ICU3

Patients Name: EPC [redacted] (3-5 D)

Date: 8·15·03

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		119/67																								
TEMP		97.3														97.6										
HR		67														53										
RR		18														18										
SaO2		99														98%										
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	Tota
IVF																										
IVPB																										
NGT																										
PO		350						600			340															
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			55				600				400							850							660	
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDICAL RECORD-SUPPLEMENTAL MEDI

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET b(a)-2

OTSG APPROVED (Date)
QA APPR 08MAR89

		INITIAL SHIFT ASSESSMENT	
N E U R O		Time: 0600 Initals: [redacted]	Time: 1900 Initals: [redacted]
	Pupils	3mm PERRL	Perrla
	Sensorium	Alert, able to follow	Alert & Oriented x 3
	LOC / GCS	simple commands and express needs	follows commands
C A R D I A C	Cardiac Rhythm	SR c Ø CP	NSR
	PRI: / QRS:	—	
	Pulse Strength	+2 pulses in all 4 ext.	+2 pulses all extremities
	Cap Refil / JVD	Cap refill < 3 sec	Cap refill < 3 sec
	Edema	Ø noted	
	Chest Pain		
R E S P	Respiratory Pattern	RRR, equal chest rise	RRR
	Breath Sounds	CTA throughout	Clear Bilat
	Secretions	Ø noted @ this time	Ø
	Cough	Ø noted	Ø
S K I N	Color	WNL for race	Normal to race
	Integrity	2 BLE wound c drsg	
	Backside	DH	
I V	Access Devices	(L) FA c NS @ 30cc/°	(L) FA IV
	Location	Ø s/s of infection	Ø s/s of infection
	Condition		
G I	Abdomen	Soft, nontender	Soft, non tender
	Bowel Sounds	(+) in all 4 quadrants	normoactive all 4 quads
	Stoma/Ostomy	Ø noted	
G U	Device	Urinal	pt voids to urinal
	Color / Clarity	Ø void @ this time	Clear yellow urine

(Continue on reverse)

PREPARED BY (Signature & Title)

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

DATE 16 AUG 03

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

EPW [redacted] b(4)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: 2PW [redacted] 6(4)-4 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	120/68				128/61				143/49					135/70												
TEMP	96.5				97.3				97.3																	
HR	63				62				61					65												
RR	16				16				18					18												
SaO2	99				98				96					99												
FiO2																										
Source	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	T
IVF	30	30	30	30	30	30	30	30	30																	
IVPB																										
NGT																										
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	575		575											500				400					600			
NGT																										
STOOL																										
DRAIN																										
Total	575		575																							

. . . CAL RECORD-SUPPLEMENTAL MED . . . DATA

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

REPORT TITLE	OTSG APPROVED (Date)
INTENSIVE CARE NURSING FLOW SHEET	QA APPR 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 1200 Initals: [redacted] b(u)-2	Time: 2400 Initals: [redacted] b(u)-2
NEURO	Pupils	PERRLA	Perrla
	Sensorium	A+O x 3	A+O X3
	LOC / GCS	Follows Commands, Responsive	
CARDIAC	Cardiac Rhythm	—	—
	PRI: / QRS:	—	—
	Pulse Strength	+3 pulses in all extremities	+3 pulses x 4 extremities
	Cap Refil / JVD	<3 secs / Ø JVD	Cap refil <3 sec
	Edema	None	Ø
	Chest Pain	None	Ø
RESP	Respiratory Pattern	Regular + Unlabored	RRR Ø SOB
	Breath Sounds	Diminished but CTA	CTA
	Secretions	None	Ø
	Cough	None	Ø
SKIN	Color	Normal for race	Normal for Race
	Integrity	Wound to BLE	intact x̄ wounds to B/E
	Backside	None	Ø
IV	Access Devices	18G IV in Ⓛ AC	18g PIV Ⓛ ac
	Location		
	Condition	Ø s/s of infection @ IV site	Ø s/s of infection or infiltration
GI	Abdomen	soft, Tender to Palpation	soft, nondistended
	Bowel Sounds	Hypoactive	
	Stoma/Ostomy	Ø N/V	Ø
GU	Device	Voiding s̄ difficulty	Voids to urinal
	Color / Clarity	Golden yellow	

(Continue on reverse)

PREPARED BY	DEPARTMENT/SERVICE/CLINIC	DATE
b(u)-2 [redacted] cpt/An	ICU3, [redacted] b-2-2	18 Aug 03

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

[redacted]

b(u)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 16444

ICU3

Patients Name: [redacted] 19(4)-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							132/64																			
TEMP							97.8																			
HR							86																			
RR																										
SaO2							98																			
FiO2							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 LR	30	30	30	30	30	30	30	30	30	30	30	30	360													
IVPB																										
NGT																										
PO					240		260			240		240	980													
Total													1340													

C PUT	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							900		500		475		1875					300					400			
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 16445

DOD-029834

ACLU-RDI 1637 p.5

CAL RECORD-SUPPLEMENTAL MED DATA

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

REPORT TITLE
INTENSIVE CARE NURSING F W SHEET

OTSG APPROVED (Date)
QA APPR 08MAR8

		INITIAL SHIFT ASSESSMENT		
		Time: 0800 Initals: [redacted] b(6)-2	Time:	Initals:
NEURO	Pupils	PERRL		
	Sensorium	Pt alert + responsive to		
	LOC / GCS	touch + voice stimuli		
CARDIAC	Cardiac Rhythm	Not on Monitor		
	PRI: / QRS:			
	Pulse Strength	Radial @ +3, Pedal @ +1		
	Cap Refil / JVD	brisk cap refill		
	Edema	Ø Ntd		
	Chest Pain	Ø		
RESP	Respiratory Pattern	Reg R+R, equal rise+fall		
	Breath Sounds	CTA bilat		
	Secretions	Ø Ntd		
	Cough	Ø Ntd		
SKIN	Color	NFR		
	Integrity	dressings intact		
	Backside	Ø Ntd problems		
IV	Access Devices	LFA PIV c LR@ KVO		
	Location	Slight tenderness @ site c		
	Condition	Ø Ntd erythema / edema		
GI	Abdomen	Lower quads firm + tender to		
	Bowel Sounds	palpation, upper quads soft +		
	Stoma/Ostomy	Non tender. BS + X 4quads.		
		Ø Ntd N/V		
GU	Device	Pt voiding clr yellow urine to		
	Color / Clarity	urinal @ bedside in adequate		
		amounts.		

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] 9/6/06

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

DATE 19Aug03

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

b(6)-2

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

MEDCOM - 16446

USAPPC V2.00

ICU3

Patients Name: [redacted] 1-13 D

Date: 19 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			140/																							
NBP	125/70		/50																							
TEMP			97.6																							
HR	58		61																							
RR	18		16																							
SaO2	98%		98%																							
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
IVF																										
IVPB																										
NGT																										
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	5	1
URINE			525																							
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 16447

ACLU-RDI 1637 p.7

DOD-029836

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.)
A11D1	IZ

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
[redacted]	EPW [redacted] b(4)-4	EPW	M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADI	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
ZZZZZZZZ	29Y	X	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	Z	1430	b(4)-4

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
		9	YEAR [ ] [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
6	ICU3	UNK

ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK

NAME: [redacted]

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
50 b(2)-2		030819

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
AEAA		030811

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

FOR LOCAL USE

Cellulitis

b(4)-2

ADMITTING OFFICER (Signature, as required) [redacted]

DA FORM 2985, MAR 89 MEDCOM - 16448 USAPPCV1.0

INPATIENT TREATMENT RECORD COVER SHEET

b(6)=4

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]	[redacted] EPW	[redacted]	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	22	—	—	—	—	NO

11. EMP	12. SSN	13. ORGANIZATION	14. WARD
~~9920~~	[redacted]	—	ICW #2

15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NO	—	K-78	—	—	WIA

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
Direct from ER	1845	AEAA

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
unk	~~SOA~~	17 Aug 03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
unk	unk	14 Aug 03	DR. [redacted] b(6)-2

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

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Dx: GSW to (R) calf / thigh

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
Ø	Ø	Ø	Ø	3	3

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
	b(6)-2		b(6)-2		

SIGNATURE OF ATTENDING MEDICAL OFFI[redacted] EDICAL RECORDS OFFICER

Dr [redacted]

DA FORM 3647, MAY [redacted] MEDCOM - 16449

EDITION OF 1 AUG 76 IS OBSOLETE

MEDICAL RECORD

ABBREVIATED MEDICAL RECORD

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

PHYSICAL EXAMINATION

See [redacted]

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

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

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

b(4)-4

[redacted]

E & W

ABBREVIATED MEDICAL RECORD
Standard Form 509

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

509-106

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | progress notes ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14Aug03 2030	~~BBS~~ pt. admitted to ICWZ @1800 from EMT, S/P GSW @ calf & @ thigh, debridement done @ 624th FST today - Keflex dsg on calf & thigh, small amount of blood on calf dsg. on admission - VSS, T 101.8, 650mg PO tylenol given, temp @ present 98.2 - lungs c slight exp. wheezes, pt. reports he smokes 1 PPD - BS @ x 4 quads - pt. oriented, understands small commands in english - pt. denies ~~illegal~~ illegal drug use - SL patent in @ FA - thigh dsg CDI on admission, neuro √'s WNL in @ foot [redacted]
14Aug03 2130	VSS - Alert x3 Pearla 3 wn - saline lock to @ FA patent @ SIS infiltratum. Lungs: ~~clear~~ Rhanci BIL ~~BIL~~ even Reg - HR - NSR - BS @ x 4 quads. Pedal pulses +3 Radial +3. Dsgs to @ leg small amt of bloody drainage noted and intact. T-97°Ax. Amb x1 c crutches to BR on ward. offers occ @ present. Restraints to UE and LE in place and secure. [redacted]
15Aug03 0815	Pt. awake & alert sitting up in bed. HR Regular, bowel sounds (+) x 4 quad Lung sounds c @ sided inspiratory wheezes, @ side c inspiratory rhonchi in upper lobe & inspiratory wheezes throughout. IV in @ wrist flushed well & 3cc NS. Dsg's to @ LE saturated c bright red bld. Dsgs Δ'd, to upper thigh &

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

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

REGISTER NO. | WARD NO. ICWZ

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-8.202-1
USAPA V2.00

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	lower calf, 2 wands to upper thigh & 2 wands to lower calf all approx. dimensized packed c̄ sterile iodiform, wands s̄ s/s of infection. (L) pedal pulse (+), (+) sensation, <3 sec cap refill, limited ROM in ankle, knee, & toes. Pt. s̄ complaints @ this time. VSS. Will continue to monitor [redacted]
15Aug03 1700	assumed care @1300 - VSS, T 100.8 - no c/o pain @ this time - SL patent - dsg on (L) calf & thigh CDI, neurov's WNL in (L) foot - Tc present 100.4°F, given 650mg tylenol PO —— [redacted] CR, AN ——
15Aug03 2130	VSS - Alert x3 - DRSG to (L) leg dry and intact. PearLa gm HR-NSR - Lungs CTA B/L - Resp even reg BS ⊕ x4 quads. Pedal and Radial pulses +4. Cap 5 >3 sec. heplock patent ∅ s/s infiltrates Restraints to UE and LE in Place and secure. ∅ c/o (L) leg pain @ Present. up to ward BR c̄ Crutches per self M. —— S [redacted]
16Aug03 0330	Resting quietly @ present. ∅ c/o (L) leg pain drsg dry and intact. Restraints to UE and LE in place and secure. IV Ancef given via periphal saline lock is patent ∅ s/s of infiltration. —— [redacted]
16Aug03 0630	Assumed PT care at 0545. PT A&O x3. VSS. Laying in bed. No c/o pain or discomfort heplock flushed Pulses + x4 Lungs CTA, BS+. Will continue to monitor —— PFC [redacted]
0845	Dsg Δ done. MD in to see wounds. 2 wounds to upper thigh and two wounds to lower calf of (L) LE. packed loosely c̄ iodiform gauze. All sites free of infection. Limited ROM to (L) LE. NV checks WNL. Amb c̄ crutches [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

USAPPC V1.10
USAPA V2.00

MEDCOM - 16452

b(a)-2 All

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
16Aug03 1450	assumed care @1300-VSS-no c/o pain @this time-small amount of serosang. drainage on underside of calf & thigh dsg-SL patent-pt. using crutches to ambulate-[redacted]
16Aug03 1620	neuro V's WNL in (L) foot, (+) movement, (+) sensation-had BM-[redacted] CRIAT
16Aug03 2145	VSS-Abd x 3 dsgs to (L) leg dry and intact. ø c/o pain or discomfort @present. Pearla 4m-Lungs-slight Rhonci and wheezes to upper lobes bil. HR-NSR-BS (+) x 4 equals Pedal and Radial pulses 4+. Amb to BR w/ crutches c min Assist from staff. Restraints in place and secure.-[redacted] Lab d/a
17Aug03 0718	Assume pt care @ 0500. Pt awake and alert. VSS. HR reg. Lungs CTA. Abd soft. BS x 4. Amb c crutches to BR. Dsg to (L) thigh and (L) calf CDI. (+) ROM (+) pulse (+) sensation to (L) LE. Tylenol 650mg given for pain. SL patent. Will cont. to monitor-[redacted]
1300	Dsg Δ done. Wounds packed c iodaform. Sites free of infection, possibly discharged in 2 days-[redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO. FCW2

[redacted]

EPW

[redacted]

b(a)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 16453

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17 Aug 03	(1) Dc Summary - s/p soft tissue ..... (3) sw (1) calf & thigh - treated i Anef / keflex & drsgs Δ, - Plan cont dsg Δs BID until wounds granulate
	[redacted]
	b(6)-2 All
17Aug03 1600	assumed care @ 1300 - VSS - no c/o pain @ this time - dsg on (2) thigh & calf CDI, neuro's WNL in (2) feet, no edema - SL patent - pt. has meds & DC Summary & awaits discharge to EPW camp or Fort gate - [redacted] AW
17Aug03 1930	calf & thigh dsgs on (2) leg Δ, all 4 wounds tunnel slightly, no bleeding noted, serosang drng. On old dsgs, wounds loosely packed C & iodoform soaked in NaCl, pt. given IT Percocet for pain [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | 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)*

(EPW) [redacted]

b(6)-4

REGISTER NO. | WARD NO. ICW2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 9/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 16454

b(6)-2

MEDICAL RECORD	PROGRESS NOTES

DATE	
17AUG03 2300	USS — Alert x3 — dsg to (L) leg dry and intact. Pearla. Lungs CTA Resp even reg. HR — NSR BS (+) x4 quads. Pedal and Radial pulses +3. Restraints to UE and LE in place and secure. Saline lock to (L) wrist is patent (-) s/s of infiltration. Pt sleeping at this time ——— Sgt [redacted] /LCO
18AUG03 0430	Percocet 5mg ii PO for c/o (L) leg pain. Resting quietly c present of further c/o pain or discomfort. Restraint to UE in place and secure ——— Sgt [redacted] /LCO
18AUG03 0700	Pt. asleep in bed s̄ complaints @ this time. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. USS. HL in (R) wrist s̄ s/s of infection. DSG's to (L) thigh & calf C/D, pedal pulse palpable (+) sensation, cap refill <3sec. All other assessment findings WNL. Will continue to monitor ——— [redacted] /AN

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8/14/63	
1445	22 o/o EPW s/p GSW x2 to (R) LE
	#1 - ant mid thigh, exit at post mid thigh
	#2 ant mid calf to post mid calf
	(R) PT/DP pulses strong
	No obvious hematoma, minimal destruction at exit site
	X-ray of femur + tib/fib (-)
	s/p clean wound + debride, devitalized tissue + pack c Kerlix
	- Ancef 1gm IV
	- tetanus if available
	- observe 24 hrs
	- frequent vascular √ - qi x8 hr
	qb x8
8/14/63	all 4 wound debrided [redacted] CPT [redacted]
1500	& sterile cleansing
	packed c 1/4" Iodoform gauze [redacted]

b(6)-2

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

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]

12-6-82

[redacted] b(6)-2

[redacted]

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

MEDCOM - 16456

ACLU-RDI 1637 p.16

DOD-029845

NSN 7540-00-634-4178

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17Aug03	D/C Summary -S/P soft tissue GSW @ calf & thigh -treated c ancef/Keflex and dressing D's Plan-continue dressing D's BID until wounds granulate

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

EPW [redacted]

[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

MEDCOM - 16457

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted]

RECORDS MAINTAINED AT b(2)-2

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX: 22

AGE: M

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)*: 14AUG03 | TIME: 1630

TRANSPORTATION TO FACILITY: MEDEVAC

THIRD PARTY INSURANCE

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

CURRENT MEDICATIONS

ALLERGIES: Ø

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW to L leg + thigh

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☑ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME					
BP	142/80				
PULSE	99				
RESP	18				
TEMP					
WT					

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☑ PULSE OX 97% ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATE

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

MEDCOM - 16458

NSN 7540-01-075-3786

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

TEST RESULTS

CBC	WBC 17.8	SMAC	V33	4.7	ABG/PULSE OX			RADIOLOGY Check if read by radiologist ☐
	H/H 13.6		99	19	SUP 02	PH	PO2	RESULTS X-ray (L) tib-fib-ank (L) thigh
	PLT				PCO2	SAT	OTHER	
PT					U/A DIP			EKG INTERPRETATION
APTT		BHCG	ETOH	GLU 94	MICRO			

PROVIDER HISTORY/PHYSICAL

22 yr old Iraqi male (EPW) shot by M.P. for reportedly selling illegal drugs. Has GSW (L) thigh & (L) tibia/fibula. Seen by [redacted] b-2-2
Already had debridement

T P-99 B.P. 142/82

Allergies: 0
MEDS: 0
PMHX: 0

Adult, awake in NAD severe distress
HEENT - Normocephalic
EAT -
Lungs - clear A&P - scar on chest wall
Heart - S1,S2 - Reg w/o S3 or S4 or M
Abd - soft - NT - ND - B.S.
Legs - Pedal pulses - Neuro bilateral
GSW - (L) thigh & (L) calve

Tatoo - RT arm

Orders
CS chems
Soft - tissue GSW
plan admit for observation

b(6)-2

[redacted] MA)

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

[redacted]

DIAGNOSIS
1) GSW (L) thigh (L) calve

CODES

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

[redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

[redacted] b(6)-4

12-6-82

4TH FORWARD SURGICAL TEAM PATIENT RECORD

1410

DTG IN: 8/14/03 1345

TO OR:

NAME: Iraqi EPW

SSN: N/A UNIT:

WT LBS: WT KG:

ALLERGIES: NKDA

TIME OF INJURY: ?

DETAILS OF INJURY EVENT: None available

GCS PRIOR TO ARRIVIAL=

AIRWAY: PATENT ETT ORAL NASAL
Patent

CHEST: Numerous scars on chest tatoo (R) shoulder
Clear
RIGHT BS= LEFT BS=

NEURO: GCS= 15
A+O

HEAD, FACE, & NECK:
Clear

ABDOMEN:
(+)BS X4 Quads

PELVIS:
clear

UPPER LEGS:
GSW (L) T leg
~~GSW (L) T leg~~

LOWER LEGS:
(+)pedal pulses / ABRASION to (R) inner ankle / tatoo (L) calf
GSW (L) ↓ leg

ARMS: tatoo (R) arm
Clear

POSTERIOR:
clear, exit wounds (L) thigh (L) calf

TIME	IV	SZ	SITE
1415	1	18	(R) forearm
1420	2	18	(L) wrist
	3		
	4		

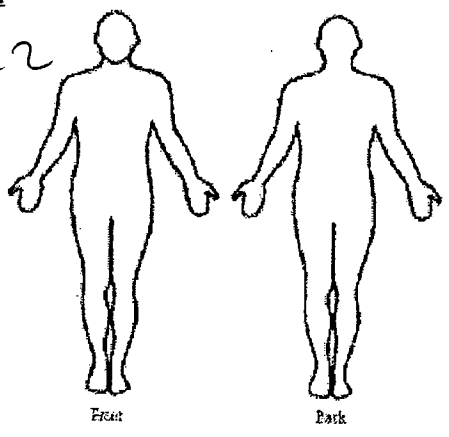
[redacted] b(6)-2

LITERS OF FLUID IN:
1 LR 1000 cc each

UNITS OF BLOOD IN:

TIME	MED & DOSE	DR
1425	Ancef 1gm	[redacted]

TIME	INTERVENTION
Ø	OXYGEN ON & RATE:
	ETT SIZE:
	SURG. AIRWAY
	CT #1 & SITE:
	CT #2 & SITE:
	FOLEY
	GASTRIC



ANESTHESIA / OR

TIMES	
IN:	
INCISION:	
PROC. END:	
TO ACW:	
ANESTESIA TECH.	
MAC:	
REGIONAL:	
GENERAL:	

MEDICATIONS

MIDAZOAM
PENTOTHAL
ETOMIDATE
FENTANYL
MSO4
SUCCINYL.
ROCURONIUM
VECURONIUM
AGENTS: Lidocaine 1% - local

ANTIBIOTIC:
REVERSAL:
OTHER:

FLUID TOTALS	
CRYSTAL:	
COLLOID:	
EBV:	
EBL:	
U.O.:	
DRAINS:	

VITAL SIGNS			
TIME:	1415	1420	1425
BP:	125/83	138/78	148/72
HR:	98	99	84
RR:	16	16	16
SpO2:	98	98	100
TEMP:			

RECOVERY

TIME IN: O2 VIA & RATE:

SURGEON(S): OIC [redacted] b(6)-2

PROCEURE:
Debridement of GSW's
↓ leg ¼" entry, ¼" exit
↑ leg dime size entry, 2cm exit wound

DRESSINGS:
(L) ↓ leg, iodoform ½", 4x4, kerlex
(L) ↑ leg iodoform 4x4, kerlex

TUBES:
Ø

DRAINS:
Ø

IV SITE RE-EVALUATION

IV	SZ	SITE	RATE	AMT IN BAG
18		(R) forearm		
18		(L) wrist		

POST-OP MEDICATIONS

TIME	MED & DOSE	ROUTE
1505	MSO4 4mg	IV

CUMULATIVE I & O

INTAKE SOURCE	INTAKE AMT	OUTPUT SOURCE	OUTPUT AMT
LR	300 (ACW)	Urine	
TOTAL=		TOTAL=	

POST-ANESTHESIA RECOVERY SCORE

ADMIT=	
30 MIN=	
D/C=	

VITAL SIGNS

	ADMIT	D/C
BP:	148/82	124/70
HR:	82	82
RR:	16	20
TEMP:	97.8	98

SpO2 98 | 97

MEDCOM - 16460

i-STAT EG7+

Pt: 000000000000 [redacted]

Pt Name [redacted]

b(6) - 4

Na_____140 mmol/L
K_____4.0 mmol/L
TCO2_____27 mmol/L
iCa_____1.21 mmol/L
Hct_____45 %PCV
Hb*_____15 g/dL
*via Hct

At 37C
PH_____7.424
PCO2_____38.8 mmHg
PO2_____62 mmHg
HCO3_____25 mmol/L
BEecf_____1 mmol/L
sO2*_____9[illegible]
*calculated

Sample Type_:

14FEB03 14:22

Oper 0000000

Physician:_____

Ser# [redacted]

Ver: JAMS044C
CLEW A89

RDULT

TIME	HR/PR	SpO2	SYS / DIA - MEAN	RR
HH:MM	BPM	%	mmHg	RPM
15:45	85	97	138 / 76	96 OFF
15:31	82	97	134 / 77	97 OFF
15:30	89	99	SEARCH	OFF
15:15	93	96	SEARCH	OFF
15:10	88	STBY	145 / 81	106 OFF
15:06	87	98	143 / 80	101 OFF
15:00	99	95	153 / 80	106 OFF
14:55	95	96	159 / 93	114 OFF
14:50	83	99	163 / 88	113 OFF
14:48	82	98	148 / 86	107 OFF

NIBP TREND 08/14/03

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY		1							
POST- DAY									
MONTH-YEAR	DAY	14	15	16	17	18			
19	HOUR								

PULSE (0)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	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: 18, 16, 20, 16, 20, 16, 16, 16

BLOOD PRESSURE: 138/98; [illegible]/84, 130/70; 134/70, 104/[illegible]; 120/70; 114/[illegible], 120/76; 112/70

[illegible] 96 95 99% 95% 97 97 97

Record special data only when so ordered

HEIGHT: | WEIGHT →

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. ICWZ

[redacted] b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 16462

Ward/Section:	REQUESTING PHYSICIAN: b(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: # b(6)-4	DATE: 14-0803	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 (ar 41-51 mmHg (ven)
PO2		80-105 mmHg (art N/A (ven)
TCO2		23-27 mmol/L (art 24-29 mmol/L (ve
HCO3		22-26 mmol/L (art 23-28 mmol/L (ve
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/
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		
typ + hold		

(Piccolo) Chemistry 12

======= PICCOLO =======
14/08/03 17:26
REFERENCE RANGE: MALE
PATIENT #: b(6) 4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: DR #: 000
SERIAL #:

GLU	94	73-118	MG/DL
BUN	11	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	824*	39-380	U/L
NA+	133	128-145	MMOL/L
K+	4.7	3.3-4.7	MMOL/L
CL-	99	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS: b(6)-2

REPORTED BY: [redacted] **DATE:** 8-04-03 **LAB ID NO.:**

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

LAST, FIRST, MI. [redacted] b(6)-4 | DATE 14-08-03 | TIME | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	[redacted]	4.8-10.8 x 10^3
RBC		
HGB		
HCT		
MCV		
MCH		
MCHC		
PLT		
LYMP		
MONO		
EOS		
BASO		
NEUT		
Lymph		Baso
Atyp		Imm
RBC Morph		

14-08-03 17:14

			Reference Limits	
WBC	12.7 H	x10^3/uL	4.5	10.5
RBC	4.75	x10^6/uL	4.00	6.00
HGB	13.6	g/dL	11.0	18.0
HCT	42.4	%	35.0	60.0
MCV	91.8	fL	86.0	99.9
MCH	28.7	pg	27.0	31.0
MCHC	31.3 L	g/dL	33.0	37.0
PLT	362	x10^3/uL	150.	450.
LYMP	14.8	%	20.5	51.1
NEUT	3.6 *	x10^3/uL	1.2	3.4

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] | **DATE:** 8-14-03 | **LAB ID NO.:**

b(6)-2

b(6)-4 ↓ All   b(6)-2 All ↓

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION: [redacted] (EPW) [redacted]

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 10

DATE OF ORDER: 14 Au 03 | TIME OF ORDER: ____ HOURS | LIST TIME ORDER NOTED AND SIGN

Admit ortho
s/p GSW [illegible] calf, [illegible] thigh
vitals routine
activity as tol
diet [illegible]
IV KVO
meds Tylenol 650 mg po q6 h
Ancef [illegible] g IV q 8°

[redacted]

PATIENT IDENTIFICATION: [redacted] (EPW) [redacted]

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 10

noted [redacted] 1845

PATIENT IDENTIFICATION: [redacted]

DATE [redacted] TIME OF ORDER 0800

28° V5

8/16/03 ____ HOURS 2328

- Daily Dressing D's ✓
- Hydrocodone ✓
- Reverent [illegible] po q4° prn [illegible]

[redacted]

noted [redacted] 0817 16 AUG 0[illegible]

[redacted]

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 10

PATIENT IDENTIFICATION: [redacted]

DATE OF ORDER: 17 Aug 03 | TIME OF ORDER: 1500 HOURS

- D/C to EPW Camp
- Keflex 500 mg po QID
- BID wet D's [illegible]

[redacted] 1545

[redacted]

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

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

MEDCOM - 16465

b(6)-2 ✓ b(6)-2 ✓

CLINICAL RECORD

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

Mo. 8 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 14	15	16	17	18
14	[redacted]	vitals: routine	05	✓				
			13	[redacted]				
			21					
			/					
14	[redacted]	astol. activity	05	✓				
			13	[redacted]				
			21					
			/					
14	[redacted]	regular diet	07	/				
			11	/				
			17	/				
16	[redacted]	~~Daily Dsg A's~~ Δ see below	13	/	/	[redacted]		
17	[redacted]	BID w/ Dsg A's	20	/	/	/		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW @ calf/thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted] b(6)-4

[redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 16466

b(6)-2

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo 8 Yr 03	
Order Date / Clerk	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
14 [redacted]	admit-ortho	14	/	1800	[redacted]
17 [redacted]	DC to EPW camp	now	now		

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

USAPA V1.00

b(4)-2 A11

CLINICAL RECORD

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

Mo. 8 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 14	15	16	17	18
14	[redacted]	~~EV: KVO~~	05	1				
16		HL @ tolerating po	13	[redacted]				
			21					
14	[redacted]	Ancef 1gm IV	08	[redacted]				
		q8o	16					
			24					
17	[redacted]	Keflex 500mg po	06	—— 1				
		QID	12	—— 1				
			18	—— 1				
			24	—— 1				

DC'd 17 Aug 03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (L) calf/thigh

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW [redacted]

[redacted]

b(4)-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 - 16468

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. ____ Yr. ____
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	b(a)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
-14-	[redacted]	Tylenol 650mg PO q6° pr-pain	14Aug 1630 mg; 15Aug 0815 ff PO; 15Aug 1710 ff PO; 16Aug 0615 ff PO; 16Aug 1205 ff PO; 17Aug 0717 ff PO; (+)
-16-	[redacted]	Percocet ÷/11 PO q4° PRN for pain	17Aug 0303 1930 ff; 17Aug 2400; (+)

USAPA V1.00

MEDCOM - 16469

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM | RANK / GRADE | MALE / HOMME | FEMALE / FEMME

SSN / NUMÉRO MATRICULE | SPECIALTY CODE / GPM | RELIGION / RELIGION

2. UNIT / UNITÉ

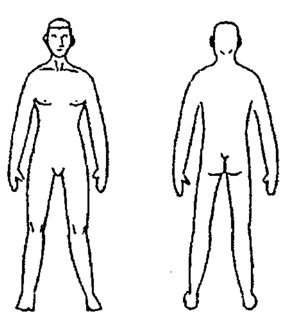
FORCE / ÉLÉMENT: A/T | AF/A | N/M | MC/M

NATIONALITY / NATIONALITÉ

BC / BC | NBI / BNC | DISEASE / MALADIE | PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT — BACK / ARRIÈRE



- AIRWAY / TRACHÉE
- HEAD / TÊTE
- WOUND / BLESSURE
- NECK/BACK INJURY / BLESSURE AU COU/AU DOS
- BURN / BRÛLURE
- AMPUTATION / AMPUTATION
- STRESS / TENSION
- OTHER *(Specify)* / AUTRE *(Spécifier)*

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE

- ALERT / ALERTE
- VERBAL RESPONSE / RÉPONSE VERBALE
- PAIN RESPONSE / RÉPONSE À LA DOULEUR
- UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS | TIME / HEURE | 6. TOURNIQUET / GARROT: NO / NON | YES / OUI | TIME / HEURE

7. MORPHINE / MORPHINE: NO / NON | YES / OUI | DOSE / DOSE | TIME / HEURE | 8. IV / IV | TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

GSW TO (L) thigh & leg.

18G IV Cath - 500cc NS
#1 Bag

10. DISPOSITION / DISPOSITION

- RETURNED TO DUTY / RETOUR À L'UNITÉ
- [X] EVACUATED / EVACUÉ [redacted]
- DECEASED / DÉCÉDÉ

TIME / HEURE

11. PROVIDER / UNIT / OFFICER MÉDICALE / UNITÉ | DATE/DATE *(YYMMDD)*

DD Form 1380, DEC 91 — *This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.*

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

MEDCOM - 16470

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.)	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A / / D 1	I Z	[redacted] b(6)-4	CI	M

3. REGISTER NUMBER	6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
[redacted]	[redacted]	02	2	2	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
	2	ICW #2	~~[redacted]~~

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 8	[redacted]

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0 b(2)-2	ICW #2	UNK
[redacted] b-22		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. [redacted]	[redacted] TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
5 0		0 3 0 8 1 7

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A E A A		0 3 0 8 1 4

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

FOR LOCAL USE

DX: GSW to (L) calf / thigh

Inj Trauma
450 1

Proc 83.45
88.29

Dx 890.0
891.0
E991.2

890.0
891.0
E991.2

b(6)-2

ADMITTING OFFICER (Signature, as required)

DR [redacted]

SIG [redacted] TTING CLERK

DA FORM 2985, MAR 89 MEDCOM - 16471 USAPPCV1.0

INPATIENT TREATMENT RECORD COVER SHEET

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

1 REGISTER NUMBER [redacted]	2 NAME (Last, First, MI) Unknow Iraqi name	3 GRADE EPW			ADMISSION REMARKS
4 SEX M	5 AGE 56	6 RACE X	7 RELIGION Z	8 LENGTH OF SVC —	9 ETS —	10 PREVIOUS ADMISSION	
11 PMS 99	12 SSN [redacted]		13 ORGANIZATION b(6)-4			14 WARD ICU1	
15 PATIENT STATUS 2	16 RATING DOS	17 DEPT EER K78	18 BRANCH OF SVC	19 UIC/ZIP		20 TYPE CASE WIA	wounded in action
21 SOURCE OF ADMISSION; AUTHORITY FOR ADMISSION 0. Direct from ER.				22 HOUR OF ADMISSION Dr. orders 08:46	23 CLINIC SERVICE [redacted]		
24 NAME, RELATIONSHIP OF EMERGENCY ADDRESSEE			25 TYPE DISPOSITION 05	26 DATE OF DISPOSITION 03,11,30			
27 ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27a TELEPHONE NO	28 DATE OF THIS ADMISSION 03,11,16		ADMITTING OFFICER	
29 NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b(2)-2				30 DATE OF INITIAL ADMISSION		32 UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED	
31 SELECTED [redacted]							

☐ Check if Continued on Reverse

33 CAUSE OF INJURY

34 DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

DX. S/P GTS E tracheostomy.

