OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
2200	500 (SP)	500			
0100	200 (urethra)	700			
0500	600 SP	1300			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

OSTOMY STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 00 HOURS TO 00 HOURS | TOTAL HOURS COVERED 24 | DATE 15OCT03 / 16OCT03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0700	Juice	180	180
	H_2O	360	540
1000	H_2O	250	790
1200	Juice	180	970
1200	H_2O	200	1170
1400	H_2O	250	1420
1600	H_2O	250	1670
16OCT03 0530			

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
06 15OCT03	75cc/hr	LR	900	1800	900
1000	100	Cipro	100	1100	1000
1200	100	Tagamet	100	1300	1100
1800 15OCT03	75cc/hr	LR IVF	900	0500	900cc
2200 15OCT03	100cc	Cipro	100	2300	1000cc
2400 16OCT03	100cc	Tagamet	100	0100	1100cc
0500 16OCT03	100cc	Tagamet	100	0600	1200 cc

= IV Shift Total

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE.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

[redacted] (b)(6)-4

MEDCOM - 21042

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0800	500	500			
1300	450	950			
1600	470	1420			
2030	375	375			
2200	425	800			
0040	425	1225			
0530	900 →	(2125)			

(Residual) ~~CATH~~ Supra Pubic

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1300	30	30	0040	275	550
1600	15	45	0530	∅	(550cc)
2030	200	200	1329 shift total =		(550cc)
2200	75	275			

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
0700	Brown	Loose	150	150
1600	Brown	Loose	340	490
0040	Brown	Loose	100	100

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

[redacted] (b)(6)-4

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE 16 Oct 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1200 0600	400 H_2O	400	400
1800	juice	200	
1800	H_2O	200	800
2200	H_2O	100	900

BLOOD/BLOOD DERIVATIVES

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

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE *(Include Medications)*	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0600	75cc	LR, Cipro, Tagament		1800	900
1200	75cc	LR	950		
1800		Cipro, Tagam	300		2150

IRRIGATIONS *(N/G, Bladder, etc.)*

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] (b)(6)-4

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
0000	450	450			
0900	250	700			
1200	150	850			
2400	1000	1850	(SP)		
2200	100 void	1950			
05	200 SP	2150			
05	200 voided	(2350)			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL
1200	200	SP cath	200

GRAND TOTAL OUTPUT

REMARKS

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

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

INTAKE EQUIVALENTS *(Serving levels cc)*

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

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 06 HOURS TO 06 HOURS | TOTAL HOURS COVERED | DATE 17 OCT 03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
0600	Bottle water @ bedside	1.5L	
800	juice	180	1680
2100	H_2O	400	2080

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
0000		LR @ 150			

IRRIGATIONS (N/G, Bladder, etc.)

Suprapubic Cath

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
0100	Clear yellow Urine	400cc	400cc
1000	clamped suprapubic		
1345	Urinated ~~250cc~~ 100cc	100cc	residual

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1345	250cc				
1700	500	750cc			
2100	600	1350			
0400	300	1650			

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

OSTOMY — STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL
2100	brown	semi-solid	200	200

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM 0600 HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE 18 Oct

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE *(Include Medications)*	AMOUNT RECD	TIME COMPL	ACCUM TOTAL

IRRIGATIONS *(N/G, Bladder, etc.)*

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
	Suprapubic Cath		
06-1000	light yellow	600cc	

BLOOD/BLOOD DERIVATIVES

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

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

OUTPUT

URINE

VOID / RESIDUAL

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1000	200cc	200cc			
VOID@2000	200cc	→	2000	50cc	
VOID@0400	200	→	0400	<10cc	
VOID@0400	200	→	0400	<10cc	

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT

TIME	AMOUNT	TYPE	ACCUM TOTAL

GRAND TOTAL OUTPUT

REMARKS

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

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

INTAKE EQUIVALENTS *(Serving levels cc)*

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

DD FORM 792, JAN 74

Ward/Section: Emrg	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 4 oct 03	TIME 1938	SSN/PEEUDO SSN: [redacted] (b)(6)-4

======= PICCOLO =======
10/04/03 19:38
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] (b)(6)-2 DR #: 000
SERIAL #: [redacted]
(b)(6)-4

TEST	RESULT	REF. RANGE
ALB	3.3	3.3-5.5 G/DL
ALP	122*	26-84 U/L
ALT	31	10-47 U/L
AMY	152*	14-97 U/L
AST	35	11-38 U/L
TBIL	0.8	0.2-1.6 MG/DL
BUN	8	7-22 MG/DL
CA++	9.6	8.0-10.3 MG/DL
CHOL	115	100-200 MG/DL
CRE	0.8	0.6-1.2 MG/DL
GLU	99	73-118 MG/DL
TP	7.6	6.4-8.1 G/DL

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

TEST	RESULT	REF. RANGE
Na		3.5-5.5 g/dl
K		26-84 u/l
Cl		10-47 u/l
pH		14-97 u/l
PCO2		11-38 u/l
PO2		0.2-1.6 mg/dl
TCO2		7-22 mg/dl
HCO3		8.0-10.3 mg/dl
SO2		100-200 mg/dl
BEecf		0.6-1.2 mg/dl
AnGap		73-118 mg/dl
Ca		6.4-8.1 g/dl
BUN		73-118 mg/dl
Creat		7-22 mg/dl
Hct		0.6-1.2 mg/dl
Hgb		39-380 /l (M) 30-190 /l (F)
Tropoin-		128-145 mmol/l
Drug of Abuse		3.3-4.7 mmol/l
		98-108 mmol/l
	tCO2	18-33 mmol/l

(Piccolo) Chemistry 12

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}	136	128-145 mmol/l
K^{+}	4.0	3.3-4.7 mmol/l
Cl^{-}	99	98-108 mmol/l
tCO2	36	18-33 mmol/l

(Piccolo) Metabolic Panel

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
Na		3.5-5.5 g/dl
K		26-84 u/l
Cl		10-47 u/l
pH		14-97 u/l
PCO2		11-38 u/l
PO2		0.2-1.6 mg/dl
TCO2		7-22 mg/dl
HCO3		8.0-10.3 mg/dl
SO2		100-200 mg/dl
BEecf		0.6-1.2 mg/dl
AnGap		73-118 mg/dl
Ca		6.4-8.1 g/dl
BUN		73-118 mg/dl
Creat		7-22 mg/dl
Hct		0.6-1.2 mg/dl
Hgb		39-380 /l (M) 30-190 /l (F)
Tropoin-		128-145 mmol/l
Drug of Abuse		3.3-4.7 mmol/l
		98-108 mmol/l
	tCO2	18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 10-4-03	LAB ID NO.:

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

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fi(M) 81-99 fi(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	12.8	9.8-13.6 secs
APTT	31.8	21-34 SESS
D dimer		<20 ug/ml
FDP		< 10 ug /ml

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Cloudy	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.010	N/A
Bld	Small	Negative
pH	8.0	N/A
Prot	30	Negative
Urob	0.2	0.2-1.0
Nit	Pos	Negative
Leuk	Pos	Negative
HCG		Negative

CSF

Cell Count			
Directigen		Negative	

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

SSA - Small Bacteria Moderate
RBC - 10-15
WBC 20-30
Urine Culture Performed

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 10-4-03	LAB ID NO.:

MEDCOM - 21051

[redacted] (b)(2)-2

Microbiology Request Form

Last Name: EPW
First Name:
Patient # or SSN: [redacted] (b)(6)-4

Ward: EMT / ICWI
Room:
Bed:
Physician:

Collected by:
Date:
Time:

Source: Urine
Site: Clean Catch

[redacted]

Received by: SPC [redacted] (b)(6)-2
Date: 10-4-03
Time: 2000

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

Laboratory Results

Escherichia Coli
Pseudomonas aeruginosa

Reported
Date: 90ct03
Time: 0958
Tech: [redacted] (b)(6)-2
Reviewer: [redacted] (b)(6)-2

Number of attached sheets:

MEDCOM - 21052

Name: [redacted] (b)(2)-2
Patient ID: [redacted] (b)(6)-4 Specimen: [redacted] (b)(6)-4 Status: Final
Ward/Rm: W1/ Source: Urine Collected:
Ward of Iso: Attd. Phys:

1 Escherichia coli
2 Pseudomonas aeruginosa Status: Final Status: Final

1 E. coli

Drug	MIC	Interps
Amox/K Clav (c)	<=8/4	S
Amp/Sulbactam (c)	>16/8	R
Ampicillin	>16	R
Aztreonam	<=8	S
Cefazolin	16	I
Cefepime	<=8	S
Cefotaxime (c)	<=8	S
Cefotetan	<=16	S
Cefoxitin	<=8	S
Ceftazidime (a)	<=8	S
Ceftriaxone (c)	<=8	S
Cefuroxime (b)	<=4	S
Cephalothin	>16	R
Chloramphenicol	<=8	S
Ciprofloxacin	<=1	S
ESBL-a Scrn	<=4	
ESBL-b Scrn	<=1	
Gatifloxacin	<=2	S
Gentamicin	<=4	S
Imipenem (c)	<=4	S
Levofloxacin	<=2	S
Meropenem (c)	<=4	S
Moxifloxacin	<=2	S
Nitrofurantoin	<=32	
Norfloxacin	<=4	
Pip/Tazo (d)	<=16	S
Piperacillin (a)	>64	R
Tetracycline	>8	R
Ticar/K Clav (a)	64	I
Tobramycin	<=4	S
Trimeth/Sulfa	>2/38	R

2 P. aeruginosa

Drug	MIC	Interps
Amox/K Clav (c)	>16/8	
Amp/Sulbactam (c)	>16/8	
Ampicillin	>16	
Aztreonam	<=8	S
Cefazolin	>16	
Cefepime	<=8	S
Cefotaxime (c)	>32	R
Cefotetan	>32	
Cefoxitin	>16	
Ceftazidime (a)	>16	R
Ceftriaxone (c)	32	I
Cefuroxime (b)	>16	
Cephalothin	>16	
Chloramphenicol	>16	
Ciprofloxacin	<=1	S
ESBL-a Scrn	>4	
ESBL-b Scrn	>1	
Gentamicin	>8	R
Imipenem (c)	<=4	S
Levofloxacin	<=2	S
Meropenem (c)	<=4	S
Nitrofurantoin	>64	
Norfloxacin	<=4	
Pip/Tazo (d)	>64	R
Piperacillin (a)	>64	R
Tetracycline	>8	
Ticar/K Clav (a)	<=16	S
Tobramycin	>8	R
Trimeth/Sulfa	>2/38	

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
— = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints. For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name:
Patient ID: [redacted] (b)(6)-4 Specimen: [redacted] (b)(6)-4 Status: Final
Ward/Rm: W1/ Source: Urine Collected:
Ward of Iso: Req. Phys:

Printed 10/9/2003 9:44:06 AM

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

Ward/Section: ICU #	REQUESTING PHYSICAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted] (b)(6)-4	DATE 6 OCT	TIME 0912
		SSN/PEEUDO SSN: E[redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fi(M) 81-99 fi(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.030	N/A
Bld	Mod	Negative
pH	6.0	N/A
Prot	1+	Negative
Urob	0.2	0.2-1.0
Nit	pos	Negative
Leuk	Mod	Negative
HCG		Negative

CSF

Cell Count			
Directigen		Negative	

Coagulation Studies

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

SSA = 1+
25-30 WBC 1+ Bac
40-45 RBC 0-2 Hyline Casts/LPF

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

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

HEMATOLOGY

SPECIMEN/LAB RPT. NO.

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

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY MD TECH

DATE 60CT03

LAB. ID. NO.

REMARKS CBC

TEST(S)	SPECIMEN TAKEN DATE	TIME A.M. P.M.	REQUESTED	RESULTS	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 549-107
STANDARD FORM 549 (Rev. 7-78)
PRESCRIBED BY GSA/ICMR
FPMR (41-CFR) 201-45.505

ID: [redacted] (6)(6)-4
WD

06-10-03
03:55

			Patient Limits	
WBC	16.6 H	x10^3/uL	4.5	10.5
RBC	3.90 L	x10^6/uL	4.00	6.00
Hgb	11.3	g/dL	11.0	18.0
Hct	35.3	%	35.0	60.0
MCV	90.4	fL	80.0	99.9
MCH	29.1	pg	27.0	31.0
MCHC	32.2 L	g/dL	33.0	37.0
Plt	608. H	x10^3/uL	150.	450.
LY%	13.8 #L	%	20.5	51.1
LY#	2.3 *	x10^3/uL	1.2	3.4

(b)(6)-4

ID [redacted] 04-10-03
WB 19:37

				Patient Limits	
WBC	15.4	H	x10^3/uL	4.5	10.5
RBC	3.99	L	x10^6/uL	4.00	6.00
Hgb	11.3		g/dL	11.0	18.0
Hct	36.7		%	35.0	60.0
MCV	91.9		fL	80.0	99.9
MCH	28.3		pg	27.0	31.0
MCHC	30.7	L	g/dL	33.0	37.0
Plt	549.	H	x10^3/uL	150.	450.
LY%	20.0	*	%	20.5	51.1
LY#	3.1	*	x10^3/uL	1.2	3.4

======= PACOLO =======
10/06/03 04:21
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(6)-4.....

GLU	108	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.6	0.6-1.2	MG/DL
CK	30*	39-380	U/L
NA+	130	128-145	MMOL
K+	4.0	3.3-4.7	MMOL
CL-	94*	98-108	MMOL
tCO2	25	18-33	MMOL

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

(b)(6)-4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/06/03 09:20

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 13.1 sec.
RESULT NOT RANGE CHECKED
Ratio = 1.1
Calculated INR = 1.12
Sample Type:citrated wh. blood
Test Date :10/06/03
Test Time :09:19
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/07/03 05:06
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 11.4 sec.
RESULT OUT OF RANGE
Ratio = 0.9
Calculated INR = 0.90
Sample Type:citrated wh. blood
Test Date :10/07/03
Test Time :05:05
Card Lot [redacted] (b)(6)-2
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/06/03 09:24
(b)(6)-4
Patient ID [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 29.9 sec.
RESULT NOT RANGE CHECKED
Sample Type:citrated wh. blood
Test Date :10/06/03
Test Time :09:21
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/07/03 05:09
(b)(6)-4
Patient ID [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 49.8 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :10/07/03
Test Time :05:06
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

ID [redacted] (b)(6)-4 06-10-03
WB (b)(6)-4 09:15

				Patient Limits	
WBC	15.8	H	x10^3/uL	4.5	10.5
RBC	3.87	L	x10^6/uL	4.00	6.00
Hgb	11.0	L	g/dL	11.0	18.0
Hct	35.0		%	35.0	60.0
MCV	90.5		fL	80.0	99.9
MCH	28.4		pg	27.0	31.0
MCHC	31.4	L	g/dL	33.0	37.0
Plt	615.	H	x10^3/uL	150.	450.
LY%	15.5	*	%	20.5	51.1
LY#	2.4	*	x10^3/uL	1.2	3.4

(b)(6)-4

ID: [redacted] 07-10-03
WB [redacted] 05:06

				Patient Limits	
WBC	14.4	H	x10^3/uL	4.5	10.5
RBC	3.87	L	x10^6/uL	4.00	6.00
Hgb	11.0		g/dL	11.0	18.0
Hct	35.4		%	35.0	60.0
MCV	91.4		fL	80.0	99.9
MCH	28.5		pg	27.0	31.0
MCHC	31.2	L	g/dL	33.0	37.0
Plt	600.	H	x10^3/uL	150.	450.
LY%	16.9	*	%	20.5	51.1
LY#	2.4	*	x10^3/uL	1.2	3.4

(b)(6)-2

Ward/Section: ICU #1	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST,MI. [redacted] (b)(6)-4	DATE 30 OCT	TIME 0448	SSN/PEEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fi(M) 81-99 fi(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

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

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TE		
BI		
C		
C		
C		
C		
T		

======= PICCOLO =======
10/07/03 05:02
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: (b)(6)-4 [redacted]

GLU	117	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	24*	39-380	U/L
NA+	127*	128-145	MMOL
K+	4.2	3.3-4.7	MMOL
CL-	93*	98-108	MMOL
tCO2	24	18-33	MMOL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/dl
+		3.3-4.7 mmol/l
L^{-}		98-108 mmol/l
CO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:

RAPIDPOINT COAG ANALYZER V4.
SERIAL [redacted] 10/08/03 04:44
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 12.6 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR = 1.05
Sample Type:citrated wh. blood
Test Date :10/08/03
Test Time :04:42
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/08/03 04:47
(b)(6)-4
Patient ID [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 28.5 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :10/08/03
Test Time :04:44
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/09/03 05:39
(b)(6)-4
Patient ID [redacted] (b)(6)-4
Test Name :PT
Test Result:= 12.1 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR = 0.99
Sample Type:citrated wh. blood
Test Date :10/09/03
Test Time :05:37
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/09/03 05:41
(b)(6)-4
Patient ID [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 33.7 sec.
Sample Type:citrated wh. blood
Test Date :10/09/03
Test Time :05:39
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

[redacted] (b)(6)-4

WBC	12.1 h	x10^3/uL	4.5	10.5
RBC	4.01	x10^6/uL	4.00	6.00
Hgb	11.4	g/dL	11.0	18.0
Hct	36.7	%	35.0	60.0
MCV	91.4	fL	80.0	99.0
MCH	28.4	pg	27.0	31.0
MCHC	31.1 L	g/dL	33.0	37.0
Plt	596. H	x10^3/uL	150.	450.
Lym	20.5 *	%	20.5	51.1
Lym	2.5 *	x10^3/uL	1.2	3.4

[redacted] (b)(6)-4

WBC	11.2 h	x10^3/uL	4.5	10.5
RBC	3.82 L	x10^6/uL	4.00	6.00
Hgb	10.9 L	g/dL	11.0	18.0
Hct	34.8 L	%	35.0	60.0
MCV	91.1	fL	80.0	99.0
MCH	27.8	pg	27.0	31.0
MCHC	30.6 L	g/dL	33.0	37.0
Plt	571. H	x10^3/uL	150.	450.
Lym	35.4 *	%	20.5	51.1
Lym	3.9 *	x10^3/uL	1.2	3.4

[redacted] (b)(6)-4

WBC	[illegible]	x10^3/uL	4.5	10.5
RBC	[illegible] L	x10^6/uL	4.00	6.00
Hgb	[illegible] L	g/dL	11.0	18.0
Hct	[illegible] L	%	35.0	60.0
MCV	90.8	fL	80.0	99.0
MCH	[illegible]	pg	27.0	31.0
MCHC	[illegible] L	g/dL	33.0	37.0
Plt	[illegible] H	x10^3/uL	150.	450.
Lym	[illegible]	%	20.5	51.1
Lym	2.0 *	x10^3/uL	1.2	3.4

======= PICCOLO =======
08/10/03 04:29
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] (b)(6)-4

GLU	97	73-118	MG/DL
BUN	11	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	26*	39-380	U/L
NA+	[redacted]*	128-145	MMOL
K+	4.2	3.3-4.7	MMOL
CL-	94*	98-108	MMOL
tCO2	26	18-33	MMOL

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

[redacted] (b)(6)-4

WBC	[illegible]	x10^3/uL	4.5	10.5
RBC	[illegible]	x10^6/uL	4.00	6.00
Hgb	[illegible]	g/dL	11.0	18.0
Hct	[illegible]	%	35.0	60.0
MCV	[illegible]	fL	80.0	99.0
MCH	[illegible]	pg	27.0	31.0
MCHC	[illegible] L	g/dL	33.0	37.0
Plt	[illegible] H	x10^3/uL	150.	450.
Lym	[illegible]	%	20.5	51.1
Lym	2.0 *	x10^3/uL	1.2	3.4

(b)(6)-2

Ward/Section: ICU #1	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 80700	TIME 0430
SSN/PSEUDO SSN: [redacted] (b)(6)-4		

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fi(M) 81-99 fi(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section: ICWA#	REQUES[redacted]	**LABORATORY RESULT FORM** (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted] (b)(6)-4	DATE 9OCT03 / TIME @0130	S[redacted]O SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fl(M) 81-99 fl(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

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

Urinalysis

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 21061

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

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
AL		
AL		
AS		
TI		
BU		
C		
CL		
CR		
GL		
TP		
GL		
BU		
CR		
NA		
K		
CL		
tC		

PICCOLO
09/10/03 05:09
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3151AM
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
(b)(6)-4

GLU	107	73-118	MG/DL
BUN	10	7-22	MG/DL
CRE	1.3*	0.6-1.2	MG/DL
CK	20*	39-380	U/L
NA+	~~128*~~ B4	128-145	MMOL
K+	4.1	3.3-4.7	MMOL
CL-	92*	98-108	MMOL
tCO2	25	18-33	MMOL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
A++		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
A+		128-145 mmol/dl
+		3.3-4.7 mmol/l
-		98-108 mmol/l
O2		18-33 mmol/l

(Piccolo) Liver Panel Plus

ST	RESULT	REF. RANGE
B		3.3-5.5 g/dl
P		26-84 u/l
T		10-47 u/l
T		14-97 u/l
IY		11-38 u/l
IL		0.2-1.6 mg/dl
T		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

ST	RESULT	REF. RANGE
+		128-145 mmol/l
		3.3-4.7 mmol/l
-		98-108 mmol/l
2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: 12W1	REQUESTING PHYSICAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI [redacted] (b)(6)-4	DATE 100403 / TIME 0510	SSN/PEEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fl(M) 81-99 fl(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Coagulation Studies

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

Blood Bank (MUST SUBMIT SF 518 W REQ

UNIT	

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source

======= PICCOLO =======
10/10/03 05:50
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3151AA4
OPER #: [redacted] (b)(6)-2 DR #: 000
SERIAL #: [redacted] (b)(6)-4

GLU	102	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	16*	39-380	U/L
NA+	130	128-145	MMOL/L
K+	4.5	3.3-4.7	MMOL/L
CL-	95*	98-108	MMOL/L
tCO2	26	18-33	MMOL/L

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-4

Ward/Section: [redacted] ICU	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI [redacted] (b)(6)-4	DATE 100403 TIME 0510	SSN/PEEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

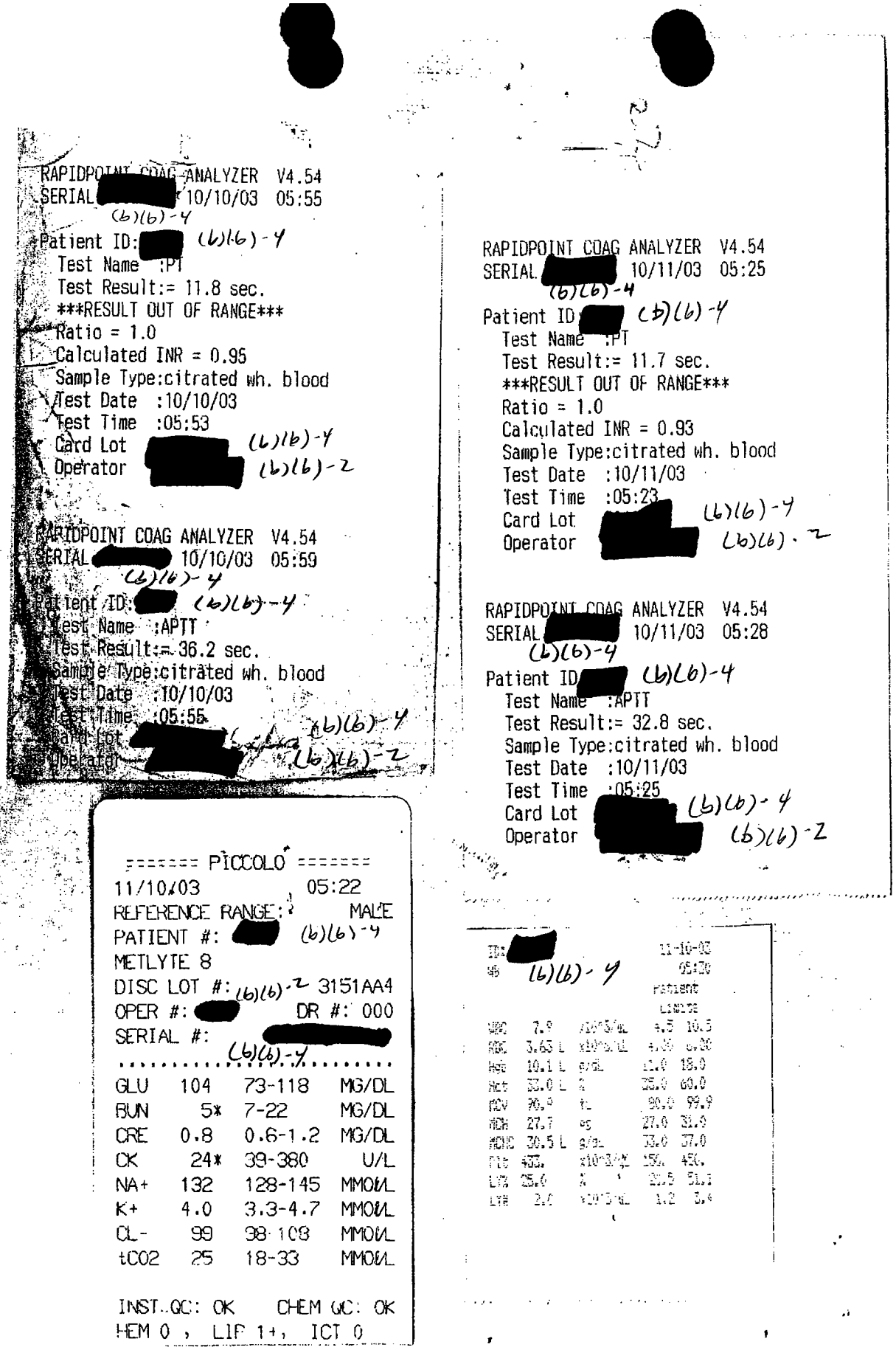
TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AST		14-97 u/l
AMY		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:



RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/10/03 05:55
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 11.8 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR = 0.95
Sample Type:citrated wh. blood
Test Date :10/10/03
Test Time :05:53
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/10/03 05:59
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 36.2 sec.
Sample Type:citrated wh. blood
Test Date :10/10/03
Test Time :05:55
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/11/03 05:25
(b)(6)-4
Patient ID [redacted] (b)(6)-4
Test Name :PT
Test Result:= 11.7 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR = 0.93
Sample Type:citrated wh. blood
Test Date :10/11/03
Test Time :05:23
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/11/03 05:28
(b)(6)-4
Patient ID [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 32.8 sec.
Sample Type:citrated wh. blood
Test Date :10/11/03
Test Time :05:25
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

======= PICCOLO =======
11/10/03 05:22
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted] (b)(6)-4

GLU	104	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	24*	39-380	U/L
NA+	132	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	99	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

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

ID# [redacted] 11-10-03
#6 (b)(6)-4 05:20
Patient
Limits

WBC	7.9	/10^3/uL	4.5	10.5
RBC	3.63 L	x10^6/uL	4.20	6.30
Hgb	10.1 L	g/dL	11.0	16.0
Hct	33.0 L	%	35.0	60.0
MCV	90.9	fL	90.0	99.9
MCH	27.7	pg	27.0	31.0
MCHC	30.5 L	g/dL	33.0	37.0
Plt	433.	x10^3/uL	150.	450.
Lym	25.0	%	20.5	51.3
Lym	2.0	x10^3/uL	1.2	3.4

Ward/Section: ICWI	REQUESTING PHYSICAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. #[redacted] (b)(6)-4	DATE 110403 TIME 0455	SSN/PEEUDO 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 x10	Color		N/A	RPR		Negative
RBC		4.7-6.1 x10	App		N/A	Mono		Negative
Hgb		14-18 g/dl(M) 12-16 g/dl(F)	Glu		Negative	**Microbiology**		
Hct		42-52%(M) 37-47%(F)	Bili		Negative	Source		
MCV		80-94 fi(M) 81-99 fi(F)	Ket		Negative	Gram Stain		
Plt		130-500 x10³ verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative

(Hematology) Manual Differential				pH		N/A	Micro Parasites	
Segs		Mono		Prot		Negative	Malaria	
Bands		Eos		Urob		0.2-1.0	O & P	
Lymph		Baso		Nit		Negative	Other	
Atyp		Imm		Leuk		Negative	**Macroscopic Urinalysis**	
RBC Morph.				HCG		Negative		

Spun Hematocrit		42-52%(M) 37-47%(F)	**CSF**			**Blood Bank**
Set 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 WITHE EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
APTT		21-34 SESS			
D dimer		<20 ug/ml			
FDP		< 10 ug /ml			

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

Ward/Section: 10W1	REQUESTING PHYSICAN:			CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI: #[redacted](6)(6)-4		DATE: 110403	TIME: 0955	SSN/PEEUDO SSN: #[redacted](6)(6)-4	

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section: ICU 1	REQUESTING PH: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, ML [redacted] (b)(6)-4		DATE 12 OCT	TIME 0400	SSN/PEER [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fi(M) 81-99 fi(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/12/03 03:43
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 12.3 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR = 1.01
Sample Type:citrated wh. blood
Test Date :10/12/03
Test Time :03:41
Card Lot [redacted] (b)(6)-4
Operator : [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/12/03 03:46
(b)(6)-4
Patient ID [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 35.1 sec.
Sample Type:citrated wh. blood
Test Date :10/12/03
Test Time :03:43
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

======= PICCOLO =======
12/10/03 03:38
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3151AA4
OPER # [redacted] DR #: 000
SERIAL #: [redacted]
(b)(6)-4

GLU	106	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	22*	39-380	U/L
NA+	135* 136	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	93*	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

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

(b)(6)-4

WBC	10.2	x10^3/uL	4.5 10.5
RBC	3.74 L	x10^6/uL	4.00 6.00
Hgb	10.4 L	g/dL	11.0 18.0
Hct	33.9 L	%	35.0 50.0
MCV	90.6	fL	80.0 99.0
MCH	27.7	pg	27.0 31.0
MCHC	30.6 L	g/dL	33.0 37.0
Plt	444.	x10^3/uL	150. 450.
Lym	28.0 *	%	20.5 51.1
Lym	2.8 *	x10^3/uL	1.2 3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/13/03 03:54
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 13.4 sec.
Ratio = 1.1
Calculated INR = 1.16
Sample Type:citrated wh. blood
Test Date :10/13/03
Test Time :03:53
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/13/03 03:57
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 33.5 sec.
Sample Type:citrated wh. blood
Test Date :10/13/03
Test Time :03:54
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

======= PICCOLO =======
13/10/03 03:52
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
(b)(6)-4

GLU	134*	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	20*	39-380	U/L
NA+	135 136	128-145	MMOL/L
K+	3.9	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	25	18-33	MMOL/L

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

[redacted] (b)(6)-4

(b)(6)-2

Ward/Section: ICW1	REQUESTING PHYS: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. #[redacted] (b)(6)-4	DATE 19OCT TIME 0400	SSN/PEERIDO SSN: #[redacted] (b)(6)-4

G-STAT

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
CI		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI.	DATE 10-13-03 TIME	SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

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

Piccolo Metabolic 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(b)(6)-2

Ward/Section: ICW 1	REQUESTIN[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted] (b)(6)-4	DATE 30 OCT 08	TIME 0400
		SSN/PE[redacted] (b)(6)-4

(Hematology) RBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10
RBC		4.7-6.1 x10
Hgb		14-18 g/dl(M) 12-16 g/dl(F)
Hct		42-52%(M) 37-47%(F)
MCV		80-94 fi(M) 81-99 fi(F)
Plt		130-500 x10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

[redacted] (b)(6)-4

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

l/Section:	REQUESTING PHYSICAN:	DATE 10-14-09 TIME	SSN/PEEUDO SSN:
T, FIRST,MI.			

