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

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

Date: 20 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			12							14							16							
TEMP			97.4							99.5							100					98.9		
SAO2																	99							
MAP																								
O2 Mode																								
																	148/70							
																	92							

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	TOTAL
FOLEY					500																					
UOP							120													200				200		
BM						X																				

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5101

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

NURSING [redacted] W SHEET
MEDTREFAC 2/Temp Form

Date: 19APR03 [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										12							14			12				
TEMP		99.1								97.5							100.2			99.3				
SAO2		97%															99			99.3				
MAP																								
O2 Mode																								
										130/74							144/78			130/72				
																	95							

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	TOTAL
FOLEY																										
UOP																	500				350			475		
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5103

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

NURSING [redacted]W SHEET
MEDTREFAC 2/Temp Form

Date: 18 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																								

	16	23
RR	18	18
TEMP	99.9	101.6
SAO2		97
MAP		
O2 Mode		
	80/62	108/68
		105

	04
SAO2	98.2

DRIP/DOSE

Name: (b)(6)-4

NURSING FLOW SHEET

MEDTREFAC 6550/12/Temp Form

Date: 18 APR 05

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		V																						
80																								
60																								
40																								
RR																								
TEMP																								
SAO2																								
MAP																								
O2 Mode		17/8																						

DRIP/DOSE

3/23 1/3 START 1626 Before Blood Vitals Q5x3 Q15x2 Q

FREQ. VITAL SIGNS post Vitals 2 2hr 2/2

TIME	1764	1831	1836	1841	1856	1911	2011	2111	2205						
BP	122/64	122/60	124/60	126/60	123/64	118/50	126/60	122/64	126/64						
HR	112	104	96	100	100	92	92	86	120						
RR	24	24	20	20	20	20	18	20	20						
TEMP	100.4	100.3	100.5	100.3	100.4	100.1	99.7	99.1	99.6						
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	TOTA
PO																										
IVPB																										

MEDCOM - 5106

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												300					300								
UOP												~~350~~													
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: 4/14/2003

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
200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								

RR																								
TEMP		99.2															14							
SAO2		98								105.8							99.7							
MAP																	98							
O2 Mode																								
B8		110/100																						
																	100/70							
																	88							

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	TOTA
PO																										
IVPB																										

MEDCOM - 5108

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																			425							
UOP				200																						
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

Nam (b)(6)-4

NURSING FLOW SHEET

MEDTREFAC 6550/12/Temp Form

Date: 10APR03

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					22					18												
TEMP		99.3					100.0					100.7						99.3						
SAO2	96						97%					96						99						
MAP																								
O2 Mode																								
B/P		118/61					124/66											130/60						
HR																		91						

DRIP/DOSE

MEDCOM - 5109

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	TOTA
PO																										
IVPB																										

MEDCOM - 5110

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						680							300	
UOP				575																						
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: 15APR03

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		12					14					16					16							
TEMP		98.9					100.4					101.5					101.7			100.7				
SAO2																	99			96				
MAP																								
O2 Mode																								
BP		145/77													132/61		156/70			129/60				
																	107			102				

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																				500						

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																										
UOP							1800c									1500										
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5112

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

NURSING [redacted] W S[redacted]ET
MEDTREFAC-6550/12/Temp Form

Date: 14 APR [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		18				14						16		16	18			20						
TEMP		100.1				99.0						99.4						99.1						
SAO2																		99						
MAP																								
O2 Mode																								
BP		100/60				130/60						100/70												

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						1000											1000									
UOP																										
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5114

Name: (b)(6)-4

NURSING FLOW SHEET
MEDTREPAC 4430/12/Temp Form

Date: 13 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		24				22						28												
TEMP		101.2				99.3									99.2									
SAO2		97%																						
MAP																								
O2 Mode																								
BP		130/46				136								140/64										

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	TOTAL
FOLEY																										
UOP														800												
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5116

Name: (b)(6)-4

NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Date: 12 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		20				18				16		18				20								
TEMP		100.4				99.3				99.6														
SAO2		99				99				99														
MAP																								
O2 Mode																								
BP		144/74				130/66				130/68														

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	TOTA
FOLEY																										
UOP																	100						900			
BM																										
Hemovac																	10									

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5118

Name: (b)(6)-4

NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Date: 11 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									92															
60																								
40																								

RR									14				16			16	18							
TEMP									98.8			101.7	100.9			102.6	101.9							
SAO2									96				96			97	22 30							
MAP																								
O2 Mode																								
B/P									132/80			132/92	118/68			137/60	132/60							120/80

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	TOTA
PO																										
IVPB	200																									

MEDCOM - 5120

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														350												
UOP						400				120																
BM																										
JP																1Dcc										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

(b)(6)-4

10 April 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
CUFF / AL / HR 200																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR		20					20				20													19
TEMP		98.7					98.3				[illegible]													99.3
SAO2		98									98													98
MAP																								
O2 Mode																								
BP		104/60					113/48																	130/60
							96																	

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	TOTA
PO																										
IVPB																										
IV								900					900		400											

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			120					350					470													
UOP																										
BM																										
JP										30cc																

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5122

Name: (b)(6)-4

NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Date: 9 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		12								16							18							
TEMP		98.7								100.3							100.7			99.4				
SAO2		97					98										99%							
MAP																								
O2 Mode																								
BP		103/48															112/64							

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	TOTA
PO																										
IVPB																										
																									500	

MEDCOM - 5124

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	TO
FOLEY																										
UOP																										
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR OUTPUT PRESENT WEIGHT

(b)(6)-4

Q4

9 APR 03

CUFF

AL

HR

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																			12					12
TEMP	96.4																		98.2					97.6
SAO2																			96	98				96
MAP																								
O2 Mode																								
BP:																			120/80					120/76

DRIP/DOSE

0700-1900	Time:	Signature:

NEUROLOGICAL

Level of Consciousness
Oriented to: Person ✓ Place ✓ Time ✓
Responds to: Verbal ✓ Pain ___ Unresponsive
Pupils R / L
Size / Reaction: ___ / ___ / ___ / ___
Motor Strength S = Strong W = Weak TR = Trace A = Absent
Extremities: Upper L S R S; Lower L W R W
☐ See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial	+	+
Femoral			Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent
Rhythm: ___ Ectopy: ___
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: ___
☐ See Narrative

RESPIRATORY

Breath Sounds: ✓ Clear ✓ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: N/A
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: Normal Exam
Auscultation: Normal Exam
Palpation: - Masses found
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard
Diet: ___
Tubes / Bags / Suction / Drainage:
@ bowel sounds
☐ See Narrative ☐ NGT Placement

GU

☒ Void Urine: Color / Character
Straw cloudy
Catheter: —
Other:
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture

Incisions / Dressings / Leisions / Dermal Ulcers
~~bilateral~~ GSW x3 to bilateral lower extremity
☐ See Narrative 7 wounds (open)

0710 Assumed care of Pt. Pt Alert and Oriented x 3. VSS No complaints voiced at this time. PERRLA Lungs CTA Abdominal EXAM Normal Pt received W/D Dressing x 3 and bacitracin and clean gauze to Penis/~~bear~~ head. Pt tolorated procedure well. (b)(6)-2
~~0430 Pt IV infiltrated, Entered in R Hand IV infusing well Ancef bags~~ (b)(6)-2
0800 Ancef infused (b)(6)-2
0905 Pt c/o pain Nurse notified (b)(6)-2
0910 Pt refused Chow (b)(6)-2
0931 - Consult & Notes from ~~HM3~~ HM3 (b)(6)-2 (b)(6)-2
0935 - Keep IV @ KVO (b)(6)-2
1250 - Pt refused Chow or oral fluids IV remains to be removed once tolerating P.O will continue to Monitor (b)(6)-2
1500 Rounds MBR ASLEEP AT THIS TIME IVF's infusing J difficulty LR @ KVO in LFA NO S/S of infiltration ~~Pt vac~~ Will continue to monitor this Pt (b)(6)-2
1500 Pt rolled on back from left side Per MD order (Position Pt q2 hrs)
1525 1600 Dressing Δ not done Δ due to Surgeon completing task earlier today (b)(6)-2

ΓE WARD - 24 HOUR FLOW SHEET

18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
		148/44				136/86						
		204										
		(b)(6)-2 78				81 18						
		98.6										

200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20

Temp

18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
						600						
				500					400		800	

glabellar tap or loud auditory stimulus

6 - No response to light glabellar tap or loud auditory stimulus

it glabellar tap or loud auditory stimulus

1900-0700 | Time: 1900 | Signature: [redacted] (b)(6)-2

NEUROLOGICAL

Level of Consciousness

Oriented to: Person ✓ Place ✓ Time ✓

Responds to: Verbal ✓ Pain ___ Unresponsive ___

Pupils R / L

Size / 3 / 4 | 3 / 4

Motor Strength Extremities:

S = Strong
W = Weak
TR = Trace
A = Absent

	L	R
Upper	5	5
Lower	w	w

☐ See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	4	+	Posterior Tibial	+	+
Femoral			Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: RSR Ectopy: 0

Murmur: ___ Rub: ___ S1: ___ S2: ___

Neck Veins: ___

Edema: ___

☐ See Narrative

RESPIRATORY

Breath Sounds: ☑ Clear ☑ Bilat

Location:

Crackles /Rales: ___ Dim: ___

Wheezes: ___ Absent: ___

Rhonchi: ___

Cough: Productive / Unproductive: ___

Sputum: Color and Character: ___

Tubes: ☐ ET ☐ Trach

Size: ___ Location: ___

O2: ☐ Canula ☐ Mask

Chest Tubes: ___

☐ See Narrative

GASTROINTESTINAL

Observation: FLAT

Auscultation: BS x4 faint

Palpation: soft

Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard

Tubes / Bags / Suction / Drainage:

Plantis c abrasion (wound to glass, red/pink c bacitracin applied (b)(6)-2

☐ See Narrative ☐ NGT Placement

GU

☒ Void Urine: Color / Character yellow

Catheter: ___

Other: ___

☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture

Incisions / Dressings / Leisions / Dermal Ulcers

6 W x 3 Lower extremity bilat

☐ See Narrative

Pt assessed case OPPT, see secondary assessment

1700 Comfort c assessment c s/s as noted. Dressing to R upper leg c gauze over drainage, pulse bed c through dressing c drainage on dressing. Pt reports pain medication c tylenol c 1930 p medication c 1910 drug A to left thigh, wounds pink c edema present/serosanguinous drainage. Pt c urinating @ intake (b)(6)-2

(b)(3)-1

Addressograph:

(b)(6)-4

4/5

Date:

Allergies

Diagnosis

Age:

DOB:

SIGNATURE

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

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

(b)(6)-2

	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17.
	0650					1207					
SpO2	18					18					
Respirations											
Temp	98.7					98.9					

IV'S	ANCEF		100								8
	LR @ KVO									300	~~300~~
	Gent				100						100
INTAKE	PO										
	NG/TF										
	Other										
	Cummulative Intake		100		200					500	600
OUTPUT	Urine Volume	300	200	200		175	200	75	250		250
	Emesis										
	NG Residual/sump										
	Bowel Movement										
	OTHER										
	Cummulative Output	300	500	700		875	1075	1150	1400		1650

RAMSEY SEDATION SCALE:

1 - Pt. Anxious and irritated or restless

2 - Cooperative, oriented and tranquil

3 - Responds to commands only

4 - Brisk response to

5 - Sluggish response t

PAIN	Medicated										
	Dose / Route										
	Intensity (1-10) Pre / Post Med										
	Sedation Scale										
Nursing care	BATH PARTIAL/COMPLETE										
	ACTIVITY(Turn L, R, B, ch, amb)										
	IV Site CDI? Q2 hrs										
	IV Site CDI? Q2 hrs										
	TCBD										
	Wound care										
Miscellaneous											

0300-1500

0700-1900 | Time: | Signature:

Shift Δ

NEUROLOGICAL

Level of Consciousness
Oriented to: Person / Place / Time /
Responds to: Verbal / Pain ___ Unresponsive
Pupils R L
Size / Reaction: / /
Motor Strength S = Strong W = Weak TR = Trace A = Absent
Extremities: Upper L S R S; Lower L S R W
☐ See Narrative

CARDIOVASCULAR

Pulses R L
Radial + + Posterior Tibial
Femoral Dorsalis Pedis + +
+ = Normal - = Weak 0 = Absent
Rhythm: ___ Ectopy: ___
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: ___
☐ See Narrative

RESPIRATORY

Breath Sounds: ✓ Clear ✓ Bilat
Location:
Crackles / Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: ___
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: WNL
Auscultation: WNL
Palpation: WNL
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard
Diet: ___
Tubes / Bags / Suction / Drainage:
N/A
☐ See Narrative ☐ NGT Placement

GU

☐ Void Urine: Color / Character
Catheter: foley Dark amber
Other:
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
Warm to touch normal color Ⓞ moisture
Incisions / Dressings / Leisions / Dermal Ulcers
W-D Dressing x 5 intact
☐ See Narrative

0330 Assumed care of pt [redacted] (b)(6)-2
0341 - Pt c/o pain. IV infiltrated. Attempted twice
IV pt fore arm bad flash vein blew. HN [redacted] (b)(6)-2
attempted x 3 left arm good flash vein blew HM3
[redacted] (b)(6)-2 Attempt x 1 IV success Hills. Morphine 8mg
pushed by HM3 [redacted] (b)(6)-2 under Nurse watch. Axes
started. Will continue to monitor [redacted] (b)(6)-2 LPN
LATE ENTRY
0730 Am assessment Pt A&O x 3 Ⓞ steady
pulse. Cap refill > 3sec in both fingers and
toes Pt resting peacefully refused chow
will continue to montor [redacted] (b)(6)-2
0905 PT TO BE DIC [redacted] (b)(6)-2
0915 Pt left ward via gurney for
Medevac [redacted] (b)(6)-2

(b)(3)-1

Addressograph:

(b)(6)-4

Date: 8 Apr 03

Allergies

Diagnosis

Age:

DOB:

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

04 05 06 07 08

	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00	17
SpO2											
Respirations					RV						
200											
190											
180											
170											
160											
150											
140											
130											
120											
110											
100											
90											
80											
70											
60											
50											
40											
30											
20											
Temp					96.6						

		7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
IV'S											
INTAKE	PO										
	NG/TF										
	Other										
	Cummulative Intake										
OUTPUT	Urine Volume										
	Emesis										
	NG Residual/sump										
	Bowel Movement										
	OTHER										
	Cummulative Output										

RAMSEY SEDATION SCALE:

1 - Pt. Anxious and irritated or restless

2 - Cooperative, oriented and tranquil

3 - Responds to commands only

4 - Brisk response to

5 - Sluggish response t

		7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
PAIN	Medicated										
	Dose / Route										
	Intensity (1-10) Pre / Post Med										
	Sedation Scale										
Nursing care	BATH PARTIAL/COMPLETE										
	ACTIVITY(Turn L, R, B, ch, amb)			--							
	IV Site CDI? Q2 hrs										
	IV Site CDI? Q2 hrs										
	TCBD										
	Wound care										
Miscellaneous											

0300-1500

Shift Δ

~~0700-1900~~ Time: Signature:

NEUROLOGICAL

Level of Consciousness
Oriented to: Person ✓ Place ✓ Time ✓
Responds to: Verbal ✓ Pain ___ Unresponsive

Pupils R / L
Size / Reaction: ___ / ___ / ___ / ___

Motor Strength S = Strong W = Weak TR = Trace A = Absent

Extremities:	L	R
Upper	S	S
Lower	S	W

☐ See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial	+	+
Femoral			Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: ___ Ectopy: ___
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: ___
☐ See Narrative

RESPIRATORY

Breath Sounds: ✓ Clear ✓ Bilat
Location: CTA
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: P
Sputum: Color and Character: whit thick
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: WNL
Auscultation: (+) Bowel sounds x 4
Palpation: Soft pain to palpation
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard
Diet: REG
Tubes / Bags / Suction / Drainage:
No Tubes etc
☐ See Narrative ☐ NGT Placement

GU

✓ Void Urine: Color / Character
Clear yellow ⊖ odor
Catheter: NA
Other:
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
WNL
Incisions / Dressings / Leisions / Dermal Ulcers
wounds x 7 Bacitracin to penis
5 W-D dressing Bilat L E
☐ See Narrative

0335- Assumed care of this pt. Pt resting comfortably. Will cont to monitor. [b)(6)-2]
0720 Medicated ⊕ MSO4 2mg IVP for pt D26 # pain coverage [b)(6)-2]
0700 1st AM Assessment Pt A ⊖ x 3 PERRLA pupils ⊕3 bilat pulse noted in radial, posterior tibial, and dorsalis pedis strong regular pulse. Lungs CTA Pt has cough producing thick white sputum. Abdominal exam within Normal limits except pt c/o pain/discomfort upon palpation of lower quads. Nurse informed Pt voids clear yellow urine ⊖ odor skin temp warm to touch ⊖ turgur No excess moisture noted on Pt wound. Dressed W-D And bacitracin applied to tip of penis. Pt voices No other complains and nothing out of ordinary is observed ~~with~~ Am care provided. Oral care, clean bed linen AND complete bed bath performed will continue to monitor [b)(6)-2]
0630 LE DRSNG Δ W-D Dressing Δ TO 4 wound ⊕ SEROSAGUENOUS fluid ⊖ S/S infection Applied BACITRACIN TO TIP OF PENIS PT TOLERATED PROCEDURE WELL will CONTINUE to MONITOR [b)(6)-2]
0945 Pt ate 50% of beef stew [b)(6)-2]
1005 - Pt medicated c 2mg [b)(6)-2] per request pt [b)(6)-2] NC
1213 medicated c MSO4 3mg [b)(6)-2] NC
1220 Pt need foley catheter per ⊕P instructions. Pt tolerated release of 800 cc clear amber urine. Pt provided relief of pain from distention. [b)(6)-2]
1400 Pt D/C'd from [b)(6)-2]

TE WARD - 24 HOUR FLOW SHEET

1000 1100 1200 1300 1400 1500 1600 1700 1800 1900 2000 2100 2200 2300 0000 0100 0200

~~10:00~~ ~~11:00~~ 1535 ~~12:00~~ ~~13:00~~ ~~14:00~~ ~~15:00~~ ~~16:00~~ ~~17:00~~ ~~18:00~~ ~~19:00~~ ~~20:00~~ ~~21:00~~ ~~22:00~~ ~~23:00~~

16

200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20

98.6

Temp

1400 1800

900

2550

glabellar tap or loud auditory stimulus

6 - No response to light glabellar tap or loud auditory stimulus

it glabellar tap or loud auditory stimulus

1900-0700	Time	Signature

NEUROLOGICAL

Level of Consciousness
Oriented to: Person ✓ Place ✓ Time ✓
Responds to: Verbal ✓ Pain ___ Unresponsive ___

Pupils R L
Size / 3 / + 3 / 4

Motor Strength S = Strong W = Weak TR = Trace A = Absent
Extremities:

	L	R
Upper	W	W
Lower	W	TR

☐ See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial	+	+
Femoral	+	+	Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: TRR Ectopy: Ø
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: ___
☐ See Narrative

RESPIRATORY

Breath Sounds: ✓ Clear ✓ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: ___
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: WNL
Auscultation: (+) BOWEL SOUNDS X4Q
Palpation: Ø DIFFICULTIES
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard

Tubes / Bags / Suction / Drainage:

☐ See Narrative ☐ NGT Placement

GENITOURINARY

✓ Void **Urine: Color / Character**
TEA COLOR / SLIGHTLY TURBID
Catheter: FOLEY → GRAV
Other:
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
WARM / DRY
Incisions / Dressings / Leisions / Dermal Ulcers
PENIS, (L) LEX2
☐ See Narrative

1915 - IV SITE C 'GE FROM (L) FOREARM TO (R) WRIST. PT LERATED Σ COMPLAINT. PT RESTING COMFORTABLY. HN [b)(6)-2]

2210 - DRSG Δ @ (L) MED U LEG. REMOVED PACKING. Ø DRAINAGE, Ø EDEMA, Ø ERYTHEMA, Ø PURULENT DRAINAGE Ø S/S INFECTION. PACKED Σ DAKIN SOAKED GAUZE. COVERED Σ CLEAN DRSG & KERLIX WRAP. DRSG Δ @ (L) LAT L LEG. REMOVED PACKING. Ø S/S INFECTION Ø DRAINAGE Ø EDEMA Ø PURULENT DRAINAGE (+) ERYTHEMA. PACKED Σ DAKIN SOAKED GAUZE. COVERED Σ CLEAN GAUZE & KERLIX WRAP. CARE TO WOUND @ TIP OF PENIS. BACITRACIN APPLIED TO WOUND. PT TOLERATED Σ COMPLAINT. PT RESTING COMFORTABLY. HN [b)(6)-2]

0333 PT medicated Σ 2mg FSO4 [b)(6)-2]
will monitor [b)(6)-2] [illegible]
0558 PT requested pain meds given [b)(6)-2] [illegible]

Addressograph: (b)(6)-4

Bed Q

Date: 7 April 03

Allergies

Diagnosis

Age:

DOB:

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

(b)(3)-1

	0300	0400	0500	0600	07	0800	0900	1000	1100	1200
	~~7:00~~	~~8:00~~	~~9:00~~	~~10:00~~	~~11:00~~	~~12:00~~	~~13:00~~	~~14:00~~	~~15:00~~	~~16:00~~
SpO2	16									
Respirations										
Temp	98.6					98.7				

		0300	0400	0500	0600	0700	0800	0900	1000	1100	1200
IV'S	ANCEF						100				
	MORPHINE			400		2 cc					
INTAKE	PO										
	NG/TF										
	Other										
	Cummulative Intake			4		6	106				
OUTPUT	Urine Volume			150		100			400		800
	Emesis										
	NG Residual/sump										
	Bowel Movement										
	OTHER										
	Cummulative Output			150		250			650		1450

RAMSEY SEDATION SCALE:

1 - Pt. Anxious and irritated or restless

2 - Cooperative, oriented and tranquil

3 - Responds to commands only

4 - Brisk response to

5 - Sluggish response t

PAIN	Medicated										
	Dose / Route										
	Intensity (1-10) Pre / Post Med										
	Sedation Scale										
Nursing care	BATH PARTIAL/COMPLETE										
	ACTIVITY(Turn L, R, B, ch, amb)										
	IV Site CDI? Q2 hrs										
	IV Site CDI? Q2 hrs										
	TCBD										
	Wound care										
Miscellaneous											

0700-1900 Time: Signature:

NEUROLOGICAL

Level of Consciousness
Oriented to: Person ✓ Place ✓ Time ✓
Responds to: Verbal ✓ Pain ___ Unresponsive
Pupils R L
Size / Reaction: ___ / ___ ___ / ___
Motor Strength S = Strong W = Weak TR = Trace A = Absent
Extremities: Upper L S R S; Lower L TR R TR
☐ See Narrative

CARDIOVASCULAR

Pulses R L
Radial + +
Femoral
Posterior Tibial
Dorsalis Pedis + +
+ = Normal - = Weak 0 = Absent
Rhythm: ___ Ectopy: ___
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: ___
☐ See Narrative

RESPIRATORY

Breath Sounds: ☑ Clear ☑ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: ___
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: WNL
Auscultation: WNL
Palpation:
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard
Diet: ___
Tubes / Bags / Suction / Drainage:
☐ See Narrative ☐ NGT Placement

GU

☐ Void Urine: Color / Character
Catheter: ___
Other: ___
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
GSW x 3 Bilat L B
Incisions / Dressings / Leisions / Dermal Ulcers
☐ See Narrative

SHIFT A
0500 Assumed care of pt @ this time. Pt resting peacefully @ rise and fall of chest & breath sounds. Gives informed LR @ KVO & No difficulty will continue to monitor. (b)(6)-2
0530 Pt drank 40cc H2O (b)(6)-2
0840 Pt ate 2 MRE crackers and apple jelly also drank 2 cups H2O No c/o pain (out of ordinary) or discomfort at this time. IV Replacked due to tolerating P.O. (b)(6)-2
1145 Medicated I MSO4 3mg IVP for pain (b)(6)-2
1400 Dressing Δ's to All wounds BEO
~~LAY~~ Linens Δ AM CARE performed
Pt tolerated procedure well.

1900-0700 | Time: | Signature: (b)(6)-2

NEUROLOGICAL

Level of Consciousness
Oriented to: Person ✓ Place ✓ Time ✓
Responds to: Verbal ✓ Pain ✓ Unresponsive ___

Pupils R L
Size / 3 / + 3 / +

Motor Strength S = Strong W = Weak TR = Trace A = Absent

	L	R
Upper	5	5
Lower	TR	TR

Extremities:
☐ See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial	+	+
Femoral	+	+	Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: NSR Ectopy: Ø
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: 1
☐ See Narrative

RESPIRATORY

Breath Sounds: ✓ Clear ✓ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: ___
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: WNL
Auscultation: (+) BOWEL SOUNDS x 4Q
Palpation: SOFT
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard

Tubes / Bags / Suction / Drainage:

☐ See Narrative ☐ NGT Placement

GU

☐ Void **Urine: Color / Character**
NO VOID
Catheter: ___
Other: ___
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
DRY / WARM / WNL
Incisions / Dressings / Lesions / Dermal Ulcers
PENIS, (L) MED U LEG, (L) LAT L LEG
☐ See Narrative

1545 - SHIFT A. SUMED CARE OF PT. PT RESTING COMFORTABLY W/O S/S COMPLAINT. HN (b)(6)-2
2200 - DRSG A @ (L) MED U LEG. REMOVED PACKING, Ø DRAINAGE, Ø EDEMA, Ø S/S INFECTION, Ø ERYTHEMA, Ø PURULENT DRAINAGE. PACKED W/ DAKIN SOAKED GAUZE, COVERED W/ CLEAN GAUZE + KERLIX WRAP. DRSG A @ (L) LAT L LEG. REMOVED PACKING. (+) SERROSENGUOUS DRAINAGE, Ø EDEMA, Ø ERYTHEMA, Ø S/S INFECTION, Ø PURULENT DRAINAGE. PACKED W/ DAKIN SOAKED GAUZE, COVERED W/ CLEAN DRSG + KERLIX WRAP. WOUND @ TIP OF PENIS, Ø DRAINAGE, Ø EDEMA, (+) ERYTHEMA, Ø S/S INFECTION, Ø PURULENT DRAINAGE. APPLIED BACITRACIN. PT TOLERATED W/O COMPLAINT. PT RESTING COMFORTABLY. HN (b)(6)-2
2214 Carum c̄ above pt. (b)(6)-2 c̄ family. My WP passed to Pvt. Tolerated well (b)(6)-2

FLEET HOSPITAL AC

Addressograph:

(b)(6)-2

Date: 6 Apr 03

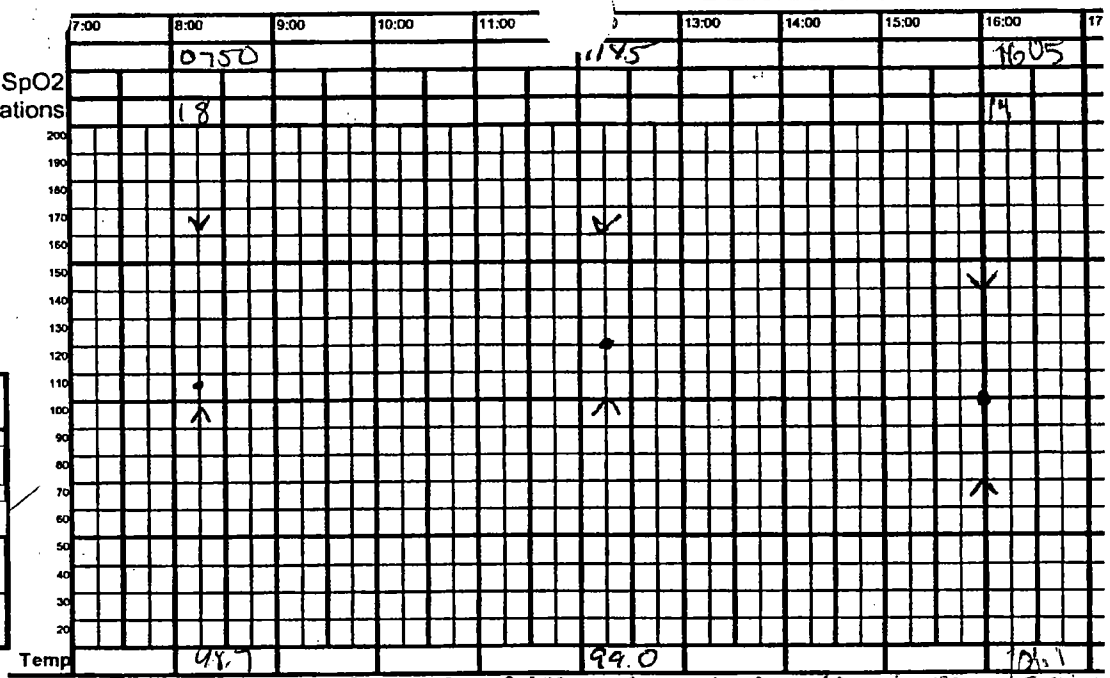
Allergies

Diagnosis

Age:

DOB:

SIGNATURE	
(b)(6)-2	(b)(6)-2
(b)(6)-2 CDR, NC	(b)(6)-2



		0400	0500	0600	0700	0800	0900	1000	1100	1200	1300
IV'S	LR @ KVO				→	800					
INTAKE	PO		40			80					
	NG/TF										
	Other										
	Cummulative Intake		40			920					
OUTPUT	Urine Volume		300		200		300				
	Emesis										
	NG Residual/sump										
	Bowel Movement										
	OTHER										
	Cummulative Output		300		500		800				

RAMSEY SEDATION SCALE:

1 - Pt. Anxious and irritated or restless
2 - Cooperative, oriented and tranquil
3 - Responds to commands only
4 - Brisk response to
5 - Sluggish response t

PAIN	Medicated										
	Dose / Route										
	Intensity (1-10) Pre / Post Med										
	Sedation Scale										
Nursing care	BATH PARTIAL/COMPLETE										
	ACTIVITY(Turn L, R, B, ch, amb)										
	IV Site CDI? Q2 hrs										
	IV Site CDI? Q2 hrs										
	TCBD										
	Wound care										
Miscellaneous											

0700-1900 | Time: 0934 | Signature:

NEUROLOGICAL

Level of Consciousness
Oriented to: Person X Place X Time X
Responds to: Verbal X Pain ___ Unresponsive

Pupils R / L
Size / Reaction: ___ / ___ / ___ / ___

Motor Strength S = Strong, W = Weak, TR = Trace, A = Absent
Extremities: Upper L S R S; Lower L S R S

☐ See Narrative

CARDIOVASCULAR

Pulses R L
Radial + +
Femoral
Posterior Tibial
Dorsalis Pedis + +
+ = Normal - = Weak 0 = Absent

Rhythm: ___ Ectopy: ___
Murmur: ___ Rub: ___ S1: S1 S2: ___
Neck Veins: ___
Edema: (R) THIGH (L) LEGS
☐ See Narrative

RESPIRATORY

Breath Sounds: ☒ Clear ☐ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: U
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: NORMAL
Auscultation: BOWEL SOUNDS PRESENT
Palpation: FIRM
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard
Diet: ___
Tubes / Bags / Suction / Drainage:
☐ See Narrative ☐ NGT Placement

GU

☒ Void Urine: Color / Character
Catheter: ___
Other: ___
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
NORMAL
Incisions / Dressings / Leisions / Dermal Ulcers
DRESSINGS ON (L)(R) LEGS.
☐ See Narrative

0945 PT VITAL SIGNS TAKEN. PULSE: 112, B/P 162/107 RESPIRATIONS: 18, TEMP: 100.1. [redacted]
0950 PT IS A+O X 3 AND RESPONDS TO VERBAL STIMULI. PT IS PERRLA AND HAS STRONG MOTOR SKILLS IN ALL FOUR EXTREMITIES. PT PULSES ARE NORMAL, S1 > S2, BREATH SOUNDS ARE CLEAR (-) COUGH. GI IS NORMAL WITH BOWEL SOUNDS PRESENT AND FIRM UPON PALPATION. NO VOID NOTED. SKIN IS NORMAL AND THERE ARE DRESSING ON (L) + (R) LEGS. [redacted]
1000 Concur c̄ above note. Pt given MSO4 5mg IVP @ 0900 for MO edem. Pt to OR via gurney [redacted] Lcdr MC
1330 Returned from OR via gurney [redacted] Lcdr MC
1345 mbr receiving LR @ 250cc/hr in L LE. No sys of infection or infiltration to infusion site.
1450 MBR IV REPLACED DUE TO INFILTRATION
1500 GENT VOIDING. Infusing in R HAND. NO SYS of infection or infiltration to infusion site. IVF's infusing well will continue to monitor. [redacted]
Concur c̄ above note [redacted] Lcdr

IE WARD - 24 HOUR FLOW SHEET

	18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
			142/86				139/80				136/80		
			79				69				70		
			18				16				16		
Temp			99.1				98.8				98.1		
	150	150	150	150	150	150	150	150	150	150	150		
	90												
				350				300			150		

glabellar tap or loud auditory stimulus

6 - No response to light glabellar tap or loud auditory stimulus

it glabellar tap or loud auditory stimulus

1900-0700 | Time | Signature (b)(6)-2

NEUROLOGICAL

Level of Consciousness
Oriented to: Person ✓ Place ✓ Time ✓
Responds to: Verbal ✓ Pain ✓ Unresponsive ___

Pupils R L
Size / 2-3 / + | 2-3 / +

Motor Strength Extremities:
S = Strong
W = Weak
TR = Trace
A = Absent

	L	R
Upper	5	5
Lower	5	W

☐ See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial		
Femoral			Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: RRR Ectopy: ∅
Murmur: ___ Rub: ___ S1: WNL S2: WNL
Neck Veins: ___
Edema: ___
☐ See Narrative

RESPIRATORY

Breath Sounds: ☒ Clear ☐ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: ___
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: Normal
Auscultation: BS x4
Palpation:
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard
Tubes / Bags / Suction / Drainage: Gero Bag
~~Midline incision & staples~~
~~Abdomen C/D/I~~
☒ See Narrative ☐ NGT Placement

GU

☐ Void Urine: Color / Character
VOIDS
Catheter: ___
Other: ___
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
IV (R) Hand
Incisions / Dressings / Leisions / Dermal Ulcers
Drsg on (L) (R) Legs
☐ See Narrative

1700 Assumed care of PT. See Secondary assessment (b)(6)-2
2000 IV changed to (L) FA 18g. (b)(6)-2
2300 Dressing Δ complete, New Bag LR hung (b)(6)-2
2300 Comm. assumed care @ 1700. Pt medicated c̄ Ung IVP prn to dry Δ, tolerated well, only drsg/ml removed. Package in tact c̄ sanguinous drainage typically to (L) medial thigh. (b)(6)-2
0130 Pt c/o 10 pain, given Dilaudid IVP (b)(6)-2
0415 No [illegible] Δ in to assist pt [illegible] primarily asleep. c̄ c/o pain (b)(6)-2

(b)(3)-1

Addressograph:

(b)(6)-4

Date: 04APR03

Allergies

Diagnosis

Age:

DOB:

SIGNATURE

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

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

	7:00	8:00	9:00	10:00	11:00		13:00	14:00	15:00	16:00	17
SpO2			0946							96%	
Respirations			18	112						14	
Temp			100.1							99.3	

		7:00	8:00	9:00	10:00	11:00		13:00	14:00	15:00	16:00	17
IV'S	LR @ 150/hr	150	150	150	150	150	150	150	150	150	250	
	~~KVO TF~~										50	
											30	
INTAKE	PO										1680	
	NG/TF											
	Other											
	Cummulative Intake											
OUTPUT	Urine Volume											
	Emesis											
	NG Residual/sump											
	Bowel Movement											
	OTHER											
	Cummulative Output											

RAMSEY SEDATION SCALE:

1 - Pt. Anxious and irritated or restless

2 - Cooperative, oriented and tranquil

3 - Responds to commands only

4 - Brisk response to l

5 - Sluggish response t

		7:00	8:00	9:00	10:00	11:00		13:00	14:00	15:00	16:00	17
PAIN	Medicated											
	Dose / Route											
	Intensity (1-10) Pre / Post Med											
	Sedation Scale											
Nursing care	BATH PARTIAL/COMPLETE											
	ACTIVITY(Turn L, R, B, ch, amb)											
	IV Site CDI? Q2 hrs											
	IV Site CDI? Q2 hrs											
	TCBD											
	Wound care											
Miscellaneous												

Day Of Surgery
Vital Signs

(b)(6)-4

HOLDING AREA: Versed_____mg IV Fentanyl 50 mcg IV Ancef/_____ _____gm IVPB

NAVHOSPPNCLA OVERPRINT (10-94) IV 16 / 18 / 20 ga in R / L Hnd / FA / AC (L) EJ

1050

WT 60 Kg **CLINICAL RECORD** ☒ Drugs / Equipment / O2 / Suction / Checked **ANESTHESIA**

	1100	30	1200	30	1300	30	1400
O2 L/MIN	4-2-1-1						
N2O Air L/Min							
DES / SEVO % 150	3-2.5-2						
(FEN) SUF / ALF / REM	50						
PRO / (PEN) / ETO	200						
(SUX) / MIVA / ATR	100						
NOR / PAV / ZEM / NIM							
MS04							
EKG	SR	SR	SR				
ET CO_2	36	40	47				
FIO_2	1.0						
SaO_2%	100	100	100				
Temp. / S/A/R/E		36.5	37.2				
Urine ML							
EBL ML							
Tidal Volume		400	440				
Resp. Rate		8	8				
Peak Pressure							
Vent Mode		SV					
Blood / Products							
IV / LR / DSLR		500		700			
IV							

AGENTS / MONITORS / VENT / FLUIDS

● = PULSE
O = SPONT RESP
⊘ = ASST RESP
⊗ = CNTRL RESP
⊘ = VENTILATOR
X CUFF BP
÷ ART LINE
X = MAP
I = INTUBATE
R = REVERSAL
E = EXTUBATE

200 180 160 140 120 100 80 60 40 20

Symbols for Remarks

POSITION

	START	STOP
Anesthesia	1020	1147
Procedure	1112	1143

PRE-PROCEDURE
☑ Identified: ☑ ID Band ☐ Questioning
☑ Chart Reviewed ☐ Permit Signed
☑ NPO Since
Pre-anesthetic State: ☑ Calm
☑ Awake ☐ Asleep
☐ Apprehensive ☐ Confused
☐ Uncooperative ☐ Unresponsive

PATIENT SAFETY
☑ Anes. Machine # 3 Checked
☑ Safety Belt On ☐ Axillary Roll
☑ Armboard Restraints ☐ Arms Tucked
☑ Pressure points checked and padded
☑ Eye Care: ☐ Ointment ☐ Saline
☑ Taped ☐ Pads ☐ Goggles

ANESTHETIC TECHNIQUE
General: ☑ Pre-Oxygenation ☐ L.T.A.
☐ Rapid Sequences ☐ Cricoid Pressure
☑ Intravenous ☐ Inhalation
☐ Intramuscular ☐ Rectal
Regional: ☐ Spinal ☐ Epidural
☐ Axillary ☐ Bier Block ☐ Ankle Block
☐ _____ ☐ Position_____
☐ Prep_____ ☐ Local_____
☐ Needle _____
☐ Drugs(s)_____
☐ Dose_____ ☐ Attempts x_____
☐ Site_____ ☐ Level_____
☐ Catheter_____ ☐ See Remarks
Other: ☐ M.A.C. ☐ _____

AIRWAY MANAGEMENT
Intubation: ☑ Oral Tube size 7.0
☑ Stylet used ☐ Nasal ☑ Regular
☐ Magill's ☑ Direct ☐ RAE
☐ Fiber optic ☐ Blind ☑ Atraumatic
☑ Blade MIL 2 ☐ LMA
☑ Secured at 20 cm ☐ Dbl Lum
☑ Attempts x 1 ☑ ET CO_2 present
☑ Breath sounds BILAT
☐ Uncuffed, leaks at_____cm H_2O
☑ Cuffed ☑ Min. occ. pres. ☑ Air ☐ NS
Airway: ☐ Oral ☐ Nasal ☐ Difficult,
Circuit: ☑ Circle ☐ NRB see Remarks
☐ Mask Case ☐ Nasal Cannula
☐ Via Tracheostomy ☐ Simple O_2 mask

FLUID TOTALS
Crystalloid 700 EBL Min
Blood_____ Urine _____

REMARKS
Smooth IV induction. Atraumatic intubation.

MONITORS AND EQUIPMENT
☐ Steth ☐ Precord ☐ Esoph ☐ Other
☑ Non-Invasive B/P ☐ Left ☑ Right
☑ Continuous EKG ☐ V Lead EKG
☑ Pulse Oximeter ☑ Oxygen Sensor
☑ End Tidal CO_2 ☐ Gas Analyzer
☑ Temp. ES ☐ Nerve Stimulator
☐ Warming Blanket ☐ Fluid Warmer
☐ Airway Humidifier ☐ Foley Catheter
☐ NG / OG Tube ☐ Art. Line_____

EMERGENCE
Oral Suctioning ☐ Head Lift x 5 sec. ☐
Extubation: AWAKE ☐ ASLEEP ☐
TOF 4/4 with Sus Tet. ☐

RECOVERY
Location 102 Time 1147
B/P 110/65 O_2 Sat. 100
P 100 R 16 T 97.9
☐ Awake ☑ Stable ☐ Nasal Oxygen
☑ Drowsy ☐ Unstable ☐ Mask Oxygen
☐ Somnolent ☐ Intubated ☐ T-piece Oxygen
☐ Unarousable ☐ Ventilator ☐ Oral/nasal airway

PACU NOTES
Parr_____

NARCOTICS	FENT/SUF/REM	MIDAZ
ISSUED	250 10	
USED	100	
WASTED	150	

PROCEDURE Debridements LEG & penis

SURGEON(S) (b)(6)-2

ANESTHESIA (b)(6)-2

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

(For typed or written entries give Name—last, first, middle, grade, date, hospital or medical facility.)

