INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(3)-1		2. NAME (Last, First, MI) (b)(6)-4 (b)(6)-4				3. GRADE	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE IRAQI	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP 99		12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD ICW2	
15. FLYING STATUS WO	16. RATING/ DSG	17. DEPT./ BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE INS	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct				22. HOURS OF ADMISSION 2100	23. CLINIC SERVICE AZAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION 12MAY03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 4MAY03		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1					30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

65W R Knee ~~891~~
~~899~~

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
8				8	8

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

(b)(6)-2 SIGNA (b)(6)-2 OFFICER

DA FORM 3647, MAY 79

MEDCOM - 5372

USAPPC V1.10

INPATIENT TREATMENT RECORD COVER SHEET

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

1. (b)(3)-1		2. NAME (Last, First, MI) (b)(6)-4	(b)(6)-4			3. GRADE	ADMISSION REMARKS
4. SEX	5. AGE	6. RACE IRAQI	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION	
11. FMP 99		12. SSN (b)(6)-4		13. ORGANIZATION		14. WARD ICW2	
15. FLYING STATUS NO	16. RATING/DSG	17. DEPT./BEN	18. BRANCH/CORPS	19. UIC/ZIP		20. TYPE CASE INS	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct				22. HOURS OF ADMISSION 2100	23. CLINIC SERVICE AZAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE			25. TYPE DISPOSITION		26. DATE OF DISPOSITION 12MAY03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)			27b. TELEPHONE NO.		28. DATE OF THIS ADMISSION 4MAY03		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1					30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

65W R Knee ~~891~~
~~E94~~

III (2)
869.0
959.01
780.39
790.7
891.0
112.5
780.6
E991.2

III (3)
869.0
E991.2

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
8				8	8

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

(b)(6)-2 SIGN (b)(6)-2 FICER

DA FORM 3647, MAY 79 MEDCOM - 5373

EDITION OF 1 AUG 76 IS OBSOLETE USAPPC

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER (b)(3)-1	2. NAME (Last, First, MI) (b)(6)-4	(b)(6)-4	3. GRADE	ADMISSION REMARKS		
4. SEX	5. AGE	6. RACE IRAQI	7. RELIGION	8. LENGTH OF SVC	9. ETS	10. PREVIOUS ADMISSION
11. FMP 99	12. SSN (b)(6)-4	13. ORGANIZATION	14. WARD ICW2			
15. FLYING STATUS NO	16. DSG	BEN	18. BRANCH/CORPS	19. UIC/ZIP	20. TYPE CASE INS	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct	22. HOURS OF ADMISSION 2100	23. CLINIC SERVICE AZAA				
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE	25. TYPE DISPOSITION	26. DATE OF DISPOSITION 12 MAY 03				
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 4 MAY 03	ADMITTING OFFICER			
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY (b)(3)-1	30. DATE OF INTIAL ADMISSION	32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED				

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

65W R Knee ~~891~~

~~E94~~

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
8				8	8

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

SI (b)(6)-2 SIGN (b)(6)-2 FFICER

DA FORM 3647, MAY 79 MEDCOM - 5374 USAPPC V1.10

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
4 May @ 2215	AOX3 Pupils PERRLA membranes intact Resps. equal (B) labored on exhilation Breath sounds exinalatory wheezing heard throughout (B) Abdomen soft non tender Foley inserted 250 cc of dark amber blood tinged urine urine in tubing clear yellow 2 decubitus ulcers midline back on saccrum and coxxyx pulses +3 radial & pedal (B) incision on (R) knee ~~well granul~~ (b)(6)-2 no drainage noted sutures intact Pt c/o pn cth ~~sacral~~ (b)(6)-2 incision site will continue to monitor. VSS (b)(6)-2 SPC 91
5 May 03 @ 0130	pt c/o pain. medicated c̄ Tylenol #3. Foley to bedside drainage c̄ dark brown urine. pt c̄ (B) heel protectors Ø skin breaks at this time. Duoderm present to sacral area + coccyx area c̄ pink tissue exposed c̄ good healing. Quarter sized old wound to (R) occippital area of head s̄ drainage. Suture present to (R) knee edges well approximated. Ø s/s of infection (+) pedal (+) sensation (+) cap refill. pt restless. NAD will cont to monitor. V. (b)(6)-2
5 May 03 @ 0545	pt resting quietly @ this time. pt restless most of the night. Total urine output from Foley 450 cc dark yellow. Foley draining ~~clear~~ cloudy yellow urine. ~~pt appears to be confe~~ (b)(6)-2 Language barrier present. Interpreter present x 1 this shift Explain purpose of Foley + nurse @ bedside. no other significant changes. NAD. (b)(6)-2 2LT/AN

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
5 May 03 @ 0600	pt restless throughout the night. pt has (B) Stage I pressure ulcer to heels L > R. Heel protectors in place. pt verbalizes Ø discomfort at this time. (B) heels c̄ skin breakage will cont to monitor. (b)(6)-2 [redacted] 2LT/AN
5 MAY 03 @ 0800 (b)(6)-2 [redacted]	Nursing assessment: Alert, follows commands appropriately. Flat affect noted. Lungs clear in all fields. Heart S1 S2 to Auscultation Rate 105, Regular. ABD c̄ active Bowel sound x4 quads, Soft, Nontender. Foley to gravity bedside drain, clear yellow urine. (R) Knee c̄ Blue sutures intact to surgical site No open areas Noted. peripheral pulses intact x4 radial/dorsalis pedis, cap refill < 3 sec. Decub to sacrum/coccyx covered c̄ Duoderm, breakdown stage II to R. lat heals (blisters) heal protectors in place. — IV saline lock to (L) FA No other complications/complaints noted @ this time. will continue to assess/monitor, pending transfer to vipar today. (b)(6)-2 [redacted]
5 MAY 03 1400 hrs	I/O: Foley c̄ Amber urine 240cc but this shift — (b)(6)-2 [redacted] SSG [illegible]
05 May 03 2200	Pt got up to bedside comode. BM x1. legs very weak, can't support body weight. Blister to heal x2, heal protector on. Sutures to (R) knee CDI, Foley draining clear yellow urine. comfed to sacrum intact. — SSG (b)(6)-2 [redacted]
06 May 03 @	VSS. pt displays decreased restlessness from previous night. foley to Bedside drainage amber colored urine. IV to (L) forearm patent + flushed well c̄ NS. (b)(6)-2 [redacted] ~~Heel protectors to~~ (B) heel protectors in place. no other significant changes since 5 May 03 assessment pt NAD. will cont to monitor (b)(6)-2 [redacted] 2LT/AN
06 May 03 @ 0555	Foley to BSD Emptied c̄ 450cc yellow urine. (b)(6)-2 [redacted] 2LT/AN
6 May 03 0900	Pt A&O x3 c/o LBP, foley cath ⇒ gravity drainage. Medicated c̄ T3 ii tabs for c/o pain (b)(6)-2 [redacted] SSG 91WM6
1100 hrs.	Pt ↑ OOB ⇒ Chair x 40 mins. AM care performed. Back message given suture line (R) Knee intact (b)(6)-2 [redacted] SSG 91WM6

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | Nursing ~~PROGRESS~~ NOTES

DATE	NOTES
6 May 03 1140 hrs.	Foley cath D/C s̄ complaint. Translator informed Pt must void c̄ in 6 hrs. (b)(6)-2 SSG 91WM6
1330 hrs.	Medicated c̄ T3 ii tabs PO for c/o pain Ø self void @ present (b)(6)-2 SSG 91WM6
2200	Pt got up to bedside comode, BM x 1. Pt voided @ 1745. c/o vertigo while sitting up in chair. Heal protectors applied to ~~heal pr~~ (b)(6)-2 blistered heal x 2. No other c/o complaint noted. SSG (b)(6)-2 91WM6
7 May 03 @ 0120	pt moaning but states no pain at this time. Heel protectors repositioned; loosened by pt movement. urinal @ bedside. sutures present (b)(6)-2 to (R) knee edges well approx no S/S of infection. no increase in size of Stage I decubitus to (B) heels. ~~Sacrum~~ (b)(6)-2 coccyx area pink c̄ no drainage noted. pt ~~moves~~ (b)(6)-2 repositions self constantly during the night. no other significant changes noted. (b)(6)-2 2LT/AW
7 May 03 @ 0530	pt void 340 cc amber urine s̄ assistance. pt repositioned self throughout the night. medicated @ 0210 for pain c̄ Tylenol #3; effective. will cont to monitor. (b)(6)-2 2LT/A
7 May 03	Pt A&O x 3, AM care c̄ staff assist 75% AM meal consumed s̄ c/o N/V TOOB → chair x 45 mins Suture line (R) knee intact c/o pain c̄ chair → bed transfer. Encouraged to not lay supine. Medicated c̄ T3 ii tabs for c/o pain. Assist, Monitor PRN (b)(6)-2 SSG 91WM6

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
7May03 1330hrs.	Sutures (R) knee removed c̄ mild pt. discomfort refused pain meds. (R) leg ↑'ed Pt encourage to rotate from side ⇒ side and not lay supine. No other deficit noted (b)(6)-2 SSG 91WM6
7May@2215	Pt sleeping VSS had 1 BM large void w/ difficulty complained of Pn given 2T3 @ 2145 Pt ambulated c̄ assist to chair & bedside commode. Pt sometimes becomes very aggitated, but is resting comfortably now. (b)(6)-2 91WM6 SPL
8May03@0625	pt rested quietly throughout the night. medicated x 1 this shift for pain. no other significant changes. will continue to monitor. (b)(6)-2 2LT/AN
8May03 0910	A&Ox3 AM care performed AM meal c̄ c/o N/V suture line (R) knee intact, Encouraged to turn side to side releaving pressure to back. ↑ OOB → PT → crutch walk c̄ only 2-3 steps. Pt to return later today (b)(6)-2 SSG 91WM6
8May03 2108	Pt Alert on arrival to shift. Pt had two visitors today. Changed pt's heel protectors & washed old pair. sutures to (R) knee intact c̄ s/s infection. VSS. Pt requested pain med for leg pain. Pt has removed (L) bootie & is laying from side to side and on abdomen. VSS. No distress noted @ present. Will continue to monitor. (b)(6)-2 CPL/AN
8May03@2345	pt VSS. pt moaning @ 2300. pt quietly resting @ 2345 in position of comfort on (L) side. (R) Heel protectors in place. no other significant changes at this time. (b)(6)-2 2LT/AN
9May03@0640	pt void 750cc (b)(6) amber ~~dark~~ urine. (b)(6)-2 2LT/AN

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	PT Note
1345	(S) Per Dr (b)(6)-2 pnt seen for Rom of (R) LE and ambulation
	(O) (R) knee Rom 15-60
	(I) Bed mobility
	sits edge of Bed c̄ good Balance - dizzy
	stands c̄ crutches PWB (R) LE
	stands edge of Bed c̄ fair balance
	unable to ambulate beyond bed 2° to dizziness
	(A) deconditioned, vertigo, hypotensive c̄ good potential
	(P) BCD to see for above Rom and ambulation
	to be ↑ as tol c̄ PT Nursing teamwork (b)(6)-2 PT
9May03	PT Note: Pnt amb c̄ crutches. % pain to (R) Knee / dizziness. cont relab as tol. - (b)(6)-2 PT

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)

MEDCOM - 5379

509-114

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | Nursing ~~PROGRESS~~ NOTES

DATE	NOTES
9 May 03 0830	A&Ox3 c/o mild discomfort sacral area small edema & discoloration, Suture line (R) Knee remains intact. VS WNL AM care per self. Continue to assist Monitor Medicate PRN (b)(6)-2 SSG 91WM6
9 MAY 03 @1600	Nursing Assessment: VSS, Alert, able to change position in bed and sit up. Dizzy when standing, lungs clear in all fields, heart rate 105 while sitting S1 S2 to Auscultation. Active bowel sounds x4 quads, soft, Non tender voiding per urinal ē difficulty. decub to sacrum/coccyx and to heals bilat. heal protectors in place bilat. peripheral pulses intact radial/dorsalis pedis - cap refill < 3 sec. No complications noted. request pain med for (R) Knee, Two + 3 given. will continue to assess and monitor. (b)(6)-2 SSG
10 May 03 @ 0400	pt VSS NAD resting quietly c periodic moaning. no c/o pain at this time. no other significant changes noted. will continue to monitor. (b)(6)-2 LLT/AN
10 May 03 @ 1230	nsg note: VSS - afebrile. Egg crate to bilat heels. Crutches @ bedside. Pt able to roll from side to side & sit on edge of bed ad lib. ⊕ PO intake. ⊖ other sig Δs. Will continue to monitor. (b)(6)-2 LLT/AN
10 May 03 1830	Nursing Note: VSS. Tolerated reg diet well. heel protectors on bilaterally. Wound to (R) leg above Knee closed ē redness mild swelling noted. Pt turning from side to side through shift. Pedal pulses present →

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
	x 2 : SKIN warm & dry. No distress voiced @ present [redacted] CPT/PAN
11 May 03 0830hrs	A&Ox3 50% of AM meal consumed ≤ c/o N/V ⊕ LBOM (R) Knee, heel protectors present. Encourage to Rotate (L) → (R) ↓ pressure on back. ↑ → BSC ⊕ results. [redacted] SSG 91WM6
1400hrs	Transfered to ICU 2 via crutch ambulation & personal items & chart [redacted] SSG Memo
1432	Recieved pt. Initial assesment: Pt alert and orientate. No c/o Pressure sores bilateral heels, Vs stable. Continue to monitor [redacted]
2200	Pt cont stable. Crutch-walked length of wards poor gait technique Rt Knee wound intact. No c/o. Refused dinner. Ate only sun-flower seeds. Rotates side to side perself to keep off heels. [redacted]
11 May 03 2340	Pt. report received, initial assesment completed redness & swelling to (R) Knee VSS no c/o of pain will continue monitor [redacted] JLJ/AN
12 Mar 0900	Pt AxO - C/O Pain on standing. Assessment Benign healing decub on secrum on (R) clean mirror. No other issues. To depart (R) in custody of MPs. [redacted] LT
12 May 03	Discharge note S/P GSW (R) thigh, wound closed. needs ROM, strengthening [redacted] MASTRIC

FPI LEX Printed on Recycled Paper

STANDARD FORM 509 (REV. 5-99) BACK

MEDCOM - 5381

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																
POST-	DAY															
MONTH-YEAR	DAY	4	5			6		6		7		7		8		
19	HOUR	23	07	15	23		200	23				23	08	1600	23	

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD	20	20	20	18		20	18		6	18	18	6	18	18
BLOOD PRESSURE	120/82	102/55	109/75	124/72		118/62	122/69	107/55	107/55	110/59	95/60		110/70	103/64
	127	105	105	97	100/55	95	89			81	80	101/41	94	91
	98.6	98.6	99.1	98.4		98.3	97.6			98.8	98.3		99.0	97.5
HEIGHT: WEIGHT →														

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

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

Compound 8

(b)(6)-4

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY														
POST- DAY	9		9	10	10		11				12			
MONTH-YEAR / DAY	MAY		May	MAY	May									
19 / HOUR	0700	1600	23	08	1500			1430	22		2400		0800	
RESPIRATION RECORD	16	16	18	16	16		16	16	16				18	
BLOOD PRESSURE		[illegible]	128/67	111/75	119/82			138/72	110/65			113/68	116/80	
P		105	81	88	90		112/67	96	96			84	[illegible]	
		99.2	97.9	97.8	97.1			99.3	98.8			98.5	97.9	
HEIGHT: / WEIGHT →														

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

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

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

(b)(6)-4

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

ISING UNIT	ROOM NO.	BED NO.

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

- ~~Admit to ICU~~
- VSQ1H
- Pulse Ox
- ~~Diffusion Tx~~
- Tylenol #3 1 tab PO q4h prn pain
- Foley to gravity drainage
- Insert NG tube to suction
- 24hr Chart √ complete 0110 5 May 03 (b)(6)-2

IENT IDENTIFICATION

ISING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

6 MAY 03 1035

1) D/C foley, if no urine output by 6 PM start D/C Q12

2) D/C nasogenic suction Keflex 1 gm PO Q8 D/C

6 MAY 03 1440 hrs (b)(6)-2

IENT IDENTIFICATION

ISING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME | HOURS

7 May 03

1 Apply ace wrap to Rt knee prn

2 A.D → ROM + ambulate (b)(6)-2

24hr Chart √ complete 0315 8 May 03 (b)(6)-2

7 May 03 1330 hrs

Acknowledged !!

IENT IDENTIFICATION

ISING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

5/8/03 0730

1) If General surgery does not D/C pt to ER w/ consult

(b)(6)-2 PT

7 May 03 1744

(b)(6)-2

8 MAY 03 0730

ISING UNIT	ROOM NO.	BED NO.

(b)(6)-2

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-383-710

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 ITEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4			08 May 03 0900 HOURS	
			D/C to facility for rehab. (b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.		
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
			2003 05 11 0732 HOURS	
			— Physical therapy to see + work on low extremity contractures.	
NURSING UNIT	ROOM NO.	BED NO.	— Mon transfer to appropriate (b)(6)-2 MAY 03	
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
			faculty when available HOURS (b)(6)-2	
			— Restoril 1 Caps hs prn	
NURSING UNIT	ROOM NO.	BED NO.	(b)(6)-2	
PATIENT IDENTIFICATION			DATE OF ORDER / TIME OF ORDER	
			31 MAY 03 HOURS	
			D/C to MD Custody	
NURSING UNIT	ROOM NO.	BED NO.	(b)(6)-2	

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1994-383-710

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
6 May 03	(b)(6)-2	D/C Foley cath, If no void by 6° then	6 May 03	1140	1140	(b)(6)-2
		START CIC QID				
6 May 03	(b)(6)-2	If urgency start Ditropan XL 5mg				
		P.O. QDPM (If needed write order				
		on reverse)				
8 May 03	(b)(6)-2	If General Surgery done c̄				(b)(6)-2
		pt D/C to EPW camp				
8 May 03	(b)(6)-2	D/C to EPW camp				(b)(6)-2
8 May 03		D/C to Facility for Rehab	8 May (b)(6)-2			

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
5/4		Tylenol #3 ⅡPO Q4hrs prn	4 May 2335	5 May 1004	6 May 0900	6 May 1330	6 May 2230	7 May 0210	7 May 0800	7 May 1535	7 May 2145	8 May 0235	8 May 11	8 May 1030	8 May 2035	9 May 0045
			(b)(6)-2													
7 May	(b)(6)-2	EUCERIN CREAM to Buttock PRN	(b)(6)-2													
4 May 03		Tylenol #3 ⅡPO	9 May 03 1600		9 May 03 ⅡTabs @ 2110		10 May 03 @ 1450 2 tabs PO		10 May 2330							
		Q4hrs PRN	(b)(6)-2													
11 May 03		Restoril ⅠHS PRN														

☆ U.S. GPO: 1998-432-786/85214

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. 05 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY
5/4	-----	VS routine

5/4	-----	Foley to gravity

5/4	-----	REG DIET

5/4	[redacted]	PT → ROM & Ambulation

HR	DATE DISPENSED 4 5 6 7 8 9 10 11 12
07	[redacted]
15	
23	
07	D/C
15	
23	
07	
12	
19	
02	
15	
15	
21	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: (R) knee GSW Concussion

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

[redacted]

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

24 01 02 03 04 05 06

DA FORM 4678 ED... MEDCOM - 5387 ...USTED.

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6): (b)(3)-1
MTF LOCATION (7–8): IZ (State or Country Code.)

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

6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26): 1963 01 01
7. AGE AT ADMISSION (27–29): 40 y
8. RACE (30): X
9. ETHNIC BACK-GROUND (31): 9
RELIGION

10. LENGTH OF SERVICE (32–34): —
ETS
11. FMP (35–36): 20
12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4

ORGANIZATION (Active Duty Only)
13. MARITAL STATUS (46): Z
ADMISSION: 2100

14. FLYING STATUS (47–49): N O
15. BENEFICIARY CATEGORY (50–52): K78
16. ZIP CODE OF RESIDENCE (53–61): 09330 00000

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

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

21. TYPE OF DISPOSITION (73–74): 05
22. MTF TRANSFERRED TO (75–80):
23. DATE OF DISPOSITION (Y Y Y Y M M D D) (81–88): 20030512

24. CLINIC SVC - ADMITTING (89–92): AEAA
25. MTF TRANSFERRED FROM (93–98):
26. DATE THIS ADMISSION (Y Y Y Y M M D D) (99–106): 20030504

27. LOCATION OF OCCURRENCE (Battle Casualty Only) (107–108): IZ
28. MTF OF INITIAL ADMISSION (109–114):
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D) (115–122):

FOR LOCAL USE
DX: 8505 GJW R Kane DX:
9973 99662 E8799
5070 03819 E993
4820 78039 E9912
48282 8911
48283 88110
5185 9221
5119 1123
2762 2859
Px: 9604, 9671, 0331

Trauma
1
Injury
459

ADMITTING OFFICER (Signature): (b)(6)-2
SIGNATURE OF ADMITTING CLERK: (b)(6)-2

DA FORM 2585, MAR 2000 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

MEDCOM - 5388

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF (1–6): (b)(3)-1
MTF LOCATION (7–8) (State or Country Code.): I Q
NAME (Last, First, Middle Initial): (b)(6)-4 F
4. PAY GRADE (16–17):
5. SEX (18):
3. REGISTER NUMBER (9–15): (b)(6)-4
(b)(6)-4
6. DATE OF BIRTH (Y Y Y Y M M D D) (19–26):
7. AGE AT ADMISSION (27–29):
8. RACE (30): I
9. ETHNIC BACK-GROUND (31):
RELIGION:
10. LENGTH OF SERVICE (32–34):
ETS:
11. FMP (35–36): 9 9
12. SOCIAL SECURITY NUMBER (37–45): (b)(6)-4
ORGANIZATION (Active Duty Only):
13. MARITAL STATUS (46):
HOUR OF ADMISSION: 2100
BRANCH / CORPS:
14. FLYING STATUS (47–49): N O
15. BENEFICIARY CATEGORY (50–52):
16. ZIP CODE OF RESIDENCE (53–61):
17. UNIT LOCATION (State or Country Code) (62–63):
18. MOS (64–70):
19. TRAUMA (71): IN
PREV. ADMISSION: YEAR ☐ NO
20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION (72): Direct
WARD: ICW2
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE:
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code):
(b)(3)-1 NT FACILITY
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE:
21. TYPE OF DISPOSITION (73–74):
22. MTF TRANSFERRED TO (75–80):
23. DATE OF DISPOSITION (Y Y Y Y M M D D) (81–88): 2 0 0 3 0 5 1 2
24. CLINIC SVC - ADMITTING (89–92): A E A F
25. MTF TRANSFERRED FROM (93–98):
26. DATE THIS ADMISSION (Y Y Y Y M M D D) (99–106): 2 0 0 3 0 5 0 4
27. LOCATION OF OCCURRENCE (Battle Casualty Only) (107–108):
28. MTF OF INITIAL ADMISSION (109–114):
29. DATE INITIAL ADMISSION (Y Y Y Y M M D D) (115–122):
FOR LOCAL USE: GSW R Knee
ADMITTING OFFICER (Signature, as required): (b)(6)-2
SIGNATURE OF ADMITTING CLERK: (b)(6)-2

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF						MTF LOCATION		
1	2	3	4	5	6	7	8	(State or Country Code.)
(b)(3)-1						I	G	

3. REGISTER NUMBER							NAME (Last, First, Middle Initial)	4. PAY GRADE		5. SEX
9	10	11	12	13	14	15		16	17	18
(b)(6)-4							(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		RELIGION
19	20	21	22	23	24	25	26	27	28	29	30	31	BACK-GROUND	
											I			

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

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

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

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

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

21. TYPE OF DISPOSITION		22. MTF TRANSFERRED TO						23. DATE OF DISPOSITION (Y Y Y Y M M D D)							
73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88
								2	0	0	3	0	5	1	2

24. CLINIC SVC - ADMITTING				25. MTF TRANSFERRED FROM						26. DATE THIS ADMISSION (Y Y Y Y M M D D)							
89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106
A	E	A	F							2	0	0	3	0	5	0	4

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

FOR LOCAL USE

GSW R Knee

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

(b)(6)-4

PW)

(b)(3)-1

Ⓡ Knee GSW ; (poss 1+D done at same point)

~~Exhibited 4/19/03~~

Confirmed EPW!

Can't be released to local Hospitals.

Can be released to another Military Hospital.

(b)(6)-4

(b)(6)-4

Bed 14

(b)(3)-1

Name: ,

CHCS Name (b)(6)-4

(b)(6)-4

Date of Admission: 4/18/2003

Date of Transfer:

Prognosis: Good

History: 40's something year old Iraqi Man admited from Field Hospital with poor records, but at best as with the diagnosis as below, admitted to (b)(3)-1 Patient admitted intubated, apparently injury, unconcious and incoherent.

Hospital Course:

Admitted to ICU 2.Extubated. Abx as above. Transferred out of icu 4/21/03 to 4 For STB. Continues c Candida rash. Signed out to medicine, for primary care. Cont PT NEUROLOGY: EVAL 4/23: exam mc diffuse axonal injury. Priorities are mobilizati

Diagnoses:

1.Right knee gsw: soft tissues only, presumptively on 4/9/03; I &D'd at some point and now skin closed fracture; Sutures due out any time, week of 4/28/03.; Right arm small skin defect: dry gauze only need

2.Concussion: CT scan Brain: negative here (no prior ct done) , flat affect, probably has rue weakness All other fine. PT working with pt. 3.Pneumonia vs pulm. contusion : patient admitted intubated; extuba

4. FUO: febrile on admit: unclear source: pancultured; started on Rocephin and tobramycin, d/c'd 4/2 Extensive Intercrural Candidiasis Dermatitis with extension to perianal area, upper LE and mid back, c

Surgeries/Treatment

I&D Right knee, skin closed; date unknown

Recommendations:

1. Continue Diflucan and Nystatin for Candida dermatitis. 2. Will need PT for strengthening, probably weakness, needs rehab facility.Neurology: Priorities are mobilization, PT, rehab

SpecialNeeds: Rehab facility

(b)(6)-2

Physicia LCDR Dept of FAMILY PRACTICE

(b)(3)-1

Name: ,

CHCS Name (b)(6)-4

SSN: (b)(6)-4

Date of Admission: 4/18/2003

Date of Transfer:

Prognosis: Good

History: 40's something year old Iraqi Man admited from Field Hospital with poor records, but at best as with the diagnosis as below, admitted to (b)(3)-1 Patient admitted intubated, apparently injury, unconcious and incoherent.

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2.Concussion: CT scan Brain: negative here (no prior ct done) , flat affect, probably has rue weakness All other fine. PT working with pt. 3.Pneumonia vs pulm. contusion : patient admitted intubated; extuba

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Surgeries/Treatment

I&D Right knee, skin closed; date unknown

Recommendations:

1. Continue Diflucan and Nystatin for Candida dermatitis. 2. Will need PT for strengthening, probably weakness, needs rehab facility.Neurology: Priorities are mobilization, PT, rehab

SpecialNeeds: Rehab facility

Physician: (b)(6)-2 LCDR Dept of FAMILY PRACTICE

(b)(3)-1

CHCS Name: (b)(6)-4

Date of Admission: 4/18/2003

Date of Transfer:

(b)(6)-4 EPW

Age: Gender: M

History:

40's something year old Iraqi Man admited from Field Hospital with poor records, but at best as gathered: with the diagnosis as below, admitted to (b)(3)-1 Patient admitted intubated, apparently since day of injury, unconcious and incoherent.

Hospital Course:

Admitted to ICU 2.Extubated. Abx as above. Transferred out of icu 4/21/03 to 4 For STB. Continues care to Candida rash.
Signed out to medicine, for primary care. Cont PT NEUROLOGY: EVAL 4/23: exam most C/W diffuse axonal injury. Priorities are mobilizati

Diagnoses:

1.Right knee gsw: soft tissues only, presumptively on 4/9/03; I &D'd at some point and now skin closed; Xray here no fracture; Sutures due out any time, week of 4/28/03.; Right arm small skin defect: dry gauze only needed qd as of 4/22/03.,
2.Concussion: CT scan Brain: negative here (no prior ct done) , flat affect, probably has rue weakness, but moves it. All other fine. PT working with pt. 3.Pneumonia vs pulm. contusion : patient admitted intubated; extubated 4/19/03; off abx 4/21/03, 4. FUO: febrile on admit: unclear source: pancultured; started on Rocephin and tobramycin, d/c'd 4/21/03 5. Extensive Intercrural Candidiasis Dermatitis with extension to perianal area, upper LE and mid back, on Nystatin powder and Diflucan oral

Surgeries/Treatment:

I&D Right knee, skin closed; date unknown, ,

Recommendations:

1. Continue Diflucan and Nystatin for Candida dermatitis. 2. Will need PT for strengthening, probably has RUE weakness, needs rehab facility.Neurology: Priorities are mobilization, PT, rehab

Special Needs:

Rehab facility

Prognosis: Good

Physician: (b)(6)-2 LCDR Dept of FAMILY PRACTICE 4/24/2003

(b)(6)-2

Name: ,

CHCS Name: (b)(6)-4

(b)(6)-4 Iraqi civilian

Prognosis: Good

Date of Admission: 4/18/2003

Date of Transfer:

History:

40's something year old Iraqi Man admited from Field Hospital with poor records, but at best as gathered: with the diagnosis as below, admitted to (b)(3)-1 . Patient admitted intubated, apparently since day of injury, unconcious and incoherent.

Hospital Course:

Admitted to ICU 2:Extubated. Abx as above. Transferred out of icu 4/21/03 to 4 For STB. Continues care to Candida rash. Signed out to medicine, for primary care. Cont PT NEUROLOGY: EVAL 4/23: exam most C/W diffuse axonal injury. Priorities are mobilizati,

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1.Right knee gsw: soft tissues only, presumptively on 4/9/03; I &D'd at some point and now skin closed; Xray here no fracture; Sutures due out any time, week of 4/28/03.; Right arm small skin defect: dry gauze only needed qd as of 4/22/03.; 2.Concussion: CT scan Brain: negative here (no prior ct done) , flat affect, probably has rue weakness, but moves it. All other fine. PT working with pt. 3.Pneumonia vs pulm. contusion : patient admitted intubated; extubated 4/19/03; off abx 4/21/03; 4. FUO: febrile on admit: unclear source: pancultured; started on Rocephin and tobramycin, d/c'd

Surgeries/Treatmen

I&D Right knee, skin closed; date unknown; ;

Recommendations:

1. Continue Diflucan and Nystatin for Candida dermatitis. 2. Will need PT for strengthening, probably has RUE weakness, needs rehab facility.Neurology: Priorities are mobilization, PT, rehab

SpecialNeeds:

Rehab facility

Physician: _____

(b)(6)-2 LCDR Dept of INTMED/CARD

5/3/2003

(b)(3)-1

CASUA[illegible] RECEIVING

LINICAL RECORD

ABBREVIATED MEDICAL R[illegible]
(Sign all notes)

TRIAGE CATEGORY (Circle one)
Immediate
Delayed
Minimal
Expectant

: KBAPR03 Time: 1548 arrived on board USNS Comfort

isported by: (Circle one) Helo Boat Pier Other _____

(Circle one) LITTER AMBULATORY

E: 7 40's HEIGHT (ft' in"): _____ Weight (lbs): _____

TORY: GSW to (R) Knee ~~+ Splint~~ I+Doff (R) Knee

.ERGIES: Unknown
RRENT MEDS: was on Ropehine
ST ILLNESSES:
ST MEAL: (Date) ? (Time) _____
ents Preceding Injury: _____

TAL SIGNS	TIME	TEMP	PULSE	B/P	RESP RATE	GCS	CAP REFILL (pres/abs)
)MISSION	1548		148	174/102	~~35~~ 12	3	Pos
SCHARGE							

upils: = OR ≠ (Circle one)

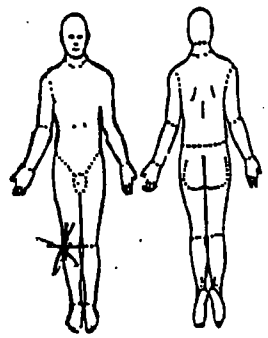
L reactive / sluggish / fixed (Circle one)
L ● ● ◉ ● ●

R reactive / sluggish / fixed (Circle one)
R ● ● ◉ ● ●

JURIES

Airway Obstruction	Yes	No
Breath Sounds	(+	-)
Hemorrhage		
Laceration		
Puncture		
Wound		
Trauma Amputation		
Concussion		
Fracture		
Dislocation		
Burn		

BURN
1° ____ %
2° ____ %
3° ____ %



LAB: Trauma Panel
Hb/Hct
Lytes/BUN/Glue
ABG
UA
T&C _____ units
Blood sputum Urine

XRAY
C-spine
CXR KUB Crosstable lateral
Abdominal RLE
IVP
Extremity
Head CT

Glasgow Coma Score (GCS)

A. Eye Opening	Points
Spontaneous	4
To voice	3
To pain	4
None	1

(Total "A") _____

B. Verbal Responses	
Oriented	5
Confused	4
Inappropriate words	3
Incomprehensible words	2
None	1

Total "B" _____

C. Motor Responses	
Obeys command	6
Localize pain	5
Withdraw (pain)	4
Flexion (pain)	3
Extension (pain)	2
None	1

Total "C" _____

IAGNOSIS:

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

Continue on reverse side

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

REGISTER NO.

WARD NO.

