518-123 OR IN AM NSN 7540-00-634-4158

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 17 July 03

DATE AND HOUR REQUIRED ON CALL

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

DIAGNOSIS OR OPERATIVE PROCEDURE S/P (L) Leg Amputation

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

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

DATE VERIFIED clot in

TIME VERIFIED Lab

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO. [redacted]

DONOR (b)(6)-4

ABO [redacted]

Rh

RECIPIENT

ABO [redacted]

Rh

TEST INTERPRETATION

ANTIBODY SCREEN: NA

CROSSMATCH: Comp

PREVIOUS RECORD CHECK: [x] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST (b)(6)-2 [redacted]

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 16 Jul 03

REMARKS: Etp 19 Jul 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)* [redacted] (b)(6)-2

AT *(Hour)* 2235 ON *(Date)* 16 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.

1st VERIFIER *(Signature)* [redacted] CPT/AN (b)(6)-2

2nd VERIFIER *(Signature)* [redacted]

PRE-TRANSFUSION

TEMP. 38.0 PULSE 119 BP 122/72

DATE OF TRANSFUSION 16 July 03

TIME STARTED 2240

POST-TRANSFUSION DATA

AMOUNT GIVEN 350 ML

TIME/DATE COMPLETED/INTERRUPTED 2400 16 Jul 03

REACTION [x] NONE [ ] SUSPECTED

TEMPERATURE 38.1

PULSE 120

BLOOD PRESSURE 140/74

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

[ ] OTHER *(Specify)*

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

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

SIGNATURE OF PERSON NOTING ABOVE [redacted] CPT/AN

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility) (b)(6)-2

SEX MALE

WARD ICU #1

EPW [redacted] (b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

ORIGINAL

518-123 NSN 7540-00-634-4158

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: 17 July 03

DATE AND HOUR REQUIRED: ON CALL

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)*: Dr [redacted] (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: S/p (L) Leg Amputation

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

DATE VERIFIED: clot in

TIME VERIFIED: LAB

SECTION II – PRE-TRANSFUSION TESTING

UN [redacted]

TRANSFUSION NO.

PATIENT NO. [redacted]

DONOR / RECIPIENT (b)(6)-4

ABO [redacted] / ABO [redacted]

Rh / Rh

TEST INTERPRETATION

ANTIBODY SCREEN: MA

CROSSMATCH: Comp

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] (b)(6)-2

[ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 16 Jul 03

REMARKS: Exp 19 Jul 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted] (b)(6)-2

AT *(Hour)* 1130 ON *(Date)* 17 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.

1st VERIFIER *(Signature)*: [redacted] (b)(6)-2

2nd VERIFIER *(Signature)*: [redacted] III/AN (b)(6)-2

PRE-TRANSFUSION

TEMP. 35 PULSE 114 BP 84/40

DATE OF TRANSFUSION 17 Jul 03 TIME STARTED 1140

POST-TRANSFUSION DATA

AMOUNT GIVEN: Total ML

TIME/DATE COMPLETED/INTERRUPTED: 17 July 1200

REACTION: [X] NONE [ ] SUSPECTED

TEMPERATURE: 99 PULSE: 111 BLOOD PRESSURE: 106/44

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION

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

[ ] OTHER *(Specify)*

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

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

SIGN [redacted] (b)(6)-2 LTC CRNA AN

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle initial; Sex; Birth date; Blood type; Rh factor; hospital or medical facility)

MALE

WARD ICU #1

EPW [redacted] (b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

518-123 NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

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

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- [ ] TYPE AND SCREEN
- [x] CROSSMATCH

DATE REQUESTED: 16 July

DATE AND HOUR REQUIRED: ASAP

REQUESTING PHYSICIAN *(Print)*: Dr [redacted] (b)(6)-2

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P (L) Leg Amputation

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

VOLUME REQUESTED *(If applicable)*: _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER: [redacted] (b)(6)-2 CPT/AN

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: _____

HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED: clot in Lab

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UN [redacted]

DO[redacted]

ABO [redacted]

Rh [redacted]

TRANSFUSION NO.

PATIENT NO. [redacted]

RECIPIENT (b)(6)-4

ABO [redacted]

Rh [redacted]

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
N/A	COMP

PREVIOUS RECORD CHECK:
- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [redacted] (b)(6)-2

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 16 Jul 03

REMARKS: Exp 18 Jul 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED [redacted] (b)(6)-2

AT *(Hour)* [redacted]0953 ON *(Date)* 17 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.

1st [redacted]ER *(Signature)* [redacted] (b)(6)-2 RN

2[redacted] (b)(6)-2 [redacted] LT RN

PRE-TRANSFUSION

TEMP. 38.7 PULSE 131 BP 155/77

DATE OF TRANSFUSION 17 Jul 03 TIME STARTED 1000

POST-TRANSFUSION DATA

AMOUNT GIVEN: TOTAL ML

TIME/DATE COMPLETED/INTERRUPTED: 17 Jul 03

REACTION
- [x] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
36	14	110/70

If reaction is suspected—IMMEDIATELY:

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

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
- [x] NO
- [ ] YES *(Specify)*

SIGNATURE [redacted] (b)(6)-2

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, midd[redacted] rate; hospital or medical facility)

EPW [redacted] (b)(6)-4

SEX: Male

WARD: IUU#1

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

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				DATE OF ORDER	TIME OF ORDER	LIST ORD NOTED SIG
#[redacted] (b)(6)-4				13 July 03	1530 HOURS	
			1	500cc RL Bolus now please [redacted]		
			2	↓ IMV to 12 [redacted]		
			3	↓ FiO_2 to 0.4 [redacted] (b)(6)-2		
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
#[redacted] (b)(6)-4				13 July 03	1800 HOURS	
			1	700 cc IVF Bolus RL, then		
			2	D IVF to NS @ 125cc/°		
			3	↓ IMV to 10		
				(b)(6)-2 [redacted]		
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
#[redacted] (b)(6)-4				7-14	0645 HOURS	0645
				500cc NS bolus U/O Dr. [redacted]		[redacted]
				(b)(6)-2 [redacted] (b)(6)-2		
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
(b)(6)-4 #[redacted]				14 July 03	1800 HOURS	
			1	Extubate		
			2	all propofol		
			3	repeat ABG 30 min 7 extubation		
			4	O_2 via mask / NC to keep SaO_2 >98%		
NURSING UNIT	ROOM NO.	BED NO.		(b)(6)-2 [redacted]		

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

PATIENT IDENTIFICATION

EPW [redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 13 July 03 TIME OF ORDER 1330 HOURS

Admit to ICU 1
SIA @ recovery for lap & thor trauma ✓
critical
Vitals q 15 min, strict I&O, monitor ✓
foley to gravity NOT to LCDS. ✓
NPO (b)(6)-2 ✓
Bedrest [redacted] LTC ✓

PATIENT IDENTIFICATION

EPW [redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 13 July 03 [redacted] ORDER 1330 HOURS

Vent IMV 14 / .5 / 800 / 5 PEEP ✓
CXR on arrival to ICU. ✓
transfuse remaining for HCT ✓
transfuse 2 u PRBC, each unit ~1° ✓
Warm patient actively to 38°C ✓
routine critical care ✓
(b)(6)-2 [redacted] LTC

PATIENT IDENTIFICATION

EPW [redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 13 July 03 [redacted] ORDER 1330 HOURS

change axillary, abdominal gauze & pin
bacitracin to R pos @ abdin
change L knee, R back injury q day & prn ✓
Ancef 1 g IV q8°
Gentam 80 mg IV q8°. ✓
(b)(6)-2 [redacted] LTC

PATIENT IDENTIFICATION

EPW [redacted] (b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 13 July 03 [redacted] ORDER 1330 HOURS

propofol gtt ; titrate to effect ✓
Repeat CBC, PT/PTT / ABG when blood transfused. ✓
call MD for M < 80 cc/h or bleeding or SBP < 90 — (b)(6)-2 ✓
IVF RL @ 125 cc/h [redacted] LTC ✓

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MA[redacted]

MEDCOM - 14445)1-478-200

all (b)(6)-4

all (b)(6)-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]

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	14 July 03	0930 HOURS	
1	500 cc NS IVF Bolus		[redacted] 0940
2	Δ IVF to NS @ 150 cc/o		
3	Repeat ABG ~30 min after bolus		

NURSING UNIT | ROOM NO. | BED NO.

[redacted] LTC

PATIENT IDENTIFICATION

#[redacted]

	DATE OF ORDER	TIME OF ORDER
	14 JUL 03	1100 HOURS
1	Albuterol NeBs 0.5 cc in 2.5 NS Apesol Q4 hrs	

NURSING UNIT | ROOM NO. | BED NO.

[redacted] V.O. DR [redacted] MAJ/AN

PATIENT IDENTIFICATION

#[redacted]

	DATE OF ORDER	TIME OF ORDER
	14 July 03	2135 HOURS
1	Admit to CCU	
2	S/P (L) popliteal artery interposition graft SVG(R)	
3	Renew previous orders	
4	4 AM labs CBC, chem 7, ABG	
5	MSO4 2-6mg IV q1 prn.	

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

#[redacted]

	DATE OF ORDER	TIME O[redacted]
	14 July 03	2135 HOURS
6	CXR port AP in AM	

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

ICU 7

all (b)(6)-2

all (b)(6)-4

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			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
GPW [redacted]			15 July 03	00/15 HOURS	[redacted]
			1	Admit to ICU-1	
			2	S/P decl of X many	
			3	resume orders.	
			4	keep sedated	
			5	propofol gtt to effect	
NURSING UNIT	ROOM NO.	BED NO.		AM labs, CBC chem 7, PT/PTT/ABG	
				[redacted]	

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			15 July 03	0830 HOURS	0200
			1	Δ albuterol nebs to q4 prn	
			2	start p CXR	
NURSING UNIT	ROOM NO.	BED NO.		[redacted]	

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
# [redacted]			15JUL03	0924 HOURS	
			1	Spine Precautions - Flat Bed Rest Log Roll to Turn	
NURSING UNIT	ROOM NO.	BED NO.		[redacted]	

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
[redacted]			7.15	1330 HOURS	1330
			per Dr. [redacted] 250cc		
			S/1 albumin for ↓ UO.		
done			7/17 0900		
NURSING UNIT	ROOM NO.	BED NO.	40 KCl in 100cc NS over		
			V.O. OR [redacted]		

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

#[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 15 July 03 — TIME OF ORDER: 1545 HOURS

1 Admit to CCU-1
2 Stable
3 S/P (2) knee discontinuation
4 Resume all previous orders.
5 Wean & Wake to extubate

(b)(6)-2 [redacted]

LIST TIME ORDER NOTED AND SIGN: 1600

PATIENT IDENTIFICATION

#[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

2245 10 JUL 03

T.O.

(1) keep intubated - resume prev settings
(2) prepare for sedation.

(b)(6)-2 [redacted]

(b)(6)-2 OR [redacted]

PATIENT IDENTIFICATION

#[redacted]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 16 July 03 — TIME OF ORDER: 0820 HOURS

(1) deep suction q 6 & prn
(2) CPT q4 - log roll
(3) wean to extubate
(4) QAM pCXR
(5) NPO 7mn

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

16 July 03 C0840

PATIENT IDENTIFICATION

(b)(6)-4

#[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 16 July 03 — TIME OF ORDER: 2046 HOURS

(1) Transfuse T on PRBC
(2) IVF to 125cc/0
(3) Type & cross for two additional units

[redacted] (b)(6)-2

ICU I

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	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
# [redacted] (b)(6)-4	17 July 03	0935 HOURS	(b)(6)-2 [redacted]
	① transfuse 2 units PRBC, each over 2 hours (b)(6)-2 [redacted]		
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
# [redacted] (b)(6)-4	17JUL03 (b)(6)-2	1158 HOURS	17JUL03 [redacted] (b)(6)-2
	① Unclamp lumbar drain and drain 20 cc spinal fluid ≤ 10		
	② Call Dr. [redacted] with any lumbar drain problems.		
	③ Clear liquids when fully awake.		
NURSING UNIT / ROOM NO. / BED NO.			

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
	17JUL03 [redacted] HOURS (b)(6)-2		
	Hold T[redacted] for now		
	V.O. Dr [redacted] (b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.	[redacted] (b)(6)-2		

PATIENT IDENTIFICATION	DATE OF ORDER	TIME OF ORDER	
(b)(6)-4 # [redacted]	17JUL03	1640 HOURS	
	① May use prop-fol boluses until versed drip arrives		
	[redacted] (b)(6)-2		
NURSING UNIT / ROOM NO. / BED NO.			

all (b)(6)-4

all (b)(6)-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			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
#[redacted]			17 July 03	1245 HOURS	[redacted]
			(1) Admit to ICU-1		
			S/P (2) TKA washout, central line, lumbar drain		
			(2) Resume all prep orders.		
NURSING UNIT	ROOM NO.	BED NO.	(3) pCXR on arrival to ICU		1350
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
#[redacted]			17 July 03	1245 HOURS	
			(1) Lumbar drain per neurosurg.		17 July
			(2) Sips clears when awake. MUST HAVE ASPIRATION PRECAUTIONS WHEN FEEDING		[redacted]
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
#[redacted]			17 July 03	1245 HOURS	
			(1) ~~Place Dobhoff feeding tube may begin ensure 20cc once position verified.~~		[redacted]
			(2) DC Sips		
			(3) ensure, 20cc/° pGT [redacted]		
NURSING UNIT	ROOM NO.	BED NO.			
PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
#[redacted]			17 July 03	1300 HOURS	
			~~DC Sips~~		
			(1) Check residuals q2°, hold for >80cc		[redacted]
			(2) lamp 20 mg IV now please.		
NURSING UNIT	ROOM NO.	BED NO.			

ICU I

#[redacted]

(b)(6)-4

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

DATE OF ORDER	TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
17 Jul 03	1831	
1) Albumin / Ahmed rel NW		(b)(6)-2 [redacted]
2) Albumin 25/3.0cc q40		
3) ~~Gentamycin~~ Gentamycin 300mg IV QD		
4) DC Arrest		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

#[redacted]

(b)(6)-4

DATE OF ORDER	TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
5) Fortaz 2gm IV q8°	1730	[redacted]
6) Repeat ABG after vent.		
7) CBC, Mag, 18, ABG in AM		

NURSING UNIT | ROOM NO. | BED NO.

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

DATE OF ORDER	TIME OF ORDER / HOURS	LIST TIME ORDER NOTED AND SIGN
17 Jul 03	1615	
Vent settings: SIMV 14 TV 600 PEEP 5 FIO2 100% Weaned to keep sats > 93%		
2) D/C Fortaz.		
3) Zosyn 3.375 gm IV q6° >1st dose		06 12 18 24
4) Ancef 400 g IV q12° NW		06 18

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER	TIME	
17 July 03	1630	[redacted]
Versed 2mg + Nitroprusside 40 mg in 250 cc D5W		(b)(6)-2
[redacted]		[redacted] RN

NURSING UNIT | ROOM NO. | BED NO.

Noted @ 1715 [redacted]

(b)(6)-2

all (b)(6)-4 (with one exception that is individually annotated)

all (b)(6)-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]

Noted 1812 17 Jul 03 (b)(6)-2

NURSING UNIT | ROOM NO. [redacted]

DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
17 Jul 03	1800 HOURS	
(1) Δ Vent ↑ Peep 8 ↓ Rate to 12	done 1805	
(2) Chem 12 Now	Done 1805	
(3) Tylenol 650 mg PR Q4° Prn T >101.5		
Vo: Dr [redacted]		
[redacted] For [redacted]		

PATIENT IDENTIFICATION

[redacted]

DATE OF ORDER	TIME OF ORDER	
18 JUL 03	0828 HOURS	
(b) KCl 40 meq / 100 cc NS over 2° (central Line)		
[redacted]		[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted]

DATE OF ORDER	TIME OF ORDER	
18 July 03	0830 HOURS	[redacted]
(1) Chem 7 after current run of KCl		
(2) Δ to MSO4 gtt once fentanyl / gtt		
(3) Reglan 10 mg IV q 8°		
(4) Suction ETT q 4° q prn		
(5) QAM labs CBC, chem 12, ABG		
(6) QAM CXR		

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

[redacted]

DATE OF ORDER	TIME OF ORDER	
18 July 03	1130 HOURS	1130
[redacted]		
19 JUL 03		
(1) KCl 40 meq / 100 NS / 2 Hours		

NURSING UNIT | ROOM NO. | BED NO.

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] (b)(6)-4

NURSING UNIT | ROOM NO | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

19 July 03 | 0930

1 Adjust to icu-p

2 S/P washout / branch

3 Resume all previous orders.

~~4~~ Dilaudid syp per cdiff today

5 QD & prn dressing Δs; 4x4; pack corner of dsg into wound to keep skin edges separated. [redacted] (b)(6)-2

PATIENT IDENTIFICATION

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

NURSING UNIT | ROOM NO | BED NO

DATE OF ORDER | TIME OF ORDER | HOURS

[redacted] (b)(6)-2

6 Wean FiO2 to keep SaO2 >95%

7 chem 7 after run of 40meq KCl

~~8 40mg~~

8 1g MgSO4 in 100cc NS IV w/o

9 ↓ PEEP to 5

10 Repeat ABG 30min after change. (b)(6)-2 [redacted]

PATIENT IDENTIFICATION

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

NURSING UNIT | ROOM NO | BED NO

DATE OF ORDER | TIME OF ORDER | HOURS

19 July 03 | 1130

1 ~~4g NaCl tablets (crushed) per NGT q6h~~ ~~per~~ changed to see below [redacted] (b)(6)-2 [redacted] 1130.

1/10 4g sodium phrg ~~tablets~~ via NG, Rx [redacted] (b)(6)-2 [redacted] (b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT | ROOM NO | BED NO

DATE OF ORDER | TIME OF ORDER | HOURS

1 Continue 4g NaCl p-NGT q6h

2 3% NaCl, 40cc/h x 1000cc

3 500cc NS IV F bolus now please [redacted] (b)(6)-2

Noted @ 1245 [redacted] (b)(6)-2 Cpt AW

CLINICAL RECORD - DOCTOR'S ORDERS

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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] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 19 Jul 03 — TIME OF ORDER: 1940 HOURS — LIST TIME ORDER NOTED AND SIGN

(1) Give 250 cc of 5% Albumin Done
Vo: Dr [redacted] cpt/AW
for [redacted] (b)(6)-2
[redacted] (b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 19 July 03 — TIME OF ORDER: 2130 HOURS

1 Enzone @ 10 cc/°
2 V residuals q 4°, hold [illegible]

Noted [redacted] cpt/AW [redacted] 19 Jul 03 (w/ Odt)
(b)(6)-2 (b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 20 July 03 — TIME OF ORDER: 0945 HOURS

1 D/C 3% NaCl done
2 repeat Nat 0930 done
3 D/C NaCl per NAT.
4 Wean sedation
5 40 KCl in 100 cc NS IV ~2° 1130/done

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 20 July 03 — TIME OF ORDER: 0945 HOURS

(1) D/C TF
(2) Continue sedation

[redacted] (b)(6)-2

Ducolax in colostomy QD until results
V.O. Same / [redacted] (b)(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77 WHICH MAY BE U[redacted]

All (b)(6)-4 All (b)(6)-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			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
#[redacted]			21 July 03	0930 HOURS	
			1	MVI (elixir?) T PNGT QD	
			2	Restart TF @ 20cc/1°	
			3	Erythromycin 500mg PNGT q 6° x 72°	
			4	NPO > MN	
			5	KCl 40meq in 100cc NS N ~ 2°	1130 done
NURSING UNIT	ROOM NO.	BED NO.		Noted @ 1200 [redacted] RN [redacted]	

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
#[redacted]			22JUL03	0626 HOURS	[redacted]
			(1)	↑ Lumbar drainage to 30 cc/hr.	
				[redacted]	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
#[redacted]			22 July 03		
			(1)	Restart NaCl 4g 0905 HOURS	
				pNGT q 6°	
			(2)	KCl 40meq in 100cc NS N ~ 2°	[redacted]
			(3)	MgSO4 2g in 100cc NS IV ~ 2°	
			(4)	Restart TF @ 20cc/1°	13
				[redacted]	
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			T.O. 7/22/03 2150	HOURS	
			(1) D/C erythromycin		
			(2) Mystatin swish & swallow suspension		
			~~10,~~ [redacted] 2mL QID		
			[redacted] TG, M/ DR. [redacted]		
NURSING UNIT	ROOM NO.	BED NO.			

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

MEDCOM - 14455

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

CLINICAL RECORD - DOCTOR'S ORDERS

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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]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 23 July 03 TIME OF ORDER: 1000 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Repeat chem 7; if Na 125 on Lon start 3% NaCl @ 20 cc/° 1200
2. Δ TF to Jevity plus @ 40 cc/° [redacted]
3. ↓ IMV to 8 1100
4. V ABG 30 minutes after Vent change 1130
5. Lasix 20 mg IV this Am 1200
6. KCl 40 meq in 100 cc NS IV ~ 2° [redacted]

PATIENT IDENTIFICATION

ICU-1 #[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 23 July 03 TIME OF ORDER: [redacted] 1000 HOURS

7. D/C chem 12 QAM
8. Δ QAM labs to CBC, chem 7, ABG.

[redacted] Noted 23 Jul 03 [redacted] 1240

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 23 Jul 03 TIME OF ORDER: 1700 HOURS

NPO p MD

V.O. DR [redacted] [redacted]

23 July 03 0720

1. 2 g MgSO4 in 100 cc NS IV ~ 1° done
2. ↑ 3% NaCl to 30 cc/°
3. 40 meq KCl in 100 cc NS IV ~ 2° 1000 done

24 [redacted] [redacted]

PATIENT IDENTIFICATION

#[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 24 July 03 TIME OF ORDER: 1700 HOURS

1. Admit to ICU-1
2. S/P closure (L) TKA
3. Resume all predp order
4. MD to Δ dosg
5. Resume TF @ 20 cc/°.
6. Chem 8

[redacted] 24 July 03

DA FORM 1 APR 79 4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE [redacted]

MEDCOM - 14456

A11 (b)(6)-4

A11 (b)(6)-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

DATE OF ORDER: 25 July 03 — TIME OF ORDER: 0046 HOURS

LIST TIME ORDER NOTED AND SIGN

1. 5 mg Haldol IV Q 1° until ~~[illegible]~~ Relaxed
   MAX 15 mg.
2. 2 mg IV Ativan x 1

[redacted] NP 2 MOS

[redacted] CPT AN

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

#[redacted]

DATE OF ORDER: 25 July 03 — TIME OF ORDER: 0815 HOURS

1. d/c Haldol
2. ↑TF 20 cc/1° q 8° to goal of 80 cc/1°
3. lasix 20 mg IV QAM fine Wh
4. d/c QAM ABG.
5. Keep SaO2 >95% via NC
6. chem 7 @ 1800 today.

[redacted] 25 July 03 0815

NURSING UNIT: KW-1 | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

#[redacted]

DATE OF ORDER: 25 July 03 — TIME OF ORDER: 0815 HOURS

7. 40 meq KCl in 100 cc NS IV ~2°
8. d/c Zantac

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

#[redacted]

DATE OF ORDER: 26 July 03 — TIME OF ORDER: 0820 HOURS

- 40 meq KCl in 100 cc NS IV ~20.
- d/c [redacted]
  20 mg lasix today @ noon
- d/c 3% NaCl
  ~~2 g NaCl p NGT q 8° even~~
- Haldol 2.0 mg PO q 24°
  ↑TF to 80 cc/1°

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

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

2 MEDCOM - 14457 _ 26 JUL 03 @ 1845 MS [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

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 20 July 03 — TIME OF ORDER: 1630 HOURS — LIST TIME ORDER NOTED AND SIGN

1 Aspirin 325mg T PNGT do, 1st dose now

2 Halcion 5mg PNGT @ 1800 daily

Noted @ 1700 [redacted] (b)(6)-2

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 26 Jul 03 — TIME OF ORDER: 1800 HOURS

Clarification:

① Haldol 0.5 mg per NGT @ 1800 daily

[redacted] (b)(6)-2

CPT/N

noted 26 Jul @ 1800 [redacted] (b)(6)-2

24 hr cc Dr 26 Jul 03 @ 1845 hrs

PATIENT IDENTIFICATION

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

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 27 JUL 03 — TIME OF ORDER: 0649 HOURS

(1) Clamp Lumbar Drain

[redacted] (b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

#[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 27 July 03 — TIME OF ORDER: HOURS

(1) CPT q 4° (c̄ nebs)

(2) Albuterol / Atrovent nebs q 4°

(3) Δ Halcion 10mg PNGT @ 1800 daily

(4) D/C reglan

(5) 40 meq KCl in 200 cc NS IV ~ 2° x 2 runs

(6) D/C oral / NGT NaCl supplements

(7) Henlock IVF (b)(6)-2 [redacted]

(b)(6)-2 [redacted]

DA FORM 1 APR 79 4256 REPLAC MEDCOM - 14458 ICH 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] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

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

T.O.

1. D/C TF
2. NGT to LIWS
3. HL IVF

(b)(6)-2

(b)(6)-2 DR [redacted] / [redacted]

PATIENT IDENTIFICATION

(b)(6)-4 [redacted]

done @

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 28 July 03 | TIME OF ORDER 1100 HOURS

1. DC Albuterol
2. DC Larix
3. 500 cc NS IVF bolus now please
4. 40 meg KCl in 100 cc NS IV ~20 done
5. 2 g MgSO4 in 100 cc NS IV ~2° done
6. IVF NS 100 cc/o (b)(6)-2
7. Remove stapler @ leg [redacted] done

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 28 July 03 | TIME OF ORDER 1415 HOURS

1. 500 cc NS IVF bolus please

(b)(6)-2 [redacted]

Noted @ 1630 (b)(6)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 28 Jul 03 | TIME OF ORDER 1600 HOURS

TF to 20cc/hr @ 60° to max of 80cc/hr

2mg Ativan now (done)

Noted @ 1650 (b)(6)-2 [redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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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			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
#[redacted] (b)(6)-4			29 July 03	1610 HOURS	
			1 Diflucan 800 mg N now, then 400 mg N q12°	[redacted] (b)(6)-2	[redacted] 1630
				(b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.			
ICU 1		8			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
#[redacted] (b)(6)-4			29 July 03	1640 HOURS	(b)(6)-2
			1 Please send purple top to lab for Malaria with next fever spike. (101.5)	[redacted]	[redacted] 1680
				(b)(6)-2	[redacted] (b)(6)-2
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
#[redacted] (b)(6)-4			29 Jul 03	1705 HOURS	(b)(6)-2
			1 V.O. Continue Diflucan 200 mg IV q.d. first dose 1800.	[redacted]	[redacted]
			(b)(6)-2 [redacted]	(b)(6)-2 [redacted]	[redacted] (b)(6)-2
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			30 July 03	0915 HOURS	
			1 D/C Vanco		
			2 D/C IVF		
			3 D/C advent		
			4 advance to reg diet		
			5 Δ vitals to q 4°	(b)(6)-2	
NURSING UNIT	ROOM NO.	BED NO.			

Noted @ 1550 [redacted] (b)(6)-2

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

MEDCOM - 14460

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			DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
ICU Pharmacy 1050			28 July 03	1645 HOURS	
			1 Diflucan 400 mg IV now, then 200 mg IV QD.		
#[redacted] (b)(6)-4			2 Vancomycin 1g IV q 12°		
			3 Ceftriaxone 1g IV q 12°		
			4 please send urine for fungus (b)(6)-2		
NURSING UNIT	ROOM NO.	BED NO.	[redacted]		

PATIENT IDENTIFICATION			DATE OF ORDER	[redacted]	
			29JUL03	0638 HOURS	(b)(6)-2 [redacted]
#[redacted] (b)(6)-4			1 LP tray to bedside - in OR.		
			[redacted] (b)(6)-2		
NURSING UNIT	ROOM NO.	BED NO.			

PATIENT IDENTIFICATION			DATE OF ORDER	TIME OF ORDER	
			29 July 03	0830 HOURS	
			1 s/c Halcion		
			2 s/c Haldol		
			3 s/c Ativan		
			4 NT suction q 4° & pm (may use nasal trumpet.)		
NURSING UNIT	ROOM NO.	BED NO.	[redacted] (b)(6)-2		

PATIENT IDENTIFICATION			DATE OF ORDER	[redacted]	
			29JUL03	0908 HOURS	
#[redacted] (b)(6)-4			1 CSF for protein / Glucose Gram Stain Cell Count.		
			[redacted] (b)(6)-2		
NURSING UNIT	ROOM NO.	BED NO.	[redacted] (b)(6)-2		

DA FORM 1 APR 79 4256 REPLA[redacted]AY BE USED.

MEDCOM - 14461

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

(b)(6)-4

#[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 01 AUG 03 TIME OF ORDER: 0644 HOURS

LIST TIME ORDER NOTED AND SIGN

1 To radiology for AP/Lateral lumbar X-rays today.

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

(b)(6)-4

#[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 2 Aug 03 TIME OF ORDER: 1100 HOURS

1 d/c Infusion

2 no labs tomorrow

3 calorie count

4 ensure T can PO TID. [redacted]

(b)(6)-2

PATIENT IDENTIFICATION

(b)(6)-4

#[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 2 Aug 03 TIME OF ORDER: 1200 HOURS

1 esc, chem 8 in AM

2 D axilla drsg to Dry drsg QD & prn

3 d/c Nystatin S/S

(b)(6)-2 [redacted]

(b)(6)-2 [redacted]

PATIENT IDENTIFICATION

(b)(6)-4

#[redacted]

(b)(6)-2 [redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 3 Aug 03 TIME OF ORDER: 0835 H[redacted]

1 Transfer to ICW (b)(6)-2

2 d/c all labs [redacted]

3 d/c MSO4

4 Tylenol #3 T-II PO q 4-6° PRN

(b)(6)-2 [redacted]

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

CLINICAL RECORD - DOCTOR'S ORDERS

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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

(b)(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 3 Aug 03 — TIME OF ORDER: 0830 HOURS — LIST TIME ORDER NOTED AND SIGN

- Axilla Dry sterile dsg QD ✓
1 Dsg Δs - leg Dry sterile dsg QD, c̄ ACE ✓
- abdo W→O c̄ NS BID ✓
2 ✓ Reg diet c̄ ensure supplements, T̄ can TID
3 ✓ Aspiration precautions - HOS ↑ 20° when eating
4 ✓ Spinal fx precautions - log rol only; cannot sit up or get out of bed.

