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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
[illegible]/30/07	Surgery POD #2
	No Tx. Pain controlled. Hungry
	ABD soft non tend
	(L) RLN paresis, hypoglossal paresis, facial droop
	(L) UE strength 4/5
	Wounds ↓ drainage, serous d/c
	A/ s/p neck explor GSW neck. Stable
	P Tx ward
	[redacted] (b)(6)-2

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

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

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

MEDCOM - 17841

MEDICAL RECORD	PROGRESS NOTES

DATE

28 Aug 1526 Received pt ~~resting~~ from ICU in stable condition. VSS, sats @ 95%, no resp distress noted. LS w/ minor wheeze, clear w/ cough excpt CPD and LS. Pt able to raise dark blue bed halfway w/ enc. Tol PO, H_2O. IV to @ ac patent & intact IVF infusing w/o apparent complication. @ fa HL patent & intact, flushes easily. HOB ↑, pt able to cough up own secretions, needs enc - suction @ BS as precaution for resp management. Staples to @ neck - OTA w/ bacitracin. Dns to @ neck ear and back of head w/ dsg c/i, drsg Δ done in ICU prior to arrival. Per report pt foley d/c'd @ 1130, pt has not yet voided c this time. Restraints in place per CPW protocol. Circulation and sensation frequently checked and intact. Medicated x1 w/ ~~#~~ percocet. Will cont to monitor. HR [redacted] (b)(6)-2 pulse equal & bilaterally strong. MW

1616 Pt had not voided, c/o cramp, bladder distended abd heart. Stood pt to urinate & voided 100 cc w/ difficulty. Pt cont to have pain and distention and unable to urinate. Foley placed and pt

(Continue on reverse side)

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(b)(6)-1 (b)(6)-2

[redacted]

MW

(b)(6)-4

PROGRESS NOTES
Medical Record

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USAPPC V1.00

PROGRESS NOTES

DATE

30 Aug 1616 cont had relief. 1100 cc urine return upon placement distention resolved. Foley left in place, will notify md. [redacted] (b)(6)-2 /LTAR

30 Aug 2000 Pt lying on bed. HOB↑. suction @ BS VSS: O2 Sat 95%. Pt A+O, speaking in arabic. HRRR, resp. even + unlabored. productive cough c expectorant. COB + IS encouraged. Staples to (L) neck open to air c bacitracin applied. Drsg to (L) ear + back of neck CDI. Foley to gravity: cloudy yellow urine. 2 pt restraints on, circulation assessed. +2 pulses, brisk cap refill. ABX given. Will cont to monitor [redacted] (b)(6)-2 9 lumb, src [redacted] (b)(6)-2

31 Aug @0515 Drsg to neck changed. small amt of drainage noted. Bacitracin applied to (L) ear. Foley draining dark yellow cloudy urine. 2 pt restraints on. circulation assessed. Will cont to mon [redacted] (b)(6)-2 9 lumb

31 Aug 0600 VSS. Alert + cooperative. Answered questions appropriately. Pt fed self. HOB↑ 30°. Had productive cough. Lungs clear. O2 SAT 96% RA. Use of IS - pt only c 900cc/hr. Foley to gravity. Drains clear yellow urine. (L) AC IV patent & intact. enfuse LR @ 75cc/hr. Restraints removed and reapplied, skin intact. Will check restraints, skin integrity, and maintain pulses / capillary refill frequently [redacted] (b)(6)-2 ICU

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

MEDICAL RECORD	PROGRESS NOTES
DATE	
	(cont) open to air. Pt has productive cough. Enc. use of IS. wrap CMS ⊕BS x4 quads. IVF infusing into IV in ⊙ac c S/Sx infection/ infiltration. Cont. IV abx. Foley draining quantity sufficient clear yellow urine. Pt tol reg diet well. 2-point restraints in place - ⊘ S/Sx complications c circulation/skin breaks. Will cont. to monitor. (b)(6)-2 [redacted] RN
1Sep03 1930	: VSS, ⊘/10 pain @ this time, A+O x3, minimal PAIN to neck area R/T injury. Staples to (L) side of neck - open to air. Pt. has some edema to face. Sats 97% RA, ⊘ signs of distress. Pt now getting OOB and ambulating during the day. Foley to gravity draining clear yellow urine. Tolerates PO. IV Hep to (L) AC flushed & patent - continuing IV Ancef. Restraints x2 when in bed. S_1S_2, CTAB, ⊕BS x4. ⊘ other remarkable assessment findings. Continue to monitor. (b)(6)-2 [redacted] RN
1Sep03 @ 1950	- Addendum Note: Power back on now, so can assess c better light. Pt.'s left leg more swollen than (R) leg. Visual acuity WNL. DSG's to back of neck CDI. (L) ear swollen, applying bacitracin to it. Sutures to (L) ear & back of neck (under DSG's). Pt is

(Continue on reverse side)

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PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
31 Aug 1930	@ Pt sitting up in bed consuming dinner c some assistance. VSS, lungs CTA B HRRR productive cough. IS used often. O^2 Sat 96%. Drsg to R side of neck & back of neck CDI. R side staples open to air. Bacitracin applied to R ear. Foley to gravity draining dark yellow urine. c some sediment. IVF to R AC infusing c complication. Pt pulled out HL to R arm - catheter intact. Will cont to monitor [redacted] (b)(6)-2 9lwm6.
31 Aug 2030	@ Pt was sleeping c head toward R side, & woke up c swollen R eye. HOB ↑ & warm compress applied. Will mon. for ↓ in swelling. [redacted] (b)(6)-2 9pm6sec
1 Sep 03 @ 0200	Drsg d'd to back of neck, small amt of drainage. Bacitracin applied to R ear. Swelling to L side of face ↓. Pt ambulated c assistance down hallway x2. Restraints put back on. Circulation assessed frequently. HOB ↑. IVF cont to L AC c complication. Foley draining dark cloudy urine. ϕBm. Will cont to mon - [redacted] (b)(6)-2 9lwm6
1 Sep 03 @ 0430	HCT: 23.5 RBC & HGB ↓ L per this AM blood draw. Circulation assessed - [redacted] (b)(6)-2 9lwm6.
01 SEP 03	(1025) Assumed care of pt @ 0000 c report from night shift. Pt alert, speaking Arabic. VSS. Pt medicated c TYLENOL this am for pain c good relief. Drsg to back of neck CDI. staples to R ear/neck CDI -

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[redacted] (b)(6)-4

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
Continued	from 1Sep03 1950: ambulating in hall c̄
	w/ escort. (L) side of face obviously >
	swollen than (R). [redacted] /An
	(b)(6)-2
9/2/03	Surgery POD
	No Δ. [illegible]
	[illegible]
	(L) [illegible] (L) [illegible] 3/5
	[illegible]
	[illegible]
	[redacted] (b)(6)-2
02SEP03	(1240) Assumed care of pt @ 0800 p̄ report from night
	shift. Pt alert, speaking/mumbling Arabic. VSS. Pain
	controlled c̄ Percs. Staples to (L) ear/neck CDI. Drsgs
	to back of neck Δ'd this am. Pen rose drain to
	back of neck draining sm. amount sero.sang
	drainage. (L) side of face swollen. Pt able to open
	(L) eye, PERRLA. Tol reg diet. Foley d/c'd this am.
	Pt voiding clear yellow urine s̄ difficulty. SL in (L)
	arm flushes s̄ difficulty - ∅ S/Sx infection/infiltration.
	2 point restraints in place - ∅ S/Sx complications c̄
	circulation/skin break. Will cont. to monitor. [redacted]
	(b)(6)-2

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

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

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(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 6-97)
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MEDCOM - 17846

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
02SEP03	(1415) Pt OOB to amb in hallway c c/o dizziness when pt first started to amb. Pt cont. to void clear yellow urine s difficulty. monitoring. (b)(6)-2 [redacted]
2 Sep 03 @ 1935	Pt resting un bed. VSS, HOB ↑ 30°. HRRR, lungs CTA(B) prod. cough. +BS x4 qd., +2 pulses. brisk cap refill to digits. 2 pt. restraints on, circulation assessed. HL to (L) AC flushing easily. Dsg to back of neck CDI. Bactracin applied to (L) ear. Pt voiding using urinal s difficulty. Cyanosis @ BS for precautions. Will cont to monitor (b)(6)-2 [redacted] qWM6. (b)(6)-2 [redacted] SPC
2100 ↘	Pt ambulated c unsteady gait. movement c (L) side of body increasing. Will cont to monitor— (b)(6)-2 [redacted] qWM6 SPC
03SEP03	(1025) Assumed care of pt @ 0000 p report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Staples to (R) ear/neck CDI - open to air. Dsg to penrose drain d/c this am by MD. Small amount sero-sang drainage noted. Pt tol reg diet well. Voiding s difficulty. SL in (R) forearm flushes well s S/Sx infection/infiltration. 2 point restraints in place - ∅ S/Sx complications from skin breakd/circulation. Will cont. to monitor. (b)(6)-2 [redacted]
	(1505) Pt OOB to amb in hallway s difficulty. ∅ c/o dizziness, gait steady. ROM improving on (R) side. Pt sitting ↑ in chair @ this time. Will continue to monitor. (b)(6)-2 [redacted]

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 Sep 03 @ 1855	Pt a10x3, sitting Furn bed. VSS, HRRR, lungs: CTA(B), (+)BS x4 qd. drsg to pen nose drain CDI. staples to (L) side of neck + ear OTA. ϕ drainage noted. ϕ c/o pain @ this time. + pulses to extr, brisk cap refill. circulation assessed often. 2 pt restraints on. Bactracin applied to ear (L). Will cont to monitor (b)(6)-2 [redacted] 9lumbs (b)(6)-2 [redacted] CPT
3 Sep @ 2215	Pt amb. down hallway, needs minimal assistance if any. ROM c left side increasing. Heparin 5000 sq given. Will cont to monitor (b)(6)-2 [redacted] 9lumbs SPC
4 Sep 03 0900	Pt's appropriately. VSS. WNL. Staples to (L) neck & ear CDI. Penrose to back of neck d/c'd by MD this a.m. minimal sero-sang. drainage. Drsgs to back of neck d/c. Facial swelling ↓. No c/o pain. 2 pt restraints. Skin integrity & circulation intact. Tolerated breakfast. Will get OOB to ambulate & shower (b)(6)-2 [redacted] MDS
4 Sept 03 1430	OOB to shower. Neck drsgs d/c. medicated c two percocet p.o. for c/o pain. Will continue monitoring (b)(6)-2 [redacted] MDS
4 Sep 03 @ 1945	Pt a10, sitting Furn bed. New IV 18G. started to (R) arm. (SL). VSS, HRRR, lungs CTA(B), (+)BS x4 qd.

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

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

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

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
1945 CONT (4Sep03)	Sutures removed from (R) ear by MD this AM. Bacitracin applied to wound. (L) neck staples OTA: ø s/sx infection. Drsg to back of neck (2x2). Encouraging PO fluids, H2O @ BS within reach. IS encouraged. 2 pt restraints on. circulation (b)(6)-2 [redacted] applied. intact. Ambulated down hallway C minimal assistance. Will cont. to monitor [redacted] (b)(6)-2

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STANDARD FORM 600 (REV. 6-97) BACK

(b)(6)-4 [redacted]

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
5Sep03 0700			Pt complains of pain along the whole neck region. Vitals are good. Left side of neck has staples, no visual sign of drainage or infection. Left ear had staples removed, healing nicely. Given pain medication for discomfort. Will continue to access Pt. (b)(6)-2 [redacted]
			I concur w above assessment (b)(6)-2 [redacted] RN/BSN
5Sep03		1310	- Pt. c/o pain to (L) side and back of neck medicated w 11 tabs of percocets (b)(6)-2 [redacted] given
5Sep03@1915			= VSS, ϕ10 pain, A+O x3, staples to (L) side of neck, (L) facial edema, can open mouth but less movement on (L) side of mouth. ↓facial movement on (L) side in general. Applying bacitracin to (L) ear wounds. DSG's to back of neck CD1, sutures approximated. IV Hl to (L) FA infiltrated & blood return D/C'd intact. Restarted new IV Hl'd to (L) upper FA patent when flushed w good blood return. Tolerates PO well. OOB & ambulating in hallway this evening w difficulty. Steady gait, guarded of face. Will Continue to monitor. [redacted] RN/BSN (b)(6)-2

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

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 17850

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
6 Sep 03C	0700		Assumed care pt. awake A+O x3. VSS c/o pain to neck and chest. medicated c percocet II tabs. (L) side neck exploration staples CDI ø drainage or bleeding - Two GSW to back of neck c serosanguous drainage minimal 2x2 dressing applied. Lungs clear HRRR S1S2 present Active BS x4 quad TBlerating PO. Encourage to ambulate. stretch and rotate head and neck. AM care complete Will cont to monitor
			[redacted] (b)(6)-2 (b)(6)-2 (1445) I concur c above assessment. [redacted]
6 Sep 03 @ 2000			Recieved pt p report @ 1800. Rt a/o, VSS, speaking un arabic. ø c/o pain @ this time. (L) neck staples OTA. ø drainage noted. 2x2 dry to prev. penrose drain CDI. lungs: CTA(B), HRRR (+) BS x4 qdb. IS use encouraged. H2O within reach @ BS. 2 pt restraints on, circulation intact. Will ambulate tonight. Anes cont. Will monitor [redacted] (b)(6)-2 (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)*

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NURSING NOTES

Medical Record

(b)(6)-4 [redacted]

STANDARD FORM 510 (REV. 7-91)
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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Sep 03 @ 2300	: Pt sitting 1 in bed. Just finished ambulating. BM x 1, formed, brown. Restraints put back on. Circulation intact. Pain relieved temporarily c percocet. HL R AC flushing easily. anes/cont. Will monitor [redacted] (b)(6)-2 9 Iwm 6.
7 Sep @ 0515	: IV Perc given for pain [redacted] (b)(6)-2. 9 Iwm 6
7 Sep 03 0700	Assumed care A+O x 3. Medicated on prior shift c/o pain or discomfort @ this time. Lungs CTA. HRRR Active BS x 4 quads. Wounds accessed. GSW to back of neck x 2. Dressing A CDI minimal drainage. Surgical repair incision to (L) side of neck staples CDI c drainage s/s of infection. Instructed to walk and shower regaining strength and mobility to neck and upper body. Will cont to monitor [redacted] (b)(6)-2 IIWK
7 Sep 03 1920	Pt sitting 1 in bed. VSS, c c/o pain @ this time lungs CTA B, HRRR, + BS x 4. Staples to neck OTA, c new drainage noted. 2x2 to prev. penrose drain sites. c minimal sero-sang. drainage. new dsg applied. Strength to (L) side of body increasing. ambulated in hallway c steady gait. c c/o occasional dizziness. Will monitor [redacted] 9 Iwm 6.

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

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

REGISTER NO.

WARD NO. TCW 1

[redacted]

(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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MEDCOM - 17852

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7Sep@ 2230	Pt OOB, had BM. Pt told translator that he felt constipated. Will monitor [redacted] (b)(6)-2
08SEP03	(1330) Assumed care of pt @ 0600 ϕ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. SL in @ arm flushes well s S/Sx infection/ infiltration. cont. IV antx. Pt tol. reg. diet well. Voiding s difficulty. Wet→dry dressgs Δd on back of neck. ϕ S/Sx infection @ wound sites. Staples to neck - open to air - CDI. Bacitracin applied to @ ear. 2 point restraints in place s S/Sx ~~infection~~ [redacted] (b)(6)-2 complications from skin breakdown/circulation. Will cont. to monitor. [redacted] (b)(6)-2
	(1630) 20g IV started in @ forearm - flushes well s S/Sx infiltration. SL in @ forearm dcd d/t infiltration. Rom in @ arm improving. Will cont. to monitor. [redacted] (b)(6)-2
8 Sep. 03 1945	Pt resting in bed, A+OX3, VSS, LS CTA(B), +BS x4, S1 S2 present, HOB 45°, staples on neck open to air, ϕ S/Sx of infex, applied bacitracin to (L) ear, SL in (R) arm patent, voiding c/y urine, ϕ skin breakdown + proper skin integrity on pts of restraint. [redacted] (b)(6)-2 (b)(6)-2
09SEP03	(1115) Assumed care of pt @ 0600 ϕ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Pt OOB to shower this am - amb s difficulty. Staples to neck/ear CDI - open to air. Wet→dry dressgs Δd

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
09SEP03	(cont) this am. Ø S/Sx infection 2 wound sites. SL in @ arm flushes well ⊼ S/Sx infiltration/infection. Pt tol. reg diet well. Voiding ⊼ difficulty. ROM ⊼ @ UE improving. 2 point restraints in place ⊼ S/Sx complication from skin break/circulation. Will cont. to monitor. (b)(6)-2 [redacted] WAC
09sep03@1930	Assumed care @ 1800; AU VSS; pt A&O X3 speaking arabic; ⊕ sensation & movement in all extremities, ⊕ UE & movement, grasp & strength; Ø c/o pain or discomfort @ this time; pt OOB to ambin hall X1 ⊼ assistance or complications, Ø c/o dizziness during amb; staples to neck, CDI, OTA, well approximated ⊼ S/Sx infection, ⊖ drainage; dsgs Δ'd, W→D; ⊖ B.M this shift; pt voiding QS, c/o urine ⊼ difficulty; 2 point restraints (b)(6)-2 in place; skin integrity & circulation intact; cont to monitor [redacted] (b)(6)-2 CRT
10 Sep 03 0630	Pt A to x 3 VSS Ø c/o pain or discomfort @ this time. Lungs CTA HRRR S1 S2 present. Active BS tolerated PO 75% breakfast consumed. Wound care completed laceration to ⊕ side of neck ⊼ staples CDI no s/s of infection noted. ⊕ bacitracin ⊼ gauze applied. GSW x 2 to back of neck dressing Δ' CDI minimal drainage on gauze. IV ABX therapy (b)(6)-2 [redacted] cont. Will cont to monitor 1153S) I concur ⊼ above assessment. [redacted] WAC

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	REC[redacted] MAINTAINED AT (b)(6)-2
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.

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(b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10Sep03	1915= VSS, ∅ c/o pain, A+Ox3, Staples to (L) side of neck, x2 Dsg's c/d/i to opposite to back of neck CD1. Pt. seems to have a stiff neck & is guarded w/ upper neck & facial area. Applying Bacitracin to (L) ear as needed. IV Hep to (L) FA 20G flushed & patent. Swelling ↓ to (L) side of face. Pt. gets OOB & ambulates w/ difficulty. Continuing IV antibx around the clock. ∅ other remarkable assessment findings. Will continue to monitor. [redacted] RN (b)(6)-2
10Sep03	1915= restraints x2 while in bed. Skin integrity intact to extremities restrained. [redacted] RN (b)(6)-2

Use other sheet.

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
11 Sept 03 0900	Pt A+O x 3. VSS ø c/o pain. Pt guarded on left side of face. Pt self applies bacitracin. Denies food; voided clear yellow urine. Pt refuses to ambulate. No other remarkable findings. [redacted] (b)(6)-2
11 Sep 03 1910	Pt sleeping, easily aroused. HL (L) Arm flushing easily, VSS. ø c/o pain @ this time. (L) neck sutures (staples) intact ø s/sx infection noted. (L) ear incision site ø s/sx infection. clear drng to back of neck (prev. penrose drain site) minimal sero-sang drainage noted. 2 pt restraints on. +2 pulses, circulation intact. Will monitor [redacted] (b)(6)-2 9 Hume.
2030	IT Percocet given per pain [redacted] (b)(6)-2 9 Hume
12 Sept 0830	Pt. A+Ox3, VSS ø c/o pain, neck skin intact with ø signs of infection; sutures & staples intact ø infection. Outside dressing to back of neck (prev. penrose draining a little sero-sang) (b)(6)-2 pt restrained. 2 pulses and circulation intact. Will monitor [redacted]
12 Sep 03	1915 = VSS, ø c/o pain @ this time, ambulating in hallway ~ difficulty. Staples to (L) side of neck CDI, DSG's to back of neck CDI - reinforcing prn. Applies bacitracin to (L) ear by himself prn. ↓ swelling to (L)

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

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

REGISTER NO.

WARD NO. ICU #1

[redacted]

(b)(6)-4

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

MEDCOM - 17856

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(Continued 12Sep03@1915): side of face but still guarded of that area. IV Hr to (L) FA. Continuing IV antibiotics. Other remarkable findings. Will continue to monitor: [redacted] (b)(6)-2 ITS/AN
13Sept03 CSW	VSS. Alert & Oriented. COB to Br for AM care. Consumed regular diet for [redacted] (b)(6)-2 breakfast. Lungs clear Bilateral. BS(+)X4 good Abd. Soft-non distended. Peripheral pulses palpable. Left ear sutures intact and without drainage. Left neck staples intact and without drainage. Back of neck dsg dry & intact. Restraints removed & replaced. Skin under restraints intact. Will continue plan of care. [redacted] (b)(6)-2 ZCTA
1945	Rt alo, sitting ↑ in bed, VSS, clo neck pain. TI Percocet given. Staples intact to (L) neck, bacitracin applied to (L) ear. Dsg to back of neck, dry & intact. 2 pt restraints on. circulation intact. Clindamycin & Ancef cont. Will monitor [redacted] (b)(6)-2 9llcm6.
2100	ambulated in hallway for 30 min. c steady gait. & clo dizziness. [redacted] (b)(6)-2 9llcm6.
2140	Dsg to back of neck d/d. small amt of sero-sang. drainage noted. [redacted] (b)(6)-2 9llcm6.

[redacted] (b)(6)-4

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

MEDCOM - 17857

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)*
14Sep03 0500	VSS. Alert & Oriented. Lungs clear Bilateral. BS(+) x4 quad. Abd soft - non-distended. Voids clear yellow urine. Consumed regular diet for breakfast. OOB to BR this AM for AM care. (L) [redacted] neck incision with staples intact. (L) ear incision with sutures intact - dry, intact & dry to back of neck. Bacitracin applied to (L) ear canal. (L) FA Saline lock patent & intact. [redacted] Peripheral pulses palpable +2. Ambulated - steady gait. Restraints removed & reapplied skin intact under restraints. Will continue plan of care. [redacted] RN
14Sep03 1900	Pt alox3, VSS, ø c/o pain @ this time. Lungs: CTAB, HRRR, (+)BS x4 qds, +2 pulses. 2 pt restraints on, circulation intact. Bacitracin applied to (L) ear. Staples to (L) neck: ø c/s/sx infection/infiltration Dsg to back of neck dry & intact. Pt does not want to ambulate @ this time due to dizziness. Will monitor [redacted] 911WM6 SPC
2200	ambulated in hallway x 2 (30 min). ø c/o dizziness. Restraints put back on [redacted] 911WM6

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

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

[redacted]

(b)(6)-4

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

MEDCOM - 17858

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	**NOTES**
15Sept 0900	Pt. Awake + alert X3, pupils equal and reactive to light VSS, pulse regular and in range for age, nail beds and skin pink, dsg to back of the neck intact pt has ø of pain except from right IV site, new IV on left started, sutures skin intact healing well pt voiding dark yellow urine - [redacted] (b)(6)-2
16sep03@0300	Assumed care @1800; All VSS, pt A&O x3, ⊕ CMS x4, ↓ strength & movement in Ⓛ UE; otherwise NV intact; pt OOB to amb x1 to BR & then in hall for 20 min, pt tol well, ø c/o dizziness or SOB, slow, steady gait; dsg to back of neck Δ'd ⊖ drainage noted; Bacitracin applied to Ⓛ ear; sutures intact ø s/sx infection, well approximated; HL in Ⓛ FA patent & intact, freely flushes Cont c̄ abx tx; ø Δs in assessment; cont to monitor (b)(6)-2 [redacted]
16sep03@0315	2 point restraints in place; ⊕ circulation, ⊖ skin break ↓ (b)(6)-2 [redacted] (b)(6)-2 [redacted]
16Sept03 0800	VSS. Alert oriented lungs clear bilaterally. BS ⊕ X4 good. Abd soft non distended. Consume regular diet for Breakfast. Ⓛ [redacted] (b)(6)-2 neck incis intact / dry c̄ staples inplace. Ⓛ ear incision intact & dry c̄ sutures inplace. Bacitracin applied as ordered. OOB to BR. Ambulate c̄ steady gait. Saline lock to Ⓛ FA patent/intact — [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER
				[redacted]

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)-2

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
16 Sep 03 1900	Rt A&O, VSS, ∅ c/o pain. HRRR, lungs CTAB, BBS x4. staples to neck intact. ∅ drainage noted. ∅ s/s infection. Bacitracin to (L) ear. drsgs to back of neck D/I. scant amt of sero-sang drainage noted. ambulated x1 (15 min). ∅ c/o dizziness, steady gait. 2 pt restraints put on, circulation intact. Rt refused mattress to prevent skin breakdown. Will monitor (b)(6)-2 9 Wilmo. (b)(6)-2 CMT
17 Sep 0100	18ga IV restarted to (L) wrist. prev. IV c/ pain & redness. (cath intact). Will monitor (b)(6)-2 9 Wilmo
17 Sep 03 0700	- Assumed care of pt. A+O x3 VSS ∅ c/o pain or discomfort at this time Dressing change BSW to back of neck 2x2 c/ small amount of bleeding. Surgical incision to (L) side of neck closed c/ staples open to air clean ∅ s/s of infection healing well. W/I cont to monitor (b)(6)-2 9 carrico.
17 Sep 03 0900	- staples to (L) side of neck removed per MD ∅ drainage noted No bleeding W/I cont to monitor (b)(6)-2 carrico (17HD) I concur c/ above assessment. (b)(6)-2 (b)(6)-2 RA
1905	Rt resting in bed. prev. staple incision to (L) neck-∅ drainage noted. Bacitracin to (L) ear ∅ c/o pain. ambulated x1. ∅ c/o dizziness. 2 pt restraints on, circulation intact. Back of neck dsgs D/I. scant amt. blood noted. Will monitor (b)(6)-2 9 Wilmo. (b)(6)-2

BACK

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
19Sep03 1900	Pt lying in bed, a/o, VSS, LCTAB, ⊕ BS, HRRR, ø c/o pain @ this time. Prev incisions to neck c̄ ø s/sx infection. ø drainage noted. Pt ambulated x1, voiding qs via urinal. 2 pt restraints on circulation intact. Will monitor (b)(6)-2 [redacted] 91WM6
20Sep03	@0100 - I concur c̄ above assessment [redacted] (b)(6)-2
20SEP03	(1505) Assumed care of pt w/ 0600 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt amb s̄ difficulty. Incision/wounds to back of neck CDI s̄ S/Sx infection. SL in Ⓛ forearm flushes well s̄ S/Sx infiltration/infection. Pt tol. reg diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ S/Sx complications. Will continue to monitor. (b)(6)-2 [redacted]
(1910)	Pt a/o, VSS, HRRR, lungs: clear, ⊕ BSx4, ø c/o pain @ this time. Wounds to back of neck clean + dry c̄ ø s/sx infection, ø dizziness when ambulating noted. Ⓛ FA HL flushing easily. Voiding adeq. qs. 2 pt restraints on. ⊕ circulation. Will mon (b)(6)-2 [redacted] 91WM6. (b)(6)-2 [redacted]
21Sep03 0500	Received pt resting in bed this am. VSS, AxOx3, speaks Arabic. ø drainage to wounds on back of head/neck ø S/S infection noted. Amb in halls indep w/ steady gait. AM care provided. SVGS, IV access Ⓛ a C/D/I, flushes easily @ this time. ø other remarkable assessments. Restraints in place per

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
18Sep03@1200	Received at this am in stable condition, A&OX3, VSS, speaks minimal english. amb to restroom, shower provided ⊕BM, Sugs, IV Ⓛ fa patent + intact. Bacitracin to Ⓛ ear. pt has cont stiff mvmt to neck and three small wounds to back of head. ∅ other remarkable assessments. Tol po. Will cont to monitor. [redacted] (b)(6)-2
18sep03@2330	Assumed care @ 1800; VSS; A&OX3 speaking arabic c̄ minimal english; medicated c̄ percs c̄ good relief; pt ↑ ad lib amb to BR & up & down hallway c̄ supervision; S1S2, LSCTA(B); ⊕ BSx4, ⊖BM thus far, pt voiding QS, c/y urine; wounds to back of neck OTA c̄ minimal drainage - serosang; HL intact & patent, easily flushes; No Δs in assessment; 2 point restraints in place; ⊕ circulation, ⊖ skin break ↓; cont to monitor (b)(6)-2 [redacted]
19SEP03	(1125) Assumed care of pt @ 0800 p̄ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt amb in hallway s̄ difficulty. Incision/wounds to back of neck CDI s̄ S/Sx infection. SL in Ⓛ forearm flushes well s̄ S/Sx infiltration/infection. Pt voiding s̄ difficulty. Tol. reg diet well. 2 point restraints in place s̄ S/Sx complications. Will monitor [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S I.D. 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. ICW #1

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

MEDCOM - 17862

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
21Sep03 1850	ENT protocol. Ø S/S of skin breakdown/vascular issues. Will cont to monitor pt. [redacted] (b)(6)-2
1905	Pt A&O, VSS, Ø c/o pain @ this time. Ambulated x1 c̄ steady gait, Ø c/o dizziness. Back of neck wounds OTA Ø drainage noted, Ø s/sx infection. ~~at~~ [redacted] (b)(6)-2 ~~infiltrate~~ HL Ⓛ FA flushing easy. Voiding adequate qty. 2 pt restraints on ⊕ circulation. Will monitor (b)(6)-2 [redacted]
2210	Pt refused scheduled ambien 10mg. (b)(6)-2 [redacted]
22Sep03 0900	Awakens to his name. VSS. NAD. Wounds to Ⓛ side of neck, ear & back of neck open to air & healing well Ø drainage. Void per Bathroom. Skin integrity & circulation to restrained extremities without compromise. Will assess throughout shift. Will ambulate & complete Am Care (b)(6)-2 [redacted]
22Sep03 1030	Medicated c̄ 2 (two) percocet p.o. for c/o Ⓛ neck & facial pain. Will monitor for effect (b)(6)-2 [redacted]
22Sep03	1300 Sleeping; NAD. (b)(6)-2 [redacted]
22Sep03	2015 = VSS, IV to Ⓛ arm flushed & patent HL'd, wounds to back of neck healing, edema to Ⓛ side of face, Ⓛ ear wound - applying →

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.

C# [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
	bacitracin (pt. does on his own), DOB and ambulate S difficulty, pain management issues will continue to monitor (b)(6)-2 [redacted] ort/AW
9-23-03 0940	Sleeping. Tolerated breakfast well. VSS. Lungs CTA BS. Neck & ear wounds healing well. Open to air. & drainage. Great improvement on moving head. Ambulates in hall for exercise. Denies pain @ this time. Will continue monitoring (b)(6)-2 [redacted] mds/ron
9-23-03 1440	D/C to EPW Camp escorted by mps. Hospital d/c'd S complications. Pt A&O. Wounds open to air S drainage. (b)(6)-2 [redacted] mds/ron

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
9/23/03	D/C Summary
	Date Admit 8/28
	Date D/C 9/22/03
	Diagnosis: GSW neck
	Resume: Pt admitted via ER - taken to OR for
	neck exploration = Findings; no esophageal injury,
	mandible graze wound. no evidence of neuro injury,
	airway or esophageal injury. Post-op pt stable.
	CT neck post op c abscess, pt on IV abx. Slowly
	[illegible]. Other wounds stable. Pt d/c. Antibiotic[illegible]
	fine. Needs extract. Tolerate po well. Wound stable.
	Disposition: custody
	Cond: Stable
	Meds: none
	[redacted] (b)(6)-2
	[illegible]

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

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

CITY | STATE | ZIP CODE

ARRIVAL

DATE (Day, Month, Year): 28 AUG 06 | TIME: 0430

TRANSPORTATION TO FACILITY: AIR

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

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

CURRENT MEDICATIONS: Ø

ALLERGIES: NKDA

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

EMERGENCY ROOM VISIT	
DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
TETANUS	
DATE LAST SHOT	COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW to Posterior Neck

CATEGORY OF TREATMENT

- ☑ EMERGENT
- ☑ URGENT
- ☐ NON-URGENT

TIME: 0430

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

VITAL SIGNS

TIME	0430	~~0445~~ 0500	0515			
BP	103/46	100/44	101/46			
PULSE	90	91	93			
RESP	20	20	18			
TEMP	97.1					
WT	150	97% RA	97% RA			

LAB ORDERS

- ☒ CBC/DIFF ☒ ABG ☒ PT/PTT
- URINE C&S ☒ UA MSCC/CATH
- BLOOD C&S X
- ☒ T&C X2
- ☒ BHCG/URINE/BLOOD/QUANT
- ☒ CHEM: Met B

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 97% RA ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0430	16mg Anacin IV	[redacted]	[redacted]	0440	(b)(6)-2 all
0430	.5 Tetanus IM			0440	
0435	2mg MSO4 IV			0445	
0500	3mg MSO4 IV			0500	

DISPOSITION: ☐ HOME ☐ FULL DUTY

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

MODIFIED DUTY UNTIL | RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE | TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

EPW ♂ [redacted] (b)(6)-4

[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 - 17866

NSN 7540-01-075-3786

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

TEST RESULTS

CBC
- WBC
- H/H 11/33
- PLT
- PT
- APTT

SMAC: 141 | 107 | 9 / 4.0 | 28

BHCG | ETOH | GLU

VBG/PULSE OX

SUP 02	PH	PO2
50	7.30	

PCO2	SAT	OTHER
57		T+C

U/A: DIP; MICRO

RADIOLOGY — Check if read by radiologist ☐

RESULTS: CXR – no pneumo; c-spine – ¢FxØ shrapnel C7-T1, [illegible] multiple

EKG INTERPRETATION: Seen

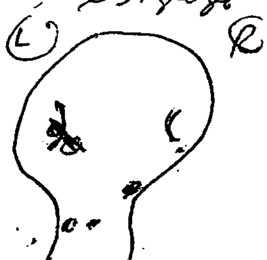
PROVIDER HISTORY/PHYSICAL

27 y/o ♂ EPW GSW to back of neck tonight "By Allelrigate"
pt AAOx3 arrived via Aerovac. last meal @ 2100.
pt c/o Ⓛ + Ⓡ side (Ant) neck pain. pt follows all commands
through interpreter. pt Ø other complaints

PMH – Ø
PSH – Ø
[illegible] – [illegible]?
See P203

Ge: WD, WN, ⊕ PAIN, AAOx3
H: ⊕ multiple wounds to back of head and thighs
N: Ⓛ ear. ⊕ TTP Ⓛ Ant neck, ⊕ Edema
O/P Ⓒ, PERRLA, [illegible] Ø Bony TTP, Ø Stepoffs
LSCTA ③ Ø r/r/w
BMRRR Ø g/r/g
Ext: ⊕ C/C/E
ABD: soft, NT, ND ⊕BS

Neuro: Nonfocal Exam
? Ⓛ Lip Droop
Old vs new.
pt not sure



A/P
to OR for Exploration
TVF 3300 prior to leaving for OR.

