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
1 AUG 03		2000	- Received PT from PACU responds to verbal stimuli. VSS HR R. Breath sounds clear Bilateral. c̄ (−) c/o breathing difficulty. PT has (+) 2OM to all extremity. c̄ (+) Pulse motion function. to all extremity. +2 cap ref. B5 x 4. PT has received 2000 cc of D5 1/2 from PACU c̄ out any complication. PT has IV of sodium chloride in (L) forearm running well c̄ (−) s/s of infection or infiltration. MD reports states PT has (−) fractures to any bones in body and all x-rays are (−). Still need MD to write down orders removing C-collar. so maintain C-collar precautions. Pearla. (−) orbital fractures, or mandibal fractures noted. PT is currently resting in bed, will cont to monitor.
			[redacted] b(4)-2
		2200	Pt. received @ 2100. VSS. Pt. alert, attempting to communicate, @ english. Pearla. HR Reg, lungs CTA, ABD soft & flat c̄ BS (+) x4. Pt c/o lower ABD tenderness c̄ palpation. Pt. on C-spine precautions c̄ full ROM x4 ext, pulses 2+ x4 ext, brisk cap refill, (+) sensation x4 ext. IV to (L) FA intact, infusing D5 1/2 c̄ 20 meq KCl @ 100 cc/hr. will cont. to monitor. [redacted] b(4)-2

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

[redacted]

b(4)-4

NURSING NOTES

Medical Record

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

[redacted]

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY: 1 2

POST- DAY

MONTH-YEAR August 2003 DAY

HOUR

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

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

b(4)-2

VITAL SIGNS RECORDS

Medical Record

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

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 14 Aug	TIME 1730 [redacted] SSN/PSEUDO SSN: [redacted] b(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (a 41-51 mmHg (ve
PO2		80-105 mmHg (ar N/A (ven)
TCO2		23-27 mmol/L (ar 24-29 mmol/L (ve
HCO3		22-26 mmol/L (ar 23-28 mmol/L (ve
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmo
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. RANG
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl

======= PICCOLO =======
01/08/03 17:52
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	3.3	3.3-5.5	G/DL
ALP	67	26-84	U/L
ALT	13	10-47	U/L
AMY	69	14-97	U/L
AST	37	11-38	U/L
TBIL	0.7	0.2-1.6	MG/DL
BUN	16	7-22	MG/DL
CA++	8.6	8.0-10.3	MG/DL
CHOL	99*	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	78	73-118	MG/DL
TP	6.9	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 2+, LIP 0 , ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl

======= PICCOLO =======
01/08/03 17:50
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	74	73-118	MG/DL
BUN	14	7-22	MG/DL
CRE	1.2	0.6-1.2	MG/DL
CK	549*	39-380	U/L
NA+	133	128-145	MMOL/L
K+	4.2	3.3-4.7	MMOL/L
CL-	103	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 2+, LIP 1+, ICT 0

REMARKS: b(6)-2

REPORTED BY: [redacted]	DATE: 01 Aug 03	LAB ID NO.:

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI. b(6)-4 [redacted]	DATE 1 Aug 03	TIME 1730	SSN/PSEUDO SSN: [redacted] b(6)-4

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10^3	Color		N/A	RPR		Negative
RBC		4.7-6.1 x 10^9	App		N/A	Mono		Negative
Hgb		14-18 g/dl (M) 12-16 g/dl (F)	Glu		Negative	**Microbiology**		
Hct		42-52% (M) 37-47% (F)	Bili		Negative	Source		
MCV		80-94 fl (M) 81-99 fl (F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10^3 verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
Bands		Eos	Urob		0.2-1.0	O & P		
Lymph		Baso	Nit		Negative	Other		
Atyp		Imm	Leuk		Negative	**Microscopic Urinalysis**		
RBC Morph			HCG		Negative			
Spun Hematocrit		42-52% (M) 37-47% (F)	**CSF**			**Blood Bank**		
Sed Rate			Cell Count			**MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED**		
Other			Directigen		Negative	ABO/Rh		

Coagulation Studies			Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)		
TEST	RESULT	REF. RANGE	UNIT	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
APTT		21-34 secs			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY: [redacted] b(6)-2	DATE: 01 Aug 03	LAB ID NO.:

ID: [redacted] 01-08-03
WB 18:19

			Patient Limits	
WBC	9.4	x10^3/uL	4.5	10.5
RBC	4.16	x10^6/uL	4.00	6.00
Hgb	12.6	g/dL	11.0	18.0
Hct	40.9	%	35.0	60.0
MCV	98.1	fL	80.0	99.9
MCH	30.3	pg	27.0	31.0
MCHC	30.9 L	g/dL	33.0	37.0
Plt	330.	x10^3/uL	150.	450.
LY%	31.8	%	20.5	51.1
LY#	3.0	x10^3/uL	1.2	3.4

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

EW# [redacted]
b(a)-4

NURSING UNIT: ICW #2 | ROOM NO. | BED NO.

DATE OF ORDER: 8/2 | TIME OF ORDER: 1015 HOURS | LIST TIME ORDER NOTED AND SIGN

Tylenol 650 mg PO q4-6 prn pain [redacted]
V.O. Dr. [redacted]
b(a)-2 [redacted]

PATIENT IDENTIFICATION

NURSING UNIT: ICW #2 | ROOM NO. | BED NO.

DATE OF ORDER: 2 AUG 03 | TIME OF ORDER: 1145 HOURS

b(a)-2

(1) MOTRIN 800 mg PO Q8 [redacted]
PRN PAIN

(2) DIC TO EPW CAMP WHE[redacted]
RIDE ARRIVES [redacted]

b(a)-2

PATIENT IDENTIFICATION

EW# b(a)-4 [redacted]

NURSING UNIT: ICW #2 | ROOM NO. | BED NO.

DATE OF ORDER: 2 Aug 03 | TIME OF ORDER: 1146 HOURS

DC IV. b(a)-2
V.O. Dr. [redacted]
b(a)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

b(6)-2 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
1Aug	[redacted]	admit to ICW2	1Aug	NOW	2015	[redacted]
1Aug	[redacted]	DX: S/P assault c̄ closed head injury				[redacted]
1Aug	[redacted]	condition: stable				[redacted]
1Aug	[redacted]	PA/Lat CXR in am	2Aug	AM		[redacted]
2Aug	[redacted]	DC C-collar	2Aug	Now	0730	[redacted]
2Aug	[redacted]	DC to BW camp when available	2Aug			

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

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													
2Aug	[redacted]	Tylenol 650mg po q4-6hrs prn	2Aug 1015													
.....	.....		650mg po													
2Aug	[redacted]	Motrin 800mg po q8° prn pain	2Aug 1145													
.....	.....		800mg po													
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															
.....	.....															

b(u)-2

USAPA V1.00

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400; the proponent agency is OTSG b(4)-4

1. REGISTRATION NUMBER [redacted]			2. NAME (Last, First, MI) UNK, EPW [redacted]			3. GRADE NA	ADMISSION REMARKS
4. SEX M	5. AGE 22	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC NA	9. ETS NA	10. PREVIOUS ADMISSION NO	
11. FMP 99		12. SSN b(4)-4 [redacted]		13. ORGANIZATION NA		14. WARD ICU1	
15. FLYING STATUS NA	16. RATING/DSG	17. DEPT/SEN K78 NA		18. BRANCH/CORPS NA	19. UIC/ZIP	20. TYPE CASE WIA	
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION DIRECT FROM OMT				22. HOURS OF ADMISSION 1010	23. CLINIC SERVICE ABKA		
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK				25. TYPE DISPOSITION SD	26. DATE OF DISPOSITION 30AUG03		
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK				27b. TELEPHONE NO.	28. DATE OF THIS ADMISSION 4AUG03	ADMITTING OFFICER b(4)-4 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

GSW TO BRAIN

998.59
E878.9
V15.5

64.44
64.41
86.22
57.32
58.22

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
0	0	0	0	26	26

36. Total Days All Facilites b(4)-2

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]	0	0	0	26	26

SIGNATURE [redacted] RECORDS OFFICER

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

22yo ō GSW to groin/perineum 11 days ago
Rx ō Ex lap and local wound care. Transferred to SPW earlier and then to GSH.

PMHx	PSHx	meds	NKDA
Ø	Ø	Ø	

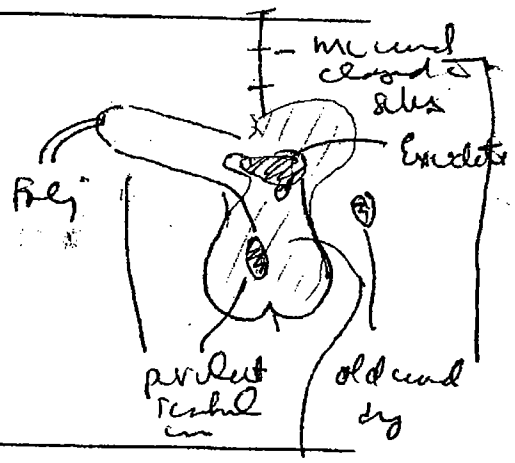
(+) tetanus in ERMT

11.1 / 8.9 / 28.3 < 402 | 142 / 110 / 11 / 3.6 / 25 / 1.0 < 99

UA 20-30 WBC
1g blood

PHYSICAL EXAMINATION

WD/WN Iraqi male
NC/AT
Neck FRM
lungs clear
RRR-1m
abd soft NTTP (+) recent US scan
tender diffuse L>R suprapubic area
rectal exam – marked edema



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

hx: Penile/scrotal injury ō penetrating discharge

Plan: to OR

[redacted] b(6)-2

	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]			

[redacted]ATION (For typed or written entries give Name last, first, middle; grade; date; hospital or medical facility)

REGISTER NO.	WARD NO.

[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

539-106

[redacted]

MEDICAL RECORD | PROGRESS NOTES

DATE

7 Sept 03 NARRATIVE SUMMARY DOA 20 Aug 03

LTC [redacted] MD DOD 7 Sept 03

REASON FOR ADMISSION: PENILE GSW

HOSPITAL COURSE: Iraqi male brought to

(b)(2)-2 [redacted] 10 days s/p GSW to (L) LQ and

abd s/p Ex lap, 1° closure of wounds at

Iraqi hospital who developed worsening

wound infection. Brought to OR on

admission and underwent Irrigation and

debridement of non viable / infected tissue

(see diagram). Wounds managed

by wet to dry dressing Δ.

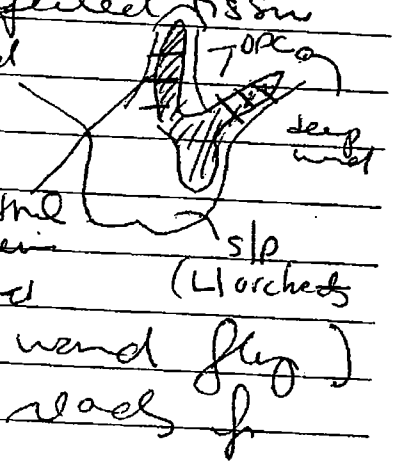
Taken back for DPC

of shaft and upper scrotal wound and

Finally flap (random, lat wound flap)

Closure. Patient now ready for

DC



Procedures: ① I/D penile wound

② Attempted DPC

③ Random flap scrotal / penile skin closure

Final Dx: Penile GSW

Plan: RTC EPW Camp

F/U as needed

(Continue on reverse side)

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

REGISTER NO. | WARD NO.

b(6)-4 [redacted]

[redacted] b(6)-2

PROGRESS NOTES
Medical Record

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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
3 August 03	S/ Pt c GSW to penis into lower abdomal.
	(+) smell. Drainage tube to (h) abdomin. Incident happened
BP 110/72	11 days ago and surgury occured at an
P 110	Iraqi hospital.
R 18	
SpO2 97	Pmtx: GSW 12-20 days old - Pelvis
T	Soxtx:
	incision
All	Drain
	Exam: Mild Distress
	GU: generalized swelling to genitals and
	penis. foul odor at site. No active
	exudate in wound
	Exit wound
	foley catheter in place & color urine
	Lungs: Clear
	Heart: RRR
	ABD: Soft NT ND (+) BS all quads
	X-ray: Pelvis
	No metal fragments
	No Bony fx.
	(OVER →)

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)-2 [redacted]

EPW b(6)-4

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

b(2)-2

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE** | AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 Aug 03	Pt returned from [redacted] c̄ sutures & foley placed by Iraqi doctor on the 24th of July. Foley draining amber urine c̄ sediment c/o
T 99.4	pain. Pt moaning during care of foley & wounds. Pt has GSW to penis ⓡ side. Abdominal sutures
110/80	ⓡ side
80	suture
15	20 sutures Clean + dry
2000	drain scab area to ⓛ thigh
	Has a clean suture line midline abdomen, a drain c̄ 2 sutures visable on ⓛ side of abdomen. Ø drainage noted. Penis has GSW tract down ⓡ side c̄ 1 suture visable. Pt visably in discomfort. Foley draining amber urine c̄ sediment. Patient medicated c̄ ⅡT Tylenol #3 po + Cipro 500mg po. Recommend that pt return to pt hold for pain management + fever management. SSG [redacted] 21W30
3 Aug 03	Per t/c c̄ Dr [redacted] b(6)-2 may send to [redacted] b(6)-2
2005	pt hold this PM [redacted] 2130

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.

b(6)-4

[redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPA V2.00

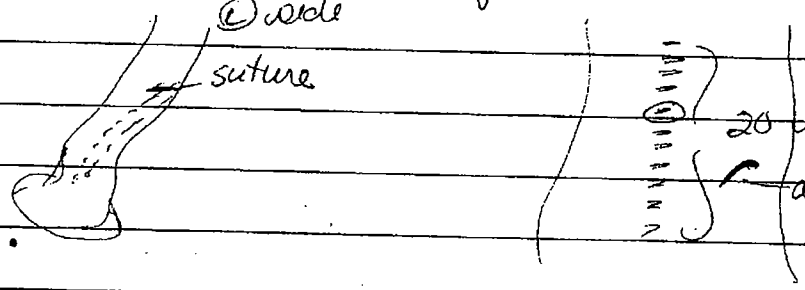
b(2)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 Aug 03	Pt returned from [redacted] c̄ sutures & foley placed by Iraqi doctor on the 24th of July. Foley draining amber urine c̄ sediment. C/O
T 99.4	pain. Pt moaning during care of foley & wounds. Pt has GSW to penis (R) side. Abdominal sutures
110/80	(R) side
80	suture
15	20 sutures
2000	Clean & dry
	drain
	scab
	~~area to (L)~~
	thigh



Has a clean suture line midline abdomen. A drain c̄ 2 sutures visible on (L) side of abdomen. ∅ drainage noted. Penis has GSW tract down (R) side c̄ 1 suture visable. Pt visably in discomfort. Foley draining amber urine c̄ sediment. Patient medicated c̄ ⅡT Tylenol #3 po & Cipro 500mg po. Recommend that pt return to pt hold for pain management & b(6)-2 fever management. —— SSG [redacted] 2/W30

3 Aug 03 2205 | Per H/C c̄ Dr Kumar may send to pt hold this PM —— SS [redacted] 3/30

b(6)-2

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

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

[redacted] b(6)-4

[redacted]

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPA V2.00

b(a)-4

[redacted]

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
3 Aug 03 (con't)	Lab: WBC ~~A~~ @ 5,950
	Wound cleaned c̄ betadine/ saline scrub to lower abdomin / penis
	Imp: Healing wound to genitals c/o pain.
	Plan: 1) Start Cipro 500mg BID
	2) Start Tylenol #3 1-2 q4-6 prn
	3) Continue to keep wound clean and dry. Bacitracin and dressing changes as needed.
	[redacted] LCSW
	b(a)-2

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

[redacted]

CLINICAL RECORD	NURSING NOTES (Sign all notes.)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
3 Aug 03		0135	Pt admitted to holding w/ minimal pain. Requested water.
			IV initiated (R) AC 1000 cc NaCl @ 100cc/hr.
			Cipro 400mg IV administered. Pt was
HL-			discharged earlier today and is returning
			w/ fever and pain. Pt resting quietly. SPC
BP-	4 Aug 03	0230	continued 1000cc NaCl IV, patient resting
P-			quietly [redacted] SPC
R-			b(a)-2
T-			[illegible] pain in penis and
SpO2-			morphine sulfate [illegible]
			resting [illegible] - if (P) - [redacted]
	4 Aug 03	0645	10mg morphine IM (R) glut - [redacted] SPC
			b(a)-2
			[illegible]
			[illegible]
			[illegible] b(a)-2
			A - [illegible] CSA wound care
			[illegible]
			b(a)-2

Continue on reverse side

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

b(a)-4

[redacted]

[redacted]

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5 Aug 03	Brief GP note wound cleaned / irrigated rechecked [redacted] b(6)-2
06 Aug 03 1710	Rec'd pt A/O - pleasant / [redacted] care. HOB ↑. dsg to penis / perineum C,D,I. foley secured & patent → cl/yellow urine. ∅ complaints voiced at this time. Repositioned pt comfort / dinner. O2 @ 2L NC & Sats 98%. See flowsheet for further assessment [redacted] Sgt/LPN b(6)-2
8 Aug/0600	Assumed pt care at approx 0530, pt in no apparent distress pt resting quietly, Changes made [redacted] b(6)-2 /LTRN
8 Aug/1000	Dressing d to penis done by Dr. Jezoir. pt premedicated c Percocet/Zofran/ per Dr. [redacted] wet to dry dressing done to penis & (L) lower abd quad. Penis site & scrotal site beefy red c small purulent yellow creamy drainage. (L) lower abd quad site mod amt creamy yellow drainage, once cleaned area beefy red & bled slightly. pt tolerated dressing d moderately well. pt now resting quietly & in no apparent distress. All VSS during dressing [redacted] b(6)-2 /LTRN
8.9/0600	Assumed pt care from LT [redacted] approx 0530 pt in no apparent distress & resting quietly in bed. CR infusing @ 100cc/hr. [redacted] b(6)-2 /LTRN
8.9/0800	Dressing Change wet to dry to penis scrotum & (L) lower abd quad done by Dr Jezoir, pt premedicated c 50mg Demerol IVP, mod amt purulent creamy drainage from (L) lower abd quad wound, penis wound beefy red c small amounts of purulent drainage, scrotum small amounts of creamy purulent drainage pt tolerated procedure relatively well [redacted] /LTRN b(6)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

9 Aug 03 Brief Op Note

Procedure: (1) Penile, scrotal, groin wound irrigation / debridement

(2) Circumcision

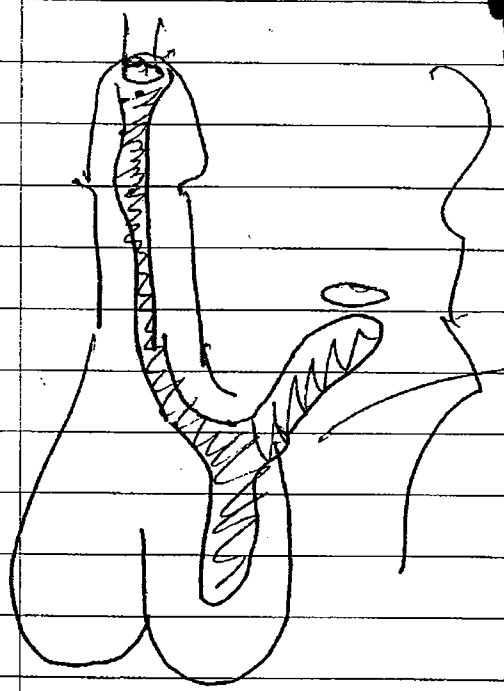
Indication: SP 8 SW Penis

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

GEPA

ABX: Gent / Ancef

Cephalexin [redacted] b(6)-2



Wounds

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
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-4

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
cont 8-5/0600			bilat lungs CTA ~ diminished bases.
			GI hypo BS denies N/V/D. NPO d/t scheduled surgery.
			GU straw colored urine C/S, F TG, urine sediment
			Lines 18G PIV RAC patent.
8-5/0820			Pt returned from OR c̄ ccl USS & in no apparent distress. Pt afebrile, dressings c/D/I/ pt placed on PCNC Spo2 96-98%, Pt currently / resting quietly denies pain b(6)-2 [redacted] KCRNBSN
			1900 05 AUG 03: Pt recieved from off going shift. Pt resting comfortable in bed. Assessment as follows: [N] PERRL 3mm; follows commands, purposeful movement; denies pain or odor [CV] S/S, NSR in 90s; 100s/70s; ⊖ JVD ⊖ edema, +3 (B) pulses PR UE; +2 (B) pulses in LE; [R] CTA (S); ⊖ cough, ⊖ IS; SpO2 97 on 2L NC, ⊖ S/S sys. [SKIN] multiple scars/sutures throughout body; midline abdl inc to lower epigastrium - c/d/I; [GU] penis with G; bulky dry - small amount of serous sts drainage noted, fully + sensitive - c̄ of penis head; moderate amount of urine; [GI] ⊖ N/V/D pt states will ↑ diet hypo active bowel sounds. [LINES] Foley, PIV RA (P) UE [PAIN]
			0600 A/O; responsive; NAD; assessment explicit [redacted]
			0800 drsgs Δ per MD; fasting labs drawn NPO b(6)-2 for procedure; pt tolerated well — [redacted]
			1200 no change in assessment; tol. po well — [redacted]
			b(6)-2

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
8-4/1530			Pt returned from OR hemodynamically stable, Pt placed on 4L NC sp02 97%, RR16 BP 125/67 HR122. NS @ KVO. Pt alert follows all commands, appropriate moves all extrem w difficulty. 6mg MSO4 IVP given for pain in groin area. b(6)-2 [redacted]
			1730 04AUG03 - Pt received from off going shift [A] Follows commands [CV] NSR 3+ pulses/LE 2+ Occlusion S1 S2 NSR-ST 110s/70s; [R] 2L NC sp02 98, CTA [GI] Middle lower abd inc. [GU] urethra expressed from surgery. Serosang drainage noted to (L) side of groin packing. Pt is in upright position, ↓ dependent position of foley. Pain controlled w/ MSO4. Bulky dsg intact - serosang drainage noted "1/2 dollar size"; [IV] (L) AC ok/clear. [PM] AM labs, control pain, Abx as ordered b(6)-2 [redacted] LT, Av
8-5/0530			Assumed pt care from LT Mawurdey. Pt resting quietly in no apparent distress. Started LR @ 100cc/hr. All VS @ change of shift. b(6)-2 [redacted] LT Rousu
8-5/0600			Pt a/o follows commands non combative, appropriate to staff perform 3 um Grish. Denies pain. CV NSR ectopy S1 S2, bilat radial & pedal pulses +2, ↓ edema. Resp even & unlabored on RA 97%, sp02 c̄ 4L NC

Continue on reverse side

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

REGISTER NO.

WARD NO.

EPCW b(6)-4 [redacted]

NURSING NOTES
Medical Record

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

NSN 7540-00-634-4176

HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE** | 600-108

b(6)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
09 Aug 03	(1800) Pt care Report Received from LT [redacted] Pt Awake's Acute Episodes noted / Reported. See DA 4700 for full assessment [redacted]
09 Aug 03	(1925) Pt care report given to LT [redacted]. Pt Remains Stable. [redacted]
09 AUG 1925	Received report. [redacted]
2130	Patient complaining of pain. Given 6 mg MSO4. [redacted] LT/AN
2230	Patient continues to have pain. Given 2 tabs Percocet. Will continue to monitor. [redacted] LT/AN
10 AUG 0045	Patient complaining of pain. Given 4 mg MSO4. [redacted] LT/AN
0300	Patient complaining of pain. Given 5 mg MSO4. [redacted] LT/AN
0400	Patient continues to have pain. Given 2 tabs Percocet. [redacted] LT/AN
0600	Report given to nurse. Except for intermittant episodes of pain, patient sleep throughout night. VSS HR 80 BP 112/72, RR 16, SaO2 97% on RA, T 98.2. [redacted] LT/AN
0630	report received; assessment complete. [redacted]
0700	new PIV to (R) Ac p med site infiltrated — 20 ga AC [redacted]
1000	dressing Δ per ms; pt tolerated procedure; pt tolerated well [redacted]
1500	OOB to chair; normal assist to use BSC; no bm; no change in status [redacted]
1800	report given to next sgt [redacted]

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

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

[redacted] b(6)-4

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 Aug 03	Urology Progress Note Patient continues to progress well c̄ dressing Δ's afebile Wound continues to granulate (+) Exudate on wound. Plan ① Cont daily dressing Δ's ② Likely DC (reappraise tomorrow [redacted]

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

AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
10 Aug 03 @ 2255	pt Report received from Cpt [redacted] b(4)-2 pt resting quietly VSS Assessment complete and WNL see flow sheet pt c/o pain and was medicated as per doctors orders pt shows no signs of acute distress @ present will continue to monitor throughout night [redacted]
11 Aug 03 @ 0500	pt VSS no problems @ present pt c̄ ∅ complaint at this time b(4)-2 pt medicated for pain c̄ ⊕ results per doctors orders no acute signs of distress noted will continue to monitor [redacted]
11 Aug 03	Brief op note OPC of penile wound → Dr Jezior CMA/General Complete [redacted] b(4)-2

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

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

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 USAPA V2.00

b(6)-2 All

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11AUG 2030			Drsg Δ per order to penile area. Premedicated ε Percocet 2 tabs.
2200			Patient sleeping. [redacted] LT/AN
12 AUG 0100			Patient sleeping. [redacted] LT/AN
0330			Patient complaining of pain. Given 2 Percocet [redacted] LT/AN
0600			Report given. [redacted] LT/AN
0620/8.12			Assumed pt care prior LT [redacted] pt resting comfortably in bed w/ no apparent distress, no IVS infusing [redacted] LT/AN
~~0600/8.12~~			~~[illegible]~~ [redacted] LT AN
1050			Pt. resting in bed c̄ eyes closed. [redacted] noted. Will continue to monitor. [redacted]
1600/8.12			pt tolerated dressing w/ well, premedicated ε 150 mcg fentanyl & 2 Percocet. No purulent drainage noted from wounds, minimal sanguinous drainage noted. Clean and wound packed [redacted] LT AN
12AUG05		2250	pt report received @ 1800 from Lt [redacted] pt resting ε complaints will continue to monitor [redacted] RC SGT
		2255	Assessment complete VSS pt penis dressing CDI [redacted] RC SGT
		@2340	pt resting comfortably in bed dressing Δ to penis Complete ε problems pt medicated as per doctors orders pt shows no signs of acute distress @ present will continue to monitor throughout night [redacted] RC SGT

b(6)-2 All

NSN 7540-00-634-4123

0-112

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

b(6)-2 All

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11 AUG 03 0600			Received report from previous shift. Pt
			awake and pleasant. 0 needs expressed.
			A'd IV drsg. VSS. Will cont. care. [redacted]
0800			Prep pt for drsg Δ. 0 needs expressed. Will
			cont care. [redacted]
0900			Dr. [redacted] completed drsg Δ. Gave
			150 mcg fentanyl for pain a procedure.
			Pt tol. well. Pt on NPO status until
			surgery later this PM. Will cont.
			care. [redacted]
1230			Pt to OR via stretcher. [redacted]
1400			Pt return from OR c̄ gauze bite block
			in mouth and new drsgs on penis. Pt
			O2 sats 95% [redacted] 95% on RA. Will cont. care.
			[redacted]
1430			Pt more awake/alert. % pain in
			penile area. Gave MSO4 4mg IVP. Will
			cont to assess pain level. [redacted]
1700			Pt resting comfortably. 0 % pain @ this
			time. Will cont care. [redacted]
1800			Gave report to next shift. [redacted]
1800			Received report. [redacted]
1830			Assessment completed. Patient resting in bed c̄ HOB ↑. Drsg
			to penis CDI. 0 Complaints c̄ this time. [redacted]

(Continue on reverse side)

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

REGISTER NO.

