
1645	Pain Management effective c̄ current medication regimen.
	received a total of 3mg Vised, 100mcg of fentron urinal to 1cu I
	and Msoy 3mg IVP @1645 and 2 percent po @1450. Dsg on the
	abd midline incision and pubic area Δ+I. Tolerated small po. Tmax 99.3

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b(6)-2

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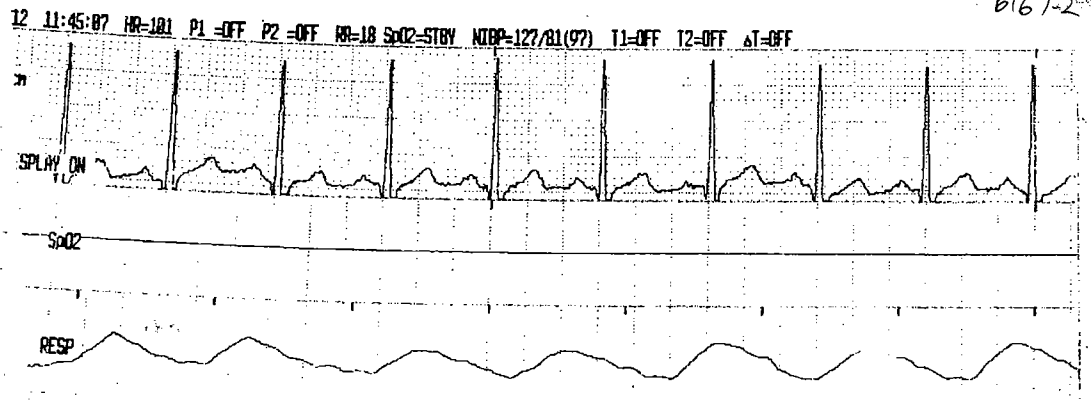
MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
10 Jun 03 1940	Pt sleeping comfortably in bed. Tolerated lunch meal well. Dressing change done. VSS, ⊖ c/o @ this time. Will continue to monitor [redacted] SST, IPV
6/12/03 1045 to	Nursing note post-op continuation. being medicated but down to 90s & tachycardia BP also down from 150s-160s/90s-100s to 120s-130s/80s, palpable peripheral pulses. Abd taut hyperactive & c/o of nausea or vomiting. Temp is 96.8 Pt given blanket for warmth. will also and continue to monitor Pts [redacted] b(6)-2

post op 6/12/03



Recovery Vitals

1045: T96.8 P142 R20 BP 144/99, 10 48 hrs: VS P=125 BP 154/94 R 18 T97

1055: T97 BP 134/97, R 18 P 119 1105 hrs VS T 97 P 107 BP 138/87 R 12

1130: VS P 105, BP 132/87 R 13 T94 12 Noon VS: HR 95, BP 128/82 R20 T97

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)

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EPW # [redacted] b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13 JUN 03	Progress note Resting comfortably after surgery yesterday Drains out put 120 per tim since surgery Abdomen Dressing intact (+) 1 mild penile swelling Ig: S/P wound closure - keep dressing in place x 48 hrs - Remove Hemom - keep drains until output ↓ [redacted] b(6)-2
13 June 03 1040	Nursing: Dsg Δ Dressing to the Abd midline incision and pelvic area as assessed for drainage and intactness. Ø Dsg change was done per H.O.'s request until in the Am tomorrow. Dsg remain dry and intact. Two JP's on the LLQ abdominal and are intact draining serosanguinous drainage under bulb ~~pressure~~ suction. The upper and the lower JP insertion sites were both intact. Will continue to monitor pt. for pain and dressing appearance. [redacted] Am b(6)-2
6/13/03 1130	Nursing: Nutrition Pt remain on Regular diet c̄ additional meals and can g insure q meal. Continues to tolerate PO's N&V but eating about 45% g meals c/t 98-100% prior to surgery. Continue to push fluids and kept on ~~[illegible]~~ RL @ 100cc/hr until he begins to eat meals at pre surgical appetite [redacted]

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b(6)-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6/12/03	Nursing: Preop Note
0730	Pt ax0X3. Preop teaching R/T procedure itself and post op expectation explained to pt via Interpreter - Pt verbalized understanding. Pt received Mgs of 3mg @0620 for pain with positive effect. Am Care done. Pt has been NPO since P MN. Labs. Chem 12 & Chem 8 CBC and T&C for PRBC's done. Ancef 1gm is accompanying pt to OR. Preop vitals BP 130/74, HR 88, Resp 18, T 98.8 Sat 98% RAU/O thru Am 2/50cc via ileal conduit. " [redacted]. 5(6)-2
6/12/03	Nursing: Post op. Note
1045	Pt received from OR via letter accompanied by Surgeon, OR Nurse and Security guard. ax0X3 frantic and crying complaining of pain. Pt immediately medicated c̄ Pentangl 100mcg IV into left PIV and Versed 2mg IV also into the left FA HL. LR @ TKO (D) FA PIV and RA PIV HL. Both IV HL flushing well. Mid Abd incision sight all the way to below the pelvis right above the Penis line has fairly bulky dsg, d & I. (R) LQ ileal conduit has drainage bag c̄ small amount of urine. Pt on RA sat 98-100% LCTA. ST 130s fecal to

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

EPW [redacted] 5(6)-4

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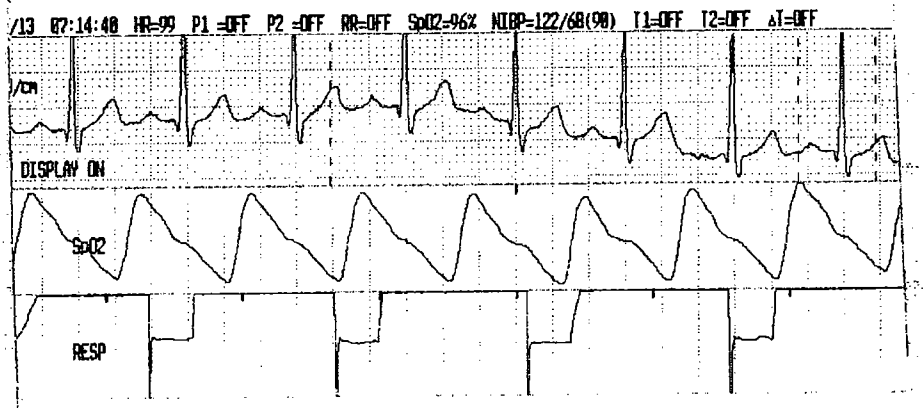
MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12-June 03 1800	USS Alert x 3 Abd dressing intact dress to ® lower back intact. has 2 JP drains in place drain dark bloody drainage 10 ml from upper and 50 ml from Lower. IV of LR @ 100 ml/hr to Peripheral line in ® FA is patent flushed ≈ NS ø s/s of infiltration. ileostomy bag ⊥ ⊥, draining clear yellow urine 550 ml @ present. Ms 2 ml IVP given for c/o Abd pain. Restraints to UE in place and secure. Sat [redacted] b(6)-2
12 June 03 2100	Vomited 1g amt of dark brown vomitous 700 ml approx. Ms 04 IV in 4mg given for c/o Abd pain. Resting quietly @ present time ⊤ eyes closed. Sat [redacted]
12 June 03 0200	Ms 04 IV 4mg given for c/o Abd pain. JP drains to Abd in place and draining dark bloody drainage 60 cc out from upper and lower. ileostomy draining clear yellow urine. Restraints to UE in place and secure. Sat [redacted] b(6)-2
13 June 03 0731	 b(6)-2

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SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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ERW [redacted] b(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1850 13 Jun 03	VSS Alert x3. Ate 70% of supper Tray drank 100ml of H_2O. Abd drsg. intact and dry, drsg to midline chest incision dry and intact. JP draining dark bloody drainage. IV of LR Running @ 100ml/hr into (L) fit Periphe line is patent. MSO_4 4mg IV given for c/o Abd pain @ 1750. Restraints to UE in place and secure. b(6)-2 SGT [redacted]
0010 14 June 03	MSO_4 IV 6mg given for c/o Abd pain. JP draing dark red blood drainage 40 from upper 60 from lower. IV cipro 400mg IV en via piggy back at 2200, Ancel 1gm IV @ 2400, ileostomy draing cloudy yellow urine c̄ sediment. Resting quietly e present c̄ eyes closed. Restraints to UE in place and secure. b(6)-2 SGT [redacted]
0330	MSO_4 IV 4mg given 0315 for c/o Abd pain. Ate 60% of MRE. drank 100ml H_2O. Resting quietly e present. b(6)-2 SGT [redacted]
0500	14 June pt doing well. assumed care. assessment done. 2mg NSO_4 given for pain. will continue to monitor. [redacted]
0830	14 June Dr Jeyior in to assess pt. drsg removed. staples intact & s/sx of infection. will continue to monitor. [redacted] b(6)-2
2030 14 June 03	VSS is Alert x 3. Ate 70% of supper 300ml intake. JP drains 20ml upper - 20ml lower. ileostomy drained 450ml cloudy yellow urine. Abd drsgs. intact and drsg to lower back intact and dry. MSO_4 given 1730 IV 4mg for c/o Abd pain & Percoat II Po @ 1800. Restraints to UE in place and secure SGT

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT [redacted] b(6)-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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REGISTER NO.	WARD NO.