GEN
ANESTHESIA

DATE 4/4/03

Standard Form 517
Prescribed by GSA ICMR
FIRMR (41 CFR) 201-45 505
OCTOBER 1975 517-112

ANESTHESIA RECOR

NMC (279(12/00))

Wt (kg) - Ht (in) - Allergies - NKDA

Procedure: Secondary closure of [illegible] Anesthe: [redacted] Surg: [redacted]

OR # 4 — See Page One — Page 1 of 1

Date	Anes. Start	In Room	Surg. S		Anes. End	Resident/SRNA
25 APR 2003	0800	0820	0842	0925	0935	

Time	0815	30	0845	0900	0915	0930	0945	1000	1015
O_2 L/M	6	1.5	1.5	1.5					
N_2O / Air L/M		1.5	1.5	1.5					
Halo / Iso / Sevo / Des	2.0	1.1	1.2	1.2					
STP / Prop. / Etomidate	150	50/100							
Sux / Cistracurium									
Ro / Rapa / Ve coronium									
Lidocaine	20								
Neostigmine / Glyco									
Ephedrine / Neo									
Midazolam									
MSO4 / Remi / Sufentanil	50-50		50						
Epid. Lido / Bupiv / Ropiv									
0.9NACL		4oz			700ml				
NS / LR									
U/O				0 ml					
EBL					125 ml				
ECG	SR	SR	SR	SR					
Temp / Or / Sk / Ax Temp		35.9	35.9	35.5					
% FiO_2	100	54	54	50					
% SaO_2	100	100	100	100					
$EtCO_2$	39	42	40	54					
	SR	SR	SR	SR					
TV	400	350	317	321					
PIP (cmH_2O)		20							
Resp. Rate	16	26	26	24					

Total Used / Wasted / Witn

Total Used / Wasted / Witn

Total

Total

Total

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 1 Wasted 4 Witn

Drawn 250 Used 150 Wasted 100 Witn

IV #18 Ga L / R Hand Wrist FA AC EJ

☐ Tourniquet _____ mmHg Times I _____ I _____

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

Antibiotics: Agent Ancef mg 1 GM over 20 minutes @ 0845-0905

● = Pulse
⊃ = Spont. Resp.
⊃ = Asst. Resp.
⊃ = Ventilator
☾ = MAP
Λ / V = NIBP
⊥ / T = A-Line
= Intubate
= Extubate

PACU / ICU

Pulse - 109
BP 152/81
Temp 95.5
RR - 16
SaO_2 - 98
Comps - + / -

① To Room. Interpreter answered all question. Pt. understands surgery.
② Propofol 2nd Dose to get LMA IN. Rigid jaw

Surgeon injected local Marcaine 0.25% plain. 10 cc into wounds

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

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 # 5 Cuffed DLT ____ Fr L / R Cotton AIRWAY

Maintenance - ~~Smooth~~ ~~Cuff checked~~ ~~Eyes taped~~ / lubed Difficult to insert LMA - Rigid jaw & muscle Relaxation

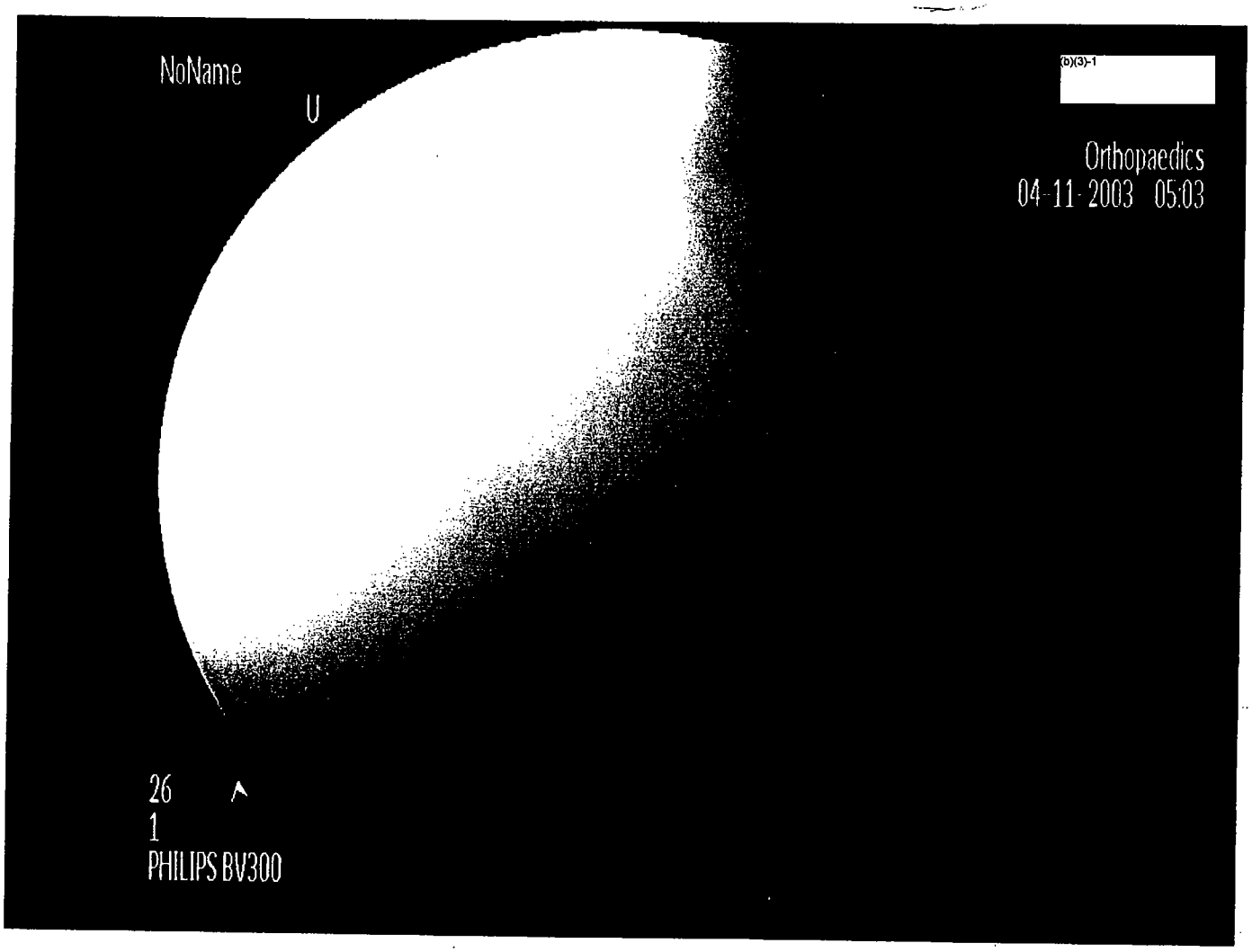
Extubation - ~~Smooth~~ LMA - Reversed SV VSS Full T4 / Head lift / Sustained tetanus Suctioned Awake / Deep

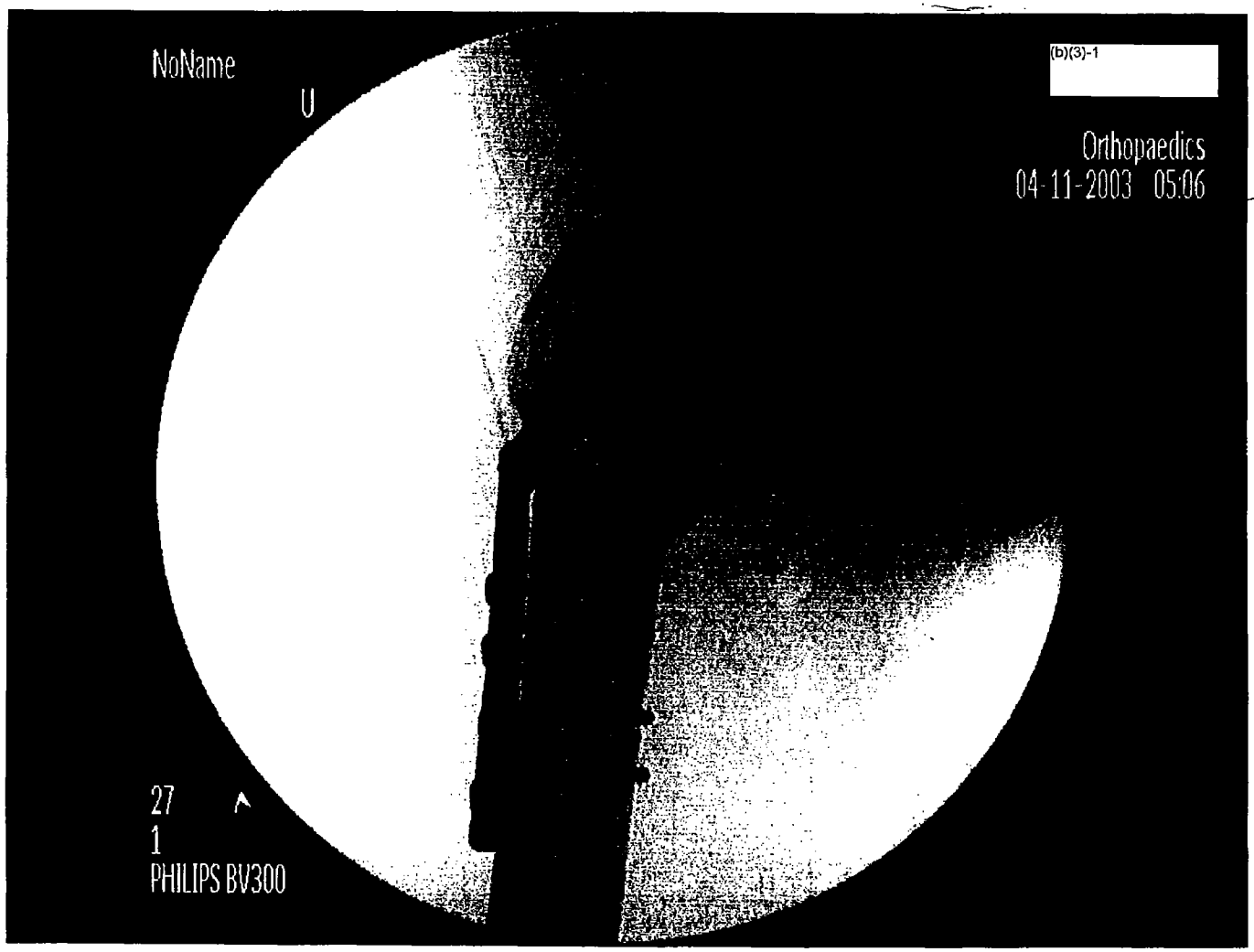
Disposition - PACU / ICU SV VSS Awake / sleepy Extubated / intubated

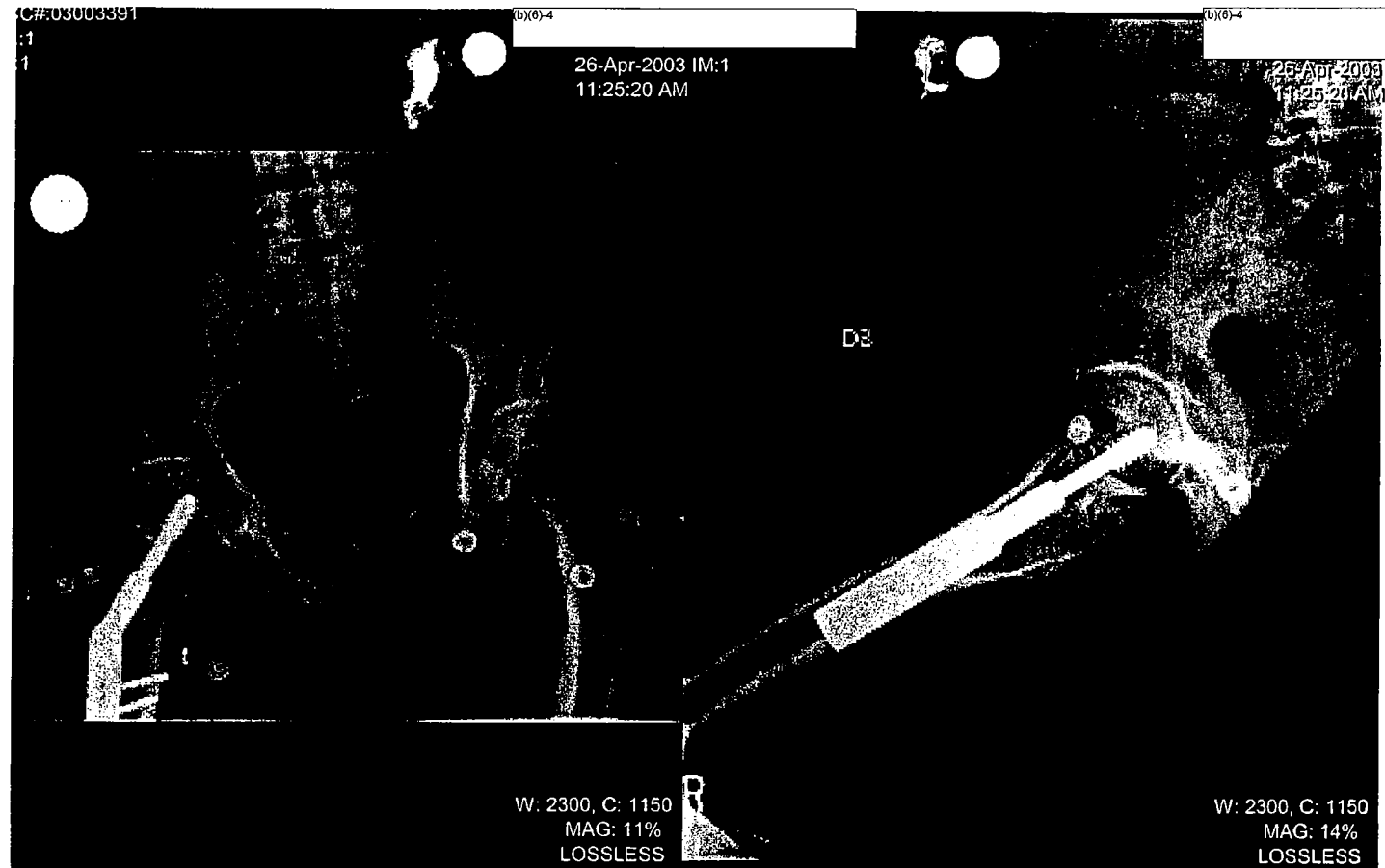
Patient Identification

[redacted]

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		


NoName
U
(b)(3)-1
Orthopaedics
04-11-2003 05:03
26
1
PHILIPS BV300


NoName
U
(b)(3)-1
Orthopaedics
04-11-2003 05:06
27
1
PHILIPS BV300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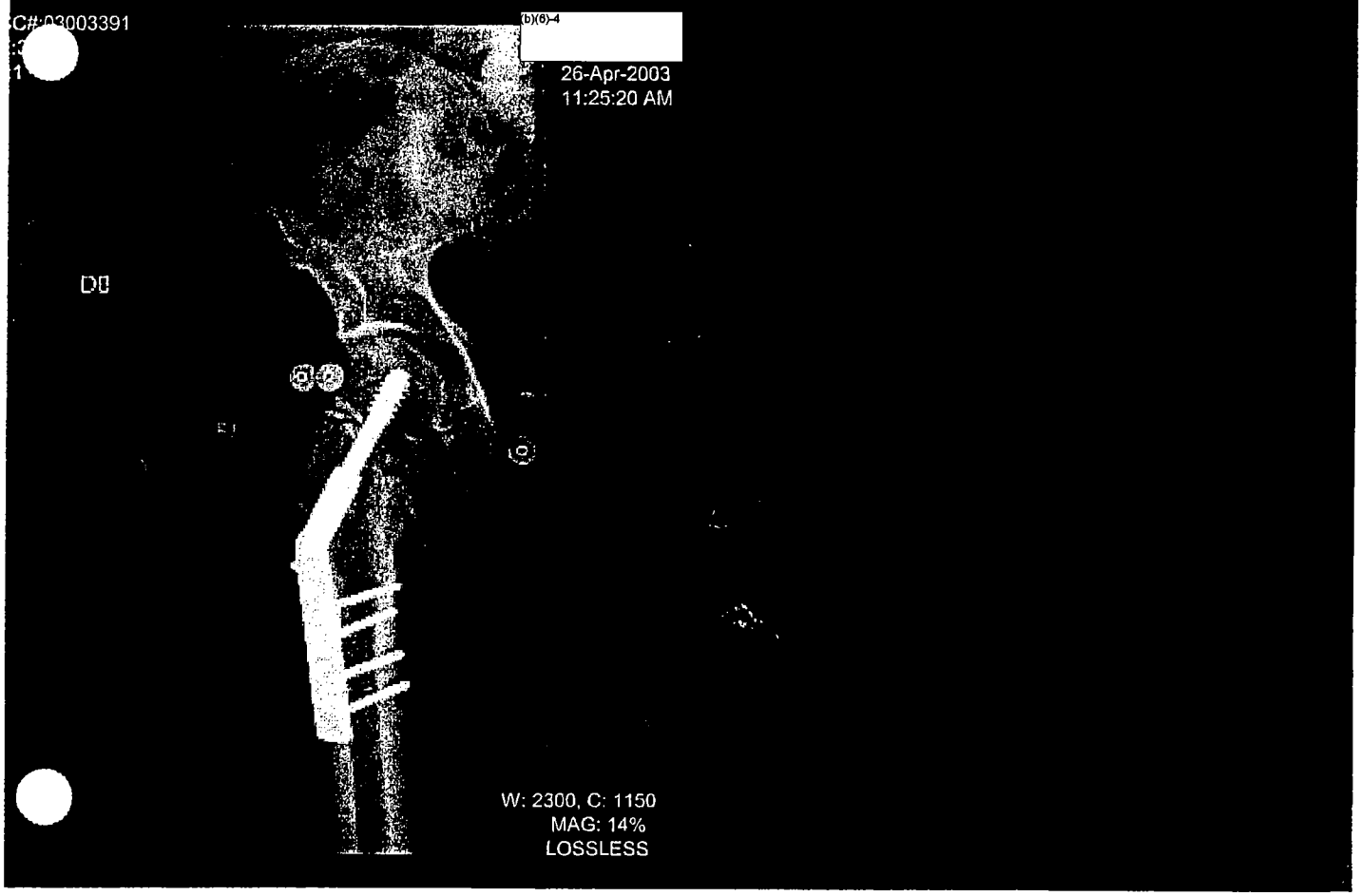
(b)(6)-4
26-Apr-2003 IM:1
11:25:20 AM
D3
W: 2300, C: 1150
MAG: 11%
LOSSLESS
R
(b)(6)-4
26-Apr-2003
11:25:20 AM
W: 2300, C: 1150
MAG: 14%
LOSSLESS


C#:03003391
:1
1
(b)(6)-4
26-Apr-2003
11:25:20 AM
D0
W: 2300, C: 1150
MAG: 14%
LOSSLESS

ATIENT 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	5. AGE	6. RACE Iraq	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION No
11. FMP 99	12. SSN (b)(6)-4			13. ORGANIZATION		14. WARD ICW7
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 2000	23. CLINIC SERVICE ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION Home	26. DATE OF DISPOSITION 6 May 03	
27. 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 Iraq					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

Tibia Fx 828

823.80
27500

CODE: _____

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
2	2				2

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 PAD OR MEDICAL RECORDS OFFICER (b)(6)-2 MD

X (b)(6)-2

LTC, MC
GENERAL SURGEON

DA FORM 3647, MAY 79 EDITION OF 1 ...

MEDCOM - 5148

USAPPC V1.10

PATIENT TREATMENT RECORD COVER SHEET

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

(b)(6)-4	2. NAME (Last, First, MI) (b)(6)-4			3. GRADE	ADMISSION REMARKS
AGE 99	5. RACE Iraqi	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION No
	(b)(6)-4	13. ORGANIZATION			14. WARD ICW1
	RATING DSG	17. DEPT./BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE Inj
21. PLACE OF ADMISSION/AUTHORITY FOR ADMISSION Sick			22. HOURS OF ADMISSION 2000	23. CLINIC SERVICE ABAA	
24. RELATIONSHIP OF EMERGENCY ADDRESSEE		25. TYPE DISPOSITION Home		26. DATE OF DISPOSITION 6 May 03	
27. EMERGENCY ADDRESSEE (Include ZIP Code)		27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 4 May 03	ADMITTING OFFICER
29. PLACE OF ORIGIN OF MEDICAL TREATMENT FACILITY (b)(3)-1				30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD COMPONENT TRANSFUSED

31. ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES, OPERATIONS AND SPECIAL PROCEDURES

Tibia Fx 828

CODE

35. Total Days This Facility

a. SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
2	2				2

36. Total Days All Facilites

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

(b)(6)-2 OFFICER MD (b)(6)-2 SIGNATURE OF PAO OR MOD X (b)(6)-2

LTC, MC
GENERAL SURGEON

DA FORM 3647, MAY 79

MEDCOM - 5149

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
04 MAY 03 2004	Pt is A&O x3 and C (R) LEG UPPER LEG 4X4(X2) AND A HEALING (R) LEG WOUND THAT HAS HAD THE STAPLES TAKEN OUT; AND ~~WITH~~ WITH A STORE STRIP ATTACHED. Pt C EQUAL BILATERAL PULSES IN HANDS. Pt C LUNGS CTA BILAT AND CLEAR THROUGHOUT. Pt C CV RRR and (A) BS throughout PA hands C CAP REFILL <5 SECONDS AND (A) PULSES IN FEET AND CAP REFILL <5 SECONDS. PT C (+) 2 EDEMA IN L & R LOWER LEGS. Pt also C HEALED WOUND (L) KNEE 3 IN. PT (R) LEG C HEALING WOUND 13 1/2 IN LONG. Pt C bruising and healing 1 1/2 WOUNDS L & R LEGS; PT ALSO C 1 IN X 1 IN WOUND (R) LOWER LEG ~~AND~~ (b)(6)-2 that is pink and S bleeding. Pt (L) LEG C 1/2 X 1 INCH that is C light brown tissue in the center and SCANT LIGHT BROWN DISCHARGE. Pt C LIMITED CONTROL OF (R) LEG. Pt L & R LEGS LOWER DRESSINGS HAVE BEEN CHANGED AND C 2(2X2) EACH. Pt 20 RR, BP 110/76, TEMP 100°, HR 97, AND SPO2 98%. — (b)(6)-2 CPT AN
04 MAY 03 2110	Pt C IBM AND 1 VOID TO the bed side comode, unable to measure amounts. — (b)(6)-2 CPT AN —
4 May 03 2200	Nsg. Shift assessment completed. Condition stable, unchanged from prior assessment. Z be dlcd in AM — (b)(6)-2 CPT

BP- 110/76
P- 97
R- 20
T- 100°
SaO2- 98%

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

DATE	NOTES
0800 5 May 03	VS: 110/90, R=18, Sp 97, P=78, T=97.5
5 May 03 0745	Pt AAOx3. sitting up in bed. c/o pain to legs. medicated c̄ 2 TC #3. legs c̄ bilateral (+) pedal pulses, moves toes easily, skin WTD. Small 2x2 dsg to S/P fixator sites intact. voiding clear yellow urine. good appetite, interacts well c̄ other patients + staff. ambulates c̄ assistance. — (b)(6)-2 MAG
5 MAY 03 1530	VS - BP 130/68, - P 94, RR 18, Temp - 98.6, SpO2 99%, Pt AEOX3 cooperative c̄ care c/o pain to the (R) Hip, medicated c̄ #(2) Tylenol #3 PO. DRSG to (R) Hip CDI. Bilat ↓ ext c̄ 1X4 DRSG to inner legs CDI, LS CTA Apex to Base, Ø SOB. BS active X4 tolerating liq diet, Pt voiding c̄ difficulty. Ambulates c̄ crutches. Pulses +3 full in ext X4 cap refill < 3 sec. — (b)(6)-2 [illegible]
2300 5 MAY 03	VS> BP 106/64 P 67 R 16 T 98.7 SpO2 99
5 May 03 2300	Shift assessment completed. VSS. Alert. Lungs CTA(B) BS(+), BM(+), voiding spontaneously clear yellow urine. Dressing to (R) hip - CDI & I also drsg to (L) LE - CDI. Neuro (✓) WNL. Ambulating c̄ crutches, guarded walk. Medicated c̄ T-3 2 tabs for c/o of pain. will monitor — (b)(6)-2 [illegible]
0800 6 May 03	VS> BP 124/82 P 76 R 16 T 98.9(O) SP 98 (b)(6)-2 [illegible]
6 May 03 0730	DC to home in stable condition. NO c/o discomfort. — (b)(6)-2 MAG

MEDICAL RECORD	PROGRESS NOTES

DATE	PRE OPERATIVE EVALUATION
	General Diagnosis: (R) gr III B open tibia Proc. Planned: I&D pus OR Anesth:
	Anesthesiologist: Surgeon:
	Anesth. Risk Classification:
	Vital Signs:
	Physical Exam Highlights:
	Procedure & risks discussed with patient: YES NO
	Prognosis: fair
	Signature (b)(6)-2

POST OPERATIVE NOTE

	Pre-Operative Dx: (R) gr III B open tibia, (R) subtroch fx, (R) closed tibia dx
	Post-Operative Dx: SAA
	Anesthesia: Procedure: (1) I&D dpc (R) LE
	Surgeon: (b)(6)-2 (2) dressing D's (R) thigh, (L) leg
	Findings: clean wound
	1.
	2.
	3.
	4.
	5.
	6.
	EBL: I/O: Tissue sent to lab:
	Prognosis: fair
	Plan: IV Abx x 48°, Need medevac to level 4 facility for IM Nail (R) subtroch. (b)(6)-2
	Signature (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*)

WARD NO.

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5-.99)
Prescribed by GSA/ICMR FPMR (41 CFR)101-11.203(B)(10)

DATE	NOTES
1/7/02	0 [illegible] 5/p left fix (P) [illegible] (A) LB ((P) open) need repeat X & D (P) TB/HS ĉ 4pc NPO p̄ R r
	(b)(6)-2
4/8/03 1130	#1 Lower extremity trauma
	#2 Presumed PE 4/7
	#3 Anemia
	Patient no longer hypoxic. On room air. Has been on IV heparin since yesterday @ 1,000 units/hour. For reasons that are unclear his PTT +2 has not prolonged. H+H today = 5.8/18.0. - will repeat if confirmed (2) units PCCs. No prior CBC's for comparison Can't put umbrella in. Not sure if PTT is accurate. Mild-moderate bleeding. Will plan to treat with heparin + 24 more hours then stop No lovenox available. Difficult ~~therapeutic~~ dilemma
	(b)(6)-2
4/8/03 0925	Brief episode of (2) precordial chest pain worse c̄ coughing, turning and TTP. O2 sat = 97-98%. Assume musculoskeletal origin
	(b)(6)-2
	MD CAPT MC USNR
	(b)(6)-2

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

4/7/03 Medicine –

0650 I did not see this patient ~~post~~ pre-op. His O2 sat post op ~82% on room air. Unknown if he is 1 or 2 days post injury. His lungs are clear and cardiac exam is normal except for rare extra systoles. Will ✓ CXR. Must assume fat emboli or pulmonary emboli from massive lower ext. injuries. He will need further surgery tomorrow. We have only IV heparin @ conc of 1,000 u/cc

(b)(6)-2

0830 CXR – clear lung fields. Must assume either fat emboli or thrombus. Will start on heparin 6,000 u load, 1,000 units/hour. ✓ a PTT before next dose

(b)(6)-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/7/03 @	0045		Pt arrived via gurney. Initial O_2 sat = 78%. Placed on 10L FM for immediate response. No S/S of resp distress. Pt very sleepy. Multiple lacs to face (R) eye bruised + swollen. L ext. jugular IV SL'd. Lungs clr to auscultation. HRR. Foley draining clr yellow urine. (R) ex fix of hip & tib fib, (L) ex-fix of tib.fib covering at insertion sites. Pt wakes to verbal stim. PIV in (R) FA. to NS. Continue to monitor — (b)(6)-2 — 47/RC
0300			Assumed care. O2 Sats @ 93% on 10L/m FM. — (b)(6)-2 — RC
0340			O2 Sats @ 94% on 10L. Open eyes. OK for TRW to Alert
	35		O2 Sats 93% on RA. Report called to OR LT (b)(6)-2 — (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
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
4/8/03	0928		Pt received from MOR attached to SpO_2
			Anesthesia in attendance. Nasal trumpet 4.0 (R) nare
			BBS Dim bases c scattered rales. Denied 12.1 mg
			IV for Risorp (b)(6)-2
	0948		Report called to CDR Fowler. VSS (b)(6)-2
	0955		Tx to Ward III PAD (b)(6)-2
	0800		Returned to Ward. VSS. Medicated for pain
	~~1000~~		2mg MS IV. DSG intact. (b)(6)-2
	1000		TXC for 2 units PRBCs (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
General Services Administration and Interagency Committee on Medical Records
FPMR 101-11.806-8—October 1975
510-109

MEDICAL RECORD	PROGRESS NOTES

DATE	PRE OPERATIVE EVALUATION
	General Diagnosis: Proc. Planned: Anesth:
	Anesthesiologist: Surgeon:
	Anesth. Risk Classification:
	Vital Signs:
	Physical Exam Highlights:
	Procedure & risks discussed with patient: YES NO
	Prognosis:
	Signature
	POST OPERATIVE NOTE
4/18/03	Pre-Operative Dx: Fx (R) femur Fx (L) Tib/Fib Fx (L) Tib Fib.
	Post-Operative Dx: SAA.
0015	Anesthesia: Procedure: CR Ex Fix femur (R)
	Surgeon: (b)(6)-2 / (b)(6)-2 " Tibia (L)
	Findings: " Tibia (L)
	1. As above.
	2.
	3.
	4.
	5.
	6.
	EBL: I/O: Tissue sent to lab:
	Prognosis: fair.
	Plan: Repeat T&O (R) tibia to 48°
	(b)(6)-2
	Signature
	(Continue on reverse side)

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record
STANDARD FORM 509 (REV. 5-.99)
Prescribed by GSA/ICMR FPMR (41 CFR)101-11.203(B)(10)

Patient ID

(b)(3)-1

Patient Profile

(b)(6)-4

Allergies	Vital Signs	Diet	Activity
	q 1 2 (4) 8 12	4/8/03 Reg	4/7 BEDREST
	Call MD for:		
	HR <____ >____		
	BP<__/__>__/__		
	RR <____ > ____	**Dressing Changes**	
	SpO2 _____	Wet to dry qd Start 4/9/03	
	Temp >		
	UOP <		

IV Therapy		O_2/Vent Settings	Misc
Fluid	Rate	O_2 3 lpm titrate O_2	
		FiO2 Sat = 90%	
		Mode	
		Rate	
		PEEP/PS	

Diagnosis	Daily Labs/Xrays/Procedures	
4/7/03 Fx Femur	Daily CBC/PTT	4/9 ☒ 4/10 ☒ @ 0700
Fx (R) & (L) Tibia		4/11
Condition		

ONE TIME ORDERS

4/7/03 CBC

4/7/03 AP (R) Femur AP (R) AND (L) Tibias

4/7/03 CXR ☒

Antiocoid PTT in 6hrs Call results to Capt Hoff

4/8/03 ☒ CBC / ☐ PT/PTT @ ~~0630~~ 0530 Daily

(b)(6)-2

4/8/03 – Pt on medivac list –
called Admin @ 1329.

TE WARD - 24 HOUR FLOW SHEET

18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
					97.7			97.5				
99%					94							
18					20				22			
100.1					99.6				99.4			

Temp

1000 cc

glabellar tap or loud auditory stimulus

6 - No response to light glabellar tap or loud auditory stimulus

it glabellar tap or loud auditory stimulus

(b)(6)-4

(b)(3)-1

Addressograph:

(b)(6)-4

Date: 4/8/03

Allergies

Diagnosis

Age:

DOB:

SIGNATURE

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

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

	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
SpO2	99									
Respirations	16			16						
Temp	99.3			484						

		7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
IV'S	NS 1000										
	LR 1000										
	2u packed cell										
INTAKE	PO										
	NG/TF										
	Other										
	Cummulative Intake										
OUTPUT	Urine Volume										
	Emesis										
	NG Residual/sump										
	Bowel Movement										
	OTHER										
	Cummulative Output										

RAMSEY SEDATION SCALE:

1 - Pt. Anxious and irritated or restless

2 - Cooperative, oriented and tranquil

3 - Responds to commands only

4 - Brisk response t

5 - Sluggish response

		7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
PAIN	Medicated				2mg MS						
	Dose / Route				2mg IM						
	Intensity (1-10) Pre / Post Med				4/2						
	Sedation Scale				2						
Nursing care	BATH PARTIAL/COMPLETE										
	ACTIVITY(Turn L, R, B, ch, amb)										
	IV Site CDI? Q2 hrs										
	IV Site CDI? Q2 hrs										
	TCBD										
	Wound care										
Miscellaneous											

1900-0700	Time	Signature

0630 V/S
HR 80 T 98.5
BP 108/80 R 16
(b)(6)-2 (HA)

NEUROLOGICAL

Level of Consciousness
Oriented to: Person X Place X Time X
Responds to: Verbal X Pain ___ Unresponsive ___

Pupils R 3 / 5 L 3 / 5
Size /

Motor Strength Extremities:
S = Strong
W = Weak
TR = Trace
A = Absent

	L	R
Upper	5	5
Lower	W	W

☐ See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial	+	+
Femoral	+	+	Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: ___ Ectopy: ___
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: ___
☐ See Narrative

RESPIRATORY

Breath Sounds: ☒ Clear ☒ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: ___
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: Flat
Auscultation: +4Q
Palpation: No Discomfort
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard

Tubes / Bags / Suction / Drainage:

☐ See Narrative ☐ NGT Placement

GU

☒ Void **Urine: Color / Character** yellowish /
Catheter: yes
Other:
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
Warm Dry Pink
Incisions / Dressings / Leisions / Dermal Ulcers
Ex. Bites on both legs

☐ See Narrative

0700-1900	Time:	Signature:

NEUROLOGICAL

Level of Consciousness VERBAL CUES

Oriented to: Person ___ Place ___ Time ___

Responds to: Verbal ___ Pain ___ Unresponsive

Pupils R PERRL L PERRL

Size / Reaction: 2 / ___ 2 / ___

Motor Strength Extremities:

S = Strong
W = Weak
TR = Trace
A = Absent

	L	R
Upper	S	S
Lower	W	W

[X] See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial		
Femoral			Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: ___ Ectopy: ___

Murmur: ___ Rub: ___ S1: ___ S2: ___

Neck Veins: FLAT

Edema: ___

[ ] See Narrative

RESPIRATORY

Breath Sounds: [X] Clear [X] Bilat

Location:

Crackles /Rales: ___ Dim: ___

Wheezes: ___ Absent: ___

Rhonchi: ___

Cough: Productive / Unproductive: ___

Sputum: Color and Character: ___

Tubes: [ ] ET [ ] Trach

Size: ___ Location: ___

O2: [ ] Canula [ ] Mask

Chest Tubes: ___

[ ] See Narrative

GASTROINTESTINAL

Observation: FLAT

Auscultation: +40

Palpation: NO DISCOMFORT

Stool: [ ] Incontinent [ ] Formed [ ] Soft [ ] Frequent [ ] Liquid [ ] Hard

Diet: ___

Tubes / Bags / Suction / Drainage:

[ ] See Narrative [ ] NGT Placement

GU

[ ] Void Urine: Color / Character

Catheter: ___

Other:

[ ] See Narrative

SKIN

Color / Turgur / Temperature / Moisture

WARM PINK DRY

Incisions / Dressings / Leisions / Dermal Ulcers

EX FIXES ON BOTH LEGS

[ ] See Narrative

PT HAS EX FIXES ON BOTH LEGS.
PT IS ALSO PRESENT C EDEMA TO BOTH FEET.

0920 40 chest discomfort + H/A. Dr (b)(6)-2 notified. EKG done (b)(6)-2

(b)(3)-1

Addressograph:

(b)(6)-4

Date: 4/8/03

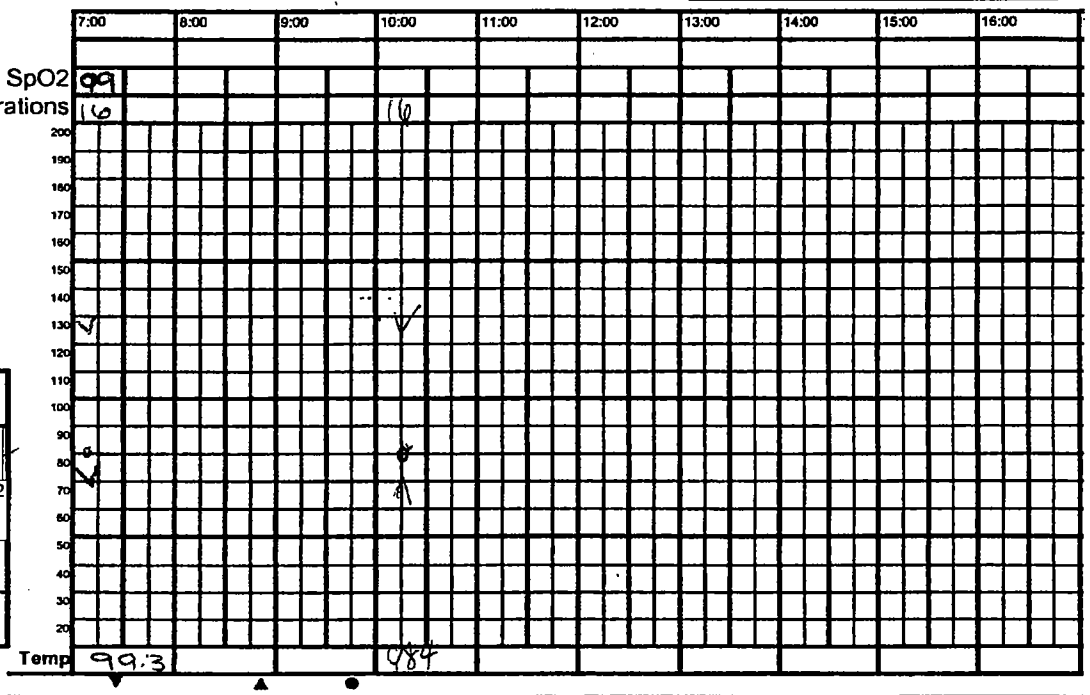
Allergies

Diagnosis

Age:

DOB:

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



		7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
IV'S	NS 1000										
	LR 1000										
	2u packed cell										
INTAKE	PO										
	NG/TF										
	Other										
	Cummulative Intake										
OUTPUT	Urine Volume										
	Emesis										
	NG Residual/sump										
	Bowel Movement										
	OTHER										
	Cummulative Output										

RAMSEY SEDATION SCALE:

1 - Pt. Anxious and irritated or restless
2 - Cooperative, oriented and tranquil
3 - Responds to commands only
4 - Brisk response to
5 - Sluggish response

		7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
PAIN	Medicated				2mg MS						
	Dose / Route				2mg IM						
	Intensity (1-10) Pre / Post Med				4/2						
	Sedation Scale				2						
Nursing care	BATH PARTIAL/COMPLETE										
	ACTIVITY(Turn L, R, B, ch, amb)										
	IV Site CDI? Q2 hrs										
	IV Site CDI? Q2 hrs										
	TCBD										
	Wound care										
Miscellaneous											

1900-0700	Time:	Signature:

1700 - Recieved Report from off going shift. Pt recieving blood @ this time. No S/S of reaction noted. Pt sitting up in gurney. Transfusion has slowed. (b)(6)-2

1710 - New I.V. site obtained to (L) FA. Blood administration site Δ'd from (L) EJ to (L) FA. Patent and no difficulties administering will continue to monitor. (b)(6)-2

NEUROLOGICAL

Level of Consciousness

Oriented to: Person X Place X Time X

Responds to: Verbal X Pain ___ Unresponsive ___

Pupils R L

Size / 3 / B 3 / B

Motor Strength Extremities:

S = Strong
W = Weak
TR = Trace
A = Absent

	L	R
Upper	S	S
Lower	S TR	S TR

☐ See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial	+	+
Femoral	+	+	Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: NSR Ectopy: ___

Murmur: ___ Rub: ___ S1: ✓ S2: ✓

Neck Veins: flat, nondistended

Edema: ___

☐ See Narrative

RESPIRATORY

Breath Sounds: ☒ Clear ☒ Bilat

Location:

Crackles /Rales: ___ Dim: ___

Wheezes: ___ Absent: ___

Rhonchi: ___

Cough: Productive / Unproductive: ___

Sputum: Color and Character: ___

Tubes: ☐ ET ☐ Trach

Size: ___ Location: ___

O2: ☐ Canula ☐ Mask

Chest Tubes: ___

☐ See Narrative

GASTROINTESTINAL

Observation: flat, non distended

Auscultation: (+) B.S. all 4 quadrants.

Palpation: no masses palpated, non tender

Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard

Tubes / Bags / Suction / Drainage:

☐ See Narrative ☐ NGT Placement

GU

☐ Void **Urine: Color / Character**

Foley to Gravity, Clear yellow

Catheter: (+)

Other:

☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture

Pink, warm, moist

Incisions / Dressings / Leisions / Dermal Ulcers

Pt has Ex fix bilat L.E. dressing to (R) foot CDI

☐ See Narrative

(b)(6)-4

0700-1900	Time:	Signature:

PT COMPLAINS OF PAIN IN BOTH LEGS.
Return from OR Post op. VSS, is so intact. Medicated + Unassured pt pain is slight.

(b)(6)-2

NEUROLOGICAL

Level of Consciousness VERBAL CUES
Oriented to: Person ✓ Place ✓ Time ✓
Responds to: Verbal ___ Pain ___ Unresponsive
Pupils R PERRL L PERRL
Size / Reaction: 2 / B 2 / B
Motor Strength S = Strong W = Weak TR = Trace A = Absent
Extremities:

	L	R
Upper	S	S
Lower	W	W

☐ **See Narrative**

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial		
Femoral	+	+	Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent
Rhythm: NSR Ectopy: 0
Murmur: 0 Rub: ___ S1: / S2: /
Neck Veins: FLAT
Edema: ___
☐ **See Narrative**

RESPIRATORY

Breath Sounds: ☒ Clear ☐ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: ___
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☒ Mask
Chest Tubes: ___
☐ **See Narrative**

GASTROINTESTINAL

Observation: FLAT
Auscultation: +4Q
Palpation: NO DISCOMFORT
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard
Diet: Reg.
Tubes / Bags / Suction / Drainage:

☐ **See Narrative** ☐ **NGT Placement**

GU

☒ **Void** **Urine: Color / Character**
Catheter: Foley cath in position
Other:
☐ **See Narrative**

SKIN

Color / Turgur / Temperature / Moisture
WARM PINK DRY
Incisions / Dressings / Leisions / Dermal Ulcers
(R) THIGH (R) SHIN (L) SHIN
☒ **See Narrative**

TE WARD - 24 HOUR FLOW SHEET

	18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
						97.7			97.5				
	96%					94							
	18					20				22			
Temp	100.1					99.6				99.4			

200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20

									1000 cc				

t glabellar tap or loud auditory stimulus

ght glabellar tap or loud auditory stimulus

6 - No response to light glabellar tap or loud auditory stimulus

1900-0700	Time:	Signature:

0630 V/S
HR 80 T 98.5
BP 108/80 R 16

(b)(6)-2

NEUROLOGICAL

Level of Consciousness
Oriented to: Person X Place X Time X
Responds to: Verbal X Pain ___ Unresponsive ___

Pupils
Size / R 3 / 3 L 3 / 3

Motor Strength
Extremities:
S = Strong
W = Weak
TR = Trace
A = Absent

	L	R
Upper	S	S
Lower	W	W

☐ See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial	+	+
Femoral	+	+	Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: ___ Ectopy: ___
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: ___
☐ See Narrative

RESPIRATORY

Breath Sounds: ☒ Clear ☒ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: ___
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: Flat
Auscultation: +4Q
Palpation: No Discomfort
Stool: ☐ Incontinent ☐ Formed ☐ Soft
☐ Frequent ☐ Liquid ☐ Hard

Tubes / Bags / Suction / Drainage:

☐ See Narrative ☐ NGT Placement

GU

☒ Void **Urine: Color / Character** yellowish /
Catheter: yes
Other:
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
Warm Dry Pink
Incisions / Dressings / Leisions / Dermal Ulcers
Ex Cracks on both legs
☐ See Narrative

(b)(3)-1

Addressograph:

(b)(6)-4

Date: 4/9/03

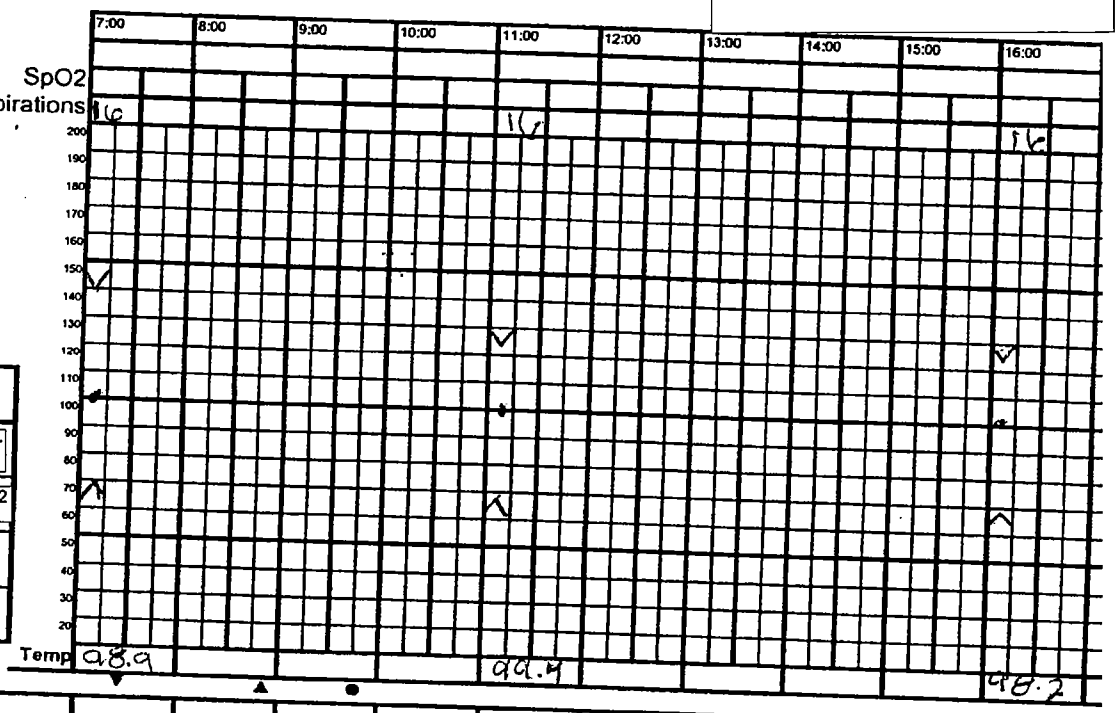
Allergies

Diagnosis

Age:

DOB:

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



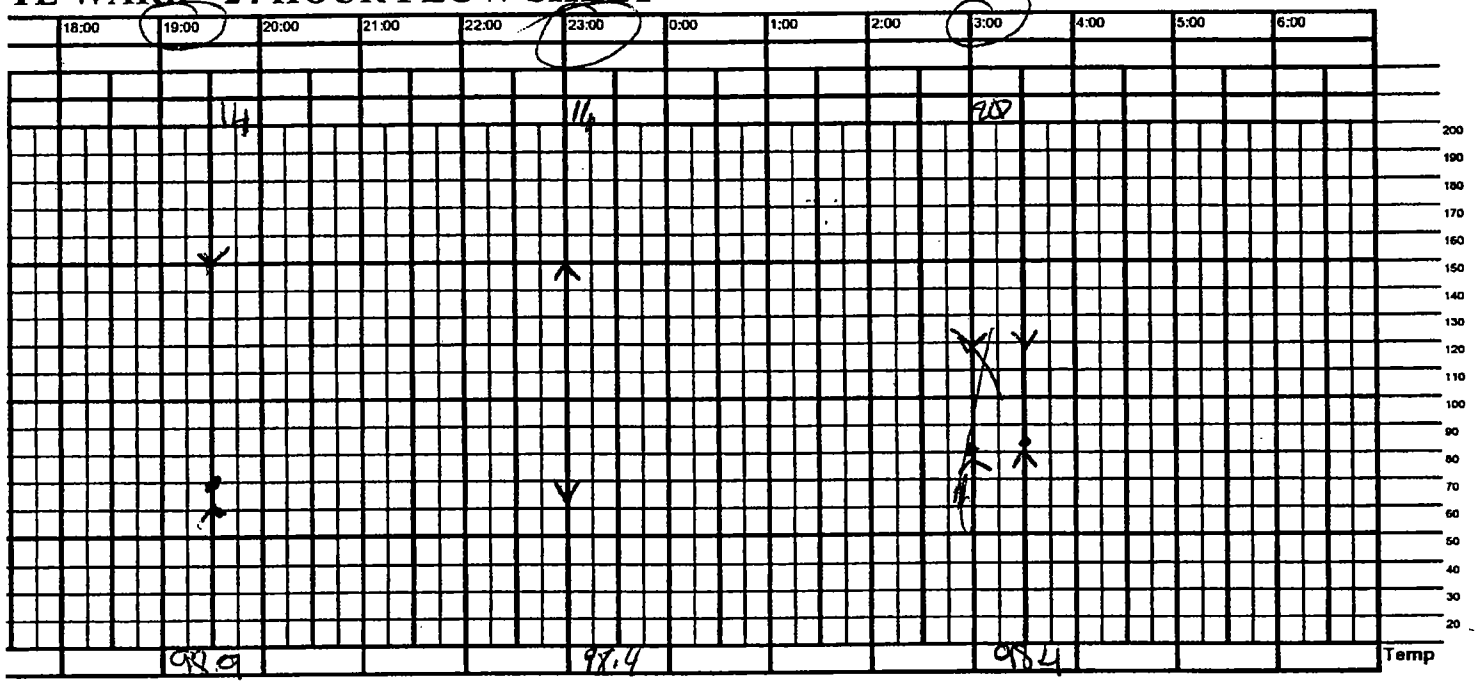
		7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
IV'S	Hall IV										
	TVPB ANCEF										50
INTAKE	PO										
	NG/TF										
	Other										
	Cummulative Intake										
OUTPUT	Urine Volume										
	Emesis										1400
	NG Residual/sump										
	Bowel Movement										
	OTHER										
	Cummulative Output										

RAMSEY SEDATION SCALE:

1 - Pt. Anxious and irritated or restless
2 - Cooperative, oriented and tranquil
3 - Responds to commands only
4 - Brisk response to lig
5 - Sluggish response to

PAIN	Medicated	0640	0730								
	Dose / Route	Tyl #3	MS						1400		
	Intensity (1-10) Pre / Post Med	0/7	4mg IV						MS		
	Sedation Scale	PO							4mg IV		
Nursing care	BATH PARTIAL/COMPLETE										
	ACTIVITY(Turn L, R, B, ch, amb)	✓									
	IV Site CDI? Q2 hrs	✓									
	IV Site CDI? Q2 hrs										
	TCBD										
	Wound care								✓		
Miscellaneous											

TE WARD - 24 HOUR FLOW SHEET



t glabellar tap or loud auditory stimulus

ght glabellar tap or loud auditory stimulus

6 - No response to light glabellar tap or loud auditory stimulus

0700-1900 | Time: | Signature:

NEUROLOGICAL

Level of Consciousness VERBAL CUES

Oriented to: Person ___ Place ___ Time ___

Responds to: Verbal ___ Pain ___ Unresponsive

Pupils R PERRL L PERRL

Size / Reaction: 2 / 2 /

Motor Strength S = Strong W = Weak TR = Trace A = Absent

Extremities:

	L	R
Upper	S	S
Lower	W	W

[X] See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial		
Femoral			Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: ___ Ectopy: ___

Murmur: ___ Rub: ___ S1: ___ S2: ___

Neck Veins: FLAT

Edema: ___

[ ] See Narrative

RESPIRATORY

Breath Sounds: [X] Clear [X] Bilat

Location:

Crackles /Rales: ___ Dim: ___

Wheezes: ___ Absent: ___

Rhonchi: ___

Cough: Productive / Unproductive: ___

Sputum: Color and Character: ___

Tubes: [ ] ET [ ] Trach

Size: ___ Location: ___

O2: [ ] Canula [ ] Mask

Chest Tubes: ___

[ ] See Narrative

GASTROINTESTINAL

Observation: FLAT

Auscultation: + 4Q

Palpation: NO DISCOMFORT

Stool: [ ] Incontinent [ ] Formed [ ] Soft [ ] Frequent [ ] Liquid [ ] Hard

Diet: ___

Tubes / Bags / Suction / Drainage:

[ ] See Narrative [ ] NGT Placement

GU

[ ] Void Urine: Color / Character

Catheter: ___

Other: ___

[ ] See Narrative

SKIN

Color / Turgur / Temperature / Moisture

WARM PINK DRY

Incisions / Dressings / Leisions / Dermal Ulcers

EX FIXES ON BOTH LEGS

[ ] See Narrative

PT HAS EX FIXES ON BOTH LEGS
PT IS ALSO PRESENT C EDEMA TO BOTH FEET.