(b)(6)-4

(b)(6)-4

ABBREVIATED MEDICAL REC[illegible]
STANDARD FORM 539
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

MEDCOM - 5396

510-110

(b)(3)-1

CASUALTY RECEIVING

MEDICA ATMENT RECORD (*continued*)

IRWAY nasal / oral — Incubate nasal / oral 8.5 mm tube @ 26@ lock cm teeth / nares

XYGEN Room Air — Face Mask @ 12 L / min — OTHER

UBES CHEST TUBE: size / site

N/G: guaiac neg/pos NG tube (R) nares Feeding tube (L) nares

FOLEY: dipstick blood neg / pos

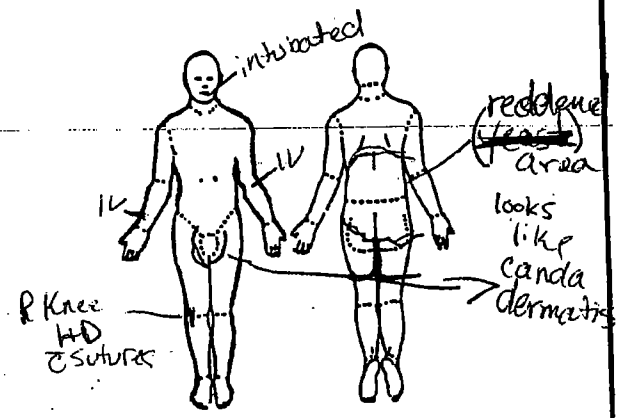
V SITES	SIZE
(R) FA (cameline)	? H/L
(L) AC (cameline)	18G

V SOLUTION	AMT INFUSED
#1 LR @ KVO	
#2	1000cc
#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

Results: (Circle one) POSITIVE NEGATIVE

OUTPUT

Chest Tube cc

Gastric cc

Foley 1000 + 1000 cc

TOTAL INTAKE cc

TOTAL OUTPUT cc

MEDICATIONS	Dose	Route	Time	Initials
Morphine				
Mefoxin				
Ancef				
Tet Tox				
Hypertet				

MEDICATIONS	Dose	Route	Time	Initials
Fentynl	1000ug	IVP	1736	RC
Propaphol	120mg	IVP	1804	RC

DATE	HOUR A.M.	HOUR P.M.	TRANSFERRED Time: to OR ICU BURN ICU WARD:
18APR02		1642	Pt to CT for head CT.
		1716	Pt return from CT. Will inspect posterior + get rectal temp. NG-Tube to LCWS.
		1739	Rectal temp 101.4
		1755	Report called to ICU. LCDR (b)(6)-2

☆ U. S. GPO: 1987-181-247/60056

MEDCOM - 5397

(Reverse)

All' gres: unknown

PATIENT PROFILE

NAVMED 6550/12 (5-80) S/N 0105-LF-206-5560

✓	ACTIVITY	DATE
✓	Bedrest	
	Bathroom Privileges	
✓	Up in chair	
	Ambulate	
	Commode	
	Needs assistance	
	Restricted to unit	
	Hospital Privileges	
	Other	

✓	BATH	DATE
	Bed bath	
	Shower	
	Tub	
	Needs assistance	
	Foley Care	

ORAL HYGIENE	DATE
Self	
Needs assistance	
Special	

DIET	DATE
NPO	
Advance Diet as tolerated	4/20

FEEDING	DATE
Self	
Needs assistance	
Gavage	

✓	VITAL SIGNS	FREQ
	Temp	q
	Pulse	q
	Resp	q
	B/P	q
	Other	
	SAO2	q1°
	Neuro	

FLUIDS
Forced to:
Restricted to:
I & O

✓	SPECIAL NOTES
	Dentures
	Speech impediment
	Language barrier
	Prosthetic device
	Visual impairment
	Blind
	Contact lenses
	Glasses
	Hearing defect
	Other

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/18		Isolation: standard	
		Weight QD	
4/18		TEDs / SCDs (B) only	
4/18		Foley to gravity	
		NG to LIS	
		Chest Tube to 20cm	
4/18		HOB ↑ 30°	
		C collar / Log Roll	
4/18		Dsg Δ's BID → iodoform	
		W→D (R) breathing, cover c	
		dry gauze, xeroform to	
		scab/chest with gauze	
4/19		pulmonary toilet → IS q2h	
		TCDB q2°	
4/18		Call MD:	
		Temp >101.5 or <98	
		Hourly UOP < 0.5cc/kg	
		MAP <60 SBP >200 DBP >110	

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/18		IV: NONE	
4/20		Keep on (R)+(L) sides most of the time. Pay attention to scraps/wounds to O2: back + buttox	
4/18		Vent:	
4/18		Titrate SAO2 93-97% using NC/FM prn	
		Spirometry x 10/1°	
		Protocols:	
4/18		Electrolyte	
4/18		Other: Enteral Feeding	

ADDRESSOGRAPH

(b)(6)-4

(b)(6)-4

DIAGNOSIS Adm 4/18
Pneumonia / Blast inj.

AGE	HEIGHT	WEIGHT

PATIENT CLASSIFICATION

OP/SPECIAL PROCEDURES
Debridement

FINDINGS:

	DATE ON	DATE OFF
SI	4/18	
VSI		
RELIGIOUS RITES		

ALLERGIES: Unknown

DATE ORD.	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
					Adm: CBC, Chem 7		
					Chem 20, ABG done		
					PT/PTT, T+C or		
					T+H x ___ units		
					PCXR done		
				4/18	Amylase/Lipase	4/19 ☑	
				4/18	UA rnu ☑		
				4/19	CXR 4/20 AM ☐		
				4/19	CBC 4/20 AM ☐		
					Daily		
				4/18	QAM CBC Chem 7		
					~~ABG, LFT's,~~		
					~~Amylase/Lipase~~		
					~~PT/PTT~~ Mg/Ca/PO4		
				4/18	PCXR (while		
					intubated		

ADDRESSOGRAPH

Allergies: Unknown

NAVMED 6550/8 (REV. 4-74) S/N 0105-LF-216-5581 PG 1 OF 2

MEDICAL RECORD | **MEDICATION ADMINISTRATION RECORD**

SCHEDULED DRUGS — MONTH APR 19 2003 — DATES GIVEN

ORDER DATE	MEDICATION- DOSAGE- FREQUENCY ROUTE OF ADMINISTRATION	HOURS	18	19	20	21	22	23	24
4/18	Zantac 50 mg IV Q8°	0600	X	(b)(6)-2	(b)(6)-2				
		1400	X		D/C		4/20		
		2200	(b)(6)-2						
4/18	Vitamin K 10 mg SQ QWM-3	0900	X		(b)(6)-2		X	X	X
4/18	Fluconazole 400 mg po BID	0900	X						
		2100	X		(b)(6)-2				
4/18	Tobramycin 425 mg IVPB Q24°	2400	(b)(6)-2						
~~4/18~~	~~Tobra~~		X	X	X	X	X	X	X
4/18	Rocephin 2 Gms Q8°	0600	X	(b)(6)-2					
		1400	X						
		2200	(b)(6)-2						
4/18	Nystatin Powder to rash BID (Creme)	0900	X						
		2100	(b)(6)-2						
4/18	NAFCILLIN 2 gm IV. PB Q4°	0400	X			(b)(6)-2			
		0800	X						
		1200	X						
		1600	X						
		2000	X						
		2400	(b)(6)-2						
4/20	albuterol / Atrovent Ud	0600			(b)(6)-2				
	CPT	1200							
		1800		RT aware of	D/C				
		000							

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		

ADDRESSOGRAPH PLATE
(b)(6)-4
(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. ICU #2

SINGLE DOSE, PRE- OP PRN & VARIABLE DOSE ORDERS SEE REVERSE

Allergies unknown

MEDICATION ADMINISTRATION RECORD 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																	
4/18	MSO4 2-6mg IV Q1° prn pain	DATE	4/19	4/20	4/21														
		TIME	1340	1845	0450														
		DOSE	2mg	2mg	6mg														
		INIT.	(b)(6)-2																
4/18	Tylenol 650mg supp pr Q6h prn Temp >101	DATE																	
		TIME																	
		DOSE																	
		INIT.																	
		DATE																	
		TIME																	
		DOSE																	
		INIT.																	
		DATE																	
		TIME																	
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		TIME																	
		DOSE																	
		INIT.																	
		DATE																	
		TIME																	
		DOSE																	
		INIT.																	

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		cl. lig mag	4/21		Pulse			Speech impediment
	Up in chair			Tub		need help			Resp			Language barrier
	Ambulate			Needs assistance					B/P			Prosthetic device
	Commode								Other			Visual impairment
	Needs assistance								Neurochecks			Blind
	Restricted to unit											Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE							Glasses
	Other			Self		FEEDING	DATE		FLUIDS			Hearing defect
✓	Encourage	4/21		Needs assistance		Self			Forced to:			Other
	OOB-chair			Special		Needs assistance			Restricted to:			
						Gavage	4/21		& O			

95

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/21		Encourage OOB to chair	PID	4/25		NS at 100cc/hr x 24°	
4/25		~~Foley to gravity~~					
4/21		PT for ambulation					
4/22		Δ dsg to (R) arm					
		Apply dry gauze					
		over small skin					
		defect. ∅ iodoform					
		∅ packing to defect					
4/25		TEDs					
4/25		Oz via NC or FM to keep					
		Sat ≥ 93%					
						Medicine	
				4/21		DZ (b)(6)-2	

ADDRESSOGRAPH

(b)(6)-4

(b)(6)-4

DIAGNOSIS

4/21 Possible chest contusion to chest GSW to (R) ~~ct~~ (R) knee

AGE | HEIGHT | WEIGHT

PATIENT CLASSIFICATION

OP/SPECIAL PROCEDURES

	DATE ON	DATE OFF
SI		
VSI		
RELIGIOUS RITES		

FINDINGS:

[redacted]

RACK

MEDCOM - 5402

ALLERGIES:

DATE ORD.	DATE RENEW	MEDICATIONS	TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
4/21		Nafcillin 2gram IVPB q6°	06 12 18 24				
4/21		Fluconazole 200mg PO BID	09 21				
4/21		Lovenox 30mg po BID	09 21				
4/21		Lidex ointment to rash on	09 21				
		back BID					
4/21		FeSO4 1 tab PO QD					
4/21		MVI 1 tab PO QD					
4/21		Folic Acid 1 tab PO QD					
4/25		Imipenem 500mg IVPB q8°	08-16-24				
4/25							
					Daily Labs		
					CBC, Chem 7, differential		

ADDRESSOGRAPH

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	4/26		Bed bath		NPO			Temp q	Q4°		Dentures
	Bathroom Privileges			Shower		Regular Diet	4/28		Pulse q			Speech impediment
	Up in chair			Tub					Resp q			Language barrier
	Ambulate			Needs assistance					B/P q			Prosthetic device
	Commode			Foley Care					Other			Visual impairment
	Needs assistance								SAO_2			Blind
	Restricted to unit								Neuro	Q4°		Contact lenses
	Hospital Privileges			ORAL HYGIENE	DATE							Glasses
	Other			Self		FEEDING	DATE		FLUIDS			Hearing defect
	OOB → chair	4/28		Needs assistance		Self			Forced to:			Other
				Special		Needs assistance			Restricted to:			
						Gavage			I & O			

DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES	DATE ORD.	DATE RENEW	TREATMENTS/SPECIAL NOTES	TIMES
4/26		Isolation: Contact		4/27		IV: D/C HF → HL	
		Weight QD		4/28		SSRI; Call Dr. (b)(6)-2	
4/26		TEDs / SCDs				(pager #972) q6° c̄	
4/26		Foley to gravity				glucose results	
4/26		~~NG to LIS~~					
		~~Chest Tube to 20cm~~					
4/26		HOB ↑ ~~30°~~ 60°				O_2:	
		C collar / Log Roll				Vent:	
4/26		Consult-Gen Surgery		4/26		Titrate SAO_2 93-97%	
						using NC/FM prn	
4/28		D/C NG / TF		4/26		Spirometry x 10/1°	
4/26		Call MD:					
		Temp > 101.5 or < 98				Protocols:	
		Hourly UOP < 0.5cc/kg				Electrolyte	
		MAP < 60 SBP > 200 DBP > 110				Other:	

ADDRESSOGRAPH

(b)(6)-4

(b)(3)-1

PERSONAL DATA PRIV ACT 1974

DIAGNOSIS

AGE	HEIGHT	WEIGHT

PATIENT CLASSIFICATION

OP/SPECIAL PROCEDURES

	DATE ON	DATE OFF
SI		
VSI		
RELIGIOUS RITES		

FINDINGS:

ALLERGIES:

i-STAT EG7+

Pt [(b)(6)-4]

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

Na_____150 mmol/L

[ ]_____3.9 mmol/L

TCO2_____21 mmol/L

iCa_____1.18 mmol/L

Hct_____28 %PCV

Hb*_____10 g/dL

*via Hct

At 37C

pH_____7.445

PCO2_____29.4 mmHg

PO2_____32 mmHg

HCO3_____20 mmol/L

BE,B_____-3 mmol/L

s[ ]*_____66 %

*calculated

At Patient Temp

pH_____7.412

PCO2_____32.3 mmHg

PO2_____38 mmHg

Patient Temp: 102.5F

FIO2_____: 30

Sample Type_: VEN

26APR03 16:56

Oper: [(b)(6)-2]

Physician:_____

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

Ver: [(b)(6)-2]

ICATIONS

---

i-STAT G3+

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

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

TCO2_____20 mmol/L

[ ]7C

P[ ]_____7.416

PCO2_____29.5 mmHg

PO2_____37 mmHg

HCO3_____19 mmol/L

BE,B_____-5 mmol/L

sO2*_____73 %

*calculated

VENOUS GAS

Sample Type_: VEN

27APR03 06:04

Oper: [(b)(6)-2]

P[ ]ician:_____

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

Ver: [(b)(6)-2]

TIME (HOURS TO BE GIVEN)	DATE OF ORDER	LABORATORY/DIAGNOSTIC TESTS EXAMINATIONS/ CONSULTATIONS	DATE SENT	DATE COMP
		Adm: CBC, Chem 7		
		Chem 20, ABG	Amylase ☒	
		PT/PTT, T+C or	Lipase	
		T+H x 2 units		
	4/26	PCXR ☒		
	4/26	Pan culture ☒		
	4/26	CT - abd/pelvis ☒		
	4/26	Transfuse 2u PRBC ☒	☒	
	4/26	Venous ABG ☒ Blood ☒		
	4/27	dilantin level ☒		
	4/27	PT consult ☐	M. [(b)(6)-2] to eval by PT	
	4/27			
	4/26	QAM: CBC Chem 7		
		ABG, LFT's,		
		Amylase/Lipase		
		PT/PTT, Mg/Ca/PO4		
	4/27	Dilantin [illegible]		
	4/26	PCXR [illegible]		
		A [illegible] [(b)(6)-2]		
	4/	[illegible] QAM		

PERSONAL DATA

MEDICAL RECORD | PROGRESS NOTES

DATE 18APR03

Critical care (continued)

CXR - bilat alveolar infiltrates metal in soft tissue on (L) in
(R) >> (L)
ETT and NG good position

CT head, CSPine (-)
(R) knee - metal, no fx
abd - NSBGP

A/P (1) post op resp failure - CXR
can pneumonia as most likely etiology
blast/ARDS less likely - temp curve
has been ↓ - Abs per order
culture - low threshold for inspection
(2) Candida - fluconazole (no IV
available per NG - add gpc cellulitis
coverage.
(3) line, A-line
(4) wound care
(5) formal MS level. hold propofol
and reval once "settled in"
(6) hold drugs other than propofol
c CNS effects if possible.
(6) vent - wean support as tolerated

(Continue on reverse side)

(b)(6)-2

REGIS

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

(b)(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

PROGRESS NOTES

DATE	
	MD PN // Gen Surg.
4/19/03.	HD # 2
1010	S: Stable overnight ↓ HR ↓ Temp.
	Extubated this Am: on O2 NC. propofol off
	now abo;
	O: Tm: 101.4° (Admit) TN: 98 HR: 120-130's
	Gen: Awake / Alert / Follows commands per RN
	+ translator
	Wounds: (R) knee: ∅ fluctuance ∅ discharge
	(R) Arm: rash burn = intact ∅ erythema
	small: defect: 1.5 cm x 1 cm
	repacked c̄ iodoform // ∅ erythema
	A/P: Multiple problems but improved dramatically
	p̄ admit. s/p Probable concussion; (R) knee GSW.
	(1) Extubated per ICU Team. On Abx =
	infection source in w/u - probable
	pneumonia. Primary management per ICU Team
	(2) Re: Soft tissue injury to (R) knee
	∅ sx of infection. ∅ Fx on film.
	Follow / monitor.
	(3) Continue DSG D to (R) Arm: ∅ sx
	of infection.
	(4) Will follow c̄ you // 1ry management
	per ICU Team. ∅ surgical issues.
	Medical issues are main issue now.

(b)(6)-2

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MEDICAL RECORD	PROGRESS NOTES

DATE 4-18-03

Critical Care

- 40ish y.o. ♂ iraqi EPW transferred here from (b)(3)-1 after sustaining shrapnel wounds ?6 sm (L) lance to (R) mean and back/Bathtubs c̄ ? Blast injury - debrided @ FST where tachycardia, febrile to 102° - Cneud c̄ Abs and transferred to (b)(3)-1 when were able to wen off vent - lower grade temps in series of Abs including Rocephin, gent, Clinda, lenofloxacin, Anet attempts @ weaning → tachypnea - never coherent (+) agitation - unable to do c̄ - transferred here.

unkn PMH / allergies

PE: WD/WN WO♂ c̄ ETT @ 23 cm @ lips

NG and DHT in nares

missing head and ext spm/muscles

BP - 110/75 R - 18 GCS - 9 T

P - 126 Sinus Sat - 99 (30%, PEEP-5 TV-750 R-12 A/C)

HEENT - as above

no lacerations, trauma, slep off noted

PERRL, ~ 4mm.

resists light in eye

Coughs c̄ suction

(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

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
Prescribed by GSA/ICMR,
FPMR (41 CFR) 101-11.806-8
509-110

PROGRESS NOTES

DATE 18 APR 03 | Critical Care (continued)

neck - Supple ⊖ JVD, nodes
tracheal deviation a thymegaly

lg. Cause rhonchi - clear sweetness
c̄ agressive suctioning - copious amounts
of brown secretions and ? old
clots

Card - RR & tachycardia

abd - soft ⊖ Hsm ⊕ BS, sc. ↓

back - extension cardial rash c̄ satellite
lesion extending from groin to back
3-4 small lacerations over back

ext - as above, large lacerations (post op)
c̄ suction ⊕ knee - small effusion (?)
no erythema

neuro - in propofol but opens eyes
and moves ⊕ side to noxious stimuli
sum moment ⊕ upper

labs: 133 | 96 - 115
4.2 | 29 \ 12/0.9 LDH - 1861
PO4 - 5.3 CK - 827 AST/ALT - 72/57
Mg - 2.2 GGT - 78
PT/PTT - 15.7/22.7 11.3 \ 10.9 / 32.1 plt - 352
inR - 1.3

STANDARD FORM 509 BACK (Rev. 11-77)

☆ U.S. GOVERNMENT PRINTING OFFICE: 1985-461-275/20017

MEDICAL RECORD	PROGRESS NOTES
DATE	CT reviewed ~ no pathology revealed,
4.18.03	no fract; heme, shift; masses.
	Currently no neurosurg issues. Rec
	normocarbia, ✓ for metabolic/toxic etiology.
	Thx for this consult!
	(b)(6)-2 (b)(6)-2 MD LCDR MC USNR

(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	LAB Results / CXR / PLAIN Films
4/18/03.	
1825	133 | 96 | 12 / 115
	4.2 | 29 | 0.9 CK: 857
	7.6 | 2.2 | 5.3 LDH: 1861
	Uric Acid 2.6 Alk Ø: 98
	AST: 72 TB: 0.7
	ALT: 57 GGT: 78
	PTT: 22.7
	PT: 15.3 INR: 1.3
	11.3 / 32.1 | 10.9 / 352
1) Cont. rest as per ICU management.	FOLLOW UP: ICU team informed of CK result
	CXR / KUB / (R) knee Film.
2) Will consult ORTHO re: any further addressing of (R) knee	KUB: shrapnel over sacrum nondilated small / large bowel suggestive of ileus. Bony / soft tissue NML
	C-Spine: NML
	CXR: (R>L) (B) airspace process pneumonic VS. contusion; ?CHF component ↑ pulm vein. small (R) pleural effusion
	(R) knee: significant soft-tissue disruption Anteriorly above patella c associated metallic foreign bodies c Fx seen.

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO.

WARD NO.

PROGRESS NOTE

STANDARD FORM 509 (Rev. 1

Prescribed by GSA/ICMR, FIRM[illegible] CFR) 201-45.505

509-111

(b)(6)-2

MEDICAL RECORD	PROGRESS NOTES

DATE

MD Admit NOTE

4/18/03. 1715

40's Iraqi man admitted from the field hospital S/P (R) knee GSW ? 4/9/03 ? ō unresponsive status (intubated) since arrival to prior facility. Pen notes → incoherent speech // S/P I + D : (R) GSW. Etiology of Head injury is unclear → ? concussion.

Pt admitted intubated; unconscious; pen notes pt. had been tried on T piece, but unable to be extubated. Pt prior on TF's, though has both Dobhoff TF + NGJ in place. Pt also likely infected ē prior temps as high as 101.8 ϕ source.

VS: 1548 HR: 148 174/102 12 GCS: 3

Gen: intubated // sedated. 101.4 rectal ϕ eye opening ϕ verbal response ϕ motor resp.

PERRL;

Heart: RRR's m lungs: occ. rhonchi on Ant Auscultation

Abd: SOFT / hypoactive BS

(R) forearm soft tissue defect? SCAB noninfected.

EXT: (R) distal THIGH proximal to knee ē Sewn laceration ϕ pus stitches in place

Foley draining clear urine

Genital: Exam c/o CANDIDA intertrigal dermatitis ō

(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

PROGRESS NOTES

DATE

4/18/03 1715

local dissemination to involve dermatitis in BACK (lower) → ↑ down legs:
Some trunkal edema.
A/P: Transfer to ICU.
① Neuro: unclear etiology of unresponsiveness = ? concussion
CT SCAN Head Here: ⊖
r/o metabolic etiologies
② CV: Hyperdynamic state: TACHYCARDIA likely 2nd to infection; stable BP's monitor.
③ Pulm: on vent (admit ABG:
7.41/42/90/26/ on 50% FiO2
✓ CXR // GOAL: Extubation.
④ GI: Was on TF's – ✓ WUB
resume TF's if tol. GI proph.
⑤ GU: Good UO. Follow LABS.
⑥ REN: monitor cyts.
⑦ ID: pancultured: source unclear
Empiric Abx: Rocephin / TOBRA.
Significant CANDIDA intercrural → CANDIDA dermatitis → Low BACK dissemination
Would start systemic diflucan IV to cover for possible candidemia.

(b)(6)-2

U.S. GOVERNMENT PRINTING OFFICE: 1990 262-081/20182 . 11-77)

(b)(6)-4

MEDICAL RECORD	PROGRESS NOTES
DATE 4/19/03	ICU
	* USNS comfort d-2
	* d-1 s/p extubation ("p̄ op pneumonia")
(meds)	* (R) knee wound
Zantac	* skin rash - candida +/- bacterial cellulitis
vit K	* (R) arm S/T defect
Fluconazole Po d-1	* potable concussion
tobramycin d-1	
Rocephin d-1	(PEX) Afeb Tm 100⁴ on arrival 4/18 @ 1800
Nafcillin d-1	P-120 120/80 Awake, responsive, some verbal
Nystatin d-1	moves all 4, sensation intact
	Neck - ok
(LABS)	lungs - poor air movement laterally + bases
12.8 / (24) ↓ / 428	RRR S SM
	~~Abd~~ N/T
134/100 / 4.0/32 / 11/0.9 / (196)	EXT (R) leg swollen / knee wound (L) = nl
Amyl 92	Skin small pustular rash groin,
Lipase (645)	red flanks (B) (cellulitis ?)
PT/PTT nl	
"acetone (+)" (?)	(1) seems stable but needs cont'd
	aggressive pulm toilet - problems listed above
(CXR)	(2) Anemia - STABLE FROM 21.00 4/18
(B) "pulm edema"	(3) ↑ lipase - ne ↓ as try to feed/
resolved - small	take sips po.
residual (R) pl.	
effusion	

(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. RN/CDR

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

PROGRESS NOTES

DATE	
	MD PN : Gen Surg
4/20/03.	HD# 3
1300	S: continues stable overnight. moving all ext. ? (R) Arm ϕ moved
	stable p̄ extubation. NOW and
	yesterday on RA c̄ SATS: 97-100%,
	O: TM: 99.6 TN: 99.6 Afebrile since
	admit on 4/18/03.
	2781/5450.
	wounds all stable ϕ signs/symptoms
	of infection.
	(R) knee: sutures intact
	ϕ erythema ϕ pus
	(R) arm: small defect: intact.
	ϕ erythema
	A/P: HD # 3: Management in ICU
	(1) Pneumonia: continue abx.
	(2) Continue drg Δ's Bid.
	(3) Wkn transfers out of ICU → to
	Medicine c̄ G.Surg. Consult
	(4) sutures (R) knee due out in another
	7-10 days.

(b)(6)-2

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MEDCOM - 5415

MEDICAL RECORD	PROGRESS NOTES

DATE 4/20/03

CCM * HD #3
* probs: see 4/19 (list)

Tm 100[8] I 2781 O 5450

Zantac 50 q8 HR 90-115 UO 60-90/h

vit K 10 sq QAM Tc 99[6] HR-120 131/78 SpO2 98 on RA

Fluconazole 400 po BID Labs (14) 27 / 588 137 / 104 / 4.1 / 27 10/0.8 / 128 P-3.3 M-2.3

Tobra 425 Q24° PEX: A+A but poorly follows

Rocephin 2g Q8° Commands - seems dazed.

Nystatin Response to painful stim → dazed look s̄ much

Natcillin 2g Q4 withdrawal. PRRL / conjug

Alb/Atrov U/CPT Lungs clear

MSO4 - prn Abd soft N/T Extr: (B) heel decubs L>R • Knee wound OK

skin erythematous cellulitis ~~looking~~

appearance 2/3 of back but sl improved on flanks. Groin = seems better

Imp: # ↑ WBC but afebrile Abx probably sufficient for cellulitis which does not seem worse

Knee + arm S/T wounds OK per surgery - leave sutures another wk

Concussion likely accounts for his neuro state

resp: ϕ issues (CXR = nl)

Pl: • Keep in ICU for wound care / observation another 1-2 d Keep on side

• DVT prophylax

(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. (b)(6)-2

MD/CDR

(b)(6)-4

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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FPMR (41 CFR) 101-11.806-8
509-110

PROGRESS NOTES

DATE 4/21/03 0905

ICU * HD # 3
* (R) knee + (R) arm soft tissue wounds
* skin rash flanks + back
* s/p probable concussion

fluconazole
tobramycin
rocephin
nystatin
nafcillin
zantac
Lovenox prophyl.
~~nafcillin~~
nystatin

(R) IJ-3L

VSS/Afeb SpO2 96 on RA HR 114

(PEX) peculiar / stunned / dumb affect c̄ me — however, was responding to translator + trying to move in bed using (B) arms earlier

lungs ~ clear
Abd N/T
(R) knee wound (R) arm dressed
flank erythema sl improved
groin rash improved.

Labs + cultures 13.4 / 27 / 909 ↔ 138 / 105 / 139 / 4.4 / 26 / 18/0.9

4/18 U/A 20-50 WBC but + bacteria
4/18 BLOOD CK → No growth so far
4/18 LDH, CK + lipase sl ↑ ; amylase nl (not repeated)
TB 0.7 (nl)

(Imp) #(1) concussion / odd affect — clearly interacts differently c̄ me, won't hold up arms, looks blankly but then responds to translator + moves on his own.

#(2) No distress / No resp issues — mild contusion or lung injury resolved

#(3) skin rash — 1° fungal ? bacterial — would cont. nafcillin + fluconazole & d/c rocephin / tobramycin p̄ another day or two. All rx was empiric based on diffuse erythematous / pustular rash suggestive of candida.

#(4) soft tissue injury — knee / arm — cont'd f/u by surgeon.

(b)(6)-2

MD/CDR

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MEDCOM - 5417

MEDICAL RECORD	PROGRESS NOTES

DATE

MD PN // Gen. Surgery

4/21/03. 1100

Ø issues

wounds OK : Ø erythema

continue dry Δ's on (R) arm

Primary flu c̄ ICU Team / once transfers to medicine for 1°= care // sutures out in 1 wk. Ø surgical issues

(b)(6)-2

4/22/03. 0930

MD PN // Gen Surg.

Recovering well. Transferred to 4 FORWARD STARBOARD. Pt to work c̄ patient

Candide dermatitis rash improving.

Transferred to medicine : Dr. (b)(6)-2

d/w Dr Potts → Ø surgical issues

- Will sign off
- (R) Arm Ø fasteners packing needed : cover c̄ dry gauze : minimal defect c̄ Ø tracking.
- (R) Knee : well healed remove sutures next week.
- If questions, contact Dr. (b)(6)-2 (I will be returning to US) (b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

PROGRESS NOTES
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PROGRESS NOTES

DATE

22APR03 P.T. NOTE

0949 S: Pnt seen by P.T. this AM. Upon arrival pnt not talkative but stared at staff.

O: Transfered pnt from supine to EOB ~~EL~~ UPT c̄ mod-max assist x1, EOB to stand pivot to W/C c̄ max assist x2. PROM performed on all major joints of (D) UE & LE.

A: Pnt does give any participation, does not apply any weight on LE during transfers. Grimaced during (L) knee ROM.

P: 1. Will see pnt QD.

2. Perform ROM, Transfer exercises

3. Progress to crutch training as mental status improves.

(b)(6)-2

HM2 (b)(6)-2

22APR03 Medical Nutrition Tx

1855 O: Per HM: ate dinner then vomited. Diet Rx: Regular

Per HM - has tolerated ENSURE s̄ vomiting.

Dx: GSW to (R) knee. Wt ≈ 70kg.

Labs 21 APR03: Hgb/Hct 9.4↓/27.3↓

A/P: Kcal needs: 30-35 kcal/kg/day = 2100-2450 kcal

Protein needs: 1.5-2.0 g/kg/day = 105-140 g/day

~~Re~~ RM Hgb/Hct ↓ - recommend offer FeSO4 + MVI c̄ fruit juice to ↑ absorption. Recommend full liquid diet + ENSURE TID to ↑ PO intake s̄ vomiting. KD to fl q̄ 2-3 days.

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

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

STANDARD FORM 509 BACK (Rev. 11-77)

☆ U.S.GPO:1984-0-421-526/124

PROGRESS NOTES

DATE	
April 24 03	– Pt admitted to ICU intubated on Vent
1335 hrs	c̄ possible chest contusion + Pleural
	effusion – CXR next day normal +
	– extubated – off vent for 6 hrs –
	– GSW to R Tertiary open
	– GSW R Knee infused — clean
	– Central line in site for IV NAFCILLIN
	2h OBA — x 4 – 7 hours
	Possible head injury + contusion –
	Does not respond appropriately always.
	– Pt on home bank & [illegible]
	may be tangent. – ? – ? Drugs ? Tegen
	– Drug + sealing [illegible] –
	on Fluconazole 200 mg IID x 4 hrs
	– Cultures pending – Afebrile
	chest clear –
	– P – 1. Cotin NAFCILLIN 2h OBA
	2. Cotin Fluconazole 200 mg BID
	3. Encourage ambulation OAB
	4. I/J.
	5. – Index BID to [illegible]. –
	6 Aircraft [illegible]

(b)(6)-2

(b)(6)-2

STANDARD FORM 509 BACK (Rev. 11-77)

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(b)(6)-4

MEDCOM - 5420

MEDICAL RECORD	PROGRESS NOTES
DATE	
April 22 03	Note BP a little high – No trend
0905 hrs	– Is having Q shift BP's –
	Continue [illegible]

(b)(6)-2

(Continue on reverse side)

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

REGISTER NO.	WARD NO.

PROGRESS NOTES
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MEDICAL RECORD	PROGRESS NOTES

DATE

23 APR 03 P.T. NOTE

Pnt transfered from supine to EOB c̄ max assist x1, EOB to w/c c̄ max assist x2. PROM performed on (B) UE and LE. Pnt just stares and does not talk nor moves. Cont. c̄ transfer and ROM exercises. staff encouraged to get pnt OOB.