EPW [redacted] b(6)-4

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 June 0500	assumed care of patient. assessment done. pt complain of pain. 2 mg of MSO4 given @ this time. ∅ changes from plan of care. pt tolerating po fluids. afebrile Dr Fezior plans for drsg change this Am. Both JP drains in place. ∅ drainage noted from sites, will continue to monitor. ——— [redacted] CPT/AN b(6)-2
14 Jun 03	Progress Note Wound intact change persists Plan → keep JP's in place [redacted] b(6)-2 Nursing:

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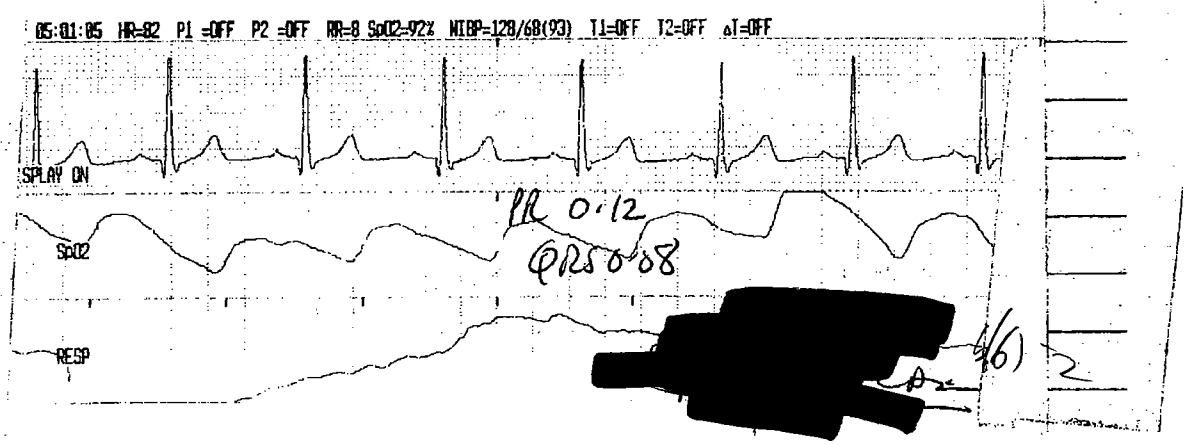
MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
2300 14 June 03	DRSG to (R) Lower back Δd c̄ wet to dry drsg. small amount of dark Red bloody drainage noted on dressing. Msoy 2m IV given @ 2230 for c/o Abd pain. wound is pink @ center c̄ scare tissue @ the edges. — Sgt [redacted] b(6)-2
0400 15 June 03	DRSGS to Abd one dry and intact JP draining dark bloody drainage 40 ml upper 10 ml lower. ileostomy draining clear yellow urine 1000ml to present. Restraints to UE in place, and secure. Resting quietly c̄ eyes closed. - Sgt [redacted] b(6)-2
6/15/03 0500	 [redacted] b(6)-2
6/15/03 0516	Nursing: IVF. Received Report from Off-going shift that Rt is eating very well and as much as ~~pre op~~ he did pre op. IV thus'd heplocked and running @ 10cc/hr to keep vein open. IV site is clean dry and intact. [redacted] b(6)-2

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

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REGISTER NO.	WARD NO.

EPW [redacted] b(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6/15/03	Nursing: Dsg Δ
1000 HS	Pt premedicated c̄ MSO4 5mg WP x1 prior to dsg Δ. Old
	Dressings removed c̄ Sacral mid line abdominal incision
	and pelvic wounds. Wounds assessed for color smell
	and other sfs of infection. The lower back wound is
	clean c̄ ~~Appy~~ small amount of Sero drainage. The wound is healing
	but area is raised. Mid line abd ~~dsg~~ sew wound moist not closing + [redacted]
15 SWD	Progress note
	Day well
	afebrile
	wound intact dry
	JP out 90/80
	Jn: Progress well for closure
	Ph 9 AM Lab
	TKO fluids / hep bolus [redacted]
	b(6)-2
6/15/03	Nursing: Continuation Dsg Δ
1000	The Pelvic wound has staples which is clean and
	dry distal to the Pelvis but moist on the last segment of the
	stapled wound proximal to the Pelvis. Ø sfs of infection noted -
	Pt c/o of pain c̄ point tenderness but pain disappeared c̄
	termination of palpation. All wounds were dressed c̄ wet to
	dry dressing reinforced c̄ lower all dressing over abd
	dsg - pt tolerated dressing [redacted]
	b(6)-2

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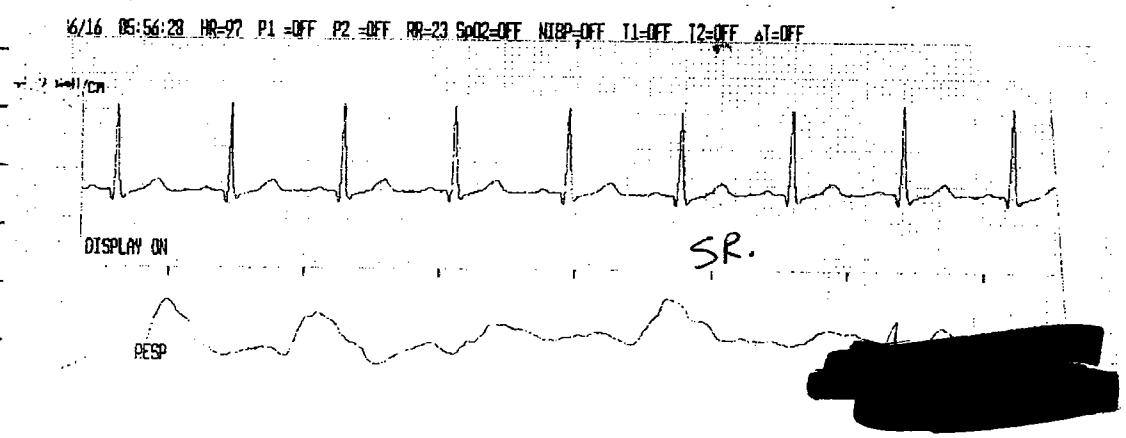
MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
15 Jun 03 1800	Rec'd pt asleep in NAD VSS/Afeb. ∅ complaints voiced. Positioned ↑ for dinner. Tol PO well. Urostomy bag/dsgs. Intact/secured. Care plan reinforced; dsgs, pain control/distraction techniques, nutrition/wnd healing, rehab-coping, act level/diet, D/C planning ~~[illegible]~~ needs reinforcement see flowsheet for further assessment. b(6)-2 [redacted] Sgt/LPN.
15 Jun 03 1900	Dsg Δ done to upper abd/lower back; tol well. wnds moist/pink ∅ S/S of infx noted! Continues to use MSO4 for pain?/~~slep~~ sleep. b(6)-2 [redacted] Sgt/LPN
16 Jun 03 0330	Pt slept on/off throughout the night. Medicated PRN c̄ effect. relief. Appetite remains the same ↑ VSS/Afebrile. [redacted] Sgt/LPN
16 June 03. 0556 hr	Nursing: b(6)-2



[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.