WARD NO.

NURSING NOTES
Medical Record

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

[redacted]

b(6)-4

#[redacted] b(6)-4

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
13Aug03	0618		Received report from night shift nurse. Pt. resting in bed c̄ eyes opened. ∅ complaint @ present time. VSS. 3U foley shut. Will continue to monitor. b(6)-2
	0730		Sitting up in bed eating breakfast. ∅ complaints. Will monitor.
	0749		Percocet Tab ii p.o for c/o pain. [redacted] monitor.
	0830		M.D. figure @ Bs. Drsg changed done c̄ 15cm of Foley. as pain management. Will continue to monitor.
	0946		Resting in bed c̄ eyes closed. RR 12+ even. ∅ distress noted @ present time. Will continue to monitor.
	1138		Pt. resting in bed. c̄ eyes closed. ∅ distress noted. Resp even & non labored RR 16. [redacted] monitor.
~~1315~~	1315		Lying in bed reading a book. ∅ complaints voiced. Denies any pain. Will [redacted]
	1346		c/o pain. Percocet Tab ii p.o. given for c[redacted]int.
	1528		Resting c̄ eyes closed. ∅ distress noted. [redacted] continue to monitor.
	1746		Sitting in bed eating ~~in bed~~ b(6)-2 dinner [redacted] monitor.

[redacted]

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
13Aug03		1815	Received report from SGT [redacted] Pt on RA, VSS, Dressing to penis c/o f. Foley to gravity, H/L to ⓡ ET, will continue to monitor. [redacted] BPC, 9/w MG
13Aug03		2200	Pt resting comfortably in bed VSS. will continue to monitor. [redacted]
14Aug03		0200	Pt resting comfortably in bed. VSS will continue to monitor. [redacted]
14Aug03	0600		Received report from previous shift. Pt resting c̄ eyes closed. Ø S/S or % pain. Will cont. care. [redacted] b(a)-2
	0720		Pt % pain penile area. Gave percocet ii. Will cont to assess pain level. [redacted] b(a)-2
	1000		Completed dsg Δ. Placed fine mesh gauze c̄ NS in (D) lower abd wound and by penrose drain and around penis. Used fluffs to support penis. Placed koban around penis. Pt assisted c̄ dsg Δ. Will cont. care. Gave fentanyl 150 mcg. [redacted] b(a)-2
	1250		Pt c/o pain penile area. Gave percocet ii. Will cont to assess pain level. [redacted] b(a)-2
	1500		Pt resting comfortably c̄ eyes closed. Ø % pain. Will cont. care. [redacted] b(a)-2
	1600		Pt peripheral line infiltrated. Will restart IV. [redacted]
	1735		Pt % pain. Gave percocet ii Will cont. care [redacted]

b(a)-2

b(6)-2 All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
15 Aug 03	Pt Lying in bed awake c̄ Ø Ntd complaints. VSS, will
1000	continue to monitor. [redacted]
1100	Pt Lying in bed sleeping + appears to be resting
	comfortably @ this time. Will monitor. [redacted]
1230	Pt sitting up in bed eating lunch, Ø Ntd complaints
	or distress. Pt stable, will monitor. [redacted]
1500	Pt Lying in bed talking to pt next to him +
	appears to be in cheery mood. VSS, pt stable. Will
	continue to monitor. [redacted]
1800	Received Report. [redacted]
2030	Drsg Δ to penis/LLQ. Premedicated c̄ Fentanyl 150 mcg, Perc 2
	Site CD c̄ sutures intact, Patient tolerated [redacted]
16 Aug 0300	Pt complaining of pain. Give 2 Percocets. [redacted]
0600	Report given. [redacted]
Aug 0600	Received Report from Nightshift + assumed care of Pt.
	Will monitor. [redacted]
0750	Pt pre-medicated for Drsng Δ c̄ 2 tabs of percocet. Pt
	stable, Will monitor. [redacted]
0840	Pt medicated c̄ 150 mcg fentanyl + drsng Δ performed. Wet
	to dry packing to open wounds + covered c̄ super sponge
	Flufs. Penis wraped c̄ wet to dry + coban. Pt tolerated
	Well, Will monitor. [redacted]
	Urology
	Patient progressing nicely
	Can't drain Δ's [redacted]
	b(6)-2

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

b(6)-2A11

UTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RE

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
14 Aug 03 1745	18 gauge (R) bicep. Flushes well. Gave report to next shift. Will cont. care. — [redacted]
1800	Received report from LCT [redacted] Pt has H/L to (R) upper arm. Foley to gravity. Dressing to penis C/D/I. Resting comfortably in bed. Will continue to monitor. — [redacted] SPC, 9/WM6
2000	Premedicated pt c̄ percocet II tabs for dressing Δ. [redacted] SPC, 9/WM6 —
2100	Dressing Δ complete, pt tolerated procedure well, will continue to monitor. [redacted]
0100	Pt resting comfortably in bed, will continue to monitor. [redacted] SPC, 9/WM6 —
0300	Pt c/o pain. administered II tab percocet. Will continue to monitor. [redacted] SPC, 9/WM6 —
0610	Received report from nightshift + assumed care of pt. — [redacted] 9/WM6
0700	Pt sat up in bed to eat breakfast. Ø Ntd complaints @ this time. VSS, Pt appears to be in a cheerly mood. Will monitor. — [redacted] 9/WM6
0820	Pt lying in bed asleep. Woken up + pre-medicated for dressing Δ c̄ 2 tabs percocet. Will monitor. — [redacted] 9/WM6
0900-1930 ~~0900~~ [redacted]	Pt medicated c̄ 150 mcg Fentanyl IVP + dressing changes performed. Pt tolerated well. Will monitor. — [redacted] 9/WM6

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORD 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 b(6)-4 [redacted]

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

USAPA V2.00

b(6)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each ent[redacted]
17Aug03	100cc output. [redacted]
0650	100mcg Fent for dsg Δ pre-med. [redacted]
0828	Percocet Tab ii p.o. for c/o pain after dressing Δ. Will continue to monitor. [redacted]
1031	Resting in bed c̄ eyes closed. Easy to [redacted] Will monitor.
1323	Resting in bed c̄ eyes opened. Ø complaints voiced @ present time. Will continue to monitor. [redacted]
1412	c/o pain. Percocet Tab ii p.o. given for com[redacted]
1625	Resting in bed c̄ eyes opened. Ø complaints. Will continue to monitor. [redacted]
1758	Percocet Tab ii p.o. for pain. [redacted]
17Aug03 @ 1810	pt report recieved @ 1800 from Sgt [redacted] pt sitting in bed pt c/o pain to penile area previous shift medicated pt as per doctors orders no other problems noted @ present will continue to monitor - [redacted] PFC 9/WMC
@1740	HR-85 BP-115/52 RR-16 SPO2-98% T-99.0 assement WNL GSW to penis dressing CDI pt c/o pain will medicate for dressing Δ and will continue to monitor. [redacted]
@2200	pt VSS medicated for pain dressing Δ complete pt resting quietly in bed no signs of acute distress noted @ present [redacted]
6 Aug 03 0830	Nursing: Pt had emesis x 1. Dr. [redacted] notified. Unsuccessful at starting PIV. Pt given Phenergan 12.5mg IM @ 0820 for c/o further nausea [redacted]
6 Aug 03	Nursing: VS: T-103.5, BP 112/72, HR-127, Sats 99% on RA. Pt diaphoretic, ⊕ chills. Pt assessed by Dr. [redacted]. New orders written. Pt given Tylenol 650mg PO @ 0815.

STANDARD FORM 600 (REV. 6-97) BACK

USAPA V2.00

[redacted]

b(6)-4

b(a)-2

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
Aug 1050	Pt medicated c̄ 100mcg Fentanyl. Penrose drain + sutures removed by DR [redacted] + dressings Δ'd again. Pt tolerated well, will monitor. — [redacted]
1200	Pt sitting up in bed complaining of groin pain, medicated c̄ 2 tabs Percoset. Will monitor. — [redacted]
1530	Pt lying in bed sleeping + appears to be resting comfortably @ this time. Pt stable c̄ Ø signs of distress. Will monitor. — [redacted]
1800	Report given to Nightshift. — [redacted]
16Aug03 1826	pt report recieved @ 1800 from Sp[redacted] No problems noted @ present will continue to monitor — [redacted]
@2130	pt doing well resting in bed @ this time dressing Δ complete dressing CDI no other problems @ present VSS Assessment complete For details see ICU3 Flowsheet — [redacted]
@2400	pt VSS no problems @ present will continue to monitor — [redacted]
0040 17Aug03	Recieved report from PFC [redacted]. Resting in bed c̄ eyes closed. Ø distress noted. VSS; BP 113/57 RR 12 HR 78 Temp 96.8 SpO2 99% RA Bandage noted to penis. Fc to BS draining yellow urine. Will continue to monit[redacted]

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

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

REGISTER NO.

WARD NO. ICU-3

EPW # [redacted]

b(a)-4

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

USAPA V2.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
18 Aug 03	Pregum Note Fever today T 103 do chills and drang and foly wound continues to heal well now Suspect UTI Plan - D to Urosyn / UPB DC Cefo Send UA / CBC / Chem 8 ABS b(6)-2 [redacted]
18 Aug 03 1040	Nursing: T-104.3 despite Tylenol. Ice packs applied to armpits + groin area. Cold ~~compr~~ towel applied to forehead. 20G IV started in R AC. LR started @ 125 cc/hr. CBC, Chem 8, + UA sent to lab. CXR pending due to patient back up in Radiology. Will continue to monitor. [redacted] b(6)-2

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

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

[redacted]

b(6)-4

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

USAPA V2.00

b(4)-2

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
18 Aug 03 1134	Nursing: T-102.2, remains diaphoretic, ∅ chills, ∅ N/V. Will continue to monitor. — [redacted] SPC/AW
18 Aug 03 1212	Nursing: T-101.1, pt c/o pain from penis. Pt given 2 tabs Percocet @ 1200. — [redacted] SPC/AW
18 Aug 03 1652	Nursing: Pt c/o ↑ bladder pressure. Suprapubic area distended on palpation. Pt last voided @ 1000 ≈ 210cc. Dr. Jeyar notified. Order written to Δ foley cath. Pt premedicated ≈ 150mcg Fentanyl IVP. Foley d'c'd. New 16G Foley Catheter inserted ≈ difficulty. Pt immediately had 325 cc UOP ≈ insertion. Wet to Dry Dressing Δ done on ~~penile & penis~~ groin area 1655 SPC. Small amount of purulent drainage noted. Pt given additional 50mcg Fentanyl IVP during Dressing Δ. Pt escorted to radiology via wheelchair. Pt able to stand ≈ difficulty. Pt assisted back to bed ≈ complaint. — [redacted] SPC/AW
1800	Received report from of going shift. Pt resting comfortably in bed. VSS. Foley draining to gravity, ↓ U to CFA, Dressing to penis C, D, I. Will continue to monitor [redacted] SPC, 91WM6
2200	Pt resting comfortably in bed. VSS. Will continue to monitor [redacted] SPC, 91WM6
0200	Pt resting comfortably in bed, VSS, will continue to monitor. [redacted] SPC, 91WM6
0600	Reported off to day shift. [redacted] SPC, 91WM6

STANDARD FORM 600 (REV. 6-97) BACK

LSAPA V2.00

NSN 7540-00-634-4176

b(6)-2 All

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19 Aug 03	Nurses, NCO Assessment: It walked to floor & back, 5 incent. AAOx3. Airway intact, breathing even and unlabored, LS CTA (B). Abd soft, nontender 5 distention. Midline incision well approximated, 5 s/s infection. Tolerating PO well. BS(+)x4. Foley draining clear yellow urine. Foley elevated on [redacted] all, secured c̄ tape. Scrotal support in place, Kerlix fluff placed between scrotum and supporter (also in creases of groin). Koban to penis. Drsg to groin is CDI, with drsg Δ, old drsg had old semi purulent drng. Replaced c̄ fine mesh gauze for packing of smaller, superior wound and larger wound near scrotum. Fine mesh gauze moistened c̄ NS. Covered c̄ gauze & taped. Drsg to (R) inguinal area also covered c̄ gauze, Penis wrapped c̄ gauze & Koban. Visually intact beyond wrap. Some purulent drng noted to end of penis. Cleansed c̄ soap & H_2O. IV to (L) AC c̄ LR @ 125 c/hr. — [redacted] CRNA
19 Aug 03 1330	Pt awake and alert. PERRLA. Lungs CTA Bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Healing midline incision intact. Drsg x1 to abd & x4 to scrotum intact. Scrotal support in place. Foley and Koban to penis. Strong pulses and brisk cap refill x4 extremities. Ø complaints [redacted] CRNA/AN
2030	Drsg Δ to abd and groin done. Wounds x2 to groin area red & fresh bleeding, Ø

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
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

b(6)-2
All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
19Aug03 2030 (cont)	purulent drainage. Fine mesh gauze w/ D. Wound to underside of penis wrapped c̄ gauze and koban. Sutures intact. Scrotal support c̄ gauze inside strap to prevent chaffing. Tetanus given prerred. [redacted]
2300	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA. BS (+) XY. Foley → gravity c̄ yellow urine, some sediment noted. will send UA in A.M. Dressings to penis, scrotal support c̄ I. IVF infusing c̄ diff. will cont. to monitor. [redacted]
	Urology Note Patient looks good Pla DC foley DC IV meds c̄ urang DC IV fluid Permit 1-2 days [redacted]
20Aug03 0900	Foley D/C'd per MD order [redacted] Pt. awake & alert sitting up in bed. MD in to view status of penile wounds. Base of penis on (L) side wound repacked c̄ dry sterile gauze, sutures removed. HL in (L) AC c̄ s/s of infection. VSS. Penile wounds c̄ s/s of infection. MD stated that graft to penis will be done in a few days. Pt. c/o pain x1, ii percocet given. AM care completed. Pt. c̄ other complaints @ this time. Will continue to monitor. [redacted]

NSN 7540-00-634-4176

b(6)-2 A11

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
20Aug03 1330	Pt awake and alert. PERRLA. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Dry dsg to wounds x2 to groin area. CDI. Penis wrapped c̄ dry gauze, Ø PCOran. Voiding well to BR. Ø Complaints. [redacted]
2030	Dsg change done to groin and penis wounds. Dry gauze c̄ minimal drainage noted to old dsg. Penis wrapped c̄ gauze. Ø complaints [redacted]
2117	Pt. care assumed @2100. Pt. c/o pain to groin. ¢̄ Percocet given. HR Reg, lungs CTA, BS(+) x4. Dsg to penis CDI. Pt. voiding. ∫ diff. Will cont. to monitor. [redacted]
21Aug03 0630	Pt sleeping, arousable c̄ verbal stimuli. Lungs CTA bilat, Ø resp distress. NSR. Abd soft, non-tender, bowel sounds active x4 quads. Scar to midline abd, wound well healed. Dsg to groin and penis intact, small amt of sanguinous drainage noted to dsg at base of penis. Voiding well to BR. Ø complaints [redacted]

HOSPITAL OR MEDICAL FACILITY

SPONSOR'S NAME	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
	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. ICU2

EPW [redacted]

b(6)-4

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

b(6)-2
All

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
21AUG03	(1710) Pt admitted to unit via litter in stable condition. Pt A/O speaking Arabic. Lungs CTA(B). ⊕bs x4 quads. VSS. Drsg to penis Δd this pm and drsg to LLQ Δd. Φ s/sx infection @ site of wounds. Pt voiding s̄ difficulty. Pt restrained via wrists bilat. Will continue to monitor. Pt resting quietly @ this time. Φ C/O pain. [redacted] (JA)
21 AUG 03 2226	JSS. AO. Mild c/o pain to groin area. DSG Δ performed. ⊕ pulses. Scrotal wound fluffy, β noted, Δ with AB ointment. Resting comfortably in bed. [redacted]
22AUG03	(1125) Assumed care of pt @ 0700 p̄ report from night shift. Pt alert speaking Arabic. VSS. Pt medicated c̄ ⅡT Perc this am for pain c̄ good relief. Drsg to penis Δd this am. Bacitracin applied to wound. Φ s/sx of infection. Drsg Δd to LLQ. Pt voiding s̄ difficulty. 2 point restraints in place. Pt resting quietly @ this time. AM care done by pt. Will cont. to monitor. [redacted] (JA)
	(1705) Pt OOB to amb in room s̄ difficulty this pm. [redacted] (JA)
22 AUG 03 2034	JSS. AO. PERRLA. BS(+)x4. S1, S2. +SCAB. Penis pain @ this time to scrotum. Wound remains fluffy s̄ s/s of infection. No evidence of abscess to entire line. [redacted]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

510-112

MEDICAL RECORD

b(6)-2 A11

NURSING NOTES
(Sign all notes)

NSN 7540-00-634-412

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
21/08/03			Bryan Nutt Ryan well Slaughter in Am [redacted]
23AUG03	1050		Assumed care of pt at 0700 p̄ report from night shift. Pt alert, speaking Arabic. Drsg to penis Δd this am. Bacitracin applied to wound on penis. Wet→dry drsg Δd on LLQ. Pt medicated c̄ ii Percc p̄ drugs Δd. Will monitor for relief of pain. VSS. Voiding s̄ difficulty. Am care done by pt this am. 2 point restraints in place. monitoring [redacted]
23 AUG 03	2100		VSS. AO. DSG to scrotum has small amount of purulent drainage, attempt CPI. ∅ s/s nal odor, bleeding or dehiscence. ⊕ pulses. Pertz computed in bed. [redacted]
Jm 24AUG03	1316		Received pt resting in bed. VSS, alert, speaking arabic. Dry Δ'd, c/d/i. ∅ wound drainage noted. is c̄ing PO ⊕ x4. HRR, pulses equal bilat. SLS. Medicated x1 for pain w/ ii Tabs percocet. Pt to OR in AM, NPO @ MN. will cont to monitor [redacted]

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

(Continue on reverse side)

REGISTER NO.

WARD NO.

#[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

NURSING NOTES
(Sign all notes)

b(6)-2 A11

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
24 AUG 03 1940			JSS. AO. Mild c/o pain to groin site. Provided 2 Percocet for pain. Vounds are OTA and NPO p MN. Ambulated x1 to bathroom [redacted] Ad at system WNL. [redacted]
Kary (N)	1100		Received pt resting in bed, VSS, IV patent and infusing NS @ 125 cc/hr. No changes to previous assessment. Pt NPO for OR today. No c/o pain so far this shift. Am care done. Tourniquets in place, will cut to monitor [redacted] WNL
23 AUG 03	3:45		

NSN 7540-00-634-4176

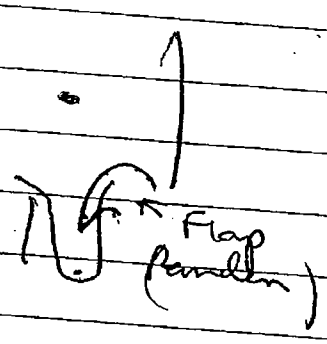
b(6)-2 All

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
25 Aug 03	Brief op note Procedure: Random(L) Cavernoid flap reconstruction of (R) grade 1 penis OSW Dr [redacted] GETA SBL min Antibiotic Cipro 400 mg Cyclo 4
26 Aug 03	Progress note Wound / Dressing intact No S/S infection Bedrest Cipro Dressing off in AM PO antibiotics 29-78
27 Aug 03	Progress note Wound looks good healing Discharge out in AM [redacted]



HOSPITAL OR MEDICAL FACILITY | STATUS | [redacted] | RECORDS MAINTAINED AT

SPONSOR'S NAME | SSN/ID NO. | [redacted] ONSHIP 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.

b(6)-4

[redacted]

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

b(6)-2 All

MEDICAL RECORD	PROGRESS NOTES
DATE	
26Aug03 @2000	Pt A|Ox3, VSS, c/o pain II percocet given @ 1930 c̄ noted relief. Prog to perform CPT c̄ scrotal support. JP drain c̄ sero-sanguinous drainage (20cc). +2 pulses, equal, lungs CTA (B) (+) BS x4 qdz. HL to (R) AC patent. Resting in bed. conversat-ing c̄ others. 2 pt restraints on. c̄ good circulation. Will cont to mon [redacted] Illume
26Aug @ 0055	Pt c/o pain II Percocet given. pt voiding often (cyu). foley to gravity. Will cont to monitor. [redacted] Illume
@0115	I concur c̄ above assessment. [redacted]
27Aug 0800	VSS Alert & oriented. (R) AC IV c̄ pain + swelling. (R) AC IV D/C'd warm compress applied to (R) AC. Anesthesia started IV to (L) FA X1 attempt. IV patent & intact. Saline locked. Restraints removed & reapplied will check restraints & circulation frequently. Dr Jession removed penrose drain this AM. Foley to gravity drainage clear yellow urine. D/C X1 to bedside suction. Will continue to monitor [redacted]

(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. [redacted]

WARD NO.

b(6)-4 [redacted]

PROGRESS NOTES
Medical Record

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

b(6)-2
A11

PROGRESS NOTES

DATE	
	S/P OR 25 Aug 03 @ 1800
25 Aug @ 1855	Pt received from ICU via litter. VSS, Pt A+O x3, speaking in aphric. s/p penile skin reconstruction. Drsg to penis CDI, foley to gravity, JP drain to bulb suction & serosanguinous drainage noted (5cc). pt urinated 100cc cyu on arrival. Pt c/o pain: given 6mg MSO4, & 2 percocets. & c/o nausea afterward. ∅ emesis, Restraints in place, all other assesment findings WNL. Will cont to monitor — [redacted] 91WMC SR
25 Aug @ 1930	Abx given. Pt emesis x3, could not tolerate Reg diet tonight. Will cont to monitor — [redacted] 91WMC SR
25 Aug @ 2300	I concur c above assessment. Addendum: Phenergan ordered for nausea. Results noted. WILL monitor. [redacted] 91W
26 Aug 03 @ 0800	VSS. A&O. Penile dressing Dry & Intact. Foley to gravity drawing clear yellow urine. JP x 1 with serosanguinous drainage 20cc output emptied @ this time. Tolerating Regular diet. Restraints removed & replaced. Will check restraints freq. (R) AC IV patent & intact infusing LR @ 100cc/hr. Due to episode of N/V last pm will have pt eat lunch before heplocking IV. No pain or distress voiced or noted — [redacted] 2CTR

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

#[redacted]

b(6)-4

NSN 7540-00-634-4176

MEDICAL RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE** — AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
27 aug03 @ 2010	Rt a/o x3, VSS, HRRR, lungs CTA (B) (+) BS x4 ad. abd: soft, NT. Drsg to penis c̄ small amt of old blood. ø active bleeding @ this time. JP draining 10cc serosanguenous fluid. voiding cyu often c̄ difficulty. HL to DFA patent & flushing easily. Abx given earlier today (1300). Foley to gravity. circulation assessed. 2 pt restraints on. will cont to monitor —
27 aug03 @ 2100	b(6)-2 [redacted] 3 9 11 WM6.
28 Aug03 1000.	b(6)-2 [redacted] VSS A&O (L) AC IV x̄ patent & intact. Flexion without difficulty. Drsg to penis intact. JP to bulb suction intact. Abnt 5cc of serosanguinous drainage noted. Shaved self ~~yesterday~~ By with assist. Foley care done. Foley drang clear yellow urine. Restraints removed and replaced. Will check restraints and extremities frequently. b(6)-2 [redacted]
28 AUG 03 1920	VSS. A.O. (+) pulses. LSCABG. DSG's to groin CDT & JP drain patent but bloody serous drainage. Intact. FTG drainage light yellow urine in tub sufficient. Restraints comfortable. [redacted]

HOSPITAL OR MEDICAL FACILITY

SPONSOR'S NAME	STATUS	DEPART./SERVICE [redacted]
	SSN/ID NO.	RELATIONSHIP TO SPONSOR b(6)-2

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

b(6)-4

REGISTER NO.	WARD NO.

EPW # [redacted]

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

b(6)-2
A11

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
29AUG03	(1005) Assumed care of pt @ 0600 p̄ report from night shift. Pt alert speaking Arabic. Pain controlled c̄ Percs. VSS. Pt had 1 episode of emesis p̄ eating breakfast. medicated c̄ 25mg Phenergan IVP c̄ good relief of N/V. UP pulled this am by MD. Site covered c̄ gauze. Small amount of sero-sang drainage noted on drsg. Steri-strips CDI to groin/penis area. Ø s/sx infection @ site. Bacitracin applied to underside of shaft of penis wound. Pt tol. reg diet well. Foley draining quantity sufficient clear yellow urine. AM care done by pt. 2 point restraints in place - Ø s/sx complications c̄ skin break↓/circulation. Will cont. to monitor [redacted] 4D Au
29AUG03 1910	Pt resting in bed, A+Ox3, VSS, LS CTA(B), ⊕BS x4, S1 S2 present, c/o pain coming from groin area, medicated c̄ 2 percs, c/o some nausea but refused medication, foley draining proper amount c/y urine, steri strips CDI to groin/penis area, proper circulation and skin integrity on pts of restraint. [redacted] 9 11 W4 6

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

MEDICAL RECORD | PROGRESS NOTES

DATE

30 Aug 03 Progress note
wound looks good
A to heal cgr
DC IV
DC Rx [redacted] b(6)-2

30AUG03 (1045) Assumed care of pt @ 0600 ~~p~~ report from night shift. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs and MSO4 bmg IM x 1. IV dlcd this am d/t infiltration. Ad to po Cipro. Foley dlcd this am - pt voided quantity sufficient clear yellow urine s̄ difficulty. Drsg to ⊕ groin Ad this am. Bacitracin applied to wounds on penis. ϕ s/sx infection. Steri-strips to groin CDI. Pt amb in hallway to latrine. s̄ difficulty. ⊕BM. Tol reg diet well. 2 point restraints in place s̄ s/sx complications from skin breakdown/circulation. Will continue to monitor.

b(6)-4 [redacted] USA

30AUG03 2100 Pt resting in bed, A+Ox3, VSS, LS CTA ⊕, ⊕BS x4, drsg's to groin area CDI, pt voiding well c/y urine, ϕ c/o pain or discomfort @

(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.