(b)(6)-2

HM - USN
PT TECHNICIAN
(b)(6)-2

23 Apr 03 Neurology

40's appearing Iraqi ♂ who came to us 4/18 c̄ little Hx other than multiple trauma ~~[illegible]~~ c̄ blast injury & was probably tubed x at least 7 days c̄ failure to wean at 2 prior hospital. he was never coherent, was febrile off & on since 18 April through multiple antibiotics - he always had trouble moving R arm, Head CT some ↓ sulcal markings (−) focal & lateral (spine ok (C7-T1 not seen) On Icu he was extubated successfully. still isn't speaking to staff & won't / can't walk -

Pts Iraqi friends say he been

(Continue on reverse side)

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

(b)(6)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
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PROGRESS NOTES

DATE

(Say he's scared & he told them he won't talk to us from fear)
talking to them - nurses say he'll
squeeze their hands ok at times -
T 101 now Neck supple
MSE Hypervigilant not stuporous -
Follows some Arabic want speak commands - uncooperative
PERRL Fom = R ↓ VII (slight)
corneal - ok Gag & tongue ok
Motor - move all
4, he has 4/5 weak all 4 -
R proximal arm 3/5 - Tone is ↓ R arm
ok otherwise - PTRs are +2 except
+1 R arm Toes ↓↓ - Feels pain all 4 -

(A) Poor exam & uncooperative but
this looks to me like diffuse axonal
injury - his deficits are stable from ICH
could have some ICH Neuropathy
but has not been tubed that long -
Will repeat head CT & ✓ (b)(6)-2
CT cervical spine. If this is
ok needs PT nutrition & out of bed -
I don't see CNS infection at this point -
If doesn't move along & fever persist may need LP -
The R arm could be brachial plexus but
DAI more likely now - will have to settle out - (b)(6)-2

Fever - would w/n routinely (including central line

☆ U.S.G.P.O.: 1986-491-248/20616

STANDARD FORM 509 BACK (Rev. 11-77)

PROGRESS NOTES

DATE	
4-24-03	S. arrived on ward to access pt, lying flat
0845	in bed, roomate attempting to feed pt egg.
	Pt diaphoretic, fever 103.8, pulse 140, RR
	52. - pulse ox 88 -
	Pt. put in chair upright and suctioned
	orally c̄ lg amts. Creamy sputum obtained
	Lungs - ↓ BS bases c̄ gurgling/rhonchi
	+ lungs wet upper lung fields - pulse ox
	p̄ suction 97. O_2 on 6L/NC. c̄ pulse
	ox's at 95-96%.
	Pt taken to Xray for stat AP/LAT Chest.
0910	When lifted from chair to stool, pulse
	dizz to feet, resp brucy visible, eyes
	rolled back c̄ loss of stool. There was
	tremoring of arms + legs c̄ hard tonic/clonic
	movements. Color became dusky -
	Pt layed onto floor + code blue called.
	(b)(6)-2 FNRC

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MEDCOM - 5424

MEDICAL RECORD	PROGRESS NOTES
DATE	

1115 - 120/84 - intermittent C.P

MI @ 2yrs ago age 59

120/80

↑ C P when feeling depressed

Feeling very depressed due to loss of 3 sons. They were killed in front of him.

1125 not dizzy now

① HTN

② ↑ Lipids

(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
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MEDICAL RECORD	PROGRESS NOTES

DATE 4/24/03 1350

Critical Care:

- See prior notes for history

transferred to ward 4/21 - no notes other than Surg - went to radiology this Am → fond down c̄ loc, stool ~~[illegible]~~/urine incontinent - woke up over ~20 min - bagged briefly and given amp D50 (Bs below subsequently returned high) Probable blast injury c̄ ? CH1 - CT head/neck negative on admission but no history of coherent behavior @ FH3 or here febrile on ward to 103' this Am

Currently

BP - 110/60 100°

P - 126 R - 20

Sinus Sats 100% (3e)

PERRL, tracks objects / people walking by

opens mouth ⊕ gag / cough but not strong

neck - supple ⊕ IV in plane (put in on admission) - site ok.

Lung - CTA

Card - tacky, regular ⊖ (m)

(Continue on reverse side)

Meds

Nafcillin 2.96°

Flucanazole 200 bid

Invenox 30 bid

Index to bale

FeSO4 tid

MVI / folate

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

REGISTER NO.

WARD NO. ICU

(b)(6)-4

PROGRESS NOTES

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PROGRESS NOTES

DATE

Critical care (continued)

abd - soft ⊕ BS

back - rash less appears to be healing

CXR - during exp ↓ lung vol OW clear

ext - diffuse hyperreflexia
+4 both lower ext., stitches @ knee

nano - as above
will move both upper ext

Labs ⊕ Sputum - A-baumanii (sens - imipenem)

	1630 4/18	2151 4/18 (4/18)	4/19	4/20	4/21	(0350) 4/24	4/24
WBC	11.3	14.9	12.8	14	13.4	21.1	20.5
Hgb	10.9	9.0	8.6	9.2	9.4	11.3	10.4
Hct	32.1	25.4	24.0	27.1	27.3	32.6	30.2
pet	352	400	428	588	909	942	790

	4/18	4/19	4/20	4/21	4/24	4/24
Na	133	134	137	138	144	144
K+	4.2	4.0	4.1	4.4	4.2	5.9
Cl-	96	100	104	105	109	110
CO_2	29	32	27	26	43	15
Bun	12	11	10	18	43	51
creat	~~115~~ 0.9	0.9	0.8	0.9	1.8	2.7
gluc.	115	196	128	139	199	290 (code)

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STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 5427

MEDICAL RECORD	PROGRESS NOTES

DATE 4/24/03 1430

Critical care (Continued)

Labs (now)

~~A/P~~ ④

CK - 1538

Mg - 3.3

UA - 10

143 | 110 / 56/23
4.4 | 22 \ 339

20.5 \ 10.4 / 30.2

790 K.

Pos - 7.7

alb - 3.1

AST - 104 / ALT - 81

GGT - 139 +

UA : 1.020 / 5.0 / 30 protein)

mod bili mod Hg b

5-10 WBC 1-3 RBC

A - ① prob seizure in Radiology - etiology (seizure disorder / CHI / 2° to hypotension) not clear - hyperreflexic - new since admission (perhaps masked by propofol / sedative for vent)

- CT head
- EEG

② Renal - suspect pre renal etiology
- hydrate
- follow lytes creat

③ fever - d/c line (TLC - culture tip)
d/c hafcillin ? LP - ✓ CT
imipenem (cover accentus bonti)
flumigyl

(Continue on reverse side)

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

(b)(6)-4

Culture blood urine
CXR clear

REGISTER NO.

WARD NO. ICU

PROGRESS NOTES

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PROGRESS NOTES

DATE

4/24/03 A/P (Continued)

1430 (4) Rash - Continue fluconazole / Index

(5) metabolic acidosis - resolving
rapidly expect 2° to seizure

(6) ✓ words

(b)(6)-2

CAPT/MC

Neurology

24 Apr 03 EEG = mild gen slow $\bar{S}$ focal findings
or epileptiform activity - would
go ahead & load ≡ Dilantin
to be careful - he is going
off to parts unknown - I think
myoclonus is metabolic in origin & will improve -

(b)(6)-2 CDR MC (b)(6)-2

24 Apr 03 Critical Care:
- LP performed - opening pressure - 12 cm
clear colorless fluid, ~5cc removed and
sent to Studies
tube 1 & 4 cell count, differential
tube 3 - gram stain culture
tube 2 - protein, glucose

(b)(6)-2

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MEDCOM - 5429

MEDICAL RECORD	PROGRESS NOTES
DATE 25 Apr 03	ICU D2 POD DCI
1000	♂ Blast CHI, (R) knee ft, ? Infection bounce c̄ ? Sz, s/p ALI
?	Event - bunce, LP
Imipen	Neuro - moves 4/4, clonus on LE, closes eyes light
Fluconazole	and resists lid opening, avoids dropped hand
Lidex	to face suggestive of malingering/factitious c̄ strength
PSRI	of clonus. Likely Sz yesterday, CSF normal
Thiamine	① Dilantin ② ✓ TSH, give Bia, folate, thiamine
Folate	CV - MAP 70-80s HR 110-120s pulses 4/4 ⊕ 200 ⊕
Bia 1mg SQ	① HR stable c̄ good HNO + perfusion
D5 ½ NS @ 200	② volume via PO + 24° NS @ 100 cc/°
	Pulm - Lags CTA secr 1/3 RA 98%
	① Resolving VAP - Pulm Toilet (OOB, nebs, CPT, ICS)
	GI - ⊕ LS ⊕ BM
152 / 120 / 37 / 4.3 / 24 / 1.4 / 212	① Feed PO, pull NG, ~~[illegible]~~
(16) 9.7 / 736	FEN - lytes wnl D/C D5 + SSRI, WS to ↓ Na ↓ creat
CSF n/c	Heme - stable
slight ↑ pulse	ID - Tm 100³ WBC 16 improved
	VAP Acinobacter - Imipen SD 5/5
⊕ Feed ⊕ DVT ⊕ Gut ⊕ Td	line infxn - 3° d/c
	Stable for floor to continue Neuro evaluation

(b)(6)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

(b)(6)-4

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-77)

Prescr... GSA/ICMR,

FIR... 201-45.505

...-111

MEDICAL RECORD	PROGRESS NOTES

DATE

25 Apr 03 Neurology

Pt is now back in ICU $\bar{p}$ septic episode with a convulsive syncope ~~syncope~~. CT EEG & LP are ok (LP = Prot 45 1 WBC)

~~He has~~ His exam is still ↓ DTR strength & tone ~~all~~ 3 extremities (R arm being worst) & ↑ tone & clonus L leg - but Toes ~~↓↓~~ ↓↓ & superficial reflexes ok - not very good (b)(6)-2 cord lesion.

He is still uncooperative & I still think he can speak but won't -

(A) Puzzling. He either has ~~a~~ closed head injury + sepsis 2° unknown source (occult abcess?) + noncooperation OR he has a partial cord injury - C or T spine

- A rational approach would be to X Ray T & L Spine (& ~~to~~ get swimmers view to see C_7 - T_1) & if ~~neg~~ neg, Fix metabolic & infection, issues & mobilize with help from other Iraqis (he has

(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

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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FIR[illegible] ') 201-45.505
-111

PROGRESS NOTES

DATE

friends a world)
Would cover c̄ Dilantin
despite ~~[illegible]~~ Non epileptic EEG

(b)(6)-2 [redacted]

[illegible]

(b)(6)-2 [redacted]

26APR03 P.T. NOTE
Pnt transfered from supine to EOB c̄ mod assist x2, EOB to stand pivoting to bedside chair c̄ max assist x2. PROM performed on all joints of (B) UE and LE. Pnt ~~[illegible]~~ (b)(6)-2 still doesn't talk nor move ind. Cont P.T. QD. ——— (b)(6)-2 [redacted]

HM - USN
PT TECHNICIAN
(b)(6)-2 [redacted]

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STANDARD FORM 509 BACK (Rev. 11-77)

MEDICAL RECORD	PROGRESS NOTES

DATE 4/26/03 1215

ID consult

40 y/o c̄ GSW (B) knee + head blast/closed injury c̄ residual neuro deficits. 2 [redacted] coded + went to unit c̄ SZ + likely sepsis - blood Cx (-) thus far. Pt stabilized + sent back to the ward. Febrile yesterday to 102°F c̄ ↑WBC. Asked to consult re: fevers, ↑WBC. Pt also c̄ hx "candidal" rash + acinetobacter VAP.

O: PMHx as above

All: NKDA.

HEENT: Ø thrush. Ø nodes

Heart: RRR ≡ (M)

Lungs: Harsh BS bilat. ↓BS + fine crackles bases.

Abd: (+) NABS.

Skin: Scaling resolving rash back + groin.

Central line site (L) neck - mild TIP mild erythema

Ext: mild stage 1 on heels

Wounds (R) arm + (R) knee look ok.

Meds

Flucon 200qd 4/18-7	Imp 4/24-
Tobra 4/18-22	Iidex
CTX 4/18-22	Iovenox
Nafcillin 4/18-24	Zantac
Nystatin 4/18	Dilantin
	nebs

(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

PROGRESS NOTES
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PROGRESS NOTES

DATE

Labs

4/18 Acinetobacter baumanii Sputum - imp(S) only

4/24 urine NG

4/24 Sputum - α-strep

E coli - amik, cefox, imp(S)

4/24 CSF - NG 1 WBC 11 RBC 30 n 20 p

4/24 Sputum - E coli

4/24 - Cath tip GNR x 2, staph species.

Impressions:

40 y/o ♀ Closed head injury + GSW to (R) knee and arm. Subsequently ♀ Acinetobacter pneumonia. Now ♀ E coli pneumonia, line infection ♀ GNR + staph species. Line now out - needs 7d antibx.

Skin condition looks like resolving tinea, skin too dry, needs emollients. No evidence CNS infection

Rec: Imipenem for 8-12 more days.

Add vancomycin 1gm q 8 hrs. For staph for 5 days.

D/C fluconazole - Δ to clotrimazole cream 1% bid

D/C Nystatin S/S. - no thrush.

D/C Tidex - will worsen fungal skin conditions will follow ♀ you.

(b)(6)-2

(b)(6)-2

(b)(6)-2

LCDR, MC, USN INFECTIOUS DISEASE

(b)(6)-2

MEDICAL RECORD	PROGRESS NOTES

DATE

4/26/03 Internal Med HD #9

1315 Middle age Iraqi admitted to ICU on 18th, xfer from (b)(3)-1 3 s/p blast/shrapnel injury, intubated + sedated. He was extubated on HD #1 Abn neuro findings - blank stare, inconsistent response to commands, non-focal exam. Xfer to floor HD #4 (Apr 21) Neuro consultant (Dr (b)(6)-2 found likely diffuse axonal injury -

Seizure in radiology HD #7 (Apr 24) so back to ICU. On admit there also ↑ creat 2.7, fever, WBC 21 K. (+ Acineto ⊕ from 18th) Nafcillin A to imiperium, glucose contd. Back to Floor HD #8 (Apr 25) with Dilantin load. Continues to show altered mental status, clouds.

Now on Floor, sitting in chair until appeared to become fatigued - when being helped back to bed dosat to 70's; BP 110/ pulse 120-140. 101², 130/90, pulse up to 130's p̄ O₂ FM + Fluid boles.

EEG - diffuse slowing 5 focal or epilept. activ.

LP - nl pressure (WBC, RBC

micro - see Dr (b)(6)-2 note today.

(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
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PROGRESS NOTES

DATE

Lungs sound coarse cup on R –
RT suctioned ~60 cc tan / beige
phlegm.
Labs show Na 154 this AM.
water deficit calc:

$$\left(\begin{matrix}\text{estimated}\\ \text{current body}\\ \text{water}\end{matrix}\right)\left(\frac{Na}{140}-1\right) = .5(80\,kg)\left(\frac{154}{140}-1\right)$$

$$= 4\,l$$

@ correction rate .5 mEq Na/°, need
14/.5 = 28° to infuse 4l free water = 140 cc/°
1/2 NS bolus given for ~hypotension
+ tachycardia. Now will proceed
with 1/2 NS 100 cc/° (50 cc/° free water)
+ D5W @ ~~100~~ 80 cc/°

(430 – UOP >100/° – will A to all D5W (140 cc/°)

A/P ① pneumonia clinically –
E coli 4/24. On Imip/
now Vanc. Good suction
today, will cont.
② polymicrobial cotn tip cx of 4/24
incl GNR x 2 + staph
Will add tobramycin 5 mg/kg =
400 mg now + qD for ① + ②
③ Hypernatremia as above, Free water
④ Neuro – wassers p̄ tx TNs

(b)(6)-2

(b)(6)-2

STANDARD F

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MEDICAL RECORD	PROGRESS NOTES
DATE 26 Apr 03 1700	Transfer Note
	Pt arrived in ICU c̄ Temp 102.5 +
	RA Spoc — MAP 73, HR 127.
	Likely is febrile from infectious source (VAP,
	sacral/pelvic abscess, Abd abscess, ?).
	Recent negative LP + negative CT head. Manifests
	fecticia's + clonus type symptoms.
	Neuro — moves all 4, PERRLA, slp52
	① Dilantin
	② Tx septic physiology
	CV — MAP 73 CVP 7-9 ④ Foley urine
	① HD stable c̄ ~~[illegible]~~ mild mottling + Vspoc 66%
	during fever. will tx fever + give 500cc
	bolus and re ✓ for venSpo > 75%
13) 8.8/632	Pulm — ✓ CFR sputum for Cx
15.4/124/24	① Imipenem + Tobra + Pulm toilet
4.4/25/1.2	
~~7.45~~/29/	GI — ⊕BS soft NT ① Zantac
7.4/32/66%	FEN — ↑Na → volume
	Heme — Tx Zanity
	ID — sputum 24 Apr Ecoli Imipenem, Cefasite
	sputum 18 Apr Acrobacter Imipenem
	① Imipenem / Tobra
	② CT abd/pelvis + Sx look ③ Pan Cx

(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 (b)(6)-2

PI

ST

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509-111

MEDICAL RECORD	PROGRESS NOTES

DATE 4-27-03

0960

Critical care:

- uneventful night since arrival - tmax 1025

on arrival CXR/CT shows new lower lobe pneumonia, (R) >> (L) - pros aspiration given timing after Radiology event.

		mech:
110/70	CVP - 6-9.	½ NSS
110 sinus	I/O - 2350/2205	Invenox 30 bid
R - 18-24	T - 99.8	ZANTAC 50 98°
Sat. 96 (RA)		VAnc 1 912°
NG in place		Tobra 5 mg/kg 92.4°
looks comfortable		Dilantin 100 tid
acc. q.h		albuterol/mucinol
lungs - ↓ bs, rhonchi bilat		Imipenem 500 96°
Care - RPR		18.2 > 10.0 / 29.0
abd - soft active Bs		429 K
Stage I breakdown over buttocks/coccyx.		147 / 120 / 40 / 23 < 124 / 1.1 / 25
Clinds still persist		
Skin as above - peeling in area of pre rash		Amylase - 92
	7.42/29.5/37	lipase - 423
	(venous)	

(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

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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FPMR (41 CFR) 101-11.806-8
509-110

(b)(3)-1

MEDCOM - 5438

PERSONAL DATA PRIV ACT 1974

PROGRESS NOTES

DATE 4-27-03 Critical Care

- CT reviewed

CXR admission (B) lower lobe infiltrate (both on CT)

A/P (1) Pneumonia - concerned to aspiration (most likely) vs acinetobacter follow tumors, sputum, CXRs

(2) neuro - Chms/MS - etiology under needs further time to sort out long term prognosis

- splint/PT consult (spine films ok) (-) Shaped in canal on CT - ✓ dilantin level.

(3) Lytes - Na & mg - ↑ D5 1/2 to 150 cc/m (lungs will tolerate

(4) nutrition - Amylase/lipase - ok - Begin osmolyte HN @ 20 - ↑ to target 75-80 cc/m

(b)(6)-2

STANDARD FORM 509 BACK (Rev. 11-77)

☆ U.S. GOVERNMENT PRINTING OFFICE: 1985-461-275/20017

MEDICAL RECORD	PROGRESS NOTES

DATE

27APR03 Medical Nutrition Tx's Flu:

1135 O: Osmolite HN @ 20cc/° - goal rate = 80cc/°.

Labs 27APR03's 147↑ | 120↑ | 25↑ / 124↑ / 410 | 23 | 1.1 amylase 92, lipase 423↑.

A/P's Osmolite HN @ 80cc/° = 2035kcal + 85g protein q day

Kcal needs = 30-35 kcal/kg/day = 2100-2450kcal/day.

Protein needs = ~~grav~~ ~~rem~~ 1.2-1.4 g/kg/day = 84-98 g/day

Na⁺, BUN, glucose + lipase ↑. Recommend monitor labs c̄

Osmolite HN @ 20 cc/° prior to ↑ rate of Osmolite HN.

RD to flu q 2-3 days. (b)(6)-2 MPH, RD

(b)(6)-2 MPH, RD

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

4/27/03 ID

1200 Tm 102⁵, but less febriles, sat (b)(6)-2

Seems more comfortable than yesterday (b)(6)-2 repetitive

jerking of arms + legs.

Heart: RRR c̄ (M)

Lungs: ~~HAB~~ L. BS bilat ↓ BS (B) base c̄ crackles

Abd: (+) NABS

Groin: skin still dry / flaky.

↑ 18.1 > 10 / 29 < 429 — 25 / 124 / 1.1

4/24 blood NG

4/26 urine NG

4/26 blood NG

4/24 CSF NG

4/24 sputum

E coli - amik (S) fox mp

4/24 cath tip - e coli, CNS staph, acinetobacter

(b)(6)-4

(continue on reverse side)

first, middle;

REGISTER NO.

WARD NO.

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-77)

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509-110

(b)(3)-1

PERSONAL DATA PRIV ACT 1974

PROGRESS NOTES

DATE	
	ID (cont)
	CXR: RLL pneumonia
	CT: ∅ abscess abd.
	Imp: Probable asp. pneumonia + prior acinetobacter
Imp d3	pna.
Tobra d1	Line sepsis - ecoli, CNS + acineto - line now out
Vanc d1	Ecoli is Tobra (R) amik (S) Tinea cruris/corporis
	Rec: cont vanco for line x 7d total
	Imp x 14d total
	D/C Tobra → amikacin 15mg/kg/day.
	Clotrimazole ~~bid~~ - skin
	(b)(6)-2 [redacted] (b)(6)-2 LCDR, MC, USNR (UMO/SS) INFECTIOUS DISEASE SSN (b)(6)-2
4/28/03	Inf Dis.
0950	Pt afebrile overnight. BM x 1 today -
	no diarrhea. Still somnolent c slight
	twitching of ext.
O:	Tm Afeb.
	Heart: RRR ≡ (M)
	Lungs: Harsh BS (R)
Imp d4	Abd: (+) NABS
A~~mik~~ d1	Skin: rash better - groin.
Vanc d2	↓ 12.8 9.7 28.6 105 137 100 12 109 0.3 315 33 (over)

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STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 5441

MEDICAL RECORD	PROGRESS NOTES
DATE 4/28/03	Imp: Acinetobacter + E coli pneumonia
	E coli, Acinetobacter + Coag Neg Staph line infection
	Rec: Finish up 10 more d Imp + Amik
	Vanco x 3-5 more d
	Keep glucose ↓ 200 to improve clearance
	of bacteria by PMNs.
	(b)(6)-2 (b)(6)-2 CDR MC, USNR (UMO/SS) INFECTIOUS DISEASE (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,
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509-111

MEDICAL RECORD	PROGRESS NOTES
DATE 28 Apr 03	ICU POD DCI
?	♂ GSW RCE + S_2 + Aspirate Pneumonia
Lovenox	Event ∅
Zantac	Neuro - sedated / somnolent mves all 4
Vanco	① no sedation / analgesia
Imipenn	② ? somnolence + shaking
Dilantin 100 TID	CV - MAP 80 HR 100 s pulses 4/ (b)(6)-2 ≈ 1000
Wacl res 2 to 60	① HD stable c̄ good perfusion (b)(6)-2
Amicacin	② D/C MF
Cutanizol	Palm - RA → 100% sec ? swallow log shrink
OSM 80	① Palm Toilet (OOB chi, 3° reb) + Aux
D5 ½ NS 150	GI - ⊕BS ⊕BM diarrhea
	① D/C TF + NG → ADAT
	FEK - given K, Zeoli
	Heme - stable
	ID - Tm 100 ↑ WBC 12 ↓
	VAP Eoli → Imipenn / Amikacin
142 / 114 / 18	
3.7 / 24 / 0.9 (2400)	
12 9 405	
Dilant 10	(b)(6)-2

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

(b)(6)-4

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

(b)(6)-4

PROGRESS NOTES

DATE	
4/29/03	IP
0900	Much better today. Tm 100.4
	Sometimes orients to others, but mostly somnolent +
	disoriented
O:	Afebrile
	Heart: RRR 3 (M)
Imp d5	Lungs: CTAB
amik d2	Abd: (+) NABS
vanc d3	Ext: Ø CCE
	↓ 11.3 \ 10.2 / 383 29.4 141 / 111 / 15 104 2.6 3.4 / 26
	Imp: Acinetobacter Ecoli; pnA
	Acinetobacter, Ecoli, CNS line inf
	Rec: 9 more days Imp + Amik
	vanc d3/7 for line inf. finish 4 more d.
	(b)(6)-2
	LCDR, MC, USNR (UMO/SS) INFECTIOUS DISEASE (b)(6)-2

★U.S.GPO:1990-262-081/20173 STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 5444

MEDICAL RECORD	PROGRESS NOTES
DATE 29 Apr 03	ICU D 4 POD DOI
?	♂ GSW RLE + Aspirate pneumonia, Sz
Cuvenx	Events - ✓
Zantac	Neuro - PERRLA, moves all 4, refused to eat
Vanco	spit out food in his mouth
Imipenn	① no sedation/analgesia yet still sedated c̄
Dilantin	shaking LE and fasciculus component. Will contin
Jnch	Dilantin and allow septic picture to clear
Amacin	CV - MAP 90 HR 80-100 pulses 4/4 even HUO 150
Clotriazol	① HD stable c̄ good pertusin + HUO. Currently
	relying on PO for volume, but at current
	cooperation rate c̄ PO will likely dehydrate
	Pulm - CFR - clear lungs - shortly sec 2/3
	RA → 100%
	① Pulm toilet (OOB chair, rebs)
	GI - Reg diet Zantac ⊕BS ⊕BR (diarrhea)
141 / 111 / 15 / 3.4 / 26 / 0.8 (101)	① ?cdiff → Flagyl ?worms → Albendazole
11) 10 (383)	FEN - Lyte protocol
Dilantin 3	Heme - stable
	ID - Tm 100.5 WBC 11
	~~Vanco~~ line intact - Vanco 4/26
⊕DVT ⊕Gut	VAP - ecoli - Imipenn 4/26 Amakacin 4/25
⊕Food ⊕Tul	① May need to hydrate c̄ Amakacin if creat ↑

(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

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

520 GPO PO
Ashe 400
+1

PROGRESS NOTES

DATE	
29APR03	Medical Nutrition Tx's Plus
1000	O: Diet Rx: Regular. ø PO intake today per RN.
	Observed- breakfast tray by ward kitchen - untouched.
	Labs 29APR03 141 / 3.4 / 119 / 20 / 15 / .8 / 104
	A/P: ø PO intake. Pt. trays kept by ward kitchen
	area when passed. If pt. refuses meal, offer
	2 cans ENSURE. Please record PO intake in nursing notes.
	Labs WNL & K+ ↓ & Cl- ↑ - will monitor.
	RD to fu q 2-3 days. [redacted] MPH, RK
	(b)(6)-2 MPH, RD
	LT, MSC, USNR (b)(6)-2 (b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE 1MAY03	Ward Medicine
0 870	
Lovenox 30 qd	T/O BP 110/80 P 10 RR 16 O2 sat 99%
Zantac 50 qd	
vancolg qd	RLL wound healy
imipenem 500 q6	Chest CTA
dilantin 200 TID	ORRR.
Probs	
GSW RLL	4/30 FSBG 104 110 114
premonita	phenytoin level 6.3
SZ disorder	11.0 / 32.3 / 36.8
acinetobacter	A/P
line infection	1.) ID dg 5/7 vancoycin for line infection
	dg 7 imipenem for acinetobacter
	dg 4 amikacin + E. coli pna.
	2.) resp - cont all/unknown
	3.) SZ - disorder continue 200 TID - disorder
	goal level 10-20.
	(b)(6)-2
	(b)(6)-2 (b)(6)-2

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

PROGRESS NOTES
STANDARD FORM 509 (Rev. 11-77)
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FIRMR (41 CFR) 201-45.505
509-111

PROGRESS NOTES

DATE	
5/1/03	Awake, conversational, best he's been so far.
1030	C/O pain in his (R) leg.
O:	Afebrile VSS
	Heart: RRR
	Lungs: Hard BS (R) (L)
	Abd: (+) NABS ∅ Mass
	EXT: (R) leg wound sites OK
	(R) central line - groin 6/c 9/6
	Imp: Line infection d 5/7 vanco
	pneumonia - klebsiella d 7/14 imp + amik.
	Rec: 7 more d of imp + amik
	2 more d vanco

(b)(6)-2

LCDR, MC, USNR (UMO/SS)
INFECTIOUS DISEASE
(b)(6)-2

MEDICAL RECORD	PROGRESS NOTES
DATE	
5/2/03	ID
1025	Afebrile.
	Pt does not believe he had pneumonia. Seems untrusting/ paranoid
O:	Heart: RRR S (M)
	Lungs: CTAB
	Abd: NABS:
	Lines OR, wound (R) leg ok
	Imp: line infection diff, vanco for Staph. Pneumonia - Klebsiella very (R) day # 8/14 of imp + amik. Glycemic control good.
	Rec: cont Abx.
	(b)(6)-2 (b)(6)-2 LCDR, MC, USNR (UMO/SS) INFECTIOUS DISEASE (b)(6)-2
2MAY03	Medical Nutrition Tx F/U
1115	S: Per translator - pt. states has not eaten anything from 4/30 - 5/2 x milk (ENSURE?) this AM.
	O: Diet Rx: Regular. Per RN - pt eating 1/3 to 1/2 of meals + juice.
	Labs 2MAY: Hgb/Hct 10.6/31.1 L
	Glucose 5/1/03: 0600 = 96, 1200 = 98, 1600 = 101.
	A/P: Blood glucose levels WNL. Conflicting reports of PO intake. Recommend document PO intake in nursing notes for RD to assess. Hgb/Hct ↓, but slight improvement (Continue on reverse side) continued on back.

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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509-110

PROGRESS NOTES

DATE	
2MAY03	Medical Nutrition Tx's Flu's
1115	since 29 APR03. If pt. refuses meal or eats < 1/2 of
	meal, offer ENSURE. RD to monitor PO intake via
	nursing notes + staff interview. RD to flu q
	2-3 days. (b)(6)-2 [redacted] MPH, RD
	(b)(6)-2 [redacted] MPH, RD
	LT, MSC, USNR (b)(6)-2 [redacted]
2MAY03	Wcal mo
	s: ? pounded. (b)(6)-2 [redacted]
	o: afebrile vs
	exam: deferred.
	phys to m 5.5
	K 3.5
	Ass/ Plan 1) cont abx of live warm 1 day 6/7 vnc
	cont anitron / [illegible] for
	2) s2 diarrh - cont dilantin pneumo
	(b)(6)-2 [redacted]

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STANDARD FORM 509 BACK (Rev. 11-77)

MEDCOM - 5450

MEDICAL RECORD	PROGRESS NOTES

DATE

Ø2 May Ø3 P.T. Note

Pnt seen this P.M. for ROM of (R) LE. Pnt c/o ↑ pain upon (R) Knee extension. AROM 10° – 120°. (I) c̄ bed mobility. Will attemp to ambulate in the A.M.

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

P.T. Tech

6/3/03 ~~FP~~

1026 Asleep - Coughs occasionally

Afebrile -

Heart: RRR 3 (M)

Lungs: CTAB

Abd: (T) NABS

7.4 12.1 37.2 35.1 10 117 08

Imp: Line Infection day 7/7 vanco

Pneumonia - aspiration d 9/14 for Ecoli + acinetobacter

Rec: D/C vanco, D/C triple lumen (R) groin

Continue imipenem + amikacin x 5 more days

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

~~LCDR, MC, USNR (UMO/SS)~~

INFECTIOUS DISEASE

(b)(6)-2 [redacted]

Ø3 May Ø3 P.T. Note - Pnt lying supine in gurney upon arrival. (I) c̄ bed mobility, Required Min. (A) X1 EOB to stand c̄ walker, ambulated 27ft c/o ↑ pain (R) LE. Pnt non-compliant c̄ sitting or lying supine positioning to prevent/correct (R) Knee Ext. contractor. — (b)(6)-2 [redacted] HMC (FMF)

P.T. Tech

(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 [redacted]

REGISTER NO.

WARD NO.

PROGRESS NOTES

STANDARD FORM 509 (Rev. 11-77)

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FIRM 201-45.505

111

PROGRESS NOTES Respiratory NOTE

DATE	
26 Apr 03	RT Therapy note: Pt in low fowlers position on Partial rebreather mask.
(pre)	Sats 93% AR 10z Resp. 30. post → Sats 98%
	HR 98/19 RR 32 BS → Coarse Rhonchi c̄ ↓ bas PT
	Tol Tx well CPT not given PT
	unable to tolerate. Continue nebs
	As ordered. Xray AP + Lat Shows Clear
	However PT Sounds B/S Course and wet in R Lobe.
	Continue nebs until Xray in A.M.
	(b)(6)-2 [redacted]
30 APR 03	RT NOTE: SVN c̄ UD Albutrol via AFM given. BS
0905	Clear + ↓ Tlo. p̄ - ØΔ. spo2 98% RA — (b)(6)-2 [redacted]
3 May 03	RT NOTE: SVN c̄ UD ALBUTROL VIA MP IN SFP.
	BS Clear + ↓ Tlo p̄ FAINT INSP CRACKLES RLL. — (b)(6)-2 [redacted]

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MEDCOM - 5452

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/18/03		1820	Admit from CasRec.
		1900	ASSUMED CARE OF PT. PT ON A/C Vent. RESTING FLAT ON BED. (b)(6)-2
		1905	20 mg. of Propofol given to Pt. I.V. push by RN. (b)(6)-2 (b)(6)-2
		2015	ASSESSMENT COMPLETED. NEURO: PT. RESPONSIVE TO PAIN STIMULI. PERLA + REACTIONS BOTH EYES. MOVES (L) EXTREMITIES SPONTANEOUSLY (R) EXTREMITIES EXTENDED. CARDIO: S_1S_2, ST. c̄ B.P. 120's/80's + H.R. >120. Cap. refil x4 + Pulses x4. 8 equal. RESP PT. entubated ETT 8.5 25 cm @ Lip. Sats 100 V. A/C MODE c̄ Peep of 5 FiO_2 of 50%. P.S. of 10 + V.T. of 720. G.I.: + B.M. ABD soft to TOUCH SOME BRUISING NOTED IN RLQ. N.G. TUBE IN (R) NOSTRIL PLACEMENT CHECKED HOOKED UP TO SUCTION. FEEDING TUBE (L) NOSTRIL Ø T.F. @ THIS TIME. G.U.: FOLEY TO GRAVITY ≥100 cc/hr of clear yellow U/O. SKIN: Sutures NOTED TO (R) KNEE c̄ DRY BLOOD DRAINAGE NOTED. WARM SKIN TO TOUCH. TEMP @ 100.0°F AXILARY. DRESSING UPPER ELBOW NOTED c̄ armboard. Ø drainage REDNESS TO (L) + (R) FLANK of THORSO. BRUISING ON (L) FLANK c̄ swelling NOTED. RASH + DISCOLORATION TO back / lower back / inner thighs noted. M.O. AWARE. SWELLING TO (R) Lower Extremity +1. Slight swelling to hands + (L) lower extremity. LINES: I.V. TO (R) forearm (L) arm, T.L.C. on (L) side of NECK Ø redness/swelling noted all lines flushable. Receiving propofol @ 30 cc/hr. (50 mcg/kl/hr.). RESPIRATION SOUNDS. Equal + Clear to coarse equal chest expansion. NO ORDERS FROM M.O. given to RN @ THIS TIME.
	2040		FiO_2 ↓ 30% by M.O. (b)(6)-2
	2050		Propofol ↑ to 60 mcg/k/min. (b)(6)-2
	2050		I.V. on (L) arm removed. (b)(6)-2

Rate: 120's
Rythm: Sat.
P → R ≥ .12
QRS ≥ .12
P → P Reg
R → R Reg

NURSING NOTES
Standard Form 510
(Reverse)

CLINICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
	2055	ARMBOARD REMOVED, SOFT RESTRAINT PLACED ON (L) UPPER EXTREMITY.	
		DRESSING ON (R) FOREARM NOTED Ø DRAINAGE.	(b)(6)-2
	2100	ORDERS RECEIVED BY M.O. TO RN.	(b)(6)-2
	2130	A LINE PLACED ON (R) WRIST BY M.O. O'NEIL, LINE ZEROED.	(b)(6)-2
	2320 ~~2330~~	VENT. SETTINGS Δ TO PSV BY R.T. RESP NOW 15, P.S. 20,	
		FiO_2 30.	(b)(6)-2
4/19	0035	PT REASSESSED. VENT MODE NOW ON PSV, PT. BREATH SOUNDS	
		CLEAR — COARSE. SATS @ 100%. PT NOW RESTING HEAD	
		↑ 30° COMFORTABLY. MOVEMENT OF (L) EXTREMITIES	
		SPONTANEOUSLY NOTED. U/O of >200cc/hr. STILL CLEAR.	
		ROTATING PT IN BED @ 2°. NG TUBE STILL CONNECTED TO	
		SUCTION. PT TOLERATING WELL. Ø RESPONSE TO PAINFUL	
		STIMULI. NO OTHER Δ FROM INITIAL ASSESS.	(b)(6)-2
	0300	PT AM CARE COMPLETED. NYSTATIN CREAM PLACED ON	
		BACK + THIGHS FOR RASH. PT. TOLERATED WELL.	(b)(6)-2
	0400	PT. REASSESSED. NO Δ FROM ~~INITIAL~~ ASSESSMENT DONE @ MIDNIGHT.	
		PT. LABS OBTAINED.	(b)(6)-2
	0525	DRESSING Δ TO (R) FOREARM, WOUND PACKED W/ IODOFORM PACKING	
		STRIPS, DRY GAUZE PLACED ON TOP.	(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)*

REGISTER NO.