EPW #

[redacted] b(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6/16/03	Nursing: ADLs.
0745	Pt remain a+o X3. Prefers to sleep than participate in plan of care and nursing interventions. Requires encouragement and rigid instructions before compliance. Pt however follows treatment regimen once its clear that the goal of the day is absolute compliance and provision of comfort measures re encouragement and pain mgt intervention such as PO-73 and Mosoff IV push. Pt did self care personal hygiene today only assisted c̄ those distal parts of the body that will cause excessive stress on his suture lines. Pt requires ongoing teaching on how to transition from total care c̄ ADLs to limited selfcare and eventually c̄ aid of PT/OT to fill selfcare in future. Will continue to reinforce teaching. [redacted]
6/16/03	Nursing Dressing Δ [redacted] b(6)-2
0845	Explained to pain plan of care specifically to dsg change and what level of cooperation and position change will be needed. Premedicated pt c̄ two lykos #3. PO X1 prior to removal of old dressing in the lower back, Midline Abd incision and the para umbilicus staples running down to the supra pubic area. Wound assessments were done c̄ as follows: LB wound healing c̄ sign of formation of scar tissue dark colored c̄ very small around of drainage noted pt displaced ∅ discomfort except mild problem c̄ position Δs. The mid line Abd incision is clean pink and moist no s/s of infection noted pt also displaced moderate discomfort mostly with tape adherence to his skin. The Para Abdicus staples dry & intact at 3/4 length of the suture line from below umbilicus to the distal supra pubic area. The lower proximal supra pubic 1/3 of the staple line is

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
6/16/03	Continuation: Nsg Note Dsg Δ.
0845	moist c̄ staples still intact. Small amount of sero sanguinous drainage noted. Pt displayed anticipating pain and discomfort as the supra pubic staples are approached. At 0945 Nso4 Yng IVP X 1 was given @ the end of Dsg Δ c̄ pain free effect. Two JP's attached to the cpdnc wound #ed. Upper and lower JP drains g lesser output of sero fluid today. The upper drain is about 20cc with the lower < 20cc. Will continue c̄ strict monitoring of 120 and comfort levels – [redacted] b(6)-2
10 Ounds	Progressive afebrile Wound intact Drain output significant Plan → Δ or oral Cipro Cont Current plan [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.

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1800 16 June 03	Alert x 3 USS Abd dressings intact and dry. Ileostomy draing clr yellow urine c̄ mod. amt of sediment, 700cal ~~[illegible]~~ out to present, dress to (R) Lower back dry and intact. (R) heel wound pink c̄ drainage wrapped c̄ kerlex dry gauze. MSO4 4mg given 1740 for c/o Abd pain. Restraints to UE in place and secure. Ate 30% of supper TRAY and 50% of an MRE drank Total of 500ml of H2O. — SGT [redacted] 6/6
1930 16 June 03	MSO4 1U 6mg given for c/o Abd pain 1910. Tylenol #3 ii Po given @ 1840 also. — SGT [redacted] 6/6
2230 16 June 03	Tylenol #3 ii Po given for c/o Abd pain. — SGT [redacted]
0400 17 June 03	DRSSS bd to mid-sternum to Pubus. wet to dry c̄ mod amts of clear bloody drainage, dress to (R) Lower back had small amt of dark red bloody drainage. Tylenol #3 ii Po given @ 0345 for c/o Abd pain. Restraints to [redacted] UE in place and secure. — SGT [redacted] 6/6-2
	Pregnant Dry well PVD #5 afebrile wound slightly separated Dx: Cont c̄ [redacted] 6/6-2

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] 6/6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES (NOT Related to PIV) KW
17Jun03	1530 PT NOTED to have erythemia + raised whelps to (L) ~~Low~~ upper ~~Extr~~. Restraint removed & redness +
-1630	swelling has subsided, No Further complications noted [redacted]
1630	Ducolox given for abd pain + constipation No BM yet. DSg Δ to abd & back wounds. No S/S of infection currently CDI. Urostomy bag cleaned & rinsed w/ sterile irrigation H2O. Sediment noted around stoma, Pink in color No S/S of infection. b(6)-2 [redacted]
	(R) PIV DC'd, New PIV in left forearm 20g patent w/ 10 ml LR p/hr. b(6)-2 [redacted]
1800 17Jun03	VSS, Alert x3. MSO4 6cc given for c/o Abd pain. had 1g. BM from Ducolax supp. Drsg to mid-line chest to pubis dry and intact, drsg to (R) lower back dry and intact. ileostomy draining clear yellow urine. 1L of LR @ 10ml/hr TKO to (L) FA is patent c̄ S/S of infiltration. Restraint to (R) wrist off (L) UE in place and secure. Ø Reddness OR swelling noted to (R) wrist will monitor. -SGT [redacted] b(6)-2
1900	Vomited 1g amt of light brown c̄ bites of food mixed in
17Jun03	vomitous. 12.5g Phenergan IV given. -SGT [redacted] b(6)-2
2000	PT continues to have hausee c̄ dry heaves. vomited small amt
17Jun03	light brown c̄ food mixed-in. VSS will cont to monitor. -SGT [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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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0200 18 Jan 00	Dress to mid-line sternum to Pubs Δ'd c̄ wet to dry. mod amts of dark bloody drainage notd. Drss to ® lower back small amt of light red bloody drainage. Δ'd c̄ wet to dry drss. OS/S of infusion notd. Ø further vomiting or c/o Nausea. — SGT [redacted] b(6)-2
0400	IV Phenergan 12.5mg given for c/o Nausea. Pt Had dry heaves; MS 4 Cy IV given for c/o Abd pain. — SGT [redacted] b(6)-2
0430	Resting quietly, Ø further c/o Nausea or vomiting. USS. SGT [redacted] b(6)-2
0530	18 ~~May~~ June 03 - Recieved report from night Shift. USS, A+O×3. Pt. resting well at this time. [redacted] b(6)-2
0821-18 ~~May~~ June 03 -	Nursing: drains JP drains to pelvic wounds has 30cc of sero drainage - drain bulb functioning fine in the upper JP. The lower ~~JP~~ JP bulb is not functioning and has no suction. Drain sites are dry + intact. — [redacted] b(6)-2
0830 6/18/03	Nursing: nutrition Pt. had very poor apetite @ breakfast + refused breakfast. will cont. to encourage increased PO intake. — [redacted] b(6)-2
1325 6/18/03	Nursing b(6)-2 Dr. D/C JP ~~JP~~ ×2. Dressing Δ. site pink + moist. Pt. tolerated lunch well. Pt. ate half of lunch still complaining of ⊕N. 25mg Phenergan given @ 1305. [redacted] b(6)-2

STAND[redacted] FORM 509 (REV. 5/1999) BACK USAPA V1.00

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6/18/03 1400	Nursing: Nausea. Pt c/o of Nausea vomited about 250cc of digested food. phenergan 12.5mg IVP given c̄ MSO4 6mg IVPX1. Medication for Nausea and pain were effective. [redacted]
6/18/03 1400 HRS	Nursing: Nausea Alteration in Comfort. Pain [redacted] b(6)-2 Pt c/o of Abdominal-pelvic pain extreme pain. Irritable Bowel Evaluation. On assessment patient was found to have vomited about 200 cc of digested food and apparently applied strong abdominal pressure during nausea that his pelvic dressing was pushed out by bleeding under the dressing. Moderate amount of Serodrainage saturated the disbolyd dressing from the pelvic c̄ moderate amount of blood clots. Dressing was changed and moist Super Sponge slightly packed into the wound reinforced c̄ dry Super Sponge c̄ pressure applied c̄ over all tape. Pt's primary physician was notified. [redacted] b(6)-2
	Addendum: Pt was given 20mg qsp 6mg of MSO4 IVP c̄ 12.5mg phenergan c̄ 150MRS. for pain prior to dressing [redacted]
6/18 03 1900	Pt. premedicated dsg Δ; fol well/as usual. winds to leaves back/abd. b(6)-2 pink/moist/beefy red-ϕ S/S of infx. noted. moderate amts of sang drainage noted to leaves/deep hole. Refusing dinner-now. ϕ N/V/D now. Mor. Emotional Support provided. [redacted] Sgt/USN

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE b(6)-2	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(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
6/18 2030	Pt. continues c̄ panic tantrums/intermittent episodes of anxiety (restlessness). Reinforced coping mechanisms/distraction techniques, deep breathing exercises vs. MSO_4/other Narcs. Pt. found asleep in NAD. ~~[illegible]~~ complaining of severe pain/yelling. Reassured - Pt teaching reinforced/reemphasized; MSO_4 → side effects, nutrition, rehab, pain threshold/tolerance, pain management, repositioning, nausea, wnd. healing, D/C planning, P.T.; Needs much reinforcement. Pt currently resting in NAD. HOB ↑. Supplemental drinks highly encouraged. VSS/Afeb. Urostomy bag secured → Q.S. [redacted] Sgt/LPN
c̄ translator	
See flowsheet for further assessment	
6/19/03 0100	Pt c̄ episode of NAUSEA + emesis - phenergan given; consequently dsg again soiled/saturated from straining/pressure; dsg reinforced. small clots noted. C.N./M.D. aware. Pt. given bag for emesis and was observed by M.P./Guard → throwing bag on ground & purposely vomitted on himself & floor p̄ specific instructions given → emesis, infx. control, hygiene, consideration - NGT placed; tol poorly. placement verified & secured. Abd X-rays ~~done~~ & CBC/chem 8 done. will repeat in A.M. Pt currently resting in NAD HOB ↑. VSS/Afeb. Linen/Chux Δ'ed PRN. Pt Will cont. to monitor/Babysit. [redacted] Sgt/LPN

b(6)-2

b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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REGISTER NO.	WARD NO.