Dr. O

GSW to Abdomen
S/P Ex Lap
Nursing Cardiorespiratory
Tracheostomy.
STSG

879.3
E991.2
707.0

43.6
45.61
45.74
45.76
43.7
46.20
45.14
45.79
46.99
43.39

35. Total Days This Facility

35a ABSENT SICK DAYS	35b OTHER DAYS	35c CONV LIV/DOD CARE DAYS	35d SUPPLEMENTAL CARE DAYS	35e BED DAYS	35f TOTAL SICK DAYS
10	0	0	0	14	14

36. Total Days All Facilities b(6)-2

36a ABSENT SICK DAYS [redacted]	36b OTHER DAYS	36c CONV LIV/DOD CARE DAYS	36d SUPPLEMENTAL CARE DAYS [redacted]	36e BED DAYS	36f TOTAL SICK DAYS
		0			14

37 SIGNATURE OF [redacted] Dr. O

38 SIGNATURE [redacted]

DA FORM 3647, MAY 76 EDITION [redacted] USAPPC

MEDCOM - 16472

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

86y Iraqi EPW presented with GSW
abd. [illegible] pain. Seen bloody on
bed.
PMH ∅
PSH ∅
NKDA

PHYSICAL EXAMINATION

Lying [illegible]. [illegible]
[illegible]
Abd soft, ND, [illegible]
[illegible]
[illegible]

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

Dx GSW to Abd
[illegible]

[redacted] b(6)-2

[redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION

[redacted] *l or written entries give Name last, first, [redacted]dle; grade; date; hospital or medical facility)*

REGISTER NO.	WARD NO.

[redacted]
b(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREAT'	ANIZATION (Sign each entry)

16 Aug 03. b(a)-2 A 11

1845. ~~500cc~~ 500cc hespan started for ↑ UOP and CVP @ ~10mmHg.

1900. ↑ UOP recorded. MD aware. BP ↑ to 110's-120's, HR ↓ to 120's. Will cont to monitor [redacted]

1930. CVP transduced @ ~ 11-12 mmHg. 500cc ~~5%~~ 5% albumin started. BP remains @ 110's-120's HR 120's. ~220cc urine noted @ this time [redacted]

2000. CVP transduced @ 14-15 mmHg. 60cc UOP noted ~~H~~ ABG obtained 7.288/44/37/21/-5/100% RT @ BS. FiO2 ↓ to 60%. SpO2 holding @ 100%. Will monitor [redacted]

2030. Updated MD on pts. cond. CBC drawn and sent to lab.

2100. Dr [redacted] updated on pt condition. HH 9/28. CVP 11 mmHg. UO 90cc. Orders recd. [redacted]

2130. 500cc 5% Albumin started. Awaiting T+C to be completed for pending transfusion [redacted]

2145 Returned phone call to RT [redacted] explaining RT had surgery & will go back in 24-48° for further surg, on vent cond guarded. She explained RT is [redacted] (b)(6)-4 [redacted] LTC, a

2200. Albumin bolus complete. HR ↓ to 110's-120's, BP 110's/60's. Transfusion of PRBCs pending [redacted]

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

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

[redacted]

b(a)-4

b(6) & All

18 Aug 03.	
2225.	Blood transfusion started using 16G IV to (L) AC. 98.3/122/118/69/100%/16. Will monitor
2230.	Pt suctioned x 2. Moderate amount tan secretions obtained. 128/114/62/16/100%/98.° [redacted]
2235	HR-125, BP 115/63, 16, SpO2 100% 98.2 [redacted]
2250.	HR 122, BP 117/66, RR 16, SpO2 100%. T 98.5
2320.	HR 120, BP 113/66, RR 16, SpO2 100% [redacted]
2350.	HR 117, BP 111/63, RR 16, SpO2 100% [redacted]
17 Aug 03.	
0030.	~~Dr~~ MD @ BS. Updated on pts condition. 1st Blood transfusion complete. Vitals stable. 98.8, 119, 114/68. Will start 2nd unit [redacted]
0055	2nd transfusion started. 98.6, 119, 114/68. [redacted]
0100.	HR 119, BP 110/68, RR 16, SpO2 100, 98.6
0105	HR 118, 110/66, 98.6 [redacted]
0115.	HR 119, BP 109/65, T
0140.	HR 117, BP 107/64 T 98.2 [redacted]
0250.	HR 115, BP 109/62, 98.° No S/S of transfusion reaction
0315.	Pt suctioned X3. Moderate amount tan colored secretions noted. SpO2 remains 100%. Updated MD on pts condition [redacted]
0430.	ABG, CBC, Chem drawn via A-line and sent to lab. 7.33/36/13/19/-6/99% [redacted]
17 Aug 03 0610	Received report from previous shift. Pt sedated & appears comfortable. HR 110, RR 10-16. BP low (90s/50s). Will notify Dr. [redacted] UO > 30cc/°. All PIV intact c 0% of infectio Vent in place SIMV 16, 800, 5, 50%. peak 37. Drsgs Dtl. [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2

b(6)- 2 All

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
16 Aug 03 1000	Received pt from OR via stretcher. Pt vented: SIMV A/C, TV 750, RR 12, FiO2 50%, peep 5. ETT 8.0 @ 24 @ Lip secure. All PIV and A-line secure. Drsg midabd, (R)+(L) flank secure. foley draining @ urine. Pt body temp cold. Unable to get temperature. O2 sats 100%. Placed extra blankets and heating lamp on pt. Will cont. care. [redacted] LT
1035	Drew labs per order. Will report results to Dr. [redacted] [redacted] LT/RT
1104	Pt BP ↓ (80s/50s). Notified Dr [redacted] Gave 1L bolus LR @ 1125. Drew ABG @ 1137. Vent ΔS made per Dr. [redacted] V.O. Will redraw ABG. [redacted]
Late entry 1035	Started transfusion FFP. Pt temp still low. Applied MRE heaters and warm NS bottles per Dr. [redacted] Will cont. care. [redacted]
1225	Gave 1 unit PRBC per order. Pt BP ↑ 120s/100s. Dr. [redacted] notified. ↑ MSO4 gtt to 5mg/°. Pt temp 91.6. Got heat blanket from EMT. (R) flank drsg saturated. Reinforced c abd pads.
Late entry 1216	Drew ABG. Notified Dr. [redacted] of results. Will redraw @ 30 min. [redacted]

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

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

b(6)-4

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

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
16 Aug 03 1300	Started 2nd unit PRBC. Pt BP 120s/100s. Notified Dr. [redacted] Gave 4mg IVP. Will recheck BP ≈ 15min. Rechecked BP. No Δ in BP. Pushed 4mg MSO4 @ 1320. Drew ABG @ 1313. Dr. [redacted] viewed ABG. 0 vent Δs made. Will cont to monitor pt condition. [redacted]
1350	↑ MSO4 to 7mg I°. BP 160s/100s. Notified Dr. [redacted] Fentanyl 100mcg IVP x 1 new. Ordered. Gave fentanyl @ 1405. Will cont to monitor. [redacted]
1425	BP remains 160s/100s. Will cont to monitor. [redacted]
1430	Pt moving head around. ↑ versed to 5mg I°. Will cont. care. [redacted]
1504	Pt BP 180s/100. Gave versed 3mg IVP. Will cont to monitor BP. [redacted]
1520	Pt temp ↑ 94°. Pt BP ↓ 120s/80s. ↑ versed 7mg I° due to pt moving head. [redacted]
1800.	Report received from LT [redacted]. Pt in process of receiving 1L LR bolus. BP ↑ to 100's/50's, HR ↑ 130's. UOP decreased. ABG obtained 7.25/42/52/19/-8/81%. Pt manually ventilated @ 100% O2. Sp02 ↑ to 100%. Vent changes TV ↑ to 800 and FiO2 ↑ to 100%. Sp02 maintaining @ 100%. ETT pulled 2cm back.
late entry 1700	Drew ABG and labs per order. Will show results to Dr. [redacted] Pt BP ↓ 100s/80s and HR ↑ 120s-130s. Gave albumin 500cc bolus, fentanyl 100mcg IVP and vecuronium 10mg IVP per order. At 1745 (L) SC cvc/tls was placed. CXR completed to show proper placement. Pt started on fentanyl and vecuronium gtt. At 1705 Dr. [redacted]
1705 *1745	started 1000cc LR bolus. Will cont care. Gave report to next shift. [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

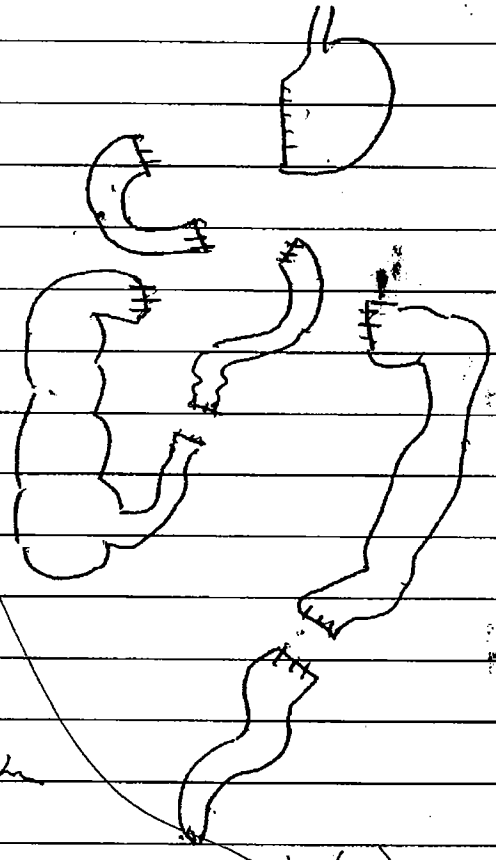
USAPA V2

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)*
	OP NOTE
8/16/03	Indication GSW to Abdomen
	Procedure - see diagram
	① Distal Gastrectomy
	② SB Resection x 2
	③ Transverse colectomy
	④ Sigmoid colectomy.
	Anesth - GETA
	Surgeons - [redacted] / [redacted]
	Findings: obliterated distal stomach, transection @ Lig of Treitz Multiple enterotomies at mid small bowel
	Transverse colon transection and Colotomy in Sigmoid Colon.
	Resection obtained and contaminated controlled operation ended due ↑ PT, PTT, Temp ~ 31°C, and Acidemia
	Plan reexploration ~ 24-48hrs



b(6) - 2

[redacted]

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

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

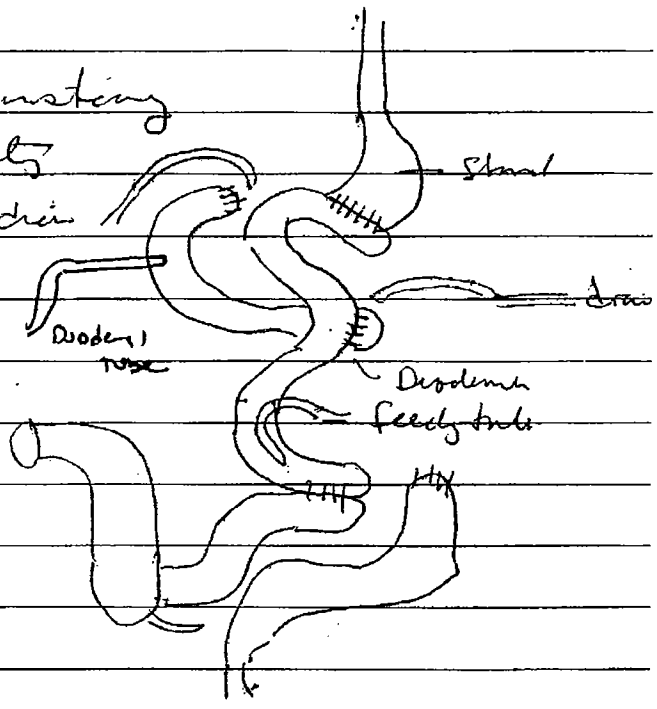
CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03	Brief Op Note

(1) "Roux en Y" gastrojejunostomy with duodenojejunostomy
(2) ileorrhaphy
(3) Right colon colostomy
(4) Hartman's pouch
(5) placement of duodenal drainage tube
(6) Placement of feeding jejunostomy



D: [redacted] | B: [redacted] b(6)-2
Fluid
EBL 200 cc
GETA
Drains JP x2 | duodenal drainage tube | foley | Colostomy | central line, A line, pulmonary line | NG tube, endotracheal tube b(6)-2
Ceftriaxone [redacted]

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

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

[redacted]
b(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | b(6)-2 | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
17 Aug 03 0700	Dr. [redacted] viewed labs + ABG. Ø vent Δ's made. CaCl I amp @ 5%. Albumin ordered for low BP. Will cont. monitor BP. H+H (11, 33). Ca^{++} 6.5. ABG. 7.338, 36.2, 135, 19, -6, 99%. Will cont. care. —— [redacted]
0800	Pt BP ↑ 110s/60s. UO ↑ ≈ 20cc. CVP ↑ from 10 to 13. Will cont to monitor. —— [redacted]
0900	Shaved pt. Cleaned pt face + body. Δ'd NGT and ETT tie. ETT remains 20cm @ lip. Completed foley care and did passive ROM. Δ'd drsg on (R) shoulder. Applied sulfamylon cream to burn ℗ washing wound ō NS. Pt temp remained in 99°. Temp ↓ 97.7 ℗ bed bath completed. Suctioned pt x ii. Thick white secretions noted. Peak remains 35. Will cont. care. —— [redacted]
1100	Pt BP ↑ 120-130s/60s. Ted fentanyl to 90mcg/h. Will cont to monitor pain level and BP. Pt O2 sats remain 99-100%. Throughout morning part of shift. —— [redacted]
1300	Drew CBC per order. Plt 64. Showed Dr. b(6)-2 [redacted] Prep pt for OR. Sent 2 SF518's to lab. Will cont. care. —— [redacted]

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

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
17 Aug 03 1340	Drew ABG per Dr. [redacted] ABG 7.339, 48, 94, 22, -4, 97%. Drew Coag. per Dr. [redacted] Will report results. [redacted]
1424	Coag. results given to Dr. [redacted] Ordered 2 units FFP. Pt VSS for pt. HR low 100s, BP 120s/60s, RR 16, O2 sats 99-100%. Will cont. care. [redacted]
1600	FFP not ready according to lab. Attempted to notify Dr. [redacted] Unsuccessful. Will try again. [redacted]
1650	Able to infuse 1 unit FFP. Pt BP ↑ 130s/70s. ↑ fentanyl to 100mcg/hr. Pt have PVCs. Will cont to monitor. [redacted]
18 Aug 03 2230	Pt returned from OR via litter, intubated. VSS. Pt stable. Wounds dry to abd. Pt connected to vent. SIMV 16, 800, 50%, 5, SpO2 100%. Pt placed on versed @ 3mg/hr and fentanyl @ 100mcg/hr. HOB flat. Will cont to monitor [redacted]
2246	ABG via A line - 7.34/38.7/89/21/-5/96% No changes at this time [redacted]
0115	Pt resting quietly. No mvmts noted @ this time. Fentanyl ↓ to 80mcg/hr. Will monitor [redacted]
0600	Report given to LT [redacted]
0600	Received report from previous shift. Pt moving L arm and head slightly in bed. HR low 100s and BP 100s/70s. All PIV lines intact. Pt vented SIMV 16, 800, 5, 55%, peak 37. Suctioned pt x ii. Thick white secretions noted in scant amts. O2 sats remained 98-99%. (R) duodenal drain to gravity. 2 abd JP drains in place and J-tube clamped NGT @ NS. Will cont. care. [redacted]

STANDARD FORM 600 (REV 6-97) BACK

USAPA V2

b(6)-2 A11

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 Aug 03 0640	Dr. [redacted] viewed labs. Ø new orders given. Flushed duodenal tube. 155cc of brown drainage noted. Pt BP ↑ 130s/60s. Ted fentanyl to 80mcg/°. Pt resting comfortably @ this time. BP 100s/60s. Will cont. care. [redacted]
0800	Pt resting. O2 sats 97%. UO 36cc. Will cont to monitor UO. [redacted]
1000	Pt UO 26 @ 0900. Informed Dr. [redacted]. 5% Albumin in 500cc ordered. Transduced CVP 10. Will recheck p albumin infusion. UO ↑ 60cc during half of infusion. Will cont. care. [redacted]
1040	Noted sputum in ETT. Deep suctioned pt x ii. Thin white secretions noted. Upon 2nd deep suction, pt spewed bloody sputum from mouth. Suctioned mouth x iii. Pt became more awake (moving BLE + BUE). Gave 4mg versed bolus. BP ↑ 190s/60s. ↑ fentanyl to 90 mcg/°. @ 1100 pt appears calm. BP ↓ 120s/60s. HR ↓ 113. O2 Sats 97-99%. Will cont. care. [redacted]
1200	Completed bed bath + foley care. Pt restless. Gave 2mg IVP versed. Pt appears calm. O2 sats 93%. p turning pt. Suctioned pt x iii. Thin white secretions noted. O2 sats remained 100% while ambu. Currently 97%. [redacted]

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

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18AUG03	Surgery POD 1/2
IUF	Very stable overnight
Versed	HR 100-110 Afeb BP 110-145/60's
Fentanyl	SAT 97% 5L%
Unasyn	UO 26-120 q1h IP1 ~20cc/h
ZANTAC	IP2 ~20cc/h
	Duodenal Tube - ~100/d20
	Chest CRTA
	CV RRR 2+SP
	Abd ND soft BS
	wounds c/d
	BMP 141 / 107 / 26 ; 4.0 / 24 / 1.3 ; 6.0 / 33 / 62 ; 89
	ABG 7.37/40/~~82~~/-2
	Alb 2.2
	Alk Phos 27
	ALT 62
	TB 2.8
	Amy 176
	A/P Doing well w/ fluid requirement, resolving tachycardia, Avoid BS prior to TF.
	b(6)-2 [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2

b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 Aug 03 1300	Wet to dry dsg midline abd incision: Scant amt sanguinous fluid. Replaced dsg around JP tubes, duodenal tube + J-tube due to saturation c 4x4s. Pt moving BUE. Restrains pt BUE c Kerlex. Gave pt 3mg versed IVP. ↑ fentanyl to 100mcg/1° due to ↑ BP 140s/60s. Will cont. care. — [redacted] OTR
1500	Pt BP 130-140s/60s. + Pt moving BUE. ↑ed versed to 7mg/1° and gave 3mg IVP bolus. ~~Pt~~ Gave 50mcg fentanyl. Will cont. to monitor. — [redacted] CT/RN
1600	Flushed J-tube c 10cc NS. Flushed duodenal tube c 10cc NS. Will cont. care. — [redacted] RN
1720	Ø N's made c pt. HR ↓ 90s, BP 140s/60s. Pt appears comfortable. Will cont. care. — [redacted] CT/RN
1810	Gave report to night shift. — [redacted] CT/RN
1830	Recieved report from ICT [redacted] — [redacted] SWM6
2000	pt VSS. FiO_2 ↓ to 50%. Will do ABG in 30 mins [redacted]
2045	Results of ABG recieved. PO_2 63 mmhg. RT suggests repeat ABG in 1 hour. Will repeat in 1hr — [redacted] SWM6
2145	Repeat ABG PO_2 64. FiO_2 ↑ to 55% [redacted] SWM6
2340	FiO_2 ↓ to 50% — [redacted]
19Aug03 0030	ABG 7.43, 35, 85, 24, Ø, 97%. ↓ RR from 20 → 18 [redacted]

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

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

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.
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 entry)*
19 Aug 03 1530	PT BP 165/74, Fentanyl gtt ↑ to 150 mcg/hr, Versed gtt ↑ to 8 mg/hr [redacted]
0320	pt VSS, afebrile. Deep suction done [redacted]
0620	Report given to ILT [redacted]
19 Aug 03 0600	Received report from previous shift. PT vented SIMV 18, 700, 5, 50%, peak 39. All PIVs, JP tubes, J-tube colostomy, duodenal tube intact. HR 90's. BP 140s/60s. Viewed labs. Will report abnormal results to Dr. [redacted] All drsgs D+I ✗ a little drainage from duodenal tube. Will cont. care. [redacted]
0650	Dr. [redacted] viewed labs. KCl run ordered + MIVF ↓ed 75cc/° due to large hourly UO. Will cont care. [redacted]
0800	UO 430cc/°. O2 sats 99%. Will cont. care. [redacted]
1000	Noted white secretions in pt ETT and in mouth. Suctioned pt x 1 ↑. Large amt thin white secretions noted. O2 sats ↑ from 96% to 98%. Drained JP tubes. JP1 + JP2 both have serous fluid. Temp 99.9. Will cont to monitor temp. Pt BP 190s/80s. ↑ fentanyl to 175 mcg/°. Will cont to assess pain level. [redacted]
1100	Completed dsg Δ. Midabd incision noted greenish sanguineus drainage. Wet to dry dsg midabd incision + Ⓡ abcess under colostomy. Applied silvadene to Ⓡ shoulder/chest burn prn mang c NS. Completed bed bath + foley care. Flushed duodenal tube + J-tube c 10cc NS. Covered Ⓛ puncture wound c 4x4. Noted sanguineous drainage. Pt O2 sats 99% throughout dsg Δ. BP 180s/60s. BP ↓ 160s/60s. Gave 50 mcg fentanyl bolus. [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2

b(6)-2 All

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
19 AUG 03 1300	Pt stable @ this time. Temp 100.4 BP ↑ 160/40 but has ↓ 140S/70s in last half hour Duodenal drain flowing continuously. O2 sats 100%. Will cont. care. [redacted]
1500	Pt resting c ∅ problems/difficulty. O2 sats 100%. BP 140S/70s, RR 18. Will cont. care [redacted]
1700	Pt resting c any difficulty. Sating 100% vented. Temp 100.4. Will cont. care. [redacted]
1800	Received report from off going shift. Pt. [redacted] condition remain stable. Temp 100.6. All lines intact o redness/swelling noted to areas. JP drain [redacted] to BS. F/C to BS. Will continue to monitor. [redacted]
2000	Pt. resting in bed c discomfort noted. SpO2 98%. Temp 100.8. Deep suctioning performed, got back moderate amount [redacted] white secretions. Will continue to monitor [redacted]
2032	Pressure 96/54. Used ↓ 4mg And Int ↓ 10mg. Will [redacted] MD. [redacted]
2315	Resting in bed c discomfort noted. Vitals ↑ [redacted] ↑ RR Will continue to monitor. [redacted]
2355	Filter exchanged via RT. [redacted]
20 AUG 03 0053	o distress noted. Temp 100.1. Will continue to monitor. [redacted]

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

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

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 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
20 Aug 03 0845	Pt restless and waking up. Gave versed 3mg IVP. Will cont. care. [redacted] LCT/RA
1010-1210	Completed bed bath, passive ROM and foley care. Completed drsg Δ wet to dry mid line abd and (R) flank wound. Noted green drainage from both wounds. Will notify MD. Δ'd burn drsg (R) shoulder/chest. Used silvadene. Pt tol. drsg Δ well. Pt woke and moved around. Gave 4mg versed total throughout. Shaved pt face and Δ'd ETT tie. Applied bacitracin. Will cont care [redacted] TCD
1120	Started 2nd unit PRBC Unit # 2776416.

	1125	1130	1135	1140	1155	1210	1225	1240	1310	1340	1440	1535
Temp	100.4	100.4	100.4	100.6	100.7	100.7	100.7	100.6	100.5	100.6	100.5	100.3
HR	88	87	89	124	91	85	86	88	85	84	85	81
BP	170/70	175/73	170/74	153/82	190/76	173/71	149/66	147/65	169/72	174/68	171/73	139/68

	Infusion complete & transfusion of [redacted]
1255	Pt becoming agitated. Gave 2mg versed. Suctioned pt x 1. Thin white secretions noted. [redacted]
1500	Pt resting comfortably. Ø agitation noted. Blood infusing. Will cont care. [redacted]
1545	Drew post K + CBC lab. Results Hct/Hgb (10.2/33.2), K+ 3.7. Will report results to MD. [redacted]
1815	Received Report. [redacted] LT/AN
0600	Patient sedated. SIMV 18 TV 800 FiO2 50 Peep 5. Drains in place. PIVs flushed. Drsg mid abd CDI. Monitor resp, UOP, drains, sedation, ABP/NIBP. [redacted] LT

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2 00

MEDCOM - 16487

b(6) - 2 A11

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 AUG 03	Received report from previous shift. Sputum noted in ETT. Deep suctioned pt x iii. Noted yellow tinged sputum. While suctioning noticed pink frothy sputum from mouth. Notified Dr. [redacted], obtained CXR. (R) lung pneumonia and (R) upper lobe aspirate noted. New orders written. Will cont. care. — [redacted] USA
0650	Dr. [redacted] viewed CXR. ETT advanced 2.0cm. Now 22cm @ teeth. Started KCl 40meq run due to K 2.5 Started new abx zosyn. Will start cipro. Will get repeat CXR for ETT advancement. Will cont. care. [redacted] 1915
0805	Started 1st unit PRBC due to H/H (8.1, 25.5). Dr. [redacted] viewed CXR. Advanced ETT 1.0cm. Now 24cm @ lip. Pt also had bowel movement into (R) colostomy. Brown liquid stool noted. Also green bile drainage noted around duodenal tube. Will complete drsg [redacted] 0712
0800	Unit #0913303 @ 1107. — [redacted]

	0300	0810	0815	0820	0835	0850	0903	0910	0918	1020	1120	1200
Temp	101.5	101.5	101.5	101.5	101.4	101.4	101.3	101.2	101.1	100.8	100.6	
HR	101	104	101	104	93	92	92	91	97	86	83	
BP	154/64	149/70	156/64	137/62	136/59	139/60	142/59	147/61	170/68	155/64	157/68	

Infusion completed @ 0 difficulty. — [redacted] USAF

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

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

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

b(6)-2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
Aug 20, 2003	Dr [redacted] notified of Pt. temp. 101.4 [illegible]
0206	Tylenol 650mg thru NG tube. [redacted]
0222	Tylenol 650mg given for ↑ temp of 101.4 [redacted]
	monitor. [redacted]
0326	Temp 101.8. Will continue to monitor. [redacted]
0513	Pt. resting in bed ̅s discomfort noted. Temp ↑ 101.7.
	SpO2 97%. ∅ distress noted. Will continue to [redacted]
	monitor. [redacted]
	Surgery Progress Note
meds	POD # 3 s/p Reconstruct of
Zosyn #1	intestinal tract following GSW vent SIMV 18 / TV 810
Cipro #1	to mid abdomen. 50% PEEP 5
Versed	CV: HR 104 143/63 NSR by monitor 5.4 / 25 8.1 < 80
Fentanyl	Pul (+) (L) pneumo d/w aspirate on CXR RR 18
Zantac	vent as listed SaO2 98%
LR @ 75cc/h	ABG 7.502 / 32.4 / 72 / 25 / 2 / 96%
	Renal UOP x 24° 2127 cc / now ≈ 50-60 cc/h.
Foley	Creat 1.2 143 / 109 / 20 < 83 ; (2.5) / 8 / 1.2
duodenal JP x 2	
~~J tube~~	NUT: ∅ Alb 1.7
A line	
	ID: (+) pneumo Tmax 101.7
	wound: green discharge f (R) GSW wound Drain 85 OP1, 110 OP2
	Bile drain 600
	Imp: ① ↓ Hct 25 Plan: Transfer 2nd ABA
	② (L) pneumonia KCl replete
	③ K+ ↓ 2.5 Δ to Zosyn / Cipro
	④ ↓ Alb
	Extubate per [redacted]

[redacted]

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

MEDCOM - 16489

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	23 AUG 03 KLL #1 DIET ROSTER
BED 1	588 - TUBE FEEDING JEVITY
BED 2	421 - REGULAR
BED 3	624 - REGULAR
BED 4	626 - REGULAR
BED 5	596 - REGULAR

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

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

REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 16490

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
21 AUG 03 1150	B'd drsg (L) SC cordis using aseptic technique. (-) S/S of infection noted. Noted red fluid through NG-T. Serous fluids in both JP tubes. Flushed duodenal tube + J-tube c 10cc NS each. Irrigated (R) colostomy bag c NS. Brown liquid stool noted. Will cont. care. [redacted]
1330	Vent alarming high pressure. White colored sputum noted in ETT. Suctioned pt x it. Pt also biting ETT and attempting to open eyes. Gave 3mg versed IVP. Also fed rate versed to 11mg/°. Will cont care. [redacted]
1445	Pt breathing over the vent + moving eyelids. Gave 3mg versed IVP. Will cont. care. [redacted]
1600	Pt resting c (-) S/S of wakefulness, ↑ BP, ↓ O2 sats. O2 sats 100%. Will cont. care. [redacted]
1800	Drew Kt lab. Gave report to night shift. [redacted]
1800.	Received report from LT [redacted]. Pt in bed. [redacted]
1945	Lab results back. Kt 2.5. Notified Dr [redacted]. Order received. Pt given 40meq KCl IVP over 2 hrs. [redacted]
2000	Pt suctioned x3. Copious amounts thin white secretions obtained. Sp02 remains 100%. Will cont. to monitor [redacted]
2115	Dr [redacted] @ BS. Updated on pt condition and KCl results. Orders received. [redacted]
2250	Drsg d'd to midline abd incision, R flank wound, (L) flank wound, tube sites and (R) chest burn area. Silvadene applied to burn. (R) flank and midline incision c green/yellow drng noted, wounds pink in appearance. Wounds packed c ½ Dakins soaked gauze. Bacitracin applied around tube sites and covered c gauze. No drng noted, but some redness noted. [redacted]

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

21 JUL 03
0000 Received report from previous shift. Pt resting comfortably. NGT to LIS. Zosyn piggyback infusing. All IV lines intact. ETT #8.0 @ 24cm @ lip. Vent: SIMV 18, 790, 5, 50%, peak 32, O2 sats 100%. Will cont. care. [redacted] 10/SW

0630 D/C'd PIV (R) Hand due to infiltration. Δ'd IV tubing H.L and drsg Δ c opsite to (R)+(L) FA PIVs. Pt UO > 30cc/° Viewed labs: K+ 2.5, H+H (10.8, 34), ABG 7.488, 34.2, 99, 26, 3, 98%. Will report results to Dr. [redacted] 10/SW

0800 KCl run 40 mEq started. Pt O2 sats 100%. Will cont. care [redacted] 10/SW

0930 Pt overbreathing vent. Gave 3mg versed IVP. Lovenox prophylaxis ordered. Informed Dr. [redacted] of green fluid in incisions. Dakin's solution 1/4 strength ordered. Will cont. care [redacted] 10/SW

1000 Began drsg Δ Pt resp & BP ↑. Gave 3mg versed and 50 mcg fentanyl. Pt well rested throughout drsg Δ. Noted greenish spots in both midline abd + (R) flank wound. Wet to dry using dakin's soln 1/4 strength. Δ burn drsg (R) shoulder/chest. Applied silvadene to washings NS. Applied emycin ointment to bilat. eyes. Completed bed bath + foley care. KCl run still infusing. Will cont care. [redacted] 10/SW

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

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

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

MEDCOM - 16492

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 Aug 2003	Pertinent Medicine
0520	50a WM POD #5 from GSW to Abdomen → colostomy / ileostomy
L Rad 150cc/hr	and burn to (2) chest. Stable overnight
Vent	12 T/hr Temp - 101° (Max) yesterday 73 100% RR-18
Neuro	Oriented: asleep, sedated
Resp	Lungs: scattered rhonchi
Cardio	CV: RRR
Abdo	Abdomen: +BS incisions clean today
Extr	Ext: edema
Labs	144/110/18 / 2.5 / 94 Alb - 1.7 7.48/34/98 123 / 31 / 11 (142)
CXR	Progressive consolidation LUL → atelectasis vs pneumonia of lower (1) lobe (2) upper lobe → chronic changes
A/P	(1) Neuro → sedated but breathing with ventilation. Comfortable but unstable. Tolerating with ↓ vent
	(2) Pulm → ? aspiration pneumonia versus early ARDS NO ↑ O2 requirements or high peak airway pressures. NO ↓ vent Continue Zosyn / Cipro. Afebrile past 24 WBC - 12K
	(3) Cardio → hemodynamically stable with good urine output
	(4) Renal → potassium replacement this am
	(5) Heme → H/H stable

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

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	(6) GI → remains NPO, several more days until
	bowel function returns
	(7) GI → prophylaxis
	(8) Needs DVT prophylaxis until plts over 144
	b(6)-2
	[redacted]

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

MEDCOM - 16494

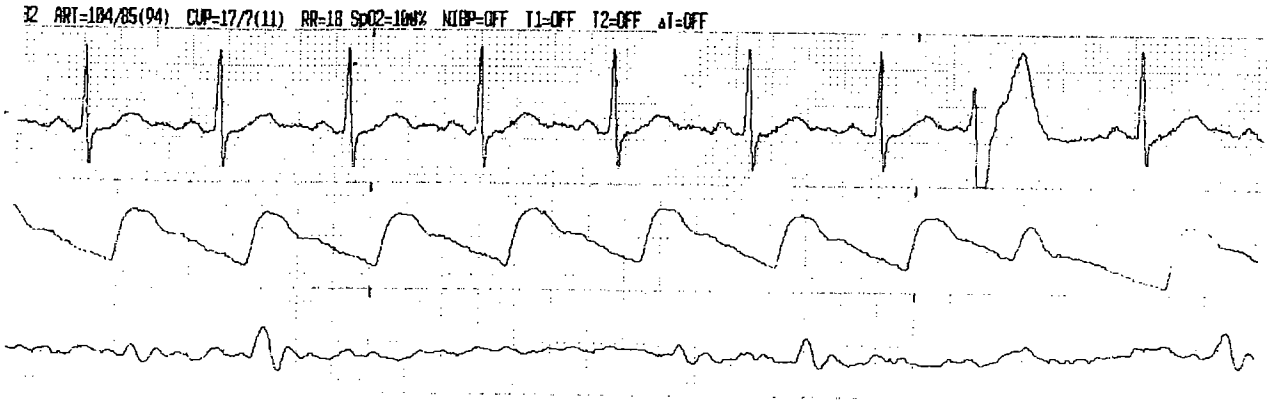
ACLU-RDI 1637 p.54

DOD-029883

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 Aug 03	
2250	Pt suctioned x3 by RT. Spo2 remains 100%. Large amount thin White secretions obtained — [redacted] b(6)-2