[redacted]

ST	RESULT	REF. RANGE
BC		4.8-10.8 x10
C		4.7-6.1 x10
b		14-18 g/dl(M) 12-16 g/dl(F)
t		42-52%(M) 37-47%(F)
CV		80-94 fi(M) 81-99 fi(F)
lt		130-500 x10³ verified
ymph %		20.5-51.1%

[redacted]

Segs		Mono			
Bands		Eos			
Lymph		Baso			
Atyp		Imm			
RBC Morph					

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

[redacted]

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

REMARKS:

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

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

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

Ward/Section: ICU#1 | REQUESTING PHYSICAN: [redacted] | DATE: 14OCT03 | TIME: 0500 | SSN/PSEUDO SSN: [redacted] (b)(6)-4

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

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropo.in-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

[redacted]

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

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

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

/Section: ICU #1	REQUESTING PHYSICAN:	DATE / TIME	SSN/PEEUDO SSN:
, FIRST,MI. [redacted] (6)(6)-4		10/15/03	

(Hematology) CBC

ST	RESULT	REF. RANGE
BC		4.8-10.8 x10
C		4.7-6.1 x10
b		14-18 g/dl(M) 12-16 g/dl(F)
t		42-52%(M) 37-47%(F)
CV		80-94 fl(M) 8 -99 fl(F)
lt		130-500 x10³ verified
ymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

======= PICCOLO =======
14/10/03 05:56
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: [redacted] (b)(6)-2 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(6)-4.....

GLU	107	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	19*	39-380	U/L
NA+	129	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

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

======= PICCOLO =======
15/10/03 05:16
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(6)-4.....

GLU	95	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	28*	39-380	U/L
NA+	130	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	96*	98-108	MMOL/L
tCO2	21	18-33	MMOL/L

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

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/14/03 05:58
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 13.8 sec.
Ratio = 1.1
Calculated INR = 1.22
Sample Type:citrated wh. blood
Test Date :10/14/03
Test Time :05:56
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/14/03 06:02
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 37.5 sec.
Sample Type:citrated wh. blood
Test Date :10/14/03
Test Time :05:58
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/15/03 05:33
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 12.4 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR = 1.03
Sample Type:citrated wh. blood
Test Date :10/15/03
Test Time :05:31
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 10/15/03 05:36
(b)(6)-4
Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 36.3 sec.
Sample Type:citrated wh. blood
Test Date :10/15/03
Test Time :05:33
Card Lot [redacted] (b)(6)-4
Operator [redacted] (b)(6)-2

(b)(6)-4

ID: [redacted] 15-10-03
WB 05:12

			Patient Limits	
WBC	8.4	x10^3/uL	4.5	10.5
RBC	3.51 L	x10^6/uL	4.00	6.00
Hgb	10.0 L	g/dL	11.0	18.0
Hct	31.6 L	%	35.0	48.0
MCV	89.9	fL	80.0	99.9
MCH	28.5	pg	27.0	31.0
MCHC	31.7 L	g/dL	33.0	37.0
Plt	292.	x10^3/uL	150.	450.
LY%	29.3	%	20.5	51.1
LY#	2.4	x10^3/uL	1.2	3.4

(b)(6)-4
[redacted]

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

Ward/Section: ICU #1

REQUESTING PHYSICAN: [redacted] (b)(6)-2

DATE: 15OCT03 TIME: 0830

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

SSN/PEEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:

DATE:

LAB ID NO.:

EPW# [redacted] (6)(6)-4
ICW#1

[redacted]

HEMATOLOGY

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

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

SPECIMEN SOURCE: ☐ VEIN ☐ CAP ☐ OTHER (Specify)

SPECIMEN/LAB RPT. NO.

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

MD TECH

DATE 16 Oct 03 @0400

LAB. ID. NO.

REMARKS CBC

549-107

HEMATOLOGY

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

TEST(S)	SPECIMEN TAKEN: DATE	TIME	A.M. P.M.	(X)	RESULTS: REQUESTED	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	PROTHROMBIN: CONTROL	PROTHROMBIN: PATIENT	% ACTIVITY	RATIO	SICKLING TEST	LE PREP

(6)(6)-4

ID: [redacted]
WB: [redacted]

16-10-03
04:47

			Patient Limits	
WBC	10.3	x10^3/uL	4.5	10.5
RBC	3.67 L	x10^6/uL	4.00	6.00
Hgb	10.4 L	g/dL	11.0	18.0
Hct	32.9 L	%	35.0	60.0
MCV	89.6	fL	80.0	99.9
MCH	28.5	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	289.	x10^3/uL	150.	450.
LYZ	19.1 *L	%	20.5	51.1
LY#	2.0 *	x10^3/uL	1.2	3.4

RAPIDPOINT [redacted]
SERIAL [redacted] 10/16/03 04:51
(6)(6)-4
Patient ID: [redacted] (6)(6)-4
Test Name :PT
Test Result:= 11.6 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR = 0.92
Sample Type:citrated wh. blood
Test Date :10/16/03
Test Time :04:49
Card Lot [redacted] (6)(6)-4
Operator [redacted] (6)(6)-2

RAPIDPOINT [redacted] ANALYZER V4.54
SERIAL [redacted] 10/16/03 04:55
(6)(6)-4
Patient ID: [redacted] (6)(6)-4
Test Name :APTT
Test Result:= 18.5 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :10/16/03
Test Time :04:51
Card Lot [redacted] (6)(6)-4
Operator [redacted] (6)(6)-2

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

ICU#1

SPECIMEN/LAB RPT. NO

MISC

URGENCY
☑ ROUTINE
TODAY ☐
☐ PRE-OP
STAT ☐

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

SPECIMEN SOURCE (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY MD TECH

DATE 16Oct03 0400

LAB ID NO.

REMARKS PT/PTT

TESTIS)
SPECIMEN TAKEN
DATE
TIME A.M. P.M.
REQUESTED
RESULTS

MISCELLANEOUS
557-107

EPW#[redacted] (6)(6)-4
ICU#1

[redacted]

SPECIMEN/LAB. RPT. NO.

CHEM 1

URGENCY
☒ ROUTINE
TODAY ☐
PRE-OP ☐
STAT ☐

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

SPECIMEN SOURCE
☐ BLOOD
☐ OTHER (Specify)

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY MD TECH

DATE 16OCT03 @0400

LAB. ID. NO.

REMARKS CHEM 8

546-107

CHEMISTRY I
STANDARD FORM 546 (Rev. 8-77)
PRESCRIBED BY GSA ICMR
FIRMR (41 CFR) 201-45.505

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

= PICCOLO =

16/10/03 04:57
REFERENCE RANGE: MALE
PATIENT #: [redacted] (6)(6)-4
METLYTE 8
DISC LOT #: [redacted] (6)(6)-3152AA1
OPER #: [redacted] (6)(6) DR #: 000
SERIAL #: [redacted]
(6)(6)-4

GLU	98	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	30*	39-380	U/L
NA+	132	128-145	MMOL/L
K+	4.3	3.3-4.7	MMOL/L
CL-	98	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

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

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
CT [redacted] (b)(6)-2 /pelvis with/ oral/ IV contrast	25	M	[redacted]	ER	
	FILM NO. (b)(6)-4			PREGNANT ☐ YES ☒ NO	
	REQUESTED BY (Print) [redacted] (b)(6)-2			TELEPHONE/PAGE NO.	
	SIGNATURE OF REQUESTOR			DATE REQUESTED	

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

Slip Cpp Lap 9/22. Prolonged ileus r/o Abscess

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)
10/4		

RADIOLOGIC REPORT

[redacted] (b)(6)-2

6 x 3 x 4 cm (L) paracolic abscess right to (L) colon and lateral to colostomy site/Foley cath.

2) Suprapubic catheter.

3) contrast collection extends through anterior (R) pelvic wall – 2nd colostomy site / hernia/rupture.

4) (+) free air.

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

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name — last, first, middle, Medical Facility)*	LOCATION OF MEDICAL RECORDS
[redacted] (b)(6)-4	LOCATION OF RADIOLOGIC FACILITY
	SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

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

MEDCOM - 21081

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

Abd / Pelvis CT

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
			ICU 1	

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY (Print)

TELEPHONE/PAGE NO.

SIGNATURE OF REQUESTOR [redacted] (6)(6)-2

DATE REQUESTED

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

R/O Abscess

DATE OF EXAMINATION (Month, day, year)	DATE OF REPORT (Month, day, year)	DATE OF TRANSCRIPTION (Month, day, year)
10/16/07		

RADIOLOGIC REPORT

No evidence of abscess, free fluid/air as queried. Sig j air in bladder

No other sig S.

[redacted] (6)(6)-2

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

[redacted] (6)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

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

MEDCOM - 21082

NSN 7540-00-634-4165

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

Abscess Drainage Cath

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be

(Description of operation or procedure in layman's language)

CT guided Abscess drainage/use of local anesthetic
Risks include, bleeding, infection, organ injury, failure, drug reaction, add death.

which is to be performed by or under the direction of Dr. [redacted] (b)(6)-2

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: NKDA

(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

[redacted] (b)(6)-2

(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

[redacted] (b)(6)-2 [redacted] (b)(6)-4 6 OCT 03

(Signature of Members of operating team) *(Signature of Patient)* *(Date and Time)*

3. SPONSOR OR GUARDIAN: (When patient is a minor or una[redacted]sent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team) *(Signature of Sponsor/Legal Guardian)* *(Date and Time)*

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.

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Medical Record

STANDARD FORM 522 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR)

USAPPC V2.00

MEDCOM - 21083

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#4 | ROOM NO. | BED NO.

DATE OF ORDER: [illegible] | TIME OF ORDER: ______ HOURS | LIST TIME ORDER NOTED AND SIGN

1. Admit ICW
2. S/P GSW Abdomen 8/30
3. [illegible]
4. VS [illegible]
5. Incentive spirometer
6. [illegible] daily
7. TF [illegible] 30 cc/hr

PATIENT IDENTIFICATION

Noted [redacted] (b)(6)-2 500[illegible]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER ______ HOURS

8. Nutrition consult
9. ~~Regular diet (po)~~ NPO
10. CBC [illegible] q Am
11. Zantac 50 mg IV q [illegible] — [illegible] 300mg
12. ~~Percocet 1-2 q 4-6 prn pain~~
13. LR @ 75 cc/hr
14. NG [illegible] [redacted] (b)(6)-2

PATIENT IDENTIFICATION

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

15. Change out Foley
16. Cipro 400 mg [illegible] q12°
17. Wet to dry dressing to (L) hip (R) butt bid
18. Decubitus precautions
19. TLC care [redacted] (b)(6)-2

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

PATIENT IDENTIFICATION

500cc c 1[illegible] [redacted] (b)(6)-2

500 c 10[illegible] [redacted] (b)(6)-2

DATE OF ORDER | TIME OF ORDER ______ HOURS

MSO4 3-5 mg IVP q 2-3° prn pain

Versed 1 mg IVP q 2-3° prn [illegible]

Δ Zantac to Tagamet 300 mg IV [redacted] (b)(6)-2

NURSING UNIT | ROOM NO. 240 | BED NO. [illegible] [redacted] 1LT/AN 2230 (b)(6)-2

DA FORM 4256, 1 APR 79 — 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] (6)(6)-4

[redacted] (6)(6)-2

NURSING UNIT | ROOM NO.

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

1) No feeds.
2) Pt to CT for ABSCESS DRAINAGE procedure at 1250 on 6 OCT 03.

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

PATIENT IDENTIFICATION

[redacted] (6)(6)-2

DATE OF ORDER | TIME OF ORDER | HOURS

6 OCT 03
CBC
PT/PTT

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

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

6 OCT 1500
1) Abscess drain to gravity record 1 bag q 8 hours
VO DR. [redacted] (6)(6)-2

(6)(6)-2

(6)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

[redacted] (6)(6)-2

PATIENT IDENTIFICATION

[redacted] (6)(6)-2

DATE OF ORDER | TIME OF ORDER | HOURS

07 OCT 03 1210
D/C tube feeding
V.O. Dr [redacted] MD (6)(6)-2 (6)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

[redacted] (6)(6)-2

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

MEDCOM - 21085

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] (6)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW #	10	B

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
1900 — 8OCT03	HOURS	
(1) DC NGT		
(2) START JEVITY @ 30cc/hr per Reg		
(3) Clear liquid diet.		
V.O. DR [redacted] (6)(6)-2		(6)(6)-2
(6)(6)-2		
24 V 2145 8OCT03 [redacted] (6)(6)-2		

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

NURSING UNIT	ROOM NO.	BED NO.
[redacted]	[redacted]	[redacted]

DATE OF ORDER	TIME OF ORDER	
10/13	2030 HOURS	
(1) Reg diet		
[redacted] (6)(6)-2		
(6)(6)-2		
11 OCT @ 2200-1		

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

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
10/13	2030 HOURS	
(1) ~~CT to SXO~~		
V.O. DR [redacted] (6)(6)-2		
error		
(6)(6)-2		

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

NURSING UNIT	ROOM NO.	BED NO.
[redacted]	[redacted]	[redacted]

DATE OF ORDER	TIME OF ORDER	
10/5	0400 HOURS	
(1) Clamp suprapubic tube		
(2) After voiding, unclamp tube and record output from tube		
[redacted] (6)(6)-2		
[redacted] (6)(6)-2		

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

MEDCOM - 21086

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (6)(6)-4 Nurtec 10/17/03 (6)(6)-2	10/17	1115 HOURS	
	(1) Change Cipro to 500mg po bid		
	(2) ~~Change~~ D/C Tegaserod		
	(3) Reinstate 150mg po bid		
	(4) D/C Zofran		
NURSING UNIT: 24V/900 ROOM NO.: 1800CT03 BED NO.: [redacted] (6)(6)-2	(6)(6)-2 [redacted] (6)(6)-2 [redacted]		
PATIENT IDENTIFICATION Nurtec 19oct03 [redacted] (6)(6)-2	DATE OF ORDER 20 Oct 03	TIME OF ORDER 900 HOURS	
	(1) Please check residual from Suprapubic catheter after each void.		
NURSING UNIT: 24V ROOM NO.: 20 BED NO.: Oct 03 0340hrs	(6)(6)-2 [redacted]		
PATIENT IDENTIFICATION [redacted] (6)(6)-4 NOTED 22OCT03 0850 MG (6)(6)-2	DATE OF ORDER 22 Oct 03	TIME OF ORDER 0800 HOURS	
	(1) Start Tube feeding Jevity 40cc/hr		
	(6)(6)-2 [redacted] (6)(6)-2		
NURSING UNIT: 24V/0200 ROOM NO.: 2300CT03 BED NO.: (6)(6)-2 [redacted]	(6)(6)-2 [redacted]		
PATIENT IDENTIFICATION 24 V 0520 [redacted] (6)(6)-4	DATE OF ORDER 24 Oct 03	HOURS	2CP
NURSING UNIT: ROOM NO.: BED NO.:			

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

MEDCOM - 21087

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(6)(6)-2 [redacted]			1 NOV 03	(6)(2)-2 HOURS	
			21 Transfer to [redacted] with		
			arrangements made/completed		
			[redacted]	(6)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.			
24 [redacted]					
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
(6)(6)-2				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
				HOURS	
NURSING UNIT	ROOM NO.	BED NO.			

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

CLINICAL RECORD | **THERAPEUTIC DOCUMENTATION CARE PLAN** (NON-MEDICATION) | Mo. ____ Yr. 2003

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

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 4 5 6 7 8 9 10 11 12 13 14 15 16
(b)(6)-2 4	[redacted]	VS: routine	6	X [redacted]
			18	[redacted]
(b)(6)-2 4	[redacted]	Incentive spirometer	6	X [redacted]
			18	[redacted]
(b)(6)-2 4	[redacted]	Ambulate daily	6	X [redacted]
			18	[redacted]
[redacted]				
(b)(6)-2 4	[redacted]	NPO	6	X [redacted]
			18	[redacted]
(b)(6)-2 4	[redacted]	CBC & Chem8 QAM	04	[redacted]
(b)(6)-2	(P)	PTT Dr [redacted]	X	
(b)(6)-2 4	[redacted]	NG to LIS,	02	X X [redacted]
		irrigate 30cc	06	X [redacted]
		Q4°C water	10	X [redacted]
			14	X [redacted]
			18	X [redacted]
			22	X [redacted]
(b)(6)-2 4	[redacted]	Wet→dry dsg	10	X [redacted]
		to (L) hip, (R) butt	22	X [redacted]
		BID		X
(b)(6)-2 4	[redacted]	Decubitus prec	6	X [redacted]
			18	X [redacted]
(b)(6)-2 4	[redacted]	NIO: (R) Subclavian	10	/ / / / / / / / / / / / / [redacted]
		CL drsg Δ, sterile		X
		technique Q3D.		X
(b)(6)-2 6	[redacted]	Abdrain to gravity	06	/ / [redacted]
		Hosg Δ	18	/ / [redacted]

(b)(6)-

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW abdomen

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

(b)(6)-4 [redacted]

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(b)(6)-2 10/5	[redacted]	admit ICN, Stable				
(b)(6)-2 4	[redacted]	Nutrition consult	10/5			
(b)(6)-2 A	[redacted]	Change out Foley (3)	10/5			
(b)(6)-2 10/7 10/03	[redacted]	D/C tube feeding	10/7	—	1300	[redacted] (b)(6)-
(b)(6)-2 8	[redacted]	D/C NOT	done 1900			[redacted] (b)(6)-2
(b)(6)-2 15 10/8	[redacted]	Clamp suprapubic tube				
(b)(6)-2 15	[redacted]	After voiding, unclamp tube/record output from tube				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
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CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. ____ Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 8	9	10	11	12	13	14	15
8	[redacted]	Clear liquid diet	6	✓	[redacted]						
			18	KR							
8	[redacted]	Jevity @ 30cc/hr	6	✓	[redacted]						
		per feeding tube	18	KR						Held	
8	[redacted]	NIO: ✓ feeding tube	6	✓	[redacted]						
		residuals & chart	18	KR						Held	
		amt on I&O sheet	1								
		Q8°	1								
8	[redacted]	NIO: Δ TF ? TF line Q24°	20	[redacted]						Held	
11 OCT 03	[redacted]	Regular diet	06	/	/	/	[redacted]				
			18	/	/	/	[redacted]				
RECON OF 15 OCT 03	[redacted]	US Routine	06	—	—	—	—	—	✓	[redacted]	
			18	—	—	—	—	—	✓	✓	
		Incentive Sp Ironotor	06	X	✓				✓		
			18						✓		
		Ambulate Daily	06								
			18								
		CBC & Chem 8 QAM	04								
		PT/PTT	X								
		Wet → dry drsg	10	/	/	/	/	/	/	/	[redacted]
		to (L) hip (R) buttock BID	22	/	/	/	/	/	/	/	
		NIO @ Subclavian	10	/	/	/	/	/	/	X	X
		CL drsg & Δ, Sterile									
		technique Q3D									
		Decubitus precau.	06	/	/	/	/	/	/	/	
5 OCT 03	[redacted]		18	/	/	/	/	/	/	/	

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO	PRIMARY DIAGNOSIS: GSW abdomen	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 - 21091

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. 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 15 16 17 18 19 20 21 22 23 24 25 26 27 28
(6)(6)-2 recopied 15 OCT	[redacted]	Regular diet	06	[redacted]
			18	[redacted]
(6)(6)-2	[redacted]	Routine Vital Sign	06	[redacted]
			18	[redacted]
(6)(6)-2	[redacted]	Incentive Spirometer	06	[redacted]
			18	[redacted]
(6)(6)-2	[redacted]	Ambulate Daily	06	[redacted]
			18	[redacted]
(6)(6)-2	[redacted]	CBC, Chem 8, ~~PT/PTT~~	04	[redacted] → DC'd 1000 16 OCT
		PT/PTT @ Am		
(6)(6)-2	[redacted]	Wet → Dry dsg	10	[redacted]
		to (L) hip & (R) buttock	22	
		BID		
		[redacted]		
		[redacted]		
(6)(6)-2 recopied 15 OCT	[redacted]	Decubitus precau.	06	[redacted]
			18	[redacted]
(6)(6)-2 19 Oct	[redacted]	Vaseline gauze dsg	10	/ / [redacted] / / / /
		to LUQ stoma QOD.		/
(6)(6)-2 19 Oct	[redacted]	Please check residual	06	/ / / / [redacted]
		from suprapubic cath	18	/ / / / [redacted] → DC
		after each void		
(6)(6)-2 22 OCT	[redacted]	START TUBE FEEDING -	06 18	[redacted]
		JEVITY 40cc/hr	18 06	[redacted]

Z-(6)(6)

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to ABD

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

PATIENT IDENTIFICATION:

[redacted] (6)(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 - 21092

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo 10 Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
15 Oct	[redacted]	Clamp suprapubic tube	15 Oct	—	1015	[redacted]
15 Oct	[redacted]	P Voiding, unclamp tube &	15 Oct	—	1300	[redacted]
		record output from tube	✓	✓	✓	✓

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

USAPA V1.00

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

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 29	30	31	1	2
(b)(6)-2	[redacted]	1700 Regular diet	6	[redacted]				
CONDITION			18	[redacted]				
(b)(6)-2	[redacted]	Routine VS	6	[redacted]				
			18	[redacted]				
(b)(6)-2	[redacted]	IS	6	[redacted]				
			18	[redacted]				
(b)(6)-2	[redacted]	AMB daily	6	[redacted]				
			18	[redacted]				
(b)(6)-2	[redacted]	WTD drsg Δ to (D)hip	6	[redacted]				
		& (R) buttock BID	18	[redacted]				
(b)(6)-2	[redacted]	Decubitus precautions	6	[redacted]				
			18	[redacted]				
(b)(6)-2	[redacted]	N10: vaseline gauze drsg	10	/		/	[redacted]	/
		to LUQ stoma QOD	1					
(b)(6)-2	[redacted]	TF: Jevity @ 40cc/h	6	[redacted]				
			18	[redacted]				
(b)(6)-2	[redacted]	N10: √residuals qs	6	[redacted]				
		& document	18	[redacted]				

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P EX-LAP

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 - 21094

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
	----	Tx to [redacted] when arrangement made				
	----	(6)(2) - 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. ___ Yr. ___

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 2 3 4 5 6 7 8 9 10
(6)(6)-2 20Oct03	[redacted]	IVF DS ½NS C 20 KCL @ 125cc/hr	06	[redacted]
			18	
(6)(6)-2 20Oct03	[redacted]	Zantac 50mg IV q 8°	02	
			14	
			22	
(6)(6)-2 20Oct03	[redacted]	Erythromycin 500mg IV q8°		
(6)(6)-2 03Oct03	[redacted]	Reglan 10mg IV Q6°	06	[redacted]
			12	
			18	
			24	
(6)(6)-2 4Oct03	[redacted]	Erythromycin 200mg IV q8° 30 minutes before meals	06	
			12	
			18	
(6)(6)-2 20Oct03	[redacted]	Zantac 50mg IV q8°	08	
			16	
			24	

(6)(6)-2

Time change 4 Oct 03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: 1 S/P EXP/Lap adhesions Cond. Stable 1-tube placement

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ___

PATIENT IDENTIFICATION:

[redacted] (6)(6)-4

[redacted] (6)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 MEDCOM - 21096 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. ____ Yr. ____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
2 Oct	[redacted]	NS 1000ml bolus	2 Oct	2145	2200	[redacted]
3 Oct	[redacted]	NS 1000ml bolus	3 Oct	0945	1030	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED		
27 Sept	[redacted]	Reglan 10mg IV q 4-6° prn Nausea/Pain	Date	30 Oct	30 Oct
			Time	1600	1700
			Dose	10mg	10mg
			Initial		[redacted]
26 Sept	[redacted]	Phenergan 12.5-25mg IV q 6° prn nausea	Date		
			Time		
			Dose		
			Initial		
27 Sept	[redacted]	Morphine 2-8mg IV q 2° prn pain	Date	30 Oct	
			Time	1000	
			Dose		
			Initial		[redacted]

MEDCOM - 21097 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: 4 5 6 7 8 9 10 11 12 13 14 15
(b)(6)-2	4	[redacted]	Zantac 50mg IVP q8°	6 / 14 / 22	4: X / X / X; D/C
(b)(6)-2	4	[redacted]	LR @ 75cc/hr	6 / 18	4: X; [redacted]
(b)(6)-2	4	[redacted]	Cipro 400mg IV q12°	10 / 22	4: X / X; [redacted]
(b)(6)-2	5	[redacted]	Tagamet 300mg IVPB q6°	06 / 12 / 18 / 24	/ / / /; [redacted]
			PRN meds *		
(b)(6)-2	4	[redacted]	Percocet 1-2 q4-6 prn pain	D/T/I	9oct 0230; 9oct 2020; 9oct 0030; 9oct 2045; 10oct 1030; 10oct 1545; 10oct 2225; 11oct 2100; 12oct 0230; 13oct 0500; 13oct 1900; 14oct 0415; [redacted]
(b)(6)-2	5oct	[redacted]	MSO4 3-5mg IVP q 2-3° pain	D/T / D/I	5oct 1020 5mg; 6oct 1430 5mg; 6oct 2200 5mg; 7oct 0230 5mg; 8oct 2000 5mg; 8oct 0030 [illegible]; 9oct 0320 4mg; 9oct 1920 5mg; 10/9 1530 [illegible]; 10/9 1240 5mg; 11oct 2130 5mg; 11oct 1545 5mg; 11oct [illegible] 5mg; 11oct 1620 5mg; [redacted]
(b)(6)-2	5oct05	[redacted]	Versed 1mg IVP q2-3° PRN pain	D/T/I	D/C'd
(b)(6)-2	5oct	[redacted]	MSO4 3-5mg IVP q2-3° PRN	D/T / D/I	12oct 0900 5mg; 12oct 1830 5mg; 13oct 1230 5mg; 14oct 0415 4mg; [redacted]

Rewritten 15 Oct 03 [redacted] (b)(6)-2

ALLERGIES: [ ] YES [ ] NO

PRIMARY DIAGNOSIS: GSW abdomen

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

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. Ø Yr. Ø3

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 15 16 17 18 19 20 21 22 23 24 25 26 27 28
(b)(6)-2 recopied 15OCT03	[redacted]	LR @ 75cc/hr	06	[redacted] D/Ced 17 Oct 03
			18	[redacted]
(b)(6)-2 recopied 15 Oct 03	[redacted]	Cipro 400mg IV	10	[redacted] d/ced 17 Oct 03
		Q 12° (started 4 Oct 03)	22	[redacted]
(b)(6)-2 recopied 15Oct	[redacted]	Tagament 300mg	06	[redacted]
		IVPB Q6°	12	[redacted] d/ced 17 Oct 03
			18	[redacted]
			24	[redacted]
(b)(6)-2 17Oct	[redacted]	Cipro 500 mg P.O	10	✓ ✓ [redacted]
		BID	22	✓ ✓ [redacted]
(b)(6)-2 17Oct	[redacted]	Zantac 150 mg	10	✓ ✓ [redacted]
		P.O BID	22	✓ ✓ [redacted]

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to ABD

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

" 23 24 01 02 03 04 05 06

MEDCOM - 21099

DA FORM 4870 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 10 Yr. 03			
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													
4	[redacted]	Percocet 1-2 q 4-6° PRN PAIN	14Oct 1330	14Oct 1830	14Oct 2300	15Oct 0500	15Oct 0900	15Oct 2045	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
5 Oct		MSO4 3-5mg IVP q 2-3° PRN	14Oct 1200													
4	[redacted]	Percocet 1-2 po q 4-6° PRN	D/T 19Oct 1700	20Oct 0800	20Oct 1436	20Oct 1950	21Oct 0145	21Oct 2000	22Oct 0125	22Oct 1355	23Oct 0815	23Oct 1430	23 2000	24 0000	24Oct 1945	
			D/1													
4	[redacted]	Percocet 1-2 po q 4-6° PRN	D/T 25Oct 1230	26Oct 2020	26Oct 0400	26Oct 2000	27Oct 0745	27Oct 1542	28Oct 2200	28Oct 2115	29Oct 0230					
			D/1													

(6)(6)-2

*U.S. GPO: 1998-454-110/95216

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 29 30 31 1 2
(b)(6)-2 17OCT	[redacted]	Cipro 500mg po BID	10	[redacted]
	-----		22	[redacted]
(b)(6)-2 17OCT	[redacted]	Zantac 150mg po BID	10	[redacted]
	-----		22	[redacted]

(b)(6)-2

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P EX-LAP

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 1 FEB 79 4678 EDITION OF MEDCOM - 21101 EXHAUSTED.

