[redacted] [redacted]

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
1 AUG 03		2000	- Received PT from PACU responds to verbal stimuli. VSS HR NSR. Breath sounds clear B. lateral. C (-) % breathing difficulty. PT has (+) 2 DM to all extremity. C (+) Pulse motor function to all extremity. +2 cap ref. B5 x 4. PT has received 2000 cc of D5 1/2 from PACU C/O at any orientation. PT has IV of sodium chloride in (L) forearm running well C (-) S/S of infection or infiltration. MD reports states PT has (-) fractures to any bones in body and all x-rays are (-). Still need MD to write down orders regarding C-collar. SO maintain C-collar precautions. Peerla. (-) orbital fractures, or mandibal fractures noted. PT is currently resting in bed, will continue to monitor. [redacted] b(6)-2
		2200	Pt. received @ 2100. VSS. Pt. alert, attempting to communicate, @ english. ferrla. HK Reg, lungs CTA, ABD soft & flat C BS @ XY. Pt c/o lower ABD tenderness C palpation. Pt. on C-spine precautions C full ROM x 4 ext, pulses 2+ x 4 ext, brisk cap refill, (+) sensation x 4 ext. IV to (L) FA intact, infusing D5 1/2 C 20 meq KCl @ 100 cc/hr. will cont. to monitor. [redacted] b(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

NURSING NOTES

Medical Record

[redacted]

MEDCOM - 15641

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR August 2003 DAY

HOUR

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-2

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 15642

[redacted] b(a)-2 [redacted]

Ward/Section: ENT | REQUESTING PHYSICIAN: [redacted]

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

LAST, FIRST, MI. b(a)-4 [redacted] | DATE 18 Aug | TIME 1730 | SSN/PSEUDO SSN: [redacted] b(a)-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 (a 41-51 mmHg (ve
PO2		80-105 mmHg (ar N/A (ven)
TCO2		23-27 mmol/L (ar 24-29 mmol/L (v
HCO3		22-26 mmol/L (a 23-28 mmol/L (v
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmo
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. RANG
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl

======= PICCOLO =======
01/08/03 17:52
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(a)-2
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	3.3	3.3-5.5	G/DL
ALP	67	26-84	U/L
ALT	13	10-47	U/L
AMY	69	14-97	U/L
AST	37	11-38	U/L
TBIL	0.7	0.2-1.6	MG/DL
BUN	16	7-22	MG/DL
CA++	8.6	8.0-10.3	MG/DL
CHOL	99*	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	78	73-118	MG/DL
TP	6.9	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

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

======= PICCOLO =======
01/08/03 17:50
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(a)-2
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	74	73-118	MG/DL
BUN	14	7-22	MG/DL
CRE	1.2	0.6-1.2	MG/DL
CK	549*	39-380	U/L
NA+	133	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 2+, LIP 1+, ICT 0

REMARKS: b(a)-2

REPORTED BY: [redacted] **DATE:** 18/Aug 03 **LAB ID NO.:**

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] b(a)-2	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(a)-4 [redacted]	DATE 1 Aug 03	TIME 1730 SSN/PSEUDO SSN: [redacted] b(a)-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		

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(a)-2	**DATE:** 1 Aug 03	**LAB ID NO.:**

ID: [redacted]
WB

01-08-03
18:19

			Patient Limits	
WBC	9.4	x10^3/uL	4.5	10.5
RBC	4.16	x10^6/uL	4.00	6.00
Hgb	12.6	g/dL	11.0	18.0
Hct	40.9	%	35.0	60.0
MCV	98.1	fL	80.0	99.9
MCH	30.3	pg	27.0	31.0
MCHC	30.9 L	g/dL	33.0	37.0
Plt	330.	x10^3/uL	150.	450.
LY%	31.8	%	20.5	51.1
LY#	3.0	x10^3/uL	1.2	3.4

[redacted]

MEDCOM - 15645

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
AW# [redacted] b(a)-4	8/2	1015 HOURS	
NURSING UNIT: ICW #2 / ROOM NO. / BED NO.	Tylenol 650 mg PO q4-6 prn pain V.O. Dr. [redacted] b(a)-2		[redacted] AW

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	2 AUG 03	1145 HOURS	b(a)-2 [redacted]
NURSING UNIT: ICW #2 / ROOM NO. / BED NO.	(1) MOTRIN 800 mg PO Q8 PRN PAIN (2) DIC TO EPW CAMP WHEN RNDE ARRIVES [redacted] b(a)-2		AW

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
AW# b(a)-4 [redacted]	2 AUG 03	1146 HOURS	
NURSING UNIT: ICW #2 / ROOM NO. / BED NO.	DC IV. b(a)-2 V.O. Dr. [redacted] b(a)-2		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
		HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

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

MEDCOM - 15646

b(6)-2

b(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
1 Aug	[redacted]	Admit to ICU 2	1 Aug	Now	2015	[redacted]
1 Aug	[redacted]	DX: S/P assault c closed head injury				[redacted]
1 Aug	[redacted]	condition: stable				[redacted]
1 Aug	[redacted]	PA/Lat CXR in AM	2 Aug	AM		[redacted]
2 Aug	[redacted]	DC C-collar	2 Aug	Now	0730	[redacted]
2 Aug	[redacted]	DC to BW emp when available	2 Aug			

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr ____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	.....					
	.....					
	.....					
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	.....					

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
2Aug	[redacted]	Tylenol 650mg PO q4-6hrs prn	2Aug 1015
.....	.....		650mg PO x1
2Aug	[redacted]	Motrin 800mg PO q8° prn pain	2Aug 1145
.....	.....		800mg PO x1
.....	.....		
.....	.....		
.....	.....		
.....	.....		
.....	.....		

b(4)-2

USAPA V1.00

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400; the proponent agency is OTSG b(4)-4

1. SERIAL NUMBER	2. NAME (Last, First, MI)			3. GRADE	ADMISSION REMARKS
[redacted]	UNK, EPW [redacted]			NA	
4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	22	UNK	UNK	NA	NA	NO
11. FMP	12. SSN b(4)-4			13. ORGANIZATION		14. WARD
99	[redacted]			NA		ICU1
15. FLYING STATUS	16. RATING/ DSG	17. DEPT/ SEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE
NA		K78 NA	NA			WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM OMT	1010	ABKA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	SD	30AUG03
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	**27b. TELEPHONE NO.**	**28. DATE OF THIS ADMISSION**
UNK		4AUG03

ADMITTING OFFICER b(4)-4 or [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2

30. DATE OF INTIAL ADMISSION

32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW TO GROIN

998.59
E878.9
V15.5

64.44
64.41
86.22
57.32
58.22

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	26	26

36. Total Days All Facilites b(4)-2

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
[redacted]	0	0	0	26	26

SIGNATURE [redacted] RECORDS OFFICER

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

22yo ♂ GSW to groin/perineum 11 deep ago
Rx = Ex lap and local wound care. Transfered
to SPW camp and then to GSH.

PMHx: ∅ PSHx: ∅ meds: ∅ NKDA

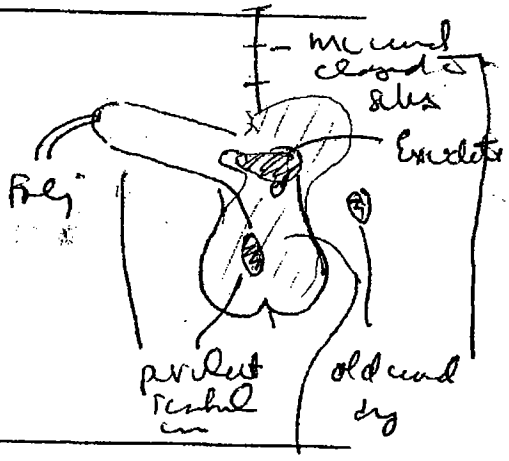
(+) tetanus in ER

11.1 / 8.9 / 28.3 <402 142/110/11 / 3.6/25/1.0 <99

UA 20-30 WBC
1g blood

PHYSICAL EXAMINATION

WD/WN Iraqi male
NC/AT
Neck FROM
Resp clear
RRR-no MRG
Abd soft NT NTP (+) bowel sounds
Groin diffuse L>R suprapubic area
erythema — marked edema



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

Imp: Penile/scrotal injury ∅ purulent discharge

Plan: to OR

[redacted] b(6)-2

	DATE	IDENTIFICATION NO.	ORGANIZATION
ATION (For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

[redacted] b(6)-4

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

MEDCOM - 15650

[redacted]

MEDICAL RECORD | PROGRESS NOTES

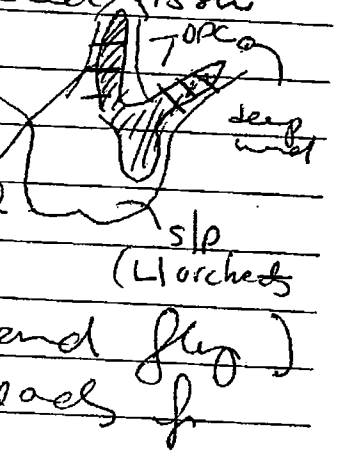
DATE

7 Sept 03 NARRATIVE SUMMARY DOA 20 Aug 03

LTC [redacted] MD DOD 7 Sept 03

REASON FOR ADMISSION: PENILE GSW

HOSPITAL COURSE: Iraqi male brought to (b)(2)-2 [redacted] 10 days s/p GSW to (L) LQ and abd s/p Ex Lap, 1° Closure of wounds at Iraqi hospital who developed worsening wound infxn. Brought to OR on admission and underwent Irrigation and debridement of non viable / infected tissue (see diagram). Wounds managed by wet to dry dsgs Δ's. Taken back to OR for DPC of shaft and upper scrotal wound and eventually flap (random, lat wound flap) closure. Patient now ready for DC



Procedures: ① I/D penile wound
② Attempted DPC
③ Random flap scrotal / penile skin closure

Final Dx: Penile GSW

Plan: RTC EPW Camp

F/U as needed

(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 [redacted]

b(6)-2 [redacted]

PROGRESS NOTES
Medical Record

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

MEDCOM - 15651

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
3August 03	S/ Pt c GSW to penis into lower abdomal.
	(+) smell. Drainage tube to (R) abdomin. Incident happened
BP 110/72	11 days ago and surgury occured at an
P 110	Iraqi hospital.
R 18	
Spo2 97	PmHx: GSW 12-20 days old - Pelvis
T	SocHx:
	incision
All	Drain
	Exam: Mild Distress
	GU: generalized swelling to genitals & penis. foul odor at site. no active exudate in wound
	exit wound
	foley catheter in place & color urine
	Lungs: clear
	Heart: RRR
	ABD: SOFT NT ND (+) BS all quads
	X-ray: Pelvis
	No metal fragments
	no Bony fx.
	(OVER → S)

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] b(6)-2 [redacted] | REGISTER NO. | WARD NO.

EPW ↓ b(6)-4

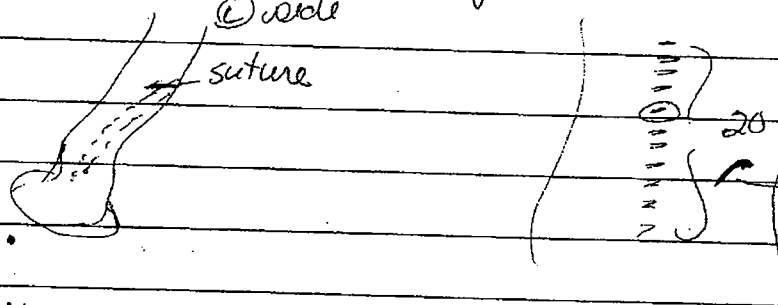
CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 15652

b(2)-2

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE** — AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
3 Aug 03	Pt returned from [redacted] c sutures x foley placed by [redacted] on the 24th of July. Foley draining amber urine c sediment. C/O pain. Pt moaning during care of foley & wounds. Pt has GSW to penis ⓓ side. Abdominal sutures
T 99.4	
110/80	
80	
15	
2000	



Has a clean suture line midline abdomen, 1 drain c 2 sutures visable on ⓛ side of abdomen. Ø drainage noted. Penis had GSW tract down ⓓ side c 1 suture visable. Pt visably in discomfort. Foley draining amber urine c sediment. Patient medicated c IT Tylenol #3 po + Cipro 500mg po. Recommend that pt returns to pt hold for pain management + fever management. [redacted] SSG [redacted] 2/w3d

3 Aug 03 2005 — Per t/c c Dr [redacted] b(6)-2 may send to [redacted] b(6)-2 pt hold this PM [redacted] SSG

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.

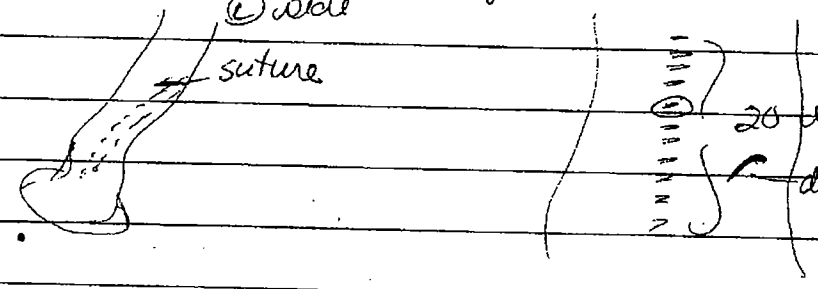
b(6)-4 [redacted]

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

b(a)-2

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE** — AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 Aug 03	Pt returned from [redacted] c sutures x foley placed by Iraqi docs on the 24th of July. Foley draining amber urine c sediment. C/O pain. Pt moaning during care of foley & wounds. Pt has GSW to penis ⓛ side. Abdominal sutures
T 99.4	
110/80	
80	
15	
2000	



Has a clean suture line midline abdomen, A drain c 2 sutures visible on ⓛ side of abdomen. ↓ drainage noted. Penis had GSW tract down ⓛ side c 1 suture visable. Pt visably in discomfort. Foley draining amber urine c sediment. Patient medicated c IT Tylenol #3 po + Cipro 500mg po. Recommend that pt return to pt hold for pain management + b(a)-2 illness management. [redacted] SSG 2/W3D

3 Aug 03 2205 — Per t/c c Dr Kumar may send to [redacted] pt hold this PM [redacted] 3/30

b(a)-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.)* [redacted] b(a)-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 USAPA V2.00

MEDCOM - 15654

b(a)-4

[redacted]

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
3 Aug 03 (cont)	Lab: WBC ~~4~~ @ 5,950 Wound cleaned ē betadine/saline scrub to lower abdomen/penis Imp: Healing wound to genitals c/o pain. Plan: 1) Start Cipro 500 mg B-D 2) Start Tylenol #3 1-2 q 4-6 prn 3) Continue to keep wound clean and dry. Bacitracin and dressing changes as needed. [redacted] LCSW b(a)-2

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 15655

[redacted]

CLINICAL RECORD			NURSING NOTES (Sign all notes.)
DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
3 Aug 03		2135	Pt admitted to holding w/ minimal pain. Requested water. IV initiated @ AC 1000 cc NaCl @ 100cc/hr. Cipro 400mg IV administered. Pt was discharged earlier today and is returning w/ fever and pain. Pt resting quietly. SPC
	3 Aug 03	2330	continued 1000 cc NaCl IV, patient resting
BP-			quietly [redacted] SPC
P-			b(a)-2
R-		•	
T-		L	lowered pain in arms and
SpO2-			Morphine SO4 10 mg IM @ [redacted]
			resting dose - if (P) - [redacted] SPC
	4 Aug 03		
	0645		10mg morphine IM (L) glut - [redacted] SPC
			b(a)-2
			[redacted]
			[redacted] b(a)-2
			[redacted]
			[redacted] b(a)-2

Continue on reverse side

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

b(a)-4

[redacted]

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5 Aug 03	Brief Op Note wnd cleaned/irrigated redressed b(6)-2 [redacted]
06 Aug 03 1710	Rec'd pt A/O - pleasant [redacted] re. Hx of T. dsgs to penis/perineum C,D,+I. foley secured + patent → dk/yellow urine. ϕ complaints voiced at this time. Repositioned pt comfort/dinner. O, @ 22 RC & Sats 98%. See flowsheet for further assessment [redacted] b(6)-2 Sgt/LPN
7 Aug/0600	Assumed pt care at approx 0530, pt in no apparent distress pt moving quietly, Changes are reached [redacted] b(6)-2 ICT BN
8 Aug/1000	Dressing Δ to penis done by Dr. Jezoir. pt premedicated c 50mg/Ketamy/ per Dr. [redacted] wet to dry dressing done to penis ① lower abd quad. Penis site & scrotal site deeply red c small purulent yellow creamy drainage. ② lower abd quad site mod amt creamy yellow drainage, once cleaned area deeply red & bled slightly. pt tolerated dressing Δ moderately well. pt now resting quietly c/o no apparent distress. VSS during dressing [redacted] b(6)-2 ILT BN
8.9/0600	Assumed pt care from LT [redacted] b(6)-2 approx 0530 pt in no apparent distress & resting quietly in bed. CR in place @ 100cc/hr. [redacted] b(6)-2 ILT BN
8.9/0800	wet to dry Dressing Change to penis, scrotum & ② lower abd quad done by Dr Jezoir, pt premedicated c 50mg Ketamy/ IVP, mod amt purulent creamy drainage from ② lower abd quad wound, penis wound irrigated c small amounts of purulent drainage & scrotum small amounts of creamy purulent drainage pt tolerated procedure relatively well [redacted] b(6)-2 ILT BN

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

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

9 Aug 03

Brief op Note

Procedure: ① Penile, scrotal, groin wound irrigation / debridement

② Urethroscopy

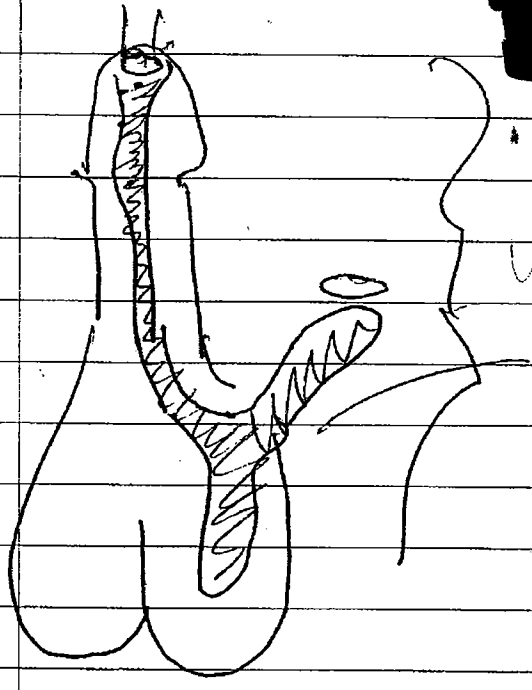
Indication: SP GSW Penis

b(6)-2 Surg Dr [redacted] / Dr [redacted] b(6)-2

GEPA

ABX: Gent / Ancef

Cephalexin 500 [redacted] b(6)-2



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

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

REGISTER NO.

WARD NO.

[redacted] b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-4 [illegible]

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
cont 8-5/0600			bilat lungs CTA ↓ diminished bases.
			GI hypo BS dwies N/V/D. NPO d/t scheduled surgery.
			GU straw colored urine QS. FTG, sterile sediment
			IVing 18G PIV RAC patent.
8-5/0820			Pt returned from OR c eel USS a in no apparent distress. Pt afebrile, dressings c/d/I/ pt placed on
			4LNC SpO2 96-98%. Pt currently resting quietly
			denies pain. b(6)-2 [redacted]
			1900 05 AUG 03: Pt recieved from OR going
			right. Pt resting comfortable in bed. Assessment
			as follows: [N] PERRL 3mm; follows commands, purposeful
			movement; denies pain or odor; [CV] S1S2, NSR; in 90s;
			110s/70s; (+) JVD edema, +3 (R) pulses, +2 (L) pulses
			UE; [R] CTA (S); (+) cough, IS; sats 97 on 2L
			NC; (+) S1S2 sys. [Skin] multiple scabs/sores thighs
			body; midline abd incision to lower epigastrium - C/D/I;
			[GU] voids with foley; bulky dsg - small amount of serous
			sats drainage noted; foley to gravity - 50 cc's per
			hour; moderate amount of urine; [GI] (+) NOR
			x4 clears will f/u diet hypo active bowel
			sounds. [Lines] foley, PIV x4 (R) UE [PLW]
0600			A/O; responds; NAD; assumes cyclic [redacted]
0800			dsgs Δ per ord; fentanyl 100 mcg IVP b(6)-2
			for pain; pt tolerated well — [redacted]
1200			no change in assmt; tol. po well — [redacted]
			b(6)-2

*U.S. Government Printing Office: 1995 - 404-763/20065

MEDCOM - 15659

STANDARD FORM 510 (REV. 7-91) BACK

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
8-4/1530			Pt returned from OR hemodynamically stable, Pt placed on 4L NC spo2 97% RR 16 BP 125/67 HR 122. NSR @ 120. Pt alert follows all commands, appropriate, maneuvered extremities difficulty. 6mg MSO4 IVP given for pain in groin area. b(6) [redacted]
			1730 04AUG03 - Pt received from off SDIU shift (A) Follows commands [CV] VSS 97% RA/RL 2+ Occhen S, S2 NSR - ST 110s/40s; [R] CTA CTAB 98% on 4L NC [GI] Midline lower abd inc. C/D/I [GU] urethra exposed from surgery. Scrotum drainage noted to (L) side of gauze packing. Pt is in upright position, & dependent position of toilet. Pain controlled w/ MSO4. Bulky dsg intact - scrotum drainage noted - "golf ball size"; [INJ] (L) AC at flange. [PAIN] Ambulates, voided w/o, pain, Abx as ordered — b(6)-2 [redacted] —
8-5/0530			Assumed pt care from CT Thursday. Pt resting quietly in no apparent distress. Started LR @ 100cc/hr. All VSS & Change of Shift. — b(6)-2 [redacted] (CT RUSH)
8-5/0600			A&O x3 follows commands non-combative, appropriate to staff per bedside check. Denies pain. CV NSR c ectopy S1, S2, bilat. radial & pedal pulses +2, abdomen soft, BS x4 quad. Voiding adequate amts clear yellow urine. Scrotum dsg intact, no drainage noted. Ambulates w/ steady gait. Continue on reverse side. 98% RA, sp2 c 4L NC

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

REGISTER NO.

WARD NO.

EPW b(6)-4 [redacted]

NURSING NOTES
Medical Record

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

MEDCOM - 15660

NSN 7540-00-634-4176

HEALTH RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE** — 600-108

b(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
09 Aug 03	(1800) Pt care Report Received from LT [redacted] Pt Awake's Acute Episodes noted / Reported. See DA 4700 for full assessment [redacted]
09 Aug 03	(1925) Pt care report given to LT [redacted] Pt Remains Stable. [redacted]
09 AUG 1925	Received report. [redacted] LT/AN
2130	Patient complaining of pain. Given 6 mg MSO4. [redacted] LT/AN
2230	Patient continues to have pain. Given 2 tabs Percocet. Will continue to monitor. [redacted] LT/AN
10 AUG 0045	Patient complaining of pain. Given 4 mg MSO4. [redacted] LT/AN
0300	Patient complaining of pain. Given 5 mg MSO4. [redacted] LT/AN
0400	Patient continues to have pain. Given 2 tabs Percocet. [redacted]
0600	Report given to nurse. Except for intermittant episodes of pain, patient sleep throughout night. VSS HR 80 BP 112/72, RR 16, SaO2 97% on RA, T 98.2. [redacted] LT/AN
0630	report recvd; assessment complete. [redacted]
0700	new PIV to @ Rt AC placed site unremarkable [redacted] 20 ga AC [redacted]
1000	drsg A pm ms; [redacted] pt tolerated well [redacted]
1500	[redacted] to dsch [redacted] [redacted] no drsg [redacted]
1820	[redacted]

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

b(6)-4 [redacted]

MEDCOM - 15661 MEDICAL CARE **STANDARD FORM 600** (REV. 5-84) Prescribed by GSA and ICMR

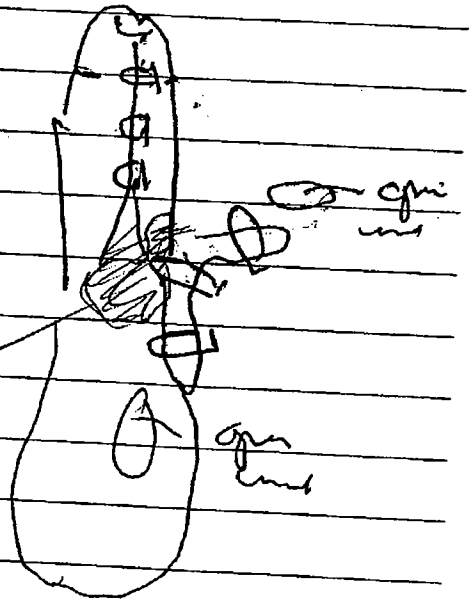
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Aug 03	Urology Progress Note Patient continues to progress well c dressing Δ's afebrile wound continues to granulate c+l exudate noted Plan ① Cont daily dressing Δ's ② Likely D/C (reapproach tomorrow

[redacted]

MEDICAL RECORD — AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
10 Aug 03 @2255	pt Report received From Cpt [redacted] b(6)-2 pt resting quietly VSS Assessment complete and WNL see flow sheet pt c/o pain and was medicated as per doctors orders pt shows no signs of acute distress @ present will continue to monitor throughout night [redacted]
11 Aug 03 @ 0500	pt VSS no problems @ present pt c @ complaint at this time b(6)-2 pt medicated for pain c @ results per doctors orders no acute signs of distress noted will continue to monitor [redacted] b(6)-2
11 Aug 03	Brief Op note OPC of penile wound Dr Jezior CMA/ General @ inpt [redacted] sterile



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

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

TIENT'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 [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 - 15663

b(a)-2 All

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11AUG 2030			Drsg Δ per order to penile area, Premedicated & Percocet 2 tabs.
2200			Patient sleeping. [redacted] LCT/AN
12 AUG 0100			Patient sleeping. LCT/AN
0330			Patient complaining of pain. Given 2 Percocet [redacted] LCT/AN
0600			Report given.
0623/8.12			Assumed pt care from LCT [redacted] pt resting comfortably in bed w/ no apparent distress, no IVS infusing [redacted] LCT AN
~~0623/8.12~~			~~pt resting~~
1050			Pt. resting in bed c eyes closed. [redacted] noted. Will continue to monitor.
1600/8.12			pt received dressing Δ well, premedicated & 150 mg Ranitidine & 2 Percocet. No purulent drainage noted from wounds, minimal sanguinous drainage noted. Clean and wound packed [redacted] LCT AN
12AUG05	2250		pt report received @ 1800 from LT [redacted] pt resting c complaints will continue to monitor [redacted] PFC Sims
	2255		Assessment complete VSS pt penis dressing CDI [redacted] PFC Sims
	@2340		pt resting comfortably in bed dressing Δ to penis Complete c problem pt medicated as per doctors orders pt shows no signs of acute distress @ present will continue to monitor throughout night [redacted] PFC Sims

overnment Printing Office: 1995 - 404-763/20065

b(6)-2 All

0-112

NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

b(6)-2 All

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11 AUG 03 0600			Received report from previous shift. Pt awake and pleasant. Ø needs expressed. A'd IV drsg. VSS. Will cont. care. [redacted]
0800			Prep pt for drsg Δ. Ø needs expressed. Will cont care. [redacted]
0900			Dr. [redacted] completed drsg Δ. Gave 150 mcg Fentanyl for pain a procedure. Pt tol. well. Pt on NPO status until surgery later this PM. Will cont. care. [redacted]
1230			Pt to OR via stretcher [redacted]
1400			Pt return from OR c gauze bite block in mouth and new drsgs on penis. Pt O2 sats 95% on RA. Will cont. cau. [redacted]
1430			Pt more awake/alert. C/o pain in penile area. Gave MSO4 4mg IVP. Will cont to assess pain level. [redacted]
1500			Pt resting comfortably. Ø c/o pain @ this time. Will cont cau [redacted]
1800			Gave report to next shift. [redacted]
1800			Received report. [redacted]
1830			Assessment completed. Patient resting in bed c HOB 4. Drsg to penis CDI. Ø Complaints @ this time [redacted]

(Continue on reverse side)

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

[redacted]

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

b(6)-4

MEDCOM - 15665

[redacted] b(6)-4

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
13Aug03	0018		Received report from night shift nurse. Pt. resting in bed c eyes closed. ø complaint @present time. VSS. 3cc foley shut. [redacted] b(6)-2 continue to monitor.
	0130		Sitting up in bed eating breakfast. ø complaints. Will monitor.
	0749		Percocet 5/325 1 p.o. for c/o pain. [redacted] monitor.
	0830		M.D. Lyne @ Bs. Orders changed done c Bsmy & Foley as pain management. Will continue to monitor.
	0946		Resting in bed c eyes closed. RR 12+ unlab. ø distress noted @present time. Will continue to monitor.
	1138		Pt. resting in bed. c eyes closed. ø distress noted. Resp even & non labored RR 16. [redacted] monitor.
~~1315~~	1315		Lying in bed reading a book. ø complaints voiced. Denies any pain. Will [redacted]
	1346		c/o pain. Percocet 5/325 1 p.o. given for [redacted]
	1528		Resting c eyes closed ø distress noted. [redacted] continue to monitor.
	1746		Sitting in bed eating [redacted] b(6)-7 dinner [redacted] monitor.

