Automated Facsimile [b)(3)-1]

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[b)(6)-4]	[b)(6)-4]					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M		X	MUSLIM			NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[b)(6)-4]					ICU	
15. FlyStatus	17. Dept / Ben		18. BranchCorps	19. UIC / ZIP		20. Type Case	
	K78-PRISONER OF WAR/INTER					DIS	
21. Source of Admission			22. Hour Of Adm:	23. Clinic Service			
Direct from ER			10:00	AEA - ORTHOPEDICS			
24. Name/Relation of Emergency Addressee			25. Type Disp	26. Date of Disp			
			TRF C-ACF	2003-06-15			
27a. Address of Emergency Addressee			27b. Telephone No	28. Date This Adm:		AdmittingOfficer:	
				2003-06-11		[b)(6)-2]	
29. ReportingMTF				30. Date Init Adm		32. Units Blood Components	
[b)(3)-1]				~~2003-06-11~~			

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW to Leg

965.4 891

35. Total Days This Facility					
Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

35. Total Days This Facility					
Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days

Signature of Attending Medical Officer [b)(6)-2] COL, MC

Signature of PAD or Medical Records Officer [b)(6)-2] [b)(6)-2] SSG, PAD NCOIC

Automated Facsimile - DA FORM 3647, May 79 MEDCOM - 6117

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

See Admit H+P

(b)(6)-2

PHYSICAL EXAMINATION

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

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

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

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

(b)(6)-4

MEDCOM - 6118

NSN 7540-00-634-4178 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6/11/07	Admit (K+P
1136	27 yo Inj: s/p GSW (R) LUE ~3 hrs
	during Lucia activity Seen @ FST. Tx to
	[b)(3)-1] via
	pain: 9/10 diffuse
	AW: ϕ
	RR: ϕ
	C
	Bloodfield, NAD
	Chest: CTA, equal
	CV: RRR
	Abd: Benign
	Ext: (R) LE: TT PTA sensation through
	knee. 2+ DP. 2+ PT, PT. New splint
	Xrays: (R) knee: Patella Fx, open joint @ air
	Lab: ϕ
	A/P: GSW (R) knee, open joint
	P/: OR consult

[b)(6)-2]

[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.

[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

MEDCOM - 6119

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
Urology	Asked to see patient for Renal U/S
11 Jun 03	because of poss flank pain.
	Renal U/S → (R) kidney - ϕ hydronephrosis
	ϕ stone
	GU- ↓↓ testis 9.4cm x 6.8 cm
	(R) hypospadias (L) kidney - ϕ hydronephrosis
	hooded foreskin & stone
	chordee 10.8cm x 7.3cm
	UA/ yellow/ glu-neg/ bld-neg/ LE-neg/ nitrite-neg
	1.030/ pH 5.0/ Urob - 0.2/
	Doubt renal calculi 2° blood in urine and
	no evidence of hydronephrosis. [b)(6)-2] MD
	LTC, ME
	Urology [b)(3)-1]
6/11/03	O/N Pt
1420	Procedure: (R) Knee Arthroscopy
	(R) Knee Debridement, Placement of drain
	Surgeon: Caudill Watson
	Anes: GETA
	Findings - open (R) knee: Patella intact
	R. tibia plateau (lateral) (grade 3 chondromalacia)
	Tourniquet time - 2hr 1min
	Fluids - 1300 cc
	[b)(6)-2]
	[b)(6)-2]

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 Jun 03	ORTHO CONSULT:
TIME:	27 y/o m Inspc EPW shot in ® knee
T:	this Am (while attempting to shoot US troops)
R:	Brought by MPs. Awake & alert
B/P:	O: ® KNEE:
P:	Entrance wound in Sup. popliteal fossa (midline)
MED:	Exit wound at inferior patellar border.
	⊖ LACHMAN ⊖ Post Lachman
ALLER:	⊖ Ant/Post Drawer ⊖ MCL/LCL Laxity
	Rom: 0-90°
LMP:	motor 1/5 4/5 TA EHL GS
	® 6 4 ——→ (poor cooperation)
	ⓛ 5 ——→
TOB:	SENS - WNL LT
	Pulses: ⊕ DP ⊕ PTA
ETOH:	Cap refill < 2 sec.
	® knee
	X-ray: ⊖ Fx / Dislocation, Bullet fragment
PMHx:	near inf pole patella, Free air in joint
	A: GSW ® knee (thru & thru)
PSH:	penetrated joint, No apparent vascular inj
	Patient received instructions regarding P: 1) Trans to CSH for I&D
FMHx:	diagnosis, plan of care, medications, follow-up, and verbalizes understanding. 2)
	Initials: _____

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	CO	AT
DISCOM AID STATION		ARMY	D.A	
SPONSOR'S NAME	SSN/ID NO.	RELATION	SOB	

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

REGISTER NO. | WARD NO.

NAME AND RANK: (b)(6)-4

SSN:

UNIT AND UNIT PHONE:

DOB: 7 Feb 78

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

MEDCOM - 6121

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 JUN 03a	1845: Nursing Transfer in note: Pt was transfered from ICU via stretcher: A is in two point hand restraints, Foley draining to gravity, urine is medium straw colored. Hemovac draining Serosanguinous fluid. IV to left arm over is KOI. Currently resting quietly & any complaints. Pt asked staff if he could have a cigarette, and was told this was not allowed by the staff. No complaints at this time, will continue to monitor. — (b)(6)-2 CPT Kn
11 JUN 03a	1945: Respiratory assessment: pt O2 Sats were 86% on room air. Breath sounds: wheezing that clears w/ cough. Placed on O2 2-4L, sats back up to 100%. Pt encouraged to use Incentive Spirometer. Will continue to monitor — (b)(6)-2
11 JUN 03a	2000: Respiratory reassessment: Pt has O2 sats of 99-100% on room air — (b)(6)-2
11 JUN 03a	2035: Hemovac output: output was 25cc of Serosanguinous fluid. While measuring output

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.
(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

MEDCOM - 6122

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	pt. c/o pain and was given morphine 4mg. Will cont to monitor [b)(6)-2]
12JUN0320	123 RN output (Hemovac) was 150cc, Urine output was 1000cc [b)(6)-2]
12JUN0430	- RN note - pt c/o pain at approx. 0430. Temp slightly elevated, given phenocet 2 tabs [b)(6)-2]
120600 Jun 03	Nursing Assessment: Pt is awake, alert. Blood b/l/d/l per MP SOP. Airway is intact. Breathing is even, unlabored but shallow. Atelectasis and minute wheezes noted to bases bilaterally. Pt's head raised & O2 @3L placed for sats in 70's. Abd is soft, nontender, + distention. BS@x4. Foley to gravity draining clear yellow urine. FROM's to @UE, @LE. Neurovascularly intact to all extremities. BLE kept limited by pain and posterior splint. Splint is from heel to mid thigh on @leg. Hemovac draining serosang fluid. IV to @AC flushes well & + s/s of infiltration or infiltration. [b)(6)-2] LAT, AW
6/12	Surgeon POD #1 S/P GPW @ KMC - @ Cayluk Tylenol Ancef ZTec Neuro/vasc intact D/C drain tomorrow, cont Abx [b)(6)-2] MT/Hunter.
121500 Jun 03	Hemovac output = 5cc this shift - C [b)(6)-2] CSTAW
121505 Jun 03	Hemovac DC'd. Tip of hemovac intact. [b)(6)-2] CSTAW
1815 12JUN03	Pt stable. Transferred off ward upon questioning c MP. @ complaints [b)(6)-2] WAW
2200	Returned to ward in stable condition. @ complaints. PERRLA. Breath sounds clear after coughing. Abd soft, non-tender

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 6123

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
12 JUN03 1600	NARRATIVE SUMMARY ADMISSION DX- (R) KNEE GSW C OPEN JOINT & PATELLAR TENDON PARTIAL AVULSION. (R) SUPERFICIAL BUTTOCK WOUND DISCHARGE DX- SAME C CORRECT FOR INCORRECT TIBIAL PATELLA AT NOTCH PROCEDURE PERFORMED (R) KNEE ARTHROTOMY WITH DEBRIDEMENT AND REPAIR OF PARTIAL PATELLAR TENDON AVULSION. ADMITTED 11 JUN 03 DISCHARGED 12 JUN 03 CLINICAL RESUME- 27y/o INADVERTANT COMBATANT SHOT POST TO ANT TANDEM RIGHT KNEE BY 5.56mm ROUND. ROUND MISSED NV BUNDLE, PASSED THROUGH CRUCIATES WITHOUT DISRUPTING THEM, & EXITING TAC MEDIAL 1/3 OF THE PATELLAR TENDON C ~30% DISRUPTION OF ITS SUBSTANCE. FORMALLY DEBRIDED THROUGH MEDIALLY BASED ARTHROTOMY 9HR POST-INJURY & CLOSED OPEN WOUNDS. URINE OUTPUT <125cc OVER LAST 12HR & D/C'D. (OVER)

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.
(b)(6)-4		

PROGRESS NOTES
Medical Record

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

MEDCOM - 6124

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	RECEIVED TETNUS TOXOID & IV ANCEF. ARTHROTOMY IS CLOSED W/ RUNNING ABSORBABLE SUBCUTICULAR. LAST SCHEDULED DOSE OF ANCEF TO BE ADMINISTERED AT 0600 14JUN03.
	ACUITY- WEIGHT BEAR AS TOLERATED IN SPLINTS. KNEE TO REMAIN SPLINTED FOR AMBULATION FOR FOUR WEEKS. CURRENT LOW GRADE FEVER 2° ATELECTASIS. NEEDS TO USE INCENTIVE SPIROMETER AS INSTRUCTED. DIET REGULAR
	MEDS ANCEF AS ABOVE PERCOCET 1-2 PO Q 6° PRN PAIN
	FLU WOUND ✓ BID MD. OFFICER IN 72° MAY FU @ [(b)(3)-1] FOR ANY SIGNS OF WOUND INFECTION.
	[(b)(6)-2] LTC, MC ORTHOPEDIC SERVICE

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12June03	bowel sounds Active x 4 quads. (R) leg dsg CDI, wrapped face wrap. Voiding to urinal. Brisk cap refill and strong pulses x4 extremities. [redacted]
13Jun03 0330	Pt Stable. Sleeping comfortably, easily arousable. (R) leg elevated, dsg CDI. Pt made to cough and deep breath to clear lungs. Complains of headache
13Jun03 0800	Nursing Shift note Pt arousable by verbal stim tolerating PO intake, BS to slight wheezing, unable to fully expand lungs until repositioned to full upright. Blindfold in place. (L) knee w/ scant amount of serous drainage. No major changes. Continue to monitor [redacted]
6/13/03	Surgery Day #3 Day wk. Accu-Chk qAM. Tm c.w.s. SATs wnl falling Stable Apyr. with frequent c/o's wait Asm. Pt with s/l to welco. [redacted]

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

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

[redacted]

REGISTER NO. | WARD NO.

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

MEDCOM - 6126

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13JUN03	2250: Shift RN assessment note: Pt has c/o pain to legx2 this shift and was medicated with 2mg MSO4 @ 2030 + 2200; pt pointed towards Rt leg both times and said "allum". After admin at 2230, pt appeared more comfortable. IV continues to infuse into Rt forearm. Pt did not have much of an appetite this shift at approx. 1800 dinner. Is asking for water PO at regular intervals. Voiding in urinal. BS. Bowel sounds present in all 4 quads. Resps even + unlabored w/ clear breath sounds. Will continue to monitor [redacted] cor
14 0600 June 03	Nursing Assessment: Pt is awake, alert, O&S, Resting in bed. Breathing even and unlabored but breath sounds are diminished in bases. Atelectasis also noted to bases. Abd is soft, nontender, and + distended. BS @ x4. Voids spontaneously. ROM to BUE and BLE. Limited ROM to BLE 2° splint & ACE. Neurovascularly intact to all extremities. IV to (Rt) AC infusing freely. Dsg to RLE is CDI. Pt removed blue blood pressure cuff and arm restraints this shift. Pt responded to English instructions freely. [redacted] cor

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPARTMENT/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]

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

MEDCOM - 6127

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6/14/07	Surgery After site D/C Surgery written Ok for D/C (b)(6)-2 (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

MEDCOM - 6128

NSN 7540-00-634-4176 600-108

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15JUN03	0155: RN shift assessment: Pt has c/o leg pain x1 this shift (0015AM) and was given 2mg morphine; fell asleep & any further complaints approx. 15 minutes after administration. Wet to dry dressing was changed; some scant serosanguinous drainage noted during Δ. Pt refused to eat the majority of his dinner (opting to eat only fruit + cake). Rt leg ↑, pedal pulse palpable. Voiding & any difficulties; QS. Bowel sounds present x4 quads. Continues w/ slight wheeze that clears w/ cough; resps are even + unlabored. Will continue to monitor — [b)(6)-2]
15JUN03	0410 Assessment: Pt sleeping, easily arousal. VSS, ⊕BS x4. Pt has inspiratory & expiratory wheezing, encourage pt to cough several times, ↓ wheezing noted. Dsg to ⊕LE CDI, ⊕ foot & bonds cap refill, ≠ DP pulse. IVF NS @150, IV site to ⊕ ac & S/S infection — IOI [b)(6)-2], AV
	0410 ADL: Offer pt breakfast & attempt to feed, pt refuse. - IOI [b)(6)-2],
	0855 Dsg Δ: Δ dsg to ⊕ outer thigh. Sm amt sero-sang drainage present on gauze. Wound to pink & full edges - IOI [b)(6)-2]

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

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDCOM - 6129

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6/18/03	Surgery Wound OK Pt discharge to CI F/U at with PA. No further F/U at [redacted] (b)(3)-1 necessary. [redacted] (b)(6)-2 [redacted] (b)(6)-2

*U.S. Government Printing Office: 1995 — 387-722/20035

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 6130

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): EMT

LOG NUMBER:

ARRIVAL
DATE: DAY 11 | MONTH Jun | YR. 03
TIME: 1046

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE ☐ OTHER (Specify)

CURRENT MEDS. (tetanus immunization and other data)
Accutane

HISTORY OBTAINED FROM
☐ PATIENT ☐ OTHER (Specify)

ALLERGIES
Acutane

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)
(b)(6)-4

HOME TELE. NO. (Inc. area code)

CHIEF COMPLAINT(S) (Include symptom(s), duration)
Gun Shot wound to R knee

SEX: M | AGE: 27

POSSIBLE THIRD PARTY PAYER?
☐ YES ☐ NO

VITAL SIGNS

TIME	1054	1108	1120
BP	123/73	100/54	113/47
PULSE	87	98	85
RESP.	18	18	18
TEMP.	98.6		
WT. (Child)			

CATEGORY (See reverse)
☐ EMERGENT
☐ URGENT
☐ NON-URGENT

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

TIME SEEN BY PROVIDER: 1100

27 yo ♂ w/ Gun Shot wound to ® knee when fleeing after firing upon US Forces. Last Meal 1700 yesterday. 7/10 pain. ToI @ ~0300 this Am.

PMHx: Seasonal Allergies, ? RLQ Intestinal prob., Psoriasis, Tab + ETOH

O: WDWN male NAD to ® Knee GSW. Non Toxic Abdomen. Respirations ~ Equal. Flexcuffs.

HEENT: WNL.
Lungs: CTA.
Cor: RRR.
Abd: BS's NT ND.
Ext: GSW to ML ® popliteal fossa to lateral Knee. Crepitus. PT + DP pulses by palp, Biphasic dopplar pulses. warm CRT < 2sec. N/V intact.

ORDERS | INITS. | TIME
CBC, Tx S, Chem 7
Lytes, UA
Irrigate wnd.
Restraints
Td 5cc IM.
Levaquin 750 mg IV

Fentanyl 100 ug IV

ASSESSMENT/DIAGNOSIS
GSW ® Knee.

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

CONDITION UPON RELEASE
☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED
TIME OF RELEASE:

(b)(6)-2

T+S.

RLE:
® Knee!
XRay ® Arm in joint with Cortical defect lat aspect of distal femur

(b)(6)-2

E ON SF 507, IF NEEDED)

(b)(6)-2

MAJ MC

T ions ordered, any limitations and follow-up

To OR.

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

(b)(6)-4

EMERGENCY CARE AND TREATMENT
MEDCOM - 6131

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY: anesthesia

2. PATIENT ID VERIFIED BY [redacted] AND PROCEDURE: LLQ

3. DATE: 11 Jun 03 TIME PATIENT ARRIVED IN SUITE:

4. PATIENT IN ROOM TIME: 1130 NUMBER: 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: pt sedated prior to arrival to OR.... ⊕ Smoker All = Acuzol

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	Jtt [redacted] 66E	RELIEF CIRCULATOR	CP7 CAGG (break)

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Ⓡ hip bump; padded arm boards

8. SKIN PREPARATION

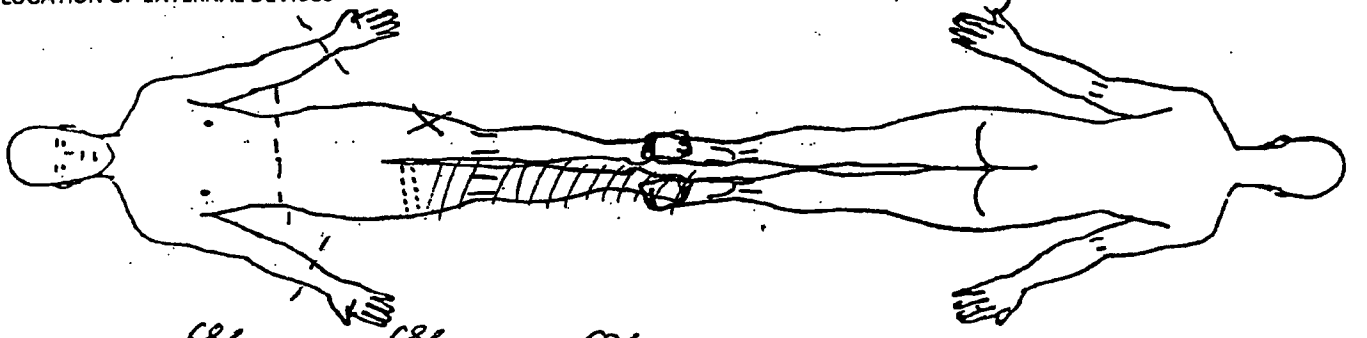
HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: or [redacted]; ϕ nicks / cuts

PREP SOLUTION (Specify) SITE: Ⓡ leg-foot to T ϕ Beta/Beta BY WHOM:
SITE: BY WHOM: Chase

COMMENTS: ϕ pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (CSC) -- Safety Strap (CSC) === Tourniquet (CSC) @ 275 for 121 min ///=prep

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No	C	C	C
Needle Sharp	☒ Yes ☐ No	C	C	C
Instrument	☐ Yes ☒ No	/	/	/
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]

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

☒ ESU NO: # 1 cut/coag = 40/40
GROUND PAD: BRAND Valley Lab
LOT NO: H9402 4

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES MEDCOM - 6132 WHICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S [b)(6)-2]

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ IF YES, SITE to (R) Knee

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, Xeroform, Ster. Strips, Benzoin

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	16 fr Foley	Hemovac 400 ml	
SITE	Bladder pt arrived c in place	Right Knee	

19. ADDITIONAL INFORMATION

Dr [b)(6)-2]

Dr [b)(6)-2]

CPT [b)(6)-2] CRNA

20. OPERATION(S) PERFORMED

(R) Knee I+D

21. PATIENT TRANSFERRED TO ICU TIME 1420 METHOD litter

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

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

MEDCOM - 6133

511–119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 11 Jun 03 | 12 Jun 03 | 12 Jun 03 | 13 Jun | 14 Jun | 15 Jun

19 | HOUR: 2000 | 0414 | 1615 | 2101 | 0400 | 0600 | 1230 | 1620

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

Record special data only when so ordered

	2000	0414	1615	2101	0400	0600	1230	1620
BLOOD PRESSURE	136/68	127/66	124/68	121/63	120/82	105/81	124/70	108/73
T	100.4	100.6	99.6	100.6	102.5	99.0	99.0	98.1
P	104	104	88	104	101	93	84	82
HEIGHT: WEIGHT →	99.9	90.6	88.5	84	92/60	94.9	94.2	93.6
R	20	24			28			

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

(b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 6134

Ward/Section: EMT | REQ ING PHYSICIAN: (b)(6)-2

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

LAST, FIRST, MI: (b)(6)-4 | DATE: 7 | TIME: 1115 | SSN/PSEUDO SSN: (b)(6)-4

HEMATOLOGY

TEST	RESULT	REF. RANGE
WBC	13.6	4.8-10.8 x 10^3
RBC	4.26	4.7-6.1 x 10^9
Hgb	13.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	41.4	42-52% (M) 37-47% (F)
MCV	97.2	80-94 fl (M) 81-99 fl (F)
Plt	221.	130-500 x 10^3 verified
Lymph %	16.8	20.5-51.1%

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

URINALYSIS

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Cloudy	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	NEG	Negative
SG	1.030	N/A
Bld	NEG	Negative
pH	5.0	N/A
Prot	NEG	Negative
Urob	0.2	0.2-1.0
Nit	NEG	Negative
Leuk	NEG	Negative
HCG		Negative

Cell Count		
Directigen		Negative

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		

BLOOD BANK

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh:

COAGULATION

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

TEST	RESULT	REF. RANGE
ALB	4.0	3.5-5.5 g/dl
ALP	45	26-84 u/l
ALT	25	10-47 u/l
AMY	9 *	14-97 u/l
AST	30	11-38 u/l
TBIL	0.7	0.2-1.6 mg/dl
BUN	16	7-22 mg/dl
CA^{++}	8.6	8.0-10.3mg/dl
CHOL	157	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	115	73-118 mg/dl
TP	7.5	6.4-8.1 g/dl

TEST	RESULT	REF. RANGE
GLU	108	73-118 mg/dl
BUN	15	7-22 mg/dl
CRE	0.6	0.6-1.2 mg/dl
CK	132	39-380 u/l (M) 30-190 u/l (F)
NA^+	135	128-145 mmol/l
K^-	5.5 *	3.3-4.7 mmol/l
CL^-	104	98-108 mmol/l
tCO_2	24	18-33 mmol/l

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

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

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

REMARKS:

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

Ward/Section: ICU	REQU... G PHYSICIAN: Dr (b)(6)-2 (b)(6)-2	LA... ORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST FIRST MI (b)(6)-4 (b)(6)-4	DATE 11 Jun	TIME 0306 SSN/PSEUDO SSN: (b)(6)-4

Hematology (CBC)

TEST	RESULT	REF. RANGE
WBC	18.5	4.8-10.8 x 10^3
RBC	3.75	4.7-6.1 x 10^6
Hgb	10.3	14-18 g/dl (M) 12-16 g/dl (F)
Hct	31.9	42-52% (M) 37-47% (F)
MCV	85.1	80-94 fl (M) 81-99 fl (F)
Plt	186	130-500 x 10^3 verified
Lymph %	11.7	20.5-51.1%

Hematology Manual Diff

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	14.1	9.8-13.6 secs
APTT	52.4	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

TEST	RESULT	REF. RANGE
Color	amber	N/A
App	clr	N/A
Glu	neg	Negative
Bili	large	Negative Keto = large
Ket	mod	Negative ace = mod
SG	1.015	N/A
Bld	neg	Negative
pH	6.0	N/A
Prot	neg	Negative
Urob	norm	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

UNIT	TYPE	CROSSMATCH

Micro-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		

Miscellaneous Tests

REMARKS:

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

MEDICAL RECORD – ANESTHESIA

TOTALS — TOTAL TIME: 1hr 30 min; TOTAL UNITS: 200

FLUIDS – THERAPY
- CRYSTALLOID – 1300
- COLLOID –
- BLOOD –

REMARKS — Code drugs with numbers, events with letters

1) From ER 7 OR
2) Pulse ox, BP cuff, ECG monitors in place. Positioned
1259 1 hr TQ time Dr. Granville anes
1329 1½ hr TQ time
Pt. intubated by SRNA Ti 5cc/kg SpO2 >95 1.5 MAC sevo for maint. Pt. extubated awake
1359 2 hr TQ time Dr. Granville anes
TQ RLE 275 mm
↑ 1159
↓ 1400
121 min

RECOVERY AT 1418
PACU / ICU (Specify) / OTHER — 97.2
CONDITION: sleeping
RESP – 14 SpO2 – 100
BP 109/48 HR – 81

	Start	Room	End
ANES	1105	1130	1422
PROC	Ready	Begin	End
	1145	1203	1419

PROCEDURES and CPT Codes
(R) knee debridement

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
1) 1 attempt ETT smooth ETT 1 airway SRNA
2) 8.0 → (cuff) 24cm @ RLQ ETT c+ [b)(6)-2]

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

SURGEON [b)(6)-2]
ANESTHETIST [b)(6)-2]
[b)(6)-2]
CPT, AN
CRNA

PROCEDURE LOCATION: OR
DATE: 6/11/03
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED 1 Jan 99
PATIENT PROOF
MEDCOM - 6138
*U.S. GPO: 2002-729-180/40137

ACLU-RDI 1330 p.22

DOD 15235

PRE-ANESTHESIA AND POST-ANESTHESIA EVALUATION

AGE: 27 HRS DAYS MOS YRS SEX: M MALE ( ) FEMALE

PROPOSED PROCEDURE: Scope (R) knee SURGICAL SERVICE: Ortho

ASA PHYSICAL STAUS 1 2 3 4 5 E

WEIGHT: 75 KG LB HEIGHT: 68 IN.

ALLERGIES: Penicillin

HABITS:
TOBACCO: 2 PPD
ETOH:
DRUGS: Denies

CURRENT MEDICATIONS:
([ ] = ordered as premed)
[ ] NONE
[ ]
[ ]
[ ]
[ ]
[ ]

PREMEDICATION:
None Yes (@ ____ Hrs) /OC
____ ' ____ mg IV IM PO
____ ' ____ mg IV IM PO
____ ' ____ mg IV IM PO

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

NPO 5pm 6/12/03

PREOPERATIVE ASSESSMENT

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	N	Y
Endocrine System:	Diabetes	N	Y
	Steroids	N	Y
	Thyroid	N	Y
Neurological:	Seizures	N	Y
	Neuropathy	N	Y
	Other	N	Y
Gynecological:	Pregnancy	N	Y
Other Significant Hx:		N	Y
		N	Y
Familial HX	GSW to (R) knee		

PAST SURGICAL/ANESTHETIC HISTORY
Denies
Hernia?

PHYSICAL EXAMINATION
BP 123/73 HR 87 RESP 18 98.6
HEENT - Teeth WNL (L) Kink
Trachea Midline
TMJ/Neck
Oropharynx
Nares
CHEST:
CARDIAC:
EXTREMITIES:
IV Access: #18G (L) AC
Ulnar Filling:
BACK:
OTHER:

ANESTHETIC PLAN: [ ] Local [ ] MAC - [ ] Regional (Specify): [X] General: Mask Intubation

INFORMED CONSENT/COUNSELLING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian. The patient/legal guardian seems to understand and agrees. Questions answered. d/w pt via interpreter. Questions answered

Signed: (b)(6)-2 CPT AN DATE: 6/11/03 TIME: 1102 Hrs

(b)(6)-2 CPT, AN CRNA

CONDITION UPON ARRIVAL TO P.A.R.R. ____

VITAL SIGNS: BP ____ HR ____ RESP ____ SaO_2 ____

RESP STATUS: [ ] Spontaneous [ ] Assisted [ ] Cont'd

MENTAL STATUS: [ ] Awake [ ] Alert [ ] Lethargic [ ] Asleep

[ ] Responsive [ ] Unresponsive Block Level ____

REPORT GIVEN: [ ] Yes [ ] No

SEE Anesthesia Record

POST-ANESTHESIA EVALUATION AND NOTE

[redacted] ESTHETIC COMPLICATIONS [ ] OTHER

(b)(6)-2

Signed: (b)(6)-2 DATE: 12 June 03 TIME 0400 Hrs

MAN/CRNA

PATIENT IDENTIFICATION: (Ward: ____)

(b)(6)-4

WAMC Form 2300
1 Aug 92 (HSXC-SU)

MEDCOM - 6139

☆ U.S. GPO: 1994-828-533/00102

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

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

DATE OF ORDER: 6/11/03 TIME OF ORDER: 1940 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit ICW
2. S/P GSW (R) Knee
3. Ancef 1g IVP q8
4. Hemovac to suction. record op q8°
5. Percocet (1-2 tabs) q 4-6 prn pain
6. Regular diet
7. IVF NS @ 150 cc/hr

PATIENT IDENTIFICATION: (b)(6)-4

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

DATE OF ORDER: TIME OF OR HOURS

8. Morphine 2mg q 15 min up to 16mg in 4hrs prn pain
9. Foley

11 JUN 03 @ 1830

PATIENT IDENTIFICATION: (b)(6)-4

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

DATE OF ORDER: TIME OF OR

11 JUN 03 2030 HOURS

1. Clarification: MS04 2mg IVP q 15 mins up to 16 mg q 4° prn pain.

11 JUN 03 @ 1830

PATIENT IDENTIFICATION: (b)(6)-4

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

Q 4° chart check 12 JUN 03 2003

PATIENT IDENTIFICATION: (b)(6)-4

DATE OF ORDER: 12 June 03 TIME OF ORDER: 1510 HOURS

DC (b)(6)-2

V.O. Dr. (b)(6)-2

0038

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

13 June 03 0380 (b)(6)-2 WDAD Q4°V

DA FORM 4256 1 APR 79 REPLACES EDITION OF 1 JUL 77 WHICH MAY B

14 JUN 03 Chart Check Q4° (b)(6)-2

15 JUN 03 @ 0100 Q4° Chart Check (b)(6)-2

U.S. GOVERNMENT PRINTING OFFICE: 1994 752-710

MEDCOM - 6140

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.

MD: JJP

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE/COMPLETED 11 12 13 14 15 16 17 18
11JUN03	(b)(6)-2	Ancef 1 gm IVP Q8	8	/ (b)(6)-2
			16	/ (b)(6)-2
			24	(b)(6)-2
11JUN03	(b)(6)-2	IVF: NS @ 150cc/hr	6	/ (b)(6)-2
			14	/ (b)(6)-2
			22	(b)(6)-2

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ALLERGIES: ☒ YES ☐ NO

Ancef

PRIMARY DIAGNOSIS: (R) Knee GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIME.

D 8 9 10 11 12 ...

E ... 17 18 19 ...

N 24 01 02 03 04 05 ...

DA FORM 4077, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED.

MEDCOM - 6141

Verify by Initialing

TH EUTIC DOCUMENTATION CARE PL
(NON-MEDICATION)

Mo JUN Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
11 JUN 03	[redacted]	Admit to ICW	11 JUN 03	1800	1800	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION. TIME/DATE COMPLETED
11 JUN 03	[redacted]	Percocet 1-2 tabs Q4-6h prn pain	12 JUN 03 [redacted]
11 JUN 03	[redacted]	Morphine 2mg Q15min up to 16mg in 4hrs prn pain. IVP	11 JUN 03 [redacted] 31 MAY 03 [redacted] 13 JUN 03 [redacted] 14 JUN 03 [redacted] 14 JUN 03 [redacted] 16 JUN 03 [redacted]

USAPA V1.00

MEDCOM - 6142

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13	14	15	16	17	18	19	20
11JUN03	[b)(6)-2]	Hemovac to suction	6	/ [b)(6)-2]									
		record output	14	/									
		Q8.	22	[b)(6)-2]									
11JUN03	[b)(6)-2]	Regular Diet	06	/ [b)(6)-2]									
			12	/ [b)(6)-2]									
			18	[b)(6)-2]									
11JUN03	[b)(6)-2]	Foley care	06	/ [b)(6)-2]									
			14	/ [b)(6)-2]									
			22	[b)(6)-2]									
11JUN03	[b)(6)-2]	VS Q8	06	/ [b)(6)-2]									
			18	/ [b)(6)-2]									
			22	[b)(6)-2]									
12JUN	[b)(6)-2]	NTO: W-7) Drsg to (L)	06	/ [b)(6)-2]									
		lateral thigh BID	18	/ [b)(6)-2]									

D/C Hemovac 12JUN03 [b)(6)-2]

Foley D/C [b)(6)-2]

ALLERGIES: [X] YES [ ] NO
Accuzol

PRIMARY DIAGNOSIS:
(R) knee GSW

ADDITIONAL PAGES IN USE: [ ] YES [ ] NO
PAGE NO: _____

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 6143

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)		Mo 6 Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
12	(b)(6)-2	DC hemovac	12		done	(b)(6)-2

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

USAPA V1.00

MEDCOM - 6144

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

OTSG APPROVED (Date)

REPORT TITLE: Post-Anesthesia Care Unit (PACU) Flow Sheet 200

(R) Knee Debrid. Bone

Date: 11 Jun 03
Time In: 1420
Allergies: ACUZOL
Pre-op V/S:
Procedures: (R) Knee Debridement SP GSW to Knee

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

OR Intake: Crystalloid 1500 NS Colloid
OR Output: UOP 200 cc EBL Min
Meds/Times:

Drains: Hemovac NG JP T-tube Foley TLS

Airway: Nasal Oral Removed ETT Trach Other

Pre Op Meds

History

Time	1415	1420	1430	1500	1530	1600	1630
SaO2	98	98	98	98	98	98	97
FiO2	28%	4	4	4	5	5	5
Methods	NC	NC	NC	NC	NC	NC	NC
RR	15	14	16	16	15	15	16
T							
Time	1415						
Pain (0-10)	0						
LOS							

240 220 200 180 160 140 120 100 80 60 40 20

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	2	2	
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	
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	2	2	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	7	

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

PREPARED BY (Signature & Title) [b)(6)-2] DEPARTMENT/SERVICE/CLINIC DATE 11 Jun 03

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

☐ 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

MEDICATION

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1900	4	Morphine 2g	IV			[b)(6)-2]

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
1445							
Adm	(R) LE	hip flexion		P	<3B	Cool	PK
15'	(R) LE	Knee [illegible]		P	<3	C	PK
30'	(R) LE	Hip flexion		P	B	C	PK
45'	(R) LE	Knee [illegible]		P	B	C	PK
60'	(R) LE			P	B	C	PK
90'	(R) LE			P	B	C	PK
D/C							

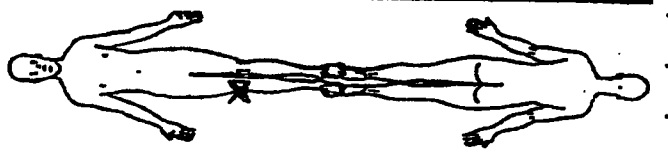
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) LE	Gauze/ACE	Hemovac
30'	(R) LE	Gauze/ACE	Hemovac
60'	(R) LE	Gauze/ACE	Hemovac
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NO

1415: Arrived on ICU from OR via litter SP (R) Knee debridement. Pt has hemovac to wound. Dsg dry/intact E ACE wrap. (+) pulse, cap refill <3 sec. O2 @ 50% per Venturi Mask. [b)(6)-2] [illegible]

1445: Pain [illegible] per Pt. Given 2mg Morphine IVP. [b)(6)-2] [illegible]

1450: Pt has foley to gravity draining clear/yellow urine. NS infusing @ 150-/hr into (L) arm. VSS, WNL. EPW restrained to litter @ event (+) pulse, ROM. [b)(6)-2] [illegible]

1600: UOP 125cc clear, amber urine VSS. [b)(6)-2] [illegible]

1610 O2 d to 35% via VM SpO2 @ 97% [b)(6)-2] [illegible]

1700 UOP 125cc, VSS, WNL. Responsive to verbal command still sleepy able to follow commands. Pt meets criteria to transfer to ICW awaiting Transport. [b)(6)-2] [illegible]

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:

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. [illegible]ION (State or Country Code)
1 2 3 4 5 6 7 8	
(b)(3)-1	

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26	27 28 29	30	31	UNKNOWN
		X	9	

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34	N/A	35 36	37 38 39 40 41 42 43 44 45
		9 9	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	46	1000	N/A
	U		

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	NO
62 63	64 65 66 67 68 69 70	71		X
		0		

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72	ICU	
0		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
(b)(3)-1		

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
73 74	75 76 77 78 79 80	81 82 83 84 85 86 87 88
2 4		2 0 0 3 0 6 1 5

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
89 90 91 92	93 94 95 96 97 98	99 100 101 102 103 104 105 106
A E A A		2 0 0 3 0 6 1 1

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
107 108	109 110 111 112 113 114	115 116 117 118 119 120 121 122

FOR LOCAL USE

DX: GSW RIGHT KNEE

(b)(6)-2

(b)(6)-2 LTC, MC

SIGNATURE OF ADMITTING CLERK (b)(6)-2

(b)(6)-2 HC, 91G10

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

MEDCOM - 6147

Admission a... ...ding Information

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

1. Reporting MTF	2. MTF Location				
(b)(3)-1	(b)(3)-1				
3. Register Number	Name (Last, First, MI)		4. Pay Grade	5. Sex	
(b)(6)-4	(b)(6)-4		FGN	M	
6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion	
		X	Z	MUSLIM	
10. Length of Service	ETS	11. FMP	12. Social Security Number		
		99	(b)(6)-4		
Organization (Active Duty Only)		13. Marital Status	Hour of Admission	Branch / Corps:	
			10:00		
14. Flying Status	15. Beneficiary Category		16. Zip Code of Residence:		
	K78-PRISONER OF WAR/INTERNEES				
17. Unit Location	18. MOS		19. Trauma	Prev. Admission	
IZ			DIS	NO	
20. Source of Admission	Ward:		Name / Relationship of Emergency Addressee		
Direct from ER	ICU		Address of Emergency Addressee		
Name and Location of Medical Treatment Facility: (b)(3)-1			Telephone Number of Emergency Addressee		
21. Type of Disposition	22. MTF Transferred To		23. Date of Disposition (YYYYMMDD)		
TRF C-ACF			2003-06-15		
24. Clinic Svc - Admitting	25. MTF Transferred From		26. Date this Admission (YYYYMMDD)		
AEA - ORTHOPEDICS			2003-06-11		
27. Location of Occurrence	28. MTF of Initial Admission		29. Date of Initial Admission		
IZ			~~2003-06-11~~		

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW to Leg

965.4 891

Procedure Narrative(s): DX 8912 Proc 8388 8628

Cause of Injury Narrative: E9912 E8498 Trauma 1 Inj 450

(b)(6)-2

Admitting Officer (Signature, as required)

(b)(6)-2, LTC, MC

Signature of Admitting Clerk

(b)(6)-2

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 6148

(b)(3)-1

ATIENT 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
(b)(6)-4	(b)(6)-4			N/A	
4. SEX / 5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	X	UNK		N/A	
11. FMP	12. SSN		13. ORGANIZATION		14. WARD
99	(b)(6)-4		N/A		ICW
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
N/A		K78	N/A	N/A	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM ER	0623	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
		03 JUL 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		20 JUN 03	DR. (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX: GSW TO CHEST

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	13	13

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	13	13

SIGNATURE OF ATTENDING MEDICAL OFFICER

(b)(6)-2 LTC, MC

(b)(6)-2 PAD OR MEDICAL RECORDS OFFI

SIC NCOIC PAD

DA FORM 3647, MAY 79

MEDCOM - 6149

USAPPC V1.10

MEDICAL RECORD | ABBREVIATED MEDICAL RECORD

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

20yo Emp ♂ BP s/p GSW chest

Seen at Bx med → CT

Tx [b)(3)-1] → 2u pRBC, To OR

PHYSICAL EXAMINATION

VS CW/SD HR RD

Chest canal Bx (P) CT. Value x2 over lower

CW x 2cm

And right flank ⊗

Ext q ecch. (P) Thorax flank wound

PROGRESS (Enter date of discharge, and final diagnosis)

A/ GSW chest, open lung ± CW defect

P/ To OR, explor + closure

[b)(6)-2]

[b)(6)-2]

SIGNATURE OF PHYSICIAN | DATE | IDENTIFICATION NO.

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

[b)(6)-4]

ABBREVIATED MEDICAL RECORD
Standard Form 56a
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975

MEDCOM - 6150

117

MEDICAL RECORD	PROGRESS NOTES
DATE	
6/20/03	Op Note Procedure: Thoracotomy (R) CT placement x2 Surgeon - [b)(6)-2] Anth GETA 2 volumes of Finding: (1) Large CW defect (2) Open pleural injury & leak (3) Pulmonary contusion RML (4) Hemothorax Fluids EBL: 300 cc LR TO ICU, intubated [b)(6)-2] [b)(6)-2] MD

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[b)(6)-4]

PROGRESS NOTES
Medical Record

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

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AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1030 20Jun03	Nursing Admit / Post op note: Patient returned from OR s/p (R) chest exploration c 2 chest tubes, vented SIMV rate 18, TV 700, FIO2 100%, peep 5, sats 100%. Intubated c #8 ET, 23cm @ lip. CT put to 20 cm Suction, NGT to LIS. A line in place, zeroed + leveled. ABG, labs done. Drainage to CT dsg marked, & xray done. Propofol, fentanyl gtt started, LR to 100cc/°. See post op VS below.

	HR	B/P	RR	Sats
1030	52	147/83	19	100%
1035	54	153/85	19	100%
1040	48	158/86	18	100%
1045	54	172/95	20	100%
1100	55	164/89	20	100%
1115	59	149/98	18	100%
1130	66	155/90	18	100%

Patient temp ↓ @ 93.5 initially, warm saline bag applied to armpits/groin. Temp now 95°. Will continue to monitor

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI) | (b)(6)-2

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

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

(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
1130	Rate on vent ↓ to 14 bpm, FIO_2 to 50%.
20Jun03	will repeat ABG in 30mins. — (b)(6)-2
1230	See ABG results, FIO_2 to 70%, rate to 16 bpm
20Jun03	will repeat ABG in 30 mins. — (b)(6)-2
1330	ABG; 7.39, 34, 160, 21 sats 99%. will leave
20Jun03	Vent setting as above, check ABG in AM & Chest xray — (b)(6)-2 CPT/ON
1630	NN: Patient temp ↑ 100°F, UOP 50cc/hr x
20Jun03	past 3hrs MD team aware. Will Continue to monitor trends — (b)(6)-2 CPT/AN
20 June 03 1800	Received report on pt, assumed care. Pt sedated, intubated, ventilated. IV (+) Propofol → sedation, (+) Fentanyl → pain, (+) NS → maintenance fluids infusing through secured (L) ET. CT's x 2: (R) side #2 #1 anteriorly secured w/ dressing, tape, drainage marked & unchanged from previous assessment. CT #1 to posterior (R) side in tact, secured & dry & bandage - drainage marked, unchanged from previous assessment. CT #1 & #2 to 20 cm suction. NGT to (R) nare, secured, placed to LIS & minimal amt of sl'd brown drainage out. 18g PIV x 2 (L) AC intact, in place sl'd. CV & resp monitoring per A-L, secured, to (L) radial, in place & secured, (+) zero. (+) Foley & gravity, dark clear UOP, OP 7/180 cc/hr. VS stable. Full assessment & I/O's noted on DA Form 4700. Plan: Cont close monitoring resp, cardiac status. Maintain close visual on neurologic status & maintaining Sedative state via titration of propofol. Continue pain control via Fentanyl cont infusion. Monitor fluid output / intake closely. — (b)(6)-2
21/20	1730: pt spontaneously awakens, alert, oriented, requesting through hand gesturing pencil for writing. Pt scribbled note in arabic. Translation pending. Propofol bolus 3cc's administered & (+) results VS remained stable

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

(b)(6)-4

MEDCOM - 6153

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30 June 03	1725 (late note.) Lasix 20mg IVSP administered through 18g PIV UOP pending (b)(6)-2
	1745: Propofol ↑ from 24.2 mcg/kg/min → 40 mcg/kg/min = 13.2 cc/hr. VS stable
	99/62: HR 115 via A-Line RR 16 sats 100%. (b)(6)-2
	1810: MRI medicom places HOLE !
	2000: Pt remains sedated. VS stable (b)(6)-2
	2100: KVO occluded, flushed, Propofol bolus 4mg, BP ↓ 88/50 HR 100. Pt placed in reverse trendelenburg position, Propofol ↓ 7cg/hr, LR 250 bolus infused. (b)(6)-2
	2120: BP 120/69 HR 104 pt awake, alert, gesturing w/ hands. Propofol ↑ 13.2 cc/hr = 40 mcg/kg/min. Pt repositioned to HOB 15°. VS Remain stable (b)(6)-2
	2130: Pt awake, gesturing b/l at u/ext. Propofol ↑ 60 mcg/kg/min = 19.8 cc/hr. Pt returns sedated state (b)(6)-2
	2200: UOP hx 30 cc hr. LR [error] (b)(6)-2 maintenance fluid ↑ to 200 cc/hr. UOP mentoring to cont (b)(6)-2
	2230: FIO_2 ↓ to 60%, SaO_2 = 100% n = 16. (b)(6)-2
	2300: ABG drawn; pH 7.551 PCO_2 46.3 PO_2 161; HCO3 23 SO_2 100%, TV 700 ImV: 16 PEEP 5: TV ↓ 650, FIO_2 ↓ 50%
	ABG drawn in 30 min. CMC
	2310: Report given to incoming nurse, LT (b)(6)-2 Care of pt transferred to this

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST / FIRST / MI) | SPONSOR'S ID NUMBER (SSN or Other) (b)(6)-2

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

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

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 - 6154

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 Jun 03 2310	Report received from last shift, Client in bed connected to vent, monitor, chest tube x2, foley cath, NGT → LIS, and IVF and meds infusing. [redacted] LCT-Hv
2400	Complete assessment done, Pupils 2-3 mm, reactive to light, client sedated on propofol and fentanyl gtt drips. Heart in sinus rhythm c ectopy. Apical pulse strong and regular, pulses palpable. left radial art line intact, zeroed, good waveform on monitor, good blood flow, fingers to left hand warm c cap refill <2 secs. — Abdomen flat soft c hypoactive BS. NGT placement checked c 30 cc air bolus, placement, connected to LIS, small amt brown drainage noted. foley patent c dark yellow urine draining to bag. Bath given. T+P for comfort. 8.0 mm ETT @ 23 cm @ lip line vent settings checked. breath sounds clear bilat c RLQ c diminished breathe sounds. Chest tubes x2 to right chest, dressing intact over site c old drainage marked. no crepitus noted around site. Both chest tube to 20 cm H_2O suction, bubbling noted in both tubes. [redacted] LCT-Hv
21 Jun 03 0015	Abgs drawn from left radial art line — [redacted] LCT-Hv
0030	Vent changes made, VT ↓ 600 ml / RR ↓ 14 / FiO_2 ↓ 45% due to Abg results of: PH 7.464, PCO_2 31.5, PO_2 100, HCO_3 23, BE −1, SO_2 98%. [redacted] LCT-Hv
0030	late entry @ 2400 client c fentanyl @ 100 mcg/hr, propofol @ 60 mcg/kg/min (19.8 ml/hr) and LR @ 200 cc/hr infusing via left neck PIV, flushes easily @ blood return. left forearm PIV clamped, flushed easily c 10 cc NS. [redacted] LCT-Hv
0260	NBP 87/42, ABP 80/41, Propofol titrated down to 40 mcg/kg/min, Fentanyl ↑ 150 mcg/hr. urine appears cloudy, 250 cc LR bolus given + UA sent to lab [redacted] LCT-Hv

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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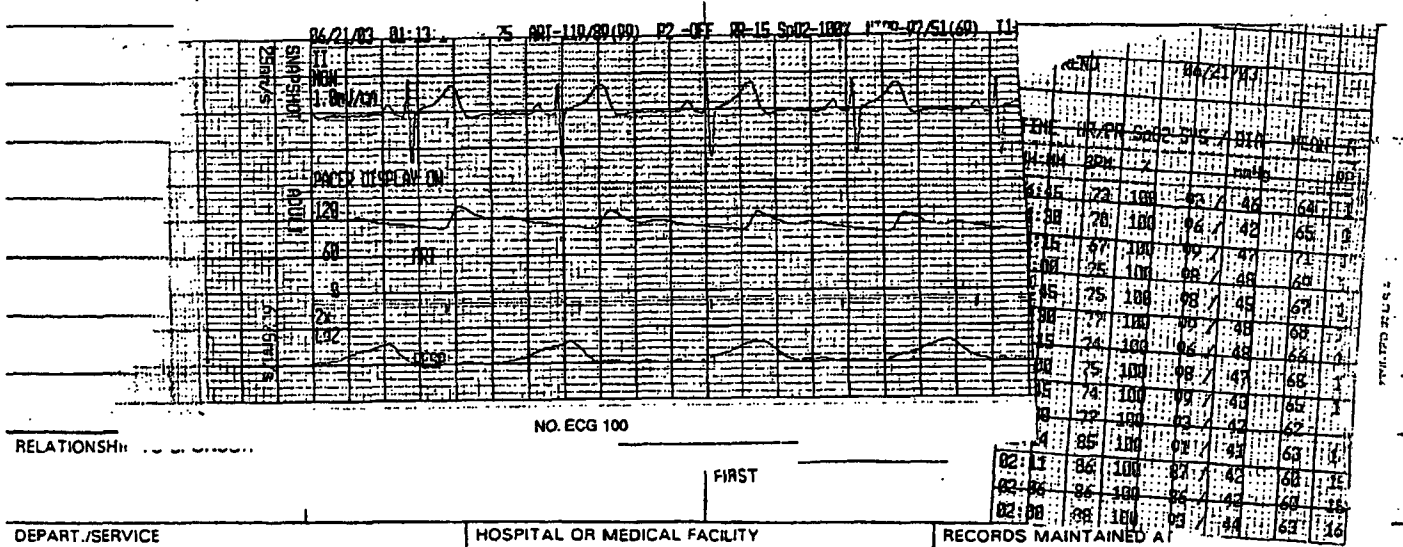
MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21 Jun 03 0215	Art line waveform dampened, reading on monitor very positional NBP 91/41 will continue to monitor — [redacted] KT-Hi
0230	NBP 93/42, art line waveform continues to appear dampened [redacted] KT RN
0300	NBP 98/47, urine output 35 cc this hour — [redacted] KT-Hi
0400	Assessment done, Propofol titrated down between 0200 and 0300 to 40 mcg/kg/min (13.2 ml/hr) and between 0300 to 0400 to 30 mcg/kg/min (9.9 ml/hr) client tol well. Fentanyl titrated up to 150 mcg/hr @ 0200, ~~Hbss~~ no change in assessment at this time — [redacted] KT RN
0500	Propofol titrated ↓ to 25 mcg/kg/min @ 8.3 ml/hr, Hbgs done @ 0445 from right radial stick ~~5~~ difficulty — Report given to next shift — [redacted] KT-Hi



RELATIONSHI... FIRST

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

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

[redacted]

MEDCOM - 6156

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1000 21 Jun 03	NN: Patient extubated @ 0930. NRB @ 12L placed, ABG obtained, neb given per RT. NGT d/c. A line d/c. Will continue to monitor, repeat ABG this pm — [redacted] CPT/ AN
21 Jun 03 1030	See Critical Care flowsheet for full Nursing assessment and VS — [redacted] CPT/ AN
21 June 03 1300 Resp Therapy	Attempted to wean FIO2 on Pt. D/C O2 from NRB mask @ 10 L/min to a 50% Venturi. Pt desated to mid 80's quickly c/o SOB & Difficulty breathing. Returned to NRB @ 10 L/min. Pt O2 SAT Returned to 98%. Pt resting comfortably c no S/S of Resp difficulty. — [redacted] CRT
21 Jun 03 1400	Patient c/o pain & temp to 102°. Medicated c tylenol and toradol per orders. Will continue to monitor — [redacted] CPT AN
21 Jun 03 1640	End of Shift note: no change in assessment from above. Will start on clears tonight given IS, will encourage use. — [redacted] CPT AN

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

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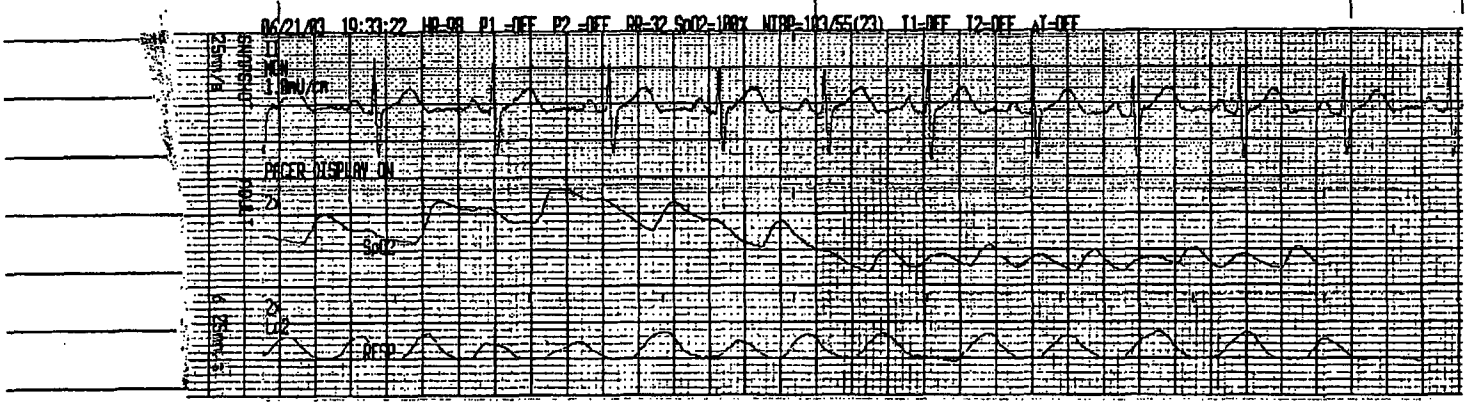
MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21 Jun 03 1700	Report from day shift, client in bed connected to monitor, on NRB mask, chest tube x2 to Right chest connected to suction @ 20cm H2O pressure, foley patent and draining IVF infusing via Left neck PIV. [redacted] VSS
1800	Assessment done, see DA Form 4700. Good effort on incentive spirometer. [redacted] VSS.