0920 C.O. chest discomfort + H/A. Dr (b)(6)-2 notified. EKG done (b)(6)-2

TE WARD - 24 HOUR FLOW SHEET

	18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
												98%	
												20	

200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40 30 20

Temp 97.6A

t glabellar tap or loud auditory stimulus

ght glabellar tap or loud auditory stimulus

6 - No response to light glabellar tap or loud auditory stimulus

(b)(3)-1

Addressograph:

(b)(6)-4

Date: 4/7/03

Allergies

Diagnosis

Age:

DOB:

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

	7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
SpO2	97		96		96					
Respirations	16				16				16	
Temp	95.7				98.2				99.7	

		7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
IV'S	NS			1000							
	TVPB		50					100			50
	Hep drip										
INTAKE	PO										
	NG/TF										
	Other										
	Cummulative Intake										
OUTPUT	Urine Volume										
	Emesis										
	NG Residual/sump										
	Bowel Movement										
	OTHER										
	Cummulative Output										

RAMSEY SEDATION SCALE:

1 - Pt. Anxious and Irritated or restless
2 - Cooperative, oriented and tranquil
3 - Responds to commands only
4 - Brisk response t
5 - Sluggish response

		7:00	8:00	9:00	10:00	11:00	12:00	13:00	14:00	15:00	16:00
PAIN	Medicated			MS							
	Dose / Route			5mg							
	Intensity (1-10) Pre / Post Med			IV							
	Sedation Scale										
Nursing care	BATH PARTIAL/COMPLETE										
	ACTIVITY(Turn L, R, B, ch, amb)			✓							
	IV Site CDI? Q2 hrs			✓							
	IV Site CDI? Q2 hrs										
	TCBD										
	Wound care										
Miscellaneous	pulse ox	92%		96%		96-98%		95-96%		98%	
		O2 2-10L		O2 2-2L							

1900-0700	Time:	Signature:

2120 - lab PT/PTT drawn sent to lab. (b)(6)-2
2330 - Received Heparin orders. (b)(6)-2
0045 - Pt complaint of pain, dressing saturated. Dressing Reinforced. (b)(6)-2

NEUROLOGICAL

Level of Consciousness
Oriented to: Person ✓ Place ___ Time ___
Responds to: Verbal ✓ Pain ___ Unresponsive ___
Pupils PERRLA

	R	L
Size /	/	/

Motor Strength Extremities:
S = Strong
W = Weak
TR = Trace
A = Absent

	L	R
Upper	S	S
Lower	W	W

☐ See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial	~~0~~	
Femoral	~~0~~	+	Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: NSR Ectopy: ___
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: Bilat LE Edema
☐ See Narrative

RESPIRATORY

Breath Sounds: ☐ Clear ☐ ✓ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: ___
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☐ ✓ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: FLAT
Auscultation: +BS
Palpation: Soft
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard

Tubes / Bags / Suction / Drainage:

☐ See Narrative ☐ NGT Placement

GU

☐ Void **Urine:** Color / Character
Yellow
Catheter: Foley
Other:
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
Normal
Incisions / Dressings / Leisions / Dermal Ulcers

☐ ✓ See Narrative

0700-1900	Time	Signature:	

NEUROLOGICAL

Level of Consciousness VERBAL CUES
Oriented to: Person ___ Place ___ Time ___
Responds to: Verbal ___ Pain ___ Unresponsive
Pupils R L
Size / Reaction: 2 / 2
Motor Strength Extremities: S = Strong, W = Weak, TR = Trace, A = Absent

	L	R
Upper	S	S
Lower	S	S

☐ See Narrative

CARDIOVASCULAR

Pulses

	R	L		R	L
Radial	+	+	Posterior Tibial		
Femoral			Dorsalis Pedis	+	+

+ = Normal - = Weak 0 = Absent

Rhythm: ___ Ectopy: ___
Murmur: ___ Rub: ___ S1: ___ S2: ___
Neck Veins: ___
Edema: ___
☐ See Narrative

RESPIRATORY

Breath Sounds: ☒ Clear ☑ Bilat
Location:
Crackles /Rales: ___ Dim: ___
Wheezes: ___ Absent: ___
Rhonchi: ___
Cough: Productive / Unproductive: ___
Sputum: Color and Character: ___
Tubes: ☐ ET ☐ Trach
Size: ___ Location: ___
O2: ☐ Canula ☒ Mask
Chest Tubes: ___
☐ See Narrative

GASTROINTESTINAL

Observation: FLAT
Auscultation: +4 Q
Palpation: NO DISCOMFORT
Stool: ☐ Incontinent ☐ Formed ☐ Soft ☐ Frequent ☐ Liquid ☐ Hard
Diet: ___
Tubes / Bags / Suction / Drainage:
☐ See Narrative ☐ NGT Placement

GU

☐ Void Urine: Color / Character
Catheter: ___
Other:
☐ See Narrative

SKIN

Color / Turgur / Temperature / Moisture
COOL MOIST PINK
Incisions / Dressings / Leisions / Dermal Ulcers
(R) SHIN (L) SHIN (R) THIGH
☐ See Narrative

0800 Resting comfortably. O2 @ 2L via mask. O2 Sat @ 96%. Taken to X-ray for chest film. Suspected PE. Will start Heparin drip. (b)(6)-2

Heparin 6,000 bolus infused w/ difficulty. Heparin drip started (b)(6)-2

'TE WARD - 24 HOUR FLOW SHEET

	18:00	19:00	20:00	21:00	22:00	23:00	0:00	1:00	2:00	3:00	4:00	5:00	6:00
					2240								
					97				97				
					20				20				
Temp					98.8				97.5				
				1000			500cc						
					400			400					

t glabellar tap or loud auditory stimulus

ght glabellar tap or loud auditory stimulus

6 - No response to light glabellar tap or loud auditory stimulus

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR 2003

DAY

HOUR 1210 15 20 35 50 1305 1335 1445 1505 1530 35 40 55 1640 1685 1705 1745

PULSE (O) — TEMP. F (●)

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

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

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 18 16 18 18 18 18 18 18 18 18 18 18 18

BLOOD PRESSURE

HEIGHT: WEIGHT-#

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.

VITAL SIGNS RECORD

STANDARD FORM 511 (REV. 9-79)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
511-113
*U.S. Government Printing Office: 1991 — 281-782/40096

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST-OP DAY																	
MONTH-YEAR	DAY	4/3/23		1645	1715												
19	HOUR		1645														

PULSE (O)	TEMP. F (●)	TEMP. C (Centigrade Equivalents, for Reference only)
	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

Post VS
BP 100
BP 102/54
RR 16

Record special data only when so ordered

BLOOD PRESSURE		134/66			
HEIGHT:	WEIGHT:	RR16			
		101.7	102.2	101.9	101.8
		1645	1650	1655	1715

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

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORD

STANDARD FORM 511 (REV. 9-79)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
511-113

MEDICAL RECORD | VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

PULSE (O) TEMP. F (●)

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

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

TEMP. C (Centigrade Equivalents, for Reference only)

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

RESPIRATION RECORD

Record special data only when so ordered

BLOOD PRESSURE

HEIGHT: WEIGHT→

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

REGISTER NO.

WARD NO.

VITAL SIGNS RECORD

511-113

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

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															
MONTH-YEAR	DAY														
19	HOUR	0045	0050	0055	0100	0115	0130	0145	0200	0230	0300				
PULSE (O)	TEMP. F (●)	89	89	98	85	92	98	93	90	96					
		02 10L	02 10L	02 10L	02 5L	02 5L	02 5L		02	5L FM					
180	104°														
170	103°														
160	102°														
150	101°														
140	100°														
130	99°														
	98.6°														
120	98°														
110	97°														
100	96°														
90	95°														
80															
70															
60															
50															
40															

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD															
				18	18	18	18	16	14	18	18				
BLOOD PRESSURE		140/55	140/57	137/71	120/64	~~120~~/25/18	131/82	120/80	117/86	130/67					
HEIGHT:	WEIGHT→														
		R	16												

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.

VITAL SIGNS RECORD

STANDARD FORM 511 (REV. 9-75)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

511-113

(b)(6)-4

Government Printing Office: 1989-241-175/80290

CO 145
HE 145

Completed @ 0654

LABORATORY REQUEST FORM

FOR CHEMISTRY, SEROLOGY, AND COAGULATION, CHECK DESIRED TESTS.
FOR ALL OTHERS, CIRCLE DESIRED PANEL.

Check	CHEMISTRY	Result	URINALYSIS	Result	RBC MORPHOLOGY
	GLU		Spec Gravity		
	BUN		pH		
	CREAT		Leukocytes		
	NA		Nitrite		
	K		Protein		
	CL		Glucose		MICROBIOLOGY
	CO_2		Ketones		Culture Site:
	Phos		Urobilinogen		
	AST		Bilirubin		Results:
	ALT		Blood		
	LDH		Hemoglobin		
	TBIL		MICROSCOPIC		
	ALB				Sensitivity:
	CA				
	CHOL				
	TRIG				
	CK		HEMATOLOGY	CBC	
	TP		WBC	6.7	
	MG		RBC	2.03	
	AMYL		HGB	5.8	PV - reported to b-6-2
	LIPASE		HCT	18.0	CDR [redacted]
			MCV	88.6	@ 0629 (4/8/03)
	SEROLOGY		RDW	13.7	
	MONOSPOT		PLT	155	
			MPV	7.0	MCH 28.5
	COAGULATION		DIFFERENTIAL		MCHC 32.1
✓	PT	12.1	NEUTRO		
✓	PTT	28.1	BAND		
			META	Reported to CDR	
	BLOOD GAS		MYELO	(b)(6)-2	
	pH		PROMYELO	@ 0800 4/8/03	
	PCO_2		BLAST		
	PO_2		EOSINO		
	LACTATE		BASO		
	BICARBONATE		LYMPH		
	TOTAL CO_2		MONO		
	BASE EXCESS		NUCLEATED RBC		
	O_2 SAT				

Patient Name: (b)(6)-4 Location: WARD III

FMP/SSN: Provider: (b)(6)-2

Date: 4/8/03

(b)(6)-4

MEDCOM - 5180

(b)(6)-4

ID: (b)(6)-4 9-Apr-2003 0:47:56 (b)(3)-1

45years
Male Other
60in 125lbs

Vent. rate 89 bpm
PR interval 118 ms
QRS duration 110 ms
QT/QTc 332/403 ms
P-R-T axes 86 74 50

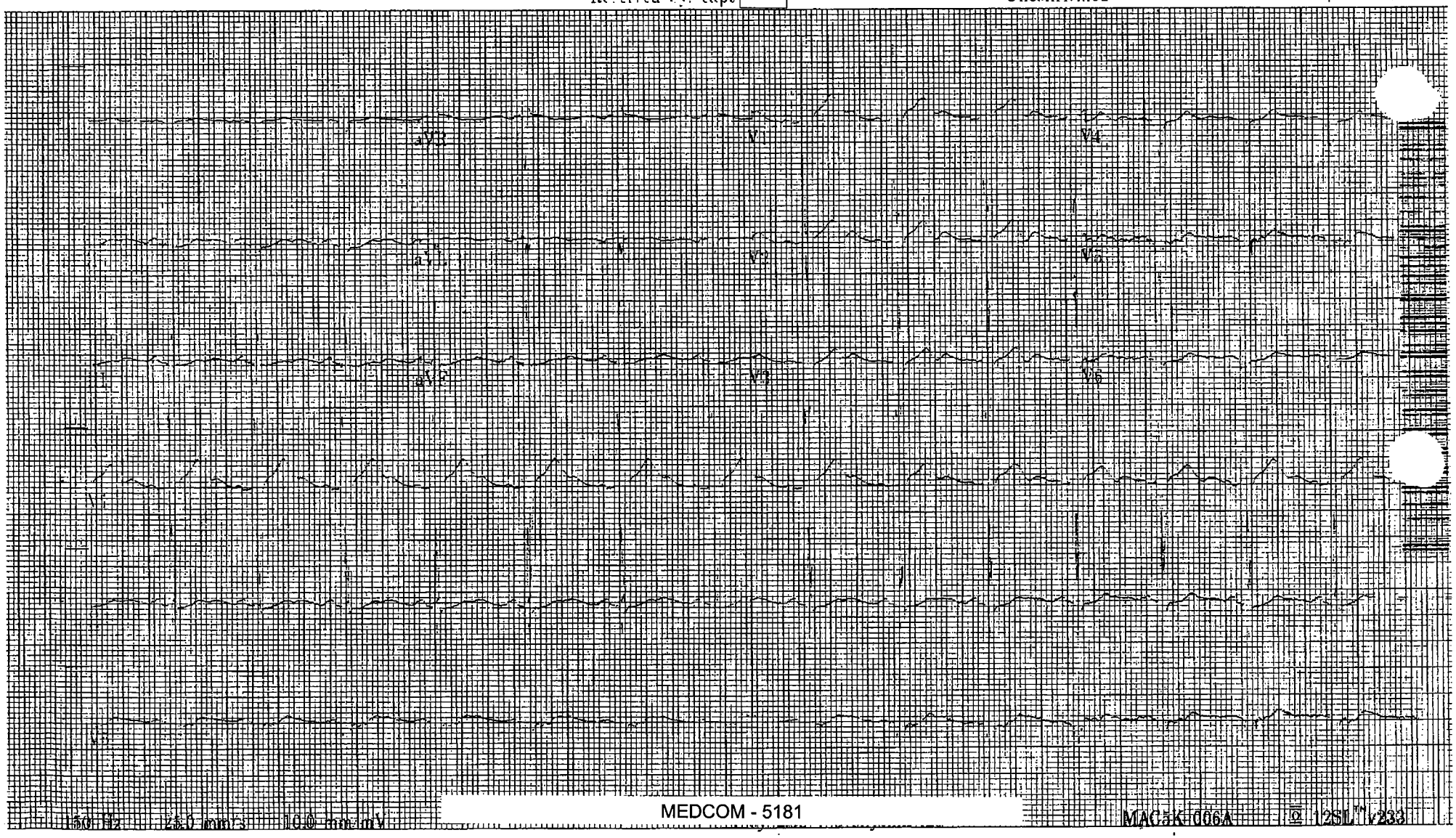
*** Age and gender specific ECG analysis ***
Normal sinus rhythm
Minimal voltage criteria for LVH, may be normal variant
Borderline ECG

(b)(6)-2

(b)(6)-2

Technician: (b)(6)-2
Test ind:

Referred by: capt (b)(6)-2 Unconfirmed



150 Hz 25.0 mm/s 10.0 mm/mV

HE171
C0171

0850
TIME COMPLETED

(b)(3)-1

LABORATORY REQUEST FORM

FOR CHEMISTRY, SEROLOGY, AND COAGULATION, CHECK DESIRED TESTS.
FOR ALL OTHERS, CIRCLE DESIRED PANEL.

Check	CHEMISTRY	Result	URINALYSIS	Result	RBC MORPHOLOGY
	GLU		Spec Gravity		
	BUN		pH		
	CREAT		Leukocytes		
	NA		Nitrite		
	K		Protein		
	CL		Glucose		MICROBIOLOGY
	CO_2		Ketones		Culture Site:
	Phos		Urobilinogen		
	AST		Bilirubin		Results:
	ALT		Blood		
	LDH		Hemoglobin		
	TBIL		MICROSCOPIC		
	ALB				Sensitivity:
	CA				
	CHOL				
	TRIG				
	CK		HEMATOLOGY		
	TP		WBC	6.2	MCH 29.2
	MG		RBC	2.56	MCHC 32.6
	AMYL		HGB	7.5	
	LIPASE		HCT CBC	23.0	
			MCV	89.7	
	SEROLOGY		RDW	13.4	
	MONOSPOT		PLT	191	
			MPV	7.3	
	COAGULATION		DIFFERENTIAL		
	PT	11.4	NEUTRO		
	PTT	24.0	BAND		
			META		
	BLOOD GAS		MYELO		
	pH		PROMYELO		
	PCO_2		BLAST		
	PO_2		EOSINO		
	LACTATE		BASO		
	BICARBONATE		LYMPH		
	TOTAL CO_2		MONO		
	BASE EXCESS		NUCLEATED RBC		
	O_2 SAT				

Patient Name: (b)(6)-4 Location: WARD III

FMP/SSN: Provider: Dr. (b)(6)-2

Patient ID: Date: 4-9-03

Completed @ 2216

LABORATORY REQUEST FORM

FOR CHEMISTRY, SEROLOGY, AND COAGULATION, CHECK DESIRED TESTS.
FOR ALL OTHERS, CIRCLE DESIRED PANEL.

Check	CHEMISTRY	Result
	GLU	
	BUN	
	CREAT	
	NA	
	K	
	CL	
	CO_2	
	Phos	
	AST	
	ALT	
	LDH	
	TBIL	
	ALB	
	CA	
	CHOL	
	TRIG	
	CK	
	TP	
	MG	
	AMYL	
	LIPASE	

	SEROLOGY	
	MONOSPOT	

	COAGULATION	
CO14	PT	12.4
	PTT	28.5 ~~26.0~~

	BLOOD GAS	
	pH	
	PCO_2	
	PO_2	
	LACTATE	
	BICARBONATE	
	TOTAL CO_2	
	BASE EXCESS	
	O_2 SAT	

URINALYSIS	Result
Spec Gravity	
pH	
Leukocytes	
Nitrite	
Protein	
Glucose	
Ketones	
Urobilinogen	
Bilirubin	
Blood	
Hemoglobin	

MICROSCOPIC

HEMATOLOGY	
WBC	
RBC	
HGB	
HCT	
MCV	
RDW	
PLT	
MPV	
DIFFERENTIAL	
NEUTRO	
~~BAND~~	drawn @ 2102
META	
MYELO	
PROMYELO	
BLAST	
EOSINO	
BASO	
LYMPH	
MONO	
NUCLEATED RBC	

RBC MORPHOLOGY

MICROBIOLOGY

Culture Site:

Results:

Sensitivity:

4/7/03 2300 Dw Dr (b)(6)-2

Patient Name: EPW Location: WARD III

FMP/SSN: Ø16Ø Provider: Dr (b)(6)-2 / CPT (b)(6)-2

Date: 07 APR 03

Repeat CBC in AM

6000 Bolus 1400
1000u/hr

1300u/hr check in 6hrs

MEDCOM - 5183

HE 157

Test Personed 1720

LABORATORY REQUEST FORM

FOR CHEMISTRY, SEROLOGY, AND COAGULATION, CHECK DESIRED TESTS.
FOR ALL OTHERS, CIRCLE DESIRED PANEL.

Check	CHEMISTRY	Result	URINALYSIS	Result	RBC MORPHOLOGY
	GLU		Spec Gravity		
	BUN		pH		
	CREAT		Leukocytes		
	NA		Nitrite		
	K		Protein		
	CL		Glucose		MICROBIOLOGY
	CO_2		Ketones		Culture Site:
	Phos		Urobilinogen		
	AST		Bilirubin		Results:
	ALT		Blood		
	LDH		Hemoglobin		
	TBIL		MICROSCOPIC		
	ALB				Sensitivity:
	CA				
	CHOL				
	TRIG				
	CK		HEMATOLOGY	CBC	
	TP		WBC	8.5	MCH 28.5
	MG		RBC	2.24	MCHC 32.0
	AMYL		HGB	6.4	
	LIPASE		HCT	19.9	
			MCV	89.1	
	SEROLOGY		RDW	13.6	
	MONOSPOT		PLT	158	
			MPV	8.5	
	COAGULATION		DIFFERENTIAL		
	PT	12.6	NEUTRO		
	PTT	23.7	BAND		
			META		
	BLOOD GAS		MYELO		
	pH		PROMYELO		
	PCO_2		BLAST		
	PO_2		EOSINO		
	LACTATE		BASO		
	BICARBONATE		LYMPH		
	TOTAL CO_2		MONO		
	BASE EXCESS		NUCLEATED RBC		
	O_2 SAT				

Patient Name: EPW

Location: WARD 3

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

Provider: (b)(6)-2

Date: 4/8/03 1000

Bed I

(b)(3)-1

HE 125
0751
TIME COMPLETED

LABORATORY REQUEST FORM

FOR CHEMISTRY, SEROLOGY, AND COAGULATION, CHECK DESIRED TESTS.
FOR ALL OTHERS, CIRCLE DESIRED PANEL.

Check	CHEMISTRY	Result	URINALYSIS	Result	RBC MORPHOLOGY
	GLU		Spec Gravity		
	BUN		pH		(b)(6)-2
	CREAT		Leukocytes		
	NA		Nitrite		
	K		Protein		
	CL		Glucose		MICROBIOLOGY
	CO_2		Ketones		Culture Site:
	Phos		Urobilinogen		
	AST		Bilirubin		Results:
	ALT		Blood		
	LDH		Hemoglobin		
	TBIL		MICROSCOPIC		
	ALB				Sensitivity:
	CA				
	CHOL				
	TRIG		CBC		
	CK		HEMATOLOGY		
	TP		WBC	11.8	
	MG		RBC	2.76	
	AMYL		HGB	8.0	
	LIPASE		HCT	24.4	MCH 28.9
			MCV	88.6	MCHC 32.7
	SEROLOGY		RDW	13.6	
	MONOSPOT		PLT	154	
			MPV	7.6	
	COAGULATION		DIFFERENTIAL		
	PT		NEUTRO		
	PTT		BAND		
			META		
	BLOOD GAS		MYELO		
	pH		PROMYELO		
	PCO_2		BLAST		
	PO_2		EOSINO		
	LACTATE		BASO		
	BICARBONATE		LYMPH		
	TOTAL CO_2		MONO		
	BASE EXCESS		NUCLEATED RBC		
	O_2 SAT				

Patient Name: (b)(6)-4 Location: WARD III

FMP/SSN: (b)(6)-4 Provider: (b)(6)-2

Patient ID: (b)(6)-4 Date: 07 APR 03/0705

He 205 >5 Test complete 0800

(b)(3)-1

LABORATORY REQUEST FORM

FOR CHEMISTRY, SEROLOGY, AND COAGULATION, CHECK DESIRED TESTS.
FOR ALL OTHERS, CIRCLE DESIRED PANEL.

Check	CHEMISTRY	Result	URINALYSIS	Result	RBC MORPHOLOGY
	GLU		Spec Gravity		
	BUN		pH		
	CREAT		Leukocytes		
	NA		Nitrite		
	K		Protein		
	CL		Glucose		MICROBIOLOGY
	CO_2		Ketones		Culture Site:
	Phos		Urobilinogen		
	AST		Bilirubin		Results:
	ALT		Blood		
	LDH		Hemoglobin		
	TBIL		MICROSCOPIC		
	ALB				Sensitivity:
	CA				
	CHOL				
	TRIG				
	CK		HEMATOLOGY	CBC	
	TP		WBC	6.8	
	MG		RBC	2.81	
	AMYL		HGB	8.4	
	LIPASE		HCT	25.4	
			MCV	90.3	
	SEROLOGY		RDW	13.5	MCH ~ 29.7
	MONOSPOT		PLT	241	MCHC ~ 32.9
			MPV	6.9	
	COAGULATION	COAG	DIFFERENTIAL		
	PT	11.5	NEUTRO		
	PTT	23.0	BAND		
			META		
	BLOOD GAS		MYELO		
	pH		PROMYELO		
	PCO_2		BLAST		
	PO_2		EOSINO		
	LACTATE		BASO		
	BICARBONATE		LYMPH		
	TOTAL CO_2		MONO		
	BASE EXCESS		NUCLEATED RBC		
	O_2 SAT				

Patient Name: (b)(6)-4 Location: WARD 3

FMP/SSN: Provider: (b)(6)-2

Patient ID: (b)(6)-4 Date: 4/18

Day Of Surgery
Vital Signs 1 27/28 90

HOLDING AREA: Versed_____mg IV Fentanyl_____mcg IV Ancef/_____ _____gm IVPB

NAVHOSPPNCLA OVERPRINT (10-94) IV 16 (18) 20 ga in R / L Hnd / FA / AC

WT 67 Kg **CLINICAL RECORD** ☒ Drugs / Equipment / O2 / Suction / Checked **ANESTHESIA**

	START	STOP
Anesthesia	0820	0930
Procedure	0855	0910

AGENTS

	8	9	10
O_2 L/MIN	6	6	6
N2O Air L/Min			
DES / SEVO %	2	2.5	2.5
FEN / SUF / ALF / REM			
PRO / PEN / ETO	200		
SUX / MIVA / ATR	100		
NOR / PAV / ZEM / NIM			
0.9% NS	100		

MONITORS

	8	9	10
EKG	SR	SR	SR
ET CO_2	40	40	40
FIO_2	1	1	1
SaO_2%	100	100	100
Temp. / S/A/R/E			
Urine ML			
EBL ML			

● = PULSE
O = SPONT RESP
Ø = ASST RESP
⊕ = CNTRL RESP
⊕ = VENTILATOR

X CUFF BP
÷ ART LINE

X = MAP
I = INTUBATE
R = REVERSAL
E = EXTUBATE

200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

VITAL

	8	9	10
Tidal Volume			
Resp. Rate			
Peak Pressure			
Vent Mode			

Symbols for Remarks

FLUIDS

	8	9	10
Blood / Products			
IV. LR / DSLR			
IV			

POSITION supine BRP Head cervical

PRE-PROCEDURE
☑ Identified: ☑ ID Band ☐ Questioning
☑ Chart Reviewed ☐ Permit Signed
☑ NPO Since
Pre-anesthetic State: ☐ Calm
☐ Awake ☐ Asleep
☐ Apprehensive ☐ Confused
☐ Uncooperative ☐ Unresponsive

PATIENT SAFETY
☑ Anes. Machine # 1 Checked
☑ Safety Belt On ☐ Axillary Roll
☑ Armboard Restraints ☐ Arms Tucked
☑ Pressure points checked and padded
☑ Eye Care: ☐ Ointment ☐ Saline
☑ Taped ☐ Pads ☐ Goggles

ANESTHETIC TECHNIQUE
General: ☑ Pre-Oxygenation ☐ L.T.A.
☑ Rapid Sequences ☐ Cricoid Pressure
☐ Intravenous ☐ Inhalation
☐ Intramuscular ☐ Rectal
Regional: ☐ Spinal ☐ Epidural
☐ Axillary ☐ Bier Block ☐ Ankle Block
☐ _____ ☐ Position_____
☐ Prep_____ ☐ Local_____
☐ Needle N/A
☐ Drugs(s)_____
☐ Dose_____ ☐ Attempts x_____
☐ Site_____ ☐ Level_____
☐ Catheter_____ ☐ See Remarks
Other: ☐ M.A.C. ☐ _____

AIRWAY MANAGEMENT
Intubation: ☑ Oral Tube size 7
☑ Stylet used ☐ Nasal ☑ Regular
☐ Magill's ☑ DLS ☐ RAE
☐ Fiber optic ☐ Blind ☐ Atraumatic
☑ Glide Mc3 ☐ LMA
☑ Secured at 22 cm ☐ Dbl Lum
☑ Attempts x 1 ☑ ET CO_2 present
☐ Breath sounds _____
☑ Uncuffed, leaks at _____ cm H_2O
☑ Cuffed ☐ Min. occ. pres ☑ XP ☐ NS
Airway: ☐ Oral ☐ Nasal ☐ Difficult, see Remarks
Circuit: ☐ Circle ☐ NRB
☐ Mask Case ☐ Nasal Cannula
☐ Via Tracheostomy ☐ Simple O_2 mask

FLUID TOTALS
Crystalloid 700 EBL 100
Blood 0 Urine 0

RECOVERY
Location PACU Time 0920
B/P 169/60 O_2 Sat. 92
P R 20 T
☐ Awake ☑ Stable ☐ Nasal Oxygen
☐ Drowsy ☐ Unstable ☑ Mask Oxygen
☐ Somnolent ☐ Intubated ☐ T-piece Oxygen
☐ Unarousable ☐ Ventilator ☐ Oral/nasal airway

PACU NOTES
Pain_____

NARCOTICS	FENT/SUF/REM	MIDAZ
ISSUED		
USED		
WASTED		

REMARKS
① TO OR A/A; ETT BLA M&N/ SMOOTH I/E
② TO ICU MR 210 ATRNE A/W

MONITORS AND EQUIPMENT
☑ Sleth ☐ Precord ☐ Esoph ☐ Other
☑ Non-Invasive B/P ☐ Left ☐ Right
☑ Continuous EKG ☐ V Lead EKG
☑ Pulse Oximeter ☑ Oxygen Sensor
☑ End-Tidal CO_2 ☐ Gas Analyzer
☑ Temp._____ ☐ Nerve Stimulator
☐ Warming Blanket ☐ Fluid Warmer
☐ Airway Humidifier ☐ Foley Catheter
☐ NG / OG Tube ☐ Art. Line_____

EMERGENCE
Oral Suctioning ☑ Head Lift x 5 sec. ☑
Extubation: AWAKE ☑ ASLEEP ☐

PROCEDURE ① BLA
SURGEON(S) (b)(6)-2
AN (b)(6)-2 (b)(6)-2 (b)(6)-2
PATIENT'S IDENTIFICATION *(For typed or written entries give Name—last, first, middle, grade, date, hospital or medical facility.)*
(b)(6)-4
DATE 4-1-03
ANESTHESIA

Standard Form 517
Prescribed by GSA ICMR
FIRMR (41 CFR) 201-45 505
OCTOBER 1975 517-112

MEDCOM - 5187

APRIL 7

Post-Op Orders

Date 2415 Time 4-6-03

1. ADMIT TO: [ ] ACW [ ] ICU (Wd3)
2. DIAGNOSIS/PROCEDURE (print):
   Fx fem, Fx (R) + (L) tibia.
3. VITAL SIGNS: [ ] Per Post-op Routine [✓] Q4hr
4. ACTIVITY: [X] Bedrest [ ] Up with Assistance
5. ALLERGIES:
6. NURSING: [ ] I/O [ ] Foley to gravity [ ] NG to LIS
   [ ] CT to -20CM H_2O Suction [ ] IS Q1° while awake
7. DIET: [ ] NPO [✓] Reg [ ] Clear Liq [ ] Full Liq
8. IV FLUIDS: [ ] Lactd Rngr @ ____ CC/hr [ ] Normal Saline @ ____ CC/hr
9. LABS: [✓] CBC [ ] Chem 7 [ ] CAMP [ ] UA [ ] PT,PTT [ ] LFT's
   Frequency (such as STAT, Q-AM) ____
10. Type and Cross ____ Units
11. PARAMETERS: Call MD T>101, SBP>180<90, DPB>100, Pulse>120, UOP <____cc/____hr, RR>24
12. MEDICATIONS:
    [✓] Morphine 10 mg IV, Q 3 hr, PRN Pain
    [ ] Demerol ____ mg [ ] IM [ ] IV, Q____hr, PRN Pain
    [✓] Tylenol #3, 1-2 PO q4hr PRN Pain
    [ ] Percocet 1-2 Q4° PO PRN PAIN
    [ ] Zantac 50mg IV Q8°
    [ ] Phenergen 12.5-25 mg IV/IM PRN N/V
    [✓] Oxygen @ 3 L per min Titrate to keep sat > 92%
    [✓] Ancef 1g IV Q8° x 48 hrs
    [ ] Rocephin 1g IV Q12°
    [ ] Gentamycin ____ mg IV load & pharmacy to dose
    [ ] Cipro ____ mg IV Q12°
    [ ] Clindamycin ____ mg IV, Q ____ hr
    [ ] Penicillin G, ____ Million Units IV Q ____ hrs
    [ ] Unasyn ____ gram IV, Q ____ hr
    [ ] Transfuse ____ units packed cells
13. DRESSINGS: Ø
14. DRAINS: Ø
15. RADIOLOGY: AP (R) fem AP (R) and (L) tibias.
16. OTHER: (b)(6)-2 Dr. (b)(6)-2 Ass. (b)(6)-2
    NPO p MN on 4-7-03 for surg on 4-8-03

DOCTOR SIGNATURE:

PATIENT IDENTIFICATION:
FULL NAME:
FULL SSN: (b)(6)-4

Day Of Surgery
Vital Signs

ASA I E

HOLDING AREA: Versed ____ mg IV Fentanyl ____ mcg IV Ancef/ ____ ____ gm IVPB

NAVHOSPPNCLA OVERPRINT (10-94) IV 16 (18) 20 ga in (R) / L Hnd / (FA) / AC

WT 75 Kg **CLINICAL RECORD** ☑ Drugs / Equipment / O2 / Suction / Checked **ANESTHESIA**

	(23)		30				(24)		30				(01)		30				(02)					
O2 L/MIN	1		0.7		0.7		0.7		0.7		1													
N2O Air L/Min																								
DES / SEVO % 150	(2)		1.5		1.5		1.5		1.5		X													
FEN / SUF / ALF / REM (250)																								
PRO / PEN / ETO																								
SUX / MIVA / ATR (120)																								
NOR / PAV / ZEM / NIM			4																					
MSO4 mg (10)			10				10																	
EKG II	SR		SR		SR		SR		SR		X													
ET CO2	(+)		40		40		38		41		40													
FIO2	100		100		100		100		100		100													
SaO2 %	100		100		100		100		100		100													
Temp. / S/A/R/E	normal		37.2				36.4		36.5		36.3													
Urine ML											100													
EBL ML							30				100													
Tidal Volume	(0)	(0)	(0)		750				(0)	(0)	1894	12												
Resp. Rate					8																			
Peak Pressure					33																			
Vent Mode					VC																			
Blood / Products																								
IV / LR / DSLR					700				1000		1200													
IV																								
POSITION	HPP																							

Symbols for Remarks

● = PULSE
O = SPONT RESP
Ø = ASST RESP
⊕ = CNTRL RESP
⊕ = VENTILATOR
X CUFF BP
+ ART LINE
X = MAP
I = INTUBATE
R = REVERSAL
E = EXTUBATE

06 68 100

PACU USS (00)

	START	STOP
Anesthesia	2255	0039
Procedure	2315	0025

PRE-PROCEDURE
☑ Identified: ☐ ID Band ☐ Questioning
☑ Chart Reviewed ☐ Permit Signed
☑ NPO Since
Pre-anesthetic State: ☐ Calm
☑ Awake ☐ Asleep
☐ Apprehensive ☐ Confused
☐ Uncooperative ☐ Unresponsive

PATIENT SAFETY
☑ Anes. Machine # 1B Checked
☑ Safety Belt On ☐ Axillary Roll
☑ Armboard Restraints ☐ Arms Tucked
☑ Pressure points checked and padded
☑ Eye Care: ☐ Ointment ☐ Saline
☑ Taped ☐ Pads ☐ Goggles

ANESTHETIC TECHNIQUE
General: ☐ Pre-Oxygenation ☐ L.T.A.
☑ Rapid Sequences ☐ Cricoid Pressure
☑ Intravenous ☐ Inhalation
☐ Intramuscular ☐ Rectal
Regional: ☐ Spinal ☐ Epidural
☐ Axillary ☐ Blar Block ☐ Ankle Block
☐ ____ ☑ Position ____
☐ Prep ____ ☐ Local ____
☐ Needle ____
☐ Drugs(s) ____
☐ Dose ____ ☐ Attempts x ____
☐ Site ____ ☐ Level ____
☐ Catheter ____ ☐ See Remarks
Other: ☐ M.A.C. ☐ ____

AIRWAY MANAGEMENT
Intubation: ☐ Oral Tube size 7.0
☑ Stylet used ☐ Nasal ☐ Regular
☐ Magill's ☑ Diffict ☐ RAE
☐ Fiber optic ☐ Blind ☐ Airaumatic
☐ Blade MAC 3 ☐ LMA
☑ Secured at 21 cm ☐ Dbl Lum
☑ Attempts x 1 ☑ ET CO2 present
☑ Breath sounds (=) BBS
☐ Uncuffed, leaks at ____ cm H2O
☑ Cuffed ☑ Min. occ. pres. ☐ Air ☐ NS
Airway: ☐ Oral ☐ Nasal ☐ Difficult, see Remarks
Circuit: ☐ Circle ☐ NRB
☐ Mask Case ☐ Nasal Cannula
☐ Via Tracheostomy ☐ Simple O2 mask

FLUID TOTALS
Crystalloid 1200 EBL 100
Blood ____ Urine 100

REMARKS 2300 monitors on, USS, RSI
2308 (R) 18g F.A. placed
0017 Tgm Ancef IV

MONITORS AND EQUIPMENT
☑ Steth ☐ Precord ☐ Esoph ☐ Other
☑ Non-invasive B/P ☐ Left ☐ Right
☑ Continuous EKG ☐ V Lead EKG
☑ Pulse Oximetar ☑ Oxygen Sensor
☑ End Tidal CO2 ☐ Gas Analyzer
☑ Temp. normal ☑ Nerve Stimulator
☐ Warming Blanket ☐ Fluid Warmer
☐ Airway Humidifier ☑ Foley Catheter
☐ NG / OG Tube ☐ Art. Line ____

EMERGENCE
Oral Suctioning ☑ Head Lift x 5 sec. ☐
Extubation: AWAKE ☑ ASLEEP ☐
TOF 4/4 with Sus Tet. ☑

RECOVERY
Location PACU Time 0045
B/P 110/58 O2 Sat. 96
P 80 R 16 T 36.0
☐ Awake ☑ Stable ☐ Nasal Oxygen
☑ Drowsy ☐ Unstable ☐ Mask Oxygen
☐ Somnolent ☐ Intubated ☐ T-piece Oxygen
☐ Unarousable ☐ Ventilator ☐ Oral/nasal airway

PACU NOTES
USS Pain ____

NARCOTICS	FENT/SUF/REM	MIDAZ
ISSUED	250 mg	3
USED	250 mg	3
WASTED	Ø	Ø

MSO4

PROCEDURE (R) LE Tibia / Fibia fx (L) femur fx. Dr (b)(6)-2

SURGEON(S) (b)(6)-2

ANESTHESIA LT (b)(6)-2 1695 CRNA

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

(For typed or written entries give Name—last, first, middle, grade, date, hospital or medical facility.)

(b)(6)-2

ANESTHESIA

DATE 4/6/03

Standard Form 517
Prescribed by GSA ICMR
FIRMR (41 CFR) 201-45 505
OCTOBER 1975 517-112

516-109 NSN 7540-00-634-4156

MEDICAL RECORD | OR # 1R

OPERATION REPORT

PREOPERATIVE DIAGNOSIS (R) Femur fx
Bilat tibia fx

SURGEON (b)(6)-2	FIRST ASSISTANT	SECOND ASSISTANT	
ANESTHETIST (b)(6)-2	ANESTHETIC General		TIME BEGAN: 0830 TIME ENDED: 0923
CIRCULATING NURSE (b)(6)-2	SCRUB NURSE (b)(6)-2	TIME OPERATION BEGAN 0855	TIME OPERATION COMPLETED 0910

OPERATIVE DIAGNOSES

SAA

DRAINS (Kind and number)	SPONGE COUNT VERIFIED
Ø	NA

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

Ø

OPERATION PERFORMED

I & D (R) LE
Delayed Primary Closure (R) LE wound

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)	PROSTHETIC DEVICES (LOT no.)	DATE OF OPERATION
	—	8APR03

Pre-Operative Nsg Assessment:
Dentures: Y (N) Implants: —
Allergies: UNK Foley inserted by: (b)(6)-2
NPO: (Y) N Safety Straps ~~Y~~ N

Intra Operative Nsg Assessment
Anesthesia: General Prep: Betadine S&P
Bovie Equip #: ✓ Irrigation: NS
Bovie Pad #: ✓ Medications: Ø
/Blood

Post Operative
EBL: 100
Wound Class: 3
DSG: Plain Kerlix
U/O: Ø
Fluids: 700
Counts: Initial NA Final NA

SIGNATURE OF SURGEON (b)(6)-2	DATE 8APR03
PATIENT'S IDENTIFICATION (For typed or w[illegible] give: Name - last, first, middle; [illegible] grade; date; ho[illegible] dical facility) (b)(6)-4	REGISTER/I.D. NO. / WARD NO.

OPERATION REPORT
Medical Record

STANDARD FORM 516 (REV 5-83)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

516-109 NSN 7540-00-634-4156

MEDICAL RECORD | OR # | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS

GSW - Bil LE, hip & eye Fx (R) hip Fx Bil Tib/Fib

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
(b)(6)-2	Capt (b)(6)-2	Ø	
ANESTHETIST	ANESTHETIC		TIME BEGAN: 2255
LT (b)(6)-2	GE Mac		TIME ENDED: 0045
(b)(6)-2	SCRUB NURSE (b)(6)-2	TIME OPERATION BEGAN 2315	TIME OPERATION COMPLETED 0025

OPERATIVE DIAGNOSES

DRAINS (Kind and number)	SPONGE COUNT VERIFIED
16Fr foley	

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

Ø

OPERATION PERFORMED

DESCRIPTION OF OPERATION (Type(s) of suture used, gross findings, etc.)	PROSTHETIC DEVICES (LOT no.)	DATE OF OPERATION
	✓	4/6/03/4/7/03

Pre-Operative Nsg Assessment:

Dentures: Y (N) Implants: Howmedic Ostconics Hip screw X-Fix

Allergies: UNK Foley inserted by: _____

NPO: Y (N) Safety Straps (Y) Abd

Intra Operative Nsg Assessment

Anesthesia: _____ Prep: S & S Betadine

Bovie Equip #: _____ Irrigation: NACL

Bovie Pad #: _____ Medications: _____

/Blood

Post Operative

EBL: 100cc

Wound Class: _____

DSG: _____

U/O: 100cc

Fluids: 1200 LR

Counts: Initial Ø Final Ø

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

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)	REGISTER/I.D. NO.	WARD NO.
(b)(6)-4		

OPERATION REPORT
Medical Record

MEDCOM - 5191

STANDARD FORM 516 (REV 5-83)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

MEDICAL RECORD	BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I—TRANSFUSION REQUISITION

☒ RED BLOOD CELLS ☐ OTHER (*Specify*)	UNITS 1 OR ..... ML	DATE REQUESTED 4/8/03	DATE AND HOUR WANTED 4/8/03 1100	PHYSI (b)(6)-2
KNOWN IMMUNE ANTIBODY FORMATION ☐ Rh ☐ Others	PREVIOUS TRANSFUSIONS ☐ Yes ☐ No ☒ Unknown		REACTIONS TO PREVIOUS TRANSFUSIONS ☒ Unknown ☐ No ☐ Yes (*Type*)	
DIAGNOSIS GSW Lower extremity	IF PATIENT IS FEMALE, IS THERE HISTORY OF ☐ Hemolytic Disease of Newborn ☐ RhIG Treatment ☐ Stillbirth ☐ Miscarriage ☐ Delivery			

REMARKS (*Pertinent Patient History*)

I have taken a blood specimen on the below named patient, verified the name, and verified the specimen tube label.

SI (b)(6)-2 2ND

VERIFICATION SIGNATURE (*if required*) (b)(6)-2 CSR

PATIENT SIGNATURE (*or verifier if patient unable to sign*)

SECTION II—BLOOD TYPE, COMPATIBILITY INFORMATION AND CERTIFICATION

UNIT NO. (b)(6)-4

TRANSFUSION NO. (b)(6)-4

DONOR		RECIPIENT	
ABO TYPE	A	ABO TYPE	AB
Rh TYPE	POS	Rh TYPE	POS

COMPATIBILITY INFORMATION

	SALINE	ALBUMIN	COOMBS
MAJOR (*DC/PS*)	—	—	1+
MINOR (*PC/DS*)			

☐ Compatibility Tests Not Performed (*Explain below*)

REMARKS: exp 4/17/03

SIGNATURE (*Person performing tests*) (b)(6)-2

DATE 4/8/03

SIGNATURE (*Verifier, if required*) (b)(6)-2 1440 4-8-03

SECTION III—RECORD OF TRANSFUSION

ADMINISTRATION

DATE OF TRANSFUSION — MONTH 04 — DAY 08 — YEAR 2003

TIME STARTED 1530

IDENTIFICATION:

I have examined the blood or blood component container label and blood or blood component transfusion form and I find that all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this blood or blood component transfusion form and on the patient identification tag.

☒ YES ☐ NO T 99.9 R. 18 BP 132/70 P 80

VERIFIED BY (b)(6)-2 NA CCO

(b)(6)-2 N STARTING TRANSFUSION CTSL NC

POST TRANSFUSION DATA

AMOUNT GIVEN 1004 ML — TIME COMPLETED/INTERRUPTED 1750

REACTION: ☒ NONE ☐ SUSPECTED

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion; treat shock if present, keep intravenous open
2. Notify Physician and Transfusion Service
3. Follow transfusion reaction procedures

DESCRIBE: ☐ URTICARIA ☐ CHILL/FEVER ☐ HEMOLYSIS/PAIN

RECORD: Temp. 100.1 Pulse 88 B/P 138/60

Other difficulties (*equipment, clots, etc.*) ☐ No ☒ Yes (*Specify*) Δ IV site from ES to

SIGNATURE OF PERSON NOTE (b)(6)-2 LTOL, NC. RN

PATIENTS IDENTIFICATION—USE EMBOSSER—(*for typed or written entries give: Name—Last, first, middle, rank/rate; hospital number and name of facility.*)

(b)(6)-4

SEX M — WARD NO. 3

BLOOD OR BLOOD COMPONENT TRANSFUSION

STANDARD FORM 518 (REV. 9-76)
Prescribed by GSA and Interagency Committee on Medical Records
FPMR (41 CFR) 101-11.806-8
518-118

MEDICAL RECORD COPY

☆ GPO : 1982 O - 381-531 (3534)

MEDICAL RECORD	BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I—TRANSFUSION REQUISITION

☒ RED BLOOD CELLS ☐ OTHER (*Specify*)	UNITS 1 OR.....ML	DATE REQUESTED 4/8/03	DATE AND HOUR WANTED 4/8/03 1100	PHYSICIA (b)(6)-2
KNOWN IMMUNE ANTIBODY FORMATION ☐ Rh ☐ Others	PREVIOUS TRANSFUSIONS ☐ Yes ☐ No ☒ Unknown		REACTIONS TO PREVIOUS TRANSFUSIONS ☒ Unknown ☐ No ☐ Yes (*Type*)	
DIAGNOSIS GSW lower Extremity	IF PATIENT IS FEMALE, IS THERE HISTORY OF ☐ Hemolytic Disease of Newborn ☐ RhIG Treatment ☐ Stillbirth ☐ Miscarriage ☐ Delivery			

REMARKS (*Pertinent Patient History*)

Unknown

I have taken a blood specimen on the below named patient, verified the name, and verified the specimen tube label.