PATIENT IDENTIFICATION

(b)(6)-4 # [redacted] (b)(6)-2

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 3 Aug 03 — TIME OF ORDER: 0830 HOURS [redacted] (b)(6)-2

5 ✓ foley to gravity, record q 8°
6 Ceftriaxone T̄ g N q 12° ✓
7 ASA 325 mg T̄ PO QD ✓
8 MVI T̄ PO QD ✓
9 Tylenol #3 T̄-T̄T̄ po q 4-6° prn ✓
10 Colace T̄ PO QD (100 mg) (b)(6)-2

[redacted]

PATIENT IDENTIFICATION

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

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: ✓ — TIME OF ORDER: HOURS

11 ✓ encourage deep breath/cough q 1° while awake
12 ✓ PT to work with pt in bed - cannot stand
13 Vitals q shift ✓
14 Routine colostomy care ✓ (b)(6)-2

(b)(6)-2

24° V'S Q [redacted] ICTAN 8/4/03 [redacted] 2208.

PATIENT IDENTIFICATION

24° V's Q [redacted] (b)(6)-2

24° V'S [redacted] (b)(6)-2

(b)(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: ICTAN 8/5/03 — TIME OF ORDER: 2108 HOURS

ICTAN 8/6/03 2217

1. Tylenol 325 mg T̄-T̄T̄ po q 4° prn

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

(b)(6)-2

(b)(6)-2

24° V'S [redacted] ICTAN

[redacted] (b)(6)-2

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] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER (b)(6)-2 | TIME OF ORDER (b)(6)-2 | HOURS | LIST TIME ORDER NOTED AND SIGN

8-15-03 2116 [redacted] / CT [redacted]

(1) U/A in AM (b)(6)-2 [redacted] LCTAN.

(b)(6)-2 [redacted]

(b)(6)-2

(b)(6)-2 [redacted] / CTAN 8-15-03 2300

PATIENT IDENTIFICATION

[redacted] (b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.
TCW #2		24 hr/dm

DATE OF ORDER 19 AUG | TIME OF ORDER | HOURS

(1) Δ Foley Catheter

(2) D.Flucan 200 mg po q Δ x 3

(3) Irrigate bladder 250 cc sterile water with 40 mg Gentamycin

(b)(6)-2 [redacted] 19 1900 Noted (b)(6)-2

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

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
[redacted] 0115	[redacted]	

DATE OF ORDER 8/27/03 | TIME OF ORDER | HOURS

1) Elavil 75 mg po q hs

2) Remeron 300 mg po TID

(b)(6)-2 [redacted]

(b)(6)-2 Noted

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
[redacted] — (b)(6)-4		

DATE OF ORDER 31 aug 03 | TIME OF ORDER 0822 | HOURS

(1) DC Rocephin

V.O. Dr [redacted] (b)(6)-2 [redacted] (b)(6)-2

Noted

(b)(6)-2

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

(b)(6)-2

CLINICAL RECORD - DOCTOR'S ORD

F ... of this form, see AR 40-66, the proponent age ... 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] (b)(6)-4

DATE OF ORDER: 07SEP03 TIME OF ORDER: 1246 HOURS

1. May raise head of bed ad-lib
2. Up to chair & shift.
3. D/C Spine Precautions.

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

LIST TIME ORDER NOTED AND SIGN: [redacted] 1331

NURSING UNIT: 1CW #1 ROOM NO.: [redacted] BED NO.: [redacted] 8SEP03

PATIENT IDENTIFICATION

DATE OF ORDER: 15Sept TIME OF ORDER: 1631 HOURS

1. Ambien 10mg qhs PRN
VO Dr. [redacted] (b)(6)-2 [redacted] (b)(6)-2

NURSING UNIT: 24° ROOM NO.: (b)(6)4 [redacted] BED NO.: 8SEP03 [redacted] (b)(6)-2 [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER: 9/28/03 TIME OF ORDER: 2230 HOURS

V.O. Dr. [redacted] (b)(6)-2
Place FTG please

[redacted] RN (b)(6)-2

NURSING UNIT: 1CW1 24° ROOM NO.: (b)(6)-4 [redacted] 30 SEP 03 BED NO.: [redacted]

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT ROOM NO. BED NO.

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

'LINICAL RECORD - DOCTOR'S ORDEF

For this form, see AR 40-66, the proponent agen SG

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]

(b)(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER 07SEP03 (b)(6)-2 TIME OF ORDER 0955 HOURS

LIST TIME ORDER NOTED AND SIGN

1. ~~Transfer ICU - [redacted] - Neuro.~~
2. Diagnosis GSW (multiple) - paraplegia.
3. Condition Good
4. Vitals q 8°
5. Activity Bed Rest, Roll side-side q 2°
6. Nursing D/C Foley, replace/record output if no void 8° after removed.

PATIENT IDENTIFICATION

noted & transcribed 7Sep03 2200 [redacted] 14/AN

(b)(6)-2

NURSING UNIT	ROOM	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

(b)(6)-2

Sacral Decub dressing dry BID - MAT [redacted] to follow.
Colostomy Care.

7. Diet Regular.
8. IV None.
9. Meds Lovenox 40 mg SQ q Day.

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

Multivitamin 1 po q Day.
Colace 100 mg po BID.
Elavil 75 mg po q HS
Neurontin 600 mg po TID.
Tylenol 650 mg po q 4° prn.
Ensure Shake/Equivalent TID & HS.

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER TIME OF ORDER HOURS

10. Lab None.
11. X-Ray - On call for L-Spine Films today.

(b)(6)-2

24° Chart 7Sep03 [redacted] 14/AN

(b)(6)-2

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

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			↓	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
#[redacted] (b)(6)-4				060ct03	0849 HOURS	
			(1)	Discharge to Prison Hospital		
				[redacted] (b)(6)-2		[redacted] (b)(6)-2
NURSING UNIT	ROOM NO.	BED NO.		(b)(6)-2		
ICW1						
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				
PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

All (b)(6)-2 except for 2 at bottom

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. 07 Yr. 2003

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 13	14	15	16	17	18	19	20	21	22	23	24	25	26
7/13	[redacted]	Vitals q 15min then	05	[redacted]													
		Q1hr	22														
7/13	[redacted]	Strict 1's + 0's	05														
			22														
7/13	[redacted]	monitor foley to	05														
		gravity	22														
7/13	[redacted]	NGT LCNS	05														
			22														
7/13	[redacted]	Diet: ~~NPO~~ TF	05														
		goal 2200-2500 kcal/24°	22														
7/13	[redacted]	Bedrest: Activity	05														
			22														
7/13	[redacted]	Vent IMV 14/5/800/	05														
		[illegible]	22														
7/13	[redacted]	Routine Colostomy	05														
		Care	22														
7/13	[redacted]	Δ Axillary, abd dsg q	05														
		day & PRN	22														
7/13	[redacted]	Δ (L) Knee, (R) back	05														
		injury dsg q day & prn	22														
7/13	[redacted]	Call MD for UOP < 500%	05														
		or bleeding or SBP < 90	22														
7/13	[redacted]	bacitracin to (R) toes	05														
		(R) tibia	22														
7/15	[redacted]	Spine precautions, flat	05	/	/	/											
		bedrest log roll to turn	17	/	[redacted]												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P (R) neck exp / ex lap ō Hartmans

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW

[redacted] # [redacted]

(b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

MEDCOM - 14468

All: (b)(6)-2

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
		admit to ICU				
7/13	[redacted]	S/p (R) neck exp / ex lap c̄ Hartmans				
		~~cond critical~~				
		CXR on arrival to ICU	done			
		~~transfer Remaining FFP~~				
		~~transfuse 2 unit PRBC each~~				
		~~unit ~1°~~				
		Warm patient actively to 88°F	done			
		~~routine colostomy care~~				
		Repeat CBC, PT/PTT/ABG when			[redacted]	
		blood transfused				
6/14		CBC, C7, ABG in AM	6/15	6/15	0	[redacted]
6/14		CXR in AM	6/15	0		
16 July	[redacted]	Transfuse 1 unit PRBC x 1 now	16 July	now		
17		TRANSFER 2 UNITS PRBC OVER ①	17 July 03	now		
		2 HR EACH ②	17 July 03			

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

USAPA V1.00

All (b)(6)-2 except for one at bottom

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 17/2	18	19	20	21	22	23	24	25	26	27	28	29	30
17 Jul 03	[redacted]	UNCLAMP LUMBAR	5A	[redacted]													
22 July	[redacted]	DRAIN AND DRAIN 30cc ~~2 ml~~	5A	[redacted]										[redacted]			
		SPINAL FLUID ≥ 1°															
17 Jul 03		CALL MD [redacted] WITH	5A	[redacted]													
		ANY LUMBAR DRAIN	5A	[redacted]										[redacted]			
		PROBLEMS															
~~17 Jul 03~~		~~CLEAR LIQUIDS WHEN~~	~~5A~~														
		~~FULLY AWAKE~~	~~5A~~	~~D/C 17 Jul 03~~													
~~17 Jul 03~~		~~SIPS CLEARS WHEN~~	~~5A~~														
		~~AWAKE MUST TAKE~~	~~5A~~	~~D/C 17 Jul 03~~													
		~~ASPIRATION PRECAUTION~~															
		~~WHEN FEEDING~~															
17 July	[redacted]	Suction BTT q 4° &	05	/	[redacted]												
		PRN	17	/	[redacted]												
17 July	[redacted]	CBC, Chem R, ABG	04	/	/	[redacted]				done							
		q am															
17 July	[redacted]	PCXR q am	04	/	/	[redacted]	done			done							
7-19	[redacted]	QD & PRN drsg Δ's, 4x4	05	/	/	[redacted]											
		pack corners of dressing	17														
		into wound to keep wound															
		edges seperated.															
~~7-19~~	[redacted]	~~[illegible] 4° hatch~~	~~05~~	/	/	/	[redacted]										
		~~[illegible]~~	~~17~~	/	/	[redacted]											

Extubated 24 Jul 03

A'D 23 Jul 03 [illegible]

Rewritten

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAP

MEDCOM - 14470

All (b)(6)-2

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo _____ Yr 2003

Verify by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
[illegible]	[redacted]	CXR on arrival OD PCU	170ct	1 PM	1 PM	[redacted]
	-----	CENTRAL LINE				

170ct	[redacted]	Resp PBC after NEB	170ct	1620	1620	[redacted]
[illegible]	[redacted]	Hold TF [illegible]			1700	[redacted]
[illegible]	[redacted]	Chem 7 ↑ current KCL	18[illegible]	DW	1230	[redacted]
7-19	[redacted]	Chem 7 faster run of 40 mEq KCL	7-19	ASAP	1230	[redacted]
7-19	[redacted]	↓ Peep 5 "	7-19	ASAP	1140	[redacted]
7-19	[redacted]	Repeat ABG 30 min after change	7-19	ASAP	1220	[redacted]
[illegible]	[redacted]	NPO ↑ MN	[illegible]	2400		[redacted]
22[illegible]	[redacted]	Restart TF @ 20cc/hr	22[illegible]	Noon		[redacted]
[illegible]	[redacted]	NPO ↑ MN	[illegible]	[illegible]		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
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USAPA V1.00

All (b)(6)-2 except one at bottom.

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 25	26	27	28	29	30	31	1	2	3	4	5	6
13 July	[redacted]	Vitals q 4°	05	[redacted]												
			17													
13 July	[redacted]	Strict I:O's	05													
			17													
13 July	[redacted]	Monitor Foley to gravity	05													
			17													
13 July	[redacted]	Diet: TF goal 2200-2500 kCal (Verify Plus)	05													
		24-1 20 cc/hr to goal 90 cc/hr	17													
13 July	[redacted]	Activity: Bedrest	05													
			17													
13 July	[redacted]	Routine Colostomy care	05													
			17													
13 July	[redacted]	Δ Axillary, abd dsg q day & PRN	05													
			17													
13 July	[redacted]	ΔD Knee (R) back injury dsg q day and PRN	05													
			17													
13 July	[redacted]	Call MD for UOP 50 cc/h or bleeding or SBP <90	05													
			17													
13 July	[redacted]	Bacitracin to (R) toes (R) tibia	05													
			17													
17 July	[redacted]	Unclamp lumbar drain and	05													
		drain 30cc spinal fluid q 1°	17													
17 July	[redacted]	Call MD [redacted] to lumbar	05													
		drain problems	17													
17 July	[redacted]	Dressing Δ's QD & PRN Pack	05													
		4x4 gauzes in wound to keep	17													
		wound edges separated.														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P (R) neck Ex lap c̄ hartmann's S/P (R) BKA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

All (b)(6) - 2 except one at bottom

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 13	14	15	16	17	18	19	20	21	22	23	24	25	26
16 July	[redacted]	Deep suction Q6°; PRN	06	/	/	/	[redacted]										
			12	/	/	/	[redacted]										
			18	/	/	/	[redacted]										
			24	/	/	/	[redacted]										
16 July	[redacted]	CPT q 4° - log roll	04	/	/	/	/	/	/		[redacted]						
			08	/	/	/	/	[redacted]									
			12	/	/	/	Va	[redacted]									
			16	/	/	/	Wa	[redacted]									
			20	/	/	/	CSK	[redacted]									
			24	/	/	/	CSK	[redacted]									
16 July	[redacted]	PCXR q 8am. q am	04	/	/	/	/	[redacted]									
		Vent setting	05	/			/	[redacted]									
17 July 03	[redacted]	SIMV 14 TV 800, peep 8cm FIO2 100% wean to keep sats 79%	17	/			/	[redacted]									
21 Jun 03	[redacted]	Restart TF @ 20cc/h	05	/													
			17	/													
		✓ residuals Q4° hold residuals 7100															
23 Jul	[redacted]	ΔTF to [redacted]	05														
—		Plus @ 40cc/hr	17														
23 Jul	[redacted]	CBC, Chem 7, ABG, QAM	04														
23 July	[redacted]	CBC, Chem 7 q am	04	/	/	/	/	/	/	/	/	/	/	/	/	/	

D/C [redacted] 1832

Extubated 1905 24 July [redacted]

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

EPW [redacted] (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

All (b)(6)-2

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
16 July	[redacted]	Wean to extubate	16 July	0900		
		~~PCX~~ ERROR				
16 July	[redacted]	NPO P̄ MN	16 July	2400		
17 July	[redacted]	CBC, Mexyl 8, ABG in AM	17 Jul 03	0400	0400	[redacted]
23 Jul	[redacted]	Repeat Chem 7, if Na 125 or less				
		start 3% NaCl @ 20cc/hr				

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

USAPA V1.00

All (b)(6)-2 except bottom one.

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 25	26	27	28	29	30	31	1	2	3	4	5	6	7
16July	[redacted]	CPT q 4° lg roll	04	/	[redacted]												
			08	[redacted]													
			12	[redacted]													
			16	[redacted]													
			20	[redacted]													
			24	[redacted]													
25July	[redacted]	CBC, Chem 8 qam	04	[redacted]													
25July	[redacted]	Keep SaO_2 >95% via ATC	05	[redacted]													
		[redacted]	17	[redacted]													
27Jul	[redacted]	Chest PT Q4	05	/	/	[redacted]											
			17	/	/	[redacted]											
28Jul	[redacted]	PT to 30cc/hr	05	/		[redacted]											
		0° to max OS	17	/		[redacted]											
		80cc/hr															
30July	[redacted]	QD and PRN dsg Δ's	05	/	/	/	/	/	[redacted]								
		pack wound to keep	17	/	/	/	/	/	[redacted]								
		edges seprated															
2Aug	[redacted]	Δ Q8h dsg to	05	—	—	—	—	—	—	—	[redacted]						
		dry dsg	17	—	—	—	—	—	—	—	[redacted]						

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1

All (b)(6)-2

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
25 July	[redacted]	Chem 7 @ 1800 today	25 July	1800	1744	[redacted]
29 July	[redacted]	Purple top for malaria to lab if temp ≥ 101.5				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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USAPA V1.00

All (b)(6)-2 except bottom one

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. 09 Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 31	01	02	03	4	5	6	7	8	9	10	11	12	13
8.3	[redacted]	Encourage deep breathing	6	[redacted]													
		91° WS	18														
8.3	[redacted]	Axilla dry sterile drsg QD	10														
8.3	[redacted]	Abd W→D c̄ NS drsg	10														
		Δ BID	22														
8.3	[redacted]	VS Q shift	6														
			18														
8.3	[redacted]	Routine colostomy care	6														
			18														
8.3	[redacted]	Reg diet c̄ ensure TID	6														
			18														
8.3	[redacted]	Aspiration precautions	6														
		HOB ↑ 20° when eating	18														
8.3	[redacted]	Spinal precautions,	6														
		Logroll only -	18														
		cannot situp / OOB	X														
8.3	[redacted]	P.T. to work c̄ Pt in	6														
		bed, cannot stand	18														
8.3	[redacted]	Foley to gravity	6														
			18														
9/7	[redacted]	May raise head of	06														
		bed ad-lib	18														
9/7	[redacted]	Up to chair q shift	06														
			18														
			18														
			06														

D/C 01SEP03

D/C 9/7

D/C'd

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: L2-5 VERT FX, T12 paraplegia, S/P EX-LAP c̄ colostomy, (L) BKA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78

EDITION OF 1 DEC 77 ...

USAPA V1.00

All (b)(6)-2 Except bottom one

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. 09 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 21	22	23	24	25	26	27	28	29	30	1	2	3	4
07 SEP 03	[redacted]	vitals q8°	06	[redacted]													
			18														
07	[redacted]	Sacral decub dresg ΔBID	10														
		dry-mayl mellon to follow	2[illegible]														
07	[redacted]	Diet: regular	06														
			18														
07	[redacted]	Ensure shake or equiv.	08														
		TID and HS	12														
			17														
			22														
07	[redacted]	may raise HOB and	06														
		1lb	18														
07	[redacted]	up to chair QS	06														
			18														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (multiple) c̄ paralysis

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES

USE PENCIL. CIRCLE ACTION TIMES

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

both (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
9/28	[redacted]	Place FTG please	9/28	2230	2330	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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USAPA V1.00

All (b)(6)-2 Except bottom one

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 ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 5	6
7sep	[redacted]	Vitals q 8°	06	[redacted]	
			18		
7sep	[redacted]	sacral decub drsg Δ	10		
		dry MAJ [redacted] TO Follow	22		
7sep	[redacted]	Diet legular	06		
			18		
7sep	[redacted]	Ensure shake or equiv	08		
		TID and HS	12		
			17		
			22		
7sep	[redacted]	MAY Raise HOB adlib	06		
			18		
7sep	[redacted]	Up to chair QS	06		
			18		

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: C5W (Multiple) C paralysis

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO:

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

(b)(6)-2

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(NON-MEDICATION)*					Mo Oct Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
10/6	[redacted]	D/C to prison hospital	10/6				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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USAPA V1.00

All (b)(6)-2 except bottom one

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. 09 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	13	14	15	16	17	18	19	20
7Sep03	[redacted]	Vital q 8	06-18	X	[redacted]												
			18-06	[redacted]													
			X														
7Sep03	[redacted]	Activity: Bedrest,	06-18	X	[redacted]												
		Roll side-side q2°	18-06	[redacted]													
7Sep03	[redacted]	Sacral Decub Dressng	10	X	[redacted]												
		Δ BID - DRY - Maj	22	[redacted]													
		[redacted] to follow															
			X														
7Sep03	[redacted]	Diet: Regular	08	X	[redacted]												
			12	X	[redacted]												
			17	X	[redacted]												
			X														
7Sep03	[redacted]	Ensure Shake/	08	X	[redacted]												
		Equivalent shake	12	X	[redacted]												
		TID + HS	17	X	[redacted]												
			22	[redacted]													
7Sep	[redacted]	MAY RAISE HOB ADLIB	06	X	X	[redacted]											
			18	X	X	[redacted]											
7Sep	[redacted]	up to chair QS	6	X	X	[redacted]											
			18	X	X	[redacted]											

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (Multiple) = paraplegia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

All (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 09 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
07 Sep03	[redacted]	Condition: good	7Sep03			
07 Sep03	[redacted]	D/C Foley, replace/record output if no	7Sep03			[redacted]
	-----	void 8° after removal				
7Sep03	[redacted]	Labs: NONE		noted		
7Sep03	[redacted]	Xray - o/c for L-Spine Films	7Sep03		done	[redacted]
	-----	today				

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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USAPA V1.00

All (b)(6)-2 except bottom one.

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. 09 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 21	22	23	24	25	26	27	28	29	30	1	2	3	4
07 SEP 03	[redacted]	Lovenox 40mg SQ q	10	[redacted]													
		day															
07	[redacted]	multivitamin 1 po	10	[redacted]													
		q day															
07	[redacted]	Colace 100mg po BID	10	[redacted]													
			22	[redacted]													
07	[redacted]	Elavil 75mg po q HS	22	[redacted]													
07	[redacted]	Neurontin 600mg po	06	[redacted]													
		TID	14	[redacted]													
			22	[redacted]													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (multiple) c̄ paralysis

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO. _____

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

A11(b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. 09 Yr. 03
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													
15sep	[redacted]	Ambien 10mg	D/T	24 2330	25sep 2215	27sep 2130	29sep 2230	1OCT03 2230		2OCT03 2200		3OCT03 2200		4OCT03 2224	5OCT 2305
		qhs PRN	D/I	10mg [redacted]		10mg [redacted]		1 (1mg) [redacted]		1 (10mg) [redacted]		10mg [redacted]		2 [redacted]	2 [redacted]

USAPA V1.00

All (b)(6)-2 Except bottom one.

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. 10 Yr 03

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 5	6	7	8	9	10
7 Sep	[redacted]	Lovenox 40 mg SQ QDAY	10	[redacted]					
7 sep	[redacted]	multivitamin 1 PO QDAY	10	[redacted]					
7 Sep	[redacted]	colace 100mg PO BID	10	[redacted]					
			22	[redacted]					
7 Sep	[redacted]	Neurontin 600mg PO TID	06	[redacted]					
			14	[redacted]					
			22	[redacted]					
7 sep	[redacted]	Elavil 25mg PO q HS	22	[redacted]					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (Multiple) c̄ paralysis

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

All (b)(6)-2 Except bottom one

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. 09 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	13	14	15	16	17	18	19	20
7Sep03	[redacted]	IV: NONE	06-18	X	[redacted]												
			18-06	[redacted]													
7Sep03	[redacted]	Lovenox 40mg SQ	10	X	[redacted]												
		q Day															
7Sep03	[redacted]	Multivitamin ÷ PO	10	X	[redacted]												
		q day															
7Sep03	[redacted]	Colace 100mg PO Bid	10	X	[redacted]												
			22	[redacted]													
7Sep03	[redacted]	Elavil 75mg PO QHS	22	[redacted]													
7Sep03	[redacted]	Neurontin 600mg	06	X	[redacted]												
		PO TID	14	X	[redacted]												
			22	[redacted]													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: GSW (multiple) c̄ paraplegia

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

All (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 09 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
12 SEP03	[redacted]	IV-NONE	12 SEP03	—	—	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
7Sep03	[redacted]	Tylenol 650mg po q4° PRN	D/T/I	08SEP 1400 [redacted]	9Sep 2350 [redacted]	10 11SEP03 0030 650mg [redacted]		11SEP03 2012 650mg [redacted]		12SEP03 2000 650mg [redacted]		13SEP 1740 π [redacted]	14SEP 0030 ¼ [redacted]	15SEP 1930 ¼ [redacted]	15SEP 2315 π [redacted]	18SEP 1930 [redacted]
15Sept	[redacted]	Ambien 10mg ghs PRN po	D/T	[illegible]	19 2300	20 2200	21 2200									
			D/I	[illegible] [redacted]	10mg [redacted]	10mg [redacted]	10mg [redacted]									

USAPA V1.00

All (b)(6)-2 EXCEPT bottom one

CLINICAL RECORD

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

Mo. ____ Yr. ____

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6	7	8	9	10	11	12	13	14	15	16
8.3	[redacted]	VS Q shift.	5	/	[redacted]												
			13	/													
			21														
8.3	[redacted]	Routine Colostomy care	5	/	[redacted]												
			13	/													
			21														
8.3	[redacted]	Reg Diet c̄ ensure supplement 1 can TID.	7	/	[redacted]												
			11	/													
			17	/													
8.3	[redacted]	Aspiration precautions HOB ↑ 20° when eating.	7	/	[redacted]												
			11	/													
			17	/													
8.3	[redacted]	Spinal Fx precautions — log roll only. Cannot sit up or get OOB.	5	/	[redacted]												
			13	/													
			21														
8.3	[redacted]	PT to work c̄ Patient in bed — cannot stand	5	/	[redacted]												
			13	/													
			21														
8.3	[redacted]	Foley to gravity, record Q8U	5	/	[redacted]												
			13	/													
			21														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:
① L2-5 vertebral fxs
② T12 paraplegia
③ ⓛ flank colostomy
④ s/p exlap
⑤ ⓛTKA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

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

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo _____ Yr _____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
8-3	[redacted]	TX to IEW#2	8/3	2100	2115	[redacted]
8-15	[redacted]	UA in AM	8/16	AM	0330	[redacted]
		(b)(6)-2	(b)(6)-2			
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Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
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USAPA V1.00

All (b)(6)-2 except one at bottom.

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

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6	7	8	9	10	11	12	13	14	15	16
8.3	[redacted]	Encourage deep	5	/	[redacted]												
		breathing/ cough	13	/	[redacted]												
		Q1° WA	21	[redacted]													
8.3	[redacted]	Axilla dry/sterile	08	/	[redacted]							1030		1030			
		drsng QD															
8.3	[redacted]	Leg dry sterile drsng	08	/	[redacted]												
		c̄ Ace QD															
												1030					
8.3	[redacted]	ABD W→D c̄ NS	08	[redacted]													
		drsng Δ BID	20														

D/c'd no longer needed

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:
① L2-5 vertebral fxs
② T12 paraplegia
③ ⓒ flank colostomy
④ s/p exlap
⑤ ⓑ IVA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ___

PATIENT IDENTIFICATION:

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

1CW2

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

DA FORM 4677, 1 OCT 78 EDITION OF 1 DEC 77 MAY BE USED. USAPA V1.00

All (b)(6)-2 Except one at bottom.

CLINICAL RECORD

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

Mo. ____ Yr. ____

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 3	4	5	6	7	8	9	10	11	12	13	14	15	16
8·3	[redacted]	Ceftriaxone 1gm	10	[redacted]													
		IV Q8°	22														
8·3	[redacted]	ASA 325mg PO QD	08	[redacted]													
8·3	[redacted]	MVI PO QD	08	[redacted]													
8·3	[redacted]	Colace PO QD (100mg)	08	[redacted]													

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: ① L2-5 ~~fx~~ vertebral frx ④ s/p ex lap
② T12 paraplegia ⑤ ⓛ TKA
③ ⓛ flank colostomy

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION:

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

1CW2

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

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

All (b)(6)-2

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo ____ Yr ____
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED													
8-3	[redacted]	T#3 ⅂-⅂⅂ POQ 4-6° PRN	86-03 2205 ⅂⅂ [redacted]		8Aug 0620 ⅂ po [redacted]	9Aug 2110 ⅂⅂ po [redacted]	10Aug 03 ⅂⅂ po 2023 [redacted]		8-13 2110 ⅂⅂ [redacted]							
8Aug	[redacted]	Tylenol 325mg ⅂-⅂⅂ po Q4° PRN	11Aug ⅂ 1800 [redacted]	14Aug ⅂ 1515 [redacted]	16Aug ⅂⅂ po 1830 [redacted]	18Aug 0622 ⅂⅂ po [redacted]										

USAPA V1.00

All (b)(6)-2 EXCEPT bottom one.