CONSULT WITH	TIME	ACTION
[redacted] (b)(6)-2	Ancef 1gm	
	d70.5 TM	
	5mg MSO4 IV	

DIAGNOSIS
① GSW to Neck and ② Ear

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

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

CODES (b)(6)-2

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

EPW ♂
[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

510-112

NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8.28/0900			Assumed pt care from anesthesia @ approx 0820. Pt arrived hemodynamically stable. Pt arrived on CRO KVO. Pt placed on vent: SIMV 16, VT 650, fio2 60%, peep 5. Pt placed on versed, fentanyl & vecuronium drip. NG placed to LIS, foley placed to gravity. Pt in no apparent distress. (b)(6)-2 [redacted] ICTRU
8.28/1030			(R) femoral-A line placed, zeroed & correlating c NIBP, CXRay done for ETT placement (b)(6)-2 [redacted] ICTRU
8.28/1900			Pt remains paralyzed on vec & sedated c versed & fentanyl c pertinent. Remains hemodynamically stable & afebrile. Vent settings d/d to fio2 ↓ to 35% & RR ↓ 14 will redraw ABG q4hrs 30-45mins. UO remains high ~ 200cc/hr. (b)(6)-2 [redacted] ICTRU
8.28/1645			Dr. (b)(6)-2 [redacted] notified of ↑ U/O. Per Dr. (b)(6)-2 [redacted], UX & chem sent (b)(6)-2 [redacted] ICTRU.
8.28/1800.			Report given to CT (b)(6)-2 [redacted] for change of shift pt stable (b)(6)-2 [redacted] ICTRU

(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.

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

NURSING NOTES

Medical Record

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

MEDCOM - 17868

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8/28/03		1800	NSG ASSESSMENT AS FOLLOWS: Received report from off going staff. Pt resting comfortably in bed ↑HOB 15°. (N) paralyzed on vecuronium @ 100 mcg/kg/hr, sedated ā versed @ 4mg/hr & fent @ 100mcg/hr; PERRL 3mm; Ø movement noted; (R) SIMV of 14; 35% FiO2, PEEP 5, TV 650; #8 ETT 22 @ the teeth; CTA (B) Θ S/S cyanosis noted. (CVS) S1, S2 NSR (80s); Art BP currently 100/60. Periorbital edema noted; cool distal extremities; pulses in LE > UE (3+ > 2+); cap refill < 3 sec. (GI) NPO to LIWS; flushing NGT as ordered; hypoactive BS Θ ___ (GU) ⊕ U/O (see I/O); Clear yellow urine, foley to gravity. (Skin) neck wounds with (S) penrose drains - scant/marked amount of serosang drainage noted. (Lines) foley, ETT, PIV x2; (R) fem art line. (Plan) monitor through night; position for comfort ā interrupting; [redacted] / KNR
			[redacted] ICTR
			[redacted]
8/28/03	2200		Pt remains vented with no Δ's to above settings. ⊕ sedation; ⊕ paralytic; Position Δ'd. ⊕ interacting with staff via ↑HR, BP when stimulated with sternal chest rub/movement of body.
			[redacted] ICT/Ar
			[redacted]

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

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 17869

ACLU-RDI 1644 p.29

DOD-031443

510-112

NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
8.29.03	0630		Assumed pt care from LT (b)(6)-2 [redacted] at change of shift pt in no apparent distress. A&O x 3 & afebrile. @ change of shift pt on 1.4mcg/kg/min vec, 2mg/hr versed, 70mcg/hr fentanyl, 125cc/hr LR, NG (Cuare to LIS, FTG, on vent settings SIMV 14, peep 5, fio2 35% Vt 650 spo2 100%, no overbreathing vent. Pt non-responsive to painful stimuli either upper or lower ↑ HR & ↑ BP to painful stimuli (b)(6)-2 [redacted] ICTAN
8.29.03	0900		At approx 0900 per V/O Dr (b)(6)-2 [redacted] vecuronium turned off for possible extubation. versed & fentanyl remain @ 2mg/hr & 70mcg/hr respectively. will cont to monitor closely (b)(6)-2 [redacted] ICTAN
8.29	1430		At approx 1430 pt extubated 5 complications. Dr. (b)(6)-2 [redacted] & RT present @ time of extubation. Pt currently on 2L NC @ spo2 98-100%. RR 14-18 all other VSS. ABG sent 40 mins post extubation. ABG grossly WNL. Dr. (b)(6)-2 [redacted] assessed pt during rounds & no further actions rqd. Pt in no apparent distress this time. pt currently resting quietly in bed
8.29	1600		LUE remains weak as so does (L) side facial drooping. Dr (b)(6)-2 [redacted] aware (b)(6)-2 [redacted] ICTAN
29Aug03	2050		Received report from LT (b)(6)-2 [redacted] and assumed care of pt. See DA from 4700 for assessment data. @ 1900 added more pressure tubing to a-line so transducer could be replaced for proper (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.

GPW [redacted]

(b)(6)-4

NURSING NOTES
Medical Record

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

MEDCOM - 17870

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
cont.			Zeroing. New tubing added, zeroed & BP's corelating. SL to (P) AC flushed. Assisted pt to turn on (L) side. Foley still draining well. Fentanyl was increased d/t pt c/o pain in neck/throat. Interpreter came to tell pt plan of care. Gave pt small sips of H2O. Tolerated well. (b)(6)-2 [redacted] TAN
	0420		Pt has been up all night asking to be Suctioned but there is nothing to suction. Occasionally Pt will have strong cough able to clear secretions on own. VSS. (b)(6)-2 [redacted] TAN
	0615		Drew labs through A line @ 0430. Taken to lab. Washed up patient. Δ'd some liner. Δ'd bandages on head. 1 Penrose drain to (R) side of upper neck. Moderate Serosanguineous drainage. 1 Penrose drain to (L) side of neck by drainage (RN) minimal drainage. Pt (b)(6)-2 1 Penrose drain behind (L) ear. Staples intact from behind (L) ear and down (L) side of neck from head. Slightly painful for patient. Still unable to lift (L) arm but can move hand. Pt put on RA and sats >95%. Report given to LT (b)(6)-2 [redacted] LVT/RN Pt stable @ this time.
0.3d	0730		Assumed pt care from (b)(6)-2 [redacted] Pt in no apparent distress @ Change of shift. Pt awake on RA @ 25cc/hr d/t pt @ 5cc/hr. Dr. (b)(6)-2 [redacted] changed dressing, applied Steristrips as slightly approx 2cm each (R). Wounds draining Serosang moderate amounts of purulent drainage noted. Pt bleeding dressing/wound. Reported to Dr. [redacted] (b)(6)-2 [redacted] (b)(6)-2
0.35	0800		

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
30 Aug 03	0930		Assumed care, agree c̄ the initial assessment. OOB to chair [illegible] well. Translator @ bedside. update given to pt for coughing & deep breathing rationale given [illegible] X10. pt verbalized agreement [illegible]
	1000		Tolerate drinking H_2O s̄ difficulty (b)(6)-2 [redacted]
	1130		Pt back to bed. pt [illegible] very hesitate to move. [redacted] translator @ bedside. (b)(6)-2 [redacted]
	1200		Tolerate cl. liquid diet s̄ difficulty (b)(6)-2 [redacted]
	1235		DC'ed Foley. orders received to xfer to ward. (b)(6)-2 [redacted]
	1300		Report given to ICW (LT [redacted]) (b)(6)-2 DC'ed A-line x5 min pressure applied drsg. (b)(6)-2 [redacted]
	1300		Updated RS when Foley cath was DC'ed @ 1235 [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 [redacted] facility)

[redacted]

(b)(6)-4

REGISTER NO.

WARD NO.

NURSING NOTES

Medical Record

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

MEDCOM - 17872

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
30 Aug 03	0930		Assumed care, agree c̄ the initial assessment. OOB to chair assisted with translator @ bedside. update given to pt for coughing & deep breathing rationale given. Pt ISO x10. pt verbalized agreement
	1000		tolerate drinking H_2O s̄ difficulty (b)(6)-2 [redacted]
	1130		Pt back to bed, pt remains very hesitant to move. translator @ bedside. (b)(6)-2 [redacted]
	1200		tolerate cl. liquid diet s̄ difficulty (b)(6)-2 [redacted]
	1235		DC'ed Foley, orders received to go to ward. (b)(6)-2 [redacted]
	1300		Report given to ICW (LT [redacted] (b)(6)-2
			DC'ed A-line x5 min pressure applied dsg. (b)(6)-2 [redacted]
	1300		Updated NS when Foley cath was DC'ed @ 1235 (b)(6)-2 [redacted]

(Continue on reverse side)

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

[redacted]

(b)(6)-4

REGISTER NO. WARD NO.

NURSING NOTES

Medical Record

MEDCOM - 17873

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

ACLU-RDI 1644 p.33

DOD-031447

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 27 HEIGHT: WEIGHT: 70	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE: C-spine - cleared Neck Exploration NPO @ 2100

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: (-) Implants: ? Medications: ?
Jewelry removed: yes no Family waiting: yes no
(+) TUB

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

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

[redacted] (b)(6)-4

DA FORM 5179, JUN 91 Previous editions are obsolete. MEDCOM - 17874 Needles 8 L-5+5 4x8 10 USAPA V1.01

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

(b)(6)-2 10. [redacted] COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.
[redacted] CRNA 28 Aug 03 DATE

11. POSTOPERATIVE EVALUATION:

(b)(6)-2

12. PREOPERTIVE EVALUATION PREPARED BY (S[redacted] CRNA DATE: 8/28/03 TIME: 0535	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title [redacted] CPT, AN DATE: 28 Aug 03 TIME: 0830

(b)(6)-2

REVERSE OF DA FORM 5179, JUN 91 MEDCOM - 17875 USAPA V1.01

MEDICAL RECORD — INTRAOPERA[illegible]OCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: cart BY: OR stff

2. PATIENT ID [redacted] VERIFIED BY [redacted] CPT [illegible]

3. DATE: 28 aug03 TIME PATIENT ARRIVED IN SUITE: —

4. PATIENT IN ROOM TIME: 0547 (b)(6)-2 NUMBER: 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: speaks & english ; info through translator

6. NURSING PERSONNEL

ASSIGNED SCRUB	Spc [redacted] 91D (b)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] (b)(6)-2 66E; CPT [redacted] 66E	RELIEF CIRCULATOR	CPT [redacted] 66E (0705-end) (b)(6)-2

7. POSITION AND POSITIONAL AIDS (Specify) (b)(6)-2

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

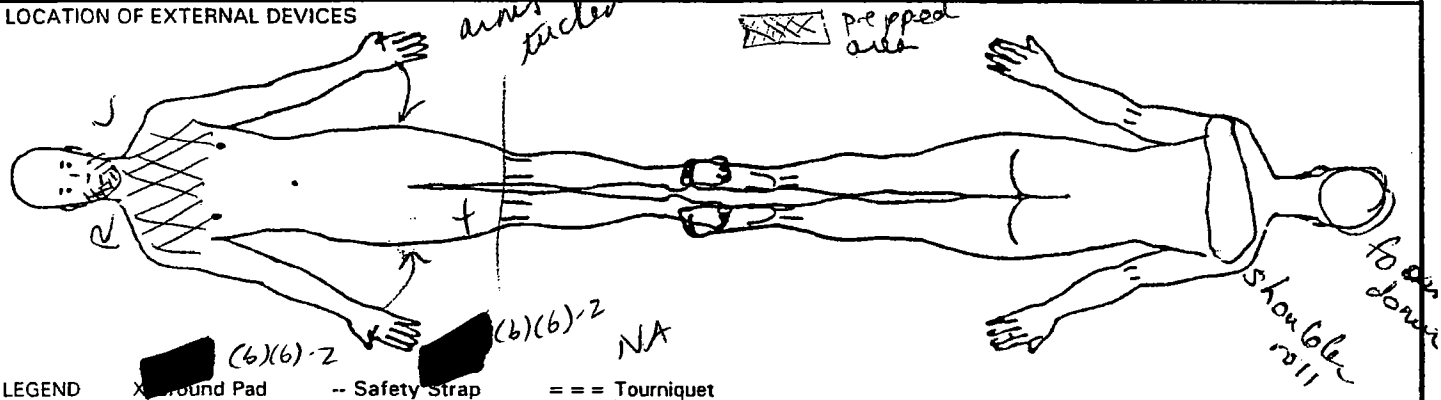
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine
SITE: face see #9 BY WHOM: [redacted]
SITE: BY WHOM: (b)(6)-2
COMMENTS: * pooling

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No	/	E	E	(b)(6)-2 [redacted]	(b)(6)-2 [redacted]
Needle Sharp	☑ Yes ☐ No	/	E	E		
Instrument	☐ Yes ☑ No					
Other	☐ Yes ☑ No					

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

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

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO 40/40

☑ ESU NO: 105305 VL
GROUND PAD: BRAND VL Rem Poly II
LOT NO: [redacted]

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES MEDCOM - 17876 [illegible]HICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) (b)(6)-2 YES ☐ NO ☐ (b)(6)-2

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Bacitracin ointment	QS	intraop	topical	[redacted]	Dr [redacted]
Surgicel	QS	intraop	topical	[redacted]	Dr. [redacted]
				(b)(6)-2	(b)(6)-2

WOUND IRRIGATION 0.9% NaCl ☑ YES ☐ NO, TYPE(S):

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 16 FR Foley (EMT)	2. Penrose	3.
SITE	1. Bladder	2. (L) ear.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
- 4x8's
- medipore

19. ADDITIONAL INFORMATION

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

Foley draining clear yellow urine

Zeta

20. OPERATION(S) PERFORMED

Neck Exploration, NG tube placement

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU3/RR	0830	litter

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

REVERSE O[redacted]5179-1, OCT 87 MEDCOM - 17877 USAPA V1.01

[redacted] CPT, AR

ICU #3

(b)(6)-4 [redacted]

8. ETT 24@lip

28TH COMBAT SUPPORT HOSPITAL VENTILATOR FLOW SHEET

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	PCO2	PO2	BE	HCO3	SaO2	REMARKS	INT
28 Aug	1015	SIMV	16	650	50	5	22	0	60	100	124/83							↓ FIO2 40%	[redacted]
28 Aug	1225	SIMV	16	650	35	5	23	0	66	100	126/85								
28 Aug	1408	SIMV	16	650	35	5	23	0	78	100	131/90								
28 Aug	1600	SIMV	14	650	35	5	22	0	81	100	124/72								
28 Aug	1800	SIMV	14	650	35	5	23	0	88	100	128/74								
28 Aug	2005	SIMV	14	650	35	5	23	0	84	100	124/71								
28 Aug	2321	SIMV	14	650	35	5	22	0	79	100	133/72								
29 Aug	0153	SIMV	14	650	35	5	17	0	93	100	118/68								
29 Aug	0602	SIMV	14	650	35	6	24	0	97	100	128/72								
29 Aug	0800	SIMV	12	650	35	5	24	12	85	100	120/64								
29 Aug	1000	SIMV	12	650	35	5	19	12	85	100	121/62								
29 Aug	1200	SIMV	12	650	35	5	26	12	95	100	117/65		(6)(6)	2					
29 Aug	1500	Pt extubated by CPT [redacted] /LT [redacted]						(6)(6)-2											

(b)(6)-2

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY	5 Sep 03						
POST- DAY		5 Sep 03	6 Sep	7 Sep			
MONTH-YEAR / DAY					08 SEP 03	09 SEP 03	10 Sep
19 / HOUR	0739	1900	0800 / 1815	0700 / 1830	8	84	0630 / 1900

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

107/65 H88 T98.3 R16	115/61 P84 P16 O2 96% RA	18 92/52 H94 T100.4 98% RA	8 95% RA	16 116/63 H79 T98.4 98% RA	16 113/60 96% RA	8 117/61 98% (RA) / 111/56 74 98.1 97%	8 105/61 104/61 98% (RA) 97% RA	16 105/56 H68 T98 98% RA / 113/59 P92 P16 O2 98% RA

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95)

MEDCOM - 17879

NSN 7540-00-634-41.

...DICAL RECORD — VITAL S... C RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

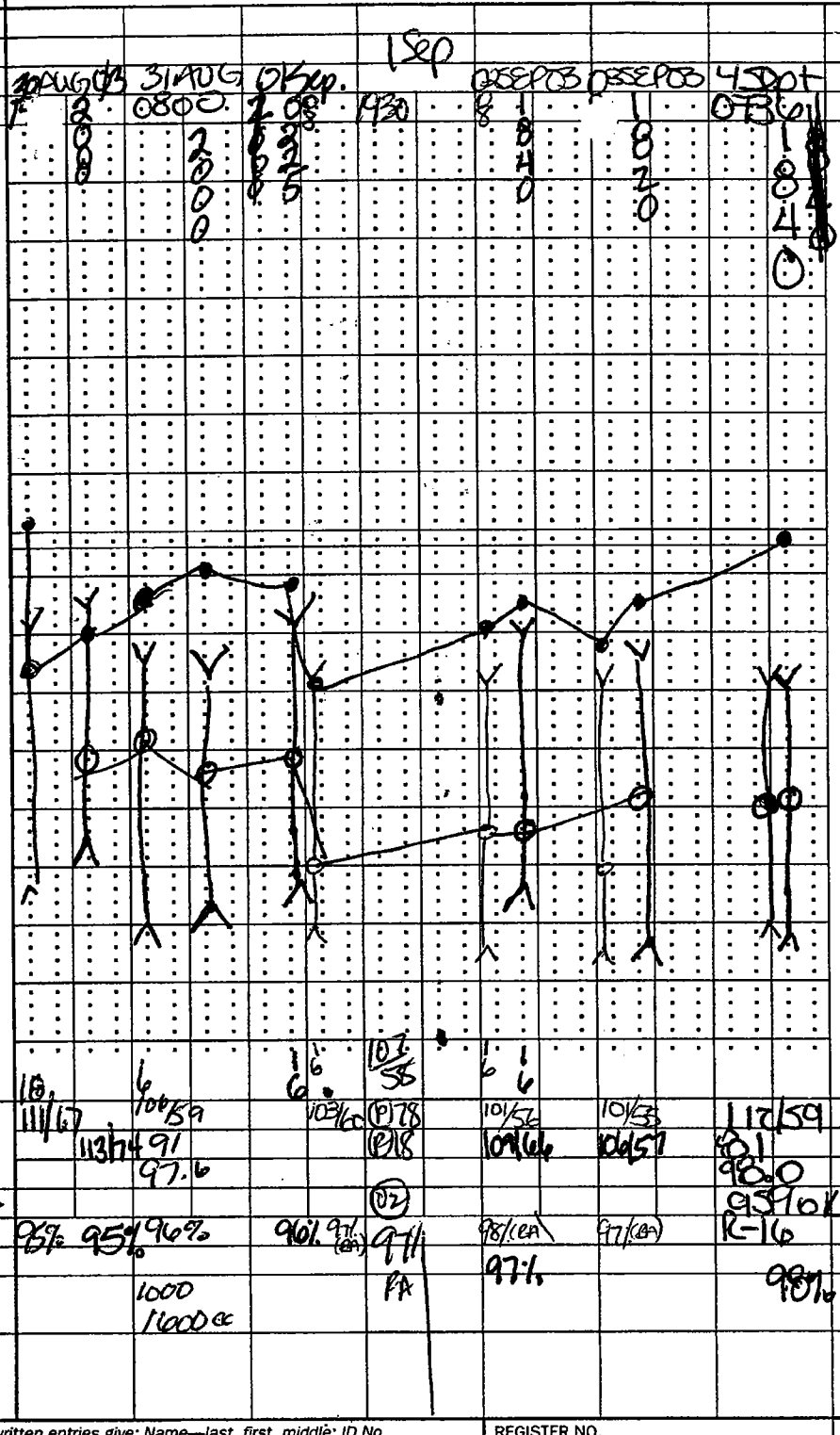
PULSE (O) | TEMP. F (°)

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

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

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

(Centigrade Equivalents, for Reference only)



RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

Urine Out

1000 / 1600 cc

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

#[redacted]

(b)(6) -4

REGISTER NO.

WARD NO. TCW#1

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY
POST- DAY
MONTH-YEAR 16 Sep 03 17 Sep 03 18 Sep 03 19 Sep 03 20 Sep 03 9/21 9/22
DAY
19 HOUR

PULSE (0) | TEMP. F (°) | TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

(b)(6)-4

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

MEDCOM - 17881

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (O) | TEMP. F (°)

105° | 180 | 104° | 170 | 103° | 160 | 102° | 150 | 101° | 140 | 100° | 130 | 99° 98.6° | 120 | 98° | 110 | 97° | 100 | 96° | 90 | 95° | 80 | 70 | 60 | 50 | 40

TEMP. C

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

(Centigrade Equivalents, for Reference only)

11 Sept 03 | 11/12 | 12 Sept | 13 Sept | 14 Sept | 15 Sept

11 Sept

1800 | 1900 | 1200

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT

Record special data only when so ordered

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

REGISTER NO.

WARD NO. TCW#1

[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 - 17882

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY: 23 Sept

19 | HOUR

PULSE (0) | TEMP. F (°)

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 112/64

79

97.0

HEIGHT: | WEIGHT → 210 lb

Record special data only when so ordered

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

EPW

[redacted]

(b)(6)-4

REGISTER NO.

WARD NO.

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

(b)(6)-2 [redacted]

(b)(6)-4 [redacted]

EPW

CBC

Chem 7

Abg

ICU 3

[redacted]

(b)(6)-2

(b)(6)-2

ID: [redacted]

DOB [redacted]

28-AUG-03
01:55

			Patient Limits	
WBC	17.6 H	x10^3/uL	4.5	10.5
RBC	5.08 L	x10^6/uL	4.90	6.00
Hgb	9.0 L	g/dL	13.1	18.0
Hct	38.6 L	%	36.0	54.0
MCV	92.9	fL	80.0	99.9
MCH	29.3	pg	27.0	31.0
MCHC	31.5 L	g/dL	32.0	37.0
Plt	152.	x10^3/uL	150.	450.
LY%	9.3	% L	30.5	51.1
LY#	1.8	x10^3/uL	1.2	3.4

---

i-STAT G3+

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

Pt Name:_____

TCO2_____22 mmol/L

At 37C

PH_____7.477

PCO2_____28.8 mmHg

PO2_____178 mmHg

HCO3_____21 mmol/L

BEecf_____-2 mmol/L

SO2*_____100 %

*calculated

Sample Type_:

28AUG03 10:09

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAM5046A
CLEW A93

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

28/08/03 09:57

REFERENCE RANGE: MALE

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

BASIC METABOLIC

DISC LOT #: 3203AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

GLU	137*	73-118	MG/DL
BUN	6*	7-22	MG/DL
CA++	7.4*	8.0-10.3	MG/DL
CRE	0.4*	0.6-1.2	MG/DL
NA+	132	128-145	MMOL
K+	3.9	3.3-4.7	MMOL
CL-	107	98-108	MMOL
tCO2	20	18-33	MMOL

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

D

Ward/Section: EMT	REQUESTING PHYSICIAN: DR [redacted] (b)(6)-2	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. EPW	DATE 28 AUG 03	TIME 0440	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Methyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS: ABG (0440) 664 PH= 7.294 PCO2=57.8
PO2=15 HCO2=28 TCO2=30 BC=2 SO2 HG=11 HCT 32
NA=141 K=4.0 CL=107 TO2 28 BUN 9 CREAT

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

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. FDW	DATE 28AUG08	TIME 0440	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*	*TEST*	*RESULT*	*REF. RANGE*
WBC		4.8-10.8 x 10^3	Color	Yellow	N/A	RPR		Negative
RBC		4.7-6.1 x 10^6	App	Clear	N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu	Neg	Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili	Neg	Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket	Neg	Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG	1.010	N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld	Neg	Negative	H. pylori		Negative
(Hematology) Manual Differential			pH	7.0	N/A	Micro Parasites		
Segs		Mono		Prot	Neg	Negative	Malaria	
Bands		Eos		Urob	0.2	0.2-1.0	O & P	
Lymph		Baso		Nit	Neg	Negative	Other	
Atyp		Imm		Leuk		Negative	**Microscopic Urinalysis**	
RBC Morph				HCG		Negative		

Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**
Other			Directigen		Negative	ABO/Rh	

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

REMARKS:

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

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

REMARKS
(b)(6)-2
Chem 7

Enter in above space
REQUESTING PHYSICIANS SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
TECH MD DATE
8/28/03
LAB ID NO.

URGENCY: ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT ☐
PATIENT STAT: BED ☐ OUTPATIEN ☐ NP ☐
SPECIMEN SOI (Specify)
SPECIMEN/LAB

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

(b)(6)-4

TEST(S)
SPECIMEN
DATE | A.M. P.M.

RESULTS	REQUESTED	(X)
	GLUCOSE	
	UREA N.	
	CREATININE	
	URIC ACID	
	SODIUM	
	POTASSIUM	
	CHLORIDE	
	CO_2	
	PHOSPHATE	
	CALCIUM	
	TOTAL PROTEIN	
	ALBUMIN	
	GLOBULIN	
	ALKALINE PHOSPHATASE	
	ACID PHOSPHATASE	
	SGOT	
	LDH	
	CPK	
	BILIRUBIN (TOTAL)	
	BILIRUBIN (DIRECT)	
	CHOLESTEROL	
	TRIGLYCERIDES	
	AMYLASE	
	LIPASE	
	PROFILE (Specify)	

CHEMISTRY I
(ARD FORM 546 (Rev. 8-77)
RIBED BY GSA ICMR
(41 CFR) 201-45.505
546-107

REMARKS
(b)(6)-2
Enter in above space
REQUESTING PHYSICIANS SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY
TECH MD DATE
LAB. ID. NO.

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

LABORATORY FILE

(b)(6)-4
8/28/03
CBC, Chem 7, ESR

i-STAT G3+

Pt: (b)(6)-4

Pt Name:_____

TCO2_____26 mmol/l

At 37C

pH_____7.544

PCO2_____29.3 mmHg

PO2_____141 mmHg

HCO3_____25 mmol/L

BEecf_____3 mmol/L

sO2*_____99 %

*calculated

Sample Type_:

29AUG03 04:32

Oper:

Physician:_____

Ser#

Ver: JAM5046A
CLE

======= PICCOLO =======
28/08/03 16:53
REFERENCE RANGE: MALE
PATIENT #: (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: DR #: 000
SERIAL #:

GLU	101	73-118	MG/DL
BUN	4*	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	910*	39-380	U/L
Na+	128	128-145	MMOL
K+	3.5	3.3-4.7	MMOL
CL-	104	98-108	MMOL
tCO2	20	18-33	MMOL

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

(b)(6)-4
28-AUG-03
20:42

				Patient Limits	
WBC	11.7 H	x10^3/uL		4.5	10.5
RBC	2.96 L	x10^6/uL		4.00	6.00
HGB	8.8 L	g/dL		11.0	18.0
HCT	27.2 L	%		35.0	60.0
MCV	91.9	fL		80.0	99.9
MCH	29.7	pg		27.0	31.0
MCHC	32.5 L	g/dL		33.0	37.0
PLT	230.	x10^3/uL		150.	450.
LYM%	21.3 *	%		20.5	51.1
LYM#	2.5 *	x10^3/uL		1.2	3.4

MEDCOM - 17887

SPECIMEN TAKEN

DATE 8 28 | TIME 1630 | A.M. P.M.

REQUESTED

RESULTS

yellow
Hazy
GLU — Neg
BIL — Neg
KET — Neg
SG — 1.010
BLD — Neg
pH — 6.0
PROT — Neg
URO — Neg 0.2
WBC — Neg

REMARKS

Cr [redacted]

Urinalysis

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY (b)(6)-2

TECH | MD | DATE 8/28/[redacted] 1630

ICU 3 [redacted] (b)(6)-4

MISC

URGENCY

☒ ROUTINE

☐ TODAY

☐ PRE-OP

☐ STAT

(b)(6)-2

LAB ID NO.

PATIENT STATUS

☐ BED

☐ OUTPATIENT

☐ NP

SPECIMEN SOURCE (Specify)

SPECIMEN/LAB RPT

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Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505

557-107

==== ==== PICCOLO =======
28/08/03 05:01
REFERENCE RANGE: MALE
PATIENT # [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 31[illegible]4A4
OPER #: [redacted] DR #. 000
SERIAL #: [redacted]

[illegible]	126*	73-118	MG/DL
[illegible]	8	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	419*	39-380	U/L
NA+	129	128-145	MMOL/L
K+	3.6	3.3-4.7	MMOL/L
CL-	109*	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

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

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 08/28/03 05:05 AM

Patient I[redacted] (b)(6)-4
Test Name :APTT
Test Result:= 30.6 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :08/28/03
Test Time :05:03 AM
Card Lot :010301
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 08/28/03 05:[illegible]

Patient ID[redacted] (b)(6)-4
Test Name :PT
Test Result:= 19.[illegible] sec.
RESULT NOT RANGE CHECKED
Ratio = 1.6
Calculated INR = 2.10
Sample Type:citrated wh. blood
Test Date :08/28/03
Test Time :05:06 AM
Card Lot :080201
Operator : [redacted]

MEDCOM - 17888

(b)(6)-4

ID: [redacted]

				Patient Limits	
WBC	14.1 H	x10^3/uL		4.5	10.5
RBC	3.27 L	x10^6/uL		4.00	5.00
Hgb	9.6 L	g/dL		11.0	18.0
Hct	30.3 L	%		35.0	60.0
MCV	92.8	fL		80.0	99.9
MCH	29.3	pg		27.0	31.0
MCHC	31.6 L	g/dL		33.0	37.0
PLT		x10^3/uL		150.	450.
LYM%	10.5	%		20.5	51.1
LYM#	1.5 *	x10^3/uL		1.2	3.4

---

i-STAT G3+

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

Pt Name:_____

TCO2_____23 mmol/L

At 37C

pH_____7.485

PCO2_____29.3 mmHg

PO2_____142 mmHg

HCO3_____22 mmol/L

BEecf_____-1 mmol/L

sO2*_____99 %

*calculated

At Patient Temp

pH_____7.485

PCO2_____29.3 mmHg

PO2_____142 mmHg

Patient Temp: 98.6F

FIO2_____: 30

Sample Type_: ART

28AUG03 14:58

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

AT G3+

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

Pt Name:_____

TCO2_____24 mmol/L

At 37C

pH_____7.467

PCO2_____32.1 mmHg

PO2_____110 mmHg

HCO3_____23 mmol/L

BEecf_____0 mmol/L

sO2*_____99 %

*calculated

At Patient Temp

pH_____7.468

PCO2_____32.0 mmHg

PO2_____110 mmHg

Patient Temp: 98.4F

FIO2_____: 35

Sample Type_: ART

28AUG03 15:56

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

---

i-STAT G3+

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

Pt Name:_____

TCO2_____26 mmol/L

At 37C

PH_____7.469

PCO2_____34.6 mmHg

PO2_____125 mmHg

HCO3_____25 mmol/L

BEecf_____1 mmol/L

sO2*_____99 %

*calculated

At Patient Temp

PH_____7.460

PCO2_____35.5 mmHg

PO2_____129 mmHg

Patient Temp: 99.7F

FIO2_____: .35

Sample Type_: ART

29AUG03 09:22

Oper: 0

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

---

i-STAT G3+

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

Pt Name:_____

TCO2_____29 mmol/L

At 37C

PH_____7.358

PCO2_____49.0 mmHg

PO2_____109 mmHg

HCO3_____28 mmol/L

BEecf_____2 mmol/L

sO2*_____98 %

*calculated

At Patient Temp

PH_____7.345

PCO2_____51.1 mmHg

PO2_____115 mmHg

Patient Temp: 100.3F

Sample Type_: ART

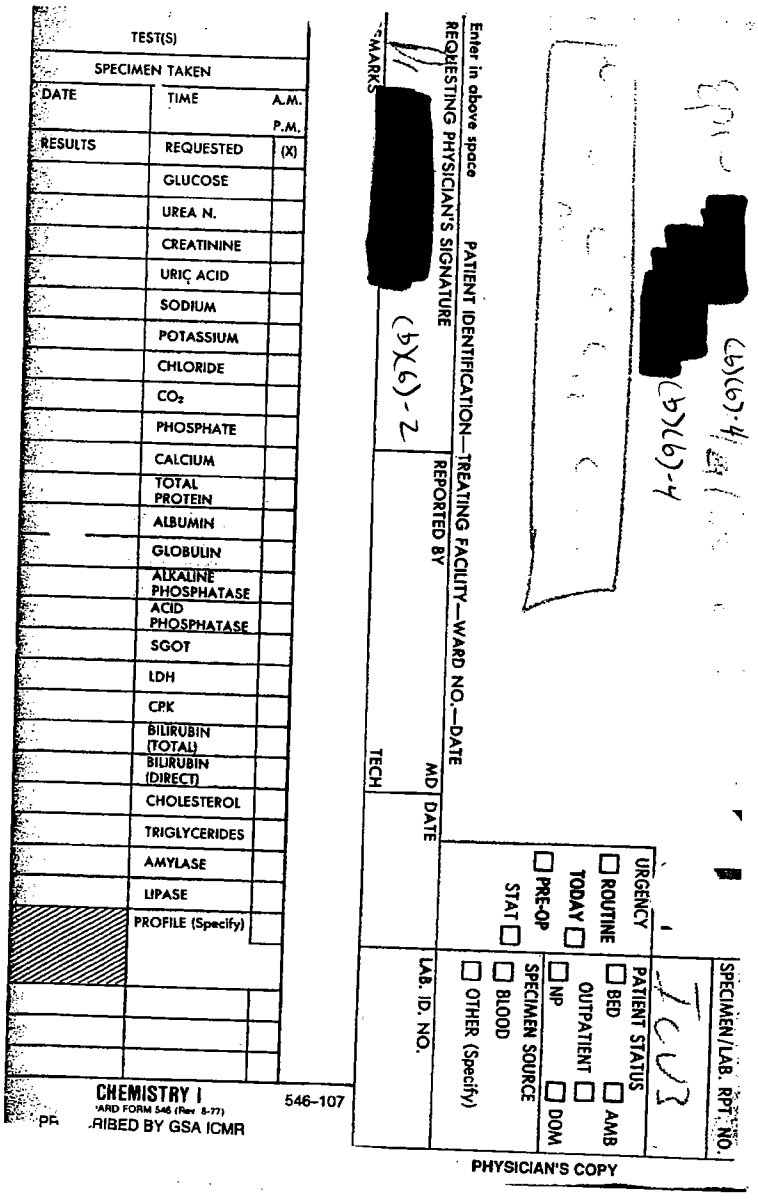
29AUG03 15:33

Oper: 0

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93



TEST(S)
SPECIMEN TAKEN
DATE | TIME | A.M. P.M.
RESULTS | REQUESTED (X)
GLUCOSE
UREA N.
CREATININE
URIC ACID
SODIUM
POTASSIUM
CHLORIDE
CO_2
PHOSPHATE
CALCIUM
TOTAL PROTEIN
ALBUMIN
GLOBULIN
ALKALINE PHOSPHATASE
ACID PHOSPHATASE
SGOT
LDH
CPK
BILIRUBIN (TOTAL)
BILIRUBIN (DIRECT)
CHOLESTEROL
TRIGLYCERIDES
AMYLASE
LIPASE
PROFILE (Specify)
CHEMISTRY I
ARD FORM 546 (Rev. 8-77)
SCRIBED BY GSA ICMR
546-107
PR
Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
MARKS
(b)(6)-2
REPORTED BY
TECH
MD
DATE
URGENCY
ROUTINE
TODAY
PRE-OP
STAT
PATIENT STATUS
BED
AMB
OUTPATIENT
NP
DOM
SPECIMEN SOURCE
BLOOD
OTHER (Specify)
LAB. ID. NO.
SPECIMEN/LAB. RPT. NO.
PHYSICIAN'S COPY
(b)(6)-4
(b)(6)-4

PICCOLO
29/08/03 04:40
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3082AA1
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

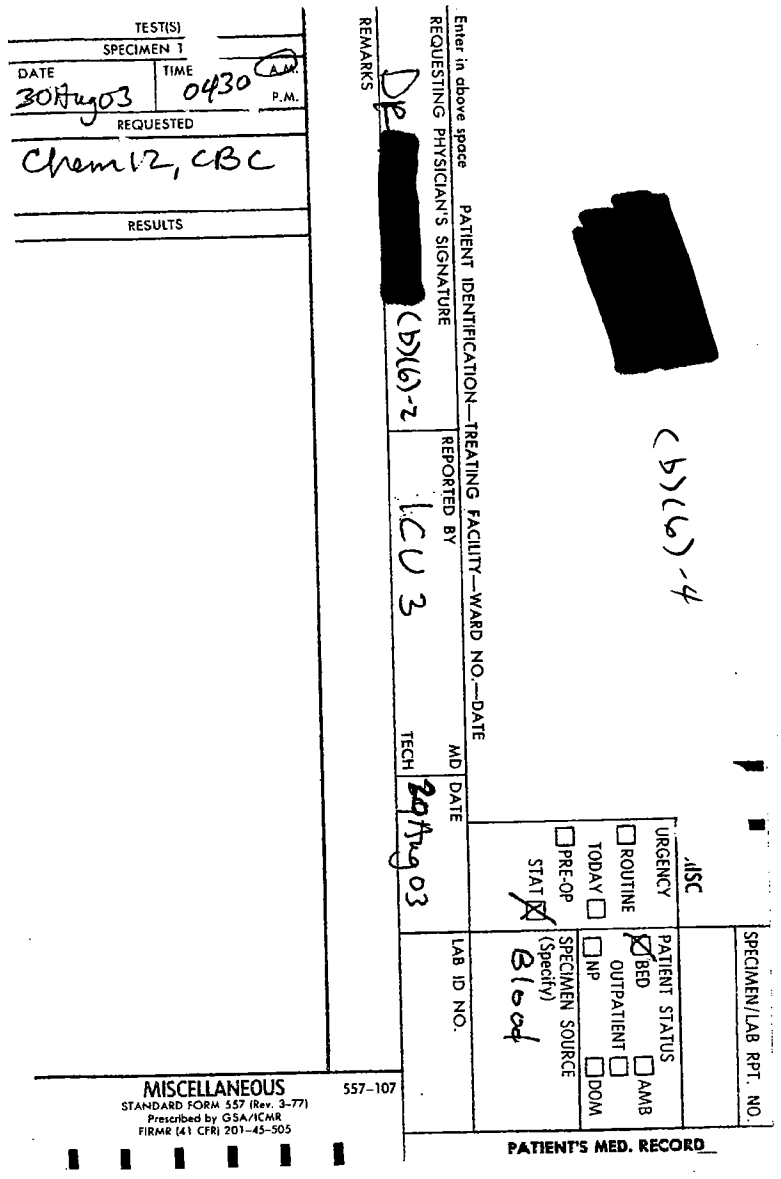
ALB	2.5*	3.3-5.5	G/DL
ALP	52	26-84	U/L
ALT	12	10-47	U/L
[illegible]Y	104*	14-97	U/L
AST	32	11 38	U/L
TBIL	2.3*	0.2-1.6	MG/DL
BUN	3*	7-22	MG/DL
CA++	7.8*	8.0-10.3	MG/DL
CHOL	66*	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	112	73-118	MG/DL
TP	4.9*	6.4-8.1	G/DL

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

PICCOLO
29/08/03 04:38
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	107	73-118	MG/DL
BUN	3*	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	1155*	39-380	U/L
NA+	127*	128-145	MMOL
K+	3.3	3.3-4.7	MMOL
CL-	103	98-108	MMOL
tCO2	21	18-33	MMOL

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



TEST(S)
SPECIMEN 1
DATE 30Aug03 TIME 0430 A.M. P.M.
REQUESTED
Chem12, CBC
RESULTS

REMARKS Dr [redacted]

Enter in above space
REQUESTING PHYSICIAN'S SIGNATURE
(b)(6)-2

PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REPORTED BY ICU 3
TECH
MD DATE 30Aug03

(b)(6)-4

DISC
URGENCY ☐ ROUTINE ☐ TODAY ☐ STAT ☒ PRE-OP
PATIENT STATUS ☒ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM
SPECIMEN SOURCE (Specify) Blood
LAB ID NO.
SPECIMEN/LAB RPT. NO.