(b)(6)-2 CHR

VERIFICATION SIGNATURE (*If required*) (b)(6)-2 CHR

PATIENT SIGNATURE (*or verifier if patient unable to sign*)

SECTION II—BLOOD TYPE, COMPATIBILITY INFORMATION AND CERTIFICATION

UNIT NO. (b)(6)-4

TRANSFUSION NO. (b)(6)-4

DONOR		RECIPIENT	
ABO TYPE	AB	ABO TYPE	AB
Rh TYPE	POS	Rh TYPE	POS

COMPATIBILITY INFORMATION

	SALINE	ALBUMIN	COOMBS
MAJOR (*DC/PS*)	=	=	1+
MINOR (*PC/DS*)			

☐ Compatibility Tests Not Performed (*Explain below*)

REMARKS:

exp. 4/17/03

SIGNATURE (*Person performing tests*) (b)(6)-2

DATE 4/8/03

SIGNATURE (*Verifier, if required*) (b)(6)-2 LTJG NC USNR

SECTION III—RECORD OF TRANSFUSION

ADMINISTRATION

DATE OF TRANSFUSION | MONTH 4 | DAY 8 | YEAR 2003

TIME STARTED 1210

IDENTIFICATION:

I have examined the blood or blood component container label and blood or blood component transfusion form and I find that all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this blood or blood component transfusion form and on the patient identification tag.

☒ YES ☐ NO

POST TRANSFUSION DATA 1438

AMOUNT GIVEN 250 ML | TIME COMPLETED/INTERRUPTED

REACTION: ☒ NONE ☐ SUSPECTED

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion; treat shock if present, keep intravenous open
2. Notify Physician and Transfusion Service
3. Follow transfusion reaction procedures

DESCRIBE: ☐ URTICARIA ☐ CHILL/FEVER ☐ HEMOLYSIS/PAIN

RECORD: Temp. 99.3 Pulse 78 B/P 130/84

Other difficulties (*equipment, clots, etc.*) ☒ No ☐ Yes (*Specify*)

VERIFIED BY (b)(6)-2 LCDR USN

SIGNATURE OF PERSON STARTING TRANSFUSION (b)(6)-2 LTJG NC

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2 LTJG NC USNR

PATIENTS IDENTIFICATION—USE EMBOSSER—(*for typed or written entries give: Name—Last, first, middle, rank/rate; hospital number and name of facility.*)

(b)(6)-4

SEX M | WARD NO. 3

BLOOD OR BLOOD COMPONENT TRANSFUSION

STANDARD FORM 518 (REV. 9-76)
Prescribed by GSA and Interagency Committee on Medical Records
FPMR (41 CFR) 101-11.806-8
518-118

MEDICAL RECORD COPY

☆GPO : 1982 O - 381-531 (3534)

NSN 7540-00-634-4162

519-218

PATIENT IDENTIFICATION (For typed or written entries give: Name — last, first, middle, Medical Facility)	AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
(b)(6)-4 (b)(6)-4				III	

EXAMINATION REQUESTED (Use SF 519-B for multiple exams)

AP (R) FEMUR AP (R) AND (L) TIBIAS / CXR

REQUESTED BY	TELEPHONE NO.
DR (b)(6)-2	

LOCATION OF MEDICAL RECORDS	FILM NO.	DATE REQUESTED	PREGNANT
		07 APR 03	☐ YES ☐ NO

SPECIFIC REASON(S) FOR REQUEST (Complaints and findings) (b)(6)-2

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

RADIOLOGIC REPORT

CXR — Ø infiltrate

(R) — prox femur s/p Ex Fix c̄ h/w in place subtrochanteric comminuted fx. Major fx frags in fairly good alignment, butterfly frag s̄ sig displacement on this view

(R) tib-fib single view — Ex fix h/w in place now

SIGNATURE	LOCATION OF RADIOLOGIC FACILITY

1 — MEDICAL RECORD

RADIOLOGIC CONSULTATION REQUEST/REPORT

STANDARD FORM 519-A (REV. 8-83)
Prescribed by GSA/ICMR
FPMR (41 CFR) 201-45.505

☆ U.S GOVERNMENT PRINTING OFFICE : 1987-181-243/40522

(1) tib-fib (cr-td) prox fib Fx oblique mildly displaced
tibia major Fx frags in fairly good alignment
butterfly frags s/ sig displacement

(2) tib-fib — single view — oblique lateral — comminuted
Fx distal diaphysis, Ex Fix h/w in place major
Fx frags s/ distracted mildly displaced
fib Ø clearly eval'd

(b)(6)-2

NSN 7540-00-634-4121

MEDICAL RECORD — DOCTOR'S ORDERS

(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/7/03 0700			1) Chest Xray	(b)(6)-2	
				(b)(6)-2	
				(b)(6)-2	CDR, NC, USN
			Noted		4/7/03 0700
4/7/03 0830		✓	1) Titrate O2 to provide O2 sat = 90%.		
		✓	2) Heparin 6,000 units bolus followed by heparin drip 1,000 units/hour to be run at 100 cc/hour		
		✓	3) activated PTT in 6 hours — call results to me		
				(b)(6)-2	Noted (b)(6)-2 4/7/03 1120
4/7/03			4) NPO ā MN for surgery 4/8		
				(b)(6)-2	
				Noted (b)(6)-2	4/7/03 CDR, NC, USN 1530
4/7/03 @ 2100			~~[illegible]~~ 24° cc completed	(b)(6)-2	4/7/03

— OVER —

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 5196

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/7/03 2320		1	CBC in am		
		2	Heparin drip to deliver 1500 u/hr → 150cc/hr.		
		3	Redraw PT/PTT 6° after change		
			(b)(6)-2		
				CDR USN FNP	
4/7/03 2330			DTS regard Heparin drip order as above - will continue @ 100cc/hr and redraw pt/ptt in 6 hrs.		
			(b)(6)-2		
				CDR USN FNP	
4/8/03 0000			ORDERS NOTED / TRANSCRIBED	(b)(6)-2 LT USN	
4/8/03 0630		1)	Transfuse with 2 units packed cells. Each unit over 2 hours	(b)(6)-2	
		2)	Daily CBCs	(b)(6)-2	
		3)	Daily PTTs.	(b)(6)-2	
			4/8/03 0930	(b)(6)-2	(b)(6)-2
4/9/03 1430		✓	Meclizine 25mg po now and		
		✓	q 6 hours prn for dizziness		
			(b)(6)-2		
			(b)(6)-2 MD CAPT MC USNR	Noted 4/9/03 1550	(b)(6)-2 CDR, NC USN
			(b)(6)-2		

(b)(6)-4

STANDARD FORM 508 (Rev. 3-94) BACK

Post-Op Orders

Date_____ **Time** 4-8-03

1. ADMIT TO: [ ] ICU [ ] WARD 1 [ ] WARD 2 [X] WARD 3
2. DIAGNOSIS/PROCEDURE (print): s/p I&D (R) tibia fx c dpc
3. VITAL SIGNS: [X] Per Post-op Routine [ ] Q4hr
4. ACTIVITY: [X] Bedrest [ ] Up with Assistance
5. ALLERGIES:
6. NURSING: [ ] I/O [ ] Foley to gravity [ ] NG to LIS
   [ ] CT to -20CM H_2O Suction [ ] IS Q1° while awake
7. DIET: [ ] NPO [X] Reg [ ] Clear Liq [ ] Full Liq
8. IV FLUIDS: [ ] Lactd Rngr @ ___ _____CC/hr [ ] Normal Saline @ _____CC/hr
9. LABS: [ ] CBC [ ] Chem 7 [ ] CAMP [ ] UA [ ] PT,PTT [ ] LFT's
   Frequency (such as STAT, Q-AM) _____
10. Type and Cross _____ Units
11. PARAMETERS: Call MD T>101, SBP>180<90, DPB>100, Pulse>120, UOP <_____cc/_____hr, RR>24
12. MEDICATIONS:
    [X] Morphine ___ 8-10 mg IV, Q _____hr, PRN Pain
    [ ] Demerol ___ _____mg [ ] IM [ ] IV, Q_____hr, PRN Pain
    [X] Tylenol #3, 1-2 PO q4hr PRN Pain
    [ ] Tylenol, 325 mg, 1-2 PO q4hrs PRN
    [ ] Motrin, 800 mg po q8hrs prn
    [ ] Zantac 50mg IV Q8°
    [ ] Phenergen 12.5-25 mg IV/IM PRN N/V
    [ ] Oxygen @ _____ L per _____ Titrate to keep sat > 92%
    [X] Ancef 1g IV Q8° x 48
    [ ] Rocephin 1g IV Q12°
    [ ] Gentamycin _____ mg IV load & pharmacy to dose
    [ ] Cipro _____ mg IV Q12°
    [ ] Clindamycin _____mg IV, Q _____ hr
    [ ] Penicillin G, _____ Million Units IV Q _____ hrs
    [ ] Dicloxacillin, 500 mg PO q6hrs
    [ ] Keflex, 500 mg po q6hrs
    [ ] Milk of Magnesia, 30-60 cc po qhs prn constipation
    [ ] Benadryl, 25-50 mg po qhs prn insomnia
    [ ] Transfuse _____ units packed cells
13. DRESSINGS: wet to dry (R) leg QD. Start 4-9-03.
14. DRAINS:
15. RADIOLOGY:
16. OTHER: medevac to medical facility for further orthopedic care.

notified by (b)(6)-2 L7SD NC

DOCTOR SIGNATURE (b)(6)-2

PATIENT IDENTIFICATIO (b)(6)-4
FULL NAME:
FULL SSN:

CASREC PROCEDURES			TIME				NOTES/PLANS:
☐ Oral airway	☐ Nasal airway	EOA/PTL	Cuff BP	/		/	Toradol .5cc IM
☐ ETT #	☐ NTT #	☐ RSI	Pulse				2055
☐ Crico #	☐ O_2 @ _____	L/Min via _____	Resp				
Breath Sounds: L:	R:		Temp				
☐ IVs # ☐Peripheral	☐ Central	☐ Intraosseous	O_2 Sat				
☐ IV Fluids 1 2 3 4 5 6		☐ Blood 1 2 3 4 5	GCS				
☐ CPR P ASG:	☐ Legs	☐ Abdomen	Urine Out				
☐ Urinary cath	☐ Gastric tube		Blood Out				
☐ Chest tube:	☐ R ☐ L	☐ Both	Fluid In				
☐ C-spine protection	☐ Spine protection, Time on:		Blood In				
☐ Splints Type:							
☐ Medications: Morphine 10mg IV Push 2015							

ADMISSION ORDERS

1. ADMIT TO: [X] OR/PREP [ ] ACW [ ] ICU
2. DIAGNOSIS (print): Bil Tib Fib Fx
3. VITAL SIGNS: [X] Q1° [ ] Q4°
4. ACTIVITY: [X] Bedrest [ ] Up with Assistance
5. ALLERGIES:
6. NURSING: [X] I/O [ ] Foley to gravity [ ] NG to LIS
   [ ] CT to -20CM H_2O Suction [ ] IS Q1° while awake
7. DIET: [X] NPO [ ] Reg [ ] Clear Liq [ ] Full Liq
8. IV FLUIDS: [X] Lactd Rngr @ 250 CC/hr [ ] Normal Saline @ ____CC/hr
9. LABS: [ ] CBC [ ] Chem 7 [ ] CAMP [ ] UA
   [ ] PT, PTT [ ] LFT's [ ] NOW [ ] a.m. [ ] Type & Cross ____ units
10. PARAMETERS: Call MD T>101, SBP>180<90, DBP>100, Pulse>120, U.O. < __/__hr
11. MEDICATIONS:
    [ ] MSO4 ____ mg, Q ____ hr PRN PAIN IV
    [ ] Demerol _____ mg, Q _____ hr PRN PAIN IV
    [ ] Percocet 1-2 Q4° PO PRN PAIN
    [ ] Zantac 50mg IV Q8°
    [ ] Phenergen 12.5-25 mg IV/IM PRN N/V
    [ ] Oxygen @ _____ L per _____ Titrate to keep sat > 92%
    [ ] Ancef 1g IV Q8°
    [ ] Rocephin 1g IV Q12°
    [ ] Gentamycin _____ mg IV load & pharmacy to dose
    [ ] Cipro _____ mg IV Q12°
    [ ] Clindamycin _____mg IV, Q _____ hr
    [ ] Unasyn _____ gram IV, Q _____ hr
    [ ] Transfuse _____ units packed cells
12. CULTURES: _____
13. RADIOLOGY: [ ] Port CXR [ ] KUB

DOCTOR SIGNATURE: (b)(6)-2

(b)(6)-2
CDR MC USN
STAFF FAMILY PHYSICIAN
(b)(6)-2

PATIENT IDENTIFICATION:
FULL NAME:
FULL SSN:

CASUALTY RECEIVING

CHIEF COMPLAINT: (R) hip, (R) knee Bile. Tib/fib poss Fx

MECHANISM OF INJURY

VITAL SIGNS 86/78
BP- P- 108 R- 14 T- 100.3 axi.

HISTORY

Allergies: Unk.
Medications: Unk
Past Illnesses: Unk
Last Meal: Last Tenanus:
Events:
Pregnant? ☐ Yes ☐ LMP_____ ☐ No
Spine protection device removed @ _____

PROCEDURES BEFORE ARRIVAL

☐ Oral airway ☐ Nasal airway ☐ EOA / PTL
☐ ETT # ☐ NTT # ☐ RSI
☐ Crico # ☐ O_2 @ _____ L/min via _____
Breath Sounds: L: R:
☐ Ivs # ☐ Peripheral ☐ Central ☐ Intraosseous
☐ IV Fluids 1 2 3 4 5 6 ☐ Blood 1 2 3 4 5
☐ CPR ☐ PASG: ☐ Legs ☐ Abdomen
☐ Urinary cath ☐ Gastric tube
☐ Chest tube: ☐ R ☐ L ☐ Both
☐ C-spine protection ☐ Spine protection, Time on:
☐ Splints Type:
☐ Medications:
☐ Other procedures:

INITIAL ASSESSMENT

AIRWAY ☑ Normal ☐ Compromised
C-SPINE ☑ Normal ☐ Suspect Injury

BREATHING
☑ Normal
☐ Tracheal Deviation
☐ Resp. Distress
☐ Tension PTX
☐ Chest Wall trauma

CIRCULATION

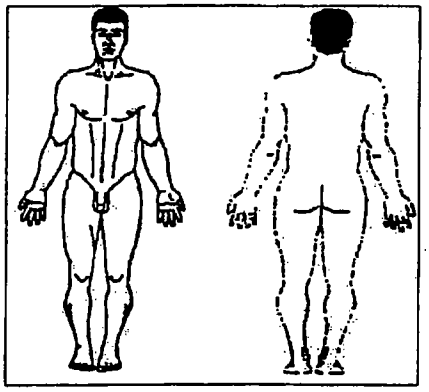
Skin/mucous: ☑ Pink ☐ Pale
Membrane color: ☐ Flushed ☐ Jaundiced ☐ Ashen ☐ Cyanotic
Pulses: ☑ Normal, Site ☐ Bounding, Site ☐ Weak, Site ☐ Absent, Site
Rate 70 /minute Rhythm_____
Skin temp: ☐ Warm ☐ Hot ☐ Cool/cold
Skin moisture: ☐ WNL ☐ Dry ☑ Moist

DISABILITY

GCS Score: Eye opening score 4 /4
Verbal score 5 /5
Best motor score 6 /6
TOTAL GCS SCORE: 15 /15
RTS Score: Respiratory score_____
Systolic BP score_____
GCS Score_____
TOTAL GCS SCORE:_____

	Right	Left
Pupil Size:	2 mm	2 mm
Reactive?	☐	☐
Arms move?	☑	☑
Legs move?	☐	☐

IDENTIFY INJURY SITE BY LETTER



A - Abrasion F - Fracture T - Temderness
B - Burn G - GSW
C - Contusion H - Hematoma
D - Deformity L - Laceration
E - Edema S - Stab Wound

Head: Scalp wound to forehead
Maxillofacial: Swollen (R) eyelid
Neck, Face
C-spine/neck: No pain
Chest: LCT
LRX
NT
Abdomen: NT
Ecchyme
Perineum: Foley
Musculoskeletal: Edema (R) shoulder
Tenderness (R) knee (R) hip
(R) groin
(L) Tib/fib Fx
DP in tact bilat

PATIENT IDENTIFICATION:
FULL NAME:
FULL SSN: (b)(6)-4

Bed I

PRN/ONE TIME MEDS

PRN MEDS

Medication	Date/Time 4/7/03	Dose/Init	Date/Time	Dose/Init	Date/Time	Dose/Init	Date/Time	Dose/Init	Date/Time	Dose/Init
MSO4 8-10mg IV	5mg IV		4/8 1013	6mg / JF	5mg 4/8/03	10mg 4/8/03	4/9 4mg IV		4/9 1318	5mg MCA
Q3° HR PRN	TW 0900		0000 / JF	4/8	2 20mg	7m 2359	TW 0730		4/9 1500	5mg TW
TYLENOL #3	4/9 0630 TW									
1-2 PO Q4° PRN										
PAIN										
Meclizine 25mg	L									
q6 prn dizziness										
MSO4 8-10mg IV	4/9/03 6mg	4/9/03 8355 4mg	4/9/03 0330 6mg 7m	4/9 0320 4mg W	~~4/8 0000 5mg JF 5 clear~~ 4/10 5mg	ΔD	DOSE			
Q3° ~~for pain~~	7m 1815									
MSO4 15-20mg IV	4/10 10mg IV									
Q3-4° FOR PAIN	0842 W									

ONE TME MEDS

Medication	Date/Time	Dose/Init	Medication	Date/Time	Dose/Init	Medication		Date/Time	Dose/Init
Meclizine 25mg	4/9 1120 TW								
po now									

(b)(6)-4

Patient Id

MCA (b)(6)-2 TWL

(b)(3)-1

Bed I

M.A.R.

MEDICAL ADMINISTRATION RECORD

Date	4/7	4/8	4/9							
Medication	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init	Time Init
ANCEF 1G IVQ8° x 48°	0800 1600 2400 (b)(6)-2	0800 1600 2400 (b)(6)-2	0800 1600 2400 (b)(6)-2							
Heparin 6,000u bolus followed by 1,000u/hr drip run @ 100cc/hr * PTT in 6 hrs.	1400 bolus (b)(6)-2									

SIGNATURE	INIT

(b)(6)-4

Patient Id

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

IENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
5/4/03	2500 HOURS	

Admit to ICW 1
Dx Lithium Ft
Cond - Good
VS PR
Activity - ad Lib

ISING UNIT | ROOM NO. | BED NO.

IENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

MMSE 2-5 mg IV Q 3-6 PRN
Tylenol #3 + 30 PO Q4-6 PRN
Diet Regular
DC to Valier INPAT

(b)(6)-2

(b)(6)-2

5/4/03 2031

ISING UNIT | ROOM NO. | BED NO.

IENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
5/6/03	0730 HOURS	

(1) Valium 5 mg IV Q 6 PRN

(2) D/C Haldol

ISING UNIT | ROOM NO. | BED NO.

(b)(6)-2

(b)(6)-2

6 May 03 0730

IENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER	
	HOURS	

ISING UNIT | ROOM NO. | BED NO.

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1984 - 423-718

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. 5 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 4	5	6
5/4	(b)(6)-2	VS Routine	06	/		
			14	/		
			22	(b)(6)-2		
			/			
5/4	(b)(6)-2	Activity Ad-lib	07		(b)(6)-2	
			15	/		
			15		(b)(6)-2	
			23			
			23			
			07			
			/			
5/4	(b)(6)-2	Diet Regular	B	/	(b)(6)-2	
			L	/		
			D	/	(b)(6)-2	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: tibia fx

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 5 Yr 53
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5/4	(b)(6)-2	Admit to ICU-1 - good	5/4	done		
5/4		D/C to Viper in AM	5/5	06		
5/6		D/C to home	5/6			
	.....					
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
.....	.....															
.....	.....															
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USAPA V1.00

CLINICAL RECORD

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

Mo. 5 Y 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED														
	.....																	
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ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: tibia fx.

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

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
	.....					
	.....					
	.....					
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	.....					
	.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
5/4	(b)(6)-2	MSO4 2-5mg IV	5 May 0850													
.....	.....	q3-6° PRN	5 mg IM													
.....	.....		(b)(6)-2													
5/4	(b)(6)-2	Tylenol #3 1-2	04 May 03 II	5 May 1300	5 May 0745 II		5 May 03 150 II	5 May 1700	10 May 0400							
.....	.....	PO q 4-6° PRN	2300		(b)(6)-2		(b)(6)-2	(b)(6)-2	(b)(6)-2							
.....	.....		(b)(6)-2													
5/6	(b)(6)-2	Valium 5mg PO														
.....	.....	q 6° PRN														
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															

USAPA V1.00

T-055

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
(b)(3)-1	I Q	(b)(6)-4	(b)(6)-4		

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
		Fiaji		

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
		9 9	(b)(6)-4

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
		2000	

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
		INJ	YEAR ☒ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
2 A	ICW1	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
NAME A (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)
Hosp		0 3 0 5 0 6

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

FOR LOCAL USE

Tiba TX

ADMITTI (b)(6)-2 as required MD (b)(6)-2

LTC, MC
GENERAL SURGEON

SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 5208

7-05

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	(b)(3)-1
2. MTF LOCATION (State or Country Code)	IZ
3. REGISTER NUMBER	(b)(6)-4
NAME (Last, First, Middle Initial)	(b)(6)-4
4. PAY GRADE	
5. SEX	M
6. DATE OF BIRTH (Y Y Y Y M M D D)	19730101
7. AGE AT ADMISSION	30
8. RACE	
9. ETHNIC BACKGROUND	9
RELIGION	
10. LENGTH OF SERVICE	
ETS	
11. FMP	99
12. SOCIAL SECURITY NUMBER	(b)(6)-4
ORGANIZATION (Active Duty Only)	
13. MARITAL STATUS	Z
HOUR OF ADMISSION	2000
BRANCH / CORPS	
14. FLYING STATUS	
15. BENEFICIARY CATEGORY	K91
16. ZIP CODE OF RESIDENCE	09330000
17. UNIT LOCATION (State or Country Code)	
18. MOS	
19. TRAUMA	INJ
PREV. ADMISSION	YEAR: ☒ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	1
WARD	ICW1
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	
NAME A	(b)(3)-1
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE	
21. TYPE OF DISPOSITION	05 Home
22. MTF TRANSFERRED TO	
23. DATE OF DISPOSITION (Y Y M M D D)	20030506
24. CLINIC SVC - ADMITTING	ABAA
25. MTF TRANSFERRED FROM	
26. DATE THIS ADMISSION (Y Y M M D D)	20030504
27. LOCATION OF OCCURRENCE (Battle Casualty Only)	IZ
28. MTF OF INITIAL ADMISSION	
29. DATE INITIAL ADMISSION (Y Y M M D D)	

FOR LOCAL USE DX: 82380
82390
82022
4159
2859
53081
56400
E8120

Tibia Fx

Trauma 9 Inj 109

Px: 7906, 7817, 7905, 7815, 7857, 7855, 9904

ADMITT (b)(6)-2 (as required), MD (b)(6)-2

LTC, MC
GENERAL SURGEON

SIGNATURE OF ADMITTING CLERK (b)(6)-2

DA FORM 2985, MAR 89 EDITION OF MAY 79 IS OBSOLETE

MEDCOM - 5209

MEDICAL RECORD	PROGRESS NOTES
DATE	
01May03	P.T. Note
	Pt ambulated 180ft on crutches SBA x 1 WBAT
	(R) LE. Tolerated Rom Ex to (R) LE well. will
	cont. c̄ P.T. QD — (b)(6)-2 HMC(F.M.F)
	P.T. Tech
02May03	P.T. Note
	Pt ambulated 80ft on crutches (I) on Flat surfaces.
	c/o (B) LE pain, tolerated Rom Ex to (R) LE well.
	Will cont Rom Ex QD — (b)(6)-2 HMC(F.M.F)
	P.T. Tech
03May03	P.T. Note
	Pt tolerated Rom Ex well today. Performed
	Heel slides and ankle pumps. Instruct Pt to
	perform these exercises TID. Pt voiced of
	understanding Tx plan — (b)(6)-2 HMC(F.M.F)
	P.T. Tech
3MAY03	Medical Nutrition Tx: FU:
1340	~~Exam~~ O: Per RN: Eating over 75% ē meal + snacking
	on fruit. ϕ current labs. Diet Rx: Regular.
	A/P: PO intake good. Recommend continue
	encourage PO intake. RD to f/u 3-5 days.
	(b)(6)-2 MPH, RD
	(b)(6)-2 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)
Prescribed by GSA/ICMR,
FIRMR (41 CFR) 201-45.505
509-111

MEDICAL RECORD	PROGRESS NOTES
DATE 26 APR 03	Medical Nutrition Tx's F/U's
1430	S: Per translator - ate 3 meals 4/25 & breakfast / lunch 4/26 + snacks.
	O: Diet Rx: Regular & current labs. (b)(6)-2
	A/P: PO intake good. Recommend continue encourage PO intake. RD to f/u q 3-5 days. (b)(6)-2 MPH, RD
	(b)(6)-2 MPH, RD
	LT, MSC, USNR (b)(6)-2
27 Apr 03	P.T. Note
1000	Pt seen this A.M., required min (A) x 1 sit ↔ stand ambulated 30 ft WBAT on crutches c̄ hands on Assistance making slow progress with crutch ambulation. will cont. P.T. QD (b)(6)-2 Hnc (FNF)
	P.T. Tech
Apr 27 '03	Internal Med (HD) #18 (b)(6)-4 (B) tibial IM rod
1814	Afeb today, 101.8 yest 0200. #13 (R) femur IM rod
	Blood cx ⊖ to date (from 24th)
	wound cx ⊕ few staphylococci sens in pen
	and also enterobacter cloacae sens in i tro.
—	on exam, stable c drainage c̄ the site
	cx on 24th.
—	A/P persistent ↑ temp (fever) (HD) needed. Will Dr (b)(6)-2 — will discuss. d/c

(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. (b)(6)-2 WARD NO. (b)(6)-4

on inj + urine

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

PROGRESS NOTES

DATE	
28 APR 03	P.T. Note Pat refused to Ambulate on crutches today. tolerated PROM to (R) Knee c/o pain throughout P.T. session. PROM (R) Knee 0°–60° will attempt to ambulate in the A.M. — (b)(6)-2 HM C (FMP) P.T. Tech
29 APR 03	P.T. Note Pat seen this A.M. AAROM 0°–70°. Ambulated c̄ crutches CGA x 1 60ft. will cont P.T. QD — (b)(6)-2 HM C (FMP) P.T. Tech
29 APR 03 1510	Medical Nutrition Tx F/U S: Per translator: 4/28 – Ate 3 meals. 4/29 – Ate 2 meals. O: Diet Rx: Regular. & current labs. A/P: PO intake good. Recommend continue encourage PO intake RD to f/u q 3-5 days. (b)(6)-2 MPH, RD
30 APR 03	P.T. NOTE Pat seen this AM. Needed min assist x1 in bed mobility. PROM performed (R) ankle and Knee 0–65 deg. Ambulation exercises deferred due to pain. Pat improving daily. Cont P.T. QD. — (b)(6)-2 HM USN PT TECHNICIAN (b)(6)-2

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

MEDICAL RECORD	PROGRESS NOTES

DATE

22 Apr 03 P.T. Note

Pt seen this P.M., required Min (B) x 1 supine ↔ sit and mod (A) x 1 sit ↔ stand. Pt c/o ↑ pain (B) LE upon standing, having difficulty crutch Trng. Pt probably due to ↑ pain (B) LE upon standing. Pt did not tolerate (R) LE ROM c/o pain throughout TX session. Will cont. QD — (b)(6)-2 HMC (FP)

P.T. Tech

23 APR 03 P.T. NOTE

1410 Pt transferred from supine to BOB c̄ min-mod assist, BOB to stand c̄ mod assist x 1. Ambulated 10 feet c̄ crutches and CGA x 1. Transferred from stand to sit c̄ min assist and sit to supine c̄ min-mod assist x 1. PROM performed on (B) ankle and knee. Tolerated session well c̄ much pain and not yet safe c̄ crutches. Will cont. P.T. QD. — (b)(6)-2

HM2 (b)(6)-2

Apr 24 03 Internal Med HD #15 (b)(6)-4 (B) tibial IM nail

0830 (b)(6)-4 (R) femur IM nail

Spike to 103.4 last night. On exam there is an area on (R) prox ankle that is draining + tender (staple site).

Vsw 95.4 130/90

(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.

12.4 25.5

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

DATE	
Apr 24 '03 0842	c/o (left) wrist [illegible] Blood cx x2 + CXR (negative). Will culture drainage + cover with dressing + wrap given that pt is on the scrub [illegible] ward + that MRSA has been isolated around ship, + that pt has 3 vets. Will consolidate as situation allows (b)(6)-2
24 Apr 03	P.T. Note Pnt seen this P.M. Pre medicated prior to P.T. Session Required min (A) x 1 sit ↔ stand, Pnt ambulated 10ft on crutches c̄ CGA x 1, Pnt is unstable on crutches. Tolerated ROM (R) LE well c̄ pain during exercise. (R) Knee ROM 0°-70°. Will cont P.T. QD (b)(6)-2 HMC(FNP) P.T. Tech
26 Apr 03 1030	P.T. Note Pnt seen this A.M., in good spirits willing to work with P.T. Ambulated 5ft on crutches c̄ CGA x 1 unstable. Tolerated ROM (R) LE well c̄ (b)(6)-2 HMC(FNP) P.T. Tech

MEDICAL RECORD	PROGRESS NOTES
DATE	
Apr 21 0840	Internal Med HD # 12 (b)(6)-4 (B) tibial nail (b)(6)-4 (R) femur nail
	Need anticoag for high risk – long bone Gx. Has been very sensitive to warfarin – INR as high as 20.5. This AM 2.5. (b)(6)-2 I am asking pharmacy about compounding (4 mg doses (only 5 mg pills available) – alternative is return to Coumadin
	✓ PT again this PM (b)(6)-2
Apr 21	ORTHO
	Doing charged – Hunter nailed (R) calf – W → D (Auto Aid) (L) Medial Calf. DNR
	(R) Knee Moderate effusion
	Personal PT – Non; Certain tomorrow.
	(b)(6)-2
	(Continue on

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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PROGRESS NOTES

DATE	
21APR03	P.T. Note
	Pt seen this PM for crutch Trng sitting in W/C upon arrival. Required min (A) x1 sit → stand ambulated 5 ft c̄ mod to max x 2 c̄ crutches c/o pain (B) LE during crutch Trng session. Will cont c̄ crutch Trng and ROM Ex QD —
	(b)(6)-2 HMC(FMF)
	P.T. Tech
21APR03	~~Medical Nutrition Tx Flow~~
1700	O: Per HM- eating ≤ 50% of dinner. Diet Rx: Regular. Ate bread + corn + 1 can ENSURE tonight. Labs 21APR03: Hgb/Hct ~~[illegible]~~ 8.2/23.9↓
	A/P: PO intake fair-poor. Hgb/Hct↓ - recommend FeSO4 c̄ fruit juice to ↑ absorption. Recommend continue to encourage PO intake c̄ Regular diet + ENSURE TID. RD to f/u q 2-3 days. (b)(6)-2 MPH, RD
	(b)(6)-2 MPH, RD
	LT, MSC, USNR (b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	
14Apr03	ORTHO Brief Op Note
	PreOp Dx: Comminuted Subtrochanteric Femur Fracture
	Post Op Dx: Same
	Procedure: IM nailing & Cephalomedullary fixation.
	Surgeon: Martin / Girard
	Anesthesia General
	EBL 200cc Drains JP x 2
	Complications Ø
	Disposition To RR Stable condition
	Findings: Smashed comminuted proximal femoral fracture & segmental bone infractions. 14 mm x 400 mm IM nail placed from proximal-distal & cephalomedullary [redacted]
	Pt tolerated procedure well.
	[redacted]
15Apr03	Rash on abd + chest subsiding. D/c contact precautions.
19Apr03	D/c Tobramycin.
Medicine Note	(Continue on reverse side) [redacted]

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

[redacted]

REC [redacted] WARD NO.

PROGRESS NOTES
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PROGRESS NOTES

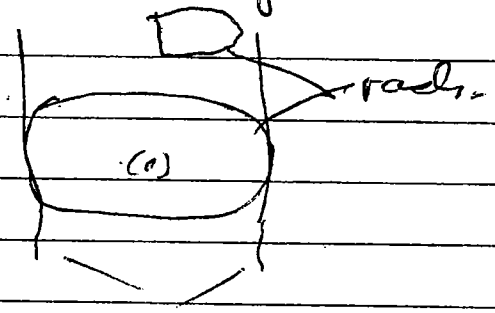
DATE	
	ID
4/16/03	Pt w/ rash seen 3 days ago – ? acinetobacter.
1340	Subsequently No Δ in rash on abd & Abx – D/ced, now c̄ rash on back
	Imp Fixed drug eruption back – 2° Augmentin or Tobi
	Rec: D/C All Abx.
	(b)(6)-2
	(b)(6)-2 LCDR, MC, USNR (UMO/SS) INFECTIOUS DISEASE (b)(6)-2
16APR03	Medical Nutrition Tx:
2025	OSPx: @ +1 6 1/f/b fx c̄ Ex Flx. R femur Fx.
	Wt ≈ 70kg. Per HM – ate d/river ate orange. Drank Ensure
	Labs 16APR03 Hgb/Hct 8.0 L/23.6 L mcv/mch 92.3/31.3
	A/P: Kcal needs: 30-35 kcal/kg/day = 2100-2450 kcal/day
	Protein needs: 1.5-2.0 g/kg/day = 105-140 g/day.
	PO intake good. Hgb/Hct low; mcv/mch WNL –
	recommend MVI + FeSO4. RD to f/u q 2-3 days.
	(b)(6)-2 MPH, RD

MEDICAL RECORD	PROGRESS NOTES
DATE	
13 Apr 03	Surg

Asked to see pt. for rash. Pt alert but uncomfortable. Erythematous MACULAR vesicular rash over abdomen ASIS to costal margin bilat & scattered other pat. maj on (+) Chest. ~1/2 pt area. BLE ingui + RT thigh Ex fix. Temp 100.6. WBC 10K 76 segs.

MACULAR rash.

Tiny vesicles.



Dx: Suspicion for.
Acinetobacter
Cellulitis.
US - other Dx vert fascitis as this is 1° cutaneous & underlying wound, edema & muscular pain.

Plan 1) Δ Abx from Ancef/Gent to Vanc/Imipenem
2) Bld cx's x2, CBC c diff, CMP.
3) Contact precautions
4) Dcw Dr (b)(6)-2 Ortho.
5) Med Photo.

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

LCDR MC USN

(Continue)

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

(b)(6)-4

WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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MEDICAL RECORD	PROGRESS NOTES
DATE	
12 Apr	Ortho No new complaints AFVSS PT SNVI Scheduled for (R) hip fixation on Monday. Cont Cont therapy (b)(6)-2
4/12/03 1015	Int Med Called/asked to see pt for rash - This has developed since yest, and is a pruritic coalescent plaque, centered at umbilicus. On (R) side within this plaque was the bovie patch. Additionally, there is a 2nd area on upper (L) chest w/ angular demarcation. These areas are quite well defined as shown. I think this is most likely a contact dermatitis - possibly something used in OR prior to application of Bovie pads. DDx includes cellulitis or other infectious Rx or a drug Rxn. We will follow - if this gets worse w/ ancef, then change abx. (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

REG (b)(6)-2 CDR MC (b)(6)-2 WARD NO.

PROGRESS NOTES
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PROGRESS NOTES

DATE	
13 APR 03 0530	Called to see pt due to left anterior chest pain beginning approx 30 min ago. EKG - ϕ acute changes, VS stable,
Medicine	ϕ diaphoresis, ϕ ↓ in O_2 Sats, ϕ difficulty breathing. Pt on Lovenox. Was given Percocet at 2400 and was not premedicated c̄ Benadryl. Rash on abd & chest seems the same.
	O: Alert, NAD. breathing easily.
	Hrt - RRR c̄ gallop/murmur systolic @ LSB ϕ radiation.
	Chest - (+) compression pain.
	Lungs - clear in all areas.
	Abd - soft, (+) epigastric pain
	EKG - NSR ϕ acute changes.
	PO_2 - 98%.
	Skin - maculovesicular type rash - not spreading - blanching.
	A: 1) GERD / Constipation
	2) Contact Derm.
	P: give Motrin now - Start Sucralfate/Colace.
	Benadryl t PRN 25-50mg
	Hydrocortisone Cream 1% TID.
	~~Prednisone - Halcinonide 0.05~~ cream ~~BID~~ PRN.
	CXR now -
	(b)(6)-2 NP (b)(6)-2 GDR NC USN

PROGRESS NOTES

DATE	
1 Apr 03	Orders Brief Op Note
	PreOp Dx: (1) (B) Tibia/Fib Fx (R) Grade III open
	(2) Subtrochanteric Femur Fx (R)
	PostOp Dx same
	Procedure: (1) I&D including (R) Tibia
	(2) I&D including (L) Tibia
	(3) I&D [redacted] (R) Open Tibia Fx
	(4) Adjustment of (R) Femur Ex-Fix.
	Surgeon Dr. [redacted]
	Anesthesia General
	EBL 100cc Drains Ø
	Complications Ø
	Findings: (1) Left thigh I&D including 5 medial transpatellar approach. Proximal & distal intramedullary X2
	(2) Right Tibia Fibula including 5 proximal and distal intramedullary X 2
	(3) I&D of (R) Thigh Medial wound closed loosely c̄ O-prolene. All other wounds closed c̄ staples
	Pt tolerated procedure well
	[redacted]
	[redacted]

MEDICAL RECORD	PROGRESS NOTES

DATE
12 APR 03
1930

Medicine

Called for rash to Abd, chest, back. - began approx 3° ago - spreading. ⊕ itch. O/w translates - rash began post blood products at the first camp he was in - has also been having Rocef since that camp.

O: Chest, NAD.

HENT - mucus membranes clear

conjunctivae clear

neck - supple ¢ ? lymph.

lungs - CTAP. Pulse ox 97% RA

Abd - flat, soft, non-tender

Skin - macular erythematous eruption ± papules/wheals of abd, ⊕ upper ant chest, & back.

Examined ≈ Dr's Gable + Hilsted.

A: Allergic dermatitis - ? drug vs bacterial

P: Benadryl 25mg IV once

Benadryl 50mg PO TID 1/2° prior to Rocef.

Will see prior to next dose.

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

CDR/NC/USN (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	
10 Apr 03	CASREC Admit Note
1630	45yo IRAQI ♂ involved in MVC ~5 days ago sustaining
	Bilat Tib/Fib Fx's, (R) Femur Fx's, Multiple facial Abrasions
	?LOC. Pt has had Ext. Fix Appliances placed ~7Apr03.
	Postop O_2S_2 - 82% - Med Consult to R/O PE - ?Dx
	of Fat Embolism vs PE. Placed on Heparin.
	Now 100% on Rm Air.
	PSH: Ext. Fix Placed 7Apr03, Washout 9Apr03
	PMH NIC
	Meds: Ancef / MSO4 / Heparin
	VSS: BP - 154/72 P - 80 R - 12 O_2S 100% Rm Air
	PE: HEENT - Multiple facial Abrasions.
	Tm's Clear AU, PERRLA/EOMI Nares patent
	oropharynx Clear ⊖ facial Fx's.
	Neck Sft Supple - Sore (R) SCM. trach midline
	Chest: CTAB ⊖ w/r/r Cor: RRR
	ABD: NT/ND ⊕BS
	Filly to gravity
	Back - Abrasion x1 ⊖ Scoliosis / Steps
	Extrem: UE WNL
	LE (R) Subtrochanter Fx c Ext Fix
	(R) Open tib/Fib
	(L) open tib/Fib
Pulses Intact	Neuro Intact

(Continued 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. (b)(6)-2 NO.

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

PROGRESS NOTES

DATE	
10 April 03	LABS pending
(cont)	XR's ordered CXR
	Pelvis
	Assess: S/P MVC (R) Subtrochanter Fx
	(B) Tib/Fib Fx's
	Ext. Fix Appliances in place.
	Plan: Ortho to Assume Tx

(b)(6)-2

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
13 APR 03	0230		ASSUME PT CARE @ 2350 12 APR 03. BILAT TIB/FIB C̄ SOFT CAST, (+) PMS, <3 CAP REFILL, 3+ EDEMA, (R) FEMUR FX C̄ FIX C̄ DRESSING C/D/I. PT C/O OF PAIN, NOTIFIED RN, MED GIVEN. WSITE (L) FA S/S INFECTION C/D/I. WILL CONTINUE TO MONITOR. —— HN (b)(6)-2
15 APR 03	0035		Assumed Pt Care. Pt VSS, Pt ≤ 4/10 Pain, BS + hypoactive cap refill < 1-2 secs, neuro checks to RLE intact, LLE Drsg CDI, RLE serosanguinous drainage at JP drain site reinforced c̄ 4x4 gauze, JPs draining moderate amount serosanguinous fluid, foley clear yellow —— (b)(6)-2
	0200		Genitals elevated c̄ rolled sheet to reduce edema (b)(6)-2
16 APR 03	0230		Pt Assessment. Pt. VSS, +HR, +BS, LS CLBIL, Pt has 2 JP drains, JP1 draining serous fluid & JP2 draining serous sanguinous fluid. Pts drsg on (R) thigh reinforced c̄ 4x4's Pts drsg on RLE wrapped in kurlex & Ace wrap. Pt resting well —— HN (b)(6)-2
	0300		Concur, PT scrotum elevated to relieve edema (b)(6)-2
16 APR 03	1955		assumed care of pt @ 1500. pt c/o px to legs. px relieved c̄ ii percocet. DSG to LUE CDI. (+) pulse, cap refill less than 3 sec pt able to move fingers. LLE DSG CDI. cap refill less than 3 sec. unable to feel pulse and pt unable to move toes. RLE DSG CDI. JP drain c̄ minimal serosangouinous

(b)(6)-4

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/10/03		2345	Pt USS. Pt c̄ Bil tib/fib c̄ ex-fix (Bilateral and (R) femur fx. Ex-fixators to BLE c/d/i. circulatory checks wnl. pt c/o pain. pt given morphine IVP. ordered morphine prn. IV site c/d/i. Foley draining clear yellow urine, adequate output. Pt NPO p̄ MN for OR in am 4/11. Continue to monitor. —— JDG (b)(6)-2
4/11/03	0330		BILAT TIB/FIB c̄ EX-FIX & (R) FEMUR FX. EX-FIX TO BLE C/D/I c̄ 2+ EDEMA ON LLE (+) PMS (PARTIAL MOVEMENTS). Ø C/O OF PAIN. FOLEY DRAINING CLEAR YELLOW URINE c̄ SEDIMENTS. PT. ASLEEP @ THIS TIME. WILL CONTINUE TO MONITOR — HN (b)(6)-2
12 APR 03	0100		ASSUMED PT. CARE @ 2345. PT HAS SOFT CAST TO BOTH LEGS BELOW KNEES; INTACT, DRY, SLIGHT BLEEDING FROM FIX. REMOVAL, 2+ EDEMA ON LLE (+) PMS - PARTIAL MOVEMENTS B/C OF SOFT CAST. RC/O OF PAIN, NOTIFIED PN, MED GIVEN. WILL CONTINUE TO MONITOR. —— HN (b)(6)-2
			PT. HAS FOLEY DRAINING CLEAR YELLOW URINE c̄ SEDIMENTS. WILL CONTINUE TO MONITOR. —— HN (b)(6)-2
			PT. HAS EXFIX TO (R) HIP, DRESSING C/D/I. WILL CONTINUE TO MONITOR. —— HN (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
			Kortex c/o/I. Pt % of pain >5 pt recieves 6mg MSO4 via doctors orders Q2HRS IVP. Pt ↓ any other complaints at this time. Pt resting well will continue to monitor. ——— HN (b)(6)-2
18 Apr 03	0200		Concur c above corpsman assessment. Continue to monitor. ——— AD (b)(6)-2
18APR03	2200		ASSUMED PT CARE @ 1500. ALERT AND AWAKE. V/S ~~AO~~ WNL. Δ'd DRESSINGS ON RLE MEDIAL CALF N-D. WOUND PINK C̄ HEALTHY TISSUE SURROUNDING. Δ'd RLE THIGH DRY DRESSING. STICHES INTACT, PINK C̄ HEALTHY ~~[illegible]~~ (b)(6)-2 TISSUE SURROUNDING Δ'd (L) SHIN - XEROFORM. WOUND PINK C̄ HEALTHY TISSUE SURROUNDING. PT HAS RASH BUE. PT C/O PAIN. MEDICATED C̄ MSO4, VALIUM AND PERCOCET. ——— (b)(6)-2 HN.
4/20/03 Apr	1000		Assumed care - Assisted via Am care - up to BP via gurney. Bil. LE swollen - multiple staple area open to a.n. Will do dressing changes to LE - wet to dry. Dr Gilstead is aware of Am labs. Will continue to evaluate. — (b)(6)-2
4/20/03	1400		No results c̄ mom - Fluids seem to be gone. LLE - (P) gauze noted wet → dry. (R) LE - hematoma noted - wet to dry & above that area c̄ xeroform ——— (b)(6)-2

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
continued			drainage. Cap refill less than 3 sec.
16APR03			Unable to feel pulse and pt unable
		1955	to move toes. Pt has edema to
			scrotum. Scrotum is red and
			elevated c̄ towel. Pt has IV site
			to (L) forearm c̄ NSNS hanging. VS
			WNL will continue to monitor pt
			for px. (b)(6)-2 HH
17APR03		0005	Assumed Pt care, Pt VSS, HRF, LS
			CBILAT, Pt has edema to scrotum, elevated
			on towel, Pt has LUE wrapped in Kurlex c/p/f
			pt also has drsg on LLE wrapped in Kurlex c/p/z
			JP2 draining serous sanguineous fluid. Pt. cap refill
			<1-2secs pt. resting c̄ c/o @ this time HH (b)(6)-2
		0210	concur with above, BLE c̄ +1 edema, elevated c̄ pillow
			will monitor (b)(6)-2
18APR		0700	Assumed Pt care. Pt. VSS; +HR, +BS,
			LS CBILAT, Pt not in respiratory distress for S.O.D,
			Pt has +1 to +2 edema on scrotum. Elevated on towel
			Pt has drsg to ~~both~~ BLE all ~~wrap~~ wrapped in

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

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(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/21/03		1755	ASSUMED PT CARE @ 1530 PT AAOX3. (R) LE DSG C/D/I (+) NEURO, (+) PULSES. (L) LE DSG C/D/I. PT HAS STAGE II DECUBITIS ON SACRAL AREA COVERED T OP SITE. PT HAD CRUTCH TRAINING THIS SHIFT. PT RESTING @ THIS TIME NOT C/O PAIN — (b)(6)-2
4/22/03	0737		Assumed care - (L) ankle area — gren - acetic acid applied - clean & redness & sutures removed from around area. Below that old staple area - (+) pus noted. Dr (b)(6)-2 evaluated - dry dressing applied. (R) hip area ↑ less drainage - steristrips in place. PT to ambulate. Hematoma site to (R) hip area remains - ↓ size. Old hematoma site open to air. Continue to compression 2 pairs below. (-) Abd. pain. Dr (b)(6)-2 to monitor for ↑ redness - site. — (b)(6)-2 RN
4/22/03		1730	ASSUMED PT CARE @ 1530 PT AAOX3. (R) LE DSG C/D/I (+) NEURO (+) PULSES. (L) LE DSG C/D/I (+) NEURO (+) PULSES. STAGE II DECUBITIS ON SACRAL AREA IS COVERED T OP SITE. PT SLEEPING NOT C/O PAIN — (b)(6)-2 RN

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/20	2000hrs		Dsg change completed per MOS order. (L) LE wound dressed w/ xeroform. Lower LLE wound & ecchymosis and some serosang drng along (R) margin of wound. Skin slightly macerated surrounding wound. (R) LE wound dressed c̄ W→D. Yellow drng noted on wound bed, serous drng from wound. (R) hip dressing Ad. Minimal serosang drng. Medicated for c/o pain. Staples on RLEC shin & ankle are redened. Dr (b)(6)-2 noted. Ankle site c̄ small blistering noted. Instructed to remove all staples BilAt LE Below the Knee. Do not remove staples @ knees or thigh. (b)(6)-2 -HOR/fe
4/21/03	1100		Assumed care - (D) Zin and Adol. gns. held morning mom. Dr (b)(6)-2 to see pt. - ordered to remove all staples & sutures. Done. (R) hip continue to have some drainage - open to a.a. (L) LE dressing done c̄ acetic acid solution wet to dry. (D) gren. (L) LE - Dr (b)(6)-2 examined hematoma. Dry, tight dressing applied. Offer - Hematoma continue on reverse side to a.a. PT to evaluate pt.

