LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	pulse. Pt able to wiggle toes. lungs CTA. B&A x4. Will continue to monitor - [redacted] 11WH6
1930	Pt sleeping, easily aroused. VSS, lungs CTAB HRRR, +BS, ø complaints @ this time. +leg drsg D/I. +pedal pulses. Pt can move toes. LR @ 125cc/hr unto +AC 5/15/5x infection or infiltration. Will monitor [redacted] 9IWM6.
24 Sep 2355	abx given. pt voiding clr via urinal. ø distress noted. +leg elevated. Will mon [redacted] 9IWM6.
24 Sep 0400	Received pt resting in bed, VSS, ø acute distress noted @ this time. Sleeping intermittently but easily awakened. +LE drsg A/D [redacted] c/D/I +pulse, pt able to wiggle toes. +cap refill. LR @ 125cc/hr via +ac access infusing w/o apparent complication. Pt has +LE ↑, but will "kick" blankets for elevation assy. Pt also needs ass. ere to be OOB. VSS. clr mod yellow urine Will cont to monitor [redacted]
24 Sep (1950)	Pt alo, vss, ø clo pain, +LE drsg CDI, + distal pulses, able to move toes. IV HL to +AC ø edema, ø redness. pt does not want to get OOB. voiding mod. yellow urine via urinal. TOC reg diet well. ø N/V. ICTAB, HRRR +BSx4 qd. Will monitor - [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
24 SEP 03	Ortho Discharge Note [redacted] (b)(2)-2
K3	
	Injured in hotel bombing 22 SEP 03
	Wound over (R) tibia. To OR, I+D, irrigated 6 liters. Small puncture in tibial cortex otherwise fracture stable. Wound remained clean and dry. Penrose drain removed today.
	PLAN: Crutches for comfort. Weight bear as tolerated.
	Keflex 250 mg P.O. Q10 × 10 days.
	T#3 1-2 P.O. Q4-6 hrs PRN #20.
	Sutures out in 7 days.
	[redacted] (b)(6)-2
	DMC

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 Sep 03 0709	Pt sleep. Awakens easily. Oriented. VSS Lungs CTA Abd soft nontender c (+)BS x 4 quads. LLE drsg c Ace Wrap C.D.I. Pedal pulses strong. Brisk capillary refill. Moves toes c difficulty. Heplock patent. Finished one Gram infusing. Pt denies pain/discomfort @ this time. Preparing to Am Care & Breakfast.
25 Sep 03 0712	Will continue monitoring. [redacted] pending D/C today.
25 Sep 03 1000	Pt ambulating well in room. No complaints. Offered Pt refused breakfast. [redacted]
25 Sep 03 1630 +4:30	Pt A & O. VSS. D/C per md order. Escorted to PAD.
26 Sep 03	Pt A+O x3 w/o c/o pain or discomfort. OK for discharge this morning. DC medication @ bedside ambulates well c crutches. Escorted to PAD c chart and interpreter to ensure pt. gets home. [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)*

[redacted] (5)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1998)
Prescribed by GSA/ICNR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25Sep03	1930: VSS, A+O, c/o pain, crutch walks OOB WBAT c difficulty, (+)LE wrapped in Dsg c ACE, neurovascularly intact c 2+ pedal pulse, CRT<3secs & (+) sensation + movement of (+) toes. (+)LE elevated when in bed. Pt has D/C meds @ BS, pending D/C at next soonest possible time. Will monitor. [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22 SEP 03	Ortho Op Note - [redacted] (b)(2)-2
1405	
	Pre Op Dx - Open (L) tibia fx
	Post Op Dx - Same
	Procedure - I+D (L) tibia with wound closure
	Surgeon - [redacted] (b)(6)-2 -
	[illegible] - [redacted] [illegible] - [redacted]
	[illegible] -
	Findings - Grade II open fx, with small 3x3 mm puncture of anterior of tibia. Curetted, Irrigated & debrided. Wound closed primarily in layers over penrose drain
	PLAN: Dressing change in 48 hours. Pull drain after. IV Ancef x 72 hours, then oral Keflex
	[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.

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

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER [redacted]

RECORDS MAINTAINED AT (5)(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 22 Sep 05 | TIME 900

TRANSPORTATION TO FACILITY

SEX	DUTY/LOCAL PHONE		MILITARY STATUS			
M	AREA CODE	NUMBER	ITEM	YES	NO	N/A
			PRP			
AGE	HOME PHONE		FLYING STATUS			
32	AREA CODE	NUMBER	MEDICAL HISTORY OBTAINED FROM			

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

CURRENT MEDICATIONS: PO Doxy

ALLERGIES: PCN (rash)

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☒ YES ☐ NO

CHIEF COMPLAINT: Rt foot injury

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME

INITIALS (5)(6)-2

VITAL SIGNS

TIME	2356	0930			
BP	120/69	120/80			
PULSE	101	105			
RESP	16				
TEMP	98.2				
WT					

LAB ORDERS

✓ CBC/DIFF	ABG	✓ PT/PTT	BHCG/URINE/BLOOD/QUANT		
URINE C&S	UA MSCC/CATH		CHEM:		
BLOOD C&S X					
✓ met 8 met 12 0910 pm					
✓ type & screen 0910 pm					

X-RAY ORDERS

CXR PA & LAT/PORTABLE		C-SPINE	
ACUTE ABDOMEN		LS SPINE	
SINUS		HEAD CT	
ANKLE R/L	X	✓ 5:6	(2)

ORDERS (5)(6)-2

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	TIME	PATIENT'S RESPONSE
910	Keflex	[redacted]	0914	
915	Irrigation			
	1g Ancef		0920	

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 ☐ DETERIORATE

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] (5)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

NSN 7540-01-075-3786

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

TEST RESULTS

CBC	WBC	SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐		
	H/H			SUP 02	PH	PO2	RESULTS			
	PLT			PCO2	SAT	OTHER				
PT				U/A	DIP		EKG INTERPRETATION			
APTT	BHCG	ETOH	GLU		MICRO					

PROVIDER HISTORY/PHYSICAL

see H+P admission form by COL [redacted] (b)(6)-2

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
			PROVIDER SIGNATURE AND STAMP
DIAGNOSIS			CODES

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

510–112

NSN 7540–00–634–4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS (Include medication and treatment when indicated)
09/22/03	0900		32 y/o ♂ presented in ED c/o pain to (Lt) tib/fib area, Pt states he heard a large explosion and something hit his (Lt) lower tibial area. Pt reveals PERRLA LS = clear all fields skin warm & dry (+) Neuro motor & sensory, Bloods drawn, ortho consult done Dr [redacted] Pt vitals assessed, Pt given tentanus lacerat [redacted] xray on (Lt) tib fib done [redacted] RN
	1007		Pt [redacted] to ICU S/t [redacted] c/o [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.

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7–91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201–9.202–1

MEDCOM - 20248

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 32 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): 3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:
I+D left leg

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications:
Jewelry removed: yes/no Family waiting: yes/no

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL Potential for anxiety related to traumatic injury; language barrier; ~~family separation~~; surgical environment	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.
B. AERATION Potential for respiratory dysfunction due to sedation; positioning; injury	PT. will be able to breathe without difficulty during immediate intra-operative 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 integuity due to bovie pad; position; fluid shift	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)
[redacted] (5)(6)-4

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

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CPT MN 22 Sept 03 DATE

11. POSTOPERATIVE EVALUATION:

Both Sides: intact

Drsg: clean

Breathing: no SOB

(b)(6)-2

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) Maj [redacted]

DATE: 22 Sept 03 TIME: 1810

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

DATE: 22 Sept 03 TIME: 1915

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD — INTRAOPERATIVE [illegible]MENT

For use of this form, see AR 40-407, the p[illegible] ...is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERA[illegible]OM VIA Litter B[redacted]

2. PATIENT IDEN[illegible] RECORD REVIEWED AND PROCEDURE VERIFIED B[redacted] MAJ AN

3. DATE 22 Sept 03 TIME PATIENT ARRIVED IN SUITE 1815

4. PATIENT IN ROOM TIME 1816 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA (b)(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	CPT [redacted] (1845 - EOC)

7. POSITION AND POSITIONAL AIDS (Specify)

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

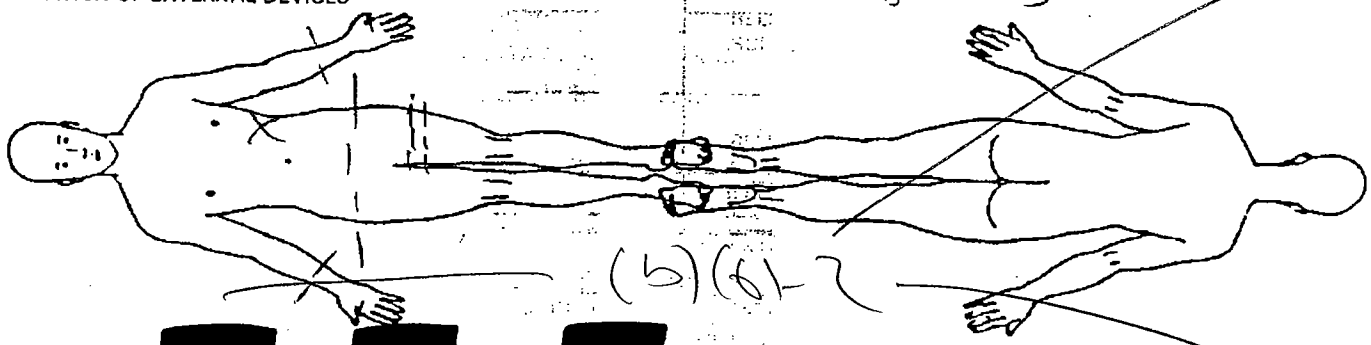
COMMENTS: arms on armboards <90° bilaterally

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine / Betadine
SITE: Left leg BY WHOM: MAJ [redacted]
SITE: BY WHOM:
COMMENTS: ϕ pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X G[redacted] – S[redacted] = [redacted]iquet

10. COUNTS — C = Correct | = Incorrect

			Other**	First Closing Count	Final Closing Count
Sponge	☐ Yes	☐ No		C	C
Needle Sharp	☑ Yes	☐ No		C	C
Instrument	☐ Yes	☑ No			
Other	☐ Yes	☑ No			

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

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

[redacted] (b)(6)-2

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

Cut 30 coag 30

☒ ESU NO: Valleylab Force 40
GROUND PAD: BRAND Valleylab Rem Polyhesive
LOT NO: 70211

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 20251

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): NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*: Ace wrap, Kerlix, fluffs

17. TUBES, DRAINS/PACKING YES ☒ NO ☑

	1.	2.	3.
TYPE/SIZE	1. 3/8 in Penrose	2.	3.
SITE	1. Ⓛ calf	2.	3.

19. ADDITIONAL INFORMATION

WCI

Surgeon: [redacted]

Anesthesia: [redacted]

pre-op: Bowie site and Tourniquet site intact.

20. OPERATION(S) PERFORMED

I + D (L) LE (b)(6)-2

21. PATIENT TRANSFERRED TO: PACU TIME sent DA7389 METHOD dillon

[redacted] MAJ AN [redacted] CRT-14N

REVISED DA FORM 5179-1, OCT 87 MEDCOM - 20252 USAPA V1.00

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 22 Sept | 23 Sept | 24 Sept | 25 Sept

19 | HOUR

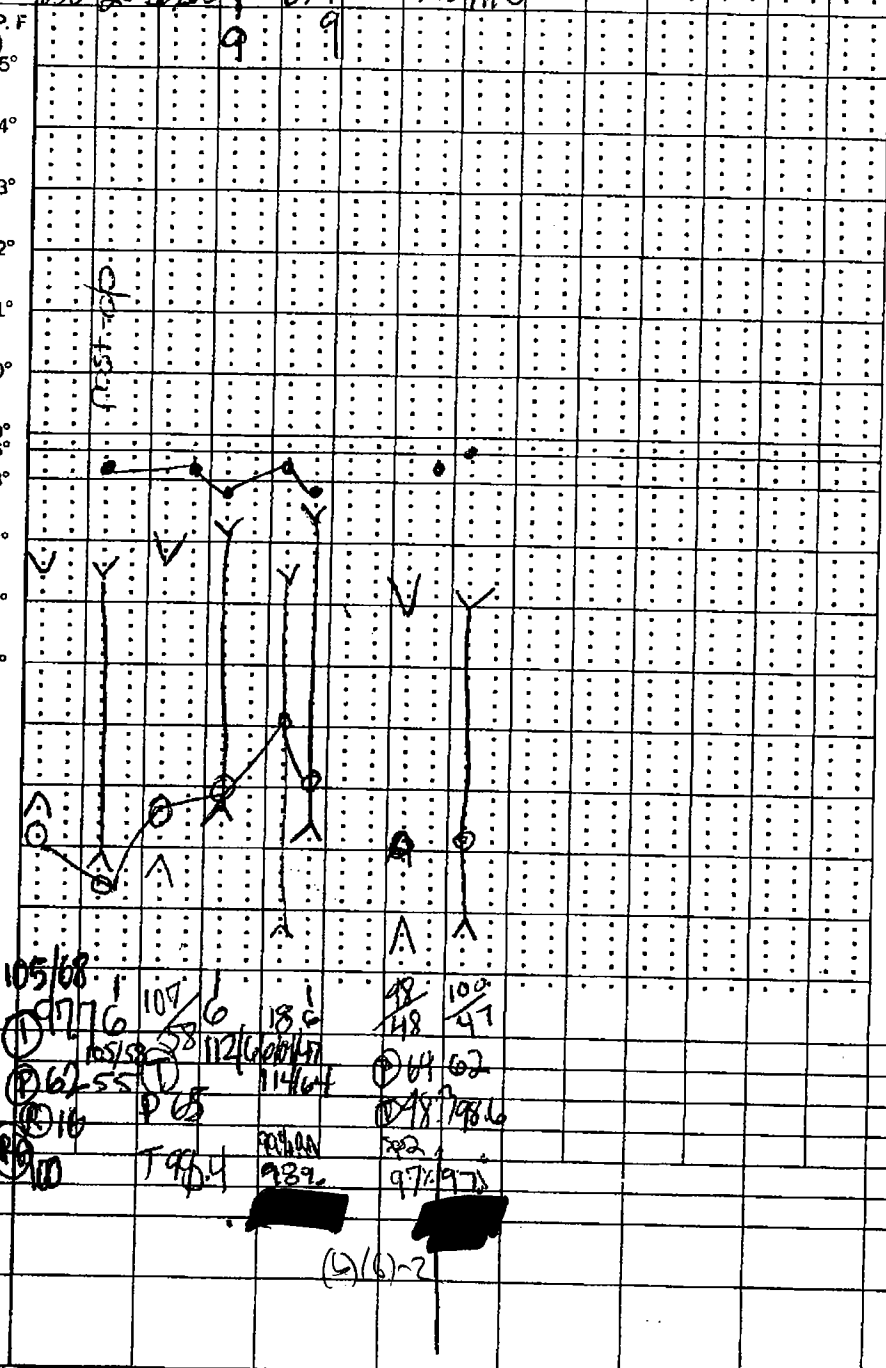
PULSE (O) | TEMP. F (°)

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

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.

[redacted] (5)(6)-2

[redacted] (5)(6)-2

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 20253

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)	
Fentanyl	(50µ)	150 50
Norcuron	(1/4)	2
	( )	
	( )	
	( )	
VOLAT AGENT	Forane % del	F25-2-15-4
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2 3	L/Min	

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

FLUIDS

LINE site		
NS-RSTO	☐ Warmed	
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS — URINE –

PHYS STATUS 1 2/3 4 5 E

BODY WEIGHT — KG / LB

HEMATOCRIT:

INITIAL DATA:

BP – 124/72

HR – 115-95

BLOOD TYPE CHECK — OK? – Y / N

PATIENT RECHECK — OK for PROCEDURE? — TIME –

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

TIME → 1800 15 30 45 1900 15 30 45

220 200 180 160 140 120 100 80 60 40 20

VENTILATION: VT – ml; f – breaths/min: 16 12 10; Peak inf pres / PEEP; MODE – S(pon) A(ssist) C(on): A A S

MONITORS / ACCESS: BP/Auto Cuff ✓ — BP / oth — ART line — Steth – PC/ES — Gas analyzer — Warming blkt — Conv warmer

ET-CO2 (torr) — FIO2 (Frac or %): 38 65% — SpO2 (%): 100 100 — ECG: ST SR — TEMP – site — N-M Block (T/4)

Mark with letters & symbols, explain under REMARKS — EVENTS Position → (1) (2) (3) (4) (5)

TOTALS — TOTAL IN: 415cc — TOTAL URINE

FLUIDS - SUMMARY: CRYSTALLOID – 250cc; COLLOID –; BLOOD – 0

REMARKS –

Code drugs with numbers, events with letters

(1) V/S Taken
(2) Induced c Lidocaine 20mg Diprivan 140mg Anectine 80mg O2 Forane
(3) Procedure began
(4) Procedure ended
(5) O2, breathing TO recovery

RECOVERY AT — PACU ICU (Specify) — OTHER

CONDITION:

RESP – 11 — SpO2 – 99 — BP – 88/33 — HR – 74

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1805	1816	1912
	Ready	Begin	End
PROC	1830	1834	1902

PROCEDURES and CPT Codes: Washing – Debridement (2) leg wound c closure

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: MASK

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: 90mA [redacted]

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

[redacted]
(b)(6)-4

SURGEONS:

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

PROCEDURE LOCATION

DATE 22 Sep '03

PAGE 1 OF

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 20254

ANESTHESIA PLAN OF CARE PRE [illegible] CEDURAL ASSESSMENT (Sedation/Ar [illegible] sia)

Age 3 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: I&D L leg open (12) tib Fx
SURGICAL SERVICE: ortho - [redacted] 2° Blast inj
NPO SINCE: (5)(6)-2

ASA Physical State 1 2 3 4 5 E
WT: 20 KG/LB HT: ____ IN.
ALLERGIES: Ø

HABITS:
TOBACCO: ____
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) 0715 Ancef
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

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

LABORATORY STUDIES:

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 105/68 HR 64 R 16 T 98.1 96%
Pain Scale 0-10 ____
HEENT - Teeth WNL
Trachea ____
TMJ/Neck mod I
Oropharnyx 3 FB Mall
Nares ____
CHEST: CTA BL
CARDIAC: RRR
EXTREMITIES:
IV Access: (L) PIV
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since 0700 ASA Breakfast

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

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

The patient/legal [illegible] seems to understand and agrees. Questions answered.
(5)(6)-2
Signed: [redacted] mt count Date: 9.22.03 Time: 1145 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) I&D L leg ICW 2 Rm 10

H [redacted] (5)(6)-4
[redacted]

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS

ANESTHESIA SERVICE RECORD

Previous edition is obsolete
*U.S. GPO: 2001-629-183/40002

MEDCOM - 20255

MEDICAL RECORD - DOCTOR'S ORL.

For use of this form, see MEDCOM Circular 40-5

DIRECTIONS: The provider will DATE, TIME, and SIGN each order or set of orders recorded. Only one order is allowed per line. Nursing will list the time the new order(s) are noted and initial in the column provided. Orders completed during the shift in which they were written do not require recopying. They may be signed off, as completed, in the far right column.

ORDER NUMBER	DATE, TIME, & SIGNATURE REQUIRED FOR EACH ORDER OR SET OF ORDERS	ORDER NOTED TIME & INITIALS	COMPLETED TIME & INITIALS
TLO	POST ANESTHESIA ORDERS (circled Items) 9/22/03	1925	
~~1~~	~~VS q 5 min X 15 min, then q 15 min until~~ discharge.		
2	~~Supplemental oxygen.~~		
3	Morphine / Meperidine ____ mg IV now and ____ mg q 3-5 min prn pain for a max dose of ____ mg.		
4	Zofran ____ ~~mg IV prn N/V q 15 min, may repeat~~ x ____.		
5	~~Metoclopramide~~ ____ ~~mg IV prn~~ N/V x 1.		
6	~~Droperidol~~ ____ mg IV prn N/V x 1.		
7	Phenergan 12.5-25 mg IV prn N/V x 1.		
8	~~Benadryl 25-50mg IVP q1 hr prn, itching while in~~ PACU.		
9	IVF: ____ @ ____ ~~cc/hr.~~		
10	Discharge from recovery status when PACU discharge criteria met.		
	[redacted] STASS, CDT, CRNA		
	(b)(6)-2		

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

Complete the following information on page 1 only. Note any changes on subsequent pages.

Diagnosis: _____

Height: _____ Weight: _____ Diet: _____

Allergies: _____

Nursing Unit	Room No.	Bed No.	Page No.
PACU, 28th CSH			1 of 1

MEDCOM FORM 688-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE MC 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, 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: 22 SEP 03 TIME OF ORDER: 0945 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICW-1
2. Dx - Open (L) Tibia Fx
3. Condition - Stable
4. VS - Routine
5. Bed Rest
6. To O.R. Today

PATIENT IDENTIFICATION

Noted [redacted] 22SEP03 1025

DATE OF ORDER TIME OF ORDER HOURS

7. NPO
8. MSO4 2-8mg IVP Q 1 hr PRN

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-2

DATE OF ORDER: 22 SEPT 03 TIME OF ORDER: 1905 HOURS

1. To ICW-1
2. S/P I&D (L) Open Tibia Fx
3. Condition - Stable
4. VS - Routine
5. Up ad lib, WBAT
6. Elevate (L) Leg
7. Regular Diet

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

Noted [redacted]

DATE OF ORDER TIME OF ORDER HOURS

8. NL at 125cc/hr, Hep lock when tolerating P.O.
9. Tylenol 650mg P.O. Q 4 hrs PRN
10. Percocet 1-2 P.O. Q 4-6 hrs PRN
11. MSO4 - 2-8mg IVP Q 1 hr PRN
12. Ancef 1 gm IVPB Q 8 hrs.

[redacted]

NURSING UNIT 240 | ROOM NO. 2145 | BED NO. 228 [redacted]

DA FORM 1 APR 79 4256 REPLACE[redacted]OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 20257

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 | ROOM NO. | BED NO.

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

24 SEP 03 1630 HOURS

1. ADMIT TO MED
2. DISCONTINUE TOMORROW
3. KEFLEX 250mg P.O. QID x 10 DAYS
4. P.T. FOR GAIT TRAINING & MOBILIZATION, WBAT
5. SUTURES OUT IN 7 DAYS
6. PPD 1:2 P.O. QD 4-6 HRS

Noted [redacted] 24SEP03 1635

PATIENT IDENTIFICATION

[redacted] 24SEP03 1635

DATE OF ORDER | TIME OF ORDER

HOURS

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 20258

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 22 23 24 25 26 27 28 29
22 [illegible] 03	[redacted]	VS routine	06	[redacted]
			18	
22	[redacted]	Bed rest	06	[redacted] > D/C'd
			18	X
22	[redacted]	~~HPO KAS~~	06	[redacted] > D/C'd
			18	
22	[redacted]	ACT: up ad lib, WBAT	6	X [redacted]
			18	
22	[redacted]	Elevate (L) leg	6	[redacted]
			18	
22	[redacted]	Regular diet	6	X [redacted]
			18	

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: OPEN (R) TIBIA FX / S/P I+D

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 4077-1-OCT 79 MEDCOM - 20259 SED 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]	Admit to ICW #1 - Cond. - stable	22 SEP 03			[redacted]	
22	[redacted]	To OR today	22				
22	[redacted]	TO ICW-1, stable					
24 SEP 03	[redacted]	DIC tomorrow	25 SEP 03				
24	[redacted]	PT for crutches/ambulation WBAT					
24	[redacted]	Sutures out in 7 days	24	NOTED		[redacted]	
		(b)(6)-2					

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

USAPA V1.00

22	4S	LR@125cc/hr HL when taking PO	22 23 24 25 26 27 28 29 6 X [redacted] 16 [redacted] X
22	4S	Ancef + gm IVPB q8°	8 X [redacted] 16 X 2
24	BR	Keflex 250mg PO QD x 10 days	10 X X X 0 1 2 3 4 5 6 7 8 9 10 X

(b)(6)-2

D/C'd

D/C'd (dsch. med)

OPEN @ TIBIA FX / S/P I+D

#[redacted]

(b)(6)-7

Page 09 of 03

24 Sep 03 [redacted] DIC meds: Keflex 250mg po QID x 10 days
T3 1-2 po q 4-6° prn

(b)(6)-2

22 Sep 03 [redacted] MSO4 2-8mg IVP q1° prn — D/T 1625 6mg IV/IM

22 [redacted] Tylenol 650mg po q4° prn — D/T D/I

22 [redacted] Percocet + - ++ po q4-6° prn — D/T D/I

24 Sep [redacted] Tylenol #3 T-TT po q4°-6° prn. — D/I D/T (Discharge med)

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED *(Date)*

Date: 22 Sept
Time In: 1915
Allergies: NKDA
Pre-op V/S: 124/72 115
Procedures: I/D (L) Ankle

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 250 Colloid Ø
OR Output: UOP Ø EBL <15cc
Meds/Times: Fentanyl

[redacted] (b)(6)-2

Drains: Hemovac, NG, JP, T-tube, Foley, TLS

Airway: Nasal, (Oral), ETT, Trach, Other

Pre Op Meds History

Time	1915	1920	1925	1945	1955	2000	2030
SaO2	99	100	99	100	100	100	100
FiO2							
Methods	RA	RA	RA	RA	RA	RA	RA
RR	13	10	12	11	15	10	
T	96.4						

(Vital signs graph: 240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20)

Time								
Pain (0-10)								
LOS								

Pacu Intake

Time	Solution	Amount	Site	[redacted]	Infused
2000	NS				600

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1	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)

(b)(6)-2 PREPARED BY *(Signature & Title)* [redacted] 1LT AN

DEPARTMENT/SERVICE/CLINIC PACU / ICW 7

DATE 22 Sep 03

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

[redacted] (b)(6)-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete USAPPC V2.00

MEDCOM - 20263

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1935		Phenergan 12.5mg	IVP			[redacted]
					(b)(6)-2	

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(L)leg	+	+	P	B	C	P
15'	(L)leg	+	+	P	B	C	Pk
30'							
45'							
60'							
90'							
D/C	(L)leg	+	+	P	B	C	Pk

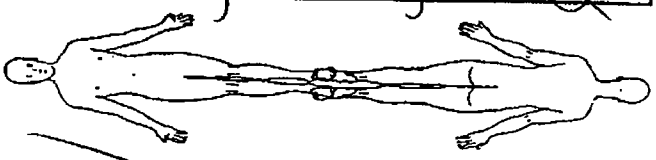
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(L)leg	binky	Ø
30'	(L)leg	binky	Ø
60'			
D/C	(L)leg	binky	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1945	NSR	No	NO

NURSING NOTES

1915 Recv'd pt from OR, pt had oral airway. NS infusing into (L)AC. Pt able to follow commands. O2 Sats 99-100%, SGT [redacted] 2025 pt transferred to ICW1 in Stable Cond. VSS SGT [redacted] (b)(6)-2

Discharge Criteria:
Date: 9.22.03 Time: 2025 PARS: 9
BP: 117/59 T: 97 HR: 64 RR: 20 Sa02: 100
Pain Level at D/C (0-10):
Intake: 600 Output: 0
Additional Data:
Transferred To: ICW2
Report Given To: SGT [redacted]
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: (b)(6)-2
Cleared IAW Recovery Room SOP
Signature: [redacted]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A11D1	IZ	[redacted]	[redacted] (5)(6)-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
UNK	32Y	Z	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	0900	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K79	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	NO
		1		☒

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

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
	UNK	UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
		030924

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AEAA		030922

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

FOR LOCAL USE

DX: OPEN (L) TIB FIB Fx

DX 82390
E993
Proc 7966
Trauma 9
Inj 999

ADMITTING OFFI[redacted] (5)(6)-2

SIGNATURE [redacted]

DA FORM 3985 MAR 89 MEDCOM - 20265

INPATIENT TREATMENT RECORD COVER SHEET

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

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

4 SEX	5 AGE	6 PACE	7 RELIGION	8 LENGTH OF SVC	9 ETS	10 PREVIOUS ADMISSION
M	32y	X	MUSLIM	(b)(6)-4		NO

11 FMP	12 SSN	13 ORGANIZATION	14 WARD
99	[redacted]		ICU2

15 FLYING STATUS	16 OSG	17 DEPT/BEN	18 BRANCH/CORPS	19 UIC/ZIP	20 TYPE CASE
		K78			WIA

21 SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22 HOURS OF ADMISSION	23 CLINIC SERVICE
Direct From ER	1900	Gen Surg.

24 NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25 TYPE DISPOSITION	26 DATE OF DISPOSITION	
	D/C TO CAMP	~~27 SEP 2003~~	01 oct 2003

27a ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b TELEPHONE NO.	28 DATE OF THIS ADMISSION	ADMITTING OFFICER
		23 Sep 2003	

29 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30 DATE OF INITIAL ADMISSION	32 UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted]		

31 [redacted] ADMINISTRATIVE DATA

(b)(2)-2

☐ Check if Continued on Reverse

33 CAUSE OF INJURY

34 DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: S/P EX LAP GSW TO ABD

Dx	Px
878.40	23.19
879.2	24.5
881.10	86.59
E991.2	54.11
E.991.9	93.54
	88.24
	99.04

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	4	4

36. Total Days All Facilities

a ABSENT SICK DAYS	b OTHER DAYS	c CONV LV/COOP CARE DAYS	d SUPPLEMENTAL CARE DAYS	e BED DAYS	f TOTAL SICK DAYS
0	[redacted]	0	0	4	4

37 SIGNATURE OF ATTENDING MEDICAL OFF [redacted]

DA FORM 3647, MAY [redacted] MEDCOM - 20266 USAPPC V1.

(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
23Sept03 1645	ORTHO consult – Intra-op. 1 32 male Iraqi EPW GSW Face, Abd, shrapnel to (R) Forearm. Consult was intra-op, so no preop NV exam is available. Pt is recently S/P ex Lap for GSW abdomen and facial soft tissue repair pending.
*	exam (R) UE. multiple shrapnel entrance wounds volar forearm all less than 1cm ø. no gross deformity or crepitus noted. FROM wrist/Elbow. easily palpable radial pulse. hand well perfused. (-) Allen test.
	XRAYS – proximal hardware (plate) Radial diaphysis ø acute Fx. Soft tissue shrapnel only ø intra-artic shrapnel. Compartments soft and compressible.
A/P	Soft tissues peppered ē shrapnel.
–	Applied volar splint p surgical scrub to forearm
–	Abx for skin flora x 48°.
–	Will cont to follow with you
–	reinforce dressing prn.