NO. ECG 100

21 Jun 03 1945	Medicated c 4mg MSO4 for pain, sat client up in bed. TSX10, good effort. [redacted] VSS
21 June 03 2100	pt requesting more blanket. Two blanket applied SaO2 @ 89%, encouraged to take deep breath. pt able to follow instructions. Lungs coarse rhonchi and crackles, auscultated throughout

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | SPONSOR'S ID NUMBER (SSN or DoD ID) [redacted]

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY [redacted] Ft. Hood, TX

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]

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 - 6158

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21 June 03	Lung fields ↑ more on posterior bases. HR IR BP 112/61 RR 36 shallow, pt on 100% NRB. Lasix 20 mg IVP given. Evaluate Lung sounds for diuresis. [b)(6)-2] MMSA. CXR ordered. Dr. [b)(6)-2] called to bedside and here to evaluate pt @ bedside.
21 June 03 2120	pt unable to tolerate being flat. SaO2 ↓ 87% during portable CXR. ↑ HOB to 45°. SaO2 ↑ to 96% RR 40 to 45. Labored. CXR shows ↑ infiltrants to (R) lower and middle lobe. Continue to monitor RR closely. pt able to follow simple directions.
2125	pt requesting po H2O. Pranks small cup H2O. SaO2 ↓ 87% c mask on for a minute. Skin warm dry. [b)(6)-2] SMSA. Responding IVP Lasix. Urine clear water color draining. Will check lyte panel via M.D. pt calm and cooperative [b)(6)-2] RRT
2200	Lung sounds improving Scattered Rhonchi c crackles to bases O2 Sat ↑ 98%, RR 30, client calm, minimal accessory muscle use for respirations. [b)(6)-2] RRT
2305	Medicated c Singulair for pain [b)(6)-2] CPT
2320	Medicated c 30 mg Toradol for pain [b)(6)-2] CPT
2325	Lungs c coarse rhonchi and crackles bilat. Dr. [b)(6)-2] notified, order obtained 20 mg Lasix given IVP, will monitor closely. [b)(6)-2] CPT

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[b)(6)-4]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21 Jun03 2400	Assessment done, lungs ō wheezes bilat — [redacted]
22Jun03 0025	Albuterol treatment given bid PT for wheezing — [redacted]
0045	lungs ē rhonchi bilat, O2 sat 100%, IS NO ō good effort — [redacted]
0200	client asleep, lungs with scattered rhonchi, O2 sat 99% on 100% NRB, minimal use of accessory muscles for respirations — [redacted]
0300	lungs ō scattered wheeze, O2 sat 100% on NRB, changed to 50% Ventimask at this time, will monitor O2 sat closely — [redacted]
0310	O2 sat 98% on 50% ventimask — [redacted]
0400	blood drawn and sent to lab, temp 101°, medicated ē tylenol for pain with 5mg MS, lungs clear to upper lobes, scattered rhonchi to bilat bases ō diminished sounds to RLL — [redacted]
0500	Report given to next shift — [redacted]
22Jun03	Surgery Day 2 Extubated yet currently febrile poor inspiratory effort ē hypercapnia / hypoxia on 50% ventilating, fluid overload NG out chest tube yet yet o/p GU, incentive spirometer Cont Antibs [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.

PROGRESS NOTES
Medical Record

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[redacted]

MEDCOM - 6160

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
21 Jun03 2400	Assessment done, lungs ō wheezes bilat — [redacted]
22Jun03 0025	Albuterol treatment given by RT for wheezing — [redacted]
0045	lungs ē rhonchi bilat, O2 sat 99 100%, IS 1100 cc good effort, — [redacted]
0200	client asleep, lungs with scattered rhonchi, O2sat 99% on 100% NRB, minimal use of accessory muscles for respirations — [redacted]
0300	lungs ō scattered wheeze, O2 sat 100% on NRB, changed to 50% Ventimask at this time, will monitor O2 sat closely — [redacted]
0310	O2 Sat 98% on 50% ventimask — [redacted]
0400	blood drawn and sent to lab, temp 101, medicated ē tylenol for pain with 5mg MS, lungs clear to upper lobes, scattered rhonchi to bilat bases ō diminished sounds to RLL — [redacted]
0500	Report given to next shift — [redacted]
22Jun03	Surgery Day 2 Extubated pt currently febrile for improving effort ē hypoxemia / hypoxia on 50% ventilatory effort will d/c and check the pt at ABG, incentive spirometer. Cont Antibx [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.

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Medical Record

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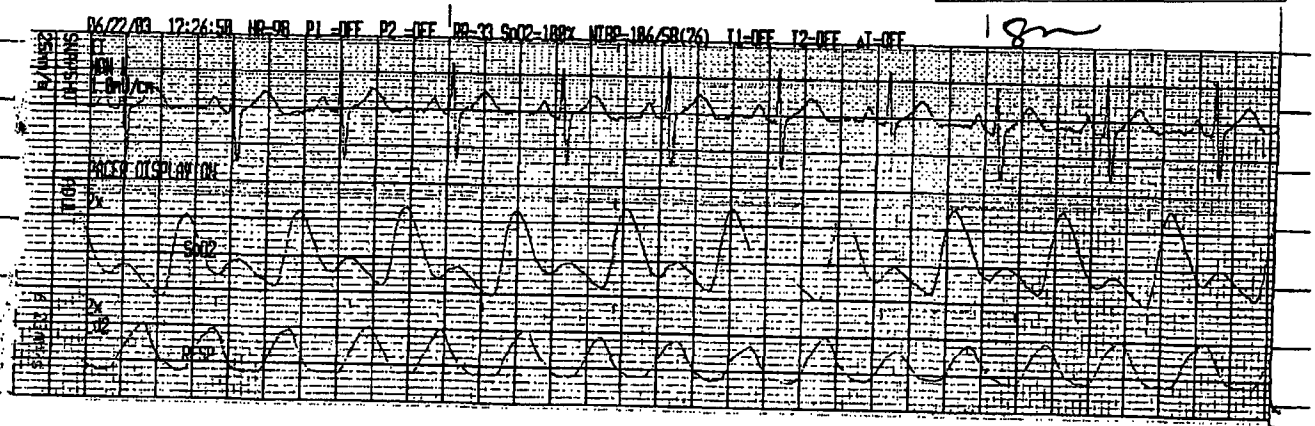
[redacted]

MEDCOM - 6161

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22 Jun 1600	Pt had a temp of 101.9 650mg Tylenol were administered, one hour later pt temp remains elevated @ 101.4. Pt c/o pain in middle of back. 3mg MSO4 administered. MO notified of temp. [redacted] LPN
22 Jun 03 1700	Report received from day shift. Client in bed connected to monitor and oxygen. chest tube patent c 20cm H2O suction, foley → gravity. IV's infusing via left neck PIV. [redacted] LPN
1720	Assessment done see DA Form 4700. [redacted] LPN

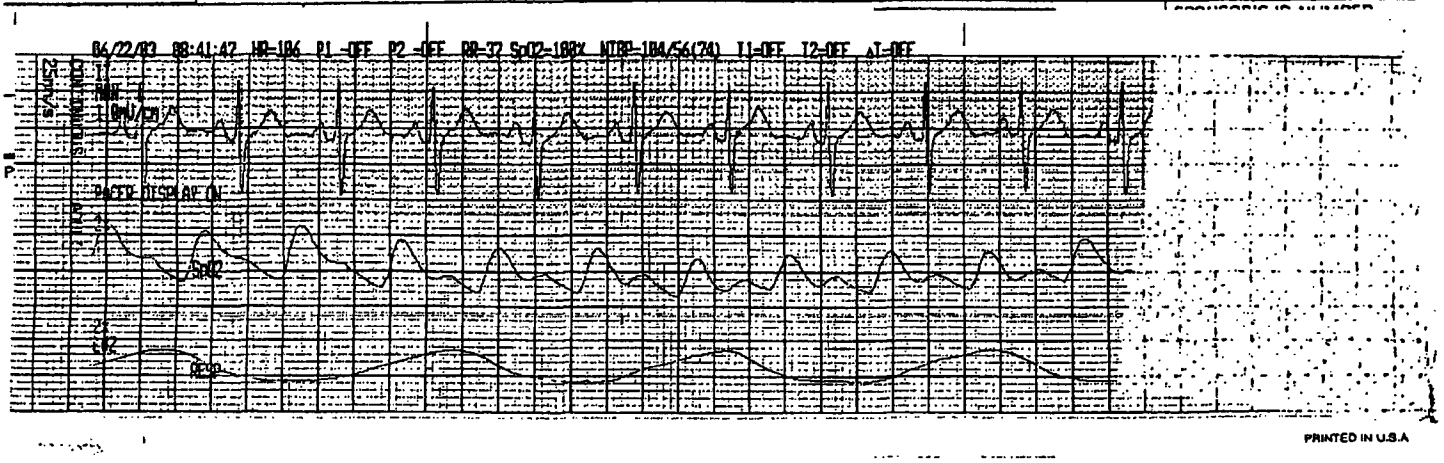


1900	Temp ↑ 101.9, medicated c tylenol PO, medicated with Toradol 30mg + MS 5mg IVP for pain. [redacted] LPN
2000	client OOB to chair with two assist, NRB mask @ 100%. D/C'd, placed on 50% venti-mask at this time. [redacted] LPN
2100	Complete bath given in chair, foley care done, teeth brushed, dsg change done to left neck PIV. [redacted] LPN
2200	back to bed, client temp ↓ 99.8, ↓ SpO2 to 40% venti-mask. [redacted] LPN
2215	Pulse ox 96% on 40% venti-mask @ 8L/m. [redacted] LPN
2220	good effort c IS x10. lung clear RUL, RLL, LUL, diminished to right lower lobe. [redacted] LPN

STANDARD

MEDCOM - 6162

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
22Jun03 0600	Pt awake - no % pain or discomfort however appears to be using accessory muscles to breathe @ a rate of 40-50. 4mg MSO_4 administered. Assessment performed - see DA 4700. VS otherwise stable, pleuravacs @ 20cm H_2O to suction putting out approx 5-10cc/° each. CXR repeated this AM. Will monitor — [b)(6)-2] LPN
0630	Pt attempted to eat breakfast however continued to de-sat to 85%. Switched to non-rebreather @ 10lpm. ABG drawn - PO2 @ 57 - MD notified — [b)(6)-2] SGT/LPN
0800	MD came to assess pt - pulled anterior chest tube. 3mg IVMSO4 administered. — [b)(6)-2] LPN
1115	@ 40 x 2° - MD notified. 30mg Toradol given in order to get pt OOB to chair — [b)(6)-2] LPN
1118	Patient c decreased breath sounds in all fields. Respirations labored with rate of 37-40. Pulse ox 100% on non rebreather. Equal rise and fall of chest noted without use of abdominal muscles. DR [b)(6)-2] notified. Ordered to monitor after given Toradol 30mg IVP and assist patient out of bed to chair. — [b)(6)-2] [illegible]
1300	Pt OOB in Chair - Spoke to interpreter, interpreter stated that his mental state was better today. Pt tolerated move OOB - voiced concern for his family. VSS. — [b)(6)-2]



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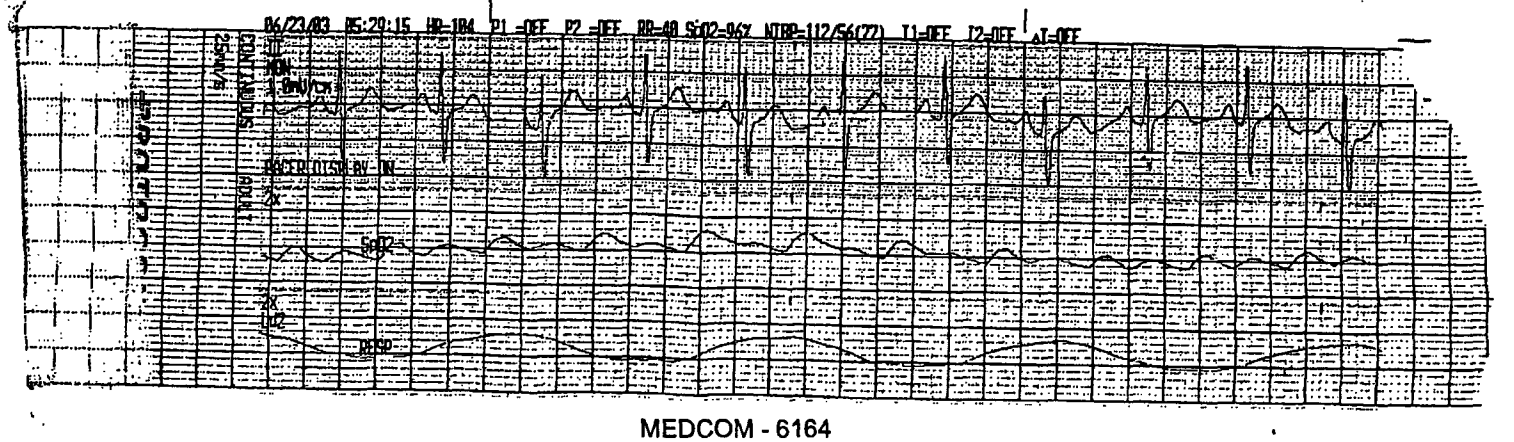
MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
22 Jun 03 2300	Report given to next shift, client in bed on 40% ventimask. LR @ 75 cc/hr via left neck PIV. right chest tube to suction/pressure, gently bubbling noted in chamber drsg D&I. HOB elevated. [redacted]
22 June 03	2300: Received report, assumed care of pt. Pt sleeping supine, HOB @ 75°, (+) Ventmask in place @ 40% & 8L. RR = 23-25 BPM Sats 96-97% Ø evidence respiratory difficulties. Cardiac monitoring in place, cuff to (L) brachial. VS stable. LR infusing @ 75 cc/hr (L) EJ Ø evidence of phlebitis or infection @ insertion site. (+) Indwelling catheter, dark concentrated urine. UOP L 30cc/L. will continue to monitor. CT in place, to (R) thorax. Drsg CDI, (+) Recoil @ 20 cm suction (+) Serous sanguinous drainage. L 10 cc/hr. Plan: monitor resp status, attempt to wean, maintain HOB ↑. Encourage I.S. Monitor UOP, consider Bolus if ↓ UOP, Maintain good pain control. A&O x 4 this time, asleep w/out evidence distress or discomfort. Complete assessment noted on DA Form 4700 — [redacted]
	2330: VENTIMASK SETTING ↓ from 40% @ 8L to 35% @ 8L. Sats 97% RR 23-24, Ø evidence distress — [redacted]
	2335: (+) IS - 10 Breaths @ app 200 cc/sec. — [redacted]
	0115: UOP = 20 cc from 0000-0100. (+) ↑ crackles to (L) L Base, inf 99% RA Lasix 20mg IVP administered. Eval pending — [redacted]
	0135: Sats ↓ 89% RA 03 @ 7L° RR 47. Rx reposition, placed on Ventimask

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



MEDCOM - 6164

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23 June 05 0135 (Cont)	↑ from 35% to 40% @ 8L Sats ↑ 94% - 95% RR ↓ 34 BPM VOP pending total since last administration. TS x 5 breaths between 600 - 650 cc/sec. Breathing remains tachypneic; shallow. Pt encouraged slow, deep breaths. [b)(6)-2] 0315: Pt sleeping quietly VS stable sats 97% RR 34, no evidence respiratory difficulties will cont. to monitor. 0435: CBC, Chem 8 drawn from (L) AC. LR infusing @ flush CXR, no evidence of filtration. Lab values pending. @ TS x 10 ē 5 @ 700 cc/sec. 120cc PO H_2O. Pt returns to sleep VS. Stable [b)(6)-2]
0530	Pt awake - assessment performed see DA 4700 - VSS. Will monitor. [b)(6)-2] LPN
0700	Still only 10cc urine out this shift - lungs still rhonchi on (R) side however breath sounds are diminishing - Pt ate small amt breakfast - Ad to NC, tolerating well. Will monitor UO & resp status. [b)(6)-2] LPN
1100	Pt was OOB to chair for one hour & 1/2. tolerates well. Repeat CXR done for CT waterseal. Awaiting orders from MD. [b)(6)-2] LPN
1330	Still minimal urine output Foley d/c'd per Dr [b)(6)-2] order. 1i Percocet given for % pain in back. [b)(6)-2] LPN
1430	Pt OOB to chair - incentive spirometer done. pt tolerated well. O2 back ↓ to 4 lpm, Sats 100%. [b)(6)-2] LPN
1735	Received report, assumed care of pt Pt resting in bed, awake, alert oriented. O2 per NC @ 4L sats @ 99-100% RR 25-30 BPM, CT to water seal minimal OP. Resting resp. unlabored & distress. LR infusing to (L) E) w/o evidence of infiltration. Infusing rate 75 cc/hr

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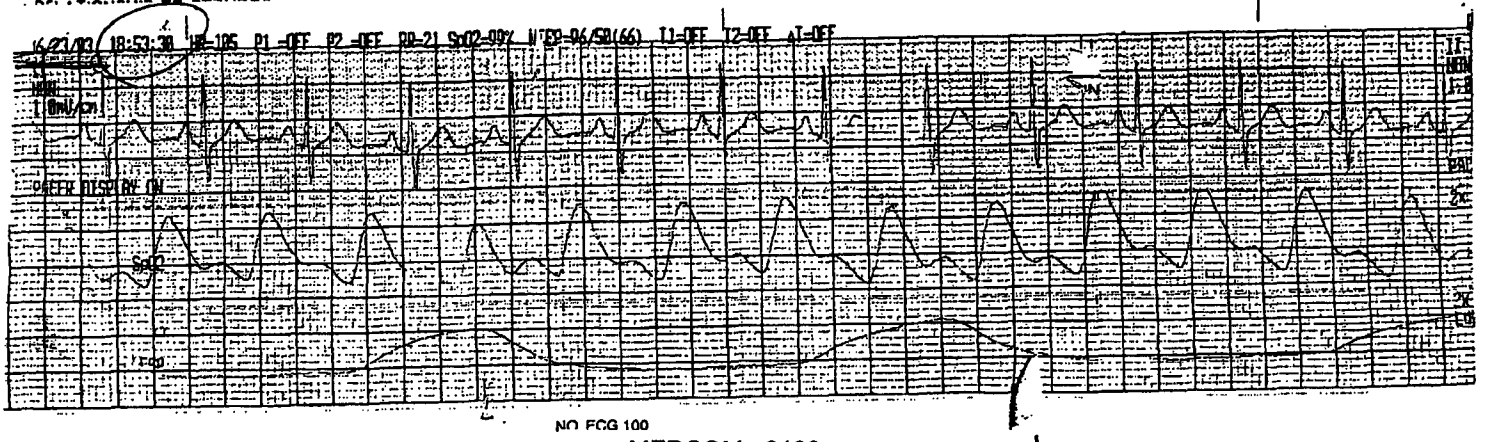
MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
24 Jun 03	resting w/o rest resp. distress. (B) diarrhea small, brown loose stool - [redacted] 0415: Fotegeron: (S) c/o abd. pain. (O) 55 x y g. (A) tenderness on palpation, abdomen taut, (E) distention. Foley placed > 400 cc dark concentrated urine out. B. retained to sleep. NC placed @ 5L thru nasal pt, sats @ 93-99% RR 22. Pt resting comfortably [redacted]
	0430: labs drawn, CBC, chem 8 - taken to lab values pending [redacted]
	0445: Foley D/C'd 475 cc concentrated yellow urine out- pt resting, VS stable [redacted]
24 Jun 03 0530	Assumed care of pt resting in bed. lungs c coarse breath sounds noted bilaterally c diminished breath sounds noted in (B) lower lobe. (B) lateral chest tube c minimal amt of serous sanguinous drainage. Encourage use of incentive spirometer and coughing. O_2 @ 3L via NC c sats 96-99%. See NA 4700 for initial assessment. Pt still unable to void, will monitor urinary status. Will continue to monitor [redacted]
0700	Pt tolerated small amt of breakfast. Advised to eat more than a few bites. Currently denies discomfort, will continue to monitor [redacted] cp/to
0930	Pt c diarrhea x4. Ambulated to chair and cleaned. c/o stomach cramps and was placed on bedside commode [redacted] cp/to
1000	Pt c another episode of diarrhea c small amt of urine noted. HR increased to 110 c ↑ resp rate. Encouraged cough + deep breathing. Will continue to monitor [redacted] cp/to



MEDCOM - 6166

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23 June 1335 (NSG Cont.)	(+) continuous cardiac monitoring; VS stable @ this time. UOP s/p D/C of foley pending. Plan: Cont. close resp monitoring. Encourage OOB, incentive spirometer c goal of 10 consecutive breaths >400 cc/sec. and participation in ADLs. Attempt wean pain Rx to ↓ from 4L - 2L NC. 2) Monitor UOP - I/O - carefully. In-out Cath c Rx as needed output. 3) Maintain good pain control, RTC - c Percocet & Toradol. For full assessment see Flt. Form 4700 — [b)(6)-2]
1830:	Percocet ii Tab PO administered for pain control. —
1930:	Pt OOB to chair, (+) complete BATH, shampoo -, (+) BM x 1, small soft runny brown stool. UOP appx. 15 cc. Pt [b)(6)-2] not pres No actual taken @ this time. PO fluid intake encouraged Incentive spirometer x 20 c pt successful c 900 cc/sec x 10 breaths. Pt weak on feet, requires assistance OOB, to bed. Pt cooperative & calm @ this time. Sat @ 98-100% w/ O_2 @ 5L per NC. Deep breathy encouraged. Denies to ET & N/T dyspnea from bath. [b)(6)-2]
0130	Pt assisted back into bed VS stable. O_2 ↓ 3L c sats remain @ 98%. RR 20-30's. No evidence of distress, pt calm & cooperative.
2135	LATE NOTE; 1830 Pt consumed 10-15 % / every meal c C/ N/V or abdominal discomfort. [b)(6)-2]
2300:	Pt awake, (+) VS x 20 hours consistent @ 900 cc/sec. Continue performance. Toradol 30mg given for RTC pain management. Rx's unchanged from previous recommend. [b)(6)-2]
0100:	Pt sleeping quietly. VS stable No evidence distress -
0315:	Pt to Bedpan. (+) Nasat to 4L 98's. RR 30's SI WNL HR 110. Ventimask placed @ 50% @ 10L, pt repositioned, HOB @ 90°, Deep slow Breathing encouraged Sats stabilized @ 95% RR 20 HR 95. Pt

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[b)(6)-4]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24 Jun 03 1200	Pt c another episode of diarrhea. Stool sample sent to lab for fecal WBC count. Pt c/o feeling dizzy, was cleaned and placed back into bed. Vs stable, will continue to monitor — (b)(6)-2 — cpt Jon
1500	Pt c episode of incontinence/diarrhea. States he was asleep and noticed when he awoken that he had gone. Cleaned up and placed back in bed. Will continue to monitor — (b)(6)-2 — cpt Jon
1600	Pt c episode of diarrhea. Ambulated to bedside commode x 1 without difficulty. Doctors aware and Flagyl ordered. Vs stable, will continue to monitor — (b)(6)-2 — cpt Jon
1700	Report given to oncoming shift — (b)(6)-2 — cpt Jo
1720	Pt sitting up in bed, answering questions from interrogator - Pt c NC @ 3L Pulse ox 97% VSS 105/72 P-100 R-16 EJ 18G IV c/a infusing LR @ 75cc/hr (L) side lateral CT to 20cm suction DSD CDI Sutures to (R) hand well approx c/s/d/i - will continue to monitor c interrogation — [redacted] (b)(6)-2
1800	Pt. tolerating reg diet - Lungs (L) side upper lobe audible wheezes - Productive cough - weak effort (+) pain with cough guarding (R) side - Percocet for pain - Pt up c chair encouraged coughing and standing exercises arms - 200 cc PO H2O, apple, peanuts — (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NO. (SSN or Other)
	LAST	FIRST	MI	[redacted] (b)(6)-2

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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)*

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(b)(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24Jun03	
2100	Pt. Pulse ox ↓ — lying in bed - sleeping - mouth breather ↑ O2 ↓ 5L NC Pulse ox ↑ 98% EJ dsg A'd 200 cc UO - will continue to monitor — [b)(6)-2] (b)(6)-2
2300	Pt up to chair x15 minutes IV ancef administered - CT draining sm amt of serosanguinous discharge — [b)(6)-2] (b)(6)-2
0100	Pt sleeping, NAD, VSS 110/58 P-90 R-16 Pulse ox 92%-94% 3L NC — [b)(6)-2] (b)(6)-2
0300	Pt's complaints — requested water 100cc CT output 50 cc serosanguinous 108/57 P-89 R-26 Pulse ox 100% 4L NC - Productive Cough enc. IS will continue to monitor — [b)(6)-2] (b)(6)-2
0400	PCXR request sent in - Labs drawn Pt's complaints - awake 110/64 - P-93 Pulse ox 100% on 3L NC R-20 — [b)(6)-2] (b)(6)-2

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES	
25Jun03	Pt OOB to BSC. Tolerated well. — [b)(6)-2]	LPN
0800	Pt had loose BM x1 — [b)(6)-2]	LPN
1000	Pt OOB to BSC again. Pt had loose liquid BM x1 — [b)(6)-2]	LPN
1720	Received report from [redacted] (b)(6)-2 on pt who is resting quietly c eyes closed. NC on @ 6 LPM humidified O_2. LR @ 75 cc/HR to (R) EJ, @ SS of infiltration. HOB @ 30°, chest tube #1 to water seal on (R) chest, 20 cm H_2O. VSS-SR [b)(6)-2]	
2130	PT → BTB Benadryl 50mg given as order for insomnia. Pt in bed c eyes closed will monitor — [b)(6)-2]	SGT USTIME
0100	Pt. sat in portable toilet seat, after having had a BM in pants, cleaned, stool was soft and runny, pt was able to dress self and be returned to bed. O_2 was turned down to 2 LPM via NC earlier, pt. has tolerated well, SaO_2 98% will continue to monitor — [b)(6)-2]	
0530	Report received. Pt awake & c/o pain in stomach. Benty/ given. Assessment performed - see DA4100. [b)(6)-2]	LPN

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.

[b)(6)-4]

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25Jun03	Pt OOB to BSC. Tolerated well. — [redacted] LPN
0800	Pt had loose BM x1 — [redacted] LPN
1000	Pt OOB to BSC again. Pt had loose liquid BM x1. [redacted] LPN
1720	Received report From [redacted] (b)(6)-2 on pt who is resting quietly c eyes closed. NC on @ 6 LPM humidified O_2. LR @ 75 cc/HR to (L) EJ. @ ss of infiltration HOB @ 30°, chest tube x1 to water seal on (R) chest, 20 cm H_2O. VSS — SR [redacted]
2130	PT → BTB Benadryl 50mg given as order for insomnia. Pt in bed c eyes closed will monitor — [redacted] SOT ust guard me
0100	Pt. sat in portable toilet seat, after having had a BM in pants, and directed, stool was soft and runny, pt was able to dress self and be returned to bed. O_2 was turned down to 2LPM via NC earlier, pt. has tolerated well, SaO_2 98% Will continue to monitor — [redacted]
0530	Report received. Pt awake & c/o pain in stomach. Benty/ given. Assessment performed - see DA4100. [redacted] LPN

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)*

[redacted] (b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
0700	Pt refused breakfast, drank apple juice. Refused Carnation shake. Still Ø BM this sh. ft. Pt c/o mild nausea. Pt continues to sleep reguardless of nausea. Will monitor for discomfort. [redacted] CRN
0830	Pt OOB to BSC. BMx 1, liquid 1 some semi formed stool, pt had Ø c/o nausea. Received 0800 dose of Phenergan. Returned to bed & is sleeping. Will monitor. [redacted] SGT [illegible]
1200	Pt attempted to eat lunch - had episode of nausea but no vomiting. 4mg Zofran given IV. [redacted] LRN
1200	Chest tube turned on to suction per Dr. [redacted] LRN
1400	Pt c another episode of diarrhea, approx 500cc fluid, some semi formed stool. Dr. [redacted] notified. [redacted] LRN
1700	Report recieved from dayshift - Pt A+O×3 Vital
26 June 03	Signs Stable 112/60 P-92 R-26 Pulse ox 98% on 2LNC (L) EJ intact LR @ 75 cc/hr - patent & sl ox of inf Lungs continue to sound junky - will enc. activity and incentive spirometry - productive rattling cough - Pt seems to have somewhat labored breathing Pt weak, not active ateblu CT x1 (R) lateral side Ad by dayshift CDI 20 cm continuous suction - t/o (LC average 10-20 cc output serous sanguinous - will continue to monitor [redacted] SGT [illegible]
1730	Pt tolerated diet 1 apple - 2 bites of bread 1 packet of jelly 50 cc H20 [redacted] SGT [illegible]
1800	Two Percocet for pain/prophylactic to enc coughing OOB activities

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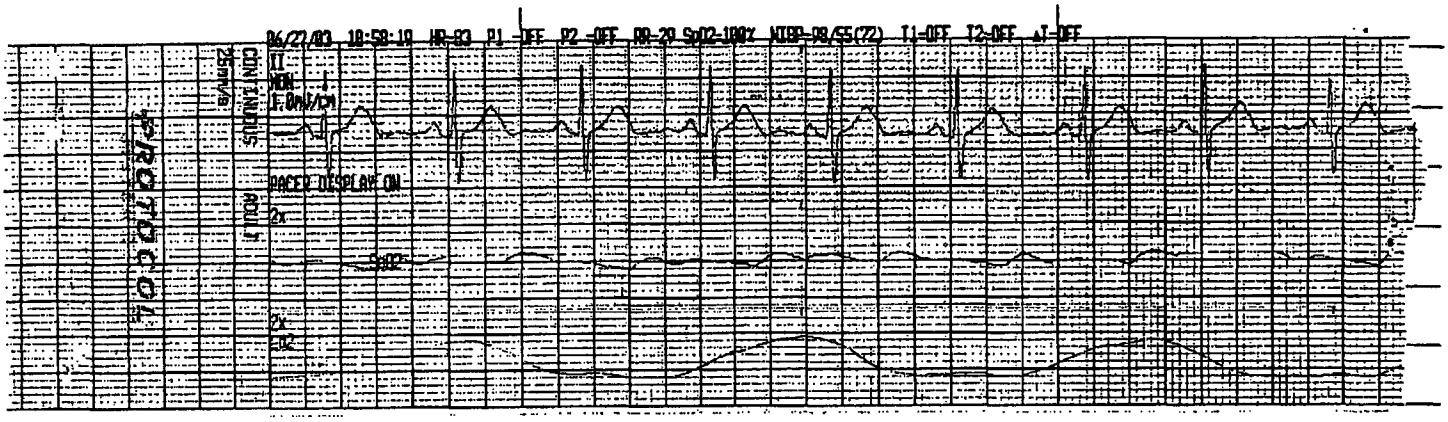
LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27 JUNE 1100	Pt back in bed c very little assist x1. [redacted]



1230	Pt appetite fair for lunch, ate 75%. PO fluid intake good. Ø c/o nausea at this time. [redacted]
1400	Temp starting to ↑ to 101°. Will monitor. Skin warm to touch c Ø diaphoresis. [redacted]
1600	Temp 99.7. Ø interventions given [redacted]
1700	Report received from SPC [redacted], CT to Ⓡ side, continuous suction, Ⓐ 1L c LR @ 75 cc/HR, ⊕ edema to Ⓑ feet, ⊕ pedal pulses. [redacted] SPC [redacted]
1900	Pt. up to bedside chair c assistance x1 hour, walked up and down ward, USS [redacted] SPC [redacted]
28 JUNE 0015	Pt. voided approximately 150 cc's. Zaroxolyn given to prevent further water. USS [redacted] SPC [redacted]
0200	Pt. resting quietly c eyes closed. USS [redacted] SPC [redacted]
0400	Pt. resting quietly c eyes closed. USS - SPC [redacted]

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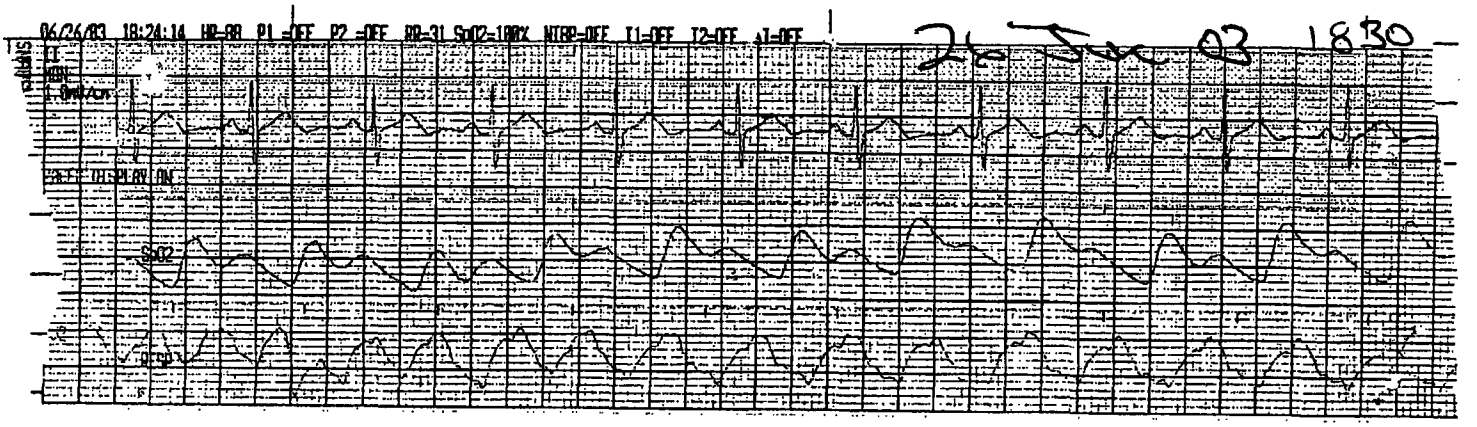
LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES



1830	Pt OOB to chair x20 minutes - tolerated well
	V.S. Sign Stable HR-93 Pulse ox 98% 2L NC
	Pt weak - productive cough & exertion
	no physical effort to move - Pt needs to be
	strongly enc to move ——— [b)(6)-2] SGT GIVENS
2100	Stitches/Sutures x2 to (R) hand removed
	wound well approximated @ SSX of index dig and
	scabbed over @ pain, FROM (R) hand. [b)(6)-2] SGT
2200	300 cc urine output yellow clear - (+) Nature
	Pt OOB to commode x 20 minutes Temp
	99° @ Tylenol 650mg PO administered IV
	4mg MSO4 for comfort/sleep - Pt encouraged to
	Cough, Deep Breathe - will continue to monitor
	while asleep ——— [b)(6)-2] SGT GIVENS
2300	Pt sleeping CT to section 200 on HS
	LR infusing @ 75 cc/hr. Pulse ox 99% 2L
2200	Addendum to 2200 note
	MSO4 instead of Percocet due
	to tylenol dosage

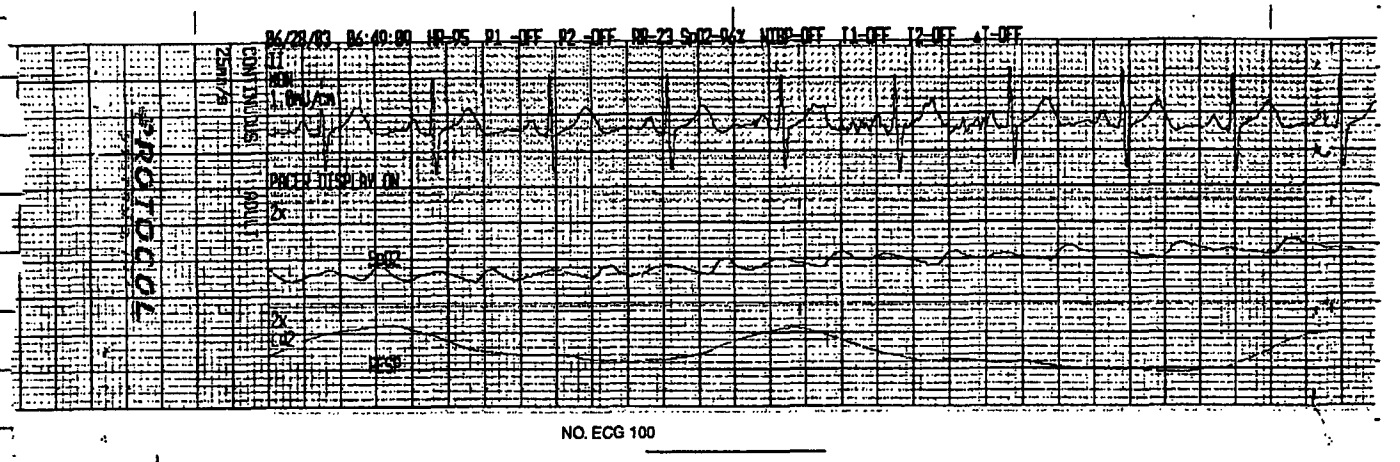
STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

MEDCOM - 6174

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28 JUN 03 0515	Assumed care of pt @ 0500 report rec'd. Assessment complete see ICU Flow sheet. CXR obtained. (b)(6)-2



NO. ECG 100

0715	Pt ate 30% bkft. Encouraged to eat more but gestured he was full. (b)(6)-2
0800	Am care done by pt. Assist only c washing d.& back. (b)(6)-2
0815	Pt assisted OOB to bedside chair c minimal assist x1 (b)(6)-2
0930	Pt ambulated approximately 300' c used assistance x1. Gait steady but took shuffled steps. Encouraged to take bigger steps but did not. SPO2 90-95% during ambulation. (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.
(b)(6)-4		

PROGRESS NOTES
Medical Record

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

MEDCOM - 6175

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28 JUN 1057	Order rec'd to transfer pt to ICW. [redacted]
1057	Report given to ICW nurse
1125	Transferred pt to ICW. Pt ambulated as he did earlier in AM, [redacted]
28/2000 JUN 03	NURSING ASSESSMENT: Pt ambulated to ICW c steff. Pt is awake, alert, Ox3. Airway intact, breathing is even & unlabored. Lung sounds diminished to bases (B). CT to (R) Pleur. Drsg CDI, CT to low suction. Abd soft, nontender, & distended. Pt c/o ↓appetite. BS(+)x4 but hyperactive. Amb'g ASAT on'd on ward but per report, pt ambs spontaneously. ROM and neurovascularly intact to all extremities. IV to (L) ES, Pulses wdl c no s/s of infiltrate or infection. Restraints in place per ICW protocol. [redacted] CPAM
28/1800 JUN 03	WOP for shift c 675, dark, fleecolored urine. CT output since assmt on ward c 5cc. [redacted] CPAM
28 JUN 03 @ 1800	RN Shift assessment: Chest tube dressing is CDI; Resps are even and unlabored. Chest tube draining scr sanguinous fluid. Appears very suspicious with regards to food. Encouraged pt by opening food packets in front of him. Will continue to monitor [redacted] cm
29 JUN 03 @ 0100	RN - Pt c/o pain at 2200 and was given long PRN MSO4. Pt was also repositioned and seemed to appear more comfortable [redacted]

NSN 7540-00-634-4176 — 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
29 0700 JUN 03	Nursing Assessment: Pt is awake, alert, Ox3, A&Ox3, talkative, breathing is even and unlabored. Lung sounds diminished to bases (B). CT to (R) chest drainage, drsg CDI. (R) leaks noted to tubing system, water seal + bubbles. CT is to continuous suction. Pt has minimal serosanguinous drainage. Abd is soft, nontender, + distention. Pt voids spontaneously. PPMs and neurovascularly intact to all extremities. IV to (L) FA, drsg loose, re-dressed using sterile technique. Pt c/o pain to back side. Upon inspection, noted a ½ dollar sized 2° pressure sore to sacral area, at superior edge of anal cleft. Pt turned to (L) side and padded + blankets. Will continue to monitor. [b)(6)-2]
290830 JUN 03	Ambulation Note (Nursing): Pt ambulate approx 300 feet with standby assist. Also sat in chair for approx ½ hour. Appetite has been minimal. For breakfast, pt drank milk + Carnation Instant Breakfast. Able to orally take pt into eating an apple. Drsg to (R) FA d/t using sterile technique. Site cleaned + probe + alcohol prior to replacing occlusive drsg. CT replaced to suction. [b)(6)-2]
29 JUN 03 2040	RN shift assessment note: Pt appetite appears to be a bit heartier this shift, ate approx 40% of dinner (and verbalized a desire for nice fruit which he was given). Swelling to both feet/ankles still seen (non-pitting edema), so feet are raised on pillows. Denied any pain. Voiding + any difficulty. Breath sounds WNL for baseline. Will get

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)* [b)(6)-4]

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE — MEDCOM - 6177

STANDARD FORM 600 (REV. 5-84) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	pt to get up to bedside chair. Will continue to monitor — [redacted] CAR
30JUN03 0200	RE + C/O pain to abd. Pointed to midline up above umbilical area. MS04 for pain: [redacted]
30 JUN 03 0230	RN shift update: At approx 2200, found pt's IJ IV to be non-patent and red. IJ removed, and new IV placed into left bicept area. Pt was also placed in a chair next to bed for approx ½ hr. C/O nausea upon getting back in to bed and was given Zofran at 2300. No episodes of emesis. Will cont to monitor — [redacted] CRT
30 JUN 03 0415	RN: CXR done — [redacted] CAR
30 JUN 0620	Nursing Assessment: Pt awake, ø C/O pain. Pt alert, attempts to respond using hand gestures. Lungs sound clr, difficult to get pt to take a deep breath, ↓ BS, ø N/V @ present. Pt has mild edema BLE, feet are elevated. Chest tube to ® flank to waterseal, intact; ø drainage noted @ site. Dreg above chest tube ODI. Chest tube is draining sero-sang fluid — LT [redacted] AA
0620	Nursing Assessment: Pt has decub ulcer to sacral area, nickel size. Attempt to get pt on side & off ulcer, pt refuses. Repositioned blanket under pt to take pressure off area. Pt is voiding clr, tea colored urine — LT [redacted] AA
0715	Nursing - Pt ↑ OOB to chair, Personal hygiene performed by pt, Δ pt linen & pajamas — LT [redacted] AA
0920	Nursing: Pt back to bed & assist — LT [redacted] AA

*U.S. Government Printing Office: 1995 — 387-722/20035

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 6178

ACLU-RDI 1330 p.62

DOD 15275

PROGRESS NOTES

DATE	
30 Jun 03	Nursing: Nutrition: Pt refuse lunch brought by NCD.
1210	Ate rice from MRE meal, pt tolerated well ——— LT [b)(6)-2]
1840	Nursing: Chest Tube – Pt has 45 cc of sero-sang drainage from chest tube since 0500 ——— LT [b)(6)-2]
1800	Nursing assessment: Pt alert at this time. AAOx3. PERRLA. Mucous membranes pink, moist and intact. Neck supple, FROM. Lungs CTA bilat. Diminished breath sounds to (R) side. Chest tube drsg. CDI, no new drainage noted. 30cc sero sanguinous drainage to water seal. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Ate good amt of dinner – rice, fruit and vegetables. Ø N/V. Strong pulses and brisk cap refill x4 extremities. Pt lying on (L) side to keep off of nickel Dsg'd decubitus ulcer on Sacrum. Ø drsg, open to air. [b)(6)-2] LT
01 July 03	Pt c/o "acidity" to abd. Given 30cc
0100	Maalox PO. Effective for pain. [b)(6)-2] LT
0300	Bm to bedpan x1. Dark, formed stool. 700 cc dark yellow urine to urinal [b)(6)-2] JT
0500	30cc sero-sanguinous drainage to chest tube since 1800 last night ——— [redacted] (b)(6)-2 LT
0630	Nursing Note: Asst pt ↑ OOB to chair for breakfast ——— LT [b)(6)-2]
0820	Nursing Assessment: Pt ↑ in chair, requesting to get back in bed. Pt tachycardic, HR 110. Lungs CTA. BBS. c/o Drsg to (R) flank @ chest tube c serous, dried drainage. Drsg

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
	above chest tube, site CDI. Pt ate approx 50% of
	Breakfast (fruit cocktail & milk bread) — LCT [redacted] AN
0830	Nursing: Assist pt back to bed — LCT [redacted] AN
1205	Nursing: Pt ↑ OOB C assist. Ambulate the ward x 2.
	Pt tolerated well — LCT [redacted] AN
1450	Nursing: Vitals Pt temp ↑ 100.4, BP 88/52, R=28,
	Will recheck vitals — LCT [redacted] AN
1500.	Nursing: Vitals. Pt use IS x 10, ↑ OOB to chair. T=99.7,
	BP 98/58, R=30, P=109 palpated. Assist pt back to bed
	— LCT [redacted] AN
1520	Nursing: Vitals T 99.7 BP 88/30 R 30 P=111.
	Inform MD; MD wants pt ↑ OOB to amb — LCT [redacted] AN
1 July 13 @ 1750	Nursing notes: Assumed care of Pt @ 0. Pt C/O of
	not wanting food Pt only ate Cracker and OJ.
	Pt non compliant when told he must turn to (R) Side
	Pt indicated C Signs that too much pain
	on (R) Side.. Voided 450 cc. dark urine in BS Urinal
	will continue to monitor Status — [redacted] Concepcion
2014	Assessment completed. Pt Oriented non compliant C
	getting out of Bed & turning on Right Side
	Dressing intact. Breathing Intact. Lungs CTA
	C/V WNL (R) Side. No IV access Pt Voids Spontaneously
	will continue to monitor Status — [redacted] Concepcion

(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.