MISCELLANEOUS
STANDARD FORM 557 (Rev. 3-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45-505
557-107

PATIENT'S MED. RECORD

======= PICCOLO =======
30/08/03 04:34
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.5*	3.3-5.5	G/DL
ALP	55	26-84	U/L
ALT	27	10-47	U/L
AMY	105*	14-97	U/L
AST	41*	11-38	U/L
TBIL	2.5*	0.2-1.6	MG/DL
BUN	4*	7-22	MG/DL
CA++	7.8*	8.0-10.3	MG/DL
CHOL	53*	100-200	MG/DL
CRE	0.8	0.6-1.2	MG/DL
GLU	112	73-118	MG/DL
TP	5.0*	6.4-8.1	G/DL

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

EPW #1
ICW 1
31 Aug @ 0400
(b)(6)-4

CBC
(b)(6)-2
31Aug03@0400
EPW #1
ICW #1
(b)(6)-4

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

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

REMARKS
(b)(6)-2
REPORTED BY
TECH
MD
DATE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
URGENCY: ROUTINE, TODAY, PRE-OP, STAT
LAB. ID. NO.
SPECIMEN SOURCE: VEIN, OTHER (Specify), CAP
PATIENT STATUS: BED, OUTPATIENT, NP, DOM, AMB
SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

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

CHEMISTRY I
STANDARD FORM 546 (Rev. 8-77)
546-107

Chem 12

REMARKS
(b)(6)-2
REPORTED BY
TECH
MD
DATE
PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
URGENCY: ROUTINE, TODAY, PRE-OP, STAT
LAB. ID. NO.
SPECIMEN SOURCE: BLOOD, OTHER (Specify)
PATIENT STATUS: BED, OUTPATIENT, NP, DOM, AMB
SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

======= PICCOLO =======
31/08/03 04:10
REFERENCE RANGE: MALE
PATIENT [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3082AA4
OPER #[redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.7*	3.3-5.5	G/DL
ALP	57	26-84	U/L
ALT	30	10-47	U/L
AMY	112*	14-97	U/L
AST	43*	11-38	U/L
TBIL	1.8*	0.2-1.6	MG/DL
BUN	<2*	7-22	MG/DL
CA++	8.2	8.0-10.3	MG/DL
CHOL	107	100-200	MG/DL
CRE	0.8	0.6-1.2	MG/DL
GLU	117	73-118	MG/DL
TP	5.4*	6.4-8.1	G/DL

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

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

01/09/03 04:00

REFERENCE RANGE: MALE

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

GENERAL CHEMISTRY 12

DISC LOT #: 3142AA4

OPER #: [redacted] DR #: 000

SERIAL #: [redacted]

ALB	2.8*	3.3-5.5	G/DL
ALP	71	26-84	U/L
ALT	20	10-47	U/L
AMY	90	14-97	U/L
AST	37	11-38	U/L
TBIL	1.2	0.2-1.6	MG/DL
BUN	<2*	7-22	MG/DL
CA++	8.7	8.0-10.3	MG/DL
CHOL	143	100-200	MG/DL
CRE	0.8	0.6-1.2	MG/DL
GLU	108	73-118	MG/DL
TP	6.3*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

ICW1 [redacted] (b)(6)-4 911103 @ 0415

ICW1 [redacted] (b)(6)-4 911103 @ 0415

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

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

SPECIMEN SOURCE: BLOOD ☐

SPECIMEN/LAB. RPT. NO.

PATIENT'S MED. RECORD

TEST(S)

SPECIMEN TAKEN

DATE / TIME A.M. P.M.

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

HEMATOLOGY

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

REMARKS CBC

(b)(6)-2 [redacted]

ON—TREATING FACILITY—WARD NO.—DATE

REPORTED BY

TECH MD DATE

LAB. ID. NO.

HE... BY

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

PATIENT'S: BED ☐ OUTPATIEN NP ☐

SPECIMEN: VEIN ☐ OTHER (Spe

SPECIMEN/LAB RPT. NO.

ICW1 [redacted] 911103@0415 (b)(6)-4

1 Sep 0400

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 20 DAYS MOS YRS 27 Sex (/) MALE ( ) FEMALE

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

PROPOSED PROCEDURE: _____
SURGICAL SERVICE: _____
NPO SINCE: 2100 / 0330 (OSW)

HABITS:
TOBACCO: yes
ETOH: 0
DRUGS: _____

CURRENT MEDICATIONS:
( ) = ordered as premed

(/) Ø
( ) _____
( ) _____
( ) Iga Ancef
( ) Tetanus
( ) Ms04 5mg

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

LABORATORY STUDIES:
HB/HCT: 11 / 33
U/A: _____
OTHER: _____

3400mc NS
T+C 2ii

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION
BP 101/50 HR 98 R 32 T ____
Pain Scale 0-10 8
HEENT - Teeth intact
Trachea midline
TMJ/Neck limited ROM
Oropharnyx MP4; MO-1 FB
Nares patent 2° to 10 pu
CHEST: Course equal (B)
CARDIAC: RRR S1 S2
EXTREMITIES:
IV Access: 18G / 18G (R) 4 (L) AC
Ulnar Filling: _____
BACK: _____
OTHER: C-Spine cleared

NPO Since 2100 / 0330 OSW

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.

Signed: (b)(6)-2 CRNA/MAJ Date: 28 Aug 03 Time: 0538 Hrs

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

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) _____

(b)(6)-4

SEDATION KEY:

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

Jolacco GSW → face

MEDICAL RECORD - ANESTHESIA

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

NKDA

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

DRUG (Units)											TOTALS
Midazolam (1) (mg)											5mg
Fentanyl (mcg)											
Lidocaine (mg)	50	50									
Propofol (mg)	80										
Sux (mg)	160								4		
VCB (mg)	80								50		
VOLAT AGENT Iso % del		8									
% e.t.	0.8	1.0	2 1.0	1.0	0.8	1.0	0.8	0.8	10 0.8		
AIR L/Min											
N2O L/Min											
O2 L/Min	10 ~ 2 ~ 2		2	2	2	2	2	2	2	2	

TOTAL EBL: 600

TOTAL URINE: 500

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

3400 ER

FLUIDS

LINE site		
18G (R) AC ☐ Warmed	(600mL NS ER)	
18G (L) AC ☐ Warmed	LR #1 →	
☐ Warmed	LR #2 →	1000 LR3 → → NS →
☐ Warmed		→ LR4 →

FLUIDS SUMMARY
CRYSTALLOID- LR 3000
COLLOID-
BLOOD-

LOSSES
EST BLOOD LOSS + Urine → 200 — 25 — 575/600
URINE - 500

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

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 33

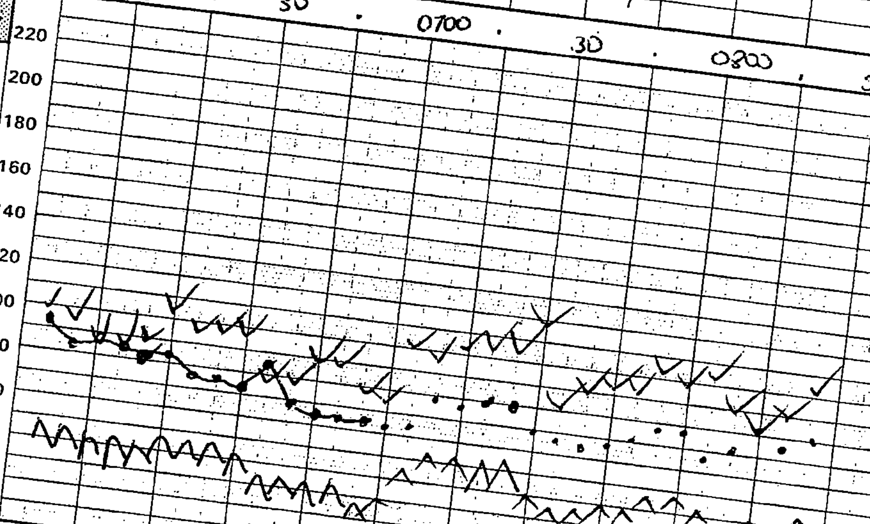
INITIAL DATA:
BP- 104/80
HR- 98

EQUIP CHECK
OK?- (Y) N

PATIENT RECHECK
K for PROCEDURE [redacted]
TIME- 0530

TIME → 0545 06 · 30 · 0700 · 30 · 0800 · 30

SYMBOLS:
BP by cuff V Λ
Heart rate ●
Resp rate
BR (transduced)
TOURNIQUET T—T
[(b)(6)-2] ANES- X-X
PROC- ⊙-Ø



VT - ml	=	750	740	770	810	720	700	710	700	680	700
f - breaths/min	=	13	10	10	8	8	8	8	8	8	8
Peak inf pres / PEEP	=	16	16	17	19-17	18	18	17	18	21	18
MODE - S(pon), A(ssist), C(on)	S ~	C ~	C ~	C	C	C	CV	C	C	C	C
✓BP/Auto Cuff / ✓ET CO2 (torr)	35	35	34	31	32	34	34	33	34	35	34
✓BP/oth / ✓FiO2 (Frac or %)	0.76	0.76	0.76	0.76	0.76	.75	.75	.75	.74	.75	.76
ART line / ✓SpO2 (%)	100	100	100	100	100	100	100	100	100	100	100
Steth- PC/ES / ✓ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer / ✓TEMP-site Ax				35.4	35.3	35.4	35.4	35.4	35.4	35.4	35.2
✓N-M Block (T/4)	0/4	4/4		1/4							
✓BS	(+)=			1/4							

Warming blkt × 1 blanket →
Fluid warmer

Use letters & symbols, enter REMARKS: EVENTS (1) (2) (3) Position → turned 90° (3) (3)

PROCEDURES and CPT Codes: Neck exploration

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

REMARKS
Code drugs with numbers, events with letters
(1) Pre-op assessment. Counseled ĉ interpreter. C-spine cleared. Pt never supported ĉ C-collar. Dr. [redacted] D. [redacted]
(2) Room, monitors, 100% O2, Induced. Intubated. See Airway management. (b)(6)-
(3) Phenylephrine 100mcg IV
0700 NeoSyn 200mcg IV
0830 TRANS → INTB ICU - BED 1

RECOVERY AT:
PACU (ICU BED 1) (Specify)
OTHER
CONDITION: STABLE MECH VENT
RESP- 16 SpO2- 100
BP- 120/60 HR- 86

ANESTHESIA / PROCEDURE TIMES
ANES	Start 0530	Room 0545	End 0840
PROC	Ready 0555	Begin 0620	End 0815

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA RSI c̄ Cricoid

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
DLx c̄ MAC 4 Grade I view, no visible blood in OP; 8.0 styletted OETT 24 @ teeth + BBS; sust ETCO2

(b)(6)-2
SURGEONS: [redacted] (b)(6)-2
(b)(6)-2
ANESTHETISTS [redacted]
MAJ [redacted] CRNA

PROCEDURE LOCATION: Z
DATE: 28 Aug 03
PAGE

DA FORM 7389, FEB 1998

MEDCOM - 17896

COPY 1 [redacted]

ACLU-RDI 1644 p.56

DOD-031470

NSN 7540-01-165-7294 591-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATIONS (S) REQUESTED: CT scan neck, jaw

AGE	SEX	SSN (Sponsor)	WARD/CLINC	REGISTER NO.
26	M		ICU1	

FILM NO.

PREGNANT ☐ YES ☒ NO

REQUESTED BY (Print): (b)(6)-2 (b)(6)-2

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR [redacted]

DATE REQUESTED: /

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

26yo s/p GSW neck s/p exploration 10d ago. Pt w/ ↑ pain, swelling at operative site, ⊖ neck.

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

RADIOLOGIC REPORT

1) Large (L) perinasal/buccal soft tissue metallic debris w/ signif metallic artifact. W/o drainable fluid collection/abscess.

2) Soft tissue swelling, inflammation and some air.

3) (L) vert artery intact but ~~[illegible]~~ caliber throughout (from C2 ↑) – cannot exclude dissection.

4) Carotid appear intact. (b)(6)-2 [redacted]

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

[redacted] (b)(6)-4

LOCATION OF MEDICAL RECORDS [redacted] (b)(2)-2

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

MEDCOM - 17897

RADIOLOGIC CONSULTATION STANDARD FORM 519 R

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

ICU 3

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 8/28 TIME OF ORDER 1 Ut HOURS

LIST TIME ORDER NOTED AND SIGN

(1) Admit ICU — 0900
(2) Cond: critical
(3) Sp CSW neck, ear
(4) VS routine q1°
(5) NL to LIS
(6) Irrigate NL ĩ 30 c. water q4°
(7) Foley

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU 3		

DATE OF ORDER TIME OF ORDER HOURS

(8) INF ut a 125 cc/hr
(9) Ancef 1g ivp q8°
(10) Zantac 50 mg ivp q8°
(11) Labs now: CBC, Chem 12, ABG
(12) AM Labs: CBC, Chem 12
(13) CXR upon arrival to ICU
(14) Versed ivd titrate to effect

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU 3		

DATE OF ORDER TIME OF ORDER HOURS

(15) Fentanyl ivk titrate to effect
(16) Bactrain to (6) ear wound

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU3		

DATE OF ORDER 8.28 TIME OF ORDER 0900 HOURS

(1) Vent: SIMV: 16, 50%, peep 5, vt 650 per V/O Dr. [redacted] (b)(6)-2
(2) Vecuronium drip titrate to effect per V/O Dr. [redacted] (b)(6)-2

0900

[redacted] (b)(6)-2

ILTRW

[redacted] (b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] CPW

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER (b)(6)-2 TIME OF ORDER 0900 HOURS — LIST TIME ORDER NOTED AND SIGN

1. Per V/O Dr. [redacted] Vecuronium off until further notice — 0905 ILUTRN [redacted] (b)(6)-2
2. Per V/O Dr. [redacted] (b)(6)-2 rate for LR ↓ to 75cc/hr

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 29Aug03 TIME OF ORDER 1900 HOURS

1) DC Vecuronium DONE
2) DC Versed DONE
3) DC NGT DONE
4) Diet: NPO
V.O. Dr [redacted] (b)(6)-2 ILUTMN [redacted] (b)(6)-2 — noted ILUTMN 08/29/03 2250 (b)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 29Aug03 TIME OF ORDER 2050 HOURS

1) Diet: Sips of water
Dr. [redacted] (b)(6)-2 [redacted] (b)(6)-2 ILUTMN
24°V [redacted] (b)(6)-2 ILUTMN 08/29/03 2310

PATIENT IDENTIFICATION

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 8:30 TIME OF ORDER 0730 HOURS — 0730 [redacted] (b)(6)-2

1. per V/O Dr. [redacted] (b)(6)-2 Diet: Adlv as tolerated
2. per V/O Dr. [redacted] (b)(6)-2 1-2 percocet 4-6° p.r.n
3. D/C fentanyl per V/O Dr. [redacted] (b)(6)-2
4. D/C foley per V/O Dr. [redacted] (b)(6)-2
5. D/C Zantac per V/O Dr. [redacted] (b)(6)-2
6. Transfer with [redacted] (b)(6)-2

DA FORM 1 APR 79 4256 [redacted] (b)(6)-2 PREVIOUS EDITION OF 1 JUL 77 WHICH MAY BE USED.

MEDCOM - 17899

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICU	2[redacted]	30

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	9/1	1430 HOURS	
(1)	D/C All Labs		
(2)	D/C IV Fluid		
(3)	Out of bed ambulate daily		
(4)	~~Heparin~~		
(4)	Heparin 5000 u sq bid		
	(b)(6)-2		(b)(6)-2 MD

9/1/03 1440

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
2W	2015	03

	DATE OF ORDER	TIME OF ORDER
	9/2	0800 HOURS
(4)	D/C Heparin	
(5)	Out bed ambulate	

(b)(6)-2 Noted 2 Sep 03 1045

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
2W	2015	05

	DATE OF ORDER	TIME OF ORDER
	9/10	1530 HOURS
(1)	Clindamycin 600 mg IVPB q 8	

(b)(6)-2

(b)(6)-2 Noted 10 Sep 03 1045

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

Noted 17 Sept 1040 2CTS

(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
2W	2015	17SEP03

	DATE OF ORDER	TIME OF ORDER
	9/17	HOURS
	D/C IV site	

(b)(6)-2

(b)(6)-2

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted]

(b)(6)-4

NURSING UNIT: ICW#1 | ROOM NO.: 1245 | BED NO.: 2100

DATE OF ORDER: 9/20 | TIME OF ORDER: 1000 | HOURS

1) Ambien 10mg PO qHS

(b)(6)-2 MATTHEW

LIST TIME ORDER NOTED AND SIGN

(b)(6)-2 Noted 20Sep03 1A

PATIENT IDENTIFICATION

#[redacted]

(b)(6)-4

DATE OF ORDER: 9/22 | TIME OF ORDER | HOURS

2) D/C Ambien

(b)(6)-2

NURSING UNIT: CW1 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-2

(b)(6)-2

23Sep03 1430

DATE OF ORDER | TIME OF ORDER | HOURS

UNIT | ROOM NO. | BED NO.

IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

ROOM NO. | BED NO.

256 REPLACES EDITION OF 1 JUL 77, WHICH MAY

MEDCOM - 17901

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. Aug Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 28 29 30 31 01 02 03 4 5 6 7 8 9 10 11
8-28	(b)(6)-2	[redacted] VS routine q [redacted]	06	[redacted]
			18	[redacted] d/c 30 AUG 03
8.28	(b)(6)-2	NG to LIS	06	[redacted]
	(b)(6)-2		18	[redacted] d/c'd 08/29/03
8.28	[redacted]	Irrigate NGT 30cc	06	[redacted]
	(b)(6)-2	water q 4°	18	[redacted]
8.28	[redacted]	Reflex to Provera	06	[redacted]
			18	[redacted] d/c 30 AUG 03
8.28	[redacted]	F/Os q [redacted]	06	[redacted]
	(b)(6)-2		18	[redacted] d/c 30 AUG 03
8.28	[redacted]	CBC chem 7 q am	06	[redacted] d/c 1 Sept 03
	(b)(6)-2		18	[redacted]
8.28	[redacted]	Cardiac Cath q	06	[redacted]
	(b)(6)-2		18	[redacted] d/c 30 AUG 03
29 Aug 03	(b)(6)-2 [redacted]	Dict: NPO		d/c'd
29 Aug 03	[redacted]	Diet: sips of water	06	[redacted]
	(b)(6)-2		18	[redacted]
8.30	[redacted]	Diet: Adv as tol	06	[redacted]
	(b)(6)-2		18	[redacted]
30 AUG 03	[redacted]	VS routine - q shift	06	[redacted]
	(b)(6)-2		18	[redacted]
1 Sept	[redacted]	OOB ~~to~~ Ambulate	06	[redacted]
	(b)(6)-2	daily	18	[redacted]

(b)(6)-2 all

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P Explor Neck/Back GSW S/P GSW neck/rear

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 17902

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo Aug Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
8.28	(b)(6)-2	Admit to ICU	8.28	0830	0830	[redacted]	(b)(6)-2
8.28	(b)(6)-2	CBC, chem 12, ABG now	8.28	ASAP 0930	0930	[redacted]	(b)(6)-2
28 Aug	(b)(6)-2	CXR upon arrival to ICU	28 Aug				
28 Aug	(b)(6)-2	Vent: SIMV 16, 50%, peep 5 TV 650	28 Aug				
8.30	(b)(6)-2	d/c foley	8.30 ASAP	—		[redacted]	(b)(6)-2
30 AUGB	(b)(6)-2	transfer to ward	30 AUGB	—	—	[redacted]	(b)(6)-2
1 Sept	(b)(6)-2	D/C all labs	1 Sept	—	—	[redacted]	(b)(6)-2
02 SEP03	[redacted]	DC foley - DTV in 8°	02 SEP03	—	0735	[redacted]	(b)(6)-2
	(b)(6)-2						

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

USAPA V1.00

CLINICAL RECORD

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

Mo. ____ Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 11 12 13 14 15 16 17 18 19 20 21 22 23 24
30 day	[redacted]	DIET: adv as tolerated	6	[redacted]
	(b)(6)-2		14	[redacted]
	(b)(6)-2		22	[redacted]
30 day	[redacted]	VS-Routine - QS	6	[redacted]
			14	[redacted]
	(b)(6)-2		22	[redacted]
30 day	[redacted]	OOB to AMB Daily	6	[redacted]
			14	[redacted]
			22	[redacted]

all (b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW to neck/ear

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 17904

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo 09 Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/23	[redacted]	D/C today	9/23		1435	[redacted]
		(b)(6)-2				(b)(6)-2

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

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 08 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 28 29 30 31 01 02 03 4 5 6 7 08 9 10
8/28	[redacted] (b)(6)-2	Ancef 1g IVPB 8°	08	[redacted]
	(b)(6)-2		16	[redacted]
			24	[redacted]
8/28	[redacted]	Zantac 50mg IVPB 8°	08	[redacted] D/C 8300 / 0730
	(b)(6)-2		16	[redacted]
			24	[redacted]
8/28	[redacted]	IVF LR@125cc/hr	08	[redacted] D/C 8/29/0900
	(b)(6)-2		16	[redacted]
8/28	[redacted]	Versed IV titrate to effect	08	[redacted] D/C'd 08/29/03 [redacted]
			16	[redacted]
8/28	(b)(6)-2 [redacted]	Fentanyl IV titrate to effect	08	[redacted] D/C 8/30 0730
			16	[redacted]
8/28	(b)(6)-2 [redacted]	Vecuronium IV d titrate to effect	08	[redacted] D/C'd 08/29/03 [redacted]
			16	[redacted]
8/28	(b)(6)-2 [redacted] (b)(6)-2	Bacitracin to O car wound	08	[redacted]
			16	[redacted]
8/29	[redacted] (b)(6)-2	LR@ 75cc/hr	08	[redacted] D/C 9/1/03 1435
			16	[redacted]
8/28	[redacted]			
1/Sept	[redacted] (b)(6)-2	Heparin 5000u sq bid	10	[redacted]
			22	[redacted]
10 Sept 03	[redacted]	Clindamycin 600mg IV q8°	08	
	(b)(6)-2		16	[redacted]
			24	[redacted]

all (b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW neck/ear R/T GSW
S/P neck Exploration

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

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDCOM - 17906

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 08-09 Yr. 08

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
8/30	[redacted]	Percocet 1-2 tabs	30 MAY 2000 31 MAY 2000 01 SEP 0800 1 SEP 2210 2 SEP 0715 2 SEP 1755 2 SEP 2345 3 SEP 0715 3 SEP 1650 4 SEP 0019 4 SEP 1410 5 SEP 0030
	(b)(6)-2	4-6° prn	[redacted]
8/30	[redacted]	Percocet 1-2 tabs	5 SEP 0416 5 SEP 1315 5 SEP 2110 6 SEP 1600 6 SEP 2116 7 SEP 0515 7 SEP 1145 7 SEP 1930 8 SEP 0120 8 SEP 0924 8 SEP 1525 8 SEP 2045
	(b)(6)-2	4-6° PRN	[redacted]
8/30	[redacted]	Percocet 1-2 tabs po q4-6° PRN	D/T 9 SEP 0230 9 SEP 0936 9 SEP 2350 10 SEP 0945 10 SEP 2330
	(b)(6)-2		D/1 [redacted]

(b)(6)-2 all

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 11	12	13	14	15	16	17	18	19	20	21	22	23	24
8/28	[redacted]	Ancef 1gm IVP q8°	8	[redacted]									D/C'ed				
	(b)(6)-2		16														
			24														
8/28	[redacted]	Bactracin to L ear wound	10	[redacted]													
	(b)(6)-2		22														
9/1	[redacted]	Heparin 5000u SQ BID	10	[redacted]													
	(b)(6)-2		22														
10 Sept 03	[redacted]	Clindamycin 600mg IVq8°	08	[redacted]									D/C'ed				
	(b)(6)-2		16														
			24														
20 SEP 03	[redacted]	Amplen 10mg po qhs	22	/	/	/	/	/	/	/	/	/	[redacted]				
	(b)(6)-2																

(b)(6)-2 all

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS: S/P GSW to neck/ear	ADDITIONAL PAGES IN USE: ☐ YES ☐ NO PAGE NO. ____

PATIENT IDENTIFICATION:

[redacted]

(b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 09 Yr. 08			
Order Date / Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
8/30	[redacted]	Percocet 1-2 tab. Q4-6 PRN	D/I	11Sep 2030	12 0415	12Sep 2215	13Sep 2000	2350	16th 2140	17 2300	18 2300	19Sep 0940	19 2220	20Sep 1115	22 0200	
	(b)(6)-2		D/I	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
8/30	[redacted]	Percocet 1-2 tabs	Date Time	9/22 1050	9/22 2030	23Sep 1210										
	(b)(6)-2	Q4-6° prn	Dose Init	(2) [redacted]	[redacted]	[redacted]										
		(rewritten)	T/E	E	[redacted]	E										

(b)(6)-2 all

USAPA V1.00

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

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0830	INITIALS [redacted] (b)(6)-2	INITIALS		INITIALS
	PUPILS	3mm sluggish perl				
	SENSORIUM	paralyzed c vec, sed c versed & fent drip. Ø movement x4 extrem, Ø response to pain & stimuli				
RESPIRATORY	RESPIRATORY PATTERN	even unlabored vent				
	BREATH SOUNDS	SIMV 16 FiO2 650 peep 5				
	SECRETIONS	VE 650 ETT #8 24cm @ lip, CTA (B) Ø secretions not overbreathing vent.				
SKIN	COLOR	appropriate for race				
	INTEGRITY	see progress note				
IV SITE	LOCATION	(L) AC PIV (R) AC PIV				
	CONDITION	(R) femoral A-line, zeroed all patent				
GASTRO	ABDOMEN	Soft non distended				
	BOWEL SOUNDS	hypo BS x4 Ø N/V/D NG (R) nare to LCS. Char brown fluid out				
GU	URINE: COLOR/CLARITY	straw colored FTC GS.				
CARDIOVASCULAR	CARDIAC RHYTHM	NSR S ectopy S1 S2 BP stable, Ø JVD +2 radial & pedal pulses cap refill <3 secs trace peripheral edema,				

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) 1800-0600

DEPARTMENT/SERVICE/CLINIC ICW 3

DATE 8-27

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

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

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

DA FORM 4700 1 MAY 78
Proponent: Dept of Nurs

MEDCOM - 17910

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

0900 - on vec, versed fentanyl
1500 - remains on vec, versed, fentanyl

NEUROLOGICAL ASSESSMENT

		HOURS	R 0900	L 1500
COMA SCALE	EYES OPEN	SPONTANEOUSLY 4		
		TO SPEECH 3		
		TO PAIN 2		
		NO EYE OPENING 1	1	1
	BEST VERBAL RESPONSE	ORIENTED 5		
		CONFUSED 4		
		VERBALIZES 3		
		VOCALIZES 2		
		NO VOCALIZATION 1	1	1
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6		
		LOCALIZES PAIN 5		
		FLEXION WITHDRAWAL 4		
		ABNORMAL FLEXION 3		
		EXTENSION TO PAIN 2		
		NO MOTOR RESPONSE 1	1	1
LIMB MOVEMENT	ARMS	NORMAL POWER		
		MILD WEAKNESS		
		SEVERE WEAKNESS		
		ABNORMAL FLEXION		
		ABNORMAL EXTENSION		
		NO RESPONSE	1	1
	LEGS	NORMAL POWER		
		MILD WEAKNESS		
		SEVERE WEAKNESS		
		ABNORMAL FLEXION		
		ABNORMAL EXTENSION		
		NO RESPONSE	1	1
PUPILS	RIGHT	SIZE	3	
		REACTION	+	
	LEFT	SIZE	3	
		REACTION	+	
PUPIL SCALE			2 3 4 5 6 7 mm	
ICP				
CEREBRAL PERFUSION PRESSURE				

LEGEND

- C Closed by swelling
- T Trach/Endo
- S Slurring
- D Dysphasia
- R Receptive
- E Expressive
- R Right
- L Left

Record separately if there is a difference between the two sides.

- ++ Brisk
- + Slow
- - No Response
- + Intact
- - Abnormal

VASCULAR ASSESSMENT

HOURS		
	R	
	L	
	R	
	L	
	R	
	L	
	R	
	L	
	R	
	L	

LEGEND

- ++ Normal
- + Weak
- - Absent
- D Doppler
- R Right
- L Left

MEDCOM - 17911

M AL RECORD-SUPPLEMENTAL MEDIC. TA
For use of thi , see AR 40-66; the proponent agency is the Office of .... Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0640 Inital: [redacted] (b)(6)-2	Time: 1830 Inital: [redacted] (b)(6)-2
NEURO	Pupils	3mm sluggish Perrl, paralyzed c̄ vec,	Perrl 3mm, Sluggish. Slight (L)
	Sensorium	sedated c̄ versed pain mgd c̄ fent drip.	sided facial droop + weakness (L) arm. Good
	LOC / GCS	Moves all extrem, Ø observable respons	strength in grips R>L. Moves all other
		to painful stimuli other than ↑HR & BP.	extremities. Eyes follow. Moderate cough.
CARDIAC	Cardiac Rhythm	NSR s̄ ectopy S1S2, +2 radial & pedal	ST 110's-120's s̄ ectopy. S1S2.
	PRI / QRS:	pulses bilat, Cap refill <3secs Ø JVD.	Radial/Pedal pulses 3+. Cap refill
	Pulse Strength	periorbital edema, +1 bilat hand edema	all extremities <3sec. Ø JVD or (L) side
	Cap Refil / JVD	nonpitting. UTA chest pain. pt ventilated	2+ edema BUE. Ø CP per interpreter.
	Edema		
	Chest Pain		
RESP	Respiratory Pattern	even unlabored vent: SIMV 14, peep 5	Regular, even, unlabored. Course
	Breath Sounds	fio2 35% VT 650 ETT# 8 24cm @ lip.	crackles over anterior upper lobes.
	Secretions	Rales bilat & throughout. Ø secretions	↑ secretions. Moderate cough. Occasionally
	Cough	Ø cough. Not over breathing vent SPO2	able to clear secretions. Thick, clear-
		100%.	yellow secretions. Voice slightly hoarse
SKIN	Color	appropriate for race.	WNL, Warm, dry. Dressings to
	Integrity	see progress note	(L) jugular area and back of neck.
	Backside	intact Ø indications of breakdown	Serosanguaneous drainage. Minimal.
			Dressing over (L) ear.
IV	Access Devices	PIV & ~~Arterial~~ femoral A-line	(L) AC IV infusing LR @ 75cc° c̄ Fentanyl
	Location	(L) @ AC (R) fem art line	to titrate. (R) AC SL flushed c̄ resistance
	Condition	all patent, A-line zeroed & correlating	A-line to (R) groin. ~~Pressure tubing~~ Dressings
		c̄ NIBP	CDI. Ø S/S of infection.
GI	Abdomen	Soft nondistended ~~hypo BS x4~~	Soft, nondistended. Hypoactive BS x4.
	Bowel Sounds	hypo x4	Nontender. Ø BM. NPO.
	Stoma/Ostomy	Ø NG (L) nare to LIS. Scant-	
		small clear brown drainage	
GU	Device	FTG	Foley to DD. Clear yellow urine.
	Color / Clarity	amber clear QS.	tube secured to leg.