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
13Aug03		1815	Received report from SGT [redacted] Pt on RA, VSS, Dressing to penis C/D/I. Foley to gravity, I/O to @ ER, will continue to monitor. [redacted] RC, 9/10 M6
13Aug 03		2200	Pt resting comfortably in bed VSS. will continue to monitor. [redacted]
14 Aug 03		0200	Pt resting comfortably in bed. VSS will continue to monitor. [redacted]
14 Aug 03	0600		Received report from previous shift. Pt resting c eyes closed. 0 S/S or % pain. Will cont. care. [redacted] b(a)-2
	0720		Pt % pain penile area. Gave percocet it. Will cont to assess pain level. [redacted] b(a)-2
	1000		Completed dsg Δ. Placed fine mesh gauze c NS in (D) lower abd wound and by penrose drain and around penis. Used fluffs to support penis. Placed kerlex around penis. Pt assisted c dsg Δ. Will cont. care. Gave fentanyl 150 mcg. [redacted] b(a)-2
	1250		Pt c/o pain penile area. Gave percocet it. Will cont to assess pain level. [redacted] b(a)-2
	1500		Pt resting comfortably c eyes closed. 0 % pain. Will cont. care. [redacted] b(a)-2
	1600		Pt peripheral line infiltrated. Will restart IV. [redacted]
	1735		Pt % pain. Gave percocet it Will cont care [redacted] STA b(a)-2

S. Government Printing Office: 1995 - 404-7

MEDCOM - 15667

ACLU-RDI 1633 p.27

DOD-029056

b(a)-2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
15 Aug 03	Pt Lying in bed Awake c Ø Ntd complaints. VSS, will
1000	Continue to monitor. [redacted] 9/WMG
1100	Pt Lying in bed sleeping & appears to be resting
	comfortably @ this time. Will monitor. [redacted] 9/WMG
1230	Pt sitting up in bed eating lunch, Ø Ntd complaints
	or distress. Pt stable, will monitor. [redacted] 9/WME
1500	Pt Lying in bed talking to pt next to him &
	appears to be in cheery mood. VSS, pt stable, will
	continue to monitor. [redacted] 9/WMG
1800	Received Report. [redacted] T/AN
2030	Drsg Δ to penis/LLQ. Premedicated c fentanyl 150 mcg, Perc 2
16 Aug 0300	Site CD c sutures intact, Patient tolerated [redacted] T/AN
0600	Pt complaining of pain. Give 2 Percocets. [redacted] T/AN
	Report given. [redacted] T/AN
16 Aug 0600	Received Report From Nightshift & assumed care of Pt.
	Will monitor. [redacted] 9/WMG
0750	Pt Pre-medicated For Drsng Δ c 2 tabs of Percocet. Pt
	stable, Will monitor. [redacted] 9/WMG
0840	Pt medicated c 150 mcg fentanyl & drsng Δ Performed. Wet
	to dry packing to open wounds & covered c super sponge
	Fluffs. Penis Wraped c Wet to dry & coban. Pt tolerated
	Well, Will monitor. [redacted] 9/WMG
	Urology
	Patient progressing nicely
	Con't drsng Δ's
	[redacted] b(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

b(6)-2 A11

JTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RE[illegible]

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 Aug 03 1745	18 gauge @ bicep. Flushes well. Gave report to next shift. Will cont. care. — [redacted] 7/4W
1800	Received report from LCT [redacted] Pt has H/L to @ upper arm. ✓ Dressing to penis c/d/I. Foley to gravity KP Resting comfortably in bed. Will continue to monitor. — [redacted] SPC, 9 WM6
2000	Premedicated at ē percocet ii tabs for dressing Δ. [redacted] SPC, 9 WM6 —
2100	Dressing Δ complete, pt tolerated procedure well, will continue to monitor. [redacted]
0100	pt resting comfortably in bed, will continue to monitor. [redacted] SPC, 9 WM6 —
0300	Pt c/o pain. administered ii tabs percocet. Will continue to monitor. [redacted] SPC, 9 WM6 —
0610	Received report from nightshift + assumed care of pt. — [redacted] 9 WM6
0700	Pt sat up in bed to eat breakfast. Ø N/V/D complaints @ this time. VSS, Pt appears to be in a cheery mood. Will monitor. — [redacted] 9 WM6
0820	Pt lying in bed asleep. Woken up + Pre-Medicated for dressing Δ ē 2 tabs Percocet. Will monitor. — [redacted] 9 WM6
0900-1930 ~~0700~~	Pt Medicated ē 150 mcg Fentanyl IVP + dressing changes Performed. Pt tolerated well. Will monitor. — [redacted] 9 WM6

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

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

EPW b(6)-4 [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

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each ent
17Aug03	100cc output. [redacted]
0650	10mg Tint for dsg Δ pre-med. [redacted]
0828	Percocet Tab ii p.o. for c/o pain after dsg Δ. Will continue to monitor. [redacted]
1031	Resting in bed c eyes closed. Easy to [redacted] Will monitor.
1323	Resting in bed c eyes opened. Ø complants voiced @ present time. Will continue to monitor. [redacted]
1412	c/o pain. Percocet Tab ii p.o. given for [redacted]
1625	Resting in bed c eyes opened. Ø complants. Will continue to monitor. [redacted]
1758	Percocet Tab ii p.o. for pain. [redacted]
17Aug03 @1810	pt report recieved @1800 from Sgt [redacted] pt sitting in bed pt c/o pain to penile area previous shift medicated pt as per doctors orders no other problems noted @ present will continue to monitor [redacted] PFC 91W
@1740	HR-85 BP-116/52 RR-16 SPO2-98% T-99.0 assement WNL GSW to penis dressing CDI pt c/o pain will medicate for dressing Δ and with continue to monitor [redacted]
@2200	pt VSS medicated for pain dressing Δ complete pt resting quietly in bed no signs of acute distress noted @ present [redacted]
6 Aug 03	Nursing: Pt had emesis x 1. Dr. [redacted] notified.
0830	Unsuccessful at starting PIV. Pt given Phenergan 12.5mg IM @ 0820 for c/o further nausea [redacted]
6 Aug 03	Nursing: VS: T-103.5, BP 116/72, HR-127, Sats 99% on RA. Pt Diaphoretic, ⊕ chills. Pt assessed by Dr. [redacted]. New orders written. Pt given Tylenol 650mg PO @ 0815. [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

[redacted]

b(6)-4

MEDCOM - 15670

[redacted] USAPA V2.00

b(a)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
Aug 1050	Pt medicated c 100mcg Fentanyl. Penrose drain & sutures removed by DR [redacted] & dressings d'd again. Pt tolerated well, will monitor. — [redacted] 9W/MG
1200	Pt sitting up in bed complaining of groin pain, medicated c 2 tabs Percocet. Will monitor. — [redacted]
1530	Pt LYing in bed sleeping & appears to be resting comfortably @ this time. Pt stable c Ø signs of distress. Will monitor. — [redacted]
1800	Report given to Nightshift. — [redacted]
16Aug03 1826	pt report recieved @ 1800 From Spc [redacted] No problems noted@ present will continue to monitor — [redacted]
@2130	pt doing well resting in bed @ this time dressing & complete dressing CDI no other problems @ present VSS Assessment complete For details see ICU3 Flowsheet — [redacted]
@2400	pt VSS no problems @ present will continue to monitor — [redacted]
0040 17Aug03	Recieved report from PFC [redacted]. Resting in bed c eyes closed. Ø distress noted. VSS; BP 113/57 RR 12 HR 78 Temp 96.8 SpO2 99% RA Bandage noted to penis. Foley to BS draining yellow urine. Will continue to monitor [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS
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. ICU-3

EPW # [redacted]

b(a)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 Aug 03	Pregnant G6 Fever today T 103 d/c chills and diaphoresis and foley wound continues to heal well now Suspect UTI Plan - D to Urinary/UPB DC Cefpo Send UA/CBC/Chem 8 ABS b(6)-2 [redacted]
18 Aug 03 1040	Nursing: T-104.3 despite Tylenol. Ice packs applied to armpits + groin area. Cold ~~wash~~ towel applied to forehead. 20G IV started in R AC, LR started @ 125 cc/hr. CBC, Chem 8, + UA sent to lab. CXR pending due to patient back up in Radiology. Will continue to monitor. [redacted] b(6)-2

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* [redacted] b(6)-9

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

b(a)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18 Aug 03 1134	Nursing: T-102.2, remains diaphoretic, & chills, ØN/V. Will continue to monitor. [redacted]
18 Aug 03 1212	Nursing: T-101.1, pt c/o pain from penis. Pt given 2 tabs Percocet @ 1200. [redacted]
18 Aug 03 1652	Nursing: Pt c/o bladder pressure. Suprapubic area distended on palpation. Pt last voided @ 1000 ± 210cc. Dr. Jejour notified. Order written to Δ foley cath. Pt premedicated ± 150mg Fentanyl IVP. Foley d/c'd. New 16G Foley Catheter inserted ± difficulty. Pt immediately had 325 cc vol ↑ insertion. Wet to Dry dressing Δ done on ~~penile & penoscrotal~~ 1655 groin area. Small amount of purulent drainage noted. Pt given additional 50mcg Fentanyl IVP during Dressing Δ. Pt escorted to radiology via wheelchair. Pt able to stand ± difficulty. Pt assisted back to bed ± complaint. [redacted]
1800	Received report from off going shift. Pt resting comfortably in bed. VSS. Foley draining to gravity, ↓ U to CFA, Dressing to penis C, D, I W. Will continue to monitor [redacted] SPC, 9WMC
2200	Pt resting comfortably in bed VSS. Will continue to monitor [redacted] SPC, 9WMC
0200	Pt resting comfortably in bed, VSS, Will continue to monitor [redacted] SPC, 9WMC
0600	Reported off to day shift [redacted] SPC, 9WMC

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LSAPA V2.00

NSN 7540-00-634-4176

b(6)-2 All

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19 Aug 03	Nurses, NCO Assessment: Pt awake to Hear & oriented x3. Alert, AAOx3. Airway intact, breathing even and unlabored, LS CTA(B). Abd soft, nontender & distended. Midline incision well approximated, & s/s infection. Tolerating PO well. BS(+)x4. Foley draining clear yellow urine. Foley elevated on [redacted] all, secured & tape. Scrotal support in place, Kerlix fluff placed between scrotum and supporter (also in creases of groin). Kotex to penis. Dsg to groin & CDE, with dsg Δ, old dsg had old serosanguinous drg. Replaced & fine mesh gauze for packing of smaller, superior wound and larger wound near scrotum. Fine mesh gauze moistened & NS. Covered & gauze & taped. Dsg to [redacted] original area also covered & gauze, penis wrapped & gauze & Kotex. Visually, intact beyond wrap. Some purulent drg noted to end of penis. Cleansed & soap & H2O. IV to (L) AC & LR @ 125 cc/hr. [redacted] CPT Arn
19 Aug 03 1330	Pt awake and alert. PERRLA. Lungs CTA bilat, & resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Healing midline incision intact. Drsg x1 to abd & x4 to scrotum intact. Scrotal support in place. Foley and Kotex to penis. Strong pulses and brisk cap refill x4 extremities. & complaints [redacted] CA/AP
2030	Drsg Δ to abd and groin done. Wounds x2 to groin area red & fresh bleeding &

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

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

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

EHW [redacted]

b(6)-4

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

MEDCOM - 15674

b(6)-2
All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19Aug03 2030 (cont)	purulent drainage. Fine mesh gauze to D. Wound to underside of penis wrapped c gauze and koban. Sutures intact. Scrotal support c gauze inside strap to prevent chaffing. Tetanus [redacted] given prn. ———
2300	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA. BS @ X4. Foley → gravity c yellow urine, some sediment noted. will send UA in A.M. Drsgs to penis, scrotal support CDI. IVF infusing [redacted] diff. Will cont. to monitor. ———
	Urology Note Patient Coombs gent Pln Defer DC IV Meds & Urang DC Wfast Permit 1-2 Diet [redacted]
20Aug03 0700	Foley D/C'd per MD order ——— [redacted] Pt. awake & alert sitting up in bed. MD in to view status of penile wands. Base of penis on (L) side. Wand repacked c dry sterile gauze, sutures removed. HL in (L) AC c s/s of infection. VSS. Penile wands c s/s of infection. MD stated that graft to penis will be done in a few days. Pt. c/o pain x1, ii percocet given. AM care completed. Pt. c other complaints @ this time. Will continue to monitor. ——— [redacted]

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b(6)-2 A11

MEDICAL RECORD — AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
20Aug03 1330	Pt awake and alert. PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Dry dsg to wounds x2 to groin area. CDI. Penis wrapped t dry gauze, Ø Foley. Voiding well to BR. Ø Complaints. [redacted]
2030	Dsg change done to groin and penis wounds. Dry gauze t minimal drainage noted to old dsg. Penis wrapped t gauze. Ø complaints [redacted]
2117	Pt. care assumed @2100. Pt. c/o pain to groin. Ti Percocet given. HR Reg, lungs CTA, BS+ x4. Dsg to penis. CDI. Pt. voiding. S diff. Will cont. to monitor. [redacted]
21aug03 0630	Pt sleeping, arousable t verbal stimuli. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Scar to midline abd, wound well healed. Dsg to groin and penis intact, small amt of sanguinous drainage noted to dsg at base of penis. Voiding well to BR. Ø complaints [redacted]

HOSPITAL OR MEDICAL FACILITY

SPONSOR'S NAME	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
	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. ICU2

EPW [redacted]

b(4)-4

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

MEDCOM - 15676

b(6)-2
All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
21AUG03	(1710) Pt admitted to unit via litter in stable condition. Pt A/O speaking Arabic. Lungs CTA. ⊕BS x4 quads. VSS. Drsg to penis Δd this pm and drsg to LLQ Δd. Φ S/Sx infection @ site of wounds. Pt voiding s difficulty. Pt restrained via wrists bilat. Will continue to monitor. Pt resting quietly @ this time. Φ C/O pain. [redacted] (WA)
21 AUG 03 2226	VSS. AO. Mild c/o pain to groin area. DSG Δ performed. ⊕ pulses. Scrotal wound fluffy, ↓ redness, Jackson AB intact. Resty comfortably in bed. [redacted]
22AUG03	(1125) Assumed care of pt @ 0700 ↓ report from night shift. Pt alert speaking Arabic. VSS. Pt medicated c IT Perc this am for pain c good relief. Drsg to penis Δd this am. Bacitracin applied to wound. Φ S/Sx of infection. Drsg Δd to LLQ. Pt voiding s difficulty. 2 point restraints in place. Pt resting quietly @ this time. AM care done by pt. Will cont. to monitor. [redacted] (WA)
	(1705) Pt OOB to amb in room s difficulty this pm. [redacted] (WA)
22 AUG 03 2034	VSS. AO. PERRLA. BS⊕x4. 5, 5. ↓SC/AB. Denies pain @ this time to scrotum. Wound remains fluffy c s/s of infection. No evidence of dehiscence to suture line. [redacted]

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510-112

MEDICAL RECORD — NURSING NOTES (Sign all notes) — b(6)-2 A11 — NSN 7540-00-634-412

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
2x/08/05			Bryan Nutt Ryswell Skin graft to Am [redacted]
23AUG05	1050		Assumed care of pt @ 0700 p report from night shift. Pt alert, speaking Arabic. Drsg to penis cd this am. Bacitracin applied to wound on penis. Wet→dry drsg Ad on WC. Pt medicated c fi Perc p drsgs Ad. Will monitor for relief of pain. VSS. Voiding s difficulty. Am care done by pt this am. 2 point restraints in place. monitoring [redacted] (WA)
23 AUG 05	2100		VSS. AO. DSG to continue. Less small amount of purulent drainage, continue CPT. @ 5/5 rad calves, bleeding or tenderness. @ pulses. Bertty completed in bed. [redacted]
for 24 AUG 05	1316		Received pt resting in bed. VSS, alert, speaking arabic. Dry Ad, c/d/i. @ wound drainage noted. 13 cms BSE x4. HRR pulses equal bilat. SCDs Medicated x1 for pain w/ fi Tabs percat. Pt to OR in AM. NAO @ MN. will cont to Monitor [redacted]

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, hospital or medical facility) [redacted] rank; rate; (Continue on reverse side)

REGISTER NO. | WARD NO.

[redacted] b(6)-4

NURSING NOTES
Medical Record

MEDCOM - 15678

STANDARD FORM 510 (REV. 7-91)
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NURSING NOTES
(Sign all notes) b(6)-2 A11

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 AUG 03 1540			ISS. A&O. Mild c/o pain to groin site. Provided 2 Percocet for pain. Vitals are OTA and WNL. Ambulated x1 to bathroom [redacted]. Ad lib system WNL. [redacted]
Kay CD	1100		Received pt resting in bed, ISS, in patient and infusing NS @ 125 cc/hr. No changes to previous assessment. Pt NPO for OR today. No c/o pain at this shift. Am care done. Restraints in place, will cont to monitor. [redacted]
	1145		

*U.S. Government Printing Office: 1995 - 404-763/20065

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MEDCOM - 15679

NSN 7540-00-634-4176

b(6)-2 All

MEDICAL RECORD — AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
25 Aug 03	Brief Op Note Procedure: Random(L) Coronal flap reconstruction of (R) groin penis c&w Dr [redacted] GETA SBL min Antibiotic Cipro 400 mg Cystoscopy
26 Aug 03	Progress Note Wound/Dressing chart NO Singles Bedrest Cipro Dressing off in AM Wound Care 24-78°
27 Aug 03	Progress Note Wound Care/Dressing change Discharge to [redacted]

Flap (random)

[redacted]

HOSPITAL OR MEDICAL FACILITY | STATUS | 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

[redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDCOM - 15680

b(6)-2 All

MEDICAL RECORD	PROGRESS NOTES
DATE	

26Aug03 @2000 Pt A|Ox3, VSS, c/o pain 7/10 percocet given @ 1930 c noted relief. Prog to pend CPT c scrotal support. JP drain c serosanguinous drainage (20cc). +2 pulses, equal, lungs CTA B, +BS x4 qds. +HL TO @ AC patent. Resting in bed. conversating c others. 2p dressings dr. c good circulation. Will cont to mon [redacted] alleme

26Aug@0055 Pt c/o pain 7/10 Percocet given. pt voiding often (cm) foley to gravity. Will cont to monitor. [redacted] allerm

@0815 - I concur c above assessment. [redacted]

27Aug 0900 VSS Alert & Oriented. (R) AC IV c pain + swelling. (R) AC IV D/cd warm compress applied to (R) AC. Anesthesia started IV to (L) FA X1 attempt. IV patent & intact. Saline locked. Restraints removed & reapplied with check restraints & circulation frequently. Dr Jejon removed penrose drain this AM. Foley to remain draining clear yellow urine. D/S X1 to both puncture wil continue to monitor [redacted]

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

(Continue on reverse side)

REGISTER NO. [redacted]

WARD NO.

b(6)-4 [redacted]

PROGRESS NOTES
Medical Record

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b(6)-2
A11

PROGRESS NOTES

DATE	
	S/P OR 25 Aug 03 @ 1800
25 Aug @ 1855	Pt received from ICU via litter. VSS, Pt A+O x3, speaking in arabic. s/p penile skin reconstruction. Drsg to penis CDT, foley to gravity, JP drain to bulb suction & ser/sang drainage noted (5cc). pt urinated 100cc cyu on arrival. Pt c/o pain: given 6mg MSO4 & 2 percocets. & c/o nausea afterward. & emesis, Restraints in place, all other assesment findings WNL. Will cont to monitor — [redacted] 9W MedSR
25 Aug @ 1930	Abx given. Pt emesis x3, could not tolerate Reg diet tonight Will cont to monitor — [redacted] 9W MedSR
25 Aug 2300	I concur w/ assessment. addendum: Phenergan ordered for nausea. Allergy noted. will monitor. [redacted] RN
26 Aug 03 @ 0800	VSS. A&O. Penile dsg dry & intact. Foley to gravity drainage clear yellow urine. JP with serosanguinous drainage 20 cc output emptied at this time. Tolerating Regular diet. Restraints removed & replaced. Will check restraint freq. PIV patent & intact infusing LR @ 100 cc/hr. Due to episode of N/V last pm will have pt eat lunch before replacing IV. No pain or distress voiced or noted — [redacted] 2CTR

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[redacted]
b(6)-4

NSN 7540-00-634-4176

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE** — AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
27 Aug 03 @ 2010	Rt a&Ox3, VSS, HRRR, lungs CTA(B), +BSx4 quad. abd: soft, NT. Drsg to penis c small amt of old blood. ø active bleeding @ this time. JP draining 10cc serosanguinous fluid. voiding c/o often & difficulty. IHL to DFA patent & flushing easily. Abx given earlier today (1300). Foley to gravity. Circulation assessed. 2 pt restraints on. Will cont to monitor. — b(6)-2 [redacted] 3 wm6.
27 Aug 03 @ 2100	b(6)-2 [redacted]
28 Aug 03 1000.	VSS A&O ⓓ AC IV & patent & intact. Flexion without difficulty. Drsg to penis intact. JP to bulb suction intact. About 5cc of serosanguinous drainage noted. Shaved self Yesterday with am care. Foley Care done. Foley draing clear yellow urine. Restraints removed and upheld. Will check restraints and extremities frequently. b(6)-2 [redacted]
28 AUG 03 1920	VSS. AO. ⓓ pulses. BSCABs. D5 ½ to gain CBT & JP drain putty dist bloody serous drainage. Intact. FTG dressing light yellow urine in tube sufficient. Restraints removed. [redacted]

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE

SPONSOR'S NAME | SSN/ID NO. | RELATIONSHIP TO SPONSOR b(6)-2

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

b(6)-4

PW # [redacted]

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

MEDCOM - 15683

b(6)-2
All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
29AUG03	(1005) Assumed care of pt @ 0000 ~~p~~ report from night shift. Pt alert speaking Arabic. Pain controlled ~~c~~ Percs. VSS. Pt had ~~t~~ episode of emesis ~~p~~ eating breakfast. medicated ~~c~~ 25mg Phenergan IVP ~~c~~ good relief of N/V. IV pulled this am by MD. Site covered ~~c~~ gauze. Small amount of sero-sang drainage noted on dsg. Steri-strips CDI to groin/penis area. ~~ϕ~~ S/Sx infection @ site. Bacitracin applied to underside of shaft of penis wound. Pt tol. reg diet well. Foley draining quantity sufficient clear yellow urine. AM care done by pt. 2 point restraints in place - ~~ϕ~~ S/Sx complications ~~c~~ skin breakdown/circulation. Will cont. to monitor [redacted] IV Ativ
29AUG03 1910	Pt resting in bed, A+Ox3, VSS, LS CTA(B), +BS x4, S_1S_2 present, c/o pain coming from groin area, medicated ~~c~~ ii percs, c/o some nausea but refused medication, foley draining proper amount c/y urine, steri strips CDI to groin/penis area, proper circulation and skin integrity on pts of restraint. [redacted] 91WM46

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MEDICAL RECORD | PROGRESS NOTES

DATE

30 Aug 03 Progress note
Wound looks good
A to med cgn
DC IV
DC Foley [redacted] b(6)-2

30AUG03 (1045) Assumed care of pt @ 0600 ☐ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled ☐ Percs and MSO4 bang IM x 1. N dlcd this am d/t infiltration. Ad to po Cipro. Foley dlcd this am - pt voided quantity sufficient clear yellow urine ☐ difficulty. Drsg to ⓒ groin Ad this am. Bacitracin applied to wounds on penis. ϕ S/Sx infection. Steri-strips to groin CDI. Pt amb in hallway to latrine. ☐ difficulty. ⊕BM. Tol reg diet well. 2 point restraints in place ☐ S/Sx complications from skin breakdown/circulation. Will continue to monitor.

b(6)-4 [redacted] USA

30AUG03 2100 Pt resting in bed, A+Ox3, VSS, L/S CTA ⓑ, ⊕BS x4, dsg's to groin area CDI, pt voiding well c/y urine, ϕ c/o pain or discomfort @

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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b(a)-3 A11

PROGRESS NOTES

DATE	
	this time. [redacted] @1WW46
@2200	2-pt restraints on & skin intergrity circulation intact [redacted]
31aug03	Received pt resting in bed. USS, alert & c/d/i; restraints in place w/ good skin integrity & circulation. SVSS, med x1 for pain amb indep. In restraints per CPW protocal, w/ good skin integrity and circulation. No other remarkable assessments, refer [redacted]
31aug03 2330	Assumed care @1800; USS, pt A&OX3, ø c/o pain/discomfort @ this time; penile dsg C.D.I. 3 drainage; pt to shower this PM per MD orders; pt up amb ± escort; TOPD; restraints in place, circulation & skin intergrity intact; cont to monitor [redacted]
01sept 1339	Received pt resting in bed, USS, ø acute distress noted. A+OX3. Pt to shower for wound drainage. Dsg applied: gauze w/ tape restraints. Up amb x2, BRM x1, SVSS. Tol po. Will cont to monitor. [redacted]
1Sep.03 1950	Pt resting in bed, A+OX3, LS CTA (B), (+) BS x4, ø c/o pain @ this time, wounds on groin area appear ± ø S/Sx of infex, small drainage on gauze, taken to shower for wound drainage, pt ambulated around ward, proper circulation & skin integrity on pts. of restraint. @1WW46 [redacted]

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b(4)-2
All

MEDICAL RECORD | PROGRESS NOTES

DATE	
31Aug03	Urology PW wound c serosanguinous discharge (+) foul odor 0 fever Plan shower BID [redacted]
2Sep03 0900	VSS Pt A&O. OOB to BR to shower & have BM. Lung clear. BS(+). Peripheral pulses palpable. wound without drainage noted at this time. Consumed regular diet for breakfast. Restraints removed & reapplied. Skin under restraints intact with check restraints, skin integrity and adequate circulation present. [redacted]
2Sep03 1745	Pt A+Ox3, VSS, LSCTA(B), (+)BS x4, pt had a BM, ambulated around ward + took a shower, medicated for pain c 2 percocet tabs, incision on groin area healing well, minimal bloody drainage, applied bacitracin, proper circulation + skin integrity on pts [redacted] of restraint.