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

(b)(6)-2 REGISTER NO. (b)(6)-2 WARD NO.

(b)(6)-4

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DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/24/03	1300		Assumed care - ⓡLE ankle site - drainage - sent for culture. ⓡLE calf acetic acid applied to area. ↓ swelling in ⓡ knee. Steri strips in place - ∅ drainage. Removed staples in ⓛ thigh. Hl started. Antibiotic started per Dr (b)(6)-2 Afebrile - Tmax 99.2 Dpsite applied to sacral area. PT to see pt for ROM / crutches. Will continue to monitor - (b)(6)-2 m
24 APR 03	1730		ASSUMED PT CARE @ 1500. VS STABLE S/+ S2 PRESENT LUNG CTA. LLE ANKLE SITE ~~SM~~ MINIMAL DRAINAGE. SOME SWELLING TO ⓡKNEE. STARISTRIPS IN PLACE. PT DENIED PAIN @ THIS TIME WILL CONTINUE TO MONITOR — (b)(6)-2 HN
4/24/03	1006		Assumed care - ⓡLE sites - ~~pus~~ drainage noted - changed ⓣ 1% Acetic Acid. Otic Lpns; Dr (b)(6)-2 to see pt, ?DVT ⓡ LE - TED hose applied. Continue ⓣ Lasix BID. Up to chair. Dr (b)(6)-2 said - go to PT. Steristrips in place. ⓡ Lip - No change. Steristrips in place. No Temp thi Am. Antibiotic continue. Will continue to monitor, Loo pending (b)(6)-2 m

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/23/03	10	16	Assumed care - (R) leg continue to be swollen - steri strips intact - (R) hip ø drainage. (R) calf - (+) drainage - place acetic acid to site - Wet to dry. open to air @ old staple area. (R) ankle. (R) knee c̄ swelling. (L) calf - hematoma open to air. Turning side to side for sacral area. Opsite in place. No complaints @ this time. (b)(6)-2
4/23/03	2030		Dressing Δ to (R) LE. Medial calf/shin wound w/ yellow eschar noted. Wound bed cleansed w/ Acetic Acid and packed c̄ W → Dry. Open blister distal to wound is draining purulent drng. Area washed air dry open to Air. Will continue to monitor (b)(6)-2
4/23/03		2152	LATE ENTRY. ASSUMED PT CARE @ 1530. PT RESTING COMFORTABLY IN BED. PT A:O x 3; VS STABLE. (R) LE DRESSING C/D/I; CHANGED DURING SHIFT. (R) HIP ø DRAINAGE. (L) CALF OPEN TO AIR. PT HAS NO COMPLAINTS AT THIS TIME. HN (b)(6)-2

Continue on reverse side

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DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26APR03		845	PT'S dressing on RLE Ad. Site reddened Dressed c̄ ~~acetic acid~~ dilute acetic acid and gauze. Covered c̄ 4x4 and tape. Will assess if necessary. (b)(6)-2 EIN
26APR	2350		BLE ASSESSED; (+) CMS TO BOTH. INCISION (R) THIGH C/D/I c̄ ∅ S/S INFECTION NOTED. (L) ANKLE C/D/I. (R) CALF COVERED c̄ GAUZE & TAPE C/D/I. PT. MEDICATED c̄ MSO4 5mg & BENADRYL (b)(6)-2
27Apr	0100		Pt IV Access was pulled new 20g in RFA by HN (b)(6)-2 Pt tolerated (b)(6)-2 HN CSH
27Apr03	0800		Assumed care of pt @ 0700. Pt resting (sleeping) c̄ eyes closed. No c/o of pn. VS WNL (+) neurochecks. Pt has ted hose c̄ drainage on (L) lower extremity and (R) inner ankle area. (b)(6)-2 CHN
27APR03	0930		AM CARE GIVEN, BED BATH DONE, DRESSING CHANGE DONE, W-D WOUND CLEA, NO S/S OF INFECTION. (b)(6)-2 HN
			Concern c̄ above. PT in to see pt. Ambulates c̄ crutches (b)(6)-2 EAS
27APR03		1600	ASSUMED CARE. V/S STABLE CIRC/NEURO CHECK GOOD. LUNG SOUND CTA HEART SOUND RRR, RRR (+) B.S. RLE 4x4 DRESSINGS (R) HIPE EXTERNAL FIX. WILL CONTINUE TO MONITOR (b)(6)-2
27Apr03		2040	VSS. c/o of pain (B) LEs. MSO4 & percocet given. no more complaints at this time, will continue to monitor. concern c̄ above assessment. (b)(6)-2 EAS, RC

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25APR03		1625	ASSUMED PT CARE @ 1530 PT AWOX3 (+) BOWEL SOUNDS, CLEAR LUNG SOUNDS. OPSITE COVERING DECUBITUS STAGE II ON SACCRAL AREA. (R) LE DSG C/O/I, SOME SWELLING TO RIGHT KNEE. (L) ANKLE DSG DRAINAGE NOTED. (+) MUSCL, CIRC CHECKS. PT RESTING @ THIS TIME NOT C/O PAIN (b)(6)-2
26APR03	0815		ASSUME CARE OF PT @ THIS TIME. PT WOUNDS APPEAR FINE. PT HAS SOME DRAINAGE WHICH IS MOSTLY BLOOD. OTHERWISE DRESSINGS are clean dry and intact. PT NOW resting comfortably & LITTLE to NAD. will continue to monitor pt (b)(6)-2
26APR03	1650		PT care assumed. PT has moderate edema bilateral LE c̄ TED Hose. 2 gauze dressings on (L) ankle. Pt resting comfortably. ∃ any c/o pain or discomfort at this time. PT has sacral decubit c̄ opsite dressing change. (b)(6)-2
26APR03	1830		Agree c̄ above corpsman note & assessment (b)(6)-2

Continue on reverse side

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(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
29APR03	1515		Agree c̄ above assessment. Pt has incision to (R) femur. Area scabbing, no drainage noted. 4x4 gauze to (R) hip. Dsg c/d/I. Multiple soft tissue wounds BLE. Areas OTA. No drainage. (b)(6)-2 JTJ, LPN
29Apr03	2045		Assumed care of pt. @ 1900; VSS, A+Ox3. Changed dressing on thigh, minimal drainage. Ao Medicated for pain. Will continue to monitor (b)(6)-2
30APR03	1000		ASSUMED CARE @ 0700. VSS. DRESSING TO (R) THIGH, DSG C/D/I. WOUNDS TO BLE ARE OTA. Ø DRAINAGE. CXC TO (R) ANKLE. DSG C/D/I. WILL CONTINUE TO MONITOR. (b)(6)-2
30APR03	1000		Agree c̄ above assessment. Pt c/o pain in (R) leg. 5mg MSOq given. Will cont to monitor (b)(6)-2 JTJ, LPN
30Apr03		2020	Assumed care of Pt @ 1900, VSS. Pt OOB to bathroom via wheelchair. No complaints of pain at this time. Will continue to monitor. (b)(6)-2
1MAY03			⊙ PT NAD AO RLE INTACT (+) moderate edema DSG C/D/I (-) S/S infection limited ROM capillary full sensation CTA ABD-NT/ND H-RRR (-) RRG (b)(6)-2

(b)(6)-4

MEDCOM - 5236

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
28 Apr 03	0400		Assumed pt care 2300. pt VS wnl. temp elevated 100.8 pt used I.S. X10. neuro's within normal limits. Drsg RLE ankle c/d/i. (R) hip steri strips. scabs on legs healing. pt resting will continue to monitor. (b)(6)-2
28 Apr	0600		Initial assessment noted. Medicated for pain. Resting quietly (b)(6)-2
28APR03	0850		Pt lying in bed @ this time. Pt c/o pain in (R) femur. Pt medicated c̄ 2 Percocets. Pt has incision to (R) thigh. Area pink, incision healing, scabbing. Well approximated no drainage. Steristrips have old drainage but intact. (b)(6)-2 YTfa MC
28APR03	0832		Pt has multiple shrapnel wounds to ~~LRE~~, RLE. Areas scabbing and healing well. Pt has 4x4 gauze/tape dsg to R ankle. No drainage. (b)(6)-2 YTfa MC
		1900	Assumed pt care VSS pt [illegible] c/o complaints pt is sleeping. Will continue to monitor Resp and Pain (b)(6)-2
29APR03		1300	ASSUMED CARE @ 0700. VSS. PT HAS 4X4 TO (R) ANKLE, (D) HR, RR, BS. WILL CONTINUE TO MONITOR. (b)(6)-2 HN

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

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CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
1MAY	1325		Concur c̄ HM3 (b)(6)-2 Dsg. to Lateral (L) calf D'd. AM care done. Ambulating okay on crutches. (b)(6)-2
1May		205	Assumed care of pt @ 1900; VSS, A+O x3. Pt seems to be in good spirits. Will continue to monitor (b)(6)-2
2MAY	02	0100	Pt with steristrips to L knee. RLE with numerous abrasions. Pt reports minimal pain. plays with dressings on BLE. 2X2 on RLE replaced after pt removed. Will continue to monitor. (b)(6)-2
2MAY03	0828		ASSUMED PT CARE @ 0700 PT AAO X3. AM CARE DONE. VSS. PT C/O MINIMAL PAIN NURSE NOTIFIED AND MEDICATED. PT AMBULATING C̄ CRUTCHES WELL. PT RESTING @ THIS TIME (b)(6)-2
			Concur c̄ HM (b)(6)-2 above assessment. Dsg's to (R) upper thigh D'd. Bacitracin applied & covered c̄ ABD pad. Dsg's to (R) ankle D'd W→D. Will cont. to monitor (b)(6)-2
2MAY03		2000	Assumed Pt care @ 1930. PT UP in bed. Pt AAOx3 in nad at this time. VIS taken →

Continue on reverse side

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(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			within normal Range Pt verbal when asked questions NEURO checks completed. HLR RRR IN no Resp distress. BS present in all four quadrants. Equal strength to upper and Lower extremities. Strong pulses. Pt has RAC 206. site cld/l. Pt has several dressings to LE. LLE Pt has steri stripes to knee cap. site cld/l. Pt has dressing to LLE. site covered with gauze and tape. Pt has steri stripes to RLE Along thigh. Dressing to RLE Gauze and tape. Pt ambulate to head via crutches. still needs more training. Pt in good spirits. will continue to monitor. (b)(6)-2 (b)(6)-2
			checked on pt. Pt resting at this time. up oob c crutches a few times to the head voiding w/o complaints. will continue to monitor (b)(6)-2 (b)(6)-2 (b)(6)-2

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NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
03May02	0845		Assumed Pt care. Pt is A+Ox3. Pt vitals signs are W/N/L. Pt lungs sounds are clear bilaterally. Pt has multiple abrasion to both lower extremities. Pt is s/p I+D BLE Ex Fix (R) Hip. Pt ambulates well crutches. Will monitor pt throughout shift.
			Concur c̄ assessment by HN (b)(6)-2 Dsg. to (R) upper thigh & Dsg to bilat calves, Δ'd c̄ acetic acid. Upper thigh draining minimal amt. of serous drainage. (R) calf c̄ 2 dsg's. draining moderate amt. of sanginous drainage + thick yellow drainage. Pt. doing well. Will cont. to monitor ———
			——— EVS (b)(6)-2
3May		2130	Assumed care of Pt @ 1900, A+O x3, VSS, ~~Medi~~ Pt, lung sounds clear. Pt up and around moving well on crutches. Medicated for pain. Pt has multiple abrasions BLE. Pt in very good spirits. Will continue to monitor. ——— (b)(6)-2
04May2003 0730			(R) hip dsg Δd this AM ——— (b)(6)-2 EVS/M

PATIENT PROFILE

NAVMED 6550/12 (5-80) S/N 0105-LF- 60

✓	ACTIVITY	DATE	✓	BATH	DATE	DIET	DATE	✓	VITAL SIGNS	FREQ	✓	SPECIAL NOTES
	Bedrest			Bed bath		NPO			Temp			Dentures
	Bathroom Privileges			Shower					Pulse			Speech impediment
	Up in chair	4/14		Tub		Reg	4/14		Resp	Q8		Language barrier
	Ambulate			Needs assistance					B/P			Prosthetic device
	Commode								Other			Visual impairment
	Needs assistance											Blind
	Restricted to unit											Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE				N/V ✓ & Vitals			Glasses
	Other			Self		FEEDING	DATE		FLUIDS			Hearing defect
	V@B to Chair			Needs assistance		Self			Forced to:			Other
4/17	TID			Special		Needs assistance			Restricted to:			
						Gavage			I & O	Q8		

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/10		HOB ↑ 30°		4/18		H/L when PO	
4/16		Elevate Sandbag					
				4/21		PT - ROM BIL LE (called 0935 4/21)	
						WB c CRUTCHES - TRAINING	
4/16		Dry Dressing Δ to (R) thigh					
		W-D dressing to Medial calf					
4/11		If N/V Changes, Call WMO to assess					
4/11		If U/O < 30cc/hr, Bolus 500cc NS and Assess results. Call WMO if no Improvement.					
						Ortho - (b)(6)-2	

ADDRESSOGRAPH

(b)(6)-4

DIAGNOSIS

(R) Femur fx
(B) 9th-10th fx

AGE | HEIGHT | WEIGHT

PATIENT CLASSIFICATION

OP/SPECIAL PROCEDURES

S/P IM nailing (R) Femur
IM rod tibia x 2

	DATE ON	DATE OFF
SI		
VSI		
RELIGIOUS RITES		

FINDINGS:

PATIENT PROFILE

NAVMED 6550/12 (5-80) S/N 0105-LF-200-5560

✓	ACTIVITY	DATE	✓	BATH	DATE	DIET	DATE	✓	VITAL SIGNS	FREQ	✓	SPECIAL NOTES
	Bedrest			Bed bath		NPO			Temp			Dentures
	Bathroom Privileges			Shower		REG	4/14		Pulse	QS		Speech impediment
X	Up in chair	4/14		Tub					Resp			Language barrier
	Ambulate			Needs assistance					B/P			Prosthetic device
	Commode								Other NM			Visual impairment
X	Needs assistance	4/14										Blind
	Restricted to unit											Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE							Glasses
	Other			Self		FEEDING	DATE		FLUIDS			Hearing defect
X	↑HOB 30°L	4/10		Needs assistance		Self			Forced to:			Other
				Special		Needs assistance			Restricted to:			
						Gavage			I & O	QS		

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/16		– DRY DRESSING (R) THIGH		4/18		(b)(6)-2	
		– W→D DRESSING TO					
		MEDIAL CALVES					
4/21		PT - ROM BIL LE					
		WB ⊂ CRUTCH TRAINING		4/23		(b)(6)-2 completed	
		ORTHO - DR. (b)(6)-2					

ADDRESSOGRAPH

(b)(6)-4

DIAGNOSIS

(R) FEMORAL FX

(B) TIB-FIB FX

AGE	HEIGHT	WEIGHT

PATIENT CLASSIFICATION

OP/SPECIAL PROCEDURES

S/P NAILING (R) FEMUR

IM ROD TIBIA x 2

	DATE ON	DATE OFF
SI		
VSI		
RELIGIOUS RITES		

FINDINGS:

PATIENT PROFILE

NAVMED 6550/12 (5-80) S/N 0105-LF- 060

Revert

✓	ACTIVITY	DATE	✓	BATH	DATE	DIET	DATE	✓	VITAL SIGNS	FREQ	✓	SPECIAL NOTES
✓	Bedrest			Bed bath		NPO			Temp	Q1 x4 (4/14)		Dentures
	Bathroom Privileges			Shower					Pulse	Q4 x24 (4/15)		Speech Impediment
	Up in chair	4/14		Tub		Reg	4/14		Resp	Q8° (4/16)		Language barrier
	Ambulate			Needs assistance					B/P			Prosthetic device
	Commode								Other			Visual impairment
	Needs assistance											Blind
	Restricted to unit											Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE				NV ✓	≥ Vitals		Glasses
	Other			Self		FEEDING	DATE		FLUIDS			Hearing defect
✓	Elevate BLE	4/14		Needs assistance		Self			Forced to:			Other
				Special		Needs assistance			Restricted to:			
						Gavage			I & O	QS x 48°		

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/10		HOB ≤ 30°		4/15		DSNS 100/hr	
4/16		Straight Cath Q6°	02,08,14,20	4/14		PT for OOB to chair	
		Encourage to void on own					
4/16		Dry dressing to (R) thigh JP drain					
		W→D dressing to medial calves					
4/14	4/15	Wound care team					
4/11		D/C NV changes. Call WMO to assess					
		+ bivalve cast if present					
4/11		D/C W/O <300cc/hr. Bolus 500cc NS					
		and Assess results. Call WMO if					
		no improvement.					
~~4/16~~		~~Crutches as tolerated~~					
4/14		Reinforce RLE dressing				Dolan - R.	

(b)(6)-2

ADDRESSOGRAPH

(b)(6)-4

DIAGNOSIS

~~(B) Tib/Fib fx c̄ Ex fix~~

(R) Femur Fx c̄ Ex fix

4/11 S/P (B) IM Nailing Tibia

OP/SPECIAL PROCEDURES

4/14 S/P IM Nailing (R) Prox Femur

FINDINGS:

AGE	HEIGHT	WEIGHT

PATIENT CLASSIFICATION

Stable

	DATE ON	DATE OFF
SI		
VSI		
RELIGIOUS RITES		

Guard

NEUROVASCULAR CHECK FLOW SHEET

DATE	TIME	1535	1555	1615	1630	1645	115	1730	1745	1800	1815	1845
		RLE	RLE	RLE	RLE	RLE	RLE	RLE				
NEUROLOGICAL CHECK												
EXTREMITY												
PAIN (pain)	ABSENT											
	MILD											
	MODERATE											
	SEVERE											
SENSATION (sensation)	NORMAL											
	NUMBNESS											
	TINGLING											
	ABSENT											
BLANCHING (Blanching) (N - Normal; S - Sluggish)		N	N	N	N	N	N	N	N	N	N	N
ACTIVE MOTOR FUNCTION	NORMAL											
	LIMITED											
	ABSENT											
SIGNS OF COMPARTMENT SYNDROME	PAIN ON PASSIVE MOTION											
	PAIN UNRELIEVED BY ANALGESICS											
VASCULAR CHECK												
COLOR (COLOR)	RED											
	PINK											
	PALE											
	BLUE											
SKIN TEMPERATURE (SKIN TEMP)	HOT											
	WARM											
	COOL											
	COLD											
PULSE (PULSE) SITE R/LLE	NORMAL											
	WEAK											
	ABSENT											
EDEMA (EDEMA) SITE RLE LLE	NONE											
	SMALL											
	MODERATE											
	LARGE											

COMMENTS

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

NNMC 6520/74

NNMC CRANIO-CEREBRAL CHECK SHEET

ATE	TIME																							
FILS		R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	P	L	R	L	R	L
PUPIL SIZE SCALE (MM) 2 3 4 5 6 7 8	SIZE																								
	REACTION																								
TOR STRENGTH ARMS (MOTOR STRENGTH ARMS)	STRONG																								
	WEAK																								
	NONE																								
TOR STRENGTH LEGS (MOTOR STRENGTH LEGS)	STRONG																								
	WEAK																								
	NONE																								
GLASGOW COMA SCALE: EYES OPEN (EYES OPEN)	SPONTANEOUSLY 4																								
	TO SPEECH 3																								
	TO PAIN 2																								
	NONE 1																								
BEST VERBAL RESPONSE (BEST VERBAL RESPONSE)	ORIENTED 5																								
	CONFUSED 4																								
	INAPPROPRIATE WORDS 3																								
	INCOMPREHENSIBLE WORDS 2																								
	NONE 1																								
BEST MOTOR RESPONSE (BEST MOTOR RESPONSE)	OBEYS COMMANDS 6																								
	LOCALIZED TO PAIN 5																								
	WITHDRAWS TO PAIN 4																								
	FLEXION TO PAIN 3																								
	EXTENSION TO PAIN 2																								
	NONE 1																								
RESPIRATORY RATE (RESPIRATORY RATE)	REGULAR																								
	IRREGULAR																								
DAS REFLEX	P = PRESENT / A = ABSENT																								

INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE

Patient Identification

(b)(3)-1

erative Plan Of Care & Nursin

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

Trauma# or Patient #

Diagnosis: (R) Femur Fx (L) tibia/fibula Fx **Planned Procedure:** Im rod (L) tibia

Date: 4/11/03 Arrival Time: 1000 Interviewer: LCDR (b)(6)-2

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

From:
☐ CASREC
☐ ICU
☑ Ward _____
☐ OTHER:

Transport Via:
☑ Gurney
☐ Litter
☐ Ambulated
☐ Wheelchair
☐ Other

Patient ID:
☐ Trauma card
☐ Verbal
☑ Chart
☑ Armband
☐ Other

Blood Ordered:
☑ N/A
☐ Yes ☐ Consent
☐ T/C #Units _____
☐ T/H #Units _____
Comments:

Surgical/Anesthesia Consent Verified:
☐ Procedure
☐ Consent complete, dated, signed
☑ Emergent case; no consent, MD note

Preop Labs (HCG, etc):
☐ None ☑ Yes
Test/Results: _____

Drug/Latex Allergies:
☑ NKDA
Allergy/Reaction: _____

Present On Admission:
☐ N/A
☐ Oxygen
☑ IV Site: #1 (L) Arm
#2 _____
☐ Foley
☐ Endotrachial Tube
☐ Arterial Line Site: _____
☐ Drain(s) _____
☐ Chest Tube(s) _____
☐ See RN Note # _____

Past Medical History:
☑ None known
☐ Smoker ppd/yrs ___/___
☐ ETOH ☐ Asthma
☐ HTN ☐ CAD
☐ GERD ☐ CBR exposure
☐ Other:

Past Surgical History:
☐ None known
☑ Yes
List: Ex Fix Both Legs

Cultural Needs Addressed:
☐ Yes ☑ No
List: _____

Pre-Op Pain:
☐ No
☑ Yes Level _____(0-10)
Action Taken: _____
Location/type: _____

Last PO Intake: (date/time)
Solid: 4/10/03 2400
Liquid: 4/10/03 2400

In Chart:
☑ H&P ☑ Yes ☐ No
☐ EKG ☐ Yes ☐ No
☐ CXR ☐ Yes ☐ No
☐ Other: _____

Skin Condition:
☑ Intact
☐ Other: _____

Limitations:
☐ N/A ☐ Auditory
☑ Language ☐ Visual
☑ Mobility ☐ Prosthesis
☐ Other: _____

Personal Items:
☑ 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:
☑ Alert/Oriented
☐ Disoriented
☐ Anxious
☐ Appropriate for age
☐ Other
☑ Calm
☐ Sedated
☐ Unresponsive

Comfort Measures Implemented:
☐ Clear, concise explanations
☐ Communicated patient concerns to other staff members
☐ Remain with patient during induction

Pre-op Teaching Included:
☑ 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

Operative Position:
☑ Supine
☐ Prone
☐ Jackknife
☐ Lithotomy
☐ Other:
☐ Beach chair
☐ Sitting
☐ Lateral L / R

Positional Aids:
☐ Arms <90
Armboard: ☐ L ☑ R
Tucked: ☐ L ☐ R
☐ Airplane
☑ Fracture Table
☐ Hand Table
☐ Stirrups
☐ Other:
☐ Axillary roll
☐ Gel Pad
☐ Leg Holder
☐ Tape
☐ Bean Bag
☐ Gel donut
☐ Pillows
☐ Wilson Frame

Comments: _____

ESU # 1
Pad Site: (R) leg
Pad Lot # 61277
Site Clear at end of case? ☐ No ☐ Yes
If No, see RN note # _____
Bipolar: ___ Max Cut 30 Coag 30

DVT Prevention:
SCD used ☑ No ☐ Yes
Pressure: ___ ☐ Left ☐ Right
Teds: ☐ No ☐ Yes
Bair Hugger used: ☐ No ☑ Yes
Other warming techniques:

Tourniquet:
☐ Arm ☐ Leg
☐ Left ☐ Right
☐ webril applied
↑ ___ ↓ ___
↑ ___ ↓ ___
_____
Applied by: N/A
Total Min: _____

Comments: _____

(b)(6)-4

Comments: _____

Potential For Infect' 'utcome: Appropriate Actions Taken to P 'nfection ☑ Yes ☐ No

Vound Classification: I ☐ II ☐ III ☑ IV

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

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

Solutions. ations: ☑ Normal saline ☐ Other: _____
☐ Sterile water
☐ Local _____
☐ Antibiotics _____

rains/Packing: ☐ None
Foley FR: 18
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: (R) + (L) legs

☐ 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:	Correct?			
RMO	_____	Sharps	☐ Yes	☐ No	☐ N/A
SNA	_____	Sponges	☐ Yes	☐ No	☐ N/A
___	DRN	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.

nplants:
em / Lot # / Exp Date:

(L)
459. 40
459. 48
459. 38
459. 46

AFFIX TO PATIENT RECORD
Manufactured or Distributed by
SYNTHES® 1101 Synthes Avenue Monument, CO 80132
11MM TI CANNULATED TIBIAL NAIL
380MM - STERILE
CAT # 485.138S
MCN # 4499711 EXP: 12/2011
MAT: T1-6Al-7Nb

(R)
459. 44
459 34
459 40
459. 46

AFFIX TO PATIENT RECORD
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11MM TI CANNULATED TIBIAL NAIL
380MM - STERILE
CAT # 485.138S
MCN # 4493266 EXP: 12/2011
MAT: T1-6Al-7Nb

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

ırgical Procedure Performed: IM R.L (L) tibia + (R) tibia

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

Initial/Name Box: (please print)

(b)(6)-2 | LCDR/NC
Primary OR RN Signature **Date** 4/11/03 1531 **Relief OR RN Signature** **Date/Time**

NSN 7540-00-[illegible]

SURGICAL RECORD

OPERATION REPORT

PREOPERATIVE DIAGNOSIS

(R) hip fx

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
Dr. (b)(6)-2	Dr.	—	
ANESTHETIST	ANESTHETIC		TIME BEGAN: 0835
LCDR (b)(6)-2	Gen		TIME ENDED: 1200
CIRCULATING NURSE	SCRUB NURSE	TIME OPERATION BEGAN	TIME OPERATION COMPLETED
LT (b)(6)-2	HM3 (b)(6)-2 HM2 (b)(6)-2	0915	1346

OPERATIVE DIAGNOSES

SAA

DRAINS (Kind and number)

JPX2 (R) femoral

SPONGES, INSTRUMENTS VERIFIED (b)(6)-2

Count correct x2

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION

None

OPERATION PERFORMED

(R) Femoral Rodding

DESCRIPTION OF OPERATION (Typed) (Include name of operation, incisions, etc.)

EBL 300 cc's
IVLR — cc's
U/O 800 cc's
3000 LR
50cc RBC

LTjg (b)(6)-2 INC 0835-1200
1200-

PROSTHETIC DEVICES (List inc.)

See below

Synthes

DATE OF OPERATION

4/14/03

AFFIX TO PATIENT RECORD
Manufactured or Distributed by 0007
SYNTHES® 1101 Synthes Avenue Monument, CO 80132
14MM TI CANNULATED FEMORAL NAIL 400MM-STERILE
CAT # 474.441S
MCN # 4455188 EXP: 12/2011
MAT: Ti-6Al-7Nb

Disrupts see Brief OP Note.

4.9 Lock Bolt
459.46x1
48x1

SIGNATURE OF SURGEON (b)(6)-2

DATE 4/14/03

(b)(6)-2

REGISTRAR NO.

OPERATION REPORT

STANDARD FORM [illegible]

516-108 NSN 7540-00-634-4156

MEDICAL RECORD | **OPERATION REPORT**

PREOPERATIVE DIAGNOSIS: (R) + (L) tibia Fx c̄ Ex Fix

SURGEON	FIRST ASSISTANT	SECOND ASSISTANT	
Dr (b)(6)-2	—	—	
ANESTHETIST	**ANESTHETIC**		TIME BEGAN: 1125
Dr (b)(6)-2	(b)(6)-2 ETT		TIME ENDED: 1531
CIRCULATING NURSE	**SCRUB NURSE**	**TIME OPERATION BEGAN**	**TIME OPERATION COMPLETED**
LCDR (b)(6)-2	HM3 (b)(6)-2	(1) 1200	(1) 1325
OPERATIVE DIAGNOSES	HM (b)(6)-2	(2) 1350	(2) 1523
	HM2 (b)(6)-2		

DRAINS *(Kind and number)*: ∅

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

MATERIAL FORWARDED TO LABORATORY FOR EXAMINATION: ∅

OPERATION PERFORMED

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

PROSTHETIC DEVICES *(Lot no.)*

DATE OF OPERATION: 11 April 03

(L) Tibia

AFFIX TO PATIENT RECORD
Manufactured or Distributed by 0003
SYNTHES® 1101 Synthes Avenue Monument, CO 80132
11MM TI CANNULATED TIBIAL NAIL
380MM - STERILE
CAT # 485.138S
MCN # 4499711 EXP: 12/2011
MAT: Ti-6Al-7Nb

Synthes 4.9 mm
Ti screws
459.40
459.48
459.38
459.46

(R) Tibia

AFFIX TO PATIENT RECORD
Manufactured or Distributed by 0008
SYNTHES® 1101 Synthes Avenue Monument, CO 80132
11MM TI CANNULATED TIBIAL NAIL
380MM - STERILE
CAT # 485.138S
MCN # 4493266 EXP: 12/2011
MAT: Ti-6Al-7Nb

459.44
459.34
459.40
459.46
4.9 mm screws

SIGNATURE OF SURGEON

DATE: 11 Apr 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*: (b)(6)-4

REGISTER/I.D. NO.

WARD NO.

Total Fluid - 3300
EBL - 200 cc
UOP - 800 cc

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

NNMC NEUROVASCULAR CHECK SHEET

DATE 14APR03	TIME	1411	1426	1441	1530	1600						
NEUROLOGICAL CHECK												
EXTREMITY												
PAIN	ABSENT	(b)(6)-2										
	RELIEVED											
	MODERATE											
	SEVERE											
SENSATION	NORMAL	(b)(6)-2										
	HARDNESS											
	TINGLING											
	ABSENT											
BLANCHING (N - Normal; S - Sluggish)		(b)(6)-2	(b)(6)-2									
ACTIVE MOTOR FUNCTION	NORMAL					(b)(6)-2						
	LIMITED	(b)(6)-2										
	ABSENT											
SIGNS OF COMPARTMENT SYNDROME	PAIN ON PASSIVE MOTION	Ø	Ø	(b)(6)-2	Ø	Ø	Ø					
	PAIN UNRELIEVED BY ANALGESICS	Ø	Ø		Ø	Ø	Ø					
VASCULAR CHECK												
COLOR	RED											
	PINK	(b)(6)-2										
	PALE											
	BLUE											
SKIN TEMPERATURE	HOT											
	WARM	(b)(6)-2										
	COOL											
	COLD											
PULSE SITE _____	NORMAL											
	WEAK	1	1		1	(b)(6)-2						
	ABSENT											
EDEMA SITE _____	NONE	(b)(6)-2										
	SMALL											
_____	MODERATE											
	LARGE											

COMMENTS

Pt. unable to access due to bandage.

INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE	INITIAL	SIGNATURE / TITLE
(b)(6)-2	(b)(6)-2 HM3				

30s m/o ♂ 70Kg No. I of II (20mcg Fentanyl)

ANTIBIOTIC: φ
TIME GIVIEN:
OTHER:

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

ALLERGIES PACU 20mg MSO4, 100mcg Fentanyl, 2mg Versed, Percocet PO

OPERATION PERFORMED: Bilat Spinal Nerve Ext-Fixator (R) Femur

AGENTS AND TECHNICS OF ANESTHESIA: GETA

1500 HOUR(S) 15 30 45 1600 15 30 45 1700 15 30 45

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

Spinal Level:

EKG to monitor on ☑
Rhythm ST

BP ⅟ art
BP ∨/∧ cuff
Pulse = •
% Sat:

RESP. RATE →

NUMBERS FOR REMARKS: 1 2 3 4 5 6 7

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK	10		AOW	1600
N/C	2L		1635	1833
VENTILAT.				

FLUID THERAPY

TYPE	5% D/W	BLOOD	SALINE	OTHER
OPERATING ROOM	300			
RECOVERY ROOM	950			
TOTAL	1250			

BLOOD LOSS IN OR: 200 cc
WARD PRE-OP BP 130 / 68 mmHg 72 HR
TUBES: ☐ N/G ☑ FOLEY
IV IN L Hand @ 950 cc OF LR AT 100 cc/hr AOW
IV IN L Hand @ 100 cc OF LR AT 120 cc/hr TOW
ART. LINE IN
T-TUBES, HEMOVAC IN

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD 5 FWD
DATE 4/11/03 HRS 1535	DATE 4/11/03 HRS 1900

DRESSINGS: LOCATIONS ACE BANDAGE TO LLE & RLE — ACE BANDAGE TO RLE - Small Drainage
STATUS: RLE CDT, LLE → MODERATE DRAINAGE — STATUS: LLE - moderate drainage

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	AOW	1818					
CC	800	500					
TOTAL		1300					
SP. GR							
S/A							

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	1	1
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	8	9

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by DR. (b)(6)-2
PMH: ASA 1
Neuro: A+ O X 2
Pain (Yes) No Action: Med per DR's order / will continue mon.
CV: SR
IV: Patent
Other: Warm sheets applied / side rails up x2
BLE elevated
(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 N/A HRS

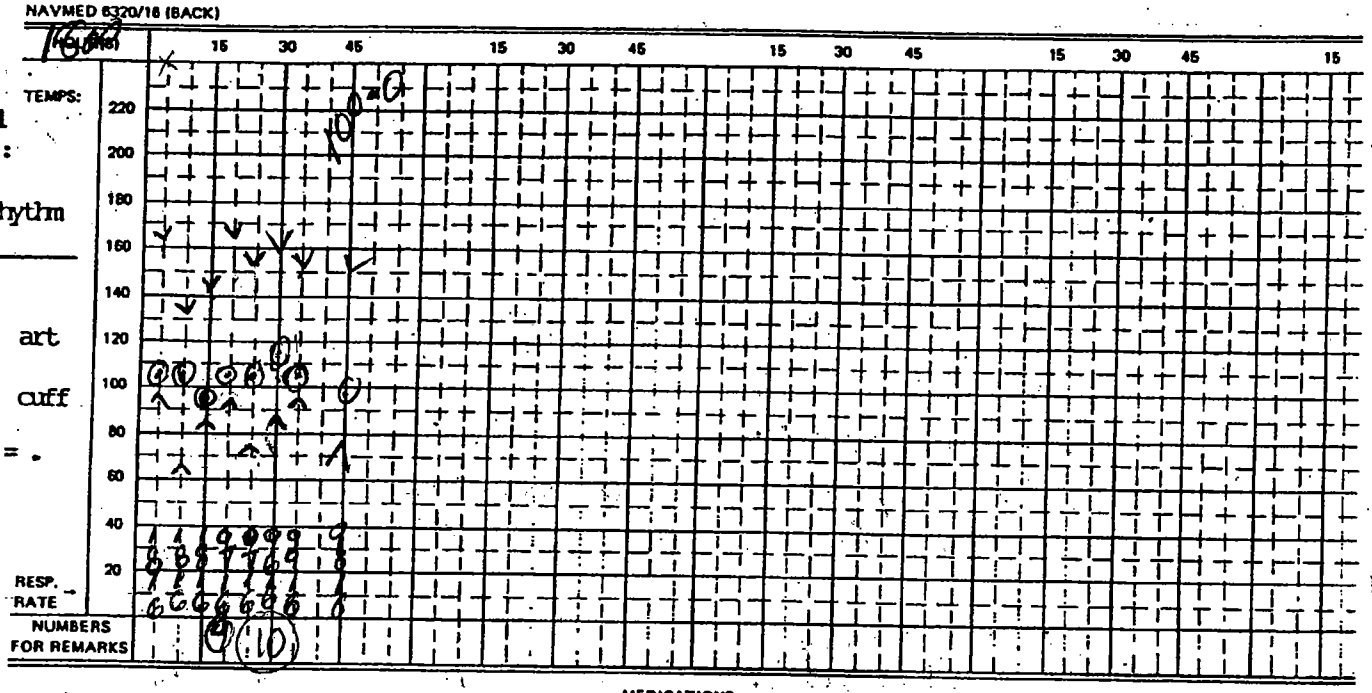
CONDITION ON TOW: ☒ GOOD ☐ FAIR ☐ POOR ☐ CRITICAL

RECOVERY: ☐ COMPLICATED ☒ UNEVENTFUL

PATIENT'S IDENTIFICATION: (b)(6)-2

SIGNATURE OF RECEIVING AND RELEASING OFFICERS: (b)(6)-2 TOW (b)(6)-2 (b)(6)-2 LCDR/NC LCDR/NC

NAVMED 6320/18 (BACK)



MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
1538	MSO4	3mg	IVP	(b)(6)-2
1539	MSO4	3mg	IVP	
1542	MSO4	3mg	IVP	
1555	MSO4	3mg	IVP	
1600	MSO4	3mg	IVP	
1604	MSO4	3mg	IVP	
1603				

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

(2) Elevated pt's lower extremities. (3) Pt cont to c/o of Pain Dr (b)(6)-2 notified of same. Versed 2mg given IVP, will cont to monitor (5) Resting quietly, will cont to monitor for pain relief (b)(6)-2 (6) Continue to c/o Pain. Fentanyl 25 mcg given (7) X-ray done to BE (b)(6)-2 1745 - Dr. (b)(6)-2 @ bedside to assess elevated B/P Labetol 10mg given, will cont monitor. (b)(6)-2

TOW Note: Neuro: A + O x 2

Pain: Yes/No Action: Resting comfortably. Received 20 mg MSO4 / 100 mcg Fentanyl 5 mg Versed IM (b)(6)-2

Pulmonary: B Equal ↓ Clear

CV: S_1 S_2 EKG Rhythm: SR IV: patent

Skin/Wound: Moderate amt drainage Drainage Yes/No Color: bloody Edema Yes/No

GI: Abd soft ⊂ BS +

GU: Foley Yes/No Color of urine: yellow Due to void: N/A

Instructions/Interventions in PACU: Encourage to deep breathe via incentivator

Report called to: LT JG (b)(6)-2 By: LCDR (b)(6)-2

TOWed to: 5 Forward Stretcher By: MN (b)(6)-2

U.S. Government Printing Office: 1991 — 504-109/20525 2-1

Page II of II

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

ALLERGIES

ANTIBIOTIC:
TIME GIVIEN:
OTHER:

OPERATION PERFORMED	AGENTS AND TECHNICS OF ANESTHESIA

HOUR(S): 15 30 45 15 30 45 15 30 45

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

Spinal Level:

EKG to monitor on ☐ Rhythm

BP ⅟ art

BP V/Λ cuff

Pulse = •

% Sat:

RESP. RATE

NUMBERS FOR REMARKS

OXYGEN THERAPY

ROUTE	L/M	%	ON	OFF
MASK				
T-BAR				
VENTILAT.				

FLUID THERAPY

TYPE	5% D/W	BLOOD	SALINE	OTHER
OPERATING ROOM				
RECOVERY ROOM				
TOTAL				

BLOOD LOSS IN OR: _____ CC

WARD PRE-OP BP / mmHg

TUBES: ☐ N/G ☐ FOLEY

IV IN _____ c̄ _____ cc
OF _____ AT _____ cc/hr AOW

IV IN _____ c̄ _____ cc
OF _____ AT _____ cc/hr TOW

ART. LINE IN _____

T-TUBES, HEMOVAC IN _____

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD _____
DATE _____ HRS _____	DATE _____ HRS _____

DRESSINGS: LOCATIONS _____

STATUS: | STATUS:

ENDOTRACHEAL TUBE – ORAL OR NASAL

☐ YES ☐ NO | ☐ YES ☐ NO

AIRWAY / BREATH SOUNDS

☐ CLEAR ☐ PLAST AIRWAY ☐ OBSTRUCTS EASILY | STATUS:

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

REMARKS *(AS NUMBERED)* AND PERTINENT PATIENT PROGRESS NOTES

1) AOW from MOR accompanied by

PMH:

Neuro:

Pain Yes/No Action:

CV: IV:

Other:

(CONT'D ON REVERSE)

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

See Page

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

RECOVERY:
☐ COMPLICATED
☐ UNEVENTFUL

PATIENT'S IDENTIFICATION:

(b)(6)-4

SIGNATURE OF RECEIVING AND RELEASING OFFICERS
AOW
TOW

NAVMED 6320/16 (BACK)

1800

HOUR(S): 15 30 45 15 30 45 15 30 45 15 30 45 15

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

Spinal Level:

EKG Rhythm

BP ↓ art

BP ∨ ∧ cuff

Pulse = •

% Sat:

RESP. RATE →

NUMBERS FOR REMARKS: 9 10

(b)(6)-2

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
1635	Fentanyl	25 mcg	IVP	(b)(6)-2
1645	Fentanyl	25 mcg	IVP	(b)(6)-2
1715	Fentanyl	25 mcg	IVP	
1735	Fentanyl	25 mcg	IVP	
1745	Labetalol	10 mg	IVP	
1813	Percocet (~~2 tabs~~)	2 tabs	PO	(b)(6)-2 ENS/NC

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

(8) HemoCue done by (b)(6)-2 Hemoglobin 9.8 (10) (9) BLE's elevated on blankets (AM) (10) BLE's lowered (a) PT's request. PT re-positioned in Bed. PT tolerating PO fluids well (b)(6)-2 Resting comfortably, discharge criteria met (b)(6)-2

TCW Note: Neuro:

Pain: Yes/No Action:

Pulmonary:

CV: EKG Rhythm: IV:

Skin/Wound: Drainage Yes/No Color: Edema Yes/No

GI:

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

Instructions/Interventions in PACU:

Report called to: By:

TCWed to: By:

*U.S. Government Printing Office: 1991 — 504-109/20525 2-1

ANESTHESIA RECOR

NMC 279 (12/00)

See 1

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

Procedure	Anesthesiologist	Surgeon	OR #
See ps. 1	(b)(6)-2 (b)(6)-2 MD	See ps. 1	1

Date	Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	Resident/SRNA	Page 2 of 2
See ps. 1							See Page One

Time	1400	X 30		X 1500		X 30		X 1600		X 30		
O_2 L/M	.7	.7	.7	1	1	1/8						
N_2O / Air L/M	1	1	1	2	2	2/						
Halo / Iso / Sevo / Des	1.5	1.5	1.5	.9	.7	X						
STP / Prop. / Etomidate												
Sux / Cistracurium												
Ro / Rapa / Ve coronium												
Lidocaine												
Neostigmine / Glyco												
Ephedrine / Neo												
Midazolam												
MSO_4 / Remi / Sufentanyl	100	150	100	150								
Epid. Lido / Bupiv / Ropiv												
1600 NS LR			2200		2900	3300						
700 U/O	700					800						
150 EBL	150					200						

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 Times I ____ I ____

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

		Antibiotics
	Total	Agent -
3300	Total	mg -
800	Total	over minutes
200	Total	@

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

PACU / ICU
Pulse - 98
BP - 135/90
Temp - 98.3
RR - 18
SaO_2 - 99
Comps - + / -

1350 → 14^05 JBBlink

ECG	SR	SR	SR	SR	SR	SR
N_2O / Ox / Sk / Ax Temp	36.4	36.3	36.3	36.6	36.8	36.8
% FiO_2	29	.3	.3	.3	.3	.3/1.0
% SaO_2	99	99	99	99	99	99/100
$EtCO_2$	34	34	34	36	36	40/45
TOF		4/4	4/4		4/4	
TV	782	CV	780	CV	763	SV
PIP (cmH_2O)	28		28		27	
Resp. Rate	14		14		14	12

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

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 RECOR

NMC 2799(12/00)

Wt (kg) - ~70kg Ht (in) - ?