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | (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

(b)(6)-2 [redacted]

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	OMFS Brief OP NOTE
23 Sep 03 @1900	Pre OP dx: GSW to face. Post op dx: Same Procedure: Irrt of lower anterior teeth, alveloplasty and irrigation and closure of facial wounds Surgeon: [redacted] (b)(6)-2 Anesth: NETA Finding: Shattered anterior mandibular teeth, avulsed lower left Commissure EBL: 250cc U/O: 1700cc Fluids: 3300LR 2u PRBC 1000cc Hespan Comp: ∅ Cond: Stable, remained intubated & transferred to SICU 2 Serent on standard monitors. (b)(6)-2 [redacted] MD

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24 Sept 03 0840	ORTHO HD#1 intubated/sedated. (R) UE Splinted. Q active bleeding Findings will perfused. - Soft tissue Swelling (R) Forearm. Q Fx - May remove splint in 1-2 days. local wound care - will sign off. contact me c questions. [redacted]
24 SEP 03 (0845hrs)	Assumed care of patient @ 0615 hrs. See DA Form 4700 "Intensive Care Nursing Flow Sheet" for initial Shift assessment info. Pt. currently sedated & relaxed. Will continue c current plan of care and monitor accordingly. [redacted]
24 Sept 03 0900	POD#1 S/P Exp Lap. - GSW to abd. VSS U.O. good Vent SIMV 10/ 800/s /40% abd soft [redacted] CDE

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST (b)(6)-2 FIRST [redacted] NUMBER

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

EPW

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24 Sept 03	cont 10.0 / 13.6 / 42.2 / 218 — 141 / 3.8 — (— iCa++ 1.1 7.36 / 38 / 93 / 21 / 97% Doing well cont NGT to passive gas from below Vent management up to Dr [redacted]
24 Sep 03 (1000hrs)	Patient relaxed/comfortable. Sedation regimen of Versed/Fentanyl effective. SaO_2 remains > 98% on FiO_2 @ 40% via ventilator. Vent settings remain: SIMV-10, PEEP-5, TV-800ml. N/G remains patent through (R) nare collecting gastric drainage via LIS. Cardiovascular remains unremarkable, as well as GI/GU. (R) hand c ace wrap dressing C,D,I. Edema to (R) UE unchanged @ 1+. Capillary refill still < 3 secs. All lines are currently patent & intact. Received a.m. care, reapplied bacitracin ointment to [redacted]. Will continue c present plan of care.
24 Sep 03 (1030hrs)	Sedation (Versed/Fentanyl) now off to start vent weaning. 7.5mm nasal/tracheal tube, suction catheter (14 fr), O_2 mask and syringe @ the bedside in preparation for extubation per order of Dr [redacted]. R.T. (SGT [redacted]) informed of weaning initiation. Monitor accordingly until ready for extubation. [redacted]
24 Sep 03 (1235hrs)	Patient alert c eyes open. MAE c limitations to (R) UE D/T restrictions. Understands plan to extubate when vent is ready. Dr [redacted] @ bedside along c R.T. (SGT [redacted]). Nasal/tracheal tube cuff deflated & 10cc syringe. Suction on @ bedside c Yankauer. Tube removed from (R) nare. Encouraged to cough, but did not. (R) bloody drainage from (R) nare. Suction applied to clear nare. SaO_2 > 96% c 7L O_2 via NRB. Tolerated extubation well s respiratory compromise. Currently resting comfortably in bed s noted distress. Plan to monitor SaO_2 post extubation, Maintain N/G to LIS and pain [redacted]

STANDARD [redacted]

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
(24SEP03) 1535hrs	Patient continuing to do well post-extubation ~ now 3hrs ago. SAO2 99% via O2 face mask. C/o abd discomfort x 1 briefly, but went back to sleep. Resting comfortably now s̄ indications of discomfort. Will request IV analgesic for mild/moderate discomfort. [redacted] /w
24Sep03 (1840hrs)	Post-extubation blood drawn for ABG. Await results and provide for Dr [redacted] /w
(1600hrs)	ABG results: PH-7.36, PCO_2-44.7, PO_2-100, HCO_3-26, BE-Ø. Remains on FM via mask c̄ SAO_2 @ 97%. Resting s̄ respiratory distress or abd discomfort. — [redacted]
24SEPT03 7017	s/p extubation pt. tolerating 5FM well sats @ 98%. Pt translator came to translate. Issue: personal effects c̄ IRAQI POLICE and [illegible] (R) arm. Dr [illegible] consult for orders [redacted]
24 Sep03 2030	Rec'd pt from previous nurse. Alert & active communicating via interpreter. Oriented ~~to [illegible]~~ error in conversation. Respirations even and unlabored O2 via FM c̄ 4L s̄ SpO2 97%. No c/o pain or present. VSS. (R) hand c̄ ace bandage no drainage. Pt resting s̄ any distress noted. Will cont to monitor - Angel Westra
25Sep03 0500	Pt resting comfortably. Assisting c̄ turning. AM care due. O2 via FM 4L NGT LIWS. No changes in status VSS. No distress noted throughout night [redacted]

(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

#[redacted] EPW

(b)(6)-7

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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USAPA V1.00

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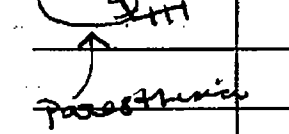
MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	OMFS POD # 2. Ancef #3
15 Sep 03 @ 0800	Pt lying in bed asking questions about his injury & NGT in place doing well. Oral & skin facial wounds healing well and closed 1° & no active bleeding. CN III intact. (+) Paresthesia ½ lower left lip area. VS: BP 132/78 P 109 SpO_2 97 RA T 97 CV RRR Lungs CTA(B) Abd ◊ BS heard Ext: (R) arm dressing in place ◊ C/C/E. A/P S/P GSW to face + abdomen (1) will clamp + D/C NGT per Gen Surg (2) continue bacitracin to face (3) oral care today (b)(6)-2



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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1998)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 Sept 03 0830	Gyn Surg POD #2 Doing well extubated yesterday HR 84 BP 119/70 96% on 4L O2 N.C. NSA output: 300/24° will clamp for 8° then pull if remains nauseated OOB → chair d/c foley will evaluate for transfer to floor this pm [redacted]
25 Sep 03 (0930hrs)	Assumed care of pt @ 0615hrs p receiving Δ-of-shift report. Initial c/o lower abd discomfort unrelieved by bed repositioning. Given 3mg MSO4 IVP for moderate, which resulted in ↓ discomfort and visual relaxation/sleep ∃ further c/o pain. (done @ 0645hrs). See DA Form 4700 "Intensive Care Nursing Flow Sheet" for initial shift assessment info. Received order from Dr [redacted] to clamp NG x 8°, followed by d/c'ing if ø nausea/vomiting (order carried out @ 0730hrs). Foley cath d/c'd as ordered. Explained procedure to patient, as well as importance of voiding in the next 6-8hrs. Verbalized understanding through translator. Plan: foley to ↑ in chair, wean ↓ O2 (currently 2L via NC) → SaO2 > 95% possible d/c NG p 8° re-eval and then clear liquids [redacted]
25 Sep 03 (1000hrs)	Patient ø spontaneous void into urinal (100cc). No c/o discomfort during void. Verbalized void complete. Will continue to monitor urine out, post foley cath, and ~~abd~~ potential for abd distention [redacted]
25 Sep 03 (1130hrs)	Pt ø c/o lower abd discomfort. Assessment shows no Δ in GI status since Δ of shift. ø nausea/ø vomiting @ this time. Given MSO4 3mg IVP for abd pain. Will monitor for effectiveness [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 Sep 03 (1420hrs)	Pt doing very well this afternoon. Continues to tolerate clamped N/G tube, as well as voiding spontaneously ~ discomfort. SaO_2 >95% ~ 2l O_2 NC. Remains in NSR, lungs CTA abd soft ~ RRR. No Δ in care this afternoon ~ plan to still get OOB [redacted]
25 Sep 03 (1730hrs)	Pt remained ~ c/o nausea or vomiting episode. Abd unchanged from start of shift. N/G d/c'd @ 1530hrs. Tolerated ~ emesis or respiratory compromise. Oral care completed ~ Swish and suction Cepacol mouth wash. Tolerating po fluids (water) ~ problem as long as he drinks from (R) side of mouth ~~Now~~ through a straw. OOB in chair @ 1630hrs. Tolerated very well ~ ↓ SaO_2, although remains on O_2 @ 2l NC. Noted serosanguinous drainage from underneath bottom of abd incision disp. Reinforced ~ ABD pad & extra absorbent H&H drawn and sent to lab; awaiting results. Finally, received order for Chest PT. Will start this evening by unit. Plan: remain up in chair for awhile longer, give clear liquid diet, monitor SaO_2 & Chest PT [redacted] as well drainage from abd incision [redacted]

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

[redacted] EPW
(5)(6)(F)

PROGRESS NOTES
Medical Record

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
26 Sep 03 0630	Assumed care of pt resting comfortably in bed. Denies discomfort present time. See DA 4700 for initial assessment [redacted]
26 Sept 03 0907	Gen Surg
	Dominguez
	on 2 l O2 now Sat 98%
	HR 72 BP 111/62
	labs pend.
	nutrition consult
	transfer to floor. [redacted]
0915	Pt given MSO4 2mg IVP for c/o abdominal discomfort. Pt to be transferred to ICW1. [redacted]

(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
26 Sep 03 1020	Nursing: Assumed care of pt. transfer from IC #2 per wheelchair. Dx. s/p exp. lap and facial repair. Dressing to abdomin re-enforced. Ø post op dressing Δ order. Minimal bleeding noticed to dressing. Facial laceration @ corner of mouth to cheek approx. 4 inches sutures intact bacitracin applied TID. VSS afebrile Active BS x4 quads Ø BM noted. Tolerating CL diet advance as tolerated. Nutrition consult pending. Lungs CTA. HHKR suction @ BS. Will cont to monitor [redacted]
26 Sep @ 2145	Assumed care of pt @ 1800. Pt Adult speaking arabic. LS CTA, IS encouraged. (+) BS, treated smant of regular diet. (R) cheek and gum c sutures, CDI, bacitracen applied. ML abd incision c dsg c marked drainage noted. Percocet given for pain c good relief noted. (R) IJ Triple lumen c IVFs, all ports flush well, dsg to be Δ'd tomorrow. 2pt restraints on S S/SX of skin or circulation compromise. HOB T 30°. (R) FA/hand in splint, wrapped in Kerlix CDI. (+) CMS to (R) hand. Plan: encourage CDB, mouth pain control, will monitor [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S [redacted]
	LAST	FIRST	MI	(SSN or Oth

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
# [redacted] (6)(6)-4		

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27 Sept 03	Gen Surg
	Afeb VSS
	% roof of hard palate irritation
	not eating well will start Ensure tid
	cont IVF until taking po better [redacted]
	(b)(6)-4

STANDARD FORM 509 (REV. 5/1999) BACK
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	OMS POD# 4
27 Sep 03 @ 1508	Pt lying in bed & c/o pain this pm. Pt not tolerating PO diet well. most likely 2° to recent extractions and oral wounds. Oral wounds healing well c no s/s of infx. skin sutures in place and wounds closed 1° c no s/s of infx. left commissure area granulating in. bacitracin on all external wounds. VSS, AF CV RRR lungs CTA(B) Abd: midline staples in place Ext: (R) forearm dressing in place
	A/P S/P GSW to face ① nutrition consult submitted ② will D/C skin sutures in 2-4 days.

(b)(6)-2 [redacted] MMS 10C

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

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
[redacted] (b)(6)-4		

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
29 Sep 03 @1600	OMS POD #6 Pt healing c (L) commissure granulating in. Skin sutures in place and chin wound closed 1°. intra oral wounds healing well. defect present (L) Commissure. Removed Prolene sutures 5 difficulty replaced bacitracin. plan for D/C to Prison hospital on 1st of OCT 03. (b)(6)-2 [redacted] maj lee

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9/28/03	(cont) Medicated c one percocet p.o. for c/o facial pain. Will monitor for effect. Will assist c ambulation in halls for exercise. [redacted] Eyes
9/28/03 1300	Sleeping. NAD. Will continue to monitor [redacted] MAE
(1930)	Rt c/o, VSS, LCTAB, HRR, [redacted], (R) U TLC IVF @ 75cc/hr ø redness or edema noted. Bacitracin applied to face wounds. (R) arm c ace wrap CDI. facial incisions c sutures intact. suction @ BS, HOB ↑ 30°. ambulated in hallway x1. abd midline incision OTA. ø c/o pain @ this time. Arch cont. Restraints on ⊕ circulation. Will monitor [redacted] q1hr.
29Sept03	Rec'd report and assumed care of pt. Pt has triple lumen (R) EJ patent D5% NS @ TKO. ø redness or swelling @ insertion site. (R) forearm bandage D&I cap refill brisk. Pt able to wiggle fingers. Med abd staples intact. 2x2 on med @ umbilical site D&I. ø skin breakdown under restraints. Left (R) side of face intact. Bacitracin to face most [redacted] CTA. BS ⊕. Continue to monitor [redacted] q1hr

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (5)(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27 Sep 03 0700	Nursing: Assumed care A+O x3. VSS Ø c/o pain or discomfort @ this time s/p exp lap. Abdominal dressing dc'd staples open to air CDI betadine cleansed. IVF 75 cc/hr. (R) IJ triple lumen Lungs CTA HRRR S1 S2 present. Active BS tolerating PO c̄ some difficulty due to incision and cuts to palat. reg diet c̄ ensure. Urinating s̄ difficulty BM this am. Encouraged to ambulate x2 this am. Will cont to monitor [redacted]
	(1630) I concur c̄ above assessment. [redacted]
27 Sep 03	2200 - assumed care of pt @ 1800. VSS, no c/o c̄ exception of n/a, 1 percocet given c̄ good relief noted. LS CTA, ⊕ BS x 4 quads ML incision OTA c̄ exception 2x2 drsg CDI. (R) FA splint c̄ drsg CDI. (R) IJ TL c̄ IVFS @ 75cc/°, Drsg Δ'd c̄ sterile technique. Diet Δ'd to mech soft for ease in chewing 2° cheek s gumline incision. Bacitracin applied to cheek incision Voiding to urinal s̄ difficulty, quantity sufficient. ↑ AMB in hallway x1 c̄ difficulty Plan: monitor pain, monitor ol status encourage CDB, AMB. [redacted]
28 Sep 03 0800	A+O. VSS. Lungs CTAB. Resp even & unlabored. Encouraging deep breathing exercise. Abd soft & tender to touch ⊕ BS x4. Tolerated breakfast (mechanical soft). (R) IJ triple lumen patent c̄ D5½NS @ 75cc°. (R) Arm Ace Wrap drsg intact. Facial incisions c̄ sutures intact. Bacitracin applied. Abd midline staples CDI & open to air.

STANDARD FORM 509 (REV. 5/1998) BACK
USAPA V1.00

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ACLU-RDI 1656 p.41

DOD-033855

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29Sep 2145	Assumed care of pt @1800. VSS, no c/o. MI abd ~~drsg~~ incision OTA, c exception 2x2 CDI @BS @pm per pt report. IS CTA, encouraged CDB. @ check incision & sutures removed healing well, bacitracin applied as ordered @ RJTL & IVFs @ 75cc/hr, serous well. Drsg to abd tomorrow. Tol mech soft diets c difficulty. Plan: monitor wounds, pain. [redacted] (b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
30Sept 1200	Assumed care of pt. Pt ambulated in hallway. Med abd staples taken out per Dr [redacted]. Area clean and dry. Triple lumen D/C per Dr [redacted] 2x2 & tape area pressure held x 5 minutes. Lungs CTA. Pt has soft cast on (R). Cap. refill brisk. BSA. Will continue to monitor [redacted] IWHO
1700	Pt c/o pain while eating. Pt has ulcer looking sores in and around mouth. Pt given T prn per MD order [redacted] PIWHO
30SEP@ 1930	-Assumed care by pt @1800. VSS. C/O pain in his mouth and inability to eat food served. Encouraged soft food (ie pudding, jello, juice). LSCTA, MI incision abdomen healing well (staples removed (R)IJ removed, insertion site S S/Sx of infection. (L) chest incision healing, though still bothers pt to eat. Plan: monitor pain control, enc po intake. 2pt restraints on S S/Sx of skin or circulation compromise. Will monitor [redacted]
1 Oct 05	0717 - Assumed care of pt. 0800 Assessment completed. VSS AO - [redacted] Pt.

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
	[redacted]	PEREIRA	A	

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

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(cont'd)	c/o pain in mouth. LS CTA (B), Resp even unlabored, abd. tender, firm, BSX4, voiding per urinal. Two restraints in place (B) I E (+) Circulation @ shin breakdown. midline incision CTA. @ slsx inf. splint (R) arm. <3 cap refill. Will cont. to monitor pt. [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1988) BACK
USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Transfer Summary
01 OCT 03	
@0737	PT S/P GSW to Face, Abdomen and right forearm. Pt taken to the OR ON 23 SEPTEMBER 03 for an Exploratory Laparotomy (negative), washout of Right forearm wound and extraction of fractured teeth and Closure of mouth wounds.
	D/C cond: Stable
	D/c diet: Soft
	D/C meds Keflex 500mg po q6° until gone Percocet 1-2 tab po q4-6° prn pain Bacitracin towards TID
	Plan
	① Pt needs abdominal wound checked prn
	② Right forearm dressing can be changed and D/C'd prn
	③ mouth wnd need bacitracin TID Pt will need removable partial, dentures or implants.

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
#[redacted] (b)(6)-4		

PROGRESS NOTES
Medical Record

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

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER | TREAT [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) 23/09/03 | TIME 1452

TRANSPORTATION TO FACILITY F-LA

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

CURRENT MEDICATIONS: unable to answer

ALLERGIES: unable to answer

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					

CHIEF COMPLAINT: GSW

CATEGORY OF TREATMENT

- ☐ EMERGENT
- ☒ URGENT
- ☐ NON-URGENT

TIME: 1452

INITIALS

VITAL SIGNS

TIME	1452				
BP	139/94				
PULSE	110ST				
RESP					
TEMP					
WT	02 99%				

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION

☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY

☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE

☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATE

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)-7

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: WBC	SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
CBC: H/H	SMAC		SUP 02	PH	PO2	RESULTS	
CBC: PLT	SMAC		PCO2	SAT	OTHER		
PT			U/A: DIP			EKG INTERPRETATION	
APTT	BHCG	ETOH / GLU	U/A: MICRO				

PROVIDER HISTORY/PHYSICAL

ABCDs. Airway patent - stonmonitor no echopy/ CTA(B).
GSW cheek left side
IV - 18g (L) AC infusing NS
.on arrival - 18g AC rt infusing NS - 600in bag - bag changed ou
1500 - Foley cath in no gross blood noted (P) CXR done
clear yellow urine

Injuries- GSW left cheek - airway patent
GSW rt abd - posterior clear

To OR @ 1503 T Dr [redacted]

(b)(6)-2

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

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)-1

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 - 20287

NSN 7540-01-165-7294 [redacted] 519-301

~~RADIOLOGIC~~ CONSULTATION REQUEST/REPORT

(Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations)

EXAMINATION(S) REQUESTED	AGE / SEX / SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
Nutrition Consult	M EPW [redacted]	ICU2	
	FILM NO.		PREGNANT ☐ YES ☒ NO
	REQUESTED BY (Print) CPT [redacted]		TELEPHONE/PAGE NO.
	SIGNATURE O CPT [redacted]		DATE REQUESTED 20/9/03

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

(1) Pt will be here long term (5)(6)-2

(2) SP Ex Lap / GSW to FACE + PEG D / MISSING teeth

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

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
# EPW [redacted] (5)(6)-7	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

MEDCOM - 20288 LTATION ORT

3 — RADIOLOGY

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

Emergency - no pre-op assessmen

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 32 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): 3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE: Ex LAP

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications:
Jewelry removed: yes/no Family waiting: yes/no

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; ~~family separation;~~ surgical environment	✓ 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.~~
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	✓ PT. will be able to breathe without difficulty during immediate intra-operative 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 integuity due to bovie pad; position; fluid shift	✓ 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)

[redacted] (b)(1)-2

EPW

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.01

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

[redacted] CRNA 23 Sept 03 DATE

11. POSTOPERATIVE EVALUATION.

Bair Site: intact
Drsg: clean
Breathing: intubated

(b)(6)-2

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted] CRNA

DATE: 23 Sept 03 TIME: 1510

13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title [redacted] CRNA

DATE: 23 Sept 03 TIME: 1900

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the prop[illegible] is t[illegible] ffice of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING RO[illegible] VIA litter BY anesthesia

2. PATIENT IDENTIFIED, R[illegible]ORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted]

3. DATE 23 Sept 03 TIME PATIENT ARRIVED IN SUITE 1510

4. PATIENT IN ROO[illegible] TIME 1510 NUMBER 5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: (b)(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] CPT [redacted]	RELIEF CIRCULATOR INT:	Maj [redacted] (1235-1800)

7. POSITION AND POSITIONAL A[illegible]

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

COMMENTS: Proper body alignment maintained, arms on padded armboards at less than 90°, position approved by surgeon + anesthesia

8. SKIN PREPARATION

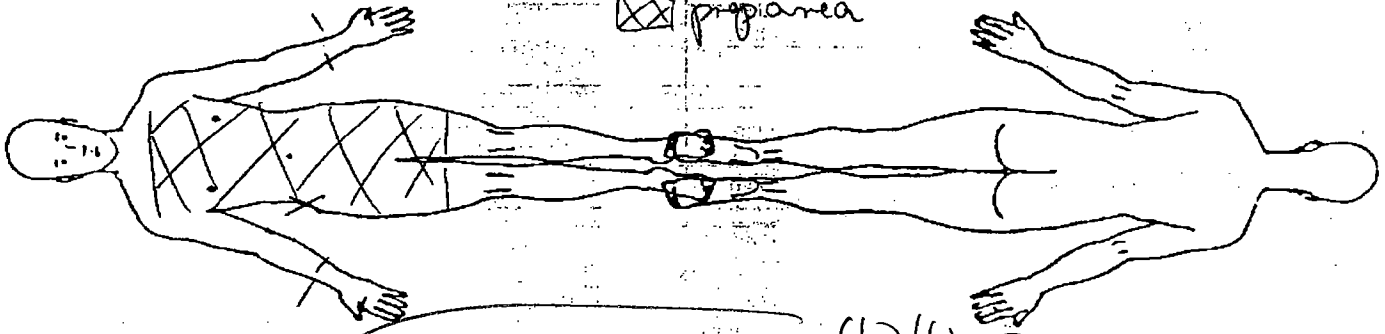
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: no nicks or cuts noted

PREP SOLUTION (Specify) Betadine (Betad)
SITE: Abdomen BY WHOM [redacted]
SITE: BY WHOM:

COMMENTS: no pooling or skin d's noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pa[illegible] Safety [redacted] = = Tourniquet N/A (b)(6)-2

C = Correct I = Incorrect Initial [redacted]

10. COUNTS			Tumor Bed/Other Cavity	First Closing Count	Final Closing Count
Sponge	☒ Yes	☐ No	C	C	C
Needle Sharp	☒ Yes	☐ No	C	C	C
Instrument	☒ Yes	☐ No	C	C	C
Other	☐ Yes	☒ No			

SCRUB [redacted] CIRCULATOR [redacted]

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

[redacted] (b)(6)-7
EPW

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

☒ ESU NO: Valleylab Force
GROUND PAD: BRAND VL Ram Polyhesive II
LOT NO: 70011 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

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13. PROSTHESIS, IMPLANTS [ ] YES [ ] NO IF YES NAME: ID NUMB[illegible] MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES [X] NO [ ]

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Lidocaine w Epi 1:100,000	8 cc	1110	Inj.	[redacted]	[redacted]
Bacitracin ointment	QS	1110	topical		
				(b)(6)-2	

WOUND IRRIGATION [X] YES [ ] NO; TYPE(S):
0.9% NaCl

OTHER ORDERS	TIME	CARRIED OUT BY
none		

[redacted]

15. X-RAY IN OPERATING ROOM YES [X] NO [ ] IF YES, SITE (R) arm / Head

16. LABORATORY SPECIMENS

SPECIMEN (S) YES [ ] NO [X]	NAME	NAME
FROZEN SECTION (FS) YES [ ] NO [X]	NAME	NAME
CULTURE (C) YES [ ] NO [X]	NAME	NAME
NAME	NAME (b)(6)-2	NAME
NAME	NAME	NAME

17. TUBES, DRAINS/PACKING YES [ ] NO [X]

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

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8
Tape
Splint → (R) arm

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

- 16F FIC in place upon arrival to OR → placed in ER

20. OPERATION(S) PERFORMED
Ex Lap, Closure of facial wounds
I+D (R) arm

21. PATIENT TRANSFERRED TO	TIME SEE	METHOD
ICU-2	DA7389	Litter

22. [redacted] CPT IAN

REVERSE [redacted] 87 MEDCOM - 20292 USAPA V1.00

(b)(6)-2

(b)(2)-2

[redacted] **VENTILATOR FLOW SHEET** ICU #2

[redacted] (b)(6)-4

GSW to mouth

7.5 ETT nasal intubation

DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS	INT
23Sept	1900	SIMV	10	800	50	5	25	11	68	100		7.36	38.7	174	-4	22	100		[redacted]
	2315	SIMV	10	800	40	5	27	10	66	100	135/79								
24Sept	0140	SIMV	10	800	40	5	27	10	67	100	127/76								
	0600	SIMV	10	800	40	5	28	10	62	98	116/61								(b)(6)-2
	0800	SIMV	10	800	40	5	27	10	60	99	112/68								
	1000	SIMV	10	800	40	5	27	10	60	99	113/62								
	1200	SIMV	10	800	40	5	24	13	85	100	130/78								
			EXT		1300														

75 @ nar

DOD-033867

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ACLU-RDI 1656 p.53

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR: 26 Sep | 27 Sep | 28 | 29 | 30 | 10-03

DAY

19

HOUR: 1800 | 0700 | 1800 | 0800 | 1800 | 0800

PULSE (0) / TEMP. F (°)

PULSE (0)	TEMP. F (°)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99° / 98.6°	37.2° / 37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

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.

[redacted] (5)(6)-4

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

(5)(6)-2

Ward/Section: EM7 | REQUEST [redacted] | **LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

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

(Hematology) CBC

TEST	RESULT		REF. RANGE
WBC			4.8-10.8 x 10³
RBC			
Hgb			
Hct			
MCV			
MCH			
MCHC			
Plt			
Lymph		Baso	

ID: [redacted]
MB
23-09-03
15:06
Patient Limits

WBC	11.3 H	x10^3/uL	4.5 10.5
RBC	5.04	x10^6/uL	4.00 6.00
Hgb	14.6	g/dL	11.0 18.0
Hct	46.0	%	35.0 60.0
MCV	91.3	fL	80.0 99.9
MCH	28.9	pg	27.0 31.0
MCHC	31.7 L	g/dL	33.0 37.0
Plt	285.	x10^3/uL	150. 450.
LY%	12.6	%	20.5 51.1
LYM	1.4 *	x10^3/uL	1.2 3.4

Urinalysis

TEST	RESULT	REF. RANGE
Color		
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
[illegible]uk		Negative
[illegible]CG		Negative

[illegible] Serology

TEST	RESULT	REF. RANGE
[illegible]RR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

CSF

[illegible]ell [illegible]ount
[illegible]irectigen — Negative

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

[illegible]TE: | LAB ID NO.:

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(5)(6)-1

RAPID
SERIAL #[redacted]

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 :09/23/03
Test Time :03:05 PM
Card Lot :010301
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/23/03 03:10 PM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 16.5 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/23/03
Test Time :03:07 PM
Card Lot :100208
Operator [redacted]

(b)(6)-2

Ward/Section: EMT | REQUESTING [redacted]N: | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, M[redacted] | DATE 23Sep | TIME 1450 | SSN/[redacted]SN: [redacted]

I-STAT EDIT

Pt: [redacted]

Pt Name: _____

Na_____144 mmol/L
K_____3.6 mmol/L
TCO2_____19 mmol/L
iCa_____1.13 mmol/L
Hct_____29 %PCV
Hb*_____10 g/dL
*via Hct

At 37C
pH_____7.276
PCO2_____39.0 mmHg
PO2_____399 mmHg
HCO3_____18 mmol/L
BEecf_____-9 mmol/L
sO2*_____100 %
*calculated

At Patient Temp
pH_____7.304
PCO2_____35.8 mmHg
PO2_____387 mmHg

Patient Temp: 35.0C
FIO2_____: 76
Sample Type_:

23SEP

Oper: [redacted]

Physician:_____

Ser# [redacted]

(b)(6)-4

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======
09/23/03 03:16 PM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	105	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.5*	0.6-1.2	MG/DL
CK	555*	39-380	U/L
NA+	122*	128-145	MMOL/L
K+	3.7	3.3-4.7	MMOL/L
CL-	101	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl

======= PICCOLO =======
09/23/03 03:43 PM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	3.3	3.3-5.5	G/DL
ALP	49	26-84	U/L
ALT	35	10-47	U/L
AMY	42	14-97	U/L
AST	37	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
GGT	21	5-65	U/L
TP	6.3*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 2+, LIP 0 , ICT 0

(b)(6)-2

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

(5)(6)-2

Ward/Section: ICU, H2 | REQUESTING PHYSICIAN: Dr. [redacted] | **LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST,MI. # [redacted] | DATE 23 SEP | TIME @ 2015 | SSN/PEEUDO SSN:

(Hematology) CBC

TEST	RESULT
WBC	
RBC	
Hgb	
Hct	
MCV	
Plt	
Lymph %	

ID: [redacted] 23-09-03 20:25
WB
(5)(6)-7

			Patient Limits	
WBC	10.4	x10^3/uL	4.5	10.5
RBC	4.73	x10^6/uL	4.00	6.00
Hgb	13.8	g/dL	11.0	18.0
Hct	42.6	%	35.0	60.0
MCV	90.2	fL	80.0	99.9
MCH	29.2	pg	27.0	31.0
MCHC	32.4 L	g/dL	33.0	37.0
Plt	198.	x10^3/uL	150.	450.
LYZ	8.3	%	20.5	51.1
LYM	0.9	x10^3/uL	1.2	3.4

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

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		

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

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

UNIT	TYPE	CROSSMATCH

REMARKS: ABG T: 984

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

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

(i-STAT)

TEST	RESULT	REF. RANGE
Na		136-145 mmol/l
K		3.5-5.5 g/dl
Cl		26-84 u/l
pH		10-47 u/l
PCO2		14-97 u/l
PO2		11-38 u/l
TCO2		0.2-1.6 mg/dl
HCO3		7-22 mg/dl
SO2		8.0-10.3 mg/dl
BEecf		100-200 mg/dl
AnGap		0.6-1.2 mg/dl
Ca		73-118 mg/dl
BUN		6.4-8.1 g/dl
GLU		
Creat		
Hct		
Hgb		

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

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

Na_____141 mmol/L
K_____4.1 mmol/L
TCO2_____23 mmol/L
iCa_____1.01 mmol/L
Hct_____39 %PCV
Hb*_____13 g/dL
*via Hct

At 37C
pH_____7.361
PCO2_____38.7 mmHg
PO2_____174 mmHg
HCO3_____22 mmol/L
BEecf_____-4 mmol/L
sO2*_____100 %
*calculated

At Patient Temp
pH_____7.362
PCO2_____38.5 mmHg
PO2_____174 mmHg

Patient Temp: 98.4F
Sample Type_: ART

235EP03 20:23

Oper: [redacted]

Physician:_____

Ser# [redacted]

(Piccolo) Chemistry 12

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) 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) Metlyte 8

TEST	RESULT	REF. RANGE
		136-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

(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

REMAR

REPORTED BY:	DATE:	LAB ID NO.:

Temp 36.2 °C
F.O2 74%

Ward/Section:	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted]	DATE 9/23/05 TIME	SSN/PEEUDO SSN:

(i-STAT) (6)(6)-6

Pt: [redacted]
Pt Name:_____

Na_____148 mmol/L
K_____3.9 mmol/L
TCO2_____22 mmol/L
iCa_____1.12 mmol/L
Hct_____32 %PCV
Hb*_____11 g/dL
*via Hct

At 37C
pH_____7.281
PCO2_____43.4 mmHg
PO2_____485 mmHg
HCO3_____20 mmol/L
BEecf_____-6 mmol/L
sO2*_____100 %
*calculated

At Patient Temp
pH_____7.293
PCO2_____41.9 mmHg
PO2_____480 mmHg

Patient Temp: 36.2C
Sample Type:

23SEP05 18:00

Oper: [redacted]
Physician:_____
Ser# [redacted]
Ver: [redacted]

TEST	RESULT	REF. RANGE
Na		3.5-5.5 g/dl
K		26-84 u/l
Cl		10-47 u/l
pH		14-97 u/l
PCO2		11-38 u/l
PO2		0.2-1.6 mg/dl
TCO2		7-22 mg/dl
HCO3		8.0-10.3 mg/dl
SO2		100-200 mg/dl
BEecf		0.6-1.2 mg/dl
AnGap		73-118 mg/dl
Ca		6.4-8.1 g/dl
BUN		
GLU		
Creat		
Hct		
Hgb		

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

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) Metabolic Panel

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) Liver Panel Plus

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

(Piccolo) Electrolyte

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
		73-118 mg/dl
		7-22 mg/dl
		0.6-1.2 mg/dl
		39-380 /l (M) 30-190 /l (F)
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

REMAI

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST,MI.		DATE	TIME		SSN/PEEUDO SSN:

(i-STAT)

i-STAT EG7+

Pt: [redacted] (b)(6)-7

Pt Name:_____

Na_____142 mmol/L
K_____3.7 mmol/L
TCO2_____23 mmol/L
iCa_____1.02 mmol/L
Hct_____39 %PCV
Hb*_____13 g/dL
*via Hct

At 37C
PH_____7.383
PCO2_____37.3 mmHg
PO2_____171 mmHg
HCO3_____22 mmol/L
BEecf_____-3 mmol/L
sO2*_____100 %
*calculated

Sample Type_:

23SEP03 23:09

Oper: [redacted]

Physician:_____

Ser# [redacted]

(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^{++}		8.0-10.3 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.:

(5)(6)-2

Ward/Section: ICU HD	REQUESTING PHYSICIAN: Dr. [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (5)(6)-4	DATE 2468 TIME 0530	SSN/PEEUDO SSN:

(Hematology) CBC

ID: [redacted] (5)(6)-7 24-09-03 05:37 WB

TEST				Patient Limits	
WBC	WBC	10.0	x10^3/uL	4.5	10.5
RBC	RBC	4.68	x10^6/uL	4.00	6.00
Hgb	Hgb	13.6	g/dL	11.0	18.0
Hct	Hct	42.2	%	35.0	60.0
MCV	MCV	90.3	fL	80.0	99.0
	MCH	29.1	pg	27.0	31.0
Plt	MCHC	32.2 L	g/dL	33.0	37.0
Lymph %	Plt	218.	x10^3/uL	150.	450.
	LY%	6.9 *L	%	20.5	51.1
	LY#	0.7 *L	x10^3/uL	1.2	3.4

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

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		

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS: ABG T:971

REPORTED BY:	DATE:	LAB ID NO.:

(6)(6)-2

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

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

LAST, FIRST, MI.: [redacted] | DATE: 24SEP03 | TIME: 0530 | SSN/PEEUDO SSN:

