MEDICAL RECORD - ANESTHESIA

For u[illegible] his form, see AR 40-66; the proponent agency [illegible] OTSG

NKDA

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

DRUG (Units)													TOTALS	TOTAL EBL
Fentanyl (500) (mcg)														500
MS04 (10) (mg)			3			2							20	
VCB (30) (mg)				5						5				TOTAL URINE
Midazolam (mg)														PG
Decadron (mg)		10												
VOLAT AGENT [illegible] % del / % e.t.	1.8	2.0	1.8	1.8	1.3	1.8	2.0	1.5	1.8	1.5	1.3	1.3		
AIR L/Min														
N2O L/Min														
O2 L/Min	2 ~ 1		1	1	1	1	1	2	2	2	2	2		

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

FLUIDS SUMMARY
CRYSTALLOID- [illegible]
COLLOID- 500mL Hespan
BLOOD-

FLUIDS
LINE site 18 (R) AC ☒ Warmed — Sodium LR #7
18 (L) AC ☒ Warmed — LR #6 — 6000 — 6500 — 7000
☐ Warmed
☐ Warmed

LOSSES
EST BLOOD LOSS 200 — 300 — 400 — 400
URINE - 2100 — 3200 — 3550 — 3800 — 3900

PHYS STATUS 1 2 3 4 5 E

TIME → 1130 x 1200 x 30 · 1300 x 30 x 1400 x 30

pH	Na 7.34	141	
pCO2	K+ 41.1	5.56	
pO2	iCa 419	1.15	
HCO3	Act 23	28	
BE	-2		

(1400:) 7.34 / 139; 42.7 / 4.9; 522 / 1.11; 23 / 40; -3

BODY WEIGHT: See KG LB
HEMATOCRIT: [illegible]
INITIAL DATA: BP PG HR [illegible]
EQUIP CHECK OK? Y N
PATIENT RECHECK
OK for PROCEDURE? TIME

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

Scale: 220 200 180 160 140 120 100 80 60 40 20

REMARKS
Code drugs with numbers, events with letters
- Throatpack in 11[illegible]
- TP out 1453
- On [redacted] [illegible]
- ④ 20 [illegible] IV
- ⑤ Banks [illegible] repeat given —
- ⑥ LR [illegible] ↑
- 66-2

VENTIL

VT - ml	690	800	700	760	780	670	680	750	680	870	920	820
f - breaths/min	8	9	10	9	10	10	10	10	10	10	10	10
Peak inf pres / PEEP	28	30	30	30	27	29	35	28	29	28	28	28
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	C	C	C	C
ET CO2 (torr)	30	32	33	35	33	35	35	35	35	33	33	33
FIO2 (Frac or %)	0.76	0.76	0.76	0.75	0.76	.76	.76	.76	0.76	0.76	0.76	0.76
SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
ECG: PAC's	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
TEMP-site	unavailable											
N-M Block (T/4)	0/4	x			1/4	0/4		0/4	0/4	0/4	1/4	0/4

MONITORS/ACCESSORIES: BP/Auto Cuff; BP/oth; ART line; Steth- PC/ES; Gas analyzer; Warming blkt — x1 Blanket; Conv warmer

Mark with letters & symbols, explain under REMARKS — EVENTS Position → ④ ⑤ ⑥

RECOVERY AT
PACU ICU (Specify)
OTHER See
CONDITION PG
RESP- SpO2-
BP- HR-

ANESTHESIA / PROCEDURE TIMES
	Start	Room	End
ANES			
	Ready	Begin	End
PROC			

PROCEDURES and CPT Codes: PG

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — PG

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

b(6)-4

[redacted]

Civ

SURGEONS: b(6)-2

[redacted] CRNA/MAJ

PROCEDURE LOCATION: Trauma
DATE: 2 Sep 03
PAGE 2 OF 3

MEDICAL RECORD - ANESTHESIA

For u[se of th]is form, see AR 40-66; the proponent agency [is] OTSG

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)								
Fentanyl 500 (mg)								
MSO4 [15] (mg)		2			3			
Vec [40] (mg)				5				
Midazolam ∅ (mg)			1	1	(27) 1			
( )								
( )								
VOLAT AGENT Iso % del / % e.t.	1.4	1.4	1.4	1.4	1.4	1.4		
AIR L/Min								
N2O L/Min								
O2 L/Min	2	2	2	2	2	2		

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

TOTALS — TOTAL EBL: See — TOTAL URINE: Pg

FLUIDS SUMMARY
CRYSTALLOID-
COLLOID- #1
BLOOD-

FLUIDS

LINE site 18G (R) AC ☒ Warmed — 1800 —— 2800
18G (L) AC ☒ Warmed
☐ Warmed — [#4 PRBC]
☐ Warmed

LOSSES

EST BLOOD LOSS: 400 — 500
URINE - 2900

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: See KG LB

HEMATOCRIT: Pg

INITIAL DATA:
BP- #1
HR-

EQUIP CHECK
OK? Y N

PATIENT RECHECK
OK for PROCEDURE?
TIME-

TIME 1430 x 1500 x 30 x 1600

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

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

pH / Na	7.34	140
pCO2 / K	33.4	4.6
pO2 / Ca++	431	1.3
HCO3 / HCT	23	20
BD	-2	

[redacted] Family Physician

VENTIL

VT - ml	900	790	750	920	830	700
f - breaths/min	10	10	10	10	10	10
Peak inf pres / PEEP	28	28	29	28	28	
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C

MONITORS/ACCESSORIES

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

✓ ET CO2 (torr)	34	33	35	35	35	
✓ FIO2 (Frac or %)	0.76	0.76	0.76	0.76	0.76	0.76
✓ SpO2 (%)	100	100	100	100	100	100
✓ ECG	SR	SR	SR	SR	SR	SR
TEMP-site axilla	→	→	→			
✓ N-M Block (T/4)	0/4	0/4	0/4	1/4		0/4

Warming blkt: x1 Blanket →

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (7)

REMARKS
Code drugs with numbers, events with letters

(4) 2455658 PRBC
(7) Xeroform gauze packed to roof of mouth by the surgeon
(8) TO ICU-2 via litter, APL SaO2 monitor
Report to RN
Suctioned: Cricothyrotomy — moderate blood secretions
FiO2 70% SIMV + 5 PEEP, 1:2 TV 800mL

RECOVERY AT
PACU ICU (Specify)
OTHER See
CONDITION:
RESP Pg SpO2
BP- HR-

ANESTHESIA / PROCEDURE TIMES #1
ANES: Start · Room · End
PROC: Ready · Begin · End

PROCEDURES and CPT Codes:

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* See Pg 1

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

[redacted]

Iraqi CIV

SURGEONS: b(6)-2

[redacted] CRNA/MAJ

PROCEDURE LOCATION: Trauma
DATE: 2 Sept 03
PAGE 3 OF 3

DA FORM 7389, FEB 1998 — MEDCOM - 1844 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

[redacted]

ACLU-RDI 1647 p.2

DOD-032016

MEDICAL RECORD - ANESTHESIA

Fr … f this form, see AR 40-66; the proponent agen… : OTSG

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

DRUG	(Units)				
Fentanyl	(mcg)	100/100			
Versed	(mg)	2	3		
	( )				
	( )				
	( )				
	( )				
VOLAT AGENT 1.50	% del	1.5	1.5	2.0	(I)
	% e.t.				
AIR	L/Min				
N2O	L/Min				
O2	L/Min	1	2	2	

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

FLUIDS

LINE site	
LR Rt (L) AC	☐ Warmed
	☐ Warmed
	☐ Warmed
	☐ Warmed

LOSSES — EST BLOOD LOSS; URINE -

TOTALS	TOTAL EBL
250	5 min
	TOTAL URIN
	130

FLUIDS - SUMMARY

CRYSTALLOID: 500

COLLOID: 0

BLOOD: 0

REMARKS

Code drugs with numbers, events with letters

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 75 (KG) LB

HEMATOCRIT:

INITIAL DATA:

BP- 130 / 78

HR- 87

EQUIP CHECK

OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? Yes

TIME- 0820

TIME → 0815 · 30 · 0900 · 30 · 1000 · 30 · 1100

SYMBOLS:

BP by cuff: V ^

Heart rate: ●

Resp rate

BR (transduced): ╪

TOURNIQUET: T—T

ANES- X-X

PROC- ⊙-⊙

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

VENTIL

VT - ml		560	440	600	610
f - breaths/min		12	12	12	12
Peak inf pres / PEEP		30	29	16	16
MODE - S(pon), A(assist), C(on)		CV	CV	CV	CV

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	30			32
BP/oth	FIO2 (Frac or %)	.60	.60	.60	.60
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR			SR
Gas analyzer	TEMP-site	AxAL			
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

Mark with letters & symbols, explain under REMARKS — EVENTS Position → 01

RECOVERY AT 0915

PACU ICU _____ (Specify)

OTHER _____

CONDITION:

RESP- 10 SpO2- 100

BP- 135/69 HR- 73

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0800	0815	0925
PROC	Ready	Begin	End
	0825	0835	0905

PROCEDURES and CPT Codes:

TRACH

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

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

#[redacted]

b(6)-4

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

b(6)-2

[redacted]

PROCEDURE LOCATION: OR1

DATE: 4 SEP 05

PAGE 1 OF

DA FORM 7389, FEB 1998 … PATIENT'S MEDICAL RECORD USAPA V1.00

MEDCOM - 18443

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 2 DAYS MOS YRS Sex ( ) ~~MALE~~ ( ) FEMALE

PROPOSED PROCEDURE: Cricothyroidotomy
SURGICAL SERVICE: General, ortho, OF Surgeon
NPO SINCE: _____

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

HABITS:
TOBACCO: ?
ETOH: ?
DRUGS: _____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) _____
( ) _____
( ) _____
( ) _____
( ) _____
( ) _____

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

LABORATORY STUDIES:

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

133 | 20 | 7 (197
3.0 | 104 | 1.1
23.7 > 12.8 / 39.6 (332

PREOPERATIVE ASSESSMENT

PAST MEDICAL HISTORY/SYSTEMS REVIEW Emergency

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

PAST SURGICAL/ANESTHETIC
Kidney stone removed

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 _____
HEENT - Teeth open/chipped
Trachea WNL
TMJ/Neck WNL
Oropharynx WNL
Nares _____
CHEST: Lungs CTA (B)
CARDIAC: _____
EXTREMITIES: _____
IV Access: 18G (R) + (L) AC
Ulnar Filling: _____
BACK: _____
OTHER: _____

(SW - (L) lip; (SW mandible laceration (R) thumb

NPO Since _____

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

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. Interpreter present in OR; Propofol + Fenta TIF, supervise Cricothyroidotomy
The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: [redacted] 66-2 Date: 2 Sept 03 Time: 0803 Hrs

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

Signed: _____ Date: _____ Time: _____ Hrs

SEDATION KEY:

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

Patient Identification: (Ward) b(6)-4

[redacted]

Iraqi CIV

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age ~~25~~ DAYS MOS (YRS) Sex ~~M~~ MALE ~~( ) FEMALE~~

PROPOSED PROCEDURE: TRACHEOSTOMY & MOUTH I&D
SURGICAL SERVICE: GEN & OMF
NPO SINCE: _____

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

HABITS:
TOBACCO: _____
ETOH: _____
DRUGS: _____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) ZANTAC
( ) FENT
( ) VERSED
( ) DECADRON
( ) COPECESSOR PRN
( ) PHENERGAN PRN
TYLENOL PRN

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

LABORATORY STUDIES:

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

10.6 / 7.3 / 174 / 22.8
H/O BLOOD INFN 2SEP03
↑ GLU 139
↑ CREAT 1.3
↑ CK 622

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

CRICOTHYROTOMY
H/O RENAL STONES & (6) SURG

ASSESSMENT
PAST SURGICAL/ANESTHETIC
FACE REPAIR PGSW
(2) HIP REPAIR GSW } 2SEP03
EXP LAPAROTOMY

PHYSICAL EXAMINATION
BP 131/61 HR 73 R 14 T ___
Pain Scale 0-10 _____
HEENT - Teeth _____
Trachea _____ SURG
TMJ/Neck _____ SITE
Oropharnyx _____
Nares _____
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES: _____
IV Access: _____
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since _____

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): _____ C2IC → TRACH
{X} General: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. 66-2

The patient/legal guardian understand and agrees. Questions answered.
Signed: [redacted] Date: 04SEP03 Time: 0655 Hrs

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

Signed: _____ Date: _____ Time: _____ Hrs

SEDATION KEY:

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

Patient Identification: (Ward) ICU-2
CIV [redacted]
[redacted] b(4) - 4

— Returned 14 STAT

518-124 NSN 7540-00-634-4159

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)

- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of _______ units)
- [ ] CRYOPRECIPITATE (Pool of _______ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) ____________

VOLUME REQUESTED (If applicable) ____________ ML

REMARKS: [redacted] b(6)-2

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

b(6)-2

DATE REQUESTED 2 Sept 03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ____________
HEMOLYTIC DISEASE OF NEWBORN? ____________

REQUESTING PHYSI[redacted]

DIAG[redacted] OPERATIVE PROCEDURE GSW

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

SIGNATU[redacted] b(6)-2

2 Sept 03

[redacted] VERIFIED 807

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO 2455658

TRANSFUSION NO.

PATIENT NO 66-4 [redacted]

DONOR ABO B Rh POS

RECIPIENT ABO B Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Comp

PREVIOUS RECORD CHECK.
- [ ] RECORD
- [x] NO RECORD

SIGNATU[redacted] b(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQU[redacted] DATE 2 Sep 03

REMARKS: b(6)-2

Exp - 4 Sep 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signatur[redacted]

b(6)-2

AT (Hour) ~~1410~~ 1504 ON (Date) 2 Sep 03

IDENTIFICATION

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

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

2nd VERIFIER (Sign[redacted]

TEM[redacted] PULSE 86 BP 118/58

DATE OF TRANSFUSION 2 Sept 03 TIME STARTED 1503

POST-TRANSFUSION DATA

AMOUNT GIVEN all ML

TIME/DATE (COMPLETED)/INTERRUPTED 1515 9/02/03

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 35 PULSE 88 BLOOD PRESSURE 125/61

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

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [x] NO
- [ ] YES (Specify)

SIGNATURE OF [redacted] CRNA/MAJ

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name —La[redacted] rate: hospital or medical facility)

[redacted] SEX Male EMS

[redacted] b(6)-4

b(6)-2

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 18446

Medical Record Copy

ACLU-RDI 1647 p.6

DOD-032020

NSN 7540-01-165-7294

591-3(

RADIC IC CONSULTATION REQUEST/F RT

(Radiology/Nuc edicine/Ultrasound/Computed Tomography ations)

EXAMINATIONS (S) REQUESTED: Portable CXR in A.M.

AGE	SEX	SSN *(Sponsor)*	WARD/CLINIC	REGISTER NO.
			ICU 2	

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY: Dr [redacted] b(6)-2

TELEPHONE/PAGE NO.: apt

DATE REQUESTED: 1 SEP

SPECIFIC REASON(S) FOR REQUEST *(Complaints and findings)*

Intubated

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give : Name - last, first, middle, Medical Fucility)*

CIV

[redacted]

b(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1—MEDICAL RECORD

STANDARD FORM 519-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

MEDCOM - 18447

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
25Sep03	Surgery Op Note
	Pre-op Dx: Severe facial trauma c̄ Respiratory Distress
	Left flank wound + Right 2nd digit wound
	Proc: Emergent Cricothyroidotomy c̄ placement of #4 Shiley trach
	Ex-Lap + G-tube / washout of flank c̄ I+D
	Findings: NBC Ex-Lap
	EBL:
	Fluids: 8500 crystalloids, 500 colloid
	UO: 3900
	Complications: Ø
	Patient stable at end of case. Dr [redacted] to
	operate on facial trauma b(6)-2
	Surgeons: [redacted] [redacted]

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

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

REGISTER NO. | WARD NO.

[redacted]
b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

MEDCOM - 18448

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

ICU 2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 2 Sep 03 TIME OF ORDER: 1545 HOURS

LIST TIME ORDER NOTED AND SIGN

1 - ADMIT TO ICU
2 - NPO
3 - VS q1°
4 - I/O q1°
5 - G-TUBE TO GRAVITY DRAINAGE
6 - CHART G-TUBE DRAINAGE
7 - ADD ROUTINE TRACH CARE

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

8 - BED-REST HOB 0-45°
9 - MSO4 1-5 mg q1° PRN PAIN
10 - ZOFRAN [illegible] mg IVPB q6° PRN NAUSEA
11 - ZANTAC 50 mg IVPB q8°
12 - ANCEF 1gm q8° IVPB
13 - CXR PORT q A.M + ON ARR[redacted]
14 - CBC, PT/PTT q [illegible] ON ARRIV[redacted]

noted [illegible] 2 Sept 03 [illegible] [redacted]

b(6)-2

PATIENT IDENTIFICATION

b(6)-4

[redacted]

ICU 2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: & 9 AM TIME OF ORDER HOURS

~~15 - fentanyl + versed drip titrate to effect~~
(16) Tv 750 SIMV 16 peep 5 FiO2 70%
(17) Lopressor 2.5mg IV PRN to maintain [illegible] <100
(18) ~~[illegible]~~ (KR) [redacted]

b(6)-2

2 Sept 03 Chart [illegible] 2 Sept 03 [illegible]

PATIENT IDENTIFICATION

DATE OF ORDER: 2 Sept 03 TIME OF ORDER: 1950 HOURS

(1) ~~Decadron 10mg IV x 1 dose now then decadron 8mg IV x 2 doses then decadron 6mg IV x 2 doses then D/C [decadron q 8°]~~

[redacted]

b(6)

note 2 Sept [illegible] [redacted]

Ø38

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOV

MEDCOM - 18449

b(6)-2 All

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

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

DATE OF ORDER: 2 Sept 03 | TIME OF ORDER: 2300 HOURS

1) Tylenol 1gm PR q4° PRN

2) LR @ 125cc/hr maintainence

[redacted]

[redacted]

PATIENT IDENTIFICATION

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

DATE OF ORDER: 3 Sept 03 | TIME OF ORDER: 0015 HOURS

1) Δ vent settings SIMV 14

TV 750 FiO2 40% peep 5 [redacted]

repeat ABG in AM [redacted]

V.O. Dr [redacted] RN

[redacted]

24° chart ✓ 3 Sept 0100

PATIENT IDENTIFICATION

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

DATE OF ORDER: 3 Sept 03 | TIME OF ORDER: 0815 HOURS

1- TV to 700 ✓

2- [illegible] vent

3- [illegible]

4- clean [illegible] wounds

c̄ H2O2 + Saline +

replace bacitracin BID [redacted]

PATIENT IDENTIFICATION

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

DATE OF ORDER: 3 Sep 03 | TIME OF ORDER [redacted] HOURS

1- ABG

[redacted]

[illegible] [redacted]

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

MEDCOM - 18450

MEDICAL RECORD | PROGRESS NOTES

DATE

3 Sep 03
@ 0909

Brief OP NOTE

Pre OP dx: GSW to face c cricothyroidotomy
Post OP dx: Same
Procedure: tracheostomy + EUA
Surg: [redacted] b(6)-2
Anesth: General
U/O: 130cc
fluids 500cc LR
EBL: min
comp: 0
Condition: Stable remained sedated & transferred to ICU on proper monitors & vent.
b(6)-2 [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

MEDCOM - 18451

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR 141 CFR)
USAPPC V1.00

b(6)-2 unless noted differently

CLINICAL RECORD - DOCTOR'S ORDERS

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

THE DOCTOR SHALL RECORD DATE 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] b(6)-4		4 Sep 03	0909 HOURS	
	①	Resume previous orders		
	②	100cc q 4° hold for residual >100 - [illegible]		
	③	Oral care BID		
		(there is xeroform gauze in palate)		
NURSING UNIT / ROOM NO. / BED NO.		[redacted]		4 Sept 03 [illegible]
PATIENT IDENTIFICATION	[redacted]	DATE OF ORDER 4Sept03	TIME OF ORDER 1040 HOURS	
	①	Wean pt to trach mask/collar ↓RR to 2 ē SIMV. p̄ wean pt off sedation. Keep SPO2 >93%.		
		V.O. Dr. [redacted] CP[redacted]		
NURSING UNIT / ROOM NO. / BED NO.				noted [illegible]
PATIENT IDENTIFICATION		DATE OF ORDER 4Sept03	TIME OF ORDER 1040 HOURS	
	①	ABG p̄ wean to trach collar		
		V.O. Dr. [redacted] CPT [redacted]		
NURSING UNIT / ROOM NO. / BED NO.		CP[redacted]		
PATIENT IDENTIFICATION		DATE OF ORDER 5Sep03	TIME OF ORDER 0900 HOURS	
	①	Okay for sips of water + clears		
		CP[redacted] [illegible] noted		noted
NURSING UNIT / ROOM NO. / BED NO.				

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

MEDCOM - 18452

MEDICAL RECORD | PROGRESS NOTES

DATE	
5 3OP03	Surgery
	Pt Doing well - Awake + Alert
	CNS: Follows commands
	Lungs: c TM 30% Trach mask O2 SAT = 100%
	7.47/40/213/30/6/100%
	Cor: HR 103 132/76
	Abd: soft, NT, ND ⊕BS
	Renal: 129/4.0 / 107/21 / 13/1.1 < 156 I/O IV 125cc/hr 236 OUT
	Heme: 10.7 > 8/23.5 < 214
	Tm: 5.143/3
	Plan: TF 400cc 94°
	IVF to 50cc/hr
	cont labs
	b(6)-2
	[redacted]

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

MEDCOM - 18453

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]
b(6)-4

DONE / noted

NURSING UNIT | ROOM-NO. | BED NO.

DATE OF ORDER: 5 Sep 03 TIME OF ORDER: 1500 HOURS

LIST TIME ORDER NOTED AND SIGN

1 - IVR to 50cc/hr
2 - Jevity 400cc q 4 hours

b(6)-2
5/9/03
1500
CPT [redacted] [redacted]

PATIENT IDENTIFICATION

Civ # [redacted]
b(6)-4

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.: 1

DATE OF ORDER: 6 Sep 03 TIME OF ORDER: ______ HOURS

1 - Titrate Fentanyl off
2. T3 Elixir q 4prn 2 teaspoons through tube
3. 1-5 mg MSO4 q1° IVP prn break/through pain
4 - Hep-lock IV when [redacted]

noted @ 15[illegible] [redacted]

[redacted]

b(6)-2

PATIENT IDENTIFICATION

Civ # [redacted]

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.: 1

DATE OF ORDER TIME OF ORDER ______ HOURS

PATIENT IDENTIFICATION

Civ # [redacted]
b(6)-4

NURSING UNIT: ICU #2 | ROOM NO. | BED NO.: 1

DATE OF ORDER TIME OF ORDER ______ HOURS

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

MEDCOM - 18454

MEDICAL RECORD	PROGRESS NOTES

DATE	
6 Sep 03	Surgery Progress Note
	Pt stable, awake & alert
	... HR 90-120 129/85
	Lungs: CTA 31% trach mask 7.42/47/142/31/6/99%
	Abd: soft, NT, ND ⊕ BS tolerating tube feeds
	Renal: 132/104/12 / 4.0/24/1.5 < 154 I/O ~150cc/hr UO
	Heme: 8.0 > 9.7 / 30 < 243
	ID Tc 99' Tm 99'
	Imp: stable s/p face + abdominal ... injury
	Plan: monitor ...
	cont current management [redacted] b(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

Civ # [redacted] b(4)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 18455

b(6)-2 All
unless noted otherwise

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 7 Sep 03 TIME OF ORDER: 1202 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Δ pain meds to Roxicet elixe ~~Percocet 1-2 tabs~~ [redacted] 5-10 ml per G tube q 6° prn pain

[redacted]

PATIENT IDENTIFICATION

Noted done

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 7 Sept 03 TIME OF ORDER: 1322 HOURS

(1) D/C Roxicet Elixer
(2) Percocet i - ii tabs q 4-6° PRN PN - CRUSH then give per G Tube
V.O. Dr [redacted]

CPT [redacted]

PATIENT IDENTIFICATION

done noted

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 7 Sep 03 TIME OF ORDER: 1600 HOURS

(1) Benadryl 25-50mg IV q 4° prn insomnia
(2) Ambien 5mg per g tube crushed @ HS for insomnia if benadryl ineffective [redacted]

CPT [redacted] (RN) 7/9/03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

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

MEDCOM - 18456

b(6)-2 A11

CLINICAL RECORD

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

Mo. [illegible] Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RE[illegible]NG ACTIONS, F[illegible]ENCY, TIME	HR	DATE COMPLETED 2 3 4 5 [illegible] 7 8 9
2 Sept	[redacted]	NPO	07	[redacted]
			12	[redacted]
			18	[redacted]
2 Sept	[redacted]	V/S Q1°	06	[redacted]
			18	[redacted]
2 Sept	[redacted]	I/O Q1°	06	[redacted]
			18	[redacted]
2 Sept	[redacted]	G-tube to gravity drainage	06	[redacted]
			18	[redacted]
2 Sept	[redacted]	Routine trach care	06	[redacted]
			18	[redacted]
2 Sept	[redacted]	Bedrest, HOB ↑ 45°	06	[redacted]
			18	[redacted]
2 Sept	[redacted]	CXR QAM + on arrival	05	[redacted]
2 Sept	[redacted]	CBC, PT/PTT, + chem 7 on arrival + QAM	05	[redacted]
2 Sept	[redacted]	Vent settings: ~~TV 750,~~ [redacted] SIMV 16, TV 750, Peep 5, FiO2 70%	06 / 18	[redacted] Δ'd 3 Sept 03 [illegible]
2 Sept	[redacted]	N/O: Δ IV Tubing Q72°	06 / 18	[redacted]
2 Sept	[redacted]	N/O: Δ IV site Q72°	06 / 18	[redacted]
2 Sept	[redacted]	N/O: Foley care Q5	06 / 18	[redacted]
3 Sept	[redacted]	Vent settings: SIMV 14, TV 750, Peep 5, FiO2 40%	06 / 18	[redacted]

ALLERGIES: ☐ YES ☑ NO NKDA

PRIMARY DIAGNOSIS: Cricothyroidotomy / (R) hip I+D / closure of mouth wounds / open gastrostomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

#[redacted]

b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 18457

b(a)-2 AM

Verify by initialing: Order Date	Clerk Nurse	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) — SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
2 Sept	[redacted]	Admit to ICU	2 Sept	—	1630	[redacted]
3 Sept	[redacted]	↓ TV 700	3 Sept	ASAP	1130	[redacted]
3 Sept	[redacted]	ABGs	3 Sept	1130	1110	[redacted]
3/9	[redacted]	wean sedation	3/9	cont	cont	[redacted]
3/9	[redacted]	wean vent	3/9	cont	cont	[redacted]
4/9	[redacted]	Resume all previous orders	4/9	0900	0900	[redacted]

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

MEDCOM - 18458

b(6)-2

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*

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

Mo. Sept 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
3/9	[redacted]	Clean face wounds c̄ H2O & saline + Replace Bacitracin BID	18	[redacted]
4/9	[redacted]	Oral care BID (Change Xeroform gauze on palate)	06 / 18	[redacted]
4/9	[redacted]	Wean pt to trach collar-mask. ↓RR to 2 c̄ SIMV. p̄ weaning pt from sedation. Keep SpO2 >93%.	06 / 18	[redacted] D/C 7Sept03
5/9	[redacted]	Okay for sips of water & clears	06 / 18	[redacted]

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: s/p chicothiradectomy / (L) hip ?/o / closure of mouth wounds / open gastrostomy /

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

I/C # [redacted]
254.0.0 b(6)4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 MEDCOM - 18459 USED. USAPA V1.00

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
4/9	[redacted]	Abx p pt on trach collar	4/Sept			

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. 8 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
7 Sep	[redacted]	Nursing order:	08	[redacted]		
		clean trach. tube	16		b(6)	b(6)-2
b(6)-2		q 8°	24			

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:

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

PATIENT IDENTIFICATION:
CTV [redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2 AMI

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.* SEP *Yr.* 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2 3 4 5 6 7 8 9
2 Sept	[redacted]	Zantac 50mg IVPB Q8°	08 / 16 / 24	[redacted]
2 Sept	[redacted]	Ancef 1gm q8° IVPB	08 / 16 / 24	[redacted]
2 Sept	[redacted]	Fentanyl gtt, titrate to effect	06 / 18	[redacted] D/C 6Sept03
2 Sept	[redacted]	Versed gtt, titrate to effect	06 / 18	[redacted]
2Sept	[redacted]	Decadron 8 mg IV x 2 doses Q8°	04 / 12	[redacted] X X
2Sept	[redacted]	Decadron 6mg IV x 2 doses Q8°	20 / 04	[redacted] X X
2Sept	[redacted]	LR @ 125 cc/hr	06 / 18	[redacted] D/C 5/9/03
4Sept	[redacted]	JEVITY 100cc Q4° hold for residuals >100	08 / 12 / 16 / 20 / 24 / 04	[redacted] D/C
5Sept	[redacted]	JEVITY 400cc Q4hr.	08 / 12 / 16 / 20	Rewritten

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: cricothyroidotomy / ⓡ hip I+D / closure of mouth wounds / open gastrostomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

#[redacted]
b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 18462

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. SEP Yr. 03	
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
2Sept	[redacted]	Decadron 10mg IV x1 now	2Sept	2000	2000	[redacted]
6SEP03	[redacted]	TITRATE FENTANYL OFF	6 SEP	7SEP		[redacted]
6 SEP	[redacted]	HEPLOCK IV WHEN ABLE	6 SEP	7SEP 0705		[redacted]

b(6)-2 All

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
2Sept	[redacted]	Lopressor 2.5mg IV prn maint. Diastolic <90	2Sept 1810 [redacted]													
2Sept	[redacted]	MSO4 1-5 mg IV Q1° prn pain	[redacted] 1430	Rewritten, see below												
2Sept	[redacted]	Phenergan 25mg IV Q6° prn-nausea														
2Sept	[redacted]	Tylenol 1gm PR Q4° prn	2Sept 2000 [redacted]													
6 Sep	[redacted]	MSO4 1-5mg IV q1° PRN PAIN	1430 4mg [redacted]	NEW ORDER See Below												
6 SEP 03	[redacted]	T3 ELIXIR q4hrs PRN 2 teaspoons through NG-TUBE	7SEP 0600 10cc [redacted]	7SEP 1000 10cc	7SEP 2115 10cc	6SEP 0459 10cc										
6 SEP	[redacted]	MSO4 1-5mg IVP q1° PRN BREAKTHROUGH PAIN	7SEP 1830 4mg [redacted]	7SEP 2330 4mg	SEP 0110 3mg	7SEP 03 3mg	7SEP 0610 3mg	7Sept 0740 2mg	7SEP 0840 4mg	7SEP 1200 4mg	7Sept 1450 5mg	7Sept 1850 5mg IVP	7Sept 2230 5mg IVP	8SEP 00 5mg	8SEP 03 3mg	
		Percocet 1-2 tabs Q4-6° PRN pn - crush - give per GT	7Sept 1600 2400 [redacted]													

MEDCOM - 18463 USAPA V1.00

ACLU-RDI 1647 p.23

DOD-032037

b(6)-2 *11

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. SEP Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5	6	7	8
5Sept	[redacted]	Jevity 400cc Q4°	08	/ [redacted]			
			12	/			
			16				
			20				
			24				
			04				
			/				
5Sept	[redacted]	LR @ 50cc	[redacted]	[redacted]			
			/				

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: cricothyroidotomy, Ⓛ hip, H/o closure of mouth wounds, [illegible] open gastrostomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

#[redacted] b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. Sep	Yr. 03		
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED	
7Sept	[redacted]	Benedryl 25-50mg IV	7Sept 1020	7Sept 2310
		Q4° prn insomnia	50mg [redacted]	
		Ambien 5mg per G tube	7SEP 5mg	
7Sept	[redacted]	Crush @ HS for insomnia	2335 [redacted]	
		if Benedryl ineffective		

b(6)-2 All

USAPA V1.00

MEDCOM - 18465

b(6)-2

INITIAL SHIFT ASSESSMENT

		Time: Initals:	Time: 16 Initals: [redacted]
N E U R O	Pupils	OD 2-3 unreactive / OS - 3mm - Reactive sluggish	Ø reaction to OD, sluggish reaction to LO
	Sensorium	Responds to pn stimuli	Responds to stimulation
	LOC / GCS	Sedated - Versed 5mg Fent 20mcg	Sedated Versed 4mg - Fent 12mcg
C A R D I A C	Cardiac Rhythm	ST c HR 107's - 110	ST, HR = low 100's
	PRI: / QRS:	- Ø ectopy noted -	Ø ectopy
	Pulse Strength	2-3+ B UE/LE	2+-3+ x4 extremities
	Cap Refil / JVD	<3sec ØJVD	<3sec x4 extremities / Ø JVD
	Edema	FACIAL - mandible R>L	Face - bilat mandible
	Chest Pain	NONE TO REPORT D/T Sedation	Ø
		Ø EKG Δes noted.	
R E S P	Respiratory Pattern	Thyroid/cricoidotomy c #4 Shiley -	cricoidotomy / equal rise + fall of chest
	Breath Sounds	cuffed = BBS - CTA PaO2 193% on a.m. ABG	CTA
	Secretions	oral secretions @ this time	
	Cough	Ø cough : SIMV RR 14, TV 750	None SIMV = 14; P = 5, TV = 700
		FiO2 35%, PS SpO2 ≈ 100%	FIO2 - 35%
S K I N	Color	Brown - intact except for surgical [illegible]	Normal
	Integrity	FACIAL incisions c sutures on B	Sutures to face, wound to abd, R
	Backside	mandibles c lip involvement; Nasal	thumb, and L hip area
		packing + midline inc c CDI.	
I V	Access Devices	R AC c L AC 18g, D art line	L IV AC, R IV AC, A line L Radial
	Location	D AC c fluid infusing. R AC	Ø Signs of infection
	Condition	HL - IVPB / Patent	
G I	Abdomen L hip	Flat, tenderness assumed d/t surgical	Dsg to Abd c reinforced dsg
	Bowel Sounds c dsg CDI	inc. BS RLQ - hypoactive ⊖ to all	hypoactive x 4 quad.
	Stoma/Ostomy	other quads. midline inc., CDI	GT to gravity, L upper quad
		Reinforced on p.m. shift : GT to gravity	
G U	Device	Foley to Gravity.	Foley to gravity
	Color / Clarity	clear - yellow - urine - 100cc	clear and yellow urine
		MIVF @ 125cc	

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

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 3 Sept 03

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

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

UNIT: Police Officer GENDER: male

STATUS: US: AD / CIV IRAQI: (CIV) / EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78 USAPPC V3.00

I/C # [redacted]

b(6)-4

MEDCOM - 18466

ACLU-RDI 1647 p.26

DOD-032040

b(6)-2

INITIAL SHIFT ASSESSMENT

		Time: 10 Initals: [redacted]	Time: Initals: [redacted]
NEURO	Pupils	OD 2mm unreactive OS ≥3mm sluggish	Alert, responds to voice
	Sensorium	⊕sensation sedated versed 4mg°	Sedated Versed @ 4mg/hr
	LOC / GCS	Fent 125mcg. GCS:	Fent @ 75 mcg/hr
			Agitated + restless
CARDIAC	Cardiac Rhythm	NSR RRR ◦ouffric HR 100's.	ST 110-120's Ø ectopy S1S2
	PRI: / QRS:	2-3+ pulses ⓑ UE/LE. CR<3sec.	Ø murmur 2+ pulses all extrem
	Pulse Strength	trace edema to body-extremities	1+ edema, generalized, B/P
	Cap Refil / JVD	mostly. 2-3+ to Ⓛ jaw-mandible	MAP 100-110's when agitated
	Edema	area c̄ 2+ swelling Ⓡ mandible area	
	Chest Pain	None to reports or s/s of.	
RESP	Respiratory Pattern	Trach #8 Shiley cuffed. SIMV RR14	Trach #8 Shiley cuffed SIMV
	Breath Sounds	TV 700 FiO2 35%. PS. SPO2 100%.	14 TV 700 FiO2 35% peep 5
	Secretions	Bloody-Thick secretions post OR.	sats 100% HOB ↑ 75° per pt
	Cough	⊕cough-needs prn suctioning	request, sanguinous drng noted to trach + oral cavity
SKIN	Color	Brown - warm	W+D norm for race
	Integrity	intact except Ⓛ hip c̄ sutures +	Ⓡ thumb Ⓛ hip dsgs CDI
	Backside	penrose drng, abd midline-staples	Midline abd staples intact,
		ota CDI, multi facial sut. + mouth sut	dsg to G-tube site CDI
IV	Access Devices	18g Ⓛ AC 18g Ⓡ AC Ⓛ ART	18G Ⓛ+Ⓡ AC patent Ø S/Sx
	Location	Radial	infection LR @ 125 cc/hr
	Condition	Patent. Ⓡ AC HL - IVABX +	Ⓛ rad A-line correlated
		Q4° NS flushes	well c̄ cuff pressure
GI	Abdomen	Soft, Tenderness assumed,	Soft, tender BS ⊕ x 4 quads
	Bowel Sounds	BS to RLQ + RUQ. Ø BM.	Gtube to gravity, levity
	Stoma/Ostomy	GTube LUQ to gravity.	100cc Q4°
		Dark grn liquid drng.	
GU	Device	Foley placed 2Sept03	Foley drng cl yellow
	Color / Clarity	~100-200cc cyu.	
		s/p f/o mouth wounds / trach.	