...gies - NKDA

Procedure (L) (R) Tibial / Tibial nails	Anesthesiologist (b)(6)-2	(b)(6)-2 MD	Surgeon (b)(6)-2	OR # 1
Date 4.11.03	Anes. Start 1100	In Room 1125	Surg. Start 1200	Surg. End 1523
Anes. End 1535	Resident/SRNA —	Page 1 of 2	See Page One	

Time	1130	1200	30	1300	30	1400
O_2 L/M	8/1	1	1	1	1	1
N_2O / Air L/M	2	2	2	2	2	2
Halo / Iso / Sevo / Des		.4	.4	.7	.6	.7
STP Prop / Etomidate	200					
Sux / Cistracurium	160					
Ro / Rapa / Ve / Pancuronium			6			
Lidocaine	60					
Neostigmine / Glyco						
Ephedrine / Neo						
Midazolam						
MSO4 / Remi / Su / Pancuronium	250		250		160	
Epid. Lido / Bupiv / Ropiv						
NS LR	—	200	—	900 — 1100	—	1200
U/O						100
EBL						150

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

IV - 14 Ga L R Hand Wrist FA AC EJ

Tourniquet ____ mmHg Times ____ ____

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

Antibiotics: Agent - ; ing - ; over minutes; @

Total ____ Total ____ Total ____ Total ____

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

PACU / ICU: Pulse - ; BP - ; Temp - ; RR - ; SaO_2 - ; Comps - + / -

ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR
Nn / Or / Sk / Ax Temp	—	35.9	36.1	36.0	36.2	36.3	36.5	36.5	36.6	36.6
% FiO_2	1.0	.3	.3	.3	.3	.3	.3	.3	.3	.3
% SaO_2	100	100	100	100	100	100	100	100	100	100
$EtCO_2$	+	34	35	39	36	36	37	37	37	37
TOF		4/4		0/4	0/4				4/4	
TV	CV	766	CV	680	CV	740	CV	718	CV	737
PIP (cmH_2O)		24		24		24		22		22
Resp. Rate	14	12		13		13		14		14

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 Style Y / N Bil BS / $EtCO_2$ x 3 / CTN

Tube taped @ 23 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 / SS; Full T4 / Head lift / Sustained tetanus; Suctioned; Awake / Deep

Disposition - PACU / ICU; SV / SS; Awake / sleepy; Extubated / Intubated

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 ____; Seldinger Technique; CVP manually transduced; Cordis 9.5 / 8.5 Fr; SLIC; 2 / 3 - lumen

Comments / Drugs:

Patient Identification (b)(6)-4

(b)(6)-2

NNMC 6320/279 (Dec-00)

Pre / Post-anesthetic Summary

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
(R) (L) ~~Femur~~ tibial nailing	~30	~70kg	?	(1) 2 3 4 5 (E)	NKDA

Chemistries: —

Hematology: H / H - —; Platelets -; WBCs -

Coags: PT - —; INR -; PTT -

Urinalysis / HCG: —

NPO – p MN
Teeth – ∅ loose
Airway – Mp (I) / II / III / IV
FROM, 3 FB O, 3 FB HM

Respiratory: Cough: Sputum: Asthma: COPD: Recent URI: TB: ∅
Lung Exam: CTA (B)
CXR: —

CV: HTN: CAD: MI: CHF: VHD: ∅
Arrythmias:
Exercise Tolerance: ?
Cardiac Exam: RRR ∅ m's
ECG: —

CNS / Skeletal: Seizure: CVA: LOC: Neuro: Muscle: Skeletal: ∅

Misc: —

Other: Hepatic: Renal: GI: Endo: Heme: ∅
EtOH: ?
Tobacco: ?

Previous Anesthetics: ?
Family Hx: ∅

Current Medications: —

Premedication: —

Preoperative Diagnoses: (1) GSWs (B) LE's

Vitals	Pre-op	DOS
BP:	130/68	
HR:	72	
Resp:	16	
Temp:	—	
FHR:	—	

Day of Surgery
- ☑ Chart Reviewed / patient examined
- ☑ Risks / benefits / options discussed with patient
- ☑ Patient questions answered
- ☑ Patient / parent / guardian understands and accepts risks
- ☑ NPO after MN liq., _____ clears, _____ solids

Plan: GEA

Evaluator Signature: (b)(6)-2 Date: 4-11-03
(b)(6)-2

Staff MD / CRNA signature: (b)(6)-2 Date & Time: 4-11-03 1100 MD

Patient identification: (b)(6)-4

Post-operative note

☐ No apparent anesthetic complications

Signature Date

NNMC 6320/279 (Dec-10)

Pre / Post-anesthetic Sumn

Proposed Operation	Age	Weight (kg)	Height (in)	ASA Status	Allergies
(R) Femoral Nail	≈ 30	≈ 70		1 2 3 4 5 E	NKDA

Chemistries

Hematology
H/H - 6.5/19.7
Platelets -
WBCs -

Coags
PT -
INR -
PTT -

Urinalysis / HCG

NPO - 5 MN
Teeth - intact
Airway - MP I / II / III / IV
FROM, ____ FB O, ____ FB HM

Respiratory
Cough:
Sputum:
Asthma:
COPD:
Recent URI:
TB:
Lung Exam: LTA
CXR:

CV
HTN:
CAD:
MI:
CHF:
VHD:
Arrythmias:
Exercise Tolerance:
Cardiac Exam: RRR
ECG:

CNS / Skeletal
Seizure:
CVA:
LOC:
Neuro:
Muscle:
Skeletal:

Misc

Other
Hepatic:
Renal:
GI:
Endo:
Heme:
EtOH: ?
Tobacco: ?

Previous Anesthetics: (R) Tibial Nailing
Family Hx: Ø

Current Medications: Ø

Premedication: Ø

Preoperative Diagnoses
1) (R) Femur FX
2) Anemia

Vitals	Pre-op	DOS
BP:		
HR:		
Resp:		
Temp:		
FHR:		

Evaluator Signature | Date

Day of Surgery
- ☒ Chart Reviewed / patient examined
- ☐ Risks / benefits / options discussed with patient
- ☐ Patient questions answered
- ☐ Patient / parent / guardian understands and accepts risks
- ☒ NPO after _____ liq., _____ clears, _____ solids

Plan:

Staff MD / CRNA signature: (b)(6)-2 | Date & Time: 4/14/03

(b)(6)-2
LCDR/USN
ANESTHESIA

Patient identification: (b)(6)-4

Post-operative note
☒ No apparent anesthetic complications
(b)(6)-2
Signature | Date 4/14/3

ANESTHESIA RECOR

NMC (b)(6)-2 ...g) - 70 Ht (in) - ...gies - NKDA

Procedure: (R) Femoral Nail

(b)(6)-2

Surgeon: (b)(6)-2

Date	Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	Resident/SRNA
14 Apr 03	0815	0835	0915	1346	1400	

OR # 9 — Page 1 of 3 — See Page One

Time	0830	45	0900	15	30	45	1000	15	30	45	1100
O_2 L/M	8	1	1	1	1	1	1	1	1	1	1
N_2O / Air L/M		2	2	2	2	2	2	2	2	2	2
Halo / Iso / Sevo / Des		1	.8	.8	.8	.8	.8	.8	.8	.8	.8
STP / Prop / Etomidate	100										
Sux / Cisracurium											
Ro / Rapa / Ve curonium	6		2			2					
Lidocaine											
Neostigmine / Glyco											
Ephedrine / Neo										24	
Midazolam											
MSO$_4$ / Remi / Su / Fentanyl	200				15						
Epid. Lido / Bupiv / Ropiv											
PRBC											
NS / LR					500						250
D/D					500			1000			
EBL					5K		100				

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: RBC Used 500 Wasted Ø Witns ___

Drawn: 25 Used 250 Wasted Ø Witns ___

Tourniquet L / R Thigh, Calf, Ankle, Hand, Wrist, FA, AC, EJ

mmHg Times 1 Used 100 wasted 0

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

Antibiotics: Agent - ; mg - ; over minutes; @

500	Total	
1000	Total	
3000	Total	
800	Total	
300	Total	

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

PACU / ICU: Pulse 167; BP 129/72; Temp 98.7; RR 120 clear; SaO_2 100; Comps - + / -

ECG	ST	SR	SR	SR	SR	SR	SR	SR	SR	SR
Anes / Np / Or / Sk / Ai Temp					36.6	36.6	36.6	36.6	36.7	36.9
% FiO_2	1.00	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.3
% SaO_2	100	100	99	99	99	99	99	99	99	98
$EtCO_2$		35	35	35	35	33	33	32	44	46
TV		V		V		V		V	0	0
PIP (cmH_2O)		900	V	908	V	798	V	820		964
Resp. Rate		30		50		34		30		
		12		12		11		11	21	21

0925 b.w.k, [illegible] received [illegible] RNA

(b)(6)-2

(b)(6)-4 + unit PRBC's initiated @1015

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

Intubation - Mac / Mil 2 Grade 1 view Tube Size 7; Attempts 1; Oral / Nasal L / R w/o / w/ Cuff; Stylet Y / N; Bil BS; $EtCO_2$ x3 / CIN

Tube taped @ 23 cm - lips / teeth / nares; Trauma Y / N; FOB / LW / Blind; LMA # ___; DLT ___ Fr L / R

Maintenance - Smooth; Cuff checked; Eyes taped / lubed

Extubation - Smooth; Reversal; 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	Tuohy / Whitacre / Quincke	Level ___	
Betadine prep x 3	Needle guage ___		
Local infiltration	Sitting	Lines	
Site ___ L / R	Lateral R / L	Seldinger Technique	
Attempts ___	LOR in 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 RECOR

NMC (279(12/00))

Wt (kg) - 70 Ht (in) - .gies - NKDA

Procedure					
(2) Femoral Nail	(b)(6)-2	(b)(6)-2	(b)(6)-2		OR # 9
Date 4/14/3	Anes. Start	Room ANESTHES...		Anes. End	Resident/SRNA	Page 3 of 3

See Page One

Time	1330	45	1400	15	30
O_2 L/M	1-2	5			
N_2O / Air L/M	2X				
Evap Halo / Iso / Sevo / Des	0.5X				
STP / Prop. / Etomidate					
Sux / Cistracurium					
Ro / Rapa / Ve curonium					
Lidocaine					
Neostigmine / Glyco					
Ephedrine / Neo					
Midazolam					
MSO_4 / Remi / Su / fentanyl					
Epid. Lido / Bupiv / Ropiv					
NS / LR					
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_____ Used_____ Wasted_____ Witns_____
Drawn_____ Used_____ Wasted_____ Witns_____

IV - _____ Ga L / R Hand 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.
Ⓥ = Ventilator
X = MAP
Λ / V = NIBP
⊥ / T = A-Line
I = Intubate
E = Extubate

PACU / ICU
Pulse -
BP -
Temp -
RR -
SaO_2 -
Comps - + / -

ECG	ST	ST
Es / Np / Or / Sk / Ax Temp	37.8	X
% FiO_2	1.00	1.00
% SaO_2	100	100
$EtCO_2$	45	43
	0	0
TV	460	483
PIP (cmH_2O)		
Resp. Rate	22	21

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

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:

Patient Identification
(b)(6)-4

ANESTHESIA RECOR

(b)(6)-2

Wt (kg) - 70 Ht (in) - .gies - NKDA

Procedure: (R) Femoral Nail

Anesthesiologist: (b)(6)-2

Surgeon: (b)(6)-2

OR # 9

Date: 4/14/03

Anes. Start	In Room	Surg. Start	Surg. End	Anes. End	Resident/SRNA

Page 2 of 3 — See Page One

Time	1100	15	30	45	1200	15	30	45	1300	15	30
O_2 L/M	1	1	1	1	1	1	1	1	1	1	1
N_2O / Air L/M	2	2	2	2	2	2	2	2	2	2	2
Halo / Iso / Sevo / Des	.8	.8	.8	1.0	1.3	1.2	1.0	1.0	.9	.8	
STP / Prop. / Etomidate											
Sux / Cistracurium											
Ro / Rapa / Ve curonium											
Lidocaine											
Neostigmine / Glyco											
Ephedrine / Neo											
Midazolam											
MSO_4 / Remi / Su / fentanyl	25		50	50	25-25	25-25	50				
Epid. Lido / Bupiv / Ropiv											
Demerol							30/20/20/30				
NS	800							1000			
PRBCs	X						500				
NS (LR)	2000							3000			
U/O	120/675									800	
EBL		200								300	

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 Times 1 ____ 1 ____
60 / 90 / 120 / 130 / 140 / 150 min - Surgeons informed

Antibiotics
Total
Total
Total
Total
Agent -
ing -
over minutes
@

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

PACU / ICU
Pulse -
BP -
Temp -
RR -
SaO_2 -
Comps - + / -

(b)(6)-4 2nd unit of PRBCs initiated @1110

1143 (b)(6)-2 for lumbar relief

1225 - 2nd PRBC unit completed.

	1100	15	30	45	1200	15	30	45	1300	15	30
ECG	SR	SR	SR	SR	SR	SR	SR	SR	SR	SR	
Es / Np / Or / Sk / Ax Temp	37.2	37.2	37.3	37.3	37.3	37.3	37.5	37.5	37.7	37.7	
% FiO_2	.29	.29	.29	29	29	29	29	29	29	29	
% SaO_2	99	99	98	97	97	97	99	99	99	99	
$EtCO_2$	43	42	43	46	49	50	47	46	49	48	
	0	0	0	0	0	0	0	0	0	0	
TV	445	391	445	426	387	381	419	441	464	508	
PIP (cmH_2O)											
Resp. Rate	24	26	23	21	21	20	21	19	19	19	

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

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:

/ ~ 7/0 / 10mg /

ANTIBIOTIC: Imipenum 500mg
TIME GIVEN: 0600
OTHER: fentanyl 750
demerol 10mg

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

ALLERGIES

OPERATION PERFORMED: (R) femoral nail

AGENTS AND TECHNICS OF ANESTHESIA: (b)(6)-2

HOUR(S) 15 30 45 1100 15 30 45 1500 15 30 45

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

Spinal Level:

EKG to monitor on ☑ Rhythm

BP ⅄ art

BP ∨ ∧ cuff

Pulse = •

% Sat:

RESP. RATE

NUMBERS FOR REMARKS: (1)

OXYGEN THERAPY				
ROUTE	L/M	%	ON	OFF
MASK	10L		AOW	1444
T-BAR				
VENTILAT.				

FLUID THERAPY				
TYPE	5% D/RL	BLOOD	SALINE	OTHER
OPERATING ROOM	3000	500		
RECOVERY ROOM	1000			
TOTAL	4000	500		

BLOOD LOSS IN OR: 300 cc

WARD PRE-OP BP / mmHg

TUBES: ☐ N/G ☐ FOLEY

IV IN H/A ≈ 2000 cc OF LR AT 125 cc/hr AOW
16, 18

IV IN L/A ≈ 2000 cc OF LR AT 125 cc/hr TOW

~~ART. LINE IN~~

~~T-TUBES, HEMOVAC IN~~

ADMISSION	DISCHARGE
FROM MOR/SPEC. STUDY	TO WARD 5F Pmt
DATE 4/13/03 HRS 1357	DATE 4/14/03 HRS

DRESSINGS: LOCATIONS (L) & (R) leg

STATUS: LDI

STATUS: Has sensation

ENDOTRACHEAL TUBE – ORAL OR NASAL: ☐ YES ☑ NO ☐ YES ☑ NO

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

STATUS:

	MOR	PACU	URINARY OUTPUT		JP	DRAINAGE #1	DRAINAGE #2
TIME	AOW	TOW			1509		
CC	800	350				40cc	40cc
TOTAL	800	1150				33cc	20cc
SP. GR							32cc
S/A						10	36

#1 #2
12 20
total
(1) (2)

REMARKS (AS NUMBERED) AND PERTINENT PATIENT PROGRESS NOTES

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

PMH: ASA 2

Neuro: able to respond to verbal & tactal stimu

Pain Yes (No) Action:

CV: warm, IV: patient

Other: siderails x 2, warm blankets.

(CONT'D ON REVERSE)

POST-ANESTHESIA RECOVERY SCORE (ALDRETE SCORE)			A	D
Able to move 4 extremities voluntarily or on command	2	Activity	1	1
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	9	9

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

RECOVERY: ☐ COMPLICATED ☐ UNEVENTFUL

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

SIGNATURE OF RECEIVING AND RELEASING OFFICERS: (b)(6)-2

TOW (b)(6)-2

NAVMED 6320/16 (BACK)

HOUR(S) 1600 15 30 45 15 30 45 15 30 45 15 30 45 15

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

Spinal Level:

EKG Rhythm

BP ↓ art

BP ↑ cuff

Pulse = •

% Sat:

RESP. RATE

NUMBERS FOR REMARKS

MEDICATIONS

TIME	DRUG	DOSE	ROUTE	NURSE
1440	Morphine	2mg	IVP	(b)(6)-2
1444	Tobramycin	100mg	IVP	(b)(6)-2
1501	Fentanyl	25mcg.	IVP	(b)(6)-2
1507	Morphine	2mg	IVP	(b)(6)-2
1511	Fentanyl	25mg	IVP	(b)(6)-2
1539	Morphine	2mg	IVP	(b)(6)-2

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

(1) pt d/c from O2. (2) pt. can remain O2 levels on room air. (3) pt had X-rays taken of (R) leg. At 1530 Phys. was called and notified of malfunctioning JPTI. Phys. said to reinforce and sight was reinforced. Tobramycin consumed entirely at 1541. (4) JP's drained and emptied. Pt. [illegible] extremity. No interventions (individualized) [illegible] per protocol. (b)(6)-2

TOW Note: Neuro: Pt. A&O x3, Responsive to verbal commands

Pain: Yes/No Action:

Pulmonary: Lungs clear Bilaterally: O2 stats maintaining ≥ 97.

CV: S1S2, warm, normal cap refill. EKG Rhythm: NSR IV: Patent / intact

Skin/Wound: Ends approximated. Drainage Yes/No Color: Sero Sanguinous Edema Yes/No

GI: No N/V

GU: Foley Yes/No Color of urine: Amber Due to void: N/A

Instructions/Interventions in PACU: Intake and output of JP drains.

Report called to: LPN (b)(6)-2 By: (b)(6)-2

TOWed to: 5 Forward Post By: (b)(6)-2

[illegible]: 1991 — 504-109/20525 2-1

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED ASAP 15APR03

DATE AND HOUR REQUIRED

REQUESTING PHYSICIAN *(Print)* (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE Anemia

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

VOLUME REQUESTED *(If applicable)* 1 unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER (b)(6)-2 ENS NC

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED 15 APR 03

TIME VERIFIED 0755

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO. (b)(6)-4 PA

TEST INTERPRETATION

ANTIBODY SCREEN: NEG

CROSSMATCH: Comp

PREVIOUS RECORD CHECK:
- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

DONOR
ABO O
Rh POS

RECIPIENT
ABO AB
Rh POS

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 4/15/03

REMARKS:

UNIT EXPIRES: 17APR03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* (b)(6)-2

AT *(Hour)* 1355 ON *(Date)* 15APR03

IDENTIFICATION

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

1st VERIFIER *(Signature)* (b)(6)-2

2nd VERIFIER *(Signature)* (b)(6)-2 LCDR NC USN

PRE-TRANSFUSION

TEMP. 99.3 PULSE 102 90 BP 150 68

DATE OF TRANSFUSION 15APR03

TIME STARTED 1005

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED 15APR03 1650

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE 99.7 PULSE 102 BLOOD PRESSURE 110 68

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [x] NO
- [ ] YES *(Specify)*

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

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility) (b)(6)-4

SEX M

WARD 5W 5PWD 5TBD

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

Medical Record Copy

MEDCOM - 5264

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED ASAP

DATE AND HOUR REQUIRED 15 APR 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE ANEMIA

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

SIGNATURE OF VERIFIER BS ORIGINAL

DATE VERIFIED 15 APR 03

TIME VERIFIED 0755

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO. (b)(6)-4

PATIENT NO.

DONOR ABO O Rh POS

RECIPIENT ABO AB Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NEG	COMP

PREVIOUS RECORD CHECK: [x] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED DATE 4/15/03

REMARKS:

UNIT EXPIRES: 17 APR 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* (b)(6)-2

AT *(Hour)* 0935 ON *(Date)* 4/15/03

IDENTIFICATION

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

1st VERIFIED *(Signature)* (b)(6)-2 ENS, NC

2nd VERIFIED *(Signature)* (b)(6)-2 ENS/NC

PRE-TRANSFUSION TEMP. 99.3 PULSE 90 BP 150/82

DATE OF TRANSFUSION 15 APR 03 TIME STARTED 1005

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ML

TIME/DATE COMPLETED/INTERRUPTED 15 APR 03 1240

REACTION [x] NONE [ ] SUSPECTED

TEMPERATURE 99.8 PULSE 94 BLOOD PRESSURE 162/70

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [x] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTED ABOVE (b)(6)-2 ENS, NC

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

(b)(6)-4

SEX M

WARD 17NW (SBO)

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 5265

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 14 Apr-03

DATE AND HOUR REQUIRED 14 Apr-03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE

Hip Fx

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

SIGNATURE OF VERIFIER (b)(6)-2

DATE VERIFIED 14 Apr-03

TIME VERIFIED 0900

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO. (b)(6)-4

PATIENT NO.

DONOR

ABO A

Rh POS

RECIPIENT

ABO AB

Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NEG	COMP

PREVIOUS RECORD CHECK:

- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 4-14-03

REMARKS:

Exp: 14 APR 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

(b)(6)-2

AT *(Hour)* 1007 ON *(Date)* 4-14-03

IDENTIFICATION

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

1st VERIFIER *(Signature)* (b)(6)-2 LTJG (b)(6)-2

2nd VERIFIER *(Signature)* (b)(6)-2 LCDR/USN ANESTHESIA

PRE-TRANSFUSION

TEMP. 36.6 PULSE 70 BP 108/47

DATE OF TRANSFUSION 4/14/03 TIME STARTED 10:15

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME/DATE COMPLETED/INTERRUPTED 4/14/03 11:00

REACTION [x] NONE [ ] SUSPECTED

TEMPERATURE 37.1 PULSE 63 BLOOD PRESSURE 119/55

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

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

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

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2 (b)(6)-2 LCDR/USN ANESTHESIA

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

(b)(6)-4

SEX

WARD

(b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

MEDCOM - 5266

Medical Record Copy

518-124 NSN 7540-00-634-4159

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- [x] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of _____ units)*
- [ ] CRYOPRECIPITATE *(Pool of _____ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* _____

VOLUME REQUESTED *(if applicable)* _____ ML

REMARKS:

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED 14 April 03

DATE AND HOUR REQUIRED 14 Apr 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE Chip Ex

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

SIGNATURE OF VERIFIER (b)(6)-2

DATE VERIFIED 14 April 03

TIME VERIFIED 0900

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO. (b)(6)-4

PATIE

DONOR
ABO A
Rh POS

RECIPIENT
ABO AB
Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NEG	COMP

PREVIOUS RECORD CHECK:
- [ ] RECORD
- [x] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 4-14-03

REMARKS:

CXP. 14APR03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* (b)(6)-2

AT *(Hour)* 1107 ON *(Date)* 4/14/03

IDENTIFICATION

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

1st VERIFIER *(Signature)* (b)(6)-2 LTjg, NC (b)(6)-2

2nd VERIFIER *(Signature)* (b)(6)-2 LCDR/USN ANESTHESIA

PRE-TRANSFUSION
TEMP. 37.3 PULSE 64 BP 111/40

DATE OF TRANSFUSION 4/14/03 TIME STARTED 1110

POST-TRANSFUSION DATA

AMOUNT GIVEN 250 ML

TIME/DATE COMPLETED/INTERRUPTED 1225 4/14/03

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
37.4	88	122/48

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

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [x] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE (b)(6)-2 (b)(6)-2 LCDR/USN ANESTHESIA

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

(b)(6)-4

WARD

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

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

Medical Record Copy

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/27/03 0038			CHART VERIFIED	(b)(6)-2	
4/28/03			no further orders chart verified	(b)(6)-2	
29APR2003 0025			no new orders 24° chart ✓	(b)(6)-2	EWS/RC
30APR2003 0230			24° chart ✓ Ø new orders	(b)(6)-2	EWS/RC
01May2003 0200			24° chart ✓ Ø new orders	(b)(6)-2	EWS/RC
02May2003 0100			24° chart ✓ Ø new orders	(b)(6)-2	EWS/RC
03May2003 0155			24° chart ✓ Ø new orders	(b)(6)-2	
04May2003 0035			VO from Dr (b)(6)-2 to EWS Percocet 1-2 tabs PO Q4-6 prn	(b)(6)-2 (b)(6)-2	EWS/RC

(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.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FPMR 101-11. 806-8
508-110

MEDICAL RECORD			DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/22/03 2000			VO Dr (b)(6)-2	(b)(6)-2	
			① D/C Lovenox		
			② Give 10mg Vit K SQ x 1 now.		
				(b)(6)-2	CDR
22APR2003 2040			VO from Dr. (b)(6)-2 to EMS	(b)(6)-2	
			Vit K 10mg SQ x 3 days (start today)		
			• PT/PTT/INR in AM	(b)(6)-2	RN/NC
				(b)(6)-2	
			22APR2003 2230 (b)(6)-2		RN/NC
4/23/03 0119			Chart verified	(b)(6)-2	
~~4/23/03 2400~~			~~VO DR (b)(6)-2 DOG (b)(6)-2~~		
~~4/23/03 2400~~			~~VO DR (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. 5 ICWD

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505
508-111
☆U.S. GPO: 1988—201-760/80076

508-112 7540-01-044-5515

MEDICAL RECORD

DOCTOR'S ORDERS

INSTRUCTIONS: Place form on **firm surface**; use pressure on ball point pen. Sign all orders.
Nurse: Remove one copy and send to Pharmacy after each order is written.

DATE AND TIME START	STOP	Rx	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/23/03 2400			VO DR (b)(6)-2 / LTJG (b)(6)-2		
			(1) BLOOD Cx x 2		
			(2) URINE A & Cx		
			(3) CXR	(b)(6)-2	
4/24/03 0115			chart verified	(b)(6)-2	
Apr 24 '03 0828		(1)	Fortipaque 500 cc IV q 6°		(b)(6)-2
		(3)	Vancomycin 1g IV q 12°		(b)(6)-2
		(3)	Send sputum for culture (from outside) (b)(6)-2		(b)(6)-2 (b)(6)-2
		(4)	Lovenox 30 cc SQ BID		(b)(6)-2
				(b)(6)-2	
					24 Apr 03 0835
25 Apr 03 0100			24° Chart Verification	(b)(6)-2	
Apr 25 '03 0814		(1)	CBC PT/INR now (b)(6)-2		
			thrombo PRP (in CHCS) (b)(6)-2		
				(b)(6)-2	
4/26/03 0341			chart verified		(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. ~~5~~ Forward

WARD NO.

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

USNS COMFORT (T-AH 20)

PeriOperative Plan Of Care & Nursin

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

Trauma# or Patient #

Diagnosis: Ex R hip Planned Procedure: Bi R hip

Date: 1/14/03 Arrival Time: Interviewer: (b)(6)-2

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

From:
☐ CASREC
☐ ICU
☒ Ward _____
☐ OTHER:

Transport Via:
☒ Gurney
☐ Litter
☐ Ambulated
☐ Wheelchair
☐ Other

Patient ID:
☐ Trauma card
☒ Verbal
☒ Chart
☒ Armband
☒ Other

Blood Ordered:
☐ N/A
☒ Yes ☐ Consent
☐ T/C #Units 2
☐ T/H #Units _____
Comments: (b)(6)-2

Surgical/Anesthesia Consent Verified:
☐ Procedure
☒ Consent complete, dated, signed
☐ Emergent case; no consent, MD note

Preop Labs (HCG, etc):
☐ None ☒ Yes
Test/Results: (b)(6)-2

Drug/Latex Allergies:
☒ NKDA
Allergy/Reaction: _____

Present On Admission:
☐ N/A
☐ Oxygen
☒ IV Site: #1 18ga ⓓ F/A
#2 _____
☒ Foley
☐ Endotrachial Tube
☐ Arterial Line Site: _____
☐ Drain(s) _____
☐ Chest Tube(s) _____
☐ See RN Note # _____

Past Medical History:
☒ None known
☐ Smoker ppd/yrs ____/____
☐ ETOH ☐ Asthma
☐ HTN ☐ CAD
☐ GERD ☐ CBR exposure
☐ Other:

Past Surgical History:
☐ None known
☒ Yes
List: See pt's chart

Cultural Needs Addressed:
☐ Yes ☒ No
List: _____

Pre-Op Pain:
☒ No Not able to access
☐ Yes Level _____(0-10)
Action Taken: _____
Location/type: _____

Last PO Intake: (date/time)
Solid: 2300 4/14/03
Liquid: SAA

In Chart:
☐ H&P ☒ Yes ☐ No
☐ EKG ☐ Yes ☒ No
☐ CXR ☐ Yes ☒ No
☐ Other: _____

Skin Condition:
☐ Intact
☒ Other: _____

Limitations:
☐ N/A ☐ Auditory
☒ Language ☐ Visual
☒ Mobility ☐ Prosthesis
☐ Other: _____

Personal Items:
☒ 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:
☐ Alert/Oriented
☐ Disoriented.
☐ Anxious.
☐ Appropriate for age
☐ Other
☒ Calm
☐ Sedated
☐ Unresponsive

Comfort Measures Implemented:
☐ Clear, concise explanations
☒ Communicated patient concerns to other staff members
☒ Remain with patient during induction

Pre-op Teaching Included:
☐ 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

Operative Position:
☒ Supine
☐ Prone
☐ Jackknife
☐ Lithotomy
☐ Other:
☐ Beach chair
☐ Sitting
☐ Lateral L / R

Positional Aids:
☒ Arms <90
Armboard: ☐ L ☐ R
Tucked: ☐ L ☐ R
☐ Airplane
☒ Fracture Table
☐ Hand Table
☐ Stirrups
☐ Other:
☐ Axillary roll
☐ Gel Pad
☐ Leg Holder
☐ Tape
☐ Bean Bag
☐ Gel donut
☐ Pillows
☐ Wilson Frame

Comments: _____

ESU # _____
Pad Site: Dr Wh
Pad Lot # 6/2/11
Site Clear at end of case? ☐ No ☐ Yes
If No, see RN note # _____
Bipolar: ___ Max Cut___ Coag ____

DVT Prevention:
SCD used ☐ No ☐ Yes
Pressure: ___ ☐ Left ☐ Right
Teds: ☐ No ☐ Yes
Bair Hugger used: ☐ No ☒ Yes
Other warming techniques:

Tourniquet:
☐ Arm ☐ Leg
☐ Left ☐ Right
☐ webril applied
↑ ____ ↓ ____
↑ ____ ↓ ____
_____
Applied by: _____
Total Min: _____

Comments: _____

(b)(6)-4

Comments: _____

Potential For Infec[illegible]tcome: Appropriate Actions Taken to [illegible]fection ☒ Yes ☐ No

Wound Classification:
☐ I ☒ II ☐ III ☐ IV

Shave Prep:
☐ Shave ☐ Clipper
Area: _____ By: _____

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

Solutions/[illegible]ions:
☒ Normal sa[illegible]
☐ Sterile water
☐ Local _____
☐ Antibiotics _____
☐ Other: _____

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

Dressing: Location: R / L

☐ 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]
(b)(6)-2
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: _____
☐ 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]urgical Procedure Performed: R Femoral Rodding

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

AFFIX TO PATIENT RECORD
Manufactured or Distributed by
SYNTHES® 1101 Synthes Avenue Monument, CO 80132
14MM TI CANNULATED FEMORAL
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MAT: Ti-6Al-7Nb

Lock Belt
4/4
459.46 X1
444 X1

Initial/Name Box: (please print)

(b)(6)-2
[illegible] Signature
14 Apr 3
Date

Relief OR RN Signature
Date/Time

508-112 7540-01-044-5515

MEDICAL RECORD

DOCTOR'S ORDERS

INSTRUCTIONS: Place form on **firm surface**; use pressure on ball point pen. Sign all orders.
Nurse: Remove one copy and send to Pharmacy after each order is written.

DATE AND TIME START	STOP	Rx	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/21/03	1112		VO Dr (b)(6)-2 & Dr (b)(6)-2 — remove all staples & suture + @ Lt, bilat. Knees and @ ankle. —	(b)(6)-2	
22 Apr 03	0430		24° Chart Verification —	(b)(6)-2	
Apr 22 '03 0849		1	Lovenox 30 g SQ BID — (no more coumadin given pt's high sensitivity)		(b)(6)-2
		2	PT/INR @ 1800 + also CBC	(b)(6)-2 (b)(6)-2	
Noted 0905 4/22/03				(b)(6)-2	
Apr 22 '03 0914		1	Morphine 800 g po TID		(b)(6)-2
		2	Aciphex 20 g po BID		
Noted 0930 4/22/03				(b)(6)-2 (b)(6)-2	
4/22/03	1050	1)	MVI + TAB PO QDAY		
		2)	FeSO4 325mg PO QDAY	(b)(6)-2	
			V.O. Dr (b)(6)-2		
4/23/03	0119		Chart verified —	(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.

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

508-112 7540-01-044-5515

MEDICAL RECORD

DOCTOR'S ORDERS

INSTRUCTIONS: Place form on **firm surface**; use pressure on ball point pen. Sign all orders.
Nurse: Remove one copy and send to Pharmacy after each order is written.

DATE AND TIME START	STOP	Rx	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
Apr 20 '03 2200		(c)	f/c coumadin — we will dose with one time a day	4/20/03 2200	(b)(6)-2
			(b)(6)-2	(b)(6)-2	LCDR/NC
4/20/03 2300			VO Dr (b)(6)-2 to LCDR (b)(6)-2		Faxed 23rd 4/24/03
		(1)	Give 1mg Vit K IV x1 now.	(b)(6)-2	LCDR/NC
4/21/03 0801			~~CHART VERIFIED~~	(b)(6)-2	
4/21/03 0850		(2)	PT INR @ 1800 today (in UHS / min LL)		(b)(6)-2
Noted 0900			4/21/03 (b)(6)-2	(b)(6)-2	
4/21/03			PT - Rom (B) LE - WBAT c crutches. Crutch training.		(b)(6)-2
Noted 0930			4/21/03 (b)(6)-2	(b)(6)-2	

CDR

Continue on reverse side

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

REGISTER NO.

WARD NO.

(b)(6)-4

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
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DOCTOR'S ORDERS
(Sign all orders)

EDICAL RECORD

TIME	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
					(b)(6)-2
2 '03		(1)	repeat PT/INR now	(b)(6)-2	
33			Noted 1040 4/19/03		
			(b)(6)-2		(b)(6)-2
					(b)(6)-2
9 '03		(2)	Vitamin K 1.0 mg iv		(b)(6)-2
143			for INR 20.5 (PT 67.8)		
		(3)	PT/INR in 12°		
			Noted 1145 4/19/03	(b)(6)-2	
			(b)(6)-2		(b)(6)-2
/19/03 2200			INR at MN 4/19/03 Give 0.5 mg Vit. K IV if INR is greater than 10.		
			(b)(6)-2	CDR, NC	
			(b)(6)-2 4/19/03		
			24 Chart Verified 20 Apr 03 0000	(b)(6)-2	
4/20/03			1400 TO Dr (b)(6)-2 (b)(6)-2 + CDR (b)(6)-2		
			- Fleets x1 now	(b)(6)-2	
4/21/03			0000		

(Continue on reverse side)

REGISTER NO. chart verified WARD NO. (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)-2

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
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FIRMR (41 CFR) 201-45-505
508-112

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

E AND TIME		RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
T	STOP				
-03 1050			1. D'C previous Valium order and MSO4 order:		(b)(6)-2
			2. Valium 5 mg po at 08-1400-2000. Hold if to sedated		
			3. Morphine 2-10 mg IV q3-4h prn pain Hold if to sedated. Cdr	(b)(6)-2	FNP
			4. Nubaine supp 1 PR now. May repeat tomorrow if needed. Cdr	(b)(6)-2	FNP
			noted 4/18/03 1435	(b)(6)-2	
			24° Chart verification 19 Apr 03 @0338	(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.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
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FIRMR (41 CFR) 201-45-505
508-112

MEDICAL RECORD | **DOCTOR'S ORDERS** (Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
					(b)(6)-2
1603	1615		1. valium 5mg po tid	(b)(6)-2	
			Hold if patient is to sedated		
			2. Stop Valium IV order Cdr	(b)(6)-2	FNPC
			3. CBC in am Cdr	(b)(6)-2	FNPC
			Noted (b)(6)-2 LTSLNC 4/16/03 1855		
4/17/03	0130		24° chart verification	(b)(6)-2	ENS.NC
4/17/03	0815	①	OOB in chair TID	(b)(6)-2 ENP.	(b)(6)-2
4/17/03	1045		V.O. from Dr. (b)(6)-2 to ENS	(b)(6)-2	
			① 10 mg Coumadin PO x1 today.		
			② 5 mg Coumadin PO start 4/18.		
			③ QAM coags.		
			④ D/C Lovenox		
			Noted 1210 4/17/03 (b)(6)-2 FNSNC		
4-17-03	1530		1. Give MSO4 6mg IVP q2h. Hold if	(b)(6)-2	(b)(6)-2
			patient becomes to sedated Cdr	(b)(6)-2	
			2. T Valium to 10mg. give @0800,		(b)(6)-2
			given 5mg at 1400 and 5mg @2000		
			3. D/C Thursday Valium order CDR	(b)(6)-2	FNPC
			Noted (b)(6)-2 LTS (b)(6)-2	4/17/03 1630	
				(b)(6)-2	
				LDX	WARD NO. 4/17/03

PATIENT'S IDENTIFICATION (For typed or written entries: name; middle; grade; rank; rate; hospital or medical facility)

(b)(6)-4

4/18/03 @0030 - 24° chart ✓

(b)(6)-2

FIRMR (41 CFR) 201-45-505
508-112

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
15APR03	0930	1	D/C Contact Precautions		
		2	D/C Tobramycin.		
		3	A IV ℞ 5D in .9% NSS. @100cc/hr.	(b)(6)-2	(b)(6)-2
15APR03	1500	1	Hydrocortisone cream ℞ to trash TID liberally	(b)(6)-2	(b)(6)-2
4/16/03 @0200			24° chart verification		(b)(6)-2
4/16/03	0940		V.O. MD (b)(6)-2 → ENS (b)(6)-2		(b)(6)-2
			1 D/C foley		
			2 W→D dressg to medial calves		
			3 Dry dressg to (R) thigh's JP drain		
			(b)(6)-2	(b)(6)-2	ENS/MC
			LCDR 4/16/03		
4/16/03			T.O. DC (b)(6)-2 per LCDR, (b)(6)-2 straight cath q6, + encourage pt to void on own.		
			(b)(6)-2 (b)(6)-2 LCDR 4/16/03 1600		
4/17/03					

(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.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDICAL RECORD		DOCTOR'S ORDERS (ORTHOPEDI[illegible]IT/POST OP) (Sign all orde[illegible]		
DATE AND TIME START	STOP	Rx	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/14		1.	ADMIT TO: ORTHO STAFF: [(b)(6)-2] WARD: 5FOR		[(b)(6)-2]
		2.	DX: S/p IM nailing (R) Prox Femur — IM NAIL	Tibia X	
		3.	CONDITION: STABLE		
		4.	ALLERGIES: NKDA		
		5.	VITAL SIGNS: Q 1 hr X 4 THRU Q 4 hr X 24 hr THEN Q 8 hr		
		6.	NURSING: - N/V CHECKS W/ VITALS - I & O's q 8 hr x 48 hrs - Foley to gravity (remove 6 A.M. on _____), - drain to self suction - Remove wound dressing and replace w/ sterile dressing on POD #2		
		7.	Diet: Clears, advance as tolerated		
		8.	Activity: PT for OOB to Chair		
		9.	LABS: CHEM 7, CBC in AM; CBC q AM POD # 2 & #3		
		10.	IV: D5LR@100cc/hr		
		11.	MEDS: - Ancef 1g IV q 8 hr x 48 hr ~~- Gentamicin 80 mg IV q 8 hr x 48 hr OR~~ ~~- Gentamycin (5-7.5mg/kg) ____ mg IV x 48 hrs~~ - ~~Heparin 5000 U SQ q 8~~ hr - Lovenox 30mg SQ BID - MSO4 6 mg IM or IV q 4hr prn pain significant - Phenergan 25 mg IM or IV q 4 hr prn - Percocet 1 - 2 tabs po q 3 hr prn pain moderate - Tylenol 650 mg po q 4 hr prn - MOM 30cc po q 4 hr prn - Benadryl 25mg po q 4 hr prn - Surfak 240mg po bid prn		
		12.	Other Meds: Tobramycin 120mg IV q 8° D/C Imipenem		
		13.	Call Ortho tech for casts, splints, traction equipment or cast bivalving		
		14.	X-rays: AP/Lat (R) Femur & Pelvis		
		15.	Transfuse _____ units PRBC if HCT less than _____ Type and Hold for _____ units Type and Screen for _____ units		

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

(See reverse side)

PATIENT'S IDENTIFICATION

[(b)(6)-4]

4/14/03 1850

15 Am 03 — 24° chart

[(b)(6)-2]

DATE AND TIME START	DATE AND TIME STOP	Rx	DOCTOR'S ORDERS (ORTHOPEDICS ADMIT/POST OP) *(Sign all orders)*	Doctor's Signature	Nurse's Signature
		16.	Pin care - ½ strength H2O2 q 8 hr to all exposed pins		
		17.	Dressing changes		
		18.	Traction - pin care to exposed pins		
		19.	Misc: Elevate (B) LE while in bed.		(b)(6)-2
		20.	If N / V changes occur, call Charge Nurse / Ward Medical Officer to assess and bivalve cast if present		(b)(6)-2
		21.	If UOP < 30 cc/hr, bolus 500 cc NS and assess results. Call Ward Medical Officer if no improvement.		
		22.	Oxygen:		
		23.	Physical Therapy:		
			Noted (b)(6)-2		
			4/15/03 1850		
			(b)(6)-2 (PHYSICIAN SIGNATURE)		

15 Apr 03 @ 0215 — 24° chart verification DG (b)(6)-2 NC

PATIENT'S IDENTIFICATION

(b)(6)-4

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/14/03			**ANESTHESIA PACU ORDERS**		
		1.	Admit to PACU.	(b)(6)-2	
		2.	Allergies: NKDA		
		3.	Vital signs per PACU protocol.		
		4.	O2: ___FM @ 10LPM, ___ ___% Blowby, ✓ NP @ 1-4 LPM.		(b)(6)-2
		5.	IVF: LR at 150 cc/hr		
		6.	On ward: 02 @ 2-3 LPM via NC: YES NO		
		7.	Pain medication:		
			Ketorolac ___mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)		(b)(6)-2
			MSO4 1-2 mg IV q 5-10 min prn; max dose 20 mg		
			Fentanyl 25 mcg IV q 5 min prn; max dose 100 mcg		
			Percocet ___ tab(s) p.o. with sip of water		(b)(6)-2
			Other: Versed 1-2mg IVP prn agitation; Demerol 25mg IVP prn shivering		
		8.	Antiemetics:		
			(3) Ondansetron 4 mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)		
			(1) Metoclopramide 10 mg IV x1 (0.15 mg/kg; max 10 mg)		
			(2) ~~Droperidol .625 mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~		
			Other ___		
		9.	Clear liquids as tolerated: YES NO		
		10.	Notify Anesthesia (pager (b)(3)-1 for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol.		
			(rev 3/2002)	(OVER)	

(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name–last, first, middle; grade; rank; rate; hospital or medical facility)* (b)(6)-4

REGISTER NO.