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. 08 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 17	18	19	20	21	22	23	24	25	26	27	28	29	30
8·3	[redacted]	Ceftriaxone ¼ gm	10	[redacted]													
		IV ~~Q8°~~ Q12°	22														
8·3	[redacted]	ASA 325mg ¼ PO QD	08	[redacted]													
8·3	[redacted]	MVI ¼ PO QD	08	[redacted]													
8·3	[redacted]	Colace ¼ PO QD	08	[redacted]													
19	[redacted]	Diffucan 200mg PO qdy x3 dys	10	/	/	[redacted]			/	/							
27 AUG 03	[redacted]	Elevil 75mg po Qhs	22	/	/	/	/	/	/	/	/	/	/	[redacted]			
27	[redacted]	Neurontin 300mg	08	/	/	/	/	/	/	/	/	/	/	/	[redacted]		
		po TID.	16	/	/	/	/	/	/	/	/	/	[redacted]				
			24	/	/	/	/	/	/	/	/	/	/	[redacted]			

Neurotheet

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS:
1. L2-5 vert. Fx
2. T12 paraplegia
3. ① flank colostomy
4. s/p ex-lap
5. ① TKA.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

All (b)(6)-2

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
19	[redacted]	Irrigate bladder c̄ 250cc sterile H_2O c̄ 40mg Gentamycin	19	Today	0900	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
8-3	[redacted]	T#3 ⊤-⊤⊤ PO. Q4-6° PRN	18Aug03 2006 ⊤⊤PO [redacted]	8-19 2141 ⊤⊤PO [redacted]	19Aug 0955 ⊤⊤PO	21Aug 1950 ⊤⊤ All	22Aug 0645 ⊤⊤ All	22Aug 1100 ⊤⊤ VI 10W [redacted]	22Aug03 2100 ⊤⊤ [redacted]	23Aug 0800 ⊤⊤ [redacted]	23Aug 1313 ⊤⊤ [redacted]	23Aug 2030 ⊤⊤PO [redacted]	24Aug03 1900 ⊤⊤ [redacted]			
8-3	[redacted]	Tylenol ⊤-⊤⊤ 325mg tab P.O. Q4° PRN	8-17 213 ⊤⊤ [redacted]	18Aug 0600 ⊤⊤PO [redacted]	18Aug 1235 ⊤⊤PO [redacted]	18Aug03 1700 ⊤⊤PO [redacted]	1900 2000 ⊤⊤PO [redacted]	19Aug 2319 ⊤⊤PO [redacted]	20Aug 0915 ⊤⊤PO [redacted]	24Aug 0810 ⊤⊤ [redacted]	24Aug 2300 ⊤⊤ [redacted]					
8-3	[redacted]	Tylenol #3 ⊤-⊤⊤ PO q 4-6° pm	25AUG 0720 ⊤⊤ [redacted]	25AUG 1530 ⊤⊤ [redacted]	25 2130 ⊤⊤ [redacted]	26AUG 0730 ⊤⊤ [redacted]	26AUG 1330 ⊤⊤ [redacted]	26AUG 1905 2 [redacted]	26AUG 0730 ⊤⊤ [redacted]	26AUG 1310 ⊤⊤ [redacted]	27AUG 1917 2 [redacted]	29Aug 1500 ⊤⊤ [redacted]				
8/27	[redacted]	Percoset ⊤⊤ PO PRN for pain q 4-6°	27AUG 0317 2 [redacted]	28Aug 2230 ⊤⊤ [redacted]	29Aug03 2045 ⊤⊤ [redacted]	30th 1845 ⊤⊤ [redacted]	31 0015 ⊤⊤ [redacted]									

All (b)(6)-2 EXCEPT for bottom one

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 08 Yr. 83

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 17	18	19	20	21	22	23	24	25	26	27	28	29	30
8.3	[redacted]	Encourage deep breathing Q1° WA.;	07	[redacted]													
			13														
			21														
8.3	[redacted]	Axilla dry sterile Drsng QD	08														
8.3	[redacted]	ABOW 7D c̄ NS dvsng BID	08														
			20														
8.3	[redacted]	VS Qshift.	07														
			13														
			21														
8.3	[redacted]	Routine Colostomy care.	07														
			13														
			21														
8.3	[redacted]	Reg Diet c̄ ensure Supplement ↑ C an TID	7														
			11														
			17														
8.3	[redacted]	Aspiration precautions HOB ↑ 20° when eating	7														
			11														
			19														
8.3	[redacted]	Spinal precautions, log roll only, cannot sit up or get OOB	07														
			13														
			19														

Rewritten on new sheet

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS:
① L2-S vert fx
② T12 paraplegia
③ C flank colostomy
④ S/P ex-lap
⑤ C TKA.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

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

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. USAPA V1.00

All (b)(6)-2 EXCEPT bottom one

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. 08 Yr. 03

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

DATE DISPENSED

HR	17	18	19	20	21	22	23	24	25	26	27	28	29	30
07	[redacted]													
13														
19														
07	[redacted]													
13														
19														

new sheets

RECURRING MEDICATIONS, DOSE, FREQUENCY
Pt to work c̄ pt in bed, cannot stand.
Foley 7 gravity, record Q8°

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS:
(1) L2-5 vertebr. fy
(2) T12 paraplegia
(3) (L) Flank colostomy
(4) s/p ex-lap.
(5) (L) TKA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

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	

PATIENT IDENTIFICATION:

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

USAPA V1.00

DA FORM 4 DEC 77 WILL BE USED UNTIL EXHAUSTED.

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*				Mo. 08 Yr. 03
Order Date	**Clerk/ Nurse**	**SINGLE ORDER, PRE-OPERATIVES**	**Date to be Given**	**Time to be Given**	**Time Given**	**Initials**
19	[redacted]	Foley catheter (b)(6)-2	19	Today	0900	[redacted] (b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	*INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION* TIME/DATE DISPENSED													
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(b)(6)-4

USAPA V1.00

[redacted]

All (b)(6)-2 EXCEPT bottom one

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. 08 Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 30	1	2	03	04	5	6	7	8	9	10	11	12	13
8/3	[redacted]	Ceftriaxone + gm	10	Dc'd 31 Aug 03													
		IV 912	22														
8/3	[redacted]	ASA 325mg + po QD	08	[redacted]													
8/3	[redacted]	MVI + po QD	08	[redacted]													
8/3	[redacted]	Colace + po QD	08	[redacted]													
8/3	[redacted]	Elavil 75mg po QHS	22	[redacted]													
8/3	[redacted]	NEURONTIN 300mg	08	[redacted]													
		po TID	14	[redacted]													
			24	[redacted]													

Dc'd

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: L2-5 VERT FX T12 para — S/P EXLAP c̄ colostomy (L) BKA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 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. 09 Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
		All (b)(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
8.3	[redacted]	Tylenol #3 + # po Q4-6 PRN	D/T	2 Sep 11 tab	01SEP 0940	01SEP 1700	02SEP 0705	2SEP 2345	4SEP 0010	4 Sep 0830	4 Sept 1350	4SEP 1433	4SEP 2333	7 Sep 1150	8SEP 2115	
			D/1	1615 12 mo	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2	2	[redacted]	#	
8.3	[redacted]	Tylenol + # 325mg tabs po Q4 PRN	D/T	01SEP 09[illegible]	01SEP 17[illegible]	02SEP 0705	[redacted]	02SEP 1860	03SEP 1730							
			D/1	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
~~8.3~~	[redacted]	~~Percocet # po Q4-6 PRN pain~~	~~D/T~~	~~[illegible]~~												
			~~D/1~~	[redacted]												

USAPA V1.00

All (b)(6)-2 EXCEPT bottom one

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 26	27	28	29	30	31	01	02	03
26Jul03	[redacted]	Aspirin 325mg ½ PNGT QD 1st dose now	08	[redacted]								
26Jul03	[redacted]	Halcion 5mg PNGT @ 1800 daily	18	OK								
27Jul	[redacted]	Albuterol / Atrovent	06	/	[redacted]							
		Nebs Q4	10	/								
			14	/								
			18	/								
			22	/								
			02									
27Jul	[redacted]	Halcion 10mg PNGT 1800 daily	18	/	NOO							
28Jul	[redacted]	IVF NS 100cc/h	05	/	/	[redacted]						
			17	/	/							
28Jul	[redacted]	Diflucan 400mg IV now then 200mg IV QD	19	/	/	[redacted]						
						D/C						
28Jul	[redacted]	Vancomycin 1g IV Q12°	10	/	/	/	[redacted]					
			22	/	/	[redacted]						
28Jul	[redacted]	Ceftriaxon 1g IV Q12°	10	/	/	/	[redacted]					
			22	/	/	[redacted]						
[redacted]	29Jul	Diflucan ~~800~~ 200mg IV ~~Q12°~~ q day	10	/	/	/	[redacted]					
			06	/	/	/						
30July	[redacted]	Diflucan 200mg IV QD	10	/	/	/	/	[redacted]				DC

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

MEDCOM - 14501

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
		All: (b)(6)-2				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED													
17 Jul 03	[redacted]	Tylenol 650mg PR PRN														
		T>101.5														
17 Jul		MSOC 2-6mg IV PRN Q1hr PRN PAIN	2 Aug 03 2000 [illegible]	2 Aug 03 2[illegible] [illegible]	3 Aug 03 0440 [illegible]	3 Aug 03 1330 [illegible]										
			[redacted]													
		T#3 1-2 tabs PO Q 4-6 PRN [illegible]														

USAPA V1.00

All (b)(6)-2 except bottom one

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 20	21	22	23	24	25	26	27
20Jul03	[redacted]	Duolax in colostomy	10	[redacted]							
		QD until results									
20Jul03	[redacted]	mitt (ex/c/a) + PRN	10	/							
		QD									
21Jul03	[redacted]	Erythromycin 500mg	06	X	X	[redacted]	8	12			
		PRN + q6° x 72°	12	X	[redacted]		9	X			
			18	X	[redacted]		12	X			
			24	X	[redacted]			X			
22Jul	[redacted]	~~Restat NaCl 400g~~	24			/	[redacted]				
		~~(1 MRE PKT) per NGT~~	06			/	[redacted]				
		~~q6°~~	12			/	[redacted]				
		~~0~~	18			/	[redacted]				
2/20/03	2	Nystatin 2ML QID°	06	/	/	/	[redacted]				
	2	Pax Movim (scrub in	12	/	/	/	[redacted]				
		mouth in tongue)	18	/	/	/	[redacted]				
			24	/	/	[redacted]					
23Jul	[redacted]	3% NaCl @ 20cc/hr	05	/		/	[redacted]				
			17	/		/	[redacted]				

Allergies: ☐ YES ☐ NO — NKDA

Primary diagnosis: S/P (B) neck exp lap c̄ hemorrhagic

Additional pages in use: ☐ YES ☐ NO — Page No. ___

Patient identification: EDW # [redacted] (b)(6)-4

Dispensing times — Use pencil. Circle med times

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

All (b)(6)-2 EXCEPT bottom one

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 (17 18 19 20 21 22 23 24 25 26 27 28 29 30)
17 Jul 03	------	S/P (2) TKA WAUKEGAN, CENTRAL	8A	[redacted]
	------	LNS, LUMBAR PAIN —	8A	[redacted]
	------	REMAINDER ALL PRE-OP		
	------	ORDERS		
	------			
17 Jul 03	[redacted]	[redacted]		
7/13	[redacted]	ANSSE 1.5 [illegible]	8A	[illegible]
			14	
	------		22	

7/13	[redacted]	ZANTAC 50 MG IV QD HANDS	8A	[redacted]
	[redacted]		14	
	------		22	
	------			
7 Jul	[redacted]	[illegible] NS @ 125/150 cc/hr	8A	[redacted]
	------		8P	

9/Jul	[redacted]	ALBUTEROL 2.5/3ml Q4 HRS	12	[redacted]
	------		4A	
	------		8A	
	------		2P	
	------		6P	
	------		8PA	

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

All (b)(6) - 2

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
17 Jul	[redacted]	Lasix 20 mg IV NOW PLEASE	17 Jul	1330	1330	[redacted]
17 Jul	[redacted]	Albuterol / Atrovent nebulizer. NOW	17 Jul	1540	1540	[redacted]
18 July	[redacted]	40 meq KCL in 100cc NS over 2° via central line	18 July	0700	0800	[redacted]
18 July	[redacted]	40 meq KCL in 100cc NS over 2° via central line	18 July	1200	1500	[redacted]
7-19	[redacted]	Ducolox suppository per colostomy x 1	7-19	ASAP ~~1230~~	1230	[redacted]
7-19	[redacted]	MSG SO4 in 100cc NS IV in 1°	7-19	ASAP	1140	[redacted]
7-19	[redacted]	40 meq KCL in 100cc NS IV over 2°	7-19	ASA	1000	[redacted]
22 Jul	[redacted]	40 meq KCL in 100cc NS over 2°	22 Jul	ASAP	1441	[redacted]
22 Jul	[redacted]	2g MAG SO4 in 100cc NS over 2°	22 Jul	ASAP	1800	[redacted]
23 Jul	[redacted]	Lasix 20 mg IV this AM	23 Jul			[redacted]
23 Jul	[redacted]	KCL 40 MEQ in 100cc NS IV	23 Jul			[redacted]
		over 2 hrs.				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
15 Jul	[redacted]	Albuterol nebulizer														
		to Q4 hrs PRN														
6/7/96	[redacted]	MSO4 2-6 mg IV	5 mg IV 24 July [redacted] 2200	5 mg IV 24 July [redacted] 2204												
		Q1 hr PRN														
17 Jul 03	[redacted]	Tylenol 650 mg PR	17 Jul 2030 650 mg [redacted]	18 Jul 2530 650 mg PR [redacted]	18 July 0630 650 PR [redacted]	18 July 1400 650 PR [redacted]	18 July 2100 650 PR [redacted]	19 Jul 0400 650 PR [redacted]	7-19 1500 650 PR [redacted]	7-19 1400 PR [redacted]	7/20 [redacted] 7/22 1945					
		PRN TYLOLS														

USAPA V1.00

All (b)(6)-2 EXCEPT bottom one

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 17	18	19	20	21	22	23	24	25	26	27	28	29	30
17 Jul	[redacted]	G Sutamian 300mg IV	18	[redacted]										D/C			
		QD															
17 Jul	[redacted]	Fortaz 2 GM IV	6														
		Q 8 AM	2														
17 Jul	[redacted]	Versed gtt	05	[redacted]										D/C'd			
			17														
17 Jul	[redacted]	Zosyn 3.375 gm	06														
		IV Q6° 1st dose	12											D/C			
		now	18														
			24														
17 Jul	[redacted]	Cipro 400mg IV	06											D/C			
		Q12° 1st now	18														
18 July	[redacted]	NSO4 gtt	06														
			18														
18 July	[redacted]	Reglan 10mg IV q8°	08														
			16											D/C			
			24														
19 Jul 03	[redacted]	4g Nach p-not Q6	06														
			12														
			18														
			24														
19 Jul 03	[redacted]	3% NACL @ 40 cc/hr															
19 Jul 03	[redacted]	Swsure @ 10 cc/hr	06														
			17														

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

MEDCOM - 14506

All: (b)(6)-2

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
19 Jul 03	[redacted]	3% NACh @ 40 cc/hr X 1000 cc	19 Jul 03	1740		
19 Jul 03	[redacted]	500 cc IV Bolus Now	19 Jul 03	1700	1700	[redacted]
28 Jul 04	[redacted]	5mg Haldol IV Q1° until Relaxed	5mg	0048	25 July 04	[redacted]
	-----	MAX 15mg MAX	5mg	0130	25 July	[redacted]
	-----		5mg	DC - 25 July 03		[redacted]
	-----	Ativan 2mg Ativan X 1	28 July 04	0055 Now		[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
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USAPA V1.00

All (b)(6)-2 EXCEPT bottom one.

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. July Yr. 03

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

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 25	26	27	28	29	30	31	01	02
16 July	[redacted]	NS @ 125cc/hr	05	[redacted]	[redacted]	[redacted]						
			17	[redacted]	[redacted]	[redacted]						
16 July	[redacted]	Albuterol 2.5mg/3.0cc q 4°	04	/		[redacted]						
			08	[redacted]	[redacted]	[redacted]						
			12	[redacted]	[redacted]	[redacted]						
			16	[redacted]	[redacted]	[redacted]						
			20	[redacted]	[redacted]	[redacted]						
			24	[redacted]	[redacted]	[redacted]						
17 July	[redacted]	Gentamycin 300mg IV q D	18	[redacted]	[redacted]							
		Zosyn 3.375gm IV q 6°	06	[redacted]	[redacted]							
			12	[redacted]	[redacted]							
			18	[redacted]	[redacted]							
			24	[redacted]	[redacted]							
17 July	[redacted]	Cipro 400mg IV q 12°	06	[redacted]	[redacted]							
			18	[redacted]	[redacted]							
		Reglan 10mg IV q 8°	08	[redacted]	[redacted]	[redacted]						
			16	[redacted]	[redacted]	[redacted]						
			24	[redacted]	[redacted]	[redacted]						
20 July	[redacted]	Nystatin 2ml QID	06	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
		per mouth (scrub in mouth	12	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
		and tongue)	18	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
			24	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	
23 July	[redacted]	3% NaCl @ 30cc/hr	05	[redacted]	[redacted]							
			17	[redacted]	[redacted]							
25 July	[redacted]	Lasix 20mg IV q am	06	[redacted]	[redacted]	[redacted]						
26 July	[redacted]	Haldol 2.0mg po	10	[redacted]	[redacted]	[redacted]						
		Q 2 98										

D/C 1x 26 July 03 @ 0820 hrs

D/C'D 27 Jul 03

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

EPW II [redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

All : (b)(6)-2

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	
25 July	[redacted]	40 meq KCl in 100cc NS IV over 2°	25 July	0900			
27 Jul	[redacted]	40 meq KCl in 100cc NS IV over 2°	27 Jul			done	
	-----	X 2	27 Jul				

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
12 July	[redacted]	Tylenol 650 PR PRN T>101.5	[redacted]													
12 July	[redacted]	Morphine 2-4 mg IV PRN Q1H	7-26-03 0129 4mg	26 Jul 0230	[redacted]	[redacted]	26 Jul 1140 5mg	28 Jul 1245 5mg	30 July 1230 [redacted]	8/31 July 1000	8/31 July am	8/1/03 July Noon	8-1-03 7:15 Clerk 3mg	8-1-03 7:15 TB 3mg	8-1-03 7:15 [redacted] 3mg	8-1-03 8:15 [illegible] 2mg
			[redacted]	[redacted]	[redacted]	[redacted]				[redacted]	2200	0800				
10 Jul		Morphine sulfate 2-4 mg IV PRN PRN Q4H	[redacted] 0001 8/2													

USAPA V1.00

All: (b)(6)-2 Except bottom one.

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	DATE DISPENSED 13	14	15	16	17	18	19	20
7/13	[redacted]	~~IVF RLS @ 125cc/hr~~	06	[redacted]							
			22	[redacted]							
7/13	[redacted]	Ancef 1g IV q 8°	06	/	[redacted]				[redacted]		
			14	[redacted]							
			22	[redacted]							
7/13	[redacted]	Zantac 50mg IV q8°	06	/	[redacted]						
			14	[redacted]							
			22	[redacted]							
7/13	[redacted]	propofol gtt, titrate to effect	05	[redacted]				/			
			22	[redacted]							
7/14	[redacted]	IVF to NS @ 150cc/hr	05	/	[redacted]						
			17	/	[redacted]						
7/14	[redacted]	Albuterol Neb 0.5 cc in 2.5 NS	04	/							
		Atrovent q4 hrs	08	/	[redacted]						
			12	/							
			16	/	[redacted]						
			20	/	[redacted]						
			24	/	[redacted]						

Renal Hem see new order sheet

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: s/p (R) Neck exp/ex lap (L) Hartmans — (L) penetrating wound from (R) SVG

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.:

PATIENT IDENTIFICATION:

EPW. [redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

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

All: (b)(6)-2

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
7/13	[redacted]	transfuse 4 units PRBC's / T unit FFP	13 July 14	ASAP	1330	[redacted]
7/14	[redacted]	SOBCC US bolus	7/14	ASAP	0005	[redacted]
7/14	[redacted]	SOBCC US bolus	7/14	ASAP	0930	[redacted]
7/14	[redacted]	ABG post bolus infusion	7/14	ASAP	[illegible]	[redacted]
7/15	[redacted]	250 5% Albumin	7/15	ASAP	1345	[redacted]
7/15	[redacted]	STAT CXRay	7/15	ASAP	done	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
6/14/13		MSO4 2 tims IV 9 1/2	6mg 0001 13 July	6mg 0100 13 July	—	[illegible]										
7/15	[redacted]	albuterol tog 4° prn	[redacted]	[redacted]		[illegible]										
7/15 PR		Tylenol 650 mg	650mg PR 7/15	650mg PR 7/17		[illegible]										
		Pre Cure	PR	[redacted] 0200		[illegible]										

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

(b)(6)-2

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME		INITIALS [redacted]	1730	INITIALS [redacted]		INITIALS
NEURO	PUPILS	PERRLA.		3mm PERRLA			
	SENSORIUM	RESPONSIVE TO PHYSICAL & VERBAL STIMULI		Responsive to Painful Stimulus			
RESPIRATORY	RESPIRATORY PATTERN	BILATERAL & NORMAL		Vent - Unlabored			
	BREATH SOUNDS	AUDIBLE UPPER LOBES		Crackles throughout			
	SECRETIONS	ORAL SUCTION PRN		Diminished Rales Suction - PRN Gray			
SKIN	COLOR	PALE		Pale, Warm, Dry			
	INTEGRITY	WOUNDS TO SIDES AND (R) LKA		Wounds (R) Lower back (L) Lower Back			
IV SITE	LOCATION	(R) ARM A-LINE		(R) Underarm - Sero Sanq			
	CONDITION	(R) ARM NS. PATENT. PATENT.		L Leg - Sero Sanq Medial Arm CDI (R) Leg - CDI			
GASTRO	ABDOMEN	SOFT		Soft N-T			
	BOWEL SOUNDS	ABSENT		(+) BS			
GU	URINE:	FOLEY		Foley			
	COLOR/CLARITY	DARK YELLOW/ CLEAR.		Dark Yellow			
CARDIOVASCULAR	CARDIAC RHYTHM	SR; PAINFUL.		S.S.A			

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] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 2nd

DATE:

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

EPW# [redacted] — (b)(6)-4

ICU #1

☐ 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)

44.1

E	DX													HOSPITAL DAY			
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line	148	164	142	134	139	125	150	153		135	142	155	152			142	143
BP Cuff	78	78	68	67	75	75	80	70		72	77	77	72			69	68
Temperature	38.2	38.3	37.9	37.8	37.3	37.1	37.1	37.7		37.8	38.1	38.7	39			35	40
Pulse	122	121	119	115	112	115	103	110		120	122	128	125			142	144
Respiratory Rate	33	25	24	22	22	25	17	20		24	28	24	25			37	37
SpO2	96	95	97	95	98	97	97	99		99	98	98	100			97	96
Mode	NC	FM	FM	FM	FM	FM	FM	FM		FM	FM	FM	FM			FM	FM
O2	4L	10L	10L	10L	10L	10L	10L	10L		8L	8L	5L	100			10L	10L
spin																	
intermittent																	
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15
NS	125	125	125	125	125	125	125	125	1000	125	125	125	125			125	625
Fent	10	10	10	10	10	10	12	12	84	12	12	12	12			12	60
Zantac							50		50							50	50
Pas cf f							50		50							50	50
NS ≈ 40 mg/kg																50	50
TOTALS									1184								835
URINE HOUR / TOTAL	120 / 120	120 / 240	120 / 360	140 / 500	100 / 600	120 / 720	200 / 920		420	160 / 180	80 / 240	160 / 400	130 / 530			1250 / 1780	1080 / 2780
URINE sp gr																	
URINE S/A																	
NG OUTPUT																	
NG pH																	
NG tube GUIAC				200			50	250	250	10		25					85
EMESIS																	
STOOL																	
DRAINS Lumbar																12	19

SURGERY

Respiratory

[redacted] (b)(6)-4

#4.7

DAY

	16	17	18	19	20	21	22	23	
BP	142/66	140	78	165/59	140/52	126/53	105/60	94/56	
		46	46						
TEMP 46.2		44	38	38.7	39.3	39.3	39.5	38.7	
PULSE 48			39.4	123	135	148	139	132	
RR 46		14	13	16	17	20	17	13	
SPO2 99		100	97	100	100	96	97	99	
MODE FM									
O2 02									

	16	17	18	19	20	21	22	23	8° T
NS 125/hr 125		125	150	150	150	150	150	150	1150
Fentanyl 12		12	20	20	20	20	20	20	144
			4	4	5	7	6	5	31
			500						500
				100	50			50	200

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

DTSG APPROVED (Date) QA Appr 8 Mar 89

14 JUL 88

INITIAL SHIFT ASSESSMENT

NEURO	TIME	0600	INITIALS [redacted]		INITIALS	[redacted]	INITIALS [redacted]
	PUPILS	4mm brisk perrla					
	SENSORIUM	sedated c propofol					
		fentanyl drip.					
				(b)(6)-2			
RESPIRATORY	RESPIRATORY PATTERN	even & unlabored					
	BREATH SOUNDS	CTA diminished base					
	SECRETIONS	none					
		SIMV 40/VT 800					
		peep 5 RR 10.					
		ETT # 7 24cm lip.					
SKIN	COLOR	appropriate for race					
	INTEGRITY	see wound note.					
IV SITE	LOCATION	L SC PIV					
	CONDITION	patent					
	L.	L Sem. Cordis					
	C.	patent.					
	L.	L. Rad d-line,					
	C.						
GASTRO	ABDOMEN	firm distended					
	BOWEL SOUNDS	hypo BS LQ.					
		NG/Rowe GS					
		Quad stoma pink, drainage.					
GU	URINE	amber same					
	COLOR/CLARITY	sediment FTG.					
CARDIOVASCULAR	CARDIAC RHYTHM	ST S ectopy	+2 radial pulses				
		120s-130s BP lyal	+1 pedal pulses				
		sclera edema					
		+1 non pitting bilat UE					
		+2 non pitting					

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; SA - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

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

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

[redacted] (b)(6)-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)

[redacted] (b)(6)-4

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS	
EYES OPEN	SPONTANEOUSLY	4	
	TO SPEECH	3	
	TO PAIN	2	
	NO EYE OPENING	1	1
BEST VERBAL RESPONSE	ORIENTED	5	
	CONFUSED	4	
	VERBALIZES	3	
	VOCALIZES	2	
	NO VOCALIZATION	1	1T
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		✓
LIMB MOVEMENT — LEGS	NORMAL POWER		
	MILD WEAKNESS		
	SEVERE WEAKNESS		
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		✓
PUPILS — RIGHT	SIZE		4
	REACTION		+
PUPILS — LEFT	SIZE		4
	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 use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	INITIALS	INITIALS	1730	INITIALS [redacted]
NEURO	PUPILS	0600				
	SENSORIUM	2mm sluggish pupils. crossable to physical stimuli unable to move lower extremities responds to painful stimuli T-12			SLUGGISH 2MM PERRL isolated prev/Pent - breathing tube - moves to B/L off CV meds	
RESPIRATORY	RESPIRATORY PATTERN	even unlabored				
	BREATH SOUNDS	CTA diminished @ bases			CTA diminished	
	SECRETIONS	Small amount clear ET tube			Sats 96-100	
		Deep suction q 1-2 hr to ETT & suction q hr.			Lungs diminished Sats 100, PEEP 5, 40%	
SKIN	COLOR	appropriate for race			- NSR	
	INTEGRITY	no wound care			- O2 amp, - DSEC/pH - multiple ABG & CXR	
IV SITE	LOCATION	R SC, R FJ			- Diuresis (A) UC	
	CONDITION	patent			- (+) flow, patent access	
	L femoral	pain			- (-) redness	
	L radial A-line	patent				
GASTRO	ABDOMEN	Firm distended [redacted] (b)(6)-2			Firm, tense	
	BOWEL SOUNDS	ABS (+) and decreasing. Stool pink, brown semi-formed. medium clear loop.			(+) bowel sounds	
GU	URINE	brown foley c			dark/tea colored, 25 cc/hr	
	COLOR/CLARITY	sediment.				
CARDIOVASCULAR	CARDIAC RHYTHM	NSR - ST 5 ectopy (+) PVD +2 radial pulse +1 (R) pedal pulse.			NST, PVCs, +2 pulse, cool, cap x 4, edematous w/ pitting	

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 Quest

DATE: 7-15-03

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)

(b)(6)-2 [redacted]

EMW

15 JUL 03

POST-OP DAY

16	17	18	19	20	21	22	23	
145	68	139	117	154	143	178	113	
71		51	21	60	60	67	56	
374					383			
118	119	115	143	135	139	136	126	
10	60	10	19	12	7	10	10	
97	95	98	96	100	97	97	97	
SINV	SINV	SINV	SINV	SINV	SINV	SINV	SINV	
40	40	40	40	40	40	40	40	

HOSPITAL DAY

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
Arterial Line				100	110	112	120				121	110	130	129	122			
CVP/Cvl				60	59	62	57				59	57	67	70	55			
Temperature				35.9	36.0	36.3	36.2	CT			35.8				37.0			
Pulse				93	97	99	100				110	107	101	111	110			
Respiratory Rate				10	10	10	10				10	10	10	10	10			
Sats				100	100	100	100				100	100	100	100	100			
Mode				SIMV	SIMV	SIMV	SIMV				SIMV	SIMV	SIMV	SIMV	SIMV			
FiO2				40	40	40	40				40	40	40	40	40			

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF - NS				150	150	150	150	75		75	150	150	150	150	150			
Aqua					5.4	6.8	6.8				6.8	6.8	6.8	6.8	6.8			
Fentanyl								5			5	5	5	5	5			
TOTALS																		

		TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE		HOUR / TOTAL						100 / 100					150	50	50	50	50			
		Urine																		
		Sta																		
NG		OUTPUT																		
		pH																		
		GUIAC																		
EMESIS																				
STOOL																				
DRAINS																				
TOTALS																				

Surgeon's
100mcg fent.
20 vec
1 PRBC
1 hespan

~~15 JUL 03~~

[redacted] (b)(6)-4

400cc crystalloid
200cc urine
q8h 200cc

NEUROLOGICAL ASSESSMENT

		HOURS	06
COMA SCALE	EYES OPEN	SPONTANEOUSLY 4	
		TO SPEECH 3	
		TO PAIN 2	2
		NO EYE OPENING 1	
	BEST VERBAL RESPONSE	ORIENTED 5	
		CONFUSED 4	
		VERBALIZES 3	
		VOCALIZES 2	
		NO VOCALIZATION 1	1T
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6	
		LOCALIZES PAIN 5	
		FLEXION WITHDRAWAL 4	
		ABNORMAL FLEXION 3	
		EXTENSION TO PAIN 2	
		NO MOTOR RESPONSE 1	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	7
		REACTION	+
	LEFT	SIZE	7
		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		06	08	11
	R	+	+	+
	L	−	−	−
	R			
	L			
	R			
	L			
	R			
	L			
	R			
	L			