22 Aug 03	
0400.	Labs + ABG drawn via A-line and sent to lab 7.48/32.9/118/26/25/99%. RT notified of ABG results. Rate ↓ to 116 BPM. K+ ↑ 3.3. KCl IVPB continues to infuse as ordered — [redacted]
0515.	J-tube and duodenal tube flushed c 10cc H_2O as ordered [redacted]
0600.	Report given to Lt [redacted] — b(6)-2 — [redacted]
22 Aug 03 0700	Received report from Lt [redacted] Pt Vented SIMV16, 790, 5, 50%, peak 30. All IV lines + drsgs intact. Versed + fentanyl, + KCl 80 MEq running infusing. Will cont care. [redacted]

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

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

b(6)-4

[redacted]

REGISTER NO.	WARD NO.
	ICU3

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 - 16495

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8-23/0800cont	draining scant serous drainage Go fdbk to gravity amber QS (neg (L) sc cardis → patent [redacted] ILT RN
8-23/1600	(D) sc cardis pulled (D) SC cardis started by Dr. [redacted] pt tolerated procedure well. XRAY confirmed placement per Dr. [redacted] ILT RN

b(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
22 Aug 03 2230	Rt note: Pt arrived to unit one hour ago via litter + heli. Vent settings SIMV 16, 800, +5, 50% c̄ PIP @ 45. Sx pt out c̄ thick yellow secretions PIP @ 32. ABG done @ 1009 7.46/35/131/25/1/99%. ↓ FiO2 40%. Vent setting at this time 1033 is SIMV 16 800 +5 40%, PIP 31, ETT 8.0 22 @ teeth. Will continue to monitor — b(6)-2 Sgt [redacted] 91V20
8-22/0930	Pt arrived via litter @ approx 0930. Pt in no apparent distress @ time of admission. Pt on 11mg/hr [illegible], 200mcg/hr [illegible] @ 75cc D5½NS c̄ 20 KCl. Pt on vent SIMV 50%, 16, 5, Vt 800, SpO2 100%. Pt's NG placed to LCS per [redacted] b(6)-2 @ bedside. Changed colostomy bag @ midline abdominal incision. Abdominal incision c̄ small purulent areas, area cleansed c̄ dakins ½ strength, incision packed c̄ 4x4s, dressed c̄ 2 ABDs. Jejunostomy & duodenum site, insertion sites c/d/i, no signs of infection, Ø redness, swelling or drainage. Pt tolerated dressing changes well. US removed staple [illegible]. ABG sent per Dr. [redacted] b(6)-2. No other actions req'd @ this time [redacted] b(6)-2

EGA# [redacted] b(6)-4

08/22/03 10:50:5_ HR=88 P1 =88/81(84) P2 =OFF RR=16 SpO2=100% NIBP=OFF T1=OFF T2=OFF ΔT=OFF 08/22
III MON 0.5mV/cm
PACER DISPLAY ON
140
70 P1
0
2x Ld2

i-STAT EG7+
Pt:
Pt Name: [redacted] b(6)-4
Na 147 mmol/L
K 3.4 mmol/L
iCa 1.13 mmol/L
TCO2 26 mmol/L
Hct 28 %PCV
Hb* 10 g/dL
*via Hct
At 37C
pH 7.463
PCO2 35.1 mmHg
PO2 131 mmHg
HCO3 25 mmol/L
BEecf 1 mmol/L
sO2* 99 %
*calculated
Sample Type:
22AUG03 10:09
Oper: [redacted]
Physician:
Ser# [redacted]
Ver: JAMS04&A CLEW A93

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

MEDCOM - 16497

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	22 AUG 03 1920: Assumed care for patient resting comfortably in bed: Assessment as follows: (N) sedated on versed @ 7/hr + fentanyl 150/hr; Pupils @ 2mm sluggish; Responds to painful stimuli; (R) (b) coarse breath sounds; (L) > (R) upper < lower lobe; (-) s/s dyspnea; SaO2 99% on #8 ETT 22 @ lip w/ vent setting of SIMV 16, 35%; TV 800; PEEP 5; (CV) NSR (currently 81); S1, S2; pulses +3/4 to UE, +1/4; +2-3 edema to UE/LE; 99.6 (GI) NGT to (R) nare (LIWS) draining clear scant amount of drainage; JP x 2 to abd; jejunostomy tube clamped @ 20; [illegible] d/s to (R) [illegible] small amount of dark drainage; midline abd inc c/d/i; colostomy to (R) side abdomen (GU) Moderate dark urine [illegible] foley; (+) scrotal edema; (LINES) (L) SC cords; (L) radial art line; AV x 2; foley, ETT; (SKIN) (R) UE dsg is clean/d/i; (L) UE dsg c/d/i; (PAIN) [illegible]
	[redacted] , RN
	[redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

[redacted] b(6)-4

MEDCOM - 16498

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
8-23/0800	Assumed pt care at approx 0730 from CT [redacted]. Pt in NAD apparent distress @ change of shift, although slight ↑ WOB noted. Dr Young aware of ↑ WOB no action rqd. Per Dr [redacted] maintain vented alert & titrate fentanyl gtt. Pt currently @ 50 mcg/hr fentanyl gtt, DSH2 NS @ 20 kcl @ 75 cc/hr, jevity @ 20 cc/hr. Nasal to LIS, FTG, jejunostomy tube currently infusing jevity, duodenum drain to gravity, colostomy draining semi solid stool, JP x2 intact & to vacuum. No other issues noted. [redacted] b(6)-2
8-23/0800	N Perrl 3mm sluggish on 50 mcg fentanyl, responsive to painful stimuli, +ag reflex. CV ST SR, ↑ BP 200/60s (Dr. Young aware), +2 radial & pedal pulses bilat, +2 pitting edema bilat UE & LE, ↓ JVD. Periorbital & scleral edema noted. Resp even & slightly labored vent SIMV 16 vt 800 peep 5 fio2 35%, spo2 97-99%. Coarse BS bilat upper lobes, rhonchi lower lobes bilat. mod-lg thick white deep suctioning. Per Dr. [redacted] no change rqd @ this time. ETT #8 22 cm @ lip. GI: Soft, slightly distended, (+) BS, (+) flatus, to LIS, jejunum drain infusing jevity 20 cc/hr, colostomy (R) quad, stoma beefy red, putting out mostly liquid stool but becoming increasingly more solid. Duodenum drain remains intact draining yellow fluid, JPs x2 intact.

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.

EPW [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

[redacted]

MEDCOM - 16499

[redacted] b(6)-4 P.23

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE						NOTES						
	06	07	08	09	10	11	12	13	14	15	16	
HR	162*	106	103	101	111	109	103	104	101	114	111	
BP: ALINE												
BP CUFF	201/82*	216/87	192/85	179/81	197/90	134/73	134/68	121/76	129/68	142/75	139/68	
RR	28	34	24	26	16	16	24	26	26	16	16	
SATS	100	100	95	98	98	98	99	98	98	99	99	
MODE	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	
F_iO_2	35	35	35	35	50	50	50	50	50	50		
TEMP	98.7		100.4				99.4					
IVF	75	75	75	75	75	75	75	75	75	30	30	
PRBC IVF	50											
Pert	14	14	7	7	14	14	14	14	4	14	14	
versed	6.5	OFF	OFF	OFF	2	2	2	2	2	2	2	
Levit	20	20	20	30	40	50	125	175	140	140	140	
Foley	100	100	95	110	85	70	55	60	40	140	60	
duodenal	600		120				130					
NGT	100					50						
	*session minimal											
JP #1	5											
JP #2	25											

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

MEDCOM - 16500

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
23AUG03	Surgery
1130	No events overnight (+) stool in Bag with Air
Versed	VS - Tm 99.3 HR 90's-100
20mg Lopressor	SAT 99% 40%
ZANTAC	UO 80 c/hr Stool 500 Duodenal Tube - 180/shift
LR	IP 1 10 cc/shift IP 2 is 0 shift
Vecuronium	Abd - ND Soft wounds enhance with some
Fentanyl	Necrotic tissue no infx. mid line wound ok.
Cipro	chest CSW
	CXR - (+) Lung fluffy infiltrate
	24.6 / 32.2 / 315 — 128 / 108 / 11 — 4.2 / 21 / 1.1 — 123 — Alb 1.4 — Alk 46 — AST 36 — ~~Alk 25~~ — TB 6.0 — Amy 39
	A/P Over all doing well. ↑WBC concern
	? clear localization. would CT if Available.
	P- Cont Sed wean as tolerable
	Resp - cont Abx for pneumon NO wean yet.
	CV NO Pmn
	Renal - ok
	Heme - ok
	ID - use ? etiology Cx when ever. Use D body.
	GI - wk Duodenal content with feeds. [redacted]

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

b(6)-2

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 16501

038

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23AUG07	Procedure Note
	Central Line
	PLE 7 day old (C)SC Line
	(R) SC cordis placed on 3rd stick
	US Modified sterile seldinger technique
	Placement confirmed US & modified CXR.
	Complications: Arterial stick but no Dilations
	x2.
	CXR.

[redacted]

b(6)-2

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

MEDCOM - 16502

038

b(6)-2 A11

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
25 AUG 03 1105	Pt resting comfortably. O2 sats 98%. RR 16. BP 110/60s. Peak pressure 26. Will cont care. [redacted] LCT/SW
1130	Pt BP ↑ 130s/60s. Eyes moving in eyelids. Gave 16mg propofol IVP. Will cont to monitor. [redacted]
1255	Pt overbreathing vent. Noted very little sputum in ETT. Peak 41. Suctioned pt x ii. Large amt thin white sputum noted. Gave pt 30mg propofol IVP. Peak ↓ 30. Will cont to monitor. [redacted]
1312	Pt BP 130s/60s. Attempted to Δ pt position. BP remain same. Gave pt 30 mg propofol IVP. Will cont to monitor. [redacted] LCT
1415	Pt BP ↑ 150s/60s. Overbreathing vent RR 19-26. Gave 30mg propofol IVP & ↑ rate to 90 mcg/kg/min. Will cont care. [redacted]
1420	Pt BP ↑ 140s/60s. Peak 31. Suctioned pt x ii. Deep suctioned thin white secretions noted. O2 sats 98%. BP ↓ 130s/60s. Will cont care. [redacted]
1514	Noticed feces near midabd incision. Δ'd dsg. Noted drainage around duodenal drain, JP 1 + JP 2, + J-tube yellow fluid. Δ'd drsgs. Will cont care. [redacted]
1700	Pt BP 140s/60s. Peak 28. O2 sats 99%. Will cont. care. [redacted]
1755	Gave tylenol for temp 101.5 via NGT. Gave report to night shift. [redacted]

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

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

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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 16503

038

b(6)-2A11

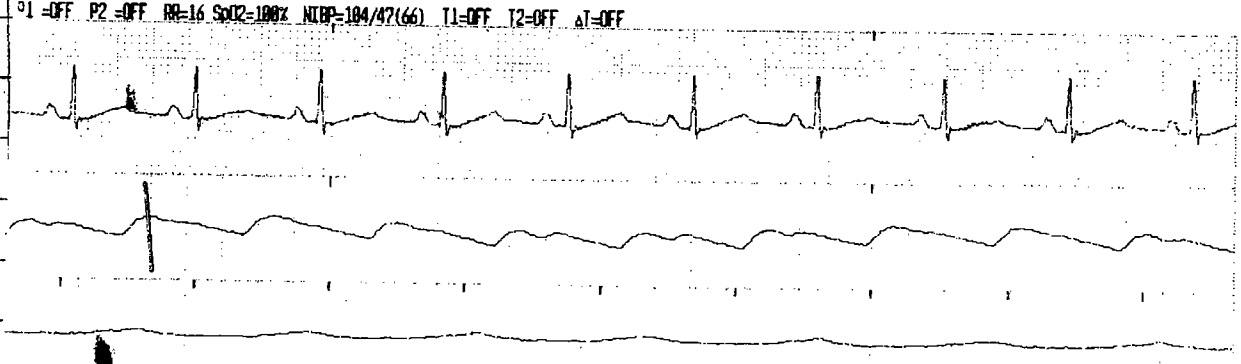
LAST NAME	FIR. E	MIDDL L	ID NUMBER

DATE	NOTES
25 Aug 03 1800	Received report from LT [redacted] Pt on bed rest, sedated. Pt on a ventod. Cordis to @ SC c 3L. Foley draining to gravity. JP 1+2 to bulb drain. Will continue to monitor. [redacted] SPC, q1WM6
1900	Changed ostomy bag. Stoma look pink and beefy. Drained 200cc of liquidy stool. Will continue to monitor [redacted] SPC, q1WM6
2200	Dsg Δ complete. Areas look red and beefy. Will continue to monitor. [redacted] SPC q1WM6
26 Aug 03 0200	Pt resting in bed. VSS. Changed ostomy bag. drained 200 cc of liquidy stool. Will continue to monitor. [redacted] SPC q1WM6
26 AUG 03 0600	Received report from previous shift. Vented SIMV16, 800, 16, 5peep, 40%. FIO2, peak 21. All IV lines intact. Temp 100.7, ST 100s, Sats 99-100%. NGT @ nare to LIS. Propofol @ 1100 mcg/kg/min, fentanyl @ 125 mcg/°, NS½ NS c 20 KCl @ 36cc/° infusing in triple lumen, NS @ 30cc/° infusing into cordis @ SC. All drains intact. Will cont. care. [redacted]
0630	Dr. [redacted] viewed labs & ABG. No new orders written. Viewed wounds. Completed dsg Δ. Midabd wound had yellowish substance, Yellow mucous from @ JP tube and duodenal tube. Dr. [redacted] aware. Pt RR ↑ HOs. Gave 50mg propofol IVP. Also gave 30mg. fentanyl @ 0710 due to ↑ BP 140s/90's. Wet to dry dsg to midabd. incision + @ flank wound using dakin's soln. and [redacted]

b(6)-2 A11

LAST NAME	NAME	M	INITIAL	ID NUMBER

DATE	NOTES
26 Aug 03 1215	pressure ↓ 28. RR ↓ 22. BP still elevated & pt moving eyes + eyebrows. Gave 50mg propofol IVP. will cont to [redacted]
1250	Stopped TF per Dr [redacted] Pt prep. for OR. [redacted]
1430	Pt to OR via stretcher c O2. [redacted]
1440-1800	Pt return from OR. New order to hold TF. Noted 2 (R) JP drains + 1 (L) JP drain c sanguinous drainage to bulb suction, duodenal drain in place, midline abd incision suture together c penrose drain. (R) flank wound c sanguinous drainage noted. A'd (R) colostomy bag. A'd (R) shoulder burn dsg. Applied silvadene. 2x2 gauze around 3 JP drains, J-tube, + duodenal drain. Pt O2 sats 90-94% upon arrival. Temp 97.7. A'd dsg (R) flank wound (applied 4x4). ETT remains 26cm @ lip. O2 sats ↑ 99% by 1810. RR 16, HR 805-905. Placed rolls under (R) feet.
26 Aug 03 1800	Gave report to Lt. [redacted] Report rec'd from LT [redacted] Pt remains intubated. [redacted] Will monitor [redacted]



2015. Pt suctioned x 1. Copious amounts thin white secretions. SpO2 ↑ to 99-100% following suctioning. SpO2 97% prior to suction. cont

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

038

MEDCOM - 16505

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

b1c)-2 All

DATE	NOTES
26 Aug 03 0130	cont'd... (R) flank wound has yellowish substance. Dr [redacted] aware. Colostomy bag coming apart near wound. Used tincture benzoin to seal. Unsuccessful. Will attempt to Δ bag if possible. Pt temp ↓ 100.5. Will cont. care [redacted]
0730	Pt RR 40s-50s. Gave 30mg propofol IVP. Will cont to monitor RR. [redacted]
0820	Completed bed bath + linen Δ. Completed foley care. Placed pt on (R) side. Pt RR ↑ 40s. BP ↑ 140s/60's. Gave 20mg propofol IVP. Δ'd drsg on (L) radial A-line. A-line not correlating c NIBP. Will cont. care. [redacted]
1000	Pt peak pressure 50. BP ↑ 150s/60s. RR ↑ 40s-50s. Deep suctioned pt x III. Noted large amt thin white secretions. O2 sats ↑ 96%-98-99%. peak pressures ↓ 30 BP ↓ 120-130s/50s. RR ↓ low 20s. Δ'd NGT tape. Applied [redacted] emycin to (B) eyes. Applied bacitracin to all drains. Will cont. care. [redacted]
1045	Pt RR ↑ 26. Gave 30mg propofol IVP. Will cont. care. [redacted]
1215	Noticed RR ↑ high 20s. Peak pressure 40s. Deep suctioned pt x III. Noted large amt thin white secretions, BS rhonchi (B) Ut. Suctioned mouth. Peak cont

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

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

b1c)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 16506

038

MEDICAL RECORD | PROGRESS NOTES

b(6)-2 A-11

DATE

26 Augas 2015 Peak pressure ↓ to mid to upper 30's ~~from~~ following cont. suction from lower 40's prior to suctioning. Will cont. to monitor Pt turned to (L) side and 30mg Propofol and 30 mcg fentanyl IVP given [redacted] ↑ work of breathing

2030 Pt appears more comfortable SpO2 100%, RR 16 down from 20's [redacted]

2300 Pt turned to (R) side. Pt suctioned. Copious amounts thin white secretions. SpO2 98%, Peak pressures upper 20's. Temp ↑ to 101.5. Tylenol 650mg per NGT given. Will monitor [redacted]

0200 Pt turned to L side. Pt suctioned x3. Burn wound redressed per protocol. Drsg d/d to midline abd incision. Drsg saturated c sero-sanguinous drng. Will monitor [redacted]

0600 Report given to day shift. [redacted]

0615 Care of patient + report received from previous shift. VSS. & S/S of pain or discomfort will cont. to monitor [redacted] LPN

0800 Tube feeds started @ 60cc/hr Jevity c duodenal juice. Temp to 101.4. Pt given Tylenol 650mg PR [redacted] other VSS. will cont to monitor

(Continue on reverse side)

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

b(6)-4

[redacted]

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 16507

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — PROGRESS NOTES

DATE	NOTES
27 AUG 03 1200	Pt VSS T↓ 100.8. Q s/s of pain or distress [redacted] will cont to monitor
1200	Pt VSS T- 100.7 Pt sedated. will cont to [redacted] monitor
1400	Tube feeds to goal rate of 125 cc/hr. VSS T- 100.8 pt shows Q s/s of pain or discomfort will [redacted] cont to monitor
1700	Pt suctioned x minimal secretions. T- 100.3 [redacted] VSS will cont to monitor
1800	T- 100.3 VSS Q s/s of pain or discomfort. Report [redacted] care of pt. given to oncoming shift
1800	Received report from SPC. [redacted] Pt. remains on vent. SIMV 16, 800, 16. 5 peep, 40% FIO2 peak 34. Drsg lied as ordered. Duodenal & J-tube flushed. Temp 100.5. Tylenol given for ↑ temp. Edema noted to ↑ & ↑ Extremities. ↓ distress noted @ present time. Will [redacted] continue to monitor for s/s of distress.
2000	Bolus of propofol given via ETT. Deep suction done, scant amount of secretion noted. SpO2 96%. Temp 101.3 will [redacted] monitor temp.
2207	SpO2 98%. Temp 100.8 Resting c discomfort. [redacted]

SPONSOR'S NAME — LAST — FIRST — MI — SPON. SSN

RELATIONSHIP TO SPONSOR — RECORDS MAINTAINED AT

DEPART./SERVICE — HOSPITAL OR MEDICAL FACILITY — REGISTER NO. — WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries, give Name - last, first, middle; DoD or SSN, Sex, Date of Birth, Pay Grade)

b(6)-4 [redacted]

PROGRESS NOTES
Medical Record

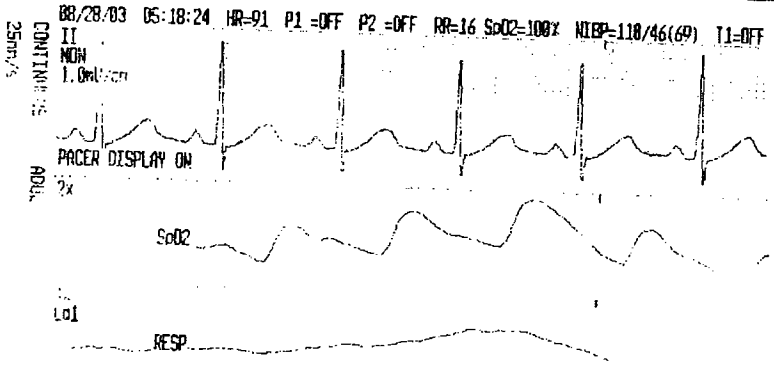
STANDARD FORM 509 (REV. 8/
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.200(

MEDCOM - 16508

ACLU-RDI 1637 p.68

DOD-029897

DATE	NOTES
28Aug03 2330	Temp 100° SpO2 98% & chills noted @ [redacted] HRNC. Will continue to monitor.
0215	Resting in bed & discomfort noted. Will [redacted] continue to monitor.
0445	Resting in bed & discomfort noted. Pt. NPO 2hrs. TO OR this am, Possible trach. Will cont. to [redacted] monitor



b(6)-2 All

0615	Received report & care of pt from previous shift. Pt sedated in bed c propofol & Fentanyl VSS. T-101.4 will cont to monitor [redacted]
0800	Pt VSS T-101.1 & s/s of pain or discomfort. Will cont to monitor [redacted]
1015	Pt currently receiving first of two units PRBC. Transfusion started at 0955 Pt shows no s/s of negative reaction. VSS will cont to monitor [redacted]
1215	Pt to OR 2nd of 2 units PRBC started at 1120. 28Aug03 pt shows no s/s of negative reaction. Transfusion to be completed in OR. VSS [redacted]

b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

#[redacted]

b(6)-4

100

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — PROGRESS NOTES

DATE	NOTES
8/28	Op Note Procedures ① Craniectomy ② Abd Lavage Surgeon [redacted] b(6)-2 Anes GETA Fluids 1L EBL min Findings ① purulent fluid c/c ② Lesser Sac abscess ③ Jejunal bi [redacted] x2 placed [redacted] b(6)-2

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name - last, first, middle; Number SS#, Sex, Date of Birth, Rank, Grade)

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

DEPART SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.(

[redacted] b(6)-4

MEDCOM - 16510

MEDICAL RECORD	PROGRESS NOTES
DATE	

1Sept03 Surgery

POD # 1 from mast recon washout of upper abdomen stable on avg wt

Neuro - sedated, dysarrated,

resp - 7.39/36/93/22/-3/97%

pneumonia cleared tracheb off on cont to wean vent

CV - Tachy and hypertensive when sedation lifted

Renal - 148/3.0 (118/23 14/1.4 Good UO.

Heme - 15.9/29 (1015 ↑ pt concerning for organ infx

ID - No clin. to date will CL F spiking still concern for infx

GI - TO full TF.

[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

PROGRESS NOTES
Medical Record

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

MEDCOM - 16511

MEDICAL RECORD	PROGRESS NOTES
DATE	
1 Sep 03 1615 pm	Procedure Note (L) subclavian Pt unable to give consent (R) subclavian introducer and TLC >7 days old with fever last nite (L) subclavian TLC passed over wire without difficulty. Tolerated procedure well. (R) medial port line passed over wire. CXR confirmed placement of TLC (-)PTX. (R) subclavian pulled. Catch tips sent for culture. b(6)-2 [redacted] MD Pulm/Crit Care
2 Sep 03 1500	Nursing Cont'd: well. Pt opened eyes spontaneously but does not follow commands. Burn care done on (R) shoulder, BLE, and back of head. Stage III decub noted on back of head. 3° burns noted on (R) shoulder and BLE. Silvadene cream applied. Small amount of serosanguinous drainage noted on distal portion of mid-line abdominal incision. Incision cleaned c soap + water. Dry dressing applied. (R) flank wound healing well. Ø drainage noted. Wound irrigated c NS and packed c gauze moistened c Dakin's solution. Erythema noted around JP tubes x 5 and T tube. Bacitracin applied around sites and covered c 2x2 dressing. New colostomy wafer applied. Stoma red and healthy. Old wafer not sticking to skin well. Cont'd

Continue on reverse side

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

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

[redacted] b(6) 4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
2 Sep 03 1500	Nursing Cont'd: BUE and LBCE elevated on blankets. Fentanyl concentration changed to 1000 mcg/100 ml. Continues to receive Fentanyl @ 100 mcg/hr for rate of 10 cc/hr. Pt resting quietly @ this ± distress. [redacted]
2 Sep 03 1711	Nursing: T-101.2, Pt given 650 mg Tylenol via J tube.
02 Sep 03 0600.	Report rec'd from day shift. See Da 4700 for b(4)-2 Assessment [redacted]
1930.	SBP noted to be decreased to low 100's, 90's. Propofol ↓ to 60 mcg/kg/min HR ↓ to low 100's-110. SpO2 remains 98% RR 18-21/min Will cont to monitor [redacted]
2000.	Peak pressures ↑ to 30. RT @ BS. Suctioned Pt ×3. Thick yellow sputum obtained SpO2 remains 98%. Peak pressures ↓ to 26-27 ± suctioning. [redacted]
2015.	Map ↓ to 65-67 mmHg. SBP remains in low to mid 70's. IVF holding. Propofol ↓ to 50 mcg/kg/min [redacted]
2315.	Drsg D's complete to wounds. Drsg's D'd to A-line and central line. No redness or drng noted from both sites. Drsg D'd to (A) chest burn area per burn protocol. (R) flank wound irrigated ē NS and repacked ē Dakins soaked gauze. Wound appears pink ē some active bleeding and areas of white exudate. Midline abd. drsg D'd. Sutures intact, wound approximated. Redness noted, but no drng. Tube insertion sites cleansed ē NS & betadine and redressed. Some redness noted around sites. Drsgs D'd to (B)LE wounds using burn protocol. Bleeding noted around edges. Wafer D'd to (R) ileostomy. Stoma [illegible]

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

[redacted] b(4)-4

MEDICAL RECORD | PROGRESS NOTES

DATE

02Sep03.

2315 cont. appears pink and moist. Trach care complete. Pt suctioned x3. Obtained thick yellow sputum. Oral care complete. Linens d'd. Pt turned to (L) side. VSS throughout. SBP ↑ to 150's, RR ↑ to 30's. Propofol 80mg IVP given and gtt rate b(6)-2 ↑ to 60 mcg/kg/min. Will cont. to monitor [redacted]

2330 + RR ↓ to ~~30~~ 16-18/min. SBP ↓ to 120's [redacted]

03Sep03. Will cont. care. [redacted]

0100 Pt turned to (R) side. Suctioned x2. Small amount thick yellow drng obtained. Distal & medial ports flushed on CVC. Both ports flush easily and have + positive blood return. [redacted]

0300 Pt turned to (L) side. 600cc duodenal drng. 300cc added back to TF. [redacted]

0350 CBC, Chem, ABG drawn and Vice A-line and sent to lab. ABG. 7.43/33.5/133/22/-2/99% [redacted]

0500 Pt turned to (R) side. SBP ↑ to 140's-150's. Propofol gtt ↑ to 70mcg/kg/min. Will monitor [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

b(6)-4 [redacted]

PROGRESS NOTES
Medical Record

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

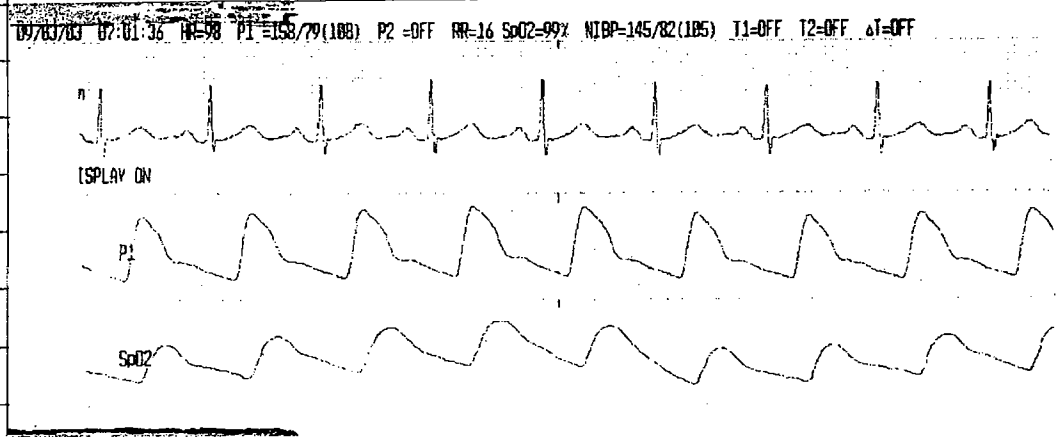
MEDCOM - 16514

PROGRESS NOTES

DATE

3 Sep 03

0934



See ICU flow sheet for complete assessment. NGT DC'd @ 0720. Trach patent and intact. No respiratory distress noted. Sats 99% on following vent settings: TV-400, R-16, SIMV, FiO2-40%, Peep-5. All dressings c/d/I. JPs intact. Foul odor noted from JP #3. Receiving Fentanyl @ 100 mcg/hr, Propofol @ 70 mcg/kg/min, and D5½NS ± 20KCl @ 30 cc/hr. Started on 2gm Mg SO4 ± 40 meq KCl infusion @ 0815. Foley to gravity. Draining >50 cc/hrs. Pt having copious purulent drainage from trach. Sample sent for culture. BUE & BLE elevated on blankets. No distress noted @ this time. b(6)-2 [redacted] cc/tw

3 Sep 03 1410

Nursing: From 1130-1400, bath, foley care, oral care, trach care, and dressing c completed. Silvadene cream applied to burns on ⓟ shoulder, BLE, and stage II decub ulcer on back of head. Wet to dry dressing c Dakin's solution done for packing on ⓟ flank. Bacitracin applied to JP sites, Wound vac drain, JP tube site, and Hickman-line abdominal incision. Small amount of serosanguinous drainage [redacted] b(6)-2 tw (Cont'd)

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

MEDICAL RECORD | PROGRESS NOTES

DATE	
3Sept03	Pulmonary/Critical Care
08[00]	EPW s/p ex lap, multiple washouts, trach. No
meds	events overnite
fentanyl	154/78 98.8 100 16
Zantac	General: asleep arouses to stimuli. Does not follow commands
lovenox	HEENT: trach
D5 1/2NS + 20KCl @ 80cc/hr	LUNGS: scattered rhonchi
Jevity at 80cc/hr	CV: Regular tachycardia (L) subclavian
Reglan	Abdomen: midline incision JP x5
Unasyn	Ext: Oedema
	(Labs): 7.43/34/133 -2 18.1 > 9/28 < 941 I/O - 4564/4480
	151/123/20 131, 3.4/23/1.0 AST-49 alk ϕ - 148
	ALT-35 T.Bili - 1.8
A/P	(1) Neuro → opens eyes intermittently. Does not follow commands
	Would decrease propofol daily to assess status.
	(2) Pulm → low O_2 requirements. Secretions around trach
	but no clinical pneumonia
	(3) CV → hemodynamically stable. Labetalol prn for elevated BP
	Needs standing dose of medication. Place on Atenolol 25 QD
	(4) Renal → needs free water or more 1/2 NS. Will ↑ fluids
	with more KCl given borderline K^+
	(5) Heme → 9/28 no current issues
	(6) ID → changed Abx yesterday. WBC ↓ with plt. No fever

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

[redacted] b(6)-2

MEDCOM - 16516

PROGRESS NOTES

DATE

Source of infection. Do not have IV flucanazole. PO flucanazole for now but limited effectiveness for fungemia or systemic infection. If further fevers would DC to improve. Lines changed

(7) GI → start tube feeds

$\frac{24}{1920}$ Jevity + $\frac{2\frac{1}{2}}{720}$ propofol = 2640 kcal/day

Meets caloric requirements. Bile added to Jevity

(8) Abdomen followed by CT scan

(9) Disposition → expect prolonged ICU course. Biggest risk further infection + MSOF

[redacted]

DLW-2

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

LAST NAME	NAME	M.	NITIAL	ID NUMBER

DATE	NOTES
4 sep 03	Surgery Neuro sedated, tracheed resp imv 96/800/5/40% 7.37/40/90/24/-2 Doing well Resolved/Resolving pneumonia c/w wean from Mech vent. cv - stable Renal ▽ 148/4.1 (121/24, 22/143, 0.8) Doing well it still ↑ BUN will ↑ Fw. Heme 20/28 (9.08 ID - ↑Temp 99-100.5 WBC 20 midline wound opened Drains working Abx expanded to Flue/Rocephin/Unasyn. D#3 Appears Defervescing today. will watch plts cx for persistent TWBC. GI DAT FS TF well. Wnds: ② SC 3-Lumen 2 days. [redacted] b(6)-2
4 Sep 03 1933	Nursing: From 1130-1500 bath completed; foley care and trach care done. Dressings changed. Silvadene cream applied to burns on ② shoulders, BLE, and back of head. Wet to dry dressing using Dakins solution used on ② flank wound. Wound beefy red, & purulent drainage noted. Opening in wound noted in mid-line abdominal incision. Dr. [redacted] notified [redacted] b(6)-4 b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
~~04 Sep 03~~	
0330	Labs drawn via A-line and sent to lab. ABG 7.37/40.5/90/24/-2/97%. BP ↑ to 140's, HR ↑ 110, Peak pressure ↑ to 40's. Propofol 80mg IVP given & rate ↑ to 70mcg/kg/min. SBP ↓ to 110's, HR ↓ to low 100's, peak pressures ↓ to upper 20's, spO2 ↑ 98% — b(6)-2 [redacted]
0415	Pt turned to (R) side —
0600	Report given to day shift —
4 Sep 03	Nursing: HR-105, BP-143/64, R-20, Sats 98% on vent.
0746	TV-800, SIMV, R-16, FiO2-40%, Peep 5. Trach intact. Suctioning thick yellow blood tinged secretions from trach. Suctioning moderate amount of thin white oral secretions. No respiratory distress noted. See ICU flow sheet for complete nursing assessment. Receiving D5 1/2 NS c 40meq KCl @ 100cc/hr, Fentanyl @ 100mcg/hr, and Propofol @ 70mcg/kg/min via proximal port. Medial and Distal ports patent to NS flush. Foley to gravity, voiding >150cc/hr. BUE + BLE elevated on ~~pillows~~ 0900 blankets. [redacted]
4 Sep 03	Nursing: Pt sleeping quietly & distress. Propofol
0831	~~↓ 60mcg/hr~~ 0832 ↓ 60 mcg/kg/min. Labs shown to Dr. [redacted]. No new orders written. — [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST [redacted] | FIRST | MI | (SSN or Other) b(6)-2

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

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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

[redacted]

MEDCOM - 16519

b(6)-2 #11

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
4 Sep 03 1533	Nursing Cont'd: Sutures removed on 3/4 of wound. ~~Wound Dehisced~~ Intestines loosely packed c Kerlex sponges moistened c NS. Distal portion of incision continues to leave 2" x 1/2" small amount of serosanguinous drainage. 4x4 dressing applied, sutures intact. #5 JP Drain DC'd by Dr. [redacted]. 2x2 Dressing applied. Erythema noted on JP Drains, J Tube, and Duodenal Drain. Bacitracin applied and covered c 2x2 dressings. Propofol held to determine pt's functional status. Pt opens eyes spontaneously and moves hands slightly but no purposeful movement noted. Propofol restarted @ 60 mcg/kg/hr when pt's breathing becoming more labored, RR ↑ 40s, pt restless. RR ↓ 20s, pt sleeping more easily c propofol restarted. D5 1/2 NS c 40 KCl DC'd @ 1300. BUE, BLE, and scrotum elevated. [redacted] 4/9/03 to
14 Sep 03 1710	Nursing: BP ↓ 102/51, MAP 68. Propofol ↓ 50 mcg/kg/min and Fentanyl ↓ 80 mcg/hr.
5 Sep 03 0010	Pt BP ↓ 104/53, MAP 68, Propofol ↓ to 20 mcg/kg/min to raise BP. will cont. to monitor. [redacted] 5 Sep 03
5 Sep 03 @ 0120	Pt BP between 150s-140s, Propofol ↑ to 50 mcg/kg/min will cont. to monitor. [redacted] 9/11/6/03.