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED															
(b)(6)-2 5OCT	[redacted]	MSO4 35mg IVP Q2-3H PRN	D/T															
		PRN																
4OCT	[redacted]	PERCOCET 1-2 PO Q4-6° PRN	D/T	29OCT 0830 [redacted]	30OCT 0900 [redacted]	2OCT 1600	3OCT 1930	1NOV 2015										

(b)(6)-2

*U.S. GPO: 1998-454-110/95216

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						2. ...F LOCATION		
1	2	3	4	5	6	7	8	(State or Country Code.)
A								

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

6. DATE OF BIRTH (YYYYMMDD)								7. AGE AT ADMISSION			8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	
								2	4	Y			

10. LENGTH OF SERVICE			ETS	11. FMP		12. SOCIAL SECURITY NUMBER								
32	33	34		35	36	37	38	39	40	41	42	43	44	45
						[redacted]								

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46		(b)(6)-4

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

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

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

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

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (YYYYMMDD)							
89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106
										2	0	0	3	1	0	0	4

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

FOR LOCAL USE

Dx: V5843 5695

Pr: 5459 8962 4503 966 8801

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK

Admission and Coding Information

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

1. Reporting MTF	2. [illegible]	
0580 [redacted]	(b)(2)-Z IZ	

3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
(b)(6)-4 [redacted]	[redacted] (b)(6)-4	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
[redacted]	24Y	X	9	UNKNOWN

10. Length of Service	ETS	11. FMP	12. Social Security Number	
		99	[redacted] (b)(6)-4	

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
	Z	19:00	ARMY

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
	K78-PRISONER OF WAR/INTERNEES	

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
IZ		BC	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICW1	Address of Emergency Addressee
Name and Location of Medical Treatment Facility: 0580 - 28th CSH - Iraq; No Install Provided		Telephone Number of Emergency Addressee

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF-OTH		2003-11-02

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
ABA - GENERAL SURGERY		2003-10-04

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
IZ		2003-10-04

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW ABDOMEN

Procedure Narrative(s):

Cause of Injury Narrative:

Admitting O[redacted]quired)	Signature of Admitting Clerk
[redacted] (b)(6)-Z	[redacted] (b)(6)-Z

Automated Facsimile - DA FORM 2985, MAR 2000

MEDCOM - 21104

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted]	[redacted] (b)(6)-4					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	40Y		UNKNOWN			NO	
11. FMP	12. SSN	13. Organization				14. Ward	
99	[redacted]	(b)(6)-4				ICW1	
15. FlyStatus	17. Dept / Ben		18. BranchCorps	19. UIC / ZIP		20. Type Case	
N/A	K78-PRISONER OF WAR/INTER					BC	
21. Source of Admission		22. Hour Of Adm:	23. Clinic Service				
Direct from ER		02:05	ABA - GENERAL SURGERY				
24. Name/Relation of Emergency Addressee		25. Type Disp	26. Date of Disp				
		TRF C-ACF	2003-10-08				
27a. Address of Emergency Addressee		27b. Telephone No	28. Date This Adm:	AdmittingOfficer:			
			2003-10-05	[redacted] (b)(6)-2			
29. ReportingMTF			30. Date Init Adm	32. Units Blood Components			
0580 [redacted] - Iraq (b)(2)-2			2003-10-05				

31. Selected Administrative Data

Marital Status: Z DoB: [redacted]

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW SHOULDER

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
Ø	Ø	Ø	Ø	4	4

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
Ø	Ø	Ø	Ø	4	4

(b)(6)-2

Sig[redacted]ding Medical Officer (b)(6)-2

Signature of PAD or Medical Records Officer

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

MEDCOM - 21105

Automated Facsimile - DA FORM 3647, May 79

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

? 20yo Iraqi male s/p GSW (R) shoulder.
unknown circumstances.
No Ψ.

Denies φ PSHx φ [illegible] [illegible]

PHYSICAL EXAMINATION

AFVSS
NAD
Heart [illegible]
Chest CTA clear
Abd benign
Ext - (R) shoulder graze wound. small wound entry.
does not appear to communicate c joint

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

A/ Superficial graze wound (R) shld

P/ Irrigate clean & cover
[illegible]

(b)(6)-2

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	05		

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

[redacted] (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

MEDCOM - 21106

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5oct03@0450	pt Admitted to (CW) via W/C in stable condition; A&O x3 speaking arabic & little English, ⊕CMS, NV intact throughout; brisk cap Ref, ⊕pulses x4; SS2, LS CTA(B); ⊕BSx2, abd soft ⊖TTP; pt voiding clear, yellow urine per urinal; dsg to (R) shoulder, GSW through & through CDI, 4x4 in place; PIV to (R) AC patent & ⊖S/Sx infection/infiltration; cont to monitor (b)(6)-2 [redacted]
5oct03	0813 - assumed care of pt. @0000 Assessment completed. VSS - A+O speaking arabic. PERRLA - LS CTA(B), HR normal sinus SIS2 present, BESP even, unlabored, abd soft - nontender, voiding per urinal, restraints in place & ⊖ skin breakdown (+) circulation. TU (R) FA CDI & ⊖ S/Sx inf/infiltration. Pt. tol PO well. GSW to (R) shoulder. Dsng CDI. Will cont. to monitor pt. (b)(6)-2 [redacted]
1430	~~took pt. to x-ray via wheelchair. Pt. tolerated well. Dressing change to (L) AC per MD. Pt. resting well at this time. Will cont. to monitor pt.~~ (b)(6)-7 [redacted]
(1955)	Pt A&O, VSS, LCTAB, HRRR, ⊕BSx4 qda. Unlabored & unlabored. GSW to (R) shoulder & dsg CDI. Voiding cyu via urinal, ⊘ complaint

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 - 21107

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
(1955)	of pain or discomfort @ time. HL to (L)
Ø5OCTØ3	ARM (AC) flushing easily ⊖ redness or
	edema noted. 2 pt restraints on s̄ comp-
	romise to circulation/skin. ancas cont (b)(6)-2
	per orders. Will monitor [redacted]
0500	Ø c/o pain all shift, drsg c̄ scant bloody
	show (b)(6)-2 [redacted]
6Oct03	0900 - USS-AD Assumed care of pt @
	0600. Assessment completed. PERRLA,
	LS CTA (B), HR NSR, respirations even, unlabored
	abd. soft, nontender BS x4. GSW (R)
	shoulder. Drsng Δ completed c̄ min
	drainage. Sutures intact. Pt. ambulated
	in hallway x 15 mins + conducted
	personal hygiene. HL IV (L) FA. CDI
	flushes well. Pt resting well @ this (b)(6)-2
	time. Will cont. to monitor pt. [redacted]
6Oct03	I concur c̄ above assessment. Will continue
1000	monitoring pt. throughout shift [redacted]
6Oct03	1725 - Pt. tolerates PO well. Pt (b)(6)-2
	up in bed @ this time. Ø c/o (b)(6)-2
	pain. Will cont. to monitor [redacted]
(1915)	Pt a/o, VSS, Ø c/o pain, LCTAB, ⊕BS, HRRR, drsg to
	(R) shoulder CDI, sutures intact. HL (L) FA
	flushing well. Abx given as ordered. 2 pt
	restraints on s̄ compromise to skin or
	circulation. Will monitor [redacted]
	(b)(6)-2

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

MEDCOM - 21108

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7 Oct 03 1240	Assumed care @ 0600. VSS. A&O. Speaks arabic but responds appropriately to english. HRRR. Ø resp. issues. Ø Abd issues. Voiding clear yellow urine per urinal. MAE. Skin warm & dry. (R) shoulder dsg CDI. Sutures intact. Wound healing well. (L) FA IV flushed & patent. Pt denies pain. AM Care done. Will continue to monitor 2 pt restraint & skin/circulation compromise. (6)(6)-2 MA
(2010)	Rt a10, VSS, Ø complaints of pain or discomfort. ~~Resp distress~~. Resp even & unlabored, ⊕ BS x4, HRRR, getting OOB often to void. dsg to (R) shoulder CDI. Sutures intact. (L) hand flushed. 2 pt restraints on = compromise to skin/circulation will monitor [redacted] 91WM6
8 Oct 03 dsg CDI	Pt A+Ox3, VSS Pt has Ø pain or discomfort (6)(6)-2 at this time, right shoulder wound sealed with sutures and looks pinkish in color, healing well, HRRR Ø resp issues, HL dfcd, restraints x2 in place, Ø complaints awaiting d/c to Iraqi Hospital (6)(6)-2 [redacted]
	(1330) I concur w above. Pt d/c to Iraqi hospital —

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)*

(6)(6)-4 (6)(6)-4

[redacted]

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

AST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08OCT03	(cont.) ambulatory - in stable condition. [redacted] (6)(6)-2

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

[redacted] (b)(6)-2

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FACILITY [redacted] (b)(2)-2

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

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

CITY [redacted] | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* 05OCT03 | TIME 0200

TRANSPORTATION TO FACILITY AIR eVAC

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

CURRENT MEDICATIONS: Q

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 (R) shoulder

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT (b)(6)-2

TIME: 0200

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

VITAL SIGNS

TIME	0200			
BP	144/73			
PULSE	64			
RESP	12			
TEMP	97			
WT	52 kg			

LAB ORDERS

CBC/[redacted]	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH	CHEM: [redacted] (b)(6)-2	
BLOOD C&S X		Lytes	

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 100 (b)(6)-2 ☐ MONITOR (b)(6)-2 ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0210	IV RUS - 1000 cc	[redacted]	[redacted] (b)(6)-2	0210	
0210	Tetanus	(b)(6)-2	(b)(6)-2	0244	
0245	1gm Ancef			0245	

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)

[redacted] (b)(6)-4

[redacted] (b)(6)-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-86)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 21111

NSN 7540-01-075-3786

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

TEST RESULTS

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

PROVIDER HISTORY/PHYSICAL

See H&P

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

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

[redacted]

(6)(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 558 (REV. 9-98)
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
10/4/03			Narrative Summary
			Admitted c GSW
			D/C 10/8
			Diagnosis GSW shoulder
			Hosp Course Pt to OR c GSW shoulder
			wound cleaned in OR, closed. Pt
			tolerated well. D/C to Iraqi hosp ADT #3
			[illegible]
			Dispo Iraqi hosp
			[redacted] (b)(6)-2
			[redacted] (b)(6)-2

(Continue on reverse side)

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

[redacted] (b)(6)-4

[redacted]

NURSING NOTES
Medical Record

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

MEDCOM - 21113

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR: Oct 03 | DAY: 5 / 6 / 7 Oct 1995

19 | HOUR

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

135/70 | 120/64 | 99/62 | 104/62 | 112/66 | 107/56

P 57 | T 96.9 | 97 | 98% | 98%

99%RA | 99% RA | 98% RA | 99% RA | RA

O2 Source

108/71

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

[redacted] (b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 21114

(b)(6)-2

Ward/Section: EMT	REQUESTING PHYSICAN: DOC [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted] (b)(6)-4	DATE 05OCT03	TIME 0200	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology/CBC)

TEST	RESULT	REF. RANGE
WBC	ID: [redacted] (b)(6)-4	05-10-03 02:22
RBC	WB	Patient Limits
Hgb	WBC 16.7 H	x10^3/uL 4.5 10.5
Hct	RBC 5.48	x10^6/uL 4.00 6.00
MCV	Hgb 15.6	g/dL 11.0 18.0
Plt	Hct 49.3	% 35.0 60.0
Lymph %	MCV 89.9	fL 80.0 99.9
(Hemat	MCH 28.4	pg 27.0 31.0
	MCHC 31.6 L	g/dL 33.0 37.0
	Plt 361.	x10^3/uL 150. 450.
	LY% 9.0 *L	% 20.5 51.1
	LY# 1.5 *	x10^3/uL 1.2 3.4

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Coagulation Studies

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 21115

Ward/Section: EMT	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI: [redacted] (b)(6)-4	DATE: 05OCT03 TIME: 0200	SSN/PEEUDO SSN: (b)(6)-4 [redacted]

i-STAT			(Piccolo) Chemistry 12			(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Na								3-118 mg/dl
K								-22 mg/dl
Cl								.0-10.3 mg/dl
pH								.6-1.2 mg/dl
PCO2								28-145 mmol/dl
PO2								.3-4.7 mmol/l
TCO2								98-108 mmol/l
HCO3								18-33 mmol/l
SO2								pel Plus
BEecf								EF. RANGE
AnGap								3.3-5.5 g/dl
Ca								26-84 u/l
BUN								10-47 u/l
GLU			olo) Metly					14-97 u/l
Creat			ESULT					11-38 u/l
Hct								0.2-1.6 mg/dl
Hgb								5-65 u/l
Mis								5.4-8.1 g/dl
TEST	RI							blyte
Tropoin-1								EF. RANGE
Drug of Abuse								8-145 mmol/l
								-4.7 mmol/l
								-108 mmol/l
						tCO2		18-33 mmol/l

======= PICCOLO =======
10/05/03 02:25
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: (b)(6)-2 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(6)-4.....

GLU	126*	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	298	39-380	U/L
NA+	134	128-145	MMOL/L
K+	4.7	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	19	18-33	MMOL/L

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

======= PICCOLO =======
05/10/03 02:24
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: (b)(6)-2 3204AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(6)-4.....

ALB	4.3	3.3-5.5	G/DL
ALP	59	26-84	U/L
ALT	22	10-47	U/L
AMY	32	14-97	U/L
AST	34	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
BUN	7	7-22	MG/DL
CA++	9.4	8.0-10.3	MG/DL
CHOL	145	100-200	MG/DL
CRE	0.9	0.6-1.2	MG/DL
GLU	127*	73-118	MG/DL
TP	7.6	6.4-8.1	G/DL

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

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

Noted [redacted] 0830 0855

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER c8/4 | TIME OF ORDER 0820 HOURS | LIST TIME ORDER NOTED AND SIGN

(C) D/C today to Iraqi Hosp w/ meds

[redacted] (b)(6)-2

[redacted] (b)(6)-2

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION | DATE OF ORDER | TIME OF ORDER ______ HOURS

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 21117

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

Noted [redacted]

(b)(6)-2

	DATE OF ORDER / TIME OF ORDER ______ HOURS	LIST TIME ORDER NOTED AND SIGN
	c/J	
1	Admit ICW	
2	s/p GSW shoulder	
3	VS routine	
4	Ad lib activity	
5	Ancef 1g iv q8 x 6 doses	
6	Reg diet	
7	Percocet 1-2 tabs q4-6 prn [redacted]	(b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.
ICW	24° ✓ 5Oct03 @0510	[redacted]

(b)(6)-2

PATIENT IDENTIFICATION

	DATE OF ORDER / TIME OF ORDER ______ HOURS	

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

	DATE OF ORDER / TIME OF ORDER ______ HOURS	

NURSING UNIT	ROOM NO.	BED NO.

PATIENT IDENTIFICATION

	DATE OF ORDER / TIME OF ORDER ______ HOURS	

NURSING UNIT	ROOM NO.	BED NO.

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

MEDCOM - 21118

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

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	8
5	[redacted]	VS routine	6	[redacted]			
			10	[redacted]			
5	[redacted]	ACT: ad lib	6	[redacted]			
			18	[redacted]			
5	[redacted]	Regular	6	[redacted]			
			18	[redacted]			

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW shoulder

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

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 10 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
[redacted]	[redacted]	D/C today to Iraqi hosp. -0 meds				
	----	(b)(6)-2				

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

MEDCOM - 21120

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 5 6 7
5	[redacted]	Ancef + gm	8	[redacted]
(b)(6)-2		IVPB Q8°	16	[redacted] with Dicel
		x 6 doses	24	[redacted]
(b)(6)-2		PRN meds		
5	[redacted]	Percocet 1-2 tabs D/T		
		4-6° PRN		

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO | PRIMARY DIAGNOSIS: GSW x 1 multiple

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Admission and Coding Information

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

1. Reporting MTF	2. MTF Loc	
0580 - [redacted] (b)(2)-2	IZ	

3. Register Number	Name (Last, First, MI)	4. Pay Grade	5. Sex
[redacted] (b)(6)-4	[redacted] (b)(6)-4	FGN	M

6. DoB (YYYYMMDD)	7. Age at Admission	8. Race	9. Ethnicity	Religion
[redacted]	40Y			UNKNOWN

10. Length of Service	ETS	11. FMP	12. Social Security Number
		99	[redacted] (b)(6)-4

Organization (Active Duty Only)	13. Marital Status	Hour of Admission	Branch / Corps:
	Z	02:05	

14. Flying Status	15. Beneficiary Category	16. Zip Code of Residence:
N/A	K78-PRISONER OF WAR/INTERNEES	

17. Unit Location	18. MOS	19. Trauma	Prev. Admission
IZ		BC	NO

20. Source of Admission	Ward:	Name / Relationship of Emergency Addressee
Direct from ER	ICW1	Address of Emergency Addressee

Name and Location of Medical Treatment Facility:	Telephone Number of Emergency Addressee
0580[redacted] Iraq; No Install Provided (b)(2)-2	

21. Type of Disposition	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD)
TRF C-ACF		2003-10-08

24. Clinic Svc - Admitting	25. MTF Transferred From	26. Date this Admission (YYYYMMDD)
ABA - GENERAL SURGERY		2003-10-05

27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission
		2003-10-05

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW SHOULDER

Procedure Narrative(s): T: 1 Dx: 88000 E9912 Inj: 450

Cause of Injury Narrative: 86.59

Adm[redacted] Signature, as required)	Signature of Admitting Clerk
[redacted] (b)(6)-2	[redacted] (b)(6)-2 SPC, 91G68

(b)(6)-4

TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted]	[redacted] (b)(6)-4					FGN	
4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm	
M	18Y	X	ISLAMIC			NO	
11. FMP	12. SSN	13. Organization				14. Ward	
~~99~~ 20	[redacted]	(b)(6)-4				ICW1	
15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case			
	K78-PRISONER OF WAR/INTER			DIS			
21. Source of Admission	22. Hour Of Adm:	23. Clinic Service					
Direct from ER	17:36	ABA - GENERAL SURGERY					
24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp					
	TRF-OTH	2003-10-26					
27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:				
		2003-10-18	[redacted] (b)(6)-2				
29. ReportingMTF		30. Date Init Adm	32. Units Blood Components				
0580 [redacted] Iraq (b)(2)-2		~~2003-10-05~~					

31. Selected Administrative Data

Marital Status: Z

In/Out Patient: Inpatient

DoB: [redacted]

MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

R FEMUR FX

[illegible]

35. Total Days This Facility					
Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	17	17

35. Total Days This Facility					
Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	17	17

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

Automated Facsimile - DA FORM 3647, May 79

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

MEDCOM - 21123

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

18yo Iraqi male sustained gsw to (R) lat femur
injury by US soldier.
Developmentally delayed.
Ex fix-splint
allergies ?
Meds ?
PMH ?

PHYSICAL EXAMINATION

AAOx3
NCAT PERRLA
clear CTA
CV RRR
ext - (R) femur fx
(R) 2+DP 2+PT pulses

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

To OR for Ex fix
admit to ortho

(6)(6) - 2

SIGNATURE OF PHYSICIAN [redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION
PATIENT'S IDENTIFICATION [redacted] *(For typ... middle; grad... ...ries give Name last, first, ...pital 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

MEDCOM - 21124

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18 Oct 03 1730	Assumed care of Pt @ 1640 From EMT. Received via Gurney. Pt has Open wound on (b)(6)-2 [redacted] ~~R~~ ~~thigh~~ (R) Anterior thigh. Wound cleaned ē ½ NS ŧ Hydrogen Peroxide. Then Packed ē wet dressing. Pt recieving 2U of O⊕ Blood. VSS. No S/Sx of reaction.
(b)(6)-2	Will continue to monitor. [redacted] Spec 91WM6
(1830)	I concur ē above assessment. Pt premedicated ē po Benedryl / Tylenol prior to start of blood transfusion. ⊕ adv. rxn noted. VSS. See SF 511. Report given to oncoming shift. (b)(6)-2 [redacted]
[redacted]	assumed care @ 1800. Pt sleeping but arousable. Pt recieving 1st unit of O+ blood @ this time.
(b)(6)-4	VS recorded on SF511. Pt now awake, no S/Sx of reaction, resp. even & unlabored, LCTAB, O2 Sats @ 98-99% RA. Tol. 10% dinner. tolerating PO fluids well. Drsg. to (R) anterior thigh dry & intact. small amt sero-sang drainage noted. Drsg S/d. Monitoring [redacted] 91WM6
	(b)(6)-2

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

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
8OCT(2208)	2nd unit started. (O+ blood) BP 84/47, R: 20 P: 67 temp 98.4 (AX), O2 sats 99% RA. LOC VS: See DF-511. (6)(6)-4 [redacted] (6)(6)-2 [redacted] 9mm. 2310: no reaction noted, LCTAB, O2 sats 98% RA.
10CT @0090	Infusion completed S/Sx of reaction. See DF 511 for VS record. CBC due in AM @0700. Will cont. to monitor [redacted] (6)(6)-2
190CT@1300	Pt. sitting up in bed, A+O but drowsy. Pt. refused both breakfast & lunch, compliant c drinking water. Pt. has no C/O pain. V.S.S. Pt. given bed bath & oral care. W. to D DRSNG d'd at (R) thigh. Small amount of serosanguinous drainage to old DRSNG. Pt. transferred to BSC this AM loose BM. Pt. responds inappropriately at times. Pt. not given Colace because of loose stool. CBC drawn @ 0745. HCT=28. [redacted] (6)(6)-2 2LT, AM
19OCT@1330	All other assessments WNL. EPW restraint protocol used. D sign of skin breakdown. [redacted] (6)(6)-2 2LT, AM
	Assumed care @ 1800; AIIOSS, [redacted] (6)(6)-2 alert, able to verbalize needs pt TOLPO, but refuses to eat; was able to get him to eat 1 slice of bread From dinner; denies pain; dsg to (R) thigh d; sm amt sero-sang drng to old dsg; no significant As in assessment; Restraints in place; (+) circ (-) skin breakd; Cont to monito [redacted] (6)(6)-2
200CT08	1215 - VSS - AO. Assumed care of pt @ 0600. Pt. pulled out IV. Attempted to restart new IV x3. Pt. had BM in bed. BM was dark black tarry stool liq and soft-non-tender. Drsng D to (R)

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
(cont'd)	hup. cdi c mun drainage. (-) s/sx infection. Pt. had one waffle for breakfast and refused the rest. Ber for med personal hygiene + pt. refused mouth care @ this time. Pt. restraint in place (b)(6)-2 [redacted] c ø skin breakdown @ this time [redacted]
1415	Pt. had Bm. Liquid dark black brn. [redacted] (b)(6)-2 Will monitor.
20oct03(0) 2300	Assumed care @ 1800; All VSS, pt alert, verbalizes needs; pt ate 75% of dinner; Tol well; ø c/o pain or discomfort @ this time; dsg to (R) anterior thigh Δd, min. drainage old dsg, ø s/sx infection; pt voiding s difficulty per urinal; oral care provided; ø significant Δs; Restraints in place (b)(6)-2 [redacted], Ø circ, ø skin breakdown, cont to monitor
21OCT03	(11d5) Assumed care of pt @ 0700 p report from night shift. Pt alert, speaking Arabic. VSS. ø c/o pain. Dsg to RLE dd-wet-dry. ø s/sx infection @ site. Personal hygiene done by pt this am c assist. from staff. Oral hygiene done. Pt OOB to chair - tol well. Tol. reg diet ≈ 50% of lunch. voiding s difficulty. Awaiting Bm for stool cx. 2 point restraints in place s s/sx complications. Will cont. to monitor. (b)(6)-2 [redacted] (JMA)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
21 OCT 2003 2029	ontow Report of melena. ϕ quiet yet AF VSS Wound unS'd. Hct 28 on 10/19 Dist NVI Cx - Enterococcus D/c Heparin Start Zantac rev Hct 1 Keyzol → cipro. OOB c PT (b)(6)-2 [redacted] (b)(6)-2
210CT03 0020 (b)(6)-2	VSS. Alert. Lungs clear. Abd soft non-ds tender. Bs ⊕ x4 quad. Oral care done. Peripheral pulses palpable ±2. ϕ IV access 20 gauge IV inserted to (R) FA. and Saline locked Started Cipro IV as ordered. (R) thigh dsg dsg. OOB dsg c serosanguin drainage. Hct H lab results given to Dr [redacted]. Voids amber colored urine. Will continue care as planned. [redacted] (b)(6)-2 (b)(6)-2
220CT03 (0635)	Assumed care of pt @ desk p report from night shift. A alert, speaking Arabic. VSS. ϕ c/o pain. Personal hygiene done by pt this am, c min. assist. from staff. oral hygiene done. A OOB to chair @ this time. Tol. well. Skin @ forearm flushes well c sign infection/infiltration. Pt refused to eat

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
22OCT03 (0835)	(cont) breakfast this am. Voiding S difficulty. Cont. to wait for Bm for stool cx. 2-point restraints in place S S/Sx complications. Will cont. to monitor. [redacted] (b)(6)-2
(1400)	Pt back to bed. wet → dry drsg on RLE Δ'd. Pt tol. well. Monitoring. [redacted] (b)(6)-2
22OCT03 1940	Pt Alert. Lungs clear. BS (D) x4 quad. Abd soft non-distended. Peripheral pulses +2. Pt pulled out (R) FA Saline lock. Restarted 20g 1¼ inj IV each to (R) FA x1 attempt. (L) Arm restrained to prevent pulling out IV. Repositioned for comfort & to prevent pressure area. Will continue care as ordered. [redacted] (b)(6)-2
23OCT03 (1355)	Assumed care of pt @ 0700 per report from night shift. Pt alert, speaking Arabic. VSS. Ø c/o pain. Pt OOB to chair this am - tol. well. Drsg to RLE Δ'd, wet → dry. Ø S/Sx infection. SL in @ ac fistules well S S/Sx infiltration. Tol. 25% of breakfast and lunch. Good juice/H2O intake. Voiding S difficulty. 2-point restraints in place S S/Sx complications. Will continue to monitor. [redacted] (b)(6)-2
(1740)	@ large black tarry Bm. Sample taken to lab

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. ICU1

#[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	MI	ID NUMBER

DATE	NOTES (b)(6)-2
	(cont) For guiac monitoring - [redacted]
23OCT03	VSS. Alert & Oriented. Lungs clear. BS (+)
1900	X4 quad. Abd soft non-distended. Voiding
	clear yellow urine. (R) FA saline lock
	patent & intact. Ate 70% of dinner (R)
	thigh wound with pink tissue noted.
	Old drsg c serosanguinous drainage.
	Oral care done p dinner c small (b)(6)-2
	amt of bleeding noted to gums. Repos.
	Repositioned for comfort. Will continue
	care as ordered. (b)(6)-2 [redacted]
24OCT03	VSS. AO. Oral care performed by technician. WTD DSG c/d
1000	performed to (R) thigh c difficulty. (+)2 pulse to BLE's.
	LSCLAB. Tolerated ≤20% of AM meal. Encouraged to
	eat. Provided Ensure @ the bedside. HRR. PERRLA.
	Cont to monitor. (b)(6)-2 [redacted]
1200	OOBTC and then to BSC for BM x1. Soft,
	formed, large amount of brown stool.
	(b)(6)-2 [redacted] (b)(6)-2
1600	Changed linen & placed back in bed. [redacted]
24OCT03@2015	Pt laying in bed. c/o (-) pain. Lung sounds clear throughout all lobes. (b)(6)-2
	(+) Bowel sounds. (R) thigh DSG completed. (-) S/Sx of infection. W->D.
	packed c gauze + NS. Pt ate only ice cream + bread for dinner.
	Refused meal. [redacted]
24OCT03	MTF STAFF (b)(6)-2
	- (R) Hip wound clean c no change.
	(b)(6)-2 [redacted]

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

MEDCOM - 21130

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
25 OCT 03 1140	VSS: AO. DSG intact to ② inner thigh. ② pulses. Refused AM meal. Encouraged to eat and drink water. Pleasant DOTC @ this time. No s/s of skin breakdown @ this time. Minimal amount of urine produced, light amber in color. [redacted] (b)(6)-2

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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

MEDCOM - 21131

...RECORD - PATIENT ACTIVITIES FLOWSHEET
For use of this form, see MEDCOM Circular 40-5

SECTION I - PATIENT ASSESSMENT

DATE: 10/25/03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 20 | HOSPITAL DAY: 25

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time 1530 To ICW1 From ICW2 ☐ AMBULATORY ☐ CRUTCHES ☒ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time ______ Physician Dr [redacted] (b)(6)-2

Procedure/Diagnosis ______ Anesthesia (Specify): ______

LOC A&O x 3 B/P 95/44 P 78 R 18 T 98.3

Dressing/cast: Rear ⓡ femoral Neurovascular checks ______

Intake (IV, po) ______ Tubes ______

Medication ______ Output (EBL, other) ______

Other ______ Voided ☐ No ☐ Yes Amount: ______

Report From 2T [redacted] (b)(6)-2 Received By [redacted] (b)(6)-2

TIME:	1530	2000	1400														
BP ARTERIAL LINE	—	—															
BP CUFF	95/44	93/47	96/42														
TEMPERATURE	98.3	99.2	98.7														
PULSE	78	78	79														
RESPIRATORY RATE	17	18	18														
OXYGEN (L/%)	—	—	—														
PULSE OXIMETER	100	99	98														
O2 METHOD	RA	RA	RA														

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

TIME:	2000	2130	0400					
PAIN INTENSITY (10 / 5 / 0)	X (0)	0	X (0)					
MED ADMINISTERED (Y/N)		NA						
RELIEF ACCEPTABLE (Y/N)		NA						

TIME:				
FINGER STICK GLUCOSE	NA			
INSULIN (Y/N)				

SPECIAL NEEDS

TIME:	1530	2130
*Falls prevention protocol	[redacted]	
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

(b)(6)-2

YESTERDAY'S WEIGHT: ______
TODAY'S WEIGHT: ______
WEIGHT CHANGE: ______
*Per hospital policy.

HOUR TOTALS	PO	IV #1	IV #2				TOTAL IN	Urine		Stool			TOTAL OUT

IDENTIFICATION

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

DIAGNOSIS: Chronic anemia / s/p ⓡ femoral ...
DRG: ______
LOS: ______ ADMISSION DATE: 05/15/03
CASE MANAGER: ______ EXPECTED RELEASE: ______
PRIMARY CARE MANAGER: Dr [redacted] (b)(6)-2
ISOLATION REQUIRED (Specify): ______

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

IRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column.