LEGEND

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

447 15 J2 L 03

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

16 July 03

OTSG APPROVED (I

QA Appr 8 Mar 8

INITIAL SHIFT ASSESSMENT

	TIME	WG 0800	INITIALS [redacted]	1830	INITIALS [redacted]		INIT
NEURO	PUPILS	PERRLA 3mm (b)(6)-2		3 mm Perrla (b)(6)-2			
	SENSORIUM	Sedated, responds to stimulus		A&O pt flat on back. Moves uppers only.			
RESPIRATORY	RESPIRATORY PATTERN	Reg.		even & unlabored			
	BREATH SOUNDS	Coarse, diminished bases.		clear in uppers diminished in bases. Sats @ 97% on 4L of O2 @ 1830.			
	SECRETIONS						
SKIN	COLOR			Normal for Race			
	INTEGRITY	See progress note		multipule GSW dsgs to back, leg, flank			
IV SITE	LOCATION	(L) FA x2		(L) FA x2			
	CONDITION	CD/I		Intact and flush well Ø s/s of infection			
GASTRO	ABDOMEN	Firm, flat. colostomy		Lg Flat, colostomy			
	BOWEL SOUNDS	Absent NG to LIS		BS Absent x4 quads. NG Tube to LIS. NPO			
GU	URINE:			foley to gravity			
	COLOR/CLARITY	Dark yellow/clear		dark yellow/clear >100cc/hr			
CARDIOVASCULAR	CARDIAC RHYTHM	ST HR 100-110's. (L) DP +1, UE +2 bilat.		ST 120's febrile 38.8 at pulses in uppers and RLE. Generlized 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

PREPARED BY (S[redacted]le) [redacted] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 2 unit

DATE: 16 July 03

(Continue on revers

PATIENT'S IDENTIFIC[redacted] or typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

[redacted] (b)(6)-4

16 JUL 03

☐ HISTORY/PHYSICAL ☐ FLOW CHA

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (S)

☐ DIAGNOSTIC STUDIES

UL03

E	DX													HOSPITAL DAY			
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line	119	130	130	122	137	143	135	109		120	100	126	142	131	143	134	117
~~BP Cuff~~	65	60	65	62	64	70	65	62		68	67	64	67	68	69	67	65
Temperature	38.1	38.0	37.9	37.9	37.8	37.6	37.6	37.2		37.3	37.3	37.3	37.4	37.4	37.6	37.6	37.7
Pulse	129	123	121	121	115	112	112	110		110	109	118	115	113	122	119	121
Respiratory Rate	17	10	10	10	10	10	15	10		15	12	21	21	20	24	22	22
Sats	98	100	100	100	97	100	99	100		100	99	97%	94%	97%	94%	96	94
MODE	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV		SIMV	SIMV	6LSM	6LSM	6L	8LSM	8LSM	8LSM
FiO2	40	40	40	40	40	40	40	40		40	40						
pain																	
intervention																	
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15
NS	150	150	150	150	150	150	150	150	1200	150	150	150	150	150	150	150	150
~~BO~~ Fent	3	3	3	3	3	3	3	3	24	3	4	4	4	4	4	6	6
Prop.	9.6	19.2	9.6	9.6	12.0	12.0	16	19	107	7	12	0	0	0	0	0	0
BOLUS																	
ABY							100		100								
TOTALS									1431								
URINE HOUR / TOTAL	50	50 / 100	50 / 150	70 / 220	70 / 290	70 / 355	90 / 445	60 / 505	505	75 / 75	100 / 175	100 / 275	180 / 455	170 / 620	200 / 820	180 / 950	140 / 1070
URINE sp gr																	
URINE S/A																	
NG OUTPUT																	
NG pH																	
NG GUIAC																	
EMESIS																	
STOOL																	
DRAINS																	

1254

102

[redacted] (b)(6)-4

SIMV 30%, 7, PEEP 5, SUCTV
- JUL: 7.37, 36.2, 53, 21, 86, -4

DAY									
	16	17	18	19	20	21	22	23	
B/P	115	109	125	131	136	113	125	142	
	66	61	74	71	68	66	70	71	
Temp	37.8	37.7	38.0	38.1	38.1	38.8	38.1	37.9	
HR	126	130	126	121	117	127	119	114	
RR	22	22	23	24	23	26	24	25	
SAT	94	96	97	98	97	97	97	97	
O2	6L	6SM	6L	4L	4L	4L	4L	4L	
mode			NC	NC	NC	NC	NC	NC	
	16	17	18	19	20	21	22	23	8°T
NS	150	150	150	150	150	150	150	150	
Cent	6	8	8	8	8	8	10	10	
Abx	100								
	120/100	120/240	130/370	130/500	180/680	200/880	120/1000	180/1180	
NG	600								

ACUITY LEVEL CLASSIFICATION

RESPIRATORY		TIME	0000	0400	0800	0800	0930	1200
		MODE	SIMV	SIMV	SIMV	SIMV	SIMV	CSM
		F_IO_2	40	40	40	40	40	—
		TV	800	800	800	800	800	—
		RATE	10	10	10	7	7	—
		PEEP	5	5	5	5	5	—
ABG		pH	7.389	7.36		7.30	7.36	7.38
	A	PCO_2	33.7	37.8		42	37	35
		pO_2	88	107		95	81	69
	B	HCO_3	21	22		21	21	21
		SAT	97	98		97	96	93
	G	BASE	-4	-4		-5	-4	-5

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

wt Yesterday _____ wt Today _____

INTAKE: IV _____ po _____

OUTPUT: Urine: _____

NURSE'S SIGNATURE

[redacted] CNT/AN

(b)(6)-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): OBKH, OKAH

Date: 17 Jul 03
Time In: 1300
Allergies: _____ OR Intake: Crystalloid 1300 Colloid _____
Pre-op V/S: _____ OR Output: UOP 400 EBL 0
Procedures: _____ Meds/Times: _____

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

2U PRBCS
155/71
125

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

Pre Op Meds History

Time																
SaO2																
FiO2																
Methods																
240																
220																
200																
180																
160																
140																
120																
100																
80																
60																
40																
20																
RR																
T																
Time																
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			
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			
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain			
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic			
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,			

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 & Title): [redacted] RN

DEPARTMENT/SERVICE/CLINIC: ICU-7

DATE: 17 Jul 03

PATIENT'S IDENTIFI[redacted] (Name - last, first, middle; grade; da[redacted]ital or medical facility)

(b)(6)-2

[redacted]

(b)(6)-4

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

MEDICAL RECORD—SUPPLEMENTAL M[illegible]CAL 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	0500	INITIALS [redacted]	1700	INITIALS [redacted] (b)(6)-2	INITIALS
NEURO	PUPILS	PERRLA (b)(6)-2		3mm PERRLA		
	SENSORIUM	Sedated rent/versed.		Sedated, Withdraws to Pain		
RESPIRATORY	RESPIRATORY PATTERN	Reg/Vent		~~Reg~~ Vent		
	BREATH SOUNDS	Coarse c̄ exp crackles.		Coarse c̄ exp crackles		
	SECRETIONS	Thick yellow per report.		Yellow Sputum Via ET		
SKIN	COLOR	WNL		WNL		
	INTEGRITY	see progress note		see Progress notes		
IV SITE	LOCATION	3 lumen (L) SC		TL (L) SC		
	CONDITION	Ø S/S infection		Ø S/S WA		
		(L) radial arthrine		(L) A-Lin		
GASTRO	ABDOMEN	Rnn/Flat		Soft/NT		
	BOWEL SOUNDS	Absent		Ø BS		
		NG drainage green Mud.		NG to LS		
GU	URINE:					
	COLOR/CLARITY	dark yellow, small and sediment.		Dark Yellow		
CARDIOVASCULAR	CARDIAC RHYTHM	ST		ST		
		Radial pulses +2 bilat.		to Pulse BUE		
		LLE +1 DP		LLE +1		
		RLE BKA		RLE BKA		

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)

PREPARE[illegible] (Signature & [illegible]le)
[redacted] CPT/AN (b)(6)-2

DEPARTMENT/SERVICE/CLINIC
ICU Quest

DATE
7-18-03

PATIENT'S IDE[illegible] or typed or written entries give: Name—last, first, middle; grade; da[illegible]ospital or medical facility)

EPW # [redacted] (b)(6)-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)

18 July 03

18 Jul 03 Mult GSW s/p Colostomy s/p (D)BKA s/p Lumbar Drain

E	DX													HOSPITAL DAY			
TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line	110/53	93/47	127/58	129/56	133/65	118/55	117/57	141/63		127/58	129/60	114/61	124/64	114/56	114/53	95/57	101/56
BP Cuff	102/54	96/54	132/75	111/63	114/61	105/55	107/59	101/54			115/69	115/69	107/80	121/60	112/65	104/80	104/80
Temperature	38.5	38.5	38.6	38.3	38.1	38.4	38.2	38.1		37.9	37.8	37.7	37.7	37.7	37.8	38.0	38.0
Pulse	133	133	128	126	124	125	121	121		121	123	119	109	112	127	125	119
Respiratory Rate	12	13	13	12	12	13	13	13		12	12	12	12	12	12	12	12
Spo2	100	94	100	100		100	100	100		100	100	100	100	100	100%	100	100
						SIMV	SIMV	SIMV		SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
						12	12	12		12	12	12	12	12	12	12	12
						.50	.50	.45		.40	.40	.40	.40	.40	.35	.35	.35
pain																	
intervention																	
TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15
IVF (LR)	150	150	150	150	150	150	150	150	1200	150	150	150	150	150	150	150	150	1200
Fentyal	20	20	20	20	20	10	10	10	130	10	10	10	10	10	10	10	7	77
Versed	5.5	5.5	5.5	5.5	5.5	5.5	5.5	6	45	6	6	6	6	6	6	6	5	47
IVPB	50	~~50~~						150	200	100	100				50	50	100	400
TOTALS									1525									1724
URINE HOUR / TOTAL	60/60	65/125	60/185	40/225	100/325	60/585	90/475	100/575	95/575	100/575	90/660	160/340	90/430	100/530	80/610	95/705	70/775	
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
~~Emesis~~ Lumbar	0	20	10	20	20	20	20	20	130	20	20	15	20	20	10	20	20	145
STOOL																		
DRAINS																		

total out 705

922

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

DAY

	16	17	18	19	20	21	22	23	
	104/65	120/65	118/67	134/67	67/83	146/53	147/68	62/75	
	104/60								
	[illegible]	38.2	38.3	38.0	38.1	38.4	38.3	38.3	
	121	125	123	117	121	127	114	114	
	12	12	13	13	13	12	13	12	
	98	97	97	100	100	100	100	100	
FiO2		35							

	16	17	18	19	20	21	22	23	8° T
IVF	150	150	150	125	125	125	125	125	1178
Ferd	7	7	7	10	10	10	10	10	71
Verbel	4	4	4	4	4	4	4	4	32
MSOY									
WPB			250	100			50		400
									1678
	90/90		160/250	95/345	120/465	190/645	195/840	130/970	970
									50
Lumber	20	18	18	20	20	20	20	20	156

1724
1525

1126

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME	04	04					
		MODE	SIMV	SIMV					
		F_iO_2	60	50					
		TV	800	800					
		RATE	12	12					
		PEEP	8	8					
	A	pH	7.43						
	A	PCO_2	39.3						
	B	pO_2	161						
	B	HCO_3	26						
	G	SAT	99						
	G	BASE	+2						

LABORATORY DATA	TIME	0400						
	GLUCOSE	115						
	Na/K	137/2.8						
	Cl/CO_2	103/26						
	BUN/Cr	11						
	WBC/PLATELET	13.2/149						
	Hct/Hgb	33.4/10.7						

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

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE
IV 4927
po

OUTPUT
Urine: 2310
Lumber 431
50
2791

NURSE'S SIGNATURE
[redacted] AN
(b)(6) - 2

For MEDICAL RECORD—SUPPLEMENTAL MEDICAL DAT
this form, see AR 40-66; the proponent agency is the Office of The ral

REPORT TITLE
INTENSIVE CA RSING FLOW SHEET (b)(6)-2

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	0600	INITIALS [redacted]	1700	INITIALS [redacted]		INITIALS
NEURO	PUPILS		4mm fixed ~~[illegible]~~		3mm sluggish			
	SENSORIUM		Sedated & nursed in bed		Sedated & nursed			
			non cooperative [illegible]		[illegible]			
RESPIRATORY	RESPIRATORY PATTERN		overventilated [illegible]		Vent @ FIO2 35%			
	BREATH SOUNDS		Flex 30, peep 8 RR 10		~~[illegible]~~ CTA ↑ (B)			
	SECRETIONS		ETT 8.5 27cm @		Diminished (B)			
			white/dark, absent [illegible]					
			c. loose, large volume					
			[illegible] secretions					
SKIN	COLOR		jaundiced		jaundiced			
	INTEGRITY		like prepreparata					
I.V. SITE	LOCATION		LSC TL central		LSC TL			
	CONDITION		L Radial A-line		L Radial A-line			
			both patent, A-line					
			correlating c NIBP					
GASTRO	ABDOMEN		Fullness slightly distended, soft softly distended					
	BOWEL SOUNDS		~~(B)~~ BS ~~(B)~~ Bowel sounds ~~(B)~~ BS					
			colostomy stoma ~~[illegible]~~		Colostomy			
			upper slightly dusky [illegible] sanguinous					
GU	URINE:		dark amber [illegible]		DARK AMBER			
	COLOR/CLARITY		Clear					
CARDIOVASCULAR	CARDIAC RHYTHM		ST sinus ~~(B)~~ JVD		ST			
			+2 radial pulse +(B) pedal					

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	DATE
	ICU Quest	

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

CPW [redacted] (b)(6)-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)

CPW [redacted] (b)(6)-4

14 Jul 03

19 Jul 2

DATE

PAGE 2 OF 4

HOSPITAL DAY

VITAL SIGNS	TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
	BP Arterial Line	140/63	141/69	127/54	129/63	133/63	117/63	97/57	120/68		127/65	OR	144/72	98/57	101/58	116/68	135/58	137/62	
	BP Cuff																		
	Temperature	38.4	38.4		38.2	38.7	38.4						37						
	Pulse	121	130	131	125	123	136	120	115		117		116	119	120	123	126	125	
	Respiratory Rate	13	16	13	12	14	10	10	10		10		10	14	13	10	12	12	
	SPO2	100	100	100	100	100	100	100	100		100		100	100	100	100	100	97	
	pain																		
	intervention																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	IVF NS	125	125	125	125	125	125	125	125	1000	125		125	125	125	125	125	125	1000
	MSO3	4	4	4	4	4	4	4	4	32	4		4	4	4	4	4	4	32
	Versed	4	4	4	4	4	4	4.5	4.5	33.5	4.5		4.5	5	5	5	5	5	34
	IVPB	50	50					300		350			50	50	100	50			250
	TOTALS									1415									1316

OUTPUT																			
	URINE	HOUR / TOTAL	140/140	140/280	110/390	120/510	120/630	110/740	90/830	80/910		110/110		130/240	200/440	100/540	160/700	200/900	140/1040
		10 gr																	
		S/A																	
	NG	OUTPUT																	
		pH											100						
		GUIAC																	
	EMESIS																		
	STOOL																		
	DRAINS	Lumbar	20	20	20	20	20	20	20	20	160			2	0	10	12	4	10
	TOTALS																		

EPW [redacted] (b)(6)-4

POST-OP DAY

	16	17	18	19	20	21	22	23	
V	134	116	[illegible]	101	91	86	123	115	
I	62	76	[illegible]	90	54	44	69	64	
T	38.7	38.9	39.1	39.3	39.9	38.5	38.3	38.1	
A	124	139	135	138	127		124	121	
L	97	[illegible]	9	12	10	10	10	10	
	35	[illegible]	100	100	100	100	99	99	

	16	17	18	19	20	21	22	23	8°T
NS	125	125	125	125	125	125	125	125	1000
MS4	4	4	4	4	4	4	4	4	32
MS2	5	5	5	5	5	5	5	5	40
ZVRB									
8%	40	40	40	40	40	40	40	40	320
			300	250				10	560
		220	140	220	80	120	120	155	1962
		220	360	580	660	880	1000		1155
		10	12	20	20	20	30	20	132

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA			
	TIME	04	1430
	MODE	SIM	SMN
	F_IO_2	35	30
	TV	800	800
	RATE	12	10
	PEEP	8	8
A	pH	7585	
A	PCO_2	325	
A	pO_2	241	
B	HCO_3	31	
B	SAT	100	
G	BASE	9	

LABORATORY DATA									
	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° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE: IV 4691; PO _____; TOTAL _____

OUTPUT: Urine: 3105; NO 100; 330; TOTAL _____

BALANCE 3435

NURSE'S SIGNATURE | INITIALS

+1256

EPW [redacted] (b)(6)-4

11
160
38
132
330

1 1
1415
1316
1962
4691

1
1910
1040
1155
3105

1
4691
3435
1256

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS	08
EYES OPEN	SPONTANEOUSLY	4	
	TO SPEECH	3	
	TO PAIN	2	
	NO EYE OPENING	1	1
BEST VERBAL RESPONSE	ORIENTED	5	
	CONFUSED	4	
	VERBALIZES	3	
	VOCALIZES	2	
	NO VOCALIZATION	1	1T
BEST MOTOR RESPONSE	OBEYS COMMANDS	6	
	LOCALIZES PAIN	5	
	FLEXION WITHDRAWAL	4	
	ABNORMAL FLEXION	3	
	EXTENSION TO PAIN	2	2
	NO MOTOR RESPONSE	1	
LIMB MOVEMENT — ARMS	NORMAL POWER		
	MILD WEAKNESS		
	SEVERE WEAKNESS		/
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		
LIMB MOVEMENT — LEGS	NORMAL POWER		
	MILD WEAKNESS		
	SEVERE WEAKNESS		/
	ABNORMAL FLEXION		
	ABNORMAL EXTENSION		
	NO RESPONSE		
PUPILS — RIGHT	SIZE		4
	REACTION		+
PUPILS — LEFT	SIZE		4
	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 | | |

For MEDICAL RECORD–SUPPLEMENTAL MEDICAL DATA
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	0610 INITIALS	INITIALS	INITIALS
NEUROLOGICAL	PUPILS	pupils 3mm RL		
	SENSORIUM	sluggish		
		sedated on		
		morphine drip		
		AO x 3 eyes open		
RESPIRATORY	RESPIRATORY PATTERN	Vent. AC 12		
	BREATH SOUNDS	bil. unlabored		
	SECRETIONS	orally intubated		
		ETT secure at		
		22 cm at gum		
		clear secretions		
SKIN	COLOR	ruddy skin		
	INTEGRITY	warm pale		
		dry intact		
I.V. SITE	LOCATION	R IJ Groin		
	CONDITION	patent,		
		dressing		
		clean & dry		
		IV fluids		
		Heparin drip		
		Dobutrex drip		
GASTRO	ABDOMEN	soft, NT		
	BOWEL SOUNDS	active, NT		
		OTP Nutrition		
		resumed feeds		
GU	URINE:	yellow & clear		
	COLOR/CLARITY	dark yellow		
		urine output		
CARDIOVASCULAR	CARDIAC RHYTHM	S-Tachycardia		
		normal BP		
		MAP > 65		
		pulses palpable		
		CRT < 2 sec		

Sp Pulmonary 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 ([redacted] RN | DEPARTMENT/SERVICE/CLINIC: ICU 2 unit | DATE: 20 Jul 03

PATIENT'S IDENTIFICATION (Use this space to identify patient, if necessary give: Name—last, first, middle; grade; [redacted] hospital or medical facility)
(b)(6)-2
EPW [redacted] -(b)(6)-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)

20 Jul 03

20 Jul Mul (GSW)

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	125/65	114/78	99/60	112/85	95/60	105/60	90/50	96/51		86/50	116/70	108/60	99/61		102/56	94/50	100/60
	BP Cuff																	
	Temperature	37.7	37.7	37.4	37.3	39.1	38.2	38.4			38.6	38.8	38.1			38.6	38.4	38.6
	Pulse	117	117	112	111	112	117	114	112		108	110	112	110		114	114	125
	Respiratory Rate	10	10	10	10	11	10	10	12		10	10	10	10		11	12	12
	SPO2	99	100	98	99	100	99	99	99		99	99	99	99		100	100	100

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	IVF NS	125	125	125	125	125	125	125	125	100	125	125	125	125		125	125	125	875
	3% NACL	40	40	40	40	40	40	40		240									240
	MSO4	4	4	4	4	4	4	4	4	32	4	4	4	4		4	4	4	28
	Versed	5	5	5	5	5	5	2	2	22	2	2	2	2		2	2	2	16
	IVPB						50	100	50	200						100	50	50	200
	R+Fun															100			100
	TOTALS																		2314

OUTPUT		HOUR	TOTAL	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	URINE			195	100	100	105	115	110	110	100	1550	100	100	100	100		100	100	100	1750
					300	400	505	600	710	820	920		920	1020	1120	1220		1320	1420	1520	
		Na gr																			
		Sus																			
	NG	OUTPUT																			
		pH																			
		GUIAC																			
	EMESIS																				
	STOOL			Colostomy																	
	DRAINS			Lumbar	20	10	10	10	18	20	10	78	10	18	20	18		15	10	10	15
	TOTALS											1650									

1240
66
1398
108
1506

114

18/36

CPW [redacted] (b)(6)-4

POST-OP DAY

	16	17	18	19	20	21	22	23
	[illegible]	[illegible]	[illegible]	112	135	140	114	150
	[illegible]	[illegible]	63	69	70	73	65	54
	[illegible]	[illegible]	39.1	39.1	39.1	39.1	38.7	37.7
	[illegible]	[illegible]	120	119	115	128	128	120
	[illegible]	[illegible]	98	100	100	100	97	99

	16	17	18	19	20	21	22	23	8°T
	[illegible]	[illegible]	125	125	125	125	125	125	
	[illegible]	[illegible]	4	4	4	4	4	4	
	[illegible]	[illegible]	2	2	3	3	3	3	
			250						
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	20	8	20	20	20	[illegible]	[illegible]	[illegible]	[illegible]

NS
MSO4
VORSEN
IUPB

ACUITY LEVEL CLASSIFICATION

		TIME	04
RESPIRATORY		MODE	SIMV
		F_iO_2	35
		TV	800
		RATE	10
		PEEP	5
ARTERIAL BLOOD GASES	A	pH	7.41
		PCO_2	45
		pO_2	114
	B	HCO_3	28
		SAT	99
	G	BASE	4

	TIME	04
LABORATORY DATA	GLUCOSE	87
	Na/K	142/3.8
	Cl/CO_2	107/27
	BUN/Cr	12/.7
	WBC/PLATELET	33/190
	Hct/Hgb	30/9.7

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

24 HR TOTALS

wt Yesterday _____ wt Today _____

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

BALANCE _____

NURSE'S [redacted] INITIALS

(b)(6)-2

EPW [redacted] (b)(6)-4

QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0510	INITIALS		INITIALS		INITIALS
NEURO	PUPILS	[illegible]					
	SENSORIUM	[illegible]					
RESPIRATORY	RESPIRATORY PATTERN	[illegible]					
	BREATH SOUNDS	[illegible]					
	SECRETIONS	[illegible]					
SKIN	COLOR	[illegible]					
	INTEGRITY	[illegible]					
IV SITE	LOCATION	[illegible]					
	CONDITION	[illegible]					
GASTRO	ABDOMEN	[illegible]					
	BOWEL SOUNDS	[illegible]					
GU	URINE: COLOR/CLARITY	[illegible]					
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible]					

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 [redacted] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 2/6/03

(Continue on reverse)

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

[redacted] (b)(6)-4 2/6/03

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

A FORM 1 MAY 78 4700
ponent Dept of Nurs

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

DATE | DX | HOSPITAL DAY | PAGE

VITAL SIGNS	TIME	05	06	07	08	09	10	11	12		13	14	15	16	17	18	19	20
	BP Arterial Line	131	136/77	118/63	114/68	118/61	97/57	117/64	136/74		114/64	110/62	98/57	114/64	125/67	120/64	120/70	138/70
	~~BP Cuff~~	62																
	Temperature	37.2	37.7	37.7	37.8	37.7	37.8	37.7	37.7		38	38.3	38.7	38.3	38.6	38.6	38.1	37.2
	Pulse	110	112	106	110	118	114	109	116		118	117	117	125	119	127	121	116
	Respiratory Rate	10	10	10	10	10	10	10	14		14	10	10	10	10	13	15	13
	Sats	100	100	99	99	99	98	99	99		97	97	96	98	98	96	97	99
	pain																	
	intervention																	

INTAKE	TIME	05	06	07	08	09	10	11	12	8°T	13	14	15	16	17	18	19	20
	NS	125	125	125	125	125	125	125	125	1500	125	125	125	125	125	125	125	125
	Mody	4	4	4	4	4	4	4	4	32	4	4	4	4	4	4	4	4
	Vertigo	2	2	2	2	2	2	2	2	16	2	2	2	2	2	2	2	2
	IVPB		50/50	100					100	300						150		300
	TOTALS									1548								

OUTPUT																		
URINE	HOUR / TOTAL	80	70/150	50/200	100/300	50/350	70/420	80/500	100/600	600	80	75/155	110/265	130/395	150/545	140/685	130/835	160/995
	~~kg~~																	
Lumbar	~~sm vert~~	15	10	10	20	15	10	20	20	120	10	5	10	10	20	12	15	16
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
~~STOOL~~ Colostomy																		

For MEDICAL RECORD—SUPPLEMENTAL MEDICAL DA
s form, see AR 40-66; the proponent agency is the Office of The ...al

REPORT TITLE

INTENSIVE CA... ...RSING FLOW SHEET

TSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

			INITIALS		INITIALS		INITIALS
NEURO	TIME	0600					
	PUPILS	6mm/slow					
	SENSORIUM	Sedated ± MSO4 + versed.					
RESPIRATORY	RESPIRATORY PATTERN	equal/rise/fall					
	BREATH SOUNDS	coarse (B)					
	SECRETIONS	thick, mon.					
SKIN	COLOR	jaundice					
	INTEGRITY	multiple surg. sites					
I.V. SITE	LOCATION	(L) TLC CDI					
	CONDITION	(L) Radial Aline CDI					
GASTRO	ABDOMEN	flat,					
	BOWEL SOUNDS	hypo					
		Stoma pink					
GU	URINE	foley					
	COLOR/CLARITY	gold/clear					
		750/hr					
CARDIOVASCULAR	CARDIAC RHYTHM	ST - ectopy					

See progress note

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)

PRE[redacted]RY (Surname, ...)

[redacted]

...NT'S IDENTIFICATION (For typed or ... middle; grade; date; hospital or medical ...