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

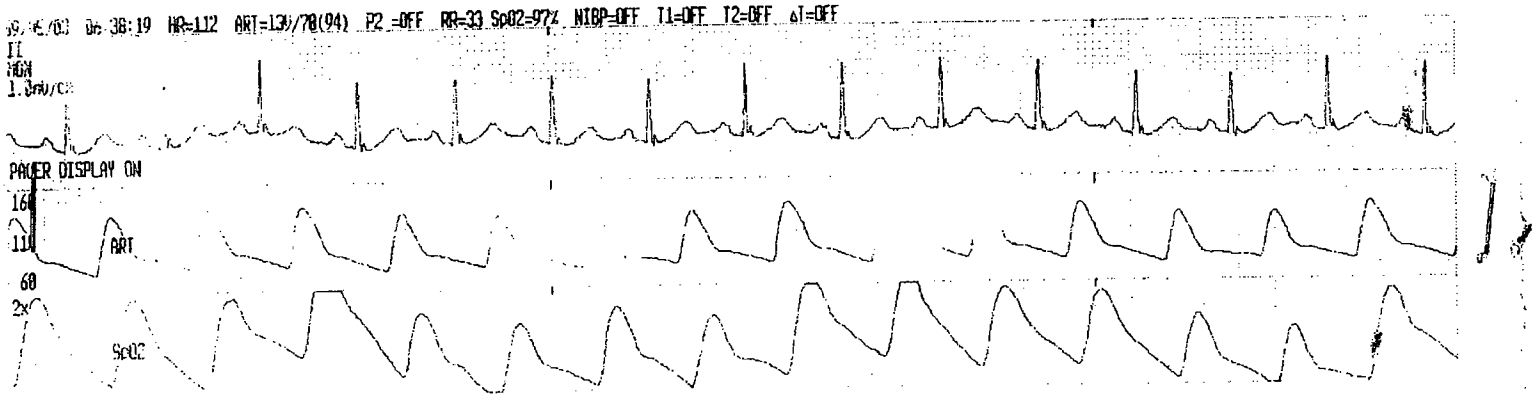
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* [redacted] b(6)-4

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 - 16520

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
05Sept03 0600	Received report from night shift. Pt sedated c propofol @ 50mcg/kg/min + fentanyl @ 80mcg/°. (L) SC 3-lumen + (R) radial A-line intact. Flushed 3-lumen c 5cc heparin. Flushes well. Pt vented SIMV 16, 800, 5, 40%, peak pressure 29. TF running @ 120cc/°. Pt HOB ↑ 30°. Noted pussy drainage in 4 JP tubes. Wet drsg in midabd incision. Will cont. care. b(6)-2 [redacted] UTA
0650	Pt BP 140s/100s-70s. ↑ fentanyl to 90 mcg/°. Will cont to monitor BP. b(6)-2 [redacted] UTA
0745	Pt peak pressure 32-34. BP ↑ 140s-150s/60s-70s. BS rhonchi throughout. Deep suctioned pt x V. Thick white secretions noted. O2 sats 94-96%. Suction O2 sats ↑ 98%. Peak pressure 31. BP ↓ 120s/60s. Rhonchi still heard [illegible]



0830-1030	Completed drsg Δ to midline abd incision, (R) flank, (R) shoulder + (R) LE. Wet kerlex roll to open midline abd incision. Bacitracin to lower midline abd incision that is sutured. Noted serous colored drainage from lower abd incision. ¼th strength dakin's soln for (R) flank wound. wet to dry drsg. Wound looks clean. cont'd...

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

MEDCOM - 16521

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES b(6)-2 A11
05Sept03 0830-1030	cont'd... Cleaned (R) shoulder burn + (B)LE blisters c hibidens + rinsed c NS. Applied silvadene + covered drsgs c Hx Hs. Completed bed bath + foley care. Used cloth tape to secure all drsgs. Elevated (B)UE + (B)LE due to edema. Will cont care. —[redacted] 1674
1000	Stopped propofol per V.O. Dr. [redacted] to wake pt. Pt temp @ 1000 98°, O2 sats 94%, BP 109/66, BP ↑ 170s-190s/60s, PR ↑ 40s, O2 sats ↑ 98% p suctioning x iii. Thin white secretions noted c some thick mucous plugs. Suctioned pt mouth also. Pt eyes open + moving hands + head. Got interp x ii. Pt not responsive to any questions by interpretor. Gave 25mg atenolol @ 1100. Will cont to monitor. [redacted] TOTAL
1100-1230	Restrained pt due to almost pulled out A-line. D'd A-line drsg + (L)SC 3-lumen drsg using sterile technique. A-line positional. Suctioned pt x iii. Thin/thick white secretions noted. Pt BP ↑ 1100s-200s/80. Pt O2 sats 96-98%. Peak pressure mid 20s to low 50s via c suctioning. RR 20s-low 30s. HR 100s-120s. Will notify Dr. [redacted] of these events. Will cont to monitor pt. D'd midline abd drsg due to saturation. Emptied JP drains. Noted pussy yellow drainage in JP #1, 2 + 4 + duodenal like drainage in JP 3. Semi formed pasty stool noted. Will cont. care. [redacted] 1674

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 16522

638

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
05Sept03 1400	Pt temp ↑ 100.8, BP 163/96 via A-line but not correlating c NIBP 156/94. O2 sats 98%. Suctioned pt x iii. Thick thin sputum noted. Will cont. care. — [redacted]
1530	Completed trach care. Pt sats 95-96% on RA. RR ↑ 34. Will cont. care. — [redacted]
1600	Dr. [redacted] V.O to turn propofol to 25mcg/kg/min. Raised pt HOB. O2 sats 98%. BP [redacted]. Will cont. care. — [redacted]
1700	Pt resting c eyes closed. BP 130s/70s. O2 sats 99%. HR low 100s. — [redacted]
1800	Gave report to night shift. — [redacted]
5Sep03 2205	Pt suctioned by RT x iii for small thick white secretions. [redacted]
5Sep03 2315	Prog Ns completed, trach care completed c [redacted] on RA RR 32. Will cont to monitor. — [redacted]
6Sep03 0750	Nursing: T-101.5, BP 120/60, HR 109, R 16, Sats 97% on following vent settings: TV-800, SIMV, R-16, FiO2-40%, Peep 5. Trach intact, ∅ respiratory distress noted. Receiving Fentanyl @ 90mcg/hr and Propofol @ 25 mcg/kg/min infusing through proximal port. Medial and Distal ports flush easily & resistance. Foley to gravity, voiding ≈ 100cc/hr. BUE + BLE elevated on blankets, Scrotum elevated c towel. Pt resting quietly @ this time. [redacted]
6Sep03 0825	Nursing: T-101.9, pt given 650mg Tylenol via J-Tube. Skin Diaphoretic. Will continue to monitor. [redacted]
6Sep03 1041	Nursing: T-101.7. Bath completed. Foley and oral care done. ~~Pt shaved~~ Face shaved 9/6 1042. Notified by Dr. [redacted] that pt is on call to O.R. Tube feeding stopped. [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDCOM - 16523

038

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5 Sept 03	Pulmonary / Critical Care
08[30]	Pt asleep with eyes closed but tachypneic. Labile
Meds	blood pressure overnight
Propofol	117/60 101' 16 97% Tmax 101'
Fentanyl	General: asleep but arousable does not follow commands
Tubefeeds	LUNGS: scattered rhonchi
Zantac	CV: RRR
Morphine	Ext: 2+ edema
Unasyn	Abdom: granulation tissue JPs draining
Fluconazole	(Labs): 23.2 > 10/31 < 839 % 35/38/55 133/4.6 | 116/18 | 18/1.1 144
	Albumin - 1.5
A/P	(1) Neuro → wean propofol today. Need to assess
	mental status.
	(2) Pulm → Need to begin weaning process. Wean sedation
	as tolerated. Tachypnea + agitation with open abdomen
	limit progress
	(3) CV → will ↑ Atenolol and continue prn Lopressor
	BP a function of sedation
	(4) Renal → Good urine output with nl BUN/Cr DC IV fluids Na-137
	(5) Hse → H/H stable
	(6) I.D. → fluconazole / morphine / unasyn. Febrile today

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

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

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

[redacted] b(6)-4

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

MEDCOM - 16524 [redacted]

LAST NAME	FI[...]ME	MIDD.[...]AL	ID NUMBER

DATE	NOTES
	New lines / cultures sent
	(?) Continue to follow
	b(6)-2 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDCOM - 16525

[redacted]

ACLU-RDI 1637 p.85

DOD-029914

b(6)-2 All

PROGRESS NOTES

DATE	
6Sep03 1817	Nursing: TF c Jevity restarted @ 20 cc/hr. Dr. [redacted] notified of ABG and CXR results. Dr. [redacted] assessing pt. Dressing Δs for burns to R shoulder, BLE, and stage III decub to back of head completed. Silvadene cream applied. Pt tolerated procedure well. Report given to LT [redacted]
1820	Dr [redacted] @ BS. Updated on pts. condition viewed CXR. Possible branch to be done. Order for repeat ~~CXR~~ ABG.
1825	SpO2 ↑ to 100%, peak pressures @ ~ 24-25 cmH2O. 7.41/46.9/28/18/30/5/100%. Will monitor. [redacted]
1845	Dr [redacted] @ BS for branch. Pt remained on vent during tx. SpO2 remained 91-93% during procedure. Peep ↑ to 10 following procedure, pt remains on 100% FiO2. Will wean FiO2 to keep SpO2 >93%. Will monitor [redacted]
1945	SpO2 remains 100% on 100% FiO2 and Peep 10. FiO2 ↓ to 50% while Peep remains @ 10. Will cont. to monitor
2000	CXR obtained. Dr [redacted] shown results. New orders for albuterol Nebs q 4°. Will notify RT.
2020	Dr [redacted] updated on pt condition. SpO2 holding @ 93-94% on 50% FiO2. No new orders rec'd. Will monitor [redacted]
2200	Dsg Δ's complete to (R) chest burn area. Wound appears white c some pink areas noted. Redressed utilizing burn dsg protocol. Midline abd dsg d/c'd. Vaseline gauze placed over ~~bowel~~ exposed bowel. Normal saline gauze lightly packed into wound. Bowel appears pink and moist. (R) flank wound dsg appears pink and moist c (cont)

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

MEDCOM - 16526

MEDICAL RECORD	PROGRESS NOTES
DATE	
6 Sep 03 1305	Nursing: ABP 88/43, MAP 57. Propofol and Fentanyl drips held. BP↑ 141/99. Fentanyl restarted @ 90mcg/hr and Propofol @ 25 mcg/kg/min. Pt continues to move c nonpurposeful movements. [redacted]
6 Sep 03 1320	Nursing: T-102.1 @ 1300. Unable to give Tylenol via J tube due to NPO status in preparation for OR. @ Tylenol suppository in Pharmacy. Will continue to monitor. [redacted]
6 Sep 03 1400	Nursing: T-101.8, BP 138/80, MAP 100. Sats 97% on Vent support. [redacted]
6 Sep 03 1722	Nursing: Pt arrived back from OR @ 1640. See PACU flowsheet for frequent VS. Sats 88-90% on 40% FiO2 via Vent. Pt ventilated c BVM. Sats ↑ 95% then went back down to 88% p placed back on vent. ~~Pt suction~~ 1724 Trach suctioned x mod secretions removed. HOB 45° c effect. Dr. [redacted] and Dr. [redacted] notified. FiO2 ↑ 100%. Sats ↑ 99%. ABG done and PCXR done per Dr. [redacted] request 1723 Trach care completed. Trach patent. JP drains #3 and #4 placed on LIS per Dr. [redacted]. SBP 100-110s, MAP ≈ 75. Fentanyl restarted @ 90 mcg/hr and Propofol @ 10 mcg/kg/min. Will continue to monitor. [redacted]

b(4)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
Medical Record

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

[redacted]

b(4)-4

PROGRESS NOTES

DATE	
07Sept 0600	cont'd... Jevity infusing @ 20cc/°. JP #2+4 to US. JP #1+3 bulb suction. UO > 30cc/°. All drsgs C, D, I. Will cont. care. [redacted]
0700	Dr. [redacted] viewed labs. New orders given. Vent RR 12. Will get ABG in 1°. Portable CXR done. Will notify RT of vent Δ's. [redacted]
0745	Repeat CXR. Drew ABG. Results: 7.43, 42.9, 119, 29, 5, O2 Sats 99%. Suctioned pt. thin white secretions noted. O2 sats 98-99%. Will cont. care.
0800	Notified RT of vent Δ. Will notify Dr. [redacted] of ABG results.
0930-1100	Completed bed path, passive ROM, + foley care. Δ'd burn drsg on (R) shoulder, blister drsgs (B) LE + decub drsg on head. Cleaned c nibiclens + rinsed c NS. Applied silvadene + covered c 4x4s. Noticed decub on back of head near nape of neck. Made towel ring to keep head off bed. Elevated (B) LE + (B) UE. Δ'd (R) flank wound drsg c ½ strength dakin's soln. Wound is pink. Δ'd midline abd incision. Placed petroleum gauze on intestines. Have placed NS soaked kerlex into wound + covered c abd pads. Applied bacitracin around JP drains + J-tube. Completed trach care. Noted copious white/yellow sputum when suctioning. Pt O2 sats ↑ 100%. ↓ peak pressure ↓ from 30s to 20s. Covered pt c extra sheet due to temp 95-96°. Pt appears ~~her~~ less agitated. Will cont. care. [redacted]

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

MEDCOM - 16528

b(6) - 2
All

MEDICAL RECORD	PROGRESS NOTES
DATE	

06Sep03. some white exudate noted. Wound repacked c ½ Dakins
2200 cont. dsn gauze. Tube care completed. Trach care and
oral care complete. Pt turned to (L) side following
procedures. [redacted]
2230 ~~SpO2 ↓ to 40?~~ FiO2 ↓ to 40%. SpO2 99-100%
on SD7. Pt suctioned x 4. Copious amounts
yellow secretions obtained. ~~SpO2~~ Pt manually
ventilated during procedure. SpO2 98-99% following
procedure.
07Sep03. / / / / / / /
0005. Pt turned to (R) side. Pt c nonpurposeful
mvmts. Propofol ↑ to 12.5mcg/kg/min and b(6)-2 Fentanyl ↑ to 100mcg/hr. Will monitor [redacted]
0200. Pt placed on back. Pt continues c non-
purposeful mvmt. RR 17-22BPM, SBP 120's/130's. WNL
cont. gtts @ current rate. [redacted]
0400. CBC, Chem, ABG drawn and sent to lab. 7.52/33.8/
84/28/5/97% [redacted]
0430. Abd wound dsg D/d for dampness. Gauze packing
remains moist. [redacted]
07Sept03 0600 Received report from previous shift. Pt moving BUE
+ eyes open. Fentanyl @ 100mcg/° + propofol @ 20mcg/° infusing.
BP 130s/70s. RR teens. O2sat 98%. SIMV 16, 800, 10, 40%. FiO2, peak 34 on ET

(continued on reverse side)

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

PROGRESS NOTES
Medical Record

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

[redacted]

b(6)-4

b(6)-2

PROGRESS NOTES

DATE	
07 Sep03 1800 cont	Pt unsuccessful. <2 sec cap refill noted to (B) hands, (T)2 (B) radial pulses, hands warm and dry. Will cont. to monitor [redacted]
1900:	Pt appears agitated, moving extremities, grimacing, lifting head. HR 90's, SBP 150's. Gave fentanyl 50mcg and 20mg propofol IVP. HR ↓ to 80's, SBP ↓ to 110's-120's. Pt ~~was~~ not grimacing moving extremities as much. Fentanyl gtt rate ↑ to 100mcg/hr. Will monitor [redacted]
2130.	Trach care completed. Pt suctioned x4. Copious amounts thick yellow secretions obtained. SpO2 100%. Drsgs d/c'd to (B), LE using burn protocol. Wounds appear white with bleeding noted at edges. Drsg d/c'd to (L) Chest burn area using burn drsg protocol. Burn areas appear white c ~~some~~ white areas noted. Some pink edges noted. Wounds cleansed to back of head. ~~He~~ Shaved ~~air~~ hair around wounds. Silvadene applied. Head wrapped c gauze to keep drsgs intact - Head placed on foam doughnut. Pt tolerated procedures well. VSS throughout. [redacted]
2330.	Drsg d/c'd to midline abd incision. Xeroform gauze sticking to intestine. Irrigated c NS to enhance removal of dressings. Intestine appear pink and moist. Vaseline gauze reapplied - packed lightly soaked in NS. Green liquid drng noted from site. [redacted]
08Sep03. 0200.	Pt suctioned x4 Manually ventilated during procedure. Copious amounts thin yellow secretions obtained. SpO2 100% during procedure. Placed back on vent p procedure.

STANDARD FORM 509 (REV. 7-91) BACK

MEDICAL RECORD | PROGRESS NOTES b(6)-2 A11

DATE	
07 Sept 03	Pt BP ↓ from 132s-136s/70s to 106s/60s. ↓ propofol gtt to 10mcg/kg/min
1340	Will cont to monitor. [redacted]
1445	Suctioned pt x iii. Copious white/yellow sputum noted. Pt O2 sats 97%. RR12. Will cont. care. [redacted]
1455	Restrained pt (R) arm due to pulling onto JP drain. Will cont. to monitor soft restraint. [redacted]
1600	Pt A-line about to be pulled out by pt. Readressed A-line. Good square wave form. Placed (R) arm is sam splint to protect a line + restrained pts (R) arm. S'ostomy bag due to leakage into midabd wound. Cleaned midabd wound c NS. S'd drsg. NS soaked kerlex. Pt had BM brown liquidy. ↓ peep to 5 per V.O. Dr. [redacted] ↑ed TF to 40cc/° due to V.O. Dr. [redacted] Disconnected JP # 3+4 from LIS. Now on bulb suction. Will cont. care. [redacted]
1700	↑ed pt fentanyl to 70 mcg/° + ↑ed propofol to 20 mcg/kg/min in attempt to slightly sedate pt while not ↓ing pt BP < 100 systolically. Will monitor BP. Pt O2 sats 98%. Pt temp ↑ 98°. Will cont. care. [redacted]
1800	Gave report to night shift. [redacted]
07 Sept 03 1800	Report received. Pt currently in soft wrist restraints. Pt has numerous drains ~~at~~ in abd and monitoring lines. Pt continues to move (L) UE, pulling @ medical equipment. Pt does not appear oriented and makes non purposeful movements. Attempts to reposition (cont)

(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. ICU 1

CPW [redacted] b(6)-2

PROGRESS NOTES
Medical Record

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

b(6)-2
A11

PROGRESS NOTES

08Sept03 0700	cont'd... Notified RT. Will cont. care [redacted]
0735	RT ↓ed RR to 8. Pt O2 sats remained >98%. Suctioned pt x iii. Copious yellow tinged sputum noted. Will cont. care. [redacted]
0755	Got interpretor. Pt able to follow some simple commands. Pt closed eyes. Pt unable to squeeze hand. Interpretor believes pt still a little confused. Interpretor explained vent + tubes. Will recheck mental status in a couple of hours. [redacted]
0915	Placed pt on TC 50% FiO2 by RT. Interpretor @ bedside to explain events. Pt O2 sats 98-99%. RR 20s to 30s. Emptied JP drains. JP#1 sanguinous drainage. JP#2 pussy drainage. JP#3 duodenal juice. JP#4 pussy drainage. Dr. [redacted] aware. Suctioned pt x ii. Pt able to cough some sputum. Copious yellow tinged sputum noted. Will cont to monitor. [redacted]
1024	Midline abd drsg D'd by Dr [redacted] Used fluffs soaked in NS. Placed petroleum gauze on intestines + placed fluffs in areas of skin separation. Loosely packed. Noted some pussy drainage. Dr. [redacted] viewed ABG 7.361, 40.3, 87, 31, 8, 97%. O2 sats 98-100%. Suctioned pt numerous times. Copious yellow-tinged sputum noted. Will cont. care [redacted]
1135	Started fentanyl gtt @ 10mcg/°. Will cont to assess pain level. Completed bed bath, burn drsgs Ds + foley care. D'd linens. Will cont. care. [redacted]

FORM 509 (REV. 7-91) BACK

MEDCOM - 16532

MEDICAL RECORD | PROGRESS NOTES b(6)-2 A11

DATE

08 Sep 03.

0400. CBC, Chem, ABG drawn & via A-line and sent to lab. Results pending. Medial and distal port of [redacted] flushed ē blood return present. [redacted]

0530. J-tube flushed ē 35cc's H_2O. Flushing sluggish. TF@50cc/hr p̄ pt had BM via colostomy. Pt Suctioned x 3. SpO2 99-100% during procedure. Moderate amount - thin yellow secretions [redacted]

0600. Report given to day shift. [redacted]

08 Sept 03 @0600 Received report from previous shift. Pt awake & moving BUE + BLE ext unpurposefully. Propofol + fentanyl infusing. All IV lines are intact. BLE elevated. Jevity infusing @50cc/° from J-tube. Two arm soft restraints in place. Cap refill <3 sec. Will cont. care. [redacted]

0700 Viewed lab results. ABG. 7.49, 46.5, 112, 31.8, 99% @ vent settings SIMV 12, 800, 5, 40%. peak 23. H+H 8.2, 25.7 Plt 662, WBC 17.6. Dr. [redacted] viewed labs & CXR. New orders to try pt on trach collar for 1° + ↑ TF to 80cc/°. Notified Dr. [redacted] that petroleum gauze sticking to intestine. Will do dsg Δ c Dr. [redacted] Stopped propofol + fentanyl @ 0710 in preparation for trach collar trials. cont. -

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

PROGRESS NOTES
Medical Record

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

[redacted]
b(6)-4

MEDICAL RECORD	PROGRESS NOTES
DATE	
05 Sept 08 1300	Ted fentanyl to 15mcg/°. Completed mouth care + trach care. Pt seems to tolerate fentanyl rate of 15mcg/°. Ted rate to 30mcg/°. Suctioned pt numerous times. Copious thick yellow-tinged sputum noted. Pt tol. trach care well. Pt moving (B)LE's any difficulty. Moves (B)LE occasionally. (B)LE elevated. O2 sats 100% on humidified trach collar. RR low 30s. Will cont. care. [redacted] LCT
1500	Pt resting comfortably. O2 sats 100% on 50%. T-piece humidified trach collar. Suctioned pt x ii. Copious sputum noted. Restraint on (R) wrist in place. Cap refill 2-3 sec. Will cont. care. [redacted] LCT
1700	Pt resting. VSs. Will cont. care. [redacted] LCT
1800	Gave report to night shift. [redacted] LCT
1800	Received Report [redacted] LCT
2300	Changed mid abd and (R) flank and (R) lat upper chest RUE burn dsg. Patient tolerated well. [redacted] LCT/AH
2330	Trach care done. Foley care done. LCT/AH

b(6)-2 AH

(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

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

MEDCOM - 16534

PROGRESS NOTES

DATE	
9Sept 03	Surgery
Atenolol	No events over night
Albuterol	Neuro Spont EO, tracking purposeful movement
Aucon...	Resp - Trach Good CXR with T infiltrate of
Rocephin	(R) Lung.
Unasyn	Cor HR 80-100 BP 140-180/70
Zantac	Renal - UO 110-150cc/hr (+) N1000cc for the day
Fentanyl	marked ↓ in peripheral Edema.
	Heme - HCT 26 Plt 662
	ID Afeb WBC ↓ to 17.6
	GI tol TF @ Goal of 80cc/hr
	overall Doing well with the wound c̄
	exposed bowel is issue currently c̄ W→D
	Dressings. will eventually Require STSG when
	clean and Granulated.
	[redacted] b(6)-2
9 Sep 03 0700	Received report from ongoing shift. Lines, drains, TC c̄ 35% intact. Pt on mild sedation of Fentanyl @ 60mcg/hr, pt wide awake c̄ appear to be unpurposeful movement. Donot follow command. Respond better to the interpreter but no consistency c̄ following command. VSS. Afebile [redacted] Mej/ArN
1120	AM bed bath completed. Wound care done c̄ physician earlier. See above note. Pt received KCl 40mEq drip for K+ 2-8. Tolera TLC. Antibiotic therapy (Unasyn + Rocephin) in progress for WBC 17.6. General edema resolving + UO per foley > 50cc/hr. Dressing changed as per ordered. Abd wound c̄ trace of infected exudate

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

MEDCOM - 16535

ACLU-RDI 1637 p.95

DOD-029924

b(6)-2-A11

PROGRESS NOTES

DATE	
10Sep03 0853	Nursing Cont'd: Dressing changed by Dr. [redacted] Stool leaking from colostomy site to wound. Wound irrigated c sterile water. Vaseline gauze and Kerlex moistened c NS applied to mid abdominal wound. New wafer and bag applied to colostomy site. Tincture of [redacted] 0900 Benzoin applied to skin to help c adhesion of wafer. Stoma pink and healthy ϕ leaking noted from colostomy site. Wet to dry dressing change done on ⓟ flank wound. Site packed c Kerlex moistened c Dakin's solution. Wound granulating, ϕ drainage or foul odor noted. JP sites + T tube cleaned, Bacitracin applied and covered c 2x2 dressings. Pt tolerated procedure. Pt restless, moving all over bed. BLE elevated. Will continue to monitor. [redacted] SN/Am
10Sep03 1056	Nursing: Bath, 1056 foley care, and oral care completed. Pt's face shaved. ROM exercises done on BLE. Pt moving BUE more frequently. Colostomy intact, wafer adhering to skin. JPs drained. Pt having bloody drainage from JP #1. Foul odor noted from JP #3. Serous drainage noted from JP #2-4. Pt repositioned in bed. Pt has strong cough and able to cough up thick secretions from trach. [redacted] SN/Am
10Sep03 1352	Nursing: Trach care completed. Pt continues to have productive cough. TLC Dressing d/d using sterile technique. Site cleaned c Betadine. Tincture of [redacted] 1358 Benzoin applied for adhesion. ϕs/s of infection. [redacted] SN/Am

MEDICAL RECORD | PROGRESS NOTES

DATE	
	Continuation b(6)-2
9 Sep03	"appearing". MD made aware. Drains exit sites intact free from
1120	infection S+S. Colostomy wafer & bag changed, colostomy site (stoma)
	c̄ excellent vascularization s̄ drainage or irritation. VSS. [redacted] /Mn
1330	Pt turned q2° to relieve pressure off sacrum, no skin breakdown
	noted. Bed sore noted back of the head from prolonged bedbound
	applied dressing. Relieve pressure off affected area q2°.
1700	Pt turned q2° dressing changed to calf c̄ W-D dressing covered
	c̄ Tegaderm & Kerlix, dressing to the bed sore on the back of the
	head changed as well c̄ W-D dressing & tegaderm. Continue to
	reposition pt to take pressure off problem areas. Afebrile
	all shift. Remained on mild ~~sedation~~ sedation of Fentanyl
	60 mcg/hr. Remained awake most shift but continue to
	unable to obey commands. —— [redacted] /An
1800	Received report. —— b(6)-2 [redacted] LT/AN
10SEP03 0300	Assessment completed @ 1830. VSS. A-Line BP does
	not correlate c̄ NBP, will continue to draw blood
	from A-Line PRN. Patient agitated most of night.
10Sep03	Nursing: See ICU flowsheet for assessment. VS: T-98.8,
0853	BP-152/82, HR-98, R-33, Sats 99% on 35% humidified
	trach collar. Trach patent. Suctioning moderate amount
	of thick yellow secretions from trach ~~x3~~ 0855 x6. Dr [redacted]
	notified of low Hct and K. Pt started on 20 meq KCl
	infusion @ 0850. Mid-line abdominal incision (Cont'd)

(Continue on reverse side)

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

REGISTER NO. [redacted]

b(6)-2

PROGRESS NOTES
Medical Record

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

EPW [redacted] b(6)-4

b(a)-2A1)

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Sep 03 1750	Nursing: A line DC'd. Direct pressure applied for 6 mins. Ø bleeding noted. 4×4 dressing placed on site. Mid-Abdominal dressing D'd by Dr [redacted] Vaseline gauze ē Kerlex moistened ē NS applied to wound. (R) flank dressing D'd. Wet to dry dressing done. Report given to Cpt [redacted] 97/Az
10 Sep 03 1800	Received report from CPT [redacted], Pt resting in bed HOB TF @ 80 c/hr, Feed @ 50 meq/hr, JP drains to bulb suction, Pt wiggling in bed VSS, will continue ↑ monitor [redacted]
2100	Abdominal dressing changed Vaseline gauze applied to exposed organs, Aseptic Technique. Fluff gauze moistened ē NS applied on top. Covered ē ABD dressing after works, Abdominal puncture wound dressing changed ē Betadine W-D dressing, JP drain insertion sites cleaned, no oozing noted, minimal redness ↑ swelling around sites, lines stripped, 2×2 applied over site, (R) chest dressing changed ē sulfamylon W-D dressing, (B) LE dressing changed ē sulfamylon W-D dressing, Back of head dressing changed ē sulfamylon W-D dressing ↑ covered ē opsite, positioned pt for comfort. Placed pt on ~~RA ē humidified~~ [redacted] humidified RA. Sats remained in the mid-90's, RR-hi-20's, unlabored. Pt required frequent suctioning, thin, white

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]

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

D(a)-4

MEDCOM - 16538

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	secretions. Pt c good strong cough. Will continue to monitor and leave in humidified RA for now [redacted] i cpt/pd
11 Sep 03	Nursing: See ICU flowsheet for nursing assessment.
0831	Sats 93% on RA, RR 30-40s. Pt placed back on O2 @ 28%
	FiO2 via [redacted] humidified trach collar. Pt coughing [redacted] up thick yellow secretions. Trach patent. ~~Respiratory~~
	Pt restless, moving all over bed. Pt attempting to look over side rails and laying head on top of side rails. Pt not following commands. Two point soft restraints applied on BUE to keep pt in bed. Pulses strong and easily palpable. Skin breakdown noted @ restraint sites.
	Dr. [redacted] notified of lab results. Order written for KCl replacement. Will continue to monitor. [redacted]
11 Sep 03	Surgery b(6)-2 A11
1000	NO Acute event overnight TO Full TF
	Neuro - Awake, indicates No c Tongue click
	Resp - ↓ SAT to 93-94 today but was on RA
	increased to 24% Now 97% on RA post ICU
	extubate. → send Aspirate for Cx
	Cor - 90-100 - 150/96
	No issues
	Renal 154 / 3.1 | 113 / 27 | 137 / 1.0 A162.1 A098 A022 Amy 102 Ar 31 TB 1.2
	GNG Prob FWD 2° to ~~PE~~ and Diuresis. will Add Fw c K Replacement and c TF to rate.
	[redacted] b(6)-2

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

b(6)-2 All

PROGRESS NOTES

DATE	
11Sep03	Nursing Cont'd: applied for adhesion. Pt [redacted] 1057
1047	40meq KCl in 500cc D5W [redacted] 1057 ~~started~~ infusion started @ 1048. Pt remains restless, scooting down in bed, flailing arms and legs. Interpreter asked to speak to pt but pt not following commands. Restraints removed during bath and reapplied afterwards. Pulses remain strong, & skin breakdown noted. Pt repositioned in bed, placed on (L) side. [redacted]
1110	Wound care: pressure sore nursing note: LE: change dressing to pressure sore to buttock LE, yellowish necks noted ~~to~~ the wound, measuring 2x3cm and approximately 1x2 cm in some areas (R) LE for 3 small wounds (L) LE for two. Applied ~~sulfamylon solution~~ Sulfamylon solution to [redacted] W-D dressing, covered ~~c~~ Tegaderm dressing to preserve moisture, per wound care nurse specialist recommendation. Assp: Pt has 4 multiple size pressure sore (unspecified) yellowish necks noted. Applied ~~the~~ Sulfamylon solution W-D dressing covered ~~c~~ Tegaderm transparent dressing. Staining of yellowish exudate noted on the old dressing, very minimal. Dressing has been changed ~~c~~ above procedure X 3 days. Plan: observe wound appearance each day & document progress. [redacted] Maj IAN
11Sep03 1307	Nursing: PIV started in (R) wrist ~~c~~ 18G I.V. Patent to flush. ~~&~~ edema, ~~&~~ erythema. (L) Subclavian TLC d/c'd. Pressure applied for 5 mins. 4x4 dressing applied over site. ~~&~~ bleeding noted. Restraints on, ~~&~~ skin breakdown noted. Pulses easily palpable. [redacted]

MEDICAL RECORD	PROGRESS NOTES
DATE	
11 Sep 03	Surgery (cont'd)
ZANTAC	Heme $\frac{\text{Hct } 27}{\text{Plt } 675}$
Lovenox	
Rocephin D9	FD WBC 16.4 AFeS ward looks good.
Unasyn D9	① will D/c central line.
	② cont abx for now.
	GI TOL TF will Alb >2.0. b(6)-2
	[redacted]
11 Sep 03 1047	Nursing: Bath, foley care, and oral care completed. Stool leaking on abdominal dressing. ϕ stool noted in wounds. Mid-abdominal wounds irrigated c NS. Vaseline gauze, b(6)-2 [redacted] 1049 ~~applied~~ and Kerlex moistened c NS applied. Wet to dry dressing change done on ② flank wound using Hakins solution. JP + G tube sites cleaned, Bacitracin applied and covered c 2x2 dressing. Stoma cleaned, looks pink and healthy. New wafer applied, Tincture of Benzoin (cont'd)

(Continue on reverse side)

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

REGISTER NO. [redacted] RECORD NO. 4/4

b(6)-4 [redacted]

b(6)-2

PROGRESS NOTES Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
12 Sep 07	Surgery
	No events ovn NKDA
	VSS Afeb. 24% Trach collar & 94-98% SAT
	UO 60 - 200 cc/hr
	Chest CBTA
	Abd good stoma function Dressing clean.
	Drains JP3 (Duod— 90cc/day.)
	A/P Doing well continued hypernatremia
	will add 50 cc/hr free water and
	D all infusions to D5W.