PREPARED BY (Signature): CPT [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 4Sept03

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

NAME: F/C # [redacted] RANK: b(6)-2 AGE: 25

UNIT: Police Officer b(6)-4 GENDER: male

STATUS: US: AD / CIV IRAQI: (CIV) / EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V3.00

MEDCOM - 18467

ACLU-RDI 1647 p.27

DOD-032041

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

b(6)-2

		INITIAL SHIFT ASSESSMENT	
N		Time: Initals:	Time: 1400 Initals: [redacted]
E	Pupils	Alert - MAE, makes appropriate	Alert
U	Sensorium	hand gestures (+) purposeful	Purposeful movements
R	LOC / GCS	mvmt, (+) sensation - Agitation episode	Versed @ 2mg/hr Fent @ 50mg
O		Fent @ 50mcg° / Versed 2mg°	
C	Cardiac Rhythm	NSR HR 80's - 100's (when agitated)	NSR = HR upper 90s
A	PRI / QRS:	S1S2 ectopy noted / RRR	ectopy
R	Pulse Strength	2+ UE/LE	palpable x4 extremities, 2+
D	Cap Refil / JVD	<3 sec	<3 sec x4 extremities
I	Edema	Generalized to neck/face	to neck + face
A	Chest Pain	∅	∅
C			
R	Respiratory Pattern	RR 14-26, humidified trach collar, Shiley ē cuffed	unlabored, trach collar
E	Breath Sounds	BBS, CTA - suction PRN	clear bilat
S	Secretions	none as of now - often old	none at this time
P	Cough	bloody - thick secretions	occasional minimal production
		(+) cough ē productivity	at this time.
S	Color	Brown	Normal
K	Integrity	(L) hip / midline ABD, (L) thumb	sutures to face, (L) hip, staples to mid. ABD
I	Backside	+ facial wounds @ mouth +	tongue ē sutures
N		inner mouth / tongue	
I	Access Devices	(L) AC 18g	(L) B.UE, (R) forearm 18 ga IV
I	Location	(R) AC 18g	A line (L) rad. ul
V	Condition	(L) ART - RADIAL - placed 2Sept03	∅ signs of infection
		All patent	
G	Abdomen	SNT ND	Tender to touch, staple midline
G	Bowel Sounds	+BS x 4 quads	+ BS x4 quad.
I	Stoma/Ostomy	∅ stoma/ostomy	∅
G	Device	Foley placed 2/9/03	Foley
U	Color / Clarity	CYU ~ 100-200cc°	Clear + yellow

b(6)-2

PREPARED BY (Signature & Title) CP[redacted]

DEPARTMENT/SERVICE/CLINIC
ICU #1, 28TH Combat Support Hospital

DATE
5 Sept 03

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

NAME: #700 RANK: AGE: 25

UNIT: police officer GENDER: male

STATUS: US: AD / CIV IRAQI: CIV / EPW

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 18468

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

[redacted]

INITIAL SHIFT ASSESSMENT

		Time: 0800 Initals: [redacted]	Time: 1920 Initals: [redacted]
NEURO	Pupils	PERRLA reactive 3-4mm	Perrla
	Sensorium	⊕ sensation to AE c pins/needles	⊕ sensation
	LOC / GCS	to touch; Alert, Orient, MAE, FC, spont mvmt	Alert
CARDIAC	Cardiac Rhythm	NSR to ST HR 80's - low 100's	Pt. presently in Sinus tach [illegible]
	PRI / QRS:	RRR	
	Pulse Strength	2-3+ c CR <3sec throughout	2+-3 cap refill <3sec
	Cap Refil / JVD	∅ JVD	∅ JVD
	Edema	1+ facial/neck edema c some	+ to face and neck
	Chest Pain	generalized throughout	None
RESP	Respiratory Pattern	RR 18-12 BPM c SpO2 99% RA	equal rise and fall of chest, unlabored
	Breath Sounds	suction via trach x 2 for	Clear bilat
	Secretions	dry, mucus plug c saline flush.	thick secretions from trach
	Cough	thick-bloody-yellow secretions	opening.
		⊕ cough c productivity; Humidification	
SKIN	Color	Brown intact except for	Normal
	Integrity	Ⓡ hip sutures c drng - Δ drsng	sutures to face, staples to abd, and
	Backside	PD-OS midline ABD inc staples	Ⓛ side of hip.
		OTA/CDI facial/mouth sutures, bacitracin / clean	
IV	Access Devices	Ⓛ bicept 18g IV FLUSH Q4-6° / patent	IV to Ⓡ forearm
	Location	Ⓡ FA 18g IV FLUSH Q4-6° / patent	
	Condition	patent / intact ∅ s/s infection	∅ s/s of infection
GI	Abdomen	FSNTND	c staples, minimal swelling noted on abd
	Bowel Sounds	x4 quads ∅ BM	Active ∅ BM
	Stoma/Ostomy	GT c Jevity feeds Q4° 400cc.	
GU	Device	foley ave 200cc° q 1-2°	Foley
	Color / Clarity	∅ MIVF - gold amber in color -	Amber urine

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC
ICU #1, 28TH Combat Support Hospital

DATE

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

NAME: [redacted]

RANK:

AGE: 25

UNIT: b(6)-4

GENDER: M

STATUS: US: AD / CIV IRAQI: CIV (circled) EPW

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

DA FORM 4700, MAY 78 USAPPC V2.00

MEDCOM - 18469

ACLU-RDI 1647 p.29

DOD-032043

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(6)-1

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted]	Time: 1850 Initals: [redacted]
N			
E	Pupils	Alert intermittently, ↑ anxious from time to	Alert at times
U	Sensorium	time. Communicates c hand gestures & [illegible]	Sedated c 2mg of versed, agitated and restless
R	LOC / GCS	@ bedside. ⊕ movement all extremities	Fent @ 10mcg/hr [illegible]
O		Versed @ 2mg/h, FENT @ 50mcg/h	
C	Cardiac Rhythm	ST → 100-110 bpm	
A	PRI / QRS:	$S_1 S_2$ s̄ @ current rate 100.	$S_1 + S_2$ present
R	Pulse Strength	2+-3+ x 4	2+-3+ x 4 extremities.
D	Cap Refil / JVD	brisk; < 3sec throughout	less than 3sec x4
I	Edema	decreased from yesterday, but generalized to face/neck	to face and neck area
A	Chest Pain	Ø	
C			
R	Respiratory Pattern	RRR c̄ use of accessory muscles (#8 Shiley trach)	[redacted] Equal rise & fall of chest
E	Breath Sounds	upper lobes CTA, bases diminished	Clear bilat; diminished at Bases
S	Secretions	Intermittent, thick white c̄ spontaneous cough; suction	around trach site thick blood tinged
P	Cough	⊕ when instructed to do so	Ø
		FiO2 @ humidified trach collar @ ~ 31%	
S	Color	normal for nationality	Normal
K	Integrity	intact x̄ for multi facial lac's (sutured) Ⓛ hip pressure	sutures to face lip, Ⓛ hip
I	Backside	dressing, old midline incision c̄ staples.	ABD c̄ staples
N			
	Access Devices	Ⓛ AC PIV #18ga patent / intact	IV Ⓛ Bicep area 18ga patent
I	Location	Ⓡ AC PIV #18ga patent / intact	IV Ⓡ forearm area 18ga patent
V	Condition	Ⓛ arterial line (radial site) patent	Ø sign of infection.
	Abdomen	Semi-round, soft & nondistended	soft & tender to touch
G	Bowel Sounds	hyperactive bowel sounds x 4	Active x 4 quad
I	Stoma/Ostomy	PEG tube patent / intact s̄ signs/sx infection	GT - patent
	Device	#16 Foley Cath to gravity drain	Foley
G	Color / Clarity	yellow, clear w/ c̄ U/O ~ 200cc/h	clear & yellow urine
U			

[redacted] b(6)-3

DEPARTMENT/SERVICE/CLINIC
ICU #1, 28TH Combat Support Hospital

DATE
6 SEP 03

PAT[redacted] written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

NAME: # [redacted] RANK: AGE:

UNIT: b(6)-4 GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

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

DA FORM 4700, MAY 78 USAPPC V2.00

MEDCOM - 18470

ADMISSION [illegible] CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A	1	1	0	1	

2. LOCATION (State or Country Code.)

7	8
1	Z

3. REGISTER NUMBER [redacted]

9	10	11	12	13	14	15
[redacted]						

NAME (Last, First, Middle Initial)

EPW [redacted] b(6)-4

4. PAY GRADE

16	17

5. SEX

18
M

6. DATE OF BIRTH (Y Y Y Y M M D D)

19	20	21	22	23	24	25	26
1	9	7	8	0	1	0	1

7. AGE AT ADMISSION

27	28	29
2	5	Y

8. RACE

30
X

9. ETHNIC BACK-GROUND

31
9

RELIGION

10. LENGTH OF SERVICE

32	33	34

ETS

11. FMP

35	36

12. SOCIAL SECURITY NUMBER

37	38	[redacted]
[redacted]		

ORGANIZATION (Active Duty Only)

13. MARITAL STATUS

46

HOUR OF ADMISSION

BRANCH / CORPS

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61

17. UNIT LOCATION (State or Country Code)

62	63

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71

PREV. ADMISSION

YEAR

☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72

WARD

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION

73	74

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION (Y Y M M D D)

81	82	83	84	85	86

24. CLINIC SVC - ADMITTING

87	88	89	90

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION (Y Y M M D D)

97	98	99	100	101	102

27. LOCATION OF OCCURRENCE (Battle Casualty Only)

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

29. DATE INITIAL ADMISSION (Y Y M M D D)

111	112	113	114	115	116

FOR LOCAL USE

DX 802.5 8830 8900
802.31 87364 V550
873.61 V551
87363 87343 E9912
873.43
E9228

PROC
5412 7673
4319 2752
8628 311
2551
7676

I T
1 450

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK

ADMISSION [illegible] CODING INFORMATION

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

1. REPORTING MTF

1	2	3	4	5	6
A	/	/	D	/	

2. [illegible] LOCATION *(State or Country Code.)*

7	8
I	Z

3. REGISTER NUMBER

9	10	11	12	13	14	15
[redacted]						

NAME *(Last, First, Middle Initial)* EPW # [redacted] b(6)-4

4. PAY GRADE

16	17
	EPW

5. SEX

18
M

6. DATE OF BIRTH *(Y Y Y Y M M D D)*

19	20	21	22	23	24	25	26
Z	Z	Z	Z	Z	Z	Z	Z

7. AGE AT ADMISSION

27	28	29
2	5	Y

8. RACE

30
X

9. ETHNIC BACKGROUND

31
9

RELIGION UNK

10. LENGTH OF SERVICE

32	33	34

ETS

11. FMP

35	36
9	9

12. SOCIAL SECURITY NUMBER

37	38	39	40	41	42	43	44	45
[redacted]								

ORGANIZATION *(Active Duty Only)*

13. MARITAL STATUS

46
Z

HOUR OF ADMISSION 1545

BRANCH / CORPS b(6)-4

14. FLYING STATUS

47	48	49

15. BENEFICIARY CATEGORY

50	51	52
K	7	8

16. ZIP CODE OF RESIDENCE

53	54	55	56	57	58	59	60	61
Z	Z	Z	Z	Z				

17. UNIT LOCATION *(State or Country Code)*

62	63

18. MOS

64	65	66	67	68	69	70

19. TRAUMA

71
1

PREV. ADMISSION YEAR [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION

72
8

WARD ICU

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK

ADDRESS OF EMERGENCY ADDRESSEE *(Include ZIP Code)* UNK

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] 62.2

21. TYPE OF DISPOSITION

73	74
5	2

22. MTF TRANSFERRED TO

75	76	77	78	79	80

23. DATE OF DISPOSITION *(Y Y M M D D)*

81	82	83	84	85	86
0	3	0	9	0	7

24. CLINIC SVC - ADMITTING

87	88	89	90

25. MTF TRANSFERRED FROM

91	92	93	94	95	96

26. DATE THIS ADMISSION *(Y Y M M D D)*

97	98	99	100	101	102
0	3	0	9	0	2

27. LOCATION OF OCCURRENCE *(Battle Casualty Only)*

103	104

28. MTF OF INITIAL ADMISSION

105	106	107	108	109	110

29. DATE INITIAL ADMISSION *(Y Y M M D D)*

111	112	113	114	115	116

FOR LOCAL USE

GSW (L) hip, jaw PROC. 86.28

b(6)-2

ADM[redacted]

SIGNATURE OF ADMITTING CLERK [redacted]

DA FO[redacted]

MEDCOM - 18472

ACLU-RDI 1647 p.32

DOD-032046

INPATIENT TREATMENT RECORD COVER SHEET

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

b(6)-4

1. REGISTER NUMBER	2. NAME (Last, First, MI)	3. GRADE	ADMISSION REMARKS
[redacted] b(6)-4	UNK - EPW [redacted] b(6)-4	EPW	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	31	X	MUSLIM	—	—	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
9920	[redacted]	—	ICW1

15. FLYING STATUS	16. OSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. DIC/ZIP	20. TYPE CASE
NO	—	K7B	b(6)-4 —	—	NBI. ~~ICWI~~

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER.	1800	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	D/C TO CAMP	3 Sept 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	2 Sept 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] b(2)-2		

31. [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

Motorcycle Accident.

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: MULTI CONTUSIONS & ABRASIONS

780.09
910.0
723.1
913.0
922.1
E819.2

35. Total Days This Facility

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

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
		b(6)-2			

SIGNATURE OF ATTENDING MED [redacted] b(6)-2

DR. [redacted]

DA FORM 3647, MAY 75 MEDCOM - 184 USAPPC V1.10

b(6)-1

[redacted]

PATIENT'S CLEARANCE RECORD

For use of this form, see AR 40-2; the proponent agency is OTSG

DATE OF DISCHARGE	TIME OF DISCHARGE
03SEP03	1625

SIGNATURE OF [redacted] OFFICER

[redacted] b(6)-2

PATIENT'S IDENTIFICATION

ACTIVITY CLEARANCE

(The final activity with which the patient must clear will be the disposition office.)

Military	INITIALS*	Non-military	INITIALS*
1. Patient's Trust Fund		1. Patient's Trust Fund	
2. Medical Services Account Officer		2. Medical Services Account Officer	
3. Clothing and Baggage		3. Clothing and Baggage	
4. Medical Holding Unit		4. Postal Service	
a. Supply		5. Change of Address	
b. Pay Section		6. Other *(Specify)*	
c. Service Records		7.	
d. Insurance and Allotments		8.	
5. Postal Service		9.	
6. Change of Address		10.	
7. Other *(Specify)*		11.	
8.		12.	
9.		13.	

[redacted] b(6)-2

REMARKS

b(6)-2

[redacted]

DATE

3 Sep 2003

* INITIALS OF PERSON AUTHORIZING CLEARANCE

DA FORM 4029, MAR 73 USE DA FORM 8-258, 1 DEC 59, WHICH WILL BE U

USAPPC V1.00

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

See ER sheet

PHYSICAL EXAMINATION

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

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD - PROGRESS NOTES

DATE | NOTES

2 Sep 03 26 y/o ♂ wiaqi admitted via EMT. Pt alert + follows @1900 commands. Pt has multiple abrasions to extr, contusion to chest, abrasions to face. VSS. ◊ IV access upon arrival to ward. labs, xrays & tetanus done in ER. HRRR, lungs CTAB, hypo active BS x4 quads. extr. (upper) bandaged c Kerlix. 800mg motrin given for pain. Tol. PO fluids well. Pt resting @ this time. awaiting next convoy to EPW camp. ◊ other remarkable assessment findings noted. Will cont to monito[redacted] b(6)-2

03 Sep 03 (0920) Assumed care of pt @ 0600 ☐ report from night shift. A+ alert, speaking Arabic. VSS. lungs CTA. ⊕ BS x4 quads. multiple abrasions noted on BUE and face. Contusion to chest. Dsg to ⊕ forearms. Ad this am - ◊ S/Sx infection. Pt tol clear liquids. Will adv. to reg diet for lunch. Awaiting tx to EPW camp. Will cont to monitor [redacted] b(6)-2 WA

(1025) Pt amb to ER ☐ difficulty. P[redacted] for D/C to EPW camp. Ambulatory - escorted by MPs. Records to PAD [redacted] b(6)-2 WA

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST) | NUMBER

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED [redacted]

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO. ICW 1

EPW #[redacted] b(6) WA

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

MEDCOM - 18476

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
SEP 0 2 2003	S - 20 y/o old driver [illegible]
O2 sat 97	in motorcycle accident 2-3 days ago
pulse 81	No history available -
BP - 150/76	brought to prison today
Resp. 18	pt with left arm pain -
	chest / Abd pain -
	[illegible] No history available
	held for vehicular homicide - person hit c motorcycle died
	[redacted] (on D) 13:30
	[illegible] pt awake
	disoriented - b(6)-2
	moaning in pain
	Eyes - [illegible]
	[illegible] occiput - [illegible] tenderness
	Neck - tender & [illegible]
	[illegible] old blood [illegible]
	lip laceration
	Lungs - clear ant chest wall
	tender ant. chest
	Abd - BS present [redacted]

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

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

REGISTER NO.	WARD NO.

D16067 # b(6)-4 [redacted]

CPW

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPA V2.00

MEDCOM - 18477

CoB 109th ASMB
BIAP IRAQ

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	~~tender pelvis only ant. No Ctl. bed~~
	~~Lap. no obvious pain from~~
	Skin: Large abrasion both arms
	A - Several day old motorcycle accident -
	apparent LOC / amnesia -
	~~- tender Neck -~~
	- Chest
	- lower Abd
	Large abrasions of both arms
	apparent deformity at elbow area
	P - To CSH for evaluation
	Xray - 13:30
	Morphine Sulfate 10mg IM [redacted] c/
	b(6)-2

STANDARD FORM 600 (REV. 6-97) BACK
USAPA V2.00

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 2 Sept 03 | TIME: 1500

TRANSPORTATION TO FACILITY

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
M			PRP			✓	ADDITIONAL INSURANCE		✓
AGE	HOME PHONE		FLYING STATUS			✓	DD 2568 IN CHART		✓
31	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM: interpreter, forearm surgery				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: "sedatives"

ALLERGIES: Ø

INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT	
ITEM	YES	NO	WHEN *(Date)*	DATE LAST VISIT	24 HOUR RETURN: ☐ YES ☑ NO
IS THIS AN INJURY?	✓		WHERE	TETANUS	
INJURY/SAFETY FORMS		✓		DATE LAST SHOT	COMPLETED INTITIAL SERIES: ☐ YES ☐ NO
HOW: MVC					

CHIEF COMPLAINT: neck

CATEGORY OF TREATMENT

☐ EMERGENT ☒ URGENT ☐ NON-URGENT

TIME: 1500

INITIALS: CH

VITAL SIGNS

TIME	1500	1700			
BP	117/93	125/63			
PULSE	76	80			
RESP	20	18			
TEMP	97.9				
WT	80 kg				

LAB ORDERS

☒ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT		
URINE C&S ☒	UA MSCC/CATH		☒ CHEM: 12 / lytes		
BLOOD C&S X					

X-RAY ORDERS

☒ CXR PA & LAT/PORTABLE	☒	C-SPINE	
ACUTE ABDOMEN		LS SPINE	
SINUS		HEAD CT	
ANKLE R/L	X	pelvis	

ORDERS

☒ PULSE OX 96 % ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1520	Td 0.5 cc IM	Duis	Lt [redacted]	1520	
1520	Toradol 30mg IV	Duis	Lt	1520	
			b(6)-2		

DISPOSITION: ☐ HOME ☐ FULL DUTY

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW

[redacted]

b(6)-2

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
	WBC		SUP 02	PH	PO2	RESULTS: C-spine - Nml skull - NO	
	H/H		PCO2	SAT	OTHER	Bilateral forearm - Nml	
	PLT		U/A DIP			Pelvis - Nml	
PT			MICRO			EKG INTERPRETATION CXR - Nml	
APTT		BHCG / ETOH / GLU					

PROVIDER HISTORY/PHYSICAL

26 yr old Iraqi male "EPW" in motorcycle accident 3 days ago.
He is being held for vehicular homicide. ~~Person he hit~~

PMH: Surgery (L) Forearm
MEDS: sedative
Allergies: ∅
∅ acute
alert, follows commands
HEAD - multiple abrasion
Mouth - not injured
Eye: PERRLA EOM +
Ear - TMs - clear
nose - clear
Heart - RR no (M)
Lungs - clear A/P
TTP + - lower sternum
Back - clear. Nontender
Abd - soft, B.S. - Nml, no masses
Rectal
G.U. - ∅
Large abrasion - bilateral lower arm

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

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

DIAGNOSIS
1) Multiple contusion & abrasions
Abrasion - bilateral forearm
Contusion - sternum

CODES

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

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

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 18480

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	1	2
POST- DAY		
MONTH-YEAR / DAY	2 Sep 03	03 Sep 03
19 / HOUR	1	8
PULSE (O) / TEMP. F (•)		
RESPIRATION RECORD	16	16
BLOOD PRESSURE	129/75	125/57
HEIGHT: / WEIGHT →		
	99%	98(RA)

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

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

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

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

epw# [redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 18481

b(6) -4

ID: [redacted]
AD

09-02-03
07:21

				Patient Limits	
WBC	11.3 H	x10^3/mL		4.5	10.5
RBC	5.53	x10^6/mL		4.00	6.00
Hgb	15.1	g/dL		11.0	18.0
Hct	47.4	%		35.0	60.0
MCV	88.8	fL		80.0	99.9
MCH	28.3	pg		27.0	31.0
MCHC	31.9 L	g/dL		33.0	37.0
Plt	263.	x10^3/mL		150.	450.
LY%	27.2 *	%		20.5	51.1
LY#	3.1 *	x10^3/mL		1.2	3.4

Ward/Section: EMT | REQUESTING PHYSICIAN: [redacted] b(6)-2 | ORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. EPW | DATE | TIME | SSN/[redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fl(M) 81-99 fl(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

======= PICCOLO =======
02/09/03 15:15
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 0000100676

ALB	3.6	3.3-5.5	G/DL
ALP	72	26-84	U/L
ALT	28	10-47	U/L
AMY	43	14-97	U/L
AST	28	11-38	U/L
TBIL	0.8	0.2-1.6	MG/DL
BUN	22	7-22	MG/DL
CA++	9.4	8.0-10.3	MG/DL
CHOL	154	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	107	73-118	MG/DL
TP	8.5*	6.4-8.1	G/DL

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

Misc. Serology

TEST	RESULT	REF. RANGE
R		Negative
no		Negative

Microbiology

Bld		Negative
ylori		Negative

Macroscopic Urinalysis

Blood Bank

ST SUBMIT SF 518 WITH
RY UNIT REQUESTED

/Rh

ssmatch
/ERY UNIT OF BLOOD

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

REMARKS:

REPORTED BY: Sye | DATE: 9-2-03 | LAB ID NO.:

[redacted] b(6)-4

Color - Yellow
App - Hazy
Glucose - Neg
Bili - Neg
Ketone - trace
Specific gravity - 1.030
Blood - Neg
pH - 6.0
protein - 30 +
urobili - 0.2
nitrite - Neg
SSA - Trace
mucus - Heavy
Epi - 0-1

MEDCOM - 18483

b(6)-4

Ward/Section:	R. .STING PHYSICAN:	CHE..ISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI.	DATE / TIME	SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Chemistry P2

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M) 30-190 /l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/dl
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

---

i-STAT EC8+

Pt: [redacted] b(6)-4

Pt Name:_____

Glu_____101 mg/dL

BUN_____27 mg/dL

Na_____139 mmol/L

K_____3.4 mmol/L

Cl_____105 mmol/L

TCO2_____26 mmol/L

AnGap_____11 mmol/L

Hct_____48 %PCV

Hb*_____16 g/dL

*via Hct

PH_____7.501

PCO2_____32.3 mmHg

HCO3_____25 mmol/L

BEecf_____2 mmol/L

Sample Type_:

02SEP03 15:18

Oper: [redacted] b(6)-2

Physician:_____

** PRINT CANCELLED **

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW # [redacted] b(6)-4

DATE OF ORDER: 2 Sept — TIME OF ORDER: 1800 HOURS

1) Admit to ICW

Dx: Multiple contussion & abrasions

Abrasions - both arms, head

Contussion - sternum (Boarder)

2) Condition: Stable

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER — HOURS

3) V.S. per routine

4) I.V. at TKO rate

5) Diet: ~~Adv~~ Clear liquids

Advance as tolerated

6) Activity: Bedrest

7) Notify Dr. [redacted] of need #

8) Return to EPW camp when next convoy available

b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER — HOURS

9) Tet toxoid, X-ray skull, CXR, arm — done in ER

9) Motrin 800 mg P.O. q8h prn pain

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER — TIME OF ORDER: 2000 / 2SEP03 HOURS

11) D/C INFS / D/C IV

V.O. Dr [redacted]

b(6)-2

b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

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

MEDCOM - 18486

b(6)-2

CLINICAL RECORD

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

Mo. 09 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 2	3
2	[redacted]	VS: Routine	6	X	[redacted]
			18		
2	[redacted]	Clear liquids, adv as tol	6	X	
			18		
2	[redacted]	BR	6	X	
			18		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Mult contusions & abrasions Head trauma concussion

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 18487

b(6)-2 ALL

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
2	[redacted]	Admit ICW, stable	03 SEP 03			[redacted]	
2	[redacted]	Notify Dr [redacted] of ward #	03				
2	[redacted]	Return to EPW camp when next convoy available	03 SEP 03			[redacted]	
2	[redacted]	labs, Xray, tet tox given in ER				[redacted]	

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 09 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
[redacted]			23	4
			[redacted]	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Mult contussions & abrasions
sternum contussion

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

PATIENT IDENTIFICATION:

[redacted]

b(6)- 4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 18489

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*	Mo. 09 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
R	[redacted]	Motrin 800mg po q8° prn pain	D/T	[illegible] 1900	03Sep 0905	03Sep										
		b(6)-2	D/I	I [redacted]	800mg											

USAPA V1.00

MEDCOM - 18490

038

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF: A 1 1 D 1 — LOCATION (State or Country Code.): I Z

3. REGISTER NUMBER: [redacted]

NAME (Last, First, Middle Initial): [redacted] EPW

4. PAY GRADE: EPW

5. SEX: M

6. DATE OF BIRTH (YYYYMMDD): 19 7 0 1 0 1

7. AGE AT ADMISSION: 3 1 Y

8. RACE: X

9. ETHNIC BACK-GROUND: 9

RELIGION: MUSLIM

10. LENGTH OF SERVICE: —

ETS: —

11. FMP: 9 9 XX

12. SOCIAL SECURITY NUMBER: b(6)-4 [redacted]

ORGANIZATION (Active Duty Only): —

13. MARITAL STATUS: 4

ADMISSION: 1800

BRANCH / CORPS: —

14. FLYING STATUS: N O

15. BENEFICIARY CATEGORY: K 7 8

16. ZIP CODE OF RESIDENCE: —

17. UNIT LOCATION (State or Country Code): —

18. MOS: —

19. TRAUMA: 9

PREV. ADMISSION: YEAR — NO: X

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 7 b(2)-2

WARD: ICU1

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: —

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): —

NAME AND LOCATION [redacted]

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: —

21. TYPE OF DISPOSITION: 7 5

22. MTF TRANSFERRED TO:

23. DATE OF DISPOSITION (YYYYMMDD): 2 0 0 3 0 9 0 3

24. CLINIC SVC - ADMITTING:

25. MTF TRANSFERRED FROM:

26. DATE THIS ADMISSION (YYYYMMDD): 2 0 0 3 0 9 0 2

27. LOCATION OF OCCURRENCE (Battle Casualty Only):

28. MTF OF INITIAL ADMISSION:

29. DATE INITIAL ADMISSION (YYYYMMDD):

FOR LOCAL USE

DX: MULTI CONTUSIONS & ABRASIONS

DX T INJ
9248 9 989
9221
E8193

ADMITTING OFFICER (Signature, as required): DR. [redacted] b(6)-2

SIGNATURE OF ADMITTING CLERK: [redacted]

DA FORM 2985, MAR 2000

MEDCOM - 18491

USAPA V1.00

INPATIENT TREATMENT RECORD COVER SHEET

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

b(6)-4

1. REGISTER NUMBER	2. [redacted] EPW	3. GRADE	ADMISSION REMARKS
[redacted]		N/A	

4. SEX	AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	23	UNK	UNK	N/A	N/A	NO

11. FMP	12. [redacted]	ORGANIZATION	14. WARD
98		N/A	ICU

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N/A		~~N/A~~ KZ8	N/A		

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM EMT	0600	80th 03

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNKNOWN	DT 05	~~30 SEP 03~~

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	08 SEP 03	

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] b(2)-2		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: SHRAPNEL, GSW TO (L) ARM (L) LEG

DX: B1230
9031
9552
8901
E9912
E9919

Px: BG22
3083
8605
7812
7842

Trauma
1
Injury
949

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	29	

36. Total Days All Facilites

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

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

MEDCOM - 18492

DA FORM 3647, MAY 79

EDITION OF 1 AUG 78 IS OBS[redacted]

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

23 yo Iraqi male Tx'd from 2ACR FST - wounds from M203. Incident occurred at around ~5pm 9/7.
At FST, taken to OR noted - (L) BA transection. (L) humerus Fx (L) ulnar n transection. pt s/p ExFix. small shunt; ? ... upper tourniquet. Pt also had (R) thigh wound I+D
Arrived to FST A+O. 28Lb intubated
PMHx unk. meds unk. PSHx unk.

PHYSICAL EXAMINATION

Intubated. paralyzed 156/73 P 88 R13 100%
HEENT OP clear. Scalp lacs.
Chest: CTA (B). CV: RRR
Abd soft, ND
Ext: (L) UEx blast wound visible shunt. 1+ rad pulse.
1 bar 1 pin ExFix
(R) LEx thigh wound 2 x 2cm. clean. 2+ (B) DP.

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

A/ Shrapnel / GSW (L) Arm. (R) LE
FST ExFix, shunt

P/ OR. Revision ExFix, BA bypass

[redacted] b(6)2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	9/8		

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

REGISTER NO.	WARD NO.

[redacted] b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

MEDCOM - 18493

b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
# [redacted]			# 723

DATE	NOTES
2400	85-158/88-16
	CBC/Chem 12 Lytes T&S, UA, PT, PTT
0015	156/73-79 100% O2 sat
0025	ABG done in Right radial [redacted]
	b(6)-2
8 Sept 03	Brief Op Note
	Preop Dx: MGSW ® thigh / Ⓛ arm s/p ex fix ē brachial art shunt per FST.
	Procedure ① Ⓛ brachial artery interposition graft ē Ⓛ GSV
	② Placement additional ex-fix pins Ⓛ humerus, re-adjust ex-fix
	③ washout ® thigh
	④ Ⓛ forearm fasciotomies
	Surgeon Matsumoto / Sam / Givens Anesth GETA
	IOF ① Ⓛ Ulnar nerve nearly severed in upper arm ② Severe comminuted Ⓛ humerus fx ③ palpable Ⓛ radial pulse @ end of case ④ Forearm compartments as well as biceps tight – fasciotomies yielded good release and softening of compartments.
	EBL
	Intra op fluids [illegible]
	Pt tolerated procedure well, to ICU stable [redacted]
	b(6)-2

[redacted] b(6)-4 MEDCOM - 18494 [redacted] 5/1999) BACK USAPA V1.00

ACLU-RDI 1647 p.54

DOD-032068

MEDICAL RECORD	PROGRESS NOTES
DATE	
9 Sep 2003 0600	received report from night shift. Patient condition stable. IV infusing via EJ s̄ difficulty. Serosanguinous drainage noted on occlusive dressing around fixator on L arm. foley draining clear yellow urine. Patient awake + alert appropriately responsive [redacted]
	b(6)-2
0645	Heparin drip placed on hold, for OR today. [redacted]
0800	pt pickup for OR. transferred via litter condition stable [redacted]
0950	return from OR sleepy FM @ 31% c̄ adeq sats (100%) VS stable occlusive dressing + fixator in place on L arm b(6)-2 [redacted]
1000	pt sleepy but arousable, free movement in all extremities except L arm FM @ 31% O_2 c̄ sats 100%, breathing reg + non labored; NSR → ST, heart sounds S, S2 bowel cap. refill < 3sec, pulses palpable x 4 extremities; abd soft non tender bowel sounds present x 4; foley catheter to gravity drain c̄ clear yellow urine in adeq amount, external fixator to humerus L arm. occlusive dressing from below shoulder to hand on L arm. Occlusive dressing to L thigh from groin to above the knee Occlusive dressing on anterior R thigh c̄ small amount of serosanguinous drainage observed; 18G peripheral IV in R AC heplocked c̄ extension tubing 18 gauge (R) external jugular IV infusing LR @ 125cc/h [redacted]
	b(6)-2
9/10/03	Surgery
	Arm well perfused 2+ Radial pulse. Still no motor in hand [illegible] mention [illegible]. Wound clean. Plan to go to OR in 2-3 days to close wound. Hct stable @ 23%
	b(6)-2 [redacted]

(Continue on reverse [redacted]

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

REGISTER NO.

WARD NO. ICU-1

PROGRESS NOTES
Medical Record

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

[redacted]

b(6)-4

MEDCOM - 18495

PROGRESS NOTES b(6)-2 A11

DATE	
10 Sep 03 0600	report received from night shift condition stable resting ̄s difficulty
10 Sep 03 0800	dsg Δ done by Dr [redacted] 5mg MSO4 given pre dressing Δ pt tolerated
	procedure well V/S remain stable [redacted]
10 Sep 03 1200	pt not eating much but drinking plenty of fluid, milk ensure water [redacted]
1515 10 Sep 03	pt getting up OOB to chair ̄c assistance condition remains stable
1700	pt returned to bed tolerated setting up ̄s difficulty given
	2 percocet for pain upon return to bed [redacted]
1830	pt still complain of pain morphine given IV [redacted]
11 Sep 03	Pt remained afebrile throughout this shift T max 100.5, cont to
	have pt use his incentive spirometer. Pt medicated x2 for pain &
	Q 2° NV V/S performed ̄c +2 pulses, warm dry skin & capillary
	refill < 3 secs. Will cont. to monitor. [redacted]
11 Sep 03	Received report & care of pt from [redacted]. Pt
0610	Sleeping in bed. ∅ s/s of pain or discomfort Will
	cont to monitor [redacted]
0730	Pt C/O pain to (L) arm. Given 2 percocet for pain
	T↑ 101.5 Pt given 650mg Tylenol PO for temp
	VSS will cont to monitor [redacted]
0930	Pt to X-Ray for Follow up on (L) Humerus. Pt
	received 5mg MSO4 for pain in (L) Arm before going
	to X-Ray T-↓ 100.3 VSS will cont to monitor [redacted]
1000	Pt to Chair [illegible] after returning from X-Ray T-100.0
	VSS will cont to monitor [redacted]
1230	Pt back into bed. Pt consumed 1/3 lunch. C/O
	pain to (L) arm. Received 2 percocet for pain VSS
	will cont to monitor [redacted]

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

MEDCOM - 18496

ACLU-RDI 1647 p.56

DOD-032070

MEDICAL RECORD	PROGRESS NOTES b(6)-2 All
11Sep03 1630	Pt IV to (R) AC DC'd. IV restarted to (R) hand 20ga placed. Saline locked. VSS will cont to monitor [redacted]
1800	Report + care of pt given to oncoming sh[redacted]
11SEP03 2315	Assessment completed @ 2100, patient resting c̄ eyes closed prior to this time, VSS. Patient complaining of pain to (L) arm @ 2100, given MSO4 5mg IVP. Patient complaining of pain @ 2315 to (L) arm, given Percocet 2 tabs. Patient told about NPO status p̄ MN. Sensation to (L) hand intact, cap refill < 3sec, (R) pulse +2. [redacted] LT/AN
12SEP03 0345	Patient complaining of pain to (L) arm, given MSO4 5mg, will continue to monitor. [redacted] LT AN
12Sep03 0810	Nursing: See ICU flowsheet for nursing assessment. T-100.4, HR-98, BP 142/62, SaO2 100% on RA. Pt escorted to O.R. by anesthesia. [redacted] 83/AN
12Sep03 ~~0810~~ 1311	Nursing: 0800 dose of Ancef not given due to pt being in O.R. Next dose scheduled for 1600. [redacted] /AN
12Sep03 1339	Nursing: Pt escorted back from PACU. T-100.3, BP 156/69, HR-114, R-11, Sats 98% on RA. Respirations regular and unlabored. Airway patent. LUE elevated on blankets. Skin warm to touch (Cont'd)

(Continue on reverse side)

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

REGISTER NO. [redacted]

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
12 Sep 03 1359	Nursing: Cap refill <3 secs. Unable to assess pulse Due to splint. External fixator intact. Pt c/o pain. Given 5mg Morphine IVP @ 1320 and 2 tabs Percocet @ 1325. Pt tolerating PO fluids & N/V. Pt sleeping quietly @ this time. b(6)-2 [redacted]
12 Sep 03 1522	Nursing: Pt c/o (L) arm pain. Given 5mg Morphine T-102.4, given Tylenol 650 mg PO and encouraged to use incentive spirometer. Pt averages 2400 ml TV on I.S. Fingers on (L) arm warm to touch cap refill <3 secs, (+) movement, (+) sensation. [redacted]
12 Sep 03 1610	Nursing: Dr. [redacted] notified of temperature, pain control requirements, and A line. ~~Heparine~~ Order given to D/C H504 to @ 30 mins, D/C A line, and encourage ambulation. Will continue to monitor. b(6)-2 [redacted]
12 Sep 03 1721	Nursing: T-102.3, pt using I.S. & difficulty. Pt tolerating PO fluids & N/V. A line D/C'd. Direct pressure applied for 5 mins & bleeding noted, ~~4×4 Dressing~~ 1734 [redacted] 2×2 Dressing applied. Pt given PRN Morphine for c/o pain. [redacted] b(6)-2

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

[redacted] b(6)-4

MEDCOM - 18498

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MEDICAL RECORD | **PROGRESS NOTES** b(e)-2, An

DATE	NOTES
15 Sept 03 0730	Pt received 3mg Morphine for c/o pain to (L) arm [redacted] will cont to monitor
0930	Pt c/o pain to (L) arm. Pt received 2 percocet for pain. N/V checks to (L) extremity done & no changes. Pt has +2 pulses in (L) Radial <3 sec cap refill. & sensation in pinky ring, middle, or index finger. Sensation felt in thumb. Unable to move arm, hand, or fingers. VSS will Cont. to monitor [redacted]
1148	N/V check done to (L) upper extremities & Changes noted will cont to monitor [redacted]
1215	IV to [redacted] (R) bicep D/C'd. IV restarted to (R) forearm 20ga patent to NS flush [redacted]
1240	Pt received 7mg Morphine and 2mg Versed for Dsg Δ to (R) arm. Dsg Δ's complete pt tolerated well. VSS T-98.5 will cont to monitor [redacted]
1440	Pt received 3mg Morphine for c/o pain in (L) arm. Dsg Δ's to bilat. upper legs completed. will Cont. to monitor [redacted]
1445	N/V checks to LUE done & changes noted. will Cont to monitor [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. ICU 1

[redacted]

b(e)-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

MEDCOM - 18499

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1540	Pt C/o pain to LUE. Pt received 5mg Morphine for pain. will cont to monitor [redacted]
1730	Pt C/o pain to LUE + received 2 tabs percocet for pain. VSS. T-99.1 will cont to monitor [redacted]
1800	Report + care of pt given to oncoming [redacted]
1820	Pt report received from SPC [redacted]. Pt denies any pain @ time. Pt is in bed eating. VSS. Dressings are CDI. Assessment complete. Will continue to monitor Pt. [redacted] [illegible]
2110	Pt given T1 Percocet for pain. neuro checks have been the same. Pt in bed resting. will continue to monitor. [redacted] [illegible]
2220	Pt received 3mg MSO4 for pain, given by charge nurse [redacted]
[illegible]	(0000) Pt VSS, neuro check the same feeling in [illegible] will continue to monitor. [redacted] [illegible]
	(0130) 5mg MSO4 given for pain. will continue to monitor [illegible] Pt. VSS. [redacted] [illegible]
	(0300) VSS, Pt resting in bed. neuro check c no Δ. [redacted] [illegible]
	(0500) Pt has received 2mg of MSO4 for pain c good effect. Pt now sleeping in bed. VSS. Temp is ↓ to 99.1. Pt has urine to foley DS. will continue to monitor [redacted] neuro [redacted]
0600	Received report & care of pt from previous shift. Pt sleeping in bed will cont to monitor [redacted]
0730	Pt received 2 tabs percocet for C/o pain to LUE. Consumed 90% of breakfast. will cont to monitor [redacted]

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES b(6)-2A11 ↓
18 Sept 03 1758	Returned to ICU 1 s̄ distress noted. Tolerates p.o. s̄ difficulty. (L) arm elevated per order. Will continue to monitor. [redacted]
1830	Report recieved from SGT [redacted]. pt VSS afebrile. pt denies pain @ this time. Neuro ✓ (L) Hand - full sensation to thumb and index finger. Ø sensation to remaining fingers. radial pulse +4. Will continue to monitor [redacted] 91WM6
2000	Neuro ✓: same as previous check [redacted]
2200	pt temp 101.5. Tylenol 650 mg given. will recheck temp in 1 hour. Neuro ✓: same as previous ✓ no change in sensation to (L) hand [redacted] 91WM6
2300	Temp recheck 98.9 [redacted] 91WM6
2400	Neuro ✓: No Δ from previous check [redacted]
0200	Neuro ✓: No Δ from previous check [redacted] 91WM6
0400	pt resting in bed, VSS afebrile. Neuro ✓: No Δ from previous ✓ [redacted] 91WM6
19 Sept 03 0600	Received report from previous shift. Pt resting c̄ eyes closed. VSS. Pt c/o pain (L) upper arm + thumb + pointer finger. Gave MSO4 mg IVP. Pt also c/o no sleep during night. All IV lines intact. (L) arm elevated. Allen-1LT

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

#[redacted]

b(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

MEDCOM - 18501

LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

DATE	NOTES
19 Sept 03 0800	Ø Δ in NV ✓ of LUE. Prep pt for transfer to ICW. Gave brief report to Lt Gross. Will cont care & complete drsg Δ in ICW.
	b(6)-2 [redacted]
0925	Gave versed 2mg IVP + MSO_4 4mg IVP in prep. for drsg Δ Transferred pt to ICW. Will cont care.
	b(6)-2 [redacted]
1020	Completed drsg Δ. Incision well approximated + intact c̄ suture Ⓛ UE. Applied bacitracin + completed pin care using betadine. Cleaned Ⓛ arm c̄ NS. Wrapped Ⓛ UE c̄ kerlex. Replaced half splint + wrapped c̄ ace bandage. Pt assisted. Small amt blood noted on lower aspect of bicep. Δ'd drsg Ⓑ upper thigh. Sutures Ⓡ thigh intact, wound well approximated c̄ Ø s/s of infection. Ⓛ thigh staples intact. Wound well approximated c̄ Ø s/s of infection. Applied bacitracin to Ⓑ upper thigh wounds. Covered c̄ 4x4 + secured c̄ cloth tape. Pt c/o pain. Gave 4mg MSO_4 IVP. Pt resting c̄ eyes closed @ this time. Lt Gross @ bedside assisting c̄ drsg Δ.
	b(6)2 [redacted]
Sept 1550	Received pt in stable condition, A+Ox3, [illegible], arabic speaking. Drsg Δ'd [illegible] w/ LT [redacted] VS, amb w/ steady gait. Drg remain c/d/i. tol po. IV Ⓛ fc patent + intact. Ø c/o pain for this part of shift. [illegible]

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDCOM - 18502

ACLU-RDI 1647 p.62

DOD-032076

b(6)-2

MEDICAL RECORD | **PROGRESS NOTES**

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DATE	NOTES
9/19 Sep 03 @ 1539	care. Pt able to feel two fingers only @ this time, pinky & ring. Pt unable to wiggle fingers. (+) pulse and hand/fingers warm to touch. Limited mobility noted w/ (L) arm. Ø other remarkable assessments @ this time. Will cont. monitor pt [redacted]
20Sep03 @ 0100	Assumed care @ 1800; All VSS; A&Ox3, (+) [redacted] intact, brisk cap ref (+) pulses x4; pt amb to BR s̄ difficulty; Ø c/o pain; (+) sensation in thumb & pointer finger; Ø sensation in remaining fingers; (+) movement in all fingers; otherwise, NV intact; S1S2, LSCTA(B), (+) BSx4; Ø BM this shift, pt voiding QS, clear, yellow urine; HL patent, cont c̄ IV abx, enc. IS use, (L) arm elevated; restraints in place, (+) circulation, Ø skin breakdown; cont to monitor [redacted]
20Sep03 @ 0800	VSS alert/orient OOB to BR for AM care. Neurovasc check to (L) UE WNL. Sling in place to (L) UE. Pin care done to external fix. (R) FA IV patent & intact. Saline lock dsg clean. BS (+) x4 quads. Peripheral pulses palpable. Will continue plan of care [redacted]

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

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

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

REGISTER NO. | WARD NO.