WARD NO.

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NURSING NOTES
Standard Form 510
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FIRMR (41 CFR) 201-45-505
510-110

(b)(6)-4

NURSING NOTES

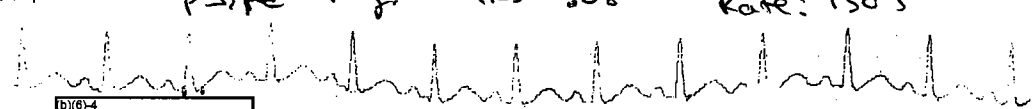
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
19APR03	—	1700	Dr (b)(6)-2 notified of pt's rigor + rash to back. ID will be consulted (b)(6)-2 [illegible]
19APR03	—	1845	ID in to assess pt's rash (b)(6)-2 [illegible]
4/19/03	—	1900	ASSUMED CARE OF PT. PT. RESTING COMFORTABLY IN BED, HOB ↑30°. PT. AWAKE + ORIENTED. (b)(6)-2
		1930	ASSESSMENT COMPLETE. NEURO: Perla reaction (+)/BRISK. PT AWAKE & and follows commands. MOVES ALL EXTREMITIES, constantly shakes LLE, M.O. aware. LIMITED MOVT TO RLE. SCD'S ON @ 45 mmHg. CARDIO. S_1S_2 ST. c̄ H.R. in 130's B.P. 140's/90's. SWELLING TO RLE. SLIGHT ON HANDS. CAP REFILL <3 SECS X4, PULSES X4 all equal in strength. RESP: Equal/bilateral chest expansion, clear breath sounds breathing in the 30's. O_2 Sats >95% breathing comfortably to R.A. G.I.: + B.S. ∅ B.M. @ THIS TIME, ON CLEAR DIET. ABD. Soft to palpation. G.U: Folley to gravity u/o of >200 c/hr. urine clear + yellow in color. Lines: T.L.C. to (L) side of neck. ∅ redness/swelling c̄ + Blood return, flushing good. Skin: Warm to touch pt. slightly sweating Temps = >100.00 & <101.0, axillary. STITCHES to (R) knee c̄ drainage noted. Dressings on (R) clavicle + (R) forearm intact ∅ drainage. Rash on back noted. Redness to both sides of Thorso noted, warm to touch. NO FLUIDS RUNNING @ THIS TIME. (b)(6)-2

[illegible]/19/03 23:58:16 HR=131 P1 =OFF P2 =OFF [illegible]

R→R = Reg P→R = .12 Rythm: S.T.

P→P = Reg QRS = .08 Rate: 130's



(b)(6)-4

HM3 [illegible]

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/19	0719		Assumed care of pt. ♂ GSW (R) knee ⊼ rash on back.
			N: responds to pain, Perrl 3mm, GCS 6T, moves (L) side
			extremities. CV: pulses x4, cap refill L3, $S_1 S_2$ BP 130/20
			HR 117 Resp: ON Vent CPAP/770/Peep15/FIO2 30/PS18
			FTT 25 @ Lip Bi lat Lung sounds CTA. ~~RBP~~ GI: BS x9 4
			Hypoactive GU: FTG good output clear yellow ∅ BM
			Skin: Wound to (R) knee, (R) forearm (R) shoulder, rash
			on back. Pressure blisters forming on both heels. Pillow
			placed to elevate off bed, but pt moves off. IV: D5 @
			125 ml/hr, propofol 60 mcg/k/mn, (L) IJ triple lumen
			A Line in (R) wrist, 21g in (R) forearm. (b)(6)-2
19 Apr	0730		~~Spontan~~ SPT breathing trial done, pt tolerated well - (b)(6)-2
19 Apr	0830		Pt extubated by RT, suction done, creamy chunky
			secreations noted, pt on humidifier mask, O_2 SAT 100%.
			HOB elevated well continue to monitor (b)(6)-2
19 APR 03	1100	—	Pt ↑ in ch. Pt does ∅ bear weight - lifted per staff.
			Tolerated well. ⊼ 1° returned to bed (b)(6)-2
19 APR 03	—	1300	Pt on RA + tol well. Mild amt shakiness to (B) LE.
			pt much more alert (b)(6)-2 WJG/A
19 APR 03	—	1500	Pt occas agitated + shaky. 2mg MSO4 IVP given IVF's
			D/C'd, VSS no Δ's in assessment (b)(6)-2 WJG/A

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
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NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			RASH COVERING BACK + BUTTOCKS AREA.
			HN (b)(6)-2 1145 20/APR/03
		1600	PT OUT OF BED SITTING IN A WHEEL CHAIR PT TOLERATING WELL. WE ARE TRYING TO GET PATIENT TO EAT REGULAR DIET. PT WILL DRINK ENSURE + APPLE JUICE AND DOES WELL. PT WILL HOLD HIS OWN CUP IN (L) HAND ONLY. PT CLAIMS HE CANNOT FEEL (R) ARM.
			HN (b)(6)-2 1800
20/APR/03		1800	END OF SHIFT REPORT. PT IS NOW BACK IN BED RESTING AT THIS TIME. PT WAS OUT OF BED FOR 2 HOURS TOLERATED WELL. SAT IN WHEELCHAIR AND DRANK HIS COOL-AID HOLDING HIS OWN CUP. PT STARTED BECOMING AGGITATED AND STARTED SWEATING A LOT. PUT PT INTO BED AGAIN W/ HN (b)(6)-2 + PO. GLASS. NEURO: PT IS AWAKE AND ALERT HAD CONVERSATION W/ TRANSLATOR. PT KNOWS WHO HE IS AND WAS ASKING ABOUT FAMILY RESPONDS TO SIMPLE COMMANDS. CARDIO: PT IS ST W/ HR: 116. B/P: 127/90 MAP: 97. PT HAS STRONG PULSES IN ALL EXTREMITIES AND + CAPILLARY REFILL. PT IS S_1S_2. PT HAS HAD A LOW GRADE TEMP 98.3 HIGHEST TEMP 100.°. RESPIRATORY: PT IS ON ROOM AIR AND SATING AT 96% LUNGS ARE A LITTLE CORSE BUT IMPROVES WITH CHEST PT AND SUCTION.. PT USUALLY COUGHS ↑ HIMSELF. GI: PT IS ON REGULAR DIET BUT DID NOT EAT DINNER. DRANK ENSURE AND JUICE INSTEAD. PT HAS + BOWEL SOUNDS IN ALL 4 QUADRENTS. GU: PT HAS FOLEY TO GRAVITY VOIDING CLEAR YELLOW URINE RD-100 CC/HR.

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
1/20/03		1130	ASSUMED CARE OF PT AT 1030 Am. PT IS RESTING WITH HOB @ 35°. PT DOES NOT SHOW ANY SIGHNS OF DISSTRESS. NEURO: PT IS AWAKE EYES OPEN. PUPILS ARE PERRLA. PT WILL FOLLOW SOME SIMPLE COMMANDS. DOES SPEAK IN HIS OWN LANGUAGE. PT DOES NOT SEEM TO BE ORIENTED AS TO PLACE OR TIME. CARDIO: PT IS ST HR: 148 B/P: 130/91 MAP: 103. PT IS S_1S_2. PT HAS A LOW GRADE TEMP OF 99.2 AT THIS TIME WILL CONTINUE TO MONITOR. PT HAS STRONG PULSES IN ALL 4 EXTREMITIES, GOOD CAPILLARY REFILL IN ALL 4 EXTREMITIES. NO EDEMA NOTED AT THIS TIME. RESPIRATORY: PT IS ON ROOM AIR SATING AT 98%. PT LUNGS ARE CORSE BUT IMPROVE WITH CHEST PT AND SUCKION IN SUCTION: THICK WHITE SS FLUID. LARGE AMOUNTS. PT OFTEN COUGHS IT UP ON HIS OWN. GI: PT IS ON A CLEAR LIQUID DIET AND SEEMS TO BE TOLERATING WELL. PT HAS + BOWEL SOUNDS IN ALL 4 QUADRENTS. HAD 1 SMALL BOWEL MOVEMENT VOIDED LIQUID ORANGE-BROWN STOOL. GU: PT HAS FOLEY TO GRAVITY VOIDING DARK YELLOW URINE 60-100 CC/HR. IV: PT HAS (L) SUBCLAVIAN TLC. NO FLUIDS AT THIS TIME. SKIN: PT HAS LARGE

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

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WARD NO. ICU #2

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(b)(6)-4

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
20APR03		2000	ENT: Pt. c rash across entire back, reddish blotches, rash extending to lateral (R)+(L) torso noted at this time, has returned wound on (R) anterior thigh. Pt SCD's removed by on coming shift. Pt resting in bed at this time VSS — HM3 (b)(6)-2 (b)(6)-2
20APR03		2015	VS to be taken q 2° as per RN LTJG (b)(6)-2 — HM3 (b)(6)-2
20APR03		2300	Pt. resting HR: 125-135 Sats 95% room air — HM3 (b)(6)-2
21APR03		0025	Pt. awake, laying on (R) side VSS, ST 122-135. shaking in (R) leg subsided. — HM3 (b)(6)-2
21APR03		0530	Pt. resting sats 98% VSS ST 133-135 beats per min — HM3 (b)(6)-2
21APR03		0555	Pt. turned over on back. HR down to 114-116, resting at this time — HM3 (b)(6)-2
21APR03		0645	Pt. awake laying in prone position VSS Sats 97% — HM3 (b)(6)-2

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
20/APR/03	Cont.		TV: (L) SUBCLAVIAN TLC ONLY USED FOR MEDS. FLUIDS: NO MAINTENCE FLUIDS SKIN: PT HAS A BAD RASH ON BACK + BUTTOCKS DR WANTS PT ON (R) OR (L) SIDE COMPLETLY AT ALL TIMES. PT HAS INCISION ON LOWR (R) LEG. SITE IS CLOSED WITH STICHES AND IS CLEAN + DRY. PT HAS A SMALL WOUND ON (R) FOREARM PACKED WITH PACKING STRIP + 4x4 ON TOP, ROLLER GAUZE TO HOLD IN PLACE.
			HN (b)(6)-2 1830 20/APR/03
20APR03	1840		Agree c̄ above documentation by HN (b)(6)-2 Pt stable & issues. Will con't to monitor (b)(6)-2 UJG/NC
20APR03	1930		Assume care of pt. pt. resting in semi fowlers position - HOB 45° Pt. A&O x3, ~~has generalized~~ has bandage on (b)(6)-2 (R) forearm from wrist to elbow, pt. moves arm, but does not flex fingers. ~~Cap refill <3 secs x4 extremities~~ (b)(6)-2 CV: Pt c̄ ST, HR 145-148, pulses +, equa and bilateral in extremities x4. Resp: 24-32 breaths per min lung sounds coarse, equal pise & fall of chest. Sats 99% on room air. GI: Bowel sounds active, abd c̄ firmness or distention o palpation. Pt. taking in food, meds PO. GU: Pt. has foley cath, draining to gravity producing normal urine out put 80-100cc urine colour yellow/amber. Neuro: Pt. A&O x3 cap refills <3se pt. has generalized continuous twitching in ~~left~~ (R) lower extremi

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

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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
21APR03	8	1630	Pt is alert, unable to determine if he understands just stares. Dsg to (R) FA CDI, (R) thigh/knee sutures CDI. Ap. neg, LS coarse throughout. no clopain @ this time. WM continue to monitor (b)(6)-2 CDR
22APR03 0200			Assumed care of patient @ 2300 ~~alert~~ ERROR vital signs stable, alert unable to determine mental status. (R) forearm dressing intact, (R) thigh/knee sutures intact. foley to gravity draining clear amber urine. (L) triple lumen central line intact. patient demonstrating fine tremors, no clo pain nor discomfort @ this time — (b)(6)-2 CDR
22APR03 0545			BP↑ 120-140s/100-110, pulse 113-120 Temp 98.6 ~~(RA)~~ ERROR, O2 SATS 95% (RA) Dr. (b)(6)-2 notified, will observe for now (b)(6)-2 CDR

Continue on reverse side

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WARD NO.

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(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/21/03	0700		Assumed PT care. PT is resting in his bed. pt is alert and awake and is trying to speak. PT has a bandaged (R) forearm which he moves and flexes fingers slightly. PT has pulses in both upper extremities with normal heart beat clear lung sounds and pupils that are reactive to light and 2mm in diameter. Bowl sounds are active. PT moves both lower extremities and has pulses in all of them. PT has a rash on his back. Also pt has foley to gravity with clear yellow urine. —— HN (b)(6)-2
21APR03	0850		Agree with above documentation by HN (b)(6)-2 Pt stable. TLC (L) subclavian HL. Pt drinking fluids. Pt wakes & is interactive trying to communicate. Will con't to monitor —— (b)(6)-2 JTJG/NC
	1200		No Δ in above assessment —— (b)(6)-2 JTJG/NC
	1350		Report called to 4 FwdS. Plan for pt transfer. Pt tolerated reg diet for lunch. VSS. —— (b)(6)-2 JTJG/NC
4/21/03			Pt received from ICU, sleepy but easily arousable. VSS, afebrile. (R) Left IJ triple lumen intact. Incision to (R) knee open to air clean dry. Dressing to (R) UE clean dry & intact MAEW. Stable will continue to monitor Rash to back —— (b)(6)-2

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NURSING NOTES
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(Reverse)

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NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/22/03		1810	back into bed & is resting well. (b)(6)-2 [redacted]
4/22/03		1810	Concur with above assessment. (b)(6)-2 [redacted]
4/22/03		2330	ASSUMED CARE OF PT. PT VS ARE STABLE
			All DRSGS C,D,I, PT IS SLEEPING AND HAS
			NO C/O PAIN AT THIS TIME WILL CONTINUE
			TO MONITOR THROUGHOUT SHIFT (b)(6)-2 [redacted]
			Rt Sided hemiparesis noted; pt unable to sit up
			independently; pash noted to have well contin to mon
			(b)(6)-2 [redacted]
23APR03		1600	ASSUMED PT CARE. V/S WNL. PT RESTING & SOCIALIZING
			IN BED. LUNG SOUNDS CTA. C&E BILATERALLY
			HEART SOUND RIR2, RRR, (+)BS. UNABLE TO
			VISUALIZE WOUNDS DUE TO DRESSINGS. (b)(6)-2 [redacted]
			ACE RANDAGE @ (R) FOREARM WILL CONTINUE TO
			MONITOR (b)(6)-2 [redacted]
23Apr03		1600	Concur with above assessment. (b)(6)-2 [redacted] ENS/NC
			Patient with flat affect. strength decreased
			generally. R>L. Patient has not verbalized anything
			on this shift. Patient is also hesitant to
			follow commands. will continue to monitor.
			(b)(6)-2 [redacted] ENS/NC

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NURSING NOTES
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(Reverse)

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/22/03		1200	Assumed pt care at 0730. Pt alert but unable to determine orientation. Pt OOB up to chair. Has productive cough c thick clear secretions. Appears unable to use RUE. Able to hold cup c left hand to drink c minimal assist. TLC to LUE, dsg CDI. Pt ate 50% of meal c total assist and prompting for swallowing. Cont to have tremors mostly to LUE and occasionally LUE. Feet are mottled, will inc. elevate LE. Hair and upper body washed. Pt has small BM. Dry flaky skin noted to buttocks and lower back. Report given to 4FP and pt transferred via wheelchair. (b)(6)-2 LVN, RN
4/22/03		1810	Assumed PM care. Lungs & heart clear to auscultate. Positive bowel sounds. T AR noted, 1176pm. PT unresponsive to verbal stimuli. Neuro checks stable, PERRLA. Rt. arm dsg. dry & intact c edema X2. Rt. knee CSW c edema X2, c/o redness or drainage. 1800 pt vomited while sitting up in W/C. PT put

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.

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NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
23 April 2003			Pt care assumed @ 2300; Pt resting in
	2300		pool of liquid brown stool; tolerated
			bath well; HR 145 2200 of clear yellow
			urine drained from foley p̄ pt turned to side
			+ 102.1 will continue to monitor (b)(6)-2
	0200		T. 100.3 will continue to monitor (b)(6)-2
	0430		T 101.3 will continue to monitor
	0640		T 101.9 Tylenol administered PR will continue
			to monitor (b)(6)-2

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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
24 April 05	0310		Pt's temp was taken @ this time & noticing pt was shivering and sweating. Pt's temp was 103.1F° axilary. Nurse was notified. 650mg tylenol PR were given to pt. High temp work up was done. Pt's temp will be reassessed in 1/2°. (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
4/24/03		1800	(CONT.) CV: ST; S1 S2 +2 PULSES TO ALL EXTREMITIES; P.V x2 (L)&(R)
			AC. RESP: LS/CL BILAT. DUMBASES SPO2 100% ON RA
			GI: NGT CLAMPED BS HYPO NO FLATUS OR BM GU: FOLEY
			TO GRAVITY DRAINING ADEQUATE AMT. OF CL/YELL URINE.
			INTEG: RASH TO BACK - APPLYING LIDEX BID BUTTOCKS
			EXCORIATED - KEEPING AREA CLEAN & DRY. WILL CONTINUE
			TO MONITOR VS/I&O q 1°. WILL ASSESS FOR PAIN/
			DISCOMFORT & TURN PT. q 2° WILL NOTIFY PHYSICIAN
			OF ANY Δ'S IN PT. CONDITION (b)(6)-2
4/24/03		2130	PCXR TO VERIFY NGT PLACEMENT. NGT IS OKAY TO USE AS
4/24/03		2200	LUMBAR PUNCTURE PERFORMED BY DR. (b)(6)-2 20mg PROPOFOL
			GIVEN. PT. TOLERATED PROCEDURE WELL. CSF SENT TO
			LAB (b)(6)-2
4/25/03		0000	ASSESSMENT UNCHANGED (b)(6)-2
4/25/03	0725		Assumed care of pt. Neuro: Pupils (5) movement also in arms but stronger in legs
			in all extremities, clonis in legs, bilat pulses
			(4) caprefill 3sec, color NFR. CV: S1 S2
			ST 1 teens to 120's. Pulm: productive
			cough c̄ secretions, pt swallows secretions.
			Lungs CBTA GI: NG tube hypoactive
			BS, Abd SNTND. GU: Foley draining
			ample amounts of clear yellow urine.
			Integ: Rash to back, GSKI to
			(R) PA & (R) thigh. Devices (L) AC 20G
			Recieved from Eng. (b)(6)-2 (b)(6)-2

CLINICAL RECORD — NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS — Include medication and treatment when indicated
4/25/03	1005		PT FROM Xray Radiology POST CODE-BLUE. PT EYES OPEN SPONTANEOUS, NOT Following Commands, pupils 3mm (4)(3). PT + fine Tremors noted To (L) LE NOTED. O2 @ 10-15L/mid VENTURI. BS (+) CTA. RR-20-24. BP 90-110/50-70. PULSES (+) X4. 18GA IN (R) ACE for IV FLUSING. HCT 100-120 SINUS TACH TEMP 100.1 (R) GI BS X4 + ABDOMEN NT, ND, S. GOO-Billy DRAINING CLEAR YELLOW M-D-O BEDSIDE. [b)(6)-2]
4/25/03	1030		LABS DRAWN, CPAP MODE, IVF D5 1/2 NS @ 150 cc/o VIA TLC IN (L) IJ. SCD PLACED ON PATIENT. PT MOVE ALL EXT'S X4 SPONTANEOUSLY + EQUAL FINE TREMORS NOTED. [b)(6)-2]
4/25/03	1100		NC @ 3-4L/mid PLACED + SATS > 95. PT + INCISION/STAPLES TO (R) THIGH AND ANKLE WRAP To (R) FA NOTED. [b)(6)-2]
4/25/03	1200		NEURO TECH @ BS for EEG. [b)(6)-2]
	1400		EEG DONE. [b)(6)-2]
	1410		PT To CT SCAN [b)(6)-2]
	1500		PT RETURNED FROM CT 2 PLEUR. + CONTACT precautions
4/25	1600		CPAP DONE, TLC WITH TIP SAT, CXR BOTH SIDES [b)(6)-2]
4/25	1700		NGT PLACED VERIFIED + LOC AIR
4/24	1900		PT. IN QUIET ICU BED NEURO: ALERT, OBEYS Commands, PERRLA, MOVES (L) SIDE EXTREMITIES. No MOVEMENT on (R) SIDE. MYOCLONUS To BLK

→ *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.

[b)(6)-4]

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4/25

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/25	0755		Pt resting $\bar{S}$ complications or signs of discomfort. (b)(6)-2 HN
4/25	0845		Pt recieved Lidex cream to Lower back & buttocks. (b)(6)-2
	1000		Pt resting $\bar{S}$ signs of pain, pt tolerating ice chips. (b)(6)-2 HN
	1000		Mo assessed pt for neuro status & function in extremities. (b)(6)-2 HN
	1100		Pt being TOW ~~to~~ about after orders are done. (b)(6)-2 HN
			Pt resting comfortably $\bar{S}$ signs of pain. (b)(6)-2 HN
4/25	1650		PT in Low Fowlers position c̄ NPC. attempted to induced sputum $\bar{S}$ results. PT instructed by interpreter to Cough pt unable. F/b Oral suctioning and nebulizer per NP. Sats 97% HR 113 RR 18. post → B/S rhonic c̄ ØA HR 128 RR 22 Sats 98%. Continue nebs as Orderd. (b)(6)-2
4/25/03	1651		Albuterol / Mucomyst Tx given early / NP. Hold 1800 Tx Tolbesume by RT. (b)(6)-2 HN (b)(6)-2

NURSING NOTES
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(Reverse)

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
25 APR 85		1630	ASSUMED PT CARE. PT RESTING IN BED V/S WNL TEMP @ 102.1 CMDR (b)(6)-2 NOTIFIED. PT REPOSITIONED TO COUGH UP SECRETIONS @ BS. LUNG SOUNDS WEAK & DIMINISHED. HEART SOUNDS NSR. RRR. HEART RATE @ 122. @ RUE WEAKENED. @ LLE WEAKENED & WEAK PULSE, WARM TO TOUCH. @ 3 SEC CAP REFILL NEURO CHECK BAD. PT STABLE WILL CONTINUE TO MONITOR. (b)(6)-2
		1630	Pt does not follow commands well. He is unresponsive to most verbal stimuli. Does withdraw to pain. Will continue to monitor lungs, neuro status. (b)(6)-2 ENS, NC
		1900	Pt to go to X-ray with 101.5 temp. CDR (b)(6)-2 told. Will give report to X-ray techs and send corpsman with pt. (b)(6)-2 ENS, NC

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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
4/26/03		1900	assumed pt care, in process of Dr. (b)(6)-2 putting NG tube in, placed after mult attempts, confirmed by auscultation and X Ray, placed in order to give CT contrast due to pt ↓ mental status - N- pt opens eyes only to painful stimuli, PERRLA 4mm, does not follow commands, lethargic, moving LLE spontaneously, clonus to BLE. Lungs - Clear Dim Bil, SpO2 95-98% on Room air thick frothy oral secretion suctioned upon pulm toilet. CV - stacky, $S_1 S_2$, CVP-11, stable BP, +2 pulse x 4 ext, gen edema to all 4 ext. GI - +BS, S, NT, ND, NGT (L) Nare NPO for CT scan of abd c̄ contrast, GU - foley to grav draining clear yellow urine. Skin - (R) LE incision s/p surgery several days ago, sutures intact, TEDS & venodynes lines - (R) Fem TLC c̄ .45 NS @ 100 cc/hr (L) wrist PIV. ~~~~ LTJB (b)(6)-2
4/26/03		2340	Pt to CT scan ~~~~ LTJB (b)(6)-2
4/27/03		0015	Pt returns from CT scan c̄ difficulty - LTJB (b)(6)-2
4/27/03	0700		ASSUMED PT CARE @ 0645. PT laying IN BED c̄ HOB @ 45°. NEURO: EYES OPEN SPONTANEOUSLY, (+) MOVEMENT X 4 c̄ ↓'D MOVEMENT TO RLE DUE TO (R) KNEE INCISION, (+) 3 STRENGTH X 3 c̄ (+) 2 TO RLE. PUPILS PERRLA c̄ 4mm PUPIL SIZES, CV: (+) $S_1 S_2$, <3 CAPREFILL, (+) PULSES X 4, CVP @ 10

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. ICU #2

NURSING NOTES
Standard Form 510
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
510-110

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/27	0700		Cont. from other side, NBP @ 104/76 c̄ ST @ 110. PT has TCDS + SCD's, c̄ minimal swelling x 4. Resp: PT on room air c̄ SATS @ 96%, R/R @ 20, LS coarse (R) sine (L) stenosis, PT Dx c̄ Pneumonia. GI: NPO, c̄ NGT @ (R) nare to suction draining lime green fluid. BS active x4, ØBM. GU: Foley draining yellow urine @ 100 cc/hr. Skin: PT has TLC (R) femoral, (L) 18 G IV heplocked in (L) wrist. PT has (R) knee incision c̄ sutures. Site looks good. Ø s/s infection, sutures intact, Ø drainage noted @ this time. — HM3 (b)(6)-2
4/27	0945		Noted stage 1 DQ on coayx, applied duoderm to site. — HM3 (b)(6)-2
4/27	1100		Osmolite HN TF started @ 20 cc/hr. ↑ Q4° to goal of 80 cc/hr. (b)(6)-2
4/27	1400		TF advanced to 40 cc/HR, Ø cc residual at this time. — HM3 (b)(6)-2
4/27	1530		D'D linen + performed mouth care c̄ glycerin swabs. — HM3 (b)(6)-2
4/27	1830		Checked TF residual Ø cc noted @ this time. TF advanced to 60 cc/hr. — HM3 (b)(6)-2
4/27/03		1900	concur c̄ HM3 (b)(6)-2 document (b)(6)-2
4/27/03		1910	Shift assesment: PT awake appears to be comfortable uncontrollable shakes. Neuro: PERRLA, pupil size 4 can obey commands but has trouble moving ext when asked. Cardio: S1 S2 RS, cap refill <4 x4 ext. (+) edma +1 x4 ext. pulses x4 ext. Resp: RA, LS coarse, demisioned in lower lobes. Coughing PT has Pneumonia. GI/GU: ~~NPO~~ (+) BS NG tube tube feeding Osmolite HN @ 60 cc Foley to gravity yellow clear urine. Skin: sutures (R) knee No signs of infection ducubicus on coayx cover c̄ duoderm ext x4 warm + dry. IV: TLC (R) fem D5 1/2 NS cont (b)(6)-2

★U.S.GPO:1990-0-281-782/20252

NURSING NOTES
Standard Form 510
(Reverse)

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
26APR03	0400		Pt was shown how to use I.S. After corpsman did it Pt did it. Pt then began to smile. Pt is resting @ this time. Will continue to monitor. — (b)(6)-2 HA
26APR03	0526		Pt incouraged to use I.S. Pt then couched up clear, white spudum. — (b)(6)-2 HA
4/26/03		0555	Nub c̄ UD Albuterol /1cc Mucamyst x 15 min. B/S clear bilat pre/post neb. CPT attempted, pt pushed hands away. Ø cough noted. Ø adverse effects noted. — (b)(6)-2 HN PT
4/26/03	0600		PT. GIVEN BED BATH @ 0300 AND GIVEN CHEST P.T. @ 0310. PT. GIVEN TYLENOL RECTALLY @ 0240. WILL CONTINUE TO MONITOR. — HN (b)(6)-2
4/26/03	0605		ASSUMED PT. CARE @ 2355. FOLEY DRAINING CLEAR YELLOW URINE. (R) THIGH STITCHES C/D/I Ø DRAINAGE, <2 CAP REFILL; BLE ARE WEAK, (+) PULSE, (+) SENSATION. DRY HEEL TO BOTH FOOT, APPLIED LOTION, PUT SOFT HEEL PAD APPLIED. 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)

REGISTER NO.

WARD NO.

(b)(6)-4

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

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
4/28/03	1630	(cont)	drink of Ensure c̄ shake of head. Assents to tea by nodding. (b)(6)-2 ENS/NC
4/28/03		1900	Assumed care, VSS, CVP 10 Pt calm, relaxed Temp 100 orally. Tylenol given. Ø verbal some mumbling Eye Perrla, CV. NSR/ST Ø ectopy noted, S1 S2 lung rhonchi noted clears c̄ rough sats 99-100% RA. ILS in use. minimal. HR 100's, JCL to (K) groin, flushes well Ø S/S infection ABX tx cont. Abd soft, (-) tender (+) BS (+) BM x 1 loose brown. (R) knee c̄ lg sutures c/p/I Ø S/S infection. (+) pulses Cont to follow (b)(6)-2
4/28/03	add.	1950	Pt ā decub c̄ tegaderm to sacral area covered. Pt c̄ visible shaking, noted to LE. Drowsy Ø seizures noted pupils, (+) reaction Dilantin as ordered (b)(6)-2
4/28/03		0000	Assessment unchanged, NAD, cont to follow ā ABX + resp Tx (b)(6)-2
4/29/03		0400	Assessment unchanged, NAD, cont to follow (b)(6)-2
4/29/03	0700		Assumed care of pt. Agree c̄ assessment from last night. Pt follows simple commands. Mumbles. Remains on RA, high 90s - 100% sats. Soft flat abd. BS x 4 quads. Foley to gravity. (b)(6)-2 ENS/NC
4/29/03		1420	Report called to ENS (b)(6)-2 (b)(6)-2 ENS/NC

★U.S.GPO:1990-0-281-782/20252

NURSING NOTES
Standard Form 510
(Reverse)

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS (Include medication and treatment when indicated)
4/28/03		1910	@ 150 cc/hr. HN [redacted]
	continue		
		1950	PT used incentive spirometer 2 deep breaths HN [redacted]
		2200	RT on (R) side. HN [redacted]
		2400	PT roll removed pt is now on back. HN [redacted]
		0544	PT am care given sheets Dsd HN [redacted]
4/28/03	0700	0700 – 1200	Assumed care of pt. Neuro: sleeps comfortably. PEARL. Has been noted to sleep most of the time. Resp: RA, sat's 100%. Rhonchi throughout. = (B) chest insp. CV: NSR. $S_1 S_2$. Strong & equal pulses x4. Cap r. fill <3s. GI: NG c TF @ 80cc/hr. D/C'd by 11am as ordered. Pt. now on reg. diet. Large BM x1. GU: Foley to gravity. 100-200cc/hr. Clear, yellow urine. Skin: Wound to (R) knee: stitches. OTA. C+D+I. Ø drainage noted. Decub. on buttocks, covered c Tegaderm. [redacted] EAS/RE
4/28/03		1500	Pt. c visible shaking of LE, (B). Dr's are aware. Pt. already on Dilantin. No seizure activity noted: Ø lip-smacking, Ø rhythmic movements of UE & LE. Pt. also noted to remain silent. Has not spoken once during shift, even when spoken to in Arabic. Neurosurgeon also aware of this issue. [redacted] EAS/DC
4/28/03		1630	Pt. OOB → chair c full assist. Pt. awake. Remains quiet. Denies → (cont)

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.