(Continue on reverse)

600-1800 PREPARED BY (Signature & Title) 1800-0600

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

DATE
8.29.03

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

NAME: # [redacted] EPW RANK: AGE:

UNIT: (b)(6)-4 GENDER:

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

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

DA FORM 4700, MAY 78

USAPPC V2.00

CPW # [redacted] 29 AUG 03
(b)(6)-4

ICU Flowsheet **Patient Name:** [redacted] (b)(6)-4 **Date:** 8 / 29 / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature						100.1	99.6					100.8										99.8				
Pulse	96	98	89	91	94	91	86	90	91	83	85	103		97	99	125	123	134	121	115	123	111	95	103	104	
B/P A-Line	114/65	116/66	119/65	113/65	123/67	120/65	119/63	123/67	127/71	123/62	122/63	128/71		120/65	123/66	129/68	129/68	110/62	123/69	125/70	115/63	112/63	111/62	129/72	133/71	
MAP	88	89		81																	89	87	80	91	93	
B/P Cuff	127/67		120/67		113/66		125/67																		124/73	
Respirations	14	14	14	14	14	14	14	12	12	12	12	12		12	12	15	17	19	19	14	21	14	14	16	14	
Sa02	100	100	100	100	100	100	100	100	100	100	100	100		100	100	99	100	100	98	100	100	100	100	100	100	
F.O2	35%					35%		35	35	35	35	35		35	35	[redacted] (b)(6)-2	2A	2A	2L	2L	2L	2L	2L	2L	2L	
MODE	SIMV					SIMV		SIMV	SIMV	SIMV	SIMV	SIMV		SIMV	SIMV	[redacted]	NC	NC	NC	NC	NC	NC	NC	NC	NC	
Intake	**24**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**Total**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**Total**
IVF - LR	125	125	125	125	125	125	125	125	125	75	75	75	1350	75	75	75	75	75	75	75	75	75	75	75	75	900
VERSED	3	3	3	2	2	2	2 (8:05)	2	2	2	2	1	26	1	off.	off	off	off	off	off	D/C'd					1
FENT	14	14	14	14	14	14	14/98	14	14	14	14	12	166	12	12	6	6	6	6	6	6	6.6	6.6	6.6	6.6	76.4
VAC	6.3	6.3	6.3	5.9	5.9	5.9	5.9 (11:00)	5.9	5.9	off	off	off	54	off	off	off	off	off	off	off	D/C'd					
IVPB									100				100					100					(6X6)-2			100
~~PO intake~~ NGT	30				30				30				90	30				30			D/C'd		[redacted] (b)(6)-2			60
~~O.R. IN~~ PO													[redacted]	(b)(6)-2									30	30	30	90
Totals													1786													1227.4
Output	**24**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**Total**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**Total**
Urine Hourly	0/13	100	150/6.25	200	200/1025	200/1225	175	200	250	200	200	150	2500	100	75/175	100/275	100/375	75/450	150/600	75/675	150/825	125/950	125/1075	100/1175	100/1275	1275
NG Tube						200						100	300							200	D/C'd					200
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals													2800													1475

12 / 24 hour input	1786	3013.7
12 / 24 hour output	2800	4275
12 / 24 hour balance	714	-1261.3

MEDCOM - 17913

;AL RECORD-SUPPLEMENTAL MEDI(ATA

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

REPORT TITLE: INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date): QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0700 Initals:	Time: Initals:
NEURO	Pupils	3mm sluggish R=L	
	Sensorium	alert appropriate follows commands.	
	LOC / GCS	(L) lower extrem weak but weight	
		bearing (L) UE weak non weight bearing	
CARDIAC	Cardiac Rhythm	ST s ectopy S1S2	
	PRI: / QRS:		
	Pulse Strength	+2 radial & +2 pedal pulses	
	Cap Refil / JVD	<3 secs ∅ JVD.	
	Edema	+2 non pitting UE bilat.	
	Chest Pain	∅ denies.	
RESP	Respiratory Pattern	even unlabored	
	Breath Sounds	coarse upper lobes bilat.	
	Secretions	thick white or yellow c strong cough	
	Cough	strong.	
SKIN	Color	appropriate for race	
	Integrity	[illegible]	
	Backside	intact ∅ breakdown.	
IV	Access Devices	(L) SC & (R) SC PIV 18G.	
	Location	(R) femoral A-line zeroed &	
	Condition	correlating c NIBP.	
GI	Abdomen	soft nontender [illegible]	
	Bowel Sounds	hypo BS x F.	
	Stoma/Ostomy	∅	
		[illegible]	
GU	Device	FTG	
	Color / Clarity	clear/yellow.	

(Continue on reverse)

PREPARED BY (Signature & Title) 0600-1800 [redacted] (b)(6)-2 RN 0600-0603

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

DATE 8-30-03

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

NAME: [redacted] RANK: AGE:

UNIT: (b)(6)-4 GENDER:

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

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 17914

ICU Flowsheet

Patient Name: EPW [redacted] (b)(6)-4 Date: 8 / 30 / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature		99.7 (R)			99.1 (R)			99.1																		
Pulse	116	114	112	103	92	100	112	109	106																	
B/P A-Line	120/64	113/62	123/65	115/64	124/65	118/61	117/61	119/63	116/65	118/71	120/70	109/61		116/63												
MAP	87	88	86	83	89	81	84																			
B/P Cuff	118/68		114/65		116/64		109/65																			
Respirations	15	15	19	13	17	20	18	18	17	18	17	18		19												
Sa02	100	98	99	100	100	100	96	97	CR	92	110	102		103												
FiO_2	2L	2L	2L	2L	2L	2L	✓			RA	RA	RA		RA												
Mode	NC	NC	NC	NC	NC	NC	RA	RA	RA			OT		OT												
Intake	**24**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**Total**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**Total**
IVF	75	75	75	75	75	75	75	75	75	75	75	75	900	75												
Fentanyl	6.6	6.6	6.6	8	10	10	10	10	10				698													
IVPB	50	50							100				200													
														840												
PO intake	30										120		150													
O.R. IN																										
Totals																										
Output	**24**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**Total**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**Total**
Urine Hourly	75	75/150	50/200	100/300	100/400	100/500	75/575	75/650	50	100/800	75/875	90/965	965													
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals													965													

24 hour input	
24 hour output	
24 hour balance	

Trauma Resuscitation Form

Name:	SSN:
Date and time of injury: 28AUG03 2200 zulu	Date and time of arrival: 28 AUG03 2245 zulu

Chief complaint: GSW → post neck

Pre-hospital information

Mechanism of injury:
- [x] Gunshot wound
- [ ] Stabbing
- [ ] Burn
- [ ] Chemical casualty
- [ ] Other: ______

Procedures before arrival
- [x] Airway: type Nasal trumpet size # ______
- [ ] O_2 @ ______ L/min via ______
- [ ] IV's: location and # ______
- [ ] Chest tube: location ______ size # ______
- [ ] Splints: Type ______
- [ ] Medications: ______
- [ ] Chemical casualty:
  - [ ] Decontamination date/time: ______

	Dosage	Date/time
[ ] Atropine:		
[ ] 2-PAM:		
[ ] Other:		

- [ ] Other procedures: ______

AMPLE history

Allergies: / Medications: / Past illnesses: / Last meal: / Events: — Unknown

Last Tetanus:

P = 76

BP = 94/52

shot @ oil line, initially unconscious now GCS15

Initial assessment

Airway
- [x] Patent
- [ ] Obstructed

Breathing
- [x] Normal
- [ ] Labored
- [ ] Symmetrical
- [ ] Asymmetrical

Trachea midline? [x] Yes [ ] No

Breath sounds:	Right	Left
Present	[x]	[x]
Clear	[ ]	[ ]
Decreased	[ ]	[ ]
Absent	[ ]	[ ]
Rales/Rhonchi	[ ]	[ ]

Crepitus: [ ] Yes [x] No

Initial assessment

Circulation

Skin/mucous membrane color:
- [x] Pink
- [ ] Flushed
- [ ] Pale
- [ ] Jaundiced
- [ ] Ashen
- [ ] Cyanotic

Skin temperature: [x] Warm [ ] Hot [ ] Cool

Skin moisture: [x] Normal [ ] Dry [ ] Moist

Pulses:

	Carotid R	Carotid L	Radial R	Radial L	Femoral R	Femoral L
Normal	[x]	[x]	[x]	[x]	[x]	[x]
Bounding	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Weak	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Absent	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Disability

Glasgow Coma Scale (circle appropriate scores):

	Score:
1. Eye opening:	
Spontaneous	4
To voice	3
To pain	2
None	1
2. Verbal:	
Oriented	5
Confused	4
Inappropriate words	3
Incomplete words	2
None	1
3. Motor:	
Obeys commands	6
Localizes to pain	5
Withdrawls to pain	4
Flexion	3
Extension	2
None	1
Total GCS	15

Pupillary response

Pupil reaction:	Right	Left
Brisk	[x]	[x]
Constricted	[ ]	[ ]
Sluggish	[ ]	[ ]
Dilated	[ ]	[ ]
Nonreactive	[ ]	[ ]
Size	5 mm	5 mm

1 2 3 4 5 6 7 8

Trauma Resuscitation Form

Physical examination:

Age (years): ? Height (inches): _____ Weight (kg's): _____

Head, eyes, ears, nose, throat: see diagram TM's clear, ⊖ obvious hematoma, face atraumatic

Neck:

Chest: CTA (B), heart sounds nl

Back: atraumatic

Cervical/Thoracic/Lumbar spine:

Abdomen: soft NT, ND

Perineum and rectum:

Extremity: ⊖ trauma, strength appears intact x 4,

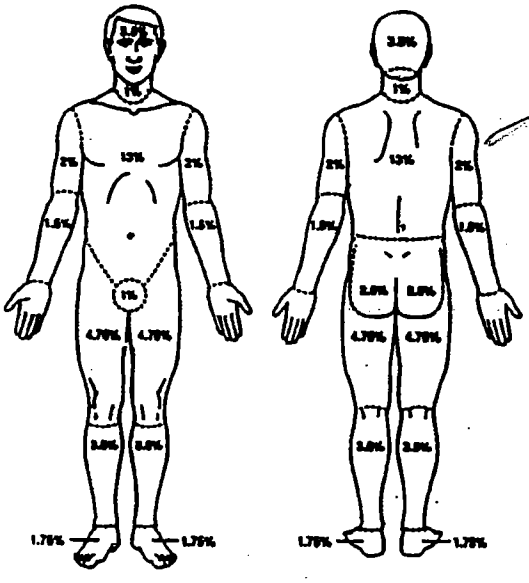
Skin: warm, pink

Neurologic:

Other: GCS = 15, pt. moves all 4 extremities

Diagram for documenting injuries
(Identify injury site by number)

1. Laceration
2. Abrasion
3. Hematoma
4. Contusion
5. Deformity
6. Fracture
7. GSW(s)
8. Stab wound(s)
9. Pain
10. Cold injury
11. Edema
12. Amputation
13. Avulsion
14. Burn
15. Other (Describe)



5 entrance exit wounds in post. neck

(With permission from JB Lippincott Company. After Deming RH. Burns. In: Greenfield LJ, Mulholland MW, Oldham KT, and Zelenock GB, eds. Surgery: Scientific Principles and Practice. Philadelphia, JB Lippincott Company, 1993.)

Trauma Resuscitation Form

Burn data (fill in appropriate boxes)

Area	Adult BSA	2°	3°	Total
Head	7			
Neck	2			
Ant. Trunk	13			
Post. Trunk	13			
R. Buttock	$2\frac{1}{2}$			
L. Buttock	$2\frac{1}{2}$			
Genitalia	1			
R.U. Arm	4			
L.U. Arm	4			
R.L. Arm	3			
L.L. Arm	3			
R. Hand	$2\frac{1}{2}$			
L. Hand	$2\frac{1}{2}$			
R. Thigh	$5\frac{1}{2}$			
L. Thigh	$5\frac{1}{2}$			
R. Leg	7			
L. Leg	7			
R. Foot	$3\frac{1}{2}$			
L. Foot	$3\frac{1}{2}$			
	Total			

(With permission from McGraw-Hill Inc. Allyn Goodwin CW, Finkelstein JL, and Madden MR. Burns. In: Schwartz SI, Shires GT, and Spencer FC, eds. Principles of Surgery. Sixth edition. New York, McGraw-Hill Inc., 1994.)

Laboratory data

CBC:	Lytes, BUN, Cr, Glu:	UA:

ABG:

Time	FIO_2	pH	PO_2	PCO_2	BD

Other labs:

X-Ray

C-spine: collared: shrapnel frags @ (L) cspine (C_1 & C_2)

CXR:

Pelvis:

Other:

Trauma Resuscitation Form

Procedures performed by trauma team	
Time:	Procedure:
2200 2nd	① AC → 1 L NS
"	4 MG MSO4 IV
2240	1 GM ANCEF ②
2300 ±	1 L NS running
2300	1 L LR Running ③

Medications			
Time:	Drug:	Dosage:	Route:

Trauma fluid resuscitation data

Estimated initial postburn IV fluid requirement

1. IV fluid of choice: Lactated Ringer's solution.
   (Use the following equations)
2. Total fluid requirement (TFR):
   TFR = 4 ml x wt (kg's) x % burn (2° and 3°)

   TFR = (4 x _____ x _____) = _____cc
3. Estimated fluid requirement 1ST 8 hours post burn:

   (TFR/2) = _____cc
4. Estimated fluid requirement next 16 hours post burn:

   (TFR/2) = _____cc

Resuscitation area fluid intake and output

Intake:		Output:	
LR	_____ml	Blood	_____ml
PRBC	_____ml	Urine	_____ml
FFP	_____ml	NG tube	_____ml
Platelets	_____ml	Chest tube	_____ml
Other	_____ml	Other	_____ml
Total	_____ml	Total	_____ml

Vital signs

Time:	23 2nd								
BP:	90/47								
Pulse:	78								
Temp:									
Resp:	40								
GCS:	15								

Notes: PT WAS combative on arrival, GCS 15

Impression: GSW x 5 to neck, neurovascularly intact. GCS 15

Plan: Med-evac → TMT echelon

(b)(6)-2

[redacted] MD

Signature: [redacted] MD

(b)(6)-2

(With permission from the American College of Surgeons Committee on Trauma, *Advanced Trauma Life Support Student Manual*, 1993 edition.)

ADMISSION AND CODING INFORMATION

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

Field	Entry
1. REPORTING MTF (1–6)	A I I D I
2. MTF LOCATION (State or Country Code.) (7–8)	I Z
3. REGISTER NUMBER (9–15)	[redacted]
NAME (Last, First, Middle Initial)	(b)(6)-4
4. PAY GRADE (16–17)	
5. SEX (18)	M
6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26)	[redacted]
7. AGE AT ADMISSION (27–29)	2 7 y
8. RACE (30)	Z
9. ETHNIC BACKGROUND (31)	9
RELIGION	
10. LENGTH OF SERVICE (32–34)	
ETS	NA
11. FMP (35–36)	9 9
12. SOCIAL SECURITY NUMBER (37–45)	(b)(6)-4 [redacted]
ORGANIZATION (Active Duty Only)	NA
13. MARITAL STATUS (46)	Z
HOUR OF ADMISSION	0900
BRANCH / CORPS	NA
14. FLYING STATUS (47–49)	
15. BENEFICIARY CATEGORY (50–52)	K 7 8
16. ZIP CODE OF RESIDENCE (53–61)	
17. UNIT LOCATION (State or Country Code) (62–63)	I Z
18. MOS (64–70)	
19. TRAUMA (71)	
PREV. ADMISSION	YEAR: — ; NO: ✓
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72)	O
WARD	ICU 3
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	Unk
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	Unk
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE	Unk
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	[redacted] (b)(2)-2
21. TYPE OF DISPOSITION (73–74)	5 0
22. MTF TRANSFERRED TO (75–80)	
23. DATE OF DISPOSITION (Y Y M M D D) (81–86)	0 3 0 9 2 2
24. CLINIC SVC - ADMITTING (87–90)	A B A A
25. MTF TRANSFERRED FROM (91–96)	
26. DATE THIS ADMISSION (Y Y M M D D) (97–102)	0 3 0 8 2 8
27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104)	
28. MTF OF INITIAL ADMISSION (105–110)	
29. DATE INITIAL ADMISSION (Y Y M M D D) (111–116)	

FOR LOCAL USE

GSW TO POSTERIOR NECK

I: 9 Dx: 874? 9?8? PR: 0609

Inj: 569 80220 E9912 966

8059

A[redacted] Signature, as required) (b)(6)-2

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

SIGNATURE OF ADMITTING CLERK [redacted] (b)(6)-2

DA FORM 2985, MAR 90

MEDCOM - 17920

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (MI)	GRADE	ADMISSION REMARKS
[redacted] (b)(6)-4	UNK	NA	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
M	28	UNK	UNK	NA	NA	NO

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted] (b)(6)-4	NA	ICU3

15. FLYING STATUS	16. RATING/ DSG	17. DEPT/ BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE
NA		NA	NA	.....	NBI

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

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	24	~~10/5/03~~ 11/3/03

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	8/29/03	(b)(6)-2 Dr. [redacted]

29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED
[redacted] (b)(2)-2	8/29/03	(b)(6)-2

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW TO CHEST
Paraplegia
Sacral decubitus

875.1
862.1
864.14
952.15
707.0
E991.2

34.84
50.22
43.19
31.1
86.22
86.64

86.28
46.10
86.22

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	38	38

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0	38	38

SIGNATURE OF ATTENDING MEDICAL OFFICER [redacted] (b)(6)-2 (b)(6)-2 Dr [redacted]

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

DA FORM 3647, M [redacted] (b)(6)-2 EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

MEDCOM - 17921

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER	2. NAME (Last, First, Middle)		GRADE	ADMISSION REMARKS
[redacted] (b)(6)-4	UNK		N/A	

4. SEX	5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
		UNK	UNK	N/A	N/A	ND

11. FMP	12. SSN	13. ORGANIZATION	14. WARD
99	[redacted] (b)(6)-4	N/A	ICU

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

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION	22. HOURS OF ADMISSION	23. CLINIC SERVICE
DIRECT FROM EMT	1300	

24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION
UNK	01	31 [illegible]

27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION	ADMITTING OFFICER
UNK	UNK	20SEP03	

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

35. Total Days This Facility

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

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. [redacted]	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
0	0	0	0		

SIGNATURE OF ATTENDING MEDICAL OFFICER	SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER
	(b)(6)-2

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

MEDCOM - 17922

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

(b)(6)-4

[redacted]

ICU #3

1) Head w/o

2) A/P w/ IV and oral (max 500 cc spread over 1 ½ hr)

3) T10 - T12.

1) Local (R) ant PTX Small

2) Small (R) local oblig. fis PTX

3) (R) C Tube

4) (B) Bilat.l opacity / atlx / consolid.

5) (R) ant hepat lacerat

6) (B) stiabed kid — pyelonephritis ~~xx~~ slight edem[illegible]

7) Med free [illegible] pelvis

8) (a) T11 vert body Shattered,
(b) (L) lamina fx
(c) small fragm

9) Brain ~~xxx~~ Mild gray/white loss c/w anoxic inj

10) (R) ant chest exit wound

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

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

2 GW IRAQI GSW SHOT IN CHEST 2 APPARENT POSTERIOR ENTRANCE WOUND 2 STIT THROUGH RIGHT ANTERIOR CHEST. PT TREATED 2 TUBE THORACOSTOMY & EX-LAP. PT RESPONDED TO NMS STELLATE LACERATION OF CHEST LIVER TREATED 2 PACKS. PT ARRIVED ENTUBATED & PARALYZED.

PMH: PSH: MEDS: ALL:

PHYSICAL EXAMINATION

VS HR 56 140/70 RR 16 SAT 100%

H: NL
E: PERRL, NL
M: NL
N: NL
T:
NECK: NL CROWNS
BACK: NL CROWNS
LUNGS: CTA
CVS: RRR

ABD: DRESSINGS CLEAN DRY INTACT
PELVIS: STABLE

WOUNDS: ENTRANCE (8) POSTERIOR NEAR MIDLINE
EXIT (10) CHEST T

VASC

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

DISP: STABLE S/P TUBE THORACOSTOMY & LIVER LAC
PLAN TO ICU
SOS ORDERS

[redacted] (6)(6)-2

	DATE	IDENTIFICATION NO.	ORGANIZATION
	29NOV03		

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

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
29 Aug 03	(S) 28 y/o Iraqi male s/p GSW.
	(+) wheezing (+) pain Ø LOC (+) SOB
Vitals	(O)
BP HR SpO2	
80/60 117 95	WNWD Male Mod distress AOx3
@ 1300	CN I-~~XII~~ grossly intact
82/58 97 97	Card - RRR s̄ M/R/G
@ 1307	Distal pulses (=) (B)
96/62 74 98	Cap refill < 3 sec (B)
@ 1315	Lungs - (+) wheezing 2° sucking chest wound
119/68 76 98	on (R) lower lobe & middle lobe
@ 1524	~~Entrance wound~~ - 7mm x 6mm puncture on
	(R) post chest
	~~Exit~~ - (+) 1in x 3in exit wound
	(+) wheezing c̄ minimal bleeding
	between (R) 7-9th ribs
	(A) GSW - Sucking Chest wound - (R) sided
	(P) O2 via NRB mask @ 12L/min
	1000mL LR IV @ (L) Dorsal wrist
	Asherman chest seal applied to (R) ant chest s̄
	4x4 over entrance to (R) post chest
	Pt stable & ready for transport (b)(6)-2

[redacted]

HOSPITAL OR MEDICAL FACILITY | STATUS | DEPART./SERVICE

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

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. 2C T. SP. | WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 5)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 17925

1330 P-80
R-40

1335 P-
R-40

1340 P-78
R-40

1345 P
R Changed O2

1350 P-80
R-34

1355 P-80
R-34

1400 P-78
R-40

1405 P-76
R-40

1410 P-78
R-

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/29/03 1530	Surg
	(b)(6)-2
	Surg - CPT [redacted]
	Op Note Fwd Asr. Cal [redacted]
	(b)(6)-2
	(R) Chest tube c 950 cc blood output
	Exploratory c repair of diaphragm
	c O'Prolene. (approx 4cm
	laceration)
	Lung stellate liver wound to (R)
	ant lobe of liver c continuous
	ooze of blood → packing + surgical
	+ ... 6 laparotomy
	sponges used to pack liver
	+ abdomen closed c #1 looped PDS
	(R) lower chest exit wound deep tissue
	closed c single 2'0 vicryl &
	packed
	Sterile drsg applied
	(b)(6)-2
	[redacted]
	(b)(6)-2

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

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

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

REGISTER NO. | WARD NO.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
30 AUG 03	OP NOTES
	PRE-OP DX: GSW TO CHEST & LIVER S/P EX-LAP
	& PACKING OF LIVER & REPAIR OF DIAPHRAGM &
	TUBE THORACOSTOMY
	PROC: EX-LAP & LIVER RESECTION (NON-ANATOMICAL),
	REMOVAL OF SPONGES & WASH-OUT
	SURG: [redacted] (b)(6)-2 / [redacted] (b)(6)-2
	EBL: 400 cc
	UO: 165 cc
	FLUIDS: 1700 LR 2u PRBC
	DRAINS: 2 JPs PLACED
	NO COMPLICATIONS (b)(6)-2 [redacted]
	STABLE TO ICU

STANDARD FORM 600 (REV. 6-97) BACK

*U.S. GPO: 2002 - 491-600/50618

Nursing Note

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
28/Aug 03 1618	EPW ↑ arrived via MEDEVAC. Pt c [redacted] (b)(6)-2 ET in place @ 24 teeth. VSS 138/62, 77, 24, 1C 100% on vent. Chest to to (R) side of chest to continuous suction. Foley to gravity. AND A CDI A to (R) Lower back CDS. 18G IV to (R) Bicept c NS, 18 to (L) FA c Albumin and NS infusing. # of infused fluids unknown. Total of 1400cc of blood from CT. Pt remains sedated. Will continue to monitor
1700	DR [redacted] (b)(6)-2 completed from CXR and KUB Complete. Labs drawn and sent c ABG's from (R) femoral Artery. 142/65 48 16 100% on Vent. Report given to ICU3 by [redacted] (b)(6)-2, RN. Pt Rt in to place ET Tube to 26 @ teeth. Pt ready for Transport. Off vent to BVM. [redacted] (b)(6)-2 with RN.
1709	Pt WAKING up reaching for ET tube Combat Vec., 5 mg versed, 100 mg of Fentanyl IV given. Pt to ICU3 [redacted] (b)(6)-2 in

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.)

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

REGISTER NO. | WARD NO.

MEDICAL RECORD | PROGRESS TES

DATE

1700 pt removed from OR ER via litter; transfer to bed 5 blanket; VSS; temp 95.6 axilla; pt cuml c spine blanket, blanket, A/C fml 96; Vent per MD V.O.; ETT @ 23 cm; NGT to LWS; CT to SX; foley to gravity; pt GCS 3 c vee on bard; pt hydrated for T-Spine xray; MD [redacted] (b)(6)-2 in to see pt; [redacted] (b)(6)-2 xrays done;

1800 SBP > 120; HR 49-65; pt cuml c additional blankets for warmth; temp @ 95° axilla; [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.

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
29AUG03	Neurosurgery Consult
2032	History 28 y/o EPW GSW posterior chest @ ~1200 today. [redacted] packed abdomen / (R) Chest tube c hypotension 82/60 and 850 cc output (R). Op note documents liver injury - packed and sent here, arrival ~1600. Initial exam @ FST documents awake patient but does not mention lower extremity function
	Exam Intubated, sedated c propofol and Fentanyl. HR 67. BP 126/84.
	Eyes open to noxious.
	Localizes uppers to noxious.
	Lowers plegic.
	Perineum (+) Foley. (+) Priap. Rectum good tone. (+) Stool (-) blood. (-) bulbocavernosus (-) Cremasteric
	LE Reflexes Flaccid.
	AP T/L Spine x-rays show no malalignment. There is a foreign body in the midline at T-11. Lateral not completed.
	Back exam: Midline wound dressed @ Low thorax.
	Impression: Flaccid plegia, appears complete
	Plan: (1.) CT Scan when stable.
	(2.) Log Roll Precautions for now.
	(3.) Will not offer steroids in this case.

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RE[redacted]NTAINED AT (b)(6)-2

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

REGISTER N[redacted] | 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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31 Aug 03 0300	Pt's HR increased from 80's; 90's to 120's between 2300 hrs & now. WOP continues dark, concentrated & average of 40-60 cc per hr. CBC, chem 7 & coags sent to lab. MD notified of HR change, who in turn evaluated the pt for bleeding. No evidence of continued bleeding per MD - H/H WNL. 1/2 L of CR given as bolus. CXR req. MD also notified of temporary vent disconnection. After returning from lab RN noted ETT disconnected from vent. O_2 sats ↓ 30's% HR ↑ 170's; sys BP 150's. Pt immediately bagged; brought up to 100% O_2 & ETT & immediate stabilization of vital signs to prevent events. LPN watching over pt @ the time stated pt could not have been disconnected for more than 30 secs since he had checked on pt right before RN's arrival. [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)*

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

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PROGRESS NOTES
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15Sep03	SURGERY
	CNS: PT SEDATED / ANALGESED
	LUNGS: C+A CVR: ↓ BILATERAL OPACITIES VENT FIO_2 50% RR22
	SIMV PSUP 7 TV 500 7.37/45/136/26/1/99%
	CVS: RRR HR 91-115 134/54
	ABD: SOFT, NT, ND @ BS 700cc TF c/w BILE LAST SHIFT
	NG: 250 LAST SHIFT
	RENAL: 140/10.4/1.4 < 81 UO > 40cc/hr
	HEME: 9.7 / 30.2 / 131 INR 1.4 PTT 99.2 TC 99
	ENDO: STABLE
	IMPROVED OXYGENATION
	PLAN: FIO_2 TO 40%
	PUSH TO 5
	DC VEC
	HOLD VERSED
	[redacted] (b)(6)-2

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

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PROGRESS NOTES

DATE	
1400;	CL placed per MS Yang; CX taken for placement; Xray read by MS Yang – OK to use CL given; pt currently stable; VS noted @ 1400; [redacted] (b)(6)-2
(1800)	Continues hemodynamically stable; no change in status; vec ↑ slowly to effect; temp ↓ 94.8 – pt covered c blanket,
(b)(6)-2	[redacted] (b)(6)-2
31 Aug 03	Assumed pt's care @ 0600 USS afebrile, assessment done
0800	see flow sheet ↓ F_iO_2 @ 0815 (50%) ABG's sent @ 0900 Ph 7.36 PCO_2 40.9 PO_2 84 HCO_3 24 SO_2 96%. Suctioning pt. prn. thick mucous in small amounts. Will continue to monitor
	[redacted] ICT/AU
	(b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	

30 Aug 3 Arrept resus; pt sedated adequately; moves upper extrems to painful stimuli x 5x; T-11 GSW; Propofol @ 30 mcg; Labs obtained by Night nurse. [redacted] (b)(6)-2

(0845) PRBC #1 started; 103, 103/42, 20, 98.2 (0850) 105/43, 101 98.5, 25, (0855) 106/45, 99, 26, 99. (0923) unit complete; no s/s of rxn; 111/48, 97, 26, 98.7 [redacted] (b)(6)-2

0900 ↓ UOP discussed w/ anesth; will cont [redacted] (b)(6)-2

(0945) PRBC #2: 121/51, 93, 24, (0950) 123/52, 91, 24, 98.7 (0955) 115/50, 93, 30, 98.5 — no s/s of rxn; (1030) 121/51, 93, 26, 98.2

(1000) Propofol ↑ to 19 cc/hr to d/c PA-cont PAmp (45-50) [redacted] (b)(6)-2

(1045) PRBC's complete; LR bolus 500 cc & blood cultured for ↓ UOP as discussed w/ [redacted] (b)(6)-2; no other orders given; will transfuse FFP & LR bolus

(1100) Foley d/c'd to ensure ∅ blockage — no blockage noted [redacted] (b)(6)-2

(1130) FFP started; 114/54, 96, 16, 92.4 (1135) 115/53, 87, 16, 92.4 (1140) unit complete; ∅ s/s of rxn noted; 107/55, 97.4, 85 [redacted] (b)(6)-2

(1145) FFP #2: 92.4, 88, 120/57, 16 (1150) 114/56, 87, 96.3a, 22 (1155) 114/57, 84, 96.3 16 — unit complete; [redacted] (b)(6)-2

(1230) SBP ↓ 80's; SaO2 ↓ 88-90's; ↑ PAmp - 60's; no [redacted] (b)(6)-2 noted; Multiple LR/NS bolus given (x3) FFP complete (2 units rapidly transfused); Dopamine started; Vec started & loaded over 10 mg IVP; Versed started @ 2 mg [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)

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WARD NO.