[redacted]

b(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

MEDCOM - 18503

AST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(6)-2 A11
20Sep03 @ 2050	Assumed care @ 1800; USS; A&Ox3, ⊕ sensation to thumb & pointer finger, ⊖ sensation to other digits; ⊖ movement in [redacted] ~~affected~~ (L) hand & digits; ⊕ circulation; ⊕ pulses x4, brisk cap ref throughout, otherwise pt NV intact; Ex-fix in place, dsg CDI & ⊖ drainage; HL in (R) FA patent s̄ s/sx infection/infiltration; cont c̄ IV abx; pt OOB to amb to BR c̄ in hall X1, pt tol well s̄ complications; (L) arm ↑; IS use encouraged; cont c̄ Q2° NVV; restraints in place, ⊕ circulation, ⊖ skin break, cont to monitor [redacted]
21 Sept 03 [illegible]	Alert & Oriented. (L) UE drsg dry. (L) UE lateral incision from (L) axilla to left wrist. Sutures intact c̄ 2cm open area to incision 1cm above elbow. Has sensation to (L) UE. Capillary refill < 3 sec (L) fingertips (L) Radial & brachial pulse palpable +2. Pin care done to (L) upper arm Extern fix. Sutures to (L) & (R) thigh intact with edges to wounds well approximated. OOB to BR & ~~tolerated~~ well. Sling / ~~[illegible]~~ splint in place to (L) UE. (R) FA IV patent & intact Saline locked Keep open. BS ⊕ x4 quad. Abd soft non-~~dis~~ distended. Percocet ii tabs given for pain. Will continue with plan of care. [redacted] 2LT AN
21 Sept 03 1915	External fixator to upper ~~[illegible]~~ [redacted] (L) arm dressing intact. ⊕ distal pulse sutures to (B) thighs intact. No sign of infection. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDCOM - 18504

LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

DATE	NOTES
23 sep 03 0200	- Assumed care of pt. A&O x3 VSS. c/o pain to (R) shoulder that radiates to (R) flank throbbing pain. Medicated c MSO4 5mg for relief. q2 Neuro check to (L) UE vein graft. from (L) thigh surgical incision c sutures open to air clean dry and intact. (L) UE warm good cap refill strong radial pulse. External fixator pin care complete dressing to bicep changed. States having SOB pain upon inhalation O2 sat 98% on RA Lungs clear bilat. IS @ bedside. Will cont to monitor [redacted]
	(1150) I concur c above assessment. [redacted]
	b(6)-2 A11
24 SEP 03 2013	VSS. AO. Provided 2 Tylenol for T @ 101.6. Pin care performed as ordered and tolerated well, but c/o SOB and states feeling "hot." Vital signs checked. All within systems WNL. (+) Radial pulse to (L) arm, (+) CNS to all fingers on (L) arm. Sutures to antecubital area and upper arm intact. [redacted]
0730	Received pt resting in bed [redacted] VSS w/ ↑ T of 103, gave ii percocet for pain w/ additional i Tylenol T ↓ 101.9. Drsg Δ done w/ bacitracin on suture line. gauze dsg on upper arm and pin care. Bilateral wounds on thighs covered w/ bacitracin (R) sutures intact, (L) staples intact. edges well approximated. pt c/o's to have ↓ motor & sensation in LUE. HL (R) FC patent, flushes easily. OOB + amb indep. Restraints in place per ...

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MEDCOM - 18505

ACLU-RDI 1647 p.65

DOD-032079

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MEDICAL RECORD	PROGRESS NOTES

NOTES b(6)-2 All

DATE	
23 Sep 03 0700	- Assumed care of pt. A+Ox3. VSS. Lungs CTA HRRR Active BS x4 good tolerating PO well. GSW to (R) anterior thigh open to air healing well Ø bleeding noted. (R) LE vein graft incision line open to air sutures in place Ø drainage. (L) UE c external fixator surgical incision from hand to axillary sutures in place dressing 4x4 dry the inner bicep drainage noted. Remains afebrile Ø s/s of infection will cont to monitor. [redacted] RN.
23Sep03@1930	Assumed care @ 1900; VSS, pt A&Ox3 speaking both arabic & english; Ø distress in NVV, cont c Q2° NVV; pain controlled c perc & MSO4; pt amb x1 in hall s difficulty; Ex-fix in place, dsg to (L) bicep CDI s drainage; GSW to (R) anterior Quad OTA sutures intact, Ø drainage, well approximated; sutures to (L) LE OTA s drainage, well approximated; sutures to (L) UE intact, s drainage, well approximated Ø s/sx infection; pt voiding s difficulty, Ø BM thus far; restraints in place; (+) circulation Ø skin breakdown [redacted] cont to monitor [redacted]

SPONSOR'S NAME

RELATIONSHIP TO SPONSOR	LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
		REGISTER NO.	WARD NO.	

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

PROGRESS NOTES
Medical Record

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

[redacted]

b(6)-4

MEDCOM - 18506

LAST NAME

FIRST NAME

b(6)-2 A11

DATE

MIDDLE INITIAL

ID NUMBER

NOTES

Pt. verbalized understanding. LSCLAB. 5, 5, PERRLA.

BS (+) x4. Urine light yellow QS. [redacted]

24 Sep 03 - Assumed care of pt. A+O x 3. USS Ø c/o pain or

0700 discomfort @ this time. Dressing Δ to (R) posterior thigh GSW 4x4 secured c tape CDI. External fixator to (L) LE pin care complete incision to leg c suture 4x4 dressing for minimal drainage secured c kerlix. Tenz CTA HRRR Active BS. Tolerating PO. Urinating per urinal s difficulty. GSW to (L) ankle suture intact wound open to air Ø drainage noted. Will cont to monitor [redacted] RN

(1240) I concur c above assessment. [redacted]

24 SEP 03 USS. Pin care performed to LLE.

2227 (+) pulse to LLE. DSG intact (R) thigh. L thigh & calf sutures to (L) leg OTA. WNL. Tolerated OOBTC c minimal assistance. [redacted]

Sep 24 2C 1054 Received pt resting in bed, USS, A + O x 3, arabic speaking. Dsg to (L) thigh/ex fix Δ'd, pin care done. Dry W->D done on (R) thigh wound, serosang. drainage noted. IV started (R) fa, patent, flushes easily. Sugs, Ø pm this shift. Pt able to flex (L) LE ... aspect. Ø other remarkable assessments @ this time. Will cont to monitor. Restraints on per CPW protocol Ø skin breakdown or circulation issues noted [redacted]

Sep 03 USS. AO. DSG placed to (R) inner thigh s complaint. BS (+) x4.

1341 (+) pulse to LLE. Pin care performed. Elevated LLE. [redacted]

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ACLU-RDI 1647 p.67

DOD-032081

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	CDI c ⊖ s/s inf. ⊕ pedal pulses.
	cap refil < 3 seconds. Pt. resting [redacted]
	@ this time will cont to monitor pt. [redacted]
	Assumed care @ 1800; VSS, pt A&O x 3, ⊕ CMS, brisk cap Ref, ⊕ pulses x 4, ⊘ c/o pain or
?Sep03 @ 1900	discomfort @ this time; Ex-fix in place, dsg CDI s drainage; ⊖ s/sx infection;
	SL in Ⓡ wrist patent s s/sx infection/infiltration; S1S2, CSCTA Ⓑ; ⊕ BSx4, pt voiding
	QS, clear yellow urine dark yellow urine; all dsgs CDI; pt OOBTC c assistance;
	restraints in place, ⊕ circulation, ⊖ skin break; cont to monitor [redacted]
	- Assumed care pt. awake A&O x 3 VSS. ⊘ c/o pain
23 Sep 03	or discomfort @ this time lungs clear bilat HRRR. Active
0700	BSx4 quads. Voiding QS per urinal. External fixator to Ⓛ LE
	intact pin care complete incision to leg dressing with 4x4
	and wrapped c kerlix. GSW to Ⓛ ankle ace wrap taken off
	stitches CDI 2x2 dressing applied to open area of wound to
	ankle. GSW to Ⓡ posterior thigh ace wrap taken off. Wet → Dry
	dressing applied c 4x4 secured c tape. Will cont to monitor [redacted]
	cont c IV ABX therapy
	VSS. AO. Acting like a baby. Ⓡ thigh DSG Δ'd
24 SEP 03	for 0430 AM. ⊕ pulses BLE. Pins intact & clean.
0125	Reinforced understanding of restraint policy to patient.

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

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

b(6)-2 A11

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	cont protocol, ø skin breakdown or circulation issues noted. ø other remarkable assessments @ this time. will cont to monitor [redacted] b(6)-2
25 SEP 03 2217	VSS, AO ø pain. Ambulated x1 for 10 min on ward. Placed [illegible] to lower pin site @ change. [illegible] intact to ⊕ radial pulse to to ⓑ arm. Unable to move fingers. States [illegible] pain. States [illegible] in ⓛ wrist and ⓛ [illegible]. b(6)-2 [redacted]
Sept 26 @ 11°°	Received pt resting in bed, VSS, A+O x3, Speaks arabic and some english. OOBTC and amb in hallways today. Dsg to ⓛ arm Δ'd and pins care done. Bacitracin applied to suture line. ROM performed w/ pt assist and pt taught to perform ROM of ⓛ arm on own. Pt has ↓ movement and sensation to ⓛ arm, esp ⓛ hand. ⊕ ROM this shift, pt indicated good relief. ø other remarkable assessments @ this time. Pt applied bacitracin to bilateral ⓛ wounds, ⓛ LE Staples intact and ® sutures intact. Restraints per cont protocol, ø skin breakdown or circulation issues noted. will cont to monitor [redacted] b(6)-2

SPONSOR'S NAME

RELATIONSHIP TO SPONSOR | LAST | FIRST | ...'S ID NUMBER (...other)

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PROGRESS NOTES
Medical Record

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C# [redacted]

b(6)-4

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
26 Sep 03 2010	Rt c/o, VSS, Ø c/o pain @ this time. LCTAB, HRRR, ⊕BS x4 qds. Drg ∆'d to Ⓡ thigh. 4x4 applied. Pin care done to Ⓛ ex-fix. Ⓛ leg incision OTA c̄ 2x2 to open area. ⊕ pedal pulses, Restraints on, ⊕ circulation. Gentamycin + ancef cont. voiding qyu via urinal. Will monitor [redacted] 91WM6-SPC b(6)-2 [redacted]
27 Sep 0240	c/o pain to Ⓛ leg. II Percocet given per MD orders. Relief noted. Will monitor [redacted] 91WM6
27 Sept 03 @0900	VSS. Alert & oriented. OOB → chair for Breakfast & AM care. Tolerated Well. Ambulated c̄ assist to BR. Had BM x1 medium formed Brown. Peripheral pulses +2 Pin care done to Ⓛ ex fix. Ⓛ leg incision with sutures intact. Percocet 2 tabs given P.O [redacted] for pain. Restraints 2 points applied. Skin intact under restraints. Will continue plan of care b(6)-2 [redacted] AS

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

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PROGRESS NOTES
Medical Record

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#[redacted]
b(6)-4

MEDCOM - 18510

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27sep03@0315	Assumed care @ 1800; All USS; pt A&Ox3, ØΔ neurovascularly, cont ē Neuro ✓: b(6)-2 A11
	(L) arm ↑, pt amb x1 for 20 min; pain controlled ē percs; pin care
	complete; dsg to (L) UE CDI s̄ drainage; sutures to thighs (B) intact s̄ s/s
	infection, ⊖ drng; well approximated - self-application of bacitracin;
	pt assisted ROM performed, ⊖ BM this shift; pt voiding QS s̄ difficulty
	restraints in place, ⊕ circulation, ⊖ skin break ↓; cont to monitor [redacted]
27 Sept 03 0900	USS Alert / oriented (L) arm sling in place after
	drsg changed. Sutures from (L) wrist to below bend of
	elbow removed. incision edges well approximated.
	Pin care done to (L) upper arm ext. Peripheral
	pulses palpable. (L) arm ↑ on folded blankets.
	HOB ↑ 30°. (R) FA Saline lock patent & infused.
	Flushed without difficulty. (R) & (L) incision clean
	and dressed as ordered. OOB → BR ad lib.
	Remain ē 2 point restraints while in bed.
	Will continue plan of care [redacted]
28sep03@2245	Assumed care @ 1800; All [redacted] T: 101.9 ē pt c/o pain, [redacted] LCTA
	relief, Temp retaken T: 98.0°; All other USS; pt A&O, No Δ neurovascularly; pt
	↑ amb in hall x1 for 15 min s̄ difficulty; dsg to (L) arm Δd, wrapped ē
	Kerlix - CDI, scant amt of drainage on old dsg; pin care complete ē
	1/2 sterile H_2O : 1/2 NS; min. drainage noted; SL patent, cont ē IV abx;
	Restraints in place, ⊕ circ. ⊖ skin break ↓, cont to monitor [redacted]
Sept 03 0900	USS Alert & oriented OOB → BR with (L) arm
	in sling. (R) FA Saline lock patent and
	intact. HOB ↑ 30°. (L) arm elevated on folded
	blankets. Peripheral pulses palpable. Pin care
	done to (L) UE external fixator. (R) + (L) thigh

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

[redacted]

MEDCOM - 18511

ACLU-RDI 1647 p.71

DOD-032085

LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

b(6)-2 + 11

DATE	NOTES
27 Sep 03 2100	Pt A/O, VSS, (R) thigh dsg Δ'd. ⊕ pulses to (B) ext. pin care done. (L) thigh sutures OTA. open area covered. minimal drainage @ pin sites. OOB to chair ē minimal assistance. OOB @ this time. Restraints on. ⊕ circulation. ∅ c/o pain. Will monitor [redacted] 91WM6 SPC [redacted]
28 Sept 0900	VSS; AxO; OOB → chair for breakfast & AM care. Ambulated ē assist to BR. Tolerated well. Had BM. Peripheral pulses palpable. (R) FA IV patent & intact. Fluids without difficulty. Pin care done with minimal ambulation. Will continue plan of care. [redacted]
28 Sep 03	2100: VSS c/o pain, save ĪĪ percs for pain as ordered, Dsg to (R) back thigh Δ'd CDI - reinforcing PRN. ex-fix to (L) LE intact, sutures to (L) LE approximated & CDI. (L) LE elevated, edema noted. IV H/L to (R) FA flushed & patent, continuing IV antibx around the clock. Tolerates PO, OOB PRN s̄ difficulty. Pain management & palliative care. 2+ pedal pulse (L) foot. Will continue to monitor for acute Δs. [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28 Sep 03	2330: IV to (R) FA infiltrated, D/C'd intact. IV 18G restarted to (L) AC running Ancef 1gm IV @ present time. b(6)-2 [redacted]
29 Sep 03 0800	Received pt resting in bed, VSS, A&Ox3, speaks arabic. Pt amb to BR w/ walker, no wt bearing (L) BM, am care. amb to chair w/walker (L) LE ↑. Pin care done, bacitracin applied to suture lines. IV to (L) AC patent & intact flushes easily. Medicated w/ percocet x1 this AM. Will cont to monitor pt. Restraints in place per EPW protocol Ø breakdown noted [redacted] b(6)-2
29 Sep 03	2045: VSS, c/o pain, gave 2 percocet tabs PO as ordered, ex fix to (L) LE in place, Dsg's CDI, sutures approximated, Dsg to back of (R) thigh D'd W→D. IV HL to (L) AC 18G flushed & patent, running Gent IV. Continuing antibx IV around the clock. X2 restraints when in bed (-) skin breakdown. Pain control palliative care. Continue to monitor. b(6)-2 [redacted]

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[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	(continue)
28 Sep 03	R/L thigh dry ___ all ___ [redacted]
28 Sep. 03	Will continue plan of care [redacted]
1845	Pt resting in bed, A+Ox3, VSS, LS CTA Ⓑ, ⊕ BS x4, SL Ⓡ FA patent, Ex Fix Ⓛ arm, arm elevated, pin dsg's CDI, voiding w/o complications, denies pain at this time, proper circulation + ø skin break down on pts of restraint. [redacted] b(6)-2
29 Sep 03	(1455) Assumed care of pt [redacted] p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs/Neurontin. Ex fix in place on LUE. Pin care done. Incision on LUE covered c̄ Kerlex drsg p̄ Bacitracin applied. ↓ ROM noted c̄ Ⓛ hand/wrist. PT notified of consult. Pt amb well. Tol. reg diet well. Voiding s̄ difficulty. Pt OOB to shower this am for personal hygiene. SL in Ⓡ forearm flushes well s̄ s/sx infection/infiltration. 2 point restraints in place s̄ s/sx complications. Will continue to monitor [redacted] b(6)-2

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

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[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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MEDCOM - 18514

b(6)-2 All

DATE	NOTES
29 Sep 03 1845	Pt resting in bed, A+O x3, VSS, Ex Fix to LUE, incision covered c̄ kerlix CDI, pt able to move LUE, movement limited because of injury, peripheral pulses equal bilat, LS CTA (B), (+) BS x4, abd soft flat non tender, pt voiding well, HL IV (R) FA intact, ∅ s/sx of infex, pt ambulates w/o complications, ∅ s/sx of poor circulation or skin break down on pts of restraints. [redacted]
29Sep03	2110: I concur c̄ above assessment. [redacted]
30SEP03	(1450) Assumed care of pt @ 0700 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs/ Neurontin. Ex fix in place on LUE. ↓ROM in LUE. Skin warm to touch, cap refill <3secs. Pin care done. Drsg to LUE cd. Incision CDI s̄ s/sx infection. Bacitracin applied to incision. SL in (R) forearm flushes well s̄ s/sx infection/infiltration. Pt amb in hallway s̄ difficulty. Tol. reg diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ s/sx complications. Will continue to monitor. [redacted]
(1900)	Pt a/o, VSS, ∅ c/o pain @ this time. ex. fix intact to (L)UE. pin care done. ↓ROM LUE. brisk cap refill, skin: warm + dry. drsg (L)UE CDI. HL (R) arm patent ambulating s̄ difficulty. neurontin cont as sched. dosage 1 to 600mg TID. NV vis (L)UE @ 2°. Restraints on (B)LE (+) circulation, will monitor [redacted]
2100	last dose ancef given, Keflex started PO per orders. [redacted] 91WM6 SPC

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

b(6)-4

MEDCOM - 18515

ACLU-RDI 1647 p.75

DOD-032089

LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

DATE	NOTES
30SEP03	(1105) Assumed care of pt @ 0600 p̄ report from night shift.
	Pt alert, speaking Arabic. VSS. Pain controlled c̄ MSO4. Pt
	OOB to shower for personal hygiene this am. Amb c̄
	assist of walker. ↑ to chair for 2°. Ex fix in place on
	LLE. Pt able to move LLE. ⊕ pedal pulse equal bilat.
	Cap refill <3 secs. Sutures to LLE CDI. Drsg to back of
	Ⓡ thigh old, wet → dry. ∅ s/sx infection @ wound site
	SL in Ⓛ ac flushes well s̄ s/sx complications. Pt remains
	NPO for sx today. 2 point restraints in place s̄ s/sx
	complications. Will cont. to monitor. [redacted]
	(1300) SL in Ⓛ ac d/cd d/t infiltration. 18g IV started
	in Ⓡ forearm. LR infusing @ TKO d/t NPO status
	for surgery. Monitoring [redacted]
	(1515) Pt to OR via gurney in stable condition.
	[redacted]
	(1715) Pt tx back to ward p̄ surgery via gurney in
	stable cond. Drsg to LLE CDI. MSO4 given for pain
	monitoring [redacted]
30SEP03	VSS. AO. DSG's to Ⓛ thigh and pins intact. ⊕ pulses to BLE.
2000	DSG A'd to Ⓡ inner thigh and wrapped. CR ≤ 3 seconds.
	Post op dressing to Ⓛ thigh left in place. ∅ s/s of
	wound infection to either extremities. [redacted]
01OCT03	(1050) Assumed care of pt @ 0600 p̄ report from
	night shift. Pt alert, speaking Arabic VSS. Pain
	controlled c̄ Percs. Pt OOB to BR c̄ assist of walker.
	Personal hygiene done. Drsgs to LLE d/cd, steri
	strips to incisions intact c̄ small amount sero-sang

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b(6)-2
All

MEDCOM - 18516

ACLU-RDI 1647 p.76

DOD-032090

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DATE	NOTES
Ø1OCTØ3	(1725) Assumed care of pt @ ØØØØ p̄ report from night shift. Pt alert, speaking Arabic. VSS. Drsg to [illegible] LUE Δd. incision CDI. Pin care done to ex fix. Pt tol. well. Pain controlled c̄ Percs. Pt tol. reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor. [redacted]
1OCT.Ø3 1845	Pt A+Ox3, VSS, OOB to BR + ambulate, [redacted] Ex Fix on LUE, dsg on LUE CDI, denies pain, voiding well, LS CTA Ⓑ, ⊕ BS x4, ø s/sx of poor circulation or skin breakdown on pts of restraint. [redacted]
1 Oct 03	2100: I concur c̄ above assessment [redacted]
2Oct03 @ 1400	received pt resting in bed, VSS, a+ox3, arabic speaking. medicated x1 5mg MSO4 for pain prior to dsg Δ. wound cleaned w/ NS, bacitracin applied to suture lines, + pin care done. pt assist w/ dsg Δ, and is self sufficient in ROM exercises. s/sx, tol po. OOB + amb in hallways. restraints appl @ pw protocol, ø skin breakdown noted. Numbness [redacted] in sensation of sm fingers in arm. will cont to monitor [redacted]

b(6)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | [redacted]

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b(6)-4

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MEDCOM - 18517

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2oct03@2115	Assumed care @1800; All VSS; pt A&OX3, ØΔ Neurovascularly; cont c̄ NV✓; dsg to Ⓛ UE Δ'd, minimal drainage; pin care complete; ⊖ drainage; SL in Ⓡ FA patent; pt ↑ to amb in hall X1 for 15 min s̄ diff, pt voiding QS, clear, yellow urine s̄ diff; Restraints in place, ⊕ circulation, ⊖ skin breakdown; cont to monitor [redacted]
	b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

MEDCOM - 18518

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ACLU-RDI 1647 p.78

DOD-032092

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
03OCT06 1147	Received pt resting in bed VSS, tol po, A+Ox3, arabic speaking. Drsg to (L) arm removed and left OTA per MD instruction, pin wound cleansed w/ NS and bacitracin applied to suture line. Pin care done w/ 1/2 strength H_2O_2. Pt able to self perform ROM exercise to (L) arm and pt state cont ↓ feeling and movmt to (L) arm. Ex fix in place w/ sling for support during amb and when up ad lib. Pt amb in hallways indep. ROM, and arm care provided. [redacted] Restraints in place per CPU protocol, ø breakdown noted. ø other remarkable [redacted] @ this time. Will cont to monitor pt [redacted]
	Assumed care @ 1800; All VSS, pt A+Ox3, ⊖ Δs Neurovas[redacted] ↑ to amb in hall X1 for 30 min. Tol well; Ex-fix in place; pin care complete c̄ 1/2 strength H_2O_2; ⊖ s/sx infection; (L) arm OTA, bacitracin applied; (L) arm ↑ on pillow; pt [redacted] performs ROM; ⊖ significant Δs in assessment. Restraints in place; ⊕ circulation, ⊖ skin break ↓; cont to monitor [redacted]
	b(6)-2

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E # [redacted] b(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
4Oct03 0900	VSS. Alert Oriented. OOB → BR for AM care. Pin care done to Ex fix to (R) upper arm. Ø drainage noted from pin sites. (L) arm ↑ on folded blankets. NVV WNL's to (L) UE. Denies pain or discomfort @ this time. Will continue care as planned. [redacted]
4oct03 2100	Assumed care @ 1800; All VSS, pt A&O, Ø Δ NV; pt medicated c̄ perc ĭ MS04 for pain; ↑ amb in hall, pt in NAD; Ex-fix in place, pin care done Ø drainage; Ø s/sx infection; (L) arm ↑; Ø Δ's; Restraints in place, ⊕ circ, Ø skin breakdown, cont to monitor. [redacted]
5Oct03 0900	VSS. Alert & Oriented. OOB ambulated to BR. (L) arm in sling (L) fingers capillary refill < 3 sec (L) radial / brachial pulse palpable. Pin site to ext fix (L) humerus without drainage and crustation. (L) arm ↑ on folded blankets. Denies pain or discomfort @ this time. Will continue plan of care. [redacted]
5OCT. 04	Pt A+Ox3, VSS, LS CTA(B), ⊕ BSx4, Ex Fix LUE in place, incision on LUE open to air, Ø drainage noted, c/o moderate pain to LUE, voiding s̄ difficulty, pt able to move fingers, radial pulse equal (B), LUE elevated c̄ blanket, Ø s/sx of poor circulation or skin integrity on pts of restraint. [redacted] 9W

b(6)-2A11

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
06OCT03	(1625) Assumed care of pt @ [redacted] report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Neurontin. Ex fix in place on LUE. Pin care done. Incision on LUE CDI - open to air. LUE elevated on pillow. Skin warm to touch. Cap refill <3secs. Pt OOB to BR this am for personal hygiene. Amb well. SL in @ forearm dlcd d/t infiltration - catheter intact. Ta. reg diet well. Voiding c difficulty. 2 point restraints in place c s/sx complications. Will continue to monitor. b(6)-2 [redacted] USAF
6OCT03 1945	Pt A+Ox3, VSS, Ex Fix @ LUE, dsgs on pins intact, incision LUE healed, abd soft flat nontender, OOB to BR + ambulate, voiding well, pain controlled c percs pt had x RAYS taken, xRAYS @ bedside, Elavil 20mg PO QHS, Ø s/sx of poor circulation or skin breakdown on pts of restraint. b(6)-2 [redacted] qiw
07OCT03	(1610) Assumed care of pt @ [redacted] report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs/Neurontin. Ex fix in place on LUE. Pin care

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
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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. ICW#1

#[redacted]

b(6)-4

PROGRESS NOTES
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MEDICAL RECORD

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PROGRESS NOTES

DATE	NOTES
10-8-03	Summary This is a [redacted] male who sustained a gunshot wound to his left arm. He sustained a Comminuted humerus fracture and lacerated his brachial artery, median nerve, ulnar nerve, and musculocutaneous nerve. The radial nerve was found to be intact but contused. The brachial artery was repaired with a vein graft, the nerves were tagged with suture, and the humerus was fixed with an external fixator. His wounds are closed and pin sites are clean. There is no callous at the fracture site and there is some sensory radial nerve function. The patient wishes to keep his arm even if not fully functional. In three months consideration for nerve repair + grafting should be made at a facility equipped to do that. This facility does not have that capability Currently he is treated with Neurontin 600mg po TID, Elavil 25 mg po qHS for nerve pain. Twice a day pin site care should be done and external fixator removed when fracture is healed. b(6)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | [redacted] NUMBER (SSN or Other) | DEPART./SERVICE: Orthopedic Surgery | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

[redacted]

b(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
07OCT03 (1600)	(cont) done. ↓ ROM on LUE. Cap refill <3secs. incision on LUE CDI-open to air. Tol reg diet well. Voiding s difficulty. 2 point restraints in place s s/sx complications. Will cont to monitor. [redacted] USAF
7OCT.03 1930	Pt A+O x3, VSS, OOB to ambulate, Ex Fix LUE in place, pin care done, radial pulses equal (B), pt unable to move fingers on (L) hand, pain controlled c percs + neurotin, voiding well, abd soft + flat nontender, incision on LUE appears healed, 2 pt restraint, o s/sx of poor circulation or skin breakdown. [redacted]
08OCT03 (1255)	Assumed care of pt @ 0600 & report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs/Neurontin. Pt amb well. OOB to BR for personal hygiene. Ex fix in place on LUE. ↓ ROM noted c LUE. Pin care done. Skin warm to touch. Incision to LUE CDI-open to air. Tol reg diet well. Voiding s difficulty. 2 point restraints in place s s/sx complications. Awaiting tx to Iraqi hospital. Will continue to monitor. [redacted] USAF
	(1330) Pt tx to Iraqi hosp in stable condition - ambulatory c meds for dlc. [redacted] USAF
	b(6)-2 All

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

ICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7 Sept 03	Brief Op Note & H&P
1107 pm	Reportedly struck in LUE c RPG. Unable
	to move (L) fingers or (L) UE
	Other noted injuries: (R) thigh shrapnel wound
	c ≈ 1x2cm not thigh wound. (-) FA
	(R) parietal/occipital c ≈ 3cm + 4cm lacs.
	Pre op Dx: 1) (L) humerus fx
	2) Large soft tissue defect to (L)
	medial bicep
	3) Neuro not intact - (+) sensory
	(-) motor
	Post op Dx: Above
	4) Transected (L) brachial artery
	5) Transected (L) ulnar nerve
	Surgeon: [redacted] b(6)-2
	EBL: ~??
	IVF's: see anesthesia
	Procedure: 1) Explore (L) UE c shunt of (L)
	brachial art. Dopplerable pulse, <2sec cap refill
	2) Ligation of basilic + cephalic vein
	3) Gross approx + marking of ulnar nerve c
	4-0 prolene
	4) Ex-fix for stabilization of (L) humerus
	5) Debridement + packing of (R) thigh

ITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE | RECORDS MAINTAINED AT

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

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

[redacted]

CHRON[redacted]

USAPA V2.00

MEDCOM - 18524 b(6)-2

ACLU-RDI 1647 p.84

DOD-032098

Ⓐ 7mm x 5mm possible GSW Ⓑ Ⓓ ant thigh
Ⓓ exit wound. minimal bleeding
Ⓐ GSW Ⓒ arm, 2 lacs/anal to Ⓚ posterior parietal,
possible GSW to Ⓛ ant thigh

Ⓟ 1000 mL LR IV Ⓛ Antibx @ 1823
1000 mL LR IV Ⓒ Antibx @ 1840
10mg Morphine Inj; Ⓒ Gluteal @ 1828
15 L/min O2 @ 1840 - d/c @ 1900
1000 mL LR IV Ⓛ Antibx @ 1903
Pt stable for transport to 125th FSB. b(6)-2
Bag #4 1000mL LR hung in
FLA @ 1925

[redacted]
2LT, SP, PA-C

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
07Sep03	(S) 23 y/o Iraqi male c̄ GSW to (L) arm. Pt presents to 1/2 ACR FAS one to one-half hour s/p incident. Ø LOC
Vitals	(+) pn @ 9 (1-10)

BP	P	R	O2	Time
18/62	150	29	97	18:20
0/60	130	28	96	18:33
8/70	113	24	100	18:42
MB				
1/50	118	28	100	18:57
30/70	127	25	99	19:12
4/60	113	24	99	19:22

PMH - Ø   PSH - Ø

Allergies - Ø   Meds - Ø

(O) WNWD Iraqi male Mod distress

A&O x 4

PERRLA

Lungs - CTA (B) Heart Tachy

↑ s̄ WCR Ø M/R

Abd - BS (+) x 6 [illegible] DP/PT pulses (B)

Ø blood @ opening of meatus Cap refill < 3 sec (B)

Rectal - Ø bleeding WNL N/V intact x (L) extremity

(+) GSW - entrance - (L) Deltoid 7mm x [illegible]

exit - medial arm

(+) 2 lac/avulsions on (R) post parietal region

- minimal bleeding

①2 in ②1 in

Over ↗

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: [redacted] first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) | REGISTER NO. | WARD NO.