(i-STAT)

(3)(6)-4

Pt: [redacted]

Pt Name: _____

Na_____141 mmol/L
K_____3.8 mmol/L
TCO2_____23 mmol/L
iCa_____1.10 mmol/L
Hct_____40 %PCV
Hb*_____14 g/dL
*via Hct

At 37C
pH_____7.359
PCO2_____38.0 mmHg
PO2_____93 mmHg
HCO3_____21 mmol/L
BEecf_____-4 mmol/L
sO2*_____97 %
*calculated

Sample Type_:

24SEP03 05:37

Oper: [redacted]

Physician: _____

[redacted]

TEST	RESULT	REF. RANGE
Na		
K		
Cl		
pH		
PCO2		
PO2		
TCO2		
HCO3		
SO2		
BEecf		
AnGap		
Ca		
BUN		
GLU		
Creat		
Hct		
Hgb		

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
		3.5-5.5 g/dl
		26-84 u/l
		10-47 u/l
		14-97 u/l
		11-38 u/l
		0.2-1.6 mg/dl
		7-22 mg/dl
		8.0-10.3 mg/dl
		100-200 mg/dl
		0.6-1.2 mg/dl
		73-118 mg/dl
		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
		73-118 mg/dl
		7-22 mg/dl
		0.6-1.2 mg/dl
		39-380 /l (M) 30-190 /l (F)
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		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: ABG T:97.9

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

(b)(6)-2

Ward/Section: ICU #2

REQUESTING PHYSICAN: [redacted]

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

LAST, FIRST, MI. [redacted]

DATE: 24 Sep

TIME: 1540

SSN/PSEUDO SSN: [redacted]

(b)(6)-4

EXTUBATED O2 40 MASK

i-STAT

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
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 (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		

[redacted]

Sample Type_1

24SEP03 15:51

Oper [redacted]

Physician

Ser# [redacted]

Ver# [redacted]

(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: ABG

REPORTED BY: [redacted]

DATE: 24Sep03

LAB ID NO.:

(b)(6)-2

Ward/Section: ICU (b)(6)-2

REQUESTING PHYSICIAN: [redacted]

LAST, FIRST, MI. [redacted]

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

DATE 25 Sep 03 TIME 1120 hrs

SSN/PEEUDO SSN: [redacted] (b)(6)-7

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymph %		

ID: [redacted] (b)(6)-7 WB 25-09-03 17:36

			Patient Limits	
WBC	11.8 H	x10^3/uL	4.5	10.5
RBC	4.80	x10^6/uL	4.00	6.00
Hgb	13.8	g/dL	11.0	18.0
Hct	44.1	%	35.0	60.0
MCV	91.8	fL	80.0	99.9
MCH	28.7	pg	27.0	31.0
MCHC	31.2 L	g/dL	33.0	37.0
Plt	296.	x10^3/uL	150.	450.
LY%	7.2 *	%	20.5	51.1
LY#	0.8 *	x10^3/uL	1.2	3.4

(Hematology) Manual Differential

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

DATE: 25 Sep 03

LAB ID NO.:

(b)(6)-7 (b)(6)-2

Ward/Section: ICU #1	REQUESTING PHYSICA [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted]	DATE 27SEP	TIME 0520	SSN/PEEUDO 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)
Plt		
Lymph %		

(Hematolo

Segs	
Bands	
Lymph	
Atyp	
RBC Morph	
Spun Hematocrit	
Set Rate	
Other	

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Nep
Ket		Ne
		N/
		N
		N/
		N
		0.
		N
		N

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source

Negative

Negative

CSF

Cong

IST SUBMI

F BLOOD

ID: [redacted] 27-09-03
WB 05:41
Patient Limits

WBC	6.0	x10^3/uL	4.5	10.5
RBC	4.70	x10^6/uL	4.00	6.00
Hgb	13.4	g/dL	11.0	18.0
Hct	42.8	%	35.0	50.0
MCV	91.0	fL	80.0	99.9
MCH	28.4	pg	27.0	31.0
MCHC	31.2 L	g/dL	33.0	37.0
Plt	193. *	x10^3/uL	150.	450.
LY%	27.9	%	29.5	51.1
LY#	1.7	x10^3/uL	1.2	3.4

(5)(6)-7

======= PICCOLO =======
27/09/03 06:02
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	95	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	968*	39-380	U/L
NA+	130	128-145	MMOL
K+	3.7	3.3-4.7	MMOL
CL-	100	98-108	MMOL
tCO2	23	18-33	MMOL

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

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

REMARKS:

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

(b)(6)-2

Ward/Section: ICU #1	REQUESTING PHYSICA[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST,ML [redacted]		DATE 8/28	TIME 0530	SSN/PEEUDO SSN [redacted] (b)(6)-4

(Hematology) CBC	
TEST	[redacted] (b)(6)-4
WBC	
RBC	
Hgb	
Hct	
MCV	
Plt	
Lymph %	

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

Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Color		N/A	RPR		Negative
App		N/A	Mono		Negative
Glu		Negative	**Microbiology**		
Bili		Negative	Source		
Ket		Negative	Gram Stain		
SG		N/A	Occ Bld		Negative
Bld		Negative	H. pylori		Negative
pH		N/A	Micro Parasites		
Prot		Negative	Malaria		
Urob		0.2-1.0	O & P		
Nit		Negative	Other		
Leuk		Negative	**Macroscopic Urinalysis**		
HCG		Negative			

CSF			Blood Bank	
Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
Directigen		Negative	ABO/Rh	

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

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

Ward/Section:	REQUESTING PHYSICAN:	CHEMISTRY 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
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 (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
Het		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
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/
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 m
CHOL		100-200 m
CRE		0.6-1.2 mg
GLU		73-118 mg
TP		6.4-8.1 g/

(Piccolo) Metlyte 8

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

K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

PICCOLO
28/09/03 06:00
REFERENCE RANGE:
PATIENT #: [redacted] MALE
BASIC METABOLIC (5)(6)-4
DISC LOT #: 3203AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	104	73-118	MG/DL
BUN	8	7-22	MG/DL
CA++	8.0	8.0-10.3	MG/DL
CRE	0.8	0.6-1.2	MG/DL
NA+	136	128-145	MMOL
K+	3.8	3.3-4.7	MMOL
CL-	96*	98-108	MMOL
tCO2	27	18-33	MMOL

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: 1CW 1 | REQUESTING PHYSICAN: | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST,MI. EPW #[redacted] | DATE 29SEP | TIME 0400 | SSN/PERID #[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 x10
Lymph %		

(Hematology)

Segs	
Bands	
Lymph	
Atyp	
RBC Morph	
Spun Hematocrit	
Set Rate	
Other	

Coagulation

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 SESS
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		Negativ
SG		N/A
		Negativ
		N/A
		Negativ
		0.2-1.0
		Negativ
		Negativ
		Negativ

CSF

Blood SUBMIT SF

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono	--	Negative

Microbiology

(b)(6)

[redacted]

Patient Limits

WBC	6.6	x10^3/uL	4.8	10.8
RBC	5.13	x10^6/uL	4.00	6.00
Hgb	14.9	g/dL	12.0	18.0
Hct	46.3	%	35.0	60.0
MCV	90.5	fL	80.0	99.0
MCH	29.1	pg	27.0	31.0
MCHC	32.2 L	g/dL	33.0	37.0
PLT	298.	x10^3/uL	150.	450.
HCT	17.2	mL %	20.0	51.0
LYM#	1.5 *	x10^3/uL	1.2	3.4

======= PICCOLO =======

29/09/03 03:55

REFERENCE RANGE: MALE

PATIENT #: [redacted]

METLYTE 8

DISC LOT #: 3141AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	108	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	145	39-380	U/L
NA+	129	128-145	MMOL
K+	4.3	3.3-4.7	MMOL
CL-	97*	98-108	MMOL
tCO2	24	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

REMARKS: (CBC/met panel.)

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

~~10~~ A

(5)(6)-2

Ward/Section: ICW#1 | REQUESTING PHYSICAN: [redacted] | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST,MI. [redacted] | DATE 9130 | TIME 0500 | SSN/PSEUDO 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 fi(M) 81-99 fi(F)
Plt		130-500 x10³ verified
Lymph %		

(Hematolo

Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		
Set Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
		Negative
		N/A
		Negative
		0.2-1.0
		Negative
		Negative
		Negative

CSF

		Negati

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

(5)(6)-4

[redacted]

PICCOLO

09/30/03 06:46 AM

REFERENCE RANGE: MALE

PATIENT #: [redacted]

BASIC METABOLIC

DISC LOT #: 3203AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	102	73-118	MG/DL
BUN	11	7-22	MG/DL
CA++	8.6	8.0-10.3	MG/DL
CRE	0.9	0.6-1.2	MG/DL
NA+	133	128-145	MMOL
K+	4.2	3.3-4.7	MMOL
CL-	100	98-108	MMOL
tCO2	25	18-33	MMOL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

Coag

Blood B
IST SUBMIT SF 51
R

D

TEST			UNIT	
PT		9.8-13.6 secs		
APTT		21-34 SESS		
D dimer		<20 ug/ml		
FDP		< 10 ug /ml		

REMARKS:

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

MEDCOM - 20309

Ward/Section: | REQUESTING PHYSICAN: | **LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

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

(Hematology) CBC | **Urinalysis** | **Misc. Serology**

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		
Hct		
MCV		
Plt		
Lymph		
(Hem		
Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematoc		
Set Rate		
Other		

TEST	RESULT
Color	
App	

(b)(6)-4

ID [redacted] 01-10-03
05:40

			Patient Limits	
WBC	9.2	x10^3/uL	4.5	10.5
RBC	5.63	x10^6/uL	4.00	6.00
Hgb	16.2	g/dL	11.0	18.0
Hct	50.9	%	35.0	60.0
MCV	90.4	fL	80.0	99.9
MCH	28.8	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	371.	x10^3/uL	150.	450.
LY%	17.9 -L	%	20.5	51.1
LY#	1.6 *	x10^3/uL	1.2	3.4

PICCOLO
01/10/03 05:50
REFERENCE RANGE: MALE
PATIENT #: [redacted]
BASIC METABOLIC
DISC LOT #: 3203AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	99	73-118	MG/DL
BUN	12	7-22	MG/DL
CA++	8.8	8.0-10.3	MG/DL
CRE	1.0	0.6-1.2	MG/DL
NA+	137	128-145	MMOL/L
K+	5.0*	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

REF. RANGE: Negative, Negative, Negative, Negative

CSF | ...nalysis | ...8 WITH ...ESTED | ...ctigen

Coagulation Studies | (MUST SUBMIT ... | BLOOD

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

MATCH

REMARKS:

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

MEDCOM - 20310

Seen in EMT emergent GSW to abd, face (L) arm – NKDA per trans. No oth information obtained
to OR – VS in EMT 122/101/10/105 ; 3.7/19/1.5

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS (Continuous / Repeated Drugs; Specify units – MG / MCG / ML; "I" = Constant Infusion)

DRUG (Units)													TOTALS
Versed (mg)	2									1		1	5mg
Fent ( )	<250>	50			50				50			50	500ug
Propofol ( )	140												
Sccs ( )	100												
Roc Vec ( )		50		10		5							
VOLAT AGENT Iso % del	1.0	0.5	0.4	X	1.5	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	10→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: 250 / 330

TOTAL URINE: 1700

FLUIDS - SUMMARY
- CRYSTALLOID– LR 330
- COLLOID– 2-Hispan 1000cc
- BLOOD– 2 U PRBC

FLUIDS

LINE site	Warmed				
(L) PIV	#1 LR #3	1000	1400	1450
(R) PIV	#2 NS	1000		1100
(R) IJ triple	NS #3	Blood #1	#2	500
Hispan	(500)	500		

LOSSES					
EST BLOOD LOSS	100	250			
URINE–	225	1000	1400	1550	

PHYS STATUS: 1 (2) 3 4 5 (E)

TIME → 1500 · 30 · 1600 · 30 · 1700 · X · 20 X

BODY WEIGHT: 80 (KG)

HEMATOCRIT: 46

INITIAL DATA: BP – 128/74; HR – 106

EQUIP CHECK: OK? – (Y) N

PATIENT PROGRESS: OK for PROCEDURE? TIME – 1450

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

Grid annotations: Emt; Hct 46; PT 12.4; PTT 16.5; INR 1.03; ABG; pH 7.3; Hct 29; Hb 10; 1864434; 10 58693

VENTILATION / MONITORS

VT – ml	+	570	850	710	670	660	640	650	660	650	660	660
f – breaths/min	+	10	8	8	8	8	9	9	9	8	8	8
Peak insp pres / PEEP	=	22	28	18	18	26	21	23	23	23	23	23
MODE – S(pon), A(ssist), C(on)	S–C	C	C	C	C	C	C	C	C	C	C	C
ET CO2 (torr)	+	27	28	33	33	32	32	31	31	31	31	31
FIO2 (Frac or %)	0.76	0.76	0.76	0.76	.76	.75	.74	.75	.74	.73	.74	.73
SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100	100
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
TEMP- site					36.1		35.8		36.0		36.2	36.4
N-M Block (T/4)		0/4								4/4		

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

EVENTS (Mark with letters & symbols, explain under REMARKS): ① ② ③ ④ ⑤⑥

Position →

REMARKS- (Code drugs with numbers, events with letters)

1. Room, monitors, O2 Induced, OG placed, Phenylephrine TTE 50-100mcg
2. Cefotetan 2gm IVP
3. Scopolamine 0.4mg

(R) IJ placed by [redacted]

(L) Radial A-line placed by MAJ Fedele

4. Decadron 10mg
5. Throat pack in
6. Local 1% lido c epi 8cc

oral ETT Δ to 7.5 nasal RAE c one attempt under visualization grade I view. ⊕ETCO2 ⊕ bilat BS @ 27 cm nares.

RECOVERY AT
- PACU (ICU) 2 (Specify)
- OTHER
- CONDITION: Stable on vent
- RESP– Vent; SpO2– 100
- BP– 118/67; HR– 68

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	1430	1510	1920

	Ready	Begin	End
PROC	1520	1525	1858

PROCEDURES and CPT Codes: (R) forearm; Exlap, GSW (L) face

ANESTHETIC TECHNIQUES: (Describe block technique under Remarks) GETA; RSI c cricoid

AIRWAY MANAGEMENT: (Intubation route, blade, technique, comments) 8.0 ETT placed c 3 MAC grade I view, c stylet ⊕ ETCO2 ⊕ BBS secured 23cm @ teeth.

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

#[redacted]

(b)(6)-4

SURGEON [redacted]

AN[redacted]

(b)(6)-C

PROCEDURE LOCATION: 2 (1)

DATE: 23 Sept 03

PAGE 1 OF 2

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 20311

MEDICAL RECORD — ANESTHESIA

total 15

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

DRUG	(Unite)	
Fent (200)	( )	50
Versed 4mg	( )	1
Vec	( )	5
	( )	
	( )	
	( )	
VOLAT AGENT Forane	% del	1.5 1 1 1
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	2 2 2 2

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

FLUIDS

LINE site (R) TH #3	☐ Warmed	1200 1750
(R) TH #4	☐ Warmed	700 1000
Periph #5 (L)	☐ Warmed	1550 1550
	☐ Warmed	

LOSSES

EST BLOOD LOSS	200 250
URINE –	1700

TOTALS

TOTAL URINE: sep 1

FLUIDS - SUMMARY
CRYSTALLOID –
COLLOID –
BLOOD –

REMARKS-

Code drugs with numbers, events with letters

1900 Pt transferred to bed. Vent ETCO2 bag valve mask – Pulse ox. VCS. Report given

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT KG LB

HEMATOCRIT:

INITIAL DATA: BP – HR –

SOAP CHECK: OK? Y N

PATIENT RECHECK: OK for PROCEDURE? TIME –

TIME → 800 x 830 x 900 x 930 x 20

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

220 200 180 160 140 120 100 80 60 40 20

7.28 42.9 48.7 20 4 11/27

VENTILATION

	800	830	900	930	20
VT – ml	650	650	650		
f – breaths/min	8	8	8		
Peak inf pres / PEEP	23	24	25		
MODE – S(pon), A(assist), C(on)	C	C	C		

MONITORS / ACCESSORIES

BP/Auto Cuff	✓	ET CO2 (torr)	32	32	32
BP / oth	✓	FIO2 (Frac or %)	.74	.67	.67
ART line	✓	SpO2 (%)	100	100	100
Steth- PC/ES	✓	ECG	SR	SR	SR
Gas analyzer	✓	TEMP- site	36.4	36.6	36.6
		M-M Block (T/4)	4/4		
Warming blkt					
Conv warmer					

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

RECOVERY AT

PACU ICU _____ (Specify)
OTHER _____
CONDITION: sep 1
RESP – SpO2 –
BP – HR –

ANESTHESIA PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: (R) forearm EX LAP GSW face

ANESTHETIC TECHNIQUES: Describe block technique under Remarks #

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

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

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

SURGEON [redacted] (K)

ANESTH [redacted]

(b)(6)-2

PROCEDURE LOCATION 2 (A)

DATE 23 Sept 03

PAGE 2 OF 2

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 20312

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)*: 1 unit ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH 4

DATE REQUESTED: 23 Sept

DATE AND HOUR REQUIRED: 1453

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]

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW to abd

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

SIGNATURE OF VERIFIER: [redacted] CPT L

DATE VERIFIED: 23 Sept

TIME VERIFIED: 1453

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: [redacted]

TRANSFUSION NO.

PATIENT NO.: [redacted]

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	compat

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: exp 27 Sep03

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

SIGNATURE OF PERSON PERFORMING TEST: [redacted]

DATE: 23 Sep03

DONOR	RECIPIENT
ABO O	ABO O
Rh Neg	Rh Neg

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted]

AT *(Hour)*: 1552 ON *(Date)*: 23 Sep03

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 VER: [redacted]

2nd V: [redacted]

PRE-TRANSFUSION

TEMP.	PULSE	BP
36.1	89	104/58

DATE OF TRANSFUSION: 9/23/03

TIME STARTED: 1600

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1 ML

TIME/DATE COMPLETED/INTERRUPTED: 1638

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
35.8	74	111/66

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

SIGNATURE: [redacted]

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

[redacted] (b)(6)-4

SEX: M

WARD: EMT

(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 - 20313

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)*: 1 unit ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH 4

DATE REQUESTED: 23 Sept

DATE AND HOUR REQUIRED: 1455

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]

DIAGNOSIS OR [illegible]TIVE PROCEDURE: GSWabd

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

SIGNATURE OF VERIFIER: [redacted]

DATE VERIFIED: 23 Sept

TIME VERIFIED: 1455

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: [redacted]

TRANSFUSION NO.

PATIENT NO.: [redacted]

DONOR
ABO: O
Rh: Neg

RECIPIENT
ABO: O
Rh: Neg

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	compat

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 23 Sep 03

REMARKS: exp 29 Sep 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted]

AT *(Hour)*: 1553 ON *(Date)*: 23 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 *(Signature)*: [redacted]

2nd V[redacted]

PRE-TR[redacted]

TEMP. 35.9 PULSE 80 BP 107/69

DATE OF TRANSFUSION: 9/23/03

TIME STARTED: 1640

POST-TRANSFUSION DATA

AMOUNT GIVEN: 1U ML

TIME/DATE COMPLETED/INTERRUPTED: 1735 9/23/03

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[x] NONE [ ] SUSPECTED	36.2	75	96/63

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)*

SIGN[redacted]

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank, rate; hospital or medical facility)

[redacted]

SEX: M WARD: 7M7

(b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

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

MEDCOM - 20314

Medical Record Copy

ACLU-RDI 1656 p.74

DOD-033888

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]

(5)(61-7

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 23Sep03 TIME OF ORDER 1900 HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Admit to ICU #2

(2) Dx: S/P EX LAP GSW Abdomen
WASH OUT (R) Forearm
Ext of teeth + closure
of facial wounds
S/P GSW Face

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

(3) Cond: Stable HOURS

(4) Vitals: Per routine

(5) Aller: UNK

(6) Activ: Bedrest

(7) Nurs: HOB ↑ 30°
Foley to Gravity
Yankauer Suction to BS

(8) Diet: NPO

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

(9) IV: NS @ 125cc/hr HOURS

(10) meds: Ancef 1gm IV q8°
Decadron 10mg IV @ 2300
then Decadron 8mg IV
x 2 doses (q8°)
then Decadron 6mg IV
x 2 doses then D/C
Lentamil / drip to track
to Sedation

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

Versed HOURS

Bacitracin to face wounds
TID

(11) Vent: SIMV 10 TV 800 50% FIO2
Peep 5

(12) ABG + CBC now + AM

[redacted]

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

MEDCOM - 20315

2-19(5)

Double Sided

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] EPW

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

DATE OF ORDER: 24 Sep 03 | TIME OF ORDER: @ 0845 HOURS | LIST TIME ORDER NOTED AND SIGN

1) Hold Sedation
wean to extubate

[redacted]

Noted @ 0845 24 SEP 03

PATIENT IDENTIFICATION

#[redacted] EPW

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

DATE OF ORDER: 24 Sep 03 | TIME OF ORDER: HOURS

MSO4 2-4 mg IV q 1-2° prn

[redacted]

[redacted]

2355 24 Sep 03

PATIENT IDENTIFICATION

#[redacted] EPW

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

DATE OF ORDER: | TIME OF ORDER: HOURS

Clamp NGT x 8°
~~If~~ without emesis or nausea for 8°
then D/C NGT
OOB → chair

[redacted]

[redacted]

Noted @ 0650 hrs 25 Sep 03

PATIENT IDENTIFICATION

#[redacted] EPW

[redacted]

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

DATE OF ORDER: 25 Sep 03 | TIME OF ORDER: 0800 HOURS

1) Start oral care

[redacted]

D/C Foley

Noted @ 0805 25 Sep 03

[redacted]

(b)(6)-4

(b)(6)-2

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

MEDCOM - 20316

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-363-710

Double-Sided

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

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

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER HOURS	LIST TIME ORDER NOTED AND SIGN
~~Transfer to floor~~		
~~If OSW to add 1 face~~		
~~Suppl facial wounds~~		
25 Sep 03	@1630	Noted @ 1645 25 Sep 03
① H&H		
② Chest PT		

PATIENT IDENTIFICATION

[redacted] EPW

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

DATE OF ORDER	TIME OF ORDER HOURS
26 Sept 03	0910
✓ Transfer to floor d/ OR c/ Dr [redacted]	
✓ Stable	
✓ S/P Suppl lap / Facial repairs	
✓ Salbutamol NEBS	
✓ NS D5 ½ NS at 100 cc/h	
✓ Walk routine	

PATIENT IDENTIFICATION

[redacted] EPW

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

DATE OF ORDER	TIME OF ORDER HOURS
26 Sept 03	0910
✓ Ancef 2 gm IVPB q 8°	
✓ Bacitracin to face wounds TID	
✓ Percocet 2 PO q 4-6° prn	
✓ Clear liquids advance as tolerated.	
✓ OOB → chair → ambulate → halls	
Chest PT	

PATIENT IDENTIFICATION

[redacted] EPW

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

DATE OF ORDER	TIME OF ORDER HOURS
26 Sept 03	0910
✓ Yankauer suction to bedside	
✓ HOB at 30°	
Labs CBC & plt → qam	
BMA 7 OCH → qam	
[redacted]	

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

MEDCOM - 20317

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994 - 563-710

(b)(6)-5

(b)(6)-2

(b)(6)

ACLU-RDI 1656 p.77

DOD-033891

Db Ele 3 Jeel

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] EPW

Noted [redacted] 27 Sep 03

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

DATE OF ORDER: 27 Sept 03 | TIME OF ORDER: 1020 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Ensure + can tol
(2) ↓ IVF to 75 cc/hr
(3) OK to leave midline dressing off

[redacted]

29 Sep 03 0200 [redacted]

(5)(6)-2

PATIENT IDENTIFICATION

[redacted] EPW

DATE OF ORDER | TIME OF ORDER ____ HOURS

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

(5)(6)-5

PATIENT IDENTIFICATION

[redacted] EPW

DATE OF ORDER | TIME OF ORDER ____ HOURS

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

PATIENT IDENTIFICATION

[redacted] EPW

[redacted]

DATE OF ORDER | TIME OF ORDER ____ HOURS

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

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

☆ U.S. MEDCOM - 20318 363-710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
#[redacted]			27 Sep 03	@ 1810 HOURS	
			① Δ diet to mechanical soft diet		
			[redacted]		MAJ/DC
NURSING UNIT	ROOM NO.	BED NO.			
24	27 Sep 2200	[redacted]			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
[redacted]			30 Sep 03	1030 HOURS	
			D/C all IVF per [redacted]		
			VO D[redacted]		
NURSING UNIT	ROOM NO.	BED NO.			
24	2300	308 [redacted]			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

DA FORM 1 APR 79 4256 REPL/ MEDCOM - 20319 HICH MAY BE USED.

CLINICAL RECORD

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

Mo. 9 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 23	24	25	26	27	28	29	30
23Sep03	[redacted]	Vitals per Routine	06	/	[redacted]						
			18	[redacted]							
23Sep	[redacted]	Nothing by Mouth	06	/	[redacted]						
			18	[redacted]							
23Sep	[redacted]	HOB ↑ 30°	06	/	[redacted]						
			18	[redacted]							
23Sep	[redacted]	[redacted]	06	[redacted]							
		[redacted]	18	[redacted]							
23Sep	[redacted]	Yankeur suction to	06	/	[redacted]						
		BS	18	[redacted]							
23Sep	[redacted]	Diet: NPO	06	/	[redacted]						
			18	[redacted]							
25 SEP 03	[redacted]	OOB TO CHAIR	06	/	/	[redacted]					
			18	/	/	[redacted]					
25SEP 03	[redacted]	CHEST PT	06	/	/	[redacted]					
			18	/	/	[redacted]					
25Sep03	[redacted]	Diet: clear liquids	06	/	/	[redacted]					
		as tolerated	18	/	/	[redacted]					

ALLERGIES: ☐ YES ☐ NO
Unknown

PRIMARY DIAGNOSIS:
S/P EX Lap, GSW Abdomen and face
washout (R)FA, Teeth extraction; closure facial wounds

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

(b)(6)-2

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

MEDCOM - 20320

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo 9 Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
23 Sep	[redacted]	Admit ICU2 ; Condition Stable	23 Sep	NOW	1915	[redacted]
23 Sep		ABG + CBC now	23 Sep	NOW	DON	
23 Sep		ABG, + CBC in AM	24 Sep	0500	Done	
25 SEP		CLAMP NG x 8°; IF WITHOUT EMESIS OR NAUSEA FOR 8°, THEN	25 SEP	NOW	clamped 0730 D/C @ 1530	
		NGT D/C'd				
25 Sep		D/C Foley	25 Sep	AM	pulled: 0930 1st void: 1000	
25 Sep		H&H	25 Sep	pm	1720	
		(5)(6)-2				(5)(6)-2

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

USAPA V1.00

CLINICAL RECORD

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

Mo. ____ Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED
26 Sept	[redacted]	Vitals routine	06 12 18 24	26 27 28 29 30 1
26 Sept	[redacted]	Clear liquid advance as tolerated	06 12 18 24	[redacted]
26 Sept	[redacted]	OOB → chair → ambulate in halls	06 12 18 24	[redacted]
26 Sept	[redacted]	chest PT	06 12 18 24	[redacted]
26 Sept	[redacted]	Yankeur suction @ bedside	06 12 18 24	[redacted]
26 Sept	[redacted]	HOB @ 30°	06 12 18 24	[redacted]
26 Sep	[redacted]	Labs CBC E plt SMA 7 E CA+ q AM	04	/
27 Sept 03	[redacted]	ERSR TSH TD	08	/
			12	/
			17	/
27	[redacted]	Mechanical Soft diet	6	/ /
			10	/ [redacted]

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: ex lap / fascial repair

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 — PREVIOUS EDITION OF THIS FORM MAY BE USED.

MEDCOM - 20322

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
27 SEP 03	[redacted]	ck to leave midline dsg off	27 SEP 03			[redacted]
		(b)(6)-2				

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

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23	24	25	26	27	28	29	30
23 Sep	[redacted]	IV: NS @ 125/hr	06	/							
			18	/							
[redacted]											
23 Sep	[redacted]	Bacitracin to face wounds TID	06	/							
			14	/							
			22	/							
23 Sep	[redacted]	Ancef 1gm IV q 8°	06	/							
			14	/							
			22	/							
[redacted]											
23 Sep	[redacted]	Decadron 4mg IV TID x 2 doses then D/C (23)	23	/	/	/	/	/	/	/	/
			13	/	/	/	/	/	/	/	/
[redacted]											

(5)(6)-2

Rewritten 26 Sept

Rewritten 26 Sept

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
unknown	SIP Ex Lap, GSW ABD and face, washout (R) FA Teeth extraction, closure facial wounds	PAGE NO.

PATIENT IDENTIFICATION:

EPW

[redacted] (5)(6)-7

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 — MEDCOM - 20324 — USAPA V1.00

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 9 Yr. 03			
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
23 Sep [redacted]	Decadron 10mg IV @ 2300	23 Sep	2300	2300	[redacted]
24 SEP [redacted]	HOLD SEDATION; WEAN TO EXTUBATE	24-SEP	AM	1030hrs	[redacted]
	(5)(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED															
24Sep	[redacted]	MSO4 2-4mg IV	25 SEP 0145 3mg	25 Sep 1130 3mg	25 Sep 1615 2mg	25SEP 2000 2mg	26SEP 0945 2mg	[redacted]										
		q 1-2° prn																

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

MAR 9 1-03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 26 27 28 29 30 1
26Sept	[redacted]	D5½NS @ 100 cc/hr ↓ to 75cc/hr	06 18	[redacted] → D/C'd
26Sept	[redacted]	Ancef 1 gm IVPB q 8°	06 14 22	[redacted] → D/C'd 30Sept @ 1400
26Sept	[redacted]	Bacitracin to face wounds TID	06 14 22	[redacted]

(5)(6)-2

ALLERGIES: ☐ YES ☒ NO — PRIMARY DIAGNOSIS: exp lap/facial repair — ADDITIONAL PAGES IN USE: ☐ YES ☐ NO — PAGE NO.