	TIME: 1530 INITIALS: [redacted]	TIME: 2130 INITIALS: [redacted]	TIME: INITIALS:
. NEUROLOGICAL: Alert and oriented to me place and name. Responds appropriately. ommunication is adequate to express needs. upils equal and reactive to light.	☑ (b)(6)-2	☑ (b)(6)-2	☐
. CARDIOVASCULAR: Pulse regular & rate ithin range for age. No dependent edema. allbeds and mucous membranes pink. No calf nderness. *(See page 3 for extremity erfusion)*	☑	☑	☐
. PULMONARY: Respirations within normal te for age group; quiet and regular. Depth is gular. No cough. No abnormal breath ounds.	☑	☑	☐
. G.I.: Abdomen soft and non-distended. owel sounds active. Reports no N/V/pain ith eating and no problems chewing/ wallowing. Denies constipation, diarrhea or ctal bleeding.	☑	☑	☐
G.U.: Reports no dysuria, retention, gency, frequency, nocturia. Urine clear, llow/amber. No unusual discharge.	☑	☑	☐
MUSCULOSKELETAL: Normal muscle velopment and mass for age. No formities. No assistive devices needed. rmal active ROM without pain. No joint elling/tenderness, weakness or paresthesia.	☐ small for gestational age.	☐ Developmentally delayed.	☐
SKIN: Warm, dry, intact. Good turgor. No shes, inflammation, ulcers, breaks in skin. redness, blanching, irritation over bony minences. Mucous membranes moist.	☐ dry.	☐ wound to ® thigh.	☐
PAIN: No complaints of pain/ discomfort. *ee page 1 for documenting pain intensity.)*	☑	☑	☐
PSYCHOSOCIAL: Behavior is appropriate the situation. Anxiety is controlled or mild d appropriate to situation. Interacts propriately with others. (b)(6)-2	☑	☑	☐

IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness + - Central line)

IE: 1530 INITIALS: [redacted]	TIME: 2130 INITIALS: [redacted]	TIME: INITIALS:
patency ✓ q ___ hr:	IV patency ✓ q 8 hr: (b)(6)-2	IV patency ✓ q ___ hr:
site care provided:	IV site care provided:	IV site care provided:
tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION CONDITION	LOCATION CONDITION	LOCATION CONDITION
Site #1: ® arm OK	IV Site #1: ® arm OK	IV Site #1:
Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

NEUROVASCULAR

CAPILLARY REFILL	→
TEMPERATURE	W
EDEMA	0
SENSATION	S
MOTION	Ø
PASSIVE FLEXION	D
PERIPHERAL PULSE	2

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(> 5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

- Orient to environment pr[redacted]
- Side rails (2/4) up
- Bed position low
- Call light within reach

OTHER

- Review & post lab results
- Notify MD abnormal labs
- Incontinent urine/stool
- Linen change prn
- Turn/reposition q2h
- ROM q2h if immobile
- Antiembolic hose

(b)(6)

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE:	TYPE: Regular
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: f
☐ SELF ☒ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☐ COMPLETE	☐ SELF ☐ ASSIST ☑ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☑ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR (circled); ☐ SELF ☑ ASSIST; # TIMES/SHIFT

TEACHING

TIME: INITIALS:	TIME: 2130 INITIAL[redacted]	TIME: INITIALS:
CONTENT: 1. GO NOTIFY SGT AT IF GETTING OUT OF BED. 2 TO GET PCC [illegible] food.	CONTENT: -Plan of care (b)(6)-2 -	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
(b)(6)-4 C[redacted]	(b)(6)-2 [redacted] (b)(6)-2	(b)(6)-2 [redacted] (b)(6)-2	0600. N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1830	NSG - (R) FEMORAL	DRESSING - NORMAL SMALL WOUND	DSG. INTACT
	2100	(R) thigh	Red	W→D = VS

SECTION IV - NOTES

1530 - Pt alert and oriented x 3. Able to talk & follow [illegible]. VS stable; [illegible] to ask for help if getting out of bed - [redacted] (b)(6)-2
(b)(6)-2
1800 (R) leg [illegible] [illegible] [illegible] control of (R) leg [redacted]
1800 Pt alert and responsive to others - eats [illegible] food
[illegible] meds PO. - not [illegible] of distress [redacted] (b)(6)-2
2130: Awake. No verbal communication. [redacted] No c/o pain [illegible] (b)(6)-2
signs of pain or distress. Will continue to monitor [redacted]
0520: TO OR via stretcher. [redacted]
(b)(6)-2

[illegible]-R (TEST) (MCHC) MAR 99

Page [illegible] of [illegible] pages

MEDCOM - 21135

ACLU-RDI 1660 p.95

DOD-034711

...CORD - PATIENT ACTIVITIES FLOWSHEET

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

DATE: 26 OCT 03 | SECTION I - PATIENT ASSESSMENT | PATIENT ACUITY LEVEL: III | POST-OP DAY: 21 | HOSPITAL DAY: 26

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____

Procedure/Diagnosis _____ Anesthesia (Specify): _____

LOC _____ B/P _____ P _____ R _____ T _____

Dressing/cast _____ Neurovascular checks _____

Intake (IV, po) _____ Tubes _____

Medication _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Other _____

Report From _____ Received By _____

TIME:	0400	0800	1200	2000	0400
BP ARTERIAL LINE	/	/	/	/	/
BP CUFF	96/42	84/40	98/40	107/52	101/62
TEMPERATURE	98.7	99.3	100.9	99.6	99.2
PULSE	79	77	98	76	79
RESPIRATORY RATE	18	16	18	16	16
OXYGEN (L/%)	/	/	/	/	/
PULSE OXIMETER	98	100%	97%	99%	98
O2 METHOD	RA	RA	RA	RA	RA

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

TIME:	0730	2045	0400
PAIN INTENSITY (10 / 5 / 0)			
MED ADMINISTERED (Y/N)	X	0	X
RELIEF ACCEPTABLE (Y/N)	N	NA	
	NA	NA	

TIME:	NA
FINGER STICK GLUCOSE	
SLIDING (Y/N)	

SPECIAL NEEDS

TIME: 0730 2045

(6)(6)-2 [redacted]

*Falls prevention protocol	NA	NA
*Restraint protocol		
*Seizure precautions		
*Isolation precautions		

YESTERDAY'S WEIGHT: NA

TODAY'S WEIGHT: /

WEIGHT CHANGE: /

*Per hospital policy.

	PO	IV #1	IV #2	TOTAL IN	Urine	Stool	TOTAL OUT
	NA						

IDENTIFICATION

(6)(6)-4 [redacted]

DIAGNOSIS: Chronic Anemia s/p @four fx

CRG: _____ ADMISSION DATE: 05 OCT 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

FORM 689-R (TEST) (MCHO) MAR 99 PREVIOUS EDITIONS ARE OBSOLETE Page 1 of 4 pages MC V1.00

MEDCOM - 21136

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column. (b)(6)-2 (b)(6)-2

	TIME: 0730 INITIALS: [redacted]	TIME: 2045 INITIALS: [redacted]	TIME: INITIALS:
. NEUROLOGICAL: Alert and oriented to me place and name. Responds appropriately. ommunication is adequate to express needs. upils equal and reactive to light.	☐ mentally delayed	☑	☐
. CARDIOVASCULAR: Pulse regular & rate ithin range for age. No dependent edema. ailbeds and mucous membranes pink. No calf nderness. *(See page 3 for extremity erfusion)*	☑	☑	☐
. PULMONARY: Respirations within normal te for age group; quiet and regular. Depth is gular. No cough. No abnormal breath ounds.	☑	☑	☐
. G.I.: Abdomen soft and non-distended. owel sounds active. Reports no N/V/pain ith eating and no problems chewing/ allowing. Denies constipation, diarrhea or ctal bleeding.	☑	☑	☐
. G.U.: Reports no dysuria, retention, gency, frequency, nocturia. Urine clear, llow/amber. No unusual discharge.	☑	☑	☐
. MUSCULOSKELETAL: Normal muscle velopment and mass for age. No formities. No assistive devices needed. rmal active ROM without pain. No joint velling/tenderness, weakness or paresthesia.	☐ generalized weakness	☐ Generalized weakness Developmentally delayed	☐
. SKIN: Warm, dry, intact. Good turgor. No shes, inflammation, ulcers, breaks in skin, redness, blanching, irritation over bony minences. Mucous membranes moist.	☐ R hip wound	☐ R hip wound	☐
PAIN: No complaints of pain/ discomfort. *e page 1 for documenting pain intensity.)*	☑ Ø c/o pain	☑	☐
PSYCHOSOCIAL: Behavior is appropriate the situation. Anxiety is controlled or mild d appropriate to situation. Interacts propriately with others. (b)(6)-2	☑	☑ (b)(6)-2	☐

. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness + - Central line)

TIME: 0730 INITIALS: [redacted]	TIME: 2045 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 12 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) FA / CK	IV Site #1: NO ACCESS	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL'a IV.	Comments:	Comments:

NEUROVASCULAR

CAPILLARY REFILL	
TEMPERATURE	
EDEMA	
SENSATION	N/A
MOTION	
PASSIVE FLEXION	
PERIPHERAL PULSE	

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(> 5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

Band visible/legible	[redacted]	(b)(6)-2
Orient to environment prn	[redacted]	(b)(6)-2
Side rails (2/4) up	NA	NA
Bed position low	[redacted]	(b)(6)-2
Call light within reach	NA	

OTHER

Review & post lab results	[redacted]	(b)(6)-2
Notify MD abnormal labs	[redacted]	(b)(6)-2
Incontinent urine/stool	NA [redacted]	
Linen change prn	[redacted]	(b)(6)-2
Turn/reposition q2h	NA	NA
ROM q2h if immobile		
Antiembolic hose		

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE: Regular	TYPE: Regular
PERCENT CONSUMED: NPO	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☐ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☒ TOTAL	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	(BEDREST) AMBULATE BSC BRP (CHAIR) ☐ SELF ☒ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	(BEDREST) AMBULATE BSC BRP (CHAIR) ☐ SELF ☒ ASSIST # TIMES/SHIFT

TEACHING

TIME: 0730 INITIALS: [redacted]	TIME: 2045 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: (b)(6)-2 – comfort care	CONTENT: (b)(6)-2 – Plan of care –	CONTENT:
☒ Patient/Family Verbalizes Understanding	☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE (b)(6)-2	SHIFT
[redacted] (b)(6)-4 (b)(6)-2 (b)(6)-2	[redacted]	[redacted] DUT/AW	0600-18
		[redacted] DUT/AW (b)(6)-2	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

0600 Pt to OR via litter. (b)(6)-2 [redacted] JLLAW

0700 Pt back from OR via litter. VSS. Pt c D/C orders to ad home today. [redacted] JLLAW (b)(6)-2

2045: Awake & alert. Denies any pain or discomfort @ this time. Oral care done. Will continue to monitor. [redacted] An (b)(6)-2

DA FORM 3838-R (TEST) PREVIOUS EDITIONS MAY BE USED

Page 4 of 6 pages

MEDCOM - 21139

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 29 OCT 03 | PATIENT ACUITY LEVEL: II | POST-OP DAY: 22 | HOSPITAL DAY: 27

TRANSFER

COMPLETE ONLY AT TIME OF ADMISSION OR PATIENT TRANSFER IN - TELEPHONE REPORT:

Time _____ To _____ From _____ ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Total ER/RR/PACU time _____ Physician _____ Anesthesia (Specify): _____

Procedure/Diagnosis _____ B/P _____ P _____ R _____ T _____

LOC _____ Neurovascular checks _____

Dressing/cast _____ Tubes _____

Intake (IV, po) _____ Output (EBL, other) _____ Voided ☐ No ☐ Yes Amount: _____

Medication _____

Other _____

Report From _____ Received By _____

VITAL SIGNS

TIME:	0400															
BP ARTERIAL LINE	—															
BP CUFF	101/62															
TEMPERATURE	99.2															
PULSE	79															
RESPIRATORY RATE	18															
OXYGEN (L/%)	—															
PULSE OXIMETER	98															
O2 METHOD	RA															

Oxygen Method Key: NC = Nasal cannula; MT = Mist tent; NR = Non rebreather; PR = Partial rebreather; FM = Face mask; A = Aerosol; VM = Venturi mask; TC = Trach collar

PAIN

TIME:	0800															
PAIN INTENSITY (10 / 5 / 0)	X															
MED ADMINISTERED (Y/N)	NA															
RELIEF ACCEPTABLE (Y/N)	1															

OTHER

TIME:	NA															
FINGER STICK GLUCOSE																
INSULIN (Y/N)	1															

SPECIAL NEEDS

TIME:	NA
*Skin breakdown prevention	
*Falls prevention protocol	
*Restraint protocol	
*Seizure precautions	
*Isolation precautions	

YESTERDAY'S WEIGHT: _____

TODAY'S WEIGHT: _____

WEIGHT CHANGE: _____

*Per hospital policy.

24 HOUR TOTALS	PO	IV #1	IV #2					TOTAL IN	Urine		Stool			TOTAL OUT
	NA													

PATIENT IDENTIFICATION

(6)(6)-4

C [redacted]

DIAGNOSIS: Chronic Anemia s/p @ femur fx

DRG: _____ ADMISSION DATE: 5 Oct 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: _____

ISOLATION REQUIRED (Specify): _____

SECTION II - PATIENT ASSESSMENT - REVIEW OF SYSTEMS

DIRECTIONS: A check ✓ in the small box indicates patient assessment criteria have been MET. If all the stated criteria are not met, a brief explanation of abnormal findings will be noted in the appropriate column. (b)(6)-2

	TIME: 0800 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
1. **NEUROLOGICAL:** Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☐ - mentally delayed	☐	☐
2. **CARDIOVASCULAR:** Pulse regular & rate within range for age. No dependent edema. Nailbeds and mucous membranes pink. No calf tenderness. *(See page 3 for extremity perfusion)*	☑	☐	☐
3. **PULMONARY:** Respirations within normal rate for age group; quiet and regular. Depth is regular. No cough. No abnormal breath sounds.	☑	☐	☐
4. **G.I.:** Abdomen soft and non-distended. Bowel sounds active. Reports no N/V/pain with eating and no problems chewing/ swallowing. Denies constipation, diarrhea or rectal bleeding.	☑	☐	☐
5. **G.U.:** Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☐	☐
6. **MUSCULOSKELETAL:** Normal muscle development and mass for age. No deformities. No assistive devices needed. Normal active ROM without pain. No joint swelling/tenderness, weakness or paresthesia.	☐ - weakness when ambulating	☐	☐
7. **SKIN:** Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ - sutures to R hip	☐	☐
8. **PAIN:** No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐	☐
9. **PSYCHOSOCIAL:** Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others. (b)(6)-2	☑	☐	☐

10. IV SITE ASSESSMENT: (LEGEND: P - Puffy I - Infiltrated R - Reddened OK - No swelling/redness * - Central line)

TIME: 0800 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided:	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: NO IV	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: accessed	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE:	TIME:						
COLOR							
CAPILLARY REFILL							
TEMPERATURE							
EDEMA							
SENSATION							
MOTION							
PASSIVE FLEXION							
PERIPHERAL PULSE							

N/A

LEGEND

Color: P-pink (normal); C-cyanotic; W-pale, white
Capillary Refill: 1-(0-2 secs); 2-(3-5 secs); 3-(> 5 secs)
Temperature: C-cool; W-warm; H-hot
Edema: 0-None; 1-mild; 2-moderate; 3-severe; 4-pitting
Sensation: A-absent; N-numb; T-tingling; S-sensation (present)
Motion: U-unable to move; M-move-no pain; P-move-pain; R-full ROM
Passive Flexion: D-dorsal flexion pain; P-plantar flexion pain; 0-no pain
Peripheral Pulse: 0-absent; 1-weak; 2-normal; 3-strong; 4-bounding; D-doppler, P-palpable

SAFETY

TIME:	0800	
ID band visible/legible	[redacted]	(b)(6)-2
Orient to environment prn	[redacted]	(b)(6)-2
Side rails (2/4) up	N/A	
Bed position low	[redacted]	(b)(6)-2
Call light within reach	N/A	

OTHER

Review & post lab results	[redacted]	(b)(6)-2
Notify MD abnormal labs	[redacted]	(b)(6)-2
Incontinent urine/stool	N/A	
Linen change prn	[redacted]	(b)(6)-2
Turn/reposition q2h	N/A	
ROM q2h if immobile	1	
Antiembolic hose		

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Regular	TYPE: Regular
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED:
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADLs

	0700-1500	1500-2300	2300-0700
BATH/ORAL CARE	☐ SELF ☐ COMPLETE ☒ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL	☐ SELF ☐ COMPLETE ☐ ASSIST ☐ TOTAL
TYPE OF ACTIVITY (Circle all that apply)	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☒ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0800 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: (b)(6)-2 - ambulation - COB → chair - awaiting D/C home	CONTENT:	CONTENT:
☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

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

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] 2LT/AN	0678
(b)(6)-2	(b)(6)-2	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE

SECTION IV - NOTES

1310 Pt father @ bedside ready to bring pt home. Ø meds ordered. Pt understands instructions regarding suture removal & non weight bearing on (R) foot via interpreter. Pt. D/c'd home. [redacted] (6)(6) - 2

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERA[illegible]NG ROOM
VIA litter BY ANESTHESIA

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

3. DATE 26 Oct 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0525 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: able to follow cmmds, aware, NPO pmn
ϕ allergies.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] (6)(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] (6)(6)-2	RELIEF CIRCULATOR INT.	

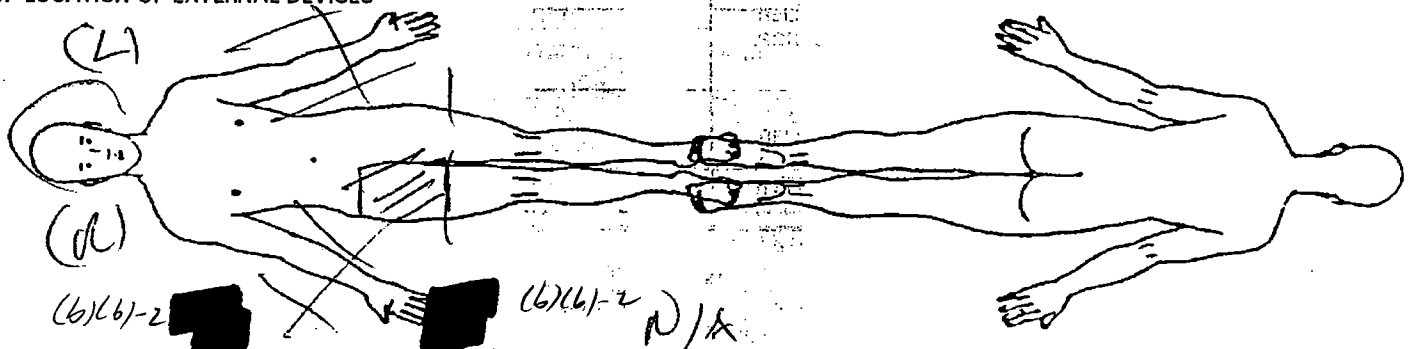
7. POSITION AND POSITIONAL AIDS (Specify) Pt placed in SP Arms on arm boards <90°
☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP
COMMENTS: Strapped. Warm blanket used. ALL PPP.

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) BETADINE Sol
SITE: (L) thigh BY WHOM: [redacted] (6)(6)-2
SITE: BY WHOM:
COMMENTS: ϕ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

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

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)
[redacted] (6)(6)-4

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

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

DA FORM 5179-1, OCT 87 REPLACES DA[illegible] MEDCOM - 21144 H IS OBSOLETE. USAPA V1.00

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

(6)(6)-2

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
[redacted] Xylo - Epi 1:100,000	7.0cc	Intop	injectn	[redacted] (6)(6)-2	[redacted] (6)(6)-2

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S): Nacl

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] (6)(6)-2

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)* fluff Kerlix 4x8 TAPE

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

S: [redacted] (6)(6)-2 ANESTHESIA TYPE Local & Sedation

A: [redacted] (6)(6)-2

20. OPERATION(S) PERFORMED

DPC (R) thigh

21. PATIENT TRANSFERRED TO Stat TIME 0545 METHOD Litter

22. [redacted] SIGNATURE MAJ Bow (6)(6)-2

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

18OCT 18OCT 18OCT 18/19OCT 20OCT 21 22

PULSE (0) | TEMP. F (°)

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

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

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

O2sats

(Source)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 21146

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY | HOUR

19

PULSE (O) | TEMP. F (°)

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

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

TEMP. C

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

[redacted] (6)(6)-4

REGISTER NO.

WARD NO.

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

[redacted] (b)(2)-2

Microbiology Request Form

Last Name: EPW [redacted] (b)(6)-4
First Name:
Patient # or SSN: [redacted] (b)(6)-4
Collected by: [redacted] (b)(6)-2
Date: 18 Oct 03
Time: 1430

Ward: ENT
Room:
Bed:
Physician: [redacted] (b)(6)-2
Source: R wound
Site: R thigh

[redacted]

Received by: [redacted] (b)(6)-2
Date: 18Oct03
Time: 1441

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

Laboratory Results

Enterococcus faecalis

Reported
Date: 21Oct03
Time: 1417
Tech: [redacted] (b)(6)-2
Reviewer: [redacted] (b)(6)-2

Number of attached sheets:

MEDCOM - 21148

DOD-034724

ACLU-RDI 1660 p.108

Ward/Section: Emt | REQUEST: [redacted] (6)(6)-2 | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: Epw [redacted] (6)(6)-4 | DATE: 180603 | TIME: 1435 | SSN/PS: [redacted] SSN: (6)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymph%		
(Hemat		
Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

[redacted] (6)(6)-4

10-10-03 14:40 Patient Limits

WBC	2.3	L	x10^3/uL	4.5 10.5
RBC	2.61	L	x10^6/uL	4.00 6.00
Hgb	5.7	L	g/dL	11.0 18.0
Hct	18.6	L	%	35.0 60.0
MCV	71.0	L	fL	80.0 99.9
MCH	21.9	L	pg	27.0 31.0
MCHC	30.8	L	g/dL	33.0 37.0
Plt	447.	*	x10^3/uL	150. 450.
LYZ	33.3	*	%	20.5 51.1
LYM	0.8	*L	x10^3/uL	1.2 3.4

Mono | Eos | Baso | Imm

Coagulation Studies

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

REMARKS:

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
Appr	Clear	N/A
Glu	Neg	Negative
Bili	Small	Negative
Ket	Neg	Negative
SG	1.015	N/A
Bld	Neg	Negative
pH	8.5	N/A
Prot	Trace	Negative
Urob	8	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Epi- Neg

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

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

LAST, FIRST, MI: Epw [redacted] (b)(6)-4 | DATE: 180603 | TIME: 1935 | SSN/PSEUDO SSN: [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	[redacted]	
RBC	(b)(6)-4	
Hgb		
Hct		
MCV		
Plt		
Lymph %		
(Hema		

10-10-03 14:40 Patient Limits

WBC	2.3 L	x10^3/uL	4.5	10.5
RBC	2.61 L	x10^6/uL	4.00	6.00
Hgb	5.7 L	g/dL	11.0	18.0
Hct	18.6 L	%	35.0	60.0
MCV	71.0 L	fL	80.0	99.9
MCH	21.9 L	pg	27.0	31.0
MCHC	30.8 L	g/dL	33.0	37.0
Plt	447. *	x10^3/uL	150.	450.
LY%	33.3 *	%	20.5	51.1
LYM	0.8 *L	x10^3/uL	1.2	3.4

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
Acp	Clear	N/A
Glu	Neg	Negative
Bili	small	Negative
Ket	Neg	Negative
SG	1.015	N/A
Bld	Neg	Negative
pH	8.5	N/A
Prot	Trace	Negative
Urob	8	0.2-1.0
Nit	Neg	Negative
Leuk	Neg	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Echo- Neg

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh:

Blood Bank Unit Crossmatch

(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

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

(b)(6)-2

Ward/Section: ICW1 | [redacted] PHYSICIAN: | LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. epw# [redacted] | DATE 19 OCT | TIME 0700 | SSN/PSEUDO # [redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	[redacted] (b)(6)-4	
RBC		
Hgb		
Hct	28.0	
MCV		
Plt		
Lymph %		
(Hema		

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

(b)(6)-4 **Urinalysis**

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

[redacted] (b)(6)-4

[redacted]logy Report (b)(2)-2

Name:	Specimen: [redacted] (b)(6)-4	Status:	Final
Patient ID: [redacted] (b)(6)-4	Source: Wound/Sterile site	Collected:	
Ward/Rm: 1	Ward of Iso:	Attd. Phys:	

1 Enterococcus faecalis Status: Final

1. E. faecalis

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	<=4/2				
Amp/Sulbactam (c)	<=8/4				
Ampicillin	2	S			
Cefazolin	16				
Cefepime	16				
Cefotaxime (c)	32				
Ceftriaxone (c)	>32				
Cephalothin	16				
Chloramphenicol	<=8	S			
Ciprofloxacin	<=1	S			
Clindamycin	>2				
Erythromycin	<=0.5	S			
Gatifloxacin	<=2				
Gent. Synergy	<=500	S			
Gentamicin	8				
Imipenem (c)	<=4				
Levofloxacin	<=2	S			
Linezolid	<=2	S			
Moxifloxacin	<=2				
Nitrofurantoin	<=32				
Norfloxacin	<=4				
Ofloxacin	4				
Oxacillin	>2				
Penicillin	2	S			
Pip/Tazo (d)	<=4				
Rifampin	<=1	S			
Strep. Synergy	<=1000	S			
Synercid	>2	R			
Tetracycline	<=4	S			
Trimeth/Sulfa	<=2/38				
Vancomycin	<=2	S			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL. Confirmatory tests needed to differentiate ESBL from other beta-lactamases.
IB = Inducible Beta-lactamase. Appears in place of Sensitive with species known to possess inducible beta-lactamases; potentially they may become resistant to all beta-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined beta-lactam drugs.

For blood and CSF Isolates, a beta-lactamase test is recommended for Enterococcus species.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
(b) Breakpoints based on parenteral dose. For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R). Footnote (c) applies to this drug.
(c) For streptococci refer to penicillin interpretations. For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation.
(d) For non beta-lactamase producing enterococci, refer to the penicillin interpretation. Footnote (a) also applies to this drug.

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002. Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints.
For S. pneumoniae, cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis. For non-meningitis infections, use <2=S, 2=I, >2=R.

Name:	Specimen: [redacted] (b)(6)-4	Status:	Final (b)(6)-2
Patient ID: [redacted] (b)(6)-4	Source: Wound/Sterile site	Collected:	
Ward/Rm: 1	Ward of Iso:	Req. Phys:	[redacted]

Printed 10/21/2003 2:15:27 PM

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

(b)(6)-2

MEDCOM - 21152

Ward/Section: ICU	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted] (b)(6)-4	DATE: 2 OCT	TIME: 2115
SSN/PSEUDO SSN:		

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	[redacted] (b)(6)-4	
RBC		
Hgb		
Hct		
MCV		
Plt		
Lymph %		
(Hemo		
Segs		
Bands		
Lymph		
Atyp		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

(6)(2)-2 [redacted]

Microbiology Request Form

F.05

Last Name: [redacted] (6)(6)-4
First Name:
Patient # or SSN: [redacted] (6)(6)-4

Collected by: L [redacted] (6)(6)-2
Date: 23Oct03
Time: 1740

Ward: ICW1
Room: 2
Bed: 2E
Physician:

Source: Stool
Site:

[redacted]

Received by: SPC [redacted] (6)(6)-2
Date: 23 OCT 03
Time: 1740

Specimen #:

Laboratory Results

Fecal occult Blood Negative

Reported
Date: 23 OCT 03
Time: 1830
Tech: [redacted] (6)(6)-2
Reviewer:

Number of attached sheets:

NKDA

MEDICAL RECORD — ANESTHESIA

DRUGS	Dose	Time
Versed	(2)	10-10
Propofol	(2)	
	( )	
	( )	
	( )	

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

% del	
% e.t.	
AIR	L/Min
N2O	L/Min
O2	L/Min RA →

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

LINE site 20G-(R)AC ☐ Warmed — IR #1

☐ Warmed

☐ Warmed

☐ Warmed

URINES — EST BLOOD LOSS — URINE –

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 50 (KG) LB

HEMATOCRIT: —

INITIAL DATA: BP – 101/39 HR– 101

BOOM CHECK: OK?– (Y) N

PATIENT IDENTIFIED: OK for PROCEDU[redacted] (6)(6)-2 TIME– 0536

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

TIME → 0515 . 45 0600 . 30 . 0700

220 200 180 160 140 120 100 80 60 40 20

VT – ml	+ +
f – breaths/min	20 20
Peak inf pres / PEEP	— —
MODE– S(pon), A(ssist), C(on)	S S
BP/Auto Cuff	ET CO2 (torr)
BP / oth	FIO2 (Frac or %) RA →
ART line	SpO2 (%) 100 99
Steth- PC/ES	ECG SR SR
Gas analyzer	TEMP- site available
	N-M Block (T/4)
Warming blkt	✓ Blankets
Conv warmer	

Mark with letters & symbols, explain under REMARKS — EVENTS — Position → (1) (2) 0 (3)

TOTALS: 2 / 20 — TOTAL URINE: Ø

FLUIDS – SUMMARY: CRYSTALLOID 150 — COLLOID– Ø — BLOOD– Ø

REMARKS– Code drugs with numbers, events with letters

(1) Room, monitor Sedation TTE

(2) Lidocaine 1% c 1:200K epi 7ML injected into wound

(3) To PACU Report to [redacted]

RECOVERY AT 0580 — PACU ICU (Specify) — OTHER T 96.7 — CONDITION: Stable; awake — RESP– 20 SpO2– 100 — BP– 90/48 HR– 102

	Start	Room	End
ANES	0515	0525	0555
	Ready	Begin	End
PROC	0530	0535	0548

PROCEDURES and CPT Codes: RPC (R) High wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: MAC + sedation + local

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: Natural

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

#[redacted] (6)(6)-1

SURGEONS: [redacted] (6)(6)-2

ANESTHE[redacted] (6)(6)-2 CRNA

PROCEDURE LOCATION 2(2)

DATE 26 Oct 03

PAGE 1 OF 1

MEDCOM - 21155 [redacted] THESIA

WAMC OP 376 REVISED

518-124

NSN 7540-00-634-415.