[redacted]

b(6)-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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8 Sept 03	(Op note - ortho)
0400	Dx (L) III ° Humerus Fx
	Rx Revision Ex Fix
	Surgeon [redacted] b(6)-2
	GETA
	Plan re-check ° fluoro [redacted]
	~ 48°
8/9	OP Note b(6)-2
	Procedure: Washout (L) Arm
	Revision X Fix
	Surgeon [redacted] b(6)-2
	Fluid 3000 2u PRBC
	Findings - ∅ bleeding - ∅ hematoma
	To ICU, Ash
	[redacted] b(6)-2
	[redacted]
	# [redacted] b(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0600 8 Sep 03	Received Pt from OR accompanied by anesthesia & surgeon around 0440. Ø spontaneous movement. Versed & fent gtt started. Heparin gtt started @ 800 u/hr. D5LR not available at pharm. LR @ 125 going as substitute for now until order clarified. NGT inserted by anesthesia, 600 cc of clear, gastric drainage suctioned initially. ~~Placement~~ Placed on LIS. Currently, NGT clamped 2° to aspirin administration per NGT (325 mg). LUE pulse +2, cap refill <3sec, warm & dry fingers, pulse ox sensed from (L) middle finger c̄ good waveform. Pt's temp initially @ 93.6 blankets on & warming lamp on now @ 94.7, will continue to warm pt. Pt hypertensive initially in the 170's/90's, Bolused c̄ 8mg Versed & 100 mcg fent, currently BP in the 140's/70's, fent 100 mcg/hr, versed 10 mg/hr. Report given to CPT Rogski — b(6)-2 [redacted] CPT/AN
8 Sep 03 0833	Nursing: T-94.9, HR 107, R 14, Sats 100% on following vent settings: SIMV, TV 800, FiO2 50%, R 14, Peep 5, See ICU flow sheet for complete nursing assessment. ETT intact, airway patent. Heating lamp on, more blankets applied to pt. Strong pulses palpated in (L) radial. Skin warm to touch, cap refill <3 secs, (+) edema. Skin on (R) arm and BLE cool to touch. Pulses weak on palpation. (R) hand and feet wrapped in chux to ↑ warmth. (L) arm dressing (posterior portion) soaked in blood. Dr. Matsumoto notified (L) arm (Cont'd) b(6)-2 [redacted]

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

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

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

[redacted]

b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1
USAPA V2.00

MEDCOM - 18528

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8 Sep 03 0833	Nursing Cont'd: Dressing reinforced. Dressings to Ⓡthigh and Ⓛthigh c/d/I. Receiving LR @ 125 cc/hr, Fentanyl @ 100 mcg/hr, Versed ↓ 5 mg/hr, and Heparin @ 800 u/hr. Foley to gravity. Voiding >200 cc/hr. CBC, PTT, Chem 8, + ABG sent to lab. Results pending. Will continue to monitor. [redacted]
8 Sep 03 1004	Nursing: HR 140s, ABP 91/43, NBP 106/51. Dr. [redacted] notified of HR, BP, and lab results. Pt LR bolus @ 0940. Fio2 ↓ 40% and RR ↓ 12. Heparin ↓ 700 u/hr. [redacted] Pt assessed by Dr. [redacted]
8 Sep 03 1040	Nursing: Ⓛarm Dressing soaked in blood, blood pouring down chux. Dressing reinforced. Dr. [redacted] notified. ∅ new orders written. [redacted]
8 Sep 03 1115	Nursing: ABG drawn. pH - 7.376, pO2 - 207, HCO3 - 22, Sat - 100%, BE (-3). Pt waking up. Opens eyes spontaneously, lifts head from bed. Pt lifting Rarm towards ETT. Pt notified [redacted] 1124 of his location, condition, and purpose of ETT through interpreter. Pt continues to attempt to raise hand [redacted] towards his ETT. Soft-restraint applied to Ⓡwrist. [redacted]
8 Sep 03 1323	Nursing: HR 130-140s, UOP 20-28 cc/hr. Attempted to radio Dr. [redacted] ∅ response @ this time. Pt awake, writing simple words on paper for translator. ∅ respiratory distress noted. Versed Concentration Δ'd to 100 mg/50 ml = 2.5 cc for 5 mg Versed. [redacted]
8 Sep 03 1415	Nursing: UOP - 16 cc this hour. HR 156. Versed ↑ 7.5 mg/hr. BP 97/51. [redacted]

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MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry) b(6)-2
8 Sep 03 1435	Nursing: H/H - 8.9/26.9, PT/PTT - 14.5/46.3. Dr. [redacted] called on radio x 2. Pt awake, writing on paper that he wants ETT out. Restraint remains on (R) wrist. HR-140s, Sats 100%. b(6)-2 [redacted] SN/Stu
8 Sep 03 1520	Nursing: b(6)-2 Dr. [redacted] notified of VS, ↓ UOP, labs q [redacted] pt gesturing to have ETT pulled out. (L) UE dressing Δ'd by Dr. [redacted] (L) arm elevated on blanket. Pulse strong, skin warm to touch, ↑ movement. Pt tolerated procedure well. Versed and Fentanyl gtts weaned [redacted] off in preparation for extubation. [redacted] SN/Stu
8 Sep 03	PRBC VS b(6)-2

Time	HR	BP	T	R	Comments
1546	130	125/53	101.3	20	PRBC transfusion started
1550	149	143/39	—	17	—
1555	142	122/37	—	18	—
1600	144	138/50	101.6	21	↓ s/s of reaction
1615	158	129/36	—	19	—
1630	143	105/45		18	NG DC'd, Instructed
transfusion completed 1725	131	114/51	101.8	18	on I.S. use, Tolerating PO fluids

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE [redacted] MAINTAINED AT

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPO b(6)-2 [redacted] SN/Stu

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

[redacted]

b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 Sep 03 1610	Nursing: RT notified that pt ready for extubation. ETT D/C'd, mouth suctioned, airway clear and patent. Placed on 40% Venti Mask. HOB ↑ 45°. [redacted]
8 Sep 03 1650	Nursing: Sats 99% on Venti Mask. Pt placed on 2L NC. Sats 99%. No distress noted. Dr. [redacted] notified of fever. Incentive spirometer encouraged. [redacted]
8 Sep 03 1733	Nursing: 1st unit PRBC transfusion completed @ 1725 S/S of transfusion reaction. 2nd unit PRBC transfusion started @ 1733. Lasix 20 mg IV given @ 1730. Pt had emesis x 1. Will continue to monitor. [redacted]
8 Sep 03	PRBC Transfusion b(6)-2 All

Time	HR	BP	R	T	COMMENTS
1733	135	133/70	18	101.8	PRBC transfusion started
1737	131	126/43	21	—	—
1741	136	111/39	19	101.9	Ø S/S of transfusion Reacted
1745	134	114/51	18	—	—
1800	143	116/43	23	101.9	[redacted]
1815	141	116/43	26	—	
1830	137	122/68	21		
1845	131	110/53	19	100	
1900	138	119/63	21	100	Completed [redacted] 8 SEP 03

STANDARD FORM 600 (REV. 6-97) **BACK**
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9/12/03	Op Note
	Procedure: Adjust Ex Fix
	Nerve exploration
	Washout wound
	Surgeon [redacted] b(6)-2
	Anes GETA
	Fluids LR 1600 uop 850
	Findings: (1) Radial n. impingement on pin
	(2) median, ulnar nerve complete transection
	To ICU, stable
	[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
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MEDCOM - 18532

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
13 Sep 03	Pt Medicated ĉ 2 tabs Percocet For (L) Arm
1555	Pain Per PRN order. Will Monitor. [redacted] 9/WMC
1600	N/V check ĉ ø changes to status. [redacted] 9/WMC
1615-1700	Pt ↑ OOB Ambulated to BR For BM. Pt was Not able to have BM. While on toilet, bathed Pt + Changed his Pants. Pt then Ambutated back to bed + layed down ĉ Arm elevated. Pt Now Sleeping + appears to be resting Comfortably @ this time. VSS, temp ↓ to 99.9, will continue to Monitor. [redacted] 9/WMC
13 Sep 1830	Received report from SPC clinic @ 1800, Pt resting comfortably in bed (L) UE elevated, no sensation on (L) small finger, ring finger, & middle finger, unable to move all 5 (L) fingers. Pt's baseline per SPC clinic, ↑2 pulse (L) UE. warm & dry, cap refill <3secs on (L) UE. Pt ate 80% of dinner, [redacted] CPT/bm
2030	Medicated pt ō 5mg MSO4 for (L) UE pa[redacted]
2130	Pt C/O (L) UE pain, no relief from MSO4, medicated ō 2 tabs percocet. VSS will reassess for effectiven[redacted] CPT
2200	Pt state relief from pain, falling in & out of [redacted]. Pulses ↑2 (L) UE since 1800 will intinue to monito[r] pulse [redacted] CPT/bm
2300	ø c/o pain, no significant change on neuro-[redacted] (L) UE since last assessmt. [redacted] CPT/bm
0400	Labs drawn, Medicated pt ō 5mg MS[redacted] (L) UE pain ø significant change on neuro-vascular ✓ since last assessmt, VSS will monitor [redacted] CPT/bm
13 0600	Received report + assumed care of Pt. ø Report[redacted] change in N/V status + ø other Reported significant changes. Pt appears to be resting comfortably @ this time. Will assess + Monitor. [redacted] 9/6/06

b(6)-2 All

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13SEP05 0600	Received report & assumed care of Pt. VSS, Pt lying in bed looking around room & appears to be resting comfortable @ this time c Ø Ntd complaints or concerns Will assess & continue to Monitor. [redacted] 9/13/05
0800	Assessment Complete, IV Ancef Started. Pt lying in bed eating breakfast @ this time. VSS, Ø Ntd complaints. Will monitor. [redacted] 9/13/05
0801	N/V assessment done, Pulses Palpable to Radial & Pedal Pulses bilat @ +4 c brisk cap refill. Unable to lift (L) arm or Move any Fingers on (L) hand. Loss of Feeling to middle, ring, & PINKY Fingers, ~~sensation to~~ to (L) hand, sensation to Pointer Finger & thumb Present. NC All extremeties warm & dry to touch. [redacted] 9/13/05
0910	Pt Medicated c 5mg MSO4 for (L) arm pain Per PRN orders. [redacted] 9/13/05
1000	N/V check done c Ø changes to status. [redacted] 9/13/05
1115	Pt medicated c 2tabs Percocet for (L) Arm Pain per PRN order. Will Monitor. [redacted] 9/13/05
1200	N/V check done c Ø changes to status. [redacted] 9/13/05
1315	Pt Sitting up in bed eating lunch. Ø complaints or concerns Ntd @ this time. [redacted] 9/13/05
1400	N/V check done c Ø Ntd changes to status. [redacted] 9/13/05

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		ICU3

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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MEDICAL RECORD — AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE b(6)-2 ATTN

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14Sep03 0645	Pt Medicated c 2 tabs Percocet per PRN order for (L) arm pain. Will re-assess in 1°. [redacted] WMG
0700	Assessment complete to include detailed N/V check. Radial Pulse to LUE baseline @ +3 + [redacted] bilat LE baseline @ +3. Pt has sensation to Thumb + Pointer Finger of LUE c Ø sensation to Pinky, ring, + middle fingers of LUE. Pt Not able to move any LUE Fingers. Brisk cap refill to all extremeties. Will continue to monitor N/V status. [redacted] 9WMG
0730	Pt Finished c breakfast, ate about 60% of meal. Pt Lying in bed + appears to be resting comfortably @ this time. Will continue to monitor. [redacted] 9WMG
0800	N/V check done c Ø changes to status @ this time. VSS, temp ↓ to 98.4°. Pt sitting in bed c ØNtd complaints or concerns + appears to be resting comfortably. [redacted] 9WMG
1000	Pt Medicated c 5mg MSO4 for (L) arm Pain Per PRN order. N/V check done c Ø changes Ntd. Will monitor. [redacted] 9WMG
1030-1100	Pt Pre Medicated c 5mg MSO4 + 2mg Versed for LUE dressing Δ. Dressing Change Performed by DR's [redacted] + [redacted]. Old dressing removed, Kerlex Fluffs Applied + wrapped c Kerlex rolls. Splint then applied to arm. Pt tolerated well. [redacted] 9WMG
1210	Pt complaining of LUE Pain, Medicated c 2mg MSO4 + 2 tabs Percocet Per PRN orders. Will monitor. [redacted] 9WMG

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. ICU3

[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 USAPA V2.00

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14Sep03 1220	Re-elevated LUE following new splint placement for dressing change. [redacted] 9/WMG
Late Entry	1200 - N/V check done c̄ Ø changes to status. Will continue to monitor. [redacted] 9/WMG
1400	N/V check done c̄ Ø changes to status ntd. Pt was sleeping before assessment + appeared to be resting comfortably. Will continue to monitor. [redacted] 9/WMG
1600	N/V check done c̄ Ø ntd changes to status. Bilateral inner thigh dressings changed. Old dressings removed, sites wiped clean c̄ Normal [redacted] saline, ~~but~~ 4x4's applied + secured c̄ cloth tape. ~~Pt medicated~~ [redacted] 9/WMG
1645	Pt medicated c̄ 2 tabs Percocet for LUE [redacted] PRN orders. VSS, will continue to monitor. [redacted] 9/WMG
1800	N/V check done c̄ Ø ntd changes to status [redacted] 9/WMG
1805	Report given to nightshift. [redacted] 9/WMG
1806	Pt complaining of pain, medicated c̄ 3mg MSO4 per PRN order. [redacted] 9/WMG
1815	Received report from SPC [illegible] - Pt sleeping in bed. VSS. Will continue to monitor. [redacted] 9/[illegible]
2000	Pt sleeping in bed. Pt received [illegible] c̄ good effect. VSS. Will continue to monitor. [redacted] 9/[illegible]
2200	Pt resting in bed. 3mg MSO4 [illegible] will continue to monitor. [redacted] 9/[illegible]
15Sep03	0200 Pt resting in bed. VSS, Ø BM this shift. Urine QS to foley. Neuro check [illegible] [redacted] [illegible]
0600	Received report + care of pt. from previous N[redacted] Pt awake in bed. [redacted]

b(6)-2 All

MEDCOM - 18536

NSN 7540-00-634-4176

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MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22SEP03 0800	1317. Assumed care of Pt. @ 0800. Assessment completed. VSS. AO PERRLA Lungs CTA(B) Resp. even-unlabored, NSR, IV(L) wrist C redness. IV DC'd. New IV c heplock started to (L) FA. CDI 18G. Pt. Ambulated to latrine. Performed am care c no c/o pain. Abd soft, non-tender BS x4. (L) UE dsng Δd. Pin care performed. Incision to (L) wrist to (L) armpit. Sutures intact (-) S/S of infection. Cap refill < 3secs (+) radial + pedal pulses. Dsng Δ to (L) + (R) thighs c (-) S/S inf. staples intact. Voiding per urinal. Tolerating PO well. no complaints of pain @ this time. Will cont c to monitor pt. b(6)-2
22sep03 1930	Assumed care @ 1800; All VSS, Pt A&OX3, NVV done. (+) sensation in thumb & pointer finger; (-) sensation in remaining digits; (+) movement in (L) arm & hand. Pt states he has sensation from his wrist up through his arm; pt OOB to amb in hall X1 for 30 min; cont c NVV q2°, 0 c/o pain/discomfort @ this time; IS was encouraged; (L) arm ↑; pin care completed; dsg to (L) arm & bilat. thighs CDI c drainage; all sutures intact, (-) drainage, well approximated; restraints in place, (+) circulation, (-) skin breakdown, cont to monitor b(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	REG [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.)*

REGISTER NO.	WARD NO.

[redacted]

b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 8-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 18537

510-112

MEDICAL RECORD

NSN 7540-00-634-412

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8 Sep 03		2300	Pt taken to x-Ray for QUE, drsg reinforced, Dr [redacted] made aware of Pt Temp 102.3 & ordered Tylenol 650mg pm fever >101, given Temp 100.7. Will [redacted] to monitor. [redacted] 9/8/03
9 Sep 03	0030		At NPO p midnight, Temp 100.1. Cont c 2hr neuro check to QLE, pt c @ pulse & warm extremity c cap refill <3 sec. Will cont to monitor. [redacted] 9/9/03

b(6)-2 A11

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

[redacted] b(6)-4

MEDCOM - 18538

STANDARD FORM 510 (REV. 7-91)

"Ahmed

FORWARD SURGICAL TEAM
PATIENT RECORD

DTG IN: 2010*

NAME: Iraqi National - Indur snp TO OR:

SSN: UNIT:

WT LBS: 175 WT KG:

ALLERGIES: NKDA

TIME	IV	SZ	SITE
	1		Brought in Field (L) arm
2015	2	16	(L) hand
	3		
	4		

LITERS OF FLUID IN: 2nd Bag ↑ 2015 (w/r 1 - Bag 5 total (LR)
Bag 6 - 2030, ↑ 2040

UNITS OF BLOOD IN: #1 ↑ 2040

TIME	MED & DOSE	INIT.
2010	Ancef 1gm	
2025	Fentanyl 50	

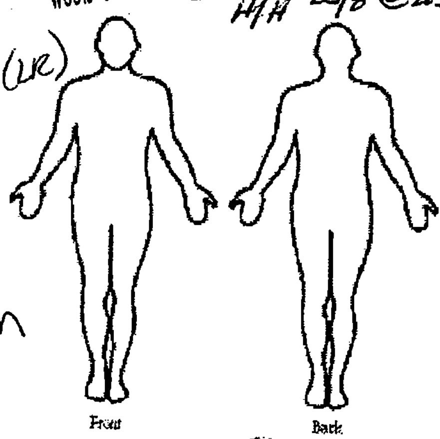
TIME	INTERVENTION
2015	OXYGEN ON & RATE: 6 via FM
	ETT SIZE:
	SURG. AIRWAY
	CT #1 & SITE:
	CT #2 & SITE:
2055	FOLEY 16F
	GASTRIC

TIME OF INJURY:

DETAILS OF INJURY EVENT: Shot when firing @ troops

GCS PRIOR TO ARRIVIAL=

W0018 03 082934 (N) (Vasopressors) H/H 23/8 @ 2030



4633858 #2

AIRWAY: Patent — PATENT / (ETT) / ORAL NASAL — FM @ 6 lpm → intub. in OR

CHEST: clean

RIGHT BS= LEFT BS=

NEURO: Alert GCS=

HEAD, FACE, & NECK: laceration (2) down to skull approx 1" long

ABDOMEN: clean

PELVIS: clean

UPPER LEGS: GSW RT thigh - no exit wound

LOWER LEGS: clean

ARMS: (L) arm - Drsg ↑ (L) arm / Sam radial splint; (L) Deltoid ½ inch exit - Ronial - R/O fx humerus

POSTERIOR: clean

ANESTHESIA / OR

TIMES	
IN:	2100
INCISION:	2115
PROC. END:	2345
TO ACW:	2353
ANESTESIA TECH.	
MAC:	
REGIONAL:	
(GENERAL)	RSI c cricoid

MEDICATIONS:
- MIDAZOAM
- PENTOTHAL
- (ETOMIDATE) 20mg
- (FENTANYL) 250mcg
- MSO4
- SUCCINYL.
- (ROCURONIUM) 150mg
- VECURONIUM
- (AGENTS) Forane

ANTIBIOTIC: see preop

REVERSAL:

OTHER: Albumin 50cc, Scopolamine 6.4

FLUID TOTALS	
CRYSTAL:	7000
COLLOID:	Alb 500 / Alb 50
EBV:	
EBL:	
U.O.:	400
DRAINS:	
1½ LR	
#6, #7, 8	

VITAL SIGNS			PACU
TIME:	2110	2345	
BP:	92/40	116/57	
HR:	86	94	
RR:	10	10	
SpO2:	100	101	
TEMP:	97		

PROCED: SHUNT TO (L) ARM; EXFIX (L) ARM

RECOVERY

TIME IN: | O2 VIA & RATE:

SURGEON(S):

PROCEURE:

DRESSINGS:

TUBES:

DRAINS:

IV SITE RE-EVALUATION

IV	SZ	SITE	RATE	AMT IN BAG

POST-ANESTHESIA RECOVERY SCORE

ADMIT=	
30 MIN=	
D/C=	

POST-OP MEDICATIONS

TIME	MED & DOSE	ROUTE

VITAL SIGNS

	ADMIT	D/C
BP:		
HR:		
RR:		
SpO2		
TEMP:		

CUMULATIVE I & O

INTAKE SOURCE	INTAKE AMT	OUTPUT SOURCE	OUTPUT AMT
TOTAL=		TOTAL=	

Doppel radial Pulse p OR.

MEDCOM - 18539

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: 23

HEIGHT:

WEIGHT: 175 lbs.

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

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

4. PROPOSED SURGICAL PROCEDURE: Revision of Ex Fix Brachial artery Repair S/P GSW Emergency Case
Intubated
Foley Cath

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

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

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

EPW [redacted]
blw-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since ? ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: NO

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.0

MEDCOM - 18540

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

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

[redacted] 8 Sept 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] IT/AN
DATE: 8 Sep 03 TIME: 0030 blwr

13. POSTOPERATIVE EVALUATION PREPARED BY [redacted]
DATE: 8 Sept TIME: 0430

REVERSE OF FORM 5179, JUN 91 MEDCOM - 18541 USAPA V1.0

MEDICAL RECORD	INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

2. PATIENT IDENTIFIED, R[redacted] OCEDURE
VERIFIED BY CPT [redacted]

3. DATE 12 Sept 03
TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM
TIME 0815 b(6)-2 NUMBER 2-2 (1)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:
NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	LTC [redacted] 040-1110 b(6)-2

7. POSITION AND POSITIONAL AIDS (Specify) armboard used

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

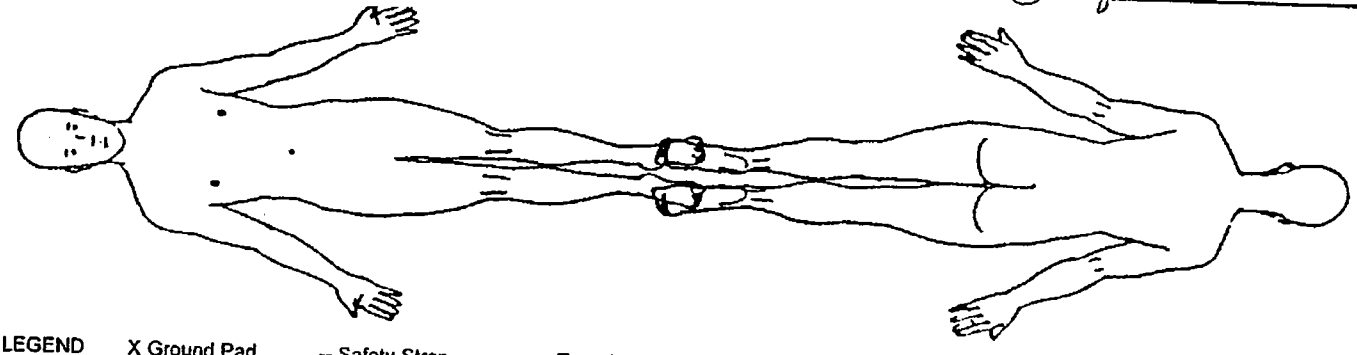
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betad/Beta
SITE: (L) arm BY WHOM: CPT [redacted]
SITE: BY WHOM:
COMMENTS: no pooling of prep noted

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

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

b(6)-2

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

[redacted] b(6)-4

12 Sep 03 [redacted] b(2)-2

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO
CUT 20 COAG 150

☒ ESU NO: Valleylab
GROUND PAD: BRAND Valleylab E7507
LOT NO: 69670J

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FO[redacted] BSOLETE. MEDCOM - 18542 USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO; TYPE(S):
0.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)*

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
- fluffs
- Kerlix
- ace wraps.

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: [redacted] Maj. CRNA Anesthesia Type:

Bovie Pad site intact pre-op_____; post-op_____ Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op_____; post-op_____
Tourniquet Time: Up____ Down____ NA b(6)-2 All
DA5179 In Chart

20. OPERATION(S) PERFORMED
I&D (L) arm., Wound Exploration, adjust ex-fix (L) arm.

21. PATIENT TRANSFERRED TO ICU3 TIME 230 METHOD [redacted]

22. REGIST[redacted] CPT/AN [redacted] LTC, AN

REVER[redacted] USAPA V1.01

MEDCOM - 18543

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Wheeled litter BY Anesthesia

2. PATIENT IDENTIFIED [redacted] AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2

3. DATE 09SEP03 TIME PATIENT ARRIVED IN SUITE 0810

4. PATIENT IN ROOM TIME 0810 NUMBER 2/1/1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt on padded OR bed, head on foam doughnut, Bilateral Arms extended out to sides x 90°. RUE secured to padded armboard @ safety strap. LUE prepped into Sterile field + placed on padded double armboards. folded towels under heels. Correct Body Alignment maintained

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

COMMENTS:

8. SKIN PREPARATION

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

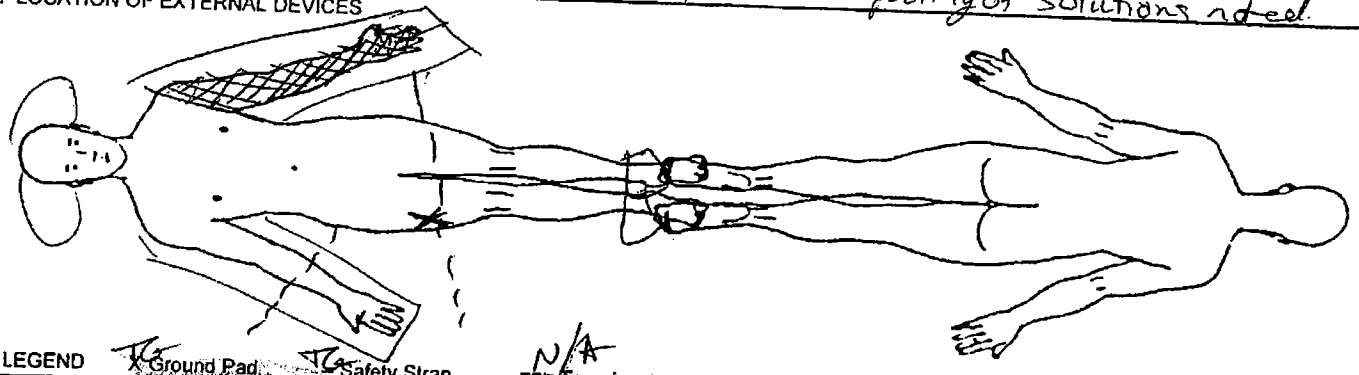
COMMENTS:

PREP SOLUTION (Specify) Betg/Beta SITE: LUE BY WHOM: CPT [redacted]

SITE: BY WHOM: MAJ [redacted]

COMMENTS: no pooling of solutions noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND ☒ Ground Pad ☒ Safety Strap N/A Tourniquet

C = Correct I = Incorrect b(6)-2

10. COUNTS		Initial Count Other	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No	C		C
Needle Sharp	☒ Yes ☐ No	C		
Instrument	☐ Yes ☒ No			
Other	☐ Yes ☒ No			

SCRUB	CIRCULATOR
SPC [redacted]	CPT [redacted]

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

[redacted] b(6)-4

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

☒ ESU NO: R8E 105305

GROUND PAD: BRAND Valleylab Polyhesive II REM

LOT NO: 68936/2005-03

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST) [illegible] OBSOLETE. USAPA V1.01

MEDCOM - 18544

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

just previous exfix remains.

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

QS. 0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ fluoro via C-Arm IF YES, SITE (L) UE

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

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

18. DRESSING/IMMOBILIZATION *(Specify)*

KERLEX Fluffs
KERLEX Rolls
Xeroform Gauze

19. ADDITIONAL INFORMATION

WC-III

Surgeons: Dr [redacted] Anesthesia: MAJ [redacted] CRNA Anesthesia Type: GEN LMA

Dr [redacted]

Dr [redacted] b6-2

Bovie Pad site intact pre-op CDI; post-op CDI Bovie Settings: Coag/Cut 40/40 Blend 1

Tourniquet Site intact pre-op N/A post-op______

Tourniquet Time: Up N/A Down_____

20. OPERATION(S) PERFORMED

washout LUE + ExFix adjustment

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 1	0940	wheeled litter

22. REG[redacted] ...OT/An

REVERS[redacted] b(6)-2 MEDCOM - 18545 USAPA V1.01

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia
2. PATIENT IDENTIFIED VERIFIED BY LT [redacted] AND PROCEDURE b(6)-2
3. DATE 8 Sep 03 TIME PATIENT ARRIVED IN SUITE
4. PATIENT IN ROOM TIME 0114 NUMBER 2-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA Emergency Case S/P GSW EPW intubated Patent Foley cath 16 Fr.

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

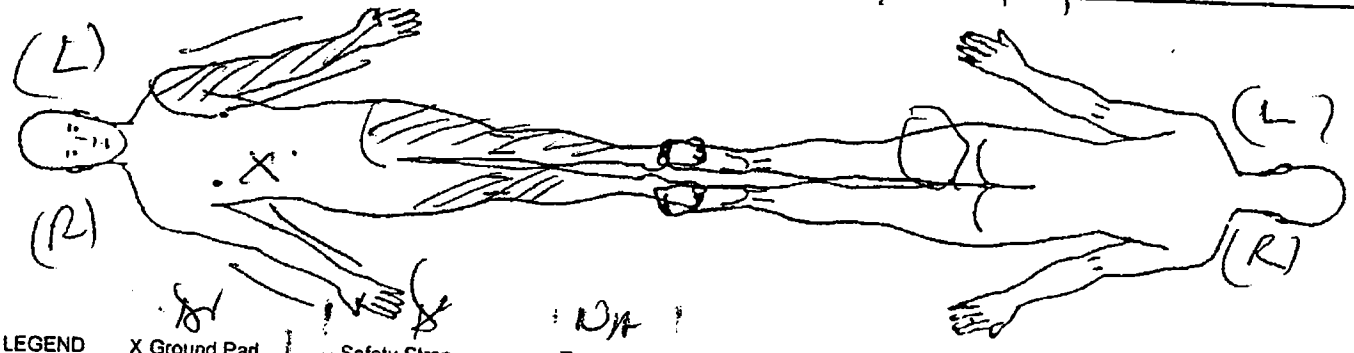
COMMENTS: Pt placed on OR bed. Arms on arm boards <90° Safety strap across chest. All pts. Bump under (L) hip. Intubated.

8. SKIN PREPARATION

HAIR REMOVAL ☑ YES ☐ NO
DONE BY: ☑ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☑ RAZOR ☐ CLIP
COMMENTS: ϕ cuts or nicks noted

PREP SOLUTION (Specify) Betadine b(6)-2
SITE: (L) leg (Foley) BY WHOM: [redacted]
SITE: (L) arm
COMMENTS: ϕ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad | – Safety Strap === Tourniquet

Initial:

10. COUNTS		Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No		C	C
Needle Sharp	☒ Yes ☐ No			
Instrument	☐ Yes ☒ No			
Other	☐ Yes ☒ No			

C = Correct I = Incorrect

SCRUB	CIRCULATOR
b(6)-2 [redacted] SPC	[redacted] MAJ

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

EPW # [redacted] b(6)-4

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

☒ ESU NO: Valleylab 40 RS6 102395
GROUND PAD: BRAND Valley Rem
LOT NO: 68245 2005/02

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST) WHICH IS OBSOLETE. MEDCOM - 18546 USAPA V1.01

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

b(6)-2

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Heparin c NaCl (10000u/1000ml)	QS	intraop	Injection	[redacted]	Dr [redacted]

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

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted]		

PHYSI[redacted] b(6)-2

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

	1.	2.	3.
TYPE/SIZE	Foley 16Fr	½ Penrose	
SITE	(Bladder)	(R) leg	

18. DRESSING/IMMOBILIZATION *(Specify)*
ARM (L) fluff Kerlix ABD's ACE
(L) Leg TEFA 4x8 TAPE

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

Bovie Pad site intact pre-op ✓ ; post-op ✓ Bovie Settings: Coag/Cut 40/40
Tourniquet Site intact pre-op N/A post-op N/A
Tourniquet Time: Up N/A Down N/A

DA5179 Initiated

20. OPERATION(S) PERFORMED
External fix adjustment (L) arm / Brachial artery repair vein graft
I&D (R) leg

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	0425	Litter c O2

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

511-119

MEDICAL RECORD

VITAL SIGNS RECORD

NSN 7540-00-634-4124

HOSPITAL DAY								
POST- DAY								
MONTH-YEAR / DAY	19 Sep 03	20	21	21	22 Sept	22 Sept	23 Sept 03	
19 / HOUR			0830	1800	0910	1812		

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE	132/71	113/61, 119/68	138/64	134/67	126/71	106/64	125/66	134/64
			P 92		P 82	99	T 97.9	
HEIGHT: / WEIGHT →			T 98.2 99.4		98% RA		H 86	
			R 18		T-98.1	99.4		
	98% RA	97%	98% RA	98.1°	R-16	98.5°	98%	98% RA
		99% RA						

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 18548

104

MEDICAL RECORD | **EMERGENCY CARE AND TREATMENT** *(Patient)*

7540-01-075-371

LOG NUMBER [redacted]

RECORDS MAINTAINED AT b(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY

STATE | ZIP CODE

ARRIVAL
DATE (Day, Month, Year) 7 Sept 03 | TIME 2345

TRANSPORTATION TO FACILITY Air evac

SEX ♂

DUTY/LOCAL PHONE — AREA CODE | NUMBER

AGE 23

HOME PHONE — AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			
MEDICAL HISTORY OBTAINED FROM			

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS
unknown

ALLERGIES
unknown

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT
DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS
DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT
GSW rt upper leg / GSW Lt upper arm

CATEGORY OF TREATMENT
☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	0350	2355	0001		
BP	152/88		158/80		
PULSE	151				
RESP	~~28~~ 12	100	85		
TEMP		12	12		
WT					

LAB ORDERS
CBC/DIFF (circled) | ABG | PT/PTT
URINE C&S | UA (circled) MSCC/CATH | BHCG/URINE/BLOOD/QUANT
BLOOD C&S X | CHEM: [illegible]
Type Screen

X-RAY ORDERS
CXR PA & LAT/PORTABLE (circled) | C-SPINE
ACUTE ABDOMEN | LS SPINE
SINUS | HEAD CT
ANKLE R/L | [illegible]
Skull

☒ PULSE OX 100%

ORDERS

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
[illegible]	10mg vec		Vecuronium [illegible]		
[illegible]	5mg morphine 2350		MSO4 5[illegible]		
55	[illegible] Gentamycin 0005			[illegible] 0005	
	Ancef 1g IV 0005				

☐ MONITOR ☐ ECG

DISPOSITION
☐ HOME ☐ FULL DUTY
MODIFIED DUTY UNTIL
DISPOSITION QUARTERS /OFF DUTY ☐ 24 HRS. ☐ 48 HRS. ☐ 72 HRS
RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE
☐ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record
STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
(41 CFR) 101-11.203(b)(10)

MEDCOM - 18549

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

Upon arrival pt intubated, foley catheter in place. Ring given to PAD
soft tissue Rt thigh, GSW Lt upper arm.

? Age reported 23 y/o ♂ s/p GSW to arm @ ~1700 last night, seen by [illegible] team, ORIF
c ext fix Ⓛ humerus. (Injury c/w [illegible]) ⊕Ⓛ brachial plexus?/vessel repair done
(see note)

O: Intubated: Head ⊕ 2cm lac Ⓡ post occ/parietal to galea, ∅ active bleed/stepoff
Chest: CTA Ⓑ = c̄ vent CVS nml ∅ m/r/g HR 100 on monitor Abd: ∅ [illegible] soft ∅ [illegible]
Ext: ex fix in place Ⓛ humerus ∅ active bleed/⊕ pulses = Ⓑ
Back:
Pelvis stable

A/P Ⓛ s/p GSW/post op, pt stable, begin to wake for [illegible], purposeful
given [illegible]/Vec. Eval by Surg/Ortho ⟶ [illegible]

CONSULT WITH	TIME	ACTION
Surg		
Orth		

RESIDENT/MEDICAL STUDENT SIGNATURE [redacted] STAMP

PROVIDER SIGNA[redacted]

DIAGNOSIS

CODES b(6)-2

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

[redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 553 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)

MEDCOM - 18550

038

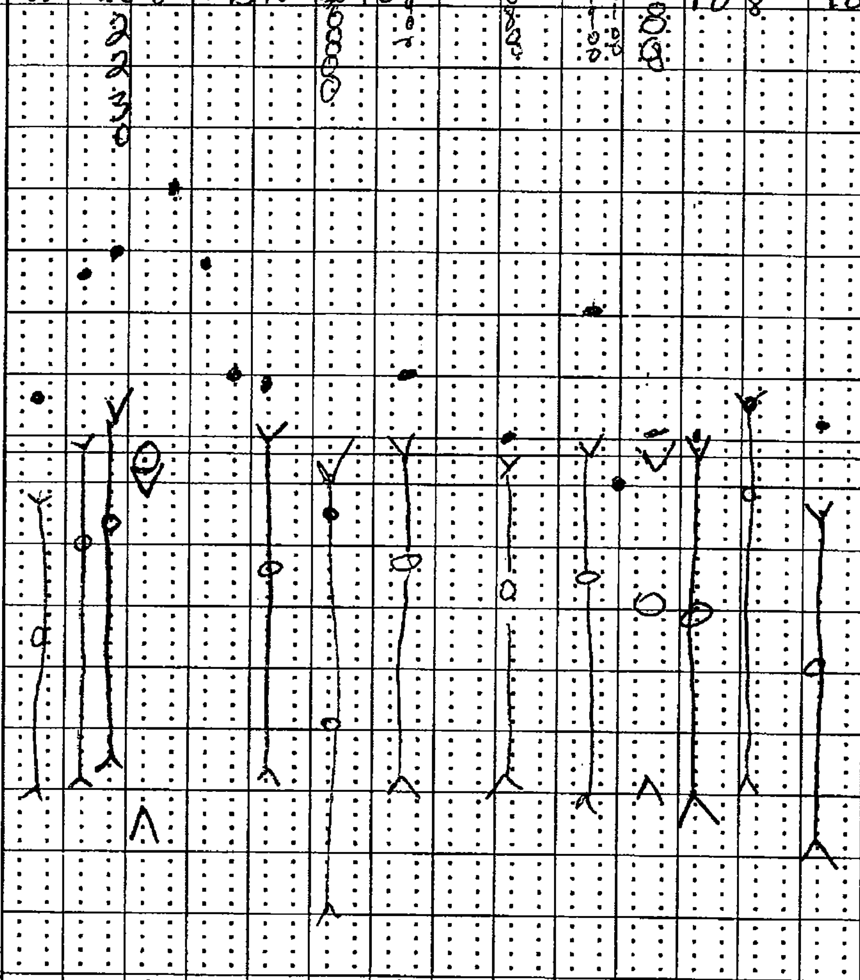
MEDICAL RECORD | VITAL SIGNS RECORD

HOSPITAL DAY							
POST- DAY							
MONTH-YEAR Sep 2003 / DAY	24 Sep	25 Sept	25 Sept	26 Sept	27 Sept	28 Sep	29 Sep 03
HOUR	0630, 1520	0800, 13	1400, 2350	0	0, 1	0, 18	8, 18

PULSE (O) / TEMP. F (•): 180 / 104°, 170 / 103°, 160 / 102°, 150 / 101°, 140 / 100°, 130 / 99° 98.6°, 120 / 98°, 110 / 97°, 100 / 96°, 90 / 95°, 80, 70, 60, 50, 40; 105°

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

(Centigrade Equivalents, for Reference only)



RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE	117/70, 128/71, 125, 118/67	130/73, 106	126/72	127/70, 123/70	127/70, 133/73, 115/63
	95, 110, 102.8				99, 92
	T 99, 101.0				99, 99
HEIGHT: / WEIGHT →	98%, 99%, 95%	97%, 99%	98% RA	97%, 98% RA	97%, 100%, 97% (RA), 98%
	12 RA				
	135/76, 114, 98.1, 102°				

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

REGISTER NO.

WARD NO.