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#[redacted] b(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19 Jun 03 0450	Pt currently sleeping in NAD. Repositioned PRN to keep HOBT. Pt continues to slide down. Pt teaching done; NGT tube, positioning, meds/side effects, Emesis bag continues to be thrown on floor. Pt very easily agitated w/any ~~medical~~ procedure/labs/IV's. VSS/Afeb. Urostomy bag leaking this A.m. Δed out. b(6)-2 [redacted] Sgt/LPN.
0800 6/19/03	Recieved report from night shift. Pt complains of ⊕N. Phenergram 12.5mg given @ 0650. Pt. vomited 50cc. Pt. ambulated to X-ray well. Pt. resting well at this time c̄ HOBT. b(6)-2 [redacted]
0900 6/19/03	① Dressing Δ. site looks good. [redacted] site pink + moist. stoma pink + moist c̄ ileostomy intact. Wound packed w/ steristrips. ~~Ducot~~ Dulcolex was given @ 1000 by Drs orders. Pt. resting well @ this time c̄ no c/o (N+V) [redacted]
1340 6/19/03	Pt. resting well @ this time. VSS ∅ c/o pain. Pt. had very big BM @ 1115. b(6)-2 [redacted]
19 Jun 03 1800 VSS/Afeb.	Rec'd pt A&O/calm. Repositioned ↑ in bed. HOBT. Care plan reinforced; NGT tube rest (G.I.), diet, act. level, coping, meds side effects, positioning, Urostomy, dsg Δs, safety; needs reinforcement. See flowsheet for further assessment. [redacted] Sgt/LPN. b(6)-2
19 Jun 03 2110	Dsg Δ done; tol well (Abd) winds beefy red. - back almost closed → healing spont. ∅S/S of infs noted. Urostomy bag/wafer replaced due to leak. stoma pink/moist → cleansed ∅S/S of infs. noted. linen/chux Δed. PIV to LFA infiltrated + D/c'd. New PIV 20g started (? ?). LR @ 75cc/hr maint. NGT patent/secured. draining [illegible] [redacted] Sgt/LPN. b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 JUN 03	b(6)-2 Patient [redacted] is 5 days out for local attempt to close post pelvic defect. Today patient develops bilious vomit. 1st foley MSO4 injection thinks repetitive (+) BM yesterday. NG inserted & run output. AAS clest(-) old isolated dilated small bowel aphtile loop c̄ air fluid lines. PS: old soft NTP (+) BS(-) rebound/gr. (+) open pelvic wound. VOP brush, clear. Patient received 28 mg MSO4 throughout day. He appears agitated. Pg: Question of small bowel obstruct unknown etiology. NG tube. - Labs now repeat @ [illegible] @ 0600 [illegible] [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.

EPW [redacted] b(6)-4

PROGRESS NOTES
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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
20 JUN 03	Progress Note
	Patient here of GSW to pelvis s/p urinary diversion c̄
meds	Bricker loop.
Colace 100	c/o N.V improved c̄ NG output (
FeSO4 325 g	900 cc in last 6 hr)
Cyprs	plan films c̄ (+) AW fluid levels / dilated loop
Dhungri	small bowel
MSO4	(+) BM yesterd
	PE: wound fixed open (+) blood clots
	tenderness around pubic bone
	Plan: (1) Cont NG output
	(2) Xrays today [redacted] b(6)-2
1000	Colace & IRON held while [redacted] per dr's orders
	dsg A to abd. No S/S infection [redacted]
1600	DC NAT, pt c/o hunger & thirst, still NPO untill b(6)-2
	tomorrow. [redacted] b(6)-2

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

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REGISTER NO.	WARD NO.

[redacted] b(6)-4

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6/29/03	Progress Note
	Patient comfortable in bed
	Vac dressing in place: c̄ min drain output
	Plan: V wound in 24-48°
	[redacted] b(6)-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] b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	Con't NOTES
30 Jun 03 0900	Assistance. Medicated c̄ two Percocet tabs for c/o pain. Resting comfortably @ this time. Will continue to monitor. [redacted] LPN 1/6-2
30 Jun 03 1150	Pt Asleep @ this time. VSS. ∅ c/o. Will continue to monitor + assess. [redacted], LPN 1/6-2
30 Jun 03 1530	Pt c/o pain. Medicated c̄ 4mg of MSO4. Dressing A done. JP drain D/C'D. H/L to (R) Arm restarted. ∅ other c/o @ this time [redacted] LPN 1/6-2
1800 30 Jun 03	VSS - Alert x3. Ate 80% of supper drank 500 ml h2o. saline lock to (R) fa. is patent ∅ infiltration. Abd drsg. dry and intact. Foley draining clear yellow urine. Restraints to UE in place and secure. Sat [redacted]
0200 01 Jul 03	Percocet ii Po given @ 0100. and MSO4 3mg IVP for c/o Abd pain. Resting quietly @ present. — Sat [redacted] 1/6-2
0400 01 Jul 03	VSS - Resting quietly c̄ eyes close offers ∅ c/o pain or discomfort. Restraints to UE in place and secure - sat wt [illegible]
0540 01 July 03	VSS - A+O x3 Pt. follows commands well. IV site in (R) FA. site clean, dry + intact c̄ (-) inf (-) swell. Resp. even, unlabored, lungs CTA. Abd. drsng clean, dry + intact. Urostomy bag intact. Pt. resting well @ this time. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		[redacted]	SPONSOR'S ID NUMBER (SSN or Other) 1/6-2
	LAST	FIRST		

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] 1/6-4
ICU # [redacted]

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
~~04~~ 1600 July 03	VSS - A+O X3 - dressing Δ conducted @ 1530. 4mg MSO4 given for pain. wound looks good c̄ ⊖ S/S of infection. drsng clean dry + intact. urostomy bag started leaking. changed bag c̄ new one. stoma is beefy red. Pt. is able to help out with the drsngs and is doing more. Pt. is resting well at this time. Tolerated breakfast and lunch well — [redacted] 1/6-2
1925 01 Jul 03	VSS - Alert X3 Ate 30% of Supper TRAY DRAIN 3 and h2o. Abd drsg dry & intact. foley draining clear yellow urine. MSO4 1VP given for c/o Abd pain. Restraints to UE in place and secure. — Sat [redacted] 1/6-2
01 Jul 03 2330	T-102⁴ - c/o being hot then cold; shivering hotel. Tylenol 650mg PO given. ØN & V. MSO4 3mg IVP given for c/o Abd pain. will monitor. — Sat [redacted]
02 Jul 03 0030	T-103 - Percoat ii PO given for c/o pain. Sat [redacted] 1/6-2
02 Jul 03 0230	T-99⁹ - VSS - O2 SAT 97% ~~O2 @ 3 L/m. via NC~~. Ø c/o pain on discomfort @ present. — Sat [redacted]
0915 02 Jul 03	T-99¹ - VSS - Alert X3. Ø c/o Abd pain. ileostomy patent draining clear yellow urine. — Sat [redacted] 1/6-2
2 Jul 03 0930	Pt resting in bed. NAD. H/L to ⓡ ARM intact. ⊖ S/S of redness or swelling. Urostomy bag draining clear yellow urine. Dressing to abdomen C, D + I. VSS. Will continue to monitor [redacted] 1/6-2