NURSING NOTES
Standard Form 510
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
510-110

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS — Include medication and treatment when indicated
			sutures intact. Bilat heels breakdown evident L >R. Areas of redness ~~Breakdown~~ to back, hips, & upper arms ~~to back hips but less today~~ but skin still intact. (R) femoral TLC to be flushed. Foley draining clear yellow urine. Lungs diminished bilat @ bases. IS used; respiratory in to do neb tx for pt. Will continue to monitor. (b)(6)-2 ENS NE
30APR03	2100		Assumed care of pt. pt V.S.S. except for ↑100.4° fever tylenol given. pt sheets changed and decubis ulcer on gluteus maximus debrided and new dressings placed. pt is in no apparent distress at this time. Will continue to monitor V.S. and pain managment. (b)(6)-2 ENS
1May03	0030		Care assumed @ 0700. Pt resting in bed. Translator page b/c pt c/o complaining but denying pain. Concerned about personal property per translator. Pt admin to be contacted by LT (b)(6)-2. Lungs slightly coarse @ bases but air transfer heard. IS used. ©BS. Foley draining clear yellow urine. R femoral TLC dressing Δ'd 30Apr by ENS (b)(6)-2 Pedal pulses palpable bilat. Pt has marked tremors in LLE esp when moved. Bilat heel decubiti R>L. Pt feet elevated on two pillows. Will continue to monitor. Dr. (b)(6)-2 to be notified of heel & buttock decubiti if not ~~awake soon~~ notified 30Apr previously (b)(6)-2
1MAY03		2252	ASSUMED CARE @ 1900. PT AOX3 FOLEY DRAWING CLEAR YELLOW URINE. VS WITHIN PARAMETERS. R FEMORAL TLC DRESSING CDI. PT FEET ELEVATED. NO COMPLAINTS. WILL CONTINUE TO MONITOR DURING SHIFT (b)(6)-2

☆ U.S. GOVERNMENT PRINTING OFFICE : 1983 O - 421-526 (2201)

NURSING NOTES
Standard Form 510
(Reverse)

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
29Apr03		1600	Transfer from ICU, received report from ENS Delcasal at 1410, arrived to ward 1450, VS: T=99.7, R=18, O_2=97% RA, BP=124/82, P=100, encouraged IS, (R) Knee sutures OTA intact no S/S infection, Circ check (R) LE WNL, Foley Cl Yel Urine, Lungs R Cl Dim / Cl Dim L, HOB ↑ 72° — (b)(6)-2 ENS, NC
		1630	PT has rash on back and neck — (b)(6)-2 ENS, NC
		1830	Dr. (b)(6)-2 paged, and is aware of rash, Temp 99.8, he will examine PT in am — (b)(6)-2 ENS, NC
			PT has ~~bre~~ skin breakdown on back, (R) Knee +2 edema, decub on sacral area, legs have tremors and MD is aware, patch of hair on scalp c̄ exudate — (b)(6)-2 ENS
30Apr03	0240		Pt awake + appears aggitated. HOB @ 70°. VSS Pt had BM @ this time. Post cleanup, pt calm + resting. Folley drawing clear yellow urine Sacral area c̄ stage II ulcers covered c̄ duoderm @ this time. (R) LE stitches intact open to air @ this time. Will continue to monitor — ENS (b)(6)-2 NC
~~29~~ 30Apr03	0900		Assumed care @ 0700. Pt had bought of diarrhea - brown & odorless. Pt has stage 2 to 3 decubitus ~~to A~~ c̄ surrounding, breakdown to sacral area. Duoderm applied to sacral area & upper buttocks bilat. R thigh

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

REGISTER NO. | WARD NO.

(b)(6)-4

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

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
5/2/03		1250	RT NOTE: SVN c̄ VO Albuterol via MP in SFP. BS c̄ - Clear tho ↓ bibasilar. Strong NPC. VSS. (b)(6)-2 [redacted] HRI
5/2/03		1330	Assumed care 1000 PT no c/o pain, am care, Δ duoderm sacral area stage II ulcer cleaned c̄ NS, TLC drsg intact, Lung R Cl/Dim Cl/Dim L, (R) knee sutures ⊖ TA intact, HOB ↑ 72°, PT able to adjust self in bed, refused to stay off back, both feet elevated to keep heels off bed, blister on (R) heel (b)(6)-2 [redacted] EAS
5/2/03		1810	SVN c̄ VO Albuterol via MP in HFP. BS - Clear tho, ↓ bibasilar. Spo2 98% RA (b)(6)-2 [redacted] HRI
5/2/03		2250	Pt. sleeping with complaint. VSS, UOP - 700 cc. (R) Knee sutures - clean, dry & intact. HOB ↑ 72°. Cont. to monitor (b)(6)-2 [redacted] NC
5/3/03		1415	SVN c̄ VO ALBUTEROL VIA MP IN WHEELCHAIR. BS - Clear tho NPC. IS x10 (b)(6)-2 [redacted] HRI

NC
03 May 03
NFE (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)

REGISTER NO.

WARD NO.

NURSING NOTES
Standard Form 510
General Services Administration and Interagency Committee on Medical Records
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510-109

CLINICAL RECORD	NURSING NOTES (Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
03May03		1540	Care assumed @ 0700. Pt resting in gurney. Per order pt to be moved to regular bed, have pt consult, & be OOB to chair TID. Pt had BM this AM. Foley draining clear dk yellow urine. Duoderm to buttocks D'd. Ø advancement in break down noted. Sacral area to approx center of buttocks covered. R hip has stage I breakdown. Covered c duoderm. Peripheral IV placed. R femoral IV to be D/C'd. Lungs CTA bilat. RLE thigh sutures intact. Circ/neuro WNL except pt has tremors with extensive movement of extremity. Pt is to see pt this PM. Currently resting. VS WNL. Will continue to monitor. — (b)(6)-2 NB NC
04May	1005		Care assumed @ 0700. Pt resting in bed. Lungs CTA bilat. VS WNL, chest expans symmetric. Ø N/V this am. R AC IV infiltrated. New site to be established & medication restarted. Foley draining clear yellow urine. R femoral TLC removal site covered c gauze CDI. Femoral & pedal pulses palpable. Pt has movement & sensation to all extremities. Tremors noted in bilat LE. Sacral & buttock decubiti covered c duoderm. RLE thigh sutures intact. Pt to be trans today. — (b)(6)-2 NB NC

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
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510-109

ICU ADMISSION ORDERS
(Circle appropriate order)

1. **Admit to ICU: Date/Time** 2020 18 Apr 03
2. **Admitting physician** (b)(6)-2
3. **Diagnosis:** Pneumonia / blast injury
4. **Procedures:** debridment
5. **Condition:** SL VSL
6. **Allergies:** unknown
7. **Isolation:**
   - Standard — All patients
   - Airborne — Small pox, Measles, Varicella, Pulmonary tuberculosis, unknown.
   - Droplet — Pneumonic plague, Meningococcus, Influenza
   - Contact — MRSA, Viral hemorrhagic fevers
8. **Nursing:**
   - Vital Signs (BP, Pulse, Temp, SAO2,) every hour
   - **Call MD** — **Temp >101.5 or <98**; **Hourly Urine Output < 0.5 cc/kg**; **MAP < 60 or SBP >200 or DBP >110**
   - Neuro checks
   - Weight QD
   - Teds/SCDS — (R) only
   - Foley to gravity
   - NG to LIS
   - Chest tube to -20cm H20 pleurovac
   - Head of Bed elevated to 30 degrees
   - C-spine collar and log roll
   - Incentive Spirometry 10reps Q1hr
9. **Diet:** NPO
   - Clear liquids
   - Regular
   - Advance as tolerated
10. **Activity:** Bed rest
11. **IVF:** LR at _____ cc/hr or D5/NSS at 125 cc/hr.
12. **Radiology:** CXR on admission and QAM (while intubated)

(b)(6)-2

CAPT/MC/USN

(b)(6)-4

4/10/03

MEDCOM - 5480

13. **Labs:**

done Mg PO4

On admission to ICU: CBC, Chem7, Chem 20, ABG, PT/PTT, Type/Cross **or** Type /Hold ____units

QAM : CBC Chem 7 ABG A

LFTs Amylase/Lipase x 1 day (Am 4/19)

PT/PTT Mg/Ca/PO4

14. **Oxygen:** Titrate to SpO2 93-97% using nasal cannula, face mask prn

Ventilator protocol

15. **Meds:** Ancef 1gm IVPB Q8hrs x 6 doses

Vancomycin 1gm IV Q12hrs (if PCN allergic) x 4 doses

Mefoxin 1gm IV Q8hrs x 6 doses

Heparin 5000 units SQ BID

Prilosec 40mg slurry NG/po QD or Zantac 50mg IV q 8

PRN: Morphine sulfate 2-6mg IV Q 1hr prn pain

Ativan 1-2mg IV Q 1hr prn agitation

Tylenol 650mg supp pr Q6hr prn Temp >101

Benadryl 25 mg IV/P0 Q 4hrs PRN itch

Phenergan 12.5mg to 25mg P0/IV Q4hrs PRN nausea

Vistaril 12.5mg 25mg P0 Q4hrs PRN nausea

UA - Send please.

16. **MISC.**

- Vitamin K+ 10mg SQ 9Am x 3 days
- Fluconazole 400mg po via NG tube BID

Tobramycin 425 IVPB q24°

Rocephin 2 grams q8°

Nystatin powder to rash

propofol infusion - titrate to Ramsey 2-3

dressing Δ's bid - iodofin wet → dry (B) forearms

Cover ō dry gauze, xerofin to scab/Cover with gauze

(b)(6)-2

4/18/03 @ 2130

Faxed 3 NOKA

Protocols

Burn

Insulin IV drip

Heparin IV drip

Electrolyte

Insulin Subcutaneous sliding scale

Enteral Feeding

(b)(6)-4

(b)(6)-2

PAL #7

CAPT/[illegible]

(b)(6)-4

ICU ADMISSION ORDERS
(Circle appropriate order)

(b)(6)-2

1. **Admit to ICU: Date/Time** 4/24/03 1000
2. **Admitting physician** (b)(6)-2
3. **Diagnosis:** dam in Radiology
4. **Procedures:** (-)
5. **Condition:** SL VSL
6. **Allergies:** CODEINE
7. **Isolation:**

Standard	All patients
Airborne	Small pox, Measles, Varicella, Pulmonary tuberculosis, unkno
Droplet	Pneumonic plague, Meningococcus, Influenza
Contact	MRSA, Viral hemorrhagic fevers

8. **Nursing:**
   - Vital Signs (BP, Pulse, Temp, SAO2,) every hour
     - **Call MD**
       - **Temp >101.5 or <98**
       - **Hourly Urine Output < 0.5 cc/kg**
       - **MAP < 60 or SBP >200 or DBP >110**
   - Neuro checks
   - Weight QD
   - Teds/SCDS
   - Foley to gravity
   - NG to LIS
   - Chest tube to -20cm H20 pleurovac
   - Head of Bed elevated to 30 degrees
   - C-spine collar and log roll
   - Incentive Spirometry 10reps Q1hr
9. **Diet:** NPO
   - Clear liquids
   - Regular
   - Advance as tolerated
10. **Activity:** Bed rest
11. **IVF:** LR at _____cc/hr or NSS at 150 cc/hr.
12. **Radiology:** CXR on admission and QAM (while intubated)

(b)(6)-2

(b)(6)-4

(b)(6)-2

MEDCOM - 5482

1/24/03

13. **Labs:** K6, Mg+ (b)(6)-2

On admission to ICU: CBC, Chem7, Chem 20, ABG, PT/PTT, Type/Cross or Type /Hold ____units

QAM: CBC Chem 7 ABG (b)(6)-2

LFTs Amylase/Lipase

PT/PTT Mg/Ca/PO4

14. **Oxygen:** Titrate to SpO2 93-97% using nasal cannula, face mask prn (b)(6)-2

Ventilator protocol

15. **Meds:** Ancef 1gm IVPB Q8hrs x 6 doses

Vancomycin 1gm IV Q12hrs (if PCN allergic) x 4 doses

Mefoxin 1gm IV Q8hrs x 6 doses

Heparin 5000 units SQ BID

Prilosec 40mg slurry NG/po QD or Zantac 50mg IV q 8

PRN: Morphine sulfate 2-6mg IV Q 1hr prn pain

Ativan 1-2mg IV Q 1hr prn agitation

Tylenol 650mg supp pr Q6hr prn Temp >101

Benadryl 25 mg IV/P0 Q 4hrs PRN itch

Phenergan 12.5mg to 25mg P0/IV Q4hrs PRN nausea

Vistaril 12.5mg 25mg P0 Q4hrs PRN nausea

16. **MISC.**

~~Flucinazole~~

EEG / CT head (non con) (b)(6)-2

UA

Protocols

Burn

Insulin IV drip

Heparin IV drip

Electrolyte

Insulin Subcutaneous sliding scale

Enteral Feeding

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

4/24/03 1720

ICU ADMISSION ORDERS
(Circle appropriate order)

1. **Admit to ICU: Date/Time** 20 Apr 05 1645
2. **Admitting physician** [redacted]
3. **Diagnosis:** Pneumonia
4. **Procedures:** ø
5. **Condition:** SL VSL
6. **Allergies:** ø
7. **Isolation:**
   - ~~Standard~~ — All patients
   - Airborne — Small pox, Measles, Varicella, Pulmonary tuberculosis, unknown.
   - Droplet — Pneumonic plague, Meningococcus, Influenza
   - Contact — MRSA, Viral hemorrhagic fevers

   Aerosolization [redacted]
8. **Nursing:**
   - Vital Signs (BP, Pulse, Temp, SAO_2,) every hour [redacted]
   - **Call MD**
     - **Temp >101.5 or <98**
     - **Hourly Urine Output < 0.5 cc/kg**
     - **MAP < 60 or SBP >200 or DBP >110**
   - Neuro checks [redacted]
   - Weight QD
   - ~~Teds/SCDS~~ [redacted]
   - ~~Foley to gravity~~ [redacted]
   - ~~NG to LIS~~ [redacted]
   - Chest ~~tube to~~ -20cm H_2O pleurovac
   - ~~Head of Bed elevated to 30~~ 60 degrees [redacted]
   - C-spine collar and log roll
   - Incentive Spirometry 10reps Q1hr
9. **Diet:** NPO
   - Clear liquids
   - Regular
   - Advance as tolerated [redacted]
10. **Activity:** ~~Bed rest~~ [redacted]
11. **IVF:** LR at _____cc/hr or ~~1/2 NS~~ at 100 cc/hr. 500 cc IV NS bolus [redacted]
12. **Radiology:** CXR on admission and QAM (while intubated) [redacted]

[redacted]

PERSONAL DATA PRIVACY ACT 1974

[redacted]

[redacted]

MEDCOM - 5484

13. **Labs:**

Amylase, Lipase

On admission to ICU: CBC, Chem7, Chem 20, ABG, PT/PTT, Type/Cross **or** Type /Hold ____units

QAM: CBC | Chem 7 | ABG

LFTs | Amylase/Lipase

PT/PTT | Mg/Ca/PO4

Pan Cx

14. **Oxygen:** Titrate to SpO2 93-97% using nasal cannula, face mask prn (b)(6)-2

Ventilator protocol

15. **Meds:** Ancef 1gm IVPB Q8hrs x 6 doses

Vancomycin 1gm IV Q12hrs (if PCN allergic) x 4 doses

Mefoxin 1gm IV Q8hrs x 6 doses

Heparin 5000 units SQ BID — Lovenox 30mg SQ BID (b)(6)-2

Prilosec 40mg slurry NG/po QD or Zantac 50mg IV q 8

PRN: Morphine sulfate 2-6mg IV Q 1hr prn pain

Ativan 1-2mg IV Q 1hr prn agitation

Tylenol 650mg supp pr Q6hr prn Temp >101 (b)(6)-2

Benadryl 25 mg IV/P0 Q 4hrs PRN itch

Phenergan 12.5mg to 25mg P0/IV Q4hrs PRN nausea

Vistaril 12.5mg 25mg P0 Q4hrs PRN nausea (b)(6)-2

16. **MISC.** Vancomycin 1gm IV Q12° (b)(6)-2

Imipenum 500mg IV Q8° (b)(6)-2

Tobramycin 5mg/kg IV 7 first now (b)(6)-2

CT - Abd/pelvis for abscess pockets

Consults - Gen Surgery (b)(6)-2 (b)(6)-2

↳ Is his/but/pelvis source Infection

Tx 2 units PRBC (b)(6)-2

Venous AsG p̄ Blood

Motrin 500mg po prn fever Q8° (b)(6)-2

Dilantin 100mg IV TID (b)(6)-2

Albuterol/Mucomyst/25% NaCl neb Q6° (b)(6)-2

Protocols

Burn (b)(6)-4

Heparin IV drip

Electrolyte

Insulin Subcutaneous sliding scale (b)(6)-2

Enteral Feeding (b)(6)-2

WG to LIS

(b)(3)-1

PERSONAL DATA PRIV ACT 1974

(b)(6)-4

(b)(6)-4

UDR/L
4/26/03

TRANSFER TO WARD O[illegible]DERS
(Circle appropriate order)

1. **Admit to** S Dest **on DATE/TIME** 29 Apr 03
2. **Admitting physician** (b)(6)-2
3. **Diagnosis:** Aspiration Pneumonia
4. **Procedures:**
5. **Condition:** SL VSL STABLE
6. **Allergies:** NKA
7. **Isolation:** Standard — All patients
   Contact — MRSA, Viral hemorrhagic fevers Aerobic
8. **Nursing:**
   Vital Signs (BP, Pulse, Temp,) every four hours
   Call MD **Temp >101.5 or <98**
   Hourly Urine Output < 0.5 cc/kg
   MAP < 60 or SBP >200 or DBP >110
   Weight QD
   Neuro checks
   Teds/SCDS
   Foley to gravity
   NG to LIS
   Chest tube to -20cm H20 pleurovac
   Head of Bed elevated to 30 degrees — keep in stretcher HOB ↑ + 72°
   C-spine collar and log roll
   Incentive Spirometry 10reps Q1hr
9. **Diet:** NPO
   Clear liquids
   Regular
   Advance as tolerated
10. **Activity:** Bed rest
    Out of bed with assistance
    Ad Lib
12. **IVF:** LR at ____cc/hr **or** _____ at _____cc/hr. Or Heparin Lock

25 Apr 03 1620

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-2

(b)(6)-4

11. **Labs:** + Dilantin level Q AM

QAM: ~~CBC~~ Chem 7 ABG

LFTs Amylase/Lipase

PT/PTT Mg/Ca/PO4

(b)(6)-2

13. **Radiology:**

(b)(6)-2

14. **Oxygen:**

(b)(6)-2

15. **Meds:** Ancef 1gm IVPB Q8hrs x 6 doses total

Vancomycin 1gm IV Q12hrs (if PCN allergic) x 4 doses total

Mefoxin 1gm IV Q8hrs x 6 doses total

Heparin 5000 units SQ BID

Prilosec slurrey 40mg NG/po QD or Zantac 50 mg IV q 8 hrs

PRN: Morphine sulfate 2-6mg IV Q 1hr prn pain

Ativan 1-2mg IV Q 1hr prn agitation

Tylenol 650mg supp pr Q6hr prn Temp >101

Benadryl 25 mg IV/P0 Q 4hrs PRN itch

Phenergan 12.5mg to 25mg P0/IV Q4hrs PRN nausea

Vistaril 12.5mg 25mg P0 Q4hrs PRN nausea

16. **MISC.**

(b)(6)-2

Lovenox 30mg SQ BID

Zantac 50mg IV Q8°

Vancomycin 1gm IV Q12°

Imipenem 500mg IV Q8°

Albuterol 1 q4 QID +prn

Amikacin 15mg/kg Q24°

Flagyl 500mg po/IV Q8°

Dilantin 200mg IV TID

29 Apr 03 1620

(b)(6)-2

(b)(6)-4

(b)(6)-2

0910
Code radiology pm 9

CODE BLUE

NURSING DOCUMENTATION SHEET

(b)(6)-4

DATE: 24 Apr 03 | DIAGNOSIS: resp arrest | LOCATION — UNIT/ROOM #: CSRRC bay 9 | PAGE #___ OF #___

PATIENT PLATE

EMERGENCY ROOM ONLY — RESCUE SQUAD ARRIVAL
MODE OF RESUSCITATION ☐CPR ☐THUMPER
AIRWAY MANAGEMENT ☐ET ☐EOA ☐N/A
SIZE
O2 THERAPY ☒AMBU ☐MASK
ADDITIONAL EQUIPMENT ☐MAST ☐C-COLLAR ☐BACKBOARD ☐OTHER ___
THERAPY — SITE LAC 18G FLUID/RATE LR@999
MEDS PRIOR TO ARRIVAL
none

☐WITNESSED — DESCRIBE PRECIPITATING EVENTS AT THE TIME OF ARREST
☒UNWITNESSED
pt in radiology when code blue called, pt found on floor, bagging commenced approx 0910, transferred pt to csrrc bay 9 on gurney
AIRWAY MANAGEMENT ☐ORAL ☒BAG/MASK ☐ET ☐TRACH ☐OTHER
INTUBATION
TIME ___
SIZE ___
CM ___
(LIPLINE) ___
INTUBATION BY
☐ANESTHESIOLOGIST
☐INTERN/RESIDENT
☐ATTENDING PHYSICIAN

NOTIFIED ☒ATTENDING PHYSICIAN TIME 0910 DV.
TIME RESPONDED ___
☐FAMILY/TIME ___ BY ___ N/A
☐ME/TIME ___ N/A
PERSONAL BELONGINGS TO
ER ONLY
☐POLICE/TIME ___
☐POLICE N/A

(b)(6)-2

TIME	BP	HR	R	PRE TX CARDIAC RHYTHM	DEFIB JOULES	DRUGS NAME/DOSAGE/ROUTE	IV INSERTION SITE/SOLUTION/RATE	POST TX CARDIAC RHYTHM	ABG ✓
0920		144					LAC 18G LR 999		✓
0922	82/29	141	22			1 amp D50	LAC		
0924									
0927							RAC 18G LR 999		
0929									
0930									
0931									
~ 22									
0933	89/59	134	24						

TIME	HR/PR	SYS	DIA	MEAN	SpO2
HH:MM	BPM	SYS-mmHg	DIA-mmHg		%
09:31	134	93	68	68	100
09:30	134	92	61	74	100
09:29	132	89	59	67	100
09:28	132	103	53	67	100
09:26	130	38	54	68	100
09:26	131	87	53	62	100
09:24	132	92	58	68	100
09:24	131	90	58	68	100
09:20	141	82	29	50	100

(b)(6)-4

PROGRESS NOTES (PROCEDURES/TX/RESPONSE)
hr 144, LR hung B/P
pox 100% via ambu - GCS-3
Pt incontinent of stool, foley placed
lung sounds auscultated clear bilat, abd BS heard
BG obtained — 307
positive corneal reflex
pt awake & responsive - eyes open
GCS-12

PROTOCOL SYSTEMS, INC.

☐EXPIRED — TIME PRONOUNCED
OUTCOME
☐TRANSFERRED TO TIME
☐PATIENT REMAINS IN UNIT
POST CODE SUPPORTIVE THERAPY INCLUDES ☐ET ☐VENTILATOR
☐ANTIARRYTHMICS ☐VASOPRESSORS ☐TEMPORARY PACEMAKER

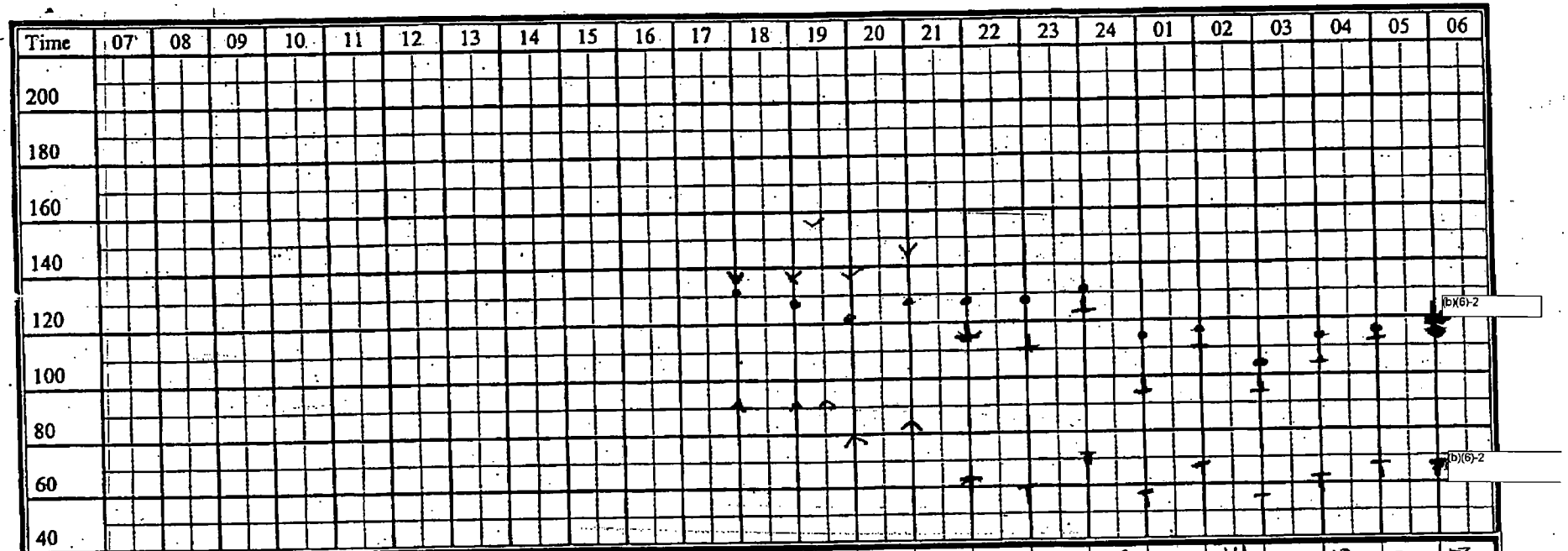
☐SEE OTHER CODE BLUE DOCUMENTATION SHEET/TOTAL #
☐DOCUMENTATION COMPLETED ON THIS SIDE
☐CODE BLUE CRITIQUE DONE

NAME OF MANAGING PHYSICIAN: DV (b)(6)-2
NAME OF MEDICATION RN: (b)(6)-2
RECORDING SIGNATURE: (b)(6)-2
PHYSICIAN SIGNATURE: (b)(6)-2 CRNA/MD/DO

Time: (b)(6)-4

NURSING [illegible]W SHEET
MEDTREFAC-6550/12/Temp Form

Date: 4/18/03



	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	06
RR												20		14	12	20	18	22	20	14	20	18	20	18
TEMP												100.4	100.3	100.0	100.3	100.2	100.1	98.9	99.6	98.9	98.4	98.8	98.8	98.7
SAO2												100	100	100	98	100	100	100	100	100	100	100	100	100
MAP												107	103	96	92	81	73	86	69	83	66	74	77	84
O2 Mode														Vent A/C	Vent A/C	Vent A/C	Vent A/C	Vent PSV	Vent PSV	Vent PSV	Vent PSV	Vent PSV	Vent PSV	Vent PSV
T.V.														750	700	720	750	493	652	880	805	694	883	676
Peep														5	5	5	5	15	15	15	15	15	15	15
FiO_2														50	30	30	30	30	30	30	30	30	30	30
P.S.														~~12~~	/	/	/	20	20	20	20	18	18	18
Mg/kg/min Propofol													40	50	60	60	60	60	60	60	60	60	60	60

DRIP DOSE

FREQ. VITAL SIGNS

TIME																
BP																
HR																
RR																
TEMP																
SAO_2																

INPUT/OUTPUT

N	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
O																										
VPB																		100 350						100	100	650
NS																	125	125	125	125	125	125	125	125	125	1125
[illegible]														24	30	36	36	36	36	36	36	36	36	36	36	411
																										2189

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												200		200	110	200	200	200	224	60	60	80	100	160	200	1834
UOP																										
BM																									125	125
N.G.T.																										
																										1959

PREVIOUS 24 HOUR INPUT ~~2189~~ PREVIOUS 24 HOUR OUTPUT ~~1959~~ PREVIOUS WEIGHT _____

PRESENT 24 HOUR INPUT 2189 PRESENT 24 HOUR OUTPUT 1959 PRESENT WEIGHT _____

MEDCOM - 5490

Neurovascular/Neuromuscular Check (MEDTREFAC 6550/12/Temp Form)

NAME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
EYES OPEN														2	1	1	1	1	1	1	1	1	1	1
VERBAL														1	1	1	1	1	1	1	1	1	1	1
MOTOR														2	4	4	4	4	4	4	4	4	4	4
TOTAL														5	6	6	6	6	6	6	6	6	6	6
PUPIL REAC R/L	/	/	/	/	/	/	/	/	/	/	/	/	/	+ +	+ +	+ +	+ +	+ +	+ +	+ +	+ +	+ +	+ +	+ +
PUPIL SIZE R/L	/	/	/	/	/	/	/	/	/	/	/	/	/	2 2	3 3	3 3	3 3	3 3	3 2	4 3	4 4	4 4	4 4	4 4
LUE COLOR														NFR	NFR	NFR	NFR	NFR	NFR	NFR	NFR	NFR	NFR	NFR
PULSES														+	+	+	+	+	+	+	+	+	+	+
CAP REFILL														<3	<3	<3	<3	<3	<3	<3	<3	<3	<3	<3
MOVEMENT														+2	+	+	+	+	+	+	+	+	+	+
STRENGTH														2	3	3	3	3	3	3	3	3	3	3
RUE COLOR														NFR	NFR	NFR	NFR	NFR	NFR	NFR	NFR	NFR	NFR	NFR
PULSES														+	+	+	+	+	+	+	+	+	+	+
CAP REFILL														<3	<3	<3	<3	<3	<3	<3	<3	<3	<3	<3
MOVEMENT														+2	—	—	—	—	E	E	E	E	E	E
STENGTH														2	—	—	—	—	/	/	/	/	/	/
LLE COLOR														NFR	NFR	NFR	NFR	NFR	NFR	NFR	NFR	NFR	NFR	NFR
PULSES														+	+	+	+	+	+	+	+	+	+	+
CAP REFILL														<3	<3	<3	<3	<3	<3	<3	<3	<3	<3	<3
MOVEMENT														+	+	+	+	+	+	+	+	+	+	+
STRENGTH														2	3	3	3	3	3	3	3	3	3	3
E COLOR														NFR	NFR	NFR	NFR	NFR	NFR	NFR	NFR	NFR	NFR	NFR
PULSES														+	+	+	+	+	+	+	+	+	+	+
CAP REFILL														<3	<3	<3	<3	<3	<3	<3	<3	<3	<3	<3
MOVEMENT														—	+	+	+	+	E	E	E	E	E	E
STRENGTH														—	1	1	1	1	1	1	1	1	1	1

RESPONSE	1	2	3	4	5	6
EYES OPEN	Never	To Pain	To Sound	Spontaneously		
VERBAL	None	Incomprehensible	Inappropriate	Confused Conversa-	Oriented	
MOTOR	None	Extension	Flexion-Abnormal	Flexion-Withdrawal	Localizes Pain	Obeys Commands

LEGEND

Movement: + -
Strength: 0 - +5/5
P = Pronator Drift
FW = Flexion/Withdrawal
E = Extension
FL = Flaccid
FA = Flexion Abnormal

Reflexes:
- = Absent
+ = Present

Pupil Reaction:
S = Sluggish
+ = Reactive
- = Nonreactive

PUPIL SIZE SCALE (MM)

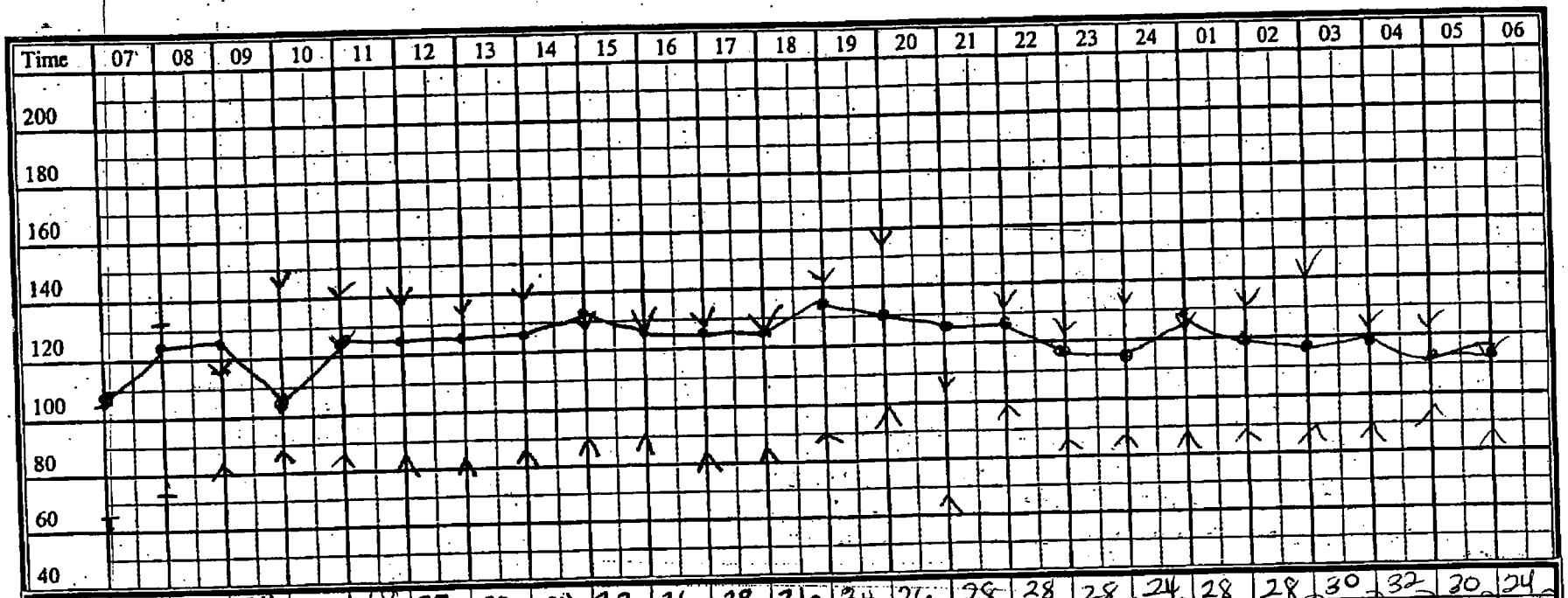
SIZE

MEDCOM - 5491

Name: (b)(6)-4

NURSING FLOW SHEET
MEDTREFAC-6550/12/Temp Form

Date: 4/19/03 – 4/20/03



RR	11	30	24	22	18	22	20	24	22	26	28	26	34	26	28	28	28	24	28	28	30	32	30	24
TEMP	98.6		99.3	99.4	98.7	99.4	100.3	100.1	100.1	100.6	99.9	100.6	100.8	98.4	100.2	99.1	100.2	98.8	100.2	100.8	98.4	99.3	100.1	99.1
SAO2	100	100	100	98	98	100	97	97	97	98	95	95	97	100	97	97	97	97	96	96	94	98	100	95
MAP	75	95		97	98	97	91	97	103	102	97	96	102	107	84	103	97	97	90	97	98	97	98	96
O2 Mode	CPAP	CPAP		SL NC	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
T.V.	778	1627																						
Peep	15	5																						
FiO2	30	30																						
P.S.	18	5																						