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

#[redacted]

b(6)-4

MEDCOM - 18551

ACLU-RDI 1647 p.111

DOD-032125

511-119

MEDICAL RECORD

VITAL SIGNS RECORD

NSN 7540-00-634-4124

HOSPITAL DAY			
POST- DAY			
MONTH-YEAR OCT ~~19~~2003 — DAY	070903		080903
HOUR	08	20	08

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD	18	12/68	18
BLOOD PRESSURE	125/67	81 / 97⁸	119/49
HEIGHT: / WEIGHT →			
O2 Sat	98 (RA)	98%	99 (RA)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 18552

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (°)

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

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

TEMP. C

40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted]

D16)-4

MEDCOM - 18553

Icu #1

28TH COMBAT SUPPORT HOSPITAL VENTILATOR FLOW SHEET

Pt [redacted] b(6)-1
Size 7.5cm
24cm @ lip

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS	INT
8Sep03	0433	SIMV	14	750	50	5	23	14	80	100%	61/89								
	554	SIMV	14	750	50	5	22	14	89	100	148/90								
	08K	SIMV	14	750	50	5	24	14	95	100									
	1020	SIMV	↓12	750	↓40	5	24	12	136	100	69/36								
	1200	SIMV	12	9800	40	5	24	24	1-18	100	97/51								
	1400	SIMV		800	40	5	30	28	162	100									
			EXT,			1600													

b6-2

[redacted] b(6)-2

ICU #1

28TH COMBAT SUPPORT HOSPITAL VENTILATOR FLOW SHEET

(L) lower ext. 8.0 ETT 23 @ lip

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
8 Oct 03	0545	SIMV	10	900	40%	5	28	0	93	100	139/71							
	0800	SIMV	10	900	40	5	24	10	99	100	[illegible]/80							JDK
	1000	SIMV	10	900	40	5	26	10	101	100	157/83							RRR
	1200	SIMV	10	900	40	5	24	10	106	100	[illegible]/87							RRR
	1400	SIMV	10	900	40	5	22	10	103	100	164/85							RRR
	1559	SIMV	10	900	40	5	25	10	114	100	144/71							RRR
	1841	SIMV	10	900	40	5	23	10	109	100	180/81							oaa
	2010	SIMV	10	900	40	5	32	10	125	100	156/86							2025 CT A only
	2200	SIMV	14	900	40	5	29	14	130	100	154/83							
9 Oct	0002	SIMV	14	900	40	5	29	14	117	100	157/82							
	0200	evaced to Germany																JDK JDK

MEDCOM - 18555

Ward/Section:	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, M: # [redacted] b(6)-4	DATE	TIME	SSN/PSEUDO SSN:

i-STAT

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Methyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted]	DATE: 9Sep03	LAB ID NO.:

b(6)-2

Ward/Section: ICU-1	REQUESTING PHYSICIAN: [redacted] ICU-2		LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] ICU-24	DATE 9 Sep 03	TIME 0920	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b(6)-4	DATE [redacted] TIME 0032	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color	Yellow	N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App	HZY	N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu	NEG	Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili	NEG	Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket	NEG	Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG	1.020	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	IRG	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	6.0	N/A	Micro Parasites		
Segs		Mono	Prot	TR	Negative	Malaria		
Bands		Eos	Urob	0.2	0.2-1.0	O & P		
Lymph		Baso	Nit	NEG	Negative	Other		
Atyp		Imm	Leuk	NEG	Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

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

REMARKS:

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

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 8 Sept 03	TIME 0010
		SSN/PSEUDO SSN: [redacted] b(6)-4

i-STAT

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

Misc. Chemistry (CK)

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Methyte 8

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

(Piccolo) Metab[illegible] Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

i-STAT G3+

Pt: [redacted] b(6)-4

Pt Name:_____

TCO2_____23 mmol/L

At 37C

PH_____7.422

PCO2_____33.5 mmHg

PO2_____284 mmHg

HCO3_____22 mmol/L

BEecf_____-3 mmol/L

sO2*_____100 %

*calculated

At Patient Temp

PH_____7.456

PCO2_____30.3 mmHg

PO2_____273 mmHg

Patient Temp: 94.5F

FIO2_____: 50

Sample Type_: ART

08SEP03 07:17

Oper: [redacted]

Physician:_____

Ser# 42015

Ver: JAMS046A
CLEW A93

i-STAT G3+

Pt: [redacted]

Pt Name:_____

TCO2_____18 mmol/L

At 37C

PH_____7.483

PCO2_____23.4 mmHg

PO2_____136 mmHg

HCO3_____18 mmol/L

BEecf_____-6 mmol/L

sO2*_____99 %

*calculated

At Patient Temp

PH_____7.461

PCO2_____23.6 mmHg

PO2_____137 mmHg

Patient Temp: 98.9F

FIO2_____: 80

Sample Type_:

05SEP03 04:32

Oper: [redacted] b(6)-2

Physician:_____

Ser# 42011

Ver: JAMS046A

i-STAT EG7+

Pt: 0 [redacted]

Pt Name:_____

Na_____142 mmol/L

K_____3.7 mmol/L

TCO2_____21 mmol/L

iCa_____1.28 mmol/L

Hct_____23 %PCV

Hb*_____8 g/dL

*via Hct

At 37C

PH_____7.089

PCO2_____63.8 mmHg

PO2_____25 mmHg

HCO3_____19 mmol/L

BEecf_____-11 mmol/L

sO2*_____27 %

*calculated

Sample Type_:

10MAR03 [illegible]

Oper: [redacted]

Physician:_____

Ser [illegible]

i-STAT G3+

Pt: [redacted] b(6)-4

Pt Name:_____

TCO2_____22 mmol/L

At 37C

PH_____7.300

PCO2_____41.8 mmHg

PO2_____310 mmHg

HCO3_____21 mmol/L

BEecf_____-6 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

08SEP03 03:01

Oper: [redacted] b(6)-2

Physician:_____

Ser# 42011

Ver: JAMS046A
CLEW A93

i-STAT G3+ RR12

Pt: [redacted] b(6)-4 FIO 100%

Pt Name:_____

TCO2_____24 mmol/L

At 37C

PH_____7.293

PCO2_____46.0 mmHg

PO2_____463 mmHg

HC[illegible]_____22 mmol/L

BEecf_____-4 mmol/L

sO2*_____100 %

*calculated

FIO2_____: 100

Sample Type_: ART

08SEP03 00:24

Oper: [redacted] b(6)-2

Physician:_____

Ser# 42011

Ver: JAMS046A
CLEW A93

[illegible]

Pt Name:_____

[illegible] 23 mmol/L

[illegible] 7.376

[illegible] 37.6 mmHg

[illegible] 297 mmHg

[illegible] 22 mmol/L

[illegible] -3 mmol/L

[illegible] 100 %

[illegible] calculated

[illegible] Patient Temp

[illegible] 7.380

[illegible] 37.2 mmHg

[illegible] 295 mmHg

Temp: 98.1F

[illegible] 40

Type_: ART

08SEP03 10:53

Oper: [redacted]

Physician:_____

Ser# 42015

Pt: [redacted] b(6)-4

Pt Name:_____

Na_____137 mmol/L

K_____3.8 mmol/L

TCO2_____28 mmol/L

iCa_____1.15 mmol/L

Hct_____21 %PCV

Hb*_____7 g/dL

*via Hct

At 37C

PH_____7.312

PCO2_____53.2 mmHg

PO2_____545 mmHg

HCO3_____27 mmol/L

BEecf_____1 mmol/L

sO2*_____100 %

*calculated

Sample Type_:

09SEP03 09:09

Oper: [redacted] b(6)-2

Physician:_____

Ser# 42011

Ver: JAMS046A
CLEW A93

STANDARD FORM 545 (rev. 10-75)
545-108

LABORATORY REPORT DISPLAY

[redacted] PICCOLO [redacted]
08/09/03 00:34
REFERENCE RANGE: MALE
PATIENT #: 0723
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: 0000100676

GLU	119*	73-118	MG/DL
BUN	12	7-22	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
CK	2817*	39-380	U/L
NA+	136	128-145	MMOL
K+	5.9*	3.3-4.7	MMOL
CL-	105	98-108	MMOL
tCO2	20	18-33	MMOL

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

[redacted] PICCOLO [redacted]
08/09/03 00:34
REFERENCE RANGE: MALE
PATIENT #: 0723
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: 0000100684

ALB	3.4	3.3-5.5	G/DL
ALP	41	26-84	U/L
ALT	36	10-47	U/L
AMY	463*	14-97	U/L
AST	57*	11-38	U/L
TBIL	1.4	0.2-1.6	MG/DL
BUN	12	7-22	MG/DL
CA++	7.7*	8.0-10.3	MG/DL
CHOL	59*	100-200	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
GLU	125*	73-118	MG/DL
TP	5.4*	6.4-8.1	G/DL

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

REMOVE PROTECTIVE STRIP—PLACE TOP OF 3D REPORT HERE AND SUCCEEDING ONES ON LINES TO THE RIGHT

PRESSURE MUST BE APPLIED TO ATTACH LABORATORY REPORTS

① ② ③ ④ ⑤ ⑥ ⑦

ALIGN ALL LABORATORY REPORTS ALONG THIS BASE LINE

INSTRUCTIONS: This form may be used to display laboratory reports as a flow sheet to be read as a progressive table. If so, a separate sheet should be used for each type of report form. When assorted report forms are mounted on the display sheet, both test names and results should always be visible.

ENTER IN SPACE BELOW: PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

[redacted]

b(2)-4

FORMS DISPLAYED ON THIS SHEET ARE *(Check one)*

MOUNTED ON STRIPS 1 THROUGH 7

- [X] CHEMISTRY I (SF 546)
- [ ] CHEMISTRY II (SF 547)
- [ ] CHEMISTRY III (SF 548)
- [X] HEMATOLOGY (SF 549)
- [ ] URINALYSIS (SF 550)
- [ ] SEROLOGY (SF 551)
- [ ] SPINAL FLUID (SF 555)

MOUNTED ON STRIPS 1, 3, 5, AND 7

- [ ] PARASITOLOGY (SF 552)
- [ ] IMMUNOHEMATOLOGY (SF 556)
- [ ] ASSORTED FORMS
- [ ] OTHER *(Specify)*

MOUNTED ON STRIPS 1, 4, AND 7

- [ ] MICROBIOLOGY I (SF 553)
- [ ] MICROBIOLOGY II (SF 554)
- [ ] MISCELLANEOUS (SF 557)
- [ ] ASSORTED FORMS

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LABORATORY REPORT DISPLAY

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MEDCOM - 18561

HEMATOLOGY — STANDARD FORM 549 (Rev. 7-78) — 549-107

TEST(S)

SPECIMEN TAKEN

DATE: 9 Sep 03 — TIME: [illegible] A.M. / P.M.

RESULTS	REQUESTED	(X)
	RBC COUNT	
	HEMOGLOBIN	
	HEMATOCRIT	
	MCV	
	MCH	
	MCHC	
	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH — IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
less than adequate	PLATELETS	
	RBC	
	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PT — CONTROL	
	PT — PATIENT	
	PTT — CONTROL	
	PTT — PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS: CBC/PT/PTT

[redacted] b(6)-2

REQUESTING PHYSICIAN'S SIGNATURE

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

[redacted] b(6)-4

ICU#1

REPORTED BY — TECH — MD — DATE: 9 Sep 03

LAB. ID. NO.

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

PATIENT STATUS: ☐ BED ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ VEIN ☐ OTHER (Specify) ☐ CAP

SPECIMEN

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

549-107

HEMATOLOGY — STANDARD FORM 549 (Rev. 7-78) — 549-107

TEST(S)

SPECIMEN TAKEN

DATE: 9 Sep 2003 — TIME: 1800 A.M. / P.M.

RESULTS	REQUESTED	(X)
	RBC COUNT	
	HEMOGLOBIN	
	HEMATOCRIT	
	MCV	
	MCH	
	MCHC	
	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH — IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PT — CONTROL	
	PT — PATIENT	
	PTT — CONTROL	
	PTT — PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS: CBC

Dr [redacted] b(6)-2

REQUESTING PHYSICIAN'S SIGNATURE

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

[redacted] b(6)-4

REPORTED BY — TECH — MD — DATE

LAB. ID. NO.

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

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

SPECIMEN SOURCE: ☐ VEIN ☐ OTHER (Specify) ☐ CAP

SPECIM. NO.

PATIENT'S MED. RECORD

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

549-107

[redacted] b(6)-4

CHEM I

SPECIMEN

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

PATIENT STATUS: ☐ BED ☐ AM. ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

LABORATORY FILE

ICU#1

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

PICCOLO 04:44
09/09/03
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 0000100C94

C	126*	73-118	MG/DL
E	16	7-22	MG/DL
C	1.6*	0.6-1.2	MG/DL
C	488C*	39-380	U/L
A	128	128-145	MMOL/L
K	3.8	3.3-4.7	MMOL/L
C	105	98-108	MMOL/L
t	21	18-33	MMOL/L

I QC: OK CHEM QC: OK
HEM 0, LIP 0, ICT 0

MEDCOM - 18562

ACLU-RDI 1647 p.122

DOD-032136

#[redacted] b(a)-4

ICU#1

HEMATOLOGY

SPEC NO.

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

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

LABORATORY FILE

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

REQUESTING PHYSICIAN'S SIGNATURE: [redacted] b(a)-2

REPORTED BY — MD — DATE — TECH 10Sep03 — LAB. ID. NO.

CBC

TEST(S)	SPECIMEN TAKEN	DATE	TIME	A.M. / P.M.	REQUESTED (X)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	PT CONTROL	PT PATIENT	PTT CONTROL	PTT PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP
RESULTS		10Sep03	0430	A.M.																		Less than	adequate											

WBC DIFF AND BLOOD CELL MORPH

549-107

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

#[redacted] b(a)-4

ICU#1

CHEM I

SPECIMEN

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

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

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

PATIENT'S MED. RECORD

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

PICCOLO
10/09/03 04:35
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(a)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: 0000100684

GLU	123*	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	1.7*	0.6-1.2	MG/DL
CK	3069*	39-380	U/L
NA+	123*	128-145	MMOL/L
K+	3.8	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

b(a)-2

MEDCOM - 18563

11/09/03 04:40
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6) 0000100676

GLU	106	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	1709*	39-380	U/L
NA+	133	128-145	MMOL/L
K+	3.4	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	27	18-33	MMOL/L

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

FIRMR (41 CFR) 201-45.505

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

ICU #1

[redacted] b(6)-4

CHEM 1

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

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

SPECIMEN SOURCE: ☐ BLOOD ☐ OTHER (Specify)

LAB ID. NO.

SPECIMEN/LAB. RPT. NO.

LABORATORY FILE

TEST(S)

SPECIMEN TAKEN: DATE 11 Sep 03 TIME 0420 A.M.

RESULTS	REQUESTED	(X)
	RBC COUNT	
	HEMOGLOBIN	
	HEMATOCRIT	
	MCV	
	MCH	
	MCHC	
	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PT: CONTROL	
	PT: PATIENT	
	PTT: CONTROL	
	PTT: PATIENT	
	% ACTIVITY	
	RATIO	
	SICKLING TEST	
	LE PREP	

REMARKS: Hem 8 PT/PTT/CBC

REQUESTING PHYSICIAN'S SIGNATURE [redacted] b(6)-2

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

ICU #1

REPORTED BY: TECH 11 Sep 03 MD DATE

[redacted] b(6)-4

HEMATOLOGY

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

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB RPT.

HEMATOLOGY 549-107
STANDARD FORM 549 (Rev 7-78)
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FIRMR (41-CFR) 201-45.505

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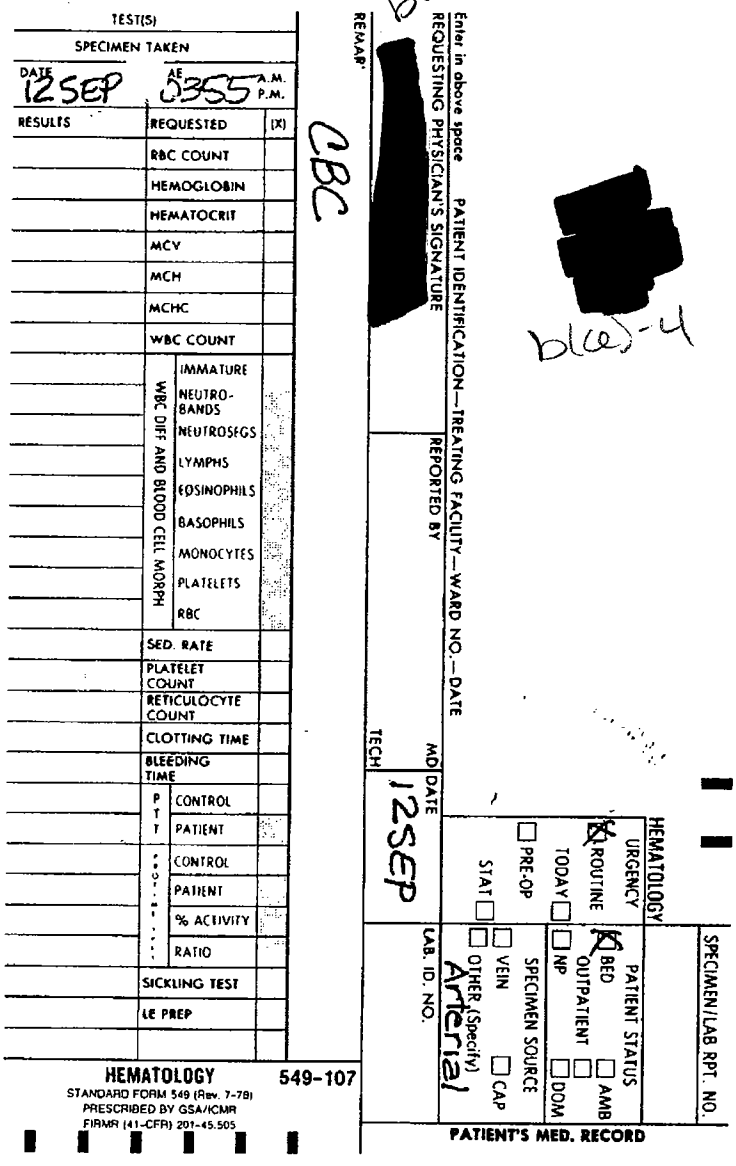

TEST(S)
SPECIMEN TAKEN
DATE 12SEP AE 0355 A.M. P.M.
RESULTS | REQUESTED | (X)
RBC COUNT
HEMOGLOBIN
HEMATOCRIT
MCV
MCH
MCHC
WBC COUNT
WBC DIFF AND BLOOD CELL MORPH: IMMATURE, NEUTRO-BANDS, NEUTROSEGS, LYMPHS, EOSINOPHILS, BASOPHILS, MONOCYTES, PLATELETS, RBC
SED. RATE
PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
PTT: CONTROL, PATIENT
PROTIME: CONTROL, PATIENT, % ACTIVITY, RATIO
SICKLING TEST
LE PREP
CBC
REMARKS
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
TECH
MD
DATE 12SEP
HEMATOLOGY
URGENCY: ROUTINE, TODAY, PRE-OP, STAT
PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM
SPECIMEN SOURCE: VEIN, CAP, OTHER (Specify) Arterial
LAB. ID. NO.
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD
HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
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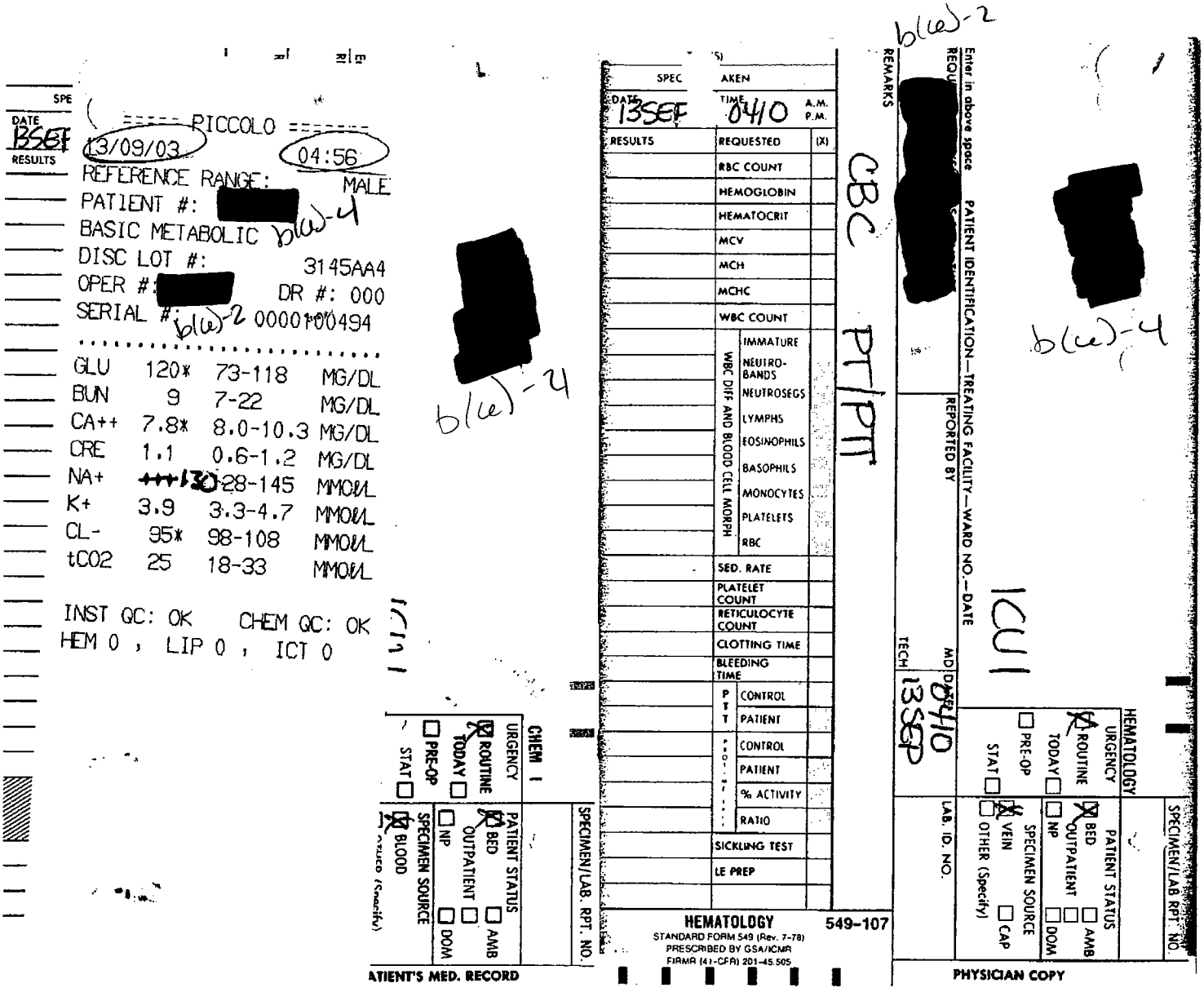
549-107

TEST(S)
SPECIMEN TAKEN
DATE 12SEP TIME 0355 A.M. P.M.
RESULTS | REQUESTED | (X)
GLUCOSE
UREA N.
CREATININE
URIC ACID
SODIUM
POTASSIUM
CHLORIDE
CO_2
PHOSPHATE
CALCIUM
TOTAL PROTEIN
ALBUMIN
GLOBULIN
ALKALINE PHOSPHATASE
ACID PHOSPHATASE
SGOT
LDH
CPK
BILIRUBIN (TOTAL)
BILIRUBIN (DIRECT)
CHOLESTEROL
TRIGLYCERIDES
AMYLASE
LIPASE
PROFILE (Specify)
Chem 8, PT/PTT
REMARKS
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
TECH
MD
DATE 12SEP
CHEM I
URGENCY: ROUTINE, TODAY, PRE-OP, STAT
PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM
SPECIMEN SOURCE: BLOOD, OTHER (Specify)
LAB. ID. NO.
SPECIMEN/LAB. RPT. NO.
PHYSICIAN'S COPY
CHEMISTRY I
STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505
546-107



SPE
DATE 13SEP
RESULTS

===== PICCOLO =====
13/09/03 04:56
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3145AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 0000100494

GLU	120*	73-118	MG/DL
BUN	9	7-22	MG/DL
CA++	7.8*	8.0-10.3	MG/DL
CRE	1.1	0.6-1.2	MG/DL
NA+	~~+++130~~	28-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	95*	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

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

ICU 1

[redacted] b(6)-4

CHEM 1
URGENCY: ROUTINE ☒ TODAY ☐ PRE-OP ☐ STAT ☐
PATIENT STATUS: BED ☒ OUTPATIENT ☐ AMB ☐ NP ☐ DOM ☐
SPECIMEN SOURCE: BLOOD ☒ (Specify)
SPECIMEN/LAB. RPT. NO.
PATIENT'S MED. RECORD

SPEC AKEN
DATE 13SEP TIME 0410 A.M. P.M.

RESULTS	REQUESTED	(X)
	RBC COUNT	
	HEMOGLOBIN	
	HEMATOCRIT	
	MCV	
	MCH	
	MCHC	
	WBC COUNT	
	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
	NEUTRO-BANDS	
	NEUTROSEGS	
	LYMPHS	
	EOSINOPHILS	
	BASOPHILS	
	MONOCYTES	
	PLATELETS	
	RBC	
	SED. RATE	
	PLATELET COUNT	
	RETICULOCYTE COUNT	
	CLOTTING TIME	
	BLEEDING TIME	
	PTT CONTROL	
	PTT PATIENT	
	PT CONTROL	
	PT PATIENT	
	PT % ACTIVITY	
	PT RATIO	
	SICKLING TEST	
	LE PREP	

CBC PT/PTT

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505
549-107

REMARKS [redacted] b(6)-2
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQU
REPORTED BY
MD
TECH
DATE 0410 13SEP

ICU1

[redacted] b(6)-4

HEMATOLOGY
URGENCY: ROUTINE ☒ TODAY ☐ PRE-OP ☐ STAT ☐
PATIENT STATUS: BED ☒ OUTPATIENT ☐ AMB ☐ NP ☐ DOM ☐
SPECIMEN SOURCE: VEIN ☒ CAP ☐ OTHER (Specify)
LAB. ID. NO.
SPECIMEN/LAB RPT. NO.
PHYSICIAN COPY

b(6)-2

CHEMISTRY I

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

REMARKS [redacted]

REQUESTING PHYSICIAN'S SIGNATURE [redacted]

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

[redacted]

b(6)-4

REPORTED BY | MD | TECH | DATE @0420 | 1458P03

CHEM I

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

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

SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify)

LAB. ID. NO.

SPECIMEN/LAB. RPT. NO.

LABORATORY FILE

CHEMISTRY I
STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505
546-107

b(6)-2

MISCELLANEOUS

TEST(S)	
SPECIMEN TAKEN	
DATE	TIME A.M. / P.M.
REQUESTED	
RESULTS	

PT/PTT

REMARKS [redacted]

REQUESTING PHYSICIAN'S SIGNATURE

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

[redacted]

b(6)-4

REPORTED BY | MD | TECH | DATE @0420 | 1458P03

MISC

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

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

SPECIMEN SOURCE (Specify) Vein

LAB ID NO.

SPECIMEN/LAB RPT. NO.

LABORATORY FILE

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
557-107

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

#[redacted]

b(6)-4

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

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

SPECIMEN SOURCE: ☒ VEIN ☐ CAP ☐ OTHER (Specify)

LABORATORY FILE

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted] b(6)-2

REPORTED BY | MD | TECH | DATE @0420 | 1458P03

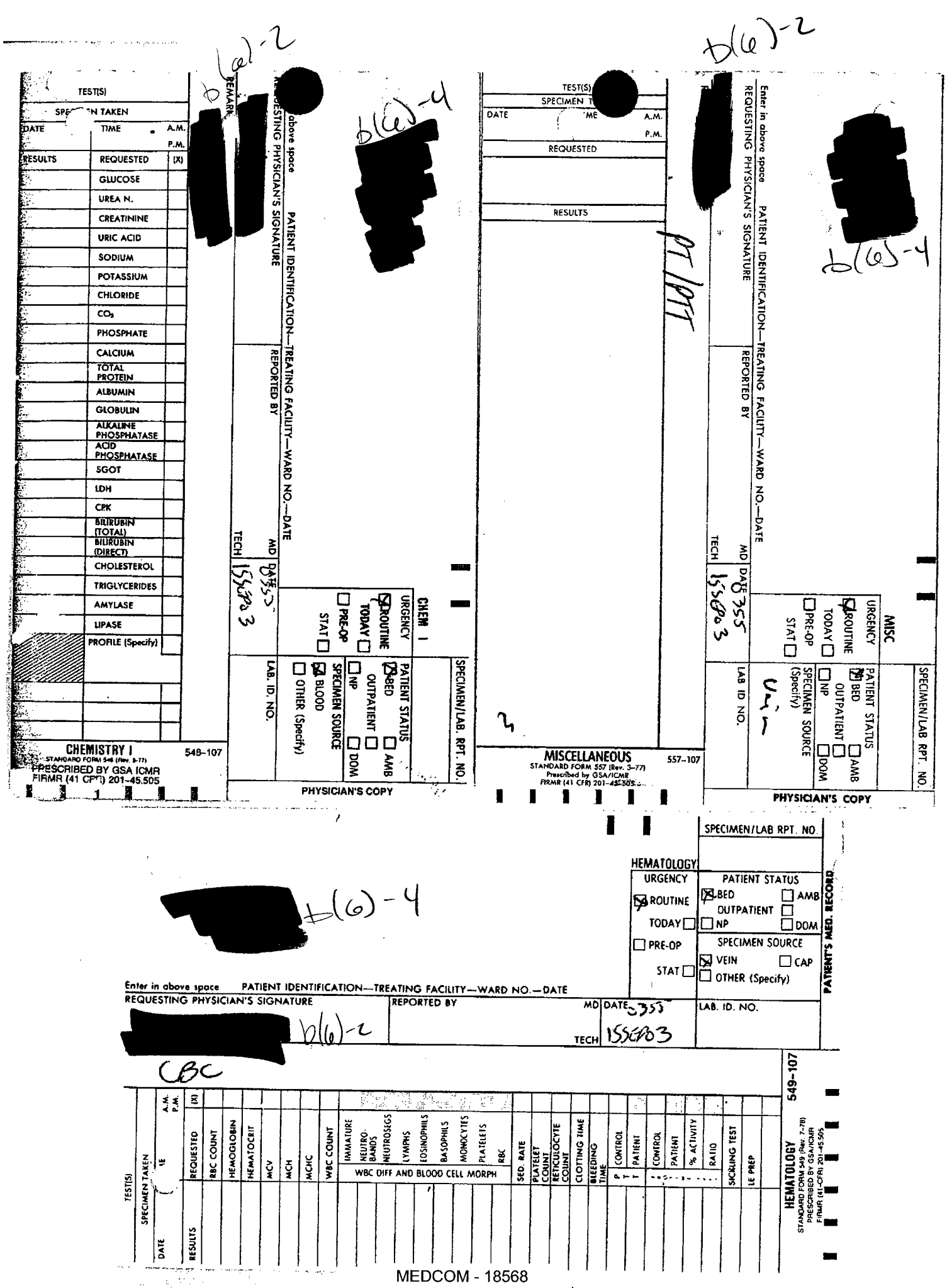
LAB. ID. NO.

REMARKS CBC

TEST(S)	SPECIMEN TAKEN	DATE	TIME	A.M. P.M.	RESULTS	REQUESTED (X)	RBC COUNT	HEMOGLOBIN	HEMATOCRIT	MCV	MCH	MCHC	WBC COUNT	WBC DIFF AND BLOOD CELL MORPH: IMMATURE	NEUTRO-BANDS	NEUTROSEGS	LYMPHS	EOSINOPHILS	BASOPHILS	MONOCYTES	PLATELETS	RBC	SED. RATE	PLATELET COUNT	RETICULOCYTE COUNT	CLOTTING TIME	BLEEDING TIME	PT: CONTROL	PT: PATIENT	PTT: CONTROL	PTT: PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP

HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505
549-107

MEDCOM - 18567



TEST(S)
SPECIMEN TAKEN
DATE TIME A.M. P.M.
RESULTS | REQUESTED | (X)
GLUCOSE
UREA N.
CREATININE
URIC ACID
SODIUM
POTASSIUM
CHLORIDE
CO_2
PHOSPHATE
CALCIUM
TOTAL PROTEIN
ALBUMIN
GLOBULIN
ALKALINE PHOSPHATASE
ACID PHOSPHATASE
SGOT
LDH
CPK
BILIRUBIN (TOTAL)
BILIRUBIN (DIRECT)
CHOLESTEROL
TRIGLYCERIDES
AMYLASE
LIPASE
PROFILE (Specify)
CHEMISTRY I
STANDARD FORM 548 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505
548-107
REMARKS
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
MD
TECH
DATE 155EP03
CHEM I
URGENCY: ROUTINE, TODAY, PRE-OP, STAT
PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM
SPECIMEN SOURCE: BLOOD, OTHER (Specify)
LAB. ID. NO.
SPECIMEN/LAB RPT. NO.
PHYSICIAN'S COPY

TEST(S)
SPECIMEN TAKEN
DATE TIME A.M. P.M.
REQUESTED
RESULTS
PT/PTT
MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
557-107
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
MD
TECH
DATE 155EP03
MISC
URGENCY: ROUTINE, TODAY, PRE-OP, STAT
PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM
SPECIMEN SOURCE (Specify): Urine
LAB ID NO.
SPECIMEN/LAB RPT. NO.
PHYSICIAN'S COPY

HEMATOLOGY
URGENCY: ROUTINE, TODAY, PRE-OP, STAT
PATIENT STATUS: BED, AMB, OUTPATIENT, NP, DOM
SPECIMEN SOURCE: VEIN, CAP, OTHER (Specify)
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
MD
TECH 155EP03
DATE 355
LAB. ID. NO.
CBC
TEST(S)
SPECIMEN TAKEN
DATE TIME A.M. P.M.
RESULTS | REQUESTED | (X)
RBC COUNT
HEMOGLOBIN
HEMATOCRIT
MCV
MCH
MCHC
WBC COUNT
WBC DIFF AND BLOOD CELL MORPH: IMMATURE, NEUTRO-BANDS, NEUTROSEGS, LYMPHS, EOSINOPHILS, BASOPHILS, MONOCYTES, PLATELETS, RBC
SED. RATE
PLATELET COUNT
RETICULOCYTE COUNT
CLOTTING TIME
BLEEDING TIME
P T T: CONTROL, PATIENT
CONTROL
PATIENT
% ACTIVITY
RATIO
SICKLING TEST
LE PREP
HEMATOLOGY
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505
549-107

MEDCOM - 18568

b(6)-2

======= PICCOLO =======
08/09/03 07:53
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 0000100676

GLU	133*	73-118	MG/DL
BUN	12	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	>5000*	39-380	U/L
NA+	132	128-145	MMOL
K+	3.5	3.3-4.7	MMOL
CL-	108	98-108	MMOL
tCO2	19	18-33	MMOL

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

ICU

b(6)-4 [redacted]

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

CHEM 1
URGENCY: ☐ ROUTINE ☐ PRE-OP STAT ☒ TODAY ☐
PATIENT STATUS: ☒ BED ☐ OUTPATIENT ☐ AMB ☐ DOM
SPECIMEN SOURCE: ☒ BLOOD ☐ OTHER (Specify) ☐ NP
SPECIMEN/LAB RPT. NO.

PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

PATIENT'S MED. RECORD

TEST(S)
SPECIMEN TAKEN DATE / TIME A.M. P.M.
RESULTS | REQUESTED | (X)

RBC COUNT	
HEMOGLOBIN	
HEMATOCRIT	
MCV	
MCH	
MCHC	
WBC COUNT	
WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
NEUTRO-BANDS	
NEUTROSEGS	
LYMPHS	
EOSINOPHILS	
BASOPHILS	
MONOCYTES	
PLATELETS	
RBC	
SED. RATE	
PLATELET COUNT	
RETICULOCYTE COUNT	
CLOTTING TIME	
BLEEDING TIME	
PTT CONTROL	
PTT PATIENT	
[illegible] CONTROL	
[illegible] PATIENT	
% ACTIVITY	
RATIO	
SICKLING TEST	
LE PREP	

HEMATOLOGY 549-107
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

REMARKS: CBC, PT/PTT
REQUESTING PHYSICIAN'S SIGNATURE: [redacted]
REPORTED BY
MD DATE
TECH 8 Sep 03

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

HEMATOLOGY
URGENCY: ☐ ROUTINE ☐ PRE-OP STAT ☐ TODAY ☐
PATIENT STATUS: ☒ BED ☐ OUTPATIENT ☐ AMB ☐ NP ☐ DOM
SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☒ OTHER (Specify) Artery
LAB. ID. NO.
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD

ICU

b(6)-4 [redacted]

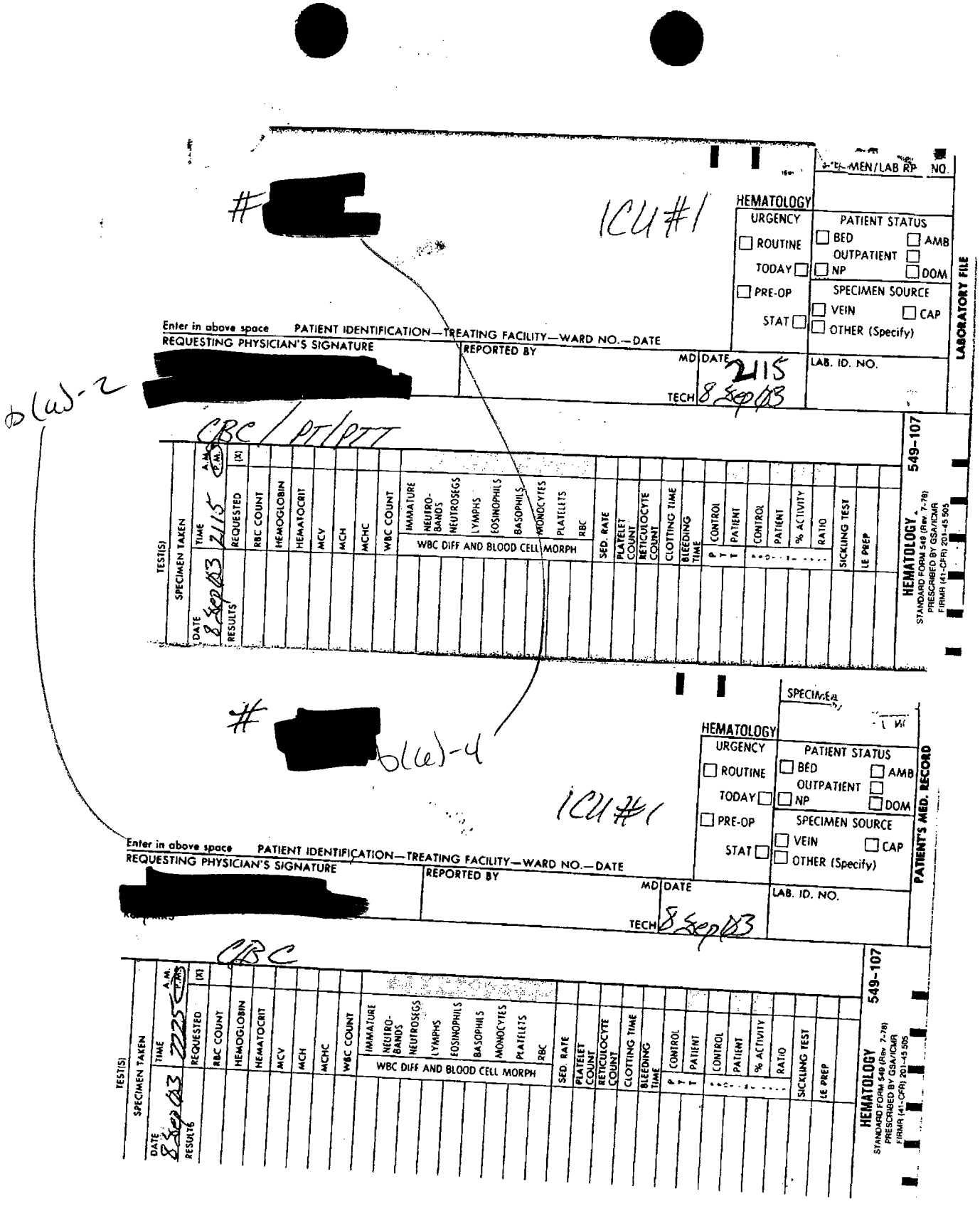
Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE b(6)-2 [redacted]
REPORTED BY
MD DATE
TECH 8 Sep 03
REMARKS: CBC, PT/PTT

HEMATOLOGY
URGENCY: ☐ ROUTINE ☐ PRE-OP STAT ☒ TODAY ☐
PATIENT STATUS: ☒ BED ☐ OUTPATIENT ☐ AMB ☐ NP ☐ DOM
SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☒ OTHER (Specify) Artery
LAB. ID. NO.
SPECIMEN/LAB RPT. NO.
PATIENT'S MED. RECORD

TEST(S)
SPECIMEN TAKEN DATE / TIME A.M. P.M.
RESULTS | REQUESTED | (X)

RBC COUNT	
HEMOGLOBIN	
HEMATOCRIT	
MCV	
MCH	
MCHC	
WBC COUNT	
WBC DIFF AND BLOOD CELL MORPH: IMMATURE	
NEUTRO-BANDS	
NEUTROSEGS	
LYMPHS	
EOSINOPHILS	
BASOPHILS	
MONOCYTES	
PLATELETS	
RBC	
SED. RATE	
PLATELET COUNT	
RETICULOCYTE COUNT	
CLOTTING TIME	
BLEEDING TIME	
PTT CONTROL	
PTT PATIENT	
[illegible] CONTROL	
[illegible] PATIENT	
% ACTIVITY	
RATIO	
SICKLING TEST	
LE PREP	

HEMATOLOGY 549-107
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505



[redacted] ICU #1

HEMATOLOGY

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

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

SPECIMEN/LAB RP NO.