[redacted] b(6)-4

PROGRESS NOTES
Medical Record

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

b(a)-2
A11

PROGRESS NOTES

DATE	
	this time. [redacted] AIWM6
@2200	2-pt restraints on & skin integrity circulation intact [redacted]
	min monitor [redacted]
31aug03	Received pt resting in bed. USS, dress c/d/i, restraints in place w/ good skin integrity & circulation. SVQS, med x1 for pain. Amb indep. In restraints per CPW protocol, w/ good skin integrity and circulation. No other remarkable assessments, rate [redacted]
31Aug03@2330	Assumed care @1800; USS, pt A&OX3, c/o pain/discomfort @ this time; penile dsg CDI & drainage; pt to shower this PM per MD orders; pt up amb c escort; TOLPO; restraints in place, circulation & skin integrity intact; cont to monitor [redacted]
01Sept 1530	Received pt resting in bed, USS, ø acute distress noted. A+OX3. Pt to shower for wound drainage. Dress applied: gauze w/ bacitracin. ~~W pain~~ amb x2, BM x1, SVQS. Tol po. Will cont to monitor. [redacted]
1Sep.03 1950	Pt resting in bed, A+OX3, LS CTA (B), (+) BS x4, ø c/o pain @ this time, wounds on groin area appear c ø s/sx of infex, small drainage on gauze, taken to shower for wound drainage, pt ambulated around ward, proper circulation + skin integrity on pts. of restraint. [redacted] AIWM6

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

b(4)-2
A11

MEDICAL RECORD | PROGRESS NOTES

DATE	
31 Aug 03	Urology PN wound c̄ serosanguinous discharge (+) foul odor Ø fever Plan shower BID [redacted]
2 Sep 03 0900	VSS Pt AO. OOB to BR to dressing change. BM. Lungs clear. BS(+). Peripheral pulses palpable. wound without drainage noted to this time. Consumed regular diet for Breakfast. Restraints removed and reapplied. Skin under restraints intact. will check restraints, skin integrity and distal circulation frequently. [redacted]
2 Sep 03 1745	Pt A+OX3, VSS, LS CTA(B), (+)BS x4, pt had a BM, ambulated around ward + took a shower, medicated for pain c̄ 2 percocet tabs, incision on groin area healing well, minimal bloody drainage, applied bacitracin, proper circulation + skin integrity on pts. [redacted] of restraint. [redacted]

(Continue on reverse side)

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

[redacted]

b(4)-4

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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

b(6)-2 A11

PROGRESS NOTES

DATE	
3 Sep 03 @ 0700	Assumed care of pt awake alert and oriented X3. VSS ∅ c/o pain or discomfort @ this time lungs CTA HRRR S1 S2 present tolerating PO well Dressing to (R) groin area CDI ∅ evidence of bleeding. Will cont to monitor and access [redacted]
3 Sep 03	Pt AtOX3, VSS, S CTA (B), (+) BS x4, ~~VSS~~, dsg on groin area CDI, abd soft flat non tender, S1 S2 present, peripheral pulses +2, voiding c/y urine, ambulates independently, assessed for proper circulation ~~[illegible]~~ and skin integrity on pts. of restraint. [redacted]
4 Sep 03 0900	VSS alert & Oriented. Lungs clear. BS (+) x4 Qual. Consumed regular diet for breakfast Urine clear yellow [illegible] Peripheral pulses +2. Incision ~~[illegible]~~ above penis intact & steri drip. Scant amount of old drainage & dry dry removed Steri strips and dry dry replaced. Restraints removed and reapplied Skin under restraints intact Will check restraints, skin integrity and extremities circul. q1hr frequently [redacted]
4 Sep 03 @ 2015	Pt c/o, VSS, lungs CTA (B) (+) BS x4 ad. +2 pulses. Incision above penis CDI, ∅ c/o pain @ this time. Circulation intact. 2 pt restraints on. voiding c/y ∅ difficulty. ambulated ∅ difficulty. Will cont to monitor [redacted]

STANDARD FORM 509 (REV. 7-91) BACK
USAPPC V1.00

NSN 7540-00-634-4176

b(6)-2 All

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5 Sep Ø3 @ 0430	Pt voided. 1800 cc cyu this shift. Ø BM (CYU). Pt is sleeping @ this time. Ø distress noted. Approx. intake 1500 cc (1 bottle H2O). Circulation intact. 2 pt. restraints on. Will cont to monitor [redacted] GIWM6
05 Sep 03	(0915) Assumed care of pt @ 0600 ~~p~~ report from night shift. Pt A/O X3, speaking some English. VSS. Ø c/o pain @ this time. Pt amb ~~s~~ difficulty. Pt showered this am independently. Incision to @ groin CDI. Ø s/sx infection on penis or incision. Pt voiding ~~s~~ difficulty. Tol. reg diet well. 2 point restraints in place ~~s~~ s/sx complications ~~c~~ circulation / skin breakdown. Will cont. to monitor. [redacted] WAW
5 Sep. Ø3	Pt sitting in bed, A+O x3, VSS, LS CTA (B), (+) BS x4, pt ambulated to BR w/o difficulty, had a BM, c/o diahrea, incision on groin area Ø s/sx of infex, Ø c/o pain @ this time, proper circulation + skin integrity on pts of restraint. [redacted] GIWM6

HOSPITAL OR MEDICAL FACILITY

SPONSOR'S NAME	STATUS	DEPART./SERVICE	RECORD [redacted]
	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. ICW 1

[redacted]

b(6)-4

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

b(4)-2 A11

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
6 Sept 03 0700	Pt VSS, lungs and bilcs are good. Not c/o any pain. Has no problem at this time with sitting up in bed. Incision is healing nicely, see no signs of infection. Will continue to access the Pt. S/C [redacted]
	(0725) I concur c above assessment. — [redacted]
6 Sep 0830	pt c/o pain to groin region medicated c Percocet. ii tabs will monitor for affectiveness. — [redacted]
6 Sep 1500	~~Assumed~~ Pt. c/o pain to groin area percocet ii tabs administered will cont to monitor — [redacted]
6 Sep 03 1815	Pt resting in bed, A+Ox3, VSS, LS CTA (R), (+) BS, Ø c/o pain, pt ambulated, Ø drainage or s/sx of infex on wound in groin area, proper circulation + skin integrity on pt's of restraint. — [redacted]
7 Sept 03 0630	- Assumed care of pt. awake alert and oriented x3. VSS Ø c/o pain or discomfort. Lungs CTA. HRRR S1 S2 present. Active BS. x 4 quads. Urinating Ø S c difficulty. Ambulates without difficulty. Wound to groin region healing well Ø drainage / bleeding Ø signs of infection. Discharge orders for EPW camp, pt ready for dc. — [redacted]

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

558-104

b(2)-2

7540-01-075-371

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT *(Patient)*

LOG NUMBER | TREATMENT FA[redacted]

RECORDS MAINTAINED [redacted]

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

SEX: M

AGE

DUTY/LOCAL PHONE — AREA CODE | NUMBER

HOME PHONE — AREA CODE | NUMBER

ARRIVAL

DATE *(Day, Month, Year)*: 04 Aug 03 | TIME: 0935

TRANSPORTATION TO FACILITY

MILITARY STATUS

ITEM	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE

ITEM	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

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

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW Abdomen

CATEGORY OF TREATMENT

☐ EMERGENT
☒ URGENT
☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME	0940				
BP	115/62				
PULSE	96				
RESP	20				
TEMP	98.4				
WT	5'02" 988				

LAB ORDERS

CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		CHEM: 17
BLOOD C&S X			lytes

X-RAY ORDERS

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

☐ PULSE OX

ORDERS

☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE
	Gelu TLNS				
1100	#Ptnas x5cc				

DISPOSITION

☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE

☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

[redacted] b(2)4

EMERGENCY CARE AND TREATMENT *(Patient)*
Medical Record

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

b(6)-2 [redacted]

b(6)-2

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

TEST RESULTS

CBC		SMAC	
WBC	11.1		142 / 110 / 11
H/H	8.9/28.3		3.6 / 25 / 1.0 — 99
PLT	402		
PT			
APTT		BHCG	ETOH / GLU

ABG/PULSE OX		
SUP 02	PH	PO2
PCO2	SAT	OTHER

U/A	
DIP	
MICRO	

RADIOLOGY	Check if read by radiologist ☐
RESULTS	
EKG INTERPRETATION	

UA 1.030 WBC 20-30 small bacteria
4+ blood

PROVIDER HISTORY/PHYSICAL

22 y/o ♂ S/p GSW 24 Jul to pelvis and groin area. pt seen @ Drager hospital, sent to 109th EPW to ? unknown ~~bis~~ class/medical. Evac to CSH. ∅ transfer note.
Pt c/o ~~Abd~~ pain ↑ x 24°. ∅ N/V/F/rash ∅D ⊕N Cipro 400g IV given yesterday 3 days ago

Pmh ∅
PSH ∅
∅ prev meds
NKDA

OS A&O x 4 – mod distress. VSS
~~HEENT~~ OP/MP clear/pat mm PD neck supple NT ~~JVD~~
~~eyes~~ clear/dry
CV: ~~CTA~~ ⊕ W: nm ~~bil~~ left ~~HR~~ 100
Abd: ⊕ perc tend ⊕ midline suture in place rectal: NL tone/Lesion neg lt brown stool.
GU: circ ⊕ urethral impl ⊕ drain ⊕ inguinal impl
⊕ lac along pubic shaft ⊕ lac @ base of penile shaft c̄ pus. Foley in place
Back: ∅ lac/bruise/lesions ∅ st-pfft

A/P Stable (post op) GSW

Admit IW 2 IV Abx

CONSULT WITH	TIME	ACTION

b(6)-2

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP [redacted]

PROVIDER SIGNATURE AND [redacted] BTW

DIAGNOSIS
① GSW to groin/abd (infection)
②

CODES

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

[redacted]

b(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

MEDICAL RECORD

AUTHORIZED FOR LOCAL REPRODUCTION

CONSULTATION SHEET

REQUEST

TO: Surgery

FROM: (Requesting physician or [redacted] b(6)-2

REASON FOR REQUEST (Complaints and findings)

Gunshot wound - 20 sepsis.
erosion of penis wound

DATE OF REQUEST

PROVISIONAL DIAGNOSIS

b(6)-2 Gunshot wound penis - 20 infection

[redacted] 6/1/12

APPROVED

PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL

☐ ROUTINE ☐ 72 HOURS ☐ TODAY ☐ EMERGENCY

RECORD REVIEWED ☐ YES ☐ NO

CONSULTATION REPORT

PATIENT EXAMINED ☐ YES ☐ NO

TELEMEDICINE ☐ YES ☐ NO

NATURE AND TITLE

(Continue on reverse side)

PITAL OR MEDICAL FACILITY

DATE

RECORDS MAINTAINED AT

TION TO SPONSOR

DEPARTMENT/SERVICE OF PATIENT

SPONSOR'S NAME (Last, first, middle)

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

SPONSOR'S ID NUMBER (SSN or Other)

REGISTER NO.

WARD NO.

[redacted] b(6)-4

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)
USAPA V1.00

3 Aug 03

1. Transfer to holding
2. Dx UTI / wound infection
3. Condition Fair Immediate, delay, minimal, expectant
4. VS Q 15min Q 2° Q 4-6°
   Per Routine
   Call physician if BP>160/90 < 90/60
   P >120 < 50
   R >25 < 10
5. Activity: ___ Bed Rest X Bathroom Privileges ___ Ambulate TID
   ___ With Assistance
6. Nursing:
   ___ Dressing Changes QD or more PRN
   ___ Cold Pack PRN
   ___ ECG PRN for S & S of CV problems
7. Diet: ___ NPO ___ Clear Liquids ___ Advance diet as tolerated
   X Regular diet
8. IV Fluids ___ LR- Wide open until pt. Stable
   ___ LR TKO
   X ~~LR~~ NaCl - @ 100 cc/hr
9. Allergies NKA
10. Pain Control
    ___ Morphine Sulfate
    ___ a. 10 mg IV/IM/SQ of 2-4° PRN pain
    ___ b. or follow bolus by infusion of 0.05-0.1 mg/kg/hr
    ___ c. or 10-30 mg PO q 4° PRN pain
    X Tylenol 3 1-2 tabs PO q 4-6° PRN pain
    ___ Ibuprofen 800 mg TID PRN pain/fever
    X Tylenol 325 – 650 mg Q 4-6° PRN pain/fever
11. Ship Out: ___ Immediate ___ on next available transport
    Hold: ___ Till further notice ___ for ___ hours monitor vital signs
12. Meds
    ✓ Ciprofloxacin 400 mg IVPB Bid with one dose on admission

13. Labs /X-Ray

14. PRN Meds:
    a. Benadryl 30 mg Q 4-6° PRN insomnia
    b. MOM or Mylanta PRN for GI
    c. O_2 2 liters per mask for S & S of respiratory difficulty

b(6)-4 [redacted]

Dr. [redacted] major

Noted – Jaxtman SPC

[redacted] ASM B

(b)(2)-2

TIME: SIGN

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:

Oriented / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radial Pedal

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 Dimness / 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/Intac. Suction/Cont. Suction/Intermittent 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:

TIME: SIGNATURE:

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm 97.9

Color: Pale / Cyanotic / Jaundiced

Mucous Membranes: Moist / Dry / Cracked Normal for Race

Skin Breakdown: None Location: Size: Pants line

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Oriented / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): 80 Radial ++ Pedal ++

Capillary Refill: <3 Seconds Homan's Sign

Jugular Venous Distension Ø Edema Ø

Heart Sounds Reg

Rhythm NSR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms				
Site			(L) AC	
Solution			5 cal/hr	

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: b

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		

CAB

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: CDI

NG Tube: Clamped/Intac. Suction/Cont. Suction/Intermittent Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Clear Yellow Character:

Voiding: Continent / Foley Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Calm : cooperative

OTHER:

ICU Flowsheet Patient Name: 527 Date: 10 / AUG / 2003

Vitital 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				97°			98.2 98				96.8							118		97.9				97.8		
Pulse				78			80				75							75		80				90		
B/P² A-Line																		70								
MAAP																										
B/P² Cuff				116/80			112/72				112/70									122/60				112/82		
Respirations				18			16				16							20		16				16		
SaO2				95			97				95							95		98%				97%		
				RA			RA				RA							RA		RA				RA		
I 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:	75	75	75	75	75	75	75	75	75	75	75	75	900	75	75	75	75	75	75	75	75	75	75	75	75	
PO I Intake				60	60				100		500		660													
O.RR. IN																										
Totals	75/75	150/150	225/225	300/300	435/435	510/510	585/585																			
O 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
Urine Hourly				500		250/750					250/1000		1000							250/1000		250/500		300/800		
NG I Tube																										
Drains #1																										
#2																										
#3																										
Emesis																										
Stool																										
O.RR. OUT													1000													
Totals				500/500		250/750																				

[redacted]

24 hour input	
24 hour output	
24 hour balance	

Pg. 4

MEDCOM - 15696

TIME: 0600 SIGN [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature WARM

Color: Pale / Cyanotic / Jaundiced WNL to race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive GCS:

Oriented / Disoriented Pupils: 3mm PERRL

Extremity Movement: Full / Limited / None due to dx

CARDIOVASCULAR

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

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

Jugular Venous Distension Ø Edema Ø

Heart Sounds: S1S2

Rhythm SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site			L FA	
Solution			LR @ 75ml/h	
Chest Pain				

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Pattern: RRR 16

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor

Chest Drainage System Gravity: Suction cm:

Air Leak No Yes Crackles

Character of Drainage:

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

Artificial Airway Size: Type: Position:

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

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: to Penis D+I

NG Tube: Clamped/Free, Suction/Cont. Suction/Decompression/Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character Ø

Urine: Ø

GENITOURINARY

Urine Color: Yellow/amber Character: sediment

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

Pleasant + cooperative.

OTHER:

TIME: SIGNATURE: [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature Warm

Color: Pale / Cyanotic / Jaundiced Normal for Race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc: Alert / Lethargic / Unresponsive moves extremities

Oriented / Disoriented Pupils: PERRLA 3mm

Extremity Movement: Full / Limited / None due to injury

CARDIOVASCULAR

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

Capillary Refill: <3 Seconds — Homan's Sign

Jugular Venous Distension Edema

Heart Sounds: S1 S2

Rhythm SR PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral 1	Peripheral 2
Waveforms			[redacted]	
Site			L FA	
Solution			LR @ 75ml/h	
Chest Pain				

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Pattern: RRR

Cough: Productive / Nonproductive / None

Sputum: Color / Amount / Consistency / Odor None

Chest Drainage System Gravity: Suction cm:

Air Leak NO Yes Crackles

Character of Drainage:

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

Artificial Airway Size: Type: Position:

Breath Sounds	Anterior Location	Posterior Location
Crackles	CTA (B)	
Wheezes		
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings: to Penis CDI

NG Tube: Clamped/Free, Suction/Cont. Suction/Decompression/Drainage

NG Drainage: Color Character

Tube Feeding: Day No: Strength: Rate: Aspirate

Stool: Character

Urine: Voiding Spontaneously via Cath

GENITOURINARY

Urine Color: Character: Clear

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

b(6)-2

ICU Flowsheet Patient Name: [redacted] Date: 12/ AUG/ 2003

Vitital 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			98.4				98.7					98.3								98.7		99.5		99.3		
Pulse			121				89					77				89				82				67		
B/P > A-Line																										
MA&P																										
B/P > Cuff			111/60				111/63					116/65				116/72				118/68				118/58		
Respirations			19				18					18				16				16				16		
Sa002			99				98					98				98	98			98				99		
							RA					RA				RA	RA			RA				RA		
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:	75	75	75	0																						
				~~220~~																						
PO Intake				220			300					200			400	300			300			100		200	100	
O.RR. IN																										
Totals	75/75	75/150	75/225	220/445																						
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
Urine Hourly							300		200/500			250/750				300				400		100			300	
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis																										
Stool																										
O.RR. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 15698

12 AUG 03 ..... b(6) = 2

TIME: 0600 SIGN/ [redacted]

SKIN AND MUCOUS MEMBRANES

Skin: Loose / Tight / Diaphoretic / Shiny / Dry

Skin: Temperature warm

Color: Pale / Cyanotic / Jaundiced appropriate for race

Mucous Membranes: Moist / Dry / Cracked

Skin Breakdown: None Location: Size:

NEUROLOGICAL

Loc / Alert / Lethargic / Unresponsive GCS:

Oriented / Disoriented Pupils: Perrla

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): 2 Radials 2 Pedals

Capillary Refill: <3 sec Boxends <3 sec Homan's Sign 0

Jugular Venous Distension 0 Edema 0

Heart Sounds S1 S2

Rhythm ST PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral	Peripheral
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

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

Breathing Patterns: even & unlabored

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	CTA (B)	
Diminished		
Absent		

GASTROINTESTINAL

Abdomen: Soft / Firm / Hard / Distended cm Girth

Bowel Sounds: Normal / Hyperactive / Hypoactive / Absent

Dressings:

NG Tube: Discontinue, Suction/Cont. Suction/Decompression Drainage

NG Drainage: Color Character

Tube Feeding: Over No: Strength: Rate: Aspirate:

Stool: Character

Drains:

GENITOURINARY

Urine Color: amber Character: clear

Voiding: Continent / Incontinent / Catheter FFG

EMOTIONAL/PSYCHOSOCIAL

cooperative, pleasant, appropriate affect

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:

Oriented / Disoriented Pupils:

Extremity Movement: Full / Limited / None

CARDIOVASCULAR

Pulse (0 - 4): Radials Pedals

Capillary Refill: Boxends Homan's Sign

Jugular Venous Distension Edema

Heart Sounds

Rhythm PRI: QRS:

Vascular Catheter	Central	Arterial	Peripheral	Peripheral
Waveforms				
Site				
Solution				

Chest Pain

RESPIRATORY

Chest Expansion / Symmetrical / Asymmetrical

Resonation / 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: Discontinue, Suction/Cont. Suction/Decompression Drainage

NG Drainage: Color Character

Tube Feeding: Over No: Strength: Rate: Aspirate

Stool: Character

Drains:

GENITOURINARY

Urine Color: Character:

Voiding: Continent / Incontinent / Catheter

EMOTIONAL/PSYCHOSOCIAL

OTHER:

ICU Flowsheet **Patient Name:** **Date:** 11 / AUG / 2003

Vitital 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			97.2				98.2				97.8					98.5						98.6				
Pulse			78				85				76					108				89		94				
B/P = A-Line																										
MAP																										
B/P = Cuff			114/58				114/65				114/78					98/55				114/64		112/67				
Resepirations			16				15				16					16				16		18				
SaO02			96%				98%				99%					94%				97		96				
Source			RA				RA				RA					RA				RA		RA				
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: LR	75	75	75	75	75	75	75	75	75	75	75	75		200 in OR		75	75	75	75	75	75	75	75	75	75	
PO Intake																										
O.RR. IN																										
Totals															200/200	75/275	75/350	75/425	75/500	75/575	75/650	75/725	75/800	75/875	75/950	
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
Urine Hourly			350/700			350/1050		350/1400					2100	275/275			275/550		100/2240			275				
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis																										
Stool																										
EBL															5											
O.RR. OUT																										
Totals																										

[redacted] 11 Aug 03

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 15700

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 22 HEIGHT: WEIGHT: 70kg	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [ ] NO [✓] YES (type): Pelvic s/p GSW penis.

4. PROPOSED SURGICAL PROCEDURE: Drsg Δ penile wounds

5. ADDITIONAL INFORMATION: Last PO: NPO 7 MN Medical Hx: Ø Implants: Ø Medications: Ancef, Gent, MSO4, Phenergan, Ketoconazole, Percocet
Jewelry removed: yes/no Family waiting: yes/no

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	Ø Pt. verbalizes any specific anxiety. Ø Pt. exhibits relaxed body posture.	Ø Allow pt. to verbalize freely. Ø Explain OR environment and answer questions regarding surgery. Ø Offer comfort measures, (e.g., warm blanket, touch) Ø Explain all nursing procedures before they are done. Ø Remain with pt. whenever possible. Ø Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	Ø PT. will be able to breathe without difficulty during immediate intra-operative phase.	Ø Offer to elevate head of litter or offer pillow. Ø Observe pt. while awaiting surgery for signs of distress Ø Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	Ø PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	Ø Utilize pressure preventing devices on OR table and accessories. Ø Check for proper positioning and support to maintain good body alignment. Ø Pad pressure points. Ø Place ESU ground pad on non compromised skin surface area. Ø Keep prep fluids from pooling.

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

[redacted] b(6)-4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	ø Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	ø Check for support stockings or ace wraps. If none, check with doctors. ø Check that safety straps are correctly applied. ø Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ø Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	ø Pt. will be transferred to OR table without difficulty. ø Pt. will not experience unnecessary physical discomfort.	ø Have sufficient people available for transfer. ø Insure proper body alignment. ø Allow patient to lie in position of comfort while waiting for surgery. ø Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. ø Pt. will be able to understand instructions. ø Minimize danger of injury during intraop period.	ø Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. ø Speak clearly and slowly. ø Address pt. from either side. ø Validate pt.'s understanding of verbal communications. ø Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes. b(6)-2 All	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] RN 5 Aug 03 DATE

11. POSTOPERATIVE EVALUATION:

Pt. ~~s~~ s/s of acute distress. Drsg CDI

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED
[redacted] RN	[redacted] RN
DATE: 5 Aug 03 TIME: 0712	DATE: 5 Aug 03 TIME: 0825

REVERSE OF DA FORM 5179, JUN 91 USAPA V1.01

C1010

MEDICAL RECORD	PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT For use of this form, see AR 40-407; the proponent agency is The Office of the Surgeon General.
1. AGE: 22 HEIGHT: WEIGHT: 70 Kg	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [ ] NO [X] YES (type): See H+P

4. PROPOSED SURGICAL PROCEDURE: Denis Graft

5. ADDITIONAL INFORMATION: See H+P / patient Chart

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to Traumatic injury; language barrier; family separation; surgical environment	✓ Pt. verbalizes any specific anxiety. ✓ Pt. exhibits relaxed body posture.	✓ Allow pt. to verbalize freely. ✓ Explain OR environment and answer questions regarding surgery. ✓ Offer comfort measures, (e.g., warm blanket, touch) ✓ Explain all nursing procedures before they are done. ✓ Remain with pt. whenever possible. ✓ Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury; previous medical condition	✓ PT. will be able to breathe without difficulty during immediate intra-operative phase.	✓ Offer to elevate head of litter or offer pillow. ✓ Observe pt. while awaiting surgery for signs of distress ✓ Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; poistion; fluid shift	✓ PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	✓ Utilize pressure preventing devices on OR table and accessories. ✓ Check for proper positioning and support to maintain good body alignment. ✓ Pad pressure points. ✓ Place ESU ground pad on non compromised skin surface area. ✓ Keep prep fluids from pooling.