DRIP / DOSE

Propofol mcg/kg/min	Ld	D/c'd →																						

FREQ. VITAL SIGNS

TIME															
BP															
HR															
RR															
TEMP															
SAO2															

S: _____

INPUT/OUTPUT

N	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
PO											30		30	50	Ø	90	Ø	180	Ø	Ø	Ø	Ø	120	Ø	Ø	440
VPB	50				100			100		100			350	Ø	100	Ø	100	Ø	225	125	Ø	Ø	100	Ø	150	800
5N.S	125	125	125	175	125	125	125	125	125	D/c'd			1125													
[illegible]	36	D/c'd											36													
																										1240

1541

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	200	200	220	220+180	270	220	220	335	450	280	310	240	3305	200	220	175	200	200	200	220	140	165	100	45	105	1970
UOP																										
BM																										
N.G. Tube	6		175	D/c'd									~~180~~ 175													
																										1970

3480

PREVIOUS 24 HOUR INPUT 2189 PREVIOUS 24 HOUR OUTPUT 1959 PREVIOUS WEIGHT _____

PRESENT 24 HOUR INPUT 2781 PRESENT 24 HOUR OUTPUT 5450 PRESENT WEIGHT _____ 19Apr-20Apr 2003

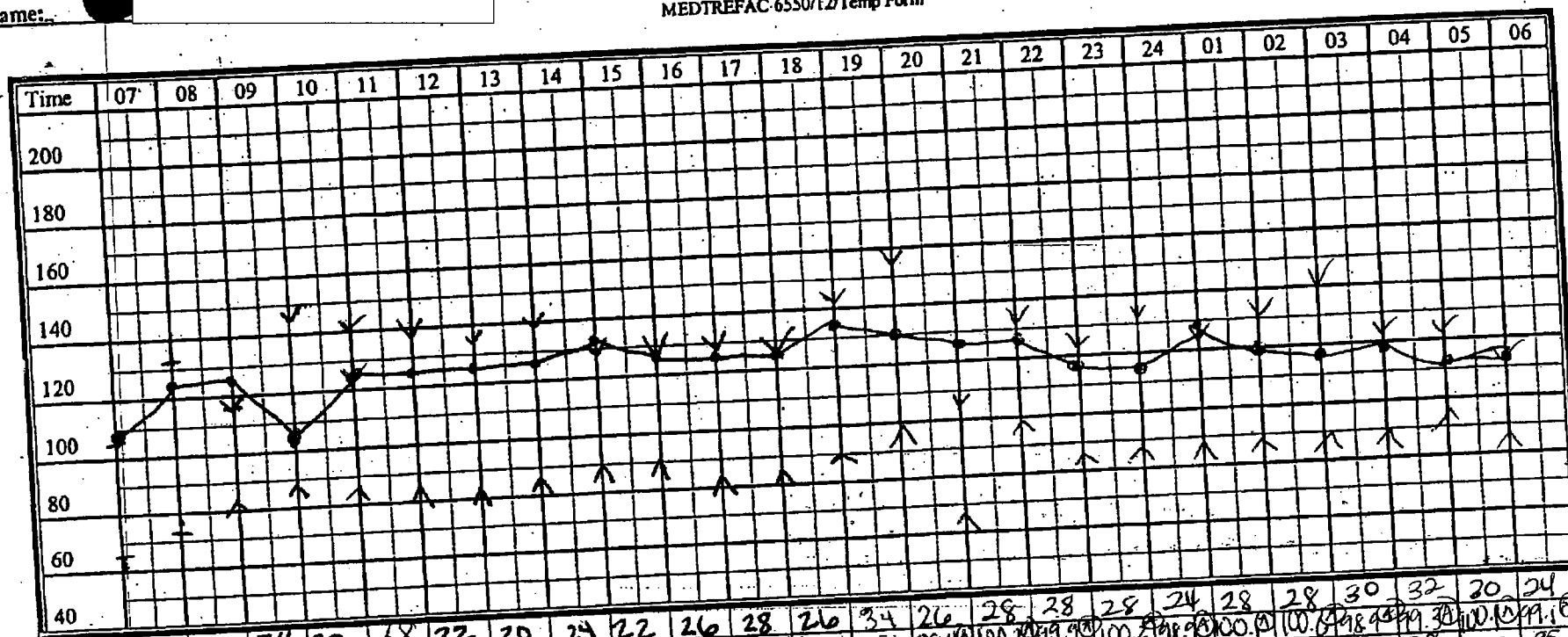
MEDCOM - 5493

Name: (b)(6)-4

NURSING [redacted]W SHEET

MEDTREFAC 6550/12/Temp Form

Date: 4/19/03 – 4/2[redacted]03



RR	11	30	24	22	18	22	20	24	22	26	28	26	34	26	28	28	28	24	28	28	30	32	30	24
TEMP	98.6		99.3	99.4	99.7	99.4	100.3	100.1	100.1	100.6	99.9	100.6	100.8	98.4	100.2	99.9	100.2	98.9	100.1	100.6	98.9	99.3	100.1	99.1
SAO2	100	100	100	98	98	100	97	97	97	98	95	95	97	100	97	97	97	97	96	96	94	98	100	95
MAP	75	95		97	98	97	91	97	103	102	97	96	102	107	84	103	97	97	90	97	98	97	98	74
O2 Mode	CPAP	CPAP		5L NC	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA
T.V.	778	627																						
Peep	15	5																						
FiO2	30	30																						
P.S.	18	5																						

Propofol mcg/kg/min	60	D/C'd →

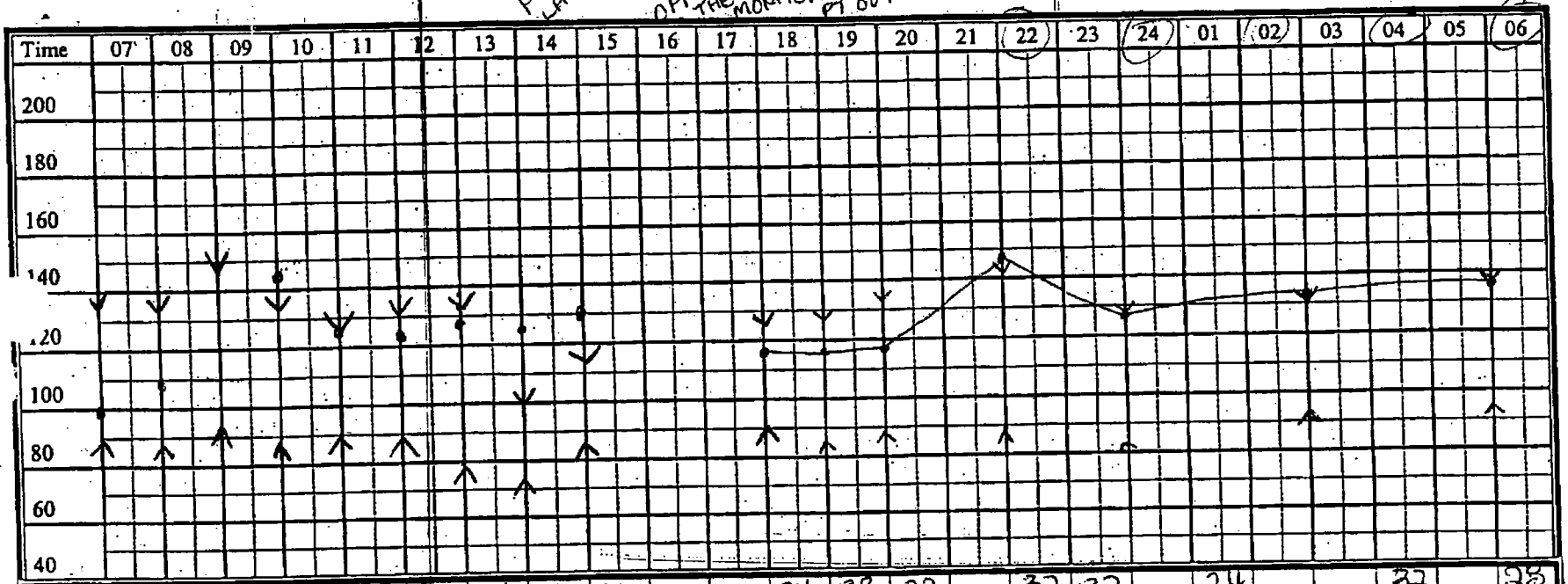
DRIP DOSE

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

PT IS LAYING DOWN OFF THE MONITOR PT OUT OF BED.

NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Date: 20Apr-21Apr 2003



RR	32	32	32	35	32	24	24	22	22			24	32	32		32	32		24			32		28
TEMP	99.7	99.4	97.9	99.1	98.6	98.4	99.6	100	99.8			98.3	98.6	99.9	99.9	99.1	99.3	98.9	98.9	98.9	99.0	100	99.8	98.4
SAO2	97	100	97	98	98	100	98	94	96			96	97	98		96	97		96			95		97
MAP	96	91	103	102	91	97	97	78	97			97	96	97		103	92		109			103		103
O2 Mode	RA	RA	RA	RA	RA	RA	RA	RA	RA			RA	Room Air	Room Air		Room Air	Room Air		Room Air			Room Air		Room Air

DRIP/DOSE

Neurovascular/Neuromuscular Check (MEDTREFAC 6550/12/Temp Form)

	TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
	EYES OPEN	4					4				4				4				4				4		
	VERBAL	~~5~~ 4					4				5				5				5				3		
	MOTOR	6					6				6				6				6				6		
	TOTAL	~~14~~ 15					14				15				15				15				15		
	PUPIL REAC R/L	+ / +	/	/	/	/	+ / 3	/	/	/	+ / 3	/	/	/	+ / 3	/	/	/	+ / 3	/	/	/	+ / 3	/	/
	PUPIL SIZE R/L	3 / 3	/	/	/	/	+ / 3	/	/	/	+ / 3	/	/	/	+ / 3	/	/	/	+ / 3	/	/	/	+ / 3	/	/
LUE	COLOR	NFR					NFR				NFR				Nml				Nml				Nml		
	PULSES	+2					+				+				+				+				+		
	CAP REFILL	<2					+				+				+				+				+		
	MOVEMENT	+					+				+				+				+				+		
	STRENGTH	5					+2				+2				+2				+2				+2		
UE	COLOR	NFR					NFR				NFR				Nml				Nml				Nml		
	PULSES	+2					+				+				+				+				+		
	CAP REFILL	<2					+				+				+				+				+		
	MOVEMENT	+					+				+				+				+				+		
	STENGTH	5					+5				+5				+5				+5				+5		
LE	COLOR	NFR					NFR				NFR				NFR				Nml				Nml		
	PULSES	+2					+				+				+				+				+		
	CAP REFILL	<2					+				+				+				+				+		
	MOVEMENT	+					+				+				+				+				+		
	STRENGTH	5					+5				+5				+5				+5				+5		
RLE	COLOR	NFR					NFR				NFR				Mtl				Nml				Nml		
	PULSES	+2					+				+				+				+				+		
	CAP REFILL	<2					+				+				+				+				+		
	MOVEMENT	+					+				+				+				+				+		
	STRENGTH	5					+5				+5				+5				+5				+5		

MEDCOM - 5496

RESPONSE	1	2	3	4	5	6
EYES OPEN	Never	To Pain	To Sound	Spontaneously		
VERBAL	None	Incomprehensible	Inappropriate	Confused Conversa-	Oriented	
MOTOR	None	Extension	Flexion-Abnormal	Flexion-Withdrawal	Localizes Pain	Obeys Commands

LEGEND

Movement: + -
Strength: 0 - +5/5
P = Pronator Drift
FW = Flexion/Withdrawal
E = Extension
FL = Flaccid
FA = Flexion Abnormal

Reflexes:
- = Absent
+ = Present

Pupil Reaction:
S = Sluggish
+ = Reactive
- = Nonreactive

PUPIL SIZE SCALE (MM)

Neurovascular/Neuromuscular [illegible]CK (MEDTREFAC 6550/12/Temp Form)

TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
EYES OPEN		4				4										4								
VERBAL		5				5										5								
MOTOR		6				6										6								
TOTAL		15				15										15								
PUPIL REAC R/L		+ / +				+ / +										+ / +								
PUPIL SIZE R/L		2 / 2				2 / 2										2 / 2								
LUE COLOR		NFR				NFR										NFR								
PULSES		+				+										+								
CAP REFILL		L2				L2										<2								
MOVEMENT		+				+										+								
STRENGTH		3				3										3								
UE COLOR		NFR				NFR										NFR								
PULSES		+				+										+								
CAP REFILL		L2				L2										<2								
MOVEMENT		+				+										+								
STENGTH		2				2										3								
LE COLOR		NFR				NFR										NFR								
PULSES		+				+										+								
CAP REFILL		L2				L2										<2								
MOVEMENT		+				+										+								
STRENGTH		2				2										2								
E COLOR		NFR				NFR										NFR								
PULSES		+				+										+								
CAP REFILL		L2				L2										<2								
MOVEMENT		+				+										+								
STRENGTH		2				2										2								

RESPONSE	1	2	3	4	5	6
EYES OPEN	Never	To Pain	To Sound	Spontaneously		
VERBAL	None	Incomprehensible	Inappropriate	Confused Conversa-	Oriented	
MOTOR	None	Extension	Flexion-Abnormal	Flexion-Withdrawal	Localizes Pain	Obeys Commands

LEGEND

Movements: + -
Strength: 0 - +5/5
P = Pronator Drift
FW = Flexion/Withdrawal
E = Extension
FL = Flaccid
FA = Flexion Abnormal

Reflexes:
- = Absent
+ = Present
Pupil Reaction:
S = Sluggish
+ = Reactive
- = Nonreactive

PUPIL SIZE SCALE (MM)

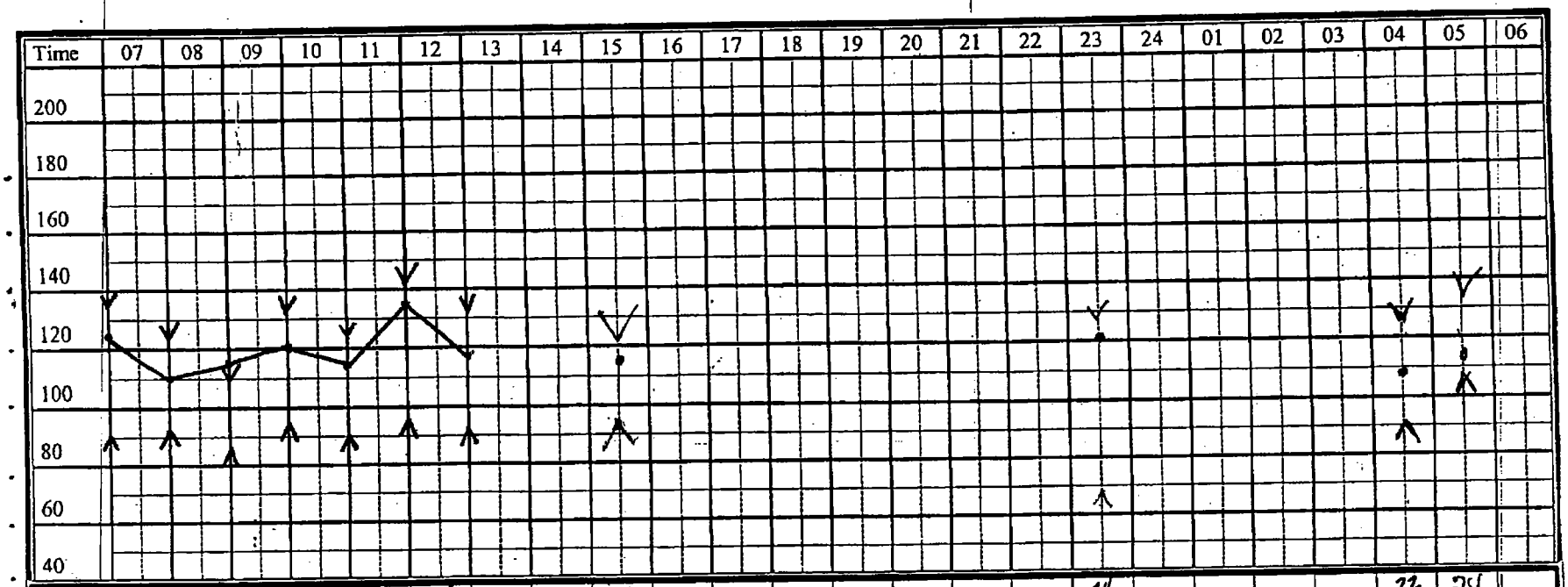
SIZE

MEDCOM - 5497

Name: (b)(6)-4

NURSING FLOW SHEET
MEDTREFAC 6550/12/Temp Form

Date: 4-21-03



RR	28	24	24	28	20	26	28		26								24					22	24	
TEMP	98.7	97.6	98.6	97	97.8	97.6	99.1		99.4								100.1					99.0	98.6	
SAO2	97	96	95	97	98	97	95		96														95	
MAP	104	103	91	103	102	103	102																	
O2 Mode	RA	RA	RA	RA	RA	RA	RA																RA	
																	124/66					140/102		
																						120/80	Repeat	

FREQ. VITAL SIGNS

TIME																
BP																
HR																
RR																
TEMP																
SAO2																

otes:

INPUT/OUTPUT

N	07	08	09	10	11	12	13	14	15	16	17	18	TOTAL	19	20	21	22	23	24	01	02	03	04	05	06	TOTAL
O																										
VPB																			200							

MEDCOM - 5499

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	23	40	29	31	33	10	29																			
EMP																				33						
EM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

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

NURSING [redacted] SHEET
MEDTREFAC 65[redacted]/Temp Form

Date: 22 AUG 05

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		V															V							
100		o								o														
80		/\								V							o							
60										/\														
40																								
RR		20								18							18							
TEMP		97.3								99.6							99.3							
SAO2		95								96														
MAP																								
O2 Mode																								
B/P										102/70														
HR										117														

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			300																							
UOP																										
BM																										

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5501

4/24/03

NURSING [redacted] SHEET
MEDTREFAC-655[redacted] Temp Form

Time	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			28	24	24	24	20	20	24	20	24	24	24	24	22	20	20	20	20	20	20	20	
TEMP			100	99	—	—	—	100	—	—	—	—	—	99.2	—	—	—	99.4	—	—	100.3	—	
SAO2			100	100	100	100	100	95	100	100	100	100	100	98	100	94	99	99	98	98	98	98	97
MAP			73	80	85	85	80	85	80	85	86	85	86	85	85	85	85	79	79	69	79	80	73
O2 Mode			100% NRB	100% NRB	3L NC	3L NC	3L NC	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA

(b)(6)-4

FREQ. VITAL SIGNS

T E															
B															
H															
R															
T P															
S															

N

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
PC																										
IV									100	100			200						100					100		200
NS					150	150	150	150	150	150	150	150	1200	150	150	150	150	—	—	—	—	—				600
05½									125	125	125	125	500	125	125	125	125	200	200	200	200	200	200	200	200	2100
									1000				1000													
													2700													2900
																										5600

OI	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
FC					500	90	80	100	160	180	200	200	1600	200	200	200	210	190	80	210	120	190	210	110	160	2080
UC									210																	
BM																										
																										3680

PR OUS 24 HOUR INPUT _____ PREVIOUS 24 HOUR OUTPUT _____ PREVIOUS WEIGHT _____

PR NT 24 H INPUT 5600 PRESENT 24 HOUR OUTPUT 3680 PRESENT WEIGHT _____

#1920

MEDCOM - 5503

TIME	07	08	09	10	11	12	13	14	15	16	17	19	20	21	22	23	00	01	02	03	04	05	06
EYES OPEN				4		4				4			4				4				4		
VERBAL				1		1				1			2				1				1		
MOTOR				5		5				5			5				5				5		
TOTAL				10		10				10			11				10				10		
PUPIL REAC R/L	/	/	/	+/+	/	+/+	/	/	/	+/+	/	/	+/+	/	/	/	+/+	/	/	/	+/+	/	/
PUPIL SIZE R/L	/	/	/	5/5	/	5/5	/	/	/	5/5	/	/	5/5	/	/	/	5/5	/	/	/	5/5	/	/
COLOR RUE				NFL		NFL				NFL			NFL				NFL				NFL		
PULSES				+		+				+			+				+				+		
CAP REFILL				<3		<3				<3			<3				<3				<3		
OVEMENT				—		(+)				(+)			(+)				—				—		
STRENGTH		—		—		4/5							0				0				0		
COLOR LUE				NFL		NFL				NFL			NFL				NFL				NFL		
PULSES				+		+				+			+				+				+		
CAP REFILL				<3		<3				<3			<3				<3				<3		
MOVEMENT													+				+				+		
STENGTH													+2				+2				+2		
COLOR RLE				NFL		NFL				NFL			NFL				NFL				NFL		
PULSES				+		+				+			+				+				+		
CAP REFILL				<3		<3				<3			<3				<3				<3		
MOVEMENT													+				+				+		
STRENGTH													+2				+2				+2		
COLOR RLG				NFL		NFL				NFL			NFL				NFL				NFL		
PULSES				+		+				+			+				+				+		
CAP REFILL				<3		<3				<3			<3				<3				<3		
MOVEMENT													—				—				—		
STRENGTH													0				0				0		

RESPONSE	1	2	3	4	5	6
EYES OPEN	Never	To Pain	To Sound	Spontaneously		
VERBAL	None	Incomprehensible	Inappropriate	Confused Conversa-	Oriented	
MOTOR	None	Extension	Flexion-Abnormal	Flexion-Withdrawal	Localizes Pain	Obeys Commands

LEGEND

Movement: + -
Strength: 0 - +5/5
P = Pronator Drift
FW = Flexion/Withdrawal
E = Extension
FL = Flaccid
FA = Flexion Abnormal

Reflexes:
- = Absent
+ = Present

Pupil Reaction:
S = Sluggish
+ = Reactive
- = Nonreactive

PUPIL SIZE SCALE (mm)

SIZE

MEDCOM - 5504

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

NURSING [redacted] SHEET
MEDTREFAC 65 [redacted] Temp Form

Date: 25 APR 07

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									V	V								↓						
100																								
80																								
60									^	^								^						
40																								
RR									22	18								22						
TEMP									101.0	102.1		101.5						101.7		101.4	101.0	101.3		101.9
SAO2									96	96								96						
MAP																								
O2 Mode																		RA						
BP									120/64	120/72								129/68						
pulse									120	122								130						

DRIP / DOSE

FREQ. VITAL SIGNS

INPUT/OUTPUT

Tylenol 2030

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
								H20	100					235											

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
													720												

US 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

T.24 JR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5506

NURSING [redacted] SHEET

MEDTREFAC-655[redacted] Temp Form

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																								
120																								
100																								
80																								

MEDCOM - 5507

	20	38	38	36	38	20
MP			100.4		100.5	
O2	98	98	99	98	97	98
AP	86	77	80	86	86	80
de	RA	RA	RA	RA	RA	RA

FREQ. VITAL SIGNS

T	E																
B																	
H																	
R																	
T	D																
S																	

N

INPUT/OUTPUT

Ioechinos PO

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	TOT
PO		30	30		0																					
IVPB		100	0			100																				
~~D5 1/2 NS~~	200	200	200	200																						
NS					100	100																				

+50

OI	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
FC	110	170	155	160	165	150																				
UC																										
BM																										

PREVIOUS 24 HOUR INPUT 6600

PRESENT 24 HOUR INPUT

PREVIOUS 24 HOUR OUTPUT 3680

PRESENT 24 HOUR OUTPUT +1920

PREVIOUS WEIGHT

PRESENT WEIGHT

MEDCOM - 5508

TIME		08	09	10	11	12	13	14	15	16	17		19	20	21	22	23	00	01	02	03	04	05	
EYES OPEN	4				4																			
VERBAL	0				0																			
MOTOR	4				4																			
TOTAL	8				8																			
PUPIL REAC R/L	+ 3				+ 3																			
PUPIL SIZE R/L	+ 3				+ 3																			
COLOR	NFR				NFR																			
PULSES	+				+																			
CAP REFILL	3sec				3sec																			
MOVEMENT	+2				+1																			
STRENGTH	+2				+1																			
COLOR	NFR				NFR																			
PULSES	+				+																			
CAP REFILL	3sec				3sec																			
MOVEMENT	+				+																			
STENGTH	+1				+1																			
COLOR	NFR				NFR																			
PULSES	+				+																			
CAP REFILL	3sec				3sec																			
MOVEMENT	+2				+1																			
STRENGTH	+2				+1																			
COLOR	NFR				NFR																			
PULSES	+				+																			
CAP REFILL	3sec				3sec																			
MOVEMENT	+				+																			
STRENGTH	+1				+1																			

MEDCOM - 5509

RESPONSE	1	2	3	4	5	6
EYES OPEN	Never	To Pain	To Sound	Spontaneously		
VERBAL	None	Incomprehensible	Inappropriate	Confused Conversa-	Oriented	
MOTOR	None	Extension	Flexion-Abnormal	Flexion-Withdrawal	Localizes Pain	Obeys Commands

LEGEND

Movement: + -
Strength: 0 - +5/5
P = Pronator Drift
FW = Flexion/Withdrawal
E = Extension
FL = Flaccid
FA = Flexion Abnormal

Reflexes:
- = Absent
+ = Present

Pupil Reaction:
S = Sluggish
+ = Reactive
- = Nonreactive

PUPIL SIZE SCALE (mm)

SIZE

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

NURSING [redacted] SHEET
MEDTREFAC 65[redacted] Temp Form

Date: 4/26/03 [redacted]

end of 2nd [redacted] PRBC

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	20	22	22	20	24				20	22	24
TEMP											102.5	101.4	100.4	100.4	99.6			98.7				99.6	99.9	98.9
SAO2											98	100	99	97	96	97	97	96				95	95	100
MAP											78	68	76	68	73	73	84	79				92	85	90
O2 Mode											RA			RA	RA	RA	RA	RA				RA	RA	RA
CVP														11	13	15	15	10	9	9	8	10	9	7

See frequent vitals on reverse

FF

DRIP DOSE

pre transfer [redacted] 4/27/03 start 5 5 5 15 FREQ. VITAL SIGNS 15 15 end 1st start 2nd 5 5 5 15 15

TIME	0040	0050	0055	0100	0105	0120	0135	0150	0210	0225	0230	0235	0240	0255	0310	0325
BP	115/67	119/70	111/68	119/74	116/74	110/76	108/76	109/77	109/79	118/79	106/76	107/80	107/75	116/83	120/84	113/80
HR	115	114	116	118	118	117	113	117	115	104	105	111	102	107	110	110
RR	20	20	22	20	24	22	20	20	22	22	20	24	22	20	24	20
TEMP	98.7	98.8	98.9	99.0	98.9	99.3	99.1	99.0	98.9	99.0	98.9	99.4	99.1	99.1	98.9	99.3
SAO2	96	97	97	96	96	96	96	97	96	97	96	98	97	100	97	95

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																										
NS																100		100	100	100						500
.45NS														500	100	100	100	100	60							860
																								100	100	200
PRBCs																										
CT- Hep															250	250	250	250			300		458			750
																										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
FOLEY											100	200	300		60	60	50	120	160	115	240	250	250	100	200	2205
UOP																										
BM																										

PREVIOUS 24 HOUR INPUT 2350 PREVIOUS 24 HOUR OUTPUT _____ PREVIOUS WEIGHT _____

PRESENT 24 H INPUT 2350 PRESENT 24 HOUR OUTPUT 2205 PRESENT WEIGHT _____

MEDCOM - 5511

Neurovascular/Neuromuscular Check (MEDTREFAC 6550/12/Temp Form)

TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
EYES OPEN											4				4					4				
VERBAL											1				1					1				
MOTOR											1				5					5				
TOTAL											6				10					10				
PUPIL REAC R/L	/	/	/	/	/	/	/	/	/	/	+/+	/	/	/	+/+	/	/	/	/	+/+	/	/	/	/
PUPIL SIZE R/L	/	/	/	/	/	/	/	/	/	/	4/4	/	/	/	4/4	/	/	/	/	4/4	/	/	/	/
L' COLOR											Pink				NFR					NFR				
PULSES											4/4				+2					+2				
CAP REFILL											<3				<3					<3				
MOVEMENT											—				+					+				
STRENGTH											Pink				+2 weak					+2				
K' COLOR											4/4				NFR					NFR				
PULSES											<3				+2					+2				
CAP REFILL											—				<3					<3				
MOVEMENT											+				+					+				
STENGTH											Pink				+2 weak					+2				
L' COLOR											+				NFR					NFR				
PULSES											Pink				+2					+2				
CAP REFILL											—				<3					<3				
MOVEMENT											+				+					+				
STRENGTH											Pink				+2 weak					+2				
R' COLOR											Pink				NFR					NFR				
PULSES											Pink				+2					+2				
CAP REFILL											FL				<3					<3				
MOVEMENT											—				+					+				
STRENGTH											—				+2 weak					+2				

RESPONSE	1	2	3	4	5	6
EYES OPEN	Never	To Pain	To Sound	Spontaneously		
VERBAL	None	Incomprehensible	Inappropriate	Confused Conversa-	Oriented	
MOTOR	None	Extension	Flexion-Abnormal	Flexion-Withdrawal	Localizes Pain	Obeys Commands

LEGEND

Movement: + -
Strength: 0 - +5/5
P = Pronator Drift
FW = Flexion/Withdrawal
E = Extension
FL = Flaccid
FA = Flexion Abnormal

Reflexes:
- = Absent
+ = Present

Pupil Reaction:
S = Sluggish
+ = Reactive
- = Nonreactive

PUPIL SIZE SCALE (mm)

SIZE

MEDCOM - 5512

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

NURSING [redacted] SHEET
MEDTREPAC-65[redacted] Temp Form

Date: 26 APR 03

30

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		V																						
100						✓				V														
80																								
60		^				^				^														
40																								
RR		18				36				48														
TEMP		100.2				101.2				102.2														
SAO2		97				70-82				99														
MAP																								
O2 Mode						6L MASK																		
		115					136/90			150-40														

DRIP / DOSE

FREQ. VITAL SIGNS

INPUT/OUTPUT

I can Ensure

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
H_2O			120																						
			237																						

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
				900			720																		

US 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

T.24 HR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5514

Neurovascular/Neuromuscular Check (MEDTREFAC 6550/12/Temp Form)

TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
EYES OPEN		4				4				4				4				4				4		
VERBAL		1*				1				1				2				2				2		
MOTOR		6				6				6				6				6				6		
TOTAL		11*				11				11				12				12				12		
PUPIL REAC R/L		+ +				+ +				+ +				+ +				+ +				+ +		
PUPIL SIZE R/L		3mm 3mm				3mm				3mm				3mm				3mm				3 3		
LUE COLOR		PINK				PINK				PINK				Pink				Pink				Pink		
PULSES		+				+				+				+				+				WNL		
CAP REFILL		<3s.				<3s.				<3s.				<3s.				<3s.				+		
MOVEMENT		+				+				+				+				+				<3s.		
STRENGTH		+3				+3				+3				+3				+3				+		
RUE COLOR																								
PULSES																						P		
CAP REFILL																								
MOVEMENT																								
STENGTH																								
LLE COLOR																								
PULSES																								
CAP REFILL																								
MOVEMENT																								
STRENGTH																								
RLE COLOR																								
PULSES																								
CAP REFILL																								
MOVEMENT																								
STRENGTH		↓*				↓*				↓*				↓				↓						

(b)(6)-2

RESPONSE	1	2	3	4	5	6
EYES OPEN	Never	To Pain	To Sound	Spontaneously		
VERBAL	None	Incomprehensible	Inappropriate	Confused Conversa-	Oriented	
MOTOR	None	Extension	Flexion-Abnormal	Flexion-Withdrawal	Localizes Pain	Obeys Commands

LEGEND

Movement: + -
Strength: 0 - +5/5
P = Pronator Drift
FW = Flexion/Withdrawal
E = Extension
FL = Flaccid
FA = Flexion Abnormal

Reflexes:
- = Absent
+ = Present

Pupil Reaction:
S = Sluggish
+ = Reactive
- = Nonreactive

PUPIL SIZE SCALE (MM)