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
2 Jul 03	Nursing: Shift assessment Pt alert, Ø resp. distress, Ø
0745	SOB, lungs CTA, slight pain to (R) side, poor intake of
	V2C milk only, voiding >30cc/hr. BS (+) x4 quad, Pain meds
	given for discomfort. Continue to monitor — [b)(6)-2] CPT BN
2 JUL 03	NURSING · ASSESSMENT - PT A+O x3, PERRLA, LUNGS CTA BICAT,
	S1-S2 STRONG AND REGULAR, CAP REFILL <3, RADIAL PALPABLE X
	4 EXTREMITIES, HYPO ACTIVE BOWEL SOUNDS x4. DRSG TO (R)
	ANTERIOR CHEST C.D.I, INCISION SHOWS NO SIGNS OF INFECTION.
	PT IS RESTRAINED AND EXPECTED TO BE D/C SOON.
	COMPLAINS OF MINIMAL PAIN WILL CONTINUE TO MONITOR — [b)(6)-2] SGT, USN
3 Jul 03	Nursing Note: Assessment: Pt awake, c/o acidity to
0440	stomach, Ø given Maalox. Pt ↑ OOB to chair for breakfast
	c minimal assist. Pt amb down ward X ↓ — ILT [b)(6)-2] AN
0755	Nursing Assessment: VSS, lung CTA, BS x4, abd soft flat. Pt
	voiding tea color urine, 750 cc. Drsg to (R) chest CDI,
	steri strips CDI c edges well approximated. Decub ulcer to
	sacrum open c ~~scant~~ white edges, Ø drainage Dressing
	noted. Pt lying on side — ILT [b)(6)-2] N
3 July 03	Nutrition Note
0 A:	Pt has been followed by NCD since admission.
	Pt has presented a challenge as he has been
	refusing most foods offered especially high protein
	foods. Intake of protein foods has been
	inadequate. Interpreter consulted pt to avoid

Continue on reverse side

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

REGISTER NO.

WARD NO.

[b)(6)-4]

PROGRESS NOTES
Medical Record

STANDARD FORM 508 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC V1.00

MEDCOM - 6181

MEDICAL RECORD	PROGRESS NOTES
DATE	
7/2/07	O/C Summary 15yo c/o GSW chest 6/20 to OR for wound exploration, closure of chest tube thoracotomy Course uneventful Pt O/C POD #12 Pt c sacral decubit, under portup O/C Diagnosis: GSW chest Procedure: thoracotomy 6/20 Meds on O/C: Percocet prn pain [b)(6)-2] MAJ [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)*

[b)(6)-4]

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
3 July 03	Nutrition Note (cont)
A:	meat items from U.S. as they don't meet halaal requirements. We attempted to work around this ~ peanut butter, milk and Humanitarian Rations with limited success. Pt has begun eating small amounts of meat. Pt's estimated needs: 2200-2300 kcal (45 kcal/kg) estimated 50 Kg; 75-100 gms protein (1.5-2.0 gms/kg)
P:	Will monitor intake x 48^{6} ~ kcal count to assess current intake. (b)(6)-2 [redacted] MAJ, SP RD/LDN

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

(See Instructions on Back of this Sheet)

EMERGENCY CARE AND TREATMENT (Medical Record)

TREATMENT FACILITY (Name) (b)(3)-1

LOG NUMBER

TIME

20 Jun 03 0620

TRANSPORTATION (To Hospital) (Attach care provider sheet)

CONTENT NEED (Explain Medication and other data)

4/k

PATIENT PROPERTY (Patient / Disposition)

4/k

GSW chest - EPW

m

POx 91 | 91 | 95

0620	0636	0635
105/-	105/51	105/50
90	126	122
44	44	44
75	75	

- FRONT 3rd - THUMB (R) hand
- CHEST TUBE IN
- PT ARRIVED W/BANDAGE OVER chest wound (R) supine chest - GUNSHOT WOUND
- IV IN (L) ARM - N/RS / 2nd IV IN (R) ARM - AMBU BAG
- 0625 (L) Blood drawn for testing
- 0625 BLOOD TRANSFU ONEG UNIT # 2453211 - 0653 (E)
- ONEG UNIT # 1641861 - 0653 (E) 10710
- IV out of (L) ARM
- SUCTION/CHEST TUBE - SWITCHED OUT 70cc blood - IV IN JUGULAR - 0640 - N 0647
- POx: 100 - Pulse 93 BP: 111/46 RESP-24 (w/ Assn)
- 100mg Fentanyl IV - 0645
- 5mg Versed IV 0645
- ULTRASOUND - FAST neg 0646
- 0647 Ventilated by AMBU - RESP shared - CHEST TUBE IN 649
- 100mg Succylcholine IV
- ETT 8.0 at 24 (L) Placement Verified
- NG TUBE 0651 - GASTRIC CONTENTS - Placement verified
- POx - 99 RESP: 20 PULSE 101 BP 161/46 TEMP 98.7
- ON VENTILATOR 0700 - 600 TV Speed 100% FIO2 Rate 14 0653
- 10mg ~~Tubocurarine~~ Vecuronium / 600 Tidal Volume 100%
- ULTRASOUND 0705 - FAST EXAM (E)
- P-O2 100 PULSE 94 RESP 20 BP 114/58 - 0710
- 0725 SAT 91% 100% FIO2 PULSE 77 ST 123/75
- ABG 7.2/47.5/179/19/-9 on 100% ↓ 700 TV & Rate 18
- TO OR - 0754 - EBL (L) chest tube - 80cc
- H+H 9.9 PT/PTT 31.8 / 13/28.1 WBC 21.9
- HOP 10cc clear yellow
- LR 1500cc PRBCS - 2U

	UNITS	TIME
CHEST X-RAY		0
CHEST TUBE		06
IV		0615
ANCEF 1gm IV		0621
.5 TETANUS		0621
FULEX		0625

GSW (L) chest

QUARTERS

	AS INC	AS DEC

RETURN TO DUTY UNTIL: MONTH / YEAR

	TODAY
	ROUTINE

OR - ICU

0754

(b)(6)-4

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT (Doctor)	TIME SEEN BY PROVIDER
		0620

TEST RESULTS

WBC	SMAC	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
21.9		SUP O2 100%	PH 7.246	PO2 420	RESULTS	
H/H 10/33		PCO2 FiO_2 1.0	SAT	OTHER		
PLT 327	1.3 / 152				EKG INTERPRETATION	
T	BHCG / ETOH / GLU	U/A	DIP / MICRO			

PROVIDER HISTORY/PHYSICAL

Pt is a ~20yo Iraqi EPW ♂ who had fired his AK47 vs a tank, then was shot xT to Chest by M-4 @0330. Had CT placed @BAS in Samarra & sent here

PMH: ?

O: WD Thin Iraqi ♂ in Mod Resp Distress Alert, moves spont Eye spont, spont verbal.
HEENT: MM. Scant bld in A/W Trachea mL, ⊖JVD.
Lungs: ↓BS on (R) ↑ wet BS (B) Chest GSW x2: 1) (R) ant Chest wall @ 4th rib.
Cor RR ⊖. 2) R ant ax line ~ 6th rib.
Abd: ⊕BS. S. NT ND ⊖Rib. FAST ⊖. CT in (R) Chest + Helmet.
GU NL.
Rectal: WL Prost. ⊖ Bld.

EPC: Hypotensive & Tension physiology → Ted fluid resuscitation + gave 2x O+ bld prbc ē improved BP. Sats remained in low 90's even after CT put to suction. Pt then RSI'd ē 8.0 ETT 20cm @ teeth

TOOR for wnd mgmt. 1) SIMV 14 600 5 100% 2) 600 5 100%

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

[b)(6)-2]

DIAGNOSIS

GSW Chest

CODE

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

[b)(6)-4]

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)

MEDCOM - 6185

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
20June03	late	note	0817 See S58 for admit info. 18-24yo IRAQi EPW presented to ED c/o being seen at TMC c GSW entrance (R+) ant chest + exit (R) mid AXillary large blow-out. - chest tube already sutured in place c Heimlich valve + switched to 20 cm H_2O seal suction Pleurovac. Pt. Obviously anxious, Resp rate 40's, Breath Sounds (L), slightly diminished (R) - P/CXR showed collapsed (R) chest wall (L) side + expandable c wall suction, positive pressure ventilations (started c 100% NRM) c sedation, + intubation. RSI - see S58. Sat maintained > 90%, CXR confirmed placement ETT, CT, INSERT INF7, 8 cc SQL chest tube, 1 Liter LR IV + 18g (R) Ant. - in. new (L) EJ inserted + II units PRBC given - Foley inserted maintained B/P 790 Sys, O2 Sat > 95%, post CXR - (R+) lung area reexpanded. - anesthesia + surgery at bedside - Pt. Stable - plan to take to OR for closure/explore GSW sites (chest. RT at bedside - See ABG's final setting SIMV rate 18, TV 700, FIO2 100% + peep 5 - All tubes taped well - chest tube + sternal dermal pressure sites dsg's Reinforced c tape - report given to OR/anesthesia - to OR 0754 via litter — [b)(6)-2] /mas/law

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) [b)(6)-4]

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 - 6186

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 20 ish
HEIGHT:
WEIGHT: Unk

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

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

4. PROPOSED SURGICAL PROCEDURE: (R) Chest wound exploration

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition CWD to (R) chest
Tobacco Unk ppd X ___ yrs. Body Piercing ✓ Diabetes (Y) (N) ROM WNL ASA/Motrin w/72 hrs (Y) (N)
ETOH unk Implants ✓ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures ✓ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS: ✓

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

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

(b)(6)-4

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

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

MEDCOM - 6187

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

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

(b)(6)-2 [redacted] UT/AN 20 Jun 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2 [redacted] UT/AN
DATE: 20 Jun 03 TIME: 0745

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2 [redacted] UT/AN
DATE: 20 Jun 03 TIME: 1010

REVERSE OF FORM 5179, JUN 91

USAPA V1.0

MEDCOM - 6188

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: litter BY: anesthesia

2. PATIENT VERIFIED BY [b)(6)-2] AND PROCEDURE ct/MR

3. DATE: 20 JUN 03 TIME PATIENT ARRIVED IN SUITE:

4. PATIENT IN ROOM TIME: 0745 NUMBER: 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: pt arrived from ER intubated

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [b)(6)-2]	91D	RELIEF SCRUB	
	Spc [b)(6)-2]	91D		
ASSIGNED CIRCULATOR	St [b)(6)-2]	66E	RELIEF CIRCULATOR	
	St [b)(6)-2]	66E		

7. POSITION AND POSITIONAL AIDS (Specify)

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

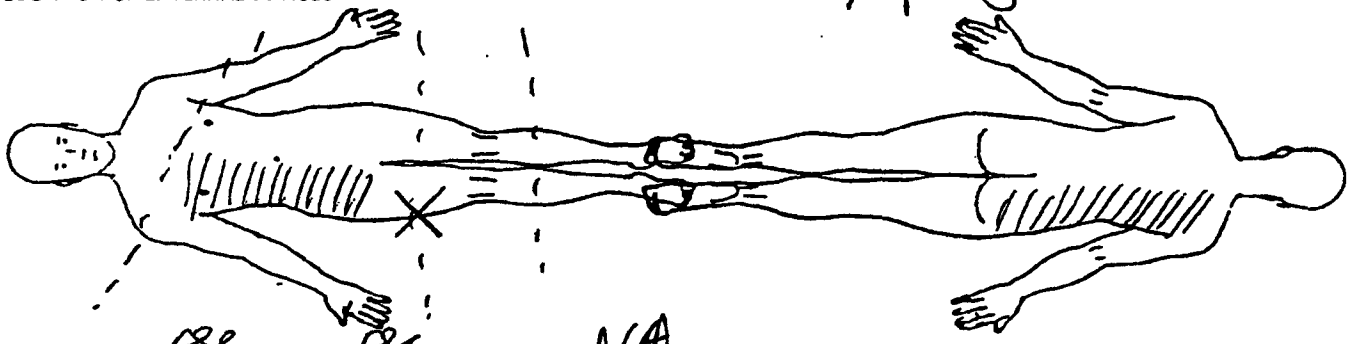
COMMENTS: Bean bag, pillow between legs; Ⓛ axillary Roll; Ⓡ arm ⓒ pillow on Mayo Stand

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Beta/Beta
SITE: Ⓡ Thorax to post. + BY WHOM: [b)(6)-2]
SITE: ant. midline Ⓡ arm to Ⓡ hip BY WHOM:
COMMENTS: ∅ pooling or irritation

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
Sponge	☒ Yes ☐ No	C	C	C
Needle Sharp	☒ Yes ☐ No	C	C	C
Instrument	☐ Yes ☒ No	/	/	/
Other	☐ Yes ☒ No	/	/	/

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

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

[b)(6)-4]

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

☐ ESU NO: #1 cut/coag = 50/50
GROUND PAD: BRAND Valley Lab
LOT NO: H9402 4

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA MEDCOM - 6189 H IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

[b)(6)-2]

PH

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)
petroleum gauze 4x8s

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Foley	2. 36 fr x2 Chest tubes	3.
SITE	1. Bladder -placed in ER-	2. ® Thorax	3.

19. ADDITIONAL INFORMATION

Dr [b)(6)-2]

Dr [b)(6)-2]

May [b)(6)-2] CRNA / CPT [b)(6)-2] CRNA / cpt [b)(6)-2] CRNA

20. OPERATIONS PERFORMED

1) ® chest wound exploration
2) Chest tube placement x 2 ® Thorax
3) ® hand wound closure

21. PATIENT TRANSFERRED TO ICU TIME 10 10 METHOD litter

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

REVERSE OF DA FORM 5179-1, OCT

USAPA V1.01

MEDCOM - 6190

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	9	10	11	12	13	14	15
POST- DAY	3	9	11	11	12	13	4
MONTH-YEAR Jul / DAY	28	29	30	31	1	2	[b)(6)-2]
19 2007 / HOUR	1400	2200 0400 1400	1400	0400 1400	2200 0400 1400	2200 0400 1400	

PULSE (0) / TEMP. F (°): 105° · 104° · 103° · 102° · 101° · 100° · 99° · 98.6° · 98° · 97° · 96° · 95°

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

9	10	11	12	13	14	15
99/50 111/50	110/60	94/47 108/66	104/55	94/44	84/44	94/45
111/50			94/53	88/52	82/31	91/51

HEIGHT: / WEIGHT →

9	10	11	12	13	14	15
SPO2 95%	98%	98%	95%	96%	99%	98%

Record special data only when so ordered

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

[b)(6)-4]

REGISTER NO.

WARD NO.

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

MEDCOM - 6191

PT# 0013
ETT 8.0
22cm @ lip

VENT FLOW SHEET

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	I/E TIME	Spont RATE	PLATEAU	HR	SO2	BP	ET	CUFF	INITIAL
20JunO3	1030	SIMV	18	700	100%	+5	41	1:2.0	4	—	51	100%	169/91	8.0	MLT	[redacted]
ABG	1050	PH	7.430	PCO_2 30.0		PO_2 244		HCO_3 20		BE -4	SO2	100%	—	—	—	
	1105	—	↓ 14	—	↓ 50%	—	—	—	—	—	—	—	—	—	—	(b)(6)-2
	1205	SIMV	14	700	50%	+5	37	1:2.0	2	—	86	98%	154/66	8.0	MLT	
ABG	1225	PH	7.253	PCO_2 45.3		PO_2 68		HCO_3 20		SO_2						
ABG	1230	PH	7.267	PCO_2 45		PO_2 69		HCO_3 21		BE -6	SO_2	90%	—	—	—	
	1235	—	↑ 16	—	↑ 70%	—	—	—	—	—	—	—	—	—	—	
ABG	1330	PH	7.395	PCO_2 34.3		PO_2	1160	HCO_3	21	BE -4	SO_2	99%	—	—	—	[redacted]
	1400	SIMV	16	700	70%	+5	35	1:2.0	Ø	—	78	100%	140/78	8.0	MLT	
	1610	SIMV	16	700	70%	+5	34	1:2.0	Ø	—	96	100%	124/63	8.0	MLT	(b)(6)-2
	1810	SIMV	16	700	70%	5	33	1:2	0	—	106	100	101/63	8	MLT	
	2000	SIMV	16	700	70	5	31	1:2	0	—	110	100	97/57	8	MLT	
	2240	SIMV	16	700	60	5	33	1:2	0	—	85	100	108/60	8	MLT	
	2350	SIMV	16	650	50	5	34	1:2	0	—	89	100	96/63	8	MLT	
	0200	SIMV	14	600	45	5	23	1:2	—	—	74	100	94/43	8	MLT	
	0430	SIMV	14	600	45	6	24	1:2	2	—	71	100	92/42	8	MLT	
	0600	S	738	38.6	80	23	2	96%								
	0600	SIMV	14	600	45%	+5	25	1:2.0	1	—	76	100%	85/53	8.0	MLT	[redacted]
	0750	SIMV	14	600	45%	+5	29	1:2.0	3	—	90	100%	102/49	8.0	MLT	(b)(6)-2
	0830	Pt Extubated and placed on NRB @ 12 L/min									108	98%	121/63	—		

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-4

i-STAT G3+

Pt: (b)(6)-4 NRB @ 12 L/min

Pt Name:_____

TCO2_____25 mmol/L

At 37C — post extubation #1

pH_____7.331

PCO2_____44.6 mmHg

PO2_____60 mmHg

HCO3_____24 mmol/L

BEecf_____-2 mmol/L

sO2*_____89 %

*calculated

At Patient Temp

pH_____7.336

PCO2_____44.0 mmHg

PO2_____58 mmHg

Patient Temp: 98.0F

FIO2_____: 70

Sample Type_: ART

21JUN03 10:01

Oper: 4132

Physician:_____

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

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

---

i-STAT G3+

Pt: (b)(6)-4 post extubation #2

Pt Name:_____

TCO2_____25 mmol/L

At 37C

pH_____7.336

PCO2_____44.3 mmHg

PO2_____67 mmHg

HCO3_____24 mmol/L

BEecf_____-2 mmol/L

sO2*_____92 %

*calculated

At Patient Temp

pH_____7.333

PCO2_____44.8 mmHg

PO2_____68 mmHg

Patient Temp: 99.0F

FIO2_____: 70

Sample Type_: ART

21JUN03 10:25

Oper: 8945

Physician:_____

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

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

---

i-STAT G3+

Pt: (b)(6)-4

Pt Name:_____

TCO2_____29 mmol

At 37C

pH_____7.426

PCO2_____42.4 mmHg

PO2_____51 mmHg

HCO3_____28 mmol

BEecf_____4 mmol

*calculated

At Patient Temp

pH_____7.408

PCO2_____44.8 mmHg

PO2_____56 mmHg

Patient Temp: 100.8I

FIO2_____: 50

Sample Type_: ART

22JUN03 06:57

Oper: 1529

Physician:_____

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

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

_____31 mmol/L

At 37C

pH_____7.484

PCO2_____39.3 mmHg

PO2_____63 mmHg

HCO3_____30 mmol/L

BEecf_____6 mmol/L

sO2*_____93 %

*calculated

At Patient Temp

pH_____7.471

PCO2_____40.8 mmHg

PO2_____67 mmHg

Patient Temp: 100.1F

FIO2_____: 70

Sample Type_: ART

22JUN03 08:24

Oper: 4132

Physician:_____

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

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

---

i-STAT G3+ VT 600
RR 14
FIO2 45
PEEP 5

Pt: (b)(6)-4

Pt Name:_____

TCO2_____24 mmol/L

At 37C

PH_____7.386

PCO2_____38.6 mmHg

PO2_____80 mmHg

HCO3_____23 mmol/L

BEecf_____-2 mmol/L

sO2*_____96 %

*calculated

At Patient Temp

PH_____7.390

PCO2_____38.1 mmHg

PO2_____78 mmHg

Patient Temp: 98.1F

FIO2_____: 45

Sample Type_: ART

21JUN03 04:46

Oper: 1383

Physician:_____

Ser# 42813

Ver: (b)(6)-2

---

i-STAT G3+ 18,700

Pt: (b)(6)-4 15 100%

Pt Name:_____

TCO2_____22 mmol/L

At 37C

PH_____7.389

PCO2_____33.9 mmHg

PO2_____244 mmHg

HCO3_____20 mmol/L

BEecf_____-4 mmol/L

sO2*_____100 %

*calculated

At Patient Temp

PH_____7.430

PCO2_____30.0 mmHg

PO2_____231 mmHg

Patient Temp: 93.5F

FIO2_____: 100

Sample Type_: ART

20JUN03 11:00

Oper: 4132

Physician:_____

Ser# 42813

Ver: (b)(6)-2

↓ VT to 600 ml
↓ RR to 14
↓ SiO2 to 45%

i-STAT G3+

Pt: (b)(6)-4 TV 650

Pt Name: RR 16

FiO2 50%

TCO2_____24 mmol/L

At 37C

PH_____7.464

PCO2_____31.5 mmHg

PO2_____100 mmHg

HCO3_____23 mmol/L

mmol/L

Calculated

At Patient Temp

PH_____7.466

PCO2_____31.2 mmHg

PO2_____99 mmHg

Patient Temp: 98.3F

FIO2_____: 50

Sample Type_: ART

21JUN03 00:15

Oper: 4017

Physician:

Ser# 42813

Ver: (b)(6)-2

---

i-STAT G3+

Pt: (b)(6)-4

Pt Name:_____

TCO2_____22 mmol/L

At 37C

PH_____7.247

PCO2_____48.3 mmHg

PO2_____69 mmHg

HCO3_____21 mmol/L

BEecf_____-6 mmol/L

sO2*_____90 %

*calculated

At Patient Temp

PH_____7.267

PCO2_____45.3 mmHg

PO2_____62 mmHg

Patient Temp: 96.0F

FIO2_____: 50

Sample Type_: ART

20JUN03 12:30

Oper: 4132

Physician:_____

Ser# 42813

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

R 14
TV 700
FIO2 50
P 5

---

i-STAT G3+

Pt: (b)(6)-4

Pt Name:_____

TCO2_____22 mmol/L

At 37C

PH_____7.395

PCO2_____34.3 mmHg

PO2_____160 mmHg

HCO3_____ mmol/L

BEecf_____ mol/L

sO2*_____

*calculated

At Patient Temp

PH_____7.397

PCO2_____34.0 mmHg

PO2_____159 mmHg

Patient Temp: 98.3F

FIO2_____: 70

Sample Type_: ART

20JUN03 13:32

Oper: 4132

Physician:__

Ser# 42813

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

SIMV
FIO2 70
R 16
TV 700
P5

20JUN03 1230
2 FIO2 = 60%
IV TUBE

---

i-STAT G3+ IMV 16
PEEP 5

: (b)(6)-4

Pt Name:_____

TCO2_____24 mmol/L

At 37C

PH_____7.551

PCO2_____26.3 mmHg

PO2_____161 mmHg

HCO3_____23 mmol/L

BEecf_____1 mmol/L

sO2*_____100 %

*calculated

At Patient Temp

PH_____7.535

PCO2_____27.5 mmHg

PO2_____167 mmHg

Patient Temp: 100.4F

FIO2_____: 60

Sample Type_: ART

20JUN03 22:52

Oper: 98.3

Physician:_____

Ser# 42813

Ver: [redacted]

(b)(6)-2

ABG

TEST	RESULT	REF. RANGE
Na	141	138-146 mmol/L
K	4.2	3.5-4.9 mmol/L
Cl	99	98-109 mmol/L
pH	7.261	7.31-7.45
PCO2	43.0	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	195	80-105 mmHg (art) N/A (ven)
TCO2	21	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	19	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	100	95-98%
BEecf	-5	(-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	26	38-51% PCV
Hgb	9	12-17 g/dl

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

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

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

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

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

REMARKS:

REPORTED BY: (b)(6)-2

DATE: 20 Jun 03

LAB ID NO.:

ABG

(b)(6)-4

TEST	RESULT	REF. RANGE
Na	142	138-146 mmol/L
K	4.3	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.282	7.31-7.45
PCO2	39.5	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	109	80-105 mmHg (art) N/A (ven)
TCO2	20	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	19	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	98%	95-98%
BEecf	-8	(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca	1.23	1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	28	38-51% PCV
Hgb	10	12-17 g/dl

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

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

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

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

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

REMARKS:

REPORTED BY: (b)(6)-2

DATE: 20 Jan 03

LAB ID NO.:

Ward/Section: ICU 2	REPORTING PHYSICIAN: [b)(6)-2]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [b)(6)-4]	DATE: 20 Jun 03	TIME: 1030
		SSN/PSEUDO SSN: [b)(6)-4]

TEST	RESULT	REF. RANGE
WBC	15.0	4.8-10.8 x 10^3
RBC	3.80	4.7-6.1 x 10^9
Hgb	10.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	33.9	42-52% (M) 37-47% (F)
MCV	89.2	80-94 fl (M) 81-99 fl (F)
Plt	168	130-500 x 10^3 verified
Lymph %	11.5	20.5-51.1%

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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

Cell Count		
Directigen		Negative

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

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

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

REMARKS:

REPORTED BY: [b)(6)-2]	DATE: 20 Jun 03	LAB ID NO.:

Chemistry Only

Ward/Section: ICU2 | REQUESTING PHYSICIAN: (b)(6)-2 | CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. (b)(6)-4 | DATE 10 Jan 12 | TIME 1030 | SSN/PSEUDO SSN: (b)(6)-4

[redacted]

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
HCO3		23-27 mmol/L (art) 24-29 mmol/L (ven)
tCO2		22-26 mmol/L (art) 23-28 mmol/L (ven)
SO2		95-98%
Bfact		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

[redacted]

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

[redacted]

TEST	RESULT	REF. RANGE
GLU	121 *	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	0.6	0.6-1.2 mg/dl
CK	1356	39-380 u/l (M) 30-190 u/l (F)
NA+	138	128-145 mmol/l
K+	5.0 *	3.3-4.7 mmol/l
CL-	107	98-108 mmol/l
tCO2	21	18-33 mmol/l

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

[redacted]

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

[redacted]

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: No Hemolysis noted!

Ward Section

REQUESTING PHYSICIAN

(b)(6)-2

LABORATORY RESULTS

(Privacy Act of 1974)

LAST, FIRST, MI

DATE

TIME

SSN

(b)(6)-4

WBC		3.6-10.8 x 10³	Color		N/A	RPR		Negative
RBC		4.2-5.4 (M) 3.8-5.1 (F)	App		N/A	Mono		Negative
Hgb		14-17 g/dl (M) 12-16 g/dl (F)	Glu		Negative			
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 (F)	Ket		Negative	Organism Stain		
MCH		80-100 um2 verified	SG		N/A	Occ Bld		Negative
MCHC			Bld		Negative	Hemoglobin		Negative
					N/A	WBC		
						Parasites		
	Manual		Pro		Negative	Yeast		
	Eos		Urob		0.2-1.0	Other		
	Baso		Nit		Negative	Other		
	Smear		Leuk		Negative			
			HCG		Negative			
			Cell			MUST SUBMIT SLIDE WITH EVERY UNIT REQUESTED		
			Count					
			Diff		Diff	ABO/Rh		
TEST	RESULT	RANGE	UNIT		TYPE		CROSSMATCH	
Hgb		9-16 g						
Hct		27-48 %						
		20 mg/ml						
		5-10 IU/ml						

REMARKS

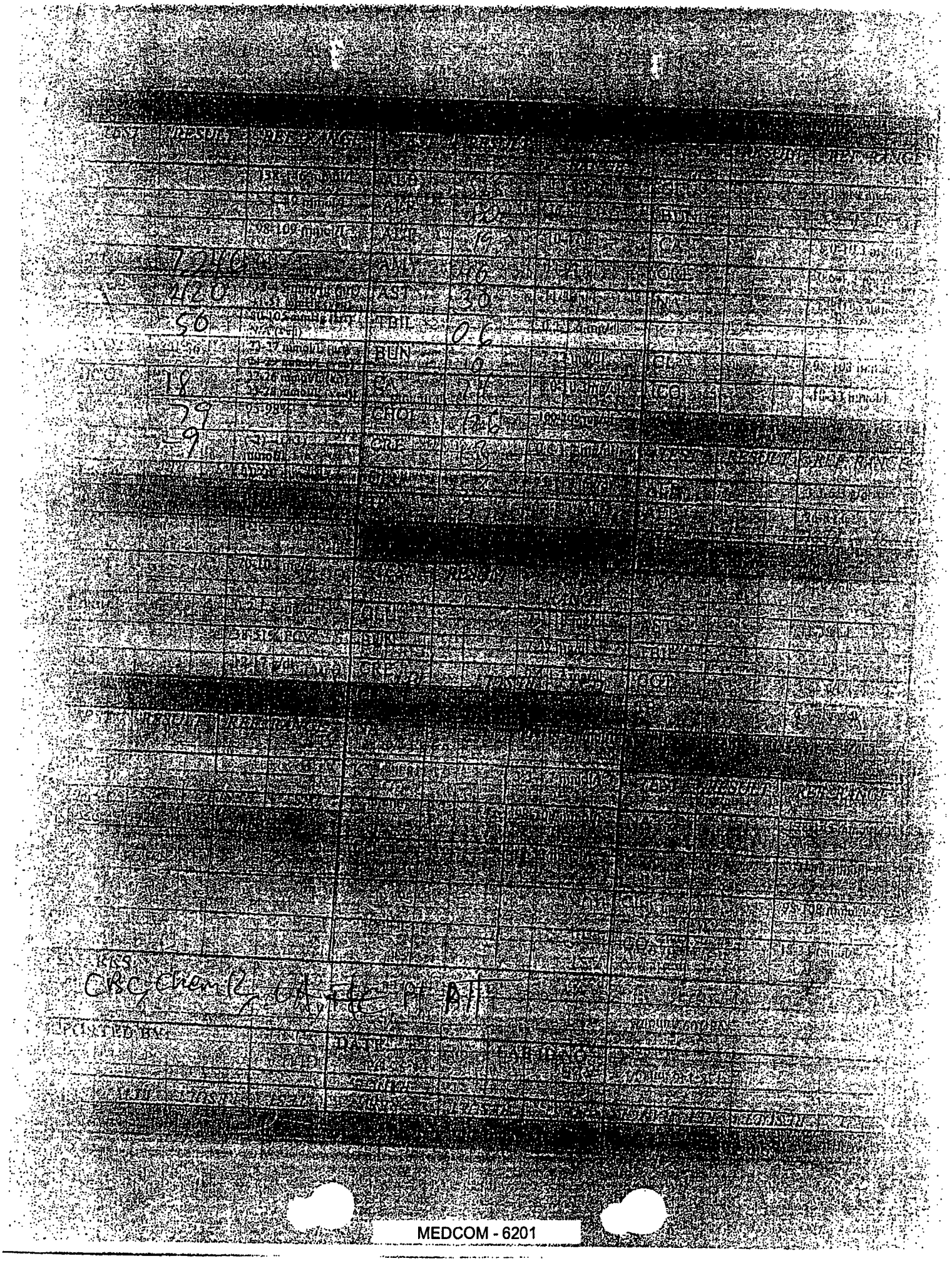
REQUESTED BY

(b)(6)-2

DATE

LAB ID NO.

MEDCOM - 6200


7.2 G
420
50
18
29
9
CBC, Chem 12, UA, Hep A Ab
MEDCOM - 6201

Chemistry Only

Ward/Section: ICU | REQUESTING PHYSICIAN: Dr (b)(6)-2 | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)-4 | DATE: 21 JAN | TIME: 0400 | SSN/PSEUDO SSN: (b)(6)-4

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

TEST	RESULT	REF. RANGE
GLU	87	73-118 mg/dl
BUN	12	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	1648	39-380 u/l (M) 30-190 u/l (F)
NA^+	136	128-145 mmol/l
K^+	4.0	3.3-4.7 mmol/l
CL^-	107	98-108 mmol/l
tCO_2	24	18-33 mmol/l

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

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

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

REMARKS:

Ward/Section: ICU | REQUESTING PHYSICIAN: Dr [b)(6)-2] | **LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [b)(6)-4] | DATE: 21 Jun | TIME: 0450 | SSN/PSEUDO SSN:

TEST	RESULT	REF. RANGE
WBC	9.0	4.8-10.8 x 10^3
RBC	3.02	4.7-6.1 x 10^9
Hgb	8.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	26.8	42-52% (M) 37-47% (F)
MCV	88.7	80-94 fl (M) 81-99 fl (F)
Plt	148	130-500 x 10^3 verified
Lymph %	.229	20.5-51.1%

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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

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 — Type & Crossmatch — SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [b)(6)-2] | DATE: 21 Jun | LAB ID NO.: 07

Ward/Section: ICU | PHYSICIAN: | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)-4 | DATE: 21 Jun 03 | TIME: 0200 | SSN/PSEUDO SSN: (b)(6)-4

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%

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	clrd.	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.030	N/A
Bld	neg	Negative trace
pH	5.0 5.0 sf	N/A
Prot	trace	Negative 5 SA = (2)
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

Cell Count		Directigen		Negative

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
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		

Microscopic Urinalysis

0-5 RBC
much, much amorph sed

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Blood Bank Unit Crossmatch

SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED

UNIT	TYPE	CROSSMATCH

REMARKS:

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

MED SECTION	REQUESTING PHYSICIAN	LAB/UNIT
ICU	DR (b)(6)-2	Wells Form

LAST, FIRST, MI.	DATE	TIME	SSN / PSEUDO SSN
(b)(6)-4	22 Jun 04		(b)(6)-4

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

TEST	RESULT	REF. RANGE
GLU	103	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	3152	39-380 u/l (M) 30-190 u/l (F)
NA+	139	128-145 mmol/l
K+	3.7	3.3-4.7 mmol/l
CL-	99	98-108 mmol/l
tCO_2	26	18-33 mmol/l

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

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

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

WARD/SECTION TCU | MEDICAL OFFICER/PHYSICIAN [redacted] | (Subject to the Privacy Act of 1974)

LAST, FIRST, MI [redacted] | DATE 23 JUL 08 | TIME | SSN/PSEUDO SSN [redacted]

[redacted]

TEST	RESULT	REF RANGE
WBC	9.2	4.8-10.8 x 10^3
RBC	3.06	4.7-6.1 x 10^9
Hgb	8.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.1	42-52% (M) 37-47% (F)
MCV	88.5	80-94 fl (M) 81-99 fl (F)
Plt	168	130-500 x 10^3 verified
Lymph %	29%	20.5-51.1%
[redacted]		
Segs		Mono
Bands		Eos
Lymph		Baso
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

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
[redacted]		
Cell Count		
Directigen		Negative

TEST	RESULT	REF RANGE
RPR		Negative
Mono		Negative
[redacted]		
Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		
[redacted]		
MUST SUBMIT SPECIMEN WITH EVERY UNIT REQUESTED		
ABO/Rh		

[redacted]

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

REMARKS:

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

(b)(6)-2

LABORATORY ... DAS form

(b)(6)-4

DATE 22-Sep-03 TIME 0020

(b)(6)-4

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

RESULT	REF. RANGE

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

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA+		138-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO_2		18-33 mmol/l

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

TEST	RESULT	REF. RANGE
NA+	134	138-145 mmol/l
K+	3.6	3.3-4.7 mmol/l
CL-	96	98-108 mmol/l
tCO_2	26	18-33 mmol/l

REMARKS:

REPORTED BY: DATE: LAB ID NO.:

MEDCOM - 6207

(Sub) .o the Privacy Act of 1974)

LAST, FIRST, MI (b)(6) | DATE 23 June | TIME 0400 | SSN/PSEUDO SSN: (b)(6)

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	9.4	~~4.8-10.8 x 10^3~~
RBC	2.80	4.7-6.1 x 10^9
Hgb	8.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	26.0	42-52% (M) 37-47% (F)
MCV	89.8	80-94 fl (M) 81-99 fl (F)
Plt	194	130-500 x 10^3 verified
Lymph %	7.8	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Other	

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

(Misc) Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 6208

Chem 8

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

TEST	RESULT	REF. RANGE
GLU	104	73-118 mg/dl
BUN	10	7-22 mg/dl
CRE	0.5	0.6-1.2 mg/dl
CK	2579	39-380 u/l (M) 30-190 u/l (F)
NA^+	128	128-145 mmol/l
K^+	3.5	3.3-4.7 mmol/l
CL^-	97	98-108 mmol/l
tCO_2	27	18-33 mmol/l

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

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

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

REMARKS:

REPORTED BY:

DATE: 23 June 0400

LAB ID NO.:

Requesting Phys: [redacted] ICU Laboratory DD Form

(b)(6)-4

Date: 25 Jan 03 Time: 0530 SGM/PSeUDO SSN

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
pCO2		35-45 mmHg (art) 41-51 mmHg (ven)
pO2		80-105 mmHg (art) N/A (ven)
tCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
tCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
O2		95-98%
Excf		(-2) – (+3) mmol/L
AGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

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

TEST	RESULT	REF. RANGE
GLU	89	73-118 mg/dl
BUN	15	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA+	136	128-145 mmol/l
K+	3.7	3.3-4.7 mmol/l
CL-	97	98-108 mmol/l
tCO2	30	18-33 mmol/l

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

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
GGT		5-65 u/l
TP		6.4-8.1 g/dl

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

RTS:

REPORTED BY: (b)(6)-2 DATE: 25 Jan 03 LAB ID NO:

MEDCOM - 6210

(b)(6)-4

Med Section

(Subject to the Privacy Act of 1974)

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

TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE	TEST	RESULT	REF RANGE
WBC	10.0	4.8-10.8 x10³	Color		N/A	RPR		Negative
RBC	3.26	4.7-6.1 x10⁶	App		N/A	Mono		Negative
Hgb	9.3	14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	[redacted]		
Hct	29.6	42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV	90.6	80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt	355	130-399 x10³ Verified	SG		N/A	Occ Bld		Negative
Lymph%	13.5	20.5-51.1%	Bld		Negative	H. pylori		Negative
[redacted]			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		1mm	Leuk		Negative	[redacted]		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	[redacted]					
Sed Rate			Cal Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

[redacted]

TEST	RESULT	REF RANGE	[redacted]	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		≤20 ug/ml			
FDP		≤10 ug/ml			

REMARKS:

REPORTED BY: DATE: LAB ID NO:

MEDCOM - 6211

Patient Section: FCU | Requesting Pt: [redacted] | Laboratory: CBS Form

Last, First, MI: [redacted] | Date: 26 Jun | Time: 0500 | SSN / Pseudo SSN: [redacted]

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

TEST	RESULT	REF. RANGE
GLU	96	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE	0.3 *	0.6-1.2 mg/dl
CK	387 *	39-380 u/l (M) 30-190 u/l (F)
NA+	138	128-145 mmol/l
K+	3.6	3.3-4.7 mmol/l
CL-	101	98-108 mmol/l
tCO2	23	18-33 mmol/l

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

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

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: [redacted] | DATE: 26 JUN 03 | LAB ID NO.:

Ward/Section ICU | Requesting Physician [b](6)-2 | (Subject to the Privacy Act of 1974)

LAST, FIRST, MI [b](6)-4 | DATE 26 Jun | TIME 0500 | SSN/PSEUDO SSN: [b](6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	12.1	4.8-10.8 x 10^3
RBC	3.11	4.7-6.1 x 10^9
Hgb	9.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	26.4	42-52% (M) 37-47% (F)
MCV	91.1	80-94 fl (M) 81-99 fl (F)
Plt	384	130-500 x 10^3 verified
Lymph %	11.4	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

GSR

Cell Count		
Directigen		Negative

(Hematology) Miscellaneous

Misc		

(Hematology) 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		

Microbiology (cont'd)

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Requirements

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

UNIT	TYPE	CROSSMATCH

REMARKS:

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

(Subject to the Priva

LAST, FIRST, MI (b)(6)-4	DATE 24 June	TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	10.9	4.8-10.8 x 10^3
RBC	3.11	4.7-6.1 x 10^6
Hgb	9.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.0	42-52% (M) 37-47% (F)
MCV	89.8	80-94 fl (M) 81-99 fl (F)
Plt	269	130-500 x 10^3 verified
Lymph %	11.4	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2	DATE: 24 Jun 07	LAB ID NO.:

ICU (b)(6)-4 - ICU - 24 hr 03- 0400

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

TEST	RESULT	REF. RANGE
GLU	95	73-118 mg/dl
BUN	14	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	1868	39-380 u/l (M) 30-190 u/l (F)
NA^+	135	128-145 mmol/l I STAT
K^+	3.8	3.3-4.7 mmol/l
CL^-	98	98-108 mmol/l
tCO_2	25	18-33 mmol/l

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

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

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

REMARKS:

REPORTED BY: (b)(6)-2

DATE: 24 Jan 03

LAB ID NO.:

Chem 8

PRE-ANESTHESIA AND POST-ANESTHESIA EVALUATION

AGE: 18-23 HRS DAYS MOS (YRS) 20 SEX: X MALE ( ) FEMALE

PROPOSED PROCEDURE: _____ SURGICAL SERVICE: G.S.

ASA PHYSICAL STAUS 1 (2) 3 4 5 E

WEIGHT: 58 → 70 KG/LB HEIGHT: 67 IN.

ALLERGIES: NKA

HABITS:

TOBACCO: _____

ETOH: _____

DRUGS: _____

CURRENT MEDICATIONS:

( ]= ordered as premed

[ ] _____

[ ] _____

[ ] _____ NKA

[ ] _____

[ ] _____

[ ] _____

PREMEDICATION:

None Yes (@ _____ Hrs) /OC

_____ ' _____ mg IV IM PO

_____ ' _____ mg IV IM PO

_____ ' _____ mg IV IM PO

LABORATORY STUDIES:

HB/HCT: 31 8 / _____

U/A: _____

OTHER:

PREOPERATIVE ASSESSMENT

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	GSW chest x2
	Bronchitis/URI	N	Y	by M-4
	COPD	N	Y	(HX) C.T.
	Other	N	Y	_____
Renal System:	Acute/Chronic RF	N	Y	_____
Gastrointestinal:	Hepatitis	N	Y	_____
	Hiatal Hernia	N	Y	NKA
	PUD	N	Y	_____
Endocrine System:	Diabetes	N	Y	_____
	Steroids	N	Y	Pt.
	Thyroid	N	Y	Intubated
Neurological:	Seizures	N	Y	_____
	Neuropathy	N	Y	Pt was
	Other	N	Y	_____
Gynecological:	Pregnancy	N	Y	Lt. Chest
Other Significant Hx:		N	Y	_____
		N	Y	_____
Familial HX				

PAST SURGICAL/ANESTHETIC HISTORY

NKA

PHYSICAL EXAMINATION

BP 90/40 HR _____ RESP _____

HEENT - Teeth _____

Trachea _____

TMJ/Neck _____ Intubated

Oropharynx _____ Lt. ETT

Nares _____

CHEST: _____

CARDIAC: 8.0 ETT 20 cm

EXTREMITIES: - Lt. Leg

IV Access: _____

Ulnar Filling: _____

BACK: _____

OTHER: _____

ANESTHETIC PLAN: [ ] Local [ ] MAC - [ ] Regional (Specify): _____ [X] General: Mask Intubation

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

T (b)(6)-2

S

Questions answered.

DATE: 6/20/03 TIME: 0900 Hrs

CONDITION UPON ARRIVAL TO P.A.R.R. _____

VITAL SIGNS: BP _____ HR _____ RESP _____ SuO_2 _____

RESP STATUS: [ ] Spontaneous [ ] Assisted [ ] Cont'd

MENTAL STATUS: [ ] Awake [ ] Alert [ ] Lethargic [ ] Asleep

[ ] Responsive [ ] Unresponsive Block Level _____

REPORT GIVEN: [ ] Yes [ ] No

POST-ANESTHESIA EVALUATION AND NOTE

[ ] NO APPARENT ANESTHETIC COMPLICATIONS [ ] OTHER

Pt. remains intubated
No apparent S/S anesthesia Comp.

(b)(6)-2

DATE: 6/20/03 TIME 2200 Hrs

(b)(6)-2

PATIENT IDENTIFICATION: (Ward: _____)

(b)(6)-4

WAMC Form 2300
1 Aug 92 (HSXC-SU)

PREVIOUS EDITION IS OBSOLETE

MEDCOM - 6216

☆ U.S.GPO: 1994-628-533/00102

PATIENT RECORD COPY

F 1-line / 1 attempt (L) radial

#18G (L) leg

MEDICAL RECORD — ANESTHESIA

TOTALS	500
TOTAL URINE	700
FLUID SUMMARY	
CRYSTALLOID	1500
COLLOID	0
BLOOD	0

CONTINUOUS / REPEATED DRUGS — SPECIFY UNITS – MG / MCG / ML, "1"=CONSTANT INFUSION

Fentanyl	MCG	100	50		100	100	100	50	
Vecuronium	MG	5	5		5	5	6		
VOLATILE AGENT	% del	1.0	1.3	1.2	1.2	1.5	1.4	1.0	X
	% e.t.								
AIR	L/Min								
N2O	L/Min								
O2	L/Min	8	1.5	1.5	1.5	1.5	1.5	8	

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

LINE site	R	IJ	Warmed
18 (L)			Warmed
1000			Warmed
			Warmed

300

300

LOSSES: EST BLOOD LOSS — URINE – 550 150/700

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 50 (KG) LB

HEMATOCRIT: 28

INITIAL DATA: BP – 90, 42 HR – 98

TIME CHECK: OK? (Y) N

PATIENT ASSESSED: OK for PROCEDURE? (Y) TIME – 0746

TIME → 0745 0800 . 30 . 0900 . 30 . 1000 . 30

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

220 200 180 160 140 120 100 80 60 40 20

VT – ml	740	730	740	760	780	8	640	700	700						
f – breaths/min	9	8	8	8	7	7	8	8							
Peak inf pres / PEEP	24	24	25	53	31	53	31	5	32	33	34	31			
MODE– S(pon), A(assist), C(on)	C	C	C	C	C	C	C	C	C	C	C	C			
BP/Auto Cuff															
BP / oth															
ART line (L)															
Steth- PC/ES															
Gas analyzer															
Warming blkt															
Conv warmer															
ET CO2 (torr)	31	31	34	32	30	33	33	33	31						
FIO2 (Frac or %)	.8	.79	.79	.79	.79	.79	.79	.79	.79						
SpO2 (%)	99	96	98	97	98	100	100	100	100						
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR						
TEMP- site															
N-M Block (T/4)															
	98		97	3/4		2/4		0/4							
				3/4											

Mark with letters & symbols, explain under REMARKS — EVENTS — Position — pressure pts padded BUEC90 on tape LLD

PROCEDURES and CPT Codes: (R) chest wound exploration placement #2 (R)

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
(D) NOT placed - Stomach lit. DV MAC 3

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: pressure pts removed under DL # 37 (L) OUT unsuccessful 3 difficultly 29 cm (R) Mip ⊕ETCO2 BBS⊕ WNL. ⊕placement verified 3 fiberoptic

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

(b)(6)-4

SURGEONS (b)(6)-2 (b)(6)-2 (b)(6)-2 CDR

REMARKS — Code drugs with numbers, events with letters

(1) → OR from EMTT. ventilated c ambu bag.
(2) → Monitors, O2 & narcotics.
(3) DLT (37 FR) inserted (see below) Positioned L/D c fiberoptic & BBS. VWR
(4) Positioned LLD c assist 5 personnel. ETT position verified c fiberoptic & BBS. Eyes taped free of pressure. axilla roll under dependent arm. (R) arm on pillow all pressure pts padded.
0915 (R) ↓ down (R) hand ↑.
0936 MAC 3 comp IV DLT removed, #8.0 insert DLT #1 MAC 3 22 cm (R) lip. → ICU via stretcher vent. ambu bag keep

RECOVERY AT 1611
PACU ICU (Specify) OTHER 93-1
CONDITION: intubated
RESP – 10 SpO2 – 100 BP – 113/50 HR – 61

ANES	Start	Room	End
	0710	0745	1600
PROC	Ready	Begin	End
	0820	0849	1005

PROCEDURE LOCATION OR 1-1
DATE 20 June 03
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 37[illegible] REVISED 1 Jan [illegible]

PATIENT RECORD

MEDCOM - 6217

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

NSN 7540-01-165-7294 519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
Portable CXR		M	(b)(6)-4	ICU	
	FILM NO.				PREGNANT ☐ YES ☒ NO
	REQUESTED BY (Print)				TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR [redacted] (b)(6)-2				DATE REQUESTED 01Jul08

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

S/P GSW Chest, S/P Thoracotomy
Chest tube (R) side

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
(b)(6)-4	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
MEDCOM - 6218

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

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 6/20/03 TIME OF ORDER 10A HOURS

LIST TIME ORDER NOTED AND SIGN

√ (1) Admit ICU

√ (2) SIP GSW chest
√ SIP (E) Thoracotomy

√ (3) Chest tube x2 to -20 suction

√ (4) NG to LIS

√ (5) Foley to gravity

√ (6) Ancef 1g IVP q8°

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

√ (7) Zantac 50mg IVP bid

(8) Vent TV 700
PS
FiO2
PEEP 5

NURSING UNIT | ROOM NO. | BED NO.

√ (9) Wean PRN

√ (10) IVF 2 L @ 100 cc/hr

noted & sent 20 Jun 03 @ 1135 (b)(6)-2 CPT (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

√ (11) Labs now + q AM:
CBC, Chem 8

√ (12) CXR upon arrival to ICU

(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 6/20 TIME OF ORDER 1070 HOURS

√ (1) Fentanyl titrate prn

√ (L) Propofol titrate prn

noted & sent 20 Jun 03 @ 1135 (b)(6)-2 CPT (b)(6)-2

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

24 V 21 Jun 03 @ 0400 (b)(6)-2 LTA

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-383-710

MEDCOM - 6219

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

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER 2200 HOURS | LIST TIME ORDER NOTED AND SIGN

① ↑ Maintenance IVF to 200 cc/hr. Keep UO > 50 cc/hr.