[redacted]

b1c) - 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. ICU3

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 - 16542

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES** b(6)-2 A11

DATE	NOTES
12 Sep 03 0615	Received report & Care of pt from previous shift [redacted]
0830	Pt sleeping in bed. VSS & s/s of pain or discomfort will cont to monitor [redacted]
1030	Dsg d/s to Abd, (R) flank & bilat lower legs completed. Abdominal (R) flank wet to dry dressing c Dakins solution. Wound appear pink to beefy red. Dsg's to bilat lower legs & (R) chest wet to dry dressing c 5% Sulfa Mylon solution. Eschar remains on wounds. VSS & s/s of pain or discomfort will cont to monitor [redacted]
1245	Pt awake in bed VSS T: 99.6. Pt to start on D5W @ 50 cc/hr and all infusions made with D5W per MD. will cont to monitor [redacted]
1530	Pt remains on T/C @ 24% O2 SaO2 94%-98%. Trach care performed. VSS will cont to monitor [redacted]
1730	Ostomy bag changed & ostomy cleaned. VSS & s/s of pain or discomfort [redacted]
1800	Report & Care of patient given to oncoming shift [redacted]
1800	Received report. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 16543

038

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
588			

DATE	NOTES
~~12SEP~~ 2200	Drsg Δ to mid abd. Vaseline guaze to small area on Ⓡ side of wound, wet→dry drsg applied. 2x2's cut and placed around drains. Ⓛ medial wound dressed c dressing soaked in ¼ strength Dakins soln. Ⓡ lateral wound dressed c dressing soaked in 1/4 strength Dakins. Posterior calfs dressed with Sulfamylon-soaked dressings. Posterior cranium dressed c sulfamylon dressings. Patient tolerated well. VSS remain stable. #8 Shiley ~~to bed~~ FC @ 24% O2, sao2 > 95%. Foley to gravity. Drsg CDI to abdomen, BLE, posterior skull. [redacted] ICU/AH
135ep03 0600	Report recieved from ICT [redacted]. pt VSS, afebrile. [redacted] 9/11/06
0800	pt bath done at this time [redacted] 9/11/06
	b(6)-2 All
	Surgery
	No events over night
	VSS Afeb.
	Abd wound - clean up with evolve granulation tissue.
	17 \ 29 / 6.71 — 139 / 3.9 \ 105 / 25 \ 20 / 180 / 0.8 — Alb 1.9 — Alk Φ 93 — ALT 14 — AST 27 — Amy 41 — TBil 1
	A/P No Appreciable A's hyperkalemia resolved. T TF to 100 D/C OSW in AS [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

b(a)-2
All

PROGRESS NOTES

DATE	
2200 12 Sep	Ø's continuation Abdominal wound dressing changed, petrolatum dressing applied on exposed organs. NS soaked fluff applied over it. Wound edges dark red c minimal swelling, Ø discharge, Ø odor, Ø contamination from previous leak of ostomy. Ostomy wafer replaced, bag replaced. Tincture of ~~iodine~~ benzoin used for max adhesion, ~~Wound~~ puncture wound below abdominal ~~adhesion~~ incision dressing changed c NS W-D dressing, granulating well. wound edges look healthy c min redness & swelling, Ø odor, Ø discharge: Addendum to stoma note: Stoma pinkish/red Ø signs of necrosis. (L) LE dressing changed c sulfanylon W-D and covered c Tegaderm. 2 wounds both covered c yellowish layer, bleeding noted upon cleaning; minimal exudate on old dressing. (R) LE dressing changed c sulfanylon W-D & covered c Tegaderm. Wound c yellowish layer, bleeding noted upon cleaning. Restraints released. ROM (B) UE done. good pulses, pt not fighting restraints, foley care done, Ø discharge noted, Trach care done. Pt requiring less suctioning. Pt placed on RA x 2 hrs. Sats 92%, placed back on 24% TC humidified @ 2100. will keep on 24%. TC [redacted] CPT /pw
2400	laid pt flat in bed. Ø leakage noted on ostomy wafer, bag [redacted]
12 Sep 0200	Restraints released. Ø skin breakdown noted, addendum on 2200 stoma note. Skin breakdown noted on skin below stoma: (L) V possible skin tear from stoma wafer 2° to frequent wafer replacement because of leakage. Recommend placement of 4x4 on leakage site to prevent contamination vs replacement of ostomy wafer. Leakage maybe unavoidable because of deepening contour of belly on leakage site & stiff construction of ostomy ring. Ø leakage noted @ this time, 4x4 in place and clean, partly stool in ostomy bag. Pt on (L) side. [redacted] CPT /pw
0400 12 Sep	Restraints released, Ø skin breakdown noted. Labs drawn. Pt flat on back. 4x4 between stoma & wound clean [redacted] CPT /pw

2 skin breakdown

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

588

MEDCOM - 16545

b(6)-2 A11

MEDICAL RECORD	PROGRESS NOTES
DATE	
11 Sep 03 1750	Nursing: Stool leaking from colostomy wafer to mid-abdominal abdomen. Ø stool noted @ abdominal wound. Wounds irrigated c NS. Vaseline gauze applied along c Kerlex moistened c NS. Pt sleeping quietly, report given to Cpt [redacted] [redacted] SS/RN
11 Sep 03 1800	Report received from CPT [redacted] Pt resting quietly & comfortably in bed, awakens easily, TF @ 80 c/hr, MSO4 @ 7mg/hr PRN - 20's even unlabored, 97% & 24% TC. Will leave on 7mg/hr MSO4 for now & titrate down as necessary. SP's to bulb suction. Wafer around stoma leaking on abdominal incision site, Ø contamination noted on wound, Ø active oozing of stool noted on leak, ~~MT~~ 4x4 gauze placed between ~~back~~ leakage site & wound to prevent contamination, will replace hourly. Pt positioned on (R) side. Soft restraints x2 on (B)LE, good pulses, restraints released, Ø skin breakdown noted. will continue & monitor/pull
2000	Pt somnolent, but awakens easily, MSO4 ↓ 4mg/hr. PR 20, even unlabored, will monitor & titrate MSO4 as necessary. Pt on (R) side [redacted] PT/RN
2200	Pt on (L) side, Head dressing changed c sulfamylon W-D & Tegaderm, 4 pressure sores, 3 c yellowish skin layer, 1 c red/black scab. ~~dam~~ head resting on donut, Ø discharge, Ø odor, (R) chest/shoulder dressing changed c sulfamylon W-D. bleeding noted p cleaning wound, yellowish skin layer slowly debriding, 2 wounds, one on (R) chest, one on armpit,

(continue on reverse side)

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

continued next page

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

[redacted]

b(6)-4

b(6)-2
All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 Sept 03 1005	cont'd... aspect liver. Lower abd incision pink c some yellowish plaque-like exudate. Wet to dry dsg c NS. Will cont. care. [redacted] LTA
1100	Turned pt to (R) side. O2 sats 94%. Pt may go to OR later today. Drew chem 8. Results Na+ 146. Will cont. care [redacted] LTA
1245	Deep suctioned pt x III. Copious white/yellow tinged sputum noted. O2 sats ↑ 96%. Will cont care. [redacted] LTA
1400	Pt resting quietly. Pt on back. O2 sats 95%. Easily awaken. Will cont. care. [redacted] LTA
1600	Ø Δ's in status. Receiving neb tx. O2 sats 95-98%. Will cont. care. [redacted] LTA
1800	PT VSS c Ø significant Δ's. Gave report to night shift. [redacted] LTA
1820 15sep	Received report from previous shift. Pt resting quietly in bed. D5 W c 50 cc/hr, MSO4 c 2mg/hr, Ø leak noted on colostomy wafer, will cntinu to monitor [redacted] cm/pm
2100	Pt c vigorous cough, thick yellow sputum, [redacted] lavaged c 3 cc NS, bagged & suctioned. Copius thick yellow sputum upon suctioning. Pt on (L) side. [redacted]
2400	Pt's facial hair & head shaved, Trach care done, mouth care done, foley care done. Head dressing changed c sulfamylon soaked w-D Topsite, (R) chest, shoulder dressing changed c sulfamylon soaked w-D dressing, Abdominal incision dressing changed, petroleum dressing applied to protruding part of bowel, w-D dressing applied over Ø contamination noted from colostomy, cntinued
1600 15sep	

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15Sept03 0720-0910	cont'd... sulfamylon soln + tegraderm to (R) LE + head decub. Little drainage noted from (R) shoulder + scant amt bleeding. Used cloth tape to secure (R) shoulder burn. Completed foley care + turned pt onto (R) side. Completed passive ROM. Interpreter explained why do passive ROM. 0 % pain from pt. PT unable to move limbs + does not feel sharp pain (R) UE, or (L) LE. Pt able to do shoulder shrug + follow some commands. Pt RR ↓ 25. O2 sats 93-96%. Received neb tx. Noted yellowish drainage from (L) J-tube. Applied bacitracin to all 4 JP tubes + J-tube. Δ'd (R) flank wound c 1/4 strength dakin's soln. Wound pinkish/red c small amt yellow exudate. Pt had copious amt sputum upon turning pt. Will cont. care. b(6)-2 [redacted]
0950	Completed trachcare. Thick yellowish sputum noted in cannula. Pt O2 sats remain 93-94%. RR ↓ low-mid teens. Will cont. care. Emptied colostomy. Brown pasty-like feces noted. Stoma pink + moist [redacted]
1045	Δ'd midline abd incision. Fistula scant amt blood. Placed vasaline gauze on fistula. Wound pink x lower cont'd...

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted]

b(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16 Sep 2400	Continuation: W-D debrided solution to premature wounds. WD ointment applied to bilateral UE wounds & covered c Tegaderm. VSS, will continue to monitor. b(6)-2 [redacted]
16 Sep 0300	Pt c good strong cough. Thick yellow sputum [redacted] suctioned x3 humidified 24% FC, 97%, able to move all 4 ext, will continue to monitor VSS b(6)-2 [redacted]
16 Sept 0300 0600	Received report from previous shift. Pt awake in bed. TC humidified air @ 24% FiO2. Copious white sputum noted. Pt appears more awake than yesterday. Moving all 4 extremities + able to turn self onto side. Gave pt H2O. Pt appears to tolerate well. Elevated HOB to 30°. All drsgs C, D, I. B L E elevated. IV line intact — [redacted]
0700-0830	Completed bed bath + foley care. Δ'd R shoulder burn drsg. B L E blister drsgs + decub head drsg. Washed all areas c hibiclens + rinsed c NS. Applied sulfamylon soln + covered c tegaderm x R shoulder burn drsg (covered c cloth tape). Ø S/S of infection noted. Δ'd R plant wound + midline abd incision wound. R plant wound pink c minimal amt of yellow plaque substance. Wet to dry ½ strength dakins

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

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

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

b(6)-2
All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16 Sept 03 0700-0830	cont'd... used. Midline abd incision moist c̄ Ø s/s of infection. Notified Dr. [redacted] of my concern about Fistula of intestine. Dr. [redacted] said it was fine. Ø new orders written. Covered fistula c̄ vascaline gauze + wet to dry c̄ NS. Noted bloody mucus arnd J-tube. Applied bacitracin to all 4 JP tubes and J-tube. All 4 JP tubes to bulb suction. Emptied (R) colostomy. Stoma pink + moist. Pasty-like stool noted. Δ'd linens. Elevated BLE + HOB. ↑ed MSO4 gtt rate to 7cc/° due to ↑ed HR 120s + ↑BP 140s/80s. Will cont care. [redacted]
0900	BP ↓ 130s/80s, temp 98.9, HR 107. Pt appears comfortable. Pt able to express needs through interpretor. Pt nods yes that he's comfortable, not in pain + it's hard to breath c̄ trach. Completed trach care. Pt 98% on RA. Copious white/blood tinged sputum noted. Pt has strong cough. Able to cough some sputum out. Will cont care. [redacted]
16 Sept 03	surgery
	No events overnight
	VSS Afeb Tm 100.5
	Chest CTA
	Abd NABS wound good granulation
	Stoma viable
	ext wounds Granulating. A/P stable cont Fuel
	141/29 | 554 129/108/23 4.3/24/1.1 Dressg Δ's. OOB to chair
	today [redacted]

[redacted] 9 (REV. 5/1999) BACK
USAPA V1.00

MEDCOM - 16550

ACLU-RDI 1637 p.110

DOD-029939

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16 Sept 03 1100	Pt resting c eyes closed. O2 sats 98-99% on 24% FiO2 humidified trach collar. Deep suction pt x iii. Copious amt ~~frth~~ sputum noted. Will cont care. b(6)-2 [redacted]
1200	Dr [redacted] viewed labs. Δ MIVF to ½ NS @ 50cc + activity up to chair. Will cont. care. b(6)-2 [redacted]
1240	Δ'd colostomy bag + wafer due to leakage. Δ'd midline abd incision drsg due to soiling. Will cont. care. b(6)-2 [redacted]
1500-1620	Pt OOB to chair. Pt unable to sustain own body weight or stand erect. Pt on RA c sats 98-99%. Interpretor present to explain procedure Pt tol well. O2 sats 98-99% throughout. Pt able to communicate c interpretor to express needs Placed TF on hold. Pt c/o pain. Ted MSO4 gtt from 5mg/h to 7mg/h. Pt sat in chair ≈ 1°. Placed pt back in bed. Pt on RA c O2 sats 98%., coughed copious white sputum. Deep suctioned x iii. Will cont. care b(6)-2 [redacted]
1800	Gave report to next shift. [redacted]

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

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

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

EPW [redacted]
b(6)-4

PROGRESS NOTES
Medical Record

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

b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
#588			

DATE	NOTES
16 Sep 03	Report received from ILT [redacted]. Pt VSS
1805	SaO2 98% on RA.
1810	Pt's colostomy leaked into abdominal wound. Colostomy wafer and bag were changed. Abdominal wounds were irrigated c saline and dakins solution. Once Abd wounds were cleaned they were redressed. - J. Morrison
2000	Dressings to burns on @ arm + @ chest Δ'd @ this time. Wounds appear to be healing well - [redacted]
2045	Dressings to burns on BLE Δ'd @ this time. Wounds appear to be healing well [redacted]
2400	Dressings to back of head Δ'd. Healing well [redacted]
2130	Trach cleaned [redacted]
2200	Foley cath Δ'd. @ S/S of infection when old catheter removed [redacted]
2400	Pt becoming increasingly agitated MSO4 off
17 Sept 03	T to 8 mg/hr [redacted] 9MM6
0200	Pt VSS, afebrile [redacted]
0400	AM labs drawn, CXR done [redacted]
17 Sept 03 @ 0710	pt report received @ 0600 From SPC [redacted] pt VSS pt assessment complete See pt flowsheet for details pt dressing CDI @ this time will change per schedule pt resting in bed c eyes closed NO SIGNS of acute distress noted @ present will continue to monitor throughout duty [redacted] RCG/ism
0815	Pt deep suctioned @ this time. 2 cc NS put down trach + pt suctioned. Able to cough well on his own. O2 sat's @ 96% upon completion. [redacted] 9/16/16

STANDARD FORM 509 (REV. 5/1998) BACK

USAPA V1.00

b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17Sep 03 0200	Pt resting comfortably in bed, VSS will continue to monitor [redacted] SPC, 9 WMG
17 Sept 03 0600	Received report from night shift. Pt resting c eyes closed. (R) arm elevated. Drsg (R) arm C, D, I. 0 % pain @ this time. PIV line intact. VSS. Will cont. care. [redacted]
0615	NV ✓ completed. +3 bounding (R) radial pulse. Pt able to feel sensation in thumb + pointer finger. No feeling in other three fingers. Will cont. care. [redacted]
0710	Pt % pain (R) arm pain. Motioning tightness. Gave MSO4 [illegible] mg IVP. Will cont. to assess pain Level. [redacted]
0800 - 0930	Pt ambulate to bathroom s assistance. (R) arm in sling. Δ'd linen. Completed bed bath c some assistance. Elevated (R) arm. NV ✓ Δ's: pt able to Feel some dulled pressure on middle finger. Will cont care. [redacted]
1000	Pt % pain (R) arm. Gave MSO4 [illegible] mg IVP. 0 ✓'s in NV ✓. Will cont to monitor pain control. [redacted]
1200	Pt resting c eyes closed. 0 Δ's in NV ✓. Will cont. care. [redacted]
1330	Pt ambulate to bathroom c little assistance. Medicated c versed 4mg IVP + MSO4 5mg IVP for drsg Δ @ 1350. [redacted]
1400	0 Δ's in NV ✓ of (R) arm. +2 pulse c feelings (sensation to touch) on thumb, pointer finger + dulled sensation middle finger. [redacted]

STANDARD FORM 509 (REV. 6/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0930	Pt OOB TC. Minimal c/o pain to LUE [redacted] Will cont to monitor.
1030	Pt received 3mg M_3O_4 for c/o pain to LUE [redacted] VSS T-100.2. Will cont to monitor.
1230	Pt back into bed from chair after ambulating on ward. Minimal c/o pain in LUE while ambulating [redacted] VSS T-98.5° will cont to monitor.
1430	Pt sleeping in bed & s/s of pain or discomfort. Will [redacted] cont to monitor.
1545	Dsg Δ to LUE Completed. Pt received 7mg M_3O_4 + 2mg Versed for pain during dsg. Δ. [redacted] VSS T-100.1 will cont to monitor.
1630	Foley DC'd per Dr.'s orders. [redacted]
1800	Report + care of pt. given to oncoming [redacted]
1800	Received report from SRC Palmer Pt resting comfortably in bed. VSS. Ethereal fireball to (L) arm. Dressing CDI. HL to (R) Ext (D) flush c s/s of infection. Will continued to monitor. [redacted]
2200	Pt resting comfortably in bed. VSS. Will continue to monitor. [redacted] 2 WWII6

b(6)-2 An1

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

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

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

REGISTER NO. | WARD NO. ICU 1

1. [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17 Sep 03 1440	Completed dsg / Pt tol well. Pt assisted as much as capable. Open incisions upper arm red, moist c Ø S/S of infections. Small amt bleeding when removed dsg. Sutures on forearm intact. Elevated (L) arm when completed Δ. Washed wounds c NS + applied fluffs. Replaced splint. Wrapped (L) arm c Kerlex roll + ace bandage. Incision on (L) upper thigh: staples intact, wound well approximated. Ø drainage noted Incision on (R) upper thigh: sutures intact c Ø drainage noted. Covered incisions c bacitracin 4x4 gauze + cloth tape. Will cont. care [redacted]
1600	Ø Δ's in NV x. +2 palpable pulse. Ø % pain discomfort. Pt NPO p MN to OR [redacted] Pt understands. Will cont. care. [redacted]
1620	Pt ambulate to bathroom. Pt grimacing in pain. Gave MSO4 5mg IVP. Will cont to monitor pain level. [redacted]
1730	Pt resting quietly c eyes closed. Will cont. care [redacted]
1800	Gave report to next shift. [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME (LAST, FIRST, MI) | SPONSOR'S ID NUMBER (SSN or Other) b(6)-2 A11

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

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

b(6)-2 All

LAST NAME 723	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17Sep03	Report recieved from previous shift. Pt
1820	vss, afebrile. Ex fix to (L) arm, Drsg CDI. pulse
	in (L) arm +4. Full sensation to thumb & index finger,
	decreased sensation to middle finger, Ø sensation
	to remaining 2 digits [redacted] 9mm6
2000	Neuro (Hand) ✓: Full sensation to thumb & index finger,
	decreased sensation to middle finger, Ø sensation to
	remaining 2 digits. Pulse +4 [redacted]
2200	Patient lying in bed. ambulated to bathroom,
	percocet given for c/o pain to (L) arm. Neuro
	checks same as previous check. [redacted] 9mm6
2400	Neuro ✓ same as previous check [redacted]
0115	MSO4 5mg given for c/o pain in (L) arm [redacted]
0200	Neuro ✓ same as previous ✓ [redacted]
0400	Neuro ✓ same as previous ✓ [redacted]
0600	Neuro ✓ same as previous ✓. pt vss. Report
	given to dayshift [redacted] 9mm6
18Sept03	Recieved report from Spc. [redacted] Pt. resting in
0630	bed c complaints. (L) arm ↑ as Ordered. Neuro ✓
	to (L) hand: full sensation to thumb and index finger
	and decreased sensation to middle finger. No
	sensation to remaining two fingers. ++ pulse to
	extremities. Temp 98.7. Resp even & non labored
	breath sounds clear @ present time. Will
	continue to monitor. [redacted]

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES** b(6)-2 A-11

DATE	NOTES
17 Sept 03 @ 0910	pt VSS pt deep suction due to Sat ↓ 94% Sat ↑ 98 after suctioning pt laying in bed ☐ eyes open No signs of acute distress noted — [redacted] PFC 91WMS
17 Sept 03 @ 1115	pt VSS pt dressing A's complete all dressings CDI ostomy bag reinforced ☐ op site pt resting calmly @ present ROM complete no acute signs of distress noted @ present will continue to monitor — [redacted] PFC 91WMS
17 Sept 03 @ 1500	pt VSS pt deep suctioned for low O2 sat 93-94% pt Sats @ 96-97% now pt became slightly agitated interpreter call to translate pt wanted "a knife to cut cords" pt calm now laying in bed with eyes open no other problems @ present will continue to monitor throughout duty — [redacted] PFC 91WMS
17 Sept 03 @ 1530	ostomy bag redone & changed by Maj. [redacted] pt resting well @ this time will continue to monitor — [redacted] PFC 91W
1800	Took report from PFC Bailey. VSS. Pt in bed no distress noted. Pt's abdominal dressing D/O by ND on day shift. Will continue to monitor. — [redacted] 91WMS
2000	Pt's VSS, abdominal dressing D/d due to colostomy bag leak called ostomy nurse D/d. Pt in bed awake. — [redacted] 91WMS
2200	Pt's colostomy bag D/C along ☐ abdominal dressing. VSS. Will continue to monitor. — [redacted] 91WMS (over)

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)

EPW [redacted]

b(6)-4

REGISTER NO.

WARD NO. ICU 1

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 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18SEP03	(0100) Pt's BP ↑. resting in bed. all meningeal CDT. will continue to monitor BP. [redacted]
	(0300) Pt pulled IV out. IV d/c'd to (L) wrist 18g. Pt's BP still elevated. other VSS. afebrile. will continue to monitor [redacted]
	(0500) Pt's VSS, resting in bed. 114 @ 176. will continue to monitor. [redacted]
18Sep 0814	RT note: Pt on trach collar. Pt removed. 97 SpO2 on RA HR 114, RR 18. UO Alb given + pt refused. no d/c [redacted]
0615	Received report + care of pt from previous shift. Pt awake in bed and appears to be agitated and is moving in bed attempts to pull trach out and pull IV out will cont to monitor [redacted]
0740	Pt received 2mg Ativan IV for agitation per MD orders VSS T 100.1 will cont to monitor [redacted]
0815	Fentanyl Patched, 50 mcg/hr, placed @ 0800 to backside of upper left shoulder VSS T 99.2 Pt sleeping in bed Ø s/s of pain, distress or agitation will cont to monitor [redacted]
1100	Pt sleeping in bed. Ø s/s of pain or distress or agitation. VSS. will cont to monitor [redacted]
1330	Pt sleeping. VSS Ø s/s of pain or distress. Will cont to monitor [redacted]
1540	Dsg Δ's to Abdomen, (R) flank, back of head, bilat. lower legs completed. Trach care performed. Pt awake. VSS will cont to monitor [redacted]
1800	Report + care of pt given to oncoming shift [redacted]

STANDARD FORM 509 (REV. …)
USAPA V1.00

MEDCOM - 16558

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18 Aug 05 0745	MS04 5mg given IV for pain. [redacted] b(a)-2
0811	NO Δ in neuro ✓ @ present time. Will cont to monitor. [redacted]
0905	Ø further c/o pain @ present time. Pt. returned NPO for surg. AM care completed @ 0830. Will continue to monitor. [redacted]
0926	c/o (L) arm pain. MS04 5mg IV given as Rx for complaint. Will continue to monitor for S/Sx of distress. [redacted]
1032	MS04 5mg given for c/o arm pain. [redacted]
1032	NO Δ in neuro ✓. +3 pulse to (L) above Radial pulse. [redacted]
1104	Pt resting in bed Ø distress @ present time. NO complaints voiced @ time. Will continue to monitor. [redacted]
1202	+3 pulse to (L) radial. Ø complaints @ present time. full sensation remains in thumb & index finger. ↓ sensation to middle finger. NO sensation to last two fingers. Will continue monitoring pt. as Rx. and MD. [redacted]

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

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

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

REGISTER NO. | WARD NO.

[redacted] bcw-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

DATE	NOTES
18 Sept. 1215	Pt. to go to OR this pm. DISCHARGE not done.
1230	Pt. C/O (L) arm pain. MS04 5mg IV given for complaint.
1349	0 further complaints voiced @ present time.
1404	Percocet 2ab "P.O. given for C/O (L) arm pain. Will continue to monitor.
1405	Radial pulse to (L) extremity +3. Sensation to thumb & index finger. V Sensation to middle finger & 0 sensation voiced of last two fingers. will continue to monitor
1441	No further complaints voiced @ present time. will continue to monitor.
	Brief Note
	Pre Op Dx: open wound (L) Arm
	Post Op Dx: same
	Procedure: I+D DPC of (L) Arm b(6)-2A11
	Surgeon: MATSUMOTO / OKOCHI
	Anesthesia - GETA
	EBL: min
	Fluids: 900cc LR
	Drugs: Clean wounds
	Cx: 0
18 Sept 03 1758	Return from OR. Ambulated [redacted] difficulty.

[redacted] b(6)-4

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

b(a)-2 All

DATE	NOTES
13 Aug 03 1800	Received report from SPC [redacted] Pt resting in Bed. Pt tracked. IV to Qwrst. Foley to gravity. Pt On restricts. VSS, Will continue to monitor [redacted] SPC, 9 WMG
2000	Pt resting comfortably in bed VSS. Will continue to monitor [redacted] SPC, 9 WMG
2200	Dog A complete. Track cas complete VSS Will continue to monitor [redacted] SPC, 9 WMG
19 Sep 03 2400	Pt resting comfortably in bed VSS will continue to monitor [redacted] SPC, 9 WMG
0200	Pt resting comfortably in bed. VSS. Will continue to monitor [redacted] SPC 9 WMG
0800	Received report from oncoming shift. Pt in bed awake, alert oriented to simple conversation today. Calm & cooperative. Ortony bag leaked to the dressing. Changed ortony bag & the dressing. Wound appear clean no infection noted in the edges, no odor. Pt NPO, stopped tube feeding for OR today to close the wound. VSS. Labs 8.7/27.3/504. Contact c POC. [redacted] Maj MC

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

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

REGISTER NO. | WARD NO.

#[redacted]

b(a)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19 SEP 03	Op Note
1100	Indication open Abd
	Procedure STSG from (R) Ant Thigh
	to Abdomen
	Surgeons - [redacted] / [redacted] b(6)-2 All
	Anest GETA [redacted]
	Findings 2 x 8 - STSG @ 0.14 - taken
	from (R) Ant Thigh meshed 3:1
	Applied to Ant Abd wound with
	Modified VAC dressing.
	NO comps
	TO PACU in good cond.
	[redacted]
19 Sep 03	Graft to the abdomen from the (R) thigh
1250	JP drains. VSS 160-170, 130/50 - 20 - 100% sat Mech vent
T 98.2	Trach strong productive cough NSR 90's, Limited 2 mg J-tube
	hypoactive BS, 120cc foley. Versed 8 mg c MSO4 3 mg @ 1145.
	Pt in bed awake + slightly disoriented. Gave Ativan 2 mg c
	MSO4 2 mg IVP, ↑ MSO4 drip to 10 mg X 1 hour until sedation
	is reach then titrate down to effect. Wound dressing
	attached to suction. Continue c post op + wound care.
	[redacted] Mg / AN
1600	Pt calm, wound vac suction intact @ 125 mm Hg. Pt stable
	Afebrile [redacted] Mg / AN

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES b(6)-2 All ↓
19 SEP 03 1800	Received Report. Abd vac to suction, Foley to Gravity, TC to Room air, SaO_2 > 95%. 18G PIV (L) Wrist. Resting quietly
20 SEP 0100	in bed ō HOB ↑ 30°. Drsgs to wounds intact. [redacted] LCT/AN Dreg Δ to (R) abd, BLE. Trach Care. Change colostomy bag. Mouth Care. [redacted] LCT/AN
0445	Report given. Patient resting comfortable. Restraints currently off. [redacted] LCT/AN
20 Sep 03 0944	Nursing: VSS, afebrile. See ICU flowsheet for nursing assessment. Pt receiving scheduled dose of Ativan plus PRN ativan as needed. Pt has episodes of restlessness but otherwise sleeping for most of shift. Receiving D5 ½ NS ē 20 meq KCl @ 120 cc/hr and Morphine @ 5mg/hr. Pt turned to (R) side to facilitate drainage of colostomy bag. ∅ leaks noted from colostomy bag. Wound vac to mid-abdominal wound intact. Will continue to monitor. [redacted] LCT/AN
1700	Pt to sleeping in bed sedated ē MSO4 + Ativan VSS. Afebrile Dsg Δs complete. ∅ s/s of pain distress. Will cont to monitor [redacted]
1530	Pt easily awaken by touch pt received 1 mg Ativan

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted]

b(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1988)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

blue - 2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20Sept03	at 1900 VSS will cont to monitor — [redacted]
24Sept03	2330: RT note: Pt awake pre tx HR 91, RR 23, SpO2 96 on RA BBS CTA, UO A/O given. Post tx HR , RR , SpO2 97%. ϕ cough. Nurse states ~~just sx prior to tx~~ has sx a lot out of pt. Will continue to monitor — [redacted]
2200	pt lying in bed. VSS. Increasing agitated. Ativan + Haldol being used for sedation. — [redacted] 9/W/06
25Sep 0615	Received Report From Nightshift + Assumed care of Pt. VSS, Pt Lying in bed sleeping + appears to be resting comfortably @ this time. — [redacted] 9/W/06
1200	Pt mildly sedated c MSO4 @ 7 mg/hr c PRN Ativan. Received total of 2 mg @ 0900 - 1100. Wound vac intact + suction put out blood tinged secretions @ 100 cc @ 0600. JP x4 drained 5-10 cc of yellowish cloudy secretions. Dressing changed W-D to LE, Lead, R side flank + Axillary area. Wound appear clean. IV intact. D5W c 20KCl @ 120 cc/hr. Foley draining clear yellow urine q.s. Turned c assistance to skin breakdown in the sacral area. Afebrile VSS — [redacted] Maj (AN)
1600	Pt c intermittent agitation, well managed c Ativan 1mg - 2mg IVP, c MSO4 @ 7 mg/hr. Scant amt of dry secretions. RT came to administer neb treatment and reinstall NS air humidification. Afebrile, VSS — [redacted] Maj (AN)
25Sep 1810	Received report From dayshift. VSS, Pt appears to be stable. ϕ: Concerns or Problems Ntd in Report. Pt Lightly sedated c MSO4 @ 7mg/° + Scheduled + PRN Ativan. Will monitor. — [redacted] 9/W/06
1845	Assessment complete, see DA 4700 — [redacted] 9/W/06

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
Surgery 20040903	Progress Note Event - TO OR for STSG to Ant Abd wall VS - Stable AFeb 40 100-120cc/hr Chest CTA Abd - Vac Dressing in place ↓ contamination Stoma ↑ minimal output JPS 1 3 2 4 ext - Graft Donor site ok. LABS - 12.0 / 573 / 28.8 — 140 / 103 / 15 — 4.1 / 24 / 1.3 A/P Doing well POD#1 STSG plan to take Dressing Down Mon ~ Noon as long as it is not Contaminated off Abx 24 hrs ↓ Fever. Continue Current care. b(6)-2 [redacted]

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

b(6)-4 [redacted]

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES b(a)-2 All ↓
11Sep 2005	Pt becoming very aggitated + restless, Medicated ☇ 1 mg Ativan IVP Per PRN orders. VSS, Will continue to monitor. — [redacted] RWMG
2015	Pt Lying in bed sleeping + appears to be resting comfortable @ this time. Will continue current Plan of care. — [redacted] RWMG
2230	Pt Lying in bed sleeping + appears to be resting comfortably @ this time. VSS, Sedated ☇ MSO4, & Ativan, + haldol. Will continue to monitor. — [redacted] RWMG
2330-2345	Dressing Changes Performed, Pt tolerated well. VSS, Will continue to monitor. — [redacted] RWMG
12Sep 0200	Pt Lying in bed sleeping + appears to be resting comfortably @ this time. Lightly sedated ☇ MSO4 + Ativan currently. VSS, Pt appears to be stable @ this time. Will continue to monitor. — [redacted] RWMG
0345	Pt becoming aggitated, Medicated ☇ 1 mg Ativan. Will monitor for effectiveness. — [redacted] RWMG
0405	Pt Lying in bed sleeping + appears to be resting comfortably @ this time. VSS, Will continue ☇ current Plan of Care. — [redacted] RWMG
0600	Report given to Nightshift. — [redacted] RWMG

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO. ICU-1	

EPW # [redacted]

b(a)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
9/22/03	Surgery
	No events
	VSS Afeb.
	Wound Abd Take of About 50% of STSG
	to Dowbell did not take on Wound.
	WBC ↓ 16/10 today off Abx.
	A/p Advance diet.
	[redacted]
	b(6)-2
23 Sep 03	Received report from ongoing shift. Pt VSS, intermittent
0800	agitation reported. Plan: Wound care to the abd + [illegible]
	wounds as ordered. [redacted] Maj/AN
0900	Pt extremely agitated. Thru the interpreter "he thought someone
	was chasing to kill him". Gave Ativan 1mg c 4mg MSO4, c
	excellent result. VSS [redacted] Maj/AN
1430	Dressing to the wounds changed. Abdominal wounds
	packed c Vaseline gauze + W-D NS dressing. Site intact on
	the graft site. Pressure sore dressings changed wounds appear
	clean, debridement c sulfamylon W-D effective. (R) armpit
	dressing change c sulfamylon, site with adequate vascularization

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.