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

EPW [redacted]

b(6)-4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; previous surgery	✓ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	✓ Check for support stockings or ace wraps. If none, check with doctors. ✓ Check that safety straps are correctly applied. ✓ Offer pillow for under knees. ~~Place and take down legs from stirrups with slow bilateral motion.~~ ✓ Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	✓ Pt. will be transferred to OR table without difficulty. ✓ Pt. will not experience unnecessary physical discomfort.	✓ Have sufficient people available for transfer. ✓ Insure proper body alignment. ✓ Allow patient to lie in position of comfort while waiting for surgery. ✓ Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury ; sedation F.2. ✓ Potential for decreased communictaion due to languag e barrier; sedation; pain; injury F.3. Potential injury due to dentures.	✓ Pt. will be made aware of surroundings prior to anesthesia induction. ✓ Pt. will be transferred safely to OR table. ✓ Pt. will be able to understand instructions. ✓ Minimize danger of injury during intraop period. Iraqi National	✓ Introduce self. Keep pt. informed as to where he/she is and what is happening. ✓ Inform pt. in which direction to move and assist if necessary. ✓ Speak clearly and slowly. ✓ Address pt. from Either side. ✓ Validate pt.'s understanding of verbal communications. ✓ Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. b(6)-2 All	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NU[redacted]D/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CPT/AN 25 Aug 03 DATE

11. POSTOPER[redacted]

Bovie Side:
Dog:
Breathing:

12. PREOPERTIV[redacted] BY CPT/AN
(Signature and T[redacted]

DATE: 25 Aug 03 TIME:

13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title) [redacted]

DATE: 25 Aug 03 TIME: 1630

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.0

b(u)-2

MEDICAL RECORD — **INTRAOPERA** — **DOCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA litter BY Anesthesia

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted] CPT/AN

3. DATE 4 AUG 03 TIME PATIENT ARRIVED IN SUITE 1400

4. PATIENT IN R[redacted] TIME 1400 NUMBER 2 -

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

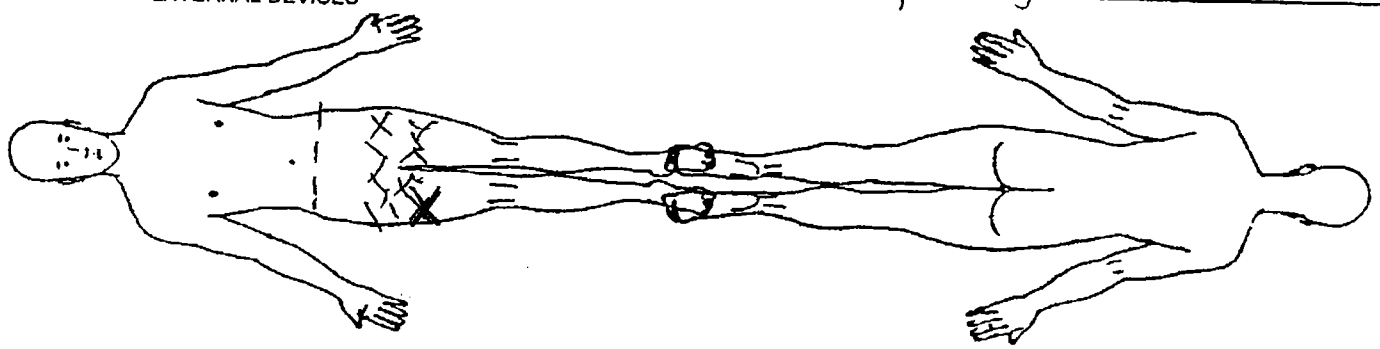
COMMENTS: Proper body alignment maintained

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: Dr. [redacted]

PREP SOLUTION *(Specify)* Betadine scrub/soln
SITE: Perineal area BY WHOM: [redacted]
SITE: Genitalia BY WHOM: [redacted]
COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES



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

C = Correct I = Incorrect Initial C [redacted] / [redacted]

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No					
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

#[redacted]

b(u)-4

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

☒ ESU NO: #3
GROUND PAD: BRAND Valleylab
LOT NO: 68936

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	Fine Mesh Gauze	16Fr Foley	
SITE	Penis, wounds	bladder	

18. DRESSING/IMMOBILIZATION *(Specify)*

Fluffs
4x8
Coban
Scrotal support

19. ADDITIONAL INFORMATION

WC

Surgeons: [redacted]

Anesthesia: [redacted] CRNA

Anesthesia Type: General

Foley in place upon arrival. Removed prior to prep.

Bovie Pad site intact pre-op X ; post-op X Bovie Settings: Coag/Cut

20. OPERATION(S) PERFORMED

1. I & D penile, scrotal, groin wounds
2. urethroscopy

21. PATIENT TRANSFERRED TO		TIME	METHOD
ICU	b(6)-2	1511	Litter

22. REGISTERED NURSE SIGNATURE KC [redacted] CPT/AN

REVERSE OF DA FORM 5179-1, OCT 8. USAPA V1.01

b(6)-2

MEDICAL RECORD

INTRAOPERA[illegible] DOCUMENT

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

1. PATIENT TRANSPORTED TO OPERATING ROOM
VIA
BY

2. PATIENT IDENTIFI[illegible] RECORD REVIEWED AND PROCEDURE VERIFIED BY 1LT [redacted]

3. DATE 5 Aug 03
TIME PATIENT ARRIVED IN SUITE 0753

4. PATIENT IN ROOM
TIME 0753
NUMBER 1-1

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NPO p MN, NKDA Patent Foley cath

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] 91D	RELIEF SCRUB	
ASSIGNED CIRCULATOR	1LT [redacted] 66E	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify) A. supine on padded OR table BUE on padded armboards. < 90°

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

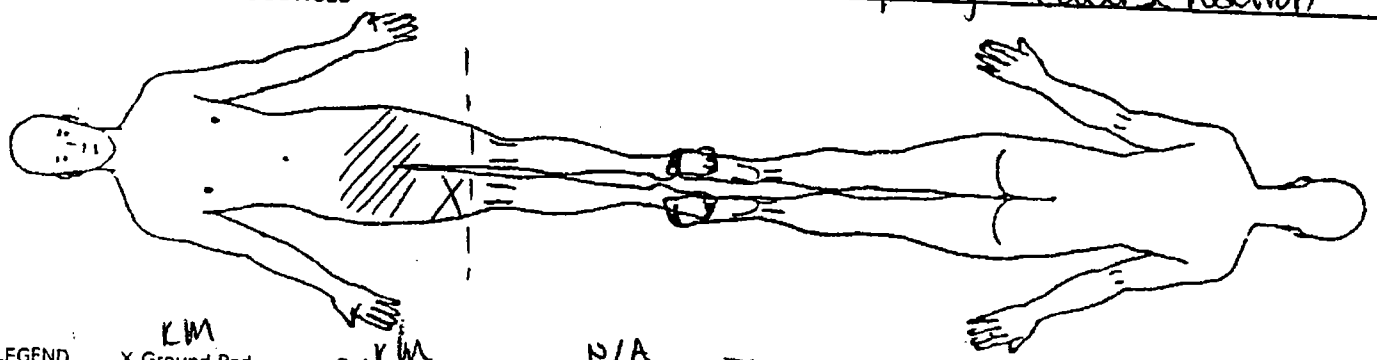
COMMENTS: Normal anatomic body alignment maintained.

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP
COMMENTS: N/A

PREP SOLUTION (Specify) HiBiclens
SITE: Groin/Penis BY WHOM: Dr. [redacted]
SITE: BY WHOM:
COMMENTS: No pooling or adverse reaction

9. LOCATION OF EXTERNAL DEVICES



LEGEND X Ground Pad (LM) -- Safety Strap (KM) = = = Tourniquet (N/A) ▨ prep

Initial: SSG [redacted] 1LT

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No		C	C	SSG [redacted]	1LT [redacted]
Needle Sharp	☒ Yes	☐ No					
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

[redacted]

b(6)-4

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

☒ ESU NO: #4 Cut 20 coag 20
GROUND PAD: BRAND VL REM Polyhesive II
LOT NO: 65706 Exp 2004-11

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 MEDCOM - 15707

REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
N/A					

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl - Q.S

OTHER ORDERS	TIME	CARRIED OUT BY
N/A		

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. Intersorb c̄ NaCl	2.	3.
SITE	1. Penile wounds	2.	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
4x8
Coban
fluffs
scrotal support

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted]
Anesthesia: CPT [redacted]

b(a)-2 All

DA5179 Initiated

20. OPERATION(S) PERFORMED
Dressing Δ of penile wound

21. PATIENT TRANSFERRED TO ICU 1 TIME 0825 METHOD Litter c̄ O2

22. REGISTERED NURSE SIGNATURE [redacted] RN

REVERSE OF DA FORM 5179-1, OCT [redacted] USAPA V1.01

MEDICAL RECORD | INTRAOPER[illegible] DOCUMENT

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

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

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY ILT [redacted] b(6)-2

3. DATE 11 Aug 03 TIME PATIENT ARRIVED IN SUITE 1245

4. PATIENT IN ROOM TIME 1245 NUMBER 2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: NKDA, NPO ~~p~~ 0700

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] b(6)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	LTC [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS (Specify)

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

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

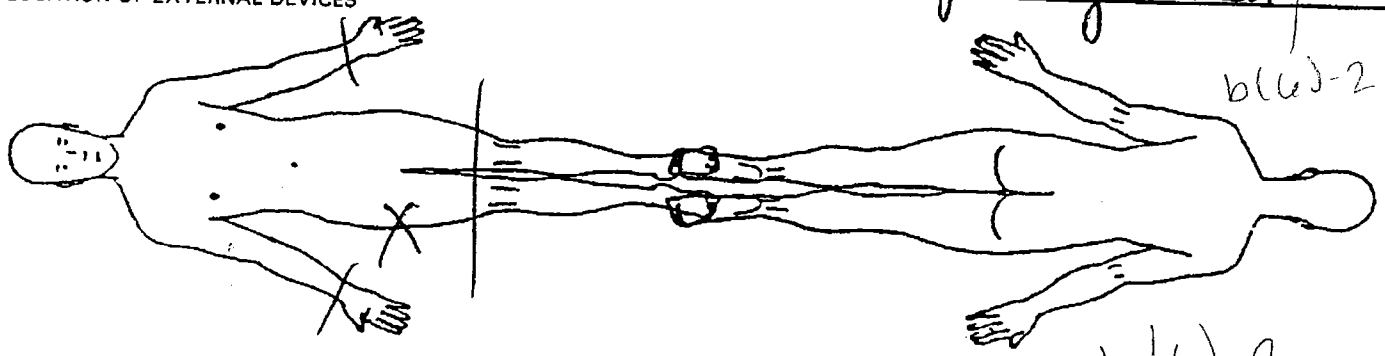
PREP SOLUTION (Specify) Betadine soap/sol. BY WHOM: LTC [redacted]

SITE: Groin

SITE: BY WHOM:

COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes	☐ No	✓	C	C	SSG [redacted]	LTC [redacted]
Needle Sharp	☒ Yes	☐ No	✓				
Instrument	☐ Yes	☒ No					
Other	☐ Yes	☒ No					

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

[redacted]

b(6)-4

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

☒ ESU NO: Valleylab Force 2

GROUND PAD: BRAND REM polyhesive

LOT NO: 65706

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

b(6)-7

C : 30 coag: 30

MEDCOM - 15709

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
0.9% NaCl Q.S

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☒

TYPE/SIZE	1. 1/4" penrose	2.	3.
SITE	1. wound superior + (Lt) of penis		3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Fine mesh gauze
Coban
4x8
fluffs Scrotal support

19. ADDITIONAL INFORMATION
Surgeon: Dr. [redacted]
Anesthesia: Maj. [redacted] CRNA

b(6)-2 A11

DA 5179 In Chart

20. OPERATION(S) PERFORMED
Closure / revision penile GSW

21. PATIENT TRANSFERRED TO ICU 3 TIME 1350 METHOD Litter & O2

22. [redacted], LTC, AN

REVERSE OF DA FORM 5179-1, OCT 8 USAPA V1.01

b(6)-2

MEDICAL RECORD — INTRAOPERA[redacted]OCUMENT

For use of this form, see AR 40-66, t[redacted] The Surgeon General.

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

2. PATIEN[redacted]D AND PROCEDURE VERIFIED [redacted]PT/AL

3. DATE 25 Aug 03 TIME PATIENT ARRIVED IN SUITE 1450

4. PATIENT [redacted] TIME 1450 [redacted]MBER 1-5

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SPC [redacted] RT	RELIEF SCRUB	
	b(6)-2		
ASSIGNED CIRCULATOR	error [redacted] All	RELIEF CIRCULATOR	
	CPT [redacted]		

7. POSITION AND POSITIONAL AIDS (Specif[redacted]

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

COMMENTS: proper body alignment maintained, arms on padded armboards at less than 90°, position approved by surgeon + anesthesia

no nicks or cuts noted

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO Dr. [redacted]

DONE BY: ☒ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP

COMMENTS: ~~no pooling or skin Δ's noted~~ error, scr

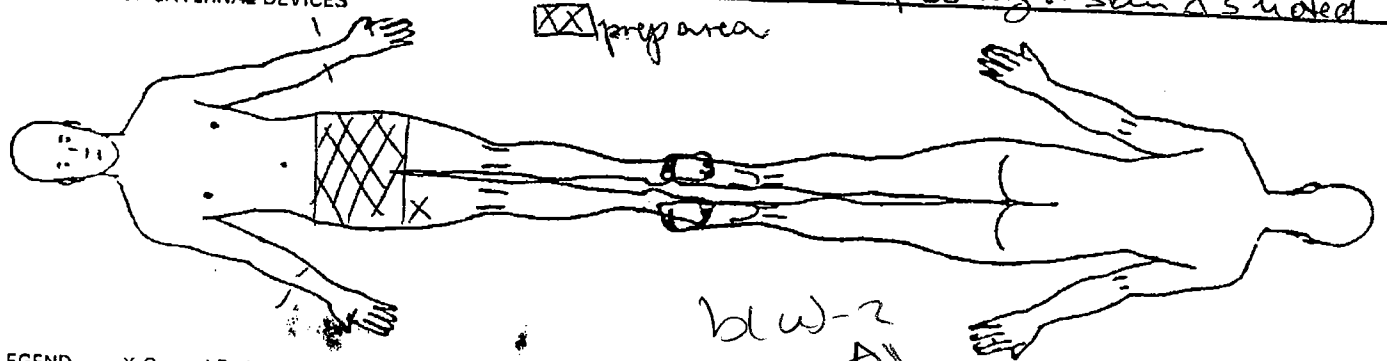
PREP SOLUTION (Specify) ~~Betn/Betn~~ error [redacted]

SITE: Penis/Scrotal area BY WHOM: [redacted]

SITE: BY WHOM: [redacted]

COMMENTS: no pooling or skin Δ's noted

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect Initial: [redacted]

		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	NA	C	C	[redacted]	[redacted]
Needle Sharp	☒ Yes ☐ No		C	C		
Instrument	☐ Yes ☒ No	NA	NA	NA	NA	NA
Other	☐ Yes ☒ No					

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

#EPW [redacted]

b(6)-4

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

☒ ESU NO: Valleylab Force 40

GROUND PAD: 30130 BRAND VL Rem Polyhesive II

LOT NO: 65706 2004-11

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

DA FORM 5179-1, OCT 87 MEDCOM - 15711

REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY
~~None~~ 16F FIC to bladder via urethra	110	[redacted]

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 10mm JP Dra[redacted]	2. 16F FIC	3.
SITE	1. Groin	2. Bladder	3.

18. DRESSING/IMMOBILIZATION *(Specify)*
Coban Steristrips
Penrose
Scrotal Support

19. ADDITIONAL INFORMATION
Surgeon: [redacted]
Anesthesia: [redacted]

b(4)-2 All

20. OPERATION(S) PERFORMED
DPC Penis Wound

21. PATIENT TRANSFERRED TO PACU b(4)-2 TIME 2el DA7389 METHOD Lifter

22. REGISTERED NURSE SIGNATURE [redacted] TIAN

REVERSE OF DA FORM 5179-[redacted] USAPA V1.01

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY															
POST-	DAY	1													
MONTH-YEAR	DAY	3 Aug 03		4 Aug 03											
19	HOUR	2300		0605											
PULSE (O)	TEMP. F (●)														
	105°														
180	104°														
170	103°														
160	102°														
150	101°														
140	100°														
130	99°														
	98.6°														
120	98°														
110	97°														
100	96°														
90	95°														
80															
70															
60															
50															
40															

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

Record special data only when so ordered														
BLOOD PRESSURE			108/70											
HEIGHT:	WEIGHT→													
Spo2			98											
Resp.			14											

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

REGISTER NO.

WARD NO.

511-112-01

[redacted]

b(6)-4

VITAL SIGNS RECORD

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

511-119

MEDICAL RECORD

NSN 7540-00-634-4124

VITAL SIGNS RECORD

HOSPITAL DAY

POST-DAY

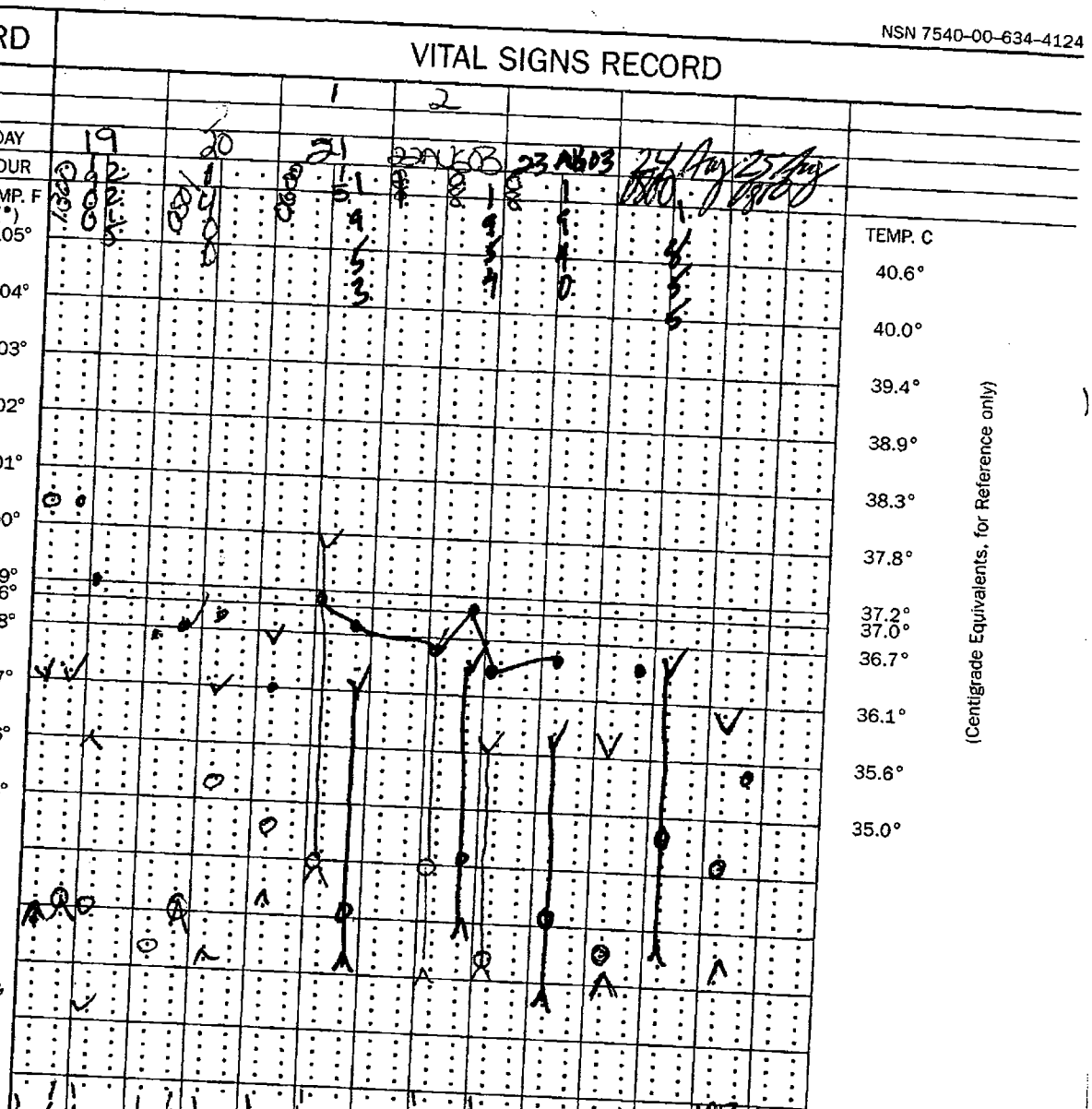
MONTH-YEAR

19

PULSE (O)

TEMP. F (•)

TEMP. C (Centigrade Equivalents, for Reference only)



Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW2

EPW #[redacted]

b(4)-4

VITAL SIGNS RECORDS

Medical Record

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

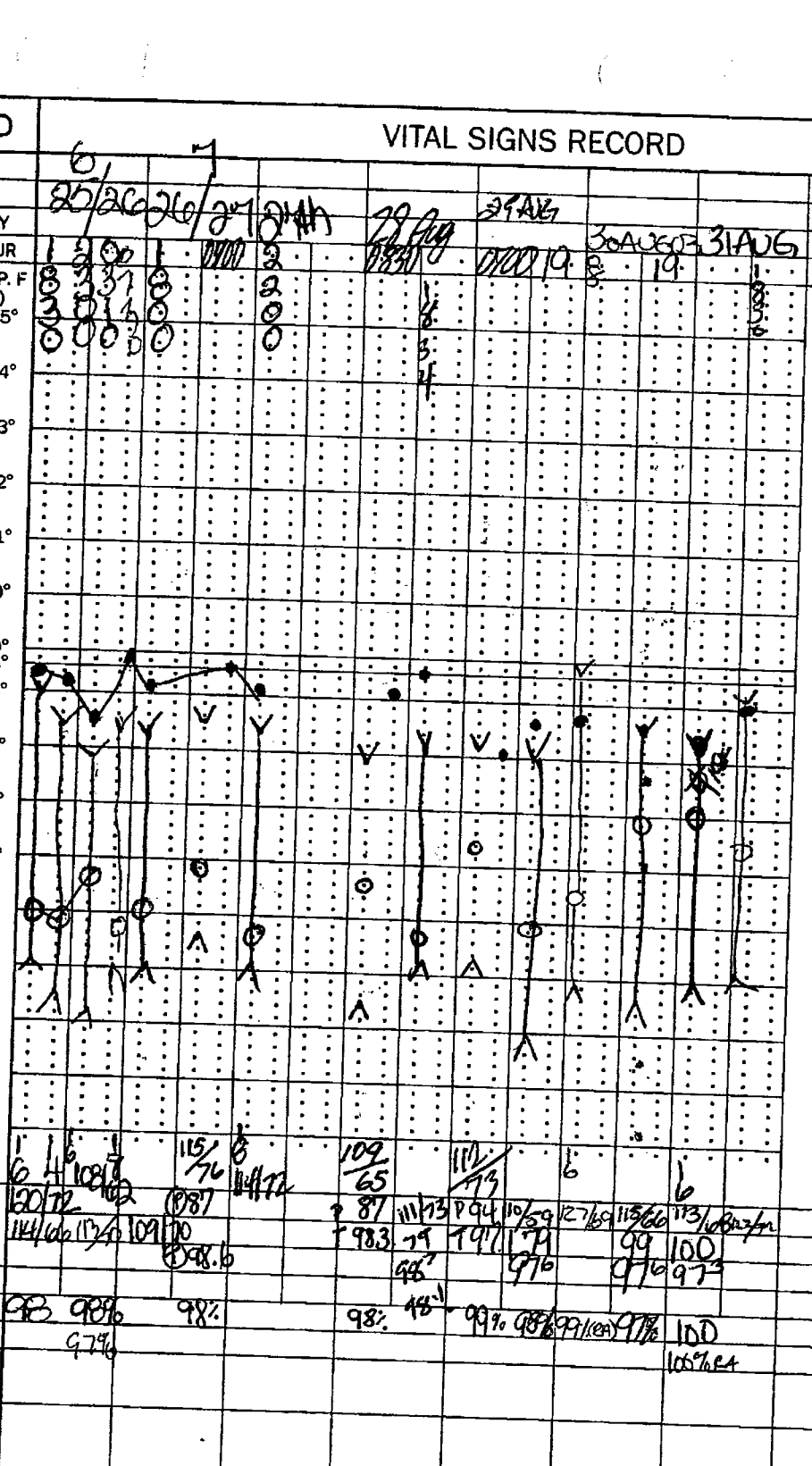
HOSPITAL DAY

POST- DAY

MONTH-YEAR DAY

19 HOUR

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



RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

#[redacted]

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

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

b(6)-4

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY															
POST- DAY		1 Sept	1		2 Sept			3 Sep		3 Sep.		4 Sept			
MONTH-YEAR	DAY	0800	1		0400							0425	0558 03		
19	HOUR		18						0720	18			1	8	

PULSE (O) — TEMP. F (•) — TEMP. C

105° — 40.6°
180 — 104° — 40.0°
170 — 103° — 39.4°
160 — 102° — 38.9°
150 — 101° — 38.3°
140 — 100° — 37.8°
130 — 99° — 37.2°
98.6° — 37.0°
120 — 98° — 36.7°
110 — 97° — 36.1°
100 — 96° — 35.6°
90 — 95° — 35.0°
80
70
60
50
40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE	107/68	113/61	107/52		119/72	105/72	116/70	106/56	109/58	121/67
	T 97.3	79	72		96	112	88	69		
	64	96	96.8		97.5	97.2			96.8	
HEIGHT: WEIGHT →			R-18		99%	99%	98%	99%	RA	
		99%			RA			R-16	99% (RA)	
	98%		99%						99% RA	

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

[redacted]

b(6)-4

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

511-119

NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																
POST-	DAY	Sept 5	6 Sep.	7 Sep												
MONTH-YEAR	DAY															
19	HOUR	18	0700	18		0630										

PULSE (0)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD																
BLOOD PRESSURE		112/64	RIG 114/74	119/89		6 111/64										
		85	74 21	112		476										
		98	475	98		T										
HEIGHT:	WEIGHT →	98%	99%	98%		99%										
						DA										

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICW#1

#[redacted]

b(6)-4

VITAL SIGNS RECORDS

Medical Record

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

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE

INT

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
	25Aug		
1835	H20	600	600
2000	H20	1440	500cc
	26Aug03		
1800	240 H20		240
2000	120 H20		360
0330	500 H20		860

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT REC'D	TIME COMPL	ACCUM TOTAL
		25Aug			
1700	1000	NS	950	2330	950
2335	1000	LR	900		1850
		26Aug03			
1830		Ø			
1830		Cipro IVS	250		250cc

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl. Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

[redacted] b(6)-4

INTAKE EQUIVALENTS (Serving levels cc)

MEDICINE GLASS (1 oz) .30	HALF PINT MILK 240
SMALL FRUIT CUP 120	LARGE SOUP BOWL.....240
COFFEE CUP.....160	LARGE WATER GLASS..240
LARGE COFFEE MUG...180	PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792

EDITION OF 1 SEP 54 IS OBSOLETE. REPLACES DA FORM 3630(TEMP) 1 JUL 72

MEDCOM - 15718

*U.S.GPO:1998-404-613/30343

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM _____ TO _____ HOURS | TOTAL HOURS COVERED | DATE

INT OUTS

FOLEY ~~OTHER~~

TIME	TYPE	AMOUNT	ACCUM TOTAL
1800	Urine cyu	100	100
0001	Urine cyu	600	700
0145	Urine cyu	450	1150
	26 Aug		
1830	100 cyu		100cc
2300	600 cyu		700cc
0330	200 cyu		900cc

~~INTRAVENOUS~~

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
		emesis x2			
		26 Aug 03			
		Ø			

JP

~~IRRIGATIONS (N/G, Bladder, etc.)~~

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
1800	serosang.	5cc	
2330	serosang	12cc	17cc
	26 Aug 03		
2000	serosang.	20cc	20cc

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. Bl, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

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

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)* .30
SMALL FRUIT CUP 120
COFFEE CUP.....160
LARGE COFFEE MUG...180
HALF PINT MILK 240
LARGE SOUP BOWL.....240
LARGE WATER GLASS..240
PLASTIC OR PAPER JUICE CONTAINER...180

DD FORM 1 JAN 74 792 EDITION 1 JUL 72 REPLACES DA FORM 3630(TEMP)

MEDCOM - 15719

*U.S.GPO:1996-404-613/30343

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974)

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ____ HOURS TO ____ HOURS | TOTAL HOURS COVERED | DATE 27Aug03

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
1815	H20	100	100
2000	H20	500	600
2315	H20	400	1000
0035	H20	200	1200
	H20	100	1300

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
1800	250	cipro ENS			250

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

OUTPUT

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
* JP output *			
2000	10cc		10cc
1/28 0030	8 cc		18cc
0456	6cc		24cc
1/29 0500	<35cc in JP		

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL
2000	urine	700	700
2300	urine (cyu)	500	1200
0035	(cyu)	800	2000
0500	(cyu)	200	2200

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. B1, A1b, P. cells etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

DD FORM 792, JAN 74 (EG) EDITION OF 1 SEP 54 IS OBSOLETE. Designed using Perform Pro, WHS/DIOR, Jun 94

28 AUG

Intake

0700 H2O 450
Juice 180

IV
Cipro 250

JP

Foley

TWENTY-FOUR HOUR PATIENT INTAKE AND OUTPUT WORKSHEET

FROM ___ HOURS TO 0 HOURS | TOTAL HOURS COVERED 24 | DATE 28 AUG

INTAKE

ORAL

TIME	TYPE	AMOUNT	ACCUM TOTAL
07	H2O	450	450
	Juice	180	630
1200	H2O	450	1080
	Tea	180	1160
1720	H2O	450	1810
8/28	Juice	180	1790
1930	H2O	230	2020
8/29			
0700	juice	240	240cc
07	milk	240	480cc
1230	juice	240	720cc
↓	H2O	600	1220cc
1800	milk	240	1460cc
1800	juice	240	1700cc
	~~H2O tns~~		
1/31 1900	H2O	240	240
1/01 0700	milk	240	240
0800	H2O	240	480

INTRAVENOUS

TIME STARTED	AMOUNT	TYPE (Include Medications)	AMOUNT RECD	TIME COMPL	ACCUM TOTAL
06	250	Cipro	250	07	250
1720	250	Cipro	250	1800	500
		29AUG03			
0630	250	Cipro	250		250cc
0630	12	NS flush	12		262cc
1745	8	NS flush	8		270cc
1750	250	Cipro			

IRRIGATIONS (N/G, Bladder, etc.)