LAB. ID. NO.

LABORATORY FILE

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted]

REPORTED BY

MD DATE 215

TECH 8 Sep 03

b(6)-2

CBC / PT/PTT

TEST(S) | SPECIMEN TAKEN: DATE 8 Sep 03, TIME 2115, A.M. P.M. | RESULTS | REQUESTED [X]

RBC COUNT | HEMOGLOBIN | HEMATOCRIT | MCV | MCH | MCHC | WBC COUNT

WBC DIFF AND BLOOD CELL MORPH: IMMATURE | NEUTRO-BANDS | NEUTROSEGS | LYMPHS | EOSINOPHILS | BASOPHILS | MONOCYTES | PLATELETS | RBC

SED. RATE | PLATELET COUNT | RETICULOCYTE COUNT | CLOTTING TIME | BLEEDING TIME | PTT: CONTROL, PATIENT | CONTROL, PATIENT | % ACTIVITY | RATIO | SICKLING TEST | LE PREP

549-107

HEMATOLOGY

STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

[redacted] b(6)-4

ICU #1

HEMATOLOGY

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

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

SPECIMEN

LAB. ID. NO.

PATIENT'S MED. RECORD

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

REQUESTING PHYSICIAN'S SIGNATURE [redacted]

REPORTED BY

MD DATE

TECH 8 Sep 03

CBC

TEST(S) | SPECIMEN TAKEN: DATE 8 Sep 03, TIME 2115, A.M. P.M. | RESULTS | REQUESTED [X]

RBC COUNT | HEMOGLOBIN | HEMATOCRIT | MCV | MCH | MCHC | WBC COUNT

WBC DIFF AND BLOOD CELL MORPH: IMMATURE | NEUTRO-BANDS | NEUTROSEGS | LYMPHS | EOSINOPHILS | BASOPHILS | MONOCYTES | PLATELETS | RBC

SED. RATE | PLATELET COUNT | RETICULOCYTE COUNT | CLOTTING TIME | BLEEDING TIME | PTT: CONTROL, PATIENT | CONTROL, PATIENT | % ACTIVITY | RATIO | SICKLING TEST | LE PREP

549-107

HEMATOLOGY

STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FIRMR (41-CFR) 201-45.505

==== PICCOLO : ====

15/09/03 04:24

REFERENCE RANGE: MALE

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

METLYTE 8

DISC LOT #: 3141AA4

OPER #: [redacted] DR #: 000

SERIAL #: 0000100494

b(6)-2

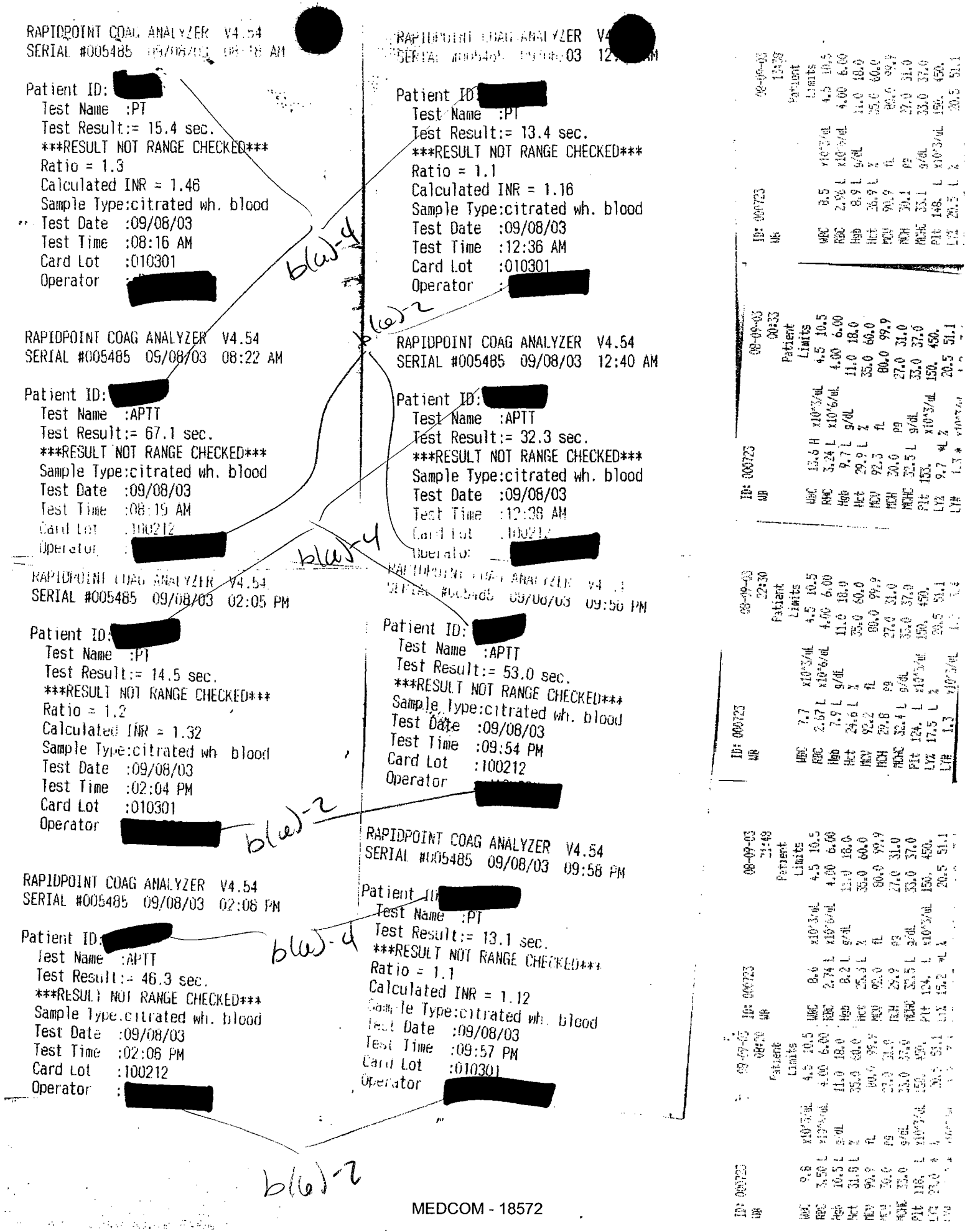
GLU	110	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	149	39-380	U/L
NA+	121*	128-145	MMOL
K+	3.8	3.3-4.7	MMOL
CL-	98	98-108	MMOL
tCO2	26	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 1+, ICT 0

[redacted]

MEDCOM - 18571



RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 08:16 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 15.4 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.3
Calculated INR = 1.46
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :08:16 AM
Card Lot :010301
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 12:36 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 13.4 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.16
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :12:36 AM
Card Lot :010301
Operator [redacted]

b(6)-4

b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 08:22 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 67.1 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :08:19 AM
Card Lot :100212
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 12:40 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 32.3 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :12:38 AM
Card Lot :100212
Operator [redacted]

b(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 02:05 PM

Patient ID: [redacted]
Test Name :PT
Test Result:= 14.5 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.32
Sample Type:citrated wh blood
Test Date :09/08/03
Test Time :02:04 PM
Card Lot :010301
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 09:56 PM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 53.0 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :09:54 PM
Card Lot :100212
Operator [redacted]

b(6)-2

b(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 02:06 PM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 46.3 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :02:06 PM
Card Lot :100212
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/08/03 09:58 PM

Patient ID: [redacted]
Test Name :PT
Test Result:= 13.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.12
Sample Type:citrated wh. blood
Test Date :09/08/03
Test Time :09:57 PM
Card Lot :010301
Operator [redacted]

b(6)-2

MEDCOM - 18572

RAPIDI [illegible] ANALYZER [illegible]
SERIAL [illegible]

b(6)-4

Patient ID [redacted]
Test Name :PT
Test Result:- 14.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.2
Calculated INR = 1.26
Sample Type:citrated wh. blood
Test Date :09/09/03
Test Time :04:56 AM
Card Lot :010301
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/09/03 05:02 AM

Patient ID [redacted]
Test Name :APTT
Test Result:- 40.8 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/09/03
Test Time :04:59 AM
Card Lot :100212
Operator [redacted]

b(6)-2

ID: [redacted]
WB

09-09-03
17:49

				Patient Limits	
WBC	6.4		x10^3/uL	4.5	10.5
RBC	2.53	L	x10^6/uL	4.00	6.00
Hgb	7.5	L	g/dL	11.0	18.0
Hct	23.4	L	%	35.0	60.0
MCV	92.4		fL	80.0	99.9
MCH	29.8		pg	27.0	31.0
MCHC	32.3	L	g/dL	33.0	37.0
Plt	111.	L	x10^3/uL	150.	450.
LY%	21.7		%	20.5	51.1
LY#	1.4		x10^3/uL	1.2	3.4

ID: [redacted]
WB

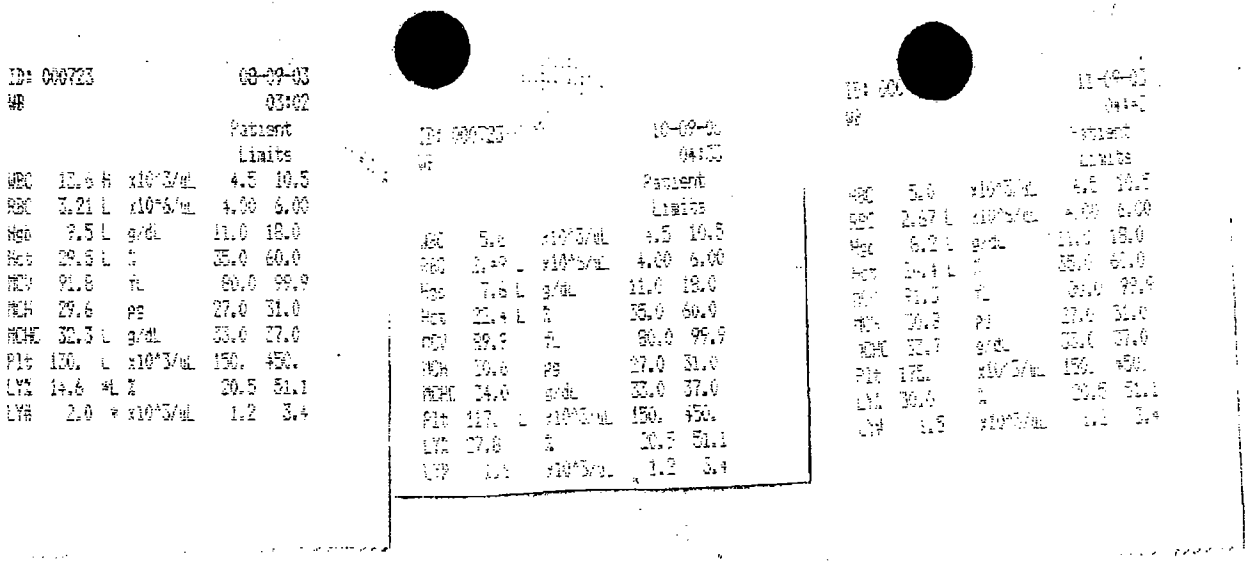
09-09-03
12:28

				Patient Limits	
WBC	9.3		x10^3/uL	4.5	10.5
RBC	2.54	L	x10^6/uL	4.00	6.00
Hgb	7.5	L	g/dL	11.0	18.0
Hct	22.3	L	%	35.0	60.0
MCV	[illegible]		fL	80.0	99.9
MCH	29.5		pg	27.0	31.0
MCHC	32.2	L	g/dL	33.0	37.0
Plt	106.	L	x10^3/uL	150.	450.
LY%	16.8	*L	%	20.5	51.1
LY#	1.6	*	x10^3/uL	1.2	3.4

ID: [redacted]
WB

[illegible]
[illegible]

				Patient Limits	
WBC	7.0		x10^3/uL	4.5	10.5
RBC	2.41	L	x10^6/uL	4.00	6.00
Hgb	7.3	L	g/dL	11.0	18.0
Hct	22.1	L	%	35.0	60.0
MCV	91.5		fL	80.0	99.9
MCH	30.1		pg	27.0	31.0
MCHC	32.9	L	g/dL	33.0	37.0
Plt	114.	L	x10^3/uL	150.	450.
LY%	22.5		%	20.5	51.1
LY#	1.6		x10^3/uL	1.2	3.4



ID: 000723 08-09-03
WB 03:02

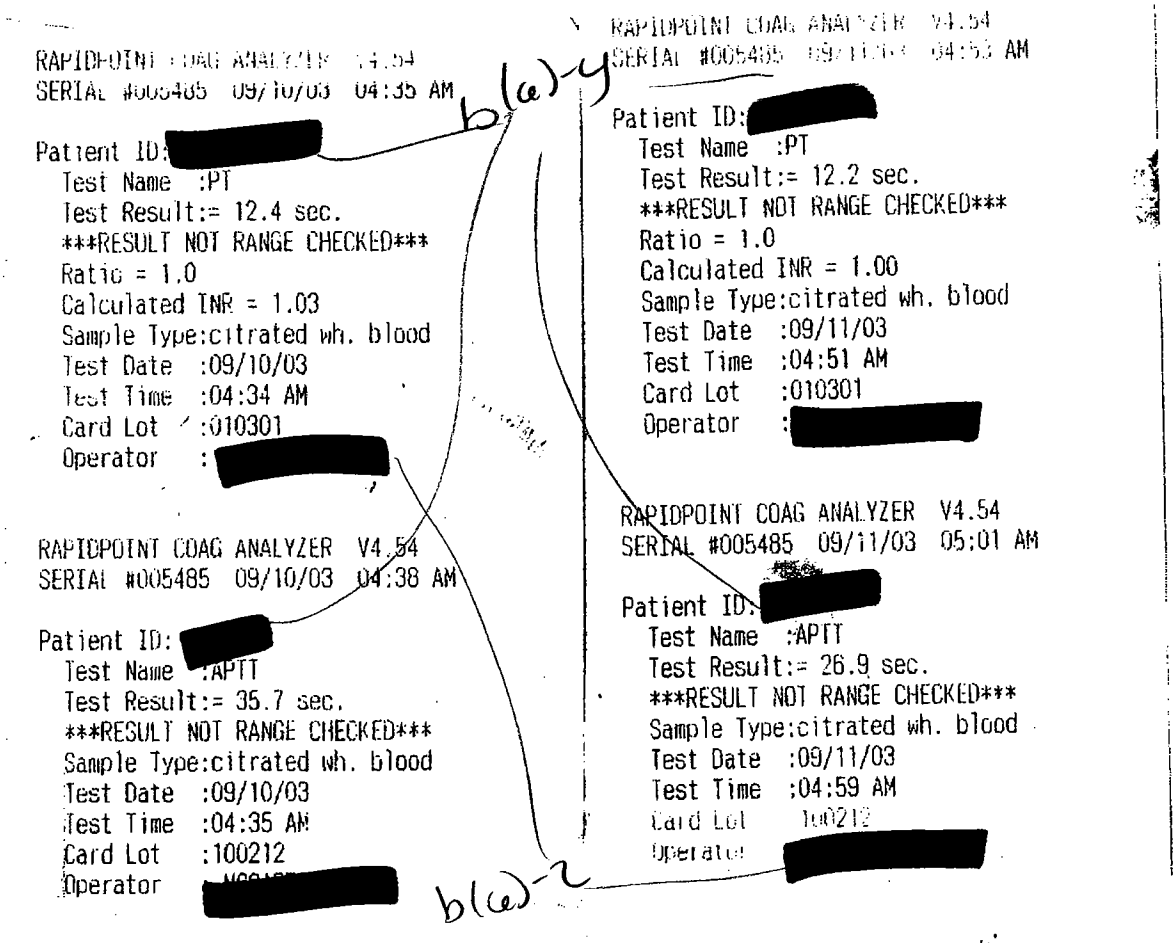
				Patient Limits
WBC	12.6	H	x10^3/uL	4.5 10.5
RBC	3.21	L	x10^6/uL	4.00 6.00
Hgb	9.5	L	g/dL	11.0 18.0
Hct	28.6	L	%	35.0 60.0
MCV	91.8		fL	80.0 99.0
MCH	29.6		pg	27.0 31.0
MCHC	32.3	L	g/dL	33.0 37.0
Plt	130.	L	x10^3/uL	150. 450.
LY%	14.6	*L	%	20.5 51.1
LY#	2.0	*	x10^3/uL	1.2 3.4

ID: 000723 10-09-03
WB 04:55

				Patient Limits
WBC	5.2		x10^3/uL	4.5 10.5
RBC	2.49	L	x10^6/uL	4.00 6.00
Hgb	7.6	L	g/dL	11.0 18.0
Hct	22.4	L	%	35.0 60.0
MCV	89.9		fL	80.0 99.0
MCH	30.6		pg	27.0 31.0
MCHC	34.0		g/dL	33.0 37.0
Plt	117.	L	x10^3/uL	150. 450.
LY%	27.0		%	20.5 51.1
LY#	1.4		x10^3/uL	1.2 3.4

ID: 000 11-09-03
WB 04:52

				Patient Limits
WBC	5.0		x10^3/uL	4.5 10.5
RBC	2.67	L	x10^6/uL	4.00 6.00
Hgb	8.2	L	g/dL	11.0 18.0
Hct	24.4	L	%	35.0 60.0
MCV	91.3		fL	80.0 99.0
MCH	30.8		pg	27.0 31.0
MCHC	33.7		g/dL	33.0 37.0
Plt	175.		x10^3/uL	150. 450.
LY%	30.6		%	20.5 51.1
LY#	1.5		x10^3/uL	1.2 3.4



RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/10/03 04:35 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 12.4 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.0
Calculated INR = 1.03
Sample Type:citrated wh. blood
Test Date :09/10/03
Test Time :04:34 AM
Card Lot :010301
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/10/03 04:38 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 35.7 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/10/03
Test Time :04:35 AM
Card Lot :100212
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/11/03 04:53 AM

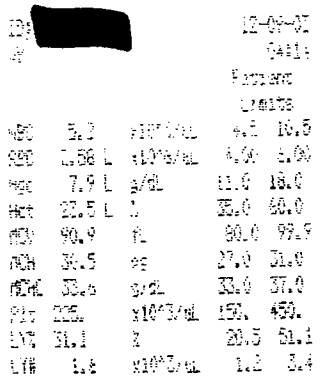
Patient ID: [redacted]
Test Name :PT
Test Result:= 12.2 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.0
Calculated INR = 1.00
Sample Type:citrated wh. blood
Test Date :09/11/03
Test Time :04:51 AM
Card Lot :010301
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/11/03 05:01 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 26.9 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/11/03
Test Time :04:59 AM
Card Lot 100212
Operator [redacted]

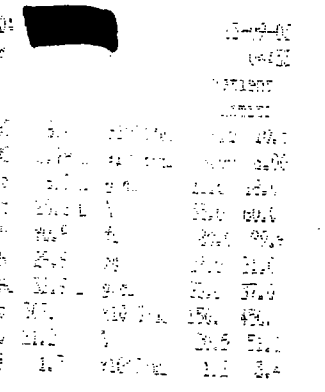
b(a)-4

b(a)-2



RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/12/03 04:19 AM

Patient ID: [redacted]
Test Name :PT
Test Result:= 12.2 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.0
Calculated INR = 1.00
Sample Type:citrated wh. blood
Test Date :09/12/03
Test Time :04:18 AM
Card Lot :010301
Operator : [redacted] b(6)-2



RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/12/03 04:23 AM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 26.3 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/12/03
Test Time :04:19 AM
Card Lot :100212
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/13/03 04:34 AM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 13.0 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.11
Sample Type:citrated wh. blood
Test Date :09/13/03
Test Time :04:32 AM
Card Lot :010301
Operator : [redacted] b(6)-2

PICCOLO
12/09/03 04:11
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: 034 DR #: 000
SERIAL #: 0000100676

GLU	108	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	1.4*	0.6-1.2	MG/DL
CK	712*	39-380	U/L
NA+	133	128-145	MMOL
K+	3.6	3.3-4.7	MMOL
CL-	97*	98-108	MMOL
tCO2	22	18-33	MMOL

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

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 09/13/03 04:40 AM

Patient ID: [redacted] b(6)-4
Test Name :APTT
Test Result:= 31.4 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/13/03
Test Time :04:37 AM
Card Lot :100212
Operator : [redacted] b(6)-2

ID: [redacted] 14-09-03
MB 04:49

			Patient Limits	
WBC	8.8	x10^3/uL	4.5	10.5
RBC	2.65 L	x10^6/uL	4.00	6.00
Hgb	7.8 L	g/dL	11.0	18.0
Hct	24.5 L	%	35.0	60.0
MCV	92.4	fL	80.0	99.9
MCH	29.6	pg	27.0	31.0
MCHC	32.1 L	g/dL	33.0	37.0
Plt	443.	x10^3/uL	150.	450.
LYX	19.5 *	%	20.5	51.1
LYM	1.7 *	x10^3/uL	1.2	3.4

ID: [redacted] 15-09-03
MB 04:10

			Patient Limits	
WBC	7.6	x10^3/uL	4.5	10.5
RBC	2.50 L	x10^6/uL	4.00	6.00
Hgb	7.6 L	g/dL	11.0	18.0
Hct	22.7 L	%	35.0	60.0
MCV	90.7	fL	80.0	99.9
MCH	30.5	pg	27.0	31.0
MCHC	33.6	g/dL	33.0	37.0
Plt	560. H	x10^3/uL	150.	450.
LYX	21.5	%	20.5	51.1
LYM	1.6	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #0005485 09/14/03 04:52 AM

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= 13.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.12
Sample Type:citrated wh. blood
Test Date :09/14/03
Test Time :04:50 AM
Card Lot :010301
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #0005485 09/14/03 04:55 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 35.8 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/14/03
Test Time :04:52 AM
Card
Oper

RAPID
SERIA

Patient ID: [redacted] b(6)-4
Test Name :PT
Test Result:= [illegible] sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.11
Sample Type:citrated wh. blood
Test Date :09/15/03
Test Time :04:16 AM
Card Lot :010301
Operator [redacted] b(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #0005485 09/15/03 04:20 AM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 31.4 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/15/03
Test Time :04:17 AM
Card Lot :100212
Operator [redacted] b(6)-2

==== PICCOLO =======
14/09/03 05:24
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3145AA4
OPER #: [redacted] DR #: 000
SERIAL #: b(6)-2 0000100494

GLU	111	73-118	MG/DL
BUN	3*	7-22	MG/DL
CA++	8.1	8.0-10.3	MG/DL
CRE	1.1	0.6-1.2	MG/DL
NA+	~~116*~~ 131	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

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

23 Y O

GSW to (L) shoulder

NKDA

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)													TOTALS
fentanyl (mcg)	100		100 50										250 mcg
vec (mg)	10		10										
heparin units/hr							10	800			10		
MSO4 (mg)											5	5	10 mg
VOLAT AGENT iso % del	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	2	2	2	2	2	2	2	2	2	2	2	2	

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

TOTAL EBL: 100

TOTAL URINE: 1200

FLUIDS SUMMARY

CRYSTALLOID- LR 1300 NS 1000

COLLOID-

BLOOD- PRBC 2 unit

FLUIDS

LINE site: (R) 18 (?) / + (R) 18 (?) AC

- ☐ Warmed — NS ——— #2 — 800
- ☐ Warmed — LR ——— 1000
- ☐ Warmed — PRBC ——— #2
- ☐ Warmed

LOSSES

EST BLOOD LOSS

URINE - 900

PHYS STATUS: (1) 2 3 4 5 E

BODY WEIGHT: 90 (KG) LB

HEMATOCRIT: 29.9

INITIAL DATA: BP- 110/70 HR- 70's

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? (+) TIME- 0100

TIME ▶ 15 30 X 0200 X 30 X 0300 X 30 X 0400

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

220 200 180 160 140 120 100 80 60 40 20

REMARKS

Code drugs with numbers, events with letters

0101 - Seen in ER - intubated

0114 - Dr OR - monitors on

0230 - #1 PRBC

1262676

0245 - 5000 u heparin IV

0300 - 9.5/130 13.4/29.5

7.30/41.8/310/21 -6 100%

0410 - PRBC #2

4825461

VENTIL

VT - ml	810	810	810	810	810	820	810	830	730	850	830	830
f - breaths/min	9	9	9	9	9	9	9	9	9	9	9	9
Peak inf pres / PEEP	23	23	23	23	23	23	23	23	20	24	24	24
MODE - S(pon), A(ssist), C(on)	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV	CV

MONITORS/ACCESSORIES

BP/Auto Cuff; BP/oth; ART line; Steth- PC/ES; Gas analyzer; O2

ET CO2 (torr)	32	32	32	32	33	34	34	32	33	30	30	30
FiO2 (Frac or %)	.44	.44	.44	.44	.51	.5	.5	.51	.51	.49	.49	.49
SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
ECG	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
TEMP-site												
N-M Block (T/4)	0/4	4/4	4/4	0/4		0/4	0/4	4/4	0/4			

Warming blkt — blankets

Conv warmer

Mark with letters & symbols, explain under REMARKS: EVENTS; Position → (?) — arms < 90° abducted / padded

RECOVERY AT: PACU ICU (Specify) OTHER stable

CONDITION: RESP- 10 SpO2- 97% BP- 116/78 HR- 78

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0100	0114	0415
	Ready	Begin	End
PROC	0230	0230	0415

PROCEDURE... b(6)-2 [redacted] (L) brachial artery repair

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA — 18 intubated orally - BBS + CO2 +

PATIENT... [redacted] ...entries: Name, Grade/Rate, Medical facility

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

b(6)-2

[redacted]

b(6)-4

[redacted]

S [redacted] Sewn

PROCEDURE LOCATION: 2-2

DATE: 25 Sep 03

PAGE 1 OF 2

DA FORM 7389, FEB 1998

COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

MEDCOM - 18577

ACLU-RDI 1647 p.137

DOD-032151

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)	
	( )	
	( )	
	( )	
	( )	
	( )	
	( )	
VOLAT AGENT 180	% del	10 X
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	2

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

FLUIDS — LINE site #18 @ AC ☐ Warmed LR; #18 @ ☐ Warmed NS; ☐ Warmed; ☐ Warmed

LOSSES — EST BLOOD LOSS; URINE –

PHYS STATUS (1) 2 3 4 5 (E)

BODY WEIGHT: KG LB

HEMATOCRIT:

INITIAL DATA: BP– HR–

EQUIP CHECK: OK?– Y N

PATIENT RECHECK: OK for PROCEDURE? TIME–

TIME → 15:30

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

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

VENTILATION: VT – ml 800; f – breaths/min 9; Peak inf pres / PEEP 23; MODE– S(pon), A(ssist), C(on) C

MONITORS: ✓ BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES; Gas analyzer; ✓ ET CO2 (torr) 32; ✓ FIO2 (Frac or %) 99; ✓ SpO2 (%) 100; ✓ ECG NSR; TEMP- site 35; N-M Block (T/4) 4/4; ✓ Warming blkt Blankets; Conv warmer

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

TOTALS | TOTAL IN | TOTAL URINE

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

REMARKS– Code drugs with numbers, events with letters

0120– To ICU 1 VSS monitors on

RECOVERY AT: PACU ICU ____ (Specify) OTHER ____
CONDITION: RESP– SpO2– BP– HR–

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES			
	Ready	**Begin**	**End**
PROC			

PROCEDURES and CPT Codes: Revise (L) Ex fix / (L) brachial artery repair

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — See p1

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

b(6)-4

[redacted]

SURGEONS: b(6)-2

ANESTH [redacted] THESIA

PROCEDURE LOCATION #2-2

DATE 8/4/03

PAGE 2 OF 2

MEDCOM - 18578 — OP 376 REVISED 1 Jan 90

PATIENT RECORD

ACLU-RDI 1647 p.138

DOD-032152

Heparin gtt d/c @ 0715 to have 2u PRBC now for ... 9/4

7.3 / 22.1 — 114K @ 0500

128 / 3.8 — <126

K 1J
R Aline
Foley

RA SaO2 97%
RR 101
ABP 158/67
Tmax 102.3 @ 23..

Ancef @ 0800
Gent @ 06
Percocet @ 0300
29.8 ...

23 y/o m-S
NKA
90 kg
ASA II

MEDICAL RECORD — ANESTHESIA

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

DRUG	Units		TOTALS
Fent	(mcg)	50 50 50 50	200 mcg
Versed	(mg)	2/3	5 mg
Lido	(mg)	60	
Propofol	(mg)	150 50	
MSO4	( )	3	3 mg
VOLAT AGENT Forane	% del	1.5 1.8 1.5 1.5 1.0	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	8 2 2 2 2 2	

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

TOTAL EBL: 50
TOTAL URINE: 325

FLUIDS

LINE site		
LR	☐ Warmed	200 ↑
NS	☐ Warmed	1000
	☐ Warmed	
Bld	☐ Warmed	#1 #2

LOSSES
EST BLOOD LOSS — 50
URINE — 200 325

FLUIDS – SUMMARY
CRYSTALLOID– 1300
COLLOID– Ø
BLOOD– 2u PRBCs

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 90 (KG) LB

HEMATOCRIT: 22.1

INITIAL DATA
BP – 120
HR – 86

CORR / CHECK
OK? – (Y) N

PATIENT PROFILE
OK for PROCEDURE?
TIME– 0730

TIME ➔ 08 X 20 X 09 X 30 X 10

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

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

Lab values on grid: pH 7.312; PCO2 53.2; PO2 545; HCO3 27; BE +1; SO2 100; Hct 21; Hb 7; Na 137; K 3.8

VT – ml		550	410	480	490	460	500
f – breaths/min	12	16	17	9	12	13	14
Peak insp pres / PEEP							
MODE– S(pon), A(ssist), C(on)	S-C	A	S	S	S	S	S
ET CO2 (torr)	36	45	47	50	49	48	46
FIO2 (Frac or %)	.60	.60	.60	.65	.67	.69	.69
SpO2 (%)	100	100	100	100	100	100	100
ECG		SR	SR	SR	SR	SR	SR
TEMP- site	Skin	35					
N-M Block (T/4)					36	36	X

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

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

REMARKS
Code drugs with numbers, events with letters

0810 in OR monitors applied.

4361681

1863590

0915 Induction proseal placed two attempts as below –

0935 Proseal out, spont resp c̄ oral airway –

0940 transferred to litter, Oral airway out, spont Resp, Responsive to ICU c̄ mask O2 ... Report given

RECOVERY AT	ICU
PACU	ICU 0950 (Specify)
OTHER	T99.4 ax
CONDITION:	Responsive
RESP– 17	SpO2– 100
BP– 131/66	HR– 83

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0730	0810	1000
	Ready	Begin	End
PROC	0820	0850	0930

PROCEDURES and CPT Codes
9/8
S/P L Humerus Ex Fix, (L) ... Vein Graft to L Brachial ...

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
Proseal – #4 unsuccessful x1 Δ to #5 x1 attempt

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments #5 Proseal placed
⊕ ETCO2 ⊕ BBS b(6)-2

PATIENT IDENTIFICATION — Typed or written entries: Name, Grade/Rate, Medical facility
#[redacted] civ s/p GSW

b(6)-4

SURGEON: [redacted] b(6)-2

ANESTHETIST: [redacted]

PROCEDURE LOCATION: [redacted]

DATE: 9/9/03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

MEDCOM - 18579

... OP 376 REVISED

ACLU-RDI 1647 p.139

DOD-032153

Ancef Gent peracet MSO4, Tylenol   Okay A-line — ... IV (HL)   CTA MPI Foley

MEDICAL RECORD - ANESTHESIA

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

ANESTHETIC AGENTS AND DRUGS

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

DRUG (Units)													TOTALS
fentanyl (UG)	250	50				100	100		50				750
lidocaine (MG)	40												
propofol (MG)	200												
Succ (MG)	100												
MSO4 (MG)					5 5								10
( )													
VOLAT AGENT 150 % del / % e.t.		1.7	1.7	1.7	1.7	1.7	2.5	1.7	1.7	1.7	1.7	1.5	
AIR L/Min													
N2O L/Min													
O2 L/Min	6	2	2	2	2	2	2	2	2	2	2	2	

TOTAL EBL: Min

TOTAL URINE: 350

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

FLUIDS

LINE site: 20 (R) hand — Warmed ☐ — LR — #2 LR — 1400

Warmed ☐ / Warmed ☐ / Warmed ☐

FLUIDS SUMMARY: CRYSTALLOID- LR 1600; COLLOID- —; BLOOD- —

LOSSES

EST BLOOD LOSS

URINE - 200 — 350

PHYS STATUS: 1 (2) 3 4 5 E

TIME: 0915 30 X (0945) X 30 X (1000) X 30 X (1100)

BODY WEIGHT: 90 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP- 112/80; HR- 75

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE (P); TIME- 0810

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

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

Canady break X

REMARKS

Code drugs with numbers, events with letters

O920 – Mat. 10 – N.A. then place. Chart ... Pro 25 ... O920 – DA CR – ... on Induction

1230 – Spont resp. Opened eyes. Suction → extubated to PACU/SS

VENTIL

VT - ml		810	810	820	810	850	820	820	820	820	330	950
f - breaths/min	15	10	10	10	10	10	10	10	10	10		
Peak inf pres / PEEP		18	18	18	18	18	19	19	19	19	7	14
MODE - S(pon), A(ssist), C(on)	S	CV	CV	CV	CV	CV	CV	CV	CV	CV	SV	C

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)		36	34	34	35	35	35	37	34	34		
BP/oth	FIO2 (Frac or %)		.76	.76	.76	.76	.77	.76	.76	.76	.76	.76	.76
ART line	SpO2 (%)	98	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	NS	NS	NS	NS	NS	NS	ST	ST	ST	ST	ST	ST
Gas analyzer	TEMP-site	skin			35								
CO2	N-M Block (T/4)			4/4									

Warming blkt — sheets/blankets

Conv warmer

49

RECOVERY AT

PACU (circled) / ICU (Specify)

OTHER: stable

CONDITION: RESP- 15; SpO2- 97%; BP- 165/82; HR- 120

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0900	0850	1245
	Ready	**Begin**	**End**
PROC	0930	0918	1230

Mark with letters & symbols, explain under REMARKS

EVENTS / Position: supine, arm 90 abducted, padded

PROCEDURES and CPT Codes: (L) arm fx repair / revision of ex fix

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GETA #8 ...

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — ETT #3 Miller, taped 22cm teeth – eyes taped. [illegible] ST [illegible] DLxT ... Gr I view. ETT easily passed. BBS= ... Atraumatic. Teeth ok.

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

[redacted] b(6)-4

[redacted] CU...

SURGEON [redacted] b(6)-2

PROCEDURE LOCATION: #2

DATE: 12 ...

PAGE / OF

DA FOR[redacted] S MEDICAL RECORD — USAPA V1.00

MEDCOM - 18580

ACLU-RDI 1647 p.140

DOD-032154

NKDD

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)						
MSO4 (mg)						
VOLAT AGENT 150 % del	1.5	1.5	1.5	X		
% e.t.						
AIR L/Min						
N2O L/Min						
O2 L/Min	2	2	2	6	6	6

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

TOTALS: 1g 1 | TOTAL EBL | TOTAL URINE

FLUIDS — LINE site: 20 (R) hand ☐ Warmed 1st 1400; ☐ Warmed; ☐ Warmed; ☐ Warmed

FLUIDS SUMMARY: CRYSTALLOID- COLLOID- BLOOD-

REMARKS: *Code drugs with numbers, events with letters*

LOSSES — EST BLOOD LOSS; URINE - 300 — 350

PHYS STATUS: 1 (2) 3 4 5 E

TIME: 10 15 30 45 (DW) 1 30

BODY WEIGHT: 90 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP- 161/80; HR- 70's

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? TIME- 08W

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

Chart scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20 — Canady Break

VENTIL

VT - ml	960	770	770	540	480	530
f - breaths/min	10					
Peak inf pres / PEEP	21	19	19	7	10	16
MODE - S(pon), A(ssist), C(on)	C	S	S	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	35	47	47	50	51	48
BP/oth	FiO2 (Frac or %)	0.76	.76	.73	.73	.75	.75
ART line	SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	ECG	ST	ST	ST	ST	ST	ST
Gas analyzer CO2	TEMP-site	35					
	N-M Block (T/4)						
Warming blkt	sheets/blanket						
Conv warmer							

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

RECOVERY AT: PACU ICU ____ (Specify) OTHER ____ CONDITION: RESP- SpO2- BP- HR-

ANESTHESIA / PROCEDURE TIMES

ANES	Start	Room	End
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: Revise ex fix LUE

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* — See US 1

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

[redacted] b(6)-4

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

SURGEONS: b(6)-4

ANE[redacted]

PROCEDURE LOCATION: 2-2

DATE: 12 Sep 03

PAGE 2 OF

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

MEDCOM - 18581

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 23 DAYS MOS YRS

Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: Lt. Wrist (L) ex fix (L) brachial artery repair
SURGICAL SERVICE: 85 Ortho
NPO SINCE:

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

HABITS:
TOBACCO:
ETOH:
DRUGS:

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

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

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

13.6/29.9, 9.1, 153; 13/41.5, 12/119; 5.9/20.1; 13.4/32.3

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

arrived intubated from ER

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 110/[illegible] HR 120 R ____ T ____
Pain Scale 0-10
HEENT - Teeth
Trachea
TMJ/Neck intubated
Oropharynx
Nares
CHEST: BBS=/CTA
CARDIAC: S1S2 RRR
EXTREMITIES:
IV Access: OK
Ulnar Filling: OK
BACK: OK
OTHER:

NPO Since

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

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. b(6)-2
The patien[redacted]s. Questions answered. unable to consent
Signed:[redacted] Date: 0220 Time: 8 Sep 03 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

information taken from PST notes

Patient Identification: [redacted]

b(6)-4

* GSW to (L) shoulder

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

MEDCOM - 18582

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

518–124

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

NSN 7540–00–634–4159

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1 U ML

REMARKS:

b(6)-2

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

- [X] TYPE AND SCREEN ~~2 units~~
- [X] CROSSMATCH

DATE REQUESTED 8 Sept 03

DATE AND HOUR REQUIRED 0005

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ______

HEMOLYTIC DISEASE OF NEWBORN? ______

REQUES[redacted]SICIAN *(Print)* [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE GSW rt les / Lt arm

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

SIGNATU[redacted] b(6)-2

DATE VE[redacted] 8 Sept 03

TIME VERIFIED 0032

SECTION II – PRE-TRANSFUSION TESTING

UNIT[redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR	RECIPIENT
ABO O	ABO O
Rh Pos	Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQ[redacted]

REMARKS: EXP 09 SEP 2003

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [ ] NO RECORD

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

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT (Hour) [redacted] ON *(Date)* 8 Sep 03

IDENTIFICATION

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

1st VERIF[redacted]

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

PR[redacted]

TEMP. 101.8 PULSE 135 BP 133/70

DATE OF TRANSFUSION 8 Sep 03 TIME STARTED 1733

POST-TRANSFUSION DATA

AMOUNT GIVEN 425 ML

TIME/DATE COMPLETED/INTERRUPTED 1918 8 Sep 03

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
100.8	138	119/63

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

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

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

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

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—[redacted] rate; hospital or medical facility)

#[redacted]

b(6)-4

SEX M WARD ICU #1

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

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Medical Record Copy

MEDCOM - 18583

518-124

MEDICAL RECORD

NSN 7540-00-634-4159

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 1U ML

REMARKS:

b(6)-4

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

- [X] TYPE AND SCREEN ~~2 units~~ 3
- [X] CROSSMATCH

DATE REQUESTED 8 Sept 03

DATE AND HOUR REQUIRED 0005

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

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

DIAGNOSIS OR OPERATIVE PROCEDURE GSW Rt les / Ltarm

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

SIGNA [redacted] blue-2

DATE VERIFIED 8 Sept 03

TIME VERIFIED 0032

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR	RECIPIENT
ABO O	ABO O
Rh Pos	Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: EXP 09 SEP 2003

DATE b(6)-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted]

AT *(Hour)* 1553 ON *(Date)* 8-Sep-03

IDENTIFICATION

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

1st VERIFIER [redacted] 49/AW

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

PRE-TR [redacted]

TEMP. 101.3 PULSE 130 BP 125/53

DATE OF TRANSFUSION 8 Sep 03 TIME STARTED 1546

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, [redacted] rate; hospital or medical facility)

[redacted]

b(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN 425 ML

TIME/DATE COMPLETED/INTERRUPTED 8 Sep 03 1725

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
101.8	131	114/51

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

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

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

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

49/AW

M

WARD ICU1

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR. FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

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518–124

MEDICAL RECORD

NSN 7540-00-634-4159

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* 4 U ML

REMARKS:

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

- [X] TYPE AND SCREEN ~~2 UNITS~~
- [X] CROSSMATCH

DATE REQUESTED 8 Sept 03

DATE AND HOUR REQUIRED 0005

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

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

DIAGNOSIS OR OPERATIVE PROCEDURE GSW Rt leg

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

SIGNATURE [redacted] b(6)-2

DATE VERIFIED 8 Sept 03

TIME VERIFIED 0032

SECTION II – PRE-TRANSFUSION TESTING

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

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PERFORMING TESTS [redacted]

DONOR	RECIPIENT
ABO O	ABO O
Rh POS	Rh POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQU[redacted]

DATE

REMARKS: EXP 09 SEP 2003

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND [redacted]

AT *(Hour)* 0220 ON *(Date)* 8 SEP 03

IDENTIFICATION

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

1st [redacted] b(6)-2

2nd [redacted]

PRE-TRANSFUSION

TEMP. [redacted] PULSE 96 BP 110/43

DATE OF TRANSFUSION 9 SEP 03 TIME STARTED 0230

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, [redacted] rate; hospital or medical facility)

[redacted] b(6)-4

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

AMOUNT GIVEN 1 unit ML

TIME/DA[redacted] 0300 8 SEP 03

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE 35 | PULSE 86 | BLOOD PRESSURE 123/61

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

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

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

SI[redacted] b(6)-2

WARD

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

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518-124

MEDICAL RECORD

NSN 7540-00-634-4159

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)*

2 units ML

REMARKS:

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

- ☒ TYPE AND SCREEN ~~2 units~~
- ☒ CROSSMATCH

DATE REQUESTED 8 Sept 03

DATE AND HOUR REQUIRED 0005

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(P...* [redacted] b(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

GSW Rt leg/Rt arm

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

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

DATE VERIFIED 8 Sept 03

TIME VERIFIED 0032

SECTION II – PRE-TRANSFUSION TESTING

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

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO O

Rh POS

RECIPIENT

ABO O

Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQ...