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

[redacted]

b(4)-4

(Continue on reverse side)

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PROGRESS NOTES
Medical Record

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b(6)-2 A11

PROGRESS NOTES

DATE	
3 Sep 03 @ 0700	Assumed care of pt awake alert and oriented X3. VSS & c/o pain or discomfort @ this time lungs CTA HRRR S1,S2 present tolerating PO well Dressing to Rgroin area CDI & evidence of bleeding. Will cont to monitor and access [redacted]
3 Sep 03	Pt A+OX3, VSS, LS CTA (B), (+)BS x4, [redacted] dsg on groin area CDI, abd soft flat non tender, S1, S2 present, peripheral pulses +2, voiding c/y urine, ambulates independently, assessed for proper circulation [redacted] and skin integrity on pts. of restraint. [redacted]
4 Sep 03 0900	VSS Alert & Oriented. Lungs clear. BS (+) x4 Quad. Consumed regular diet for breakfast Urine clear yellow in [redacted] Peripheral pulses +2. Incision [redacted] above penis intact & Steri Strip. Scant amount of old drainage & dry dsg removed. Groin dime sized dry dsg replaced. Restraints removed and reapplied & clean under restraints intact. Will check restraints, skin integrity and extremities circul. q4h frequently [redacted]
4 Sep 03 @ 2015	Pt A&O, VSS, lungs CTA (B) (+)BS x4 quad. +2 pulses. Incision above penis CDI, & c/o pain @ this time. circulation intact. 2 pt restraints on voiding cyc & difficulty. ambulated & difficulty. Will cont to monitor [redacted]

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b(6)-2 All

MEDICAL RECORD — AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5 Sep Ø3 @ 0430	Pt voided. 1800 cc cyu this shift. Ø BM (CYU). Pt is sleeping @ this time. Ø distress noted. Approx. intake 1560 cc (1 bottle H2O). Circulation intact. 2 pt. restraints on. Will cont to monitor- [redacted] GIWM6
05Sep03	(0915) Assumed care of pt w/ above p report from night shift. Pt A/O X3, speaking some English. VSS Ø C/O pain w/ this time. Pt amb S difficulty. Pt showered this am independently. Incision to @ groin CDI. Ø S/Sx infection on penis or incision. Pt voiding S difficulty. Tol. reg diet well. 2 point restraints in place S S/Sx complications c circulation / skin breakdown. Will cont. to monitor. [redacted] WDAW
5 Sep. Ø3	Pt sitting in bed, A+O X3, VSS, LS CTA (B), (+) BS x4, pt ambulated to BR w/o difficulty, had a BM, c/o diahrea, incision on groin area Ø s/sx of infex, Ø c/o pain @ this time, proper circulation + skin integrity on pts of restraint. [redacted] GIWM6

HOSPITAL OR MEDICAL FACILITY

SPONSOR'S NAME	STATUS	DEPART./SERVICE	RECORD [redacted]
	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. ICW 1

[redacted]

b(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDCOM - 15689

b(4)-2 All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
6 Sept 03 0700	Pt VSS, lungs and bilcs are good. Not c/o any pain. Has no problem at this time with sitting up in bed. Incision is healing nicely, see no signs of infection. Will continue to access the Pt. S/C [redacted]
	(0725) I concur c above assessment. [redacted]
6 Sep 0830	pt c/o pain to groin region medicated c percocet. it tabs will monitor for affectiveness. [redacted]
6 Sep 1500	~~Assumed~~ Pt. c/o pain to groin area percocet II tabs administered will cont to monitor [redacted]
6 Sep 03 1815	Pt resting in bed, A+Ox3, VSS, LS CTA (B), (+)BS, Ø c/o pain, pt ambulated, Ø drainage or s/sx of infex on wound in groin area, proper circulation + skin integrity on pts of restraint. [redacted]
7 sept 03 0630	Assumed care of pt. awake alert and oriented x3. VSS Ø c/o pain or discomfort. Lungs CTA. HRRR S1 S2 present. Active BS. x 4 quads. Urinating QS c difficulty. Ambulates without difficulty. Wound to groin region healing well Ø drainage / bleeding Ø signs of infection. Discharge orders for EPW camp. Pt ready for dc. [redacted]

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MEDCOM - 15690

558-104

b(2)-2

7540-01-075-371

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FA[redacted]

RECORDS MAINTAINED [redacted]

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)*: 04 Aug 03 | TIME: 0935

TRANSPORTATION TO FACILITY

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: GSW Abdoman

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	0940			
BP	115/62			
PULSE	96			
RESP	25			
TEMP	98.4			
WT	98			

LAB ORDERS

CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		CHEM: 17
BLOOD C&S X			lytes

X-RAY ORDERS

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

☐ PULSE OX ☐ MONITOR ☐ ECG

ORDERS

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	Solu-T 1 NS				
1100	Phos Soc				

DISPOSITION

☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE

☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b(2)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)

MEDCOM - 15691

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

MEDICAL RECORD | **EMERGENCY CARE AND TREATMENT (Doctor)** | TIME SEEN BY PROVIDER [redacted]

TEST RESULTS

CBC: WBC 11.1; H/H 8.9/28.3; PLT 402 — SMAC: 142 | 110 | 11 / 3.6 | 25 | 1.0 (99) — PT — APTT — BHCG — ETOH — GLU

ABG/PULSE OX: SUP 02 — PH — PO2 — PCO2 — SAT — OTHER

U/A: DIP — MICRO

RADIOLOGY — Check if read by radiologist ☐ — RESULTS

EKG INTERPRETATION — WNL

PROVIDER HISTORY/PHYSICAL

22 y/o ♂ S/p GSW 24 Jul to Pelvis and groin area. pt seen @ Draper hospital, sent to 109th EPW to ? unknown bld clot/medical. Evac to CSH. ϕ transfer note.
Pt c/o HA pain ↑ x 24°. ϕ N/V/chills ϕD ϕN Cipro 400g IV given yesterday 3 Aug 09

PMH ϕ
PSH ϕ
ϕ prescribed
NKDA

O: A+O x 4 – mod distress. VSS
EENT: OP/NP clear/pat mm ϕ D neck supple NT ϕ LAD
eyes clear/dry
CV: CTA/S Wimm ϕ click RR 100
Abd: ⊕ perc tenderness ⊕ midline suture in place rectal: NL tone/brown heme neg lt brown stool.
GU: ⊕ circ ϕ phimosis ⊕ full empl ⊕ lac @ base of penile shaft c pus. Foley in place
⊕ lac along penile shaft
Back: ϕ lacs/contusions/abrasions ϕ steps

A/P Stable (post op) GSW

Admit IVAW 2 IV Abx

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP b(6)-2 [redacted]

PROVIDER SIGNATURE AND [redacted] BSN

DIAGNOSIS
① GSW to groin/abd (infection)
②

CODES

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

[redacted] b(6)-4

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

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CONSULTATION SHEET

REQUEST

TO: Surgery

FROM: (Requesting physician or [redacted]) b(6)-2

REASON FOR REQUEST (Complaints and findings)

Gunshot wound - 20 sepsis.
erosion of penis wound

DATE OF REQUEST

PROVISIONAL DIAGNOSIS

b(6)-2 Gunshot wound penis - 20 infection

[redacted]

APPROVED 6/1/12

PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL

☐ ROUTINE ☐ TODAY
☐ 72 HOURS ☐ EMERGENCY

RECORD REVIEWED ☐ YES ☐ NO

CONSULTATION REPORT

PATIENT EXAMINED ☐ YES ☐ NO

TELEMEDICINE ☐ YES ☐ NO

NATURE AND TITLE

(Continue on reverse side)

DATE

PITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

TION TO SPONSOR

DEPARTMENT/SERVICE OF PATIENT

SPONSOR'S NAME (Last, first, middle)

NT'S IDENTIFICATION (For typed or written entries, give: Name – last, first, middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade)

SPONSOR'S ID NUMBER (SSN or Other)

REGISTER NO.

WARD NO.

[redacted] b(6)-4

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

3 Aug 03

1. Transfer to holding
2. Dx UTI / wound infection
3. Condition Fair Immediate, delay, minimal, expectant
4. VS Q 15min Q 2° Q 4-6°
   Per Routine
   Call physician if BP>160/90 < 90/60
   P >120 < 50
   R >25 < 10
5. Activity: ___ Bed Rest X Bathroom Privileges ___ Ambulate TID
   ___ With Assistance
6. Nursing:
   ___ Dressing Changes QD or more PRN
   ___ Cold Pack PRN
   ___ ECG PRN for S & S of CV problems
7. Diet: ___ NPO ___ Clear Liquids ___ Advance diet as tolerated
   X Regular diet
8. IV Fluids ___ LR- Wide open until pt. Stable
   ___ LR TKO
   X LR - @ 100 cc/hr
9. Allergies NKA
10. Pain Control
    ___ Morphine Sulfate
    ___ a. 10 mg IV/IM/SQ of 2-4° PRN pain
    ___ b. or follow bolus by infusion of 0.05-0.1 mg/kg/hr
    ___ c. or 10-30 mg PO q 4° PRN pain
    X Tylenol 3 1-2 tabs PO q 4-6° PRN pain
    ___ Ibuprofen 800 mg TID PRN pain/fever
    X Tylenol 325 – 650 mg Q 4-6° PRN pain/fever
11. Ship Out: ___ Immediate ___ on next available transport
    Hold: ___ Till further notice ___ for ___ hours monitor vital signs
12. Meds
    ✓ Ciprofloxacin 400 mg IVPB BID with one dose on admission

13. Labs /X-Ray

14. PRN Meds:
    a. Benadryl 30 mg Q 4-6° PRN insomnia
    b. MOM or Mylanta PRN for GI
    c. O_2 2 liters per mask for S & S of respiratory difficulty

(b)(6)-4 [redacted]

noted – jaxtman SPC

Dr. [redacted] major

[redacted] ASM B

(b)(2)-2

TIME: SIGN

SKIN AND MUCOUS MEMBRANES

Skin: Lesions / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds:

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Pulmonary	Peripheral
Waveforms				
Site				
Dressing				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes -- Crepitus

Character of Drainage:

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

Artificial Airway Size: Type: Position:

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Antac. Suction/Cont. Suction/Intermittent Drainage

NG Drainage: Color Character

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

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Ostomy

EMOTIONAL/PSYCHOSOCIAL

OTHER:

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Lesions / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm 97.9

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size: Penis wo

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): 80 Radials ++ Pedals ++

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension Ø Edema Ø

Heart Sounds: Reg

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Pulmonary	Peripheral
Waveforms				
Site				(L) AC
Dressing				Scabs

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: N

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

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

Artificial Airway Size: Type: Position:

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: CDI

NG Tube: Clamped/Antac. Suction/Cont. Suction/Intermittent Drainage

NG Drainage: Color Character

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

Stool: Character

Drains:

GENITOURINARY

Urine Color: Clear Yellow Character:

Voiding: Continent / Foley Incontinent / Ostomy

EMOTIONAL/PSYCHOSOCIAL

Calm : cooperative

OTHER:

MEDCOM - 15695

ICU Flowsheet

Patient Name: 527

Date: 10 / AUG / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature				97%			98.2 98				96.8							118		97.9				98.8		
Pulse				78			80				75							75		80				90		
B/P a A-Line																		70								
MAP																										
B/P a Cuff				116/80			112/72				112/70									122/60				112/52		
Respirations				18			16				16							20		16				16		
Sa002				95			97				95							95		98%				97%		
				RA			RA				RA							RA		RA				RA		
I Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF:	75	75	75	75	75	75	75	75	75	75	75	75	900	75	75	75	75	75	75	25	75	75	75	75	75	
PO I Intake				60	60				100		500		660													
O.RR. IN																										
Totals	75/75	150	225	300	435	510	585																			
O Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly				500		250/150					250/100		1000							250/100		250/500		300/800		
NG I Tube																										
Drains #1																										
#2																										
#3																										
Emesis																										
Stool																										
O.RR. OUT													1000													
Totals				500/500		250/750																				

[redacted]

24 hour input	
24 hour output	
24 hour balance	

5.169

TIME: 0600 SIGN [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: (Loose) / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature WARM

Color: Pale / Cyanotic / Jaundiced WNL for race

Mucous Membranes: (Moist) / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc: (Alert) / Lethargic / Unresponsive GCS:

Oriented / Disoriented Pupils: 3mm PERRL

Extremity Movement: Full / Limited / None due to dy

CARDIOVASCULAR

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

Capillary Refill: <3 Seconds Homan's Sign (-)

Jugular Veins: Distension Ø Edema Ø

Heart Sounds: S1S2

Rhythm SR PR: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site			(L) FA	
Solution			LR @ 75	

Chest Pain

RESPIRATORY

Chest Expansion / (Symmetrical) / Asymmetrical

Respiration / (No Dyspnea) / SOB / Labored / Use of Access Muscles

Breathing Pattern: RRR 16

Cough: Productive / Nonproductive / (None)

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes --- Crackle

Character of Drainage:

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

Artificial Airway Size: Type: Position:

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

GASTROINTESTINAL

Abdomen: (Soft) / Firm / Hard / Distended ___ cm Girth

Bowel Sounds: (Normal) / Hyperactive / Hypoactive / Absent

Dressings: to Penis D+I

NG Tube: Gastrointestinal, Duodenal, Gastric, Suction/Decompression Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspiration

Stool: Character Ø

Drains: Ø

GENITOURINARY

Urine Color: Yellow/amber Character: sediment

Voiding: Continent / Incontinent / (Catheter)

EMOTIONAL/PSYCHOSOCIAL

Pleasant + cooperative.

OTHER:

TIME: SIGNATURE [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: (Loose) / Tight / Diaphoretic / Shiny / (Dry)

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: (Moist) / Dry / Cracked

Skin Breakdown: (None) Location: Size:

NEUROLOGICAL

Loc: (Alert) / Lethargic / Unresponsive moves extremities

Oriented / Disoriented Pupils: PERRLA 3mm

Extremity Movement: Full / Limited / None due to injury

CARDIOVASCULAR

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

Capillary Refill: <3 Seconds --- Homan's Sign

Jugular Veins: Distension Edema

Heart Sounds: S1 S2

Rhythm SR PR: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site			L FA	
Solution			LR @ 75 cc/h	

Chest Pain

RESPIRATORY

Chest Expansion: (Symmetrical) / Asymmetrical

Respiration: (No Dyspnea) / SOB / Labored / Use of Access Muscles

Breathing Pattern: RRR

Cough: Productive / Nonproductive / (None)

Sputum: Color / Amount / Consistency / Odor None

Chest Drainage System Gravity: Suction cm:

Air Leak NO Yes Crackles

Character of Drainage:

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

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior Location	Posterior/Location
Crackles	CTA (B)	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: (Soft) / Firm / Hard / Distended am Girth

Bowel Sounds: (Normal) / Hyperactive / Hypoactive / Absent

Dressings: to Penis CDI

NG Tube: Gastrointestinal, Duodenal, Suction/Decompression Drain

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspiration

Stool: Character

Drains: Voiding Spontaneously via Cath

GENITOURINARY

Urine Color: Character: Clear

Voiding: Continent / Incontinent / (Catheter)

EMOTIONAL/PSYCHOSOCIAL

OTHER:

6/6-2

ICU Flowsheet **Patient Name:** [redacted] **Date:** 12 AUG 2003

Vitital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature			98.4				98.7					98.5								98.7		99.5		99.3		
Pulse			121				89					72				89				82				67		
B/P's A-Line																										
MAP																										
B/P's Cuff			111/61				111/63					116/65				116/72				118/68				119/58		
Respirations			19				18					16				16				16				16		
Sa002			99				98					98				98	98			95				99		
							RA					RA				RA	RA			RA				RA		
Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF:	75	75	75	0																						
				~~220~~																						
PO Intake				220			300					200			400	300			300			100		200	100	
O.RR. IN																										
Totals	75/75	75/150	75/225	220/445																						
Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly							300		200 cc			250 450				300				400		100			300	
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis																										
Stool																										
O.RR. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

12 AUG 03 ..... b(6) = 2

TIME: 0600 SIGN/ [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm

Color: Pale / Cyanotic / Jaundiced appropriate for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS:

Oriented / Disoriented Pupils: PERRLA

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): 2 Radials 2 Pedals

Capillary Refill: L 3 seconds R 3 Homan's Sign +

Jugular Venous Distension + Edema +

Heart Sounds: S1 S2

Rhythm: ST PR: QRS:

Vascular Catheter	Central	Arterial	Pulmonary	Peripheral
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Pattern: even and unlabored

Cough: Productive / Nonproductive None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

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

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior Location	Posterior Location
Crackles	CTA	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended firm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Intact, Suction/Cont. Suction/Intermittent Drainage

NG Drainage: Color Character

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

Stool: Character

Drains:

GENITOURINARY

Urine Color: amber Character: clear

Voiding: Continent Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Cooperative, pleasant appropriate affect

OTHER:

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS:

Oriented / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds:

Rhythm: PR: QRS:

Vascular Catheter	Central	Arterial	Pulmonary	Peripheral
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Pattern:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

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

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior Location	Posterior Lung
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended firm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Intact, Suction/Cont. Suction/Intermittent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

ICU Flowsheet

Patient Name: [redacted]

Date: 11 Aug 2003

Vitital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature			97.2				98.2				97.8					98.5						98.6				
Pulse			78				85				76					108				89		94				
B/P = A-Line																										
MAP																										
B/P = Cuff			114/68				116/65				114/78					98/56				114/64		112/67				
Respirations			16				15				16					16				16		18				
SaO2			96%				98%				99%					94%				97		96				
Source			RA				RA				RA					RA				RA		RA				
I Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF: LR	75	75	75	75	75	75	75	75	75	75	75	75		200 mOR		75	75	75	75	75	75	75	75	75	75	
PO I Intake																										
O.R. IN																										
Totals															200/200	75/275	75/350	75/425	75/500	75/575	75/650	75/725	75/800	75/875	75/950	
O Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly			350/350			350/700		700/1400					2100	775/775			775/1550		100/1650			275				
NG I Tube																										
Drains #1																										
#2																										
#3																										
Emesis																										
Stool																										
EBL															5											
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

[redacted]

11 Aug 03

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 22
HEIGHT:
WEIGHT: 70kg

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA

3. PREVIOUS SURGERY [ ] NO [✓] YES (type): Pelvic s/p GSW penis.

4. PROPOSED SURGICAL PROCEDURE: Drsg Δ penile wounds

5. ADDITIONAL INFORMATION: Last PO: NPO 7 MN Medical Hx: Ø Implants: Ø Medications: Ancef, Gent, MSO4, Phenergan, Ketoconazole, Percocet
Jewelry removed: (yes)/no Family waiting: yes/(no)

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	Ø Pt. verbalizes any specific anxiety. Ø Pt. exhibits relaxed body posture.	Ø Allow pt. to verbalize freely. Ø Explain OR environment and answer questions regarding surgery. Ø Offer comfort measures, (e.g., warm blanket, touch) Ø Explain all nursing procedures before they are done. Ø Remain with pt. whenever possible. Ø Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	Ø PT. will be able to breathe without difficulty during immediate intra-operative phase.	Ø Offer to elevate head of litter or offer pillow. Ø Observe pt. while awaiting surgery for signs of distress Ø Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	Ø PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	Ø Utilize pressure preventing devices on OR table and accessories. Ø Check for proper positioning and support to maintain good body alignment. Ø Pad pressure points. Ø Place ESU ground pad on non compromised skin surface area. Ø Keep prep fluids from pooling.

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

[redacted] b(6)-4

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

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

[redacted] RN 5 Aug 03 DATE

11. POSTOPERATIVE EVALUATION:

Pt. s/s of acute distress. Drsg CDI

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

DATE: 5 Aug 03 TIME: 0712

13. PREOPERTIVE EVALUATION PREPARED [redacted] RN

DATE: 5 Aug 03 TIME: 0825

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDICAL RECORD

C1p10

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: 22
HEIGHT:
WEIGHT: 70 Kg

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA

3. PREVIOUS SURGERY [ ] NO [X] YES (type): See H+P

4. PROPOSED SURGICAL PROCEDURE: Penis Graft

5. ADDITIONAL INFORMATION: See H+P/ patient chart

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to Traumatic injury; language barrier; family separation; surgical environment	✓ Pt. verbalizes any specific anxiety. ✓ Pt. exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures, (e.g., warm blanket, touch) ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. ✓ Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury; previous medical condition	✓ PT. will be able to breathe without difficulty during immediate intra-operative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress ✓ Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; poistion; fluid shift	✓ PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

EPW [redacted]

b(6)-4

DA FORM 5179, JUN 91 Previous editions are obsolete. MEDCOM - 15703 USAPA V1.0

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; previous surgery	✓ 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.~~ (V) ✓ Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	✓ 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. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury ; sedation F.2. ✓ Potential for decreased communictaion due to languag e barrier; sedation; pain; injury F.3. Potential injury due to dentures.	✓ 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. Iraqi National	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from Either side. o Validate pt.'s understanding of verbal communications. ✓ 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.
✓ b(6)-2 A ✓		✓

10. OR NURS[redacted] D/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CPT/AN 25 Aug 03 DATE

11. POSTOPER[redacted]
Bovie Side:
Dog:
Breathing:

12. PREOPERTIV[redacted] BY CPT/AN
(Signature and T[redacted])

DATE: 25 Aug 03 TIME:

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

DATE: 25 Aug 03 TIME: 1635

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.0

b(a)-2

MEDICAL RECORD — **INTRAOPERA DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY Anesthesia

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

3. DATE 4 AUG 03 TIME PATIENT ARRIVED IN SUITE 1400

4. PATIENT IN R... TIME 1400 NUMBER 2-

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

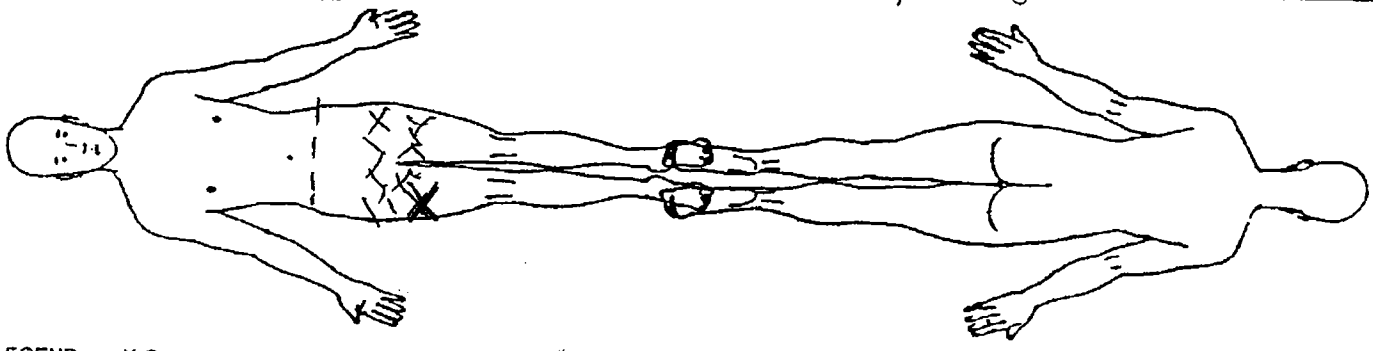
COMMENTS: Proper body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: Dr. [redacted]

PREP SOLUTION *(Specify)* Betadine Scrub/Soln
SITE: Perineal area BY WHOM: [redacted]
SITE: Genitalia BY WHOM: [redacted]
COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap ==Tourniquet

C = Correct I = Incorrect Inital C [redacted] I [redacted]

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

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

[redacted]

b(a)-4

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

☒ ESU NO: # 3
GROUND PAD: BRAND Valleylab
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA F... MEDCOM - 15705 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% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Fluffs 4x8 Coban Scrotal support

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	Fine Mesh Gauze	16Fr Foley	
SITE	Penis, wounds	bladder	

19. ADDITIONAL INFORMATION

WC

Surgeons: [redacted]

Anesthesia: [redacted] CRNA

Anesthesia Type: General

Foley in place upon arrival. Removed prior to prep.

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

20. OPERATION(S) PERFORMED

1. I & D penile, scrotal, groin wounds
2. urethroscopy

21. PATIENT TRANSFERRED TO		TIME	METHOD
ICU	b(6)-2	1511	Litter

22. REGISTERED NURSE SIGNATURE KC [redacted] CPT/AN

REVERSE OF DA FORM 5179-1, OCT 8 USAPA V1.01

MEDCOM - 15706

b(6)-2

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: — BY:
2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY ILT [redacted]
3. DATE: 6 Aug 03 — TIME PATIENT ARRIVED IN SUITE: 0753
4. PATIENT IN ROOM — TIME: 0753 — NUMBER: 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO p MN. NKDA — Patent Foley cath

6. NURSING PERSONNEL

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

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

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

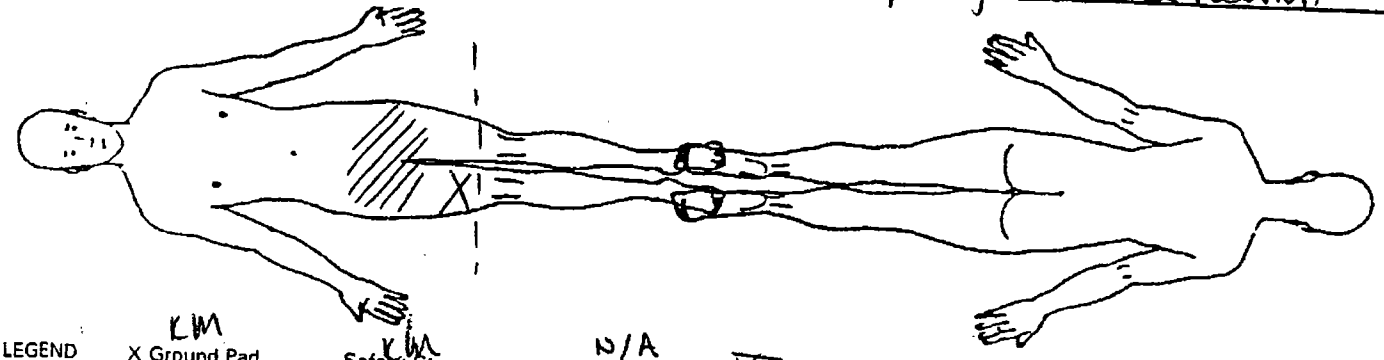
COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) HiBiClens
SITE: Groin / Penis — BY WHOM: Dr. [redacted]
SITE: — BY WHOM:
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND: X Ground Pad (KM) -- Safety Strap (KM) = = = Tourniquet (N/A) ▨ prep

Initial: SSG [redacted] ILT

C = Correct I = Incorrect

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

SCRUB: SSG [redacted]
CIRCULATOR: 1LT [redacted]

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

[redacted]

b(6)-4

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

☒ ESU NO: #4 Cut 20 Coag 20
GROUND PAD: BRAND VL Pem Polyhesive II
LOT NO: 65706 Exp 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 — MEDCOM - 15707 — REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE

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
N/A					

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

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Intersorb c NaCl	2.	3.
SITE	1. Penile wounds	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8
Coban
fluffs
scrotal support

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted]
Anesthesia: CPT [redacted]
b(a)-2 All

DA5179 Initiated

20. OPERATION(S) PERFORMED
Dressing Δ of penile wound

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 1	0825	Litter c O2

22. REGISTERED NURSE SIGNATURE [redacted] RN

REVERSE OF DA FORM 5179-1, OCT 8; USAPA V1.01

MEDCOM - 15708

MEDICAL RECORD — INTRAOPERA[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: LITTER BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY ILT [redacted] b(6)-2

3. DATE 11 Aug 03 TIME PATIENT ARRIVED IN SUITE 1245

4. PATIENT IN ROOM TIME 1245 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA, NPO @ 0700

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	LTC [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS:

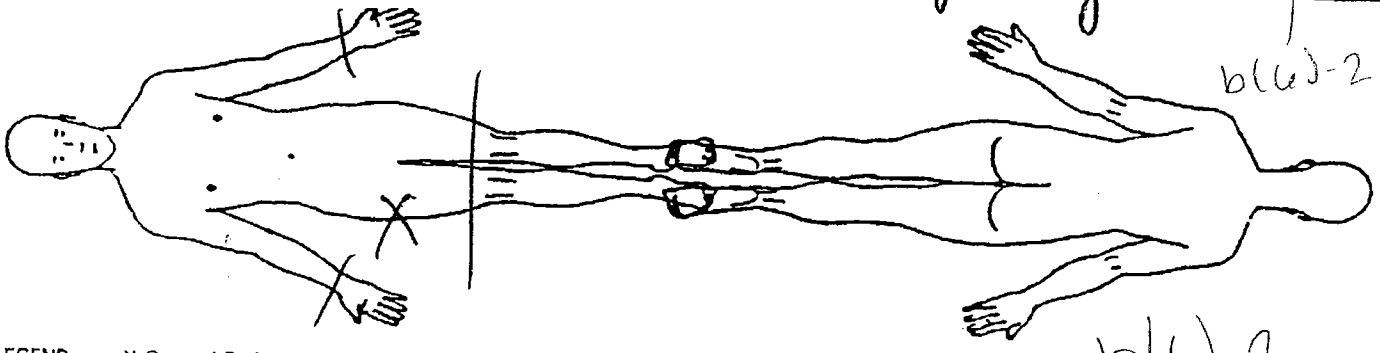
8. SKIN PREPARATION

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

COMMENTS:

PREP SOLUTION (Specify) Betadine soap/sol.
SITE: Groin
SITE:
BY WHOM: LTC [redacted]
BY WHOM:
COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count
Sponge	[X] Yes [ ] No	✓	C	C
Needle Sharp	[X] Yes [ ] No	✓	C	C
Instrument	[ ] Yes [X] No			
Other	[ ] Yes [X] No			

SCRUB: SSG [redacted]
CIRCULATOR: LTC [redacted]

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

[redacted] b(6)-4

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

[X] ESU NO: Valleylab Force 2
GROUND PAD: BRAND REM polyhesive
LOT NO: 65706 8

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

[ ] BIPOLAR NO:

c : 30 coag: 30

DA FORM 5179-1, OCT 87 MEDCOM - 15709 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS, SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☒

TYPE/SIZE	1. 1/4" penrose	2.	3.
SITE	1. wound superior + (Lt) of penis	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fine mesh gauze
Coban
4x8 fluffs
Scrotal support

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted]
Anesthesia: Maj. [redacted] CRNA

b(6)-2 All

DA 5179 In Chart

20. OPERATION(S) PERFORMED
Closure / revision penile GSW

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 3	1350	Litter & O2

22. [redacted], LTC, AN

REVERSE OF DA FORM 5179-1, OCT 8 USAPA V1.01

MEDCOM - 15710

b(6)-2

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY Anesthesia
2. PATIENT VERIFIED [redacted] AND PROCEDURE
3. DATE 23 Aug 03 — TIME PATIENT ARRIVED IN SUITE 1450
4. PATIENT TIME 1450 [redacted] NUMBER 1-5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] RT b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	error [redacted] All CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

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

no nicks or cuts noted

8. SKIN PREPARATION

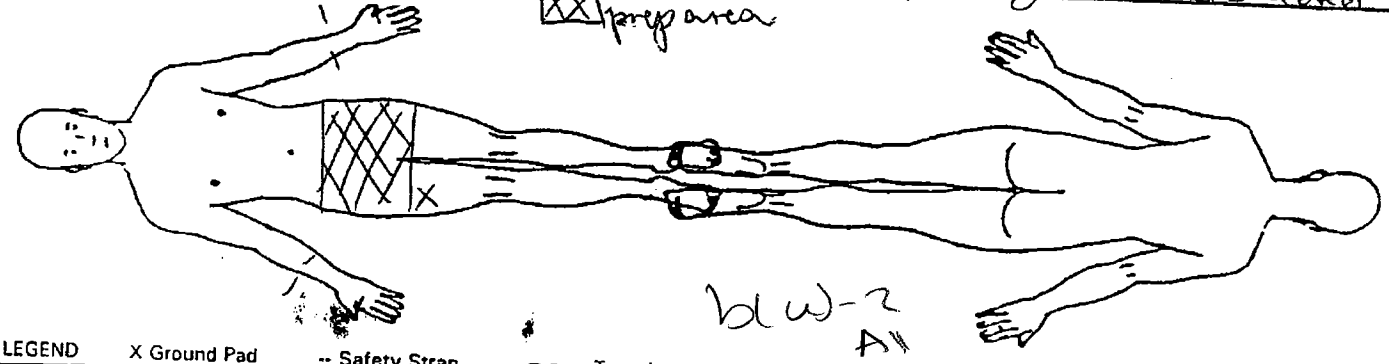
HAIR REMOVAL ☒ YES ☐ NO — DONE BY: ☒ OR ☐ NURSING UNIT — METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: ~~no pooling or skin d's noted~~ error, scr

PREP SOLUTION (Specify): ~~Betn/Betn~~ error [redacted]
SITE: Penis/Scrotal area — BY WHOM: [redacted]
SITE: — BY WHOM:

COMMENTS: no pooling or skin d's noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Initial: [redacted]

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	NA	C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes	☐ No		C	C		
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No	NA	NA	NA	NA	NA

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

#EPW [redacted]
b(6)-4

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

☒ ESU NO: Valleylab Force 40
GROUND PAD: 30130 BRAND VL Rem Polyhesive II LOT NO: 65706 2004-11
☐ ESU NO:
GROUND PAD: BRAND LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 — MEDCOM - 15711 — REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE

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):
NaCl 0.9%

OTHER ORDERS	TIME	CARRIED OUT BY
~~None~~ 16 F FIC to bladder via urethra	1110	[redacted]

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)* Coban Steristrips Fluffs Scrotal Support

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	10mm JP Dra[redacted]	16 F FIC	
SITE	Groin	Bladder	

19. ADDITIONAL INFORMATION
Surgeon: [redacted]
Anesthesia: [redacted]
b(4)-2 A11

20. OPERATION(S) PERFORMED
DPC Penis Wound

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU b(4)-2	1389	Litter

22. REGISTERED NURSE SIGNATURE [redacted]TIAN

REVERSE OF DA FORM 5179-[redacted] USAPA V1.01

MEDCOM - 15712

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY			
POST- DAY		1	
MONTH-YEAR	DAY	3 Aug 03	4 Aug 03
19	HOUR	1300	0805

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE		108/70
HEIGHT:	WEIGHT→	
SpO2		98
resp.		14

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

REGISTER NO.

