INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(6)-4			2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX M	5. AGE	6. RACE Iraqi	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP 99		(b)(6)-4		13. ORGANIZATION		14. WARD ICW3	
15. FLYING STATUS	16. RATING/ DSG	17. DEPT./ BEN		18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE	

21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION: Direct	22. HOURS OF ADMISSION: 2100	23. CLINIC SERVICE: ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION: Home	26. DATE OF DISPOSITION: 6 May 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION: 4 May 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1		30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED A

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

E991 Grenade

Soft tissue inj to both thighs, r arm, penis, & left groin

916.9 959.1

Dressing 93.57

959.09
69610 CPT
911.0
890.0
884.0

35. Total Days This Facility

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
					250.00

36. Total Days All Facilites

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

SIGNAT (b)(6)-2 OFFICER MC

LTC, MC

GENERAL SURGEON

(b)(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER

INPATIENT TREATMENT RECORD COVER SHEET

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

REGISTER NUMBER (b)(6)-4	2. (b)(6)-4 1. First, MI)			3. GRADE	ADMISSION REMARKS
4. SEX 5. AGE	6. RACE	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
11. PAY 99	12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD
15. FLYING STATUS	16. RATING DSG	17. DEPT. BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE Inj
21. SOURCE OF ADMISSION AUTHORITY FOR ADMISSION Direct			22. HOURS OF ADMISSION 2100	23. CLINIC SERVICE AEAA	
24. NAME RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION Home	26. DATE OF DISPOSITION 6 May 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 4 May 03	ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES OPERATIONS AND SPECIAL PROCEDURES

Soft tissue inj to both thighs, R arm, penis & left groin

35. Total Days This Facility

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

36. Total Days All Facilites

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

SIGNATURE OF ATTENDING MEDICAL OFFICER

=original signed= (b)(6)-2

DA FORM 3647, MAY 79 EDITION OF 1

MEDCOM - 4688

PROGRESS NOTES

DATE	
4 May 03 2200	VS 110/60, 20, 96%, 87, 98.9°, Pt has wounds to (R) outer thigh, Stitches in place, 4X4 to (L) lower thigh and perineal area, ∅ complaints @ this time. [redacted] 91WMC/sgt
4 May 03 2330	Pt received from Evening Shift. FS BG 267 - NPH [redacted] 3u gave SQ ABD. Pt Did eat Evening Meal. All soft tissue wounds c̄ S/S of complication. Pt c/o Pain Med
5 May 03 0030	ō Ti T#3 PO. [redacted] MAJ AN
0600	V.S. 118/72 68 16 98.1°. Pain Med effective. [redacted] MAJ AN Pt resting and slept throughout remainder of shift. [redacted] MAJ AN
5 MAY 03	VSS - Glucose 10g 3u NPH administered. BP 121/76 P-76, RR-19, SAO2 99% Pt resting on bed. At 0 & 3. Diabetic, glucose taken this Am before breakfast. 10g. Given 3u NPH after breakfast. Several ~~wounds~~ soft tissue wounds. W. Drsg to Upper (L) ~~thigh~~ leg CDI. Upper (R) ~~thigh~~ leg Drsg CDI also. No complaints of pain from Pt. Lung sounds CTA Bilat. BS active + 4 ~~quads~~ Cap refill <3 secs on all extremities. [redacted] SPC [redacted] 91WMC
5 May 03 1500	VS 110/60, 72, 98, 20, T. 98.2°, Pt resting in Bed, ∅ complaints, drsg to RLE CDI, packing in place c̄ Stitches. Will continue to monitor. [redacted] /sgt

☆U.S. GPO: 1995-397-405 STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 4689

MEDICAL RECORD	PROGRESS NOTES
DATE	
5 May 03 2350	V.S. 118/72 68 16 98.4; PT's has incisional wounds post-op several weeks old. that are ~~5~~ S/G of complications. PT resting ~~5~~ complaint. (b)(6)-2 MAT HW
6 May 03	VS - BP 120/80, HR-69, 99.0, SAO2 98% Glucose, 146. 3U NPH given (b)(6)-2 5pm (b)(6)-2 9lwm
6 May 03 1300	- Pt D'cd to home, ambulatory, pt states Understanding of instructions, Drsg changed prior to D'C, pt has meds for home use, instructions and follow-up procedures explained for drsg change. (b)(6)-2 - 4lwm6/sgt

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES

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

509-111

CLINICAL RECORD

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

Mo. ____ Yr. ____

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4	5	6
4may03	(b)(6)-2	VS - PR	07	(b)(6)-2		
			15	(b)(6)-2		
			23			
4may03	(b)(6)-2	Activity as tolerated	07	(b)(6)-2		
			15	(b)(6)-2		
			23			
4may03	(b)(6)-2	Diet - Regular	07	(b)(6)-2		
			12			
			17	(b)(6)-2		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Set of tissue wounds, 18Dm

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo MAY Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
4May03	(b)(6)-2	Cond- Stable ADMT TO FCW-3	4 May	Now	~2200	(b)(6)-2

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

USAPA V

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE (MEDICATIONS)

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

Mo.____ Yr.____

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4	5	6
4May03	(b)(6)-2	Continue current insulin	07			
		dose A/C in AM	15	(b)(6)-2		
			23	(b)(6)-2		
4May03	(b)(6)-2	NPH 34 ℄ Breakfast	07			
		/ P evening meal	18	(b)(6)	(b)(	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: Left foot tissue wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ____

PATIENT IDENTIFICATION:

(b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

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

DA FORM 1 FEB 79 4678

EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.

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

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED
4 may 03	(b)(6)-2	MSO4 2-5mg IV q	
		3-6° prn	
4 may 03	(b)(6)-2	Tylenol # 3 1-11 po	0030 Smart
		q 4-6° prn	Ti (b)(6)-2

ADMISSION AND [illegible]DING INFORMATION

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

1 REPORTING MTF	2. [illegible]OCATION (State or Country Code)
1 2 3 4 5 6	7 8
(b)(3)-1	

3 REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15	(b)(6)-4	16 17	18 M
(b)(8)-4			

6 DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACK-GROUND	RELIGION
19 20 21 22 23 24 25 26: 1 9 5 5 0 1 0 1	27 28 29: 4 8 Y 48	30: X	31: 9	

10 LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34 —		35 36: 9 9	37 38 39 40 41 42 43 44 45 (b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
	46: 2		

14 FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
47 48 49 —	50 51 52: K 9 1	53 54 55 56 57 58 59 60 61: 0 9 3 3 0 0 0 0 0

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

20 SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: 1		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME AND LOC (b)(3)-1		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21 TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
73 74: 0 5 Home	75 76 77 78 79 80	81 82 83 84 85 86: 2 0 0 3 0 5 0 6

24 CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
87 88 89 90: A E A A	91 92 93 94 95 96	97 98 99 100 101 102: 2 0 0 3 0 5 0 4

27 LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
103 104: I Z	105 106 107 108 109 110	111 112 113 114 115 116

FOR LOCAL USE DX: 88111
99812
8795
8901
8781
87271
25000
E9919

Trauma 1 Inj 445

soft tissue inj to both thighs, R arm, penis, & L groin

Px: 8622 8674 8015.194

ADMITTING OFFICER (Signature, as applied) EB9TB

=original signed=

(b)(8)-2

DA FORM 2985, MAR 89

ADMISSION A CODING INFORMATION

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

1. REPORTING MTF (1–8): (b)(3)-1
/F LOCATION (State or Country Code)

3. REGISTER NUMBER (9–15): (b)(6)-4
NAME (Last, First, Middle Initial): (b)(6)-4 (b)(6)-4
4. PAY GRADE (16–17):
5. SEX (18): M

6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26):
7. AGE AT ADMISSION (27–29):
8. RACE (30): Iraqi
9. ETHNIC BACK-GROUND (31):
RELIGION:

10. LENGTH OF SERVICE (32–34):
ETS:
11. FMP (35–36): 9 9
12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4

ORGANIZATION (Active Duty Only):
13. MARITAL STATUS (46):
HOUR OF ADMISSION: 2100
BRANCH / CORPS:

14. FLYING STATUS (47–49):
15. BENEFICIARY CATEGORY (50–52):
16. ZIP CODE OF RESIDENCE (53–61):

17. UNIT LOCATION (State or Country Code) (62–63):
18. MOS (64–70):
19. TRAUMA (71):
PREV. ADMISSION: YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): D
WARD: ICW2
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
NAME (b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:

21. TYPE OF DISPOSITION (73–74): Home
22. MTF TRANSFERRED TO (75–80):
23. DATE OF DISPOSITION (Y Y M M D D) (81–86): 0 3 0 5 0 6

24. CLINIC SVC - ADMITTING (87–90): A B A A
25. MTF TRANSFERRED FROM (91–96):
26. DATE THIS ADMISSION (Y Y M M D D) (97–102): 0 3 0 5 0 4

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (103–104):
28. MTF OF INITIAL ADMISSION (105–110):
29. DATE INITIAL ADMISSION (Y Y M M D D) (111–116):

FOR LOCAL USE

Soft tissue inj to both thighs R arm, penis, & L groin

ADMITTING OFFICER (Signature as require (b)(6)-2, MD
LTC, MC
GENERAL SURGEO
(b)(6)-2
(b)(6)-2

DA FORM 2985, MAR 89 MAY 79 IS OBSOLETE

MEDCOM - 4696

(b)(3)-1

Name: (b)(6)-4

CHCS Name: (b)(6)-4

(b)(6)-4 Iraqi civilian

Prognosis: Good

Date of Admission: 4/10/2003

Date of Transfer:

History:

48 y/o Iraqi male, multiple soft tissue wouns from a hand genade, 5 days prior to admission. Wounds to rt elbow, left groin, bilateral thihgs, and penis.

Hospital Course:

Pt developed infected hematoma rt thigh. Cultures + for acinitobacter/enterobacter. Wounds healing by secondary intention with advancement every three days. Afebrile, nl wbc, DM well controlled. Needs assistance with ambulation. AD TM perf repaired,

Diagnoses:

Soft tissue injuries to both thighs, right arm, penis and left groin; Diabetes Mellitus type 2; AD TM perf

Surgeries/Treatmen

DPC wounds after I&D 15 Apr 03, I&D Rt thigh infected hematoma/abcsess 17 Apr 03; Extraction of schrapnel from left hip joint 20 Apr 03; DPC wounds after extraction of schrapnel Rt thigh 23 Apr 03, S/P right tympanoplasty 25APR

Recommendations:

Soft tissue wound care, oral DM medication, NPH Insulin for tight control until wounds healed. F/U with Medicine, ENT, General Surgery or Ortho.

SpecialNeeds:

Completed Primaxin course. PT for gait and ROM . Wet to dry NS dressing changes. NS W to D changes BID. Change cotton ball in right ear daily and start cortisporin ear drops 3 drops BID for 10 days in right ear. no water in the ear.

Physician:

(b)(6)-2 CDR Dept of General Surgery 5/3/2003

(b)(3)-1

(b)(6)-4

CHCS Name: (b)(6)-4

(b)(6)-4 EPW

Date of Admission: 4/10/2003

Date of Transfer:

Age: Gender: M

History:

48 y/o Iraqi male, multiple soft tissue wouns from a hand genade, 5 days prior to admission.

Hospital Course:

Pt developed infected hematoma rt thigh. Cultures + for acinitobacter/enterobacter. Wounds healing by secondary intention
with advancement every three days. Afebrile, nl wbc, DM well controlled. Needs assistance with ambulation

Diagnoses:

Soft tissue injuries to both thighs, right arm, penis and left groin, Diabetes Mellitus type 2, AD TM perf

Surgeries/Treatment:

DPC wounds after I&D 15 Apr 03, DPC wounds after extraction of schrapnel Rt thigh 23 Apr 03, Extraction of schrapnel from
left hip joint 20 Apr 03

Recommendations:

Soft tissue wound care, oral DM medication, NPH and sliding scale insulin for tight control until wounds healed. Gait assistance with walker of crutches.

Special Needs:

Continue primaxin for 4 days. PT for gait assistance. ENT Tympanoplasty if perf doesn't heal. Wet to dry NS dressing changes. Small sites we use iodoform gauze.

Prognosis: Good

Physician: (b)(6)-2 CDR Dept of General Surgery

4/24/2003

CLINICAL RECORD

ABBREVIATED MEDICAL RECORD
(Sign all notes)

TRIAGE CATEGORY (Circle one)
Immediate
Delayed
Minimal
Expectant

Date: 10 Time: 1530 arrived on board USNS Comfort

Transported by: (Circle one) Helo Boat Pier Other

MA: (Circle one) LITTER AMBULATORY

AGE: 47 HEIGHT (ft' in"): Weight (lbs):

HISTORY: Pt came to (b)(3)-1 with ~~X~~ MGSW X 5 days.

ALLERGIES: NKMA
CURRENT MEDS: Pills for Diabetics
PAST ILLNESSES: Diabetic
LAST MEAL: (Date) 09MAR03 (Time) Dinner
Events Preceding injury: Hand Grenade, Rebelled to Iraqi soldiers.

VITAL SIGNS	TIME	TEMP	PULSE	B/P	RESP RATE	GCS	~~CAP REFILL (prestaba)~~
ADMISSION	1530	101.9	94	106/66	24	15	SpO2 95%
DISCHARGE							

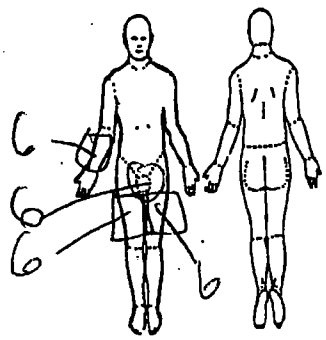
Pupils: (Circle one) = OR ≠

L reactive / sluggish / fixed (Circle one)
R reactive / sluggish / fixed (Circle one)

L ● ● ● ● ●
R ● ● ● ● ●

INJURIES
1. Airway Obstruction ☐ Yes ☐ No
2. Breath Sounds (+ ↓ -)
3. Hemorrhage
4. Laceration
5. Puncture
6. Wound
7. Trauma, Amputation
8. Concussion
9. Fracture
10. Dislocation
11. Burn
12.
13.

BURN
1° %
2° %
3° %



LAB
Hb/Hct
Lytes/BUN/Glue
ABG
UA
T&C 4 units
PT, CMP

XRAY
C-spine
CXR
Abdominal
IVP
Extremity

Glasgow Coma Score (GCS)

	Points
A. Eye Opening	
Spontaneous	4
To voice	3
To pain	4
None	1
4 (Total "A")	
B. Verbal Responses	
Oriented	5
Confused	4
Inappropriate words	3
Incomprehensible words	2
None	1
5 Total "B"	
C. Motor Responses	
Obeys command	6
Localize pain	5
Withdraw (pain)	4
Flexion (pain)	3
Extension (pain)	2
None	1
6 Total "C"	

DIAGNOSIS:

Level of Consciousness (LOC) (Circle one)
A - Alert
V - Responds to Vocal Stimuli
P - Responds to Painful Stimuli
U - Unresponsiveness

Continue on reverse side

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

(b)(6)-4

REGISTER NO.

WARD NO.

ABBREVIATED MEDICAL R
STANDARD FORM 539
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
510-110

(b)(3)-1 CASUALTY RECEIVING

MEDICAL TREATMENT RECORD *(continued)*

AIRWAY nasal / oral Incubate nasal / oral _____ mm tube @ _____ cm teeth / nares

OXYGEN Room Air Face Mask @ 12 L / min OTHER _____

TUBES CHEST TUBE: size / site _____

N/G: guaiac neg/pos _____

FOLEY: dipstick blood neg / pos _____

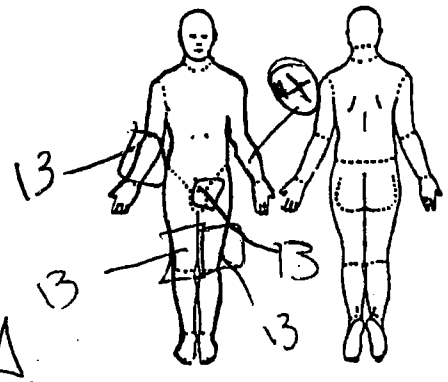
IV SITES	SIZE
(L) Forearm	18G

IV SOLUTION	AMT INFUSED
#1 NS	~~500~~ 1000cc
#2	300cc
#3	
#4	

BLOOD PRODUCTS	AMT INFUSED

TREATMENTS

1. Oxygen
2. Cricothyrotomy
3. Tracheotomy
4. IV Sites
5. Pressure Dressings
6. MAST
7. Apply Hemostat
8. Sutures
9. Tourniquet
10. Bandage
11. Splint
12. Cast
13. Dressing Δ
14.



PERITONEAL LAVAGE

Comments _____

Results: (Circle one) POSITIVE NEGATIVE

OUTPUT

Chest Tube _____ cc

Gastric _____ cc

Foley _____ cc

TOTAL INTAKE _____ cc TOTAL OUTPUT _____ cc

MEDICATIONS	Dose	Route	Time	Initials	MEDICATIONS	Dose	Route	Time	Initials
Morphine	5mg	IMP	1813	(b)(6)-2					
Mefoxin									
Ancef	1gm	IVPB	1900	(b)(6)-2					
Tet Tox									
Hypertet									

DATE	HOUR A.M.	HOUR P.M.	TRANSFERRED Time: _____ to OR ICU BURN ICU WARD: _____

☆ U. S. GPO: 1987-181-247/60056

MEDICAL RECORD | **PROGRESS NOTES**

TE

vol 02 48 y/o Iraqi male, 5 days ago
multiple ~~G S W's~~ Grenade + Frag wounds to
thighs, penis, (L) knee, Rt elbow.
Underwent Debridgement + exploration
of (L) femoral artery at the time.
Also, struck in head c̄ pistol 5 days ago, no LOC

Meds - Diabetes pills NKDA Last meal yesterday.
PMH - DM II H_2O overhour ago

P.E.
Head - small nodule, top of scalp. No other
injuries. PERRL. Neck not tender.
Chest - clear
Heart - no (m)
Abd - benign. Superficial wound (L) groin.
Ext - (R) forearm, superficial wound.
Both thighs with soft tissue wounds, clear
Back - no injury | Motor, sensory, + pulses intact.
Rectal - negative
Over

(Continue on reverse side)

REGISTER NO. | WARD NO.

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

(b)(6)-4

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

PROGRESS NOTES

DATE

A: 1) Multiple soft tissue injuries, including (R) forearm, (L) groin, both thighs.
2) Type II DM.

P: 1) Admit to ward
2) Wound care, daily wet to dry
3) IV antibiotics
4) Monitor blood sugar.