PATIENT IDENTIFICATION

[redacted] (6)(6)-7

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 3803, 1 FEB 72 — PREVIOUS EDITIONS OBSOLETE — USAPA V1.00

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

(b)(6)-2

Order/ Entry Date	Clerk/ Nurse	P.R.N. MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
26 Sept	[redacted]	Percocet 1 PO q 4-6° PRN	2014 2358 0458 0958 1915 1915 [redacted]
24 Sept	[redacted]	MSO4 2-4 mg IV q 1-2° PRN	2814 2214 2210 0545 4mg 4mg [redacted]

USAFA V1.78

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE **Post-Anesthesia Care Unit (PACU) Flow Sheet** | OTSG APPROVED *(Date)*

Date: 22 SEP Anesthesia Type (Circle)): (General) Spinal Epidural IV Sedation Nerve Block

Time In: 1416

Allergies: NKDA OR Intake: Crystalloid 3300 Colloid 1000 Hespan

Pre-op V/S: 120/74 HR 106 OR Output: UOP 1700 EBL 250 [illegible] RBL

Procedures: Meds/Times: [illegible]

GSW (R) forearm, Explap (L) grazing bullet to (L) side of face knock out teeth

Drains: Hemovac, NG, JP, T-tube, Foley, TLS

Airway: Nasal, Oral, (ETT), Trach, Other

Margin notes: [illegible] 2[illegible] ; 30 ; 23

Pre Op Meds — History

Time	1416	1420	1430	1440	1455	1510
SaO2						
FIO2						
Methods						
240						
220						
200						
180						
160						
140	140					
				135		
120		122	125		129	
100						
80	88	87	91	85	85	
60	•	•	•	•	•	
40						
20						
RR	10	18	9	10	10	
T	97.3					
Time						
Pain (0-10)						
LOS						

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

V/S: X = A-line BP, ˆ = Cuff BP, • = Pulse

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

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

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

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

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICW2

DATE: 22 SEP

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

EPW

(b)(6)-2

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete

USAPPC V2.00

MEDCOM - 20328

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

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

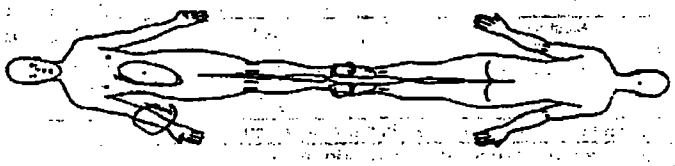
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Bilateral ABD	Bulky	On-ABD
30'	"	"	"
60'	"	"	"
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
2030	Foley	Clear-Yellow	1000 cc

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1415: Pt. to ICU2 from OR via gurney being bagged. Pt. arrived intubated via (L) nares. Pt. arrived sedated. VSS. Pt. placed on monitors. CA [redacted] (b)(6)-2

Discharge Criteria:

Date: **Time:** **PARS:**

BP: **T:** **HR:** **RR:** **SaO2:**

Pain Level at D/C (0-10):

Intake: _____ **Output:** _____

Additional Data: _____

Transferred To: _____

Report Given To: _____

Transferred Via: W/C Litter Gurney Ambulance

Transferred By: _____

Cleared IAW Recovery Room SOP B-3

Charge Nurse Signature: _____

MEDCOM - 20329

INITIAL SHIFT ASSESSMENT

		Time: 1920 Initals: [redacted] (6)(6)	Time:	Initals:
NEURO	Pupils	2mm No reative to light		
	Sensorium	Sedated Versed at 6mg/hr		
	LOC / GCS	↓ NGT @25 at (R) nares		
CARDIAC	Cardiac Rhythm	NSR		
	PRI / QRS:			
	Pulse Strength	3 x4 extremities		
	Cap Refil / JVD	<3sec x4 / ⊖ JVD		
	Edema	to abd and (L) face		
	Chest Pain	⊖		
RESP	Respiratory Pattern	SIMV 10 / equal rise + fall of chest		
	Breath Sounds	clear		
	Secretions	⊖		
	Cough	⊖		
SKIN	Color	Normal		
	Integrity	(R) forearm, Cow, (L) side of face ⊖		
	Backside	sutures; Ex Lap		
IV	Access Devices	Triple lumen catether to (R) side		
	Location	of neck. IV (L) AC		
	Condition	⊖ signs of infection		
GI	Abdomen	slight edema around surgical site		
	Bowel Sounds	Hyperactive x4 quad		
	Stoma / Ostomy	⊖		
GU	Device	Foley		
	Color / Clarity	clear + yellow		
		(6)(6)-2		

PREPARED BY (Signature) [redacted] | DEPARTMENT/SERVICE/CLINIC ICU [redacted] | DATE 23SEP03

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

NAME: H [redacted] (6)(2)-7 RANK: AGE:

UNIT: (6)(6)-4 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

USAPPC V2.00

PT'S NAME: [redacted] (6)(6)-4

DATE: ~~23SEP @ 2100~~ 23SEP - 24SEP

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
P INV	--														146/89	141/82	138/79	141/84	130/78	136/79	124/74	119/69	116/68	118/70
NIBP														132/88	127/83	120/74	116/72	118/73	114/71	111/66	106/62	105/57	101/56	103/66
MP																98.9	99.2		99.1		98.4		97.5	
PULSE														69	69	68	65	67	67	65	69	59	62	61
RESP														11	10	10	10	10	10	10	10	10	10	10
SP02														120	100	100	100	100	110	100	100	98	98	97
FIO2															45	40	40	40	40	40	40	40	40	40
Peep															5	5	5	5	35	35	5	5	5	5
SIMV															10	10	10	10	10	10	10	10	10	10
TVolume															800	800	800	800	800	800	800	800	800	800
INPUT															125	125	125	125	125	125	125	125	125	125
IV															6	6	10	6	9	8	8	8	7	7
Versed															24	24	29.5	24	24	24	24	24	24	24
Fent																50								
Ancef																		45						
Dexmed																								
PO																								
NGT																								
O.R. IN															155	205	185	154.5	156	157	157	157	156	156
SUB TOTAL															155	360	515	674.5	798.5	886.5	1043.5	1200.5	1356.5	1512.5
TOTAL																	154							
OUTPUT															1000	700	275	325	275	275	225	125	125	160
URINE																								200
NGT																								
STOOL																								
O.R. OUT															1000	700	275	325	275	275	225	125	125	360
SUB TOTAL															1000	1700	1975	2300	2575	2850	3075	3200	3325	3685
TOTAL																								

MEDCOM - 20331

ACLU-RDI 1656 p.91

DOD-033905

INTENSIVE CARE NURSING FLOW SHEET | QA Appr 8 Mar 89

(b)(6)-2

INITIAL SHEET ASSESSMENT

		Time: 0630hrs Initals: [redacted]	Time: Initals: [redacted]
NEURO	Pupils	2mm (B) PERRLA → sluggish	Pupils 2mm reactive
	Sensorium	(R) MAE, TURNS HEAD, OPENS EYES	Moves extremities Alert
	LOC / GCS	SEDATED (VERSED @ 8mg/hr ; FENTO 120mcg/hr)	talkative. Communicating via interpreter
CARDIAC	Cardiac Rhythm	NSR @ RATE @ 101 bpm	SR 3 ectopy
	PRI / QRS	S_1S_2 ~ @	
	Pulse Strength	3+ x 4 extremities	
	Cap Refil / JVD	< 3 secs ALL EXTREMITIES / Ø JVD	< 3 secs
	Edema	1+ (B) HAND, (R) FACIAL EDEMA	facial edema
	Chest Pain	Ø	
RESP	Respiratory Pattern	INTUBATED NASALLY (L) NARE (25cm NOSE : SIZE-7.5)	O2 via Mask Reg unlabored
	Breath Sounds	CTA ALL LOBES; EQUAL RISE/FALL OF CHEST	BBS CTA equal chest expansion
	Secretions	MNL → ABSENT	
	Cough	N/A	NA
		SIMV @ 10, PEEP-5, TV-800cc, FiO2-40%	
SKIN	Color	NORMAL FOR NATIONALITY	Normal
	Integrity	INTACT ~ FOR (R) UE ACE WRAP DSG (NO NEW DRNG)	sutures to (L) mandible
	Backside	(L) MANDIBLE ~ SUTURES INTACT (BACITRACIN)	
IV	Access Devices	(R) IJ DOUBLE LUMEN (NSC 125/VERSED @ 2mg/hr)	(R) IJ PIV X 1
	Location	PATENT/INTACT	18G
	Condition	-(R) AC # 18ga HL ~ FENT @ 120 mcg/hr (PATENT/INTACT)	(R) Radial Aline
		-(L) RADIAL A-LINE (PATENT/INTACT)	CPI, Ø S/S infection
GI	Abdomen	ROUND/SOFT ~ midline incision/dressing intact (old blood drng noted)	NO bowel sounds, round
	Bowel Sounds	ABSENT ALL QUADS	midline incision dsg ~ old
	Stoma/Ostomy	Ø	drainage noted
		N/G LIS (Greenish colored DRNG)	NGT LIS (R) nare
GU	Device	Foley CATH TO GRAVITY DRNG	foley
	Color / Clarity	yellow / clear	yellow clear urine
		U/O ~ 125 c/hr	

Continued on reverse

PREP[redacted] (b)(6)-2 | DEPARTMENT/SERVICE/CLINIC ICU #1, [redacted] | DATE 24 SEP 03

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

NAME: #[redacted] RANK: AGE: 32-34

UNIT: (b)(6)-4 GENDER: ♂

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

(b)(6)-2

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78 USAPPC V1.00

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

PT'S NAME: [redacted] EPW (5)(6)-4

DATE: 24 SEP - 25 SEP

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
INV	104/64	110/63	110/66	117/69	120/68	124/70	122/77	118/69	104/68	119/71	123/72	117/69	119/70	133/74	115/69	108/65	104/63	99/56	97/58	112/68	112/59	108/65	119/70	118/69
NIBP	47/51	99/49	96/50	100/52	114/58	108/55	116/60	113/60	110/60	116/57	105/58	121/66	120/68	133/74	113/61	108/53		93/43	97/46			99		
TEMP	96.9 TM			97 TM		98 TM		99 TM		98 TM		98.8				98.4								
PULSE	61	62	60	61	74	67	106	85	89	92	88	96	107	123	95	99	90	94	97	84	101	99	86	87
RESP	10	10	10	10	16	10	18	17	17	15	17	20	15	17	20	18	18	19	19	19	20	24	16	12
SP02	96%	99%	99%	99%	100%	100%	100%	99%	99%	99%	98%	98%	98	98	96	97	97	97	98	97	97	97	97	97
FIO2	40%	40%	40%	40%	40%	40%	7L	6L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L	4L
PEEP	5	5	5	5	5	5	NPB	NPB	MASK	MASK	MASK	MASK	MASK	MASK	M									
TV	800	800	800	800	800	800	—	—	—	—	—	—	—	—										
SIMV	10	10	10	10	10	10	—	—	—	—	—	—	—	—										
MAP	70	68	68	70	82	79	75	81	80	80	79	87	86	93	88									
INPUT																								
IV (MAINT)	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
IVPB	RECENS 50															50								50
VERSED	8	8	8	8	0	0																		
FENT	12.5	12.5	12.5	12.5	0	0																		
PO	NPO	—	—	—	—	—	—	—	—	—	—	—	—	—										
NGT																1								175
O.R. IN																175								
SUB TOTAL	150.5	145.5	145.5	140.5	125	125	125	125	125	125	125	125	125	125		175								
TOTAL	150.5	296.0	441.5	582.0	707	832	957	1082	1207	1332	1457	1582	1707	1832	1952	2127	2252	2377	2502	2627	2752	2877	3002	3177
OUTPUT																							350	
URINE	200	180		150	125		275		350		300		520	250	300	200	150	200	175	200	250	150	150	175
NGT											300													
STOOL																								
O.R. OUT											600		520	250										
SUBTOTAL	200	180		150	125		275		350		1800		2400	2650	2950	3150	3300	3500	3675	3875	4125	4275	4625	4800
TOTAL	200	380		530	655		930		1280		1880		2400	2650										

INTENSIVE CARE NURSING FLOW SHEET

INITIAL SHIFT ASSESSMENT

		Time: 0630hrs Initals: [redacted]	Time:	Initals:
N E U R O	Pupils	3mm, PERRLA (BRISK) (b)(6)-2		
	Sensorium	INTACT TO TACTILE STIMULATION		
	LOC / GCS	ALERT, ORIENTED. RESPONDS TO ALL HAND GESTURES & TRANSLATED COMMANDS		
C A R D I A C	Cardiac Rhythm	RRR (NSR @ 80 bpm)		
	PRI: / QRS:	S_1S_2 S (-)		
	Pulse Strength	3+ (L) UE / (R) LE (RADIAL), (L) UE (BRACHIAL)		
	Cap Refil / JVD	< 3 secs x 4 extremities / & JVD		
	Edema	facial edema mod / 1+ (R) hand		
	Chest Pain	ABSENT / denies		
R E S P	Respiratory Pattern	RR @ 18 bpm & SOB / OR Difficulty breathing		
	Breath Sounds	CTA in all lobes, equal RISE/fall of chest		
	Secretions	ABSENT		
	Cough	ABSENT		
S K I N	Color	NORMAL for NATIONALITY		
	Integrity	INTACT & for (R) UE - ACE WRAP / (L) eyebrow LAC c SUTURES		
	Backside	INTACT (c s/s infection)		
		BACKside (UNREMARKABLE)		
I V	Access Devices	(L) RADIAL ALINE INTACT / PATENT		
	Location	(L) AC #18ga HL INTACT / PATENT		
	Condition	(R) IJ IV INTACT / PATENT (NSC @ 125cc/hr)		
G I	Abdomen	ROUND, tender c BS+		
	Bowel Sounds	ABSENT throughout		
	Stoma/Ostomy	N/A		
		N/G Clamp for next 8° > poss D/c		
G U	Device	Foley Cath to gravity DRAINAGE		
	Color / Clarity	yellow / clear (c s/s of infection		

PS [redacted] (Initial) (b)(6)-2 DEPARTMENT/SERVICE/CLINIC (b)(2)-2 DATE 25 SEP 03

ICU #1, [redacted]

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

NAME: [redacted] RANK: AGE: 32-34?

UNIT: 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 V1.00

[redacted] EPW

(b)(6)-7

PT'S NAME: # [redacted] EPW

DATE: 25 Sep 03

♂ (5)(6)-4

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
INV	128/71	114/64	115/68	116/70	115/67	119/69	124/74	124/74	119/71	125/67	140/84	132	118	127	122	114	122	116	115	120	116	116	96	94/56
NiBP	107/55	120/75	107/57	117/63	104/56	116/64	101/63	110/60	111/59	117/70		80	76	76	53	58	56	62	58	60	70	66	67	113/50
TEMP	97		97 TM	98 TM		97 TM		98 TM		98 TM		97.8		99		98.7		99		98.9				
PULSE	80	97	73	93	83	84	86	94	96	91	90	91	76	85	73	72	90	72	85	78	82	88	72	72
RESP	17	16	18	15	12	15	18	17	21	21	15	14	18	15	14	12	16	18	16	17	16	20	18	10
SP02	99%	95%	96%	95%	96%	95%	96%	95%	96%	96%	95%	97	96	96	97	92	97	95	98	98	94	95	94	95
FIO2	4L	4L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	2L	NC
MODE	MASK	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC
INPUT	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
IV								50								50								50
IVPB																								
DECADRON	5																							
PO	NPO	-	-	-	-	-	-	-	-	60	60		30		60		60		30					
NGT																								
O.R. IN																								
SUB TOTAL	130	125	125	125	125	125	125	125	125	185	185	125	155	125	185	175	185	125	155	125	125	125		
TOTAL	130	255	380	505	630	755	880	1005	1130	1315	1500	1625	1780	1905	2090	2265	2450	2575	2730	2855	2980	3105		
OUTPUT				1st void																				
URINE	300	200	150	100			350			250	225			195		150			175					
NGT	300																							
STOOL																								
O.R. OUT							350			250	225													
SUBTOTAL	600	200	150	100			350			250	225			195		150			175					
TOTAL	600	800	950	1050			1400			1650	1875			2070		2220			2395					

MEDCOM - 20335

ACLU-RDI 1656 p.95

DOD-033909

INITIAL SHIFT ASSESSMENT

	Time: 0630 Initials: [redacted] (5)(6)	Time: Initials:
Pupils	Pupils 4mm + brisk. Moves all extremities. Follows simple commands & difficulty	
Sensorium		
LOC / GCS		
Cardiac Rhythm	NSR c HR in 100's. Palpable pulses in all extremities	
PRI: / QRS:		
Pulse Strength	Cap refill < 3 seconds. No evidence of JVD. Slight swelling noted on L jaw	
Cap Refil / JVD		
Edema		
Chest Pain		
Respiratory Pattern	Lungs CTA bilaterally c O2 sats 96-97% on RA. 2L O2 via N/C	
Breath Sounds		
Secretions	has productive cough c	
Cough	yellow mucous noted.	
Color	Color normal for race. No	
Integrity	evidence of skin breakdown	
Backside		
Access Devices	L IJ patient dual 18ga CAC	
Location	NS infusing @ 125cc/hr	
Condition		
Abdomen	Abdomen round and	
Bowel Sounds	slightly distended. Hypoactive	
Stoma/Ostomy	bowel sounds noted. Dsg c small	
	area of old drainage noted	
Device	voiding spontaneously s	
Color / Clarity	difficulty via urinal	
	(5)(6)-7	

Continue on reverse.

PREPARED BY: [redacted] CDT/AN

DEPARTMENT/SERVICE/CLINIC: ICU #[redacted]

DATE: 24 Sep 03

PATIENT'S IDENTIFI[redacted] (When entries give: Name – last, first, middle; grade; date; hospital or medical facility)

NAME: [redacted] RANK: AGE:

UNIT: (6)(6)-7 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

PT'S NAME: #[redacted] (b)(6)-7

DATE: 26 Sept 03

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
BP INV	108/65	109/67	112/63																					
BP NIBP	114/57	119/60	128/62																					
TEMP	97.9																							
PULSE	76	78	72																					
RESP	18	16	16																					
SP02	96	96	98																					
FIO2	2L	2L	2L																					
SOURCE	N/C	N/C	N/C																					
INPUT																								
IV NS	125	125	125																					
IVPB																								
PO		200																						
NGT																								
O.R. IN																								
SUB TOTAL																								
TOTAL																								
OUTPUT																								
URINE		360																						
NGT																								
STOOL																								
O.R. OUT																								
SUBTOTAL																								
TOTAL																								

MEDCOM - 20337

ACLU-RDI 1656 p.97

DOD-033911

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

Date of birth :- 1974 or 1970

The charges :- Stealing + kidnapping
Rape [redacted] + shooting

The I.P's

The I.P who is incharge of the case :-

1LT [redacted] (b)(6)-4

The Police Station :- [redacted]

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

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A11D1	IE	[redacted]	UNK - EPW (5)(6)-4	EPW	M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
—	32Y	X	9	MUSLIM

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
—	—	99 30	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	U	1900.	—

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
—	K78	—

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICU2	—

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] (5)(6)-7	—	—

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
05		030901

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
ABAA		030923

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

FOR LOCAL USE

DX: S/P EX LAP GSW TO ABD

Dx	Px		Trauma	Injury
873.40	23.19	93.54	9	569
879.2	24.5	88.24	3	544
881.10	86.59	99.04		
E991.2	54.11			
E991.9				

ADMITTING OFFICER (Signature) [redacted] SIGNATURE OF ADMITTING CLERK [redacted]

DR

DA FORM 3086-MAR

MEDCOM - 20339 (5)(6)-2

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]				3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 33Y	6. RACE Z UNK		10. PREVIOUS ADMISSION N	
11. FMP 99	12. SSN [redacted]	13. ORGANIZATION (b)(6)-7		14. WARD ICW1	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN ~~K79~~ K78	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE NBI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: DIRECT FROM ER	22. HOURS OF ADMISSION: 1010	23. CLINIC SERVICE	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE: UNK	25. TYPE DISPOSITION: 04	26. DATE OF DISPOSITION: 030111	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION: 030925	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]		30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE: (b)(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: (L) OPEN CHEST WOUND
(R) OPEN BACK WOUND

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

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

SIGNATURE OF ATTENDING MEDICAL OFFICER: DR [redacted]

SIGNA [redacted]

DA FORM 3647, MAY 79 EDITION OF 1 A [redacted] OBSOLETE USAPA V1.10

(b)(6)-2

MEDCOM - 20340

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

33 Y/O M GPW, MULTIPLE UPPER EXTREMITY FROM MINE 10 WKS AGO. ALSO WAS [illegible] TO (L) LEG WITH SKIN GRAFT, AND OVER (R) ANTERIOR TIBIA. HAS DEAD EXPOSED BONE OVER (R) ANTERIOR TIBIA.

PMH ?

PSH ?

ALL: ?

MEDS ?

PHYSICAL EXAMINATION

HEENT: WNL
NECK: SUPPLE
LUNGS - CLEAR
CHEST: R/R
EXT: (R) AKA, (L) BKA.
(R) LEG - OPEN, DRAINING WOUND OVER (R) ANTERIOR TIBIA, WITH DEAD, EXPOSED TIBIA. WAS SEEN [illegible] (L) CLEAN GRAFT SITE

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

(A). (R) OPEN TIBIA WOUND / (L) OPEN GRAFT SITE

(P). I+D, REMOVE DEAD BONE.

(b)(6)-2

SIGNATURE OF [redacted]	DATE 25 SEP 03	IDENTIFICATION NO.	ORGANIZATION

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

[redacted]

(b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

MEDCOM - 20341

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25Sep03 1800	Received pt in stable condition. VSS afebrile. (L) fa amp below elbow, healed. (R) fa amputated above elbow. Abrasions noted on (L) LE. (R) LE w/ open wound below knee w/ blackened bone showing. Toradol given per md order. EJ (L) patent + intact. Pt has no tremors noted. Talkative and active on arrival, currently sleeping. Restraint on (L) LE w/ kerlix wrapped around leg under restraint. [redacted]
25 SEP 03 2240	VSS. AO. (R) [illegible] open Fx [illegible], black @ marrow and evident of infection. WTD DSG placed over wound. Wound wrapped over. Multiple abrasions to amputated extremities. (+) pulse to BLE. (R) leg atrophied c/t (L) leg. H&V. Fed minimal amount of PM meal. [illegible] the [illegible] [redacted]

(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26SEP03 1310	Ortho Op Note Pre Op Dx - [redacted] (R) Tibia fracture Post Op Dx - Procedure - I+D [redacted] Tibia. Surgeon - [redacted] GBL - 2mV PROPOFOL - 300 cc Findings - Exposed tibial tuberosity removed, and skin edges mobilized Closed with 0 prolene Plaster Report I+D in 48 hours. [redacted]
26SEP03	(1430) Assumed care of pt at bedside. Report from night shift. Pt alert, speaking Arabic. VSS. Pt agitated most of this shift. Amb to BR this am S difficulty. To OR today at 1130 via gurney. Tx to gurney S difficulty. Returned from OR in stable cond. IVF infusing S S/Sx infection/infiltration into @ RJ. Pt tol. po fluids S difficulty. Drsgs to BLE CDI. Pt able to move BLE S difficulty. +pedal pulse equal bilat. Cap refill <3 secs. 1 point restraint in place, S S/Sx complications - will cont. to monitor. [redacted]
27SEP03 0345	Assumed care @ 1800; All VSS, pt A&O speaking arabic, pt agitated & multiple outbursts @ other pts; pt amb to BR X 3 difficulty

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
	(cont) dsg to b/l at LE CDI ∓ drainage; ⊕ CMS in ⊕ LE, brisk cap R&F ⊕ pedal pulses, persistent edema in ⊕ LE, non-pitting; pain controlled ∓ T3 ∓ X1; 4 point restraint in place; ⊕ circulation, ⊖ skin breakd; Cont to monitor [redacted]
	IVF @ 100 cc/hr infusing ∓ S/Sx infection/infiltration [redacted]
27SEP03	(1530) Assumed care of pt via report from night shift. Pt alert, speaking Arabic. Pt cont to be angry and be disruptive. VSS. Pt medicated ∓ Tylenol for pain. Dsg to BLE CDI. Small amount of drainage noted to both sites. Pt amb well to BR. ⊕ EJ flushes well ∓ S/Sx infection/infiltration. Tol reg diet well. Voiding ∓ diff. 4 point restraint in place ∓ S/Sx complications. Will cont. to monitor. [redacted] WHAO
28Sep03 0015	Assumed care @ 1800; A&O x 5, pt A&O being very temperamental ∓ multiple outbursts to other pts as well as ∓ staff; cont ∓ scheduled Ativan & meds given for pain, pt amb to BR x 2 ∓ difficulty; Dsgs to BLE CDI, ⊖ drainage noted; voiding ∓ difficulty; EJ flushes well, ∓ S/Sx infection/infiltration; restraint in place, ⊕ circ, ⊖ skin breakd; cont to monitor [redacted]
28Sep03 @ 0530	Attempt to place 16F Foley catheter failed; Went to ICU & asked [redacted] to come assist, then grabbed a 10F catheter, after many

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REGISTER NO. | WARD NO. ICU #1

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	attempts, none were successful; suggested Urology consult & Dr. [redacted] (b)(6)-2 [redacted]
28Sep03	0922 - Assumed care of pt. @ 0900. Assessment completed. PERRLA, lungs CTA (B). Resp even unlabored, abd soft nontender, BS x4. voiding per urinal. Ambulated to BR x 1 this AM. personal hygiene conducted. One restraint in place to (L) LE. (+) circulation (-) skin breakdown HL IV cath to (L) EJ. (-) S/S infection/infiltration Pt. NPO for surgery this AM. Pt. resting well @ this time. Will cont. to monitor. [redacted]
28Sep03	0940 - 155 A+O Pt. resting well @ this time. Pt. encouraged to do LE. ROM exercises. (+) edema to (B) feet. (+) pedal pulses (+) circulation. Will cont. to monitor
28Sep03	1515 - Pt. resting well @ this time. TOL lunch well. Pt. will go to surgery tomorrow. NPO p MN. Dr. [redacted] (b)(6)-2 attempted to insert foley catheter. Unsuccessful due to closure of urethra. Pt. scheduled for AM tomorrow. follow up per Dr. [redacted] (b)(6)-2 [redacted]
28 Sep 03 2000hrs	Pt A+O x 3, VSS, LS CTA (B), (+) BS x 4, abd soft flat nontender, HL (D) EJ intact, medicated for pain, dsg on (R) LE c ~~SS~~ drainage noted, dsg LLE CDI, NPO @ MN, proper circulation +

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
28 Sep. 03 Cont.	∅ skin breakdown on pts of restraint. [redacted] 9IW RN
29 Sept	around care rec'd pt. VSS PERRLA, lung CTA(B) respirations even and unlabored, abd soft non-tender, BS x 4 pt c/o difficulty urinating. pt NPO awaiting surgery (when foley may be inserted) restraints x 1, circulation intact except for injury site skin intact ∅ edema, no other remarkable findings [redacted]
29 Sep. 03 1915	Pt recieved from OR, VSS, BP-97/68 P-74 R-20 SPO2-98% T-98.8, c/o pain, medicated ∈ 2 pcs Tylenol #3, Tol PO well, HL IV D EJ, SP Cath to gravity draining c/y urine, amount sufficient, wound on LLE wrapped ∈ kerlix CDI, RLE wrapped ∈ ace wrap CDI, pt ambulates ∈ shuffled gait, LS CTA (B), (+) BS x4, abd soft flat non-tender, ∅ s/sx of infx on pts of restraint. [redacted] poor circulation or skin breakdown on pts of restraint. [redacted] 9IW

(5)(6)-2

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[redacted] (5)(6)-4

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LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

DATE	NOTES
28Sep03	Wnd: I concur above assessment. [redacted]
30 Sep 03 0700	- Assumed care of pt. A+O x3. VSS & c/o pain or discomfort @ this time. Superpubic cath to gravity drain clear yellow urine. Remains NPO p MN on call for OR 1 Oct 03. Wound bilat LE Dressing intact & active bleeding noted. Will cont to monitor [redacted]
(2000)	Rt alert, VSS, c/o pain often. SP cath intact and draining ayu. drugs to (B) LE CDI. NPO for OR in Am. IV H+L to (D) RT. (S) edema or redness @ site Rt amb. to BR's difficulty @ circulation, Restrain On. Will monitor [redacted] 9lumb SPC- (5)(6)2
30/oct 03 0700	- Assumed care pt. A+O x3. VSS Remains NPO on call for surgery this morning. IV antibiotics cont. Superpubic cath to gravity clear yellow urine QS. Dressing to bilat lower extremities Central line care given to @ IJ & s/s of infection Will cont to monitor [redacted]
1 Oct 03 1015	Post Op Note Pre-Op Dx: Closed open (R) tibia, Post Op Dx Procedure: (1) I+D to (R) Tibia (2) Application of VAC device Surgeon: [redacted] Findings: Wound clean after I+D, VAC applied PLAN: re-look in 3 days [redacted] (6)(6)-7

[redacted] (6)(6)-7

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PROGRESS NOTES

DATE	NOTES
01OCT03 (1200)	Pt returned from OR via gurney in stable cond. VSS. Pt medicated c IV T3 for pain. Drsg to RLE c vac. device to cont. suction. IVF infusing into @ LW c s/sx infection/infiltration. Pt alert, speaking Arabic. Drsg to LLE @ D. monitoring. [redacted] WAD
1OCT03 1900	Pt resting in bed, easily aroused, VSS, medicated for pain c 2 T+3, dsg's to LE @ CDI, suction continuous to RLE, @ drng noted, IV HL to @ W c @ s/sx of infex, @ s/sx of poor circulation or skin break down on pts of restraint, LS CTA @, @ BSx4 [redacted] WAD
1OCT03	2100: I concur c above ass[redacted] WAD
1 Oct 03	Neurology Note. No reported seizure activity. Will start tapering of Ativan. No need for continued use of Theamine IV. Will start on MVI q D. [redacted] MD

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LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
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[redacted] (b)(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2Oct03@1400	Received pt resting in bed, VSS, Tol PO, SVGS. A&Ox3, speaks arabic. Wound vac to (R) LE in place & on low ptx. Pt sleeping most of shift. Med. x1 w/ ii tabs tylenol for pain. IV to (R) EJ patent & intact, flushes easily. Restraints per CPW protocol, ∅ breakdown noted. ∅ other remarkable assessments. Will cont to monitor. [redacted]
2Oct03@2130	Assumed care @ 1800; All VSS, pt A&Ox3, NV intact; pt amb c̄ [illegible], tol PO; Suction to (R) LE c̄ wound vac in place; pt sleeping most shift; ∅ c/o pain; EJ patent flushes easily; Restraints in place, ⊕ circ. ⊖ skin break ↓; ∅ Δs in assessment; Cont to monitor [redacted]
3Oct03@1400	Received pt resting in bed, VSS, tol po, arabic speaking, alert & oriented. Wound vac to (L) LE intact, (R) LE wound dsg'd w/ kerlex, min to scant serous drainage noted. EJ to (R) neck patent and flushes easily. Medicated x1 ii percocets for pain. restraints per CPW protocol. ETOH suprapubic catheter to gravity drainage, QS clr yellow. ∅ other remarkable assessments at this time. Will cont to monitor pt. [redacted] LPN. (b)(6)-2
3Oct03@2145	Assumed care @ 1800; All VSS; pt A&O speaking [redacted]; ∅ meds given for pain; wound vac intact, draining minimal amt Fluid; dsg to (L) LE CDI, ∅ drainage; SP tube draining QS, clear, dark yellow urine; EJ patent c̄ flushes well; cont c̄ IV alex; pt ↑ to amb to BR; ⊖ BM; ⊖ significant Δs in assessment; Rest in place, ⊕ circ. ⊖ skin breakdown; cont to monitor [redacted]
	[signature]

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[redacted] (b)(6)-4

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DATE	NOTES
4 Oct 03 BW	Received from PACU Alert & oriented. Speaking loudly about wanting to return to CPW Camp. VSS. Lungs clear BS (T) x4 quadrants. Suprapubic with patent & intact drainage device connected to LCS. (R) lower extremity vac. device connected to LCS. Drsg to (L) lower extremity dry & intact. Regular 500ml IVPB given. (L) IJ patent & heplocked. Pt tolerated regular diet for lunch. Will continue plan of care. [redacted] (7A)
4 Oct 03 @ 2310	Assumed care @ 1800; All VSS, pt A&O, pt OOB to BSC, (D) BM; SP tube patent & draining QS, clear yellow urine; wound vac to (R) LE intact hooked to LCS; drsg to (L) LE CDI; EJ patent, flushes easily; cont'd IV abx; pertinent A's; Rec cont to monitor [redacted]
5 Oct 03	Pt A+O x3, VSS, PERRLA, pt c/o stomach pain, moved OOB to bedside commode where it had (D) BM, SP catheter draining clear yellow urine, wound to (R) lower extremity hooked to suction, skin warm, dry and intact, ambulates x1 IV dc'd, (D) circulation [redacted]
5 Oct 03 1735	Pt given abx. Sng @ 1735 [redacted] (5)(6)-2

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[redacted] (5)(6)-7

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5OCT.03 2030	Pt sleeping but easily aroused, pain controlled c PCA T#3, LS CTA (B), (+) BS x4, foley → gravity draining c/y urine LCS to (R) leg wound, minimal amount of greenish drainage noted, pt able to move LE x2, pedal pulses equal (B), SP cath intact, ø s/sx of infx, ø s/sx of poor circulation + skin breakdown on pts of restraint. [redacted] GW
6OCT03	(1715) Assumed care of pt asd above & report from night shift. A&O alert, speaking Arabic. VSS. ø c/o pain. (e) IV dcd this am d/t infiltration. Awaiting anesthesia to start new IV. Dsg to LLE dct this am. Dsg to RLE intact c VAC device to low cont. suction. (+) pedal pulses equal bilat. Pt able to move BLE. SP cath draining quantity sufficient clear yellow urine. Tol. reg diet well. 1: point restraint in place s/sx complications. Will cont to monitor. [redacted] GW (1735) (e) IV started per anesthesia. Levaquin started @ 1750. ø s/sx infiltration. monitoring. [redacted] GW
6OCT.03 2000	Pt A&Ox3, VSS, ~~P0~~ J LS CTA (B) (+) BS x4, HL IV (R) IJ intact, ø s/sx of infiltration, pain controlled c PCA T#3, opsite dsg on (R) LE CDI, dsg (L) LE CDI, NPO p MN TOOR in AM, sux turned off for hrs of sleep, SP cath draining c/y urine, intact, pedal pulses equal (B), tol reg diet well, ø s/sx of poor circulation or skin breakdown on pts of restraint. [redacted] GW

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DATE / NOTES

7 Oct 03 0700 — Assumed care of pt. AT0X3 VSS. Ø c/o pain or discomfort @this time. Foley to gravity clear yellow urine. Suction to (L) LE continuous small amount of serosanguous fluid. Cont. IV Antibiotic tx. Central line (R) IJ patent site CDI. Multi amputation. Remain NPO for surgery. Will cont to monitor

7 Oct 03 2100 — Pt asleep, easily aroused, AOX3, VSS, LS CTA (B), @BS x4, SP cath in place draining c/y urine, amount sufficient, dsg on abd CDI, LCS to RLE, dsg on LE x2 CDI, pain controlled c T#3, IV HL (R) IJ intact, Ø s/sx of infex or infiltration, 2 pt restraint in place, Ø s/sx of poor circulation or skin breakdown [redacted] (6)(6)-2

8 Oct 03 0700 — Assumed care of pt. AT0X3. VSS Lungs clear Ht. Superpubic cath to gravity clear yellow urine. HCCK IV ABX continue. Suction to LLE small amt of serous fluid. Central Line @IJ patent. Will cont to monitor