② ↓ FiO2 to 60% - ABG in 30 min

VIO Dr. (b)(6)-2

(b)(6)-2 MHJ MC

PATIENT IDENTIFICATION

DATE OF ORDER 20 June | TIME OF ORDER 2300 HOURS

① ↓ TV 650, ↓ FiO2 50%

② ABG in 30 min

VIO Dr. (b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

(b)(6)-2 MHJ Aa

PATIENT IDENTIFICATION

DATE OF ORDER 21 June | TIME OF ORDER HOURS

↓ FiO2 to 45%

↓ TV 600

↓ IMV 14

~~ABG in 30 min~~

VO Dr. (b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

(b)(6)-2 MHJ, MC

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER 0200 HOURS

21 June 03

250 ml LR Boluses X1 now

VIO Dr. (b)(6)-2

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

(b)(6)-2 MHJ MC

2BV 21 Jun 03 @ 0400 (b)(6)-2

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

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MEDCOM - 6220

ACLU-RDI 1330 p.104

DOD 15317

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
20 JUN 03	1200 HOURS	
① IV - ↑ Rate 175 cc/hr.		noted (b)(6)-2 1230 6/20/03
(b)(6)-2		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	
20 Jun 03	1615 HOURS	
① Decrease IVF rate to LR @ 100 cc/hr.		noted (b)(6)-2 1615 6/20/03
VO: Dr (b)(6)-2 (b)(6)-2		

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	
20 Jun 03	1715 HOURS	
① 20 mg Lasix IVP now x1		
VO: Dr (b)(6)-2		

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	
20 June	2100 HOURS	
250 ml LR 500 ml Bolus X 1 now		
VO Dr (b)(6)-2 (b)(6)-2		
D/C'd 21 Jun 03 @ 0400 (b)(6)-2		1600

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

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MEDCOM - 6221

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 FORMAT IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

0500 HOURS

get UA done @ 0520

VO Dr (b)(6)-2 RN (b)(6)-2

LIST TIME ORDER NOTED AND SIGN

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

21 Jun 03 1000 HOURS

↓ IVF to 100cc/° LR

DIC NGT, vent settings

DIC Fentanyl, propofol

noted (b)(6)-2

6/21/03

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

21 Jun 03 1200 HOURS

MSO4 4-6mg IVP Q 2° prn pain.

noted (b)(6)-2

6/21/03

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

HOURS

Toradol 30mg IVP Q8° prn pain.

noted (b)(6)-2

Tylenol 650mg PO prn Q4° fever >101.

6/21/03

DA FORM 4256

REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USE

24°/ 22 Jun 03 @ 052

(b)(6)-2

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MEDCOM - 6222

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

21 June 03 2100 HOURS

Lasix 20mg Inj X 1 now

Portable CXR

(b)(6)-2 [redacted]

NPO Diet

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

21 Jun 03 2325 HOURS

Lasix 20mg Inj X 1 now

NPO Diet

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

21 Jun 03 2345 HOURS

Albuterol 0.5cc in 2.5 mL NS X 1 now

(b)(6)-2 [redacted]

NPO Diet

NURSING UNIT | ROOM NO. | BED NO.

PRN x 22 Jun 03 @ 0020

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

22 Jun 03 0115 HOURS

Lasix 20 mg IVP X 1 now

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994—383-710

MEDCOM - 6223

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]

DATE OF ORDER 22 June 03 TIME OF ORDER 0700 HOURS

Lasix 80mg IVP ← Duplicate order from 22 Jun 03 @0715

V.O. Dr. [b)(6)-2] [b)(6)-2] [b)(6)-2] 0700

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION [b)(6)-4]

DATE OF ORDER 6/22 TIME OF ORDER 8 30 HOURS

noted [b)(6)-2] 22 Jun @1730

(1) Out of bed to chair bid

(2) ↓ IVF to 75 cc/hr

[b)(6)-2]

NURSING UNIT | ROOM NO. | BED NO.

[b)(6)-2]

PATIENT IDENTIFICATION [b)(6)-2] [b)(6)-2] 23 June 03 @150

DATE OF ORDER 23 June TIME OF ORDER 0145 HOURS

Lasix 20mg IVP x1 now

V.O. Dr. [b)(6)-2]

NURSING UNIT | ROOM NO. | BED NO. [b)(6)-2]

94° chart ✓ done

[b)(6)-2] [b)(6)-2] [b)(6)-2] MMT, AN

0200

PATIENT IDENTIFICATION [b)(6)-2]

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

23 June 0230 HOURS

Resume T-P-R qs 94-6° p.d

V.O. Dr [b)(6)-2] [b)(6)-2] [b)(6)-2] 0230

NURSING UNIT | ROOM NO. | BED NO.

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

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MEDCOM - 6224

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 23 June 03 TIME OF ORDER 1630 HOURS

Change Zantac 150 mg po BID

V.O. Dr (b)(6)-2 (b)(6)-2 mrgd

LIST TIME ORDER NOTED AND SIGN 1630 (b)(6)-2 D mrgd

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

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 23 June 03 TIME OF ORDER 1330 HOURS

D/C Foley

CT to H/O seal

Wean O2

(b)(6)-2

V/O Dr (b)(6)-2

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2

(b)(6)-2

24 June 03 0430

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 24 June 03 TIME OF ORDER 0400 HOURS

I & O cath

portable CXR q AM

V/O Dr (b)(6)-2 (b)(6)-2

(b)(6)-2

MAJ MC

PATIENT IDENTIFICATION

(b)(6)-2

Chest X done 0400 24

(b)(6)-2

TIME OF ORDER

HOURS

24 JUN 03 1600

① Flagyl 500mg po tid x 10d. 1st dose now

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

Applied & sent @ 1615 CPT

(b)(6)-2

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

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MEDCOM - 6225

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

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 25 JUN 03 TIME OF ORDER 2030 HOURS

LIST TIME ORDER NOTED AND SIGN 2100 25 June

(1) Benty/ 20mg po qid - 1st dose now (b)(6)-2
prn stomach cramps only when req
(2) Benadryl 50mg po q6hs prn insomnia.

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

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 6/26 TIME OF ORDER 1600 HOURS

(1) CT to Surgery
(2) N/C Lab
(3) X-ray 6/27 AM (b)(6)-2 (b)(6)-2
(4) Zofran 4mg IV (b)(6)-2

26 JUN 03 1200

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 27 JUN TIME OF ORDER 1615 HOURS

(1) Heplock IV

V.O. Dr (b)(6)-2

noted (b)(6)-2 1615 27 JUN

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 28 JUN TIME OF ORDER 1055 HOURS

(1) Transfer to ICW c present orders

noted (b)(6)-2 1055 28 JUN

V.O. Dr (b)(6)-2

D40 chart check 29 JUN 03 (b)(6)-2

(b)(6)-4

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

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MEDCOM - 6226

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)-2

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

DATE OF ORDER: 6 Jul 03 | TIME OF ORDER: 1600 HOURS | LIST TIME ORDER NOTED AND SIGN

1. CPK in AM 6/30 (b)(6)-2

2. Q4h vital signs (b)(6)-2 (b)(6)-2

PATIENT IDENTIFICATION (b)(6)-2

DATE OF ORDER: 30 Jun 03 | TIME OF ORDER: 1730 HOURS

noted 1730 30 Jun 03 (b)(6)-2

1. Mylox 20cc po now and q6° per nausea (b)(6)-2 MD

01 July 03 0500 (b)(6)-2 LT/MD 24°✓

1 Jul 2003 1620

NURSING UNIT | ROOM NO. | BED NO.

1. DIC ANCEF

VO: Dr (b)(6)-2 LT (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER

24°✓ 02 July 03 @ 0230 (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER: 7/2 | TIME OF ORDER: 0930 HOURS

DC to EPW Cap + MPs

V.O. Dr (b)(6)-2 (b)(6)-2 LT, MD

Notes 3 July (b)(6)-2

(b)(6)-4

1. Q4h vital signs (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

C ...ICAL 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

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
29 Jan 03	1430 HOURS	
Place CT to infer sec.		
V.O. Dr. (b)(6)-2 / (b)(6)-2		

NURSING UNIT	ROOM NO.	BED NO.
ICU		

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.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER _____ HOURS

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DA FORM 1 APR 75 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

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MEDCOM - 6228

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.	Month Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
20Jun	(b)(6)-2	Chest tube x2 to 20cm suction	05	(b)(6)-2 D/C 6/21/03
			17	(b)(6)-2
20Jun		NGT to US	05	(b)(6)-2 D/C 6/21/03
			17	(b)(6)-2
20Jun		Foley to gravity	05	(b)(6)-2 D/C'd 23 June 03
			17	(b)(6)-2
20Jun		Vent settings: TV 700, Resp 5, Rate 18, FiO2 100%	05	(b)(6)-2 D/C 6/21/03
			17	(b)(6)-2
		Wean FiO2 as needed		
20Jun		CBC + chem 8 Qam	04	(b)(6)-2 DC'd 20 Jun 03
22Jun03		OOB → Chair BID	05	(b)(6)-2
			17	(b)(6)-2
23 Jun		Chest tube to water seal	05	
			17	
23 June		Portable CXR q 9m	04	(b)(6)-2 DMR
				(b)(6)-2
21Jun03		CT to suction	08	(b)(6)-2 NC'd 23 Jun 03
			17	
23Jun		Portable CXR q am	04	(b)(6)-2
28Jun		NIO: IsO2	06	(b)(6)-2
			14	
			22	(b)(6)-2
29Jun		CT to suction	06	(b)(6)-2
	------		14	(b)(6)-2 D/C
	------		22	(b)(6)-2

ALLERGIES: ☐ YES ☐ NO — unknown

PRIMARY DIAGNOSIS: S/p GSW / S/p @ Thoracotomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 6229

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 6 Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
20Jun	(b)(6)-2	Admit to ICU	20Jun	~	1015	(b)(6)-2
20Jun		Labs now + QAM: CBC, Chem 8	20Jun	~	1030	
20Jun		CXR upon arrival to ICU	20Jun	Now	done	
20Jun		Abgs in 30 min	20Jun	/	2300	
20Jun		↓ VT to 650, FiO2 50%	20Jun	/	2300	
20 Jun		Abg in 30 min	21Jun 03	/	0015 ~~2300~~	
20 Jun		↓ FiO2 to 45%, ↓ TV 600, ↓ SIMV 14	21Jun 03	/	0030	
21Jun03		Get UA	21Jun03	/	0200	
21Jun03		CXR portable	21Jun	/	2100	
23Jun		I&O catheter	~~23Jun~~	0500	0400	
22Jun		D/C labs	22Jun	AM	~	
22Jun		Xray 6/27 AM	22Jun	AM	D/C	
22Jun		CXR in AM	~~23Jun~~	AM	DONE	
7/2		D/C to Camp Ez Mij	7/2	Today		

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED: 20 21 22 23 24 25 26 27 28 29 30 01 2 3
20 Jun	(b)(6)-2	Ancef 1gram IVP Q6°	04	(b)(6)-2
			10	
			16	
			22	
20 Jun	(b)(6)-2	Zantac 50mg IVP BID	10	Ordered 23 Jun 03
			22	
20 Jun	(b)(6)-2	LR @ 100cc/hr	05	D/C 6/20 @ 1250
			17	
20 Jun	(b)(6)-2	Fentanyl gtt, titrate to effect (1000mcg/100mLNS)	05	D/C 1000 6/21/03
			17	
			05	
			17	
20 Jun	(b)(6)-2	Propofol gtt, titrate to effect	05	D/C 1000 6/21/03
			17	
20 Jun	(b)(6)-2	LR @ 75cc/°	05	D/C 6/20 @ 1600
			17	
20 Jun	(b)(6)-2	LR @ 100cc/°	05	date changed 20 Jun 03.
			17	
20 Jun 03	(b)(6)-2	↑ maintenance IVF to 200cc/hr	05	D/C 6/21 1100
		(LR)	17	
21 Jun	(b)(6)-2	LR @ 100cc/°	05	
			17	
22 Jun 03	(b)(6)-2	LR @ 75cc/hr	05	
			17	
23 Jun 03	(b)(6)-2	Zantac 150mg po BID	10	
			22	
		~~D/C WEAN~~ error		

ALLERGIES: ☐ YES ☐ NO — unknown

PRIMARY DIAGNOSIS: S/P GSW chest / S/P @ Thoracotomy

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

PATIENT IDENTIFICATION: (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 6231

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing

Mo. 6 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
20 Jun 03	b)(6)-2	↓ FiO_2 to 60%.	20 Jun		2300	done before PT. b)(6)-2
20 Jun 03		20mg Lasix IVP now X1	20 Jun 03		1530	done by CAT b)(6)-2
20 Jun 03		250 ml LR Bolus X1 now	20 Jun 03		2100	done by b)(6)-2
21 Jun 03		250 ml LR Bolus X1 now	21 Jun 03		0200	b)(6)-2
21 Jun 03		Lasix 20mg IVP X1 now	21 Jun		2107	
21 Jun		Lasix 20mg IVP X1 now	21 Jun		2325	
21 Jun 03		Albuterol 2.5mg in 3ml X1 now	22 Jun 03		0028	
22 Jun 03		Lasix 20mg IVP x 1 now	22 Jun 03	0730	0730	b)(6)-2
22 Jun 03		Lasix 20mg IVP x 1 now	22 Jun 03	0130	0130	
22 Jun		D/C ANCEF			1620	
22 Jun		D/C to EPW camp w/ MPS				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
21 Jun	b)(6)-2	MSO4 4-6mg IVP Q2° prn pain	21 Jun 1200 · 21 Jun 1400 · 21 Jun 1945 · 21 Jun 03 2300 · 22 Jun 0400 · 22 Jun 0800 · 22 Jun 1400 · 22 Jun 1900 · 22 Jun 2200 · 28 JUN 2200 · 23 JUN 0200 · 30 Jun 0200 · 1800
21 Jun	b)(6)-2	Toradol 30mg IVP Q8° prn pain	21 Jun 1400 · 21 Jun 2320 · 22 Jun 0400 · 1900 22 Jun 03 · 0400 · 0800
21 Jun	b)(6)-2	Tylenol 650mg PO Q4° prn fever >101.5	21 Jun 1400 · 22 Jun 00 0400 · 21 Jun 1500 · 21 Jun 03 1900 · 22 Jun 0400 · 22 Jun 1100 · 1500 · 1800 · 2200 · 23 Jun 0200 · 0600 · 1000 · 1400 · 1800 · 2200 · 24 Jun 0200 · 0600 · 1000 · 1400 · 1800 · 2200 · 25 Jun 0200 · 0600 · 1000 · 1400 · 1800 · 2200 · 26 Jun 0200 · 0600 · 1000 · 1400 · 1800 · 2200 · 27 Jun 0200 · 0600 · 1000 · 1400 · 1800 (July)
22 Jun 03	b)(6)-2	Percocet 1-2 po Q4° prn	23 Jun 00 · 23 Jun 0400 · 23 Jun 0800 · 1200 · 1600 · 2000 · 24 Jun 0000 · 0400 · 0800 · 1200 · 1600 · 2000 · 25 Jun 0000 · 0400 · 0800 · 1200 · 1600 · 2000 · 26 Jun 0000 · 0400 · 0800 · 1200 · 1600 · 2000 · 27 Jun 0000 · 0400 · 0800 · 1200 · 1600 · 2000 · 28 Jun 0000 · 0400 · 0800 · 1200 · 1600 · 2000 · 29 Jun 0000 · 0400 · 0800 · 1200 · 1600 · 2000 · 30 Jun 0000 · 0400 · 0800 · 1200 · 1600 · 2000 · 1 July 0000 · 0400 · 0800 · 1200 · 1600

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.	Marine Y rDB

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23	24	25	26	27	28	29	30	1	2	3
24 Jun	(b)(6)-2	O2 - WEAN	05	✓	(b)(6)-2							D/C'd		
			17	(b)(6)-2										
24 Jun	(b)(6)-2	Flagyl 500mg PO x 10 days,	18	✓	✓	(b)(6)-2								✓
		1st dose now (PO)	16	(b)(6)-2			(b)(6)-2							✓
			14	✓	(b)(6)-2									✓
25 Jun 0	(b)(6)-2	Bentyl 20mg p.o.	06	✓	✓	✓	(b)(6)-2							
		QID - 1st dose now	12	✓	✓	✓								
			18	✓	✓	✓								
			24	✓	✓	(b)(6)-2	Held							

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS:	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
unknown	S/P GSW ® chest 5/P ® thoracotomy	PAGE NO.

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)					Mo. Jan Yr. 2008
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
30Jan	(b)(6)-2	Maalox 30 cc po now	(b)(6)-2 now	now	1730	(b)(6)-2	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
25Jan	(b)(6)-2	Benadryl 50mg p.o QHS prn insomnia	
26Jan	(b)(6)-2	Zofran 4mg IV q 4° prn nausea	29 Jan 4mg 2300 (b)(6)-2
27Jan	(b)(6)-2	Bentyl 20mg q.i.d. prn stomach cramps	
30Jan	(b)(6)-2	Maalox 20cc PO prn q4° nausea	0100 (b)(6)-2

USAPA V1.00

MEDCOM - 6234

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.	Male Y rO3

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED: 23	24	25	26	27	28	29	30	1	2	3
24 Jun	(b)(6)-2	O2 - WEAN	05	/	(b)(6)-2							D/C	D/C	D/C
			17	(b)(6)-2										
24 Jun	(b)(6)-2	Flagyl 500mg PO x 10 days,	08	4	/	(b)(6)-2								/
		1st dose now (PO)	16	(b)(6)-2			(b)(6)-2							/
			24	/	(b)(6)-2									/
25 June	(b)(6)-2	Bentyl 20mg p.o.	06	/	/	/	(b)(6)-2							
		Q1D 1st dose now	12	/	/	/								
			18	/	/	/								
			24	/	/	(b)(6)-2 HOLD								

ALLERGIES: ☐ YES ☐ NO — unknown

PRIMARY DIAGNOSIS: S/P GSW (R) chest S/P (R) thoracotomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 6235

POST-OP DAY 23 24 01 02 03 04 05

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	23	24	01	02	03	04	05
T	99.4	98.3		98.6		98.1	
P	80	95	86	85	74	75	
R	16	16	14	14	14	15	
SpO2	100%	100%	100%	100%	100%	100%	
FiO2	50	50%	45%	45%	45%	45%	
Mode	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	

INTAKE

	23	24	01	02	03	04	05	
	200	200	200	200	200	200		2815
	0							200
	10	10	10	10	15	15		165
	19.8	19.8	19.8	19.8	13.2	9.9		222
	—							
	0			250				500
	—							6
								3968

OUTPUT

	23	24	01	02	03	04	05	
	30	30	30	25	35	40		1660
	0							
	0							
	4	10	15	5	0	5	0	219
	22	6	10	10	10	5	5	219
								2198

RESPIRATORY DATA

	TIME	1100	1230	1330	1800	2300	2305	2400	0830
	MODE	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
	F_iO_2	100	50	70	70	60	60	50	45
	TV	700	700	700	700	700	650	650	600
	RATE	18	14	16	16	16	16	16	14
	PEEP	5	5	5	5	5	5	5	5
A	pH	7.43	7.28	7.39		7.551		7.464	
A	PCO_2	30	45	34		26.3		31.5	
A	pO_2	231	69	160		161		100	
B	HCO_3	20	21	21		23		23	
	SAT	100%	90%	99%	100%	100%		98%	
G	BASE	-4	-6	-4		1		-1	

LABORATORY DATA

TIME	1030
GLUCOSE	171
Na/K	138/5.0
Cl/CO_2	107/24
BUN/Cr	9/.6
WBC/PLATELET	15/168
Hct/Hgb	10.8/33.9

ACTIVITY DAILY LIVING

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

q2 hr

24 HR TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL	3968	TOTAL	2098

BALANCE +1870

NURSE'S SIGNATURE | INITIALS

(b)(6)-2 (b)(6)-2 (b)(6)-2 ILT AN

MEDCOM - 6236

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
DA Appr 8 Mar 89

[redacted]

INITIAL SHIFT ASSESSMENT

		TIME	1030	INITIALS		INITIALS	1830	INITIALS
NEURO		PUPILS	1mm, minimal reaction to light				Reactive, slow-sluggish 2mm/2	
		SENSORIUM	Sedated on 15mcg/kg/min propofol				SEDATED: Propofol 24 mcg/kg/m	
			pain control & 50mcg/hr fentanyl				Analgesia: Fentanyl 100 mg/hr	
			Occasionally awakes spontaneously				& intermittent spontaneous	
			& purposeful movements of R UE				awakening & follows correct	
RESPIRATORY		RESPIRATORY PATTERN	Vent SIMV Rate 16 FIO2 70, TV 700				VENT SIMV R 16 FIO2 70 TV 7	
		BREATH SOUNDS	peep 5, sats 100%. #8 ETT 23cm lip				peep 5, sats 100%. #8 ETT @	
		SECRETIONS	Small amount bloody secretions				23cm @ lip. CT x 2, (R) side	
			suctioned initially upon return from				#1 posterior - D/C dressing, chan	
			OR. R CT x2 (anterior, posterior)				#2 anterior - D/C dressing	
			L lung clear, R lung & pleural rub				drainage as marked on previous c	
SKIN		COLOR	pale, warm, dry				BS: clear throughout, diminished	
		INTEGRITY	Incision to R chest wall & drg				in Region of insult.	
			drainage marked @ sites bleeding					
IV SITE		LOCATION	[redacted]				IV's: #1 - Opsite dsg c/d/i - secured.	
		CONDITION	R @ FA - patent - HL				@ forearm - infect./infil. IV infusing	
		IV meds -	Zantac 50mg IVPB BID				@ 100 cc/hr. Fentanyl @ 100 cc/hr @ 50 mg/cc @ 8 gtts/min. #2 - @ AC - opposite CT - c/d/i	
			Ancef 1gm @ 6°				@ forearm - infection @ Flush @ 80	
		gtt -	fentanyl 10mcg/cc				A-Line @ R radial transduced - zero	
			propofol 10mg/cc				@ waveform, @ secured.	
GASTRO		ABDOMEN	Soft N/T, BSO @ Stool				BS: ↓ BS x 4 q. abd soft, non	
		BOWEL SOUNDS	NGT in place to LIS, minimal				distended, @ BM. NGT in tact,	
			output. @ NPO, to OR				@ nare, secured to LIS, minimal	
			remain NPO.				light brown OP.	
GU		URINE:	Clear medium yellow, ↓ to				Indwelling Foley to gravity, clear	
		COLOR/CLARITY	1cc/kg/hr from 2-4 cc/kg/hr				yellow urine amber.	
			post op. @ bladder distention					
CARDIO-VASCULAR		CARDIAC RHYTHM	Initially bradycardic upon				NSR, tachy @ 110's BP: 90's	
			return from OR, now NSR				systolically, 50's diastolic	
			rate 70-80, BP elevated (slightly)				- stable. T: 100.3	
			but stable, Afebrile				Radial pulses R/L at 2+, Dorsal	
							2+ cap refill < 3sec. @ swelling	

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] CPT/AN

DEPARTMENT/SERVICE/CLINIC ICU 2 east

DATE 20 June 89

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

[redacted]

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

MEDCOM - 6237

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

DATE																HOSPITAL DAY				
		DS 05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
VITAL SIGNS	TIME																		
	BP Arterial Line						143/81	148/83	146/79	139/79	138/66	137/74	125/62	111/64	97/80	92/60	95/56	88/49	90/53
	BP Cuff						113/52	128/87	124/61	144/66	110/64	144/69	114/68	105/58	99/68	95/68	91/59	92/50	
	Temperature						93.5	95.1	96.0	98.3	98.5	99.2	100.6		100.3	100.1	100.9	100.5	99.9
	Pulse						61	59	78	81	77	91	92	109	112	111	112	100	100
	Respiratory Rate						25	14	14	18	16	16	16	16	16	16	16	16	16
	Sats						100	100	99	100	100	100	100	100	109	100%	100%	100%	100%
	FIO2						100	100	50	40	70	70	70	70	70	70	70	70	60
	mode						SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
	open intervention																		
INTAKE	TIME																		
	time	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
	LR						100	100	100	175	175	175	175	100	100	100	100	100	100
	IVPB							50					50	Ø	Ø	Ø	Ø	Ø	100
	Fentanyl							5	5	5	5	5	10	10	10	10	10	10	10
	~~Versed~~ Propofol							5	5	6	8	8	8	13.2	13.2	13.2	13.2	7	19.8
	Bolus/Blood																		
	Bolus LR																	250	
	Bolus Propofol															2cc		4cc	
	TOTALS						100	160	155	186	188	186	143	123.2	123.2	125.2	143.2	292	229.8
OUTPUT	URINE HOUR / TOTAL						Ø	200/200	200/400	100/500	50/550	50/600	50/650	150/800	150/950	200/1150	50/1400	40/1440	30/1470
	URINE sp gr																		
	URINE S/A																		
	NG OUTPUT						Ø				25				75	Ø			
	NG pH																		
	NG GUIAC																		
	EMESIS														Ø	Ø	Ø	Ø	
	STOOL														Ø	Ø	Ø	Ø	
	DRAINS CT#1						52	38	34	4	7	2	4	2	3	6	10	12	6
	DRAINS CT#2						28	30	9	12	18	11	7	3	3	4	12	12	4
	TOTALS						80	68	43	16	25	16	11	5	6	10			

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-65; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0700	INITIALS [b](6)-2		INITIALS [b](6)-2		INITIALS [b](6)-2
NEURO		PUPILS	1-2mm minimally reactive		3mm Reactive			
		SENSORIUM	Propofol to 30mg/h, fentanyl		Alert and oriented			
			to 50mcg/h to extubate		moves all extremities.			
			awake & Spont, moves all					
			extremities					
RESPIRATORY		RESPIRATORY PATTERN	Vent SIMV Rate 14, TV 600		easy, nonlaboreed.			
		BREATH SOUNDS	FIO_2 45% Peep 5, breathing		diminished to RLL			
		SECRETIONS	over vent when awake		nonproductive cough.			
			Sats 100%. Breath sounds		on 10L NRB mask; IS x 10			
			Clear, diminished @		↑ to 600cc/sec. Right deltoid			
			pleural rub on (R) Kray claire		x2 patent, draining, rd drainage			
SKIN		COLOR	pale, warm + dry		WNL			
		INTEGRITY	Incision to (R) chest @		(R) chest drng @ drainage: mod			
			drg (R) new drainage noted		monitor, (R) reinfuse as returns			
IV SITE		LOCATION	18g to (L) EJ @ 125cc/hr		(L) neck PIV @ KVO @ 100cc/hr			
		CONDITION	18g to (L) FA WNL		Patent, (+) blood return			
	Aline		20g to (R) RAD @ poor wave from		drsg change due to site			
	CT #1		posterior chest 0-5cc/h bloody		~~PIV~~ to heplock to left			
	CT #2		anterior chest 0-5cc/h bloody		AC, flushed, patent (+)			
					blood return			
GASTRO		ABDOMEN	Soft, flat N/T BS (+)		soft, flat			
		BOWEL SOUNDS	NGT to WS @ 25cc/4°		(+) BS x 4 quads			
			brown drainage BStool		ate lunch yellow (+) N/V.			
			(-) N/V/D, remains NPO		(+) BM.			
GU		URINE:	medium yellow @		clear → foley → gravity			
		COLOR/CLARITY	(amber colored) 1cc/kg/hr		clear yellow, patent			
			@ bladder distention					
CARDIOVASCULAR		CARDIAC RHYTHM	NSR 70's, BP stable		Sinus tach → sinus rhythm			
			ACB's H/H 26/8		VSS (+) pulses R4. Apical			
			pulses palpable x4 ext.		pulse strong, regular, S			
			Leaks, ABG drawn		& S heard.			
	Plan:		Extubate this am					

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 21 Jun 03

PATIENT IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility) [b](6)-4

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

DATE 21-22 June 03 | DX S/P Gunshot Wound to chest s/p ex thoracotomy | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	93/44	NA	NA	NA	NA	NA	N/A	—										→
BP Cuff	98/48	92/44	101/46	102/49	108/48	124/63	101/51	119/60		112/56	106/54	102/54	101/44	105/53	107/53	101/48	100/59	
Temperature		98°				99°					102°		100.9		99.6	99.4		
Pulse	75	73	72	89	96	105	92	105		115	111	102	88	90	101	88	90	
Respiratory Rate	18	15	16	17	19	32	21	38		38	39	24	21	22	28	21	23	
Sats	100%	100%	100%	99%	99%	97%	99%	100%		95%	98%	98%	100%	99%	99%	99%	99%	
FiO_2	45	45	45	45	45	12L	12L	10L		10L	10L	10L	10L	10L	10L	10L	10L	
Mode	SIMV	SIMV	SIMV	SIMV	SIMV	NRB	NRB	NRB		NRB	NRB	NRB	NRB	NRB	NRB	NRB	NRB	
open intervention																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
LR	200	200	200	200	200	200	100	100	1400	100	100	100	100	100	50	100	100	
IVPB	50					100							50					
Fentanyl	15	15	15	5	0	0	D/C	←	50									→
Propofol	83	83	7	3	0	0	D/C		26.6									→
PO															120			
Subtotal										100	100	100	150					
TOTALS	273	223	222	208	200	300	100	100		100	200	300	400					

OUTPUT

URINE	HOUR	65	60	70	70	100	50	75	75	565	200	125	75	150	65	275	150	100	
	TOTAL	65	125	195	265	365	415	490	565		765	890	965	1115	1210	1485	1635	1735	1735
	sp gr																		
	S/A																		
NG	OUTPUT		25°				D/C°			25									→
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	CT #1	0	10	5	5	10	25	5	5	8	15	0	0	5	20	5	10	15	
	CT #2	5	15	10	10	10	25	5	5	4	50	50	0	25	5	5	5	15	
TOTALS		70	[illegible]											210					

110 BS RS 12

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	21	22	23	24	01	02	03	04	
	116/69	102/55	109/60	99/53	104/62	102/54	102/51	106/65	
		99.8	99.9			99.6		101.7	
	89	105	104	91	102	99	100	116	
	36	30	38	25	31	33	32	35	
	84%	98%	94%	96%	99%	99%	100%	98%	
	10L NRB	10L	10L	10L	10L	10L	10L	50%	
	NRB	NRB	NRB	NRB	NRB	NRB	NRB	VM	

INTAKE

	21	22	23	24	01	02	03	04	
									240
	100	100	100	100	100	100	100	100	300
		100						50	350
									50
									266
								50	170
									3597

OUTPUT

	500/500	RLQ 1416	725/2185	575/2760	500/3260	100/3360	50/3410	40/3450	5165
	20ml IV D/c'd		20ml Urine						
	25	5	5	5	5	0	5	0	185
	20	5	5	0	5	0	0	5	220
									5590

RESPIRATORY THERAPY

		0500								
TIME										
MODE		SMV								
F_iO_2		45%								
TV		600								
RATE		14								
PEEP		5								
A	pH	7.39								
A	PCO_2	38.1								
A	pO_2	78								
B	HCO_3	23								
B	SAT	96%								
G	BASE	-2								

LABORATORY DATA

		0400	@ 0020							
TIME										
GLUCOSE		87								
Na/K		136/4.0								
Cl/CO_2		101/24								
BUN/Cr		12/0.9								
WBC/PLATELET		9.0/168								
Hct/Hgb		8.8/26.8								
CK/Lymph%		184/22.9								
RBC/MCV		3.02/88.7								

ACTIVITIES / NURSING CARE

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

TURN / SUCTION — TIME

24 I&O TOTALS

NURSE'S SIGNATURE — INITIALS

(b)(6)-2 — (b)(6)-2 — (b)(6)-2 — CTA

wt Yesterday _____ wt Today _____

	INTAKE	OUTPUT
IV	_____	Urine: _____
PO	_____	_____
	_____	_____
TOTAL	3597	TOTAL 5590
BALANCE		-1993

MEDCOM - 6241

DATE			05	06	07	08	09	10	11	12		13	14	15	16	HOSPITAL DAY 17	18	19	20	
VITAL SIGNS	TIME		~~04~~	~~07~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~	/	~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	/
	BP Arterial Line																			
	BP Cuff		109/88	100/80	109/87	109/71	111/85	104/81	109/86	109/85		81/41	103/81	109/85	102/82	104/83	103/81	110/83	102/86	
	Temperature		100.8		100.3	100.1	100.4			100.4				101.9		101.2		101.9	100.8	
	Pulse		112	103	97	104	108	101	109	117		117	109	117	101	101	104	119	113	
	Respiratory Rate		41	25	40	32	27	28	42	42		43	45	38	39	41	28	32	45	
	Ventimask 50%		10L	10L	NRB	Simp	11	Simp	12	12		12	12	12	12	12 NRB	NRB V2	NRB 12	Ventimask 100%	
	Sats		97%	95%	98%	100%	100%	100	100	99		100	99	100	100	100%	100%	99%	100%	
	Meds																			
	open																			
	intermittent																			
INTAKE	TIME		~~00~~	~~01~~	~~01~~	~~03~~	~~02~~	~~05~~	~~06~~	~~12~~	8°T	~~13~~	~~17~~	~~15~~	~~16~~	~~17~~	~~18~~	~~19~~	~~20~~	8°T
	LR		100	100	100	100	75	75	75	75		76	75	75	75	75	75	76	75	
	PO					50				250										
	IV meds							100							50					
	TOTALS		100	100	100	150	75	175	75	325		75	75	75	125	75	75	75		
OUTPUT	URINE	HOUR	70	0	15	700	75	0	0	15		125	125	0	20	30	35	25	200	
		TOTAL	70	70	85	785	810	810	810	825		940	1065	1065	1085	1115	1150	1175	1375	
		10 gr																		
		SIA																		
	NG	OUTPUT																		
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS	CT #1	10	0	5	0	0	0	5	10		15	15	0	0	0	0	10	10	
		CT #2	10	0	0															
	TOTALS		90	0	90	75	90	810	810	825		965	2nd	3rd	4th	5th	6th	7th	2 liters	

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0530	INITIAL (b)(6)-2	1720	INITIALS (b)(6)-2	2320	INITIALS (b)(6)-2
NEURO		PUPILS	3mm, PERLA		PERRL		PERRL 3mm 3mm	
		SENSORIUM	Alert & oriented, awake, responds appropriately		Sleepy, but easily arouseable to verbal stimulus		sleeping - awakens to external stimuli; alert oriented; moves all extremities; follows commands	
RESPIRATORY		RESPIRATORY PATTERN	labored - rate 40-50		tachypneic 20-30's		Tachypneic - 24-27 BPM	
		BREATH SOUNDS	Rhonchi throughout, (R) base		Clear to upper lobes,		Chest movement symmetrical	
		SECRETIONS	∅ noted		scattered inbergs to LLL		BS: crackles (L) lower base	
					diminished to RLL. Chest		Rhonchi (R) LL, diminished	
					tube x1 to L chest; drsgs		(R) M/L lobe. ∅ secretions	
					intact. on 12L NRB mask		orally. (A) CT (R) antimicrobial	
SKIN		COLOR	normal for race		WNL		suction.	
		INTEGRITY	intact - dressing to CSW		small incisions & stitches to anterior		skin; normal for race	
			entry/exit wounds on chest		hand. Dry OTI to R chest		Dressing to (R) mid clavicular	
I.V. THERAPY		LOCATION	(L) ET, (R) FA		R wrist. PIV, flushes well		& (R) lateral thoracic regions	
		CONDITION	(L) ET patent & LR @		(R) blood returns LR @ 75 cc/hr		CDI; ∅ cardiac drsgs	
			100 cc/hr, (L) FA patent,		infusing. Left AC ~~PIV~~		(A) (L) ET. LR infusing	
			flushed, heplocked		heplock unable to flush, clinical		@ 75 cc/hr. Opposite wrist	
					pack back w/ two attempted primary		C, D, (A) BKA, (R) posterior	
					line DC'd at this time			
GASTRO		ABDOMEN	soft, non-tender		soft nontender.		soft, nontender, non distended	
		BOWEL SOUNDS	(A) x 4 quadrants		(A) BS x 4 quads.		(A) BS x 4q.	
GU		URINE:	Foley to gravity		foley → gravity		Foley to gravity, UOP	
		COLOR/CLARITY	clear yellow		clear yellow		dark yellow, concentrated	
					∅ sediment.		UOP @ 30 cc/hr.	
CARDIOVASCULAR		CARDIAC RHYTHM	NSR rate 100-105		sinus tachycardia		NSR, S1S2 present.	
			see attached rhythm		Ectopy pulses		HR 93-95 BPM.	
			STRIP		palpable x4 and		∅ peripheral edema	
			CTx2 to 20 cm H2O suction		strong. good cap		cap refill <3 sec	
			Output 5-10 cc/∅ each		refill.		radial, pedal pulses x4 = +2	

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; SIA - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (b)(6)-2 LDN/SGT

DEPARTMENT/SERVICE/CLINIC ICU 2 east

DATE 22 JUN 05

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS									
	24	22	23	24	00	02	03	04	
	93/51	117/57	101/56	101/60	102/56	114/58	105/50	107/55	
		998	—	1004			1013		
	99	112	93	99	96	96	101	114	
	34	35	27	25	26	36	32	31	
	VM 50%	VM 40	VM 40	VM 35%	VM 39%	VM 45%	VM 45%	VM 45%	
	96%	94%	95%	98%	95%	98%	97%	96%	
					laxix				

INTAKE									
	24	22	23	24	00	02	03	04	
	75	25	15	15	75	75	75	75	
			0	0	0	120	0	0	
		100	0	0	0	0	0	0	
	75	75	75	75	75	195	75	75	2445

OUTPUT									
	25/220	25/245	19/164	18/252	20/300	350/185	175/200	59/206	2082
					20 ml/hr				
					3 six				
	10	15	2	3	0	7	7	10	10
	35	40	21	21	20	557	182	65	2324

RESPIRATORY	TIME	0700	0800	2200	2330	0130				
	MODE	Vent Mask	NRB	VM	VM	VM				
	F_iO_2 Vent Mask	50%	50%	40%	35%	40%				
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GASES	A pH	7.480	7.471							
	A PCO_2 44.9	42.4	40.8							
	pO_2	56	67							
	B HCO_3	28	30							
	SAT	87%	93%							
	G BASE	4	6							

LABORATORY	TIME	0430								
	GLUCOSE	108								
	Na/K	139/3.7								
	Cl/CO_2	99/26								
	BUN/Cr	8/0.7								
	WBC/PLATELET	9.3/168								
	Hct/Hgb	27/8.9								

ACTIVITY/TURNING	TIME					TIME				
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN

SUCTION

24 HR TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	2082
po			
TOTAL	2445	TOTAL	2321
		BALANCE	119

NURSE'S SIGNATURE | INITIALS

(b)(6)-2 | (b)(6)-2

(b)(6)-2 | (b)(6)-2

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0530	INITIALS (b)(6)-2	1830	INITIALS (b)(6)-2		INITIALS
NEURO		PUPILS	3mm, PERLA		Perrl 3mm/3mm			
		SENSORIUM	Alert & oriented, responds appropriately, follows commands		awake, alert x3 verbal, follows commands, moves all extremities purposely.			
RESPIRATORY		RESPIRATORY PATTERN	rapid, unlabored		Tachypnea 20's-30's, non-labored			
		BREATH SOUNDS	Rhonchi @ Side diminished/bs		" diffuse, chest expansion equal, symmetrical			
		SECRETIONS	Ø noted		@ nasal O2 @ 4L/min via Ø succesky mask. BS - rhonchi bilat throughout, @ CT to wall suction for moderate amt of thick yellow/green mucus			
SKIN		COLOR	normal for race					
		INTEGRITY	entry wound @ upper chest		@ bronchopneumonia drainage @ dressing, dry intact @ drainage yellowish noted to dressing, ↓ amt.			
IV SITE		LOCATION	@ IJ, LRL 75cc/hr		@ cough, wet, non-productive.			
		CONDITION	patent, Ø blood return but flushes		Dressing over CT insertion site to @ internal jugular vein. Patient to maintain to keep O2 seal. @ TPN infusing 75 cc/hr @ peripheral infiltration.			
GASTRO		ABDOMEN	soft, non-distended		soft, non-tender non-distended			
		BOWEL SOUNDS	@ x4 quads		@ Bs x 4q			
GU		URINE: COLOR/CLARITY	Foley to gravity dark yellow, clear		@ Foley - d/c'd early pm / VOP yesterday. No void @ this time			
CARDIOVASCULAR		CARDIAC RHYTHM	NSR - sinus tach see rhythm strip		NSR - sinus tach. Ø ectopy @ radial, pedal pulses 2+. @ cool/clammy to peripherally. Cap refill < 3 sec.			

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREP (b)(6)-2 | SGT/LPN | DEPARTMENT/SERVICE/CLINIC: ICU 2 west | DATE: 23 Jun 03

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

(b)(6)-4

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

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	—																	
BP Cuff	106/55	107/61	114/70	88/45	103/50	97/56	99/50	104/50	109/60	107/68	104/44	95/50	104/61	98/48	107/47	96/50	95/59	
Temperature	101.2				101													
Pulse	100	108	117	120	113	100	89	97	115	115	107	104	106	101	117	106	100	
Respiratory Rate	33	40	38	30	40	33	23	25	38	38	28	29	26	22	35	20	20	
Mode	VM	VM	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
FiO_2	40%	40%																
SpO_2	97%	95	98	99	99	99	100	100	96	96	98	99	100	100%	99%	99%	98	
Liters O2	9L	8L	6L	6L	6L	6L	6L	6L	6L	6L	4L	5L	5L	4L	4L	3L	5L	
pain															Pruritus			
intervention																	Pt ↓ levels (Endocrinology)	

INTAKE

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°
LR	75	75	75	76	75	75	75	75	75	75	75	75	75	75	75	75	75	
PO	120												0	Ø	240	Ø	Ø	
IV Meds.	50							100					Ø	Ø	Ø	Ø	Ø	
TOTALS	245																	

OUTPUT

Foley URINE HOUR	0	Ø	10	20	20	100	75	10		Ø	Ø	Ø	Ø	Ø	0	Ø	15	
URINE TOTAL	0	Ø	10	30	50	150	225	235		235							46	
SP GR										Foley D/C'd								
S/A																		
NG OUTPUT	/																	
NG PH																		
NG GUIAC																		
EMESIS	0	Ø																
STOOL	0																	
DRAINS CT	5	5	5	\	Ø	10	10	Ø		Ø	Ø	Ø	15	5	18	10	5	
TOTALS																		

MEDCOM - 6246

POST-OP DAY: 0 02 03 04

VITAL SIGNS

	21	22	23	24	~~30~~	~~22~~	~~30~~	~~18~~	
	95/59	105/51	1??/51	107/61	99/48	98/55	128/68	98/54	
	100.1					98.7		100.0	
	100	98	100	104	91	89	103	98	
	20	22	20	29	18	19	34	21	
	NC	NC	NC	NC	NC	NC	[illegible] NC	NC	
	97%	100%	98%	95%	98%	97%	84%	99%	
	5L	.05L	3L	3L	3L	3L	5L	5L	
	Hand [illegible]						↓ VM 50% ⇓ 95% ↓ NC		
		Tonsil [illegible]				Tonsil [illegible]			

INTAKE

	16	17	18	19	20	21	22	23	8° T
	75	75	75	75	75	75	75	75	900
	120	Ø	Ø	240	Ø	Ø	0	240	960
	Ø	50	Ø	Ø	Ø	Ø	0	100	250
									2110

OUTPUT

	Ø/290	Ø/290	Ø/290	0/290	0/290	0/290	0/290	450/740	740
	X1					X1	Foley Placed		
	5	Ø	Ø	5	Ø	10cc	10cc	~~40~~	~~40~~ (110)

ACUITY LEVEL CLASSIFICATION

RESPIRATORY THERAPY

	TIME	2300	~~0300~~	0400						
	MODE	VM		NC						
	F_iO_2	50%		↓						
	TV			✓						
	RATE			10						
	PEEP									
A	pH									
	PCO_2									
B	pO_2									
	HCO_3									
	SAT									
G	BASE									

LABORATORY

TIME	0400								
GLUCOSE	104								
Na/K	128/3.5								
Cl/CO_2	97/21								
BUN/Cr	10/.5								
WBC/PLATELET	9.4/194								
Hct/Hgb	26/8.6								

ACTIVITIES OF DAILY LIVING

TIME	2300 / 0200				TURN	TIME
MOUTH CARE	(b)(6)-2					
BATH						
SKIN CARE						
FOLEY CARE					SUCTION	
TRACH CARE						
ROM EXERCISES						

24° I&O TOTALS | **NURSE'S SIGNATURE** | **INITIALS**

wt Yesterday ______ wt Today ______

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

INTAKE		OUTPUT	
IV	1150	Urine:	740
PO	960	Stool X2	app. 50cc
TOTAL	2110	TOTAL	790cc

BALANCE______

MEDCOM - 6247

- June 03

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME (0730) / INITIALS	INITIALS SL	2000 / INITIALS SL
NEURO	PUPILS	Pupils 3mm+brisk.		Pupils 3mm Perrl
	SENSORIUM	Round+reactive to light		9+10x3 @verbal
		Alert and responds		to pain stimuli
		appropriately to verbal		
		stimuli		
RESPIRATORY SYSTEM	RESPIRATORY PATTERN	lungs c course sounds		Diminished BS
	BREATH SOUNDS	noted bilaterally, dim		bilat productive
	SECRETIONS	breath sounds noted in		cough - weak effort
		@ lower lobe. O2 sats 95-99%		NK 3L > Sat 90%
		on O2 @ 3-4L via n/c. Desat		Desats at time of sleep
		upon exertion. CT to Cont		mouth breather
INTEGUMENTARY SYSTEM	COLOR	Skin normal for race		normal for race
	INTEGRITY	no evidence of skin		
		breakdown noted		
	LOCATION	IV noted to @ EJ patent		IV @ EJ DSG
	CONDITION	and c edema or		Δd ϕ S/Sx of inf
		erythema		
GASTRO	ABDOMEN	Abdomen round+soft		non-distended
	BOWEL SOUNDS	c bowel sounds noted x		soft ϕBm This
		4 quads. Last BM last		shift
		night		
GU	URINE:	Pt last voided c dressing		+void 200cc
	COLOR/CLARITY	cath @ 0400. Will cont		dk yellow urine
		to monitor bladder function		
CARDIOVASCULAR	CARDIAC RHYTHM	Normal sinus rhythm		normal Sinus
		c rate in high 80s. @		Pulse rate 90-120s
		palpable pulses small		↑ upon exertion
		extremities. No edema		
		noted.		