PREVIOUS RECORD CHECK:

☐ RECORD ☑ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

REMARKS:

EXP 09 SEP 2003

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted]

AT 0408 ON *(Date)* 8 SEP 03

IDENTIFICATION

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

1st VERIF... [redacted]

2nd V... [redacted]

PRE-TRANSFUSION

TEMP. 35 PULSE 88 BP 117/64

DATE OF TRANSFUSION 8 SEP 2003

TIME STARTED 0409

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, mi... grade, rank; hospital or medical facility)

[redacted] b(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN ~~1 unit~~ ML

TIME/DATE COMPLETED/INTERRUPTED 0415 8 SEP 03

REACTION

☐ NONE ☐ SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
35	105	123/67

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN

☐ OTHER *(Specify)*

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

☑ NO ☐ YES *(Specify)*

SIGNATURE OF PE... [redacted] b(6)-2

WARD

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

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518-124

NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED *(If applicable)*
_____ ML

REMARKS:
1 unit

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED
09 Sept 03

DATE AND HOUR REQUIRED
ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

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

DIAGNOSIS OR OPERATIVE PROCEDURE
s/p GSW

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

SIGNATURE
[redacted] b(6)-2

DATE VERIFIED
08 Sept 03

TIME VERIFIED
[redacted]

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. b(4)-4
[redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR
ABO O
Rh POS

RECIPIENT
ABO O
Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	COMP

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST
[redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 9-5-03

REMARKS:
EXP: 12 Sep 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*
[redacted] b6-2

AT *(Hour)* 0757

ON *(Date)* 9-5-03

IDENTIFICATION

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

1 [redacted] MD

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

PRE-T

TEMP. 37

PULSE 100

BP 75/40

DATE OF TRANSFUSION
9/9/03

TIME STARTED
0725

POST-TRANSFUSION DATA

AMOUNT GIVEN
1U ML

TIME/DATE COMPLETED/INTERRUPTED
9/9/03 0850

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
95.5	96	100/55

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

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIF[redacted]ment, clots, etc.)
[redacted] b(4)-2

m

WARD
TCU-1

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, midd[redacted]rate; hospital or medical facility)

[redacted]
b(4)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

MEDCOM - 18587

518-124

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

NSN 7540-00-634-4159

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)

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

VOLUME REQUESTED (If applicable) ______ ML

REMARKS: 1 unit

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

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 09 Sept 03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ______

HEMOLYTIC DISEASE OF NEWBORN? ______

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

DIAGNOSIS OR OPERATIVE PROCEDURE s/p GSW

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

SIGNATURE [redacted] b(6)-2

DATE VERIFIED 08 Sept 03

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

b(6)-4

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR	RECIPIENT
ABO 0	ABO 0
Rh POS	Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	Comp

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: EXP: 12 Sep 03

PREVIOUS RECORD CHECK:

- [X] RECORD
- [ ] NO RECORD

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

DATE 9-9-03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature) [redacted] b6-2

AT (Hour) 0757 ON (Date) 9 Sep 03

IDENTIFICATION

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

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

[redacted] LTC

[redacted] CRNA

TEMP. 37 PULSE 110 BP 114/60

DATE OF TRANSFUSION 9/9/03

TIME STARTED 0810

POST-TRANSFUSION DATA

AMOUNT GIVEN 320 ML

TIME/DATE COMPLETED/INTERRUPTED 9/9 0820

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE 37 PULSE 100 BLOOD PRESSURE 90/50

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)

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

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

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, [redacted] rate; hospital or medical facility)

SEX M WARD ICU-1

[redacted]

b(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

Medical Record Copy

MEDCOM - 18588

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

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

PATIENT IDENTIFICATION
[redacted]
b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 8 Sep
TIME OF ORDER: 0600 HOURS
LIST TIME ORDER NOTED AND SIGN

① Δ D5LR → D5 @ 125cc/hr
VO Dr [redacted]

PATIENT IDENTIFICATION
[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 8 Sep 03
TIME OF ORDER: 0746 HOURS
0820 8 Sep 03 [redacted]

Δ IVF to LR @ 125cc/hr
V.O. per Dr. [redacted]

b(6)-2

PATIENT IDENTIFICATION
b(6)-4
[redacted]

NURSING UNIT | ROOM NO. | BED NO.
24° chart [redacted]

DATE OF ORDER: 9/8
TIME OF ORDER: 930 HOURS

(1) Vent RR 12 FiO2 40%
(2) ABG 1 hour
(3) 1L LR now
(4) ↓Heparin 700u/h
(5) CBC, PT/PTT @ 1400

b(6)-2 [redacted] 8 Sep 03 0949

8 Sep 03
1236 [redacted] b(6)-2

PATIENT IDENTIFICATION
[redacted]
b(6)-2

DATE OF ORDER: 8 Sep 03
TIME OF ORDER: 1505 HOURS

b(6)-2 [redacted]

① Transfuse 2 units PRBCs
② Give 500cc NS Bolus
③ Wean pt off Versed and Fentanyl. Notify RT when ready to extubate pt.
V.O. per Dr. [redacted]

1509 8 Sep 03

NURSING UNIT | ROOM NO. | BED NO.
b(6)-2
v/ chart | check [redacted]

DA FORM 4256, 1 APR 79 — EDITION OF 1 JUL 77, WHICH MAY BE USED [redacted]

MEDCOM - 18589

b(6)-2

ACLU-RDI 1647 p.149

DOD-032163

b(6)-2 unless noted otherwise

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

DATE OF ORDER 9/8 TIME OF ORDER 1600 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) D/C NG
(2) Clears
(3) Lasix 20mg iv between units 3&4
(4) elevate arm
(5) IS.

[redacted]

NURSING UNIT ICU 1 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

(1) Left humerus AP + Lat X ray
(2) NPO p MN

[redacted]

[redacted] 8 Sep 03 1611

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 9/8 TIME OF ORDER 2100 HOURS

(1) Tylenol 650 mg po prn temp > 101 Noted

[redacted]

[redacted] 2100

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 9/9 TIME OF ORDER 0700 HOURS

(1) Transfuse 2u PRBC now noted

[redacted]

[redacted]

NURSING UNIT 24° chart check | ROOM NO. | BE[redacted]

CRT/RN 11 Sep 03 0700

DA FORM 1 APR 79 4256 [redacted] OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 18590

1

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]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9/9/03 TIME OF ORDER 0630 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Hold Heparin drip

V/O Dr [redacted] b(6)-2

PATIENT IDENTIFICATION b(6)-4 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9/9 TIME OF ORDER HOURS

(1) Resume previous orders

(2) D/C Heparin drip

(3) Regular diet

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9/9/03 TIME OF ORDER 1600 HOURS

(1) CBC @ 1800

(2) Replace IV V/O Dr [redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 9/10 TIME OF ORDER 0800 HOURS

(1) OOB to chair

b(6)-2 [redacted]

NURSING UNIT 24 hour check done | ROOM NO. | BED NO.

[redacted] b(6)-2

11 Sep 03 1000

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

MEDCOM - 18591

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

Post-op) Admit ICU
S/P Revision Ex Fix (L) Humerus,
(L) thigh Nv Graft to
(L) Brachial Ac
Vitals - routine
- NV checks q1° x 6°
then q 2°
Activity strict BR

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

~~W → D pacing BSD~~ (R) thigh
Meds Ancef 1g IV q 8°
Gent 100 mg IV q 6°
MSO4 2-5 mg IV q 2° PRN
Percocet 1-2 po q 4° PRN
Lab ~~cbc in AM~~ Chm
Reg ~~Diet~~ NPO an
IV D5LR @ 125 cc/h

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

Heparin 800 u/h IV
~~PT/PTT 2° p ordered~~ ~~to ICU~~
ASA 325 mg ~~PO~~ QD, 1st dose on arrival to ICU. [redacted]
~~MSO4 2-6~~

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 9/9 | TIME OF ORDER 0130 HOURS

(1) Vent TV800 R14 FiO2 50%
Peep 5.
(2) NG to CIS
(3) ~~Morphine 2-4 mg IV q15 min prn pain~~
(3) Versed iv drip titrate to effect
(4) Fentanyl iv drip titrate to effect
(5) AM labs CBC, PT/PTT, Chem 8

Noted [redacted] 0810 9/9/03

NURSING UNIT | ROOM NO. | BED NO.

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

24° Chart ✓ [redacted] [redacted] [redacted] b(6)-2

MEDCOM - 18592

[redacted] 1AW 9/9/03

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

[redacted]

NURSING UNIT: ICU 1 | ROOM NO.: | BED NO.: 4

DATE OF ORDER: 9-11-03 | TIME OF ORDER: 0900 HOURS | LIST TIME ORDER NOTED AND SIGN

XR - (L) humerus AP + LAT Re: F/U F[redacted]

b(6)-2

Noted 11 Sep 03 0900 [redacted]

24° Chart Check 11 Sep03 2330 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT: ICU 1 | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	HOURS	LIST TIME ORDER NOTED AND SIGN
11 Sep 03	1850		
V.O. [redacted]			b(6)-2
NPO p Midnight for OR			
[redacted]			b(6)-2
24° Chart Check 11 Sep 03 2330			[redacted] AN

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

038

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

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

DATE OF ORDER 9/12 TIME OF ORDER 1230 HOURS

LIST TIME ORDER NOTED AND SIGN

1) Resume orders
2) Reg diet
3) OOB / Ambulate

b(6)-2 [redacted]

12 Sep 03 1255

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4 [redacted]

DATE OF ORDER 12 Sep 03 TIME OF ORDER 1600 HOURS

V.O. Δ Morphine to 2-5 mg IV Q 30 mins PRN per Dr. [redacted]

b(6)-2

b(6)-2 [redacted] 1601 12 Sep 03

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

b(6)-4 [redacted]

DATE OF ORDER 12 Sep 03 TIME OF ORDER 1627 HOURS

D/C A line b(6)-2

v.o. per Dr [redacted]

b(6)-2 [redacted] 12 Sep 03 1649

NURSING UNIT | ROOM NO. b(6)-2 | BED NO.

24° ✓ done [redacted] 14 Sep 0030

PATIENT IDENT[redacted]

b(6)-4 [redacted]

DATE OF ORDER 9/14 TIME OF ORDER 0930 HOURS

1) Colace 100 bid po
2) Δ L thigh dressing qd.
3) Ambien 10 mg qhs PO

Ntd by [redacted] 14 Sep 03 1000

b(6)-2 [redacted]

b(6)-2

NURSING UNIT | ROOM NO.

240° Chart [redacted] 14 Sep 03 1109

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

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

DATE OF ORDER: 9/14 TIME OF ORDER: 1000 HOURS

(1) Daily dressing change in AM

Meds - Morphine 7-10mg ivp PRN Dressing Δ

Versed 2-4mg ivp PRN Dressing Δ

b(6)2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DISC TIME ORDER NOTED AND SIGN: [redacted] b(6)2 .../...n 14 Sep03

PATIENT IDENTIFICATION

#[redacted]

DATE OF ORDER: 9/15 TIME OF ORDER: [redacted] HOURS

(1) D/C Art Line

[redacted]

b(6)2

NURSING UNIT | ROOM NO. | BED NO.

[redacted] Noted ... 15 Sep 03

PATIENT IDENTIFICATION

b(6)-4

#[redacted]

DATE OF ORDER: 16 Sep03 TIME OF ORDER: 1605 HOURS

D/C Foley

V.O. per Dr [redacted]

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

b(6)-2 [redacted] .../...n 16 Sep03

PATIENT IDENTIFICATION

[redacted]

DATE OF ORDER: 17 Sept 03 TIME OF ORDER: 1600 HOURS

(1) NPO @ MN

V.O. Dr [redacted]

Noted 17 Sep03 1600 .../...n

NURSING UNIT | ROOM

b(6)-4

24° Chart [redacted] .../AW 0926 18 Sep03

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

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"USE BALL POINT PEN - PRESS FIRMLY - NO CARBON PAPER REQUIRED"

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

NURSING UNIT: b(6)-4 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION [redacted] b(6)-4

NURSING UNIT: ICW 1 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	17 SEPT 03	1630 HOURS	
1	RESUME PREVIOUS ORDERS		
2	IV: LR @ 150 CC/HR. D/C LOCK WHEN TOLERATING PO WELL		
3	REGULAR DIET		
	[redacted] 9/16/03 0230		
	30 SEPT 03	0030 HOURS	b(6)-2
1	NPO		
2	PO OR IVS PRN		
	b(6)-2 [redacted]		9/30/03 0740
	DATE OF ORDER	TIME OF ORDER HOURS	
	DATE OF ORDER	TIME OF ORDER HOURS	

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

MEDCOM - 18597

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]

NURSING UNIT: ICU1 | ROOM NO.: | BED NO.: 4

DATE OF ORDER: 9/18/03 TIME OF ORDER: 1700 HOURS

~ Resume preop orders, meds & activity

~ D/C Gentamycin

b(6)-2 [redacted]

LIST TIME ORDER NOTED AND SIGN: Transcribed 1757 on 18 Sept 03 [redacted] b(6)-2

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

NURSING UNIT: ICU1 | ROOM NO.: | BED NO.: 4

DATE OF ORDER: 19 Sept 03 TIME OF ORDER: 0705 HOURS

① Transfer to ICW/Dx S/P ex fix Ⓛ numerous [illegible] (L) thigh vein graft to Ⓛ [illegible]

② Resume orders from ICU1

✓ Ancef 1 gm IV Q8°

✓ ASA 325mg po QDAY

✓ Colace 100mg po BID

✓ Ambien 10mg po QHS

✓ Morphine 7-10mg IVP prn drsg Δ

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

NURSING UNIT: ICU1 | ROOM NO.: | BED NO.: 4

✓ Versed 2-4mg IVP prn drsg Δ

✓ Morphine 2-5mg IV Q30min prn

Percocet 1-2 tabs po Q4° prn

✓ Vitals: routine

✓ NV check Ⓛ UE Q2°

✓ Elevate arm

✓ Incentive spirometer

✓ Reg Diet

PATIENT IDENTIFICATION: # [redacted]

✓ OOB/ambulate

✓ Δ Ⓛ-Ⓡ thigh drsg QD

✓ Daily drsg Δ in am (Ⓛ Arm)

[redacted] b(6)-2

[redacted] b(6)-2 19 Sep [illegible]

NURSING UNIT: ICU1 | ROOM NO.: 21 | BED NO.: 4 — 19 SEP 03 [redacted]

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

U.S. GOVERNMENT PRINTING OFFICE

USE BALL POINT PEN - PRESS FIRMLY / NO CARBON PAPER REQUIRED

b(6)-2 All unless noted otherwise

CLINICAL RECORD DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4

C# [redacted]

DATE OF ORDER: 19 Sep 03 TIME OF ORDER: 1755 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) 30cc milk of magnesia

x1 now [redacted]

NURSING UNIT / ROOM NO. / BED NO.

2W/21 Sep 03 @ 0015 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 9-22-03 TIME OF ORDER: 1530 HOURS

- Begin pin site care BID & instruct patient in care
- Physical therapy for ROM at elbow & wrist.

[redacted]

Noted [redacted] 22 Sep 03 1600

NURSING UNIT

2W/0200 23 Sep 03 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: V.O. 9/24/03 TIME OF ORDER: 9/ 1835 HOURS

Tylenol PO 625mg q6° prn for T>101.5 [redacted]

[redacted]

9/24/03 1840

NURSING UNIT / ROOM NO. / BED NO.

PATIENT IDENTIFICATION

EPW# [redacted]

b(6)-4

DATE OF ORDER: 9/25/03 TIME OF ORDER: 1640 HOURS

Neurontin 300mg po TID

[redacted]

[redacted] 9/25/03 1645

NURSING UNIT / ROOM NO. / BED NO.

ICW/ 27 275ep03@0325 [redacted]

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

U.S. GOVERNMENT PRINTING OFFICE: 19__—___

USE BALL POINT PEN—PRESS FIRMLY / NO CARBON PAPER REQUIRED

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

Noted 30 Sept 03 0945 b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
9/30	0800 HOURS	
① ↑ Neurontin to 600 ~~tid~~ tid		
[redacted]		

PATIENT IDENTIFICATION

b(6)-4 [redacted]

noted 2230 9-30-03 b(6)-2

NURSING UNIT	ROOM NO.	BED NO.
2W 0245 [illegible]		

DATE OF ORDER	TIME OF ORDER	
9/30/03	2230 HOURS	
√ ⑦ D/C Ancef		
√ ⑧ Start Keflex 500 mg ① ID po		
√ ⑨ start elavil 10 mg po q HS		
[redacted]		

PATIENT IDENTIFICATION

b(6)-4 [redacted]

Noted [redacted] b(6)-2

NURSING UNIT	ROOM NO.	BED NO.
ICU #1		29 [illegible]

DATE OF ORDER	TIME OF ORDER	
10-6-03	2045 HOURS	
① ↑ elavil to 25 mg po q HS		
XR - AP + LAT ② humerus		
[redacted]		

PATIENT IDENTIFICATION

b(6)-2 Noted [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
10-8-03	1000 HOURS	
d/c pt to Iraqi hospital		
[redacted] b(6)-2		

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

MEDCOM - 18600

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. Sept. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 8 8 9 10 11 12 13 14 15 16 17 18 19 20
8Sep03	[redacted]	Vitals: routine	06	[redacted]
			18	
8Sep03	[redacted]	IV check (L)UE q1° x6°	06	
		then q 2°	18	
8Sep03	[redacted]	Activity - Strict Bedrest	06	
			18	
8Sep03	[redacted]	Diet NPO	06	
			18	
08Sep03	[redacted]	ven. TV 800 RR 14	06	
		FiO2 50%, Peep 5	18	
08Sep03	[redacted]	NG to LIS.	06	
			18	
08Sep03	[redacted]	AM labs CBC, PT/PTT, Chem 8	04	
8 Sep03	[redacted]	Clears	06	
			18	
8 Sep03	[redacted]	Elevate Arm	06	
			18	
8 Sep03	[redacted]	Incentive Spirometer	06	
			18	
9 Sep 03 renewed 12 Sep03	[redacted]	reg. diet	07	
			12	
			17	
12Sep03	[redacted]	OOB to chair	06	
			18	
12Sep03	[redacted]	OOB / Ambulate	06	
			18	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Ex Fix (L) humerus (L) thigh vein graft to (L) Brachial A/C

ADDITIONAL PAGES IN... ☐ YES ☐ NO

PAGE NO:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

b(6)-2

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

MEDCOM - 18601

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo SEP Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8Sep03	[redacted]	ABG 1 hour	8Sep03	1040	1053	[redacted]
8Sep03	[redacted]	CBC, PT/PTT @ 1400	8Sep03	1400	1340	
8Sep03	[redacted]	Left Humerus AP + Lat X ray	8Sep03		2300	
8Sep03	[redacted]	NPO p MN	9Sep03	0001	0001	
9Sep	[redacted]	Resume previous orders	9Sep	noted		
9Sep	[redacted]	CBC @ 1800	9Sep	1800		
11Sep03	[redacted]	X Ray L Humerus AP + Lat F/U FX	11Sep03	Now	1000	
11Sep03	[redacted]	NPO p Midnight to OR in A.M.	11Sep03	2400	2400	
12Sep03	[redacted]	Resume Orders	12Sep03		1233	
12Sep03	[redacted]	D/C A line	12Sep03		1655	
16Sep03	[redacted]	D/C Foley	16Sep03		1630	
17Sep03	[redacted]	NPO p MN	17Sept	2400	[redacted]	
		b(6)-2 A1				

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

USAPA V1.00

b(6)-2 AR

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 20 21
14Sep03	[redacted]	Δ(L)+(R) Thigh dressings QD	08	NC [redacted]
			X	
14Sep03	[redacted]	Daily Dressing Δ in AM (L arm)	10	[redacted]
			X	

Refused

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Ex Fix (L) humerus, (L) thigh Vein Graft to (L) Brachial a.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 18603

b(6)-2 All

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. 09 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED: 21 22 23 24 25 26 27 28 29 30 1 2 3 4
8 Sep	[redacted]	Ancef 1gm IV q8°	[redacted]	[redacted] DC'd 30 Sep03
8 Sep	[redacted]	ASA 325mg po QD	10	[redacted]
14 Sep	[redacted]	Colace 100mg po BID		[redacted]
14 Sep	[redacted]	Ambien 10mg po QHS		[redacted]
25 Sep / 30SEP03	[redacted]	Neurontin 300mg po TID (↑ to 600mg) 30SEP03	06 / 14 / 22	[redacted]
30 SEP	[redacted]	Keflex 500mg PO QID	06 / 12 / 18 / 24	[redacted]
30SEP03	[redacted]	elavil 10mg PO QHS	22	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: s/p EXFIX (L) humerus, (L) thigh vein graft to (L) brachial a.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.:

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES
USE PENCIL, CIRCLE ACTION TIMES

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

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

b(6)-2

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	*Mo.* 9 *Yr.* 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED													
		PRN MEDS															
9/19-9/22	[redacted]	Percocet 1-2 tabs po	D/T	25 Sep 2330	26 Sep [illegible]	26 Sep 1650	26 Sep 2030	27/		28 Sep 1500	29 Sep 0110	28 Sep 2200	29 Sep 0110	[illegible] 1224	[illegible] 1805	30 Sep 0920	
		q4°	D/I	[redacted]						[redacted]							
19 Sep 03	[redacted]	Percocet I-II tabs po	D/T	[illegible] 1315	[illegible]	[illegible] 2336	[illegible] 0003	[illegible] 1000	3 Oct 1225								
		q4° prn	D/I	[redacted]													

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS: S/P Ex Fix (L) humerus, (L) thigh graft to (L) Brachial AC	ADDITIONAL PAGES IN USE: ☒ YES ☐ NO PAGE NO. 3

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. Sep Yr. 23
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		b(6) - 2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
9/19 9/22	[redacted]	Morphine 7-10mg IVP prn dosg Δ	Date	22Sep	22Sep	23Oct										
			Time	0100	2320	2100										
			Dose	5mg	7mg	7mg										
			Init	[redacted]												
9/19 9/22	[redacted]	VERSED 2-4mg IVP prn dosg Δ	Date													
			Time			D/C'd										
			Dose													
			Init													
9/19 9/22	[redacted]	Morphine 2-5mg IV q 30 min prn	Date	23Sep	23Sep	24Sep	24Sep	24Sep	24Sep	24Sep	25Sep	25Sep	25Sep			
			Time	0555	1445	0420	0745	1057	0230	1000	1230	1800				
			Dose	5mg	5mg	5mg	5mg	5mg	4mg	4mg	5mg	5mg				
			Init	[redacted]												
9/19 9/22	[redacted]	Percocet 1-2 tabs PO q 4° prn	Date	20Sep	21Sep	21Sep	21Sep	21Sep	22Sep	23Sep	23Sep	23Sep	24Sep	24Sep	24Sep	25Sep
			Time	1940	0030	0810	2034	0715	2150	0555	1520	2120				
			Dose	1	1	1	2	1	1	1	1	1	1	1	1	1
			Init	[redacted]												
24Sep	[redacted]	Tylenol/625mg PO q6° Co T>101.5	Date	24Sep	24Sep	25Sep										
			Time	1811	2218	0826										
			Dose	2	2	2										
			Init	[redacted]												

USAPA V1.00

b(6)-7 A11

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PL... (MEDICATIONS)

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

Mo. 10 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4 5 6 07 08
8 Sept	[redacted]	ASA 325 mg PO QD	10	[redacted]
8 Sept	[redacted]	Colace 100mg PO BID	10	
		~~AB~~	2a	
8 Sept	[redacted]	Ambien 10mg PO QSH	22	
30 Sept	[redacted]	Neurontin 600mg PO TID	06	
			14	
			20	
30 Sept	[redacted]	Keflex 500mg PO QID	06	
			12	
			18	
			24	
30 Sept	[redacted]	Elavil 10mg PO QHS	2	
6 Oct	[redacted]	Elavil 25mg po QHS	22	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: SP Ex fix (L) humerus / (R) ~~humerus~~ (L) tib fib (L) thigh vein graft to (R) brachial

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

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

MEDCOM - 18607

Verify by Initialing	THERA[illegible]IC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo._____ Yr._____

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
19 Sept	[redacted]	Percocet 1-2 tabs PO Q4-6 PRN	D/T	4 Oct 2030	5 Oct 0700	5 Oct 2245	6 Oct 0500	6 Oct 1945	7 Oct 0430	7 Oct 1100	7 Oct 1730	7 Oct 2250	7 Oct 0800			
			D/I	"	"	"	"	"	"	"	"	"	"			
			E/I													
		blank														

USAPA V1.00

b(6)-2

CLINICAL RECORD — TH[illegible]EUTIC DOCUMENTATION CARE PL[illegible]ON-MEDICATION)

For use of this form, see AR 40-4 the proponent agency is the Office of The Surg[illegible]eneral.

Mo. 10 Yr. 2003

VERIFY BY INITIALING ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION HR	DATE COMPLETED
8 Sept	[redacted]	VS Routine	06	04 5 [redacted]
			18	
8 Sept	[redacted]	NV Check LUE q2°	06	
		(L) Arm to be left OTA	18	
8 Sept	[redacted]	↑ (L) Arm	18	
			06	
8 Sept	[redacted]	Regular diet	06	
			18	
8 Sept	[redacted]	OOB / Ambulate	09	
			18	
8 Sept	[redacted]	Pin site care BID	06	
			18	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Ex-fix (L) humerus / (L) thigh vein graft to (L) Brachial

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

PATIENT IDENTIFICATION: [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 18609

Rec'd - 2

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo 10 Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
10	[redacted]	XR - AP/LAT (L) humerus	10/07			[redacted]
08 OCT 03		P/C pt to Iraqi hosp				

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

MEDCOM - 18610

b(6)-2 A11

CLINICAL RECORD | THE[...]UTIC DOCUMENTATION CARE PLA[...] (N-MEDICATION) | Mo. 09 Yr. 2003

For use of this form, see AR 40-40[...]; the proponent agency is the Office of The Surgeo[...] [...]eral.

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED: 21 22 23 2[...] [redacted] 30 01 02 03
08 Sep	[redacted]	VS: routine	6	[redacted]
reinitiated			18	[redacted]
8 Sep	[redacted]	NV check LUE Q2°	6	[redacted]
	[redacted]		18	[redacted]
8 Sep	[redacted]	Elevate arm	6	[redacted]
			18	[redacted]
8 Sep	[redacted]	Incentive Spirometer	6	[redacted]
	[redacted]		18	[redacted]
8 Sep	[redacted]	Regular diet	6	[redacted]
			18	[redacted]
8 Sep	[redacted]	OOB/ambulate	6	[redacted]
			18	[redacted]
14 Sep	[redacted]	Δ (L) + (R) thigh	08	[redacted]
		drsgs QD	X	DIC
14 Sep	[redacted]	Daily drsg Δs to (L)	08	[redacted]
		arm in AM	X	[redacted]
22 Sep 03	[redacted]	Pin site care BID and	10	[redacted]
	[redacted]	instruct pt in care	22	[redacted]
13 Oct	[redacted]	(L) arm to be left	06	[redacted]
		OTA	18	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P EX-FIX (L) humerus, (R) thigh vein graft to (L) brachial a/c

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
22 Sep 03	[redacted]	Physical therapy for ROM @ elbow/wrist				
		b(6)-2				

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

b(6)-2 A11

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. 9 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
08Sep03	[redacted]	Ancef 1 gm IV q 8°	08	[redacted]
			16	
			24	
08Sep03	[redacted]	Gent 100mg IV q 16°	06	
			12	
			18	
			24	
08Sep03	[redacted]	IV-D5LR @ 125cc/hr	06	
			18	
08Sep03	[redacted]	Heparin 800 u/hr IV	06	
			18	
08Sep03	[redacted]	ASA 325 mg PO qday	10	
08Sep03	[redacted]	Versed drip. Titrate to effect	06	
			18	
06Sep03	[redacted]	Fentanyl gtt Titrate to effect	06	
			18	
8Sep03	[redacted]	ΔIVF to LR @ 125cc/hr	06	
			18	
8Sep03	[redacted]	↓ Heparin to 700u/hr	06	
			18	
8Sep03	[redacted]	Ven: SIMV, TV 800, R14, FiO2 — 50%, Peep 5	06	
			18	
8Sep03	[redacted]	Vent: SIMV, TV 800, R12, FiO2 40%, Peep 5	06	
			18	
14Sep03	[redacted]	Celebrex 100mg PO Bid	10	
			22	
14Sep03	[redacted]	Ambien 10mg PO QHS	22	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Ex Fix, (L) humerus, (L) thigh vein graft, TO (L) Brachial AC.

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO.: 1

PATIENT IDENTIFICATION: [redacted]

b(6)-1

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	

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MEDCOM - 18613

b(6)-2 A11

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing — Mo. ________ Yr. ________

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
08Sep03	[redacted]	ASA 325mg per NG – 1st dose now	8Sep	0600	0600	[redacted]
8Sep03	[redacted]	Vent RR-12, FiO2 40%	8Sep03		0938	[redacted]
8Sep03	[redacted]	1L LR Now	8Sep03		0940	[redacted]
8Sep03	[redacted]	Transfuse 2units PRBCs	8Sep03	#1	1546	[redacted]
			8Sep03	#2	1733	
8Sep03	[redacted]	Give 500cc NS Bolus	8Sep03		1540	[redacted]
8Sep03	[redacted]	Wean pt off Versed + Fentanyl. Notify RT when ready to extubate pt.	8Sep03		1558	[redacted]
8Sep03	[redacted]	Lasix 20mg IV in between units blood	8Sep03		1730	[redacted]
[illegible]	[redacted]	Transfuse 2 units PRBC	9Sep03	done ICU		[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
08Sep03	[redacted]	MSO4 2-5mg IV q 2° prn (D T D I)	MSO4 5mg IV; MSO4 5mg IV; MSO4 5mg IV; MSO4 5mg IV; 11SEP 2100; 12SEP 0330; 12SEP 0555; 12Sep03 5mg; 12Sep03 1515 / 10Sep 0910; 10Sep 1830; 0930 11Sep03; 1500; 5mg; 5mg; 5mg; 1320; 5mg / [redacted] / Δ'd DC 1600 12Sep03
08Sep03	[redacted]	Percocet 1-2 PO q 4° PRN	8Sep 1925; 9Sep 0715; 9Sep 1525; 9Sep 2315; 10Sep 0615; 10Sep 1500; 10Sep 2310; 11Sep 0730; 11Sep 1230; 11Sep 1806; 11SEP 2320; 12Sep03 1325; 12Sep 1910; 13Sep 1115 / ii; ii; ii; ii; ii po; ii po; ii; ii; ii; ii; ii; ii; ii; ii / [redacted]
8Sep	[redacted]	Tylenol 650mg po prn temp ≥101	8Sep 2115; 9Sep 1830; 11Sep 0030; 12Sep 1521; 2050; 13Sep 0205 / 650mg; 650mg; 650mg; 650mg; 650mg; 650mg / [redacted]
12Sep03	[redacted]	Δ Morphine to 2-5mg IV Q 30mins PRN	12Sep 1626; 12Sep03 1735; 12Sep 2155; 13Sep 0005; 13Sep 0445; 13Sep 1050; 14Sep 0400; 14Sep 1000; 14Sep 1210; 14Sep 2125; 15Sep 0320; 15Sep 0730; 15Sep 1430; 15Sep 1530 / 5mg; 5mg; 5mg; 5mg; 5mg; 5mg; 5mg; 5mg; 3mg; 3mg; 3mg; 3mg; 3mg / [redacted]
08Sep03	[redacted]	Percocet 1-2 PO q4° PRN	13Sep03 1555; 13Sep 2130; 14Sep 0645; 14Sep 1215; 14Sep 1645; 14Sep03 1940; 15Sep 1538; 15Sep03 2140; 16Sep 0738; 16Sep 1900; 16Sep 2327; 17Sep 2160; 18Sep / 2tab; 2; 2tabs; 2tab; 2tab; ii; ii; ii; ii; ii; ii; ii / [redacted]

Rewritten (left margin) — Rewritten (right margin)

USAPA V1.00

MEDCOM - 18614

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. Sept Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:
S/P Ex Fix, (L) humerus, (L) thigh vein graft to (L) Brachial AC

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

PATIENT IDENTIFICATION:
b(6)-4

[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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MEDCOM - 18615

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

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		b(6)-2 All				

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	TIME/DATE DISPENSED
14 Sep 03	[redacted]	Morphine 7-10mg IVP PRN Dressing Δ	14 Sep 03 5mg 1036; 15 Sep 03 7mg 1240; 16 Sep 03 7mg 1515; 17 Sep 5mg 1350; 18 Sep 7mg 1119; 19 Sep 5mg 0925; [redacted]
14 Sep 03	[redacted]	Versed 2-4mg IVP PRN Dressing Δ	14 Sep 03 1038; 15 Sep 03 1295; 16 Sep 03 1520; 17 Sep #3 18 Sep 5mg; [illegible] 9mg; 19 Sep 03 0925 2mg; [redacted]
17 Sep 03	[redacted]	Δ Morphine to 2-5mg IV Q 30 mins PR[redacted]	15 Sep 03 @ 2220 3mg; 16 Sep 03 @ 2125 5mg; 16 Sep 03 @ 0410 2mg; 16 Sep 1834 3mg; 16 Sep 2140 5mg; 17 Sep 0140 5mg; 17 Sep 0520 5mg; 17 Sept 0715 5mg; 17 Sept 1000 5mg; 17 Sep 1350 5mg; 17 Sep 1620 5mg; 18 Sep 0110 5mg; 18 Sep 0319 5mg; 18 Sept 0745 5mg; [redacted]; 18 Sep 0430 5mg; 0714 5mg; 0909 5mg; 1052 5mg; 18 Sept 1230 5mg; 18 Sep 1550 5mg; 18 Sep 1955 5mg; 19 Sep 0210 5mg; 19 Sep 0245 5mg; 0430 5mg; 0610 5mg; 1000 4mg; [redacted]
rewritten 15 Sept 03	[redacted]	Percocet 1-2 PO Q4° PRN	18 Sept 1404 TI; 19 Sep 1850 TI/A; 18 Sep 2314 TI A; [redacted]

rewritten from 15 Sep 03 2222

USAPA V1.00

MEDCOM - 18616

[redacted]CAL RECORD-SUPPLEMENTAL ME[redacted] DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

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

SHIFT ASSESSMENT 08 Sep [redacted]

		TIME:	INITIALS:	TIME: 0500	INITIAL[redacted]
NEURO	PUPILS			Perrla Sluggish 3mm	
	SENSORIUM			Ø Spont movement	
	EXTREMITY MOVEMENT			post-op sedation ↓ muscle relaxation	
	SEDATION			fent 100 mcg/hr versed 10mg/hr	
	PAIN CONTROL				
RESP	RESPIRATORY PATTERN			Vent SIMV-14, P-5, 50%, 100%	
	BREATH SOUNDS			PIP- mid-20's, 28cm @ hub	
	SECRETIONS			CTA bilaterally ↓ dim. bases	
	O2 SOURCE/FLOW/SAO2				
	VENTILATOR SETTINGS				
CV	CARDIAC RHYTHM			SR, NSR, Ø ectopy ↑2 pulses	
	CAPILLARY REFILL			x4 ext. - LUE edema	
	PULSES			cap refill <3 sec x4 ext	
	EDEMA			LUE, warm & dry, LLE, RUE, RLE:	
				cool & dry	
GI	ABDOMEN			flat ND, NT, ~~BS~~ Ø BS x 4 quad	
	BOWEL SOUNDS			NGT → LIS	
	BOWEL MOVEMENT				
	NGT/OGT				
	TUBE FEDDINGS				
	DRAINS				
GU	VOIDING			foley clear yellow adequate amt	
	COLOR/CLARITY				
SKIN	COLOR			- LUE dressing saturated ↓ sanguinous drainage	
	INTEGRITY			- LUE dressing CDI	
				- RUE dressing sat ↓ serosanguinous drainage	
				- LUE ex-fix	
ACCESS	#1 TYPE/LOCATION/SIZE			(R) IJ PIV	dressg CDI
	DRESSING CONDITION			(R) Ac PIV	Ø S/S of infxn
	IV FLUID/RATE			(R) radial A-line	
	#2 TYPE/LOCATION/SIZE				
	DRESSING CONDITION				
	IV FLUIDS/RATE				