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08OCT03	(1645) I concur c above assessment. [redacted]
28OCT03 2030	Pt Awake A&O and speaking arabic. VSS Ø c/o pain. Drsg to RLE Intact. Vac device turned off for hs. SP draining QS c/x u. Pt consumed 10% of diet this pm. 4point restraints in place. Will continue to monitor. [redacted] 91WMB
9 OCT 03 0940	Assumed pt. care @ 0800. Pt. A+O x3. VSS. lungs CTA. VAC to Ⓡ tib continuous c brownish drain. Supra pubic tube to gravity c clear yellow urine off. IV LR @ 125cc/hr infusing in Ⓡ neck s signs of infiltration Ø complaints @ this time. will cont to monitor [redacted] 91WMB
9oct03 @ 1930	Assumed care @ 1800; All VSS [redacted] dsg to Ⓡ tib CDI, wound vac intact, cont suction draining brown/red liquid; will be D/C'd @ HS, Ø s/sx infection; SP Tube in place draining QS, clear yellow urine; TOL PO c poor diet; IV patent infusing LR @ 125 c/hr s s/s infection; cont to monitor [redacted]
10 Oct 03 0700	Assumed care pt. A+O x3 VSS. Remains NPO on call to OR this morning. LIC suction to Ⓡ LE wound small amt of serous brown fluid. lungs clear. HRRR Active BS x4 Super pubic cath draining clear yellow urine QS. Ⓡ IJ cath. site CDI Ø s/s of infection Will cont to monitor [redacted]
10 OCT 03 1915	Pt sleeping, easily aroused, pain controlled c Tylenol #3, LS CTA Ⓑ, ⊕ BS x4, dsgs on LE x2 CDI, suction in place on Ⓡ LE, small amount of drainage noted, suction

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DOD-033927

MEDICAL RECORD — **PROGRESS NOTES** — AUTHORIZED FOR LOCAL REPRODUCTION

DATE	NOTES
12 Oct 03 @ 1112	Recvd pt resting in bed, VSS, tol PO, wound vac to RLE intact + ca LCS. (L) LE (thin) atrophic in gauze. (R) LE intact & swelling on scrotum noted c this time. cont IV ABX, med. w/ T3s for pain. restraints per cpw protocol & breakdown noted. Will cont to monitor. [redacted]
12 Oct 03 @ 1930	Assumed care @ 1900; All VSS, pt A&O; [redacted], although minimal appetite; wound vac intact; dsg CDI & drainage; (R) LE patent, S/Sx infection/infiltration; cont c abx; c/o pain @ this time; Restraints in place, (+) circ, (-) skin breakdown, cont to monitor [redacted] (5)(6)-2
13 Oct 03 @ 1000	Recvd pt resting in bed, VSS, tol PO, ABX's, wound vac to RLE intact to LCS. Gauze to (R) LE intact, clean, dry. Suprapubic cath intact & leakage noted, drain dark yellow urine. (R) LE intact, flushes easily, & redness or swelling noted. cont IVAB, restraints per cpw protocol & breakdown noted. Will cont to monitor [redacted]
13 Oct 03 @ 2055	Assumed care @ 1800; All VSS, pt alert, in NAD, c/o pain @ this time, pt appetite ↑, ate 100% of dinner in addition to another plate; wound vac to RLE intact on Cont Suction, minimal OP noted; SP tube patent & intact draining @ S, clear, yellow urine S difficulty, (R) LE patent, easily flushes, S S/Sx infection/infiltration,

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(Cont) cont c̄ IV abx; Restraints in place, ⊕ circ, ⊖ skin break; cont to monitor [redacted]
13Oct03@2315	(R) EJ became dislodged; Cpt Watters successfully placed 18g cath in (L) EJ p̄ 1 failed attempt; patent & easily flushes s̄ s/sx infection/infiltration. Cont to monitor [redacted]
14Oct03 @1038	Rec'd report and assumed care of pt. Pt awake lying in bed tolerated reg meal. Foley (S/P) to gravity. Drain to (R) leg to low continuous suction. EJ flushed c̄ 5cc of NS good blood return. lungs CTA ⊕ BS. ⊖ S/S of resp distress pain or discomfort. Will continue to monitor — [redacted] 91WM6
(1930)	Pt alert, sitting ↑ in bed, ∅ c/o pain @ this time. consumed 100% of dinner. (L) EJ patent, ∅ s/sx infection/infiltration, SP foley intact draining cyu. H2O @ BS. (R) leg to low cont suction c̄ scant drainage. Restraint in place ō compromise to skin/circulation - Will monitor [redacted] 91WM6
2200	2 [redacted] Tylenol #3 tabs given for (L) stump pain c̄ noted relief. vac device c̄ scant drainage. Will monitor c [redacted] 91WM6
15OCT03 1026	Assumed care of Pt @ 0600. (L) EJ patent, SP Foley draining CYU (R) LE to low cont suction c̄ minimal drainage. Pain controlled c̄ Tylenol #3. Will continue to monitor. [redacted] 91WM6
	(1300) I concur c̄ above assessment. [redacted]

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NOTES

15OCT03 (1950) Rt alert, speaking arabic, Ø c/o pain, usleepi often. tol. 100% dinner today. LCTAB, HRRR, ⊕BSXH, VSS, Ⓡ leg to cont. low Suction c min-imal drainage. Ⓓ IJ patent. IV zosyn cont per MD orders. 1 pt restraint on c compron-ise to skin or circulation. Will monitor—

0300 Rt slept thru night c Ø complaints, [redacted] 9IWM6—SP cath intact draining cyn. (for output see form DD 792. [redacted] 11WM6.

160ct@0726 Pt ate 75% breakfast c assist. VSS. Ⓡ wound vac drainage serous sanguinous minimal. med c Ty #3 @ 11 for pain. Will continue to monitor. Lung sounds clear through all lobes. ⊕ pedal pulses. EJ in Ⓡ side appears CDI. ⊕ foley draining clear yellow urine ⊕ Bowel sounds. [redacted]

160CT03 @1330 Assumed care of Pt @1800. VSS, alert, speaking arabic. LS CTA, ⊕BS, tol regular, voiding per SP cath cly urine. Ⓡ LE wound connected to vacuum device, min output noted, ⊕ CMS to RLE, +2 DP pulses, equal bilat. Ⓓ IJ patent dsg Δ's c new CDI. 1pt restraint SS/SX q shift or circulation compromise. Plan: IVABX as ordered (CONT)

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NOTES

DATE	NOTES
2145	(CONT) monitor NV status, monitor output from LLE wound, pain control. [redacted]
0500-	minimal drainage noted from RLE wound. [redacted]
0510-	Pt output per SP cath = 900cc for 12° shift [redacted]
17 Oct 03	VSS alert (L) IJ IV patent & intact. Lungs
0900	clear. BS (+) x4 quad. Abd soft non distended
	Supra pubic cath intact & patent draining clear
	yellow urine. (R) LE wound to LCS ē scant amt
	of drainage. Peripheral pulses palpable (+) +2.
	Reposition Q2hrs for comfort. Will continue
	planned of care [redacted]
17 Oct	(L) IJ IV infiltrated IV D/C. Dr
1730	Albertson informed. New order to Hold ABX
	NPO p̄ MN for OR in AM. Will report
	to oncoming shift [redacted]
17 OCT 03	assumed care of pt @1800. VSS, c/o pain, controlled c̄
2330	T#3 tabs. alert, speaking arabic. LS CTA, (+)BS, void per
	SP cath, draining clear yellow urine to foley bag. RLE
	wound to suction, dsg CDI, minimal drainage noted.
	(+) CMS to RLE, +2 DP pulses, equal (B/L). IVF & Abx on hold.
	4 pt restraint on s̄ s/sx of skin/circulation compromise.
	Plan: NPO p̄ MN, to OR in AM. Monitor pain control,
	monitor wound & drainage. [redacted]
18 OCT 03	Pt voided a total of 1600cc c/y urine from 1800-0600
@0545	hrs per SP cath. [redacted]

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DOD-033931

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18Oct03 @2300	Assumed care of Pt @ 1800. VSS. 9/10 pain to LLE ? head(?). (Pt points to head ? leg.) Tylenol #3 given c good relief noted. LS CTA, @ BS, tol reg diet well assisted feeding. SPcath to foley bag yellow urine. RLE c opsite disg CDI, attached to skin, min drainage noted. (L) IJ replaced, dsg CDI. Plan: cont IVFs x as ordered, monitor wound? suction, pain control. Rpt restraint on ? S/Sx of skin/circulation compromise. will cont to monitor. [redacted]
@0500	Pt shift totals: I/S: Meds = 100cc Outs = UOP = 900cc PO. = ~~500cc~~ 1000cc
19 Oct03 1705	Assume care of Pt @ 0600. A+Ox3, VSS Sat in chair for an hour. C/O pain given Tylenol. 2pt restraint & skin compromise, distal pulse present. Foley to gravity, clear yellow urine. Ambulatory to restroom. Will cont. to monitor. [redacted] (1745) I concur c above assessment [redacted]
19 Oct03 2030	Pt Awake & agitated. Pt voiding small amount of urine via urethra sporatically. Drsg to (R) LE c DI c cont suction on Drain. Pt in 1 point restrain. Given 30 mg Toradol. Will continue to monitor. [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18 2000	Received pt this am resting in bed. VSS, NPO for surgery. @ IV access, no c/o pain at this time per night shift nurse, abx on hold. held po meds due to NPO status. Pt returned from surgery on stable condition. (L) leg wrapped and immobilized per pt request. Tol PO, pt medicated for pain w/ ↓ T3, pt demanding valium (no order). (L) IV access patent to (R) neck, placed during OR time. Wound vac to (R) LE replaced and to low cont suction, @ recordable drainage noted @ this time. Supra pubic catheter intact & voided @ [redacted] yellow urine, some sediment noted. IV access heplocked @ this time. Restraints per CPW protocol, @ breakdown noted @ SUBS. Restraints to (R) LE, pt removed ~~the~~ gauze placed under restraint (at pt request) w/ ~~the~~ [redacted] by Surg. Abrasions noted on (L) LE w/o change. Will cont to monitor pt [redacted]

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DATE	NOTES
20OCT03 @1000	Pt awake, VSS, ø c/o pain. pt upset about urine leaking from penis. c/o urgency to void. Suprapubic catheter intact draining dark yellow urine. (R) leg to high cont suction c minimal drainage. Sm cordone. 1 pt restraint on & compromise to skin/circulation. Will monitor (b)(6)-7 [redacted] 9 IWMC —
1030	MD([redacted])@BS. sutures to SP cath site removed. new SP cath placed /14 french foley catheter). Monitoring ([redacted]) 9 IWMC.
1345	Pt had formed BM x2. (L) IJ patent, flushing easily. ø skin breakdown noted @ this time. total UOP this shift 450cc. Encouraging H2O. Monitoring ([redacted]) 9 IWMC
1630	Pt still c/ frequent c/o urgency to void. MD aware. bladder non-distended @ this time. [redacted]
20 OCT @ 2330	assumed care @1800. VSS. Pt yelling, kicking @ leg drsg & SX tubing, attempting to pull SPcath, shifting body in bed to move chux padding from under hips. Halcion 5mg IV & Versed to calm pt @ 1900. Pt continues to yell, turn, slide (CONT)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			S[redacted]
	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.
# [redacted] (b)(6)-7		

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2330	(CONT) up & down in bed. RLE wound drsg pulled down from top of wound as a result of pt shifting & kicking. Pt restraints placed on legs. MD @ BS, checking SP cath. SP removed & replaced c LUE FR by MD. Through interpreter, pt stated he could not control void through urethra. Cpt. @ this time had 2 voids to bed pads. Ditropan ordered & given. Pt ↑ amb to BR for BM's difficulties. RLE drsg secured c tape, sxn on. SP cath secured to thigh c tape. (D) IJ HL, flushes well. Plan: monitor SP cath & UOP, monitor behavior, IV Rx as ordered. 2nd restraint removed @ 2300 c promise not to disturb SP & leg dressing. + pt restraint bilat's S/Sx of skin or circulation compromise. Will cont. to monitor [redacted]
21 OCT 03 (0800)	Pt aware, still upset about not having control over void. SP cath foley empty @ this time. Due to saturation of bed pads condom catheter put on pt. Due to pt shifting frequently (R) leg drsg coming off. reinforced c tape & kerlix. Ditropan given as ordered. Pt ambulated x 3 in hall & to bathroom. Ø skin breakdown noted @ this time. Pt consumed 50% breakfast this AM. (D) IJ flushed well, site cleaned & drsg SL. Will monitor [redacted] 9 in the AM
1330	Pt c 300cc cyu in condom cath foley bag. S/P cath c Ø drainage today. Pt calm @ this time. Monitoring [redacted] 9 in the AM

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
(1600) 21OCT03	Suprapubic cath. removed per MD orders. Ø output from SP cath. today. Cont to monitor [redacted] IWMo.
21OCT03 2035	Pt laying in bed. c/o pain. Medicated c tylenol 3#'s. Will continue to monitor. Pt c condom cath draining clear, yellow urine. Has wound vac to (R) lower leg. Suctioning c difficulty. Lung sounds clear through all lobes. (+) bowel sounds. (+) IJ flushes well. Ø S/Sx infection. [redacted] IWMo
22 OCT 03 0700	Assumed care of pt. AFOx3 VSS Ø c/o pain or discomfort @ this time. Lungs clear HCRR Active BS x 4 quads. Condom catheter in place secured c tape. CTU QS. Wound vac to (R) LE cont suction serous drainage minimal amts. (+) IJ Intact HL IV ASX tx cont Remains afebrile Will cont to monitor [redacted] IWMo
22OCT03 2100	Assumed care of Pt at 1800 hrs. VSS c/o pain controlled c Tylenol 3. LS CTA (B). S1 S2 Present (+) BS x 4 quads. (R) LE Drsg COI c LC Suction Draining. Ø S/Sx of infection. Will continue to monitor Pt. [redacted] Sgt 91WMb

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.	

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PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23 Oct 03 1458	Assume care of PT @ 0600. A+Ox3, VSS C/O pain given [redacted] Tylenol. Broke out in sweat for brief period. Dsg Δ on (A) leg, Δ ed Kerlix on (R) leg. Bacitracin applied to graph site. Is ambulatory. Will continue to monitor. ——— 91W [redacted]
23 OCT 03 [redacted] 1800 2350	Assumed care of Pt @ 1800 hrs. Pt A+O Temp 104.2°F(O) Administered 650mg Tylenol. Encouraged IS removed covers (Blankets) Applied Ice pack To posterior neck (L) Axilla. groin region. Temp ↓ 102.1°F(O) @ 2130 hours. LS CTA (B) S1 S2 present (+) BS x4 quads Pt void via condom cath. Dark amber urine. Pt NPO p̄ midnight for OR on 24 oct 03. (R) LE Dsg CDI. Drain to RLE on Low continuous suction. Will cont to monitor. ——— [redacted] Spc 91W/MP
24 OCT 03 1005	A.O. 7 @ 1014 and provided 2 Tylenol & encouraged IS to bring down T. Diaphoretic @ times. Accompanied to BR and had shower x1. DSG reinforced to RLE & minimal serosanguinous drainage upon ambulating & shifted. London cuff in place and during light amber urine, QS. FTG. LSCTAB HSR. ——— [redacted] RG
24 OCT 03	0730 - assumed care of pt @ [redacted] C temp of 103.3. checked temp again @ 1900 Temp 104.4. Ice pack applied to groin area & back of neck. cool wash cloth applied to forehead Encouraging to drink plenty of water. will cont. to monitor pt. & temp. ——— [redacted]

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
240103	2000 - U/A collected per MD order-awaiting Results. [redacted]
2120	- Pt. temp. 102.4
2230	- Temp. 100.3. IV infiltrated previous shift. New IV started to (L) EJ. CDI. (-) edema (-) Redness. Pt. resting well @ this time. [redacted]
0130	- Pt. ambulated to latrine (+)BM. Assessment completed (S) CTA (B), Resp even unlabored abd soft nontender. B5 x4 quads. Foley to gravity draining clear yellow urine. Dsng in place to (R) CC + VAC on low continous suction. Minimal drainage. 3 small wound on (L) ankle. dsng applied to prevent irritation from restraint. IV (L) EJ CDI. Pt. resting well @ this time will cont. to monitor for further changes. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25 OCT 03 1205	VSS. AO. Vasc – drain intact to RLE. Sustains moderate amount of serosanguinous drainage. CL (Triple) placed to OES. Hematoma to OES region from first attempt. Pressure dsg applied. FTG is random with intact. Sodium moderate amount to soaker area. Provided fluids and perineal BM x1. [redacted]
25 OCT 03 1930	VSS Alert & Oriented. Central line patent & intact. RLE = dry drsg intact and wound vac to continue low suction. Voiding clear yellow urine. No pain or distress noted. Will continue care as planned. [redacted]
26 OCT 0900	Rt alo, VSS, Ø c/o pain. pt pulled condom cath off x2. Rt requests foley via translator. Rt ambulated x1. vac drain to low con't wsn & minimal serosang drainage. Rt refuses surgery via translator but requests supra-public catheter being reinserted. UOP since adm 1000cc qs. IJ central line drsg CDI, flushing easily. MD informed of pt requests. Will monitor [redacted] 91 WM6 SPC

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

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PROGRESS NOTES
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LAST NAME	FI	NAME	MIDDLE	AL	ID NUMBER

DATE	NOTES
(1030)	Pt urinated 300cc via urinal. Pt non-compliant c̄ care @ this time. Linen Δ'd x 3 due to void. MD aware of pt condition. Will monitor [redacted] 91WM6
(1100)	Pt yelling, interpreteur @ BS to comfort pt. Pt uncooperative, Pt tells translator that he wants a needle to pierce his penis because he is unable to void. Dr. [redacted] @ BS to talk c̄ pt (attempted to put in 8 FR. foley cath) c̄ failed. Pt voided approx 200cc @ this time on bedpad. Condom cath put back on per pt request, within 10 min pt pulled cath. off again. Plan: attempt to put condom cath back on, or assist pt c̄ using urinal frequently, monitor UOP & pain control. [redacted] 91WM6
1300	Pt still yelling c/o urge to void, bladder distended. Ø UOP since 1100. MD aware of situation. Translator @ BS. [redacted] 91WM6.
1450	Pt still c̄ urge to void. 8FR foley inserted s̄ difficulty. Will monitor output [redacted] 91WM6
1600	Pt UOP since foley insertion: 280cc cyu. bladder no longer distended. Monitoring [redacted] 91WM6
1630	Pt now calm & sleeping c̄ Ø complaints [redacted]
~~27Oct03 0700~~	~~Pt Δ [illegible] antibiotic Run [redacted] Draining Dark urine. [illegible] [redacted] [illegible] [redacted] EDT. Denies pain. Will mon [redacted]~~ 91WM6

(b)(6)-2

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(b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
27OCT03	Pt A&O VSS FTG CYU, Antibiotics continue
0200	Pt cooperative and un agitated. Will continue
	To Monitor. ——— [redacted]
27OCT03	VSS. A&O. BS ⊕x4. LSCLAB. Assisted ā Am feeding this Am.
1200	FYG voiding clear yellow urine ō difficulty. Cont ō AB
	Tx. CL D&I s/d ō difficulty. Cont to monitor. [redacted]
27OCT03	Assumed care @ 1700. Denies pain. Foley B
2200	gravity draining small amount of CYU. Cont
	c̄ Abtx. CL Drsg CDI. Will continue to Mon-
	itor. ——— [redacted] 91WM6
28 Oct	Pt. A&Ox3, VSS pt c/o pain in his penis and
	headache from sunction attached to his lower left leg
	extremity. Pt ambulated with ~~gait~~ some difficulty
	pt c/o skin also from [redacted] left leg. Clean
	[signature] —(1700) I concur. [redacted]
28OCT03	assumed care of pt @ 1800. VSS, alert, speaking arabic.
@2140	LS CTA, ⊕BS, ⊕BM this P.M.; (R)LE wound c̄ dsg, attached
	to SXN, CDI, some serosanguinous drainage noted in
	SXN tubing. Foley draining yellow urine, some sediment
	noted. (L) neck CL (TL) distal port & medial port flush, prox
	port does not flush. CL dressing Δ done c̄ sterile technique.

(b)(6)-2

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2145	(CONT) Pt c/o itching; order obtained for Benadryl, given c good relief noted. Pt restraint in S/Sx of skin/ circulation compromise. Plan: NPO pMN for Sx, monitor
29OCT03	drsg. will cont to monitor. [redacted]
(0755)	Pt sleeping, easily aroused. VSS, NPO for OR today. Ext to (R) leg c minimal serosang drainage on tubing. 0 c/o pain. Foley patent adt qu. 100cc since 0600 LCTAB @ BSx4 adt, 0800 dose Betropan given. 1 pt restraint on S compromise to skin or circulation. Will monitor [redacted] 9MM.
29OCT03	Ortho Op Note
1420	Pre-Op Dx > Open (R) tibia
	Post Op Dx
	Procedure - Excision - cutaneous flap to (R) tibia.
	Surgeon - [redacted]
	Size - < 50 cm²
	Findings - No granulation tissue over fibula in 1 x 3cm area. Loose medial myocutaneous flap, moist, pliable, no tension on graft, good bleeding from flap.
	Plan: recheck in 2-3 days. Split thickness skin graft to cover donor area.
	[redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
(1530) 29OCT03	Rt back from OR, a10, VSS, Ø c/o pain, (R) leg c bandage & ace wrap. Rt tol. PO well. (+) pulses equal dirl to (R) feet. (+) BSx4 qdb, 1 pt restraint on 5 compromise to skin or circulation well monitor [redacted] 91WM6.
1700	pt c/o itching. 25mg Benadryl given PO [redacted].
29OCT@2030	Pt asleep. ~~Denies any~~ @ c/o pain at this time. Pt has (+) foley draining clear, yellow urine. VSS. (L) leg wrapped 2° old wound healing. (R) Leg wrapped c ace bandage. CDI. (+) pedal pulses B/L. Tolerating PO. [redacted]
30OCT (0900)	Rt a10, VSS, Ø complaints, LCTAB, (+) BSx4, abd: soft NT, ND, (non-distended). foley draining (8 FR). cyu. drsg to (R) leg dry & intact c ace bandage. (+) pedal pulses equal dirl. Tol. 90% Reg diet. foley care done. (-) neck CL (TL). drsg CDI. Ø edema or redness @ site. Pt OOB to amb. to BR x1. 1 pt restraint on 5 compromise to skin or circulation well monitor [redacted] 91WM6.

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

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PROGRESS NOTES
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LAST NAME	FI	NAME	MIDDLE	AL	ID NUMBER

DATE	NOTES
30OCT@2330	Pt AAOx3, VSS. Rt c/o pain to groin area where foley placed. Foley appears patent + draining clear, yellow urine. Medicated c 2 Ty#3. Will continue to monitor. TLC-2/3 flush well. Cont' IV ABX. To1 Reg diet. DSG to (R) Lower leg ODI. Kerlex gauze ~~pte~~ wrapped around (L) ankle to ↓ friction c restraint. [redacted]
31OCT03 (1000)	Rt c/o, VSS, Ø c/o pain, foley draining QS cyu. abd: soft, NT, ND. NPO for OR today. (R) DCL TA Ø redness or edema @ site. (R) leg dsg dry + intact, Ø drainage noted thru bandage. 1 pt restraint on Ø compromise to skin or circulation. Will monitor [redacted] q1hr
(1615)	Rt back from OR, VSS, Ø c/o pain. (R) leg c bandage + ace wrap. Ø drainage noted thru ace wrap. Rt tol. 100% Reg diet, (+) equal pulses, brisk cap refill. 1 pt restraint on - Will monitor [redacted] q1hr
~~31OCT03~~ 1NOV03 @0145	Assumed care of pt @1800. VSS. Sleeping most of shift. When awake, alert & arguing. (D) neck ace flushes well. LS CTA, (+) BSx4 quads, RLE c dsg from ankle to hip, CDI, (+) CMS to LE, +2 DP pulses equal BIL. Foley to gravity, draining c/y urine. Pt requesting (yelling) for foley to be flushed c a strange, thorough foley working properly. Refused to flush foley, pt arguing & demanding T#3 stars given for pain c good relief noted. Pt. Cont IV Abx, monitor dsg, pain control. Will cont. to monitor [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1 NOV 03 0700	Assumed care of pt. A+O x3. VSS IV ABX TX cont Afebrile. Ø c/o pain @ this time. Lung clear HRRR Active BS Tolerating PO well. Urinary catheter & drunk to gravity - Clear yellow urine QS @ Leg wound dressing Ace Wrapped CDI Upper extremities amputations. Ø evidence of skin breakdown noted Will cont to monitor [redacted]
01 NOV 03 PM	VSS A+O. Foley drains clear yellow urine Consumed 100% of Regular diet for dinner @ Leg dsg dry & intact. @ IJ IV Replock patent and intact. Will continue plan of care [redacted]
2 NOV 03 0700	Assumed care of pt. A+O x3. Ø s/s of infection afebrile IV ABX Tx. c/o pain medicated ☐ tylenol #3 II tabs. Lungs clear HRRR Active BS BM this AM Foley to gravity CYU Multi upper extremity amputation @ LE fib-fib fracture @ leg Ace wrapped. Will cont to monitor [redacted]
2 NOV @ 0030	VSS. Pt c/o itching on chest + back. Called interpreter to converse ☐ pt. Pt stated cannot sleep at night ☐ itching. Medicated ☐ 30mg Restoril to help sleep at night. Will continue to monitor. DSG to @ fib-fib CDI — D

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

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PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE	ISN NUMBER

DATE	NOTES
	(cont'). Pt has foley draining yellow urine c small amount of ~~urine~~ sediment noted. Pt has IV ABX infusing into TLC. Rechecked pt. Pt asleep resting comfortably. Pt consumed sm amount of dinner. Will monitor throughout night on pt's status. [redacted]
0130	Pt became loud + c/o itching + pain. ~~Intervention~~ Offered Tylenol #3 1/1 for pain. Pt refused. Pt continued to raise voice & repeated attempts to ~~tell~~ verbally to keep voice ↓. Called interpreter to find out what pt saying. Interpreter said that pt do itching. Spoke through interpreter to tell pt will inform MD ~ itching, but offered tylenol #3 again. pt refused. Pt warned multiple times to keep voice ↓. Pt did not. Kerlex placed in mouth for about 5 seconds x2. Taken out + pt lowered voice. Pt laying in bed. [redacted]
3 NOV 03 (1300)	Rt AOB, VSS, Ø c/o pain, Ⓡ leg re-wrapped c Kerlix + ace bandage. dd blood noted on Kerlix. Ⓓ pulses to Ⓑ legs. drsg to Ⓡ leg (ankle) S'D (WTD). Rt c/o itching, medicated c 25mg Benadryl IV c noted relief. foley to gravity draining cyst. (flushed x1). abd: soft, NT, ND. Pt had BM x2. today on BSC. Zosyn + levaquin IV con't per MD orders. Ⓓ SC ch c red port. flushing easily. Ⓔ redness or edema @ site. 1 pt re-straint on Ⓢ compromise to skin/circulation. Will monitor [redacted] 91WM6 (SPC)

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LAST NAME	FIRST NAME	MIDDLE	ISN NUMBER

DATE	NOTES
	(cont'). Pt has foley draining yellow urine c small amount of ~~redish~~ sediment noted. Pt has IV ABX infusing c/o to TLC. Rechecked pt. Pt asleep & resting comfortably. Pt consumed sm amount of dinner. Will monitor throughout night on pt's status. [redacted]
0430	Pt became loud & c/o itching & pain. ~~Intervention~~ Offered Tylenol #3 1/1 for pain. Pt refused. Pt continued to raise voice & repeated attempts to talk privately to keep voice ↓. Called interpreter to find out what pt saying. Interpreter said that pt c/o itching. Spoke through interpreter to tell pt will inform MD re itching, but offered tylenol #3 again. pt refused. Pt warned multiple times to keep voice ↓. Pt did not. Kerlex placed in mouth for about 5 seconds x2. Taken out & pt lowered voice. Pt laying in bed. [redacted]
3 NOV 03 (1300)	Rt A&O, VSS, 0 c/o pain, (R) leg re-wrapped c Kerlix & ace bandage. old blood noted on Kerlix. ⊕ pulses to (R) legs. drsg to (R) leg (ankle) D&D (WTD). Rt c/o itching, medicated c 25mg Benadryl IV c noted relief. foley to gravity draining clr. (flushed x1). Abd: soft, NT, ND. Pt had BM x2. today on BSC. Zosyn & levaquin IV con't per MD orders. DSC CH c red port flushing easily. ⊖ redness or edema @ site. 1 pt re-straint on & compromise to skin/circulation. Will monitor [redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
5NOV03 @0345	Pt complained of itching-throughout night, not relieved from Benadryl (though pt fell asleep) or from atarax. No rash present. Will monitor [redacted]
(0755)	Pt A10, VSS, ø complaints, AM care done, Pt had formed BM x 1 to BSC. Nitropan given per orders. Pt consumed 95% breakfast this AM. Foley to gravity c cyu noted. drsg to (R) leg CDI. (+) CMS, 1 pt restraint d/c to (R) leg. Will compromise to skin/circulation. Will monitor [redacted]
(1620)	Kerlix removed by Du [redacted] (R) calf raw ~~OTA~~ c wrapped c fluffs & Kerlix, (R) thigh c xeroform OTA trimmed edges prn. Will monitor [redacted] qnurse
5NOV03 1900	Pt A+Ox3, VSS, ate 90% of dinner, did not want ensure, CL dsg Δ'd, ø s/sx of infex to site, dsg (R) leg CDI, voices ø c/o pain, xeroform on (R) thigh intact + trimmed on sides, foley to gravity draining cyu, 5mg Ambien adm. as per orders, IV meds given, CL flushes well, 2 point restraint, ø complications. [redacted] qnurse
2020	Pt c/o pain to (R) LE, adm [redacted] tabs IV #3, will cont. to monitor. [redacted] qnurse

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DATE	NOTES (b)(6)-2
3NOV@2330	Pt c/o itching. Informed Dr [redacted] that pt c/o itching + too early to give Benadryl. Dr. [redacted] VO 1x order now Benadryl. Medicated pt. Pt found ~~for~~ relief for ~30min. Pt c/o itching cont. Got ~~verb~~ VO from Dr. [redacted] for Atarax 25mg PO PRN Q6°. Medicated pt. Will continue to monitor pt's status. Pt cont' IV ABX. Pt has Ⓡ LE wrapped c̄ kerlex + ace wrap DSG CDI.
4NOV@0330	Pt slept most of night. ⊖ c/o itching til 0500. Med again c̄ 25mg Atarax PO. Will monitor [redacted]
4 Nov 03 0700	Assumed care of pt. A+O x3. VSS Ø c/o pain [redacted] @ this time c/o itching to lower extremities and trunk of body. IV ABX TX cont pt Afebrile. BM x2 this am AM care given ⓇLE kerlix wrapped dry blood present Ø order for dsg change Will cont to monitor [redacted]
4 Nov 03 @2200	Assumed care of pt @1800. VSS. C/o itching, but pt fell asleep from Ø eating. Medicated @2130 for itching c̄ Atarax po, will monitor relief. RLE Kerlix dsg CDI, ⊕ CMS to RLE (foot), +2 DP pulse. Foley draining clear yellow urine. ↓pt restraint Ø s/sx skin/circulation compromise. Plan: monitor itching, monitor dsg (Pt tol. large amt of po fluids.) [redacted]

(b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
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DATE	NOTES
6 NOV Ø3 (1Ø2Ø)	Pt a&o, VSS, C|O pain often but refusing Tylenol #3. Atarax PO 25mg given for itching. (R) leg drsg c small amt. serous drainage. Drsg re-inforced. Pt attempted to walk but said (via translator) there was too much pain. AM care complete. foley draining QS cyu (care done to foley). DSC TLC dlue port not flushing. IV levaquin & zosyn cont per MD orders. ⊖edema or redness @ CL site. drsg CDI. Xeroform to (R) thigh trimmed. 1 pt restraint on 3 compromise to skin or circulation. Will monitor ([redacted]) 91WM6-7
1615	Dr [redacted] @BS. drsg A&D to (R) leg, bacitracin applied, fluffs applied then wrapped c Kerlix. Vo given to do this drsg A daily. Will monitor [redacted] 91WM6
6 NOV. Ø3 1930	Pt A+O x3, VSS, drsg RLE CDI, c/o pain + itching, adm Tyl #3 + Atarax as per orders, Xeroform to (R) thigh wound CDI, foley draining cyu, CL site Ø S/Sx of infex, ate most of diet, 1 point restraint, Ø complications. [redacted] QW

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI) | DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)* | REGISTER NO. | WARD NO. ICWH1

[redacted] (b)(6)-7

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7 NOV 03 (1430)	Pt A&O, VSS, Ø c/o pain, (R) leg dsg D'd (bacitracin applied) to graft site. (R) thigh c xeroform intact edges trimmed. Dsg to (L) leg D'd, area scabbing up. Wrapped c Kerlix for pt comfort/request. +2 pulses to (R) foot, ambulated to BR x2 c mild pain c/o itching cont, medicated c atarax c relief noted. Foley draining @S cpw. 1 pt restraint on while un-lock's compromise to skin or circulation. Will monitor [redacted] TNWMC
(1530)	Foley removed d/t pt. c/o pain. Pt now voiding in urinal c assistance. no longer c c/o pain or urge to void. Will monitor [redacted] 911WMC
8 NOV 03 @ 0145	Assumed care of pt @ 1800. VSS. C/O itching ? pain, Atarax given c relief noted. T#3 tabs given for pain @ HS c relief noted. LS CTA, (+) BS, voiding p urinal c assistance c difficulty. RLE dsg CDI, (+) CMS, (L) wrist CL flushes well. IVABX cont. 2pt restraints on S/SX skin circulation compromise. Pain cont IVABX, monitor dsg, itch/pain control [redacted]
8 NOV 03	(1800) Assumed care of pt @ 0000. A&O alert, speaking Arabic. VSS. T3s given for pain c good relief. A&O c itching - medicated c 25mg Benadryl po and given bath for relief. Relief of itching noted. Pt amb in hallway c difficulty. Dsg to RLE CDI - Bacitracin

STANDARD FORM 509 (REV. 5/1999) BA
USAPA V

[redacted] (b)(6)-4

MEDCOM - 20377

MEDICAL RECORD	PROGRESS NOTES	AUTHORIZED FOR LOCAL REPRODUCTION
DATE	NOTES	

8Nov03 (cont) applied to wound. ϕ S/Sx infection. @ IV flushes well ϵ S/Sx infection/infiltration. Tol reg diet well. Voiding ≥ 200cc clear yellow urine ϵ each void into urinal. Bladder nondistended. ϕ BM this am. 1 point restraint in place ϵ S/Sx complications. Will cont to monitor. [redacted] USN

9Nov03 @0115 assumed care of pt @1800. VSS. ~~T~~ c/o constant 10/10 pain ϵ itching. Atarax ϵ T#3 given ϵ good relief noted. Tol po well. (L) neck CL flushes well. RUE dsg CDI, (R) thigh graft healing ϵ S/Sx of infection. Voiding per urinal ϵ assistance. ? urinary incontinence D/T pt urinating small amt ~~before~~ immediately ϵ asking for urinal. 1 pt restraint in S/Sx skin/circulation compromise. Plan: cont po, monitor dsg, itch/pain control. [redacted] USN

9 Nov 03 0833 Assumed care @ 0600. A ϵ O Able to make needs known. VSS. T to bathroom ϵ asst for AM care. (L) neck central line flushed ϵ patent. ϕ sign infection or infiltration. (R) thigh xeroform dsg intact ϵ trimmed. Site healing. RUE dsg D ϵ plenty of bacitracin ϵ Kerlix fluffs. Wound site ϵ intact sutures.