(b)(6)-2

★U.S.GPO:1990-262-081/20173

STANDARD FORM 509 BACK (Rev. 11-77)

MEDICAL RECORD | **PROGRESS NOTES**

DATE

12APR03 Medical Nutrition Tx's

1120 ~~S- Deferred~~ S: Per translator ate breakfast.

O: Dx's Multiple GSW. Wt ≈ 85kg. Meds: MVI q AM.

Labs 11APR03: Glucose 261↑

Labs 10APR03: Hgb/Hct 8.9↓/26.3↓ 133↓ | 96 | 12 / 66↑ 3.3↓ | 31 | .8

Diet Rx's ↑K+/ADA

A: Glucose ↑ - Hx of DM? Hgb/Hct ↓ - will monitor c̄ MVI tx. Na+/K+ ↓ - will monitor.

Kcal needs: 30-35 kcal/kg/day = 2550-2975 kcal/day

Protein needs: 1.5-2.0 g/kg/day = 127-170 g/day

P: Pt. would benefit from Regular diet & concentrated sweets c̄ snacks of olives (AM) + nuts (PM + HS) to ↓ glucose - will f/u q 2-3 days.

(b)(6)-2 MPH, RD

(b)(6)-2 MPH, RD

LT, MSC, USNR (b)(6)-2

12April 03

16 20 S: Doing well. Vague pain in testicles today. Mild pain, controlled c̄ meds

O: Wounds dressed, draining.

A: 1) Soft tissue wounds - slow healing process starts.

P: 1) Cont wound care. (R) fine any pelvis to both for retained foreign bodies.

A: 2) DM II. on Rx levels.

P: 2) Follow Glucose (Continue on reverse side) CAPT (b)(6)-2

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

(b)(6)-4

REGISTER NO.

WARD NO. (b)(6)-2

PROGRESS NOTES

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

PROGRESS NOTES

DATE

14 Apr 03

Sayer

Asked to see pt with wound care issues.
Multiple clean wounds. Rt thigh may require
grafting + advancement. All others may benefit from
Debridement + Delayed closure.
Will schedule for MAR.

(b)(6)-2

CDR MC

(b)(6)-2

☆ U.S.G.P.O.: 1986-491-248/20616

STANDARD FORM 509 BACK (Rev. 11-77)

PROGRESS NOTES

ICAL RECORD

OP Note:
Preop Dx: Multiple GSW Rt Elbow, Left groin x 2
Rt Thigh x 2 Left Thigh x 3.
Post op Dx SAA.
Surgeon (b)(6)-2 [redacted]
Procedure I + D Above wounds Advancement flap
closure (L) + Rt thigh.
Findings No pos or abscess. RT thigh hematoma
evacuated.
EBL minimal.
To RR stable. (b)(6)-2 [redacted]

Ax 03 POD 1 DPC.
5 new cop carts. sl dizzy c̄ quick is positive
Wind RT Ear Drum perf → seen by ENT.
Dressing drainage.
USS ofeb.
No signs of infection
Ambulate (b)(6)-2 [redacted]

ER NO. WARD NO.

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

(b)(6)-4 [redacted]

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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DATE

16 Apr 03

PROGRESS NOTES

CTSP for T102

(b)(3)-1

NO pain, cough, or discomfort.

Chest bodily utilization

BG's 224 to 270.

Wound Rt elbow ⊼ erythema

Left Groin ⊼ erythema.

Left thigh drainage around gauge ⊕ erythema.

Rt thigh drainage around gauge ⊕ erythema.

Bld cx X 2 Urine cx. Changed Dressing but left packing

Dp: SID I+D ⊼ DPE. No overt sign of infection

all wounds draining ⊼ erythema

Plans 1) Cx spikes. Cbld + urine.

2) CXR in AM

3) Continue current care

4) ICS 810

(b)(6)-2

☆ U.S.G.P.O.: 1986-491-248/20616

STANDARD FORM 509 BACK (Rev. 11-77)

PROGRESS NOTES

DICAL RECORD

Prep
3 (+) Thigh, Groin Dressing Δ - Rt Thigh
Rectus Exploration/Debridement
Prep Dx Pass muscle necrosis, ? organized hematoma
or infection Rt Thigh
Need for Dressing Δ's.
Post Dx SAA. RT thigh pass hematoma infection
Surgery (b)(6)-2
EBL minimal.
Cx's RT Thigh taken.
To RR stable.

(b)(6)-2

Apr 03 Surgery FIU.
PE had one temp spike which was cx'd (blood
mend), cxr and wound eval. All are adequately
drained. Exploration of the Rt superior thigh
demonstrated an undrained hematoma c̄ necrotic
muscle which could have been the source.
All wounds were repacked. Cx's of wounds
@ First operation were ⊕ for acinetobacter.
Glucose control is good → We'll treat c̄

(Continue on reverse side)

REGISTER NO. | WARD NO.

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

(b)(6)-4

PROGRESS NOTES
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DATE

PROGRESS NOTES

Primaxin, Contact Precautions, Acetic acid 3% dressing Δ's and, re-meal. Any temp spike ✓ bld cx's x2. ID + wound staff aware.

(b)(6)-2

CDRMC

17 Apr 03 Sugry

Dressing Δ's. BLE, RUE. Wounds are widely open. Tmax 104. Bld cx's. Charged needs this afternoon to Primaxin from Dwaf. No frank pus encountered. Wounds + Dressings draining. Ø erythema. Ø rash. Pt alert + common calcium Δ'd c̄ WTOD 3% acetic acid c̄ 10 sedatives 20mg MSO4 / 3 Versed pulse ox 100% eat throughout.

(b)(6)-2

☆ U.S.G.P.O.: 1986-491-248/20616

STANDARD FORM 509 BACK (Rev. 11-77)

MEDICAL RECORD | **PROGRESS NOTES**

DATE

18 Apr 03 Pt alert + oriented. feels well.
Tmax 104° ~ 4-6 hours p̄ operative washout.
Cx ⊕ Bilat Thigh fine washout 15 Apr.
for Acinitobacter. Bld cx's pending.
Placed in contact precautions. started Primaxin.
Dressing Δ's on ward going well.
Today Req'd 35 mg MSO4 + 3 mg Versed.
He was still alert.
All wounds look clean Opus + widely
Draining. Acetic acid 3% Dressing Δ's.
BG 207

15.3 7.8 23.5 4.15

for Acinitobacter Wound infection.
DM.
Plan 1) BID / TID Dressing Δ's.
2) Primaxin [redacted]
3) ✓ Bld cx's.
4) Tight control of DM c̄ sliding scale
+ oral agent.
5 Continue surveillance for sources of
undrained pus

(b)(6)-2

(Continue

WARD NO.

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

(b)(6)-4

PROGRESS NOTES
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DATE

PROGRESS NOTES

18APR03 Medical Nutrition Tx's Flus

1325 O: Ate lunch per RN. FBS 17APR=87; 18APR 207

ss insulin. Diet Rx's Regular

A/P: Blood glucose elevated this AM - ~~will mo~~ error (b)(6)-2

Recommend offer HS snack c̄ cheese leggs + fruit to

↓ FBS in AM. RD to flu q̄ 2-3 days.

(b)(6)-2 (b)(6)-2 MPH, RD

(b)(6)-2 LT, MSC, USNR MPH, RD (b)(6)-2

18Apr03 Surgery

A wound dressing c̄ temp spike ∅ pus

wound is beefy red s̄ exudate.

Bld x2.

on Pmoxin

(b)(6)-2 CD am

19 Apr 03 Surgery Staff

Pt alert + cooperative

VSS Tmax 102

UOP qs AM fasting Glucose 97 Rec'd 24 a Ins ...

WBC ↓.

Wounds look healthy, granulating + no erythema

Widely drained.

Pt: GSW perins + lower extremity

Plan CT Acetabulum + Rt elbow, Wound care.

(b)(6)-2

STA

★ U.S.G.P.O.: 1988-491-248/20616

MEDCOM - 4710

MEDICAL RECORD | **PROGRESS NOTES**

DATE

9 Apr 03 1930

Sugar
Ct of pelvis + Rt elbow -
: (L) hip : bullet frag near or touching femoral head
(R) Elbow fragment near or touching radial head -
Concern for intra articular fragment + poss
suppressed septic arthritis → Dr [redacted] (b)(6)-2
evaluated + booked Rt Elbow scope
+ Left hip exploration. I/C change -
dressing p̄ they complete [redacted] (b)(6)-2

CDRMC

19 Apr 03 2020

Δ Dressings
All appear healthy + healing.
To OR Tomorrow [redacted] (b)(6)-2

CDRMC

19 Apr 03

Wound Care.
Wounds clean. Reduced
Improving daily. S/P Excision of (L) Hip
intra articular bullet fragment. Continue
Present care. [redacted] (b)(6)-2

WARD NO.

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

[redacted] (b)(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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PROGRESS NOTES

DATE	
Apr 20 '03 2200	Internal Med Present regimen for DM - SS plus NPH 4 AM / 4 PM, plus glyburide 10 mg qAM. BG <200, no clear trend c̄ frequent NPO periods etc. Will ↑ glyburide to 10 BID + monitor, goal is oral +/- NPH for xfer to level 2/1 (b)(6)-2 [redacted]
21APR03 1650	Medical Nutrition Tx's Flu's O's Ate 75% of dinner. Diet Rx's Regular; ØENSURE (Glucose) Labs 21APR03: FBS 144, 1100=156, 1600=98 Hgb/Hct 8.1↓/ 23.9↓ mcv/mcH 93.5/31.9 A/P's Hgb/Hct↓ - recommend FeSO4. PO intake good. Blood glucose levels normalizing since 18APR03 - will monitor c̄ Regular diet. RD to flu q̄ 2-3 days. (b)(6)-2 [redacted] MPH, RD LT, MSC, [illegible]

☆ U.S.G.P.O.: 1986-491-248/20616

STANDARD FORM 509 BACK (Rev. 11-77)

PROGRESS NOTES

DATE 4/20/03

Brief Op Note

Pre Op Dx: Multiple GSW (B) Thigh, (R) elbow

Procedure ~~Post Op Dx~~: (L) hip arthrotomy & fragment removal

(b)(6)-2

Dressing Δ's BLE, RUE

~~Procedure~~

(b)(6)-2

Surgeons: (b)(6)-2

Complications

EBL: min

Fluids: 1100 cc

Findings - fragment anterolat to femoral head, intracapsular

Disp: PACU, stable

(b)(6)-2

(b)(6)-4

PROGRESS NOTES

DATE

Apr 03 Surgery
Pt 5 complaints. tol po
(b)(3)-1 [redacted] Dm Glucose consistently <150.
Wounds clean + granulating (L) hip surgery
site clean 5 signs of infection. cx ⊖
Rt elbow wound clean but not granulating
Bld cx ⊖.
(b)(6)-2 [redacted]
Jp: 1) Dm controlled.
2) 2° Granulating Wounds
Mult GSW

Apr 22 03 1652 Internal Med
Rec'd Glyburide 10 BID on 21st –
BG that day 144/156/98/110. The following
Am (today) not recorded. Apparently did not
receive Am NPH or glyb today – + BG
–/147/162. I have reviewed process c̄
staff hope to get better adherence and/or
records. No A in urgence. Antic d/c of
SS soon through (b)(6)-2 [redacted]

STANDARD FORM 509 BACK (Rev. 11-77)

☆ U.S.G.P.O.: 1986-491-248/20616

MEDICAL RECORD

DATE

PROGRESS NOTES

2 (Apr 05) Surgery

Tmax 10 i. DM controlled c̄ 10 mg Glyburide BID
+ 4 u NPH 2x/d. Glucose < 154.

VSS. tol dressing Δ's well 10 mg MSO4/2 Vessel.

LE + pelvic wounds granulating R elbow ODC
but little granulation.

Surgical wound: still dressed. → will Δ tomorrow

7.1 | 86 | 23.9 | 485 NL Diff. 132 | 97 | 8 | 3.7 | 32 | 0.8 | 144.

Bld cx sets x 3 No Growth

Urine cx > 10^6 E cloacae.

Wound cx E cloacae + Acinitobacter

both orgs sens Imipenem only.

Jr: Doing Well.

DM controlled medically

Multiple GSW.

POD 1 (L) Hip ultra-articular Extraction Bullet

Plan 1) Continue Cement Care.

2) PT Gait

(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)

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES

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MEDICAL RECORD | **PROGRESS NOTES**

DATE

23 Apr 03 Surgery.
Preop: DM.
Schrapnel Rt Thigh X2.
DPC
Postop Dx SAA
Finding Schrapnel. X2 RT Thigh
Clean Wounds
Surgery (b)(6)-2 / HM3 (b)(6)-2
QBL minimal
TO PACU Stable. (b)(6)-2

24 Apr 03 Surgery Staff.
Feels good. ↓ medication requirement for
dressing Δ. 10 mg IM MSO4.
Wound clean + dry ⊕ erythema minimal exudate.
Ⓔ Hip incision clean → staples should come out.
4 more days (Monday). Rt Thigh staples
should come out next wed.
Dp: Schrapnel Wounds.
DM.
Plan 1) LOO 2) DC (b)(6)-2

(Continue on revers

WARD NO.

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

(b)(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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PROGRESS NOTES

DATE	
24 Apr 03	P.T. Note
1440	Pnt seen this P.M., stood up at bedside and then ambulated 80 ft $\bar{s}$ assistive device. Pnt would occassionally utilize other Hospital Beds for support. Pnt refused crutches. Nurse staff notified. D/C from P.T. @ this time ——— [redacted] (b)(6)-2 HMC(FMF) P.T. Tech
25 APR 03	Medical Nutrition Tx's F/U:
1800	O: Per HM - PO intake good. Eating apple. ss insulin Glucose 155 ↑. Fe 44 ↓. Diet Rx's Regular; ØENSURE
	A/P: Iron stores low - recommend $FeSO_4$. Blood glucose level elevated - will monitor $\bar{c}$ ss insulin. PO intake good - will monitor. RD to f/u $\bar{q}$ 3-5 days. [redacted] (b)(6)-2 MPH, RD
	[redacted] (b)(6)-2 MPH, RD LT, MSC, USNR (b)(6)-2
26 Apr 03	P.T. Note
1445	Pnt seen by P.T. this P.M., ambulated 160 ft $\bar{s}$ assitive device, utilized other Beds for support occassionally. Will ambulate QD ——— [redacted] (b)(6)-2 HMC(FMF) P.T. Tech

☆ U.S.G.P.O.: 1986-491-248/20616

PROGRESS NOTES

DATE	
	OTO HNS
25 APR 2003	Oral Consent Obtained
0800	Drag male c̄ AD perforation s/p blast injury one month ago. no otorrhea, no vertigo.
	PE – 35% AT Pars Tensa central perforation dry.
	Plan – medial graft tympanoplasty
25 APR 2003	Brief Op Note
1130	Pre Op Dx: AD. Perforation 35% clean
	Post Op Dx: SAA
	Procedure: medial Graft Tympanoplasty AD
	Surgeon: (b)(6)-2 [redacted]
	Anesthesia: Gen ETT
	Comp.: Ø
	post Op Stable to PACU
	512 to operated Ear
	Facial Nerve Intact
	(b)(6)-2 [redacted]
26 Apr 03	Surgery
	T complaints ambulates c̄ some assistance
	USS after. OSS Insulin.
	(b)(6)-4 [redacted] lean, intact + closing.
	[illegible] Daine Wall.
	(b)(3)-1 [redacted]
	(b)(6)-4 [redacted] (b)(3)-1 [redacted] Continue current care. (b)(6)-2 [redacted]

PERSONAL DATA PRIV ACT 1974

☆ U.S.G.P.O.: 1986 491-248/20616 (11-77)

MEDICAL RECORD	PROGRESS NOTES
DATE	
27APR	P.T. Note, Pt sitting @ EOB just returning from head (ind) Pt ambulated approx 80 feet c̄ occassional reaching for balance when asked if he needed to hold on for balance, Pt was able to amb ind. D/C P.T. @ this time. Reconsult if needed — HM3 (b)(6)-2
27APR03 1515	Medical Nutrition Tx: F/U: S: Per translator: 4/26 - Ate 3 meals + apple + orange + 1 ENSURE 4/27 - ate 2 meals + 1/2 chocolate milk + 1 orange + ENSURE O: Diet Rx: Regular. & current labs. A/P: PO intake good - recommend continue to encourage PO intake. RD to f/u q 3-5 days. (b)(6)-2 MPH, RD MPH, RD LT, MSC, USNR (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)

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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MEDICAL RECORD	PROGRESS NOTES
DATE	
29Apr03	Surgery Pt E Penney. & requests to leave. VSS. afeb. Rt thigh staples + ⓒ hip staples Infection Tourism ✓ wounds + advance closure (b)(6)-2 [redacted]
30Apr03 @ 0205	24° Chart (b)(6)-2 [redacted] ENS (b)(6)-2 [redacted] ve
29APR2003	0 to HNS Pos up AD Tympanoplasty Doing less Ear - Clear + Dry Lt Hon Bull Changed. Will start drops in 2 days. (b)(6)-2 [redacted]
30Apr03	Surgery Doing well DC'd staples Advanced wound closed Rt thigh + ⓒ Medical Thigh. Continue present Continue on rev (b)(6)-2 [redacted] 4579

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

(b)(6)-4 [redacted]

NO.

Prescribed by GSA/FIRMR
FIRMR (41 CFR) 201-45.505
509-111

PROGRESS NOTES

DATE	
30APR03	Medical Nutrition Tx's F/U's
1435	S: Per translator: 4/29 – Ate 3meals 4/30 Ate 2meals.
	O: Diet Rx: Regular... Labs 4/30: glucose=77
	Labs 29APR: Glucose @ 0504=118, 1216=183↑, 1610=87.
	A/P: Blood glucose levels mostly WNL. PO intake good. Recommend continue encourage PO intake c̄ 3 meals q̄ day. RD to f/u q̄ 3-5 days.
	MPH, RD
	(b)(6)-2 MPH, RD
	LT, MSC, USNR (b)(6)-2

PROGRESS NOTES

DATE	
1 May 03	Surgery Staff.
	Pt 5 new complaints
	Wounds healing 2° intention c̄ serial closure q
	3 days. Most wounds closed.
	DM controlled c̄ NPH & oral agents
	Jp: Schepeel wounds.
	(Rev.) Good to go.
	(b)(6)-2
	CDRMC
2 May 03	Surgery Staff.
	Wounds clean & healing.
	DM good control.
	Ready to go.
	(b)(6)-2

★U.S.GPO:1990-262-081/20173

STANDARD FORM 509 BACK (Rev. 11-77)

MEDICAL RECORD	PROGRESS NOTES
DATE	
3 May 03	USS afeb. DM controlled.
	Wounds clean + healing 2°.
	Ambulatory. tol ADA Diet
	Transport
	(b)(6)-2
	CDAMC

(Continue on reverse side)

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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509-111

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/25/03		1650	assumed pt care V/S stable pt has dressing on (L) EAR CDI Pt has staples on (R) thigh NO signs or redness. ALL Dressings on (B) thighs are CDI, groin area is also Dressed CDI Pt is resting comfortably in RACK NO C/O pain will continue to monitor [redacted] (b)(6)-2 HW
4/26/03	1450		Assumed care - (R) ear bandaide in place. Dr [redacted] (b)(6)-2 completed dressing changes. medicated MSO4 10mg.
4/27/03	1430		Pt Ambulating on ward. Wound care team on ward to Δ dsg. No C/O pain. minimal drng on (L) ear dsg. [redacted] (b)(6)-2 scope
4/27/03	2020		VSS. Pt. occasionally sitting up on edge of bed. Ate well at dinner. BG - 138 at 1630. Voiding - nl. (L) thigh dressing - serosanguineous scant amt. from sutured area. Reinforced dressing & reapplied ~~ace wrap~~ stockinette. N/V checks LLE - normal. Will continue to monitor - [redacted] (b)(6)-2 CDR, NC
4/28/03	1240		Pt Ambulating on ward. No C/O Pain this Afternoon. Dsg Δ by Wound care team, medicated c̄ 4mg MSO4 c̄ good results. Will continue to ambulate & monitor. [redacted] (b)(6)-2 LCDR

Continue on reverse side

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

REGISTER NO.