WARD NO.

511-112-01

[redacted]

b(6)-4

VITAL SIGNS RECORD

STANDARD FORM 511 (REV. 9-79)
Prescribed by GSA and Interagency Committee on Medical Records
FPMR (41 CFR) 101-11.806-8

MEDCOM - 15713

511-119

MEDICAL RECORD

NSN 7540-00-634-4124

VITAL SIGNS RECORD

HOSPITAL DAY
POST- DAY
MONTH-YEAR
DAY 19 20 21 22 23 24 25
HOUR

PULSE (0) | TEMP. F (•)

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

KPW # [redacted]

b(4)-4

VITAL SIGNS RECORDS
Medical Record

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

MEDCOM - 15714

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR

19

DAY

HOUR

PULSE (0)

TEMP. F (°)

TEMP. C

105° 40.6°

180 104° 40.0°

170 103° 39.4°

160 102° 38.9°

150 101° 38.3°

140 100° 37.8°

130 99° 98.6° 37.2° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

#[redacted]

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 - 15715

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (0) — TEMP. F (°) — TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

[redacted]

b(6)-4

REGISTER NO.

WARD NO.

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

MEDCOM - 15716

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY: 5

MONTH-YEAR: Sept 6 Sep. 7 Sep

DAY

19 HOUR: 18 0728 18 0630

PULSE (0) | TEMP. F (°) | TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 112/69 RVG 114/71 119/69 111/64; 85 74 21 112 H 76; 98° H 75 98% T; 98% 99% 98% 99%

HEIGHT: WEIGHT →

Record special data only when so ordered

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

#[redacted]

b(6)-4

REGISTER NO.

WARD NO. ICW #1

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 15717

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ___ HOURS TO ___ HOURS | TOTAL HOURS COVERED | DATE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1835	H2O	600cc	600
2000	H2O	NMO	500cc
	Zantac 03		
1800	240 H2O		240
2000	120 H2O		360
0330	500 H2O		860

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1700	1000	NS Zantac 03	950	2330	950
2335	1000	LR	900		1850
		Zantac 03			
1830		Cipro IVS	250		2500

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72

MEDCOM - 15718

*U.S.GPO:1998-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ TO _____ HOURS | TOTAL HOURS COVERED | DATE

INTAKE / OUTPUT

OUTPUT

FOLEY

TIME	TYPE	AMOUNT	ACCUM TOTAL
1800	Urine cgu	100	100
0001	Urine cgu	600	700
0145	Urine cgu	450	1150
	26 Aug		
1830	100 cgu		1000cc
2300	600 cgu		7000cc
0330	200 cgu		9000cc

JP

INTAKE

TIME STARTED	AMOUNT	TYPE (Include Medication)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
		emesis x2			
		26 Aug 03			
		Ø			

IRRIGATIONS (N/G or Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1800	serosang.	5cc	
2330	serosang.	12cc	17cc
	26 Aug 03		
2000	serosang.	200cc	200cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
GRAND TOTAL INTAKE			

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

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792 EDITION 1 JUL 72 REPLACES DA FORM 3630(TEMP) MEDCOM - 15719 *U.S.GPO:1996-404-613/30343

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE 27 Aug 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1815	H2O	100	100
2000	H2O	500	600
2315	H2O	400	1000
0035	H2O	200	1200
	H2O	100	1300

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1800	250	Cipro IVS			250

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
*	JP output	*	
2000	10cc	10cc	
0030	8 cc	18cc	
0456	6cc	24cc	
0500	25cc in JP		

OUTPUT

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
2000	Urine	700	700
2300	urine (cyu)	500	1200
0035	(cyu)	800	2000
0500	(cyu)	200	2200

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

MEDCOM - 15720

28 AUG

Intake

D5W H2O 450
Juice 180

IV
Cipro 250

JP

Foley

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM [illegible] HOURS TO 0[illegible] HOURS | TOTAL HOURS COVERED 24 | DATE 28 AUG

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
07	H2O	450	450
	Juice	180	630
1200	H2O	450	1080
	Tea	180	1160
1720	H2O	450	1810
8/28	Juice	180	1790
1930	H2O	230	2020
8/29			
0700	juice	240	240cc
07	milk	240	480cc
1230	juice	240	720cc
↓	H2O	600	1220cc
1800	milk	240	1460cc
1800	juice	240	1700cc
	~~H2O IVF~~		
1/31 1900	H2O	240	240
1/01 0700	Milk	240	240
0800	H2O	240	480

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
06	250	Cipro	250	07	250
1720	250	Cipro	250	1800	500
		29AUG03			
0630	250	Cipro	250		250cc
0630	12	NS flush	12		262cc
1745	8	NS flush	8		270cc
1750	250	Cipro			

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. BI, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

[redacted]

b(6)-4

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1040	700	700			
1600	400	1100			
		29AUG03			
0700	1000	1000cc			
1750	600	1600cc			
31					
0800	400	400			
0700	800	1200			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL
0850	200	Yellow	200cc

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT JP2

TIME	AMOUNT	TYPE	ACCUM TOTAL
1500	10cc	Serosanguinous	10cc
0500		Serosanguinous	
		D/C'd 29AUG03	
		GRAND TOTAL OUTPUT	

REMARKS

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

b(6) - 4

[redacted]

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

DD FORM 792, JAN 74 EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(7 MP) 1 JUL 72 WHICH MAY BE USED. USAPPC V1.00

ID: [redacted]
WB 05-08-03
04:25

				Patient Limits
WBC	15.3	H	x10^3/uL	4.5 10.5
RBC	3.31	L	x10^6/uL	4.00 6.00
Hgb	9.6	L	g/dL	11.0 18.0
Hct	30.9	L	%	35.0 60.0
MCV	93.3		fL	80.0 99.9
MCH	29.0		pg	27.0 31.0
MCHC	31.1	L	g/dL	33.0 37.0
Plt	460.	H	x10^3/uL	150. 450.
LY%	20.1	*	%	20.5 51.1
LY#	3.1	*	x10^3/uL	1.2 3.4

---

i-STAT CREA

Pt: [redacted] b(4)-4

Pt Name:_____

Crea_____1.3 mg/dL

Sample Type_:

18AUG03 10:53

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

---

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____102 mg/dL

BUN_____13 mg/dL

Na_____134 mmol/L

K_____4.0 mmol/L

Cl_____101 mmol/L

TCO2_____31 mmol/L

AnGap_____7 mmol/L

Hct_____37 %PCV

Hb*_____13 g/dL

*via Hct

pH_____7.510

PCO2_____37.4 mmHg

HCO3_____30 mmol/L

BEecf_____7 mmol/L

Sample Type_:

ID: [redacted]
WB 06-08-03
04:25

				Patient Limits
WBC	11.1	H	x10^3/uL	4.5 10.5
RBC	3.40	L	x10^6/uL	4.00 6.00
Hgb	9.8	L	g/dL	11.0 18.0
Hct	31.5	L	%	35.0 60.0
MCV	92.6		fL	80.0 99.9
MCH	28.7		pg	27.0 31.0
MCHC	31.1	L	g/dL	33.0 37.0
Plt	491.	H	x10^3/uL	150. 450.
LY%	25.0	*	%	20.5 51.1
LY#	2.8	*	x10^3/uL	1.2 3.4

ID: [redacted]
WB 07-08-03
04:23

				Patient Limits
WBC	10.9	H	x10^3/uL	4.5 10.5
RBC	3.61	L	x10^6/uL	4.00 6.00
Hgb	10.5	L	g/dL	11.0 18.0
Hct	33.6	L	%	35.0 60.0
MCV	92.9		fL	80.0 99.9
MCH	29.1		pg	27.0 31.0
MCHC	31.4	L	g/dL	33.0 37.0
Plt	491.	H	x10^3/uL	150. 450.
LY%	23.0	*	%	20.5 51.1
LY#	2.5	*	x10^3/uL	1.2 3.4

ID: [redacted]
WB 08-24-03
09:18

				Patient Limits
WBC	10.7	H	x10^3/uL	4.5 10.5
RBC	4.27		x10^6/uL	4.00 6.00
Hgb	12.2		g/dL	11.0 18.0
Hct	39.0		%	35.0 60.0
MCV	91.3		fL	80.0 99.9
MCH	28.5		pg	27.0 31.0
MCHC	31.2	L	g/dL	33.0 37.0
Plt	432.		x10^3/uL	150. 450.
LY%	27.2	*	%	20.5 51.1
LY#	2.9	*	x10^3/uL	1.2 3.4

i-STAT EC8+

Pt: [redacted] b(6)-4

Pt Name:_____

Glu	99	mg/dL
BUN	11	mg/dL
Na	142	mmol/L
K	3.6	mmol/L
Cl	110	mmol/L
TCO2	25	mmol/L
AnGap	11	mmol/L
Hct	26	%PCV
Hb*	9	g/dL

*via Hct

PH	7.388	
PCO2	40.1	mmHg
HCO3	24	mmol/L
BEecf	-1	mmol/L

Sample Type_:

04AUG03 10:07

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID: [redacted] 04-08-03
WB 10:06

				Patient Limits	
WBC	11.1	H	x10^3/uL	4.5	10.5
RBC	3.04	L	x10^6/uL	4.00	6.00
Hgb	8.9	L	g/dL	11.0	18.0
Hct	28.3	L	%	35.0	60.0
MCV	93.0		fL	80.0	99.9
MCH	29.3		pg	27.0	31.0
MCHC	31.5	L	g/dL	33.0	37.0
Plt	402.		x10^3/uL	150.	450.
LY%	26.8	*	%	20.5	51.1
LY#	3.0	*	x10^3/uL	1.2	3.4

TESTIS

SPECIMEN TAKEN DATE	TIME A.M. P.M.	RESULTS	REQUESTED	(X)
			ROUTINE	
			COLOR	
21.030			SPECIFIC GRAVITY	
0,2			UROBILINOGEN	
			OCCULT BLOOD	
Neg			BILE	
Neg			KETONES	
Neg			GLUCOSE	
Trace			PROTEIN	
5.0			pH	
			MICROSCOPIC	
small			WBC	
Lg +++++			RBC	
			EPITH CELLS	
			WBC	CASTS
			RBC	CASTS
			HYALINE	CASTS
			GRANULAR	CASTS
			BACTERIA	
			CRYSTALS	
			MUCUS	
Pos			NITRITE	
			BENCE-JONES PROTEIN	
			HEMOSIDERIN	
			HCG	

REMARKS

TECH

MD DATE

REPORTED BY

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQUESTING PHYSICIAN'S SIGNATURE

b(6)-4

[redacted]

URINALYSIS

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

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

SPECIMEN SOURCE: ☐ ROUTINE ☐ OTHER (Specify)

LAB. ID NO.

SPECIMEN/LAB RPT NO

PATIENTS MED. RECORD

URINALYSIS 550-106
Standard Form 550 (Rev. 4-77)
General Services Administration and Interagency Committee on Medical Records FPMR 101-11.806-8

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 21 Aug 03	TIME	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
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	Yellow	N/A
App	Slightly Cloudy	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.030	N/A
Bld	Large	Negative
pH	5.0	N/A
Prot	Small	Negative
Urob	0.2	0.2-1.0
Nit	Positive	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

SSA-Small
WBC-20-30
RBC-20-30
Bacti-Small

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: b(6)-2

REPORTED BY: [redacted]	DATE: 21 Aug 03	LAB ID NO.:

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 4Aug03 / TIME	SSN/PSEUDO SSN: [redacted] b(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF.	
======= PICCOLO =======			
04/08/03		10:10	
REFERENCE RANGE:		MALE	
PATIENT #: [redacted]			
GENERAL CHEMISTRY 12			
DISC LOT #:		3142AA4	
OPER #: [redacted]		DR #: 000	
SERIAL #: [redacted]			
ALB	2.5*	3.3-5.5	G/DL
ALP	44	26-84	U/L
ALT	27	10-47	U/L
AMY	34	14-97	U/L
AST	23	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
BUN	10	7-22	MG/DL
CA++	8.2	8.0-10.3	MG/DL
CHOL	66*	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	106	73-118	MG/DL
TP	6.3*	6.4-8.1	G/DL
INST QC: OK		CHEM QC: OK	
HEM 0 , LIP 0 , ICT 0			

(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
CO_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: b(6)-2

REPORTED BY: [redacted]	DATE: 4 Aug 03	LAB ID NO.:

Ward/Section: ICU

REQUESTING PHYSICIAN: [redacted]

b(6)-2

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

LAST, FIRST, MI. [redacted] b(6)-4

DATE 8/5/03

TIME 0500

SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/
pH		7.31-7.45
PCO2		35-45 mmHg 41-51 mmHg (v
PO2		80-105 mmHg (N/A (ven)
TCO2		23-27 mmol/L (a 24-29 mmol/L (v
HCO3		22-26 mmol/L (a 23-28 mmol/L (v
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

======= PICCOLO =======
05/08/03 04:24
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	85	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	59	55-380	U/L
NA+	♦♦♦	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	100	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

Na-135

(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
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]

DATE: 5Aug03

LAB ID NO.:

b(6)-2

b(4)-4

Ward/Section: ICU 1	REQUESTING PHYSICIAN: [redacted]	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b(4)-2	DATE 8/5/03	TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: [redacted] **DATE:** 5Aug03 **LAB ID NO.:**

b(4)-2

[redacted]

[redacted] b(6)-4

Ward/Section: [redacted] REQUESTING PHYSICIAN: [redacted] b(6)-2

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

LAST, FIRST, MI.

DATE: 18-Aug-03 TIME: 0400 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			

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] **DATE:** 6 Aug 03 **LAB ID NO.:**

b(6)-4

[redacted] b(6)-2

Ward/Section: [redacted]	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI:	DATE: 8-6-03	TIME: 0400
		SSN/PSEUDO SSN:

i-STAT

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 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

======= PICCOLO =======
06/08/03 04:37
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	86	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	66	39-380	U/L
NA+	♦♦♦	128-145	MMOL
K+	4.1	3.3-4.7	MMOL
CL-	95*	98-108	MMOL
tCO2	22	18-33	MMOL

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

Na 133

tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]

DATE: 6 Aug 03

LAB ID NO.:

b(6)-2

b(a)-4

Ward/Section: TC	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted]	DATE 07Aug03	TIME 0400	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		

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	
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: [redacted]	DATE: 7 Aug 03	LAB ID NO.:

b(a)-2

Ward/Section: [redacted] | REQUESTING PHYSICIAN: [redacted]

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

LAST, FIRST, MI: [redacted] b(6)-4 | DATE: 07AUG03 | TIME: 0402 | SSN/PSEUDO SSN:

i-STAT

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l

======= PICCOLO =======
07/08/03 04:27
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	91	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	54	39-380	U/L
NA+	123*	128-145	MMOL
K+	4.6	3.3-4.7	MMOL
CL-	99	98-108	MMOL
tCO2	24	18-33	MMOL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
[illegible]		8.0-10.3 mg/dl
[illegible]E		0.6-1.2 mg/dl
[illegible]		128-145 mmol/l
[illegible]		3.3-4.7 mmol/l
[illegible]		98-108 mmol/l
[illegible]O_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
[illegible]LB		3.3-5.5 g/dl
[illegible]LP		26-84 u/l
[illegible]LT		10-47 u/l
[illegible]MY		14-97 u/l
[illegible]ST		11-38 u/l
[illegible]BIL		0.2-1.6 mg/dl
[illegible]GT		5-65 u/l
[illegible]P		6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted] b(6)-2 | **DATE:** 7 Aug 03 | **LAB ID NO.:**

Ward/Section: [redacted] REQUESTING PHYSICIAN: [redacted] b(6)-2

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

LAST, FIRST, MI: [redacted] DATE: 18 Aug 03 TIME: 1045 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 10^6
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	yellow	N/A
App	cloudy	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.020	N/A
Bld	large	Negative
pH	6.5	N/A
Prot	trace	Negative
Urob	0.2	0.2-1.0
Nit	neg	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

SQ - trace
Rbc - 1-2
Wbc - 1-2

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: b(6)-2

REPORTED BY: [redacted] **DATE:** 8-18-03 **LAB ID NO.:**

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

i-STAT

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

(Piccolo) Methyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 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.:
[redacted]	18Aug03	

b(6)-2

b(6)-2

Ward/Section:	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, Middle: [redacted]		DATE: 8/24/03 TIME: SSN/PSEUDO SSN: # [redacted]

b(6)-4

b(6)-4

(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		5-65 u/l
CA++		6.4-8.1 g/dl
CHOL		
CREA		
GLU		
TP		

(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
tCO2		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
BUN		5-65 u/l
CA++		6.4-8.1 g/dl
CHOL		
CREA		
GLU		
TP		

(Piccolo) Electrolyte

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

PICCOLO
24/08/03 17:17
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METHYTE 8
DISC LOT #: 3152AA4
DISP #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	84	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	1.5*	0.6-1.2	MG/DL
CK	33*	39 380	U/L
NA+	132	128-145	MMOL
K+	4.4	3.3-4.7	MMOL
CL-	97*	98-108	MMOL
tCO2	22	18-33	MMOL

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

REMARKS:

b(6)-2

REPORTED BY: [redacted] **DATE:** 8-24-03 **LAB ID NO.:**

See other Side

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

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: 28-45-9 20

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

MEDICAL RECORD - ANESTHESI[illegible]

[illegible] of this form, see AR 40-66; the proponent agen[illegible]e OTSG

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

DRUG	(Units)	
Fentanyl	(ug)	100-50-100-50
Versed	(mg)	2.5/2.5
Lipocaine	(mg)	100
propofol	(mg)	80
	( )	
	( )	
VOLAT AGENT Sevo	% del	0/2/2/1.5/1/1/1
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	3/3/3/3/3/3/3

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

FLUIDS

LINE site		
LR 18g RAC	☐ Warmed	#1 — 300
NS 18g LAC	☐ Warmed	#1 — 200
	☐ Warmed	

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT 70 KG LB

HEMATOCRIT

INITIAL DATA

BP- 113 / 68

HR- 94

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? Y

TIME- 1400

TIME 1400 x 1430 A 1500

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

220 200 180 160 140 120 100 80 60 40 20

1g Ancef IVPB 1400 — 500 cc LR

VENTIL

VT - ml		750	740	740	520
f - breaths/min		8	8	8	8
Peak inf pres / PEEP		23	23	23	21
MODE - S(pon), A(ssist), C(on)		S-C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	✓	ET CO2 (torr)	38	35	42	53
BP/oth	✓	FIO2 (Frac or %)	80	.82	.83	.83
ART line	✓	SpO2 (%)	100	100	100	100
Steth- PC/ES	✓	ECG	SR	SR	SR	SR
Gas analyzer	✓	TEMP-site				
	✓	N-M Block (T/4)	4/4	4-9	4-4	
Warming blkt						
Conv warmer						

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

TOTALS

TOTAL EBL	TOTAL URINE
MIN	Ø

FLUIDS SUMMARY

CRYSTALLOID- 500

COLLOID- Ø

BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

1345 PT ID PREOP ASSESSMENT PER 2400.

1409 RM, O_2, monitors

1414 LW inserted

1440 PT ↑ PIP TO 41, slight wheeze, .25 mg Verb SC given

1508 PT RTC — SEN-ext-SKG

1513 TO ICU 1

1518 RPT TO [redacted] RN

RECOVERY AT 1515

PACU (ICU) T (Specify)

OTHER

CONDITION: stable T 100.3

RESP- 28 SpO2- 96% BP- 125/67 HR- 120

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1345	1358	1525
PROC	Ready	Begin	End
	1409	1432	1501

PROCEDURES and CPT Codes: Cystoscopy / Scrotal washout

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* GETA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility* b(6)-2

[redacted] ICU-2

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

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* LW x1 inserted atraumatically, cuff↑ on 8.0ETT, $@Et_{CO_2}$ 0605, taped to (R) OA inserted

SURGEONS: [redacted] b(6)-2

ANESTH[redacted] CRNA

PROCEDURE LOCATION: OR 2

DATE: 4 AUG 03

PAGE 1 OF

DA FORM 7389, FEB 1998 — MEDCOM - 15738 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 22 DAYS MOS (YRS) Sex (M) MALE ( ) FEMALE

PROPOSED PROCEDURE: Scrotal Washout/Cystoscopy
SURGICAL SERVICE: Urology
NPO SINCE: 0700 today

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

HABITS:
TOBACCO: No
ETOH: NO
DRUGS: NO

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Ancef 1g IV, 8°
( ) gentamicin 400mg IV
( ) D 1/2 NS @ 24°
( ) ____
( ) MSO4
( ) Phenergan

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

LABORATORY STUDIES:
HB/HCT: 8 / 28
U/A: 20-30 WBC; large blood
OTHER: ____

Plts 402,000
WBC 11,000
142 | 110 | 11 (<99)
3.6 | 25 | 1.0

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	NA
Other Significant Hx:	N	(Y)	GSW to groin/penis 11 days ago — now has purulent discharge from penile/scrotal area
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Exploratory Laparotomy on 24 July 03

PHYSICAL EXAMINATION
BP 116/69 HR 82 R 15 T 100°
Pain Scale 0-10 ____
HEENT - Teeth OK
Trachea Midline
TMJ/Neck Full ROM
Oropharynx MP I TMD TC
Nares ____
CHEST: ____
CARDIAC: ____
EXTREMITIES: ____
IV Access: 18 ga (R) AC
Ulnar Filling: ____
BACK: ____
OTHER: ____

NPO Since 0700 today

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (X) General: Mask Intubation
Interpreter used during interview — pt understands plan

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

The patient/[redacted] b(6)-2 understand and agrees. Questions answered.
Signed: [redacted] MD Date: 04 AUG 2003 Time: 1143 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

SEDATION KEY:

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

Patient Identification: (Ward) ICU 1

[redacted] b(6)-4

4.2 | 21 | 100 | 78 | 1.1 NKDA

MEDICAL RECORD - ANESTHESIA

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

DRUG (Units)

Versed (mg)	2	
Lidocaine (Mg)	20	
propofol (mg)	100	
Fentanyl (ug)	50	25
( )		
( )		
VOLAT AGENT Sevo % del	4	2%
% e.t.		
AIR L/Min		
N2O L/Min		
O2 L/Min	4	4

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

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

TOTALS: 2 mg; 20 mg; 100 mg; 75 mg

TOTAL EBL: min

TOTAL URINE: in FC

FLUIDS SUMMARY

CRYSTALLOID- 500 cc

COLLIDOR-

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

Pt IDd in pacu. Monitors applied. To pacu, placed on 3L NC. VLT [redacted] given. Report.

LINE site

- [ ] Warmed — M O'Neal
- [ ] Warmed
- [ ] Warmed
- [ ] Warmed

LOSSES: EST BLOOD LOSS; URINE - FC

To floor medical

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT: 8.6 / 30.9

INITIAL DATA: BP 127 94; HR 95

EQUIP CHECK: OK? (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME 0715

TIME 0800 0830

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

220 200 180 160 140 120 100 80 60 40 20

MONITORS/ACCESSORIES / VENTIL

VT - ml				
f - breaths/min		16	10	12
Peak inf pres / PEEP				
MODE - S(pon), A(assist), C(on)		S	S	S
BP/Auto Cuff	ET CO2 (torr)	34	38	36
BP/oth	FIO2 (Frac or %)	1.0	1.0	1.0
ART line	SpO2 %	100	100	100
Steth- PC/ES	ECG	ST	ST	ST
Gas analyzer	TEMP-site	37	37	
	N-M Block (T/4)			
Warming blkt				
Conv warmer				

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

RECOVERY AT

PACU (ICU 2) (Specify)

OTHER

CONDITION: Stable

RESP- 20 / SpO2 98 98 BP- 129/73 HR- 105

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0745	0750	0832
PROC	Ready	Begin	End
	0755	0757	0827

PROCEDURES and CPT Codes: dressing change of pens

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

Endotracheal inhalation maintained

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

Mask

SURGEON [redacted] b(6)-2

ANES [redacted]

PROCEDURE LOCATION: OR 1

DATE: 05 Aug 03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 — MEDCOM - 15740 — COPY 1 - PATIENT'S MEDICAL RECORD

ANESTHESIA PLAN OF CARE-PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 22 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: Disg chg
SURGICAL SERVICE: _____
NPO SINCE: _____

ASA Physical State 1 2 3 4 5 E
WT: 10 KG/LB HT: _____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: N
ETOH: N
DRUGS: N

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) MS04
( ) phenergan
( ) Neo/Bet
( ) ketoconazole
( ) Gent
( ) Cefzol

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

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

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	GSW 24 July
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

Exp Lap 24 July
4 Aug cysto washout

PHYSICAL EXAMINATION
BP 124 HR 75 R 16 T 100.7
Pain Scale 0-10 _____
HEENT - Teeth _____
Trachea _____
TMJ/Neck _____
Oropharnyx _____
Nares _____
CHEST: _____
CARDIAC: _____
EXTREMITIES: _____
IV Access: Rt Hand
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since _____

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: [redacted] b(6)-2 Date: 05 Aug 03 Time: 0745 Hrs

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

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) _____

[redacted] b(6)-4 PCU

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.

Cefuroxime 1.5GM IVPB MKDA ASA I GA as per previous workup

2240 1245 13 30

MEDICAL RECORD - ANESTHESIA

...e of this form, see AR 40-66; the proponent agen...ne OTSG

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

DRUG	(Units)			
Versed	(mL)	6		
Fentanyl	(mcg)	150	50, 50, 50	
Propofol	(mL)	180		
( )				
( )				
VOLAT AGENT: Forane	% del	1½	1½	X
	% e.t.			
AIR	L/Min			
N2O	L/Min			
O2	L/Min	2		

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

FLUIDS — LINE site: 1. SA/C #18 ☐ Warmed; ☐ Warmed; ☐ Warmed; ☐ Warmed

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG / LB

HEMATOCRIT: 33.6

INITIAL DATA: BP- 116/65; HR- 85

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME- 1030

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

TIME → 1245 13 30 4

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

MONITORS/ACCESSORIES/VENT

VT - ml		700	700	800	800
f - breaths/min		12	12	10	10
Peak inf pres / PEEP		22	22	20/4	21
MODE - S(pon), A(ssist), C(on)		CV	CV	CV	CV
BP/Auto Cuff	ET CO2 (torr)	35	35	T	T
BP/oth	FIO2 (Frac or %)				
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site	95	95		
	N-M Block (T/4)	4/4			
Warming blkt					
Conv warmer					

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

TOTALS: TOTAL EBL 200 / 1.2 L / 5; TOTAL URINE 1.8 L / 5 / Ray

FLUIDS - SUMMARY: CRYSTALLOID- 2.0 L; COLLOID- 0; BLOOD- 0

REMARKS (Code drugs with numbers, events with letters)

1. Urine monitor on
2. See below
3. Foley

RECOVERY AT: PACU ICU 3 (Specify); OTHER

CONDITION: RESP- 18; SpO2- 93; BP-; HR- 78

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1230	1245	1345
PROC	1255	1330	1345

PROCEDURES and CPT Codes: Delayed Primary Closure

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: G/A - #4 LMA

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

[redacted] b(6)-4

ICU 3

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: ORA #4 LMA BL-BS Cobra-atic

SURGEON: [redacted] 210R b(6)-2

PROCEDURE LOCATION: OR 2

DATE: 11 AUG 03

PAGE 1

DA FORM 7389, FEB 1998 — MEDCOM - 15742 — COPY 1 - PATIENT'S MEDICAL RECORD

PRE-ANESTHETIC ASSESSI AND PLAN OF CARE

AGE: 34 Days Mos Yrs

GENDER: (X) Male ( ) Female

ALLERGIES: NKDA

P S: 1 2 3 4 5 E

WT: 80 (KG) Lb HT: ____ In.

