Automated Facsimile

INPATIENT TREATMENT RECOR[illegible] 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]	b(6)-4	FGN	

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	13Y	X				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
NO	K78-PRISONER OF WAR/INTER			DIS

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	06:35	AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-12-20

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-12	OLIVERIO

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] b(2)-2	2003-11-12	

31. Selected Administrative Data

Marital Status: DoB: 1990-01-01

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34 Diagnosis / Operations and Special Procedures:

OPEN R FEMUR/TIBIA FX

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	9	9

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	9	9

Signature of Attending Medical Officer

[redacted] b(6)-2 [redacted] Mark R. White

Automated Facsimile - DA FORM 3647, May 79

MEDCOM - 23870

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

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

1. [redacted]

3. Grade: FGN

Admission Remarks

4. Sex: M
5. Age: 13Y
6. Race: X
7. Religion:
8. LnthOfSvc:
9. ETS:
10. PrevAdm: NO

11. FMP: 99
12. SSN: [redacted]
13. Organization: b(6)-4
14. Ward: ICW1

15. FlyStatus: NO
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: 06:35
23. Clinic Service: AEA - ORTHOPEDICS

24. Name/Relation of Emergency Addressee
25. Type Disp: TRF-OTH
26. Date of Disp: 2003-12-20

27a. Address of Emergency Addressee
27b. Telephone No
28. Date This Adm: 2003-11-12
AdmittingOfficer: OLIVERIO

29. ReportingMTF: [redacted] b(2)-2
30. Date Init Adm: 2003-11-12
32. Units Blood Components

31. Selected Administrative Data

Marital Status:
DoB: 1990-01-01
In/Out Patient: Inpatient
MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

OPEN R FEMUR/~~TIBULA~~ FX
TIBIA

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	9	9

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	9	9

Sig[redacted]ing Medical Officer

[redacted] b(6)-2

Signature of PAD or Medical Records Officer

[redacted]

Automated Facsimile - DA FORM 3647, May 79

MEDCOM - 23871

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

13 y.o. ♂ passenger in truck that got shot at a checkpoint. I+D done at 28th CSH, (R) femur and (R) tibia x-fixes applied. States he has ↓'d sensation over toes

PMH (-)

PSH (-)

NKDA

PHYSICAL EXAMINATION

Heent - small abrasion (R) eye-lid

Neck - supple

Lungs - clear CV RRR AT/NC

Abd soft, nontender

10 foot, [illegible]

Ext - (R) femur, (R) tibia x-fix, dressings. ↓ sensation (R) foot, moves toes weakly, poor effort

Dressing (L)

2x5 cm wound (L) calf 2x2 cm wound (R) buttock ~~(R) [illegible] wound~~

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

X-rays (1) comminuted (R) midshaft femur fx, [illegible]

(2) comminuted distal 1/3 tibia fx, fib fx, [illegible]

(L) tib-fib [illegible]

(A) fractures (R) tibia, (R) femur, open wounds

(P) I+D tomorrow

b(6)-2

SIGNATURE [redacted] DATE 12 Nov 03 IDENTIFICATION NO. ORGANIZATION

PATIENT [redacted] (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 - 23872

MEDICAL RECORD | PROGRESS NOTES

DATE

12 Nov 2003

OPERATIVE NOTE

DIAGNOSIS: 1) Ⓡ Open Femur Fx - Type III

2) Ⓡ Open Distal Tibia Fx - Type III 3) Ⓛ Leg soft tissue injury

PROCEDURE: 1) I&D, Fx-Fix Ⓡ Femur

2) I&D, Fx-Fix Ⓡ Tibia

3) I&D Ⓛ Leg soft tissue injury.

SURGEON: [redacted] b(6)-2

FINDINGS: Severe soft tissue injury to Ⓡ Thigh and Ⓡ Leg. Obtained Doppler DP pulse. Placed #10 Abx beads in Ant thigh, #7 Abx beads in post thigh, and #10 Abx beads in Ⓡ tibia wound

FLUIDS: 2,000 cc LR EBL: 500 cc

3 units PRBC

Received Ancef, PCN, and Tetanus Pre-op

b(6)-2 [redacted] Bal

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR.
FIRMR (41 CFR) 201-45.505
509-111

14 yr old.

b(6) - 2 A11

ST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13 Nov 03	100 cc/h. Pt LLE ~ Ace wrap CDI. RLE has Ex Fix in place. Dsg Draining Sero Sang Fluid. Triple lumin in (R) Femoral Artery. No S/Sx of infection. PT NPO @ midnigh for OR on 13NOV 03. [redacted] 91WM6
13NOV03@1930	Pt. care assumed @ 0600. Pt. to O.R. for I&D of (R) femur, (R) tibia, and (L) lower leg. Pt. ~~to~~ (from) received from PACU @ 1315, pt. tachy (130s), temp 100.5°. Other V.S.S. Pt. drowsy, ex-fix to (R) femur & (R) tibia, dressings to (R) upper & lower leg & (L) lower leg. DRSNG's CDI, ace-wrapped. Pt. given H_2O PO, tolerating well. Lungs clear bilat. (+) BS all four quads. Foley to gravity, clear dark yellow. LR infusing at 100cc/h to (L) femoral art. line. Will cont. to monitor. [redacted] ECT, RN
13NOV.03 ~~1935~~ 1935	Pt asleep, responsive to verbal stimuli, VSS. T-101.6, adm Tylenol 650mg as per orders, will continue to monitor, LS CTA (B), (+) BS x4, encouraged use of IS, pt understands, IV FL LR @ 100cc/hr, (-) S/Sx of infex/infiltration, Ex Fix on (R) thigh + (R) Tibia intact, dsg + ace wrap CDI, blood drainage noted on (R) foot area, FTG draining CYU, pt on BR, refuses to eat diet, encouraged to increase fluid intake, (R) eye lid swollen, scratch ~ scap on middle of eyelid, (-) drainage noted, g+fs +x 2 point restraint, (-) complications. [redacted] RN/ I concur ~ above assessment 2cm

STANDARD FORM 509 (REV. 5/1998) BACK

USAPA V1.00

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
11 Nov 2003	CNN 14 yo ♂ sustained multiple GSW's to (R) LE's. No head, chest, or abd trauma. Awake & alert PE (R) LE - Unable to assess neuro exam 2° to pt distress. No palpable DP or PT. Good cap Refill. Obvious (R) Femur Fx c large soft tissue wound. Obvious distal tibia Fx c large soft tissue wound. Partial amputation (R) 5th toe Xrays - 1) (R) Femur Fx - prox shaft, comminuted 2) (R) Distal tibia Fx - comminuted No Radiographs of foot (L) Tibia - No Fx (A/P) 1) Open (R) Femur Fx 2) Open (R) Distal tibia Fx 3) (L) LE soft tissue wound 4) (R) 5th toe near amputation [redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART/S	ADMITTED AT
	blk) - 2		
SPONSOR'S NAME	**SSN/ID NO.**	**REL**	
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Dat*			**WARD NO.**

14 yr old

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

14 yr old

b(2)-2

[redacted] Trauma Flow Sheet

Name: Epw 2 SSN____ Unit____

Blood Type

Date and time of injury: 11 Nov 03 Time of Arrival 2350 FLA

MOI: GSW

HPI: Iraqi child presents to CMED via FLA after gun fight near Jordanian Hospital this pm

Primary Survey

PMHX:
PSHX:
Meds:
Allergies:

Airway: (Patent) Mechanically maintained by____

Breathing: (Spontaneous) Assisted by____

Circulation:

Pulse: (Present) Absent CPR

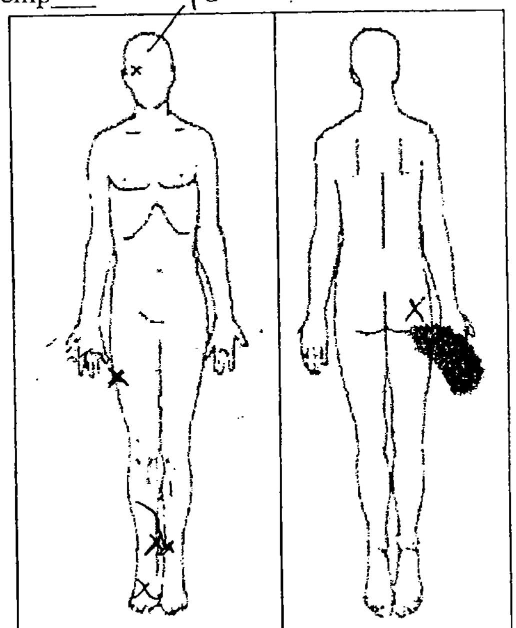
Color: Normal (Abnormal)

Cap refill: Normal (Delayed)

Secondary Survey

Intial Vital Signs: b/p 140 / 100 pulse ~~185~~ 155 Resp 26 Pulse Ox 100 Temp___

FB Cornea OD



GEN: AOx3

HEAD: Laceration on (R) eyelid FB OD Cornea globe intact

NECK: Solid No step off from

HEART: $S_1 S_2$ 153 Hr

LUNGS: Clear Bilat

CHEST: Solid (−) crep NTTP

ABD: Soft No TD NTTP (−) BS

PELVIS: Solid NTTP

EXT: GSW to (R) thigh, (R) Ankle, (L) Calf
(−) posterior tibial or pedal pulses (B)

RECTAL: Clear (−) gross blood

NEURO: INTACT

(−) Pulse in (R)

CN II - XII grossly intact
LE unable to move (L) foot

GLASCOW COMA		
EYES OPEN	Spontaneously	(4)
	To Speech	3
	To Pain	2
	None	1
BEST VERBAL RESPONSE	Oriented	(5)
	Confused	4
	Inappropriate sounds	3
	Incomprehensible sounds	2
	None	1
BEST MOTOR REPONSE	Obeys Commands	(6)
	Localizes Pain	5
	Withdraws to Pain	4
	Flexes to Pain	3
	Extends to Pain	2
	None	1
	TOTAL	

RTS

Revised Trauma Score		
GLASCOW COMA TOTAL	13-15	(4)
	9-12	3
	6-8	2
	4-5	1
	3	0
SYSTOLIC BLOOD PRESSURE	>89 mmHg	4
	76-89 mmHg	3
	50-75 mmHg	2
	01-49 mmHg	1
	No pulse	0
RESPIRATORY RATE	10-29 / min	4
	>29 / min	3
	6-9 / min	2
	1-5 / min	1
	None	0
	TOTAL	

X-RAY:
1. (R) Thigh
2. (R) Ankle
3. pelvis
4. (L) Leg

LAB: 9 / 28

MEDCOM - 23876

ACLU-RDI 1685 p.7

DOD-037454

Interventions

Airway / Breathing: NRB mask @ 15 LPM

Circulation: (3) Lumen in (R) FEM
NS @ TKO + Bolus x 1
20 mg/kg

Other:

Blood 20 mg/kg IV Bolus

MEDICATIONS

Time	Drug	Dose	Route	Initials
0017	Ancef	500	IVPB	[redacted]

b(6)-2

Blood Components

Unit #	Type	Time	Response
1866318	O Neg	0016	HR ↓

1866318

1866350

Vital Signs

Time	B/P	Pulse	Resp	Pulse Ox	Temp	GCS
0010	75/48	153	14	98%	100	
0030	90/50	114	20	99%	97	
	/					
	/					
	/					
	/					

Transfer Instructions:

NOTES:

Personal Effects:
2 shirts
500 DINAR

Prepared by: [redacted] b(6)-2

Team Leader: [redacted]

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
12NOV03	(1200) Pt admitted to unit via gurney from EMT in stable condition. Pt alert, speaking Arabic. VSS. Denies pain @ this time. Pt temp on adm. 101.° axillery- Pt c shivering, medicated c 650mg Tylenol po. Temp @ 1° - 101.3 axillary. Cont. IV Fluids, enc. po fluids, and given IS. Demonstrated correct use of IS. Dsg to lower RLE reinforced d/t saturation c sero-sang drainage. Dsg to upper RLE and LLE intact c small amount sero sang drainage. Ex fix in place on femur and tibia. Pt able to move all extremities. Blood cleared off face and torso. @ femoral TL infusing IVFs c S/Sx infection/ infiltration. Pt tol. po well. Foley draining quantity sufficient clear yellow urine. 1: point restraint in place c S/Sx complications. Will cont. to monitor. b(6)-2 [redacted] PA)
	(1500) Pt temp 100.2. Pt cont. to drink water and use IS. Scrape noted on @ eyelid. Sclera of @ eye red. Denies pain. Will monitor. [redacted] MD A)
12Nov02 2200	Assumed care of Pt @ 1800. Pt Temp 101.3 @. 650 mg of tylenol administered. removed covers. Encouraged IS. Pt refused to comply. Pt has LR @

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. CW1

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

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DICAL RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 NOV 08	Ortho Op Note Pre Op Dx: (1) Open (R) femur fracture (2) Open (L) tibia fracture (3) Multiple fragmentary wounds (R) calf (R) leg Post Op Dx: same Procedure: I+D (R) leg. Surgeon - [redacted] b(6)-2 Findings - Segmental bone fragments excised from (R) & (L) lower legs, (R) thigh. Tissue OK. Bone fragments, wounds irrigated & debrided each. Both replaced in femur, tibia & [illegible] wound had, bone graft made, (R) thigh had vessel loop weave done on thigh wound. PLAN: Repeat I+D in 48 hours [redacted] b(6)-2

PITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE [redacted] NTAINED
NSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

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

MEDCOM - 23879

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 Nov 03	Ortho Op Note
	Pre Op Note (1) Open (R) femur fx
	(2) Open (R) tibia fx
	(3) ~~Open~~ (L) calf soft tissue wound
	Post Op Dx - same
	Procedure - I+D of all wounds adjust
	x-fix
	Surgeon: [redacted] b(6)-2
	[illegible]
	Findings: Able to pull muscle
	remnants over tibia fx. Pocket
	of debris found in posterior aspect
	of hip.
	Plan: repeat I+D in 48 hrs
Nov 03	Ortho Op Note
1250	Pre Op Dx: Multiple frag wounds, open fx
	Post Op Dx: Same
	Procedure: I+D of wounds
	Surgeon: Ortho
	[illegible] bone wounds, OPL [illegible]
	[illegible] closing in [illegible] thigh wound
	Plan: repeat I+D in 48 hours
	b(6)-2 [redacted]

STANDARD FORM 600 (REV. 6-97) BA
*U.S. GPO: 2002 - 491-600-5

MEDCOM - 23880

ACLU-RDI 1685 p.11

DOD-037458

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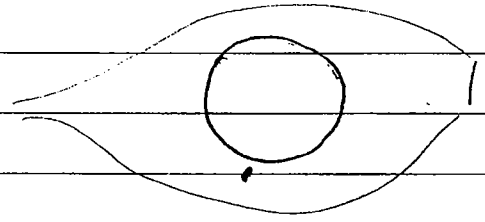
MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14NOV03 1238	Ophth Note
	Asked to see #1289
	Passenger in vehicle that got shot at-
	Doesn't speak English/read English
	Bedside exam
	½ healing laceration
	cory 3 mg small black spot inferior sclera
	cornea cl
	AC D&Q
	iris WNL
	
	DFE lens cl
	Vitreous - ø sig inflammation
	white fibrin vs old heme
	small rock/fragment in vitreous
	macula: heme/commotio maculae
	Y/P : commotio/heme
	over

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

b(6) - 4

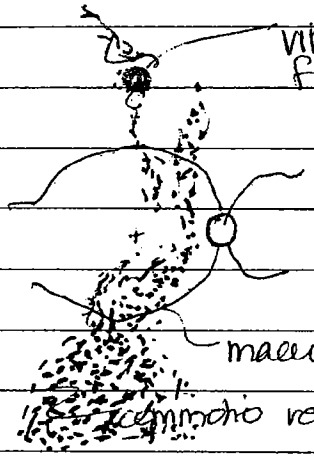
PROGRESS NOTES
Medical Record

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



Imp: small IOFB/c retinal heme/commotio
dependence of endophthalmitis ; will follow

Plan: ~~Cipro 400mg IV q12~~ on ancef & gent
Ocuflox 1 gtts OD q 2° while awake
Ultimately should have foreign body removed
to decrease Retinal Detachment risk

[redacted]
b(6) - 2

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
4 Nov 03 Cont	Pt moves (L) LE Toes. ≤3 sec cap refil. (R) LE Ex fix pins in place & intact. Drsg on (R) LE. Draining Sero Sang Fluid. (R) LE cap refil ≤3 sec. Warm & Dry to touch. Unable or refuses to move toes. Pt c/o abd Discomfort. Checked Foley Cath. FTG Draining c/s/cl. LR infusing @ 100 cc/h via 18G cath to Upper Left arm. PERRLA Briskly. Puncture wound to OD inferior to pupil .5 mm in diameter. Will continue to monitor. [redacted] b(6)-2 Spc. 91WM6
15 Nov 03 @ 1600	Assumed care of pt @ 0600. Temp 99.3° other VSS. A&O. C/O pain, requesting apple. Pt. NPO for surgery. Pt. To OR. @ 1100. Returned from PACU @ 1400. V.S.S. A&O. Taking H_2O PO, refuses food including apple. LR @ 100 cc/h to (L) upper arm. Ex-fix to (R) femur & (R) tibia, pcc-wrapped, CDI. (L) lower leg pcc-wrapped CDI. (+) pulses bilat. LE. Pt. unable to move (R) LE. Jobraden to OD & GTTS @ 2° while awake. HCT post-21.2, CRNA informed prior to SX. Pt. in 2-point restraints, (-) signs of skin breakdown. All the assessments WNL. [redacted] b(6)-2 Spc 91WM6
15 Nov 03	2000 Pt sleeping OD gtts held. [redacted] Spc 91WM6
15 Nov 03	2100 pt. pulls out IV access. New IV access started on (R) hand. (-) swelling or redness on site. [redacted] 91W10. PFC.
15 Nov 03 @ 2130	Assumed care of pt. @ 1800 on 15 Nov. Temp. 102.9°F other VSS. Administer 650 mg Tylenol per order. pt. comply to proper use of IS. A+O speaking Arabic. refuses to eat dinner but ate ice cream after persuasion. (-) c/o pn as of now. IV LR @ 100 cc/hr. (-) s/sx infex on IV site. HRRR. LSCTA (B) BSX4. Abd soft + nontender, firmness (+) on midsection of LQ.

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

[redacted] b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 Nov 03 @ 1600	Assumed care of pt. @ 0600. Temp 101.4°C @ 0900. Tylenol 650 mg given PO. Pt. drowsy & confused while febrile. Temp. @ 1030 was 98.8°. Pt. pulled out femoral line @ 1000, minimal drainage dressing applied & sutures removed. New IV started at (L) AC, IV became occluded @ 1700 due pt. abducting & flexing arms. New IV started to (L) upper arm. LR infusing @ 100cc/hr. Foley draining clear yellow urine, significant output. Pt. tolerating water PO, refused meals. Ex-fix to (R) thigh (S.A.) femur & tibia, are wrapped. (L) LE are wrapped, large amount of sero-sang. drainage. MD did not D any dressing this shift changes pads to LE A&D filet. Pt. occasionally screams out for mother as translated by interpreter. Pt. in 2-point restraints. O signs of skin breakdown. All other assessments WNL. [redacted] 2CE, ANC
14 Nov 03 2030	Assumed care @ 1800 hrs. Alert Speaking Arabic. Able to communicate needs. Denies pain @ this time. Temp 101.4° F (A). Administered 650 mg Tylenol. Encouraged IS. Encouraged H2O PO. LS in RLL slightly Diminished. All other LS CTA. Heart Rate Rythm Regular. S1 and S2 present. Abd Soft Flat non tender +BS x 4 quad. LLE Drsg CDI. ~~RLE~~ (L) Foot cool and Dry to touch. (L) Femoral Pulse positive

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

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

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

[redacted]

b(6)-4

PROGRESS NOTES
Medical Record

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

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
15 NOV @ 2130 CONT'	FTG draining CYM. Ⓡ LE Ex Fix intact. Ⓡ LE + Ⓛ LE dsg CDI. ⊖ ROM on RLE. bilateral dorsalis pedis pulse nonpalpable. skin warm, dry, intact. pt. continuously picking on Ⓡ eyelid causing minimal bleeding which easily clotted. told to stop touching Ⓡ eye but refused to comply. restraints on both arms shortened to prevent from picking eye and IV access. will continue to monitor b(6)-2 [redacted] PFC 9|W|O
16 NOV 03 @ 0200	Temp. 101.8°F @ 2100. encouraged use of IS, AG refuse to use IS properly. blanket removed. Ice packs applied to nape, armpits and groin areas. Temp 100.0°F Ⓐ @ 2300. Administer Tylenol 650mg per order. Temp. lowered to 99.3°F Ⓐ @ 0100 b(6)-2 [redacted] PFC 9|W|O
16 NOV 03	(0915) VSS. ~~⊖ c/o pain~~ ⊕ c/o pain. ⊕ Foley draining clear, yellow urine. IV to Ⓛ hand. Infusing IV ABx ~~5~~ difficulty. SL ~~p~~ ABx. DIC. LR @ 75° tol PO well. Pt ate apple + orange for breakfast. ~~Refused~~ Ex-Fix to Ⓡ femur + Tib-fib. intact. Ⓡ ft has dark brown blood on ace bandage. ⊖ active bleeding. Will continue to monitor. Pt unable to move toes in Ⓡ ft. Not able to ~~palpate dorsalis~~ dorsal pulse. Toes warm to touch, ⊕ brisk cap refill. Ⓛ leg splint CDI. ⊕ 2 pedal pulse, warm to touch, able to move toes. Pt has superficial laceration ~~between~~ on Ⓡ eyelid. Pt picks at wound. Encouraged pt not to pick, but continue to touch wound. b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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[redacted]
b(6)-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
16NOV03	(1640) Pt requested to go commode. Transfered pt from Bed to commode. ⊖ BM. Pt OOB ~ 1 hr. Pt on/off crying. Ⓟ tibfib DSG felt wet. ⊖ order to Δ DSG. Reinforced DSG ◻ ABD pad + kerlex. Will continue to monitor. b(6)-2 [redacted]
16 Nov 03 2050	Pt Awake and A&O. Temp 101.4° F Ⓐ. Blankets removed 650mg of Tylenol administered. Pt crying out for Mom. LS CTA Ⓑ $S_1 S_2$ Present. ⊕ BS x4 quads. Pt pulled IV cath out. New IV 22g to Ⓛ Upper Arm. Ⓒ Arm restrained so Pt cannot bend Arm. Ⓡ Arm restrained so pt cannot pull IV out. FT/S draining CYU ⊖ difficulty qs. ⓁLE Dsg CDI. + pedal pulse ≤3 sec. Cap refill. Pt can move toes. ⓇLE Ex fix for Femur and Tib Fib intact and in place. Dsg is CDI. Pt cannot move Ⓡ Foot Toes. ⊕ pedal Pulse. [redacted] Warm & Dry. Will continue to monitor. [redacted]
16 Nov 03 2300	Pt had Suppository inserted for BM [redacted] Will cont to Monitor. b(6)-2 [redacted]
17 Nov 03 1225	Pt To Bed Side comode. [redacted] x1 Large [redacted]
17NOV03	(1045) NSG - Temp 100.9. Pt frequently calls out. Pt been told to keep voice ↓. Pt refuses. Interpreter stated reason for pt calling 2° lonely and asks for mom. ⊕ Foley draining clear, yellow. Pt down to OR at this time. [redacted] b(6)-2

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17NOV03 2300	(CONT) of circulation compromise. New IV 22G started in (L) FA for IVABX therapy. Plan: monitor temp, monitor neuro/vascular status BLE monitor drsgs, enc po intake & enc I/S. Will cont IVABX's gtts as ordered. [redacted]
18NOV03 @0600	- nutrition consult sent D/T decreased appetite. b(6)-2 [redacted]
18NOV03	(1015) NSG - VSS. A+O. Premedicated pt c total of 4mg MSO4 prior to DSG Δ's. Pt tol DSG Δ's well. WTD DSG to B/L LE. ⊖S/Sx of infection. Ⓡ upper thigh DSG saturated c serosanguinous drainage. ⊖order to Δ DSG. Removed superficial DSG + Reinforced c ABD x2 + Kerlex. Will clarify c MD if wants to Δ DSG completely. Pt sat in chair c B/L Legs elevated for ~2hrs. Pt tol well. Pt back in bed. IVABX running. IV in Ⓛ FA intact. ⊖S/Sx of infection. Ⓡ LE +1 pedal pulse. Pt unable to move toes, warm to touch, Ⓓ cap Refill. Ⓛ LE Ⓓ2 pedal pulse, warm to touch, pt able to move toes. Pt able to urinate s any difficulty. b(6)-2 [redacted]
	(1230) Clarified c Dr. [redacted] ~ Δ DSG to Ⓡ upper ex-fix. Dr. [redacted] does not want DSG Δ for Ⓡ upper ex-fix. Pt aware will go for surgery 18NOV03. Pt [redacted] appetite. Eats only fruit off tray. b(6)-2 [redacted]
19NOV03 0200	Assumed care of pt @1800. VSS. no C/o. Alert, speaking Arabic. LSCTA, ⊕BS, ↓ appetite, void per urinal QS. RLE ex-fix x2, thigh drsg reinforced c Kerlix, calf drsg Δd WTD c ace wrap in place. Ⓓ C/S, ↓ movement, Ⓓ cap refill; LLE drsg Δd WTD c ace wrap, Ⓓ CMS, Ⓓ cap refill. Ⓡ eye c sm wound in lower cornea, eye gtts cont. Pt DC'd own IV, new IV restarted, Ⓓ FA 20G. (CONT) [redacted]

b(6)-4 [redacted]

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
17NOV03	(1530) NSG - Pt back from O.R. VS - 137/96, 99°, 98% RA, 147. Will recheck ~~BP~~ BP + HR. Pt A+O. DIC'ed foley @ ~ 1300. Will monitor U/O. Ex-fix to (R) upper thigh DSG has bloody drainage on pin area. No new order to Δ DSG until 18NOV AM. Will continue to monitor. B/L calf-ankle ~~DP~~ DSG CDI. ~~Pt able to~~ (L) leg +2 palpable pedal pulse, move toes, warm to touch. (R) leg +1 pedal pulse, move toes, warm to touch. Did not administer Q2° eye gtts 2° to pt in O.R. Will Resume eye gtts + IV ABX. Pt to po well. Pt asleep at this time. b(6)-2 [redacted] 29pp
17NOV03 @2300	assumed care of pt @1800. VS rechecked, WNL except tachycardic @120bpm & temp 101.1 (oral). MD aware. Tylenol given c T ↓ 99.4. NO C/O, speaking Arabic. Alert, follows commands; LS CTA, continues IS when reminded; (+)BS, tol very little food, only fruit & soda. DTV by 1930, (-)void & I+O cath @2015 c 250cc residual, foley D/C'd. Pt voided approx 600cc @2230. RLE c 2 ex-fix c drsgs, upper thigh dsg reinforced D/T sero-sanguinous drainage. (+)C/S, but unable to move toes. LLE calf dsg CDI, (+)CMS, cool to touch, +1 DP. Opt restrained IVS & s/sx of skin (CONT)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME b(6)-2 [redacted]		
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[redacted] b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18 Nov 03	Nutrition Note: NSg reports pt c̄ poor po intake, will only consume apples, oranges, + Soda. Pt communicates c̄ translator that his appetite is ↓, he wants the restraints removed to eat. He likes chicken + juice; Pt states he will eat after translator explains that he must eat to heal, grow. Pt began to eat meat, rice, muffin + drank all of juice box. Will provide pt c̄ extra juice at meals. Recommend continuing pt on current diet, provide lots of encouragement to ↑ po intake. bid -2 [redacted] RD/LD
~~7/14/05~~	

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DATE	NOTES
(cont)	Both leg wounds were beefy red with little drainage.
19NOV03	Ø odor present. Maintains pedal pulses and mobility
	in 2° legs. Tobradex q2° is making a difference
	in (R) eye. Doesn't have much of an apetite, seems
	to like apples. Will cont. to monitor. b(6)-2 [redacted]
	(1700) I concur c above. [redacted]
20NOV03 @0400	assumed care of pt @1800. VSS, Alert, yelling, c/o restraints.
	Through interpreter, explained/reinforced rules c pt. LS CTA; ⊕BS,
	Tol reg diet ≥ 75% of dinner meal; voided per urinal QS; RLE
	c x2 ex-fix, drsgs c serosanguinous drainage noted. Drsgs Δ'd
	to BLE, all wound beds red c drainage noted, sutures
	exposed to (R) thigh wounds. RLE ⊕ c/s, ⊘ movement,
	⊕ cap refill. LLE ⊕ CMS, ⊕ cap refill. ↑ OOBTC c complete
	assistance. (R) eye wound healing, cont eye gtts Q2° new
	IV to (R) FA, 20g flushes well. (R) wrist IV D/C'd cath
	intact. 2pt restraints MS s/sx of skin/circulation
	compromise. Plan: cont IV Abx, monitor drsgs, monitor
	NV status. b(6)-2 [redacted]
20NOV03	(1330) Assumed care of ~~0000~~. Pt alert, speaking Arabic.
	VSS. Ø c/o pain @ this time. Pt OOB to BSC. ⊕
	large BM. Pt ↑ to chair. Tol. well. DSGs to BLE
	Δd WTD. Pt assisted c dsg Δ medicated c 2mg
	MSO4 prior to dsg Δ - tol. well. Ex Fix in place x
	2 on RLE. Pt unable to move toes on (R) foot. Cap
	refill <3secs. (R) eye slightly swollen. cont OD gtts as
	ordered. SL in (R) forearm flushes well s s/sx
	infection/infiltration. 1 point restraint in place s s/sx

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
19NOV@ 0200	(CONT) 2 pt restraints c̄ S/SX of skin/circulation compromise. Plan: NPO pMN for surgery tomorrow 11/19 pain control, monitor dsgs. [redacted] [illegible]
	b(6)-2
19 Nov 03 1000	Ortho Op Note
	Pre Op Dx: Multiple fragmentation wounds
	Post Op Dx: Same
	Procedure: I+D of wounds
	Surgeon: [redacted] b(6)-2
	[illegible]
	Findings: [illegible] buttock wound [illegible]. Vessel loops [illegible].
	Plan: Repeat I+D in 48-72 hrs
	b(6)-2 [redacted]
19Nov03 1730	Assume care of pt @ 0600. VSS, A+O ø c/o pain today. Went to OR this morning, vitals stable upon return. Ex-fix to Ⓡ leg remains intact, kerlix around Ⓡ leg reinforced. Add drsg's to Ⓡ and Ⓛ leg achilles.