(Continue on reverse)

PR[redacted] b(6)-2

DEPARTMENT/SERVICE/CLINIC
ICU #1, 28TH Combat Support Hospital

DATE
8 Sep 03

PA[redacted]CATION (For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)

NAME: [redacted] RANK: AGE:

UNIT: b(6)-4 GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

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

ICU1

Patients Name: [redacted] blew

Date: 8 Sep

0440

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																								171/89	166/86	
NBP																										
TEMP																								98.6	94.3	
HR																								81	77	
RR																								14	14	
SaO2																								100	100	
FiO2																								50	50	
Source																								Vent	Vent	
MAP																								115	110	

ITAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B																										
T																								66		
1/2																								10	10	
red																								10	10	
parin																								16	16	
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE																								50		
NGT																								600		
STOOL																										
DRAIN																										
Total																										

MEDCOM - 18618

#773

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0630	INITIALS [redacted]		INITIALS	1815	INITIALS [redacted]
	PUPLIS	PERRLA, Reaction Sluggish				PEARL (R)	
	SENSORIUM	At on Versed + Fentanyl				At A&O speaking Arabic	
		Does not respond to					
		stimuli					
RESPIRATORY	RESPIRATION PATTERN	Regular, Unlabored				RRR	
	BREATH SOUNDS	CTA				CTA (R)	
	SECRETIONS	None				Ø	
		Vent: SIMV, TV 800, FiO2 50%					
		Peep 5, ETT 27cm @ Hub					
SKIN	COLOR	Normal for Race				WNL	
	INTEGRITY	Dressing to LUE (L)				Drsg to RUE bloody, drsg to	
		thigh, R thigh				RFLEG CDI	
IV SITE	LOCATION	(R) EJ, (R) AC				(R) EJ infusing LR @ 125cc	
	CONDITION	Patent, S/S of infection				& Hep @ 1ml = 50u/hr, (R) AC	
		@ IV sites				infusing PRBC's, (R) radial	
		(R) Radial A line				A-line	
		Leveled + Zeroed, Waveform					
		sharp, Ø S/S of infection					
GASTRO	ABDOMEN	Soft Nontender				Flat, soft, nontender	
	BOWEL SOUNDS	Absent				(+) bowel sounds	
		NG to (L) Nare to LIS					
		Placement verified					
GU	URINE	Foley to gravity				Foley to gravity	
	COLOR/CLARITY	Dark Yellow				Clear yellow	
CARDIOVASCULAR	CARDIACRHYTHM	ST				ST (+) (R) pulses & cap refill	
		Edema (L) arm, ØJVD				< 3 sec	
		Cap Refill < 3 secs					

LEGEND

Cr - Creatinine
F_iO_2 - Fraction of inspired O_2
P_iO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & [redacted] b(6)-2 DEPARTMENT/SERVICE/CINC ICU DATE Sep 03

PATIENT'S INDICATIONS (For typ[redacted]give: Name—Last, First, middle; grade; date; hospital or medi[redacted]

[redacted]

b(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DATE 8 Sep 03 | DX | HOSPITAL DAY

VITAL SIGNS

TIME	06	07	08	09	10	11	12	13		14	15	16	17	18	19	20	21	
BP Arterial line	136/80	136/77	121/61	91/43	105/49	71/39	81/44	81/41		83/50	157/70	105/64	135/67	115/43	119/63	115/59	114/54	
BP Cuff *	142/81	127/79	119/75	106/51	111/54	101/54	109/44	124/63		97/51	143/39	138/50	120/65	116/47		112/55	110/55	
Temperature	94.7	94.5	94.9	96.6	98.1	99.5	98.9				101.3	101.6	99.8	101.8	100.0	100.3	101.4	
Pulse	87	94	107	142	137	143	136	136		156	148	144	138	140	138	134	128	
Respiratory Rate	14	14	22	15	13	12	14	14		12	20	20	21	18	18	21	19	
MAP	99	93	89	67	68	72	70	78		72	101	83	92	87	93	79	77	
O2 Sats	100	100	100	100	100	100	100	100		100	99	99	99	97%	97%	98%	98%	
O2	50%	50%	50%	50%	40%	40%	40%	40%		40%	40%	40%	2L	RA		RA	RA	
Mode	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV		SIMV	VM	VM	NC					

INTAKE

TIME	06	07	08	09	10	11	12	13	8°T	14	15	16	17	18	19	20	21	8°T
LR	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	2000
Fentanyl	10	10	10	10	10	10	10	10	80	10	/							90
Versed	5	5	5	5	5	5	5	5	40	2.8	/							42.8
Heparin	16	16	16	16	14	14	14	14	120	14	14	14	14	14	14	14	14	232
IVPB	100		50				100		250			50		100				400
Bolus					1000				1000		NS 500							1500
PRBC												425	425					850
PO												240	460		260	100		860
TOTALS									2490									5914.8

OUTPUT

	HOUR / TOTAL	250	170	225	170	100	30	20	28	993	16	40	45	70	45	200	200	28	1827
URINE	SP gr																		
	S/A																		
NG	OUTPUT								650	650									
	PH																		
	GUIAC																		
EMESIS															400				400
STOOL																			
DRAINS																			

POST-OP DAY

VITAL SIGNS	12	23	24	01	02	03	04	05	
	124/57		124/61	127/62	128/66	159/68	131/68	126/63	
	124/62	110/63	114/58	121/60	121/65	147/73	126/69	122/61	
	100.7		100		99.3		99.4		
	122	121	121	109	105	110	107	100	
	19	19	20	17	14	18	16	15	
	84	80	79	82	86	98	90	82	
	98%	97%	98%	98%	99%	98%	98%	98%	
	RA	RA	RA	RA	RA	RA	RA	RA	

INTAKE / OUTPUT	12	23	24	01	02	03	04	05	8°T
INTAKE	125	125	125	125	125	125	125	125	3000
									90
									42.8
	14	14	14	14	14	14	14	14	344
			150						550
									1500
									850
		100	240						1200
OUTPUT	95/1922	75/1997	40/2037	55/2092	80/2172	70/2242	90/2332	60/2392	2392
									6500
									4000

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		1	2
TIME		0718	1053
MODE		SIMV	SIMV
F_iO_2		50%	40%
TV		800	800
RATE		14	12
PEEP		5	5
ABG	pH	7.422	7.376
	PCO_2	33.5	37.6
	pO_2	284	207
	HCO_3	22	22
	SAT	100%	100%
	BASE	-3	-3

LABORATORY DATA	
TIME	0710
CLUCOSE	133
Na/K	132/3.5
Cl/CO₂	108/19
BUN/Cr	12/0.8
WBC/PLATELET	9.5/118
Hct/Hgb	31.3/10.5
CK	7500
PT/PTT	15.4/37.1
INR	1.46

ACTIVITIES OF DAILY LIVING

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

TURN
SUCTION
TIME

24° 180 TOTALS

WT Yesterday ______ wt Today ______

INTAKE: IV 6376.8

OUTPUT: Urine: 2392; 1050

NURSE'S SIGNATURE / INITIALS: [redacted]

b(6)-2

MEDCOM - 18621

NEUROLOGICAL ASSESSMENT

		HOURS	06	07	08	09	10	11
GLASCOW COMA SCALE	EYES OPEN	SPONTANEOUSLY 4						
		TO SPEECH 3						
		TO PAIN 2						
		NO EYE OPENING 1						
	BEST VERAL RESPONSE	ORIENTED 5						
		CONFUSED 4						
		VERBALIZES 3						
		VOCALIZES 2						
		NO VOCALIZATION 1						
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6						
		LOCALIZESPAIN 5						
		FLEXION WITHDRAWAL 4						
		ABNORMAL FLEXION 3						
		EXTENSION TO PAIN 2						
		NO RESPONSE 1						
LIMB MOVEMENT	ARMS	NORMAL POWER						
		MILD WEAKNESS						
		SEVERE WEAKNESS						
		ABNORMAL FLEXION						
		ABNORMAL EXTENSION						
		NO RESPONSE	X	X	X	X	X	X
	LEGS	NORMAL POWER						
		MILD WEAKNESS						
		SEVERE WEAKNESS						
		ABNORMAL FLEXION						
		ABNORMAL EXTENSION						
		NO RESPONSE	X	X	X	X	✓	X
PUPILS	RIGHT	SIZE	3					
		REACTION	+					
	LEFT	SIZE	3					
		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 tow sides

++ Brisk
+ Slow
No Response

+ Intact
– Abnormal

VASCULAR ASSESSMENT

HOURS		06	07	08	09	10	11	12	13	14
Radial	R	+	++	++	++	++	+	+	+	+
	L	+	++	++	++	++	+	+	+	++
Pedal	R	+					+	D		+
	L	+					+	D		+
	R									
	L									
	R									
	L									

++ Normal
+ Weak
– Absent
D Doppler
R Right

[redacted]CAL RECORD-SUPPLEMENTAL ME[redacted]DATA

For use of [redacted]orm, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET — b(6)-2

OTSG APPROVED (Date): QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0630 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]
NEURO	PUPILS	WNL PERL	PERRL (B)
	SENSORIUM	moves all extremities L arm a day	A&O x3 speaking Arabic
	EXTREMITY MOVEMENT	sensation response [illegible]	Moves all extremities, (R) UE c a lot of assistance
	SEDATION		Ø
	PAIN CONTROL		C/O pain in (R) UE
RESP	RESPIRATORY PATTERN	reg non labored	Reg, nonlabored
	BREATH SOUNDS	CTA	CTA
	SECRETIONS	Ø	Ø
	O2 SOURCE/FLOW/SAO2	Room air	Room air
	VENTILATOR SETTINGS	NA	NA
CV	CARDIAC RHYTHM	NSR [illegible]	ST [illegible]
	CAPILLARY REFILL	< 3 sec	< 3 sec
	PULSES	palpable x 4 extremities	(+) all extremities
	EDEMA	Ø	(R) hand
GI	ABDOMEN	soft non-tender	Flat soft nontender
	BOWEL SOUNDS	present x 4	(+) x 4 quads
	BOWEL MOVEMENT	UTA	Ø
	NGT/OGT	Ø	Ø
	TUBE FEDDINGS	Ø	Ø
	DRAINS	Ø	Ø
GU	VOIDING	via foley clear yellow urine	Foley to gravity
	COLOR/CLARITY	in adequate amounts	clear yellow
SKIN	COLOR	[illegible]	WNL
	INTEGRITY	[illegible]	Drsg (R) UE c old serosanguenous drainage, drsg to
		[illegible]	(R)(L) [illegible] High CDI
		dry + intact	
ACCESS	#1 TYPE/LOCATION/SIZE	18 G (R) EJ IV [illegible]	18 ga (R) EJ
	DRESSING CONDITION	18 G (R) AC IV heplock	
	IV FLUID/RATE	LR @ 125 cc/h	heplocked
	#2 TYPE/LOCATION/SIZE		18 ga (R) AC
	DRESSING CONDITION		
	IV FLUIDS/RATE		heplocked

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] b(6)-4 [redacted] 1LT MC M3

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 9 Sep 03

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

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

RANK: CI

AGE:

UNIT: ICU #1

GENDER: M

STATUS: US: AD / CIV

IRAQI: CIV / EPW

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

DA FORM 4700, MAY 78

MEDCOM - 18623

USAPPC V2.00

ICU1

Patients Name: [redacted] 0940 0945 5(e)-4

Date: 9 Sep 2003

VITALS	06	07	~~08~~	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	131/62	148/65	137/66			164/70			128/80		113/81					157/56	135/71	136/65	146/74	125/61	125/62	127/62	126/59	[illegible]/60	127/[illegible]	
NBP	128/64	~~138/66~~		137/59	138/60	141/68	129/63	141/63		128/70		133/[illegible]		119/49	131/64	150/66	129/59	134/62	134/62	129/56	127/53	130/56	124/57	126/58	120/62	
TEMP	98.3	99.8	99.1					100.5		101.5		101.3		101.8		101.3		100.3		100.2		99.7		99.2		
HR	104	101	83	98	97	101	107	118	111	119	114	114		125	109	113	121	109	117	106	99	100	94	96	92	
RR	16	16	17	21	14	16	15	14	13	18	20	21		17	17	20	17	11	23	16	15	14	15	13	14	
SaO2	97%	97	100	98	97	100	100	100	100	98	100	100		95%	99%	98%	98%	97%	100%	96%	97%	97%	97%	98%	98%	
FiO2			31%	31	31	21	~~100~~																			
Source	RA	RA	31% FM	FM	FM	FM	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	
MAP	88	89																								
[illegible]																										

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
LR	125	125			125	125	125	125	125	125	125	125	1250	125												1375
B	100		50				100				50		300	100						150						550
T																										
D	14	14	—										28													28
RBC				250	250								500													500
o						60	240						300	240				200	100							540
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	75/75	70/145		325/470		300/770	160/930	200/1130	200/1330	200/1530	180/1710	200/1910	1910	70/1980	190/2170	200/2370	100/2470	120/2590	115/2705	190/2895	180/3075	200/3275	200/3475	180/3655	170/3825	3825
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 18624

[redacted]CAL RECORD-SUPPLEMENTAL ME[redacted] DATA

For use of [redacted]rm, see AR 40-66; the proponent agency is the Office [redacted] Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

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

SHIFT ASSESSMENT

		TIME: INITIALS: [redacted]	TIME: 1830 INITIAL[redacted]
NEURO	PUPILS	pupils PERL	PERRL (B)
	SENSORIUM	ŝ sensation or movement in L arm	A&O x3 speaking Arabic
	EXTREMITY MOVEMENT	+ hand all other extremities moved	Moves all extremities (L)UE ē assistance
	SEDATION	ŝ difficulty	Ø
	PAIN CONTROL	pain control ē IV morphine + po percocet	Pt given 5mg MSO4 IV for pain
RESP	RESPIRATORY PATTERN	reg + unlabored	Reg ē unlabored
	BREATH SOUNDS	CTA all lobes	CTA (B)
	SECRETIONS	Ø	Ø
	O2 SOURCE/FLOW/SAO2	Room air	Room air
	VENTILATOR SETTINGS	Ø	Ø
CV	CARDIAC RHYTHM	NSR ⇄ ST ŝ ectopy [illegible]	SR to ST ē S1, S2 noted
	CAPILLARY REFILL	<3 sec	<3 sec
	PULSES	palpable x 4 extremities	⊕ x4 extremities
	EDEMA	Ø	Ø
			(R) radial A-line, flushed & zeroed
GI	ABDOMEN	soft non tender	Flat soft nontender
	BOWEL SOUNDS	present x 4 quads	⊕ x4 quads
	BOWEL MOVEMENT	Ø	Ø
	NGT/OGT	Ø	Ø
	TUBE FEDDINGS	Ø	Ø
	DRAINS	Ø	Ø
GU	VOIDING	per foley clear yellow	Foley to gravity
	COLOR/CLARITY	in adequate amounts	Clear - light yellow
SKIN	COLOR	WNL	WNL
	INTEGRITY	[illegible] dressing left arm	Drsg (L)UE mod amount serous fluid
		external fixator L humerus	Drsg (B) thigh CDI
		dress to L+R thigh over burns	
		ŝ drainage	
ACCESS	#1 TYPE/LOCATION/SIZE	R radial A line ē good wave[illegible]	(R)EJ IV heplocked
	DRESSING CONDITION	R AC peripheral IV heplocked	
	IV FLUID/RATE	R EJ line heplocked	
	#2 TYPE/LOCATION/SIZE		(R)AC peripheral IV heplocked
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY [redacted] b(6)-2 [illegible]

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 10 Sep 03

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

NAME: [redacted]

RANK: CI

AGE:

UNIT: b(6)-4

GENDER: M

STATUS: US: AD / CIV

IRAQI: CIV / EPW / CI

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

DA FORM 4700, MAY 78

MEDCOM - 18625

USAPPC V2.00

ICU1

Patients Name: #[redacted]

Date: 10 Sep 2003

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	134/61	133/61	142/73	135/62							165/93					134/63	131/62	135/65			132/64	132/64	130/65	124/62	134/65	
NBP	134/66				136/61	136/69	135/68								129/70	131/64	132/67	132/64	135/66	129/65	132/65	144/63	132/65	135/69	134/65	
TEMP	99.1			100.6	99.8					100.3					100.5		99.9		99.6			100.5		99.7		
HR	94	104	99	104	100	100	98	93		102	103			97	94	97	116	97	96	92	94	101	94	100	94	
RR	17	23	13	17	13	15	14	14		14				21	18	14	25	18	12	14	13	19	13	20	16	
SaO2	98	96	99	97	97	97	95	98		97				98	98%	97%	100%	99%	98%	98%	97%	96%	96%	95%	100%	
FiO2																										
Source	RA	RA	RA	RA	RA	RA	RA	RA		RA				RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	
MAP																										

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B	100		50				100				50		380	100		~~240~~				~~240~~ 150						550
T																										
O		480		240			480	240			240					240				200				180	100	2340
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	150/150	300/550	300/550	240/790				200/990	300/1290	200/1490		600/2090	2010	300/2310	300/2610	120/2730	200/2930	240/3170	250/3420	300/3720	240/3960	250/4210	150/4360	340/4700	150	4850
NGT																										
STOOL																										
DRAIN																										
Total																										

[redacted]CAL RECORD-SUPPLEMENTAL ME[redacted]L D[redacted]TA

For use of [redacted]orm, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET (b)(6)-2

OTSG APPROVED (Date): QA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 0645 INITIALS [redacted]	TIME: 2100 INITIAL [redacted]
NEURO	PUPILS	3mm PERRL	PERRLA 3mm
	SENSORIUM	Awake + Alert Unable to	Alert, Follows commands
	EXTREMITY MOVEMENT	move LUE All other extremities	LUE ± ex-fib humerous unable to
	SEDATION	Pt move without difficulty	move fingers. Moves other extre-
	PAIN CONTROL	Percocet/Morphine	mities unaided. Sensation to LUE ④
			Percocet/MSO4 upon request
RESP	RESPIRATORY PATTERN	RRR Symmetrical chest expansion	RRR RA SaO2 100%
	BREATH SOUNDS	CTA bilat	CTA (B)
	SECRETIONS	& Secretions	ϕ
	O2 SOURCE/FLOW/SAO2	RA	RA/100%
	VENTILATOR SETTINGS		—
CV	CARDIAC RHYTHM	S1S2 +2 pulses x4 extremities	SR/ST S1/S2
	CAPILLARY REFILL	<3 Cap refill	<3 sec
	PULSES		+2 x 4 extremities
	EDEMA		ϕ
GI	ABDOMEN	+BS x4 quads. Soft Non	Soft, Flat, Nontender
	BOWEL SOUNDS	tender & distentions	(+)
	BOWEL MOVEMENT		ϕ
	NGT/OGT		—
	TUBE FEDDINGS		—
	DRAINS		—
GU	VOIDING	Voids to foley	Foley to gravity
	COLOR/CLARITY	clear yellow	Light yellow, clear
SKIN	COLOR	NFR, external fixator to	NFR, Warm, Dry
	INTEGRITY	(L) Humerus	Drsg to LUE CDI ± Ex Fix
			to humerous. Sensation in
			fingers, unable to move fingers
			skin to (L) fingers warm & dry
ACCESS	#1 TYPE/LOCATION/SIZE	18ga (R) A/C Site CDI	18G PIV (R) AC
	DRESSING CONDITION	& S/S of erythema	CDI
	IV FLUID/RATE	A-line to (R) Radial	HL
	#2 TYPE/LOCATION/SIZE		A-Line 20G (L) Radial
	DRESSING CONDITION		CDI
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] (b)(6)-2 9MAR03

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 11 Sep 03

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

NAME: # [redacted] RANK: AGE:

UNIT: (b)(6)-4 GENDER: M

STATUS: US: AD / CIV IRAQI: CIV / EPW / (CI)

☐ HISTORY/PHYSICAL ☒ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78 MEDCOM - 18627 USAPPC V2.00

ICU1 Patients Name: [redacted] b(6)-4 Date: 11 Sep 03

NPO @ MN

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	(04)	05	
A-Line																	139/55				136/65	100/62	134/66	169/71		
NBP	144/71	133/67	137/69	137/72		137/69			114/60	128/62	127/73	121/65		125/70	115/62	124/62	122/61	120/63	120/60	122/66	136/68	131/73	124/69	134/68		
TEMP		101.5	100.5	100.3	100.0	99.8		99.1	98.6		98.7						99.5 ⓞ				100.5		99.6 ⓞ			
HR	106	99	102	107		101		100	101	89	94	93		98	~~100~~ 93	95	~~100~~	92	91	95	99	95	87	91		
RR	16	15	14	14		13		15	13	11	14	18		13	14	12	12	9	12	13	13	16	12	10		
SaO2	99%	98%	98	98%		99%		98%	100	100	100	99		100	100	99	100	99	100	100	99	100	100	99		
FiO2																										
Source	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA		
MAP																										

MEDCOM - 18628

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B	100		50				100				50		300							150						150
T																										
PO		120	120	150			250						640				240		240	NPO						480
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	200/200	150/350	150/500	110/610	100/710	110/820	120/940	150/1090	120/1210	260/1470	200/1670	200/1870	1936	80/80	110/190	100/290	150/440	150/590	140/730	160/890	120/1110	160/1270	140/1410			
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 12 Sept 03 Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block
Time In: 1730
Allergies: NKDA OR Intake: Crystalloid 1600 Colloid —
Pre-op V/S: 112/80, 70 OR Output: UOP 350 EBL min
Procedures: I+D (L) Arm, Ext fix adjustment Meds/Times: Fentanyl, MSO4

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	1730	1735	1740	1750
SaO2	97	98	100	98
FIO2				
Methods				
240				
220				
200				
180				
160				
140				
120				
100				
80				
60				
40				
20				
RR				
T				

Time										
Pain (0-10)										
LOS										

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1730	NS	400	(L) hand	OR	1600

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S
X = A-line BP
˅ = Cuff BP
˄ = Pulse

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

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

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

(Continue on reverse)

PREPARED BY [redacted] LPN b(6)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 12 Sept 03

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

[redacted] b(6)-4
ICU #1

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDCOM - 18629

MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L) arm	FROM	+		B	W	PK
15'							
30'							
45'							
60'							
90'							
D/C							

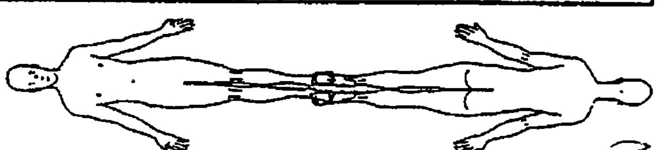
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent Color: C = Cyanotic, P = Pale, Pk = Pink Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L) arm	Splint c ext fix	⊘
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1230	ST	⊘	⊘

WAMC OP 173-E

NURSING NOTES

Pt to recovery room from OR s/p (L) arm fix repair. Pt asleep easily arousable. Ext. fix and bulky splint to (L) arm intact. ⊘ drainage noted. IV of NS infusing into (R) hand. A [illegible] ⊘ s/s of redness or swelling. A-line intact to (R) radial area. ⊘ c/o pain @ this time. NV intact. VSS. Will continue to monitor & assess [redacted]

- Pt to ICU #1 Report given to SPC [redacted]

b(6)-2 A11

Discharge Criteria:
Date: **Time:** **PARS:**
BP: 141/70 **T:** 99.2 **HR:** 111 **RR:** 14 **Sa02:** 98
Pain Level at D/C (0-10):
Intake: 50 **Output:** ⊘
Additional Data:
Transferred To: ICU #1
Report Given To: ICU #1 SPC [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: SG [redacted]
Cleared IAW Recovery Ro[redacted]
Charge Nurse Signature: [redacted]

[redacted] RECORD-SUPPLEMENTAL ME[redacted] 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

SHIFT ASSESS[redacted]T b(6)-2

		TIME: 0635 INITIAL[redacted]	TIME: INITIALS:
NEURO	PUPILS	PERRLA	PERRL (B)
	SENSORIUM	A+OX3	A&OX3 speaking broken English & Arabic
	EXTREMITY MOVEMENT	Active in RUE & RLE. Ø movement LUE	movement (B) LE's, (R) UE
	SEDATION	N/A	Ø
	PAIN CONTROL	Morphine	A c/o pain taking MSO4 & Percocet
RESP	RESPIRATORY PATTERN	Regular + Unlabored	Reg unlabored
	BREATH SOUNDS	CTA	CTA
	SECRETIONS	None	Ø
	O2 SOURCE/FLOW/SAO2	RA	Room Air
	VENTILATOR SETTINGS	N/A	N/A
CV	CARDIAC RHYTHM	ST, Ø ectopy	ST & SI, SB noted
	CAPILLARY REFILL	<3 secs	<3 sec X 4 extremities
	PULSES	+3 in all extremeties	(+) in all extremities
	EDEMA	LUE + BLE	(D) UE
		~~Skin~~ 0058	
GI	ABDOMEN	Soft, Nontender	Flat, soft nontender
	BOWEL SOUNDS	Active	(+) all quads
	BOWEL MOVEMENT	None	Ø
	NGT/OGT	—	N/A
	TUBE FEDDINGS	—	N/A
	DRAINS	—	N/A
		Ø N/S	
GU	VOIDING	Foley to Gravity	Foley to gravity
	COLOR/CLARITY	Straw, Clear	Clear yellow
SKIN	COLOR	Normal for race	WNL
	INTEGRITY	Serous drainage noted on LUE dressing	Dsg to (D) UE CDI
ACCESS	#1 TYPE/LOCATION/SIZE	18G IV (R) Hand	18ga PIV (R) hand
	DRESSING CONDITION	Ø D/I, Ø S/S of infection, Patient	
	IV FLUID/RATE	Saline Lock	
	#2 TYPE/LOCATION/SIZE	(R) Radial A-line	
	DRESSING CONDITION	C/D/I, Ø S/S of infection	
	IV FLUIDS/RATE	NS to Pressure Bag	

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 12SEP03

PATIENT [redacted] (If typed or written entries give: Name – last, first, middle; grade; date; hospital; unit; etc.)

NA[redacted]NK: AGE:

UNIT: [redacted] b(6)-4 GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

ICU1

Patients Name: # [redacted] 3(e)-4

Date: 12 Sept 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line									145/82	138/63	136/84	137/67		133/73												
NBP	151/65	142/62						156/69	164/75	174/68	138/63	144/82		↓	148/80	144/79	139/76	132/72	132/74	126/68	139/69	132/73	127/64	134/70	138/84	
TEMP	100.4							100.3		102.4		102.3		102.3	102		101.9		102		101.3	101		100.3		
HR	97	99	2					114	119	119	113	115		110	111	117	109	105	105	110	114	114	105	103	101	
RR	10	14	0					11	19	21	15	23		13	11	14	16	19	17	18	22	19	17	17	16	
SaO2	99	100						98	98	98	98	98		98	99%	99%	99%	99%	99%	98%	99%	99%	100%	100%	100%	
FiO2			2					RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	
Source	RA	RA	0						185/140																	
MAP									101	69	86	87		94	104	101	92	97	95	91	95	94	94	98	98	

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IV						OR	1600	600	RAC				2200													2200
PB	100						100				50		250	100												350
NT																										
PO								160	380	480	500	480	2000		240		1000				200					
Total													(4450)													

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	140	140	125				OR	350	100	100	100	100	1175	120	55	60	180	180	100	140	80	170	180	250	160	1720
NGT																										
STOOL																										
DRAIN																										
Total													(1175)													

ICU1

Patients Name: #[redacted] 0161

Date: 13 Sep 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	136/74		138/75				127/69				137/75			135/69		148/68				145/56				140/60		
TEMP	100.4		98.5						100.2			101.0		100.2		99.7				99.8				100.4		
HR	102		101				100				110			106		109				102				109		
RR	16		18				16				14			19		12				15				21		
SaO2	100%		100%				100%				99%			99%		99%				100				100		
FiO2							—				—															
Source	RA		RA				RA				RA			RA		RA				RA				RA		
MAP																										

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B	100		50				100				50	100	400							150						
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	120/120						310/130					1500/500	1500			500				100				600		
NGT																										
STOOL																										
DRAIN																										
Total																										

M[illegible]AL RECORD-SUPPLEMENTAL MED[illegible] DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

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

SHIFT ASSESSMENT [redacted]

		TIME: 0730 INITIALS: [redacted]	TIME: 1840 INITIALS: [redacted]
NEURO	PUPILS	PERRL	PERRLA, A&O X3, interacts c staff, appropriate, ex-fix (L) UE elevated, Ø sensation small ring & middle finger on (L) UE, Ø movement all 5 (L) fingers, moves all 3 other ext.
	SENSORIUM	Pt alert + oriented X3	
	EXTREMITY MOVEMENT	Limited ROM to LUE	
	SEDATION	Ø	
	PAIN CONTROL		
RESP	RESPIRATORY PATTERN	Reg R+R	even and unlabored, 98% RA
	BREATH SOUNDS	CTA bilat	CTA bilaterally
	SECRETIONS	Ø Ntd	
	O2 SOURCE/FLOW/SAO2	RA	
	VENTILATOR SETTINGS	N/A	
CV	CARDIAC RHYTHM		S1S2, ST Ø ectopy
	CAPILLARY REFILL	brisk	+2 pulses x 4ext, all ext warm & dry Ø edema noted
	PULSES	Radial + Pedal Pulses @ +4 bilat	
	EDEMA	Ø Ntd	
GI	ABDOMEN		soft NT, ND, BS x 4quad ate 90% of dinner, tolerated well.
	BOWEL SOUNDS	BS + X 4 Quads	
	BOWEL MOVEMENT	Ø to this point in shift	
	NGT/OGT	Ø	
	TUBE FEDDINGS	Ø	
	DRAINS	Ø	
GU	VOIDING	Pt voiding Clr yellow urine ~~tNC~~	foley clear yellow adequate amt
	COLOR/CLARITY	via Foley to gravity in adequate Amounts	
SKIN	COLOR	NFR	ace wrap (L) UE CDI, Bilateral (L) & (R) inner thigh dressing CDI
	INTEGRITY	Dressings to (L) arm + bilat inner thighs intact.	
ACCESS	#1 TYPE/LOCATION/SIZE	(R) bicep PIV Dressing C/D/I	(R) bicep PIV, patent Ø s/s of infection
	DRESSING CONDITION	Flushes well. Heplocked	
	IV FLUID/RATE		
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 13 Sep 03

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

NAME: [redacted] RANK: AGE:

UNIT: b(6)-4 GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW CI

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

DA FORM 4700, MAY 78

MEDCOM - 18634

USAPPC V2.00

...CAL RECORD-SUPPLEMENTAL ME... DATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

b(6)-2

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

	SHIFT ASSESSMENT		
		TIME: 0700 INITIALS: [redacted]	TIME: 1830 INITIA[redacted]
NEURO	PUPILS	PERRL	3mm PERRL Pt responds
	SENSORIUM	Pt Alert to touch+Voice. Able to follow Commands	to verbal stimuli, follows
	EXTREMITY MOVEMENT	Limited LUE movement	simple commands
	SEDATION	Ø	
	PAIN CONTROL	Pt receiving Percocet + MSO4 PRN	MSO4 & Percocet
		c̄ Moderate Pain Control	
RESP	RESPIRATORY PATTERN	Reg R+R	even, equal rise/fall of
	BREATH SOUNDS	CTA bilat	chest, lung sounds clear in
	SECRETIONS	Ø Ntd	all fields bilat.
	O2 SOURCE/FLOW/SAO2	Pt on RA, O_2 sats @ 100%	
	VENTILATOR SETTINGS		
CV	CARDIAC RHYTHM		S_1S_2 normal. no ectopy or
	CAPILLARY REFILL	brisk	murmurs noted. Pulses palpable
	PULSES	+3 bilat radials + Pedals	in radial & pedal
	EDEMA	Ø Ntd	
GI	ABDOMEN	Soft, Non tender Non-distended	(—) TTP (+) BS x 4 quads
	BOWEL SOUNDS	+ x 4 Quads	
	BOWEL MOVEMENT	Ø to this point in shift	
	NGT/OGT	Ø	
	TUBE FEDDINGS	Ø	
	DRAINS	Ø	
GU	VOIDING	Pt voiding Clr Yellow via Foley	pt has foley QS clear /
	COLOR/CLARITY	to gravity in adequate Amounts.	yellow
SKIN	COLOR	NFR	NFR, thigh wounds (B) clean
	INTEGRITY	Bilat inner thigh + LUE	External fixator to (L) arm
		dressings intact.	
ACCESS	#1 TYPE/LOCATION/SIZE	PIV to (L) bicep heplocked.	(R) Bicep HL
	DRESSING CONDITION	Dressing C/D/I c̄ Ø Ntd	
	IV FLUID/RATE	erythema/Edema.	
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY *(Signature & Title)* b(6)-2
[redacted] 91WM6

DEPARTMENT/SERVICE/CLINIC
ICU #1, 28TH Combat Support Hospital

DATE
14 Sep 03

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

NAME: RANK: AGE:

UNIT: [redacted] GENDER:

b(6)-4

STATUS: US: AD / CIV IRAQI: CIV / EPW

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

DA FORM 4700, MAY 78

MEDCOM - 18635

USAPPC V2.00

ICU1

Patients Name: [redacted]

Date: ~~14 Oct~~ 14 SEP 07

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP			161/72				143/60				137/46					132/43				132/56				148/69		
TEMP		99.8	98.4				99.1				99.9					99°								98.7		
HR			109				94				98					103				95				105		
RR			20				17				12					18				15				20		
SaO2		100%	99%				100%				100%					99				100				99		
FiO2																										
S[redacted]e		RA	RA				RA				RA					RA				RA				RA		
MAP																										

MEDCOM - 18636

ITAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
[redacted]																										
[redacted]B																										
[redacted]T																										
PO [redacted]																										
[redacted]tal																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	280/280		175/455						850/1305			450/1755	1755			85	100	200	100	350	120	150	125	300		2230
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89

b(6)-2

INITIAL SHIFT ASSESSMENT

		Time: Initals: [redacted]	Time: 1815 Initals: [redacted]
NEURO	Pupils	3mm PERRL Book	Pupils 3mm & PERRL
	Sensorium	Follows commands appropriately	Pt follows simple commands
	LOC / GCS	LUE & movement all other extremities have purposeful movement	Pt is awake/alert
CARDIAC	Cardiac Rhythm	S,S2 +2 pulses x4 extremities	S,S2 normal & no ectopy
	PRI: / QRS:	<3 sec cap refill	5/6 murmur noted. Pulses
	Pulse Strength		are palpable x 4 extremities.
	Cap Refil / JVD		Cap refill. < 3sec.
	Edema		
	Chest Pain		
RESP	Respiratory Pattern	RRR symmetrical rise & fall	RR on labored & equal
	Breath Sounds	of chest CTA bilat	rise & fall of chest. Lung
	Secretions	& secretions	sounds are clear in
	Cough		all fields.
SKIN	Color	NFR External fixators	NFR
	Integrity	(L) humerus	
	Backside		
IV	Access Devices	18 ga IV to (R) bicep	20g (R) wrist flushing
	Location	Site CDI & erythema	with no difficulties. & S/S
	Condition		of infection/infiltration. HL
GI	Abdomen	+BS x 4 quads Soft non-	(-) TRD (+) BS x 4 quads
	Bowel Sounds	tender & distention	tolerating reg diet
	Stoma/Ostomy		
GU	Device	Foley to gravity Clear	Pt has foley to gravity
	Color / Clarity	yellow urine	Q, clear yellow.

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU #1, 28TH Combat Support Hospital

DATE: 15 Sep 03

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

NAME: [redacted] RANK: AGE:

b(6)-4

UNIT: ICU 1 GENDER: M

STATUS: US: AD / CIV IRAQI: CIV / EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

MEDCOM - 18637

ICU3

Patients Name: [redacted]

Date: 15 Sept 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																116/				114/				122/		
NBP			136/65				133/65				138/67					62				55				60		
TEMP			100.1				98.5				99.1					98.6				100.2				99.1		
HR			105				89				99					110				97				98		
RR			20				17				14					23				16				21		
SaO2			99%				99				99					100				98				98		
FiO2																										
Source			RA				RA				RA					RA										
[redacted]																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Tot
IVF																										
IVPB	100		50				100				50		200	100						150						
NGT																										
[redacted]																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE	150	160	210	190	180	300	150	110	110	120	110	150	1940	200	200	250	250	125	100	150	100	100	100	150	80	
NGT																										
STOOL																										
DRAIN																										
Total																										

[redacted] RECORD-SUPPLEMENTAL MED[redacted] 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)*
OA Appr 8 Mar 89

SHIFT ASSESSMENT

		TIME: 1100 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]
NEURO	PUPILS	PERL	Perrla
	SENSORIUM	Follow all command	Follows commands, understands
	EXTREMITY MOVEMENT	Limited usage to (L) extremities	& speaks some english
	SEDATION		
	PAIN CONTROL		
RESP	RESPIRATORY PATTERN	12	RRR
	BREATH SOUNDS	CLEAR	Clear bilat
	SECRETIONS	Ø	—
	O2 SOURCE/FLOW/SAO2	Ø	—
	VENTILATOR SETTINGS	Ø	—
CV	CARDIAC RHYTHM	HR 90	SR 90's
	CAPILLARY REFILL		< 3sec
	PULSES	+4 to (L)	+2 pulses & LUE +4
	EDEMA		
GI	ABDOMEN	LUQ, soft & non distended	Soft, non distended
	BOWEL SOUNDS	4 quadrant	BS active x4 quads
	BOWEL MOVEMENT		
	NGT/OGT	Ø	—
	TUBE FEDDINGS	Ø	—
	DRAINS		
GU	VOIDING	Pt self	Voids to urinal
	COLOR/CLARITY		
SKIN	COLOR	normal for race	Normal for Race
	INTEGRITY	Skin warm + dry to touch.	Skin warm & dry to touch
ACCESS	#1 TYPE/LOCATION/SIZE	(R) wrist Hep lock. @ risk of infection.	(R) wrist (HL)
	DRESSING CONDITION		
	IV FLUID/RATE		
	#2 TYPE/LOCATION/SIZE		
	DRESSING CONDITION		
	IV FLUIDS/RATE		

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC
ICU #1, 28TH Combat Support Hospital

DATE
18 Sept 03

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

NAME: [redacted]

RANK:

AGE:

UNIT: b6) -4

GENDER:

STATUS: US: AD / CIV

IRAQI: CIV / EPW

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

ICU1

Patients Name: [redacted]

Date: 18sep03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	134/73	117/60	114/60				115/61							136/75				114/66				128/68				
TEMP	98.7						98.7							98.7				101.5								
HR	89	90	90				91							105				105				100				
RR	18	12	12				14							18				18				16				
SaO2	100%	100%	100%				100%							100%				100%				100%				
FiO2	—	—	—				—							—				—				RA				
Source	RA	RA	RA				RA							RA				RA								
MAP	—	—					—																			

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
B	100	50																								
T																										
PO																										
Total																			500		625 / 1125					

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE			X1																							
NGT																										
STOOL																										
DRAIN																										
Total																										