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)*

_____ ML

REMARKS: 1 U

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

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 18 Oct 03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted] (6)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

Anemia

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

SIGNATURE OF VERIFIER (6)(6)-2

[redacted]

DATE 18 Oct 03

TIME VERIFIED 1540

SECTION II – PRE-TRANSFUSION TESTING

(6)(6)-4

UNIT NO. [redacted] (6)(6)-4

TRANSFUSION NO.

PATIENT NO.

DONOR

ABO O

Rh POS

RECIPIENT

ABO O

Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Compatible

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK:

- [X] RECORD
- [ ] NO RECORD

(6)(6)-2

SIGNATURE [redacted]

DATE 18 Oct 03

REMARKS:

EXP 23 Oct 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

[redacted] (6)(6)-2

AT *(Hour)* 1641

ON *(Date)* 18 Oct 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

[redacted] (6)(6)-2

[redacted] (6)(6)-2 Spc 9 WMC

TEMP. 98° PULSE 103 BP 96/47

DATE OF TRANSFUSION 18 Oct 03

TIME STARTED 1655

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

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

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED 2015/18 Oct 03

REACTION	TEMPERATURE	PULSE	BLOOD PRESSURE
[X] NONE [ ] SUSPECTED	98.5	65	90/42

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)* none

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE (6)(6)-2

[redacted] 9 WMC

SEX Male

WARD EMT

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 21156

Medical Record Copy

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted]

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

10-18-03 _____ HOURS

- Readmit / CW-2 - Dr. (illegible)
- Stable
- Routine V/S/tals
- Bed rest - OOB to chair ↑ assist
- Wet to dry dressing BS
- BID dsg @ R thigh
- IVF D5 NS @ 125 cc/hr

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

Noted

(b)(6)-4

[redacted]

1800 10/18/03

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

_____ HOURS

- Regular Diet
- Oral hygiene BID
- Keflex 500 mg q 12
- Tylenol 650 mg po q 4h prn pain
- Transfuse 2u PRBC.
  Premedicate: 25 mg Benadryl + 650 mg Tylenol

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

DATE OF ORDER | TIME OF ORDER

10-18-03 1600 HOURS [redacted] (b)(6)-2

Ofesay 325 mg po TID

[redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

(b)(6)-4

[redacted]

DATE OF ORDER | TIME OF ORDER

10/18/03 _____ HOURS

224 - Heparin 5000 u SQ BID (10+22)

- PTT only, otherwise bedrest
- OOB to chair BID at least [redacted] (b)(6)-2 MD.
- Colace 1 po bid
- rev HCT tomorrow [redacted] (b)(6)-2
- Percocet 1-2 po q4h prn
- Heparin IV [redacted] (b)(6)-2
- Qshift Vital Signs [redacted] (b)(6)-2
- DS (R) thigh [redacted] (b)(6)-2

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 21157

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 (6)(6)-4 [redacted]

DATE OF ORDER 20OCT03 TIME OF ORDER 1600 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Guiac next stool.
V.O. DR [redacted] (6)(6)-2 (6)(6)-2

NURSING UNIT ICW1 ROOM NO. 24 BED NO. 20 Oct 03 2000

(6)(6)-2

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

DATE OF ORDER 21 OCT 2003 TIME OF ORDER 2027 HOURS

- D/C Heparin
- Zantac 50mg IV q8° 08 16 24
- D/C Keflex
- Cipro 400mg IV BID
- H/H please

Noted 21 Oct 03 2130 [redacted] (6)(6)-2

NURSING UNIT ICW1 ROOM NO. BED NO.

(6)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER

OOB to chair BID at least HOURS

Skin breakdown precaution [redacted] (6)(6)-2

NURSING UNIT ROOM NO. BED NO.

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

DATE OF ORDER TIME OF ORDER

22OCT03 HOURS

Clarification order

D/C Keflex

V.O Dr [redacted] (6)(6)-2 (6)(6)-2 2OTN

Noted 22 Oct 03 [redacted] (6)(6)-2

NURSING UNIT ICW1 ROOM NO. 24 BED NO. 20

23 Oct 03 0030 [redacted] 2OTN

(6)(6)-2

DA FORM 4256 MEDCOM - 21158

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

CW [redacted]

(6)(6)-4

(6)(6)-2

NURSING UNIT: ICU2 | ROOM NO. | BED NO.

DATE OF ORDER: 10-25-03 | TIME OF ORDER: _____ HOURS | LIST TIME ORDER NOTED AND SIGN

NPO effective MN

[redacted] (6)(6)-2

Noted 25 OCT 03 1910 [redacted]

24 V 26 OCT 03 0410 [redacted] (6)(6)-2

PATIENT IDENTIFICATION

CW [redacted]

(6)(6)-4

(6)(6)-2

NURSING UNIT: ICU2 | ROOM NO. | BED NO.

DATE OF ORDER: 10-26-03 | TIME OF ORDER: 0530 HOURS

Noted 26 OCT 03 0200 [redacted]

V- Resume preop orders (regular) then

V- D/C pt today to home

V- Remove sutures at civilian hospital in 10 days.

V- Non weight bearing on Right leg x 8 weeks.

PATIENT IDENTIFICATION

[redacted] (6)(6)-2

(6)(6)-2

NURSING UNIT: | ROOM NO. | BED NO.

DATE OF ORDER: 26 Oct 03 | TIME OF ORDER: 1600 HOURS

Noted 26 OCT 03 1630 [redacted] (6)(6)-2

V.O. from Dr. [redacted] to LT [redacted]: (6)(6)-2

① D/C all meds

② D/C IV

2-48 V 27 OCT 03 0455 [redacted] (6)(6)-2

PATIENT IDENTIFICATION

NURSING UNIT: | ROOM NO. | BED NO.

DATE OF ORDER: | TIME OF ORDER: _____ HOURS

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

MEDCOM - 21159

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]

(6)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

25 OCT 03 | 1000 HOURS

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

(1) Zantac 150mg PO BID

(2) D/C 50mg Zantac IVPB

(3) Include Ensure TID F Meals

[redacted] RN

1000

(6)(6)-2

25 OCT 02

PATIENT IDENTIFICATION

[redacted]

(6)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

_____ HOURS

PATIENT IDENTIFICATION

[redacted]

(6)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

_____ HOURS

PATIENT IDENTIFICATION

[redacted]

(6)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

_____ HOURS

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

[redacted] (6)(6)-4

MEDCOM - 21160

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. 10 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 18 19 20 21 22 23 24 25 26 27 28
(b)(6)-2 18 OCT 03	[redacted]	Routine vitals (Q Shift)	06 18	[redacted]
(b)(6)-2 18	[redacted]	BR - OOB to chair c assist BID (at least)	06 18	[redacted]
(b)(6)-2 18	[redacted]	Wet-dry dsg c/a BID @ thigh c NS	10 22	[redacted]
(b)(6)-2 18	[redacted]	Regular diet	06 18	[redacted]
(b)(6)-2 18	[redacted]	Oral hygiene BID	10 22	[redacted]
(b)(6)-2 18 OCT	[redacted]	FF NWB c PT only otherwise bedrest	6 18	[redacted]
(b)(6)-2 21 OCT	[redacted]	OOB to chair BID @ Least	06 18	[redacted]
(b)(6)-2 21 OCT	[redacted]	Skin Breakdown precautions	6 18	[redacted]
(b)(6)-2 25 OCT	[redacted]	Ensure c Meals TID	6 12 18	[redacted]

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: CHRONIC ANEMIA

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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 10 Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
18 OCT03	[redacted]	Readmit ICW#1 – Dr [redacted]	18 OCT03	—	—	[redacted]
18	[redacted]	Stable (6)(6)-2	18	—	—	[redacted]
18	[redacted]	Transfuse 2 units PRBC	18 OCT03	① ASAP	1655	[redacted]
	-----		18	② —	2200	[redacted]
19 OCT	[redacted]	✓ HCT in AM	19 OCT	0700	0745	[redacted]
20 OCT	[redacted]	Guiac next stool	20 OCT	—	20 OCT03 1140	[redacted]
21 Oct	[redacted]	Ht / Ht plesse	21 Oct	✓	2115	[redacted]
25 Oct	[redacted]	NPO ∃ MN	26 Oct	2000	dave	[redacted]
26 Oct	[redacted]	D/C pt today to home	26 Oct	today		
26 Oct	[redacted]	Remove sutures @ civilian hospital	26 Oct			
	-----	in 10 days				
26 Oct	[redacted]	Non wt bearing on (L) leg x 6 wks	26 Oct			

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

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. 10 Yr. 03

VERIFY BY INITIALING | INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18 19 20 21 22 23 24 25 26
(6)(6)-2 18 OCT 03	[redacted]	IVF D5 1/2 NS @ 125cc/	06	[redacted] D/C'd
	-----	hr → Heplocked	18	
(6)(6)-2 18	[redacted]	Keflex 500mg QID	06	[redacted]
	-----		12	[redacted] D/C'd 21 Oct 03
	-----		18	
(6)(6)-2	-----		24	
(6)(6)-2 18	[redacted]	FeSO4 325mg PO TID	06	[redacted] D/C'd
	-----		14	
	-----		22	
(6)(6)-2 18 OCT	[redacted]	Heplock IV	6	[redacted] DC'd
	-----		18	
(6)(6)-2 18 OCT	[redacted]	Colace 100 PO BID	10	[redacted] D/C'd
	-----		22	
(6)(6)-2 18 OCT	[redacted]	Heparin 5000 u	10	[redacted] D/C'd 21 Oct 03
	-----	SQ BID	22	
(6)(6)-2 21 Oct	[redacted]	Zantac 50mg	08	[redacted] D/C'd
	-----	IVPB Q8°	16	
(6)(6)-2	[redacted]		24	
(6)(6)-2 21 Oct	[redacted]	CIPRO IVPB 400mg	10	[redacted] D/C'd
	-----	IVPB BID	22	
(6)(6)-2	[redacted]			
(6)(6)-2 25 OCT	[redacted]	Zantac 150mg PO	10	[redacted] Received
	-----	BID	22	
(6)(6)-2 25 OCT	[redacted]	Zantac 150 mg PO	10	[redacted] D/C'd
	-----	BID	22	

	-----			

(6)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: CHRONIC ANEMIA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (6)(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

23 24 01 02 03 04 05 06

MEDCOM - 21163

DA FORM 4870

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)			Mo. 10 Yr. 03	
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
18 OCT03	[redacted]	Premedicate c 25mg Benadryl/650mg Tylenol	18 OCT03	—	1650	[redacted] (6)(6)-2
26Oct	[redacted]	D/c all meds, D/c IV	26Oct	NPW	Done	[redacted] (6)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
18OCT03	[redacted]	Tylenol 650mg po q4° prn pain	D/T 26 OCT 1428
			D/I 650 MG PO
18OCT	[redacted]	percocet 1-2 tabs PO Q4° PRN	D/T [redacted]
			D/I

(6)(6)-2

*U.S. GPO: 1998-454-110/95216

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: TRAUMA FLOWSHEET
The proponent is Dept of Surgery

OTSG APPROVED (Date): QI Appr 11 Jun 97

EMS REPORT

TIME: 1350 ETA: UNIT:
MED COM: [Y] [N] GSW to (L) femur

ARRIVAL STATUS

TIME 1354 ☐ IV x ____ ☐ O_2 ____ l/min ☐ C-Spine Immob
Meds: ☑ UKN ☐ None ☐ Yes: ____
Allergies: ☑ UKN ☐ None ☐ Yes: ____
Tetanus: ☑ UKN ☐ Current Last Meal/Fluid Intake ____ hrs
LMP: ____ ☑ 1350 GSW to (L) femur
6A 6D 5th

PRIMARY SURVEY

AIRWAY
☐ Natural Patient [Y] [N]
☐ ETT____ ☐ ____
☐ Secretions____

BRETHING
☐ Labored ☐ Unlabored ☐ Absent
TRACHEA: ☐ Midline ☐ Deviated [L] [R]
CHEST SYMMETRY: [L] > = < [R]

CIRCULATION
PULSE: ☐ Present ☐ Absent
BLEEDING: [Y] [N]
HEART TONES: ☐ Clear ☐ Muffled
SKIN: ☐ Warm ☐ Cool ☐ Hot
☐ Pink ☐ Pale ☐ Cyanotic ☐ ____
☐ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY
GCS: E 4
V 5
M 6
SPHINCTER TONE: ☑ WNL ☐ None

HEAD
PUPILS: ☑ Equal ☐ Fixed ☑ React ☐ Dilated [L] [R]
TM: ☐ Clear ☐ Blood [L] [R]

NECK
C-Spine Tenderness: [Y] [N]
Pain @ ____
JVD: [Y] [N]

HEART
RHYTHM: ☑ Regular ☐ ____
PULSES: ☐ Central ☐ Peripheral

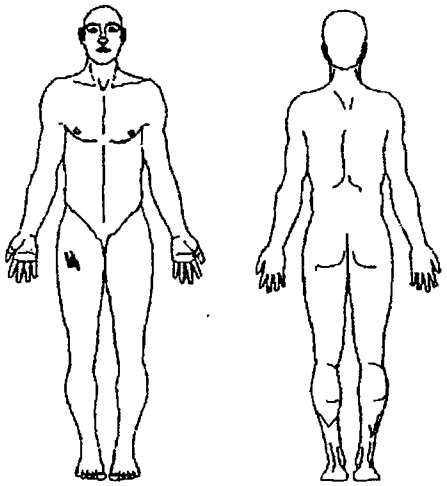
LUNGS
BREATH SOUNDS: ☑ Bilat ☑ Equal ☐ Clear
Decreased [L] [R] Absent [L] [R]
Wheezes [L] [R] Crackles [L] [R]

ABDOMEN
☑ Soft ☐ Rigid ☑ Non-Tender
☐ Tender:

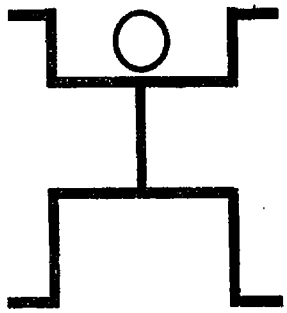
PELVIS
☑ Stable ☐ Unstable ☐ ____
Blood at meatus/vagina: [Y] [N]
Heme +/ - Prostate: ☐ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration
(P)uncture (W)ound
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound



VASCULAR ASSESSMENT



+ Strong	+ Palpable	D Dopler

RN [redacted] (b)(6)-2
PREPA[redacted] (b)(6)-2
PHYSICIAN
(Continue on reverse)
DEPARTMENT/SERVICE/CLINIC
DATE

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

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

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

DA FORM 1 MAY 78 4700

REQUIREMENT OF PRIVACY ACT OF 1974 IS COVERED BY DD FORM 2005.
PREVIOUS EDITION IS OBSOLETE.

EAMC OP 503, 1 Dec 98

MEDCOM - 21165

VITAL SIGNS

~~Rectal~~ Temp: 97.1 99 [illegible]

GCS:

TIME	BP	HR	RHY	RR	SAO2	FIO2	MODE	E	V	M	T
1350	89/45	88	SR	14	100						
1400	96/38	84	SR	14	100						
1415	83/44	86	SR	14	100						
1430	82/44	86									
1450	87/35	86									
1520	87/54	84									
	/										
	/										
	/										
	/										
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	/										
	/					(b)(6)-2					
	/										
	/										
	/										
	/										
	/										
	/										

GLASGOW COMA SCALE

EYE OPENING	VERBAL RESPONSE	MOTOR RESPONSE
(4) Spontaneous	(5) Oriented	(6) Obeys Commands
3 - To Voice	4 - Confused	5 - Localizes Pain
2 - To Pain	3 - Inapp Words	4 - Withdraws to Pain
1 - None	2 - Incomp Speech	3 - Flexion to Pain
	1 - None	2 - Extension to Pain
		1 - None

TIME	PROCEDURE	PERFORMED BY:
	☐ Backboard Removed	BY:
	☐ Downgraded	BY:

NOTES

1350 18 y/o [illegible] presented in ED unknown complaints. Pt has [illegible] GSW to (R) femur. Bloods drawn [illegible] [illegible] [illegible] as per [illegible] ~~[illegible]~~ Pt hypotensive Pt able to urinate 700cc [illegible] urine, blood culture drawn [redacted] (b)(6)-2
Pt pulse ox 100% on [redacted] (b)(6)-2
1430 labs pending [redacted] (b)(6)-2
1530 Dr [redacted] [illegible] Pt along c̄ (b)(6)-2
[illegible] [illegible] [illegible] to Nurse [redacted] ICU (b)(6)-2
[redacted] (b)(6)-2

S: Pt is a 20 yo Iraqi EPW s/p GSW to (R) thigh ORIF who was sent to EPW camp today instead of EPW hospital. EPW camp immediately sent him to the 2[illegible] CSH (b)(6)-2

PMHx ?
PSHx (R) femur ORIF
Meds
[illegible]
NKDA

O: WDWN Thin Iraqi [illegible] NAD NonToxic ⊖ Resp distress
HEENT: WNL
Lungs: (B) [illegible] CTA
Cor: RRR [illegible]
Abd: [illegible] S, NT, ND [illegible]
Ext: (R) femur [illegible] lat healed surgical incision.
1x1/2" ant pocket c̄ purulent D/c + old Drsg ⊖ red streaks. [illegible]

A: Post op ORIF (R) Femur: (1) Anemic (2) Leukopenic (3) Hypotensive
R/o Sepsis

2.3) 5/18 (440

130 / 3.5 | 23 (120
AG 16

P: IVF Bolus. Labs + CX.
Admit to ORTHO. (b)(6)-2

UA:

TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
	ET Intubation		☐ Oral ☐ Nasal Teeth		☐ $ETCO_2$ Change ☐ BBS Post Int ☐ Post CXR
	Gastric Tube		☐ Oral ☐ Nasal		☐ Air ☐ Contents ☐ Verified_____ Suction: Y N
	Urinary		☐ Meatus ☐ Supra-Public		☐ Return_____cc ☐ Heme Dip: + - ☐ Secured
	DPL		☐ Opened ☐ Closed		☐ Grossly: + - Cell count Sent@_____
	Chest Tube #1		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac____cm ☐ Autotransfuser
	12 Lead	Rhythm:		Comments	

TIME	PROCEDURE	ACCOMPANED BY	RETURN
	CT Scan: ☐ Contrast		
	☐ Head ☐ Abd ☐ Pelvis		
	☐ C-Spine ☐ T/L Spine ☐ Chest		
	☐		
	A-Gram Site:		

IV ACCESS & FLUIDS

TIME	#	GA	IAW SOP		SITE	IVF TYPE	AMT UP	AMT IN
1415	1	18	(Y)	N	(L)HAC	NS	1000cc	
1430	2	18	(Y)	N	LHAC	NS	1000cc	
			Y	N				
			Y	N				

MEDICATIONS

MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE

ABG SITE	TIME	$\%O_2$	pH	BE	pCO_2	PO_2	O_2 Sat	HCO_3
1)								
2)								

LABS

TIME	LABS
	☐ D-stick_____ ☐ SHct_____
	☐ D-stick_____ ☐ SHct_____
	☐ CBC ☐ Chem ☐ PT/PTT ☐ ETOH ☐ T&S ☐ T&C x_____
	☐ Tox Screen
	☐ UA ☐ HCG
	☐ OTHER
	☐ OTHER

X-RAYS

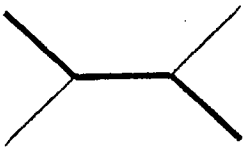
TIME	LABS
	☐ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
	☐ Pelvis
	☐
	☐

BLOOD PRODUCTS

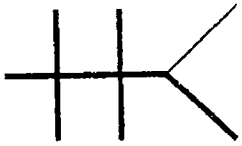
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INIT

LAB RESULTS

CBC:



Chem:



INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other	Urine	Other	700cc Dark
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys	[redacted]			
Surgeon	(b)(6)-2			
Anesth				
X-Ray				
RT				
Ortho				
Neuro				
Chaplain				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOD See DA Form 3696	
	Other: See Nursing Notes	

DISPOSITION

☐ Home ☐ _____

Admitted to_____

Report Called to_____

Time Transferred_____

Accompanied By_____

Via: ☐ Stretcher ☐ Wheelchair

MEDCOM - 21167 utions: ☐ Yes ☐ No

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 26oct03
Time In: 0552
Allergies: NKDA
Pre-op V/S: 101/54 / 101
Procedures: wound closure

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 150 Colloid
OR Output: UOP 0 EBL min
Meds/Times: Cefzol

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds

History

Time	0552	0600	0607	0623	0635	0647
SaO2	100	100	100	100	100	
FiO2						
Methods	RA	RA	RA	NC4L	NC4L	
240						
220						
200						
180						
160						
140						
120						
100	V	V	V	V	✓	
80						
60						
40						
20						
RR	19	14	12	16	18	
T	96.7					
Time						
Pain (0-10)						
LOS						

OK

Pacu Intake

(6)(6)-2

Time	Solution	Amount	Site	By	Infused
0552	4866 LR	400	RAC	[redacted]	

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	2	2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	0		
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	10	10

Codes

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

V/S
X = A-line BP
* = Cuff BP
= Pulse

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

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

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

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

(Continue on reverse)

[redacted] (6)(6)-2 91cm6

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 26OCT 03

typed or written entries give: Name – last, grade; date; hospital or medical facility)

[redacted] (6)(6)-4

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

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

MEDICATIONS

Allergies:

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

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'	R thigh	+	+	P	<3	W	Pk
30'	R thigh	+	+	P	<3	W	Pk
45'							
60'							
90'							
D/C							

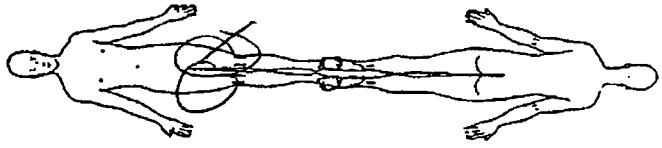
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic, P = Pale, Pk = Pink
Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	R thigh	2x2	Ø
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
0552	NSR	Ø	Ø

WAMC OP 173-E

NURSING NOTES

PT Received From OR. SP 4 Wound Closure NSR Right. PARS 9 (b)(6)-2
SaO2 100% on RA — SP [redacted]
Face Report to S67 [redacted] — SP [redacted]
(b)(6)-2 (b)(6)-2

Discharge Criteria:
Date: **Time:** **PARS:**
BP: **T:** **HR:** **RR:** **Sa02:**
Pain Level at D/C (0-10):
Intake:_____ **Output:**_____
Additional Data:_____
Transferred To:_____
Report Given To:_____
Transferred Via: W/C Litter Gurney Ambulance
Transferred By:_____
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature:_____

Automated Facsimile

(b)(6)-4

INPATIENT TREATMENT RECORD COVER SHEET

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

1. Register Nbr	2. Name					3. Grade	Admission Remarks
[redacted]	[redacted] (b)(6)-4						
4. Sex M	5. Age 21Y	6. Race X	7. Religion ISLAMIC	8. LnthOfSvc	9. ETS	10. PrevAdm NO	
11. FMP ~~99~~ 20	12. SSN (b)(6)-4 [redacted]	13. Organization (b)(6)-4				14. Ward ICU1	
15. FlyStatus	17. Dept / Ben K78-PRISONER OF WAR/INTER		18. BranchCorps	19. UIC / ZIP		20. Type Case DIS	
21. Source of Admission Direct from ER			22. Hour Of Adm: 08:42	23. Clinic Service AEA - ORTHOPEDICS			
24. Name/Relation of Emergency Addressee			25. Type Disp TRF C-ACF	26. Date of Disp 2003-10-19			
27a. Address of Emergency Addressee			27b. Telephone No	28. Date This Adm: 2003-10-06		AdmittingOfficer: [redacted] (b)(6)-2	
29. ReportingMTF 0580[redacted] Iraq (b)(2)-2				30. Date Init Adm ~~2003-10-06~~		32. Units Blood Components	

31. Selected Administrative Data

Marital Status:

In/Out Patient: Inpatient

DoB: [redacted]

MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

LLE FEMUR FX segmental

Dx 73381
9053
V5415
E9290

Inj Trauma
299 9

Pr: 7935
99104 (2)
8877
9338

35. Total Days This Facility					
Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	14	14

35. Total Days This Facility					
Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	14	14

(b)(6)-2

Signature of Attending Medical Officer [redacted] (b)(6)-2

[redacted] Medical Records Officer MAJ [redacted] (b)(6)-2

(b)(6)-2

Automated Facsimile - DA FORM 3647, May 79

MEDCOM - 21170

PERSONAL DATA REPORT

GENERAL INFORMATION

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

Name (F,M,L): [redacted]

Full Name: (b)(6)-4

WMD Category:

Operational Status:

Occupation:

National ID #: [redacted] (b)(6)-4

Gender: MALE

Race:

Hair Color:

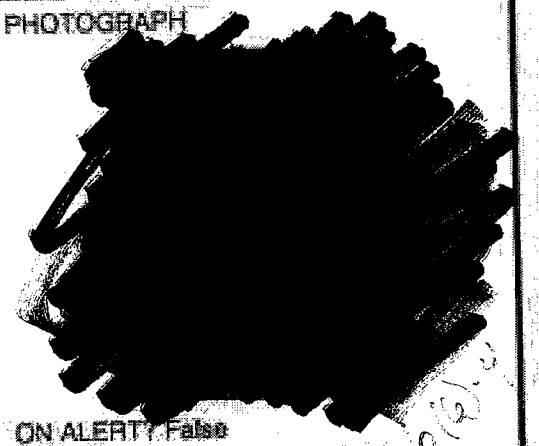
Eye Color:

Build:

Height (in): Min: Max:

Weight (lb): Min: Max:

PHOTOGRAPH



ON ALERT? False

T/A W/COALITION VEHICLE /ILL ENTERING IRAQ

PERSONAL DATA

Birthdate: 01JAN62

Birthplace: , ,

Death Date:

Religion:

Nationality:

Primary Citizenship:

2nd Citizenship:

Ethnicity:

Marital Status: Unknown

Personnel Status: Unknown

EXTENDED EPW INFORMATION

EPW Status: DETAINED

Camp Name: BCF

Compound: HARDSITE

Blood Type:

Accused Crime: T/A W/COALITION VEHICLE /ILL ENTERING IRAQ

Dietary Notes:

DNA Sample?

Physical Exam?

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

21 y/o ~~M~~ Iraqi ♂, passenger in car, involved in MVC while driving 9 days ago. Taken to EPW camp

PMHx: ∅
PSHx: ∅
Meds ∅
Allergies: NKDA

PHYSICAL EXAMINATION

XR: comminuted supracondylar femur fx w/ over proximal femur

HEAD: NC/AT
Chest: CTA
CVR: S1S2
ABD: soft
EXT: (L) leg, marked swelling, shortened, sensory intact
(L) thigh hip → knee
2+DP/PT, 5/5 EHL/FHL

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

(A) (L) Proximal femur fx, Distal femur fx

(P) ORIF

(b)(6)-2

[redacted] | DATE 10/6/13 | IDENTIFICATION NO. | ORGANIZATION | REGISTER NO. | WARD NO.

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

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

[redacted] (b)(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DICAL RECORD	NOTES
ATE	
2 Oct 03	Nursing: Pt admitted from ER @ 1215 for
1550	ⓛ Femur Fx. VS: T-99.2, HR-95, BP-135/76, R-22,
	Sats 99% on RA. ⓛ leg swollen, strong pedal
	pulses palpated, feet cool to touch, cap refill
	<3 secs, (+) movement, (+) sensation. Assisted Dr.
	[redacted] (b)(6)-2 pin insertion and traction
	Pt given 50 mg Fentanyl IV and [redacted] (b)(6)-2 Versed
	2 mg IVP during procedure. Pt placed on 10lb
	traction, weights hanging freely. IV in ⓡ AC
	infiltrated. [redacted] (b)(6)-2 infiltrated. 18G IV started in ⓡ Hand
	receiving NS @ 100 cc/hr. HOB ↑ 45°. Will
	continue to monitor. [redacted] (b)(6)-2
06 OCT 03 1800	Received report from previous shift. Pt awake in
	bed c ⓓ % pain/discomfort @ this time. Pt OOB ambulated
	in traction c 10lb weight suspended from guard.
	Drsg CDI. Pt ate dinner ≈ 50%. ⓓ needs expressed.
	With cont. care. [redacted] (b)(6)-2
2100	Pt resting c eyes closed. ⓓ % pain @ this time
	Will cont. care. [redacted] (b)(6)-2
07 OCT 03 0600	Pt c/o H/A. Gave Percocet it tabs. Will cont to assess
	pain level. [redacted] (b)(6)-2

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

RELATIONSHIP TO SPONSOR | RECORDS MAINTAINED AT | WARD NO.

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | REGISTER NO.

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1
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[redacted] (b)(6)-4

(b)(6)-4

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

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

DATE: 7 OCT 03

Time:

P: 90

BP: 126/72

T: —

R: 12-24

SpO2: 98%

Meds: ~~Motrin~~ Ibuprofen

ALL: NKDA

PMHX: MVA 11/14/03

FMHX:

LMC:

TOB:

Detainee [redacted] Adult ♂ Detainee c Hx of MVA prior to detention. Initially presented c lower leg splint and c/o (L) leg pain & seeing Iraqi physician. Now c/o R(L) leg pain, deformity and swelling.

Exam: Moderate pain (L) leg.
obvious deformity to (L) distal femur
Mod amount swelling & ecchymosis
VSS afebrile
(+) (L) knee effusion
Normal CMS distal
(+) pedal & post tib pulses
Normal ROM @ Ankle

A: (1) Initial assesment showed ↓ swelling ecchymosis or deformity above the knee.
(2) Now Appears device applied by Iraqi physician and lack of x-ray have caused distal femur fx to become malaligned (cover-

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

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

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

Name: (b)(6)-4 Rank:
SSN: # [redacted] Sex:
DOB: Out time:
Unit: (b)(2)-2

[redacted]

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

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(cont)

(b)(2)-2

Plan: ① Transfer to [redacted] for Orthopedic consult and definitive treatment as soon as transport can be arranged.

② Splint applied in medical tent. Splint material substandard but providing relief.

③ Continued checks to ensure no deterioration prior to transport.

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

5 OCT 03 patients Splint slipped out of place last evening. Continue to provide relief to leg. Maintains pair to good immobilization. ? How long.