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

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

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

[redacted] (b)(6)-4

REGISTER NO. | WARD NO. ICW1

PROGRESS NOTES
Medical Record

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

ST NAME	MI	INITIAL	ID NUMBER

DATE	NOTES
1 Nov 03	(Cont.) Pt medicated c T#3 two tabs p.o. for c/o RLE pain & atarax 25mg p.o for c/o itching all over esp. to LLE. See DA Form 4678 for wnd times. One pt. restraint s compromise to skin or circulation. Will continue Abx therapy, pain/itch control & ambulation. [redacted] mwk
09 Nov 03 1410	Medicated c atarax 25mg p.o [redacted] c/o itching. Will monitor [redacted]
09 Nov 03 1515	Pt sleeping. No acute d[redacted] mwk
09 Nov 03 1610	Medicated c T#3 two tabs for c/o pain. Will monitor for effect [redacted] mwk
09 Nov 03 1725	Ambulating in hall s difficulty. Pt loves eating icecream. Denies pain s [redacted] this time.
09 NOV @ 2340	Pt amb onward + sat in chair in early evening. @ Foley. Pt urinated s difficulty into urinal. c/o itching. Med c 25mg Atarax. Will monitor effects. DSG to @ LE CDI. VSS. Infusing IV ABX. Tol well. TLC occluded x2. White lumen functional. Pt asleep. Will monitor pain + itching. [redacted]
10 NOV @ 0000	Pt c/o pain to @ LE. Med c 2 Ty #3. Will continue to [redacted] Pt laying in bed + attempting to sleep.
10 NOV 03	(0400) Assumed care of pt @ 0000. Pt alert, speaking Arabic. VSS. Pt medicated c T3s for pain and Benadryl for itching. Will monitor for relief. @ SC flushes well s S/Sx infection/infiltration. Pt OOB to chair and amb in hallway s difficulty. DSG to @

STANDARD FORM 509 (REV. 5/1999) USA

[redacted] (b)(6)-4

MEDCOM - 20379

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
10NOV03	(cont) Δd. Bacitracin applied to wound. Φ S/Sx infection. Sutures to RLE CDI. Pt tol. reg diet well. Voiding ≈150-250cc clear yellow urine into urinal ☐ each void. Bladder nondistended. 1 point restraint in place ☐ S/Sx complications. Will cont. to monitor. [redacted]
	(1730) Dsg to RLE reapplied ☐ wound was open to air for 1°. Pt OOB to chair ⓦ this time. Will monitor. [redacted]
9NOV@0015	Pt amb on ward ☐ steady gait. Pt conversing ☐ staff. Appears to have Ⓕ demeanor. Aware to DIC to EPN. Pt c/o itching. Med ☐ 25mg PO Atarax. Will continue to monitor. Pt requires assistance ☐ urinal. Urinating clear, yellow + sufficient amt. DSG to ~~BIL~~ BIL LE CDI. TLC x2 occluded. White flushes well, Θ blood return. Cont IVABX. [redacted]
11NOV 0010	Pt c/o itching. Med ☐ Benadryl IV 25mg. Will monitor. [redacted]
11NOV03	(1010) Assumed care ⓦ brief. Pt alert, speaking Arabic. VSS. Φ c/o pain. Cont. to c/o itching. medicated ☐ Atarax this am. Pt OOB to amb in hallway ☐ difficulty. ↑ to chair for 1°. Dsg to RLE Δd.

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] (5)(6)-7

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 - 20380

(5)(6)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
11 Nov 05 (1010)	(cont) Bacitracin applied to wound. Ø S/Sx infection. @ IV flushes well ē S/Sx infection/infiltration. Tol. reg diet well. Ø BM this am. Voiding clear yellow urine into urinal 100-200cc ē q void. 1 point restraint in place ē S/Sx complications. Awaiting trans. to EAW camp. will cont. to monitor. [redacted] (1430) @ IV d/cd - cath intact. Pt stable for d/c ambulatory - escorted by MPs. [redacted] (5)(6)-2

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

ISN# 18070

23 SEP 03
192[redacted] "Seizing & foaming at the mouth"
Friend says pt seizes off & on
O Could not get a clear history from friend
Pt had asked for Valium earlier in evening

BP 124/52 Pt was jerking in all four extremities & foaming at the mouth
P80 No apparent trouble c respiration
Lungs clear
CVS - Reg cardiac rhythm
Loud systolic (m) along L sternal border
Other physical features described above
* Valium 5mg given IV
Jerking stopped
Sleeping
A Seizure - ? withdrawal; Leg wounds (as above)
P Delivered to prison O/pt Clinic for over night stay
To [redacted] for surgical consultation

(b)(2)-2

[redacted] [illegible]

MEDCOM - 20382

(b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
24SEP03 1750	S - [illegible] to [illegible]
	Lost arm in bomb blast
5'5" 96 lbs	has wounds on both legs
	O ♂ has no (R) upper extremity + an amputation mid (L) forearm
Meds:	5 x 7 cm open wound ant (R) knee, caudal to patella
Benzylpenicillin	Tendon is exposed + eroded
Cephalexin	8 x 3 cm open superficial
Piroxicam [illegible]	wound posteromedial (L) calf ; site of previous graft
Framycetin Sulfate [illegible] 0.5% eye oint	A Infected wound, (R) knee
	Open wound (L) calf
	Double amputation, upper extremit.
	P To new O/Pt clinic + treatment by physicians (Done)
	[illegible] in A.M. for surgical considerations

[redacted] [illegible]

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE | [illegible]

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.

[redacted]

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD Navy

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
25 SEP 1440	33 y/o Iraqi OF. EPW who presents for evaluation of an open (R) tibial injury, multiple amputations and possible GTC seizure while at EPW camp (23 Sep). Patient (through interpreter) admits to a 18 year history of seizure and drug use including significant alcohol consumption ("12 packs of beer" per day) in addition to use of Valium / Ativan. Patient says he has at least one seizure per day for years.
	Neuro exam: limited due to patient multiple injuries and language barrier, awake, alert, fairly cooperative but with non physiologic / inconsistent findings, responds to visual threat bilateral, verbose, speech fluent, perseverative but questionable judgment / insight, moves extremities, but (R) arm amputated at shoulder / (L) arm below elbow, sensation + towards response to PP
	Imp: Probable withdrawal seizure related to chronic alcohol use/abuse and use of Valium
	Rec: (1) Ativan 1 mg IV/IO q8° (hold if lethargic) for SZ prevention or patient scheduled to go to OR tomorrow
	(2) Thiamine 100 mg PO (3) call neuro if breakthrough seizure

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

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. (5)(6)-7

WARD NO.

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

NSN 7540-01-075-3786

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

LOG NUMBER | TREATMENT FACILITY [redacted]

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 25 Sept 2003 | TIME: 1040

TRANSPORTATION TO FACILITY: Ground MP

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

CURRENT MEDICATIONS: ~~Valium~~

ALLERGIES: Ø

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: (L) Tib Fib Injury

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

TIME: 1040

INITIALS: [redacted]

VITAL SIGNS

TIME	1040	1400	14:30			
BP	119/69		116/92			
PULSE	82	87	91			
RESP	18	16	20			
TEMP	97.1 T		96.9			
~~WT~~	98#	ex 100%,				

LAB ORDERS					X-RAY ORDERS		
☒ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT		CXR PA & LAT/PORTABLE		C-SPINE
URINE C&S	UA MSCC/CATH		☒ CHEM: Met 8		ACUTE ABDOMEN		LS SPINE
BLOOD C&S X			X SED RATE		SINUS		HEAD CT
			(b)(6)-7		ANKLE R/L	X (L) Knee	
					X (L) Leg		

ORDERS

☒ PULSE OX 100% ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1100	Percocet # 10	[redacted]	[redacted]	1100	
1400	MSO4 10mg IV.			1400	

DISPOSITION	DISPOSITION QUARTERS /OFF DUTY	PATIENT/DISCHARGE INSTRUCTIONS
☐ HOME ☐ FULL DUTY	☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.	
MODIFIED DUTY UNTIL	RETURN TO DUTY	

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶	TO	WHEN
☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATE	TIME OF RELEASE	I have received and understand these instructions.		
		PATIENT'S SIGNATURE		

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

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

MEDCOM - 20385

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER
		1050.

TEST RESULTS

CBC	WBC	SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
	H/H			SUP 02	PH	PO2	RESULTS	
	PLT			PCO2	SAT	OTHER		
PT				U/A	DIP		EKG INTERPRETATION	
APTT	BHCG	ETOH	GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

S: Pt is a 37yo Iraqi EPW s/p mine blast 3mo. Told he needed surgery for his open Tibia + (L) Tib/fib injury. Denies fevers. Pt lost (B) Arms in same mine blast 3mo & had surgery done to stumps.

PMHx ⊖.
NKDA.
PSHx
(B) UE Amps. 3mo.
⊖ meds.

O: WDWN mod-severe distress
HEENT: WNL
Lungs: (B) CTA.
Cor: RRR ⊖⊖
Abd: BS's, NTND
Ext: (R) Prox Tibia c exposed black bone @ plateau.
(L) Tib fib c open pattern wound. ⊕ Dried blood on LE c mod swelling
↑ TTP over entire (L) LE below knee. + pulses.

5 / 11 / 302
35
ESR 42
136 | 104 | 7.5
3.9 | 19 | .95
CK 614

X-Ray: (B) mid shaft Cortical Tibia Defect
(B) Tibia Plateau bony defect

Chem 20
PT/PTT INR pending

Admit to J Ward
D/w Dr. [redacted]

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
(S)(6)-2

PRO[redacted]STAMP
[redacted]

DIAGNOSIS
Osteomyelitis

CODES

PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name – last, first, middle; ID no. (SSN or other); hospital or medical facility)*
[redacted]
(L)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
Cont.			turned off during HS as per orders, SP cath in place, dsg on abd CDI, Pt tol PO well, had good appetite, IV (R) IJ intact, ∅ s/sx of infex or infiltration, 2 pt restraint in place, ∅ skin breakdown or poor circulation noted. [redacted] RN
11 OCT 03		1550	Assumed care of pt @ 0000 ~~p~~ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled ~~c~~ Tylenol. Pt OOB to BR for personal hygene ~~c~~ assistance from staff. Amb well. Pt c/o HA from suction machine noise. Suction machine moved into BR. Pt sleeping @ this time. Drsg to RLE CDI. Drsg to RLE CDI ~~c~~ vac. device to low cont. suction. Pt tol. reg diet well ~~c~~ assist. in feedings. Foley draining quantity sufficient clear yellow urine. @BM. IVF infusing into (R) N ~~s~~ s/sx infection infiltration. 1 point restraint in place ~~s~~ s/sx complications. Will cont. to monitor [redacted]
		1750	Pt tol. po well. IVFs SLd in (R) IV [redacted]
11 OCT. 03		2100	Pt A+Ox3, VSS, medicated for pain, continuous suction to RLE draining minimal amount of drainage, SP cath draining c/y urine, IV HL (D) IJ patent Pt tol diet well, 1pt restraint in

*U.S. Government Printing Office: 1995 - 404-763/20085

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 20387

510–112

NSN 7540–00–634–4123

MEDICAL RECORD

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
Cont.			place s/sx of complications. [redacted] 9/W (b)(6)1-2

(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.

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7–91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201–9.202–1

MEDCOM - 20388

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

4. PROPOSED SURGICAL PROCEDURE:

I&D Bil Lags

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications:
Jewelry removed: yes/no Family waiting: yes/no See previous 5179

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; ~~language barrier~~; family separation; surgical environment	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. o Maintain family interface.
B. ~~AERATION~~ ___ Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative 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 integuity due to bovie pad; position; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. o 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)

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

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

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] MAJ AN 26 Sep 03 DATE

11. POSTOPERATIVE EVALUATION:

Pt awake but drowsy; attempting to communicate. Pt breathing room air. Dressings dry & intact.

(5)(6)-2

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] MAJ AN	[redacted] MAJ AN
DATE: 26 Sep 03 TIME: 1215	DATE: 26 Sept 03 TIME: 1325

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDCOM - 20390

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the prop agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY CPT [redacted]

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

3. DATE: 31 Oct 03 TIME PATIENT ARRIVED IN SUITE: 1305

4. PATIENT IN ROOM
TIME: 1307 NUMBER: 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: (b)(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	INT:

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

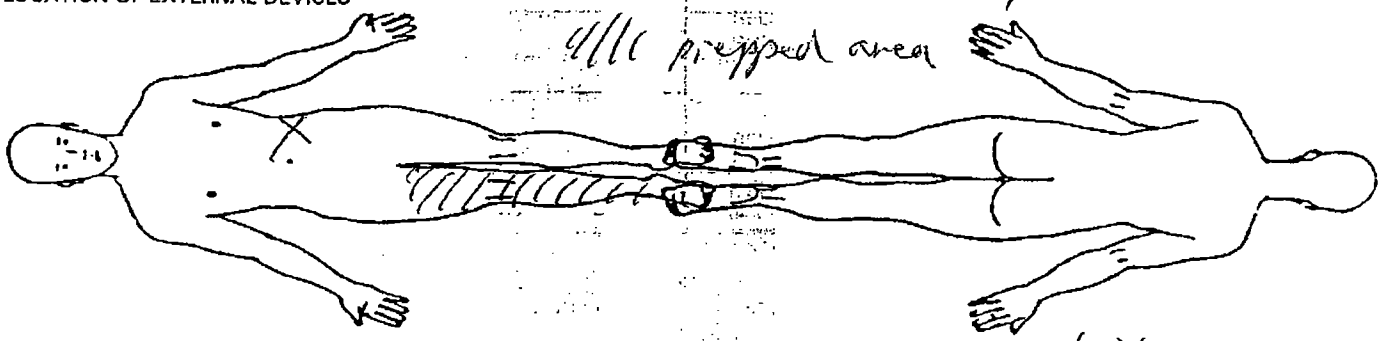
COMMENTS: Left arm on padded armboard out @ 90° (b)(6)-2

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)*: Betadine scrub & solution
SITE: Rt leg
SITE:
BY WHOM: MAJ [redacted]
BY WHOM:
COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet (b)(6)-2

10. COUNTS			C = Correct I = Incorrect: Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No		C	C	PFC [redacted]	MAJ [redacted]
Needle Sharp	☑ Yes	☐ No		C	C		
Instrument	☐ Yes	☑ No				PFC	
Other	☐ Yes	☑ No					

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

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

(b)(6)-2

31 Oct 03 [redacted]

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

☑ ESU NO: REF 112395
GROUND PAD: BRAND Valleylab
LOT NO: 65206 Exp 2004-11
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 20391

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

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): NS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*

Xeroform 4X8's } Rt thigh

Xeroform Bacitracin Fluff, Kerlix, Ace } Rt thigh

17. TUBES, DRAINS/PACKING YES ☐ NO ☐

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

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted] Assist: Dr [redacted]

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

Cautery: Cut-30 Coag 30 Bovie plate site post-op-

20. OPERATION(S) PERFORMED

STSG from Rt thigh to Rt calf

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU		Lifter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ AN 31 Oct 03

REVERSE OF DA FORM 3179-1, OCT 87 (b)(6)-2 MEDCOM - 20392 USAPA V1.00

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM — VIA litter — BY anesthesia
2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted]
3. DATE: 29 Oct 03 — TIME PATIENT ARRIVED IN SUITE:
4. PATIENT IN ROOM — TIME: — NUMBER:

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: (b)(6)-2

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

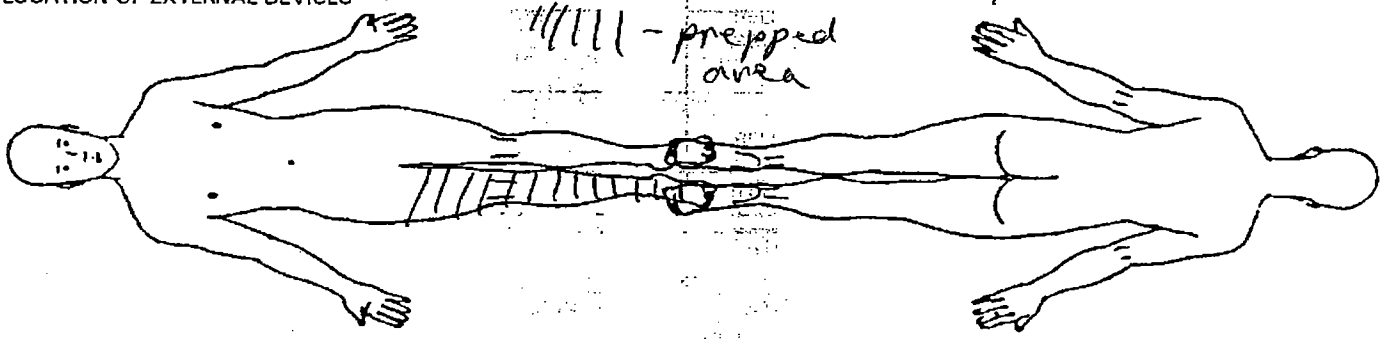
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Hibiclens + Saline
SITE: Rt Leg — BY WHOM: CPT [redacted]
SITE: — BY WHOM:
COMMENTS: No pooling of solution (b)(6)-2

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS — C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No			C	SPC [redacted] (b)(6)-2	MAJ [redacted]
Needle Sharp	☒ Yes ☐ No			C		
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

[redacted] (b)(6)-4
(b)(6)-2
29 Oct 03

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

☑ ESU NO: Valleylab Force 2
GROUND PAD: BRAND VL Dura Polyhesive II
LOT NO: 70011 Exp 2005-04
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 — REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. — USAPA V1.00

MEDCOM - 20393

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

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% Normal

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

19. ADDITIONAL INFORMATION

Surgeon: [redacted] Assist: Dr [redacted]
Anesthesia: (b)(6)-2
Cautery: Coag: 30 Cut: 30

20. OPERATION(S) PERFORMED

I+D ® Tibia

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU (ICU3) (b)(6)-2	See DA7389	Litter

22. REGISTERED NURSE SIGNATURE [redacted] MA) AN 29 Oct 03

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDCOM - 20394

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the prop[illegible] the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECO[illegible]VED AND PROCEDURE
VERIFIED BY 1LT [redacted]

3. DATE 18 OCT 03 TIME PATIENT ARRIVED IN SUITE 1040

4. PATIENT IN ROOM TIME 1045 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA, NPO (b)(6)-2

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

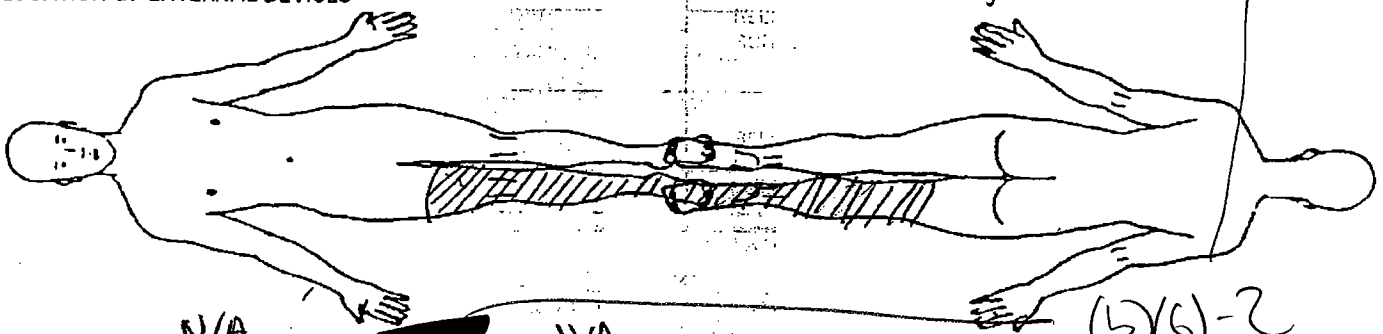
COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION Hibiclens [redacted]

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

PREP SOLUTION *(Specify)* ~~Betadine~~/~~Betadine~~
SITE: Right leg BY WHOM: 1LT [redacted]
SITE: BY WHOM:
COMMENTS: No pooling or adv

9. LOCATION OF EXTERNAL DEVICES



N/A [redacted] N/A (b)(6)-2

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

INITIAL: SPC Day 1LT Malachi

10. COUNTS

			C = Correct I = Incorrect				
			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No			C	SPC [redacted]	1LT [redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

[redacted] (b)(6)-4

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

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

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 20395

13. PROSTHESIS, IMPLANTS [ ] YES [X] NO IF YES NAME: ID NUMBER IFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES [ ] NO [X]

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S):
0.9% NaCl- QS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES [ ] NO [X] IF YES, SITE

16. LABORATORY SPECIMENS

SPECIMEN (S) YES [ ] NO [X]	NAME	NAME
FROZEN SECTION (FS) YES [ ] NO [X]	NAME	NAME
CULTURE (C) YES [ ] NO [X]	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Fluffs Ioban

17. TUBES, DRAINS/PACKING YES [X] NO [ ]

	1.	2.	3.
TYPE/SIZE	10mm J-P		
SITE	(R) tibia		

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted]
Anesthesia: CRT

(b)(6)-2

DA 5179 in Chart

20. OPERATION(S) PERFORMED

IMN (R) tibia

21. PATIENT TRANSFERRED TO	TIME See DA 7389	METHOD Litter
PACU		

22. REGISTERED NURSE SIGNATURE [redacted] RT/AN

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.00

MEDCOM - 20396

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia

2. PATIENT VERIFIED BY [redacted] AND PROCEDURE MAJ/th

3. DATE 15 OCT 03 TIME PATIENT ARRIVED IN SUITE 1105

4. PATIENT TIME 1105 NUMBER 1-3

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: (b)(6)-2

6. NURSING PERSONNEL

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

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

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

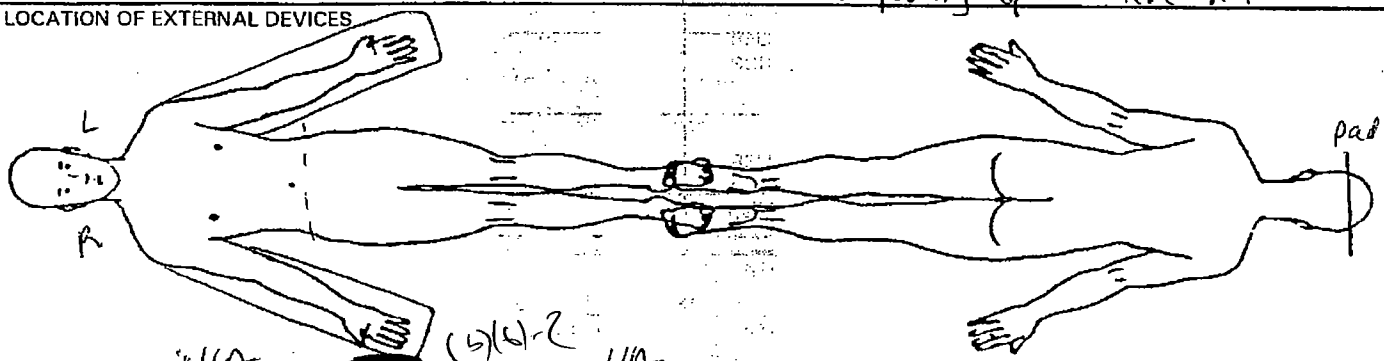
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: (R) leg BY WHOM: MAJ [redacted]
SITE: BY WHOM:
COMMENTS: No pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



(b)(6)-2 N/A N/A

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

C = Correct I = Incorrect

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

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

[redacted] (b)(6)-4

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

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

DA FORM 5179-1, OCT 87 — REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. — USAPA V1.00

MEDCOM - 20397

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 10mm JP	2.	3.
SITE	1. (R) Tibia	2.	3.

19. ADDITIONAL INFORMATION

Surgeon [redacted] Anesthesia [redacted]

LTC [redacted]

(b)(6)-2

20. OPERATION(S) PERFORMED

I & D (R) Tibia

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	1140	Litter c or

22. REGISTER [redacted] MAJ/AN

REVERSE OF DA FORM 5179-1, OCT USAPA V1.00

MEDCOM - 20398

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the prop[illegible]ency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia | 2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] MAJ/AN

3. DATE 0 OCT 03 TIME PATIENT ARRIVED IN SUITE 1110 | 4. PATIENT IN ROOM TIME 1110 NUMBER 23

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] ORT	RELIEF SCRUB	(b)(6)-2
ASSIGNED CIRCULATOR	MAJ [redacted], AN	RELIEF CIRCULATOR INT	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt transferred to OR table, anatomically aligned for surgical procedure & pad under head. Pt (B) amputee upper extremities

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

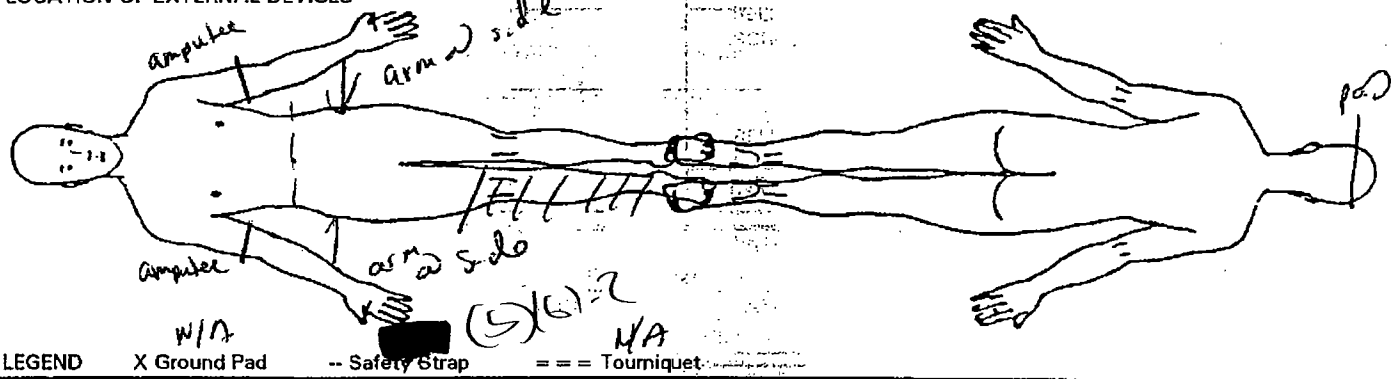
PREP SOLUTION *(Specify)* Betadine/Betadine

SITE: (R) leg BY WHOM: MAJ [redacted]

SITE: XX See #9 BY WHOM:

COMMENTS: ⊘ Pooling of Solution noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

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

[redacted] (b)(6)-4

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

☐ ESU NO: _____

GROUND PAD: BRAND _____

LOT NO: _____

☐ ESU NO: _____

GROUND PAD: BRAND _____

LOT NO: _____

☐ BIPOLAR NO: _____

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 20399

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	10mm JP		
SITE	(R) Leg		

19. ADDITIONAL INFORMATION

Surgeon [redacted] Anesthesia [redacted]

(b)(6)-2

20. OPERATION(S) PERFORMED

I+D (2) Tibia

21. PATIENT TRANSFERRED TO PACU TIME 1205 METHOD Litter + O2

22. REGIST[redacted] MAJ/AN

REVERSE OF DA FORM 5179-1, OCT [redacted] MEDCOM - 20400 USAPA V1.00

MEDICAL RECORD — **INTRAOPERA[illegible] D[illegible] UMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA letter BY anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED B[redacted] CPT/AN

3. DATE 7OCT03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 1445 NUMBER 1-1 (4)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Spanish speaker.

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D	RELIEF SCRUB	(5)(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR	CPT [redacted] (1500 - EOC)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

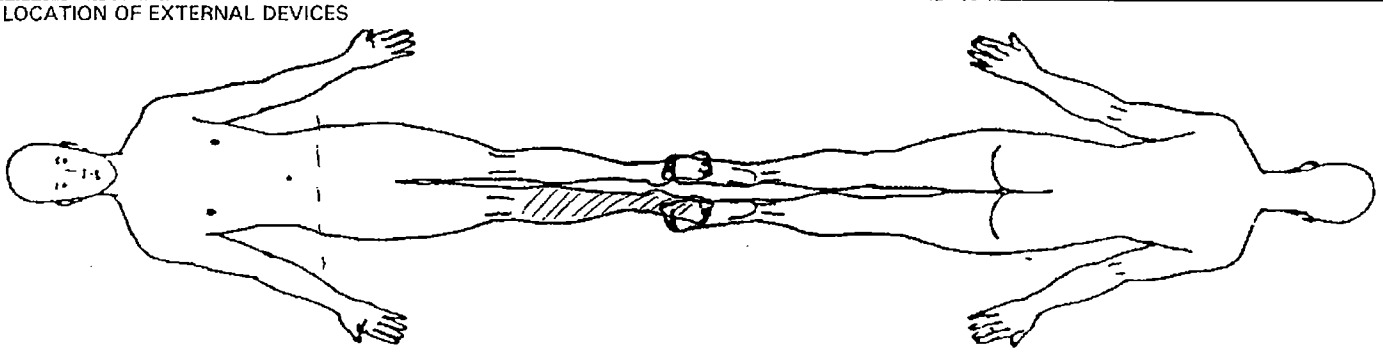
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Beta/Beta
SITE: BY WHOM:
SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB (5)(6)-2	CIRCULATOR
Sponge	☒ Yes	☐ No			C	[redacted]	[redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☐ No	/	/	/	/	/
Other	☐ Yes	☐ No					

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

#[redacted] (5)(6)-4

[redacted] (5)(2)-2

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

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

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

☐ BIPOLAR NO: _____

DA FORM 5179-1, OCT 87 REPLACES D/ MEDCOM - 20401 CH IS OBSOLETE. USAPA V1.00

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
None		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. JP Drain	2.	3.
SITE	1. (R) leg	2.	3.

