POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
BP			118/70				115/60		
P			16				16		
R			22				15		
SpO2			18				99		
RA/O2			RA				RA		

	16	17	18	19	20	21	22	23	8°T
I/O									

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_iO_2									
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GAS	A	pH								
		PCO_2								
		pO_2								
	B	HCO_3								
		SAT								
	G	BASE								

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES OF DAILY LIVING	TIME									
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

TURN	TIME						
SUCTION							

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	_____	Urine:	_____
po	_____		_____
	_____		_____
TOTAL	_____	TOTAL	_____

BALANCE _____

NURSE'S SIGNATURE	INITIALS

NEUROLOGICAL ASSESSMENT

		HOURS	
COMA SCALE	EYES OPEN	SPONTANEOUSLY	4
		TO SPEECH	3
		TO PAIN	2
		NO EYE OPENING	1
	BEST VERBAL RESPONSE	ORIENTED	5
		CONFUSED	4
		VERBALIZES	3
		VOCALIZES	2
		NO VOCALIZATION	1
	BEST MOTOR RESPONSE	OBEYS COMMANDS	6
		LOCALIZES PAIN	5
		FLEXION WITHDRAWAL	4
		ABNORMAL FLEXION	3
		EXTENSION TO PAIN	2
		NO MOTOR RESPONSE	1
LIMB MOVEMENT	ARMS	NORMAL POWER	
		MILD WEAKNESS	
		SEVERE WEAKNESS	
		ABNORMAL FLEXION	
		ABNORMAL EXTENSION	
		NO RESPONSE	
	LEGS	NORMAL POWER	
		MILD WEAKNESS	
		SEVERE WEAKNESS	
		ABNORMAL FLEXION	
		ABNORMAL EXTENSION	
		NO RESPONSE	
PUPILS	RIGHT	SIZE	
		REACTION	
	LEFT	SIZE	
		REACTION	
PUPIL SCALE		2 3 4 5 6 7 mm	
ICP			
CEREBRAL PERFUSION PRESSURE			

LEGEND

- C Closed by swelling
- T Trach/Endo
- S Slurring
- D Dysphasia
- R Receptive
- E Expressive
- R Right
- L Left

Record separately if there is a difference between the two sides.

- + + Brisk
- + Slow
- - No Response
- + Intact
- - Abnormal

VASCULAR ASSESSMENT

HOURS	
	R / L
	R / L
	R / L
	R / L
	R / L

LEGEND

- + + Normal
- + Weak
- - Absent
- D Doppler
- R Right
- L Left

For

...ICAL RECORD—SUPPLEMENTAL MEDICAL DA...
See AR 40-66; the proponent agency is the Office of Th... C

REPORT TITLE
INTENSIVE C... NURSING FLOW SHEET

G APPROVED (Date)
VA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

b6-2

		TIME 0700	INITIALS	INITIALS	[redacted]
NEURO	PUPILS	Pupils peerla bright			3mm Peerla
	SENSORIUM	a/o follows commands			follows commands
		appropriate affect			
		moves all extremities			
RESPIRATORY	RESPIRATORY PATTERN	even & unlabored			
	BREATH SOUNDS	CTA bilat			
	SECRETIONS	∅ no cough			∅ cough
		spec. 98-99 on RA.			
SKIN	COLOR	appropriate for race			Appropriate for race
	INTEGRITY	see wound note.			
IV SITE	LOCATION	∅			∅
	CONDITION				
					LLE - pitting edema, slight tenderness
					RUE - [illegible]
GASTRO	ABDOMEN	soft nontender.			
	BOWEL SOUNDS	BS x 4			BS x 4
		∅ N/V/D			∅ N/V/D
		Good appetite. 75% of breakfast			
GU	URINE	urinal @ bedside			voids spontaneously
	COLOR/CLARITY	amber clear			urinal at bedside
CARDIOVASCULAR	CARDIAC RHYTHM	NSR 5 ectopy			NSR
		+2 pulses UE & LE.			+2 pulses x 4
		+2 edema noted			+1 edema most new
		RLE ∅ JVD.			to RLE
		LEGEND: cr - Creatinine; F_IO_2 - Fraction of inspired O_2; FiO_2 - Fraction of inspired air; ICP - Intracranial Pressure; PCO_2 - Pressure of arterial CO_2; PEEP - Positive End Expiratory Pressure; Sat - Fractional Saturation; Sat - Saturation; Trach - Tracheostomy			

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE
	ICU	

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

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

DA FORM 1 MAY 78 4700
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 Apr 90 (HSXC-NU)

[redacted] b6-4

14 JUL 03

DATE | DX | HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line					115			112									120	
	BP Cuff					70			68									70	
	Temperature					97.5			98.1									98.4	
	Pulse					77			80									84	
	Respiratory Rate					12			16									14	
	SpO2					97			98									97	
	BNO2					RA			RA									RA	

INTAKE	TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
		400							300					300				500	
	TOTALS																		

OUTPUT																			
	URINE	HOUR / TOTAL	400										300					500	
		Spg																	
		S/A																	
	NG	OUTPUT																	
		pH																	
		GUIAC																	
	EMESIS																		
	STOOL																		
	DRAINS																		
	TOTALS																		

E [redacted] b6-4

POST-OP DAY

	16	17	18	19	20	21	22	23	
BP			145/64						
M			116						
Sats			98						
HR			85						

	16	17	18	19	20	21	22	23	8" T
Urine				UD					

ACUITY LEVEL CLASSIFICATION

RESPIRATORY		TIME									
		MODE									
		F_IO_2									
		TV									
		RATE									
		PEEP									
	A	pH									
		PCO_2									
	B	pO_2									
		HCO_3									
		SAT									
	G	BASE									

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES OF DAILY LIVING	TIME				TURN	TIME				
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE				SUCTION					
	TRACH CARE									
	ROM EXERCISES									

24 I&O TOTALS		NURSE'S SIGNATURE	INITIALS
wt Yesterday	wt Today		
INTAKE	OUTPUT		
IV	Urine:		
po			
TOTAL	TOTAL		
BALANCE			

[redacted] b6-4

NEUROLOGICAL ASSESSMENT

		HOURS	07	1730
COMAS	EYES OPEN	SPONTANEOUSLY 4	4	4
		TO SPEECH 3		
		TO PAIN 2		
		NO EYE OPENING 1		
	BEST VERBAL RESPONSE	ORIENTED 5	5	5
		CONFUSED 4		
		VERBALIZES 3		
		VOCALIZES 2		
		NO VOCALIZATION 1		
GALE	BEST MOTOR RESPONSE	OBEYS COMMANDS 6	6	6
		LOCALIZES PAIN 5		
		FLEXION WITHDRAWAL 4		
		ABNORMAL FLEXION 3		
		EXTENSION TO PAIN 2		
		NO MOTOR RESPONSE 1		
LIMB MOVEMENT	ARMS	NORMAL POWER	✓	✓
		MILD WEAKNESS		
		SEVERE WEAKNESS		
		ABNORMAL FLEXION		
		ABNORMAL EXTENSION		
		NO RESPONSE		
	LEGS	NORMAL POWER	L	L
		MILD WEAKNESS	R	R
		SEVERE WEAKNESS		
		ABNORMAL FLEXION		
		ABNORMAL EXTENSION		
		NO RESPONSE		
PUPILS	RIGHT	SIZE	3	3
		REACTION	+	
	LEFT	SIZE	3	3
		REACTION	+	
PUPIL SCALE			2 3 4 5 6 7 mm	
ICP				
CEREBRAL PERFUSION PRESSURE				

LEGEND

C Closed by swelling

T Trach/Endo
S Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left
Record separately if there is a difference between the two sides

+ + Brisk
+ Slow
- No Response

+ Intact
- Abnormal

VASCULAR ASSESSMENT

HOURS																										
	R/L																									
	R/L																									
	R/L																									
	R/L																									
	R/L																									

LEGEND

+ + Normal
+ Weak
- Absent
D Doppler
R Right
L Left

E [redacted] 66-4

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHEET ASSESSMENT

		TIME	INITIALS	INITIALS	INITIALS
NEURO	PUPILS	0600	[redacted]	b6-2	
	SENSORIUM	3mm-Perrla			
		AOX3			
		verbalizes small			
		amount of pain			
RESPIRATORY	RESPIRATORY PATTERN	even unlabored			
	BREATH SOUNDS	CTA (B)			
	SECRETIONS	Ø			
SKIN	COLOR	warm & dry			
	INTEGRITY	NFR, stitches			
		(R) UL, ex fix (R) LL			
IV SITE	LOCATION				
	CONDITION	Ø			
GASTRO	ABDOMEN	NT, ND,			
	BOWEL SOUNDS	soft, no masses			
		palpable			
GU	URINE	void via urthal			
	COLOR/CLARITY				
CARDIOVASCULAR	CARDIAC RHYTHM	S1, S2, SR			

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; F/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU 2nd

DATE: 15 July 03

middle; grade; date; hospital or medical facility) Name—last, first, b6-2

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

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

WAMC OP 375 (Redesignated) 1 Apr 90 (HSXC-NU)

CPW [redacted] b6-4

DATE

HOSPITAL DAY

VITAL SIGNS																	
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line					110		120										
BP Cuff					70		82										
Temperature					96.9												
Pulse					90		88										
Respiratory Rate					16		22										
SpO					99		98										

INTAKE																		
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
					40													
TOTALS																		

OUTPUT																		
URINE	HOUR / TOTAL																	
	10 SP																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

EPW [redacted] b6-4

POST-OP DAY

16	17	18	19	20	21	22	23		

16	17	18	19	20	21	22	23	8°T			

ACUITY LEVEL CLASSIFICATION

RESPIRATORY		TIME									
		MODE									
		F_IO_2									
		TV									
		RATE									
		PEEP									
	A	pH									
		PCO_2									
		pO_2									
	B	HCO_3									
		SAT									
	G	BASE									

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	CL/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES OF DAILY LIVING	TIME				TURN	TIME			
	MOUTH CARE								
	BATH								
	SKIN CARE								
	FOLEY CARE				SUCTION				
	TRACH CARE								
	ROM EXERCISES								

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	_____	Urine:	_____
po	_____		_____
	_____		_____
TOTAL	_____	TOTAL	_____

BALANCE _____

NURSE'S SIGNATURE	INITIALS

EPW [redacted] b6-4

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: **Post-Anesthesia Care Unit (PACU) Flow Sheet**

OTSG APPROVED *(Date)*

Date: 18 Jul 03
Time In: 2030
Allergies: _____ OR Intake: Crystalloid 600 Colloid _____
Pre-op V/S: _____ OR Output: UOP _____ EBL _____
Procedures: MS (R) femur Meds/Times: _____
adjust ex-fix

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	2030	2035	2040	2045	2100	2115	2145								
SaO2	94	93	97	95	93	93	95								
FiO2	[redacted]														
Methods															
240															
220															
200															
180															
160															
140	✓	✓													
				✓											
120	•	•	✓		✓	✓	✓								
100			•	•	•	•	•								
80		∧	∧	∧											
	∩				∧	∧	∧								
60															
40															
20															
RR	12	14	14	13	14	10	14								
T	97														

b6-2

Time										
Pain (0-10)										
LOS										

Patient teaching done; Wound Care, Pain Management,
T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	1	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	8	8	9

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
" = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted] CPT/AN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 18 Jul 03

PATIENT'S IDENTIFICATION *(For typed or [redacted] use: Name — last, first, middle; grade; date; hospital or medical facility)* b6-2

[redacted] b6-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	Rleg	+	+	P	B	W	PK
15'	Rleg	+	+	P	B	W	PK
30'	Rleg	+	+	P	B	W	PK
45'							
60'							
90'							
D/C							

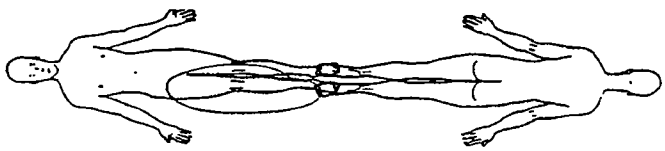
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia			N/A				
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	R femur	Lertex	none
30'	R femur	Lertex	none
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Discharge Criteria:
Date: 18Jun03 **Time:** 2200 **PARS:** 9
BP: 119/74 **T:** 98.8 **HR:** 104 **RR:** 16 **Sa02:** 95%
Pain Level at D/C (0-10):
Intake: 0 **Output:** 0
Additional Data:
Transferred To: ICW 2
Report Given To:
Transferred Via: W/C Litter Gurney Ambulance
Transferred By: CpH [redacted]
Cleared IAW Recovery Room SOP R-2 [redacted]
Charge Nurse Signature [redacted]

b6-2

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 21 JUL 03
Time In: 2240
Allergies: NKDA
Pre-op V/S: 130/74 87
Procedures: I/D (R) FEMUR

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 350 Colloid
OR Output: UOP Ø EBL <50cc
Meds/Times:

VERSED
FENT

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds History

Time	2240	2245	2250	2305	2320
SaO2	100	99	99	100	100
FiO2	RA	RA	RA	RA	RA
Methods					
240					
220					
200					
180					
160					
140	V	V	V	V	
120					
100	•	•	•	•	
80	^	^	^		
60					
40				^	
20					
RR	19	22	24	16	
T	97				99

Pacu Intake					
Time	Solution	Amount	Site	By	Infused
X-rays:			Labs:		

Post-Anesthesia Recovery score

Criteria	ADM	30"	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	[redacted] b6-2	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	/	/	/
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	9	10	10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
^ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Time	2240	2300
Pain (0-10)	Ø	4/5
LOS		

Patient teaching done: Wound Care, Pain Management, T. C. & DB., Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] b6-2 b2-2

DEPARTMENT/SERVICE/CLINIC: [redacted] ICU 2

DATE: 21 JUL 03

PAT[redacted]TION (For typed or written entries give: Name – last, first, [redacted] hospital or medical facility)

[redacted] b6-4

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

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
2300		MSO4 3MG	IVP			[redacted]
2310		BENADRYL 50MG	IVP			[redacted]
						b6-2

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	RLE	Ø	+	+	BR	W	NL
15'							
30'							
45'							
60'							
90'							
D/C	RLE	Ø	+	+	BR	W	NL

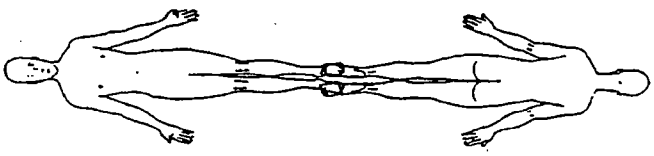
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?

NURSING NOTES

b6-2

2300 3MG MSO4 FOR PAIN [redacted]
2310 PT C C/O ITCHING REDNESS TO RA 2° TO MSO4 IVP INFORMED MD GRANGER ORDERED 50MG BENADRYL IVP. MED GIVEN. VSS WILL MONITOR.
[redacted]

Discharge Criteria:
Date: 21 JUL 4 **Time:** 2330 **PARS:** 10
BP: 128/74 **T:** 97.6 **HR:** 85 **RR:** 18 **SaO2:** 100
Pain Level at D/C (0-10):
Intake: Ø **Output:** Ø
Additional Data: Ø
Transferred To: ICW 2
Report Given To: 1LT [redacted] — all b6-2
Transferred Via: W/C (Litter) Gurney Ambulance
Transferred By: 1LT [redacted], SGT [redacted]
Cleared IAW Recovery Room SOP B-3
Charge Nurse Signature: [redacted] YGAN

WAMC OP 173-E

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

#[redacted] b6-4

7012

REPORT TITLE: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 4 Aug 03 Anesthesia Type (Circle)): General Spinal Epidural LMA
Time In: IV Sedation Nerve Block
Allergies: NKA OR Intake: Crystalloid 600 Colloid
Pre-op V/S: 142/88 P 78 OR Output: UOP 0 EBL 30
Procedures: Endoscopy ext Meds/Times: Fentanyl/40mcg
External fixator x fix adjustment Reglan / Mag [redacted] b6-2

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds / History

Time	1330	1340	1350	1400	1410	1420
SaO2	98	97	100	98	100	96
FiO2	RA	RA	NC	RA	RA	RA
Methods	RA	RA	RA			
240						
220						
200						
180						
160						
140						
120	↑	↑	↑	↑		
100	↑	↑	↑	↑	↑	↑
80	↓	↓	↓	↓	•	•
60				↓	↓	↓
40						
20						
RR	12	12	10	10	14	12
T	95	98.6			98.1	

Time	
Pain (0-10)	
LOS	

Patient teaching done; Wound Care, Pain Management, T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	2	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	2
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	~~2~~	1
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	11	9	10

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
^ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

PREP[redacted] (Title) [redacted] CPTA

DEPARTMENT/SERVICE/CLINIC: ICU2

DATE: 4 Aug 03

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

[redacted] b6-2

[redacted] b6-4

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

DA FORM 4700, MAY 78 WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) Previous edition is obsolete

USAPPC V2.00

Grw (R) Ellmed Exto . / Lrm

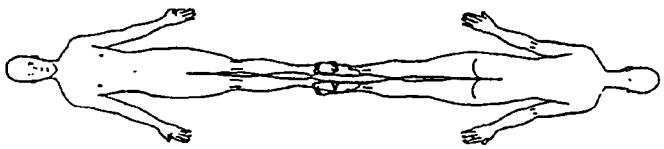
MEDICATIONS						
Allergies:						
Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR							
Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm							
15'							
30'							
45'							
60'							
90'							
D/C							

Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS							
	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS			
Time	Location	Type	Drainage
Adm			
30'			
60'			
D/C			



PACU OUTPUT			
Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM			
Time	Rhythm	Symptomatic?	Rhythm Strip Run?

WAMC OP 173-E

NURSING NOTES

Pt arrived via letter accompanied by anethesia. c/o slight pain med 25mcg in PACU given by May Cherry VSS, pulse Ox 98% RA X-fix (R) LE +2 pulse pedal capillary <3 sec drsg CDI temp 95° covered c another blanket. lungs CTA HRR RR 12 p̄ MSO4 well cont to monitor — bb-2 [redacted] mcj / 1440 - AOX3. VSS. ØN/V Ø pain No changes in status — [redacted] bb-2

Discharge Criteria:
Date: 4Aug03 **Time:** 1440 **PARS:** 10
BP: 109/61 **T:** **HR:** 82 **RR:** 12 **Sa02:** 96
Pain Level at D/C (0-10):
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: ICW 2
Report Given To: Cpt [redacted] -bb-2
Transferred Via: W/C (Litter) Gurney / Ambulance
Transferred By: _____
Cleared IAW Recovery Room SOP R-2
Charge Nurse Signature: [redacted]

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 D 1	I Z	[redacted]	EPW [redacted] b6-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
		Z	9	unk

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	9 9	Ø Ø Ø Ø Ø Ø [redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	1430	N/A b6-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K M 93	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	1CU1	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] b2-2	

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
5 Ø		Ø 3 Ø 8 2 6

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A E A A		Ø 3 Ø 7 Ø 5

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)

FOR LOCAL USE

Dx: GSW (R) Femur fx

DX	PROC.
82111	8604

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
[redacted] b6-2	b6-2 [redacted], SPC, 91G10

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
1 2 3 4 5 6 / A	7 8	9 10 11 12 13 14 15 [redacted]	EPD [redacted] 106-4	16 17	18

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

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

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

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

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

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

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

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

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

FOR LOCAL USE

DX
82111
E9912
[redacted] 106-2

PROC
7815
8604
7845

T I
1 450

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

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) EPW [redacted] b6-4			3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE 56y	6. RACE	7. RELIGION unk	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION No	
11. FMP 99		12. SSN [redacted]		13. ORGANIZATION N/A		14. WARD ICU3	
15. FLYING STATUS N/A	16. RATING/ DSG	17. DEPT./ BEN K79		18. BRANCH/CORPS N/A	19. UIC/ZIP	20. TYPE CASE N/A	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION 0020	23. CLINIC SERVICE AEAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —			25. TYPE DISPOSITION 56		26. DATE OF DISPOSITION 08 JUL 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —			27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 8 JUL 03		ADMITTING OFFICER Dr. [redacted] b6-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b2-2					30. DATE OF INITIAL ADMISSION		32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

IED

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

Shrapnel to (L) knee

891.0
E928.9

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
Ø	Ø	Ø	Ø	1	1

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
Ø	Ø	Ø	Ø	1	1

SIGNATURE OF ATTENDING MEDICAL OFFICER [redacted] Dr. [redacted] b6-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER For [redacted] b6-2

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

Stay to 5th c̄ referred shoulder for 3-4 wks.
Sent here b/c of concern for need for TKD.
Pt + 50 other complaints at this time

T-T/O/Asthma

PHYSICAL EXAMINATION

Gen: WD, WN, NAD, AAO x 3 – Ambulating well
adult male

Ext: ∅ edema, ∅ TTP, ∅ Erythema, ∅ warmth,
ROM ∅ strength of R. Knee.
FARom.

Knee x-ray – ∅ shown

9.6 | 12 / 40 | 200

142 | 103 | 14 / 112
3.3 | 31 | 1.0

LFTs – wnl

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

Case + pt. Discussed + Examined c̄ orthopedic surgery
(1) No Evidence of Need for TKR @ this time.
(2) Return to EFW (Appen A.m.

SIGN[redacted] b6-2	DATE 8 July 03	IDENTIFICATION NO.	ORGANIZATION

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

REGISTER NO.	WARD NO.

[redacted] b6-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8 July 03 0120	ICIV 60's 4.0. Male, admitted from ER c̄ propel wound to the left knee, not visible on examination. however, pt c/o tenderness to the site. Jeropel wound was reported to be old, pt was seen in the ER previously. Pt was placed on Keflex 250 mg p.o. QID + Tylenol #3 p.o. for pain. Pt to stay overnight + scheduled to be DC @ 0800 in AM. DC summary completed. Prescription filled. VS. T97.8-53-12-100/60 on admission. Pt awake, does not speak English. In NAD. b6-2 [redacted] Maj/AN
1320	Heart rate in the Mid-40's, BP 100/52, MD made aware. No intervention needed. Pt appear to be stable. In NAD. Continue to monitor drop in HR c̄ BP. b6-2 [redacted] Maj/AN
0300	Pt sleeping, here no c/o pain since admission. Remain sinus bradycardic @ 43-14-12, Sat 94% RA. Plan: Return to EPW camp in AM. Night supervisor informed of the plan. b6-2 [redacted] Maj/AN
0400	Pt observed to be asleep since admission. No issue so far. b6-2 [redacted] Maj/AN
8 JUL 03 0500	Received [redacted] report from previous shift. Pt resting c̄ eyes closed. Ø S/S of pain. Sinus brady HR. Pt on continuous monitoring. D/C summary and home meds present. Will cont. care. b6-2 [redacted] 1LT/AN

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED [redacted]
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

#0 [redacted] b6-4

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8 JULY 03 0800	Pt resting quietly. Loosened restraints and placed one restraint on (L) ankle. Cap. refill <3sec and restraint 2 finger widths away from skin. Will cont. care. — [redacted]
1200	Pt ate lunch well. Awaiting transport to EPW camp. Unneeds expressed @ this time. Will cont. care. [redacted]
1420	Transfer pt to EPW camp via litter. — [redacted]
	all b6-2

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
8 July 03	
	Transfer summary
	pt c shrapnel retained chronically.
	No sign of infection or effusion. x-ray reviewed with
	orthopedics. pt ambulates well. pt examined by
	orthopedics. No I+D needed. Return to FOB
	camp.
	[redacted] M.D.
	b6-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

REGISTER NO.	WARD NO.

[redacted] b6-4

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

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREATMENT FACILITY EMT
		RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: IRAQ CIV

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)*: 7 JUL 4 02 | TIME: 2325

TRANSPORTATION TO FACILITY

SEX: M

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

AGE: 56

MILITARY STATUS			
ITEM	YES	NO	N/A
PRP			
FLYING STATUS			
MEDICAL HISTORY OBTAINED FROM			

THIRD PARTY INSURANCE		
ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: Ø

ALLERGIES: INSULIN

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			
HOW			

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: (L) Leg PN

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME: 2325

INITIALS: [redacted] b6-2

VITAL SIGNS

TIME					
BP					
PULSE					
RESP					
TEMP					
WT					

LAB ORDERS

X CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		X CHEM: 12/Lytes
BLOOD C&S X	X ESR		

X-RAY ORDERS

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

ORDERS

☒ PULSE OX 93%

☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
0010	50 mg Benadryl IV	[redacted]	b6-2		
0010	25 mg Phenergan IV				

DISPOSITION: ☐ HOME ☐ FULL DUTY

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

CIV [redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC										
WBC 9.6			142	202	14	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
H/H 12/40					112	SUP O2	PH	PO2	RESULTS	
PLT 290			3.3	3,	10	PCO2	SAT	OTHER		
PT						U/A	DIP	UPJS and ESR	EKG INTERPRETATION	
APTT	BHCG	ETOH	GLU				MICRO			

PROVIDER HISTORY/PHYSICAL

See 539

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

[redacted]

DIAGNOSIS

① Retained shrapnel ② Knee

CODES b6-2

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

[redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin Temperature: warm

Color: Pale / Cyanotic / Jaundiced: NL

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: PERRLA

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials (+) Pedals (+)

Capillary Refill: <3 Seconds Homan's Sign (−)

Jugular Venous Distension (−) Edema (−)

Heart Sounds S1S2

Rhythm SB @ 45 BPM PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain: 0

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: Even, unlabored

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor: 0

Chest Drainage System Gravity: 0 Suction cm:

Air Leak — No — Yes — Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	CTA	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: 0

~~NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage~~

~~NG Drainage: Color~~ Character

~~Tube Feeding: Day No:~~ Strength: Rate: Aspirate:

~~Stool: Character~~

~~Drains:~~

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Calm, cooperative, speak no English

OTHER:

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripher
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Locati
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

[redacted] b6-4

PT'S NAME: [redacted] 66-21 8 JULY 03

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	101/61				102/48				96/52															
TEMP	95.5				96.5				96.7															
HR	49				52				48															
RR	14				14				15															
SA02	95%																							
INPUT																								
PO		60		500				360																
IV																								
NGT																								
TOTAL																								
OUTPUT																								
URINE				725				125																
NGT																								
STOOL																								
TOTAL																								
BALANCE																								

MEDCOM - 13866

PATIENT ASSESSMENT CHW [redacted] 66-4 0 JULY 05

TIME: 0525 SIGNATURE: [redacted] 66-2 IGW

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature WARM

Color: Pale / Cyanotic / Jaundiced WNL for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: — Size: —

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS: —

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): 2+ Radials 2+ Pedals

Capillary Refill: < 3 Seconds Homan's Sign (−)

Jugular Venous Distension (−) Edema (−)

Heart Sounds S1 S2

Rhythm SB PRI: — QRS: —

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms	—	—		
Site	—	—	(R) wrist	—
Solution	—	—	H.L	—

Chest Pain Ø

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: RR

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor N/A

Chest Drainage System Gravity: — Suction cm: —

~~Air Leak No Yes Crepitus~~

~~Character of Drainage:~~

Trachea / Midline / Deviated (R) / Deviated (L)

~~Artificial Airway Size: Type: Position:~~

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes	clear throughout	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: Ø

~~NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage~~

~~NG Drainage: Color Character~~

~~Tube Feeding: Day No: Strength: Rate: Aspirate:~~

Stool: Character Ø @ this time

Drains Ø

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

PATIENT ASSESSMENT

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

Ward/Section: EMT	REQUESTING PHYSICIAN: Dr. [redacted] b6-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. [redacted] b6-4		DATE 7 JUL 03	TIME 2340	SSN/PSEUDO SSN: [redacted] b6-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		
[illegible]		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB	3.4	3.5-5.5 g/dl
ALP	51	26-84 u/l
ALT	12	10-47 u/l
AMY	41	14-97 u/l
AST	23	11-38 u/l
TBIL	0.7	0.2-1.6 mg/dl
BUN	14	7-22 mg/dl
CA^{++}	9.1	8.0-10.3mg/dl
CHOL	117	100-200 mg/dl
CRE	1.0	0.6-1.2 mg/dl
GLU	112	73-118 mg/dl
TP	7.2	6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+	142	128-145 mmol/l
K^+	3.3	3.3-4.7 mmol/l
CL^-	102	98-108 mmol/l
tCO_2	31	18-33 mmol/l

REMARKS:

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 8 July 03 TIME OF ORDER: 0020 HOURS

LIST TIME ORDER NOTED AND SIGN

Admit to 7 CW #3
Dx: ① Knee sprain
Condition: Stable
V Vitals per Routine
All: NKDA
Meds: 250 mg Keflex P.O. Q.I.D
650 mg Tylenol P.O. Q.I.D prn pain or fever

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: Heplock IV TIME OF ORDER: HOURS

Diet: Regular
Activity as tolerated
Plan: Return to EPW Clinic in A.M.
- ~~Note~~ Prescriptions
- Transfer Summary Done.
Discharge patient at 0800 8 July 03.

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER

[redacted] MD b6-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

EPW 48

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. 7 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 7	8	9	10	11	12
8 July	[redacted]	Keflex 250g po qid	06	/	[redacted]				
			12	/	[redacted]				
		b6-2	18	/				b6-2	
			22	[redacted]					
8 July	[redacted]	Lepthock IV	05	/	[redacted]				
			17	[redacted]					

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: (L) Knee ~~Sprain~~ avulsion

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW – [redacted] b6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

Order/ Expir Date	**Clerk/ Nurse**	**PRN MEDICATION, DOSE, FREQUENCY**	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* **TIME/DATE DISPENSED**													
7 July	[redacted]	tylenol 650 g po														
- - - - -	6-6-2	qtd prn pain or fever														
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															
- - - - -	- - - - -															

USAPA V1.00

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)* For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 7 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 7	8	9	10	11	12
8 Jul 03	[redacted]	diet - reg	06	/	[redacted]				
			12		[redacted]		b6-2		
		b6-2	17						
8 Jul 03	[redacted]	activity as tolerates	05	/	[redacted]				
			17						

ALLERGIES: ☐ YES ☐ NO

NKDA

PRIMARY DIAGNOSIS: (L) knee ~~osteoarthrosis~~ arthropathy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW - [redacted] b6-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo July Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
8 July	[redacted]	return to EPW camp in am	8 July	AM			
8 July	[redacted]	no prescription, transfer summary done	8 July	noted		[redacted]	
8 July	[redacted]	discharge patient @ 0800 8 July 03	8 July	0800		bb-2	
	-----	all bb-2					

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

USAPA V1.00

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 D 1	E Z	[redacted]	EPW [redacted] b6-4		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	5 6 4	Z	9	unk

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	9 9	Ø Ø Ø Ø Ø Ø [redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U	ØØ2Ø	N/A

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 9	

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

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	1Cu3	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
[redacted] MEDICAL TREATMENT FACILITY b2-2		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
5 Ø		Ø 3 Ø 7 Ø 8

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A E A A		Ø 3 Ø 7 Ø 8

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)

FOR LOCAL USE

DX3 (L) Knee strain

Dx 8911
E9919

Inj Trauma
443 1

ADMITTING OFFICER (Signature, as required)

[redacted] b6-2 b6-2
Dr. [redacted]

SIGNATURE OF ADMITTING CLERK

[redacted] b6-2
SPC, 91G/B

DA FORM 2085 MAY 80 EDITION OF MAY 80 IS OBSOLETE

INPATIENT TREATMENT RECORD COVER SHEET

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

1. [redacted]			2. NAME (Last, First, MI) EPW # [redacted] b6-4			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. AGE 20	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION N	
11. FMP 99		12. SSN [redacted] b6-4		13. ORGANIZATION —		14. WARD ICU3	
15. FLYING STATUS N	16. RATING/DSG —	17. DEPT./BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE WIA	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION direct from ER				22. HOURS OF ADMISSION 1422	23. CLINIC SERVICE ABFA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK				25. TYPE DISPOSITION 50	26. DATE OF DISPOSITION 18JUL03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK				27b. TELEPHONE NO. UNK	28. DATE OF THIS ADMISSION 08JUL03		ADMITTING OFFICER [redacted] b6-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] 62-2					30. DATE OF INTIAL ADMISSION		32. COMPONENT TRANSFUSED

31. SELECTED ADMINISTRATIVE DATA

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW ® mandible, GSW ® thigh

802.20
873.64
873.63
874.8
891.0
990.0
E-921.2

86.04
86.59
25.51
23.09
76.73

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
Ø	Ø	Ø	Ø	10	10

36. Total Days All Facilites

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

SIGNATURE O[redacted] — b6-2 — [redacted]FFICER

DA FORM 3647, MAY 79 [redacted] EDITION OF 1 AUG 78 IS OBSOLETE USAPPC V1.10

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

20y ♂ Bch GSW Face, (R) LEx. Seen at 240 FST → tracheostomy.
wound exploration in Face + (R) LEx and packed.
Pt is 28 CM ED MD sizes c̄ minimal oozing from facial wounds.
Unknown PMHx.