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
2 Jul 03 1535	Dressing Δ done. Pt up to bedside commode. Bright red blood coming from head of penis. Physician notified. H/L to (R) arm intact. Pt had large BM. VSS & other c/o @ this time b(6)-2 [redacted] LPN
2 Jul 03 1650	H/L site changed to (L) arm & S/S of redness or edema. b(6)-2 [redacted], LPN
02 Jul 03 1720	Pt. assessment done. Pt currently in NAD / requesting MRE's. dsg to abd C & I. new PIV patent/benign. Care plan reinforced: Urostomy bag, ~~Need~~ [redacted] independence, act. level, diet, coping, DK planning; needs reinforcement. [redacted] b(6)-2 Sgt LPN
02 Jul 03 0300	Pt. Currently sleeping in NAD. Medicated PRN for sleep. Dsgs intact. VSS / Arlab. b(6)-2 [redacted] Sgt / LPN
late entry	~~02 Jul 03~~ 1720 - Dsg. Δ done; tol well. abd. wounds healing spout. hole ↓ in size. Ø S/S of infx. noted. b(6)-2 [redacted] Sgt / LPN
3 Jul 03 0800	Pt ↑ OOB to BSC. Tolerated A.M meal well. H/L to (L) A.C. intact. Ø S/S of redness or swelling. Dressing to Abd & pelvis C, D & I. Pt c/o pain. Medicated c̄ two Tylenol #3 tabs for c/o pain. Will continue to assess for pain. [redacted], LPN b(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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EPW [redacted] b(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3JUL03 1545	Pt ↑ OOB to bedside commode. c/o pain. Medicated c̄ two Tylenol #3 for c/o pain. H/c remains intact. Nursing c/o ⊖. Spoke c̄ physical therapy. Will plan to have pt ambulate. Plan by Dr [redacted] to for pt to be D/C next week. NAD. VSS [redacted] b(6)-2
1500 03JUL03	VSS - Alert x3 - Ate two of MRE intake 50% hx. Amb c̄ Assist back and forth x1 on ward. Abd drsg dry and intact ⊖ [redacted]. Saline lock to ⊖ RA patent ⊖ s/s of infiltration. MSO4 4mg IVP given hr c/o Abd pain. [redacted] ileostomy draining clear yellow urine. up in chair ⊖ present. - Sgt [redacted] b(6)-2
0130 04JUL03	VSS Abd drsg ⊖ small amt of bloody drainage noted. Repacked c̄ wet gauze soaked c̄ Normal saline. Count c̄ Abd drsg. wound to Abd is setting less deep and circumference is setting smaller. ⊖ s/s of infection ⊖ redness ⊖ swelling on [redacted]. foul drainage. ileostomy draining clear yellow urine. good out to present. Resting quietly c̄ eyes closed. Restraint to UE in place and secure. Sgt [redacted] b(6)-2
0500 04JUL03	T-3 given ii PO hr c/o Abd pain. Awake ⊖ present sitting up in bed eating on EMR. Restraints in place and secure. Sgt [redacted] b(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

EPCU [redacted] b(6)-4

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 JUL 03	Progress Note
	Patient continues to improve daily
	Wound nearly closed
	afebrile ought
	Plan (1) OOB
	(2) DC Cyn/Zantac
	[redacted] b(6)-2
4 JUL 03	Progress Note
	Progressing well
	Wound nearly closed
	Plan - Consult as rs [redacted] b(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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[redacted] b(6)-4

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 Jul 03	Pt resting in bed c̄ ∅ c/o. H/L patent & intact
0900	Dressing change done by physician. Urostomy
	bag continues to drain clear, yellow, urine.
	Will continue to monitor pt — [redacted]
4 Jul 03	Pt ↑ OOB walking around ward. ∅ c/o pain.
1345	Tolerated lunch ∑ difficulty. Urostomy continues
	draining yellow urine c̄ sediment. H/L remains
	intact. VSS. ∅ c/o @ this time. [redacted]
4 Jul 03	Pt c/o pain. Medicated c̄ two Tylenol #3
1415	tabs for pain. Will monitor for effectiveness [redacted]
4 Jul 03	Pt sitting up in bed c̄ legs elevated on chair.
1600	Pt had one large BM. Pt had bright red
	blood coming from head of penis. ∅ c/o pain
	Will continue to monitor. Assess. [redacted]
0400 5 Jul 03	VSS A+Ox3 follows commands and drsng
	c+d+I. Pt. resting well @ this time — [redacted]
1500 5 Jul 03	VSS - A+Ox3. Pt. ambulated well this
	afternoon. Pt. ambul. 25 meters @ is
	now complaining of pain in the
	whole (R) leg. Percocet given @ 1410
	for pain. Abd. drsng A. clean, d+I intact.
	Pt. sitting upright at this time. — [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS [redacted]
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] | REGISTER NO. | WARD NO.

EPW #[redacted]

ICU #1

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)*
1820 05JUL03	VSS-Alert X3-A te 80% of supper drank 500ml H2O. Saline lock to Ø hand is patent flushed c̄ NS MS04IVP 4mg given for pain. Abd drsg Δd small amt of bleeding noted from penis. Abd wound had mod amt of bloody drainage. dwet gauze applied covered c̄ 4x4 and Abd pad. drsg to mid-chest had small amt of bloody drainage noted. can c̄ dry drsg. ileostomy is patent draining clear yellow urine. Resting quietly in bed @ present. Restraints in place ~~to~~ VS and secure. —— SGT [redacted] 1/6-2
1610 6July03	VSS-A+O x3-Pt ambulated well 100ft. Ø C/O pain. Pt tolerated lunch well. Bathed himself. Pt. had large BM. —— [redacted]
1640 6July03	Pt. urostomy bag started leaking @1430. changed bag. Pt. tolerated well [redacted] 1700 06JUL03 - Pt rotating [illegible]. — [redacted] 1/6-2
1740 06JUL03	VSS-Alert X3-A te 60% of supper drank 500ml fluid. Abd drsg ~~[illegible]~~ dry & int. ileostomy draining clear yellow urine. saline lock to R hand is patent @ s/s infiltration. Ø C/O Abd pain. sitting up in bed Reading quietly. will monitor. —— SGT [redacted] 1/6-2

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. [redacted]

EPW-[redacted] 1/6-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	1830 06JUL03 NOTES
	[N] AAO x3
	[R] CTA ⊖ ignorans
	[CV] S1, S2, NSR, <3 sec, ⊕ pulse x4 (3+)
	[GI] ⊖ N ⊖ V; tol. reg diet 100%
	[GU] wasting to GU
	[SKIN] midline abdomen c/d/I; lower sacrum ssk [illegible]
	[TV] 16 to ⊕ hour
	[PLAN] Anticipate D/C to GPW camp this week
	0300 07JUL03 - pt c/o [illegible] to perio, moderate amount of
	fresh red blood coming from perio tip. Wounds to wastering
	midline incision are c/d/I. Notified Dr. [redacted] 6/6-2
	[redacted] 1 LT AN
	[redacted]

	1800	22	02	04
HR	98	96	106	90
BP	116/73	111/64	114/69	116/60
RR	16	16/100%	16/100	22/100
wrestling		900		800/1700
TPMS	98.0			97.9

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] 6/6-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7 Jul 03 0810	Received report from previous shift. Pt resting in bed. Abd dressing C, D+I. Urostomy bag intact. #/L to (R) hand intact. ∅ s/s of redness or swelling. ∅ c/o pain. Will continue to monitor. — [redacted] LPN
7 Jul 03 1500	Pt c/o pain. Medicated c̄ ii Percocet tabs for c/o pain. — [redacted], LPN
7 Jul 03 1600	Reinforced urostomy bag. Pt sitting up c̄ ∅ c/o. — [redacted] LPN
~~0200 ∅ 7 Jul ∅~~	
8 Jul 03	Wound almost closed. Looking for D/C [redacted]

b/61-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
0130 08JUL03	Lump noted to inner aspect of of upper R Arm. when palpated felt a pulse is soft non-moveable. Poss. Anyerism of Artery? will pass on to next shift and monitor. USS is Resting quietly @ present c̄ Restraint to UE in place and secure. — sat [redacted] b(6)-2
0420 07JUL03	USS - Alert x3 m304 SQ 4mg given @ 2130 for c/o Abd pain. Drsg Δ'd to Abd small amt of blood noted. covered c̄ wet 4x4 covered c̄ Abd drsg. ileostomy bag Δ'd and sited cleaned ⊖ Redness ⊖ drainage Percocet ii Po sicker for c/o Abd pain. — sat [redacted] b(6)-2
8Jul03 0720	Pt resting in bed. ⊖ c/o. Abd. dressing intact Will continue to monitor. — [redacted] LPN b(6)-2
8Jul03 1030	Dressing Δ done. Wound Almost closed. Urostomy bag remains intact draining yellow urine c̄ sediment. ⊖ c/o @ this time. Will continue to monitor & assess. — [redacted] LPN b(6)-2
8Jul03 1500	Removed staples from Abdominal Area. Pt. c/o pain. Medicated c̄ ii Percocet tabs. [redacted] LPN b(6)-2
8JUL03 1745	USS - Alert x3 Ate 40% of supper Ate 2-MRES drank sound h2o. ileostomy draining clear yellow urine. Abd drsg dry and intact. Lump to inner aspect of R upper arm no Δ'd. Resting quietly in bed. Restraints to UE in place and secure. - sat [redacted]