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; SA - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

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

DATE: 22 June 03

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

(b)(6)-2 (b)(6)-4

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

Jeff Jan 5

DATE 24 DX CSW (R) chest HOSPITAL DAY 5

VITAL SIGNS

TIME	05	06	07	08	04	09	11	12		15	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff	97/54	104/55	101/53	93/50	97/53	101/65	109/59	111/64		109/67	96/49	113/56	115/67	104/73	126/60	134/88	116/80	
Temperature	100.0					97.5						99.6			98.8			
Pulse	96	98	91	77	78	110	92	91		89	82	111	101	102	120	116	110	97
Respiratory Rate	19	17	16	14	16	35	17	17		16	19	32	23	31	24	32	26	
Sats	99%	96	95	100	98	95	98	96		100	100	93	96	97	96	93	91	
Mode	NC	NC	NC	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	NC
flow rate	3L	3L	3L	3L	3L	3L	3L	3L		3L	3L	3L	3L	3L	3L	3L	3L	3L
humidified	dry																	
oxygen saturation																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
LR	75	75	75	75	75	75	75	75	300	75	75	75	75	75	75	75	75	300
PO	0	30				150								100			100	150
IV meds	0					50						100						150
Subtotal	75	105	75	75	75	145	75	75		75	75	175	75	75	75	75	175	150
TOTALS	75	180	255	330	405	550	625	700	300	75	150	325	400	475				150

OUTPUT

		HOUR / TOTAL																	
URINE		0	0	—	—	x1											1900 200		
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUAIAC																		
EMESIS		/																	
STOOL		/			x1	x1		200				x1	x1						
DRAINS	CT	0	0	0	5	0	50	0	0		0	0	0	0	0	0	0	0	
TOTALS					5		55	255	255									200	

24 June 03

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	24	22	23	00	01	02	03	04	
	101/55								
	92	96							
	16	22							
	94	92							
	NC	NC	NC	NC	NC	NC	NC	NC	
	3L	3L	3L	3L	3L	3L	3L	3L	

INTAKE

	16	22	23	00	01	02	03	04	8°T
	75	75	75	75	75	75	75	75	300
		50							50
									350
									1700

OUTPUT

			1200 800						
	ϕ	ϕ							
									200
									450

RESPIRATORY DATA

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

LABORATORY DATA

TIME	0400									
GLUCOSE	95									
Na/K	135 / 3.8									
$ClCO_2$	98 / 25									
BUN/Cr	14 / .7									
WBC/PLATELET	10.9 / 269									
Hct/Hgb	28.0 / 9.1									

ACTIVITIES OF DAILY LIVING

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

24 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	1700	Urine:	650
po	X		
TOTAL		TOTAL	
		BALANCE	+1050

NURSE'S SIGNATURE / INITIALS

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

(b)(6)-2

MEDCOM - 6250

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0530	INITIALS SS	1730	INITIALS		INITIALS
NEURO	PUPILS	2mm, PERLA		3 — PERLA			
	SENSORIUM	Alert & oriented		A+O×3			
		responds					
		appropriately					
RESPIRATORY	RESPIRATORY PATTERN	unlabored, rate 20-35		RR R 30-35			
	BREATH SOUNDS	rhonchi (L) side (R) diminished		rhonchi (L) side			
	SECRETIONS	Ø noted, pt is		diminished (R)			
		coughing productively		non-productive			
		but not spitting		cough ⊖ suction			
		sputum					
SKIN	COLOR	normal for race		WNL for race			
	INTEGRITY	intact, GSW (R) upper		GSW to (R) chest			
		chest, chest tubes, ite		CT to (R) side			
IV SITES	LOCATION	(L) EJ, LRO 75cc/hr		(L) IJ LRO 75			
	CONDITION	patent, infusing,		⊖ SS fluid			
		Ø s/s infiltration,					
		infection, dsg Δd					
		last shift					
GASTRO	ABDOMEN	soft, non-distended		soft, non-distended			
	BOWEL SOUNDS	hyperactive x4 quads		hyper x4 ⊖			
G.U.	URINE:	Ø urine out yet		dark yellow			
	COLOR/CLARITY	this shift					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR		NSR			
		palpable pulses x 4					
		HR 85-95					
		see rhythm strip					

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (b)(6)-2 LPN

DEPARTMENT/SERVICE/CLINIC ICU 2 west

DATE 25 Jun 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE		BX 05	06	07	08	09	10	11	12		13	14	15	16	HOSPITAL DAY 17	18	19	20	
VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line																		
	BP Cuff	111/60	119/64	116/61	113/	110/65	104/68	107/	107/60		116/	112/	111/57	114/65	114/	106/50	105/61		
	Temperature	98																	
	Pulse	89	91	94	86	88	93	81	95		88	95	94	107	106	108	87	87	
	Respiratory Rate	26	30	34	23	13	32	27	27		31	39	31	42	34	34	30	32	
	Sats	100	100	96	100	100	99	100	99		99	99	99	99	97	100%	100%	99	
	O2	6L	3L	3L	3L	3L	6L	6L	2L		2L	2L	2L	2L	6L	6L	6L	6L	
	Source			NC	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	
	pain intensity																		
INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	LR	75	75	75	75	75	75	75	75		75	75	75	75	75	75	75	75	
	PO					200		100	100										
	IV meds						50												
	Subtotal																		
	TOTALS																		
OUTPUT	URINE HOUR	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø		Ø	Ø	Ø	Ø	Ø	0	0	0	
	URINE TOTAL	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø		Ø	Ø	Ø	Ø	Ø	0	0	0	
	SP GR																		
	S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC			40cc	80cc		30cc												
	EMESIS			XT	XT		XT							XT					
	STOOL																Diarrhea x1		
	DRAINS CT		10	15	10	Ø	10	Ø	Ø		5	Ø	5	15	Ø				
	DRAINS																		
	DRAINS																		
	TOTALS																		

MEDCOM - 6252

POST-OP DAY 21 22 23 24 01 02 03 04

VITAL SIGNS

	16	17	18	19	20	21	22	23	
		102/61	137/63	109/57	106/61	105/59	113/67	118/64	
		92	82	88	75	84	77	78	
		27	32	34	21	32	34	32	
		100	100	100	97	98	100	100	
		2L	2L	2L	2L	2L	2L	2L	
		NC	NC	NC	NC	NC	NC	NC	

INTAKE

	16	17	18	19	20	21	22	23	
	75	75	75	75	75	75	75	75	8°T 1725
									460
				50				50	150

OUTPUT

	0/0	0/0	0/0	425/420	0/420	0/420	0/420	0/420	2L
				Diarrhea x1					

ACUITY LEVEL CLASSIFICATION

RESPIRATORY

		16	17	18	19	20	21	22	23	
TIME										
MODE										
F_iO_2										
TV										
RATE										
PEEP										
ABG	pH									
A	PCO_2									
	pO_2									
B	HCO_3									
	SAT									
G	BASE									

LABORATORY

	16	17	18	19	20	21	22	23	
TIME	0400								
GLUCOSE	89								
Na/K	139/3.7								
Cl/CO_2	97/30								
BUN/Cr	15/0.7								
WBC/PLATELET	10/333								
Hct/Hgb	29.6/9.3								

ACTIVITIES DAILY LIVING

	16	17	18	19	20	21	22	23	
TIME									
MOUTH CARE									
BATH									
SKIN CARE									
FOLEY CARE									
TRACH CARE									
ROM EXERCISES									

TURN — TIME

SUCTION — TIME

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE — INITIALS

MEDCOM - 6253

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0530	INITIALS SS	1800	INITIALS SSL		INITIALS
NEURO		PUPILS	2mm, PERLA		Perrl 3mm			
		SENSORIUM	awake, alert, oriented, responds appropriately		awake, quiet responds to verbal commands			
RESPIRATORY		RESPIRATORY PATTERN	unlabored, rate 20-30		somewhat labored			
		BREATH SOUNDS	rhonchi, diminished R side		breathing c exertion			
		SECRETIONS	productive cough, weak effort		rattly cough			
			FS q°					
SKIN		COLOR	normal for race		normal			
		INTEGRITY	CGW Rupperchest - CT insertion site					
IV SITE		LOCATION	(L) FT		(L) ES Dsg Δ			
		CONDITION	LR infusing @ 75cc/hr patent, Ø S/S infiltration		20 Jan @ 5pm d/c'd pt LR @ 75 cc/hr			
GASTRO		ABDOMEN	soft, non-tender		soft - non-tender			
		BOWEL SOUNDS	Ø x 4 quads c/o pain & cramping episodes of diarrhea		noisy active BS			
GU		URINE: COLOR/CLARITY	No urine yet this shift		will monitor.			
CARDIOVASCULAR		CARDIAC RHYTHM	NSR - see strip pulses palpable x4		normal sinus S1S2 cap refill brisk < 3 seconds			

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (b)(6)-2 LPN

DEPARTMENT/SERVICE/CLINIC: ICU 2 east

DATE: 26 Jan 03

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

(b)(6)-4

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

DATE		DX 05	06	07	08	09	10	11	12		13	14	15	16	HOSPITAL DAY 17	18	19	20	
VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line																		
	BP Cuff	114/61	113/55	108/58	109/55	98/51	117/65	110/61	113/66		104/56	99/54	95/60	111/64	112/60	121/62	116/60	114/60	
	Temperature																		
	Pulse	78	80	75	85	68	86	79	92		95	89	85	85	92	90s	———	100s	
	Respiratory Rate	40	29	26	22	22	38	30	39		26	29	25	29	30	22	24	22	
	Sat%	99	97	100	100	100	99	97	99		99	99	100	100	99	98	98	100	
	amt	2L	2L	2L	2L	2L	2L	2L	2L		2L	2L	2L	2L	2L	2L	2L	2L	
	method	NC	NC	NC	NC	NC	NC	NC	NC		NC	NC	NC	NC	NC	NC	NC	NC	
	pain intensity																		
INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	LR	75	75	75	75	75	75	75	75	300	95	75	75	75	75	75	75	75	300
	PO								200	200		—	200		50				250
	IV meds						60			50				50					50
	TOTALS									550									600
OUTPUT	URINE HOUR	0	0	0	0	100	0	350	0	550	0	400	0	0	0	0	0	0	950
	URINE TOTAL																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS																		
	STOOL					XT		XT				XT							
	DRAINS CT	0 0	20	20	10	0	15	26	120	25	10	10	0	0	5	5	0	55	
	DRAINS	15 15																	
	TOTALS																		

POST-OP DAY

	22	23	24	01	02	03	04
VITAL SIGNS	16	17	18	19	20	21	22	23	
	118/80	124/62	124/60	148/88	124/60	106/68	114/-	102/52	
		99.6							
	96	98	98	106	108	92	90	88	
	20	22	24	22	20	22	24	22	
	99	99	99	100	100	98	99	99	
	2L	2L	2L	2L	2L	2L	2L	2L	
	NC	NC	NC	NC	NC	NC	NC	NC	
INTAKE	16	17	18	19	20	21	22	23	8°T
	75	75	75	75	75	75	75	75	300
		100				100			200
				50				50	100
									600
OUTPUT	0	300	0	0	0				
	0	0	0	5	0	0	0	5	
									185

ACUITY LEVEL CLASSIFICATION

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

	TIME	0500							
LABORATORY	GLUCOSE	96							
	Na/K	138/3.6							
	Cl/CO_2	101/25							
	BUN/Cr	11/0.3							
	WBC/PLATELET	12.1/484							
	Hct/Hgb	28.3/9							

	TIME								
TODAY'S ACTIVITIES	MOUTH CARE								
	BATH								
	SKIN CARE								
	FOLEY CARE								
	TRACH CARE								
	ROM EXERCISES								

TURN	TIME								
SUCTION									

24*HR TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	1100	Urine:	1250
po	650		
			185 drain
TOTAL	1750	TOTAL	1435
		BALANCE	315

NURSE'S SIGNATURE	INITIALS
(b)(6)-2	(b)(6)-2

MEDCOM - 6256

NEUROLOGICAL ASSESSMENT

HOURS

LEGEND

C Closed by swelling

CEREBRAL

EXTENSION TO PAIN 2
NO MOTOR RESPONSE 1

LIMB MOVEMENT

ARMS
NORMAL POWER
MILD WEAKNESS
SEVERE WEAKNESS
ABNORMAL FLEXION
ABNORMAL EXTENSION
NO RESPONSE

LEGS
NORMAL POWER
MILD WEAKNESS
SEVERE WEAKNESS
ABNORMAL FLEXION
ABNORMAL EXTENSION
NO RESPONSE

R Right
L Left
Record separately if there is a difference between the two sides.

PUPILS

RIGHT — SIZE / REACTION
LEFT — SIZE / REACTION

◆◆ Brisk
◆ Slow
– No Response

PUPIL SCALE: 2 3 4 5 6 7 mm

ICP

CEREBRAL PERFUSION PRESSURE

◆ Intact
– Abnormal

VASCULAR ASSESSMENT

HOURS

R L

LEGEND

◆◆ Normal
◆ Weak
– Absent
D Doppler
R Right
L Left

MEDCOM - 6257

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0545	INITIALS (b)(6)-2	1730	INITIALS (b)(6)-2		INITIALS
NEURO		PUPILS	PERRL 4mm		⊕ 3mm			
		SENSORIUM	Alert eyes open on cmd. ⊕ tactil stimuli		A+O×3			
RESPIRATORY		RESPIRATORY PATTERN	even unlabored		RRR			
		BREATH SOUNDS	↓diminished RML/RLL		diminished to ⓡ side			
		SECRETIONS	clear RUL + L lung		ⓛ side clear			
			⊘ secretions		⊖ secretions			
			small non-productive cough		non-productive cough			
SKIN		COLOR	WNL		Normal for race			
		INTEGRITY	DSD over chest tube site		DRSG to ⓡ chest wall			
			DSD anterior CT site/DI		CT + ⓡ posterior lung CDI			
IV SITE CATH		LOCATION	⊘ (LL)		Δ LL			
		CONDITION	⊘ infection ⊘ infiltration		⊖ Sx of infiltration,			
			LR infusing @ 75cc/hr		⊖ infection			
					LR @ 75 cc/HR			
		ABDOMEN	Soft non distended		soft - non-distended			
		BOWEL SOUNDS	⊕ 4 quads		⊕ x4 hyperactive			
GU		URINE:	⊘ at this time		none @ this time			
		COLOR/CLARITY						
CARDIOVASCULAR		CARDIAC RHYTHM	S1 S2 NSR		NSR			
			peripheral pulse +4 all extremities		pulses ++ to extremities			
			1+ edema b/l feet		cap refill <3 sec.			

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; SIA - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Name & Title) (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 2 east

DATE: 27 JUN 03

PATIENT (If other than addressee, enter name and address in order indicated. If deliveries give: Name—last, first, middle initial, Rank, Grade, Service or Agency) (b)(6)-4

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

28 Jun ← | 27 Jun →

DATE | DX | HOSPITAL DAY

	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
VITAL SIGNS	BP Arterial Line																		
	BP Cuff	104/53	110/62	130/56	99/53	111/65		107/58	115/74		100/57	104/60	92/46	98/55	104/55	103/56	91/45	107/53	
	Temperature	99.7		99.4				98.7			98.8	98.3	98.0	98.1	98.2	100.2	101.1	100.3	
	Pulse	83	74	70	84	111		89	98		85	114	106	100	78	103	105	100	
	Respiratory Rate	27	22	16	19	31		22	21		22	33	34	30	27	31	32	29	
	SPO2	96	95	92	96	95		97%	98%		96%	94%	97%	98%	100	98	97	97	
	CJ	0	0	0	0	0		2L	2L		2L	2L	2L	2L	2L	2L	2L	2L	
	pain																		
	intervention																		
INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	~~PO~~ IV	75	75	75	75	75	75	75	75/150		75/225	75/450	75/375	75/450	75/0	75/600	75/675	75/450	
	PO								320			180				480			
	IVPB												50						
	TOTALS																		
OUTPUT	URINE HOUR / TOTAL							700								1000/1000			
	URINE sp gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUAC																		
	EMESIS																		
	STOOL																		
	DRAINS CT	20						35	30		5		25	15	0	0	50	20	
	TOTALS																		

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	/
	99/47	104/52	95/55	97/55	102/53	129/64	102/55	99/61	
	99[17]	99[17]				992			
	88	88	73	88	79	82	74	84	
	27	37	25	26	18	22	19	29	
	98	96	96	96	96	96	96	95	
	2L	2L	0	0	0	0	0L	0L	

INTAKE	16	17	18	19	20	21	22	23	8°T
	75/0[24]	0	75	75	75	75	75	75	
	50								
							50		

OUTPUT									
					80[1]				
	0	5	5	0	20	5	0	20	1480

ACUITY LEVEL CLASSIFICATION

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

LABORATORY DATA	TIME	0520								
	GLUCOSE	96								
	Na/K	138/3.6								
	Cl/CO_2	101/23								
	BUN/Cr	11/0.3								
	WBC/PLATELET									
	Hct/Hgb									

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

TURN	TIME										
SUCTION											

24°I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE | INITIALS

MEDCOM - 6260

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0515	INITIALS		INITIALS		INITIALS
NEURO		PUPILS	PEARL 2-3mm Brisk					
		SENSORIUM	Reactive					
			Alert to tactil stimuli					
			Moves all extremeties					
RESPIRATORY		RESPIRATORY PATTERN	even unlabored					
		BREATH SOUNDS	diminished @ lwr. clear					
		SECRETIONS	@ lung					
			Ø secretions Ø cough					
			at this time. Chest tube					
			to sx ± bloody drng					
SKIN		COLOR	WNL					
		INTEGRITY	DSD to Chest tube					
			insertion & infusion Ct site					
I.V. SITE		LOCATION	(C) IJ					
		CONDITION	Ø infection Ø infiltration					
			heplock Flushes &					
			difficulty					
GASTRO		ABDOMEN	soft nondistended					
		BOWEL SOUNDS	(+)4 Quads					
GU		URINE:	@ at this time					
		COLOR/CLARITY						
CARDIOVASCULAR		CARDIAC RHYTHM	S1 S2 NSR					
			peripheral pulses (+)4					
			all extremeties					
			(+)3 edema bilat Feet					

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2

DEPARTMENT/SERVICE/CLINIC ICU 2 west

DATE 28 Jan 03

PATIENT (For typed entries give: Name—last, first, middle initial; Social Security Number; facility) (b)(6)-4

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

DATE		05	06	07	08	09	10	11	12		13	14	15	16	HOSPITAL DAY 17	18	19	20	
VITALS	TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~	/	~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	/
	BP Arterial Line																		
	BP Cuff	106/68	108/54	104/60	102/64	93/54	90/52	99/64											
	Temperature		98.6	98.7	98.1	97.8	97.6	97.8											
	Pulse	76	82	99	124	115	109	92											
	Respiratory Rate	19	22	29	30	24	30	35											
	$S_c O_2$	95	96	94	92	96	96	97											
			(b)(6)-2																
	pain intervention	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
INTAKE	TIME	~~24~~	~~01~~	~~02~~	~~03~~	~~04~~	~~05~~	~~06~~	~~07~~	8°T	~~08~~	~~09~~	~~10~~	~~11~~	~~12~~	~~13~~	~~14~~	~~15~~	8°T
	LR	75	75																
	IUPB	50			400	↓													
	PO				400	60													
	TOTALS																		
OUTPUT	URINE HOUR / TOTAL																		
	URINE sp gr																		
	URINE S/A																		
	NG OUTPUT																		
	NG pH																		
	NG GUIAC																		
	EMESIS																		
	STOOL																		
	DRAINS CT	15	20	15	20	15	Ø	5											
	DRAINS																		
	DRAINS																		
	TOTALS																		

POST-OP DAY

	21	22	23	24	01	02	03	04	
VITAL SIGNS	16	17	18	19	20	21	22	23	
	21	22	23	24	01	02	03	04	
INTAKE	16	17	18	19	20	21	22	23	8°T
OUTPUT									

ACUITY LEVEL CLASSIFICATION

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

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

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

TURN	TIME									
SUCTION										

24 H&O TOTALS

wt Yesterday _____ wt Today _____

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

BALANCE _____

NURSE'S SIGNATURE	INITIALS

MEDCOM - 6263

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. NATIONALITY (State or Country Code)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(3)-1	I Z	9 10 11: 0 0 0 (b)(6)-4	(b)(6)-4	16 17:	18: M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 8 3 0 1 0 1	27 28 29: 2 0 Y	30: X	31: 9	UNKOWN

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34:	N/A	35 36: 9 9	37 38 39 40 41 42 43 44 45: (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	46: U	0623	N/A

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49: N O	50 51 52: K 7 8	53 54 55 56 57 58 59 60 61: 0 9 3 2 3

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63: 1 Z	64 65 66 67 68 69 70:	71: 9	YEAR: [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 0	ICW	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
73 74: 0 5	75 76 77 78 79 80:	81 82 83 84 85 86 87 88: 2 0 0 3 0 7 0 3

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
89 90 91 92: A B A A	93 94 95 96 97 98:	99 100 101 102 103 104 105 106: 2 0 0 3 0 6 2 0

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
107 108: 1 Z	109 110 111 112 113 114:	115 116 117 118 119 120 121 122:

FOR LOCAL USE

DX: GSW TOCHEST

Dx: 8603
8820
E9912

Pr: 3402
3404

Inj Trauma
450 1

ADMITTING OFFICER (Signature, as required)

(b)(6)-2 LTC, MC (b)(6)-2 (b)(6)-2 91G

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBS USAPA V1.00

MEDCOM - 6264

(b)(3)-1

...NT 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
(b)(6)-4	(b)(6)-4				NA	NONE
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M		NA	NA	NA	NA	NONE
11. FMP	12. SSN		13. ORGANIZATION			14. WARD
99	(b)(6)-4		NA			ICW
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE
NONE	NA	K78	NA	NA		NA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM ER	0530	AAAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
NA	XFER TO EPW HOLD	030713 1500

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
NA	NA	030705	(b)(6)-2 LT

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1	030705	NA

31. SELECTED ADMINISTRATIVE DATA

NA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX:MULTIPLE SHRAPNEL RIGHT LEG

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	8	8

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	8	8

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD MEDICAL RECORDS OFFICE
(b)(6)-2 LTC, MC	(b)(6)-2 (b)(6)-2 SSG, NCOIC, PAD

DA FORM 3647, MAY 79 — EDITION OF 1 AUG 78 IS OBSOLETE — USAPPC V1.10

MEDCOM - 6265

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

19 y/o IRAQI ♂, PW 2° ATTACKING US FORCES IN SAMARRA, C RLE FRAGMENT WOUNDS. INITIAL UNKNOWN (E) RX @ BAS & GROUND TRTD TO [b)(3)-1] TOI UN CIVILIAN ADMITTED MEMBERS AT USF WHILE UNDER OBS.

UNKNOWN (E) INITIAL ENC 2° NO TRAUMA LATER

PMH
PSH
MEDS
ALL
IMMUNIZ
ROS

PHYSICAL EXAMINATION

NAD TEENAGER
ALERT AT
NEUR NL FAMOM
CONST STA CONVRS (E) ABD SOFT NT CNABS
EXT - BUE LLE N RLE C MULT FRAG WOUNDS -
FEW PUST & MOD TRUCK, MANY ANT-MED LLE - DISTAL PULSES
INTACT & SYMMETRIC. APPARENTLY NVI. KNEE NT NO
EFFUSION FAMOM

XR NO FXS - NO INCIDENT FB - MULTIPLE SM METALLIC

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

FRAGS ON TORSAL SURFACE
A - FRAGMENT WOUNDS RLE
P - TD, ANTIBIOTICS, WOUND EXCISION IN O.R.

[b)(6)-2]

0635

LTC MC
SIGN [b)(6)-2]
OR

DATE	IDENTIFICATION NO.	ORGANIZATION
5 JUL 03		

PAT (*For written entries give Name last, first, middle; date; hospital or medical facility*)

REGISTER NO.	WARD NO.

[b)(6)-4]

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

[b)(6)-4]

MEDCOM - 6266

MEDICAL RECORD	PROGRESS NOTES
DATE	
5 Jul 03 1800	Nursing Admission ~~Personnel~~ Pt. received from ER. VS 125/64, 88, 24, 99.9. (D) resp. distress. Drowsy. Desires H2O. unable to understand that he is going to surgery. Pt. prepared for Surgery — (b)(6)-2 — DRAWN
5 JUL 03 1330	OP NOTE PREOP Dx RLE (THIGH & LEG) FRAGMENT WOUNDS POST OP Dx SAME PROCEDURE DEBRIDEMENT RLE SURG ENTRANCE ANES GETA NON CUM FINDS POOR CBL MM SPZ OF BRAIN OF CSF FINDINGS MULTIPLE FRAGMENT WOUNDS 0.3-3cm RLE. OF KNEE OR ANKLE PENETRATION TO ICU FOR NEURO MONITORING.
1800	Nursing assessment: Pt stable at this time. Sleeping, easily arousable oriented x3. PERRLA. Lungs CTA bilat. NSR. Abd soft, non-tender, bowel sounds active x4quads. Drsg to (R) leg CDI. Brisk cap refill and strong pulses x4 extremities. Alert and oriented. (R) knee and FROM t

(b)(6)-2

ORTHOPEDIC SERVICE

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
(Cont)	(R) toes. Eating 50% dinner. Using IS, able to raise one knee. 0 C/O pain. [redacted] KW/RN
6 Jun 03	POD 1 SLING ARM 0 VSSA FWB 3wks NVI distally DSG intact A AMBG with P DFC 8 Jun 03
6 Jun 03 1600	Nursing: Shift note Pt with BS, clear + equal bilaterally, shallow breathing, BS (R) 4 Quads, Voiding w/o difficulty. Pain x1 this shift. 0 significant changes this shift. Continue to monitor [redacted] CPM
06 Jun 03 1800	Nursing assessment: Pt stable at this time. AAOx3. PERRLA. Mucous membranes pink moist & intact. Neck supple, FROM. Lungs CTA bilat. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Ate 50% dinner, tolerate well. Voiding dark yellow urine to urinal, encouraging PO intake of fluids. Using IS. Encouragement & C/O pain at this time. Strong pulses and brisk cap refill x4 extremities. (R) leg. Dsg from heel to groin. 0 drainage noted to dsg. [redacted] CA/A
2245	IV [redacted] AC infiltrated. 20g to (R) FA started [redacted] CA/A

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

MEDCOM - 6268

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
07July03 0030	Pt c/o pain to (R) leg. Percocet 1/1 tabs for pain. Will monitor [redacted] LT/ON
070715 July 03	Nursing Assessment: Pt awake, alert, O2. Airway intact, breathing even and unlabored, LS clear to all fields (B). Abd soft, nontender, + distention. BS(+)4. Moves spontaneously. ROM and neurovascularly intact to (B) UE and (L) LE. (R) LE ROM limited 2° pain & drsg. 4x3 ACE gauze from ankle to mid thigh. (R) foot is edematous but neurovascularly intact. Pt does not want to straighten (R) leg completely 2° pain. Will get interpreter & explain that he needs to maintain ROM. IV w/ (D) AC flushes + s/s infection/inflammation. [redacted]
7 JUL 03 0745	S LOCAL PAIN & STIFFNESS O VSSA NVI DISTALLY DSG INTACT A STABLE P DPE TO MORROW
7 Jul 03 1717	Nursing Notes: Assumed care of Pt at 1700. Breathing intact & SOB or Labored Breathing. Lung CTA. Pt tolerated Regular diet ate about 80% of meal. IV SL flushes well & S/S of infection at site. Cont on Basic [redacted] LT/ON

LTC, MC
ORTHOPEDIC SERVICE

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

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)* | SEX

RELATIONSHIP TO SPONSOR | STATUS | RANK/GRADE

SPONSOR'S NAME | ORGANIZATION

DEPART./SERVICE | SSN/IDENTIFICATION NO. | DATE OF BIRTH

MEDCOM - 6269 OF MEDICAL CARE **STANDARD FORM 600** (REV. 6-84)

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
02 July 08 1717	Abd Soft & tender. Eyes PERRL. Cor Rrh/ x4 bilat. (R) Leg elevated. ∅ drainage or foul odor noted. Will Continue to monitor Pt Status [redacted] Evening Io
1745	Pt c/o Pain 4mg IV MSO4 given. Will continue to monitor Status [redacted] Evening IOIC
1930	Pt c/o pain 2 Percocet PO given. Will Continue to Monitor Status. 475cc clear yellow urine Emptied from Bedside urinal [redacted] Evening
2205	Pt Asleep [redacted] Evening.
0430	Pt c/o Pain Percocet 11 tabs PO given. Will Continue to monitor Pt Pain Status [redacted] Evening IC
08 1030 July 08	NURSING ASSESSMENT: Pt is awake, seen 0x3, alert. Airway intact, breathing even and unlabored. Lung sounds clear to all fields (B). Abd soft, nontender, & distention. BS@x4. Voids spontaneously. Neurovascularly intact to all extremities. (R) UE and LLE have FROM. (R) LE has gauze & ACE from ankle to mid thigh, (R) foot is swollen but pulses palpable (R) foot is cleaned but pt is somewhat non-compliant. Even @ talking through interpreter, pt does not keep leg straight, to maintain extension capabilities. Wound (R) FA is tender but not red, swollen, and fluctuant well. Will attempt to contact [redacted] evening
& 1203	OF NOTE
1915	PROCEDURE FRAG WOUNDS RLE
	POST OP Dx SAME
	PROCEDURE DEBRIDEMENT & IRR (R) LE FRAG WOUNDS.
	SURG ENGINEER ANES CELTA SCHRADER
	FINDS II CR TSI MUSC SOFT & BRAINS & CXO
	FINDINGS CLEAN WOUNDS & SIGN INFECTION. MUSC
	CRUSH BURNS, TO ICU FOR MONITORING STAT [redacted] LTC [redacted] ORTHOPEDIC MEDICINE

*U.S. Government Printing Office: 1995 — 387-722/20035

STANDARD FORM 600 BACK (REV. 5-84)

MEDCOM - 6270

MEDICAL RECORD	PROGRESS NOTES
DATE 9 JUL 03	POD 1 S NO C/O O VSS/A ADI DSG/INTACT A CLASSIC P LOCAL WOUND CARE. 3D PROPHY ABX
	[b)(6)-2] LTC, MC ORTHOPEDIC SERVICE
9 JUL 03 1630	Nursing: Ambulation Pt up OOB to chair, learning to put best leg down first & pivoting. C/O pain ↓ 20 min. Received morphine x2 this shift. Cont to monitor [b)(6)-2] CPM
9 JUL 03 2330	Nursing: Pt OOB, pivots, uses CRA BLUM, S1-S2 sounds + regular, (+) BS x4. Dsg to RLE C, D, I. Ambulates with crutch assistance. RLE elevated and straight. Will continue to monitor [b)(6)-2] SGT, USA
10 JUL 03 0100	Nursing Assessment: Pt sleeping, easily aroused. Flush HR 5 difficulty. Lungs CTA, (+) BS x4, abd soft, flat, HL 79 & reg. ~~2+ x 2 Pulse x4 extrem.~~, RLE C +2 Pulse & LLE +2 Pulse. RLE C brisk cap refill, warm, dry & mild edema. Dsg to RLE CDI — ILI [b)(6)-2] AM

(Continue on reverse side)

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

[b)(6)-4]

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)
USAPPC 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
8 Jul 03		2030	- ASSESSMENT - PT BACK FROM DEPARTMENT OF RLE. A&Ox3, PEARLA, LUNGS CTA BILAT, S1-S2 STRONG AND REGULAR, LAP RESPS c/3, PULSES PALPABLE IN ALL EXTREMITIES, WEAK IN RLE. PT CAN FEEL TOUCH TO RLE. DRSG TO RLE C,D,I. LR D75%@HR TO LUE. WILL CONTINUE TO MONITOR THROUGHOUT (b)(6)-2 SGT, LPN
9 Jul 03	1118		Nursing: Shift assessment Pt bright & alert Speech in Arabic/native tongue. Able to express pain thru gestures. Level unknown. O resp. distress, VSS, BS (+) voiding clear yellow urine 730cc per ° (R) LE remain in bent shape, encouraged to wiggle toes & straighten leg. No other changes noted. Continue to monitor (b)(6)-2 CPT
10 Jul 03	1709		Nursing: Assumed care of Pt A&O. Sitting up in bed. ∅ Complain of pain. Eyes PERRL, ~~Treatment at bedside~~. IV SL RUA well ∅ S/S of infection at site. ∅ bid soft and not tender. Pt Able to move all extremities. Pt tolerated regular diet. Encourage Pt to stretch injured (R) Leg ∅ drainage or odors from site. Will Continue to monitor Pt's status (b)(6)-2 LCpl

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) (b)(6)-4

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 - 6272

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
10 Jul 03		1916	Pt ambulated to BR Pt D&C to UDA Spontaneously clear yellow urine voided. Pt c/o pain after ambulation. Pt back in Restraints. (b)(6)-2 1 LSTAN
		2252	Pt c/o Pain in leg 2mg MSO4 IV given IV flushes DC. will continue to monitor Pain Status (b)(6)-2 1 LSTAN
		2311	Pt Asleep 1 LSTAN
12 Jul 03	1118		Urinary: Right Nephrostomy

*U.S. Government Printing Office: 1995 - 404-783/20065

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 6273

PROGRESS NOTES

DATE	
11 0955 Jul 03	NURSING ASSESSMENT: Assumed care of pt. Pt awake, alert, Ox3. Airway intact, breath even and unlabored, LS clear to all fields (B). Abd soft, nondistended, + distention. BS@x4. FROM and neurovascularly intact to (B) UE and LLE. RLE has limited ROM 2° pain and weak. RLE is neurovascularly intact. Pt is doing a better job of keeping (b)(6)-2 RLE straight, improving ROM. Pt is up & ambulates c steady assist (b)(6)-2 using an
11 Jul 03	2150- AOx3, PERRLA, EOMI, CTA BILAT, S1-S2 REGULAR AND (b)(6)-2 @ BS x4. RLE DSG C, D, Z, ELEVATED, MOTOR+SENSORY (b)(6)-2 INTACT. PT CAN FLEX, WIGGLE, PLANTAR FLEX PALPABLE. (b)(6)-2 AMBULATES WITH CRUTCH ASSISTANCE. — SSG, USN
12 Jul 03 1440	Nursing: Shift assessment: Pt alert, communicating in native tongue & non-verbal. VSS. No resp. distress. BM x1 this shift. (b)(6)-2 Leg drsg. changed this shift. Sutures intact & explained by interpreter. Ambulated x2 this shift. Increasing pressure to (b)(6)-2 foot. Continue to monitor (b)(6)-2 (CPNA)
12 July 03 1719	Nursing Notes: Assumed care of Pt lying on bed. Pt elevated Regular diet OK. (b)(6)-2 Pain at this time. Breathing intact SR w/ quad and SQ and non tender IV SL intact. Able to move extremities OK. Ambulated independently. Encouraged to keep (b)(6)-2 Leg extended. Will continue to monitor Pt status (b)(6)-2 LCT/sd
13 0600 Jul 03	NURSING ASSESSMENT: Pt awake, alert, Ox3. Airway intact, breathing even and unlabored, LS clear to all fields (B). Abd soft, nondistended, + distention. BS(+)x4. Voids spontaneously. From to (B) UE, LLE, and neurovascularly intact. RLE neurovascularly intact. Kept ROM to knee limited by pain. Encouraged ROM exercises. (b)(6)-2 IV access. (b)(6)-2 USN

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

MEDICAL RECORD [redacted] PROGRESS NOTES

DATE 13 JUN 03

[redacted]

ADMITTING & D/C DIAGNOSES
FRAGMENT WOUNDS RIGHT THIGH & LEG
ADMITTED 5 JUN 03
DISCHARGED 13 JUN 03
PROCEDURES - WOUND DEBRIDEMENT 5 JUN 03
DELAYED PRIMARY CLOSURE 8 JUN 03

CLINICAL RESUME -
1940 IRAQI MALE SUSTAINED FRAGMENT WOUNDS (R) THIGH & LEG WHEN ENGAGED BY US FORCES AS HE ATTEMPTED TO ENGAGE THEM. WOUNDS OF LEG WENT TO PERIOSTEUM BUT NO FXS NOTED. HOSPITAL COURSE WAS UNREMARKABLE. ABX WERE D/C'D ON HD 7.

DISPOSITION: D/C IN NAD CUSTODY
MEDICATIONS CONTAB 7.5 #20 1 PO Q 4° PRN
DIET REG
ACT WBAT
F/U SUTURES OUT AT BAS/ASMC IN 1 WK.

[redacted]

(Continue on reverse)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; [illegible] -- [redacted]

REGIST [redacted] WARD NO

LTC, MC
ORTHOPEDIC SERVICE
PROGRESS NOTES
Medical Record

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

MEDCOM - 6275

NSN 7540-01-075-3786

MEDICAL RECORD — EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER | TREATMENT FACILITY: (b)(6)-4 | RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS | CITY | STATE | ZIP CODE

SEX: M | AGE | DUTY/LOCAL PHONE: AREA CODE / NUMBER | HOME PHONE: AREA CODE / NUMBER

MILITARY STATUS

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

ARRIVAL

DATE (Day, Month, Year): 5 July 03 | TIME: 0450

TRANSPORTATION TO FACILITY: Ambulance

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS

ALLERGIES: ?

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: Shrapnel wound (R) Lower leg

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME | INITIALS

VITAL SIGNS

TIME	0502	556			
BP	127/71	132/68			
PULSE	105	92			
RESP	98/20	98/26			
TEMP	97.4 oral	979			
WT					

LAB ORDERS

X	CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
	URINE C&S	UA MSCC/CATH		X CHEM: Met 8
X	BLOOD C&S X			

X-RAY ORDERS

	CXR PA & LAT/PORTABLE	C-SPINE
	ACUTE ABDOMEN	LS SPINE
	SINUS	HEAD CT
	ANKLE R/L	
X	(R) LE	

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
526	ANCEF 1gm IV				
527	Tetanus				
634	MSO4 5mg				

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

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED
ADMIT TO UNIT/SERVICE
TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.
PATIENT'S SIGNATURE

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

(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

MEDICAL RECORD | **(Doctor)** | 0500

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

S: ≈15 yo male c Ⓡ lower leg shrapnel wounds. Had been seen earlier - has sutures to one wound. Ambulated into CMT. Alert and cooperative. TOI 0000.

O: Pt is alert & cooperative
VSS
HEENT - WNL
Neck - WNL
Chest - CTA, no distress
Abd - BS Ⓝ
Pelvic - stable
Back - ~~fragments~~. atraumatic
Ext: mult frag to Ⓡ LE below knee to bare foot. Ⓓ mult frags up p thigh to buttock
+PP N/V intact.
Rectal: Ⓓ Bld. NL Tone. Nl prostate Ⓓ.

XRay: mult frag to lower leg. Other's.

135 | 106 | 13
4.4 | 22. | 1.1
172
CK 619.
16 | 13
42
Tel, Clr 1.025 5.0
Tns 9/10.

Admitted to ICW - repeat exam - pt stable - transferred via litter [b)(6)-2] MAT MD

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP [b)(6)-2] [b)(6)-2] MAT, MC.

DIAGNOSIS
mult frag wounds to Ⓡ LE.

CODES

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

[b)(6)-4]

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

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA: Cart BY MAJ [redacted] CRNA

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY

3. DATE 20030705 TIME PATIENT ARRIVED IN SUITE 1215

4. PATIENT IN ROOM TIME 1215 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: A&OX3. Consent ✓'d.

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] AN,66E SGT [redacted] AN,66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) (B) arms abducted less than 90° on padded armboards. Amsco bed padded.

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

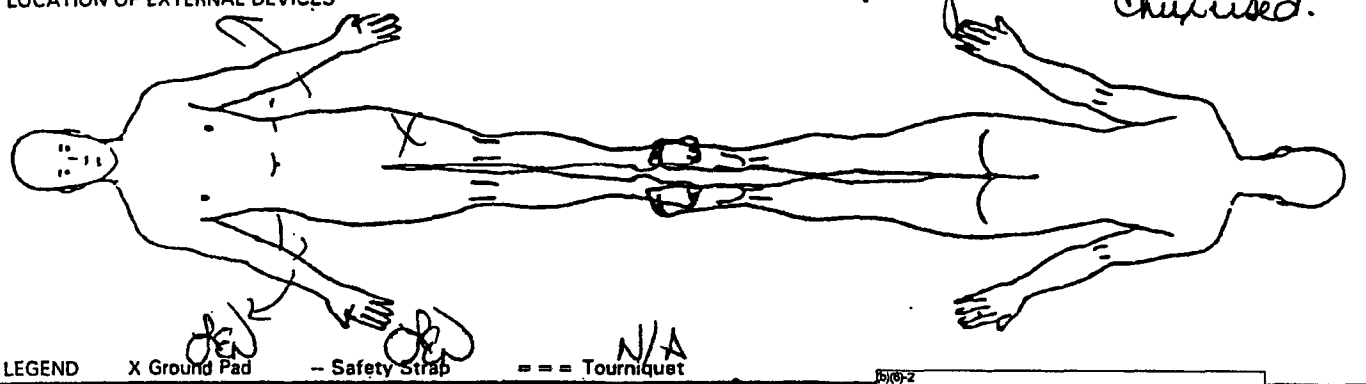
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadyne 7.5% + NSS / [redacted]
SITE: RLE to groin BY WHOM: [redacted]
SITE: ____ BY WHOM: [redacted], SGT
COMMENTS: No pooling noted. 1015 U-drape + Chux used.

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Init by: [redacted]

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

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

☒ ESU NO: 000442
GROUND PAD: BRAND VL Polyhesive
LOT NO: EXP 05092, HH402-4

☐ 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 V1.01

MEDCOM - 6278

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): NSS

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 ☒

	1.	2.	3.
TYPE/SIZE			
SITE			

Fluff
Kerlix
Ace Wrap

19. ADDITIONAL INFORMATION

15YO, EBW 45kg. NPO Prior to arrival to EmT in a.m.

Transferred to ICU via stretcher. Drowsy, Bone graft site clear, dry, intact. Dressing CDI to RLE.

20. OPERATION(S) PERFORMED

Debridement, RLE wounds.

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU	1325	litter

22. REGISTERED NURSE SIGNATURE (b)(6)-2

MEDCOM - 6279

INTRAOPERATIVE DOCUMENT

MEDICAL RECORD

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

1. PATIENT TRANSPORTED TO OPERATING ROOM BY anesthesia
VIA Litter
TIME PATIENT ARRIVED IN SUITE

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] 1470AV

3. DATE 8 July 03

4. PATIENT IN ROOM TIME 1745 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] 910	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: Bump (R) hip

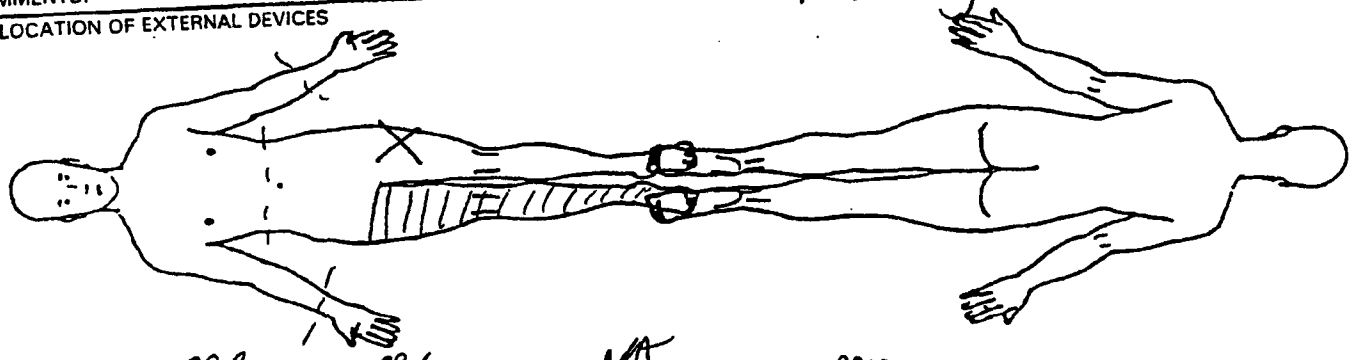
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION (Specify) Betadine/Brandt's Sol
SITE: (R) leg - foot to groin BY WHOM: [redacted]
SITE: BY WHOM:
COMMENTS: ∅ pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad CSC – Safety Strap MT = = = Tourniquet /// = prep

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count
Sponge	☒ Yes ☐ No	C	C	C
Needle Sharp	☒ Yes ☐ No	C	C	C
Instrument	☐ Yes ☒ No	/	/	/
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]

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

☒ ESU NO: X 1 cut/coag: 30/30
GROUND PAD: BRAND Valley Lab
LOT NO: H9402 4

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

USAPA V1.C

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

MEDCOM - 6280

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): NSS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted]

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)*
Kerlex
Webril
Ace

19. ADDITIONAL INFORMATION
Dr [redacted]

cpt [redacted] CRNA

20. OPERATION(S) PERFORMED
I+D of RLE wounds

21. PATIENT TRANSFERRED TO TCU TIME 1920 METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted]

MEDCOM - 6281

REVERSE OF DA FORM 5179-1 OCT [redacted] USAPA V1.01

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY	1/2	1	3	4	5	6	7
POST- DAY							
MONTH-YEAR / DAY	6	6	7	8	9	10	11
2003 / HOUR	2200 0600	1400 1400	0600 1400	2200 0600	1400 2200	0600 1400	2200 0600

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

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

(Centigrade Equivalents, for Reference only)

[(b)(6)-2]

See Continuation Sheet

RESPIRATION RECORD

	18	20	18	18	20	18	18	18	18	18	18	18	18

BLOOD PRESSURE

	150/90	118/64	124/68	118/64	124/62	128/76		105/56	107/64	124/68	93/60	112/58	108/64	96/47
														105/55

HEIGHT: / WEIGHT →

99%		99%	100	98%	98%	97%	98%	98	98	98%	98%	99	98%

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.

[(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 - 6282

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		8		9															
POST- DAY																			
MONTH-YEAR	DAY	12		13															
2019	HOUR	0004	1200	0000	1400														
PULSE (O)	TEMP. F (°)																		TEMP. C
	105°																		40.6°
180	104°																		40.0°
170	103°																		39.4°
160	102°																		38.9°
150	101°																		38.3°
140	100°																		37.8°
130	99°																		37.2°
	98.6°																		37.0°
120	98°																		36.7°
110	97°																		36.1°
100	96°																		35.6°
90	95°																		35.0°
80																			
70																			
60																			
50																			
40																			
RESPIRATION RECORD		18	19	16	14														
BLOOD PRESSURE			100/76	100/76	116/66														
				121/61															
	97.7	96	97																
HEIGHT:	WEIGHT →		149	100/76	99														

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.

(Centigrade Equivalents, for Reference only)

STANDARD FORM 511 (REV. 7-95) BACK

Ward/Section: CMT | REQUESTING PHYSICIAN: (b)(6)-2 | **LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)-4 | DATE: 5 JUL | TIME: 0520 | SSN/PSEUDO SSN:

Hematology

TEST	RESULT	REF. RANGE
WBC	15.8	4.8-10.8 x 10^3
RBC	5.37	4.7-6.1 x 10^9
Hgb	12.9	14-18 g/dl (M) 12-16 g/dl (F)
Hct	42.3	42-52% (M) 37-47% (F)
MCV	78.8	80-94 fl (M) 81-99 fl (F)
Plt	422	130-500 x 10^3 verified
Lymph %	18.7	20.5-51.1%

Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Clear	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	NEG	Negative
SG	1.025	N/A
Bld	NEG	Negative
pH	5.0	N/A
Prot	NEG	Negative
Urob	0.2	0.2-1.0
Nit	NEG	Negative
Leuk	NEG	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Micro-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		

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh:

Coagulation

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

UNIT	TYPE	CROSSMATCH

REMARKS: Type & Screen

REPORTED BY: (b)(6)-2 | DATE: 05 JUL 03 | LAB ID NO.:

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

TEST	RESULT Mat 8	REF. RANGE
GLU	172 #	73-118 mg/dl
BUN	13	7-22 mg/dl
CRE	1.1	0.6-1.2 mg/dl
CK	619 #	39-380 u/l (M) 30-190 u/l (F)
NA^+	135	128-145 mmol/l
K^-	4.4	3.3-4.7 mmol/l
CL^-	106	98-108 mmol/l
tCO_2	22	18-33 mmol/l

TEST	RESULT Mat 8	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^-		128-145 mmol/l
K^-		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

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

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

REMARKS:

REPORTED BY: b)(6)-2

DATE: 05 JUL 03

LAB ID NO.:

(Subject to the Privacy Act of 1974)

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN:
(b)(6)-4	5 Jul 03	0710	

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	14.4 L	4.8-10.8 x 10^3
RBC	5.25	4.7-6.1 x 10^9
Hgb	12.6	14-18 g/dl (M) 12-16 g/dl (F)
Hct	41.8	42-52% (M) 37-47% (F)
MCV	79.7	80-94 fl (M) 81-99 fl (F)
Plt	201	130-500 x 10^3 verified
Lymph %	11.5 L	20.5-51.1%

(Hematology) Manual Differential

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
(b)(6)-2	05 Jul 03	

LAST FIRST MI	DATE	TIME	SSN/PSEUDO SSN:
(b)(6)-4	06JUL	0430	(b)(6)-4

Hematology (CBC)

TEST	RESULT	REF. RANGE
WBC	10.4	4.8-10.8 x 10^3
RBC	4.57	4.7-6.1 x 10^6
Hgb	11.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	36.2	42-52% (M) 37-47% (F)
MCV	79.2	80-94 fl (M) 81-99 fl (F)
Plt	326	130-500 x 10^3 verified
Lymph %	20.4	20.5-51.1%

Hematology (Manual Differential)

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

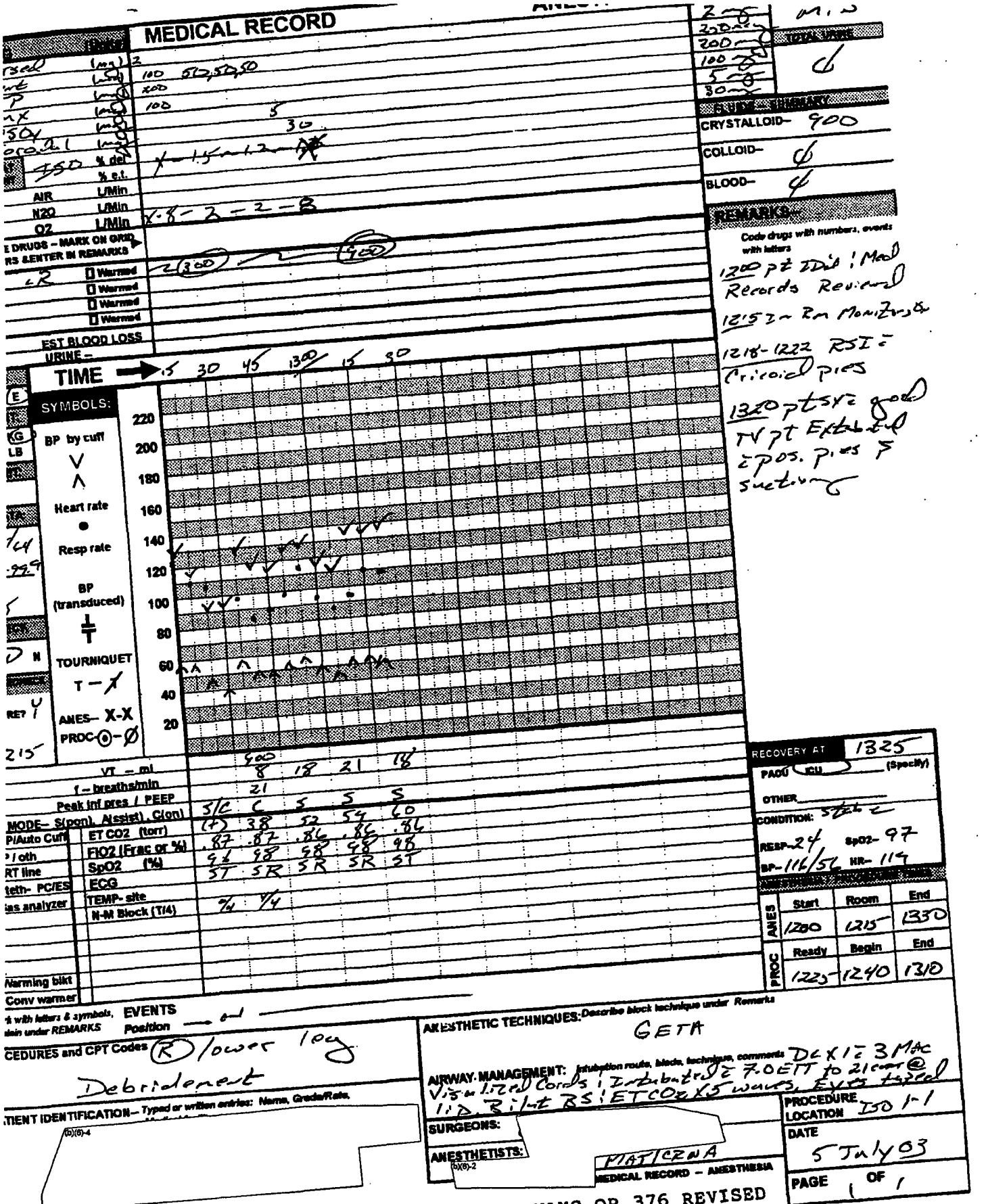
Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2	DATE: 06 Jul 03	LAB ID NO.:

MEDICAL RECORD



TIME 15 30 45 1300 15 30

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

VT – ml: 500 8 18 21 18

f – breaths/min: 21

Peak inf pres / PEEP: 5/C C S S S

MODE– S(pon), A(assist), C(on): (+) 38 52 54 60

ET CO2 (torr): .87 .87 .86 .86 .86

FIO2 (Frac or %): 96 98 98 98 98

SpO2 (%): ST SR SR SR ST

ECG

TEMP- site

N-M Block (T/4): T/4 T/4

2 – 0 mL
200 – 0
200 – 0
100 – 0
5 – 0
30 – X

TOTAL URINE: 0

FLUID SUMMARY
CRYSTALLOID– 900
COLLOID– 0
BLOOD– 0

REMARKS–
Code drugs with numbers, events with letters

1200 pt to OR / Med Records Reviewed
1215 – Rm Monitors &
1218-1222 RSI c Cricoid pres
1320 pt sx good TV pt Extubated c pos. pres & suctioning

RECOVERY AT 1325
PACU ICU (Specify)
OTHER
CONDITION: stable
RESP- 24 SpO2- 97
BP- 116/56 HR- 114

	Start	Room	End
ANES	1200	1215	1330
PROC	Ready	Begin	End
	1223	1240	1310

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

PROCEDURES and CPT Codes: (R) lower leg Debridement

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Dex c 3 Mac c 7.0 ETT to 21 cm @ Visualized Cords c Intubator c ETCO2 x 5 waves, Eyes taped B/L. B/L Brt BS

SURGEONS:

ANESTHETISTS: (b)(6)-2 MAJ CRNA

PROCEDURE LOCATION: ISO 1-1

DATE: 5 July 03

PAGE 1 OF 1

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

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED
1 Jan 99

PATIENT RECORD

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

MEDICAL RECORD

DRUG	Dose
Versed	(mg)
fentanyl	(mcg)
CTP	(mg)
Succ / NMS24	(mg)
	( )

AGENT	
~~Iso~~ Sevo	% del
	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min

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

LINE site LRCC / Rt LA ☐ Warmed

ANCEF 1g WPB ☐ Warmed ☐ Warmed ☐ Warmed

EST BLOOD LOSS

URINE – Nonoliguric

WATER

ASA STATUS: 1 2 3 4 5 E

BODY WEIGHT: N45 KG LB

HEMATOCRIT: 36.2

INITIAL DATA: BP – 110 / 50 HR – 85

SAFETY CHECK: OK? – (Y) N

PATIENT ID VERIFIED: OK for PROCEDURE YES TIME – 1730

TIME → 1745 1800 @ 30 @ 1900 @ 30 @ 2000 @ 30

SYMBOLS: BP by cuff (Reg / Adult) · Heart rate · Resp rate · BP (transduced) · TOURNIQUET T – X · ANES – X-X · PROC – Ø

220 200 180 160 140 120 100 80 60 40 20

I:E = 1:2 | VT – ml | 700 700 >120 >150 >700 500

f – breaths/min | 16 10 10 25 14 22 20 22

Peak inf pres / PEEP | 18 14 – – –

MODE – S(pon), A(assist), C(on) | S C C S S/A S/A SPO S

BP/Auto Cuff | ET CO2 (torr) | @ 90 34 48 52 54 58 –

BP / oth | FIO2 (Frac or %) | .84 .83 .84 .84 .84 .83 PA

ART line | SpO2 (%) | 100 100 100 99 99 99 98

Steth – PC/ES | ECG | SR SR SR SR SR SR SR

Gas analyzer | TEMP – site Axil | 94 94 94=37

N-M Block (T/4) |

Warming blkt | ✓

Conv warmer

Mark with letters & symbols, explain under REMARKS — EVENTS — Position → O ← → → → → → Arms < 90°, padded / secured.