PHYSICAL EXAMINATION

130/60 P60
Moving LUEx, B/L LEx c̄ stimulation
Paralyzed, No pupillary response.
Head: large (R) parietal scalp wound packed w/ minimal c̄ active bleeding
Lungs and CV NAD Abd benign.
Left RLEx wound clean

PROGRESS (Enter date of discharge and final diagnosis)

A/ GSW Face, RLEx s/p hemi, debrided at FST (240)

P/ OR exploration

[redacted] 66-2

[redacted]	DATE	IDENTIFICATION NO.	ORGANIZATION
FAT [redacted] (If typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

[redacted] 66-4

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975 539-106

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTI

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
9 Jul 03	240TH PST OPERATIVE NOTE
TIME: 2332	
T:	PRE-OP Dx: ① GSW to ⓛ upper lip → ⓡ mandible Fx/
R:	② GSW ⓡ post thigh (No Fx NVI distally, Pulses
B/P:	③ GSW ⓡ lower leg (superficial)
P:	POST-OP Dx: Same
MED:	PROCEDURE: ① ZONE 3 neck exploration, Resection of ⓡ Submandibular gland, ⓡ Carotid in
ALLER:	② TRACHEOSTOMY GSW thru the hp, upper incisors
	③ I+D ⓡ leg GSW x 2 ⓡ mandible shattered
LMP:	SURGEONS: CASTO, NOONBURG, LUCAS Carotid Sheath intact
	ANESTH: GEN
TOB:	EBL: 500 cc b6-2 [redacted]
	FLUID: 2400 cc LR, 2 u PRBC
ETOH:	FOLEY to gravity
	TRACHEOSTOMY
PMHx:	COMPLICATIONS Ø
PSH:	Disp → CSH trached, Clinically Paralyzed [redacted] b6-2
	[redacted] MS
FMHx:	Patient received instructions regarding diagnosis, plan of care, medications, follow-up, and verbalizes understanding. Initials: _____ [redacted] MAJ MC MD
	[redacted] 240TH PST

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
DISCOM AID STATION		ARMY	D.A.S.
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

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

NAME AND RANK: [redacted] REGISTER NO. [redacted] b6-2

[redacted]

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
7 JUL 03	047) 119/67 P-77 R-34 O2-100 T-
	052) 132/66 68 30 100
	0100) 152/74 73 22 100
	0105) 151/71 85 17 100
	0110) 151/77 78 20 100
	0115) 149/82 101 14 100
	0120)
	MEDS ORDERED
	ANCef 1 gm
	TETANUS. SCC (IM)
	5(14) LP

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
28 CSH/EMT			
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
66-4			

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

EPW [redacted]

[redacted]

Component Requested

MEDCOM - 13878

MEDICAL RECORD	PROGRESS NOTES
DATE	
7/8/03	Discharge Summary

= 30yo Iraqi ♂ s/p GSW to face and right LEx. Taken initially to 240 PST where facial wound debrided, packed tracheostomy placed and leg wound debrided. Tx soon thereafter to [redacted] b2-2 Tikrit where, upon evaluation in ED pt noted to have massive oropharyngeal bleeding. Taken to OR emergently and bleeding stopped by approximating tongue c 2-0 chromic running sutures. Mandible noted to be unstable with displaced open fracture of angle of mandible as well as displaced fracture on contralateral anterior mandible. In addition palate noted to have trauma. Due to limited experience with this, I packed the oropharynx, carefully placed an OG tube and stabilized patient in FCU and discussed case with Dr. [redacted] b6-2 who will evaluate patient at Baghdad. Current meds are: LR @ 150cc/hr; Zantac 50mg IV q8; Propofol sedation; Ampicillin 1g IV q6°; Clindamycin 600mg IV q8°. Patient received 4u PRBC in 28 cSM OR, 2u FFP postop. Pulse ox not stable @ 33%. Dressing changed this AM c minimal bleeding.

[redacted] b6-2

(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
Medical Record

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

Tikrit EPW # [redacted] b6-4

AUTHORIZED FOR LOCA

:DICAL RECORD

PROGRESS NOTES

DATE	NOTES
8 Jul 03 1540	Nursing Admission Note: 30 y/o ♂ air evac from Tikrit. Pt arrived on Vent via trach on following settings: FiO_2 - 40%, SIMV - 10, TV - 700, Peep 5, Sa_{O_2} 100%, RR 10-13. Respirations regular + unlabored. Pt opens eyes spontaneously and gestures c̄ hands. GCS - 11. Pt has orogastric tube c̄ dressing to mandible and neck. Moderate amount of blood noted on dressing. Trach intact. Mild rhonchi auscultated in upper lobes. Abdomen soft + tender to palpation in all quadrant. Pt vomited ≈ 150cc of brown drainage from mouth p̄ palpating RLQ. Mouth suctioned and OGT placed to LIS. Ø drainage noted from OGT. Ace wrap dressing noted [redacted] on (R) leg from thigh to foot. Strong (R) femoral pulse palpated. (R) pedal + (R) posterior tibial pulses present but weak. Cap refill < 3secs. Foley intact draining > 200cc of clear, dark yellow urine. Pt has (L) subclavian cordis, 16G IV in (R) AC + 16G IV in (L) AC. (R) radial A-line zeroed and leveled. Sharp waveform noted. Ø s/s of infection noted @ IV or A-line sites. Strong (Cont'd

:NSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI [redacted] | SPONSOR'S ID (SSN or Other) [redacted]

/SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINT[redacted]

S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. b6-2 | WARD NC

EPW # [redacted] b6-4

PROGRESS NOTES
Medical Record
STANDARD FORM 50

AUTHORIZED FOR LOCAL REPROD

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
8 Jul 03 1540	Nursing Cont'd: radial pulses palpated. Receiving LR @ 125 cc/hr via Cordis. Propofol infusing @ 5 mcg/kg/min via IV in (L) AC. Fentanyl started @ 25 mcg/min and ↑ to 50 mcg/min per BP and pain level via cordis. Moderate bloody drainage [redacted] ~~on (R) posterior the~~ 1615 dressing of (R) posterior thigh. (+) Motion, (+) Sensation to (R) foot. HOB ↑ 30°. Pt resting quietly @ this time. Pt not attempting to pull at invasive lines or trach tube. ABG + b6-2 ~~labs~~ labs drawn. Will continue to monitor. [redacted] /AN
8 Jul 03 1643	Nursing: Strong pulses palpated in (B) pedal pulses + posterior tibia. Propofol ↑ to 7.5 mcg/kg/min. Pt resting intermittently. Pt calm + cooperative. [redacted] /AN
1700	Received report on patient. b6-2 [redacted] /AN
1800	Assessment completed. T 100.6 will monitor. [redacted] /AN
2000	Patient to CT via stretcher, monitored, on vent. 5 person transfer Head CT completed. Patient VSS throughout. Repositioned patient in bed. Redressed (R) leg c̄ extra packing. Increased Propofol Will continue to monitor. [redacted] /AN
2200	Patient sleeping. T 99.6 b6-2 [redacted] /AN

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			[redacted] NUMBER
	LAST	FIRST	MI	(SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

EPW [redacted] b6-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
EPW 420			

DATE	NOTES
19JUL03 0000	Patient sleeping. VSS. b6-2 [redacted] ICT/AN
0200	Patient sleeping. VSS. [redacted] ICT/AN
0400	Patient repositioned for comfort. Patient washed his own face. Will continue to monitor. b6-2 [redacted] ICT/AN
0500	Report given to nurse. [redacted] ICT/AN
0526	Recieved report from LT [redacted]. Pt responsive to touch.
19July03	makes hand gestures for needs/wants. VSS. Bandage remain to facial area & Rt leg. Will monitor. b6-2 Sgt [redacted]
0554	Pt. to go to SRG/OR at this time. Sgt [redacted]
0940	Returned from OR. Sutures noted to (Rt) lower jaw area. I+D of (Rt) leg I+D of face + wired jaw. T/C draining at bedside. Trach remains in place. Vent setting remain the same. Will continue to monitor. b6-2 Sgt [redacted]
1100	Pt. resting in bed c̄ eyes closed. Ø distress noted. VSS. condition remain stable. Will continue to monitor. b6-2 SGT [redacted]
1200	Pt. resting in bed c̄ eyes closed. Opens eyes spontaneously. Ø distress noted @ present time. Nasal suction done due to accummalation of drainage, color dull red. Ø complication. Trach care done c̄ difficulty. Will continue to monitor. b6-2 Sgt [redacted]
1346	condition remain stabled. Open eyes spontaneously. Ø distress noted. will monitor. b6-2 Sgt [redacted]
1548	Pt. remain stabled. open eyes spontaneously. Ø distress noted @ present time. will monitor. b6-2 Sgt [redacted]

STANDARD FORM 509 (REV. 3/1999) BACK
USAPA V1.00

EPW [redacted] b6-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES	
09July03 1645	Pt. resting c̄ eyes closed. Eyes opens spontaneously. Ø distress noted. condition remain stable. Will monitor. — Sgt. [redacted]	
09JUL03 1700	Received report. Patient in bed c̄ HOB ↑30°. Plan to switch to TC — [redacted]	ILT/AN
1800	Assessment completed — [redacted]	ILT/AN
1805	A to TC, FIO2 50% — [redacted]	ILT/AN
1900	VSS on TC. — [redacted]	ILT/AN
2000	VSS on TC, FIO2 ↓35% — [redacted]	ILT/AN
2010	Suctioned bloody secretions from mouth. [redacted]	ILT/AN
2030	Foley care p̄ Trach care — [redacted]	ILT/AN
2315	Suctioned bloody secretions from mouth. [redacted]	ILT/AN
2400	Patient sleeping. VSS. Monitoring Temp. [redacted]	ILT/AN
10JUL03 0100	T 100.4 Will continue to monitor. — [redacted]	ILT/AN
0300	T 101.2 Will continue to monitor. — [redacted]	ILT/AN
0500	Report given to nurse. — [redacted]	ILT/AN
0515	Rcvd report and care of pt. from previous shift — [redacted]	
0700	Pt sleeping in bed. Awakens spontaneously & s/s of pain, discomfort will cont to monitor — [redacted]	
1000	Pt resting in bed & s/s of pain/discomfort VSS	

b11 b6-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.	WARD NO.

EPW [redacted] b6-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 July 03	will cont to monitor — b6-2 [redacted] CPN
1300	Pt resting comfortably in bed VSS. will cont to monitor — b6-2 [redacted]
1600	Pt resting in bed. ∅ s/s of pain/discomfort. VSS. will cont to monitor — [redacted]
11 July 03 0500	Received report and care of pt. from previous shift. VSS. — [redacted] CPN
11 July 03 0830	Ortho Op Note b6-2
	Pre-Op Dx - OSA (R) leg
	Post Op Dx - same
	Procedure - I+D with DPC (R) leg wound
	Surgeon - [redacted] b6-2
	Anesthesia - MAC 3% Lidocaine 1000 cc
	Findings - Wound clean. Aspirated bright pulse - evac. Thigh wound closed with 2-0 vicryl and 3-0 nylon over JP drain. Calf wound closed with 3-0 nylon
	PLAN - Pull drain in 24-48 hours
	[redacted]
1200	Pt returned from OR. Recovering in bed VSS will cont to monitor — [redacted] b6-2 CPN
1200	Pt sleeping in bed. VSS. ∅ s/s of pain or discomfort will cont to monitor — [redacted] CPN
1510	Pt ⅋ pain (L) leg. Gave fentanyl 50 mcg IVP. b6-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCT

:AL RECORD | PROGRESS NOTES

:E	NOTES
11 July 03 1525	Pt resting in bed. VSS, Pt had positive response to IVP of Fentanyl & C/O pain or discomfort. will cont to monitor — b6-2 [redacted] LPN
1700	Pt resting in bed awake & alert. VSS T-max 101.8 Report and care of pt. given to oncoming shift — [redacted] LPN
1700	Received report. — b6-2 [redacted] ILT/AN
1800	Assessment completed. — [redacted] ILT/AN
1810	T 100.3 Will monitor. — [redacted] ILT/AN
2000	T 101.2. Will monitor. — b6-2 [redacted] ILT/AN
2200	T 100.2. Patient resting @ eyes closed — [redacted] ILT/AN
2400	VSS. Patient asleep. — [redacted] ILT/AN
12 JUL 03 0200	VSS. Patient asleep — b6-2 [redacted] ILT/AN
0400	VSS. Patient resting c̄ eyes closed. — [redacted] ILT/AN
0500	Report given. VSS. TC@ 31% FiO2 (▲@ 0300 from 35% FiO2 by RT), SaO2 > 95%, ABG drawn@ 0330. Suctioned mouth and nasal area five times, bloody secretions from mouth and nose, totalling approximately 100cc for shift. JP draining minimal amount s/s fluid. Foley to gravity draining dark yellow/orange urine. Staples to (R) jaw intact. Dressing to RLE CDI & JP drain. Generalized edema. (L) SC Cordis, (R) Rad A-Line,

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

SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO

[redacted] b6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV 5/
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(
USAPA

ME	FIRST NAME	MIDDLE INITIAL	ID NUMBER
O[redacted] b6-4			

DATE	NOTES
12JUL03 0500 (cont)	(R) FA 16g PIV. LR@125cc/°, Fentanyl 50mcg/h. [redacted] b6-2 LCT/AN
12JUL03 0500	Received report from previous shift. Pt awake. Suctioned pt mouth and bilat. nares. Sanguinous mucous noted from (L) nare. Pt (R) peripheral IV dislodged. D/C'd IV. Pt TC FiO2 31% humidified air c̄ O2 sats low 90s. Pt appears to have Ø pain @ this time. LR@ 125cc/h infusing and fentanyl gtt @ 5.0ml/h (50 mcg) infusing. Temp 100.8. Will cont. to monitor temp. Viewed labs. H+H low (7.0, 22.3), RBC 2.42. Abnormal ABG PO2 60, HCO3 30. Will notify MD of results. b6-2 [redacted] LCT/AN
0700	Pt O2 sats ↓ 80s. Drew ABG. Results: pH 7.591, PCO2 34.3, PO2 50, HCO3 33, SO2 91%. Showed results to Dr. [redacted] b6-2. Ordered CXR and deep suctioned pt. Scant amt thick mucus brown tinged noted. Showed results to Dr. [redacted] b6-2 No new orders given. O2 sats remain in high 80s to low 90s p̄ deep suctioning. Will cont to monitor. b6-2 [redacted] LCT/AN
0900	Pt sats remain in 80's. Ø new orders written. Completed Trach care and S'd trach tie. Deep suctioned pt x iii. Thick brown tinged mucous noted. Will cont care b6-2 [redacted] LCT/AN
1000	Dr. [redacted] b6-2 in to see pt. Reviewed labs. New orders written. Trach care ↑ O2 sats to low 90s. Started 18 gauge (L) FA IV for blood. Will cont. care. [redacted] b6-2 LCT/AN

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
12 July 03 1122	Started 1st unit PRBC @ 1122. Unit # 2453991.

	1127	1130	1137	1142	1157	1212	1227	1242	1302
Temp	100.3	100.6	100.4	100.3	100.2	99.8	99.8	100.2	
pulse	78	72	72	86	89	80	78	72	
NIBP	116/62	118/62	123/64	118/65	124/64	123/65	125/67	127/65	

DATE	NOTES
12 July 03 1302	Started 2nd unit PRBC @ 1302. Unit # W0204-03-001319

	1307	1312	1317	1322	1337	1352	1407	1422	1452
Temp	99.5	99.5	100.3	99.9	100.4	100.4	100.0	100.0	100.7
Pulse	80	82	82	85	75	78	81	76	63
NIBP	120/67	103/64	122/71	125/71	124/68	124/67	123/69	124/66	120/69

1500 2nd unit PRBC complete. 0 rxn to blood noted. Sustained pt x I throughout blood transfer. Thick blood tinged mucus noted from (R) nare. Thin clear sputum noted from mouth. Pt very demanding. Will cont. care. [redacted] b6-2

1600 Gave pt bed bath and oral hygiene care. Pt resting quietly c̄ eyes closed @ this time. Will cont. care. [redacted] b6-2

1700 Gave report to night shift. [redacted] b6-2

1700 Received Report from day shift - [redacted] SPC, 9/WMC

1900 Pt Resting comfortably in bed, continue pain management. Will continue to monitor - [redacted] SPC, 9/WMC

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	b6-2

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b6-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
2100.	Pt appears to be resting comfortably in bed. Suctioned mouth and nose. sanguinous fluid suctioned from nose. Continue pain management. Will continue to monitor. — [redacted] b6-2 SPC, 91WM6 —
2300	Pt taken off Treach collar. SAT's @ 95 on RA. Will continue to monitor b6-2 [redacted] SPC, 91WM6 —
0100	Treach care complete. Pt SAT's @ 93%. Will continue to monitor — b6-2 [redacted], SPC, 91WM6 —
0200	Pt complaining of breakthrough pain ↑ Fent to 75 mcg/hr. Will continue to monitor b6-2 [redacted], SPC, 91WM6
0330	Pt placed on Treach collar 31% O_2 due to SAT's of 88%. SAT's ↑ to 95% Will continue to monitor [redacted] b6-2
13 Jul 03 0732	Nursing: See ICU Flow Sheet for nursing assessment. VSS, T-100.5. Pt able to use Yankauer suction to suction his mouth. Trach patent, ∅ respiratory distress noted. Small amount of old blood noted on RLE dressing. Receiving LR @ 125 ml/hr and Fentanyl @ 75 mcg/hr. Resting quietly in bed. b6-2 [redacted] SPC/RN
13 Jul 03 0821	Nursing: LR ↓ 75 ml/hr. Pt given Lasix 20 mg IV @ 0809 per Dr. [redacted] b6-2 's orders. Dr. [redacted] b6-2 reviewed CXR + labs. JP drain removed by Dr. [redacted] b6-2. Will continue to monitor. — b6-2 [redacted] SPC/RN
13 Jul 03 1245	9P-1245 Nursing: Bath and foley care completed. Dressing removed from RLE. RLE ⊕ edema. Xenoform dressing noted on ⊕ thigh & ⊕ calf. Sites cleaned + wrapped & Kerlex. OOB to chair x1. Gait unsteady. RLE elevated.

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

b6-2 [redacted] SPC/RN

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
13 Jul 03 1338	Nursing: Pt remains sitting up in chair in stable condition. Pt using Yankauer suction. Pt coughing thick, tan secretions from Trach. Sleeping [redacted] quietly @ this time. b6-2 [redacted] CS/AN
13 Jul 03 1530	Nursing: Pt ambulated to radiology for PA + LAT and back. Ø respiratory distress noted. Remains on 31% TC. Sats 95%. Pt assisted back to bed. Small amount of serosanguinous drainage noted from dressing on Ⓡ thigh. Dr. [redacted], Dr. [redacted], b6-2 + Dr. [redacted] updated on pt's condition. Pt sleeping quietly @ this time. b6-2 [redacted] CS/AN
13 Jul 03 ~~1500~~ 1700	Nursing: Trach care completed. Pt sleeping, S complaints. Report given to night shift nurse [redacted]
	Received report from off going shift. Pt on trach collar, 31% O_2 SATS @ 94%. Foley draining to gravity, dark yellow urine, b6-2 sufficient. Will continue to monitor. [redacted] SPC, 91WM6
1900	Pt appears to be sleeping comfortably in bed. b6-2 [redacted] Good pain control. Will continue to monitor. [redacted] SPC, 91WM

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

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

[redacted] b6-4

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13 Jul 03	Pt appears to be sleeping comfortably. Continue
2100	pain management will continue to monitor: [redacted] SPC, 91WM6
2300	Track care complete. Pt appears to be sleeping b6-2
	comfortably. will continue to monitor. [redacted] SPC, 91WM6
0100	Pt appears to be sleeping comfortably. Will continue
	to monitor [redacted] b6-2, SPC, 91WM6
0300	Pt appears to be resting comfortably in bed.
	Drew labs via A-line. VSS, will continue
	to monitor: [redacted] b6-2 SPC 91WM6
0500	Report given to day shift [redacted] SPC, 91WM6
0500	Pt received report from previous shift. VSS.
	Ø c/o @ this time. will continue to monitor.
0850	A-line PICC catheter intact. dressing changed on
	(N) lower extr. Xeroform dressing applied, Bacitracin to wound
	on (L) lower ext { face, suture removal. Pt on Bedside,
	will continue to monitor, b6-2 [redacted] 07/0
1000	Pt resting in bed & s/s of pain VSS. will
	continue to monitor. b6-2 [redacted]
1200	Pt ambulated to X-Ray for CXR and returned to
	bed. VSS. S_aO_2 dropped to 90% while ambulating
	but rose to 95% when resting in bed. will cont.
	to monitor. b6-2 [redacted] LPN
1500	Pt resting in bed & s/s of pain discomfort. VSS
	will cont to monitor. b6-2 [redacted]
14 Jul 03 1800	Recieved pt resting in bed. pt uses yankauer to suction mouth
	and nostrils. will cont to monitor. b6-2 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

NSN 7540-00-634

DICAL RECORD — NURSING (Sign all r.)

TE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14 Jul 03 2100			suctioned pt c̄ greenish white phlegm from trach. pt resting in bed s̄ complaints of pain will cont to monitor. b6-2 [redacted]
15 Jul 03 0100			after performing trach care pt noticed he was not on trach collar. The Interpreter came in and explained to the pt that he is being closely monitored and the pt slowed his breathing down. pt now resting s̄ any complaints. will cont to monitor b6-2 [redacted] LCR
15 JULY 03 0500			~~Received pt from~~ b6-2 [redacted] Received report from previous shift. Pt resting quietly c̄ eyes closed. LR and fentanyl infusing. Will cont. care. b6-2 [redacted] LCT/SN
0600			Pt temp 100³ previously. Pt temp 99³ currently. Will cont. to assess temp. Will prep pt for d/c tomorrow. b6-2 [redacted] LCT/SN
0840			Pt resting quietly. ↓ed Fentanyl gtt to 70 mcg/h. Will cont. care. b6-2 [redacted] LCT/SN
0940			Weaned pt off fentanyl gtt. Gave pt bedbath. Pt had 0 % pain. O₂ sats ↓ed to high 80's. Deep suctioned pt x ii. Thick brown tinged mucus noted. Pt sats ↑ed to low 90s. Will cont. care. b6-2 [redacted] LCT/SN

(Continue on reverse side)

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

REGISTER NO.

WARD NO. 1C47

[redacted] b6-4

NURSING NOTES
Medical Record

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
~~0700~~	b6-2 Pt resting comfortably in bed. VSS, Will
0300	continue to monitor. [redacted] SPC, 9 WM16
0400	was told not to do ABG by Mr. Newmyer.
	Will continue to monitor. [redacted] b6-2
0500	Gave Report to on coming shift. [redacted]
16 Jul 03	Nursing: Pt c/o [redacted] b6-2 pain around face. Pt given
0545	2 tabs Percocet PO diluted in water. Pt refused
	Percocet. Pt sleeping @ this time ∓ further complaints.
	b6-2 [redacted] SS/RN
16 Jul 03	Nursing: See Flow Sheet for Nursing Assessment.
0633	Lung sounds coarse in (R) upper lobes. Sats 95% on RA.
	Respirations regular + unlabored. Trach suctioned
	x 3. Suctioned small amount of thin white secretions.
	Lung sounds CTA in all lobes after suction.
	b6-2 [redacted] SS/RN
16 Jul 03	Nursing: Bath completed c̄ pt assistance. Dressing
0957	changed on anterior (R) thigh + (R) calf. Sutures intact,
	∅ erythema, (+) edema, [redacted] 1001 small amount of sersosanguinous
	drainage noted on (R) thigh incision, ∅ foul odor or
	pus noted. Incisions cleaned c̄ soap and water.
	Strips of [redacted] 1035 ~~xeroform~~ xeroform dressing applied
	to both incision sites + covered c̄ 4x4 dressing.
	Pt assisted to sit up @ edge of bed. Pt c/o
	dizziness, body swaying. Pt assisted up to chair
	~~when~~ [redacted] 1039 p̄ 10 mins. RLE elevated on stool c̄ blanket.
	Pt having ↑ productive cough from trach. (Cont'd)
	b6-2 [redacted] SS/RN

[redacted] b6-4

16 Jul 03 0957: Nursing Cont'd: Pt suctioned two separate times x 5 total. Suctioning thick, yellow, blood tinged secretions from trach. Pt offered PO fluids, pt refusing @ this time. Lungs remain CTA. Sats ↑ 97-100% ~~suctioning~~ suction [redacted] 1057 b6-2 CH/AN

16 Jun 03 1145 Nursing: Pt assisted to ambulate up and down hallway of ICU x 1 [redacted] before pt c/o dizziness. Pt assisted ~~up to~~ 1145 back to bed. HOB ↑ 45°. Suctioned trach x 1. Suctioned thin tan, blood tinged secretions. Pt made comfortable in bed. (R) leg elevated on blanket. Yankauer suction @ BSD near pt. Will continue to monitor. [redacted] b6-2 CH/AN

16 Jun 03 1536 Nursing: Trach care completed. Continued to suction thick tan/blood tinged secretions from trach. Sats 97% on RA. Resting quietly in bed c̄ complaints. [redacted] b6-2 CH/AN

16 Jun 1700 Received report from day shift. Pt appears to be resting comfortably in bed. Pt treached on RA SATS @ 98%. Cardio to (L) SC (+) flush c̄ LR @ 75 cc/hr. IV to (L) FA HC (+) flush. Will continue to monitor [redacted] b6-2

1845 Pt complaining of pain c̄ urination. Sent urinalysis to lab. [redacted] b6-2

2000 Lab results normal on urinalysis. Will inform day shift to inform doctor [redacted]

MEDICAL RECORD | PROGRESS NOTES

DATE | NOTES

16Jul03 2100 Trach care complete Pt tolerated procedure well VSS. Will continue to monitor. [redacted]

17Jul03 0100 Pt appears to be resting comfortably in bed. VSS. Will continue to monitor [redacted] b6-2

0510 Received report from SPC [redacted] b6-2 + assumed care of Pt. VSS, Will Monitor. [redacted] 9/WMG

0700 Pt Lying in bed sleeping + appears to be resting comfortably @ this time. Will continue to monitor. [redacted] b6-2 9/WMG

0905 Pt sitting up in bed awake. Ø Ntd complaints @ this time, Will continue to monitor. [redacted] b6-2 9/WMG

1000 Lowed Pt's head flat + had him take a deep breath + hold it while cordis was being pulled. Held direct manual pressure over site for 10mins. Then 4x4 taped in place c Ø bleeding Ntd. Ø change in mental status Ntd, VSS, Will continue to monitor. [redacted] b6-2 9/WMG

1100 Pt Lying in bed sleeping + appears to be resting comfortably @ this time, will continue to monitor. [redacted] b6-2 9/WMG

1330 Pt sitting ↑ in bed. Ø Ntd complaints @ this time, VSS, Will continue to monitor. [redacted] 9/WMG

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS ROOM USE ONLY

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.

[redacted] b6-4

PROGRESS NOTES

17July03(1700) PT CARE Report Recieved from SPC [redacted]. b6-2 Pt Awake Alert, oriented person, place, & event. Skin warm, dry, c̄ no ↓s pallor/cyanosis. No acute episode noted or reported. Sitting midfowler's in Bed. [redacted] b6-2 9 WMP

/03 17:38:19 HR=70 P1 =OFF P2 =OFF RR=31 SpO2=98% NIBP=OFF T1=OFF T2=OFF AI=OFF

1/cm

DISPLAY ON

17July03(1800) PT up to chair. Ambulates [redacted] c̄ stooped posture. Able to support weight c̄ B/L LE. Unsteady gait. Requires (1) staff to assist. Suctioned for ↓ amt thick, tenacious yellow sputum. Cough reflex strong. Drank juice & some ensure s̄ dysphagia noted/reported. [redacted] b6-2 9 WMP

17July(2000) Trach care done. Inner cannula cleaned c̄ peroxide solution & rinsed c̄ NS. Replaced to stop/ease outer cannula s̄ incident. Pt c̄ ↑ secretions ~~and~~ [redacted] leaking at stoma site. Uses yankauer suction for oral care/secretions s̄ problems. Wires intact. Wire cutters b̄ bedside. [redacted] b6-2 9 WMP

17July(2030) Pt Back to Bed s̄ incident. [redacted] 9 WMP

18July(0100) Suctioned c̄ secretion characteristics unchanged. [redacted] b6-2 9 WMP

18July(0500) Pt care report given to SGT [redacted] Pt awake s̄ acute episode noted/Reported. [redacted] b6-2 9 WMP

AUTHORIZED FOR LOCAL REPRODUC

AL RECORD | PROGRESS NOTES

E | NOTES

Discharge | Transfer Summary

Admit Dx: Gun shot wounds RIGHT mandible and RIGHT LEG.
① Comminuted Right mandibular body fracture.
② Right thigh soft tissue defe

Discharge Diagnosis: Same
D/C cond: Stable
D/C diet: Blended thru straw | Liqu
D/C meds: Zosyn 3.375mg IV q6°
Cipro 400mg IV q12°
fentanyl PRN Pain
Procedures: ① Tracheostomy (Prior to arrival
② Closure of face wound
③ Placement of maxillomandi fixation with arch bar and wires.
④ Washout and closure of right leg wound

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

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

[redacted] b6-4

PROGRESS NOTES
Medical Record

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

ST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Plan:
	① Pt will need follow up wound care for right leg.
	② Pt will need Right facial sutures removed in 4-5 days.
	③ Pt will need Archbars and wires removed in 6 weeks with bone graft once healed to right mandible if ne
	b6-2 [redacted]
	OMFS MA

STANDARD FORM 509 (REV

MEDICAL RECORD | PROGRESS NOTES

DATE	NOTES
18 July 03 0546	Received report from Sgt [redacted] b6-2 Pt. resting in bed w/ complaints @ present time. Ø distress noted @ present time. Condition remains stable. Will continue to monitor. Sgt [redacted]
0640	Transferred out of facility. Sgt [redacted] b6-2

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS ACCOUNT SHEET

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.