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

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0345 09JUL03	USS - Tylenol II Po for c/o Abd/leg pain. ileostomy draining clear yellow URine. Abd DSRS Δ'd small amt of light green/bloody drainage noted wet to dry drsg applied covered c̄ Abd pad. Resting quietly in bed c̄ Restraints in place and secure. — SaT [redacted] 5(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
09Jul03	Assumed care of pt. VSS. Pt. resting quietly @ this time. Abd.
0530	dressing CDI. Urostomy bag intact. Pt. restrained to bed,
	+2 radial pulses. Ø c/o pn @ this time. Will continue to
	monitor [redacted]
0730	Pt. continues to rest, Ø c/o pn. [redacted]
1000	Pt. OOB to chair, bathes himself. c/o pn Abd & leg. ∏ per
	coret given po. Eats breakfast, reg diet. Tolerates well. b(6)-2
	Will continue to monitor [redacted]
1100	Pt. ambulates c̄ assistance starting off. Able ambulate
	on his own after gaining balance. Ø c/o pn. Tolerated
	lunch well @ 1130. HOS 1 Bm. Will continue to monitor
1300	Pt. OOB to chair. VSS Ø distress noted. [redacted]
1415	Pt. c/o Abd. & leg pn. ∏ percoret po given. Will continue b(6)-2
	to monitor [redacted]
1450	Dressing change to mid abdominal area, wound almost
	completely closed. Dressing CDI [redacted]
1650	Pt. resting quietly. Ø c/o pn @ this time. Will brief oncoming b(6)-2
	shift of pt. status [redacted]
1925	Rpt Received @ 1700, physical assessment completed +
	Recorded on Flow sheet. Dressing Δcd, Wounds Pink
	well approximated [redacted] Cpt/An
	b(6)-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(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0545	Assumed care of pt. VSS. Pt c/o (R) leg pn, ⅡⅡ Tylenol 325mg given po. Ø further complaints @ this time. Abd. drsg (two) CDI. Urostomy intact draining Clr yellow c̄ sediment. Pt. restraints intact, palpable radial pulses to both extremities. Will continue to monitor 1/6-2 [redacted]
0900	Pt. up, does personal hygiene. Tolerates breakfast well. Dr. [redacted] by bedside to assess healing process of wounds. Ø c/o pn @ this time 1/6-2 [redacted]
1125	Pt. c/o of (R) leg pn ⅡⅡ Tylenol 325mg given po. Pt. ambulated, unable to move steadily in a straight path. Bottom of (R) foot seems to be causing pt. pn. Ø lacerations Ø edema, skin very hard. Placed gauze around foot to have some support. Will inform MD 6/6-2 [redacted]
1315	Pt. resting c̄ Ø c/o pn. [redacted]
1615	Dressing change complete. Pt. eating dinner. Ø complaints [redacted]
11 July 03	
	0530 Rc'd pt lying in bed, unrestrained due to - pt moves & ambulates on his own ad-lib. Pt resting comfortably in NAD [redacted]
0600	Pt c/o pain 650 Tylenol, refused, will cont to monitor, pt frustrated & wants MS04 to sleep, explained to pt MS04 is for pain not for sleep. Will cont to monitor, 0612 Pt c/o (R) knee pain, Given a heat pack & pt took Tylenol [redacted] 1/6-2

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] 6/6-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 July 03	0830 Δ pt urostomy bag due to leakage, cleaned stoma and abdomen wound. Ø S/S infection present. Pt tolerated well, did not eat breakfast. — [redacted]
	930 Pt moved to bedside comode, pers. hygiene — [redacted]
	1000 Pt ambulated for approx 15-20 minutes, tolerated very well. Pt now resting. Will cont to monitor — [redacted]
	1600 Pt noted to have blood from penis. DR aware & advised not to be alarmed it will take 3mo to stop. No other changes noted [redacted] b(6)-2
12 Jul 03 0500	Pt sitting up in bed. VSS A/O x3. Assessment completed (see flow sheet) Ø C/O pn @ this time. Will continue to monitor — [redacted]
0900	Pt sitting up & eating breakfast, tolerating well. C/O (R) leg pn. TT 325mg Tylenol given po @ 0930. Personal hygiene continue. Will continue to monitor — [redacted] b(6)-2
1100	Pt. ambulated for approx. 3min. very unstable due to pn in (R) leg. Pt. back in bed & resting. Will attempt to have pt. ambulate later in the day. — [redacted] b(6)-2
1400	Pt. continues to rest quietly c̄ Ø complaints @ this time. — [redacted]
1515	DSG Δ complete, wet to dry. Pt. ate lunch @ 1500, tolerated well. Ø complaints @ this time — [redacted]
1600	Dr. ([redacted]) by bedside to discuss possible discharge in near future. Will brief oncoming shift of pt — [redacted] b(6)-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.

EPN [redacted] b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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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)*
1743 12JuL03	VSS - Alert x3 - Abd drsg dry and intact. offers ø c/o pain or discomfort present. ileostomy draining clear yellow urine. Restraint to UE in place and secure. Resting quietly in bed c̄ eyes closed @ present. — Sat [redacted] 6/6-2
0200 12JuL03	VSS - Alert x3 - Abd drsg Δ'd small Amt of bloodly drainage noted from wound. ~~Repacked~~ [redacted] moist 4x4 placed on wound and covered c̄ Abd drsg. ileostomy draining clear yellow urine. Restraint to UE in place and secure. - Sat [redacted]
0430 12JuL03	VSS - Tylenol 325mg ii Po given @ 0400 for c/o Abd & leg pain. sitting up in bed quietly. Restraints in place and secure. — Sat [redacted] 6/6-2
13Jul03 0530	VSS. A/O x3. Pt. lying in bed c̄ Ø c/o pn. Urostomy to continous drain, yellow c̄ sediment. Wet to dry dressing, intact. Assessment complete (see flowsheet)
13Jul03 0615	Pt c/o (R) leg pn ii Tylenol 325mg po. Will continue to monitor [redacted]
13Jul03 1030	Pt. ambulated down the ward floor once & back to bedside. 6/6-2 VSS. Ø c/o pn @ this time. [redacted]
13Jul03 1430	Pt. had first BM of the day, solid stool & dark in color. Ate lunch @ 1400, tolerated well. [redacted]
13Jul03 1655	Dsg Δ @ 1600. Ø c/o pn, resting quietly. Will brief oncoming shift [redacted] 6/6-2

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] 6/6-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 July	1200. Received pt from Sgt [redacted] b(6)-2. No c/o pain. VSS assessment done, dressings changed. Site looks dry it is healing well — Sgt [redacted] b(6)-2
	2300 - Urostomy bag leaking. Spc [redacted] b(6)-2 changed it — Sgt [redacted]
	0145 - Pt c/o pain & percocets given. Pt sitting up singing in bed — Sgt [redacted] b(6)-2
14 July 03	0530 Received report from Sgt [redacted] b(6)-2. No c/o severe pain, headache noted. 1 Percoset given @ 0530. Assessment performed, DRSG & CDI, will monitor & later in shift. — [redacted] b(6)-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] b(6)-4		

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM [redacted] (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)*
14 JUL 03	NARRATIVE SUMMARY [redacted] b(2)-2
	DOA 30 May 03
	DOD 14 JUL 03
	LTC [redacted] MD b(6)-2
	Reason for admission: GSW to pelvis
	Hospital Course: Patient came in transfer f 86 CSH after sustaining a GSW to arm and pelvis during the early period of the conflict. He required vascular repair of an arterial injury to the arm and subsequently went on to a supra pubic, Dorsal vein ligation, and ileal loop urinary diversion. This left him with a significant lower abd soft tissue defect. Pt here @ the 28 CSH. Here we allowed progressive closure of the wound by 2nd intent until adequate granulation had occurred. Random abd wall flaps were then created and wound partially closed. A wound vacuum and routine wound care allowed f final closure. He is ready for Discharge
	(cont)

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(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
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Final Dx: (1) s/p ileal loop urinary diversion to solitary kidney
s/p suprapubicity / nephrectomy
(2) ~~[illegible]~~ bloody drainage of penis – NO Rx required
(3) Abd wound closed by combined local flap + 2nd intent
(4) Single episode SBO managed by NG tube c̄ spontaneous resolution

Plan: – Transfer to Prison Camp c̄ Urosky supplies
– Permit [illegible] PO q 4° in PRN
– Renal US @ 3 months.