1mg	MM
250 mcg	TOTAL UNITS
250mg	
100 mg	N/A
10 mg	
X	

FLUIDS – SUMMARY

CRYSTALLOID – LR 1500 cc

COLLOID –

BLOOD – X

REMARKS –

Code drugs with numbers, events with letters

1700 – Pre op completed. Plan GETA. @ ID. 1.8g IV patent LA.

1745 – In OR 1-1. Monitors on. FiO_2 1.0. IV induction. Eyes taped, silent. See Airway note below.

1915 Resp wnl / Reg. Opens eyes. Airway reflexes intact. TV ~500. Oral scn. Extubated c pos pressure breath. Spont resp unm.

1920 TO ICU for recovery. via litter VSS. Report to ICU staff DS

RECOVERY AT 1920

PACU (ICU) (Specify)

OTHER – T=97.6

CONDITION: Stable

RESP – 22 SpO2 – 98% BP – 153/74 HR – 110

	Start	Room	End
ANES	1700	1745	1925
PROC	Ready	Begin	End
	1753	1810	1915

PROCEDURES and CPT Codes: Debridement + DPC RLE wounds

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA (O2 / sevo)

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: DL x 1 ETT #ac 3. Grade I view VC. 7.0 ETT placed et secured @ 22 cm @ teeth. Breath left ETCO2 sustained @ BBS = SGV. bite block placed

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

(b)(6)-4

SURGEONS: (b)(6)-2

ANESTHETISTS: (b)(6)-2 CRNA

PROCEDURE LOCATION: OR 1-1

DATE: 8 JUL 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

*U.S. GPO: 2002-729-180/4013

PATIENT RECORD

ANESTHESIA PLAN OF CARE PREOPERATIVE

Age 12 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: Wash-out (R) lower leg

SURGICAL SERVICE: ORTHO

NPO SINCE: ?

ASA Physical State (1) 2 3 4 5 E

WT: 45 KG/LB HT: ____ IN.

ALLERGIES: NKDA

HABITS:
TOBACCO: ____
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Ancef
( ) Tylenol
( ) MSO4
( )
( )
( )

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

LABORATORY STUDIES:

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

135 | 104 | 13 / 172
4.4 | 22 | 1.1

15.8 > 12.9 / 42.5 < 422

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 GSW to (R) lower leg
	N	Y
Familial HX	N	Y

Unknown

ASSESSMENT

PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION

BP 125/64 HR 88 R ____ T 99.4
Pain Scale 0-10 ____
HEENT - Teeth Intact
Trachea Midline
TMJ/Neck FROM
Oropharynx MPI
Nares ____
CHEST: CTA
CARDIAC: S1S2
EXTREMITIES: MAEW
IV Access: #18 (L) Arm
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since ____

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.

Signed: ____ Date: ____ Time: ____ Hrs

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

Signed: (b)(6)-2 Date: 4 July 08 Time: 0830 Hrs

Patient Identification: (Ward) ____

(b)(6)-4

SEDATION KEY:

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

Previous edition is obsolete
☆ U.S. GPO: 2002-729-283

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

PATIENT RECORD COPY

MEDCOM - 6290

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

PROPOSED PROCEDURE: [redacted]
SURGICAL SERVICE: Ortho - [redacted]
NPO SINCE: 2400 7/7 Debridement & DPC RLE wounds

HABITS:
TOBACCO: 47
ETOH: ____
DRUGS: ____

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef 1g 8hr LD 1400
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____
( ) ____

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

LABORATORY STUDIES:
6/30
HB/HCT: 11.8 / 36.2 pre 32%
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

Unknown
Ø interpretor available.
(R)LE Shrapnel wounds

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Debride RLE SSG + GETA Comp

PHYSICAL EXAMINATION
BP 130/78 HR 72 R 14 T 99.1 B% RA
Pain Scale 0-10 ____
HEENT - Teeth Intact
Trachea midline
TMJ/Neck FROM
Oropharnyx MPI
Nares Patent
CHEST: CTA (B)
CARDIAC: S1S2
EXTREMITIES:
IV Access: (R)A 18g.
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since 2400 7/7/03

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 pati[redacted] o understand and agrees. Questions answered.
Signed: [redacted] CRNA/CRNA Date: 7/8/03 Time: 1700- Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

[redacted]

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

WAMC Form 2300 (Revised) 15 Mar 01 MCXC-DOS
Previous edition is obsolete
☆ U.S. GPO: 2002-729-283

PATIENT RECORD COPY

MEDCOM - 6291

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

EXAMINATION(S) REQUESTED	AGE / SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
R Leg (R) femur. Pelvic	M / M/S	(b)(6)-4	EMT	
	FILM NO.			PREGNANT ☐ YES ☐ NO
	REQUESTED BY (Print) Dr (b)(6)-2			TELEPHONE/PAGE NO.
	SIGNATURE OF REQUESTOR (b)(6)-2		MAT/SW	DATE REQUESTED 7 July 03

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

GSW/shrapnel to (R) Leg

DATE OF EXAMINATION *(Month, day, year)*	DATE OF REPORT *(Month, day, year)*	DATE OF TRANSCRIPTION *(Month, day, year)*
7 July 03		

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
(b)(6)-4	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

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

MEDCOM - 6292

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

T IDENTIFICATION

(b)(6)-4

DATE OF ORDER 5 Jul 03 TIME OF ORDER 0615 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICW pre op.
2. Dx mult fracture ends (R) leg.
3. Cond Stable.
4. VS q Shift.
5. CBC on arrival. done PM
6. NKDA.
7. NPO pre op.

(b)(6)-2 Noted & transcribed

ING UNIT | ROOM NO. | BED NO.

IENT IDENTIFICATION

DATE OF ORDER 5 JUL 03 TIME OF ORDER 1315 HOURS

- ✓ ADMIT TO EMERGENCE, ICW
- ✓ DX RLE FRACTURE WOUNDS
- ✓ COND STABLE
- ✓ VS ROUTINE
- ✓ ACT-EPW STATUS - OOBT TID C APPROPRIATE GUARDING
- ✓ NKDA
- ✓ NPO DIET
- ✓ LAB - CBC IN AM
- ✓ LR @ 75cc/HR, KVO LOCK WHEN NO OIC
- ✓ MEDS ANCEF 1GM IV Q8°
- ✓ MS 2MG IV Q15 PRN UP TO 16 MG IN 4°
- ✓ PERCOCET 1-2 PO Q4° PRN
- ✓ COLACE 100MG PO Q4° PRN
- ✓ I&S Q1° W/A

(b)(6)-2 Noted & transcribed 5 Jul 03 @ 1630 South

URSING UNIT | ROOM NO. | BED NO.

ATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

(b)(6)-2 MC ORTHOPEDIC SERVICE

1

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 6293

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

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
1 JUL 03 0800	____ HOURS	(b)(6)-2
NPO PRN		
		(b)(6)-2
		(b)(6)-2
24° chart ✓ 8 JUL 03 @ 0334		(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
8 JUL 03 1930	____ HOURS	
ADMIT CLD EMANUELE		
✓ DX RLE FRACTURE WARMS		
✓ COND STABLE		
✓ VS NEURO IVF		
✓ ACT RM STATUS - UP 2 TID -		
WBAT C P.T.		NOTED
NWA		(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
✓ NEG DIET	____ HOURS	
✓ NS @ 75cc/HR PRIOR WHEN PO D/C		
✓ ANCEF 1 GM IV Q8° x 9 DOSES		
✓ TYLOX / PERCOCET 1-2 PO Q 4-6° PRN PAIN		
✓ MS ENEMA Q 15' PRN IF Q 12 HG / 4HR		
✓ ES Q1° W/A		
✓ MS ENEMA NOW ← done 0435		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	____ HOURS	
4 JUL 03 @ 0400		(b)(6)-2
3 JUL 03		(b)(6)-2
D/C IV MIVF @ 1000		
NEED CONSULT #201		
FLY BAG FOR SUTURE REMOVAL IN 1 WK		(b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

UTC MC ORTHOPEDIC SERVICE

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

MEDCOM - 6294

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)

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

Mo. ___ Yr. ___

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

VERIFY BY INITIALING		RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED										
ORDER DATE	CLERK/ NURSE			5	6	7	8	9	10	11	12	13	14	
5July	[redacted]	CR @ 75cc/Hr	06	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
		Heplock Flush PRN	14	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
		Discontinued	22	[redacted]										
5July03	[redacted]	Ancef 1Gm IV QB	06	✓	[redacted]									
			14	✓	[redacted]									
			22		[redacted]									
6 July 03	[redacted]	Heplock Flush Q8hrly	6	✓	[redacted]									
			14		[redacted]									
			22		[redacted]									
8 July 03	[redacted]	Cefotetan 2g IVPB	06	✓	✓	✓	✓	[redacted]						
		Discontinued	14	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
			22	✓	✓	✓	✓	[redacted]						
9July03	[redacted]	Heplock flush Q8	6	✓	✓	✓	✓	[redacted]						
			14	✓	✓	✓	✓	[redacted]						
			22	✓	✓	✓	✓	[redacted]						

Replaced see below

DCD

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

RLE Fragment Wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ___

PATIENT IDENTIFICATION:

[redacted]

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.0

MEDCOM - 6295

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. July Yr. 03
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
---- -----	Labs: CBC in A.M	6 July	0600	0400	[redacted]
7 [redacted]	NPO p MN	8 July	0001	done	[redacted]
13	DC to MP custody: Meds Lortab #20. F/U	13 July	TOD		
	BAS for suture removal in 7 wk.				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
5 July	[redacted]	MSO4 2mg	8 July 1244 / 7 July 1400 / 7 July 2130 / 8 July 2m / 7 July 2m / 8 July 1155 / 8 July 1m / 0451 1200 / 0930 1330 / 1045 2m
----	----	IV Q15min PRN	[redacted]
----	----	up to 16mg in 4°	
5 July	[redacted]	Percocet 1-2 tabs	7 July 0830 / 7 July 0920 / 7 July 1935 / 8 July 0420
----	----	PO Q4 PRN	[redacted]
5 July	[redacted]	Tylenol PO	[redacted]
----	----	650mg PRN Q4	[redacted]
8 July	[redacted]	Tylex 1-2 tabs PO	
----	----	Q4° PRN	

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. July Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5 6 7 8 9 10 11 12 13
5 July 03	(b)(6)-2	Routine VS	06	/ (b)(6)-2
			14	/ (b)(6)-2
			22	(b)(6)-2
5 July 03	(b)(6)-2	Activity: EPW	06	/ (b)(6)-2
		status: OOB TID	14	/ (b)(6)-2
		w/ guard.	22	(b)(6)-2
5 July 03	(b)(6)-2	Reg Diet	06	/ (b)(6)-2
			12	/
			18	(b)(6)-2
5 July 03	(b)(6)-2	IS: Q1° while Awake	06	/ (b)(6)-2
			14	/
			22	(b)(6)-2

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: RLE Fragment Wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION: (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

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

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	
5Jul	(b)(6)-2	Admit to ICW c/o Dr. Granville				(b)(6)-2	
5Jul		Dx: RLE Fragment Wounds					
5Jul		Condition: Stable					

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

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

DTSG APPROVED (Date)

Date: 8 JUL 03 — Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block

Time In: 1920

Allergies: NKDA — OR Intake: Crystalloid 2. 1000 — Colloid ____ — Analgesia @1748 1mg

Pre-op V/S: 160/80 — OR Output: UOP 0 — EBL minimal

Procedures: Debridement skin graft @ leg — Meds/Times: 1mg versed 5mg Succ 100mg 250mg Fent insert laryngeal

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds ____ History ____

Time	1925	1930	1935	1940	1945	1950	2015
SaO2	RA 98%	100% NC	4L 98%	RA 97%	RA 98%	RA 98%	RA 97%
FIO2	RA	RA	4L	RA	RA	RA	RA
Methods							
240							
220							
200							
180							
160							
140							
120							
100							
80							
60							
40							
20							
RR	26	28	20	18	16	20	18
T	97.8						

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1925	LR	1000 cc	OFA	S. Hunt	100 ml

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	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	10	10

Codes

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

V/S: X = A-line BP; ° = Cuff BP; = Pulse

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

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

Time	Patient teaching done: Wound Care, Pain Management,
Pain (0-10)	T, C, & DB,. Incentive Spirometer, Comfort Measures
LOS	Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

(b)(6)-2 SSG WAMC

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 8 JUL 03

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

(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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1925	8	6mg MSO4	IV	5/10	E	[b)(6)-2]

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) leg	↓	+	P	brisk	W	PK
15'	(R) leg	↓	+	P	brisk	W	PK
30'	(R) leg	↓	+	P	brisk	W	PK
45'							
60'							
90'							
D/C	R/leg	+	+	P	brisk	W	PK

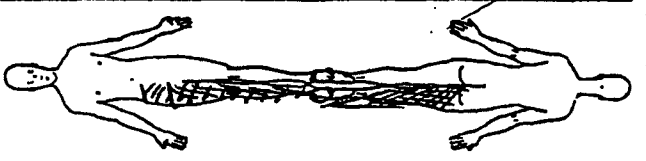
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	Gauze (R) leg	Kerlix, CDI T	
30'	(R) leg	Gauze/kerlix	CDI I
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1925	NSR	NO	

WAMC OP 173-E

NURSING NOTES

1925 Client from OR c CRNA & RN via litter and gurney - Pale ox 98% RA IVF infusing into (L) hand patent c/s/s of infiltration 12 Lead LRT 6mg MSO4 for pain - P MSO4 NT resting, calm and cooperative. Lungs clear bilat, abdomen flat, hypoactive BS x 4 quads guarding when foot is touched, right pedal pulse weak but palpable. cap refill brisk. [b)(6)-2]

2000 Client resting quietly. Pulse ox 98% on RA, prog to right foot DT. [b)(6)-2] [b)(6)-2] /CT

2020 Report given to SUT [b)(6)-2] in ICU [b)(6)-2] /CT

2025 Transferred to ICU on litter c two assists [b)(6)-2] /CT

Discharge Criteria:
Date: 8 Jul 03 **Time:** 2025 **PARS:** 10
BP: ~~Sea:~~ 1 ~~oHH:~~ in ~~RR~~ Sa02: 96%
Pain Level at D/C (0-10):
Intake: 100 ml **Output:** 0
Additional Data:
Transferred To: ICU
Report Given To: SUT [b)(6)-2]
Transferred Via: WIC Litter Gurney Ambulance
Transferred By [b)(6)-2] CT
Cleared IAW Recovery Room SOP P.3
Charge Nurse Signature [b)(6)-2] CTK

MEDCOM - 6300

Code.)

3. REGISTER NUMBER: (b)(6)-4

NAME (Last, First, Middle Initial): (b)(6)-4

4. PAY GRADE: 16 17

5. SEX: 18 — M

6. DATE OF BIRTH (YYYYMMDD): 19 20 21 22 23 24 25 26 — 1 9 8 4 0 1 0 1

7. AGE AT ADMISSION: 27 28 29 — 1 9 Y

8. RACE: 30 — X

9. ETHNIC BACKGROUND: 31 — 9

RELIGION: UNKNOWN

10. LENGTH OF SERVICE: 32 33 34

ETS: NA

11. FMP: 35 36 — 9 9

12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45 — (b)(6)-4

ORGANIZATION (Active Duty Only): NA

13. MARITAL STATUS: 46 — U

HOUR OF ADMISSION: 0615 ~~0530~~

BRANCH / CORPS: NA

14. FLYING STATUS: 47 48 49 — N A

15. BENEFICIARY CATEGORY: 50 51 52 — K 7 8

16. ZIP CODE OF RESIDENCE: 53 54 55 56 57 58 59 60 61 — 0 9 3 2 3 0 0 0 5

17. UNIT LOCATION (State or Country Code): 62 63 — N A

18. MOS: 64 65 66 67 68 69 70 — N A

19. TRAUMA: 71

PREV. ADMISSION: YEAR — [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72 — 0

WARD: ICW

NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74 — 2 4

22. MTF TRANSFERRED TO: 75 76 77 78 79 80

23. DATE OF DISPOSITION (YYYYMMDD): 81 82 83 84 85 86 87 88 — 2 0 0 3 0 7 1 3

24. CLINIC SVC - ADMITTING: 89 90 91 92 — A A A A

25. MTF TRANSFERRED FROM: 93 94 95 96 97 98

26. DATE THIS ADMISSION (YYYYMMDD): 99 100 101 102 103 104 105 106 — 2 0 0 3 0 7 0 5

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 107 108 — 1 2

28. MTF OF INITIAL ADMISSION: 109 110 111 112 113 114

29. DATE INITIAL ADMISSION (YYYYMMDD): 115 116 117 118 119 120 121 122

FOR LOCAL USE

DX:MULTIPLE SHRAPNEL RIGHT LEG

DX 8901
E9912
Proc 8628
Trauma 1
Inj 450 GM

ADMITTING OFFICER (Signature, as required): (b)(6)-2

(b)(6)-2 LTC, MC

SIGNATURE OF ADMITTING CLERK: (b)(6)-2

~~PFC~~, 91G

DA FORM 2985, MAR 2000 — EDITION OF MAR 89 IS OBSOLETE — USAPA V1.00

(b)(3)-1

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, MI)			3. GRADE	ADMISSION REMARKS
(b)(6)-4	(b)(6)-4			NO	
4. SEX / 5. AGE / 6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
M				NO	
11. FMP	12. SSN	13. ORGANIZATION		14. WARD	
99	(b)(6)-4			ICW	
15. FLYING STATUS / 16. RATING/ OSG / 17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE	
NO / K78				BI	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM ER	0535	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
	TRANSFER	13 JUL 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
		05 JUL 03	DR. (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

MULTIPLE SHRAPNEL WOUNDS AND GSW

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX:RIGHT QUADDRICEP GSW

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	8	8

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	8	8

SIGNATURE OF ATTENDING MEDICAL OFFICER

(b)(6)-2 LTC, MC

(b)(6)-2

(b)(6)-2 SSG, NCOIC PAD

DA FORM 3647, MAY 79 EDITION USAPPC V1.10

MEDCOM - 6302

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

35 y/o (NAD) OF ENGAGED @ UN BY US FORCES C EXPLOSIVE DEVICE (? MK 19) WHEN POINTED WEAPONS WHILE UNDER OBSERVATION. INITIAL STABILIZATION @ ~~BAS~~. GROUND EVAC FROM SAMARRA. NUD. Td & ABX IN ED

UNKNOWN @ INITIAL EVAL
2° NO TRANSLATOR

PMH NON
PSH
ALL NKDA
MVI'S @
NONE ZANTAC
ROS -

PHYSICAL EXAMINATION

NAD @ APPEARING MID 30'S
MULT AT
CHEST CWA NCAT NL FROM BOTH NL @ WOUNDS
CON NAD S @
ABD SOFT NT C NABS S HSM OR MASS
EXT - RUE ~~AT~~ UE @ RUE C 2cm POST-LAT
THIGH WOUND. CALVE ANT THIGH WOUND (~15cm)
C EXTRUDED QUADRICEPS. DP EPT SYMMETRIC (B)
UNABLE TO COOP C NEURO EXAM

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

XR @ FX FEMUR C SURROUNDING METALLIC DEBRIS IN ANT SOFT TISSUES

A - FRAGMENT WOUND (R) THIGH
P - DEBRIDE IN O.R.

(b)(6)-2
LTC, MC
ORTHOPEDIC SERVICE

(b)(6)-2		DATE 5 JUL 03	IDENTIFICATION NO.	ORGANIZATION
(b)(6)-4	(For written entries give Name last, first, middle; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

(b)(6)-4

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

(b)(6)-4

MEDCOM - 6303

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5 JUL 03	PREOP DX - HIGH ENERGY GSW/FRAG WOUNDS (R) QUADRICEP
1130	POSTOP DX SAME
	PROCEDURE DEBRIDEMENT (R) THIGH WOUNDS
	SURGEON CRANMORE
	ANES GETZ KERBLER
	FLUIDS 1 L LR EBL 100 cc SPEC RETAINED NONE
	FINDINGS ENTRY 2 CM UNO LAT THIGH TOUR
	VL - LARGE EXIT THRU VM - NEAR 100%
	TRANSECTION OF QUADRICEPS MOST CROSS
	BEARNS - Ø FX
	TO ICU FOR RECOVERY, STABLE
	PLAN - RESECTION DE & CLOSE IN 72° - IV ABX
	CEFAZOLIN/GENT.
	[redacted]
5 Jul 03	Nursing: Post-OP patient received from ICU. (+) BS, mag CTA,
1545	Verbalized no pain, drowsy, IV infusing w/o problem, foley d/c,
	drsg (R) leg from thigh to ankle, Ø drainage, intact. Contin Orders. [redacted] CTA

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]

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 - 6304

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
6 July 03 1600	Nursing assessment: Pt stable at this time. Sleeping but arousable. PERRLA. Lungs CTA bilat. NSR. Abd Soft, non-tender bowel sounds active x 4 quads. Strong pulses and brisk cap refill x 4 extremities. (R) leg dsg CDI. No complaints at this time. (b)(6)-2 LTC/AW
6 JUL 03	S I/O PAIN. FREQUENCY O VSSA DSG INTACT, NVI DISTALLY 138 / 100 / 28 / 9/1.0 / 98 / 7.0 / 11.6 / 9.1 A DOING WELL. HEMODYNAMICALLY STABLE. P TRANSFUSE IN ANTICIPATION OF FURTHER BLOOD LOSS AT DEBRIDEMENT 8 JUL 03. (b)(6)-2
6 Jul 03 1600	Nursing: Shift Assessment Pt. with even clear resp. this shift, Shallow at time, encouraged TS, Temp. peaked at 100.5 during blood transfusion which was not far from baseline. No ↑ in pulse rate or BP, BS (+), voided clear yellow >30cc per hour all shift. (R) leg with Dressing & Dcont amount of serous drainage, Dsg remains intact. Able to wiggle toes & feel sensation of (R) foot. (R) LE pulses pedal + dorsal intact. Transfused 2 units WB without incident see SF518. Pain X this shift. Continue to assess for change in tmpt, Pain, drainage at site (b)(6)-2

STANDARD FOR ... BACK

USAPA V1.00

MEDICAL RECORD	PROGRESS NOTES
DATE 8 JUN 03 1715	OP NOTE PREOP DX - (R) THIGH GSW C QUADRICEPS TRANSECTION - NEAR COMPLETE POST-OP DX SAME PROCEDURE - DEBRIDEMENT (R) THIGH GSW C QUADRICEPS REPAIR & IRR SURG GRANVILLE ANES GENERAL FLUIDS 700 CRYST. EBL 50 DRAINS JP (R) THIGH SPEC Ø C+S Ø FINDINGS - CLEAN WOUND C NON NONVIABLE MUSCLE & GROSS BONES - 90% DIVISION OF QUAD @ MID PORTION. TO ICU TO RECOVER STABLE (b)(6)-2 [redacted] (b)(6)-2 LTC, MC ORTHOPEDIC SERVICE

(Continue on reverse side)

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

(b)(6)-4

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
9 July 03	RN shift assessment: Pt came back from surgery
@ 0250	at approx 1800. Appeared somewhat
	sedated. Has leg bandage from upper
	(R) thigh to ankle which is CDI.
	VSWNL. Did not ask for pain meds
	during this shift. Has appeared to
	be asleep most of the shift. Resps
	even + unlabored + BS are clear — (b)(6)-2
0543	Addendum: JP has 80cc of red fluid —
	(b)(6)-2
9 JUL 2003	Nursing Assessment: Pt awake, ø C/O pain. hmsø
0816	CTA, (D)BS X4. Pt had BMx1 of soft brown stool. (L)LE
	c drsg CDI, JP intact c 30cc sero-sang. fluid. (D)ft
	c brisk cap refill, BLE cool to touch — ICT (b)(6)-2
9 JUL 03	POD 1
0940	S LOCAL PAIN
	O VSSA HCT 30
	JP MIN - DRIED Cr 0.7
	FOLEY @ CONNOR
	A STABLE
	STAPLES OUT SCROTUM & CAST ON POD 5
	(b)(6)-2 (b)(6)-2
	ORTHOPAEDIC SERVICE

(Continue...)

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

(b)(6)-4

(b)(6)-4

...NO. WARD NO.

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
9 July 03 1000	Nursing: JP drain removal: Pre-medicated @ ~~0~~ 2mg MSO4. ~~0~~ sutures holding JP. Remove bulb & pulled tubing. Tubing ~~is~~ cut across holes, MD verify tubing intact. [(b)(6)-2] [(b)(6)-2] AN
9 July 03 1455	Nursing: Vitals. Pt temp ↑ to 101. [illegible] bedside US/IS. Will recheck pt temp [(b)(6)-2] AN
9 July 1603	Nursing Tem. Pt temp remain 101.3 IP IS use. Will give tylenol & tab PO & continue IS & fluids [(b)(6)-2]
9 July 1800	Nursing assessment: Pt stable at this time. AAOx3 Peerla. Lungs CTA bilat. Use And Soft, non-tender, Bowel Sounds Active x4 quads. Pt eating well. Strong pulses and brisk cap refill x4 extremities. Moving (R) leg and toes well. Ambulated shall with PT using crutches. Voiding sufficient amts clear yellow urine to urinal. [(b)(6)-2]
2000	IV heplocked, tolerating po well. [(b)(6)-2]
10 July 03 0600	Nursing Assessment: Awake, alert, Ox3. Airway intact, breath sounds ~~&~~ unlabored, CS clear to all fields (B)s ABS soft, nontender, ~~&~~ distended. Voids spontaneously. (B)LE & (L)LE FROM and neurovascularly intact. (R)LE neurovascularly intact but ROM limited by splint & ACE. Dsg to RLE CDC. IV to (R)FA & s/s infection or infiltrating ~~dsg for pt safety~~. [(b)(6)-2]
11 July 03 0300	Nursing assessment: Pt has not c/o pain this shift. Has spent the majority resting quietly or sleeping. Good cap refill to Rt toes. Pt has difficulty adjusting self in bed. US with repositioning and back rubs to promote [(b)(6)-2]

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

MEDCOM - 6308

MEDICAL RECORD	PROGRESS NOTES
DATE	
11 JUL 03	POD 3 S NO C/O O VSSA WBC CV N HCT 29 NVI DISTALLY A STABLE P STAPLES OUT, SCD'S/SCUP, & CALF ON PODS OR 6

(b)(6)-2

(b)(6)-2

LTC, MC
ORTHOPEDIC SERVICE

11 jul 03 1720	Nursing: Shift Assessment Pt alert this shift, Responding to verbal stimuli, 0 c/o pain this shift. (R) leg dsg / ace dtd. No s/s of infection. heplock in (R) arm infiltrated received new one. No major Changes. Lungs CTA, BS active, CONT to monitor. (b)(6)-2 CFTM
12 July 03 0030	Nsg shift assessment: Pt has spent majority of the shift resting/sleeping quietly in bed. Did not require pain meds this shift. IV area is CDI. Pt VS WNL (b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
12 Jul 03 1430	Nursing: Assessment: Pt. alert, quiet, use non verbals for communication. Required multi-sticks for blood draw this am. (R) arm tenderness from previous IV. Received pain med x2, 1 BM this shift, VSS. NO resp. distress. Ambulated x2, apply slight pressure to (R) leg. C/o (L) leg/knee pain while interpreter was here. Will let physician know. No significant changes in (R) leg size, ↓ edema in (R) foot, able to wiggle toes. Continue to monitor. (b)(6)-2 RN
12 Jul 03	-2100- ASSESSMENT: A&O x3, PERRLA, LUNGS CTA BILAT, SL-S2 SINUS RHY & REGULAR & COMPLAINS OF PAIN. VSS - 000 AMBULATED W CRUTCH ASSISTANCE TOLERATED PER DIET. (b)(6)-2 GIVEN TYLENOL 650mg PO. WILL CONTINUE TO MONITOR SAT, CW
13 0600 Jul 03 BJ	NURSING ASSESSMENT: Pt alert, awake, o x 3. Airway intact, breath sounds and lung sounds clear to all (B). Abd soft, nondistended, + bowel sounds. BSO, c/o [illegible] sporadically. AROM to (B) UE and LLE. Neurovascularly intact to all extremities. (R) LE cast intact and range of motion to be changed to walking cast today. IV D/C'd intact. (b)(6)-2 BJ

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

MEDCOM - 6310

MEDICAL RECORD	PROGRESS NOTES

DATE

13 JUL 03

NAR SUM

ADMITTING & D/C DIAGNOSES-

GSW (R) THIGH C QUADRICEPS TRANSECTION PVD

PROCEDURES - 5 JUL 03 WOUND DEBRIDEMENT
8 JUL 03 QUADRICEPS REPAIR & DERMAL PRIMARY CLOSURE

CLINICAL RESUME-

THIS 35 Y/O IRAQI MALE SUSTAINED A HIGH VELOCITY GSW TO (R) ANT. THIGH BY US FORCES AS HE ATTEMPTED TO ENGAGE THEM. PE SHOWED 4CM LAT ENTRANCE & >15 ANT EXIT WOUNDS C TRANSECTION OF THE QUADRICEPS BUT NO FX.

DMOI SIGNIFICANT FOR PVD FOR WHICH HE TAKES ZANTAC

HOSPITAL COURSE - UNEVENTFUL UNCOMPLICATED DEBRIDEMENT C QUAD REPAIR & D/C SO LATER ABX D/C'D ON HD 7. STAPLES REMOVED & LONG LEG CAST PLACED ON DAY OF D/C. DISPOSITION D/C IN MP CUSTODY

ACT - WBAT F/U - ORTHO FOR CAST REMOVAL 3wks

MED - VICODIN 7.5 1 PO Q4° PRN ZANTAC 150 PO BID

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-2

ES

(b)(6)-4

(b)(6)-2

LIC, MC
ORTHOPEDIC SERVICE

Medical Record

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

MEDCOM - 6311

NSN 7540-00-634-4176 600-108

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
06July03 1800	Nursing assessment: Pt stable at this time. AAOx3. PERRLA. Lungs CTA bilat. NSR. Abd soft non-tender, bowel sounds active x4 quads. IV to (R) bicep flushing easily. Ate 50% of meal, tolerated well. Encouraged PO fluids. TS used x10 qhrs while pt awake. Strong pulses and brisk caprefill x4 extremities. (R) leg w/ drsg from toes to groin. Old drainage noted and marked to drsg. Percocet effective for pain. Ø complaints. [redacted] (b)(6)-2 ITT/AW
070650 July 03	Nursing Assessment: Pt is awake, alert, Ox3. Airway intact, breath even and unlabored LS clear to all A&Ps + Abd soft, nontender & distended. Pt w/d's spontaneously, AROM and neurovascularly intact to (B)UE and (L)LE, (R)LE has limited ROM 2° drsg & wnd. (R)LE dressed gauze & ACE from ankle to mid-thigh, CDI. Neurovascularly intact to RLE IV to (R) bicep flushes well & is TS s/s of infection or inflammation. [redacted] (b)(6)-2 LCpl AW
7 JUL 03 0800	S NO C/O O VSSA HCT 28.4 WBC 10.7 Cr 0.8 DSG & SCROTAL DRAINAGE NM DRESSING A STABLE P DPC TO MORROW [redacted] (b)(6)-2

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*
[redacted] (b)(6)-4
[redacted] (b)(6)-4

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME	ORGANIZATION	
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE
MEDCOM - 6312

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8 July 03 @ 0130	RN shift assessment: Pt was OOB x 1 this shift (to bedside chair x 30 minutes), Pt appears to be in pain when moving. Denied any need for pain meds upon being put back into bed. Linen was changed. Pt tolerating PO well. Voiding ↄ difficulties. Circulation to left foot is WNL. Will continue to monitor [redacted]
8 July 03 0800	PIV INFILTRATED, 20ga PIV cath placed in (L) FA. Flushes WNL. [redacted] SPC/LAN
8 1030 July 03	NURSING ASSESSMENT: Pt is awake, alert, Ox3e. Airway is intact, breathing even and unlabored, lung sounds clear to all fields (B). Abd soft, nontender, ↄ distention. Pt NPO for OR. BSOx4. Voids spontaneously. ROM and neurovascularly intact to (R) UE and (L) LE. (R) LE has splint ↄ gauze and RLE cast from ankle to mid thigh. Neurovascularly intact to (R) LE but ROM limited ↄ splint ↄ RLE. Drsng to RLE is CDI. IV to (R) FA flushes well ↄ ↄ s/s infiltration [redacted]

NSN 7540-01-075-3786

MEDICAL RECORD — EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER | TREATMENT FACILITY: (b)(3)-1 Iraq | RECORDS MAIN

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL — DATE (Day, Month, Year): 5 Jul 03 | TIME: 0500

TRANSPORTATION TO FACILITY: Ground Evac

SEX: M | AGE

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

MILITARY STATUS

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

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: (R) Femur Fracture

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☐ NON-URGENT

TIME: 0510

INITIAL: (b)(6)-2

VITAL SIGNS

TIME	0510	0540				
BP	136/75	131/72				
PULSE	74	69				
RESP	14	14				
TEMP	99.6	99.7				
WT						

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 100%

☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY
0510	CBC, Chem12, LFT	(b)(6)-2	(b)(6)-2
0510	Foley		
0510	UA		
0520	5mg Morphine		

TIME	PATIENT'S RESPONSE
0520	Tetanus 0.5cc (b)(6)-2
0530	Ancef 1g (b)(6)-2

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

(b)(6)-4

EMERGENCY CARE AND TREATMENT (Patient)
Medical Record

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

MEDCOM - 6314

MEDICAL RECORD | *(Doctor)* | 0500

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

(S) EPW ♂ c/o GSW Ⓡ Femur Fracture, Injury was at approx. 12 midnight. Traction splint applied.

S: Pt is ~30 yo Iraqi EPW who threw did RPG + small arms attack vs US Forces then was PMHx?
~~Shot~~ hit to Ⓡ thigh c ? explosive causing ↑ fragments to lat thigh

O: WD WN Thin. mod dist x 2 to Ⓡ thigh injury.
HEENT: WNL
Lungs: Ⓒ CTA
Cor: RRR Ⓝ Ⓔ
Abd: Ⓝ BS. S. NT ND Ⓝ Ⓔ
EXT: Smaller post-lat Ⓡ thigh entrance c Lg muscle herniation thru ant-Ⓡ thigh 2+ Pedal pulses, warm. N/V intact.
GU: Ⓝ injury
Back: Ⓝ injury, Sm Ⓡ flank abrasion.

X-Ray: Ⓝ fx mult prox lat thigh frags.

23.5 9/30 321.
Yel, Cir 1.030
all Ⓝ.
17 .9 186
LFT WNL.
B Ⓝ
~~Discharge~~ ~~to~~ ~~Ward~~

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP
(b)(6)-2

DIAGNOSIC
GSW vs frag wnd to Ⓡ lat thigh.

CODES

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

(b)(6)-4

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

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: N/A
HEIGHT: Unk N/A
WEIGHT: N/A

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

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

4. PROPOSED SURGICAL PROCEDURE: I+D (R) Thigh WD

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

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

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

(b)(6)-4

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

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

MEDCOM - 6316

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOM...	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to: ✓ 1) Intraoperative Mobility ✓ 2) Positioning ✓ 3) Existing Disease ✓ 4) Safety Devices ✓ 5) Hypothermia	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. N/A o Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to: ✓ 1) Pain ✓ 2) Intraoperative Hazards N/A 3) Prosthesis ✓ 4) Positioning ✓ 5) Transfer pt. to/from OR table E.2. ✓ Potential discomfort due to: ✓ 1) Length of Surgery ✓ 2) Positioning ✓ 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. ✓ Diminished visual perception due to being: ✓ 1) Pre-Medicated N/A 2) W/O Glasses F.2. ✓ Potential for decreased communication due to: N/A 1) Diminished Hearing ✓ 2) Language Barrier F.3. N/A Potential injury due to dentures: ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt from either side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures:
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

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

(b)(6)-2

5 Jul 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2

DATE: 5 Jul 03 TIME: 1000

13. POSTOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2

DATE: 5 Jul 03 TIME: 1140

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE:

HEIGHT:

WEIGHT:

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

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

4. PROPOSED SURGICAL PROCEDURE:
Debridement Thigh wound

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to: X 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) ___ 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety (b)(6)-2 o Pt. Exhibits relaxed body posture. No interview, Unknown history.	c Allow pt. to verbalize freely. c Explain OR environment and answer questions regarding surgery. N/A c Offer comfort measures (e.g., warm blanket, touch (b)(6)-2 c Explain all nursing procedures before they are done. N/A c Remain with pt. whenever possible (b)(6)-2 c Maintain family interface. Parents stay with pt. N/A
B. AERATION X Potential for respiratory dysfunction due to: ___ 1) Positioning X 2) Effects of Anesthesia ___ 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase (b)(6)-2	c Offer to elevate head of litter or offer pillow. c Observe pt. while awaiting surgery for signs of distress. (b)(6)-2 c Assist anesthesia during intubation and extubation.
C. INTEGUMENT X Potential impairment of skin integrity due to: X 1) Intraoperative Immobility X 2) ESU Pad Placement ___ 3) Positional Aids ___ 4) Prosthesis X 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened area (b)(6)-2	c Utilize pressure preventing devices on OR table and accessories. c Check for proper positioning and support to maintain good body alignment (b)(6)-2 o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

(b)(6)-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed N/A
! H & P ! Contacts Removed N/A
! NPO Since____ ! Jewelry Removed (b)(6)-2
! UHCG/LMP N/A ! Body Pierce Rem (b)(6)-2
! Consent/Blood Transfusion Signed/Witnessed/Dated N/A
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend: N/A

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

MEDCOM - 6318

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

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

(b)(6)-2 MAJ, AN 8 JUL 03 DATE

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

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) (b)(6)-2 CRNA

DATE: TIME:

13. POSTOPERATIVE EVALU BY (b)(6)-2 MAJ, AN

DATE: 8 JUL 03 TIME: 1710

REVERSE OF FORM 5179, JUN 91 MEDCOM - 6319 USAPA V1.0

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY: OR Staff
2. PATIENT IDENTIFICATION VERIFIED BY: (b)(6)-2 AND PROCEDURE: Cath Lab
3. DATE: 5 July 03 TIME PATIENT ARRIVED IN SUITE:
4. PATIENT IN ROOM TIME: 1033 NUMBER: 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC (b)(6)-2 .91A	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2 .66E 1LT (b)(6)-2 .66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

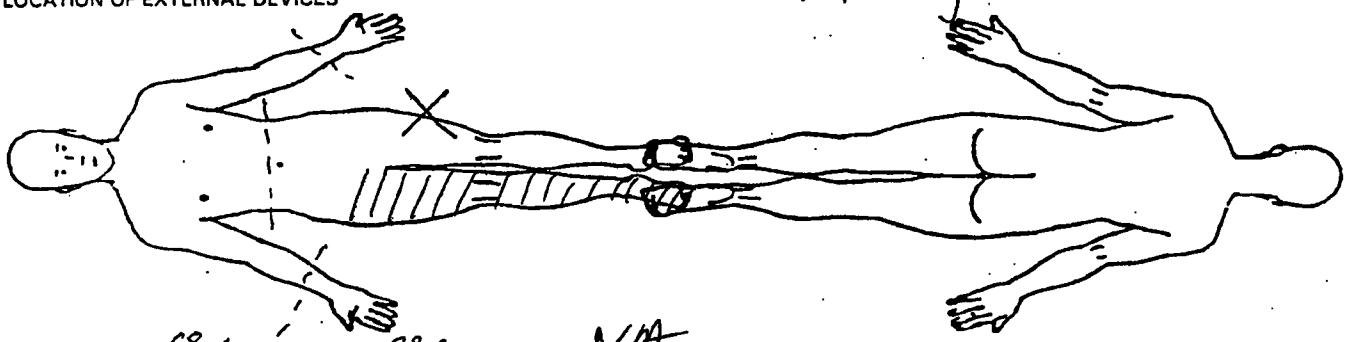
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION (Specify): Betadine / Brianti's Sol.
SITE: (R) leg - Foot to groin
BY WHOM: (b)(6)-2 (b)(6)-2
COMMENTS: ∅ pooling or irritation

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	C	C	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☒ Yes ☐ No	C	C	C		
Instrument	☐ Yes ☒ No	/	/	/		
Other	☐ Yes ☒ No	/	/	/		

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

(b)(6)-4

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

☒ ESU NO: #1 cut/coag = 30/30
GROUND PAD: BRAND: Valley Lab
LOT NO: H9402 3

☐ ESU NO:
GROUND PAD: BRAND:
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES MEDCOM - 6320 ICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

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 kerlex 5x30 Splint Ace/webril

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

Dr (b)(6)-2

CPT (b)(6)-2 CRNA

20. OPERATION(S) PERFORMED

I+D RLE WD

21. PATIENT TRANSFERRED TO ICU TIME 1155 METHOD litter

22. REGISTERED NURSE (b)(6)-2 RN/BSN

REVERSE OF DA FORM 51 USAPA V1.01

MEDCOM - 6321

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: gurney BY anesthesia

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

3. DATE 8 JUL 03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 1507 NUMBER 4

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: pt does not (b)(6)-2 speak english. no translator available.

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC (b)(6)-2 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ (b)(6)-2 66E	RELIEF CIRCULATOR	CPT (b)(6)-2 (b)(3)-1; CPT (b)(6)-2 (b)(3)-1; (b)(6)-2 (1630- (b)(3)-1

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Bump under (R) hip.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

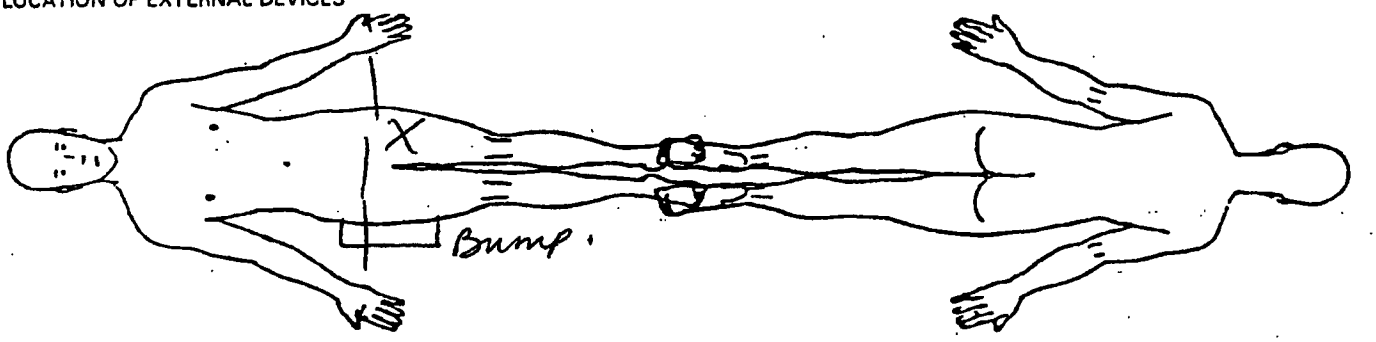
PREP SOLUTION (Specify) Betad/Betad

SITE: (R) leg BY WHOM: MAJ (b)(6)-2

SITE: BY WHOM:

COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	/	C	C	(b)(6)-2	(b)(6)-2
Needle Sharp	☒ Yes ☐ No	/	C	C		
Instrument	☐ Yes ☒ No	/	/	/		
Other	☐ Yes ☐ No	/	/	/		

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

(b)(3)-1

(b)(6)-4

(b)(3)-1

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

CUT 30 COAG 30

☒ ESU NO: Valleylab #1

GROUND PAD: BRAND 3M 9165

LOT NO: 2005-10 OT

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACE MEDCOM - 6322 HICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE (b)(6)-2

15. X-RAY IN OPERATING 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)* fluff kerlix coband ACE Xeroform Cling Mitt

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	JP 10mm	Foley	
SITE	Rt thigh GSW	Bladder - placed prior to arrival	

19. ADDITIONAL INFORMATION

Surgeon:

Dr. (b)(6)-2

anesthesia:
CPT Keebler, CRNA

20. OPERATION(S) PERFORMED

I+D (R) LE GSW

21. PATIENT TRANSFERRED TO ICU TIME 1710 METHOD Wheel

22. REGISTERED NURSE SIGNATURE (b)(6)-2 MAT SN (b)(6)-2

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

MEDCOM - 6323

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY: 1 | 2 | 3 | 4 | 5 | 6 | 7

POST- DAY

MONTH-YEAR Jul 2028 | DAY: 5 Jul | 6 | 6 | 7 | 8 | 9 | 10

HOUR: 1200 1400 2200 0600 1400 2200 0600 1400 0600 1400 2200 0600 1400 2200 0600 1400

PULSE (0) | TEMP. F (°)

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

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

(Centigrade Equivalents, for Reference only)

80 70 60 50 40

SEE BLOOD PRESSURE CONTINUATION SHEET

RESPIRATION RECORD

BLOOD PRESSURE

114/67 109/66 107/62 106/64 100/55 113/68 107/67 110/62 130/68 104/63 110/63 100/76 100.2 108/57 103/72 105/53

HEIGHT: WEIGHT → 3A1

94 98 98% 96% 100 99 100 97% 97 100% 99 99 98%

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

(b)(6)-4

MEDCOM - 6324

(b)(6)-4

51

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		8															
POST- DAY																	
MONTH-YEAR	DAY	11		12		13											
19	HOUR	0600	1400	0600	2200	1400											
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																	
RESPIRATION RECORD		16	17			17	16	16									
BLOOD PRESSURE		94/60	98/64	104/64			108/66	114/62									
			103/54		64/44												
HEIGHT: WEIGHT →		98	98	100	76 99		100	98									

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 6325

115

~~1035~~ I - 100.2 P 69 R-24 BP 165/118/68

1050

1105 - BP 114/64, 67, 100.2

1120 - BP 108/61, 72 99.7

1135 - BP 109/61, 71 99.6

1205 - BP 106/63, 65 99.6

1235 94/58, 63, 99.0

152 unit

Initial

99.1, 64,		100/52	1252
99.1	67	94/49	1307
99.2	63	93/46	1322
99.4	64	98/52	1337
99.6	71	98/48	1407
99.6	72	102/54	1437
99.6	69	103/48	1507
100.5	79	108/54	~~1537~~ 1528 Finished

2nd unit

Blood transfusion V.S.