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[redacted] b(6)-4

PROGRESS NOTES
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b(6)-2 Army

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	[illegible] [illegible]. [illegible] [illegible] [illegible]
	[illegible] 9 [illegible].
	Plz: repeat I+D in 48 hours
	[illegible] line / PICC line
	[redacted]
	[illegible]
21 NOV 03	-Assumed care of pt. A&O x 3. VSS Ø c/o pain
0800	@ this time. Lungs CTA. HRRR Active BS x4
	Remains NPO p MN o/c for surgery this AM.
	I+D of (R) thigh and LE. DSG CDI. High dsg re-
	inforced. IV ABX TX cont - Afebrile Will cont
	to monitor [redacted] [illegible]
1000	- Pt off floor to OR [illegible]
1300	- Pt return from PACU VSS Ø c/o pain or
	discomfort. Denies N/V Resume previous orders
	cont treatment regime [redacted] [illegible]
22 Nov 03 @ 0450	Assumed care @ 1800, Pt slightly afebrile 101.5° Tx tylenol administered, cont to monitor
	all other VSS; pt alert speaking arabic, able to verbalize needs; Ex-Fix to (R) LE in
	place, ⊕ CMS, +2PP, brisk cap Ret, NV intact to B: LE; dsg Δd W→D to both heels
	healing well; dsg to (R) upper thigh in place, mod. drainage, Ⓔ signs active drainage,
	S/L patent; Cont c̄ IV abx; Pt tol Reg diet c̄ in between meal snacks; Restraints
	in place, ⊕ circ, Ⓔ skin breakdown, cont to monitor [redacted]
22 NOV 03	-Assumed care of pt. A+O x 3. VSS Denies pain
0730	Lungs clear HRRR Active BS Tolerating PO well Attempted
	to have a BM this morning wasn't able to. External exfix
	to (R) femur and tibia dsg c̄ serous drainage changes PRN

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b(6)-2411

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
20NOV03 (1330)	(cont) complications. Will cont to monitor. [redacted]
20 NOV03 2000hr	VSS. A&O. Consumed 60% of Regular diet for dinner. OOB → Chair to assist. (B)LE wound tissue red moist with tendon exposed. (R) [redacted] (R) LE ex. fix pin sites without drainage or crustation. (R) FA Saline lock patent + intact. Pt aware of NPO p MN status for OR Tomorrow. Voiding clear yellow urine. Tobradex gtt instilled to OD as ordered. Will continue care as planned.
	[redacted] 2LT AN
21 NOV 03 1200	Ortho Op Note
	Pre Op Dx - Multiple GSW, open fx Rt Arm
	Procedure I&D (R) leg
	Surgeon - [redacted]
	GETA - MW
	Findings - Fresh pur from entire ... wound down to bone

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[redacted]

b(6)-4

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
22NOV03	cont- ®femur dsg reinforced as needed. OOB to chair this morning. ACM cane given. Afebrile IV ASA cont. Will monitor b(6)-2 [redacted] circum.
23Nov03@0455	Assumed care @ 1800; VSS; pt a&o speaking arabic; c/o pain/discomfort @ this time; pt OOBTC x1 for 1°; Ex-Fix x2 in place; dsgs d/t to ® thigh; ©drainage noted; dsg to upper ® thigh CDI; © s/sx infection; NV intact to affected extremity; s/l patent; cont IV abx; Restraints in place, ©circ, ©skin break ✓; pt NPO F MN for Sx 11/23. Cont to monitor. b(6)-2 [redacted]
23NOV03	(1425) NSG.- VSS. ©c/o pain. NPO ⊃ MN for O.R. today. Pt taken to O.R. for washout. ©subclavian central line placed in OR. Flushes well + ⊕ blood return. IV LR 100cc/hr infusing into central line. DSG to B/L ~~LE~~ calf CDI. B/L Ex-fix LE intact. ® upper thigh area ex-fix has ~~sero~~ sm. amt serosang drainage. Will continue to monitor. Pt able to move toes B/L. L > R mvmt. +2 pedal pulse B/L. Brisk cap refill B/L. B/L cool to touch. b(6)-2 [redacted] RGT/AW
23 NOV. 03 1945	Pt A+O×3, VSS, T-101.7, adm 650mg Tylenol, T ↓ 99°, warm + dry to touch, had episode x1 of fainting when attempting to place on bedside commode, rest made pt feel better,

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EPW

[redacted] b(6)-4

PROGRESS NOTES
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DATE	NOTES
Cont.	had a BM, formed brown stool, IV HL (L) FA intact, flushes well, CL → (L) SC intact Ø s/sx of infex, Ex Fix x2 on RLE, minimal amount of blood drainage from pin sites, dsg's on (R) buttock Δ'd, penrose drain intact packed WTD, Ø s/sx of infex, old dsg saturated c̄ blood, dsg (R) leg Δ'd, WTD, Ø s/sx of infex on wounds, beefy red, cont. eye drops Q 2°. —— b(6)-2 [redacted]
	I concur c̄ above assess [redacted]
24NOV03	(1700) NSG. USS. Pt c/o pain. Med c̄ 4mg MSO4 IV. Pt found adequate relief. AM had large soft, brown BM. Urinating clear yellow urine. Δ DSG to B/L calf + (R) upper thigh. Ex-fix x2 intact. ⊝ signs of infections. All open wounds pink c̄ minimal amt of yellow drainage. Penrose intact in (R) upper thigh (posterior) Attempted to remove gauze most proximal to inferior penrose. Gauze unable to be dislodged. Appears gauze sutured into penrose. Did not attempt to pull. Cut off excess. Informed Dr [redacted] of finding. Stated ~~he will~~ pt will go to O.R. on 25 NOV + will view finding. DSG WTO. Pt tol DSG Δ well. ~~So~~ OOB to chair for ~ hr. Pt receiving IV ABX through central line. ⊕ blood return. ⊝ resistance on infusion. D/Ced IV in (L) arm 2° infiltration. ~~Contu~~ Lesion to (R) eye lid appears to be healing well. ⊝ signs of infection. Continuing Q2° ~~e~~ eye gtts. —— [redacted]
	b(6)-2

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
23 NOV 03 1150	Ortho Op Note Pre Op Dx - Infected (R) femur fracture GSW both legs Post Op Dx - same Procedure - I & D (R) femur fracture (2) ventilator line placement Surgeon: [redacted] b(6)-2 EBL - min Fluids - 500 cc LR Findings - still some purulent drainage from (R) buttock wound. Ostomy wound clean. Plan - Drsg change x 1 NOV for ventilator line placement [redacted] b(6)-2 [redacted] COL [illegible]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
25 Nov 03 0930	Ortho Op Note
	Pre Op Dx: GSW (R) leg
	Post Op Dx - Same
	Procedure: [redacted] (R) leg
	Surgeon: [redacted] b(6)-2
	EBL - min
	Findings: [illegible] Muscle [illegible]. No pus
	Gravity [illegible] & [illegible], [illegible] [redacted]
	[illegible] b(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
25NOV03 @0700	assumed care of pt @1800. VSS. 4o pain to RLE, percocet given c good relief. LSCTA, @ BS, tol po well, NPO @ this time. VOid per urinal QS. (B)IL LE ex-fix intact, dsgs CDI. (R) thigh dsg CDI. RLE (+) C/M, ↓ sensation to toes. LLE (+) CMS. (+) DP equal BIL. (L) SC central line flushes easily. 2pt restraints in S/SX of skin/circulation breakdown. Plan: NPO for OR, Nu with drsgs ? NV STATUS. b(6)-2 [redacted]
25NOV03	(1156) NSG. VSS. Pt NPO p MN for OR. Pt taken to O.R. for washout. Washout completed. DSG CDI to all 3 DSGS. (+) 2 pedal pulses B/L c brisk cap Refill, warm to touch. (R) ~~foot, pt able~~ ft, pt has + mvmt to toes. Pt able to move toes well in (L) ft. Central line infusing NS til tol PO well + IV ABX. Ancef + gent D/C'ed. ~~IV~~ Eye gtts q2° administered. ~~(+) central line~~ b(6)-2 [redacted]
	(1600) Central line DSG Δ'ed. Used betadine + alcohol. ⊖ signs of infection. Ortho MD's spoke to pt. Plan to go to O.R. in 3 days. Pt verbalized understanding. b(6)-2 [redacted]

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

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
[redacted]			

DATE	NOTES
28NOV08 2340	assumed care of pt @1800. VSS. C/o pain to (R) thigh > femur, medicated c percocet + tab c good relief noted. Dsgs to (R) thigh, (R) calf & (L) calf dry/intact, some serous drainage noted ex-fix x2 in place & intact. (R) LE (+) c/m, ↓ sensation and ~~but~~ cannot feel light touch. (L) LE (+) c/m. (BIL) DP pulses equal @ +2. LS CTA, @ BS, tol reg diet c good appetite noted. Void per urinal QS. ↑ OOBTC x ~~1~~ hour, tol well. (L) SC central line flushes easily, IVABX cont. 2pt restraints m/s S/Sx of skin/circulation compromise. Plan: cont IVABX, enc po intake, monit drsgs & neuro-vascular status. b(6)-2 [redacted]
29NOV08 0600	Assumed care of pt @ 0600. VSS, A+O, pt. given ~~t~~ percocet as pre-med. for DSG Δ. WTD DSG Δ to all wounds, moderate sero-sang drainage to all wounds, bulky red, @ S/Sx of infx. Cushions applied to heels, @ pulses palpable LE. Pt. refused lunch, but ate 2-3 slices of bread. Urinal @ bedside → CTU. Pt. in 2-point restraints, @ signs & skin breakdown. C-line to (L) SC, patent. All other assessments WNL. [redacted] per AP b(6)-2
29NOV08 0600	Assumed care of pt @ 1800, VSS. C/o pain @ hs, ~~+~~ percocet given c good relief noted. BIL heel/calf dsgs Δ, WTD, ~~o~~ drainage noted, beefy red tissue noted. (R) thigh wound x2 WTD dsg Δ, pink-red tissue noted. Ex-fix x2 to (R) leg intact, pin care completed. Cushions to heels in place. ↓ sensation noted to (R) foot, BIL +2 DP pulses, equal BIL feet, @ ans (BLE). Begin q2° turns to prevent decubitus. 2pt restraints m/s S/Sx of skin compromise. (L) SC c/l flushes well. IVABX cont. Tol reg diet, but (CONT)

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b(6)-

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
27NOV03 @0200	(CONT) only small amts of fruit. Voiding QS to urinal. Plan: enc po, monitor dsgs, enc OOB, turn Q2°. Will continue to monitor.
27NOV03 @ 1630	Assumed care of pt. @ 0600. VSS, ØC/10 pain, A+O. Pt. Premed for premed → DSG Δ'd to bilat. LE WTD. Pt.'s wounds improving, granulating tissue, beefy red. ⊕ pulses to bilat LE, Heel cushions in place, C-line to Ⓛ SC, patent, Pt. Turned Q 2°, GTTS to Ⓡ eye Q 2° while awake, Pt. in 2-point restraints Ø signs of skin breakdown. Will cont. to monitor. [redacted] LT, AN b(6)-2
28Nov03 @ 0415	Assumed care @ 1800; VSS, pain controlled c̄ percs; pt Alert speaking arabic; dsgs to Ⓡ LE Δd W→D; dsg to upper Ⓡ thigh, posteriorally & laterally packed W→D wrapped c̄ Kerlix pin care completed; +2 PP Ⓑ; Ⓛ SC CL patent, cont c̄ IVabx; heel cushions in place, turn pt Q2° & encouraged pt to turn self while awake; cont c̄ OD gtts Q2° while awake; BM attempt X1 c̄ no success; Restraints in place, ⊕ circ, ⊖ skin break(+) cont to monitor b(6)-2 [redacted]
28NOV03	(1530) Assumed care @ 0600. Pt alert, speaking Arabic. VSS. Pain controlled c̄ MSO4 prior to surgery. Pt to OR for I/D this am. Returned via gurney in stable cond. Ø C/10 pain @ this time. Ⓛ SC CL flushes well s̄ S/Sx infection/infiltration. Dsgs to

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
28 Mar 03 1323	Ortho Op Note Pre-Op Dx: Left distal [redacted] femur fx Post-Op Dx: same Procedure: [redacted] IM nail Surgeon: [redacted] b(6)-2 Anesth: GA Findings: small 1 x 2 cm fragment of bone removed. Limited reduction Plan: 5 days to heel / sutures x 3-4 days [redacted] b(6)-2

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

NSN 7540-00-634-4176

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
28NOV03 (1530)	(cont) BLE CDI. Ex fix x2 in place on RLE. X-rays done as ordered. IVFs infusing into @ SC CL S S/Sx infection/infiltration. Giving eye gtts as ordered. @ eye slightly swollen/red. 2 point restraints in place S S/Sx complications. Will cont. to monitor. b(6)-2 [redacted]
28Nov03 0305	Assumed care @ 1800; pt slightly Febrile, accompanied c pain, T perc given c good relief; Ex-Fix X2 to (R) LE in place, pin care completed, serous drainage noted, dsgs reinforced c Kerlix; IVFs S/Ld; (L) SC CL patent, Flushes well c S/Sx infection/infiltration; cont c IV abx & OD gtts; Restraints in place, (+) circ, (-) skin breakd; cont to monitor b(6)-2 [redacted]
	Pt OOB to BSC; (+) large, brown, formed BM c difficulty [redacted]
29 Nov 03 1640	Nutrition Note: Pt c poor PO intake since admission 11/13. Via translator, have encouraged pt to ↑ intake in order to heal/grow. Pt uninterested in eating; nutritional needs not being met. b(6)-4 SNN: [redacted] kcal/day (60-65 kcal/kg) + 60-80 g Pro/day (1.5-2.0 g/kg). Recommend initiating tube feed to meet ½ ENN to better meet nutritional needs while not diminishing appetite that would likely occur c providing 100% ENN through tube feed. Recommend Osmolite @ 50 cc/hr to provide 1200 kcals + 53g Pro/day. Will continue to monitor & follow. [redacted] RD/LD
wt: 40kg	

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE CPT; 8	MAINTAINED AT b(6)-2
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

[redacted] b(6)-4

REGISTER NO.

WARD NO. ICU

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 - 23902

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MEDICAL RECORD — **PROGRESS NOTES**

DATE	NOTES
29NOV03	(2000) Assumed care of pt @ 0600. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Pt OOB to chair - tol. well. Personal hygiene done by pt c min assist. Dsgs to BLE Δd - WTD. Pt medicated c MSO4 prior to dsg Δs · tol. well. Φ S/Sx infection @ wound sites. Pt turning self in bed s difficulty. @ SCC clear flushes well s S/Sx infection/infiltration. Tol. reg diet well ≥ 75% of each meal. Voiding s difficulty. 2 point restraints in place s S/Sx complications. Will continue to monitor. b(6)-2 [redacted]
30NOV03 0200-0220	Assumed care @ 1800; USS, pt alert speaking arabic; Ø c/o pain; Pt OOBTC, dsgs to BLE Δd W→D wrapped c Kerlix, pt Tol well; wound sites beefy red, ⊖ S/Sx infections; ⊕ SCC patent, easily F/lushes s S/Sx infection/infiltration; pt voiding s difficulty; turns self in bed s difficulty; pt Tol Reg diet well, ate 50% of dinner; Restraints in place, ⊕ circ, ⊖ skin breakdown; will cont to monitor b(6)-2 [redacted]
30NOV03	(1100) NSG. VSS. Pt A+O. At beginning of shift, pt c/o pain. Med c 1 perc. Prior to DSG Δ, med c 4mg MSO4 IV. Pt tol DSG Δ well. Pin care completed c H_2O_2 + NaCl. ⊖ signs of infection. Heel cushions in place. Voiding s →

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

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

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

[redacted] b(6)-4

REGISTER NO. | WARD NO. ICW1

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
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USAPA V1.00

b1(6)-2 Atl

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont') difficulty. Clear, yellow urine. Tol po well. Consumed ~50% meal. (+)2 pedal pulses B/L LE. ~~WF~~ Warm to touch c brisk cap Refill. Pt Resting comfortably. [redacted]
1DEC03 0010	VSS-A+O pt. speaking arabic. LSCTA (B) BSx4 voiding qs per urinal pt. medicated c 4mg MSO4 prior to dsg Δ. dsg Δ completed. WTD to (R) LE = (L) Ext wrapped c herlex. (-) S/Sx inf. Ext. fixinplace. completed pin care. c 1/2 NS + 1/2 peroxide. Pt. tolerated well. Maj. melton assessed pt. decubs to (B) heels. Elevated pt. legs to keep all pressure off heels. Encouraged pt to eat dinner but refused. Encouraging PO intake. Pt. resting @ this time c to pt. restraints inplace s compromise to skin. Will monitor pt. [redacted]
01DEC03	(1525) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. Pt OOB to chair this am. pt tol. well. Dsgs to BLE Δd WTD. Wounds on thigh of RLE packed c NS soaked gauze. All wounds moist and red s S/Sx infection. Pt medicated c MSO4 prior to dsg Δs- tol. well. Pin care done to ex fixes. RLE elevated on blanket in bed. Pt able to move toes. @ SC CL flushes well s S/Sx infection/infiltration. Tol. ≥ 50% of meals. voiding s difficulty. Pt turning

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
01DEC03	(1525) self in bed & diff. cont. eye gtts as ordered. (R) eye pink and slightly swollen. 2-point restraints in place & SISX complications. Will continue to monitor. b(6)-2 [redacted] wm
0030	Assumed care of pt. @ 1800. USS-A+O. LS CTA (B), Resp-even unlabored, BS x4, Ext. fix intact to (R) LE. dsng ert. Pt. has (+) pedal pulses. Pt. medicated & 4mg MSO4 @ 1830. Pin care completed. Pt. (R) leg elevated on blanket. Pad to (L) heel elevated & no pressure to area. (-) sc intact & clean/dry/intact. Pt. tolerated 75% of reg. diet + ensure. Pt. NPO after midnight for OR in AM. Pt. voiding clr per urinal. Will continue to monitor pt. + ROM [redacted] b(6)-2
2 Dec 03 1315	Nutrition Note: Feeding tube placed to provide tube feeding to help meet calorie needs. ENN: 2400-2600 kcals/day (60-65 kcal/kg) & 60-80 g Pro (1.5-2.0). Recommend tube feed to provide 50% of ENN to avoid diminishing

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

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

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

[redacted]
b(6)-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	cont. b(6)-2 [redacted] pt's appetite that may occur if 100% END are met. ~~Hills~~ Must continue to encourage pt to eat & consume high caloric fluids (juice, Ensure Plus) in order to meet pt's needs. Recommend goal rate for Jevity Plus tube feed @ 45cc/hr to provide 1296 kcals & 60g Pro/day. Initiate c Osmolite HN, advancing to goal of 40cc/hr, then change to Jevity Plus c goal @ 45cc/hr. Will b(6)-2 Continue to monitor po intake & follow. [redacted] RD, CPT, SP
02DEC03	(1515) Assumed care of pt. Pt alert, speaking Arabic. VSS. Pain controlled c Percs. Pt to OR this am for I&D and STSG of LE. Pt returned from PACU via gurney in stable condition. Tx to bed s difficulty. Dsgs to LE CDI. Dsgs to RLE c small amount of sero sang drainage. Ex fix x2 in place on RLE. Pt able to move all toes. + pedal pulse equal bilat. Dsgs off in OR were pulled back ~5" according to placement on x-ray. Awaiting orders to start TF. Esc cl infusing IVFs s s/sx infection/infiltration. Will SL if pt tol. dinner well. Cont. OD gtts as ordered. Sclera of OD pink. Voiding s difficulty. 2 point restraints in place s s/sx complications. Will continue to monitor. b(6)-2 [redacted] RN
2 Nov 03 1640	Nutrition Note: TF in stomach, prefer bolus feeds. Recommend Osmolite HN 200cc q 4° to provide 1200 kcals & 53g Pro/day. b(6)-2 [redacted] RD/LD CPT, SP

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

DATE	NOTES
02DEC03	(1835) Administered 1st bolus TF of Osmolite HN via Dobhoff ⊽ placement verified by MD. Pt tol. well. Abd flat, non-tender. ⊕ c/o abd pain. Report given to oncoming shift. — b(6)-2 [redacted]
2345-	assumed care of pt. @ 1800. VSS + A+O. Pt. resting in bed @ this time ⅀ any complaints. Dsg Δ to (R) leg completed. LE packed ⊂ gauze sponges - WTD wrapped ⊂ perlex. LE WTD applied Perlex. all wounds beefy red ⅀ s/sx infection. Pin care completed. Decub to (R) heel noted. Blanket placed under pt. leg to keep all pressure off heel. (2) leg dsg's CDI. Pt able to move toes. (+) pedal pulses. Administered 2200 bolus TF of osmolite via dobhoff (200cc) Pt. tol. well ⅀ N/V. 1Hmg MSO4 given for pain + dsg Δ @ 2128. Tab radex + c/ts administed to pt. c/c while awake. Osc CDI ⅀ s/sx infection. Pt. in bed resting @ this time ⊂ one pt. restraint in place x2 Ext fix. will monitor pt b(6)-2 [redacted]

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*	REGISTER NO.	WARD NO.
#[redacted] b(6)-4		ICU1

PROGRESS NOTES
Medical Record

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

(b)(6)-2 + 11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
1008 30Dec03	Consulted c WoundCNS MAJ [redacted] She has looked at heel & finding (unable to stage due to necrotic tissue) Recommendation Keep heel off of mattress. LT [redacted] to show heel to COL [redacted] on rounds. [redacted] LTC on
3 DEC. 03 @ 1100	Assumed care of pt. @ 0600, VSS, A&O, ÷ Pne. & 4mg MSO4 as premed. for WTD DSG Δ to ®LE, Mod. sero-sang drainage to ®LE wounds, wounds beefy red, Ø S/Sx of infection. Pincare done, Pt. OOB → BSC, brown formed stool. Pt. has pressure ulcer to ® heel, MD notified, unable to stage ulcer due to intact necrotic tissue. Heel cushion applied & ankle elevated c Karlex roll (heel off of mattress) Pt. turned Q 2°. Foleader to DD Q 2°. CL to ⓛ SC intact, flushes well. Pt. in 2-point restraints, Ø S/Sx of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted] LT, RN.
4Dec03@0430	Assumed care @ 1800; VSS, pt alert speaking coherently; pain controlled c ÷ per Percocet; dsg Δ to RLE W → D; mod. sero-sang drainage to wd dsg; Ø S/Sx infection; pincare provided; ⓛ SC ck patent, easily flushes c S/Sx infection/infiltration; heel cushions in place, pt changing positions spontaneously to prevent skin breakdown; cont. eye gear; Restric in place c compromise to skin/circ; cont to monitor [redacted]
4Dec03@0615	Pt while giving report to dayshift, [redacted] became aware of Dobhoff placement; tape was removed from face & Dobhoff was almost completely pulled out by pt; Dobhoff was completely D/C'd per nurse; MD will be notified [redacted]

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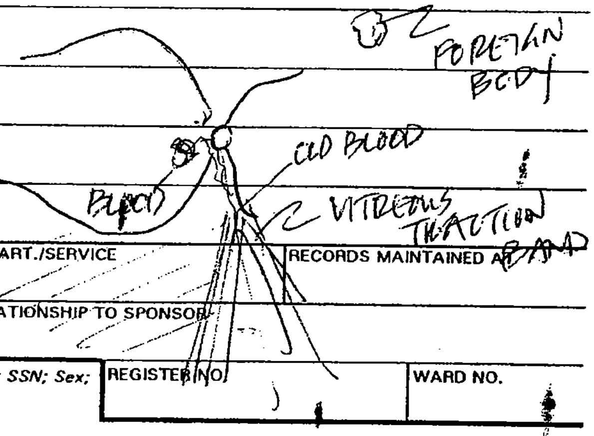
MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20 Oct 03	Ortho Op Note
1100	
	Pre-Op Dx (1) Multiple GSW (B) extremities
	(2) Open (R) femur and (R) tibia fx
	Post Op Dx - Same
	Procedure: (1) I&D with wounds
	(2) STSG to (L) leg.
	Surgeon: [redacted] b(6)-2
	EBL - min
	Fluids: 500 cc LR
	Findings - Still open (R) tibia. STSG
	for posterior (L) thigh, to (L)
	lower leg x 2.
	Plan: dressing changes in 5 days.
	b(6)-2 [redacted]
	Ophth Note
	EUA/DFE
	PLAN: TO AL HAYTHAM FOR PPVIT.