[redacted] LTCM

5(6)-2

[redacted] 5(6)-4

PATIENT ASSE ENT [redacted] ENT ASSESSMENT

ME: 0700 SIGNATURE [redacted] 6(6)-2 TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

: Loose / Tight / Diaphoretic / Shiny / Dry
: Temperature warm
or: Pale / Cyanotic / Jaundiced not for race
ous Membranes: Moist / Dry / Cracked
Breakdown: None Location: Size:

NEUROLOGICAL

/ Alert / Lethargic / Unresponsive GCS:
ntated / Disoriented Pupils:
emity Movement: Full / Limited / None

CARDIOVASCULAR

e (0 - 4): Radials +2 Pedals +2
illary Refill: Seconds <3 Homan's Sign Ø
ular Venous Distension Ø Edema Ø
rt Sounds S1 + S2
hm NSR PRI: QRS:

ular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
eforms				
			(1) AC	
ition				

st Pain Ø

RESPIRATORY

st Expansion / Symmetrical / Asymmetrical
piration / No Distress / SOB / Labored / Use of Access Muscles
thing Patterns: Even, unlabored
gh: Productive / Nonproductive / None
um: Color / Amount / Consistency / Odor Ø
st Drainage System Gravity: Ø Suction cm: Ø
Leak No Ø Yes Crepitus Ø
racter of Drainage: Ø
hea / Midline / Deviated (R) / Deviated (L)
icial Airway Size: Type: Ø Position: Ø

Breath Sounds	Anterior/Location	Posterior/Location
kles	CTA	CTA
ezes		
nished		
ent		

GASTROINTESTINAL

omen: Soft / Firm / Hard / Distended cm Girth
el Sounds: Normal / Hyperactive / Hypoactive / Absent
ssings: NBD dressing C, D+I
Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
Drainage: Color Ø Character Ø
e Feeding: Day No: Ø Strength: Ø Rate: Aspirate:
l: Character Ø
ns:

GENITOURINARY

e Color: yellow Character: Sediment
ling: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature warm
Color: Pale / Cyanotic / Jaundiced Normal for Race
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils: 3m Pearlm
Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2
Capillary Refill: Seconds >3 Homan's Sign Ø
Jugular Venous Distension Ø Edema Ø
Heart Sounds S1 & S2
Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Per
Waveforms				
Site			(1) AC	
Solution				

Chest Pain Ø

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Mus
Breathing Patterns: even Reg
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor Ø
Chest Drainage System Gravity: Suction cm:
Air Leak No Yes Crepitus Ø
Character of Drainage: Ø
Trachea / Midline / Deviated (R) / Deviated (L) Ø
Artificial Airway Size: Type: Position: Ø

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent (+) all quad
Dressings: Ø
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent D Ø
NG Drainage: Color Ø Character
Tube Feeding: Day No: Ø Strength: Rate: Aspi
Stool: Character Ø
Drains: Ø

GENITOURINARY

Urine Color: Character:
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

EPW # [redacted] Date: 30 Jun 05

5(6)-4

PATIENT ASSESSMENT

TIME: 0545 SIGNATURE: [redacted] 6(6)-2

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature Warm
Color: Pale / Cyanotic / Jaundiced normal for race
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Ø Size:

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils: PERLLA
Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2
Capillary Refill: Seconds <3sec Homan's Sign Ø
Jugular Venous Distension Ø Edema Ø
Heart Sounds S1 + S2
Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(R) Arm	
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: Even, unlabored
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor Ø
Chest Drainage System Gravity: Ø Suction cm: Ø
Air Leak No Yes Ø Crepitus
Character of Drainage: Ø
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Ø Position:

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: Dressing to ABD C+D+I
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Ø Character Ø
Tube Feeding: Day No Ø Strength: Rate: Aspirate:
Stool: Character
Drains: JP to LIS

GENITOURINARY

Urine Color: Cloudy Character: sediment
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

THER:

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature warm
Color: Pale / Cyanotic / Jaundiced normal for race
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 73 cm Homan's Sign
Jugular Venous Distension Edema
Heart Sounds NSR
Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
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	CH	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: Abd wet today packed & gauze
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: clear yellow Character:
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

DATE | DX | HOSPITAL DAY

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line			113														
BP Cuff			57				118/57				115/65		14/89		118/59		
Temperature			99.0				99.2								99.4		
Pulse			100				98				96		105		101		
Respiratory Rate			16				22				18		18		16		
Sats			98				96				97		96		94%		
Source			RA				RA				RA		RA		RA		
[illegible]																	
[illegible]																	

TIME	24	01	02	03	04	05	06	07	8T	08	09	10	11	12	13	14	15
		300		300									300				300

TOTALS																	
URINE	HOUR / TOTAL					450 emptied						600 emptied					
	sp gr																
	S/A																
NG	OUTPUT																
	pH																
	GUIAC																
EMESIS																	
STOOL											LARGE						
DRAINS	JP					200											
				Dressing soaked													
						emptied											
TOTALS																	

PAGE

OF DAY

16	17	18	19	20	21	22	23	
122/66	123/53				100/50			
	98.8							
103	103				107			
22	20				20			
96%	97				100			
RA	RA				RA			

16	17	18	19	20	21	22	23	8° T
Po	500			500				
1000				900/1900				

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

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

LABORATORY DATA

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

ACTIVITIES OF DAILY LIVING

TIME								
MOUTH CARE								
BATH								
SKIN CARE								
FOLEY CARE								
TRACH CARE								
ROM EXERCISES								

TURN

TIME				

SUCTION

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE

NURSE'S SIGNATURE

[redacted]

b(6)-2

MEDCOM - 9829

66-4

Date: 01JUL03 #[redacted]

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin : Loose / Tight / Diaphoretic / Shiny / Dry

Skin : Temperature cool

Color: Pale / Cyanotic / Jaundiced NFR

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: 3mm bilat

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): 3 Radials +3 Pedals +3

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds C

Rhythm Sinus Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: lien, unlabored

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: abd dressing clean, dry + intact

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: clear yellow Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

urostomy bag intact

OTHER:

66-2

PATIENT ASSESSMENT

TIME: 1800 SIGNATURE: SJT [redacted]

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	Peripheral 2
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 / Catheter

EMOTIONAL/PSYCHOSOCIAL

b6-4

DATE: 3/4 PATIENT ASS. b6-2 ENT. # [redacted]

TIME: SIGNATURE: [redacted], LPN

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm

Color: Pale / Cyanotic / Jaundiced Normal for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: PERRLA 3mm

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +3 Pedals +3

Capillary Refill: <3 DC Seconds <3 DC Homan's Sign Ø

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1 + S2

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(L) AC	
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: Even, unlabored

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor Ø

Chest Drainage System Gravity: Ø Suction cm: Ø

Air Leak No Ø Yes Crepitus

Character of Drainage: Ø

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

Artificial Airway Size: Type: Position:

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: C, D + I

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

NG Drainage: Color Ø Character Ø

Tube Feeding: Day No: Ø Strength: Ø Rate: Aspirate:

Stool: Character

Drains: Ø

GENITOURINARY

Urine Color: yellow Character: sediment

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

P[illegible]T ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: Pearla 3m

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials 4 Pedals 4

Capillary Refill: Seconds 7 3 Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm NSR PRI: QRS

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral
Waveforms				
Site			Salmlock (L)	FA
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: CTA B/L Rey even

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: Abd drsg dry intact

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: clear Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

EPW [redacted] b6-4

Date 03 Jul Bed # ICU 1

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

N

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	121/80		114/66		112/69		105/62		102/62		107/62			114/91				111/110				107/60		
TEMP			98.6				99.4				99.6			98.1				100				98.0		
HR	108		102		85		94		85		101			108				100				102		
RR	22		18		20		22		18		22			28				10				18		
SAO2	97		96		97		96		98		97			99				99				97		
FIO2 Source														RA				RA				RA		
INPUT																				200	200			
PO			200					200	100					300		800								
IV																								
NGT																								
TURN Q 2																								
TOTAL																								
OUTPUT																								
URINE																800		100						
NGT																								
STOOL																								
TOTAL																								
BALANCE																								
Initials																								

MEDCOM - 9832

Date 01JuL03 Bed #

Patient's Name: [redacted] b6-4

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
				92			117				117													
BP				81			58				69			146/80					152/82			144/20		119/68
TEMP														450					102.4					
HR				100			83				105			94					131			92		90
RR				10			15				15			18					33			14		14
SAO2				100%			99%				99%			100								97		
FIO2																								
INPUT				0			0				0													
PO				0			0				0			500							500			700
IV				0			0				0													
NGT				0			0				0													
TURN Q 2																								
TOTAL																								
OUTPUT				500			700				3000													
URINE																					825			700
NGT																								
STOOL																								
TOTAL																								
BALANCE																								
Initials																								