PROPOSED PROCEDURE: DPC

SURGICAL SERVICE: ORTHO

NPO SINCE: MN

PREOP DX / MECHANISM OF INJURY: S/P GSW

HABITS:

Tobacco: (+)

EtOH: (+)

Drugs: (-)

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) Ancef 1g TID (given 0800)

( ) Clindamycin 300mg Q8°

( ) ____

( ) ____

( ) ____

PREMEDICATIONS:

None / Yes @ ____ Hrs

LABORATORY STUDIES: 17AUG03

130	105	13	146
3.5	19	1.5	

10.1	9.0	335	
	26.8		

17.3 / 26.2

Other: ____

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:		
Hypertension	N	Y
Angina	N	Y
MI	N	Y
CVA	N	Y
Other	N	Y
Pulmonary:		
Asthma	N	Y
URI	N	Y
COPD	N	Y
Other	N	Y
Renal System:		
ARF/CRF	N	Y
Other	N	Y
Gastrointestinal:		
Hepatitis	N	Y
Hiatal Hernia	N	Y
GERD/PUD	N	Y
Endocrine:		
Diabetes	N	Y
Steroids	N	Y
Thyroid	N	Y
Neurological:		
Seizures	N	Y
Neuropathy	N	Y
Gynecological:		
Pregnancy	N	Y
Other	N	Y
Other Problems:	N	Y
Familial Hx	N	Y

SURGICAL HISTORY

(R) LE x 2

(L) ARM x 2 > 20 comps

PHYSICAL EXAMINATION

BP: 120/70 HR: 74 RR: ____ T: 98°

Pain (0/10 Scale): ____

Airway Exam:

Dentition intact

Trachea Midline

TMJ/C-spine FROM / TMD > 3FB

Oropharynx MP II

Chest:

Lungs CTA

Heart S1S2

IV Access: none

Ulnar Filling: ____

Back: ____

Other: ____

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: ____ (X) General: Intubation / Mask-LMA Notes: ____

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with patient and/or legal guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

b(6)-2

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

Signed: [redacted] CRNA Date: 24 AUG 03 Time: 0826

PATIENT IDEN ON:

[redacted]

b(6)-4

POST-ANESTHESIA EVALUATION AND NOTE:

( ) No apparent anesthetic complications.

( ) Other (see progress notes)

Signed: ____ Date: ____ Time: ____

Nursing Unit: ICU

MEDCOM - 15743 HOSPITAL & MEDICAL TASK FORCE-BAGHDAD

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)										
Versed (mg)	5									
Fent ( )	100	50	50	50						
Lidocaine ( )	100									
MSO4 ( )					4	2	4			
Propofol ( )	150			50						
VOLAT AGENT: Forane % del		1.5	2.0	1.5	1.5	1.5	IV			
% e.t.										
AIR L/Min										
N2O L/Min										
O2 L/Min	8	2	2	7	1	1	1	10		

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

FLUIDS

LINE site										
NS ☐ Warmed		300					600			
☐ Warmed										
☐ Warmed										
☐ Warmed										

LOSSES: EST BLOOD LOSS; URINE -

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 82 KG LB

HEMATOCRIT:

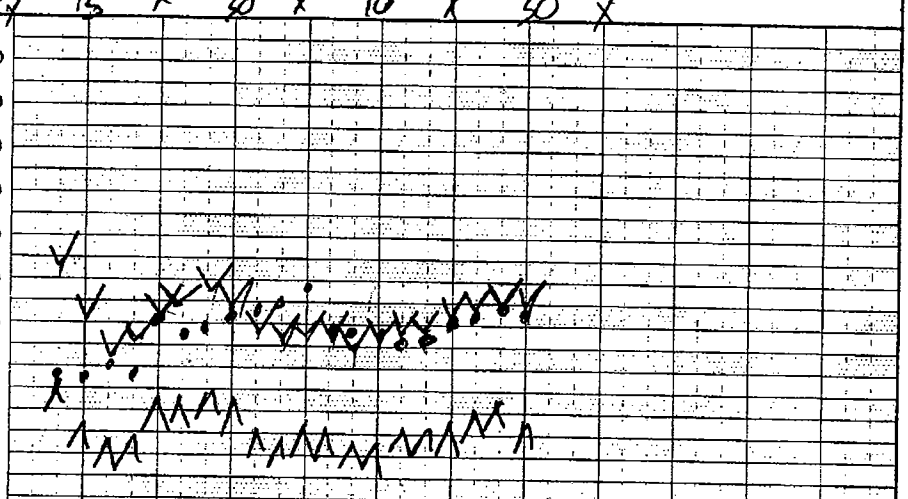
INITIAL DATA: BP- 121/71; HR- 77

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? TIME-

TIME → 1 .15 X 30 X 16 X 30 X

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



VENTIL

VT - ml	SV	CV	SV	SV	SV	SV	SV	SV
f - breaths/min		5	21	12	10	16	16	16
Peak inf pres / PEEP		19						
MODE - S(pon), A(sist), C(on)	S	C						

MONITORS/ACCESSORIES

BP/Auto Cuff / ET CO2 (torr)	38	51	49	57	40	50	43	44
BP/oth / FIO2 (Frac or %)	.77	.77	.76	.76	.76	.79	.79	.79
ART line / SpO2 (%)	100	100	100	100	100	100	100	100
Steth- PC/ES / ECG	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer / TEMP-site		37	37	37		37		
N-M Block (T/4)								
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS. EVENTS Position → 6 1

TOTALS: 5mg 250mg

TOTAL EBL: Min

TOTAL URINE: Ø

FLUIDS SUMMARY: CRYSTALLOID- 600; COLLOID- Ø; BLOOD- Ø

REMARKS

Code drugs with numbers, events with letters

1450 in OR monitors applied
1500 Induct LMA placed ⊕ ETCO2 ⊕ Bilat BS
1635 - 5 post Resp, LMA removed mask vent assist until purposeful movement. transfred to PACU.

RECOVERY AT: PACU

PACU ICU _____ (Specify)

OTHER _____

CONDITION: 5 post Resp, 100 RA,

RESP- 16 SpO2- 98

BP- 124/55 HR 112

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1400	1450	1640
PROC	Ready	Begin	End
	1500	1520	1635

PROCEDURES and CPT Codes: Penis graft / Debrid closure

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* #4 LMA

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

#[redacted] b(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* LMA placed one attempt ⊕ Bilat BS

SURGEONS: [redacted] b(6)-2

ANESTHETISTS: [redacted]

PROCEDURE LOCATION: 28th CSH Baghdad

DATE: 8/25/03

PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 15744 COPY 1 - PATIENT'S MEDICAL RECORD USAPA V1.00

PRE-ANESTHETIC ASSESSI AND PLAN OF CARE

AGE: 30 Days Mos (Yrs)

GENDER: (✓) Male ( ) Female

ALLERGIES: NKA

P S: (1) 2 3 4 5 E

WT: 75 (Kg) Lb HT: ____ In.

PROPOSED PROCEDURE: Penis Graft

SURGICAL SERVICE: Urology

NPO SINCE: MN

PREOP DX / MECHANISM OF INJURY: GSW

HABITS:

Tobacco: Ø

EtOH: ____

Drugs: ____

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) Cipro BID

( ) ____

( ) ____

( ) ____

( ) ____

( ) ____

PREMEDICATIONS:

None / Yes @ ____ Hrs

LABORATORY STUDIES:

132	97	8	84
4.4	22	1.5	

10.7 / 12.2 / 39.0 / 432

Other: ____

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:		
Hypertension	N	Y
Angina	N	Y
MI	N	Y
CVA	N	Y
Other	N	Y
Pulmonary:		
Asthma	N	Y
URI	N	Y
COPD	N	Y
Other	N	Y
Renal System:		
ARF/CRF	N	Y
Other	N	Y
Gastrointestinal:		
Hepatitis	N	Y
Hiatal Hernia	N	Y
GERD/PUD	N	Y
Endocrine:		
Diabetes	N	Y
Steroids	N	Y
Thyroid	N	Y
Neurological:		
Seizures	N	Y
Neuropathy	N	Y
Gynecological:		
Pregnancy	N	Y
Other	N	Y
Other Problems:	N	Y
Familial Hx	N	Y

SURGICAL HISTORY

DPC Debridement > 8 comps

PHYSICAL EXAMINATION

BP: ____ HR: ____ RR: ____ T: ____

Pain (0/10 Scale): ____

Airway Exam:

Dentition: intact

Trachea: midline

TMJ/C-spine: Free / 3FB

Oropharynx: MPT

Chest:

Lungs: CTA

Heart: $S_1 S_2$

IV Access: 18g

Ulnar Filling: ____

Back: ____

Other: ____

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: ____ (✓) General: (Intubation) / Mask-LMA Notes: ____

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with patient and/or guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

b(6)-2

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

Signed: [redacted] CRT CRNA Date: 25 AUG 03 Time: 0800

PATIENT IDENTIFIC [redacted]

H [redacted]

b(6)+4

POST-ANESTHESIA EVALUATION AND NOTE:

( ) No apparent anesthetic complications.

( ) Other (see progress notes)

Signed: ____ Date: ____ Time: ____

Nursing Unit: ICU

MEDCOM - 15745 [redacted] HOSPITAL & MEDICAL TASK FORCE-BAGHDAD

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b(6)-4

ICU7

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	4 Aug 03	1010 HOURS	
1	Admit ICU		1130
2	Condition: Stable		b(6)-2
3	Diet NPO		[redacted]
4	IVF NS @ 150 cc/h		
5	Foley to gravity drainage		
6	Ancef 1gm q 8° IVPB First dose now		First

PATIENT IDENTIFICATION

[redacted] b(6)-4

ICU1

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	Cent 400 mg IVPB q 24° HOURS		First
	dose now		
7	MSO4 2-6 mg IVP q 2° PRN pain		
8	Reglan 12.5 mg IVP q 6° PRN Nausea		
9	VS q 2°		
10	To OR today		
11	Observation in ICU overnight		
12	R[redacted]		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER

NKDA

[redacted] 0820 HOURS

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	5 Aug 03	HOURS	
	Resume previous orders		
	Fentanyl 50-250 mcg [redacted] Drips		AS
	Versed 2-4 mg IVP [redacted]		
	Drug D's		

b(6)-2

[redacted]

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

☆ U.S. GOVE MEDCOM - 15746

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
4 Aug 03	1800 HOURS	
Admit to ICU 1		
Dx S/P penile DSW		
Condition stable		
VS q 2hr		
Diet ~~Regular~~ clear liquids		
IVF LR @ 100 cc/hr		
Foley: Needs to be taped		

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
upward on abdomen at all times. (Record output	HOURS	
In graves drains		
Reinforce dsgs as needed		
Dressing change by MD in AM		
Please have fine mesh gauze roll and NS @ bedside		

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
in AM	HOURS	
✓ MSO4 2-6mg IVP q 2° PRN pain		
✓ Percocet 1-2 tabs PO q 4° PRN pain		
✓ Phenergan 12.5g IVP q6° PRN Nausea		
✓ Ancef 1gm q 8° (last dose @ 1400) IVPB		

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
✓ Gentamycin 400g IVPB	HOURS	
q 24° (last @ 1400)		
✓ Ketoconazole 400 mg PO		
q 8° X 9 doses.		
✓ CBC, chem 8 q AM X 3 days.		

[redacted]

b(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION MEDCOM - 15747 USE[redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION [redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

4 Aug 03 | 1800 | HOURS

NPO after Midnight } Intubate | 0530

To OR now

[redacted]

PATIENT IDENTIFICATION [redacted]

ICU 3 b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

9 Aug 03 | 0831 | HOURS

Transfer to ICU3

Dx: Penile osw

Cerebrex Stretcher

VS q 4°

Foley to gravity drainage

IVF LR @ 75 cc/h

Diet Regular

PATIENT IDENTIFICATION [redacted]

ICU3

NURSING UNIT | ROOM NO. | BED NO.

MSO4 2-4 mg IVP now prn

Percocet 1-2 PO q 4° prn

Reglan 25 mg PO q 6° or 12.5 mg IVP q 6° prn Nausea

Colace 100 mg PO BID

Ciprofloxacin 500 mg PO BID

Dexa 4 qAM @ 0800 & MD

Fentanyl 150 mcg IVP q hr

PATIENT IDENTIFICATION [redacted]

Dexa 4

Acting O ~~Bedrest~~ Bedrest c BRP

b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

8 c Pco ~~4/0~~ 4/0 2 0200 ances

dependent ion NC

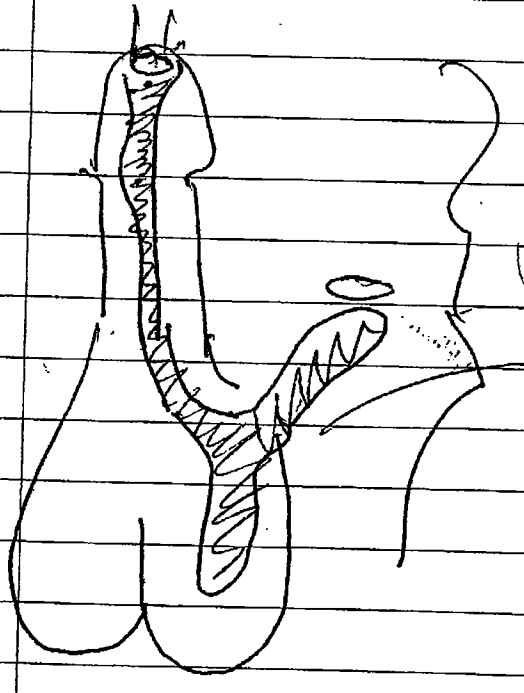
24° Chart Check 10 AUG 0030 [redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF -

MEDCOM - 15748

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 Aug 13	Brief op note Procedure: ① Penile, scrotal, groin wound exploration / debridement ② Urethroscopy Indication: SP GSW Perineum Surg Dr [redacted] / Dr [redacted] GETA ABX: Gent / Ancef Complications: [redacted] b(6)-4  Wounds

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

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

[redacted] b(6)-4

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

MEDCOM - 15749

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

11 Aug 03 | 0226 HOURS

NPO [redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

11 Aug 03 | 1400 HOURS

1. Return to ICU when medically cleared by anesthesia
2. DX: Penile GSW
3. Condition stable
4. IVF LR @ 75 cc/hr Replace when NPO
5. Regular Diet

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

6. Cipro 500 mg PO BID HOURS
7. Allow to ambulate
8. MSO4 2-6 mg IVP q 2° PRN
9. Percocet 1-2 PO q 4° PRN
10. Fentanyl 100-150 mcg IVP for drsg D's
11. Phenergan 25 mg IVP q 6° PRN Nausea
12. Colace 100 mg PO BID

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

13. Activity Bed rest HOURS
14. Dr. [redacted]
15. MEDA
16. Drsg D's → change
17. flush around penrose BID
Use wet fine mesh gauze to b(6)-2
track wound bed. Wound and
wrap penrose, wrap penrose & 4x4's and

FORM 4256 1 APR 79 REPLACES EDITION OF 12AUG 0100 24° Chart Check [redacted] MEDCOM 15750 D. [redacted] LT/MAJ

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU3	24° Chart Check	

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
15 Aug 03	2000 HOURS	

① Δ VS to q8°.
V.O. DR [redacted] /ILT/AN

b(6)-2

b(6)-2 [redacted] /ILT/AN

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU3	24° Chart	[redacted]

b(6)-2

DATE OF ORDER	TIME OF ORDER
16 Aug 03	1037 HOURS

↓ Fentanyl to 50 mcg IVP q hr prn Δ↑

b(6)-2

b(6)-2 [redacted] /AN 1740 17Aug03

b(6)-2

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU3		

DATE OF ORDER	TIME OF ORDER
18 Aug 03	0816 HOURS

Phenergan 12.5 mg IVP Q6° PRN.
May ↑ Phenergan to 25 mg IVP if 12.5 mg does not work
V.O. Dr [redacted] /SK/AN

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU3		

DATE OF ORDER	TIME OF ORDER
18 Aug 03	0900 HOURS

Restart IVF LR @ 125 a/h
↑ VS to q4° / Strict I/O
Send CBC, chem 8, UA & portable CXR
~~Start Ceftriaxone 2000 mg IVPB q 12~~
Send β Flat plate (upright and ☓ ray and CXR
NPO

[redacted] /SK/AN 1138 18Aug03

[redacted] PO

b(6)-2 TJ 1005

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

MEDCOM - 15751

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 All

PATIENT IDENTIFICATION

[redacted] b(6)-4

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

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
18 Aug 03	1541 HOURS	
① Δ Foley catheter		
② 150 mcg Fentanyl IVP prior to changing Foley catheter		[redacted] ICW
V.O. per Dr. [redacted]		[redacted] 18 Aug 03

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER
19 Aug 03	0900 HOURS
① Transfer to ICW 2 Stretcher	
② Oxycodone 6SW	
③ Cont. saline	
④ VS & shift	
⑤ Act BSC	
⑥ NKDA	
⑦ Post. nephrostomy tube [redacted] NOTED	

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER
⑧ IVF: LR @ 125 cc/hr	
⑨ Demerol 25-50 mg IVPB q 6°	
Morphine 2-6 mg IV q 2° PRN	
Phenergan 12.5 mg IV q 4° PRN	
~~Phenergan~~ Fentanyl ~~100~~ 50 mcg IVP for dressing Δ's	
⑩ Dressing Δ's - change fluffs around nephro BID and PRN first moist gauze to back	

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER
Lower abdominal wound and nephro tube @ 4x4 + Kerlix	
⑪ Strict I+O's	
⑫ Foley to gravity	

[redacted] 19/1040 Aug 03

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

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"USE BALL POINT PEN—PRESS FIRMLY [illegible] 'ER REQUIRED"

MEDCOM - 15752

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: EPW [redacted]

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

DATE OF ORDER: 20 Aug ? | TIME OF ORDER: 0837 HOURS | LIST TIME ORDER NOTED AND SIGN

- VDC fentanyl
- VDC Morphine
- Percocet 1-2 PO q4° PRN
- VDC Ativan
- VDC strict I/O
- VS temp VS to dry sponge
- Flagyl BID NGO Keflex

PATIENT IDENTIFICATION: [redacted] b(6)-2

DATE OF ORDER: Keep recent | TIME OF ORDER: TJ | HOURS

- Dsg Itch

NURSING UNIT: | ROOM NO.: 24-1 | BED NO.:

PATIENT IDENTIFICATION: [redacted] b(6)-2

DATE OF ORDER: 22 Aug 05 | TIME OF ORDER: 1400 | HOURS

- DOB Wound BID STD

NURSING UNIT: 24°/2350 | ROOM NO.: | BED NO.:

PATIENT IDENTIFICATION:

DATE OF ORDER: | TIME OF ORDER: | HOURS

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

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

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"USE BALL POINT" MEDCOM - 15753 "PAPER REQUIRED"

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

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

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	24 Aug 03	1238 HOURS	
(1)	NPO ~~after~~ after midnight		
(2)	Start IV @ ~~2100~~ 1800 hr and start IV fluid @ 125 cc/hr.		b(6)-2
(3)	Start Ciprofloxacin 400 mg IV q12 (start @ 1800 Tonight)		

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

	DATE OF ORDER	TIME OF ORDER	
	b(6)-2		
	[redacted]		
	CBC and ~~not~~ BMP IV start. Qd per [redacted]		
	[redacted] b(6)-2		

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 - 15754

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

b(6)-4 [redacted]

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

DATE OF ORDER: 25 Aug 03 | TIME OF ORDER: 1636 HOURS | LIST TIME ORDER NOTED AND SIGN

SLP penile sleeve sheath
Transport to ward when cleared by anesthesi
IVF LR@ 100 cc/hr, heplock when tolerating PO
Diet Regular
Foley to gravity drainage

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

Strict I/O
Cipro 400 mg IVPB q 12°
MSO4 2-6 mg IVP q 2° PRN pain
Percocet 1-2 PO q 4° PRN
JP drain to bulb suction. Record on I/O sheet
VS q 4° x 48° hrs q 8°
Strict Bedrest

b(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

Dr [redacted] b(6)-2
MCDA [redacted] b(6)-2
1) MSO4 2mg q 5 [redacted] 10mg MSO4
Keep MAP 10 @ sat 95% [redacted] MAT AN CRNA-
b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER: 25 AUG 03 | TIME OF ORDER: 2245 HOURS

1) Phenergan 25mg IV q 6° prn
V.O. Dr [redacted] CRNA
b(6)-2

[redacted] b(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] b(6)-2			30 Aug 03	0720 HOURS	
			✓ DC IV		
			✓ Remove Foley		
			✓ D Cipro to 500 BID PO		
NURSING UNIT	ROOM NO.	BED NO.			
2A/0200	3	[redacted]			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

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

MEDCOM - 15756

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

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

31 Aug 03 0944

Shower patient B10 for 2 days

DC Cipro

Keflex 500 [redacted] x 5 days

b(6)-2

[redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

Noted 48hrs 03 JW 2324

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

9/3/03 0707

Actigall as tolerated

Cont Shower QD

b(6)-2

[redacted]

DC Chantix 4 Sep 03 1908 [redacted] LVT/AN

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

ICU

DATE OF ORDER | TIME OF ORDER | HOURS

OK for DC to EPW Camp

[redacted]

b(6)-2

[redacted]

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

MEDCOM - 15757

b(a)-2

CLINICAL RECORD

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

Mo. ___ Yr. ___

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 8/3	8/4
8/3	[redacted]	Cipro 400mg IV BID	0900	X	
			2100		
8/3	[redacted]	Bacitracin BID	0900	X	
		apply to wound	2100	X	

ALLERGIES: ☒ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION

[redacted]

b(a)-2

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 1 OCT 78 4677 MEDCOM - 15758 USED.

b(4)-2 All

CLINICAL RECORD — **THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)** — Yr. 2003

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4 5 6 7 8 9 10 11 12 13 14 15 16 17
8-4	[redacted]	Del WPC	05	
			17	
8-4	[redacted]	Foley to gravity/drain	06	[redacted]
			18	
8-4	[redacted]	US Q 8h° (5 days)	06	[redacted] D/C
			18	
[illegible]	[redacted]	[illegible]	06	
			18	
[illegible]	[redacted]	dressing [illegible]	06	
			17	
8-4	[redacted]	NKDA	06	[redacted]
			18	
8-4	[redacted]	Diet Clear Liquids AOV to Reg	06	[redacted]
			18	
8-4	[redacted]	CBC Chem 8 q Mon, Thurs	04	[redacted]
8-4	[redacted]	Foley; Needs to be taped	06	[redacted]
		to anterior abdomen @ all	18	
		times. Reinforce flush		
		as needed.		
8-9	[redacted]	Dressing Changes to L, MD	7	[redacted] D/C
8-9	[redacted]	BR = 3RP (11 Aug 03)	06	[redacted]
			18	
11 Aug 03	[redacted]	NPO	06	[redacted] D/C 11 Aug 03
			18	
11 Aug 03	[redacted]	Regular diet	06	[redacted]
			18	

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: S/P Penile GSW with debridement R/T GSW.

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

PATIENT IDENTIFICATION: EPW [redacted]

b(4)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 — MEDCOM - 15759 — ISED. — USAPA V1.00

b(6) - 2 All

Verify by Initialing: Order Date	Clerk Nurse	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) — SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
						Mo ____ Yr 2003
3au	[redacted]	observe in ICU overnight	8-4			[redacted]
8-4	[redacted]	To OR 8 a-p 3	8-4	ASAP	1850	[redacted]
8-4	[redacted]	Dressing change by MD in AM, please	8-5		done	[redacted]
	-----	have fine mesh gauze & roll and NS				
	-----	@ bedside				
8-4	-----	NPO p mnsr	8-5	0000	0000	[redacted]
11 Aug 03	[redacted]	Return to ICU when cleared by anesthesia	11 Aug 03	done		[redacted]
11 Aug 03	[redacted]	Condition stable	11 Aug 03	done		[redacted]
16 Aug	[redacted]	Send CBC, Chem 8, UA	16 Aug 03		1220	[redacted]
16 Aug	[redacted]	Send for Flat Plate / Upright	16 Aug 03	one time	1615	[redacted]
	-----	Abd X-ray & CXR				
16 Aug 03	[redacted]	Δ Foley Catheter	16 Aug 03		1555	[redacted]
16 Aug 03	[redacted]					

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

USAPA V1.00

(b)(6)-2 All

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. ___ 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
11 AUG 03	[redacted]	Drsg Δ's → change	08	✓	[redacted]						
		fluff's around penis BID	20	[redacted]							
		use wet fine mesh gauze									
		to back lower old wound									
		and wrap penis, wrap penis									
		c 4x4 and koban									
15Aug	[redacted]	V.S. Q8H	06	[redacted]							
			18	[redacted]							
11 Aug 03	[redacted]	Regular Diet	06	✓							
Discontinued 18 Aug 03			18	✓							
16 Aug 03	[redacted]	↑ VS to Q4° / Strict	06	✓							
		I+Os	18	✓							
16 Aug 03	[redacted]	NPO	06	✓							
			18	✓							

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: GSW penis S/P Penile debridement

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO — PAGE NO: 2

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

ACTION TIMES — USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 — MEDCOM - 15761 — JSED. — USAPA V1.00

b(6)-2 A11

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mar 08 Yr 2008

VERIFY BY INITIALING

INDIC. PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS FREQUENCY, TIME	HR	DATE COMPLETED 19 20 21 22 23 24 25 26 27
19	[redacted]	Vitals q 5 pt	05	[redacted]
			13	
			21	
19	[redacted]	Ambulate BSC prn OOB to void BID + MD	05	[redacted]
			13	
			21	
19	[redacted]	Leg lift ex	07	[redacted]
			11	
			17	
19	[redacted]	Dsg c BID → use wet to dry gauze to back bur use wet to dry saline gauze prn c 4x4's to bur	08	[redacted]
			20	
19	[redacted]	Start Zosyn	05	[redacted]
19	[redacted]		13	
			21	
19	[redacted]	Foley to gravity	05	[redacted]
			13	
			21	
BOTH	[redacted]	D/C Dressing gauze fluff BID: NO Kerlix	08	[redacted]
			20	

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: GSW L-5

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION

GSW of [redacted]

b(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 72 MAY BE USED. — USAPA V1.00

MEDCOM - 15762

b(6)-2

Verify by Initialing

TH ... RE ... ICATION

Mo 08 Yr

MD Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
			1	NOW	1045	

Order/ Expir	Clerk/	PRN ACTION FREQUENCY

b(6) - 2 AM

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. 08 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 25 26 27 28 29 30 31 1 2 3 4 5 6 7
25	[redacted]	Diet: regular	6	X [redacted]
			18	[redacted]
25	[redacted]	Foley to gravity	6	X [redacted]
			18	[redacted]
25	[redacted]	Strict I+Os	6	[redacted]
			18	[redacted]
25	[redacted]	Record on I+O Sheet: Suction Record	6	[redacted]
			12	[redacted]
		on I+Os Sheet	X	[redacted]
25	[redacted]	VS Q4° x 48° (until 1800 27 Aug), then Q8°	6	X [redacted]
			18	[redacted]
			X	[redacted]
[redacted]				
4 Sep	[redacted]	Activity as tolerated	06 14 18 22	→ [redacted]
4 Sep	[redacted]	Shavers Cmk QD	06 14	→ [redacted]

ALLERGIES: ☐ YES ☒ NO	PRIMARY DIAGNOSIS: Bilateral S/P Skin reconstruction	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO:
NKDA		

PATIENT IDENTIFICATION:

EPW [redacted] b(6) 4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 MEDCOM - 15764 ISED. USAPA V1.00

b(6)-2 All

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 08 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
30 Aug	[redacted]	Remove Foley	30 Aug PO30	—	0735	[redacted]
9/7	[redacted]	O.K. for D/C to EPW Camp	9/7			

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

USAPA V1.00

b(6)-2

(b(6)-2

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo. ___ Yr. ___

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4 5 6 7 8 9 10
8-4	[redacted]	IVF NS @ 500cc/hr	05	
			17	D/C
8-4	[redacted]	Ancef 1gm q8° IVP	06	[redacted]
			14	
			22	Reinstitute
8-4	[redacted]	~~Tobra~~ Gent 400mg IVPB	10	D/C
		q24°		D/C
8-4	[redacted]	Vicodin 1-2 tabs PO q8° x 7 doses	06	[redacted]
			16	
			24	
8-4	[redacted]	IVF LR @ 100cc/hr	05	D/C
			17	8/9/03 0900
8-9	[redacted]	IVF LR @ 75cc/hr	05	
			17	Reinstitute

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: S/P debridement GSW Penis R/T

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ___

PATIENT IDENTIFICATION:

[redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

b(6)-2

[redacted]

MEDCOM - 15766

b(6) -2
All

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo._____ Yr._____

Verified by Initials	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6/4	[redacted]	Fentanyl 100 mcg IVP now		0145	0147	[redacted]