A: Continued ~~to~~ CMS distal no deterioration of condition

P: Routine transfer 6 Oct 7 Oct at the latest.

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

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PROGRESS NOTES

CAL RECORD

TE

7-03

NOTES

Discharge Summary

This is a 21 y/o Iraqi male who sustained closed ⓛ proximal femur fracture and distal supracondylar femur fracture in a car accident ten days prior to admission here (10/6/03). Subsequently he had ORIF of both his fractures of his L/L femur. He has done well post operatively. He should remain non weightbearing on his left leg for 6 weeks. At 6w - 12 weeks he can be toe touch weightbearing with gradual resumption of full weightbearing after 12 weeks. Range of motion exercises should be emphasized at knee and hip. Remain on lovenox 30 mg SQ BID until pt more independent on crutches and then change to aspirin 325 mg QD.

(6)(6)-2 [redacted]

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

RELATIONSHIP TO SPONSOR | RECORDS MAINTAINED AT

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

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199[illegible]

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USAPA V1.[illegible]

[redacted] (6)(6)-4

MEDCOM - 21176

NSN 7540-01-075-3786

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

TEST RESULTS

CBC: WBC / H/H / PLT	SMAC	ABG/PULSE OX: SUP 02 / PH / P02 / PC02 / SAT / OTHER	RADIOLOGY — Check if read by radiologist ☐
PT		U/A: DIP / MICRO	RESULTS: X-ray → (L) femur transverse. distal - femur commi.
APTT	BHCG / ETOH / GLU		EKG INTERPRETATION

PROVIDER HISTORY/PHYSICAL

Pt arrived from EPW camp c̄ c/o (L) leg injury. Arrived c̄ splint & ACE, externally rotated, (+) pedal pulses (B). pt unable to bear weight per interpreter. pt state MVC x 3 days ago. Lungs CTA, denies other c/o. ~~Car Crash~~ Car Crash in Humvee [redacted] (b)(6)-2

allergies: 0 PMH: 0 PSH: 0 Smoke x 1ppd

MEDS: 0

alert HEAD: normocephalic Heart - reg

Lungs - clear A&P Heart - RR Stretch mark abdomen

Abd - soft B.S. - normal

(L) Leg - obvious deformity external rotation thigh - ecchymotic swollen 2-3" open laceration knee.

DP pulse - 2+ moves all toes. sensory - intact

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP: [redacted] M.D. (b)(6)-2

DIAGNOSIS
1) Transverse fx (L) femur - subtrochanteric
2) Distal femur - comminuted fx

CODES

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

H[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

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ACLU-RDI 1660 p.137

DOD-034753

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — PROGRESS NOTES

Admission Date: 6 Oct 03 Diagnosis: ① Femur FX HD: 1 POD: Ø

Skin assessment must be done initially and every 7 days.

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	4	**Mobility**	No limitations	4
	Slightly limited	3		Slightly limited	3
	Very limited	2		Very limited	(2)
	Completely immobile	1		Completely immobile	1
Moisture	Rarely moist	(4)	**Nutrition**	Excellent	4
	Occasionally moist	3		Adequate (Eats >50%)	3
	Moist	2		Adequate (Rarely eats)	(2)
	Constantly moist	1		Very poor	1
Activity	Walks frequently	4	**Friction and Shear**	No apparent problem	3
	Walks occasionally	3		Potential problems	(2)
	Chairfast	(2)		Problems	1
	Bedfast	(1)			

Total Score: 15

Add the total score
Above 20 Low Risk
Between 16 and 20 Medium Risk
Between 11 and 15 High Risk
Below 10 Very High Risk

Note: A Braden Scale Score of less than 15 indicates **HIGH RISK**-requires immediate Ulcer Prevention program.

Surgical wound (s): Yes ✓ No__ Location: ① Knee Size:_____ Drainage:_____
Tubes:_____ Pins: Traction pin Appearance: clear
Dressing change: None ordered

Burn wound (s): Yes__ No__ % BSA_____ Partial_____ Full_____
Location:_____ Size_____
Appearance:_____
Dressing change:_____

Pressure Ulcer (s): Yes__ No ✓
Stage I, II, III, IV (Circle the one that applies and describe below)
Location:_____ Size:_____
Wound character: Pink___ Moist___ Dry___ Granulation tissue___ Yellow slough___ Tunneling___
Undermining___ Odor___ Purulent discharge___ Eschar___ Exudates___
Type of dressing change: Wet-to-dry___ Comfeel dressing___ Carrasyn-V Gel___ Alginate___

Physician notified/consulted for wound debridement: Yes___ No___ Date/time MD notified_____
CNS notified/consulted for Stage II and greater: Yes___ No___
Nutrition Referral: Yes___ No___
Physical Therapy Referral: Yes___ No___
Action taken:_____ Date & Time_____

[redacted] (b)(6)-4

REGISTER NO.	WARD NO.

Patient's Identification (For typed or written entries

MEDCOM - 21178

PROGRESS NOTES

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
07 OCT 03 Ø100	Pt resting c̄ eyes closed. VSS. Ø needs expressed. Will cont. care. (b)(6)-2 [redacted]
Ø600	Gave report to next shift. (b)(6)-2 [redacted]
06[illegible]	Received Pt in ICU, Bed #2. Pt AOx follows commands. No distress noted. See Intensive care flow sheet for more information. (b)(6)-2 [redacted]
0900	Pt c/o Pain to Ⓛ leg. Percocet ii Tabs po given. [redacted] (b)(6)-2
1200	VSS Pt c/o Pain to left leg. Percocet ii Tabs Po given. (b)(6)-2 [redacted]
16[illegible]	Pt c/o left leg pain. Percocet ii Tabs po given. Pt washed. Traction maintained to left leg. [redacted] (b)(6)-2
18[illegible]	VSS [illegible] peripheral pulses Ⓟ IV D5% w/ [illegible] continues. Report given to relief nurse [redacted] (b)(6)-2
7 OCT 03	Ortho staff – No new O's, ↓ edema Ⓛ thigh, N/V intact, no skin breakdown, pain well controlled. – Transfer ICW in AM
Ø800	See ICU flow sheet. [redacted] Debrided OR-F (b)(6)-2 SPC, 91WM6
Ø8 oct 2400	Pt resting comfortably in bed VSS. Neurovascular checks to ⓁLE Ⓟ pulses. Pain controlled c̄ MSO4 & Percocet. Will continue to monitor. [redacted] SPC, 91WM6 (b)(6)-2
0600	Pt resting comfortably in bed. VSS. vasculo neuro checks Ⓟ pulses to LLE. Reported off to on coming shift. [redacted] (b)(6)-2

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PROGRESS NOTES

DICAL RECORD	NOTES
ATE	
0403	Received report from off going shift. Pt.
26	resting in bed c left knee splint. C/O pain (6)(6)-2
	to (L) leg. Percocet 5/325 PO given for
	complaint. Left leg remain in traction +
	elevated. Will continue to monitor. —
	(6)(6)-2
812	AM care completed @ this time. C/O Complaints
	of pain voiced. Will continue to monitor.
	(6)(6)-2
0942	C/O pain. Percocet 5/325 given for pain. Will
	continue to monitor. (6)(6)-2
1311	Pt resting in bed c left knee splint
	in traction to (L) leg. C/O pain @ present
	time. Percocet 5/325 p.o. given for complaint.
	Will continue to monitor. (6)(6)-2
8 oct 03	Assumed care of pt. transfer from ICU #1
1430	VSS Dx @ segmental femur fx. Lungs CTA HRRR
	Voids per Urinal @ BS. Active BS x 4 quads. Medicated
	prior to transfer @ c/o pain or discomfort @ this
	time - Traction weight to LLE will cont to monitor —
	(6)(6)-2

SPONSOR'S NAME

RELATIONSHIP TO SPONSOR | LAST | FIRST | MI | SPONSOR ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | REGISTER NO. | RECORDS MAINTAINED AT | WARD NO.

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

(6)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/19
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USAPA V1

LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

DATE	NOTES
08Oct03 (1755)	I concur c above assessment. (b)(6)-2 [redacted]
0800	Assumed care of pt @ 1800. VSS. C/O pain to
@2015	LLE, medicated c Demerol c good relief noted
	alert, speaking some English, LS CTA, @BS, voids
	per urinal s difficulty. LLE in 10# traction,
	LLE supported to maintain straight alignment
	⊕CMS to LLE, ⊕2 palpable DP/popliteal pulses.
	new IV started in (R) FA 20G, HL'd per Dr [redacted] (b)(6)-2
	Plan: monitor NV status, monitor pain control,
	pt restraint on s s/sx of skin / circulation
	compromise. (b)(6)-2 [redacted] CPT
9 Oct 03	VSS. Assumed care @ 0600. A&O able to make
1455	needs known. Cardiovascular & Pulmonary function
	intact. ⊕BS. Clr voiding clear yellow urine.
	Traction to LLE intact s difficulty. (L) thigh c bruising
	all over. HL @ FA patent. Medicated @ WX c
	demerol 50mg IV for c/o pain. Will continue
	to monitor [redacted] (b)(6)-2
10 Oct 03	Medicated c 50mg demerol [redacted] (b)(6)-2
1770	[redacted] (b)(6)-2
4036020	Assumed care @ 1600; All VSS, pt A&O; [redacted] 10lb traction to (L) LE in place s
	difficulty, dsg CDI s drainage; ⊕BS, ⊕BM via bedpan; HL to (R) FA patent
	easily flushes; pt voiding QS, clear yellow urine s difficulty; ⊕CMS to
	(L) LE, ⊕pulses, boots & cap R&E, ⊘c/o pain @ this time; Restraints in
	place, ⊕circ, ⊘skin breakdown, cont to monitor [redacted] (b)(6)-2
11 Oct 03	Pt A&O LS CTAB, s s/s present ⊕BS [redacted] voids
24	(L) leg in traction. Am care completed [redacted] (b)(6)-2

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PROGRESS NOTES

MEDICAL RECORD	NOTES
DATE	OpNote
17-03	PreOpDX : Segmental (L) femur Fx.
	Proximal subtroch, distal supracondylar
	PostOpDX: same
	Procedure: ORIF (L) hip, (L) Distal femur
	c̄ Fixed angle blade plates
	(b)(6)-2 [redacted] / [redacted] (b)(6)-2
	Surgeon:
	Anesthesia: GETA
	Fluids: 3200 LR NS 7800 1000 Albumin 2u PRBC
	EBL 1800
	Urine 300cc
	Findings: Comminuted supracondylar femur Fx, transverse
	subtroch
	Complications Ø [redacted] (b)(6)-2
	PT c/o pain. Dressing Dry.
10-11-03	Sat 97% RA. BP 134/65 HR 140 T 102
1100	2+ DP/PT, +/SILT/FHL. [redacted]
	CBC pending. Drain c̄ ≈ 75cc. (b)(6)-2 [redacted]
	↑ MSO4 qh. Pain control.

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

RELATIONSHIP TO SPONSOR	RECORDS MAINTAINED AT	
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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)

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5/19[illegible])
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PROGRESS NOTES

MEDICAL RECORD	NOTES
DATE	
CTO3	pt Resting Quietly In bed VSS Assessment Complete IV in (L) wrist/hand
0630	Infusing well @ 125cc/hr A-Line in (R) wrist to monitor (L)E elevated per doctors order pt complained of pain; Pain meds given per doctors orders No problems @ present will continue to monitor — PFC gwm6
900	Percocet Tab 1 p.o. given for c/o pain. (b)(6)-2 (b)(6)-2
2905	pt temp ↑ to 102.9 will recheck temp in 30 minute No other problems present @ this time VSS will continue to monitor — (b)(6)-2 PFC gwm6
1155	temp ↓ c̄ percocet No problems @ present Pt c/o pain, pain med Frequency ↑ VSS No S/s of acute distress noted will continue to monitor (b)(6)-2 LLT [illegible]
1800	Received report. (b)(6)-2 LLT [illegible]
1900	Assessment completed. (b)(6)-2 LLT [illegible]
2345	Pain managed c̄ MSO4 and Percocets. (b)(6)-2
12Oct05 0600	Patient slept intermittently throughout night. Pain managed c̄ MSO4 / Percocets. LE warm, pulses 2+, good sensation, able to move toes. No other (b)(6)-2 complaints throughout night. Report given [illegible] LLT [illegible]
12Oct05 @0850	pt VSS Assessment complete see Flowsheet For details (+) movement sensation to (L)E pulse (+)(+) No C/o @ Present No pain meds given @ present pt laying in bed c̄ eyes closed No problems @ present will continue to monitor (b)(6)-2 PFC gwm6

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	REGISTER NO.	RECORDS MAINTAINED AT	WARD NO.

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/198[illegible]
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USAPA V1.1

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12 OCT 03 2240	Pt c/o pain (L) LE. Gave 5mg MSO4 IVP. Will cont to assess pain level. (b)(6)-2 [redacted]
0200	pt VSS, afebrile (b)(6)-2 [redacted] 1LT/ANC
13 OCT 03	pt report recieved VSS Assessment complete [redacted] pt
@ 0920	s̄ c/o @ present will continue to monitor [redacted] (b)(6)-2
13 Oct 03	pt given Fleet enema and Mag Citrate per doctors orders
@ 0555	Foley D/c'd VS stable will continue to monitor [redacted] (b)(6)-2
13 OCT 03	ONCOMING STAFF.
1400	Pt resting comfortably
	Afebrile P/11 Normal Sat 97% R.A.
	Drain out 10cc/12 hour
	Incision (L) leg clean & dry, thigh soft
	2+ DP/PT, Cap WT
	Drain pulled, Dressing D/C'd.
	XR → Transfer ICW
	(b)(6)-2 [redacted]
13 oct 03	pt VSS dressing Δ completed s̄ problems will transfer
@ 1525	to ICW p̄ X-ray of (L) femur Hip to knee will continue to monitor (b)(6)-2 [redacted] PFC
@ 1758	pt report given VSS pt waiting for X-Ray (b)(6)-2 [redacted]
@ 1820	Report recieved from PFC [redacted], PT VSS (b)(6)-2 [redacted]
@ 2200	pt transfered to ICW / (b)(6)-2 (b)(6)-2 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
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PROGRESS NOTES

CAL RECORD

DATE	NOTES
1030	+ Pt transferred from ICU, placed in bed c 2pt restraints on. LLE wrapped in ace wrap dsg CDI, ⊕CMS to LLE, +2 DP & popliteal pulses. LSCTA, ⊕BS x4quads (⊕BM today per report from ICU), voiding per urinal c difficulty. MSO4 given for pain relief during transfer. Percocet given for pain also @ this time. Plan: monitor NV status, pain control, OOBTC tomorrow, PTOT as ordered. 2pt restraints in c S/SX of skin/circulation compromise (b)(6)-2 WILL CONT. TO MONITOR.
Oct03 1000	V SS. Alert & oriented ×3. OOB → chair for breakfast. Tolerated well. Temp clam. BBT) x4quad Abd. Dept - non distended. (L) Hand IV Saline locked intact & patent @ LE dsg dry & intact. Peripheral pulses palpable +2. (L) foot capillary refill < 3sec. Will Continue Care of [redacted] (b)(6)-2 PCT
1400 Oct03 @2145	Assumed care of pt @1800. VSS. C/o pain to LLE, percocets given c good relief noted. LLE dsg CDI, ⊕CMS, +2DP & popliteal pulses. Tolerating liquid po, refused dinner meal. Pt encouraged to Lend (L) (CONT)

SPONSOR'S NAME

RELATIONSHIP TO SPONSOR | LAST | FIRST (b)(6)-2 | RECORDS MAINTAINED AT

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

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

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record
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USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2145 (cont)	↑ knee to ↑ ROM. Plan: pain control enc po intake, monitor NV status. (b)(6)-2 [redacted] CPT addendum: 1pt restraint on 3 s/ox skin/circulation compromise. (b)(6)-2 [redacted] CPT
2245-	Pt c/o chills, ~~dtd~~ sweating. T=101.6. Tylenol 650mg po given, IS encouraged (demonstrated properly to staff) good technique and po fluids encouraged. Will monitor. [redacted] CPT
0100-	Pt ↓ 99.3. Will cont to enc IS & po intake. Linen Δ'd (b)(6)-2 [redacted] CPT Dt sweats. (b)(6)-2 [redacted] CPT
0400.	Pt temp ↑ 99.9. Percocet given. Will monitor. [redacted] (b)(6)-2
15Oct03 @ 0743	Pt laying in bed. Lung sounds clear through all lung fields. ⊕ pedal pulses B/L. Ⓡ leg restrained. ⊖ S/S of skin breakdown to Ⓡ restrained leg. ⊕ Bowel sounds. Abdomen soft + non-~~dtd~~ distended. Pt refused breakfast. (b)(6)-2 [redacted] RN
0800	Pt c/o pain. Med'd "1/2 percocet. D'ed drsg to Ⓛ leg. Sutures C,D,I, ~~S&I~~ Sutures well approximated. Sterile saline + bacitracin used to clean sutures. Bacitracin applied to abrasions on leg. Wrapped in ace bandage. (b)(6)-2 [redacted]
150ct03 @ 1915	VSS, A+O, c/o pain to Ⓛ LE, administered ×1 percocets PO as ordered, Ⓛ LE c leg & ACE CDI, neurovascularly intact, 2+ pulse Ⓛ pedal, Ⓐ edema (2+), Ⓛ LE ↑, IV to Ⓟ AC Hi'd, continuing IV antibx. ×2 restraints ∴ skin breakdown? Ⓣ 101.4 but will reevaluate (gave Percocet as written earlier). Tolerates PO, voids adequate UOP, ∅ S/S of any distress, ∅ other remarkable findings. Continue to monitor for any acute Δ's. (b)(6)-2 [redacted] RN

STANDARD FORM 509 (REV. 5/1999) BACK
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PROGRESS NOTES

ICAL RECORD

DATE	NOTES
OCT 03 0730	Assumed care of Pt @ 0700. Pt Awake + A&O. Dsg to LLE Dsg CDI. LLE +3 pitting edema noted. Ant:- biotics infusing into 18G cath in R FA. Pain controlled T percocet. Will continue to monitor — [redacted] (b)(6)-2 Spc. 9/WNM
03@1930	Assumed care @ 1800; All WSS, temps slightly T, IS used, cold pack given; cont to monitor; pt A&Ox3, pain controlled T perc; staples to (L) LE OTA, @ drainage, well approximated, @ S/Sx infection; +2 pitting edema noted; HL to (R) FA patent cont T IV abx; pt OOBTC X1 for 2 hours; Rest cont to monitor [redacted] (b)(6)-2 (L) skin break ↓, Cont to monitor
'OCT 03 1000HRS	PT NOTE - HX: GAIT TRAINING T CRUTCHES NWB (L) LE T/M: PTT ASSISTED BY TRANSLATOR. PNT DEMONSTRATED UNDERSTANDING OF BASIC COMMAND/INSTRUCTION. PNT DENIED DIZZINESS OR NAUSEA OR EXCESSIVE PAIN. (b)(6)-2 (+) EDEMA; (+) ECCHYMOSIS (L) LE (KNEE, THIGH, ANKLE, TOES) PNT DEMONSTRATE [redacted] NORMAL (B) UE & (R) LE GRMT. PNT DEMONSTRATE MODERATE BALANCE (GAIT BELT APPLIED) & COOR. DX: AMBUL T CRUTCHES BID. SO ANKLE PUMPS BID FOR EDEMA CONTROL. I: SAME. PNT AMBULATE ~10'. G: AMBUL PNT ~200' & ↓ EDEMA @ ANKLE BY 75% X 2wks. (b)(6)-2 Spc [redacted] 9/WNONG PT TECH

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

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | REGISTER NO. | RECORDS MAINTAINED AT | WARD NO. ICU 4th

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

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17OCT03@ 1330	Assessment done. V.S.S. although temp slightly elevated (99.6°F) (L) leg elevated. Pt. ambulated c PT. tech using crutches. 2+ pitting edema to (L) LE, DRSNG's to (L) LE Δ'd, small amount of reddish-brown [redacted] drainage. Pt. has low urine output. Pt. encouraged to drink water. Pt. has refused to eat breakfast & lunch. Pt. encouraged to eat & drink via translator multiple times. [redacted] (b)(6)-2 2 CT, AN
17OCT03@ 1530	Pt. sitting up in bed drinking water occasionally. Pt. diaphoretic c/o pain frequently. Pt given 2 mg MSO4 IV for breakthrough pain as per MAR-s. Pt. compliant c using I.S. [redacted] (b)(6)-2 2 CT, AN
17OCT03@1650	Pt. resting quietly in bed, semi-Fowlers. EOW restraint protocol used c signs of skin breakdown. [redacted] (b)(6)-2 2CT, 1AN
(2000)	Rt sitting up in bed, temp 99, c/o pain often, II Percocet given @ 1900. (L) leg drsg dry & intact. non-compliant c ambulating to chair: due to pain. H2O encouraged, Rt consumed 50% dinner. Rt able to move toes, +2 pitting edema (L) leg elevated on blanket. 2 pt restraints compromise to skin/circulation Will monitor. [redacted] (b)(6)-2 9 Wmle.
18OCT03 1100	Assumed care of Pt @ 0600 hr. A&O. LS CTA (B). S_1S_2 Present (+) BS x 4 quads. Pt void qs c difficulty. Pt LLE Incision on out aspect of thigh closed c staples open to air LLE c +3 pitting edema. Pt [redacted] (b)(6)-2 Ambulated to Bathroom. LLE elevated c Blanket Antibiotics Running through 18 R AC. Will continue to monitor. [redacted] (b)(6)-2 Spc 9 Wmle

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

MEDICAL RECORD	NOTES
DATE	VSS. AO. Med c/o pain to LLE and provided MSO4
OCT 03	for pain. Tolerated PO med. ⊕ 2 pulse to LLE c CR
2235	≤ 2 seconds. ↓ SC ↓ AB. DSG's CDI to LLE. Voiding
	≤ 2 seconds. ↓ SC ↓ AB. DSG's CDI to LLE. Voiding
	≤ 2 seconds - [illegible] ... light yellow urine, BS ≤ difficulty. [illegible] about
	c minimal purulent drainage. Encouraged to eat PO [redacted]
	and did well for chores. (b)(6)-2

SPONSOR'S ID NUMBER (SSN or Other)

SPONSOR'S NAME: LAST | FIRST | MI

RELATIONSHIP TO SPONSOR

RECORDS MAINTAINED AT

HOSPITAL OR MEDICAL FACILITY

WARD NO.

DEPART./SERVICE

REGISTER NO.

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/19)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)
USAPA V

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

MEDCOM - 21189

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

[MEDI]CAL RECORD	NOTES
[D]ATE	
[10-]18-03	PT Performed (L) hip/knee ROM. Pnt c/o pn throughout exercise Performed (L) PEAFs x50 Performed 0-15-90 (L) knee Ambulated 50' c pnt c/o dizziness. Will cont Rehab. Per NS [redacted] 1-2 days (b)(6)-2 [redacted]
10-18-03	Irrm clin xdz. 0-90° @ knee c assist (b)(6)-2 UCs today. [redacted]
18OCT03 1720	PT A&O LS CTA (B) S1S2 present (+) BS x4 quads. VSS. (L) LE lateral thigh incision c staples OTA (b)(6)-2 PT c/o pain controled c MSO4 p Percocet. Voiding [redacted] 91 ml spontaneously. Will continue to monitor [redacted] (1750) I concur (b)(6)-2

SPONSOR'S ID NUMBER (SSN or Other)

SPONSOR'S NAME | FIRST | MI

RELATIONSHIP TO SPONSOR | LAST | RECORDS MAINTAINED AT

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | REGISTER NO. | WARD NO. ICW#1

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

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

[redacted] (b)(6)-4

MEDCOM - 21190

NSN 7540-01-075-3788

MEDICAL RECORD — EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER | TREATM [redacted] (b)(2)-2

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

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

Y | STATE | ZIP CODE

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

ARRIVAL: DATE (Day, Month, Year) 04/10/03 | TIME 0850

TRANSPORTATION TO FACILITY: FLA

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

EMERGENCY ROOM VISIT: DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS: DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

INJURY OR OCCUPATIONAL ILLNESS

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

CURRENT MEDICATIONS: ϕ

ALLERGIES: NKDA

CHIEF COMPLAINT: left Knee injury

ϕ SX ϕ med

CATEGORY OF TREATMENT

☐ EMERGENT
☐ URGENT
☒ NON-URGENT

TIME: 0850

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

VITAL SIGNS

TIME	0856	C 1125	1045	1112	
BP	129/77	124/64		120/68	
PULSE	107	101		96	
RESP	16	18		16	
TEMP	99(O)				
WT	99 / 58 A	98.8 R		100.2/60	

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

X-RAY ORDERS: ☐ CXR PA & LAT/PORTABLE | ☐ ACUTE ABDOMEN | ☐ SINUS | ☐ ANKLE R/L | ☒ L Leg/Knee | C-SPINE | LS SPINE | HEAD CT | ☒ AP Pelvis, AP/LAT Distal Femur, X-table lateral HIP

☐ ECG

ORDERS

☐ MONITOR | ☐ PULSE OX

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	5mg MSO4		[redacted]	@0905	(b)(6)-2
	5mg MSO4			@1030	(b)(6)-2

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

PATIENT/DISCHARGE INSTRUCTIONS

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

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

EMERGENCY CARE AND TREATMENT (Patient)
Medical Record

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

PLAN OF CARE FOR SKIN BREAKDOWN AND WOUND MANAGEMENT

MEDICAL RECORD — PROGRESS NOTES

Admission Date: 6 Oct 03 **Diagnosis:** ⓒ Femur Fx **HD:** 1 **POD:** Ø

Date: 6 Oct 03 Time: 1625 RN Signature: [redacted] 49/ow (b)(6)-2

Skin breakdown as evidenced by immobility, friction, shear, moisture, abrasions, surgical wound, skin tear.

Wound type: Surgical wound (s) Location:_____ Size:_____ Drainage: _____
Diabetic ulcer Tubes:_____ Pins: Traction Pin Appearance: clean
Venous stasis ulcer Dressing change: None
Other_____ Describe_____

Burn wound (s): % BSA_____ Partial_____ Full_____
Location:_____ Size_____
Appearance:_____
Dressing change:_____

Pressure Ulcer (s):
Stage I, II, III, IV (Circle the one that applies and describe below)

Location:_____ Size:_____
Wound character: Pink____ Moist____ Dry____ Granulation tissue_____ Yellow slough _____
Tunneling_____ Undermining_____ Odor_____ Purulent discharge_____ Eschar_____ Exudates _____

Refer to SOP for Dressing Change Instrucitons.

Please check the appropriate dressing Change:

- ☐ Wet to Dry Dressing
- ☐ Carrasyn-V GelDressing
- ☐ Alginate Dressing
- ☐ Comfeel Dressing
- ☐ Pin Site Care
- ☐ J-Tube Care
- ☐ Colostomy Care
- ☐ Chest Tube Care
- ☐ Burn Care

NOTE: Document daily wound and dressing change on Progress Note or Nursing Note.

Select the appropriate products used:

- ☐ Sterile 4x4 gauze dressing
- ☐ Sterile 2x2 gauze dressing
- ☐ Sterile gloves
- ☐ Kerlix (super sponge)
- ☐ Gauze bandage
- ☐ Sterile Normal Saline
- ☐ Sterile Water
- ☐ 8 x 4 Sponge gauze
- ☐ Op-site
- ☐ Tegaderm clear dressing
- ☐ Alkare skin prep
- ☐ Comfeel clear
- ☐ Comfeel pressure ulcer drsg
- ☐ Carrasyn-V Gel
- ☐ Alginate
- ☐ Bacitracin
- ☐ Silvadene Cream
- ☐ Petrolatum gauze
- ☐ Hibicleanse
- ☐ Non-adhesive dressing
- ☐ Telpha Pad
- ☐ Carra-smart film
- ☐ Sterile Q-tip applicator
- ☐ Xeroform 5 x 9.
- ☐ Moisture barrier cream
- ☐ 0.125% Dakins sol
- ☐ Betadine Swab sticks
- ☐ ½ Hydrogen Peroxide & ½ Sterile Normal Saline

Select the frequency of dressing change:

- ☐ b.i.d.
- ☐ t.i.d

MD Signature and Date:

CNS Signature and Date:

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facility)

Medical Record, SF 509

[redacted] (b)(6)-4

MEDCOM - 21192

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: 21 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [ ] NO [X] YES (type): Placement of Traction pin LLE

4. PROPOSED SURGICAL PROCEDURE:

ORIF proximal & distal femur (L)

5. ADDITIONAL INFORMATION: Last PO: lunch Medical Hx: 0 Implants: Traction Bow LLE (b)(6)-2 [redacted] (b)(6)-[redacted] Medications: Phenergan pm Demerol pm Ambien @ HS.
Jewelry removed: yes/no Family waiting: yes/no

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

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

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

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

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

[redacted] CRNA/AN (6)(6)-2 10 OCT 03 DATE

11. POSTOPERATIVE EVALUATION:

Bovie site: intact
Dsg: C&D
Resp: spontaneous

Post

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)

[redacted] CRNA/AN (6)(6)-2

DATE: 10 OCT 03 TIME: 1510

13. ~~PRE~~OPERTIVE EVALUATION PREPARED BY (Signature and Title)

[redacted] CPT/AN (6)(6)-2

DATE: 11 Oct 03 TIME: 0240

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

MEDCOM - 21194

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERAT.. VIA Litter BY Anesthesia
2. PATIENT IDENT VERIFIED BY ILT [redacted] RECORD REVIEWED AND PROCEDURE (b)(6)-2
3. DATE 10 OCT 03 TIME PATIENT ARRIVED IN SUITE 1907
4. PATIENT IN ROOM TIME 1910 NUMBER) #14
5. PREOPERATIVE EMOTIONAL STATUS
☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify)
COMMENTS: NKDA. NPO @ 1200

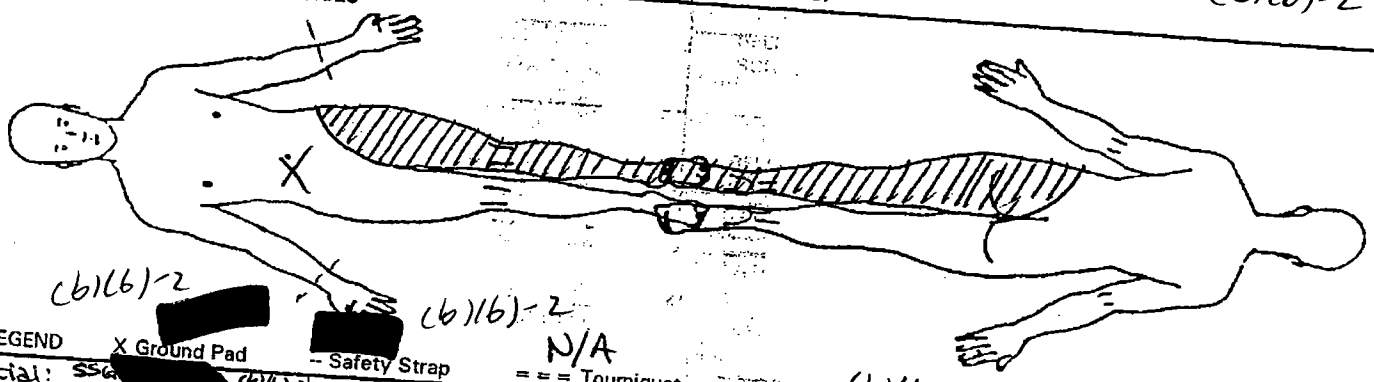
6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D (b)(6)-2	RELIEF SCRUB	(b)(6)-2
ASSIGNED CIRCULATOR	ILT [redacted] 66E (b)(6)-2	RELIEF CIRCULATOR INT:	CPT [redacted] (2300 - EOC) CPT [redacted] (0017 - 0050)

7. POSITION AND POSITIONAL AIDS (Specify) Pt. laterat on padded OR table, supported by bean bag. Axillary roll in (R) axilla. Pillow between legs. (R) arm on padded armboard. (L) arm in padded arm holder.
☐ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☒ LEFT SIDE UP ☐ RIGHT SIDE UP
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS: N/A
PREP SOLUTION (Specify) Betadine/Betadine
SITE: Left leg - hip to toes
BY WHOM: ILT [redacted] (b)(6)-2
COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet N/A
Initial: SSG [redacted] (b)(6)-2 ILT [redacted] (b)(6)-2

10. COUNTS (C = Correct I = Incorrect)

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

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

11. PATIENT IDENTIFICATION (For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)
EPW # [redacted] (b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO
☒ ESU NO: VL Force 40 Cut: 50 Coag: 50 → 65
GROUND PAD: BRAND VL REM PolyHesive II
LOT NO: 70011 Exp: 2005-04
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

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

MEDCOM - 21195

6.5 cancellous 75mm

13. PROSTHESIS, IMPLANTS [X] | IO | IF YES NAME: ID NUMBER | CTURER

Blade Plate set: 7 Hole plate - proximal — Synthes ASTF Screw Set — ortical 4.5 cortical 3.5 cortical
Load # 0228003 — 12 Hole plate-distal — Load # 0322301 — proximal — 40mm X3 — 70mm X1 — 55 X1
Hoffman II — fx — 38mm X1 — 40mm X1 — 60 X1
Load # 0426301 — 38mm X3
36mm X1

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S):
0.9% NaCl. q.s.