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

BLOOD/BLOOD DERIVATIVES

TIME STARTED	PRODUCT (i.e. BI, Alb, P. cells, etc.)	TIME COMPL	AMOUNT	ACCUM TOTAL

OTHER INTAKE

TIME	TYPE	AMOUNT	ACCUMULATIVE TOTAL

GRAND TOTAL INTAKE

USAPPC V1.00

[redacted]

b(6)-4

OUTPUT

URINE

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL
1 0410	700	700			
1600	400	1100			
—		29AUG03			
0700	1000	1000cc			
1750	600	1600cc			
1/31					
1 0840	0700	400	400		
7/03	0700	800	1200		

NASOGASTRIC

TIME	AMOUNT	TYPE	ACCUM TOTAL

CHEST

TIME	AMOUNT	ACCUM TOTAL	TIME	AMOUNT	ACCUM TOTAL

EMESIS

TIME	AMOUNT	TYPE	ACCUM TOTAL
0850	200	Yellow	200cc

STOOLS

TIME	COLOR	CHARACTER	AMOUNT	ACCUM TOTAL

OTHER OUTPUT JP

TIME	AMOUNT	TYPE	ACCUM TOTAL
1500	10cc	Serosanguinous	10cc
0500		Serosanguinous	
—		D/C d 29AUG03	

GRAND TOTAL OUTPUT

REMARKS

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

b(6) - 4

[redacted]

INTAKE EQUIVALENTS *(Serving levels cc)*

MEDICINE GLASS *(1 oz)*	30	HALF PINT MILK	240
SMALL FRUIT CUP	120	LARGE SOUP BOWL	240
COFFEE CUP	160	LARGE WATER GLASS	240
LARGE COFFEE MUG	180	PLASTIC OR PAPER JUICE CONTAINER	180

ID: [redacted]
WB 05-08-03
04:25

				Patient Limits	
WBC	15.3	H	x10^3/uL	4.5	10.5
RBC	3.31	L	x10^6/uL	4.00	6.00
Hgb	9.6	L	g/dL	11.0	18.0
Hct	30.9	L	%	35.0	60.0
MCV	93.3		fL	80.0	99.9
MCH	29.0		pg	27.0	31.0
MCHC	31.1	L	g/dL	33.0	37.0
Plt	460.	H	x10^3/uL	150.	450.
LY%	20.1	*	%	20.5	51.1
LY#	3.1	*	x10^3/uL	1.2	3.4

---

i-STAT CREA

Pt: [redacted] b(4)-4

Pt Name:_____

Crea_____1.3 mg/dL

Sample Type_:

18AUG03 10:53

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

---

i-STAT EC8+

Pt: [redacted]

Pt Name:_____

Glu_____102 mg/dL

BUN_____13 mg/dL

Na_____134 mmol/L

K_____4.0 mmol/L

Cl_____101 mmol/L

TCO2_____31 mmol/L

AnGap_____7 mmol/L

Hct_____37 %PCV

Hb*_____13 g/dL

*via Hct

pH_____7.510

PCO2_____37.4 mmHg

HCO3_____30 mmol/L

BEecf_____7 mmol/L

Sample Type_:

ID: [redacted]
WB 06-08-03
04:25

				Patient Limits	
WBC	11.1	H	x10^3/uL	4.5	10.5
RBC	3.40	L	x10^6/uL	4.00	6.00
Hgb	9.8	L	g/dL	11.0	18.0
Hct	31.5	L	%	35.0	60.0
MCV	92.6		fL	80.0	99.9
MCH	28.7		pg	27.0	31.0
MCHC	31.1	L	g/dL	33.0	37.0
Plt	491.	H	x10^3/uL	150.	450.
LY%	25.0	*	%	20.5	51.1
LY#	2.8	*	x10^3/uL	1.2	3.4

ID: [redacted]
WB [illegible]
Patient Limits

WBC	[illegible]		x10^3/uL	4.5	10.5
RBC	[illegible]		x10^6/uL	4.00	6.00
Hgb	[illegible]		g/dL	11.0	18.0
Hct	[illegible]		%	35.0	60.0
MCV	[illegible]		fL	80.0	99.9
MCH	[illegible]		pg	27.0	31.0
MCHC	[illegible]		g/dL	33.0	37.0
Plt	[illegible]		x10^3/uL	150.	450.
[illegible]	[illegible]		[illegible]	[illegible]	[illegible]

ID: [redacted]
WB 07-08-03
04:23
Patient Limits

WBC	10.9	H	x10^3/uL	4.5	10.5
RBC	3.61	L	x10^6/uL	4.00	6.00
Hgb	10.5	L	g/dL	11.0	18.0
Hct	33.6	L	%	35.0	60.0
MCV	92.9		fL	80.0	99.9
MCH	29.1		pg	27.0	31.0
MCHC	31.4	L	g/dL	33.0	37.0
Plt	491.	H	x10^3/uL	150.	450.
LY%	23.0	*	%	20.5	51.1
LY#	2.5	*	x10^3/uL	1.2	3.4

ID: [redacted]
WB 08-24-03
09:18
Patient Limits

WBC	10.7	H	x10^3/uL	4.5	10.5
RBC	4.27		x10^6/uL	4.00	6.00
Hgb	12.2		g/dL	11.0	18.0
Hct	39.0		%	35.0	60.0
MCV	91.3		fL	80.0	99.9
MCH	28.5		pg	27.0	31.0
MCHC	31.2	L	g/dL	33.0	37.0
Plt	432.		x10^3/uL	150.	450.
LY%	27.2	*	%	20.5	51.1
LY#	2.9	*	x10^3/uL	1.2	3.4

i-STAT EC8+

Pt: [redacted] b(6)-4

Pt Name:_____

Glu_____99 mg/dL
BUN_____11 mg/dL
Na_____142 mmol/L
K_____3.6 mmol/L
Cl_____110 mmol/L
TCO2_____25 mmol/L
AnGap_____11 mmol/L
Hct_____26 %PCV
Hb*_____9 g/dL
*via Hct
PH_____7.388
PCO2_____40.1 mmHg
HCO3_____24 mmol/L
BEecf_____-1 mmol/L

Sample Type_:

04AUG03 10:07

Oper: [redacted]

Physician:_____

Ser# [redacted]

Ver: JAMS046A
CLEW A93

ID: [redacted] 04-08-03
WB 10:06

			Patient Limits	
WBC	11.1 H	x10^3/uL	4.5	10.5
RBC	3.04 L	x10^6/uL	4.00	6.00
Hgb	8.9 L	g/dL	11.0	18.0
Hct	28.3 L	%	35.0	60.0
MCV	93.0	fL	80.0	99.9
MCH	29.3	pg	27.0	31.0
MCHC	31.5 L	g/dL	33.0	37.0
Plt	402.	x10^3/uL	150.	450.
LY%	26.8 *	%	20.5	51.1
LY#	3.0 *	x10^3/uL	1.2	3.4

TESTIS

SPECIMEN TAKEN

DATE | TIME | A.M. P.M.

RESULTS	REQUESTED	(X)
	ROUTINE	
	COLOR	
≥1.030	SPECIFIC GRAVITY	
0.2	UROBILINOGEN	
	OCCULT BLOOD	
Neg	BILI	
Neg	KETONES	
Neg	GLUCOSE	
Trace	PROTEIN	
5.0	pH	
	MICROSCOPIC	
Small	WBC	
Lg ++++	RBC	
	EPITH CELLS	
	CASTS: WBC	
	CASTS: RBC	
	CASTS: HYALINE	
	CASTS: GRANULAR	
	BACTERIA	
	CRYSTALS	
	MUCUS	
Pos	NITRITE	
	BENCE-JONES PROTEIN	
	HEMOSIDERIN	
	HCG	

URINALYSIS 550-106

Standard Form 550 (Rev. 4-77)
General Services Administration and Interagency Committee on Medical Records FPMR 101-11.806-8

REMARKS

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO.—DATE

REQUESTING PHYSICIAN'S SIGNATURE

REPORTED BY

TECH MD DATE

b(6)-4

[redacted]

URINALYSIS

URGENCY: ☐ ROUTINE ☐ TODAY ☐ PRE-OP ☐ STAT

PATIENT STATUS: ☐ BED ☐ AMB ☐ OUTPATIENT ☐ NP ☐ DOM

SPECIMEN SOURCE: ☐ ROUTINE ☐ OTHER (Specify)

LAB. ID NO.

SPECIMEN/LAB RPT NO

PATIENTS MED. RECORD

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 21 Aug 03 / TIME	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	Yellow	N/A
App	Slightly Cloudy	N/A
Glu	Neg	Negative
Bili	Neg	Negative
Ket	Neg	Negative
SG	1.030	N/A
Bld	Large	Negative
pH	5.0	N/A
Prot	Small	Negative
Urob	0.2	0.2-1.0
Nit	Positive	Negative
Leuk	/	Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

SSA-Small
WBC-20-30
RBC-20-30
Bacti-Small

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: b(6)-2

REPORTED BY: [redacted]	DATE: 21 Aug 03	LAB ID NO.:

b(6)-2

Ward/Section: EMT	REQUESTING PHYSICIAN: [redacted]	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. b(6)-4 [redacted]	DATE 4 Aug 03 / TIME	SSN/PSEUDO SSN: [redacted] b(6)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF.

======= PICCOLO =======
04/08/03 10:10
REFERENCE RANGE: MALE
PATIENT #: [redacted]
GENERAL CHEMISTRY 12
DISC LOT #: 3142AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

ALB	2.5*	3.3-5.5	G/DL
ALP	44	26-84	U/L
ALT	27	10-47	U/L
AMY	34	14-97	U/L
AST	23	11-38	U/L
TBIL	0.5	0.2-1.6	MG/DL
BUN	10	7-22	MG/DL
CA++	8.2	8.0-10.3	MG/DL
CHOL	66*	100-200	MG/DL
CRE	1.0	0.6-1.2	MG/DL
GLU	106	73-118	MG/DL
TP	6.3*	6.4-8.1	G/DL

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

(Piccolo) Metabolic Panel

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

b(6)-2

REPORTED BY: [redacted]	DATE: 21 Aug 03	LAB ID NO.:

Ward/Section: ICU1

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

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

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

DATE 8/5/03 | TIME over | 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
pH		7.31-7.45
PCO2		35-45 mmHg 41-51 mmHg (v
PO2		80-105 mmHg (N/A (ven)
TCO2		23-27 mmol/L (a 24-29 mmol/L (v
HCO3		22-26 mmol/L (a 23-28 mmol/L (v
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/l
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l