19. ADDITIONAL INFORMATION

Surg: [redacted]

Anesth [redacted] CRNA

Anesth General w/ mask (b)(6)-2

20. OPERATION(S) PERFORMED

I & D (R) tibia

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 3	1526	Stretcher

22. REGISTERED NURSE [redacted] (CPT / AN)

REVERSE OF [redacted]

MEDCOM - 20402 USAPA V1.00

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the prop[illegible] agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING [illegible]OOM
VIA litter BY anesthesia

2. PATIENT IDENTIFIED [illegible] [illegible]D PROCEDURE
VERIFIED BY [redacted] CPT/PN

3. DATE 40CT 03 TIME PATIENT ARRIVED IN SUITE

4. PATIEN[illegible] TIME 0935 NUMBER 2-2 (3)

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

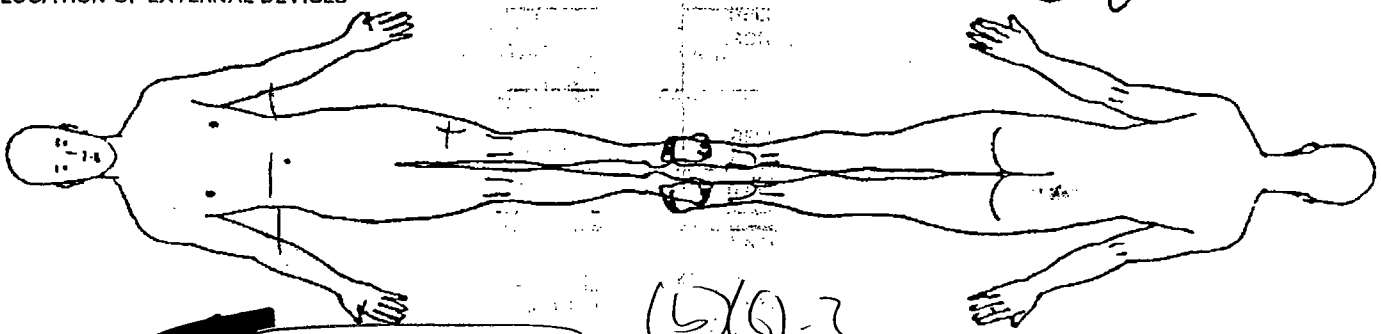
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betal Beta [redacted]
SITE: R leg BY WHOM: CP[redacted]
SITE: BY WHOM:
COMMENTS: no pooling of prep noted

9. LOCATION OF EXTERNAL DEVICES



(b)(6)-2

LEGEND X [redacted] 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	PFC [redacted]	
Needle Sharp	☒ Yes	☐ No	C		C		CPT [redacted]
Instrument	☐ Yes	☒ No	/	/	/	/	/
Other	☐ Yes	☒ No	/	/	/	/	/

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

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

[redacted] (b)(6)-2

40CT03

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

☒ ESU NO: CUT COAG [redacted]
GROUND PAD: [redacted] E7507
LOT NO: 200[redacted] 2005-04

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 20403

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; M FA JRER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* - fluffs - Ioban - kerlix - ace wrap

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	JP Drain		
SITE	(R) leg		

19. ADDITIONAL INFORMATION

20. OPERATION(S) PERFORMED I & D Right Tibia

21. PATIENT TRANSFERRED TO ICU 3 (5)(6)-2 TIME 1030 METHOD Stretcher

22. REGISTERED NURSE [redacted] CPT/AD

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.00

MEDCOM - 20404

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

ATIENT TRANSPORTED TO OPERATING ROOM BY Anesthesia | 2. PATIENT VERIFIED BY [redacted] PROCEDURE CPT(P) Ar

DATE 1 OCT 03 | TIME PATIENT ARRIVED IN SUITE | 4. PATIENT IN ROOM TIME | NUMBER 1-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted], OR-T	RELIEF SCRUB	(b)(6)-2
ASSIGNED CIRCULATOR	CPT [redacted] Ar	RELIEF CIRCULATOR INT.	

7. POSITION AND POSITIONAL AIDS (Specify) Pt transferred to OR table, anatomically aligned for surgical procedure c padding under head (B) arms on padded arm boards

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

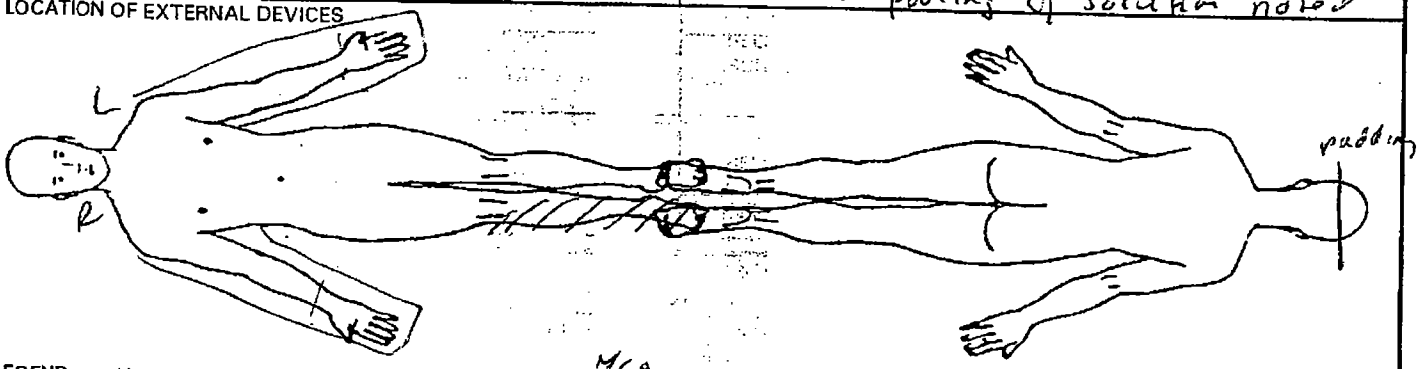
PREP SOLUTION (Specify) Betn/Betn

SITE: (R) Leg BY WHOM: CPT [redacted] Ar

SITE: BY WHOM:

COMMENTS: & pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet N/A

10. COUNTS (C = Correct I = Incorrect)

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

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

[redacted]

(b)(6)-4

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

Not used

☒ ESU NO: 405 R&E 105305

GROUND PAD: BRAND Valley Lab

LOT NO: 72041 EXP 2005-04

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 20405

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBE IUFACTURER

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): 0.9-1 NaCl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. ~~Hemovac~~ 10mm JP Drain	2.	3.
SITE	1 (R) Leg	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)* Fluffs Iobar Kerl. Benzoin ACE

19. ADDITIONAL INFORMATION

Surgeon [redacted] Anesthesia [redacted]

(b)(6)-2

20. OPERATION(S) PERFORMED

I + D (R) Tibia

21. PATIENT TRANSFERRED TO PACU TIME 1030 METHOD Litter

22. REGISTERED NURSE SIGN [redacted] PT/AT

REVERSE OF DA FORM 5179-1, OCT 80 MEDCOM - 20406 USAPA V1.00

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-407, the prop[illegible] agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING [illegible]OOM
VIA Litter BY Anesthesia

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

3. DATE 29 Sept 03 TIME PATIENT ARRIVED IN SUITE 1602

4. PATIENT IN [illegible] TIME 1602 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

(6)(6) 2

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS:

8. SKIN PREPARATION

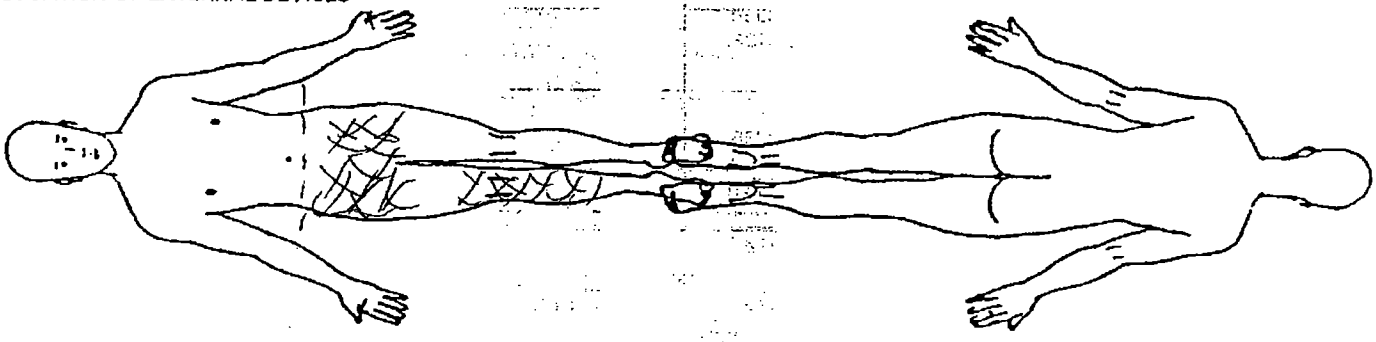
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine scrub/soln
SITE: Abd. BY WHOM [redacted]
SITE: Rt. Leg BY WHOM [redacted]

COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS			C = Correct I = Incorrect				
			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☒ No					
Needle Sharp	☐ Yes	☒ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

[redacted] (6)(6)-4

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

☐ ESU NO: _____
GROUND PAD: BRAND Valleylab
LOT NO: 68245
☐ ESU NO: _____
GROUND PAD: BRAND _____
LOT NO: _____
☐ BIPOLAR NO: _____

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 20407

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

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% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☒ NO ☐	NAME Rt. Leg Wound	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	Suprapubic cath		
SITE	lower abd		

18. DRESSING/IMMOBILIZATION *(Specify)*

4x8 Tape > Abd.

Fluffs Kerlix > leg

19. ADDITIONAL INFORMATION

Surg: [redacted] Anesth [redacted] General

(b)(6)-2

20. OPERATION(S) PERFORMED

1. Dilation of meatus
2. Percutaneous placement of suprapubic tube
3. I & D Rt. Leg Wound

21. PATIENT TRANSFERRED TO ~~OR Rec~~ PACU ~~to OR~~ TIME 1721 METHOD Lifter

22. REGISTERED NURSE SIGNATURE [redacted] CRT/AN

REVERSE OF DA FORM [redacted] OCT 87

USAPA V1.00

MEDCOM - 20408

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY CPT [redacted]

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

3. DATE 26 Sep 03 TIME PATIENT ARRIVED IN SUITE 1215

4. PATIENT IN ROOM TIME 1215 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: (5)(6)-2

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

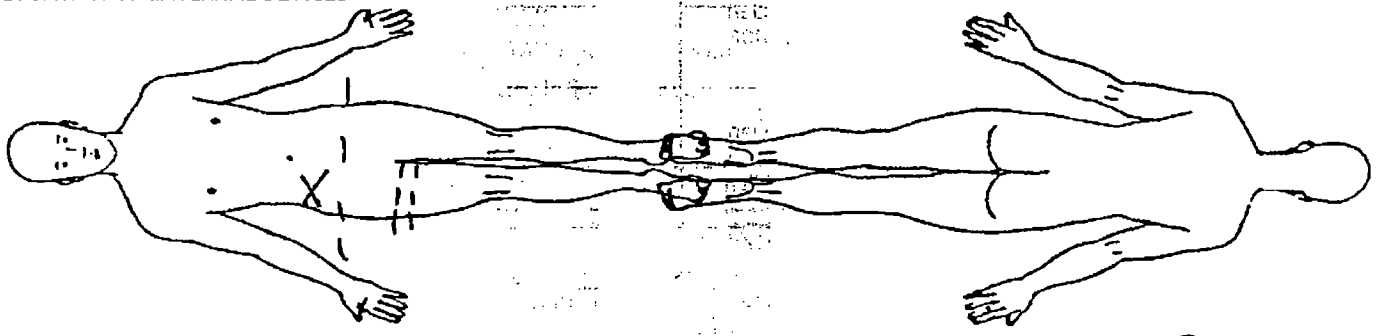
COMMENTS: Left arm on padded armboard at < 90° angle (5)(6)-2

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine scrub & solution
SITE: Rt leg BY WHOM: MAJ [redacted]
SITE: BY WHOM:
COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet (5)(6)-2

10. COUNTS			C = Correct I = Incorrect: Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No		C	C		
Needle Sharp	☑ Yes	☐ No		C	C		
Instrument	☐ Yes	☑ No				SSG [redacted]	MAJ [redacted]
Other	☐ Yes	☑ No					

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

[redacted] (5)(6)-4

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

☐ ESU NO: R8B 102395
GROUND PAD: BRAND Valleylab
LOT NO: 68936 Exp 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 20409

13. PROSTHESIS, IMPLANTS ☐ YES ☑ NO IF YES NAME: ID NUMBER; M JF. URER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO; TYPE(S): N.S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	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, Tape } Lt LL
Fluffs, Kerlix, Ace } Rt Leg

19. ADDITIONAL INFORMATION

Surgeon Dr [redacted] assist: Dr [redacted]
anes: CRNA [redacted]
Basic 30 cut/30 coag Bovie plate site clear & intact post-op
(5)(6)-2

20. OPERATION(S) PERFORMED

Dressing change & debridement Lt calf
I&D with closure Rt Leg

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	1320	Litter

22. REGISTERED NURSE SIGNATURE [redacted] MA) AN 26 Sep 03

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 20410 USAPA V1.00

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY CPT [redacted]	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY MAJ [redacted]
3. DATE TIME PATIENT ARRIVED IN SUITE	4. PATIENT IN ROOM TIME NUMBER 2-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

(b)(6)-2

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)*

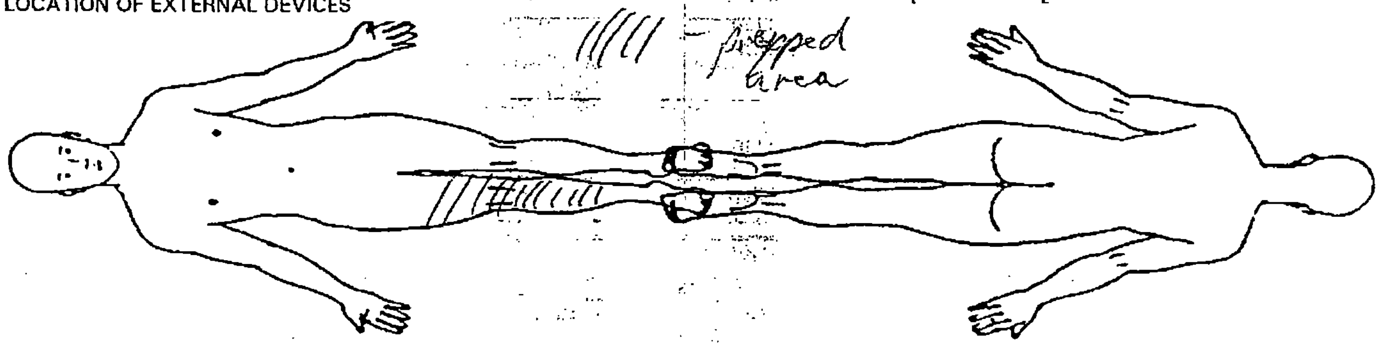
☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Left arm on padded armboard at angle < 90°

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO DONE BY: ☐ OR ☐ NURSING UNIT METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP COMMENTS:	PREP SOLUTION *(Specify)* Hibiclens & saline ~~Betadine [illegible]~~ SITE: Right Leg BY WHOM: MAJ [redacted] SITE: BY WHOM: (b)(6)-2 COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS			C = Correct I = Incorrect Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☐ No					
Needle Sharp	☐ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)* # [redacted] (b)(6)-4	12. ELECTROSURGERY DEVICE(S) (ESU) ☐ YES ☐ NO ☐ ESU NO: GROUND PAD: BRAND LOT NO: ☐ ESU NO: GROUND PAD: BRAND LOT NO: ☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 20411

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 10fr J.P.	2.	3.
SITE	1. Rt Tibia	2.	3.

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted]
Anes: CPT [redacted]
(b)(6)-2

20. OPERATION(S) PERFORMED

I+D Rt Tibia

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	1130	Litter

22. REGISTERED NURSE SIGNATURE [redacted] MAJ AN 24 Oct 03

REVERSE OF DA FORM 5179-1, OCT 87

MEDCOM - 20412

USAPA V1.00

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOVEMBER DAY: 7 | 08 | 9 | 10 | 11

19 2003 HOUR

PULSE (O) — TEMP. F (°) — TEMP. C

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: 101/56 | 97/51 | 100/59 | 94/53 | 94/57 | 95/56 | 110/68

Temp.: 97.5 | 98(A) | 101/68 | 99.04

HEIGHT: | WEIGHT

O2: 98% | (RA) | 98% | 98% | 98% | 98.7.4

O2: | | | RA | | 98% | 99(RA)

Pulse: 80 | 85 | Pulse | 83

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)-1

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY
POST- DAY
MONTH-YEAR DAY
19 HOUR

PULSE (0) | TEMP. F (°)

105° 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

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.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS
Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR: 9 Oct | 10 Oct | 10 Oct 03 | 11 | 12 Oct | 12 Oct 03 | 13 Oct | 14 Oct 03

DAY

19 HOUR: 0700 | 2000 | 08

PULSE (O) | TEMP. F (°)

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

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

EPW # [redacted] (b)(6)-7

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 20415

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR OCTOBER DAY: 23 | 24 00 | 24 00 | 25 00 | 26 | 27 | 28

19 HOUR

PULSE (0) | TEMP. F (°) | TEMP. C

105° | 40.6°

180 | 104° | 40.0°

170 | 103° | 39.4°

160 | 102° | 38.9°

150 | 101° | 38.3°

140 | 100° | 37.8°

130 | 99° | 98.6° | 37.2° | 37.0°

120 | 98° | 36.7°

110 | 97° | 36.1°

100 | 96° | 35.6°

90 | 95° | 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record 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)*

[redacted] (b)(6)-4

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) BACK

511–119

NSN 7540–00–634–4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- OLT DAY

MONTH-YEAR 19 | DAY | HOUR

PULSE (0) | TEMP. F (°)

TEMP. C

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (5)(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 - 20417

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 01 OCT 03 | 2 OCT | 3 OCT | 4 OCT | 5 OCT | 6 OCT 03 | 7 OCT

19 | HOUR: 1 | 18 | 09 | 6 | 2 | 0015 | 19 | 20 | 20

PULSE (0) | TEMP. F (°)

PULSE (0)	TEMP. F (°)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

E # [redacted] (b)(6)-1

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (O) | TEMP. F (°)

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

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

TEMP. C

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

(Centigrade Equivalents, for Reference only)

25 Sept 26 Sept 27 Sept 28 Sept 29 Sept 30 Sept

1500 1800 0600 1000 1400 1800 2200 0200 0600 1000

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.

[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 - 20419

(b)(6)-2

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

Ward/Section: FH: ICU HH | [redacted]

LAST, FIRST, MI: EPW# [redacted] (b)(6)-2 | DATE: 24 OCT 03 | TIME: 0800 | SSN/PSEUDO SSN: [redacted]

(Hematology) CBC

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

(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	Yellow	N/A
App	HAZY	N/A
Glu	Yes	Negative
Bili	Yes	Negative
Ket	Yes	Negative
SG	1.030	N/A
Bld	Large	Negative
pH	6.0	N/A
Prot	30	Negative
Urob	0.2	0.2-1.0
Nit	Yes	Negative
Leuk	Yes	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

RBC 10-20 Amorphous Sediment
WBC 5-10 SSH 3+
Yeast present - Large Quantity

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh:

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] **DATE:** 24 OCT 03 **LAB ID NO.:**

(b)(6)-2

(b)(6)-2

Ward/Section: EMT	REQUES[redacted] PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
(b)(6)-4 LAST [redacted] M.	DATE 25 Sept 05	TIME 1140	SSN [redacted] (b)(6)-7

(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	42	
Other		

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 9-25-05	LAB ID NO.:

(b)(6)-2

MEDCOM - 20421

Ward/Section:	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE / TIME	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
[illegible]		138-146 mmol/l

(6)(4)-2

======= PICCOLO =======
25/09/03 14:11
REFERENCE RANGE: MALE
PATIENT #: [redacted]
LIVER PANEL PLUS
DISC LOT #: 3154AA7
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	3.6	3.3-5.5	G/DL
ALP	65	26-84	U/L
ALT	<5*	10-47	U/L
AMY	47	14-97	U/L
AST	33	11-38	U/L
TBIL	0.7	0.2-1.6	MG/DL
GGT	16	5-65	U/L
TP	7.1	6.4-8.1	G/DL

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

======= PICCOLO =======
09/25/03 12:08 PM
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	95	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	0.5*	0.6-1.2	MG/DL
CK	614*	39-380	U/L
NA+	136	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
[illegible]J		73-118 mg/dl
[illegible]N		7-22 mg/dl
[illegible]+		8.0-10.3 mg/dl
[illegible]E		0.6-1.2 mg/dl
[illegible]F		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
[illegible]2		18-33 mmol/l

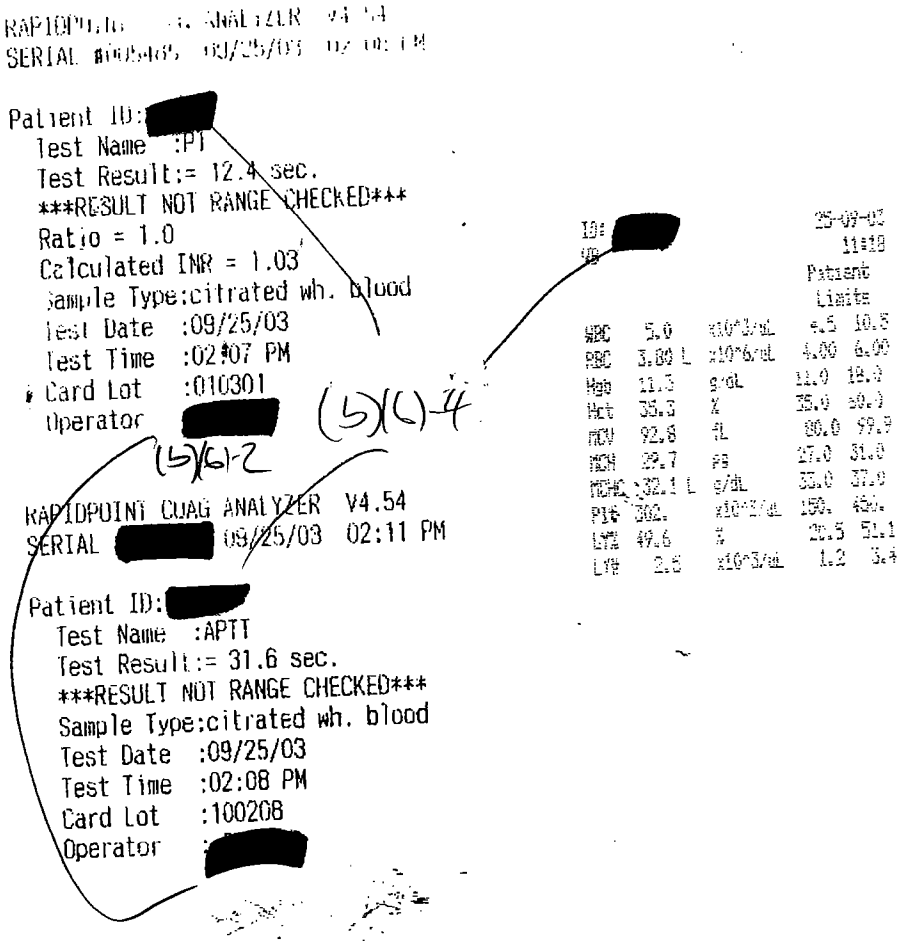
(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
[illegible]+		128-145 mmol/l
		3.3-4.7 mmol/l
[illegible]		98-108 mmol/l
[illegible]O2		18-33 mmol/l

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



RAPIDPoint [illegible] ANALYZER V4.54
SERIAL [illegible] 09/25/03 02:10 PM

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 :09/25/03
Test Time :02:07 PM
Card Lot :010301
Operator [redacted]

(5)(6)-2

(5)(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 09/25/03 02:11 PM

Patient ID: [redacted]
Test Name :APTT
Test Result:= 31.6 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :09/25/03
Test Time :02:08 PM
Card Lot :100208
Operator [redacted]

ID: [redacted]
OP

25-09-03
11:10

			Patient Limits	
WBC	5.0	x10^3/uL	4.5	10.5
RBC	3.80 L	x10^6/uL	4.00	6.00
Hgb	11.3	g/dL	11.0	18.0
Hct	35.3	%	35.0	60.0
MCV	92.8	fL	80.0	99.0
MCH	29.7	pg	27.0	31.0
MCHC	32.1 L	g/dL	33.0	37.0
PLT	302.	x10^3/uL	150.	450.
LY%	49.6	%	20.5	51.1
LY#	2.5	x10^3/uL	1.2	3.4

[redacted] (b)(6)-2

Microbiology Request Form

Last Name: [redacted]
First Name: (b)(6)-4
Patient # or SSN: [redacted]
Collected by: [redacted]
Date: 29Sept 03
Time: 1705

Ward: 16W-1
Room:
Bed:
Physician: [redacted] (b)(6)-2
Source: WBDNs + BDWs (R) TIBIA
Site: (R) TIBIA

[redacted]

Received by: [redacted]
Date: 29Sep03
Time: 1800

Specimen #: [redacted]

Laboratory Results

initial gram stain - no bacteria seen

Proteus penneri Pseudomonas aeruginosa

Reported
Date: 10-2-03
Time: 1230
Tech: [redacted]
Reviewer: [redacted] (b)(6)-2

Number of attached sheets:

Microbiology Report

Name:
Patient ID: [redacted] (5)(6)-4
Ward/Rm: W1/

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1 Proteus penneri
2 Pseudomonas aeruginosa

Status: Final
Status: Final

1 P. penneri

Drug	MIC	Interps
Amox/K Clav (c)	>16/8	R
Amp/Sulbactam (c)	16/8	I
Ampicillin	>16	R
Aztreonam	>16	R
Cefazolin	>16	R
Cefepime	>16	R
Cefotaxime (c)	>32	R
Cefotetan	>32	R
Cefoxitin	>16	R
Ceftazidime (a)	>16	R
Ceftriaxone (c)	>32	R
Cefuroxime (b)	>16	R
Cephalothin	>16	R
Chloramphenicol	<=8	S
Ciprofloxacin	>2	R
ESBL-a Scrn	>4	
ESBL-b Scrn	>1	
Gatifloxacin	<=2	S
Gentamicin	>8	R
Imipenem (c)	>8	R
Levofloxacin	4	I
Meropenem (c)	>8	R
Moxifloxacin	<=2	S
Nitrofurantoin	<=32	
Norfloxacin	>8	
Pip/Tazo (d)	>64	R
Piperacillin (a)	>64	R
Tetracycline	>8	R
Ticar/K Clav (a)	>64	R
Tobramycin	>8	R
Trimeth/Sulfa	>2/38	R

2 P. aeruginosa

Drug	MIC	Interps
Amox/K Clav (c)	>16/8	
Amp/Sulbactam (c)	>16/8	
Ampicillin	>16	
Aztreonam	<=8	S
Cefazolin	>16	
Cefepime	<=8	S
Cefotaxime (c)	32	I
Cefotetan	>32	
Cefoxitin	>16	
Ceftazidime (a)	<=8	S
Ceftriaxone (c)	>32	R
Cefuroxime (b)	>16	
Cephalothin	>16	
Chloramphenicol	>16	
Ciprofloxacin	<=1	S
ESBL-a Scrn	>4	
ESBL-b Scrn	<=1	
Gentamicin	<=4	S
Imipenem (c)	<=4	S
Levofloxacin	<=2	S
Meropenem (c)	<=4	S
Nitrofurantoin	>64	
Norfloxacin	<=4	
Pip/Tazo (d)	<=16	S
Piperacillin (a)	<=16	S
Tetracycline	>8	
Ticar/K Clav (a)	64	S
Tobramycin	<=4	S
Trimeth/Sulfa	>2/38	

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
— = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (S=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints. For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name:
Patient ID: [redacted] (5)(6)-4
Ward/Rm: W1/

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Req. Phys: [redacted]

Printed 10/2/2003 9:56:38 AM

Tech: (5)(6)-2

Arceff Lyn [redacted] (b)(2)-2

Microbiology Request Form

Last Name: [redacted]
First Name: [redacted] (b)(6)-4
Patient # or SSN: [redacted]

Ward: ICW-1
Room:
Bed:
Physician: [redacted]

Collected by: [redacted]
Date: 29 Sep 03
Time: 1705

(b)(4)-2

Source: (R) Tibia
Site:

[redacted]

Received by: [redacted]
Date: 29Sep03
Time: 1400

Specimen #: [redacted]

Laboratory Results

Proteus penneri, Pseudomonas aeruginosa

Reported
Date: 10-2-03
Time: 1230
Tech: [redacted]
Reviewer: [redacted]

Number of attached sheets:

Microbiology Report

(b)(2)-2 [redacted]

Name:
Patient ID: [redacted] (b)(6)-4
Ward/Rm: W1/

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1 Proteus penneri — Status: Final
2 Pseudomonas aeruginosa — Status: Final

1 P. penneri

Drug	MIC	Interps
Amox/K Clav (c)	>16/8	R
Amp/Sulbactam (c)	16/8	I
Ampicillin	>16	R
Aztreonam	>16	R
Cefazolin	>16	R
Cefepime	>16	R
Cefotaxime (c)	>32	R
Cefotetan	>32	R
Cefoxitin	>16	R
Ceftazidime (a)	>16	R
Ceftriaxone (c)	>32	R
Cefuroxime (b)	>16	R
Cephalothin	>16	R
Chloramphenicol	<=8	S
Ciprofloxacin	>2	R
ESBL-a Scrn	>4	
ESBL-b Scrn	>1	
Gatifloxacin	<=2	S
Gentamicin	>8	R
Imipenem (c)	>8	R
Levofloxacin	4	I
Meropenem (c)	>8	R
Moxifloxacin	<=2	S
Nitrofurantoin	<=32	
Norfloxacin	>8	
Pip/Tazo (d)	>64	R
Piperacillin (a)	>64	R
Tetracycline	>8	R
Ticar/K Clav (a)	>64	R
Tobramycin	>8	R
Trimeth/Sulfa	>2/38	R

2 P. aeruginosa

Drug	MIC	Interps
Amox/K Clav (c)	>16/8	
Amp/Sulbactam (c)	>16/8	
Ampicillin	>16	
Aztreonam	<=8	S
Cefazolin	>16	
Cefepime	<=8	S
Cefotaxime (c)	32	I
Cefotetan	>32	
Cefoxitin	>16	
Ceftazidime (a)	<=8	S
Ceftriaxone (c)	>32	R
Cefuroxime (b)	>16	
Cephalothin	>16	
Chloramphenicol	>16	
Ciprofloxacin	<=1	S
ESBL-a Scrn	>4	
ESBL-b Scrn	<=1	
Gentamicin	<=4	S
Imipenem (c)	<=4	S
Levofloxacin	<=2	S
Meropenem (c)	<=4	S
Nitrofurantoin	>64	
Norfloxacin	<=4	
Pip/Tazo (d)	<=16	S
Piperacillin (a)	<=16	S
Tetracycline	>8	
Ticar/K Clav (a)	64	S
Tobramycin	<=4	S
Trimeth/Sulfa	>2/38	

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
— = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

Levaquin 500mg IV QD

For blood and CSF isolates, a beta-lactamase test is recommended for Enterococcus species.