[redacted]

(b)(6)-2

(b)(6)-4

22 JUL 03

DEPARTMENT/SERVICE/CLINIC: ICU 2nd

DATE: 22 JUL 03

- ☐ 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 | D2 | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line							149/68	154/74		145/75	132/70	120/66	111/64	113/70	132/69	109/65	121/69	
BP Cuff																		
Temperature							36.9			37.4				37.8				
Pulse							107	108		106	107	107	110	114	121	117	119	
Respiratory Rate							10	10		10	10	10	10	10	10	10	10	
MODE							SIMV			SIMV				SIMV			SIMV	
FIO2							35			35				35			35	
SPO2							100	100		100	100	100	96	100	98	97	96	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
NS							125	125	1000	125	125	125	125	125	125	125	125	1000
VER	(18)						5	5	28	5	5	5	5	5	5	5	5	40
MSO4	(25)						4	4	33	4	4	4	4	4	4	4	4	32
IVPB							200/50/50		300								50/50	100
TF	off								30	30		5	10	10	20	20	20	110
										E-high								
TOTALS																		~~1102~~ 1332

OUTPUT

URINE	HOUR	810					50	120		50	140	160	140	180	180	220	140	
	TOTAL						860	980	980	1030	1170	1330	1470	1650	1830	2050	2190	2190
	LUMBAR	143					20	17	180	20	10	27	18	10	18	22	15	130
	SIA																	
NG	OUTPUT						Ø											
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		1200

EPW [redacted] (b)(6) -4 (22JUL03)

POST-OP DAY

	16	17	18	19	20	21	22	23	
VITAL SIGNS	114/66	119/65	114/69	127/71	130/71	158/84	130/70	134/75	
		386	38.8						
	117	124	123	120	116	123	115	112	
	10	10	12	11	12	21	10	10	
	SIMV		—		SIMV		—		
	35		—			35	—		
	96	98	97	95	98	100	98	98	

	16	17	18	19	20	21	22	23	8° T
NS	125	125	125	125	125	125	125	125	
VCR	5	5	5	5	5	5	5	5	
MSO4	4	4	4	4	4	4	4	4	
IVPB	25	25	25	25	25	25			
TF	20	30	30	30	30	40	40	40	
(TF Resid)	(10)					Ø			
IVPB			150	150					
UOP	140/140	160/300	190/490	140/630	180/810	170/980	170/1150	110/1390	
Lumbar drain	20	12	26	17	16	24	20	10	

(b)(6)-2

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA		TIME	04
		MODE	SIMV
		F_IO_2	35
		TV	800
		RATE	10
		PEEP	5
	A	pH	7.45
	A	PCO_2	429
	A	pO_2	87
	B	HCO_3	30
	B	SAT	97
	G	BASE	6

LABORATORY DATA	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

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

BALANCE _____

NURSE'S SIGNATURE	INITIALS

EPW [redacted] (b)(6)-4

(b)(6)-2

NEUROLOGICAL ASSESSMENT

		HOURS		LEGEND
COMA SCALE	EYES OPEN	SPONTANEOUSLY	4	C Closed by swelling
		TO SPEECH	3	
		TO PAIN	2	
		NO EYE OPENING	1	
	BEST VERBAL RESPONSE	ORIENTED	5	T Trach/Endo
		CONFUSED	4	S Slurring
		VERBALIZES	3	D Dysphasia
		VOCALIZES	2	R Receptive
		NO VOCALIZATION	1	E Expressive
	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		R Right
		MILD WEAKNESS		L Left
		SEVERE WEAKNESS		Record separately if there is a difference between the two sides.
		ABNORMAL FLEXION		
		ABNORMAL EXTENSION		
		NO RESPONSE		
	LEGS	NORMAL POWER		
		MILD WEAKNESS		
		SEVERE WEAKNESS		
		ABNORMAL FLEXION		
		ABNORMAL EXTENSION		
		NO RESPONSE		
PUPILS	RIGHT	SIZE	6+	+ + Brisk
		REACTION	6+	+ Slow
	LEFT	SIZE		- No Response
		REACTION		
PUPIL SCALE			2 3 4 5 6 7 mm	
ICP				+ Intact
CEREBRAL PERFUSION PRESSURE				- Abnormal

VASCULAR ASSESSMENT

HOURS		LEGEND
R pedal	R L	+ + Normal
	R L	+ Weak
	R L	- Absent
	R L	D Doppler
	R L	R Right
	R L	L Left

LAST COPY

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	0500	INITIALS	1800	INITIALS		INITIALS
NEURO	PUPILS	[illegible]		Perrl 3mm			
	SENSORIUM	[illegible]		opens eyes and			
		[illegible]		moves upper-extrems			
		[illegible]					
		[illegible]					
RESPIRATORY	RESPIRATORY PATTERN	[illegible]		SIMV 8/800/35%/5			
	BREATH SOUNDS	[illegible]		SATS 98-100%			
	SECRETIONS	[illegible]		CTA in uppers and			
		[illegible]		diminished in the			
		[illegible]		bases.			
		[illegible]		Ø/mm secretions			
SKIN	COLOR	[illegible]		warm & dry			
	INTEGRITY	[illegible]					
		[illegible]					
IV SITE	LOCATION	[illegible]		(R) SL TLP			
	CONDITION	[illegible]		Flushes well			
		[illegible]					
		[illegible]					
		[illegible]					
GASTRO	ABDOMEN	[illegible]		Abd Soft			
	BOWEL SOUNDS	[illegible]		BS Absent/			
		[illegible]		Hypoactive			
		[illegible]					
GU	URINE:	[illegible]		foley to gravity			
	COLOR/CLARITY	[illegible]					
		[illegible]					
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible]		ST 100's			
		[illegible]		Ø ectopy			
		[illegible]		Ø edema			
		[illegible]					

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 2 unit

DATE: 7-23-03

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

EPW [redacted] (b)(6)-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)

4/4

[redacted] (b)(6)-2 [redacted] (b)(6)-4

23 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	141	107	125	131	129	111	121	114		114	112	100	120	114	130	132	132	
	BP Cuff	76	74	66	68	57	61	63	64		64	60	60	68	61	72	71	74	
	Temperature	37.7	37.4	38.1	37.9	38.7	38.7	37.9	37.8		37.6	37.6	36.8	37.4	37.4	36.6	36.6	36.6	
	Pulse	112	130	111	107	121	120	107	106		101	117	110	123	123	121	125	117	
	Respiratory Rate	11	38	10	10	11	11	11	12		12	13	15	8	8	13	19	23	
	SAT	99	92	99	99	100	98	97	98		97	98	97	98	98	99	98	99	
	FiO_2	35	35	35	35	35	35	35	35		35	35	35	35	35	35	35	35	
	pain																		
	intervention																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	NS	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1000
	VERSED	5	5	5	5	4	4	4	4	36	4	4	4	4	4	4	4	4	32
	MSO4	4mL	4	4	4	4	4	4	4	32	4	4	4	4	4	4	4	4	32
	IVPB	50	50					100 / 50		250					50		50		50
	TF	40	40	40	40	off	40	40	40	280	40	40	40	40	40	40	40	40	32
	3% NaSodium														20	20	20	20	80
	TOTALS																		

OUTPUT																			
URINE	HOUR / TOTAL	165 / 165	165 / 330	175 / 505	155 / 670	200 / 870	170 / 1040	80 / 1120	85 / 1205	1548 / 1205	150	100 / 250	175 / 425	150 / 575	175 / 650	95 / 745	110 / 855	200 / 1035	1210 / 1035
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
~~SMESIS~~ residual						50			Ø	Ø						Ø			
STOOL																			
DRAINS	Lumbar	16	20	18	26	16	6	14	10	142	20	20	18	16	30	20	20	20	25 / 189
TOTALS																			

330
175
505

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	123/64	148/81	131/70	147/70	136/73	145/74	146/75	127/68	
	37	37.6	36.5	37.1	37.7	36.5	36.1	36.0	
	127	127	121	128	124	121	119	119	
	24	24	11	19	15	10	11	11	
	99	99	97	100	99	98	99	98	
	35	35	35	35	35	33	35	35	

TAKE	16	17	18	19	20	21	22	23	8° T
NS	125	125	125	125	125	125	125	125	
Vapor	4	4	4	4	4	4	4	4	
MSO4	4	4	4	4	4	4	4	4	
Cadin	20	20	20	20	20	20	20	20	
IVPB			50	200					

OUTPUT	200	150/350	225/575	200/775	200/975	225/1200	400/1600	425/2025	
	30	16	26	30	27	35	34	26	

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	TIME								
	MODE								
	F_IO_2								
	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 OF DAILY LIVING	TIME				TURN	TIME			
	MOUTH CARE								
	BATH								
	SKIN CARE								
	FOLEY CARE				SUCTION				
	TRACH CARE								
	ROM EXERCISES								

24° I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

NURSE'S SIGNATURE [redacted] INITIALS

(b)(6)-2

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS		INITIALS		INITIALS
NEURO	PUPILS	[illegible]					
	SENSORIUM	[illegible]					
		[illegible]					
		[illegible]					
		[illegible]					
RESPIRATORY	RESPIRATORY PATTERN	[illegible]					
	BREATH SOUNDS	[illegible]					
	SECRETIONS	[illegible]					
		[illegible]					
		[illegible]					
		[illegible]					
SKIN	COLOR	[illegible]					
	INTEGRITY	[illegible]					
		[illegible]					
IV SITE	LOCATION	[illegible]					
	CONDITION	[illegible]					
		[illegible]					
		[illegible]					
		[illegible]					
		[illegible]					
GASTRO	ABDOMEN	[illegible]					
	BOWEL SOUNDS	[illegible]					
		[illegible]					
		[illegible]					
GU	URINE:	[illegible]					
	COLOR/CLARITY	[illegible]					
		[illegible]					
CARDIOVASCULAR	CARDIAC RHYTHM	[illegible]					
		[illegible]					
		[illegible]					
		[illegible]					
		[illegible]					
		[illegible]					

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 [redacted] DEPARTMENT/SERVICE/CLINIC ICU 2nd DATE [illegible]

PATIENT'S [redacted] (Place an X in appropriate entries given: Name—last, first, middle; [redacted] hospital or medical facility)

(b)(6)-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)

[redacted] (b)(6)-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 SHIFT ASSESSMENT

	TIME	0500	INITIALS [redacted]	INITIALS	1400	INITIALS [redacted]
NEURO	PUPILS	PUPILS [illegible]	(b)(6)-2		PERRL 3mm	(b)(6)-2
	SENSORIUM	awake, alert, some confusion, DPEL, follows commands, moves upper extremities			follows commands; grips not; minimal UE movement - weak	
RESPIRATORY	RESPIRATORY PATTERN	RR within normal limits			(+) side	(b)(6)-2
	BREATH SOUNDS	LG coarse, bilat			crackles & diminished	
	SECRETIONS	lo consistency secretion & difficulty removing on ETT			- Sat 99% on RA	
					- resp. rate in 20s	
SKIN	COLOR	skin warm, pink			(+) chest PT	
	INTEGRITY	dermatitis, X2			NCR	
		LUQ foreskin				
IV SITE	LOCATION	both patent, normal			2 PIV to ULE - NL	
	CONDITION	NS KVO @ 100cc/hr				
GASTRO	ABDOMEN	soft, NT/ND			(+) BS x4; (+) PO intake	
	BOWEL SOUNDS	(+) bowel sounds, colostomy intact, stoma, ostomy bag			(-) GI; colostomy	
					(+) stool	
GU	URINE:	Foley, normal, cloudy			clear, yellow	
	COLOR/CLARITY	[illegible]			adequate amt	
CARDIOVASCULAR	CARDIAC RHYTHM	S-Tachycardia, normal			S/T; muscle cramping &	
		NSR, HR 120s			+2 LE pulses	S/T LEs
		ectopy beats				

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

(b)(6)-2

(Continue on reverse)

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

DEPARTMENT/SERVICE/CLINIC ICU 2 east

DATE 31 July 03

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

EPW [redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DATE 31 July | 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	121	118	120	124	129	125	132			126	129	126	134	126	129	132	125	
BP Cuff	80	73	72	76	80	81	83			77	82	80	86	80	81	83	83	
Temperature	98.4				99.6			999										
Pulse	114	111	113	121	117	120	119	119		113	111	121	126	112	115	114	115	
Respiratory Rate	26	25	24	25	22	29	25	27		25	18	32	32	24	22	32	31	
SATS	100%	99	99	99	100	100	100	100		115	100	99	99	98	99	100	99	
Mocke								RA		RA								
pain																		
intervention																		

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
NS	100	100	100	100	100	100	100	100	800	100	100	100	100	100	100	100	100	800
Jevity	80	80	80	80	80	80	80	80	640	80	80	80	80	80	off			400
ABX																		
PO							Sips	240	240	240				360				600
TOPB												250	300					250
TOTALS									1680									2050

OUTPUT

URINE	HOUR / TOTAL	150 / 150	190 / 340	130 / 470	120 / 590	90 / 680	100 / 780	95 / 875	90 / 965	965	200	100 / 300	150 / 450	200 / 650	150 / 800	175 / 875	100 / 975	90 / 1065	1065
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS									965									1065

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
	124/79	121/80					125/82		
	112	119					124		
	98	99					23		
	100	100					99		
							124		
							100		

INTAKE	16	17	18	19	20	21	22	23	8° T
	240	130	200				1200		
	120	125					1200		
		225					1425		

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA										
	TIME	2400								
	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								
	BATH								
	SKIN CARE								
	FOLEY CARE								
	TRACH CARE								
	ROM EXERCISES								

TURN	TIME								
SUCTION									

24° I&O TOTALS

wt Yesterday _____ wt Today _____

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

NURSE'S SIGNATURE

[redacted] CPT/AN

INITIALS

[redacted]

(b)(6)-2

NEUROLOGICAL ASSESSMENT

COMA SCALE		HOURS	24	04	17
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				
LIMB MOVEMENT: LEGS	NORMAL POWER				
	MILD WEAKNESS				
	SEVERE WEAKNESS				
	ABNORMAL FLEXION				
	ABNORMAL EXTENSION				
	NO RESPONSE		✓	✓	✓
PUPILS: RIGHT	SIZE		2mm	2mm	3
	REACTION		+	+	+
PUPILS: LEFT	SIZE		2mm	2mm	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

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

01 AUG 03

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS		INITIALS	(b)(6)-2	INITIALS [redacted]
NEURO	PUPILS	3mm purple				3mm pgrl	
	SENSORIUM	q/o x 2 follows commands appropriate & stay awake				AOx3; Follow commands	
						makes "ahy" / mouth	
						(Hungry; dehydrated)	
						⊖ movement ↓ to waste	
RESPIRATORY	RESPIRATORY PATTERN	even unlabored / 99% ORA				RR in 20s;	
	BREATH SOUNDS	BSCB CTA ↓ bases				⊖ cyanosis;	
	SECRETIONS	thick sputum → productive cough				CTA ⊖ cough	
SKIN	COLOR	slightly jaundiced				slightly jaundiced; ? jaundice	
	INTEGRITY	see progress notes				NSR.	
IV SITE	LOCATION	LFA PZU				(L) FA - sterile row	
	CONDITION	patent					
GASTRO	ABDOMEN	BS+ F dN/V/D				⊖N/V/D - tol.	
	BOWEL SOUNDS	colostomy → greenish				JPW ↓ on meal	
		cont stool strong				Colostomy + (L) viable	
		bowel mod				intact	
GU	URINE:	clear FTG				multiple amounts of	
	COLOR/CLARITY					clear yellow urine.	
CARDIOVASCULAR	CARDIAC RHYTHM	NSR-ST ⊖ ectopy				NSR - ST	
		palpable x3 c/p				S/1 Occasional	
		refill c3 secs				L3 ulcer (hydrogel)	

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 2 west

DATE: 8-1-03

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

[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

[redacted] (b)(6)-4

DATE 01 Aug 07 | 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~~			132		125	119	117	118		117				117			114	
	BP Cuff			80		76	82	89	82		78				83			75	
	Temperature					99½					99⁹					99⁶			
	Pulse			115		114	111	112	115		101				111			106	
	Respiratory Rate			22		23	19	20	19		21				16			19	
	SATS			99		98	98	100	99		98				99			98	
	SOURCE			RA		RA	RA	RA	RA		RA				RA			RA	
	pain																		
	intervention																		

INTAKE	TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
	ORAL			240	240			480			480				480		200	600	
	IVPB	100																	
	TOTALS																		

OUTPUT																			
URINE	HOUR / TOTAL				420 / 420		140	65	90		80	90	60	180		260		500	
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	
			116			114			
			127/73			124/79			
			20			29			
			99			98			
			M			M			
						99.0			

INTAKE	16	17	18	19	20	21	22	23	8° T
		360		240		400			

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
ABG	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 I&O TOTALS

wt Yesterday _____ wt Today _____

INTAKE		OUTPUT	
IV		Urine:	
po			
TOTAL		TOTAL	

NURSE'S SIGNATURE | INITIALS

NEUROLOGICAL ASSESSMENT

COMA SCALE	HOURS	06	18
EYES OPEN: SPONTANEOUSLY 4		4	✓
EYES OPEN: TO SPEECH 3			
EYES OPEN: TO PAIN 2			
EYES OPEN: NO EYE OPENING 1			
BEST VERBAL RESPONSE: ORIENTED 5			✓
BEST VERBAL RESPONSE: CONFUSED 4		4	
BEST VERBAL RESPONSE: VERBALIZES 3			
BEST VERBAL RESPONSE: VOCALIZES 2			
BEST VERBAL RESPONSE: NO VOCALIZATION 1			
BEST MOTOR RESPONSE: OBEYS COMMANDS 6		6	✓
BEST MOTOR RESPONSE: LOCALIZES PAIN 5			
BEST MOTOR RESPONSE: FLEXION WITHDRAWAL 4			
BEST MOTOR RESPONSE: ABNORMAL FLEXION 3			
BEST MOTOR RESPONSE: EXTENSION TO PAIN 2			
BEST MOTOR RESPONSE: NO MOTOR RESPONSE 1			
LIMB MOVEMENT: ARMS: NORMAL POWER			
LIMB MOVEMENT: ARMS: MILD WEAKNESS			
LIMB MOVEMENT: ARMS: SEVERE WEAKNESS		/	✓
LIMB MOVEMENT: ARMS: ABNORMAL FLEXION			
LIMB MOVEMENT: ARMS: ABNORMAL EXTENSION			
LIMB MOVEMENT: ARMS: NO RESPONSE			
LIMB MOVEMENT: LEGS: NORMAL POWER			
LIMB MOVEMENT: LEGS: MILD WEAKNESS			
LIMB MOVEMENT: LEGS: SEVERE WEAKNESS		/	✓
LIMB MOVEMENT: LEGS: ABNORMAL FLEXION			
LIMB MOVEMENT: LEGS: ABNORMAL EXTENSION			
LIMB MOVEMENT: LEGS: NO RESPONSE			
PUPILS: RIGHT: SIZE		3	3
PUPILS: RIGHT: REACTION		+	✓
PUPILS: LEFT: SIZE		3	3
PUPILS: LEFT: 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

14/15

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

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

REPORT TITLE

INTENSI[illegible] ARE NURSING FLOW SHEET

PUPILS	0500	
SENSORIUM	pupils RTL PERRL 3mm	
	[illegible] Follows A+O x3	
	simple commands Follows Cmds	
	[illegible] difficulty	
RESPIRATOR	Rrevenat.	CTA (B.I)
BREATH SOU	unlabored	Unlabored
SECRETIONS	[illegible]	
	currently on	
	[illegible]	
	@ 99%	
COLOR	[illegible]	WD
INTEGRITY	[illegible]	
	[illegible]	
LOCATION	[illegible]	(L)FA Patent
CONDITION	Patent [illegible]	
	well	
ABDOMEN	ABD soft NO/NT	Abd Soft Non Tender
BOWEL SOUN	[illegible]	BS x4 hyper
	[illegible] stoma pink	Colostomy Stoma Pink
	[illegible] surrounding	Midline Abd Dress DRY
URINE:	[illegible]	
COLOR	[illegible]	
	[illegible]	
CARDIAC RHY	[illegible]	ST
	[illegible]	
	110-130's [illegible]	
	beats noted	

PREPARED BY (S[illegible]

[redacted] (b)(6)-2

PATIENT'S IDENTIFICA[illegible]

middle; grade; do[illegible]

[redacted] (b)(6)-4

2 Aug 03

2 Aug 03

MEDCOM - 14553

[redacted] 2 Au, 3

(b)(6)-4

	24	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15
BP Arterial Line						103/67				103/69				112/70		
BP Cuff																
Temperature						99'					100					
Pulse						112				114				119		
Respiration Rate						20				23				23		
SPO2						99				99				99		
Mode						RA				RA				RA		
PO																
IVPB						240			360	240	240	240	240	240	360	175
Meals: B									50%							
L									50%							
D									75%							
TOTALS																
Urine						125	80	225	150	90	150	175	225	200	250	375	26
							305	305	150	240	390	565	890	1090	1440	1815	201
Drain																
Tool	Colostomy															

130/76	110/76
99	99
132	118
20	20
97	96
RA	RA
150	300
550	575
850	1125

(b)(6)-2

[redacted]

(b)(6)-4

[redacted]

2 Aug 03

[illegible]CAL RECORD-SUPPLEMENTAL MED[illegible] DATA

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

REPORT TITLE	OTSG APPROVED (Date)
INTENSIVE CARE NURSING FLOW SHEET	QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 1850 Initals: [redacted] (b)(6)-2	Time: Initals:
NEURO	Pupils	PERRL 3mm	
	Sensorium	PC / ⊖ [illegible]	
	LOC / GCS	A+O x3 [illegible]	
CARDIAC	Cardiac Rhythm	ST - S1/S2	
	PRI: / QRS:		
	Pulse Strength		
	Cap Refil / JVD	-JVD [redacted] (b)(6)-2	
	Edema	~~+2 [illegible]~~	
	Chest Pain		
RESP	Respiratory Pattern	[illegible] - 97% on RA	
	Breath Sounds	⊖ [illegible]	
	Secretions		
	Cough		
SKIN	Color	NRR	
	Integrity		
	Backside		
IV	Access Devices	[illegible]	
	Location		
	Condition		
GI	Abdomen	Midline inc. - c/d/i	
	Bowel Sounds		
	Stoma/Ostomy		
GU	Device	[illegible] - [illegible]	
	Color / Clarity	large amount	
		see I/O	

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC (b)(2)-2 [redacted]	DATE 3 Aug 03

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

NAME: EPW [redacted] (b)(6)-4 RANK: AGE:

UNIT: GENDER:

STATUS: US: AD / CIV IRAQI: CIV / EPW

OTHER:

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

DA FORM 4700, MAY 78

EPW [redacted] (b)(6)-4

ICU Flowsheet Patient Name: Date: 3 / Aug / 2003

Vital Signs	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
Temperature			98				986				98					989										
Pulse			115				110				112															
B/P A-Line																										
MAP																										
B/P Cuff			111 / 71				121 / 86				112 / 76					110 / 82						121 / 72				
Respirations			16				18				18					16						20				
			96				99				99					99						109				
																						97%				

Intake	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
IVF		300					240	240	240	120	120 / 50	120	1080 / 50		240		240	240				300				
PB																										
PO intake																										
O.R. IN																										
Totals													1130													

Output	24	01	02	03	04	05	06	07	08	09	10	11	Total	12	13	14	15	16	17	18	19	20	21	22	23	Total
Hourly		525 / 525				200 / 725	250 / 1075				500 / 1575		1575	200	125 / 1575	200 / 800	175 / 500	100 / 600	175 / 1475							
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals													1575													

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 14557

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 0 1	I 2	[redacted]	(b)(6)-4 UNK		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
		2	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	2	1330	NA

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
N	[redacted]	

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	NO
I 2				✓

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	Icu1	UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] (b)(2)-2	UNK	UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
0 1		0 3 1 0 0 6

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A A J A		0 3 0 7 1 3

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (YYMMDD)
		0 3 0 7 1 3

FOR LOCAL USE

GSW (MULTIPLE) C PARAPLEGIA

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
(b)(6)-2 D[redacted]	[redacted]

DA FORM 3985 MAR 89

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 0 1	I 2	[redacted]	(b)(6)-4 UNK		M

6. DATE OF BIRTH (Y Y Y Y M M D D)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
		2	9	UNK

10. LENGTH OF SERVICE	ETS	11. FMP	12. SOCIAL SECURITY NUMBER
	NA	9 9	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS
NA	2	1330	NA (b)(6)-4

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION YEAR	
I 2				✓ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
0	Icu1	UNK

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] (b)(2)-2	UNK	UNK

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (Y Y M M D D)
0 1		0 3 1 0 0 6

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (Y Y M M D D)
A A J A		0 3 0 7 1 3

27. LOCATION OF OCCURRENCE (Battle Casualty Only)	28. MTF OF INITIAL ADMISSION	29. DATE INITIAL ADMISSION (Y Y M M D D)
		0 3 0 7 1 3

FOR LOCAL USE

GSW (MULTIPLE) C PARAPLEGIA

ADMITTING OFFICER (Signature, as required)	SIGNATURE OF ADMITTING CLERK
(b)(6)-2 Dr [redacted]	(b)(6)-2 [redacted]

DA FORM 3985 MAR 89

MEDCOM - 14559

(b)(6)-4

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] (b)(6)-4				3. GRADE N/A	ADMISSION REMARKS
4. SEX M	5. AGE [redacted]	6. RACE Z	7. RELIGION unk	8. LENGTH OF SVC N/A	9. ETS N/A	10. PREVIOUS ADMISSION NO
11. FMP 99 (b)(6)-4	12. SSN (b)(6)-4 [redacted]		13. ORGANIZATION N/A			14. WARD 1643
15. FLYING STATUS N/A	16. RATING/ OSG	17. DEPT./ BEN K78	18. BRANCH/CORPS N/A	19. UIC/ZIP		20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION Direct from ER				22. HOURS OF ADMISSION 0808	23. CLINIC SERVICE ABAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE —			25. TYPE DISPOSITION 50		26. DATE OF DISPOSITION 17 July 03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) —			27b. TELEPHONE NO. —		28. DATE OF THIS ADMISSION 14 July 03	ADMITTING OFFICER (b)(6)-2 Dr. [redacted]
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted] (b)(2)-2					30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

31. [redacted]

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

① s/p GSW ⓡ Flank

② s/p Ex-lap

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
0	0	0	0	4	4

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
0	0	0	0	4	4

SIGNATURE OF ATTENDING MEDICAL OFFICER [redacted] (b)(6)-2

SIGNATURE OF PAD OR MEDICAL RECORDS OFFICER For [redacted] (b)(6)-2

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

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

[redacted] 40 irag's male s/p GSW in ⓛ flank out ⓡ Back.

(b)(6)-4

PHYSICAL EXAMINATION

121 125/75 92 SAT

NC AT AxOx3

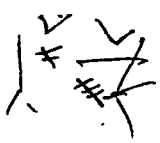
Neck No injury

Chest CBTA

Back

Abd

S/p Ex LAP stapled Clean close



entrance & exit wn clon

Ext ⊖ c/c/m

Gn wnl

rectal heme ⊖

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

A/P Adult s/p GSW to Back

⊖ ex Lap cont wound & standard post op care.

(b)(6)-2

SIGNATUR[redacted]

PATIENT'S[redacted]

DATE 14 Jul 03

IDENTIFICATION NO.

ORGANIZATION

(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

539-106

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
13 July 03	
2300	Pt c̄ GSW to Back entry (L) back @ ~ T_{10} Level c̄ large exit wound (R) lower back @ lever of Ant Sup Iliac Spine. Pt awake-alert c̄ stable VS- Chest-clear
	Abd-distended, tender, BS ⊕.
	CXR lung expanded, ∅ pneumo ∅ fluid, ∅ FB on Abd Films. [redacted] (b)(6)-2
	To OR for Exp Lap - Negative for Intrab.
	Injury + Wound Debridement + Closure. [redacted] (b)(6)-2
2340	Post Op Order
	NPO x̄ ice chips or sips of H_2O.
	IV DsLR TRA 125 cc/hr
	Foley to Gravity
	I's + O's, Routine VS.
	Ancef 1 gram IVPB q 8°.
	Morphine 2-8 mg IV q 1-2° PRN pain.
	CBC early AM.
	Evacuate to CSH in AM. (b)(6)-2 (b)(6)-2
	[redacted] MAJOR, Gen. Surgeon

HOSPITAL OR MEDICAL FACILITY	STATUS	DE[redacted]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.

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
14 July 0045 Ortho	Post-op Ortho - with the patient under general. Exploration of Wound of Back. entrance + exit preformed - Subcutaneous + Intramuscular - debridment + repair of Penrose drain (no bony involment) Blood loss less than 50 cc - pt tolerated procedure well + transferred to RR. in satisfactory condition. Cl [redacted] (b)(6)-2
	~~Post-op Orders~~ -
14JUL03 0945	NN: PT ADMITTED TO ICU VSS ST 90-110's A-FEBRILE. PHYSICAL ASSESSMENT DONE SEE FLOWSHEET. MIDLINE ABD DRESSING CDI c̄ 4X4 AND CLOTH TAPE. (R) FLANK DRESSING CDI c̄ ABD PAD + SILK TAPE. PT RESTING QUIETLY IN BED. WILL CONT TO MONITOR — [redacted] (b)(6)-2
14JUL03 1130	NN: PT VSS SR/ST A-FEBRILE. Δ'd (R) FLANK DRESSING INCISION CDI c̄ STAPLES AND PENROSE DRAIN. WOUND SITE MIDLINE LOWER BACK/ LOWER THORACIC INTACT c̄ GAUZE. 4X8 GAUZE APPLIED c̄ CLOTH TAPE. MSO4 IVP GIVEN PER PAIN. WILL CONT TO MONITOR — [redacted] (b)(6)-2
14JUL03 1630	NN: PT RESTING QUIETLY IN BED VSS NSR A-FEBRILE. PT ALERT/ORIENTED LUNG SOUNDS REMAIN CLEAR c̄ DIM BASES BILAT. PULSES RAD +3 BILAT / DP+2 BILAT. BS (+) X4 QUAD TENDER TO TOUCH. FOLEY TO GRAVITY DRAINING CLEAR YELLOW URINE. MIDLINE ABD + (R) FLANK DRESSING CDI. (R) ANKLE RESTRAINT APPLIED PER UNIT EPW POLICY. — [redacted] (b)(6)-2

STANDARD FORM 600 (REV. 6-97) BACK
*U.S. GPO: 2002 - 491-600/50618

MEDCOM - 14563

510-112 NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
14 July 03		1800	Received report from ongoing shift. Pt in bed asleep at this time. Monitor in place. VSS. IV LR @ 150 cc/hr on a dialflow. Abd dressing intact. (b)(6)-2 [redacted] Maj / AN
		1900	Medicated c̄ MSO4 3 mg for c/o wound pain. (b)(6)-2 [redacted] Maj / AN
15 July 03	0610		pt report received from Maj (b)(6)-2 [redacted] pt assessment complete see DA Form 4700 op 375 for details VSS pt resting Quitely in bed @ this time IV @ 150 cc/hr via dial-a-Flow infusing LR Foley to gravity dressing CDI no problems noted @ present will continue to monitor (b)(6)-2 [redacted] PFC 9/WA
	1415		pt resting @ this time bandages Δd without problems pt Foley d/c'd, diet advanced to clears per doctors orders no problems @ present will continue to monitor (b)(6)-2 PFC 9/WA [redacted]
	1605		pt VSS Pt resting well quietly no problems @ present will continue to monitor (b)(6)-2 [redacted] PFC 9/WA
	1800		Received report from ongoing shift, pt in bed c̄ any complaint IVF LR infusing @ 150 cc/hr via dial flow. Foley d'ced earlier pt used to void. VSS (b)(6)-2 [redacted] Maj / AN
	2000		Pt up to the outside bathroom accompanied by the MP. Voided 700 cc of urine. No other issues at this time (b)(6)-2 [redacted] Maj / AN
0300			Pt OOB to urinate, voided 550 cc dark urine. c/o hesitancy voiding but successfully able to. Dressing to the back and abdomen done, back dressing had some blood stain, abdominal staples dry & intact, cleaned c̄ Betadine. T max 100.4 ↓ 99.7. (b)(6)-2 [redacted] Maj / AN

(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.