(b)(6)-2

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA-ICMR, FIRMR (41 CFR) 201-9.202-1

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			ANESTHESIA PACU ORDERS -- CONTINUED		
		11.	Discharge patient from PACU per protocol: YES NO		
		12.	When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.		
			FOR PACU KEEP PATIENTS ONLY		
		13.	Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO		
		14.	Notify anesthesia (1506) for airway management and: (circle if applicable)		
			a. Pain management		
			b. Fluid management		
			c. Other _____		
		15.	TOW patient to ward in a.m. if patient meets discharge criteria: YES NO		
			Signature (b)(6)-2 Beeper _____		
			(b)(6)-2 LCDR/USN ANESTHESIA	(b)(6)-2	

STANDARD FORM 508 (Rev. 3-94) BACK

MEDICAL RECORD

DOCTOR'S ORDERS

(Sign all orders)

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
1535	14Apr03		T/O Dr. (b)(6)-2		
			Reinforce RLE dog. prn.		
			(b)(6)-2 LCDR NC USN		

(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.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4/13/2003 0700	late entry		V.O Dr. (b)(6)-2 / Ens (b)(6)-2 CXR portable (b)(6)-2 FNP notified (b)(6)-2		4/13/03 0745
4/13/03		D	B/d's x2 CBC c diff, CMP. Vancomycin 1gm q 12° Imipenem 500mg q 6 DC Aztreo + Gent Med Photo c macrolin pictures of AB Domen + neck Contact Isolation. (b)(6)-2 / (b)(6)-2 (b)(6)-2 (b)(6)-2		(b)(6)-2
4/13/03	1030		T.C. Dr (b)(6)-2 / ENS (b)(6)-2 D Draw CBC @ 1900; notify MO if HCT <20 Noted (b)(6)-2 NC, USNR 13APR03 1210		
4/14/03 0300			24° chart verification ABG (b)(6)-2		NC

(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. 5 FWD

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
11APR03	1930	①	Td 0.5 ml IM once Given 1930	(b)(6)-2 CDR/NC/USN	(b)(6)-2
11APR03	2100	②	Valium 5mg IV Push TID PRN for agitation.	(b)(6)-2	(b)(6)-2
			Noted (b)(6)-2 LT/SL-NC 4/11/02 2110		
12APR03	1930	①	Benadryl 50mg PO TID ½° Prior to Ancef.	(b)(6)-2 CDR/NC/USN	
		②	Benadryl 25mg IV now given	(b)(6)-2	
			Noted (b)(6)-2 LT/SL-NC 4/12/03 2045		
12 Apr 03			NPO p MN Sunday 13 Apr Pt for OR Monday 14 Apr 03		
			Noted (b)(6)-2 2050 (b)(6)-2 4/12/03	(b)(6)-2	
4/13/03	0800		24° chart verification	(b)(6)-2	
4/13/03	0630	①	Δ Benadryl to PRN 25-50mg PO q 6° PRN		(b)(6)-2
		②	Start Nizoral & Sulfak this AM.		
Cancel		③	Hydrocortisone 1% cream to rash TID.		
			(Continue on reverse side)	(b)(6)-2	4/13/03 0700

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

(b)(6)-4

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

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

MEDICAL RECORD			DOCTOR'S ORDERS (ORTHOPED [redacted] OMIT/POST OP) (Sign all ord[redacted]		
DATE AND TIME START	STOP	Rx	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
11Apr 03		1.	ADMIT TO: ORTHO STAFF: [redacted] WARD: 5Fnr		[redacted]
		2.	DX: S/p (B) IM nailing Tibia — Adjustment of (B) Femur Fx Fix		[redacted]
		3.	CONDITION: STABLE		[redacted]
		4.	ALLERGIES: NKDA		
		5.	VITAL SIGNS: Q 1 hr X 4 THRU Q 4 hr X 24 hr THEN Q 8 hr		
		6.	NURSING: - N/V CHECKS W/ VITALS - I & O's q 8 hr x 48 hrs - Foley to gravity (~~remove 6 A.M. on _____~~), - drain ~~to self suction~~ - Remove wound dressing and replace w/ sterile dressing on POD #2		
		7.	Diet: Clears, advance as tolerated		
		8.	Activity: Strict Bedrest Elevate (B) LE		
		9.	LABS: CHEM 7, CBC in AM; CBC q AM POD # 2 & #3		
		10.	IV: D5LR@100cc/hr		
		11.	MEDS: - Ancef 1g IV q 8 hr x 48 hr - Gentamicin 80 mg IV q 8 hr x 48 hr ~~OR~~ ~~- Gentamycin (5-7.5mg/kg) ___ mg IV x 48 hrs~~ ~~- Heparin 5000 U SQ q 8 hr~~ - Lovenox 30mg SQ BID - MSO4 6 mg IM or IV q 4hr prn pain significant - Phenergan 25 mg IM or IV q 4 hr prn - Percocet 1 - 2 tabs po q 3 hr prn pain moderate - Tylenol 650 mg po q 4 hr prn - MOM 30cc po q 4 hr prn - Benadryl 25mg po q 4 hr prn - Surfak 240mg po bid prn		
		12.	Other Meds: Toradol 30mg IM q 12° X 24°		
		13.	Call Ortho tech for casts, splints, traction equipment or cast bivalving		
		14.	X-rays: AP/LAT (B) Tib/Fib Done in PACU		
		15.	Transfuse _____ units PRBC if HCT less than _____ Type and Hold for _____ units Type and Screen for _____ units		

Noted [redacted] Issue 4/11/03 [redacted] [redacted]

(Continue on reverse side)

PATIENT'S IDENTIFICATION

[redacted]

[redacted]

(b)(6)-2

DATE AND TIME START	DATE AND TIME STOP	Rx	DOCTOR'S ORDERS (ORTHOPEDICS ADMIT/POST) (Sign all orders)	Doctor's Signature	Nurs Signa
		16.	Pin care - ½ strength H2O2 q 8 hr to all exposed pins		
		17.	Dressing changes		
		18.	Traction - pin care to exposed pins		
		19.	Misc:		
		20.	If N / V changes occur, call Charge Nurse / Ward Medical Officer to assess and bivalve cast if present	(b)(6)-2	
		21.	If UOP < 30 cc/hr, bolus 500 cc NS and assess results. Call Ward Medical Officer if no improvement.	(b)(6)-2	
		22.	Oxygen:		
		23.	Physical Therapy:		

Noted (b)(6)-2 LTJG-NC 4/11/03 2150 (b)(6)-2 (PHYSICIAN SIGNATURE)

24 O. Chart verification 0445 (b)(6)-2 [illegible]

PATIENT'S IDENTIFICATION

(b)(6)-4

EDICAL RECORD

DOCTOR'S OR S

(Sign all orde

DATE AND TIME START	DATE AND TIME STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
			ANESTHESIA PACU ORDERS		
		1.	Admit to PACU.		
4.11.03		2.	Allergies: NKDA		
		3.	Vital signs per PACU protocol.		
		4.	O2: ✓ FM @ 10LPM, ___ ___% Blowby, ___ NP @ _____ LPM.		
		5.	IVF: LR at 120 cc/hr		
		6.	On ward: 02 @ 2-3 LPM via NC: YES NO	(b)(6)-2	
		7.	Pain medication:		
			Ketorolac ____mg IV x1 dose (adults 30 mg max; peds consider 0.2-0.4 mg/kg)		
			MSO4 2-3 mg IV q 3 min prn; max dose 20 mg q 1°		
			Fentanyl 25 mcg IV q 5-10 min prn; max dose 100 mcg	(b)(6)-2	
			Percocet 1-2 tab(s) p.o. with sip of water 1807	(b)(6)-2	
			Other: _____	(b)(6)-2	
		8.	Antiemetics:		
			1 Ondansetron 10 mg IVP, may repeat x1 in 15 min (0.1mg/kg; max 4 mg)		
			2 Metoclopramide 4 mg IV x1 (0.15 mg/kg; max 10 mg)		
			~~Droperidol ____mg IV x 1 dose (0.01 mg/kg; max 0.625 mg) Must have baseline ECG available before administration.~~		
			Other _____		
		9.	Clear liquids as tolerated: YES NO	(b)(6)-2	
		10.	Notify Anesthesia (b)(3)-1 for airway issues, pain, nausea/vomiting not responsive to above orders or other patient problems/concerns per PACU protocol. (b)(6)-2 , MD		

(rev 3/2002) (OVER)

(b)(6)-2

noted (b)(6)-2 WOR/RN

PATIENT'S IDENTIFICATION (For typed or written entries give: middle; grade; rank; rate; hospital

REGISTER NO. 4/11/03 2/540 WARD NO.

(b)(6)-4

DOCTOR'S ORDERS
Medical Record

STANDARD FORM 508 (Rev. 3-94)
Prescribed by GSA-ICMR, FIRMR (41 CFR) 201-9.202-1

(b)(6)-4

MEDCOM - 5288

MEDICAL RECORD

DOCTOR'S ORDERS
(Sign all orders)

DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
4.11.03			**ANESTHESIA PACU ORDERS -- CONTINUED**		
		11.	Discharge patient from PACU per protocol: YES NO		
		12.	When epidural/spinal patients meet discharge criteria per PACU protocol, discharge to ward. On ward: bedrest pending full recovery of sensory and motor function; progress to ambulation with assistance.	(b)(6)-2	
			FOR PACU KEEP PATIENTS ONLY		
		13.	Release patient from anesthesia care to KEEP status when patient meets anesthesia discharge criteria: YES NO		
		14.	Notify anesthesia (b)(3)-1 for airway management and: (circle if applicable)		
			a. Pain management		
			b. Fluid management	(b)(6)-2	
			c. Other		
		15.	TOW patient to ward in a.m. if patient meets discharge criteria: YES NO		
			Signatu (b)(6)-2 Beeper		
			Noted (b)(6)-2 4/11/03 1500 LCDR (b)(6)-2	(b)(6)-2	
4-11-03	@ 1605		T.O. CDR Hartigan to LT SC Le		
			① 7-2mg versed IV push x1	Noted (b)(6)-2 LCDR (b)(6)-2	
			noted (b)(6)-2 ENS/NC		
4/11/03	1745		Labetalol 10mg IVP Now; May repeat if SBP >140 & PULSE >100	(b)(6)-2 (b)(6)-2 (b)(6)-2	
			(b)(6)-2	(b)(6)-2	
			Noted (b)(6)-2 LCDR (b)(6)-2		
			ted (b)(6)-2 ENS/NC		

STANDARD FORM 508 (Rev. 3-94) 3

MEDICAL RECORD		DOCTOR'S ORDERS (Sign all orders)		
DATE AND TIME START	STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
10 Apr 03 1610			Admit to ORTHO Service ([redacted]) —	(b)(6)-2	(b)(6)-2
			Dx: (B) Tib/Fib Fx's c Ex Fix Applied (R)		
			(R) Femur Fx (subtrochanter) —		
			Cond: Stable —		
			NKDA —		
			Vitals per Routine —		
			Bed Rest - Elevate (B) LE —		
			HOB ↑30°, I/O —		
			Foley to Gravity —		
			Reg Diet —		
			Heplock IV —		
			Meds: MSO_4 - 5-10 mg IV Slow q3° prn severe pain		
			Tylenol #3 ¢ po q4° prn pain —		
			Ancef 1g IVPB q8° prn [redacted]	(b)(6)-2	
			Tylenol 650 mg po q4-6° pr HA/T > 101° —		
			LABS: CBC/PT/PTT — Done [redacted]	(b)(6)-2	
			Noted [redacted] [redacted]	(b)(6)-2	
			2150 [redacted] 4/10/03	(b)(6)-2	
10 Apr 03			NPO p̄ MN for OR in am —		(b)(6)-2
			Lovenox 30 mg SQ BID Stop p̄ MN		
			[redacted] 1925	(b)(6)-2	
			Noted [redacted]	(b)(6)-2	

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

(b)(6)-4

REGISTER NO. 4/10/03 2188

WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-75)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45-505
508-112

NAVMED 6550/B (REV. 4-74) S/N 01(.16-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH Apr ~~19~~ 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/13	4/14	4/15	4/16	4/17	4/18	4/19
~~4/13~~	~~Vancomycin 1gm q12°~~	~~0900~~	(b)(6)-2						
		~~2100~~							
4/13	Imipenum 500mg IV q6°	0600	X						
		1200	(b)(6)-2						
		1800							
		2400							
4/13	Vancomycin 1gm q12°	1100	(b)(6)-2						
		2300							

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2				

ADDRESSOGRAPH PLATE

(b)(6)-4

Injection Site Code

1 = Left Buttock
2 = Right Buttock
3 = Left Deltoid
4 = Right Deltoid
5 = Left Leg
6 = Right Leg
7 = Left Arm
8 = Right Arm
9 = Abdomen

WARD NO.

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDCOM - 5291

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																
4/11	Tylenol 650mg PO Q4° PRN	DATE																
		TIME																
		DOSE																
		INIT.																
4/11	MOM 30cc PO Q4° PRN	DATE	4/12															
		TIME	0620															
		DOSE	30															
		INIT.	(b)(6)-2															
4/11	Benadryl 25mg PO Q4° PRN	DATE	4/12															
		TIME	1840															
		DOSE	1															
		INIT.	(b)(6)-2															
4/11	Sulfak 240mg PO BID PRN	DATE	4/13															
		TIME	0620															
		DOSE	240															
		INIT.	(b)(6)-2															
4/13	BENADRYL 25-50mg PO q6° PRN	DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																

NAVMED 6550/8 (REV. 4-74) S/N 010 216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH April 15 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/10	4/11	4/12	4/13			
4/10	Ancef 1gm IVPB Q8°	0800	X	(b)(6)-2					
		1600	X	HELD	DC'd				
		2400							
4/11	Ancef 1gm IVPB Q8° x48°	0800	X	X	(b)(6)-2		X	X	X
	Give Benadryl 30 min	1600	X	X	(b)(6)-2	X	X	X	X
	Prior to Ancef	2400	X	(b)(6)-2		X	X	X	X
4/11	Gentamycin 80 mg IV Q8° x48°	0700	X	X	(b)(6)-2		X	X	X
		1500	X	X	(b)(6)-2		X	X	X
		2300	X	(b)(6)-2		X	X	X	X
4/11	Lovenox 30 mg SQ BID	0900	X	X	(b)(6)-2				
		2100	X	X	(b)(6)-2				
4/11	Toradol 30 mg IM Q12° x 24°	0900	X	X	(b)(6)-2	X	X	X	X
		2100	X	X	X	X	X	X	X
4/12	Benadryl 50 mg PO TID	0730	X	X	X		X	X	X
	30 min Prior to Ancef	1530	X	X	X		X	X	X
		2330	X	X	(b)(6)-2	X	X	X	X
4/13	HYDROCORTISONE 1% cream								
	TO EACH TID								
4/13	SURFAK I PO qD	0900				(b)(6)-2			
4/13	MOM 30 cc BID PO	0900				(b)(6)-2			
		2100							

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2
		(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2

ADDRESSOGRAPH PLATE

(b)(6)-4

WARD NO.

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
⑨ = Abdomen

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

Page 1 of 2

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	INITIAL
Valium 5mg IVP x 1	4/11	2020	(b)(6)-2				
Benadryl 50mg	4/11	2245					
Morphine 10mg IVP x1	4/12	0005					
Benadryl 25mg IV	4/12	1930					

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN															
4/10	Morphine 5-10mg IV Q3° PRN Severe Pain	DATE	4/10	4/11	4/11	4/11	4/11											
		TIME	2130	0120	0550	0750	2010											
		DOSE	8mg	6mg	5mg	5mg	5mg											
		INIT.	(b)(6)-2															
4/10	Tylenol #3 2 Tabs PO Q4° PRN Pain	DATE	4/10	4/11														
		TIME	2300	0520														
		DOSE	11	11														
		INIT.	(b)(6)-2															
4/10	Tylenol 650mg PO Q4-6° PRN HA/T >101°	DATE																
		TIME																
		DOSE																
		INIT.																
4/11	Valium 5mg IVP TID PRN for Aggitation	DATE	4/11	4/12	4/12	4/13												
		TIME	2345	0510	1600	0615												
		DOSE	5mg	5	5	5												
		INIT.	(b)(6)-2															
4/11	Morphine 6mg IM/IV q4° PRN Pain Significant	DATE	4/11	4/12	4/12	4/12	4/12	4/12	4/13	4/13	4/13							
		TIME	6mg	6mg	6mg	6mg	2000	2100	0600	1030	1745							
		DOSE	6mg	6mg	6mg	14mg	3mg	3mg	6	6mg	6mg							
		INIT.	(b)(6)-2															
4/11	Phenergan 25mg IM/IV Q4° PRN	DATE																
		TIME																
		DOSE																
		INIT.																
4/11	Percocet 1-2 Tabs PO Q3° PRN Pain Moderate	DATE	4/11	4/12	4/12	4/12	4/12	4/12	4/12	4/13								
		TIME	2220	0230	0530	1310	1345	1615	2230	0800								
		DOSE	2	2	2	2	2	2	2	2								
		INIT.	(b)(6)-2															

Ordered & Rec'd see below

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN			MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN		
	DATE	TIME	INITIAL		DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																
4/13	BENADRYL	DATE																
	25-50 MG PO	TIME																
	Q6° PRN	DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
		INIT.																
		DATE																
		TIME																
		DOSE																
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NAVMED 6550/8 (REV. 4-74) S/N 0106-LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH APR 19 03 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	13	14	15	16	17	18	19
4/11	LOVENOX 30MG SQ BID	0900	(b)(6)-2						
		2100							
4/13	SURFAK 1 PO QD	0900	X						
4/13	MOM 30cc BID PO	0900	X						
		2100	(b)(6)-2						
4/13	IMIPENUM 500 MG IV	0600	X	(b)(6)-2					
	Q6°	1200	(b)(6)-2						
		1800			DC				
		2400							
4/13	VANCOMYCIN 1GM Q12°	1100							
		2300							
4/14/03	Tobramycin 120mg IVPB	0600	✓	X					
	q 8hrs	1400	(b)(6)-2						
		2200	X						

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
		(b)(6)-2	(b)(6)-2		

ADDRESSOGRAPH PLATE

(b)(6)-4

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
⑨ = Abdomen

WARD NO.

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

(1 of 2)

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																
4/11	VALIUM 5MG	DATE	4/13	4/14														
	IVP TID PRN	TIME	0615	2215														
	FOR AGITATION	DOSE	5MG	5mg														
		INIT.	(b)(6)-2															
4/11	MORPHINE 6MG	DATE	4/13	4/13	4/13	~~4/13~~	4/14	4/14										
	IM/IV Q4° PRN	TIME	0600	1030	1745		0145	0600										
	PAIN SIGNIFICANT	DOSE	6mg	6mg	6mg		6mg	6mg										
		INIT.	(b)(6)-2				(b)(6)-2											
4/11	PHENERGAN 25MG	DATE																
	IM/IV Q4° PRN	TIME																
		DOSE																
		INIT.																
4/11	PERCOCET 1-2TABS	DATE	4/13	4/13	4/14													
	PO Q3° PRN	TIME	0620	1845	0300													
	PAIN MODERATE	DOSE	2	2	2													
		INIT.	(b)(6)-2															
4/11	TYLENOL 650MG	DATE																
	PO Q4° PRN	TIME																
		DOSE																
		INIT.																
4/11	MOM 30CC	DATE	4/13															
	PO Q4° PRN	TIME	0620															
		DOSE	30															
		INIT.	(b)(6)-2															
4/11	SURFAK 240MG	DATE	4/13															
	PO BID PRN	TIME	0620															
		DOSE	240															
		INIT.	(b)(6)-2															

NAVMED 6550/8 (REV. 4-74) S/N 0105 -5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS | MONTH Apr ~~19~~ 2003 | DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS							

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2 EN5/NC				

ADDRESSOGRAPH PLATE

(b)(6)-4

2 of 2

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
⑨ = Abdomen

WARD NO.

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN			MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN		
	DATE	TIME	INITIAL		DATE	TIME	INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN															
4/11	Valium 5mg IVP TID PRN for agitation	DATE	4/11														
		TIME	1145														
		DOSE	5mg														
		INIT.	(b)(6)-2														
		DATE															
		TIME															
		DOSE															
		INIT.															
		DATE															
		TIME															
		DOSE															
		INIT.															
		DATE															
		TIME															
		DOSE															
		INIT.															
		DATE															
		TIME															
		DOSE															
		INIT.															
		DATE															
		TIME															
		DOSE															
		INIT.															
		DATE															
		TIME															
		DOSE															
		INIT.															

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH MAY 19 2003 — DATES GIVEN

ORDER DATE	MEDICATION-DOSAGE-FREQUENCY ROUTE OF ADMINISTRATION	HOURS	1	2	3	4	5	6	7
4/24	Imipemon 500 mg IV Q6°	06	(b)(6)-2						
		1200							
		1800							
		2400							
4/24	VANCOMICIN 1gm IV Q12°	0900	(b)(6)-2						
		2100							
4/24	Lovenox 30 mg SQ BID	0900	(b)(6)-2						
		2100	(b)(6)-2						
4/15	Hydrocoitisone Cream- TID-Liberally Apply	06	(b)(6)-2						
		14	(b)(6)-2						
		22							
4/13	MOM 30cc PO BID	09	(b)(6)-2						
		21	(b)(6)-2						
4/13	Surfak + PO QD	09							
4/18	Valium 5mg PO TID Hold if sedated	08	(b)(6)-2			0800			
		14	(b)(6)-2						
		2000	(b)(6)-2						
4/22	Motrin 800 mg PO TID	06	(b)(6)-2						
		1400	(b)(6)-2						
		2200							
4/22	Acifex 20 mg PO QD	0900							
4/22	FESO4 325 mg PO QD	09							

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2 HN	(b)(6)-2	(b)(6)-2 NG	(b)(6)-2	(b)(6)-2
(b)(6)-2	(b)(6)-2 DSNC	(b)(6)-2	(b)(6)-2		

ADDRESSOGRAPH PLATE (b)(6)-4

WARD NO.

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
⑨ = Abdomen

SINGLE DOSE, PRE-OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS – PRE-OPERATIVE

MEDICATION-DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION-DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL
tylenol 650, Benadryl 25mg PO	5/3	2115	(b)(6)-2				
Tylenol 650; Benadryl 25mg	5/4	0345	(b)(6)-2				

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																	
4/14	PERCOCETS	DATE	4/25	4/29	4/30	4/30	5/1	5/1	5/1	5/2	5/2	5/2	5/2	~~5/2~~	5/2	5/3	5/3	5/3	5/4	5/4
	1-2 TABS PO	TIME	1730	2110	0130	0200	0445	1855	2155	0240	0830	1300	~~[illegible]~~	2140	0130	1740	2000	0145	0600	
	Q3° PRN	DOSE	2	2	2	2	2	2	2	2	2	2	~~[illegible]~~	2	2	2	2	2	2	2
		INIT.	(b)(6)-2																	
4/18	MSO4 2-10mg	DATE	5/1	5/1	5/1	5/1	5/1	5/1	5/2	5/2	5/2									
	IV Q-3-4°	TIME	0350	1020	1530	1930	2140	0000	1340	2140	2414									
		DOSE	10mg	5mg	5mg	5mg	5mg	5	5	5	5.									
		INIT.	(b)(6)-2																	
4/14	percocet	DATE	5/4																	
	1-2 tabs PO	TIME	0145																	
	Q3 PRN	DOSE	2																	
		INIT.	(b)(6)-2																	
		DATE																		
		TIME																		
		DOSE																		
		INIT.																		
		DATE																		
		TIME																		
		DOSE																		
		INIT.																		
		DATE																		
		TIME																		
		DOSE																		
		INIT.																		
		DATE																		
		TIME																		
		DOSE																		
		INIT.																		

*U.S. GPO: 1986-605-009/46155

ALLERGIES:

NKDA

DATE ORD.	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
4/10		Ancef 1gm IVPB Q8°	08,16,24	4/10	CXR in AM		
4/11		~~Ancef 1gm IVPB Q8° X48°~~	08,16,24	4/11	BMP CBC 4/12		☑
4/11		~~Gentamycin 80mg IV q8° X48~~		4/11	CBC 4/13		☑
4/11	4/14	Lovenox 30mg SQ BID	09,21	4/11	CBC 4/14/ BMP 4/14		☑
4/11		Toradol 30mg IM Q12° X24°	10,22	4/13	CXR portable		☑
~~4/12~~		~~Benadryl 25-50mg PO TID Pruritus~~		4/13	CBC @ 1900 4/13	☒	
		~~Pruritus PRN~~		4/14	BMP CBC 4/15		☒
4/13		~~Hydrocortisone 1% cream to~~		4/14	CBC POD#2 4/16		☒
		rash TID		4/14	CBC POD#3 4/17		☐
4/13		mom 30cc BID PO					
4/13		Sucrafak 1 PO qd					
4/13		~~Imipenem 500mg q6°~~					
4/13		Vancomycin 1gm q12°					
~~4/14~~		~~Tobramycin 120mg IV q8°~~	~~06,14,22~~				
4/12		Benadryl 25mg IV X1 now					
4/14		Ancef 1gm IV q8° hr X48°					
~~4/14~~		~~Tobramycin 120mg IV~~	~~06,14,22~~				
		~~q8°~~					
4/15		Hydrocortisone cream 1% TID	6/14/22				
4/16		~~Augmentin 875mg po BID Oral Levaquin 500mg PO q24 Oral~~					
4/14		Sucrafak 240mg PO BID PRN					
~~4/15~~	4/14	BENADRYL 25-50 mg PO q6° Pen					
~~4/11~~	4/14	Mom 30cc PO Q4° PRN					
~~4/11~~	4/14	Tylenol 650mg PO Q4° PRN					
~~4/11~~	4/14	Percocet 1-2 tabs PO Q3° PRN Pain Moderate					
~~4/11~~	4/14	Phenergan 25mg IM/IV Q4° PRN					
~~4/11~~	4/14	Morphine 10mg IM/IV Q4° PRN Pain Significant					
4/11		Valium 5mg IVP TID PRN for Agitation					
4/10		Tylenol 650mg PO Q4-6° PRN HA/T >101°					
4/10		Tylenol #3 2 tabs PO Q4° PRN Pain					
4/10		Morphine 5-10mg IV Q3° PRN Severe					

ADDRESSOGRAPH

(b)(6)-4

Rewritten

PATIENT PROFILE

NAVMED 6550/12 (5-80) S/N 0105-LF-206-5560

✓	ACTIVITY	DATE	✓	BATH	DATE	DIET	DATE	✓	VITAL SIGNS	FREQ	✓	SPECIAL NOTES
	Bedrest			Bed bath		NPO			Temp	Q1 x 4 (4/14)		Dentures
	Bathroom Privileges			Shower					Pulse	Q4 x 24 (4/15)		Speech impediment
	Up in chair	4/14		Tub		Reg	4/14		Resp	Q8° (4/14)		Language barrier
	Ambulate			Needs assistance					B/P			Prosthetic device
	Commode								Other			Visual impairment
	Needs assistance											Blind
	Restricted to unit											Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE				NV ✓	~ Vitals		Glasses
	Other			Self		FEEDING	DATE		FLUIDS			Hearing defect
✓	Elevate (B) LE 4/14			Needs assistance		Self			Forced to:			Other
				Special		Needs assistance			Restricted to:			
						Gavage			I & O	Q3 x 48°		

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/10		HOB ↑ 30°		4/15		DSNS 100/hr	
4/16		Straight Cath Q6°	02,08,14,20	4/14		PT for OOB to chair	
		Encourage to void on own					
4/16		Dry drsg to (R) thigh JP drain					
		W→D drsg to medial calves					
4/14	4/15	wound care team					
4/11		Dj N/V changes, call WMO to assess					
		+ burn Cast if present					
4/11		Dj U/O < 30cc/hr, Bolus 500cc NS					
		and Assess results. Call WMO if					
		no improvement.					
~~4/15~~		~~Crushed pr contrac~~					
4/14		Reinforce RLE dsg				Dilaudid - Dr.	
		prn					

(b)(6)-2

ADDRESSOGRAPH

(b)(6)-4

DIAGNOSIS

~~(B) Tib/Fib fx c̄ Ex fix~~

(R) Femur Fx c̄ Ex fix

4/11 S/P (B) IM Nailing Tibia

OP/SPECIAL PROCEDURES

4/14 S/P IM Nailing (R) Prox Femur

FINDINGS:

AGE	HEIGHT	WEIGHT

PATIENT CLASSIFICATION

Stable

	DATE ON	DATE OFF
SI		
VSI		
RELIGIOUS RITES		

Gurney

ALLERGIES:

DATE ORD.	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
~~4/14~~		~~Lovenox 30mg SQ BID~~	~~09, 21~~	4/16	CBC in AM 4/17		
~~4/11~~		~~Toradol 30mg IM Q~~		4/18	QAM Coags		
4/13		MOM 30cc BID PO	09, 21	4/16	CBC, ESR in AM	4/18	
4/13		Senokot 1 PO QD	09	↓	~~TES 2U PRBCs~~	4/16	
4/15		Hydrocortisone Cream 1% TID		4/18	PT/INR 4/19		
4/16		Valium 5mg PO TID		4/18	CBC 4/19		
		Hold if pt is to sedated	4/18	4/19	REPEAT PT/INR	4/19	
4/18		Coumadin 5 mg PO QD start	800	4/19	~~REPEAT PT/INR AT 2400~~		4/19
4/17		Morphine 1cmg Q2°			~~Give 0.5mg IVPK~~		
		Hold if pt is to sedated			~~IV if INR > 10~~		
4/17		Valium 10mg PO QD @ 0800		4/20	PT/INR in AM 4/21		
4/17		Valium 5mg PO @ 1400 & 2000		4/21	~~PT/INR AT 1800~~	4/21	
4/18		VALIUM 5mg PO TID	08-14-20	4/22	~~PT/INR AT 1800~~	4/22	
		HOLD IF SEDATED		4/22	UA	4/22	
4/22		LOVENOX 30mg SQ BID	09-21	4/23	PT/PTT/INR IN AM	(4/23)	
4/22		MOTRIN 800mg PO TID	06-14-22				
4/22		ACIFEX 20mg PO BID	09-21				
4/22		$FeSO_4$ 325mg PO QDAY	0900				
4/21		VIT K 1mg IV x 1 DOSE					
4/22		MVI TAB PO QDAY	0900				
4/23		VIT K 10mg SQ x 3 days (START TODAY)					
4/18		MSO_4 2-10mg IV Q3-4° PAIN	PRN				
~~4/17~~		~~Morphine 1cmg IVP Q2°~~ HOLD IF SEDATED					
4/14		Benadryl 25-50mg PO Q6° PRN					
4/14		Tylenol 650mg PO Q4° PRN					
4/14		Percocet 1-2 Tabs PO Q3° PRN					
4/14		Phenergan 25mg IM/IV Q4° PRN					
4/14		Morphine 1cmg IM/IV Q4° PRN					

ADDRESSOGRAPH

(b)(6)-4

PATIENT PROFILE

NAVMED 6550/12 (5-80) S/N 0105-LF-206-5560

✓	ACTIVITY	DATE	✓	BATH	DATE	DIET	DATE	✓	VITAL SIGNS	FREQ	✓	SPECIAL NOTES
	Bedrest			Bed bath		NPO			Temp			Dentures
	Bathroom Privileges			Shower					Pulse			Speech impediment
	Up in chair	4/14		Tub		Reg	4/14		Resp	Q8		Language barrier
	Ambulate			Needs assistance					B/P			Prosthetic device
	Commode								Other			Visual impairment
	Needs assistance											Blind
	Restricted to unit											Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE				N/V ✓ & Vitals			Glasses
	Other			Self		FEEDING	DATE		FLUIDS			Hearing defect
✓	QOB to chair			Needs assistance		Self			Forced to:			Other
4/17	TID			Special		Needs assistance			Restricted to:			
						Gavage			I & O	QS		

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/10		HOB ↑ 30°		4/18		H/L when PO	
4/16		Elevate Sandbag					
				4/21		PT - ROM BIL LE (called 0935 4/21)	
						WB c CRUTCHES - TRAINING	
4/16		Dry Dsg Δ to (R) thigh					
		W-D dsg to Medial calves					
4/11		If N/V Changes, Call WMO to assess					
4/11		If U/O < 30cc/hr, Bolus 500cc NS and Assess results. Call WMO if no Improvement.					
						Ortho - (b)(6)-2	

ADDRESSOGRAPH

(b)(6)-4

DIAGNOSIS

(R) Femur fx
(B) 9 rib - fib fx

AGE | HEIGHT | WEIGHT

PATIENT CLASSIFICATION

OP/SPECIAL PROCEDURES

S/P IM NAILING (R) Femur
IM Rod Tibia x 2

	DATE ON	DATE OFF
SI		
VSI		
RELIGIOUS RITES		

FINDINGS:

ALLERGIES:

DATE ORD.	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
4/13		MOM 30cc PO BID	09-21	4/24	Send swab of d/c from		
4/13		SURFAK 1 CAP PO QD	0900		ankle for culture		
4/15		HYDROCORTISONE CREAM 1% TID TO ABDOMEN	06-14-22				
4/16		VALIUM 5mg PO TID HOLD IF SEDATED	08-14-20				
4/22		MOTRIN 800mg PO TID	06-14-22				
4/22		ACIFEX 20mg PO BID	09-21				
4/22		FeSO4 325mg PO QDAY	0900				
4/22		MVI 1 TAB PO QDAY	0900				
4/22		VitK 10mg SQ X 3 days D/C/ 4/24					
4/24		Imipenem 500mg IV q6h	06 12 18 24				
4/24		Vancomycin 1gm IV q12h	09 21				
4/24		Lovenox 30mg SQ BID	0921				
4/16		MSO4 2-10mg IV Q3-4°	PRN				
4/14		BENADRYL 25-50mg PO Q6°	PRN				
4/14		TYLENOL 650mg PO Q4°	PRN				
4/14		PERCOCET 1-11 TABS PO Q3°	PRN				
4/14		PHENERGAN 25mg IM/IV Q4°	PRN				

ADDRESSOGRAPH

(b)(6)-4

PATIENT PROFILE

NAVMED 6550/12 (5-80) S/N 0105-LF-206-5560

✓	ACTIVITY	DATE	✓	BATH	DATE	DIET	DATE	✓	VITAL SIGNS	FREQ	✓	SPECIAL NOTES
	Bedrest			Bed bath		NPO			Temp			Dentures
	Bathroom Privileges			Shower		REG	4/14		Pulse	QS		Speech impediment
X	Up in chair	4/14		Tub					Resp			Language barrier
	Ambulate			Needs assistance					B/P			Prosthetic device
	Commode								Other N/V			Visual impairment
X	Needs assistance	4/14										Blind
	Restricted to unit											Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE							Glasses
	Other			Self		FEEDING	DATE		FLUIDS			Hearing defect
X	↑HOB 30°L	4/19		Needs assistance		Self			Forced to:			Other
				Special		Needs assistance			Restricted to:			
						Gavage			I & O	QS		

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/16	–	DRY DRESSING (R) THIGH		4/18		(b)(6)-2	
	–	W→D DRESSING TO					
		MEDIAL CALVES					
4/21		PT - ROM BIL LE					
		WB ≈ CRUTCH TRAINING		4/23		(b)(6)-2 completed	
		ORTHO - DR. (b)(6)-2					

ADDRESSOGRAPH

(b)(6)-4

DIAGNOSIS

(R) FEMORAL FX

(B) TIB-FIB FX

OP/SPECIAL PROCEDURES

S/P NAILING (R) FEMUR

IM ROD TIBIA x 2

FINDINGS:

AGE	HEIGHT	WEIGHT

PATIENT CLASSIFICATION

	DATE ON	DATE OFF
SI		
VSI		
RELIGIOUS RITES		

NAVMED 6550/8 (REV. 4-74) S/N 0 216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH April ~~19~~ 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/24	4/25	4/26	4/27	4/28	4/29	4/30
4/24	Imipenem 500mg IV q6h	06	X	(b)(6)-2					
		12	(b)(6)-2						
		18							
		24							
4/24	Vancomycin 1gm IV q12h	09	X						
		21	(b)(6)-2						
4/24	Lovenox 30mg SQ BID	09							
		21							
4/15	Hydrocortisone Cream 1% TID - liberally apply	06							
		14							
		22	(b)(6)-2						
4/13	MOM 30cc PO BID	09							
		21							
4/13	Sulfak 1 Tab po QD	09							
4/18	Valium 5mg PO TID Hold if sedated	0800	X						
		1400	X						
		2000	X						
4/22	Motrin 800mg PO TID	0600	X						
		1400	X						
		2200	X						
4/22	Arifex 20mg PO QD	0900	X						
		2100	X						
4/22	FeSO4 325mg PO QD	0900	X						

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2
					(b)(6)-2

ADDRESSOGRAPH PLATE (b)(6)-4

1 of 2

Injection Site Code
1 = Left Buttock
2 = Right Buttock
3 = Left Deltoid
4 = Right Deltoid
5 = Left Leg
6 = Right Leg
7 = Left Arm
8 = Right Arm
9 = Abdomen

WARD NO.

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																
4/14	Percocet 1-2	DATE	4/25	4/25	4/25	4/26	4/26	4/26	4/27	4/27	4/27	4/28	4/28	4/28	4/28	4/29	4/30	4/29
	tabs PO Q3°	TIME	1500	1935	2345	0800	1840	2345	0550	0830	1810	0530	0315	0800	2115	0030	0330	0930
	PRN PAIN	DOSE	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
		INIT.	(b)(6)-2															
4/14	Phenergan IV/	DATE																
	IM Q4° PRN	TIME																
		DOSE																
		INIT.																
4/16	Tylenol 650mg	DATE	4/25	4/29	4/29													
	PO Q4° PRN	TIME	1700	1430	1825													
		DOSE	650	650	650													
		INIT.	(b)(6)-2															
4/14	MOM 30cc	DATE																
	PO q4° PRN	TIME																
		DOSE																
		INIT.																
4/14	Benadryl	DATE	4/25	4/26														
	25mg PO	TIME	2345	2345														
	q4° PRN	DOSE	25	25														
		INIT.	(b)(6)-2															
4/18	MSO4 2-10mg	DATE	4/26	4/26	4/27	4/27	4/27	4/28	4/28	4/28	4/28	4/29	4/29	4/29	4/29	4/29	4/30	
	IV Q3-4°	TIME	0249	2345	1330	1950	2230	0134	0915	1430	0040	0329	0645	0110	0446			
	PRN PAIN	DOSE	10mg	5	5	5	5	5mg	10mg	10mg	5mg	5mg	5mg	5mg	5mg			
	Hold if Sedated	INIT.	(b)(6)-2															
		DATE																
		TIME																
		DOSE																
		INIT.																

NAVMED 6550/8 (REV. 4-74) S/N [illegible]-216-5581

MEDICAL RECORD	MEDICATION ADMINISTRATION RECORD

SCHEDULED DRUGS — MONTH APRIL 19 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/18	4/19	4/20	4/21	4/22	4/23	4/24
4/18	VALIUM 5mg PO TID	0800	X	(b)(6)-2					
	HOLD IF SEDATED	1400							
		2000	(b)(6)-2						
4/22	LOVENOX 30mg SQ BID	0900	X	X	X	X	(b)(6)-2		
		2100	X	X	X	X			
4/22	MOTRIN 800mg PO TID	0600	X	X	X	X	X	(b)(6)-2	
		1400	X	X	X	X	(b)(6)-2		
		2200	X	X	X	X			
4/22	ACIFEX 20mg PO BID	0900	X	X	X	X	X		
		2100	X	X	X	X	(b)(6)-2		
4/22	MVI TAB PO QDAY	0900	X	X	X	X	X		
4/22	FeSO4 325mg PO QDAY	0900	X	X	X	X	X		
4/22	Vit K 10mg SQ x 3 days (D/C p 4/24 dose)	2200	X	X	X	X			

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2
					(b)(6)-2

ADDRESSOGRAPH PLATE (b)(6)-4

WARD NO.

Injection Site Code

1 = Left Buttock
2 = Right Buttock
3 = Left Deltoid
4 = Right Deltoid
5 = Left Leg
6 = Right Leg
7 = Left Arm
8 = Right Arm
9 = Abdomen

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

2 of 2

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL
1mg Vit K IV x 1 now	4/21	0010	(b)(6)-2				
~~Vit K 10mg SQ x1 now~~ (b)(6)-2	~~4/22~~						

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION		DOSES GIVEN															
4/14	Percocet 1-2	DATE	4/20	4/22	4/22	4/23	4/24											
	po q3 prn	TIME	1136	1550	1920	2355	2400											
	pain	DOSE	1	1	1	2	2											
		INIT.	(b)(6)-2															
4/14	Phenergan	DATE																
	25 mg IM/IV	TIME																
	q4h PRN	DOSE																
		INIT.																
4/14	Tylenol	DATE																
	650 mg po	TIME																
	q4h PRN	DOSE																
		INIT.																
4/14	MOM	DATE																
	30cc po	TIME																
	q4h PRN	DOSE																
		INIT.																
4/14	Benadryl	DATE																
	25 mg po	TIME																
	q4h PRN	DOSE																
		INIT.																
4/18	MSO4 2-10mg	DATE	4/24	4/25														
	IV Q 3-4h	TIME	1415	2330														
	Pain PRN	DOSE	10mg	10mg														
	Hold if sedated	INIT.	(b)(6)-2															
		DATE																
		TIME																
		DOSE																
		INIT.																

NAVMED 6550/8 (REV. 4-74) S/N L -216-5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH April 15 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	17	18	19	20	21	22	23
4/15	Hydrocortisone Cream 1% TID	0600	X	(b)(6)-2		(b)(6)-2			
	liberally apply	1400	X		(b)(6)-2				
		2200		(b)(6)-2					
4/13	MOM 30cc PO BID	0900	X						
		2100							
4/13	Surfak 1 Tab PO QD	0900	X						
4/17	Coumadin 5mg PO QD	1800	X			(b)(6)-2			
4/17	Morphine 10mg Q2°	0000	X	(b)(6)-2					
	IVP	0200	X						
	*Hold if pt is to sedated	0400	X						
	* record	0600	X						
	(b)(6)-2	0800	X	HOLD					
		1000	X	(b)(6)- HOLD					
		1200	X	(b)(6)- HOLD					
		1400	X						
		1600	X						
		1800	REFUSE						
		2000	(b)(6)-2						
		2200	SLEEP						
		~~240~~							
4/17	Valium 10mg PO QD	0800	X	(b)(6)-2 HOLD					
4/17	Valium 5mg PO	1400	X						
		2000	(b)(6)-2						

4/24/03 5 e l new MAR

D/C

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2
			(b)(6)-2		(b)(6)-2
			(b)(6)-2		(b)(6)-2
			(b)(6)-2		(b)(6)-2
					(b)(6)-2
		(b)(6)-2	(b)(6)-2		

ADDRESSOGRAPH PLATE

(b)(6)-4

1 of 2

Injection Site Code

① = Left Buttock
② = Right Buttock
③ = Left Deltoid
④ = Right Deltoid
⑤ = Left Leg
⑥ = Right Leg
⑦ = Left Arm
⑧ = Right Arm
⑨ = Abdomen

WARD NO.

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL
Coumadin 10mg PO	4/17	1800	(b)(6)-2				
Valium 10mg PO ~~0800~~	4/18	0800	held				
Valium 5mg at 1400	4/18	1400	(b)(6)-2				
Valium 5mg at 2000	4/18	2000					
DULCOLAX T SUPP PR	4/18	1500	(b)(6)-2				
MAY REPEAT TOMORROW PRN							
VIT K 1.0mg IV	4/19	1200	(b)(6)-2				
VIT K 1.0 mg IV	4/21						

PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN															
4/14	Phenergan	DATE															
	25mg IM/IV	TIME															
	Q4° PRN	DOSE															
		INIT.															
4/14	Percocet	DATE	4/18	4/19	4/19	4/19	4/19	4/19	4/20	~~4/20~~	4/20	4/20	4/20	4/20	4/21	4/21	4/22	4/22
	1-2 Tabs PO	TIME	1915	0001	0300	1320	1712	2240	1230		0530	1646	1945	0230	1700	2400	0330	0530
	Q3° PRN	DOSE	2	2	2	2	2	2	2		2	2	2		2	2	2	2
	Moderate Pain	INIT.	(b)(6)-2															
4/14	Tylenol	DATE	4/18															
	650mg PO	TIME	2045															
	Q4° PRN	DOSE	650mg															
		INIT.	(b)(6)-2															
4/14	MOM	DATE	4/20	4/20	4/21													
	30cc PO	TIME	0245	1135	0130													
	Q4° PRN	DOSE	30cc	30cc	30cc													
		INIT.	(b)(6)-2															
4/14	Benadryl	DATE	4/19	4/19	4/21	4/22	4/23											
	25mg PO	TIME	000	2338	2400	2345	2355											
	Q4° PRN	DOSE	50mg	50mg	25	50	50											
		INIT.	(b)(6)-2															
4/18	MSO4 2-10mg	DATE	4/18	4/19	4/19	4/20	4/20	4/20	4/21	4/21	4/21	4/21	4/22	4/22	4/22	4/23	4/23	4/24
	IV Q3-4 HRS	TIME	2115	1330	0245	1800	2000	0245	1610	1726	2030	0050	0430	1241	1715	0345	0720	0100
	PAIN PRN	DOSE	5mg	5mg	3mg	2mg	2	10mg	10mg	6mg	10mg	10	10mg	5mg	5mg	10mg	10mg	10mg
	HOLD IF SEDATED	INIT.	(b)(6)-2															
		DATE																
		TIME																
		DOSE																
		INIT.																

Rewritten

NAVMED 6550/8 (REV. 4-74) S/N (-216-5581

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD** 4/17

SCHEDULED DRUGS — MONTH April ~~19~~ 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	4/14	4/15	4/16	4/17	4/18	4/19	4/20
4/14	Ancef 1gm IVPB Q8° x48°	0500	X	(b)(6)-2		X			
		1300	X			X			
		2100	(b)(6)-2		X	X			
4/14	Lovenox 30mg SQ BID	0900	X	(b)(6)-2					
		2100	(b)(6)-2			X	D/C		
~~4/14~~	~~Tobramycin 120mg IV Q8°~~	~~0600~~	~~X~~	~~(b)(6)-2~~	~~X~~	~~X~~	~~X~~	~~X~~	~~X~~
		~~1400~~	~~X~~	~~X~~	~~X~~	~~X~~	~~X~~	~~X~~	~~X~~
		~~2200~~	~~X~~	~~X~~	~~X~~	~~X~~	~~X~~	~~X~~	~~X~~
4/15	Hydrocortisone cream 1% TID liberally	0600	—	—	(b)(6)-2				
		1400	—	—					
		2200	—	(b)(6)-2					
4/16	Valium 5mg PO TID Hold if pt is to sedated	0600	X	X	X	(b)(6)-2			
		1400	X	X	X				
		2200	X	X	(b)(6)-2				
4/13	MOM 30cc BID PO	0900	X	X	X	(b)(6)-2			
		2100	X	X	(b)(6)-2				
4/13	Senokot 1 PO QD	0900	X	X	X	(b)(6)-2			
4/13	Coumadin 5mg PO QD	1800	X	X	X	X			
4/17	Morphine								

INITIAL CODE

INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE	INITIAL	FULL SIGNATURE & TITLE
(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2	(b)(6)-2
	(b)(6)-2		(b)(6)-2		(b)(6)-2

ADDRESSOGRAPH PLATE

(b)(6)-4

~~1 of 2~~

Injection Site Code

① = Left Buttock ⑤ = Left Leg
② = Right Buttock ⑥ = Right Leg
③ = Left Deltoid ⑦ = Left Arm
④ = Right Deltoid ⑧ = Right Arm
⑨ = Abdomen

WARD NO.

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

MEDICATION ADMINISTRATION RECORD (Back) S/N 0105-LF-216-5581

SINGLE ORDERS - PRE-OPERATIVE

MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL	MEDICATION- DOSAGE ROUTE OF ADMINISTRATION	GIVEN DATE	GIVEN TIME	GIVEN INITIAL
Coumadin 10mg x 1 PO	4/17	1800					

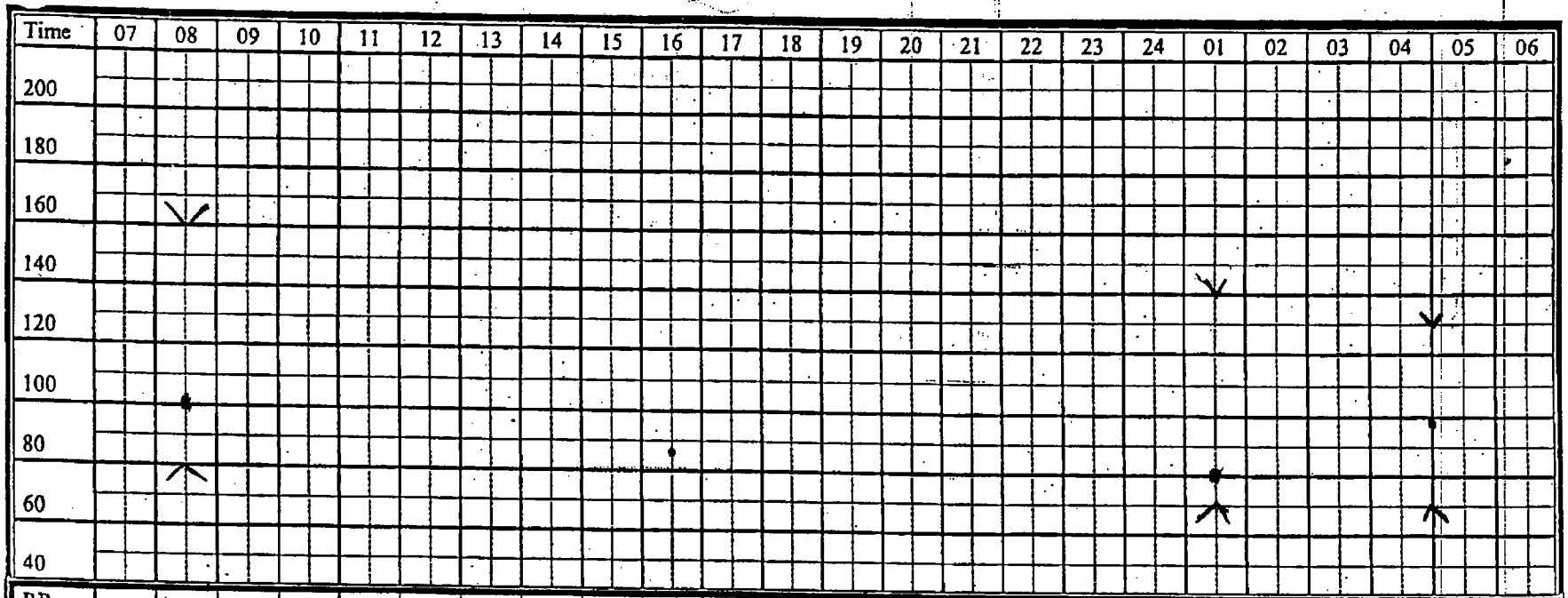
PRN AND VARIABLE DOSE MEDICATIONS

ORDER DATE	MEDICATION-DOSAGE FREQUENCY ROUTE OF ADMINISTRATION	DOSES GIVEN																
4/14	Morphine	DATE	4/14	4/15	4/15	4/15	4/16	4/16	4/16	4/16	4/16	4/16	4/16	4/17	4/17			
	1mg IM or IV	TIME	2000	0330	1400	1915	0040	0430	0845	1006	1325	2145	0420	1200				
	Q4° PRN	DOSE	10mg	5mg	10mg	4mg	5mg	6mg	5	1mg	10mg	1mg	5mg	5mg				
	Significant Pain	INIT.	(b)(6)-2															
4/14	Phenergan	DATE																
	25mg IM/IV	TIME																
	Q4° PRN	DOSE																
		INIT.																
4/14	Percocet	DATE	4/14	4/14	4/15	4/15	4/15	4/15	4/16	4/16	4/16	4/16	4/17	4/17				
	1-2 Tabs PO	TIME	1910	2200	0300	0500	1320	2000	0010	1600	1900	2341	0658	1420				
	Q3° PRN	DOSE	2	2	2	2	2	2	2	2	2	2		2				
	Moderate Pain	INIT.	(b)(6)-2															
4/14	Tylenol 650mg	DATE																
	PO Q4° PRN	TIME																
		DOSE																
		INIT.																
4/14	MOM 30cc	DATE																
	PO Q4° PRN	TIME																
		DOSE																
		INIT.																
4/14	Benadryl	DATE	4/15	4/15														
	25mg PO	TIME	1630	2030														
	Q4° PRN	DOSE	1	1														
		INIT.	(b)(6)-2															
4/14	Senfak	DATE																
	240mg PO	TIME																
	BID PRN	DOSE																
		INIT.																