WARD NO.

[redacted] (b)(6)-4

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

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28 Apr 03		1750	Assumed care 1500, pt sitting up in bed, no c/o pain, (R) ear dsg small amount serous drainage, Drsg (R) elbow CDI, (R) Thigh Drsg CDI, (L) Thigh Drsg CDI, (L) groin staples intact OTA no S/S infection, Drsg (L) lower abd CDI — (b)(6)-2 [redacted] EPS, NC
29 April 03		0600	Pt. slept well thru the night. BG -118 @ 0430. VSS. Will continue to monitor — (b)(6)-2 [redacted] CDR, NC
29 APR 03		0715	lying in bed VSS no distress noted PERRLA A&O, S1S2 RRR, lung sounds clear equal bilat BS (+)x4 tol reg diet. Wounds to (R) elbow (L) thigh and (R) thigh UTA gauze/spandage dressings c/d/i staples to (L) groin OTA c/d/i edges well approximated will continue to monitor — (b)(6)-2 [redacted] [illegible] HL to (R) FA site WNC — (b)(6)-2 [redacted] [illegible]
30 APR 03		0345	Pt. had emotional evening - crying due to concern regarding his family per translator. Ate snack well, No c/o pain. Will continue to monitor — (b)(6)-2 [redacted] CDI NC
30 APR 03		0730	VSS no distress noted A&O PERRLA S1S2 RRR lungs clear BS (+)x4 Wounds to (R) elbow + (B) thighs gauze dsg c/d/i staples to (L) groin OTA c/d/i will cont to monitor (b)(6)-2 [redacted]
30 APR 03		2100	Assumed care of pt. v.s.s @ this time. pt is in no apparent distress. pt is ~~als~~ asleep. Will continue to monitor v.s and pain management — (b)(6)-2 [redacted] [illegible]
01 MAY 03		0730	VSS & distress noted A&O PERRLA RRR S1S2 lungs clear equal bilat BS (+)x4 steri strips to (B) upper thigs c/d/i incisions to BLE c̄ sutures + W&D c/d/i. Xeroform/gauze to (R) elbow c/d/i will cont to monitor — (b)(6)-2 [redacted]

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NURSING NOTES
Standard Form 510
(Reverse)

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4 Apr 03	0840		Assumed pt care this am. Pts VS are WNL and pt shows no signs of distress. Am care was completed and pt ate 100% of meal. Pt tol food well. Pts LE are dressed and dressing is CDI. Wound care will be preformed later by nurse will cont to monitor throughout shift and control moderate pain.
	0940		Concur with above

(b)(6)-2

BNS, nc

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (9201)

NURSING NOTES
Standard Form 510
(Reverse)

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
01May03		2000	Assumed care of pt. V.S.S. @ this time. pt is sleeping and in no apparent distress. Will continue to monitor v.s and pain management. (b)(6)-2 HMJ
02MAY03		0800	VSS ø distress noted ambulating c̄ difficulty S_1S_2 RRR lung sounds clear equal bilat. BS⊕x4 incision to Ⓡ elbow Ⓡ + Ⓛ groin c̄ sutures + w→D dsg cldl: incisions to Ⓑ outer thigh c̄ steristrips cldl: will cont to monitor (b)(6)-2
02May03		2000	Assumed care of pt. v.s.s. and pt is in no apparent distress @ this time. Will continue to monitor v.s. and pain managment. (b)(6)-2
03MAY03		0730	VSS ø distress noted A+O PERRLA RRR S_1S_2 lung sounds clear equal bilat. BS⊕x4 sugars WNL incisions to Ⓑ upper thighs c̄ sutures + w→D dsg cldl: wound to Ⓡ elbow OTA incisions to Ⓑ upper outer thighs c̄ steristrips cldl: T#2 2 tabs given for lower back soreness Will cont to monitor (b)(6)-2
03 May 03		2100	Assumed care of pt. v.s.s. @ this time. pt is sleeping and in no apparent distress. Will continue to monitor vital signs and pain management (b)(6)-2 HMS

Continue on reverse side

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

REGISTER NO. | WARD NO.

JD # (b)(6)-4

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

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/10	23	20	Pt. arrived via stretcher. NAD noted. Bsg. to (R) Arm, (L) groin and bilat. femurs CDI. voiding spontaneously. VSS. Will cont. to monitor — (b)(6)-2
11APR03	Ø115		ASSUMED CARE. PT. HAD MULTIPLE GSW/SHRAPNEL TO BOTH UPPER THIGHS, (R) ELBOW, (L) PELVIS, AND PENIS: UPPER THIGH DRESSINGS TO BOTH THIGHS ~~WAS~~ PRM HAD SEROUS DRAINAGE. DRESSING CHANGE PERFORMED @ 0030. DRESSING ON (R) ELBOW C/D/I. NO DRAINAGE. DRESSING ON PELVIS C/D/I. NO DRAINAGE. PENIS DRESSING C/D/I. NO DRAINAGE. DRESSINGS ON UPPER THIGHS C/D/I. NO DRAINAGE @ THIS TIME. IV SITE ON (L) FOREARM C/D/I. NO S/SX OF INFECTION. PT. HAS NO C/O OF PAIN. PT. CURRENTLY SLEEPING. VSS. WILL CONTINUE TO MONITOR. — (b)(6)-2 HN/USN
11APR03		1410	PM care done. LR infusing @ 175. Wet to dry done to (R) Forearm and (R) thigh. PT tolerated c̄ lots of anxiety and pain after pre-medicated c̄ 5 mg MSO4 and 10 mg dering D. Ativan order obtained. (L) groin and (L) thigh dressing to be done Lower — (b)(6)-2 ENS, NC

Continue on reverse side

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

REGISTER NO. | WARD NO.

(b)(6)-4

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

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14 LVL APR 03	0200		ASSUMED PT CARE @ 2330 12 APR 03. MULTIPLE GSW/SHRAPNEL TO BOTH UPPER THIGHS, (R) ELBOW, (L) PELVIS, & PENIS; BOTH UPPER THIGH DRESSINGS C/D/I. (R) ELBOW DRESSING C/D/I. PELVIS DRESSING C/D/I. NO DRAINAGE @ THIS TIME. IV SITE (L) FA C/D/I & S/SX INFECTION. PT C/O PAIN, NOTIFIED RN, PAIN MED GIVEN. WILL CONTINUE TO MONITOR. HN (b)(6)-2
16 APR 03	0215		ASSUMED CARE OF PT @ 2330. A/O x 3. CHANGED WRAP OF LRE, DUE TO MODERATE DRAINAGE OF OLD WRAP. N/V CHECKS WNL OF BOTH LE. PT HAD COMPLAINT OF MILD LE PX. PT WAS GIVEN PX MEDS WITH NO FURTHER COMPLAINT. WILL CONTINUE TO MONITOR. (b)(6)-2 (b)(6)-2 HN
17 APR 03	2200		Assummed pt. care @ 1500. Dsg. Δ done by Dr. (b)(6)-2 in treatment room. O_2 6L NC applied and NS @ KVO started. MSO4 20mg and Versed 3mg given during procedure. Pt. had pulse ox 98-100% during procedure and no complications noted during procedure. Pt. had 104.4 temp. Tylenol 650mg given, wet clothes applied, blood cx & urine cx sent (b)(6)-2

Continue on reverse side

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

(b)(6)-4

REGISTER NO. | WARD NO.

NURSING NOTES
Standard Form 510
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
510-110

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/18/03	0435		Assumed pt care @ 2330. Dressings (B) thigh c/D/1, (L) inguinal area c/D/1, (R) upper arm c/D/1. Pt c/o of throat pain. ~~Throat~~ (b)(6)-2 Appears swollen. Enc to drink fluid & cepacol was given. Pt seem to have some relief but still c/o of pain. Will notify MD in the morning. Pt temp 100.8° @ 2400 down from 103.5° from previous shift. Temp 100.7 @ 0400 Tylenol 650 mg given. Will continue to assess & monitor patient's status. — (b)(6)-2 [redacted] Ens, NC

☆U.S. GPO: 1987-181-247/60056

NURSING NOTES
Standard Form 510
(Reverse)

MEDICAL RECORD | ~~DOCTOR'S ORDERS~~ NURS'S notes
(Sign all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
	0310		Received for MOR on stretcher.		
			Oz Sats @ 94% on RA. (R) Elbow dsg		
			(R) thigh dsg reinforced for bleeding.		
			Brith Sail CTAB.	(b)(6)-2	
	0335		Reinforce dsg (R) thigh. unwelled drag.		
			OK for TOW. Report ceiling		
			to ALL 3	(b)(6)-2	CM
19APR2003 1635			Assumed pt care at 1530. Pt awake, alert, sitting up in bed. Lungs CTAB. Productive cough, thick yellow sputum. CV-RRR. (+) BS all four quadrants. Relbow drsg - CDI. RLE, LLE drsgs - CDI. (L) groin drsg - CDI. Drsgs to be Δd this PM by Dr. Jones. NPO p̄ MN on call to OR in AM	(b)(6)-2	ENS/RC
19APR2003 2040			Drsgs Δ'd by Dr (b)(6)-2. Pt received Morphine 30mg IVP, Versed 3mg - tolerated drsg Δs well. VSS remained stable throughout.	(b)(6)-2	ENS/RC
			MSO, 2 y 10		
4/20/03	1008		Assumed care to pt - NPO at midnight to have T&D in OR today		
			Pt is aware.	(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.

156 (b)(6)-4

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111
☆ U.S.G.P.O.: 1985 - 491-248/20237

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/20/03	1000		Note continued - Bil. Extremity dressing intact - will have them changed in AOR IV was not able to be started on WOC - contacted OR to see if central could be done. Will obtain BG this morning. Held Am Glyoxide & NPH insulin due to pre op. Will continue to monitor. (b)(6)-2
4/20/03	1600		Pt returned from OR S/P shrapnel removal from (L) hip. (L) hip/inguinal incision dressed s̄ drng noted. Bilat leg wounds dressed w/ minimal drng. noted to dressings. Pt AOX3. Some c/o pain. Will medicate and monitor as needed. (b)(6)-2
4/21/03	1058		Assumed care - VS stable. Dressing to (L) hip, bilat. lower extremity - dry, intact. Have not done the shower - waiting to see if he is to have dressing changes ē Dr (b)(6)-2 IV - NS @ KVO. BG - @ 1100 156 - 2 units given. No complaints. Will continue to monitor. (b)(6)-2 CDM

Continue on reverse side

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

REGISTER NO.

WARD NO.

(b)(6)-4

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

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21APR2003 1850			Assumed pt care at 1530. Pt awake, alert. (R) elbow drsg - CDI. BLE drsgs - CDI. Drsgs to be Δd this PM by Dr. [redacted] (b)(6)-2 0% pain. [redacted] (b)(6)-2 ENS/RC
21APR2003 2245			Drsgs Δ by Dr Jones. Morphine 10mg IVP, Versed 2mg IVP [redacted] (b)(6)-2 ENS/RC
4/22/03	0922		Assumed care - NPO for OR this AM. Will clarify to see if he will be going today. Dressing to be changed c̄ Dr [redacted] (b)(6)-2 unless he goes to OR. Afebrile. [redacted] (b)(6)-2 CDN
4/22/03		1800	ASSUMED PT CARE @ 1530 PT AND X3. ALL DRSGS C/D/I TO BE CHANGED BY DR [redacted] (b)(6)-2 PT NOT C/O PAIN @ THIS TIME [redacted] (b)(6)-2
22APR2003 2230			Drsgs Δd this shift by Dr. [redacted] (b)(6)-2 Sutures placed to (L) thigh + (R) thigh wounds. Morphine 20mg IVP Versed 2mg IVP given. Pt tolerated well [redacted] (b)(6)-2
Addendum: on call to OR in AM. NPO c̄ MN. [redacted] (b)(6)-2			
4/23/03	1110		- Assumed care - NPO. Waiting for call to OR. B6 obtained - pending. Dressing intact [redacted] (b)(6)-2

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (9201)

NURSING NOTES
Standard Form 510
(Reverse)

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/23/03		1700	Assumed pt care pt returned from OR V/S Stable Dressings to (B) thighs are CDI Dressing to groin area is also CDI pt has NO C/O pain @ this time no other problems to report will continue to monitor (b)(6)-2 [redacted]
4/24/03	1200		Assumed care - VS stable. Pt (b)(6)-2 [redacted] changed all dressing. MSOY 10mg IVP given prior. Up ambulating c̄ difficulty. Plan for LOO to level II hospital @ some time. No further complaints of discomfort. Tolerating diet. Will continue to monitor. He in place for antibiotic tx. (b)(6)-2 [redacted]
4/24/03	1800		assumed pt care pt V/S Stable. NO C/O pain all dressings are CDI Pt is resting comfortably IN RACK AWAITING LOO NO other problems to note (b)(6)-2 [redacted]
25Apr 03		1244	Pt returned from OR. S/P (R) tympanoplasty. Pt has band aid on ~~over~~ right ear. Ø dmg noted. 1" incision c̄ sutures above R ear. Ointment on incision. Scant bloody dmg noted. Relbow W+D dsg c̄ ~~[illegible]~~ (b)(6)-2 [redacted] fishnet

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

REGISTER NO.

WARD NO.

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

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

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25Apr03		cont 1244	cover drsg (R) groin staples intact. Ø drng noted. W+D drsg beside staples CDI. R thigh drsg minimal drng noted. Circ/neuro WNL. LLE drsgs intact c̄ dried drng noted. Circ/neuro intact. Pt medicated c̄ T3 & MSO4 for pain. (b)(6)-2 NC

(b)(6)-4

☆ U.S GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (9201)

NURSING NOTES
Standard Form 510
(Reverse)

MEDCOM - 4735

Name: JD [redacted] (b)(6)-4

NURSING FLOW SHEET
MEDTEC/FAC 6500/12/Temp Form

Date: 10 APR 05

CUFF

AL

R

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
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140																								
120											V								V					
100																								
80											•													
60																			•					
40											^								^					
RR											20								16					
TEMP											100								100.0				99.6	
SAO2											95%								94%					
MAP																								
O2 Mode																								

DRIP/DOSE

Name: (b)(6)-4

NURSING FLOW SHEET

MEDTREFAC 6550/12/Temp Form

Date: 11APR03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
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40																								
RR			16									16					16							16
TEMP			99.4									100.3					97.8						99.6	99.1
SAO2																	97							
MAP																								
O2 Mode			RA														RA							

DRIP/DOSE

MEDCOM - 4737

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes: _____

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																		250								
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	
FOLEY																										
UOP																		800	450	420				480		
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

Name: (b)(6)-4

NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Date: 12 APR 03

CUFF

AL

R

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
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140																								
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100																								
80																								
60																								
40																								
RR			16									RL						18						
TEMP			99.7									99.9						97.2						
SAO2			98									99%						96						
MAP																								
O2 Mode																		RA						

DRIP/DOSE

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes: _____

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	T
FOLEY												475														
UOP		400	300					500						425	490		500							500		
																								550		
BM			X1																							

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 4740

Name: (b)(6)-4

NURSING [illegible]W SHEET
MEDTREEAC 6550/12/Temp Form

Date: 13APR03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
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60																								
40																								
RR		16								16								18					16	
TEMP	99.2									99.9								99.8					99.6	
SAO2																		95					96	
MAP																		122/64						
O2 Mode																								
																							120/64	

JFF

HR

DRIP/DOSE

FREQ. VITAL SIGNS

TIME	2400															
BP	112/60															
HR	68															
RR	18															
TEMP	97.2															
SAO_2	96															

Notes: _____

changed @ 1355

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB										1L																

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOT
FOLEY																										
UOP					450		800		450		425						450		475							
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

Name: (b)(6)-4

NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Date: 14 APR 03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
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140																								
120																								
100																								
80																								
60																								
40																								
RR		18					16			16									16					16
TEMP		99.1					99.1			100.8				100.1					98.1					98.8
SAO2										95									96					96
MAP																								
O2 Mode										RA														
																			118/70					120/72

DRIP/DOSE

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes:_____

INPUT/OUTPUT

I	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
O																										
PB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOT/
EY						400					500															
UOP															500		400		400			600				
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 4744

NURSING FLOW SHEET

MEDTREFAC 6550/12/Temp Form

Date: 15 APR 03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
CUFF / AL 200																								
180																								
160																								
140																								
120	✓																							
100								✓		✓									✓					
80																								
60	^							^		^									^					
40																								
RR	16							12		16									16					
TEMP	98.8							97.5		98.3									98.6					
SAO2	96							97		96									97					
MAP								Ø																
O2 Mode								Ø																
BP:	120/72							111/87																

DRIP / DOSE

MEDCOM - 4745

START 5x1 5x2 5x3 1x5 15x2 5x3 3x1 3x2 1x1

FREQ. VITAL SIGNS

TIME	2220	2225	2230	2235	2240	2245	2300	2330	2420	0120					
BP	120/70	120/68	116/68	116/68	114/64	118/66	114/66	[illegible]/68	114/66	118/70					
HR	87	73	76	73	65	72	75	74	75	70					
RR	16	16	16	16	16	16	18	16	18	16					
TEMP	99.6	99.5	99.6	99.5	98.4	98.9	98	98.5	98.4	98.7					
SAO2	98	95	95	94	93	94	95	96	96	96					
	RA	RA	RA	RA	RA	RA									

Notes:

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
O/PB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
FOLEY								340																		
UOP			330						300/500					400	300	400	300		500							
BM																										