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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
6 Dec 03	On the Op Note Pre Op Dx - Multiple GSW Post Op Dx - same Procedure: I+D of wounds Surgeon: [redacted] b(6)-2 GBL - NV Findings - 100% Loss of STSG to (L) heel/calf.
	[redacted] b(6)-2 COL MC

STANDARD FORM 600 (REV. 6-97) BACK
☆ U.S. GPO:1998-432-786/75236

NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
cont'd	prior to dsg Δ. (+) decub to (R) heel. Placed donut cushion under heel to keep all pressure off. Pt. turned @ 2°; Tobradex @ 2°, Pt. in bed resting @ this time c onept. restraint in place. will cont. to monitor pt [redacted] Female with abuse assessment
0800-1600	(0935) Assumed care @ 0800. Pt alert, speaking Arabic. VSS. Pt medicated c 4mg MSO4 prior to dsg Δ c good relief of pain. WTD dsgs to RLE Δd c NS soaked gauze. All wounds pink/moist s S/Sx infection. Pt OOB to chair this am. @ sc cl. Flushes well s Sx infection/infiltration. Pt tol. 75% of breakfast. Voiding s difficulty in urinal. Restraints removed d/t pt being cleared to civilian. Will tx to ICU via WIC. Report given to [redacted]

b(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
4 Dec @ 1630	Assumed care of pt. @ 0600. NGT D/C'd @ change of shift, pt had pulled NGT out partially. MD notified. V.S.S. A&O + Rpt. for C/O pain this AM to ®CE. Pt. ate 100%. of breakfast, Tol. well. WTD dsg Δ to all ®LE wounds, beefy red, mod. sero-sang drainage, Ø S/Sx of infx. Pt. pre-medicated @ 4mg MSO4 for dsg Δ. Pincare done. Pt. turned Q2°, Tolrodex to OD + GTTS Q2°. Pressure ulcer to ® heel, unable to stage due to necrotic tissue intact. Cushion placed under lower leg & ankle of ®CE to take pressure off of heel. ⊕ pulses to Dilat LE, Cap refill 1 sec., able to move toes Dilat, Pt. in 2-point restraints, Ø S/Sx of skin breakdown. All other assessments WNL [redacted]
5 Dec 0030	0030- assumed care of pt @ 1900. VSS-AND medicated pt. @ + perc. for pain @ 2030. ⊕ pain relief. Pt. OOB → chair x2 hrs. this shift. Tol. well. ⊕SC cdt ⊕ S/Sx inf. infusing [redacted] IV abx. pt. voiding clr yel urine. ~~WTD~~ WTD dsg Δ to ® leg wounds, wounds beefy red S S/Sx inf. Pincare completed. medicated pt. @ 4mg MSO4

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.2
USAP.

[redacted]

b(4)-4

MEDICAL RECORD	PROGRESS NOTES
DATE	
6 DEC 03	1045: Returned from OR via stretcher, VSS. Denies any pain @ this time. Awake and alert, HR - regular. Lung sounds clear bilat. Bowel sounds (+) x4. IV - (L) SC: Heplocked. Wound to (L) c, lf Dsg CDI. Wounds to (R) LE - DSG c/d/I. Ex-fix to (R) LE + (L) LE. ↓ ROM to (B) LE, will continue to monitor. [redacted] b(6)-2
6 Dec 03 1151	BP 118/54 P 111 PSO2 100 T-98.6 R-16 [redacted] 9/W IT
6 Dec 03 2330	Pt resting comfortably in bed. HR Regular, Lung sounds clear bilat, bowel sounds (+) x 4 quads. (B) LE elevated on donut ring. Ext fix to (R) LE intact. DSG d/d to (R) LE, wounds red, moist, well granulated, Ø pseudomonas drainage noted. W/D DSG c NS applied. Pincare done c H_2O_2 & NS. Central line to (L) SC intact flushes well, Ø bld return. DSG & soft splint to (L) LE intact, error donor graft site to (L) thigh c xeroform gauze applied. Pt premedicated for DSG d, pt tolerated well. Ø complaints @ this time. Will continue to monitor. [redacted] 2nd 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. ICU R

PROGRESS NOTES
Medical Record

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

Civ [redacted] b(6)-4

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

Dx - Open (R) femur + tibial fracture

Admission Date -

MEDCOM - 23913

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
12/10/13	Op Note Pre Op Dx: open (R) femur fx, open (L) TIBIA fx Post Op Dx: same Procedure: I&D of wound Surgeon: [redacted] b(6)-2 Anes: G Fluids: 600cc Drugs: Health granulation tissue Cx: 0

[redacted] b(6)-2

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

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

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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[redacted] b(6)-4

MEDCOM - 23914

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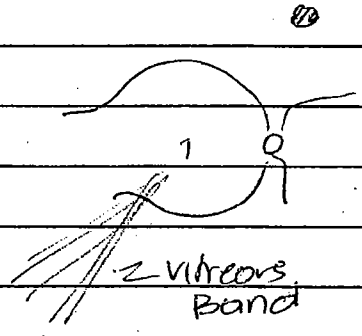
MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
10Dec03	13Y/o Iraqi child c Intraocular foreign Body OD – no significant vitrhis however pt with large vitreous trachon band. @ high risk for rehnal detachment. Request eval for possible vitrectomy to relieve rehnia trachon



Plan: referral to al-Hoythan for rehnal eval of trachon band in vitreous

[redacted] b(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
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MEDICAL RECORD	PROGRESS NOTES
DATE	Transfer Summary.
12-7-03	This is a 13 y/o ♂ who was shot by U.S. forces ≈ 12NOV03. In addition to Opthomologic injuries (see note) he sustained and open ① right femoral shaft fracture ② open right distal fibula fracture and ③ soft tissue loss to bilateral lower extremities. The fractures have been stabilized and have undergone multiple debridements. The soft tissue envelope is closed over femur, the left leg has had skin grafting performed, but there is still a large soft tissue defect with exposed tibia. This region will need microvascular flap coverage which is not available at this institution. In addition, remainder of wounds on right leg are ready for skin grafting in conjunction w/ microvascular flap.
	b(6) - 2 [redacted] Orthopaedic Surgeon
	Ophthamology
	Rx as above. ® eye : OD
	Pt had intravitreal foreign body without significant vitn's but ® blood in the inferomacular regim then developed large thick vitreous trachin band pulling on retina - threatens to pull of retina (over)

(Continue on reverse side)

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

[redacted]

b(6) - 4

PROGRESS NOTES
Medical Record

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

PROGRESS NOTES

DATE	
	referral to [redacted] for examination possible vitrectomy [redacted] b(6)-2 cont
19 Dec 03	Nutrition Note: Nsg reports pt eating well, esp. when family is around. Will snack between meals. Pt appears thin despite improved appetite & intake. Recommend adding a meal replacement TID to pt's diet. Recommend providing pt ~ Ensure/meal for pt to drink between meals in addition to his current intake. [redacted] PT, SP, RD/LD b(6)-2

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

14 yr old

62-2

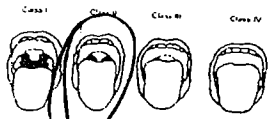
[redacted]

Name_____ SSN _____ Unit_____ Location_____

INITIAL ASSESSMENT

Airway

☑ Patent ☐ Nasal ☐ Oral
☐ Intubated ☐ Crich
☐ ETT #__ ☐ Trach



C-Spine
☐ CC ☐ BB ☐ Secured ☑ Clear

NORM MS, COMPETENT, 0 MS Δ's, GCS 15.
0 ML TENDER. 0 DISTRACTING. INJ's.

Breathing

☑ Spont Rate 32
Rhythm
☑ Reg ☐ Tachy ☐ Brady
☐ Sporad ☐ Even ☐ Abnl ___
Quality
☐ Reg ☐ Deep ☐ Labored
☑ Shall ☐ Sonorous ☐ Weak
☐ Assisted ☐ O_2 __L/min
☐ Ambu ☐ Vent
BBS R ☑ CLR ☐ RLS ☐ WHZ ☐ ABS
L ☑ CLR ☐ RLS ☐ WHZ ☐ ABS

Circulation

☑ Spont ☐ CPR
Rhythm ☐ REG ☐ TACH ☐ BRDY
Pulse _____ ☐ Strong ☐ Weak ☐ Thread
B/P ☐ RAD >80 ☐ FEM >70 ☐ CTD >60
PASG ☐ Legs ☐ ABD ☐ Both
IV's #1__ ga_____
#2__ ga_____
#3__ ga_____
☐ Tourniquet Where _____ When _____
What _____ Why _____
☑ Other (L) FEM TLC

CNS

EYES		VERBAL		MOTOR	
SPONT	4	ALRT	5	ALRT	6
CMND	3	CONFD	4	LCL P	5
PAIN	2	INAPR	3	WDR P	4
UNRSP	1	INCMP	2	FLX	3
		UNRSP	1	EXT	2
				UNRSP	1

☐ PERLA ☐ ABNL_____
☐ DIA ☐ PIN ☐ UNI ☐ FIX ☐ SLOW

MOI/DESCRIPTION

☐ Blunt ☑ Penetrating ☐ Burn
☐ Blast ☑ GSW ☐ Heat
☐ MVC ☐ Shrapnel ☐ Chem
☐ Fall ☐ Stabbed ☐ Elect
☐ Assault WITH _____ SEE 9-s ↓
☐ Other _____ EST %_____

EQUIPMENT

☐ Weapon _____
☐ Sens Items _____
☐ Other _____

Vitals: HR 173 B/P 90/50 RR_____ POX 100 % TEMP_____ °F °C

DATE/TIME	NOTES
2405 12NOV03	APPROX 10 YO M C MULT GSW TO RLE. PLAN OR FOR (R) FEM FX-OPEN + POSS (R) ANKLE/FOOT. PT A+O ×3, NON ENGLISH SPEAKING — [redacted] blds-2

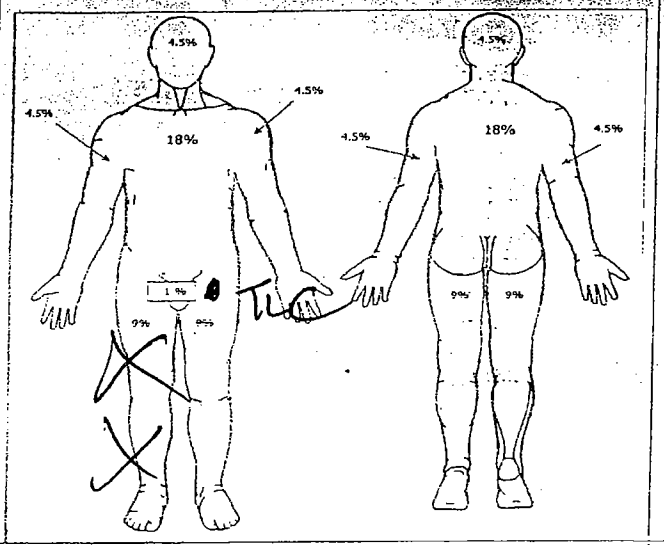
MEDCOM - 23918

62-2

[redacted]

Name _____ SSN _____ Unit _____ Location _____

Head-2-Toe/Burn Chart



INTERVENTIONS

Airway

☐ Suction ☐ Position ☐ Oral ☐ Nasal

☐ Intubated/Trach ☐ Crich By Whom _____

Breathing

☐ Assisted ☐ O_2 __L/min ☐ Ambu ☐ Vent

☐ Chest tube R #1 _____ #2 _____

L #1 _____ #2 _____

Time _____ By Whom _____

☐ Needle decomp R Time _____ L Time _____

Circulation Bag # and time

Fluid ☐ NS ☐ ___ 1L bags ☐1 ____ ☐2 ____ ☐3 ____

Blood ☐ PRBC ☐ Whole ☐1 ____ ☐2 ____ ☐3 ____

PASG ☐ Legs ☐ ABD ☐ Both

☐ Foley _____ ☐ NGT _____

Other _____

ALLERGIES _____

MEDICATIONS _____

PREVIOUS HX _____

LAST MEAL _____

EVENTS (see MOI) _____

Description of Illness

_____

_____

_____

MEDICATIONS

TIME	MEDICATION	DOSE	RTE	BY

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — **PROGRESS NOTES**

Admission Date: 12 NOV 03 **Diagnosis:** (R) Tibia & Femur FX **HD:** 37 **POD:** 36/42

Skin assessment must be done initially and every 7 days.

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	(4)	4	**Mobility**	No limitations	4	2
	Slightly limited	3			Slightly limited	3	
	Very limited	2			Very limited	(2)	
	Completed	1			Completely immobile	1	
Moisture	Rarely moist	(4)	4	**Nutrition**	Excellent	4	3
	Occasionally moist	3			Adequate (Eats >50%)	(3)	
	Moist	2			Adequate (Rarely eats)	2	
	Constantly moist	1			Very poor	1	
Activity	Walks frequently	4	3	**Friction and Shear**	No apparent problem	3	2
	Walks occasionally	(3)			Potential problems	(2)	
	Chairfast	2			Problems	1	
	Bedfast	1					

Total Score: _____

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:_____ Size:_____ Drainage: _____
Tubes:_____ Pins:_____ Appearance:_____
Dressing change:_____

Burn wound (s): Yes__ No__ % BSA_____ Partial_____ Full_____
Location:_____ Size_____
Appearance:_____
Dressing change:_____

Pressure Ulcer (s): Yes X No___
Stage I, II, III, IV (Circle the one that applies and describe below)
Location: (R) heel Size: 2cm x 2cm
Wound character: Pink Ø Moist Ø Dry Ø Granulation tissue Ø Yellow slough Ø Tunneling Ø
Undermining Ø Odor Ø Purulent discharge Ø Eschar Ø Exudates Ø
Type of dressing change: Wet-to-dry Ø Comfeel dressing Ø Carrasyn-V Gel Ø Alginate Ø

Physician notified/consulted for wound debridement: Yes Ø No___ Date/time MD notified _____
CNS notified/consulted for Stage II and greater: Yes___ No___
Nutrition Referral: Yes___ No Ø
Physical Therapy Referral: Yes Ø No___
Action taken: ~~Bromaderm~~ Date & Time 20 Dec 03
↑ heel off bed

REGISTER NO.	WARD NO.

Patient's Identification (For typed or written entries give: Name-last, first, middle; Grade; rank; hospital or medical facility)

PROGRESS NOTES
Medical Record
STANDARD FORM 509

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD — **PROGRESS NOTES**

Admission Date: 12NOV03 **Diagnosis:** Rtib/fem fx **HD:** 37 / 34 **POD:** 36 / 12

Skin assessment must be done initially and every 7 days.

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment	(4)	4	**Mobility**	No limitations	4	
	Slightly limited	3			Slightly limited	3	
	Very limited	2			Very limited	(2)	2
	Completed	1			Completely immobile	1	
Moisture	Rarely moist	(3)	4	**Nutrition**	Excellent	4	
	Occasionally moist	3			Adequate (Eats >50%)	(3)	3
	Moist	2			Adequate (Rarely eats)	2	
	Constantly moist	1			Very poor	1	
Activity	Walks frequently	4	3	**Friction and Shear**	No apparent problem	3	
	Walks occasionally	(3)			Potential problems	(2)	2
	Chairfast	2			Problems	1	
	Bedfast	1					

Total Score: 18

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:_____ Size:_____ Drainage: _____
Tubes:_____ Pins:_____ Appearance:_____
Dressing change:_____

Burn wound (s): Yes__ No__ % BSA_____ Partial_____ Full_____
Location:_____ Size_____
Appearance:_____
Dressing change:_____

Pressure Ulcer (s): Yes X No___
Stage I, II, III, IV (Circle the one that applies and describe below)
Location: (R) heel Size: 2cm x 2cm
Wound character: Pink (Q) Moist (Q) Dry (Q) Granulation tissue (Q) Yellow slough - (Q) Tunneling (Q)
Undermining (Q) Odor (Q) Purulent discharge (Q) Eschar X Exudates (Q)
Type of dressing change: Wet-to-dry (Q) Comfeel dressing (Q) Carrasyn-V Gel (Q) Alginate (Q)

Physician notified/consulted for wound debridement: Yes___ No (Q) Date/time MD notified _____
CNS notified/consulted for Stage II and greater: Yes X No_____
Nutrition Referral: Yes_____ No (Q)
Physical Therapy Referral: Yes X No_____
Action taken: (Q) Date & Time 19:44 17 Dec 03

REGISTER NO.	WARD NO.
	Taw 2

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade: rank: hospital or medical facility)

PROGRESS NOTES
Medical Record
STANDARD FORM 509

A 1 ~ 89

MEDCOM - 23921

Medical Record — Progress Notes

Braden Scale Evaluation

Date: 12.5.03

Sensory Perception	No Impairment	(4)	Mobility	No Limitations	4
	Slightly Limited	3		Slightly Limited	3
	Very Limited	2		Very Limited	(2)
	Completely Impaired	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 Problem	2
	Chairfast	(2)		Problems	1
	Bedfast	1			

Total Score: 18

Score <15 requires Immediate Ulcer Prevention Program

Above 20	Low Risk
16-19	Med Risk
11-15	High Risk
Below 10	Very High Risk

Date: _____

Sensory Perception	No Impairment	4	Mobility	No Limitations	4
	Slightly Limited	3		Slightly Limited	3
	Very Limited	2		Very Limited	2
	Completely Impaired	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 Problem	2
	Chairfast	2		Problems	1
	Bedfast	1			

Total Score: _____

Score <15 requires Immediate Ulcer Prevention Program

Above 20	Low Risk
16-19	Med Risk
11-15	High Risk
Below 10	Very High Risk

Patient ID: C [redacted]

Unit No. _____

Standard Form 509

b(6)-4

Medical Record — Progress Notes

Wound and Skin Assessment

Date and Time 12/5/03 1100 Wound number One.
Stage I-IV ~~Stage III~~ Surgical or Non-Surgical non-surgical
Location Rt. heel
Shape oval Measurements < 1in width, < 1inch length.
Tissue Color Black
Drains and Type none
Drainage (amt and color) none
Dressing Type none
Dressing Change Frequency none Wound Cleansing none.
Additional Info (turning, elevation of extremeties, etc.)
turn Q2°, elevate RLE, keep heel off pressure.

Date and Time _____ Wound number _____
Stage I-IV _____ Surgical or Non-Surgical _____
Location _____
Shape _____ Measurements _____
Tissue Color _____
Drains and Type _____
Drainage (amt and color) _____
Dressing Type _____
Dressing Change Frequency _____ Wound Cleansing _____
Additional Info (turning, elevation of extremeties, etc.) _____

Date and Time _____ Wound number _____
Stage I-IV _____ Surgical or Non-Surgical _____
Location _____
Shape _____ Measurements _____
Tissue Color _____
Drains and Type _____
Drainage (amt and color) _____
Dressing Type _____
Dressing Change Frequency _____ Wound Cleansing _____
Additional Info (turning, elevation of extremeties, etc.) _____

Patient ID: Unit No. _____
Standard Form 509

b(6).4 [redacted]

Medical Record **Progress Notes**

Wound and Skin Assessment

Date and Time 6 Dec 03 0622 Wound number 3
Stage I-IV Ø (Surgical) or Non-Surgical
Location inner, medial aspect of thigh
Shape undefined Measurements —
Tissue Color pink granulating tissue
Drains and Type Ø
Drainage (amt and color) yellow on old dressing Ø odor
Dressing Type W→D & NS
Dressing Change Frequency BID Wound Cleansing in OR
Additional Info (turning, elevation of extremeties, etc.)

Date and Time 6 Dec 03 0622 Wound number 4
Stage I-IV Ø (Surgical) or Non-Surgical
Location posterior, lateral aspect calf
Shape undefined Measurements —
Tissue Color pink granulating tissues
Drains and Type Ø
Drainage (amt and color) yellow odorless drainage on dressing
Dressing Type W→D & NS
Dressing Change Frequency BID Wound Cleansing in OR
Additional Info (turning, elevation of extremeties, etc.)

Date and Time 6 Dec 03 0622 Wound number 5
Stage I-IV Ø (Surgical) or Non-Surgical
Location RLE pin sites to Ex-fixes x2
Shape round Measurements —
Tissue Color To thigh: pink opened tissue, to calf: O+A and closed
Drains and Type Ø
Drainage (amt and color) To thigh serous scant blood
Dressing Type Ø
Dressing Change Frequency BID Wound Cleansing NS and ½ H2O ½ NS
Additional Info (turning, elevation of extremeties, etc.)

Patient ID: Unit No.
Standard Form 509

Medical Record — Progress Notes

Wound and Skin Assessment

Date and Time 6 Dec 03 0622 Wound number 1
Stage I-IV unable to assess Surgical or ~~Non-Surgical~~
Location (R) heel
Shape oblong Measurements approx 2½cm x 1½cm
Tissue Color (R) eschar
Drains and Type ~~(R)~~
Drainage (amt and color) ~~(R)~~
Dressing Type ~~(R)~~
Dressing Change Frequency ~~(R)~~ Wound Cleansing ~~(R)~~
Additional Info (turning, elevation of extremeties, etc.) Turning schedule, foam donut for padding

Date and Time 6 Dec 03 0622 Wound number 2
Stage I-IV Surgical or Non-Surgical RLE
Location Thigh
Shape undefined Measurements —
Tissue Color pink granulating
Drains and Type ~~(R)~~
Drainage (amt and color) old dressing c yellow drainage
Dressing Type W→DC NS
Dressing Change Frequency BID Wound Cleansing ~~(R)~~ PT to OR for washouts
Additional Info (turning, elevation of extremeties, etc.)

Date and Time 6 Dec 03 0625 Wound number 2
Stage I-IV (R) Surgical or Non-Surgical
Location outter aspect of calf medial
Shape undefined Measurements —
Tissue Color pink granulating; bone visible
Drains and Type ~~(R)~~
Drainage (amt and color) yellow drainage to old dressing & odor
Dressing Type wet→Dry c NS
Dressing Change Frequency (R) BID Wound Cleansing in OR
Additional Info (turning, elevation of extremeties, etc.)

Patient ID: [redacted] Unit No.
Standard Form 509

b(6)-4

MEDCOM - 23925

Medical Record

Progress Notes

Braden Scale Evaluation

Date: 16 Dec 03

Sensory Perception	No Impairment	(4)
	Slightly Limited	3
	Very Limited	2
	Completely Impaired	1
Moisture	Rarely Moist	4
	Occasionally Moist	(3)
	Moist	2
	Constantly Moist	1
Activity	Walks Frequently	4
	Walks Occasionally	(3)
	Chairfast	2
	Bedfast	1
Mobility	No Limitations	4
	Slightly Limited	3
	Very Limited	(2)
	Completely Immobile	1
Nutrition	Excellent	4
	Adequate (Eats >50%)	(3)
	Adequate (rarely eats)	2
	Very Poor	1
Friction and Shear	No Apparent Problem	3
	Potential Problem	(2)
	Problems	1

Above 20	Low Risk
16-19	Med Risk
11-15	High Risk
Below 10	Very High Risk

Total Score: 17

Score <15 requires Immediate Ulcer Prevention Program

Date: _____

Sensory Perception	No Impairment	4
	Slightly Limited	3
	Very Limited	2
	Completely Impaired	1
Moisture	Rarely Moist	4
	Occasionally Moist	3
	Moist	2
	Constantly Moist	1
Activity	Walks Frequently	4
	Walks Occasionally	3
	Chairfast	2
	Bedfast	1
Mobility	No Limitations	4
	Slightly Limited	3
	Very Limited	2
	Completely Immobile	1
Nutrition	Excellent	4
	Adequate (Eats >50%)	3
	Adequate (rarely eats)	2
	Very Poor	1
Friction and Shear	No Apparent Problem	3
	Potential Problem	2
	Problems	1

Above 20	Low Risk
16-19	Med Risk
11-15	High Risk
Below 10	Very High Risk

Total Score: _____

Score <15 requires Immediate Ulcer Prevention Program

Patient ID: [redacted] b(6)-4

Unit No. _____

Standard Form 509

MEDCOM - 23926

PLAN OF CARE FOR SKIN BREAKDOWN AND WOUND MANAGEMENT

MEDICAL RECORD — **PROGRESS NOTES**

Admission Date: _____ **Diagnosis:** BFemur/tibfib **HD:** 25 **POD:** 26

Date: 6 Dec 03 Time 0600 RN Signature: [redacted] 12/MD 10 (e) - 2

Skin breakdown as evidenced by immobility, friction, shea[redacted]re, abrasions, surgical wound, skin tear.

Wound type: (Surgical wound (s)) Location: BLE Size: See attached sheets Drainage: _____

Diabetic ulcer Tubes: _____ Pins: _____ Appearance: _____

Venous stasis ulcer Dressing change: _____

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) unable to assess/eschar

Location: Bheel Size: _____

Wound character: Pink ___ Moist ___ Dry ___ Granulation tissue ___ Yellow slough ___

Tunneling ___ Undermining ___ Odor ___ Purulent discharge ___ Eschar X 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

MEDCOM - 23927

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 12-5-93 | PATIENT ACUITY LEVEL: III | POST-OP DAY: | HOSPITAL DAY:

TRANSFER

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

Time 0935 To ICW 2 From ICWT ☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☒ STRETCHER

Total ER/RR/PACU time _____ Physician [redacted] b(6)-2 Anesthesia (Specify): _____

Procedure/Diagnosis open Rt. femur/tibia Fx B/P 101/66 P 116 R 18 T 99.6 99%

LOC _____ Neurovascular checks _____

Dressing/cast ex-fix (x2) skin graft (L) calf Tubes _____

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

Medication Pre-med for dsg Δ's.

Other Turn q2° b(6)-2

Report From CT [redacted] Received By CT [redacted]

VITAL SIGNS

TIME:	1000	2000	0400	0800												
BP ARTERIAL LINE				116												
BP CUFF	116/72	114/76	107/89	75												
TEMPERATURE	98.4	98.8	97.4	99.6												
PULSE	99	124	100	112												
RESPIRATORY RATE	18	18	20	16												
OXYGEN (L/%)																
PULSE OXIMETER	100%	100	100	99%												
O2 METHOD	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

PAIN

TIME:	1000	2000	0400	0800												
PAIN INTENSITY (10 / 5 / 0)	1	1	0	premedicated for dressing change												
MED ADMINISTERED (Y/N)			N	Y												
RELIEF ACCEPTABLE (Y/N)			N/A	Y												
Percocet				1												
MSO4				4mg												

OTHER

TIME:																
FINGER STICK GLUCOSE																
INSULIN (Y/N)																

SPECIAL NEEDS

TIME:	1100		2001
*Skin breakdown prevention	OS		EM
*Falls prevention protocol	N/A		EM
*Restraint protocol			NA
*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

PATIENT IDENTIFICATION b(6)-4

[redacted]

DIAGNOSIS: (R) open femur/tibia Fx

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____ b(6)-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): _____

MEDCOM - 23928

MEDCOM FORM 689-R (TEST) (MCHO) MAR 90 PREVIOUS EDITIONS ARE OBSOLETE Page 1 of 1 pages

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.