Discon/ Cancel Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
8-4	TB	MSO4 2-6 mg IVP q 2° prn pain	8-4 1530 TB; 8-4 2000 NM; 8-5 0000 JWH; 8-5 0130 NM; 8-5 1600 TB; 8-6 0000 NM; [redacted]; 8-7 0600 TB; 8-8 0400 NM; 8-8 0940 TB; 8-8 1400 TB; 8-8 2050 NM
8-4	TB	phenergan 12.5 mg IVP q6 prn nausea	1350 TB 6/4
8-4	TB	Percocet 1-2 tabs PO q 4° prn pain 8-4-03 & 8-9-03	8-4 1700 TB; 8-5 0000 TB; 8-5 0400 TB; 8-6 0000 NM; 8-4 2010 TB; 8-6 0700 TB; [redacted]; 8-7 0800 TB; 8-7 1400 TB; 8-8 1400 TB; 8-8 1900 TB; 8-9 0630 TB
8-4	TB	MSO4 2-6 mg IVP q 2° prn pain (Crawford)	8-8 6mg KM TB 0600; 8-9 4mg KM TB 0600
8-5	TB	fentanyl 50-250 mcg IVP for dressing chg	8-7 1000 TB; 8-8 1500 TB; 8-8 1500 TB
		versed 2-4 mg [redacted]	
		for dressing [redacted]	

USAPA V1.00

MEDCOM - 15767

b(6)-2 AR

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. AUG Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 9 10 11 12 13 14 15 16 17 18 19 20 21 22
8-9	[redacted]	LR @ 75cc/hr heplock when	9	[redacted] → H/L
(16 Aug 03)		tolerating PO	10	
8-9	[redacted]	Celebrex 100mg PO BID	22	
8-9	[redacted]	Ciprofloxacin 500mg PO BID.	22	[redacted] → D/C'd 18 Aug 03
16 Aug 03	[redacted]			

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: Penile GSW s/p Debridement Penis r/t GSW

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

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 4678, 1 FEB 79 MEDCOM - 15768 I UNTIL EXHAUSTED. USAPA V1.00

b(6)-2 A11

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
10 Aug [redacted]	150 mcg Fentanyl IVP		1000	[redacted]
18 Aug [redacted]	150 mcg Fentanyl IVP prior to changing foley catheter	18 Aug 03		1550 [redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
11 Aug 03 8-9	[redacted]	MSO4 2-6 mg IVP prn pain Q2°	8-9 6mg 1330 [redacted] / 8-9 6mg 1330 [redacted] / 9 Aug 2130 6mg [redacted] / 10 Aug 0045 [redacted] / 10 Aug 0300 [redacted] / 10 Aug 1200 [redacted] / 10 Aug 1900 3mg [redacted] / 11 Aug 0600 2mg [redacted] / 11 Aug 1430 4mg [redacted] / 11 Aug 1850 4mg [redacted] / 12 Aug 2300 4mg [redacted] / 13 Aug 0300 2mg [redacted]
8-9	[redacted]	Percocet 1-2 PO Q4 prn pain	8:9 9 Aug 2230 [redacted] / 10 Aug 0400 11 [redacted] / 10 Aug 1200 [redacted] / [redacted] / [redacted] / 12 Aug 0330 [redacted] / 12 Aug 1130 [redacted] / [redacted] / [redacted] / [redacted] / [redacted] / 13 Aug 0300 1 tab
8-9	[redacted]	Phenergan 25 mg PO Q6 or 12.5 mg IVP Q6° PRN nausea	DC'd 18 Aug 03 0134
8-9	[redacted]	Fentanyl 150 mg IVP for QAM dressing change	11 Aug 03 0900 [redacted] > D/C'd 11 Aug 03
11 Aug 03	[redacted]	Fentanyl 100-150 mcg IVP for dressing	8-12 12:00 150 [redacted] / 8-12 2330 [redacted] / 15 Aug 0900 150 [redacted] / 15 Aug 2030 150 [redacted] / 17 Aug 0811 [redacted] > D/C'd 17 Aug 03 1200 JK
13 Aug 03	[redacted]	Percocet 1-2 PO Q4 PRN for pain	0200 2 tabs / 0200 2 tabs / 14 Aug 0920 [redacted] / 14 Aug 1250 [redacted] / 14 Aug 1735 [redacted] / 15 Aug 0820 2 tabs / 15 Aug 2030 [redacted] / 16 Aug 0300 [redacted] / 16 Aug 0950 2 tabs / 16 Aug 1200 2 tabs / [redacted] / [redacted] / [redacted] / 17 Aug 1410 1 tab
16 Aug 03	[redacted]	V Fentanyl to 50 mcg IVP for Dressing	Rewritten 16 Aug 03

USAPA V1.00

b(6)-2 All

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. Aug Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19
18 Aug 03	[redacted]	Restart IVF LR @	06	[redacted]	
		125 cc/hr	18		
			X		
18 Aug 03	[redacted]	Unasyn 3gm IVPB	06	/	
		Q6°	12	[redacted]	
			18		
			24		

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
Penile GSW

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

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

DISPENSING TIMES
USE PENCIL. CIRCLE MED TIMES

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

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. May Yr. 2003

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....	b(6)-2 A11				
	.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED														
16 Aug 03	[redacted]	↓ Fentanyl to 50 mcg	16 Aug 03	17 Aug 03		16 Aug 03 1547											
.....	.....	IVP For dressing Δ	@2037 60 mg	@2000 50 mg		[redacted]											
17 Aug 03	[redacted]	Percocet 1-2 PO	17 Aug 03 1700	17 Aug 03 2300	17 Aug 03 0800	16 Aug 03 1200	16 Aug 03 1532										
.....	.....	Q4° PRN for pain	[redacted]														
18 Aug 03	[redacted]	Phenergan 12.5mg	16 Aug 03	16 Aug 03													
.....	.....	IVP Q6° PRN. May	12.5mg IM 0830														
.....	.....	↑ Phenergan to 25mg															
.....	.....	IVP if 12.5mg does															
.....	.....	not work.															
16 Aug 03	[redacted]	Tylenol 650mg															
.....	.....	PO Q4° PRN T>100.5															
.....	.....	OR when NPO															
.....	.....																

b(6)-2

CLINICAL RECORD

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

Mo. 08 Yr. 07

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION.

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19 20 21 22 23 24 25 26 27
19	[redacted]	IVF: LR@125cc/hr	01 05 13 21	[redacted] D/C'd 20 Aug 0900 [redacted]
19	[redacted]	Unasyn 3gm IVPB q6hr	06 12 18 24	[redacted] D/C'd 20 Aug 0900 [redacted]
20 Aug	[redacted]	Heplock IV	06 12 20	[redacted] D/C'd
24	[redacted]	IVF NSC 125	05	1 1 IV [redacted]
		Cipro 400mg q12	06 18	[redacted]
		D/C'd		

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS:

GSW penis

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

EPW [redacted]

b(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

USAPA V1.00

MEDCOM - 15772

b(6)-2

Time orders

b(6)-2

Date	Initial	Order	Date to be done	Time	Time done	Initial
19Aug	[redacted]	Start IV then Start IV fluids @ 125cc/hr	19Aug			[redacted]
19Aug	[redacted]	Start Ciprofloxacin 400 mg IV q12h start @ 1800 tonight	19Aug			

b(6)-2 All

PRN ORDERS

19Aug	[redacted]	MSO4 2-6mg IV q2° prn	DCd [redacted]									
19Aug	[redacted]	Percocet ti PO q4° prn	19Aug 1500 ti [redacted]	19Aug 2343 ti [redacted]	20Aug 0830 ti PO [redacted]	20Aug 2109 ti [redacted]	21Aug 2002 2 **	21Aug 0040 2 **	22Aug 1050 ti [redacted]	22Aug 1630 ti [redacted]		
19Aug	[redacted]	fentanyl 50mcg IVP for drsg <>	19Aug 2030 50mcg [redacted]	DCd 20Aug 0900 [redacted]								
19Aug	[redacted]	Percocet ti PO q4° prn	19Aug 1000 ti [redacted]	20Aug 0409 ti [redacted]	20Aug 1424 [redacted]	20Aug 2110 [redacted]						

MEDCOM - 15773

b(6) - 2 All

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. 08 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25 26 27 28 29 30 31 1 2 3 4 5 6
25	[redacted]	[redacted]		
25	[redacted]	[redacted]		
30	[redacted]	[redacted]		
31	[redacted]	[redacted]		
		PRN meds		
25	[redacted]	MSO4 2-4mg IVP Q2° PRN pain		
25	[redacted]	Percocet + - ++ po Q4° PRN		
25	[redacted]	Phenergan 25mg IVQ6° PRN		
25	[redacted]	Percocet 1 - 11 PO Q4 PRN		

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P penile skin reconstruction

NKDA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO

PATIENT IDENTIFICATION: [redacted] b(6) - 2

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 - 15774

b(6)-4

05A0603

ICU Flowsheet

Patient Name: [redacted]

Date: / / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Temperature					100.0				100.9	98.8			98.7								98.6			99.6
Pulse	86		81		95		92		95		85		75		87		93		49		98	85		78
B/P A-Line																								
MAP	83		81																					
B/P Cuff	100/66		109/64		114/72		120/70		127/74		113/66		110/62		113/66		112/63		123/72		108/62	113/65		109/64
Respirations	10		11		19		16		16		9		8		15		13		19		12	9		11
Sa02	99		97		94		97		97		98		100		100		95		97		95	93		
	2L		2L		2L		2L		2L		3L		3L		2L		2L		2L		2L	2L		4L

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF	100	100	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	100	100	100	100	
PO							50				100					100				10				100		
Meds																										
														300		150				100						
IV intake																										
O.R. IN																										
Totals																										

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly	450		100 350		90 650		60	90	100		200			175			350 350			350 850		300 1150		70 1500	100 1450	
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 15775

DICAL RECORD-SUPPLEMENTAL MEDIC[illegible]ATA

For use [illegible]rm, see AR 40-66; the proponent agency is the Office[illegible]urgeon General.

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89

b(6)-2

INITIAL SHIFT ASSESSMENT

		Time: 0600 Initals: [redacted]	Time: 1700 Initals: [redacted]
NEURO	Pupils	equal, reactive 2 mm	
	Sensorium	Alert, response	alert/oriented pleasant/cooperative
	LOC / GCS		
CARDIAC	Cardiac Rhythm	SR	NSR
	PRI: / QRS:		
	Pulse Strength	2+	
	Cap Refil / JVD	<3	
	Edema	ø	
	Chest Pain	ø	generalized to penis
			ø
RESP	Respiratory Pattern	equal unl/ful	even/unlabored
	Breath Sounds	CTA	CTA(B)
	Secretions	ø	
	Cough	ø	ø
SKIN	Color	NFR	NFL
	Integrity	surg site intact	dsg to perineum/penis
	Backside	NO breaks	C,D,I
IV	Access Devices	PIV	PIV
	Location	(R)FA	RFA
	Condition	COI	patent/benign
GI	Abdomen	Soft, NT	Soft NT/ND
	Bowel Sounds	(+)	(+)
	Stoma/Ostomy	NA	N/A
GU	Device	Foley	foley
	Color / Clarity	clear, yellow	cl/yellow

(Continue on (reverse))

PREPARED BY (Signature & Title): [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU #1 [redacted]al

DATE: 6 Aug 03

PATIENT'S IDENTIFICATION (Typed or written entries give: Name – last, first, middle; grade; date [illegible] or medical facility)

NAME: RANK: AGE:

UNIT: b(a)-2 GENDER:

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

b(2)-2

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

DA FORM 4700, MAY 78

MEDCOM - 15776

PPC V2.00

[redacted] D(6)-4

ICU Flowsheet — **Patient Name:** EPW [redacted] — **Date:** 8 / 6 / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
T[redacted]ture					100.4				96.8							101.4						100.2				
[redacted]	91		105		93		96		96		85			87		97				93		88		64		
[redacted]																										
[redacted]																										
B/P Cuff	112/64		107/58		105/59				123/65		108/60			121/64		119/55				115/63				100/50		
Respirations	16		11		20		20																			
Sa02	98		98		97		96		94		100			96		93				100		99		98		
	4L		4L		4L		2L		2L		2L			2L		2L				2L		2L		2L		
	NC		NC		NC		NC		NC		NC			NC		NC				NC		NC		NC		

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
	100	100	100	100	100	100	100	100	100	100	100	100	1200	100	100	100	100	100	100	100	100	100	100	100	100	1200
							50				50		100			50										
intake																				240		100				
. IN																										
Totals													1300													

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
[redacted] Hourly			450	335	175				975				975	850					400					1600		
NG Tube																										
Drains #1									500				500	300												
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals													1475													

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 15777

b(6)-2

...AL RECORD-SUPPLEMENTAL MEDIC... ...ATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 2000 Initals: [redacted]	Time: 0730 Initals: [redacted]
NEURO	Pupils	3mm perrla bilat.	PERRL 3+
	Sensorium	a/o follows commands appropriate	A+O, follows commands
	LOC / GCS	6 staff, makes eye contact	for purposeful movements.
		pain controlled w/ prn Tylenol #3	PAIN controlled with prn/NSR 4
CARDIAC	Cardiac Rhythm	NSR 5 ectopy, SR2	NSR - ST 80's
	PRI: / QRS:		3+ pulses on extremities.
	Pulse Strength	+2 radial/+1 dp/+1 pedal & radial	Cap refill < 3 sec
	Cap Refil / JVD	<3secs @ 30°	Ø edema
	Edema	Ø edema	Ø chest pain
	Chest Pain	Ø	
RESP	Respiratory Pattern	even unlabored	CTA bilaterally.
	Breath Sounds	CTA diminished bases	Ø secretions
	Secretions	Ø	Ø cough
	Cough	Ø	
SKIN	Color	appropriate for race	NSR
	Integrity	see prog. note	on ventilator
	Backside	Ø breakdown, pt able to turn self	- CTAB
			skin warm, dry, intact, no pressure
IV	Access Devices	RAC PIV 18G	(R) AC PIV 18G
	Location	RAC	
	Condition	patent.	patent
GI	Abdomen	soft, nontender	soft, ND/NT
	Bowel Sounds	+x4	+x4
	Stoma/Ostomy	N/A	+BS. voids q shift
GU	Device	PTG	Foley
	Color / Clarity	amber c sediment ++	amber, moderate amount

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] LTRN — Night

DEPARTMENT/SERVICE/CLINIC: ICU [redacted]

DATE: 7 Aug 03

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

NAME: SQ-1 EPW — RANK: — AGE:

UNIT: — GENDER:

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

OTHER:

b(6)-2

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC [redacted]

DA FORM 4700, MAY 78

MEDCOM - 15778

ICU Flowsheet

Patient Name: [redacted]

Date: / / 2003

	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Intake	100	100	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100	W	100	IW	80	100	100		
							50				100													50		
		150						100																		
Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly					800		400		400		350			250		400		900		110		40		25		
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

For use ...AL RECORD-SUPPLEMENTAL MEDIC ATA
...orm, see AR 40-66; the proponent agency is the Office ... Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0600 Inital: [redacted] b(6)-2	Time: 1700 Initals: [redacted] b(6)-2
NEURO	Pupils	3mm Perrl brisk.	PERRL 3mm
	Sensorium	A/O cooperative followed commands	Follows commands appropriately
	LOC / GCS	moves ext equally, appropriate for situation.	purposeful movements
CARDIAC	Cardiac Rhythm	NSR 5 ectopy 84 S1 S2	NSR -> SB 5 ect S1/S2
	PRI: -/ QRS:		
	Pulse Strength	+2 radial & pedal bilat	#3 pulses
	Cap Refil / JVD	<3secs @ 70 JVD.	<3sec @JVD
	Edema	∅	∅ edema
	Chest Pain	denies	denies CP
RESP	Respiratory Pattern	even unlabored RR 14-20	CTA (B)
	Breath Sounds	CTA bilat bases.	
	Secretions	∅	∅
	Cough	∅	∅
		94-96% on RA.	
SKIN	Color	appropriate for race	NOR
	Integrity	free of open areas or rash.	dry intact
	Backside	free of breakdown	
IV	Access Devices	18G PIV.	18G PIV to (U) VE
	Location	(R) brachial	LUE @ 1700
	Condition	patent.	patent
GI	Abdomen	soft nontender.	soft NT/ND
	Bowel Sounds	hypo BS x 4.	+BS - LLQ
	Stoma/Ostomy	∅ denies N/V/D	
		tolerated breakfast & lunch	
GU	Device	~~clear~~ STC	Foley to gravity
	Color / Clarity	straw & large amount of	sediment.
		sediment clouds @ times	

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU #1 [redacted] b(6)-2

DATE

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

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

UNIT: GENDER: M

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

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

DA FORM 4700, MAY 78

[redacted] PPC-V3.00

MEDCOM - 15780

ICU Flowsheet

Patient Name: [redacted]

Date: 8 / 18 / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	Total
Temperature	99.9						104			100.2															
Pulse	78		88		91		87		99		94		88		89				81		91		79		
BP A-Line	102/52		176/96																						
																							113/60		
Respirations	16		16		18		18				22		23		20				20		20		18		
Sa02	98		98		95		95		96		96		95		94								98		
Mode							RA		RA		RA		RA		RA								RA		
													12	13	14	15	16	17	18	19					Total
	100	100	100	100	100	100	100	100	100	100	100		600	600	100	100	100	100	100	100	100				
PB											100														
Intake							200		200																
. IN																									
Totals																									
Output	**24**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**Total**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**Total**
Urine Hourly	170		110	130	135		250		280		250			250		180		180		210		310		305		
			90/20	90	100		1350		1630		1880			0,30		2310		2490		2700		3050		3355		
NG Tube																									
Drains #1																									
#2																									
#3																									
Emesis/Stool																									
O.R. OUT																									
Totals																									

[redacted] b(4)-4

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 15781

ICAL RECORD-SUPPLEMENTAL MEDIC ATA

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: Initals:	Time: 1845 Initals: Wright, 99910mc
NEURO	Pupils	3mm per bl brisk.	
	Sensorium	a/o appropriate for age commands, moves all extremities	Alert, Oriented Person, Place, Time, Event. MAE & Purpose Cooperative.
	LOC / GCS		
CARDIAC	Cardiac Rhythm	NSR w ectopy S1/S2	S1, S2. Rhythm not Evaluated.
	PRI: / QRS:		PPP & (+) 3 dorsalis pedis. Cap refill <3 sec. No peripheral edema noted.
	Pulse Strength	+2 Radial, pedal bilat	
	Cap Refil / JVD	<3 sec, no JVD	
	Edema	declined	
	Chest Pain	∅ denies	Denies.
RESP	Respiratory Pattern	even, unlabored	RA SATS 90's.
	Breath Sounds	CTA bilat w/ b. bases	CTA Bilat.
	Secretions	∅	∅
	Cough	∅	∅
SKIN	Color	appropriate for race	membranes pink. Scrotal dressing CDI. Penile shaft & gonz w Eaton drsg. Drg CDI.
	Integrity	see progress note.	
	Backside	∅ breakdown	
IV	Access Devices	PIV 18g	PIV 18g (R) FA LR 75cc/hr Site ∅ S/Sx infection/infiltration.
	Location	LFA	
	Condition	Patent LR infusing @ 75cc/hr.	
GI	Abdomen	Soft, nontender	SOFT, FLAT, non-tender (+) BS in (4) Quads. (-) hiccups ∅ N/V.
	Bowel Sounds	hypo BS ∅	
	Stoma/Ostomy	∅ denies N/V/D.	
GU	Device	Foley	16F Foley to BSD c clear yellow urine. Penile ∅ noose prophylaxis to abdomen.
	Color / Clarity	amber c sediment.	

(Continued on reverse)

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

DEPARTMENT/SERVICE/CLINIC ICU #1, [redacted] (5)(2)-2

DATE 8.9.03

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

NAME: EPW [redacted] RANK: AGE:

UNIT: b(6)-4 GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 15782

ICU Flowsheet

Patient Name: CPL [redacted] b(6) -4 Date: 8 / 9 / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
Temperature	98.4												98°				97			97°				98°
Pulse	88				91		88		73				82				83			70				82
B/P A-Line					122/64		89/70										119/67							
MAP																								
B/P Cuff	124/68				122/64		129/70		112/67				113/67				114/66			110/80				115/66
Respirations	16				20		22	22	14				16				16			16				18
Sa02	95				96		97	96	97				95				96							97
Mode							RA		RA				RA				RA			RA				RA

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
I	100	100	100	100	100	100	60	100	100	100	100	100		60	100	100	100	100		75	75	75	75	75	75	950
F intake																										
C. IN																										
Totals																										950

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly	400				500/90		310/110		210/230					450/270				325/305			350/345				450/385	3895
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

≈3000

INTENSIVE CARE NURSING FLOW SHEET

APPROVED (Date)
Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

TIME	INITIALS	NOTES
1200	TB	1800
3mm Pupils brisk		3mm PEARL
A/O x3 per interpreter		A+Ox3, follows
follows commands non		commands; purposeful
combative, restrained		movements.
3cm		
even, unlabored		even, unlabored
CTA bilat 96/RA		CTA (3) 98% on
ϕ		2L NC; Cont to
		RA
appropriate for age.		NSR
see progress note.		
RAC PIV 18G		RAC PIV 18G
patent		
Sacral/lumbar vertical		SCD NT/ND.
incision c staples CDI/I		hyperactive bowel sounds
ϕ hypo BS x4		medicine started in the lower
		LQ's started - CDI/I - ϕ stools.
QS straw colored		Foley to straight
FTC		drainage
		SCC note —
NSR 5 ectopy +2 pulses x4		NSR - ST 5 tach.
UE & LE +2 S1, S2		110s/90s; 90s-110s;
ϕ edema		ϕ edema UE 3+ pul
		LE 2+ pulses ϕ edema.
		S1/S2

LEGEND
CP - Intracranial Pressure
$PaCO_2$ - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
F - Fractional
S - Saturation
TCH - Tracheostomy

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU

DATE

(Typed/last Name—First, Middle Initial)

☐ HISTORY/PHYS
☐ OTHER EXAM/CONSULT OR EVALUATION
☐ DIAGNOSTIC STUDY
☐ TREATMENT
☐ FLOW CHART
☐ OTHER (Specify)

EPW [redacted]
b(6)-4

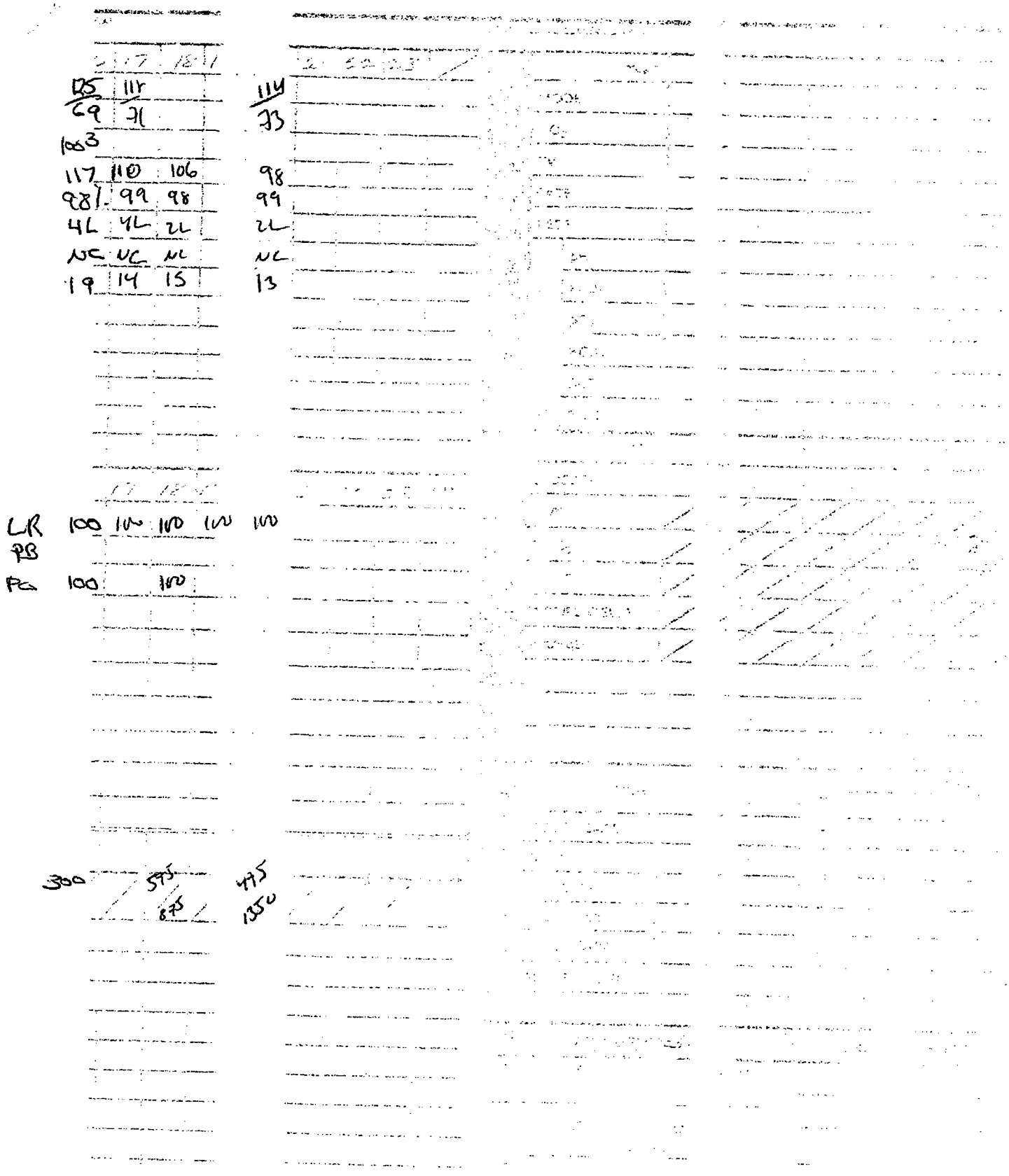
MEDCOM - 15784 MC OP 375 (Designated) Apr 9 XC-NLT

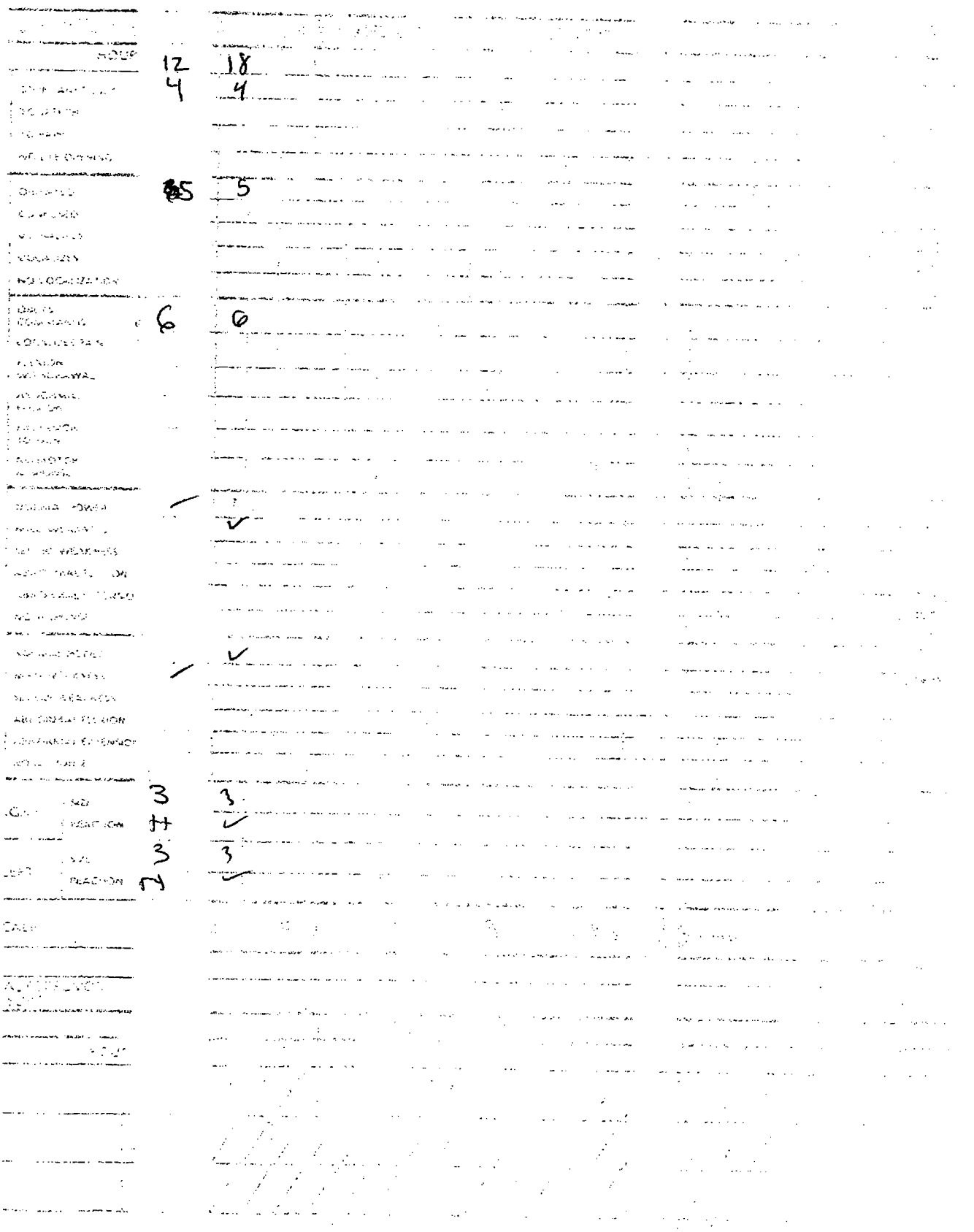
TIME				
BP Arterial Line			119/68	112/68
BP Cuff				
Temperature			100°	
Pulse			87	84
Respiratory Rate			16	20
SpO2			96	96
Mode			RA	RA
TIME				
IVM				300
IVRB				
TOTALS				
URINE	1 HOUR			
	TOTAL			350
	EMS			
	SA			
	OUT OF			
NG	GH			
	CLOSE			
EMESIS				
TOTAL				

b(a)-4

EPW [redacted]