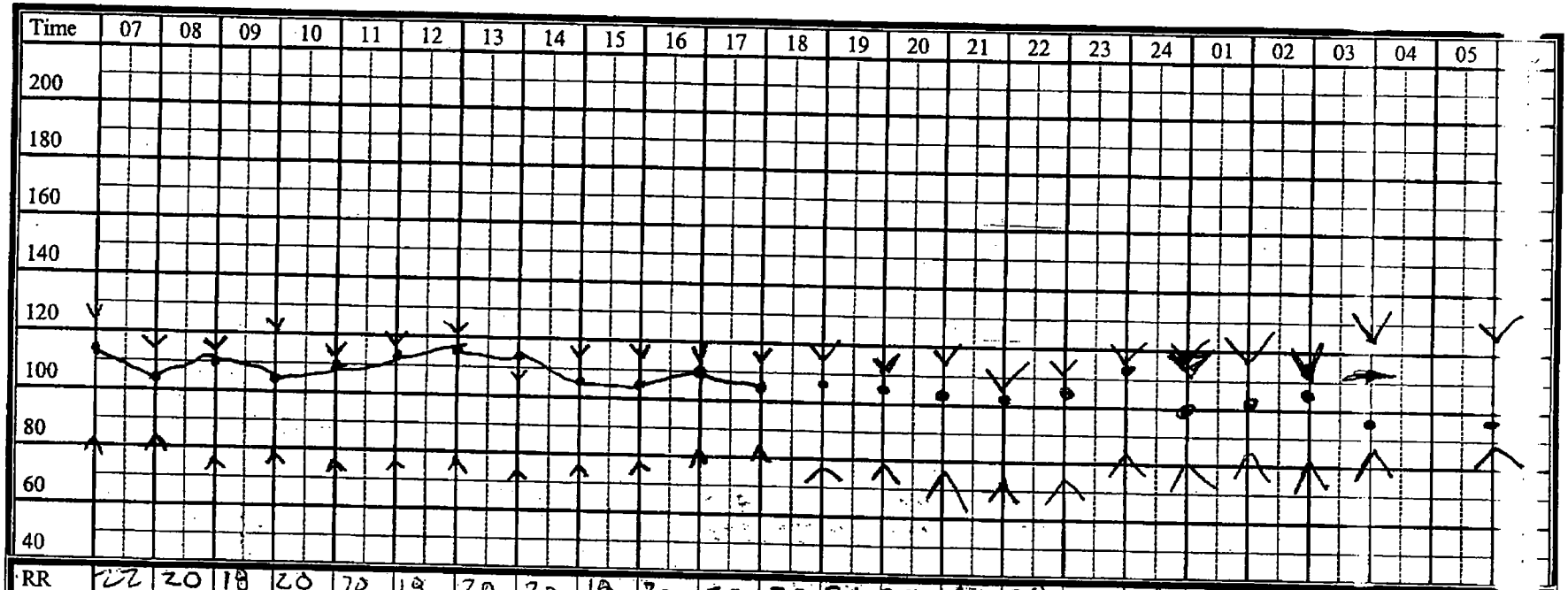
1 2 3 4 5 6 7 8 REACTION

Name (b)(6)-4

NURSING FLOW SHEET

MEDTREFAC 6550/12/Temp Form

Date: 4/27/03



Time	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04	05	
RR	22	20	18	20	20	18	20	20	18	20	20	20	21	20	22	20	20	22	22	22		23		22
TEMP	99.0	99.1	99.8	99.5	99.6	99.5	99.5	99.6	99.8	99.4	99.3	99.5	99.9	99.8	99.9	99.8	100.4	99.8	99.6	99.5			99.4	99.4
SAO2	95	95	96	97	95	96	97	95	97	97	97	98	97	98	98	99	99	98	100	100	98	100	100	100
MAP	79	90	95	85	90	87	86	85	86	90	91	90	85	90	84	79	80	95	90	90	90	90		97
O2 Mode	RA	RA	LA	RA	LA	LA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	RA	LA	RA	RA
CVP	8	6	9	8	9	9	9	9	10	10	10	8	10	9	10	10	10	10	10	10	10	11	13	10

DRIP / DOSE

FREQ. VITAL SIGNS

T E																	
B																	
H																	
R																	
T P																	
S 2																	

N 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	T
P																										
IV	100					100	50	350	100	100			800		100	100		100					100	50	50	
+45NS @100	100	100	100	150	150	150	150	150	150	150	160	150	1650													
Osmolite					20	20	20	20	40	40	40	40	240	160	160	160	160	160	160	160	160	160	160	160	160	
D5 1/2NS														150	150	150	150	150	150	150	150	150	150	150	150	
													2590													

O	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
F Y	125	125	200	100	100	195	1100	85	140	145	340	90		180	185	120	160	120	120	140	120	180	120	160	200	1905
U													1465													
BI																										
Residual										0							5					0				

PF VIOUS 24 HOUR INPUT 2350

PF ENT 24 HOUR INPUT 3870

PREVIOUS 24 HOUR OUTPUT 2205

PRESENT 24 HOUR OUTPUT 4370

PREVIOUS WEIGHT

PRESENT WEIGHT

MEDCOM - 5517

Neurovascular/Neuromuscular Check (MEDTREFAC 6550/12/Temp Form)

TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
EYES OPEN		4				4				4				4				4				4		
VERBAL		2				2				2				2				2				2		
MOTOR		5				5				5				5				5				5		
TOTAL		11				11				11				11				11				11		
PUPIL REAC R/L		+/+				+/+				+/+				+/+				+/+				+/+		
PUPIL SIZE R/L		4/4				4/4				4/4				4/4				3/3				3/3		
LUE COLOR		NFR				NFR				NFR				NFR				NFR				NFR		
LUE PULSES		+				+				+				+				+				+		
LUE CAP REFILL		<3				<3				<3				<4				<3				<3		
LUE MOVEMENT		+				+				+				+				+				+		
LUE STRENGTH		3				3				3				2				2				3		
UE COLOR		NFR				NFR				NFR				NFR				NFR				NFR		
UE PULSES		+				+				+				+				+				+		
UE CAP REFILL		<3				<3				<3				<4				<3				<3		
UE MOVEMENT		+				+				+				+				+				+		
UE STENGTH		3				3				3				2				2				3		
LLE COLOR		NFR				NFR				NFR				NFR				NFR				NFR		
LLE PULSES		+				+				+				+				+				+		
LLE CAP REFILL		<3				<3				<3				<4				<3				<4		
LLE MOVEMENT		+				+				+				+				+				+		
LLE STRENGTH		3				3				3				2				2				3		
RLE COLOR		NFR				NFR				NFR				NFR				NFR				NFR		
RLE PULSES		+				+				+				+				+				+		
RLE CAP REFILL		<3				<3				<3				<4				<4				<4		
RLE MOVEMENT		+				+				+				+				+				+		
RLE STRENGTH		2				2				2				2				2				2		

MEDCOM - 5518

RESPONSE	1	2	3	4	5	6
EYES OPEN	Never	To Pain	To Sound	Spontaneously		
VERBAL	None	Incomprehensible	Inappropriate	Confused Conversa-	Oriented	
MOTOR	None	Extension	Flexion-Abnormal	Flexion-Withdrawal	Localizes Pain	Obeys Commands

LEGEND

Movement: + -
Strength: 0 - +5/5
P = Pronator Drift
FW = Flexion/Withdrawal
E = Extension
FL = Flaccid
FA = Flexion Abnormal

Reflexes:
- = Absent
+ = Present

Pupil Reaction:
S = Sluggish
+ = Reactive
- = Nonreactive

PUPIL SIZE SCALE (MM)

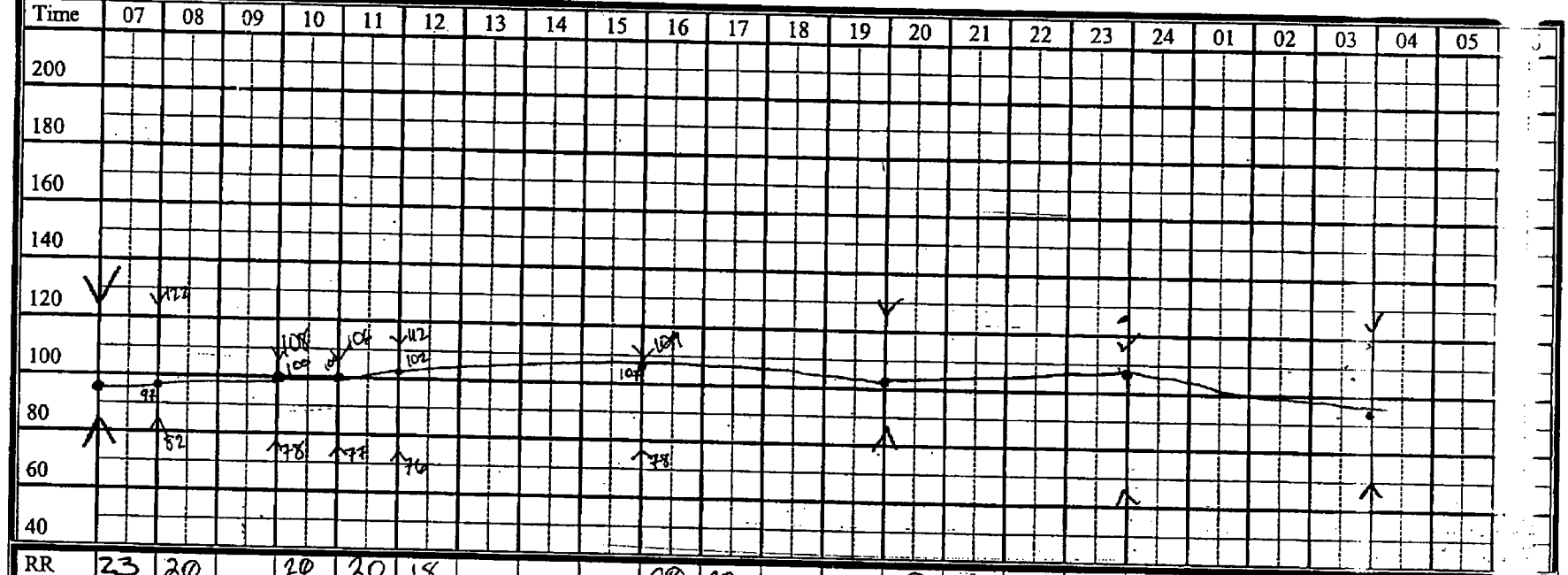
(b)(6)-4

N'11

NURSING FLOW SHEET

MEDTREFAC 6550/12/Temp Form

Date: 4/28/03



RR	23	20		20	20	18				20	20			20				22				20	
TEMP		100.1				99.4				99.1	98.9			100.4				100.1				100.5	
SAO2	100	100%		100%	100%	98%				100%	97			99				97				98	
MAP	91	92		96	85	85				91	91			92				95				89	
O2 Mode	RA	RA		RA	RA	RA				RA	RA			RA				RA				RA	
CVP	16	9		11	11	10				10	9			9				10				10	

DRIP / DOSE

FREQ. VITAL SIGNS

T	E																	
B																		
H																		
R																		
T	P																	
S	2																	

N 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
P(						10				10			20												
IV	500	100			250	100	100	50	100				750		100				100		100		150		
D5½NS	150	150	150	150	150	—	—	—	—				750												
Osmolite	80	80	80	80	80	—	—	—	—				400												
													1920												

MEDCOM - 5520

O		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
F(	Y	160	180	200	165	165	205	172	172	205	205	145	193	2167	100	100	100			300	150	150		120			
U																											
BI				x1							x1			x2													
														2167+													

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: 4/29/03

CUFF

AL

HR

DRIP

DOS

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	129								108															
100	98				110 108																			
80	81																							
60					71				78															
40																								
RR		18			16				18															
TEMP		99.0			99.2				99.7		99.8													
SAO2		100%			100%				99%															
MAP		96			85																			
O2 Mode		RA			RA				RA															
CVP		15			14																			
SS										103														

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					30																					
IVPB	100		250																							

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		305		305		325		450																		
UOP																										
BM				x1																						

PREVIOUS 24 HOUR INPUT_____ PREVIOUS 24 HOUR OUTPUT_____ PREVIOUS WEIGHT_____

PRESENT 24 HOUR INPUT_____ PRESENT 24 HOUR OUTPUT_____ PRESENT WEIGHT_____

MEDCOM - 5522

Neurovascular/Neuromuscular Check (MEDTREPAC 6550/12/Temp Form)

TIME	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	06
EYES OPEN		4				4																		
VERBAL		2				2																		
MOTOR		6				6																		
TOTAL		12				12																		
PUPIL REAC R/L		+/+				+/+																		
PUPIL SIZE R/L		2mm				3mm																		
LI COLOR		PINK				PINK																		
PULSES		+				+																		
CAP REFILL		<3s.				<3s.																		
MOVEMENT		+				+																		
STRENGTH		+3				+3																		
RI COLOR																								
PULSES																								
CAP REFILL																								
MOVEMENT																								
STENGTH																								
LI COLOR																								
PULSES																								
CAP REFILL																								
MOVEMENT																								
STRENGTH																								
RI COLOR																								
PULSES																								
CAP REFILL																								
MOVEMENT																								
STRENGTH		↓				↓																		

RESPONSE	1	2	3	4	5	6
EYES OPEN	Never	To Pain	To Sound	Spontaneously		
VERBAL	None	Incomprehensible	Inappropriate	Confused Conversa-	Oriented	
MOTOR	None	Extension	Flexion-Abnormal	Flexion-Withdrawal	Localizes Pain	Obeys Commands

LEGEND

Movement: + -
Strength: 0 - +5/5
P = Pronator Drift
FW = Flexion/Withdrawal
E = Extension
FL = Flaccid
FA = Flexion Abnormal

Reflexes:
- = Absent
+ = Present

Pupil Reaction:
S = Sluggish
+ = Reactive
- = Nonreactive

PUPIL SIZE SCALE (mm)

SIZE

MEDCOM - 5523

12 28 1 20

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY																
POST- DAY				1 MAY		2 MAY		03 May 03		04 MAY 03						
MONTH-YEAR	DAY	30 APR														
19	HOUR	1500	2300	0700	2100	0700	2300	1555	2100	0700						
PULSE (O)	TEMP. F (●)															TEMP. C
	105°															40.6°
180	104°															40.0°
170	103°															39.4°
160	102°															38.9°
150	101°															38.3°
140	100°															37.8°
130	99°															37.2°
	98.6°															37.0°
120	98°															36.7°
110	97°															36.1°
100	96°															35.6°
90	95°															35.0°
80																
70																
60																
50																
40																
RESPIRATION RECORD		1 2	2 0	1 8	1 6		2	2 6	1 8	1 6						
BLOOD PRESSURE		124/84 112/82	102/80	114/86	112/30	114/78	118/82	114/92	113/25	112/80						
HEIGHT:	WEIGHT→	99%		98% 97%		98%	98%			98%						
Out Put		1300cc		500cc 800cc		700cc										

(Centigrade Equivalents, for Reference only)

Record special data only when so ordered

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

(b)(6)-4

REGISTER NO.

WARD NO.

511-1

VITAL SIGNS RECORD

STANDARD FORM 511 (REV. 9-79)
...scribed by GSA and Interagency
...mittee on Medical Records
...R (41 CFR) 101-11.806-8

INSULIN PROTOCOL

SLIDING SCALE SUBCUTANEOUS

ISTAT EG8 Q6hrs

Glucose	Action
0-75	give 1 amp D50 and call MD
76-150	no action
151-250	2 units regular insulin SQ
251-350	4 units regular insulin SQ
351-450	6 units regular insulin SQ
>450	give 8 units regular insulin SQ and call MD

INSULIN DRIP

Start Insulin gtt at 1 unit/hr
ISTAT EG8 Q1hr

Glucose	Action
0-75	Hold insulin drip and restart in 1 hour at 1 unit/hr less
76-150	No action
151-250	increase rate by 1 unit/hr
251-400	increase rate by 2 unit /hr
>400	increase rate by 3 units/hr and notify MD

Insulin gtt range 0 to 6 units/hr, if need to exceed this range, notify MD

RESPIRATORY THERAPY TREATMENT SHEET

DATE: 4/19/03 TIME: 0935 TREATMENT: NS Atrovent / 2.5 mg Albuterol / 2cc 20% Mucomyst

PRE TREATMENT: HR- 125 RR- 26, SaO2- 91% POST TREATMENT: HR- 134 RR- 25, SaO2- 99%

LUNG SOUNDS:
PRE- Coarse 7/0 c̄ Dimin Bases

POST- Noted ↑YD Aeration / Bilat Dimin Bases

COUGH/SPUTUM: Clear → white / Moderate cough COMMENTS:

THERAPIST SIGNATURE: (b)(6)-2

DATE: 4/19/03 TIME: 1208 TREATMENT: S.A.A.

PRE TREATMENT: HR- 125, RR- 26, SaO2- 95% POST TREATMENT: HR- 129, RR- 30, SaO2- 96%

LUNG SOUNDS:
PRE- Dimin Bilat Bases

POST- Slight ↑YD Aeration RLL Anillat, Dimin LLL

COUGH/SPUTUM: Moderate COMMENTS: Pt. Swallows productive cough. NT sx. Scant amount clear secretions. Pt tolerated Tx

THERAPIST SIGNATURE: (b)(6)-2 CRT

DATE: 4/19/03 TIME: 1455 TREATMENT: CPT LLL

PRE TREATMENT: HR- 126, RR- 36, SaO2- 97% POST TREATMENT: HR- 136 RR- 34, SaO2- 97%

LUNG SOUNDS:
PRE- Dimin Bilat Bases

POST- Ø Δ

COUGH/SPUTUM: Moderate / Ø COMMENTS: Pt. Swallows productive sputum.

THERAPIST SIGNATURE: (b)(6)-2 CRT

DATE: 4/19/03 TIME: 1555 TREATMENT:

PRE TREATMENT: HR- 129, RR- 28, SaO2- 97% POST TREATMENT: HR- 137 RR- 30, SaO2- 99%

LUNG SOUNDS:
PRE- Dimin Bilat Bases

POST- Ø Δ

COUGH/SPUTUM: Moderate Cough/c COMMENTS: Pt Swallows Sputum

THERAPIST SIGNATURE: (b)(6)-2

ADDRESSOGRAPGH: (b)(6)-4

ORDERING PHY:

DIAGNOISIS:

(b)(3)-1

CP/RT Ventilator Check Off Sheet

Date	4/18	4/18	4/18	4/18	4/19	4/19	4/19	4/19				
Time	1840	1935	2135	2320	0147	0345	0550	0806				
Vent	760	760	760	760	760	760	760	760				
Mode	A/C	A/C	A/C	PSV	PSV	PSV	PSV	PSV				
VT set/actual	750	750	750	—	—	—	—	/				
VT spontaneous	800	755	720	503	741	787	721	786				
Rate set	12	12	12	—	—	—	—	/				
Rate total	18	22	18	17	12	16	14	33				
Peak flow	70	70	70	49	48	63	44	67				
Sensitivity	-2	-2	-2	-2	-2	-2	-2	-2				
Peep	5	5	5	15	15	15	15	↓5				
PIP	20	21	28	24	35	33	33	14				
Insp pause RV	12.0	16.72	13.55	11.28	9.29	13.51	10.46	21.66				
Sigh volume I:E	1:1.9	1:1.2	1:1.2	—	1:2.1	—	—	/				
Sigh rate MAP	14	10	11	16	21	24	24	7				
~~Sigh frequency~~ PS				20	20	↓12	18	↓5				
Sigh PIP					—	—	—	/				
Fio2	70%	50%	30%	30	30%	30%	30%	.3				
Waveform	Ramp	Dec	Dec	—	—	—	—	/				
High PIP alarm	50	50	50	56	50	50	56	50				
Low PIP	10	10	10	—	—	—	—	/				
Low volume	300	300	300	300	200	200	200	200				
Det. delay	—	—	—	—	—	—	—	/				
Apneic period	20	20	20	20	20	20	20	20				
Low PEEP/CPAP	—	—	—	—	—	—	—	/				
High rate	40	40	40	40	40	40	40	40				
Volume check qS	—	|	|	|	|	|	|	|				
Temp/set	—	|	|	|	|	|	|	|				
Water level	—	|	|	|	|	|	|	|				
HME	OK	OK	OK	OK	OK	OK	OK	OK				
Pt/secretion check	Copious	—	—	—	—	—	—	/				
O2 sats	100	100%	99%	99%	100%	100%	100%	100%				
Cuff Pressure	MLT	—	—	—	—	—	MLT	MLT				
Initials	(b)(6)-2											

Name/Signature	Initials
(b)(6)-2	

Pt Information/Addressograph

(b)(6)-4

Date	Time	
4/18	1840	Pt Received Placed on A/C 12x750 peep 5.0 FO2 (ETT #8 23 Lip) 70%. Pt B/S ā SXN Coarse bilat / c̄ ↓ on (L) side. Pt was SXN. Copious ant plugs were removed. B/S ī SXN ↑ bilat c̄ Shaft Rhonch. Triple lumen was placed by Dr (b)(6)-2 [redacted] - Sats stayed at 100 T/s procedure wean Fine as Tolerated (b)(6)-2 [redacted] Hrs/KA
4/19	0554	Pt remains on PB760 Vent. See flow sheet for settings and changes. #8.5 OETT remains secured properly @ 25cm @ tol. B/S equal bilat. Vent/alarms appear to be functioning properly @ this time (b)(6)-2 [redacted] Hrs
	0548	Pt. Extubated @ this time per Dr. (b)(6)-2 [redacted] Pt suctioned prior to Extubation; via OETT and Hypopharynx Small → Moderate amount of thick → thin secretions Dark Brown → clear in color. Placed pt on AFM 40% (titrate FO2 SaO2 >93%) 15(+) L/min O2. (↑) WOB, NOTED. of Dyspnea, retractions or nasal Flaring, Symmetrical breathing NOTED. Lungs, Diminish Bilat Bases Ant/lat. CPT performed to Bilat bases. Small amount of thin → thick clear and slightly frothy sputum suctioned. (b)(6)-2 [redacted] cnl

(b)(3)-1

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 24 Jan 03 - 24 Apr 03

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

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

---

24 Apr 03 @ 0350 (Coll) BLOOD

WBC	21.1	H	(4.8-10.8)	K/UL
RBC	3.6	L	(4.7-6.1)	1X10 6/UL
HGB	11.3	L	(14.0-18.0)	g/dL
HCT	32.6	L	(42-52)	%
MCV	91.2		(80-94)	fL
MCH	31.6		(27-32)	pg
MCHC	34.6		(31-37)	g/dL
RDW	14.0		(12-14)	%
PLT CNT	942.0	H	(150-450)	1x10 3/UL

Result Comment:
Critical result verified by repeat analysis
Notified CDR Stevens-Roth on 4FP of result @ 0425 ---jsf

MPV	7.8		(7.4-10.4)	FL
NEUT/100 WBC	79.2			%
NEUT%	16.7			1x10 3/UL
LYMPHS/100 WBC	12.9			%
LY#	2.7			1x10 3/UL
MONO/100 WBC	7.9			%
MONO%	1.7			1X10 3/UL

==========

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: 24 Jan 03 - 24 Apr 03

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

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

---

24 Apr 03 @ 0350 (Coll) SERUM

NA+	144		(137-145)	mmol/L
K	4.2		(3.6-5.0)	mmol/L
CL-	109	H	(97-107)	mmol/L
CO2	23		(22-31)	mmol/L
BUN	43	H	(9-21)	mg/dL
GLUCOSE	199	H	(76-110)	mg/dL
CREAT	1.8	H	(0.8-1.5)	mg/dL

==========

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

==========

2 √

LABORATORY 1-71-0 24 Apr 2003@2356 Page 1

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

Lab Certified Result Notification

] ort requested by: System Generated

(b)(6)-4 (b)(6)-4 M/6d 2391 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 24 Apr 2003@2227 Acc#: (b)(6)-2

Specimen: CSF (CEREBRO) Pri: ROUTINE Ord#: (b)(6)-4

Res Lab: LAB Req Loc: IC2

Test name	Result	Units	Normal range
WBC	.56	MM3	
RBC	11.1	MM3	
COLOR	COLORLESS		
APPEARANCE	CLEAR		

*** End of Report ***

(b)(6)-2

2 √

LABORATORY 1-71-0 24 Apr 2003@2305 Page 1

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

Lab Certified Result Notification

ort requested by: System Generated

(b)(6)-4 (b)(6)-4 M/6d 2391 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 24 Apr 2003@2225 Acc#: (b)(6)-2

Specimen: OTHER (CEREBRO) Pri: ROUTINE Ord#: (b)(6)-4

Resulting Lab: LAB Req Loc: IC2

Accession Comment(s):

CSF TUBE#2

Entered by: (b)(6)-2 on 24 Apr 2003@2226

GRAM STAIN: Final Report

GRAM STAIN: NO CELLS NOTED. NO ORGANISMS NOTED.

2 ✓

LABORATORY 1-71-0 24 Apr 2003@2217 Page 1

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

Priority Result Notification

ɔrt requested by: System Generated

(b)(6)-4 (b)(6)-4 M/6d 2391 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 24 Apr 2003@2128 Acc#: (b)(6)-2

Specimen: BLOOD (SERUM) Pri: STAT Ord#: (b)(6)-4

Res Lab: LAB Req Loc: IC2

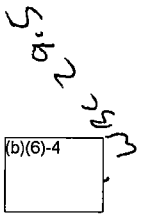
Test name	Result	Units	Normal range
NA+	151 H	mmol/L	137 - 145
K	4.7	mmol/L	3.6 - 5.0
CL-	119 H	mmol/L	97 - 107
CO2	23	mmol/L	22 - 31
BUN	48 H	mg/dL	9 - 21
GLUCOSE	210 H	mg/dL	76 - 110
CREAT	1.7 H	mg/dL	0.8 - 1.5

*** End of Report ***

1. D/w to D5 1/2NS @ 200 cc/h

2. SSI q6h subcut.

(b)(6)-2


(b)(6)-4

2 √

LABORATORY 1-71-0 24 Apr 2003@1242 Page 1

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

Priority Result Notification

I ort requested by: System Generated

(b)(6)-4 (b)(6)-4 M/6d 2391 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 24 Apr 2003@1117 Acc#: (b)(6)-2

Specimen: URINE/RA (URINE) Pri: STAT Ord#: (b)(6)-4

Res Lab: LAB Req Loc: IC2

Test name	Result	Units	Normal range
COLOR	YELLOW		
APPEARANCE	HAZY		
SG	1.020		1.010 - 1.020
Interpretation(s): Normal Range provided is for first morning void.			
PH	5.0		4.5 - 7.5
LEUKO EST	NEGATIVE		NEGATIVE
NITRITE	NEG		NEGATIVE
U PROT	30MG/DL	MG/DL	NEG
Test comment(s): SSA TEST PERFORMED WITH RESULT OF 5MG.			
U GLUCOSE	NEG	mg/dL	NEGATIVE
U KETONES	NEG	mg/dL	NEGATIVE
UROBLGN	0.2	mg/dl	0 - 1
U BILI	NEGATIVE		NEGATIVE
U HGB	MODERATE H		NEGATIVE
U WBC	5-10 H	/HPF	0 - 2
U RBC	1-3		
MUCOUS	FEW		
U EPI	1-5		
BACTERIA	FEW	/HPF	

*** End of Report ***

(b)(6)-2

2 √

LABORATORY 1-71-0 24 Apr 2003@1057 Page 1

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

Priority Result Notification

ort requested by: System Generated

(b)(6)-4 (b)(6)-4 M/6d 2391 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 24 Apr 2003@1037 Acc#: (b)(6)-2

Specimen: BLOOD (BLOOD) Pri: STAT Ord#: (b)(6)-4

Res Lab: LAB Req Loc: IC2

Test name	Result	Units	Normal range
WBC	20.5 H	K/UL	4.8 - 10.8
RBC	3.3 L	1X10 6/UL	4.7 - 6.1
HGB	10.4 L	g/dL	14.0 - 18.0
HCT	30.2 L	%	42 - 52
MCV	90.9	fL	80 - 94
MCH	31.3	pg	27 - 32
MCHC	34.4	g/dL	31 - 37
RDW	14.2 H	%	12 - 14
PLT CNT	790 H	1x10 3/UL	150 - 450
Test comment(s): NOTIFIED LT (b)(6)-2 @ 1055. (b)(6)-2.			
MPV	7.9	FL	7.4 - 10.4

*** End of Report ***

(b)(6)-2

2 √

LABORATORY 1-71-0 24 Apr 2003@1202 Page 1

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

Priority Result Notification

ort requested by: System Generated

(b)(6)-4 (b)(6)-4 M/6d 2391 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 24 Apr 2003@1037 Acc#: (b)(6)-2

Specimen: BLOOD (BLOOD) Pri: STAT Ord#: (b)(6)-4

Res Lab: LAB Req Loc: IC2

Test name	Result	Units	Normal range
SEGS/100 WBC	91	%	
L CD10	6	%	
MONO%	3	1X10 3/UL	
PLT EST	HIGH		
MORPHOLOGY	NORMAL		

*** End of Report ***

2 √

LABORATORY 1-71-0 24 Apr 2003@1119 Page 1

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

Priority Result Notification

I ort requested by: System Generated

(b)(6)-4 (b)(6)-4 M/6d 2391 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 24 Apr 2003@1037 Acc#: (b)(6)-2

Specimen: BLOOD (SERUM) Pri: STAT Ord#: (b)(6)-4

Res Lab: LAB Req Loc: IC2

Test name	Result	Units	Normal range
CK	1538 H	U/L	0 - 203

*** End of Report ***

(b)(6)-2

2 √

LABORATORY 1-71-0 24 Apr 2003@1120 Page 1

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

Priority Result Notification

I ort requested by: System Generated

(b)(6)-4 (b)(6)-4 M/6d 2391 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 24 Apr 2003@1037 Acc#: (b)(6)-2

Specimen: BLOOD (SERUM) Pri: STAT Ord#: (b)(6)-4

Res Lab: LAB Req Loc: TC2

Test name	Result	Units	Normal range
MG	3.3 H	mg/dL	1.7 - 2.2

Interpretation(s):

*** End of Report ***

(b)(6)-2

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

NF'' ORDER
1 ist LAB (b)(6)-4 (b)(6)-4 (b)(6)-4
GRAM STAIN~WARD/CLINIC COLLECT~OTHER~STERILE CON on 24 Apr 2003@2210

(b)(6)-2 LCDR,/SIGNED/PRE-ACTIVE

*** End of Report ***

(b)(6)-4 (b)(6)-4 Loc: IC2
18 Apr 2003 M PATIENT ORDER LIST
[UNK]

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

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NEW ORDER
1 LAB (b)(6)-4 (b)(6)-4 (b)(6)-4
*STAT*STAT* BASIC METABOLIC PANEL~WARD/CLINIC COLLECT~BLOOD~RED TOP on 24 Apr 2003@2050

(b)(6)-2 LCDR,/SIGNED/PRE-ACTIVE

NEW ORDER
2 Last RAD (b)(6)-4 (b)(6)-4 (b)(6)-4
CHEST, AP (PORTABLE)~Portable~DIAGNOSTIC RADIOLOGY X7420~AMB on 24 Apr 2003@2050

(b)(6)-2 LCDR,/SIGNED/PRE-ACTIVE

PORTABLE INDICATOR: YES

*** End of Report ***

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(b)(6)-4 (b)(6)-4 (b)(6)-4 Loc: IC2
18 Apr 2003 M PATIENT ORDER LIST
[UNK]

2 √

LABORATORY 1-71-0 24 Apr 2003@2301 Page 1

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

Priority Result Notification

I ort requested by: System Generated

(b)(6)-4 (b)(6)-4 M/6d 2391 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 24 Apr 2003@2228 Acc#: (b)(6)-2

Specimen: CSF (CEREBRO) Pri: STAT Ord#: (b)(6)-4

Res Lab: LAB Req Loc: IC2

Accession Comment(s):

CSF TUBE#3

Entered by: (b)(6)-2 on 24 Apr 2003@2228

Test name	Result	Units	Normal range
PROTEIN BF	45.0 H	mg/dL	15 - 40

*** End of Report ***

(b)(6)-2

2 ✓

LABORATORY 1-71-0 24 Apr 2003@2301 Page 1

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

Priority Result Notification

! ort requested by: System Generated

(b)(6)-4 (b)(6)-4 M/6d 2391 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 24 Apr 2003@2228 Acc#: (b)(6)-2

Specimen: CSF (CEREBRO) Pri: STAT Ord#: (b)(6)-4

Res Lab: LAB Req Loc: TC2

Accession Comment(s):

CSF TUBE#3

Entered by: (b)(6)-2 on 24 Apr 2003@2228

Test name	Result	Units	Normal range
GLU BF	117.0	mg/dL	

*** End of Report ***

(b)(6)-2

2 (b)(6)-4 (b)(6)-4 FOREIGN NATIONAL - POW/INTERN

18 Apr 2003 / MALE H: W:

Reg #: (b)(6)-4 Loc: CASREC MAIN Room-Bed:

Spon: (b)(6)-4 Rank: UNKNOWN D:

SF519-B Unit: RR:

Transparent print on

Personal Data - Privacy Act 1974 (PL 93-579) Printed date: 24 Apr 2003@1233

Page: 1

RADIOLOGIC EXAMINATION REPORT

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

(b)(3)-1 COMPUTED TOMOGRAPHY

Procedure: CT, HEAD W/O Exam Date: 18 Apr 2003@1610

Requested by: (b)(6)-2 Status: COMPLETE

Ward/Clinic: CASREC MAIN Exam #: (b)(6)-4

Pregnant:

Reason for Order:
S/P TRAUMA, UNCONCIOUS PT INTUBATED EVAL NEURO STATUS

Other Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

NON-CONTRAST HEAD CT shows mucosal thickening of the maxillary, ethmoid, and frontal sinuses. Thickening of nasal turbinates.
Brain is normal. No sub or epidural hematoma. No skull fracture.No hydocephalus. No hemorrhage.