(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
tCO2		18-33 mmol/l

```
======= PICCOLO =======
05/08/03              04:24
REFERENCE RANGE:      MALE
PATIENT #:  [redacted] b(6)-4
METLYTE 8
DISC LOT #:           3151AA4
OPER #: [redacted]    DR #: 000
SERIAL #: [redacted]
.......................
GLU   85   73-118   MG/DL
BUN    7   7-22     MG/DL
CRE   1.1  0.6-1.2  MG/DL
CK    59   30-380   U/L
NA+   ♦♦♦  128-145  MMOL/L
K+    4.2  3.3-4.7  MMOL/L
CL-   100  98-108   MMOL/L
tCO2  21   18-33    MMOL/L

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

Na-135

REMARKS:

REPORTED BY: [redacted] b(6)-2

DATE: 5Aug03

LAB ID NO.:

b(4)-4

Ward/Section: ICU 1	REQUESTING PHYSICIAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. [redacted] b(4)-2	DATE 8/5/03	TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY: [redacted]	DATE: 5Aug03	LAB ID NO.:

b(4)-2

[redacted]

([redacted] b(4)-4

Ward/Section:	REQUESTING PHYSICIAN: [redacted] b(4)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE: 18-09-04 TIME: 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh		

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted]	DATE: 6 Aug 03	LAB ID NO.:

b(4)-4

[redacted] b(4)-2

Ward/Section: [redacted]	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI:	DATE: 8-6-03 TIME: 0400	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/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

tCO_2		18-33 mmol/l	

======= PICCOLO =======
06/08/03 04:37
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	86	73-118	MG/DL
BUN	6*	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	66	39-380	U/L
NA+	♦♦♦	128-145	MMOL
K+	4.1	3.3-4.7	MMOL
CL-	95*	98-108	MMOL
tCO2	22	18-33	MMOL

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

Na 133

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	6 Aug 03	

b(4)-2

b(a)-4

Ward/Section:	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)	
LAST, FIRST, MI. [redacted]	DATE 07Aug03	TIME 0400	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

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

UNIT	TYPE	CROSSMATCH

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

REMARKS:

REPORTED BY:	DATE: 7Aug03	LAB ID NO.:
[redacted]		

b(a)-2

Ward/Section: [redacted] | REQUESTING PHYSICIAN: | **CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI: b(6)-4 [redacted] EPW | DATE: 07AUG03 | TIME: 0400 | SSN/PSEUDO SSN:

(STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l

======= PICCOLO =======
07/08/03 04:27
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	91	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	0.9	0.6-1.2	MG/DL
CK	54	39-380	U/L
NA+	123*	128-145	MMOL
K+	4.6	3.3-4.7	MMOL
CL-	99	98-108	MMOL
tCO2	24	18-33	MMOL

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY: [redacted] | **DATE:** 7 Aug 03 | **LAB ID NO.:**

b(6)-2

Ward/Section:	REQUESTING PHYSICIAN: [redacted] b(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: [redacted]	DATE: 18 Aug 03	TIME: 1045	SSN/PSEUDO SSN:

b(6)-4

(Hematology) CBC

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

(Hematology) Manual Differential

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

Urinalysis

TEST	RESULT	REF. RANGE
Color	yellow	N/A
App	cloudy	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.020	N/A
Bld	large	Negative
pH	6.5	N/A
Prot	trace	Negative
Urob	0.2	0.2-1.0
Nit	neg	Negative
Leuk		Negative
HCG		Negative

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

SS epithelial cells - trace
RBC - none
WBC - none

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: b(6)-2

REPORTED BY: [redacted]	DATE: 8-18-03	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI	DATE / TIME	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(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^{++}		8.0-10.3 mg/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) Methyte 8

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

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

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

(Piccolo) Electrolyte

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

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	18Aug03	

b(6)-2

b(6)-2

b(6)-4

b(6)-4

Ward/Section:	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, Middle: [redacted]	DATE: 24/AUG	TIME:	SSN/PSEUDO SSN: # [redacted]

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		
ALT		
AMY		
AST		
TBIL		
BUN		
CA+		
CHO		
CRE		
GLU		
TP		
TE		
GLU		
BUN		
CRE		
CK		
NA+		
K+		
Cl-		
tCO		

PICCOLO
24/08/03 17:17
REFERENCE RANGE: MALE
PATIENT #: [redacted]
METLYTE 8
DISC LOT #: 3152AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	84	73-118	MG/DL
BUN	8	7-22	MG/DL
CRE	1.5*	0.6-1.2	MG/DL
CK	33*	39-380	U/L
NA+	132	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	97*	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 1+, ICI 0

(Piccolo) Metabolic Panel

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

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
		3.3-5.5 g/dl
		26-84 u/l
		10-47 u/l
		14-97 u/l
		11-38 u/l
		0.2-1.6 mg/dl
		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

REMARKS:

b(6)-2

REPORTED BY: [redacted]

DATE: 8-24-03

LAB ID NO.:

See other side

Ward/Section:	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:

(Hematology) CBC

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

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Urinalysis

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

CSF

Cell Count		
Directigen		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

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

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

UNIT	TYPE	CROSSMATCH

REMARKS: 20-45-8 20

REPORTED BY:	DATE:	LAB ID NO.:

MEDICAL RECORD - ANESTHESI[redacted]

[redacted] of this form, see AR 40-66; the proponent agen[redacted]e OTSG

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

DRUG	(Units)	
Fentanyl	(ug)	100-50-100-50
Versed	(mg)	2.5/2.5
Lidocaine	(mg)	100
propofol	(mg)	80
	( )	
	( )	

VOLAT AGENT		
SEVO	% del	
	% e.t.	0/2/2/1.5/1/1/1/1
AIR	L/Min	
N2O	L/Min	
O2	L/Min	3/3/3/3/3/3/3/3

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

FLUIDS

LINE site		
LR 18g RAC	☐ Warmed	#1 — 300
NS 18g RAC	☐ Warmed	#1 — 200
	☐ Warmed	
	☐ Warmed	

LOSSES: EST BLOOD LOSS; URINE -

TOTALS	TOTAL EBL
300	MIN
	TOTAL URINE
	Ø

FLUIDS SUMMARY: CRYSTALLOID- 500; COLLOID- Ø; BLOOD- Ø

PHYS STATUS: Ø 2 3 4 5 E

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: /

INITIAL DATA: BP- 113/68; HR- 94

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Y; TIME- 1400

TIME → 1400 x 1430 x 1500 x

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

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

10 Hep/NS 1400 Cefazolin 1400 Gentamycin 1400

BOR TO ICU

VENTIL

VT - ml	750	740	740	520
f - breaths/min	8	8	8	8
Peak inf pres / PEEP	23	23	23	21
MODE - S(pon), A(ssist), C(on)	S-C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff	✓	ET CO2 (torr)	38	35	42	53
BP/oth	✓	FIO2 (Frac or %)	.80	.82	.83	.83
ART line	✓	SpO2 (%)	100	100	100	100
Steth- PC/ES	✓	ECG	SR	SR	SR	SR
Gas analyzer	✓	TEMP-site	AXILLA			
	✓	N-M Block (T/4)	4/4-94-4/4			
Warming blkt						
Conv warmer						

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

REMARKS — Code drugs with numbers, events with lettters

1345 PT ID PREOP ASSESSMENT PER 2400.
1409 RM, O2, monitors
1414 LW inserted
1440 PT c ↑ PIP TO 41, slight wheeze, .25 mg Verb SC given
1508 PT RTC - SKN-ext-sxg
1513 TO ICU
1518 RPT TO [redacted] RN

RECOVERY AT: 1515; PACU (ICU) ___ (Specify); OTHER ___; CONDITION: stable T 100.3; RESP- 28 SpO2- 98%; BP- 125/67 HR- 120

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1345	1358	1525
	Ready	Begin	End
PROC	1409	1432	1501

PROCEDURES and CPT Codes: Cystoscopy / Scrotal washout

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

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

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

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: LW x1 inserted atraumatically, cuff ↑ on 8.0 ETT, ⊕ ETCO2, ⊕ BBS, tape to ⊕ OA inserted. [redacted] tested - TBS

SURGEONS: [redacted] b(6)-2

ANESTHE[redacted] CRNA

PROCEDURE LOCATION: OR 2

DATE: 4 AUG 03

PAGE 1 OF

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 22 DAYS MOS (YRS) Sex (X) MALE ( ) FEMALE

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

PROPOSED PROCEDURE: Scrotal Washout/Cystoscopy
SURGICAL SERVICE: Urology
NPO SINCE: 0700 today

HABITS:
TOBACCO: No
ETOH: NO
DRUGS: NO

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef 1g IV q 8°
( ) gentamicin 400mg IV
( ) U q 24°
( )
( ) MSO4
( ) Phenergan

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

LABORATORY STUDIES:
HB/HCT: 8 / 28
U/A: 20-30 WBC; large blood
OTHER:
Plts 402,000
WBC 11,000
142/110/11
3.6/25/1.0 <99

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:		
Hypertension	N Y	
Angina	N Y	
MI	N Y	
CVA	N Y	
Other	N Y	
Pulmonary System:		
Asthma	N Y	
Bronchitis/URI	N Y	
COPD	N Y	
Other	N Y	
Renal System:		
Acute/Chronic RF	N Y	
Gastrointestinal:		
Hepatitis	N Y	
Hiatal Hernia	N Y	
PUD/GERD	N Y	
Endocrine System:		
Diabetes	N Y	
Steriods	N Y	
Thyroid	N Y	
Neurological:		
Seizures	N Y	
Neuropathy	N Y	
Other	N Y	
Gynecological:		
Pregnancy	N Y	NA
Other Significant Hx:	N (Y)	GSW to groin/penis 11 days ago — now has purulent discharge from penile/scrotal area
	N Y	
Familial HX	N Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC
Exploratory Laparotomy on 24 July 03

PHYSICAL EXAMINATION
BP 116/69 HR 82 R 15 T 100°
Pain Scale 0-10 ____
HEENT - Teeth OK
Trachea Midline
TMJ/Neck Full ROM
Oropharynx MPI TMDTC
Nares
CHEST:
CARDIAC:
EXTREMITIES:
IV Access: 18 ga (R) AC
Ulnar Filling:
BACK:
OTHER:

NPO Since 0700 today

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): ____ (X) General: Mask Intubation

Interpreter used during interview — pt understands plan

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

The patient/[redacted] b(6)-2 understand and agrees. Questions answered.
Signed: [redacted] MD Date: 04 AUG 2003 Time: 1143 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ICU 1

#[redacted] b(6)-4

SEDATION KEY:

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

4.2 | 21 | 100 | 7 | 1.1 | 85

MEDICAL RECORD - ANESTHESIA

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

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION		
DRUG	(Units)	
Versed	(mg)	2
Lidocaine	(Mg)	20
propofol	(mg)	100
Fentanyl	(ug)	50
	( )	
	( )	
VOLAT AGENT Sevo	% del	4
	% e.t.	
AIR	L/Min	
N2O	L/Min	
O2	L/Min	4

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

FLUIDS		
LINE site	☐ Warmed	
	☐ Warmed	
N OSNaCl	☐ Warmed	
	☐ Warmed	
LOSSES	EST BLOOD LOSS	
	URINE -	FC

TOTALS	TOTAL EBL
2 mg	min
20 mg	
100 mg	TOTAL URINE
75 mg	in FC
2	

FLUIDS SUMMARY
CRYSTALLOID- 500 cc
COLLOID-
BLOOD- Ø

REMARKS
Code drugs with numbers, events with letters
Pt I'D'd in PCU.
Monitors applied
To PCU, placed on 3L NC
LT [redacted] given Report.

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: KG / LB

HEMATOCRIT: 8.6/30.9

INITIAL DATA: BP- 127/94 HR- 95

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? Y TIME- 0715

TIME → 0800 0830

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

VENTIL: VT - ml			
f - breaths/min	16	10	12
Peak inf pres / PEEP			
MODE - S(pon), A(ssist), C(on)	S	S	S
MONITORS/ACCESSORIES: BP/Auto Cuff / ET CO2 (torr)	34	38	36
BP/oth / FIO2 (Frac or %)	1.0	1.0	1.0
ART line / SpO2 (%)	100	100	100
Steth- PC/ES / ECG	ST	ST	ST
Gas analyzer / TEMP-site Sh	37	37	
N-M Block (T/4)			
Warming blkt			
Conv warmer			

Mark with letters & symbols, explain under REMARKS — EVENTS / Position → Ord

RECOVERY AT: PACU (ICU 2) (Specify) OTHER
CONDITION: Stable
RESP- 20 SpO2 98 98 BP- 129/73 HR- 105

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0745	0750	0832
	Ready	Begin	End
PROC	0755	0757	0817

PROCEDURES and CPT Codes: dressing change of penis

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
Conduction inhalation maintained

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
Mask

SURGEON [redacted] b(6)-2

ANES [redacted]

PROCEDURE LOCATION: OR 1
DATE: 05 Aug 03
PAGE 1 OF 1

DA FORM 7389, FEB 1998 MEDCOM - 1574 [redacted]

COPY 1 - PATIENT'S MEDICAL RECORD

ANESTHESIA PLAN OF CARE-PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 22 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

PROPOSED PROCEDURE: drug chg
SURGICAL SERVICE:
NPO SINCE:

ASA Physical State 1 2 3 4 5 E
WT: 10 KG/LB HT: ____ IN.
ALLERGIES: NKDA

HABITS:
TOBACCO: N
ETOH: N
DRUGS: N

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) MS 04
( ) phenergan
( ) Versed
( ) ketocanazole
( ) Gent.
( ) Cancef

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

LABORATORY STUDIES:
HB/HCT: ____/____
U/A:
OTHER:

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

Cardiovascular:			
Hypertension	N	Y	
Angina	N	Y	
MI	N	Y	
CVA	N	Y	
Other	N	Y	
Pulmonary System:			
Asthma	N	Y	
Bronchitis/URI	N	Y	
COPD	N	Y	
Other	N	Y	
Renal System:			
Acute/Chronic RF	N	Y	GSW 24 July
Gastrointestinal:			
Hepatitis	N	Y	
Hiatal Hernia	N	Y	
PUD/GERD	N	Y	
Endocrine System:			
Diabetes	N	Y	
Steriods	N	Y	
Thyroid	N	Y	
Neurological:			
Seizures	N	Y	
Neuropathy	N	Y	
Other	N	Y	
Gynecological :			
Pregnancy	N	Y	
Other Significant Hx:			
	N	Y	
	N	Y	
Familial HX	N	Y	

ASSESSMENT
PAST SURGICAL/ANESTHETIC

Exp Lap 24 July
4 Aug cystoscopy

PHYSICAL EXAMINATION
BP 124/72 HR 95 R 16 T 100.9
Pain Scale 0-10 ____
HEENT - Teeth ____
Trachea ____
TMJ/Neck ____
Oropharnyx ____
Nares ____
CHEST:
CARDIAC:
EXTREMITIES:
IV Access: Rt Ac
Ulnar Filling:
BACK:
OTHER:

NPO Since ____

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

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

The patient/legal guardian seems to understand and agrees. Questions answered.
Signed: [redacted] b(6)-2 Date: 05 Aug 03 Time: 0745 Hrs

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

Signed: ____ Date: ____ Time: ____ Hrs

Patient Identification: (Ward) ____

[redacted] b(6)-4 PCU

SEDATION KEY:

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

Cefuroxim 1gm IV KDA ASA 1 ~~O2 s/s c pulmonis~~ workup

2240 1245

MEDICAL RECORD - ANESTHESI[illegible]

[illegible]e of this form, see AR 40-66; the proponent agen[illegible]ne OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML, "I" = CONSTANT INFUSION																	
DRUG	(Units)																
[illegible]	(mg)	8															
Fentanyl	(mcg)	160	50	50	50												
	( )																
Propofol	(mg)	180															
	( )																
	( )																
VOLAT AGENT	Forane % del		1.5														
	% e.t.																
AIR	L/Min																
N2O	L/Min																
O2	L/Min	2															

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

FLUIDS																	
LINE site: 1 RA/C #18	☐ Warmed	200															
	☐ Warmed																
	☐ Warmed																
	☐ Warmed																
LOSSES	EST BLOOD LOSS																
	URINE -																

TOTALS	TOTAL EBL
3400	5
2040	
TOTAL URINE	
1800 cc	Neg

FLUIDS - SUMMARY
CRYSTALLOID- 200
COLLOID- 0
BLOOD- 0

REMARKS
Code drugs with numbers, events with letters
1 Discussion
2 See below
3 Tourniquet

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 70 KG LB

HEMATOCRIT: 33.6

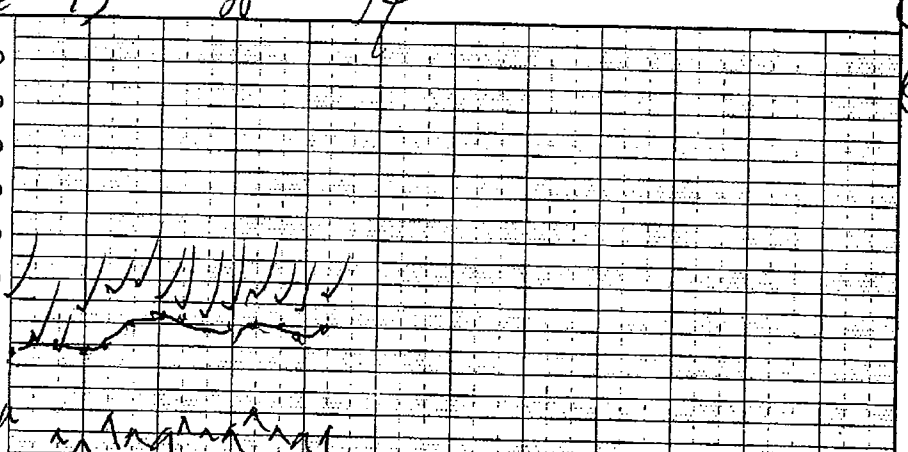
INITIAL DATA: BP- 116/65 HR- 85

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? + TIME- 1030

TIME → 1245 1315 1330 1400

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-∅



MONITORS/ACCESSORIES		1245	1315	1330	1400
	VT - ml	700	700	800	800
	f - breaths/min	12	12	10	10
	Peak inf pres / PEEP	22	22	24/	21
	MODE - S(pon), A(ssist), C(on)	CV	CV	CV	CV
BP/Auto Cuff	ET CO2 (torr)	35	35	4	4
BP/oth	FIO2 (Frac or %)	1	1	1	1
ART line	SpO2 (%)	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR
Gas analyzer	TEMP-site	95	95		
	N-M Block (T/4)	0/4			
Warming blkt					
Conv warmer					

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

RECOVERY AT
PACU ICU 3 (Specify)
OTHER
CONDITION:
RESP- 18 SpO2- 93
BP- HR- 118

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1230	1245	1315
PROC	1255	1330	1345

PROCEDURES and CPT Codes:
Delayed Primary Closure

ANESTHETIC TECHNIQUES: Describe block technique under Remarks
G/A - #4 LMA

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility
[redacted] b(6)-4
ICU 3

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments
GA #4 LMA BL-BS Cohen-etc

SURGEONS
[redacted] 210R b(6)-2
A [redacted]

PROCEDURE LOCATION: OR 2
DATE: 11 AUG 03
PAGE 1

PRE-ANESTHETIC ASSESSI[illegible] AND PLAN OF CARE

AGE: 34 Days Mos Yrs

GENDER: (X) Male ( ) Female
ALLERGIES: NKDA

P S: 1 2 3 4 5 E
WT: 80 (Kg)/Lb HT: ____ In.

PROPOSED PROCEDURE: DPC
SURGICAL SERVICE: ORTHO
NPO SINCE: MN

PREOP DX / MECHANISM OF INJURY: s/p GSW

HABITS:
Tobacco: (+)
EtOH: (+)
Drugs: Ø

CURRENT MEDICATIONS:
( ) = ordered as premed
( ) Ancef 1g TID (given 0800)
( )
( ) Clindamycin 300mg Q8°
( )
( )
( )

PREMEDICATIONS:
None / Yes @ ____ Hrs

LABORATORY STUDIES: 17AUG03

130	105	13
3.5	19	1.5

146

9.0
6.1 — 335
26.8

17.3 / 26.2

Other:

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:
Hypertension N Y
Angina N Y
MI N Y
CVA N Y
Other N Y

Pulmonary:
Asthma N Y
URI N Y
COPD N Y
Other N Y

Renal System:
ARF/CRF N Y
Other N Y

Gastrointestinal:
Hepatitis N Y
Hiatal Hernia N Y
GERD/PUD N Y

Endocrine:
Diabetes N Y
Steroids N Y
Thyroid N Y

Neurological:
Seizures N Y
Neuropathy N Y

Gynecological:
Pregnancy N Y
Other N Y

Other Problems: N Y

Familial Hx N Y

SURGICAL HISTORY
(R) LE x 2
(L) ARM x 2 > Ø comps

PHYSICAL EXAMINATION
BP: 120/70 HR: 74 RR: ____ T: 98°
Pain (0/10 Scale): ____
Airway Exam:
Dentition: intact
Trachea: Midline
TMJ/C-spine: FROM / TMJ>3FB
Oropharynx: MP II
Chest:
Lungs: CTA
Heart: S1S2
IV Access: none
Ulnar Filling: ____
Back: ____
Other: ____

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: ____ (X) General: Intubation / Mask-LMA Notes: ____

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with patient and [redacted] guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

b(6)-2

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

Signed: [redacted] PT CRNA Date: 24 AUG 03 Time: 0820

PATIENT IDEN[redacted]ON:

[redacted]

b(6)-4

POST-ANESTHESIA EVALUATION AND NOTE:
( ) No apparent anesthetic complications.
( ) Other (see progress notes)
Signed: ____ Date: ____ Time: ____

Nursing Unit: ICW

MEDICAL RECORD - ANESTHESIA

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

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

DRUG (Units)																		
Versed (mg)	5																	
Fent ( )	100		50	50	50													
Lidocaine ( )	100																	
MSOG ( )							4		2		4							
Propofol ( )	150				50													
( )																		
VOLAT AGENT: Forane % del			1.5	2.0	1.5		1.5		1.5		1.5							
% e.t.																		
AIR L/Min																		
N2O L/Min																		
O2 L/Min	8		2	2	2		1		1		1		10					

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

FLUIDS

LINE site NS																	
☐ Warmed		300							600								
☐ Warmed																	
☐ Warmed																	
☐ Warmed																	

LOSSES: EST BLOOD LOSS; URINE -

TOTALS: 5mg, 250mg

TOTAL EBL: Min

TOTAL URINE: Ø

FLUIDS SUMMARY: CRYSTALLOID- 600; COLLOID- Ø; BLOOD- Ø

PHYS STATUS: 1 2 3 4 5 E

BODY WEIGHT: 82 KG LB

HEMATOCRIT:

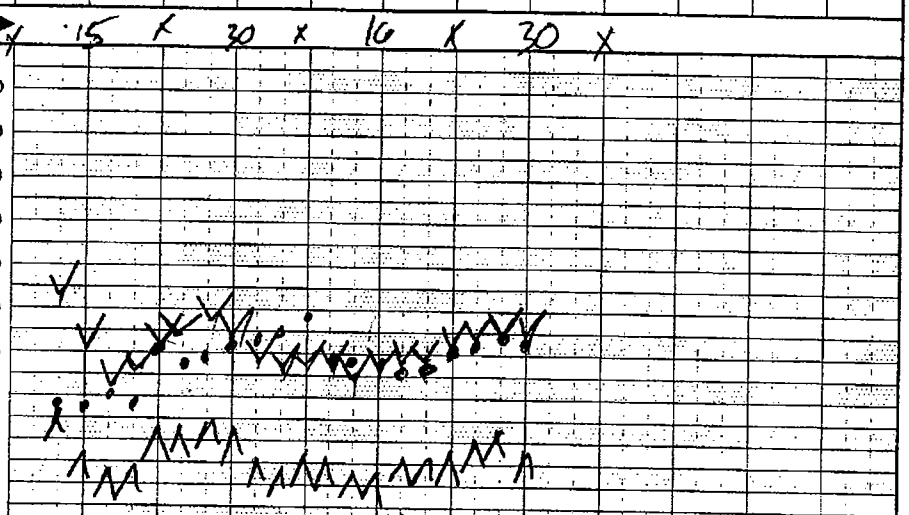
INITIAL DATA: BP- 121/71; HR- 77

EQUIP CHECK: OK?- Y N

PATIENT RECHECK: OK for PROCEDURE? TIME-

TIME → 1 15 X 30 X 16 X 30 X

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-Ø



VENTIL

VT - ml	SV	CV	SV	SV	SV	SV	SV	SV
f - breaths/min		5	21	12	10	16	16	16
Peak inf pres / PEEP		14						
MODE - S(pon), A(sist), C(on)	S	C						

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	38	51	49	57	40	50	43	44
BP/oth	FIO2 (Frac or %)	.77	.77	.76	.76	.76	.79	.79	.79
ART line	SpO2 (%)	100	100	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site		37	37	37		37		
	N-M Block (T/4)								
Warming blkt									
Conv warmer									

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

REMARKS

Code drugs with numbers, events with letters

1450 in OR monitors applied
1500 Induct LMA placed ⊕ ETCO2 ⊕ Bilat BS
1635 - spont Resp, LMA removed mask vent assist until purposful movement. transfered to PACU.

RECOVERY AT: PACU; PACU ICU ____ (Specify); OTHER ____

CONDITION: Spont Resp, cooperative

RESP- 16 SpO2- 98; BP- 124/55 112

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1400	1450	1640
	Ready	Begin	End
PROC	1500	1520	1625

PROCEDURES and CPT Codes: Penis graft / Debrid closure

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

[redacted] b(6)-4

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: #4 LMA

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments: LMA placed one attempt ⊕ Bilat BS

SURGEONS: [redacted] b(6)-2

ANES[redacted]

PROCEDURE LOCATION: 28th MSG

DATE: 8/25/03

PAGE 1 OF 1

PRE-ANESTHETIC ASSESSI[illegible] AND PLAN OF CARE

AGE: 30 Days Mos Yrs

GENDER: (✓) Male ( ) Female

ALLERGIES: NKMA

P S: 1 2 3 4 5 E

WT: 75 Kg/Lb HT: ____ In.

PROPOSED PROCEDURE: Penis Graft

SURGICAL SERVICE: Urology

NPO SINCE: MN

PREOP DX / MECHANISM OF INJURY: GSW

HABITS:

Tobacco: Ø

EtOH: Ø

Drugs: Ø

CURRENT MEDICATIONS:

( ) = ordered as premed

( ) Cipro BID

( )

( )

( )

( )

( )

PREMEDICATIONS:

None / Yes @ _____ Hrs

LABORATORY STUDIES:

132	97	8	84
4.4	22	1.5	

10.7 | 12.2 | 39.0 | 432

Other: _____

PAST MEDICAL HISTORY / SYSTEMS REVIEW

Cardiovascular:

Hypertension N Y

Angina N Y

MI N Y

CVA N Y

Other N Y

Pulmonary:

Asthma N Y

URI N Y

COPD N Y

Other N Y

Renal System:

ARF/CRF N Y

Other N Y

Gastrointestinal:

Hepatitis N Y

Hiatal Hernia N Y

GERD/PUD N Y

Endocrine:

Diabetes N Y

Steroids N Y

Thyroid N Y

Neurological:

Seizures N Y

Neuropathy N Y

Gynecological:

Pregnancy N Y

Other N Y

Other Problems: N Y

Familial Hx N Y

SURGICAL HISTORY

DPC

Debridement > 8 comps

PHYSICAL EXAMINATION

BP: ____ HR: ____ RR: ____ T: ____

Pain (0/10 Scale): ____

Airway Exam:

Dentition: intact

Trachea: midline

TMJ/C-spine: FROM / 3FB

Oropharynx: MPT

Chest:

Lungs: CTA

Heart: $S_1 S_2$

IV Access: 18g

Ulnar Filling: ____

Back: ____

Other: ____

ANESTHETIC PLAN: ( ) Local/MAC ( ) Regional: ____ (✓) General: (Intubation) Mask-LMA Notes: ____

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives, and risks of anesthesia including death have been explained to and discussed with patient and/o[illegible] guardian. The patient/legal guardian seems to understand and agrees to proceed. Questions answered.

[redacted] b(6)-2

( ) Sedated/nonresponsive/minor patient with no family or guardian present.

Signed: [redacted] CRT CRNA Date: 25 AUG 03 Time: 0800

PATIENT IDENTIFIC[redacted]

H[redacted]

b(6)+4

POST-ANESTHESIA EVALUATION AND NOTE:

( ) No apparent anesthetic complications.

( ) Other (see progress notes)

Signed: ____ Date: ____ Time: ____

Nursing Unit: ICW

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

ICU7

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
	4 Aug 03	1010 HOURS	
1	Admit ICU		1130
2	Condition: Stable		b(6)-2
3	Diet NPO		[redacted]
4	IVF NS @ 150 cc/h		
5	Foley to gravity drainage		
6	Ancef 1gm q 8° IVPB		First [redacted]
	dose now		

PATIENT IDENTIFICATION

[redacted] b(6)-4

ICU

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	Gent 400 mg IVPB q 24°	HOURS	First
	dose now		
7	MSO4 2-6 mg IVP q 2° PRN pain		
8	Reglan 12.5 mg IVP q 6° PRN nausea		
9	VS q 2°		
10	to OR today		
11	Observation in ICU overnight		
12	R [redacted]		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	NKDA	[redacted]	
		HOURS	

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

	DATE OF ORDER	TIME OF ORDER	
	5 Aug 03	HOURS	
	Resume previous orders		
	Fentanyl 50-250 mg [redacted] Drips		AS
	Versed 2-4 mg IVP [redacted]		b(6)-2
	Drug D's [redacted]		[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

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

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

4 Aug 03 1800

Admit to ICU 1

Dx s/p penile GSW

Condition stable

VS q 2hr

Diet ~~Regular~~ clear liquids

IV LR @ 100 cc/hr

Foley: Needs to be taped upward on abdomen at all times. (Record output in gravity drainage)

Reinforce flush as needed

Dressing change by MD in AM

Please have fine mesh gauze roll and NS @ bedside in AM

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

✓ MSOy 2-6mg IVP q 2° PRN pain

✓ Percocet 1-2 tabs PO q 4° PRN pain

✓ Phenergan 12.5g IVP q6° PRN Nausea

✓ Ancef 1gm q 8° (last dose @ 1400) IVPB

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

✓ Gentamycin 400g IVPB q 24° (last @ 1400)

✓ Ketoconazole 400g PO q 8° X 9 doses.

✓ CBC, chem 8 q AM X 3 days.

[redacted]

b(6)-2

DA FORM 1 APR 79 4256 REPLACES EDITION

MEDCOM - 15747

USE [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]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 4 Aug 03 TIME OF ORDER: 1800 HOURS

NPO aft Midnight } Initial 0530
to OR mrn

[redacted]

PATIENT IDENTIFICATION

[redacted]

ICU 3 b(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9 Aug 03 TIME OF ORDER: 0831 HOURS

Transfer to ICUB
Dx: Penile GSW
Cerebrovascular Stroke
VS q 1°
Foley Fogarty drainage
IVF LRS @ 75 cc/h
Diet Regular

b(6)-2

[redacted]

PATIENT IDENTIFICATION

[redacted]

ICU3

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

MSO4 2-6 mg IVP PRN pain
Percocet 1-2 PO q 4° PRN pain
Reneger 25 mg PO q 6° or
12.5 mg IVP q 6° PRN Nausea
Colace 100 mg PO BID
Ciprofloxacin 500 mg PO BID
Demy Δ qAm @ 0800 by MD
Fentanyl 150 mcg IVP q2

[redacted]

PATIENT IDENTIFICATION

[redacted]

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

Demy Δ
Activity ~~Bedrest~~ Bedrest c BRP

[redacted]

b(6)-2

8-4 Pos ~~vsf~~ U/O Δ [redacted] 0800 ances
agentamycin [redacted]

24° Chart Check 10 AUG 0030

[redacted]

DA FORM 1 APR 79 4256 REPLACES EDITION OF

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

9 Aug 03

Brief Op Note

Procedure: (1) Penile, scrotal, groin wound irrigation / debridement

(2) Urethroscopy

Indication: SP GSW to penis

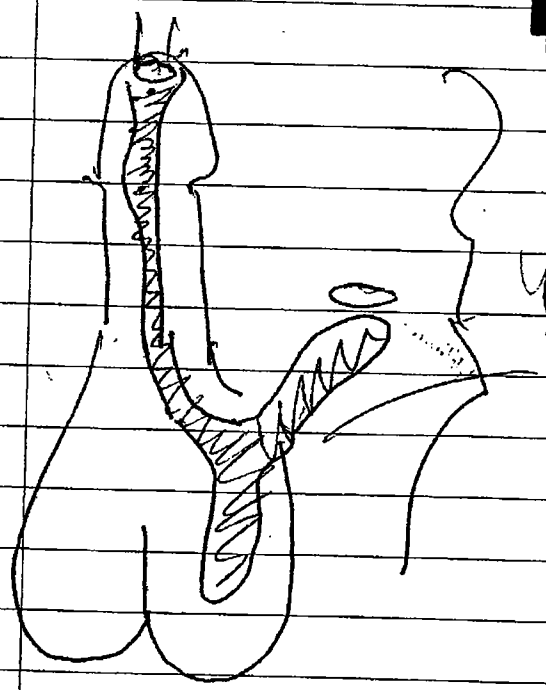
Surg Dr [redacted] / Dr [redacted]

GEPA

ABX: Gent / Ancef

Cephalexin [redacted]

b(6)-4



Wounds

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
STANDARD FORM 600 (REV. 6-9[illegible])
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202

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	LIST TIME ORDER NOTED AND SIGN
11 Aug 03	0226 HOURS	
NPO		[redacted]
[redacted]		[redacted]
		b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
11 Aug 03	1900 HOURS	
(1) Return to ICU Semiprivately anesthesia		
(2) Dx: Penile GSW		
(3) Condition stable		noted 12 Aug 03
(4) IVF LR @ 75 cc/hr Heplock when tolerating PO		[redacted]
(5) Regular Diet		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
(6) Cipro 500 mg PO BID		
(7) Apply to groin drains	HOURS	
(8) MSO4 2-6 mg IVP q 2° PRN		
(9) Percocet 1-2 PO q 4° PRN		
(10) Pentazocine 100-150 mg IVP for drain D's		
(11) Phenergan 25 mg IVP q 6° PRN refusal		
(12) Colace 100 mg PO BID		

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER	TIME OF ORDER	
(14) Activity Bed rest	HOURS	
(15) Dr. [redacted]		
(16) NKDA		
(17) Drain D's → change flush around penis BID		
Use wet fine mesh gauze to back towel and wrap penis, wrap penis & 4x4 and		b(6)-2