	TIME: 1100 INITIALS: BS	TIME: INITIALS:	TIME: 0320 1 INITIALS: EM
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☐	☑
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.	☐ ex-fix to ~~RUE, RL~~ Rt. femur, Rt. tib q	☐	☐ ex fix x 2 to (L) LE intact
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ wounds to (R) leg, skin & graft. (L) calf	☐	☐ wounds (R) LE skin graft (L) calf
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.	☑	☐	☑

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

TIME: 1100 INITIALS: BS	TIME: INITIALS:	TIME: 0320 1 INITIALS: EM
IV patency ✓ q 8 hr: PKN	IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr: PRN
IV site care provided: assessed	IV site care provided:	IV site care provided: Assessed
IV tubing changed: /	IV tubing changed:	IV tubing changed:
LOCATION CONDITION	LOCATION CONDITION	LOCATION CONDITION
IV Site #1: (L) SC OK	IV Site #1:	IV Site #1: (L) SC OK
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL'd.	Comments:	Comments: ⊖ Blood return Flushes easily

SECTION III - PATIENT INTERVENTIONS & TEACHING

b(6)-2

NEUROVASCULAR

SITE: RLE TIME:	1100	2200	
COLOR	P	P	P
CAPILLARY REFILL	1	1	1
TEMPERATURE	W	W	W
EDEMA	Ø	Ø	Ø
SENSATION	S	S	S
MOTION	P	P	P
PASSIVE FLEXION	✓	—	
PERIPHERAL PULSE	2+	2P	2P

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:	1100		[redacted]
ID band visible/legible	✓		
Orient to environment prn	✓		
Side rails (2/4) up	N/A		
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	✓		

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE: Reg	TYPE: Reg
PERCENT CONSUMED:	PERCENT CONSUMED: 75%	PERCENT CONSUMED: 70%
HOW TOLERATED:	HOW TOLERATED: well	HOW TOLERATED: well
☐ 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 c crutches BRP CHAIR ☐ SELF ☒ ASSIST # TIMES/SHIFT

TEACHING

TIME: 1108 INITIALS: [redacted]	TIME: INITIALS:	TIME: 2200 INITIALS: [redacted] b(6)-2
CONTENT: 1.) Ward/staff orientation 2) Percocet for pain, Ø sleeping pills during the day	CONTENT:	CONTENT: Dressing Δ call for assist
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
b(6)-4 C [redacted]	[redacted]	[redacted] JAN 21-09 b(6)-2	D

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1100	RLE,	① ex-fix intact, DSGS CDI	} assessed
		LLE	② DSGS CDI	
	Dual ① RLE		① Pink granulation tissue, white bone exposed, yellow drainage	① Dressing D W-SD
	② LLE		② ACE wrap dressing intact	② assessed

SECTION IV - NOTES

1100: Pt. tx to ward via wheelchair in stable condition from ICU #1. Will cont. to monitor [redacted]
0830 - Pt to OR via litter. Pt NPO since MN [redacted] AD

b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 7 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 26/2 | 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:	0800	1200	2000	0400														
BP ARTERIAL LINE	126/—		122/—	114/—														
BP CUFF	86	10 1/60	68	70														
TEMPERATURE	99.6	97.7	98.7	98.9														
PULSE	125	109	116	110														
RESPIRATORY RATE	20	18	20	20														
OXYGEN (L/%)																		
PULSE OXIMETER	100%	98	99%	99%														
O2 METHOD	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

PAIN

TIME:	0930	2200																
PAIN INTENSITY (10 / 5 / 0)	0	X																
MED ADMINISTERED (Y/N)	N	N																
RELIEF ACCEPTABLE (Y/N)	N	NA																
	MSO4																	

OTHER

TIME:																		
FINGER STICK GLUCOSE																		
INSULIN (Y/N)																		

SPECIAL NEEDS

TIME:	0930	2200
*Skin breakdown prevention	AVM	NA
*Falls prevention protocol	NA	
*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

blej-4

C [redacted]

DIAGNOSIS: S/p open femur/tibia fx S/p wash out

DRG: _____ ADMISSION DATE: 10 NOV 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.

	TIME: 0930 INITIALS: [redacted]	TIME: 2200 INITIALS: [redacted] (b6-2)	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.	☑	☑	☐
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.	☑ BM x1	☐ BM x1 @ 2000 soft formed Brn stool	☐
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.	☐ Ex fixes to (R) LE. ↓ ROM to (R) LE. Ambulates c crutches, OOBTC x1	☐ ext fix to (R) LE - pain c ROM to (R) LE	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ wounds to (R) thigh, inner & outer calf. Pin sites.	☐ donor site to (L) thigh - multiple wounds to (R) LE - wound to (L) LE	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ c/o pain to (R) LE. MSO4 4mg IVP given.	☑ ∅ c/o pain	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ b6-2	☑	☐

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

TIME: 0930 INITIALS: [redacted]	TIME: 2200 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided:	IV site care provided: NA	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) SC / ok	IV Site #1: central line (L) SC / ok	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: HL, flushes well, (+) Bld return	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: BLE	TIME: 0730	2000				
COLOR	P	P	P			
CAPILLARY REFILL	1	1	1			
TEMPERATURE	W	W	W			
EDEMA	Ø	Ø	Ø			
SENSATION	S	S	S			
MOTION	M	P	P			
PASSIVE FLEXION	D/P	NA	NA			
PERIPHERAL PULSE	2	2	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 / OTHER

	TIME:	0730	2000
SAFETY	ID band visible/legible	AVM	CA
	Orient to environment prn	AVM	CA
	Side rails (2/4) up	WA	NA
	Bed position low		CA
	Call light within reach		NA
OTHER	Review & post lab results		CA
	Notify MD abnormal labs		CA
	Incontinent urine/stool		NA
	Linen change prn	AVM	CA
	Turn/reposition q2h	NA	CA
	ROM q2h if immobile		NA
	Antiembolic hose		

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Reg		
PERCENT CONSUMED:	10%		
HOW TOLERATED:	well		
	☒ 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 662	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST; # TIMES/SHIFT

TEACHING

TIME: 0930	INITIALS: [redacted]	TIME: 2000	INITIALS: [redacted]	TIME:	INITIALS:
CONTENT: - Plan of care - Pain control		CONTENT: - pain management - PSOAS - call for assistance		CONTENT:	
☑ Patient/Family Verbalizes Understanding		☒ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding	

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
b(6)-4 [redacted]	[redacted]	[redacted] PT, Ass	4
	[redacted]	[redacted] 2LT/AN	18-06
		b(6)-2	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
		(R) outer thigh	Pink, No S/S infection	
	1800	(R) inner & outer calf	Pink, bone exposed	W→D dsg Δ c NS
	0900	(R) ANKLE	PINK, BLEEDING, BONE EXPOSED	
		(R) OUTER THIGH	PINK, DRAINAGE NOTED	W→D DSG Δ PW CARE c 50% NS

SECTION IV - NOTES

0900: Awake and alert. Premedicated for dsg Δ c MSO4 4mg IVP. OOB to chair x2. Will continue to monitor [redacted] b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 8 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 2/3 | HOSPITAL DAY: 28

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:	1200	2000	0400
BP ARTERIAL LINE	—		110
BP CUFF	111/77	117/78	72
TEMPERATURE	97.9	98°	97.6
PULSE	113	109	108
RESPIRATORY RATE	22	20	20
OXYGEN (L/%)	0		
PULSE OXIMETER	100%	100%	100%
O2 METHOD	RA		RA

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

PAIN

TIME:	0640	1200	2100
PAIN INTENSITY (10 / 5 / 0)	0		
MED ADMINISTERED (Y/N)	Y	N	N
RELIEF ACCEPTABLE (Y/N)	Y		NA
Percocet	1		

OTHER

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

SPECIAL NEEDS

TIME:	0640	2100
*Skin breakdown prevention	NA	NA
*Falls prevention protocol	NA	
*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

PATIENT IDENTIFICATION

b(6) - 4

[redacted]

DIAGNOSIS: S/p open femur/tibia fx; ex fix to RLE

DRG: _____ ADMISSION DATE: _____

LOS: _____ EXPECTED RELEASE: 10 NOV 03

CASE MANAGER: _____

PRIMARY CARE MANAGER: Olivento

ISOLATION REQUIRED (*Specify*): _____

MEDCOM - 23936

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.

	TIME: 0640 INITIALS: [redacted]	TIME: 2100 INITIALS: [redacted]	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.	☑	☑ gtts to OD	☐
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.	☑	☑ voids per urinal	☐
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.	☐ Ex fix to (R) LE (L) ROM to (B) LE. OOB To chair TID.	☐ Ex-fix (B) LE limited ROM.	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Sm. lac to (R) eyelid wounds to (R) hip + (R) inner & outer calf. Dsgs CDI. Pin sites S/S infection	☐ Wounds to (R) Leg Dsgs CDI (L) Leg Dsgs CDI	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ 6/10 pain in (B) LE. Percocet ± PO given.	☑	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑ b6-2	☑	☐

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

TIME: 0640 INITIALS: [redacted]	TIME: 2100 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q hr:
IV site care provided:	IV site care provided: flush	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (L) SC / ok	IV Site #1: (L) SC / OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (B)/E	TIME: 0640	2100
COLOR	P	P
CAPILLARY REFILL	1	1
TEMPERATURE	W	W
EDEMA	0	0
SENSATION	S	S
MOTION	M	M
PASSIVE FLEXION	P/D	0
PERIPHERAL PULSE	2P	2P

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 / OTHER

	TIME:	0640	2100
SAFETY	ID band visible/legible	AVM	W
	Orient to environment prn	AVM	W
	Side rails (2/4) up	NA	NA
	Bed position low		
	Call light within reach		
OTHER	Review & post lab results		
	Notify MD abnormal labs		
	Incontinent urine/stool		
	Linen change prn	AVM	
	Turn/reposition q2h	NA	
	ROM q2h if immobile		
	Antiembolic hose		

DIET

BREAKFAST	LUNCH	DINNER
TYPE:	TYPE:	TYPE: Reg
PERCENT CONSUMED:	PERCENT CONSUMED:	PERCENT CONSUMED: 50%
HOW TOLERATED:	HOW TOLERATED:	HOW TOLERATED: well
☐ 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: 0640	INITIALS: [redacted]	TIME: 2100	INITIALS: [redacted]	TIME:	INITIALS:
CONTENT: -Plan of care b(6)-2		CONTENT: call for assist		CONTENT: b(6)-2	
☑ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding	

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

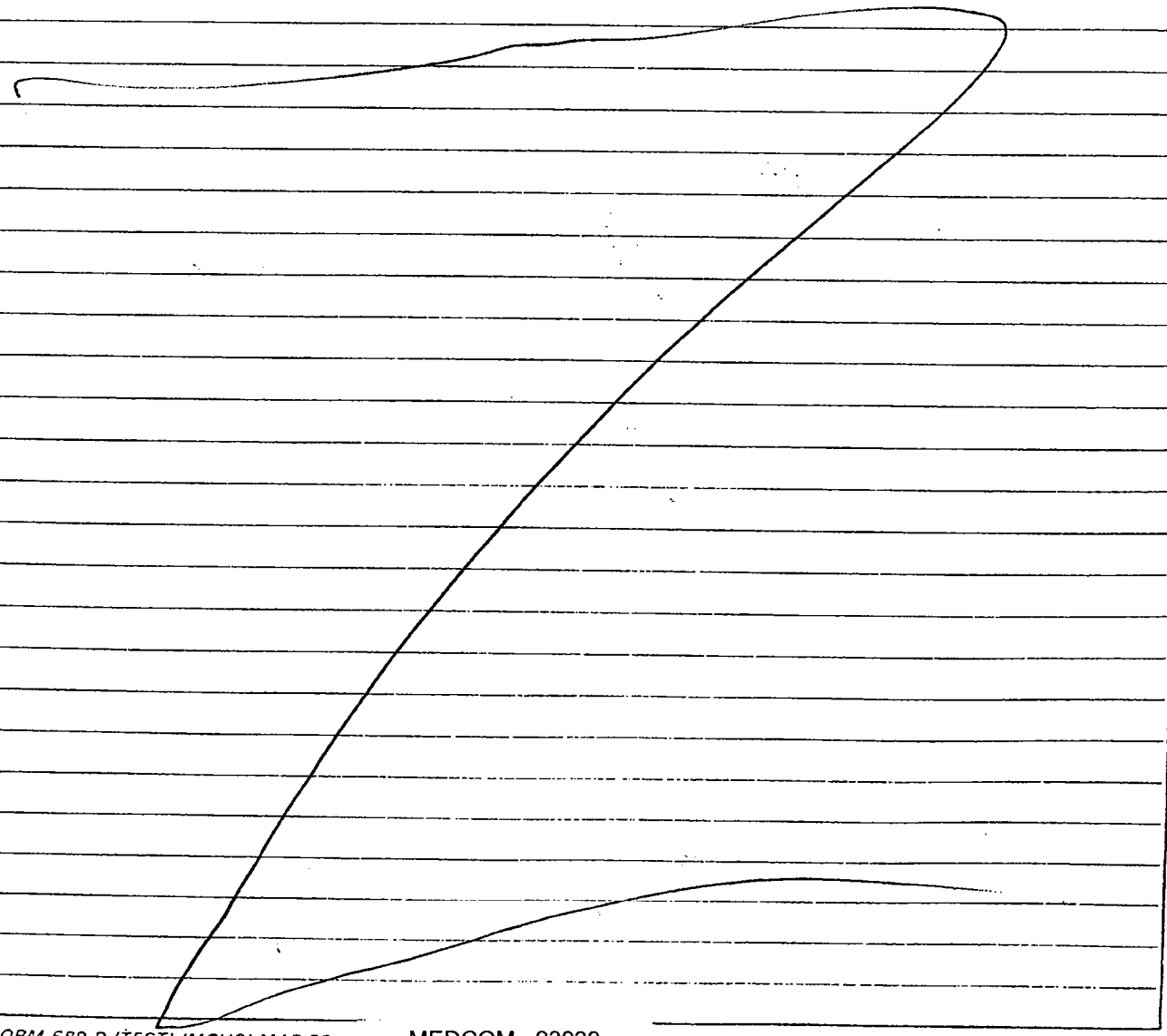
INITIALS	SIGNATURE	SHIFT
b(6)-2	[redacted] RCT RN	4
	[redacted] SPC/9/USMC	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1000	(R) Buttock; (R) thigh; (R) outer calf; (R) inner calf	Red, bleeding present No S/S infection.	W → D dsg Δ ē NS

SECTION IV - NOTES

0640: Awake & alert. C/o pain 5/10 in (R) LE. Percocet [redacted] given. (R) LE ↑ on heel cushions. Will continue to monitor. [redacted] blue 2



MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 9Dec03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 28/4 | HOSPITAL DAY: 29

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:	1200	2000	0400														
BP ARTERIAL LINE		119															
BP CUFF	127/62	55	120/70														
TEMPERATURE	97.8	98.6	97.2														
PULSE	121	55	60														
RESPIRATORY RATE	16	20	16														
OXYGEN (L/%)		98%															
PULSE OXIMETER		99%	99%														
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

PAIN

TIME:	0810	2000								
PAIN INTENSITY (10 / 5 / 0)	X	X								
MED ADMINISTERED (Y/N)	Y	Y								
RELIEF ACCEPTABLE (Y/N)	Y	Y								

OTHER

TIME:										
FINGER STICK GLUCOSE										
INSULIN (Y/N)										

SPECIAL NEEDS

TIME:	0810
*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

PATIENT IDENTIFICATION

CIV [redacted]

b(6)-4

DIAGNOSIS: S/P open femur/tibia Rx vex fix

DRG: _____ ADMISSION DATE: 10NOV03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: [redacted] b(6)-7

PRIMARY CARE MANAGER: _____

QUIRED (Specify): _____

MEDCOM - 23940

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. b6-2

	TIME: 820 INITIALS: [redacted]	TIME: 2010 INITIALS: [redacted]	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.	☑	☑	☐
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.	☐ ↓ROM TO RLE PT CAN TO CHAIR 2 ASSIST	☐ ↓ ROM (R)LE 20 to ex-fix	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ PINS ET EX FIX TO RLE & INCISIONS CDI	☐ ↓ (B)LE	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ C/O PAIN 5/10 ↑ DEEP GLUTS	☐ see pg 1	☐
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: 820 INITIALS: [redacted]	TIME: 2010 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 5 hr:	IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:
IV site care provided: FLUSHED	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: ➤ CENTRAL LINE / OK	IV Site #1: Central line / OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: SL	Comments:

b(6)-4

[redacted] MEDCOM - 23941

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (BLE)	TIME: 0730	2010					
COLOR	P	P	P				
CAPILLARY REFILL	1	1	1				
TEMPERATURE	W	H	H				
EDEMA	0	0	0				
SENSATION	S	S	S				
MOTION	P	P	P				
PASSIVE FLEXION	0	/	0				
PERIPHERAL PULSE	3	2	3				
		(R)	(L)				

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 / OTHER

	TIME: 0840	2010
ID band visible/legible	CB	ACB
Orient to environment prn	CB	ACB
Side rails (2/4) up	/	/
Bed position low		
Call light within reach		
Review & post lab results		
Notify MD abnormal labs		
Incontinent urine/stool	/	/
Linen change prn	CB	
Turn/reposition q2h	/	/
ROM q2h if immobile	/	/
Antiembolic hose	/	/

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	REG	Reg	Reg
PERCENT CONSUMED:	50	30	well 60%
HOW TOLERATED:	well	well	well
	☑ 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:	INITIALS:	TIME: 2010	INITIALS: [redacted]	TIME: b(6)-2	INITIALS:
CONTENT:	OOB TO CHAIR ↓ CANDY ET EAT MEALS ↑ ORAL FLUIDS	CONTENT:	explained – pain management – call for assist	CONTENT:	
☑ Patient/Family Verbalizes Understanding		☑ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding	

PATIENT IDENTIFICATION	INITIALS	SIGNATURE	SHIFT
b(6)-4 [redacted]	b(6)-2	[redacted] GT, RWMB	D
		[redacted] RT/RNS	

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	2200	RLE LLE	beefy red, bone exposure @ shins, pmcore dorsal gauze wrap	Δ drsg BID W-D -COT - Ø

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 11 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 30/6 | HOSPITAL DAY: 31

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:	1200	2000	0400													
BP ARTERIAL LINE	—	—														
BP CUFF	111/77	97/65	118/76													
TEMPERATURE	98.1	96.4	99.9													
PULSE	105	114	118													
RESPIRATORY RATE	20	20	16													
OXYGEN (L/%)	0	—														
PULSE OXIMETER	100%	100	100%													
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

PAIN

TIME:	0845	1200	1800													
PAIN INTENSITY (10 / 5 / 0)	X		X													
MED ADMINISTERED (Y/N)	Y	NA	N													
RELIEF ACCEPTABLE (Y/N)	Y		NA													

OTHER

TIME:	0845															
FINGER STICK GLUCOSE	NA															
INSULIN (Y/N)																

SPECIAL NEEDS

TIME:	0845	1830
*Skin breakdown prevention	ct	AW
*Falls prevention protocol	NA	NA
*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
	JPdrain:													

PATIENT IDENTIFICATION

b(6)-4

C [redacted]

DIAGNOSIS: S/P open femur/tibia fx, ex-fix

DRG: _____ ADMISSION DATE: 10 NOV 03

LOS: _____ EXPECTED RELEASE: b(6)

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

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.

	TIME: 0845 INITIALS: [redacted]	TIME: INITIALS:	TIME: 1830 INITIALS: [redacted]
1. NEUROLOGICAL: Alert and oriented to time place and name. Responds appropriately. Communication is adequate to express needs. Pupils equal and reactive to light.	☑	☐	☑
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.	☐ -ØROM to (R) ankle 2° to ext fix -pain c ROM to (R) LE	☐	☐ PWT to ROM to (R) LE 2° to ex fix x2 and pain -Passive ROM to (R) LE -Plant in hall tract
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ -wounds to (R) LE & (L) shin -graft site to (L) thigh -stage I decubitis ulcer on (R) heel	☐	☐ -wound to (R) thigh and (R) calf -stage II decub to (R) heel -Pin sites CDI
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ 5/10 c/o pain T percocet given	☐	☐ See pg 1
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☑

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

TIME: 0845 INITIALS: CT	TIME: INITIALS:	TIME: 1830 INITIALS: AW
IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:	IV patency ✓ q 8 hr:
IV site care provided: assessed	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: central line to CSC / OK	IV Site #1:	IV Site #1: (L) SC CL / OK*
IV Site #2:	IV Site #2:	IV Site #2:
Comments: line flushes well c NS & bld return.	Comments:	Comments: (+) blood return

b(4)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RLE LLE TIME:	0845	1830					
COLOR	P	P	P	P			
CAPILLARY REFILL	1	1	1	1			
TEMPERATURE	W	W	W	N			
EDEMA	1	Ø	1	Ø			
SENSATION	S	S	S	S			
MOTION (ankle / digits)	M / M	M / M	P / P	M / M			
PASSIVE FLEXION	NP	Ø	DP	Ø			
PERIPHERAL PULSE	1P	2P	1	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

TIME:	0845	1530					
ID band visible/legible	✓	[redacted]					
Orient to environment prn							
Side rails (2/4) up							
Bed position low							
Call light within reach							

OTHER

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

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Regular	TYPE: Regular	TYPE: Regular
PERCENT CONSUMED: 50%	PERCENT CONSUMED:	PERCENT CONSUMED: Reg 50%
HOW TOLERATED: Well	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 (crutches), BSC, BRP, CHAIR b(4)-2 ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR ☐ SELF ☒ ASSIST (crutches) # TIMES/SHIFT	BEDREST, AMBULATE, BSC, BRP, CHAIR ☐ SELF ☒ ASSIST # TIMES/SHIFT

TEACHING

TIME: 0845 INITIAL: [redacted]	TIME: 1830 INITIAL: [redacted] b(6)-2	TIME: INITIALS:
CONTENT: - pain management - DSG d's - COB → chair - ambulate c crutches	CONTENT: - Call for assist - Pain management - Ambulate c Walker	CONTENT:
☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION b(6)-4 [redacted]

INITIALS	b(6)-2 SIGNATURE	SHIFT
[redacted]	[redacted] 2LT/AN	0618
	CO/AN	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1100	① back of ® thigh ② inner aspect of ® calf ③ outer aspect of ® calf ④ ® calf	① tissue well granulated, ø s/s of infection ② tissue well granulated, tibia visible ± broken, ø s/s of infection ③ tissue red, well granulated, ø s/s of infection ④ graft site intact, staples intact, graft appears to be taking well	① ② ③ > W/D ± NS ④ dry 4x4 ± kerlix applied

SECTION IV - NOTES

1430 - Attempted to ambulate pt ± crutches, pt was very uncooperative. A walker was given to him to assist ō ambulation & pt continued to be uncooperative. PT was notified & attempted to encourage pt & he would not move [redacted] b(6)-2

2000 - Pt ambulated approx 20 ft ± Walker. Stood in hallway ± walker for 45 min. Pt cried but ø c/o pain or request for pain meds [redacted] b(6)-2 VM

2230 Dsg change done to ® thigh and ® calf wounds. Pin Care done to femur and tibia ex fix es using Betadine and NS. Pin sites to upper ex fix ± some drainage noted skin tight around pins. Pins to lower ex fix CDI, minimal drainage to pin sites. Wounds to ® thigh ± purulent drainage, well granulated ± s/s infection. Packed w/ Dt NS gauze. Dsg to ® calf ± s/s infection, back section of calf tissue well granulated, minimal bleeding. Wound to ® shin ± bone visible wound around bone healing well, ® granulation tissue ø s/s infection [redacted] b(6)-2 VM

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
0900	(R)LE	Ex-fixes thigh and calf ~~thigh~~ /buttock areas red to drainage	W→D DSG Δ pin care
		JP drain thigh wound ankle wound red	

SECTION IV - NOTES

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RLE	TIME: 1030	2000				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	0	0				
SENSATION	S	S				
MOTION	P	M				
PASSIVE FLEXION	0	0				
PERIPHERAL PULSE	P	2P				

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 / OTHER

	TIME:	2000
ID band visible/legible	✓	✓
Orient to environment prn	✓	
Side rails (2/4) up	✓	✓
Bed position low		
Call light within reach		
Review & post lab results		
Notify MD abnormal labs		
Incontinent urine/stool		
Linen change prn	/	✓
Turn/reposition q2h	✓	✓
ROM q2h if immobile	/	
Antiembolic hose	✓	✓

DIET

BREAKFAST	LUNCH	DINNER
TYPE: REG	TYPE: REG	TYPE: Reg
PERCENT CONSUMED: 75%	PERCENT CONSUMED: 50%	PERCENT CONSUMED: 50%
HOW TOLERATED: WELL	HOW TOLERATED: WELL	HOW TOLERATED: well
☑ 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: 1030 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: PAIN CONTROL W/ ASSIST SAFETY	CONTENT: • Pain control • DSG Δ • Ambulate c walker	CONTENT: b(6)-2
☑ Patient/Family Verbalizes Understanding	☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

C [redacted] b(6)-4

INITIALS	SIGNATURE	SHIFT
[redacted]	SGT [redacted]	D
	SPC [redacted]	N

MEDCOM - 23949

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99

Page 2 of 4 pages

ACLU-RDI 1685 p.80

DOD-037527

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.

	TIME: 1050 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]	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.	☑	☑	☐
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.	☐ Decr RLE AMBULATES c WALKER	☐ Amb c walker. Exfixes to upper and lower (R) LE	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Dsg Incisions to RLE c/d/i Exfix (x2)	☐ Skin graft donor site DLE. Open wounds c/d (R) LE	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ No pain ambulation	☐ percocet for pain	☐
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: 1050 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 5 hr:	IV patency ✓ q 5 hr:	IV patency ✓ q ___ hr:
IV site care provided: FLUSHED	IV site care provided: Flush	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) SUBC / OK	IV Site #1: (L) SC / OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: SL	Comments:

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 12Dec 03 | PATIENT ACUITY LEVEL : III | POST-OP DAY: 31/7 | HOSPITAL DAY: 32

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:	1200	2000	0400													
BP ARTERIAL LINE																
BP CUFF	106/74	115/73	110/75													
TEMPERATURE	97.0	98.2	98.3													
PULSE	103	106	100													
RESPIRATORY RATE	18	20	16													
OXYGEN (L/%)		/														
PULSE OXIMETER	100%	100%	100													
O2 METHOD	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

PAIN

TIME:	1200	2000								
PAIN INTENSITY (10 / 5 / 0)	1	0								
MED ADMINISTERED (Y/N)	Y	Y								
RELIEF ACCEPTABLE (Y/N)	Y	Y								
		persnet								

OTHER

TIME:										
FINGER STICK GLUCOSE										
INSULIN (Y/N)										

SPECIAL NEEDS

TIME:	1015	2000
*Skin breakdown prevention	b(6)-2	[redacted]
*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

PATIENT IDENTIFICATION

b(6)-4

[redacted]

DIAGNOSIS: S/p open femur/tibia fx; ex-fix

DRG: _____ ADMISSION DATE: 10Nov 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER [redacted] b(6)-2

ISOLATION REQUIRED (*Specify*): _____

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 13Dec03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 32/8 | HOSPITAL DAY: 33

TRANSFER

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

☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Time _____ To _____ From _____

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:	1200	20	04													
BP ARTERIAL LINE																
BP CUFF	109/60	114/81	100/76													
TEMPERATURE	96.1	97.9	96.5													
PULSE	101	111	97													
RESPIRATORY RATE	16	18	16													
OXYGEN (L/%)																
PULSE OXIMETER	100/70	99%	100%													
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

PAIN

TIME:	1200	20							
PAIN INTENSITY (10 / 5 / 0)	X								
MED ADMINISTERED (Y/N)									
RELIEF ACCEPTABLE (Y/N)									

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)									

SPECIAL NEEDS

TIME:			
*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

PATIENT IDENTIFICATION

CIV [redacted]

b(6)-4

DIAGNOSIS: Open (R) femur & tibia fx

DRG: _____ ADMISSION DATE: 10NOV03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (Specify): b(6)-2

b(4)-2 Atl

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.

	TIME: INITIALS:	TIME: 20 INITIA[redacted]	TIME: 1 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.	☐	☑	☐
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.	☐	☐ Ex Fix to RLE	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐	☐ Multiple wounds to RLE	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐	☐ percocet prn	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☐	☑	☐

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

TIME: _____ INITIALS: _____	TIME: 2100 INITIALS: [redacted]	TIME: _____ INITIALS: _____
IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____	IV patency ✓ q ___ hr: _____
IV site care provided: _____	IV site care provided: Flushed	IV site care provided: _____
IV tubing changed: _____	IV tubing changed: _____	IV tubing changed: _____
LOCATION CONDITION	LOCATION CONDITION	LOCATION CONDITION
IV Site #1: _____ _____	IV Site #1: Single lumen @ Subclavian ok	IV Site #1: _____ _____
IV Site #2: _____ _____	IV Site #2: _____ _____	IV Site #2: _____ _____
Comments:	Comments:	Comments:

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:						
COLOR						
CAPILLARY REFILL						
TEMPERATURE						
EDEMA						
SENSATION						
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 / OTHER

TIME:			
ID band visible/legible			
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE: Reg	TYPE:
PERCENT CONSUMED: 30%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: Well	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: INITIALS:	TIME: INITIALS:	TIME: INITIALS:
CONTENT:	CONTENT:	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

INITIALS	SIGNATURE	SHIFT

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 14 DEC 03 | PATIENT ACUITY LEVEL: ~~II~~ III | POST-OP DAY: 33/9 | HOSPITAL DAY: 34

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:	1200	2000														
BP ARTERIAL LINE	—															
BP CUFF	121/84	107/68														
TEMPERATURE	97.0	99.7														
PULSE	111	113														
RESPIRATORY RATE	20	22														
OXYGEN (L/%)	0	—														
PULSE OXIMETER	100	99%														
O2 METHOD	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

PAIN

TIME:	0725	1200	2000						
PAIN INTENSITY (10 / 5 / 0)	?	~~X~~ NA	K						
MED ADMINISTERED (Y/N)	N								
RELIEF ACCEPTABLE (Y/N)	Y								

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)									

SPECIAL NEEDS

TIME:	0725	1830
*Skin breakdown prevention	AVM	AW
*Falls prevention protocol	NA	NA
*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

PATIENT IDENTIFICATION

[redacted] b(6)-4

DIAGNOSIS: S/P open femur/tibia fx; ex fix

DRG: _____ ADMISSION DATE: 13 NOV 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: _____ b(6)-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED (*Specify*): _____

b(6)-2 A11

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.