MEDCOM - 4746

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

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

NURSING [redacted] SHEET
MEDTREFAC [redacted] Temp Form

Date: 16 APR 03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
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120																								
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80																								
60																								
40																								
RR		16								16														16
TEMP		101.1°								102.8	102.1		101	101.1		100.4	99.7	99.2						99.8
SAO2		96%								95								97						95
MAP																								
O2 Mode										RA														
																		118/64						114/64

JFF

HR

DRIP/DOSE

FREQ. VITAL SIGNS

TIME																	
BP																	
HR																	
RR																	
TEMP																	
SAO_2																	

Notes: _____

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	
FOLEY										↑								800			1000				600	
UOP	350	75								300																
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 4748

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

NURSING [redacted] SHEET
MEDTREFAC[redacted] 2/Temp Form

Date: 17APR03 [redacted]

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
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120																								
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80																								
60																								
40																								
RR					12											16		16					18	
TEMP					98.6					99.9			104.2°			103.5		100.8				100.7	100.5	99.6
SAO2					100%					91						98		98					98	
MAP					0																			
O2 Mode					10LNC					RA						RA							RA	
					121/74																			

DRIP/DOSE

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes:

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOT
FOLEY		300		700		350								1200			100			300		300				
UOP																										
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 4750

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

NURSING [redacted]W SHEET
MEDTREFAC [redacted]/Temp Form

Date: 14 APR 03 [redacted]

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR										16														
TEMP										101.7			103.4											
SAO2										94														
MAP																								
O2 Mode																								
BP										110/58														

DRIP/DOSE

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes:

INPUT/OUTPUT

N	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
O																										
VPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOT/
FOLEY																										
UOP						[illegible]			120											400	[illegible]	400		350		
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 4752

Name: (b)(6)-4

NURSING FLOW SHEET

MEDICAL FACILITY 6550/12/Temp Form

Date: 4/19/93

CUFF

AL

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR										20				20					19			18		
TEMP	99.8	99.7								100.4				102.0		101.0			99.4			98.7		
SAO2		95								95%				96%					95			95	95	
MAP																								
O2 Mode										RA				RA										
BP										118/58				120/68										

DRIP/DOSE

Vol																						500cc		

Pt. Sleepy START Transfusion [illegible]

FREQ. VITAL SIGNS

post transfusion

TIME	2050	2103	2108	2113	2128	2133	2148	2248	2348	0110					
BP	96/52	98/50	96/50	98/50	98/50	98/54		102/52	104/52	120/60					
HR	94	89	88	84	85	86	85	82	77	70					
RR	20	16	16	16	16	16	18	16	18	18					
TEMP	102.0	101.3	101.2	101.5	101.1	100.8	101.0	101.1	102°	101°					
SAO2	98%	93%	94%	93%	98%										

Notes: Pt. Sleepy from Premedication for Dsg Δ & Transfusion (b)(6)-2 [illegible]

INPUT/OUTPUT

IN	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO																										
IVPB																										

OUT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOT.
FOLEY																										
UOP	250				400							300										300				
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

Name: (b)(6)-4

NU G FLOW SHEET
MED AC 6550/12/Temp Form

Date: 20 APR 03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
CUFF 200																								
180																								
AL 160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR		16														16	20							
TEMP		99.9								100.4						102	102	101.6					100.8	
SAO2		96															92							
MAP																								
O2 Mode		RA								104/93 1st														
		118/60								140/68 2nd														
										P 92														
DRIP/DOSE UOP		200			400					450					200								300	300

Name: (b)(6)-4

NURSING FLOW SHEET

MED[illegible]AC 6550/12/Temp Form

Date: 21 APR 03

CUFF

AL

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120		✓								✓														
100																								
80																								
60		↑								↑														
40																								
RR		16								18							18							
TEMP		101.0						100.4		100.6							100.4							
SAO2		95								95%							96							
MAP																								
~~O2~~ BP ~~Mode~~		128/78				126/80		126/80		132/64							122/68							
HR										82														
							400 Ø4																	

(b)(6)-2

DRIP ~~DOSE~~

Name: (b)(6)-4

NURSING [illegible] SHEET
MEDTREFAC-65[illegible] [illegible]mp Form

Date: 22 APR 03

Time	07'	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR		16			16					14				16			14							
TEMP		99.1			99.2					99.5				99.0			98.4							
SAO2		96			95												97							
MAP																								
O2 Mode		110/60			114/68					118/70				124/66										
IVP				500				260	400													300		

DRIP/DOSE

Name: _____

NURSING FLOW SHEET

MEDTREFAC 6550/12/Temp Form

Date: _____

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
CUFF 200																								
180																								
AL 160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR																								
TEMP																								
SAO2																								
MAP																								
O2 Mode																								
DRIP/DOSE																								
UOP									400															

MEDCOM - 4758

Name: (b)(6)-4

NU[redacted]G [redacted] SHEET
MED [redacted]EFAC-65[redacted] [redacted]emp Form

Date: 23 APR 03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								

RR					16					16					18			16						
TEMP					98.3					98.6					97.2			97.8						
SAO2					95													98						
MAP																								
O2 Mode																								
BP					110/76													108/64						
VOP					300 320																			

DRIP/DOSE

MEDTREFAC 6550/12/Temp Form

24 APR 03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
00																								
80																								
60																								
40																								
20																								
00																								
80																								
60																								
40																								
RR		18									16							16						
TEMP		97.9									98.7							98.0						
SAO2		97																97						
MAP																								
O2 Mode		130/90																98/60						
Vol								380			300			350										

CUFF

AL

DRIP

MEDCOM - 4760

(b)(6)-4

25 APR 2003

07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
					V				V								V						
					^				^								^						
					18 97.4				16 97.8								17 97.9						
					120/70												124/60						
					360														500				

26 APR 2003

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
00																								
80																								
60																								
40																								
20																								
00	✓											✓						✓						
0																								
50																								
10																								
RR	16											16						16						
TEMP	98.3											98.8						97.6						
SAO2	97																	96						
MAP																								
O2 Mode	RA																							
	112/72																	110/60						
VOP								425			X1													

MEDCOM - 4762

(b)(6)-4

27 HPK 03

Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
00																								
80																								
60																								
40																								
20																								
00																								
0																								
0																								
0																								
RE			18																					
TE			98.4						98.8									18						
SA			94															98.3						
M																		96						
D			RA																					
Mo			98/58																					

(b)(6)-4

MEDTREPAC 6550/12/T

28 APR 03

	07	08	09	10	11	12	13	14	15	16	17	18	19	21	22	23	24	01	02	03	04	05	06
R		18								16			16										
EMP		98.2								98.9			99.1										
AO2		97%								95%			97%										
1A																							
2																							
Indo		RA											RA										
BP		100/68								112/68			106/64										

FREQ. VITAL SIGNS

IME																
P																
R																
R																
EMP																
AO2																

otes:

INPUT/OUTPUT

V	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
O																									
/PB																									

UT	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
OLEY																									
IOP								330																	
RM																									

PREVIOUS 24 HOUR INPUT _____ PREVIOUS 24 HOUR OUTPUT _____ PREVIOUS WEIGHT _____

PRESENT 24 HOUR INPUT PRESENT 24 HOUR OUTPUT PRESENT WEIGHT

FREQ. VITAL SIGNS

INPUT/OUTPUT

08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06

07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06
													350		300									

IS 24 HOUR INPUT _____ PREVIOUS 24 HOUR OUTPUT _____ PREVIOUS WEIGHT _____

T 24 HOUR INPUT PRESENT 24 HOUR OUTPUT PRESENT WEIGHT _____

MEDICAL RECORD | VITAL SIGNS RECORD

HOSPITAL DAY																
POST-	DAY															
MONTH-YEAR	DAY															
19	HOUR															
PULSE (O)	TEMP. (●)															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																
RESPIRATION RECORD																
BLOOD PRESSURE																
HEIGHT:	WEIGHT→															

SPO2 96.8

127/73

95

20

93%

9.7

7.0

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

511-113

(b)(6)-4

*U.S. Government Printing Office: 1989-241-175/80290

VITAL SIGNS RECORD

STANDARD FORM 511 (REV. 9-79)

Prescribed by GSA/ICMR

FIRMR (41 CFR) 201-45.505

MEDICAL RECORD | VITAL SIGNS RECORD

HOSPITAL DAY																	
POST- DAY		APR 29		APR 30		MAY 1		MAY 02		MAY 03							
MONTH-YEAR	DAY																
19	HOUR	0700	1900	0700 1400	1900	0800	2000	0700	2000	10 14	2000						
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																	
RESPIRATION RECORD		4	4	44	6	4	6	8	2	46	6						
BLOOD PRESSURE		120/72	120/72	126/78 128/74	100/54 96%	112/64	102/60	106/62	100/66	98/40 100/60	98/58						
HEIGHT:	WEIGHT→						96		97%	99% 98%	96%						

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

511-112

VITAL SIGNS RECORD

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

(b)(3)-1

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 12 Mar 03 - 11 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/1d Reg #: (b)(6)-4
Ph: Military Unit: UNKNOWN

11 Apr 03 @ 0555 (Coll) SERUM
Order comment: FASTING BLOOD SUGAR

GLUCOSE	261	H	(76-110)	mg/dL

10 Apr 03 @ 1636 (Coll) PLASMA

APTT	20.4	L	(23.8-35.5)	Seconds
PT	11.8		(11.6-14.4)	Seconds
INR	0.8			

Interpretations:
The current recommended therapeutic range for INR is 2.0-3.0 for all indications except prosthetic valves for which an INR 2.5-3.5 is recommended (Chest 108(4):231S-246S; 1995). It should be recognized that these are guidelines and adjustments may be required based on individual patient risk factors. The INR is not useful for the first 7-10 days of therapy.

10 Apr 03 @ 1636 (Coll) BLOOD

STAT WBC	9.6		(4.8-10.8)	K/UL
RBC	2.8	L	(4.7-6.1)	1X10 6/UL
HGB	8.9	L	(14.0-18.0)	g/dL
HCT	26.3	L	(42-52)	%
MCV	94.0		(80-94)	fL
MCH	31.9		(27-32)	pg
MCHC	34.0		(31-37)	g/dL
RDW	12.0		(12-14)	%
PLT CNT	292		(150-450)	1x10 3/UL
MPV	8.1		(7.4-10.4)	FL
NEUT/100 WBC	72.7			%
NEUT%	7			1x10 3/UL
LYMPHS/100 WBC	21.4			%
LY#	2.1			1x10 3/UL
MONO/100 WBC	5.9			%
MO#	0.6			1x10 3/UL
EO#	<0.7			1x10 3/UL
BAS#	<0.2			1x10 3/UL

10 Apr 03 @ 1636 (Coll) SERUM

STAT NA+	133	L	(137-145)	mmol/L
K	3.3	L	(3.6-5.0)	mmol/L
CL-	96	L	(97-107)	mmol/L
CO2	31		(22-31)	mmol/L
BUN	12		(9-21)	mg/dL
GLUCOSE	166	H	(76-110)	mg/dL
CREAT	0.8		(0.8-1.5)	mg/dL

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod S I=Intermed

Personal Data - Privacy Act 1974 (PL 93-579)
Review Results

Report requested by: (b)(6)-2

Patient: (b)(6)-4
Date of Birth: 10 Apr 2003
Age: 0
Outpatient Record Loc.:
Duty Station/Unit:

FMP/SSN: (b)(6)-4
Sex: MALE
Home Phone:
Work Phone:
Register Number: (b)(6)-4

(b)(3)-1

Procedure: PELVIS (AP ONLY)
Requested by: (b)(6)-2
Ward/Clinic: (b)(3)-1 STBD 5-43-0 X7103

DIAGNOSTIC RADIOLOGY X7420
Exam Date: 12 Apr 2003@1646
Status: COMPLETE
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
CONCERN FOR FOREIGN BODY. PLEASE EVALUATE. THANK YOU.

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

An AP view of the pelvis demonstrates metallic fragments overlying the left hip and ischium as well as the soft tissues of the left proximal thigh. No fracture or dislocation. Bone island, right femoral head.

Transcription Date/Time: 12 Apr 2003@1731

Interpreted by: (b)(6)-2 CDR,MC,USN
Supervised by:

Approved by: (b)(6)-2 CDR,MC,USN 12 Apr 2003@1849
Supervised by:

Personal Data - Privacy Act 1974 (PL 93-579)
Review Results

Report requested by: (b)(6)-2 [redacted]

Patient: (b)(3)-1 [redacted]
Date of Birth: 10 Apr 2003
Age: 0
Outpatient Record Loc.:
Duty Station/Unit:

FMP/SSN: (b)(3)-1 [redacted]
Sex: MALE
Home Phone:
Work Phone:
Register Number: (b)(6)-4 [redacted]

**********ATTENTION**********
* THIS REPORT IS PENDING APPROVAL BY RADIOLOGY AND *
* SHOULD NOT BE INTERPRETED AS THE FINAL REPORT. *
****

(b)(3)-1 [redacted]
Procedure: ELBOW, RT
Requested by: (b)(6)-2 [redacted]
Ward/Clinic: (b)(3)-1 [redacted] 5-43-0 X7103

DIAGNOSTIC RADIOLOGY X7420
Exam Date: 12 Apr 2003@1646
Status: TRANSCRIBED
Exam #: (b)(6)-4 [redacted]
Pregnant:

Reason for Order:
CONCERN FOR FOREIGN BODY. PLEASE EVALUATE. THANK YOU.

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

Four views of the right elbow demonstrate a soft tissue defect involving the dorsal aspect of the proximal forearm. No joint effusion. No acute fracture or dislocation. Metallic fragments in the soft tissues dorsal and radial to the radial head. Enthesophyte at the olecranon.

Transcription Date/Time: 12 Apr 2003@1710

Interpreted by: (b)(6)-2 [redacted], CDR,MC,USN
Supervised by:

Approved by:
Supervised by:

RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4 FMP/SSN: (b)(6)-4

(b)(3)-1

Procedure: CHEST,PA/LAT
Requested by: (b)(6)-2
Ward/Clinic: WARD (b)(3)-1 5-43-0 X7103

DIAGNOSTIC RADIOLOGY X7420
Exam Date: 11 Apr 2003@2204
Status: COMPLETE
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
Repeat from portable. Please evaluate. Thank you.

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

Mild cardiomegaly. Mild, diffuse increased interstitial markings throughout the lungs. Question possible long smoking hx in this pt vs. occupational dust exposure.

Transcription Date/Time: 11 Apr 2003@2317

Interpreted by: (b)(6)-2 CAPT,MC,USN
Supervised by:

Approved by: (b)(6)-2 CAPT,MC,USN 11 Apr 2003@2320
Supervised by:

2 √

(b)(3)-1

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 14 Mar 03 - 13 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/3d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

---

13 Apr 03 @ 0628 (Coll) SERUM

NA+	135	L	(137-145)	mmol/L
K	3.4	L	(3.6-5.0)	mmol/L
CL-	101		(97-107)	mmol/L
CO2	32	H	(22-31)	mmol/L
BUN	8	L	(9-21)	mg/dL
GLUCOSE	192	H	(76-110)	mg/dL
CREAT	0.8		(0.8-1.5)	mg/dL

==========

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed

515 – 110

MEDICAL RECORD	TISSUE EXAMINATION

SPECIMEN SUBMITTED BY

DATE OBTAINED

SPECIMEN

BRIEF CLINICAL HISTORY *(Include duration of lesion and rapidity of growth, if a neoplasm)*

PREOPERATIVE DIAGNOSIS

OPERATIVE FINDINGS

POSTOPERATIVE DIAGNOSIS

NAME OF LABORATORY

(Gross description, histologic

PATIENT I.D. AND BLOOD ISSUE TAG

(record copy)

RECEIVED

APR 1 4 2003

* Check One

_✓_ Crossmatch

_ _ _ Fresh Frozen Plasma

Triage Number _

Name (b)(6)-4

SSN_

Location _ _ (b)(3)-1 _ _

Automatic Release Time _ _ _ _ _ _ _ _ _

(b)(3)-1 BLOOD BANK (2/91)

SIGNATURE OF PATHOLOGIST

TIFICATION NO.

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

REGISTER NO.

WARD NO.

(b)(6)-4

TISSUE EXAMINATION

STANDARD FORM ... (REV. 9–77)

Prescribed by GSA ... MR, FIRMR (41 CFR) 201–45.505

MEDCOM - 4774

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(b)(3)-1 (b)(3)-1

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 16 Mar 03 - 15 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/5d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

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15 Apr 03 @ 0503 (Coll) BLOOD

WBC	8.6		(4.8-10.8)	K/UL
RBC	2.7	L	(4.7-6.1)	1X10 6/UL
HGB	8.9	L	(14.0-18.0)	g/dL
HCT	25.9	L	(42-52)	%
MCV	94.9	H	(80-94)	fL
MCH	32.5	H	(27-32)	pg
MCHC	34.2		(31-37)	g/dL
RDW	14.1	H	(12-14)	%
PLT CNT	419		(150-450)	1x10 3/UL
MPV	6.9	L	(7.4-10.4)	FL
NEUT/100 WBC	66.8			%
NEUT%	5.7			1x10 3/UL
LYMPHS/100 WBC	24.2			%
LY#	2.1			1x10 3/UL
MONO/100 WBC	9.0			%
MO#	0.8			1x10 3/UL
EO#	<0.7			1x10 3/UL
BAS#	<0.2			1x10 3/UL

15 Apr 03 @ 0503 (Coll) SERUI

Order comment: FASTING BLOOD GLUCOSE ALSO

NA+	134	L	(137-145)	mmol/L
K	3.6		(3.6-5.0)	mmol/L
CL-	102		(97-107)	mmol/L
CO2	31		(22-31)	mmol/L
BUN	10		(9-21)	mg/dL
GLUCOSE	219	H	(76-110)	mg/dL
CREAT	0.7	L	(0.8-1.5)	mg/dL

==========

L=Lo H=Hi *=Critic R=Resist S=Susc MS=Mod Susc I=Intermed

(b)(3)-1 (b)(3)-1

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 15 Apr 03 - 16 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/6d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

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16 Apr 03 @ 0537 (Coll) SERUM

Order comment: ALSO DO FASTING BLOOD GLUCOSE

NA+	132	L	(137-145)	mmol/L
K	3.6		(3.6-5.0)	mmol/L
CL-	98		(97-107)	mmol/L
CO2	29		(22-31)	mmol/L
BUN	9		(9-21)	mg/dL
GLUCOSE	198	H	(76-110)	mg/dL
CREAT	0.8		(0.8-1.5)	mg/dL
CA.	7.4	L	(8.8-10.4)	mg/dL
PHOSPHORUS.	3.4		(2.5-4.5)	mg/dL
URIC ACID	2.1	L	(3.3-8.4)	mg/dL
PROTEIN TOTAL	5.5	L	(6.3-8.3)	g/dL
ALBUMIN	2.4	L	(3.5-5.0)	g/dL
AST	21		(15-46)	U/L
ALT	33		(11-66)	U/L
LDH	497		(313-618)	U/L
ALK PHOS.	71		(70-250)	U/L
TBILI	1.0		(1.0-10.5)	mg/dL
GGT	26		(8-78)	U/L
CK.	94		(0-203)	U/L
MG.	2.1		(1.7-2.2)	mg/dL

Interpretations:

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed
[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

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(b)(3)-1 (b)(3)-1

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 22 Apr 03 - 23 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/13d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

---

23 Apr 03 @ 1116 (Coll) SERUM

ASAP GLUCOSE . . . . . 108 (76-110) mg/dL

==========

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed

[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

==========

(b)(3)-1 (b)(3)-1 23 Apr 2003@1837 Page 1

Personal Data - Privacy Act of 1974 (PL 93-579)

PATIENT LAB INQUIRY

For: 22 Apr 03 - 23 Apr 03

Report requested by: (b)(6)-2

(b)(6)-4 (b)(6)-4 M/13d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

---

23 Apr 03 @ 1718 (Coll) SERUM

GLUCOSE	180	H	(76-110)	mg/dL

23 Apr 03 @ 1116 (Coll) SERUM

ASAP GLUCOSE	108		(76-110)	mg/dL

==========

L=Lo H=Hi *=Critical R=Resist S=Susc MS=Mod Susc I=Intermed

[]=Uncert /A=Amended Comments= (O)rder, (I)nterpretations, (R)esult

==========

516-108

NSN 7540-00-634-4156

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

GSW Bilateral Thighs / Groin
(R) Elbow

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
DL (b)(6)-2	—	—	
ANESTHETIST: LCDR (b)(6)-2	ANESTHETIC: General ETT		TIME BEGAN: 0836
			TIME ENDED: 1133
CIRCULATING NURSE: LCDR (b)(6)-2	SCRUB NURSE: HN (b)(6)-2	TIME OPERATION BEGAN: 0915	TIME OPERATION COMPLETED: 1128

OPERATIVE DIAGNOSES

SAH

DRAINS (Kind and number): Ø

SPONGE (b)(6)-2

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

1) (L) Groin Aerobic + Anaerobic Cultures
2) (R) Thigh Aerobic + Anaerobic Cultures

Total Fluids - 1000 cc
EBL < 50 cc
Uop - NM

OPERATION PERFORMED

I + D Rt elbow Rt thigh Left groin x2 + Left thigh X 3
Advancement flap RT Thigh + Left thigh.