NURSING UNIT	ROOM NO.	BED NO.

A FORM 1 APR 79 4256 REPLACES EDITION OF

12AUG 0100 24° Chart Check [redacted] MEDCOM - 15750 D. [redacted]

1LT/AN

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: ICU3 | ROOM NO.: | BED NO.:

DATE OF ORDER: 15 Aug 03 | TIME OF ORDER: 2000 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) Δ VS to q8°.
V.O. DR [redacted] / [redacted] LT/AN
[redacted] b(6)-2

24° Chart Check [redacted] b(6)-2 LT/AN

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

NURSING UNIT: ICU3 | ROOM NO.: | BED NO.:

DATE OF ORDER: 16 Aug 03 | TIME OF ORDER: 1037 HOURS

↓ Fentanyl to 50 mcg IVP if they Δ↑ [redacted] b(6)-2

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

24° chart ✓ [redacted] AN/ 1710 17 Aug 03 [redacted]

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

NURSING UNIT: ICU3 | ROOM NO.: | BED NO.:

DATE OF ORDER: 18 Aug 03 | TIME OF ORDER: 0816 HOURS

Phenergan 12.5 mg IVP Q6° PRN.
May ↑ Phenergan to 25 mg IVP if 12.5 mg does not work
V.O. Dr [redacted] / [redacted] AN

b(6)-2 [redacted]

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

NURSING UNIT: ICU3 | ROOM NO.: | BED NO.:

DATE OF ORDER: 18 Aug 03 | TIME OF ORDER: 0900 HOURS

Restart IVF LRC 125 c/h
↑ VS to q4° / Strict I/O
Send CBC, chem 8, UA & culture
~~Start Unasyn 3 gm IVPB q6~~
~~Start IV Cipro 400 mg IVPB q12~~
Send f Flat plate (upright and x ray and CXR
NPO [redacted] 1138 AN 18 Aug 03

PO [redacted] b(6)-2 T> 1005

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.

b(6)-2 A11

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT	ROOM NO.	BED NO.
ICW 2		

DATE OF ORDER: 18 Aug 03 TIME OF ORDER: 1541 HOURS

LIST TIME ORDER NOTED AND SIGN

① Δ Foley catheter

② 150 mcg Fentanyl IVP prior to changing Foley catheter v.o. per Dr [redacted] / [redacted] [redacted] 18 Aug 03

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 19 Aug 03 TIME OF ORDER: 0900 HOURS

① Transfer to ICW 2 Jeziot

② Ox: penile 6SW

③ Cent good

④ VS & shift

⑤ Act BSC

⑥ NKDA

⑦ Diet: regular

NOTED [redacted]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER:

⑧ IVF: LR @ 125 cc/hr

⑨ Unasyn 3gm IVPB q 6°

Morphine 2-6 mg IV q 2° PRN

Percocet II PO q 4° PRN

~~[illegible]~~ Lasix

Fentanyl ~~100 mcg~~ 50 mcg IVP for dressing Δ's

⑩ Dressing c̄ s-change fluffs around penis BID

use net fine mesh gauze to back, lower abdominal wound and wrap penis c̄ 4x4 & Kotex

⑪ strict I+O's

⑫ Foley to gravity

19/10 Aug 03 [illegible]

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER: HOURS

[redacted]

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

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996—409-924

"USE BALL POINT PEN—PRESS FIRMLY [illegible] 'ER REQUIRED"

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-68; the proponent agency is OTSG

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

PATIENT IDENTIFICATION: EPW [redacted]

DATE OF ORDER: 20 Aug ? TIME OF ORDER: 0837 HOURS

LIST TIME ORDER NOTED AND SIGN

- DC fentanyl
- DC Morphine
- Percocet 1-2 PO q4° PRN
- DC Foley
- DC strict I/O
- Δ hem Δ to dry gauze
- flush BID No Heparin

NURSING UNIT: ICW2 ROOM NO. BED NO. noted 20 Aug 03

PATIENT IDENTIFICATION: DATE OF ORDER: TIME OF ORDER: HOURS

~~Keep~~ necessary

~~DC~~ Hep [redacted] b(6)-2

NURSING UNIT: 24-1 ROOM NO. BED NO. 22 Aug 03

PATIENT IDENTIFICATION: DATE OF ORDER: 22 Aug 03 TIME OF ORDER: 1400 HOURS

DOB walking BID & TID

b(6)-2 [redacted] noted 22 Aug 03

b(6)-2 [redacted]

NURSING UNIT: 24U/2350 ROOM NO. BED NO. 23 Aug 03

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.

☆ U.S. GOVERNMENT PRINTING OFFICE: 1996—403-974

"USE BALL POINT PAPER REQUIRED"

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: ICW #1 | ROOM NO. | BED NO.

DATE OF ORDER: 24 Aug 03 | TIME OF ORDER: 1238 HOURS | LIST TIME ORDER NOTED AND SIGN

(1) NPO ~~after~~ after midnight

(2) Start IV @ ~~2100~~ 1800 hr and start IV fluid @ 125 cc/hr. b(6)-2 [redacted]

(3) Start Ciprofloxacin 400 mg IV q12 (Start @ 1800 Tonight) [redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: [redacted] b(6)-2 [redacted] 02

CBC and ~~not~~ 8 cc/IV start. WO per [redacted] b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

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

b(6)-4 [redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW#1		

DATE OF ORDER: 25 Aug 03 TIME OF ORDER: 1636 HOURS

LIST TIME ORDER NOTED AND SIGN

S/P penile stent screen stent transp to ward when cleared by anesthesi

IVF LRC 100 cc/hr, heplock when tolerating PO

Diet Regular

Foley to gravity drainage

PATIENT IDENTIFICATION

b(6)-2 [redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER:

Strict I/O HOURS

Cipro 400 g IVPB q 12°

MSO4 2-6 mg IVP q 2° prn pain

Percocet 1-2 PO q 4° prn

J Pedrain to bulb suction record on I/O sheet

VS q 4° x 48° then q 8°

Strict Bedrest

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: TIME OF ORDER:

Dr [redacted] b(6)-2 HOURS

MCDA [redacted] b(6)-2

① MSO4 2mg q 5 [redacted] x 10 mg MSO4

Keep MAP 10 @ sat 95%

[redacted] MAT AN CRNA-

b(6)-2

PATIENT IDENTIFICATION

NURSING UNIT	ROOM NO.	BED NO.
[redacted]	2W	[redacted]

DATE OF ORDER: 25 AUG 03 TIME OF ORDER: 2245 HOURS

① Phenergan 25 mg IV q 6° prn

V.O. Dr [redacted] [redacted]

b(6)-2

b(6)-2 [redacted]

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

☆ U.S. GOVERNMENT

MEDCOM - 15755

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
				30 Aug 63	0723 HOURS	
				✓ DC IV		
				✓ Remove Foley		
				✓ Δ Cyro to 500 BID PO		
NURSING UNIT	ROOM NO.	BED NO.		[redacted]		
7A/0200	3 Aug	[redacted]				

b(4)-2 orders removed @ 0725 [redacted]

b(4)-2

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.

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.

[redacted]

DATE OF ORDER: 31 Aug 03 TIME OF ORDER: 0944 HOURS

Shower patient B10 for 2 days [redacted] b(6)-2

DC Cipro [redacted]

Keflex 500 [redacted]

x 5 days

LIST TIME ORDER NOTED AND SIGN: [redacted]

PATIENT IDENTIFICATION

[redacted]

b(6)-4

Noted 2 Sep 03

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 9/3/03 TIME OF ORDER: 0707 HOURS

Actuns as tolerated

Cont shower QD

b(6)-2 [redacted]

2nd Chart 4 Sep 03 1908 [redacted] LT/AN

PATIENT IDENTIFICATION

#[redacted]

b(6)-4

NURSING UNIT: ICW | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

OK for DC to EPW

Cmp

[redacted]

b(6)-2

[redacted]

PATIENT IDENTIFICATION

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

b(6)-2

4256 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

b(a)-2

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 8/3	8/4												
8/3	[redacted]	Cipro 400mg IV BID	0900	X													
			2100														
8/3	[redacted]	Bacitracin BID	0900	X													
		apply to wound	2100	X													

ALLERGIES: ☒ YES ☐ NO

PRIMARY DIAGNOSIS:

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: _____

PATIENT IDENTIFICATION:

[redacted]

b(a)-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

USED.

DA FORM 1 OCT 78 4677

MEDCOM - 15758

b(4)-2 All

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

Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	4	5	6	7	8	9	10	11	12	13	14	15	16	17
8-4	[redacted]	Del WPC	05														
			17														
8-4	[redacted]	Foley/urgent/drains	06	[redacted]													
			18														
8-4	[redacted]	VS Q4° (S'd x 4)	05	[redacted]													D/C
			17														
~~8-4~~	[redacted]	~~NA OR x 6 hrs~~	~~05~~														
			~~17~~														
~~8-4~~	[redacted]	~~dressing in IV wave pouch~~	~~06~~														
			17														
8-4	[redacted]	NKDA	06	[redacted]													
			18														
8-4	[redacted]	Diet Clear Liquids ADV to Rly	06	[redacted]													
			18														
8-4	[redacted]	CBC Chem 8 q AM x 3 days	04	[redacted]													
8-4	[redacted]	Foley; Needs to be taped	06	[redacted]													
		to anterior abdomen @ all	18														
		times. Reinforce flush															
		as needed.															
8-9	[redacted]	Dressing Δ Q AM & PM	7								[redacted]						D/C
		by MD															
8-9	[redacted]	BR = BRP (11 Aug 03)	06								[redacted]						
			18														
11 Aug 03	[redacted]	NPO	06														D/C 11 Aug 03
			18														
11 Aug 03	[redacted]	Regular diet	06														
			18														

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: Penile GSW
S/P Penile debridement R/T GSW.

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO: 1

PATIENT IDENTIFICATION:
EPW [redacted]

b(4)-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 All

Verify by Initialing: Order Date	Clerk Nurse	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) — SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
						Mo ____ Yr 2003
8-4	[redacted]	observe in ICU overnight	8-4			[redacted]
8-4	[redacted]	To OR 8-4-03	8-4	ASAP	1300	[redacted]
8-4	[redacted]	Dressing change by MD in AM, please	8-5		done	[redacted]
	-----	have fine mesh gauz & roll and NS				
	-----	@ bedside				
8-4	-----	NPO p MN	8-5	0000	0000	[redacted]
11 Aug	[redacted]	Return to ICU when cleared by anesthesia	11 Aug 03	done		[redacted]
11 Aug 03	[redacted]	Condition stable	11 Aug 03	done		[redacted]
16 Aug	[redacted]	Send CBC, Chem 8, UA	16 Aug 03		1220	[redacted]
16 Aug	[redacted]	Send for Flat Plate / Upright	16 Aug 03	on call	1615	[redacted]
	-----	Abd x ray & CXR				
16 Aug 03	[redacted]	Δ Foley Catheter	16 Aug 03		1555	[redacted]
16 Aug 03	[redacted]					

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

USAPA V1.00

(b(6)-2 All

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 11	12	13	14	15	16	17	18	
11 AUG 03	[redacted]	Drsg Δ's → change	08	✓								
		fluffs around penis BID	20	[redacted]								
		use wet fine mesh gauze										
		to back lower old wound										
		and wrap penis, wrap penis										
		c̄ 4x4 and kotan										
15 Aug	[redacted]	V.S. Q8H	06	X	X	X	X	X	[redacted]			Δ'd 18 Aug 03
			18	X	X	X	X	[redacted]				
11 Aug 03	[redacted]	Regular Diet	06	/					/	[redacted]		Δ'd 18 Aug 03
Recorded 18 Aug 03			18	/					/		/	
18 Aug 03	[redacted]	↑ VS to Q4° / Strict	06	/					/	[redacted]		
		I+O's	18	/					/	[redacted]		
18 Aug 03	[redacted]	NPO	06	/					/	[redacted]		
			18	/					/	[redacted]		

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: GSW penis
S/P Penile debridement

ADDITIONAL PAGES IN USE: ☒ YES ☐ NO
PAGE NO: 2

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 A11

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.	Mar 08 Fr. 2003

VERIFY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS FREQUENCY, TIME	HR	DATE COMPLETED 19 20 21 22 23 24 25 26 27
19	[redacted]	Urin. g.s.f.f	05	[redacted]
			13	
			21	
19	[redacted]	Activity: BSC HS OOB to walk BID 7 MD	05	[redacted]
			13	
			21	
19	[redacted]	Regular Diet	07	[redacted]
			11	
			17	
19	[redacted]	Dsg Δ BID → use ck	08	[redacted]
		Pt can just peek bar	20	
		abc wash hands in peri		
		wipe peri & 4x4 & tape		
19	[redacted]	Start ZSO2	05	[redacted]
			13	
			21	
19	[redacted]	Foley to gravity	05	[redacted]
			13	
			21	
20 Aug	[redacted]	D/C Δ & dressing q 48 hrs	09	[redacted]
		BID: no Robin	20	

D/C'd

D/C'd 20 Aug 0900

D/C'd 20 Aug 0900

D/C'd 20 Aug 0900

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: GSW L-3

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.:

PATIENT IDENTIFICATION:

GSW of [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 72 MAY BE USED. — USAPA V1.00

b(6)-2

Verify by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo 08 Yr 2003

Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
19	[redacted]	Pt to ZCW#23 Confin Seg	19	Now	1045	[redacted]
20	[redacted]	DIC tdcy	20	Now	0700	
24	[redacted]	CBC ant Mex B w/ IV Stack	24	1800		

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED													
19	[redacted]	Percent 1-2 tds	2	0100	2	1600										
		8 hr	[redacted]													

USAPA V1.00

CW [redacted] b(6)-4

b(6) - 2 AII

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. 08 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	05	6	7
25	[redacted]	Diet: regular	6	X	[redacted]												RM
			18	[redacted]													
25	[redacted]	Foley to gravity	6	X	[redacted]												
			18	[redacted]													
25	[redacted]	Strict I&O's	6	[redacted]													
			18	[redacted]													
25	[redacted]	Pulmonary toilet	6	[redacted]													
		Suction prn record	18	[redacted]													
		on I&O's sheet	X														
25	[redacted]	VS Q4° x 48° (until	6	X	[redacted]												
		1800 27 Aug), then	18	[redacted]													
		Q8°	X														
[redacted]																	
4 Sep	[redacted]	Activity as tolerated	06														RM
			18														
4 Sep	[redacted]	Showers. Cont	06														RM
		QD															

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: Penile S/P skin reconstruction

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

b(6)-2 A11

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)					Mo 08 Yr 2003
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials	
30 Aug 03	[redacted]	Remove foley	30 Aug 03	—	0735	[redacted]	
9/7	[redacted]	O.K. for D/C to EPW Camp	9/7				

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

USAPA V1.00

b(6)-2

(b(6)-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. ____ Yr. ____

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 4	5	6	7	8	9	10
8-4	[redacted]	IVF NS @ 500cc/hr	05							
			17							
8-4	[redacted]	Ancef 1gm q8° IVPB	06							
			14							
			22							
8-4	[redacted]	~~Phenergan~~ Gent 400mg IVPB q24°	10							
8-4	[redacted]	~~Keflex 500mg~~ PO q8° x 7 doses	00							
			16							
			24							
8-4	[redacted]	IVF LR @ 100cc/hr	05							
			17							
8-9	[redacted]	IVF LR @ 75cc/hr	05							
			17							

Pennwalt DIC DIC DIC DIC 8/9/03 0900 Pennwalt

ALLERGIES: ☐ YES ☑ NO

PRIMARY DIAGNOSIS: Penis R/T SP abdomen GSW

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

b(6)-2

[redacted]

b(6) -2
All

Verified by Initialing

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Mo._____ Yr._____

Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
6/19	[redacted]	Fentanyl 100 mcg IVP [illegible]	[illegible]	0745	0745	[redacted]

Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
8-4	TB	MSO4 2-6 mg IVP q 2° prn pain	8-4 6mg 1530 TB	8-4 4mg 2000 NM	8-4 Jwh	8-4 2130 NM	8-5 1600 6mg TB	8-5 4mg NM	8-6 [redacted]	8-6 6mg	8-7 0400 4mg	8-7 0630 6mg TB	8-8 4mg	8-8 0900 5mg	8-8 0900 5mg	8-8 5mg 2030 NM
8-4	TB	phenergan 12.5 mg IVP q 6° prn nausea	8-4 1750 NM 6/4													
8-4	TB	Percocet 1-2 tabs PO q 4° prn pain	8-4 1420 TB	8-5 1000 TB	8-5 1600 TB	8-6 0000 NM	8-4 2010 J	8-6 2120 4mg	8-7 0800	8-7 PM	8-8 TB	8-8 1400	8-8 1900	8-9 0630		
8-4	TB	MSO4 2-6 mg IVP q 2° prn pain (nausea)	8-8 6mg 1030 TB	8-9 4mg 0630												
8-5	TB	fentanyl 50-250 mcg IVP for dressing x15	8-7 100mcg 0900 TB	8-8 150mcg Fent 1000 TB												
		versed 2-4 mg [redacted] for dressing [redacted]														

USAPA V1.00

b(6)-2 A11

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. AUG Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	9	10	11	12	13	14	15	16	17	18	19	20	21	22
8-9	[redacted]	LR @ 75cc/hr heplock when	9	[redacted]													
(16 Aug 03)		tolerating PO	12	[redacted]				H/L									
8-9	[redacted]	Celebrex 100mg PO BID	10	[redacted]													
			22	[redacted]													
8-9	[redacted]	Ciprofloxacin 500mg	10	[redacted]													
		PO BID.	22	[redacted]													
~~16 Aug 03~~	[redacted]																

D/C'd 18 AUG 03

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: Penile GSW s/p Debridement Penis r/t GSW

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

b(6)-2 A11

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	
10 Aug	[redacted]	150 mcg Fentanyl IVP		1002		[redacted]	
18 Aug	[redacted]	150 mcg Fentanyl IVP prior to changing foley catheter	18 Aug 03		1550	[redacted]	

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
11 Aug 03 8-9	[redacted]	MSO4 2-6 mg IVP q2° for pain	8:19 6mg 1330	8:19 8mg 1330	9 AUG 2130 6mg	10 AUG 0045 4mg	10 AUG 0300 5mg	10 AM 10 AM 3mg	10 AM 1200 4	10 AM 2240	11 Aug 0600 2mg	11 Aug 1430 4mg	11 AUG 1950 4mg	12 Aug 2300 4mg	13 Aug 2330 2mg	
8-9	[redacted]	Percocet 1-2 PO q4 pm pain	8:19 1330	9 AUG 2230	10 AUG 0400	10 AM 1200	10 AUG 2223	11 AM	11 AM 2000	12 AUG 0330	12 Aug 1130	8-12 1530	8-12 2-12	8-13 0530	13 Aug 03 1300	
8-9	[redacted]	Phenergan 25 mg PO q6 or 12.5 mg IVP q6° PRN nausea	DC'd 18 Aug 03 0134													
8-9	[redacted]	Fentanyl 150 mg IVP for QAM dressing change	11 Aug 03 0900	Add 11 Aug 03												
11 Aug 03	[redacted]	Fentanyl 100-150 mcg IVP for dressing	8-12 1200 1507	8-12 2330	15 AUG 0900 150 mcg	15 Aug 2030 150	17 AUG 0811 150 mcg	DC'd 17 Aug 03 1202								
13 Aug 03	[redacted]	Percocet 1-2 PO Q4 PRN for pain	12:05 2 tabs	0300 2 tabs	14 AUG 0700 2 tabs	14 AUG 1200 2 tabs	14 AUG 1735 2 tabs	15 Aug 0820 2 tabs	15 Aug 2030 2 tabs	16 Aug 0300 2 tabs	16 Aug 0750 2 tabs	16 Aug 1200 2 tabs	16 Aug 2 tabs	16 Aug 2 tabs	17 Aug 0000 2 tabs	17 Aug 1010 2 tabs
16 Aug 03	[redacted]	Fentanyl to 50 mcg IVP for dressing	Rewritten 18 Aug 03													

USAPA V1.00

b(6)-2 A11

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. Aug Yr. 2003

VERIFY BY INITIALING

INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 18	19
18 Aug 03	[redacted]	Restart IVF LR @	06	[redacted]	
		125 cc/hr	18		
			X		
18 Aug 03	[redacted]	Unasyn 3gm IVPB	06	/	
		Q6°	12	[redacted]	
			18		
			24		

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS:
Penile GSW

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

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. Aug Yr. 2003
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....	b(6)-2 A11				
	.....					

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED														
16 Aug 03	[redacted]	↓ Fentanyl to 50 mcg	16 Aug 03	17 Aug 03	17 Aug 03	16 Aug 03											
.....	.....	IVP for dressing Δ	@2000	@2000		1547											
17 Aug 03	[redacted]	Percocet 1-2 PO	17 Aug 1700	17 Aug 2300	17 Aug 0800	18 Aug 1200	18 Aug 1532										
.....	.....	Q4° PRN for pain	[redacted]														
18 Aug 03	[redacted]	Phenergan 12.5mg	16 Aug 03	16 Aug 03													
.....	.....	IVP Q6° PRN. May	12.5mg IM 0830														
.....	.....	↑ Phenergan to 25mg															
.....	.....	IVP if 12.5mg does															
.....	.....	not work.															
16 Aug 03	[redacted]	Tylenol 650mg															
.....	.....	PO Q4° PRN T>100.5															
.....	.....	OK when NPO															
.....	.....																

b(6)-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. 08 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION.

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 19	20	21	22	23	24	25	26	27
19	[redacted]	IVF LR@125u/h	05	[redacted]								
			13	[redacted]								
			21	[redacted]								
19	[redacted]	Unasyn 3gm IVPB q6hr	06	[redacted]								
			12	[redacted]								
			18	[redacted]								
			24	[redacted]								
20Aug	[redacted]	Heparin IV	06	[redacted]								
			14	[redacted]								
			22	[redacted]								
24	[redacted]	IVF NS @ 125	05	/	/	/	/	/	[redacted]			
			18	/	/	/	/	/	[redacted]			
		Cipro 400mg q12	06	/	/	/	/	/	[redacted]			
			18	/	/	/	/	/	[redacted]			

D/C'd 20Aug 0900

D/C'd 20Aug 0900

D/C'd

D/C'd

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: GSW penis

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

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

b(6)-2

Time orders

b(6)-2

Date	Initial	Order	Date to be done	Time	Time Done	Initial
18M	[redacted]	Start IV then start IV flush @ 25cc/hr	24M			[redacted]
24M	[redacted]	Start ciprofloxacin 400 mg IV q12h start @ 1800 tonight	24M			[redacted]

b(6)-2 All

PRN ORDERS

18Aug	[redacted]	MSO4 2.5mg IV q2° prn	DKCD								
19Aug	[redacted]	Percocet ii PO q4° prn	19Aug 03 1500 ii [redacted]	19Aug 2343 ii [redacted]	20Aug 0830 ii PO [redacted]	20Aug 2100 ii [redacted]	21Aug 2002 2 [redacted]	21Aug 2000 2 [redacted]	22Aug 0450 2 [redacted]	22Aug 1050 ii [redacted]	22Aug 1630 ii [redacted]
19Aug	[redacted]	fentanyl 50mcg IVP for drsg chg	19Aug 2030 50mcg [redacted]	DKCD 20Aug 0900 [redacted]							
24Aug	[redacted]	Percocet ii PO q4° prn	24Aug 1000 ii [redacted]	24MM 0600 ii [redacted]	24Aug 1424 2 [redacted]	24Aug 2330 2 [redacted]					

b(6) - 2 All

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 25	26	27	28	29	30	31	1	2	3	4	5	6
25	[redacted]	[redacted]														
25	[redacted]	[redacted]														
30	[redacted]	[redacted]														
—																
31	[redacted]	[redacted]														
		PRN meds														
25	[redacted]	MSO4 2-6mg IVP Q2° prn pain	D/T													
25	[redacted]	Percocet 1-11 po Q4° prn	D/T													
25	[redacted]	Phenergan 25mg IV Q6° prn	D/T													
25	[redacted]	Percocet 1-11 PO Q4 PRN	D/T													

ALLERGIES: ☐ YES ☒ NO

PRIMARY DIAGNOSIS: S/P penile skin reconstruction

NKDA

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO.

PATIENT IDENTIFICATION:

[redacted] b(6) - 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

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

b(6)-4

05AU6903

ICU Flowsheet

Patient Name: [redacted]

Date: / / 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					100.0				100.9	98.8			98.7								98.6			99.4
Pulse	86		81		95		92		95		85		75		87		93		49		98	85		78
B/P A-Line																								
MAP	83		81																					
B/P Cuff	100/66		109/64		119/72		120/70		127/74		113/66		110/62		113/56		112/63		123/72		108/62	113/65		109/64
Respirations	10		11		19		16		16		9		8		15		13		19		12	9		11
Sa02	99		97		94		97		97		98		100		100		95		97		95	93		
	2L		2L		2L		2L		2L		3L		3L		2L		2L		2L		2L	2L		4L

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
F	100	100	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	100	100	100	100	
S							50				100					100				100				100		
a																										
														300		150				100						
O intake																										
R. IN																										
Totals																										

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
Urine Hourly	450		100/350		90/650		60	90	100		200			175			350/350			350/850		300/1150		70/1150	100/1150	
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 15775

5

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: 0600 Initals: [redacted]	Time: 1700 Initals: [redacted]
NEURO	Pupils	equal, reactive 2mm	
	Sensorium	Alert, response	alert/oriented
	LOC / GCS		pleasant/cooperative
CARDIAC	Cardiac Rhythm	SR	NSR
	PRI: / QRS:		
	Pulse Strength	2+	
	Cap Refil / JVD	<3	
	Edema	Ø	generalized to penis
	Chest Pain	Ø	Ø
RESP	Respiratory Pattern	equal rise/fall	even/unlabored
	Breath Sounds	CTA	CTA(B)
	Secretions	Ø	
	Cough	Ø	Ø
SKIN	Color	NFR	NFR
	Integrity	surg site intact	
	Backside	NO breaks	dry to perineum/penis C,D&I
IV	Access Devices	PIV	PIV
	Location	(R) FA	RFA
	Condition	CDI	patent/benign
GI	Abdomen	Soft, NT	Soft NT/ND
	Bowel Sounds	(+)	(+)
	Stoma/Ostomy	NA	N/A
GU	Device	Foley	foley
	Color / Clarity	clear, yellow	cl/yellow

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU #1 [redacted]al

DATE: 6 Aug 03

PATIENT'S IDENTIFICATION (Typed or written entries give: Name – last, first, middle; grade; date [redacted] medical facility)

NAME: b(6)-2 RANK: AGE:

UNIT: b(6)-2 GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78 PPC V2.00

b(6)-1

[redacted]

ICU Flowsheet — **Patient Name:** EPU[redacted] — **Date:** 8 / 6 / 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					100.4				96.8							101.4						100.2				
[redacted]	91		105		93		96		96		85			87		97				93		88		64		
[redacted]																										
[redacted]																										
B/P Cuff	112/64		107/58		135/79				123/65		108/60			121/66		119/55				115/63				100/50		
Respirations	16		11		20		20																			
Sa02	98		98		97		94%		94%		100%			94%		93%				100		99		98		
	4L		4L		4L		2L		2L		2L			2L		2L				2L		2L		2L		
	NC		NC		NC		NC		NC		NC			NC		NC				NC		NC		NC		
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
	100	100	100	100	100	100	100	100	100	100	100	100	1200	100	100	100	100	100	100	100	100	100	100	100	100	1200
							50				50		100			50										
Iv intake																				240		100				
O. IN																										
Totals													1300													
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
Urine Hourly			150	225/325	175/475				850/975				975	850/850					900/1700					1600/1600		
NG Tube																										
Drains #1									500				500	300												
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals													1475													

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 15777

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
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0600 Initials: [redacted]	Time: 1930 Initials: [redacted]
NEURO	Pupils	3mm perrla brisk.	PERRL 3m
	Sensorium	a/o follows commands appropriate	A+O, follows commands
	LOC / GCS	o staff, makes eye contact	for purposeful movements
		pain controlled cooperative	pain controlled with prn/MSO4
CARDIAC	Cardiac Rhythm	NSR ~ ectopy, S1S2	NSR - SR S1S2
	PRI: / QRS:		3+ pulses on extremities
	Pulse Strength	+2 radial/dorsalis pedal & radial	cap refill < 3 sec
	Cap Refill / JVD	<3 secs ØJVD	
	Edema	Ø edema	Ø edema
	Chest Pain	Ø	Ø chest
RESP	Respiratory Pattern	even unlabored	CTA bilat
	Breath Sounds	CTA diminished bases	
	Secretions	Ø	Ø secretions
	Cough	Ø	Ø cough
SKIN	Color	appropriate for race	NSR
	Integrity	see progress note	no new tears epidermis
	Backside	Ø breakdown, prone to turn	- CPOP
		sides	skin very fragile, moisture
IV	Access Devices	RAC PIV KCL	(R) AC PIV KCL
	Location	RAC	
	Condition	patent.	patent
GI	Abdomen	soft nontender	soft, ND/NT
	Bowel Sounds	+x4	+x4
	Stoma/Ostomy	N/A	+/- NGT. NGT q prn
GU	Device	FTG	FTG
	Color / Clarity	amber c̄ sediment ØS	amber moderate sediment

PREPARED BY (Signature & Title): Day [redacted] LTRN Night [redacted]

DEPARTMENT/SERVICE/CLINIC: ICU [redacted]

DATE: 7 Aug 03

(Continue on reverse)

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

NAME: SQ-1 EPW RANK: AGE:

UNIT: GENDER:

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

OTHER:

b(6)-2

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC [redacted]

DA FORM 4700, MAY 78

[redacted]

ICU Flowsheet | **Patient Name:** | **Date: / / 2003**

	24	01	02	03	04	05	06	07	08	09	10	11		12	13	14	15	16	17	18	19	20	21	22	23	
					100.0						100							100.6								
	98		88		80		97	94	94		63			76		98		86		99		101		96		
	112																									
	62																									
			107		115		118		111		44			99		120		94		103		103		106		
			60		70		68		64		56			50		63		99		53		56		48		
	16		16		16		14		16		16			16	18	18						16				
	98		98		100		96		96		96			99	98	98	98	99		96		93		93		
	RA	NC	RA	NC	NC		NC		NC		NC			NC	NC	NC		NC		RA		RA		RA		
	2L		2L		2L		2L		2L		2L			2L	2L	2L		2L								
	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
	100	100	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100	NV	100	NV	80	PU	100		
							50				100													50		
Intake		160						100																		
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
Urine Hourly					800 / 800		400 / 1200		400 / 1600		350 / 1950			350 / 1200		400 / 2400		350 / 2750		110		40		250		
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 15779

...AL RECORD-SUPPLEMENTAL MEDIC ATA