EPW #[redacted] b6-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

9 JUN 03
0700

Author Op Note:
Pre-Op Dx - GSW Left (R) thigh and lower leg
Post-Op Dx same
Procedure: I+D, (R) leg
Surgeon: [redacted] b6-4
OR: MN
Findings: Large "shark-bite" ~ 10x 7 cm, affecting posterior aspect thigh with loss of portion of biceps femoris. Wound also involved gluteus. Vessel loops closed after some O-weight slap suture.
Superficial 2 cm laceration wound on medial calf. Closed with 3-0 nylon
PLAN: IV ABXs per OMP, Dr [redacted] then expect I+D in 48 hrs. [redacted] b6-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME		[redacted]
	LAST	FIRST	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	

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

[redacted] b6-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
9 jul 03 @ 0941	OMFS OP NOTE
	Pre op dx: ① GSW to Right neck
	② comminuted right mandibular body fx.
	③ large tongue laceration.
	④ avulsed anterior teeth 9-12
	Post op dx: Same
	Procedure: ① closure of tongue lac
	② closure of soft tissue wound
	③ ext of teeth # 9-12
	④ Placement of pt in IMF c̄ archbars & wire.
	Surg: [redacted] — b6-2
	Assist: [redacted], [redacted]
	EBL: 400cc
	fluids: 1u PRBC 2100 LR 500 Hespan 400 NS
	U/O: 700
	Anesth: trach
	findings: comminuted mand fx, tongue lac soft tissue wound.
	Comp: ①
	Condition: Pt stable & transferred to PACU on standard monitors. b6-2 [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

AUTHORIZED FOR LOCAL REPRODUCT

:AL RECORD | PROGRESS NOTES

'E | NOTES

OMFS POD #2

10 Jul 03
@0715 Pt lying in bed c̄ trach on RA. S̄ distress. Minimal facial swelling noted. vlMF in place. tongue slightly protruding from left edentulous area but no active bleeding noted. intraoral & extra oral wounds closed 1°
VS: T 98.5 BP 149/72 P 53 R 19
CV RRR lungs CTA(B) abd soft NT ND (+)BS
ext: ¢c|c|E (R) leg dressing
U/O: 1355/4200

A/P Pt stable S/P CR of comminuted mand fx + closure of lacerations.
(1) Start oral care today.

[redacted]

b6-2

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

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

#[redacted] b6-4

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

AUTHORIZED FOR LOCAL REPRODUCT

:AL RECORD | PROGRESS NOTES

'E | NOTES

11 Jul 03 OMFS POD #2

@0728 Pt lying in bed restrained 5 c/o pain per staff. On call to OR for (R) leg. Pt on trach c̄ 2L O2. ALMF stable oral wounds closed 1° c̄ no active bleeding. neck wound closed 1°.

VSS AF

CV RRR

lungs CTA

abd SOFT ND NT (+) BS

wet (R) leg dressing

A/P S/P GSW to face c̄ comminuted (R) mand fx.

(1) Pt to OR today for Right leg wound

(2) will plan to start clear liquid diet after ?

(3) can transfer to Iraqi Hospital on next opportunity. [redacted]

b6-2

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

SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO. | WARD NO.

#[redacted] b6-4

PROGRESS NOTES
Medical Record

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

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES

12 Jul 03 1815 Medicine Note

Asked to see pt for hypoxia. Sats are 88-90 on 2L. Pt denies c/o chest pain/epigastric pain. He has continuous low-grade fever 100.5-100.8. No rigors/c. HCT is 22.2. CXR negative of DLL infiltrate. Will d/c amicacin, + use gentamicin + cipro to cover pseudomonas. Will transfuse 2u pRBCs.

[redacted] b6-2

12 Jul 03 0005 POD #4

Pt c possible DLL infiltrate, and low grade temp (Tm) 100.8. PT s/p transfusion of 2u PRBC. facial & oral wounds healing well c̄ no s/s of infex. closed l° ulnar stable pt not tolerating PO well.

1. will encourage PO intake
2. encourage ambulation
3. trials off trach collar
4. follow medicine recommendations [redacted] b6-2

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

[redacted] b6-4

PROGRESS NOTES
Medical Record

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

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
15 July 03 1700			Pt resting c̄ eyes closed. O2 sats con 90's ∅ s/s of pain or needs expressed. Will cont. care. b6-2 [redacted]
1300			Completed trach care using hydrogen peroxide and NS. Pt O2 sats ted 97%. p̄ trach care. Thick brown-tinged sputum noted. Will cont. care. b6-2 [redacted]
1500			Pt awake in bed. O2 sats 97% on RA. Pt suction self c̄ yanker throughout day. UO > 100cc/hr. Will ask if can b6-2 D/C foley. ~~Will~~ [redacted] Will cont. care. [redacted]
1640			D/C'd pt foley per order. Translator explained hand signals for needing to use bathroom. "Thumbs up" means need to urinate, balled fist means BM. Translator explained pt POC and plan to transport for tomorrow. b6-2 [redacted]
1700			Gave report to next shift. [redacted]
1705			Received report from day shift. Pt resting in bed. VSS, IV to ⓡ FA, LR infusing @ 75cc/hr. Will continue to monitor. [redacted], SPC, 91WM6
1900			Pt resting comfortably. b6-2 [redacted] VSS. Will continue to monitor, b6-2 [redacted] SPC, 91WM6
2300			Pt complaining of ear ache, notified MS. Will continue to monitor, [redacted] SPC, 91WM6 b6-2

NSN 7540-00-634-4123

.2

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
1/1/03	Operation		None
	Procedure:		Fixed wound Debridement
			Glossopexy
	Surgeon:		Mehmet Dem
	PMH		[illegible]
	EBL:		[illegible]
	To Icu, intubated		
	Findings:		① Comminuted mandibular fracture c displacement at angle.
			② Trauma to tongue approximated c 2-0 chromic
			③ No placement
			[redacted] b6-2
			WA[redacted] ney

(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.

NURSING NOTES
Medical Record

558-103 (See Instructions on Back of this Sheet) NSN 7540-01-075-3786

b2-2

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): [redacted] / FMT

LOG NUMBER: NA

ARRIVAL			TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)	CURRENT MEDS. (tetanus immunization and other data)	HISTORY OBTAINED FROM
DATE		TIME	☐ PRIVATE VEHICLE ☐ AMBULANCE ☒ OTHER (Specify) PLANE	NA	☐ PATIENT ☐ OTHER (Specify)
DAY 7	MONTH JUL	YR. 03	032		ALLERGIES: NA

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code): NA

HOME TELE. NO. (Inc. area code): NA

CHIEF COMPLAINT(S) (Include symptom(s), duration): GUNSHOT WOUNDS L OMA (R) thigh FACIAL EXTR

SEX: M | AGE: NA

POSSIBLE THIRD PARTY PAYER? ☐ YES ☐ NO

TIME SEEN BY PROVIDER: 032

VITAL SIGNS			
TIME	032	037	042
BP	69/45	62/28	100/28
PULSE	147	70	57
RESP.	16	26	23
TEMP.	98.4		
WT. (Child)	99	98	100

CATEGORY (See reverse)
- ✓ EMERGENT
- URGENT
- NON-URGENT

ORDERS	INITS.	TIME
INTRAVENOUS LINE		040
XRAYS		042
LABS ABG, CBC, Chem, TYPE & H.		043
Ancef 1 Gm IV		
NPT IV 700, R14, 1 Peep		

DESCRIBE (1) Subjective data (Pertinent History); (2) Objective data (Examination - include results of tests and x-rays); (3) Assessment (Diagnosis); (4) Plan (Treatment/Procedures - include medication given and follow-up)

042 X-RAYS ORDERED (A) Lat SKULL (R) FEMUR (R) Lg. & Chest TOI ~2130 PM 42?

043 LABS - CBC (A) & Chem 12

S: Pt is a ~30yo Iraqi EPW who was shot x 3 by US forces as he was firing a weapon while riding a motorcycle. Taken to FST & had Trach done.

O: WDWN moves all 4's spont. massive trauma to (R) Jaw/face macerated tong. Trach in place. TM's white PERRL EOMI 4mm. NEGNT from OCrep. Lungs: (D) CTA. Cor RR (D) Abd: (D) BS, S, NT ND. Ext: Lg (R) lat thigh tissue defect (D) pulses, mult lower (R) leg abrasions & lacerations.

EDC: hypotension to 50's/20's improved p Level I via (L) Subclav cent line.

X-Ray: Comminuted Jaw & (R) sinus opacities. NLC & R. (D) PTX. Ext: mult frags (D) f.

11 > 7/23 < 170

7.32/32/415/-7/100%

[redacted] T. & C x 2. b6-2

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

TIME OF RELEASE: 0115

b6-2

[redacted] (DD FORM 507, IF NEEDED)

PATIENT'S IDENTIFICATION (Mechanical imprint) OR WRITTEN ENTRIES GIVE: Name - last, first, middle; SSN; DOB, service status, name and relation of sponsor or next of kin. (IMPORTANT: LIST FACILITY HOLDING TREATMENT RECORD).

EPW [redacted] b6-4 [redacted] b2-2 EPW [redacted] b6-4

SIGN [redacted] ID STAMP

INSTR [redacted] (Include medications ordered, any limitations and follow-up plans)

To OR

MEDCOM - 13906

PATIENT ASSESSMENT [redacted] b6-2

TIME: 0539 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm to touch

Color: Pale / Cyanotic / Jaundiced normal for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: PERL 3+

Extremity Movement: Full / Limited / None GSW to (R) leg

CARDIOVASCULAR

Pulse (0 - 4): Radials 1+ Pedals 1+

Capillary Refill: good Seconds Homan's Sign

Jugular Venous Distension Edema Ø

Heart Sounds normal

Rhythm normal PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(R) arm	
Solution			LR @ 30cc/hr	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: normal

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor moderate amount

Chest Drainage System Gravity: [illegible] Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	Course breath sounds heard	
Wheezes	Ø	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: dry to (R) leg

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character Ø

Drains

GENITOURINARY

Urine Color: yellow Character:

Voiding: Continent Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns:

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm.

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles		
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

18 July

[redacted] b6-4

18 July 03

[redacted] b6-4

PT'S NAME

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP	112/62																							
TEMP	98.2																							
HR	73																							
RR	24																							
SA02	98																							
INPUT																								
PO																								
IV																								
NGT																								
TOTAL																								
OUTPUT																								
URINE	200																							
NGT																								
STOOL																								
TOTAL																								
BALANCE																								

MEDCOM - 13908

PATIENT ASSESSMENT

TIME: 0622 SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: RLE Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils: PERRLA

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +3 (R) / +3 (L) Pedals +3 (R) / +3 (L)

Capillary Refill: Seconds < 3 Homan's Sign (−)

Jugular Venous Distension Ø Edema Facial, (R) thigh

Heart Sounds S1 S2

Rhythm NSR 3 Ectopy PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site	(L) subclavian cordis		18G (L) FA	
Solution	LR			

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access. Muscles

Breathing Patterns: Regular, Unlabored

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor Thin, White

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	Coarse lung	
Wheezes	sounds in	
Diminished	(R) upper lobes	
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: (R) thigh C/D/I

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate:

Stool: Character

Drains:

GENITOURINARY

Urine Color: Clear Yellow Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

66-2

TIME: ASSESSMENT SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Right lower Extremity Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Orientated / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials +3 Pedals +3

Capillary Refill: < 3 Seconds Homan's Sign

Jugular Venous Distension Ø Edema Facial

Heart Sounds S1 S2

Rhythm RR & Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site		(L) SC cordis	18G (R) FA	
Solution				

Chest Pain LR 75 cc/hr

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Respiration / No Distress / SOB / Labored / Use of Access Muscles

Breathing Patterns: RR & Rhythm

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor thin white

Chest Drainage System Gravity: Suction cm

Air Leak No Yes Crepitus

Character of Drainage:

Trachea / Midline / Deviated (R) / Deviated (L)

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior/Location	Posterior/Location
Crackles	CTA Bilat	
Wheezes		
Diminished	~~Wheezes~~	
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: to (R) LE C/D/I

NG Tube: Clamped/Inter. Suction/Cont. Suction/Dependent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character None @ this Time

Drains:

GENITOURINARY

Urine Color: clear yellow Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Pt able to communicate via hand signals, follows simple commands

OTHER:

16 Jul 03

PT'S NAME: # [redacted] 66-4

	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	01	02	03	04
BP		119/69				127/70				114/66				111/69				118/72				112/66		114/66
TEMP		99.5				99.3				99.4				98.9				98.7				99.1		99.3
HR		67				67				72				69				72				72		63
RR		13				24				24				22				18				24		22
SA02		95%				95%				98%				98%				98%				98%		96
O_2		RA				RA				RA				RA				RA				RA		RA
INPUT																								
PO										60														
LR IV	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	75	
NGT														50						250				
IVPB		50						50	250															
TOTAL																								
OUTPUT																								
URINE	300				375		375	400		800	225			425		350			350		425			
NGT																								
STOOL																								
TOTAL																								
BALANCE																								

MEDCOM - 13910

MEDICAL RECORD

PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT

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

1. AGE: 30

HEIGHT:

WEIGHT: 75

2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication)
☒ NKDA ☐ PCN ☐ LATEX ☐ IODINE ☐ TAPE ☐ FOOD
REACTION:

3. PREVIOUS SURGERY [ ] NO [X] YES (type):
I&D (R) leg

4. PROPOSED SURGICAL PROCEDURE:
I&D (R) leg / Fail down

5. ADDITIONAL INFORMATION: (Previous surgical and medical history) Skin Condition_____
Tobacco____ppd X___yrs. Body Piercing_____ Diabetes (Y) (N) ROM_____ ASA/Motrin w/72 hrs (Y) (N)
ETOH_____ Implants_____ Respiratory Disease (Asthma/COPD) (Y) (N) Anticoagulants (Y) (N)
Glasses/Contact (Y) (N) Dentures_____ Hypertension (Y) (N) Herbal Medicines (Y) (N) MEDS:

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to: X 1) Surgical Procedure & Operating Room Environment ___ 2) Separation Anxiety (Child) X 3) Surgical Outcomes	o Pt. verbalizes any specific anxiety. o Pt. Exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures. (e.g., warm blanket, touch). o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface. Parents to stay with pt.
B. AERATION X Potential for respiratory dysfunction due to: X 1) Positioning X 2) Effects of Anesthesia X 3) Medical/Smoking History	o Pt. will be able to breathe without difficulty during immediate intraoperative phase .	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress. o Assist anesthesia during intubation and extubation.
C. INTEGUMENT X Potential impairment of skin integrity due to: X 1) Intraoperative Immobility X 2) ESU Pad Placement X 3) Positional Aids ___ 4) Prosthesis X 5) Pooling of Prep Solutions	o Pt. will not exhibit signs of impairment of skin integrity (e.g., reddened areas).	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

#[redacted] b6-4

VERIFICATIONS AT HOLDING AREA:
! ID/Allergy Band ! Dentures Removed
! H & P ! Contacts Removed
! NPO Since_____ ! Jewelry Removed
! UHCG/LMP ! Body Pierce Removed
! Consent/Blood Transfusion Signed/Witnessed/Dated
! Surgical Site/Consent verified by Pt./Anesthesia/Surgeon
! Contact Precautions (Y) (N)
! Family/Friend:_____

6. PATIENT PROBLEMS AND NEEDS	PATIENT GOALS AND EXPECTED OUTCOMES	OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to: X 1) Intraoperative Mobility X 2) Positioning X 3) Existing Disease X 4) Safety Devices X 5) Hypothermia	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse.	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o. Check that rings and all body piercing has been removed.
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to: X 1) Pain X 2) Intraoperative Hazards X 3) Prosthesis X 4) Positioning X 5) Transfer pt. to/from OR table E.2. X Potential discomfort due to: X 1) Length of Surgery X 2) Positioning X 3) Arthritis	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bath towels, etc.) for positioning.
F. SPECIAL SENSES F.1. X Diminished visual perception due to being: ___ 1) Pre-Medicated ___ 2) W/O Glasses F.2. ___ Potential for decreased communication due to: ___ 1) Diminished Hearing X 2) Language Barrier F.3. ___ Potential injury due to dentures: ___ 1) Upper ___ 4) Caps ___ 2) Lower ___ 5) Crowns ___ 3) Bridges	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from ___ side. o Validate pt.'s understanding of verbal communication. o Verify removal of dentures.
G OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS Or continuation of above interventions

10. OR NURSING INTERVENTIONS COMPLETE D/ADDITIONAL INTRAOPERATIVE INTERVENTION S NOTED.

[redacted] b6-2 09 Jul 03 DATE

11. POSTOPERATIVE EVALUATION: SKIN INTEGRITY: Bovie Pad Site: ☐ Clean and Dry ☐ Red ☐ N/A DRESSING DRY & INTACT: (Y) (N)
LEVEL OF CONSCIOUSNESS: ☐ A&O ☐ Drowsy ☐ Sleepy ☐ Intubated BREATHING EASY: (Y) (N)
LEVEL OF ACTIVITY: ☐ Moves All Extremities ☐ Moves Upper Extremities
☐ Transferred to litter with roller due to spinal

12. PREOPERATIVE EVALUATION PREPARED BY (Signature and Title) [redacted] b6-2
DATE: 09 Jul 03 TIME: 0843

13. POSTOPERATIVE E[redacted] BY (Signature and Title)
DATE: 09 Jul 03 TIME: 0930 b6-2

RE

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Anesthesia Stretcher BY: Litter

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY: CPT [redacted] b6-2

3. DATE: 20030708 TIME PATIENT ARRIVED IN SUITE

4. PATIENT IN ROOM TIME: 0116 NUMBER: 1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Pleasant

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
	SST [redacted] b6-2		
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS: Arms (bilat) tucked & padded. Strap across waist

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

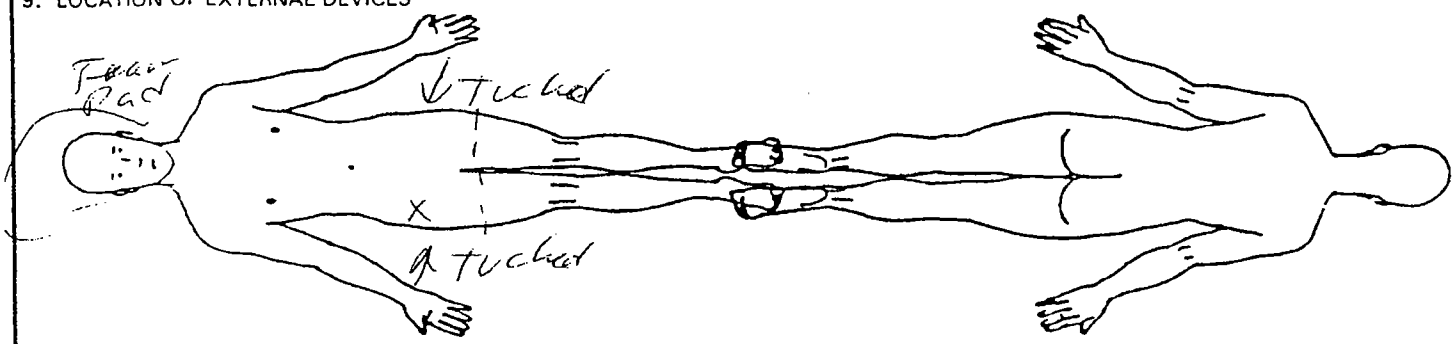
PREP SOLUTION (Specify): N/A

SITE: BY WHOM:

SITE: BY WHOM:

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB b6-2	CIRCULATOR b6-2
Sponge	☒ Yes ☐ No		C	C	SPC [redacted]	CPT [redacted]
Needle Sharp	☒ Yes ☐ No		C	C		
Instrument	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

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

[redacted] b6-4

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

☒ ESU NO: Valleylab 00042

GROUND PAD: BRAND

LOT NO: 10527

☐ ESU NO:

GROUND PAD: BRAND

TEST | RESULT | REF. RANGE

OTHER ORDERS	TIME	CARRIED OUT

PHYSICIAN'S SIGNATURE

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

LABORATORY SPECIMENS

16.		
SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

18. DRESSING/IMMOBILIZATION *(Specify)*
4X8 gauze Ray tec X2
Foley
Vest IV

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 16 Fr Foley in place prior	2. Tracheal	3.
SITE	1. Urethra Bladder	2. Trach	3.

19. ADDITIONAL INFORMATION

2 Raytecs used as packing / bb-2
MSG [redacted] CRNA, CPT [redacted] : Anesthesia (CRNA)
Dr. [redacted], Dr. [redacted] Surgeons

20. OPERATION(S) PERFORMED Facial Fossal exploration
Glossorraphy

21. PATIENT TRANSFERRED TO	TIME	METHOD
TCU bb-2	0221	Litter

22. REGISTERED NURSE SIGNATURE
CPT [redacted] AN

REVERSE OF DA FORM 5179-1, OCT 87 USAPA

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

MEDICAL RECORD

INTRAOPERA[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: [illegible] BY CPT [redacted] MSJ [redacted] b6-2

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY WO CAT

3. DATE 09 JUN 03 TIME PATIENT ARRIVED IN SUITE 0600

4. PATIENT IN ROOM TIME 0610 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted]	RELIEF SCRUB	
	SGT [redacted] — b6-2		
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	CPT [redacted] b6-2 0700-end
	LTC [redacted]		

7. POSITION AND POSITIONAL AIDS *(Specify)* Arm board bilateral. Arms tucked to side.

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

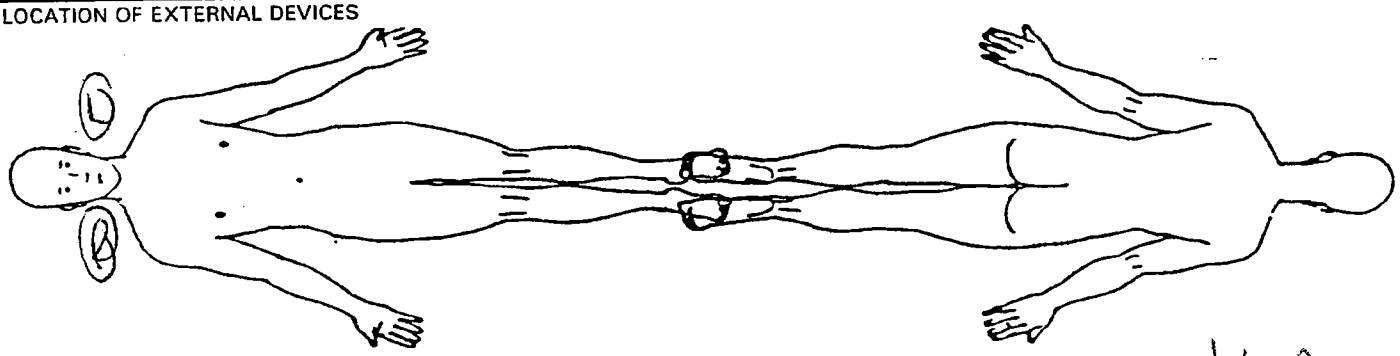
PREP SOLUTION *(Specify)* Betadine Paint Scrub

SITE: Right leg BY WHOM: CPT [redacted] — b6-2

SITE: Foot → Dilutes prep BY WHOM: LTC [redacted]

COMMENTS:

9. LOCATION OF EXTERNAL DEVICES



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

b6-2

C = Correct I = Incorrect

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

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

[redacted] b6-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 30/30

☒ ESU NO: 020450

GROUND PAD: BRAND Kellyhill

LOT NO: 65706

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

MEDCOM - 13915

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Lidocaine Epi 1:100,000	3cc	intraop	inject	[redacted]	Dr [redacted]
					b6-2

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
ACE
Kerlix

19. ADDITIONAL INFORMATION
Surgeons - Dr [redacted] / Dr [redacted] b6-2
Anesthesia - MOS [redacted] - CRNA

Throat pack in @ 0647 out @ 0907

20. OPERATION(S) PERFORMED
I&D Rupt bg /

21. PATIENT TRANSFE[redacted]D ICU #3 TIME 0930 METHOD Litter

22. [redacted]TURE [redacted] → CRNA

REVE[redacted] 8: b6-2 MEDCOM - 13916 USAPA V1.01

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA: Litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED, AND PROCEDURE VERIFIED BY ICT [redacted] /C

3. DATE 11 Jul 03 TIME PATIENT ARRIVED IN SUITE 0737

4. PATIENT IN ROOM TIME 0735 b6-2 NUMBER 1-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] CRT b6-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] AT	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt transferred to OR table anatomically aligned for surgical procedure c padding under head & arms w/ pt side.

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

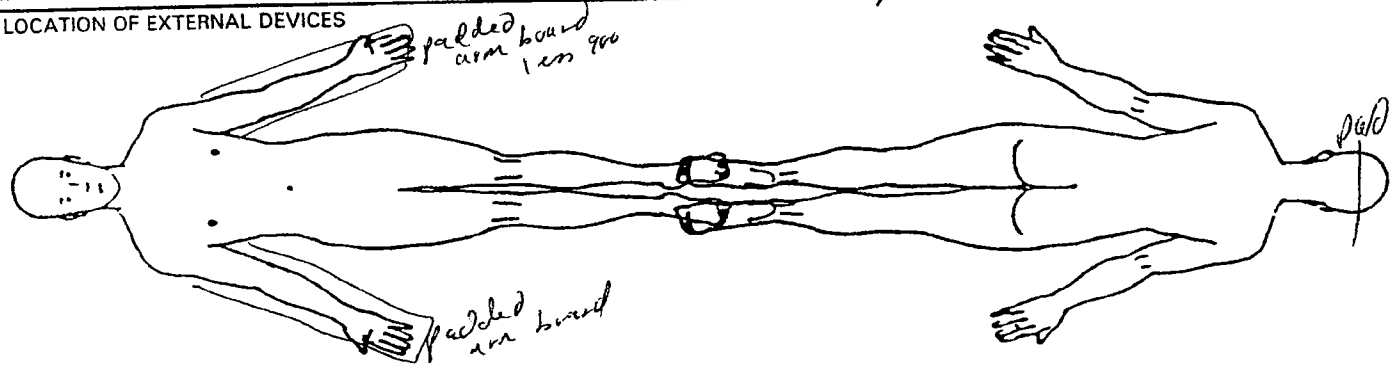
PREP SOLUTION *(Specify)* Betadine/Betadine

SITE: BY WHOM: CPT [redacted] b6-2

SITE: BY WHOM:

COMMENTS: ☒ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB b6-2	CIRCULATOR
Sponge	☒ Yes ☐ No	C	C	C	SPC [redacted]	CPT [redacted]
Needle Sharp	☒ Yes ☐ No	C	C	C		
Instrument	☐ Yes ☐ No					
Other	☐ Yes ☐ No					

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

[redacted] b6-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO 30/30

☒ ESU NO: #4

GROUND PAD: BRAND Valleylab

LOT NO: E7506

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS.SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. JP 10mm	2.	3.
SITE	1. (R) Thigh	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fluffs
Kerlix
ACE

19. ADDITIONAL INFORMATION
Surgeon
[redacted] b6-2

DA 5179 In Chart

20. OPERATION(S) PERFORMED
(R) Thigh I + D

21. PATIENT TRANSFERRED TO ICU-3 b6-2 TIME 0840 METHOD 1. Hen [illegible]

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AR

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

b6-2

Ward/Section: ICU3	ESTING PHYSICIAN: Dr. [redacted]	.TORY RESULT FORM (.t to the Privacy Act of 1974)
LAST, FIRST, MI. b6-4 [redacted]	DATE 8Jul	TIME 1500	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	13.8	4.8-10.8 x 10^3
RBC	3.21	4.7-6.1 x 10^9
Hgb	9.1	14-18 g/dl (M) 12-16 g/dl (F)
Hct	29.0	42-52% (M) 37-47% (F)
MCV	90.4	80-94 fl (M) 81-99 fl (F)
Plt	84	130-500 x 10^3 verified
Lymph %	13.9	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	**DATE:** 8Jul03	**LAB ID NO.:**

b6-2

Chemistry Univ

rd/Section: ICU3 | REQUESTING PHYSICIAN: Dr [redacted] b6-2 | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

ST, FIRST, MI. [redacted] b6-4 | DATE: 8 Jul | TIME: 1580 | SSN/PSEUDO SSN:

(i-STAT)

EST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
O2		35-45 mmHg (art) 41-51 mmHg (ven)
2		80-105 mmHg (art) N/A (ven)
O2		23-27 mmol/L (art) 24-29 mmol/L (ven)
O3		22-26 mmol/L (art) 23-28 mmol/L (ven)
?		95-98%
ecf		(-2) – (+3) mmol/L
Gap		10-20 mmol/L
		1.12-1.32 mmol/L
N		8-26 mg/dl
U		70-105 mg/dl
at		0.7-1.5 mg/dl
		38-51% PCV
)		12-17 g/dl

Misc. Chemistry

EST	RESULT	REF. RANGE
onin-I		
g of ise		

(Piccolo) Chemistry

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

(Piccolo) Metabolic

TEST	RESULT	REF. RANGE
GLU	106	73-118 mg/dl
BUN	11	7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK	1228	39-380 u/l (M) 30-190 u/l (F)
NA^+	133	128-145 mmol/l
K^+	4.2	3.3-4.7 mmol/l
CL^-	112	98-108 mmol/l
tCO_2	23	18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

MARKS: [redacted] b6-4 8 Jul 03

Ward/Section: ICU3

ESTING PHYSICIAN: [redacted] b6-2

L A ORY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] b6-4

DATE: 09JUN

TIME: 0230

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	14.6	4.8-10.8 x 10^3
RBC	2.99	4.7-6.1 x 10^9
Hgb	8.4	14-18 g/dl (M) 12-16 g/dl (F)
Hct	27.2	42-52% (M) 37-47% (F)
MCV	91.1	80-94 fl (M) 81-99 fl (F)
Plt	81	130-500 x 10^3 verified
Lymph %	—	20.5-51.1%

(Hematology) Manual Differential

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]

DATE: 9Jun03

LAB ID NO.:

b6-2

1C3 [redacted] b6-2

[redacted] b6-4 | 09JUN | 0230 |

FiO2 40%

T 98.2

(i-STAT)		
TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.483	7.31-7.45
PCO2	32.6	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	127	80-105 mmHg (art) N/A (ven)
TCO2	25	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	24	22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2	99	95-98%
BEecf	1	(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry		
TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12		
TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8		
TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel		
TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

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

(Piccolo) Electrolyte		
TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	9 July 03	

b6-2

Chemistry Only

FiO2 35

Temp 101°

Ward/Section: ICU3	REQUESTING PHYSICIAN: [redacted] b6-2		CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. O[redacted] b6-4	DATE 10 JUL	TIME 0340	SSN/PSEUDO SSN:

i-STAT

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

Picolo Chemistry 12

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

Picolo Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

Picolo Liver Panel Plus

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

Picolo Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

JB 10 Jul 03

Chemistry Only

/Section: KU3

REQUESTING PHYSICIAN: [redacted] 06-2

T, FIRST, MI. [redacted] 06-4

DATE 10JUL

TIME 0315

SSN/PSEUDO SSN:

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

(i-STAT)

ST	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
2		35-45 mmHg (art) 41-51 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
2		23-27 mmol/L (art) 24-29 mmol/L (ven)
3		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
:f		(-2) – (+3) mmol/L
ap		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
:		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

Misc. Chemistry

ST	RESULT	REF. RANGE
ain-I		
of e		

(Pseudo) Chemistry 12

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

(Pseudo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU	117	73-118 mg/dl
BUN	7	7-22 mg/dl
CRE	0.9	0.6-1.2 mg/dl
CK	281	39-380 u/l (M) 30-190 u/l (F)
NA^+	140	128-145 mmol/l
K^+	4.1	3.3-4.7 mmol/l
CL^-	106	98-108 mmol/l
tCO_2	28	18-33 mmol/l

(Pseudo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Pseudo) Liver Panel

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

(Pseudo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

ARKS:

DB 105 w/ 05

Ward/Section: ICU3	REQUESTING PHYSICIAN: [redacted] b6-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b6-6	DATE 10JUL / TIME 0315	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	12.6	4.8-10.8 x 10^3
RBC	2.68	4.7-6.1 x 10^9
Hgb	7.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	23.8	42-52% (M) 37-47% (F)
MCV	88.9	80-94 fl (M) 81-99 fl (F)
Plt	110	130-500 x 10^3 verified
Lymph %	8.4	20.5-51.1%

(Hematology) Manual Differential

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

Ward/Section: ICU 3	REQUESTING PHYSICIAN: [redacted] b6-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI. # [redacted] b6-4		DATE 11 July	TIME 0330	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	13.4	4.8-10.8 x 10^3
RBC	2.75	4.7-6.1 x 10^9
Hgb	8.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	25.0	42-52% (M) 37-47% (F)
MCV	91.0	80-94 fl (M) 81-99 fl (F)
Plt	143.	130-500 x 10^3 verified
Lymph %	12.9	20.5-51.1%

(Hematology) Manual Differential

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

Chemistry Only

Ward/Section: 1C43

REQUESTING PHYSICIAN: b6-2 [redacted]

LAST, FIRST, MI: [redacted] b6-4

DATE: 11 Jul

TIME: 0330

SSN/PSEUDO SSN:

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

(STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

REMARKS:

(Piccolo) Chemistry

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AM		
AS		
TI		
B		
C		
C		
C		
C		

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
O_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