EPW [redacted] — (b)(6)-4

ICU-3

[redacted] — (b)(2)-2

[redacted] — (b)(6)-4

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 14564

NSN 7540-00-634-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15 Jul 03	Surgery
	No events
	VSS AFCS
	Abd - wound C/D, ⊕BS Appropriate tend
	Back - wounds C/D Drain removed
	Dressing D'd
	79) 42 (272
	(b)(6)-2
	A/P POD # [redacted] ex LAP. wound debridement
	① D/c Foley
	② clears (b)(6)-2
	[redacted]
16 Jul 03	Surgery
	No events Poor PO intake
	VSS AFCS
	Abd mod distended wound C/D hypoactive BS
	Back C/D
	A/P Doing well POD 2 Awaiting Bowel Fun
	(b)(6)-2 [redacted]

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

[redacted] — (b)(6)-2
ICU-3
[redacted] (b)(2)-2

RECORDS MAINTAINED AT:		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

MEDCOM - 14565

OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
16 Jan 03 0500			Rcvd report and care of patient from previous shift (b)(6)-2 [redacted] LPN
	0530		Pt Ambulated outside to latrine. VOP 450cc urine clear amber. Pt had no c/o pain/discomfort will cont to monitor (b)(6)-2 [redacted] LP
	0930		Pt Ambulated outside to latrine. VOP 350cc urine clear yellow. Pt had minimal amount of pain & discomfort while ambulating. Will cont to monitor (b)(6)-2 [redacted] LP
	1230		Pt OOB to urinate at bedside in urinal. Pt ate minimal amount of lunch VSS will cont to monitor (b)(6)-2 [redacted] L
		1500	Pt resting in bed IV DC'd in (L) & (R) AC. IV restarted in (R) hand 20ga LR @ 150cc/hr. No c/o pain/distress (b)(6)-2 [redacted] LP
	1715		Report received from day shift. Pt resting in bed. A+O×3. Pt speaks little English. Pt c/o pain. 4mg MSO4 IVP given by RN PO. Will continue to monitor pt. (b)(6)-2 [redacted] LPN
	2000		Pt resting quietly in bed. A+O×3. No c/o pain at this time. Pt assessm complete. See assessment sheet for details. No distress noted. Pt's IV infusing well, ⅋ diff. Will continue to monitor. (b)(6)-2 [redacted]
	2200		Pt c̄ Temp 100.9. All other VSS. 1gm Tylenol given. Pt up to BS to urinate. Pt appears very depressed affect. Pt speaks more english than originally thought. Pt ⅋ c/o pain after May [redacted] give 2 mg MSO4 IVP. Will continue to monitor. (b)(6)-2 [redacted]
	0500		Pt rested well throughout night. Gave report to SPC [redacted]. (b)(6)-2 [redacted] (b)(6)-2

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

All: (b)(6)-2

...ICAL RECORD	PROGRESS NOTES

DATE	NOTES
17 July 93 0515	Received report + care of pt from previous shift. Pt sleeping in bed VSS will cont to monitor — [redacted] LPN
0830	Pt OOB to urinate at bedside in urinal UOP 400cc yellow, clear. VSS will cont to monitor — [redacted] LPN
1130	Pt awake + alert Ø C/O pain or discomfort VSS. will cont to monitor — [redacted] LPN
1400	Pt awake + alert PT OOBTC for 45 min. VSS will cont to monitor — [redacted] LPN

...NSHIP TO SPONSOR | SPONSOR'S NAME | LAST | FIRST | ...

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED

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

PROGRESS NOTES

ICAL RECORD | PROGRESS NOTES

DATE | NOTES

17JUL03 Narrative Summary (b)(2)-2
Pt Admitted to [redacted] from
Forward Surgical team. [redacted] (b)(6)-4 40
with GSW through Back underwent ex LAP - Negative and wound debridement. Routine post op course. Slow to take oral feeds. Released to Medical City for continued wound care

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

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

SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS REGISTRAR

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] (b)(6) - 4

PROGRESS NOTES

558-103

(See Instructions on Back of this Sheet) (b)(2)-2

NSN 7540-01-075-371

EMERGENCY CARE AND TREATMENT
(Medical Record)

TREATMENT FACILITY (Stamp): CMT [redacted]

LOG NUMBER

ARRIVAL

DATE			TIME
DAY	MONTH	YR.	
14	JUL	03	0735

TRANSPORTATION TO HOSPITAL (Attach care enroute sheet)
- [ ] PRIVATE VEHICLE
- [ ] AMBULANCE
- [x] OTHER (Specify) Medevac

CURRENT MEDS. (tetanus immunization and other data)

HISTORY OBTAINED FROM
- [ ] PATIENT
- [ ] OTHER (Specify)

ALLERGIES: NKDA

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

HOME TELE. NO. (Inc. area code)

(b)(6)-4

CHIEF COMPLAINT(S) (Include symptom(s), duration): trauma chest

SEX: ♂ AGE: [redacted]

POSSIBLE THIRD PARTY PAYER?
- [ ] YES
- [ ] NO

TIME SEEN BY PROVIDER: On arrival

VITAL SIGNS			
TIME	0745	0830	
BP	125/75	124/79	
PULSE	124	107	
RESP.	18	20	
TEMP.	98.3		
WT. (Child)	91		

SPA CATEGORY (See reverse)
- [ ] EMERGENT
- [ ] URGENT
- [ ] NON-URGENT (b)(6)-2

ORDERS	INITS.	TIME
4mg MSO4	[redacted]	0746
4A-OBC, PTAT		0825
MCTR/METIZ		0825
1L NACl		0800

ASSESSMENT/DIAGNOSIS: Post op Ex lap & wound (L) back STP GSW

DISPOSITION (Check all that apply)
- [ ] HOME
- [ ] FULL DUTY

QUARTERS: [ ] 24 Hrs. [ ] 48 Hrs. [ ] 72 Hrs.

MODIFIED DUTY UNTIL: DAY / MONTH / YEAR

REFERRED TO (Indicate clinic)

- [ ] EMERGENCY
- [ ] TODAY
- [ ] 72 HOURS
- [ ] ROUTINE
- [x] ADMIT TO HOSP. UNIT/SERVICE: Hosp

CONDITION UPON RELEASE
- [x] IMPROVED
- [ ] UNCHANGED
- [ ] DETERIORATED

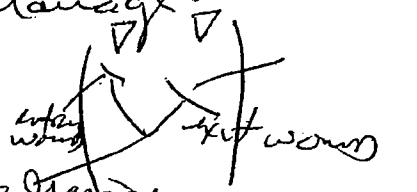
TIME OF RELEASE: 0845

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)

Head injuries; (R) eye fine
IV (R) arms (L) eye fine
Pt. post-op. STP GSW to back / ex lap. ATEU to [redacted]. pt. A&O x 3 - speaks English.
(b)(2)-2

1° survey
A, B, C → see VS.
D → GCS 15
E: No obvious ext bleeding.

2° survey
HEENT: ⊖ neck
Nontender head
Atraumatic
Heart ⊕ tachycardia S1 ⊕
Lungs CTAB/L
Chest nontender.
Abd: Ex lap SX wounds
No drainage.
Back:



no drainage
Ext's: pulses = B/L UE & LE's
Foley draining yellow urine.

ED course
O2 via A mask
IVF.
Seen by GS.

(b)(6)-2
[redacted] COL, MC
Chief of Emergency Medicine

(b)(6)-2
[redacted] IF NEEDED)
SI[redacted] AMP

PATIENT'S IDENTIFICATION (Mechanical imprint)
FOR 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)
[redacted] (b)(6)-4

IN[redacted] (Include medications ordered, any limitations and follow-up

EMERGENCY CARE AND TREATMENT

MEDCOM - 14569 Copy

STANDARD FORM 558 (Rev. 6-82)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

INSTRUCTIONS FOR COMPLETION OF THE EMERGENCY CARE AND TREATMENT FORM

NOTE: This form will be used to record all care rendered to patients in the Emergency Room and will be used in lieu of *all* locally prepared emergency room forms. This form is not a substitute for line of duty, accident/injury or third party liability forms, but it may be used as a basis for completing those forms.

1. Complete form for each patient entered on Emergency Room Log.
2. Complete all parts of form.
3. Enter patient's log number from Emergency Room Log.
4. Check appropriate condition in "category" block based on following definitions:
   Emergent—A condition which requires immediate medical attention and for which delay is harmful to the patient; such a disorder is acute and potentially threatens life or function.
   Urgent—A condition which requires medical attention within a few hours or danger can ensue; such a disorder is acute but not necessarily severe.
   Non-Urgent—A condition which does not require the immediate resources of an emergency medical services system; such a disorder is minor or non-acute.
5. Use SF 522, Request for Administration of Anesthesia and for Performance of Operations and Other Procedures, to obtain authorization for any necessary procedures.
6. Orders: Provider enters orders; i.e., CBC, UA, etc. The person completing the action enters the time and his/her initials at the time of completion.
7. Give "Patient's Copy", containing instructions, to patient, sponsor (NOK) or person accompanying patient, except when patient is admitted.
8. File original in patient's treatment record (i.e., Military Health Record, Outpatient Treatment Record or Inpatient Record) as applicable.
9. Establish a treatment record for any patient who does not have a record. File and maintain treatment record in accordance with appropriate directives.

PATIENT ASSE[illegible]NT [redacted] (b)(6)-2 [illegible]ENT ASSESSMENT

TIME: 0600 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:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

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

Capillary Refill: Seconds Homan's Sign

Jugular Venous Distension Ø Edema Ø

Heart Sounds S1 S2

Rhythm RRR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site			20ga (B) Hand	
Solution			LR @ 150cc/hr	

Chest Pain Ø

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: RRR

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor Ø

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crepitus N/A

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		
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 N/A

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

Stool: Character

Drains: Ø

GENITOURINARY

Urine Color: yellow Character: clear

Voiding: Continent / Urinal / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

pt resting in bed & c/o pain or discomfort

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			[redacted]	
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:

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		150/88		144/85		132/82		156/81		142/79														
TEMP		99.4		99.3		99.2																		
HR		83		79		71		82		72														
RR		19		18		17		20		20														
SA02		94		96		97		99		95														
INPUT																								
PO																								
IV	150	150	150	150	150	150	150	150	150	150														
NGT																								
IVPB			50							50														
TOTAL																								
OUTPUT																								
URINE				400		375		300	125	100														
NGT																								
STOOL																								
TOTAL																								
BALANCE																								

MEDCOM - 14572

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

ENT 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:

PTS 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		149/81		136/87		119/81		143/92		130/84		131/83		138/85		142/85		131/82		130/73		145/84		136/81
TEMP		100.4		99.6		99.9		100.3		100.0		100.0		100.2				100.9		100.2		99.8		99.4
HR		96		100		100		87		107		109		97		96		101		84		67		76
RR		20		18		18	18	18		20		18		17		19		16		18		17		19
SA02		93		95		94	95	95		97		95		94%		96%		95%		94%		95%		92%
																Temp 100.5								
																		Tylenol given						
INPUT																								
PO			1		75																			
IV	125	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150	150
NGT																		50						
WPB			50							50														
TOTAL																								
OUTPUT																								
URINE		350			350			300		125		325				400			300			200		
NGT																								
STOOL					800			1100		1225		1550				1950			2250			2450		
TOTAL																								
BALANCE																								

3450
225
5
Input

2450
Output

MEDCOM - 14574

(b)(6)-4

Ward/Section: GMT

TING PHYSICIAN: [redacted] (b)(6)-2

CL TRY RESULT FORM (Su .o the Privacy Act of 1974)

LAST FIRST M: [redacted]

DATE: 14/7/03 TIME: 0750

SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)			(Piccolo) Chemistry 12		(Piccolo) Metabolic Panel	
TEST	RESULT	REF. RANGE	TEST	RESULT		F. RANGE
Na		138-146 mmol/L	ALB			18 mg/dl
			ALP			mg/dl
			ALT			0.3 mg/dl
			AMY			.2 mg/dl
			AST			45 mmol/l
			TBIL			mmol/l
			BUN			8 mmol/l
			CA++			mmol/l
			CHOL			Plus
			CRE			. RANGE
			GLU			5 g/dl
			TP			u/l
			~~(Piccolo) Metab~~			u/l
			TEST	RESULT		u/l
			GLU			u/l
			BUN			5 mg/dl
			CRE			/l
			CK			g/dl
			NA^+			e
			K^+			RANGE
			CL^-			5 mmol/l
			tCO_2			mmol/l
						mmol/l
						mmol/l

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

Pt Name:_____

Glu_____127 mg/dL

BUN_____6 mg/dL

Na_____139 mmol/L

K_____3.9 mmol/L

Cl_____105 mmol/L

TCO2_____21 mmol/L

AnGap_____18 mmol/L

Hct_____41 %PCV

Hb*_____14 g/dL

*via Hct

PH_____7.282

PCO2_____41.0 mmHg

HCO3_____19 mmol/L

BEecf_____-7 mmol/L

Sample Type_:

14JUL03 08:30

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

Physician:_____

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

Ver: [redacted]

======= PICCOLO =======

14/07/03 08:37

REFERENCE RANGE: MALE

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

GENERAL CHEMISTRY 12

DISC LOT #: (b)(6)-4 [redacted]

OPER #: [redacted] (b)(6)-2 DR #: [redacted] (b)(6)-2

SERIAL #: (b)(6)-4 [redacted]

ALB	3.5	3.3-5.5	G/DL
ALP	42	26-84	U/L
ALT	104*	10-47	U/L
AMY	14	14-97	U/L
AST	69*	11-38	U/L
TBIL	1.1	0.2-1.6	MG/DL
BUN	5*	7-22	MG/DL
CA++	8.1	8.0-10.3	MG/DL
CHOL	133	100-200	MG/DL
CRE	1.1	0.6-1.2	MG/DL
GLU	134*	73-118	MG/DL
TP	6.7	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK

HEM 0 , LIP 0 , ICT 0

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
(b)(6)-2 [redacted]	14 July 03	

(b)(6)-4

ICU III

Ward/Section: am 1	[redacted] (b)(6)-2	LA[redacted]TORY RESULT FORM (Su[redacted] to the Privacy Act of 1974)
LAST FIRST MI [redacted] (b)(6)-4	DATE 14 Jul 03 / TIME 0750	SSN/PSEUDO SSN: (b)(6)-4 [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3

[redacted] (b)(6)-4

			Patient Limits	
WBC	12.3 H	x10^3/uL	4.5	10.5
RBC	4.40	x10^6/uL	4.00	6.00
Hgb	13.8	g/dL	11.0	18.0
Hct	43.4	%	35.0	60.0
MCV	98.7	fL	80.0	99.9
MCH	31.4 H	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	298.	x10^3/uL	150.	450.
LY%	9.4	%	20.5	51.1
LY#	1.2	x10^3/uL	1.2	3.4

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	100	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.030	N/A
Bld	Mod	Negative
pH	5.0	N/A
Prot	Neg	Negative
Urob	0.2	0.2-1.0
Nit	Neg	Negative
Leuk	NA	Negative
HCG		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

Clinitest - Negative
Quantity not sufficient for microscopic evaluation

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT	14.2	9.8-13.6 secs
APTT	26.3	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:	DATE:	LAB ID NO.:

-Free T4
Calcium

MEDCOM - 14577

Ward/Section: ICU 3	TING PHYSICIAN: [redacted] (b)(6)-2	LA ATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI [redacted] (b)(6)-4	DATE 7/15/03 TIME 0345	SSN/PSEUDO SSN

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
[redacted] (b)(6)-4		
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

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

CSF

Cell Count		
Directigen		Negative

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:	LAB ID NO.:

(b)(6)-2

[redacted] (b)(6)-4

Chemistry Only

Ward/Section: ICU 3

REQUESTING PHYSICIAN: [redacted] (b)(6)-2

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

LAST, FIRST, MI: (b)(6)-4 [redacted]

DATE: 7/15/03 TIME: 0345 SSN/PSEUDO SSN:

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:

Blood Chemistry

TEST	RESULT	REF.
A		
A		
A		
A		
A		
T		
B		
C		
C		
C		
G		
T		
G		
B		
C		
C		
N		
K		
C		
tl		

i-STAT EC8+

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

Pt Name:_____

Glu_____102 mg/dL

BUN_____9 mg/dL

Na_____135 mmol/L

K_____3.4 mmol/L

Cl_____103 mmol/L

TCO2_____30 mmol/L

AnGap_____7 mmol/L

Hct_____38 %PCV

Hb*_____13 g/dL

*via Hct

pH_____7.392

PCO2_____46.8 mmHg

HCO3_____29 mmol/L

BEecf_____4 mmol/L

Sample Type_:

15JUL03 04:05

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

Physician:_____

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

Ver:

Chemistry Metabolic Panel

TEST	RESULT	REF. RANGE
LU		73-118 mg/dl
UN		7-22 mg/dl
A++		8.0-10.3 mg/dl
RE		0.6-1.2 mg/dl
A+		128-145 mmol/l
+		3.3-4.7 mmol/l
L-		98-108 mmol/l
CO2		18-33 mmol/l

Chemistry 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
GT		5-65 u/l
P		6.4-8.1 g/dl

Chemistry Electrolytes

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
CO2		18-33 mmol/l

(b)(6)-4 [redacted]

0430
15 July 03

(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		80-108 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
iCa		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:	DATE:	LAB ID NO.:

EPW [redacted] (b)(6)-4

Ward/Section: 1CW3	RE[illegible]G PHYSICIAN: [redacted] (b)(6)-2	LABO[illegible]RY RESULT FORM (Subjec[illegible]ne Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN
EPW [redacted] (b)(6)-4	7/16/03	1300 0~~430~~	(b)(6)-4 [redacted]

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
[illegible]		[illegible]

(b)(6)-4

[redacted]

WBC	6.0	x10^3/uL	4.5	10.5
RBC	4.17	x10^6/uL	4.[illegible]	6.00
Hgb	[illegible]	g/dL	11.0	18.0
Mct	41.[illegible]	%	35.0	60.0
MCV	98.5	fL	80.0	99.9
MCH	30.9	pg	27.0	31.0
MCHC	31.4 L	g/dL	33.0	37.0
Plt	307.	x10^3/uL	150.	450.
LYC	[illegible]	%	20.5	51.1
LYC#	[illegible]	x10^3/uL	[illegible]	3.4

Urinalysis

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

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

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

CSF

Cell Count		
Directigen		Negative

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:	DATE:	LAB ID NO.:

Ward/Section: ICU3	RE	NG PHYSICIAN: (b)(6)-4	LABC ORY RESULT FORM (Subjec. to the Privacy Act of 1974)
LAST, FIRST, MI. # [redacted]	DATE 17 July 03	TIME 0450	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3
RBC Morph		
Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

(b)(6)-4

[redacted]

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

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

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] (b)(6)-2	DATE: 17 July 03	LAB ID NO.:

Ward/Section: ICU 3	REQ G PHYSICIAN:	CHEM Y RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: II [redacted] (b)(6)-4	DATE: 17 July 03	TIME: 0450	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

i-STAT EC8+

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

Pt Name:_____

Glu_____90 mg/dL

BUN_____10 mg/dL

Na_____138 mmol/L

K_____3.0 mmol/L

Cl_____104 mmol/L

TCO2_____29 mmol/L

AnGap_____9 mmol/L

Hct_____37 %PCV

Hb*_____13 g/dL

*via Hct

pH_____7.419

PCO2_____42.7 mmHg

HCO3_____ _28 mmol/L

BEecf_____3 mmol/L

Sample Type_:

17JUL03 05:03

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

Physician:_____

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

Ver: [redacted]

(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] (b)(6)-2	17 July 03	

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

PATIENT IDENTIFICATION

[redacted] (b)(6)-4
ICU-3
[redacted] (b)(2)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER 7/14/03 TIME OF ORDER 0809 HOURS

Admit to ICU
Dx: S/P GSW to flank s/p Ex lap
Condition stable
VS q 2 hr
Diet NPO
IVF LR @ 150 cc/h

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

Activity OOB to chair HOURS 1000
Continuous pulse oximetry (b)(6)-2 [redacted]
Ancef 1 gm q 8°
MSO4 2-6 mg IVP q 2° PRN pain
Phenergan 12.5 mg IVP q 6° PRN pain
Tradol 30 mg IVP q 6° x 4 doses
Incentive Spirometry 10 x q h while awake

PATIENT IDENTIFICATION

[redacted] (b)(6)-4
ICU-3
[redacted] (b)(2)-2

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

Foley to gravity drainage HOURS
Dressing changes to abd / flank B.I.D.
Notify MD if T > 101.5
Oxygen 2L NC wean to keep O2 sat > 92%
Staff Dr. [redacted] (b)(6)-2
CBC, chem 8 q AM x 3 days

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER TIME OF ORDER

CXR in AM HOURS

(b)(6)-2 [redacted]

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				DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
				15Jul03	1200 HOURS	
			1	D/c Foley	Noted [redacted]	
			2	Clears. (b)(6)-2		[redacted]
					15 July 03 @ 1230	
				(b)(6)-2	[redacted]	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
				16Jul07	0700 HOURS	
			1	Advance Dret	[redacted]	Noted
				(b)(6)-2		[redacted]
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
				17Jul03	HOURS	
			1	D/c Msoy	(b)(6)-2	[redacted] Noted
			2	Percocett T-II labs Po Q4° PRN		
				(b)(6)-2	[redacted]	
NURSING UNIT	ROOM NO.	BED NO.				

PATIENT IDENTIFICATION				DATE OF ORDER	TIME OF ORDER	
					HOURS	
NURSING UNIT	ROOM NO.	BED NO.				

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

All (b)(6)-2 Except Two AT bottom (which are marked)

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. 07 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 14	15	16	17	18	19	20	21	22	23	24	25	26	27
14 July	[redacted]	VS Q 2hr	05	[redacted]													
			17	[redacted]													
14 July	[redacted]	Diet: NPO	05	[redacted]													
			17	[redacted]													
14 July	[redacted]	Activity: OOB to chair	05	[redacted]													
			17	[redacted]													
14 July	[redacted]	Continious pulse oximetry	05	[redacted]													
			17	[redacted]													
14 July	[redacted]	I&O 10x qh while	05	[redacted]													
		Awake	17	[redacted]													
14 July	[redacted]	Foley to gravity drainage	05	[redacted]													
			17	[redacted]													
14 July	[redacted]	Dressing changes to	05	[redacted]													
		abd + flank BID	17	[redacted]													
14 July	[redacted]	Oxygen 2L NS wean to	05	[redacted]													
		Keep O_2 Sat > 92%	17	[redacted]													
14 July	[redacted]	CBC, Chem 8 QAM	04	/	[redacted]												
		x 3 days															
14 July	[redacted]	CXR in AM	04	—	[redacted]	front - Kp											
15 July		Clears - Advance as	05	/	/	[redacted]											
		tolerated	17	/	[redacted]												

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW (R) FLANK S/P Ex-LAP

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted] (b)(6)-4

ICU-3

[redacted] (b)(2)-2

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

All: (b)(6)-2

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
14Jul	[redacted]	Admit to ICU	14Jul		Done	[redacted]
14Jul	[redacted]	CXR in am	15 14Jul	0600		
03July	[redacted]	D/C Foley	15July	1700	Done	[redacted]
~~15July~~	[redacted]	~~LR 500cc foley [redacted]~~ error	~~15July~~	~~2100~~		[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
14Jul	[redacted]	Notify MD if T>101.5														

USAPA V1.00

All (b)(6)-2 EXCEPT bottom 2.

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	DATE DISPENSED 14	15	16	17	18	19
14July	[redacted]	Condition Stable	05	[redacted]					
			17						
14July	[redacted]	IVF LR @ 150cc/hr	05	[redacted]					
			17	[redacted]					
14July	[redacted]	Ancef 1gm Q8°	00						
			14			Times Δ'd 7/14/03 KP			
			22						
14Jul	[redacted]	Ancef 1 gm q 8°	02	[redacted]					
			10	[redacted]		time Δd to ↓ 7/15/03			
			18	[redacted]					
15July03	[redacted]	Ancef 1 gm q 8°	06	[redacted]					
			14	[redacted]					
			22	[redacted]					

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P GSW TO (R) FLANK S/P EX-LAP

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. _____

PATIENT IDENTIFICATION:

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

ICU-3

[redacted] (b)(2)-2

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

A11: (b)(6)-2

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**
14July 03	[redacted]	Toradol 30mg IVP Q6° X 4 dose.	14July03	14Jul03 09	0945	[redacted]
	-----		14July03	1600	1615	[redacted]
	-----		14July03	2200		[redacted]
	-----		15Jul03	0400	0500	[redacted]
17July 03	[redacted]	DC MsO4	17Jul03	NOW	Now	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED												
14July 03	[redacted]	MSO4 2-6mg IVP	14 Jul 03 1145	14 Jul 03 1400	14 Jul 03 1700	14 July 1900	14 July 2359	15 July 03	15 July 1130	15 July 1400	16 July 0245	16 July 1720	16 July 2108	17 July 0200	DC'd MSO4
-----	-----	Q2° prn pain	2mg [redacted]	2mg [redacted]	2mg [redacted]	3mg [redacted]	4mg [redacted]	0920 4mg [redacted]	4mg ⊕	5mg ⊕ [redacted]	4mg [redacted]	2mg [redacted]	2mg [redacted]	2mg [redacted]	
14July 03	[redacted]	Phenergan 12.5mg IVP	14 Jul 03	17 July 03 0200	⊕	⊕		[redacted]							
-----	-----	Q6° prn pain Nausea	1500 [redacted]	12.5mg IV [redacted]											
17July 03	[redacted]	Percocet I - II tabs PO													
-----	-----	Q4° prn for pain													
-----	-----														
-----	-----														
-----	-----														
-----	-----														
-----	-----														
-----	-----														
-----	-----														

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)
QA Appr 8 Mar 89 (b)(6)-2

INITIAL SHIFT ASSESSMENT

	TIME	0900 INITIALS [redacted]	(b)(6)-2 INITIALS	1800 INITIALS [redacted]
NEURO	PUPILS	PERRLA 2-3mm BILAT		PERRLA 2-3 [redacted]
	SENSORIUM	ALERT ORIENTED		A+O (b)(6)-2
		FOLLOWS COMMANDS		Speak some English
		MAE X4		verbalizes need
RESPIRATORY	RESPIRATORY PATTERN	REG		RRR, CTA
	BREATH SOUNDS	APEX BILAT CLEAR/BILAT BASE DIM		none
	SECRETIONS	NONE NOTED		
SKIN	COLOR	PALE		WNL for race
	INTEGRITY	CDI		Abd wound 2° surgery
IV SITE	LOCATION	(R) A/C 18GA/PATENT		(R) UE, HL
	CONDITION	(L) FA 18GA/PATENT		(L) UE patent, LR @ 150
				IVPB
GASTRO	ABDOMEN	SOFT TENDER TO PALP		soft distended
	BOWEL SOUNDS	BS (+) X4 QUAD		tender to touch
				Hypoactive BS
				all quadrants
GU	URINE: FOLEY	CLEAR YELLOW URINE		foley. gs clear yellow
	COLOR/CLARITY	DRAINING TO GRAVITY		urine
			(b)(6)-2	
CARDIOVASCULAR	CARDIAC RHYTHM	SR/ST 90-100'S	~~WOUND: MIDLINE ABD DRES~~ [redacted]	$S_1 S_2$, ST 100s
		NO ECTOPY NOTED		∅ ectopy
		BILAT RAD PULSE +3		Radial (+) bilateral
		BILAT DP PULSE +2		Pedal (+) bilateral

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] (b)(6)-2

DEPARTMENT/SERVICE/CLINIC
ICU 3

DATE
14 Jul 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)
[redacted] (b)(6)-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					/	/												
BP Cuff					146/84	132/72		116/66			113/65	~~104~~	121/71		117/72		104/54	
Temperature					98.8	98.6		99.4					99.5				98.3	
Pulse					113	102		100			104		98		110		102	
Respiratory Rate					33	20		16			20		16		32		18	
Sp O2					100%	100%		96%			98%		97%		95		98	
O2 MODE						6L SFM		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
LR					150	150	150	150	600	150	150	150	150	150	150	150	150	1200
ABX						50			50								50	100
TOTALS									650									

OUTPUT																		
URINE	HOUR / TOTAL	/	/	/	/	/	450/450	/	/	450	/	525/	/	/	/	/	/	1500/2025	2025
	sp gr																	
	S/A																	
NG	OUTPUT																	
	pH																	
	GUIAC																	
EMESIS																		
STOOL																		
DRAINS																		
TOTALS									450									

OST-OP DAY

	24	22	23	00	04	02	03	04	
VITAL SIGNS	123/71			118/78	1		121/75		
				100.3			99.9	99.9	
	101			109			106	113	
	21			22			14	18	
	95			96			95	95	
	RA			RA			RA	RA	

	24	22	23	00	04	02	03	04	8° T
INTAKE	150	150	150	150	150	150	150	150	1200
						50			150
									1350

OUTPUT								1200	2475 1200 3675

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

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

LABORATORY DATA

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

ACTIVITIES OF DAILY LIVING

TIME	2200		
MOUTH CARE	✓		
BATH			
SKIN CARE			
FOLEY CARE	✓		
TRACH CARE	✓		
ROM EXERCISES	✓		

TURN

TIME					

SUCTION

24° I&O TOTALS

wt Yesterday _____ wt Today _____

	INTAKE		OUTPUT
IV	1350	Urine:	3675
po			
TOTAL		TOTAL	

BALANCE -2325

NURSE'S SIGNATURE	INITIALS
[redacted] CPT/Au	[redacted]
[redacted] Mg/Ao	(b)(6)-2
(b)(6)-2	

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																								
		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	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

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS [redacted]	(b)(6)-2	INITIALS	1800	INI [redacted]
NEURO	PUPILS	2++ PERRL				PERRLA (b)(6)-2	
	SENSORIUM	pt A&O x3				A+O X3	
		purpose Full movement				Ambulating	
		x4 pt follow simple					
		commands					
RESPIRATORY	RESPIRATORY PATTERN	RR- 20 SPO2- 95%				BBS, even unlabored	
	BREATH SOUNDS	CTA @ Ø ↓ lobes				CTA	
	SECRETIONS	No secretions @ present				~ secretions	
SKIN	COLOR	Normal For Race				normal	
	INTEGRITY	gunshot wound to				wound back + abdomen	
		abdomen				staples c̄ drainage	
I.V. SITE	LOCATION	(L) forearm				(L) forearm, LR @ 150 cc	
	CONDITION	LR @ 150cc/hr infusing				an hour.	
		via dial-a-flow				(R) H.L. in place	
		No signs of infection				⊘ S+S infection	
		infiltration noted					
		Dressing CDI					
GASTRO	ABDOMEN	Soft tender due				Left tender to touch	
	BOWEL SOUNDS	to wound				slightly distended	
		hypo active bowel				Active BS all quadrants	
		sounds x4 dressing CDI					
GU	URINE:	clear bright Yellow				amber urine, voiding	
	COLOR/CLARITY	urine draining via				spontaneously	
		Foley QS					
CARDIOVASCULAR	CARDIAC RHYTHM	HR- 112 BP- 129/75				ST 100 but ↓ NSR 80-90	
		peripheral pulses x4				peripheral pulses strong	
		capillary Refill ≤ 3 sec				palpable	
		NST					

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)