Date July 3

PATIENT ASSESSMENT

E: 0100 SIGNATURE: [redacted] b6-2

SKIN AND MUCOUS MEMBRANES

Loose / Tight / Diaphoretic / Shiny / Dry

Temperature COOL

Pale / Cyanotic / Jaundiced NFR

Membranes: Moist / Dry / Cracked

eakdown: None Location: Size:

NEUROLOGICAL

ert / Lethargic / Unresponsive GCS:

ed / Disoriented Pupils: alert, [illegible]

y Movement: Full / Limited / None

CARDIOVASCULAR

) - 4): Radials +3 Pedals +3

Refill: Seconds 3 Homan's Sign

Venous Distension Ø Edema Ø

unds Ø

PRI: QRS:

Catheter	Central	Arterial	Peripheral 1	Peripheral 2
ns			[redacted]	
	urostomy		bag	

in

RESPIRATORY

pansion / Symmetrical / Asymmetrical

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

Patterns:

roductive / Nonproductive / None Productive

Color / Amount / Consistency / Odor Ø yellow, clear

nage System Gravity: Ø Suction cm:

Ø No Yes -- Crepitus

of Drainage Ø

Midline / Deviated (R) / Deviated (L) Ø

rway Size: Type: Position:

Sounds	Anterior/Location	Posterior/Location
CTA		

GASTROINTESTINAL

Soft / Firm / Hard / Distended Nontender cm Girth

ds: Normal / Hyperactive / Hypoactive / Absent

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

e: Color Character

g: Day No Strength: Rate: Aspirate:

acter Ø

GENITOURINARY

lor: urostomy Character: bright yellow

ntinent / Incontinent / Catheter

EMOTIONAL [illegible]

Comm & done [redacted] b6-2

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm - Afrebrile

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: 3 m Pearl

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +4 Pedals +4

Capillary Refill: Seconds 2-3 Homan's Sign Ø

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1 S2

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripher
Waveforms			[redacted]	
Site				
Solution				

Chest Pain Ø

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: Reg even CTAB12

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor Ø

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 BSCF X4 quads

Dressings: Abd dry and intact

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: clear yellow Character: Ileostomy

Voiding: Continent / Incontinent /

Date 3 July 03 Bed # 9

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

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
			103				109			105														
BP			169				71			69			98					124						
TEMP													982					75						
HR			104				97			94			101					97						
RR			13				13			11			20					7						
SAO2			99%				100			99%			98					98						
FIO2																								
INPUT			Ø				500cc			450			300											
PO			Ø																					
IV			Ø				Ø																	
NGT			Ø				Ø																	
TURN Q 2																								
TOTAL																								
OUTPUT			250				500			700			200				1300							
URINE			Ø														1300			900				
NGT			Ø							Ø														
STOOL			Ø							Ø														
TOTAL																								
BALANCE																								
Initials			Ø				Ø			Ø														

MEDCOM - 9835

66-4

C75W

DATE: C75W

PATIENT ASSE[redacted]ENT #[redacted]

TIME: 0740 SIGNATUR[redacted] 66-2

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm

Color: Pale / Cyanotic / Jaundiced normal / [illegible]

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: PERRLA 3mm

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +2 Pedals +2

Capillary Refill: <3 Seconds Homan's Sign Ø

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1 S2

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			R hand	
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: EVEN

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor Ø

Chest Drainage System Gravity: Ø Suction cm: Ø

Air Leak No Yes Crepitus

Character of Drainage: Ø

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

Artificial Airway Size: Type: Position:

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: Abd. C, D & I

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

NG Drainage: Color Ø Character Ø

Tube Feeding: Day No: Ø Strength: Rate: Aspirate:

Stool: Character Ø

Drains:

GENITOURINARY

Urine Color: clear Character: yellow

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

PAT[redacted] ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Afebrile - warm

Color: Pale / Cyanotic / Jaundiced Normal Rad

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 +4 Pedals +4

Capillary Refill: Seconds 73 Homan's Sign Ø

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1 S2

Rhythm NSR PRI: QRS

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			R hand	
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: Reg even CTA BIL

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor Ø

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 + Allgoad S

Dressings: Abd drsg dry intact

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: clear yellow Character: ileostomy

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

Date 7 July 03 Bed # 9

Patient's Name: # [redacted] 66-2

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP			114/66			100/68			113/78		[illegible]			128/73				115/71				112/48		
TEMP						97.8					[illegible]			97										
HR			91			92			97		98			104				101				93		
RR			22			18			18		22			20				16				18		
SAO2			98			97			97		97			99				99				99		
FIO2			RA			RA			RA		RA													
INPUT																								
PO																								
IV																								
NGT																								
TURN Q 2																								
TOTAL																								
OUTPUT																								
URINE															1300									1300
NGT																								
STOOL																								
TOTAL																								
BALANCE																								
Initials																								

MEDCOM - 9837

#[redacted] bb-4

DATE 8/24 PATIENT ASSESSMENT bb-2
TIME: 0700 SIGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature Warm
Color: Pale / Cyanotic / Jaundiced NFR
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 +2 Pedals +2
Capillary Refill: <3 Seconds Homan's Sign
Jugular Venous Distension Ø Edema Ø
Heart Sounds S1 S2
Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			N/A	
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: EVEN
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor Ø
Chest Drainage System Gravity: Ø Suction cm: Ø
Air Leak No Yes Crepitus
Character of Drainage: Ø
Trachea / Midline / Deviated (R) / Deviated (L)
Artificial Airway Size: Type: Position:

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth
Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent
Dressings: C&D I
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Ø Character Ø
Tube Feeding: Day No: Ø Strength: Rate: Aspirate:
Stool: Character Ø
Drains

GENITOURINARY

Urine Color: Yellow Character: Sediment
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

PATIENT ASSESSMENT bb-7
TIME: 1700 SIGNATURE: Sat [redacted] 8/24

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry
Skin: Temperature Warm & Fresh
Color: Pale / Cyanotic / Jaundiced NORmal for Race
Mucous Membranes: Moist / Dry / Cracked
Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:
Orientated / Disoriented Pupils: 3 mm Pearla
Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials 4 Pedals 4
Capillary Refill: Seconds >3 Homan's Sign Ø
Jugular Venous Distension Ø Edema Ø
Heart Sounds S1 S2
Rhythm NSR PRI: QRS

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical
Respiration / No Distress / SOB / Labored / Use of Access Muscles
Breathing Patterns: Reg CTA BIL
Cough: Productive / Nonproductive / None
Sputum: Color / Amount / Consistency / Odor Ø
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 BS⊕ x4 quads
Dressings: Abd drsg. dry & intact
NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage
NG Drainage: Color Character
Tube Feeding: Day No: Strength: Rate: Aspirate
Stool: Character
Drains:
Ileostomy Patent

GENITOURINARY

Urine Color: yellow Character: clear
Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

Date 08) JL 03 Bed # #9

Patient's Name. [redacted] b6-4f

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	108/70			119/60			135/77		120/66			135/79		128/74						117/21				131/76
TEMP									992					974						89				98
HR	91			85			89		92			103		87						89				96
RR	19			19			18		20			20		22						14				20
SAO2	95			96			95		97			97		99						100				99
FIO2																								
INPUT													600					5						
PO																								
IV																								
NGT																								
TURN Q 2																								
TOTAL																								
OUTPUT																								
URINE									1200							1000						750		900
NGT																								
STOOL																								
TOTAL																								
BALANCE																								
Initials																								

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: 21

HEIGHT:

WEIGHT:

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

3. PREVIOUS SURGERY [ ] NO [X] YES (type): Mar 03
SIP Pelvic SSW
(R) nephrectomy c̄ ileal conduit, Evacuation Pelvic Hematoma, Closure Bladde

4. PROPOSED SURGICAL PROCEDURE: Neck Laceration
Suprapubic skin graft

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to: ✓ 1) Surgical Procedure & Operating Room Environment 2) Separation Anxiety (Child) ✓ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	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 ✓ Potential for respiratory dysfunction due to: ✓ 1) Positioning ✓ 2) Effects of Anesthesia 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase .	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 ✓ Potential impairment of skin integrity due to: ✓ 1) Intraoperative Immobility ✓ 2) ESU Pad Placement ✓ 3) Positional Aids 4) Prosthesis ✓ 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	c Utilize pressure preventing devices on OR table and accessories. c Check for proper positioning and support to maintain good body alignment. c Pad pressure points. c Place ESU ground pad on non compromised skin surface area. c Keep prep fluids from pooling.

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

EPW # [redacted] bb-4
ICU

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: ___