CIV [redacted]
b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 16567

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
23 Sep 03	b(6)-2 A11
1430	
23 Sep 03 1545	Nutrition Note: 56 yo M wt: 68 kg, ht: 64" Current diet order regular. Per nursing, pt refuses food, drinks juice + water. Pt receiving Jevity Plus TF @ 100 cc/hr, providing 2880 kcals/day exceeding his EEN of 1700-2040 kcals/day (25-30 kcals/kg) + 82-102 g pro/day (1.2-1.5 g/kg). Recommending a decrease in TF rate to 70 cc/hr to provide 2016 kcals/day, ~~#8~~. Decreasing TF may stimulate pt's appetite. Continue to encourage po intake. [redacted] RD/LD CPT, S
1600	Pt remained manageable ~~3~~ applying restraints all day ~~X~~ for one episode of restlessness early morning. VSS remained stable. Nutritionist came to evaluate nutritional status made recommendation on ↓ TF rate to 70cc/hr. MD made aware. Continues to have watery stools. Will recommend Antidiarrheal medication to MD —— [redacted] mg/m
1700	MD ordered Flagyl 500mg po/GT for "watery stool". Started first dose @ this time.
1820	Report recieved from Maj [redacted] Pt VSS, afebrile. Foley cath in place, PIV (R) wrist, #8 trach, 4 JP drains to ABD, G tube - jevity infusing @ 100 cc/hr —— [redacted]
23 Sep 03 2300	RT note: T collar off pt. Pre tx HR 99, RR 28, SpO_2 98%. VU: Alb neb given. BBS coarse. Post tx HR 97, RR-36, SpO_2 98%. Coughing up easily. Will continue to monitor — [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22 Sep 03	Change of shift. b(6)-2 All
0800	Received report from ongoing shift. Pt resting, calm and appear to be asleep. Easily arousable to verbal stimuli. VSS, no significant change from previous day. Plan: Continue c woundcare. Day 3 of wound vacuum. IP c minimal drainage c wound vac suction. MD made aware. Heat lamp placed on graft site @ this time. [redacted] Maj/AN
1200	Dressing changed to the LE x Lead. Changed ostomy bag, drained small amount of stools (watery). Ostomy site c adequate vascularization. Afebrile. VSS. Mildly sedated [redacted] Maj/AN
1500	Wound vacuum to sectional discontinued @ 1230. Graft site semi-grafted per MD. Changed packing to W-D dressing, wound appear clean. Other wounds packed c Dakins solution W-D. No other new issues @ this time. Started TF @ 30 cc/hr @ 1400, ~~Increase~~ increase by 10 cc q 2° until target rate of 100 cc is reached. [redacted] Maj/AN
23 Sep 0000	RT note: Pt resting. BBS CTA. Pre tx HR 95, RR 20, SPO2 97 on RA. UD Alb given. Post tx HR 98, RR 23, SPO2 98-100% on RA. Will continue to monitor [redacted] giving
23 Sep 0358	RT note: Pt awake. BBS coarse crears to cough. Pt coughed up ~ 5cc yellow thick sputum. Pre tx HR 98, RR 23, SPO2 on RA 97%. UD Alb given via t-collar neb. Post tx HR 98, RR 24, SPO2 98%. Pt tol well — Sgt [redacted] giving
23 Sep 03 0330	Emptied colostomy bag and changed sheets. pt is resting in bed c any complaints will continue to monitor — [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24sep(0100)	pt asleep @ this time. Ativan & Haldol used for agitation VSS [redacted] 9mm6
24 sep 03 @ 1010	pt report recieved From Spc [redacted] VSS Assessment WNL see flowsheet for details pt trach care complete pt restraint to wrist as per EPW protocol T- tube finished pt laying in bed c. eyes closed @ this time no acute signs of distress noted will continue to monitor [redacted] PFC G/Wing
@ 1520	pt dressing A's completed tolerated well
@1920	Report recieved from PFC [redacted]. pt VSS [redacted]
24 Sept 03 2345	Rt note: Pt agitated + moving about. Collar off. BBS coarse (-) wheezes. UD Alb neb given. Pre tx 112, RR 28 SPO_2 98% on RA. Post tx 114, RR 36, SPO_2 99% on RA. Will continue to monitor [redacted] (Sq given b(6)-2
2400	pt VSS, afebrile [redacted]
0600	Report given to dayshift [redacted]
25 Sep 03 @ 0730	pt report recieved from spc [redacted] VSS assessment complete pt resting quietly at this time no signs of acute distress noted @ this time will continue to monitor [redacted] PFC screen
@ 1105	pt VSS no problems at present will continue to monitor [redacted] PFC G/wing

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

EPW [redacted] b(6)-4

ICU 1

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(a)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
EPW [redacted]			

DATE	NOTES
25sep03 @1800	Report recieved from PFC [redacted] pt vss b(a)-2 [redacted]
@2200	pt vss, dressings to Abd & R shoulder, head and B/c done.
@0200	pt vss, afebrile [redacted]
@0600	report given to dayshift

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Nursing Notes
26SEP03	Received Pt #588 in ICU I Bed #2. Pt Alert. Moves all extremities. Pt is
0600	able to follow simple commands in english. Cardiac Monitor shows
	ST. ⊖ JVD ⊘ edema. all peripheral pulses ⊕. VS see intensive care flow
	sheet for more information. IVD5%NS ̄c KCl 20 meq at 75 cc/h infusing to left hand access
	site intact ⊘ s/s of infection or infiltration. MSO4 drip at 1 mg/h infusing to left
	hand IV access. Pt has trach on room air. Breath sounds clear bilaterally. Equal
	chest expansion noted. No sign of distress noted. Abdomen nondistended soft to
	touch. Nontender. Bowel sounds ⊕. Mid abdominal surgical wound covered with
	dry dressing. JP to be on left abdominal quadrant with [illegible]
	[illegible] colostomy to right abdominal quadrant. JP bulb suction x3 in use to abdomen.
	Foley cath in place draining yellow urine to bag. Skin warm to touch. See intensive care
0900	flow sheet for VS and more information. Pt agitated ativan 1 mg IV given.
1000	VS ativan effective. Am care done. all dressings changed. Trach care done.
1100	Pt agitated Haldol 5 mg IV given. Haldol effective [redacted]
1500	VS No distress noted Pt resting in bed [redacted]
1630	Dr [redacted] ordered VS Q4h. Pt agitated. Ativan 1 mg IV given
1715	effective. Pt resting No distress noted. MSO4 drip continues at 5 mg
1800	IVD5%NS 1 liter with 20 meq KCl at 75 cc/h continues. VS No distress noted.
	Report given to relief nurse [redacted] RN.
26Sep 1800	Received report from Night shift & assumed care of Pt.
	VSS, Will monitor. [redacted] [illegible]

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

b(6)-2

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

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

REGISTER NO. | WARD NO. ICU I

EPW # [redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16Sep 1900	Pt medicated c 5mg haldol due to aggitation Per PRN order. VSS, will continue to monitor. [redacted] 9/WM6
2145	New IV started. 20G to (R) FA. [redacted] 9/WM6
2355	Pt medicated c 1mg ativan d/t aggitation Per PRN order. Will continue to monitor. [redacted] 9/WM6
17Sep 0130	Pt medicated c 5mg haldol d/t aggitation Per PRN order. VSS, Will continue to monitor. [redacted] 9/WM6
0250	Pt medicated c 1mg ativan d/t aggitation. VSS. Will continue to monitor. [redacted] 9/WM6
07Sep03	Nursing Notes
0600	Pt Alert follow Commands No distress noted IVDS %NS1L 75cc/hr and MSO4 5mg/L in progress. Safety Plan/Book in progress. See cinta
0700	flow sheet for more information Dr [redacted] visited Pt. [redacted]
1000	VPI. AM care done. Pt's Dressings changed. Pt received ativan 2mg at 0250
1400	VIS No distress noted. MSO4 drip continues at 5mg/hr IVDS %NS1L 75cc/hr
1500	continues at 75cc/hr. Pt agitated at 1400 1mg IV given effe[redacted]
1800	Pt's condition unchanged MSO4 5mg/hr continues IVDS %NS1L 75cc/hr at 75cc/hr continues. Report given to relief nurse. [redacted]
1620	Report recieved from dayshift. pt VSS [redacted] 9/WM6
2200	pt vss, pt asleep @ this time. [redacted] 9/WM6
2400	pt Dressing As done [redacted]
0200	pt asleep VSS, afebrile [redacted]
0600	Report given to dayshift [redacted]
0605	Recieved Report from Spc [redacted] Pt. resting in bed c eyes opened. 0 distress noted. Assg 2 Completed @ present time. SM given also. Pt lying in back c eyes closed. 0 distress noted. [redacted]

STANDARD FORM [redacted] BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
	b(6)-2 All
0900	Pt restless. Ativan 1mg given IV for agitation. Will
28 Sept 13	Monitor. [redacted]
0950	Pt resting & distress SpO2 100 RR 23. Will cont to monitor. [redacted]
1114	Pt. cont. to rest & distress. Will continue to monitor
1200	Agitated: Ativan 2mg given for agitati[redacted] Will monitor.
1335	Pt. lying in bed c eyes closed. RR 20 SpO2 96%. [redacted] Will monitor.
1631	Pt resting in bed & distress @ present [redacted] Will monitor.
1731	Lying in bed c eyes closed. No distress noted @ present time. SpO2 100% RR 21. Will [redacted] continue to monitor.
1820	Report received from SGT [redacted] pt VSS. No significant Δ in condition over last 12 hours.
2230	pt dressing Δs done. Wounds healing well [redacted]
2400	pt lying in bed, restraints to BUE. Continues to be uncooperative. VSS [redacted]

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

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

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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

b(4)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
29 Sept 13	Haldol 5mg. IM given via LT. [redacted]
0810	
1000	Pt. continue to remain restless. Ativan 1mg given IV for agitation. Will mon[redacted]
1044	Resting in bed c eyes closed. No resp. distress @present time. Will continue to monitor.
1221	Continue to rest quietly in bed c eyes closed. Resp. non labored. No distress noted @ present time. Will [redacted] to monitor.
1325	Pt very agitated. Broke J-tube tubing. Haldol 5mg IV given for agitation. Will continue to [redacted]
1408	Pt. remain restless. Ativan 1mg given per for agitation. Will continue to mo[redacted]
1409	Deep Suction performed on pt. Thick white secretion noted. Will continue to monitor. [redacted]
1556	Pulled J-tube out. Will notify MD +
1628	J-tube replaced via DR[redacted] X-ray Of Abd ordered c contrast. Will mo[redacted]
1806	Received report from S67 [redacted] Pt resting comfortably in bed. Will continue to monitor. [redacted] SPC, USMC

STANDARD FORM 509 (REV. 6/1999) BACK

USAPA V1.00

b(6)-2 A11

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29Sep03	Dressing ∆ complete. VSS, Pt resting
2100	comfortably in bed. Will continue
	to monitor [redacted] SPC, 9WM6
30Sep03	Pt pulled out JP tube to ⓓ side abd.
0030	Uniformed MOD; Will continue to monitor
	MOD will re-evaluate site in the AM.
	[redacted] SPC, 9WM6
0100	Changed pt ostomy bag. Area looks
	pink and beefy. Will continue to
	monitor VSS. [redacted] SPC 9WM6
0300	Pt removed foley. Placed new foley
	@ 0310. Pt tolerated procedure well.
	Will continue to monitor [redacted] SPC 9WM6
0700	Received report from ongoing shift. VSS. No significant
	change from 24° shift. Foley replaced ∆ in place
	draining clear yellow urine. See flowsheets for other
	pertinent information. Plan: Continue c wound care ∆
	assist ADL ∆ nutrition care [redacted] SPC 9WM6
1200	Wound care done. Dressing to the abdominal wound
	change W-D c NS ∆ Xeroform applied. Wound clean
	c adequate granulation in the edges. No epithelial or

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

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

REGISTER NO. | WARD NO.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

b(6)-2 (All)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30 Sep 03	Odor noted, shrapnel wounds packed c̄ W-D (NS)
1200	appear clean s̄ exudate. Ostomy in place, emptied
	watery stool, yellowish brown. Pressure sore to the
	head & LE evidence of healing & debridement in progress.
	(R) axillary burn change c̄ W-D (sulfamylon) dressing,
	healing noted on the edges. Continue c̄ W-D dressing
	change, document progress — [redacted] Maj/AN
14~~00~~	~~Pt received 15cc~~ [redacted] Trach care performed. Pt
	awake c̄ ∅ s/s of pain or distress. Will cont to
	monitor. [redacted]
18~~00~~	Report & care of pt given to oncoming shift [redacted]
1810	Report recieved from SPC [redacted] pt VSS — [redacted]
2200	pt VSS, continues to be uncooperative, does
	not follow directions given thru translator.
	Restraints applied to BLE. [redacted]
0200	pt VSS drsg Δ's done [redacted]
0600	Report given to day shift — [redacted]
~~0800~~	Recieved PT from CPT [redacted] PT VSS, Trach in
	place & c̄ foley draining amber urine. Quanity sufficient.
1000	PT ↑ to Chair x2 hrs. PT displays slight weakness to
	V Ext x2.
1130	PT put back in bed ostomy bag Δ'ed and Abd Dressing Δ'ed.
1430	Trach Care Completed, VSS, sat 98% RA.
1730	PT Drinked one cup of Dinner, Noticed Maintance fluids
	were not running Restarted fluids D5 ½ [redacted] 075cc/h
	[redacted]

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

MEDCOM - 16577

ACLU-RDI 1637 p.137

DOD-029966

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
01 OCT 1800	Received report. b(6)-2 [redacted] LT/AN
1930	Assessment completed. [redacted] LT/AN
2200	Changed ostomy bag. Drsg Δ to abd, head, BLE. Retaped J-tube in place. [redacted] LT/AN
0600 02 OCT	Report given. Patient slept off and on throughout night. VSS remained stable. b(6)-2 [redacted] LT/AN
0615 02OCT03	Received report from Lt. [redacted]. Pt. resting in bed. ∅ discomfort noted @ present time. Ostomy bag half off. Bag Δ and new drsg.s & colostomy bag done. 0800 Pt. up to chair ∫ discomfort. Am care done @ that time. 1035 Pt. back to bed ∫ discomfort. Will continue to monitor for any distress. [redacted]
1212	Pt. resting in bed c eyes closed ∫ resp. [redacted] noted. Will continue to monitor. [redacted]
1512	Trach care completed @ present time. Resting up in bed attempting to make conversation c b(6)-2 staff members. ∫ Resp. distress noted. SpO2 100% Will continue to monitor. b(6)-2 [redacted]
1636	PT consult for pt. gait ∫ Bpc [redacted] PT tech. Will continue to monitor. [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

EPW [redacted]

b(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

b(6)-2 All

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
02Oct03 1741	Pt sitting up in bed c distress. Consumed 30% of Regular diet c difficult. Will continue to [redacted] for any SOB or resp. distress.
1830	Report recieved from SGT [redacted]
2200	pt VSS, trach care done
3Oct03 0200	pt VSS, awake in bed
3Oct03 0700	pt stable, tube feeds + IV fluids infusing [redacted]
1000	dress dsg wounds leaky well a abd + legs [redacted]
1500	trach Dcd c difficult occlusion dsg to neck [redacted]
1600	pt ambulate x 20 mins c walker + assistance [redacted]
1700	pt ambulated x 30 mins c walker + assistance [redacted]
1730	IV restarted 20 gauge in L arm LR infusing @ 75cc/hr [redacted]
3Oct03 1900	recieved report from day shift. Pt pain 0 0 BTC. Pt resting sitting in chair. will cont to monitor. [redacted]
3Oct03 2100	Walked pt c little assistance c walker, no signs of distress. Tolerated dressing change to abdomen, legs and neck, changed the colostomy bag. Semi solid substance in colostomy bag. Colostomy pink and moist, pt back in bed and resting will cont to monitor. [redacted]
4Oct03 0100	Pt ambulated c walker and minimal assistance. No signs of distress. will cont to monitor [redacted]
4Oct03 1130	Nursing: Pt sitting up in chair c 2 point leather ~~restra~~ restraints on B wrists. Pt voided on floor without asking for urinal. Pt also spitting on floor. Pt attempting to get out of chair. Bedsheet tied around pt's waist to keep pt in ~~bed~~ chair. Pt able to call (Cont'd)

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

[redacted]

MEDCOM - 16579

ACLU-RDI 1637 p.139

DOD-029968

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2400 5Oct	Atenolol given @ 2350, ambulated pt in unit, dressing changed. VSS [redacted]
0100	Pt ambulated in unit, positioned pt in bed for comfort afterwards. 10 mg Ambien given via J-tube
0500	Pt intermittently asleep. Awaken easily and attempts to get out of bed throughout the night. soft restraint on mitten glove on. chest restraint on. VSS will cont to monitor [redacted] CPT/pd
05 oct 03	pt report recieved from Cpt [redacted] [redacted] resting quietly in bed
@0640	@ this time no problems @ present will continue to moniter [redacted] PFC 91WM6
@1400	pt dressing Δ complete tolerated well pt walked to ICW 1 c̄ no problems pt [redacted] cooperative no problems @ present Assessment WNL see ~~AA~~ Flowsheet VSS will continue to monitor [redacted] PFC 91WM6
@1635	pt doing well lay in bed with eyes open VSS will continue to monitor throughout day [redacted] PFC 91WM6
18ØØ	Received report from day shift. Pt resting comfortably in bed. IV to Ⓡ AC c̄ 5% dextrose in ½ NS c̄ 20KCl going @75cc/hr. will continue to monitor [redacted] SPC, 91WM6
21ØØ	Dressing Δ complete. Pt tolerated procedure well. VSS will continue to monitor. [redacted] SPC, 91WM6
6Oct Ø3 2400	Pt ↑ out of bed. Walked up and down hallway to main hallway x2. Sat ↑ in chair for ½ hr Pt tolerated well, VSS will continue to monitor [redacted] SPC, 91WM6

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

MEDCOM - 16580

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

b(6)-2A11

DATE	NOTES
4 Oct 03	Nursing Cont'd: out J-tube. Dr. [redacted] notified
1130	J tube reinserted by Dr. [redacted] (1137) - Dr. [redacted]
	20cc Gastrografffin given via J tube, ~~xxxx~~ abdominal
	X-ray taken. Dressing change completed, pt
	tolerated procedure well. Wet to dry dressing
	done on mid-abdominal wound. Site healing
	well. Wet to dry dressing c Dakins solution
	done for (R) flank wound, and silvadene cream
	applied to burn sites. Rash noted on [redacted] 1149
	on skin surrounding ~~burn #s~~ burns. Possible
	allergic reaction from tape. Paper tape on oder
	cloth tape used. Pt sleeping quietly. WC
	continue to [redacted] 1158 monitor. [redacted] 49/sm
4 Oct 03	Nursing: Pt ambulated to ICU 2 using walker c
1725	minimal assistance.
4 Oct 03	Received report from previous nurse, pt sitting up in chair,
1800	will cont. to monitor, [redacted]
2000	Colostomy bag replaced, stoma healthy red, Ø skin breakdown
	noted around stoma, Dressing changed on mid
2400	Pt removed colostomy bag bag replaced, J tube placement
	Confirmed by X-ray by Dr [redacted] TF started @ 2300

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

b(6)-2 All

DATE	NOTES
6 oct 03	Pt placed back in bed. VSS. Will continue
0100	to monitor [redacted] SPC, 91WM6
0130	Pt placed on restraints. Continuously ~~[illegible]~~
	attempting to get out of bed. Will continue to
	monitor. [redacted] SPC [redacted] 91WM6
0400	Pt resting in bed. VSS. Restraints to (R) hand
	(L) leg. Will continue to monitor [redacted] SPC, 91WM6
0600	Reported off to day shift. R. [redacted] SPC 91WM6
	Nursing Notes
6 Oct 03	Received Pt in [illegible] 1 Bed #4. Pt alert follow commands. See Intensive
0630	care flowsheet for more information. Pt in bed No distress noted [redacted]
1000	VSS [illegible] done dressings changed Pt placed OOB to chair. [redacted]
1200	VSS Pt returned to bed. No distress noted [redacted]
1800	Pt's condition unchanged IV D5½NS [illegible] continues [illegible] Feeding [illegible]
	continues. Pt ate 20% of dinner. Report given to incoming nurse. [redacted]
7 Oct 03	Received Pt in [illegible] 1 Bed #4. Pt alert follows commands. See Intensive care flow
0630	sheet for more information. No distress noted. [redacted]
0800	Dr [redacted] [illegible] examined Pt. He ordered Pt to be transferred to
	ward. Clinic contacted for bed awaiting Bed assignment. [redacted]
1000	VS. Dressing changed done to all sites. Pt placed OOB to chair [redacted]
1200	VSS [redacted] noted. Pt to be transferred to [illegible] 2 Bed #1 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 16582

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Nursing Notes Cont'd.
1600	Pt's condition unchanged IV D5%NS+KCl at 75cc/hr. Foley patent.
1618	Report given to nurse on Ward 2. Pt transferred to Ward 2. [redacted] b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
3 Oct	Pt Awake + Alert, oriented x3, VSS, pt has Ø c/o of pain at this time, drsg to abd, right upper thorax, and shoulder CDI, PERRLA, Lungs CTA, Ø resp distress, colostomy intact with liquidy brown stool, 2 JP drains also in place + intact Ø s/s infection, trach dressing CDI, pt ambulated to wheelchair, pt voiding via urinal clear yellow urine, restraints x2 in place (+) circulation
	b(6)-2 [redacted]
	(1800) I concur c above assessment [redacted]
3 Oct 03 2005	VSS. AO. BS clear in apices & diminished in bases. BS (+) x4 c colostomy draining light brown stool, quantity sufficient. (+) pulses to all extremities & CR ≤ 2 seconds. JP #1 & #2 draining light green fluid JP #1 > JP #2. J-tube infusing [illegible] @ 100 cc/hr. Used IS on own accord c difficulty. Pt [illegible] upper body DSG's Δ c c/o pain @ this time. DSG to lower E's CDI. Abd wound beefy pink c ↑ granulation. W/D placed. Silvadene applied to (R) upper torso & arm. Trach DSG Δ'd & packed c [illegible] gauze. Cont to monitor. b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9Oct03 1600	Assumed care @ 0600. Pt A&O able to make needs known. Cardiovascular & Pulmonary system intact GI - Colostomy c large amount of performed light brown stool. Ostomy care done & bag changed. Stoma small & pink. Voiding clear yellow urine. Quantity sufficient via urinal. NAE. Skin warm & dry. R upper arm wound & LLE wound healing. Dsg's done. Abd dsg Δ by MD. JP x2 c minimal light brownish green drainage. J tube flushes well. Jevity @ 10cc. Dsg over old IV site intact. New fentanyl patch placed today. Am care done. Ambulating c asst. Will continue to monitor. Pt teaching on pt not touching wound sites during dsg Δ's. b(6)-2 [redacted]
(2030)	Pt alert, speaking un aroic, VSS, ϕ complaints of pain or discomfort. LCTAB, HRRR, colostomy draining loose light brn stool. Abd dsg Δ'd & RLE dsg Δ'd. silvadene applied. JP x2 c minimal brownish green drainage. J-tube flushed. Jevity running @ 10cc/hr. Dsg over IV site intact. +pulses to extr, voiding adeq. cyu via urinal. 2 pt restraints on c compromise to skin or circulation. Will monitor [redacted] 9 Nov 06 b(6)-2

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10 OCT 03 0800	Received pt resting in bed, VSS, tol po, fluids via g-tube @ 100 cc/hr via alaris pump. BBS, JP x 2 w/ gray colored drainage, colostomy to RLQ putting out liquid, non formed stool. trach dsg to ant neck c/d/i, dsg to abd c/d/i, d'd. Pt ant to request to staff to have colostomy bag d'd, repeated attempts to pt to explain that bag is not everyday. Assess pt in colostomy care, pt ant to need assistance for self care of colostomy. Pt adl to amb w/assist. & other remarkable assessments at this time. will cont to monitor pt. @ breakdown total @ this time [redacted] b(6)-2
10 OCT. 03 2030	Pt awake, taking orders, VSS, LS CTA (B), + BS x4, S1 S2 present, denies pain @ this time, colostomy bag on (R) UQ intact, liquid brown stool, dsg on (R) arm d'd, silvadene cream applied, dsgs on abd d'd, w → D, JP on RLQ draining minimal amount of gray drainage, Jevity tube feed @ 100 cc/hr, IS @ BS, voiding well, 2 pt restraint in place s s/sx of poor

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

E# [redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Cont.	circulation or skin breakdown [redacted] GW
11Oct03 0900	VSS Alert & oriented. OOB to chair for breakfast. Tolerated well. Lungs clear BS(D) x4 quad. Peripheral pulses +2. Drsg to Bil LE dry & intact. G-tube flushed without difficulty, Voiding clear yellow urine- JP x 1 = scant amt of serosanguinous drainage. Abd dsg dry & intact. Will change drsg later this shift. Will continue ostomy pouch & moist. Will continue care as planned [redacted]
11OCT03 2015	Pt A+Ox3, VSS, dsg's on abd I&D, W→D dsg applied to granulated tissue, JP drainage to (R) flank draining small amount of sero-sang drainage, pt spilled colostomy bag on bed, cleaned pt and I&D bed, colostomy bag intact, loose brown stool, dsg's on (R) arm area I&D, applied silvadene cream to burn sites, dsg's on LE x2 I&D, J-tube intact, Jevity feed @ 100cc/hr, IS @ bedside, voiding well c/y urine, 2 pt restraint in place S s/sx of complications. [redacted] GW

1

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

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
12 Oct 03	VSS Alert & Oriented, OOB c̄ walker to
0900	BR for shower, drsg des & colostomy
	care. Tolerating well ~~JP~~ JP x1 to
	bulb suction c̄ scant ~~amt~~ amt
	of drainage noted greenish color. Abd
	soft non distended. Voiding clear yellow
	urine. CT patent and infusing Jevity
	@ 100 cc/hr. Brown liquid stool noted
	in colostomy. Colostomy stoma pink &
	moist. Denies pain or discomfort @ this
	time. Will continue care as planned.
	b(6)-2 [redacted]
12 OCT. 03	Pt A+Ox3, VSS, J-tube to LUQ intact, Jevity
1900	@ 100cc/hr, JP (R) flank draining small amount
	of blood, dsg on old trach site CDI, dsg
	on (R) arm and upper chest Δ'd, applied silva-
	dene cream to burned area, dsg's on abd
	Δ'd, W→D dsg's applied, dsg on LEx2 Δ'd,
	voiding c/y urine s̄ diff, 2 pt restrain s̄ compl-
	ications. [redacted]
	b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 16588

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13OCT03	(1625) Assumed care of pt @ 0000 c report from night shift. Pt alert, speaking Arabic. VSS. ϕ c/o pain. Pt OOB to amb in hallway X2 this shift. Personal hygiene done in BR. Jevity @ 100cc/hr into feeding tube in (L) side of abd. Flushed c difficulty. JP to abd c scant amount serosang drainage. Wet → dry dsgs on abd Δd. Dsgs to BLE Δd. Silvadene applied to RLE and RUE / (R) shoulder burn wound. All wounds c s/sx infection. Colostomy bag intact. Pt doing own colostomy care. Dsg to old trach site Δd. Sutures intact. Pt tol. reg diet well. Voiding c difficulty. 2 point restraints in place c s/sx infection complication Will cont. to monitor. [redacted] b(6)-2
13OCT.03 2015	Pt A+O X3, VSS, LS CTA (B), @BSx4, colostomy care done, dsg's on (R) upper arm area Δ'd, applied silvadene cream to burn area, dsg's on abd Δ'd, W → D to granulated tissue, JP in place (R) UQ draining minimal amount of blood, JP tube on (L) flank infusing Jevity @ 10cc/hr, ϕ s/sx of infex, dsg's on LE x2 Δ'd, applied silvadene cream on burn sites on (R) LE 2 pt restraint in place c complications. [redacted] b(6)-2
14OCT03	(1355) Assumed care of pt @ 0000 c report from night shift. Pt alert, speaking Arabic. VSS. ϕ c/o pain. Pt OOB to amb in hallway X2 this shift c assist

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14OCT03	(1405) (cont.) Drsgs to abd Δd wet→dry - ϕ S/Sx of infection @ wound sites. Drsgs to BLE Δd. Silvadene applied to wound on RLE. Drsgs to Ⓡ shoulder/arm Δd. Silvadene applied to burn sites. colostomy bag Δd x2 this shift d/t leakage from bags. Sm. amount of soft brown stool in bag @ this time. Drsg to trach site Δd - sutures intact. Personal hygiene done by pt in BR this am. Tol. reg diet well. Tube feeding of Jevity infusing into tube on Ⓛ side of abd. JP on RUQ draining scant amount of sero sang drainage. Voiding ↄ difficulty. Will continue to monitor. b(6)-2 [redacted] WMD
(1905)	Rt alert, VSS, speaking arabic, ϕ complaints of pain @ this time. Abd drsg Δ'd. (WTD) Drsgs to Ⓑ LE Δ'd. Ⓡ arm drsg Δ'd. Silvadene applied. colostomy bag draining unformed yellowish-brown stools. Jevity infusing ↄ complication. JP draining scant sero-sang drainage. Restraints on while un'ded. ↄ compromise to skin/circulation. Will monitor b(6)-2 [redacted] gWMe

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

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

REGISTER NO.

WARD NO. CW#1

#[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15OCTØ3 @ 0200.	Jg tube flushed c 10cc NS colostomy bag emptied. Will monitor [redacted] qtwn. b(6)-2
15OCTØ3	(ØHAØ) Assumed care of pt via Ø600 p report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt amb well s assist. Personal hygiene done in BR. Colostomy beg Δd d/t leakage from old beg. Abd drsgs Δd this am wet→dry. Drsg to arm/shoulder burns Δd - Silvadene applied. Drsgs to BLE Δd. Silvadene applied to RLE wound. New Fentanyl patch applied to [redacted] side of CW. [redacted] to RUQ c scant amount sero-sang drainage. Feeding tube intact c gravity infusing @ 100cc/hr. Flushed c NS s difficulty. SL in @ forearm dlcd d/t infiltration. Voiding s difficulty. 2 point restraints in place s SISX complications. Will cont. to monitor. [redacted] b(6)-2
(1900)	Pt alert, resting ↑ un bed. VSS, Ø complaint of pain or discomfort. abd drsgs Δd (WTD) drsg to arms (R) Δd, silvadene applied. Gravity @ 100cc/hr unto (R) side of abd. flushed c 10cc NS, (3cc residual). trach drsg intact. JP drain to (R) abd. c scant sero-sang drainage noted. colostomy bag emptied by pt, loose brown stool noted, stoma moist & pink. Restraints on while un bed s compromise to skin or circulation. Will monitor [redacted] qtwn b(6)-2

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

[redacted] b(6)-9

MEDCOM - 16591

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
16OCTO3 1800	Assessment done. Pt. sitting up in bed, A&O. Colostomy care done. ~~Minimal~~ (N.D.) Scant amount of serosanguinous fluid in JP drain at ® LQ of abdomen. J-tube CDI. IVSL to ® FA. DSNG to ® LE Δ'd, CDI. Trach tube DSNG intact Δ'd 150CT No other significant findings. EPW restraint protocol used. ∅ signs of skin breakdown. b(6)-2 [redacted] GT, AW
16OCTO3 2000	Assumed care @ 1900; All WSS, pt A&O; ∅ c/o pain/discomfort @ this time; colostomy bag Δ'd d/t pt pulling old one off; abd dsgs Δ'd w→D; dsgs to arms Δ'd, ~~left~~ silvadene D/C'd; JP draining scant amt sero-sanguinous fluid; J tube intact infusing Jevity @ 100 c/hr; J-tube flushed c 30cc ~~H2O~~ NS ∅ difficulty; pt voiding ∅ difficulty; Restraints in place ® arm ∅ skin breakdown, cont to monitor b(6)-2 [redacted]
17OCTO3 (1300)	Assumed care of pt & ~~report~~ ∅ report from night shift. Pt alert, speaking Arabic. VSS. ∅ c/o pain. Pt OOB to BR for personal hygiene this am. Amb well. Dsgs to abd, RLE, and ® arm/shoulder Δ'd - wet→dry. Colostomy bag intact c sm amount loose brown stool. JP to RUQ c scant amount sero-sang drainage. G-tube clogged - unable to flush. Will notify MD. Insertion sites of JP and GT cleaned c 1/2 H_2O_2. Dsg to ~~trach~~ site Δ'd. Tol reg diet well. Voiding ∅

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)*

b(6)-4 [redacted]

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 16592

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(6)-2 & 11
17OCT03 (1325)	(cont) difficulty. 2 point restraints in place ∃ SISX complications. Will cont. to monitor. [redacted]
17oct03@2000	Assumed care @ 1800; All WSS, pt A&Ox3 speaking arabic; denies pain, OOB to amb to BR ∃ difficulty; dsg to (R) arm/shoulder Δd, Moist → dry; dsgs to abd Δd W → D; very very minimal drainage noted, ∅ S/Sx infection/dcy 4x4's bandaged wrapped ∈ Kerlix placed to (R) LE; New colostomy bag placed d/t pt D/C, - intact, Sm amt, loose brown stool; G-tube patent running devity @ 100 cc/hr; G-tube Flushed ∈ 30 cc NS; pt TOL Reg diet; Restraints in place, ⊕ circ, ⊖ SKin break +, Cont to monitor [redacted]
18oct03@0[illegible]	pt Alaris pump alarm continues to go off stating "Pt side occluded." Alaris pump was turned off; devity stopped; 6 attempts to contact SOD via radio were made ∃ Success; SOD was in neither the SOD on call room, nor his personal living quarters, Plan: ~~to~~ ERROR ~~to~~ Alert oncoming shift of problem; see if they can notify his personal MD; Cont to monitor [redacted]
18OCT03	(1335) Assumed care of pt @ ⊕0000 ∃ report from night shift. Pt alert, speaking Arabic. VSS. ⊕c/o pain. Pt amb to X-ray this am for contrast study to verify placement of J-tube. Correct placement verified by radiologist. CT done to r/o free air in abdomen. ⊕ free air viewed per radiologist. Pt amb from CT room to ward ∃ difficulty. Drsgs to abd, RLE, shoulder and (R) arm Δd moist → dry. Colostomy bag Δd this am. Bag intact ∈ small amount loose brown stool. devity infusing into J-tube @ 100cc/hr. Tol. reg diet well. Voiding ∃ difficulty. Drsgs to old trach site and old IV site Δd. 2 point restraints in place ∃ SISX complications. Will continue

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18OCT03 (1335)	(cont) to monitor. b(6)-2 [redacted] MA
18OCT03@ 1842	Pt AAO×3. Denies any pain. Jevity ++ infusing at 100cc/hr ∅ difficulty. ⊕ Lung sounds clear through all lobes. Abdomen soft + non tender. ⊕ Bowel sounds. Colostomy bag draining loose brown stool. ⊕ pedal pulses. 2 pt restraints c ⊖s/sx of skin breakdown. DSG to trach ⓟ Arm+chest, + Abdomen CDI. b(6)-2 [redacted]
2000	DSG Δ's completed. Abdominal wound ⊖s/sx of infection. Pink tissue c granulation. ⓟArm + ⓡchest - ⊖s/sx of infection. ⓟ⊖ - ⊖s/sx of infection. MD looked at wounds. Continue W-D-D. [redacted]
19OCT@ 0600	~~D~~ Total 18-19Oct03 I: 2780, O: 1600 [redacted] b(6)-2
19OCT03	(1900) Assumed care of pt @ desk ⓟ report from night shift. Pt alert, speaking Aebic. VSS. ⊖ c/o pain. Pt amb in hallway x2 this shift ∅ difficulty. Abd drsgs Δd wet → dry, drsgs to ⓡ shoulder/arm Δd moist → dry, wound on ⓡ leg dressed c moist → dry drsg. All sites ∅ s/sx infection. Jevity @ 100cc/hr infusing ∅ difficulty into J-tube. Tol reg

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)*

b(6)-4

[redacted]

REGISTER NO.