	TIME: 0725 INITIAL [redacted]	TIME: 1830 INITIAL [redacted]	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.	☑	☑	☐
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.	☑	☐ Pt c/o inability to void, but put out 960cc clear yellow urine in 3hr	☐
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.	☐ Ex fix to ®LE ↓ mobility, Ambulates ± walker/crutches	☐ Ex fix to ®LE ↓ ROM to ® knee Ambulates to walker	☐
7. **SKIN:** Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ Large wounds to ® buttock, ® thigh, ® inner calf, ® outer calf. Donor site to ® thigh, Graft site to ® calf.	☐ Wound to ® LE to DSG CDI	☐
8. **PAIN:** No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑	☐ see pg 1	☐
9. **PSYCHOSOCIAL:** Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

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

TIME: 0725 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 6 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: ®SC * / OK	IV Site #1: ®SC CL / OK*	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

blw-2 of 4

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RLE	TIME: 0725	1830
COLOR	P	P
CAPILLARY REFILL	1	1
TEMPERATURE	W	W
EDEMA	Ø	Ø
SENSATION	S	S
MOTION	M	M
PASSIVE FLEXION	/	Ø
PERIPHERAL PULSE	2P	2P

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:	0725	1830
ID band visible/legible	✓	[redacted]
Orient to environment prn		
Side rails (2/4) up		
Bed position low		
Call light within reach		

OTHER

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

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Regular	Reg	Reg
PERCENT CONSUMED:	20%		50%
HOW TOLERATED:	well		well
	☑ 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: 0725 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: - Plan of care -	CONTENT: - Care for assist - Pain management - Amb - ROM	CONTENT:
☑ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

[redacted]

blw-4

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted]	
	[redacted] CO/AN	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1000	(R) buttock, (R) thigh, (R) inner and outer calf, (L) calf	Red, granulating well, Staples intact to skin graft	W → D Dsg △
	2300	(R) thigh, (R) buttock	Red, good granulation tissue, sutures intact	Dry dsg △
		(R) Calf (lateral & medial)	- lateral side red & granulation tissue - medial side & tibia bone tissue of wound bed	W → D Dsg △ to NS soaked gauze
		Pin sites	- Sites & minimal serous drainage	Cleaned & Betadine & H2O

SECTION IV - NOTES

0725: Awake & alert - Eating breakfast. No c/o pain @ this time. (B)CE ↑ - heals off of bed. Will continue to monitor. [redacted] b(6)-2

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 15Dec03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 34/10 | HOSPITAL DAY: 35

TRANSFER

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

☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Time _____ To _____ From _____

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:	1200	2000	0400														
BP ARTERIAL LINE	—	—	—														
BP CUFF	107/78	104/68	101/59														
TEMPERATURE	98.8	98.9	99.0														
PULSE	100	102	100														
RESPIRATORY RATE	16	16	18														
OXYGEN (L/%)	0	—	—														
PULSE OXIMETER	99%	98	98%														
O_2 METHOD	RA	RA	RA														

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

PAIN

TIME:	0900	1200	1830	2006	0400				
PAIN INTENSITY (10 / 5 / 0)		C	X	✓	✓				
MED ADMINISTERED (Y/N)			N						
RELIEF ACCEPTABLE (Y/N)			NA						

OTHER

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

SPECIAL NEEDS

TIME:				
*Skin breakdown prevention				
*Falls prevention protocol				
*Restraint protocol				
*Seizure precautions	N/A			
*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

PATIENT IDENTIFICATION

C[redacted] b(6)-4

DIAGNOSIS: S/P open femur/tibia fx; ex fix (R) LE

DRG: _____ ADMISSION DATE: 12Nov03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6)-2

PRIMARY CARE MANAGER [redacted]

ISOLATION REQUIRED (*Specify*): _____

b(6)-2 A11

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.

	TIME: 0900 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	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.	☑	☑	☐
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.	☐ Pt states PN & difficulty urination & q 77. urinating	☐ Pt states he has difficulty voiding but 0 S/S of difficulty	☐
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.	☐ Ext Rip R/leg L ROM, Pt ambulates c walker	☐ ↓ ROM to R LE 2° to ex fix amb c walker	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ warm to R & left. Pt has distal pulse.	☐ Dsg to R LE c wounds healing well	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ 0 c/c PN	☐ see pg 1	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

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

TIME: 0900 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: _____ INITIALS: _____
IV patency ✓ q 8 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: DSC / OK	IV Site #1: DSC CL / OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments:	Comments:

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (R) LE TIME:	0700	1830				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	1	1				
SENSATION	S	S				
MOTION	P	P				
PASSIVE FLEXION	/	DP				
PERIPHERAL PULSE	2	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 / OTHER

TIME:	0700	1830
ID band visible/legible	✓	[redacted]
Orient to environment prn		[redacted]
Side rails (2/4) up		[redacted]
Bed position low	✓	✓
Call light within reach	✓	✓
Review & post lab results		[redacted]
Notify MD abnormal labs		[redacted]
Incontinent urine/stool	✓	✓
Linen change prn		[redacted]
Turn/reposition q2h	✓	✓
ROM q2h if immobile	✓	✓
Antiembolic hose	✓	✓

DIET

BREAKFAST	LUNCH	DINNER
TYPE: Reg	TYPE: Reg	TYPE: Reg
PERCENT CONSUMED: 100%	PERCENT CONSUMED: 60%	PERCENT CONSUMED: 50%
HOW TOLERATED: well	HOW TOLERATED: well	HOW TOLERATED: well
☑ 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: 0700 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: - Plan of Care	CONTENT: 66-2 - Call for assist - Pain Management - DSG D - ROM	CONTENT:
☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

b(6)-4

[redacted]

INITIALS	SIGNATURE	SHIFT
[redacted]		D
	CW/RN	N
	b(6)-2	

MEDCOM - 23961

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	(1) (R) calf (2) (R) buttock (R) thigh	sights erythema, edges white slight drainage, no odor yellowish/brownish drainage	wet to Dry DSG Δ
0800	(L) calf		(L) calf Dry DSG Δ
2230	(R) thigh, (R) buttock	- wound ō Ø S/S infect (+) granulation tissue	W to D dsg Δ done ō NS soaked gauze
	medial calf (R)	- wound ō (+) gran tissue Ø drainage noted, bone visible in wound	
	lateral (R) calf	- (+) gran tissue, Ø S/S inf	
	pins to upper and lower ex-fix		pins cleaned ō betadine/NS

SECTION IV - NOTES

Pt CAO x3, Ø c/o PN @ this time. Pt ate small amount of breakfast. Dis DSG Δ. Pt tolerated well. Sights has Ø odor slight drainage (yellowish/brownish) ā white edges (scar tissue) ↑ HOB of bed. Placed on Donut to ↓ decubs ulcer. Will continue to monitor HOB of Pt. Pt has Ø c/o P this time [redacted] SPC(P) 91W

1600

1515CO3 I AGREE ō THE ABOVE ASSESSMENT [redacted] 1LW/NC

b(6)-2

MEDCOM FORM 689-R (TEST) (MCHO) MAR 99 — MEDCOM - 23962

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 16 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 35/11 | HOSPITAL DAY: 36

TRANSFER

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

☐ AMBULATORY ☐ CRUTCHES ☐ WHEELCHAIR ☐ STRETCHER

Time _____ To _____ From _____

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:	1200	2200	0600														
BP ARTERIAL LINE																	
BP CUFF	114/76	104/71	114/74														
TEMPERATURE	99.6	98.8	98.1														
PULSE	111	119	111														
RESPIRATORY RATE	14	16	16														
OXYGEN (L/%)																	
PULSE OXIMETER	99%	100%	100%														
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

PAIN

TIME:	1000	1200	1830	2030													
PAIN INTENSITY (10 / 5 / 0)	X	X	X	X													
MED ADMINISTERED (Y/N)	N	N	N	Y													
RELIEF ACCEPTABLE (Y/N)	NA	NA	NA	Y													
	Percocet			1													

OTHER

TIME:	1000																
FINGER STICK GLUCOSE	NA																
INSULIN (Y/N)	1																

SPECIAL NEEDS

TIME:	1000	1830
*Skip breakdown prevention	[redacted]	
*Falls prevention protocol		
*Restraint protocol		
*Seizure precautions	b(6)-2	
*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

b(6)-4

C[redacted]

DIAGNOSIS: S/P open femur/tibia fx; ex-fix

DRG: _____ ADMISSION DATE: 12 Nov 03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6)-2

PRIMARY CARE MANAGER: [redacted]

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.

	TIME: 1000 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	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.	☑	☑	☐
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.	☑	☑ blw-2 ATV	☐
5. G.U.: Reports no dysuria, retention, urgency, frequency, nocturia. Urine clear, yellow/amber. No unusual discharge.	☑	☑ Voiding 3 difficulty to BR	☐
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.	☐ -Ø ROM to (R) ankle 2° to ext fix -minimal ROM to (R) knee -pain ROM to RLE	☐ Ø ROM (R) ankle ↓ ROM to (R) knee exercises done pin care -Ptamb-TWalker 6 assist	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ -wounds to RLE -graft site to (L) calf	☐ Dsg to (R) LE Δ'd Ø S/S infection to wounds. Pin sites ↑ minimal drainage	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑ Ø c/o pain	☐ see pg 1	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

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

TIME: 1000 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided: dsg Δ'd	IV site care provided: flushed	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: Central line (L)SC / OK	IV Site #1: (L) SC CL / OK*	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL'd	Comments: Heplocked between meds	Comments:

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (BLE) TIME:	1000	1630				
COLOR	P	P				
CAPILLARY REFILL	1	1				
TEMPERATURE	W	W				
EDEMA	Ø	Ø				
SENSATION	S	S				
MOTION Knee/ankle	P/U	P/U				
PASSIVE FLEXION Knee	N/A	✓				
PERIPHERAL PULSE	DP	DP				

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:						
ID band visible/legible	[redacted]					
Orient to environment prn						
Side rails (2/4) up						
Bed position low						
Call light within reach						

OTHER

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

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Regular	Regular	Regular
PERCENT CONSUMED:	75%		50%
HOW TOLERATED:	well		well
	☒ 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 c walker # TIMES/SHIFT	BEDREST (AMBULATE) BSC BRP (CHAIR) ☒ SELF ☐ ASSIST walker # TIMES/SHIFT	BEDREST (AMBULATE) BSC BRP (CHAIR) ☒ SELF ☐ ASSIST walker # TIMES/SHIFT

TEACHING

TIME: 1000 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: b(6)-2 -pain management -call for assistance -ambulation	CONTENT: b(6)-2 -Call for assist -Pain management -Turning -Ambulation	CONTENT:
☒ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

[redacted]

b(6)-4

INITIALS	b(6)-2 SIGNATURE	SHIFT
[redacted]	DVP/AN	0618
	CW/AN	N

MEDCOM - 23965

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0100	(R) thigh, (R) buttock	-SS/S infection, good granulation tissue	WTD dsg D/C
		(R) medial calf	-fibra visible in wound, SS/S infection	
		(R) lateral calf	-good granulation tissue, min bleeding, SS/S infection	
		(R) femur ex-fix	-serous drainage from pins	Pin care c Betadine & NS
		(R) tibia ex fix	-drainage from pins	

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 17 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 36/12 | HOSPITAL DAY: 37

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	1200														
BP ARTERIAL LINE	/	—														
BP CUFF	111/79															
TEMPERATURE	99.1															
PULSE	100															
RESPIRATORY RATE	18															
OXYGEN (L/%)	/															
PULSE OXIMETER	99															
O_2 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:	0910	1830								
PAIN INTENSITY (10 / 5 / 0)	5	X								
MED ADMINISTERED (Y/N)	Y	N								
RELIEF ACCEPTABLE (Y/N)	Y	NA								

OTHER

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

SPECIAL NEEDS

TIME:	0910	1830
*Skin breakdown prevention	[redacted]	b6-2
*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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DIAGNOSIS: S/P open femur/tibia fx; ex fix (R) LE

DRG: _____ ADMISSION DATE: 12 NOV

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6)-2

PRIMARY CARE MANAGER: [redacted]

ISOLATION REQUIRED *(Specify)*: _____

b(6)-2 A1

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.

	TIME: 0915 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	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.	☑	☑	☐
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.	☐ Ambulate with Walker and minimal assist.	☐ *ROM to (R) knee exercises done pin care ØROM (R) ankle amb c walker	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ (R) thigh, (R) buttock (R) calf, (R) Femur/Tib ex Fix IV (L) IJ	☐ (R) thigh/buttock medial & lateral calf-femur/Tib ex fix	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ Medicated for pain stated	☐ See pg 1	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

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

TIME: 0915 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q 8 hr:	IV patency ✓ q ___ hr:
IV site care provided: X	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: (L) CL / OK	IV Site #1: (L) SC CL / OK*	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: HL	Comments: HL	Comments:

66-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: (R) LE	TIME:	0910	1830				
COLOR		P	P				
CAPILLARY REFILL		1	1				
TEMPERATURE		W	W				
EDEMA		0	0				
SENSATION		S	S				
MOTION		P	P				
PASSIVE FLEXION		/	DP				
PERIPHERAL PULSE		2P	2P				

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 / OTHER

	TIME:	0910	1830
ID band visible/legible		/	[redacted]
Orient to environment prn		/	[redacted]
Side rails (2/4) up		/	NA
Bed position low		/	
Call light within reach		/	
Review & post lab results		/	
Notify MD abnormal labs		/	
Incontinent urine/stool		/	
Linen change prn		/	
Turn/reposition q2h		Daily	
ROM q2h if immobile		/	
Antiembolic hose		/	

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Regular	Regular	Reg
PERCENT CONSUMED:	100%	0	25%
HOW TOLERATED:	Well	—	Well
	☑ 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 ☐ SELF (AMBULATE) ☐ ASSIST BSC BRP # TIMES/SHIFT CHAIR	BEDREST ☐ SELF (AMBULATE) ☒ ASSIST BSC BRP # TIMES/SHIFT CHAIR	BEDREST ☐ SELF (AMBULATE) ☒ ASSIST BSC BRP # TIMES/SHIFT CHAIR

TEACHING

TIME: 0910 INITIALS: [redacted]	TIME: 1830 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: Call for assist	CONTENT: ~~66-2~~ - Call for assist - Pain management - Dsg Δ - ROM	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] SGT 91LM6	4
		[redacted] T/Ha	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	0910	(R) thigh, (R) calf, (R) buttocks	Sites ̄s S/s of infection Good granulation	W-D DRSG Δ
	2310	(R) thigh (R) calf (R) buttock wounds	sites ̄s S/s infection good granulation tissue	W→D dsg Δ
		pin sites (R) femur Exfix	- sites oozing serous drainage - area reddened to ↓ pins	Pins cleaned ̄c Betadine and Water
		(R) tibia exfix	pin sites CDI	

SECTION IV - NOTES

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 18 Dec 03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 31/13 | HOSPITAL DAY: 38

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:	1200	2000	0400														
BP ARTERIAL LINE	—	—	—														
BP CUFF	108/74	122/85	112/76														
TEMPERATURE	97.8	97.9	97.2														
PULSE	100	116	107														
RESPIRATORY RATE	20	20	20														
OXYGEN (L/%)	-0-	—	—														
PULSE OXIMETER	100	100	99														
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

PAIN

TIME:	0730	1200	2000	0400					
PAIN INTENSITY (10 / 5 / 0)	X	X	X	X					
MED ADMINISTERED (Y/N)	Y	NA							
RELIEF ACCEPTABLE (Y/N)	Y								

OTHER

TIME:									
FINGER STICK GLUCOSE									
INSULIN (Y/N)									

SPECIAL NEEDS

TIME:	0730	2000
*Skin breakdown prevention	[redacted]	662
*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

PATIENT IDENTIFICATION

C [redacted]

b(6) - 4

DIAGNOSIS: S/P open femur/tibia fx; ex fix @ OR

DRG: _____ ADMISSION DATE: 12 Nov

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: b(6) - 2

PRIMARY CARE MANAGER: [redacted]

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.

	TIME: 0745 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]	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.	☑	☑ gets to (R) eye q' 2h	☐
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.	☑	☑ b(u) - < A11	☐
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.	☐ ↓ ROM TO RLE IVT x2 EX FIX	☐ AMB C walker to BR ex-fixes to RLE intact	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ MULTIPLE WOUND SITES TO RLE CDI, WELL GRANULATED (R) GRAFT SITE TO LLE	☐ Wounds to RLE, healing well Graft site/donor site LLE	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ C/O PAIN TO RLE	☐ ↑ percocet for pain	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

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

TIME: 0730 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 5 hr:	IV patency ✓ q 5 hr:	IV patency ✓ q hr:
IV site care provided: FLUSHED	IV site care provided: Flush	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: (R) SubC / OK	IV Site #1: (L) SC / OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: SL	Comments:

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RLE	TIME: 0730	2000				
COLOR	P	P				
CAPILLARY REFILL	2	2				
TEMPERATURE	W	W				
EDEMA	Ø	0				
SENSATION	S	S				
MOTION	P(RLE)	M				
PASSIVE FLEXION	Ø	Ø				
PERIPHERAL PULSE	2	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 / OTHER

	TIME: 0730	2000	
ID band visible/legible	[redacted]	[redacted]	
Orient to environment prn			
Side rails (2/4) up			
Bed position low			
Call light within reach			
Review & post lab results			
Notify MD abnormal labs			
Incontinent urine/stool			
Linen change prn			
Turn/reposition q2h			
ROM q2h if immobile			
Antiembolic hose			

DIET

BREAKFAST	LUNCH	DINNER
TYPE: REG	TYPE: REG	TYPE: REG
PERCENT CONSUMED: 75%	PERCENT CONSUMED: 100%	PERCENT CONSUMED: 100%
HOW TOLERATED: no N/V	HOW TOLERATED: Good	HOW TOLERATED: Well
☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE	☒ SELF ☐ ASSIST ☐ COMPLETE

ADL'S

	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 (circled), BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST, AMBULATE (circled) c̄ walker, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST, AMBULATE (circled) c̄ walker, BSC, BRP, CHAIR; ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: 0735 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]	TIME: INITIALS:
CONTENT: ↑ c̄ walker; Ambulate TID; ↑ PO fluids (b6-2)	CONTENT: . Ambulate c̄ walker . personal hygiene	CONTENT:
☐ Patient/Family Verbalizes Understanding	☒ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

[redacted] b(6)-4

INITIALS	SIGNATURE	SHIFT
[redacted]	[redacted] SGT/91WM6	[redacted]
	[redacted] SPC/91WM6	

b(6)-2

MEDCOM - 23973

ACLU-RDI 1685 p.104

DOD-037551

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE	TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
	1000	upper (R) Thigh & Lower (L) Leg.	Sites Both ↓ bright red in APP.	Packed NS Sol And dressed with Kerlix.
	2000	RLE	ex-fixes open wound to buttocks pink top of thigh pink Lower R leg open wound pink	W→D DSG Δ pin care done
				b(6) -

SECTION IV - NOTES

0900
1200 [redacted] PT PENDING TRANSFER TO CIVILIAN HOSP PER APO. [redacted] SAT, 5/wnb

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 19DEC03 | PATIENT ACUITY LEVEL: III | POST-OP DAY: 38/14 | HOSPITAL DAY: 39

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:	1200	2000	400														
BP ARTERIAL LINE																	
BP CUFF	119/78	135/91	113/65														
TEMPERATURE	97.5	99.1	98.7														
PULSE	105	121	105														
RESPIRATORY RATE	20	18	18														
OXYGEN (L/%)	0																
PULSE OXIMETER	98%	100	99														
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

PAIN

TIME:	1200	2000								
PAIN INTENSITY (10 / 5 / 0)	X	X								
MED ADMINISTERED (Y/N)	N	Y								
RELIEF ACCEPTABLE (Y/N)	NA	Y								
		Nerved								

OTHER

TIME:	1200	2000								
FINGER STICK GLUCOSE	NA	NA								
INSULIN (Y/N)										

SPECIAL NEEDS

TIME:	1200	2000
*Skin breakdown prevention	66-2	[redacted]
*Falls prevention protocol	NA	NA
*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

Civ [redacted] 66-4

DIAGNOSIS: S/P open femur/tibia fx: 2 ex fix @ OR

DRG: _____ ADMISSION DATE: 12NOV03

LOS: _____ EXPECTED RELEASE: _____

CASE MANAGER: 66-2

PRIMARY CARE MANAGER: [redacted]

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.

	TIME: 1200 INITIALS [redacted]	TIME: 2000 INITIALS [redacted]	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.	☑	☑ OD. stb 92° WA	☐
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.	☑ b(6)-2 A11	☑	☐
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.	☐ -limited Rom to Ⓡ knee, pain ↑ Rom - Ø ROM to Ⓡ ankle 2° to ext fix - pain ↑ Rom to Ⓡ hip	☐ up ↑ walker ↓ ROM RLE 2ex-fixes	☐
7. **SKIN:** Warm; dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ -wounds to Ⓡ LE, graft site to Ⓛ calf - stage I decub on Ⓡ heel	☐ wounds to RLE graft site Ⓛ calf Ⓡ heel with drainage site Stage II Ⓛ thigh	☐
8. **PAIN:** No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☑ Ø c/o pain	☐ ↑ percocet for pain	☐
9. **PSYCHOSOCIAL:** Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☑	☐

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

TIME: 1200 INITIALS: [redacted]	TIME: 2000 INITIALS: [redacted]	TIME: INITIALS:
IV patency ✓ q 8 hr:	IV patency ✓ q 5 hr:	IV patency ✓ q ___ hr:
IV site care provided: needs D/ring	IV site care provided: flush	IV site care provided:
IV tubing changed:	IV tubing changed:	IV tubing changed:
LOCATION / CONDITION	LOCATION / CONDITION	LOCATION / CONDITION
IV Site #1: central line Ⓡ sc / ok	IV Site #1: Ⓛ SC / OK	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments:	Comments: SL	Comments:

b(6)-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: RLE	TIME: 1200	2000					
COLOR	P	P					
CAPILLARY REFILL	1	1					
TEMPERATURE	W	W					
EDEMA	Ø	Ø					
SENSATION	S	S					
MOTION ankle/knee	U/P	U/M					
PASSIVE FLEXION	UTA	UTA					
PERIPHERAL PULSE	2P	2P					

UTA: unable to assess

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: 1200	2000
ID band visible/legible	✓	[redacted]
Orient to environment prn		
Side rails (2/4) up		
Bed position low		
Call light within reach		

OTHER

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

DIET

	BREAKFAST	LUNCH	DINNER
TYPE:	Regular	Regular	Reg
PERCENT CONSUMED:	100%	75%	75%
HOW TOLERATED:	well	well	well
	☒ 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: walker	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT: walker	BEDREST, AMBULATE, BSC, BRP, CHAIR; ☐ SELF ☒ ASSIST; # TIMES/SHIFT: walker

TEACHING

TIME: 1200	INITIALS: [redacted]	TIME: 2000	INITIALS: [redacted]	TIME:	INITIALS:
CONTENT: - pain management - ambulate c walker - call for assistance - RM to BHMC		CONTENT: b6-2 • ambulate c walker • personal hygiene • call for asst		CONTENT:	
☒ Patient/Family Verbalizes Understanding		☒ Patient/Family Verbalizes Understanding		☐ Patient/Family Verbalizes Understanding	

PATIENT IDENTIFICATION

b(6)-4

[redacted]

INITIALS	b(6)-2 SIGNATURE	SHIFT
[redacted]	LCT/AN	0600
	SPC/HMMC	N

SECTION III - INTERVENTIONS & TEACHING (Cont)

WOUND CARE

TIME	LOCATION OF WOUND	APPEARANCE	TREATMENTS AND DRESSING CHANGE
1000	① Anterior ⓡthigh ② inner & anterior ⓡcalf ③ Ⓒcalf	① red moist, S/S/Sx of infection, well-granulated ② Jagged bone visible on inner medial, both calf wounds red well granulated tissue ③ graft site ET small area open & draining scant amt of serosanguinous fluid.	① ⓑ ② ⓐ > W→D c NS pincare completed ③ ⓒ dug Kerlix applied

SECTION IV - NOTES

66-2

1000 staples removed from graft site on ⓛLE. [redacted]

MEDICAL RECORD - PATIENT ACTIVITIES FLOWSHEET

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

SECTION I - PATIENT ASSESSMENT

DATE: 20DEC03 | PATIENT ACUITY LEVEL : VII | POST-OP DAY: 39/15 | HOSPITAL DAY 40

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:	1200																
BP ARTERIAL LINE	/																
BP CUFF	111/78																
TEMPERATURE	98.9																
PULSE	115																
RESPIRATORY RATE	14																
OXYGEN (L/%)	/																
PULSE OXIMETER	99																
O_2 METHOD	/																

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:	0710									
PAIN INTENSITY (10 / 5 / 0)	4									
MED ADMINISTERED (Y/N)	N									
RELIEF ACCEPTABLE (Y/N)	Y									

OTHER

TIME:										
FINGER STICK GLUCOSE										
INSULIN (Y/N)										

SPECIAL NEEDS

TIME:	0710		
*Skin breakdown prevention	3		
*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

PATIENT IDENTIFICATION

[redacted]

b(6)-4

DIAGNOSIS: S/P open femur/tibia fx

DRG: _____ ADMISSION DATE: 12NOV03

LOS: _____ EXPECTED RELEASE: b(6)-2

CASE MANAGER: _____

PRIMARY CARE MANAGER: [redacted]

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.