EDW [redacted] (b)(6)-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																		
BP Cuff	128/75		126/75		134/87		122/74					123/60		126/61			138/91	
Temperature	99.9		99.2		98.9		99.6			100.8		99.4		99.8			100	
Pulse	110		92		98		112			112		104		118	113		113	
Respiratory Rate	20		15		16		20			24		24		20	22		22	
	95		93		96		95%			96%		94%		93%	94		96	
	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
IV	150	150	150	150	150	150	150	150		150	150	150	150	150	150	150		
IVPB	Ø	Ø	Ø	Ø	Ø	Ø	Ø	Ø		Ø	50	Ø	Ø	Ø				
PO	NPO	NPO	NPO	NPO	NPO	NPO	NPO	Δ to Liquid		240	Ø	Ø	Ø	Ø				
						Ø												
								Fallen D/Cd										
TOTALS	150	300	450	600	750	900	1050	1200		1440	1790	1940	2090	2240				
OUTPUT URINE HOUR / TOTAL	200/200	200/400	400/800	450/1250	200/1450	300/1750	300/2050	0/2050		0/2050	0/2050	0/2050	0/2050	0/2050		700		
URINE sp gr																Voided P̄ Foley DC		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

EPW [redacted] (b)(6)-4 MEDCOM - 14595 15 July 03

POST-OP DAY

VITAL SIGNS	21	22	23	00	01	02	03	04	
						1			
		136/82				133/79			
		100.4					99.7		
		103				107			
		20				22			
		98				98			
		RA				RA			

INTAKE	21	22	23	00	01	02	03	04	8° T
	150						530		

OUTPUT							550		

ACUITY LEVEL CLASSIFICATION

RESPIRATORY	TIME									
	MODE									
	F_IO_2									
	TV									
	RATE									
	PEEP									
	A: pH									
	A: PCO_2									
	B: 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	TIME				TURN	TIME				
	MOUTH CARE									
	BATH									
	SKIN CARE									
	FOLEY CARE				SUCTION					
	TRACH CARE									
	ROM EXERCISES									

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

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	X																							
		TO SPEECH 3																								
		TO PAIN 2																								
		NO EYE OPENING 1																								
	BEST VERBAL RESPONSE	ORIENTED 5	X																							
		CONFUSED 4																								
		VERBALIZES 3																								
		VOCALIZES 2																								
		NO VOCALIZATION 1																								
	BEST MOTOR RESPONSE	OBEYS COMMANDS 6	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	X																							
		SEVERE WEAKNESS																								
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
	LEGS	NORMAL POWER																								
		MILD WEAKNESS	X																							
		SEVERE WEAKNESS																								
		ABNORMAL FLEXION																								
		ABNORMAL EXTENSION																								
		NO RESPONSE																								
PUPILS	RIGHT	SIZE	Z+																							
		REACTION																								
	LEFT	SIZE	Z+																							
		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
Pedal	R		+/+																							
	L																									
Radial	R		+/+																							
	L																									
	R																									
	L																									
	R																									
	L																									
	R																									
	L																									

LEGEND

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

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]	(b)(6)-4 EPW [redacted] (b)(6)-4		m

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

10. LENGTH OF SERVICE	ETS	11. FMP [redacted] (b)(6)-4	12. SOCIAL SECURITY NUMBER
	N/A	9 9	[redacted]

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH / CORPS (b)(6)-4
N/A	U	0800	N/A

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

17. UNIT LOCATION (State or Country Code)	18. MOS	19. TRAUMA	PREV. ADMISSION
		9	YEAR / [X] NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION	WARD	NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
Ø	ICU3	

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY	ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)	TELEPHONE NUMBER OF EMERGENCY ADDRESSEE
[redacted] (b)(2)-2		

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
5 Ø		Ø 3 Ø 7 1 7

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
A B A A		Ø 3 Ø 7 1 4

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

FOR LOCAL USE

Dx: ① s/p GSW to (R) Flank
② s/p Ex-lap

(b)(6)-2

Dx 8760
Proc 5411
Trauma 9
Inj 569 [redacted]

ADMITTING OFFICER [redacted] (b)(6)-2 Dra [redacted]

SIGNATURE OF ADMITTING CLERK [redacted] SPC, 91G10

DA FORM [redacted]

1. LAST NAME, FIRST NAME / NOM ET PRÉNOM	RANK / GRADE	✓ MALE / HOMME FEMALE / FEMME
SSN / NUMÉRO MATRICULE	SPECIALTY CODE / GPM	RELIGION / RELIGION

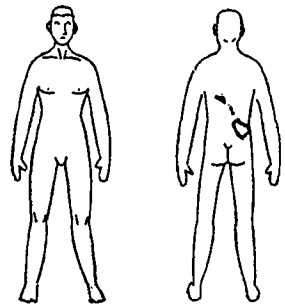
2. UNIT / UNITÉ: IRAQI

FORCE / ÉLÉMENT				NATIONALITY / NATIONALITÉ
A/T	AF/A	N/M	MC/M	IRAQI

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)

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	TIME / HEURE
110	2200	✓ NO / NON — YES / OUI	

7. MORPHINE / MORPHINE	DOSE / DOSE	TIME / HEURE	8. IV / IV	TIME / HEURE
✓ NO / NON — YES / OUI				

9. TREATMENT / OBSERVATIONS / CURRENT MEDICATION / ALLERGIES / NBC (ANTIDOTE)
TRAITEMENT / OBSERVATIONS / PRESENTE MEDICATION / ALLERGIES / ANTIDOTES

IVs - IBGA BILAT
FOLEY -
O2 - REBREATHER
X-RAY

TO SURG

10. DISPOSITION / DISPOSITION	RETURNED TO DUTY / RETOUR À L'UNITÉ	TIME / HEURE
	EVACUATED / EVACUÉ	
	DECEASED / DÉCÉDÉ	

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 - 14599

12. REASSESSMENT / RÉASSESSMENT				
DATE / DATE (YYMMDD) 030713		TIME OF ARRIVAL / HEURE D'ARRIVÉE 2230		
TIME / HEURE	2230			PACU
BP / PS	136/86			140/76
PULSE / POULS	121			123
RESP / RESP	20			76 DAT 95

DATE / TIME DATE / HEURE	13. CLINICAL COMMENTS / DIAGNOSIS INFORMATION MÉDICALE / DIAGNOSTIQUES
13 JULY 03 2230	EXPLAP: 1 & D POSTERIOR BACK & PENROSE NG - DRAIN 1 & D POSTERIOR GSW OF BACK L2-3-4 FENTANYL - 250mg MSO4 - 6mg MECURONIUM - ZANAC - 50mg FOLEY - DRAIN UO 1500
14 JULY 03 0040	14. ORDERS / ANTIBIOTICS (Specify) / TETANUS / IV FLUIDS DIRECTIVES MÉDICALES / ANTIBIOTIQUES (Spécifier) / TÉTANOS / IV FLUIDE VS - q5M x 5 IV - 150cc/° PAIN - MSO4 1.2mg IV q 20MINS NAUSEA - DROPERIDOL 0.625mg x 2 IV O2 - MASK @ 5L/MIN, O2 SAT ≥ 95% NG/FOLEY - DRAIN Exploration of Post wound entrance - Exit debridment - Repair over Penrose drain - [illegible]

(b)(6)-2

15. PROVIDER / OFFICIER MÉDICALE	DATE/DATE (YYMMDD)
[redacted] MAJ AN CRNA	030713

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 - 14600

ADMISSION AND CODING INFORMATION

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

30. AGE AT DISP			31. AUTOPSY Y / N	32. UNDERLYING CAUSE OF DEATH / SEP	33. RESIDUAL DISABILITY			34. DO NOT USE - DATA FILLER #1									35. CAUSE OF INJURY		
117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136

36. FIRST DIAGNOSIS *(Principal Diagnosis)*								37. SECOND DIAGNOSIS								38. THIRD DIAGNOSIS							
137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160

39. FOURTH DIAGNOSIS								40. FIFTH DIAGNOSIS								41. SIXTH DIAGNOSIS							
161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184

42. SEVENTH DIAGNOSIS								43. EIGHTH DIAGNOSIS							
185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200

MEDCOM - 14601

44. FIRST PROCEDURE *(Principal Diagnosis)*								45. SECOND PROCEDURE								46. THIRD PROCEDURE							
201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224

47. FOURTH PROCEDURE								48. FIFTH PROCEDURE								49. SIXTH PROCEDURE							
225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248

50. SEVENTH PROCEDURE								51. EIGHTH PROCEDURE							
249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264

52. NUMBER OF DIAGNOSTIC FIELDS CONTAINING CODES		53. NUMBER OF PROCEDURAL FIELDS CONTAINING CODES		54. PRIMARY PROVIDER SPECIALTY CODE			55. BLOOD USAGE Y / N
265	266	267	268	269	270	271	272
0	0	0	0				

(b)(6)-4

[illegible]TIENT TREATMENT RECORD COVER [illegible]ET

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

1. REGISTER NUMBER [redacted] (b)(6)-4			2. NAME (Last, First, MI) EPW [redacted] (b)(6)-4			3. GRADE EPW	ADMISSION REMARKS
4. SEX M	5. [redacted]	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION N	
11. FMP qa		12. SSN [redacted] (b)(6)-4		13. ORGANIZATION		14. WARD ICW2	
15. FLYING STATUS —	16. RATING/DSG —	17. DEPT./BEN [redacted]		18. BRANCH/CORPS —	19. UIC/ZIP —	20. TYPE CASE WIA	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION direct from ER				22. HOURS OF ADMISSION 2000	23. CLINIC SERVICE AJAA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK			25. TYPE DISPOSITION d/c to camp		26. DATE OF DISPOSITION 8Aug03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK			27b. TELEPHONE NO. UNK		28. DATE OF THIS ADMISSION 14JUL03		ADMITTING OFFICER
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]					30. DATE OF INTIAL ADMISSION		32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED
31. SELECTED [redacted] (b)(2)-2							

33. CAUSE OF INJURY

☐ Check if Continued on Reverse

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW-(R) forearm & (R) thigh

813.16
890.0
E991.2

79.32
77.63
86.22

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	25	25

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
	[redacted]				

SIGNATURE OF ATTEN[redacted] [redacted] [redacted] [redacted]CORDS OFFICER

A FORM 3647, MAY 79 (b)(6)-2 EDITION OF 1 AUG 76 IS [redacted]

MEDCOM - 14602

USAPPC V1.10

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

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

0 - Pts Consult

~ [redacted] (unknown age) y/o Iraqi male, ? engagement
(b)(6)-4
w/ US forces yesterday GSW (R) thigh & (R) forearm.
Tx by field medical team. c/o pain (R) prox FA
& (R) thigh. Numbness (R) hand. ↓ other c/o.

Ø pm/ps/med AM pain (?) Last meal last pm
Sat (F) tab

12.9
11.2 344
42.4

8
1.2 113

PHYSICAL EXAMINATION 113/63 105 99.0 98% RA

(R) FA - radial - 3-4 cm distal AC crease - ~ 3 cm wound
- ulnar - " " " " ÷ cm
- distal - Ø thumb IP flex, Ø IF FDP, 4/5 Abd,
other weak flexors (3/5) wrist ext throughout (3/5)
↓ LT median, other LT2 throughout 2+ pulses
refuses elbow ROM 2° pain, compartments soft
) thigh - anterior - ~ ÷ cm ant, ~ 4 cm post - left wounds
comp soft, NT; mild ↑ pain ≈ hip/knee PROM
distal 5/5 mm, LT2, 2+ pulses

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

12 (R) thigh (−) (R) elbow prox. radius/radial neck
comminuted fx

4) GSW - (R) thigh - soft tissue
(P) I & D
(R) prox. FA ≈ comminuted radius fx &
ANN, post med. Nerve inj
(P) I & D, delayed ORIF

PATIENT'S IDENTIFICATION	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	14 Jun	03	
(For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)		REGISTER NO.	WARD NO.

(b)(6)-2

[redacted] (b)(6)-4

ABBREVIATED MEDICAL RECORD
Standard Form 539

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

DICAL RECORD

AUTHORIZED FOR LOCAL REPRO

PROGRESS NOTES

DATE	NOTES
15 July 03	0700 - Pt alert lying in bed. Gave MSO4, 5mg for pain this AM. VSS, lungs CTA, HR reg, BS ⊕. Dsg CDI to ® arm. Dsg to ® thigh that has been reinforced last night. No new drainage noted. Pulses ⊕ & strong bilat to ↑ ad extremities. Will cont to monitor — (b)(6)-2 [redacted] 2LtAN
	0915 - Pt vomited x1 right after breakfast. Gave 12.5mg Phenergan. Pt is sleeping now. No new blood noticed to ® Dsg. VSS. Will cont to monitor — (b)(6)-2 [redacted] 2LtAN
15 July 03 1300	Assumed pt care @ 1300. pt sleeping arouses to painful stimuli. VSS. airway patent, lungs CTA. abd soft nontender BS⊕. ® thigh dressing, no new drainage noted, strong ⊕ pulse. © leg ⊕ pulse. ® arm dressing CDI, hand c̄ edema ⊕ pulse. © arm c̄ full ROM, ⊕ pulse, IV infusing D5½NS c̄ 20KCL @ 125cc/hr ō diff. ⓓ s/sx of infiltration. ⓓ complaints voiced @ this time. Will cont to monitor — [redacted] 91WM (b)(6)-2

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] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (RE
Prescribed by GSA/ICMR FPMR (41CFR) 101-11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 Jul	ortho $\bar{s}$ = 6 All (b)(6)-2 LSS AP Dsg = (1) Plan OR (R) elbow 24 - 48° [redacted] MAJ [redacted]
15 July 03 1750	(R) thigh draining lg amt of red bloody drainage. MD notified MD to come look @ thigh drsing. Will cont to monitor [redacted] 91WMC -
1900	MD @ bs. MD unwrapped drsing stated "there's no active bleeding" site rewrapped & order for NPO rec'd & noted. pt given 4mg MSO4 for pain, & will cont to monitor [redacted] 91WMC —
15 July 03	2130 Assume pt care @ 2100. pt awake and alert. ~~2~~ NS c̄ 20 meq KCL to (L) wrist no s/s redness/infiltration. 5mg MSO4 IVP for pain @ 2115. B/P ↑ will reassess to see if pain med will help. HR reg. Lungs CTA. Abd soft tender to palpate. BS x 4 (R) UE ace wrap CD+I (+) movement (+) sensation (+) pulse to hand. Swelling noted. Encouraged pt to keep ext elevated. (R) thigh Dsg CD+I. (+) pulse (+) movement below ace wrap. Will continue to monitor [redacted] 91WMC

CAL RECORD

AUTHORIZED FOR LOCAL REPR

PROGRESS NOTES

NOTES

16 July 03 0700 - Pt alert lying in bed. Gave MSO4 this AM for pain. VSS (BP 140/70), lungs CTA, HR reg, BS⊕. DSG to ® arm CDI. DSG to ® thigh CDI. IV D5½ NS + 20K at 125 into ® arm. Pulses equal & strong bilat to ↑ + ↓ extremities. Skin warm to touch. O/C to OR today. Will cont to monitor. —

(b)(6)-2 [redacted] 2 ~~4~~ AM

16 July 03 1300 assumed pt care @ 1300. pt awake et alert. VSS. pt's NPO for poss OR. lungs CTA, abd soft BS⊕. ® arm c̄ ace wrap, ® hand edematous. ® arm c̄ full ROM ⊕ pulse. IV D5½ NS + 20KCL @ 125cc/hr infusing s̄ diff, ⊕ S/SX of infiltration noted. ® thigh c̄ ace wrap, drsing CDI ⊕ pulse. ⓛ leg c̄ full ROM ⊕ pulse. pt voices ⊕ complaints @ this time. Will cont to monitor — [redacted] 91 WMC

(b)(6)-2

16 Jul 1700 Orthe

s̄ clo. Noted above, clot bled through dsg.

VSS AF

dsg Δ wounds dry now

SHIP TO SPONSOR

SPONSOR'S NAME

LAST FIRST MI

SPONSOR'S ID (SSN or Other)

Plan of ® elbow in AM

SERVICE

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(b)(6)-2

RECORDS MAINTA [redacted]

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PROGRESS NOTES
Medical Record

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[redacted] (b)(6)-4

TE All (b)(6)-2 NOTES

16 July 03 2115 Assume pt care @ 2100. Pt awake and alert. D5½NS c̄ 20 meq KCL infusing to (L) FA. no s/s redness/infiltration. VSS. HR reg. (R) arm dsg c̄ ace wrap CD+I. Swelling to (R) hand elevation encouraged (+) pulse (+) movement to hand. Abd soft tender to palpate BS x4 pt states he had BM today. pt voiding to urinal s̄ difficulty. (R) thigh Dsg CD+I (+) movement and (+) pulse below dsg. C/O pain mostly to RUE. 5mg MSO4 IVP adm. pt will be NPO p̄ MN for on call to OR in AM. Will cont. to monitor [redacted] 9lwarb

17 July 03 0515 Assumed pt. care @ 0500. Pt. resting. awake easily. A+Ox3. lungs CTA. (+) pulses x4. (+) BS x4. D5½NS c̄ 20mg KCl infusing in (L) FA s̄ difficulty. Dsing c̄ ace wrap to (R) arm CDI. Swelling to fingers on (R) hand. cap <3. (+) sensation + mov in fingers. Dsing c̄ ace wrap to (R) thigh CDI. (+) sensation and mov below site. C/O pain to (R) arm. Will continue to monitor. [redacted] 9lwarb

17 Jul 03 1230 Pt. returned from recovery room, A+Ox3. VSS. Dsing on (R) arm + thigh CDI. pt. had 750cc UOP/clear yellow. C/O pain to (R) arm. [redacted] 9lwarb

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
17 Jul 1130A	Op Note
	Dx (R) proximal radius Fx
	Rx ORIF
	Surgeon [redacted] (b)(6)-2
	GEIA
	EBL min
	Findings highly comminuted prox. radius c̄ devitalization of fragments
	AIN intact but confused
	Plan splint 10-14 d then begin early ROM
	(b)(6)-2
	[redacted] MAJ [redacted]
	(b)(6)-2

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

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

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PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES

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PROGRESS NOTES

DATE	NOTES
17 July 03 1310	assumed pt care @ 1300. pt just returning from OR. pt c/o pain given 5mg MSO4 by SFC [redacted] (b)(6)-2. lungs CTA, (R) arm c̄ splint wrapped c̄ ace wrap, drsing CDI, < 3 sec cap refill. (L) arm c̄ full ROM strong (+) pulse. IV (L) FA infusing D5½NS c̄ 20 KCL @ 125 cc/hr s̄ diff. (+) s/sx of infiltration. abd soft BS (+) x4 quads. (R) thigh c̄ ace wrap drsing CDI, (+) movement (+) sensation <3sec cap refill (+) pulse. (L) leg c̄ full ROM (+) pulse. Will cont to monitor (b)(6)-2 [redacted] 91WM6
17 July 03 1945	pt's IVF dc'd per orders. pt now HL'd. (+) c/o pain voiced. Will cont to monitor (b)(6)-2 [redacted] 91WM6
17 July 03	2230 Assume pt care @ 2100. Pt awake and alert. HL to (L) hand no s/s infiltration/redness c̄ flush. VS B/P 152/102 temp 100.6. Pt c/o pain to (R) UE ~~UE~~ NW. 00 11 percocet @ 2200. NV ✓'s WNL. (R) UE splint c̄ ace wrap CD+I. (+) movement (+) sensation to fingers. Edema noted to fingers cap refil ≥ 3sec, elevated @ this time. (R) thigh dsg c̄ ace wrap CD+I. (+) movement (+) sensation below dsg. pt voiding clear yellow UOP. No other complaints @ this time. Will continue to monitor [redacted] WM6 (b)(6)-2

IIP TO SPONSOR

SPONSOR'S NAME

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

RVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

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

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (R
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	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
18 Jul 0515	Assumed pt. care @ 0500. Pt. awake c̄ grimace on face. C/o severe pain to (R) arm. A+O x 3. lungs CTA. (+) pulses x 4. Hypo active BS x 4. (+) sensation in (R) fingers + toes. Swelling in (R) fingers. Dsng c̄ ace wrap on (R) arm + (R) thigh CDI. HL (R) hand 3 signs of infection. Temp 100.7°F. Will continue to monitor — [redacted] 922026 (b)(6)-2
18 Jul 1000 A	Ortho: POD [redacted] (b)(6)-2
	3 c/d
	AF
	Rec splint c/D
	NV 3 Δ - ∅ A2N
	weak M/U/R
	LTC U/R, ↓ M
	Dsg Δ (R) thigh. (+) gran tiss
	fib. exudate on dsg
	A Doing well
	P cont BID w → D peak ing (R) thigh.
	(b)(6)-2
	[redacted] MAJ [redacted]
	(b)(6)-2

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PROGRESS NOTES

DATE	NOTES
18 July 03 1300	pt care assumed from previous shift. temp 100.5 pt given ∴ Tylenol per floor protocol. lungs CTA, abd soft nontender BS⊕. Ⓡarm c̄ splint et ace wrap CDI, ⊕ movement ⊕ sensation, < 3 sec cap refill. Ⓛarm c̄ full ROM ⊕ pulse. HL to ⓁFA, ⊕ redness/swelling noted. Bt^os Ⓡthigh c̄ ace wrap, drsing CDI, ⊕ pulse. L↓ ext c̄ full ROM ⊕ pulse. ⊕ c/o pain voiced @ this time. Will cont to monitor (b)(6)-2 [redacted] 91WMC
18 July 03 2200	Pt. awake & alert in bed. HR Reg, lung sounds clear bilat, bowel sounds (+) x 4 quads. Pt. c/o constipation, sat on bedpan & was unsuccessful at deficating. DSG to Ⓡarm CDI, ↑ on folded blanket, limited digit ROM, (+) sensation, slightly swollen digits, cap refill < 3 sec. DSG to Ⓡthigh CDI, pedal pulses palpable, (+) digit sensation ⓇLE, cap refill < 3sec. HL in Ⓛ AC flused well c̄ 3cc NS 5 s/s of infection. All other assessment findings WNL. Will continue to monitor (b)(6)-2 [redacted] 97 IAN
19 July 0745	Pt care assumed @ 0500. VSS, pt sleeping awaken by verbal stimuli c̄ c/o pain in rue extending from shoulder to hand. Lung sounds CTA, bs⊕ x4 quads. Pt c̄ cast on rue, CDI. Pt able to wiggle fingers ⊕ sensation and capillary refill. Dsg on rle CDI, ⊕ sensation and cap refill in rle, HL in Ⓛac

IIP TO SPONSOR

SPONSOR'S NAME

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

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Medical Record

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FIRST NAME	MIDDLE INITIAL	ID NUMBER

ATE

All: (b)(6)-2 NOTES

flushes well, IV abx. Dsg Δ @ 0930, pt will be premedicated c̄ MSO4 @ 0915. Will continue to monitor. [redacted] 91WM6

19 July 03 1300 assumed pt care from previous shift. pt resting, easily aroused to verbal stimuli. VSS. lungs CTA, abd soft, BS⊕ (R)↑ ext c̄ splint & ace wrap, drsing CDI. (L)↑ ext c̄ full ROM ⊕ pulse, HL to (L)AC ⊕ redness/swelling noted. (R)↑ ext c̄ ⊕ movement ⊕ sensation of fingers. (R) thigh c̄ ace wrap drsing, drsing CDI, ⊕ pulse. (L)↓ ext c̄ full rom ⊕ pulse. pt c/o pain to (R) arm, given ⅔ percocet per prn orders. Will cont to monitor — [redacted] 91WM6

19 Jul 03 21:33 Assumed c/o pt @ 21:00. Restraints ~~x2~~ x1 (L) ankle. VS WNL per flowsheet. Skin color WNL + W/D. PERRLA ⊕ WNL LCA (B). BS x4 hypoactive. Soft splint to (R) arm C/D/I. digits warm to touch ⊕ <3 sec cap refill ⊕ edema ⊕ ROM ⊕ sensation. ↑ x2 blankets (L) ac PIV patent. (R) thigh ACE wrap dsg C/D/I. ⊕ PPP (B). Digits to (R) foot. ⊕ sensation ⊕ ROM ⊕ <3 sec. cap refill. c/o pain x1 in (R) arm. ⅔ Percocet given. Temp ↑ 100.0. Will cont. to mon. [redacted] 2LT/AN

0100 W→D dsg Δ performed. Old dsg c̄ yellow odorous drainage noted, moderate amt. New dsg c̄ NS packed to entrance and exit wounds. Dry 4x4 dsg applied and kerlix and ace wrap applied. C/D/I. Pt. premedicated c̄ 6 mg MSO4. Tolerated procedure very well. Will cont to mon. [redacted] 2LT/AN

MEDCOM 14615

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
20 Jul 03	0510: Assumed pt. care @ 0800: Pt. asleep, awake easily. Ato x3. Lungs CTA. (+) BS x4. HL in (L) AC $\bar{s}$ signs of infection. Drsng + Ace wrap on (R) arm CDI. (+) sensation and movement in (R) fingers. Drsng $\bar{c}$ ace wrap on (R) thigh CDI. (+) sensation and movement below site. Denies any discomfort @ this time. Will continue to monitor. (b)(6)-2 [redacted] 91WM6
20 July 03 1310	Assumed pt care from previous shift. Pt awake et alert - VSS. Lungs CTA. (R) arm $\bar{c}$ cast, (+) movement (+) sensation of fingers, <3 sec cap refill. fingers swollen. (L) arm $\bar{c}$ full ROM (+) pulse. HL to (L) AC (+) redness/swelling noted. Abd firm nontender BS (+) x4 quads. (R) thigh $\bar{c}$ drsing CDI. (+) movement, (+) ~~sensate~~ LSO sensation (+) pulse. (L) leg $\bar{c}$ full ROM (+) pulse. (+) C/O pain voiced @ this time. Will cont to monitor (b)(6)-2 [redacted] 91WM6
21 July 03 0150	Pt. asleep in bed $\bar{s}$ complaints. HR Regular, lung sands clear bilat, bowel sands (+) x 4 quads. (R) arm ↑ $\bar{c}$ folded blanket, minimal ROM in digits, (+) sensation, mild swelling, cap refill <3 sec. DSG Δ'd to (R) thigh $\bar{p}$ 5mg MSO4 administered. Both wounds on (R) thigh $\bar{s}$ s/s of infection, packed $\bar{c}$ wet gauze. New IV placed in (L) hand $\bar{s}$ s/s of infection, flushes well. All other assessment findings WNL. Will continue to monitor. (b)(6)-2 [redacted] 20/Ar
21 July 03	0645 - Pt alert lying in bed. Splint cast to (R) arm. Edema noted to the fingers. (+) Sensation, able to wiggle fingers. Skin warm to touch. Dsg to (R) ↑ thigh. Pulse (+) on (R) foot. HL to (L) hand. Will cont to monitor (b)(6)-2 [redacted] 2600

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All: (b)(6)-2

MEDCOM - 14617

0700 - lungs CTA, HR reg, BS⊕. Pt voicing ø complaints at this time. [redacted] 2HR

21 Jul 03 2015 assumed care of pt @ 1300 - VSS - premedicated c̄ 5mg MSO4 IVP then Δ'd dsg on (R) thigh, wounds packed c̄ damp gauze, 4x4 then Kerlix wrapped around leg - SL patent in (L) hand - (R) finger neuro V's WNL, splint & dsg intact on (R) arm [redacted]

21 July 03 2345 Pt care assumed @ 2100. VSS, pt awake and alert c̄ no complaints at this time. Lung sounds CTA, pulses palpable x4, bs⊕. Dsg on (R) thigh c̄ ace wrap CDI, pt c̄ positive sensation and cap refill in (R) foot. IV in (R) hand c̄ IV ABX running, ø s/s infection or infiltration. No complaints at this time, will continue to monitor. [redacted] 91WM6

22 July 03 0620 - Pt alert this AM lying in bed. VSS, lungs CTA, HR reg, ~~lungs CTA~~ error [redacted] BS⊕, Splint cast to (R) arm, ⊕ sensation, able to wiggle fingers, warm to touch. Dsg to (R) thigh, CDI, ⊕ sensation able to wiggle toes, warm to touch. HL to (L) hand. Voicing ø complaints right now. Will cont to monitor [redacted] 2HAU

22 July 03 1330 assumed pt care @ 1300. pt awake eating lunch. VSS (R) arm c̄ splint & ace wrap, drsing CDI, edema noted to fingers, ⊕ movement, ⊕ sensation (L) arm c̄ full ROM ⊕ pulse. Lungs CTA, abd soft nontender BS⊕ x4. (R) thigh drsing CDI ⊕ pulse. (L) leg c̄ full ROM ⊕ pulse. HL to (L) hand ⊕ redness/swelling noted. ⊕ c/o pain voiced @ this time. Will cont to monitor [redacted] 91WM6

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PROGRESS NOTES

ATE	NOTES
22 July 2300	Pt care assumed @2100. VSS, alert and awake with mild c/o pain. Lung sounds CTA pulses ⊕ x4, BS ⊕ x4. Dsg 1 on rle done c̄ 10mg MSO4 for premedication. Wound appears to be healing, no s/s infection noted. Kerlix c̄ ace wrap applied. Dsg on Ⓡ buttock CDI. Rle c̄ ⊕ sensation and cap refill. No new complaints, continue to monitor. (b)(6)-2 [redacted] 9KWMCO
23 July 03	0900 - Pt alert lying in bed. VSS, lung CTA, HR reg, BS ⊕. Splint cast to Ⓡ arm, ⊕ sensation, able to wiggle fingers, skin warm to touch. Wet → dry dsg applied to Ⓡ thigh, CDI. HL to Ⓛ arm for antibiotics. Voicing Ø complaints at this time. Will cont to monitor. (b)(6)-2 [redacted] 2LtAn
	1110 - Dsg Δ done to Ⓡ thigh wet → dry. Gave 5mg MSO4 (b)(6)-2 [redacted] 2LtAn
	1430 - Pt stable at this time. VSS. PERRLA. Mucous membranes pink moist & intact. Neck supple, FROM. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Neuro vascular check to Ⓡ arm grossly intact. Arm

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

PROGRESS NOTES
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PROGRESS NOTES

NOTES

23 July 1430 (cont) weak, but able to lift. Brisk Cap refill and strong pulse to (R) arm. Pt c̄ FROM to fingers on (R) hand. Brisk Cap refill to all extremities. Pt c̄ pain to (R) arm controlled c̄ Percocet. (R) arm and (R) leg elevated. (b)(6)-2 [redacted] LCP/AN

23 JUL 03 0130 Pt care assumed @ 2100. VSS, pt awake and alert. Lung sounds CTA, pulses palpable x4, b⊕ x4 Quads. Dsg on rue CDI, pt c̄ ⊕ sensation and able to wiggle fingers. Dsg Δ done on rle, pt premedicated c̄ 5mg MSO4, but still in apparent pain. Wound is s̄ s/s infection, Δ s̄ problems. New dsg CDI, pt c̄ ⊕ pulse and sensation in (R) foot. IV @ L wrist is positional, IV ABX running. No complaints at this time, will continue to monitor. (b)(6)-2 [redacted] 91WM6

0300 c/o pain at rue radiating distally from elbow and mild pain @ rle, ⅓ percocet given. (b)(6)-2 [redacted] 91WM4

24 0100 July 03 Nursing Assessment: Pt awake, alert, O.X.3. Airway intact, breathing even and unlabored, LS clear to all fields ⊕. Abd soft, nontender, s̄ distention. BS⊕ x4. BM x4 today. Void spontaneously. IV HL to (L) hand, flushes well & s̄ s/s infiltration/inflammation. ROM and neurovascularly intact to (L) UE and (R) LE. (R) LE limited ROM 2° cast and bulky dsg from mid-thigh (continued)

SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
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PROGRESS NOTES
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All (b)(6)-2 Except bottom one.