OTHER ORDERS	TIME	CARRIED OUT BY
16e Fr Foley Cath	Intra-op	[redacted]

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES [X] NO [ ] — C-Arm — IF YES, SITE: Left femur

16. LABORATORY SPECIMENS

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

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

	1.	2.	3.
TYPE/SIZE	1/4" Hemovac		
SITE	Lt. thigh		

Fluffs
Kerlix
ABD's
ACE

19. ADDITIONAL INFORMATION

Surgeon: Dr. [redacted] (b)(6)-2 Dr. [redacted] (b)(6)-2 — GETA — wc:I
Anesthesia: MAS [redacted] (b)(6)-2

16e Fr Foley cath placed 5 problems, draining clear yellow urine - monitored by anesthesia.

DA5179 initiated

20. OPERATION(S) PERFORMED — ORIF of proximal & distal femur (L)

0240

21. PATIENT TRANSFERRED TO	TIME See DA 7389	METHOD
PACU ICU 1		Litter & O2

22. REGISTERED NURSE SIGNATURE (b)(6)-2 [redacted] LT. - I [redacted] CPT/AN (b)(6)-2

REVERSE OF DA FORM 5179-1, OCT 87 — MEDCOM - 21196 — USAPA V1.00

NSN 7540-00-634-4124

VITAL SIGNS RECORD

ICAL RECORD

HOSPITAL DAY

DAY

EAR 19 | DAY | HOUR

PULSE (0) | TEMP. F (°)

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

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

TEMP. C

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

(Centigrade Equivalents, for Reference only)

8 Oct 9 Oct 10

1430

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

[redacted] (b)(6)-4

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

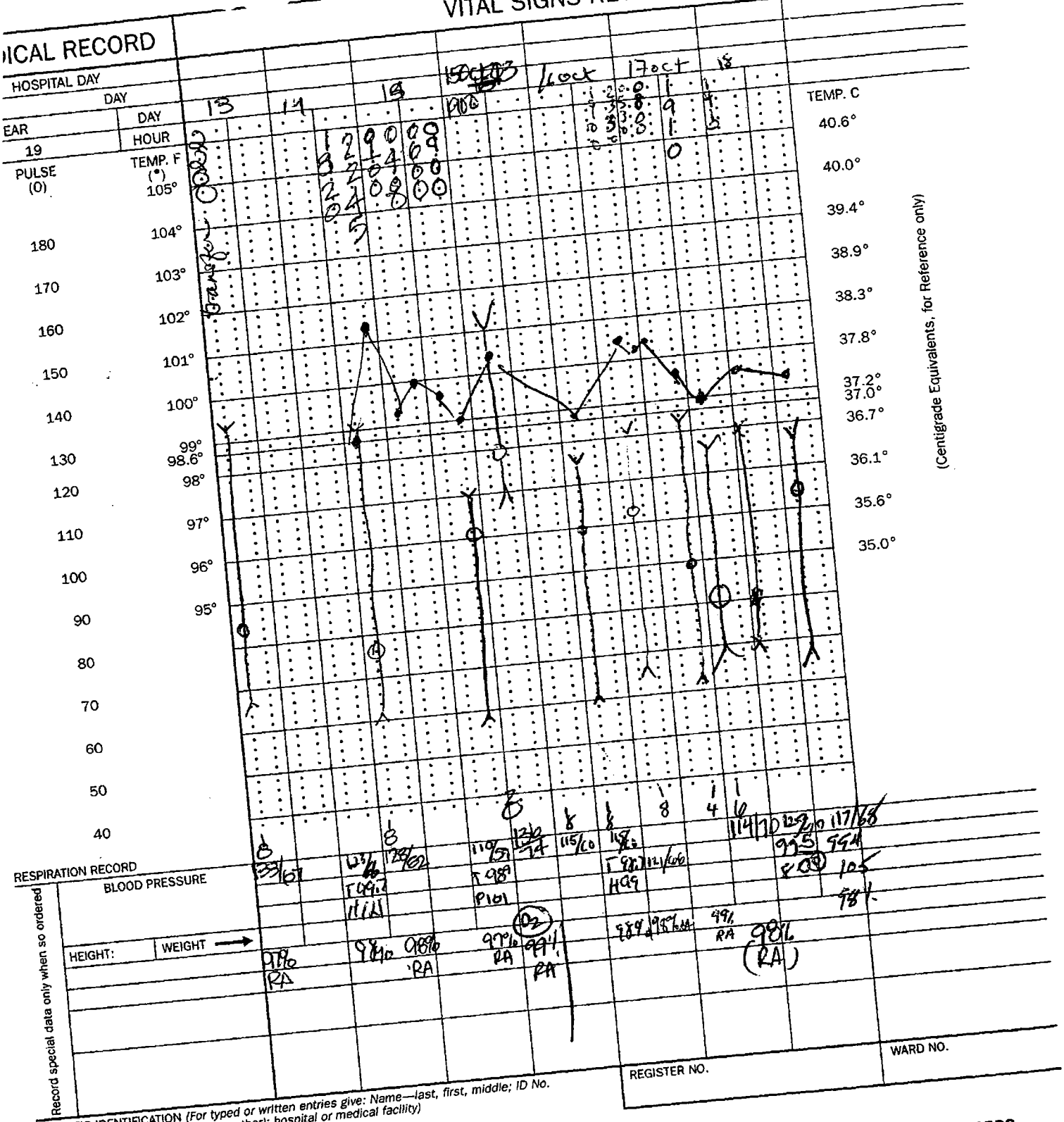
Medical Record

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

MEDCOM - 21197

NSN 7540-00-634-4124

VITAL SIGNS RECORD



VITAL SIGNS RECORDS

Medical Record

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

[redacted] 66161-4

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY 19

19 | HOUR 0 8

PULSE (O) | TEMP. F (°)

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

98% RA

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] (6)(6)-4

REGISTER NO.

WARD NO.

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

(b)(6)-2

Ward/Section: EMT	REQUESTING PHYSICA[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, M[redacted] (b)(6)-4	DATE 6 Oct 03	TIME 90C	SSN/PEEUDO 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 x10	Color		N/A	RPR		Negative
RI			App		N/A	Mono		Negative
H			Glu		Negative	Microbiology		
H			Bili		Negative	Source		
M			Ket		Negative	Gram Stain		
Pl			SG		N/A	Occ Bld		Negative
Ly			Bld		Negative	H. pylori		Negative
(			pH		N/A	Micro Parasites		
S			Prot		Negative	Malaria		
B			Urob		0.2-1.0	O & P		
Ly			Nit		Negative	Other		
At			Leuk		Negative	Macroscopic Urinalysis		
RL Morph			HCG		Negative			
Spun Hematocrit		42-52%(M) 37-47%(F)	CSF			Blood Bank		
Set Rate			Cell Count			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED		
Other			Directigen		Negative	ABO/Rh		

(b)(6)-4 [redacted]

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

REMARKS:

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

Ward/Section: EMT	REQUESTING PHYSICAN (b)(6)-2 [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted]	(b)(6)-4 DATE 60403 TIME 906	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE

======= PICCOLO =======
06/10/03 09:10
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
BASIC METABOLIC
DISC LOT #: (b)(6)-2 3203AA4
OPER # [redacted] DR #: 000
SERIAL #: [redacted]
.....(b)(6)-4.....

GLU	91	73-118	MG/DL
BUN	12	7-22	MG/DL
CA++	9.2	8.0-10.3	MG/DL
CRE	0.9	0.6-1.2	MG/DL
NA+	♦♦♦	128-145	MMOL
K+	4.3	3.3-4.7	MMOL
CL-	101	98-108	MMOL
tCO2	23	18-33	MMOL

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

Na - 139

REMARKS: (b)(6)-2

REPORTED BY: [redacted]	DATE: 60403	LAB ID NO.:

Ward/Section: OR	REQUESTING PHYSICIAN: [redacted] (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted] (b)(6)-4	DATE 10 OCT	TIME 2115
SSN/[illegible]: [redacted] (b)(6)-2		

(i-STAT) #6 + Control

TEST	RESULT	REF. RANGE
Na	139	138-146 mmol/dL
K	3.5	3.5-4.9 mmol/L
CI		98-109 mmol/L
pH	7.388	7.31-7.45
PCO2	41.4	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	430	80-105 mmHg (art) N/A (ven)
TCO2	27	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	25	22-26 mmol/L (art) 23-28 mmol/L (art)
SO2	100	95-98%
BEecf	0	(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca	1.22	1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	29	38-51% PCV
Hgb	9.4	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: (b)(6)-2 [redacted]	DATE: 10 Oct 03	LAB ID NO.:

(b)(6)-2

Ward/Section: OR	REQUESTING PHY[redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, M[redacted] (b)(6)-4	DATE 11 OCT 03	TIME 0020 ~~0000~~ SSN/P[redacted] (b)(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
[redacted]		4.8-10.8 x10
Morph		
Spun Hematocrit		42-52%(M) 37-47%(F)
Set Rate		
Other		

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Macroscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

Ward/Section: OR	REQUESTING PHYSICAN: [redacted] (b)(6)-2		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] (b)(6)-4	DATE 11 OCT 03	TIME 0000	SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT) 6+7 cartridge

TEST	RESULT	REF. RANGE
Na	144	138-146 mmol/dL
K	3.7	3.5-4.9 mmol/L
Cl	109	98-109 mmol/L
pH	7.410	7.31-7.45
PCO2	39.5	35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2	26	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	25	22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf	0	(-2) - (+3) mmol/L
AnGap	10	10-20 mmol/L
Ca	1.24	1.12-1.32 mmol/L
BUN	7	8-26 mg/dl
GLU	107	70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	41	38-51% PCV
Hgb	14	12-17 g/dl

(Piccolo) Chemistry 12

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Metlyte 8

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 21204

MEDICAL RECORD - ANESTHESIA

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

NKOA

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

DRUG (Units)													
Midazolam (mg)	2-		1			2							
Fentanyl (mg)	50-	<100>			<250>	X250>			<250>		<250>		
Ketamine (mg)	20-	20-		20	20								
Lidocaine (mg)	100	/MSO4	5		5			10	(20 mg MSO4 for case)				
Propofol (mg)	200												
VCR (mg)	5mg/100	/	5	5	(Nimbex - 4/10/10						10		
VOLAT AGENT Sevo % del		2.0	2.0	2.0	2.5	1.0	1.0	2.0	2.0	1.5	2.0	1.0	
% e.t.													
AIR L/Min													
N2O L/Min													
O2 L/Min	10	2	2	2	2	2	1	1	1	1	1	1	

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → (4)

FLUIDS

LINE site 20g (R) A	☐ Warmed	X											
18G (L) HD	☐ Warmed		LR #1				LR #1						
16G (R) A	☒ Warmed		NS #2			#3 LR Hespan 500							
	☐ Warmed												
LOSSES EST BLOOD LOSS				50	2nd/300				3rd/750	3rd/400		1st/550	
URINE -	Foley			100	3rd/250				3rd/300				

TOTALS	TOTAL EBL
5	1800
1750	
50	TOTAL URINE
500	500

FLUIDS - SUMMARY

CRYSTALLOID: LR 3200 NS 2800

COLLOID: Hesp 1000

BLOOD: 2 units

REMARKS

Code drugs with numbers, events with letters

(1) Pre-operative room, monitors, O2 induced, eyes taped closed, soft bite block + OG-P induction.

(2) 16G (R) arm — 18G (L) HD + A-line (R) radial

(3) Ancef 2gm IVPB

(4) LPT FROM MAO (b)(6)-2

(5) LABS RESULTS REC'D - SEE CHART

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT: 34.4

INITIAL DATA:

BP- 133/75

HR- 103

EQUIP CHECK

OK?- (Y) N

PATIENT RECHECK

OK for PROCEDU [redacted]

TIME- (b)(6)-2

TIME → 1945 2000 30 2100 30 2200

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

220 200 180 160 140 120 100 80 60 40 20

VENTIL

VT - ml	+	770	740	760	760	770	600	700	720	720	730	720
f - breaths/min	+	10	10	10	10	10	8	8	8	8	8	10
Peak inf pres / PEEP	—	22	23	23	23	22	20	20	20	20	20	30
MODE - S(pon), A(ssist), C(on)	S→C	C	C	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff / ET CO2 (torr)	35	33	33	34	34	35	34	34	34	34	36	31
BP/oth / FIO2 (Frac or %)	0.6	0.6	0.6	0.6	0.6	0.35	0.59	0.61	0.61	0.62	0.62	0.65
ART line / SpO2 (%)	100	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	SR
Gas analyzer / TEMP-site Nasal			39	36.1	36.1	35.9	35.6	35.4	35.4	35.6	35.3	35.6
N-M Block (T/4)	0/4		4/4	0/4	0/4	1/4	0/4	0/4	0/4	0/4	0/4	0/4
BS	+		+									
Warming blkt / x 1 Rewarm												
Conv warmer												

Mark with letters & symbols, explain under REMARKS — EVENTS / Position → (1) OR (2) RLD eyes checked (3) eyes; ar roll →

RECOVERY AT 2245

PACU (ICU) ____ (Specify)

OTHER ____

CONDITION: talking

RESP- talking SpO2- 96

BP- 128/68 HR- 106

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1900	1910	0300
PROC Ready	Begin		End
1920	2005		0233

PROCEDURES and CPT Codes:

ORIF (L) femur fx

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

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

EPW [redacted]

(b)(6)-4

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

DL x1 MAC 4 Grade 1 view 8.0 stylette ORTT 23cm @teeth + BBS + Sust E TOR

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

(b)(6)-2

CRNA/MA [redacted]

ANESTHESIA PROVIDER [redacted] (b)(6)-2 CRNA

PROCEDURE LOCATION: 1

DATE: 10 Oct 03

PAGE 1 OF

DA FORM 7389, FEB 1998

MEDCOM - 21205

USAPA V1.00

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)												
Fentanyl (mcg)	<250>					100	50	50	50			
VOLAT AGENT SEVO % del	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	1.75	2.0
% e.t.												
AIR L/Min												
N2O L/Min												
O2 L/Min	1 — 1 — 1	2 2	2	2	2	2	2	2	2	2	2	2
SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS	(6)											

TOTALS / TOTAL EBL / TOTAL URINE — PAGE ONE

FLUIDS - SUMMARY: CRYSTALLOID- COLLOID- BLOOD-

FLUIDS

LINE site		
18g (L) HD	☐ Warmed	LR4 —— HESP2 —— x —— RBC#1 —— RBC2
16g (R) A	☐ Warmed	LR5 —— x
	☐ Warmed	NS6 ——
	☐ Warmed	

LOSSES

EST BLOOD LOSS: 200/85?; 150/1000; 230/1100; 150/1400; 100/1500; 100/1600

URINE -: 50/400; 75/475; 25/450

REMARKS

Code drugs with numbers, events with letters

(6) Pt placed supine, arms secured on armboards.

(7) LAB Results - see chart

(8) OOR to ICU 1

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: KG LB

HEMATOCRIT:

INITIAL DATA: BP- HR-

EQUIP CHECK OK? Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

TIME → 230 [redacted] 2300 2330 0000 0030 0100 0130

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

Grid annotations: (b)(6)-2; (7); 1g CaCl; 1g Amicar ?; 25 mg labetalol

VENTIL / MONITORS/ACCESSORIES

VT - ml	730	730	730	750	660	680	690	680	700	680	750	570
f - breaths/min	10	10	10	8	7	8	8	8	8	8	8	12
Peak Inf pres / PEEP	28	27	27	29	27	27	27	27	27	28	30	21
MODE - S(pon), A(ssist), C(on)	CV	C	C	C	C	C	C	C	C	C	C	C
✓ BP/Auto Cuff / ✓ ET CO2 (torr)	30	30	30	29	33	34	33	34	34	34	33	32
BP/oth / ✓ FIO2 (Frac or %)	0.64	0.6	0.6	0.65	0.65	0.66	0.61	0.61	0.52	0.51	0.53	0.51
✓ ART line / ✓ SpO2 (%)	100	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	SR
Gas analyzer / ✓ TEMP-site	35.7	35.9	35.9	36.1	36.0	36.0	35.6	35.4	35.4	35.4	35.4	35.5
✓ N-M Block (T/4)	0/4	0/4	1/4	2/4	4/4	4/4	4/4	4/4	4/4			
Warming blkt												
Conv warmer												

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

RECOVERY AT: PACU ICU (Specify) OTHER CONDITION: RESP- SpO2- BP- HR- — PAGE ONE

ANESTHESIA / PROCEDURE TIMES: ANES Start Room End; PROC Ready Begin End

PROCEDURES and CPT Codes: ORIF (L) Femur FX / (L) Knee

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks* — PAGE ONE

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

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

EPW # [redacted]

(b)(6)-4

SURGEONS: PAGE ONE

ANESTHETISTS:

PROCEDURE LOCATION: 1

DATE 10 OCT 03

PAGE 2 OF

DA FORM 7389, FEB 1998 [redacted] —RBC1 —

COPY 2 - ANESTHESIA PROVIDER USAPA V1.00

MEDCOM - 21206

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)	
Fentanyl	(mcg)	50/100/100
Propofol	( )	50/30/20/50/
	( )	
	( )	
	( )	
VOLATILE AGENT	% e.t.	2.0 1.5 X
AIR	L/Min	
N2O	L/Min	
O2	L/Min	3 3 2 2 2 2

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

FLUIDS

LINE site		
Right Forearm	☐ Warmed	LR
Left Forearm	☐ Warmed	NS 1000 NS 500
	☐ Warmed	RLS X1
	☐ Warmed	

LOSSES — EST BLOOD LOSS: 150/1750 50/1800 — URINE -

TOTALS — TOTAL EBL: 0 — TOTAL URINE: 0

FLUIDS - SUMMARY — CRYSTALLOID: 2000 — COLLOID: 500 — BLOOD: 0

REMARKS — *Code drugs with numbers, events with letters*

PAGE ONE

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP: 110/70 HR: 70

EQUIP CHECK: OK? Y N

PATIENT RECHECK: OK for PROCEDURE? TIME-

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

TIME → 0130 0200 0230 0300 0330 0400 0430

Extubated 0400

		0130	0200	0230	0300	0330	0400	0430
VENTIL	VT - ml	600	510	640	420	530		
	f - breaths/min	12	8	7	9	10		
	Peak inf pres / PEEP	22						
	MODE - S(pon), A(ssist), C(on)	CV	SV	SV	SV	SV		
MONITORS/ACCESSORIES	BP/Auto Cuff	32	48	44	46	44		
	BP/oth	0.52	0.54	0.55	0.57	0.55		
	ART line	100	100	100	100	100		
	Stath- PC/ES	SR	SR	SR	SR	SR		
	Gas analyzer	356	357	X	X			
		3/4						
	Warming blkt							
	Conv warmer							

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

RECOVERY AT: PACU ICU (Specify) OTHER — CONDITION — RESP- SpO2- BP- HR-

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES			
PROC	Ready	Begin	End

PROCEDURES and CPT Codes: PAGE ONE

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

[redacted] (b)(6)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*

SURGEONS:

ANESTHETISTS:

PROCEDURE LOCATION: OR1

DATE: 10-11 OCT 03

PAGE 3 OF

DA FORM 7389, FEB 1998 — COPY 2 - ANESTHESIA PROVIDER — USAPA V1.00

MEDCOM - 21207

Sex ( ) ~~MALE~~ ( ) FEMAL ... (Sedatio ... nesthesia)

PROPOSED PROCEDURE: ORIF (L) femur
SURGICAL SERVICE: ORTHO
NPO SINCE: noon

ASA Physical State 1 (2) 3 4 5 (E)
WT: 80 (KG) LB HT: IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: yes
ETOH: no
DRUGS: no

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ø pre-op
( ) In hospital on
( ) Lovenox 30mg SQ BID
( )
( )
( )

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

LABORATORY STUDIES:
HB/HCT: ____ / ____
U/A:
OTHER:
6Oct: 4.3 | 101 | 12 / 23 | 0.9 < 91
16.6 > 11.5 / 36.4 < 657
9Oct — Hct 34.4
T&C for 2 units

PREOPERATIVE PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:
- Hypertension (N) Y
- Angina (N) Y
- MI (N) Y
- CVA (N) Y
- Other (N) Y

Ø

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

Familial HX (N) Y (N) Y

MVA 8 plus days ago, EPW admitted Oct 6, 2002

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Ø

PHYSICAL EXAMINATION
BP 133/75 HR 103 R ___ T 98.7 Sat 98%
Pain Scale 0-10
HEENT - Teeth intact
Trachea midline
TMJ/Neck FROM
Oropharynx MP II
Nares
CHEST: CTA (B)
CARDIAC: RRR (no) (m)
EXTREMITIES:
IV Access: 20 (R) A
Ulnar Filling:
BACK:
OTHER:

NPO Since 1200 Noon

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

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.
The pa[redacted]al guardian [redacted] understand and agrees. Questions answered.
(b)(6)-2
Signed: [redacted] CRNA/MAJ Date: 10/10/03 Time: 1628 Hrs

POST-[redacted]STHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ________ Date: ______ Time: ______ Hrs

Patient Identification: (Ward)

EPW [redacted] 9B
(b)(6)-4
[redacted]
(b)(6)-4

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

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

ANESTHESIA RECORD

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

MEDCOM - 21208

NSN 7540-00-634-4159

BLOOD OR BLOOD COMPONENT TRANSFUSION

RECORD

SECTION I – REQUISITION

EQUESTED (Check one)

OOD CELLS

FROZEN PLASMA

ETS (Pool of _____ units)

PRECIPITATE (Pool of _____ units)

MMUNE GLOBULIN

IER (Specify) _____

REQUESTED (If applicable) _____ ML

RKS:

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

☐ TYPE AND SCREEN

☒ CROSSMATCH

DATE REQUESTED 10-9-03

DATE AND HOUR REQUIRED ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN (Print)

DIAGNOSIS OR OPERATIVE PROCEDURE

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

SIGNATURE OF VERIFIER [redacted] (b)(6)-2

VERIFIED 10CT03

TIME VERIFIED 2024

SECTION II – PRE-TRANSFUSION TESTING

NO [redacted] (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

RECIPIENT

DONOR

ABO O

Rh POS

ABO B

Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Compatible

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

PREVIOUS RECORD CHECK:

☐ RECORD ☒ NO RECORD

SIGNATURE OF PERSON P [redacted] (b)(6)-2

DATE 10-9-03

REMARKS:

EXP 14 OCT 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Sig [redacted] (b)(6)-2

AT (Hour) 0030

ON (Date) 11 Oct 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (Sig [redacted] (b)(6)-2

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

PRE-TRANSFUSION: TEMP. 35.6 | PULSE 80 | BP 100/49

DATE OF TRANSFUSION 11 OCT (b)(6)-2

TIME STARTED 0045 0115

POST-TRANSFUSION DATA

AMOUNT GIVEN ALL ML

TIME/DATE COMPLETED/INTERRUPTED 0145 11 OCT 03

TEMPERATURE 35.7 | PULSE 84 | BLOOD PRESSURE 99/60

REACTION

☒ NONE ☐ SUSPECTED

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN

☐ OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)

☒ NO ☐ YES (Specify)

SIGNATURE OF PERSON NOTING A [redacted] CCNA (b)(6)-2

SEX [redacted] WARD ICU

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle initial; date of birth; hospital or medical facility)

[redacted] (b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

Medical Record Copy

MEDCOM - 21209

518–124

NSN 7540–00–634–4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)*

_____ ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED: 10-9-03

DATE AND HOUR REQUIRED: ASAP

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*

DIAGNOSIS OR OPERATIVE PROCEDURE

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

SIGNATURE OF VERIFIER [redacted] (b)(6)-2

DATE VERIFIED: 9Oct03

TIME VERIFIED: 2024

SECTION II – PRE-TRANSFUSION TESTING

[redacted] (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	Compatible

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [X] NO RECORD

SIGNATURE OF PERSON PE[redacted] (b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 10-9-03

DONOR	RECIPIENT
ABO O	ABO B
Rh POS	Rh POS

REMARKS: EXP 14 Oct 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] (b)(6)-2

AT *(Hour)* 0030 ON *(Date)* 11 Oct 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Sig[redacted]* (b)(6)-2

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

PRE-TRANSFUSION

TEMP. 35.6 | [redacted] 80 | BP 100/49

DATE OF TRANSFUSION 11 OCT (b)(6)-2 | TIME STARTED 0015

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, m[redacted] rate; hospital or medical facility)

[redacted] (b)(6)-4

POST-TRANSFUSION DATA

AMOUNT GIVEN: ALL ML

TIME/DATE COMPLETED/INTERRUPTED: 0145 11 OCT 03

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
35.7	84	99/50

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)*

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

WARD: ICU

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 21210

Medical Record Copy

LCW1

NSN 7540-01-165-7294

518-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

U/S Duplex

(L) LE

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.

FILM NO.

PREGNANT ☐ YES ☐ NO

REQUESTED BY (Print) [redacted] (b)(6)-2

TELEPHONE/PAGE NO.

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

DATE REQUESTED 10-28-03

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

R/o DVT (L) leg p Femur fx

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

RADIOLOGIC REPORT

(L) LE Duplex color US.

No evid of DVT.

[redacted] (b)(6)-2

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

[redacted] (b)(6)-4

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

SIGNATURE

RADIOLOGIC CONSULTATION REQUEST/REPORT
1 — MEDICAL RECORD

STANDARD FORM 518-B (8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.806-8

MEDCOM - 21211

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

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

10-6-03 ____ HOURS

- Admit ICU -
- (L) Segmental Femur Fx
- V.Stks per SOP
- IV D5 1/2NS @ 100 cc/hr
- Regular Diet
- Percocet #1 po q 4° PRN
- ~~Demerol~~ MSO4 2-8 mg IM q 2° PRN breakthru
- Lovenox 30 mg SQ BID
- Bed rest, traction to be applied.

(b)(6)-2 [redacted] 60ct 03 1245

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

6 Oct 03 1300 HOURS

① Fentanyl 50 mcg IVP Now 1630 6Oct03

② Versed 2 mg IVP Now

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

6 Oct 03 1809

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

PATIENT IDENTIFICATION

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER

07 Oct 03 1500 HOURS

- Transfer to ICU-1 under Dr. O
- Routine vitals
- 10lb traction (L) LE, ensure (L) leg is
- bolstered & feet are not rubbing against
- bed frame
- Bed rest
- Regular Diet (Cont)

(b)(6)-2 [redacted] 07 Oct 03 0800 1500

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

(b)(6)-4 [redacted]

(b)(6)-2 [redacted] Noted c wdr

NURSING UNIT | ROOM NO. | BED NO.