MEDCOM - 15785





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: 11 Aug 03
Time In: 1359
Allergies: NKDA
Pre-op V/S:
Procedures: Penile BSO

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 2000 Colloid 0
OR Output: UOP 47 EBL 5
Meds/Times:

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	1359	1430
SaO2	98	95
FiO2	1	1
Methods	NC	NC
240		
220		
200		
180		
160		
140		
120		
100		V
	V	
80		
60		
		A
40	A	
20		
RR	16	16
T	98	

Time									
Pain (0-10)									
LOS									

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C	Codes
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	0			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
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	0			
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1			
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	0			
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	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.	3			

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)*

DEPARTMENT/SERVICE/CLINIC

DATE: 11 Aug 03

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

[redacted] b(a) -4

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL D

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 08MAR89

INITIAL SHIFT ASSESSMENT

		Time: 2000 Initals: [redacted] b(6)-2	Time: Initals:
N E U R O	Pupils	PERRL	
	Sensorium	Alert & Orientated x3	
	LOC / GCS	pt follows simple commands & can move all extremities	
C A R D I A C	Cardiac Rhythm	HR- 67 BP- 118/58	
	PRI: / QRS:	NSR	
	Pulse Strength	Pulse strong x4 · Capillary Refill	
	Cap Refil / JVD	≤3 sec Ø JVD No noted	
	Edema	edema Ø chest pain @ present	
	Chest Pain		
R E S P	Respiratory Pattern	RR- 16 SPO2-99% on RA	
	Breath Sounds	Breath sounds Clear (B) Ø	
	Secretions	secretions Ø cough noted	
	Cough		
S K I N	Color	Normal For Race	
	Integrity	No breakdown noted	
	Backside	GSW to pants unAppeen	
		CDI	
I V	Access Devices	Hep lock to (R) Forearm	
	Location	Flushes well No SIGNS of	
	Condition	infiltration / infection	
G I	Abdomen	Soft Flat non-tender	
	Bowel Sounds	non distended Ø Stom/Ostom	
	Stoma/Ostomy		
G U	Device	Foley to gravity	
	Color / Clarity	Clear Yellow QS	

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (D)(2)-2
ICU 3, [redacted]

DATE
13 Aug 03

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

#[redacted]
b(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 15789

ICU3

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

Date: 13 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP																		119/54				134/54				
TEMP																		99.3				97.3				
HR																		67				97				
RR																		16				16				
SaO2																		99%				97%				
FiO2																										
Source																		RA				RA				
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IV LR														~~75~~								Heplock				
IV																										
NG																										
PO																										
tal																		200	100							

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	
URINE																100			300							
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DA

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 08MAR89**

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals: [redacted] b(6)-2	Time: Initals:
NEURO	Pupils	PERL; Alert + Oriented	PERRL, A+O x3, pt able to follow simple commands
	Sensorium		
	LOC / GCS		
CARDIAC	Cardiac Rhythm	normal; good cap. refill + pulse & chest pain	RR+R, <3 sec cap refill. (R) Pulses to (B)UE, (B)LE's
	PRI: / QRS:		
	Pulse Strength		
	Cap Refil / JVD		
	Edema		
	Chest Pain		
RESP	Respiratory Pattern	normal - 10	Normal 15 BPM, CTA Bilat & secretions
	Breath Sounds	normal	
	Secretions	&	
	Cough	non-productive cough noted	& Cough
SKIN	Color	normal for race	NFR, warm + moist mucus membrane
	Integrity	warm + dose	
	Backside		
IV	Access Devices	Saline lock to (R) arm. & redness/	H/C to (L) FA. & s/s
	Location	swelling noted to area	of redness, swelling
	Condition		& site.
GI	Abdomen	soft & soft to touch; non-	soft flat non distended
	Bowel Sounds	distented.	(B) BS x4 quad.
	Stoma/Ostomy	& Stoma/Ostomy.	
GU	Device		Foley draining to gravity.
	Color / Clarity	H/C to BS. yellow urine noted to drainage bag	clear yellow urine

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 3, [redacted] b(2)-2

DATE

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

[redacted] b(6)-4

13AUG03

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

DA FORM 4700, MAY 78

USAPPC V2.00

b(6)-4

ICU3

Patients Name: # [redacted]

Date: 8 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	116/68				116/68				108/74					105/62				108/62				115/74				
TEMP	97.2				97.4				98.3					97.4				98.5				98.8				
HR	70				87				69					78				81				82				
RR	10				12				10					16				12				12				
SaO2	98				98				99					99%				98%				98%				
FiO2	RA				RA				RA					RA				RA				RA				
Source																										
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF																										
IVF																										
IVF																										
PO			240			120				233		120														
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	
URINE			500		475		300					150		150				700				150				
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDICAL RECORD-SUPPLEMENTAL MEDICAL D

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 08MAR89

b(6)-2

		INITIAL SHIFT ASSESSMENT b(6)-2	
		Time: 0045 Initals: [redacted]	Time: 1930 Initals [redacted]
NEURO	Pupils	3mm PERRL	PERRL,
	Sensorium	Alert, able to follow	AAOx3
	LOC / GCS	commands	able to follow commands
CARDIAC	Cardiac Rhythm		
	PRI: / QRS:		
	Pulse Strength	+2 in all 4 ext.	RRR +2 x4 ext
	Cap Refil / JVD	<3 sec in all 4 ext	<3 sec
	Edema	Ø noted	
	Chest Pain	Ø noted	
RESP	Respiratory Pattern		
	Breath Sounds	CTA throughout	CTA Bilat
	Secretions	Ø noted	
	Cough	Ø noted	
SKIN	Color	WNL FOR RACE	WNL.
	Integrity	Drsg on penis D+I	Dressing to penis C/D/I
	Backside		
IV	Access Devices	(R) FA PIV. H.L.	(R) Upper extremities H/L
	Location	Ø S/S of infection	(R) flush Ø S/S of infiltration
	Condition		
GI	Abdomen	Soft, nontender	Soft nontender, nondistended
	Bowel Sounds	(+) normal in all 4 quads	(+) BS x 4 quad
	Stoma/Ostomy	Ø	
GU	Device	Foley to gravity draining	Foley to gravity draining
	Color / Clarity	clear yellow urine	clear, yellow urine.

(Continued on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (b)(2)-2
ICU 3 [redacted]

DATE
14 AUG 03

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

[redacted] b(6)-4

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

DA FORM 4700, MAY 78

MEDCOM - 15793

USAPPC V2.00

ICU3

Patients Name: [redacted] b(a)-4 Date: 14 AUG 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22*	23	00	01	02	03	04	05	
A-Line																										
NBP	118/76				118/64				110/64					110/64				115/68				118/64				
TEMP	98.9				99.9				96.8									97.5								
HR	78				75				70					70				76				69				
RR	14				14				15					15				16				12				
SaO2	98%				99%				99%					99%				99%				99%				
FiO2																										
Source	RA				RA				RA					RA				RA				RA				
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IVF																										
IVF																										
IVF																										
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	
URINE											550															
NGT																										
STOOL																										
DRAIN																										
Total											550															

MEDICAL RECORD-SUPPLEMENTAL MEDICAL D

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REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA APPR 08MAR89

		INITIAL SHIFT ASSESSMENT	
N E U R O		Time: 0640 Initals: [redacted] b(6)-2	Time: 1830 Initals: [redacted] b(6)-2
	Pupils	PERRL	PERRLA 3mm brisk
	Sensorium	Pt alert +	AOx3, moves extremities
	LOC / GCS		freely, follows simple
			commands. Pt on BR
C A R D I A C	Cardiac Rhythm	Ø Ntd ectopy	SR
	PRI: / QRS:		—
	Pulse Strength	+2 radial + pedal	+2 BUE/BLE
	Cap Refil / JVD	brisk	<3 sec
	Edema	Ø Ntd	Ø noted
	Chest Pain	Ø	Ø
R E S P	Respiratory Pattern	Reg R+R	RRR
	Breath Sounds	CTA bilat	CTA (B)
	Secretions	Ø Ntd	Ø
	Cough	Ø Ntd	Ø
S K I N	Color	NFR	Normal for Race
	Integrity	dressings intact	Dressing to penis ? LLQ intact
	Backside		Scrotal support in place
I V	Access Devices	(R) FA IV, hep locked	PIV (R) FA H/L
	Location	(R) FA	
	Condition	Ø Ntd erythema/edema	CDI
G I	Abdomen	Soft + round, nontender	Soft, round, nontender
	Bowel Sounds	+ x 4 Quads	x 4 Quds
	Stoma/Ostomy	Ø	N/A
G U	Device	Foley to gravity	Foley to gravity
	Color / Clarity	Clr Yellow	Clear Yellow

(Continue on reverse)

PREPARED BY (Signature & Title)
[redacted] 9WMG b(6)-2

DEPARTMENT/SERVICE/CLINIC (b)(2)-2
ICU 3 [redacted]

DATE
15 Aug 03

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

[redacted] b(6)-4

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

DA FORM 4700, MAY 78

MEDCOM - 15795

USAPPC V2.00

ICU3

Patients Name: #[redacted] b(a)-4 Date: 15 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	114/				106/				143/														112/70			
NBP	78				60				57																	
TEMP	97.6				97.5				98.5														97.5			
HR	88				62				96														72			
RR	18				14				16														16			
SaO2	99%				98%				96%														98			
FiO2																										
Source																							RA			
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
PO																		240					240			480
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	
URINE																									1400	
NGT																										
STOOL																										
DRAIN																										
Total																										1400

CAL ...CORD-SUPPLEMENTAL MEDICA ...T.

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 08MAR8

INITIAL SHIFT ASSESSMENT b(6)-2

		Time: Initals:	Time: 1900 Initals: [redacted]
NEURO	Pupils		PERRLA
	Sensorium		A&O x3
	LOC / GCS		pt follows all commands purposefull movement x4
CARDIAC	Cardiac Rhythm		HR - 74 BP 103/66
	PRI: / QRS:		
	Pulse Strength		⊕3 to all extremities
	Cap Refil / JVD		Cap refill ≤3sec JVD Ø
	Edema		No edema noted
	Chest Pain		Ø chest Pain
RESP	Respiratory Pattern		RR: 16 Spo2 97% on RA
	Breath Sounds		CTA Ⓑ
	Secretions		Ø secretions
	Cough		Ø Cough
SKIN	Color		normal for Race
	Integrity		GSW to Penis
	Backside		Ø breakdown
IV	Access Devices		IV to Ⓡ AC Heplocked
	Location		patent S/S of infection
	Condition		Infiltration
GI	Abdomen		Soft flat non-tender non-distended
	Bowel Sounds		BS active x4
	Stoma/Ostomy		Ø stoma
			Ø ostom
GU	Device		Foley Cath to gravity
	Color / Clarity		dark yellow urine

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC
ICU3, b(2)-2 [redacted]

DATE

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

[redacted] b(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 15797

ICU3

Patients Name: _____ Date: 16 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP															105/60											
TEMP															96.2								98.5			
HR															74								61			
RR															16								14			
SaO2															99%								99%			
FiO2																										
[illegible]e															RA								RA			
[illegible]															74											

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	T
IVF															Heplock								Heplock			
IVPB																										
NGT																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE															400								550			
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 15798

DOD-029187

ACLU-RDI 1633 p.158

ICAL RECORD-SUPPLEMENTAL MEDIC AT

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REPORT TITLE: **INTENSIVE CARE NURSING FLOW SHEET**

OTSG APPROVED (Date): **QA APPR 08MAR8**

INITIAL SHIFT ASSESSMENT

		Time: 1116 Initals: [redacted] b(6)-2	Time: Initals:
NEURO	Pupils	PERRLA	PERRL
	Sensorium	Alert x O x 3	A+O x 3
	LOC / GCS	Responsive, Cooperative, Follows Commands	follows commands
CARDIAC	Cardiac Rhythm	———	
	PRI: / QRS:	———	
	Pulse Strength	+3 x 4 extremities	+3 x4 extrem
	Cap Refil / JVD	<3 secs, ØJVD	<3 sec
	Edema	None	
	Chest Pain	None	
RESP	Respiratory Pattern	Regular, Unlabored	RR+R
	Breath Sounds	CTA	CTA Bilat
	Secretions	None	
	Cough	None	
SKIN	Color	Normal for Race	NFR
	Integrity	Dressing to Penis	Dressing to penis c/d/I
	Backside	None	
IV	Access Devices	20G IV in ⓓAC	20G IV in ⓓAC
	Location	ⓓAC	
	Condition	Ø S/S of infection, patent	Ø S/S of redness swelling
GI	Abdomen	Hypoactive, soft & mild distension	
	Bowel Sounds		ØBS x4 quad
	Stoma/Ostomy	ⓓEmesis x1	
GU	Device	16 Fr. Foley	Foley draining to gravity.
	Color / Clarity	Yellow & Sediments	

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: b(2)-2 ICU3, [redacted]

DATE: 18 Aug 03

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

[redacted] b(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 15799

ICU3

Patients Name: [redacted] bld-4 Date: 18 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP				112/72			100/64				104/62					104/68				114/72					110/68	
TEMP				103.5	104.3	102.2	101.1		100.5		99.3					98.3				98.7					98.4	
HR				127			110				96					101				98					95	
RR																										
SaO2				99%			98				96					98%				98%					98%	
FiO2				RA			RA				RA					RA				RA					RA	
[illegible]e																										
N[illegible]																										
				Iv fluid Approved Give 1 hour using IV pump																						

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	T I
IVF LR					125	125	125	125	125	125	125	125	1000	125												
IVPB							100							100												
NGT																										
	240												240	240												
Total													240													

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE					215						325		540													
NGT																										
STOOL																										
DRAIN																										
Emesis			X1																							
Total													540													

MEDCOM - 15800

DOD-029189

ACLU-RDI 1633 p.160

ICAL RECORD-SUPPLEMENTAL MEDIC ATA

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 08MAR8

INITIAL SHIFT ASSESSMENT					
		Time:	Initals:	Time:	Initals:
N E U R O	Pupils				
	Sensorium				
	LOC / GCS				
C A R D I A C	Cardiac Rhythm				
	PRI: / QRS:				
	Pulse Strength				
	Cap Refil / JVD				
	Edema				
	Chest Pain				
R E S P	Respiratory Pattern				
	Breath Sounds				
	Secretions				
	Cough				
S K I N	Color				
	Integrity				
	Backside				
I V	Access Devices				
	Location				
	Condition				
G I	Abdomen				
	Bowel Sounds				
	Stoma/Ostomy				
G U	Device				
	Color / Clarity				

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE
	ICU3, [redacted] (b)(2)-2	4 Aug 08

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

[redacted] (b)(4)

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART [redacted] (b)(2)-2
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

ICU Flowsheet Patient Name: # [redacted] b(6)-4 Date: 16 / Aug / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature									97.5																	
Pulse									75																	
B/P A-Line																										
MAP																										
B/P Cuff									114/71																	
Respirations									14																	
Sa02									99% 99%																	

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IV																										
PO Intake																										
O.R. IN																										
Totals																										

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Urine Hourly																										
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 15802

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: 25 AUG 03
Time In: 1630
Allergies: NKDA
Pre-op V/S: 121/71 77
Procedures: [illegible] graft delayed closure

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 600 Colloid ∅
OR Output: UOP ______ EBL min
Meds/Times: Versed, fentanyl, morphine

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

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds

History

Time	1630	1635	1640	1655	1710	1720	1730
SaO2	97	98	99	100	99	96	99
FIO2							
Methods	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		
RR	14	12	12	12	10	12	14
T	[illegible]						

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

Time						
Pain (0-10)	[redacted]					
LOS						

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

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1630	NS	900	(R) arm	[illegible]	100

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

(Continue on reverse)

PREPARED BY [redacted] LPN

b(a)-2

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 25 AUG 03

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

Name — last,

#[redacted] b(a)-4

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

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

USAPPC V2.00

MEDCOM - 15803

b(6) - 2 All

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1640		MSO4 2mg	IV		I	[redacted]
1650		MSO4 5mg	IV		I	
1655		MSO4 2mg	IV		I	
1700		MSO4 mg	IV		I	
1715		MSO4 7mg	IV			

NEUROVASCULAR

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

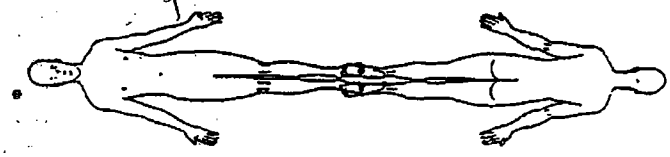
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	penis	Scrotal dressing	
30'			
60'			
D/C	penis	scrotal	



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1630	ST		

WAMC OP 173-E

NURSING NOTES

Pt to PACU from OR via stretcher s/p penile graft delayed closure. Scrotal dressing c Kerlix applied to penile area. JP drain intact. Foley cath intact draining clear yellow urine. IVF NS infusing into R) arm. c/s redness or edema to site. Pt c/o pain. Medicated c MSO4 2mg for c/o pain. Will continue to monitor for effectiveness. [redacted] LPN

1650 - Pt continues to c/o pain. Medicated c 5mg MSO4. [redacted] LPN

1655 - Medicated c 2mg MSO4 [redacted]

1700 - Medicated c 1mg MSO4 [redacted]

1718 - IV site infiltrated. IV restarted. [redacted]

1745 - Pt medicated c/o to IV infiltration. 10mg MSO4 given. [redacted]

1750 - Pt states [redacted]

1810 Pt to ICU #1 via stretcher [redacted]

Discharge Criteria:
Date: 25 Aug 08 **Time:** **PARS:**
BP: 134/0 **T:** 98.1 **HR:** 114 **RR:** 24 **Sa02:** 99% RA
Pain Level at D/C (0-10):
Intake: **Output:**
Additional Data:
Transferred To: ICU #1
Report Given To: SPC [redacted]
Transferred Via: W/C Litter Gurney Ambulance
Transferred [redacted] LPN
Cleared IAW Recovery Ro
Charge Nurse Signature: [redacted] RN

MEDCOM - 15804

ADMISSION AND CODING INFORMATION

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

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

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
	22y	2	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	Z	1010	b(6)-2

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
IZ			YEAR / NO ✓

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
O	ICU	UNK

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

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
50		030830

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
ABKA		030804

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

FOR LOCAL USE

GSW TO GROIN

Dx 99859
8781
8783
E8789
Proc 6013 6441
6442 6444
5822 Trauma
Inj 284

b(6)-2

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
[redacted] CPT MC DR.	[redacted] Sgt, USA

DA FORM 3985 MAR 89

MEDCOM - 15805

INPATIENT TREATMENT RECORD COVER SHEET

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

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

4. SEX	5. [illegible]	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	27	UNK	UNK			N

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted]	b(6)-4	FCW2

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
—	—	K78	—	—	WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
direct from ER	1140	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	~~50~~ 24	13 Aug 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	05 Aug 03	

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

31. SELECTED ADMIN[illegible] b(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW & open fx ® hand — 817.1

E991.2

79.33

79.63

86.04

86.59

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	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
	b(6)-4				

SIGNATURE OF [illegible] [redacted] FOR [redacted] MEDCOM - 15806 [redacted]

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

5 Aug 03 1330

Ortho

27 y/o RHD ♂ ~ 2 wks s/p GSW

(R) hand. ? Hx surrounding events
of other Tx. Past history, ? Fevers
of other c/o
of pm/PS/neu/AM

PHYSICAL EXAMINATION

98.2 90 117/67 A+O x 3

(R) hand wound to IF MCP area w/ exp
& dorsal. obv. necrotic &
purulent material. S/P CR,
of PIC of IP, ↓ LT to all IP
of TTP d/w, NVI d/w

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

XR highly comminuted/absent IF MCP ⇒
IF MC fx to mid-shaft

(A) Complete loss MCP IP (D) hand ~ 2 wks
out ⇒ of Tx, obvious infection
(P) D/w pt (w/ interpreter) Tx options,

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION
Plen rey	8 Dec 03		

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle initial; social security number; medical facility)*

b(6)-2

[redacted] MAT [redacted]

REGISTER NO.

WARD NO. ICU 2

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41CFR) 201-45.506
JANUARY 1987 539-106-01

[redacted]

b(6)-4

[redacted] [redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5 Aug 03	(Op Note) Dx (R) hand GSW, infection Px (R) I+D Ray resection 2 : D Surgeon [redacted] b(6)-2 [redacted]
5Aug03 2020	Pt. admitted to ICUZ S/P resection of (R) I+D ~ VSS, T max 100.2 - D5½NS @ 200 mL/hr KCl infusing @ 125 cc/hr to (L) AC 20g IV - (R) hand elevated on blanket and EV pole - pt. oriented & alert - (+) BS - lungs CTA (B) - medicated for pain @ 1850 H percocet tab - bulky Kerlix/lace wrap dressing on (R) hand, thumb, 3 & ½ fingers and pinky visible, good movement, <2 sec cap refill in fingers - pt. given bed bath due to no dressing change in 15 days b(6)-2 [redacted]
5Aug03 21:11	Rec'd c/o pt @ 21:00. Restraints x 2 (L) wrist (R) ankle. PVS WNL per flowsheet. Awake and alert in bed. Skin W/D. PERRLA (+)

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

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

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

[redacted] b(6)-4

EPW

PROGRESS NOTES
Medical Record

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

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	LCA⊙ HRR S1S2 WNL. BSS⊙x4. ⊙Hand ↑. ACE wrap dsg CDI ⊙ROM⊙ <3 sec cap refill ⊙Sensation ⊙hand digits. ↓c/o pain @this time will cont. to mon. [redacted] ALERT /AW
Addendum	R⊙AC PIV infusing @ 125cc/hr c 20meq KCL S s/s infection/infiltration [redacted] RCD/AW
0143	c/o pain in ⊙ hand. 1 Percocet given will mon [redacted]
6August03 0730	Pt. asleep in bed easily aroused by verbal stimuli. VSS. HR Regular, Lung sands clear bilat, bowel sands (+) x4 quads. ⊙ hand elevated c Kerlex tied to bed pole. DSG to ⊙ hand CDI, cap refill <3sec. (+) sensation in all 4 digits. IV in ⊙AC infusing @ 125cc/hr of D5½NS c 20 KCl meq. S s/s of infection or infiltration. Pt. S complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] ALERT/AW
6Aug03 1330	Pt care assumed @ 1300. Pt awake & alert, Pt speaks a little English. VSS. ⊙ Hand elevated c Kerlix tied to bed pole. ⊙ Sensation, <3 cap refill. Lungs CTA and sft BS ⊙x4 quads. ↓ Ext c full ROM ⊙ pulses. IV site to LAC infusing D5½NS c 20meq KCL. S diff. ⊙ complaints voiced @ this time. Will Cont to monitor [redacted] AWM
6Aug03 2120	Pt care assumed @ 2000. Pt awake and alert S c/o pain. Lung sands CTA, pulses +x4, BSt. IV c 20meq KCL infusing into ⊙ AC S s/s infection or infiltration. ⊙ gon ⊙ hand CDI ⊙ pulse and sensation in ⊙ Hand elevated c Kerlix, pt c/o pain in middle finger. IV ok @ 22 and 24, continue to monitor. [redacted] AWM

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

[redacted] MEDCOM - 15809 [redacted]

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 Aug 03	0710: Assumed pt care @ 0500. Pt. awake. A&Ox3 lungs CTA. (+) BS x 4. VSS. (R) arm elevated. Pain to (R) hand c PT. (+) movement & sensation in fingers. C/O pain to (R) hand. Will continue to monitor [redacted] 91WM6 b(a)-2
7 Aug 14xx	O/pt's Op Note Dx (R) hand s/p IF irrig closure I-D & wound Surgeon [redacted] b(a)-2
7 Aug 03 1600	assumed care @ 1300 while pt. was in OR - returned ~ 1545 S/P I&D (R) hand - VSS - D5½NS c 20 meq KCl @ 125 cc/hr infusing in to (L) 20g IV - bulky hand dressing on (R) hand, thumb, 3-5th digit visible to Lt knuckle, pt. can wiggle fingers, <2 sec cap refill in visible fingers - (+) BS - lungs CTA (B) - c/o pain, medicated c # Percocet @ 1515 in PACU b(a)-2 [redacted] CRNA

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

b(a)-4 [redacted]

EPW

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 - 15810

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

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0145 8 Aug 03	Pt care assumed @2100. VSS, A&Ox3 3 c/o pain. Lung sounds CTA, pulses + (unable to assess re), bs+x4. IV running D5 1/2 c 20 meq KCL @125cc/hr. RUE elevated, dsg CDI, no complaints. Pt had I+O today. On IV ABX. No new complaints, will continue to monitor. [redacted]
0200	2 tabs percocet given for pain in @ hand. [redacted]
080530 Aug 03	NURSING ASSESSMENT: Assumed care of pt, Army intact, breathy even and unlabored, LS clear to all fields (B), Abd soft, nontender, + distention, BS@x4. Voids spontaneously. Flaccid and nonresponsive to BLE and RUE. (B)UE lying from IV pole to maintain elevation. (R) hand wrapped c gauze & ACE wrap (only 4 fingers visible, beyond 1st phalangeal joints). Pt can wiggle fingers and they are warm to touch c brisk cap refill. Pulses not palpable 2° dsg. ROM at elbow & shoulder of (B)UE full. [redacted]
080545 Aug 03 8 AUG 03 1300	NURSING NOTE: IV in (L) AC c s/s infection or infiltration. [redacted] - Received PT alert in bed c 0 c/o pain or discomfort, VSS. Hrly neuro checks WNL. BS x4. (R) ROM to all extremity - slow c cane. Dsg to (L) Arm CDI. PT has (+) pulse noted RUE, Arm is elevated. IV D5 1/2 c 20 meq running @ 125 cc/hr c (-) s/s of infiltration or inflammation. PT is resting in bed. will call to monitor. [redacted]
8 AUG 03 1400	- PT c/o dizziness to (L) side of face. Also stated he could not see that well from OS. PT has pearls, c noted fluttering to eye. will notify MD [redacted]
9 Aug 03 0140	Pt care assumed @2100. VSS, A&Ox3, 5 c/o pain. Lung Sounds CTA, bs(+)x4. IVF d/c, SL patent c IV ABX x3. Dsg on RUE CDI, (+) sensation and ability to move fingers. RUE elevated c Kerlix. No new complaints, continue to monitor. [redacted]

b(c)-2 All

NSN 7540-00-634-4176 600-108

HEALTH RECORD PROGRESS notes ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9August03 0945	Pt. asleep in bed easily aroused to verbal stimuli c @R hand elevated on 2 folded blankets & tied up c Ace wrap. VSS. HR Regular, bowel sounds (+) x 4 quads, Lung sounds clear bilat. All fluids well c 3cc NS in @ AC & S/S of infection. @ hand ace wrap CDI, (+) sensation in digits middle finger slightly painful to the touch, cap refill < 3sec, limited ROM. Pt. c complaints @ this time. All other assessment findings WNL will continue to monitor. [redacted] SLT/AN
1130	New IV placed in @ FA. [redacted]
9Aug03 1930	assumed care @ 1300 - VSS - SL patent - IV abx d/c'd and pt. started on Keflex & cipro PO - C/O heartburn p dinner, given mylanta plus 30cc - dsg Δ done by MD today, dry 4x4 c ace wrap, pt. can wiggle fingers, middle finger tender to touch, CZ sec cap refilling @ fingers [redacted] CH, AN
10 Aug 03 0800	Pt care assumed @ 2100. VSS, a+ox3 c complaints, Lung sounds CTA, pulses palpable x4, BSO. Pt taking PO meds. Dsg on RUE CDI, hand elevated, @ pain. No complaints, will continue to monitor. [redacted] GLM16
0850	Pt. awake & alert in bed c complaints @ this time. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. Pt c IV access. Ace wrap to @ R hand CDI, cap refill < 3sec, (+) sensation, middle finger painful when touched, full ROM in digits. All other assessments WNL. Pt eating & voiding

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

lew2

epw

[redacted]

b(c)-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~~

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

MEDCOM - 15812 - 5 notes

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10Aug03	adequately. Will continue to monitor. [redacted] 2114
10Aug03 1930	assumed care @ 1300 - VSS - no c/o pain @ this time - dsg Δ'd on (R) hand, no S/S infection, Sutures intact - pt had Bm today - ambulated X10 minutes [redacted] CTA N
2323	Pt. care assumed @ 2100. VSS. HR reg. lungs CTA. (R) hand dsg CDI & brisk cap refill, (+) sensation @ each. Pt. c/o pain @ old IV site (L) AC. ⊘S/S infiltration or phlebitis noted. Will cont. to monitor. [redacted] CTA N
11Aug03	0546 Assume pt care @ 0500. Pt awake and Alert. c/o pain to old IV site (L) AC, warm compress applied. VSS. (R) hand dsg CDI. (+) movement (+) sensation to fingers. Cap refill < 3sec. HR reg. Lungs CTA. Abd soft BS x4. Will cont to monitor [redacted] 11 WMK
11Aug03 1730	assumed care @ 1300 - VSS - medicated c 650 mg tylenol PO @ ~1430 for c/o (R) hand pain - dsg Δ'd, Sutures intact, small amount of bleeding between Sutures next to middle fingers, 4x4's placed & ace wrap, pt. can move remaining fingers, middle finger continues to be tender and lacks full ROM, <2 sec cap refill in fingers - (L) bicep has small area of redness above old IV site, BS ~~ST~~ area warm to touch and slightly tender [redacted]

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8 11 03 2207.	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA. BS @ X4. Dsng to (R) hand C.D.I. Fingers (R) hand warm (+) Sensation, (+) ROM, brisk cap refill. Will cont. to monitor. b(6)-2 [redacted] TAN.
12Aug03 0538	Assume pt care @ 0500. VSS. HR reg. Lungs CTA. Abd soft non-tender BS x4. No c/o pain. Dsg to (R) hand CD+I. Fingers to (R) hand (+) ROM (+) sensation Cap refill < 2sec. possible discharge today. Will cont to monitor [redacted]
12Aug03 1410	assumed care @ 1300 - VSS - no c/o pain @ this time - dsg CDI - pt. awaiting dr to EPW camp b(6)-2 [redacted] CRT
12Aug03 2230	VSS - Alert x3 - dsg to (R) hand dry and intact. 0 c/o pain @ present. Bilateral Lungs CTA Bil Resp even BS (+) x 4 equals Radial and Pedal pulses x3. Cms to upper and lower extremities >3sec. Restraints to lower extremities replaced and secure. [redacted] b(6)-2 ALL

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

MEDCOM - 15814

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD Discharge Summary ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/13/03	Pt dc with meds. Pt & Pt counselor of hx
8/13/03	Med and wrist x3. Pt VIS stable. Pt ss/s of abstin
	[redacted] b(6)-2

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

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

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

MEDCOM - 15815

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
4 Aug 03	♂ gunshot wound to Ⓡ hand 8 days ago. Unsure
	if bullet passed through. Dressed initially & referred for care
NKA	Difficult to move trigger finger.
	O) Observation reveals entrance & exit wounds noted @ ~ 1st
R 12	knuckle of 2nd metacarpal (trigger finger). Soft tissue is
T 99.2	blown open 2° shock of projectile & trigger finger hangs @ an
P 78	abnormal angle. Neuro appears intact @ this time but diminished
04 Aug 03	X-ray shows distal end of 2nd metacarpals is shattered into numerous
132/84	small fragments, as is the proximal ½ of 1st phalynx.
	A) GSW to hand, distal 2nd metacarpal & proximal phalynx
Meds	shattered
? Bacillin	P) Pt will be placed in holding for tonight & transfer
? Keflex	to CSH in AM
	2030 MS 5mg IM given
	2215 MS 5mg IM given
	~~2230~~ Ancef 1gm IV Now and Ancef 1gm @ 0600
	IV LR @ TKO until next IV Ancef.
	b(6)-2 [redacted] 2LT, SP
2220	1Bg IV to OR-A x 1 attempt [redacted] b(6)-2
2220	Ancef 1gm IV given now [redacted] b(6)-2
2315	IV LR started 500cc bag infusing fluids @
	TKO Rate [redacted] b(6)-2

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

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

REGISTER NO. | WARD NO.