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)

Corrected + debrided all wounds.
CX's taken of medial (L) thigh
+ (R) ant thigh. Irrigated c̄
Bacitracin + NS. Closed wounds
loosely c̄ Iodoform wicks between
3-0 nylon vertical mattress sutures.
Dressed c̄ gauze + Kerlex -
Held down c̄ spandage.
To RR Stable. No pus or abscess found.
(Rt Rectus portion debrided c̄ superior tunnel + hematoma cavity debrided)

PROSTHETIC DEVICES (Lot no.):

DATE OF OPERATION: 15 April 03

Iodoform Packings
(L) Anterior Thigh - 4 pieces
(L) Lateral Thigh - 1 piece
(L) Groin - 3 pieces
Suprapubic Area - 1 piece
Medial (L) thigh - 5 pieces
(R) Elbow - 1 piece
(R) Thigh - 6 pieces

SIGNATURE OF SURGEON: (b)(6)-2 (b)(6)-2

DATE: 15 Apr 03

PATIENT'S IDENTIFICATION (For typed or written en... grade; date; hospital or m...): (b)(6)-4

...GISTER/I.D. NO.:

WARD NO.:

OPERATION REPORT
Medical Record

U.S. GOVERNMENT PRINTING OFFICE: 1990-259-301

STANDARD FORM 516 (REV. 5-83)
Prescribed by GSA and ICMR, FPMR 101-11.806-8

MEDCOM - 4779

510-103 NSN 7540-00-[illegible]-4156

MEDICAL RECORD | OPERATION REPORT

PREOPERATIVE DIAGNOSIS

"Multiple GSW Rt Elbow, Left groin x2, Rt thigh x2, + Left thigh x3."

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
Dr (b)(6)-2	—	—	
ANESTHETIST Dr (b)(6)-2	ANESTHETIC General,		TIME BEGAN: 08:21 TIME ENDED: 1950
CIRCULATING LT (b)(6)-2	SCRUB NURSE Hm2 (b)(6)-2	TIME OPERATION BEGAN 08:57.	TIME OPERATION COMPLETED 09:40

OPERATIVE

X Poss muscle necrosis Rt Thigh (Requisite Debridement.

DRAINS (Kind and number)

SPONGE COUNT VERIFIED N/A.

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

(1) Aerobic Cx Rt thigh wound (2) Anaerobic Cx Rt thigh wound / gram stain.

OPERATION PERFORMED

EBL: 510
Fluids: 1300

X I+D 4/9 wounds Debridement of RT Rectus Femoris. U/O: NM

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)

Hm3 (b)(6)-2 (b)(6)-2

PROSTHETIC DEVICES (Lot no.) —

DATE OF OPERATION 17 APR 03

Removed wound packing. Irrigated Wounds
Replaced packs (1) Thigh + groin. RT Rect Femoris.
explanation → muscle necrosis + liquefaction hematoma
Evacuated + Debrided. (Cx taken) Packed.
Tol well → to RR stable.

(b)(6)-2

SIGNATURE OF SURGEON

X

DATE 17 Apr 03

PATIENT'S IDENTIFICATION (For typed or written grade; date, hospital)

(b)(6)-4

M

(b)(6)-4

OPERATION REPORT (Medical Record)

(b)(3)-1

10APR03

PERSONAL DATA PRIV ACT 1974

MEDCOM - 4780

516-108 NSN 7540-00-634-4156

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

GSW (L) Thigh / Hip
(R) Thigh, (R) Elbow

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
DL (b)(6)-2	DL (b)(6)-2		
ANESTHETIST: ~~DL~~ (b)(6)-2 LT (b)(6)-2	ANESTHETIC: General ETT		TIME BEGAN: 1232 TIME ENDED: 1348
CIRCULATING NURSE: LCDR (b)(6)-2 LT (b)(6)-2	SCRUB NURSE: HN (b)(6)-2	TIME OPERATION BEGAN: 1302	TIME OPERATION COMPLETED: 1340

OPERATIVE DIAGNOSES

SAH

DRAINS (Kind and number): d

SPONGE COUNT VERIFIED: (b)(6)-2

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

Aerobic + Anaerobic CX (L) Hip wound

OPERATION PERFORMED

Removal Fragment (L) Hip Joint
Dressing Changes Bilateral Legs, (R) Elbow

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)

PROSTHETIC DEVICES (Lot no.)

DATE OF OPERATION: 20 April 03

Total Fluid - 1100cc
EBL - minimal
UOP - NM

Arteriosis Approach to hip
Fragment visualized with
assistance of C-Arm. Capsulotomy
performed and Fragment removed
and passed off table. C-Arm
confirmation of fragment. Joint irrigated
No evidence of infection or inflammation.
Pt tolerated procedure well. Capsule
SQ closed using 20 Vicryl Skin Closed c̄ Staples

SIGNATURE OF SURGEON: (b)(6)-2

DATE: 20 April 03

PATIENT'S IDENTIFICATION: (b)(6)-4 (Name - last, first, middle; ...ity)

REGISTER/I.D. NO.

WARD NO.

OPERATION REPORT
Medical Record

*U.S. GOVERNMENT PRINTING OFFICE: 1990-259-401

STANDARD FORM 516 (REV. 5-83)
Prescribed by GSA and ICMR, FPMR 101-11.806-8

RM 4 Case Ø2

510-108

NSN 7540-00-634-4156

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

Shrapnel / G.S.W BLE

HM3 (b)(6)-2 Surgical Assist

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
DR (b)(6)-2	Ø	Ø	
ANESTHETIC DR. (b)(6)-2	ANESTHETIC GEN ETT		TIME BEGAN: 1315 TIME ENDED: 1429
CIRCULATING NURSE LTJG (b)(6)-2	SCRUB NURSE (b)(6)-2	TIME OPERATION BEGAN 1338	TIME OPERATION COMPLETED 1425

OPERATIVE DIAGNOSES

SAA

(b)(6)-2

DRAINS (Kind and number) Ø

SPONGE COUNT VERIFIED correct x 3

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

Ø

OPERATION PERFORMED

Bullet Extraction (R) thigh X 2

Wound Closure (L) thigh.

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)

HM3 (b)(6)-2 - Clocton 0.25% Marcaine Plain Ø cc

PROSTHETIC DEVICES (Lot no.) Ø

DATE OF OPERATION 04/23/03

EBL MIN

IVF 400

Prep + draped c̄ betadine.

Rt thigh #15 blade → incised to schrapnel. → removed.

2 large pieces. closed c̄ staples.

3 • # 3-oxylon used to advance other wounds on (L) Thigh.

Dressed c̄ NS to pacu stable + alert.

(b)(6)-2

SIGNATURE OF SURGEON

DATE 04/23/03

PATIENT'S IDENTIFICATION (For typed or written entrie grade; date; hospital or medi

WARD NO. Rm 9 / case Ø1

(b)(6)-4

OPERATION REPORT
Medical Record

*U.S. GOVERNMENT PRINTING OFFICE: 1990-259-301

STANDARD FORM 516 (REV. 5-83)
Prescribed by GSA and ICMR, FPMR 101-11.806-8

MEDCOM - 4782

516-108 NSN 7540-00-634-4156

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

AD Perforation

R Tympanoplasty

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
(b)(6)-2 MD	—	—	
ANESTHETIST	ANESTHETIC		TIME BEGAN: 820
(b)(6)-2 MD	Gen ET		TIME ENDED: 1105
(b)(6)-2 Lt	SCRUB NURSE (b)(6)-2 Hm²	TIME OPERATION BEGAN 934	TIME OPERATION COMPLETED 1105

OPERATIVE DIAGNOSES

AD Perforation

DRAINS *(Kind and number)* Ø

SPONGE/COUNT VERIFIED (b)(6)-2

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION Ø

OPERATION PERFORMED

AD medial Graft Tympanoplasty

DESCRIPTION OF OPERATION *(Type(s) of suture used, gross findings, etc.)* (b)(6)-2 Hn

PROSTHETIC DEVICES *(Lot no.)*

DATE OF OPERATION 25 Apr 03

Findings - NL middle ear, nl round window reflex
35% anterior pastensa perforation, Chorda Tympani intact.

EBL Mic
LR 500
Urine NN

Operation - General ETT anesthesia, sterile prep right ear.
Harvest of post auricular temporals fascia graft.
Tympanomental flap raised graft placed in medial fashion.
TM - returned to normal anatomic position.
Perforation covered.
Gel foam in ear canal Bactracin applied.
Post op 512 to operated ear. VII intact.
Tolerated procedure well.

Xylocaine 1% c ep
8 cc

Neo myinotic
4 ft

SIGNATURE OF SURGEON (b)(6)-2

DATE 25 APR 2003

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

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

REGISTER/I.D. NO.

WARD NO.

OPERATION REPORT
Medical Record

(b)(3)-1

10 APR 03

PERSONAL DATA PRIV ACT 1974

*U.S. GOVERNMENT PRINTING OFFICE: 1990-259-101

STANDARD FORM 516 (REV. 5-83)
Prescribed by GSA and ICMR, FPMR 101-11.806-8

MEDCOM - 4783

COUNT SHEET

ITEMS		QUANTITY	ADDED	1ST	2ND	3RD
SUTURE NEEDLES		2				
KNIFE BLADES						
SCRATCH PAD		1				
HYPODERMICS		2				
CAUTERY TIPS						
RAYTEX		10				
LAP TAPES						
COTTONOIDS	1/4 x 1/4					
	½ x ½					
	½ x 1					
	½ x 3					
	1/8 x 1/8					
	1 x 1					
	3/4 x 3/4					
	1 x 3					
	1/4 x 6					
	½ x 6					
	3/4 x 6					
	1 x 6					
	2 x 6					
	3 x 6					
PEANUT/KITNERS						
BULL DOGS						
REELS						
HEMOCLIPS BOATS						
RUBBER SHODS						
DRAINS						
NOODLES						
UMBILICAL TAPES						
RUBBER BANDS						
SAFETY PINS						
WECK SPONGES						
TANN. FISIL TONSIL						
COTTON BALLS						
MISCELLANEOUS						

LOAD NO

(b)(6)-4

ADDRESSOGRAPH

10APR03

(b)(3)-1

PERSONAL DATA PRIV ACT 1974

INITIALS	OR NURSE SIGNATURE

ANESTHESIA RECOR

NMC 2279(12/00)

Wt (kg) - ~70 kg Ht (in) - ~5'10" Allergies - NKDA

Procedure	Anesthesiologist/CRNA Sign	Surgeon	OR # 1
(R) Tympanoplasty	(b)(6)-2	(b)(6)-2	See Page One

Date	Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	Resident/SRNA	Page 1 of 1
4.25.03	0820	0840	0934	1110	1125	—	

Time	0845	0900	X	30	X	1000	X	30	X	1100	X
O_2 L/M	8	1	1	1	1	1	1	1	2	2/8	
N_2O / Air L/M		2	2	2	2	2	2	2 X			
Halo / Iso / Sevo / Des		.4	.3	.3	.4	.4	.4	.4	.6	.6X	
STP / Prop / Etomidate	200										
Sux / Cistracurium											
Ro / Rapa / Vecuronium	8		2			4					
Lidocaine											
Neostigmine / Glyco										5/1	
Ephedrine / Neo											
Midazolam											
MSO_4 / Remi / Su / Fentanyl	250										
Epid. Lido / Bupiv / Ropiv											
NS / LR			200					400	500		
U/O	X										
EBL								MIN			

Checklist - O_2 / Suction / Machine / Consent / NPO

Monitors - SaO_2 / ECG / FiO_2 / NIBP L/R arm; $EtCO_2$ / PCS / ES / PNS / PIP / Temp; Mass Spec / Verbal / TEE / Fluid warmer; Air Warm / Foley / FHT / Pulm Art cath; CVP IJ / SC / Fem L/R / OG / NG L/R; A-Line Rad / Fem L/R

Position - Pressure points padded / Arms < 90°

Supine / Prone / Lithotomy / Sitting / Lateral L/R

Drawn ____ Used ____ Wasted ____ Witns ____

Drawn 250 Used 150 Wasted 100 Witns 71

IV - 20 Ga L/R Hand / Wrist / FA / AC / EJ

Tourniquet ____ mmHg Times 1 ____ 1 ____

60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

Antibiotics: Agent - ; Total ; mg - ; Total 500 ; over ; minutes ; Total N/A ; @ ; Total MIN

● = Pulse; ○ = Spont. Resp.; ⊘ = Asst. Resp.; ▽ = Ventilator; X = MAP; ∧/V = NIBP; ⊥/T = A-Line; I = Intubate; E = Extubate

PACU / ICU: Pulse - 74; BP - 122/79; Temp - 96.7; RR - 14; SaO_2 - 100%; Comps - + / -

ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Np / Or / Sk / Ax Temp		36.1	36.1	36.0	35.9	35.9	35.9	35.9	35.9	35.9
% FiO_2	1.0	.3	.3	.3	.4	.4	.4	.4	.6	1.0
% SaO_2	100	100	100	100	100	100	100	100	100	100
$EtCO_2$	+	33	34	34	35	35	34	34	34	34
TOF		4/4	4/4	0/4	3/4	4/4	0/4	0/4	0/4	4/4
TV	SV	725	CV	700	CV	710	CV	721	CV	720 SV
PIP (cmH_2O)		19		19		19		19		19
Resp. Rate		10		10		10		10		10 12

Induction: Monitors On / Preoxygenated / Smooth — Inhalation / IV — Cricoid Pressure — Rapid Sequence — Mask ventilation easy Y / N

Intubation: Mac / Mil 4 — Grade 1 view — Tube Size 7.0 — Attempts 1 — Oral / Nasal L / R — w/o / w/ Cuff — Stylet Y / N — Bil BS / $EtCO_2$ x3 / CIN

Tube taped @ 24 cm @ lips / teeth / nares — Trauma Y / N — FOB / LW / Blind — LMA # ____ — DLT ____ Fr L / R

Maintenance: Smooth — Cuff checked — Eyes taped / lubed

Extubation: Smooth — Reversed — SV / VSS — Full TOF / Head lift / Sustained tetanus — Suctioned — Awake / Deep

Disposition: PACU / ICU — SV / VSS — Awake / sleepy — Extubated / intubated

Patient Identification: (b)(6)-4

JD

10APR03

(b)(3)-1

PERSONAL DATA PRIV ACT 1974

Prep	Regional	Regional	Comments / Drugs:
☐ Sterile Technique	☐ Spinal / Epidural	☐ Catheter out - tip intact	
☐ Disposable kit	☐ Touhy / Whitacre / Quincke	☐ Level ____	
☐ Betadine prep x 3	☐ Needle guage ____		
☐ Local infiltration	☐ Sitting	**Lines**	
☐ Site ____ L/R	☐ Lateral R / L	☐ Seldinger Technique	
☐ Attempts ____	☐ LOR to Air / NS	☐ CVP manually transduced	
Blocks	☐ Paresthesia + / -	☐ Cordis 9.5 / 8.5 Fr	
☐ Nerve Stim ____ mA	☐ Heme + / -	☐ SLIC	
☐ Transarterial	☐ CSF + / -	☐ 2 / 3 - lumen	
☐ Dual cuff	☐ Test dose ⊖		
	☐ CSF ⊕ swirl		

Pe[illegible]perative Plan Of Care & Nursing N[illegible]

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☑ Yes ☐ No

'rauma# or 'atient #

Diagnosis: GSW Thigh Planned Procedure: (L) Hip Exploration

Date: 4-20-03 Arrival Time: Interviewer: LCD (b)(6)-2

Side: ☐ N/A ☐ Right ☑ Left
Age: HT: WT:

'rom:	Transport Via:	Patient ID:	Blood Ordered:	Surgical/Anesthesia Consent Verified:
☐ CASREC	☑ Gurney	☐ Trauma card	☑ N/A Comments:	☐ Procedure
☐ ICU	☐ Litter	☐ Verbal	☐ Yes ☐ Consent	☐ Consent complete, dated, signed
☐ Ward 5-F	☐ Ambulated	☑ Chart	☐ T/C #Units	☑ Emergent case; no consent, MD note
☐ OTHER:	☐ Wheelchair	☑ Armband	☐ T/H #Units	
	☐ Other	☐ Other		