WARD NO. KWH1

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19OCTØ3 (1700)	(cont) diet well. Voiding ⊼ difficulty. Colostomy bag intact ⊂ sm. amount loose brown stool. Pt doing own colostomy care well. 2 pain restraints in place ⊼ SBS complications. Will cont. to monitor [redacted] 91WM6
19OCTØ3 2045	Pt awake and lying in bed. Colostomy care completed. Dsg Δ's completed. VSS Ø c/o ~~of~~ pain. Dsg to ®LE CDI. Dsg to Abd. CDI. Dsg to ® pectoral CDI. Dsg to ®Bicept CDI. Will continue to monitor [redacted] 91WM6
20 OCTØ3	Surgery No complaints VSS AFeb wounds All closing May need STSG to Ant Abd. A/p Dsg well cont conservative. [redacted] b1c) - 2 A11
20 OCTØ3 (0800)	Pt awake, speaking arabic, VSS, MD@BS. colostomy care done, bag Δ'd. drsgs to abd, ®arms, trach site Δ'd. Qutty 100cc/hr urine using into ® J-tube. J-tube flushed ⊂ 20CCNS, HCTAB, productive cough. IS use encouraged. 2 pt restraints on ⊼ compromise to iskem or circulation. Will monitor [redacted] 91WM6
(1000)	Pt ambulated in hallway ⊼ difficulty [redacted]

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
20 Oct 03 1215	Nutrition Note: Pt c GSW to ABD. Est wt: 80 kg (per nsg.) Currently on Jevity Plus TF @ 100cc/hr providing 2880 kcals + 133g Pro/day. ENN: 2000-2400 kcals/day (25-30 kcals/kg) + 104-120g Pro/day (1.3-1.5 g/kg). Recommend ↑ TF rate to 83cc/hr, providing 2890 kcals + 110g Pro/day. [redacted] RD/LD b(6)-2 CPT, 88
20 Oct 03 2230	Assumed care of pt @ 1800 hrs. Pt has J tube c S/Sx of infection. Jevity @ 100cc/hr. Voiding c/v spontaneously ~~BT~~ c ~~BM~~ difficulty/pain. Pt denies pain. Abdominal c (L) LE Drsg Δ'd. All Drsg c DI colostomy (R) LQ c DI c Brown loose stool. Will continue to Monitor. b(6)-2 [redacted] Spec 911H/
(0900)	Pt A/O x3, VSS, Ø c/o pain, colostomy bag Δ'd, stoma care done. drsgs abd & (R) arm Δ'd. Jevity @ 100cc/hr infusing. TLC use encouraged. Q2° turning encouraged to prevent future skin breakdown. 2 pt restraints on c compromise to skin or circulation. Will monitor [redacted] 911WMC b(6)-2

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

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

b(6)-4

[redacted]

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 16596

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21004080 2041	Pt laying in bed. Denies any pain. Lung sounds clear through all lobes (+) bowel sounds. (+) colostomy bag draining loose brown stool. D'ed bag 2° leak. Pt urinating in urinal clear, yellow. Drsg D'ed completed. Abdominal wound (S) S/SX infection. Has pink + white granulocyte. (P) chest ~~drsg~~ drsg is has green + yellow drainage c slight odor (P) leg drsg has small amount of green drainage from site. bld-2 [redacted]
22 OCT 03 0200	Assumed care of pt A+O x 3. VSS Ø c/o pain or discomfort @ this time. Lung clear ~~RRRR~~ Active BS Colostomy (R) UQ abdomen in light brown ~~liquid~~ liquid stool. Perform self care stoma beefy red vascular Urinates per urinal QS. Feeding Tube (L) LQ ~~abdomen~~ Levity 100 cc/hr. Wound assessment: GSW to (P) LQ. Prior Ex Lap wound open to air healing. (R) axillary superficial wound open to air Ø active bleeding. Escar small amts. Fentanyl patch in place ~~(R)~~ (L) shoulder wall - Will send to morgue bld-2 [redacted]
3 OCT 03	1145 - Returned from OR via litter. Pt A+O x 5 VSS LS CTA (B), resp even unlabored, BS x4. Drsng to abd/chest/arm CDI (R) thigh drsng CDI. drsng to (L) LE CDI. IV (L) FA CDI. colostomy bag intact c light brown liquid stool & stoma beefy red, voiding per urinal. Feeding tube intact (L) a. Tube feeding flushed c 10cc NS. Pt. has Ø complaints @ this

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
23Oct03	Surgery Op Note
	Procedure STSG from (R) thigh to Abd/chest/Arm
	Surgeon [redacted] b(6)-2
	Anes GEN Basic
	IVF
	Findings: 18 cm STSG taken from R thigh
	Applied to open wounds
	(R) low leg wound Debrided
	to PACU in good cond. b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES b(6)-2 [redacted]
(cont'd)	time. Will cont. to monitor Pt [redacted]
23 Oct 03	Pt resting in bed. NAD. I concur c̄ above
1300	assessment. 2 pt restraint. Ø skin or wound
	circulation problems. Will continue monitoring
	throughout shift. b(6)-2 [redacted]
23 OCT 03	Pt resting in bed, A+O x3, VSS, LS CTA (B), ⊕
1930	BS x4, colostomy bag intact, stoma appears
	beefy red, brown loose stool, J tube (L) side
	of abd intact + clamped, dsg on abd secured
	c̄ staples CDI, dsg to (R) leg CDI, Ø c/o
	pain or discomfort, tol PO well, IV (L) FA
	H/L'd, Ø s/sx of infex or infiltration, voiding
	s̄ diff, 2 point restraint in place s̄ s/sx of
	complications. b(6)-2 [redacted]
	I concur c̄ above assessment [redacted]
24 OCT 03	- Assumed care of pt. A+O x 3. VSS Ø c/o pain or
0200	discomfort @ this time Fentanyl patch 50 mcg placed
	(R) chest wall. Lungs clear non productive cough. HRRR Active
	BS poor appetite Feeding tube clamped (L) abdomen (R) colosto.
	self care. Ambulates to BK Urinates s̄ difficulty. Skin good
	to burns and abdominal wound CDI Afebrile Will monitor [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

[redacted]
b(6)-4

MEDCOM - 16599

b(6)-4

#[redacted]

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(2100)	Rt a&o x3, VSS, ø c/o pain. HCTAB, HRRR, ⊕ BS x4qd. J-tube to ⓓ abd: tube care done, feeding restarted @ 75cc/hr. flushed c 10cc NS. S dis/bicultty. MD to change STSG site in 3-5 days. ⓑ ankle WTD dsg Δ'd: serosang drainage noted. ⓑ thigh graft site dsg dry & intact: retaped. colostomy bag intact - pt does own colostomy care. Encouraging Q2° turns to prevent any skin breakdown. 2 pt restraints on S compromise to skin or circulation. Will monitor [redacted] b(6)-2 9IWM6.
25 oct 03 0700	-Assumed care of pt. A+O x 3. VSS ø c/o pain or discomfort Lungs clear HRRR Active BS colostomy ⓡ UO self care. feeding tube to ⓛ abdominal wall Jevity @ 75 cc/hr. Wound assessment - Multiple skin graft to abdomin ⓡ upper arm and chest ⓓ LE moist dsg Q6° wet to dry ⓡ LE ø s/s of infection Encourag position change ø evidence of skin breakdown noted Will cont to monitor [redacted] b(6)-2 9IWM6
26 OCT 03 0230	Assumed care of pt @ 1800 hr. VSS denies c/o Pain at this time. Tube Feed of Jevity @ 75 cc/h via J tube. J tube flushed + Patent. Colostomy SelF care completed. RLE Dsg wet. Dsg'd. Skin Graft Sites to Abd and RUE moistened [redacted] b(6)-2 9IWM6

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

b(a)-2 AM

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
26 OCT 03 0200	- Assumed care of pt. A&O x3. VSS c/o pain to ⓇLE burn wound. Medicated c relief. Lungs clear HRRR Active BS Colostomy to ⓇUQ abdomin self care per pt. Wound accessment multiple skin graft siter. Ⓡupper chest wall and arm and abdomin dsg Q60 NS wet to dsg. keep dressing moist. ⓇThigh donor site 4x4 dsg intact. ⓇLE ankle burn eschis wrapped @ s/s of infection will cont to monitor [redacted] Nurse
27 OCT 03 0200	Assumed care of Pt @ 1800 hrs. Pt A&O Speaks limited amount of English. Pt Denies pain. Pt completes colostomy care. ~~RLE~~ J Tube in LUQ Ivuity Fed @ 75cc/h. Graft site on Abd Dsg CDI [redacted] dsg on ~~RE~~ ~~RE~~ chest ~~RE~~ and RUE CDI. Soaked c NS q 6°. Am[redacted] c unsteady gait. Will continue to monitor. [redacted] RNMB
27oct03	Assume care of Pt @ 0600. C/O @ pain, A&Ox3, VSS Dsg, A to abd graft site, WD dsg, to Ⓡ leg. Ambulatory to bathroom, Exercise in hall. Colostomy, bag intact. No signs of infection at dsg A sites. Will cont. to monitor. [redacted] RN/BSN
27OCT03 2200	Assumed care of Pt @ 1800. Denies pain @ this time. Drsg to Abd A'd silvadene cream applied. chest and RUE ~~RE~~ Drsg moistened c NS. Colostomy has minimal stool output. J tube flushed c [redacted] nt. Ivuity Infusing @ 75cc/h via J tube. RLE [redacted] A. Will continue to be monitored. [redacted] RNMB
	Assumed care @ 1800; A&Ox3, VSS, pt A&O speaking arabic; @ c/o pain; dsg to Ⓡ LE A&D w→D; Ⓡ thigh donor site A&D; abd skin graft site A&D c silvadene cream @ s/sx infection; dsgs to ⓇUE &Ⓡ chest CDI, @ drainage; colostomy intact, pt performed own colostomy care, J-tube patent, Ivuity running @ 75cc/hr; Restraints in place, Ⓟ circ, @ skin break ✱, Cont to monitor [redacted] RN/BS

STANDARD FORM 509 (REV. 5/[illegible]) BACK
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28 Oct 03	Surgery No complaints VSS Afeb Skin graft sites with good take Donor covered. Afp Doing well BID silvadene to STSG sites with interstices closed. b(6)-2 [redacted] Dry

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29 OCT 03 1205	VSS. AO. Tolerating PO well. Seen by MD this AM for DSG change to RLE. Open bx to all extremities. BS @ x4. Up ad lib to ambulate for 30 min and tolerated well. DSG's to arms (R) and abdomen CDI. b(6)-2 (-) s/s skin breakdown. [redacted]
29 OCT 03 2300	Assumed Pt ~~care~~ care @ 1800. Pt Denies pain. Dsg to RLE Ad. Wound has yellow coloring to area. Appear as individual packets. Dsg to Abd Ad. [redacted] wound rinsed ∈ NS @ Silvadene applied, IV [redacted] J Tube Flushed ∈ Patent. Will cont to Monitor = [redacted] Spc911AM
30 OCT 03	(1900) Assumed care of pt @ 0000. Pt alert, speaking Arabic. VSS. ∅ c/o pain. Dsgs to graft sites Ad. Silvadene cream applied to sites. ∅ S/Sx infection. Colostomy bag Ad d/t leakage from old bag Pt OOB to amb in hallway - tol. well. Dsg to RLE Ad WTD. ∅ S/Sx infection. J-tube to LUQ flushes ∈ difficulty. Tol reg diet well. Voiding ∈ difficulty. 2 point restraints in place ∈ S/Sx complications. Will cont. to monitor. b(6)-2 [redacted] MAW
30 OCT 03 2200	Assumed care of Pt @ 1800. A&O, Dsg to LLE Ad. Wound is red granulated ∈ small area of yellow. Dsg to

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

[redacted]
b(6)-4

ST NAME		AE	MIDC	ID NUMBER

DATE	NOTES
	b(6)-2
30 oct 03 Continued	~~Abd~~ Abd Δ'd cleand wound ε NS and applied Silvadene. Dsg to RUE Δ'd, cleand wound ε NS and applied Silvadene. Pt completed colostomy care. [redacted] will continue to monitor. Sgt 9th MP
31 oct 03	Assumed care @ 0600; All VSS, pt A&O speaking arabic; Ø C/o pain or discomfort; abd dsg Δ'd, wound cleansed ε NS & Silvadene wound applied, staples to skin graft ~~all~~ D/Cd per MD; dsgs to ®UE & ® chest wall Δ'd ε Silvadene applied; dsg to ®LE Δ'd w ~~2D~~; All dsgs Ø s/sx infection; ~~pt performed own colostomy care~~; J-tube patent patent, flushing ∃ difficulty; OOB to amb in hall ∃ difficulty; pt voiding Ø's, clear, yellow urine ∃ difficulty; TO! Pour U; Restraints in place, ⊕ circ, Ø skin breakdown, cont to monitor [redacted] b(6)-2
31 OCT 03	Gen Surgery Pt. doing well No issues All staples removed from grafts RLE wound healing well Dsngr ε gauze still intact Continue/current care
1 NOV 03	Surgery No new issues No A's Continue local wound care to RLE

[redacted] b(6)-2

[redacted] b(6)-2

[redacted] b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
01NOV03	(1520) Assumed care of pt @ 0000. Pt alert, speaking Arabic. VSS. ϕ c/o pain. Pt amb well in hallway. Colostomy bag Δd d/t leakage from old bag. Drsgs to skin graft sites Δd. Silvedene applied to wounds. WTD drsg on RLE Δd. ϕ S/Sx infection @ wound sites. Tol reg diet well. J-tube flushes well. Voiding S difficulty. @ point restraints intact S S/Sx complications. Will continue to monitor. b(6)-7 [redacted] (USA)
01NOV03 1900	VSS OOB → Amb to BR. Voids clear yellow urine. Consume 80% of Regular diet for dinner. Colostomy ~~drainage~~ draining soft brown stool. Dsg C/D/I on arrival. Will continue plan of care b(6)-7 [redacted]
02NOV03	(1315) Assumed care @ 0600. Pt alert, speaking Arabic. VSS. ϕ c/o pain. Drsgs to skin graft sites Δd. Silvedene applied. Pt doing own colostomy care. Amb well. WTD drsg to RLE Δd. ϕ S/Sx infection. Tol reg. diet well. Voiding S difficulty. J-tube flushes well. @ point restraints in place S S/Sx complications. Will continue to monitor. b(6)-7 [redacted] (USA)
2NOV03 2000	VSS Alert & oriented. Consumed 70% of dinner. (L) Upper arm & (R) chest thru E pink moist tissue noted. ABD wound E graying color. Colostomy stoma pink & moist. (R) LE wound E pink tissue noted & small amt yellow/tan exudate noted. Will continue care as directed [redacted]

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

[redacted] b(6)-4

MEDCOM - 16605

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3 NOV 03 @ 1400	V.S.S., A&Ox3. Pt. resting quietly in bed, All DRSNG's Δ'd, Silvadene applied to graft sites. W→D DRSNG Δ to ®LE, Colostomy care done by pt. Pt. ambulates ⊽ difficulty to BR and in hallway. J-tube removed from AR by MD, covered ⊽ dry gauze. Pt. in 2-point restraints Ø signs of skin breakdown. All other assessments WNL. b(6)-2 [redacted] 2LT, AN
3 NOV 03 @ 2330	assumed care of pt @ 1800. VSS, Ø to some pain around RU abd incision, Pct for ⊽ meds. LS CTA, ⊕BS, ⊕stool in colostomy; Voids per urinal ⊽ difficulty. Tol reg diet well. Up Amb ⊽ difficulty. RLE WTD drsg Δ'd, healing granulating tissue noted ®arm, chest & abd wounds cleansed ⊽ saline, Silvadene applied. Pt ↑amb ⊽ assistance. Plan: monitor drsgs, enc po intake. Cpt restraints on ⊽ S/Sx skin circulation compromise. Will Cont. to monitor. b(6)-2 [redacted] RN
04 NOV 03 (1025)	Assumed care of @ 0600 ⊽ report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt. amb well. Drsgs to skin graft sites Δ'd. Silvadene applied to wounds. WTD drsg to RLE Δ'd. Ø S/Sx infection @ wound sites. Colostomy bag intact ⊽ sm.

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.

b(6)-4 [redacted]

AUTHORIZED FOR LOCAL REPRODUCTI

MEDICAL RECORD | **PROGRESS** **ES**

DATE	NOTES
04NOV03 (1025)	(cont) amount soft brown stool. Pt cont. to do own colostomy care. Tol. reg. diet well. Voiding w/o difficulty. 2 point restraints in place w/ s/sx complications. Will cont. to monitor. [redacted] b(6)-2
4NOV03@ 2300	Assumed care of pt @1800. VSS. C/o pain to RLE. LS CTA, +BS, + stool to colostomy RLQ, Tol. reg diet well, void per urinal & amber urine w/ difficulty. ML abd wound & (R) chest & (R) arm wound cleaned TNS & s/i/radene applied. RLE wound healing, granulating tissue noted, o drainage, WTD disc'd. 2pt restraints on w/ s/sx of skin/circulation compromise. Plan: enc po intake, enc AMB, enc independence. Will cont. to monitor. [redacted] b(6)-2
5NOV03	No New Issues All wounds healing well If a little granulation bed develops on the RLE, may be able to graft if in a week

[redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO. KW1	

#[redacted]

b(6)-2

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
05NOV03	(1045) Assumed care @ 0800. Pt alert, speaking arabic. VSS. 0 c/o pain. OOB to amb in hallway S difficulty. Drsgs to graft sites and RLE Δd C MD present. WTD drsg applied to RLE. Moisturin cream unavailable in hospital. Vaseline gauze applied to graft sites. Will notify MD. Colostomy bag intact C sm. amount soft brown stool. Pt cont. to do own care. Pt voiding S difficulty. Tol. reg diet well. 2 point restraints in place S S&Sx complications. Will cont. to monitor. – b(6)-2 [redacted] MAW
5NOV03 @2300	assumed care of pt @ 1800. VSS. 70 C/O. Alert, speaking little English, is OA; ⊕BS, tol reg diet, ⊕BM soft & brown per colostomy; void per urinal QS. Pt ↑ AMB S assistance. MI and S ⊕ chest/arm drsgs Δd, Silvadene applied to wounds. RLE calf drsg Δ WTD, ⊖ drainage noted. 2 pt restraint on S S/Sx skin/circulation breakdown. Plan: enc AMB, enc independence, monitor drsgs. [redacted]
6 NOV03 0700	– Assumed care of pt. A+O x3. VSS Denies b(6)-7 pain or discomfort @ this time. Lungs clear HRRR Active BS. colostomy ⊕ VO self care stoma vascular. Multiple skin grafts to chest and axillary region. Burn to ⊕ RLE dry dsg xerlix wrapped Sylvadene applied to wounds. Absence of S/S of infection. Will cont to monitor [redacted] b(6)-2 grafts

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

MEDCOM - 16608

LAST NAME	'ST NAME	E INITIAL	ID NUMBER

DATE	NOTES
8 NOV 03 0200	- Assumed care of pt. A+O x3. Sleepy yet easily arousable. VSS Denies pain or discomfort. Multiple skin graft sites dsg CDI sylvadene creme applied. Donor site healing well. (R)LE wound sm amt of active bleeding. Wet + dry dsg kerlix wrapped CDI, Lungs clear HRRR Active BS colostomy self care ambulates ↓ difficulty urinating spontaneously Will cont to monitor b(6)-2 [redacted]
8 NOV. 03 1930	Pt A+O x3, VSS, LS CTA (B), (+)BSx4, Ø C/O pain or discomfort, dsg's on abd + (R) arm + chest d/d, applied silvadene to wounds, W→D dsg Δ'd on (R) lower leg, colostomy bag intact + empty, voiding qvu to urinal w/o diff. 2 point restraint Ø complications. [redacted] 9 NOV b(6)-2 [redacted]
9 NOV 03 0700	- Assumed care of pt. A+O x3. VSS Ø c/o pain or discomfort voiced having not slept well last night. Lungs clear HRRR BP WNL Atenolol 50mg QD cont. Active BS colostomy self care tolerating PO well. Voids QS spontaneously per urinal. Wound assessment: Multiple skin grafts to upper chest wall and axillary region healing well. skin graft also to abd. Sylvadene creme applied dry dsg CDI. Wound to (R)LE ankle wet + dry small amt of bleeding kerlix wrapped. Ø evidence of skin breakdown noted Will cont to monitor b(6)-2 [redacted] wound.

b(6)-4 [redacted]

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

MEDCOM - 16609

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7NOV 0005	Pt ⊖ c/o pain. Ⓣ colostomy bag ~~draining~~ intact + draining loose brown stool. Pt empties own bag. DSG to abd, chest, + arm completed. Silvadene to wounds as per order. Ⓡ ankle WTD DSG completed. Pt amb to BR c steady gait. VSS. Pt asleep + resting comfortably [redacted] b(6)-2
7Nov '03	pt AOx3, VSS ⊘ c/o pain at this time. dsg to Ⓡ upper thigh, Ⓡ scap, sternal/abd region covered with silvadene cream thin 4x4s, wounds healing well, restraints x2 in place. ⊕ circulation intact. grp. [redacted]
8NOV@0010	VSS ⊖ c/o pain. Completed DSG to Ⓡ ankle. WTD. Silvadene cream placed on Abd, chest, + Ⓡ arm. Covered areas w gauze. Ⓣ colostomy bag draining loose, brown stool. Pt asleep at this time. [redacted] T/IV b(6)-2
8NOV03	Surgery No New Wounds May try to place STSG to RLE in +-1 wk [redacted] b(6)-2

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

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

b(6)-4 [redacted]

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 16610

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9 NOV 2000	USS Alert & Oriented. (R) L Leg wound tissue pink & moist wound drainage noted. (R) chest and (R) upper arm ~~2nd~~ second degree burns c pink moist tissue noted. ABD wound with wavy looking ~~edge~~ tissue present ~~coating~~ of yellow in color. Colostomy stoma pink & moist. Urine clear yellow in color. Denies pain or discomfort. Will continue care as planned. [redacted] b(6)-2
9 NOV 03	Surgery Doing well RLE wound healing Plan to place STG next week [redacted] b(6)-2
10 NOV 03 1420	Assume care at PT @ 0600. VSS, A+Ox3 In Rpt restraints without any skin irritation. WD drsg ∆ to (R) lower leg, CDI. Abd, chest, arm silvadene was applied c 4x4; area healing nicely. Ace c dostomy c assistance. Will cont to monitor. [redacted] b(6)-2

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

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 16611

DLW-2 thru 11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 NOV 03 2000	Pt A+Ox3, VSS, dsg's to abd, (R) arm, chest Δd, Ø s/sx of infex, silvadene cream to graft sites, WTD to (R) leg, Ø c/o pain or discomfort, colostomy bag intact, 2 point restraint, Ø complications, LS CTA(B), (D)BSx4, [redacted] flw
11 NOV 03	Assume care of Pt A+Ox3, VSS. Ø c/o pain. Ambulate without assistance. Δd colostomy bag. WTD to (R) leg. Δd Abd and (R) arm dsg; ~~c~~ silvadene cream. Ø signs of skin irritation at 2pt restraint sights. [redacted] flw
11 Nov 03	Assumed care of Pt. A+O VSS Ø c/o pain. Dsg to abd and (R) upper torso and RUE Δd. silvadene cream applied. skin appears red around wounds where Tape is touching skin. Will cont[redacted] to monitor. Spc 91WML
12 NOV 03	Surgery No issues Will plan to debride wound + place STSG Monday [redacted]
12 NOV 03	(1155) Assumed care Ø Pt. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt OOB to amb in hallway. Pt did own colostomy care in BR. Dsgs to skin graft sites Δd - silvadene applied to sites. WTD dsg on RLE Δd. Ø S/Sx infection Ø wound sites. MD present Ø dsg Δs. Tol. reg diet well. voiding

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
12NOV03 (1155)	(cont) s̄ difficulty. 2-point restraints in place s̄ s/sx complications. Will cont. to monitor. b(6)-2 [redacted]
12 Nov 03	Assumed care of Pt @ 1800 hrs. Pt Denies Pain. VSS A&O. Drsg to RLE Δ'd. Wound is Pink & Smooth in appearance. Wound also appears to be smaller in size. ~~Afte~~ compare to several Days ago. Drsg to Abdomen, torso & RUE Δ'd. Silvadene applied. Pt Scheduled for STSG next week. Will continue to monitor. b(6)-2 [redacted] 91WMb
13NOV03@1300	Assumed care of pt. @ 0600. V.S.S., A&O, Ø c/o pain. Pt. OOB to BR this AM, ambulates well in hallway, steady gait. Colostomy care done & bag Δ'd. Silvadine applied to graft sites, dry gauze covering. W→D dressing Δ to Ⓡ LE, minimal sero-sang. drainage to old dressing. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted] b(6)-2
13 NOV. 03 2015	Pt A+Ox3, VSS, LS CTA Ⓑ ⊕BS x4, colostomy bag intact, abd dsg Δ'd, silvaden applied to all graft sites, Ⓡ arm + chest dsg's Δ'd, ø s/sx of infex, WTD to RLE covered c̄ kerlix, 2 point restraint s̄ s/sx of complications. b(6)-2 [redacted] 91W
	I concur c̄ above asses[redacted]

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

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

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

[redacted]
b(6)-4

REGISTER NO. | WARD NO. ICW'

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14NOV03	Man for surgery for STSG Monday [redacted] b(6)-2
14 NOV03@1600	Pt. resting quietly in bed, V.S.S., Ø c/o pain. Pt. OOB to BR this AM, performed own colostomy care, ambulates well in hallway, steady gait. All dressings A.d as per MD orders, Ø signs & infection. Minimal serosanguinous drainage to (R) LE wound. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL, Will cont. to monitor. [redacted] b(6)-2 CT, AN
14 Nov 03	Assumed care @ 1800. Pt A&O. Ø c/o pain. Drsg to RLE Δ. Wound is pink & moist Healthy in appearance Healing well. All drsg to torso Δ'd Silvadene applied. 2 point restraint Will cont. to monitor. [redacted] Sp 9 WMb
15 NOV03	Surgery Monday. No new issues [redacted] b(6)-2
15 NOV03 @ 1600	Assumed care of pt. @ 0600, V.S.S., A&O, Ø c/o pain, Frontanyd patches intact, All dressings Δ'd, Ø signs/ symptoms & infection. Pt. OOB to BR, ambulates well. New colostomy bag, old bag was leaking. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. [redacted] CT, AN b(6)-2

[redacted] b(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS N**

DATE	NOTES
15 Nov 03 2300	Assumed care @ 1800. VSS. LS CTA (B) S, S2 Present (+) BS x4 quads. Void spontaneously c difficulty. Wound to (R) LE pink healthy and healing well. W→D dressing Δ completed. Skin graft wound [redacted] Abdomen Torso e RUE cleaned and Silvadene applied. Will cont to monitor. b(6)-2 [redacted] Spc 9114MM6
16NOV03	(0900) VSS. (-)c/o pain. Pt ambo steady gait to BR. Pt empties own colostomy. Colostomy draining light brown, soft stool. DSG Δ's completed. WTD to (R) ankle. Area pink c (-)s/sx of infection. Silvadene cream placed to mid Abdomen, (R) pectoral area, (R) bicep, + covered c gauze. Tol DSG Δ well. Pt tol po diet well. b(6)-2 [redacted] 20TIAW
16Nov03 2000	VSS (-) c/o pain, LS CTA (B) HRRR, (+) BS x 4 quads, Colostomy Intact. Dsg to (R) Ankle Δ'd Wound is pink Moist. Dsg to Abd, chest e RUArm Δ'd Silvadene applied. Will cont to monitor. [redacted] Spc 9114MM6 b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

17NOV03 (1040) NSG - Pt amb to BR c steady gait. VSS. (+) colostomy intact + draining brown, loose stool. Pt NPO since midnight. Pt in O.R. at this time for skin graft. b(6)-2 [redacted]

17NOV03 (1145) Pt back from O.R. (R) leg elevated c blankets behind (R) thigh + (R) ankle. Dr. [redacted] b(6)-2 emphasized no pressure to (R) calf, keep (R) leg elevated, + strict ~~BR~~ bed rest x 3days. Pt aware of MD's instructions. DICed IV in (L) wrist 2° IV infiltrated. Will continue to monitor ~~IV~~ site. 0 c/o pain. b(6)-2 [redacted]

17Nov03 2000 Pt VSS. R leg elevated c No pressure to (R) calf. Dressing [redacted] Lotion applied to graft site [redacted] abd, chest and RUE. OTA. Pt Denies pain [redacted] will Will cont. to monitor. b(6)-2 [redacted] Sue 9 WMM

18NOV03 (0900) NSG - VSS. Pt c/o pain. medicated [redacted] 11 perc tabs. Will continue to monitor. (R) leg elevated c blankets behind (R) ankle + (R) thigh. No pressure under (R) calf. (R) upper thigh soaked c blood. Removed ~~bacitracin~~ Kerlex + put new gauze + Kerlex. Will continue to monitor bleeding. Pt did own AM care in Bed. b(6)-2 [redacted]

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

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

REGISTER NO. | WARD NO.

[redacted] b(6)-4

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19nov03 @0830	assumed care of pt @1800. VSS, no c/o. LSCTA, (+)BS, colostomy intact c brown formed stool. voiding per urinal QS. RLE elevated c pressure to (R) calf wound. (R) thigh donor site dsg c/d/i. Rpt restraints on c sig sx of skin/circulation compromise. Plan: monitor dsgs, strict BR, pain control [redacted] PT
19NOV03	General surgery, POD #2 s/p STSG to RLE [redacted] b(6)-2 Doing well no issues. Dressing d/c in 1-3 days. Will allow to get OOB to bathroom. No standing or walking. No dangling history.
	[redacted] b(6)-2
19NOV03@1345	Assumed care of pt. @0600. VSS. A&O. Pt. resting quietly in bed. (R) LE elevated on blankets. Pt. on strict bedrest. Colostomy bag intact, formed brown stool. Moisturizing lotion applied to graft sites on chest & right upper arm. STSG to (R) LE, dressing intact, mod. brown drainage to dressing. MD to Δ dressing in 1-3 days. Pt. requests to have dressing Δ'd frequently. Will have interpreter explain that the MD does not want to Δ DRSNG at this time. Voids @ bedside, clear yellow urine. Pt. given 1 tab Percocet for pain this AM. Will cont. to monitor. Pt. in 2-point restraints @ [redacted] b(6)-2 signs of skin breakdown. All other assessments WNL, [redacted] RLT, RN
19NOV03@1500	Dressing to (R) thigh skin graft donor site Δ'd, staples intact, mod. sero-sang drainage, vaseline gauze wrapped c Kerlex. 1 tab Percocet for pain. [redacted] b(6)-2 RLT, RN

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
19 NOV 1900	USS. (R) Leg ↑ on ~~pillow~~ folded blankets. Pedal pulses +2. Capillary refill brisk. Dry to R LE dsg ~~x~~ intact. Bleeding dsg intact. ~~Colos~~ Colostomy stoma pink & moist. Re-enforced pt of strict bed rest. Pt consumed 75% of Regular diet for breakfast. Denies pain in discomfort @ this time. Wound Dentures plan of care — [redacted]
20 NOV 03	Surgery POD #3 TSTG Doing very well Resting ∆ tomorrow or saturday — b(6)-2 [redacted]
20 NOV @ 1500	Assumed care of pt. @ 0600. VSS. A&O, C/O mild pain to (R) LE, refused pain meds. (R) LE elevated, pt on strict bed rest. Dsg to (R) thigh donor site CDI. Lotion applied to old SGST sites. ↑ Foot patch ∆'d, applied to chest wall. Colostomy bag intact, brown watery stool. Pt. in 2-point restraints, ∅ S/Sx of skin breakdown. All other assessments WNL. Will cont to monitor. — b(6)-2 [redacted]

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

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

REGISTER NO. | WARD NO.