	TIME: 0720 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.	☑ b(6)-2	☐	☐
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.	☐ WEAK c WALKER AMBULATES WELL c WALKER	☐	☐
7. SKIN: Warm, dry, intact. Good turgor. No rashes, inflammation, ulcers, breaks in skin. No redness, blanching, irritation over bony prominences. Mucous membranes moist.	☐ PT DENIES c/o PAIN AT THIS TIME	☐	☐
8. PAIN: No complaints of pain/ discomfort. *(See page 1 for documenting pain intensity.)*	☐ MULTIPLE HEALED SITES TO RLE WELL GRANULATED LLE GRAFT SITE c Ø STAPLES	☐	☐
9. PSYCHOSOCIAL: Behavior is appropriate to the situation. Anxiety is controlled or mild and appropriate to situation. Interacts appropriately with others.	☑	☐	☐

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 8 hr:	IV patency ✓ q ___ hr:	IV patency ✓ q ___ hr:
IV site care provided: FLUSHED	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: RBUE * / OK	IV Site #1:	IV Site #1:
IV Site #2:	IV Site #2:	IV Site #2:
Comments: Ø BLOOD RETURN	Comments:	Comments:

166-2

SECTION III - PATIENT INTERVENTIONS & TEACHING

NEUROVASCULAR

SITE: TIME:	0715						
COLOR	P						
CAPILLARY REFILL	1						
TEMPERATURE	W						
EDEMA	0						
SENSATION	S						
MOTION	D						
PASSIVE FLEXION	0						
PERIPHERAL PULSE	3						

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:	0715						
ID band visible/legible	[redacted]						
Orient to environment prn							
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	/						

DIET

BREAKFAST	LUNCH	DINNER
TYPE: REG	TYPE:	TYPE:
PERCENT CONSUMED: 90%	PERCENT CONSUMED:	PERCENT CONSUMED:
HOW TOLERATED: WELL	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 66-2	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT	BEDREST AMBULATE BSC BRP CHAIR ☐ SELF ☐ ASSIST # TIMES/SHIFT

TEACHING

TIME: 0715 INITIALS: [redacted]	TIME: INITIALS:	TIME: INITIALS:
CONTENT: ↑ c WALKER ↑ TID ↑ COMBIVENT TID ↑ ENSURE BTWN MEALS	CONTENT:	CONTENT:
☑ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding	☐ Patient/Family Verbalizes Understanding

PATIENT IDENTIFICATION

INITIALS	SIGNATURE	SHIFT
[redacted]	SGT, RN/MC	D
	66-2	

MEDICAL RECORD

INTRAOPERATIVE DOCUMENT

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

PATIENT TRANSPORTED TO OPERATING ROOM
A BY

2. PATIENT IDENTIFIED [redacted] D PROCEDURE
VERIFIED BY CPT [redacted]

DATE TIME PATIENT ARRIVED IN SUITE

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

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

POSITION AND POSITIONAL AIDS (Specify) Head to towel arms s&d <90° to

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

COMMENTS padded armboards by surgeon, legs straight bed padded. Position approved

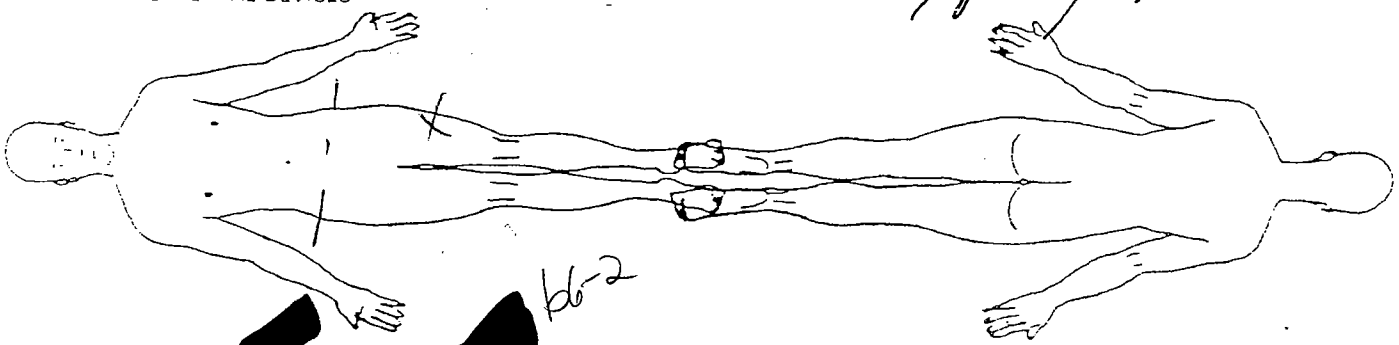
8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betad / Betad
SITE: (R) leg BY WHOM: [redacted]
SITE: (L) leg BY WHOM:

COMMENTS: ↓ post / ↓ ant b(6)-2

LOCATION OF EXTERNAL DEVICES



b(6)-2

LEGEND X Ground Pad -- Safety Strap = = = Tourniquet b(6)-2

C = Correct I = Incorrect

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

SCRUB	CIRCULATOR
SPC [redacted]	CPT [redacted]

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

Iraqi boy

14 yr old.

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

☒ ESU NO: 8
GROUND PAD: BRAND 3M
LOT NO: 1999-11CU

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

MEDCOM - 23982

Distributed by:
Stryker®
Howmedica
OSTEONICS
Full Dose
Cat. No. 6197-9-001
Control No. MEK003

X 27 Right leg

14. IRRIGATION/MEDICATIONS GIVEN | ANESTHESIA) YES ☐ NO ☒

MEDICATIONS SOLUTION	DOSAGE	METHOD	PREPARED BY	GIVEN BY
/	/	/	/	/

WOUND IRRIGATION ☒ YES ☐ NO. TYPE(S):

NSS

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES DRAINS PACKING YES ☒ NO ☐
TYPE SIZE 1. 8Fr Foley 2. 3.
SITE 1. Bladder 2. 3.

18. DRESSING/IMMOBILIZATION (Specify)
fluffs
Xeroform
Kerlex
Vessel loop (R) leg

19. ADDITIONAL INFORMATION
WC II

Surgeon [redacted]

20. OPERATION(S) PERFORMED
Ex Fix (R)

21. PATIENT TRANSFERRED TO PACU b(6)-1 [redacted] | TIME | METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT ANC

REVERSE OF DA FORM 5179-1, OCT .

MEDCOM - 23983

ACLU-RDI 1685 p.114

DOD-037561

IBN SINA HOSPITAL
28th Combat Support Hospital
Baghdad, Iraq

Microbiology Request Form

#1 - culture

Last Name: [redacted]
First Name: b(6)-4
Patient # or SSN: #[redacted]
Collected by: Dr [redacted]
Date: 10 Dec 03 b(6)-2
Time: 0900

Ward: ICU-2 (OR)
Room:
Bed:
Physician: Dr [redacted]
Source: Wound
Site: (R) Thigh

Received by: [redacted]
Date: 10 Dec 03
Time: 1000

Specimen #: 4/174

Laboratory Results

1) Klebsiella pneumoniae
2) Staphylococcus haemolyticus
3) Staphylococcus auricularis

Reported
Date: 13 Dec 03
Time: 1117
Tech: rgw
Reviewer: [redacted]

Number of attached sheets:

MEDICAL RECORD — ANESTHESIA

CONTINUOUS / REPEATED DRUGS — SPECIFY UNITS — MG / MCG / INL. (" "=CONSTANT INFUSION)

DRUG (Units)						TOTALS
Fentanyl (mg)	50	20				
Ketamine ( )	50					
Sch. (mg)	80					
Vecuronium ( )		2	1			
Atropine ( )	0.4					
MgSO4 ( )						
VOLAT AGENT Iso % del	0.5 — 0.25 — 0.5	0.5	1.0 — 2 / 1.0	2		
% e.t.						
AIR L/Min						
N2O L/Min						
O2 L/Min	5 — 5 — 5 — 5					

TOTAL EBL: 500cc
TOTAL URINE: 500 cc

SINGLE DOSE DRUGS — MARK ON GRID WITH NUMBERS & ENTER IN REMARKS: Ancef 500mg IVPB standby: Drug PCN 300,000 u IVPB @ 0205 – 0240

FLUIDS — SUMMARY
CRYSTALLOID — 2000cc
COLLOID — Albumin 50 50cc
BLOOD — PRBC ||| units

LINE site		
CVC	☐ Warmed	PRBC — 0 NS — 500 — 1000
CVC	☐ Warmed	LR — 500 — 500/1000
CVC	☐ Warmed	PRBC 2 — 00 — PRBC 2
	☐ Warmed	

LOSSES
EST BLOOD LOSS: 300 — 100/500 — 500
URINE — 400 — 100 / 500

PHYS STATUS: 1 2 3 4 5 E (3 and E circled)
BODY WEIGHT: 40 KG (KG circled)
HEMATOCRIT: —
INITIAL DATA:
BP — 101 / 70
HR — 125
EQUIP CHECK
OK? — Y (circled) N
PATIENT RECHECK for PROCEDURE? 1240
TIME — Yes

TIME → 0030 0040 X 30 X 0200 X 30 X 0300

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

Grid scale: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20
Grid annotations: HCT 33% PRBC A PRBC; ⊗; PRBC #2; PRBC #1; #3 [redacted]

VT — ml									
f — breaths/min	14	14	16	16	14	14	12	14	22
Peak inf pres / PEEP									
MODE — S(pon), A(ssist), C(on)	S	C	C	C	C	C	C	A	S
ET CO2 (torr)	32	30	30	34		32			
FIO2 (Frac or %)	.60	.34	.32	.37	.38	.39	.37 .45	.53	.51
SpO2 (%)	100	100	100	100	100	100	100 .48	100	.63 100
ECG	ST	ST	ST	ST	ST	ST	ST	ST	ST
TEMP-site		37	37.1						
N-M Block (T/4)									

Monitors: BP/Auto Cuff, BP / oth, ART line, Steth — PC/ES, Gas analyzer, Warming blkt, Conv warmer

REMARKS — Code drugs with numbers, events with letters
(A) Pt Assessed, CVC per Montgomery (C)
Femoral Katin Stein Team
(B) To OR — O2 per F Monitors on
(C) RSI pt tolerated well w/o trauma OG Tube Placed
(D) Gentle leg Swallow SXN's, Remove OG Tube Extubate
(E) To PACU — Gentle Ready c Good Air Exchange Report to fluent

RECOVERY AT 0253
PACU (circled) ICU ____ (Specify)
OTHER
CONDITION: STABLE
RESP — 22 SpO2 — 100%
BP — 100/66 HR — 148

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0030	0040	0300
	Ready	Begin	End
PROC	0050	0058	0245

Chart with letters & symbols. Explain under REMARKS
EVENTS A B C — D E
Position → Arm < 90° Pelvis Up P.P.P.

PROCEDURES and CPT Codes: Ex Fix, Femur, Right, Tibia, R, LT

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA 6.0 oral cuffed ETT 17cm @ Teeth RSI

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments Oral, DL x 1
Grade I view, Intubated. Cuff ↑ 3cc air EBBS ETCO2 (+) CP Released

PATIENT IDENTIFICATION — Typed or written entries: Name, Grade/Rate, Medical facility
Iraqi Boy
14 yr old
b/w-7

SURGEON [redacted]
[redacted] CRNA

PROCEDURE LOCATION 782 FST Fallujah Iraq
DATE 12 Nov 03
PAGE 1 OF 1

MEDICAL RECORD — ANESTHESIA
MEDCOM - 23985 P 376 REVISED 1 Jan 99
PATIENT RECORD

ACLU-RDI 1685 p.116

DOD-037563

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	8Fr	☐ ~~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	

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
	☐
	☐
	☐

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
arr	1	Brant	N	Femoral	LVP		
			Y N				
			Y N				
			Y N				

MEDICATIONS

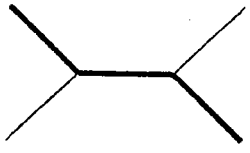
MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Fentanyl	0750	50mg	IV						

BLOOD PRODUCTS

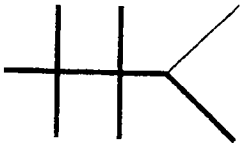
START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INT

LAB RESULTS

CBC:



Chem:



INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys				
Surgeon				
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 _____

Via: ☐ Stretcher ☐ Wheelchair

MEDCOM - 23986

VITAL SIGNS

Rectal Temp: 988

GCS:

TIME	BP	HR	RHY	RR	SAO_2	FIO_2	MODE	E	V	M	T
0700	115/82	120	~~ST~~	24	100			4	5	6	15
0710	119/83	114	[illegible]	26	100%						
0740	123/93	123	ST	24	100%						
0750	121/81	124	ST	22	99%						
	/										
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GLASGOW COMA SCALE

EYE OPENING	VREBLE 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

b(6)-4

[redacted]

MEDCOM - 23987

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:_____ ETA:_____ UNIT:_____

MED COM: [Y] [N]

ARRIVAL STATUS

TIME 700 ☐ IV x 1 ☐ O_2 _____ l/min ☐ C-Spine Immob

Meds: ☐ UKN ☐ None ☐ Yes:_____

Allergies: ☐ UKN ☒ None ☐ Yes:_____

Tetanus: ☐ UKN ☐ Current Last Meal/Fluid Intake _____ hrs

LMP: N/A ☐ _____

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

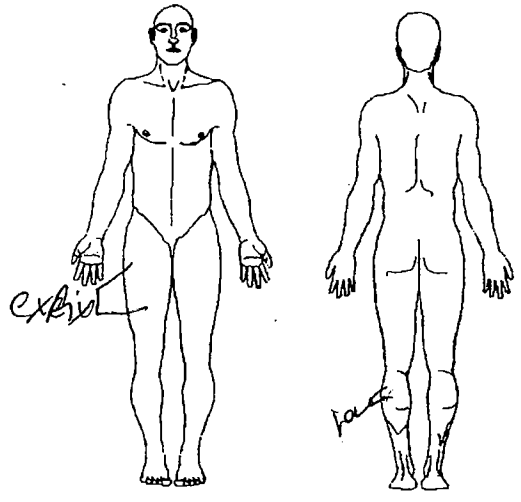
☐ Stable ☐ Unstable ☐ _____

Blood at meatus/vagina: [Y] [N]

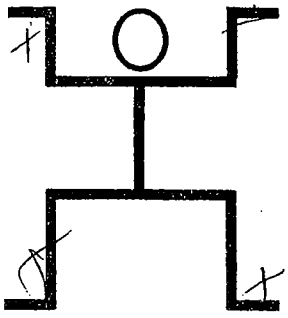
Heme + / - Prostate: ☐ WNL ☐ Abnl

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 b(6)-2

PHYSICIAN [redacted] b(6)-2

(Continue on reverse)

PRF [redacted]

DEPARTMENT/SERVICE/CLINIC Cust

DATE 12 NOV 00

PA [redacted] *entries give: Name--last, first, middle; grade;*

[redacted]

b(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

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: 12 NOV 03

TIME IN: 0255

PROCEDURE: Ex fix of (R) Femur / (R) tibia

PRE-OP VS: 101/70 BP 125 HR

TYPE ANESTHESIA: (GEN) SAB EPIDURI NERVE BLOCK IV SED.

OR INTAKE: Crystalloid: 2000 Colloid 3 units 50cc a/s

OR OUTPUT: Urine Output 500cc EBL 500cc

INTAKE						OUTPUT			
TIME	SOLUTION	Amt Hung	SITE	BY	Amt. Infused	TIME	SOURCE	COLOR	AMT
ADM	LR	500	(L) Fem.	ESC					
	LR	500	(L) Fem.	ESC					

X-RAYS DONE:

LABS DRAWN:

TIME	0258	0300	0325	0329	0330	0345	0320	0330	0345	0400	0420	0500	0530
FIO2	3L	3L	3L	3L	3L	2L	3L	3L	2.5L	2L%	RA	RA	RA
O2 SAT/100	100	100	100	100	100	A20	100	100	100	100	100	100	100
TEMP	96.7		96.9	97.0				97.5	98.0		97.2		
RESP	25	24	28	26	26	25	25	22	20	16	21	21	22
LOS													

BP by Cuff V Heart Rate

240 220 200 180 160 140 120 100 80 60 40 20 0

* LOS Level of Sensation

REACT SCORE		IN	30 Min	OUT
ACTIVITY SCORE				
(R)espirations:	0 Ventilator assistst 1 Spont. resp. <10/min: airway assistst 2 Spont. resp.: no support: >10/min	2	2	2
(E)nergy	0 Does not move legs 1 Moves legs, cannot sustain head lift 2 Sustains head lift, moves legs	0	0	2
(A)lertness	0 Awakens only with vigorous stimulation 1 Awake only when stimulated gently 2 Awake, seldom dozes	0	0	
(C)irculation Adults	0 BP 20% pre-anesthesia level 1 BP 20-50% pre-anesthesia level 2 BP 50% pre-anesthesia level	2	2	2
Infants	0 Carotid only feasible pulse palpable 1 Axillary pulse felt fleet but not wrist 2 Pulse can be felt easily at wrist			
(T)emperature	0 Axillary temp. <95 F 1 Temp. 95-96 F 2 Temp. >96 F	2	2	2

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: WARD 2-D

DATE

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

14 yrs old ~40kg

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

DA FORM 1 MAY 78 4700 MEDCOM - 23989 IEDDAC FBg OP 173 (Revised)

MEDCOM - 23990

INITIAL ASSESSMENT:

LEVEL OF CONSCIOUSNESS:
- Alert
- Responsive
- Unresponsive

AIRWAY:
- Nasal
- Oral
- Endotracheal
- Tracheostomy

OXYGEN
- Hudson Mask 40%
- Oxygen Mist
- Nasal Cannula
- Room Air

DRAINS
- Hemovac
- Jackson-Pratt
- N/G
- Foley

SIGNATURE: [redacted]

MEDICATIONS

ALLERGIES:

Time	Medication/AMT	Route/Site	BY
0325	MS04 / 2mg	IV	[redacted]
0342	MS04 / 2mg	IV	
0340	Gentamicin 80mg	IV	
			b(6)-2

DRESSINGS

	SITE	TYPE	DRAINAGE
	(R) Thigh	Ace wrap	minimal
	(R) Calf	Kerlex	minimal

CBI INFORMATION

TIME	CBI IN	URINE OUT	COLOR	URINE BAL

PACU FLUID TOTALS

CRYSTALLOID IN		URINE OUTPUT	
COLLOID IN		EMESIS	
P.O		NG TUBE	
		JP DRAIN/HEMOVAC	
TOTAL INTAKE		TOTAL OUTPUT	

DISCHARGE CRITERIA Time: Date:

REACT Score:
VS: BP R HR T
Cleared according to
WARD 2-D SOP C-2
Charge Nurse Signature:

_____

NURSES NOTES:

0300 Pt received from OR status post Ex fix (R) femur and (R) tibia. Pt. on 3L simple mask sating @ 100%. Pt is in sinus tach. Clear bilat. breath sounds. Pt. has central Triple lumen catheter in (L) femoral vein. Flushed by CPT [redacted]
0440
0427 H/H 28/9 Transfuse x1 PRBC 2773955

800 units Pen
500mg Ancef
4mg Morph

Medcom 23990

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

2. MT- .on IZ

Admissioı. ..ıd Coding Information

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

3. Register Number Name (Last, First, MI) [redacted] b(6)-4

4. Pay Grade FGN

5. Sex M

6. DoB (YYYYMMDD) 1990-01-01

7. Age at Admission 13Y

8. Race X

9. Ethnicity 9

Religion

10. Length of Service ETS

11. FMP 99

12. Social Security Number [redacted] b(6)-4

Organization (Active Duty Only)

13. Marital Status

Hour of Admission 06:35

Branch / Corps:

14. Flying Status NO

15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES

16. Zip Code of Residence:

17. Unit Location

18. MOS

19. Trauma DIS

Prev. Admission NO

20. Source of Admission Direct from ER

Ward: ICW1

Name / Relationship of Emergency Addressee

Address of Emergency Addressee

Telephone Number of Emergency Addressee

Name and Location of Medical Treatment Facility: [redacted] b(2)-2

21. Type of Disposition TRF-OTH

22. MTF Transferred To

23. Date of Disposition (YYYYMMDD) 2003-12-20

24. Clinic Svc - Admitting AEA - ORTHOPEDICS

25. MTF Transferred From

26. Date this Admission (YYYYMMDD) 2003-11-12

27. Location of Occurrence

28. MTF of Initial Admission

29. Date of Initial Admission 2003-11-12

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: OPEN R FEMUR/TIBULA FX

Procedure Narrative(s):

Cause of Injury Narrative:

Dx: 82110
82390
9910
8951
9100
8716
E8191

Px 7965 (x9)
7966
7835
7936 (x8)
8022
8302

[redacted] Officer (Signature, as required) [redacted] b(6)-? —

Signature of Admitting Clerk [redacted]

Automated Facsimile - DA FORM 2985, MAR 2000 MEDCOM - 23991

ACLU-RDI 1685 p.122

DOD-037569

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: 13 HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): nkda 3. PREVIOUS SURGERY [ ] NO [X] YES (type): Ex Fix Placement

4. PROPOSED SURGICAL PROCEDURE:
I+D of Wounds

5. ADDITIONAL INFORMATION: Last PO: MN Medical Hx: see chart Implants: Ex Fix Medications: see chart
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	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture. Language barrier - Iraqi nate.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

9. PATIENT'S IDENTIFICATION (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)
#1 [redacted] b(6)-4
[redacted] b(2)2
13 Nov 03

DA FORM 5179, JUN 91 Previous editions are obsolete. USAPA V1.01

MEDCOM - 23992

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

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

[redacted] CPT HN b(6)-2 13 NOV 03 DATE

11. POSTOPERATIVE EVALUATION:

Bovie Site: clear
Drsg: cldli
~~Anesthesia~~ emergence
Breathing: SSOB

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. ~~PRE~~POST OPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] CPT HN	[redacted] CPT HN
DATE: 13 NOV 03 TIME: 0845 b(6)-2	DATE: 13 NOV 03 TIME: 1130 b(6)-2

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDCOM - 23993

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia
2. PATIENT IDENTIFICATION RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-1
3. DATE 13 Nov 03 TIME PATIENT ARRIVED IN SUITE /
4. PATIENT IN ROOM TIME 0924 NUMBER 5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Ø

6. NURSING PERSONNEL

ASSIGNED SCRUB	PJC [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

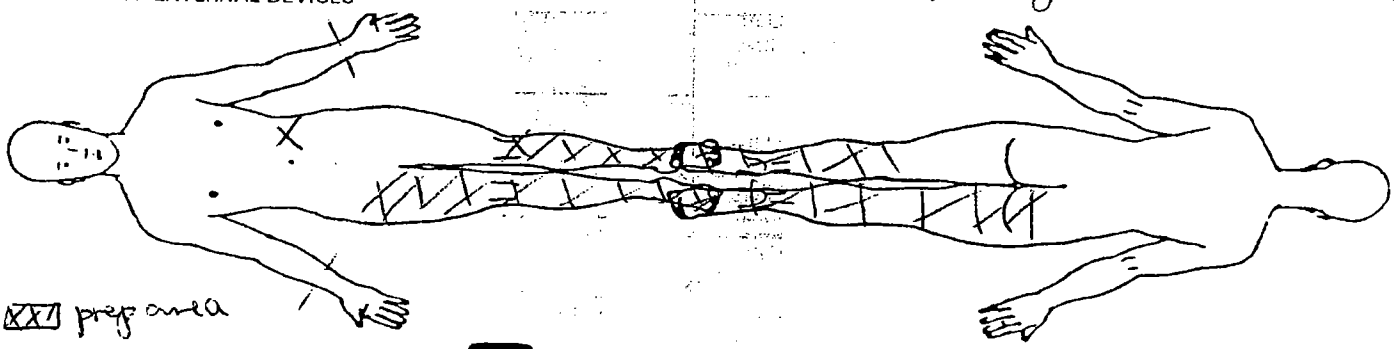
COMMENTS: correct body alignment maintained; arms on padded armboards at less than 90°, position approved by surgeon + anesthesia

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine / Betadine Paint
SITE (R) Leg BY WHOM: [redacted]
SITE (L) Lower Leg BY WHOM:
COMMENTS: no pitting or skin d's noted b(6)-2

9. LOCATION OF EXTERNAL DEVICES



XXX prepared

LEGEND X Ground Pad [redacted] -- Safety Strap [redacted] = = = Tourniquet

10. COUNTS

C = Correct I = Incorrect Initial [redacted]

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	/	/	C	[redacted] b(6)-2	[redacted]
Needle Sharp	☒ Yes	☐ No	/	/	C		
Instrument	☐ Yes	☒ No	/	/			
Other	☐ Yes	☒ No	/	/			

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

[redacted] b(6)-4
13 NOV 03 b(2)-2

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

30130

☒ ESU NO: Valleylab Force 40 RBB105305
GROUND PAD: BRAND VL Rem Polyhesive II
LOT NO: 70337 2005-05

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

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 23994

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS

	TIME	CARRIED OUT BY
none		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Ioban (R Lower Leg) Fluffs Kerlix ABD Acewrap

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

TYPE/SIZE	1.	2.	3.
	1. FIC *		
SITE	1. Bladder	2.	3.

19. ADDITIONAL INFORMATION

Surgeon: [redacted]
Anesthesia: [redacted]

* FIC already in place upon arrival to OR
- DA5179 initiated

b(6) - C All

20. OPERATION(S) PERFORMED

I+D of wounds (L Lower leg; R Tib/Fib Fx, R Femur Fx + Buttocks wound)

21. PATIENT TRANSFERRED TO	TIME	METHOD
ICU3 (PACU)	see DA7389	litter

22. REGISTERED NURSE SIGNATURE [redacted] COTTAN

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.0

MEDCOM - 23995

MEDICAL RECORD — **INTRAOPERAT[illegible] DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERA[illegible] ROOM
VIA PACU bed BY Anesthesia

2. PATIENT IDEN[illegible] RECORD REVIEWED AND PROCEDURE
VERIFIED BY CRT [redacted] b(6)-2

3. DATE 15 NOV 03 TIME PATIENT ARRIVED IN SUITE /

4. PATIENT IN ROOM TIME 1126 NUMBER 5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	RN [redacted] b(6)-2	RELIEF SCRUB	b(6)-2
ASSIGNED CIRCULATOR	CRT [redacted]	RELIEF CIRCULATOR INT	CRT [redacted] (1210-1240)

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

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

8. SKIN PREPARATION

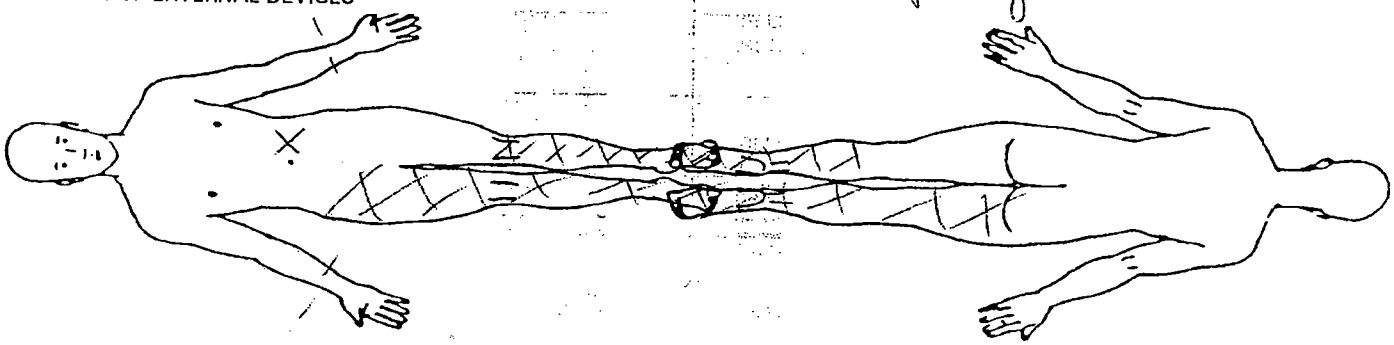
HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine Surgical Scrub Betadine Paint
SITE: (R) Leg, thigh BY WHOM: [redacted]
SITE: (L) lower leg BY WHOM: b(6)-2

COMMENTS: no pooling or skin d's noted

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS — C = Correct I = Incorrect

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

b(6)-2

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

[redacted] b(6)-4
[redacted] b(2)-2
15 NOV 03

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

30130
☒ ESU NO: Valleylab Force 40 RBE 105365
GROUND PAD: BRAND 3M
LOT NO: 9165
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 23996

IF YES NAME: ID NUMBER; MA TURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S): 0.9% Nacl (QS)

OTHER ORDERS: none

	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES ☒ NO ☐ C-arm IF YES, SITE (R) Leg

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	NAME

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. FIC *	2.	3.
SITE	1. Bladder	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Flyps
ABD
Kerlix
Ace wrap

19. ADDITIONAL INFORMATION
Surgeon: [redacted]
Anesthesia: [redacted] b(a)-2
- DA5179 on chart, * DA's noted
- * not placed in OR

20. OPERATION(S) PERFORMED
I+D wounds (R) leg; I+D wound (L) leg

21. PATIENT TRANSFERRED TO ICU3 (PACU) TIME SEE DA7389 METHOD PACU bed

22. REGISTERED NURSE SIGNATURE [redacted] CERTIFIED

REVERSE OF DA FORM 5179-1, OCT 87

Blue - 2

USAPA V1.00

MEDCOM - 23997

MEDICAL RECORD

INTRAOPER. VE DOCUMENT

For use of this form, see AR 40-407, the pro agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OF ROOM VIA Gurney BY Anesthesia

2. PATIENT IDENT. RECORD REVIEWED AND PROCEDURE VERIFIED BY CPT [redacted] b(6)-2

3. DATE 17NOV03 TIME PATIENT ARRIVED IN SUITE 1100

4. PATIENT IN ROOM TIME 1100 NUMBER 1-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKA

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 910 b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] 66E	RELIEF CIRCULATOR INT	MAJ Durst 66E (1230-End)

7. POSITION AND POSITIONAL AIDS (Specify) Pt on Padded OR bed, head on foam doughnut. Arms extended out to sides <90° in CAP secured to padded Armboards & safety straps. BLE prepped into sterile field.