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PROGRESS NOTES

NOTES

240600 July 03 Nursing Assement (continued): to fingers. Neurovascularly intact. (R) LE has ACE to thigh wrap that is CDI. Note RE: drsg Δ will come T drsg Δ. — [redacted] UTAW

241100 July 03 Nursing Drsg Note: Gauze moist c̄ drainage. Mostly serosang drsg c̄ minimal purulent drainage to either wound. Smaller wound to anterior (R) thigh approx ½ inch diameter and ½ inch deep, c̄ minimal tunnelling. (R) thigh posterior/lateral wound is approx 2 inches wide and ½ inches deep. Posterior/lateral wound has tunnelling to anterior portion (approx 3/8 inch deep) that extends to inferior/posterior portion of wound (approx ⅛ inch deep). Both wounds gently packed c̄ gauze dampened c̄ sterile H_2O. Wound beds show minimal purulent drainage and no foul odors. Wound beds are beefy red. — [redacted] UTAW

24 July 03 1330 assumed pt care @ 1300. pt awake et alert (R) UE c̄ splint cast et ace wrap, drsing CDI (+) movement, (+) sensation, <3 sec cap refill. LUE c̄ full ROM (+) pulse. HL to (L) hand, (-) redness/swelling noted. lungs CTA, abd soft BS (+) x4 quads. (R) thigh c̄ ace wrap drsing, drsing CDI, (+) movement, (+) sensation (+) pulse. LLE c̄ full ROM (+) pulse. (-) complaints voiced @ this time. Will cont to monitor - [redacted] 91WM6

25 July 0110 Pt care assumed @ 2100. BP ↑ slightly, other vss. Pt c̄ c/o pain, 5 mg MSO_4 and ⅔ percocet given to treat pain and premedicate prior to dsg Δ. Lung sounds CTA, [redacted] BS (+) x4. Dsg Δ done, pt wound appears to be healing very well, no s/s infection. (cont) [redacted] 91WM6

SPONSOR'S NAME

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PROGRESS NOTES

NOTES

0110 Pt c̄ HL on (L) hand, IV ABX running s̄ diff. Dsg
25Jn on rue CDI, pt c̄ (+) sensation and able to wiggle
fingers. RLE (+) sensation and able to wiggle
toes, no c/o pain p̄ dsg Δ. Will continue
to monitor. [redacted] alwmc

2500 July 03 Nursing Assessment: Assumed care of pt. Airway intact, breathing even and unlabored. LS clear to all fields (B). Abd soft, nontender, s̄ distention, BS(+)x4. Voids spontaneously. ROM and neurovascularly intact to LUE and LLE. ROM to RUE and RLE limited 2° injury. (R) elbow in cast c̄ ace wrap. Neurovascularly intact to (R) UE and (R) LE. Drsg to (R) thigh is ACE wrap, CDI. IV to (L) hand heplocked, c̄ s/s infection or infiltration. [redacted]

2500 July 03 Nursing Dressing Note: Smaller wound to anterior thigh had minimal purulent drainage but a significant amount of serosanguinous drainage. Re-packed c̄ ½ of 2x2 gauze. Wound continues to be approx ½ inch deep and ½ inch wide. Beefy red wound bed. Larger wound to posterior thigh is approx 1½ inches ~~deep~~ wide & ½ inch deep, c̄ tunnelling from anterior area to inferior/posterior portion of wound. Wound bed beefy red c̄ no purulent drainage. No purulent drainage to old drainage either. Re-packed c̄ 2(two) 2x2 gauze. [redacted]

25 July 03 assumed pt care @ 1300. Pt sitting ↑ in bed eating
1305 lunch tray. VSS. lungs CTA, ~~BUE c̄ full ROM (+) pulses HL to (L) hand (+) spx (-) infection noted, fingers s̄ diff. Abd soft non-tender BS(+)x4. (R) thigh c̄ ex-fix~~ (R) LE c̄ splint [redacted]
& ace wrap, drsng CDI (+) movement (+) sensation cont'd

SPONSOR'S NAME

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PROGRESS NOTES

DATE	NOTES
cont'd 25 July 03 1305	fingers c̄ edema. (L) arm c̄ full ROM (+) pulse. HL to (L) hand (1) S/SX of infection flushes well. abd soft BS (+) x4. (R) thigh c̄ ace wrap drsing, drsing CDI. (+) movement (+) sensation (+) pulse. LLE c̄ full ROM (+) pulse. (1) complaints voiced @ this time. Will cont to monitor (b)(6)-2 [redacted] 91WM6
26 July 0100	Pt care assumed @2100. VSS, awake and alert, ÷ percocet given for pain @2200. lung sounds CTA, bs (+) x4. Dsg on rue CDI, pt able to wiggle fingers and (+) sensation in rue. Pt ambulate x1, no c/o pain while ambulating. Dsg Δ done on rle. Proximal dsg c̄ little serous drainage, very little bloody drainage. Wound is beefy red, about 1cm wide, 2cm deep. Lower, distal wound site is healing well, little drainage noted. Pt was premedicated c̄ 5mg MSO4. IV ABX running, HL is in L wrist. No complaints, continue to monitor. (b)(6)-2 [redacted] 91WM6
0430	Pt c/o pain in rue, ÷ percocet given. (b)(6)-2 [redacted] 91WM6
200530 July 03	Nursing Assessment: Assumed care of pt. Airway intact, breathing even and unlabored, LS clear to all fields (B). Abd soft, nontender, ↓ distention. BS (+) x4. CBM x3 days ago. FROM and neurovascularly intact to (L) UE and (L) LE. (R) UE ROM limited by cast & ACE, CDI. RLE FROM limited by pain, but neurovascularly intact. Drsg to (R) thigh CDI. IV to (L) hand sluggish c̄ flush. Attempt to restick x3. No new IV at this time. (b)(6)-2 [redacted] 91WM6

HIP TO SPONSOR

SPONSOR'S NAME

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

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26 Jul 0845

Ortho
T < 6
c̄ wt Tlu
AF
Dsg Δ (R) elbow - wounds healing well
(R) thigh " " -
(R) hand ↑ R/M/U Fxn
remains ∅ AIN

Doing well
cont dsg Δs
Return to EPW soon

X

[redacted]

MAJ [redacted]

26 1000 July 03 Nursing Dsg Note: Dsg to (R) thigh continues to improve from yesterday. Both wounds are beefy red c̄ no purulence noted. MSO4 still required for dsg Δs - [redacted] ug, AN -

26 July 03 - assumed pt care @ 1300. pt resting quietly 1340 arouses easily to verbal stimuli. Lungs CTA abd sqt BS (+) x4. (R) thigh c̄ drsing CDI (+) movement (+) sensation (+) pulse. LLE c̄ full ROM (+) pulse. (R) UE c̄ drsing CDI, (+) movement (+) sensation (+) pulse. LLE c̄ full ROM (+) pulse. HL to (L) hand (1) S/Sx of infection. (1) complaints voiced @ this time. Will cont to monitor

[redacted] 91WMC

NOTES

DATE

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PROGRESS NOTES

NOTES

26 July 2120 Pt care assumed @ 2100. VSS, alert and awake c̄ no complaints at this time. Lung sounds CTA, pulses ⊕ x4, DSD. HL on L hand intact, flushes well. Pt taking PO abx. Dsg on Ⓡ elbow CDI, pt c̄ ⊕ sensation and rom on rue. Dsg on Rle CDI, dsg Δ to be done later. ⊕ sensation and pulse in rle, no complaints at this time, will continue to monitor. (b)(6)-2 [redacted] 91WM6

2250 Dsg Δ done. Wound healing, no drainage noted. Pt premedicated c̄ 5mg MSO4. (b)(6)-2 [redacted] 91WM6

27 July 04 1430 Pt stable at this time. AAO x3. PERRLA. Lungs CTA bilat, ∅ resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Neuro vascular check to Ⓡ arm grossly intact. Limited ROM, good strength good sensation. Brisk cap refill, strong pulses x4 extremities. ∅ complaints (b)(6)-2 [redacted] 1CT/AN

27 Jul 03 22:35 Rec'd c/o pt @ 21:20. Restraints x2 Ⓛ wrist/Ankle. VS WNL x̄ BP↑ initially @ 21:35 156/128 pt c/o pain to Ⓡ arm/hand. ii Percocet given @ 21:46. 22:35 BP 144/112 p̄ being premedicated c̄ 4mg MSO4 for Ⓡ thigh dsg Δ. Will mon and retake BP in 1°. Skin W/D. LCA Ⓑ. BS ⊕ x4. ⊕ PP Ⓑ. Ⓡ UE dsg C/D/I. Pt performed

SPONSOR'S NAME

LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSA or other)

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... and or written entries, give: Name - last, first, middle; (2) No or SSN, Sex: Date of Birth, Rank/Grade)

REGISTER NO | WARD NO

EPW [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509

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All (b)(6)-2 Except Bottom one.

Progress Note

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MEDICAL RECORD — ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
30 July 03 1345	pt care assumed @ 1300. VSS. (R) UE drsing CDI. (+) pulse, movement & sensation. LLE c̄ full ROM (+) pulse, HL to LFA (-) redness/swelling noted. lungs CTA, abd BS (+) (R) thigh c̄ drsing CDI. (+) pulse. LLE c̄ full ROM (+) pulse. (-) c/o pain noted @ this time. Will cont to monitor. [redacted] 91WM6
1400	pt c/o pain to RUE, ∴ percocet given — [redacted] 91WM6
1830	Staples removed intact & steri-strips applied, pt tol procedure well. [redacted] 91WM6
2130	PT care assumed @ 2100 - VSS, alert and awake, c/o pain in rue. Lung sounds CTA, pulses + x4, bs + x4. Dsg on rue CDI, pt c̄ (+) sensation and ROM. Active ROM performed on rue x 15 minutes. Dsg on RLE d/d. Wound pink and moist, ∅ s/s infection. + sensation and capillary refill on RLE. Will continue to monitor. [redacted] 91WM6
31 July 03 0630	Pt. awake & alert in bed c̄ c/o pain, ∴ percocet given. HR Regular, lungsounds clear bilat, bowel sounds (+) x 4 quads. HL in (L) FA flushed well c̄ 3cc NS c̄ s/s of infection. DSG to (R) elbow & (R) thigh CDI. Limited ROM in (R) shoulder, elbow, & hand, (+) sensation, <3 sec cap refill. MD in to see pt., wants to be notified before DSG Δ. Pt. c̄ other complaints @ this time. All other assessment findings WNL. VSS. Will continue to monitor. [redacted] 91WM6

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	[redacted] ED 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.
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EPW #[redacted] (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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A11 : (b)(6)-2

MEDCOM - 14631

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
31 July 03 1210	W→D DSG Δ'd to (R) arm & (R) thigh. Quarter size wound on outer aspect of FA is red fleshy colored c̄ s/s of infection, small dime size wound on inner aspect of (R) FA c̄ s/s of infection: scant amt of red tinged drainage on old dressing. MD in to view progress of healing to wound on (R) thigh. Wound is approximately half dollar in size c̄ small amt of bright red bloody drainage. Wound upacked c̄ sterile gauze & sterile H_2O. ROM performed on (R) UE. MD stated that once pt. can pack wound on his arm, he can D/C to camp. — [redacted]
31 July 03 1345	assumed pt care @ 1300. pt awake & alert. VSS RUE c̄ steri-strips & drsing, drsing CDI. (+) pulse slight movement, sensation. LUE c̄ full ROM (+) pulse HL (L) FA (+) redness/swelling noted. lungs CTA abd soft BS (+) x4. (R) thigh drsing CDI, (+) movement, sensation, pulse. LLE c̄ full ROM (+) pulse. (+) complaints voiced @ this time. Will cont to monitor — [redacted] 9WMC
31 July 2315	Pt care assumed @ 2100. VSS, alert and awake, c/o slight pain in rue. Lung sounds CTA, pulses (+) x4, BS+ x4. Active ROM performed x10 minutes. Pt taught how to Δ dsg on RLE, understands that he needs to know how to do dsg Δ. Pt OOB playing chess c̄ staff, continue to monitor. — [redacted] 9WMC
01 1 Aug 03	1100 - Pt A-Ox OOB ambulating x2 this Am. VSS, lungs CTA BS (+). Dsg Δ'd to (R) arm & (R) thigh. Pt assisted in changed. Voicing 2 complaints. Will cont to monitor — [redacted] 2CM

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

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
14 Jun 03	OP NOTE
1830	Dx GSW (R) Proximal FA, (R) thigh
	Rx I.D
	Surgeon [redacted] (b)(6)-2
	EBL min
	Plan (R) FA/Elbow - delayed ORIF of Prof. Radius/Radial Neck
	(R) Thigh - W→D Dsg Δs
	(b)(6)-2
	[redacted]
	MAS [redacted]
2000	Pt transferred from ICU#2 @ 1930. NSS x̄ ↑BP 150/100. A+O x 3. (B) LS CTA. (+) BS x 4. (R) UE dsg CDI. (+) sensation, palapable pulse, cap refil <3 sec, mvt fingers (R) hand. (+) 1 Edema (R) hand. (R) LE Dsg was saturated in blood on transfer. MD notified. Reinforced c̄ herlex, abd pad, and pressure dsg c̄ ace wrap. (R) foot (+) sensation, palapable pulse, mvt toes, cap refil <3 sec. Ø c/o pain @ rest. IVF @ 125cc/hr via patent (L) arm PIV. O/W assessment WNL Will Monitor (b)(6)-2 [redacted]

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

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

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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A11 : (b)(6) -2

MEDCOM - 14633

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
14 July 03	2140 pt [redacted] care assumed @ 2100. Pt awake and alert. B/P ↑ 172/120. 20KCL ĉ NS @ 125cc/h to (L) wrist. No s/s redness/infiltration. Ace wrap and dsg to (R) UE CD+I swelling noted to fingers (+) pulse (+) sensation (+) movement. (R) thigh dsg and ace wrap reinforced due to excessive bleeding. CD+I @ this time. (+) movement (+) pulse (+) sensation below dsg. HR reg. Lungs CTA. Abd. soft BS×4 nontender nondistended. P/O pain to LUE. ∞ percocet @ this time. Will continue to monitor [redacted]
	2345. MD informed of ↑ B/P and bleeding from thigh. Order for Verapamil unavailable from pharmacy. MD informed no new order written. Will continue to check B/P q2°. Thigh dsg reinforced. Will continue to monitor [redacted] SHUMP
	0130 B/P 132/94, temp @ 98.7° (R) thigh ↑ dsg draining sig amt of blood reinforced ĉ 8×4's and 2 ace wraps. [redacted] SHUMP
	0330 B/P 150/110, pt c/o pain. 5mg MSO4 IVP (R) thigh dsg sm amt of drainage noted [redacted] SHUMP
	0415 B/P 138/98 [redacted] SHUMP
	0425 MD informed of B/P, pt has good mentation and bleed from (R) thigh is controlled. Will continue to monitor [redacted] SHUMP

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	c̄ some difficulty, ∅ FROM. limited to about 140° angle. Ⓡ thigh dsg Δ W→D. tolerated procedure c̄ 4mg MSO4. Wound to Ⓡ thigh well approximated c̄ healthy pink granulated tissue to both wounds. ∅ further c/o pain. Able to move fingers to Ⓡ hand ⊕ sensation ⊕ <3sec cap refill ⊕ edema ∅ pitting. Ⓡ foot ⊕ sensation ⊕ <3sec cap refill. Will cont. to mon. [redacted] (b)(6)-2 ORT/AN
28 July 03	1200 - Pt alert & oriented OOB x 2 ambulating. ROM done with Ⓡ arm. Limited motion c̄ fingers + elbow. Dsg Δ'd to Ⓡ arm. Incision intact s̄ s/s of infx. Two open sores noted s̄ infx. Wet to dry dsg applied. Dsg Δ'd to Ⓡ thigh. Did not need p̄ medication. Tolerated dsg Δ well. Will cont. to monitor (b)(6)-2 [redacted] DLAN
28 July 03 2315	Pt care assumed @2100. VSS, at 0x3, ∞ percocet given for pain @2130. Lung sounds CTA, pulses ⊕ x4, bst. Dsg on rue CDI, pt c̄ ⊕ sensation and performed active rom. Dsg on Rle CDI ⊕ sensation and cap refill. 3mg MSO4 given to pt prior to dsg Δ. Wound on upper portion of thigh is almost closed, 1/2 cm open. Lower wound beefy red, ∅ s/s infection. No new complaints, cont to monitor. (b)(6)-2 [redacted] alunce

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.

EPW [redacted] (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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All: (b)(6)-2

MEDCOM - 14635

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
29 July 03	1000 - Pt alert VOB × 1 this AM. Bed bath completed. VSS, lungs CTA, BS⊕. Dsg Did to ⓡ arm. limited ROM, ⊕ Sensation, able to wiggle fingers, ⊕ pulse, did ROM exercises. Dsg Did to ⓡ thigh, ⊕ pulse, skin warm to touch. HL to ⓛ forearm → patent. Percocet given for pain. Will cont. to monitor — [redacted] 2 [illegible]
29 July 03 1320	pt care assumed @ 1300. pt resting quietly. RUE draing CDI, ⊕ sensation ⊕ pulse pt able to wiggle fingers. LUE c̄ full ROM ⊕ pulse, hL to ⓛ hand ⊖ S/Sx of infection noted. lungs CTA, abd firm BS⊕ ⓡ thigh draing CDI ⊕ movement ⊕ sensation ⊕ pulse LLE c̄ full ROM ⊕ pulse. ⊖ c/o pain/discomfort voiced @ this time. Will cont to monitor — [redacted] 9 [illegible]
29 July 2130	Pt care assumed @ 2100, VSS, c/o pain @ rue. Lung sounds CTA, pulses ⊕ x4, BS ⊕. Dsg Δ on RLE performed, no MSO4 given prior. Pt c̄ c/o pain, percocet were brought to bedside and pt was seen laughing and talking, medication withheld, pt sleeping. Dsg on RLE CDI, ⊕ pulse and sensation. Dsgs on RLE, upper wound closed, lower wound packed c̄ wet gauze. ⊕ sensation and pulse on RLE. Continue to monitor. — [redacted] [illegible]
30 July 03	P.T IV flushed good blood return @ 0600 — [redacted] 0820 - Pt A+O×3. VSS, lungs CTA, BS⊕. Dsg Δd to ⓡ arm & ⓡ thigh. ROM exercises carried out. HL to ⓛ forearm. Voicing ⊖ complaints. Will cont to monitor — [redacted] [illegible]

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NSN 7540-00-634-4176

HEALTH RECORD

600-108

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 Aug 03 1330	assumed pt care @ 1300. VSS. pt awake reading a magazine. ⊕ complaints voiced. RUE c̄ 4x4 drsing CDI to elbow area, steri strips CDI, ⊕ sensation, movement ⊕ pulse. LUE c̄ full ROM ⊕ pulse. Ⓡ thigh drsing CDI ⊕ movement ⊕ pulse. Other assessment findings WNL. Will cont to monitor (b)(6)-2 [redacted] 91WM6 (b)(6)-4
2020	pt c/o pain but laughing et talking c̄ EPW [redacted] pt given ∴ Tylenol per floor protocol (b)(6)-2 [redacted] 91WM6
1 Aug 03 2145	Pt care assumed @ 2100. VSS, alert and awake s̄ c/o pain. Lung sands CTA, pulses ⊕ x4, BS + x4. Dsg on rue CDI. Pt performed active rom and ambulated, both rue and lue c̄ + pulse ROM and sensation. Dsg Δ done to rle. Pt performed all of dsg Δ except for packing the wound. No complaints at this time, will continue to monitor. (b)(6)-2 [redacted] 91WM6
2 Aug 03	0925 - Pt alert ambulating x1 this Am on ward. VSS, lungs CTA, BS ⊕ x4, pulses ⊕ x4, Dsg Δ'd to Ⓡ arm. Steri strips in place to incision. Ø s/s of infx. Dsg Δ'd to Ⓡ thigh. Pt assisted in both Dsg Δ's. Voicing Ø complaints. Will cont. to monitor (b)(6)-2 [redacted] 26th

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

EPW

[redacted] (b)(6)-4

RECORDS MAINTAINED AT:

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 14636

STANDARD FORM 600 (REV. 5-84)
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FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
2 Aug 03 1320	pt awake et alert. VSS. RUE c̄ drsing CDI. ⊕ movement, sensation et pulse. LLE c̄ full ROM ⊕ pulse ⊕ IV access noted. lungs CTA, abd soft BS⊕. Ⓡthigh c̄ drsing CDI. LLE c̄ FROM ⊕ pulse. ⊕ complaints voiced. Will cont to monitor ——— [redacted] 91WM6
2 Aug 03 2120	Pt care assumed @ 2100. VSS, alert and awake s̄ c/o pain. Lung sounds CTA, pulses+x4, bs⊕. Dsg on rue CDI, ⊕ sensation and rom in rue. Active rom performed x10 minutes. Dsg on rle Δ'd, wand s̄ s/s infection. Pt c̄ understanding of how to Δ dsg. Dryskin noted on finger tips, lotion given. Will continue to monitor. ——— [redacted] 91WM6
3 August 03 0630	Pt - asleep in bed easily arrased by verbal stimuli. HR Regular, bowel sounds (+) x4 quads, lung sounds clear bilat. Pt. s̄ IV access. DSG to Ⓡelbow & Ⓡthigh CDI. Sterile strips to Ⓡimer forearm intact, incision s̄ s/s of infection & approximated well, Ⓡarm (+) sensation & limited ROM. Pt. c/o pain, ⊕ tylenol given. All other assessment findings WNL. Pt. s̄ other complaints @ this time. ——— [redacted] 2UT/AN
1035	DSG to Ⓡ elbow & Ⓡthigh Δ'd. Ⓡelbow wand is approx. quarter size, fleshy pink color, s̄ drainage, s̄ s/s of infection. Wand on Ⓡthigh approx. half dollar in size pink & fleshy s̄ s/s of infection, wand repacked c̄ sterile gauze in sterile water. ——— [redacted]
3 Aug 03 1315	pt awake et alert. VSS. RUE c̄ drsing CDI, steri strips intact ⊕ s/sx of infection noted. Ⓡthigh drsing CDI. Other assessment findings WNL. ⊕ c/o pain voiced @ this time. Will cont to monitor ——— [redacted] 91WM6

NSN 7540-00-634-4176

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

600-108

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
Aug 4 2315	Pt care assumed @ 2100. VSS, alert and awake, c/o pain in rue. Lung sounds CTA, pulses ⊕ x4, bs ⊕ x4. Dsg on rue CDI, ⊕ rom on rue, rom performed actively x10 minutes. Dsg Δ on rle, wand ∃ s/s infection, Pt performed most of dsg Δ. No complaints at this time, will continue to monitor. (b)(6)-2 [redacted] 4 Aug 03
4 Aug 03	0900 - Pt alert & oriented lying in bed. VSS, lungs CTA, HR reg, BS ⊕ x4, pulses ⊕ x4. Dsg CDI to (R) arm & (R) thigh. Will Δ later this shift. Voicing ∅ complaints at this time. Will cont to monitor (b)(6)-2 [redacted] 2 Aug
	1200 - Dsg Δ'd to (R) arm. Wound getting smaller. Wet → dry dsg applied. Dsg Δ'd to (R) thigh. Wound getting smaller, wet → dry dsg applied. Will cont to monitor (b)(6)-2 [redacted] 2 Aug
4 Aug 03 1300	- Received Pt Alert + oriented. VSS. HRR. Unlabored breathing. Breath sounds are bilateral. Pt has ⊕ ROM c̄ cap refills + 2 seconds. Drsg to (R) Arm CDI. Pt has ⊖ c/o pain or disorders. Pt has ambulated x2. Will cont to monitor. Pt. NAEVEL [redacted] (b)(6)-2
4 Aug 03 1305	Drsg to (R) Thigh CDI. Will cont to monitor. NAEVEL [redacted] (b)(6)-2

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

EDW [redacted] (b)(6)-4

RECORDS MAINTAINED AT:		
PATIENT'S NAME *(Last, First, Middle initial)*		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 14638

STANDARD FORM 600 (REV. 5-84)
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 Aug 03 23:03	Rec'd pt @ 21:00. VS WNL per flow sheet. Restraints x 2 (R)/(L) ankle. Awake and alert in bed skin W/D. PERRLA (+) WNL. LCA (B) HRRS, S2. BS (+) x 4. (+) PP (B). (R) arm steristrips in place. Wound incision C/D/I $\bar{c}$ s/s infection. DSG to (R) arm Δ'd wound beefy red in color $\bar{c}$ scant amt. dried blood and yellow drainage noted on old dsg. New W→D dsg applied C/D/I. Pt. performed ROM exercises $\bar{c}$ difficulty. Pt. in some pain while performing active ROM. ii Tylenol given for premedication. Wrist flexion and extension $\bar{c}$ difficulty. (L) Thigh dsg Δ'd. old dsg $\bar{c}$ scant amt yellow drainage. Wound well approximated. Skin to wound pink in color. (-) odor present. New W→D dsg applied C/D/I. Pt. tolerated (b)(6)-2 [redacted] both procedures well. (-) c/o pain @ this time will cont. to mon. (b)(6)-2 [redacted]
Addendum	RUE and RLE (+) ROM (+) sensation (+) <3 sec cap refill [redacted]
5 Aug 03	0612: Pt sleeping in bed, but easily arousable. VSS. lungs CTA, HR reg. BS (+); pulses (+) x 4. DSG to (R) arm & (R) thigh CDI. Will Δ later. Steri strips intact to incision. No c/o complaints. Will cont to monitor (b)(6)-2 [redacted]
	1130 - Dsg Δ'd to (R) arm, wound appears smaller wet → dry dsg applied. Dsg Δ'd to (R) thigh. Will cont to monitor (b)(6)-2 [redacted]
5 Aug 03 1315	Pt care assumed from previous shift. Pt resting quietly easily aroused to verbal stimuli. VSS. Lungs CTA abd soft BS (+) x 4. (R) thigh dressing CDI. (+) pulse. LLE & RLE (+) pulses. (R) LE $\bar{c}$ dressing CDI. (-) IV access noted. (-) complaints voiced @ this time. Will cont to monitor (b)(6)-2 [redacted] 9/WMC

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DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
5 Aug 03 23:38	Rec'd c/o pt @ 21:00. VS WNL per flow sheet. Restraints x 2 (L) arm (R) ankle. PERRLA (+) WNL. Skin W/D. LCA (B). HRRS, S2. BS (+) x 4. (+) PP (B). AROM performed (R) arm $\bar{s}$ difficulty. Amb. $\bar{s}$ difficulty. W→D dsgs Δ'd RU and RL Ext's. Wounds $\bar{s}$ s/s infection both $\bar{c}$ healing tissue well approximated. New W→D dsgs applied. c/o pain x 2 $\ddot{\pi}$ Percocet given. Will cont. to mon. (b)(6)-2 [redacted] 2LT AN
Addendum	(+) sensation, (+) ROM, (+) <3 sec cap refill to RE's (b)(6)-2 [redacted] 2LT AN
6 Aug 03	1130 - Pt alert & oriented OOB x1 ambulating on Wd. VSS, lungs CTA, HR reg, BS (+) x4, pulses (+) x4. ROM carried out x 2. Pain medication not required. Dsg Δ'd to (R) arm. Wound is appearing smaller. Dsg Δ'd to (R) thigh. Voicing Ø complaints. Will cont. to monitor (b)(6)-2 [redacted] 2LT AN
6 Aug 03 1315	pt lying on stomach $\bar{c}$ eyes closed, easily aroused to verbal stimuli. VSS. lungs CTA, abd BS (+) x 4. (R) thigh drsing CDI. (B) UE drsing CDI. Steri strips intact. (+) IV access noted. (+) complaints voiced @ this time. Will cont to monitor (b)(6)-2 [redacted] 91 WM6
6 Aug 03 21:12	Rec'd c/o pt @ 21:00. Restraints x 2 (R)/(L) ankles. Awake and alert in bed. PERRLA (+) WNL. LCA (B). HRRS, S2. BS (+) x 4. (+) PP (B) (R) elbow dsg C/D/I. Steri strips intact to incision

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.

EPW [redacted] (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
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