'reop Labs (HCG, etc):	Drug/Latex Allergies:	Present On Admission:	Past Medical History:	Cultural Needs Addressed:
☑ None ☐ Yes	☑ NKDA	☐ N/A	☑ None known	☐ Yes ☑ No
'est/Results:	Allergy/Reaction:	☐ Oxygen	☐ Smoker ppd/yrs ___/___	List:
		☑ IV Site: #1 (L) arm	☐ ETOH ☐ Asthma	
		#2	☐ HTN ☐ CAD	
		☐ Foley	☐ GERD ☐ CBR exposure	
		☐ Endotrachial Tube	☐ Other:	
're-Op Pain:		☐ Arterial Line Site:	Past Surgical History:	Last PO Intake: (date/time)
☑ No		☐ Drain(s)	☐ None known	Solid: 4-19-03 2400
☐ Yes Level ___(0-10)		☐ Chest Tube(s)	☑ Yes	Liquid: 4-19-03 2400
ıction Taken:			List:	
ocation/type:		☐ See RN Note #		

n Chart:	Skin Condition:	Limitations:	Personal Items:	
☐ H&P ☑ Yes ☐ No	☐ Intact	☐ N/A ☐ Auditory	☑ None	Disposition:
☐ EKG ☐ Yes ☐ No	☐ Other: Dressing to	☑ Language ☐ Visual	☐ Military gear	
☐ CXR ☐ Yes ☐ No	(L) Hip area	☑ Mobility ☐ Prosthesis	☐ Glasses	
☐ Other:		☐ Other:	☐ Dentures	
			☐ Jewelry/wallet	
			☐ Other	

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☐ Yes ☐ No

Mental/Emotional Status:	Comfort Measures Implemented:	Pre-op Teaching Included:
☑ Alert/Oriented ☑ Calm	☐ Clear, concise explanations	☑ N/A due to patient condition
☐ Disoriented ☐ Sedated	☐ Communicated patient concerns to other staff members	☐ Physical layout of OR
☐ Anxious ☐ Unresponsive	☐ Remain with patient during induction	☐ Personnel present during procedure
☐ Appropriate for age		☐ Environment (noise, temperature, etc.)
☐ Other		☐ Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☑ Yes ☐ No

Operative Position:	Positional Aids:				Comments:
☑ Supine ☐ Beach chair		☐ Airplane	☐ Axillary roll	☐ Bean Bag	
☐ Prone ☐ Sitting	☐ Arms <90	☐ Fracture Table	☐ Gel Pad	☐ Gel donut	
☐ Jackknife ☐ Lateral L / R	Armboard: ☑ L ☑ R	☐ Hand Table	☐ Leg Holder	☐ Pillows	
☐ Lithotomy	Tucked: ☐ L ☐ R	☐ Stirrups	☐ Tape	☐ Wilson Frame	
☐ Other:		☐ Other:			

ESU # 9	DVT Prevention:	Tourniquet:	
'ad Site: (R) Flank	SCD used ☐ No ☑ Yes	☐ Arm ☐ Leg	# N/A
'ad Lot # 66915	Pressure: ___ ☐ Left ☐ Right	☐ Left ☐ Right	Comments:
Site Clear at end of case? ☐ No ☑ Yes	Teds: ☐ No ☐ Yes	☐ webril applied	Applied by:
f No, see RN note #	Bair Hugger used: ☐ No ☑ Yes	↑ ↓	
Bipolar: ___ Max Cut 40 Coag 40	Other warming techniques:	↑ ↓	Total Min:

(b)(6)-4

Comments:

(b)(3)-1

Operative Plan Of Care & Nursing Note

Potential For Infectio

Outcome: Appropriate Actions Taken to Pre Infection ☑ Yes ☐ No

Vound Classification:
I ☐ II ☐ III ☑ IV

Shave Prep:
☐ Shave ☐ Clipper
Area: _____ By: _____
N/A

Skin Prep:
☑ Betadine Scrub
☐ Hibiclens
☐ Duraprep
☐ Other:

Solutions/M. ications:
☑ Normal saline
☐ Sterile water
☐ Local _____
☐ Antibiotics _____
☐ Other: _____

rains/Packing: ☑ None
Foley FR: _____
JP #1 Fr ___ Location: _____ #2 Fr ___ Location: _____
Hemovac: Size ____ Location _____
Chest tube: Location _____
Size _____ H2O Pressure: _____
Packing: type/location: _____
See RN Note # ____ for comments

Dressing: Location: Legs Bilateral

☑ ABD	☐ Cervical Collar	☐ Kling	☐ Steri-strips	☐ Benzoin
☐ Ace	☐ Coban	☐ Immobilizer	☐ Tape	☐ Mastisol
☐ Bias	☐ Drip Pad	☑ Plains	☐ Webril	☐ Bacitracin
☐ Band-Aid(s)	☐ Fluffs	☐ Sling	☑ Xeroform	
☐ Cast	☑ Kerlix	☐ Splint	☐ Other:	

Miscellaneous

ounts: (initials)
crub: RN:
Hernandez
Defrose

Correct?
Sharps ☑ Yes ☐ No ☐ N/A
Sponges ☐ Yes ☐ No ☐ N/A
Instruments ☐ Yes ☐ No ☐ N/A

See RN note # ____ for additional comments

Xray:
☐ None ☐ Other:
☐ Portable
☑ C-Arm

Skin Integrity:
☐ Clear & Intact (other than incision)
Comments: multiple packed 6 in on legs
☐ See RN note # ___ for additional comments.

nplants:
em / Lot # / Exp Date:

See RN note # ___ for additional comments.

Discharge from Operating Room

omplications:
None Comments: _____

See RN note # ____ for additional comments

Transport From OR:
☑ gurney w/ siderails up
☐ Litter w/ safety strap in place
☐ w/ Oxygen
☐ w/ Monitor
☐ Other:

Transferred To:
☑ PACU
☐ ICU
☐ Medivac
☐ Ward _____
☐ Other

Report by:
☐ Anesthesia provider ☐ RN

rgical Procedure Performed: (1) Hip Exploration / Dressing D Both legs

N Note: (number each note to corresponding area above)

Initial/Name Box: (please print)

(b)(6)-2

Primary OR RN Signature

LCD n/ac
Date

Relief OR RN Signature

Date/Time

4-20-03

(b)(3)-1

PeriOperative Plan Of Care & Nursing Note

PeriO··rative Plan Of Care & Nursing Note

Patient Assessment For Surgery - Potential For Injury - Outcome: Patient is free from signs and symptoms of injury ☒ Yes ☐ No

'rauma# or 'atient #

Diagnosis: (R) AD Pergo t/ Planned Procedure: (R) Lymphadenectomy

Date: 25 Apr Arrival Time: Interviewer: (b)(6)-2

Side: ☐ N/A ☒ Right ☐ Left

Age: HT: WT:

'rom:	Transport Via:	Patient ID:	Blood Ordered:	Surgical/Anesthesia Consent Verified:
) CASREC) ICU ☒ Ward _____) OTHER:	☒ Gurney ☐ Litter ☐ Ambulated ☐ Wheelchair ☐ Other	☐ Trauma card ☐ Verbal ☒ Chart ☒ Armband ☒ Other MD	☒ N/A ☐ Yes ☐ Consent ☐ T/C #Units _____ ☐ T/H #Units _____ Comments:	☒ Procedure ☒ Consent complete, dated, signed ☐ Emergent case; no consent, MD note

'reop Labs (HCG, etc):	Drug/Latex Allergies:	Present On Admission:	Past Medical History:	Cultural Needs Addressed:
☒ None ☐ Yes 'est/Results: _____	☒ NKDA Allergy/Reaction: _____	☐ N/A ☐ Oxygen ☒ IV Site: # L hand #2 _____ ☐ Foley ☐ Endotrachial Tube ☐ Arterial Line Site: _____ ☐ Drain(s) _____ ☐ Chest Tube(s) _____ ☐ See RN Note # _____	☐ None known ☐ Smoker ppd/yrs ____/____ ☐ ETOH ☐ Asthma ☐ HTN ☐ CAD ☐ GERD ☐ CBR exposure ☐ Other: **Past Surgical History:** ☐ None known ☒ Yes List: I & D	☒ Yes ☐ No List: _____

're-Op Pain:	Last PO Intake: (date/time)
) No) Yes Level _____(0-10) ıction Taken: _____ .ocation/type: _____	Solid: _____ Liquid: 12 MN

n Chart:	Skin Condition:	Limitations:	Personal Items:
) H&P ☒ Yes ☐ No) EKG ☐ Yes ☐ No) CXR ☐ Yes ☐ No) Other: _____	☐ Intact ☐ Other: _____	☐ N/A ☐ Language ☐ Auditory ☐ Mobility ☐ Visual ☐ Other: _____ ☐ Prosthesis	☒ None ☐ Military gear ☐ Glasses ☐ Dentures ☐ Jewelry/wallet ☐ Other Disposition:

Potential For Anxiety – Outcome: Patent demonstrates knowledge of psychological responses to an invasive procedure ☒ Yes ☐ No

Mental/Emotional Status:	Comfort Measures Implemented:	Pre-op Teaching Included:
) Alert/Oriented ☒ Calm) Disoriented ☐ Sedated) Anxious ☐ Unresponsive) Appropriate for age) Other	☒ Clear, concise explanations ☒ Communicated patient concerns to other staff members ☒ Remain with patient during induction	☐ N/A due to patient condition ☒ Physical layout of OR ☒ Personnel present during procedure ☒ Environment (noise, temperature, etc.) ☒ Post-op expectation (PACU, drains, etc.)

Potential For Impaired Skin Integrity Related To Surgical Procedure – Outcome: Patient is injury free ☒ Yes ☐ No

)perative Position:	Positional Aids:	Comments:
) Supine ☐ Beach chair) Prone ☐ Sitting) Jackknife ☐ Lateral L / R) Lithotomy) Other:	☐ Arms <90 Armboard: ☐ L ☐ R Tucked: ☒ L ☒ R ☐ Airplane ☐ Axillary roll ☐ Bean Bag ☐ Fracture Table ☐ Gel Pad ☒ Gel donut ☐ Hand Table ☐ Leg Holder ☒ Pillows ☐ Stirrups ☐ Tape ☒ Wilson Frame ☐ Other:	_____

:SU #	DVT Prevention:	Tourniquet:	Comments:
ad Site: _____ ad Lot # _____ ite Clear at end of case? ☐ No ☐ Yes f No, see RN note # _____ ipolar: ___ Max Cut___ Coag ____	SCD used ☐ No ☐ Yes Pressure: ___ ☐ Left ☐ Right Teds: ☐ No ☐ Yes **Bair Hugger used:** ☐ No ☐ Yes Other warming techniques:	☐ Arm ☐ Leg # _____ ☐ Left ☐ Right ☐ webril applied Applied by: _____ ↑ ____ ↓ ____ Total Min: _____ ↑ ↓	_____

(b)(6)-4

10APR03

(b)(3)-1

PERSONAL DATA PRIV ACT 1974

Comments: _____

(b)(3)-1

Potential For Infec[illegible] – Outcome: Appropriate Actions Taken to [illegible] Infection ☐ Yes ☐ No

Wound Classification: ☒ I ☐ II ☐ III ☐ IV

Shave Prep: ☐ Shave ☐ Clipper
Area: [illegible] By: [illegible]

Skin Prep: Paint
☐ Betadine ~~Scrub~~
☐ Hibiclens
☐ Duraprep
☐ Other:

Solution[illegible]cations:
☒ Normal saline ☐ Other:
☐ Sterile water
☐ Local Neomycin & Blu 4 gtt
☐ Antibiotics
Xylocaine 1% c epi 8cc

[illegible]rains/Packing: ☐ None
Foley FR: [illegible]
JP #1 Fr ___ Location: _____ #2 Fr ___ Location: _____
Hemovac: Size ____ Location _____
Chest tube: Location _____
Size _____ H2O Pressure: _____
Packing: type/location: _____
See RN Note # ____ for comments

Dressing: Location: _____
☐ ABD ☐ Cervical Collar ☐ Kling ☐ Steri-strips ☐ Benzoin
☐ Ace ☐ Coban ☐ Immobilizer ☐ Tape ☐ Mastisol
☐ Bias ☐ Drip Pad ☐ Plains ☐ Webril ☐ Bacitracin
☐ Band-Aid(s) ☐ Fluffs ☐ Sling ☐ Xeroform
☐ Cast ☐ Kerlix ☐ Splint ☐ Other:

Miscellaneous

[illegible]ounts: (initials)
[illegible]crub: [illegible] RN: [illegible]
Sol Bat [illegible]
Sharps ☐ Yes ☐ No ☒ N/A
Sponges ☒ Yes ☐ No ☐ N/A
Instruments ☐ Yes ☐ No ☒ N/A
See RN note # ____ for additional comments

Xray:
☒ None ☐ Other:
☐ Portable
☐ C-Arm

Skin Integrity:
☒ Clear & Intact (other than incision)
Comments: _____
☐ See RN note # ___ for additional comments.

[illegible]nplants:
[illegible]em / Lot # / Exp Date:
See RN note # ___ for additional comments.

Discharge from Operating Room

[illegible]omplications:
None Comments: _____
See RN note # ____ for additional comments

Transport From OR:
☒ gurney w/ siderails up
☐ Litter w/ safety strap in place
☐ w/ Oxygen
☐ w/ Monitor
☐ Other:

Transferred To:
☒ PACU
☐ ICU
☐ Medivac
☐ Ward ____
☐ Other

Report by:
☐ Anesthesia provider ☐ RN

[illegible]rgical Procedure Performed: Lymphoplasty

[illegible]N Note: (number each note to corresponding area above)

(b)(6)-2

(b)(6)-2

(b)(6)-2

Date

Relief OR RN Signature Date/Time

(b)(3)-1

ANTIBIOTIC:
TIME GIVIEN:
OTHER:

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV. 11-77) S/N 0105-LF-206-3281

ALLERGIES: NKDA 500mg PRIMAX

OPERATION PERFORMED: I&D (2) Leg Bullet Removal

AGENTS AND TECHNICS OF ANESTHESIA: Gen

HOUR(S): 1300 15 30 45 1400 15 30 45 5 15 30 45

TEMPS: 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

Spinal Level: N/A

EKG to monitor on [X]

Rhythm: NSR

BP ⅊ art

BP V/Λ cuff

Pulse = •

% Sat:

RESP. RATE

NUMBERS FOR REMARKS: 1 2 3 4 5

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK	10		A02	1355
~~T-BAR~~				
~~VENTILAT.~~				

FLUID THERAPY

TYPE	5% D/H2O	BLOOD	SALINE	OTHER
OPERATING ROOM	1000		200	
RECOVERY ROOM	400		0	
TOTAL	1400		200	

BLOOD LOSS IN OR: 20 cc

WARD PRE-OP BP 120/60 mmHg

TUBES: ☐ N/G ☐ FOLEY

IV IN L Arm ~~R~~ 1000 cc OF NS AT ~~KVO~~ cc/hr ACW

IV IN L Arm ~~R~~ 600 cc OF LR AT KVO cc/hr TOW

ART. LINE IN N/A

T-TUBES, HEMOVAC IN N/A

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD 5 F PORT
DATE 4/20/03 HRS 1350	DATE 4/20/03 HRS 1500

DRESSINGS: LOCATIONS (2) Leg

STATUS: CD:1 | STATUS: CD:1

ENDOTRACHEAL TUBE – ORAL OR NASAL: ☐ YES ☒ NO | ☐ YES ☒ NO

AIRWAY / BREATH SOUNDS: ☒ CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY

STATUS: clear

	MOR	PACU	URINARY OUTPUT		DRAINAGE		
TIME							
CC	Ø	Ø					
TOTAL							
SP. GR							
S/A							

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) ACW from MOR accompanied by (b)(6)-2

PMH: ASA 2

Neuro: PT awake and appropriate

Pain Yes/No Action: will continue to monitor

CV: S1, S2 ⊖ murmurs IV: Patent

Other: Side Rails up x 2, monitors on

Warm Blankets applied

(CONT'D ON REVERSE)

NAUSEA AND VOMITING: ☒ NO ☐ YES → 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT ____ HRS
SENSATION PRESENT AT ____ HRS

CONDITION ON TOW: ☒ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)

			A	D
Able to move 4 extremities voluntarily or on command	2	Activity	2	2
Able to move 2 extremities voluntarily or on command	1			
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2	Respiration	2	2
Dyspnea or limited breathing	1			
Apneic	0			
BP ±20% of preanesthetic level	2	Circulation	2	2
BP ±20-50% of preanesthetic level	1			
BP ±50% of preanesthetic level	0			
Fully awake	2	Consciousness	2	2
Arousable on calling	1			
Not responding	0			
Pink	2	Color	2	2
Pale, dusky, blotchy, jaundiced, other	1			
Cyanotic	0			
TOTALS			10	10

RECOVERY: ☐ COMPLICATED ☒ UNEVENTFUL

PATIENT'S IDENTIFICATION: (b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS

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

TOW (b)(6)-2 MVS

NAVMED 6320/18 (BACK)

HOUR(S)	15	30	45	15	30	45	15	30	45	15	30	45
TEMPS: 220												
200												
180												
160												
140												
120												
100												
80												
60												
40												
20												
RESP. RATE												
NUMBERS FOR REMARKS												

Spinal Level:

EKG Rhythm

BP ⊥ art

BP ∨ cuff

Pulse = .

% Sat:

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
1359	MSO4	2mg	IVP	
1402	MSO4	2mg	IVP	
1404	MSO4	2mg	IVP	
1406	MSO4	2mg	IVP	
1414	MSO4	2mg	IVP	
1432	MSO4	2mg	IVP	

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(2) PT Complaining of Pain Recieved 2mg MSO4. (3) BFS 168. ϕ insulin required per sliding scale. (4) Cond stable Pt has met all PACU d/c criter. Report called to 5FWD-P. (5) Transferred to 5FWD-P via gurney. SR ↑ x 2. (b)(6)-2

TOW Note: Neuro: PT Awake + Alert

Pain: Yes/No Action: Pain needs will be cont'd on ward

Pulmonary: CTA (B)

CV: S1, S2, ⊖ murmurs EKG Rhythm: NSR IV: Patent

Skin/Wound: Covered c̄ Dressings Drainage Yes/No Color: Edema Yes/No

GI: Bowel Sounds Present. Tolerating CL c̄ N/V

GU: Foley Yes/No Color of urine: ∅ Due to void: 1950

Instructions/Interventions in PACU: Unable to communicate c̄ PT Due to language Barrier.