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

PROGRESS NOTES
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31Aug03 (2345)	Received report from ILT [redacted] (b)(6)-2 and assumed care of pt @ 1815. See DA Form 4700. OP 375 for assessment data. Pt's lungs c Rhonchi all fields. Lavaged pt c NS and suctioned lungs @ 1830. Secretions very thick. Don't get secretions up c lavaging. Peak pressures 35's c suctioning. Same way c every suction. Around 2000 pt started to get blood colored drainage from NGT. Dr [redacted] (b)(6)-2 & Dr [redacted] (b)(6)-2 aware. Drainage turned back to a dull green color around 2200. Cleaned pt's mouth c cepacol mouth wash around 1845 and suctioned mouth. Pt's temp was 94.5 (R) @ 2100 rechecked 96.° (R). Drs aware. A/C in room turned off and warming blanket c supp. Heat lamps over pt. Pt's temp rechecked an hr. later and was 95.° (R). Heat lamps moved closer. Dr [redacted] (b)(6)-2 aware of pt's HOB being on the lowest end. Pt flat on back [redacted] (b)(6)-2 ILT/AN
01Sept.03 (0030)	Pt reassessed. Lungs still c Rhonchi all fields. RT came and suctioned moderate amts of yellowish-white secretions. Temp ↑ to 96.0°F (R). Heat lamps still over pt. No further O's from previous assessment. [redacted] (b)(6)-2 RT/AN
(0115)	Suctioned pt. Lavage and got moderate amt thick yellow-white secretions. Pt tolerates well. Peak pressure c 32 [redacted] RT/AN

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31 Aug 03	SURGERY INJ: GSW currently sedated & paralyzed c GSW to spine Right chest & lung & liver s/p tube thoracostomy x2, diaphragm repair & non-anatomical liver resection. Currently stable pt had hypoxic event this A.M. when he was disconnected from ventilator for unknown period. Neurological status currently unknown. CNS: sedated & paralyzed CVS: HR 114 BP 132/53 Lungs: coarse B/L BS FIO2 50% PEEP 8 RR 22 TV 500 5 cm H2O 7.34/42/88/23/-3/96% ABD: soft, NT, ND (+) BS Renal: 440/109/14/86 4.5/251/1.2 UO 460 cc last 10 hours Hem: 5.7 / 12 / 157 / 37 ID Tm 99.8 Tc 97.9 Imp: stable: Liver lac, diaphragmatic injury, Lung injury + spine injury. (b)(6)-2 Plan: cont current management

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
01Sep03(0615)	Suctioned pt approx Q°. Still having to lavage pt to get anything. RT came in before 0600 for TX. Labs drawn @ 0400. CXR done @ 0500. Brushed pt's teeth and rinsed c cepacol mouthwash @ 0515. Heating blanket taken off of pt but on lamp still over pt. JP's and foley emptied. NGT still to LIS and draining dull green liquid. CT x2 to continous suction. RT dropped FiO_2 to 45% p tx and upon results of ABG. Report given to CPT [redacted] (b)(6)-2 [redacted] CTAN (b)(6)-2

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

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MEDICAL RECORD	PROGRESS NOTES

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DATE	NOTES
1Sep03/1330	Ø passed glt 5mg/kg. Ø HR c̄ MBP
	Ø MAB 30° per Dr. orders (b)(6)-2 [redacted]
	1620 update given to Dr. Ø new
	orders received (b)(6)-2 [redacted]
MD	assessment done - see 4700; ms in assessment; no
	new orders written [redacted] (b)(6)-2
9/1/03 2130	dressing Δ's to CT x2 & JP drains x2 and M/L incision
	Ø s/s infection, Ø drainage noted. Tape @ ET tube Δ'd.
	TLC IJ flushed c̄ NS. Distal port occluded. (b)(6)-2 [redacted] LPN
9/1/03 2131	ET tube Δ'd to Ⓡ side of lip (b)(6)-2 [redacted] LPN
9/2/03 0430	A-Line d/c'd due to it infiltrating (b)(6)-2 [redacted] LPN
9/2/03 0500	Bed bath given, oral care done. Backside skin CDI.
	Ø breakdown noted. pt SX'd in ET tube and nose c̄
	scant, thick, tan-colored secretions observed. [redacted] LPN (b)(6)-2
9/2/0700	~~Assumed pt care~~ from Sgt [redacted] (b)(6)-2 [redacted] (b)(6)-2 [redacted] (b)(6)-2 @ approx 0600. At change of shift pt
	~~...resting quietly~~ sleeping in bed Ø no apparent distress
	intubated Vent SIMV VE 500 peeps for 50%. RR 22) VSS, NG to LCIS
	CT x2 water seal. LR @ 100cc/hr fentanyl drip @ 80mcg/hr, versed @
	5mg/hr. No issues noted (b)(6)-2 [redacted] 1LT RN
9/2/0730	Per Dr. [redacted] LR d/c'd to D5½NS c̄ 20KCl @ 150cc/hr, Jevity
	(b)(6)-2 100cc given via NG, NG clamped. (b)(6)-2 [redacted] 1LT RN

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

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[redacted]

(b)(6)-4

PROGRESS NOTES
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1 Sept 03	0605 Assumed care. Report given
	see ICU-3 flowsheet for initial assessment.
	0700 Sx'd as before of thick tan secretion
	reposition using logroll tech. (b)(6)-2 [redacted]
	0809 Dr [redacted] @ bedside. orders
	received (b)(6)-2, labs & CXR reviewed.
	vent Δ's made by Dr. FiO2 ↓ 40%
	PEEP ↓ 5; VEC & versed turned off.
	ABG in 30 minutes (b)(6)-2 [redacted] RN
	0840 ABG drawn per A-line sent
	to lab. Sx'd scant amt of secretion
	per ET. ∅ response from pt. (b)(6)-2 [redacted] RN
	0910 ABG results reviewed by Dr
(b)(6)-2	[redacted] orders received to call once
	pt is awake. ventilation noted. (b)(6)-2 [redacted]
	1215 Dr (b)(6)-2 [redacted] @ bedside. orders
	received to restart sedation, versed
	@ 3mg/hr. (b)(6)-2 [redacted] RN
	1730 Update given to Dr (b)(6)-2 [redacted] Dr [redacted] (b)(6)-2
	FiO2 50%. deep Sx'd scant amt of
	secretions noted (b)(6)-2 [redacted] RN

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI [redacted] | ID NUMBER or Other)

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EPW [redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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MEDCOM - 17940

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
9.2.03	0930		(b)(6)-2 Dr [redacted] placed R-Radial A-line. Line sewed ⊄ c̄ in 10 pts a[SBP NIBP maps are correlating. Pt tolerated procedure well. No changes in VS noted [redacted] KTRN—
9.2.03	1700		(b)(6)-2 Per Dr. [redacted] fentanyl turned off until further notice (b)(6)-2
9.2.03	1755		Peep ↑ 7. Dr (b)(6)-2 [redacted] called in to BP 70/63 & SPR 91 — (b)(6)-2 [redacted] KTRN—
		1900	report received; pt hypertensive; Anes nurse informed; no orders written; currently SaO2 ≥95% on 6 peep, 80% FiO2; sedation has been off by Anes nurse per MD order; pt unresponsive; ⊕ gag c̄ SX; [redacted] (b)(6)-2
		1930	MD (b)(6)-2 [redacted] to see pt; limited neuro exam done s̄ response from pt; vent VT Δ'd to 550; no other orders given — (b)(6)-2 [redacted]
		1945	pt SX per RT; small amt of tan secretions noted; VSS returned to baseline — [redacted] (b)(6)-2
		2400	pt noted to be moving head/arms. no dexm @BS; propofol added for sedation to control RR; arms restrained; episodic event of ↓ sat to 87%; pt SX'd, bagged, FiO2 ↑, peep ↑ to 8 then 10; VT remained the same; Pamp 40-50; vent Δ's made; changes slowly to previous settings slowly — (b)(6)-2 [redacted]
	0400		labs sent; CXR called; ABG done; bath given; propofol ↓ titrate for ↓ BP; SaO2 ≥90%, RR 26-30 — [redacted] (b)(6)-2 —[illegible]—

(Continue on reverse side)

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NURSING NOTES

Medical Record

MEDCOM - 17941

STANDARD FORM 510 (REV. 7–91)
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NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
3 Sep	0430		ms pixon called for ↓ sat 83% on 100% FiO2; pt bagged ↑ to 94%; POG failure noted c 100% O2 demand; vent ↑'d to H-glendin; RT notified; 500cc WS given per ... Dixon, ↓ VOP, q 1HR noted; [redacted] — [redacted] (b)(6)-2 (b)(6)-2
03SEP03	0628		Neurosurgery
			(S/O) Nonsedated Neuro exam:
			No Eye Opening }
			Intubated } GCS 3-T.
			No response in Extremities }
			Pupils S/R.
			Corneals Present
			Oculocephalics Present
			Gag Present
			Cough Brisk
			(A/P) Low comatose state consistent with global encephalopathy. Will look at CT head when completed. Understand that patient's respiratory status is guarded.
			[redacted] (b)(6)-2

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

STANDARD FORM 510 (REV. 7-91) BACK

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ACLU-RDI 1644 p.102

DOD-031516

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
0800	Pt started to dc SZT post 1L bolus IV.
0355/03	SZT > 86-87; ↑ in F.IO2 to 100%; ↓ ↑ in SZT with ↓ in pulse ox; Suctioned effectively. Difficult to pass suction catheter x 3 attempts, [redacted] (b)(6)-2 put site block in. RR 23. Propofol @ 2mg/kg/hr, Dr. Lange x 3 attempts. Successful pass of suction catheter. Suctioning revealed moderate amount of thick white secretions. SAT, ↓ to 97, ↑ FIO2 to 90%. [redacted] (b)(6)-2 DI [redacted] (b)(6)-2 in lower when staff started to bag patient. With [redacted] pt (b)(6)-2 made DNR/DNI [redacted] (b)(6)-2 ICU RN [redacted] (b)(6)-2
0815	VSS. 128, 98 on 90% FIO2; RR 23, Diprivan @ 10mg/kg/hr.
0355/03	98/41. Vasopressin given as ordered [redacted] (b)(6)-2 ICU RN [redacted] (b)(6)-2
0900	Urine output ↓ to 10cc/hr. DI [redacted] (b)(6)-2 noticed. Will notify this team and follow up with staff [redacted] (b)(6)-2 ICU RN
1015	Notified MD of 0 u/o this hour + ↓ in SZTs (coming
0355/03	At 86%), ↑ PEEP to 14; 100% FIO2. 1 Liter LR Bolus to be given. Will follow [redacted] (b)(6)-2 ICU RN

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[redacted] (b)(6)-4

PROGRESS NOTES
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0354002	Assumed care for patient. Pt. resting comfortably
0630	in bed. HOB ↑; (B) restraints on. [NEURO] Ø responds to (b)(6)-2
	nipple twist; PERRL @ 2mm - sluggish; Ø movement ~~out~~ [redacted] noted
	outside overbreathing vent. Ø sedation on; Possible CT
	today; [RESP] course (B) breath sounds; min. exp. wheeze
	noted in upper (R) quad. of (R) lobe; vent setting of
	SIMV 22. TV 550; 60% FiO2; PEEP (8); # 7 ETT 20
	cm @ teeth; Heavy work load of breathing noted [CV] Afebrile,
	ST; S1, S2, +2 edema to (B) LEs/UEs; pulses palpable +2 (LEs UEs)
	sats 93-95% on above settings; cool UEs; CT x2 to water seal
	((R) side); [GI] midline abd inc. - open x 1 with
	staples - C/D/I; JP x 2. NGT from (R) nare clamped;
	starting TF; Zantac ~~prophylaxis~~ (b)(6)-2 [redacted] [GU] minimal dark concentrated
	urine from foley 1L LR x1 given. [SKIN] heel/head donuts
	placed; patient turned q2 hours; [LINES] CT's, foley, JP x 2;
	~~(R) IJ~~ (b)(6)-2 [redacted] (R) IJ lumen x3; (L) femoral cordis; (L) radial
	A-LINE [PLAN] ↑ TF; Atb (unasyn); ? CT. will follow
	(b)(6)-2 [redacted] LLT/RN
	(b)(6)-2 [redacted]

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(b)(6)-4

PROGRESS NOTES
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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3 Sep 03	Pulmonary / Critical Care
08^40	EPW s/p GSW to Abdomen/chest. Diaphragm injury
	with liver involvement. ↑ O_2 requirements overnight with
	desaturation. Neurosurgery by Dr. [redacted] (b)(6)-2 T11 paraplegia with
	GCS-3 off versed 24hrs. On propofol
	135/85 Tmax - 101.5 126 93% [80% - FiO2)
	General: sedated, ventilated EPW
	LUNGS: [redacted] (b)(6)-2 rhonchi → scattered throughout
	CV: regular tachy CT×2 right side → water seal
	Abdomen: midline incision
	Ext: paraplegia waist down
	(Labs:) 11.8 > 10/30 < 112 7.36/41/66 -2 ⊥ / 15/1.2 135
	(CXR) diffuse perihilar fullness (R) ?? infiltrate
	question early ARDS
	(1) Neuro → cranial nerve function only. Need to stop
	propofol as oxygenation will tolerate and assess. Would
	not withdraw care until after CT and >72 hours
	off sedation. Will discuss with team.
	(2) Pulm → early ARDS. Recommend broader spectrum
	coverage such as Zosyn/Cipro. Much of infiltrate
	due to capillary leak. ? Decrease when FiO2-80%

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[redacted]

(b)(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	③ Hemodynamically stable. → extreme volume support
	④ Renal → ↑Cr → volume support but at expense of lungs
	⑤ ID → infiltrates and MOS use double gram ⊖ coverage 73 days hospitalization. World broad spectrum coverage and lungs Bld Cx sent
	⑥ Heme → no coagulopathies
	⑦ Extensive to follow medical status
	[redacted] (b)(6)-2

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
350903	Surgery Trauma patient s/p ex-lap x2 for small bowel injury + diaphragmatic injury & Right lung injury now c daily Brain scan, Pupils on Neuro-exam By Dr [redacted] (b)(6)-2 / Neurosurg Pt also c developing RLL Pneumonia CNS: No Response to Pain Lungs: Coarse b/l RS PEEP 8 SIMV RR 22 TV 530 7.36/41/66/23/-2/92% CT #1 325 cc CXR RLL infiltrate CT #2 166 CVS HR 126 114/38 Abd: soft, NT, ND (b)(6)-2 c BS wound Healing well JP Drain Minimal Loss Bilious JP #1 = 105 cc JP #2 32 cc Renal: 165/135 In 1726 UO = 1800 cc Heme: H&H 9.7/30.2 PLT 105 Rx: GSW to (R) chest, Small bowel, Diaphragm & Liver c subsequent Iatrogenic Anoxic Brain injury & New Pneumonia Plan: Unasyn 3gm IVPB q8° IVF to support Urine output DNR - NO Vasoactives Ativan + No CPR Renal consult (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. 5/1999)
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USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5Sep03	SURGERY Pt S/P OSW TO SPINE @ CHEST, DIAPHRAGM & LIVER. Pt T HIGH WBC on ZOSYN, VANC & CIPRO. NOW GRIMACES & PAINFUL STIMULI CNS: SEDATED CON: HR 101 BP 121/65 CT = 240cc LUNGS: FIO2 60% TV 550 RR 22 SIMV PEEP 10 ABG: CXR: B/L INFILTRATES ABD: SOFT, NT, ND @ BK TP1 = 48 TP2 = 227 RENAL: 025/112/29/108 2.3/L/4L 43 25 1.9 HEME: 34.5/10/25 32 ID Tm 100.3 TC 96.6 IMP: SIRS/S - CRITICAL PLAN: CONTINUE CURRENT MANAGEMENT DC JP 2 DC CT 2 ↓ DVT

(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		

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REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

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

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DATE	NOTES
4 Sep 03	UOP continues @ 5cc average since 2100 hrs. One
0000	liter LR bolus plus Hespan 500cc given per
	(b)(6)-2
	Dr [redacted] orders @ 2230 hrs. IVF's ↑ 150 cc/hr
	also. foley irrigated c̄ 40cc NS c̄ a return
	of 40cc. Pt continues to sat 98-100% on SIMV 22:
	TV 500, Peep 15 ; FIO2 50%. Dr [redacted] (b)(6)-2 aware
	of UOP. Will continue to monitor — [redacted] (b)(6)-2 CPT, ANC
4 Sep 03	
0800.	
	(b)(6)-2
9.4.03/0630	Assumed pt care from CPT [redacted] @ approx 0630. Pt is in no
	apparent distress @ change of shift. all VSS. At change of
	Shift pt rcvg D5½NS c̄ 20 kcl @ 150cc/hr, dopa @ 3 mcg/kg/hr,
	CT x2 RCW to water seal, NG Ⓡ nare clamped. Pt on
	vent RR 22, FIO2 50%, peep 15 @ Vt 500. At change of
	Shift CPT [redacted] (b)(6)-2 gave 8 mg Lasix IVP. Propofol on
	Standby. No issues noted — [redacted] (b)(6)-2 1LT ANC
9.4.03/0825	Peep ↓ 10 from 15 by Dr. [redacted] (b)(6)-2. SpO2 95% prior to change, pt currently
	93% SpO2
	(b)(6)-2
9.4.03/1105	PRBC [redacted] started per [redacted] VS: 100.4 (ax), HR 128, BP 123/67 (A-line)
1110	100.3 (ax) 126, 133/72 (A-line)
1115	100.4 (ax) 124 119/66 (A-line)

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

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[redacted] (b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES

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DATE	NOTES
0256P03	VSS: 119, 24, 114/51, 96.4. Sats 100% on FiO2 100%
1500	PEEP [redacted] (b)(6)-2 14, SIMV 22, TV 550. Will ↓ FiO2 to
	keep sats 90% < as tol.
	(b)(6)-2 [redacted] 1LT AN
	(b)(6)-2 [redacted]
	(b)(6)-2
~~1230~~	~~VSS p ↓ in sedation ... [redacted] 7... (75-79)~~
~~0256P03~~	
1730	Past 25 min report: pt ↓ in sats. ↑ FiO2 to 100%
0256P03	sats continue to ↓. ⊕ ... to 80 with ... (b)(6)-2 [redacted] patient.
	Sats 74-76% on 100% FiO2 otherwise. SBP ↓ to 80/30.
	Sedation off. Unable to contact MD; after several
	attempts Dr. [redacted] came. Put Chest Tube back
	Ⓐ water seal & inserted CT ... 3cm. [illegible] obtained
	Xray & ABG. Currently (1735) VSS. 98% on 100%
	FiO2, PEEP 14, 120s/60s, 118. Will follow
	(b)(6)-2 [redacted] 2LT AN
	(b)(6)-2 [redacted]
0256P03	1450: Pupils fixed @ 1mm. Propofol on @ 15mcg/kg/min.
	(b)(6)-2 [redacted] 1LT/AN

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REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 17950

510–112

NSN 7540–00–634–4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
Cont..			
9.4.03	1130		100.3, 124, 116/67
	1145		100.3, 124, 125/70
	1215		999, 126, 122/67
Post tfsn VS	1245		100.3 124 133/76 [redacted] complete, ⊘ adverse reaction
	1248		PRBC# [redacted] hung pre tfsn VS 100.3, 128, 108/6
	1249		" " Started
	1255		100.3, 138/69, 134
	1300		100.3, 146/73, 133
	1305		100.1, 139, 71, 132
	1335		99.9, 129/69, 133
post tfsn VS	1355		99, 132/67 130 [redacted] complete ⊘ adverse reaction. CBC, ABC & Chem 7 sent Po 2UPRBC. (b)(6)-2
4 Sept 03		1830	Recvd pt from LT [redacted]. D5½NS +20KCL infusing @150cc/hr into ® IJ TLC. pt has NG tube to ® nare to LIS, CTX2 draining serosanguinous fluid to H20 seal, JP drains X2 draining serosanguinous fluid. Pt has ® femoral AlinoSite CDT. pt has 2 blisters small to ® hip. Will Cont to monitor (b)(6)-2 [redacted]
4 Sept 03		2000	ETT tape Δ'd and ETT moved to ® side of mouth. ETT 26 cm @ teeth. Oral care also Completed (b)(6)-2 [redacted] LPN
5 Sept 03	0400		® sided JVD noted. Unable to assess ® side d/t bandages. Will Cont to monitor (Continue on reverse side) [redacted] LPN

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

REGISTER NO.

ARD NO. (b)(6)-2

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

NURSING NOTES

Medical Record

MEDCOM - 17951

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
8Sep03	0400		½ cm circular bed sore observed m/l of pt's back. Duoderm applied — [redacted] LPN (b)(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	(b)(6)-2 NOTES
0730	NSG: ~~white secretions~~ [redacted] Staff Critical & Peak Pressures to
5SEP03	65-72; Attempted to place S.T. Stick in patients Patient S.T.
	clown on staff's fingers; Multiple attempts to place S.T.
	Stick ~~left~~ (b)(6)-2 [redacted] unsuccessful due to P in resistance from patient
	(+) eye opening 5/6 patient, RR in 40's-50's; PBP in 160/80
	Upon placement of S.T. Stick peak pressure 60+; Suctioning
	revealed large amount of thick, white with blood tinged
	secretions. Semad (4-6) suctions revealed same
	amount of secretions. SATs at 83-85%; After 1st
	suction placed patient on previous vent settings.
	Currently @ SIMV 22 5PS TV 560; PEEP 10; VS: 117, 167/82, 44,
	SATs 93%; will place patient on 100% F.O2. Dr. [redacted] (b)(6)-2
	127 [redacted] (b)(6)-2 written eye opening. & response to painful
	stimuli noted. Received order to place patient on
	propofol drip. will start with [redacted] (b)(6)-2 10/hr
	[redacted]
	(b)(6)-2

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

#1 [redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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

DATE	NOTES
0630	Pt recieved from outgoing staff. ↑ HOB / resting comfortably
55P 03	Assessment as follows: (N) Ø response to painful
	stimuli; PERRL @ 3mm; Ø sedation; patient does have
	(P) gag reflex; (P) overbreathe the vent setting (R) vent setting
	of SIMV 22 TV 650 PEEP 10 100% FiO2; #7 ETT 22 @ teeth;
	Peak Airway Pressures 40s → 50s; (B) coarse breath sounds;
	SpO2 93% with RR 30's. ØS/S grunting (CV) NSR-ST
	(90s-110s); BP 115-130s systolic; CVP 9-14; ↓ pulses ×4
	(2+ (LE < UE)); +3 edema ×4 (LE > UE); S1/S2; warm
	throughout to touch (GI) midline abdomen incision -
	c/D/I; JP ×2 to bulb suction - serosanguinous drainage
	noted - NGT from (R) nare to LIWS - green drainage noted;
	(-) BS ×4 (GU) foley to gravity with dark amber
	urine. (skin) multi skin breakdown noted - most notably
	a sacral (dime sized) & (B) LE's; Prevention = turn q 2hrs +
	heel pads; (Lines) (R) fem art; (R) IJ; (L) femoral.
	(R) IJ is a triple lumen; D5½ w/20kcl running @ 150/hr.
	(Plan) possible extubation; Abg's / labs as ordered.
	Will monitor (b)(6)-2 [redacted] 1LT
	(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.

[redacted]

(b)(6)-4

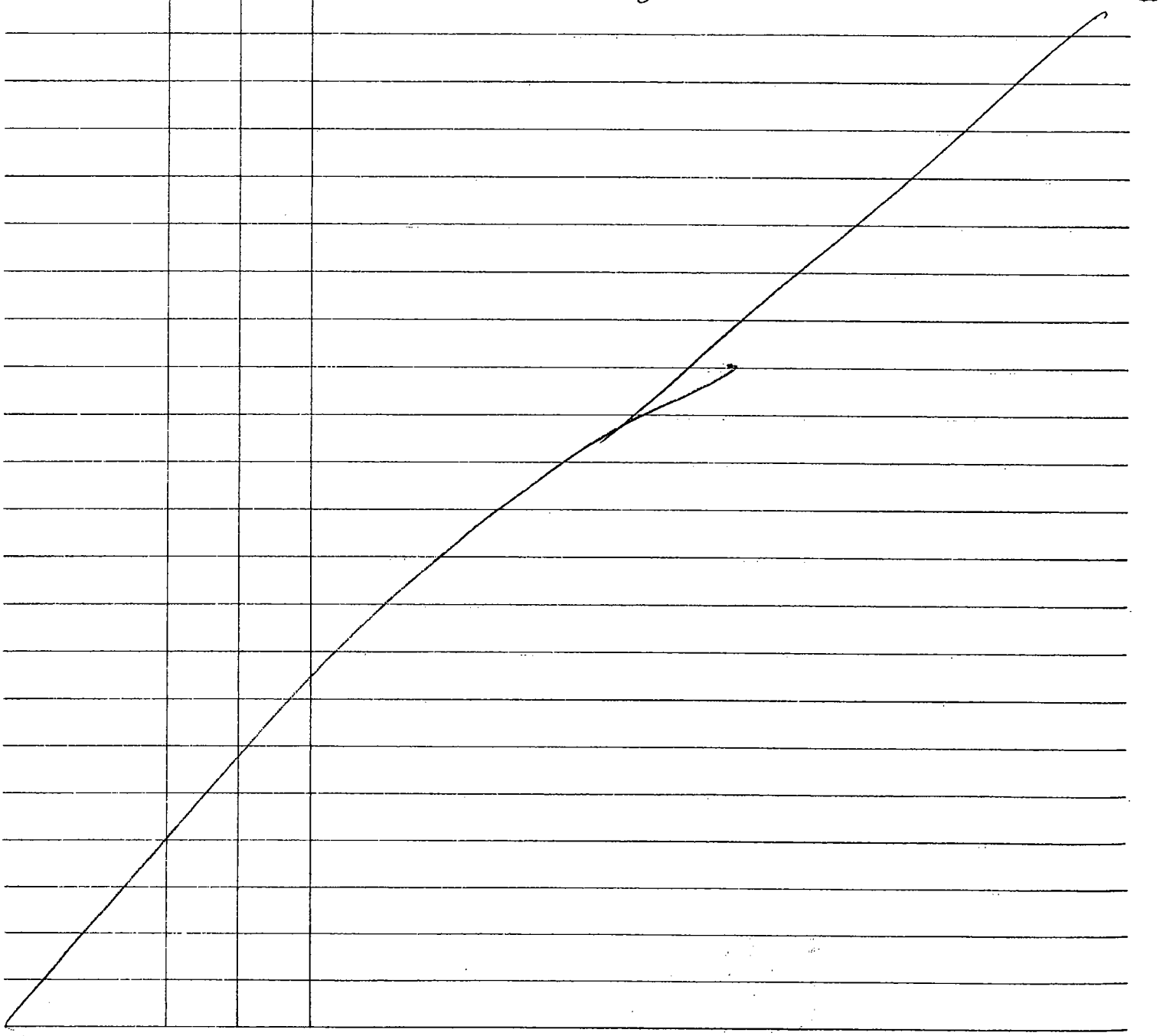
PROGRESS NOTES
Medical Record

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

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
5 Sep 2	1900		report received; pt sedated; arousable (b)(6)-2 [redacted]
	2200		ONR received; no chest compression, no vasoactive drips; NSG Supervised. (b)(6)-2 [redacted]
	0200		no change in status; SX per RT large secretions for suctioning & type & Send (b)(6)-2 [redacted]



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

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 17955

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
06 SEP 03	0420		Recieved report from off going staff. Pt resting in bed with HOB ↑30°. Assessment as follows. (N) sedated on propofol 40mcg/kg/min; Responds to head shake c suctioning with facial grimace & bite down on ETT. Fent ↑ @ 2mcg/hr. Ø voluntary movement noted. PERRL @ 2mm; (R) 26 @ the teeth; #7 ETT vent settings: SIMV 22; 650 TV; FiO2 50%; PEEP 6; coarse breath sounds although improving from previous days ((L) > (R) side); SATs 97% ↓; RR 22-35; PRR with suctioning which revealed large amounts of blood tinged thick clear secretions. (CV) NSR-ST 90s-110s; BPs 120-140 (ART); +2 pulses x4 extrem; +4 edema noted throughout body - most notable in (B) LE & scrotum; CVP 15; S1 & S2 noted; (GI) (R) nare NGT clamped; receiving jevity 100cc/hr; (-) BS; Abd NT/ND; (GU) foley to gravity; dark-clear amber urine; see I&O for amt; (Skin) multiple skin breakdown from edema - most notably on upper back, (B) LE; placed heel boots & turning q2hrs; (Lines) (R) IJ x3 lumen; (R) femoral art line; foley; ETT; (Resp) continue to wean ventilator; Pt is a DNR. Will continue to monitor. (b)(6)-2 [redacted] 1LT, AN

(Continue on reverse side) [redacted]

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 WARD NO.

[redacted] (b)(6)-4

NURSING NOTES

Medical Record

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

MEDCOM - 17956

MEDICAL RECORD — PROGRESS NOTES — AUTHORIZED FOR LOCAL REPRODUCTION

DATE | NOTES

06Sept03(2000) Received report from LT (b)(6)-2 [redacted] and assumed care of pt @ 1815. See DA Form 4700 OP 375 for assessment data. Suctioned pt. Pt started moving head back and forth, kinking the vent opened eyes a bit, and moved shoulders and a bit of arms. Rate of Fentanyl Δ'd d/t concentration in bag. Propofol increased d/t pt getting a bit agitated c moving head back and forth, biting the ETT. CTxT to H2O seal. Secured. No drainage on dressing, no air leak. Will monitor. [redacted] (b)(6)-2 NCT/AN

(2015) Propofol increased d/t increased agitation. (b)(6)-2 [redacted] NCT/AN

(2230) Around 2100 gave pt bed bath and Δ'd sheets and chux. Pt has serous drainage from old blisters. Suctioned pt around 2130 c assistance from RT. Got lg amts of red thick secretions. Pt would bite on tube when trying to insert suction catheter. Peak pressures went from 51 to 37 p suctioning. Hands propped up on blankets, leg elevated, and heal pads on. Neck supported c towel. Inserted more air into cuff of ETT. It was flattened slightly. Pt tolerated all ok. VSS back to stable. (b)(6)-2 [redacted] NCT/AN

07Sept03 (0045) No Δ in assessment. Δ'd out all IV tubing x Fentanyl. TF's given p 55cc residual checked. H2O bolus p. Central line dressing Δ to (P) IJ. Propofol needing to be increased d/t agitation. (b)(6)-2 [redacted] NCT/AN

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)-2

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
07Sep03 (0600)	Pt had periods of aggitation throughout night. Kept having to go up on propofol. Suctioned pt @0330. Needed some lavaging. Got lg amts of red-pink secretions. S/d linen under pt. S/d bite block. CXR done. Labs drawn and taken to lab. Results back. Report given to next shift. — [redacted] RT/AN (b)(6)-2
7Sep (1100)	pt status unchanged; assessment charted; no new issues noted; pt turned frequently to prevent skin breakdown (b)(6)-2 no [redacted] in to see pt, no new orders given (b)(6)-2 [redacted]
(1400)	no chge in assmt status; no new cmts = [redacted]
(1600)	report given to nn shift — [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
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EPW #[redacted]
(b)(6)-4

PROGRESS NOTES
Medical Record

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

510-112

NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
07 SEP 03	0620		Pt recieved from outgoing staff. Patient resting comfortably in bed ↑ HOB 30°; (+) sedated with 50 mcg/kg/hr of propofol; 2mcg/fentanyl; Pupils reactive @ 2mm; Grimmaces to painful stimuli; although more obtundant than yesterday; ↓ sedation to 40 mcg/kg/hr (prop.); [R] SIMV 22; TV 650; PEEP 6 FiO2 50%; #7 ETT 26 @ the teeth; coarse (B) breath sounds although improving from yesterday; (b)(6)-2 [redacted] LLL) RLL in regards to crackles/rhonchi; SAT's 95% on settings; (-) s/s of cyanosis; suctioning revealed large amounts of blood tinged, clear-milky white sputum; [CV] NSR (80s) with SBP in 110s-120s (↑ to 160 when suctioning); +2 pulses x4; +4 edema noted throughout body; most notably (B) LE @ scrotum CVPs 4-7; Temp: 95.7; S1, S2 noted. [GI] ↓ BS x4 NGT from (R) nare clamped; Anticipate TF AC; [GU]: Foley to gravity; marked (see I+O) of dark concentrated urine (output 30-70/hr); [Skin] multiple skin sores; most noted (B) LE (LSK); upper side - wet to dry dressing applied; turning Q2; [lines] (R) x3 L IJ; (R) fem art line; foley, ETT; [Plan] Abx as ordered.
			[redacted] (b)(6)-2 1LT/AN
			(b)(6)-2 [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

NURSING NOTES

Medical Record

MEDCOM - 17959

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

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
9.8/0700	Assumed pt care from Cpt (b)(6)-2 [redacted] pt in no apparent distress @ change of shift. Pt on 55mcg/kg/min of propofol, 30mcg/hr fentanyl, D5½NS c̄ 20kcl @ 125cc/hr, NG clamped, pt on vent SIMV 50%, peep 6, VT550, RR 22, CT to (R) CW to H2 seal, Foley to gravity. No issues or discrepancies noted (b)(6)-2 [redacted]
1100	report received; assessment complete & charted (b)(6)-2 [redacted]
2100	pt sx p̄ ET; HR ↓ 40's; sx [illegible] (b)(6)-2 [redacted]
0200	no chge in status; [illegible] c̄ [illegible] c̄ SX 40-50 [illegible] SaO2 79-80 on 60% FiO2; no chges made to [illegible] [illegible]; NPO for possible OR [illegible]; [illegible] 4+ pitting edema [illegible] pt [illegible]. (b)(6)-2 [redacted]
9.9/0700	Assumed pt care from Cpt (b)(6)-2 [redacted] pt in no apparent distress @ change of shift, propofol @ 60mcg/kg/min, fentanyl @ 50mcg/hr, D5½NS c̄ 20kcl @ 125cc/hr, FTG, NG clamped, CT (RCW) to cont. suction, (b)(6)-2 [redacted] all chambers functioning WNL. No air leaks noted, pt ventilated c̄ SIMV FiO2 60%, peep 8 VT550 RR22. No issues noted. Will cont to monitor (b)(6)-2 [redacted] KCT RN
9.9/1700	Tube feeding hold d/t residual 158cc (b)(6)-2 [redacted] KCT RN
1900	rpt rcvd; MAD; VSS; neuro status unchanged; pOR no chge (b)(6)-2 [redacted]

RELATIONSHIP TO SPONSOR

SPONSOR'S NAME: LAST / FIRST / MI

SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE

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RECORDS MAINTAINED AT

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REGISTER NO.

WARD NO.

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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MEDICAL RECORD | AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
10 Sep 0200	no chg in status; VSS; ✓ QS; [redacted] (b)(6)-2
0400	ABG done c̄ labs; CO2=49 pH=7.30; Paw 45-50, peep 8, VT 550; RR↑24; CTM, repeat gas. [redacted] (b)(6)-2 AM care done; no new skin breakdown noted; dressing to old same, mid-back stg I decub; pt tol. [illegible] [redacted] (b)(6)-2
0700	Assumed pt's care @ 0600 VSS. continue to monitor. Suction pt for thick secretions. Sat 98%. No changes from last night pt sedated, responded to pain stimuli open eyes while suctioning (+) cough. ✓ residual @ 0800 270cc. held feed till [redacted] (b)(6)-2. Will ✓ residual @ 1200. [redacted] (b)(6)-2 1LT AN
1200	Residual 160cc Will hold tube feed. Will check residual @ 1600
(b)(6)-2	[redacted] 1LT AN
1630	Pt c̄ no changes in condition. Suction pt for medium amount of thick clear secretions. Residual @ 1600 150cc. Will continue to moni tor.
(b)(6)-2	[redacted] 1LT AN.
9-11/0730	Assumed pt care from CPT [redacted] (b)(6)-2 @ approx 0630 pt in no apparent distress @ change of shift. At change of shift pt on 150mcg/hr fentanyl, .05mcg/kg/min propofol/ NS c̄ 20 KCL @ 125cc/hr. NG changed c̄ T to cont. sxn, F?, pt on 50% [illegible], peep 8, RR 24. VSS. No issues noted [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

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EPW [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

PROGRESS NOTES

DATE	
9.11 / 1230	Pt returned from OR hemodynamically stable. All VSS at pt asleep at time of surgery. Pt placed on 100cc/hr D5½ NS c 20KCl, 80mcg/kg/min propofol, 100mcg/hr fentanyl. Foley & PEG placed to gravity drainage, CT x2 (R) CW to cont. suction no air leaks detected. Pt trached and placed on 100% FiO2 VT 550 peep 8 RR 24, SpO2 100%. No issues noted (b)(6)-2 [redacted] /LTRN.
9/11/1700	Pt remains hemodynamically stable. Pt localizes pain, opens eyes spont & able to move arms spont. LIJ TLC c cords placement confirmed c CXR. No issues noted (b)(6)-2 [redacted] KTRN.
1900	Report received; pt sedated c propofol/fentanyl; opens eyes spont; trach c min drainage; PEG to gravity (b)(6)-2 [redacted]
2100	no change in status; SX frequently for large, thick secretions; pt tolerated well; sedation ↑ d/t ↑ agitation; frequent drsg Δ d/t large amount of drainage from abdominal wounds; (b)(6)-2 [redacted]

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

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

MEDICAL RECORD	PROGRESS NOTES

DATE	
12 Sep 03	pt moving UE; responds to commands; propofol/fentanyl for sedation; SX frequently; abdomen draining serous fluid [redacted] (b)(6)-2
0200	dsg Δ'd frequently; ML WTD done; area clean; ϕ purulent drainage; ϕ foul odor; area covered c dry dsg; (L) hand (b)(6)-2
	restraint for grabbing @ medical devices; no chge in status [redacted]
0500	frequent SX; A/C needs Δ'g; no supply of DICs; no chge in status; am care done. [redacted] (b)(6)-2
0530	DIC Δ'd · 7.6 FD [redacted] (b)(6)-2
9/13/0700	Assumed pt care from Cpt [redacted] (b)(6)-2. Pt in no apparent distress @ change of shift. D5½NS c 20 kcl infusing @ 100cc/hr, propofol @ [illegible] mcg/kg/min, fentanyl @ 60 mcg/hr. CT to cont suction, feb/pds gravity. No issues noted. [redacted] (b)(6)-2
14 / 2003	SUAG
	PT STABLE ABG MORE ALERT MOVING UE MORE
	LUNGS: CTA FiO2 40% ×20 PEEP 5 SIMV PS 5 7.45/39/149/28/4/99
	CV: HR 90s 124/59 EXT: LEFT EFFUSION SMALL
	ABD: SOFT, NT, ND ⊕BS TOLERATING TF
	Renal: 136 / 4.2 / 29 UO ~200cc/hr
	ID: AFEB CBC 4 / 23 / 624
	Imp: STABLE
	Plan: MINIMIZE IVF
	TRACH MASK ANS ABX [redacted]

(Continue on revers

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

WARD NO.