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2115	Assumed care of pt @1800. VSS - A+O speaking in arabic + some english. pt has no complaints of pain @ this time. LS CTA (B), Resp. even unlabored, BS x4. Pt. applied cream to chest + abd. to skin graph sites. (R) LE dsg CDI. Leg elevated 2, no pressure applied to positive portion of his dressing. colostomy bag intact. Two Pt. restraints in place. S compromise to skin / circulation will cont. to monitor pt. [redacted] I concur with above assessment
21 Nov '03	Assumed care @ 0600 pt awake + oriented x 3 VSS b(6)-2 pt had ∅ c/o pain at this time. Pt did ∅ of leak from colostomy bag. Bag replaced. pt self applies cream to chest. Dsg around graft site D'd except for the 2 4x4 stapled on these were reinforced w/ ABD with curlex wrap. (R) lower leg dressing in place and leg elevated as per orders. Restraints x2 in place, circulation skin intact. will monitor. [redacted]
21 Nov 03 1700	I concur c above assessment. [redacted]
21 Nov 03 2050	Assumed care @ 1800; VSS, pt A+O speaking arabic; ∅ c/o pain, pt performed own colostomy care; dsg to (R) leg graft CDI, ∅ drainage, (R) Leg ↑ ∅ pressure applied; pt applies moisture cream to chest; abd; Restraints in place, ∅ circulation, ∅ skin breaks, will cont to [redacted] b(6)-2

EPLO [redacted] b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22NOV03	Surgery 1000HRS S/C STSG Dressing taken down c 100% take. Will likely be ready for the EPW camp in Iraq [redacted] b(6)-2
22Nov'03	Pt A+O x3, VSS, pt has Ø c/o pain at this time, dsg to lower @ extremity Δ'd by Dr [redacted] healing well, shows AOM upper right thigh graft-site removed, pt maybe ready for EPW camp in a week. (Dr [redacted] predicts) @ extremity wrapped with curlex and all comp thigh injury wrapped with 4x4 curlex. Pt self apples moisturizer and empties colostomy bag. Will monitor Dressing to lower extremity changed with petroleum gauze & fluffs. Restraints x2 in place @ circulation, Ø new breakdown. Sp [redacted] (1630) I concur c above assessment. [redacted]
23Nov03 0410	Assumed care @ 1800; VSS, pt A&O speaking arabic; Ø c/o pain or discomfort @ this time; dsgs to @ LE c DI, @ drainage wrapped in kerlix & ace bandage, pt performed colostomy care & applied moisturizing creme to chest & abd; Restraints in place, @ circ, @ skin breakdown, cont to monitor. [redacted] b(6)-2

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

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

[redacted]

b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 16620

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES b(6)-2 A11
23 NOV 03 @ 1105	Pt a/o, VSS, ∅ c/o pain, new fentanyl patch applied to (R) chest wall today per orders. Xeroform c̄ Kerlix to (R) thigh, (R) lower leg c̄ xeroform & dry drsg. pt applies moisturizer cream to chest & abd, colostomy care done by pt. Restraints on s̄ compromise to skin/circulation. Will monitor. [redacted] LPN—
23 NOV. 03 2015	Pt AtOx3, VSS, ∅ c/o pain, colostomy bag intact, ace wrap RLE CDI, applying moisturizing cream on his own [redacted] xeroform to (R) thigh + leg CDI [redacted] I concur c̄ above assessment [redacted] 2LT—
24 NOV 03 1400	Pt a/o, VSS, ∅ complaints, colostomy intact, emptied by pt., ace CDI to (R)LE, xeroform to (R) thigh. Cream moisturizer put on by pt. 2 pt restraints on s̄ compromise to skin or circulation. Will monitor [redacted] 91WM6.
25 NOV 03 @0245	assumed care of pt @1800. VSS, no c/o pain. CSCA using IS, ⊕ BS, ⊕ stool per colostomy; voids per urinal QS. RLE drsg CDI, ⊕ CMS. (R) thigh donor site c̄ dry loose drsg. Pt ↑ AMB to BR s̄ assistance. 2pt restraints in s̄ s/sx of skin/circulation compromise. Plan: monitor drsg, enc AMB, enc po. [redacted] LPN
25 NOV 03	Surgery POD#8 s/p STSG. No issues. Wounds almost healed. To prison camp in 4-5 days. [redacted]

[redacted] TANDARD FORM 509 (REV. 5/1999) BAC
USAPA V1.

b1(a)-2 A-11

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25nov03 @1130	Pt A&O, VSS, ∅ complaints, skin graft donor site to (R) thigh CTA. moisture cream applied. (R) lower leg c cream applied, then xeroform & dry protective dsg. Colostomy & AM care done by pt. Pt ambulated in hallway for 15 min. 2 pt restraints on c compramise to skin or circulation. Will monitor [redacted]. LPN-
1640	Pt amb. in hall x 30 min, & emptied colostomy bag. Cont mon ([redacted]) Nurse.
26Nov03 @0800	assumed care of pt @1800. VSS, no c/o pain. LS CTA, (+) BS, tol reg diet well (+) stool to colostomy, stoma healthy ? red; voc per urinal/toilet qs. Pt ↑ AMB c assistance RLE dsg CDI (R) thigh graft site c cream applied by pt. 2pt restraints on c s/sx of skin/circulatin compromise. Plan: enc po, enc OOB, monitor dsgs. [redacted]
26 Nov '03	Assumed care of Pt @ 0600, pt awake + oriented x3, VSS, pt changed leaking colostomy bag and self applies moisturizing cream, dsng to graft site changed with shape fitted xeroform + abdx, pt ambulates without difficulty, 2 restraints x2 in place (+) circulation (+) skin break-down will monitor. [redacted]
1620	I concur c above assessment [redacted]

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

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

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

b1(a)-4

#[redacted]

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
27NOV03	Narrative Summary *(D/C summary) Date of Admission: 16AUG03 Date of Discharge: 29NOV03 Diagnosis: GSW to Abdomen with multiple injuries 1) Gastric Injury 2) Small bowel injury x 2 3) Colon injury Procedures/Dates: 1) 16AUG03 = Ex lap; distal gastrectomy, small bowel segmental resection x2; sigmoid colectomy 2) 17AUG03 = Roux en Y gastrojejunostomy; ileoileostomy; Rt sided colostomy; Hartmans pouch; placement of duodenal drainage tube; feeding jejunostomy 3) 28AUG03 = Tracheostomy; Abdominal Lavage 4) 19Sep03 = STSG to open Abdomen 5) 28Oct03 = STSG to Right arm + chest 6) 17NOV03 = STSG to Right Lower leg Course In the Hospital: The patient had several different surgeons during his time @ this facility. He was admitted c a GSW to the Abd on 16AUG03 @ which time he underwent

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

#[redacted]
blue)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

MEDCOM - 16623

(D/C summary)*

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27NOV03	Course in the Hospital: (cont) damage control surgery. He returned to the OR on 12AUG03 for definitive repair but they were unable to close his abdomen. He had one documented Abdominal Lavage on 25AUG03 when he had a tracheostomy placed. His abdomen was not able to be closed & a STSG was placed directly on his bowel 19Sep03. He had skin grafts to his L/UE and his chest which were grafted as well as one the his RLE. He is now completely healed with no open wounds or drains. Medications: Percocet one or two every 4-6 hours as needed for pain Atenolol 50mg p.o. q day Moisturizing Cream to skin graft sites and donor sites twice a day Follow-up: This patient will require no surgical followup for 6-months to a year @ which point if the skin graft is loose over his bowel he could be evaluated for colostomy take down realizing he has significant alteration of his normal anatomy. It will be up to the surgeons who are available @ the time to decide. b(6)-2 [redacted]

MEDCOM - 16624 STAN[redacted] 5/(1999) BACI

LAST NAME | FIRST NAME | DLE INITIAL | ID NUMBER

DATE	NOTES
	b(6)-2 A11
27 NOV 03 @0300	Assumed care of pt @1800. VSS, no c/o pain. (R) LE dsg CDI, (R) thigh donor site healing well. Pt applied lotion to burn sites / donor site. A+O x 4, amb in halls, tol regular diet w good appetite, voids QS to urinal / toilet. 2 pt restraints on c's S/Sx of skin / circulation compromise. Plan: enc independence, enc OOB, monitor dsg. [redacted] RZ
27 NOV @ 1140	Pt A+O, VSS, Ø complaints, (R) LE dsg CDI then removed by MD. (R) thigh site OTA. (B) sites healing well. Pt applies lotion to burn sites & donor sites himself. colostomy bag Δ Ø, pt does own colostomy care. Pt AM care complete, amb. in hallway for 10 minutes w difficulty. Voiding qu via urinal. Awaiting next camp run. Discharge meds taken to pharmacy. Will cont to monitor — [redacted] LPN-
28 Nov 03 20/55	Assumed care @1800; VSS, Ø c/o pain; pt A+O speaking both English & arabic; pt applied moisture cream to [redacted] all donor sites & graft site; Colostomy care provided per pt; pt amb in hall x1; Ø [redacted] pertinent A's in assessment; Restraints in place, (R) circ, Ø skin breakdown, will cont to monitor [redacted]
28 NOV 03	(1600) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. Ø c/o pain. Amb in hallway w diff. Colostomy bag changed x 2 this shift d/t leakage. Pt applying moisturizing cream to skin graft sites. Ø S/Sx infection. 2 point restraints in place w S/Sx complications. Will cont. to monitor [redacted]

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
28 NOV 03	No new issues. N/E [redacted] b(6)-7
29 NOV 03 0745	Assumed care @ 1800: VSS, pt alert + speaking arabic; ↓ c/o pain; pt OOB to BR, amb ↓ difficulty, colostomy care provided per pt; self-[redacted] application moisture cream to all graft sites, ↓ s/s infection; pt awaiting D/C to camp; Restraints in place, ↓ circ, ↓ skin breaks Cont to monitor b(6)-2 [redacted]
29 NOV 03	(1555) Assumed care of pt. Pt alert, speaking Arabic. VSS. ↓ c/o pain. Amb well. Skin graft sites well healed - pt applying moisture cream. Awaiting trans to EPW camp. Monitoring. b(6)-2 [redacted] (1740) Pt d/c to camp c meds/colostomy supply. amb. escorted by MPs. [redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(6)-4

LAST

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(2)-2

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER [redacted]

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX: M

AGE

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

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

ARRIVAL

DATE *(Day, Month, Year)*: 16 Aug 03 | TIME: 0846

TRANSPORTATION TO FACILITY

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: 10 morphine, 1G Ancef

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW Pox: 95

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☑ NONURGENT

TIME: 1856 b(6)-2

INITIALS: [redacted]

VITAL SIGNS

TIME	0846			
BP	114			
PULSE				
RESP	50			
TEMP				
WT				

LAB ORDERS

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

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0657	Foley	SS			
~~0711~~	~~10 mg morphine~~				
~~0717~~	~~Ancef~~				

DISPOSITION

☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

DISPOSITION QUARTERS /OFF DUTY

☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE

☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATE

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

MEDCOM - 16627

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

56 y.o. EPW GSW to Abd. Transported to EMT
w/ [illegible] NKDA
PMH Ø
PSH Ø
PE. [illegible] (B) [illegible] [illegible], mild [illegible]
Heart regular
Abd with Ant Axilla [illegible]
LUQ exit RUQ
Bowel s wound.

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

[redacted] b(6)-2

DIAGNOSIS

GSW to Abd.

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

EMERGENCY CARE AND TREATMENT ***(Doctor)***
Medical Record

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

MEDCOM - 16628

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 b(6)-2
24 AUG 03	1640		Pt restless. Gave 10mg propofol IVP. [redacted] CTA
	1715		Pt over breathing vent RR 25. Gave 30mg propofol IVP. Will cont care. BP 190s/80s. [redacted]
	1844		Gave report to next shift. [redacted]
	1800.		Report received from LT [redacted]
	2030		Wafer & colostomy bag Δ'd. Pt having yellow/green liquid stool. Stoma appears edematous and pink [redacted]
	2200.		Dsg Δ complete to midline abd incision & (R) flank wound. Both wounds appear pink c greyish/green exudate noted. Wounds repacked c 1/4 strength Dakins soln. (R) chest burn area cleansed and Silvadene applied. Bacitracin applied to tube insertion sites. Yellow drng noted duodenal tube & JP #1 ~~drng~~ sites. Will notify MD in AM. [redacted] b(6)-2
24 Aug 03			
	2245.		Pt coughing. Attempted to suction pt. Unable to pass suction cath. SpO2 99%, peak pressures ↑ to 50's. RT notified. RT @ BS. Manually ventilated pt. ETT kinked in back of mouth. Unkinked tube and suctioned. Small amount thin secretions obtained. Vocal sounds heard. Attempted to reinflate cuff per RT. ETT remains @ 24cm @ lip. SpO2 ↑ to 94-95%. Notified MD. Dr [redacted] b(6)-2 @ BS. Cuff leak present. Anesthesia notified for ETT replacement. Pt manually ventilated @ (cont.)

(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] b(6)-4

REGISTER NO. | WARD NO.

NURSING NOTES
Medical Record

038

b16)-2
A11

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 AUG 05 cont'd	0900		60 mcg/° due to ↓ BP 150s/ hos. [redacted] RSW
	0924		↑ propofol to 40 mcg/kg/min due to ↑ BP 176s/80s. Will cont to monitor & titrate as needed. [redacted]
	1000 - 1400		Completed bed bath & foley care. Δ'd dsg. Cleaned burn dsg c hibiclens & rinsed c NS. Applied silvadene cream. Cleaned midline abd & (B) wound c NS. Wet to dry dsg c ½ strength dakins soln used. Noted yellow fatty tissue. Cleaned JP tubes and duodenal tube insertion points c NS. Will cont. care. [redacted] RSW
	1130		Dr. [redacted] placed triple lumen in condis. Confirmed placement through CXR. [redacted] RSW
	1300 - 1500 1345		Turned off propofol per Dr. [redacted] in prep for extubation. Pt has little movement. BP ↑ 200s/100s. Dr. [redacted] aware. Labetalol 20 mg IVP pm ordered. Will cont. care [redacted]
	1545		Pt appears to be more awake. Moving head and arms. Suctioned pt x ii. Pt BP continue to be 170s/100s. Resp. rate range 20-31 bpm, sats 98-99%. Got interpreter but pt not responsive will cont care [redacted] RSW
	1600		Started propofol to 60 mcg/kg/min per Dr. [redacted] No extubation today due to labored breathing. + BP 200/80s. Gave 20mg propofol bolus. Suctioned pt x ii. Small amt thin white secretions noted. Will replace filter per RT. [redacted] CT RSW

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

b(6)-2 All

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			this time. ETT moved to 21½cm @ lip, sitting @ vocal cords per anesthesia. Pt suctioned Copious amounts thin yellow secretions obtained. Pt placed back on vent c 40% FiO2. SpO2 95%
25Aug03			Will monitor. Procedure complete @ appx 0020.
		0030	Pt turned to (D) side. Pt suctioned x3 c copious amounts thin white/yellow secretions.
		0300	Pt turned on (R) side. Pt suctioned x 5. Large amount thin white secretions obtained. SpO2 98-99% on 40% FiO2. Will monitor [redacted]
		0400	Labs drawn from ~~CBC, Chem~~ A-line and sent to lab. 7.45/35.7/127/25/2/99% [redacted]
		0600	Report given to RT [redacted]
25Aug03		0600	Received report from night shift. Pt vented SIMV 16, 800, 5, 40%, peaks ok. All IV lines intact. Emptied colostomy. Brownish yellow liquid noted. NGT @ nare LIS. TF @ 125cc/° infusing. Will cont. care [illegible]
		0640	Dr. [redacted] viewed labs (H+H 33.', 99), ABG, x-ray + midline abd + (R) flank wound. 0 new orders given. Completed dsg Δ. Wet-to-dry dakin's soln used for midline abd + (R) flank wound. Bacitracin placed around JP1, JP2, duodenal drain, + J-tube. Washed (R) shoulder wound c hibiclens + rinsed c NS using aseptic technique. Flushed 3-lumen. Flushes well. Pt has low grade temp 101.° Will cont to monitor. Give 20 mcg fentanyl for dsg Δ [redacted] [illegible]

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
			23AUG 1930: NSG Assessment as follows: (N) sedate on Versed/kg/hr drip & 3mg/hr [illegible] PRN with [illegible] noted: PERRL 2mm (CV) ST w/ Ø ectopy noted (a-fib (R) hx), S1, S2, +3 pulse x4 ext; +3 edema x4 ext (place UE in elevated position (UE > LE)); febrile @ 100.5, cap refill @ 3sec. (R) (resp) bilat breath sounds; HOB up to 30°; (⊖) s/s cyanosis; #8 ETT, 22cm @ lip with settings of SIMV 16, PEEP 5; 800 TV and FiO2 of 50%; (GI) NGT to LIWS in (R) nare; JP x2 to midline secr.; duodenal drain from (R) abdominal side, midline abd incision; C/D/I; ~~colost~~ colostomy intact; Replace duodenal outs with feeding @ 800/3hrs. (+) BS; (GU) foley to gravity; (R) scrotal edema; (skin) (L) knee with bulky dressing; upper (R) arm is C/D/I; (CVS) [illegible], (R) SC cont's w/ D5½ 20K @ 200cc/h ——— (Plan) Extubate in AM —— N.C. [redacted], RN
			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)

[redacted] b(6)-4

REGISTER NO. | WARD NO.

MEDCOM - 16632

NURSING NOTES
Medical Record
STANDARD FORM 510 (REV. 7-91)

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							
28 Aug 03	0955		0955	1000	1005	1020	1035	1050	1110	1st Unit PRBC Transfusion started at 0955 28 Aug 03 completed 1105 28 Aug 03 Pt. had q 5/s of a negative reaction. — b(6)-2 [redacted]
NIBP			127/45	103/42	105/43	102/42	106/45	116/54	110/49	
HR			85	85	83	86	85	84	83	
TEMP			101.2	100.9	100.9	100.9	100.6	100.6	100.7	
	1120		1120	1135	1150	1220				2nd Unit PRBC Transfusion started at 1120 28 Aug 03 Completed in QB at 1215 28 Aug 03. Pt had q s/s of negative reaction. — b(6)-2 [redacted]
NIBP			114/49	118/53	120/53					
HR			83	81	82					
TEMP			100.5	100.1	100.3					

(Continue on reverse side)

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

b(6)-4 [redacted]

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

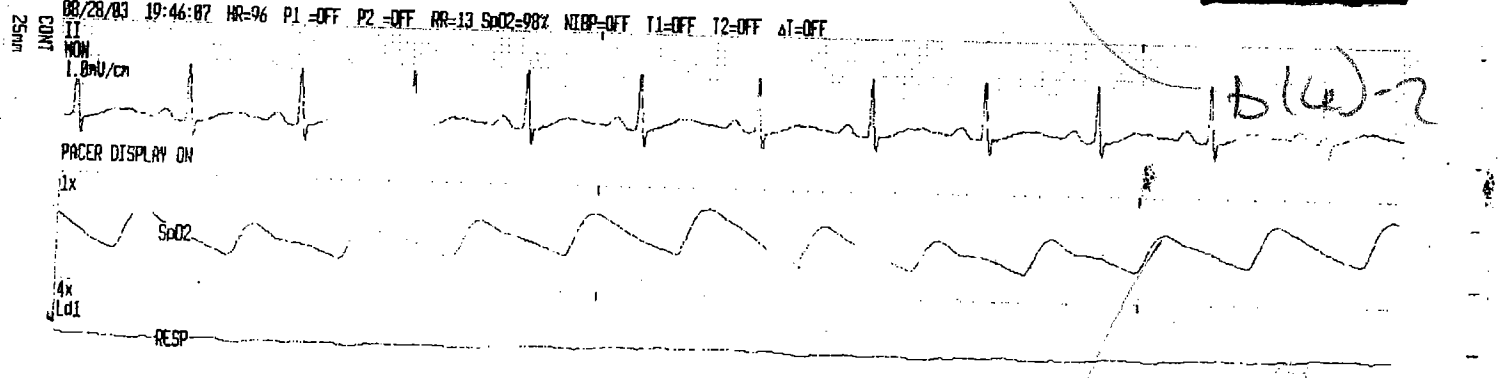
MEDCOM - 16633

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

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28 Aug 03		1400	Pt returned from OR. 2nd unit of PRBC completed at 1245 28 Aug 03. Pt Ø negative reaction. Pt received Tracheostomy, & shilley, Ex Lab + Washout of abdominal wound. [redacted]
		1700	TF started at 60cc/hr advanced to 125cc/hr within 6hrs. VSS pt shows Ø S/S of pain or discomfort. [redacted]
		1900	Report & care of pt. given to oncoming shift. [redacted]
1800 28 Aug 03	Received report.		[redacted] T/AN
1830	Assessment completed.		[redacted] T/AN



b(4)-2

2300	Drsg Δ to mid abd & RLQ. Staples to mid abd intact & s/s of drainage. RLQ wound drsg & s/s fluid.		[redacted] T/AN
0200 29Aug03	Foley care done.		[redacted] T/AN
0600	Report given.		[redacted] T/AN

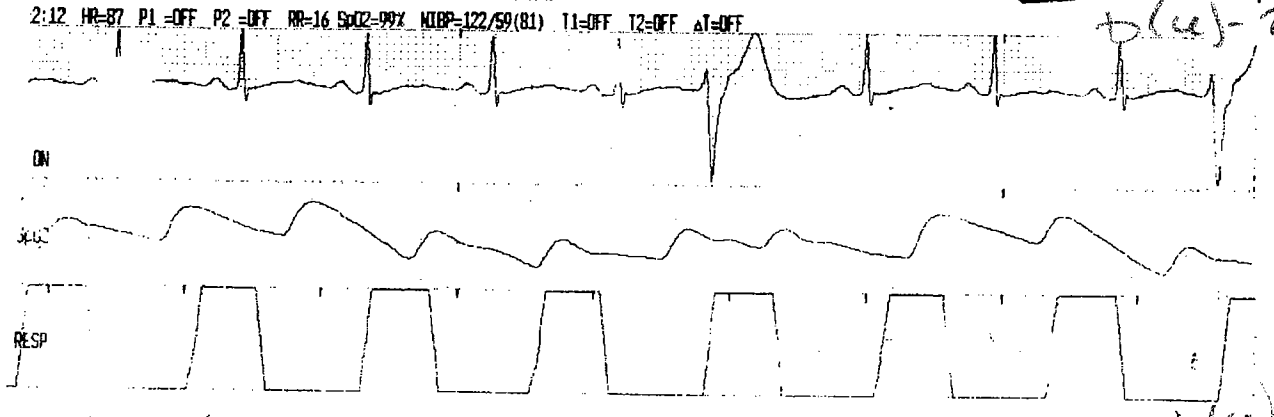
*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
29Aug03	0800-1030		cont'd... to (B) shoulder/chest region. Washed c hibiclens + rinsed c NS. Applied silvadene + covered c 4x4 drsgs. Completed bed bath. Noted blister fluid-filled on (R) LE + Stage I decubitus on back of head. Placed silvadene + 4x4 gauze on head + donut to elevate head off of bed. Elevated (B) UE + (B) LE due to edema. D'd sheets. Will cont. care [redacted]
	0820		Pt awake. Moving eyes. Gave 50mg morphine IVP. Will cont to monitor. b(6)-2 [redacted]
	1100		Completed oral care. Cleaned mouth c scope. Completed trach care using clean technique. Pt off vent on RA for ≈ 5min. O2 sats remained >90%, RR 45. Placed pt back on vent. O2 sats presently 99% @ 1205. Noted occasional PVCs while pt slightly awake. Will notify Dr. [redacted]



b(6)-2

	1300		Pt resting comfortably. O2 sats 99%. Will cont. care. [redacted]

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

STANDARD FORM 510 (REV. 7-91) BACK

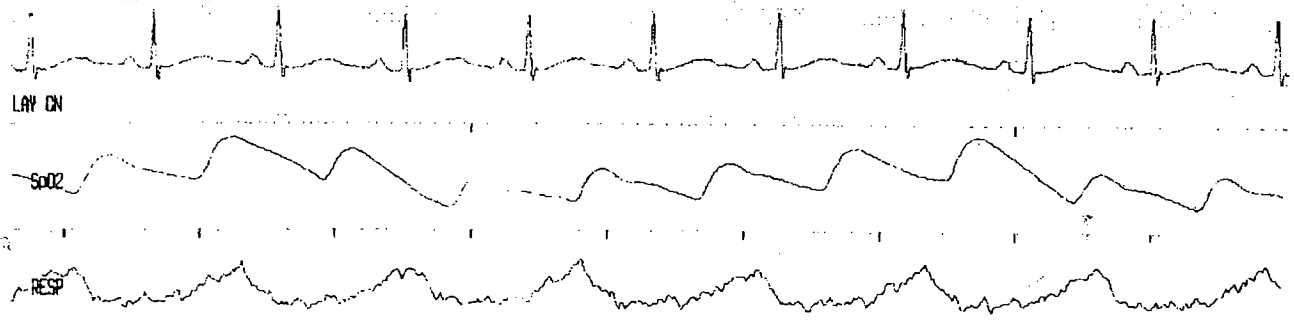
MEDCOM - 16635

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
29 Aug 03	0600		Received report from RN [redacted] Pt vented #8 shilley trach SIMV 16, 800, 5, 40%, peak 28. (B)UE +(B)LE elevated due to pitting edema. All 5 JP drains to bulb suction. (R) colostomy c semiformed brown stool. NGT to LIS c scant amt dark brown substance. Midline abd +(R) flank wound drsg C,D,I. Duodenal drain draining to gravity. TF @ 25cc/°. Viewed labs. ABG 7.381, 33.0, 108, 20, -6, 98%. H+H 29.7, 9.6, WBC 15.6, Plt 1000, K+ 3.8 will notify MD of abnormal results. Temp currently 99.4 Will cont. to monitor. — [redacted] RN

07:15:16 HR=87 P1 =OFF P2 =OFF RR=16 SpO2=100% NIBP=109/55(76) T1=OFF T2=OFF aT=OFF



0800 Completed drsg Δ. Midline abd incision held by staples, well approximated. Packed (R) flank wound c ¼ strength dakin's soln wet to dry. Dr. [redacted] viewed wounds + JP drains. Δ new orders given. Put bacitracin around all 5 JP tubes + duodenal tube Δ'd burn drsg cont'd

Continue on reverse side

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

NURSING NOTES
Medical Record

[redacted]

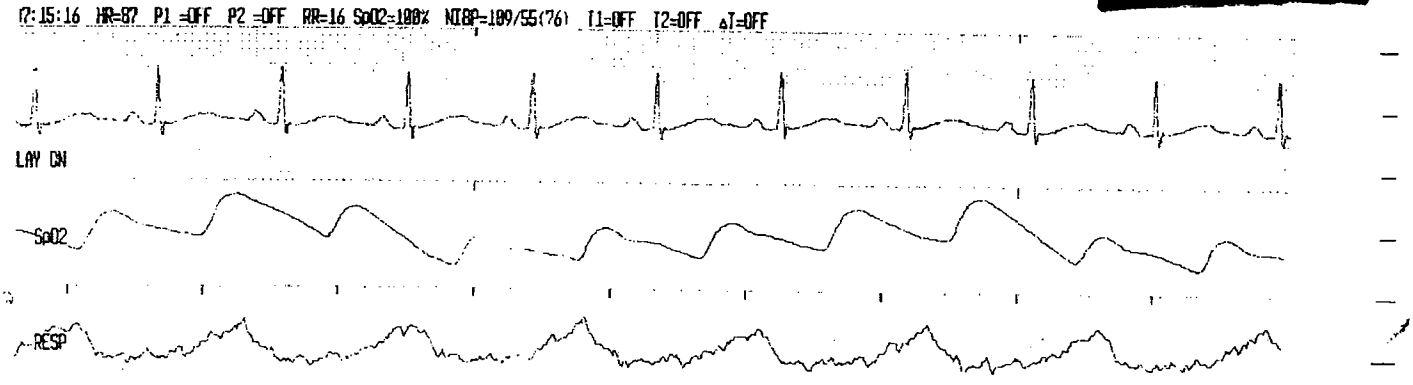
MEDCOM - 16636

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

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
29 Jul 03	0600		Received report from [redacted] Pt vented #8 shilley trach SIMV 16, 800, 5, 40%, peak 28. (B) UE +(B) LE elevated due to pitting edema. All 5 JP drains to bulb suction. (R) colostomy c semiformed brown stool. NGT to LIS c scant amt dark brown substance. Midline abd + (R) flank wound drsg C, D, I. Duodenal drain draining to gravity. TF @ 25cc/°. Viewed labs. ABG 7.38, 33.0, 108, 20, -6, 98%. H+H 29.7, 9.6, WBC 15.6, Plt 1000, K+ 3.8 will notify MD of abnormal results. Temp currently 99.4. Will cont. to monitor. — [redacted] JM



0800 Completed drsg Δ. Midline abd incision held by staples, well approximated. Packed (R) flank wound c 1/4 strength dakin's soln wet to dry. Dr. [redacted] viewed wounds + JP drains. Ø new orders given. Put bacitracin around all 5 JP tubes + duodenal tube Δ'd burn drsg as ordered

Continue on reverse side

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

REGISTER NO. | WARD NO.

NURSING NOTES
Medical Record

[redacted]

MEDCOM - 16637

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

MEDICAL RECORD — NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated Blu-2
29 Aug 03		1420	A'd (R) SC cordis dr sg using betadine + covered c opsite. [redacted] (TAA)
		1600	Notified Dr [redacted] of decub on back of head + blister (R) LE. No new orders given. [redacted] (TAA)
		1800	Temp ↑ 99.4. Will notify next shift. Pt resting c ◊ difficulty. O2 sats 99% @ rate 16 bpm. Gave report to night shift [redacted] (TAA)
29 Aug 03		1800	Report received from LT [redacted]
29 Aug 03		2315	Dr sg changed to incisions. Tube sites cleansed and Bacitracin applied around sites. Wounds are red in appearance. 4x4's placed over midline abd incision. Sutures intact, no redness or drng noted. (R) flank wound packed c gauze soaked in Dakins soln. Wound appears beefy red c small amount whitish exudate. Burn area to (R) chest and arm d'd per burn protocol. Wound is white in appearance. Large blister areas noted to (B) lower extremities. Wound debrided and cleansed using burn dr sg protocol. Mouth care complete. Thick yellow film noted on tongue. Will notify MD in AM. Trach care complete. SpO2 > 92% during procedure c RR ↑ to 50's. Pt suctioned. Copious amounts of yellow / white thin secretions [redacted] (cont)

(Continue on reverse side)

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

NURSING NOTES
Medical Record

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

[redacted]

MEDCOM - 16638

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
29Aug03 cont			obtained SBP @ 130's, put RR 30's on vent
2345 cont			following procedures. Propofol 9mg and
			fentanyl 50mcg IVP given. HR ↓ to 102,
			RR ↓ to 20's, SBP ↓ to 120's. Will continue
			to monitor [redacted]
30Aug03	0215		Pt turned to (L) side [redacted]
	0330		Labs drawn via A-line and sent to lab [redacted]
	0445		Wafer and bag D'd to colostomy. Stoma is
			edematous, but pink. Pt turned to (R)
			side. SpO2 ↓ to 96%, peak pressures ↑
			40's. Pt suctioned x4. Copious amounts b(6)-2
			thin yellow secretions obtained. Peak
			pressures ↓ to upper 20's and SpO2
			remains 96-97%. Will monitor [redacted]
30Aug03	0600		Received report from night shift. Pt verified
			#8 Shiley trach SIMV 16, 800, 5, 40%. peak 36. O2
			sats 96-97%. Pt turned on (R) side. All IV lines
			in place. (L) radial A-line reddened around insertion
			site. Will notify MD. Duodenal drain to gravity.
			NGT (R) nare to LIS c brown colored fluid. Propofol
			fentanyl, D5½c20KCL, NS infusing. Propofol
			rate ↓ed 90 mcg/kg/min. RR high 20s. Will
			cont to monitor. (B)UE + (B)LE elevated. HOB
			↑ 30°. Dsg (B)LE C, D, I. Pt temp 100.5. Will
			cont to monitor. b(6)-2 [redacted]
	0700		Dr. [redacted] viewed labs: WBC 14.5, H+H 9.0, 27.7,
			PH 1026, K+ 3.4, ABG 7.438, 37.3, 121 18, 99%. cont'd..

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

STANDARD FORM 510 (REV. 7-91) BACK

#[redacted] b(6)-4

MEDCOM - 16639

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
30AUG03	0700		cont'd... Ø vent Δ's made. Temp ↓ 100.0. Notified Dr [redacted] of A-line in >15 days. Order to hold TF for surgery. (R) colostomy in place. Will cont. care — b(6)-2 [redacted]
	0800		Suctioned pt x iii. Thin blood-tinged secretions noted. Pt O2 sats ↑ed 99%. Peak 31. Will cont. care. — b(6)-2 [redacted]
	1020		Completed trach care. Pt tol well. O2 sats 100%. Will cont. care. — [redacted]
5/30/03			Surgery
			No sig events. Tolerating TF well.
			Sedation / Paralyzed
			T [illegible] HR 80. BP [illegible]/50.
			Trach clean
			[illegible]
			WBC [illegible]
			# [illegible]
			# [illegible]
			[redacted] b(6)-4

(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

Ø38 b(6)-2

MEDCOM - 16640