Zosyn 3.375gm IV q 6°

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints. For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name:
Patient ID: [redacted] (b)(6)-4
Ward/Rm: W1/

Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected: (b)(6)-2
Req. Phys: [redacted]

Printed 10/2/2003 9:56:38 AM

Tech: _____

[redacted] (b)(6)-7

Microbiology Request Form

Last Name: Ward: ICW1

First Name: Room:

Patient # or SSN: [redacted] (b)(6)-7 Bed:

Physician: [redacted]

Collected by: [redacted]

Date: 29 SEP 03 (b)(6)-7 Source:

Time: 1705 Site: R TIBIA

[redacted]

Received by: [redacted] Specimen #: [redacted]

Date: 29 SEP 03

Time: 1800

Laboratory Results

PROTEUS PENNERI/	**PSEUDOMONAS AERUGINOSA**

Reported

Date: 2 OCT 03

Time: 1230

Tech: [redacted]

Reviewer: [redacted] Number of attached sheets:

Microbiology Report

Name: (b)(2)-2 [redacted]
Patient ID: [redacted] (b)(6)-4
Ward/Rm: W1/
Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:
Status: Final
Collected:
Attd. Phys:

1 Proteus penneri
2 Pseudomonas aeruginosa

Status: Final
Status: Final

1 P. penneri

Drug	MIC	Interps
Amox/K Clav (c)	>16/8	R
Amp/Sulbactam (c)	16/8	I
Ampicillin	>16	R
Aztreonam	>16	R
Cefazolin	>16	R
Cefepime	>16	R
Cefotaxime (c)	>32	R
Cefotetan	>32	R
Cefoxitin	>16	R
Ceftazidime (a)	>16	R
Ceftriaxone (c)	>32	R
Cefuroxime (b)	>16	R
Cephalothin	>16	R
Chloramphenicol	<=8	S
Ciprofloxacin	>2	R
ESBL-a Scrn	>4	
ESBL-b Scrn	>1	
Gatifloxacin	<=2	S
Gentamicin	>8	R
Imipenem (c)	>8	R
Levofloxacin	4	I
Meropenem (c)	>8	R
Moxifloxacin	<=2	S
Nitrofurantoin	<=32	
Norfloxacin	>8	
Pip/Tazo (d)	>64	R
Piperacillin (a)	>64	R
Tetracycline	>8	R
Ticar/K Clav (a)	>64	R
Tobramycin	>8	R
Trimeth/Sulfa	>2/38	R

2 P. aeruginosa

Drug	MIC	Interps
Amox/K Clav (c)	>16/8	
Amp/Sulbactam (c)	>16/8	
Ampicillin	>16	
Aztreonam	<=8	S
Cefazolin	>16	
Cefepime	<=8	S
Cefotaxime (c)	32	I
Cefotetan	>32	
Cefoxitin	>16	
Ceftazidime (a)	<=8	S
Ceftriaxone (c)	>32	R
Cefuroxime (b)	>16	
Cephalothin	>16	
Chloramphenicol	>16	
Ciprofloxacin	<=1	S
ESBL-a Scrn	>4	
ESBL-b Scrn	<=1	
Gentamicin	<=4	S
Imipenem (c)	<=4	S
Levofloxacin	<=2	S
Meropenem (c)	<=4	S
Nitrofurantoin	>64	
Norfloxacin	<=4	
Pip/Tazo (d)	<=16	S
Piperacillin (a)	<=16	S
Tetracycline	>8	
Ticar/K Clav (a)	64	S
Tobramycin	<=4	S
Trimeth/Sulfa	>2/38	

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints. For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name:
Patient ID: [redacted] (b)(6)-4
Ward/Rm: W1/
Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:
Status: Final (b)(6)-2
Collected:
Req. Phys: [redacted]

Printed 10/5/2003 10:04:45 AM

Page 1 of 1

Tech:

MEDCOM - 20429

Microbiology Report

Name: (b)(6)-2 [redacted]
Patient ID: [redacted]
Ward/Rm: W1/ (b)(6)-7
Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:
Status: Final
Collected:
Attd. Phys:

1 Proteus penneri
2 Pseudomonas aeruginosa

Status: Final
Status: Final

1 P. penneri

Drug	MIC	Interps
Amox/K Clav (c)	>16/8	R
Amp/Sulbactam (c)	16/8	I
Ampicillin	>16	R
Aztreonam	>16	R
Cefazolin	>16	R
Cefepime	>16	R
Cefotaxime (c)	>32	R
Cefotetan	>32	R
Cefoxitin	>16	R
Ceftazidime (a)	>16	R
Ceftriaxone (c)	>32	R
Cefuroxime (b)	>16	R
Cephalothin	>16	R
Chloramphenicol	<=8	S
Ciprofloxacin	>2	R
ESBL-a Scrn	>4	
ESBL-b Scrn	>1	
Gatifloxacin	<=2	S
Gentamicin	>8	R
Imipenem (c)	>8	R
Levofloxacin	4	I
Meropenem (c)	>8	R
Moxifloxacin	<=2	S
Nitrofurantoin	<=32	
Norfloxacin	>8	
Pip/Tazo (d)	>64	R
Piperacillin (a)	>64	R
Tetracycline	>8	R
Ticar/K Clav (a)	>64	R
Tobramycin	>8	R
Trimeth/Sulfa	>2/38	R

2 P. aeruginosa

Drug	MIC	Interps
Amox/K Clav (c)	>16/8	
Amp/Sulbactam (c)	>16/8	
Ampicillin	>16	
Aztreonam	<=8	S
Cefazolin	>16	
Cefepime	<=8	S
Cefotaxime (c)	32	I
Cefotetan	>32	
Cefoxitin	>16	
Ceftazidime (a)	<=8	S
Ceftriaxone (c)	>32	R
Cefuroxime (b)	>16	
Cephalothin	>16	
Chloramphenicol	>16	
Ciprofloxacin	<=1	S
ESBL-a Scrn	>4	
ESBL-b Scrn	<=1	
Gentamicin	<=4	S
Imipenem (c)	<=4	S
Levofloxacin	<=2	S
Meropenem (c)	<=4	S
Nitrofurantoin	>64	
Norfloxacin	<=4	
Pip/Tazo (d)	<=16	S
Piperacillin (a)	<=16	S
Tetracycline	>8	
Ticar/K Clav (a)	64	S
Tobramycin	<=4	S
Trimeth/Sulfa	>2/38	

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
— = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints. For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name:
Patient ID: [redacted] (b)(6)-7
Ward/Rm: W1/
Specimen: [redacted]
Source: Wound/Sterile site
Ward of Iso:
Status: Final
Collected: (b)(6)-7
Req. Phys: [redacted]

Printed 10/11/2003 10:20:26 AM

Tech:

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)	
FENTANYL	( )	150/100
PROPOFOL	( )	150
	( )	
	( )	
	( )	
	( )	
VOLAT AGENT	FORANE – % del	2.0/2.0/1.5/1.0/1.0%
	% e.t.	
	AIR L/Min	
	N2O L/Min	
	O2 L/Min	7 / 4 / 4 / 4 / 4 – 8

SINGLE DOSE DRUGS – MARK ON GRID WITH NUMBERS & ENTER IN REMARKS (2)

FLUIDS

LINE site		
(4) ES 18g	☐ Warmed	NS — 500
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS — URINE –

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 50 (KG) LB

HEMATOCRIT:

INITIAL DATA: BP – 94/49 HR– 86

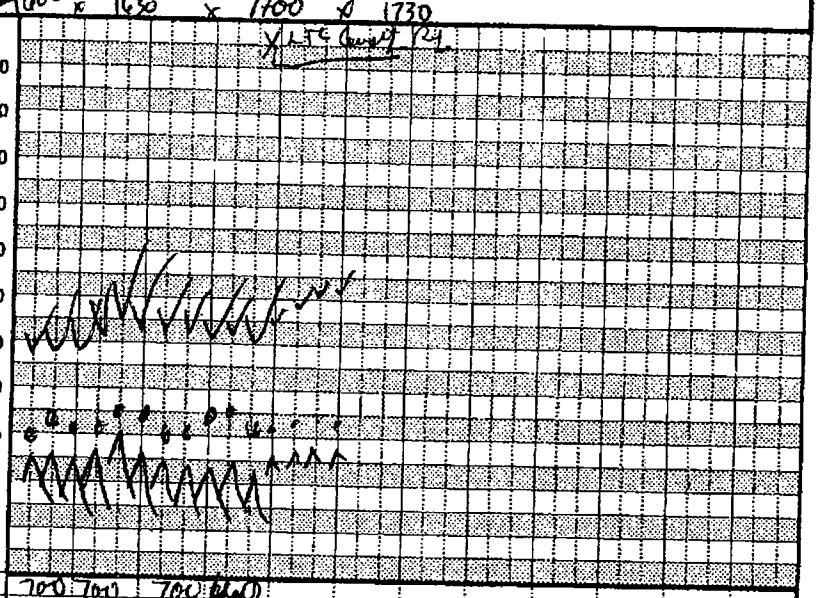
BLOOD CHECK: OK?– (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y TIME– 1605

TIME → 1600 x 1630 x 1700 x 1730

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

220 200 180 160 140 120 100 80 60 40 20



VENTILATION

VT – ml	700	700	700	600			
f – breaths/min	10	10	10	10	10	8	
Peak inf pres / PEEP	/	/	/	/	/		
MODE– S(pon), A/assist), C(on)	SV	SV	SV	SV	SV		

MONITORS & ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	51	53	42	60	60	
BP / oth	✓ FIO2 (Frac or %)	0.55	0.55	0.55	0.55	55	
ART line	✓ SpO2 (%)	100	100	100	100	100	
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SA	
Gas analyzer	✓ TEMP- site	>34° (SKIN)					
	✓ N-M Block (T/4)						
Warming blkt							
Conv warmer							

Mark with letters & symbols, explain under REMARKS. EVENTS — Position → R L C

TOTALS: 200 min

TOTAL URINE: 100

FLUIDS - SUMMARY

CRYSTALLOID– LR 700

COLLOID– 0

BLOOD– 0

REMARKS–

Code drugs with numbers, events with letters

(1) PT ID IN ICU 3-10 OR.
(2) RM-O2 monitors

procedure done to surgery & assist to PACU awake

RECOVERY AT 1722

PACU ICU (Specify)

OTHER

CONDITION: Awake

RESP– 12 SpO2– 96% on RA

BP– 122/44 HR– 110

ANESTHESIA PROVIDER TIMES

	Start	Room	End
ANES	1550	1603	1725
PROC	Ready	Begin	End
	1607	1617	1715

PROCEDURES and CPT Codes: CYST10 / I & D (2) EXT.

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GA-MASK

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments – #10 ETT Anest. FM c shop

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

[redacted]

(5)(6)-4

SURGEON: [redacted]

ANESTHETIST: [redacted] CAT CRNA

(5)(6)-2

PROCEDURE LOCATION: OR 1

DATE: 9.29.03

PAGE 1 OF

WAMC OP 376 REVISED 1 Jan 99

PATIENT RECORD

MEDCOM - 20431

NKDA NKA

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)					
Fentanyl	(mcg)	50	50	50	50	50
Lidocaine	(mg)	90				
Propofol	(mg)	200				
	( )					
	( )					
	( )					
VOLAT AGENT	50 % del / % e.t.	1.0	2.0	1.5	0.4	X
AIR	L/Min					
N2O	L/Min					
O2	L/Min	10	~2	~2	2	10

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

TOTALS	TOTAL RBC
250	< 50
90	
200	TOTAL URINE
	500

FLUIDS - SUMMARY
CRYSTALLOID – 400
COLLOID – 0
BLOOD – 0

FLUIDS
LINE site 18 (L) ET ☐ Warmed — LR
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES
EST BLOOD LOSS – NSP
URINE – 500

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 50 (KG) LB

HEMATOCRIT: 35

INITIAL DATA: BP – 140/58; HR – 80

BOOBY CHECK: OK? – (Y) N

PATIENT RECHECK: OK for PROCEDURE? JA; TIME – 0915

TIME: 0930 . 1000 . 30 . 1100

SYMBOLS: BP by cuff (V ^); Heart rate (●); Resp rate; BP (transduced) (1 T); TOURNIQUET (T – X); ANES – X-X; PROC – (0) – 0

220 200 180 160 140 120 100 80 60 40 20

VENTILATION

VT – ml	+	500	500	500	
f – breaths/min	+	6	4	4	
Peak Inf pres / PEEP	—	13	13	13	
MODE – S(pon), A(ssist), C(on)	S	C	C	C	

MONITORING ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	+	45	53	54	
BP / oth	FIO2 (Frac or %)	0.7	0.7	0.7	0.7	
ART line	SpO2 (%)	100	100	100	100	
Steth- PC/ES	ECG	SR	SR	SR	SR	
Gas analyzer	TEMP- site: axillary					
	N-M Block (T/4)					
	BS	+				
Warming blkt	1 sheet					
Conv warmer						

Mark with letters & symbols, explain under REMARKS — EVENTS (1) (2) (3) (4) — Position → 0 — 1

REMARKS-
Code drugs with numbers, events with letters
(1) Lungs CTA (B) HR RR (E) (2)
(2) Room, monitors, 100% O2 > Induced eyelids taped
(3) RR >8 & < 30 BPM TV > 4 ml/kg LMA removed no complications
(4) To PACU. Report to nurse.

RECOVERY AT: 1025
(PACU) ICU _____ (Specify)
OTHER _____
CONDITION: Stable
RESP – 30 SpO2 – 99
BP – 143/50 HR – 117

ANESTHESIA PROCEDURE TIMES

	Start	Room	End
ANES	0910	0930	1035
	Ready	Begin	End
PROC	0945	0948	1018

PROCEDURES and CPT Codes
I+D (R) leg wound + Drain JP placement

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GLMA

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical Facility
[redacted] (5)(6)-7 (b)(6)-2

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
LMA #4; Seated 40ml air into cuff + BBS
Sust ETCO2

SURGEONS: [redacted]
ANESTHETISTS: [redacted] CRNA/MAS

PROCEDURE LOCATION: 1 (One)
DATE: 1 Oct 03
PAGE 1 OF 1

NAVMED 6700/376 REVISED 1 Jan 99
PATIENT RECORD

MEDCOM - 20432

NKDA   No Δ from last Anesthetic 29 Oct 03

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)	Doses	TOTALS
Fentanyl	(mcg)	(150) (100)	250
Zemuron	(mg)	(30) 10	40
Propofol	(mg)	(150)	150
MSO4	(mg)	(5)	5
VOLAT AGENT Iso	% del	1.0 — 1.0 — 0.8 X	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	10 — 2 — 2 — 2 — 10	

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

TOTAL EBL: 50
TOTAL URINE: 50

FLUIDS
LINE site: (L) IJ x3 — Warmed ☐ — LR —— 200 —— 300

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

LOSSES
EST BLOOD LOSS
URINE - Foley 300

PHYS STATUS: 1 (2) 3 4 5 E
BODY WEIGHT: 50 (KG) LB
HEMATOCRIT: N/A
INITIAL DATA:
BP- 102/58
HR- 64
EQUIP CHECK OK?- (Y) N
PATIENT RECHECK
OK for PROCEDURE? Okay
TIME-

TIME → 1300 15 30 45 1400 15 30 45 1500

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

VENTIL

VT - ml	—	660	620	600	1000
f - breaths/min	16	8	8	8	10
Peak inf pres / PEEP	—	18	18	18	—
MODE - S(pon), A(ssist), C(on)	S	C	C	C	S

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	(+)	31	32	32	34
BP/oth	X FIO2 (Frac or %)	.77	.77	.77	.77	.77
ART line	X SpO2 (%)	100	100	100	100	100
Steth- PC/ES	X ECG	SR	SR	SR	SR	SR
Gas analyzer	X TEMP-site	Axillary				
	X N-M Block (T/4)	4/4			4/4	4/4 sustained
Warming blkt						
Conv warmer						

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

REMARKS
Code drugs with numbers, events with letters

1300 Pt id as ID'd, chart reviewed,
1305 In OR, (+) monitors (+) O2, smooth IV induction, easy ventilation, pressure pts padded, Eyes taped.
1345 4mg Zofran IV
1400 Anesthesia off 2— wean for ECC deli[illegible]
1405 Pt awake. No sx, Extubated s diff. Moved self to litter To PACU [redacted]

RECOVERY AT 1315
(PACU) ICU ____ (Specify)
OTHER
CONDITION: Stable
RESP- 16 SpO2- 100
BP- 126/80 HR- 82

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1300	1305	1320
	Ready	Begin	End
PROC	1315	1338	1310

PROCEDURES and CPT Codes:
I&D (R) leg; STSG (R) Thigh

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
DL x1 attempt c MAC 3, # 7.0 ETT, Grade I view (+)BBS (+) ETCO2 secured @ 22 cm teeth, soft bite block placed

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility
[redacted]
(5)(6)-4
(5)(6)-2

SURGEONS [redacted]

ANESTHETISTS [redacted] CPT CRNA

PROCEDURE LOCATION: OR 2
DATE: 20 Oct 03
PAGE 1 OF 1

DA FORM 7389, FEB 1998
COPY 1 - PATIENT'S MEDICAL RECORD   USAPA V1.00
MEDCOM - 20433

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS / REPEATED DRUGS; SPECIFY UNITS – MG / MCG / ML; "( )" = CONSTANT INFUSION

DRUG	Units		TOTALS
fentanyl	(mg)	150	150
Propofol	(mg)	200	
Versed	(mg)	2	2
	( )		
	( )		
	( )		
VOLAT AGENT Iso	% del	2.0	
	% e.t.		
AIR	L/Min		
N2O	L/Min		
O2	L/Min	10 – 3 – 10 – 10	

TOTAL ... (min)

TOTAL URINE: 100 cc

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

FLUIDS

LINE site: 18 (L) ES — ☐ Warmed — LR (1000)

☐ Warmed
☐ Warmed
☐ Warmed

LOSSES — EST BLOOD LOSS: ; URINE – Foley

FLUIDS – SUMMARY

CRYSTALLOID – 250 cc

COLLOID – Ø

BLOOD – Ø

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 50 KG

HEMATOCRIT:

INITIAL DATA: BP – 100/59; HR – 78

EQUIP CHECK: OK? – Y N

PATIENT READINESS: OK for PROCEDURE? – Okay; TIME – 1030

TIME: 0930 45 1000 15 30

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

VENTILATION

VT – ml	–	700		
f – breaths/min	20	16		
Peak inf pres / PEEP	–	–	–	–
MODE – S(pon), A(ssist), C(on)	S	A	A	S

MONITORS / ACCESSORIES

✗ BP/Auto Cuff	✗ ET CO2 (torr)	+	30
BP / oth	✗ FIO2 (Frac or %)	.56	.56
ART line	✗ SpO2 (%)	100	100
Steth – PC/ES ✗	✗ ECG	SR	SR
Gas analyzer	✗ TEMP – site skin	Available	
	N-M Block (T/4)		
Warming blkt			
Conv warmer			

Mark with letters & symbols, explain under REMARKS — EVENTS

Position — G →

REMARKS — Code drugs with numbers, events with letters

0930 Pt id in ICW1. Chart reviewed. To OR via litter.
0940 In room, ⊕ monitors ⊕ O2, smooth IV/mask induction, Eyes taped, PP padded,
0957 Procedure started
1025 Pt awake, to PACU awake, Report to [redacted]

RECOVERY AT 1030 — PACU ✓ ICU ____ (Specify) OTHER

CONDITION: Stable / awake

RESP – ; SpO2 – ; BP – 120/74; HR – 96

ANESTHESIA / PROCEDURE TIME

	Start	Room	End
ANES	0930	0940	1035
	Ready	**Begin**	**End**
PROC	0950	0957	1023

PROCEDURES and CPT Codes

I&D (R) leg

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — #5 FM, oral airway, (b)(6)-2

SURGEONS: [redacted]

ANESTHESIA: [redacted]

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

EPW # [redacted]

(b)(6)-4

PROCEDURE LOCATION: OR 2

DATE: 4 Oct 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED Jan 99

MEDCOM - 20434

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

(b)(6)-C

Rt. open Tib NKA Proteus/Pseudomonas 8-/49-54 S.J. 58"L [redacted] HT cm

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)												
Fent	( )	250											
Sux	( )												
Propofol	( )	100											
Versed	( )	2.5											
Ms304	( )	10/10											
	( )												
VOLAT AGENT Forane / del % e.t.		06	0.6	X									
AIR L/Min													
N2O L/Min													
O2 L/Min		8	2	8									

SINGLE DOSE DRUGS-MARK ON GRID → WITH NUMBERS & ENTER IN REMARKS: (1) (2) (3)

FLUIDS

LINE site													
18g (1) LA	☐ Warmed												
	☐ Warmed												
	☐ Warmed												
	☐ Warmed												

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 50 (KG) LB

HEMATOCRIT:

INITIAL DATA:

BP- 90 / 50

HR- 86

EQUIP CHECK

OK?- (Y) N

PATIENT RECHECK

OK for PROCEDURE? Y

TIME-

TIME 1445 1500 X 1530

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	600	810	710
f - breaths/min	12	12	8
Peak inf pres / PEEP			
MODE - S(pon), A(ssist), C(on)	SV	AV	

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	39	48	52
BP/oth	✓ FIO2 (Frac or %)	0.62	0.62	0.62
ART line	✓ SpO2 (%)	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR
Gas analyzer	✓ TEMP-site	Axil		
	(N-M Block (T/4)			
Warming blkt				
Conv warmer				

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

TOTALS

TOTAL EBL	TOTAL URINE
0	0

FLUIDS - SUMMARY

CRYSTALLOID- 300

COLLOID-

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

(1) RTO IN ICU1 - moves self to stretcher

(2) RM-02-MON.

(3) OOR TO PACU

(4) RPT TO PACU

RECOVERY AT 1530

PACU / SCU (Specify)

OTHER

CONDITION: alert - talking

RESP- SpO2- 99

BP- HR- 118

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1435	1445	1535
PROC	Ready	Begin	End
	1457	1500	1520

PROCEDURES and CPT Codes:

I & D R Tib

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

[redacted] WDI 2G

(b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GA - Mask

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

Mask c #90A

S[redacted] (b)(6)-C

A[redacted]

PROCEDURE LOCATION: 1-1

DATE: 7 OCT 05

PAGE 1 OF 1

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MEDCOM - 20435

986

MVI Levequin
Ativan
20SM

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)					
Versed (mg)	3/2				
MSO4 (mg)	5/5				
Lido Propofol (mg)	50/200				
VOLAT AGENT Forane % del		2	1	X	
% e.t.					
AIR L/Min					
N2O L/Min					
O2 L/Min	3	2	1	10	

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

TOTALS	TOTAL EBL
5 mg 10 mg	Ø
	TOTAL URINE: Ø

FLUIDS - SUMMARY
CRYSTALLOID- LR 700
COLLOID- Ø
BLOOD- Ø

FLUIDS
LINE site LR 1000 ☐ Warmed
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES EST BLOOD LOSS
URINE -

PHYS STATUS 1 (2) 3 4 5 E
BODY WEIGHT: 5 (KG) LB
HEMATOCRIT:
INITIAL DATA:
BP- 98/59
HR- 67
EQUIP CHECK OK?- (Y) N
PATIENT RECHECK OK for PROCEDURE? TIME- 1100

TIME → X 30 X 12

SYMBOLS: BP by cuff V ^; 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
1110 in OR monitors applied
1116 proseal placed (+) ETCO2 (+) BBS
1200 spont resp oral suction proseal out to PACU, talking report given.

VENTIL

VT - ml	50	50	SV	SV
f - breaths/min	5	5	8	10
Peak inf pres / PEEP	12	12		
MODE - S(pon), A(ssist), C(on)	C	C	SV	SV

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	42	42	46	44
BP/oth	✓ FIO2 (Frac or %)	.78	.78	.78	.78
ART line	✓ SpO2 (%)	100	100	100	
Steth- PC/ES	✓ ECG	SR	SR		
Gas analyzer	✓ TEMP-site	Available			
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

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

RECOVERY AT 1205
(PACU) ICU ____ (Specify)
OTHER
CONDITION: awake talking
RESP- 10 SpO2- 100
BP- 88/44 HR- 63

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1045	1110	1220
	Ready	Begin	End
PROC	1120	1130	1151

1215

PROCEDURES and CPT Codes:
I&D (R) Tibia, Replace Vac

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
#4 Proseal placed x2 attempts

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] ICN 1
(b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
(+) ETCO2 (+) BBS

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

PROCEDURE LOCATION: OR 2
DATE: 10/10/03
PAGE 1 OF 1

[redacted] 97.3-64-18 SpO2 98% 107/54 [redacted] 10/10/03 [redacted]

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)			
Versed (mg)	2		
( )			
Fent ( )	60		
Lido ( )	100		
Propo ( )			
( )			
VOLAT AGENT Forane % del	x 2	-2-	1.2
% e.t.			
AIR L/Min			
N2O L/Min			
O2 L/Min	4	2	4

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

FLUIDS

LINE site			
L FA ☐ Warmed	200	800	
☐ Warmed			
☐ Warmed			
☐ Warmed			

LOSSES EST BLOOD LOSS / URINE -

TOTALS	TOTAL EBL
	min
	TOTAL URINE
	∅

FLUIDS - SUMMARY
CRYSTALLOID- LR 400
COLLOID- ∅
BLOOD- /

REMARKS
Code drugs with numbers, events with letters

preop PNV
stelle most
INDUCTION

procedure
done to
PACU AWAKE

PHYS STATUS: 1 (2) 3 4 5 E
BODY WEIGHT: 50 (KG) LB
HEMATOCRIT:
INITIAL DATA:
BP- 109/55
HR- 40
EQUIP CHECK OK?- (Y) N
PATIENT RECHECK OK for PROCEDURE yes
TIME- 1050

TIME → 11⁰⁰ 10 30 X

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

(Grid annotations: 1.5C Gutstein Prep BARBARA)

VENTIL

VT - ml				
f - breaths/min		6	4	
Peak inf pres / PEEP				
MODE - S(pon), A(ssist), C(on)	S	C	A	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	+	50	38	
BP/oth	FIO2 (Frac or %)	.6	.6	.6	
ART line	✓ SpO2 (%)	100	100	99	
Steth- PC/ES	✓ ECG	SB	SR	SR	
Gas analyzer	TEMP-site	UNAVAILABLE			
	N-M Block (T/4)				
Warming blkt					
Conv warmer					

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

RECOVERY AT 1145
(PACU) ICU ______ (Specify)
OTHER
CONDITION: T.96
RESP- 16 SpO2-
BP- HR- 64

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1050	1105	1150
	Ready	**Begin**	**End**
PROC	1110	1120	1140

PROCEDURES and CPT Codes:
I & D open (R) tibia

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

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

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
[redacted] Wd 1 Bed 4B
(b)(6)-4
[redacted]

SURGEONS: [redacted]

ANESTHETISTS: [redacted] CRNA

PROCEDURE LOCATION: OR 1
DATE: 10/15/03
PAGE 1 OF 1

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[redacted]

MEDCOM - 20437

No Δ from last Anesthetic 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
Propofol (mg)	200			200
Fentanyl (mcg)	100			100
VOLAT AGENT Sevo % del	1.5	1.5	X	
% e.t.				
AIR L/Min				
N2O L/Min				
O2 L/Min	10	3	10	

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

TOTAL EBL: min

TOTAL URINE: 300

FLUIDS - SUMMARY
CRYSTALLOID- 400cc
COLLOID- Ø
BLOOD- Ø

FLUIDS: LINE site Ⓛ ES ☐ Warmed — LR ——— (400)

LOSSES: EST BLOOD LOSS —; URINE - Foley (300)

PHYS STATUS: 1 2 3 4 5 E (2 circled)

BODY WEIGHT: 50 KG

HEMATOCRIT:

INITIAL DATA: BP- 115/58; HR- 75

EQUIP CHECK OK?- Y N (Y circled)

PATIENT RECHECK OK for PROCEDURE? Okay TIME- 1045

TIME → 1045 1100 15 30 45 1200

SYMBOLS: BP by cuff ∨ ∧; 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

VENTIL

VT - ml	—	—	370	400	500
f - breaths/min	20	16	10	10	12
Peak inf pres / PEEP	—	—	13	13	—
MODE - S(pon), A(ssist), C(on)	S	S	S	S	S

MONITORS/ACCESSORIES

X BP/Auto Cuff	X ET CO2 (torr)	+	+	⊕	42	38
BP/oth	X FIO2 (Frac or %)	.69	.69	.69	.69	.69
ART line	X SpO2 (%)	100	100	100	100	100
Steth- PC/ES	X ECG	SR	SR	SR	SR	SR
Gas analyzer	X TEMP-site	Available ———				
	N-M Block (T/4)					
Warming blkt						
Conv warmer						

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

REMARKS
Code drugs with numbers, events with letters
1030 Pt. Id. ICW, To OR via litter,
1045 In room, ⊕ monitors ⊕ O2, Attempt IV Ⓛ hand, Ⓡ ES,
1110 IV started Ⓛ ES.
1155 To PACU - Stable, Report to [redacted]

RECOVERY AT 1155
PACU ICU ____ (Specify) (PACU circled)
OTHER
CONDITION: Stable 100%
RESP- 16 SpO2-
BP- 120/70 HR- 89

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1030	1045	1200

	Ready	Begin	End
PROC	1120	1130	1150

PROCEDURES and CPT Codes: I&D Ⓡ leg

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GA

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

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* Anesthesia mask - oral Airway

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

A[redacted]

PROCEDURE LOCATION: OR 2

DATE: 18 Oct 03

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MEDCOM - 20438

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
MSO4 (mg)	5			
Propofol (mg)	150			
Fentanyl (mg)	50		50	100
Ephedrine (mg)		10		10
( )				
( )				
VOLAT AGENT Hal % del	1.3 - .9 - .8 X			
% e.t.				
AIR L/Min				
N2O L/Min				
O2 L/Min	3 - 3 - 3 - 0			

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

TOTAL EBL: min

TOTAL URINE: 100

FLUIDS - SUMMARY
CRYSTALLOID- 100cc
COLLOID- Ø
BLOOD- Ø

FLUIDS
LINE site
18g (L) IJ — LR →
☐ Warmed ☐ Warmed ☐ Warmed ☐ Warmed

LOSSES
EST BLOOD LOSS
URINE - Foley 100

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 50 (KG) LB

HEMATOCRIT:

INITIAL DATA:
BP- 92/57
HR- 59

EQUIP CHECK
OK?- (Y) N

PATIENT RECHECK
OK for PROCEDURE: Okay
TIME-

TIME ▶ 1045 1100 15 30 45

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

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

VENTIL
VT - ml	—	—	—
f - breaths/min	16	12	12
Peak inf pres / PEEP	—	—	—
MODE - S(pon), A(ssist), C(on)	S	S	S

MONITORS/ACCESSORIES
X BP/Auto Cuff	X ET CO2 (torr)	40	43	41
BP/oth	X FIO2 (Frac or %)	>.21	>.21	>.21
ART line	X SpO2 (%)	100	100	100
Steth- PC/ES	X ECG	SR	SR	SR
Gas analyzer	TEMP-site	Available →		
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

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

REMARKS
Code drugs with numbers, events with letters
1030 Pt id as ICW, chart reviewed, TC OR.
1045 In room, ⊕ monitors, ⊕O2, Smooth IV/inhalation induction. Eyes taped, nose/ears free pressure.
1025 Pt awake to PACU - stable

RECOVERY AT 1125
(PACU) ICU ______ (Specify)
OTHER
CONDITION: Stable
RESP- 7 SpO2- 100 97
BP- 104/58 HR- 73

ANESTHESIA / PROCEDURE TIMES
	Start	Room	End
ANES	1030	1045	1130

	Ready	Begin	End
PROC	1050	1103	1122

PROCEDURES and CPT Codes: I&D (R) leg

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
Inhalation Anesthetic — oral Airway

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

AIRWAY MANAGEMENT: intubation route, blade, technique, comments
Anesthesia Mask

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

ANESTHETIST [redacted]

PROCEDURE LOCATION: OLZ
DATE: 24 Oct 03
PAGE 1 OF 1

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MEDCOM - 20439

ACLU-RDI 1656 p.199

DOD-034013

MEDICAL RECORD - ANESTHE[illegible]

[illegible] of this form, see AR 40-66; the proponent agenc[illegible] OTSG

NKDA

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

DRUG (Units)							
Phenergan (mg)	25						
MSO4 ( )	5	2	3				
Lidocaine (2)	100						
Propofol (2)	200	80					
( )							
VOLAT AGENT ISO % del		0.6	2.0	2.0	2.0	2.0	X
% e.t.							
AIR L/Min							
N2O L/Min							
O2 L/Min	10→	2	2	2	2	2	

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

FLUIDS — LINE site (L) IJ CVL ☐ Warmed; ☐ Warmed; ☐ Warmed; ☐ Warmed

LR-#1

LOSSES — EST BLOOD LOSS; URINE - 300 25 50

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 50 (KG) LB

HEMATOCRIT: —

INITIAL DATA
BP- 112/54
HR- 60

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK
OK for PROCEDURE? JR
TIME- 1245

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

TIME 1300 · 30 · 1400 · 30 · 1500

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	±	610	520	330	250	250
f - breaths/min	—	7	6	12	11	8
Peak inf pres / PEEP	—	16	15	—	—	—
MODE - S(pon), A(assist), C(on)	S→	C	C	S	S	S
ET CO2 (torr)	+	34	36	53	55	60
FIO2 (Frac or %)	0.64	0.64	0.64	0.64	0.64	0.64
SpO2 (%)	100	100	100	100	100	100
ECG	SR	SR	SR	SR	SR	SR
TEMP-site available	—			Skin		
N-M Block (T/4)	BS	T	/	t		

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

Warming blkt: X | wool blanket →

Mark with letters & symbols, explain under REMARKS — EVENTS / Position → (1) supine (2) (3)

REMARKS
Code drugs with numbers, events with letters
(1) Pre-op. IOOR monitors; O2 induced; eyelids taped closed
(2) OA placed - removal of LMA SO>8+<30BPM TV>4ml/kg. +ETCO2
(3) To PACU. Report to nurse

TOTALS

	TOTAL EBL
25	50
10	
100	TOTAL URINE
280	300

FLUIDS SUMMARY
CRYSTALLOID- 500
COLLOID- ∅
BLOOD- ∅

RECOVERY AT 1420
(PACU) ICU ____ (Specify)
OTHER ____
CONDITION: Stable; asleep
RESP- 8 SpO2- 99
BP 116/78 HR- 75

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1245	1300	1425
PROC	Ready	Begin	End
	1310	1330	1415

PROCEDURES and CPT Codes:
I+D (R) tibia + soft tissue flap

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GLMA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* LMA #4 Placed, sealed 20ml air cuff + BBS Sust ETCO2

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

[redacted]

(b)(6)-1

SURGEONS: [redacted]

PROCEDURE LOCATION: 2 (1)

DATE: 29 Oct 03

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[redacted] MEDICAL RECORD

(b)(6)-2

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