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

(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	
11Sep03	OP Note
	Post-op Dx: GSW to spine, (R) lung & liver/diaphragm
	Proc: G-tube / tracheostomy
	Complications: Ø
	Surg: [redacted] (b)(6)-2 / [redacted] (b)(6)-2
	EBL: min
	Fluids: LLR
	UO = 200 cc
	Drains: 16F malincot II Sh (?)
	Stable to ICU 3
	(b)(6)-2 [redacted]
13Sep03	Progress notes
	Pt noted (?) improving (?) spontaneous movements
	of arms.
	(?) NR 99 130/63
	Lungs: CTA (?) Ø significant (?) on CXR FiO2 50% RR 20
	TV 550 ABGS 7.36 / 47 / 114 / 27 / 2 / 98% LT out
	Abd: soft, (?) obs (?) TF
	(?) 14 / 97 UO - 200 cc/hr (?)
	Hem: 13 ⟩ 7 / 23 ⟨ 513 (?) (?) 2
	Inf: Improving
	Plan: cont current tx & ABX
	Cultures pending
	LT out
	cont b.i.d. dressing changes

(b)(6)-2 [redacted]

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

MEDCOM - 17964

ACLU-RDI 1644 p.124

DOD-031538

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
9-12-03	0800		Bl Cx x2 (aline, sc); UA/urine cx
			chem as ordered; Ceftriaxone/[illegible]/zantac
			given as ordered; Sutures to [illegible] thigh
			[illegible] [illegible] on [illegible]. [illegible]
			[illegible]. - (b)(6)-2 [redacted] [illegible]
			(b)(6)-2 [redacted]
9-12-03	1100		Midline [illegible] clsg [illegible]; placed [illegible]
			[illegible] on patient; CT clsg [illegible]; placed [illegible]
			in femur (L) [illegible] SC site. [illegible] given
			as ordered (b)(6)-2 [redacted] [illegible]
			(b)(6)-2 [redacted]
13 Sept 03	1420		Anes - Ø postop anesthesia complications [redacted]
12 Sept 03	1740		- Pt resting comfortably; Propofol x2 [illegible] (5mg)
			post clsg [illegible]. VSS. [illegible] [redacted] (b)(6)-2
			[redacted] (b)(6)-2 [illegible]
			[redacted]
			(b)(6)-2

MEDCOM - 17965

ACLU-RDI 1644 p.125

DOD-031539

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
	12 SEP 03		0720: Pt received from outgoing shift. Pt resting comfortably in bed with HOB ↑ 30°. Assessment as follows: [N] Generalized upper extrem/head spontaneous movements. Eyes open, localizes to painful stimuli. ~~Brother~~ (b)(6)-2 [redacted] Attempts to show staff 2 fingers when asked. (L)UE > (R)UE movement. Pain
		(b)(6)-2	[redacted] controlled with titration of fentanyl & propofol. [R] #8 trach with settings of SIMV 23 PEEP 8 50% TV 550; coarse breath sounds throughout (R)>(L); SATs 95% ↓ on above settings. [CV] NSR-ST, 110-130s/50-60; S_1, S_2. +3 edema throughout UE/LE; generalized weeping of serous fluid from old incision sites - most notably (R) fem.; cap refill; (T) 100.6 [GI] midline abd drsg C/D/I; BS; CT to (R) side to wall suction; G tube draining dark green fluid. [GU] foley to gravity draining dark, concentrated urine; grossly edematous scrotum. (Skin) multiple skin tears; most noticeable UE (R) & (L) LE. (Access) (R) fem arterial; (L) SC cordis with x3L; trach; foley; G TUBE; chest tube; (Plan) attempt wean off trach; continue skin care (q2° turning); will monitor, notify as ordered — [redacted] (b)(6)-2 RN/...
			(b)(6)-2 [redacted]

(Continue on reverse side)

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

[redacted] (b)(6)-4

REGISTER NO. WARD NO.

NURSING NOTES
Medical Record

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

MEDCOM - 17966

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15Sep2003	(0200) Received report and assumed care of pt @ 1915. A'd ML dressing W/D ~ assistance from previous nurse. Around 1915 did trach care. Cleaned inner cannula s'd ties and cleaned area ~ ½ H2O2 & [redacted] (b)(6)-2 NS. Pt has lg amts of thick clear secretions from around trach. Fed/pink to clear secretions from trach. Pts sats remained >96%. Tolerated well. S'd pts linen d/t BM. Gave pt bed bath. Pt was very aggitated. RR > than 32 BPM. up to 40 BPM. Pt was diaphoretic. Room was warm @ the time. Temp was 101.0 F. Informed Dr [redacted] (b)(6)-2 about pt's RR. Placed pt back on vent @ 2120 for the night. SIMV 20, TV 600, FiO2 40%, peep 5. Pt. placed on some propofol for aggitation and sedation. ABG drawn and CXR done. Dr [redacted] (b)(6)-2 saw results. Pt calmed down ~ a while. Pt didn't cough as much ~ hooked up to vent. Pt tried to communicate but couldn't write. and mouthing wasn't working. Pt been having adequate UOP. Old chest tube site s'd ~ petroleum gauze. Continuing to monitor. [redacted] (b)(6)-2 NTTMN
15Sep03(0500)	Pt's labs drawn and sent to lab. Pt suctioned per RT. Dressing Δ to ML incision. W/D. Foley care. Suctioned around the

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
cont.	trach. Cleaned skin around trach. Pt keeps trying to get out of restraints. Monitoring. (b)(6)-2 [redacted] MTN
(0600)	Δ'd pt's linen. Pt had small BM. Cleaned pt & back. Stopped pt's propofol @ 0540 and put pt back on T.C. 50%. Pt coughed for a bit then calmed down. Pt's RR in the 30's. Monitoring. [redacted] MTN (b)(6)-2

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15Sep03	1325 transfusion infusing PRBC's 2nd unit, ∅ rxn noted @ this time [redacted] (b)(6)-2
	1340 transfusion on back. Blood completed ∅ rxn noted pt able to cough up secretion, thick clear secretion noted ——— (b)(6)-2 [redacted]
	1400 CBC drawn, sent to lab. (b)(6)-2 [redacted]
	1430 update given to DR (b)(6)-2 [redacted] orders received to give ...
(b)(6)-2 [redacted]	1445 DR [redacted] @ bedside [redacted] (b)(6)-2 received speaks c pt about continual improvement. ——— (b)(6)-2 [redacted]
	1500 Deep sx'd copious amt of thick, ... color secretion. partial bath given. linen Δ'ed. midline ABD drsg Δ'ed. wound pink c ∅ odor/draining noted. turn c pillow support ——— (b)(6)-2 [redacted]
	1600 DR (b)(6)-2 [redacted] @ bedside. Labs reviewed. orders received. (b)(6)-2 [redacted]
	1610 40mg lasix IVP given. drsg applied to (R) lower leg. ——— (b)(6)-2 [redacted]
	1700 DR's round. Orders received. [redacted] (b)(6)-2
1830	UD Alb/Atr tx Given to pt pre Tx hr 97 RR 32 SpO2 100%
15Sept03	BS clear post Tx HR97 RR 30 SpO2 100% BBS course
	(b)(6)-2 SGT [redacted] 91V20
15Sep03 (1945)	Received report on pt and assumed care of pt @ 1815. See DA Form
	4700 OP 375 for assessment data. Suctioned yellowish-clear copious

STANDARD FORM 509 (REV. 5/1998) BACK

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
15Sep03	0600 Report given. pt awake. see ICU-3 flowsheet for initial assessment — [redacted] (b)(6)-2
	0630 pt assist c oral care. appears to be in good spirits. trying to locate translator — (b)(6)-2 [redacted]
	0800 translator @ bedside. update given to pt [redacted] (b)(6)-2 about condition & future outcome. pt nods c agreement — (b)(6)-2 [redacted]
	0850 DR [redacted] (b)(6)-2 @ bedside. orders received. 40mg lasix IVP given per Dr [redacted] (b)(6)-2 — (b)(6)-2 [redacted]
	0930 Blood drawn per A-line for ABG, T&C for 2u PRBCS — (b)(6)-2 [redacted]
	1000 PT consult completed, at bedside c ROM exercises. — (b)(6)-2 [redacted]
	1045 1st unit PRBC's given (b)(6)-4 [redacted]. see VS sheet for continuous monitoring — (b)(6)-2 [redacted]
	1130 1st unit PRBC's given, ∅ rxn noted. continue to reposition c pillow support LBS. — (b)(6)-2 [redacted]
	1230 2nd unit (b)(6)-4 [redacted] started. see flowsheet for continuous VS. [redacted] (b)(6)-2

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

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

EPW [redacted] ICU-3

[redacted]

PROGRESS NOTES
Medical Record

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

MEDCOM - 17970

ACLU-RDI 1644 p.130

DOD-031544

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
15Sept2003(1945)	cont - Secretions from around trach. Cleared skin around and applied 4x4 for secretions. RT came to see pt and put pt. on humidified O2. Flushed all ports to TLC c NS. Flushed well. Dressing to site was d/d yesterday @0500. Pt calm, HR down to 80's c regular even breaths. (b)(6)-2 [redacted] MAN
(2015)	Pt assisted c TF by holding syringe for feeds. Pt resisted a little but assisted. MSO4 5mg given. Pt c/o lower abdominal pain. Appeared to be effective (b)(6)-2 [redacted] ULTIAN
(2230)	Pt doing well. Calm & cooperative. C/O pain in stomach. MSO4 given. Pt turned to @ side & secured up in bed. Tolerating TC & TF problems (b)(6)-2 [redacted] ULT
0004 16 Sept	UD. Alb/Atro tx given HR 78 RR 24 SpO2 100% on 40% trach collar BBS coarse Post tx HR 76 RR 21 SpO2 100% BBS clear Pt resting comfortably (b)(6)-2 Sgt [redacted] 91W2
16Sep03(0525)	Pt has slept well throughout the night. Sats remained in the high 90's, HR down to 70's. When pt awoke c/o pain in abdomen, mainly lower. When tried to give TF pt would push tube away then put hand over abdomen. Kept pushing it away and grimacing. Held off on TF till talk to PA. Pt had a period of desating down to 88%. Bumped

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

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1998)
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USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	cont- wp FiO2 from 40% to 50%. Cleaned trach and cannula Gave pt a little extra O2 for a bit. Pt did sound a bit wheezy in Anterior lobes. P about 10 min pt went back up to >96%. Has maintained >96% on 50% FiO2. This was around 0300. @ 0400 dressing Δ to abdomen was done w→D. Tissue pink and healthy. W→D dressings Δ on DLE. White-black in color. Blood drawn and taken to lab. Pt's linen was Δ'd @ 0500 and bed bath done. PCXR was completed. (b)(6)-2 [redacted] MTAN
16 Sep 03 0530	WD Alb/Atro T4 given to pt Pre Tx BBS coarse HR 78 RR 28 SPO2 96% on Trach collar Post Tx HR 77 RR 22 SPO2 100% BBS clear (b)(6)-2 Sat [redacted] 7102
16Sep03	0600 - Received pt from Lt (b)(6)-2 [redacted] VSS. A+O. Trach 50% O2 Sats 100%. D5 ½NS + 20K running through central line Triple lumen cordis at 25cc/hr. Pt c/o pain in stomach. 5mg MSO4 given. Will continue to monitor (b)(6)-2 Sgt [redacted] LPN
	0800 - Central line dressing changed. Dressing to abdomen and R leg changed. Abd wound looks purulent. Pt refuses Jevity c/o squeezing feeling. Pt c/o pain in stomach, asked for MSO4. 5mg given (b)(6)-2 Sgt [redacted] LPN
	080 - Dr (b)(6)-2 [redacted] notified of stomach issues and Sgt (b)(6)-2 [redacted] LPN Npo to ABG. Pt instructed to get another ABG later.
17Sep03 0100	Pre Tx HR 88, RR 26, SPO2 97. WD Alb + Atro given. BBS coarse. Post Tx HR 92, RR 24, SPO2 97. Pt tol well (b)(6)-2 Sgt [redacted] 9116
17Sep03 0532	Pre Tx HR 94, RR 26, SPO2 99. WD Alb + Atro given. BBS slight coarse throughout CTA. Post Tx HR 85, RR 28, SPO2 100% on 40% T-collar - Will continue to monitor (b)(6)-2 Sgt [redacted] 9116

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
17 Sep 03	0600 Received pt from Cpt (b)(6)-2 [redacted] Pt awake and A+O. VSS. Assessment done. Pt lungs sound coarse throughout. Pt dressings c/d/i. Pt on 40% via TC. sats at 99%. Pt has no c/o pain at this time. Will attempt to eat breakfast this AM. Will notify Dr. of no BM in 2 days (b)(6)-2 Sgt [redacted] LPN
	0800 - Suctioned pt, thick secretions, O2 sats 98%. Jevity given. Pt rolled to R side (b)(6)-2 SGT [redacted] LPN
	1080 - Have had to suction pt quite often this AM. Secretions very thick (b)(6)-2 Sgt [redacted]
17 Sep T03	1830 Rcvd pt from SGT (b)(6)-3 [redacted]. Pt resting in bed, awake and A+O. attempted to feed pt dinner, pt took 1 bite of Cookie and refused anything else. Assessment completed. VSS. Sx'd pt's TC C thick mucous tinged C blood obtained. Pt's O2 Sats remain 99%-100%. Skin breakdown noticed on top and (L) side of pt's penis. (b)(6)-2 [redacted] LPN
17 Sep T03	1930 pt position D'd to back. Trach care completed. pt Sx'd via TC C thick, clear mucous obtained. pt resting at this time (b)(6)-2 [redacted]
17 Sep T03	2300 pt turned to (L) side @ 2200. pt c/o pain to abd; 5mg MSO4 given. pt coughing ↓; resting comfortably (b)(6)-2 [redacted] LPN
18 Sep T03	0430 Edema to (R) hand ↓ significantly. pt turned to (R) side. pt moved pulse ox from (L) to (R) ear on Cox

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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.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1989)
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USAPA V1.00

[redacted]
(b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
(cont'd)	his own. Pt tries to hand signal what he wants. pt doing well @ this time —— (b)(6)-2 [redacted] LPN
18SepT03	W3D dressing Δ's to M/L abd wound & (L) LE done. Tissue looks pink. Rom Exercises done x4 times this shift. pt coughing up thick clear to yellowish mucous. —— (b)(6)-2 [redacted] LPN
18 Sept03 0436	Pre tx HR 92, RR 24, SPO_2 100% on 40% T-collar. UD Alb + Atro neb given. Post tx HR 99, RR 27, SPO_2 100% on 40%. [redacted] CRTA. ↓ FiO_2 35% per ABG 7.47/44/114/9/32/99% — Sgt [redacted] (b)(6)-2 91W
18SepT03	0500 Bed bath given, linen Δ'd. pt Sx'd via TC c̄ copious clear to yellow mucous obtained. [redacted] LPN (b)(6)-2
19Sep03	0600 Report given. Assumed care. see ICU-9 flowsheet for initial assessment. —— (b)(6)-2 [redacted]
	0700 midline abd drsg Δ'ed by Dr.
(b)(6)-2	[redacted] labs returned. Ø new orders received —— (b)(6)-2 [redacted]
	0820 Sx'd trach min amt of [illegible] clear appearance —— (b)(6)-2 [redacted]
	0900 encouraged use of I.S. unable to make balls go up & down —— (b)(6)-2 [redacted]
	1050 Ambulation once again c̄ [illegible] support. —— (b)(6)-2 [redacted]
	1300 pt will not eat, tried several times. pt refused —— (b)(6)-2 [redacted]

[redacted] (b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
19 Sep 03	pt alert responsive; NAD; assessment complete [redacted] (b)(6)-2
(2100)	pt SX'd for large blood tinged sputum; S. O2 ?96 [illegible] 35? [illegible]
	pt coughing effectively; pt [illegible] [redacted] (b)(6)-2
(2400)	no chg in assessment; NAD; [illegible] [redacted] (b)(6)-2
(0300)	no chg in status; [illegible] pt's [illegible]; NAD [redacted] (b)(6)-2
(0400)	[illegible]; pt [illegible] [redacted] (b)(6)-2
9.19/0700	Assumed pt care from CPT [redacted] (b)(6)-2 pt sleeping at change of shift and
	VSS. [illegible] @ 25cc/hr, ETG, Trach intact. No issues noted.
	Will cont to monitor [redacted] (b)(6)-2 [illegible]
9/20/03	0600 Assumed care. Report given. See
	ICU-3 flowsheet for initial assessment
	0730 [redacted] (b)(6)-2 @ bedside, update
	given. Orders received. [redacted] (b)(6)-2
	0900. VSS. Translator @ bedside.
	[illegible] tried to convince pt the
	importance of eating. pt refused
	to listen. [redacted] (b)(6)-2
	1000 Repositioned assistance [redacted] (b)(6)-2
	1040 Deep SX again copious amt of
	thick white secretion [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S [redacted] NUMBER (SSN [redacted]) (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.

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

MEDCOM - 17975

ACLU-RDI 1644 p.135

DOD-031549

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20Sep03	1240 Dsg done by Dr [redacted] (b)(6)-2
	Orders received [illegible] & [illegible] [redacted] (b)(6)-2
	1330 Dietary @ bedside, nutritional
	status access [redacted] (b)(6)-2
	1615 Update given to Dr [redacted] (b)(6)-2
	about pt's status [redacted] (b)(6)-2
	1720 lower leg dsg [illegible]'ed. [redacted] (b)(6)-2
21Sep03	0900 Assumed care. Report given, initial
	assessment on ICU flowsheet [redacted]
21Sep03	1024 20mg MSO4, 25 phenergan, [illegible] (b)(6)-2
	[illegible] from OR, Report given.
	pt [illegible] to [illegible] stimulation
	placed on monitor [redacted] (b)(6)-2
	1029 VSS. Resp even unlabored. SpO2
	97%-98%. currently on 31%. [redacted] (b)(6)-2
	1300 [illegible] before [illegible]
	min amt of [illegible] secretions [redacted] (b)(6)-2
	1350 VSS. Afebrile, Ø distress
	noted [redacted] (b)(6)-2
	1615 Update given to Dr [redacted] (b)(6)-2
	Orders received [redacted] (b)(6)-2
	1720 [illegible] sips of H2O given [redacted] (b)(6)-2

[redacted] (b)(6)-4

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
20Sep03 1330	Nutrition Note: Pt not eating, refuses food. Is receiving 500cc Jevity Plus @ 4° providing 3900 kcals/day. This exceeds his est. needs of 1750-2100 kcals/day (25-30 kcal/kg) and may explain ↓ po intake. Recommend ↓TF to 65cc/hr to provide 2028 kcals/day to meet pts need; then ↓TF to 30cc/hr to meet 50% of needs + encourage pts appetite. (b)(6)-2 [redacted] RD/LD CPT, SP
21Sep03 0455	Rt note: Pt resting. HR-95, RR 20, SpO2 99% on 35% T collar. BBS CTA. Pt needs re-eval from Dr. for Resp tx due to improvement up to date. Last order on 18 Sept 03. Will notify nurse. (b)(6)-2 Sgt [redacted] 9/21/03
22 Sep 03 0726	Rt note: spoke to nurse about Δ's in RT tx. Pt is able to bring up secretions and was CTA BBS @ 0400 SD tx was not given. Tx needs to be reevaluated by doctor every 72 hours. Humidification is needed to prevent mucous plugs in pt due to bypass of nasal cavity. Please reorder treatments or Δ it to PRN. Sgt [redacted] 9/22/03 (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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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
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[redacted] (b)(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22Sep03	Assumed Pt care @ 0600. VSS. Derma. Pt interacts w/
0830	nurse. CAO make Needs Known. Lungs coarse throughout Lower Fields. Pt
	Breathing is unlaborred and does bring up Lg amounts of thick
	white secretions. RT making suggestion to Dr to make neb TID
	Prn. Skin is warm & Dry color is WNL. Pt has healing wound
	to chest @ RT nipple. Large Abdominal Dressing which is CDI
	& Dressing to LCL CDI also. Edema noted in (R) hand and
	Lower extremities +1. Pt has (L) Subclavian Triple Lumen cath, running
	D5 1/2 w/ Kcl @ 21 ml/hr. Pt also has (R) Femoral a Line all Lines
	Flushed and are Patent and free From S/S of infection/Infx. Bowel
	Sound present x4 bowel sounds hypo active. Pt refusing to eat
	will continue to push PO but if Pt still does not eat will
	give Jevity via Feeding Tube. Abdomen is non tender non distended
	Pt had Large (Very Large) Bm of loose dark brown stool
	This Am. Pt has FTG draining Light yellow urine free
	from sediment. Urinating adequate amount. Foley care done. Pt
	is S.R. NSR. W/ adequate Perfusion and cap refill. Pt currently
	resting will continue to monitor ——— pfc [redacted] CPT (b)(6)-2
22Sep03	Dressings D'D. Abdominal Incision no bleeding or redness
0940	noted D'D using W-D NACL solution, Upper wound on
	LCL has brownish exudate medium amount no redness noted.
	bottom wound had minimal amount of blood Tinged drainage
	no redness or swelling noted. LCL dressing D'D using Saline (b)(6)-2
	(b)(6)-2 [redacted] pfc [redacted]
22Sep03	Tube feeding done 500cc. Peripheral IV started in (L) AC.
1240	Running D5 1/2 NS & 1 Kcal @ 25 ml/hr. ——— pfc [redacted] CPT. (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
21 SEP 05	SURGERY NOTE
	PRE-OP DX: LLE ESCHAR
	PROC: I & D
	SURG: [redacted]
	EBL ~ 100 cc
	FLUID: 200 cc LR
	UO: 100 cc
	COMPLICATIONS: NONE
	STABLE TO ICU
	WILL START BID DRESSING CHANGES

[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

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[redacted] (b)(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22SEP03 1400	TRACH care done. Pt coughing up large amounts of ~~PINK~~ (b)(6)-2 blood TINGED SPUTUM. VASELINE GAUZE Dressing ALSO applied. PFC (b)(6)-2
22SEP03 1640	EXTERNAL ~~SUTURES~~ (sutures) removed d/dsg Trach cleaned by LT (b)(6)-2 INTERNAL sutures left in PLACE. collar tightened. PFC (b)(6)-2
22Sep03 (1900)	Received report from LT (b)(6)-2 PFC (b)(6)-2. Pt c/o sore abd. pain. MS04 given as ordered. Pain Relief. Dr (b)(6)-2 came in to see pt. Foot board removed to prevent sores on feet. Pt appears comfortable. (b)(6)-2 USTAN
22Sep03 (1945)	See DA Form 4700 OP 375 for assessment data. Pt c/o pain in lower abd. Tried to put vaseline on lips but refused. Adequate UOP. @ BM. Coughing up secretions well. (b)(6)-2 USTAN
(2230)	Around 2000 did pt's trach care. Stimulated pt to ~~go~~ cough a lot of yellow thick secretions and small dried mucous plug Cleaned around site well c ½H2O2 : NS. Put gauze under. Pt tolerated well. Gave pt TF + 50 cc H2O. Pre-medicated c MS04 prior to abd. dressing Δ. Δ'd ML abd c dakins solution w → D + 4x4's. Δ'd dressing on @ leg. Upper wound has black spots throughout lower wound beefy red. Gave pt bed bath around 2145. Δ'd linen. @ fg. BM brown ↑ Runny. Tolerated well. (b)(6)-2 USTAN

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

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EPW# (b)(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES (b)(6)-2
23Sep 0600	- Received pt from SGT [redacted] VSS. Sats 97%. No c/o pain, but has cramping in stomach. Pt had large BM, very runny. Coughing up thick secretions [redacted] (b)(6)-2
	0930 - gave pt 650mg Tylenol for temp 101.5 Will continue to monitor [redacted] (b)(6)-2
	1000 - Dressings changed. Abdominal wound is still purulent in spots. Upper wound on leg purulent, lower wound is (b)(6)-2
	Indurated. Pt is having a lot of stomach cramping. [redacted]
	1440 - pt feels up again. 650mg Tylenol given. Will continue to monitor [redacted] (b)(6)-2 LPN
	1530 - Dr. [redacted] (b)(6)-2 notified of pt temps. Ordered blood culture, urine culture, and sputum culture. Gave new orders for Vanc and Ceftaz. Pt had another large BM. Pt IV site infiltrated, new IV started on - LFA. Site c/d/i. [redacted] (b)(6)-2 LPN
23Sep03(2145)	Received report from SGT [redacted] (b)(6)-2 Pt had a lg. brown soft BM. Pts bath given and cleaned. Linen c'd. W→D dressing c to ML abdomen and (c) lateral lower leg c Dakins solution and 4x4. Trach care done. Pt coughed lg amts of secretions. Pt c/o pain in lower abdomen. MSO4 given as ordered. Pt given TF. Pt started fighting me when giving him more fentyl. C/O a lot of pain to abdomen. Only gave pt 420cc + 30cc of H2O. Pt turned on (c) side. Pt asleep at this time. [redacted] (b)(6)-2 NURSE
24Sep03(0600)	Pt did well throughout night. Did have a watery BM when coughing. Refused TF. Kept forcefully pushing away C/O nausea & cramping. Rotated q2° [redacted] (b)(6)-2 NURSE

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24SepT03 2040	pt c/o hunger Pt ate SM portion of cracker and drank H_2O — SGT [redacted] (b)(6)-2
24SepT03	2200 pt turned onto (R) side @ 2130. pt resting comfortably @ this time — SGT [redacted] (b)(6)-2
25SepT03	0120 pt c/o abd pain. 5mg MSO4 given — SGT [redacted] (b)(6)-2
25SepT03	0550 pt rested comfortably through the night. pt didn't require any deep sxing this shift. Pt given bed bath, linen D'd. pt had large runny brown BM. Dressing D's done to R/L abd and (L) LE. Both sites have beefy red looking tissue. — SGT [redacted] (b)(6)-2
25SepT03	0555 RT D'd FiO2 to 28% and O_2 to 4L. pt Sats remain 98-100%. — SGT [redacted] (b)(6)-2
25SepT03	0600 I/C assume care. Report given see ICU-3 flowsheet for initial assessment. 0750 pt ate 50% of breakfast. Seen by hospital Wex, pt requested to take bath. [redacted] (b)(6)-2 0900 deep sx'd min amt of secretions noted.

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

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

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(b)(6)-2
25Sep03	1810 tolerated lunch well ate 50% - [redacted]
	1530 [illegible] dsg c/d/i. ∅ drainage
	or odor noted. (b)(6)-2 [redacted]
	1650 5mg MSO4 given c/o back pain [redacted]
	(b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
24Sep2003	0800 Assumed care. Report given. see ICU 36 flowsheet for initial assessment [redacted]
	0630 large, loose paste stool. (b)(6)-2 [redacted]
	0750 Dr. [redacted] (b)(6)-2 @ bedside, update given, orders received (b)(6)-2 [redacted]
	0830 pt attempt to eat [illegible] bread ē difficulty (b)(6)-2 [redacted]
(b)(6)-2	1115 Dr attempts to place [illegible], ∅ success by Dr. [redacted]. [illegible] shiley [illegible] #4, inflat balloon. (b)(6)-2
	SpO2 99%, RR 20s, ∅ distress noted (b)(6)-2 [redacted]
	1230 reposition c̄ assistance. VSS [redacted] (b)(6)-2
	1345 [illegible] taken. (b)(6)-2 [redacted]
	1430 trach care given. pt remains able to clear own secretions ē difficulty (b)(6)-2 [redacted]
	1615 [illegible] placed by Dr [redacted] @ femoral [illegible]
	site care given (b)(6)-2 (b)(6)-2 [redacted]
24Sept03 1815	Rec'd pt from CPT [redacted] (b)(6)-2 pt resting in bed. pt has (R) femoral line CTLC infusing D5½NS c̄ 2K @ 25cc/hr VSS. Dressing to M/L abd and (L) LE CDI. pt c/o "cramping" to abd. pt turned to (L) side @ 1810. A/L to (L) wrist d/c'd. (b)(6)-2 [redacted] LPN

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
02Sep03	Surgery
	Pt stable AFSS
	Lungs: CTA
	CV: RRR
	Abd: soft, NT, ND ⊕BS
	Labs: noted
	UO: ~120 cc/hr
	Imp: doing well
	Plan: DC central line + art line
	DC ~~art~~ daily labs & CXR
	cont wound care
	[redacted] (b)(6)-2
26 Sep	(1900) pt alert, responsive; assessment completed ——— [redacted] (b)(6)-2
	(2400) no change in assessment; VSS ——— [redacted] (b)(6)-2
	(0400) am care done; drsg Δ'S — wounds pink, ∅ foul odor [redacted]
	∅ purulent drainage; FiO2 ↓ 28% by RT; pt tolerating well (b)(6)-2
26Sept03 0700	Performed Assessment. Midline Abd dressing C,D,I dressing to (L) leg intact. Blood culture drawn, nasal culture sent to lab. Triple lumen cath to (b)(6)-2 (L) femoral Area intact ⊖ c/o @ this time [redacted]
26Sept03 0930	Pt c/o pain. Medicated c̄ 3mg MSO4 Pt medicated @ this time ——— [redacted] LPN (b)(6)-2
26 Sep 03 1030	Dressing Change done to mid abd Area + to (L) leg. ⊕ drainage ⊘ odor noted. Will continue to monitor / assess. ——— [redacted], LPN (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
26 Sep 03 1345	Pt c/o pain. Medicated c̄ 3mg MSO4 for c/o pain. (b)(6)-2 [redacted] LPN
26 Sep 03 1700	Pt resting comfortably. ⊘ c/o @ this time. Will continue to monitor. [redacted] LPN
27 Sep 03	0600 Assumed care. Report given. SEE Tier 3 flowsheet for initial assessment. (b)(6)-2
	0730 Refused to eat breakfast. (b)(6)-2 [redacted]
	1010 Dr. [redacted] (b)(6)-2 @ bedside. Drain removed. Vaseline gauze placed over site along 4x4 gauze & secured. midline [illegible] dsg D&I, then viewed by
(b)(6)-2	Dr. [redacted] leg wound. (b)(6)-2 [redacted]
	1130 lg loose brown unformed stool. (b)(6)-2 [redacted]
	1245 pt made attempts to eat, ensure given. (b)(6)-2 [redacted]
	1340 Partial bath given. Linen [illegible]
28 Sep 03	Nursing: Pt stable during shift afebrile. Turned q 2hrs pain well managed c̄ MSO4 3-5mg IVP prn. Ate < 50% of food + cough medium amount of thick clear secretions. Abd wounds dressing changed. Will continue to monitor [redacted] 1LT AN

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

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[redacted]

(b)(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES (b)(6)-2
29Sep03(1920)	Received report from LCT [redacted] and assumed care of pt @ 1815. See DA Form 4700 OP 375 for assessment data. Pt able to talk by placing hand over old trach site. Verbalizes pain in bilateral legs, abdomen and @ arm when trying to move. MSO4 given as (b)(6)-2 ordered. Pt resting @ this time. — [redacted] USAMN
(2155)	Dressing D to Abdomen ML. W→D c Dakin's Solution. Beefy red c some white patches. Improvement from last time seeing pt. Dressing D to OLF c Dakin's solution. Improvement. Briefed. MSO4 given a D/ing dressing. Pt tolerated it well. — [redacted] (b)(6)-2 USAMN
(2155)	Also d/d old trach site dressing. Healthy red. Dabbed c Dakins Solution. — [redacted] (b)(6)-2 USAMN
29Sep03 0100	Resting quietly c HOB↑ UOP 100-120/hr @ c/o pain or discomfort. Regular Ins IVP given. — SGT [redacted] (b)(6)-2 USAMN
0300	Bed bath given c linen D. dressed to be OR by day and constant. IV of D5½NS c 2Kcl @ 25 ml/hr to @ femoral centerline all ports flush easily. offers @ c/o pain or discomfort @ present. — SGT [redacted] (b)(6)-2 USAMN
29Sep03 0530	Pt is resting quietly c HOB↑. IVof D5½NS c 20KCL, offers @ c/o Pain or Discomfort. Foley to Gravity UOP 100-110cc clear yellow. MSO4 5mg given 2350 hrs pain control and c/o pain. — SGT [redacted] (b)(6)-2 USAMN
29 Sep 03 0745	Received report from previous shift. Assessment completed. Pt refused breakfast. Tube-Feeding started. VSS. Pt resting in bed. NAD will continue to monitor. — [redacted] USAMN (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
24 Sep 03	Surgery PATIENT C GSW TO RIGHT CHEST, LUNG 2 LACERATION & T-11 C RESULTED COMPLETE PARALYSIS BELOW T-11. STABLE, ANKLES & ALERT VS: HR 90s 139/74 RR 20 100% RA LUNGS: CTA CVS: RRR ABD: SUCT. + TUBE (BR) - WOUND HEALING LLE: WOUND HEALING PLAN: TO OR WILL PLAN SKIN GRAFT TO CS IN 1-2 WEEKS SEE ORDERS [redacted] (b)(6)-2
29 Sep 03	PROGRESS STABLE AFEB NO ACUTE CHANGES CONT CURRENT MANAGEMENT [redacted] (b)(6)-2

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

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[redacted] (b)(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
29Sept03 1245	Recd pt from ICU3. Pt transfer to bed 5 c staff assistant. (D) ↓ leg DSG D&I. Foley to gravity, amber urine. Dsg to throat D&I bilat CTA diminished (L) base BS(+) triple lumen (D) femur (-) skin breakdown under restraint x1 WILL continue to monitor [redacted] (b)(6)-2
29Sep03 @2115	Assumed care of pt @1800. VSS. AAO, speaking Arabic. LS CTA, ↓ bases on (D)LL, (+)BS, Foley c clr urine. NL abd dsg & LLE dsg CDI. Dsg to old trach site CDI, Sats 94-98% on RA. (L) femoral TL c dsg CDI, flushes well. Lt restraint on S S/Sx of skin/circulation compromise. Plan: turn q2° while in bed, dsg Δs as ordered. [redacted] (b)(6)-2 CPT

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

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[redacted] (b)(6)-4

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FIRST NAME	MIDDLE INITIAL	ID NUMBER

NOTES

30Sep03 Surgery
Pt stable Afeb
Lines: [illegible]
Cor: RRR
Abd: soft NT, no BS
Wounds: Healing
Resp: stable
Plan: cont current Tx [redacted] (b)(6)-2

30Sept@1010/ Pt awake in bed all dsgs Δ ⊖ drainage wounds on legs pink ⊖ foul odor. Pt has liquid BM AM care complete Ⓛ triple lumen. GT tube clamp. lungs CTA diminished in Ⓡ base. BS⊕ ⊖ skin breakdown under restraint. Will continue to monitor [redacted] (b)(6)-2

30Sep03@2245 — assumed care of pt @1800. VSS. c/o pain to abd, medicated c̄ percocet c̄ some relief noted. Mc dsg CDI, W→D c̄ Dakins soln. wound healing, healthy red granulating tissue noted c̄ patches of white & green noted. inner stitches intact. [redacted] (b)(6)-2 dsg Δ'd, granulating tissue noted. Ⓛ femoral TL central line dsg Δ'd using sterile technique. Throat dsg CDI. LS CTA, ↓ bases RLL, enc CDB. ⊕BS x 4 quads. Plan: monitor pain issues, turn Q2° to prevent skin breakdown, encourage CDB. (b)(6)-2 [redacted] CPR
Addendum: 4pt restraint on s̄ s/sx of skin or circulation compromise. [redacted] (b)(6)-2

[redacted] (b)(6)-4

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[redacted] (b)(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10CT03 (1850) ←(cont)	prevent skin breakdown. ⊕ equal pedal pulses. brisk cap refill. 1 pt restraint on @ this time 3 compromise to circulation or skin. Will monitor (b)(6)-2 [redacted] 9IWMB
1900	NG Tube clamped, tol PO well, dressings to (b)(6)-2 ⓡ chest wall intact, ø discharge infection [redacted] 9IWMB
2230	Percocet II given for abd. pain c relief noted [redacted] (b)(6)-2 9IWMB
20CT03 0800	Pt Awake. A&O [redacted] (b)(6)-2 LS CTA ⓑ. S_1, S_2 Present. ⊕ BS x 4 quads. Abd Drsg CDI. LLE Drsg CDI. Anterior neck drsg CDI. PT wants to walk. Will have interpriter in to explain paraplegia. Pt sb "small" pain. FTG Draining sl/serne. Will
20CT03 (1900)	continue to monitor. (b)(6)-2 [redacted] 9IWMB Pt alo, VSS, clo abd pain, II Percocet given. LCTAB, HRRR, ⊕ BS x 4, abd drsg S.D. c Dakins solution red granulated tissue c patches of white & green slen. LLE drsg S.D.-red granulated tissue slen. minimal drainage to both drsgs. Drsg S.D to prev. trach site. ⓑ femoral cath drsg intact
(CONT)	(CDI). gastric tube intact c syringe attached.