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

COMMENTS: Correct Body Alignment Maintained.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

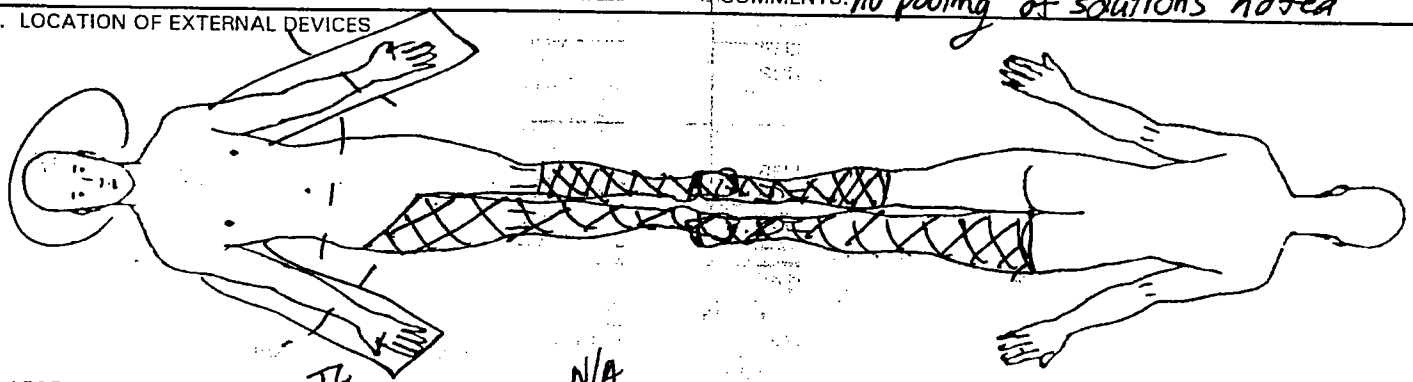
PREP SOLUTION (Specify) Beta-Beta b(6)-2

SITE: RLE & LLE BY WHOM: CPT [redacted]

SITE: (as below) BY WHOM:

COMMENTS: no pooling of solutions noted

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad TG Safety Strap =N/A= Tourniquet

C = Correct I = Incorrect b(6)-2

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

SCRUB	CIRCULATOR
PFC [redacted]	CPT [redacted]

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

[redacted] b(6)-4

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

☐ ESU NO: _____

GROUND PAD: BRAND _____

LOT NO: _____

☐ ESU NO: _____

GROUND PAD: BRAND _____

LOT NO: _____

☐ BIPOLAR NO: _____

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 23998

13. PROSTHESIS, IMPLANTS ☐ YES NO IF YES NAME: ID NUMBER; MA TURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Kerlex Fluffs, Kerlex Roll, ABD pads, ACE wrap x2

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

19. ADDITIONAL INFORMATION
WC-IV
Surgeon: Dr [redacted]
Anesthesia: Gen/LMA; CPT [redacted] CRNA
~~Both~~
b(6)-2

20. OPERATION(S) PERFORMED
I&D Bilateral Lower Extremities

21. PATIENT TRANSFERRED TO PACU | TIME 1250 | METHOD gurney

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

MEDICAL RECORD

INTRAOPER. VE DOCUMENT

For use of this form, see AR 40-407, the pro agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OF ROOM
VIA Pacu med BY Anesthesia

2. PATIENT IDENT. RECORD REVIEWED AND PROCEDURE
VERIFIED BY CPT [redacted] b(6)-2

3. DATE 19 Nov 03 TIME PATIENT ARRIVED IN SUITE 0845

4. PATIENT IN ROOM TIME 0845 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Ø

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MA [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Both arms on padded armboards at angle < 90°

8. SKIN PREPARATION

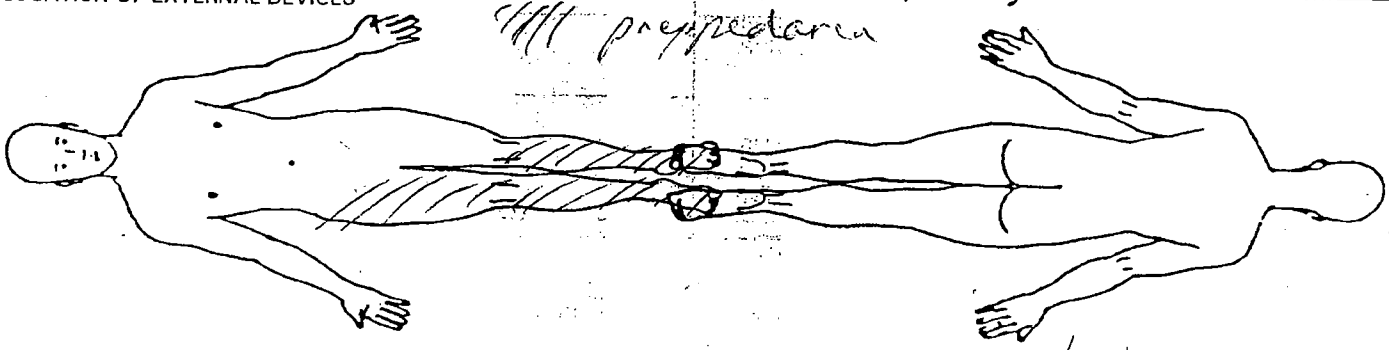
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Betadine scrub solution
SITE: Left leg BY WHOM:
SITE: Rt leg BY WHOM:

COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet b(6)-2

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count
Sponge	☑ Yes	☐ No		C	C
Needle Sharp	☑ Yes	☐ No		C	C
Instrument	☐ Yes	☐ No			
Other	☐ Yes	☑ No			

SCRUB [redacted] CIRCULATOR [redacted]

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

[redacted] b(6)-4

[redacted] b(6)-2

19 Nov 03

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 FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 24000

13. PROSTHESIS, IMPLANTS ☐ YES NO IF YES NAME: ID NUMBER; MAI RER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION *(Specify)* Fluffs Kerlix x 3 ACE wrap ~~ACE wrap~~ E/J

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION

Surgeon: [redacted]
Anesthesia: [redacted] b(6)-2

-DA5179 on chart, eAs noted

20. OPERATION(S) PERFORMED

I+D, wounds on Lt Lower Leg and Rt thigh, hip and Lower Leg

21. PATIENT TRANSFERRED TO	TIME See DA 7389	METHOD
ICU3 (PACU) b(6)-2		PACU bed

22. R[redacted] MAJ AN

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.00

MEDCOM - 24001

b(6)-2

MEDICAL RECORD — INTRAOPERA[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERA[illegible] ROOM
VIA Litter BY CPT [redacted]

2. PATIENT IDENTI[illegible] RECORD REVIEWED AND PROCEDURE
VERIFIED BY MAJ [redacted]

3. DATE 21 Nov 03 TIME PATIENT ARRIVED IN SUITE 1050

4. PATIENT IN ROOM TIME 1050 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Both arms on padded armboards at angle <90°.

8. SKIN PREPARATION

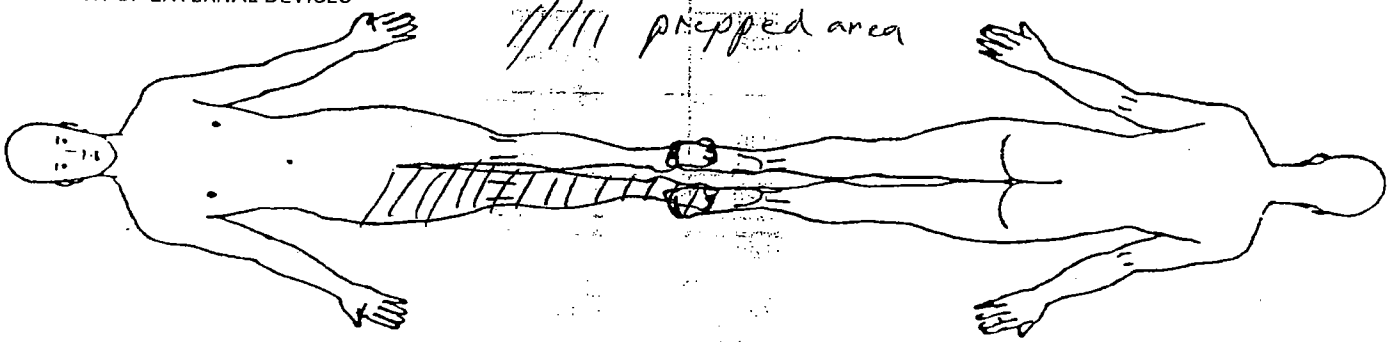
HAIR REMOVAL ☐ YES ☑ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

PREP SOLUTION (Specify) Betadine scrub & solution
SITE: Rt Leg toes to hip BY WHOM: MAJ [redacted] b(6)-2
SITE: BY WHOM:

COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes	☐ No		C	C		
Needle Sharp	☑ Yes	☐ No		C	C		
Instrument	☐ Yes	☑ No				SPC [redacted]	MAJ [redacted]
Other	☐ Yes	☐ No					

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

[redacted] b(6)-4

b(6)-2

21 Nov 03 [redacted]

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 FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 24002

13. PROSTHESIS, IMPLANTS ☐ YE .NO IF YES NAME: ID NUMBER; MA: TURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☑	NAME c) Swabs x2 of Rt thigh	NAME wound
FROZEN SECTION (FS) YES ☐ NO ☑	NAME	NAME
CULTURE (C) YES ☑ NO ☑	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 1st Penrose	2.	3.
SITE	1. Right Thigh	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs, Kerlix, ABD } to Rt hip

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted]

Anes: CPT [redacted] b(6)-2

Kerlix, Fluffs } Bil LL.

20. OPERATION(S) PERFORMED

I&D of wounds Rt Leg

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU b(6)-2	1205 See SF517	OR Litter ☐ Siderails up

22. REGISTERED NURSE SIGNATURE [redacted] MAJ AN 21 Nov 03

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.00

MEDCOM - 24003

MEDICAL RECORD

For use of this form, see AR 40-407, the propo... office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERAT... VIA Litter BY MAJ [redacted]
2. PATIENT IDENTIF... VERIFIED BY MAJ [redacted] CORD REVIEWED AND PROCEDURE
3. DATE 23 NOV 03 TIME PATIENT ARRIVED IN SUITE 1042
4. PATIENT IN ROOM TIME 1042 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

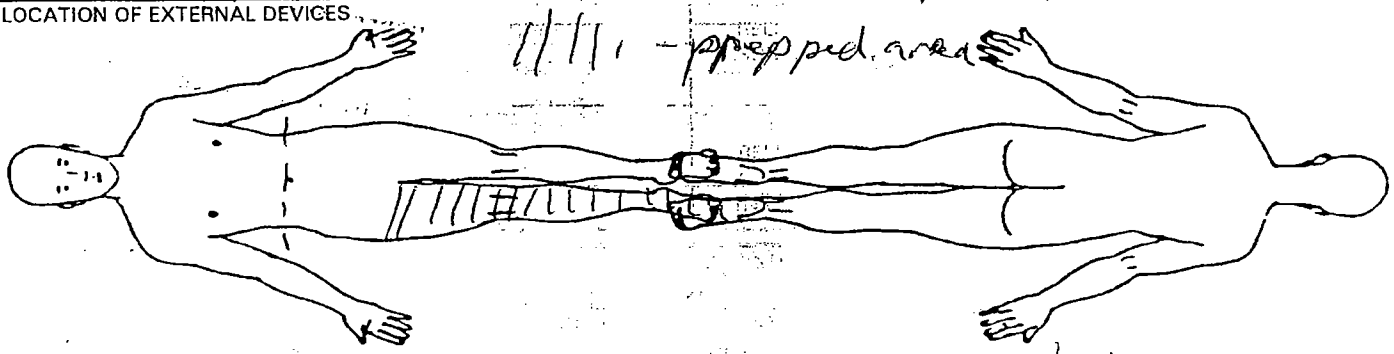
COMMENTS: ~~Both~~ pt's Rt arm on padded armboard at angle < 90°. Lt arm at side

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine Scrub & Solution
SITE: Rt Leg BY WHOM: MAJ [redacted]
SITE: BY WHOM: b(6)-2
COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

C = Correct I = Incorrect

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

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

[redacted]

b(6)-4

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

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

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 24004

13. PROSTHESIS, IMPLANTS — YES — NO — IF YES NAME: ID NUMBER — CTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☑ NO ☐

TYPE/SIZE	1. 3/8" Penrose	2.	3.
SITE	1. Rt hip	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*: Fluffs, Kerlix

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted] b(6)-2
Anes: MAJ

20. OPERATION(S) PERFORMED

I&D Rt leg, Dressing change Rt Lower Leg, Central Line placement

21. PATIENT TRANSFERRED TO	TIME	METHOD
PACU	See SF517	OR Litter

22. [redacted] MAJ AN 23 Nov 03

b(6)-2

REVERSE OF DA [illegible]

USAPA V1.00

MEDCOM - 24005

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

b(6)-2

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY [redacted]

2. PATIENT IDENTIFIED AND PROCEDURE VERIFIED BY MAJ [redacted]

3. DATE 25 Nov 03 TIME PATIENT ARRIVED IN SUITE 0827

4. PATIENT IN ROOM TIME 0827 NUMBER 2-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Pt's arms on padded armboards at angle < 90°

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☑ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

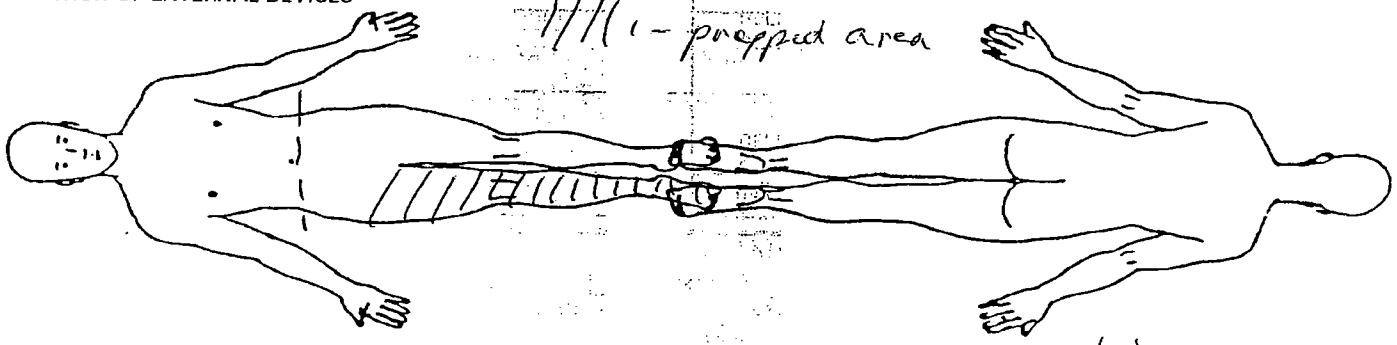
PREP SOLUTION (Specify) Betadine scrub & solution

SITE: Rt leg BY WHOM: MAJ [redacted]

SITE: BY WHOM: b(6)-2

COMMENTS: No pooling of solution

9. LOCATION OF EXTERNAL DEVICES



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

b(6)-2

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count
Sponge	☑ Yes	☐ No		C	C
Needle Sharp	☑ Yes	☐ No		C	C
Instrument	☐ Yes	☑ No			
Other	☐ Yes	☑ No			

SCRUB [redacted] SGT

CIRCULATOR [redacted] MAJ

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

[redacted] b(6)-4

b(2)-2

25 Nov 03 [redacted]

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 FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 24006

13. PROSTHESIS, IMPLANTS ☐ YES NO IF YES NAME: ID NUMBER; MA. TURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

Fluffs to Rt hip
Kerlix Rt Lower leg
Ace Lt & Rt Lower leg

17. TUBES, DRAINS/PACKING YES ☐ NO ☑

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

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted]

Anes: CPT [redacted]

b(w)-2-#11

20. OPERATION(S) PERFORMED

I&D wounds Rt Leg; Dressing change Left lower leg

21. PATIENT TRANSFERRED TO PACU TIME See SF519 METHOD OR Litter & siderail up

22. REGISTERED NURSE SIGNATURE [redacted] MAJAN 25 Nov 03

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.00

MEDCOM - 24007

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY Anesthesia

2. PATIENT IDENTITY, RECORD REVIEWED AND PROCEDURE VERIFIED BY 1LT [redacted] b(6)-2

3. DATE 28 NOV 03 — TIME PATIENT ARRIVED IN SUITE /

4. PATIENT IN ROOM TIME 1235 — NUMBER 2-3 #5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO, NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

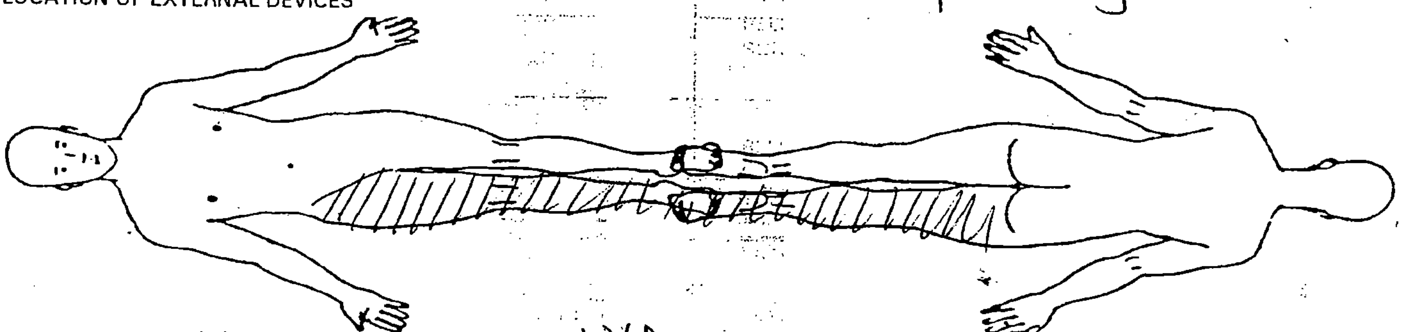
HAIR REMOVAL [ ] YES [X] NO
DONE BY: [ ] OR [ ] NURSING UNIT
METHOD: [ ] DEPILATORY [ ] RAZOR [ ] CLIP

COMMENTS:

PREP SOLUTION *(Specify)* Betadine/Betadine
SITE: (R) leg — BY WHOM: 1LT
SITE: — BY WHOM: 1LT [redacted] b(6)-2

COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad KM -- Safety Strap KM === Tourniquet N/A ▨ - prep b(6)-2

10. COUNTS

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes	[ ] No	/	/	C	SGT [redacted]	1LT [redacted]
Needle Sharp	[X] Yes	[ ] No					
Instrument	[ ] Yes	[X] No					
Other	[ ] Yes	[X] No					

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

b(6)-4

#[redacted]

[redacted] b(2)-2

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

[X] ESU NO: VL Force 40 cut 30 coag 30
GROUND PAD: BRAND VL REM PolyHesive II
LOT NO: 69441 EXP 2005-03

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

[ ] BIPOLAR NO:

DA FORM 5179-1, OCT 87 — REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. — USAPA V1.00

MEDCOM - 24008

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted]
Anesthesia: LTC [redacted]

to (6) - 2 A71

DA5179 in Chart

20. OPERATION(S) PERFORMED
I&D @ Rfemur

21. PATIENT TRANSFERRED TO PACU TIME See DA7389 METHOD Litter 2 O2

22. REGISTERED NURSE SIGN [redacted] RN

REVERSE OF DA FORM 5179-1, OCT 96

USAPA V1.00

MEDCOM - 24009

MEDICAL RECORD — INTRAOPERATIVE DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA LITTER BY ANESTHESIA

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

3. DATE 2 DEC 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0855 NUMBER 2 - 1

5. PREOPERATIVE EMOTIONAL STATUS

☒ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER (Specify) (2)

COMMENTS:
NKDA, NPO

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) Pt. prone on padded OR table. Pillows under legs. arms flexed on armboards

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

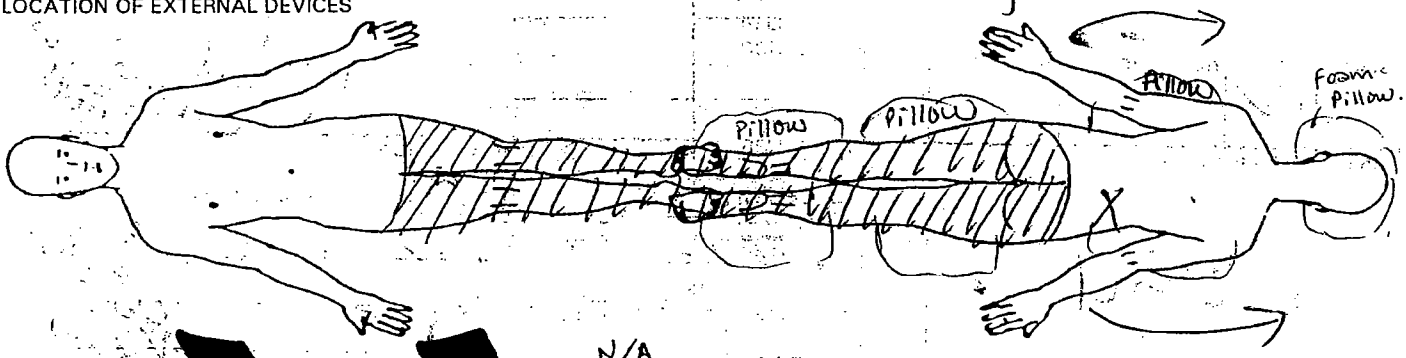
COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION km b(6)-2

HAIR REMOVAL ☒ YES ☒ NO Dr [redacted]
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP (1) Medial thigh
COMMENTS: NO nicks or cuts noted

PREP SOLUTION (Specify) Betadine/Betadine [redacted]
SITE: BLE BY WHOM: 1LT [redacted]
SITE: BY WHOM: K MAJ [redacted]
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND K Ground Pad -- Safety Strap N/A = = = Tourniquet ▨ - prep

INITIAL: PFC Geselchen / 1LT Malachi

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No			C	PFC [redacted]	1LT [redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

b(6)-2

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

[redacted] b(6)-4

b(2)-2 [redacted]

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

☒ ESU NO: VL FORCE 40 CUT 30 COAG 30
GROUND PAD: BRAND VL REM POLYHESIVE II
LOT NO: 69441 EXP: 2005-03

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

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 24010

13. PROSTHESIS, IMPLANTS [YES] NO IF YES NAME: ID NUMBER; CTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES [X] NO [ ]

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Tetracaine Opth. Soln. 0.5% LOT 58598I EXP 7-09	1 gtt	Intra-op	Topical	MFR: [redacted]	MAJ [redacted]
Mydriacyl 1% Opth. Soln. LOT 92276F EXP: 2007-08	2 gtts	Intra-op	Topical	MFR: [redacted]	MAJ [redacted]
Phenylephrine HCl 2.5% Opth. LOT: 365151 EXP 7-04	2 gtts	Intra-op	Topical	MFR: [redacted]	MAJ [redacted]
Mineral Oil LOT 092PW10A EXP Sep 04	Q.S.	Intra-op	Topical	MFR: [redacted]	Dr. [redacted]
Bacitracin Oint LOT EXP Jan-06	Q.S	Intra-op	Topical	MFR: [redacted]	Dr. [redacted]

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S):
0.9 % NaCl - Q.S.

b(6)-2

OTHER ORDERS	TIME	CARRIED OUT BY
[redacted] b(6)-2		

PHYSICIAN'S SI[redacted]

15. X-RAY IN O[redacted] IF YES, SITE
YES [ ] NO [X]

16. LABORATORY SPECIMENS

SPECIMEN (S) YES [ ] NO [X]	NAME	NAME
FROZEN SECTION (FS) YES [ ] NO [X]	NAME	NAME
CULTURE (C) YES [ ] NO [ ]	NAME	NAME
NAME	NAME	NAME
NAME	NAME	18. DRESSING/IMMOBILIZATION (Specify)

LLE: Xeroform, fluffs, kerlix, webril, splint, ACE
RLE: fluffs, kerlix

17. TUBES, DRAINS/PACKING YES [ ] NO [ ]

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

19. ADDITIONAL INFORMATION

Surgeon: Dr [redacted] Dr [redacted] Dr [redacted]
Anesthesia: MAJ [redacted]

b(6)-2 +11

DA5179 In Chart

20. OPERATION(S) PERFORMED
10 Fr. Dobbhoff feeding tube placed
STSG

21. PATIENT TRANSFERRED TO PACU TIME See DA 7389 METHOD Litter

22. REGISTERED NURSE SIGNATUR[redacted] 17 AU

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.00

MEDCOM - 24011

MEDICAL RECORD — INTRAOPERATIVE [illegible]CUMENT

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

1. PATIENT TRANSPORTED TO OPERAT[illegible]ROOM VIA Litter BY Anesthesia

2. PATIENT IDENTIF. [illegible]ORI[illegible] EVIEWED AND PROCEDURE VERIFIED BY ILT [redacted] b(6)-2

3. DATE 6 Dec 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0835 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA. NPO

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	ILT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

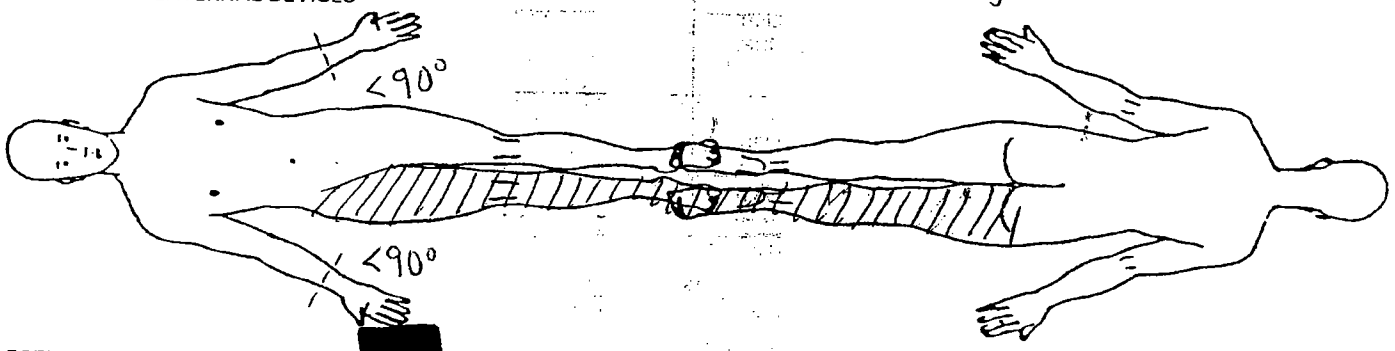
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine/Betadine
SITE: (R) leg BY WHOM: ILT [redacted]
SITE: BY WHOM: b(6)-2
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet [illegible] - prep