Transcription Date/Time: 18 Apr 2003@1809

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

Approved by: (b)(6)-2 CDR,MC,USN 18 Apr 2003@1816
Supervised by:

(b)(6)-2

(b)(6)-4 (b)(6)-4 FOREIGN NATIONAL - POW/INTERN

18 Apr 2003 / MALE H: W:

Re (b)(6)-4 Loc: CASREC MAIN Room-Bed:

Spon (b)(6)-4 Rank: UNKNOWN D:

SF519-B Unit: RR:

Transparent print on

Personal Data - Privacy Act 1974 (PL 93-579) Printed date: 24 Apr 2003@1233

Page: 1

RADIOLOGIC EXAMINATION REPORT

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

(b)(3)-1

Procedure: KNEE, RT (2) DIAGNOSTIC RADIOLOGY X7420

Requested by: (b)(6)-2 Exam Date: 18 Apr 2003@1608

Ward/Clinic: CASREC MAIN Status: COMPLETE

Exam #: (b)(6)-4

Pregnant:

Reason for Order:
trauma

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

AP and lat views of the right knee: significant soft tissue disruption anteriorly above the patella with associated metallic foreign bodies. No definite fx identified.

Transcription Date/Time: 18 Apr 2003@1749

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

Approved by: (b)(6)-2 CAPT,MC,USN 18 Apr 2003@1752
Supervised by:

(b)(6)-2

2 √

LABORATORY 1-71-0 24 Apr 2003@1404 Page 1

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

Priority Result Notification

I ort requested by: System Generated

(b)(6)-4 (b)(6)-4 M/6d 2391 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 24 Apr 2003@1037 Acc#: (b)(6)-2

Specimen: BLOOD (SERUM) Pri: STAT Ord#: (b)(6)-4

Res Lab: LAB Req Loc: IC2

Test name	Result	Units	Normal range
NA+	143	mmol/L	137 - 145
K	4.4	mmol/L	3.6 - 5.0
CL-	110 H	mmol/L	97 - 107
CO2	22	mmol/L	22 - 31
BUN	56 H	mg/dL	9 - 21
GLUCOSE	339 H*	mg/dL	76 - 110

Test comment(s): NOTIFIED IC2/(b)(6)-2.

CREAT	2.3 H	mg/dL	0.8 - 1.5
CA	8.2 L	mg/dL	8.8 - 10.4
PHOSPHORUS	7.7 H	mg/dL	2.5 - 4.5
PROTEIN TOTAL	6.8	g/dL	6.3 - 8.3
ALBUMIN	3.1 L	g/dL	3.5 - 5.0
AST	104 H	U/L	15 - 46
ALT	81 H	U/L	11 - 66
LDH	1937 H	U/L	313 - 618
ALK PHOS	85	U/L	70 - 250
TBILI	0.6 L	mg/dL	1.0 - 10.5
GGT	139 H	U/L	8 - 78
CK	1538 H	U/L	0 - 203
MG	3.3 H	mg/dL	1.7 - 2.2

Interpretation(s):

*** End of Report ***

(b)(6)-2

2 √

LABORATORY 1-71-0 24 Apr 2003@1416 Page 1

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

Priority Result Notification

ort requested by: System Generated

(b)(6)-4 (b)(6)-4 M/6d 2391 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 24 Apr 2003@1037 Acc#: (b)(6)-2

Specimen: BLOOD (SERUM) Pri: STAT Ord#: (b)(6)-4

Res Lab: LAB Req Loc: IC2

Test name	Result	Units	Normal range
URIC ACID	10.0 H	mg/dL	3.3 - 8.4

*** End of Report ***

(b)(6)-2

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 12 Apr 03 - 24 Apr 03

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

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

24 Apr 03 @ 1117 (Coll)				URINE
STAT UA.	PENDING			
24 Apr 03 @ 1037 (Coll)				SERUM
STAT CMP	UNCERTIFIED			
24 Apr 03 @ 1037 (Coll)				BLOOD
STAT WBC	20.5	H	(4.8-10.8)	K/UL
RBC	3.3	L	(4.7-6.1)	1X10 6/UL
HGB	10.4	L	(14.0-18.0)	g/dL
HCT	30.2	L	(42-52)	%
MCV	90.9		(80-94)	fL
MCH	31.3		(27-32)	pg
MCHC.	34.4		(31-37)	g/dL
RDW	14.2	H	(12-14)	%
PLT CNT	790	H	(150-450)	1x10 3/UL
Result Comment: NOTIFIED LT (b)(6)-2 @ 1055. (b)(6)-2				
MPV	7.9		(7.4-10.4)	FL
SEGS/100 WBC.	91			%
L CD10.	6			%
MONO%	3			1X10 3/UL
PLT EST	HIGH			
MORPHOLOGY.	NORMAL			
24 Apr 03 @ 1037 (Coll)				SERUM
STAT CK.	1538	H	(0-203)	U/L
MG.	3.3	H	(1.7-2.2)	mg/dL
Interpretations:				
24 Apr 03 @ 0925 (Coll)				SERUM
Order comment: code blue				
STAT NA+	144		(137-145)	mmol/L
K	5.9	H	(3.6-5.0)	mmol/L
CL-	110	H	(97-107)	mmol/L
CO2	15	L	(22-31)	mmol/L
Result Comment: SAMPLE WAS MODERATELY HEMOLYZED.				
BUN	51	H	(9-21)	mg/dL
GLUCOSE	290	H	(76-110)	mg/dL
CREAT	2.7	H	(0.8-1.5)	mg/dL

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

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 12 Apr 03 - 24 Apr 03

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

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

24 Apr 03 @ 0350 (Coll)				BLOOD
WBC	21.1	H	(4.8-10.8)	K/UL
RBC	3.6	L	(4.7-6.1)	1X10 6/UL
HGB	11.3	L	(14.0-18.0)	g/dL
HCT	32.6	L	(42-52)	%
MCV	91.2		(80-94)	fL
MCH	31.6		(27-32)	pg
MCHC	34.6		(31-37)	g/dL
RDW	14.0		(12-14)	%
PLT CNT	942.0	H	(150-450)	1x10 3/UL

Result Comment:
Critical result verified by repeat analysis
Notified CDR (b)(6)-2 on 4FP of result @ 0425 -- (b)(6)-2

MPV	7.8		(7.4-10.4)	FL
NEUT/100 WBC	79.2			%
NEUT%	16.7			1x10 3/UL
LYMPHS/100 WBC	12.9			%
LY#	2.7			1x10 3/UL
MONO/100 WBC	7.9			%
MONO%	1.7			1X10 3/UL

24 Apr 03 @ 0350 (Coll)				SERUM
NA+	144		(137-145)	mmol/L
K	4.2		(3.6-5.0)	mmol/L
CL-	109	H	(97-107)	mmol/L
CO2	23		(22-31)	mmol/L
BUN	43	H	(9-21)	mg/dL
GLUCOSE	199	H	(76-110)	mg/dL
CREAT	1.8	H	(0.8-1.5)	mg/dL

24 Apr 03 @ 0350 (Coll)		BLOOD(BLOOD)
BLD CULT	PENDING	

24 Apr 03 @ 0350 (Coll)		BLOOD(BLOOD)
BLD CULT	PENDING	

21 Apr 03 @ 0355 (Coll)				BLOOD
STAT WBC	13.4	H	(4.8-10.8)	K/UL
RBC	3.0	L	(4.7-6.1)	1X10 6/UL
HGB	9.4	L	(14.0-18.0)	g/dL
HCT	27.3	L	(42-52)	%
MCV	90.4		(80-94)	fL
MCH	31.1		(27-32)	pg

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

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 12 Apr 03 - 24 Apr 03

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

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

21 Apr 03 @ 0355 (Coll)				BLOOD
MCHC	34.4		(31-37)	g/dL
RDW	13.5		(12-14)	%
PLT CNT	909.0	H	(150-450)	1x10 3/UL
Result Comment: NOTIFIED HN (b)(6)-2 @ 0415. (b)(6)-2				
MPV	7.9		(7.4-10.4)	FL
NEUT/100 WBC	71.2			%
NEUT%	9.5			1x10 3/UL
LYMPHS/100 WBC	21.2			%
LY#	2.8			1x10 3/UL
MONO/100 WBC	7.6			%
EO#	<0.7			1x10 3/UL
BAS#	<0.2			1x10 3/UL
MONO%	1.0			1X10 3/UL
21 Apr 03 @ 0355 (Coll)				SERUM
STAT CA	8.1	L	(8.8-10.4)	mg/dL
PHOSPHORUS	3.9		(2.5-4.5)	mg/dL
MG	2.5	H	(1.7-2.2)	mg/dL
Interpretations:				
NA+	138		(137-145)	mmol/L
K	4.4		(3.6-5.0)	mmol/L
CL-	105		(97-107)	mmol/L
CO2	26		(22-31)	mmol/L
BUN	18		(9-21)	mg/dL
GLUCOSE	139	H	(76-110)	mg/dL
CREAT	0.9		(0.8-1.5)	mg/dL
20 Apr 03 @ 0407 (Coll)				BLOOD
STAT WBC	14.0	H	(4.8-10.8)	K/UL
RBC	3.0	L	(4.7-6.1)	1X10 6/UL
HGB	9.2	L	(14.0-18.0)	g/dL
HCT	27.1	L	(42-52)	%
MCV	91.0		(80-94)	fL
MCH	31.1		(27-32)	pg
MCHC	34.1		(31-37)	g/dL
RDW	13.0		(12-14)	%
PLT CNT	588.0	H	(150-450)	1x10 3/UL
MPV	8.3		(7.4-10.4)	FL
NEUT/100 WBC	80.0			%
NEUT%	11.2			1x10 3/UL
LYMPHS/100 WBC	14.7			%

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

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 12 Apr 03 - 24 Apr 03

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

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

20 Apr 03 @ 0407 (Coll)				BLOOD
LY#	2.1			1x10 3/UL
MONO/100 WBC	5.3			%
MONO%	0.7			1X10 3/UL
20 Apr 03 @ 0407 (Coll)				SERUM
STAT CA	7.7	L	(8.8-10.4)	mg/dL
PHOSPHORUS	3.3		(2.5-4.5)	mg/dL
MG	2.3	H	(1.7-2.2)	mg/dL
Interpretations:				
NA+	137		(137-145)	mmol/L
K	4.1		(3.6-5.0)	mmol/L
CL-	104		(97-107)	mmol/L
CO2	27		(22-31)	mmol/L
BUN	10		(9-21)	mg/dL
GLUCOSE	128	H	(76-110)	mg/dL
CREAT	0.8		(0.8-1.5)	mg/dL
19 Apr 03 @ 0419 (Coll)				BLOOD
WBC	12.8	H	(4.8-10.8)	K/UL
RBC	2.7	L	(4.7-6.1)	1X10 6/UL
HGB	8.6	L	(14.0-18.0)	g/dL
HCT	24.0	L	(42-52)	%
MCV	89.9		(80-94)	fL
MCH	32.4	H	(27-32)	pg
MCHC	36.0		(31-37)	g/dL
RDW	12.6		(12-14)	%
PLT CNT	428.0		(150-450)	1x10 3/UL
MPV	8.1		(7.4-10.4)	FL
NEUT/100 WBC	79.0			%
NEUT%	10.1			1x10 3/UL
LYMPHS/100 WBC	14.4			%
LY#	1.8			1x10 3/UL
MONO/100 WBC	6.6			%
MONO%	0.8			1X10 3/UL
19 Apr 03 @ 0419 (Coll)				SERUM
STAT CA	7.4	L	(8.8-10.4)	mg/dL
PHOSPHORUS	4.0		(2.5-4.5)	mg/dL
AMYLASE	92		(30-110)	U/L
LIPASE	645	H	(23-300)	U/L
MG	2.4	H	(1.7-2.2)	mg/dL

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

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 12 Apr 03 - 24 Apr 03

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

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

19 Apr 03 @ 0419 (Coll) SERUM
Interpretations:

NA+	134	L	(137-145)	mmol/L
K	4.0		(3.6-5.0)	mmol/L
CL-	100		(97-107)	mmol/L
CO2	32	H	(22-31)	mmol/L
BUN	11		(9-21)	mg/dL
GLUCOSE	196	H	(76-110)	mg/dL
CREAT	0.9		(0.8-1.5)	mg/dL

18 Apr 03 @ 2222 (Coll) URINE

ACETONE	POSITIVE			

18 Apr 03 @ 2151 (Coll) BLOOD

STAT WBC	14.9	H	(4.8-10.8)	K/UL
RBC	2.8	L	(4.7-6.1)	1X10 6/UL
HGB	9.0	L	(14.0-18.0)	g/dL
HCT	25.4	L	(42-52)	%
MCV	90.9		(80-94)	fL
MCH	32.3	H	(27-32)	pg
MCHC	35.5		(31-37)	g/dL
RDW	12.9		(12-14)	%
PLT CNT	400.0		(150-450)	1x10 3/UL
MPV	7.7		(7.4-10.4)	FL
NEUT/100 WBC	88			%
LYMPHS/100 WBC	8			%
MONO/100 WBC	2			%
BANDS/100 WBC	1			%
PLT EST	NORMAL			
MORPHOLOGY	NORMAL			

18 Apr 03 @ 2151 (Coll) SERUM

STAT CA	7.4	L	(8.8-10.4)	mg/dL
PHOSPHORUS	4.1		(2.5-4.5)	mg/dL
MG	2.2		(1.7-2.2)	mg/dL

Interpretations:

NA+	132	L	(137-145)	mmol/L
K	3.9		(3.6-5.0)	mmol/L
CL-	96	L	(97-107)	mmol/L
CO2	31		(22-31)	mmol/L
BUN	12		(9-21)	mg/dL

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

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 12 Apr 03 - 24 Apr 03

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

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

18 Apr 03 @ 2151 (Coll)					SERUM
GLUCOSE	154	H	(76-110)	mg/dL	
CREAT	0.8		(0.8-1.5)	mg/dL	
18 Apr 03 @ 2142 (Coll)					URINE
STAT COLOR	YELLOW				
APPEARANCE	CLEAR				
SG	1.005	L	(1.010-1.020)		
Interpretations:					
Normal Range provided is for first morning void.					
PH	8.0	H	(4.5-7.5)		
LEUKO EST	TRACE	H	(NEGATIVE)		
NITRITE	NEG		(NEGATIVE)		
U PROT	TRACE		(NEG)	MG/DL	
U GLUCOSE	NEG		(NEGATIVE)	mg/dL	
U KETONES	SMALL(15MG/DL)	H	(NEGATIVE)	mg/dL	
UROBLGN	0.2		(0-1)	mg/dl	
U BILI	NEGATIVE		(NEGATIVE)		
ICTOTEST	NEGATIVE				
U HGB	LARGE	H	(NEGATIVE)		
U WBC	20-50	H	(0-2)	/HPF	
U RBC	>100	H			
MUCOUS	NEG				
U EPI	NEGATIVE				
BACTERIA	NEGATIVE			/HPF	
SSA	0		(0)	mg/100ml	
18 Apr 03 @ 1641 (Coll)					SERUM
STAT NA+	133	L	(137-145)	mmol/L	
K	4.2		(3.6-5.0)	mmol/L	
CL-	96	L	(97-107)	mmol/L	
CO2	29		(22-31)	mmol/L	
BUN	12		(9-21)	mg/dL	
GLUCOSE	115	H	(76-110)	mg/dL	
CREAT	0.9		(0.8-1.5)	mg/dL	
CA	7.6	L	(8.8-10.4)	mg/dL	
PHOSPHORUS	5.3	H	(2.5-4.5)	mg/dL	
URIC ACID	2.6	L	(3.3-8.4)	mg/dL	
PROTEIN TOTAL	5.8	L	(6.3-8.3)	g/dL	
ALBUMIN	2.5	L	(3.5-5.0)	g/dL	
AST	72	H	(15-46)	U/L	
ALT	57		(11-66)	U/L	

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

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 12 Apr 03 - 24 Apr 03

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

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

18 Apr 03 @ 1641 (Coll)				SERUM
LDH	1861	H	(313-618)	U/L
ALK PHOS	98		(70-250)	U/L
TBILI	0.7	L	(1.0-10.5)	mg/dL
GGT	78		(8-78)	U/L
CK	827	H	(0-203)	U/L
MG	2.2		(1.7-2.2)	mg/dL

Interpretations:

18 Apr 03 @ 1641 (Coll)				PLASMA
STAT APTT	22.7	L	(23.8-35.5)	Seconds
PT	15.7	H	(11.6-14.4)	Seconds
INR	1.3			

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.

18 Apr 03 @ 1641 (Coll)				BLOOD
STAT WBC	11.3	H	(4.8-10.8)	K/UL
RBC	3.5	L	(4.7-6.1)	1X10 6/UL
HGB	10.9	L	(14.0-18.0)	g/dL
HCT	32.1	L	(42-52)	%
MCV	91.0		(80-94)	fL
MCH	30.9		(27-32)	pg
MCHC	34.0		(31-37)	g/dL
RDW	12.6		(12-14)	%
PLT CNT	352.0		(150-450)	1x10 3/UL
MPV	8.0		(7.4-10.4)	FL
NEUT/100 WBC	79.7			%
NEUT%	9.0			1x10 3/UL
LYMPHS/100 WBC	13.2			%
LY#	1.5			1x10 3/UL
MONO/100 WBC	7.1			%
MONO%	0.8			1X10 3/UL

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

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 12 Apr 03 - 24 Apr 03

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

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

18 Apr 03 @ 1641 (Coll) URINE

STAT COLOR	YELLOW			
APPEARANCE	CLEAR			
SG	1.010		(1.010-1.020)	

Interpretations:
Normal Range provided is for first morning void.

PH	7.0		(4.5-7.5)	
LEUKO EST	NEGATIVE		(NEGATIVE)	
NITRITE	NEG		(NEGATIVE)	
U PROT	NEG		(NEG)	MG/DL
U GLUCOSE	NEG		(NEGATIVE)	mg/dL
U KETONES		H	(NEGATIVE)	mg/dL
	MODERATE(40MG/DL)			

Result Comment: ACETEST = SMALL

UROBLGN	0.2		(0-1)	mg/dl
U BILI	NEGATIVE		(NEGATIVE)	
ICTOTEST	NEGATIVE			
U HGB	NEG		(NEGATIVE)	
U WBC	1-3	H	(0-2)	/HPF
U RBC	10-20	H		

18 Apr 03 @ 1641 (Coll) TRACHEAL ASP(SPUTUM)
RESP CUL: Final Report
Bacteriology Result:
moderate A. baumannii. Sens to: Imipenem.

18 Apr 03 @ 1641 (Coll) URINE/CC(URINE)
UA CULT: Final Report
Bacteriology Result:
no growth

18 Apr 03 @ 1641 (Coll) BLOOD(BLOOD)
Order comment: FUNGAL
BLD CULT: Final Report
Bacteriology Result:
AEROBIC AND ANAEROBIC VAILS, NO GROWTH X 5 DAYS

----------Ordered for (Uncollected)----------

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

Personal Data - Privacy Act of 1974 (PL 93-579)
PATIENT LAB INQUIRY
For: 12 Apr 03 - 24 Apr 03

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

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

24 Apr 03 @ 0924 (OrdFor)		BLOOD
Order comment: code blue		
STAT CBC	UNACKNOWLEDGED	
24 Apr 03 @ 0843 (OrdFor)		BLOOD
CBC	UNACKNOWLEDGED	
24 Apr 03 @ 0843 (OrdFor)		BLOOD
DIFF.	UNACKNOWLEDGED	

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)(6)-4 (b)(6)-4 FOREIGN NATIONAL - POW/INTERN

18 Apr 2003 / MALE H: W:

Reg #: (b)(6)-4 Loc: CASREC MAIN Room-Bed:

Spon: (b)(6)-4 Rank: UNKNOWN D:

SI -B Unit: RR:

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Personal Data - Privacy Act 1974 (PL 93-579) Printed date: 24 Apr 2003@1233

Page: 1

RADIOLOGIC EXAMINATION REPORT

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

(b)(3)-1 DIAGNOSTIC RADIOLOGY (b)(3)-1

Procedure: C-SPINE (2 VIEW)X-TABLE LAT AND AP Exam Date: 18 Apr 2003@1716

Requested by: (b)(6)-2 Status: COMPLETE

Ward/Clinic: CASREC MAIN Exam #: (b)(6)-4

Pregnant:

Reason for Order:
IRAQUI MALE, INTUBATED

Order Comment:
R/O SPINAL FX

Result Code: NORMAL

Report:

Normal portable cross-table lateral c-spine.

Transcription Date/Time: 18 Apr 2003@1753

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

Approved by: (b)(6)-2 CAPT,MC,USN 18 Apr 2003@1754
Supervised by:

(b)(6)-4 (b)(6)-4 FOREIGN NATIONAL - POW/INTERN

18 Apr 2003 / I. .E H: W:

Reg #: (b)(6)-4 Loc: CASREC MAIN Room-Bed:

Spon: (b)(6)-4 Rank: UNKNOWN D:

SF519-B Unit: RR:

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Personal Data - Privacy Act 1974 (PL 93-579) Printed date: 24 Apr 2003@1233

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RADIOLOGIC EXAMINATION REPORT

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

(b)(3)-1 DIAGNOSTIC RADIOLOGY (b)(3)-1

Procedure: KUB Exam Date: 18 Apr 2003@1716

Requested by: (b)(6)-2 Status: COMPLETE

Ward/Clinic: CASREC MAIN Exam #: (b)(6)-4

Pregnant:

Reason for Order:
IRAQI MALE, INTUBATED

Order Comment:
PLACEMENT OF NG TUBE

Result Code: SEE RADIOLOGIST'S REPORT

Report:

Portable KUB shows shrapnel over the sacrum and air within nondilated small and large bowel suggestive of ileus. Due to overlying bowel gas, a sacral fx cannot be excluded. Bones and soft tissues otherwise normal.

Transcription Date/Time: 18 Apr 2003@1728

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

Approved by: (b)(6)-2 CAPT,MC,USN 18 Apr 2003@1732
Supervised by:

Reg #: (b)(6)-4 Loc: CASREC MAJ Room-Bed:
Spon: (b)(6)-4 Rank: UNKNOWN):
SF519-B Unit: RR:

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Personal Data - Privacy Act 1974 (PL 93-579) Printed date: 24 Apr 2003@1233
Page: 1

RADIOLOGIC EXAMINATION REPORT

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

(b)(3)-1 DIAGNOSTIC RADIOLOGY (b)(3)-1

Procedure: PORTABLE, CHEST (AP ONLY) Exam Date: 18 Apr 2003@1920
Requested by: (b)(6)-2 Status: COMPLETE
Ward/Clinic: ICU #2 I-78-2 X7257 Exam #: (b)(6)-4
Pregnant:

Reason for Order:
VERIFY LEFT IJ PLACEMENT

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

Compared with exam today @ 1726. Interval placement of left IJ line - tip in S[illegible] No pneumothorax. ETT ok. No significant change in pulmonary disease.

Transcription Date/Time: 18 Apr 2003@1940

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

Approved by: (b)(6)-2 MD LCDR, MC ,USN 22 Apr 2003@1055
Supervised by:

SF519-B Unit: RR:

Transparent print on

P[illegible]nal Data - Privacy Act 1974 (PL 93-579) Printed date: 24 Apr 2003@1233
Page: 1

RADIOLOGIC EXAMINATION REPORT

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

(b)(3)-1

Procedure: CHEST, AP (PORTABLE)
Requested by: (b)(6)-2
Ward/Clinic: ICU #2 1-78-2 X7257

DIAGNOSTIC RADIOLOGY (b)(3)-1
Exam Date: 19 Apr 2003@0412
Status: COMPLETE
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
INTUBATED

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

Portable AP CXR cf yesterday evening. ETT 4.4cm above carina. Left IJ line unchanged and in good position. Much better lung volumes on this film with continued patchy infiltrates greater on the right side than on the left, s[illegible]what improved from the prior even when better volume considered. Ot[illegible]erwise stable.

Transcription Date/Time: 19 Apr 2003@0835

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

Approved by: (b)(6)-2 CAPT,MC,USN 19 Apr 2003@0838
Supervised by:

(b)(6)-4

18 Apr 2003 / MA[illegible]

FOREIGN NATIONAL - POW/INTERN
H:

Transparent print on

Personal Data - Privacy Act 1974 (PL 93-579) Printed date: 24 Apr 2003@1233
Page: 1

RADIOLOGIC EXAMINATION REPORT

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

(b)(3)-1

Procedure: PORTABLE CHEST (AP ONLY)
Requested by: (b)(6)-2
Ward/Clinic: ICU #2 1-78-2 X7257

DIAGNOSTIC RADIOLOGY (b)(3)-1
Exam Date: 20 Apr 2003@0705
Status: COMPLETE
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
PCXR RULE OUT ATELECTASIS

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

An AP portable chest radiograph is compared to a similar study from the previous day. Interval removal of endotracheal tube and enteric tube. Left internal jugular central venous catheter with tip abutting the wall of the superior vena cava. Low lung volumes with bibasilar atelectasis. No pneumothorax.

IMPRESSION: S/p removal of endotracheal and enteric tubes with bibasilar atelectasis.

Transcription Date/Time: 20 Apr 2003@1016

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

Approved by: (b)(6)-2 CDR,MC,USN 21 Apr 2003@1303
Supervised by:

(b)(6)-4

Reg #: (b)(6)-4

18 Apr 2003 / MALE
Loc: CASREC MAIN
Spon: (b)(6)-4

FOREIGN NATIONAL - POW/INTERN
H: W:
Room-Bed:
Rank: UNKNOWN

Personal Data - Privacy Act 1974 (PL 93-579) Printed date: 24 Apr 2003@1233
Page: 1

RADIOLOGIC EXAMINATION REPORT

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

(b)(3)-1

Procedure: CHEST, AP (PORTABLE)
Requested by: (b)(6)-2
Ward/Clinic: WARD 4 FWD PORT 4-47-0 X7117

DIAGNOSTIC RADIOLOGY X7420
Exam Date: 24 Apr 2003@1031
Status: TRANSCRIBED
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
r/o infiltrates

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

An AP portable chest radiograph is compared to a similar study from 20 April 2003. Central venous catheter entering from the left internal jugular vein with tip in the superior vena cava. Stable cardiomediastinal silhouette. Lungs volume are low, unchanged. No new focal parenchymal opacities. No pneumothorax. Midline trachea.

IMPRESSION: Persistent low lung volumes, but overall, no significant i rval change from 20 April.

Transcription Date/Time: 24 Apr 2003@1059

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

Approved by:
Supervised by:

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

(b)(6)-4

18 Apr 2003 / MALE
Loc: CASREC MAIN
Spon: (b)(6)-4
Unit:

FOREIGN NATIONAL - POW/INTERN
H: W:
Room-Bed:
Rank: UNKNOWN D:
RR:

Rey #: (b)(6)-4

SF519-B

(b)(6)-4

18 Apr 2003 / MALE
Reg #: (b)(6)-4
Loc: CASREC MAIN
Spon: (b)(6)-4
SF519-B
Unit:

FOREIGN NATIONAL - POW/INTERN
H: W:
Room-Bed:
Rank: UNKNOWN D:
RR:

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

Printed date: 24 Apr 2003@1233
Page: 1

RADIOLOGIC EXAMINATION REPORT

Patient: (b)(6)-4

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

(b)(3)-1

Procedure: CHEST, AP (PORTABLE)
Requested by: (b)(6)-2
Ward/Clinic: CASREC MAIN

DIAGNOSTIC RADIOLOGY X7420
Exam Date: 18 Apr 2003@1604
Status: COMPLETE
Exam #: (b)(6)-4
Pregnant:

Reason for Order:
C EC TRAUMA, COMFIRM ET TUBE PLACEMENT

Order Comment:

Result Code: SEE RADIOLOGIST'S REPORT

Report:

Portable AP chest without priors shows an ETT 5 cm above the carina. Enteric tube(s) off the film inferiorly below the diaphragm. Bilateral airspace process worse on the right suggestive of pneumonia or contusion; a component of failure is also suggested with enlarged pulmonary veins. Right pleural effusion also present. Bullet fragment overlies the left lateral sulcus. No fx or dislocation identified. No pneumothorax.

Conclusion: Diffuse bilateral airspace disease as noted, right greater than left.

Transcription Date/Time: 18 Apr 2003@1731

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

Approved by: (b)(6)-2 CAPT,MC,USN 18 Apr 2003@1737
Supervised by:

(b)(6)-4

Reg #: (b)(6)-4

SF519-B

18 Apr 2003 / MALE
Loc: CASREC MAIN
Spon: (b)(6)-4
Unit:

FOREIGN NATIONAL - POW/INTERN
H: W:
Room-Bed:
Rank: UNKNOWN D:
RR:

2 √

LABORATORY 1-71-0 25 Apr 2003@1306 Page 1

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

Lab Certified Result Notification

ort requested by: System Generated

(b)(6)-4 (b)(6)-4 M/7d 2391 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 25 Apr 2003@1101 Acc#: (b)(3)-1

Specimen: BLOOD (SERUM) Pri: ROUTINE Ord#: (b)(6)-4

Res Lab: LAB Req Loc: IC2

Test name	Result	Units	Normal range
TSH SENSITIVE	TNP	MCIU/ML	0.325 - 2.659

Test comment(s): DUPLICATE ORDER SEE TFT RESULT. DMP.\

*** End of Report ***

2 √

LABORATORY 1-71-0 25 Apr 2003@1246 Page 1

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

Lab Certified Result Notification

I ort requested by: System Generated

(b)(6)-4 (b)(6)-4 M/7d 2391 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 25 Apr 2003@1101 Acc#: (b)(3)-1

Specimen: BLOOD (SERUM) Pri: ROUTINE Ord#: (b)(6)-4

Res Lab: LAB Req Loc: IC2

Test name	Result	Units	Normal range
T3	.50	NG/ML	0.50 - 1.26
T4 FREE	1.13	NG/DL	0.91 - 1.44
TSH SENSITIVE	1.0	MCIU/ML	0.325 - 2.659

*** End of Report ***

; gathered:
' since day of

:are to
)st C/W

l; Xray here no
ed qd as of
, but moves it.
ted 4/19/03;
!1/03 5.
)n Nystatin

has RUE

4/24/2003

2 √

LABORATORY 1-71-0 25 Apr 2003@0050 Page 1

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

Lab Certified Result Notification

ort requested by: System Generated

(b)(6)-4 (b)(6)-4 M/7d 2391 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 24 Apr 2003@2227 Acc#: (b)(3)-1

Specimen: CSF (CEREBRO) Pri: ROUTINE Ord#: (b)(6)-4

Res Lab: LAB Req Loc: IC2

Test name	Result	Units	Normal range
MN CELL	80		

Test comment(s): Result is a percentage 33 of 41 cells counted were mono

PMN CELLS	20	MM3	

Test comment(s): result is a percentage 8 of 41 cells counted were poly

*** End of Report ***

(b)(6)-2

2 √

LABORATORY 1-71-0 25 Apr 2003@0506 Page 1

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

Priority Result Notification

: ort requested by: System Generated

(b)(6)-4 (b)(6)-4 M/7d (b)(6)-4 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 25 Apr 2003@0432 Acc#: (b)(3)-1

Specimen: BLOOD (BLOOD) Pri: STAT Ord#: (b)(6)-4

Res Lab: LAB Req Loc: TC2

Test name	Result	Units	Normal range
WBC	15.9 H	K/UL	4.8 - 10.8
RBC	3.1 L	1X10 6/UL	4.7 - 6.1
HGB	9.7 L	g/dL	14.0 - 18.0
HCT	28.7 L	%	42 - 52
MCV	91.9	fL	80 - 94
MCH	31.0	pg	27 - 32
MCHC	33.7	g/dL	31 - 37
RDW	14.3 H	%	12 - 14
PLT CNT	736.0 H	1x10 3/UL	150 - 450
Test comment(s): NOTIFIED LCDR (b)(6)-2 @ 0505. (b)(6)-2			
MPV	8.0	FL	7.4 - 10.4
NEUT/100 WBC	78.5	%	
NEUT%	12.5	1x10 3/UL	
LYMPHS/100 WBC	15.6	%	
LY#	2.5	1x10 3/UL	
MONO/100 WBC	5.9	%	
MO#	0.9	1x10 3/UL	

*** End of Report ***

(b)(6)-2

2 √

LABORATORY 1-71-0 25 Apr 2003@0529 Page 1

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

Priority Result Notification

I ort requested by: System Generated

(b)(6)-4 (b)(6)-4 M/7d 2391 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 25 Apr 2003@0432 Acc#: (b)(3)-1

Specimen: BLOOD (SERUM) Pri: ASAP Ord#: (b)(6)-4

Res Lab: LAB Req Loc: IC2

Test name	Result	Units	Normal range
VANCOMYCIN	6.3	ug/mL	

*** End of Report ***

(b)(6)-2

2 ✓

LABORATORY 1-71-0 25 Apr 2003@0540 Page 1

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

Priority Result Notification

ort requested by: System Generated

(b)(6)-4 (b)(6)-4 M/7d (b)(6)-4 ph#

Mil. Unit: UNKNOWN

Ordered by: (b)(6)-2 Col: 25 Apr 2003@0432 Acc#: (b)(3)-1

Specimen: BLOOD (SERUM) Pri: STAT Ord#: (b)(6)-4

Res Lab: LAB Req Loc: IC2

Test name	Result	Units	Normal range
NA+	152 H	mmol/L	137 - 145
K	4.3	mmol/L	3.6 - 5.0
CL-	120 H	mmol/L	97 - 107
CO2	24	mmol/L	22 - 31
BUN	37 H	mg/dL	9 - 21
GLUCOSE	242 H	mg/dL	76 - 110
CREAT	1.4	mg/dL	0.8 - 1.5

*** End of Report ***

(b)(6)-2