EPW [redacted] b(6)-4

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

MEDCOM - 15816

Gunshot wound to hand

b(a)·2
All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
2315	Pt. Transferred to holding [redacted]
2320	MS 5MG x 1 PRN Pain. VSS [redacted]
0430	Above noted. IV slowed to TKO, patient is resting quietly [redacted] SPC
0615	Continued NaCl 1000 cc IV infusing @ cc/hr. Ancef 1g IV administered. [redacted] SPC
0630	Pt ambulated to latrine [redacted] SPC
0715	Pt refused morning meal [redacted] SPC
0725	Pt discharged from pt holding, transferred to CSH [redacted] SPC
0745	Pt returned to holding due to Medevac delay. [redacted] SPC
0910	1000 cc LR IV continued [redacted] SPC

b(2)-2

7540-01-075-378

SB-104

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER | TREATMENT [redacted]

RECORDS MAINTA[redacted]

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: (CPW)

CITY | STATE | ZIP CODE

SEX: O

AGE: 27

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

ARRIVAL

DATE (Day, Month, Year): 5 AUG 03 | TIME: 1140

TRANSPORTATION TO FACILITY: MEDEVAC

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: Ancef cystuly

ALLERGIES: Ø NKDA

CHIEF COMPLAINT: GSW (R) hand

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

CATEGORY OF TREATMENT

TIME: 1140

INITIALS: b(2)-2 [redacted]

- ☐ EMERGENT
- ☐ URGENT
- ☒ NON-URGENT

VITAL SIGNS

TIME	1140				
BP	117/67				
PULSE	90				
RESP	18				
TEMP	98				
WT					

LAB ORDERS

☑ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		☑ CHEM: MVT B
BLOOD C&S X			

X-RAY ORDERS

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

Xray (R) hand

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	COMPLETED BY	TIME	PATIENT'S RESP
1200	Ancef 1gm IV b(2)-2		1330/100	Gentamycin IV [redacted]
1200	Bolus 1 LR		1800	Ampicillin PEN G IV
1220	Td .5cc IM			
1225	1100 Fentanyl			b(2)-2

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUAR[redacted]/OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

#[redacted] b(2)-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)

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

TEST RESULTS

WBC 8.9 | H/H 13.7/44 | PLT 256 | SMAC: 135 | 104 | 7 / 94 | 4.1 | 24 | .8

ABG/PULSE OX: SUP O2 | PH | PO2 | PCO2 | SAT | OTHER

RADIOLOGY — Check if read by radiologist ☐

RESULTS: ~~X-ray~~ ~~read~~ ⊕ comminuted fx MCPJ ☐ fx @ hand

EKG INTERPRETATION

UA: DIP | MICRO

PTT | BHCG | ETOH | GLU

PROVIDER HISTORY/PHYSICAL

27 y/o ♂ Slp GSW 13 days ago, seen by medico, seen by ? PSB yesterday for ↑ swelling - hand, given Ancef x T, eva to CSH. ϕ F/C ϕ new pain. ϕ other issues

OX Alo x4 in NAD. WSS

HEENT: OP/wnl clear/moist neck: supple, NP

Musculoskeletal: (R) hand ⊕ open lacerated wound dorsal/volar aspect hand @ index/long finger base ↓ROM flexion/extension, ϕ grip strength ⊕ pulses/dlc ↓ sensation radial/ulnar distribution

Slp GSW to (R) hand ☐ infection. Unclear initial care by.
→ Admit / Abx / Tdap / wrist splint ICW Z

CONSULT WITH	TIME	ACTION
Ortho		

RESIDENT/MEDICAL STUDENT SIGNATURE & STAMP: b(6)-2

PROVIDER SIGNATURE: [redacted]

CODES

DIAGNOSIS: GSW open fx (R) hand

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

MEDCOM - 15819

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 27
HEIGHT:
WEIGHT: 80 K

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA

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

4. PROPOSED SURGICAL PROCEDURE: Revision GSW / poss. amputation @ finger - index

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

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

#[redacted] blw-4

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

10. OR NURSING INTER[redacted]NS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] LTC 5 Aug 03 DATE

11. POSTOPERATIVE EVALUATION:

Dsg. clean & dry.
Pt. is drowsy; O_2 sat 96% on room air.

b(6)-2 AR

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] LTC, AN	[redacted] LTC, AN
DATE: 5 Aug 03 TIME: 1320	DATE: 5 Aug 03 TIME: 1515

REVERSE OF DA FORM 5179, JUN 91 USAPA V1.01

MEDICAL RECORD — INTRAOPERA[redacted]OCUMENT

b(a)-2

For use of this form, see AR 40-66, the prop[redacted]gency is th[redacted]he Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA I.Her BY (Albritton) (Mathieu)	2. PATIENT I[redacted] VERIFIED BY [redacted] D AND PROCEDURE CPT/Dr
3. DATE 7 Aug 03 — TIME PATIENT ARRIVED IN SUITE 1303	4. PATIENT IN[redacted] TIME 1303 — NUMBER 1-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] b(a)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt transferred to OR table, anatomically aligned for surgical procedure & pad under head (B) arms on padded arm boards less 90° & (R) arm on a double arm board padded.

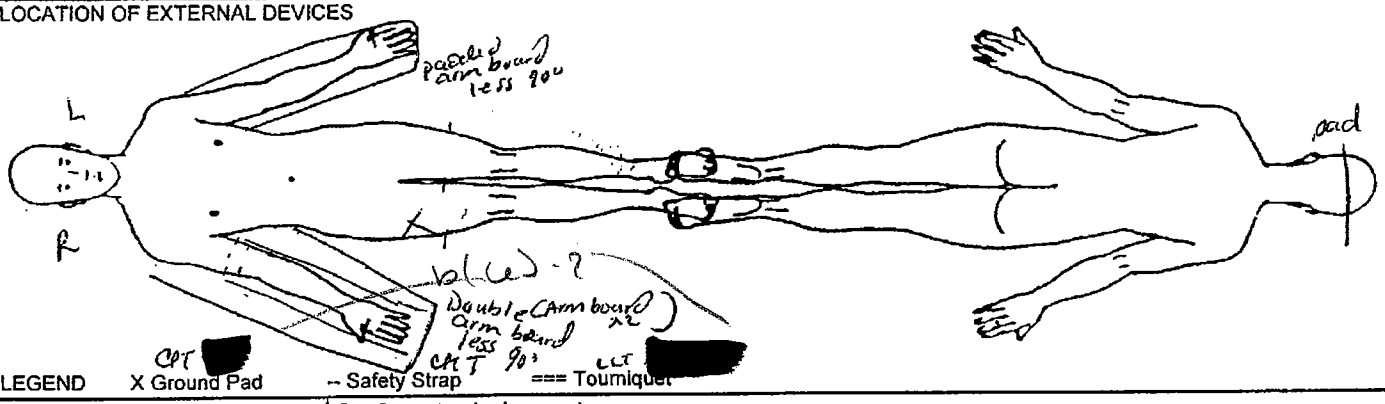
☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS:

8. SKIN PREPARATION b(a)-2

HAIR REMOVAL ☐ YES ☒ NO DONE BY: ☐ OR ☐ NURSING UNIT METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP COMMENTS:	PREP SOLUTION (Specify) Betadine/Betadine SITE (R) Hand — BY WHOM: CPT [redacted] SITE: — BY WHOM: COMMENTS: @ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



C = Correct I = Incorrect

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

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

#[redacted] b(a)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 30/30

☒ ESU NO: #1
GROUND PAD: BRAND Valley lab
LOT NO: 68936 Exp 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES [redacted]H IS OBSOLETE. MEDCOM - 15822 USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

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

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

Bovie Pad site intact pre-op Yes ; post-op Yes Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op N/A: post-op N/A Not used
Tourniquet Time: Up N/A Down N/A

b (4) - 2 All

20. OPERATION(S) PERFORMED
I + D / wound closure 4 (R) Hand

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU-2	1420	Litter to O2

22. REGISTERED NURSE SIGNATURE [redacted] CPT / AR [redacted]

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 15823 USAPA V1.01

b(a)-2

MEDICAL RECORD — [redacted] **INTRAOPERA[redacted]OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE
VIA Gurney BY Anesthesia	VERIFIED BY LTC [redacted]
3. DATE 5 Aug 03 — TIME PATIENT ARRIVED IN SUITE 1325	4. PATIENT IN ROOM TIME 1325 [redacted] 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	LTC [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Body maintained in proper alignment

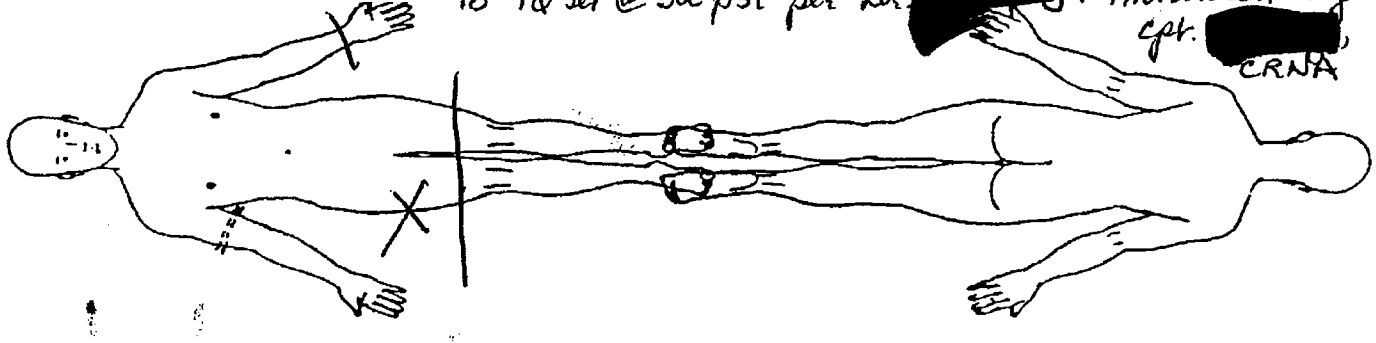
8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)*: Betadine soap/sol.
SITE: @ hand/arm BY WHOM:
SITE: BY WHOM: LTC [redacted]
COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES

18" TQ set @ 300 psi per Dr [redacted] + monitored by cpt. [redacted] CRNA



LEGEND X Ground Pad – Safety Strap === Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	✓	C	C	PFC [redacted]	LTC [redacted]
Needle Sharp	☒ Yes ☐ No	✓				
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

b(a)-4

[redacted]

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

☒ ESU NO: #4 Valleylab Force 2
GROUND PAD: BRAND REM Polyhesive II
LOT NO: 68936 0 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

cut: ~~20~~ 30 coag: ~~20~~ 30

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

MEDCOM - 15824

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs
Kerlix roll
4" ACE bandage

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION
WC III
Surgeons: Dr [redacted] Anesthesia: Cpt [redacted] CRNA Anesthesia Type: GETA

Bovie Pad site intact pre-op clear; post-op clear Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op 300; post-op clear
Tourniquet Time: Up ___ Down ___ 31 min total

b(6)-2

20. OPERATION(S) PERFORMED
Amputation Rt. index finger

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU 2	1500	via Gurney

22. REGISTERED NURSE [redacted], LTC, AN

REVERSE OF DA FORM 5179-1, OCT [redacted] USAPA V1.01

MEDCOM - 15825

511-119

NSN 7540-00-634-4

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY: 1

POST- OP DAY: DAY 5

MONTH-YEAR: August 2003 DAY: 5 6 - 7 8 9 10 11 12 13

HOUR: 6 12 6 12 6 12 6 12 6 12 6 12 6 12

PULSE (0) / TEMP. F (°)

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

EPW [redacted] b(a)-4

REGISTER NO.

WARD NO. ICU 2

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 15826

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																			
POST-	DAY	4 Aug 83																	
MONTH-YEAR	DAY	2030		5 Aug 83															
19	HOUR	2030	Aug 5 at 30	0600															

PULSE (O) / TEMP. F (●)

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD		12	16																
BLOOD PRESSURE		132	108																
		84	78																
HEIGHT:	WEIGHT→																		
Spo2		98	96																

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

511-112-01

b(6)-4

[redacted]

VITAL SIGNS RECORD

STANDARD FORM 511 (REV. 9-79)
Prescribed by GSA and Interagency Committee on Medical Records
FPMR (41 CFR) 101-11.806-8

MEDCOM - 15827

Ward/Section: EMT	REQUESTING PHYSICIAN: DR. [redacted] b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: # [redacted] b(6)-4	DATE: 5AUG03 TIME: 1205	SSN/PSEUDO: # [redacted] b(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl

======= PICCOLO =======
05/08/03 12:18
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: b(6) 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	94	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	310	39-380	U/L
NA+	135	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

(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
BIL		0.2-1.6 mg/dl
GGT		5-65 u/l
[illegible]		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: b(6)-2

REPORTED BY: [redacted]	DATE: 5 Aug 03	LAB ID NO.:

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	8.9	4.8-10.8 x 10^3
RBC	4.94	4.7-6.1 x 10^6
Hgb	13.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	44.8	42-52% (M) 37-47% (F)
MCV	90.7	80-94 fl (M) 81-99 fl (F)
Plt	256	130-500 x 10^3 verified
Lymph %	29.9	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	
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 [redacted]	DATE: 5 Aug 03	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
ICW2	[redacted] b(6)-7	
LAST, FIRST, MI: [redacted] b(6)-4	DATE: 8 Aug	TIME: 0300
		SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		

PICCOLO
08/08/03 01:40
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	99	73-118	MG/DL
BUN	4*	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	147	39-380	U/L
NA+	137	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

(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
CO2		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
BIL		0.2-1.6 mg/dl
LDH		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
CO2		18-33 mmol/l

REMARKS: b(6)-2

REPORTED BY:	DATE: 8 Aug 03	LAB ID NO.:
[redacted]		

SMOKER
27/MALE NKDA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)																							
MIDAZ	(mg)	3						2																
FENT	(mcg)	100				50		25/25	50															
PROPOFOL	(mg)	150																						
LIDO	(mg)	50																						
	( )																							
SUCC	(mg)	80																						
VOLAT AGENT SEVO	% del	4	2	2		2		1	1	X														
	% e.t.																							
AIR	L/Min																							
N2O	L/Min																							
O2	L/Min	8	2	2		2		2	2	8	8													

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → 300

FLUIDS

LINE site			
(L) A 20G	☐ Warmed	D5½NS →	→
	☐ Warmed		
	☐ Warmed		
	☐ Warmed		

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT 80 (KG) 58

HEMATOCRIT

INITIAL DATA

BP- 131/62

HR- 67

EQUIP CHECK (OK) - Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

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

TIME 1300 15 30 45 1400 15 30 45 1500 15 30 45 1600

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml		650	650	1620				
f - breaths/min	16	8	6	14	6	12	16	14
Peak inf pres / PEEP		18	18	18				
MODE - S(pon), A(ssist), C(on)	S	C	C	S	C	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	41	39	60	56	51	56	
BP/oth	FIO2 (Frac or %)	100	.85	.80	.85	.85	.80	
ART line	SpO2 (%)	100	100	100	100	100	100	
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	
Gas analyzer	TEMP-site	AVAIL →						
	N-M Block (T/4)							
Warming blkt								
Conv warmer								

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

TOTALS — 5mg; 250mcg

TOTAL EBL MIN

TOTAL URINE NA

FLUIDS SUMMARY

CRYSTALLOID- D5½NS 600

COLLOID-

BLOOD-

REMARKS

Code drugs with numbers, events with letters

1250 Pre Op EVAL
REVIEW → NO A.
20G IV → (L) A
1303 OR #1 MONITORS ↑
PreO2 IND/INT
1414 Suction
Agreed to Ext

RECOVERY AT

PACU (ICU 2) (Specify)

OTHER

CONDITION: STABLE Room Air

RESP- 20 SpO2- 96

BP- 138/71 HR- 83

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1250	1303	1430
PROC	Ready	Begin	End
	1310	1324	1413

PROCEDURES and CPT Codes: (R) HAND WD WASH & DRSG & CLOSURE

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

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

b(6)-4 #[redacted]

b(6)-2

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

DLX1/MAC3 8.0 ETT → VC = BBS(=), ETCO2(+) SECURED 22cm/LIPS
EYES TAPED.

SURGEONS [redacted]

ANESTHETIC [redacted]

PROCEDURE OR #1
LOCATION: CSH 28

DATE: 07 AUG 03

PAGE 1 OF

DA FORM 7389, FEB 1998 — MEDCOM - 15831 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

MEDICAL RECORD - ANESTHES[redacted]

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

Nisha 20 mg

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

DRUG	(Units)	
Robinul	(mg)	.2 /
Versed	(mg)	2.5 / 2.5
Lidocaine	(mg)	100
fentanyl	(ucg)	100 / 150
Propofol	(mg)	200
Succinylcholine	(mg)	100
VOLAT AGENT Sevo	% del / % e.t.	0 / X/2/2/1.5/1.5/1.5/1.5/1.5/1^
AIR	L/Min	
N2O	L/Min	
O2	L/Min	3/3/3/3/3/3/3/3/6

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

FLUIDS

LINE site		
18g (L) AC	☐ Warmed	NS 400/hr 400/500
	☐ Warmed	
	☐ Warmed	
	☐ Warmed	

LOSSES

EST BLOOD LOSS	50 100
URINE -	

TOTALS

TOTAL EBL	TOTAL URINE
.2 / 5 / 100	150 / 250 / 200 / 100 / 0

FLUIDS - SUMMARY

CRYSTALLOID- 800

COLLOID- 0

BLOOD- 0

REMARKS

Code drugs with numbers, events with letters

1312 pt ID, PREOP HX COMPLETED (PER FORM 2460)

1325 RM, O_2, MONITO.

1400 (T) ↑ 300 mmHg

1435 (T) ↓

1458 pt making purposeful mvts: SXH-ext-SXH

1500 TO ICU & RET TO CPT [redacted] RN

PHYS STATUS 1 2 3 4 5 (E)

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT: 44

INITIAL DATA:

BP- 128/67

HR- 82

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 1328

TIME 1330 X 1400 X 1420 X

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

220 200 180 160 140 120 100 80 60 40 20

10mg Versed 10mg Versed conk

VENTIL

VT - ml		850	840	480	180	240	470
f - breaths/min		8	10	6	14	17	17
Peak inf pres / PEEP		18	18	20	/	/	/
MODE - S(pon), A(ssist), C(on)		S-C	C	A	S	S	S

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	32	34	34	58	55	50
BP/oth	FIO2 (Frac or %)	.80	.80	.80	.80	.80	.80
ART line	SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	AVAIL	SKIN 34°	———	———	———	34°
	NN-M Block (T/4)	4/4	0/4	4/4			
Warming blkt							
Conv warmer							

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

RECOVERY AT 1500

PACU (CU) _____ (Specify)

OTHER _____

CONDITION: T 98.5

RESP 20 SpO2- 97 RA

BP- 132/73 HR- 81

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1312	1375	1510
PROC	Ready 1332	Begin 1403	End 1455

PROCEDURES and CPT Codes:

ORIF (L) FINGER

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

[redacted] b(a)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* ASI/C, OL #1 CMAC, grade I view, #8.0 ETT to 24@LIP, cuff A, ⊙ETCO2 ⊙BBS, tape to (R) side, OA in place, eyes taped.

SURGEONS:

[redacted] b(a)-2

[redacted] CRNA

PROCEDURE LOCATION: OR 1

DATE: 5 AUG 03

PAGE 1 OF

DA FORM 7389, FEB 1998 — MEDCOM - 15832 — COPY 1 - PATIENT'S MEDICAL RECORD — USAPA V1.00

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 27 ~~DAYS~~ ~~MOS~~ (YRS) Sex (X) MALE ( ) ~~FEMALE~~

ASA Physical State 1 (2) 3 4 5 E
WT: 80 KG/LB HT: 70 (IN)
ALLERGIES: NKDA

PROPOSED PROCEDURE: _____
SURGICAL SERVICE: _____
NPO SINCE: _____

HABITS:
TOBACCO: (+)
ETOH: (-)
DRUGS: (-)

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Ancef
( ) Pepcid
( ) PERC
( ) 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: _____

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 ___ HR ___ R ___ T ___
Pain Scale 0-10 _____
HEENT - Teeth _____
Trachea _____
TMJ/Neck _____
Oropharnyx _____
Nares _____
CHEST: _____
CARDIAC: _____
EXTREMITIES: _____
IV Access: _____
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since _____

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

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the pat[redacted]dian. b(a)2

The patient/leg[redacted] and agrees. Questions answered.

Signed: [redacted] Date: 07 Aug 03 Time: 1005 Hrs

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

Signed: _____ Date: _____ Time: _____ Hrs

SEDATION KEY:

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

Patient Identification: (Ward) ICU 2

#[redacted] b(a)-4

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 27 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: ORIF (R) Finger
SURGICAL SERVICE: ORTHO
NPO SINCE: _____

ASA Physical State 1 2 3 4 5 E
WT: 80 KG/LB HT: 70 IN
ALLERGIES: NKDA

HABITS:
TOBACCO: (+)
ETOH: (-)
DRUGS: (-)

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Ancef 2g (1200)
( ) Fentanyl 100 mcg
( ) Gent (1300)
( ) PCN (1300)
( ) _____
( ) _____

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

LABORATORY STUDIES:

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

13.5 | 104 | 7 (94)
41.1 | 24 | .8
13.7/256
8.9/44

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT

PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION

BP 105/76 HR 64 R 16 T 97.5
Pain Scale 0-10 _____
HEENT - Teeth intact
Trachea midline
TMJ/Neck 2 FB
Oropharnyx MP III+
Nares patent
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES:
IV Access: 18g (L) AC
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.

b(6)-2

The pati[redacted] understand and agrees. Questions answered.

Si[redacted] CRNA Date: 5 Aug 03 Time: 1320 Hrs

POST-ANESTHESIA [redacted]N AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) _____

#[redacted] 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.

[redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW

[redacted]

b(a)-4

NURSING UNIT	ROOM NO.	BED NO.
	24 Vs	0140

DATE OF ORDER 8 Aug 03 TIME OF ORDER 2100 HOURS

V.O from Dr [redacted] to Spc [redacted]

D/C D5½ NS @ 20 meq KCL

Saline lock (Done)

LIST TIME ORDER NOTED AND SIGN

0130 to 0800 9 Aug 03 [redacted]

9 Aug 03 [redacted] b(a)-2

PATIENT IDENTIFICATION

EPW [redacted] b(a)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW	24 Vs	TC 0210

DATE OF ORDER 9 Aug 03 TIME OF ORDER 1600 HOURS

D/c Ancef, Gent, Pen [redacted] noted 1600

Keflex 500 mg po QID

Cipro 500 mg po BID

[redacted]

10 Aug 03 [redacted]

PATIENT IDENTIFICATION

[redacted] b(a)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 12 Aug 03 TIME OF ORDER 0900 HOURS

noted prescription in pharmacy 0943 12 Aug

1. D/c to EPW comfy
2. Keflex 500 mg po QID x 7 days
3. Suture out 2 [redacted] WV

[redacted] b(a)-2

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.
[redacted]		

DATE OF ORDER TIME OF ORDER HOURS

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

☆ U.S. GC MEDCOM - 15835 -710

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: ICW #2 | ROOM NO. | BED NO. 10

DATE OF ORDER: 5 Aug 03 | TIME OF ORDER | HOURS | LIST TIME ORDER NOTED AND SIGN

Post-op [redacted] s/p [redacted]
Resection (R) [redacted]
vitals routine
After 24 start elevation [redacted]
IVF at all times
2-3 pillows
Diet regular

b(6)-2

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: ICW#2 | ROOM NO. | BED NO. 10

DATE OF ORDER | TIME OF ORDER

IVF D5 1/2 NS + 20 KCl @ 125 cc/hr
Meds: Ancef 1 g IVP q 8 hrs 01422
Gent 100 mg IVP q 6 hrs
4 10422 P & T 1 p 3 hrs done
4 10822 Pen G 4 mil units IVP q 6 hrs
Percocet 1-2 po q 4 PRN
MOM 2-5 ml IVP q 2 PRN

PATIENT IDENTIFICATION

[redacted] b(6)-4

NURSING UNIT: ICW2 | ROOM NO. | BED NO. 10

DATE OF ORDER | TIME OF ORDER | HOURS

b(6)-2 [redacted]

b(6)-2 [redacted]
SRP/ done [redacted] SRT/AD

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: ICW #2 | ROOM NO. 24 hrs | BED NO. 8 Aug 03

DATE OF ORDER | TIME OF ORDER | HOURS

7 Aug 03 0755
NPO till this afternoon for OR
V.O. Dr. [redacted]
7 Aug 1415 b(6)-2
Post-op [redacted]
request prior orders [redacted]
7 Aug 03 1600

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

MEDCOM - 15836

[redacted] b(6)-2 A11 [redacted]

CLINICAL RECORD

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

Mo. 08 Yr. 05

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
5	[redacted]	Vitals routine	05	✓ [redacted]
			13	
			21	
			✓	
5	[redacted]	activity - elevate (R) arm on 2-3 pillows @ all times	05	✓ [redacted] DC'd 1 Aug 05
			13	
			21	
			✓	
5	[redacted]	diet regular	07	✓ [redacted]
			12	✓
			17	
			✓	
9	[redacted]	dry dressing Δ to (R) hand QD	16	✓ ✓ ✓ ✓ [redacted]
			✓	
			✓	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P resection of (R) IF

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION: EPW [redacted]

b(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

9c MEDCOM - 15837 3f

[redacted] b(a)-2 A11 [redacted]

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo 8 Yr 03	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5	[redacted]	PB i p 3rd dose of Agent	6	1000	LAB unable to do PET	[redacted]
7		NPO will thru afternoon for OR	7	Today	1200	
7		resume all previous orders	7	now		
12		DC to EPW camp	12	when avail		
12		Sutures out 2 weeks	2 weeks			
	.....					
	.....					
	.....					
	.....					
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	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

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

USAPA V1.00

CLINICAL RECORD

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

Mo. ____ Yr. ____

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 8/4	8/5
8/4	[redacted]	Ancef 1g IV	0400	X	[redacted]
		b(6)-2	2200	1200	

ALLERGIES: ☐ YES ☒ NO
nkA

PRIMARY DIAGNOSIS:
gunshot wound (R) hand.

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

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 1 OCT 78 4677

EDITION OF 1 DEC 77 MAY BE USED.

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Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON MEDICATION)				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
8/4	[redacted]	Morphine Sulphate 5mg pain	2230 SD													
			2215 SD													

(6)-2

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