Report called to: 5FWD Port By: (b)(6)-2

TOWed to: 5FWD- Port By: HN (b)(6)-2 + HN (b)(6)-2

~30
~70 Kg

ANTIBIOTIC: Ø
TIME GIVEN:
OTHER:

NNMC 6320/16 (05/91)
RECOVERY ROOM RECORD
NAVMED 6320/16 (REV. 11-77) S/N 0105-LF-206-3281

ALLERGIES NKDA

OPERATION PERFORMED: (R) TYMPANOPLASTY

AGENTS AND TECHNICS OF ANESTHESIA: GA Nit Iso Pro Fent 150

OXYGEN THERAPY				
ROUTE	L/M	%	ON	OFF
MASK	10		AOW	1130
T-BAR				
VENTILAT.				

FLUID THERAPY				
TYPE	5% D/RL	BLOOD	SALINE	OTHER
OPERATING ROOM	500			
RECOVERY ROOM	50			
TOTAL	550			

BLOOD LOSS IN OR: Min CC
WARD PRE-OP BP 110 Ns mmHg
~~TUBES: ☐ N/G ☐ FOLEY~~ N/A
IV IN (R) hand c̄ ___ cc
OF LR AT 110 cc/hr AOW
IV IN (R) lt c̄ 450 cc
OF LR AT KVO cc/hr TOW
ART. LINE IN N/A
T-TUBES, HEMOVAC IN N/A

HOUR(S): 11 15 30 5 40 45 50 55 12 05 10 15 30 45 13 15 30 45

TEMPS: 220 200 180 160 140 120 100 80 60 40 20

Spinal Level: N/A

EKG to monitor on ☑ Rhythm SR

BP ⊥ art

BP ∨ ∧ cuff

Pulse = .

% Sat:

RESP. RATE

NUMBERS FOR REMARKS: 1

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD 5 FWD Port
DATE 4/25/03 HRS 1116	DATE 4/25/03 HRS 1150

DRESSINGS: LOCATIONS (R) ear

STATUS: Bandaid c/d/I — STATUS: Ø A

ENDOTRACHEAL TUBE – ORAL OR NASAL
☐ YES ☒ NO — ☐ YES ☒ NO

AIRWAY /BREATH SOUNDS
☒ CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY — STATUS: Ø A

	MOR	PACU	URINARY OUTPUT		DRAINAGE
TIME					
CC	X	Ø			
TOTAL		Ø			
SP. GR					
S/A		0			

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by Anesthesia (b)(6)-2
PMH: ASA II, Diabetes, GSW's
Neuro: Arousable c̄ stimuli
Pain Yes/(No) Action: Will continue to monitor
CV: color good, S_1S_2 IV: PATENT, INTACT
Other: (N) AOW VIA GUERNEY c̄ SIDE RAILS ↑ X2, HOB ↑ 30°, WARM BLANKETS ON (CONT'D ON REVERSE)

NAUSEA AND VOMITING: ☒ NO ☐ YES → 1 2 3 4 5 6 TIMES

CAUDAL, SPINAL, OR EPIDURAL BLOCK
MOVEMENT PRESENT AT N/A HRS
SENSATION PRESENT AT ___ HRS

CONDITION ON TOW: ☒ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)			A	D
Able to move 4 extremities voluntarily or on command	2	Activity	2	2
Able to move 2 extremities voluntarily or on command	1			
Able to move 0 extremities voluntarily or on command	0			
Able to deep breathe and cough freely	2	Respiration	2	2
Dyspnea or limited breathing	1			
Apneic	0			
BP±20% of preanesthetic level	2	Circulation	2	2
BP±20-50% of preanesthetic level	1			
BP±50% of preanesthetic level	0			
Fully awake	2	Consciousness	1	2
Arousable on calling	1			
Not responding	0			
Pink	2	Color	2	2
Pale, dusky, blotchy, jaundiced, other	1			
Cyanotic	0			
		TOTALS	9	10

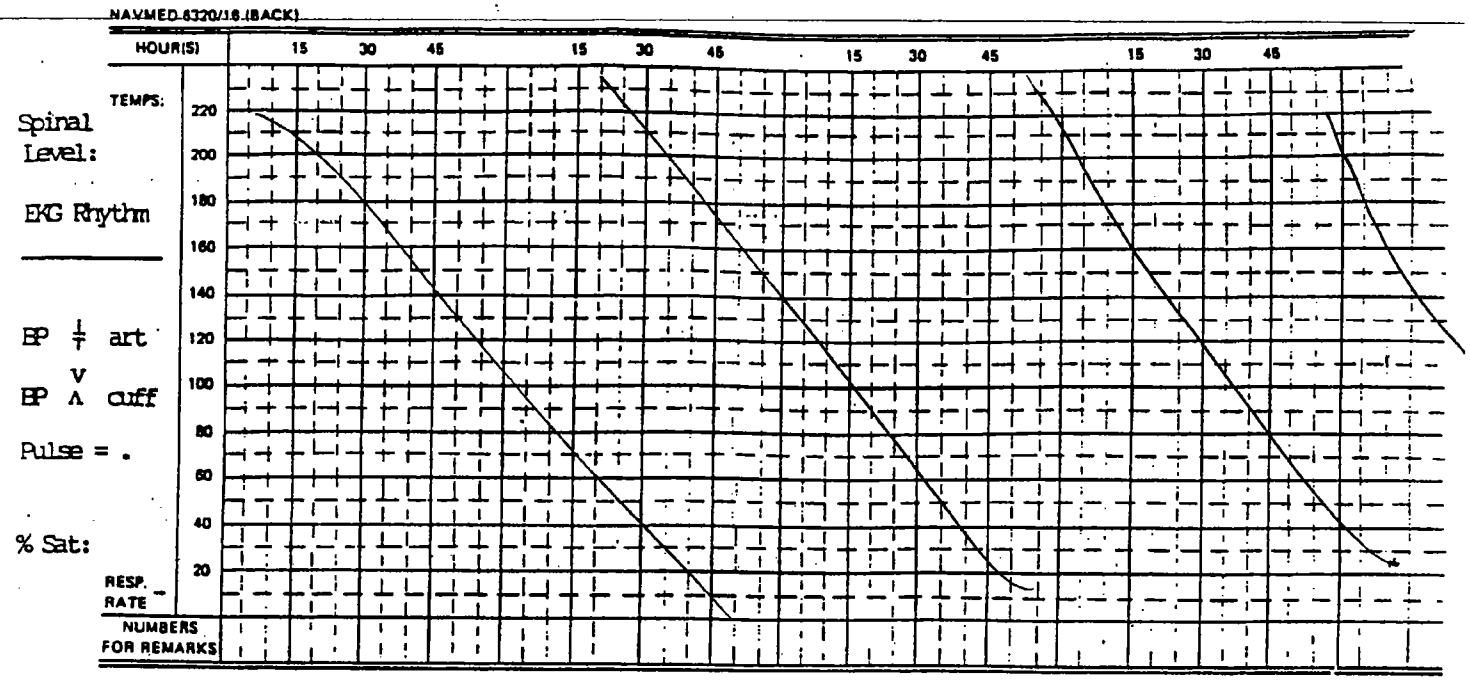
RECOVERY:
☐ COMPLICATED
☒ UNEVENTFUL

PATIENT'S IDENTIFICATION: (b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS
AOW (b)(6)-2
TOW (b)(6)-2
USN
USN (b)(6)-2

MEDCOM - 4792

NAVMED 6320/16 (BACK)



Spinal Level:

EKG Rhythm

BP ⊥ art

BP ∨ cuff

Pulse = .

% Sat:

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES (CONT'D FROM FRONT)

(2) - Resting comfortably. (3). Cond stable. Rt has met all PACU D/C criteria. Report called to 5FWD-P to CDR Baker (4) transferred to 5FWD-P via gneiss SR ↑ x2.

(b)(6)-2

TOW Note: Neuro: ALERT PT ABLE TO FOLLOW COMMANDS

Pain: (Yes)/No Action: CONTINUE TO MONITOR.

Pulmonary: CTA (B) productive cough

CV: RRR EKG Rhythm: SR IV: (R) HAND PATENT

Skin/Wound: DRESSING CDI Drainage Yes/(No) Color: Edema Yes/(No)

GI: + B.S.

GU: Foley Yes/(No) Attempted to void's success Color of urine: Due to void: 1715

Instructions/Interventions in PACU: ASK FOR PAIN MEDS PRN.

Report called to: CDR (b)(6)-2 By: (b)(6)-2 LC

TOWed to: 5FWD P By: Hm3 (b)(6)-2

ANESTHESIA RECOR

NMC #279 (12/00)

Wt (kg) - 76 Ht (in) - 170 cm .gies - NKDA

Procedure: I&D Multiple GS Ws - Closures

Ad (b)(6)-2 | LCDR/AC CRNA | Su (b)(6)-2 | At

OR # 4 | Page 1 of 2 | See Page One

Date	Anes. Start	In Room	Surg. Start	Surg. End	Resident/SRNA
4/15/03	0815	0836	0914	1028	Ø

Time	0830	X	0900	X	30	X	1000	X	30	X	1100
O_2 L/M	6-2	1	1	1	1	1	1	1	1-2	1	
N_2O Air L/M	3	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5-2	1.5	
Halo / Iso / Sevo / Des	0.8	0.7	0.7	0.6	0.6	0.6	0.6	0.6	0.6	0.6	
STP / Prop. / Etomidate	400										
Sux / Cistracurium											
Ro / Rapa / Vec / Cisatracurium	10										
Lidocaine											
Neostigmine / Glyco											
Ephedrine / Neo											
Midazolam	2										
MSO$_4$ / Remi / Su / Fentanyl	100	50		50			50				
~~Epid Lido / Bupiv / Ropiv~~											
Morphine (mg)						2			2	2	
NS LR							1000				
U/O											
EBL											

Checklist - O_2 Suction Machine Anesthesia NPO

Monitors - SaO_2 ECG FiO_2 NIBP (L) R arm; $EtCO_2$ PCS / ES PNS PIP Temp; Mass Spec Verbal TEE Fluid warmer; Air Warm Foley FHT Pulm Art cath; CVP IJ / SC / Fem L / R OG / NG L / R; A-Line Rad / Fem L / R

Position - Pressure points padded Arms < 90°; Supine Prone Lithotomy Sitting Lateral L / R

Drawn 2 Used 2 Wasted Ø Witns Ø

Drawn 250 Used 250 Wasted Ø Witns Ø

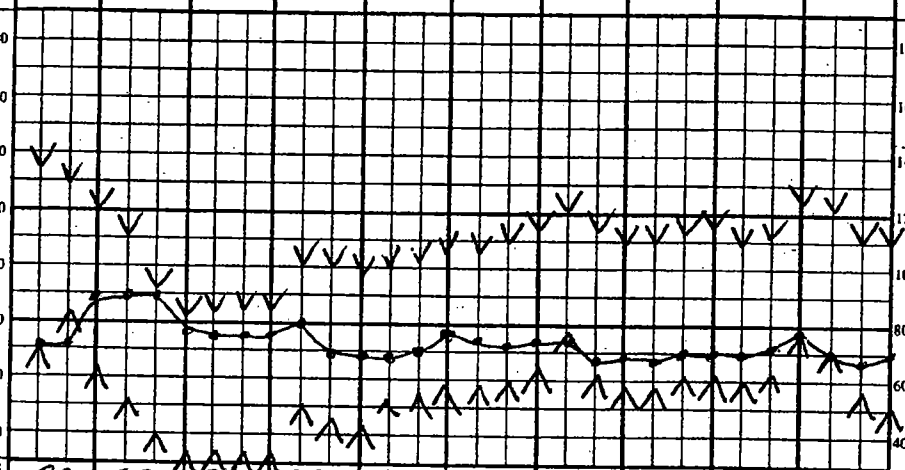
IV - 18 Ga (L) / R Hand Wrist FA AC EJ

Tourniquet mmHg Times / /

60 / 90 / 120 / 130 / 140 / 150 min - Surgeons Informed

Antibiotics: Agent - Ancef; mg. - 1 gm; over 15 minutes; @ 0850

NS LR	Total	1000
U/O	Total	700
EBL	Total	250



PACU / ~~HCU~~ 113

Pulse - 73

BP - 140/70

Temp - 96

RR - 16

SaO_2 - 100

Comps - + (-)

ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Es / Np / Or / Sk / Ax Temp	—	35.4	35.3	34.9	34.6	34.4	35.5	35.6	35.7	35.7
% FiO_2	100-50	40	37	37	39	36	36	36	50	50
% SaO_2	100	100	100	100	99	99	99	100	100	100
$EtCO_2$	+ 34	31	31	30	30	31	32	32	48	50
	Ⓥ	Ⓥ	Ⓥ	Ⓥ	Ⓥ	Ⓥ	Ⓥ	Ⓥ	Ø	Ø
TV		848	842	842	839	848	855	855	825	300
PIP (cmH$_2$O)		22	22	22	22	22	22	23	23	2
Resp. Rate		10	10	10	10	9	9	9	8	14

0930 - 0945 - Returned to (b)(6)-2

1050 Zofran 4mg IV.

1100 Continued page 2

Induction - Monitors On, Preoxygenated, Smooth. Inhalation (IV) Cricoid Pressure. Rapid Sequence. Mask ventilation easy (Y) / N

Intubation - Mac / Mil 3 Grade I view Tube Size 8.0 Attempts x1 (Oral) / Nasal L / R w/o / w/ Cuff. Stylet (Y) N Bil BS EtCO$_2$ x 3 CIN

Tube taped @ 22 cm @ lips / ~~teeth / nares~~. Trauma Y (N) FOB / LW / Bund. LMA # Ø. DLT Ø Fr L / R

Maintenance - Smooth. Cuff checked. Eyes taped / ~~lubed~~

Extubation - Smooth. ~~Reversed~~. SV / SS. Pull Tube / Head lift / Sustained tetanus. Suctioned X. Awake / Deep

Disposition - PACU / ~~HCU~~. SV / SS. Awake / Sleepy. Extubated / ~~intubated~~

Patient Identification: (b)(6)-4

Prep: ☐ Sterile Technique ☐ Disposable kit ☐ Betadine prep x 3 ☐ Local infiltration ☐ Site _____ L / R ☐ Attempts _____

Blocks: ☐ Nerve Stim _____ mA ☐ Trans-arterial ☐ Dual cuff

Regional: ☐ Spinal / Epidural ☐ Touhy / Whitacre / Quincke ☐ Needle guage _____ ☐ Sitting ☐ Lateral R / L ☐ LOR to Air / NS ☐ Paresthesia + / - ☐ Heme + / - ☐ CSF + / - ☐ Test dose ⊖ ☐ CSF ⊕ swir

Regional: ☐ Catheter out - tip intact ☐ Level _____

Lines: ☐ Seldinger Technique ☐ CVP manually transduced ☐ Cordis 9.5 / 8.5 Fr ☐ SLIC ☐ 2 / 3 - lumen

Comments / Drugs:

ANESTHESIA RECOR

NMC (12/00) | Wt (kg) - 76 | Ht (in) - 170 cm | gies - NKDA

Procedure: See Page I | Anesthesiologist: (b)(6)-2 | LEDR/NE CRNA | Surgeon: (b)(6)-2 | OR # 4 | See Page One

Date: 4/15/03 | Anes. Start | In Room | Surg. Start | Surg. End | Anes. End | Resident/SRNA | Page 2 of 2

Time	1100	X	30	X	1200	X	30	X	1300	X	30
O_2 L/M	1	1									
N_2O / Air L/M	1.5	2X									
Isoflu Halo / Iso / Sevo / Des	0.5	2X									
STP / Prop. / Etomidate											
Sux / Cistracurium											
Ro / Rapa / Ve curonium											
Lidocaine											
Neostigmine / Glyco											
Ephedrine / Neo											
Midazolam											
MSO_4 / Remi / Su / fentanyl											
Epid. Lido / Bupiv / Ropiv											
mg Morphine	2	2									
NS / LR											
U/O		1200									
EBL		<50									
ECG	SR	SR									
Es / Np / Ex / Sk / Ax Temp	35.6	3									
% FiO_2	36	34									
% SaO_2	100	100									
$EtCO_2$	46	44									
	0	0									
TV	420	534									
PIP (cmH_2O)	2										
Resp. Rate	16	13									

● = Pulse
○ = Spont. Resp.
Ø = Asst. Resp.
Ⓥ = Ventilator
X = MAP
∧ / V = NIBP
⊥ / T = A-Line
I = Intubate
E = Extubate

PACU / ICU
Pulse -
BP -
Temp -
RR
SaO2
Comps - + / -

See Page 4

Checklist - ☐ O_2 ☐ Suction ☐ Machine ☑ Consent ☐ NPO

Monitors - ☐ SaO_2 ☐ ECG ☐ FiO_2 ☐ NIBP L / R arm ☐ $EtCO_2$ ☐ PCS / ES ☐ PNS ☐ PIP ☐ Temp ☐ Mass Spec ☐ Verbal ☐ TEE ☐ Fluid warmer ☐ Air Warm ☐ Foley ☐ FHT ☐ Pulm Art cath ☐ CVP IJ / SC / Fem L / R ☐ OG / NG L / R ☐ A-Line Rad / Fem L / R

Position - ☐ Pressure points padded ☐ Arms < 90°
Supine Prone Lithotomy Sitting Lateral L / R

Drawn____ Used____ Wasted____ Witns____
Drawn____ Used____ Wasted____ Witns____

IV - ____Ga L / R Hand Wrist FA AC EJ
☐ Tourniquet ____mmHg Time I____ I____
60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

	Antibiotics
Total	Agent -
Total	mg -
Total	over minutes
Total	@

1114 LUNCH RELIEF BY CRNA (b)(6)-2 CRNA

1130 TOT 4/4, +ST. GOOD SV
XT ON PPV, PO
RETURN TO CSR (b)(6)-2 (b)(6)-2

Induction - Monitors On | Preoxygenated | Smooth | Inhalation / IV | Cricoid Pressure | Rapid Sequence | Mask ventilation easy Y / N
Intubation - Mac / Mil ____ | Grade ____ view | Tube Size ____ | Attempts ____ | Oral / Nasal L / R w/o w/ Cuff | Stylet Y / N | Bil BS / $EtCO_2$ x 3 / CIN
Tube taped @ ____ cm @ lips / teeth / nares | Trauma Y / N | FOB / LW / Blind | LMA# ____ | DLT ____ Fr L / R
Maintenance - Smooth | Cuff checked | Eyes taped / lubed
Extubation - Smooth | Reversed | SV VSS | Full T4 / Head lift / Sustained tetanus | Suctioned | Awake / Deep
Disposition - PACU / ICU | SV VSS | Awake / sleepy | Extubated / intubated

See Page 1

Prep
☐ Sterile Technique
☐ Disposable kit
☐ Betadine prep x 3
☐ Local infiltration
☐ Site ____ L / R
☐ Attempts ____

Blocks
☐ Nerve Stim ____ mA
☐ Trans-arterial
☐ Dual cuff

Regional
☐ Spinal / Epidural
☐ Touhy / Whitacre / Quincke
☐ Needle guage ____
☐ Sitting
☐ Lateral R / L
☐ LOR in Air / NS
☐ Paresthesia + / -
☐ Heme + / -
☐ CSF + / -
☐ Test dose ⊕
☐ CSF ⊕