Piccolo Electrolytes

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

```
======= PICCOLO ==== ==
11/07/03                 03:38
REFERENCE RANGE:          MALE
PATIENT #: [redacted]  b6-4
METLYTE 8
DISC LOT #:              3141AA4
OPER #: 678            DR #: 000
SERIAL #:          0000100697
.......................
GLU   104   73-118   MG/DL
BUN   10    7-22     MG/DL
CRE   0.7   0.6-1.2  MG/DL
CK    140   39-380   U/L
NA+   129   128-145  MMOL
K+    3.7   3.3-4.7  MMOL
CL-   99    98-108   MMOL
tCO2  26    18-33    MMOL

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

[redacted] b6-2
11 Jul 03

Ward/Section: 1C03

[redacted] CIAN: b6-2

LAST, FIRST, MI. b6-4 [redacted]

DATE 12JUL

TIME 0330

RY RESULT FORM
to the Privacy Act of 1974)

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 12JUL

LAB ID NO.:

[redacted] b6-1 [redacted] b6-2

13JUL 0345

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
[illegible]		14-18 g/dl (M) 12-16 g/dl (F)
[illegible]		42-52% (M) 37-47% (F)
[illegible]		80-94 fl (M) 81-99 fl (F)
[illegible]		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
[illegible]		Imm	
RBC Morph			
Hematocrit		42-52% (M) 37-47% (F)	
Sed Rate			
Other			

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

Blood Bank Unit Crossmatch

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 13 Jul 03

LAB ID NO.:

ICU 3

[redacted] b6-4 [redacted] b6-2

14 Jul 0300 [redacted] b6-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
Blasts			

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

Coagulation Studies

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

REMARKS:

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REPORTED BY: [redacted] DATE: LAB ID NO.

[redacted] b6-2

Ward/Section: 143 ICU

R[illegible]TING PHYSICIAN: Dr [redacted] b6-2

LAB[illegible]ORY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, M[illegible] [redacted] b6-4

DATE: 15 Jul 03 | TIME: 0350 | SSN PSEUDO SSN: [redacted] b6-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	9.	4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b6-2

DATE:

LAB ID NO.:

Ward/Section: ICU 3 | REQ | G PHYSICIAN: CMS | LAB (Subject | RESULT FORM Privacy Act of 1974)

LAST, FIRST, MI: O[redacted] b6-4 | DATE 16 Jul | TIME 2045 | SSN/PSEUDO SSN: O[redacted] b6-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	clear	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	mod	Negative
SG	1.012	N/A
Bld	trace	Negative
pH	8.0	N/A
Prot	neg	Negative
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

3-5 RBCs

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] b6-2 | **DATE:** 16 July 03 | **LAB ID NO.:**

Ward/Section: ICU 3 | REQU[redacted]G PHYSICIAN: b6-2 | LABO[redacted] (Subject t[redacted]rivacy Act of 1974) | RESULT FORM

LAST, FIRST, MI: O[redacted] b6-2 | DATE: 16 Jul 03 | TIME: 0430 | SSN/PSEUDO SSN: O[redacted] b2-4

(Hematology) CBC		
TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

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

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

CSF		
Cell Count		
Directigen		Negative

Misc. Serology		
TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

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

Microscopic Urinalysis

Blood Bank	
MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
ABO/Rh	

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

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

REMARKS:

REPORTED BY: [redacted] | DATE: 16 Jul 03 | LAB ID NO.:

b6-2

Ward/Section: ECU3

REQUESTING PHYSICIAN: [redacted] b6-2

LABORATORY RESULT FORM (Subject to Privacy Act of 1974)

LAST, FIRST, MI: O[redacted] b6-4

DATE: 17Jul03 TIME: 0400

SSN/PSEUDO SSN: O[redacted] b6-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 17Jul03

LAB ID NO.:

Ward Section: ICU3

REQU

PHYSICIAN: [redacted] b6-2

CHEMIS RESULT FORM
(Subject to Privacy Act of 1974)

LAST, FIRST, MI

[redacted] b6-6

DATE 18Jul03

TIME 0400

SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

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

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted] b6-2

18Jul03

DATE:

LAB ID NO.:

Ward/Section:	REQ	G PHYSICIAN:	LAB	RESULT FORM
1C43		[redacted] b6-2	(Subject	Privacy Act of 1974)
LAST, FIRST, MI.		DATE	TIME	SSN/PSEUDO SSN:
H[redacted]		b6-4 18 Sep	0450	

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^9
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]		

b6-2 18 Sep 03

Pt# [redacted] b6-2

Trach No 8

VENT FLOW SHEET

DATE	TIME	MODE	RATE	VOLUME	FIO2	PEEP	PIP	I/E TIME	Spont RATE	PLATEAU	HR	SO2	BP	ET	CUFF	INITIAL
8 Jul	230	SIMV	8	700	50	5	21	1:2	–	–	89	100	12/69	8		[redacted]
8 Jul	420	SIMV	8	700	40	5	27	1:2	4	–	98	100	87/54	8		
8 Jul	440	SIMV	–	–	–	–	–	1:2.9	–	–	91	100	115/65	8		
8 Jul 03	0530	PH 7.262	PCO2 44.8		PO2 131		HCO3 20		BE -7	SO2 98%						
8 Jul	0545	—	↑ 10													
8 Jul 03	0555	SIMV	10	700	40%	+5	26	1:2.2	2	/	87	100%				
8 Jul 03	0720	PH 7.315	PCO2	39.5	PO2	127	HCO3	20	BE -6		84	100%	/	Trach 8	MLT	
8 July	0755	SIMV	10	700	40%	+5	22	1:2.8	5	/	SO2	99%				
8 July	1010	SIMV	10	700	40%	+5	22	1:2.2	Ø	/	92	99%	109/62	Trach 8	MLT	
8 July	1200	SIMV	10	700	40%	+5	19	1:2.2	Ø	/	96	100%	120/63	Trach 8	MLT	
											107	100%	116/62	Trach 8	MLT	

[redacted] b6-2

[redacted] b6-2

---

i-STAT G3+

Pt: [redacted] b6-4

Pt Name:_____

TCO2_____21 mmol/L

At 37C

PH_____7.315

PCO2_____39.5 mmHg

PO2_____127 mmHg

HCO3_____20 mmol/L

BEecf_____-6 mmol/L

SO2*_____99 %

*calculated

Rate 10
FIO_2 40
TV 700
peep 5

At Patient Temp

PH_____7.322

PCO2_____36.7 mmHg

PO2_____124 mmHg

Patient Temp: 97.7F

FIO2_____: 40

Sample Type_: ART

08JUL03 07:26

Oper: 4132

Physician:_____

Ser# 40709

Ver: [redacted] 245A
A91

b6-2

Pt: [redacted] b6-4

Pt Name:_____

Na_____137 mmol/L

K_____3.6 mmol/L

TCO2_____34 mmol/L

iCa_____0.88 mmol/L

HCT_____15 %PCV

SO2*_____ % SL

*calculated

At 37C

PH_____7.428

PCO2_____35.0 mmHg

PO2_____242 mmHg

HCO3_____23 mmol/L

BEecf_____-2 mmol/L

SO2*_____ %

*calculated

Sample Type_:

09JUL03 07:37

Oper: 2979

Physician:_____

Ser

---

i-STAT G3+

Pt: [redacted] b6-4

Pt Name:_____

TCO2_____30 mmol/L

At 37C

PH_____ 06

PCO2_____46.0 mmHg

PO2_____107 mmHg

HCO3_____29 mmol/L

BEecf_____4 mmol/L

SO2*_____98 %

*calculated

At Patient Temp

PH_____7.386

PCO2_____48.8 mmHg

PO2_____116 mmHg

Patient Temp: 101.0F

FIO2_____: 35

Sample Type_: ART

10JUL03 03:44

Oper: 1678

Physician:_____

Ser# 40763

Ver: [redacted] 046A
A93

b6-2

31% FiO2

i STAT G3+

Pt: [redacted] b6-4

Pt Name:

TCO2_____33 mmol/L

At 37C

pH_ _____7.448

PCO2_____45.1 mmHg

PO2_____66 mmHg

HCO3_____31 mmol/L

BEecf_____7 mmol/L

sO2*_____93 %

*calculated

Sample Type_:

11JUL03 03:34

Oper: 1678

Physician:_____

Ser# 40763

Ver: [redacted]046A
[redacted]A93

b6-2

[redacted] b6-4

ID: 00[redacted] b6-4 12-07-03
MB 03:32

			Patient Limits	
WBC	9.6	x10^3/uL	4.5	10.5
RBC	2.42 L	x10^6/uL	4.00	6.00
Hgb	7.0 L	g/dL	11.0	18.0
Hct	22.3 L	%	35.0	60.0
MCV	92.1	fL	80.0	99.9
MCH	28.9	pg	27.0	31.0
MCHC	31.4 L	g/dL	33.0	37.0
Plt	161.	x10^3/uL	150.	450.
LYM%	15.0 *L	%	20.5	51.1
LYM	1.4 *	x10^3/uL	1.2	3.4

i STAT G3+

Pt: [redacted] b6-4

Pt Name:_____

TCO2_____34

At 37C

pH_____7.391

PCO2_____34.2 mmHg

PO2_____60 mmHg

HCO3_____33 mmol/L

BEecf_____11 mmol/L

sO2*_____91 %

*calculated

At Patient Temp

pH_____7.377

PCO2_____35.7 mmHg

PO2_____53 mmHg

Patient Temp: 100.2F

FIO2_____: 31

Sample Type_: ART

12JUL03 [illegible]

Oper: 0022

Physician:_____

Ser# 42015

Ver: [redacted]046A
[redacted]A03

b6-2

i STAT G3+

Pt: 000000000[redacted] b6-4

Pt Name:_____

TCO2_____31 mmol/L

At 37C

pH_____7.474

PCO2_____41.0 mmHg

PO2_____60 mmHg

HCO3_____30 mmol/L

BEecf_____7 mmol/L

sO2*_____92 %

*calculated

At Patient Temp

pH_____7.464

PCO2_____42.2 mmHg

PO2_____62 mmHg

Patient Temp: 99.0F

FIO2_____: 31

Sample Type_: ART

12JUL03 03:27

Oper:

Ser# 42015

Ver: [redacted]046A
[redacted]A03

b6-2

ID: 000[redacted] b6-4
WB 13-07-03
04:02

			Patient Limits	
WBC	12.8 H	x10^3/uL	4.5	10.5
RBC	3.12 L	x10^6/uL	4.00	6.00
Hgb	9.1 L	g/dL	11.0	18.0
Hct	28.9 L	%	35.0	60.0
MCV	92.7	fL	80.0	99.9
MCH	29.3	pg	27.0	31.0
MCHC	31.6 L	g/dL	32.0	37.0
Plt	194.	x10^3/uL	150.	450.
LYZ	14.2 #L	%	20.5	51.1
LY#	1.8 *	x10^3/uL	1.2	3.4

ID: 000[redacted] b6-4
WB 14-07-03
03:14

			Patient Limits	
WBC	12.7 H	x10^3/uL	4.5	10.5
RBC	2.91 L	x10^6/uL	4.00	6.00
Hgb	8.6 L	g/dL	11.0	18.0
Hct	27.1 L	%	35.0	60.0
MCV	93.0	fL	80.0	99.9
MCH	29.4	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	231.	x10^3/uL	150.	450.
LYZ	16.3 #L	%	20.5	51.1
LY#	2.1 *	x10^3/uL	1.2	3.4

a.1 2.1

---

i STAT GS:

Pt: 000000000[redacted] b6-4

Pt Name:_____

TCO2_____30 mmol/L

At 37C

pH_____7.440

PCO2_____41.7 mmHg

PO2_____77 mmHg

HCO3_____29 mmol/L

BEecf_____4 mmol/L

sO2%_____96 %

%calculated

At Patient Temp

pH_____7.406

PCO2_____42.5 mmHg

PO2_____72 mmHg

Patient Temp: 99.4F

FIO2_____: 21

Sample Type_: ART

14JUL03 04:30

Oper:

Physician:_____

Ser# 42015 b6-2

Ver: [redacted]046A
A03

---

i STAT GS:

Pt: 000000000[redacted] b6-4

Pt Name:_____

TCO2_____31 mmol/L

At 37C

pH_____7.462

PCO2_____42.0 mmHg

PO2_____XXX mmHg

HCO3_____30 mmol/L

BEecf_____6 mmol/L

sO2%_____XXX %

%calculated

At Patient Temp

pH_____7.457

PCO2_____42.6 mmHg

PO2_____XXX mmHg

Patient Temp: 99.2F

FIO2_____: 28

Sample Type_: ART

14JUL03 02:50

Oper:

Physician:_____

Ser# 42015 b6-2

Ver: [redacted]046A
A03

[redacted] b6-4

[redacted] b6-4

[redacted] b6-4

[redacted] b6-4

---

i-STAT G3+

Pt: [redacted] b6-4

Pt Name:_____

TCO2_____29 mmol/L

At 37C

pH_____7.447

PCO2_____40.5 mmHg

PO2_____32 mmHg

HCO3_____28 mmol/L

BEecf_____4 mmol/L

sO2*_____65 %

*calculated

Sample Type_:

18JUL03 04:09

Oper: 1678

Physician:_____

Ser# 42011

Ver: [redacted] 046A
A93

b6-2

PRBC1 - W020403 001317

MEDICAL RECORD — ANESTHESIA

DRUG	(Units)
Fentanyl	(u)
Propofol	(u)
Norcuron	(u)
	( )
Nimbex	(u)
MSO4	( )
VOLAT AGENT Forane	% del
	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min

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

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

TOTALS	TOTAL EBL
250	400
50	
10	TOTAL URINE
20	820
30	

FLUIDS – SUMMARY
CRYSTALLOID – 2100
COLLOID – 500
BLOOD – 1u PRBC – 400cc

FLUIDS: LINE site LR (R) Sub ☐ Warmed; (R) 18GAC ☐ Warmed; (L) 16GAC ☐ Warmed; ☐ Warmed

LOSSES: EST BLOOD LOSS; URINE – 60 150 100 50 100 50

PHYS STATUS: 1 (2) 3 4 5 E

BODY WEIGHT: 75 KG LB

HEMATOCRIT: 8/27

INITIAL DATA: BP – 120/60 8/27; HR – 92

EQUIP CHECK: OK? – Y N

PATIENT RECHECK: OK for PROCEDURE; TIME – 0545

TIME → 0600 0630 0700 0730 0800 0830

SYMBOLS: BP by cuff; Heart rate; Resp rate; BP (transduced); TOURNIQUET T – ; ANES – X-X; PROC – ⊙ – Ø

VENTIL: VT – ml; f – breaths/min; Peak inf pres / PEEP; MODE – S(pon), A(ssist), C(on)

MONITORS / ACCESSORIES: BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES; Gas analyzer; ET CO2 (torr); FIO2 (Frac or %); SpO2 (%); ECG; TEMP- site; N-M Block (T/4); Warming blkt; Conv warmer

	0600	0630	0700	0730	0800	0830
VT – ml	720	610	580	610	600	560
f – breaths/min	9	7	6	8	8	8
Peak inf pres / PEEP	23	25	24	25	28	27
MODE	A C	C	C	C	C	C
ET CO2 (torr)	32	30	31	31	31	31
FIO2 (Frac or %)	.88	.88	.86	.86	.88	.88
SpO2 (%)	100	100	100	100	100	100
ECG	SR	SR	SR	SR	SR	SR
N-M Block (T/4)	4/4	3/4	0/4	0/4	0/4	0/4

Mark with letters & symbols, explain under REMARKS. EVENTS: Arms tucked & padded. Position → supine

REMARKS – Code drugs with numbers, events with letters

0530 8/27 T+C 2uPRBC
Plt 81
WBC 14.6
7.48 – 127 – 32 – 25%
0647 Throat Pace In
0652 RPT FROM MAS [redacted] – CPT [redacted] CRNA
b6-2
0745 Pt unable to vent, trach tube sx'd + 10 puffs Albuterol via tube given, vent easy p tx + sxn. VT > 600 PIP 19.

RECOVERY AT ICU 3
PACU ICU #2 (Specify)
OTHER
CONDITION:
RESP – SpO2 –
BP – HR –

TIMES: THEATRE PROCEDURE TIMES

	Start	Room	End
ANES	0550	0652	0850
	Ready	Begin	End
PROC	0610	0625	0925

PROCEDURES and CPT Codes: I&D (R) leg + (R) facial wound

ANESTHETIC TECHNIQUES: Describe block technique under Remarks. GA; Eyes c̄ oint & op-site; BS = BS

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments. Pt. arrived to OR c̄ Trach → placed on vent

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility. EPW # [redacted] b6-4

SURGEONS: Dr. [redacted]

ANESTHETISTS: [redacted] MAT CRNA; [redacted] CPT CRNA

PROCEDURE LOCATION: OR #2

DATE: 9 Jul 93

PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP/376 REVISED 1 Jan 99
b6-2

PATIENT RECORD

☆ U.S. GPO: 1999 – 528-336/10085

MEDICAL RECORD — ANESTHESIA

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

DRUG	Units
	( )
	( )
	( )
	( )
	( )
	( )
VOLAT AGENT 1SO	% del 1/1/1
	% e.t.
AIR	L/Min
N2O	L/Min
O2	L/Min 3/3/3

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

Carry over
LR 1500
NS 400
1esp 500
.4 PRAL

FLUIDS

LINE site		
(L) SUBCLAV	☐ Warmed	LR3 —
(R) 16g	☐ Warmed	LR2 —
	☐ Warmed	
	☐ Warmed	

LOSSES (-100) EST BLOOD LOSS
(-100) URINE – 120

PHYS STATUS 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT:

INITIAL DATA: BP – / HR –

EQUIPMENT CHECK: OK? Y N

PATIENT CHECK: OK for PROCEDURE? TIME–

TIME →

SYMBOLS: BP by cuff; Heart rate; Resp rate; BP (transduced); TOURNIQUET T – X; ANES– X-X; PROC ⊙–Ø

220 / 200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40 / 20

VENTIL		
VT – ml	560	600
f – breaths/min	7	7
Peak inf pres / PEEP	18	18
MODE– S(pon), A(ssist), C(on)	C	C

MONITORS / ACCESSORIES				
X	BP/Auto Cuff	X	ET CO2 (torr)	34 33
	BP / oth	X	FIO2 (Frac or %)	.89 .89
X	ART line	X	SpO2 (%)	100 100
	Steth- PC/ES	X	ECG	SR SR
	Gas analyzer	X	TEMP- site	
		X	N-M Block (T/4)	0/4 0/4
	Warming blkt			
	Conv warmer			

Mark with letters & symbols, explain under REMARKS — EVENTS — Position → 0–1

TOTALS — TOTAL FLUIDS — TOTAL URINE

FLUIDS – SUMMARY: CRYSTALLOID– COLLOID– BLOOD–

REMARKS– Code drugs with numbers, events with letters

0906 THROAT PACK OUT

0933 Transferred to ICU3 c̄ SpO2 monitor + AMBU BAG c̄ O2 4L

0948 RPT TO CPT [redacted] IN.

b6-2

RECOVERY AT: PACU ICU (Specify) OTHER

CONDITION: RESP– SpO2– BP– HR–

ANES TIMES: Start Room End

PROC TIMES: Ready Begin End

PAGE ONE

PROCEDURES and CPT Codes: I&D LEG / FACIAL REPAIR 2° GSW

ANESTHETIC TECHNIQUES: Describe block technique under Remarks

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments

PAGE ONE

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

[redacted]

b6-4

SURGEONS: [redacted]

ANESTHE[redacted]ERT CRNA

PROCEDURE LOCATION: OR2

DATE: 9 JUL 03

PAGE 1 OF 2

b6-2 WAM[redacted] OP 376 REVISED 1 Jan 99

MEDICAL RECORD – ANESTHESIA

PATIENT RECORD

☆ U.S. GPO: 1999 – 528-336/10085

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age ~~30~~ 20 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: Evaskout
SURGICAL SERVICE: OS
NPO SINCE: remain NPO

ASA Physical State 1 (2) 3 4 5 E
WT: ~75 (KG)/LB HT: ____ IN.
ALLERGIES: UNKNOWN

HABITS:
TOBACCO: 7
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed

() Fentanyl 50mcg/hr
() LR 125
() Propofol 10mg/kg/min
() Pc x Anesthesia 10 mg IV Q8°
() Ancef 1gm IV Q8°
()

PREMEDICATIONS:
None Yes (@ ____ Hrs) /CC
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO
____ . ____ mg IV IM PO

LABORATORY STUDIES:
HB/HCT: 9 / 29
U/A:
OTHER: 8 jul WBC 13.8 PLT 84K

133 | 112 | 11
4.2 | 23 | 106

CR 1.2

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	7
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	7
COPD	N	Y	
Other	N	(Y)	Trach - 240 PST
Renal System:			
Acute/Chronic RF	N	Y	Foley
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	4 UPRBC (7 jul)
PUD/GERD	N	Y	OGT
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	7
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	7
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	N/A
Other Significant Hx:			
7	N	Y	
	N	Y	
Familial HX	N	Y	GSW FACE, (R) Leg

ASSESSMENT

PAST SURGICAL/ANESTHETIC
I&D (R) leg 7 jul (PST)
Stab/Gunshot of Laryngeal bleeding + Ex mandible
HX - B/P 50/20 @ PST
↑ ε level R

PHYSICAL EXAMINATION
BP 120/ HR ____ R ____ T ____
Pain Scale 0-10 ____
HEENT - Teeth wired shut
Trachea
TMJ/Neck trach
Oropharnyx
Nares
CHEST: CTA / slight rales Ronchi Bilat.
CARDIAC: S1 S2 3 (R)
EXTREMITIES: cordis (L) subclavian
IV Access: #16 GAC → L&R AC
Ulnar Filling: A-line (R)
BACK:
OTHER: OGT
Ventilator < Start 40 TV 700 FiO2 40% PEEP 5

NPO Since ____

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ b6-2 { } General: Mask Intubation

Chart Reviewed / [redacted] MAJ, CRNA

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the patient/legal guardian.

The patient/legal guardian seems to understand and agrees. Questions answered.

Signed: ____ Date: 9 Jul 03 Time: 0005 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU)
{ } NO APPARENT ANESTHETIC COMPLICATIONS { } OTHER

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ICU 3

EPW # [redacted] b6-4

SEDATION KEY:

1. **MINIMAL** (Anxiolysis) Patient responds normally to verbal commands
2. **MODERATE** (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. **DEEP SEDATION/ANALGESIA.** Patient responds purposefully following repeated or painful stimulation. Airway assistance may

former vet setting S - Rate - 10 - 700/40%/PEEP 5 → presently on trach collar @ 35%

ANESTHESIA PLAN OF CARE PA — OCCURRAL ASSESSMENT (SOAPIMOSA) — Name: Sinter/a

Age 20 DAYS MOS YRS — Sex (✓) MALE ( ) FEMALE

PROPOSED PROCEDURE: Dc D/DPC (R) thigh
SURGICAL SERVICE: ortho
NPO SINCE:

ASA Physical State 1 (2) 3 4 5 E
WT: 70 (KG)/LB HT: ___ IN
ALLERGIES: NKDA

HABITS:
TOBACCO: (+)
ETOH: (+)
DRUGS: —

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef Q8°
( ) fentanyl drip
( )
( )
( )
( )

PREMEDICATIONS:
None Yes (@ ___ Hrs) /CC
___ . ___ mg IV IM PO
___ . ___ mg IV IM PO
___ . ___ mg IV IM PO

LABORATORY STUDIES:

HS/HCT: ___/___
U/A:
OTHER:

9 July 03
12.6 / 7.7 / 23.8 / 110
ABG - 40% : 7.38/48.8/116/29 98%/H4

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	N	Y
Angina	N	Y
MI	N	Y
CVA	N	Y
Other	N	Y
Pulmonary System:		
Asthma	N	Y
Bronchitis/URI	N	Y
COPD	N	Y
Other	N	Y
Renal System:		
Acute/Chronic RF	N	Y
Gastrointestinal:		
Hepatitis	N	Y
Hiatal Hernia	N	Y
PUD/GERD	N	Y
Endocrine System:		
Diabetes	N	Y
Steroids	N	Y
Thyroid	N	Y
Neurological:		
Seizures	N	Y
Neuropathy	N	Y
Other	N	Y
Gynecological:		
Pregnancy	N	Y
Other Significant Hx:		
	N	Y
	N	Y
Familial HX	N	Y

ASSESSMENT
PAST SURGICAL/ANESTHETIC
(R) leg Dc D - 7 July
Dc D (R) leg - repair facial wounds 9 July
& Corpl.

PHYSICAL EXAMINATION
BP 172/80 HR 60 R ___ T ___ 100%
Pain Scale 0-10 ___
HEENT - Teeth ___
Trachea ___
TMJ/Neck ___ } Trached
Oropharynx ___
Nares ___
CHEST: BBS H/CTA
CARDIAC: S1 S2 RRR
EXTREMITIES: GSW (R) leg
IV Access: 14 (R) AC
Other Fitting: (L) subclavian
BACK: CVDS
OTHER: (R) external leg

GSW to face - leg

NPO Since ___

ANESTHETIC PLAN: ( ) LOCAL ( ) MAC ( ) Regional (Specify): ___ (✓) General: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to / discussed with the patient/legal guardian.

used interpreter for pre-op

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: [redacted] Date: 10 July 03 Time: 2100 Hrs

POST-ANESTHESIA EVALUATION AND NOTE (NON ASU) b6-2
( ) NO APPARENT ANESTHETIC COMPLICATIONS ( ) OTHER

Signed: ___ Date: ___ Time: ___ Hrs

SEDATION KEY:

1. MINIMAL (Anxiolysis) Patient responds normally to verbal commands
2. MODERATE (conscious sedation) Patient responds purposefully to verbal commands alone or accompanied by light tactile stimulation. Airway assistance is not necessary.
3. DEEP SEDATION/ANALGESIA Patient responds purposefully following repeated or painful stimulation. Airway assistance may

Patient Identification: (Ward) ___

EPW
[redacted] b6-4
ICU 3

MEDICAL RECORD — ANESTHESIA

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

DRUG	(Units)	
Versed	( )	2.5
Fent	( )	150 – 100
	( )	
	( )	
	( )	
MSO4	(mg)	
VOLAT. AGENT	150 % del / % e.t.	X/1.5/1.5/X
AIR	L/Min	
N2O	L/Min	
O2	L/Min	8/2/2/3

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

LINE site		
(R) AC	☐ Warmed	LOCIC
	☐ Warmed	
(L) Subclav.	☐ Warmed	LR1 — 1R
	EST BLOOD LOSS	
	URINE –	

TOTALS	TOTAL FLUID
2.5	MIN
280	TOTAL URINE
10	400

FLUIDS – SUMMARY
CRYSTALLOID 1000
COLLOID – Ø
BLOOD – Ø

REMARKS – Code drugs with numbers, event with letters

0726 PT ID, PREOP HIST. REVIEWED + Ø CHANGE.
0735 RM, O2, MONITOR
0742 TOTS
0840 OOR TO ICU
0846 RPT TO SPC [redacted] b6-2

ASA STATUS: 1 2 3 4 5 E
BODY WEIGHT: 70 KG LB
HEMATOCRIT: 23
INITIAL DATA: BP 127, 70 HR 60
EQUIP CHECK OK? – Y N
PATIENT RECHECK OK for PROCEDURE? Y
TIME 0730

SYMBOLS: BP by cuff ∨ ∧; Heart rate ●; Resp rate; BP (transduced); TOURNIQUET T – X; ANES – X-X; PROC – ⊙ – Ø

VT – ml	150	210	140
f – breaths/min	29	25	25
Peak inf pres / PEEP	/	/	/
MODE – S(pon), A(ssist), C(on)	S	S	S
ET CO2 (torr)	50	43	43
FIO2 (Frac or %)	.88	.88	.88
SpO2 (%)	100	100	100
ECG	SR	SR	SR
TEMP- site	Avail		
N-M Block (T/4)	Avail		

BP/Auto Cuff; BP / oth; ART line; Steth- PC/ES; Gas analyzer; Warming blkt; Conv warmer

Mark with letters & symbols, explain under REMARKS. EVENTS Position → Ø

RECOVERY AT 0840
PAR: ICU 3 (Specify)
OTHER
CONDITION:
RESP – 26 SpO2 – 100
BP – 133/62 HR – 97

	THEATRE PROCEDURE TIME		
ANES	Start	Room	End
	0720	0735	0850
PROC	Ready	Begin	End
	0742	0753	0830

PROCEDURES and CPT Codes
(R) LEG P.S.D

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments TRACH IN PLACE

PATIENT IDENTIFICATION – Typed or written entries: Name, Grade/Rate, Medical facility
[redacted] b6-4

SURGEONS: [redacted] b6-2
ANESTHETISTS: [redacted]

PROCEDURE LOCATION 1
DATE 11 JUL 03
PAGE 1 OF 1

MEDICAL RECORD – ANESTHESIA
WAMC OP 376 REVISED 1 Jan 99
PATIENT RECORD
☆ U.S. GPO: 1999 – 528-336/10

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)*: 1 UNIT ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 12 JULY 03

DATE AND HOUR REQUIRED: 12 JULY 03 NOW

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: NONE

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)*: Dr. [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P closure of (R) leg wound

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

SIGNATURE OF VERIFIER: [redacted] b6-2 ILT/AN

DATE VERIFIED: 12 JULY 03

TIME VERIFIED: 0330

SECTION II – PRE-TRANSFUSION TESTING

b6-4

UNIT NO. [redacted]

TRANSFUSION NO. 4

PATIENT NO. [redacted]

DON[redacted]

[redacted]

ABO: O

Rh: POS

ABO: O

Rh: POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	COMPAT

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SIGNATURE [redacted] b6-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 12 JUL 03

REMARKS:

Exp. Date: 14 Jul 2003

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted] b6-2

AT *(Hour)* 12:50 ON *(Date)* 12 Jul 2003

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient [redacted]m. The recipient is the same person named on this Blood [redacted]ion Form and on the patient identification tag.

[redacted] b6-2 12 Jul 03

[redacted] ILT/AN

PRE-TRANSFUSION

TEMP. 100.3 PULSE 80 BP 126/71

DATE OF TRANSFUSION: 12 JULY 03

TIME STARTED: 1302

POST-TRANSFUSION DATA

AMOUNT GIVEN: 350 ML

TIME DATE COMPLETED: 12 JULY 03 1516

INTERRUPTED

REACTION

- [x] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER _____

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

- [x] NO
- [ ] YES *(Specify)* _____

SIGNATURE [redacted] NOTING ABOVE [redacted] b6-2 ILT/AN

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give: NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

SEX: M

WARD: ICU3

[redacted] b6-4

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD COPY

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)*: 1 UNIT ML

REMARKS: b6-4

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

- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 12 JULY 03

DATE AND HOUR REQUIRED: 12 JULY 03 NOW

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*: NONE

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ____

HEMOLYTIC DISEASE OF NEWBORN? ____

REQUESTING PHYSICIAN *(Print)*: DR [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P closure of (R) leg wound

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

SIGNATURE OF VERIFIER: [redacted] b6-2 LCT/XN

DATE VERIFIED: 12 JULY 03

TIME VERIFIED: 0330

SECTION II – PRE-TRANSFUSION TESTING

[redacted]

TRANSFUSION NO. 3

PATIENT NO. [redacted]

DONOR

ABO: O

Rh: POS

RECIPIENT

ABO: O

Rh: POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	COMPAT

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] b6-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 12 Jul 03

REMARKS: Exp. Date: 14 Jul 2003

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted] b6-2

AT *(Hour)* 1118 ON *(Date)* 12 July 03

IDENTIFICATION

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

1st VERIFIER *(Signature)*: [redacted] b6-2 LCT/XN

2nd VERIFIER *(Signature)*: [redacted] CT/AN

PRE-TRANSFUSION

TEMP. 100.4 PULSE 75 BP 118/65

DATE OF TRANSFUSION: 12 JULY 03

TIME STARTED: 1122

POST-TRANSFUSION DATA

AMOUNT GIVEN: 350 ML

TIME DATE COMPLETED: 12 JULY 03 1300 INTERRUPTED

REACTION

- [x] NONE
- [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER ____

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

- [x] NO
- [ ] YES *(Specify)* ____

SIGNATURE OF PERSON NOTING ABOVE: [redacted] LCT/XN

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries give NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

[redacted] b6-4

b6-2

SEX: M

WARD: ICU3

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

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

VOLUME REQUESTED *(If applicable)* _____ ML

REMARKS:

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

- [ ] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 7/9/03

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

REQUESTING PHYSICIAN *(Print)* [redacted] b6-2

DIAGNOSIS OR OPERATIVE PROCEDURE

GSW face/leg

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

SIGNATURE OF VERIFIER [redacted] b6-2 CRNA

DATE VERIFIED 7/9/03

TIME VERIFIED 0620

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO. [redacted] b6-4

DONOR

ABO O

Rh pos

RECIPIENT

ABO O

Rh pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	Comp

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT [redacted] TED | DATE 09 Jul 03

REMARKS:

Exp 14 Jul 03

PREVIOUS RECORD CHECK:

[ ] RECORD [X] NO RECORD

[redacted] OF PERSON PERFORMING TEST [redacted] b6-2

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] b6-2

AT *(Hour)* 0751 ON *(Date)* 09 Jul 03

IDENTIFICATION:

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

[redacted] b6-2 CPT CRNA

[redacted] b6-2 CPT/AN

PRE-TRANSFUSION [redacted]

TEMP. 97°C PULSE 81 BP 111/58

DATE OF TRANSFUSION 7/9/03 TIME STARTED 0800

POST-TRANSFUSION DATA

AMOUNT GIVEN 1 unit ML

TIME COMPLETED 0810 DATE 7/9/03 INTERRUPTED

REACTION [X] NONE [ ] SUSPECTED

If reaction is suspected – IMMEDIATELY:

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

DESCRIPTION

[ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN

[ ] OTHER _____

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

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

SIGNATURE OF PERSON [redacted] OTING ABOVE [redacted] CPT CRNA

PATIENT IDENTIFICATION - USE EMBOSSER *(For typed or written entries [redacted] NAME - Last, first, middle; rank/rate; hospital number and name of facility.)*

b6-2

WARD

EPW # [redacted] b6-4

BLOOD OR BLOOD COMPONENT TRANSFUSION
STANDARD FORM 518 (REV. 8-86)
General Services Administration
Interagency Committee on Medical Records
FIRMR (41CFR) 201-45.505
518-122

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

#[redacted] b6-4

NURSING UNIT	ROOM NO.	BED NO.
ICU3		

DATE OF ORDER: 8 Jul 03 TIME OF ORDER: @ 1422 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU #3
2. Dx: GSW to face and leg.
3. Cond: Stable
4. Vitals: Per routine
5. aller: unknown
6. Activ: bed rest
7. Nurs: HOB ↑ 30°
   foley to gravity
   A line to monitor
   trach care q shift
8. Diet NPO
9. IV: LR @ 125 cc/hr
10. meds: Ancef 1gm IV q8° HOURS
    Decadron 10mg IV q8°
    [redacted]
    Versed Sublimaze } drip
    Versed propofol
11. Labs: ABG, CBC now & ~~am~~ Am
12. CT Face
13. Vent
    Smv 10 Tv 700 FIO2 40% p5
    b6-2 [redacted]
    Pr [redacted]
    NGT LWS [redacted] b6-2 noted [redacted]
    [redacted] b6-2 /LT/AN

NURSING UNIT	ROOM NO.	BED NO.
	24	Chart Check

0030 09 JUL 03 [redacted]

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

MEDCOM - 13950

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT	ROOM NO.	BED NO.
ICU 3		5

DATE OF ORDER 9 Jul 03 TIME OF ORDER @ 0948 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit to ICU #3
2. Dx: ① S/P Washout (R) leg
   ② Closed reduction of comminuted manad fx
   ③ Closure of tongue and soft tissue wounds.
3. Cond: Stable
4. Vitals: Per routine
5. Aller: Unknown
6. Activ: Bed rest
7. Nurs: Foley to gravity
   * Yankauer suction to BS
   Trach care q shift
   Bacitracin to wounds TID
8. Diet NPO
9. IV LR @ 125cc/hr
10. meds: Ancef 1gm IV q 8°
    Decadron 10mg x 1 dose
    then Decadron 8mg x 1 dose
    then decadron 6mg x 1 dose
    Fentanyl / Propofol drip as needed - titrate to effect
11. Suture removal ~~K~~ HOURS to BS
    as wire cutters
12. Phenergan 12.5-25mg IV q 4° pm N/V

b6-2 [redacted]

Transcribed 9 JUL 03

[redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION MEDCOM - 13951 USED.

24° Chart Check DIDO [redacted] b6-2 [redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

EPW

[redacted] b6-4

NURSING UNIT	ROOM NO.	BED NO.
JCU3		5

DATE OF ORDER: 9 Jul 03 TIME OF ORDER: 1113 HOURS

LIST TIME ORDER NOTED AND SIGN

May remove pt from Vent and place on Room Air

V.O. Per Dr. [redacted] b6-2

Transcribed 09 Jul 03 1219 [redacted] b6-2

24° Chart Check 0100 10 JUL [redacted] ICT/AN

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 10 Jul 03 @ 0715 HOURS TIME OF ORDER

0748 [redacted] 10 Jul 03

(1) Okay to start oral care c̄ toothbrush & mouthwash (gentle on pt's Rt side)

[redacted] b6-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 11 JUL 03 TIME OF ORDER: 0825 HOURS

(1) RESUME PRONING ORDERS

(2) S/P CLOSURE OF (R) LEG WOUND

(3) IV - LR at 125 cc/hr. HOW LONG WILL TAKING P.O. WITH

(4) [redacted] DIET BTS - Normal

(5) EMPTY LHO REZONO JP DRAIN Q OPT

PATIENT IDENTIFICATION 24° Chart Check 0030 12 JUL 03 [redacted] ICT/AN [redacted]

b6-2

NURSING UNIT	ROOM NO.	BED NO.

DA FORM 1 APR 79 4256 REPLACES EDITION MEDCOM - 13952 USED.

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

DATE OF ORDER 12 Jul 03 TIME OF ORDER 1000 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Transfuse 2u pRBC @ Crea 2° each
2. Lasix 3.375g IV q6°
3. Cipro 400g IV q12°
4. MC ancef

Acebal 12 Jul 03 1037 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

[redacted]

PATIENT IDENTIFICATION

[redacted] b6-4

DATE OF ORDER [redacted] HOURS b6-2

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted] b6-4

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted] b6-4

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO [redacted]

24° Chart ✓ [redacted] 13 Jul 03 0701

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

b6-2

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

DATE OF ORDER: 12 Jul 03 TIME OF ORDER: 2021 HOURS

LIST TIME ORDER NOTED AND SIGN

1. OOB c̄ assistance
2. Okay for trials off of trach collar [redacted]

NOTED 12 JUL 03 [redacted] b6-2

NURSING UNIT: ICU3 ROOM NO.: 24 BED NO.: Chart ✓

[redacted] b6-2 /SW 13 Jul 03 0700

PATIENT IDENTIFICATION

DATE OF ORDER: 13 Jul 03 TIME OF ORDER: 0800 HOURS

1. d/c PVR & 75 cath
2. Lasix 20 q IV now

[redacted] b6-2 13 Jul 03 0811

NURSING UNIT: 24 ROOM NO.: [redacted] BED NO.: Nurse /SW 1835 13 July 03

[redacted] b6-2

PATIENT IDENTIFICATION

DATE OF ORDER: 14 Jul 03 TIME OF ORDER: 0930 HOURS

1. PA CXR
2. d/c art line

NURSING UNIT: ROOM NO.: BED NO.:

[redacted] b6-2

PATIENT IDENTIFICATION

DATE OF ORDER: 15 July 03 TIME OF ORDER: 1632 HOURS

1. D/C Foley

[redacted] b6-2

NURSING UNIT: 24 ROOM NO.: Chart ✓ BED NO.: [redacted] b6-2 /SW 0541 16 Jul 03

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

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNT: 1C43 | ROOM NO. | BED NO.

DATE OF ORDER: 15 JULY 03 | TIME OF ORDER: 1920 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) PERCOCET TABS 1-2 PO Q 4-6 HRS PRN

Noted 1945 b6-2 [redacted]

PATIENT IDENTIFICATION

[redacted] b6-4

NURSING UNIT: 24° Chart | ROOM NO. | BED NO. [redacted]

DATE OF [redacted] | TIME OF ORDER | HOURS

MSO4 2mg IVP now x1
V.O. Dr [redacted] / ILT [redacted]

b6-2 b6-2

0542 16 Jul 03

PATIENT IDENTIFICATION

DATE OF ORDER: 16 July 03 | TIME OF ORDER: 1617 HOURS

(1) MSO4 2mg IVP q1° prn pain [redacted]

b6-2 [redacted] 16 Jul 03 1617

URSING UNIT | ROOM NO. | BED NO.

TIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

SING UNIT | ROOM NO. | BED NO.

FORM 1 APR 79 **4256** REPLACES EDITION OF 1 JUL 77