[b)(6)-2]

CPZ

[b)(6)-2]

Ward/Section:	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
(b)(6)-4	DATE 5 AUG 03 TIME 1500	SSN/PSEUDO SSN:

TEST	RESULT	REF. RANGE
WBC	23.5	4.8-10.8 x 10^3
RBC	3.44	4.7-6.1 x 10^6
Hgb	9.2	14-18 g/dl (M) 12-16 g/dl (F)
Hct	30.1	42-52% (M) 37-47% (F)
MCV	87.4	80-94 fl (M) 81-99 fl (F)
Plt	321	130-500 x 10^3 verified
Lymph %	8.2	20.5-51.1%

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp	\	Imm	
RBC Morph			

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

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Clear	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	NEG	Negative
SG	1.030	N/A
Bld	NEG	Negative
pH	5.0	N/A
Prot	NEG	Negative
Urob	0.2	0.2-1.0
Nit	NEG	Negative
Leuk	NEG	Negative
HCG		Negative

Cell Count		
Directigen		Negative

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

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

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh: B Pos

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: (b)(6)-2 **DATE:** 05 AUG 03 **LAB ID NO.:** (b)(6)-2

MEDCOM - 6327

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

TEST	RESULT	REF. RANGE
ALB	3.0	3.5-5.5 g/dl
ALP	54	26-84 u/l
ALT	22	10-47 u/l
AMY	85	14-97 u/l
AST	33	11-38 u/l
TBIL	0.8	0.2-1.6 mg/dl
BUN	17	7-22 mg/dl
CA^{++}	7.9	8.0-10.3mg/dl
CHOL	117	100-200 mg/dl
CRE	0.9	0.6-1.2 mg/dl
GLU	186	73-118 mg/dl
TP	6.0	6.4-8.1 g/dl

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

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

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

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

REMARKS:

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

Ward/Section: ICU	R[redacted]NG PHYSICIAN: (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. (b)(6)-4	DATE 5Jul03 / TIME 0731	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	22.0 *	4.8-10.8 x 10^3
RBC	3.12 L	4.7-6.1 x 10^6
Hgb	8.2 *	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.0 *	42-52% (M) 37-47% (F)
MCV	88.7	80-94 fl (M) 81-99 fl (F)
Plt	253	130-500 x 10^3 verified
Lymph %	7.6 *	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

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

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: (b)(6)-2	DATE: 05 Jul 03	LAB ID NO.:

MEDCOM - 6329

Ward/Section: ICU

REQUESTING PHYSICIAN: (b)(6)-2

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

LAST, FIRST, MI. #

DATE | TIME | SSN/PSEUDO SSN:

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

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

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

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

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

REMARKS:

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

MEDCOM - 6330

Ward/Section: ICU

REQUESTING PHYSICIAN: (b)(6)-2

LAST, FIRST, MI: (b)(6)-4

DATE: 06 Jul

TIME: 0400

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

SSN/PSEUDO SSN: (b)(6)-4

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

TEST	RESULT	REF. RANGE
GLU	109	73-118 mg/dl
BUN	9	7-22 mg/dl
CRE	1.0	0.6-1.2 mg/dl
CK	648	39-380 u/l (M) 30-190 u/l (F)
NA+	138	128-145 mmol/l
K+	4.1	3.3-4.7 mmol/l
CL-	100	98-108 mmol/l
tCO_2	26	18-33 mmol/l

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

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

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

REMARKS:
Methyte 8

REPORTED BY: (b)(6)-2

DATE: 06 Jul 03

LAB ID NO.:

MEDCOM - 6331

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

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

(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		

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 secs
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	

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 6332

Ward/Section: 1Cen

ATTENDING PHYSICIAN: (b)(6)-2

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

LAST, FIRST, MI: (b)(6)-4

DATE: 06 Jul

TIME: 0400

SSN/PSEUDO SSN: (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	9.1	4.8-10.8 x 10^3
RBC	2.45	4.7-6.1 x 10^9
Hgb	7.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	21.6	42-52% (M) 37-47% (F)
MCV	88.1	80-94 fl (M) 81-99 fl (F)
Plt	175	130-500 x 10^3 verified
Lymph %	17.5	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

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: (b)(6)-2

DATE: 06 Jul 03

LAB ID NO.:

MEDCOM - 6333

Ward/Section: ICU

REQUESTING PHYSICIAN: (b)(6)-2

LAST, FIRST, MI: (b)(6)-4

DATE: Thu

TIME: 0400

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

SSN/PSEUDO SSN: (b)(6)-4

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

TEST	RESULT	REF. RANGE
GLU	101	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK	1303 +	39-380 u/l (M) 30-190 u/l (F)
NA^+	132	128-145 mmol/l
K^+	4.2	3.3-4.7 mmol/l
CL^-	103	98-108 mmol/l
tCO_2	25	18-33 mmol/l

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

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

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

REMARKS:

Methyte 8, CBC

REPORTED BY: (b)(6)-2

DATE:

LAB ID NO.:

C MEDCOM - 6334

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:
(b)(6)-4	7 Jul	0400	(b)(6)-4

Hematology/CBC

TEST	RESULT	REF. RANGE
WBC	10.7	4.8-10.8 x 10^3
RBC	3.23	4.7-6.1 x 10^3
Hgb	9.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.4	42-52% (M) 37-47% (F)
MCV	88.0	80-94 fl (M) 81-99 fl (F)
Plt	148	130-500 x 10^3 verified
Lymph %	16.6	20.5-51.1%

Hematology/Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Micro Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	(b)(6)-2	DATE: 07 JUL 03	LAB ID NO.:

MEDCOM - 6335

Ward/Section:	REQU[illegible]ING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST FIRST MI (b)(6)-4	DATE 8 OCT	TIME 1555

SSN/PSEUDO SSN: (b)(6)-4

Hematology/CBC

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

Hematology/Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Coagulation/Send

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

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 Analysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank/Send

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-4

OR

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	25	38-51% PCV
Hgb	9	12-17 g/dl

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

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

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

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

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

REMARKS:

REPORTED BY: (b)(6)-2

DATE: 08 JUL 03

LAB ID NO.:

Ward/Section: ICU | REQUESTING PHYSICIAN: | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: (b)(6)-4 | DATE: 9 JUL 15 | TIME: 0415 | SSN/PSEUDO SSN:

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

TEST	RESULT	REF. RANGE
GLU	110	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK	1593	39-380 u/l (M) 30-190 u/l (F)
NA^+	131	128-145 mmol/l
K^+	5.3	3.3-4.7 mmol/l
CL^-	99	98-108 mmol/l
tCO_2	25	18-33 mmol/l

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

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

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

REMARKS:

BY: | DATE: | LAB ID NO.:

Ward/Section: | DH | MEDCOM - 6338

LAST, FIRST, MI	DATE	TIME	SSN/PSEUDO SSN:
(b)(6)-4	9 Jul 03		

Hematology (CBC)

TEST	RESULT	REF. RANGE
WBC	9.9	4.8-10.8 x 10^3
RBC	3.39	4.7-6.1 x 10^9
Hgb	10.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	30.0	42-52% (M) 37-47% (F)
MCV	88.4	80-94 fl (M) 81-99 fl (F)
Plt	286	130-500 x 10^3 verified
Lymph %	13.4	20.5-51.1%

Hematology (Manual Differential)

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: (b)(6)-2	DATE: 09 Jul 03	LAB ID NO.: (b)(6)-4

Ward/Section: ICU	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: (b)(6)-4	DATE: 10 JUL	TIME: 0400
		SSN/PSEUDO SSN:

[illegible]

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

[illegible]

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

[illegible]

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

[illegible]

TEST	RESULT	REF. RANGE
GLU	100	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK	1964	39-380 u/l (M) 30-190 u/l (F)
NA^+	136	128-145 mmol/l
K^+	4.4	3.3-4.7 mmol/l
CL^-	100	98-108 mmol/l
tCO_2	26	18-33 mmol/l

[illegible]

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

[illegible]

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

[illegible]

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

REMARKS:
CBC, Methyl 8

REPORTED BY: (b)(6)-2

DATE:

LAB ID NO.:

MEDCOM - 6340

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

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	9.7	4.8-10.8 x 10^3
RBC	3.27	4.7-6.1 x 10^9
Hgb	9.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.9	42-52% (M) 37-47% (F)
MCV	88.3	80-94 fl (M) 81-99 fl (F)
Plt	291	130-500 x 10^3 verified
Lymph %	12.5	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Other	

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

(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

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: (b)(6)-2	DATE: 10 Jan 03	LAB ID NO.:

Ward/Section	REQUES... PHYSICIAN:	CHE... TRY RESULT FORM (Subject to the Privacy Act of 1974)
ICW	(b)(6)-2	
LAST FIRST MI	DATE	TIME	SSN/PSEUDO SSN
(b)(6)-4	1/24/03	0630	(b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Methyter8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 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
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

LAST, FIRST, MI:	DATE	TIME	SSN/PSEUDO SSN:

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		

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 secs
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		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch

(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

LAST, FIRST, MI		DATE	TIME	SSN/PSEUDO SSN:
(b)(6)-4		11Jul03	(b)(6)-4	

Hematology CBC

TEST	RESULT	REF. RANGE
WBC	7.2	4.8-10.8 x 10^3
RBC	3.24	4.7-6.1 x 10^6
Hgb	9.5	14-18 g/dl (M) 12-16 g/dl (F)
Hct	28.7	42-52% (M) 37-47% (F)
MCV	88.7	80-94 fl (M) 81-99 fl (F)
Plt	371	130-500 x 10^3 verified
Lymph %	16.1	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Blood Bank

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

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

REMARKS:

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

Ward/Section: ICU	REQUESTING PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: (b)(6)-4	DATE: 11Jul03 TIME: 0926	SSN/PSEUDO SSN

(i-STAT)

TEST	RESULT	REF. RANGE
Na	133	138-146 mmol/L
K	4.3	3.5-4.9 mmol/L
Cl	96	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	32	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN	12	8-26 mg/dl
GLU	106	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) MetLyte 8

TEST	RESULT	REF. RANGE
GLU	106	73-118 mg/dl
BUN	12	7-22 mg/dl
CRE	0.7	0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA+	133	128-145 mmol/l
K+	4.3	3.3-4.7 mmol/l
CL-	96	98-108 mmol/l
tCO_2	32	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

LAST FIRST MI	DATE	TIME	SSN/PSEUDO SSN:
(b)(6)-4	12Jul03	C	

Hematology/CBC

TEST	RESULT	REF. RANGE
WBC	6.8	4.8-10.8 x 10^3
RBC	3.41	4.7-6.1 x 10^9
Hgb	10.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	30.0	42-52% (M) 37-47% (F)
MCV	87.9	80-94 fl (M) 81-99 fl (F)
Plt	467	130-500 x 10^3 verified
Lymph %	23.6	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch

MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: ICU	REQUE (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI (b)(6)-4	DATE: 12Jul	TIME: 0730	SSN/PSEUDO SSN

(i-STAT)

TEST	RESULT	REF. RANGE
Na	134	138-146 mmol/L
K	4.2	3.5-4.9 mmol/L
Cl	96	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	33	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Mellyte 8

TEST	RESULT	REF. RANGE
GLU	100	73-118 mg/dl
BUN	13	7-22 mg/dl
CRE	0.8	0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS: CHEM 7

REPORTED BY: (b)(6)-2	DATE: 12Jul03	LAB ID NO.:

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 35 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: debridement DPC (R) femur
SURGICAL SERVICE: Ortho
NPO SINCE: 0 MN

ASA Physical State 1 (2) 3 4 5 E
WT: 50 KG/LB HT: 67 IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: (+)
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed
(Gent
(Clinda
(MSO4
(Toradol qpm prior to arrival
( )
( )

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

LABORATORY STUDIES:
HB/HCT: 9.5 / 28.7
U/A:
OTHER:

133 | 103 | 8 / 101
4.2 | 25 | 0.8

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 115/57 HR 76 R ___ T ___
Pain Scale 0-10 _____
HEENT - Teeth
Trachea Midline
TMJ/Neck Pain
Oropharynx MP
Nares
CHEST: CTA
CARDIAC: S1S2
EXTREMITIES: (b)(6)-4
IV Access
Ulnar Filling:
BACK:
OTHER:

NPO Since _____

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.

Sig (b)(6)-2 Date: 7/8/03 Time: 1500 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
(X) NO AP(b)(6)-2 CATIONS { } OTHER
CPT, AN
(b)(6)-2
Date: 7/9/03 Time: 1030 Hrs

SEDATION KEY:

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

Patient Identification: (Ward) _____

(b)(6)-4

PRE-ANESTHESIA AND POST-ANESTHESIA EVALUATION

AGE: N/20 HRS DAYS MOS (YRS) SEX: (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: (R) Thigh Wash-out SURGICAL SERVICE: ortho
Deferred

ASA PHYSICAL STAUS 1 (2) 3 4 5 (E)
WEIGHT: N60 (KG/LB) HEIGHT: ____ IN.
ALLERGIES: ?

HABITS:

TOBACCO: ____
ETOH: ?
DRUGS: ____

CURRENT MEDICATIONS:

([ ]= ordered as premed)
[ ] Tetanus) iv
[ ] Anes / Epi
[ ] ____
[ ] ____
[ ] ____
[ ] ____

PREMEDICATION:

None Yes (@ ____ Hrs) PO/IC
____ ____ mg IV IM PO
____ ____ mg IV IM PO
____ ____ mg IV IM PO

LABORATORY STUDIES:

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

23.5 > 9.2 / 30.1 < 321

17 186
7.9

PREOPERATIVE ASSESSMENT

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	N	Y
Endocrine System:	Diabetes	N	Y
	Steroids	N	Y
	Thyroid	N	Y
Neurological:	Seizures	N	Y
	Neuropathy	N	Y
	Other	N	Y
Gynecological:	Pregnancy	N	Y
Other Significant Hx:		N	Y GSW to (R)
Familial HX		N	Y Thigh

Ø Tetanus available
Ø known

PAST SURGICAL/ANESTHETIC HISTORY

?
Ø

PHYSICAL EXAMINATION

BP 131/72 HR 67 RESP 14
HEENT-Teeth ____
Trachea Midline
TMJ/Neck FROM
Oropharynx MPI
Nares ____
CHEST: CTA
CARDIAC: S1S2
EXTREMITIES: ____
IV Access: #18g (R) Hand
Ulnar Filling: ____
BACK: ____
OTHER: ____

ANESTHETIC PLAN: [ ] Local [ ] MAC - [ ] Regional (Specify): ____ [X] General: Mask Intubation

INFORMED CONSENT/COUNSELLING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed wih the patient/legal guardian.
The patient/legal [redacted] stand and agrees. Questions answered.

Signed: [redacted] CRNA [redacted] DATE: 5 July 03 TIME: 0830 Hrs

CONDITION UPON ARRIVAL TO P.A.R.R. ____

VITAL SIGNS: BP ____ HR ____ RESP ____ SuO_2 ____

RESP STATUS: [ ] Spontaneous [ ] Assisted [ ] Cont'd

MENTAL STATUS: [ ] Awake [ ] Alert [ ] Lethargic [ ] Asleep

[ ] Responsive [ ] Unresponsive Block Level ____

REPORT GIVEN: [ ] Yes [ ] No

See anesthesia record

POST-ANESTHESIA EVALUATION AND NOTE

[ ] NO APPARENT ANESTHETIC COMPLICATIONS [ ] OTHER

Signed: [redacted] DATE: 5 July 03 TIME 0830 Hrs

PATIENT IDENTIFICATION: (Ward: ____)

[redacted]

ofloxacin 900mg IV

MEDICAL RECORD — ANESTHESIA

ANESTHETICS, GENERAL AND ORDERS — CONTINUOUS / REPEATED DRUGS (SPECIFY UNITS – MG / MCG / ML; I.V.=CONSTANT INFUSION)

DRUG	(Units)	
Versed	(mg)	50 50 100? 50
Fentanyl	(mcg)	
Diprivan	(mg)	50/hr
	( )	
MS04	(mg)	q 2-3 3
VOLATILE AGENT	% del	
	800 % e.t.	1.5 1.5 2.0 1.9 0.0 2.0
AIR	L/Min	
N20	L/Min	
O2	L/Min	8 2 2 2 2 2 2 8

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

FLUIDS

LINE site		
NS	☐ Warmed	1000 IV
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES — EST BLOOD LOSS: 50 — URINE –

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 50 KG / LB

HEMATOCRIT: 28.4

INITIAL DATA: BP – 115/57 HR – 76

BOOP CHECK: OK? – (Y) N

PATIENT READINESS: OK for PROCEDURE? (Y) TIME – 1507

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

TIME → 1500 · 30 · 1600 · 30 · 1700 · 30

220 200 180 160 140 120 100 80 60 40 20

MONITORS, EQUIPMENT & TECHNIQUES

VT – ml		310	510	580	490	340	7500	550	
f – breaths/min		20	12	16	12	10	16	9	10	12
Peak inf pres / PEEP									
MODE– S(pon), A(assist), C(on)		S	A	A	A	A	S	A	S	S
BP/Auto Cuff	ET CO2 (torr)		52	53	51	54	50	47	51	45
BP / oth	FIO2 (Frac or %)	.83	.84	.85	.84	.84	.84	.83	.83	.81
ART line	SpO2 (%)	99	99	99	99	99	99	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR	
Gas analyzer	TEMP- site									
	N-M Block (T/4)									
Warming blkt										
Conv warmer										

Mark with letters & symbols, explain under REMARKS — EVENTS — Position → Q — pressure pts padded BUE <90° as taped R UNA placement

TOTALS	TOTAL IN
1	50
250/0	TOTAL URINE
10/.	0

FLUIDS – SUMMARY: CRYSTALLOID – 700 · COLLOID – 0 · BLOOD – 0

REMARKS – Code drugs with numbers, events with letters

1. from ICU → OR
2. Monitors pre-O2 LMA placed.
3. H/H 25/9 #16 G IV started
4. RTA.
5. LMA removed. → ICU via stretcher in patient. Report given.

1025 – Patty CAT Schneider

RECOVERY AT 1704 — PACU ICU (Specify) — OTHER — CONDITION: sleepy — RESP – 20 SpO2 – 100 — BP – 118/54 HR – 82

ANES	Start	Room	End
	1500	1506	1711
PROC	Ready	Begin	End
	1512	1530	1701

PROCEDURES and CPT Codes: debridement / DPC

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: LMA #4 inserted / attempt ⊕ ETCO2 ⊕ BBS and T 30cc @ manually

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

SURGEONS: (b)(6)-2

ANEST: (b)(6)-2 CPT

(b)(6)-2
CPT, AN
CRNA

PROCEDURE LOCATION: OR 1-1

DATE: 08 July 03

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA

WAMC OP 376 REVISED 1 Jan 99

MEDCOM - 6350

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

MEDICAL RECORD — ANESTHESIA

DRUGS (Initial) | **TOTALS** | **TOTAL FLUIDS** 100 | **TOTAL URINE** 550

- Versed (mg) 2
- Fentanyl (mcg) 100 (50 x 150) 50
- STP (mg) 325
- Sch Nrc (mg) 100 10
- Tracrium (mg)
- Gentamycin (mg) 600 → XXX (400 → 40 ICol)
- Sevo / Iso / Forane % e.t. 1.3 1.5 1.2
- AIR L/Min
- N2O L/Min
- O2 L/Min 8 2 2 2 8

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

FLUIDS
- LINE site (RC) #18 (1) LC — Warmed — 700 — 1000
- Warmed
- Warmed
- Warmed

LOSSES — EST BLOOD LOSS — URINE – 550

FLUIDS – SUMMARY
- CRYSTALLOID– 1000
- COLLOID– 0
- BLOOD– 0

REMARKS

Code drugs with numbers, events with letters

(1) Pre-op from ICU → OR via gurney
(2) In OR monitors, pre-op. RSI, cricoid, OGT placed.
(3) Reglan 10 mg IV
(4) 3x3 excluded & SV TV >5cc/kg. Sat_2 >95% → ICU for recovery. IV patent. Report given

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 60 (KG) LB

HEMATOCRIT: 30.1

INITIAL DATA: BP – 134/64 HR – 66

IDENT CHECK OK? – (Y) N

PATIENT READINESS OK for PROCEDURE? (Y) TIME – 1034

TIME 0930 1100 1130 1200 1230

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

220 200 180 160 140 120 100 80 60 40 20

- VT – ml: 840 780 740
- f – breaths/min: 10 10 9 12
- Peak inf pres / PEEP: (12) 18/2 17/2
- MODE – S(pon), A(ssist), C(on): S C C C S
- BP/Auto Cuff (X) ET CO2 (torr): 34 34 31 40
- BP / oth (X) FIO2 (Frac or %): .87 .87 .86 .87 .9
- ART line (X) SpO2 (%): 100 100 100 100 100
- Steth – RC/ES (X) ECG: SR SR SR SR SR
- Gas analyzer (X) TEMP – site ESO: 37 37.0 37.0 37.0
- N-M Block (T/4): dy 4/4 1M

Warming blkt · Conv warmer

RECOVERY AT 1151
PACU (ICU) (Specify) OTHER
CONDITION: recovery
RESP – 22 SpO2 – 100 BP – 115/61 HR – 77

	Start	Room	End
ANES	1020	1033	1040
PROC	Ready	Begin	End
	1040	1102	1138

Mark with letters & symbols, explain under REMARKS — **EVENTS** Position → pressure pts padded but C-spine not taped d/t intubation

PROCEDURES and CPT Codes
Debridement (R) thigh wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
LMA IV attempt RSI cricoid mac 3 #8.0 ETT @ 24cm
R/P Lt (+) BBS (+) ETCO2. Atraumatic

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

SURGEONS: (b)(6)-2
(b)(6)-2 CRNA
(b)(6)-2 CPT, AN CRNA

PROCEDURE LOCATION OR 1-1
DATE 05 July 03
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED 1 Jan 99
MEDCOM - 6351
*U.S. GPO: 2002-729-180/40137

518–124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED *(If applicable)*: _____ ML

REMARKS:

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

DATE REQUESTED: 6 Jul 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

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

REQUESTING PHYSICIAN *(Print)*: DR. (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: (R) Thigh D&I

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: Cpt Pacious Cpt

DATE VERIFIED: 6/

TIME VERIFIED:

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.:

PATIENT NO.: (b)(6)-4

DONOR: ABO B, Rh Pos

RECIPIENT: ABO B, Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	Compat

PREVIOUS RECORD CHECK: [ ] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)-2

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE

REMARKS: EXP - 07 Jul 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)-2

AT *(Hour)*: 1024 ON *(Date)*: 6 Jul 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)*: (b)(6)-2 , 1LT AN

2nd VERIFIER *(Signature)*: (b)(6)-2 (CPT AN)

PRE-TRANSFUSION: TEMP. 100.2 AX | PULSE 71 | BP 104/54

DATE OF TRANSFUSION: 7 Jul 03 | TIME STARTED: 1035

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

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME/DATE COMPLETED/INTERRUPTED
450 ML	1240 7 Jul 03

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[X] NONE [ ] SUSPECTED	99.0	63	94/58

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

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

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

(b)(6)-2 VE , CPT AN

SEX: M WARD: FCU

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 - 6352

Return to Transfusion Service

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

8 JUL 03 1705

ADMIT TO (b)(6)-2

✓ DX (R) QUADRICEPS GSW

✓ COND STABLE

✓ VS ROUTINE

✓ ACT-EPW STATUS - RESTRAINTS

✓ OOB > TID

✓ PT & CRUTCH TRAIN WBAT (R)

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

✓ NKA

✓ REG DIET

✓ I/O BOARD RECORD Q8°

✓ IVF @ 75CC/HR, HEPLOCK WHEN PO ADEQUATE

NOTED 8 JUL 03 1900 (b)(6)-2

MEDS

~~ANCEF~~ ~~IVP~~ CLEOCIN 600MG Q8° IV X 9 DOSES

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

✓ GENTAMICIN 320MG IVQD X3 DOSES

✓ ZANTAC 150MG PO BID

✓ TYLOX 1-2 PO Q6° PRN PAIN

✓ MS 2MG IV Q15' PRN UP TO 16mg IN 4HR

✓ TYLENOL 650MG PO/PR Q4° PRN

✓ IS Q1° W/A

✓ CBC MONDAY 8 Q AM (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER X3D TIME (b)(6)-2

LTC, MC ORTHOPEDIC SERVICES

8 JUL 03 1745

MS 6MG IV NOW THEN REPEAT X 1 IN 15' (b)(6)-2

(b)(6)-2

(b)(6)-2

9 July 24° dont check

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 72 WHICH MAY BE USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
05 JUL 03	1600 HOURS	

Zantac 150 mg po bid
1st dose now.

(b)(6)-2

(b)(6)-2

3 JUL 03 1608

NURSING UNIT	ROOM NO.	BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER
6 JUL 03	HOURS

TYPE CROSS & TRANSFUSE
2U PRBCS EACH OVER 2HR
PREMED ~~&~~ TYLENOL 650MG PO
& 50MG BENADRYL PO
CBC, MG, PT & T, TOMORROW AM

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

(b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER

(b)(6)-2

(b)(6)-2

ITC, MC
ORTHOPEDIC SERVICE

(b)(6)-2

7 JUL 03 0700
NPO PMN

(b)(6)-2

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

(b)(6)-2

ITC, MC
ORTHOPEDIC SERVICE

7/7/03
0300

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

24° chart ✓ B Jul

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

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

MEDCOM - 6354

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 5 Jul 03 TIME OF ORDER: 0615 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU pre op.
2. Dx fragments to (R) thigh.
3. Cond stable.
4. NPO pre op.
5. IV NS @150 cc/hr
6. Foley.
7. I/O's.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

8. MSO4 5mg IV q 2-4 hr prn
9. CBC on arrival ~~+ q~~ (b)(6)-2

5 JUL 03 1140
ADMIT ICU c/o GUNSHOT
Dx (R) ANT THIGH GSW
COND STABLE

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

VS ROUTINE
ACT EPW STATUS - OOB > TID
IC APPROPRIATE GUARDING
NKDA
REG DIET
CBC METW/ES IN AM
D/C FOLEY, SCH CATH Q6° PRN UNABLE TO VOID

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

LR @75cc/hr, MAINTAIN ADEQUATE
CEFOTAN 600MG IV Q8°
GENTAMICIN 320 MG IV QD
MS 2 MG IV Q15' PRN UP TO 16 mg IN 4°
PERCOCET 1-2 TAB PO Q4° PRN
ETODOLAC 600 MG PO Q12° PRN
IS Q1° W/A

(b)(6)-2

(b)(6)-2 LIC. ORTHOPEDIC SERVICE

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY B

MEDCOM - 6355

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mo 07 Yr 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 5 6 7 8 9 10 11 12 13 14 15 16 17 18
5 Jul	(b)(6)-2	VS Routine	6	(b)(6)-2
			14	
			22	
5 Jul	(b)(6)-2	Act. EPW status/restraints	6	(b)(6)-2
		QOB 2 hld c	14	
		appropriate guardings	22	
5 Jul	(b)(6)-2	Reg diet	6	/ (b)(6)-2
			12	/
			17	(b)(6)-2
5 Jul	(b)(6)-2	IS @ 10 cm	5	(b)(6)-2 — 2 hld cl
			17	
8 July	(b)(6)-2	IP to ward, record	06	/ / / (b)(6)-2 — D hld
		output Q8h	14	/ / /
			22	/ / /
8 July	(b)(6)-2	CBC + methyfe 3	06	(b)(6)-2
		@ Am	X	

ALLERGIES: ☐ YES ☐ NO — unknown

PRIMARY DIAGNOSIS: R/o ant. thigh GSW

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION: (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

EDITION OF 1 DEC 77 MAY BE USED.

USAPA V1.00

MEDCOM - 6356

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 07 Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5Jul03	(b)(6)-2	Admit ICW Dr Granville	05Jul	1800	1505	(b)(6)-2
5Jul03		Cond Stable	5Jul	NOW	noted	
5Jul03		CBC Mellyte 8	6Jul	0300	0400	
5Jul03		DR Edey	5Jul	NOW	1545	
6Jul03		CBC, Mellyte 8	6Jul	0300	0400	
7Jul		NPO after MN	8July	0001	Done	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
5JUL	MD	Straight cath q6°	
		FU if unable to void	

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. 07 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5 6 7 8 9 10 11 12 13 14 15 16 17 18
5 Jul	(b)(6)-2	LR @ 75cc/hr x 1 liter	15	(b)(6)-2 Accidental 06 Jul 03
		when adequate	17	
5 Jul	(b)(6)-2	Cleocin 600mg IVPB	6	(b)(6)-2
			06	
			24	
5 Jul	(b)(6)-2	Gentamicin 240		(b)(6)-2
		5 mg/kg/day		
5 Jul	(b)(6)-2	T.S @ 12 MD	5	(b)(6)-2
			17	
5 Jul	(b)(6)-2	Zantac 150mg po bid	5	(b)(6)-2
		1st dose now	17	(b)(6)-2
5 Jul	(b)(6)-2	NS Flush Heps	06	(b)(6)-2
			14	
			22	(b)(6)-2
5 Jul	(b)(6)-2	LR @ 75cc/hr	06	(b)(6)-2
		Heparin Lock PO	14	
		Discontinue	22	(b)(6)-2
05 Jul	(b)(6)-2	HL	06	(b)(6)-2
			14	
			22	

ALLERGIES: ☐ YES ☐ NO — Unknown

PRIMARY DIAGNOSIS: (R) ant thigh GSW

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

PATIENT IDENTIFICATION: (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. 07 Yr. 03

Verify by Initialing

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6 Jul 03	(b)(6)-2	Premed Tylenol 650mg po 450mg	6 Jul 03	NOW	1030	(b)(6)-2
		bendadryl po				
6 Jul 03	(b)(6)-2	type + crossmatch 2u units PRBC each	6 Jul 03	ASAP	1235 1035	(b)(6)-2
		Over 7 hrs			(2) 1252 1507	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
5 Jul	(b)(6)-2	MS 2mg IV Q15 prn up to 16 mg IN 4 hrs	5 Jul 0400; 5 Jul 0445; 5 Jul 0430; 5 Jul 0445; 7 Jul 1225; 7 Jul 1620; 7 Jul 1635; 8 Jul 0445
5 Jul	(b)(6)-2	Percocet 1/2 - 1 1/2 tabs PO Q4 PRN Pain	100 Jul 1445; 7 Jul 1230 T1 PO; 7 Jul 1540 T1 PO; 12 Jul 1530 T1 PO
5 Jul	(b)(6)-2	Tylenol 650mg PO Q4 hours PRN	1605 9 Jul T PO
8 Jul	(b)(6)-2	Tylox 1-2 tabs PO Q6 PRN pain	

USAPA V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 5 JUL 03
Time In: 1325
Allergies: LATEX 88 18
Pre-op V/S:
Procedures: Debridement @ leg

Anesthesia Type (Circle)): General Spinal Epidural
IV Sedation Nerve Block
OR Intake: Crystalloid 900 Colloid
OR Output: UOP EBL
Meds/Times: 250 mg Ceft 2mg Ver 7.5mg Imsdy 30mg Toradol

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1325	1510	1515	1540	1545	1600	1615	1645	1715	1745	1900	1930	1600
SaO2	98	100	99	101	101	100	99	100	101	96	96		
FiO2	15	15	15	15	15	15	16	16	8	1			
Methods	M	M	M	M	M	M	M	M	NA	NA			
240													
220													
200													
180													
160													
140													
120	116	116	115	115	110	118	122	114	114	108	103		
100	106	90											
80			85	84	83	81	81	79	98	106			
60													
40	56	59	64	67	68	68	67	66	70	79			
20													
RR	14	20	20	19	18	19	18	18	19	20			
T	98.6	98	98	98.2	98.6	98.8	99	99	98.8	99			
Time	1325												
Pain (0-10)	NPA												
LOS													

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1530	LR		IV	(b)(6)-2	200
1400	Ancef		IV		50

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	2	2	
Blood Pressure (2) SBP +/- 20 of Pre-op (1) SBP +/- 20-50 of Pre-op (0) SBP +/- 50 of Pre-op	2	2	
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	—	—	
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	2	2	
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	8	

Codes

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

V/S
X = A-line BP
° = Cuff BP
= Pulse

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

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

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

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 CM

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 5 JUL 03

PATIENT (For medical entries give: first, initial; grave; date; hospital or medical facility)

(b)(6)-4

Name – last,

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	LLE/Sle to Ass			+	B	C	PK
15'	Sedated			+	B	C	PK
30'	↓			+	B	C	PK
45'	↓			+	B	C	PK
60'	(R)	+	+	+	B	C	PK
90'	(R)	+	+	+	B	C	PK
D/C	(R)	+	+	+	B	C	PK

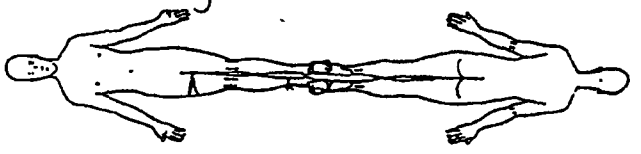
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) Les	Occlusive	Ø
30'	(R) Les	Occlusive	Ø
60'	(R) Les	Occlusive	Ø
D/C	(R) Les	Occlusive	Ø



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1325 Transferred from OR to ICU for recovery, Foley, EPW made c dx of SIP @ leg debridement. Cardi. stable, VSS. Sedated & not alert to verbal or tactile stimuli. [redacted] @ leg wrapped c gauze c & dsg. [redacted]

1355 Pt remains sedated & BS response to tactile & verbal stimuli. [redacted]

1400 BS cont to be hyperactive [redacted]

1435 Pt beginning to become alert to verbal & tactile stimuli [redacted]

1500 BS @ bot sluggish. [redacted]

1515 Report given to ICU [redacted]

Discharge Criteria:
Date: 5JUL **Time:** 1520 **PARS:**
BP: 127/82 **T:** 99° **HR:** 100 **RR:** 93 **SaO2:** KO
Pain Level at D/C (0-10):
Intake: 250 **Output:** 0
Additional Data:
Transferred To: ICU
Report Given To: CPT [redacted]
Transferred Via: WIC ~~Litter~~ Gurney Ambulance
Transferred By: [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:

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: 5Jul03 Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Time In: ~~1155~~

Allergies: unK OR Intake: Crystalloid 1000 Colloid ____

Pre-op V/S: ____ OR Output: UOP 550 EBL 100

Procedures: ____ Meds/Times: Cleo 600mg, Ancef, Reglan

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

Pre Op Meds ____ History unK

Time	1155	1200	1215	1230	1245	1300	1315	1330	1345	1400	1415
SaO2											
FiO2											
Methods											
240											
220											
200											
180											
160											
140			V								
120	V	V		V	V	V	V	V	V		
100											
80	•										
60											
40											
20											
RR	20	24	18	16	12	14	24	13	14		
T	99		98	99		99	99	99	99		

Pacu Intake

Time	Solution	Amount	Site	By	Infused
	LR	300cc	CPIV		

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

Time								
Pain (0-10)								
LOS								

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

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

(CONTINUED ON REVERSE)

PREPARED BY (b)(6)-2 SGT/LAN

DEPARTMENT/SERVICE/CLINIC: ICU

DATE: 5Jul03

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

Name - last, age 35

(b)(6)-4

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P.	Cap Refill	T	Colpr
Adm	AE	PROM	WFA	(P)	<2sec	warm	pink
15'	AE	PROM	WFA	+	<2sec	warm	pink
30'	AE	PROM	WFA	+	<2sec	warm	pink
45'	AE	+	—	P	B	W	PK
60'	AE	+	—	P	B	W	PK
90'	AE	+	—	P	B	W	PK
D/C							

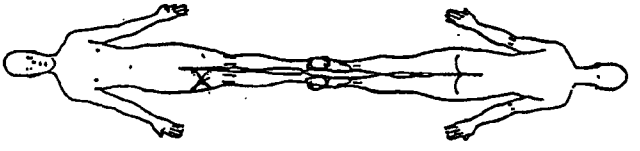
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) thigh	ACE wrap	CDI
30'	(R) thigh	ACE wrap	CDI
60'	(R) thigh	ACE wrap	CDI
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount
1248	Foley	clear, yellow	100cc
1445	Foley	clear yellow	125cc

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1245	NSR		

WAMC OP 173-E

NURSING NOTES

Pt arrived from OR @ 1135 on venti mask at 16 lpm - LR to @ PIV c Gentamycin 400mg IVPB. VSS, pt began to have very noisy respirations - gurgling & straining - nasal airway placed & pt suctioned. Small amt of tenacious mucous c blood suctioned. Pt still sats 100% c O2. (b)(6)-2 LPN

1315 - Pt on RA - still sats > 97%. (b)(6)-2 LPN

1420 - Pt opens eyes to painful stimulus - responds to questions. (b)(6)-2 LPN

1446 - Pt aroused to verbal stimulus, spoke c translator. Meets all D/C criteria. Report given to CRT (b)(6)-2 (b)(6)-2 LPN

Discharge Criteria:
Date: 5 Jul 05 **Time:** 1445 **PARS:** 11
BP: 105/50 **T:** 99° (T) **HR:** 58 **RR:** 13 **SaO2:** 98% RA
Pain Level at D/C (0-10):
Intake: 0 **Output:** 225 cc
Additional Data:
Transferred To: ICW
Report Given To: CPT (b)(6)-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By:
Cleared IAW Recovery Room SOP B-3
~~**Charge Nurse Signature:**~~

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: 8 Jul 03
Time In: 1710
Allergies: NKDA
Pre-op V/S: 115/87 76
Procedures: D/C @ Fever

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 400 Colloid
OR Output: UOP 0 EBL minimal
Meds/Times: clindamycin 1645

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

Pre Op Meds

History

Time	1710	1715	1720	1725	1730	1735	1740
SaO2	96%	98%	98%	98%	98%	98%	98%
FiO2	5L	6L	6L	6L	6L	6L	6L
Methods	NC	NC	NC	NC			
240							
220							
200							
180							
160							
140							
120							
100							
80							
60							
40							
20							
RR	14	12	15	12	11	12	12
T	98						
Time							
Pain (0-10)							
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1718	NS	300 tml	(R) FA	S Amundson	250 ml

X-rays:

Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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): b(6)-2 1LT AN

DEPARTMENT/SERVICE/CLINIC: TCU

DATE: 8 Jul 03

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

b(6)-4

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

MEDCOM - 6364

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1715	8	MSO4 2mg	IV	8	I	b(6)-2
1730	8	MSO4 2mg	IV	8	I	b(6)-2
1740		MSO4 6mg	IV		I	b(6)-2
1755		MSO4 6mg	IV		E	b(6)-2

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) foot	+	+		5	W	PK
15'							
30'							
45'							
60'							
90'							
D/C							

Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
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	(R) leg	Acewrap	CD&I
30'	(R) leg	Acewrap	CD&I
60'			
D/C			

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

1710 - recieved client from OR via litter c anesth & RN - client placed on monitor NS infusing into (L) FA PIV, site patent - Ø S/Sx of infiltration / infx - Dsg to (R) leg CD & I JP drain x 1, Ø output Peripheral IV to (L) FA patent Ø fluids site HL'd - client able move toes (R) foot pulses palpable cap refill brisk <2 sec

1715 - medicated c 2mg MSO4 for pain

1730 - renedicated for pain 2mg MSO4

1740 - 6mg IV MSO4 for pain client says he is 1— pain notified Dr [b(6)-2] 6 more mg of MSO4 given

1800 - Pain level decreased client relaxed, resting c eyes closed

1805 - Report given to CPT [b(6)-2] in PACU.

1810 Client transported on litter to PACU c two assists

[b(6)-2]

Discharge Criteria:
Date: 8JUN03 **Time:** **PARS:** 10
BP: 118/67 **T:** 98? **HR:** 69 **RR:** 12 **Sa02:** 96%
Pain Level at D/C (0-10): 1/10
Intake: 250 ml NS **Output:** 0
Additional Data:
Transferred To: PCU
Report Given To: CPT [b(6)-2]
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: [b(6)-2]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [b(6)-2]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(3)-1	I Z	(b)(6)-4	(b)(6)-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19680801	035Y	X	9	UNKNOWN

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U Z	0615 ~~0535~~	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
NO	K78	093230006

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 0	ICW	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
26		20030713

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
AEAA		20030705

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

FOR LOCAL USE

DX: ~~MUTIPLE SHRAPNEL WOUNDS TO RIGHT THIGH~~

GSW RIGHT THIGH WITH TRANSECTION QUADRICEPS

DX 8901

2851

E9412

PROC 8365

8628

Trauma 9

Inj 450

(b)(6)-2

(b)(6)-2

ADMITTING OFFICER (Signature, as required)

(b)(6)-2 LTC, MC

(b)(6)-2 SSG, 91G

DA FORM 2985, MAR 2000 · EDITION OF MAR 89 IS OBSOLETE · USAPA V1.00

MEDCOM - 6366

(b)(3)-1

PATIENT 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
(b)(6)-4	(b)(6)-4			NO	
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M		UNK	UNK	NO	NO	NO
11. FMP	12. SSN			13. ORGANIZATION		14. WARD
99				NO		OR/ICU
15. FLYING STATUS	16. RATING/ OSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. LRC/ZIP		20. TYPE CASE
NO		K78	NO			BI

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM ER	0035	ABAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
NO	EVAC	08 JUL 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
NO	NO	08 JUL 03	DR. (b)(6)-2

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
(b)(3)-1		

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY
GUN SHOT WOUNDS

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES
DX: GSW TO RIGHT MANDIBLE AND RIGHT THIGH

35. Total Days This Facility

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

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
(b)(6)-2	0	0	(b)(6)-2	1	1

SIGNATURE (b)(6)-2 CAL, LTC, MC

(b)(6)-2 SSG, NCOIC PAD

DA FORM 3647, MAY 79 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

MEDCOM - 6367

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

≈ 20yo M c/p GSW Face, (R) LEx. Seen at 240 PST → tracheostomy, wound exploration in Face + (R) LEx and packed.
Pt is 28 CM EO NO stable c copious oozing from facial wounds.
On ventilator pm/hx.

PHYSICAL EXAMINATION

130/64 P60
Moves LUEx, B. lat LEx c stimulation.
Paralyzed, No purposeful response.
Ment: Large (R) open wound packed. Oozing c copious bleeding
Cran: eyes CV reactive, Abd benign.
Ext: RLEx wound dressing

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

A/ GSW Face; RLEx s/p debridement at [redacted]

P/ ICU evaluation

[redacted]

SIG

DATE

IDENTIFICATION NO.

ORGANIZATION

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

REGISTER NO.

WARD NO.

[redacted]

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

[redacted]

MEDCOM - 6368

MEDICAL RECORD	PROGRESS NOTES
DATE	
7/8/03	Discharge Summary : 30yo Iraqi ♂ s/p GSW to face and Right LEx: Taken initially to (b)(3)-1 where facial wound debrided, packed tracheostomy placed and leg wound debrided. Tx soon thereafter to (b)(3)-1 where, upon evaluation in ED pt noted to have massive oropharyngeal bleeding. Taken to OR emergently and bleeding stopped by approximating tongue c 2-0 chromic running sutures. Mandible noted to be unstable with displaced open fracture @ angle @ mandible as well as displaced fracture on contralateral anterior mandible. In addition palate noted to have trauma. Due to limited experience with this, I packed the oropharynx, carefully placed an OG tube and stabilized patient in TICU and discussed case with Dr. (b)(6)-2 who will evaluate patient at (b)(3)-1 Current meds are: LR c IVF/hr; Zantac 50mg IV q8; Propofol sedation; Ampicillin 1g IVP q6°; Clindamycin 600mg IV q8° Patient returned 4y pROC in 28cSY OR, 2u FFP postop. Pt ap not stable c 33% Dressing changed this Am c minimal bleeding.

(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.

PROGRESS NOTES
Medical Record

(b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7 Jul 03	(b)(3)-1 OPERATIVE NOTE
TIME: 2332	~~Pre-op~~ s
T:	Pre-op Dx: (1) GSW to (L) upper Lip → (R) mandible Rx/ex.f
R:	(2) GSW (R) post thigh (No Rx NVI distally, Pulses (DP/PT) in
B/P:	(3) GSW (R) Lower leg (superficial)
P:	Post-op Dx: Same
MED:	PROCEDURE: (1) ZONE 3 neck exploration,
	Resection of (R) Submand-Sublin gland, (R) Carotid intima
ALLER:	(2) TRACHEDSTOMY GSW thru the hyp, upper incisors
	(3) I+D (R) leg GSW x 2 (R) mandible shattered Comminuted Steady
LMP:	SURGEONS: (b)(6)-2 (b)(6)-2 (b)(6)-2
	ANESTH: GET (b)(6)-2
TOB:	EBL: 500 cc
	FLUID: 2900 cc LR 2 u PRBC
ETOH:	FOLEY to gravity
	TRACHEDSTOMY
PMHx:	COMPLICATIONS Ø
PSH:	Dep → CSH tracheal, Chemically Paralyze (b)(6)-2
	(b)(6)-2 MD
FMHx:	Patient received instructions regarding diagnosis, plan of care, medications, follow-up, and verbalizes understanding. Initials: _____ MAJ MC
	ORTHO — (b)(3)-1

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
(b)(3)-1		ARMY	D.A.S.
SPONSOR'S NAME	**SSN/ID NO.**	**RELATIONSHIP TO SPONSOR**	USA (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.

NAME AND RANK: MALE IRAQI CIV

SSN:

DOB:

UNIT AND UNIT PHONE:

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

MEDCOM - 6370

Arrived → (b)(3)-1 ō GSW to face + leg
+ imminent loss of airway. Emb tracheal
intubation successful. → OR for Neck exploration
+ leg wound debridement.
No reliable hx by trauma.

(b)(6)-2 NS

NSN 7540-00-634-4176 AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7 JUL 03	047) 119/67 P-77 R-34 02-100 T-
	052) 132/66 68 -30 100
	0100) 152/74 73 22 100
	0105) 151/71 85 17 100
	0110) 151/77 78 20 100
	0115) 149/82 101 14 100
	0120)
	MEDS ~~ORDERED~~
	ANCef 1 gm
	TETANUS. SCC (IM)
	S(1L+) TR

HOSPITAL OR MEDICAL FACILITY (b)(3)-1	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.)*

(b)(6)-4

REGISTER NO.	WARD NO.

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

MEDCOM - 6372

MEDICAL RECORD	PROGRESS NOTES
DATE 8 July 03 0230	Received client from OR on litter transported by MD and anesthesia and an RN. client placed on cardiac monitor and placed on Icu bed c fine assists [b)(6)-2] wts.
0300	Assessment done, PERRL, sedated on 25mcg/kg/min of propofol infusing @ 10.5 ml/hr based on approximate weight of 70 Kg. Lungs clear bilat, vent settings VT 700ml, rate 8, peep 5, FiO2 50%. client marked c moderate amt of bloody drainage on back dressing. #8.0 shiley trach in place c sutures and trach ties, even bilat chest rise. HR sinus rhythm -> sinus tach, regular. pulses weak but palpable. Abdomen semi firm, slightly distended, (+)BS x 4 quads. OGT to LIS. placement checked, no gurgling heard over stomach, placement also checked by another RN (MAJ [b)(6)-2] unable to verify placement, Dr [b)(6)-2] notified stated "I heard it when we put it in so leave it to [b)(6)-2] suction." foley patent and draining yellow urine c some sediment noted. right radialant line placed by Dr [b)(6)-2], zeroed, good waveform on monitor, good blood return, connected to pressure 300mmHg bag. Dsg applied via sterile technique. Right and left AC PIVS c LR @ 60cc/hr via left AC. Both sites flushed and patent @ blood return, no S/S of infection or infiltation. Dsg to face with large amt of [b)(6)-2] bloody drainage, reinforced by Dr [b)(6)-2]. Large bandage dressing → (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. ICU

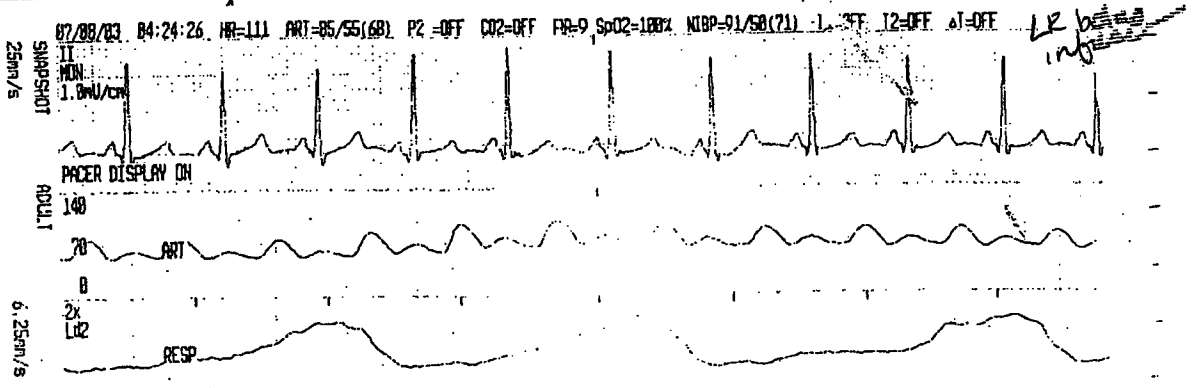
[b)(6)-4]

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
	to right leg c moderate amt of bloody drainage. (b)(6)-2 VCT RN
0335	HR ↑ 130's, medicated c 4mg MS for pain (b)(6)-2
0400	BP ↓ in 70s/50's, Dr (b)(6)-2 notified IC LR bolus started at this time. Disc to face with increased drainage, will monitor closely (b)(6)-2 VCT RN
0445	Abg results to Dr (b)(6)-2, 2 amps NaBicarb given IVP for acidosis. (b)(6)-2 VCT RN



LR bolus infusing

0500	Late note: @ 0230 report received from CRT (b)(6)-2 CRNA proceedure done was oral and facial exploration c glossoraphy under general anesthesia. client received 3mg versed, 10mg vecuronium and 100mg fentanyl given ~~dur~~ in OR. Also 1gm Ancef, 2L NS, 2L RL and 4 units PRBC in OR. EBL 500cc + 1500cc urine out in OR. (b)(6)-2 VCT RN
0500	Report given to CRT (b)(6)-2 (b)(6)-2 VCT RN

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
7/8/03 0530	NN: Assumed care of patient at 0500. Labs sent H/H; 33.7/11.0, WBC 18.6, PH 86. FFP ordered. ABG done; PH 7.26, CO_2 44.8, O_2 131, HCO_3 20 rate increased from 8 to 10. Assessment done. (b)(6)-2 CPT/AN
7/8/03 0630	At 0600 patient became hypotensive 68/35, propofol stopped, pt put in trendelenberg, bolused ☰ 1 Liter NS. B/P improved ☰ bolus. Patient awake ☰ propofol, moving arms and legs. Propofol restarted at 1/2 rate, 12.5 mcg/kg/min. Will monitor closely, FFP given. (b)(6)-2 CPT/AN
7/8/03 0730	ABG rechecked PH 7.315, CO_2 39.5, PO_2 127, HCO_3 20. Trach care done, moderate amount bloody ☰ drainage suctioned from trach (b)(6)-2 CPT/AN
7/8/03 0830	Pulses to (B) LE noted to be weaker than to UE. Feet cool to touch. Pulse not palpable on LLE, doppler only, barely palpable on (R) LE good on doppler. Ortho MD aware, will monitor. (b)(6)-2 CPT/AN
7/8/03 1000	Facial drg D'ed by MD's. Bolused ☰ 10mg Propofol. A/E paper work complete (b)(6)-2 CPT/AN

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

(b)(6)-4

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

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Name) (b)(3)-1

LOG NUMBER NA

ARRIVAL
DATE: DAY 07 MONTH Jul YR 03 TIME 032

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) PLANE

CURRENT MEDS. (tetanus immunization and other data) NA

HISTORY OBTAINED FROM ☐ PATIENT ☐ OTHER (Specify)

ALLERGIES NA

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

HOME TELE. NO. (Inc. area code) NA

CHIEF COMPLAINT(S) (Include symptom(s), duration) Gunshot wound L arm R thigh FACIAL EXAM

SEX M AGE NA

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

VITAL SIGNS			
TIME	032	037	042
BP	69/45	62/28	100/28
PULSE	147	70	59
RESP.	16	26	23
TEMP.	98.4		
WT. (Child)	99	98	100

CATEGORY (See reverse)
☒ EMERGENT
☐ URGENT
☐ NON-URGENT

ORDERS	INITS.	TIME
Central line		040
Xrays		042
Labs ABG, BCC, Clon, TYPE+4		043
Td Avert 1 gm IV		
IV NS TV 200, R14, 1.5 Peeps		

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

TIME SEEN BY PROVIDER 032

042 Xrays ordered (AP Lat SKULL, R Femur PM42?
R Leg, & Chest TOI ~2130
043 Labs - CBC UA, & Chem 12

S: Pt is a ~30yo Iraqi EPW who was shot x 3 by US forces as he was firing a weapon while riding a motorcycle. Taken to FST & had Trach done

O: Intub, moves all 4's spont. Massive trauma to R Jaw/face. Maxillary fx. Trach in place. Tm's white PERRL EOMI 4mm. Resp CTA from OCrep.
Lungs: CTA.
Cor: RRR
Abd: OBS, NT ND.
Ext: Lg R lat thigh tissue defect DP pulses, mult lower R leg abrasions & lacerations

Xray: Comminuted fx R sinus opacification
NLC/R. DPTF.
Ext: mult frags OF.