24/080 900003 [redacted] 1500

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
10-7-03	1900 HOURS	
(cont)		
- Demerol 50-75mg IV q 4° prn breakthrough		
- Phenergan 25mg IVP q 6° prn nausea		
✓ - Ambien 10mg po q HS		
✓ - Lovenox 30mg SQ BID		
(b)(6)-2 [redacted]		

PATIENT IDENTIFICATION

EPW # [redacted]

(b)(6)-4

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

DATE OF ORDER	TIME OF ORDER	
10-9-03	0800 HOURS	
- NPO prn		
- D/c Lovenox now		
(b)(6)-2 [redacted]		
(b)(6)-2 [redacted]		10/9/03 0530

PATIENT IDENTIFICATION

EPW # [redacted]

(b)(6)-4

NURSING UNIT: ICU 1 | ROOM NO.: 24° | BED NO.: 10Oct030 180 [redacted]

(b)(6)-2

DATE OF ORDER	TIME OF ORDER	
10-9-03	1720 HOURS	
CBC & T~~S~~ 2u PRBC tonight		
(b)(6)-2 [redacted]		
(b)(6)-2 [redacted]		10/9/03 1720

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER	TIME OF ORDER	
10Oct03	1630 HOURS	
(1) NPO to OR @ 1900, have ready		
(2) Bottle pt please		
Mouth care		
(3) LR @ 125mL/hr		
[redacted] (b)(6)-2	CRNA/MAJ [redacted]	(b)(6)-2

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

MEDCOM - 21213

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 10-11-03 TIME OF ORDER: ____ HOURS | LIST TIME ORDER NOTED AND SIGN

/ Admit ICU - Dr D
/ Dx: Postop Ortho (L) femur Fx
/ Condition: Stable
/ Vitals: per unit SOP
/ Bedrest
/ I.S.
/ Elevate (L) LE

PATIENT IDENTIFICATION: NOTED 0335 11 OCT [redacted] (b)(6)-2

DATE OF ORDER / TIME OF ORDER ____ HOURS

/ Foley to gravity
/ Regular Diet
/ Heplock IV when tol p.o.
/ Percocet i-ii p.o. q 4° prn
/ MSO4 2-8 mg IVP q 2° prn breakthrough pain
/ Phenergan 25 mg IVP q 6° prn nausea
/ Ancef 1 gm IVPB q 8°
/ Colace 100 mg BID

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER / TIME OF ORDER ____ HOURS

/ Lovenox 30 mg SQ BID
/ Ambien 10 mg po qHS [redacted] (b)(6)-2

- 10-11-03 1115 [redacted]
- CBC now
↑ MSO4 to q 1° dosing
Continue I.S. & pulm toilet

NURSING UNIT | ROOM NO. | BED NO.

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

PATIENT IDENTIFICATION

DATE OF ORDER / TIME OF ORDER ____ HOURS

· Record U/O / urine output q Shift (b)(6)-2 [redacted]

2400 ✓ [redacted] 12 Oct 0300

10-12-03 1500
Heplock IV
D/C IVF
(b)(6)-2 [redacted]

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

NURSING UNIT | ROOM NO. | BED NO.

2400 ✓ [redacted] 13 Oct 0300

DA FORM 1 APR 79 4[redacted]6 CPT/A REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 21214

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

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
13OCT03	0915 HOURS	
- MagCitrate ½ bottle p.o.		
- Fleets enema x1		
- D/C Foley		
(b)(6)-2 [redacted]		
13OCT03	1400	noted [redacted] (b)(6)-2
- Portable XR AP + LAT Ⓛ Femur		
Hip to knee ō ORIF		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	HOURS	
- Transfer to ICW-1 After XR		
- Regular Diet		
- OOB to chair QID		
- PT for gait training NWB Ⓛ LE from knee		
- Incentive Spirometry		
- Routine Vitals		
- Daily dressing Δ's Ⓛ leg		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	HOURS	
- Regular Diet		
- Ancef 1gm IVPB q8°		
- Levoquin 500mg IV qD		
- Percocet ii po q4° PRN		
- MSO4 2-8mg IVP q2° PRN breakthru		
- Phenergan 25mg IVP q6° PRN nausea		
- Ambien 10mg po qHS PRN insomnia		(b)(6)

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	HOURS	
- Lovenox 30mg SQ BID		[redacted]
(b)(6)-2 [redacted]		
10 Oct 03	1600	1620
D/C pt to EPW Hospital		
[redacted]		
(b)(6)-2		

NURSING UNIT | ROOM NO. | BED NO.

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

MEDCOM - 21215

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

(b)(6)-4

#[redacted]

(b)(6)-2 [redacted] Noted 18 Oct 03 1520

NURSING UNIT: ICW#1 | ROOM NO. | BED NO. 240

DATE OF ORDER: 10-18-03 | TIME OF ORDER: 10-18-03 HOURS | LIST TIME ORDER NOTED AND SIGN

- U/S Duplex (b)(6)-2 LE R/O DVT

(b)(6)-2 [redacted]

(b)(6)-2 [redacted] (b)(6)-2 [redacted] 18/15/03 2230

PATIENT IDENTIFICATION

(b)(6)-4

#[redacted]

(b)(6)-2 [redacted] Noted SA 18 OCT 03 1900 2225

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 10-18-03 | TIME OF ORDER: _____ HOURS

XRAY - AP+LAT (b)(6)-2 HIP

AP+LAT (b)(6)-2 Distal Femur

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER: _____ HOURS

PATIENT IDENTIFICATION

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

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER: _____ HOURS

DA FORM 1 APR 79 4256 REPLA[illegible] MEDCOM - 21216 [illegible]ICH MAY BE USED.

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

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 6	7	8	9	10
6 Oct 03	[redacted]	Vitals per SOP	06	[redacted]				
(b)(6)-2		(Q6°)	18					
6 Oct 03	[redacted]	Regular Diet	06	X				
(b)(6)-2			12					
			17					
6 Oct 03	[redacted]	Bedrest	06					
(b)(6)-2			18					
6 Oct 03	[redacted]	Traction to be	06					
(b)(6)-2		applied	18					
7 Oct 03	[redacted]	Vital Signs Routine	06	/	/			
(b)(6)-2			18					
7 Oct 03	[redacted]	10lb traction (L) LE, ensure	06					
(b)(6)-2		(L) leg is bolstered & feet	18					
		are not rubbing against	/					
		bed frame						

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) Segmental Femur Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

(b)(6)-2

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

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

MEDCOM - 21217

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo Oct Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
(6)(6)-2	6Oct03 [redacted]	Admit to ICU	6Oct03		1215	[redacted]	(6)(6)
(6)(6)-2	7Oct03 [redacted]	Transfer to ICU 1 in 4m	8Oct03	AM			
(6)(6)-2	9Oct [redacted]	NPO p MN	9Oct				
(6)(6)-2	9Oct [redacted]	CBC c Ts 2 U PRBC	9Oct	2000	2010	[redacted]	(6)(6)
	----	tonight					

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 11	12	13	14
(b)(6)-2 110CT	[redacted]	Condition Stable,	06	[redacted]			
			18	[redacted]			
(b)(6)-2 110CT	[redacted]	Vitals per ward SOP	06	[redacted]			
			18	[redacted]			
(b)(6)-2 110ct	[redacted]	Bedrest	06	[redacted]			
			18	[redacted]			
(b)(6)-2 110ct	[redacted]	I.S.	06	[redacted]			
			18	[redacted]			
(b)(6)-2 110ct	[redacted]	Elevate LLE	06	[redacted]			
			18	[redacted]			
(b)(6)-2 110ct	[redacted]	Foley to gravity	06	[redacted]			
			18	[redacted]			
(b)(6)-2 110ct	[redacted]	Regular Diet	06	[redacted]			
			18	[redacted]			
(b)(6)-2 11 oct 03	[redacted]	Continue I.S. pulmonary toilet	06	[redacted]			
			18	[redacted]			
(b)(6)-2 11 oct 03	[redacted]	Record ~~documentation~~ Drain output q SHIFT	06	[redacted]			D/C'D
			18	[redacted]			
(b)(6)-2 12oct03	[redacted]	Heplock IV	06	[redacted]			
			18	[redacted]			
(b)(6)-2 12oct03	[redacted]	D/C IV Fluids	06	/ [redacted]			
			18	/ [redacted]			
(b)(6)-2 13oct03	[redacted]	D/C Foley	06	/ / [redacted]			
			18	/ / [redacted]			

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ORIF (L) femur Knee Fx

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 - 21219

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo Oct Yr 2003

Verity by Initialing

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(b)(6)-2 11Oct	[redacted]	Admit ICU Dr [redacted]	11Oct	✓		[redacted]
(b)(6)-2 11oct	[redacted]	CBC Now	11Oct03	[redacted]	[redacted]	[redacted]
	----	Portable X RAY AP+LAT Femur	12oct03	[redacted]	[redacted]	[redacted]
	----	Hip to Knee ō ORIF				
(b)(6)-2 10/16	[redacted]	D/C to ENT Hosp	10/17			

2-(a)(9)

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

USAPA V1.00

CLINICAL RECORD

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

Mo. ____ Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 13	14	15	16	17	18	19	20	21
(b)(6)-2 13	[redacted]	Regular diet	6	/	[redacted]							
			18									
(b)(6)-2 13	[redacted]	COB to chair QID	08	/								
		NWB LLE	12	/								
			16	/								
			22	/								
(b)(6)-2 13	[redacted]	Incentive Spirometry	6	/								
			18	/								
(b)(6)-2 13	[redacted]	Routine VS	6	/								
			18	/								
(b)(6)-2 13	[redacted]	Daily drsg AS Dug	10	/								

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: LLE ORIF (femur)

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

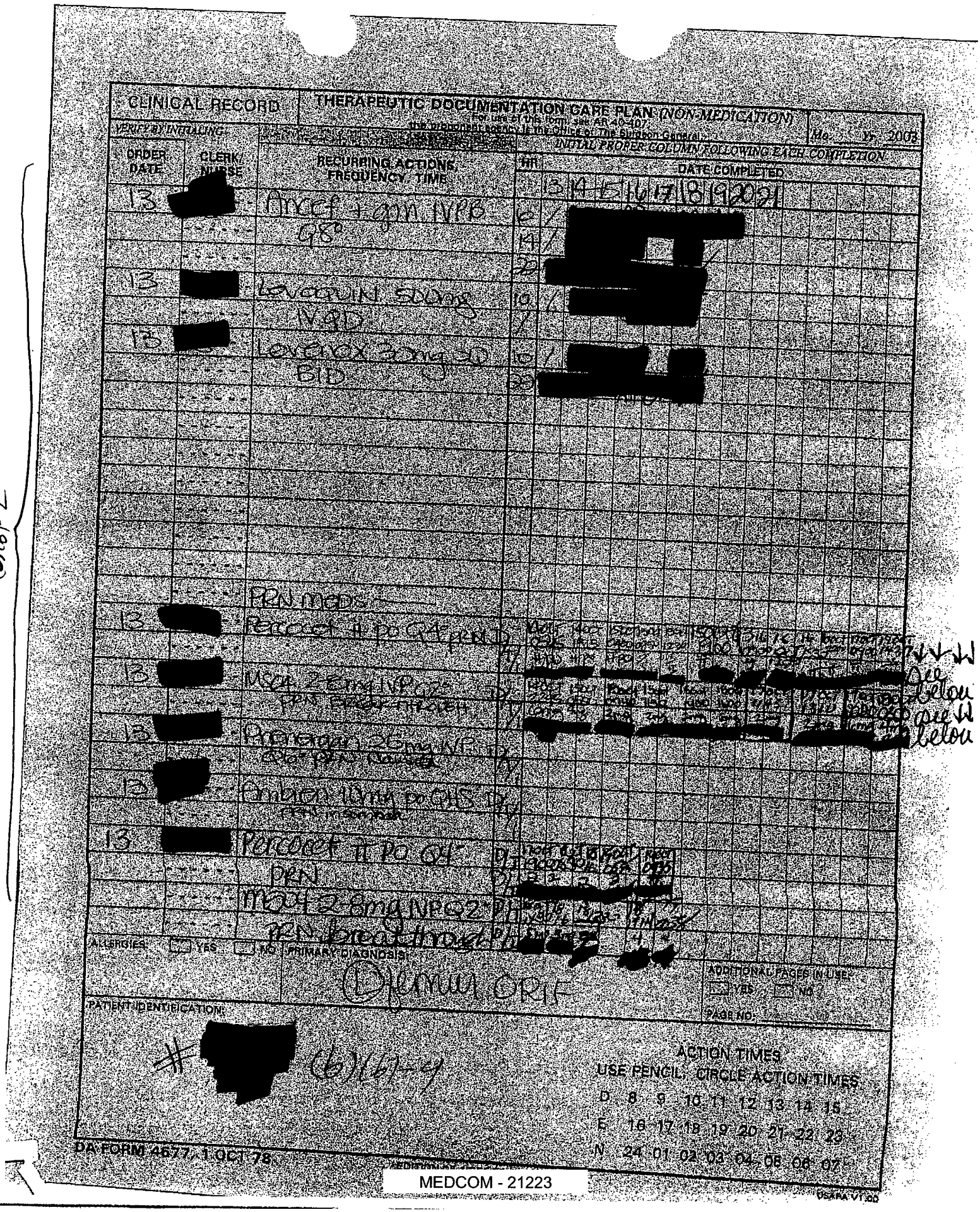
DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

MEDCOM - 21221

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)			Mo ____ Yr 2003	
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(6)(6)-2 13	[redacted]	TRANSFER ICAN #1				
(6)(6)-2 13	[redacted]	P.T. for gait training NWB LLE				
(6)(6)-2 18	[redacted]	U/S Duplex (L) LE R/O DVT	18oct	ASAP	DONE	
(6)(6)-2 18 oct 03	[redacted]	X-ray: AP/LAT (L) hip AP/LAT (L) distal femur			DONE DRYDEN	

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

USAPA V1.00



CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mo. Yr. 2003

INITIAL PROPER GOLDMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING:

ORDER DATE | CLERK/NURSE | RECURRING ACTIONS, FREQUENCY, TIME | HR | DATE COMPLETED

13 [redacted] Ancef + gm IVPB Q8°

13 [redacted] Levaquin 500mg IVPB

13 [redacted] Levaquin 30mg PO BID

PRN meds

13 [redacted] Percocet 1 PO Q4 PRN pain

13 [redacted] MSO4 2-8mg IVP Q2 PRN Breakthrough pain

13 [redacted] Phenergan 25mg IVP Q6 PRN Nausea

13 [redacted] Zofran 4mg IVP Q6 PRN Nausea

13 [redacted] Percocet 1 PO Q4 PRN

MSO4 2-8mg IVP Q2 PRN breakthrough pain

ALLERGIES: YES NO PRIMARY DIAGNOSIS: Ulcerative colitis

ADDITIONAL PAGES IN USE: YES NO

PAGE NO:

PATIENT IDENTIFICATION:

[redacted] (b)(6)-2

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES.

D 8 9 10 11 12 13 14 15

E 16 17 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

DA FORM 4677, 1 OCT 78

MEDCOM - 21223

USAPA V1.00

(b)(6)-2

Green Sheet

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. 10 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
				23 24 25 26 27
26 Oct	[redacted]	Regular diet	D	/ [redacted]
			N	[redacted]
25 Oct 03	[redacted]	MTBTD Crest QID	01	/ / [redacted]
			10	/ / [redacted]
			16	/ / [redacted]
			22	/ / [redacted]

(b)(6)-2

(b)(6)-2

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Rule Out / Ruled out

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 72 MAY BE USED. — USAPA V1.00

MEDCOM - 21224

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 10 Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
(b)(6)-2 23Oct	[redacted]	D/C Pt in Am to ER	24Oct	AM	CANCEL	
		Hospital	✓	✓	✓	✓
(b)(6)-2 25 Oct 03	[redacted]	PT for crutch ambulation	25			[redacted] (b)(6)-2
(b)(6)-2 25	[redacted]	XR - AP/LAT @ knee	25			[redacted] (b)(6)-2
(b)(6)-2 25 Oct 03	[redacted]	D/C to ER w/ comp & crutches				

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

USAPA V1.00

MEDCOM - 21225

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 6	7	8	9	10	
(b)(6)-2	6Oct03	[redacted]	IV: D5 1/2 NS @	06	[redacted]					(b)(6)-2
			100cc/hr	18	[redacted]					
(b)(6)-2	6Oct03	[redacted]	Lovenox 30mg	10	X	[redacted]				
			SQ BID	22	[redacted]					
*	7Oct03		Ambien 10mg PO qHS	22	[redacted]					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (L) Segmental Femur Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ______

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678 — MEDCOM - 21226 — EDITION OF ... WILL BE USED UNTIL EXHAUSTED.

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. Oct Yr. 03

Verify by Initialing

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6Oct03	[redacted]	Fentanyl 50 mcg IVP Now	6Oct03		1305	[redacted]
6Oct03	[redacted]	Versed 2 mg IVP Now	6Oct03		1305	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
6Oct03	[redacted]	Percocet ii PO Q4° PRN	6Oct 03 1213; 7 Oct 03 0010; 7 Oct 03 0400; 7 Oct 03 1200; 7 Oct 03 1600; 8 Oct 03 0300; 8 Oct 03 0624; 8 Oct 03 [illegible]; 8 Oct 03 1315
6Oct03	[redacted]	HS04 2-8 mg IVP Q2° PRN Breakthrough	1830 7 Oct 03 2mg; 2300 7 Oct 03 4mg; 0230 8 Oct 03 2mg

*U.S. GPO: 1998-454-110/95216

MEDCOM - 21227

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. 10 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
(b)(6)-2 10/03	[redacted]	Lovenox 30mg SQ	10	08 9 /
	-----	BID	22	[redacted] / D/C 10-05-0800
(b)(6)-2 10/03	[redacted]	Ambien 10mg SQ	22	[redacted]
	-----	BID po 9HS		

(b)(6)-

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: ⊙segmental femur fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM [illegible] 4870

EDITION OF [illegible] DEC 77 WILL BE USED UNTIL EXHAUSTED.

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED														
(b)(6)-2	[redacted]	Phenergan 25mg IVP q6° prn nausea	D/T														
			D/I														
(b)(6)-2	[redacted]	Demerol 50-75mg IV q 4° prn breakthrough	D/T	8OCT 1900	8OCT 2305	9OCT 0400	9OCT 1000	9OCT 1715	9OCT 2300								
			D/I	50mg	75mg	50mg	50mg	50mg	75mg	[redacted]							

(b)(6)-2

*U.S. GPO: 1998-454-110/95216

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
(b)(6)-2 11Oct	[redacted]	Heplock IV when taking PO	06	[redacted]			
	-----		18	[redacted]			
(b)(6)-2 11Oct	[redacted]	Ancef 1gm IVPB q8°	06	[redacted]			
1	-----		14	[redacted]			
	-----		20	[redacted]			
(b)(6)-2 11Oct	[redacted]	Colace 100mg BID	10	[redacted]			
	-----		22	[redacted]			
(b)(6)-2 11Oct	[redacted]	Lovenox 30mg SQ BID	10	[redacted]			
11	-----		22	[redacted]			
(b)(6)-2 11Oct	[redacted]	Ambien 10mg PO qHS	22	[redacted]			

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P ORIF (L) femur knee Fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

D 7 8 9 10 11 12 13 14

E 15 16 17 18 19 20 21 22

N 23 24 01 02 03 04 05 06

DA FORM 4678 MEDCOM - 21230

EDITION OF [illegible] WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. OCT Yr. 03

	Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials	
(b)(6)-2	11OCT	[redacted]	Ambien 10mg PO	11Oct	/	0320	[redacted]	(b)(6)-2
(b)(6)-2	13Oct03	[redacted]	Mag Citrate 1/2 bottle P.O.	13 oct 03	/	0930	[redacted]	(b)(6)-2
(b)(6)-2	13oct03	[redacted]	Fleets Enema x1	13 oct 03	/	0930	[redacted]	(b)(6)-2

INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED

	Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY		1	2	3	4	5	6	7	8	9	10	11	12	13	14
(b)(6)-2	11OCT	[redacted]	Percocet II PO	D	11OCT	11OCT	11OCT	11OCT	~~11Oct~~	12Oct	12Oct	12OCT	12OCT	13OCT	13OCT	13Oct	13Oct	13OCT
				T	0315	0900	1400	2200	~~0615~~	1005	1400	1800	1905	0025	0412	1000	1400	1850
			q4° PRN	D	II	II	II	II		II	II	II	II	II	II	II	II	II
				I	[redacted]					[redacted]								
(b)(6)-2	11OCT	[redacted]	MSO4 2-8 IVP q2°	D	11OCT	11Oct	11oct03	11oct03	11oct	order Δ'd see Below								
				T	0320	0410	0615	0815	1110									
			prn Breakthrough pain	D	IV	4	8	2	8									
				I	[redacted]													
(b)(6)-2	11OCT	[redacted]	Phenergan 25mg															
			IVP q6° PRN Nausea															
(b)(6)-2	11 oct	[redacted]	↑ MSO4 2-8 IVP q1°	D	11oct03	11oct	11oct03	11oct03	11oct	11oct	11OCT	11OCT	11OCT	11OCT	12OCT	12OCT	12OCT	12OCT
				T	1210	1410	1500	1700	1915	2215	2135	2240	2310	2340	0010	0040	0110	0140
				D	8mg	4mg	8mg	8mg	4mg	4	8mg	8mg	4mg	4mg	4mg	4mg	4mg	4mg
				I	[redacted]													
(b)(6)-2	11OCT	[redacted]	MSO4 2-8mg IVP	D	12OCT	12OCT	12Oct	12Oct	12OCT	13Oct	13Oct	13Oct	13OCT	13OCT				
				T	0330	0530	0915	1130	2200	0600	1050	1410	2020	2200				
			Q1°	D	8mg	6mg	5mg	5mg	5mg	5mg	5mg	5mg	5mg	6mg				
				I	[redacted]													
(b)(6)-2	11	[redacted]	Percocet II po Q4° PRN	D/T	13OCT 2250													
				D/I	II PO [redacted]													

(b)(6)-2

*U.S. GPO: 1998-454-110/95216

MEDCOM - 21231

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. ____

(6)(6)-2

(6)(6)

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 23 24 25 26 27
23 Oct	[redacted]	Lovenox 30mg SQ	10	[redacted]
	-----	BID	22	[redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: R/O DVT / Ruled out

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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 4672 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

MEDCOM - 21232

Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 10 Yr. 03

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

(b)(b)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
23 OCT	[redacted]	Percocet ii P.O	D/T	23OCT 2000	24OCT 0300	24 OCT 0715	24OCT 1115	24OCT 1900	25OCT 0030	25 0545	25OCT 1020	25OCT 1430	25OCT 2000	26OCT 0000	26OCT 0700	26OCT 1135
		Q4° prn	D/I	2	2	ii	ii	2	2	2	ii	ii	ii	ii	ii	ii
				[redacted]												
			E/I	E	E											
				26OCT 1540	26OCT 2230	27OCT 2001	27 1440	27OCT 1010								
				ii	ii	ii	ii	ii								
				[redacted]												

(b)(b)-2

*U.S. GPO: 1996-454-110/85216

MEDCOM - 21233

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 08MAR8**

INITIAL SHIFT ASSESSMENT

		Time: 1220 Inita[redacted] (b)(6)-2	Time: 1800 Initals[redacted] (b)(6)-2
NEURO	Pupils	PERRLA	PERRLA
	Sensorium	A-O x 3	Alert Oriented x 3, Follows
	LOC / GCS	Follows Commands, Cooperative	commands + express needs
CARDIAC	Cardiac Rhythm	SR to ST	SR to ST c Ectopy HR90s-100s
	PRI: / QRS:		
	Pulse Strength	+3 (R)(L) Radial; +3 (R)(L) Pedal	+3 palpable pulses in all ext
	Cap Refil / JVD	<3 secs, Ø JVD	<3 sec in all ext
	Edema	(L) LE	(L) LE.
	Chest Pain	None	←
RESP	Respiratory Pattern	Regular + Unlabored	RRR, equal chest rise
	Breath Sounds	CTA	CTA
	Secretions	None	—
	Cough	None	—
SKIN	Color	Normal for Race	WNL for race
	Integrity	lacerations to (L) knee	scab (R) knee
	Backside	Intact	Drsg (L) LE c pins to traction C,D,I
IV	Access Devices	18G PIV	18 gauge PIV (R) Hand c Ø
	Location	(R) AC	S/S of infection. NS infusing
	Condition	Patent + S/S of infection	
GI	Abdomen	Soft, Nontender	soft, nontender
	Bowel Sounds	Active	(+) normal
	Stoma/Ostomy	—	—
		Ø N/V	
GU	Device	Voiding	Voiding in urinal
	Color / Clarity	Amber, clear	

(Continue on reverse)

PREPARED BY (Sig[redacted] (b)(6)-2 — DEPARTMENT/SERVICE/CLINIC ICU[redacted] (b)(2)-2 — DATE 6 Oct 05

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

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 21234

Patients Name: [redacted] (b)(6)-4 Date: 6 Oct 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP							133/76							137/86						144/64						
TEMP							99.2							99.2						100.5						
HR							95							95						104						
RR							22							19						22						
SaO2							99							97%						100%						
FiO2							RA							RA						RA						
Source														—						—						
MAP							96							86						101						
Pedal Pulse	R/L						+3/+3				+3/+3			+3/+3						+3/+3						

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
							100	100	100	100	100	100	600	100	100	100	100	100	100	100	100	100	100	100	100	1200
B																										
T																										
PO																										
Total																										1600

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE							700				925		1625				775									
NGT																									300	2900
STOOL																										
DRAIN																										
Total																										

Total in: 1200 Total Out: 2900 (−1700)

MEDCOM - 21235

ACLU-RDI 1660 p.195

DOD-034811

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 08MAR8**

INITIAL SHIFT ASSESSMENT

		Time: 0630 Initals: [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	Reac 3 mm Brisk	PERRL
	Sensorium	Alert Follow Commands	A+O able to follow commands able to move x3 extremities limited/Rt to LE. 5, 5
	LOC / GCS	Moves All Extremities	
CARDIAC	Cardiac Rhythm	SR	
	PRI: / QRS:		
	Pulse Strength	All Peripheral Pulses (+)	(+) pulses to all 4 extremities
	Cap Refil / JVD	< 3 sec	<3 sec cap refill
	Edema	(2) Leg	LLE
	Chest Pain	Ø	
RESP	Respiratory Pattern	Reg.	RR
	Breath Sounds	Clear Bilaterally Equal Chest Exp	CTA B/L at
	Secretions	Ø	
	Cough	Ø	
SKIN	Color	Normal / Ecchymosis (L) Leg at	NFR
	Integrity	Methacy site Pin Traction to	Fixator to LLE Traction
	Backside	(L) Leg. Pin to intact NO bleeding	
IV	Access Devices	Right Hand PIV 18G	(R) Hand 18G IV @
	Location	D5 1/2 NS @ 100 cc/hr (R) AC	D5 1/2 NS 100 cc/hr
	Condition	Ø S/S infection/inflammation	Ø S/S infection
GI	Abdomen	Nontender soft	Soft round nontender
	Bowel Sounds	(+)	(+) BS x4 quad
	Stoma/Ostomy	Ø	
GU	Device	Voids to urinal	voids via urinal
	Color / Clarity	Yellow clear	dark yellow

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC: ICU [redacted]

DATE: 07 OCT 03

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

[redacted] (b)(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

Patients Name: [redacted] (6)(6)1-4 Date: 07 OCT 05

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	124/60						137/70							139/77						132/78						
TEMP	97.9						98.6							98.7						98.9						
HR	89						92							92						91						
RR	17						16																			
SaO2	100%						100							95%						98%						
FiO2	RA						RA																			
Source	—																									
MAP	98																									

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	
B																										
T																										
PO				360						360																
Total	100	100	100	460	100	100	100	100	100	460	100	100	(1560)	100												

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE		400		600			600				400		(1600)													
NGT																										
STOOL																										
DRAIN																										
Total																										

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 08MAR8**

INITIAL SHIFT ASSESSMENT

		Time: 0658 Initals: [redacted] (6)(6)-2	Time: Initals:
NEURO	Pupils	PERL.	
	Sensorium	Alert & Oriented; able to	
	LOC / GCS	make needs known	
CARDIAC	Cardiac Rhythm	HR 87	
	PRI: / QRS:		
	Pulse Strength	(+) Pulses	
	Cap Refil / JVD	2-3 Sec.	
	Edema		
	Chest Pain	0	
RESP	Respiratory Pattern	RR 12 even & nonlabored	
	Breath Sounds	CTA	
	Secretions	0	
	Cough	none noted	
SKIN	Color	normal for race	
	Integrity	warm + dry to touch.	
	Backside	Reaction to (+) leg	
		& Segmental pressure.	
IV	Access Devices	PIV to (R) hand	
	Location	(R) hand IVF: D5½ NSC 100cc/hr	
	Condition	flushes & difficult	
GI	Abdomen	flat & nondistended	
	Bowel Sounds	BAU 4 quad.	
	Stoma/Ostomy	0	
GU	Device	0	
	Color / Clarity	Urinate self - yellow	
		to urinal.	

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU3, [redacted] (6)(2)-2

DATE

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

[redacted] (6)(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

MEDCOM - 21238

Patients Nam[redacted] (6/16)-4 Date: 08 OCT 05

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	121/66							121/69																		
TEMP	98.4							98.6																		
HR	87							82																		
RR	12							17																		
SaO2	97							98																		
FiO2																										
Source	RA							RA																		
MAP																										

TAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
	100	100	100	100	100	100	100	100																		
B																										
T																										
PO	237	464			237		464																			
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE				150	600			700	625																	
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 21239

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 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 0310 Initals: [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	PERRL	
	Sensorium	A+O responds to pain +	
	LOC / GCS	verbal commands	
CARDIAC	Cardiac Rhythm	S1 S2 ~ any extra sounds	
	PRI: / QRS:		
	Pulse Strength	+3 x4 extremities	
	Cap Refil / JVD	<3 secs x4 extremities	
	Edema	Ø	
	Chest Pain	Ø noted	
RESP	Respiratory Pattern	= rise + fall of chest	
	Breath Sounds	CTA	
	Secretions	Ø	
	Cough	Ø	
SKIN	Color	NFR	
	Integrity	ORIF (L) leg	
	Backside		
IV	Access Devices	(2) hand NS 125 cc/hr	
	Location		
	Condition	Ø erythema or swelling	
GI	Abdomen	Soft round nondistended	
	Bowel Sounds	hypoactive	
	Stoma/ Ostomy		
GU	Device	foley to gravity	
	Color / Clarity	clear yellow	

(Continue on reverse)

PREPARED BY (Signature & Title)

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

DATE
10 OCT 03 - 11 OCT 03

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, MAY 78

USAPPC V2.00

MEDCOM - 21240