Initial: PFC Jones, ILT Marasci

C = Correct I = Incorrect

10. COUNTS

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

SCRUB PFC [redacted] CIRCULATOR ILT [redacted] b(6)-2

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

[redacted] b(6)-4

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

[ ] ESU NO: VL Force 40 CUT: Ø COAG: Ø
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 71516 EXP 2005-Q20
[ ] ESU NO:
GROUND PAD: BRAND
LOT NO:
[ ] BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 24012

13. PROSTHESIS, IMPLANTS YES [ ] NO IF YES NAME: ID NUMBER: MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES [X] NO [ ] KM

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Bacitracin Oint LOT: K038 Exp: Nov-05	Q.S.	Intra-op	Topical	MFR: [redacted]	Dr. [redacted] b(6)-2

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S):
0.9% NaCl - Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES [ ] NO [X] IF YES, SITE

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)*

LLE: Xeroform, fluffs, kerlix, Splint, ACE
RLE: ~~Xero~~ KM fluffs, Kerlix

17. TUBES, DRAINS/PACKING YES [ ] NO [X]

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

19. ADDITIONAL INFORMATION

Surgeon: Dr. [redacted]
Anesthesia: 1LT Woodard, MAJ [redacted]
GETA
WC: IV

b(6)-2 A11

DA5179 In Chart

20. OPERATION(S) PERFORMED
- Drsg & LLE
- I&D RLE

21. PATIENT TRANSFERRED TO PACU TIME See DA 7389 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] RN

REVERSE OF DA FORM 5179-1, OCT 8[illegible] MEDCOM - 24013 USAPA V1.00

MEDICAL RECORD

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

1. PATIENT TRANSPORTED TO OPERAT[illegible] ROOM VIA Litter BY Anesthesia

2. PATIENT IDENTIF[illegible] VERIFIED BY ILT [redacted] EVIEWED AND PROCEDURE b(6)-2

3. DATE 6 Dec 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0835 NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKMA, NPO

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted] 91D b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	ILT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

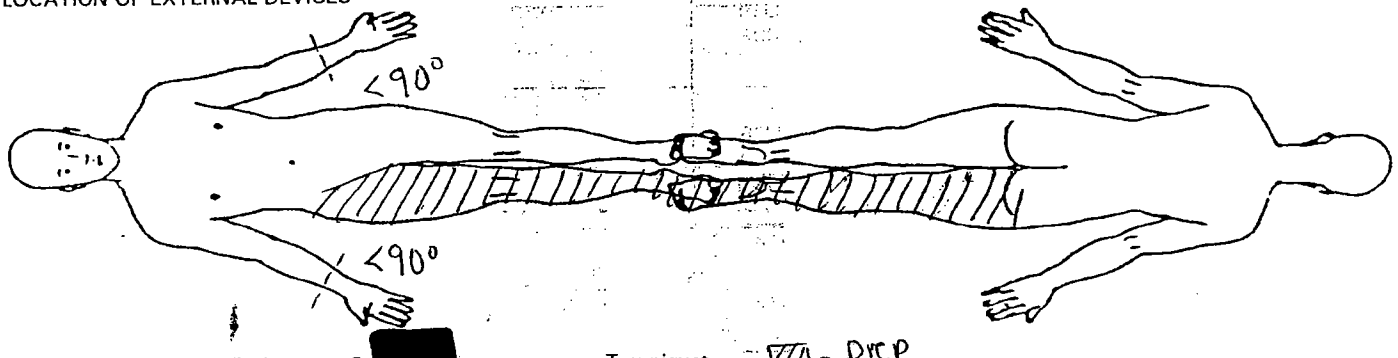
COMMENTS: Normal anatomic body alignment maintained

8. SKIN PREPARATION

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

PREP SOLUTION (Specify) Betadine/Betadine
SITE: (R) leg BY WHOM: ILT [redacted] b(6)-2
SITE: BY WHOM:
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad -- Safety Strap = = = Tourniquet N/A - prep

Initial: PFC Jones, 1LT Marasci b(6)-2

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes	[ ] No			C	PFC [redacted]	ILT [redacted]
Needle Sharp	[X] Yes	[ ] No					
Instrument	[ ] Yes	[X] No					
Other	[ ] Yes	[X] No					

C = Correct I = Incorrect

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

[redacted] b(6)-4

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

[ ] ESU NO: VL Force 40 CUT: Ø COAG: Ø
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 71516 Exp 2005-020
[ ] ESU NO:
GROUND PAD: BRAND
LOT NO:
[ ] BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 24014

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

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES [X] NO [ ] (CM)

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
Bacitracin Oint LOT: K038 EXP: NOV-05	Q.S.	Intra-op	Topical	MFR: [redacted]	Dr. [redacted]

WOUND IRRIGATION [X] YES [ ] NO, TYPE(S):
0.9% NaCl - Q.S.

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM YES [ ] NO [X] IF YES, SITE

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)* LLE: Xeroform, fluffs, kerix, Splint, ACE

17. TUBES, DRAINS/PACKING YES [ ] NO [X]

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

RLE: [redacted] fluffs, Kerlix

19. ADDITIONAL INFORMATION

Surgeon: Dr. [redacted]
Anesthesia: ILT [redacted], MAJ [redacted]

GETA
WC: IV

b(6)-2 A71

DA5179 In Chart

20. OPERATION(S) PERFORMED
- Drsg Δ LLE
- I&D RLE

21. PATIENT TRANSFERRED TO PACU TIME See DA 7389 METHOD Litter

22. REGISTERED NURSE SIGNATURE [redacted] RN

REVERSE OF DA FORM 5179-1, OCT 87

USAPA V1.00

MEDCOM - 24015

MEDICAL RECORD	INTRAOPERA[illegible]CUMENT For use of this form, see AR 40-407, the proponent [illegible]ncy is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA Litter BY Anesthesia

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

3. DATE 10 Dec 03 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME 0810 NUMBER 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

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

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt. laterat on padded OR table. position supported by bean bag. pillow between legs and arms.

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

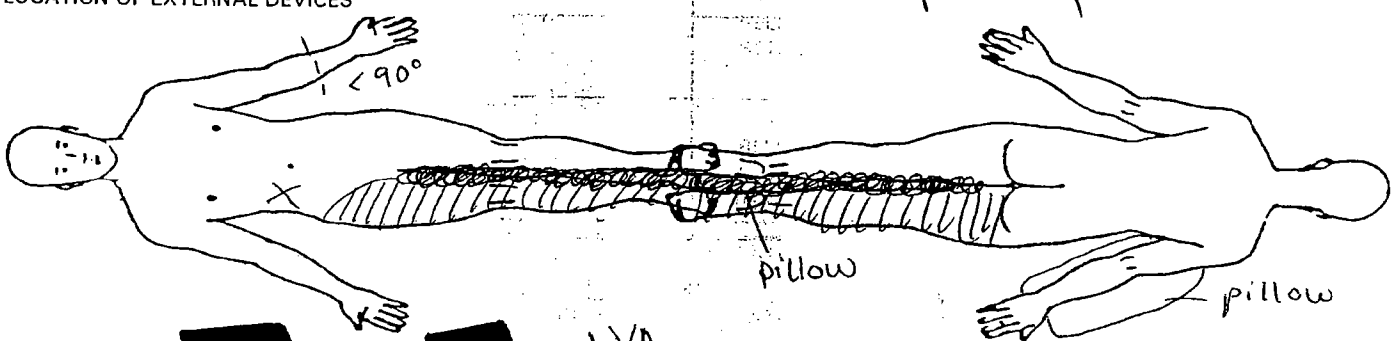
COMMENTS:

8. SKIN PREPARATION

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

PREP SOLUTION *(Specify)* Betadine / Betadine
SITE: Right leg BY WHOM:
SITE: BY WHOM: 1LT [redacted] b(6)-2
COMMENTS: No pooling

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad [redacted] -- Safety Strap = = = Tourniquet N/A — prep

Initial: SPC [redacted] ILT b(6)-2

10. COUNTS

C = Correct I = Incorrect

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No				SPC [redacted]	1LT [redacted]
Needle Sharp	☒ Yes ☐ No					
Instrument	☐ Yes ☒ No					
Other	☐ Yes ☒ No					

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

[redacted] b(6)-4

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

☒ ESU NO: VL Force 40
GROUND PAD: BRAND VL REM PolyHesive II
LOT NO:
☐ ESU NO:
GROUND PAD: BRAND
LOT NO:
☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 24016

13. PROSTHESIS, IMPLANTS ☐ YE ☒ NO IF YES NAME: ID NUMBER; MAN .CTURER

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE [redacted] b(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	

① Wound ® thigh (C)
② Wound ® thigh (Gram Stain)

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs
Kerlix

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	#10 J-P drain		
SITE	® thigh wound		

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted]
Anesthesia: ILT [redacted] b(6)-2
DA 5179 In Chart

20. OPERATION(S) PERFORMED
I&D RLE wounds
Dressing Δ LLE

21. PATIENT TRANSFERRED TO PACU TIME See DA 7389 METHOD Litter

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

REVERSE OF DA FORM 5179-1, OCT 87 MEDCOM - 24017 USAPA V1.00

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOV DAY 12 13 14 15 16 16 17

19 2003 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° 37.2°

98.6° 37.0°

120 98° 36.7°

110 97° 36.1°

100 96° 35.6°

90 95° 35.0°

80

70

60

50

40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

121/76 131/81 116/60 104/61 111/68 108/60 104/52 95/57 97/63

103/54 112

116

101.6 101.4 102.9 101.8 100.0 T

99.3 99.2 101.3 100.9

HEIGHT: WEIGHT → 0252 100(kg)

99% 99% 98% 98% 100 99% 100% 97% 98% 98% 100 98%

RA RA RA RA RA RA RA RA RA RA RA

Pulse 133 46 Pulse 127 119 100 98% 117/79

pulse 108 RA

98% RA

100% 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)

REGISTER NO.

WARD NO.

[redacted] b(6)-4

MEDICAL

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 24018

...CAL RECORD	VITAL SIGNS RECORD
HOSPITAL DAY	
DAY	NOV
DAY	18, 19, 20, 21, 21, 22, 22, 23, 24
HOUR	0630, 1900, 0746, 1900, 9?, 2000, 0800, 1200, 1900, 0800, 1900, 0930, 1900

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 18, 18, 18, 19/85, 17, 16, 18, 16, 18, 19

Record special data only when so ordered

BLOOD PRESSURE												
118/76	112/72	104/79	114/62	105	106/70	123/71	122/84	101/60	101/57	100/62	99/61	108/69
99		97.5		97.1		H 121	H 115		114		99	104/63
98.6		108	101.4	98.2		T 98.2	T 98.8	101.5	T 97.9	99.6	97.6	101.7
98%	99%	100%		99		100%	99%		100			100.4
	RA		98% RA			RA	RA	99% RA	RA	99% RA	99% RA	99% RA
												100% RA

HEIGHT: | WEIGHT →

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

REGISTER NO.

WARD NO.

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

[redacted]

b(6)-4

MEDCOM - 24019

ACLU-RDI 1685 p.150

DOD-037597

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOV | DAY: 25 | 26 | 27 | 28 | 29 | 30 | 01 DEC

19 | 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)

RESPIRATION RECORD

BLOOD PRESSURE

102/64	125/70	113/74	114/80	122/81	108/69	115/78	104/68	119/78	115/77
99.4	97.1					98.6			
103	104.1	99.6	99.1	118/78	114/74	112			
HEIGHT: WEIGHT →									
LA	100%	99%	99% RA	99% RA	100% (RA)	99% (CA)	99% RA	100% (CA)	100% RA
						99% RA			
	110/72			100% RA					
	98%								

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

[redacted]

blood - 4

MEDCOM - 24020

NSN 7540-00-634-4124

.DICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DEC DAY 02 3 DEC 4 DEC 5 1

2003 HOUR 12 0 4 8 12 16 20 24

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE 138/88 118/69 115/79 99.6

HEIGHT: WEIGHT → 116

O2 Sat 99% RA 99% RA 99% 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)*

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 - 24021

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Dec 03 | DAY 5 6 7 8 9 10 11

HOUR

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. 1W2

[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 - 24022

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DEC DAY 12 14 15 16 17

19 63 HOUR 1200 2000 1200 2000 1200

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 →

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. ICU2

STANDARD FORM 511 (REV. 7–95) BACK

[redacted]

b(6)-4

MEDCOM - 24023

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR Dec/03 DAY 18 19 20

19 HOUR

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICU2

[redacted]

ICU-4

VITAL SIGNS RECORDS

Medical Record

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

MEDCOM - 24024

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

[redacted]IC JB

TIME	AMOUNT	TYPE	ACCUM TOTAL
	8cc	BRIGHT RED	8cc
18-06	8cc	serosang fluid	16cc
		24 =	16cc

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

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

JP drain [redacted] 11 Dec

TIME	AMOUNT	TYPE	ACCUM TOTAL
1415	10cc	clear, bloody, bright red drainage	10cc
0500	15cc	red bloody/ clots	25cc
	24 hr total		
		25cc	

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)*

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

-003 06-06

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

~~NASOGASTRIC~~ JP

TIME	AMOUNT	TYPE	ACCUM TOTAL
0600 -1400	7cc	RED ET THIN	7cc
1400-2200	10cc	Red	17cc
2200-0600	0cc	———	17cc

24 hour total 17cc 12-13 Dec

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)*

C [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

13D 3 06-06 24

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
2037	620	620			

~~NASOGASTRIC~~ JP

TIME	AMOUNT	TYPE	ACCUM TOTAL
06-18	5cc	THIN RED	5cc

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)*

C, V [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

b(6)-2

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

LAST, FIRST: [redacted] b(6)-4 | DATE: 12NW | TIME: 67W | SSN: [redacted] b(6)-4

(Hematology) CBC

WBC	15.7 H	x10^3/mL
RBC	3.71 L	x10^6/mL
Hgb	10.8 L	g/dL
Hct	33.8 L	%
MCV	91.0	fL
MCH	29.1	pg
MCHC	32.0 L	g/dL
Plt	252.	x10^3/mL
LY%	21.2 *	%
LY#	3.3 *	x10^3/uL

ID: [redacted]
NB
12-11-03
07:07

	Patient Limits
	4.5 10.5
	4.00 6.00
	11.0 18.0
	35.0 60.0
	80.0 99.9
	27.0 31.0
	33.0 37.0
	150. 450.
	20.5 51.1
	1.2 3.4

Urinalysis

TEST	RESULT	REF. RANGE
Color	Straw	N/A
App	Clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.005	N/A
Bld	Trace	Negative
pH	5.0	N/A
Prot	neg	Negative
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

PICCOLO

12/11/03 07:17 AM
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
BASIC METABOLIC
DISC LOT #: 3325AA4
OPER #: 777 DR #: 000
SERIAL #: 0000100684

GLU	128*	73-118	MG/DL
BUN	11	7-22	MG/DL
CA++	7.6*	8.0-10.3	MG/DL
CRE	0.8	0.6-1.2	MG/DL
NA+	139	128-145	MMOL
K+	4.8*	3.3-4.7	MMOL
CL-	110*	98-108	MMOL
tCO2	22	18-33	MMOL

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

WBC - 1-4
CBC - 0-2

Spun Hematocrit		37-47% (F)	CSF		Blood Bank
Sed Rate			Cell Count		MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED
Other			Directigen	Negative	

[redacted] b(6)-4
ICW 1

HEMATOLOGY
URGENCY: ROUTINE [X] TODAY [ ] PRE-OP [ ] STAT [ ]
PATIENT STATUS: BED [X] AMB [ ] OUTPATIENT [ ] NP [ ] DOM [ ]
SPECIMEN SOURCE: VEIN [X] CAP [ ] OTHER (Specify)

SPECIMEN/LAB RPT. NO. 005
BLOOD
SS MATCH

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE
REQU[redacted] S SIGNATURE | REPORTED BY | MD | DATE 15NOV03 | TECH | LAB. ID. NO.

[redacted] b(6)-2

TEST(S) | SPECIMEN TAKEN: DATE 15NOV03 TIME 0555 A.M. P.M.

SED. RATE | PLATELET COUNT | RETICULOCYTE COUNT | CLOTTING TIME | BLEEDING TIME | PTT CONTROL | PTT PATIENT | PT CONTROL | PT PATIENT | % ACTIVITY | PT RATIO | SICKLING TEST | LE PREP

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

MEDCOM - 24029

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

LAST, FIRST, MI.	DATE: 13 Nov	TIME: 0500	SSN/PSEUDO SSN: # [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
W		
R		
H		
P		
L		
Pl		
L		
S		
B		
L		
Atyp		Imm
RBC Morph		

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b(6)-2	DATE: 13Nov03	LAB ID NO.:

IBN-SINA HOSPITAL
28th Combat Support Hospital
Baghdad, Iraq

1290
1289

Microbiology Request Form

Last Name: #[redacted] b(6)-4
First Name:
Patient # or SSN:
Collected by: Dr [redacted] b(6)-2
Date: 21 Nov 03
Time: 1145

Ward: CR / ICU 7
Room:
Bed:
Physician: [redacted] b(6)-2
Source: Wound
Site: Rt thigh

[redacted]

Received by: [redacted] b(6)-2
Date: 21 Nov 03
Time: 1300

Specimen #: 1139

Laboratory Results

[redacted] oxytoca
b(6)-2

Reported
Date: 23 Nov 03
Time: 1000
Tech: [redacted]
Reviewer: [redacted] b(6)-2

Number of attached sheets:

Microbiology Report [redacted] b(2)-2

Name:
Patient ID: [redacted] b(6)-4
Ward/Rm: W1/

Specimen: W139
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1 Klebsiella oxytoca Status: Final

1 K. oxytoca

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	16/8	I			
Amp/Sulbactam (c)	>16/8	R			
Ampicillin	>16	R			
Aztreonam	<=8	S			
Cefazolin	>16	R			
Cefepime	<=8	S			
Cefotaxime (c)	32	I			
Cefotetan	<=16	S			
Cefoxitin	16	I			
Ceftazidime (a)	<=8	S			
Ceftriaxone (c)	32	I			
Cefuroxime (b)	>16	R			
Cephalothin	>16	R			
Chloramphenicol	>16	R			
Ciprofloxacin	<=1	S			
ESBL-a Scrn	>4				
ESBL-b Scrn	>1				
Gatifloxacin	<=2	S			
Gentamicin	>8	R			
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	>8	R			
Trimeth/Sulfa	>2/38	R			

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

NR = Not Reported
-- = Not Tested
TPC = Trimethoprim-pancreatin strain

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

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
ESBL? = 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 I:8=S, 8-16=I, >16=R. Footnote (c) applies to this drug
(c) For streptococci refer to penicillin interpretations. For amoxicillin/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 break-points 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
Ward/Rm: W1/

Specimen: W139
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected: b(6)-2
Req. Phys: [redacted]
Tech: FD

Printed 11/23/2003 9:48:35 AM

MEDCOM - 24032

[redacted] b(2)-2

Microbiology Request Form

Last Name #[redacted] b(6)-4 Ward: OR / ICU 7

First Name: Room:

Patient # or SSN: Bed:

Physician: [redacted] b(6)-2

Collected by: [redacted]

Date: 21 Nov 03 Source: Wound

Time: 1145 Site: Rt thigh

[redacted]

Received by: [redacted] b(6)-2 Specimen #: W139

Date: 21 Nov 03

Time: 1200

Laboratory Results

Klebsiella oxytoca

Reported

Date: 23 Nov 03

Time: 1000

Tech: ZD

Reviewer: [redacted] b(6)-2 Number of attached sheets:

Microbiology Report [redacted] b(2)-2

Name:
Patient ID: [redacted] b(6)-4
Ward/Rm: W1/

Specimen: **W139**
Source: Wound/Sterile site
Ward of Iso:

Status: **Final**
Collected:
Attd. Phys:

1 Klebsiella oxytoca Status: Final

1 **K. oxytoca**

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	16/8	I			
Amp/Sulbactam (c)	>16/8	R			
Ampicillin	>16	R			
Aztreonam	<=8	S			
Cefazolin	>16	R			
Cefepime	<=8	S			
Cefotaxime (c)	32	I			
Cefotetan	<=16	S			
Cefoxitin	16	I			
Ceftazidime (a)	<=8	S			
Ceftriaxone (c)	32	I			
Cefuroxime (b)	>16	R			
Cephalothin	>16	R			
Chloramphenicol	>16	R			
Ciprofloxacin	<=1	S			
ESBL-a Scrn	>4				
ESBL-b Scrn	>1				
Gatifloxacin	<=2	S			
Gentamicin	>8	R			
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	>8	R			
Trimeth/Sulfa	>2/38	R			

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
Ward/Rm: W1/

Specimen: **W139**
Source: Wound/Sterile site
Ward of Iso:

Status: **Final**
Collected: b(6)-2
Req. Phys: [redacted]

Tech: ED

[redacted] b(2)-2

Microbiology Request Form

#2 Gram Stain

Last Name #[redacted] b(6)-1
First Name:
Patient # or SSN: #[redacted]
Collected by: Dr. [redacted] b(6)-2
Date: 10 Dec 03
Time: 0900

Ward: ICU 2 (OR)
Room:
Bed:
Physician: DR. OLIVERIO
Source: Wound
Site: (R) Thigh

[redacted]

Received by: [redacted] b(6)-2
Date: 10 Dec 03
Time: 1000

Specimen #: 4174

Laboratory Results

GPC / Gram positive cocci

Reported
Date:
Time:
Tech:
Reviewer:

Number of attached sheets:

MEDCOM - 24035

DOD-037613

ACLU-RDI 1685 p.166

[redacted] b(2)-2

(#1) - Culture

Microbiology Request Form

Last Name #[redacted] Ward: ICU-2 (OR)

First Name: b(6)-4 Room:

Patient # or SSN: [redacted] Bed:

Physician: Dr. OLIVERIO

Collected by: Dr. [redacted]

Date: 10 Dec 03 Source: Wound

Time: 0900 Site: (R) Thigh

[redacted]

Received b [redacted] b(6)-2 Specimen #: W174

Date: 10 Dec 03

Time: 1000

Laboratory Results

1) Klebsiella pneumoniae
2) Staphylococcus haemolyticus
3) Staphylococcus auricularis

Reported

Date: 13 Dec 03

Time: 1117

Tech: rgv

Reviewer: [redacted] b(6)-2

Number of attached sheets:

MEDCOM - 24036

DOD-037614

ACLU-RDI 1685 p.167

Microbiology Report

[redacted] b(2)-2

Name:	[redacted]	Specimen:	W174	Status:	Final
Patient ID:		Source:	Wound/Sterile site	Collected:	
Ward/Rm:	W1/	Ward of Iso		Attd. Phys:	

1 K. pneumoniae

Drug	MIC	Interps
Tobramycin	>8	R
Trimeth/Sulfa	>2/38	R

2 S. haemolyticus

Drug	MIC	Interps

3 S. auricularis

Drug	MIC	Interps
Amox/K Clav (c)	<=4/2	R
Amp/Sulbactam (c)	<=8/4	R
Ampicillin	2	BLAC
Azithromycin	>4	R
Cefazolin	<=8	R
Cefepime	<=8	R
Cefotaxime (c)	<=8	R
Ceftriaxone (c)	<=8	R
Cephalothin	<=8	R
Chloramphenicol	16	I
Ciprofloxacin	>2	R
Clindamycin	>2	R
Erythromycin	4	I
Gatifloxacin	<=2	S
Gentamicin	>8	R
Imipenem (c)	<=4	R
Levofloxacin	4	I
Linezolid	<=2	S
Moxifloxacin	<=2	S
Nitrofurantoin	>64	
Norfloxacin	>8	
Ofloxacin	4	I
Oxacillin	>2	R
Penicillin	>8	BLAC
Rifampin	>2	R
Synercid	<=1	S
Tetracycline	>8	R
Trimeth/Sulfa	>2/38	R
Vancomycin	<=2	S

Drug	MIC	Interps

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 [illegible] patients with granulocytopenia [illegible] serious infections
b. Breakpoints based on parenteral dose. For cefuroxime axetil [illegible] use [illegible] R. Footnote [illegible] applies to this drug
c. For streptococci refer to penicillin interpretations. For amox/K clav and amp/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

Microbiology Report

[redacted] b(2)-2

Name:
Patient ID: [redacted]
Ward/Rm: W1/ b(2)-2

Specimen: W174
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected:
Attd. Phys:

1	Klebsiella pneumoniae	Status:	Final
2	Staphylococcus haemolyticus	Status:	Final
3	Staphylococcus auricularis	Status:	Final

1 K. pneumoniae

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

2 S. haemolyticus

Drug	MIC	Interps
Amox/K Clav (c)	>4/2	R
Amp/Sulbactam (c)	16/8	R
Ampicillin	>8	BLAC
Azithromycin	>4	R
Cefazolin	>16	R
Cefepime	>16	R
Cefotaxime (c)	<=8	R
Ceftriaxone (c)	<=8	R
Cephalothin	16	R
Chloramphenicol	<=8	S
Ciprofloxacin	>2	R
Clindamycin	<=0.5	S
Erythromycin	>4	R
Gatifloxacin	4	I
Gentamicin	>8	R
Imipenem (c)	>8	R
Levofloxacin	>4	R
Linezolid	<=2	S
Moxifloxacin	<=2	S
Nitrofurantoin	<=32	
Norfloxacin	>8	
Ofloxacin	>4	R
Oxacillin	>2	R
Penicillin	>8	BLAC
Rifampin	<=1	S
Synercid	<=1	S
Tetracycline	>8	R
Trimeth/Sulfa	>2/38	R
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)
ESBL? = 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 vs 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. Susceptibility 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, 4=I, >=8=R

Name:
Patient ID: [redacted]
Ward/Rm: W1/ b(2)-4

Specimen: W174
Source: Wound/Sterile site
Ward of Iso:

Status: Final
Collected: b(6)-2
Req. Phys: [redacted]

Printed 12/13/2003 11:13:56 AM

Tech. [redacted]

MEDCOM - 24038

b(6)-4

Ward/Section: CW 1	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: b(6)-4 [redacted]	DATE: 14NOV	TIME: 0500
SSN/PSEUDO SSN: [redacted] b(6)-4		

(Hematology) CBC

TEST	RESULT	REF. RANGE
M		
Pl		
Ly		
Se		
Ba		
Ly		
Atyp		Imm
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

[redacted]

14-11-03
0444Z
Patient
Clinic
WBC 9.6 x10^3/uL 4.2 10.2
RBC 2.17 L x10^6/uL 4.00 6.00
HGB 6.5 L g/dL 11.0 18.0
HCT 19.5 L % 35.0 60.0
MCV 90.0 fL 90.0 99.9
MCH 29.8 pg 27.0 31.0
MCHC 33.1 g/dL 33.0 37.0
PLT 122. x10^3/uL 150. 450.
LYM 21.5 * % 20.5 51.1
LYM 2.1 * x10^3/uL 1.2 3.4

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

Coagulation Studies

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

b(6)-2

Ward/Section: ICW1	REQUEST [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI.	DATE 16 NOV 03	TIME 0530	SSN/PSEUDO SSN [redacted] b(6)-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		
RBC		
HGB		
HCT		
MCV		
MCH		
MCHC		
PLT		
LYM		
LYM		
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

[redacted]

16-11-03
05:30
PATIENT
LIMITS
WBC 10.3 x10^3/uL 4.8 10.8
RBC 2.15 L x10^6/uL 4.00 6.00
HGB 6.4 L g/dL 11.0 18.0
HCT 19.7 L % 35.0 50.0
MCV 91.5 fL 80.0 99.0
MCH 29.8 pg 27.0 31.0
MCHC 32.5 L g/dL 35.0 37.0
PLT 362. x10^3/uL 150. 450.
LYM% 23.4 * % 20.5 51.1
LYM# 2.2 * x10^3/uL 1.2 3.4

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

Coagulation Studies

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

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 16NOV03	LAB ID NO.:

b(6)-2