EDC: hypotension to 50's/20's improved p
Level I via L Subclav. Cent line.

11 > 7/23 < 170

7.32/32/415/-7/100%

TdC x2.

ASSESSMENT/DIAGNOSIS
GSW R Jaw/face
GSW R Thigh, mult Abrasions

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

CONDITION UPON RELEASE
☒ IMPROVED ☐ UNCHANGED
☐ DETERIORATED

TIME OF RELEASE: 0115

(b)(6)-2

SI ____ (507, IF NEEDED)

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

(b)(6)-4

ID STAMP 03 (b)(6)-2

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

To OR.

EMERGENCY CARE AND TREATMEN
MEDCOM - 6376 ...JV

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR

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
7/8/07	Operator		Nbk
	Procedure		Facial wound Debridement
			Glut sagittal
	Surgeon		Mahmoud Dem
	Pre op		Hgb 14 Hct 42 WBC 5.0
	EBL		100 cc
	To Tech		contact
	Findings		① Comminuted mandibular Fracture c displacement at angle.
			② Trauma to tongue approximated c 2-0 chromic
			③ No plates

(b)(6)-2

WATERMARK

(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 - 6377

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

For use of this form, see AR 40-68, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Anesthesia Staff BY [redacted] (b)(6)-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT (b)(6)-2

3. DATE 20030708 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0116 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Paralyzed

6. NURSING PERSONNEL

ASSIGNED SCRUB	SRC (b)(6)-2 SST (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: arms (bilat) tucked & padded. Strap across waist

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

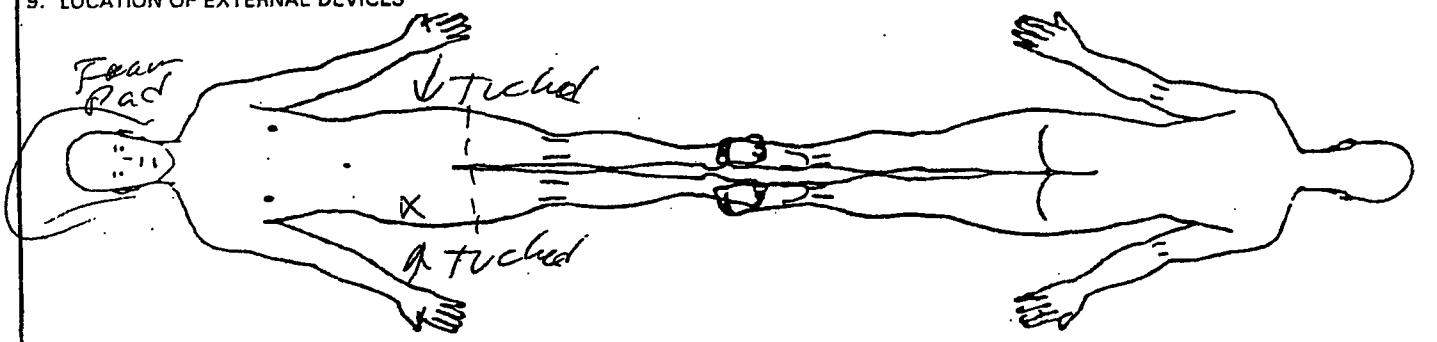
PREP SOLUTION *(Specify)* N/A

SITE: BY WHOM:

SITE: BY WHOM:

COMMENTS:

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
Sponge	☒ Yes ☐ No		C	C
Needle Sharp	☒ Yes ☐ No		C	C
Instrument	☐ Yes ☐ No			
Other	☐ Yes ☐ No			

SCRUB: SRC (b)(6)-2

CIRCULATOR: CPT (b)(6)-2

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

(b)(6)-4

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

☒ ESU NO: Valley Lab 00042

GROUND PAD: BRAND

LOT NO: 10527

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): 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)* 4X8 gauze Raytec x 2 Fluff Rest x

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 16 Fr Foley in place	2. Trached	3.
SITE	1. Urethra Bladder	2. Trach	3.

19. ADDITIONAL INFORMATION

2 Raytecs used as packing
maj [b)(6)-2] CRNA, CPT [b)(6)-2] : Anesthesia (CRNA)
DR. [b)(6)-2] DR. [b)(6)-2] : Surgeons

20. OPERATION(S) PERFORMED Facial Buccal exploration
Glossorraphy

21. PATIENT TRANSFERRED TO TCU TIME 0021 METHOD Litter

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

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

MEDCOM - 6379

Ward/Section: EMT

REQUESTING PHYSICIAN: (b)(6)-2

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

LAST FIRST MI: (b)(6)-4

DATE: 07 July

TIME: 0410

SSN/PSEUDO SSN:

Hematology/Chemistry

TEST	RESULT	REF. RANGE
WBC	11.4	4.8-10.8 x 10^3
RBC	2.40	4.7-6.1 x 10^3
Hgb	7.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	22.8	42-52% (M) 37-47% (F)
MCV	95.0	80-94 fl (M) 81-99 fl (F)
Plt	170	130-500 x 10^3 verified
Lymph %	17.4	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	SL Cloudy	N/A
Glu	NEG	Negative
Bili	NEG	Negative
Ket	NEG	Negative
SG	1.020	N/A
Bld	TR	Negative
pH	6.0	N/A
Prot	Tr	Negative
Urob	0.2	0.2-1.0
Nit	NEG	Negative
Leuk	NEG	Negative
HCG		Negative

Urine Microscopic

Cell Count		
Directigen		Negative

STD 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		

Other Comments/Results

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:

DATE:

LAB ID NO.:

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

TEST	RESULT	REF. RANGE
ALB	1.6	3.5-5.5 g/dl
ALP	26	26-84 u/l
ALT	10	10-47 u/l
AMY	102	14-97 u/l
AST	26	11-38 u/l
TBIL	2.2 *	0.2-1.6 mg/dl
BUN	8	7-22 mg/dl
CA^{++}	6.0	8.0-10.3mg/dl
CHOL	29 *	100-200 mg/dl
CRE	0.9	0.6-1.2 mg/dl
GLU	201	73-118 mg/dl
TP	2.7 *	6.4-8.1 g/dl

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

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

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

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

REMARKS:

REPORTED BY: (b)(6)-2

DATE: 07 Jul 03

LAB ID NO.:

Ward/Section ICU | REQU | PHY (b)(6)-2 | CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI | DATE | TIME | SSN/PSEUDO SSN

(i-STAT)			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na		138-146 mmol/L	ALB		3.5-5.5 g/dl	GLU		73-118 mg/dl
K		3.5-4.9 mmol/L	ALP		26-84 u/l	BUN		7-22 mg/dl
Cl		98-109 mmol/L	ALT		10-47 u/l	CA**		8.0-10.3 mg/dl
pH	7.189	7.31-7.45	AMY		14-97 u/l	CRE		0.6-1.2 mg/dl
PCO2	46.0	35-45 mmHg (art) 41-51 mmHg (ven)	AST		11-38 u/l	NA*		128-145 mmol/l
PO2	142	80-105 mmHg (art) N/A (ven)	TBIL		0.2-1.6 mg/dl	K*		3.3-4.7 mmol/l
TCO2	19	23-27 mmol/L (art) 24-29 mmol/L (ven)	BUN		7-22 mg/dl	CL*		98-108 mmol/l
HCO3	18	22-26 mmol/L (art) 23-28 mmol/L (ven)	CA**		8.0-10.3mg/dl	tCO_2		18-33 mmol/l
sO2	99	95-98%	CHOL		100-200 mg/dl	**(Piccolo) Liver Panel Plus**		
BEecf	-11	(-2) – (+3) mmol/L	CRE		0.6-1.2 mg/dl	TEST	RESULT	REF. RANGE
AnGap		10-20 mmol/L	GLU		73-118 mg/dl	ALB		3.3-5.5 g/dl
Ca		1.12-1.32 mmol/L	TP		6.4-8.1 g/dl	ALP		26-84 u/l
BUN		8-26 mg/dl	**(Piccolo) Medivet 8**			ALT		10-47 u/l
GLU		70-105 mg/dl	TEST	RESULT	REF. RANGE	AMY		14-97 u/l
Creat		0.7-1.5 mg/dl	GLU	163	73-118 mg/dl	AST		11-38 u/l
Hct		38-51% PCV	BUN	7	7-22 mg/dl	TBIL		0.2-1.6 mg/dl
Hgb		12-17 g/dl	CRE	1.1	0.6-1.2 mg/dl	GGT		5-65 u/l
Misc. Chemistry			CK	688	39-380 u/l (M) 30-190 u/l (F)	TP		6.4-8.1 g/dl
TEST	RESULT	REF. RANGE	NA*	137	128-145 mmol/l	**(Piccolo) Electrolyte**		
Troponin-I			K*	4.3	3.3-4.7 mmol/l	TEST	RESULT	REF. RANGE
Drug of Abuse			CL*	115	98-108 mmol/l	NA*		128-145 mmol/l
			tCO_2	18	18-33 mmol/l	K*		3.3-4.7 mmol/l
						CL*		98-108 mmol/l
						tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY: (b)(6)-2 | DATE: 08 Jul 03 | LAB ID NO.:

(Subject to the Privacy Act of 1974)

LAST FIRST MI: (b)(6)-4 | (b)(6)-2 | DATE: 7/8 | TIME: 0530 | SSN/PSEUDO SSN: (b)(6)-4

Hematology CBC

TEST	RESULT	REF. RANGE
WBC	18.6	4.8-10.8 x 10^3
RBC	3.70	4.7-6.1 x 10^9
Hgb	11.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	33.7	42-52% (M) 37-47% (F)
MCV	90.9	80-94 fl (M) 81-99 fl (F)
Plt	86	130-500 x 10^3 verified
Lymph %	10.2	20.5-51.1%

Hematology Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count			
Directigen		Negative	

Misc Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

(b)(6)-4 | 7/8 0230 | (b)(6)-4

DSOU

Ward/Section: ICU	REQUESTING PHYSICIAN: (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: (b)(6)-4	DATE: 7/8	TIME: 0530
		SSN/PSEUDO SSN: (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

(Piccolo) Metabolic 8

TEST	RESULT	REF. RANGE
GLU	139	73-118 mg/dl
BUN	8	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	817	39-380 u/l (M) 30-190 u/l (F)
NA+	133	128-145 mmol/l
K+	4.5	3.3-4.7 mmol/l
CL-	114	98-108 mmol/l
tCO_2	22	18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-4

7/8 0530

(b)(6)-4

1000

MEDCOM - 6384

10 Dec 12

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

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

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

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

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

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

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

REMARKS:

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

ELN

OK

(b)(6)-4 (b)(3)-1 (b)(6)-4

Ward/Section: OR | REQUESTING PHYSICIAN: (b)(6)-2 | **LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, M: (b)(6)-4 | DATE: 8 July | TIME: 0145 | SSN/PSEUDO SSN:

Hematology

TEST	RESULT	REF. RANGE
WBC	15.2	4.8-10.8 x 10^3
RBC	2.26	4.7-6.1 x 10^9
Hgb	6.8	14-18 g/dl (M) 12-16 g/dl (F)
Hct	21.1	42-52% (M) 37-47% (F)
MCV	93.2	80-94 fl (M) 81-99 fl (F)
Plt	79	130-500 x 10^3 verified
Lymph %	9.2	20.5-51.1%

Hematology (Manual Differential)

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

Cell Count

Cell Count		
Directigen		Negative

Micro 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		

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation

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

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

UNIT	TYPE	CROSSMATCH

REMARKS:

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

(OVERPRINT

Standard Form 517

CLINICAL RECORD — ANESTHESIA

ANESTHETIC(S) — 2200 15 20 45 2300 15 HOUR 45 0000 15 30 45 0100

Etomidate 20 mg
Sux 100 mg
Vec 10 mg
Succinylcholine 200 mg
Fentanyl (ug) 50 100 100

% —
L/M OXYGEN 5 5 5 5 5
CO, ABSORP.
EKG
LEVEL OF ANAL-ANESTH
PCS
TEMP
FI02 52 52 52 52 52
CODE — O2Sat 98 100 100 100 100
ECO2 25 26 27 28 28

● PULSE
○ RESP.
V
^ B.P.
X ANES.
@ OPER.
T TOURN.

220 200 180 160 140 120 100 80 60 40 20

FLUIDS
B BLOOD
N SALINE
G 5% D/W
DX EXPAND

RR 40 40 40 40 40

NUMBERS FOR REMARKS

IV FLUIDS LR 1000 2000 2000 500 500
Hespan 500 500
300

POSITION Supine 250

AGENTS AND TECHNICS
CETA

INDUCTION
SATIS ✓
UNSATIS AND WHY

REMARKS
✓ Patient ID
✓ Chart Rev
✓ Equip & D
✓ checked
Patient an
anesthesi
reassesse

X 2130 2145
2900 2205

2130 Pt c
CSW to (R) fac
& (R) leg
emergently
intubated.
2145 TO OR
2255 Throat
Pack in.
2305 TO
PACU

ENDOTRACHEAL: SIZE — BLADE MAC — ORO 7.5 — NASO — CUFF — PACK — C IV view
REMARKS: DL x3 (+) BBS (+) ETCO2

RECOVERY
REFLEX IN O.R. (+)
EMESIS (-)
ASPIR. (-)
EXCITEMENT (-)
HYPOTENSION
OTHERS

OPERATION PERFORMED
I+D CSW to Face + (R) Thigh

TOTAL FLUIDS
LR 960 ml
NS 2000
Hespan 500
EBL 260 ml

NAME(S) OF SURGEON(S)
(b)(6)-2 (b)(6)-2
(b)(6)-2
CCT/USN

PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last, first, middle; grade; date; hospital or medical facility)
(b)(6)-4

REGISTER NO.
WARD NO. (b)(3)-1
DATE 07 JUL 05

ANESTHESIA

Standard Form 517
Prescribed by GSA/ICMR
FIRMR (41CFR) 201-45.506
OCTOBER 1975
517-111

MEDCOM - 6387

MEDICAL RECORD — ANESTHESIA

ANESTHETIC AGENTS AND FLUIDS

DRUG	(Units)
Midazolam	(mg) 3
Vec	(mg) 5 5
Fentanyl	(mcg) 50 50
	( )
	( )
	( )
VOLAT. AGENT	% del 1.8 1.4 1.0 0.8 Y
	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min 2 2 2 2 2

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

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

TOTALS	TOTAL IVF
3	500cc
10	
150 mg	TOTAL URINE
Y	1500 cc

FLUIDS – SUMMARY
CRYSTALLOID– 500cc LR
COLLOID– —
BLOOD– 4u PRBC

INTAKE

LINE site	☐ Warmed	
NS	☑ Warmed	700 2000
LR	☐ Warmed	300
PRBC	☐ Warmed	1-2 3 4

LOSSES: EST BLOOD LOSS; URINE –

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

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 23

INITIAL DATA: BP – 116/61; HR– 107

BLOOD CHECK: OK?– (Y) N

PATIENT READINESS: OK for PROCEDURE (Y); TIME– 0120

TIME → 0115 30 45 0000 15 30 45 0100 15 30 45

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

220 200 180 160 140 120 100 80 60 40 20

VENTILATION

VT – ml	650 670 730 [illegible] 750
f – breaths/min	8 8 8 8 8
Peak inf pres / PEEP	28 26 25 23
MODE– S(pon), A(assist), C(on)	A C C C

MONITORING

✓ BP/Auto Cuff	✓ ET CO2 (torr)	28 31 24 30 32
BP / oth	✓ FIO2 (Frac or %)	.8C .8C .8C .8C
ART line	✓ SpO2 (%)	100 100 100 100
Steth- PC/ES	✓ ECG	ST ST ST ST ST
✓ Gas analyzer	✓ TEMP- site Axu	
	✓ N-M Block (T/4)	0/4 0/4
Warming blkt		✓
Conv warmer		

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

REMARKS
Code drugs with numbers, events with letters
0122 → in OR (Emergent Monitors on. Transient via 11 Fr c via AMB via trach.
#1 [b)(6)-4] @ 0
#2 [b)(6)-4] @ 013
#3 [b)(6)-4] @ 0157
#4 [b)(6)-4] @ 021
0215 Anes lg WPB and Roc
0221 To ICU via OR table. VSS. Report to RN. O2 on transport via AMB
57 MV TV 700 28 PEEP 5 FiO2 100%.

RECOVERY AT 0221
PACU ICU (Specify)
OTHER T=96.3
CONDITION: Stable
RESP– 8 SpO2– 100
BP– 125/78 HR– 90

ANES	Start	Room	End
	0118	0125	0330
PROC	Ready	Begin	End
	0127	0128	0220

PROCEDURES and CPT Codes
Facial & oral exploration & glossorraphy

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Trach → @ BBS2 @ ETCO2 sustained

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

SURGEONS: [b)(6)-2] / [b)(6)-2]
ANESTHETISTS: [b)(6)-2] / [b)(6)-2] LCDR
[illegible] CRNA

PROCEDURE LOCATION OR 1-1
DATE 8 Jul 03
PAGE 1 OF

MEDICAL RECORD – ANESTHESIA
WAMC OP 37 REVISED 1 Jan [illegible]
MEDCOM - 6388
*U.S. GPO: 2002-729-180/40137

PREANESTHETIC SUMMARY

OPERATION PROPOSED	AGE	WEIGHT(LBS.)	SPECIAL INFORMATION
		WT: 70 kg	CSW to face of (R) thigh.
		PHYSICAL STATUS 1 2 3 4 5 6 7 (E)	

URINALYSIS	HEMATOLOGY	BLOOD CHEMISTRY
NORMAL _____ ABNORMAL AND WHY?	HGB_____ RBC_____ HCT_____ OTHER	

RESPIRATORY SYSTEM	CIRCULATORY SYSTEM	CENTRAL NERVOUS SYSTEM	OTHER SYSTEMS
(X-RAY, ASTHMA, OTHER PATHOLOGY)	BP_____ PULSE_____ ECG (IF PERTINENT)	(CEREBROVASCULAR, POLIO, NEUROLOGICAL)	(ALLERGIES)
ASTHMA:	CVS:	NEURO:	RENAL:
SMOKING HX:	MI:		HEPATIC:
URI:	ANGINA:	SEIZURE:	GI:
PNEUM:	MURMUR:		DM:
BRONCHITIS:	RHEUM FEVER:	DENTITION:	THYROID:
TB:	HTN:	AIRWAY:	STEROIDS:
EXERCISE TOL:	EKG:		

PREVIOUS ANESTHETICS AND COMPLICATIONS

PRESENT DRUG THERAPY: E.G., STEROIDS, TRANQUILIZERS

FAMILY HX OF ANESTH COMPLICATIONS

PREOPERATIVE DIAGNOSIS

PREMEDICATION

PATIENT COUNSELLED REGARDING ANESTH OPTIONS, RISKS AND POSSIBLE COMPLICATIONS DISCUSSED. PATIENT VERBALIZES UNDERSTANDING & ACCEPTANCE OF PLAN.

(b)(6)-2

ANESTH PLAN: GETA

DATE: 07 Jul 03

POSTANESTHETIC VISITS

RECORD ALL PERTINENT COMPLICATIONS

PACU ARRIVAL NOTE:

DATE: 07 Jul 03 TIME: 2305

PT TO: PACU

MENTAL STATUS: sedated

VS: B/P: 154/ P: 99 R: 10 TEMP: 02SAT: 96

02 GIVEN AT: 5 L/M VIA: Ventilator

SPINAL LEVEL: NA

ANES COMPLICATIONS: NA

ANESTHETIST: (b)(6)-2 CRNA

SURGEON: (b)(6)-2

RECOVERY NURSE: (b)(6)-2 (b)(6)-2

REPORT GIVEN TO: (b)(6)-2

PACU DISCHARGE NOTE:

DATE: TIME:

PT TO:

MENTAL STATUS:

VS: B/P: P: R: TEMP: 02SAT:

02 GIVEN AT: L/M VIA:

DC'd at: HRS.

SPINAL LEVEL:

COMPLICATIONS:

SURGEON:

RECOVERY NURSE:

REPORT GIVEN TO:

PRE-ANESTHESIA AND POST-ANESTHESIA EVALUATION

AGE: N 20 HRS DAYS MOS (YRS) SEX: (M) MALE ( ) FEMALE

PROPOSED PROCEDURE: _____ SURGICAL SERVICE: GS

ASA PHYSICAL STAUS 1 (2) 3 4 5 (E)
WEIGHT: N 70 (KG)/LB HEIGHT: _____ IN.
ALLERGIES: ? Unknown

HABITS: ?
TOBACCO: _____
ETOH: ?
DRUGS: _____

CURRENT MEDICATIONS:
([ ]= ordered as premed)
[ ] Ancef 1g.
[ ] Tetanus
[ ] _____
[ ] _____
[ ] _____
[ ] _____

PREMEDICATION:
None Yes (@ _____ Hrs) /OC
_____ _____ mg IV IM PO
_____ _____ mg IV IM PO
_____ _____ mg IV IM PO

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

PREOPERATIVE ASSESSMENT

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:	Hypertension	N	Y
	Angina	N	Y
	MI	N	Y
	CVA	N	Y
	Other	N	Y Unknown
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	N	Y
Endocrine System:	Diabetes	N	Y
	Steroids	N	Y
	Thyroid	N	Y
Neurological:	Seizures	N	Y
	Neuropathy	N	Y
	Other	N	Y
Gynecological:	Pregnancy	N	Y
Other Significant Hx:		N	Y
		N	Y
Familial HX			

PAST SURGICAL/ANESTHETIC HISTORY

PHYSICAL EXAMINATION 100%
BP 148/63 HR 102 RESP 14
HEENT - Teeth _____
Trachea Tracheal.
TMJ/Neck _____
Oropharynx _____
Nares _____
CHEST: CTA
CARDIAC: S1 S2 RRR
EXTREMITIES: _____
IV Access: LSC Cordis
Ulnar Filling: _____
BACK: _____
OTHER: _____

ANESTHETIC PLAN: [ ] Local [ ] MAC - [ ] Regional (Specify): _____ (X) General: Mask (Intubation)

INFORMED CONSENT/COUNSELLING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed wih the patient/legal guardian.
The patient [redacted] agrees. Questions answered.
Signed: [redacted] CRNA DATE: 8 JUL 03 TIME: 0148 Hrs

CONDITION UPON ARRIVAL TO P.A.R.R. _____
VITAL SIGNS: BP _____ HR _____ RESP _____ SuO_2 _____
RESP STATUS: [ ] Spontaneous [ ] Assisted [ ] Cont'd See OR record
MENTAL STATUS: [ ] Awake [ ] Alert [ ] Lethargic [ ] Asleep
[ ] Responsive [ ] Unresponsive Block Level _____
REPORT GIVEN: [ ] Yes [ ] No

POST-ANESTHESIA EVALUATION AND NOTE
[ ] NO APPARENT ANESTHETIC COMPLICATIONS [ ] OTHER
Signed: _____ DATE: _____ TIME _____ Hrs

PATIENT IDENTIFICATION: (Ward: _____)

[redacted]

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED *(If applicable)*
_____ ML

REMARKS:

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

DATE REQUESTED 8 Jul 03

DATE AND HOUR REQUIRED 1540

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)*
(b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

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.

(b)(6)-2

DATE VERIFIED 8 Jul 03

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)-4

TRANSFUSION NO.

PATIENT NO. (b)(6)-4

DONOR	RECIPIENT
ABO O	ABO O
Rh Pos	Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	Compat

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE

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

SIGNATURE OF PERSON PERFORMING TEST
(b)(6)-2

REMARKS: EXP 08 Jul 2003

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* 0122 ON *(Date)* 08 Jul 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)* (b)(6)-2 CPT Cox

2nd VERIFIER *(Signature)* (b)(6)-2 MAJ Cruz

PRE-TR

TEMP. _____ PULSE 89 BP 137/9

DATE OF TRANSFUSION 8 Jul 03 TIME STARTED 0135

POST-TRANSFUSION DATA

AMOUNT GIVEN 350 ML

TIME/DATE COMPLETED/INTERRUPTED 0140 8 Jul 03

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[X] NONE [ ] SUSPECTED		84	137/74

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

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

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

SIGNATURE OF PERSON NOTING ABOVE
(b)(6)-2 MAJ Cruz

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

(b)(6)-4

SEX F WARD

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

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

MEDCOM - 6391

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)*

_____ ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 8 Jul 03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY O[illegible] (b)(6)-2 VERIFIED

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

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. / /

(b)(6)-2

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)-4

TRANSFUSION NO.

PATIENT NO. (b)(6)-4

DONOR	RECIPIENT
ABO O	ABO O
Rh Pos	Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	Compat

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE

REMARKS: EXP 08 Jul 2003

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* 0123 ON *(Date)* 08 Jul 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.

1 (b)(6)-2 CPT/CRNA

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION

TEMP. _____ PULSE 76 BP 138/78

DATE OF TRANSFUSION 7/8/03 TIME STARTED 0130

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

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN 350 ML

TIME/DATE COMPLETED/INTERRUPTED 0155 8 Jul 03

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[X] NONE [ ] SUSPECTED		76	138/78

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

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

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

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2 CRNA

WARD

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 6392

Medical Record Copy

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED *(If applicable)*: ____ ML

REMARKS:

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

DATE REQUESTED: 8 July 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*: (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: Mult Trauma

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: SEE Prev

DATE VERIFIED: 5F518

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)-4

TRANSFUSION NO.

PATIENT NO. (b)(6)-4

RECIPIENT

ABO O

Rh Pos

ABO O

Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	Compat

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE

REMARKS: EXP 08 Jul 03

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

SIGNATURE OF PERSON PERFORMING TEST: (b)(6)-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)-2

AT *(Hour)*: 0152 ON *(Date)*: 08 Jul 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)*: (b)(6)-2 MT/CRNA

2nd ____

PRE-TRANSFUSION

TEMP. ____ PULSE 90 BP 120/70

DATE OF TRANSFUSION: 8 Jul 03 TIME STARTED: 0212

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME COMPLETED	DATE	INTERRUPTED
ALL ML	0218	7/8/03	

REACTION
- [X] NONE
- [ ] SUSPECTED

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
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)* ____

SIGNATURE: (b)(6)-2 MT/CRNA

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

(b)(6)-4

SEX

WARD

BLOOD OR BLOOD COMPONENT TRANSFUSION STANDARD FORM 518 (REV. 8-85)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

MEDCOM - 6393

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED *(If applicable)*
____ ML

REMARKS:

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

DATE REQUESTED: 8 Jul 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

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

REQUESTING PHYSICIAN *(Print)*
(b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE
Mult Trauma

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
SEE prior

DATE VERIFIED

TIME VERIFIED 5F518

SECTION II – PRE-TRANSFUSION TESTING

(b)(6)-4

TRANSFUSION NO.

PATIENT NO.
(b)(6)-4

RECIPIENT

ABO O
Rh Pos

ABO O
Rh Pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	Compat

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

SIGNATURE OF PERSON PERFORMING TEST
(b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE

REMARKS:
EXP 08 Jul 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

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

AT *(Hour)* 0151 ON *(Date)* 08 Jul 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)*
(b)(6)-2 CPT/CRNA

2nd VERIFIER *(Signature)*
(b)(6)-2 MAJ/CRNA

PRE-TRANSFUSION

TEMP. PULSE 106 BP 103/52

DATE OF TRANSFUSION: 8 JUL 03

TIME STARTED: 0158

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME COMPLETED	INTERRUPTED
ALL ML	0210 7/8/03	

REACTION
- [X] NONE
- [ ] SUSPECTED

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
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO
- [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE
(b)(6)-2 CPT/CRNA

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*
(b)(6)-4

WARD

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDCOM - 6394

M CAL RECORD COPY

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

VOLUME REQUESTED *(If applicable)*: ____ ML

REMARKS:

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

DATE REQUESTED: 8 Jul 03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*: (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: Mult trauma

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

SIGNATURE OF VERIFIER

DATE VERIFIED: SEE prior

TIME VERIFIED: SF 318

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.: (b)(6)-4

TRANSFUSION NO.

PATIENT NO.: (b)(6)-4

	DONOR	RECIPIENT
ABO	A	O
Rh	POS	POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	N/A

PREVIOUS RECORD CHECK: [ ] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

[X] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE 8 JUL 03

REMARKS: 23 Feb 04 272 cc

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: (b)(6)-2

AT *(Hour)*: 0620 ON *(Date)*: 8 JUL 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)*: (b)(6)-2 CPT IAN

2nd VERIFIER *(Signature)*: (b)(6)-2 MAJ IAN

PRE-TRANSFUSION

TEMP. 96 PULSE 84 BP 131/66

DATE OF TRANSFUSION: 8 Jul 03 TIME STARTED: 0625

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

(b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN	TIME DATE COMPLETED	INTERRUPTED
270 ML	0647 7/8/03	

REACTION: [X] NONE [ ] SUSPECTED

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
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER ____

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [X] NO [ ] YES *(Specify)* ____

(b)(6)-2

NOTING ABOVE: CPT IAN

X ____ WARD ____

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

MEDCOM - 6395

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

(b)(6)-2

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	8 Jul 03	0230 HOURS	
1	Admit to ICU		X
2	Dx - GSW to face and (R) leg s/p laparotomy exploration		X
3	Cond: stable		X
4	VS - monitor		X
5	Activity - BR		X
6	Allergy - ?		X
	DATE OF ORDER	TIME OF ORDER HOURS	
7	Diet - NPO		X
8	~~NG~~ OG to LIS		X
9	foley to gravity		X
10	Vent: simv 700cc TV, Rate 8 PEEP 5		X
11	Strict I's and O's		X
12	~~NS~~ IV: LR @ 150 cc/hr		X
	DATE OF ORDER	TIME OF ORDER HOURS	
13	Meds: Propofol titrate for effect ~~fentanyl~~ MSO4 2-4mg IV q 1h prn pain Zantac 50mg IV TID		Start 25mcg/kg/min
14	CXR in AM		X
15	CBC, Medlyte 8, ABG in AM		X
16	ABG now		X
17	OG flush c 30cc of H_2O q 4 hours		X
	DATE OF ORDER	TIME OF ORDER HOURS	
18	Ampicillin 1gm IV q 6°		X
19	Clindamycin 600mg IV (over 30 min) q 8 (six)		X
20	Trach care q shift.		X
21	A-line to monitor.		X
	0330 08 Jul 03		LTC, m

Chart ✓ done

(b)(6)-2

FORM 4256 1 APR 79

PREVIOUS EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 6396

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.

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER 0400 HOURS | LIST TIME ORDER NOTED AND SIGN

1. DR. 1 L bolus X 1 now — done 0400 (b)(6)-2
2. Give 2 amps Na Bicarbonate now — done 0445 (b)(6)-2

V.O. Dr. (b)(6)-2

(b)(6)-2 — N/HSJ RN

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER _____ HOURS

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

MEDCOM - 6397

☆ [illegible] 4-383-710

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. July Yr. 2003

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 07 08 09 10 11 12 13
8 July 03	(b)(6)-2	VS q 1° x 4	05	(b)(6)-2
			17	(b)(6)-2
8 July 03		ACTIVITY: BR	05	(b)(6)-2
			17	(b)(6)-2
8 July 03		DIET: NPO	06	(b)(6)-2
			11	
			17	
8 July 03		Foley to gravity	05	(b)(6)-2
			17	(b)(6)-2
8 July 03		OG: flush ≥ 30cc H_2O q 4°	02	
			06	(b)(6)-2
			10	
			14	
			18	
			22	
8 July 03	(b)(6)-2	Trach care q shift	05	(b)(6)-2
			17	(b)(6)-2
8 July 03		A-line to monitor	05	(b)(6)-2
			17	(b)(6)-2
8 July 03		STRICT I/O's	05	(b)(6)-2
			17	(b)(6)-2
8 July 03		OG to LIS	05	(b)(6)-2
			17	(b)(6)-2

ALLERGIES: ☐ YES ☐ NO — Unknown

PRIMARY DIAGNOSIS: GSW to face & (R) leg s/p facial exploration

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

PATIENT IDENTIFICATION: (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 6398

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)		Mo July Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8 July	(b)(6)-2	Admit to ICU; DX: GSW to face & (R) Leg	8 July	0230	0230	(b)(6)-2
		S/P facial exploration & conditions stable				
8 July	(b)(6)-2	CXR now & 0m	8 July	0400	0400	(b)(6)-2
8 July		CBC Medlyte 8, ABG in AM	8 July	0400	done	
8 July		ABG x1 now	8 July	0300	done	

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. July Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 08 0809 10 14
8 July	(b)(6)-2	VENT: SIMV: 700 cc TV	05	/ (b)(6)-2
		Rate 8 Peep 5	17	Sn
8 July	(b)(6)-2	LR 150 cc/hr	05	/ (b)(6)-2
			17	Sn
8 July	(b)(6)-2	Propofol: start 25 mcg/kg/hr	05	/ (b)(6)-2
		titrate for effect.	17	(b)(6)-2
8 July	(b)(6)-2	Zantac 50 mg IV TID	06	/ (b)(6)-2
			14	/
			22	/
8 July	(b)(6)-2	Ampicillin 1 gm IV q 6°	4	/ (b)(6)-2
			10	/
			16	/
			22	/
8 July	(b)(6)-2	Ciprofloxacin 400 mg IV (over 30 min) q 8°	06	/ (b)(6)-2
			14	/
			22	/

ALLERGIES: ☐ YES ☐ NO — Unknown

PRIMARY DIAGNOSIS: GSW to face c/b Leg s/p facial exploration

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

PATIENT IDENTIFICATION: (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 7 Yr. 03			
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
8 July 03 [b)(6)-2]	1L LR bolus XT now	8 July 03	✓	0400	[b)(6)-2]
8 July 03	2 amps [b)(6)-2] Sodium bicarbonate IVP now	8 July 03	✓	0445	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
8 July	[b)(6)-2]	MSO4 2-4mg IV q 1° PRN pain	8 July 03 0335 4mg IV [b)(6)-2]

USAPA V1.00

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

REPORT TITLE: **POST ANESTHESIA FLOW SHEET** | OTSG APPROVED (Date)

OPERATION: GSW to (R) thigh & face SURGEON: Dr. [b(6)-2] [b(6)-2] [b(6)-2]

ANESTHESIA: General ANESTHETIST: CRNA [b(6)-2] [b(6)-2] ALLERGIES: Unknown.

TIME	TEMP	PULSE	RESP	O2 SAT	BLOOD PRESSURE PRE-OP	SPINAL LEVEL	C-SECT: FUNDUS LOCHIA PAD COUNT
pm 1110		125	11	95	86 146		
2315	~~98.8~~	88	16	100	119 140		
					/		
					/		
					/		
					/		
					/		
					/		
					/		
					/		
					/		

AIRWAY: SELF ORAL NASAL (ENDOTRACHEAL)
OXYGEN: LITERS / MIN NC % BLOW-BY
DC'd at _____ hrs
ASA LEVEL (1) 2 3 4 5 (E)
MEDICATION HISTORY: Unknown.

OTHER:
PRE-OP MEDICATIONS: Ancef 1GM.
ANESTHESIA MEDICATIONS: General

FLUIDS	TYPE	AMOUNT	OUTPUT	TYPE	AMOUNT
LR	LR	900		Foley	100
	NS	2000			
O.R.		2900	O.R.	EBL	~~200~~
	LR				
	Blood	650			
PACU			PACU		
	TOTAL	3550		TOTAL	350

POST ANESTHESIA RECOVERY SCORE		A	15	30	45	1	30	2	30	3	D
ACTIVITY	2 - Maintains head lift and open eyes; full motor activity 1 - Unable to maintain head lift/open eyes; partial motor activity 0 - Unable to lift head and open eyes; no motor activity	0									
RESPIRATORY	2 - Spontaneous respiration, coughs and deep breathes 1 - Limited effort; needs artificial airway or jaw support 0 - No spontaneous respiration; needs ventilator	0									
CIRCULATION	2 - BP ±20% preanesthetic level 1 - BP ±20-30% preanesthetic level 0 - BP ±50% preanesthetic level	2									
LEVEL OF CONSCIOUSNESS	2 - Awake and alert 1 - Arousable on calling 0 - Non-responsive	0									
COLOR	2 - Normal skin color 1 - Skin is pale, blotchy, dusky 0 - Cyanotic	2									
TOTAL		4									

LEGEND
F.F. = Fundus Firm
L.R. = Lochia Rubra
L.S. = Lochia Serosa
L.A. = Lochia Alba
U = Umbilicus
P.P. = Peri Pad

(Continue on reverse)

PREPARED BY (Signature & Title): SPC [b(6)-2] LPN/ [b(6)-2] LTC/AN. | DEPARTMENT/SERVICE/CLINIC: PACU/ICU | DATE: 7 July 2003

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name-last, first, middle; grade, rank; rate; hospital or medical facility)
Iraqi Male POW
[b(6)-4] [b(3)-1]

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

INITIAL ASSESSMENT

ADMISSION TIME: 1105	LUNGS: vent.
IV: CATHETER SIZE B C AC	
LOCATION 18g	ABDOMEN: BS x 4 quad
CONDITION Patent	
CARDIAC RHYTHM SR	SKIN: normal color
DRAINS / TUBES: endotrach	DRSG: C thigh, calf, & foot
NEUROVASCULAR STATUS:	

Cough & . .ep breathe? YES__ NO X
Affected extremity elevated? YES X NO__
Ice applied to operative site? YES__ NO X
Head of bed elevated? YES__ NO X
Heat lamps used? YES__ NO X
TIME ON _____ OFF _____
Warming blanket? YES__ NO X
TIME ON _____ OFF _____
Pediatric Patient? YES__ NO X
Parent at bedside? YES__ NO X
~~Safety instructions given?~~ ~~YES__ NO X~~
Parent verbalizes understanding? YES__ NO X

RECEIVING NOTE:
Patient received from: OR X L&D____ via:
Gurney____ Crib____ L&D bed____

Accompanied by: MD X CRNA X Other_____

Safety: Side rails up X 2? YES____ NO X
Safety belt in place? YES X NO____

DISCHARGE NOTE:
Complications? NO X YES____, describe:

Pt to ward via: Gurney X Crib____ L&D bed____

Accompanied by PACU/ICU staff.

Safety: Side rails up X 2? YES____ NO X
Safety belt in place? YES X NO____

ADDITIONAL NURSING NOTES:

Pt received with vent. at 4 brm. Vitals normal. Pt given O+ blood at 2315 with NS 300 cc. Pt has deformity to face due to GSW. Pt given O+ blood at 2327 with NS 332 cc, Endotrach in place, IVg to C & AC, Foley to gravity dressings dry & intact to C thigh, calf & foot. Oral cavity stuff with Kerlix suction to nares and side of mouth for gross blood loss. minimal blood loss but BP dropped. Responded well to crystaloid infusion of 500 cc (systolic 80-110 decision to give blood made prior transport

(b)(6)-2 Time ____

MEDICATIONS GIVEN IN PACU:

(b)(6)-4 1115 PM Blood started
volume 304

(b)(6)-4 2327 Blood started
volume 332

vectronium 10 mg

DISCHARGED AT: 2348 TO WARD: (b)(3)-1 DISCHARGED BY DR / CRNA

DRESSING R Leg

DRAINS / TUBES Endotrac

I.V. C AC LEFT TO COUNT: ~~5~~ 700 500

NEUROVASCULAR \ STATUS: unresponsive SPINAL LEVEL

REPORT CALLED TO: (b)(3)-1 CALLED BY: LTC (b)(6)-2

R.N. SIGNATURE: (b)(6)-2 LTC/AN

Reverse of FST MEDDAC FORM 229 (REC RM), Nov 99 Reverse

(b)(6)-4

7-8 July 1

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0730	INITIALS (b)(6)-2		INITIALS		INITIALS
NEURO		PUPILS	PERRL					
		SENSORIUM	Sedated from OR by anesthesia					
RESPIRATORY		RESPIRATORY PATTERN	rate & equent					
		BREATH SOUNDS	clear bilat					
		SECRETIONS	none					
			Vent 700 VT, R18, Peep 5					
			50% FiO2. #8 trach					
SKIN		COLOR	pale pink					
		INTEGRITY	see notes					
I.V. SITE		LOCATION						
		CONDITION	see notes					
GASTRO		ABDOMEN						
		BOWEL SOUNDS	all quads.					
GU		URINE:	foley → grantz					
		COLOR/CLARITY	yellow / small amt sediment noted.					
CARD-IOVASCULAR		CARDIAC RHYTHM	Sinus tach → Sinus rhythm. Pulses palpable bilat radial + pedals weak. cap refill 3 secs.					

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SaI - Saturation; TRACH - Tracheostomy

(Continue on reverse)

(b)(6)-2 | LT AN | DEPARTMENT/SERVICE/CLINIC ICU 2 west | DATE (b)(6)-2 8 July 03

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

(b)(6)-4

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

(b)(6)-4

8 July 0?

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff																		
Temperature																		
Pulse																		
Respiratory Rate																		
Oxygen Method																		
O2 Sat																		

pain intensity

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
LR																		
IVPB																		
OR fluids																		
PRBC from OR																		
TOTALS																		

OUTPUT

Foley URINE	HOUR																	
	TOTAL																	
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS	EBL from OR																	
TOTALS																		

(b)(6)-4

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS	21	22	23	24	0300 04	02	03	05	
						125/78	117/58	95/44	
						96		95	
						100	76	121	
						8	12	17	
						50%	50%	50%	
						vent	vent	vent	
						100%	100%	100%	

INTAKE	21	22	23	24	04	02	03	05	8° T
						150	150	1000	1300
								50	50
					→	400			400
						4 units			4 unit

OUTPUT						1500 Foley	1000	100	2600 1100
					→	500			500
									3100

RESPIRATORY

	TIME	0230								
	MODE	SIMV								
	F_iO_2	50%								
	TV	700								
	RATE	6								
	PEEP	5								
A	pH									
A	PCO_2									
	pO_2									
B	HCO_3									
	SAT									
G	BASE									

LABORATORY

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

ACTIVITY

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

TURN	TIME									
SUCTION										

24°I&O TOTALS

NURSE'S SIGNATURE | INITIALS

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

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

MEDCOM - 6406

ADMISSION ... CODING INFORMATION

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

1. REPORTING MTF	2. ...LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(3)-1	I Z	(b)(6)-4	(b)(6)-4	N O	M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
		X	9	UNKNOWN

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	NO	9 9	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	0035	NO

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
N O	K 7 8	0 9 3 2 3 0 0 0-0

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
[illegible] Z9	N O		YEAR [ ] X NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72 0	OR/ICU	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYYYMMDD)
2 1		2 0 0 3 0 7 0 8

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYYYMMDD)
A B A A		2 0 0 3 0 7 0 8

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYYYMMDD)
1 7		

FOR LOCAL USE

DX: GSW TO RIGHT MANDIBLE AND RIGHT THIGH

Dx: 87354
8901
E9912
Trauma Inj

PR: 311
2630
4040
8622

(b)(6)-2

(b)(6)-2 LTC, MC

(b)(6)-2

(b)(6)-2 SPC, 91G

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

MEDCOM - 6407

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) OA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

			INITIAL (b)(6)-2		INITIALS		INITIALS
NEURO	TIME	0600					
	PUPILS	Pupils 2mm, minimal					
	SENSORIUM	reaction to light, sedated					
		on propofol 20mcg/kg/min					
		off sedation, moves extremities					
		appropriately, wakes up some.					
RESPIRATORY	RESPIRATORY PATTERN	Vent SIMV rate 10, TV 700					
	BREATH SOUNDS	FIO_2 40%, peep 5. #8 Shiley					
	SECRETIONS	trach (cuffed). Sats 100%					
		moderate amount bloody					
		drainage suctioned from trach					
		lungs clear bilat, breathing easier					
SKIN	COLOR	Pale, cool to touch, bulky					
	INTEGRITY	due to head, moderate bloody					
		drainage noted, Kerlex/ace to					
IV SITE	LOCATION	LLE, small-mod bloody drng					
		Cordis (L) IJ, clamped					
		(L) AC 18g KVO 150, propofol					
		(R) AC 14g HL					
	meds:	Zantac TID, ampicillin Q6°					
		clindamycin Q8°					
GASTRO	ABDOMEN	Firm to touch, BS absent					
	BOWEL SOUNDS	no apparent tenderness. Ob					
		to LIS, minimal to 0 output					
		flushed Q4°					
GU	URINE:	Amber > 1cc/kg/hr					
	COLOR/CLARITY	foley, no bladder distention					
		noted					
CARDIOVASCULAR	CARDIAC RHYTHM	NSR, mild tachycardia 90's					
		BP stable in 90/70's					
		Pulses to BUE present / 50-60's					
		to LLE dopplar only, RLE					
		faint prep, good dopler.					

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; SVA - Fractional; SAI - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
(b)(6)-2 CPT, MN	ICU 2 east	8 July 03

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

(b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20
BP Arterial Line	108/50	87/42	124/70	105/60	105/55	114/60	111/59	116/63								
BP Cuff	100/49	75/35	122/60	161/50	104/57	114/53	114/57	115/59								
Temperature	95.9	96.0	96.9	97.7	99.4	99.3	99.2	99.3								
Pulse	85	75	93	98	101	96	106	100								
Respiratory Rate	16	10	13	17	18	12	12	10								
Sats	100	100	100	100	100	100	100	100								
FIO2	40%	40%	40%	40%	40%	40%	40%	40%								
pain																
intervention																

INTAKE

TIME	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	8°T
LR	150	150	150	150	150	150	150	150									
IVPB		150				50											
Bolus		1000															
Blood prod		270															
propofol	104	off	63	84	84	84	84	104									
NG flush		30				30											
TOTALS	160	1600	156	158	158	238	158	160									

OUTPUT

		HOUR / TOTAL	150 / 150	150 / 300	170 / 470	240 / 710	200 / 910	120 / 1030	280 / 1310	200 / 1510								
URINE		10 gr																
		SIA																
NG		OUTPUT	Ø				Ø											
		pH																
		GUIAC																
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

	21	22	23	24	01	02	03	04

INTAKE

	21	22	23	2401	02	03	04

8 T

OUTPUT

RESPIRATORY

		0530	0730
TIME		0530	0730
MODE		SIMV	SIMV
F_iO_2		40	40
TV		700	700
RATE		10	10
PEEP		5	5
ARTERIAL	pH	7.26	7.315
A	PCO_2	44.8	39.5
	pO_2	131	127
B	HCO_3	20	20
	SAT	98	99
G	BASE	-7	-6

LABORATORY

TIME	0580	
GLUCOSE	139	
Na/K	133/4.5	
Cl/CO_2	114/22	
BUN/Cr	8/0.9	
WBC/PLATELET	18.6/86	
Hct/Hgb	33.7/11.0	

ACTIVITIES OF DAILY LIVING

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

TURN

TIME						

SUCTION

24 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS

(b)(6)-2

MEDCOM - 6410