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mo. JULY Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 8	9	10	11	12	13	14	15	16	17	18
8 Jul	[redacted]	Vitals: per routine	05	[redacted]										
9 Jul 03			17	[redacted]										
8 Jul	[redacted]	Activity: Bedrest	05	[redacted]										
9 Jul 03	[redacted]		17	[redacted]										
8 Jul	[redacted]	HOB ↑ 30°	05	[redacted]										
9 Jul 03	[redacted]		17	[redacted]										
8 Jul	[redacted]	foley to gravity	05	[redacted]										
9 Jul 03			17	[redacted]										
8 Jul	[redacted]	A-line to monitor	05	[redacted]										
9 Jul 03	[redacted]		17	[redacted]										
8 Jul	[redacted]	trach care q shift	05	[redacted]										
9 Jul 03	[redacted]		17	[redacted]										
8 Jul	[redacted]	Diet: NPO	05	[redacted]										
9 Jul 03	[redacted]		17	[redacted]										
8 Jul	[redacted]	Labs: ABG, CBC	05	[redacted]										
	[redacted]	q AM												
08 JUL	[redacted]	NGT to LIS	05	[redacted]										
			17	[redacted]										

ALLERGIES: ☐ YES ☐ NO

unknown

PRIMARY DIAGNOSIS: GSW to face & leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] b6-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

USAPA V1.0

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo JUL Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
8/01	[redacted]	Admit to SCU #3	8/01		1445	[redacted]	
8/01	[redacted]	Cont stable	8/01		1445	[redacted]	
8/01	[redacted]	CT Fax	8/01	ON CALL	2200	[redacted]	
	-----	b6-2				b6-2	

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

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)

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

Mo. ____ Yr. 2003

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING: ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
09 July	[redacted]	Yankauer suction to	05	[redacted]														
		BS	17															
09 July	[redacted]	Suture removal kit to	05															
		BS as wire cutters.	17															
10 Jul 03	[redacted]	Okay to start oral care	05															
		c̄ toothbrush + mouthwash	17															
		(Gentle on pt's R side)	A															
11 July	[redacted]	Diet BTS-liquid	05															
			17															
11 July	[redacted]	Empty and record JP	05															
		drain Q shift	17															
12 JUL	[redacted]	OOB c̄ Assistance	05	X	X	X	X	[redacted]										
			17	X	X	X	X	[redacted]										
12 JUL	[redacted]	OK for trials off of	05	X	X	X	X	[redacted]										
		Trach collar	17	X	X	X	X	[redacted]										

13 July 03 1830

b6-2

b6-2

ALLERGIES: ☐ YES ☐ NO

unknown

PRIMARY DIAGNOSIS: 1) Prolonged (B) LOC
2) closed reduction of comminuted mand fx.
3) closure of tongue and soft tissue wounds

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION: EPW

#[redacted]

b6-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

USAPA V1.0

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

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*

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

Mo. July Yr. 2003

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

VERIFY BY INITIALING

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 07	08	09	10	11	12	13
8 July 03	[redacted]	VS q 1°	05	/	[redacted]					
			17	[redacted]						
8 July 03	[redacted]	ACTIVITY: BR	05	/	[redacted]					
			17	[redacted]						
8 July 03	[redacted]	DIET: NPO	06	/	[redacted]					
			11	/	[redacted]					
			17	/	[redacted]					
8 July 03	[redacted]	Foley to gravity	05	/	[redacted]					
			17	[redacted]	/					
8 July 03	[redacted]	OG: flush c 30cc H_2O q 4°	02	/	/					
			06	/	[redacted]					
			10	/	[redacted]					
			14	/	[redacted]					
			18	/						
			22	/						
8 July 03	[redacted]	Trach care q shift	05	/	[redacted]					
			17	[redacted]						
8 July 03	[redacted]	A-line to monitor	05	/	[redacted]					
			17	[redacted]						
8 July 03	[redacted]	STRICT I/O's	05	/	[redacted]					
			17	[redacted]						
8 July 03	[redacted]	OG to LIS	05	/	[redacted]					
			17	[redacted]						

b6-2

ALLERGIES: ☐ YES ☐ NO

Unknown

PRIMARY DIAGNOSIS: GSW to face & (R) leg s/p facial exploration

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

EPW # 0[redacted]

b6-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

D 8 9 10 11 12 13 14 15

E ~~16 17~~ 18 19 20 21 22 23

N 24 01 02 03 04 05 06 07

USAPA V1.00

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

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

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 8	9	10	11	12	13	14	15	16	17
8 Jul	[redacted]	LR @ 125 cc/hr	05	[redacted]									
		H.L when tol. po well (11 July)	17										
8 Jul	[redacted]	Omeg 1gm IV q8°	08	[redacted]									
			16										
			24										
8 Jul	[redacted]	Decadron IV 10mg q8°	08	[redacted]									
			16	[redacted]									
			24	[redacted]									
8 Jul	[redacted]	Propofol gtt titrate to sedation	05	[redacted]									
			17	[redacted]									
8 Jul	[redacted]	fentanyl gtt titrate to sedation	05	[redacted]									
			17	[redacted]									
8 Jul	[redacted]	VENT SIMV 10 TV 700 40% peep -5	05	[redacted]									
			17										
09 July	HOS	Bacitracin to wounds TID	08										
			16										
			24										
10 July	[redacted]	trach collar @ 35% O2 31% O2	05										
			17										
12 Jul	[redacted]	CIPRO 400mg IV q12°	12										
			24										

ALLERGIES: ☐ YES ☐ NO
unknown

PRIMARY DIAGNOSIS:
GSW to face & leg s/p closure of [redacted] wound (11 July)

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO. ___

PATIENT IDENTIFICATION:
[redacted] 66-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

66-2

66-3

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

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo. JUL Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
9July	[redacted]	Decadron 10mg x 1dose then	09 July03		1121	[redacted]
9July	[redacted]	Decadron 8mg x 1dose then	09 July 03	1800	1820	[redacted]
9July	[redacted]	Decadron 1mg x 1 dose	09 July 03	0400	0400	[redacted]
9July	[redacted]	may remove pt. from vent and	09 July03	1800	1800	[redacted]
	-----	place on Room air				
12Jul	[redacted]	Transfuse 2u PRBC over 2° each	12Jul	1030	1132	[redacted]
13Jul03	[redacted]	Lasix 20mg IV Now	13Jul03		0809	[redacted]
15Jul	[redacted]	MSO4 2mg IVP X1 Now	15Jul	2311	2311	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
2July	[redacted]	Phenergan 12.5-25mg														
-----	-----	IVQ4°pm N/V														
15Jul	[redacted]	Percocet Tab 1-2 PO	15Jul 1945 2400													
-----	-----	Q 4-6 hrs PRN	[redacted]													
-----	-----	MSO4 2mg														
-----	-----	IVP X1 N														
16Jul03	[redacted]	MSO4 2mg IVP D I	17Jul 0300													
-----	-----	Q1° PRN Pain D I	2mg IV													
-----	-----		[redacted]													
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*

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

Mo. 07 Yr. 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	12	13	14	15	16	17	18
12Jul	[redacted]	Zosyn 3.375 mg IV q 6°	06	/	[redacted]					
			12	[redacted]						
			18	[redacted]						
		b6-2	24	[redacted]						
13Jul03	[redacted]	↓ IVF (LR) to 75cc/°	05	/	[redacted]					
			17	/	[redacted]					

b6-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW to face & leg

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW [redacted] b6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

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

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) DA Appr 8 Mar 89 b6-2

INITIAL SHIFT ASSESSMENT

	TIME		INITIALS		INITIALS	1800	INITIALS [redacted]
NEURO	PUPILS	PERRLA				PERRLA 3mm brisk	
	SENSORIUM	Opens eyes spontaneously.				Opens eyes spontaneously	
		Moves BUE				moves extremities on command	
						follows simple commands	
						Propofol 7.5mcg/kg/min	
RESPIRATORY	RESPIRATORY PATTERN	Regular + Unlabored				RRR	
	BREATH SOUNDS	Rhonchi				Rhonchi upper	
	SECRETIONS					Ø secretions	
						SIMV RR10, TV700, FiO2	
						40, Peep 5, SaO2 100	
SKIN	COLOR	Normal for Race				Normal for Race	
	INTEGRITY	Dressing to mandible/neck				Dressing to mandible/neck	
		and (R) foot to thigh				blood soaked, reinforced	
I.V. SITE	LOCATION	(L) Subclavian				Drsg to (R) thigh reinforced	
	CONDITION	16G IV (R) AC				(L) SC Cordis	
		16G IV (L) AC				16g (L) AC; 16g (R) AC	
		(R) Radial A-line				(R) Rad A-Line-flushed	
		Ø S/S of infection				c̄ dicrotic notch.	
		to IV sites or A-line				LR@125cc, Fentanyl@125mcg/hr	
GASTRO	ABDOMEN	Soft + Tender				Soft, tender, flat	
	BOWEL SOUNDS	Hypoactive				BS (+)	
		Orogastric Tube				OGT c̄ Dk green drainage	
						L	
GU	URINE:	Foley to Gravity				Foley to gravity	
	COLOR/CLARITY	Clear, Dark Yellow				Cl, dk yellow QS	
CARDIOVASCULAR	CARDIAC RHYTHM	ST, Ø ectopy				ST S1/S2	
		Cap Refill c̄ 3 secs				Edema to face.	
		Peri-orbital Edema				Pulses +2 x 4 extremities	
		Facial Edema				Cap Refill < 3sec x 4 extremities	

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

b6-2

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] cft/tw

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 8 Jul 03

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

[redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

WAMC OP 375 (Redesignated) 1 Apr 90 (HSXC-NU)

DATE 8JUL03 | DX GSW to (L) mandible & (R) thigh | HOSPITAL DAY 0 | 13 14/72

VITAL SIGNS	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
	BP Arterial Line											101/53	114/58	109/57	128/63	126/63	133/68	~~106/54~~	
	BP Cuff														122/64	128/67	126/65	106/54	
	Temperature												102.8	102.6	101.3	100.6	100.4		
	Pulse											105	119	109	110	94	93	100	
	Respiratory Rate											10	11	18	13	19	16	13	
	MAP											71	77	73	82	81	87	89	
	O2 sats											100%	100%	99	100	100	100	100	
	O2 source											Vent	Vent	Vent	Vent	Vent	Vent	Vent	
	FiO2														.40	.40	.40	.40	
	pain																		
	intervention																		

INTAKE	TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
	LR											125	125	125	125	125	125	125	875
	Propofol												2.1	2.1	3.2	3.2	3.2	3.2	17.0
	Fentanyl												5	5	5	5	5	5	30
	IVPB												100						100
																			1022.0
	TOTALS											125/125	232.1/953.1	132.1/[illegible]	133.2/[illegible]	133.2/[illegible]	133.2/888.8	133.2/[illegible]	[illegible]

OUTPUT		HOUR / TOTAL	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
	URINE													200/200	100/300	175/475	125/600	120/720	120/840	840
		sp gr																		
		S/A																		
	NG	OUTPUT												150						150
		pH																		
		GUIAC																		
	EMESIS																			
	STOOL																			
	DRAINS																			
	TOTALS													350/350	100/450	175/625	125/750	120/870	120/990	990

POST-OP DAY

	21	22	23	00	01	02	03	04
BP	127/72	120/62	131/68	124/67	129/68	125/66	109/66	127/67
	139/65	126/64	119/61	110/60	114/61	133/60	140/67	133/62
		99	99			98		
P	92	94	97	99	85	77	88	73
		10	10	10	10	10	11	10
RR	86	82	78	74	78	83	88	83
MP	100	100	100	100	100	100	100	100
	Vent	Vent	Vent	Vent	Vent	Vent	Vent	Vent
FiO2	.40	.40	.40	.40	.40	.40	.40	.40

INTAKE

	21	22	23	00	01	02	03	04	8°T
NS	125	125	125	125	125	125	125	125	
Propofol	4.2	4.2	4.2	4.2	3.5	3.5	3.5	3.5	
Sint	5	5	5	5	5	5	5	5	
VPB			100						
	134.2	134.2	334.2	134.2	133.5	133.5	133.5	133.5	
	134.2	268.4	602.6	736.8	870.3	1003.8	1137.3	1270.8	

OUTPUT

	21	22	23	00	01	02	03	04
	125/125	125/250	125/375	120/495	120/615	180/795	140/935	140/1075
	125/125	125/250	125/375	120/495	120/615	180/795	140/935	140/1075

ACUITY LEVEL CLASSIFICATION

RESPIRATORY				
	TIME	ART 1445	9JUL 0230	
	MODE	SIMV	SIMV	
	F_iO_2	40%	40	
	TV	700	700	
	RATE	10	10	
	PEEP	5	5	
A	pH	7.452	7.483	
A	PCO_2	34.2	32.6	
A	pO_2	137	127	
B	HCO_3	24	25	
B	SAT	99	99	
G	BASE	0	1	

LABORATORY				
	TIME	1500	1512	0230
	GLUCOSE	106		
	Na/K	133/4.2	143/3.9	
	Cl/CO_2	112/23		
	BUN/Cr	11		
	WBC/PLATELET	13.8/84		14.6/81
	Hct/Hgb	29/9.1	22/7	27.2/8.4
	TCO2/iCa		25/1.06	
	CK	1228		
	RBC/MCV			2.99/91.1

ACTIVITIES DAILY LIVING				
	TIME	2000	2200	
	MOUTH CARE			
	BATH			
	SKIN CARE			bb-2
	FOLEY CARE	[redacted]		
	TRACH CARE		[redacted]	
	ROM EXERCISES			

TURN	TIME
	21
SUCTION	2100
	mouth

24 I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE		OUTPUT
IV	1110.8	Urine:	1075
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]
ICT/AN	
bb-2	

5cc

NEUROLOGICAL ASSESSMENT

		HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
COMA SCALE	EYES OPEN	SPONTANEOUSLY 4											X			X										
		TO SPEECH 3																								
		TO PAIN 2																								
		NO EYE OPENING 1																								
	BEST VERBAL RESPONSE	ORIENTED 5																								
		CONFUSED 4																								
		VERBALIZES 3																								
		VOCALIZES 2																								
		NO VOCALIZATION 1											X			T										
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6											X			X										
		LOCALIZES PAIN 5																								
		FLEXION WITHDRAWAL 4																								
		ABNORMAL FLEXION 3																								
		EXTENSION TO PAIN 2																								
		NO MOTOR RESPONSE 1																								
LIMB MOVEMENT	ARMS	NORMAL POWER																								
		MILD WEAKNESS																								
		SEVERE WEAKNESS														X										
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
	LEGS	NORMAL POWER																								
		MILD WEAKNESS																								
		SEVERE WEAKNESS																								
		ABNORMAL FLEXION														X										
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
PUPILS	RIGHT	SIZE										3				3mm										
		REACTION										++				++										
	LEFT	SIZE										3				3mm										
		REACTION										++				++										
PUPIL SCALE			2		3		4		5		6		7 mm													
ICP																										
CEREBRAL PERFUSION PRESSURE																										

LEGEND

- C Closed by swelling
- T Trach/Endo
- S Slurring
- D Dysphasia
- R Receptive
- E Expressive
- R Right
- L Left

Record separately if there is a difference between the two sides.

- ++ Brisk
- + Slow
- - No Response
- + Intact
- - Abnormal

VASCULAR ASSESSMENT

	HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
Radial	R	++									++				++			++		++					
	L										++				++			++		++					
Pedal	R	++									+	++	++		++			++		++					
	L	+									+	++	++		++			++		++					
	R																								
	L																								
	R																								
	L																								
	R																								
	L																								

LEGEND

- ++ Normal
- + Weak
- - Absent
- D Doppler
- R Right
- L Left

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) PA Appr 8 Mar 89 b6-2

INITIAL SHIFT ASSESSMENT

	TIME	0530	INITIALS [redacted]	b6-2	INITIALS	1800	INITIALS [redacted]
NEURO	PUPILS	PERL				PERRLA 3mm brisk	
	SENSORIUM	Open eyes Spontaneously				Follows simple commands	
						Able to move extremities	
						Fentanyl 50mcg/h	
RESPIRATORY	RESPIRATORY PATTERN	Regular + unlabored				Propofol 8.4mcg/kg/min	
	BREATH SOUNDS	Rhonchi				RRR	
	SECRETIONS					Rhonchi Upper	
						Trach	
						Switched to TC @ 50%	
						FiO2 at 1730. SaO2 100	
SKIN	COLOR	Normal for Race					
	INTEGRITY					Normal for Race	
						Stitches to (R) jawline & (L)	
						lower lip. Drsg to (R) leg CDI	
I.V. SITE	LOCATION	(L) Subclavian				(L) Sq. Cordis	
	CONDITION	16 G IV (R) AC				(R) FA 16g	
		16 G IV (L) AC				(R) Rad A-line	
		(R) Radial A-line				LR @ 125cc/°	
		Ø infection to sites					
GASTRO	ABDOMEN	Soft + flat					
	BOWEL SOUNDS	Q4 quadrant				Soft, flat, nontender	
						BS (+) x 4 quads	
						Ø BM	
GU	URINE:	F/C to bedside					
	COLOR/CLARITY	dark yellow urine				Foley to gravity	
						clear yellow urine	
						1-2cc/kg/hr	
CARDIOVASCULAR	CARDIAC RHYTHM	normal				SR	S1S2
		Trach. Edema to				Pulses +2 x4 extremities	
		face				Cap Refill <3 sec x4 extremities	
						Facial Edema	

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 9 JUL

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

[redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

[redacted] b6-4

DATE 9JUL03 | DX GSW to (L) mandible & (R) thigh | HOSPITAL DAY 1

VITAL SIGNS	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	129/63					165/111	169/72	161/63	147/85	144/55	137/60	131/61	125/69	129/62	100/67	129/75	117/89	
BP Cuff																		
Temperature	96.9						96.0	96.9	98.2	98.2	97.6	97.4	98.5		97.8		99.6	
Pulse	70					78	81	89	85	85	83	81	89	86	110	66	66	
Respiratory Rate	10				10	10	14	12	16	10	12	10	10	12	25	17	18	
O2 Sats	100				100	100	100	99	100	100	100	100	100	100	100	100	100	
O2 Source	Vent				vent	vent	vent	vent	vent	vent	vent	vent	vent	vent	TC 50%	TC	TC	
FiO2	40				40	40	40	40	40	40	40	40	40	40	50	50	35	
MAP	83						96	85	81	81	82	83	78	81	80	86	98	

pain
intervention

INTAKE	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
IVF	125				125	125	125	125	625	125	125	125	125	125	125	125	125	1000
Propofol	3.5				3.5	3.5	3.5	3.5	17.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	2.1	24.6
Fentanyl	5				5	5	5	5	25	5	5	5	5	5	5	5	5	40
NPB						100			100				100					100
					LR-OR 1500cc													
					NS-OR 400 cc													
					OR-1U PRBC													
					OR-Hesp-500cc													
																		1164.6
TOTALS	133.5 / 133.5				133.5 / 267	233.5 / 500.5	133.5 / 634	133.5 / 767.5	767.5	133.5 / 133.5	133.5 / 267	133.5 / 400.5	233.5 / 634	133.5 / 767.5	133.5 / 901.0	133.5 / 1034.5	132.1 / 1355.6	1355.6

OUTPUT		05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
URINE	HOUR	110				80	300	400	350		285	100	285	285	280	300	270	200	
	TOTAL	110			110	190	1240	1690	2040	2090	2325	2585	2870	3155	3435	3735	4000	4200	4200
	sp gr													3400 / 385					
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS													3855						

45 FOLEY

500 FFP 31.5 / 64 / 11.5 / 100 PRBC / IVF

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04
BP	109/56		134/68	132/62	131/70	129/70	131/68	131/63
Temp			101.1		100.4		101.0	
HR	68	69	69	73	66	64	59	57
RR	15	17	19	20	18	18	17	16
Sat	100	100	100	99	100	100	100	100
Device	TC	TC	TC	TC	TC	TC	TC	TC
FiO_2	.35	.35	.35	.35	.35	.35	.35	.35
MAP	101		86	81	88	84	83	81

INTAKE	21	22	23	00	01	02	03	04	8° T
IVF	125	125	125	125	125	125	125	125	1000
Prop	2.1	2.1	2.1	2.1	2.1	2.1	2.1	2.1	16.8
Fent	5	5	5	5	5	5	5	5	40
PRBC				100	~~100~~				100
									1156.8
	132.1 / 132.1	132.1 / 264.2	132.1 / 396.3	132.1 / 528.4	132.1 / 760.5	132.1 / 892.6	132.1 / 1024.7	132.1 / 1156.8	1156.8

OUTPUT	21	22	23	00	01	02	03	04	
	200 / 200	240 / 440	200 / 640	200 / 840	200 / 1040	170 / 1110	145 / 1255	120 / 1375	1375

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	0500		0344						
	MODE	SIMV		TC						
	F_iO_2	40		35						
	TV	700								
	RATE	10								
	PEEP	5								
ARTERIAL BLOOD GAS	A: pH			7.386						
	A: PCO_2			48.8						
	A: pO_2			116						
	B: HCO_3			29						
	B: SAT			98						
	G: BASE			4						

LABORATORY	TIME			0315						
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET			12.4 / 110						
	Hct/Hgb			23.8 / 9.7						
	WBC			12.6						

ACTIVITIES DAILY LIVING	TIME			
	MOUTH CARE			
	BATH	1100		
	SKIN CARE	0530		
	FOLEY CARE	1100	2030	
	TRACH CARE	1400	2000	
	ROM EXERCISES	0530		

TURN	TIME				
				1400 (R)	1530 (R)

SUCTION		1200	1500	2000 blood tinged	2315 blood tinged
	0140 Blood tinged				

24 hr I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE		OUTPUT
IV	762.5	Urine:	2040
po	1356.6		4200
	1156.8		1375
TOTAL	3274.9	TOTAL	7615

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]
[redacted] 10/AU	
106-2	

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
	EYES OPEN	SPONTANEOUSLY 4	✓																							
		TO SPEECH 3																								
		TO PAIN 2																								
		NO EYE OPENING 1																								
	BEST VERBAL RESPONSE	ORIENTED 5	✓																							
		CONFUSED 4																								
		VERBALIZES 3																								
		VOCALIZES 2																								
		NO VOCALIZATION 1																								
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6	✓																							
		LOCALIZES PAIN 5																								
		FLEXION WITHDRAWAL 4																								
		ABNORMAL FLEXION 3																								
		EXTENSION TO PAIN 2																								
		NO MOTOR RESPONSE 1																								
LIMB MOVEMENT	ARMS	NORMAL POWER	✓																							
		MILD WEAKNESS																								
		SEVERE WEAKNESS																								
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
	LEGS	NORMAL POWER																								
		MILD WEAKNESS	✓																							
		SEVERE WEAKNESS																								
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
PUPILS	RIGHT	SIZE	3																							
		REACTION	+																							
	LEFT	SIZE	3																							
		REACTION	+																							
PUPIL SCALE			● 2	● 3	● 4	● 5	● 6	● 7 mm																		
ICP																										
CEREBRAL PERFUSION PRESSURE																										

LEGEND

C Closed by swelling

T Trach/Endo
S Slurring
D Dysphasia
R Receptive
E Expressive

R Right
L Left

Record separately if there is a difference between the two sides.

+ + Brisk
+ Slow
- No Response

+ Intact
- Abnormal

VASCULAR ASSESSMENT

		HOURS	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
	R																									
	L																									
	R																									
	L																									
	R																									
	L																									
	R																									
	L																									
	R																									
	L																									

LEGEND

+ + Normal
+ Weak
- Absent
D Doppler
R Right
L Left

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b6-2

OTSG APPROVED (Date) OA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0600	INITIALS [redacted]	0300	INITIALS [redacted]		INITIALS
NEURO	PUPILS		3mm PERRL brisk		PERL 1.5 mm			
	SENSORIUM		Sleeping but awakens		responsive to R leg wheel			
			Spontaneously. Moves		to occasion drowsy			
			extremities x4					
			purposeful movement					
RESPIRATORY	RESPIRATORY PATTERN		RRR, LTA Bilat		reg rate & depth			
	BREATH SOUNDS		& secretion, suction		trach collar 35% O2			
	SECRETIONS		trach, Trach Collar		#8 shiley trach			
			FIO2 35%					
SKIN	COLOR		Normal for Race		WNL			
	INTEGRITY				decubitus			
					to (R) leg wound			
					on face open to air			
I.V. SITE	LOCATION		A-line to (R) wrist		A-line R radial			
	CONDITION		(L) SC Cordis LR		L subclavian cordis fluids			
			@ 125 cc/hr		fluids no signs of infect			
					or infiltrate			
GASTRO	ABDOMEN		+BS x 4 quad Soft		+BS x 4 quad soft			
	BOWEL SOUNDS		Non distended		non distended abd			
GU	URINE:		Clear yellow Foley		clear yellow urine			
	COLOR/CLARITY		to gravity		in urinary output via			
					foley to gravity drainage			
CARDIOVASCULAR	CARDIAC RHYTHM		S1 S2 Pulses +2 x 4 ext		S1 S2 pulses palpable			
			Cap refill >3 sec		x 4 extremities cap			
					refill < 3 sec			

LEGEND

Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] b6-2

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 10JUL03

PATIENT'S IDENTIFICATION (Print or type [redacted]e: Name—last, first, middle; grade; date; hospital or medical facility)

[redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

WAMC OP 375 (Redesignated) 1 Apr 90 (HSXC-NU)

DATE 10JUL03 | DX | HOSPITAL DAY

VITAL SIGNS	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	132/78	115/70	149/72	120/75	136/73	141/77	135/73	125/78		130/72		134/66			127/75			
BP Cuff																		
Temperature			98.5									99.2						
Pulse	58	56	53	53	56	56	55	57		57		57			58			
Respiratory Rate	15	15	19	17	12	14	10	19		14		22			20			
O_2 Sat	100	100	100	100	100	100	100	100		100		99			100			
O_2 Source	TC	TC	TC	TC	TC	TC	TC	TC		TC		TC			TC			
FIO2	35	35	35	35	35	35	35	35		35		35			35			
MAP	91	82	94	90	84	92	88	94		87		83			90			

pain intervention

INTAKE	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
IVF	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	
Fentanyl	5	5	5	5	5	5	5	5	40	5	5	5	5	5	5	5	5	
Propofol	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	12	1.5	1.5							
IVPB																		
TOTALS																		

OUTPUT		HOUR / TOTAL	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
URINE			80/80	140/220	140/360	160/520	140/660	120/780	140/920	140/1060	960	100/1160	70/1230	170/1400			130/1530			
	sp gr																			
	S/A																			
NG	OUTPUT																			
	pH																			
	GUIAC																			
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04	
						155			
						71			
						98.8			
						60			
						18			
						100			
						TC			
						35%			

INTAKE	21	22	23	00	01	02	03	04	8° T
	125	125	125	125	125	125	125	125	
	5	5	5	5	5	5	5	5	
		100							

OUTPUT									
	400					350			
	800					470			

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GAS	A: pH									
	A: PCO_2									
	A: pO_2									
	B: HCO_3									
	SAT									
	G: BASE									

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES OF DAILY LIVING	TIME									
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE									
	ROM EXERCISES									

	TIME					
TURN						
SUCTION						

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE	OUTPUT
IV	_____	Urine: _____
po	_____	_____
	_____	_____
TOTAL	_____	TOTAL _____

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[redacted]	[redacted]

W6-2

[redacted] W6-4 10 July 03

PAGE

MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)* QA Appr 8 Mar 89

b6-2 [redacted] **INITIAL SHIFT ASSESSMENT**

	TIME	[redacted] INITIALS	[redacted] INITIALS	1800 [redacted] b6-2
N	PUPILS	3mm PERRL [redacted]	b6-2	PERRLA 3mm brisk
E	SENSORIUM	Awake & Alert		Awake, A&O, moves
U		moves all extremities		all extremities, LE
R		& purposful movement		weak. Follows simple
O				commands
R	RESPIRATORY PATTERN	RRR CTA Bilat		RRR
E	BREATH SOUNDS	& Secretions. Trach		Clear (B)
S	SECRETIONS	collar 35% w/ FiO2		TC 35% FiO2 SaO2 97
P		SaO2 100%		
I				
R				
A	COLOR	Normal for Race		Normal for Race
T	INTEGRITY			Stitches to (R) jaw
I				Drsg to RLE CDI
O	LOCATION	A-line to (R) radial		(L) SC Cordis
N	CONDITION	18ga IV (R) FA NIL		(R) Rad A-Line
		Central line (L) SC		18ga (R) FA
		LR @ 125 cc/hr		LR @ 125cc/h
				Fentanyl 50mcg/h
	ABDOMEN	Hypoactive BS		Flat, Soft, Nontender
	BOWEL SOUNDS	Soft Non Tender		BS ↓
		& distention		∅ BM
	URINE:	Clear yellow foley		Foley to gravity
	COLOR/CLARITY	to gravity		Clear dk orange
				urine
	CARDIAC RHYTHM	S1 S2, Peripheral		SR S1/S2
		Pulses +2 x 4 extremities		Pulses +2 x 4 extrimities
				Cap Refill < 3sec
				Generalized edema

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SA - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PA[redacted] b6-2 | DEPARTMENT/SERVICE/CLINIC: ICU 2 east | DATE: 11 July 83

ENT'S IDENTI[redacted] *entries give: Name—last, first, dle; grade; date; hospital or medical facility)*

[redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 11 July 03
Time In: 0850
Allergies: NKDA
Pre-op V/S:
Procedures:

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1000 LR Colloid
OR Output: UOP 400 EBL Minimal
Meds/Times: 2.5 Versed 250mcg Fentanyl 10mg Ms04

Drains	Airway
Hemovac	Nasal
NG	Oral
JP	ETT
T-tube	Trach
Foley	Other
TLS	

Pre Op Meds / History

Time	0850	0855	0900	0905	0920	0935	0950
SaO2	96	97	98	99	100	100	100
FiO2							
Methods							
240							
220							
200							
180							
160							
140	^	^	^	^	^	^	^
120							
100							
80	v	v	v	v	v	v	v
60							
40							
20							
HR	77	92	86	87	77	64	70
RR	18	20	19	23	21	21	20
T	97.9	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Time	0850						
Pain (0-10)							
LOS							

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays: Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	2	1	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea			
Blood Pressure (2) SBP ≥/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse	2	2	2
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.			

Codes

AIRWAY
A = Ambu
BB = Blow-by
M = Mask
FT = Face Tent
RA = RoomAir
NC = Nasal Cannula

V/S
X = A-line BP
^ = Cuff BP
= Pulse

TEMP
S = Skin
O = Oral
A = Axillary
T = Tympanic
R = Rectal

LOS
C = Cervical
T = Thoracic
L = Lumbar
S = Sacral

Patient teaching done: Wound Care, Pain Management, T, C, & DB,. Incentive Spirometer, Comfort Measures
Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY (Signature) [redacted] b6-7 LPN

DEPARTMENT/SERVICE/CLINIC: ICU3

DATE: 11 July 03

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

[redacted] b6-4

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

DATE 11 JUL 03 | DX S/1 | Sure (R) leg wound on 11J | HOSPITAL DAY

VITAL SIGNS																			
TIME	05	06	07	08	09	10	11	12	13	13	14	15	16	17	18	19	20	21
BP Arterial Line	142/84	136/71		105/58	135/71	136/72	162/75	150/78										
BP Cuff										115/60	111/57	102/54	102/56	101/53	100 141/76	139/75	101 133/74	
Temperature					98.3	99.4	100.0	100.8		101.0	101.4	101.2	101.5	101.3	105/51	105/56	112/61	
Pulse	62	67		85	86	69	72	87		91	94	76	82	80	71	71	70	
Respiratory Rate	22	23		25	19	22	21	25		15	22	17	21	14	24	12	14	
SaO2	100	100		100	98	100	100	100		98	98	100	100	100	97	97	97	
O2 Source	TC	TC			TC	TC	TC	TC		TC	TC	TC	TC	TC	TC	TC	TC	
FIO2	35%	35%		100	35%	35%	35%	35%		35%	35%	35%	35%	35%	38	35	35	
MAP							93	98							92	92	90	
pain																		
sedation																		

INTAKE																		
TIME	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21
LR	125	125	0		125	125	125	125	125	125	125	125	125	125	125	125	125
Fentanyl	5	5			5	5	5	5	5	5	5	5	5	5	5	5	5
IVPB						100							100				
TOTALS	130 / 130	130 / 260			130 / 390	230 / 620	130 / 750	130 / 880	880	130 / 130	130 / 260	130 / 390	130 / 520	230 / 650	130 / 780	130 / 910	130 / 1040	1040

OUTPUT																			
URINE	HOUR / TOTAL	125 / 125	125 / 250	110 / 360	40	0 / 360	160 / 520	110 / 630	190 / 820	500	110 / 110	180 / 290	120 / 410	110 / 520	110 / 630	120 / 750	120 / 870	115 / 985	1035
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP													30				30
TOTALS									1300									1065

POST-OP DAY DOS

VITAL SIGNS	21	22	23	00	01	02	03	04
	138/86	139/71	133/74	112/69	106/68	121/64	124/71	135/73
	111/63	110/56	108/51	112/60	112/59	122/59	119/61	116/62
		100[2]	100[4]				99[8]	
	84	76	70	80	66	88	78	65
	20	16	10	31	33	29	19	24
	100	100	99	97	97	97	96	94
	TC	TC	TC	TC	TC	TC	TC	TC
	35	35	35	35	35	35	31	31
	92	86	89	82	79	81	91	90

INTAKE	21	22	23	00	01	02	03	04	8°T
	125	125	125	125	125	125	125	125	1000
	5	5	5	5	5	5	5	5	40
				100					100
									1140
	130/130	130/260	130/390	230/620	130/750	130/880	130/1010	130/1140	

OUTPUT	21	22	23	00	01	02	03	04	
	100/100	110/210	120/330	100/430	100/530	110/640	110/750	100/850	850
JP suction	30							10	40
								100	100

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
	TIME	0327								
	MODE	TC								
	F_iO_2	31								
	TV									
	RATE									
	PEEP									
ARTERIAL BLOOD GASES	A pH	7.464								
	A PCO_2	42.2								
	A pO_2	62								
	B HCO_3	30								
	B SAT	92								
	G BASE	7								

LABORATORY DATA										
	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET	9.6/161								
	Hct/Hgb	22.3/7								

DAILY ACTIVITIES DONE	TIME				TURN	TIME				
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE	2200			SUCTION	1800	2100	2200	0100	0300
	TRACH CARE	2200				ORAL Blood tinged	ORAL Blood tinged	ORAL Blood tinged	ORAL Blood tinged	ORAL Blood tinged
	ROM EXERCISES									

bb-2

24-HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	880	Urine:	1300
po	1040		1065
	1140		890
TOTAL	3060	TOTAL	3255

NURSE'S SIGNATURE [redacted] INITIALS [redacted]

[redacted] 12T/N [redacted]

bb-2

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0515	INITIALS [redacted]	b6-2	INITIALS		INITIALS
NEURO	PUPILS	2mm, PERRLA				3mm PERRL	
	SENSORIUM	Alert, able to follow commands & express needs				A+O, pt intubated able to communicate via hand signals able to follow commands	
RESPIRATORY	RESPIRATORY PATTERN	Regular to Tachy RR (teens-20s)				LR+Rhythm, CTA Bilat dim. Bases. clear drainage from mouth, sanguinous from nose	
	BREATH SOUNDS	clear throughout to diminished bilat & bases. Clear drainage from mouth sanguinous drainage from bilat nares					
	SECRETIONS						
SKIN	COLOR	WNL for race.				Normal for Race.	
	INTEGRITY	(R) thigh wound drsg D+I, stitches along jaw well approximated				(R) thigh dressing CDI. stitches to jaw approximated	
IV SITE	LOCATION	(L) SC single lumen cath, (R) radial A-line c̄ Ø S/S of infection, (R) FA 16 gauge dislodged				(L) Radial A line 16 g to (R) FA H/L Both c̄ Ø S/S of infection (R) flush & draw blood.	
	CONDITION						
GASTRO	ABDOMEN	soft, nontender				Soft nontender (P)	
	BOWEL SOUNDS	BS(+) x 4 quads, hyperactive BS.				BS x 4 quads hyperactive	
GU	URINE: COLOR/CLARITY	foley to gravity draining clear yellow urine				Foley to gravity draining amber urine	
CARDIOVASCULAR	CARDIAC RHYTHM	SR c̄ Ø ectopy, edema +2 on bilat T and ↓ ext, pulses palpable on all ext.				S1 S2, Ø ectopy. (P) pulses to L & U Extremities, +2 Edema to BLE	

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 12JUL03