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

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[redacted]
(b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10Oct03	1227 - assumed care of pt. @ 0000. Assessment completed. Pt. c/o pain. medicate c 7mg MSO4 + 800mg motrin per Lt. [redacted] (b)(6)-2 Relief noted. Drsng Δs performed. W→D c Dakins solution to abd. ⊖ S/Sx of infection. W→D drsng to ⓛ LE c Dakins solution. ⊖ S/Sx infect. foley to gravity draining dark yellow urine. strict I/Os. Encouraging pt. to drink H2O. Drsng D/ to trachea c min. drainage. central line to ⓛ femoral artery. CDI c ⊖ S/Sx infection. Turning q2° to prevent skin breakdown. ⊖ restraint to ULE. ⊕ circulation. ⊖ skin breakdown. ⊕ pedal pulse. <3 seconds cap refill. [redacted] (b)(6)-2 cont. to monitor pt.
(1740)	I concur c above assessment. [redacted] (b)(6)-2
(1850)	assumed care @ 1800 p report, pt alert & speaking arabic, VSS (temp 99'), ⊖ complaints @ this time. drsg Δ'd to ⓛ LE & abd (c dakins solution) & drainage noted, healthy granulated tissue seen foley to gravity draining clr/ strict I/O's. H2O @ BS. ⓛ femoral CL intact, drsg CDI, ⊖ edema or redness @ site. throat drsg CDI, O2°, turning to EPW ± [redacted] (b)(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
20CT(1900)	(R) chest wall sutures intact, ø S/Sx infection noted. Foley to gravity draining mod. yellow urine. H2O @ BS, will encourage intake. (+) equal pedal pulses, brisk cap refill. (1) 2° turns to prevent skin breakdown. Strict I/O. 2 pt restraints on, (+) circulation. Will monitor [redacted] (b)(6)-2 9MIM6 SR
(2215)	Rt had BM x2, brown-semi-liquid, CL dressing D'd using sterile technique (due to stool hitting the dressing). Will monitor [redacted] (b)(6)-2 9MIM6.
3 OCT 03	pt Awake + ORT VSS / AFVSS WOUNDS: Healing PLAN TO OR TOMORROW FOR 2° CLOSURE OF ABDOMINAL WOUND + STSG TO LOG WOUNDS [redacted] (b)(6)-2

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

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[redacted] (b)(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30CT03	PT A+O LS CTA(B). $S_1 S_2$ present. (+) BS x4 quads Ø (b)(6)-2 C/O @ this time. drsg Δd to (B)LE & Abd + [redacted] (b)(6)-3 (R) femoral [redacted] femoral CL drsg Δd. Pt x2 BM.
(b)(6)-2 (b)(6)-2	[redacted] Abdomen noted pink healthy granulated tissue c sporatic spots of pus. (B)LE wound @ pink healthy tissue. CL was contaminated c Pt Feces, Water and IS @ Bedside. Will continue to monitor. (b)(6)-2 [redacted] 9 WMB
30CT03 2000	Pt resting in bed, A+OX3, VSS, foley to gravity draining amber urine, LS CTA(B), (+)BS x4, medicated for pain c 2 percs, dsg's on abd + LLE CDI, ROM → LEx2, & S/Sx of poor circulation or skin breakd on pts of restraint, dsg on trachea CDI, turn q2°. (b)(6)-2 [redacted] 9 WW
40CT03	OP NOTE PRE-OP DX: OPEN LEG WOUND / OPEN ABDOMINAL WOUND PROC: STSG TO PROXIMAL LEFT LEG. CLOSURE OF ABDOMINAL WOUND. G-TUBE REMOVED SURG: (b)(6)-2 [redacted] (b)(6)-2 [redacted] EBL: minimal FLUID: 1L NS UO: 600cc COMPLICATIONS: Ø STABLE TO RR [redacted] (b)(6)-4

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DATE	NOTES
04OCT03	Pt A&O S_1, S_2 Present LS CTA (B), (+) BS x4 quads. Pt continues Loose bowel movements. Pt Appears to be incontinent. Pt c/o pain controled c MSO4. CL in (L) Femoral area CDI NO S/S of infection. [redacted] NS infusing at TKO in (R) hand via 20G IV. FTG Draining cyu. continue to Roll Pt [redacted] q 2°. Will continue to monitor. [redacted] Spec 91WMB (1600) I concur c above assessment. [redacted] MA)
4OCT.03 1930	Pt A+Ox3, VSS, LS CTA (B), (+) BSx4, pain controlled c percs, pt has sporadic episodes of loose BM, abd soft flat non tender, dsg's to abd + LLE CDI, foley to gravity draining c/y urine c ø s/sx of infex, IV HL (R) Hand intact, flushes well, ø s/sx of infex or infiltration, ø s/sx of poor circulation or skin breakdown on pts of restraint, ROM to LE x2. [redacted] 91W Needs pt resting in bed, VSS, Tol PO, turn q2°, Alert + oriented. Dsg Δ's done, intact, Pt had large loose liquid stool. Dsg to midline and sutures

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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[redacted]

(b)(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
05Oct03 cont	Δ'd, serosang drainage noted on old dsg. ⓁLE graft site intact w/ occlusive dsg covering. Gauze dsg intact to LLE below knee and with serous drainage note ↑ percocet for pain. Will cont to monitor. [redacted] (b)(6)-2
5Oct03	2130= VSS, A+O, follows commands, ∅ c/o pain @ present time, X1 restraint, ⊕ skin breakdown to Ⓡ wrist – dry dsg applied CDI, ∅ CL @ femoral site, D/C'd NIO for CL Dsg Δ's, Ⓛ thigh graft site has op-site CDI, midline abdomen Dsg CDI, Ⓛ shin dsg CDI, IV to Ⓛ hand flushed & patent, turning Q2, 2+ pitting edema to ⒷLE's → ↑ ⒷLE's. FTG draining clear yellow urine. Tolerates PO well, drinks plenty of H2O. Continuing to monitor for acute Δ's. [redacted] (b)(6)-2 MT/AN
6Oct03	0530= pt. had x BM large & loose light brown colored, cleaned up, provided new linens & gown. [redacted] (b)(6)-2 MT/AN
6Oct03	Assumed pt. resting in bed. VSS, tol PO, A+O x3, verbose speaking. Trach sterile to site, neck covered w/ 2x2, pt plugs to speak. ∅ for IV patent. BM large x2. Duoderm placed on skin tear Ⓑ buttock/sacral area. on RA. Ⓛ shin + Ⓛ thigh dsgs intact ∅ changes in drainage noted. Midline sutures, staples, CDI w/ minimal serosang drainage [redacted] (b)(6)-2

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7 OCT 03 @ 2215	Assumed care of pt @ 1800. VSS, 9 pain to general abdominal area. Alert, speaking Arabic. LSCTA, ⊕ BS x 4 quads, voiding amber urine per foley. Enc po intake & Po fluids. (L) thigh graft site c/d/i, opsite intact, serous drainage noted. LLE calf dsg c/d/i. Throat dsg c/d/i. PROM completed. 1 pt restraint in use in bed. S/S x 0 skin & circulation compromise. Plan: cont TCP, monitor skin integrity, enc po intake, will monitor [redacted] (b)(6)-2
8 OCT 03 @ 0000	Shift totals 1 to 5: Ins = Po fluids ≈ 300cc Out = urine = 900cc A increased to ↑ po intake [redacted] (b)(6)-2
8 oct 03 0700	- Assumed care pt. A+O x 3. Lungs clear bilat. HSRR Active BS x 4 quads Foley to gravity dark yellow urine QS. Midline abdominal incision open to air healing minimal drainage. (L) thigh skin graft site moist pink opsite dressing intact. LL calf dressing kerlix wrapped CDI. Trach site 2 dressing CDI Q2 hr position change. Prevent skin breakdown. W/ cont to assess [redacted] (b)(6)-2 Glasgow (1725) I concur 2 above assessment. [redacted] (b)(6)-2 RN
8 OCT 03 @ 2145	- Assumed care of pt @ 1800. VSS. Alert, speaking Arabic. LS CTA, ⊕ BS, tol reg diet, encouraged Po fluid intake. Foley to gravity draining clear amber urine. (L) thigh skin graft site OTA, healing well, ⊖ drainage noted. LLE calf dsg CDI. Throat - (CONTD)

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
6OCT03 @2045	Nursing assumed care of pt @1800. VSS. Alert, speaking arabic. No c/o @ this time. medicated c Percocet approx 1900 c good pain relief noted. ML incision OTA, healing well. (L) thigh graft site c oozing dsg leaking scant amt of sero sanguinous drng, o/w healthy looking. LLE Kerlix dsg CDI. Throat dsg for old trach site CDI. PROM completed to BLE. Plan: Encourage IS, enc PO intake, Turn Q2° cont ABX as ordered. Addendum: foley to gravity c clear/yellow urine noted. (b)(6)-2 [redacted] pt restraint on while in bed s S/Sx of skin circulation compromise. Will monitor. [redacted] (b)(6)-2
7 Oct 03 0700	Assumed care pt A+O x3. VSS AM care given ∅ c/o pain or discomfort @ this time. Skin graft (L) thigh ~~site~~ (b)(6)-2 [redacted] vascular pink ∅ s/s of infection. Lungs clear bilat. HRRR Foley to gravity dark yellow urine. Midline surgical incision from chest to abdomen c sutures intact healing minimal drainage. Q2° position change ROM exercise comp. Will cont to monitor [redacted] (b)(6)-2

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DATE	NOTES
8Oct03 2145	(cont) dsg c Vaseline gauze, CDI. PROM completed. Plan: cont decubitus prevention care Turn q2°, PROM, encourage po intake. [redacted] MP Addendum: 1pt restraint on 5 S/Sx of skin or circulation compromise. (b)(6)-2 [redacted] MP
9Oct03 1440	VSS. Assumed care @ 1600. A&O able to make needs known. HSRL, resp even & unlabored. Trach site has not closed. Dsg applied over site. Abd soft nontender c (+)BS. Voiding clear yellow urine quantity sufficient via foley. Pt turned q 2°. Skin warm & dry. (L) thigh skin graft site healing & signs of infection. (R) calf wound healing well. Vaseline gauze dsg applied by MJ. Pt tolerating regular diet well. HL patent. Medicated @ 1000 c percocet two tabs po for c/o pain. No complaints @ this time. Will continue to monitor. Restraint x one. S skin or circulation compromise - [redacted] (b)(6)-2 MJ
9oct@2015	Assumed care @ 1800; All VSS, pt Alert, verbalizes needs; S, Dr, LS CT, (B); (+)BSX4, FTG draining QS, clear dark yellow urine; dsg to (L) LE CDI @ drainage; graft site healing well; (b)(6)-2 pain controlled c perc. HL patent S S/Sx infection/infiltration; dsg to track site CDI S drng; (+)BM; cont to monitor [redacted]

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

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[redacted] (b)(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9 OCT 03	Pt Awake c/o pain controlled c percocet. LS CTA (B), S_1S_2 present. ⊕BS x4 quads. Pt roll curvy 2°. Drsg to (L)-E CDI. Will continue to monitor.
10 oct 03 0	Assumed care @ 1500; All VSS, pt Alert, pain managed c percocet X1; dsg to (L) LE CDI ⊖drainage, FTG patent draining QS, clear, dark yellow urine HL patent, dsg to trach site CDI, ⊖drainage; [redacted] Cont to monitor [redacted]
11 OCT 03	Assumed care @ 600 Pt A&O. BM x1 this Am. AM care completed. VSS. LS CTA (B). ⊕BM x4 quads. S_1S_2 present. Pain controlled c percocet. Will continue to monitor. [redacted] Spc 9/WMA
11 OCT 03 1000	Colace Held. BM x1 Loose — [redacted] Spc 9/WMA
(1930)	(1445) I concur c above assessment. — [redacted] Spc 9/WMA Pt alo, VSS, ⊘ complaints @ this time, drsg to LLE CDI, drsg to trach site CDI, voiding clear mod. yellow urine via foley. LCTAB, ⊕BS, HRR Q2 turns. 1 pt restraint on 5 compromise to skin or circulation Will monitor — [redacted] 9/WMA.
12 OCT 03 0900	Pt Awake Pain controlled c percocet LS CTA (B). S_1S_2 Present. ⊕BS x4 quads. DRSG TO LLE CDI Q 2° turns. ON call For transfer to Iraqi hospital. — [redacted] Spc 9/WMA.
(1855)	Pt awake, VSS, speaking Arabic, ⊘ c/o pain @ this time. (L)LE bactiracin applied. (OTA) Q2 turns being done. trach site drsg CDI. LCTAB, ⊕BS, 1 pt restraint on 5 compromise to skin or (cont)

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DATE	NOTES
9 OCT 03	DC Summary PATIENT INITIALLY SHOT THROUGH SCALP, RIGHT CHEST & LIVER. INITIAL TREATMENT INCLUDED TUBE THORACOTOMY & EXPLORATORY LAPAROTOMY & PACKING OF GRADE IV LIVER LACERATIONS. PACKS REMOVED 24 HOURS LATER. POST-OP COURSE SUGGESTIVE OF ABDOMINAL BRAIN INJURY DUE TO PLACEMENT OF G-NGT & TRACHEOSTOMY. PATIENT'S NEUROLOGICAL FUNCTION IMPROVED & PATIENT IS NOW AWAKE & ALERT. ABDOMINAL MIDLINE WOUND CLOSED 14 OCT. ALSO, STSG TO LLE X2. G-TUBE REMOVED & TRACHEOSTOMY OUT. TRACHEOSTOMY WOUND CONTINUES TO HEAL & WILL REQUIRE OCCLUSIVE DRESSING. PATIENT WILL NEED ABDOMINAL SUTURES OUT IN 7 DAYS. APPLY BACITRACIN TO SKIN GRAFTS PRN. PATIENT IS FULL PARAPLEGIC. CURRENTLY, PATIENT IS DOING WELL. WILL BE TO PRISON HOSPITAL CONT: FLAGYL FOR DIARRHEA FOR 7 DAYS [redacted] (b)(6)-2

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DATE	NOTES
12OCT@ (1855)	circulation. Sutures intact to (b)(6)-2 midline abd. (OTA). Will monitor [redacted] 9IWM6.
130CT03 1500	Pt Awak Roll q 2°. VSS. FTG draining C/V. Sacrum Dsg A. ~~D/~~ Pt Teaching IS. Pt Demonstrate proper use of IS. Will continue to monitor (b)(6)-2 [redacted] Sac 9IWM
130CT03 @2000	assumed care of pt @ 1800. no c/o. (L) thigh graft site ? (R) Calf, donor sites healing well, all OTA, sacTraction applied. ML incision healing well. Throat dsg C/D/I, minimal drainage, o/w intact. c/o abd & back pain, Percocet given c good relief noted. PRN to BLE done. Plan: Turn q2°, monitor skin breakdown, pain control. (b)(6)-2 [redacted]
140CT03 1100	VSS Alert & Oriented. Lungs clear. BSDX4 grad. Abd soft non distended. Midline abd incision c sutures intact. Edges to midline incision well approximated. (R) Calf & (L) thigh graft sites visited S/S of infects. Had large soft BM: Repositioned q2h for comfort. Wound care is planned. (b)(6)-2 [redacted]

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[redacted]
(b)(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14OCT03 @2000.	assumed care of pt @1800. NO C/O. Tol reg diet well. (L) thigh : calf wounds OTA, draining serous drainage; bacitracin applied. LS CTA, (+) BS, Foley c clear, yellow urine. Encpo intake & IS. Throat disc CDI. Plan: cont Turn Q2°, PROM to BLE, pain control. Will monitor. Lpt restraint on & skin/circulation compromise. (b)(6)-2 [redacted] RN
15Oct03 @ 0800	Pt no c/o pain. Incision mid-line abdomen. Open to air. (-)S/S of infection. (-)drainage + well approximated. Lung sounds clear through all fields. (+) bowel sounds (+) foley draining clear, yellow ~~of~~ urine. (+) BP, peripheral pulses. (L) lower leg abrasions open to air. Bacitracin application. (-)S/S of infections. (R) arm restrained. (-) skin breakdown. (b)(6)-2 [redacted] RN/RN
0850 15Oct03 @ 1930:	Med c ½ percocet. Pt incontinent of stool. D'ed pads x 1. [redacted] (b)(6)-2 VSS, (+) 101.0, gave 800mg Motrin PO, will reevaluate later. D&g to old (L) each site CDI, sutures to midline abd wound approximated, (-)drainage noted, graft sites to (L) leg open to air & (-)drainage, healing, foley to gravity draining adequate clear yellow urine. Applying bacitracin to leg PRN. Tolerates PO well. Q2: log roll turns to prevent skin breakdown, x1 restraint & skin breakdown noted, POC: palliative care, pain mgt, drainage monitoring. Continue to monitor for acute Δ's. [redacted] RN (b)(6)-2

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DATE	NOTES
16Oct03 0900	Temp 97⁸. Percocet given for pain upon request and effective. Trach site clean c̄ sterile [redacted] normal saline. Trach site without crustation/drainage. (b)(6)-2 (b)(6)-2 [redacted] Redressed with sterile dry gauze. Lungs clear Bilat. Abd soft nondistend. Midline ABD incision c̄ edges well approximated. (L) thigh donor site & (L) [redacted] (b)(6)-2 calf graft site cleaned with sterile saline & bacitracin oint applied. Ø drainage noted from either sites @ this time. Foley to gravity draining amber clear urine. Reposition Q2 for comfort. Will continue care as planned. (b)(6)-2 [redacted] 24 AR
16OCT.03 1945	Pt awake, speaking arabic, LS CTA (B), ⊕ BS x4, skin breakdown precautions, roll q2°, sutures on midline abd incision intact, foley to gravity draining c/y urine, graft sites on LLE appear clean dry intact and healing properly, 2 pt restraint s̄ complications. (b)(6)-2 [redacted]

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				(b)(6)-2

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17 Oct 03	VSS. pt A+Ox3 & c/o pain all day esp around shoulder pt given nothing for pain but at slept pt had BM, and has been rotated as per schedule restraints x2 in place, pt voiding dark amber urine. (b)(6)-2 SPC [redacted]
	(1735) I concur c above assessment. (b)(6)-2 [redacted] 07A
17OCT03 1900	Pt A+Ox3, LS CTA (B), (+) BS x4, medicated for pain c percs + motrin, dsg on old trach site CDI, skin graft sites on LLE open to air, applied bacitricin to sites, ROM on LEx2 given, logroll q 2° for skin breakdown prevention sutures to midline abd incision intact, foley → gravity draining amber urine, 2 pt restraint in place c complications. [redacted] qlw (b)(6)-2
	(b)(6)-2 [redacted] APT
18Oct03 1646	Assume care of PT @ 0600. VSS, A+Ox3. Stitches are ready to come out. c/o pain in stomach. His problem with bikes. Need buttocks drsg, area needs to be seen by Dr. Don't getting bothers. No sign of infection or bleeding at [redacted] (b)(6)-2 skin graph site. Will cont. to monitor.
	(b)(6)-2 qlw SPC [redacted]
	(1740) I concur c above assessment. [redacted] (b)(6)-2
18 Oct 03 2206	VSS. AO. Performed small BM c soft formed brown stool. Cleaned patients head / hair and BLE and performed foley care. Placed large Duoderm to stage II sacral ulcer and notified MD. Turned @ this point. Voiding light amber urine. c Foley [redacted]
	(b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
10/18	Operation Note
	Procedure: Scrotal Debridement
	Surgeon: [redacted] (b)(6)-2
	Anes: GETA
	Prep: 3 DU LR
	1 U EBL
	Findings: Large necrotic deep ulcer c purulent collection and green foul smelling tissue
	BSTLL

[redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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DATE	NOTES
19Oct03 1654	Assume care of Pt @ 0600. VSS, A+OX3. In 4x restraints, ø skin irritation. C/O ø pain. Used B.le is runny light brown color. Past 6 liles three times today. Replaced decaderm on buttocks, area looks better than yesterday. Let air dry for an hour. Will continue to monitor. 9/W SPC (b)(6)-2
	(1745) I concur c above assessment (b)(6)-2
19OCT03 2100	Pt awake and resting on (R) side. Several Decub c op site Dsg. Pt denies pain @ this time. Will continue to log roll. (b)(6)-2 Spc 9/WM6
20 OCT @ 0915	Pt awake, VSS, ø c/o pain. Q2° turns to prevent further skin breakdown. Drsg Δ'd to incision. Pt NPO today for OR. LCTAB, HRRR, ⊕BSx4qds. Foley to gravity draining mod yellow urine. 1 pt restraint for compromise to skin of circulation. Will monitor (b)(6)-2 9/WM6.
20OCT 1600	Pt left for OR via litter. 18ga IV started to (R) AC. 9/WM6 (b)(6)-2

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[redacted] (b)(6)-2

DATE	NOTES
20Oct03 1730	(L) PIV T, antibiotics. NS infusing, TKO @ this time. pt Braden Scale 13. pt high risk for further skin breakdown. pt will need PT and Nutrition consult as soon as possible. pt condition stable @ this time. Pt on regular diet pt able to feed himself. Report given to on coming shift.
20Oct03 1830	Pt resting bed alert communication limited due to language barrier. Turned to (L) side @ present VSS. No distress noted. Respirations even and unlabored BBS CTA pt c productive cough. Palpable pulses (B) paraplegic but Moves UE well asst c care. Abd soft c hypoactive bowel sounds Midline incision with skin well approximated open to air. Scarring to old surgical sites to chest walls Foley to gravity c amber urine IV LR infusing via PIV in (R) FA. Tolerated meal c complications. Will cont. to monitor status. Dsg to coccyx changed by previous shift CPI [redacted] (b)(6)-2
21Oct03 2330	Pt asleep @ intervals VSS. C/o pain to (L) shoulder Rec'd Toradol 30mg IVP per Dr [redacted] (b)(6)-2 IVF cont to infuse Will cont. to Monitor and reevaluate [redacted]

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21Oct03 0300	Pt resting comfortably No changes in status Assisting c repositioning Foley remains To BSP No distress noted pain relieved (b)(6)-2 [redacted]
0600	assumed care of pt. Pt turned to (L) side. Dsng intact. VSS. CPT [redacted] (b)(6)-2
0800	Pt has been turned + pressure kept off of sacrum area. (Neuro) AOx3, FA, moves UE only d/t paraplegic to (B)LE. UE weak. (RESP) 20 BPM c SPO2 798%. RA. CTA, BBS, even, unlabored. (CV) HR 80's, RRR, Ø ectopy noted. (+) pulses throughout. (GI/GU) Soft, tender to LQ's + midline incison c sutures. BS (+) hypoactive. (+) flatulence (foul smelling). Ø BM. Foley to gravity c urine 50cc/hr. golden yellow urine. Pt tolerating PO c intake ~35%. Interpreter explained to pt about nutritional intake must ↑ in order for proper healing. Will ask (b)(6)-2 Dr [redacted] abt Nutrition consult. Pt already getting Ensure drinks. TID. (Integ) Braden score done c W/S care sheet. Pt @ HIGH RISK for developing ulcer. Dry skin, feet skin is dry + flaky. But warm. Pressure ulcer to sacral area Stage IV - wet dry dsng Δ BID. LLE, lateral calf, graft site - ota - Ø orders for wound care to be followed. Donor site - ota - d/t no orders for dsng / site care. PIV (R) FA patent intact c LR 75 cc°. POC: PN mgmt, turn, monitor. — CPT [redacted] (b)(6)-2

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MEDICAL RECORD — **PROGRESS NOTES**

(b)(6)-2 DATE	NOTES
[redacted] 04Oct03 1700	Pt received from OR. S/P coccyx pressure ulcer debridement. Age unknown. This pt is an EPW transferred to us from ICU I prior to debridement. Upon arrival to unit, pt fully awak and alert. Unable to communicate due to language barrier. VIS: HR 86, NSR, Ø ectopy. BP 124/65 RR 20. O Sat 98%. No respiratory distress noted. Lung: CTA bilaterally. Ø cough Ø sputum. Heart S1 S2 Ø murmurs. Skin cool to touch. pt emaciated. Radial pulses - weak. Dorsalis pedal pulses strong 02+. Ø peripheral edema. Capillary refill < 3 sec. Pt is a paraplegic, unable to turn side to side & staff assistance. Pt has strong hand grip. able to sit up and able to support upper torso using upper arm. Pupils 3mm bilateral, PERL. Coccyx/buttocks region has 3cm pressure ulcer - unable to stage due to covered in hard scab. Abd soft non-tender. Active bowel sounds x4 quads. Foley intact - draining clear - coil

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

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

REGISTER NO. | WARD NO.

#[redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted] (b)(6)-2			

NOTES

2000 hrs [redacted] (b)(6)-2
1930 Amber color urine. Drained approximately 800 cc's urine in bag. Abd. has long incision from below the nipple line to symphysis pubic region. Incision line well approximated and closed [redacted] (b)(6)-2 Closed & sutures still in place. Suture line covered & dry drainage particles. (R) chest area has healed S/P CT incision sites x 2. (L) leg healed graft site that is 6 cm long 3 cm wide. wound bed pink. (L) lower leg and [redacted] (b)(6)-2 below the knee - healed wound. Temp 97.8 (F). Foot drop noted bilaterally. Removed vacuum dressing to assess S/P wound debridement. packing removed. Bloody drainage noted. Stage IV pressure ulcer that is approximately 8 cm in diameter - wound edges - irregular. wound depth approximately 2 cm deep. Tunneling noted from 7 o'clock to 11 o'clock position & 8 cm deep towards left cheek. Undermining 2-3 cm deep from 11 o'clock to 1 o'clock position wound bed red. packed wound & wet to dry Kerlex sponge. Reinforced & & 4x4's and tape. Placed pt on (L) lateral position & [redacted] (b)(6)-2 Knees supported and back. pt needs to be turned q 1-2 hrs side to side. Keep pressure totally off the back

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[redacted] (b)(6)-2 MAJ, MC

MEDCOM - 18011

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
22Oct03 1200	positioned pt on (R) lateral position, BLE supported c rolled blanket. Heels off the mattress. Pt able to assist some using side rails. — No signs of distress noted. (b)(6)-2 [redacted]
1545	Pt has turned @ 1 hr from (L) → (R). Pt has eaten 35% of b'fast + 80% of lunch. He has had a total of 3 ensures up to this time since 0100 this am. Pt asked for a snack. Ate it all c success + drank 1 glass of H2O. Appetite has ↑ today w/o any N/V. Rx mgmt c Percocet tabs Q4-6hr/prn. Pt's demeanor seems more enlightened today - smiling + participating in care. VS Q4 hr VSS. U/O ~ 60-100 cc/hr. Yellow physical therapy bands applied to each side rail - pt taught/encouraged how to utilize them. Cont to monitor. (b)(6)-2 CPT [redacted]
22Oct03 1800	Assumed care of pt. Pt in bed c eyes open resting comfortably. VSS. Will continue to monitor. SPC (b)(6)-2 [redacted]
1845	Pupils Perrla @ 3mm brisk, responds to external stimuli, moves upper extremities, paralyzed in lower extremities, HR in 60's, NSR, Ø ectopy noted, Ø S's 2 HS, Ø murmurs noted, Ø peripheral pulses X4 extremities +2, +1 edema in lower extremities, 18G (R) AC running LR @ 75 cc/hr C/D/I Ø S&S of infection, RRR unlabored, Sats High 90's, Lungs CTA Bilat c equal rise + fall, pt on reg diet + ensure

continued one next page

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22OCT03 continued	Sacral decub c w/d dsng BID. Turn Q1hr keep pressure off @ all times. LLE, thigh, anterior, donor graft site. Dta, CDI. LLE, calf, lateral anterior, graft site/dta/posttraum BID/PRN. POC: Turn Q1hr c pn mgmnt, hygiene + nutritional encouragement, ensure PT visits pt. VSS (b)(6)-2 CPT [redacted]
1100 22OCT03	Pt has been turned Q1hr from (L) -> (R). Pt now helping turn himself by using side rails. Dsng Δ to sacral area using WTNry dsng. Wound irrigated, measured, and repacked under tunneling. WOUND DIMENSIONS: 10cm L x 8cm W x tunneling from 7 o'clock to 12 o'clock c 2cm-3cm from 3 o'clock to 6 o'clock. Wound clean c Ø drainage. [redacted] (b)(6)-2 Head ulcer - 4cmL x 3cm W, staging unable to be done. P/C Δ is covered c dry tissue. Area around [redacted] (b)(6)-2 wound shaved - comfeel put over. Pt shaved, brushed teeth, + put deodorant on this AM. New gown placed. Braden scale (N/S assessment) has been done upon entering unit. VSS. D'ed to Q4° VS Record. Spoke c mo[redacted]er. About multivitamin + appetite enhancer. [redacted]

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

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

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Continued 21Oct03
	bilat equal rise + fall, pt on Reg diet + Ensure, ABD incision midline closed c sutures open to air C/D/I Ø S+S of infection, ABD soft ND. tender around incision, ØBS X4 Quadrants, Foley to gravity [redacted] (b)(6)-2 draining clear yellow urine >30cc/hr, free of sediment, Stage IV Decubitus Ulcer to coccix c wet to dry drsg Ø s+s of infection, 3 wounds from old chest tubes to (R) flank covered c duoderm Ø s+s of infection, ob track site Ø s+s of infection covered c gauze C/D/I. Will continue to monitor + turn Q1°. SPC [redacted] (b)(6)-2 q WMG
1030	Performed DRSG A to Decubitus on coccix. Continueing to turn Q1°. SPC [redacted] q WMG (b)(6)-2
22Oct03 0600	Assumed care of pt @ 0600 from SPC
(b)(6)-2 [redacted]	Pt on (R) side. CPT [redacted] (b)(6)-2
0700	Neuro AOX3 PERRLA, EOMI, communicates via gestures + interpretor. FC, move UE but LLE is weak. PT consult submitted 21Oct03. (RESP) 14-16 BPM, CTA, SPO2 ≥96% RA. No cough noted @ this time. (CV) S1S2 c HR 70's RRR. Peripheral noted @ this time. 2+ pulses to extremities. (+) edema to (B) LE. (B) LE warm, dry. (GU) Foley to gravity c ave ~ 40-60cc q hr U/O, cyu. Midline Unc, sutures, Dta. Scabbing noted. BS X 4 quads. Reg diet c poor appetite But LLE will drink Ensure drinks. Nutrition consult 21Oct03. Pt usually eats < 35% meal times (SK) (R) AC c LR 150cc/hr. (WOUND) Abd, midline, sutures/Dta/scabbed. Ø s/s infection; Decubitus occipital head. (b)(6)-2 comfeel placed or W-D Drsng A. Keep pressure off. continued [redacted] CPT

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
21Oct03 1500	Addition to RN assessment. c̄ turning q1h. Pt's head (occipital pressure ulcer) also relieved as well as sacral decubi. Begun VS Q1 @ 1400. Afebrile. Will talk c̄ Dr. [redacted] About PO pain medicine. VSS. (b)(6)-2 CPT [redacted] (b)(6)-2
1730	Pt turned Q1° ŌVS Q1 VSS. Pt drank 2 ensures + ate <35% each meal. PT + nutrition consults turned in. UR 75cc° MIVF c̄ PO intake fluids encouraged. Percocet ii tabs PO for PN. 40 → 30. 50cc hr. PIV (R) AC intact. Report to be given to SPC [redacted] (b)(6)-2 VSS CPT [redacted] (b)(6)-2
1800	Assumed care of pt. Pt resting in bed c̄ eyes open. VSS. Pt ate 75% of dinner meal. Will continue to monitor. SPC [redacted] (b)(6)-2 91WM6
1920	Pupils perrla @ 3mm, responds to external stimuli, ∅ sedation, moves upper extremities, paralyzed in lower extremities, HR in 70's, NSR, ∅ ectopy noted, ⊕ S1S2 HS, ∅ murmurs noted, ⊕ peripheral pulses x4 extremities +2, +1 edema in lower extremities, 18G (R) A/C running LR @ 75 cc/hr C/D/I ∅ S+S of infection, RRR unlabored, Sats High 90's, Lungs CTA

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

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PROGRESS NOTES
Medical Record

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[redacted] (b)(6)-4

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MEDICAL RECORD — Continued — **PROGRESS NOTES**