Regional
☐ Catheter out - tip intact
☐ Level ____

Lines
☐ Seldinger Technique
☐ CVP manually transduced
☐ Cordis 9.3 / 8.5 Fr
☐ SLIC
☐ 2 / 3 - lumen

Comments / Drugs:

Patient Identification
(b)(6)-4

ANESTHESIA RECOR

NMC 279(12/00)

Wt (kg) - 75 Ht (in) - 170cm gies - Ø

Procedure	Anesthesiologist/CRNA Signature	Surgeon	OR #
I+D (B) thigh wounds	(b)(6)-2 LCDR (b)(6)-2 MD	(b)(6)-2	5

Date	Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	Resident/SRNA	Page
4/17/03	0810	0821	0835	0940/0949	0958		1 of 1

See Page One

Time	0815	0830	0900	0930	1000
O_2 L/M	2	2	2	2	2
N_2O / Air L/M	4	4	X	2	2
Halo / Iso / Sevo / Des	4	4	4	2	2
STP / Prop. / Etomidate					
Sux / Cistracurium					
Ro / Rapa / Vecuronium					
Lidocaine					
Neostigmine / Glyco					
Ephedrine / Neo					
Midazolam	3 2				
MSO_4 / Reml / Su (Ventam)	50/50/50/50/50				
Epid. Lido / Bupiv / Ropiv					
MSO4 (mg)			5	5	5 5
NS / LR	700		500	1000	1300
U/O					
EBL					

Checklist - ☒ O_2 ☒ Suction ☒ Machine ☐ Consent ☐ NPO

Monitors - ☒ SaO_2 ☒ ECG ☒ FiO_2 ☒ NIBP (L) R arm ☒ $EtCO_2$ ☐ PCS / ES ☐ PNS ☐ PIP ☒ Temp ☒ Mass Spec ☐ Verbal ☐ TEE ☐ Fluid warmer ☐ Air Warm ☐ Foley ☐ FHT ☐ Pulm Art cath ☐ CVP IJ / SC / Fem L / R ☐ OG / NG L / R ☐ A-Line Rad / Fem L / R

Position - ☒ Pressure points padded ☒ Arms < 90° (Supine) Prone Lithotomy Sitting Lateral L / R

Drawn 5 Used 5 Wasted Ø Witns ____

Drawn 250 Used 250 Wasted Ø Witns ____

IV - 18 Ga (L) R Hand (D) Wrist (FA) AC EJ

☐ Tourniquet ____ mmHg Times I ____ I ____

60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

	Antibiotics
Total	Agent -
Total	mg
Total	over minutes
Total	@

● = Pulse
○ = Spont. Resp.
Ø = Asst. Resp.
(V) = Ventilator
X = MAP
Λ / V = NIBP
⊥ / T = A-Line
I = Intubate
E = Extubate

PACU / ICU
Pulse - 77
BP - 119/62
Temp - 96.8
RR - 16
SaO_2 - 100%
Comps - + / -

Time	0815	0830	0900	0930	1000
ECG	SR	SR	SR	SR	SR
Ts / Np / Or / Sk / Ax Temp			36.0	36.2	36.3
% FiO_2	RA/30	50	50/100/50	50	50
% SaO_2	99	100	100	100	100
$EtCO_2$	40	45	52	49	49 47
TV		760	420	440	460 485
PIP (cmH_2O)	SV	SV	SV	SV	SV SV
Resp. Rate	22	19	16	19	19 13

Has 18G HL (D) hand. Poor flow.

18G IV started (O) FA ⊽ induction.

Induction - Monitors On Preoxygenated Smooth Inhalation / IV Cricoid Pressure Rapid Sequence Mask ventilation easy Y (N) Full beard

Intubation - Mac / Mil ____ Grade ____ view Tube Size ____ Attempts ____ Oral / Nasal L / R w/o w/ Cuff Stylet Y / N Bil BS / $EtCO_2$ x 3 / CIN

Tube taped @ ____ cm @ lips / teeth / gums Trauma Y / N FOB / LW / Blind LMA # 5 DLT ____ Fr L / R

Maintenance - Smooth Cuff checked Eyes taped / lubed

Extubation - Smooth Reversed SV VSS Full T4 / Head lift / Sustained tetanus Suctioned Awake / Deep

Disposition - PACU / ICU SV VSS Awake / sleepy Extubated / intubated

Patient Identification

(b)(6)-4

Prep	Regional	Regional	Comments / Drugs:
☐ Sterile Technique	☐ Spinal / Epidural	☐ Catheter out - tip intact	
☐ Disposable kit	☐ Touhy / Whitacre / Quincke	☐ Level ____	
☐ Betadine prep x 3	☐ Needle guage ____		
☐ Local infiltration	☐ Sitting	Lines	
☐ Site ____ L / R	☐ Lateral R / L	☐ Seldinger Technique	
☐ Attempts ____	☐ LOR to Air / NS	☐ CVP manually transduced	
Blocks	☐ Paresthesia + / -	☐ Cordis 9.5 / 8.5 Fr	
☐ Nerve Stim ____ mA	☐ Heme + / -	☐ SLIC	
☐ Trans-arterial	☐ CSF + / -	☐ 2 / 3 - lumen	
☐ Dual cuff	☐ Test dose ⊖		
	☐ CSF ⊕ swirl		

ANESTHESIA RECORD

ANMC 279(12/00) | W) - | Ht (in) - | gies -

Procedure: I&D (1) Hip Removal FB

Anesthesiologist: (b)(6)-2 | Surgeon: (b)(6)-2 | OR # 9 | Page 1 of 1 | See Page One

Date	Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	Resident/SRNA
01/20/03	1215	1230	1300	1340	1347	

Time: 1230 + (3) + 30 + (4)

O_2 L/M	10	0.5	0.5	0.5	1	1.0				
N_2O / Air L/M	1	0.1	0.5	0.5	1	1.5				
Halo / Iso / Sevo / Des		0.5	0.5	0.5	0.8	0.5				
STP / Prop. / Etomidate	150									
Succ / Cisatracurium	100									
Ro / Rapa / Ve curonium										
Lidocaine										
Neostigmine / Glyco										
Ephedrine / Neo										
Midazolam										
MSO4 / Remi / Su / fentanyl	250	250	50							
Epid. Lido / Bupiv / Ropiv										
Morphine				5/5						
NS / LR				1000						
I/O					D5	100				
EBL										

Checklist - ☑ O_2 ☐ Suction ☑ Machine ☑ Consent ☐ NPO

Monitors - ☑ SaO_2 ☑ ECG ☑ FiO_2 ☑ NIBP ☑ L / R arm ☑ $EtCO_2$ ☐ PCS / ES ☐ PNS ☑ PIP ☐ Temp ☐ Mass Spec ☐ Verbal ☐ TEE ☐ Fluid warmer ☑ Air Warm ☐ Foley ☐ FHT ☐ Pulm Art cath ☐ CVP IJ / SC / Fem L / R ☐ OG / NG L / R ☐ A-Line Rad / Fem L / R

Position - ☑ Pressure points padded ☑ Arms < 90° Supine Prone Lithotomy Sitting Lateral L / R

Drawn 470 Used ____ Wasted ____ Witns ____

Drawn 500 Used 500 Wasted 0 Witns 0

IV - ____ Ga L / R Hand Wrist FA AC EJ

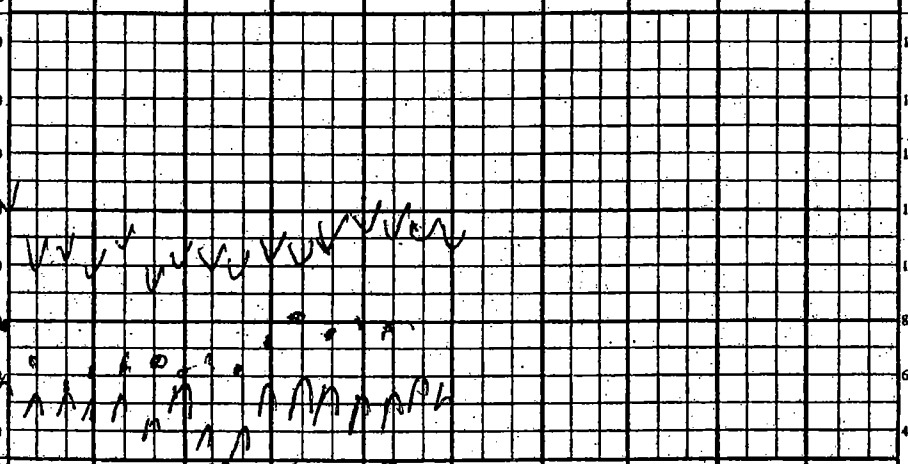
☐ Tourniquet ____ mmHg Times 1 ____ 1 ____

60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

		Antibiotics
CA	Total	Agent - Prim - X
NS 1000	Total	mg 500 mg
LR 1000	Total	over 45 minutes
EBL 20 cc	Total	@ 1215

● = Pulse
○ = Spont. Resp.
⊘ = Asst. Resp.
Ⓥ = Ventilator
X = MAP
∧ / V = NIBP
⊥ / T = A-Line
I = Intubate
E = Extubate

PACU / ICU
Pulse - 94
BP - 137
Temp - 98.1/98.3
RR - 16
SaO_2 - 99
Comps - + / -



ECG	SR	SR	SR	SR	SR
s / Np / Or / Sk / Ax Temp	37.9	37.9	37.7	37.5	37.6
% FiO_2	90 55	55	55	55	55
% SaO_2	100	100	100	100	10
$EtCO_2$	40	40	40	45	45
	0	0	0	5V	5V
TV	500	550	550		
PIP (cmH2O)	20	24	24		
Resp. Rate	10	10	10		

Procedure #2 Dig & BILE

1347 PT TO PACU, VSS Report to RN

Induction - Monitors On Preoxygenated Smooth Inhalation / IV Cricoid Pressure Rapid Sequence Mask ventilation easy Y / N

Intubation Mac / Mil 4 Grade 1 view Tube Size 8.0 Attempts 1 Oral / Nasal L / R w/o w/ Cuff Stylet Y / N BilBS / $EtCO_2$ x 3 / CIN

Tube taped @ 22 cm @ lips teeth / nares Trauma Y / N FOB / LW / Blind LMA # ____ DLT ____ Fr L / R

Maintenance - Smooth Cuff checked Eyes taped / lubed

Extubation Smooth Reversed SV VSS Full T4 / Head lift / Sustained tetanus Suctioned Awake / Deep

Disposition PACU / ICU SV VSS Awake / sleepy Extubated / intubated

Patient Identification (b)(6)-4

Prep	Regional	Regional	Comments / Drugs:
☐ Sterile Technique	☐ Spinal / Epidural	☐ Catheter out - tip intact	
☐ Disposable kit	☐ Touhy / Whitacre / Quincke	☐ Level ____	
☐ Betadine prep x 3	☐ Needle guage ____		
☐ Local infiltration	☐ Sitting	Lines	
☐ Site ____ L / R	☐ Lateral R / L	☐ Seldinger Technique	
☐ Attempts ____	☐ LOR to Air / NS	☐ CVP manually transduced	
Blocks	☐ Paresthesia + / -	☐ Cordis 9.5 / 8.5 Fr	
☐ Nerve Stim ____ mA	☐ Heme + / -	☐ SLIC	
☐ Trans-arterial	☐ CSF + / -	☐ 2 / 3 - lumen	
☐ Dual cuff	☐ Test dose ⊖		
	☐ CSF ⊕ swir		

ANESTHESIA RECOR

NMC 279(12/00)

Wt (kg) - 69 Ht (in) - .gies - NKDA

Procedure	Anesthesiologist/CRNA Signature	Surgeon	OR #
Delay Closure	(b)(6)-2	(b)(6)-2	9

Date	Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	Resident/SRNA	Page
4/23/03	1300	1315	1318	1425	1435		1 of 1

See Page One

Time	1315	1330	1400		x	1500	x
O_2 L/M	10/.7	.7	.7	.7	10		
N_2O / Air L/M	2	2	2	2	X		
Halo / Iso / Sevo / Des	.8	.7	.6	.5	X		
KET	150						
STP / Prop. / Etomidate							
Sux / Cistracurium	100						
Ro / Rapa / Ve curonium							
Lidocaine							
Neostigmine / Glyco							
Ephedrine / Neo							
Midazolam							
MSO_4 / Remi / Su / Entany	100/150		(2)				
Epid. Lido / Bupiv / Ropiv							
NS / LR		200		300	350		
U/O							
EBL				10	12		

Checklist - ☑ O_2 ☑ Suction ☑ Machine ☐ Consent ☑ NPO

Monitors - ☑ SaO_2 ☑ ECG ☑ FiO_2 ☑ NIBP L / R arm ☑ $EtCO_2$ ☐ PCS / ES ☐ PNS ☑ PIP ☑ Temp ☐ Mass Spec ☐ Verbal ☐ TEE ☐ Fluid warmer ☑ Air Warm ☐ Foley ☐ FHT ☐ Pulm Art cath ☐ CVP IJ / SC / Fem L / R ☐ OG / NG L / R ☐ A-Line Rad / Fem L / R

Position - ☑ Pressure points padded ☑ Arms < 90° Supine Prone Lithotomy Sitting Lateral L / R

Drawn 10 Used 2 Wasted 8 Witns MEO

Drawn 250 Used 250 Wasted 0 Witns MC

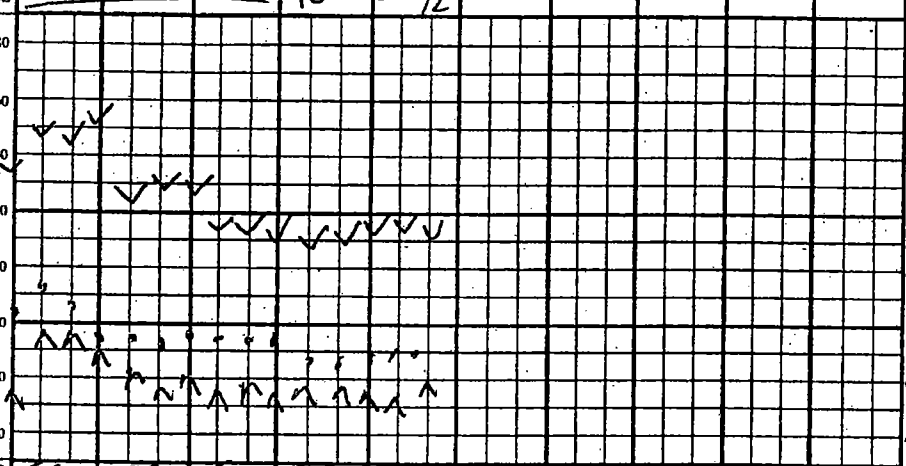
IV - ____ Ga L / R Hand Wrist FA AC EJ

☐ Tourniquet ____ mmHg Times 1 ____ 1 ____

60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

Antibiotics
Agent - Primaxin
mg - 500
over 30 minutes
@ 1315

● = Pulse
○ = Spont. Resp.
Ø = Asst. Resp.
Ⓥ = Ventilator
X = MAP
Λ / V = NIBP
⊥ / T = A-Line
I = Intubate
E = Extubate



PACU / ICU
Pulse - 95
BP - 165/95
Temp -
RR -
SaO_2 - 99
Comps - + / -

ECG	SR	SR	SR	SR	SR
Es / Np / Or / Sk / Ax Temp		358	36	36	36
% FiO_2	100	28	28	28	100
% SaO_2	100	98	98	97	100
$EtCO_2$	+	36	35	34	35
TV		635	CV	635	S/V
PIP (cmH_2O)	S/A	18		18	
Resp. Rate		12		12	

Induction - Monitors On Preoxygenated Smooth Inhalation / IV Cricoid Pressure Rapid Sequence Mask ventilation easy Y / N

Intubation - Mac / Mil 4 Grade 2 view Tube Size 8 Attempts 1 Oral / Nasal L / R w/o w/ Cuff Stylet Y / N Bil BS / $EtCO_2$ x 3 / CIN

Tube taped @ 22 cm @ lips / teeth / nares Trauma Y / N FOB / LW / Blind LMA # ____ DLT ____ Fr L / R

Maintenance - Smooth Cuff checked Eyes taped / lubed

Extubation - Smooth Reversed SV VSS Full T4 / Head lift / Sustained tetanus Suctioned Awake / Deep

Disposition - PACU / ICU SV VSS Awake / sleepy Extubated / intubated

Patient Identification

(b)(6)-4

Prep
☐ Sterile Technique
☐ Disposable kit
☐ Betadine prep x 3
☐ Local infiltration
☐ Site ____ L / R
☐ Attempts ____

Blocks
☐ Nerve Stim ____ mA
☐ Trans-arterial
☐ Dual cuff

Regional
☐ Spinal / Epidural
☐ Touhy / Whitacre / Quincke
☐ Needle guage ____
☐ Sitting
☐ Lateral R / L
☐ LOR to Air / NS
☐ Paresthesia + / -
☐ Heme + / -
☐ CSF + / -
☐ Test dose ⊖
☐ CSF ⊕ swirl

Regional
☐ Catheter out - tip intact
☐ Level ____

Lines
☐ Seldinger Technique
☐ CVP manually transduced
☐ Cordis 9.5 / 8.5 Fr
☐ SLIC
☐ 2 / 3 - lumen

Comments / Drugs:

23APR03

		1430	1445	1500	1515	1545						
EXTREMITY	(R) LOWER EXTREMITY	(b)(6)-2										
PAIN	pain											
	MILD											
	MODERATE											
	SEVERE											
SENSATION (Sensation)	NORMAL											
	NUMBNESS											
	TINGLING	(b)(6)-2										
	ABSENT											
BLANCHING Blanching (S - Normal; S - Sluggish)		(b)(6)-2										
ACTIVE MOTOR FUNCTION	NORMAL	(b)(6)-2										
	LIMITED											
	ABSENT											
SIGNS OF COMPARTMENT SYNDROME	PAIN ON PASSIVE MOTION											
	PAIN UNRELIEVED BY ANALGESICS											
COLOR COLOR	RED											
	PINK											
	PALE	(b)(6)-2										
	BLUE											
SKIN TEMPERATURE (SKIN TEMP)	HOT											
	WARM											
	COOL	(b)(6)-2										
	COLD											
PULSE SITE (PULSE) DORSALIS PEDIS	NORMAL	(b)(6)-2										
	WEAK											
	ABSENT											
EDEMA SITE (EDEMA)	NONE	(b)(6)-2										
	SMALL											
	MODERATE											
	LARGE											

COMMENTS

INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE
(b)(6)-2	HM				