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

O [redacted] b6-4

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

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

WAMC OP 375 (Redesignated) 1 Apr 90 (HSXC-NU)

DATE 12JUL | DX | HOSPITAL DAY

VITAL SIGNS																		
TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line		138/74	136/80															
BP Cuff	113/51	120/63	119/61	114/61	119/62	120/67	119/62	121/68		125/71	123/69	129/70	128/64	119/63	125/62	121/67	118/46	
Temperature	100.8	100.4	100.2	100.5		100.1	100.4	100.2		100.3	100.4	100.7	100.1	100.4	100.4	100	100.1	
Pulse	77	96	79	80	86	86	75	83		80	81	78	86	91	63	73	75	
Respiratory Rate	21	11	36	32	32	36	30	30		30	21	35	18	29	27	29	28	
SaO2	93	94	87	90	87	90	100	100		100	98	100	95	98	99	99	97	
O2 Source	TC	TC	TC	TC	TC	TC	TC	TC		TC	TC	TC	TC	TC	TC	TC	TC	
FiO2	31%	31%	31%	31%	31%	31%	31%	31%		31%	31%	31%	31%	31%	31	31	31	
MAP	80	85	82	82	82	86	82	86		91	88	91	93	83	84	86	86	
							Started 1 PRBC @ 1128			Started 2nd unit PRBC @ 1302								
pain																		
sedation																		

INTAKE																		
TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
IVF	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1000
Fentanyl	5	5	5	5	5	5	5	5	41	10	10	10	10	10	10	10	10	80
IVPB				100				100	200	200								200
Blood							350		350	~~200~~	350	900 NS						1250
									1591									2530
TOTALS																		

OUTPUT																			
URINE	HOUR / TOTAL	110 / 110	195 / 305	165 / 470	175 / 645	167 / 812	168 / 980	175 / 1155	145 / 1300	1200	175 / 1375	145 / 1520	165 / 1685	235 / 1920	145 / 1965	145 / 2110	220 / 2330	125 / 2455	2455
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	JP												20						
TOTALS																			

POST-OP DAY 1 closure (R) Leg Wound

VITAL SIGNS	21	22	23	00	01	02	03	04	
	147/74						145/70		
	119/66	128/72	118/74	119/67	119/67	118/63	113/72	123/72	
	100.4	100	100.5	100	100.9	101	101.7	101°	
	65	85	65	66	66	65	68	65	
	28	29	30	31	31	15	27	23	
	97	95	94	93	93	90	89	93	
	TC	TC	RA	RA	RA	RA	RA	RA	
	31	31	RA	RA	RA	RA	RA	31	
	86	94	94	93					

INTAKE	21	22	23	00	01	02	03	04	8° T
	125	125	125	Hep Lock	125	125	125	125	875
	10	10	10	10*	7.5	7.5	7.5	7.5	67.5
				250					250

OUTPUT	21	22	23	00	01	02	03	04	
	130/25	120/2695	125/2820	100/2920	125/3045	95/3140	200/3340	90/3430	3430
	2575								
								10	10

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	0500								
	MODE									
	F_IO_2	31%								
	TV									
	RATE									
	PEEP									
ABG	pH									
	PCO_2									
	pO_2									
	HCO_3									
	SAT									
	BASE									

LABORATORY DATA	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES DAILY LIVING	TIME			
	MOUTH CARE			
	BATH			
	SKIN CARE			
	FOLEY CARE			
	TRACH CARE			
	ROM EXERCISES			

TURN	TIME					
SUCTION						

24 hr I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV	1875	Urine	3430
IVP	450		10
Feni	147		
TOTAL	2475	TOTAL	3440
BALANCE	965		

NURSE'S SIGNATURE	INITIALS
[redacted] 14/SKI	[redacted]
b6-2	

*new bag 1000mg/1000ml

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) OA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0647	INITIALS [redacted]	b6-2	INITIALS		INITIALS
NEURO	PUPILS	PERRLA				PERRL 3mm	
	SENSORIUM	A+O x 3, Follows commands				A+O x3, pt treached able to communicate via hand signs, follows commands	
RESPIRATORY	RESPIRATORY PATTERN	Regular + Unlabored				RR unlabored.	
	BREATH SOUNDS	CTA ē Diminished Bases				CTA to BUL, diminished bases.	
	SECRETIONS	Thin White Oral Secretions				Thin white oral secretions, thick sanguinous nasal secretions	
SKIN	COLOR	Normal for Race					
	INTEGRITY	Incisions on (R) lower mandible, Dressing to RLE				NPK Incision to (R) lower Jaw. Dressing to RLE c/d/I	
IV SITE	LOCATION	18G (L) EA				18G to (L) EA	
	CONDITION	Ø S/S of infection (R) Radial A-line Ø S/S of infection				(R) Radial A-line Ø S/S to both sites	
GASTRO	ABDOMEN	Soft, Nontender				Soft nontender non distended, BS(+) X4 Quad hypoactive	
	BOWEL SOUNDS	Hypoactive, ØN/V					
GU	URINE:	Foley to Gravity				Foley to gravity	
	COLOR/CLARITY	Dark Yellow				Dark yellow quantity sufficient	
CARDIOVASCULAR	CARDIAC RHYTHM	NSR ē ectopy CV=S1,S2 Cap refill <3 secs, Generalized Edema				NSR, cap refill <3 sec generalized edema	

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

b6-2

(Continue on reverse)

PREPARED BY [redacted] CPT/AN

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 13 Jul 03

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

[redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 13 Jul 83 | DI | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line	138/72	133/71	140/70	129/71	144/72	138/51	135/69	132/67		130/74	120/45	130/72	134/74	149/74	100/98	92/94	105/79	
BP Cuff					122/67													
Temperature		100.5				99.6					98.4						100.5	
Pulse	63	65	64	57	62	71	65	64		67	68	67	83	69	71	97	70	
Respiratory Rate	21	25	24	21	19	25	21	20		19	18	19	26	18	14	23	19	
MAP	90	93	89	83	91	95	90	90		94	91	93	97	94	98	95	100	
SaO2	94	96	97	100	100	100	99	99		100	100	95	90%	96%	98%	97	97	
O2	31%	31%	31%	31%	31%	31%	31%	31%		31%	31%	31%	RA	31%	31%	31%	31	
Mode	TC	TC	TC	TC	TC	TC	TC	TC		TC	TC	TC		TC	TC	TC	TC	
pain																		
intervention																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
LR	125	125	125	75	75	75	75	75	750	75	75	75	75	75	75	75		
Fentanyl	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	60	7.5	7.5	7.5	7.5	7.5	7.5	7.5		
IVPB		50						50	100	250					50			
TOTALS									910									

OUTPUT

		TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
URINE		HOUR / TOTAL	60	60	60	40	140	110	120	80	1970	60	60	90	90	58	180	165		
		sp gr																		
		S/A																		
NG		OUTPUT																		
		pH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS		JP		Ø																
TOTALS																				

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04
	84/84	104/99	89/83	89/89	146/85	96/71	158/78	96/88
							99.2	99.4
	71	80	69	78	65	67	105	67
	85	100	85	85	95	85	97	91
	23	25	20	33	11	21	28	22
	97	96	97	97	96	96	92	97
	31	31	31	28	28	28	31	31
	TC	TC	TC	TC	TC	TC	TC	TC

INTAKE	21	22	23	00	01	02	03	04	8° T
	75	75	75	75	75	75	75	75	
	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	
			100	50					

OUTPUT								
	180/	100/	125/	125/	100/	95/	125/	125/

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME	0503
	MODE	
	F_IO_2	
	TV	
	RATE	
	PEEP	
ABG	pH	7.477
	PCO_2	34.8
	pO_2	63
	HCO_3	26
	SAT	93
	BASE	2

LABORATORY	TIME	0345
	GLUCOSE	
	Na/K	
	Cl/CO_2	
	BUN/Cr	
	WBC/PLATELET	12.8/194
	Hct/Hgb	28.9/9.1

ACTIVITIES DAILY	TIME			
	MOUTH CARE			
	BATH			
	SKIN CARE			
	FOLEY CARE			
	TRACH CARE			
	ROM EXERCISES			

TURN	TIME
SUCTION	

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS
[illegible]	

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

b6-2

OTSG APPROVED (Date) DA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0600	INITIALS [redacted]	1800	INITIALS [redacted]		INITIALS
NEURO	PUPILS		UTOX3		4+0X3 gestures needs			
	SENSORIUM		agreeive needs ↑ gestures		responds to verbal + pain stimuli			
RESPIRATORY	RESPIRATORY PATTERN		TC on 31%		Trach on RA SaO2 96%			
	BREATH SOUNDS		94% O2 Sats		CTA			
	SECRETIONS		prod cough, scant amt, thick green unlabored, even regular OTA Bil		productive cough suction ↑ yawker by self + deep suction ↑ yellow brown mucous			
SKIN	COLOR		normal for race		WFR			
	INTEGRITY		dressing on wounds		CDI to (R) thigh			
IV SITE	LOCATION		(L) sc cordis		(R) subclavian Cordis.			
	CONDITION		(R) AC PIV (R) rad line Ø S/S of infection		↑ LR @ 75cc/hr Ø erythema, swelling or heat			
GASTRO	ABDOMEN		flat NT, ND		soft flat nontender			
	BOWEL SOUNDS		BS X 4 quads		hypoactive sounds x4 quads			
GU	URINE: COLOR/CLARITY		dark amber, adequate amt,		foley to gravity ↑ dark amber yellow urine			
CARDIOVASCULAR	CARDIAC RHYTHM		S1 S2 NSR Ø ectopy		S1S2 Ø extra sounds			
			(D) upper + lower ext edema		↑ R pulses radial + pedal <3 secs cap refill			

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SA1 - Saturation; TRACH - Tracheostomy

b6-2

PREPARED [redacted] (Name & Title) WJ

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 14 Jul 03

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

[redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 1 MAY 78 4700

Proponent: Dept of Nurs

WAMC OP 375 (Redesignated) 1 Apr 90 (HSXC-NU)

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line		116	115		116	117	121/66											
BP Cuff		75	59		69	69		120/60		114/65	102/60	119/65	119/62	124/63	124/63	120/62		
Temperature		99.2				99.6												
Pulse		74	64	72	65	68	71	72		80	123	69	66	75	75	69		
Respiratory Rate		22				20	24	22		16	27	27	21	21	21	20		
O2 Sat		98			99	98	94	94		97	96	97	95	95	95	95		
O2 Source		31%			31	31	RA	RA		RA	RA	RA	RA	RA	RA	RA		
pain intervention																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
UK	75	75	75	75	75	75		75	525	75	75	75	75	75	75	75	75	600
Fent	7.5	7.5	7.5	7.5	7.5	7.5		7.5	52.5	7.5	7.5							15
IVBD										50	200				50			300
TOTALS																		

OUTPUT

URINE	HOUR	50	50	60	60	80	60	80	100		100	100	100	160	200	100	150	80	
	TOTAL	50	100	160	220	280	340	420	520	520	100	200	300	460	660	760	910	990	990
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04	
		120/70				121/70			
		98°				99°			
		76				67			
		21				20			
		97				97			
		RA				RA			

INTAKE	21	22	23	00	01	02	03	04	8° T
	75	75	75	75	75	75	75	75	600
			8	8	8	8	8	8	48
				200	50				250

OUTPUT	21	22	23	00	01	02	03	04	
	50/140	70/110	60/170	50/220	100/320	200/520	70/590	100/690	1690

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	A: pH									
	A: PCO_2									
	A: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

LABORATORY	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES DAILY LIVING	TIME				TURN	TIME			
	MOUTH CARE								
	BATH								
	SKIN CARE								
	FOLEY CARE				SUCTION				
	TRACH CARE								
	ROM EXERCISES								

24 HR I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE	OUTPUT
IV	1813	Urine: 1690
po		
TOTAL	1813	TOTAL 1690

BALANCE +123

SIGNATURE	INITIALS
[redacted] IV	[redacted]
66-2	

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) DA Appr 8 Mar 89

b6-2

INITIAL SHIFT ASSESSMENT

	TIME	0510	INITIALS [redacted]	b6-2	INITIALS	1700	INITIALS [redacted]
NEURO	PUPILS	2mm, PERRLA				2mm PERRL	
	SENSORIUM	Alert, able to follow simple commands and express needs				A&O x3, pt trached able to communicate via hand signs, able to follow simple comm	
RESPIRATORY	RESPIRATORY PATTERN	Equal chest rise, RRR				CTA Bilat, symmetrical chest rise, Pt on RA	
	BREATH SOUNDS	Clear throughout				O2 SATS @ 96%	
	SECRETIONS	Ø noted @ this time					
		TC on RA. O2 sats 94-96%.					
SKIN	COLOR	WNL for RACE				NER, Drsg to (R) leg CDI	
	INTEGRITY	Drsg to (R) leg CDI					
I.V. SITE	LOCATION	(R) SC cortis ± (+)				(+) subclavian cath	
	CONDITION	S/S of infection LR @75cc/h and Fortaz gtt @ 8cc/h (80mg/h) infusing				(-) S/S of infection LR @75cc/hr EU to (L) FA (+) flush.	
GASTRO	ABDOMEN	soft, nontender				Soft, nontender non distended	
	BOWEL SOUNDS	hyperactive x 4 quadrants				BS (+) x4 quad, hyperactive	
GU	URINE:	Foley to gravity				Voiding spontaneously via urinal, clear yellow urine	
	COLOR/CLARITY	draining dark yellow urine					
CARDIOVASCULAR	CARDIAC RHYTHM	SR ± Ectopy, HR 60s, Pitting edema +2 bilat ↓ ext. Pulses palpable throughout				S1, S2, HR, +2 pulses Bilat to Ut & L Extremities <3 sec cap refill	

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 15 July 03

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

[redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20	
BP Arterial Line																		
BP Cuff	130/70				116/65	118/65	114/57	119/67		112/52	127/70	125/67	124/66	137/75	124/66			
Temperature	100.3	99.4		98.8	98.8			100.1			99.8	99.7		99.5				
Pulse	67	65	65	63	74	65	70	80		68	68	72	71	73	66			
Respiratory Rate	19	31	30	29	28	29	25	32		32	31	13	19	11	27			
SaO2	97	95	95	92	91	88	92	92		93	97	97	96	97	98			
Source	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA			
open intubation																		

INTAKE

TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20	8°T
LR	75	75	75	75	75	75	75	75	600	75	75	75	75	75	75	75		
Fentanyl	8	7	8	8	7				38						50			
IVPB		50						250	300		50							
TOTALS																		

OUTPUT

		HOUR / TOTAL																	
URINE			90/90	145/235	205/440	162/602	163/765	185/950	152/1102	153/1255	1105	272/1377	273/1650	395/2045	435/2480	210/2690	350	325	
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04	
		120/68				136/72			
		98.6				99.2			
		72				78			
		18				22			
		98				98			
		RA				RA			

INTAKE	21	22	23	00	01	02	03	04	8° T

OUTPUT	21	22	23	00	01	02	03	04	
	200		300						

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
	A: pH									
	A: PCO_2									
	B: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

LABORATORY DATA	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES DAILY LIVING	TIME				TURN	TIME				
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE				SUCTION					
	TRACH CARE									
	ROM EXERCISES									

24 I&O TOTALS	NURSE'S SIGNATURE	INITIALS
wt Yesterday _____ wt Today _____		
INTAKE: IV _____ po _____ _____ TOTAL _____	OUTPUT: Urine: _____ _____ _____ TOTAL _____	
BALANCE _____		

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

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

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0630	INITIALS [redacted]	1730	INITIALS [redacted]		INITIALS
PUPILS		PERRL	b6-2			b6-2	
SENSORIUM		Pt Alert + Responsive to touch + voice stimuli		Awake, Alert, Oriented Cooperative, Requires ↑ prodding for self care MAE ē purposeful —			
RESPIRATORY PATTERN		Reg R+R		RA Resp. 17-18 ē			
BREATH SOUNDS		CTA bilat		SATS M100%, Occ			
SECRETIONS		Pt ē trach, Od sats @ 98% on RA Equal rise + fall, ØNtd difficulty		Cough ē Lg Amts thick, yellow tenacious sputum Bibasilar rhonchi Rhonchi ↑ (R) side. Rhonch. ↑ + ↓ lobes			
COLOR		NFR		Membranes pink			
INTEGRITY		dressings intact		LUE + (R) FA/Hand drsg CDI. Bulky drsg ū Kerlix/Ace			
LOCATION		(L) SC cordis - LR @ 75		PIV 18g (L) Antecubital			
CONDITION		(L) FA - Flushes well		FA ē LR 75° Vin Dial-A-Flow. Site ē Sign/Sx infiltration —			
ABDOMEN		Soft + Round Non tender		Soft, Flat, Nontender			
BOWEL SOUNDS		Non distended. BS + X4 Quads		(↑) BS in (4) Quads. Retain PO intake. NO Bm ∂ Present —			
URINE: COLOR/CLARITY		Clr Yellow to urinal @ bedside		Voids spontaneously PRN to urinal ē U.O. > 50ml Clear yellow			
CARDIAC RHYTHM		S1, S2 Present. ØNtd ectopy. +4 radial pulses + + 3 Pedal ē brisk cap Refill.		S1 S2 — HR 70-80's ē notes ectopy. NO NOTED distress Cap Refill < 3 seconds PPP ē (+) 3 density			

LEGEND: Cr - Creatinine; F_IO_2 - Fraction of inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

PREPARED BY (Signature & Title) [redacted] b6-2 9/WM6

(Continue on reverse)

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 17 Jul 03

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

[redacted] b6-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

DATE 17 Jul 03 DX

HOSPITAL DAY

VITAL SIGNS																			
TIME	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22
BP Arterial Line																		
BP Cuff		111/60		108/65				110/70				117/63					113/64	
Temperature		98.6		98.6				98.5				98.4	99.6		~~99.6~~		99.8	
Pulse		61		64				61				66					74	
Respiratory Rate		14		15				14				15					16	
SAO2		98%		96%				95%				98%					97	
Method		RA		RA				RA				RA					RA	
pain																		
sedation																		

INTAKE																			
TIME																			
IVF	75	75	75	75	75	75	75	75	~~75~~	75	75	75	75	75	75	75	75	~~75~~
IVPB		50						250	50					50				
PO														300				
TOTALS												1250						

OUTPUT																			
URINE	HOUR		550					625	250					450		650		350
	TOTAL							1175	1525									
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

LR 1800
IVPB 450
2250

PO 300

2550

URINE
3425

Balance
875

POST-OP DAY

VITAL SIGNS	23	24	01	02	03	04			
			114/62						
			99						
			61						
			28						
			97						
			RA						
INTAKE	75	75	75	75	75	75	75	75	
		50							
OUTPUT	350	200							

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
	A: pH									
	A: PCO_2									
	A: pO_2									
	B: HCO_3									
	B: SAT									
	G: BASE									

LABORATORY DATA	TIME									
	GLUCOSE									
	Na/K									
	Cl/CO_2									
	BUN/Cr									
	WBC/PLATELET									
	Hct/Hgb									

ACTIVITIES OF DAILY LIVING	TIME									
	MOUTH CARE	2000								
	BATH									
	SKIN CARE									
	FOLEY CARE									
	TRACH CARE	2000								
	ROM EXERCISES									

TURN	TIME									
	SOH									
SUCTION	1800									

24 I&O TOTALS	NURSE'S SIGNATURE	INITIALS
wt Yesterday _____ wt Today _____	[redacted]	[redacted]
INTAKE: IV _____ po _____ _____ TOTAL _____	OUTPUT: Urine: _____ _____ _____ TOTAL _____	
BALANCE _____		

1. REPORTING MTF						2. LOCATION (State or Country Code.)	
1	2	3	4	5	6		
A	1	1	D	1		I	Z

ADMISSION A[illegible] CODING INFORMATION

For use of this form, se[illegible] 40-400; the proponent agency is OTSG

3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
9 10 11 12 13 14 15 [redacted]	EPW # [redacted] b6-4	16 17: EPW	18: M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
19 20 21 22 23 24 25 26: Z Z Z Z Z Z Z Z	27 28 29: 2 0 Y	30: X	31: 9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
32 33 34: —	—	35 36: 9 9	37 38 39 40 41 42 43 44 45: 0 0 0 0 0 0 [redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
—	46: Z	1422	— b6-4

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
62 63: —	64 65 66 67 68 69 70: —	71: 1	YEAR: [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
72: Ø	ICU3	UNK
		ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code): UNK
NAME AND LOCATION OF MEDICAL TREATMENT FACILITY: 28th CSH South		TELEPHONE NUMBER OF EMERGENCY ADDRESSEE: UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
73 74: 5 Ø	75 76 77 78 79 80:	81 82 83 84 85 86: Ø 3 Ø 7 1 8

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
87 88 89 90: A B F A	91 92 93 94 95 96:	97 98 99 100 101 102: Ø 3 Ø 7 Ø 8

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

FOR LOCAL USE

GSW (R) mandible, GSW (R) thigh

Inj Trauma

[redacted] b6-4

Dx: 82344
8900
89100
E9912

Pr: 0609 9355
2630 9622
8345 9904(3)
3129
8659

AD[redacted] b6-2 [redacted] G CLERK

EVACUATION PATIENT RECORD

EPW # [redacted] b6-4

NAME (Last, First, Middle Initial)	2. SSN	3a. STATUS	3b. SERVICE	4. PRECEDENCE	5. GRADE
	[redacted] b6-4	EPW		(U) P R	

6. AGE	7. SEX	8. WEIGHT	9. BLOOD TYPE	10. CLASSIFICATION 91A-5F)	11. ACCEPTING PHYSICIAN	12. CITE/AUTHORITY NO.
30	Male X Female	175		AMBULATORY X LITTER		

13. APPT/SURG DATE	14a. ORIGINATING FACILITY	15a. DESTINATION FACILITY	16. NUMBER OF ATTENDANTS
7/7	28CSH Tikrit	28CSH Dagger	16a. MEDICAL: 2 / 16b. NON MED
	14b. ORIGINATING FACILITY PHONE NUMBER	15b. DESTINATION FACILITY PHONE NUMBER	

17. DIAGNOSIS

(1) GSW Face

2 GSW (2) LE x

18. X BATTLE CASUALTY | DISEASE | NON-BATTLE INJURY

19. CLINICAL ISSUES (Please indicate Yes or No on clinical issues Explain YES comments in Section 23)

	YES	NO	ISSUE		YES	NO	ISSUE		YES	NO	ISSUE
a.		X	HYPERTENSION	f.		X	MOTION SICKNESS	k.		X	AMBULATORY
b.		X	CARDIAC HX	g.		X	VISION IMPAIRED	l.		X	AMBULATORY AID
c.		X	DIABETES	h.		X	VOIDING PROBLEMS	m.		X	SELF-MEDS
d.		X	RESPIRATORY	i.		X	BOWEL PROBLEMS	n.	X		ADEQUATE SUPPLY OF MEDS
e.		X	EARS/SINUS	j.		X	SELF-CARE	o.			OTHERS

20. PHYSICIANS ORDERS

20a. DATE	20b. TIME	20c. ALLERGIES
7/7	10A	Unk

20d. DIET NPO REG | 3GM NA | CARDIAC | DIABETIC ___ CALS

RENAL ___ Gm prot ___ Gm Na ___ Meq K ___ mg PO4

TUBE ___ TYPE ___ cc/hr 1/2, 3/4, FULL STRENGHT

PEDIATRIC: AGE ___ OTHER (Specify) ___

TPN: Change to D10 at ___ cc/hr for ax of ___ days

TUBE FEEDING ___ at ___ strength at ___ cc/hr

20e. IV/BLOOD

20f. SPECIAL EQUIPMENT

	SUCTION	TRACTION	ORTHOPEDIC BRACES
	NG TUBE	IV PUMP	CHEST TUBE/HEIMLICH
	STRYKER FRAME	TRACH	RESTRAINTS
X	INCUBATOR	MONITOR	IV TYPE
		FOLEY	OTHER (Explain in 23)
		LITTERS	ROUTE:

O_2

VENTILATOR SETTINGS SIMV 40% Rate of 10

ALTITUDE RESTRICTION:

20h. RECORDS TO ACCOMPANY PATIENT

	OUTPATIENT REOCRDS	X-RAYS	FINANCIAL
	INPATIENT RECORDS	OB-RECORDS	OTHER (Specify)
	NARRATIVE SUMMARY	DENTAL RECORDS	

20i. MEDICATIONS/TREATMENTS

(1) URC @ 150 ml/hr
(2) Propofol titrate sedation
(3) Zantac 50 IVP q8
(4) Ampicillin 1g IV q6°
(5) Clindamycin 600mg IV q8

21. PRE-FLIGHT VITALS

21a. DATE/TIME	21b. TEMP	21c. PULSE	21d. RESP	21e. BP
8 Jul 03	99.3	95	16	117/57

22. BRIEF NARRATIVE

GSW Face - seen at 240 FST wound in face explored / packed, wound leg disinfected / packed. Pt 28CSH Tikrit taken to OR emergently for massive complicated bleeding. Tongue approximated & 2-0 chromic, wound packed. Pt received 4u PRBC, 2u FFP. Met in Rm 39% stable.

23. ASSESSMENT/PROGRESS

DATE/TIME	NOTES
Pt	requires

24. STAMP AND SIGNATURE OF ATTENDING PHYSICIAN

[redacted] b6-2

25. STAMP AND SIGNATURE OF FLIGHT SURGEON

AF FORM 3899, MAR 95

MEDCOM - 13994

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) EPW [redacted] b6-4			3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE 24y	6. RACE Z	7. RELIGION unk	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION NO	
11. FMP 99		12. SSN [redacted]		13. ORGANIZATION N/A		14. WARD ICW2	
15. FLYING STATUS N/A	16. RATING/ DSG	17. DEPT./ BEN K79		18. BRANCH/CORPS N/A	19. UIC/ZIP	20. TYPE CASE NBI	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION	23. CLINIC SERVICE AGNA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —			25. TYPE DISPOSITION 50		26. DATE OF DISPOSITION 9 Jul 03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —			27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 8 Jul 03		ADMITTING OFFICER Dr. [redacted] b6-2
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] b2-2					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

hip/femur contusion

719.45
E968.2

04.81

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
Ø	Ø	Ø	Ø	2	2

36. Total Days All Facilites

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

b6-2

SIGNATURE OF ATTENDING MEDICAL OFFICER [redacted] Dr. [redacted]

SIGNATURE OF PAD-OB MEDICAL RECORDS OFFICER For [redacted]

DA FORM 3647, MAY 79

MEDCOM - 13995

USAFPC V1.10

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
	WBC			SUP O2	PH	PO2	RESULTS	
	H/H			PCO2	SAT	OTHER		
	PLT							
PT				U/A	DIP		EKG INTERPRETATION	
APTT	BHCG	ETOH	GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

24 yo ♂ c/o (R) hip/femur pain s/p "being beat w a stick" 7 d ago
c/o unable to walk 2° pain & numbness/tingling.

O: A&O x-1 — no distress. VSS
Thorax: ↓ lung clear/ABT, no ⊕
Back: NT
Head: old well healed lac. ∅ steps
Chest CTA(⊕)
CVS: NVE, ⊕ w/ NT
Abd: soft, NT
Ext: ↓ pain (R) hip
⊕ pain/tightness/spasm of (R) hamstring

Procedure
Indication: femur pain, hip pain
Femur N. block
entered entry x 1 ∅ injection of MSO4, redirected, ⊕ N. stim, injected 30cc Marcaine
used 150 Marcaine

A/P ⊕ No fractures, ⊕ spasms of hamstring, ⊕ pain over hip/femur

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STU[redacted]D STAMP
b6-2

PROVIDER SIGNA[redacted]

DIAGNOSIS
hip/femur contusion

CODES

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

[redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

b6-2

SP4 [redacted] LT [redacted] Dr. [redacted] /540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREATMENT FACILITY EMT
		RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION			ARRIVAL	
STREET ADDRESS			DATE *(Day, Month, Year)* 03 JULY 03	TIME 1954
CITY	STATE	ZIP CODE	TRANSPORTATION TO FACILITY	

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

CURRENT MEDICATIONS	INJURY OR OCCUPATIONAL ILLNESS				EMERGENCY ROOM VISIT	
Ø	ITEM	YES	NO	WHEN *(Date)*	DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
	IS THIS AN INJURY?			WHERE	TETANUS	
ALLERGIES	INJURY/SAFETY FORMS				DATE LAST SHOT	COMPLETED INTITIAL SERIES ☐ YES ☐ NO
NKDA	HOW					

CHIEF COMPLAINT (R) LEG PAIN TOB: 2 PKS/DAY ETH:

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME 1950	TIME 1950					
☒ URGENT		BP 146/79					
	INITIALS [redacted] b6-2	PULSE 87					
		RESP 16					
☐ NON-URGENT		TEMP 98.1					
		WT 55KG					

LAB ORDERS						X-RAY ORDERS			
	CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT			CXR PA & LAT/PORTABLE		C-SPINE
	URINE C&S	UA MSCC/CATH		CHEM:			ACUTE ABDOMEN		LS SPINE
	BLOOD C&S X						SINUS		HEAD CT
							ANKLE R/L	X	(R) Femur/Pelvis/(R) Hip

ORDERS

☒ PULSE OX 97% ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION	DISPOSITION QUARTERS /OFF DUTY	PATIENT/DISCHARGE INSTRUCTIONS
☐ HOME ☐ FULL DUTY	☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.	
MODIFIED DUTY UNTIL	RETURN TO DUTY	

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED ▶	TO	WHEN
☐ IMPROVED ☐ UNCHANGED		I have received and understand these instructions.		
☐ DETERIORATED	TIME OF RELEASE	PATIENT'S SIGNATURE		

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

EPW [redacted] b6-4

[redacted]

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

ATIENT IDENTIFICATION

O[redacted] b6-4

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 8 Jan 03 TIME OF ORDER 2100 HOURS

LIST TI ORDE NOTED SIGN

(1) Admit ICW 2
(2) Dx hip/thigh contusion
(3) Stable
(4) NKDA
(5) Vitals qr pt tolerant
(6) Regular diet
(7) IVFs bolus TLNS flow
(8) Meds 2 percocets in am
Motrin 800 mg in am
(9) Plan:
D/C to EPW Camp in a[redacted]
See D/C Summary
Thanks! [redacted] 0700

Noted/faxed [redacted] MTAM

b6-2

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

24 VS 2330 8 Jan 03 [redacted]

DATE OF ORDER TIME [redacted] HOURS

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

ATIENT IDENTIFICATION

URSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER HOURS

ADMISSION AND CODING INFORMATION

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

1. REPORTING MTF	2. MTF LOCATION (State or Country Code.)	3. REGISTER NUMBER	NAME (Last, First, Middle Initial)	4. PAY GRADE	5. SEX
A 1 1 D 1	I Z	[redacted]	C11375 EPW [redacted] b6-4		m

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	24 y	Z	9	unk

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	N/A	99	000 00 [redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
N/A	U		N/A b6-4

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 9	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
			YEAR [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	ICW2	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)
28th CSH South	

TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
50		030709

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
AGAA		030708

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)

FOR LOCAL USE

Dx: hip / femur contusion

Dx92401
Proc0531
Trauma 9
Inj 989 [redacted] b6-2

ADMITTING OFFICER (Signature, [redacted] b6-2

Dr. [redacted] b6-2

SIGNATURE OF ADMITTING CLERK [redacted], PFC, 91GA

DA FORM 2098, MAR [redacted]

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

PHYSICAL EXAMINATION

See 558
GR

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

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

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

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

AUTHORIZED FOR LOCAL RE

EDICAL RECORD | PROGRESS NOTES

DATE	NOTES
2300 8 July 03	Pt transferred from emt c̄ dx hip/femur contusions. VSS, pt seems alert but not ~~oriented~~ completely orientated. Lung sounds CTA, pulses palpable x4, bs⊕x4. Pt able to walk, c/o pain in RLE. IV @ LAC Bolus, running well. Pt c̄ d/c orders in AM, continue to monitor. [redacted] 9WM4 b6-2
9 July 03 0600	Assumed pt. care @ 0500; Pt. resting. Awake easily by verbal command. A to x 3. Lungs CTA. ⊕ pulse x4. ⊕ BS x4. Pt. has bruises & scars over chest and abd. area. ∅ complaints @ this time. [redacted] 9WM4 b6-2
0500 98.7 78 16 110/76 98%	
9 July 03 1410	Assumed pt care @ 1300. pt resting quietly. VSS. lungs CTA, abd soft nontender BS⊕x4 quads. Crutches @ bs. will cont to monitor - [redacted] 9WM6
9 July 03 2020	pt being d/c'd to EPW camp in stable condition. [redacted] 9WM6 SGT b6-2

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

PROGRESS NOTES
Medical Record
STANDARD FORM 509

b6-4

EPW # [redacted]

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

JULY 19 2003 HOUR

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIG[redacted]

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted] b6-4

VITAL SIGNS RECORDS

Medical Record

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

CLINICAL RECORD

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

Mo. ____ *Yr.* 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 8	9	10	11	12
7/8	[redacted]	Vitals per protocol	3	/	[redacted]			
			13	/	[redacted]			
		b6-2	21	[redacted]				b6-2
7/8	[redacted]	Reg Diet.	7	/	[redacted]			
			11	/	[redacted]			
			17	/	[redacted]			

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: hip / femur contusions

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

PATIENT IDENTIFICATION:

EPW # [redacted] b6-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo _____ Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
7/8	[redacted]	Admit to ICW #2	7/8	2200	RONF	[redacted]	
	-----	b6-2 stable				b6-2	
7/8	[redacted]	D/C to EPW camp in AM,	7/8	AM.			
	-----	See D/C summary					

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

USAPA V1.00

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

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED														
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	
	- - - - - -																	

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: hip / femur contusions.

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

PATIENT IDENTIFICATION:

EPW# [redacted] b6-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo._____ Yr. _____
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
7/8	[redacted]	NS ½L Bolus	7/8	2200	2200	[redacted]
7/8	[redacted]	½ Percocetin AM & 800mg	7/9	0600		[redacted]
	-----	Motrin in a.m.				b6-2
	-----	b6-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															
-----	-----															

USAPA V1.00

M171[illegible]9

2nd PRIORITY **MODERATE** M171809

M171809

DECEASED M1718[illegible]

Mass Casualty Incident Tag
©Eastern PA EMS Council - 1997

(A) (P)

TIME	1805
AGE	24 SEX M
LUNGS	
PULSE	
RESP.	
B.P.	
A V	[illegible] I

Patient Name (if known) C1375

Notes/Treatment TRAUMA/ Inj Ant. (R) thigh ↓ROM extreme pain ∑ movement (R) femur/hip X-Ray

b6-4

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM [redacted] | RANK / GRADE | MALE / HOMME | FEMALE / FEMME
SSN / NOM [redacted] | SPECIALTY CODE / GPM | RELIGION / RELIGION

2. UNIT / UNITÉ

FORCE / ÉLÉMENT: A/T | AF/A | N/M | MC/M
NATIONALITY / NATIONALITÉ

BC / BC | NBI / BNC | DISEASE / MALADIE | PSYCH / PSYCH

3. INJURY / BLESSURE

FRONT / DEVANT BACK / ARRIÈRE

AIRWAY / TRACHÉE
HEAD / TÊTE
WOUND / BLESSURE
NECK/BACK INJURY / BLESSURE AU COU/AU DOS
BURN / BRÛLURE
AMPUTATION / AMPUTATION
STRESS / TENSION
OTHER (Specify) / AUTRE (Spécifier)

fx (R) hip ~~thigh~~

4. LEVEL OF CONSCIOUSNESS / NIVEAU DE CONSCIENCE
ALERT / ALERTE | PAIN RESPONSE / RÉPONSE À LA DOULEUR
VERBAL RESPONSE / RÉPONSE VERBALE | UNRESPONSIVE / SANS RÉPONSE

5. PULSE / POULS | TIME / HEURE | 6. TOURNIQUET / GARROT NO / NON YES / OUI | TIME / HEURE

7. MORPHINE / MORPHINE NO / NON [X] YES / OUI | DOSE / DOSE 10mg | TIME / HEURE 1857 | 8. IV / IV IM | TIME / HEURE

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATIONS / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

X-RAYS - Probable old (R) fem neck fx
morphine 10mg IM @1851

10. DISPOSITION / DISPOSITION
RETURNED TO DUTY / RETOUR À L'UNITÉ
EVACUATED / EVACUÉ
DECEASED / DÉCÉDÉ
TIME / HEURE

11. PROVIDER / UNIT / OFFICIER MÉDICALE / UNITÉ | DATE/DATE (YYMMDD)

DD Form 1380, DEC 91 — This form replaces previous editions of DD Form 1380 and DD Form 1380 (TEST), which are obsolete.

U.S. FIELD MEDICAL CARD
FICHE MÉDICALE DE L'AVANT ÉTATS-UNIS

MEDCOM - 14007

12. REASSESSMENT / RÉASSESSMENT				
DATE / DATE (YYMMDD) 03 July		TIME OF ARRIVAL / HEURE D'ARRIVÉE		
TIME / HEURE 1850	T: 98°			
BP / PS 134/73	SpO2 98			
PULSE / POULS 86				
RESP / RPM 18				

DATE / TIME DATE / HEURE	13. CLINICAL COMMENTS / DIAGNOSIS INFORMATION MÉDICALE / DIAGNOSTIQUES
	14. ORDERS / ANTIBIOTICS *(Specify)*: TETANUS / IV FLUIDS DIRECTIVES MÉDICALES / ANTIBIOTIQUES *(Spécifier)* / TÉTANOS / IV FLUIDE

15. PROVIDER / OFFICIER MÉDICALE	DATE/DATE *(YYMMDD)*

16. DISPOSITION / DISPOSITION			TIME / HEURE
		RETURNED TO DUTY / RETOUR À L'UNITÉ	
		EVACUATED / EVACUÉ	
		DECEASED / DÉCÉDÉ	

17. RELIGIOUS SERVICES / SERVICES RELIGIEUX				
		BAPTISM / BAPTISÉ		PRAYER / PRIÈRE
		ANOINTING / ONCTION		COMMUNION / COMMUNION
		CONFESSION / CONFESSION		OTHER / AUTRE

CHAPLAIN / CHAPELAIN	

DD Form 1380, DEC 91 (Back)

MEDCOM - 14008

INPATIENT TREATMENT RECORD COVER SHEET

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