DATE	NOTES
Continue 1845	Midline ABD incision closed c sutures open to air c/d/I ⊘S+S of infection, ABD soft ND but tender around incision site, ⊕BS x4 Quad., Foley to gravity draining clear yellow urine >30cc/hr free of sediment, Pressure ulcer to back of head covered c duoderm, Stage IV ulcer to coccix c wet to dry dsg c/d/I ⊘ S+S of infection, skin graft site to (L) LE ⊘S+S of infection, will continue to monitor throughout shift. SPC [redacted] (b)(6)-2 9/aM6
2200	Performed DRSG Δ to coccix + TRACH site /Neck. /— / Continued to form throughout shift. SPC [redacted] (b)(6)-2 9/aM6
23 Oct 03 1115	Nutrition F/U: PO intake improving (per nsg.). Pt consumed 80% of lunch tray yesterday + 4 Ensure. Continue to encourage PO intake. No labs noted - Will provide pt c crackers as snacks. [redacted] (b)(6)-2 RD/LD
23Oct03 1120	Late entry: assumed care of pt @ 0800 this am from SPC Smalley. VSS. Neuro sleeping but easily arousable. PERRLA, holds conversation well, PC, move LUE well, RUE c pain + weakness. Resp 14-20 BPM c SPO2 ~ 100% c RA. CTA ventilated - even. BBS. CV SR 1HR 70-90's. RRR, ⊘ ectopy noted @ this time. UE 2+ pulse, ⊕ LE 1-2+ Pitting edema

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

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PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	to @LE / feel. GIGU soft / tender / BSx4 Hypoactive. Pom x 2 - small, runny. foul - greenish in color. Adeq ↓ QS urine output. Wounds sacral decub- dsng intact - wet to dry ↓ soft packing of area and tunneling. Occipital base decube - old comfeel - will replace + clean. Intact ↓ drainage. Midline Abd inc. sutures - scabbed / ota / CDI. LLE - thigh - donor graft site / ota / CDI. LLE - calf - labial graft site ↓ Bacitracin + nonadherent dsng. VSS. CT n ——— CPT [redacted] (b)(6)-2
1200	WOUND CARE: Removed DRSng - foul odorous ↓ much drainage d/t overwet dsng. Wound clean, no drainage, no foul odor noted. Wound irrigated ↓ NS + toomey syringe. then patted dry ↓ 4x4. Afterwards a wet to dry dsng was placed, packed the tunneling + area lightly but to the edges. Two 4x4's - dry - placed over dsng then covered / secured ↓ Tegaderm OPSite. Skin barrier applied. Wound #2 Trach - old dsng removed area cleansed ↓ NS + 4x4 - then patted dry. Four 2x2's ~~on~~ then covered with a tegaderm was applied. Wound #3: occipital decube: Old comfeel removed. Area cleansed ↓ NS / dried / then new comfeel placed. Scabbing is sloughing off slightly. Expect scab removal w/in 2-3 days ↓ removal of comfeel. Then will apply wet-Dry dsng BID per MD orders. VSS ——— CPT [redacted] (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
23Oct03 1710	Summary of day: Uneventful day Pt turned Q1 hr. Doing A to sacral decube, occipital decube, trach, LLE x2. See w/s note for details of drsng A. U/O adequate today. VSS. Slight temp @ 1600. Percocet tabs x2 given x2 today for pn. Physical therapy conducted ROM exercises this AM. Pt used BANDS thus a.m/p.m. x2. Breakfast 35%, lunch 80% eaten. Pt has drank ensure drinks x2 & snacks x2 (one in AM/one in PM) of peanut butter & crackers. Pt c/o pain to (R) shoulder. ROM exercises done & encouraged. VSS. Cont to monitor (b)(6)-2 CPT [redacted]
1710	addition: nutrition to reassess pt today. Pt c ↑ appetite & intake x 48hrs - must insist on drinking the ensure's. Pt helping some c upper body in turning. (b)(6)-2 CPT [redacted]
23Oct03 1800	Assumed care of pt. Pt in bed on (L) side, VSS. Performed wound care/DRSG A to coccix c MAJ (b)(6)-2 [redacted] stage IV pressure ulcer 8cm W x 10cm L x 4cm D c tunneling to the 12 o'clock position 2cm deep, wound has slight whitish exudate to outer region, coccix bone presentable in center of

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[redacted] EPW

(b)(6)-4

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Continued	wound, debrided [redacted] (b)(6)-2 flushed + cleaned wound, repacked wound ☐ damp 4x4's, covered ☐ dry 4x4's + covered ☐ tega derm. SPC [redacted] (b)(6)-2 9WM6
1930	Pupils perla @ 3mm, responds to external stimuli, moves upper extremities ☐ paralyzed in lower extremities, HR in 90's NSR ∅ ectopy noted, ∅ S1S2 HS, ∅ murmurs noted, ∅ peripheral pulses x4 extremities +2, +1 edema noted in lower extremities 18G ® AC ☐ LR @ 75cc/hr C/D/I ∅ S+S of infection, RRR unlabored ☐ equal [redacted] (b)(6)-2 rise + fall of chest, Sats in high 90's, Lungs CTA Bilat, Reg diet + ensure, ABD soft NO, ∅ BS x4 Quad, Foley to gravity draining clear yellow urine 780cc/hr free of sediment, Stage I pressure ulcer to back of head covered ☐ duoderm, Midline ABD incision closed ☐ sutures open to air ∅ S+S of infection, Stage IV pressure ulcer to coccix described earlier in notes, skin graft sites to ® LE ∅ S+S of infection, skin color normal for race, will continue to monitor. SPC [redacted] (b)(6)-2 9WM6
2130	Pt drank 1 can of ensure. SPC [redacted] (b)(6)-2 9WM6
2200	offered pt second can of ensure but pt refused and said ensure was making him nauseated. SPC [redacted] (b)(6)-2 9WM6
0400	Performed 2nd ORSGA + afterwards pt had a bathroom Summary of night. Night was uneventful after assessment roled pt to other side, between sides had pt do arm exercises ☐ bands. Pt complained of pain to ® side hip + ® shoulder pain while awake during the night. Gave pt perscribed percocet then reassessed 45 min later and the

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24/OCT/03 1130	- Performed wound care to comic Area. STAGE IV ulcer. 8cm w x 10cm L x tunneling to 12 o'clock. Moore amount of deprimmet done around edges. Small amount of granulation noted. wound was packed w/ sterile 4x4's wet to Dry dressing. In process of wound care PT had passed watery stool followed by several hard granular stools. Cafe of dressing was redressed and skin prep Applied to perineum Area. PT given 1 TAB percocet @ 1220 for comfort. As per MD order and turned to (R) side. Call out to nurses station. USAF (b)(6)-2 [redacted]
1300	- PT tolerated lunch very well eating 75% of lunch. PT check of dressing remains WNL + Dry w/ ⊖ % pain or drainage @ present time. will call out to nurses station. USAF [redacted] (b)(6)-2
1600	- PT passed watery stool followed by a large BM. PT has passed several of these BMs. PT temp has risen to 101.3. encouraged cough + Deep breathing & ⊖ Rectal Ts. (b)(6)-2
1745	As per MD [redacted] Gave PT 2 Tylenol 325mg per tube and will send Blood culture. Will call out to nurses station. USAF [redacted] (b)(6)-2
24 Oct 03 1800	Assumed care of pt. Pt in bed w/ eyes closed resting comfortably. VSS. Will continue to monitor throughout shift. SPC [redacted] (b)(6)-2
1930	Pupils perrla @ 3mm, pt responds to external stimuli, moves upper extremities & paralyzation to lower extremities, HR in 90's, NSR, Ectopy, S1S2 HS's murmurs noted, & peripheral pulses X4 extremities +2, +2 edema to LE, BG to @ AC & LR

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[redacted] (b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	(b)(6)-2
Continued	pt was not complaining of pain. SPC [redacted] 91WM6
10/24/03	- Received PT Asleep in bed c̄ ⊖ c/o pain or discomfort.
0615	Bilateral rise + fall of chest. ⊖ Respiratory distress Noted. [redacted] (b)(6)-2
	sounds are clear throughout. PT SpO2 96% on RA. BS x 4
	c̄ Abdomen Non-Distended or rebound tenderness noted. ⊕ Radial
	+ pedal pulses present, bilaterally. PT has ⊕ Pulse motor sensation
	to upper extremities. ⊖ Sensation or movement to lower extremity.
	cap ref + 3 sec throughout. Foley to gravity draining clear
	colored urine. 18G w̄ Ⓡ AC c̄ LR @ 75cc/hr c̄ ⊖ S/S
	of infection or infiltration. Stage I pressure ulcer to back of
	head c̄ Duoderm in place CDI. ABd suture midline CDI
	open to Air c̄ ⊖ S/S of infection. Stage IV pressure
	ulcer to coccyx 8cm W x 10cm L c̄ tunneling is CDI c̄
	dressing in place currently not draining anything. SCD [illegible] to
	Ⓛ LE c̄ ⊖ S/S of infection. ↓ extremities has +2 edema noted.
	Will cont to monitor PT [redacted] [redacted] (b)(6)-2
0635	- PT refused to eat Breakfast. Encouraged PT to drink
	more. PT then ATE 25% of Breakfast. Will cont to monitor.
	(b)(6)-2
	[illegible] [redacted]
0815	- PT c/o pain to Ⓛ side of hip. PT was given Percocet
	i as per MD order + turned to Ⓛ side. [redacted]

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

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PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	clear colored urine. Drsg to trach site CDI c̄ ⊝ S/S of
	infection. MID line abdominal incision is crusty c̄
	dry yellow drainage on edge. ⊝ redness or swelling noted to suture
	sites. Drsg to Ⓛ thigh CDI. Ⓡ old IV site has some
	mild tenderness to touch + slight redness noted on IV
	insertion site. IV on Ⓛ AC LR @ 75cc/hr infusing
	well c̄ ⊝ S/S of infection or infiltration. Will cont to
	monitor pt for fever + level of comfort. [redacted] (b)(6)-2
1600	- PT has had several BM, some of which has managed
	to seep into the colostomy dressing. Dr [redacted] (b)(6)-2 notified &
	PT will be NPO After midnight in order to
	put A colostomy bag. will notify next shift.
	[redacted] [redacted] (b)(6)-2
25Oct03 1750	Braden scale done 21Oct03. Pt @ 13 - High
	Risk. Plan of care + wound drsng management
	worksheet done also. Next Braden scale to
	be done 28Oct03. CPT [redacted] w/s (b)(6)-2
2000	Pt received lying in bed on Ⓡ side. Alert, follows
	commands [redacted] (b)(6)-2 moves UE Ⓑ spont. paraplegia, LE
	positioned c̄ pillows. SR 80's 2+ UE pulses 1+ LE pulses
	2+ edema LE noted LR @ 75cc/hr infusing to Ⓛ FA
	18G, VSS - Q4°. Sats 95% on RA RR 20's L$\&$CTA. ∅
	cough or secretions. Abd soft, midline sutures intact
	⊕ BS x4, BM x2 upon turning to Ⓡ side. Sacral
	Stage IV decub packed W→D dsg Δ'd as ordered
	turning Q1° keeping off sacrum. Reg diet tol
	well, NPO p̄ MN for OR tomorrow. Foley intact drng

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DOD-031596

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
24 Oct 03 Continued	@ 75 cc/hr C/O/I ⊖S+S of infection, RRR unlabored equal rise + fall of chest, Lungs CTA Bilat, Reg Diet + Ensure, ABD soft ND, ⊕BS x4 Quadrants, ⊕BM x1 since 1800, Foley to gravity ∓ clear yellow urine >30cc/hr, Pressure ulcer Stage I to back of head covered ∓ duoderm, Pressure ulcer to coccix Stag IV 8cm W x 10cm L x 4cm D ∓ tunneling 2cm D ⊖S+S of infection, will continue to monitor. SBC
0530	Summary of shift, uneventful night, ⊕BM x4 mainly solid (b)(6)-2 large amounts of feces, Δ'd IV site to 18G @FA, temp stayed @ 1000 to 1000.8 hit 101 @ 0500 informed H. (b)(6)-2 and was told to inform oncoming shift. SBC (b)(6)-2 Flowers
25 Oct 03 0600	+ Received PT in bed c/o pain to ⓟ shoulder. Perrla + PT is Alert + Oriented x3. Gave PT 1 Percocet PO as per MD order for pain + Repositioned to ⓒ Slow. Upon turn PT had a large watery BM. PT was Afebril ∓ temp 100.3 Lawprock. PTs Duoderm size to back of head was coming loose. Reflexed and faxed a large Bloody scab covered on Duoderm patch. Reflexed patch and cleaned site. Breath sounds are clear Bilat ∓ ⊖ Resp distress. BS x4 Active. ⊖ Abdominal distension noted. ⊕ Radial + Brachial pulses throughout ⊖ PMS to ↓ Extremities. Cap Ref ↑ 3 sec throat. ↓ extremity ∓ 2+ edema noted. Foley drains

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

DATE	NOTES
	A febrile. will cont to monitor PT [redacted] (b)(6)-2
1335	PT is to renew to regular diet until probably Wednesday when PT will go to O.R. for surgery. will cont to monitor PT. [redacted] (b)(6)-2
26Oct03 2300	Pt placed on abdomen to sleep medicated c ~~t~~ Percocet and 4mg MSO4 IVP prior to (b)(6)-2 turning VSS will monitor. [redacted] RN
2335	Pt lying on abdomen Alert, follows commands pupils 2mm brisk reaction. ST 100's 2+ pulses UE 1+ pulses LE, 2+ edema LE B/P stable LR@ 75cc/hr infusing via 18G (L) FA. RR 20 sats 100% on RA LSCTA bases @ secretions. Reg diet tol well, abd sft + tender to midline incision c sutures intact. (R) BS x 4 quads BM x 2 this shift. Foley drng cl yellow sufficient amts. (R) thigh (gray/t) site DTA pink granular tissue present. Duoderm to decub Stage II to occiput intact, D'd this pm. Stage IV decub c sacral W → D ¼ Dakins sol'n dsg intact, D'd as ordered. Plan to monitor until Wed to OR for colostomy. [redacted] (b)(6)-2 LTA
27Oct03 0500	Pt placed back to (R) side. VSS will monitor. [redacted] (b)(6)-2 LTA
27Oct03 1000	Nutrition Note: Pt c liquid stools, per nsg. Recommend adding 1 scoop Metamucil to Ensure Plus to create Bulk. Give pt 1 scoop today + increase by 1 scoop/day to max of 3 scoops/day Will continue to monitor + follow. [redacted] RD/LD

OPT, SP

STANDARD [illegible] 509 (REV. 5/1999) BACK
(b)(6)-2 USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25Oct03 2000 (Cont)	cl yellow sufficient amts. Plan to Δ dsg again @ 0400. Will monitor. [redacted] (b)(6)-2 LTAN
2300	Pt turned and placed on stomach. C/o pain given 4mg MSO4 IVP and 1 Percocet PO, will monitor. [redacted] (b)(6)-2 LTAN
0250	Pt repositioned d/t tilting to (R) side, given 2mg MSO4 for pain. Will monitor. VSS [redacted] (b)(6)-2 LTAN
0400	Dsg Δ'd to Sacral area 8cm circumference c sacral bone visible, packed w/ D c Q Making SOL as ordered. Mod amt white drng noted to old dsg. Pt sleeping on abd, repositioned to assist c comfort. VSS will monitor. [redacted] (b)(6)-2 LTAN
0530	Pt turned back to side position (L) side. VSS. Will monitor. [redacted] (b)(6)-2 LTAN
0630-	Received PT Awake in bed c 0 % pain or distress. PT is still AWAITN, transfer to the O.R. for colostomy closure. VSS. Hrn (-) resp. ty distress noted. Dsg to SACRAL Area remains c 8cm circumference. Packed c Q-Tip dressg. CDI. PT is currently on (R) side

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. ICU2

[redacted]

(b)(6)-2

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
27 Oct 05 1200	necrotic tissue gone. Washed area w saline. gently patted dry. Wound bed pink-red and soft, no bleeding or lesion open. Wound size 4.5 cm long x 4 cm wide. Wound gauze - need to prevent groin adhesion or rupture - Compeed dsg applied. Cleaned abd. suture line. Sutures need to be removed. C/O pain while doing wound care. Washed the incision site w soap & water. Rinsed & patted dry. No exudate or signs & infection noted. Need to keep occipital region off the mattress by turn head side to side. - Continue to turn q1° Monitor for non-blanchable erythema
1215	pt appear comfortable @ this time. pt C/O abd. discomfort. ——— Offered lunch. pt refuses to eat. Making faces of total disgust! pt not happy with menu selection. (b)(6)-2 [redacted] RMA
1855	Received report from SGT (b)(6)-2 [redacted] Pt awake and on (L) Side. Pt eating dinner @ this time VS. 98.3 89 (b)(6)-2 125/64 18 100% RA. Will continue to monitor pt [redacted]
1930	Pt ate ½ chicken & slice bread. Poor appetite. Does not like food. Will continue to mon (b)(6)-2 [redacted]

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
270403	pt awake. requesting something to drink
1130	offered water. pt is a total care. Unable
	to move LLE 2° to paralysis. Repositioned
	every 1hr. side to side. pt continues
	to stool. Changed linen x 3 within
	30 minutes due to liquid brown stool
	Sacral dsg is done. Removed old dsg
	Stage IV pressure ulcer. that is approximately
	10cm long x 8cm wide x 4cm deep &
	2cm deep tunneling noted @ 6° clock position
	bony tissue visible. Wound bed moist
	& yellow odor or exudate. Wound bed
	pink & healthy granulation tissue present
	Wound irrigated & sterile saline. (b)(6)-2 [redacted] Wound
	packed loosely & wet to dry dakin's ½%
	solution. dry 4x4 applied over dsg
	and secured & clear op-site dsg
	to keeps dsg moist and keep stool
	from leaking into wound bed. Coccygeal
	region. Stage II pressure ulcer noted.
	Removed old dsg. 80% dry crust - cont

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | SPONSOR'S ID NUMBER

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

(b)(6)-2

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

REGISTER NO. | WARD NO.

[redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28 OCT 03	RED duoderm to occipital area prudent glued molded to scalp. old dsg. Round round & necrotic area to middle. cleaned. New duoderm applied New duoderm applied x3 areas to (R) chest wall - pt had x2 Ensure & meals & other complications (b)(6)-2 [redacted] ICU
28 OCT 03 1530	Received care of pt. @ this time. Pt. lying on (R) (L) side. Pt. has drainage to (R) hip + DRSG covered with bandage to scrotal area. Pt. had a BM w.i.l was cleaned up. Pt. turned to (R) side + DRSG d/d with a loose packing, wet with ¼ strength Dakins solution. (b)(6)-2 SPC [redacted]
2215	Pt. called over to ABD @ this time (b)(6)-2 SPC [redacted]
29 OCT 03 0615	Received Pt asleep in bed c/o pain at duration. PT is npo for surgery. Perrla 2mm Brisk. PT A+O x 3. Breathes on room Bilateral c/o Regular distress. equal rise + fall of chest. BS x4 c loose Stols. (+) Abdominal distension noted. scrotal site c/d/i Abdomen is tender to touch. PT has Foley cath to gravity drain clear colored urine - Foley intact. Capable MSM +2 Peds edema on L Extremities (+) Pedal (+) Radial pulse B. Lightly cap ref +3 sec throughout. will cont to monitor PT for comfort. (b)(6)-2 [redacted]
1600	- Excoriation noted (R) lower calve. will cont to monitor. PT spills up small amount of clear colored sputum. will cont to monitor. PT is still npo for surgery. (b)(6)-2 [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
0400	DRESSING CHANGE TO COCCYX DECUB STAGE III ULCER. IRREGULAR WOUND MARGINS C TUNNELING TO UPPER PORTION OF WOUND. DEBRIDEMENT C NACL SOLUTION EFFECTIVE AS A RESULT GRANULATION TISSUE IS PRESENT THROUGHOUT AND SLOUGH IS REMOVED C EACH APPLICATION OF NACL. COCCYX SEEN AND AREA AROUND COCCYX C (+) GRANULATION TISSUE. Ø NECROTIC TISSUE NOTED IN WOUND BED. PT TOLERATED WELL AND C DIFFICULTY. PT TURNED Q 2° HOURS TO AVOID PRESSURE TO DECUB. PLAN CONTINUE C DRESSING CHANGES AND NOTE WOUND BED. [redacted] (b)(6)-2
0800	Dsg Δ to Coccyx X 2 today - irregular wound Borders - granulation tissue present Undermining to (R) side of wound - wound packed c 1/4 Inch Iodoform Gauze c Dry 4X4 Abdominal placed to secure Dsg - pt had three loose Bowel movements during 1° hr - New IV Started to (R) AC - 20G did IV removed. to (L) AC - Medicated PRN c MSW: percocet for Pain - Bed Bath given - Foley Care and ROM exercises to (B) LE - pt instructed to use Bands for Strengthening [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.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Pt dressing to coccyx changed. Packing c slough necrotic and blood @ periphery of wound. Pt continues to have irregular wound margins (+) granulation tissue to wbc. Dakins Solution 4x4's applied and tegaderm placed over top of wound. Will continue to monitor pt [redacted] (b)(6)-2
30Oct03 0400	Wound care note: Dsg D'd to coccyx packed W→D c 1/4 Dakins sol. Pink granular tissue to edges, old dsg noted to have mod amt. yellow slough on dsg. Dsg covered c tegaderm Medicated for pain prior to D'ing dsg. Placed on (R) side. VSS will monitor. (b)(6)-2 [redacted] LCPN
0600	Assumed care of pt @ 0600. Rec'd from LCT [redacted] (b)(6)-2 Pt turned to side. Per orders. VSS. (b)(6)-2 CPT [redacted]
0900	Neuro alert, oriented, easily arousable when asleep. PERRLA, EOMI, tracks people around room. More UE, (R) weaker than (L). Physical therapy stretch bands to siderails. UAs TID/PRN. Resp clear to auscultation, slight rhonchi to UR. Breathing clear c cough. Old track wound healing c [redacted] dry dressing placed c tegaderm BID. Greenish-yellow smelling noted @ dsng D. Pt alert/unlabored. CV BP 152 HR 90's, [redacted] 100 100/50's UE pulses 2+, LE pulses 1-2+. All extremities warm. (b)(6)-2
61/60	BS to LUQ/LQ. Abd (R) quadrants d/t dsng. Colostomy to LLQ c pink-red liquid drainage. Reg diet to resume today per MD post-surgical orders. Tolerating Reg diet w/o N/V @ this time. QS % via FTG. Midline incision/covered/serosanguinous drainage noted & reinforced. Pt is AAM (alert) Stg IV sacral decubs, Stg 1-2 occipital decubs c comfort. cont. CPT [redacted] (b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
29Oct08	Brief OR note Pre Dx - Double Ulc Post Dx - Same Procedure - Exploratory Colostomy Surgeon Bryan 15[illegible] Surgeon [redacted] (b)(6)-2 Anes GET Findings - Small Bowel Adhesions. End Sigmoid Colostomy Counts Correct To Trauma SICU [redacted] (b)(6)-2
2000	Pt returned from OR. Pt sleepy, but easily arousable. Pt 2L NC SaO2 100%. VS. 101 129/64 19. Pt S/P colostomy. Pt tolerated procedure well per Anesthesia. Pt Tmax 97.9. Will continue to monitor closely. [redacted] (b)(6)-2
2200	Pt turned to L side c (resistance ~~complaints of pain~~) pt became aggressive and then medicated c 4mg MSO4 for ↑ HR and pain verbalized by pt. Pt ~~Both~~ colostomy beefy red c (+) blanching c quick return. Small amount of bloody drainage in ostomy bag. No stool noted or flatus.

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30 OCT 03 2105	Pt c/o pain to sacral area. Received ĪĪ tabs Percocet PO for pain. Will Monitor for effectiveness. —— SPC [redacted] (b)(6)-2 /1WM1
LE 30OCT03 1800	Assumed care of pt @ 1800. VSS, afebrile. A+OX3. PERRL, 3mm. Pt has decub. to back of head c duoderm dressing applied. Mucous membranes moist. Pt tolerated 25% of Reg diet c Ensure. Pt refused Ensure @ this time, will encourage @ a later time. Pt has 2x2 dressing c opsite to neck, CDI. Pt has lung sounds [redacted] (b)(6)-2 CTA bilaterally, apex to base. PR equal + unlabored. O_2 Sat 100% RA. BS active x 4 Quadrants. Ø tender, Ø distended. Pt has healing midline incision, Ø drainage noted, open to air. Pt has colostomy to LUQ c moderate red/brown drainage. Pt has foley to gravity draining clear, yellow urine > 30 cc/hr. Pt has stage 4 decub to sacral area + coccyx c Kerlix wet-to-dry, Dakins 1/4, dressing c opsite. Δ ing TID. Pt has DuoDerm dressing to Ⓡ hip. Pt has Opsite to Ⓓ thigh on a 2x4 area from graft site. Pt has 2 wounds to Ⓛ shin 2x4 horisontal, open to air. Pt has small wound to Ⓛ ankle, open to air. Pt has complete ROM to BLE. Pt has No feeling or movement to BLE. Turning Q1°. ~~Will~~ Pt has IV to Ⓡ ac, 20G c LR @ 75cc/hr. Will continue to monitor for Δ's. —— SPC [redacted] (b)(6)-2 /1WM
30 OCT 03 2100	Dressing Δ done c 1/4 Dakins solution, wet-to-dry. Loosely packed c Kerlix pads + covered c opsite. Stage IV c tunneling to Ⓡ. Will continue to monitor for Δ's. Next dressing Δ due @ 0400. —— SPC [redacted] (b)(6)-2 /1WM6
31OCT03 0015	Pt VSS, temp 100.2°. Turning Q1°. Med x 1 c ĪĪ Percocet PO this shift. Dressing Δ'd. Will continue to monitor for Δ's. —— SPC [redacted] (b)(6)-2 /1WM6
0300	Pt IV to Ⓡ ac D/c'd by pt movement. New site started to Ⓡ hand, 20G c LR @ 75cc/hr, will continue to monitor. - SPC [redacted] /1WM (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
30Oct03 0900	cont. midline abd incision dta c sutures removed. multiple @chest stg II decubes c comfeel over site. LLE-thigh graft donor site c tegaderm over - CDI, LLE shin, lateral dta, graft site. some scabbing noted. dined @AC PIV, L8g intact. placed 28-29 Oct. 03. MIVF @ 75cc/hr. POC: IVMS turn Qhr, Adv diet as tolerated, hygiene, dsng IAW pain mgmt. VSS ——— CPT [redacted] (b)(6)-2
0930	Trach site cleansed c NS p normal sterile dsng. New 2x2's placed c Tegaderm covering site. Dated + labeled. ——— (b)(6)-2 CPT [redacted]
1200	Wound care: Samuel dsng Due @ 1030 this am. Granulated tissue developing. No foul odors. No new tunneling noted. Wound margins defnable. Cleansed c 1/4 Dakins solution, wet to dry dsng placed into wound, then tegaderm placed to seal the wound. No drainage noted from site. VSS. Pt received two tabs + 5mg MSO4 IVP given for pain. (b)(6)-2 CPT [redacted]
1600	Pt has had uneventful day - Turned q2 protocol. Ate very little Bfast, but had a snack + Ensure drink abt 0900/1000. Ate 50% lunch c snack @ 1600 of crackers and water. Dsng's Dsd: Yo Qs. VSS. Afebrile (b)(6)-2 CPT [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. ICU 2

[redacted]
(b)(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(Cont.) Restraint x1's skin integrity & circulation issues. Will monitor pt's status & provide emotional support. Will provide pain control meds. MDS (b)(6)-2 [redacted] MDS on
10/31/03 2135	Duoderm placed to (R) inner knee for stage I (b)(6)-2 pressure areas. Old Neg wounds Sealed. [redacted] MDS on
10/31/03 2148	Back of head pressure wound dsg d/c. Wet to dry dsg & 4x4 on top to len fluffs & loose stockinette. (b)(6)-2 [redacted] MDS on
1NOV03 @0515	Pt (+) BM (through anus), liquid & brown, similar to colostomy output. Pt turned Q2° throughout night. (b)(6)-2 Foley & good urine output. Will monitor [redacted] QS
1NOV03@1630	Assumed care of pt. @ 0600. V.S.S., A&O, W→D DRSNG Δ to stage IV decub. to sacrum, 7-8 cm wide, 4cm deep tunneling to (L) side of decub. 25% DAKINS solution, 75% NS to Kerlex Super Sponge, topped w Combine DRSNG. DRSNG Δ'd @ 0800 & 1600. Colostomy bag Δ'd & DRY DRESSING to midline abdominal incision Δ'd. Stoma approx. 2cm to (L) of midline incision. Stool was leaking into wound due to its close proximity to stoma & Q2° turning. MD informed. Staples & penrose drain to midline incision intact. Betadine swabs applied to incision site during DRSNG Δ @ 0800. Vaseline guage & DRY Gauge to old trach site intact. IVSL to (R) arm, flushes well. (+) BM per rectum this AM. Duoderm to hips & knees intact. Pt. in 2-point restraints. (-) signs of skin breakdown, ~~other assessments WNL~~ [redacted] 2-3+ edema to LE, bilat. Foot of

(b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
2030	PT TO BE TRANSFERED TO ICW #2. AWAITING M.D. ORDERS
31 OCT 03	@ THIS TIME. PT C VSS. NAD. WILL CONTINUE TO MONITOR [redacted] (b)(6)-2
2145	PT TO TRANSFER TO ICW 1. REPORT GIVEN TO MAJ RAIGE. PT VSS.
31 OCT 03	NAD. @ THIS TIME. PT WILL BE MOVED IN HOSPITAL BED PER MD
	ORDER [redacted] (b)(6)-2 UPON
31 Oct 03	Pt to ICW #1 from ICU #2 via Hospital Bed.
(b)(6)-2 [redacted]	VS T 99°(A), P 92 R 20 B/P 124/61, RA Sat 97%.
2100	A & O. Able to make needs known. MRRL. Resp
	Equal & regular. Abd - Abd soft. (2) flank colostomy
	& loose light brown stool. Same also anal. Diaper
	placed. Foley c large amount of dark tea colored
	urine. Skin warm. Moist. Stage III (2) wound x 2 c
	Duoderm to upper (R) & Left mid. Stage III (3) pressure
	ulcers c eschar and yellow drainage to back & Lead.
	Duoderm in place. Stage I (1) pressure area to (B)
	Lips. Duoderm intact. Stage IV (4) pressure ulcer
	to coccyx c moderate yellow drainage. 4x4 dsg c opsite
	intact. Old healed midline abd wound. IV to (R)
	hand HL & patent. (B) feet + 1 pitting edema.
	Trach site dsg D/S & vaseline gauze applied. Hygiene
	care done & pt placed on (2) side. Side rails T x 4.

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
31OCT03	- Received Pt in bed c O c/o pain or discomfort. Pt AAO
0630	x 3 thru transfer. Perrla 2+ Brisk. Pt has O ROM or sensation to ↓ Extremities. Pt does have Full ROM & O Pulse motor function to (R) hand. (R) hand Pt has ROM & Asst from (L) hand. Pt is able to grasp objects Bilateral. Bilateral rise + fall of chest c slight cough heard on Inspiration on (R) lower lobe. O Respiratory distress noted. Pt SpO2 is 92% on R/A. BS x 4 O Abdominal distension noted O Rebound tenderness. BSR 80's. Bilateral Pedal + Radial pulses present. Thready. Cap ref <3 sec Thready. Skin is warm to touch Lower extremities have +2 pedal Edema noted. Back of occipital head has stage 2 ulcer c DuoDerm in place. 2x2 upper of trach site CDI. MIDline abdominal incision site CDI c O S/S of infection. Stage 4 in Coccyx Area is CDI. Will reevaluate later in Shift. Pt has a small wound to left ankle open to Air. 20G IV in (R) hand c LR @ 75 cc/hr infusing, site is not infiltrated c O S/S of infection noted. Pt is currently resting in bed. Will care to maintain [redacted] (b)(6)-2
0632	-late entry Pt also has Foley to gravity Drain clear colored urine. Colostomy bag [redacted] (b)(6)-2 to O Flank drain red/Brown drainage. O drainage @ This time. Care to maintain. [redacted] (b)(6)-2

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.

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS**

DATE	NOTES (b)(2)-2
1 Nov 03	Transfer Summary [redacted]
	23 y/o GSW to (L) Back Exiting Right
	lower chest, x-lap 22 Sept right chest tube
	placed, lap found grade IV liver laceration
	Packed and Transferred to [redacted] Pack
	removed 24° later. Postop course remarkable (b)(2)-2
	for coma suggesting anoxic brain injury which
	cleared. Treated with G-tube and Trach which
	patient tolerated the demand ...
	Developed large Decubitus requiring wide
	debridement ... to sacrum. Diverting colostomy
	performed 29 October to help with wound
	care.
	Dx- S/P GSW Abd with grade IV liver lacerat
	T12 paraplegia
	Respiratory Failure - treated with G-tube and trach
	which resolved
	Sacral Decubitus ulcer requiring debridement to
	sacrum and diverting colostomy
	He is transferred to [redacted]

(b)(2)-2

(b)(6)-2

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

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

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

REGISTER NO. | WARD NO.

[redacted]

(b)(6)-4

PROGRESS NOTES
Medical Record

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MEDCOM - 18037

LAST NAME	ME	MIDL	ID NUMBER

DATE	NOTES
	Medication 1) Flagyl 500mg IV q8° for 7 day for colitis 2) Prenatal Vitamin QD 3) Heparin 5000 U SQ BID 4) Percocet PRN. Nursing - Rollpaters q 2° Wet to dry dress to Decubitus with 1/4% dakin's solution three times a day. Rule out bony lesion. (b)(6)-2 [redacted]

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LAST NAME	ST NAME	INI	ID NUMBER

DATE	NOTES
2 NOV. 0300915	Pt. A&O x 3, V.S.S. Assessment complete. W-70 to Stage IV decub A'd @ 0830. Pt. given ii Percocet for pain @ 0820, No Δ's from previous assessment. Pt. to be transfe to ICW 2. [redacted] (b)(6)-2 2CT, AN

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

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
CONT. FROM 1NOV @1630	bed elevated. Foley draining clear amber urine c foul odor. Pt. turned Q 2°. DRY DRSNG to stop of decub to occipital aspect of head. Pt. to be transferred to [redacted] (b)(2)-1 All other assessments WNL. (b)(6)-2 [redacted] 2LT, AN
2NOV03 @0700	assumed care of pt @ 1800. VSS - c/o pain to abd & back continuously, though relief noted c percocet. LS CTA, old trach stoma covered c vaseline gauze dsg, CDI; productive cough noted, IS encouraged. NL drsg c penrose drain, CDI. (L)LQ colostomy intact, brown liquid stool noted. Tol reg diet, but does c like food, encouraged to eat. (BIL) LE edema +2 noted, legs elevated c bed, +PP (BIL) equal. Foley draining amber, foul smelling urine; Sacral Stage IV decub c Dakins soaked dsg Δ beefy red granulating tissue noted. Stage I [redacted] (b)(6)-2 decub to (BIL) hips, (bil) inner knees. Occipital lobe Stage III decub c WTD dsg noted, Stretch cap on to secure dsg. Duoderm placed on hips/knees. Blanket roll b/w knees for support. Pt turned Q2° & positioned anatomically correct. Restraints removed. Pt EPW status Δ'd to CIV status. Plan: cont po, turn Q2°, monitor skin integrity, cont dsg Δs as ordered. Will monitor [redacted] CPT (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)*

EPW # [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