Name: (b)(6)-4

ING FLOW SHEET
AC 6550/12/Temp Form

Date: 4/14/03



	08	16	01	04
RR		18	18	19
TEMP	97.8	99.0	99.8	98.9
SAO2	99		96	97
MAP				
O2 Mode				
BP		126/66	140/70	

	12
UOP	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	300								550					800										

MEDCOM - 5317

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

NURSING [redacted] SHEET
MEDTREFAC [redacted] 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																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								

RR	18								16									18						
TEMP	98.7					98.9			98.4									97.9						
SAO2	[redacted]	93%				100%			99%									98%						
MAP																		61hc						
O2 Mode																		122/68						

DRIP/DOSE

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

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

Date: 18 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																								

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
RR	18							19		16								16						
TEMP	98.8							99.9		99.8								99.7						
SAO2	98%							98										97						
MAP																								
O2 Mode								170/80										140/60						

DRIP/DOSE

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

NURSING [redacted] W SHEET
MEDTREFAC[redacted] /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																								
180																								
160																								
140																								
120																								
100																								
80																								
60																								
40																								

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
RR	18								16									18						
TEMP	98.7					98.9			98.4									97.9						
SAO2	[redacted]	93%				98%			99%									98%						
MAP																		67 hs						
O2 Mode																		122/68						

JFF

HI

DRIP/DOSE

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes:

INPUT/OUTPUT

	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
PB																										

MEDCOM - 5321

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																										
UOP	175					625		500											420		500				180	
BM																										

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] V SHEET
MEDTREFAC 2/Temp Form

Date: 16 Apr 03 [redacted]

JFF

HR

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								13							
TEMP		98.9							98.6				98.7				98.0							
SAO2		97%							97%				97%				93%							
MAP		Ø																						
O2 Mode		RA															RA							
BP		115/[illegible]															115/68							
																	72 WC							

DRIP/DOSE

MEDCOM - 5322

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

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																										
VPB																										
IV	100	100	100	100	100	100	100	100	100																	

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
EY		150																								
UOP												325		325	300		225						250			
140									500																	
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5323

NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Date: [illegible]

CUFF

AL

DRIP/DOSE

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				14		
TEMP		98.7		98.7			101.0											99.3				98.6		
SAO2				99			98											95%				97%		
MAP																								
O2 Mode				RA			RA											RA						
																		126/74				150/60		

MEDCOM - 5324

Unit #1

FREQ. VITAL SIGNS

	1st 5	2nd 5	3rd 5	1st 15	2nd 15	3rd 15	1st Hour	Bed #1	1st 5	2nd 5	3rd 5	1st 15	2nd	3rd	
TIME	0005	1010	1015	1030	1045	1100	1200	1240	1315	1320	1325	1340	1455	1510	1600
BP	150/82	160/80	160/78	158/76	158/78	150/76	160/72	162/70	158/68	158/70	160/70	140/100	138/64	138/66	148/68
HR	90	92	94	92	96	96	92	94	100	100	106	90	88	102	102
RR	16	16	16	16	16	16	16	16	18	18	18	18	16	18	18
TEMP	99.3	99.5	99.4	99.5	100.1	100.1	99.7	99.8	100.0	100.0	100.1	99.6	99.4	100.1	99.7
SAO2	99	99	99	98	98	98	98	98	98	98	98	98	98	99	
O2	RA	RA	RA	RA	RA	RA	RA	RA	RA	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
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	TOTAL
FOLEY						1300								800									640			
UOP																										
BM																										
JP#1				100					100							35			15				10			
JP#2				40					40							35			35				20			

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5325

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

NURSING [redacted] SHEET
MEDTRONIC AC 6550/12/Temp Form

Date: 14 April [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											V													
120																								
100																								
80																								
60																								
40											Λ													
RR											17							14						
TEMP											100							99.8					98.3	
SAO2											97%							99%						
MAP																								
O2 Mode																		RA						
																		136/100						

DRIP/DOSE

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

S: _____

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	TOTAL
OLEY															700				1000				500		200	
OP																										
~~GP~~																										
BM																										
JP 1											15				120	7 oz		47			70		60		50	
JP 2											45				90	1 oz		35			40		40		25	

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5327

Name: (b)(6)-4

NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Date: 13 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		20	20				16			24					20			22						
TEMP		97					96.3			100.6 Axillary					101.3			99.0						
SAO2		98					98%			99					98			99						
MAP																								
O2 Mode										RA					RA			RA						
																		132/60						

DRIP/DOSE

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO_2															

Notes:

INPUT/OUTPUT

	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
B																										

MEDCOM - 5329

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		500				1200					1200	500			700		559				600		800			
UOP																										
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: 12APR03

0350

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										100														
160																								
140																								
120																								
100																								
80																								
60																								
40																								
RR			20				20			20	20							18			18			
TEMP			99.9				100.5			100.6								99.5			99.3			
SAO2			96%				99%			99	97							97			97			
MAP																								
O2 Mode																		RA			RA			

JFF

HR

DRIP/DOSE

FREQ. VITAL SIGNS

TIME	2400	0330													
BP	160/50	158/52													
HR	94	92													
RR	18	18													
TEMP	99.5	99.3													
SAO2	97	97													

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	TOTAL
FOLEY			1200				100			200	200										1250					
UOP																										
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5331

Name: (b)(6)-4

NURSING FLOW SHEET

MEDTREFAC 6550/12/Temp Form

Date: 16APR93

(0040)

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																								
160																								
AL 140																								
120																								
100																								
80																								
60																								
40																								
RR														20					18			18		
TEMP														99.4					98.0			98.0		
SAO2																			98%			98%		
MAP																								
O2 Mode														RA					RA			RA		
DRIP/DOSE																								

FREQ. VITAL SIGNS

TIME	0040														
BP	150/60	148/60													
HR	93	92													
RR	18	18													
TEMP	98.0	98.0													
SAO2	98%RA	98%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
PO																										
IVPB																										

0040 NPO

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																				700			700			
UOP																										
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5333

Name: (b)(6)-4

NURSING FLOW SHEET

MEDTREFAC 6550/12/Temp Form

Date: 4-11-03

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													15					18				18		
TEMP													100.6					100.8				101.0		
SAO2													97%					97				97		
MAP																								
O2 Mode																		RA				RA		
B/P													144/74					167/12				140/50		

DRIP/DOSE

FREQ. VITAL SIGNS

TIME	2400	0400														
BP	162/72	160/50														
HR	100	102														
RR	18	18														
TEMP	100.8	101.0														
SAO_2	97%	97%														

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																										
LR															KVO											

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																500				1200						
UOP																										
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5335

NURSING ADMISSION NOTE

CLINICAL RECORD			NURSING NOTES (Sign all notes)
DATE	HOURS A.M.	HOURS P.M.	OBSERVATIONS Include medication and treatment when indicated SERVICE:
			ADMITTED TO: SPWO STBD FROM: (b)(3)-1 TIME ARRIVED: 1945 AGE: SEX: M
			DX: bilat ex fix to lower ext. DUE TO: MVA
			PAST MEDICAL HX:
			MEDICATIONS: Ancef DISPOSITION:
			ALLERGIES: VALUABLES: DISPOSITION:
			VS: B/P 130/60 T: 99.4 P: 91 R: 20 HT: WT:
			GENERAL APPEARANCE:
			EENT: WNL - mwet. abrasions to face
			NEUROLOGICAL: A+OX3, PERRLA
			RESPIRATORY: Lungs CTA bilaterally
			CIRCULATORY: RRR, 2+ pulses to all ext.
			URINARY: Foley - yellow urine
			GI: BS hyperactive
			MUSCULO/SKELETAL: pt can move bilat arms, wiggle toes bilat feet
			SKIN INTEGRITY: ex fix to bilat lower ext.
			COPING:
			SUMMARY AND PLAN OF CARE: on call to OR 4/11.
			will cont. to monitor.
			SIGNATURE (b)(6)-2 CTG/NC DATE: 4 APR 93 TIME: 2035

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

(b)(3)-1

...ICAL TREATMENT RECORD (*continue*

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

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

UBES CHEST TUBE: size / site _____

N/G: guaiac neg/pos _____

FOLEY: dipstick blood neg / pos _____

V SITES L forearm SIZE 18G

IV SOLUTION #1 Normal Saline AMT INFUSED

#2

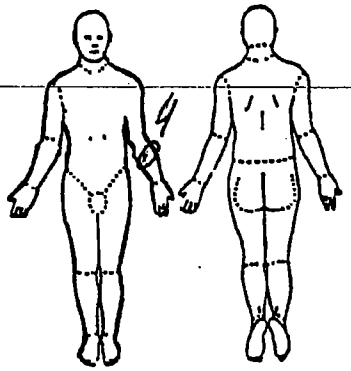
#3

#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. _____
14. _____



PERITONEAL LAVAGE Comments N/A

Results: (Circle one) POSITIVE NEGATIVE

OUTPUT
Chest Tube N/A cc
Gastric N/A cc
Foley _____ cc

TOTAL INTAKE _____ cc TOTAL OUTPUT _____ cc

MEDICATIONS	Dose	Route	Time	Initials	MEDICATIONS	Dose	Route	Time	Initials
Morphine	3MG	IVP	1837	(b)(6)-2	Ancef	1 gm	IVPB	1830	(b)(6)-2
	3MG	IVP	1940		Levenox	30MG	SQ	1925	
Mefoxin									
Ancef									
Tet Tox									
Hypertet									

DATE	HOUR A.M.	HOUR P.M.	TRANSFERRED Time: 1940 to OR ICU BURN ICU WARD: 5FWD STAR
			Report called to 5FWD STAR

(b)(6)-4

TIME	BP				
8:30	90	88	70 - 50	73 - 84	77 - 102
8:15	88	89	73	73	154
3:03	89	95	77	84	102
6:02	95	154	77	102	108

PROTOCOL SYSTEMS INC

☆ U. S. GPO: 1987-181-247/60056

MEDCOM - 5337

(Reverse)

(b)(3)-1

CASUALTY RECEIVING

UTWD

CLINICAL RECORD

ABBREVIATED MEDICAL RECORD
(Sign all notes)

TRIAGE CATEGORY (Circle one)
Immediate
Delayed
Minimal
Expectant

E: 10 APR Time: 1555 arrived on board USNS Comfort

nsported by: (Circle one) Helo Boat Pier Other

: (Circle one) LITTER AMBULATORY

E: 23 HEIGHT (ft' in"): Weight (lbs):

STORY: MV ACCIDENT SHATTERED LEGS AND HURT (R) SHOULDER

LERGIES: Ø
JRRENT MEDS: Ø
AST ILLNESSES:
AST MEAL: (Date) 5 DAYS AGO (Time) · H2O.
vents Preceding Injury:

TAL SIGNS	TIME	TEMP	PULSE	B/P	RESP RATE	GCS	CAP REFILL (pres/abs)
DMISSION	1600	97.5	90	154/77	18	15	<2 sec
ISCHARGE							

uplis: = OR ≠ (Circle one)

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

L ● ● ● ● ● R ● ● ● ● ●

NJURIES
Airway Obstruction ☐ Yes ☐ No
Breath Sounds (+ ↓ -)
Hemorrhage
Laceration
Puncture
Wound
Trauma, Amputation
Concussion
Fracture
Dislocation
Burn
FIXATORS

BURN
1° %
2° %
3° %

Multiple Facial Abrasions

Ext Fixator

LAB
Hb/Hct
Lytes/BUN/Glue
ABG
UA
T&C units

XRAY
C-spine
CXR
Abdominal
IVP
Extremity Pelvis

Glasgow Coma Score (GCS)

	Points
A. Eye Opening	
Spontaneous	4
To voice	3
To pain	2
None	1
(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
16 Total "C"	

DIAGNOSIS:
MVA Rollover: (B) External Fixat. Rs. to lower extremities. Hip External Fixator

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;
(b)(6)-4

REGISTER NO.

WARD NO.

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

MEDCOM - 5338

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

NURSING [redacted] SHEET
MEDTREFAC-65[redacted]emp Form

Date: [redacted] 28, 29 Apr 03

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
140																								
120																								
100																								
80																								
60																								
MP		20 99.5							16 99.5				16 99.9											
O2																								
AP																								
de									162/90 64				138/68											

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	TO
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																										
UOP						160		360	120			220														
BM																										

PREVIOUS 24 HOUR INPUT_____

PRESENT 24 HOUR INPUT_____

PREVIOUS 24 HOUR OUTPUT_____

PRESENT 24 HOUR OUTPUT_____

PREVIOUS WEIGHT_____

PRESENT WEIGHT_____

MEDCOM - 5340

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

NURSING [redacted] SHEET
MEDTREFAC 65 [redacted] Temp Form

Date: 27 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	20									20								18						
TEMP	98.7									98.6								100.8 98						
SAO2																								
MAP																								
O2 Mode																								
	156/92 89									112/68								112/68 90						

DRIP/DOSE

FREQ. VITAL SIGNS

INPUT/OUTPUT

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

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
			260			720									280									740	

US 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

T 24 HOUR INPUT PRESENT 24 HOUR OUTPUT PRESENT WEIGHT

MEDCOM - 5342

Name: (b)(6)-4

NURSING [redacted] SHEET
MEDTREFAC [redacted] Temp Form

Date: 26 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	24										20						18							
TEMP	101.8										100.4						99.5							
SAO2											98%													
MAP																								
O2																								
Mode																								
	136/58										150/70						140/108							
	109																							

DRIP/DOSE

FREQ. VITAL SIGNS

INPUT/OUTPUT

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

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
		220																				650			

US 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

T.24 JR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5344

ime	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		V																						
00																								
0		^																						
0																								
0																								
RR		14									16							24						
TEMP		99.4									98.0							98.7						
SAO2		99																98						
MAP																								
D2 Mode		130/90									128/62							140/70						
UOP			120			300	200	160			375					31								

CUFF

AL

MEDCOM - 5345

DRIP/DOSE

FREQ. VITAL SIGNS

IME																	
P																	
R																	
R																	
EMP																	
AO2																	

otes:

INPUT/OUTPUT

	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																									
OP																									
M																									

REVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

RESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5346

(b)(6)-4

MEDTREFAC 6550/12/Temp Form

25APR03

Time	07	08	09	10	11	12	13	14	15	16	17	18	20	21	22	23	24	01	02	03	04	05	06
300																							
280																							
260																							
240																							
220																							
200																							
180																							
160																							
140																							
120																							
100																							
80																							
60																							
RR		18					14			16						20							
TEMP		95.6					99.1			99.3						99.6							
SAO2		99								97													
MAP																							
O2 Mode		120/70																					
							128/88	66		118/54						138/80							
IV DP						300		140															

CUFF

AL

DRIP RATE

Name: (b)(6)-2

NURSING [redacted] SHEET

MEDTREFAC-65[redacted] IV [redacted]

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					V																			
120										V														
100																								
80																								
60										A														
40					A																			
RR					16					18								17						
TEMP					97.8					100.4								103.4	99.9					
SAO2					98													98						
MAP																								
O2 Mode																								
BP					140/60					120/74								140/86						
UOP					320	140	180	120																

DRIP/DOSE

Name: (b)(6)-4

NURSIN[illegible]T
MEDTREF[illegible]m

Date: 22 APRIL

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		18								16							16	22						
TEMP		98.0								97.9							100.1							
SAO2		99															96							
MAP																								
O2 Mode		110/64								106/72							124/64							
UOP			120				180	100	100													780		

DRIP/DOSE

Name: (b)(6)-4

NURSING NURSE SHEET
MEF AC 10/12/Temp Form

Date: 21 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		18								20							18							
TEMP		100.1								99.1							99.5							
SAO2		97															98							
MAP																								
O2 Mode		RA																						
		144/84															122/68							
DRIP/DOSE							500		600															

Name: (b)(6)-4

NURSING FLOW SHEET

MEDCOM 5351/13 Temp Form

Date: 20 APR 09

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		18									100%						20							
TEMP		98.8															99.4							
SAO2		99															98							
MAP																								
O2 Mode		RA																						
	124/80																						275	
OUTPUT																								
DRIP/DOSE: UOP					420																			

(b)(3)-1

Personal Data - Privacy Act of 1974 (PL 93-579)
Flowsheet Results
For: 25 Mar 03 - 24 Apr 03

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

Collection Date	WBC BLOOD	# PLT CNT BLOOD
10Apr03@1619	7.7	247
12Apr03@0535	10.9 H	326
13Apr03@0604	10.1	377
1928	9.1	426
14Apr03@0502	8.1	456 H
15Apr03@0506	10.4	434
16Apr03@0505	11.5 H	415
17Apr03@0411	12.1 H	517 H
19Apr03@0552	11.0 H	570.0 H
24Apr03@0441	12.4 H	719.0 H

L=Abnormal Low H=Abnormal High *=Critical Value @=Requesting HCP Only
#= Multiple reference ranges used. The trend may be inaccurate.

*** END OF REPORT ***

(b)(3)-1

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 18 Apr 03 - 22 Apr 03

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

(b)(6)-4 (b)(6)-4 M/12d Reg #: (b)(6)-4
Ph: Military Unit: UNKNOWN

---

22 Apr 03 @ 1723 (Coll) PLASMA
PT. . . . . 30.2 H* (11.6-14.4) Seconds
Result Comment: NOTIFIED (b)(6)-2 AT 1832 ON 22APR03.
INR 2.6
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.

21 Apr 03 @ 1720 (Coll) PLASMA
PT. . . . . 22.9 H (11.6-14.4) Seconds
INR 2.0
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.

21 Apr 03 @ 0608 (Coll) PLASMA
PT. . . . . 29.6 H (11.6-14.4) Seconds
Result Comment: NOTIFIED ENS (b)(6)-2 AT 0757 ON 21APR03.
INR 2.5
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.

20 Apr 03 @ 2207 (Coll) PLASMA
PT. . . . . 53.9 H* (11.6-14.4) Seconds
Result Comment:
NOTIFIED DR (b)(6)-2 @ 2300
RESULTS VERIFIED BY REPEAT ANALYSIS. MVLUMALI
INR 13.5
Interpretations:
The current recommended therapeutic range for INR is 2.0-3.0 for all

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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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Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 18 Apr 03 - 22 Apr 03

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

(b)(6)-4 (b)(6)-4 M/12d Reg #: (b)(6)-4
Ph: Military Unit: UNKNOWN

20 Apr 03 @ 2207 (Coll) PLASMA
Interpretations: (Cont'd)
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.

20 Apr 03 @ 0048 (Coll) PLASMA
PT. . . . . 26.4 H (11.6-14.4) Seconds
Result Comment:
NOTIFIED LCDR (b)(6)-2 0208.
RESULTS VERIFIED BY REPEAT ANALYSIS. MVLUMALI
INR 3.7
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.

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

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 18 Apr 03 - 19 Apr 03

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

(b)(6)-4 (b)(6)-4 M/9d Reg #: (b)(6)-4
Ph: Military Unit: UNKNOWN

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19 Apr 03 @ 1020 (Coll) PLASMA

PT.	67.8	H*	(11.6-14.4)	Seconds

Result Comment: RESULTS VERIFIED BY REPEAT ANALYSIS. [redacted] b-6-2

INR	20.5

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.

19 Apr 03 @ 0552 (Coll) PLASMA

APTT.	27.5		(23.8-35.5)	Seconds
PT.	56.5	H*	(11.6-14.4)	Seconds

Result Comment:
DIFFERENCE CHECK. RESULTS VERIFIED BY REPEAT ANALYSIS. MVLUMALI

INR	14.7

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.

19 Apr 03 @ 0552 (Coll) BLOOD

WBC	11.0	H	(4.8-10.8)	K/UL
RBC	2.6	L	(4.7-6.1)	1X10 6/UL
HGB	8.2	L	(14.0-18.0)	g/dL
HCT	23.9	L	(42-52)	%
MCV	91.8		(80-94)	fL
MCH	31.5		(27-32)	pg
MCHC.	34.3		(31-37)	g/dL
RDW	17.0	H	(12-14)	%
PLT CNT	570.0	H	(150-450)	1x10 3/UL
MPV	6.9	L	(7.4-10.4)	FL
NEUT/100 WBC.	69.5			%
NEUT%	7.6			1x10 3/UL
LYMPHS/100 WBC.	17.4			%
LY#	1.9			1x10 3/UL
MONO/100 WBC.	13.1			%
MONO%	1.4			1X10 3/UL

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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

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

PATIENT LAB INQUIRY

For: 18 Apr 03 - 19 Apr 03

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

(b)(6)-4 (b)(6)-4 M/9d Reg #: (b)(6)-4

Ph: Military Unit: UNKNOWN

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19 Apr 03 @ 0552 (Coll) BLOOD

ANISOCYTOSIS.	1+
POIKILOCYTOSIS.	SLIGHT
MACROCYTES.	1+
SCHISTOCYTES.	SLIGHT
SPHEROCYTES	SLIGHT
STOMATOCYTES.	SLIGHT
TARGET CELLS.	1+

18 Apr 03 @ 0506 (Coll) PLASMA

APTT.	26.6		(23.8-35.5)	Seconds
PT.	18.9	H	(11.6-14.4)	Seconds
INR	2.0			

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.

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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2 √
(b)(3)-1

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

PATIENT LAB INQUIRY

For: 17 Mar 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 @ 0505 (Coll) BLOOD

WBC	11.5	H	(4.8-10.8)	K/UL
RBC	2.6	L	(4.7-6.1)	1X10 6/UL
HGB	8.0	L	(14.0-18.0)	g/dL
HCT	23.6	L	(42-52)	%
MCV	92.3		(80-94)	fL
MCH	31.3		(27-32)	pg
MCHC	33.9		(31-37)	g/dL
RDW	15.0	H	(12-14)	%
PLT CNT	415		(150-450)	1x10 3/UL
MPV	7.2	L	(7.4-10.4)	FL
NEUT/100 WBC	71.1			%
NEUT%	8.2			1x10 3/UL
LYMPHS/100 WBC	18.4			%
LY#	2.1			1x10 3/UL
MONO/100 WBC	10.5			%
MO#	1.2			1x10 3/UL
EO#	<0.7			1x10 3/UL
BAS#	<0.2			1x10 3/UL

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

(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 @ 0506 (Coll) BLOOD

WBC	10.4		(4.8-10.8)	K/UL
RBC	2.1	L	(4.7-6.1)	1X10 6/UL
HGB	6.7	L*	(14.0-18.0)	g/dL
Result Comment: ENSIGN [redacted] NOTIFIED @0651				
HCT	19.6	L*	(42-52)	%
Result Comment: ENSIGN [redacted] NOTIFIED @0651				
MCV	92.0		(80-94)	fL
MCH	31.2		(27-32)	pg
MCHC	33.9		(31-37)	g/dL
RDW	15.5	H	(12-14)	%
PLT CNT	434		(150-450)	1x10 3/UL
MPV	7.8		(7.4-10.4)	FL
NEUT/100 WBC	73.6			%
NEUT%	7.7			1x10 3/UL
LYMPHS/100 WBC	16.4			%
LY#	1.7			1x10 3/UL
MONO/100 WBC	10.0			%
MO#	1.0			1x10 3/UL
EO#	<0.7			1x10 3/UL
BAS#	<0.2			1x10 3/UL

15 Apr 03 @ 0506 (Coll) SERUM

NA+	128	L	(137-145)	mmol/L
K	4.2		(3.6-5.0)	mmol/L
CL-	100		(97-107)	mmol/L
CO2	30		(22-31)	mmol/L
BUN	9		(9-21)	mg/dL
GLUCOSE	119	H	(76-110)	mg/dL
CREAT	0.7	L	(0.8-1.5)	mg/dL

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

MEDCOM - 5358

4/13/03 0619

PR

QRSD

QT

--AXIS-

F 83

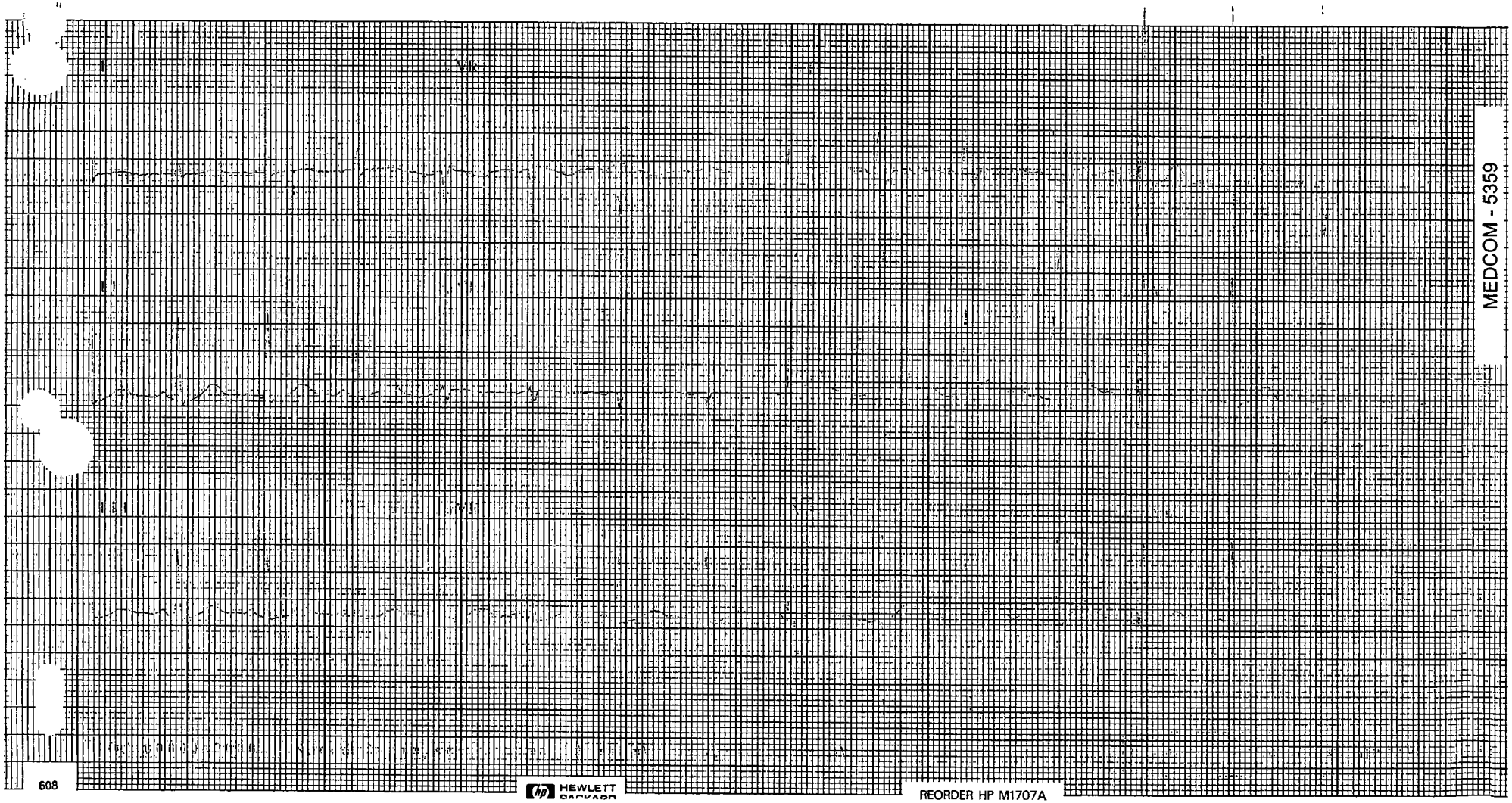
QRS 75

T 70

Registered by

BORDERLINE ECG

PRELIMINARY-MD MUST REVIEW



MEDCOM - 5359

HEWLETT PACKARD

REORDER HP M1707A

~~04/12/2003 08:10:19 PM~~

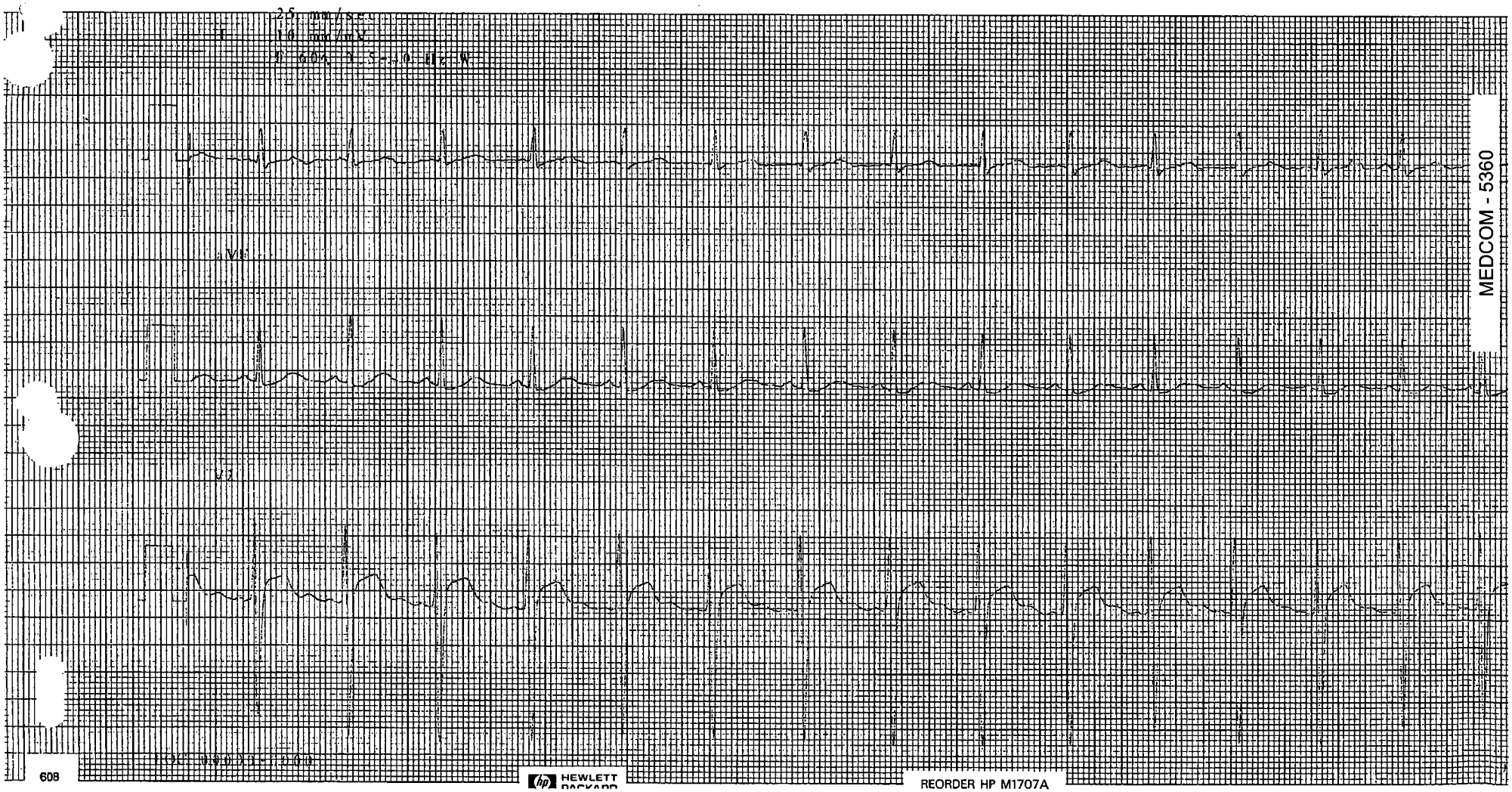
4/13/03 0615

Rx:
Dx:

BP:

Dept:
Room:
Oper.

Requested by:



608

HEWLETT PACKARD

REORDER HP M1707A

~~04/12/2003 04:33:31 PM~~

4/13/03 0449 AM

Rx:
Dx:

BP:

Dept
Room
Oper.

Rate	98	. Normal sinus rhythm, rate 98 ..... Normal P axis, PR, rate & rhythm
PR	153	. LVH by voltage ..... S V1|V2|+ R V5,V6 > 3.5 |4.0| mV
QRSD	97	
QT	356	
QTc	454	

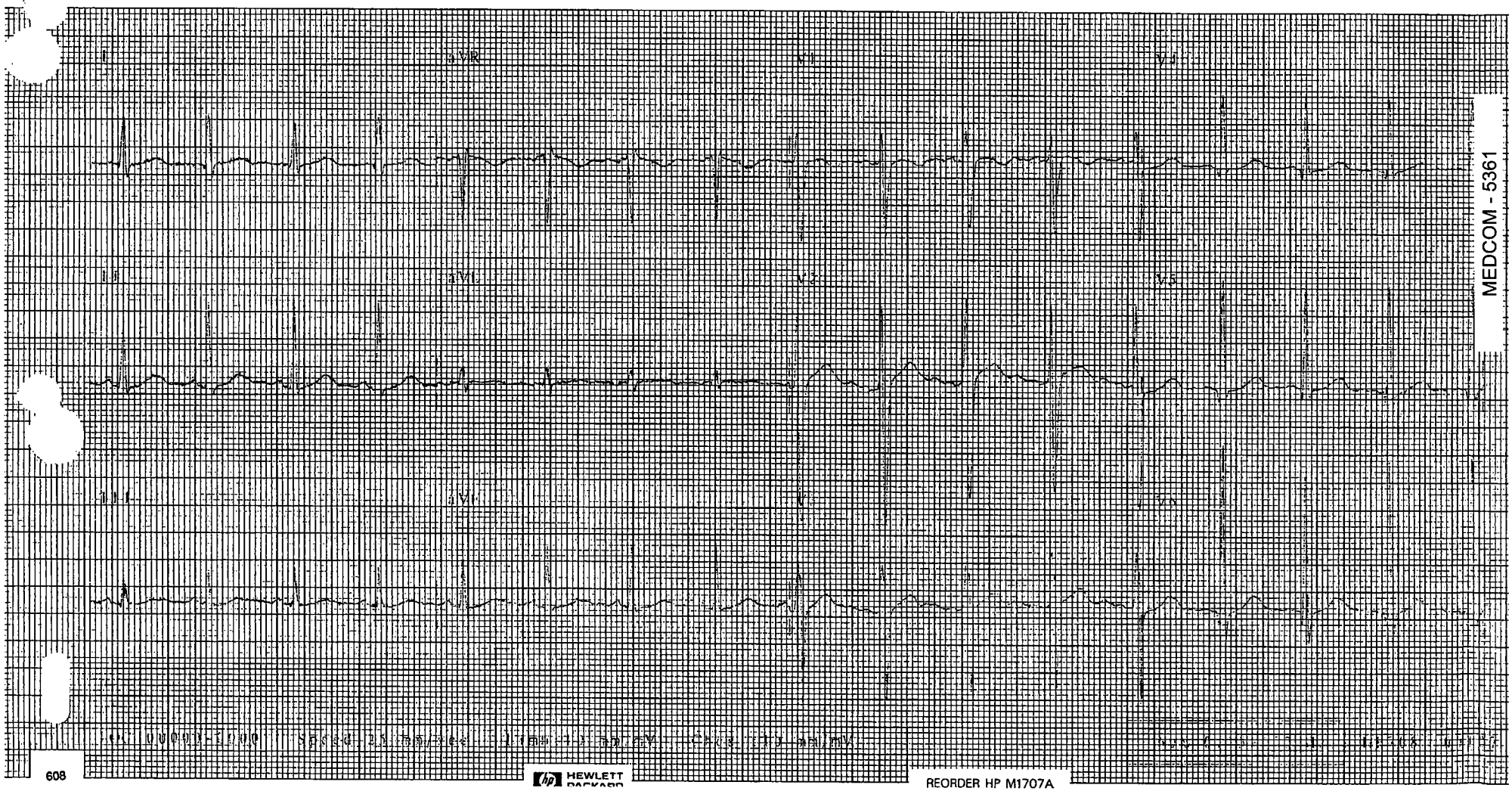
Requested by:

--AXIS--

P	82
QRS	51
T	50

- BORDERLINE ECG -

PRELIMINARY-MD MUST REVIEW



608

HEWLETT PACKARD

REORDER HP M1707A

04/12/2003 04:58:08 PM

4/13/03 0454

Rx:
Dx:

BP:

Dept.
Room:
Oper:

Rate	109	. Sinus tachycardia, rate 109 ..... Normal P axis, rate >= 100
PR	109	. Consider right atrial enlargement ..... P > .24 mV limb lead
QRSD	95	. High QRS voltage ..... R in II >= 1.5 mV
QT	332	
QTc	447	

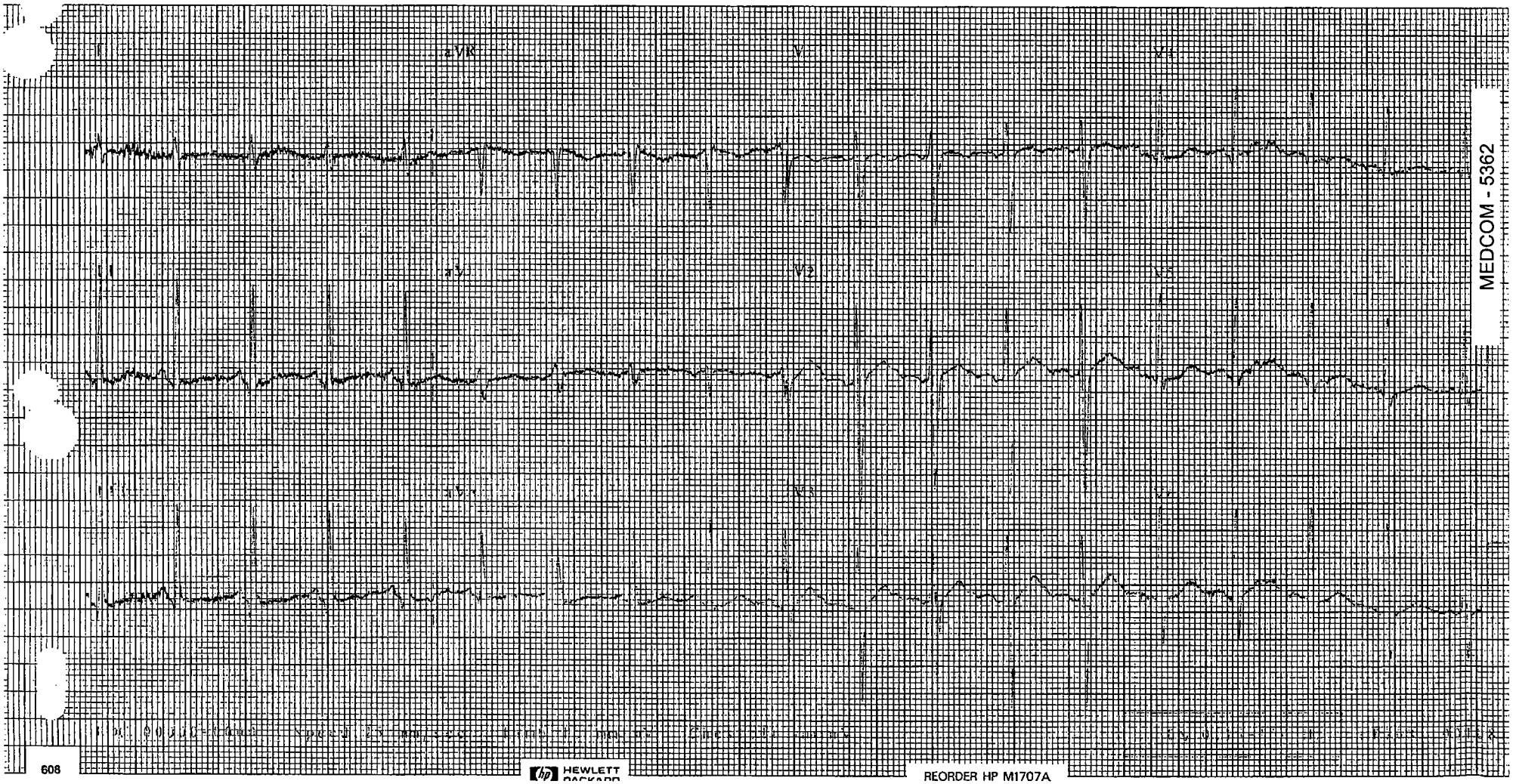
Requested by:

--AXIS--

P	95
QRS	78
T	51

- BORDERLINE ECG -

PRELIMINARY-MD MUST REVIEW



HEWLETT PACKARD
REORDER HP M1707A

(b)(3)-1

Name: ,

CHCS Name (b)(6)-4

(b)(6)-4 Iraqi civilian

Prognosis: Good

Date of Admission: 4/10/2003

Date of Transfer:

History:

MVA,

Hospital Course:

Pateint addmitted after MVA underwent initial I&D of wounds. Subsequently underwent IM nailing of bilateral Tibias followed by the IM nailing of right femur. Patient is cuurently in rehab portion of recovery.,

Diagnoses:

Right subtrochanteric femur; Right open tibia; left closed tibia

Surgeries/Treatmen

IM nailing of right tibia; IM nailing of left tbia; IM nailing of right Femur

Recommendations:

Will need crutch training. Partial weight bearing right lower extremity

SpecialNeeds:

Physician:

(b)(6)-2 LCDR Dept of Orthopedics

5/3/2003

(b)(3)-1 ,

CHCS Name: (b)(6)-4

Date of Admission: 4/10/2003

Date of Transfer:

(b)(6)-4 EPW

Age: Gender: M

History:
MVA,

Hospital Course:
Pateint addmitted after MVA underwent initial I&D of wounds. Subsequently underwent IM nailing of bilateral Tibias followed
by the IM nailing of right femur. Patient ~~is currently in~~ rehab portion of recovery.

Diagnoses:
Right subtrochanteric femur, Right open tibia, left closed tibia

Surgeries/Treatment:
IM nailing of right tibia, IM nailing of left tbia, IM nailing of right Femur

Recommendations:
Will need crutch training. Partial weight bearing right lower extremity

Special Needs:

Prognosis: Good

Physician: (b)(6)-2 LCDR Dept of Orthopedics 4/24/2003

(b)(3)-1

MEDICAL TREATMENT FACILITY

(b)(3)-1

LIFT OF OPPORTUNITY

AME (LAST, FIRST, MIDDLE) (b)(6)-4				SOCIAL SECURITY NUMBER
ANK/RATE	OFFICERS ONLY DESIG NOBC	ENLISTED NEC	BIRTH DATE	SEX
RANCH OF SERVICE	NAMED AND ADDRESS OF PARENT MILITARY COMMAND			SHIP HOMEPORT

IIC	BLOOD TYPE	RELIGIOUS PREFERENCE	MARITAL STATUS	IS SPOUSE ACTIVE DUTY	NUMBER OF DEPENDENTS

AME OF NEXT OF KIN (NOK)	RELATIONSHIP OF NOK
DDRESS OF NOK	PHONE NUMBER OF NOK

RINTED NAME OF PATIENT RECEIVING FLIGHT TRAINING	SIGNATURE OF PATIENT
RINTED NAME OF MEDHOLD COORDINATOR (b)(6)-2	SIGNATURE OF MEDHOLD COORDINATOR (b)(6)-2
RINTED NAME OF ATTENDING PHYISICIAN	SIGNATURE OF ATTENDING PHYSICIAN

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

NURSING [redacted] SHEET
MEDTREFAC-6[redacted] Temp Form

Date: [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	14													14										
TEMP	98.2													96.6										
SAO2														96%										
MAP																								
O2 Mode																								
	110/70													110/58										

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																										
UOP																										
BM																										

PREVIOUS 24 HOUR INPUT_____

PRESENT 24 HOUR INPUT_____

PREVIOUS 24 HOUR OUTPUT_____

PRESENT 24 HOUR OUTPUT_____

PREVIOUS WEIGHT_____

PRESENT WEIGHT_____

MEDCOM - 5367

Name (b)(6)-4

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

Date: 4 | MAR

	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
	18.										20				18									
TEMP	97.4										99.3				98.9									
O2																								
AP																								
BP	124/67										136/88				129/68									
HR	76										88				82									

DRIP / DOSE

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

NURSING [redacted] SHEET
MEDTREFAC-[redacted] Temp Form

Date: 1 MAY 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		18												20										
TEMP		97.2												98.4										
SAO2																								
MAP																								
O2 Mode																								
														104/68										
														82										

DRIP / DOSE

Name: (b)(6)-4

[redacted] HEET
[redacted] Form

Date: 30 APR

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	22													20										
TEMP	99.8													98.1										
SAO2																								
MAP																								
O2 Mode																								
BP	132/60													50										
HR	96													112/60										

DRIP/DOSE

FREQ[illegible]

TIME															
BP															
HR															
RR															
TEMP															
SAO2															

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	TOTAL
FOLEY																										
UOP													1500													
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5371