1. REGISTER NUMBER [redacted]			2. NAME (Last, First, MI) EPW [redacted] b6-4			3. GRADE
4. SEX M	5. AGE unk	6. RACE Z	7. RELIGION unk	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION NO
11. FMP 99		12. SSN 000-00-[redacted]		13. ORGANIZATION N/A		14. WARD ICU2
15. FLYING STATUS N/A	16. RATING/ DSG	17. DEPT. BEN K78 b6-4		18. BRANCH/CORPS N/A	19. UIC/ZIP	20. TYPE CASE DUBI
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION 1925	23. CLINIC SERVICE AAAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE				25. TYPE DISPOSITION 50	26. DATE OF DISPOSITION 15 Jul 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)				27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 09 Jul 03	ADMITTING OFFICER b6-2 D[redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY 28th CSH South					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

Heat Injury

992.5
584.9
E900.0
240.9

96.04
96.71

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
Ø	Ø	Ø	Ø	7	7

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
Ø	Ø	Ø	Ø	7	7

SIGN[redacted] b6-2 SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER [redacted]

DA FORM 2647-M

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

PMH: goiter ?sg -appy scar

30-ish appearing female EPW brought to [redacted] b2-2 c̄ fever > 105° + obtundation. He was electively intubated in the ER for GCS of 7. No other hx available.

PHYSICAL EXAMINATION

PE T [redacted] 106 (R) - 99.6 now (R) P 93 BP 112/70

Gen: well-appearing ♂ intubated + sedated
Neck: massive multinodular goiter ± thyroid bruit
Lungs CTA (B)
CV RS 1+S2 (R) 1 gallop
Sp Card
Abd: tender

RR 2.9
A-a 48
ACT 21 Amy 69
AST 33 TBILI 1.4
GGT 34
NPS 6

125 | 99 | 58 / 4.1 | 21 | 1.9 < 137

7.52 / 25.2 / 91 / 21 / 98

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

Stp (R) clinically, pt presents c̄ heat exhn c̄ MS Δ's + ARF. I do not suspect thyroid storm c̄ this time due to lack of stigmata (signs), reduction in HR c̄ IVF + ↓ of fever; will cont IVF + support on vent overnight

[redacted] b6-2

	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	9 July		
(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

[redacted] b6-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES
09 July 03 1925	Pt. admitted to ICU #2 from EMT @ 1830 c̄ dx. of heat injury. Pt. presented to EMT c̄ Temp. 106.°R. Nursing assessment done: Neuro: Pupils equal @ 2mm & reactive but sluggish. pt. is sedated. Resp: Vent. SIMV RR 14 TV 700 Peep 5 FIO2 60%. c̄ sats @ 98%. Pt. is breathing over the vent 4-8 breaths. ETT 25cm @ teeth. Equal rise/fall of chest. Crackles BUL. CV: NSR. Ø murmer. HR 80's. 2+ pulses x4. cap refill brisk. GI: ⊕ BS x4 quadrants. ⊕ BM x 2 watery, light brown in color. NGT ® nare clamped. GU: Foley to gravity c̄ moderate amt. bright yellow urine, about 200cc/hr. Lines: 18g PIV (L) FA c̄ NS @ 150cc/hr infusing. 16g PIV HL (R) FA. (R) Femoral Cordus c̄ Fent. @ 10cc/hr, Vec. @ 4cc/hr & Versed @ 4cc/hr infusing. — b6-2 [redacted] LTAn
09 July 03 2035	Pt.'s neck reddened & swollen. Able to palpate 2 large lumps on anterior of neck. ? Thyroid enlarged. Dr. [redacted] b6-2 is aware — b6-2 [redacted] LTAn
09 July 03 2115	Asked Dr. [redacted] b6-2 if he would like to draw another ABG but he said it wasn't necessary @ this time. — [redacted] LTAn
09 July 03 2145	FIO2 ↓ 40%. Pt. tolerating c̄ SpO2 maintaining @ 100%. — [redacted] b6-2 LTAn

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

EPW # [redacted] b6-4

41y/o ♂

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 July 03 0050	Pt. doing well. Sedated c̄ Fent. @ 10cc/hr, Vecuronium @ 3cc/hr & Versed @ 4cc/hr. RT in to ✓ on vent settings @ 2400. FiO2 ↓ to 35%. Pt. tolerating that c̄ sats maintained @ 100%. [redacted]
10 July 03 0200	Pt. starting to have extra movements, waking up from sedation. Bolus of 2cc Versed & 2cc Vec given. [redacted]
10 July 03 0435	VSS through the night. Chem 8 & LFT's drawn & sent to lab. [redacted]
10 July 03 (0750hrs)	Assumed care of patient @ 0530hrs. (Neuro): sedated & on vent. (Pupil) ⊕ response to painful stimuli otherwise sedated/paralytic effective. Brisk capillary refill to all extremities < 3secs and palpable pulses. (HEENT): PERRLA → 1mm ⊕ c̄ brisk response to light (sclera clear). Vitals patent. ET #8 (25cm to the teeth) c̄ vent settings @ SIMV = 14 bpm, TV @ 700ml, FiO2 @ 35%, Peep @ 5. Oral mucosa moist c̄ oral secretions removed via yankauer. (CV) = RRR s̄ @ HR 60-80 bpm. Skin color pink. (Lungs) - CTA c̄ coarse breath sounds. SaO2 > 98% (mech vent). (GU): abd non-distended, soft & flat. Hyperactive bowel sounds all quads x ⊕ upper c̄ hyperactive sounds. (Lines): IV NS @ (SDA) ⊕ forearm (#18 ga); ⊕ Femoral Cath patent & flushed. Fentanyl, Versed & Vecuronium drips d/cd @ 0700hrs for extubation. ⊕ forearm (#16 ga) Heparin lock. N/G tube in ⊕ nare clamped. (Plan): Extubate off mech ventilator [redacted]
10 July 03 (0800hrs)	K+ @ 2.5 this a.m. Order for 40mg KCl in 100cc x 2 received. Repeated K+ after receiving both K+ meds. [redacted]
10 JUL @ 0835	First 40mg KCl in 100cc NS started will monitor over next hour [redacted]
10 JUL @ 0900	Patient extubated → tolerated very well s̄ harm or difficulty breathing. SaO2 @ 98% RA ⊗ secretions. Eyes open spontaneously. Verbalizing well to questions. Will keep O2 equip @ the body & monitor over next couple of hours for resp. problems. [redacted]
10 Jul @ 0945	Second 40mg KCl in 100cc NS started. Continue c̄ current plan of care [redacted]
10 JUL @ 1100hrs	Tolerating po. fluids very well post-extubation [redacted]

STANDARD FO[redacted]5/1999) BACK

USAPA V1.00

b6-2

DICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

PROGRESS NOTES

DATE	NOTES b6-2
10 Jul 03 (1210hrs)	Repeat K+ p̄ two KCl mins now @ 3.6. Dr [redacted] informed of latest level. [redacted]
	Patient tolerating liquids very well → advanced to regular diet. [redacted]
10 JUL03 1817	Assumed care of pt @ 1700. VSS, temp 99°. Lung sounds clear bilaterally apex to base. RR equal + unlabored c̄ no use of accessory muscles noted. O2 Sat 96% RA. Radial + Pedal pulses strong + equal to palpation bilaterally. Pt has HL to (R) forearm 18G. Pt has 16G IV NS @ 150cc/hr to (L) ac. Pt has Cordis HL to (R) femoral. All sites without signs of redness, swelling, or infiltration. PERRLA. Mucous membranes moist + intact. BS active X4 Quadrants. No tenderness or distention noted to abdomen c̄ palpation. Pt reports having no BM until last pm since Saturday 05JUL03. Pt has foley to gravity draining concentrated urine ≥ 30cc/hr. Pt moves all extremities at will. Pt has large mass to neck. Bilateral; [redacted] R>L. Pt reports that mass is not painful unless pressure applied. MD aware, dx of goiter. Will continue to monitor for changes. b6-2 SPC [redacted] 11WM6
11 JUL03 0050	Pt received 10mg Ambien PO for c/o not being able to sleep, will monitor for effectiveness. SPC [redacted] 9WM6
11 July 03 0700	Nursing - Pt alert & oriented x 3, VSS. T. 99°. Lung Sounds CBA. + Bowel sounds x 4 Quadrants. Abdomen Soft. Non tender to palpation. Foley in place draining ~~Clear / Yellow Urine~~ Dark Yellow Urine. Pt c̄ HL (R) forearm

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

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

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

[redacted] b6-4

41y/o ♂

PROGRESS NOTES
Medical Record

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

USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	NS@ 150cc/hr (L) AC and (R) Femoral Line. All patent & w/o s/s of infection. Pt with goiter to (R) side of neck. c/o pain upon palpation. Pt tol Reg diet w/o complaint. Pt pending transfer to ICW #2. [redacted]
11 July 03 0965	Pt. transferred from ICU #2. to ICW #2 via ambulatory. A+O x 3. lungs CTA. (+) pulses x 4. Foley to gravity c̄ clear yellow urine. HL to (R) FA, (L) FA and (R) femoral. c/o dizziness and pain to neck area. Anterior portion of neck is swollen. will continue to monitor [redacted] b6-2
1250	Pt. voided 700cc dark amber UOP via Foley [redacted] b6-2
11 July 03 1300	pt awake & alert. VSS. Airway patent. neck swollen HL to (R) FA, (L) FA & (R) femoral, CDS/PV of infection noted to sites. lungs CTA, abd soft BS (+) x4. BLE & BUE c̄ full ROM (+) pulses. foley cath to gravity intact. (D) c/o pain voiced @ this time. Will cont to monitor - [redacted]
11 Jul 03 21:07	Pt. awake and alert in bed. Rec'd c/o pt @ 21:00. Restraint x1 to (R) wrist. PERRLA (+) WNL. Skin WD. Airway patent. Neck remains swollen. LCA (B). BS (+) x4. PIV to (R) FA bruised and patent (L) arm PIV HL patent. Femoral PIV HL patent and clamped off. c/o pain @ this time. Will cont. to mon. [redacted] b6-2
Addendum 0353	FTG c̄ cyu. [redacted]
0400	Pt. void dk yellow urine 700cc [redacted]
	Pt awoke for blood draw c̄ extremely dry buccal mucosa. H2O given will mon. [redacted]

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

b6-2

CAL RECORD | AUTHORIZED FOR LEGAL REPRO

PROGRESS NOTES

TE | NOTES

0457 Blood draw returned from lab. Platelet level @ 56. x10³/uL
fr blood draw from Fem. central line.

0457 2nd blood draw from antecub (R) arm Platelet level
@ 51. x10³/uL. Dr. [redacted] aware of both lab results.
[redacted] 21 AM b6-2

0625 Assume pt care @ 0500. pt awake and alert.
No c/o pain @ this time. VSS. Bruise to neck,
painful to palpate. Fem central line dsg CDI
no redness @ site. HR reg. Lungs CTA. Abd soft
BS x4 nontender no distended. Full ROM to extremities.
Foley cath to gravity draining dark amber urine. Sm b6-2
amt red sediment noted. Will continue to mon [redacted]

12 Jul 03 1300 assumed pt care @1300, pt awake et alert. VSS. airway
patent, anterior portion of neck swollen painful to palpate
lungs CTA, abd soft BS(+)x4. (R) femoral centralline, intact.
(L) redness/swelling noted. ↓ et ↑ ext c̄ full ROM (P) pulses.
(L) c/o pain voiced @ this time. Will cont to monitor
b6-2 [redacted] 91WM6

Foley cath to gravity intact. [redacted] 91WM6

12 Jul 2145 Rec'd c/o pt @ 21:00. Pt awake and alert in bed.
Restraints x2 (L) wrist and ankle. Skin W/D. PERRLA (+)

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

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509
Prescribed by GSA/ICMR FPMR (41 CFR) 101

[redacted] b6-4

TF	NOTES
cont'd	LCA(B). BS(+)x4. (+) PPP(B). Fem central line (+) blood return patent to flush. Mouth and buccal mucosa remains dry. Throat remains swollen. Will cont to mon [redacted]
Addendum	FTG draining yellow urine [redacted] b6-2
13 July 03	0540 Assume pt care @ 0500. pt asleep easy to awake. VSS. fem central line dsg CDI patent to flush. HR reg. Lungs CTA. Abd soft
0520 98.8 63 20 104/66 93%	tender to palpate RLQ. Foley to gravity draining yellow UOP c̄ sm amt of white and red sediment. Free ROM of extremities. Mouth dry. Throat swollen, tender to palpate. pt NPO for possible surgery today. will continue to monitor [redacted]
	0930 Foley D/C'd DTV by 1330 b6-2 [redacted]
13 July 03 1400	assumed pt care @ 1300. pt awake et alert. VSS. lungs CTA, abd soft, tender to palpate lower quads. BS(+)x4 quads. ↓et↑ ext c̄ full rom (+) pulses. IV femoral central line, dsing CDI, infusing NS @ 75cc/hr s̄ diff. (0) c/o pain voiced @ this time. Will cont to monitor b6-2 [redacted] 91wme
2200.	Pt. care assumed @ 2100. CT complete. Pt. c/o legache. Tylenol given, pt only wanted ½ 325mg tab. HR Reg, Lungs CTA, BS(+)x4. Pt. c/o having diff. c̄ speech @ times, speaks broken english. IVCL to (R) femoral infusing s̄ diff @ 75cc/hr. Dsing CDI. Will cont. to monitor. [redacted] b6-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
14 July 03	Assumed PT care @0500. PT alert to verbal stimuli. No c/o pain at this time. VSS. Goiter to neck noticeably swollen. Femoral line dry and intact no s/s of infection. Lung sounds are clear bilateral. No abdominal distention BS X4. Good pulse motor function on all
0510 97.9 58 14 116/70 95%	extremity. Skin is warm + Dry. Will continue to monitor. [redacted] b6-2
~~0630~~	
14 July 03 0630	- PT express desire not to have medical procedure done. Charge nurse notified. Continue to monitor PT. [redacted]
14 JUL 03	Surgery Offered Thyroidectomy for Asymptomatic Rapidly enlarging goiter (ovulous). Pt refuses surgery. D/C to EPW Camp [redacted]
2000	Assumed care @ 1300. VSS. A+Ox3. Ø c/o pain. Refused surgery. Femoral Line Removed, Dice + Pressure held for 10 min, then pressure taped. Pt avail [redacted] b6-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO. | WARD NO.

#[redacted] b6-4

PROGRESS NOTES
Medical Record

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

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
14 Jul 03 2210	Assume pt care @ 2100. VSS. ~~II~~-tylenol for pain @ 2105. C/o pain @ dog site of fem cath. Swelling to throat tender to palpate. HR reg lungs CTA. ~~Abd~~ soft BS x 4. Voids per urinal. Ambs w/ difficulty. Will continue to monitor — [redacted] SIGNM b6-2

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

DICAL RECORD

AUTHORIZED FOR LOCAL REPRO

PROGRESS NOTES

DATE	NOTES
15July03	1200 - Pt alert lying in bed. Central line site looks good, Ø bleeding, 4x4 removed. VSS lungs CTA, BS@. Voicing no complaints this shift. Will cont to monitor - [redacted] b6-2
15July03 1330	assumed pt care @ 1300. pt sitting ↑ in bed awake pt alert. VSS. assessment findings WNL. pt has discharge orders for the EPW camp, awaiting transportation. Ø complaints voiced. will cont to monitor — b6-2 [redacted] 91WMC
15July03 1530	pt discharged in stable condition, escorted by MP's to EPW camp — [redacted] 91WMC

ONSHIP TO SPONSOR

SPONSOR'S NAME: LAST | FIRST | MI

SPONSOR'S ID NUM (SSN or Other)

T./SERVICE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO.

[redacted] b6-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (RE
Prescribed by GSA/ICMR FPMR (41CFR) 101-11

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER TREATMEN [redacted] b2-2
		RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS: EPW # [redacted] b6-4

CITY | STATE | ZIP CODE

SEX: M

AGE

DUTY/LOCAL PHONE: AREA CODE | NUMBER

HOME PHONE: AREA CODE | NUMBER

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			
MEDICAL HISTORY OBTAINED FROM			

ARRIVAL

DATE *(Day, Month, Year)*: 09/07/03 TIME: 1707

TRANSPORTATION TO FACILITY: MEDEVAC

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		
NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS: ?

ALLERGIES: ?

INJURY OR OCCUPATIONAL ILLNESS

ITEM	YES	NO	WHEN *(Date)*
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			
HOW			

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INTITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: HEAT STROKE

CATEGORY OF TREATMENT

☐ EMERGENT

☒ URGENT

☐ NON-URGENT

TIME: 1700

INITIALS: [redacted] b6-2

VITAL SIGNS

TIME	1700	1710	1717	1725	1740
BP	91/47	89/39	106/53	101/41	101/32
PULSE	128	121	123		105
RESP	33	34	34		14 vent
TEMP		RECT 106.°		106	
~~WT~~ O2	93%		97%		100%

LAB ORDERS

☒ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S ☒	UA MSCC/CATH		CHEM: MET 8
BLOOD C&S X			

X-RAY ORDERS

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

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
1700	LFTS, CBC, COAGS, MET8, UA			1720	ABG
1710	100 LIDO, 20 ETOMIDATE,				NG tube / Foley
1715	TSH THYROID FUNCTION TEST			1710	Etomidate 20mg
1717	100 SUCC				VIC 9 Versed 2mg

DISPOSITION: ☐ HOME ☐ FULL DUTY

DISPOSITION QUARTERS /OFF DUTY: ☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS.

MODIFIED DUTY UNTIL

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☐ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

O [redacted] b6-4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

NSN 7540-01-075-3786

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

TEST RESULTS

CBC		SMAC		ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
WBC		139 / 137		SUP 02	PH	PO2	RESULTS	CXR ETT above carina Ptx Dx
H/H				PCO2	SAT	OTHER		
PLT								
PT				U/A	DIP		EKG INTERPRETATION	
APTT	BHCG	ETOH	GLU		MICRO			

PROVIDER HISTORY/PHYSICAL

Pt. EPW brought by EMS c temp 105 AX & unresponsive.

A: (+) gag, pooling of secretions.
B: Labored BIL = BS no wheezes NO rhonchi
C: BP 89/39: capr refill > 2sec.
D: GCS 4; pupils PERRL
E: Dry hot skin no rashes

2° survey
HEENT: Neck (+) goiter
Heart tachycardic S1 S2
Lungs CTA BIL
Abd: soft BS x4 no acute findings.
Ext's: No deformities dry skin.
Rectal (+) tone. RT 106.

PmHx unknown.
Soc hx ø

7.5 20/91/21/98% Pox

Pt. ETT 2° to GCS 4 → RSI; #7.5; 25 cm @ teeth CXR: tube passed thru cords. No complications. 2cm↑ carina. No infiltrates.
BP 116/48 / POx 100% Pulse 108; Vent 700 TV; FiO2 100%; RR 14 SIMV.

CONSULT WITH	TIME	ACTION
MED		

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

b6-2 [redacted]

DIAGNOSIS

Heat stroke

CODES

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

b6-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

STANDARD FORM 558 (REV. 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

Patient's Name: EPW [redacted] 66-4 9/7/03

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP														112/52	129/59	110/53	114/57	110/58	116/62	111/65	112/63	124/74	101/66	94/60
TEMP														99°	100.8°	100.0° A	99.0° A	98.0° A	97.2° A	97.3° A	97.0° A	97.0° A	97.0° A	97.5° A
HR														96	88	81	74	81	68	65	63	61	68	64
RR														14	16	14	14	14	14	14	14	14	14	14
SAO2														100	100	100	100	100	100	100	100	100	100	100
FIO2														60%	60%	60%	60%	40%	40%	40%	35%	35%	35%	35%
INPUT																								
PO																								
IV NS														150	150	150	150	150	150	150	150	150	150	150
~~NGT~~ Vec															3	4	4	4	4	3	3	3	3	3
Veis															3	4	4	4	4	4	4	4	4	4
~~TURN Q 2~~ Jent															10	10	10	10	10	10	10	10	10	10
TOTAL														150	316	484	652	820	988	1155	1322	1489	1656	1823
OUTPUT																								
URINE														250	150	300	250	400	450	275	200	225	225	200
NGT														0										
STOOL														0										
TOTAL																								
BALANCE														250	400	700	950	1350	1800	1075	1275	1500	1725	1925
Initials																								

MEDCOM - 14022

10 July 03

Patient's Name: EPW # [redacted] bb-4 Bed # 6

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
BP	111/68	122/70	105/46	110/68	111/84	111/63	115/65	109/58	96/53	105/46	110/52	104/50	101/40		93/40		97/46			102/50				104/49
TEMP	97.4	96 oral	97 oral	—	97 oral	—	98 oral	—	97 oral	—	98 oral	—	99		99		98			100				99
HR	74	67	61	58	76	61	74	60	58	64	59	66	77		74		61			72				68
RR	15	14	14	14	12	21	8	20	18	20	19	16	20		20		24			20				18
SAO2	100	100%	100%	100%	98%	100%	100%	99%	98%	96%	98%	99%	96%		95%		96			95				96
FIO2	35%	35%	35%	35%	RA	RA	RA	RA	RA	RA	RA	RA	RA		RA		RA			RA				RA
INPUT																								
PO	—	—	—	—	—	—	240	360	160			240												
IV NS	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150
~~NGT~~ Vec	3	3	D/c'd																					
Versed	4	4	D/c'd																					
~~TURN Q 2~~																								
Fent	10	10	D/c'd																					
IVPB					100	100			310 ~~150~~	~~450~~														
SUBTOTAL	167	167	150	150	250	250	390	510	~~820~~	950	150	390	~~450~~											
TOTAL	167	334	484	634	874	1124	1514	2014	2324	2774	2624	4014	4164	4314	4464	5014	5164	5314	5464	6014	6164	6214	6324	6514
OUTPUT																								
URINE	—	450	150	—	350	150	175	175	125	200	225	150	75		325		125			675				325
NGT																								
STOOL																								
~~SUBTOTAL~~		450	150	N/A	350	500	175	175	125	200	225	150	75		325		125			675				325
TOTAL		450	600	600	950	1450	1625	1800	1925	2125	2350	2500	2675		3000		3125			3800				4125
BALANCE																								
Initials																								

MEDCOM - 14023

11 JUL 03 41y/o ♂

#000-00-0[redacted] Bed #6

Time	05	06	07	08	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04
			105/46																					
BP																								
TEMP			99.9																					
HR			68																					
RR			20																					
SAO2			96																					
FIO2			RA																					
INPUT																								
PO																								
IV																								
NGT IVPB																								
TURN Q 2																								
TOTAL																								
OUTPUT																								
URINE																								
NGT																								
STOOL																								
TOTAL																								
BALANCE																								
Initials																								

MEDCOM - 14024

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST-OP DAY

MONTH-YEAR | DAY: 11 12 13 14 15 16 17

19 | HOUR

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

105° 40.6°
104° 40.0°
103° 39.4°
102° 38.9°
101° 38.3°
100° 37.8°
99° 37.2°
98.6° 37.0°
98° 36.7°
97° 36.1°
96° 35.6°
95° 35.0°

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7–95) BACK

EPW # [redacted] 66-4

EPW O[redacted] b6-4

Ward/Section: EMT	REQUESTING PHYSICIAN: Dr. [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)		
LAST, FIRST, MI: O[redacted] b6-4	b6-2	DATE: 9 Feb 03	TIME: 1725	SSN/PSEUDO SSN: O[redacted] b6-4

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	7.8	4.8-10.8 x 10^3
RBC	5.00	4.7-6.1 x 10^9
Hgb	14.0	14-18 g/dl (M) 12-16 g/dl (F)
Hct	45.1	42-52% (M) 37-47% (F)
MCV	90.3	80-94 fl (M) 81-99 fl (F)
Plt	177	130-500 x 10^3 verified
Lymph %	21.7	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	17.5	9.8-13.6 secs
APTT	20.8	21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: b6-4	DATE: [redacted] b6-2	LAB ID NO.:

[redacted] 095 N 03

EMT Dr. [redacted] b6-2

EPW O[redacted] b6-4 9 July 03 1725 | O[redacted] b6-4

(i-STAT)		
TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry		
TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12		
TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl

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

REMARKS:

REPORTED BY: [redacted] b6-2

9 Jul

======= PICCOLO =======
09/07/03 17:21
REFERENCE RANGE: MALE
PATIENT #: 0[redacted] b6-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: 432 DR #: 000
SERIAL #: 0000100697

GLU	137*	73-118	MG/DL
BUN	58*	7-22	MG/DL
CRE	1.9*	0.6-1.2	MG/DL
CK	243	39-380	U/L
NA+	125*	128-145	MMOL
K+	4.1	3.3-4.7	MMOL
CL-	99	98-108	MMOL
tCO2	21	18-33	MMOL

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

======= PICCOLO =======
09/07/03 17:21
REFERENCE RANGE: MALE
PATIENT #: 0[redacted] b6-4
LIVER PANEL PLUS
DISC LOT #: 3135BA4
OPER #: 432 DR #: 00
SERIAL #: 0000100684

ALB	2.9*	3.3-5.5	G/DL
ALP	48	26-84	U/L
ALT	21	10-47	U/L
AMY	64	14-97	U/L
AST	33	11-38	U/L
TBIL	1.4	0.2-1.6	MG/DL
GGT	34	5-65	U/L
TP	5.6*	6.4-8.1	G/DL

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

Section: IW #2 | RE[illegible] ST[illegible]NG PHYSICIAN: Dr. [redacted] b6-2

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

FIRST, MI. EPW # [redacted] b6-4 | DATE 10 JUL 03 | TIME 0400 | SSN/PSEUDO SSN:

(i-STAT)

T	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
		35-45 mmHg (art) 41-51 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
		23-27 mmol/L (art) 24-29 mmol/L (ven)
		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
		(-2) – (+3) mmol/L
		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

Misc. Chemistry

	RESULT	REF. RANGE
-I		

RKS:

RTED BY [redacted] b6-2

(Piccolo) Chemistry 12

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

======= PICCOLO =======
10/07/03 04:52
REFERENCE RANGE: MALE
PATIENT #: [redacted] b6-4
GENERAL CHEMISTRY 12
DISC LOT #: 3082AA4
OPER #: 678 DR #: 00
SERIAL #: 0000100684

ALB	3.3	3.3-5.5	G/DL
ALP	52	26-84	U/L
ALT	29	10-47	U/L
AMY	239*	14-97	U/L
AST	47*	11-38	U/L
TBIL	1.8*	0.2-1.6	MG/DL
BUN	47*	7-22	MG/DL
CA++	7.8*	8.0-10.3	MG/DL
CHOL	134	100-200	MG/DL
CRE	1.6*	0.6-1.2	MG/DL
GLU	107	73-118	MG/DL
TP	5.9*	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

Section: Ilu #2

RE[illegible]STING PHYSICIAN: [redacted] b6-2

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

FIRST, MI. # [redacted] b6-4

DATE 10 JUL 03 | TIME 1210 | SSN/PSEUDO SSN: # [redacted] b6-4

(i-STAT)

T	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
		35-45 mmHg (art) 41-51 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
		23-27 mmol/L (art) 24-29 mmol/L (ven)
		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
		(-2) – (+3) mmol/L
		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

Misc. Chemistry

	RESULT	REF. RANGE
-I		

(Piccolo) Chemistry 12

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

======= PICCOLO =======
10/07/03 12:46
REFERENCE RANGE: MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: 269 DR #: 000
SERIAL #: 0000100494
.....

GLU	92	73-118	MG/DL
BUN	32*	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	577*	39-380	U/L
NA+	130	128-145	MMOL
K+	3.6	3.3-4.7	MMOL
CL-	100	98-108	MMOL
tCO2	24	18-33	MMOL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

RKS:

TED BY: [redacted] b6-4

DATE: 10 JUL 03

LAB ID NO.:

Section: ICU #2

REQUESTING PHYSICIAN:

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

FIRST, MI. #[redacted] b6-4

DATE 11/7/03 | TIME 0649 | SSN/PSEUDO SSN: #[redacted] b6-4

(i-STAT)

T	RESULT	REF. RANGE
		138-146 mmol/L
		3.5-4.9 mmol/L
		98-109 mmol/L
		7.31-7.45
		35-45 mmHg (art) 41-51 mmHg (ven)
		80-105 mmHg (art) N/A (ven)
		23-27 mmol/L (art) 24-29 mmol/L (ven)
		22-26 mmol/L (art) 23-28 mmol/L (ven)
		95-98%
		(-2) – (+3) mmol/L
		10-20 mmol/L
		1.12-1.32 mmol/L
		8-26 mg/dl
		70-105 mg/dl
		0.7-1.5 mg/dl
		38-51% PCV
		12-17 g/dl

Misc. Chemistry

	RESULT	REF. RANGE
-I		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l

======= PICCOLO =======
11/07/03 06:55
REFERENCE RANGE: MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: 210 DR #: 000
SERIAL #: 0000100697

GLU	80	73-118	MG/DL
BUN	13	7-22	MG/DL
CRE	0.3	0.6-1.2	MG/DL
CK	854*	39-380	U/L
NA+	130	128-145	MMOL
K+	3.5	3.3-4.7	MMOL
CL-	106	98-108	MMOL
tCO2	21	18-33	MMOL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl

======= PICCOLO =======
11/07/03 06:54
REFERENCE RANGE: MALE
PATIENT #: [redacted] b6-4
LIVER PANEL PLUS
DISC LOT #: 3135BA4
OPER #: 210 DR #: 000
SERIAL #: 0000100676

ALB	2.8*	3.3-5.5	G/DL
ALP	49	26-84	U/L
ALT	85*	10-47	U/L
AMY	136*	14-97	U/L
AST	74*	11-38	U/L
TBIL	1.8*	0.2-1.6	MG/DL
GGT	24	5-65	U/L
TP	5.2*	6.4-8.1	G/DL

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

RKS:

RTED BY: [redacted] b6-2

DATE: 11/07/03

LAB ID NO.:

EPW b6-4 12 July 03
#[redacted] ICW 1637
ordered by Dr. [redacted] b6-2

(Hematology) CBC

TEST	RESULT	REF RANGE
WBC		4.8-10.8 x 10^3
RBC		4.7-6.1 x 10^6
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10^3 verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

ICW #2
#[redacted] 66-4 1057 12 Jul

(Hematology) CBC

TEST	RESULT	REF RANGE
WBC		1.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

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

Coagulation Studies

TEST	RESULT	REF RANGE
PT		9.8-13.6 secs
APTT		21-31 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS: AC site

REPORTED BY: DATE: LAB ID NO.

Ward/Section: ICW 2

LAST, FIRST, MI: EPW [redacted] b6-4

ORDERING PHYSICIAN: [redacted] b6-2

DATE: 12Jul | TIME: 0407

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

SSN-PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ve
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ve
sO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF RANGE
Troponin-I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l

======= PICCOLO =======

12/07/03 04:55

REFERENCE RANGE: MALE

PATIENT #: [redacted] b6-4

METLYTE 8

DISC LOT #: 3141AA4

OPER #: 678 DR #: 000

SERIAL #: 0000100494

GLU	80	73-118	MG/DL
BUN	13	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	762*	39-380	U/L
NA+	131	128-145	MMOL/L
K+	3.4	3.3-4.7	MMOL/L
CL-	105	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA		128-145 mmol/l
K		3.3-4.7 mmol/l
CL		98-108 mmol/l
HCO_3		18-33 mmol/l

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA		128-145 mmol/l
K		3.3-4.7 mmol/l
CL		98-108 mmol/l
CO_2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]

DATE: 12/3/03

LAB ID NO.:

b6-2

10 JUL 03

i-STAT EG7+

PCO 427

Pt Name:

b6-4

ID: 000[redacted]
WB

13-07-03
03:58

			Patient Limits	
WBC	8.2	x10^3/uL	4.5	10.5
RBC	5.06	x10^6/uL	4.00	6.00
Hgb	14.2	g/dL	11.0	18.0
Hct	46.1	%	35.0	60.0
MCV	91.0	fL	80.0	99.9
MCH	28.1	pg	27.0	31.0
MCHC	30.8 L	g/dL	33.0	37.0
Plt	94. L	x10^3/uL	150.	450.
LY%	24.5	%	20.5	51.1
LY#	2.0	x10^3/uL	1.2	3.4

b6-2

[redacted]

ID: 000[redacted] b6-4
WB

12-07-03
04:57

			Patient Limits	
WBC	8.7	x10^3/uL	4.5	10.5
RBC	4.69	x10^6/uL	4.00	6.00
Hgb	13.5	g/dL	11.0	18.0
Hct	42.9	%	35.0	60.0
MCV	91.4	fL	80.0	99.9
MCH	28.9	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	51. *L	x10^3/uL	150.	450.
LY%	24.4	%	20.5	51.1
LY#	2.1	x10^3/uL	1.2	3.4

b6-4

ID: 000[redacted]
WB

12-07-03
16:39

			Patient Limits	
WBC	9.8	x10^3/uL	4.5	10.5
RBC	5.15	x10^6/uL	4.00	6.00
Hgb	14.1	g/dL	11.0	18.0
Hct	46.7	%	35.0	60.0
MCV	90.6	fL	80.0	99.9
MCH	27.4	pg	27.0	31.0
MCHC	30.3 L	g/dL	33.0	37.0
Plt	79. L	x10^3/uL	150.	450.
LY%	23.0 *	%	20.5	51.1
LY#	2.2 *	x10^3/uL	1.2	3.4

ID: 00[redacted] b6-4
WB

12-07-03
04:12

			Patient Limits	
WBC	8.7	x10^3/uL	4.5	10.5
RBC	4.82	x10^6/uL	4.00	6.00
Hgb	13.8	g/dL	11.0	18.0
Hct	44.0	%	35.0	60.0
MCV	91.2	fL	80.0	99.9
MCH	28.6	pg	27.0	31.0
MCHC	31.3 L	g/dL	33.0	37.0
Plt	56. *	x10^3/uL	150.	450.
LY%	25.4	%	20.5	51.1
LY#	2.2	x10^3/uL	1.2	3.4

~~estimate~~

ICW 2
EPW# [redacted] b6-4 [redacted] b6-2

12 Jul 0407

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		150-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS: Fem Central line

REPORTED BY: DATE: LAB ID NO.

ICWR

#[redacted] b6-4

13 JUL 0330

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		1.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

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

Ward Section: ICW 2

LAST FIRST MI: [redacted] b6-4

REQUESTING PHYSICIAN:

DATE: 13JUL TIME: 0330

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)
SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		96-106 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		[illegible] mmol/L (art) [illegible] mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BE ecf		[illegible] mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		60-105 mg/dl
Creat		[illegible] mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF RANGE
Troponin I		Negative
Drug of Abuse		Negative
		Negative
		Negative
		Negative

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALK		[illegible]

======= PICCOLO =======
13/07/03 04:28
REFERENCE RANGE: MALE
PATIENT #: [redacted] b6-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: 678 DR #: 000
SERIAL #: 0000100494

GLU	90	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	384*	39-380	U/L
NA+	136	128-145	MMOL
K+	3.2*	3.3-4.7	MMOL
CL-	101	98-108	MMOL
tCO2	27	18-33	MMOL

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF RANGE
GLU		60-115 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
NA		128-145 mmol/L
K		3.3-4.7 mmol/L
CL		98-108 mmol/L
CO2		18-33 mmol/L

(Piccolo) Liver Panel Plus

TEST	RESULT	REF RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/L
ALT		10-47 u/L
AMY		14-97 u/L
AST		11-48 u/L
BILT		0.2-1.6 mg/dl
GGT		3-65 u/L
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted] b6-2

DATE: 13Jul03

LAB ID NO.:

NSN 7540-01-165-7294

519-301

RADIOLOGIC CONSULTATION REQUEST/REPORT

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

EXAMINATION(S) REQUESTED

CXR

AGE	SEX	SSN (Sponsor)	WARD/CLINIC	REGISTER NO.
		#[redacted] b6-4		

FILM NO.

REQUESTED BY (Print) DR [redacted] b6-2

SIGNATURE OF REQUESTOR

PRECNANT ☐ YES ☐ NO

TELEPHONE/PAGE NO.

DATE REQUESTED

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

HEAT INJURY

DATE OF EXAMINATION *(Month, day, year)*

DATE OF REPORT *(Month, day, year)*

DATE OF TRANSCRIPTION *(Month, day, year)*

RADIOLOGIC REPORT

PATIENT'S IDENTIFICATION *(For typed or written entries give: name – last, first, middle, Medical Facility)*

LOCATION OF MEDICAL RECORDS

LOCATION OF RADIOLOGIC FACILITY

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11 Jan 03 0815	Med PN Pt intubated yesterday c̄ difficulty c̄ O2 sat >95% on RA. He is back to baseline mental status. ARF has resolved c̄ rehydration, he is taking PO c̄ difficulty. Thyroid US performed yesterday revealed multi-nodular goiter. Will defer Pt to General Surgery c̄ regards to thyroidectomy. O/w pt ready for D/C. [redacted] b6-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

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

REGISTER NO	WARD NO

PROGRESS NOTES
Medical Record

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

[redacted] b6-4

10 Jul 03 0800
① Hel 40mcg in 100cc NS over 2 hrs
x2

Motel @ 0801h
[redacted] 10 Jul 03

ICU #2 6

[redacted] b6-2

10 Jul 03 0900
① [redacted]
② clear liquids in 2° then advance as tolerated
③ ✓ KP K-mus finished

Motel @ 0905
10 Jul 03
[redacted]
b6-2

[redacted] b6-4

ICU #2 6

[redacted] b6-2

11 Jul 03 0050
Ambien 10mg PO x 1 for sleep
c/o Dr. [redacted] / [redacted]

b6-2