For use orm, see AR 40-66; the proponent agency is the Office Surgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: 0600 Inital: [redacted] b(6)-2	Time: 1700 Initals: [redacted] b(6)-2
NEURO	Pupils	3mm PERRL	PERRL 3mm
	Sensorium	A/O cooperative follows commands	Follows commands appropriate
	LOC / GCS	moves all extremities appropriate	purposeful movements
		& steady.	
CARDIAC	Cardiac Rhythm	NSR 5 ectopy, S1 S2	NSR → ST 5 ect S1/S2
	PRI: / QRS:		
	Pulse Strength	+2 radial & pedal bilat	+3 pulses
	Cap Refil / JVD	<3 secs ∅ JVD	<3 sec ∅ JVD
	Edema	∅	∅ edema
	Chest Pain	denies	denies CP
RESP	Respiratory Pattern	even unlabored RR 14-20	CTA (B)
	Breath Sounds	CTA bilat ↓ bases	
	Secretions	∅	∅
	Cough	∅	∅
		94-96% on RA	
SKIN	Color	appropriate for race	NR
	Integrity	see progress note	no rashes
	Backside	free of breakdown	
IV	Access Devices	18G PIV	18G PIV to (U) UE
	Location	(R) brachial	LR @ 1100
	Condition	patent	patent
GI	Abdomen	soft nontender	soft NT/ND
	Bowel Sounds	hypo BS x 4	
	Stoma/Ostomy	∅ denies N/V/D	+N - V - D
		tolerated breakfast & lt	
GU	Device	~~clear~~ SCC	fly + gnd
	Color / Clarity	straw & large amount of	sediment
		sediment clots @ times	

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC: ICU #1 [redacted] b(2)-2

DATE

(Continue on reverse)

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

NAME: EPW [redacted] RANK: AGE:

UNIT: b(6)-4 GENDER: M

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

PPC v1.00

ICU Flowsheet | **Patient Name:** | **Date: 8 / 8 / 2003**

Vital Signs	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
Temperature	99.9						104			100.2																
Pulse	78		88		91		87		99		94			88		89				81		91		79		
[redacted]P A-Line	102/52		116/96																							
[redacted]																										
[redacted]																								113/66		
Respirations	16		16		18		18				22			23		20				20		20		18		
Sa02	98		98		95		95		96		96			95		94								98		
Mode							RA		RA		RA			RA		RA								RA		
[redacted]																										
[redacted]														12	13	14	15	16	17	18	19	[redacted]				Total
[redacted]	100	100	100	100	100	100	200	100	100	100	100			100	100	100	100	100	100	100	100	100				
[redacted] PB											100															
[redacted]																										
[redacted]																										
[redacted]																										
[redacted] intake							200		200																	
[redacted]. IN																										
Totals																										

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
Urine Hourly	[illegible]		110 / 410	130 / 510	135 / 1100		250 / 1350		280 / 1630		250 / 1880			250 / 0,20		180 / 2310		130 / 2440		130 / 2570		130 / 3070		305 / 3375		
NG Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

[redacted] b(4)-4

MEDCOM - 15781

ICAL RECORD-SUPPLEMENTAL MEDIC ATA

For use of orm, see AR 40-66; the proponent agency is the Office urgeon General.

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		Time: Initals:	Time: 1845 Initals: Wright, 09910mc
NEURO	Pupils	3mm perrla brisk.	
	Sensorium	a/o appropriate for this community	Alert, Oriented Person, Place,
	LOC / GCS	moves all extremities	time, event. MAE & Purpose
			cooperative.
CARDIAC	Cardiac Rhythm	NSR ≅ ectopy S1/S2	S1 S2. Rhythm not evaluated.
	PRI: / QRS:		PPP ≅ (+) 3 density. Cap refill
	Pulse Strength	+2 Radial pedal bilat	<3 sec. No peripheral
	Cap Refil / JVD	<3 sec. no JVD	edema noted.
	Edema	dedema	
	Chest Pain	Ø denies	Denies.
RESP	Respiratory Pattern	even unlabored	RA SATS 90's.
	Breath Sounds	CTA bilat ≅ L. bases	CTA Bilat.
	Secretions	Ø	Ø
	Cough	Ø	Ø
SKIN	Color	appropriate for race	Membranes pink. Scrotal
	Integrity	see progress note.	dressing CDI. Penile shaft
	Backside	Ø breakdown	& gauze in Foley drsg. Dry
			CDI.
IV	Access Devices	PIV 18G	PIV 18g (R) FA LR 75
	Location	LFA	Site S/Sx infection/in-
	Condition	patent	filtration.
		LR infusing @ 100 cc/hr.	
GI	Abdomen	soft nontender	SOFT, FLAT, non-tender
	Bowel Sounds	hypo BS ≅	≅ (+) BS in (4) Quads.
	Stoma/Ostomy	Ø denies N/V/D.	(+) hiccups ≅ 40 nausea.
GU	Device	Foley	16F Foley to BSD ≅ clear
	Color / Clarity	amber ≅ sediment.	urine. Penile ≅ noted priapism
			tred to abdomen.

(Continue on reverse)

[redacted] BY (Signature & Title) [redacted] TRN b(6)-2

DEPARTMENT/SERVICE/CLINIC ICU #1, [redacted] b(6)-2 al

DATE 8.9.03

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

NAME: EPW [redacted] RANK: AGE:

UNIT: b(6)-4 GENDER:

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

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

ICU Flowsheet — Patient Name: CPW [redacted] b(6)-4 — Date: 8 / 9 / 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	98.4													98°				98.7			97.9				98°	
Pulse	88				91		88		73					82				83			70				82	
B/P A-Line					122/64		89/70											119/65								
MAP																										
B/P Cuff	124/68				122/64		124/70		112/67					113/67				114/66			110/80				115/66	
Respirations	16				20		22	22	14					16				16			16				18	
Sa02	95				96		97	96	97					95				96							97	
Mode							RA		RA					RA				RA			RA				RA	

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
I	100	100	100	100	100	100	100	100	100	100	100	100		100	100	100	100	100		75	75	75	75	75	75	950
F intake																										
C. IN																										
Totals																										950

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
Urine Hourly	400				500		310		210					450				325			350				450	
NG Tube					90		110		230					270				305			345				385	3895
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

+3000

MEDCOM - 15783

INTENSIVE CARE NURSING FLOW SHEET

APPROVED (Date)
Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

TIME	INITIALS	NOTES		INITIALS
1200	TB		1800	
3mm pupils bilat. A/O x3 per interpreter follows commands non combative, moves all extrm			3mm pupils A+O x3, follows commands; purposeful movements.	
even unlabored			even, unlabored	
CTA bilat 96% on RA			CTA (R) 98% on 2L NC; Guat ↓ to RA	
Ø				
appropriate for age. see progress note.			NSR	
RAC PIV 18G patent			(R) AC PIV 18G	
Soft nontender vertical incision c stitches ODTA Ø D/I Ø hypo BS x4			SCT NT/ND. hyperactive bowel sounds. incline bed inc to lower ½'s start in - c/o/I - Ø stools. Foley to gravity	
QS straw colored FTG			— see note —	
NSR S ectopy +2 pulses x4 UE & LE ↑ S1 S2 Ø edema			NSR - ST S ectopy. 110s/90s; 90s-110s; Ø edema UE 3+ pulses LE 2+ pulse Ø edema. S1/S2	

LEGEND
Abbreviations
Pa - Pressure of Inspired O_2
Pa - Pulmonary
ICP - Intracranial Pressure
$PaCO_2$ - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
F - Fractional
S - Saturation
TCH - Tracheostomy

(Continue on reverse)

		DEPARTMENT/SERVICE/CLINIC	DATE
		ICU Quest	
		☐ HISTORY/PHYS	☐ FLOW CHART
		☐ OTHER EXAMINATION OR EVALUATION	☐ OTHER (Specify)
		☐ DIAGNOSTIC	
		☐ TREATMENT	

EPW [redacted]

b(6)-4

TIME			
BP Arterial Line			
BP Cuff	119/68	112/68	125/67
Temperature	100°		
Pulse	87	84	122
Respiratory Rate	16	20	16
SpO2	96	96	99
Mode	RA	RA	4L NC
TIME			
INM		300	100
INRB			
TOTALS			
URINE HOUR/TOTAL		350	
SpG			
NG Output			
Other			
TOTAL			

b(a)-4

EPW [redacted]

MEDCOM - 15785

125	117			114
69	71			73
103				
117	110	106		98
98	99	98		99
4L	4L	2L		2L
NC	NC	NC		NC
19	14	15		13
LR	100	100	100	100
PB				
Pa	100		100	
300		575		475
		875		1350

	12	18
	4	4
	5	5
	6	6
		✓
		✓
		✓
	3	3
	11	✓
	3	3
	11	✓

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 11 Aug 03
Time In: 1359
Allergies: NKDA
Pre-op V/S:
Procedures: Penile GSW

Anesthesia Type (Circle): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 2000 Colloid Ø
OR Output: UOP 47 EBL 5
Meds/Times:

Drains
Hemovac
NG
JP
T-tube
Foley
TLS

Airway
Nasal
Oral
ETT
Trach
Other

Pre Op Meds

History

Time	M	Ø														
SaO2	94	96														
FiO2	/	/														
Methods	RA	RA														
240																
220																
200																
180																
160																
140																
120																
100		V														
	V															
80																
60																
		^														
40	^															
20																
RR	16	16														
T	98															

Time									
Pain (0-10)									
LOS									

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

(Continue on reverse)

Pacu Intake

Time	Solution	Amount	Site	By	Infused

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	Ø		
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	Ø		
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	1		
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	Ø		
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2		
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	3		

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

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE: 11 AUG 03

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

[redacted] b(a)-4

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

MEDICAL RECORD-SUPPLEMENTAL MEDICAL D

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 08MAR89

INITIAL SHIFT ASSESSMENT

		Time: 2000 Initals: [redacted] b(6)-2	Time: Initals:
NEURO	Pupils	PERRL	
	Sensorium	Alert & Orientated x3	
	LOC / GCS	pt follows simple commands & can	
		move all extremities	
CARDIAC	Cardiac Rhythm	HR- 67 BP- 118/58	
	PRI: / QRS:	NSR	
	Pulse Strength	Pulse strong x4 · Capillary Refill	
	Cap Refil / JVD	≤3 sec Ø JVD no noted	
	Edema	edema Ø chest pain @ present	
	Chest Pain		
RESP	Respiratory Pattern	RR- 16 SpO2-99% on RA	
	Breath Sounds	Breath sounds Clear (B) Ø	
	Secretions	secretions Ø cough noted	
	Cough		
SKIN	Color	Normal for Race	
	Integrity	no breakdown noted	
	Backside	GSW to pents wrapped	
		CDI	
IV	Access Devices	Hep lock to (R) Forearm	
	Location	Flushes well no signs of	
	Condition	infiltration / infection	
GI	Abdomen	Soft Flat non-tender	
	Bowel Sounds	non distended Ø stoma/ostomy	
	Stoma/Ostomy		
GU	Device	Foley to gravity	
	Color / Clarity	Clear yellow QS	

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (b)(2)-2
ICU 3, [redacted]

DATE
13 Aug 03

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

Name — last,

#[redacted]
b(6)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

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

Date: 13 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP																		119/54				124/54				
TEMP																		99.3				97.3				
HR																		67				92				
RR																		16				16				
SaO2																		99%				97%				
FiO2																										
Source																		RA				RA				
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IV LR														~~75~~								Heplock				
IV																										
NG																										
PO																										
Total																		200	100							

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	
URINE																100			300							
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 15790

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DA

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 08MAR89

INITIAL SHIFT ASSESSMENT

		Time: 07a Initals: [redacted] b(a)-2	Time: Initals:
NEURO	Pupils	PERL; alert + oriented	PERRL, A+O x3, pt able to follow simple commands
	Sensorium		
	LOC / GCS		
CARDIAC	Cardiac Rhythm	normal; good cap. refill	RR+R, <3 sec cap refill
	PRI: / QRS:	+ pulse ⊖ chest pain	⊕ Pulses to ⊕ UE, ⊕ LE
	Pulse Strength		
	Cap Refil / JVD		
	Edema		
	Chest Pain		
RESP	Respiratory Pattern	normal - 10	Normal 15 BPM, CTA B/L
	Breath Sounds	normal	Ø secretions
	Secretions	⊖	
	Cough	non-productive cough noted	Ø cough
SKIN	Color	normal for race	NFR, warm + moist mucus membrane
	Integrity	warm + loose	
	Backside		
IV	Access Devices	~~IV~~ Heplock to (R) arm. ⊖ redness	H/L to (L) FA. Ø s/s of redness, swelling to site.
	Location	swelling noted to area	
	Condition		
GI	Abdomen	soft & soft to touch; non-distented.	soft flat non distended
	Bowel Sounds		⊕ BS x4 quad.
	Stoma/Ostomy	Ø Stoma/Ostomy.	
GU	Device		Foley draining to gravity.
	Color / Clarity	H/C to BS. yellow urine noted to drainage bag	clear yellow urine

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC
ICU 3, [redacted] (b)(2)-2

DATE

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

Name — last,

[redacted] b(a)-4
13Aug03

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

DA FORM 4700, MAY 78

USAPPC V2.00

b(a)-4

ICU3

Patients Name: #[redacted]

Date: 13 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP	116/68				116/68				108/74					105/62				108/82				115/74				
TEMP	97.2				97.4				98.3					97.4				98.5				98.8				
HR	70				87				69					78				81				82				
RR	10				12				10					15				12				12				
SaO2	98				98				99					99%				97%				98%				
FiO2	RA				RA				RA					RA				RA				RA				
Source																										
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IV																										
IV																										
NG																										
PO			240			120				233		120														
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	
URINE			500		125		300					150		150				200				150				
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 15792

MEDICAL RECORD-SUPPLEMENTAL MEDICAL D

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 08MAR89

b(6)-2

INITIAL SHIFT ASSESSMENT b(6)-2

		Time: 0005 Initals: [redacted]	Time: 1930 Initals [redacted]
NEURO	Pupils	3mm PERRL	PERRL
	Sensorium	Alert, Able to follow	A&O x3
	LOC / GCS	commands	able to follow commands
CARDIAC	Cardiac Rhythm		
	PRI: / QRS:		
	Pulse Strength	+2 in all 4 ext.	RR&R +2 x4 ext
	Cap Refil / JVD	<3 sec in all 4 ext	<3 sec
	Edema	Ø noted	
	Chest Pain	Ø noted	
RESP	Respiratory Pattern		
	Breath Sounds	CTA throughout	CTA Bilat
	Secretions	Ø noted	
	Cough	Ø noted	
SKIN	Color	WNL FOR RACE	WNL
	Integrity	Drsg on penis D+I	Dressing to penis C/D/I
	Backside		
IV	Access Devices	(R) FA PIV. H.L.	(R) upper extremities H/L
	Location	Ø S/S of infection	(R) flush Ø S/S of infection
	Condition		
GI	Abdomen	Soft, nontender	Soft nontender, nondistended
	Bowel Sounds	(+) normal in all 4 quads	(+) BS x4 quad
	Stoma/Ostomy	Ø	
GU	Device	Foley to gravity draining	Foley to gravity draining
	Color / Clarity	clear yellow urine	clear yellow urine.

(Continued on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC (b)(2)-2
ICU 3 [redacted]

DATE
14 AUG 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 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: [redacted] b(6)-4 Date: 14 AUG 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22*	23	00	01	02	03	04	05	
A-Line																										
NBP	118/76				118/64				110/64					110/64				115/68				118/74				
TEMP	98.9				99.9				96.8									97.8								
HR	78				75				70					70				76				69				
RR	14				14				15					15				16				12				
SaO2	98%				99%				99%					99%				99%				99%				
FiO2																										
Source	RA				RA				RA					RA				RA				RA				
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IV																										
IV																										
NG																										
PO																										
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	
URINE											550															
NGT																										
STOOL																										
DRAIN																										
Total											550															

MEDCOM - 15794

MEDICAL RECORD-SUPPLEMENTAL MEDICAL D

...r 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 08MAR89

INITIAL SHIFT ASSESSMENT			
		Time: 0640 Initals: [redacted] b(6)-2	Time: 1830 Initals: [redacted] b(6)-2
NEURO	Pupils	PERRL	PERRLA 3mm brisk
	Sensorium	Pt alert +	AOx3, moves extremities
	LOC / GCS		freely, follows simple
			commands. Pt on BR
CARDIAC	Cardiac Rhythm	Ø Ntd ectopy	SR
	PRI: / QRS:		—
	Pulse Strength	+2 radial + pedal	+2 BUE/BLE
	Cap Refil / JVD	brisk	<3 sec
	Edema	Ø Ntd	Ø noted
	Chest Pain	Ø	Ø
RESP	Respiratory Pattern	Reg R+R	RRR
	Breath Sounds	CTA bilat	CTA (B)
	Secretions	Ø Ntd	Ø
	Cough	Ø Ntd	Ø
SKIN	Color	NER	Normal for Race
	Integrity	dressings intact	Dressing to penis & LLQ intact
	Backside		Scrotal support in place
IV	Access Devices	(R) FA IV, hep locked	PIV (R) FA H/L
	Location	(R) FA	
	Condition	Ø Ntd erythema/edema	CDI
GI	Abdomen	Soft + round, nontender	Soft, round, nontender
	Bowel Sounds	+ x 4 Quads	x4 Quads
	Stoma/Ostomy	Ø	N/A
GU	Device	Foley to gravity	Foley to gravity
	Color / Clarity	Clr Yellow	Clear Yellow

(Continue on reverse)

PREPARED BY *(Signature & Title)*
[redacted] 91WM6 b(6)-2

DEPARTMENT/SERVICE/CLINIC
ICU 3 [redacted] (b)(2)-2

DATE
15 Aug 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 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: #[redacted] b(a)-4 Date: 15 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line	114/				106/				143/														112/70			
NBP	/78				/60				57																	
TEMP	97.6				97.5				98.5														97.5			
HR	88				62				96														72			
RR	18				14				16														16			
SaO2	99%				98%				96%														98			
FiO2																										
Source																							RA			
MAP																										

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
IV																										
IV																										
NG																										
PO																		240					240			480
Total																										

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	
URINE																									1400	
NGT																										
STOOL																										
DRAIN																										
Total																										1400

MEDCOM - 15796

CAL ...CORD-SUPPLEMENTAL MEDICA ...T.

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 08MAR8

INITIAL SHIFT ASSESSMENT b(a)-2

		Time: Initals:	Time: 1900 Initals: [redacted]
NEURO	Pupils		PERRIA
	Sensorium		A&O x3
	LOC / GCS		pt follows all commands purposefull movement x4
CARDIAC	Cardiac Rhythm		HR - 74 BP 103/66
	PRI: / QRS:		
	Pulse Strength		2+ to all extremities
	Cap Refil / JVD		Cap refill ≤3sec JVD Ø
	Edema		No edema noted
	Chest Pain		Ø chest Pain
RESP	Respiratory Pattern		RR: 16 Spo2 99% on RA
	Breath Sounds		CTA (B)
	Secretions		Ø secretions
	Cough		Ø Cough
SKIN	Color		normal for Race
	Integrity		GSW to Penis
	Backside		Ø breakdown
IV	Access Devices		IV to (R) AC Heplocked
	Location		patent ∑ S/S of infection
	Condition		Infiltration
GI	Abdomen		Soft flat non-tender non-distended
	Bowel Sounds		BS active x4
	Stoma/Ostomy		Ø stoma
			Ø ostom
GU	Device		Foley Cath to gravity
	Color / Clarity		dark yellow urine

(Continue on reverse)

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC
ICU3, [redacted] b(2)-2

DATE

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

[redacted] b(a)-4

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

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: _____ Date: 16 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05	
A-Line																										
NBP															105/60											
TEMP															96.8								98.5			
HR															74								61			
RR															16								14			
SaO2															99%								99%			
FiO2																										
[illegible]e															RA								RA			
[illegible]															74											

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	T
IVF															Heplock								Heplock			
IVPB																										
NGT																										
Total																										

[illegible]TPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE															400								550			
NGT																										
STOOL																										
DRAIN																										
Total																										

MEDCOM - 15798

ICAL RECORD-SUPPLEMENTAL MEDIC AT

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 08MAR8

INITIAL SHIFT ASSESSMENT

		Time: 1116 Initals: [redacted] b(a)-2	Time: Initals:
NEURO	Pupils	PERRLA	PERRL
	Sensorium	Alert x O x 3	A+O x 3
	LOC / GCS	Responsive, Cooperative, Follows Commands	follows commands
CARDIAC	Cardiac Rhythm	—	
	PRI: / QRS:	—	
	Pulse Strength	+3 x 4 extremities	(+)3 x4 extrem
	Cap Refil / JVD	<3 Secs, ØJVD	<3 sec
	Edema	None	
	Chest Pain	None	
RESP	Respiratory Pattern	Regular, Unlabored	RR+R
	Breath Sounds	CTA	CTA Bilat
	Secretions	None	
	Cough	None	
SKIN	Color	Normal for Race	NFR
	Integrity	Dressing to Penis	Dressing to penis c/d/I
	Backside	None	
IV	Access Devices	20G IV in (L) AC	20G IV in (L) AC
	Location	(L) AC	
	Condition	Ø S/S of infection, patent	Ø S/S of redness swelling
GI	Abdomen	Hypoactive, soft & mild > distension	
	Bowel Sounds		(+)BS x4 quad
	Stoma/Ostomy	(+) Emesis x 1	
GU	Device	16 Fr. Foley	Foley draining to gravity.
	Color / Clarity	Yellow & sediments	

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] b(a)-2

DEPARTMENT/SERVICE/CLINIC (b)(2)-2 ICU3, [redacted]

DATE 18 Aug 03

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

[redacted]

b(a)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

ICU3

Patients Name: [redacted] b(6)-4 Date: 18 Aug 03

VITALS	06	07	08	09	10	11	12	13	14	15	16	17		18	19	20	21	22	23	00	01	02	03	04	05
A-Line																									
NBP				112/72			100/68				104/62					104/68				114/77					110/68
TEMP				103.5	104.3	102.2	101.1		100.5		99.3					98.3				98.7					98.4
HR				127			110				98					101				98					95
RR																									
SaO2				99%			98				98					98%				98%					98%
FiO2				RA			RA				RA					RA				RA					RA
[redacted]																									
[redacted]																									

Tube Feeds Restarted Give 4 hours Going 8 hrs

INTAKE	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	T I
IVF LR					125	125	125	125	125	125	125	125	1000	125												
IVPB							100							100												
NGT																										
[redacted]	240												240	240												
Total													1240													

OUTPUT	06	07	08	09	10	11	12	13	14	15	16	17	Total	18	19	20	21	22	23	00	01	02	03	04	05	Total
URINE					215						325		540													
NGT																										
STOOL																										
DRAIN																										
Emesis			X1																							
Total													540													

MEDCOM - 15800

ICAL RECORD-SUPPLEMENTAL MEDIC ATA

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 08MAR8

INITIAL SHIFT ASSESSMENT			
		Time: Initals:	Time: Initals:
NEURO	Pupils		
	Sensorium		
	LOC / GCS		
CARDIAC	Cardiac Rhythm		
	PRI: / QRS:		
	Pulse Strength		
	Cap Refil / JVD		
	Edema		
	Chest Pain		
RESP	Respiratory Pattern		
	Breath Sounds		
	Secretions		
	Cough		
SKIN	Color		
	Integrity		
	Backside		
IV	Access Devices		
	Location		
	Condition		
GI	Abdomen		
	Bowel Sounds		
	Stoma/Ostomy		
GU	Device		
	Color / Clarity		

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE
	ICU3, [redacted] (b)(2)-2	18 Aug 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 [redacted] b(6)-2
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER *(Specify)*
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 4700, MAY 78

USAPPC V2.00

ICU Flowsheet Patient Name: # [redacted] b(6)-4 Date: 16 / 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									97.5																	
Pulse									75																	
B/P A-Line																										
MAP																										
B/P Cuff									114/71																	
Respirations									14																	
Sa02									99% 99%																	

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
IV																										
PO Intake																										
O.R. IN																										
Totals																										

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
Urine Hourly																										
N Tube																										
Drains #1																										
#2																										
#3																										
Emesis/Stool																										
O.R. OUT																										
Totals																										

24 hour input	
24 hour output	
24 hour balance	

MEDCOM - 15802

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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

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

OTSG APPROVED (Date)

Date: 25 AUG 03
Time In: 1630
Allergies: NKDA
Pre-op V/S: 121/71 77
Procedures: Penis graft delayed closure

Anesthesia Type (Circle)): General Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 600 Colloid
OR Output: UOP EBL
Meds/Times: VERSED, fentanyl, morphine

Drains: Hemovac, NG, JP, T-tube, Foley, TLS

Airway: Nasal, Oral, ETT, Trach, Other

Pre Op Meds History

Time	1630	1635	1640	1645	1710	1720	1730
SaO2	97	98	99	100	96	97	99
FIO2							
Methods							

240
220
200
180
160
140
120
100
80
60
40
20

RR
T

Time	
Pain (0-10)	[redacted]
LOS	

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1630	NS	900	(B) ARM	OR	100

X-rays: Labs:

Post-Anesthesia Recovery score

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

Codes

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

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

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

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

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 (Grade, Name, Signature): [redacted] LPN

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 25 AUG 03

b(a)-2

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

#[redacted] b(a)-4

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

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

USAPPC V2.00

b(6) - 2 All

MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By
1640		MSO4 2mg	IV		I	[redacted]
1650		MSO4 5mg	IV		I	
1655		MSO4 2mg	IV		I	
1700		MSO4 1mg	IV		I	
1715		MSO4 2mg	IV			

NEUROVASCULAR

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

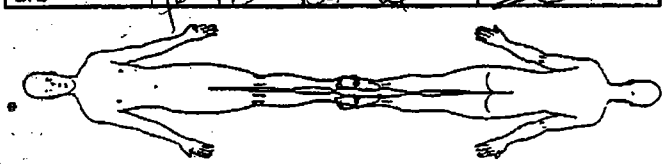
Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent
Color: C = Cyanotic,
Capillary Refill: B = Brisk, S = Sluggish P = Pale, Pk = Pink

C-SECTIONS

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

DRESSINGS

Time	Location	Type	Drainage
Adm	penis	scrotal dressing	~~0~~
30'			
60'			
D/C	penis	scrotal	~~0~~



PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1630	ST	~~0~~	~~0~~

NURSING NOTES

Pt to PACU from OR via litter s/p penis graft delayed closure. Scrotal dressing c̄ Kerlix applied to penis area. JP drain intact. Foley cath intact draining clear yellow urine. IV of NS infusing into (R) arm. ~~0~~ s/s redness or edema to site. Pt c/o pain. Medicated c̄ MSO4 2mg for c/o pain. Will continue to monitor for effectiveness. [redacted] LPN

1650 - Pt continues to c/o pain. Medicated c̄ 5mg MSO4. [redacted] LPN

1655 - Medicated c̄ 2mg MSO4 [redacted] ~~0~~

1700 - Medicated c̄ 1mg MSO4 [redacted] ~~0~~

1718 - IV site infiltrated. IV restarted. [redacted]

1745 - Pt medicated due to IV infiltration. 10mg MSO4 given. [redacted]

1750 - Pt states ~~0~~ pain [redacted]

1810 Pt to ICU #1 via litter [redacted]

Discharge Criteria:
Date: 25 Aug 03 **Time:** **PARS:**
BP: 134/80 **T:** 96 **HR:** 116 **RR:** 24 **SaO2:** 99% RA
Pain Level at D/C (0-10):
Intake: _____ **Output:** _____
Additional Data: _____
Transferred To: ICU #1
Report Given To: SPC [redacted]
Transferred Via: W/C [redacted] Gurney Ambulance
Transferre [redacted] LPN
Cleared IAW Recovery Ro [redacted]
Charge Nurse Signature: [redacted]

WAMC OP 173-E

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 2	[redacted]	UNK		M

6. DATE OF BIRTH (YYYYMMDD)	7. AGE AT ADMISSION	8. RACE	9. ETHNIC BACKGROUND	RELIGION
	22y	2	9	UNK

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

ORGANIZATION (Active Duty Only)	13. MARITAL STATUS	HOUR OF ADMISSION	BRANCH/CORPS
NA	Z	1010	b(2)-2

14. FLYING STATUS	15. BENEFICIARY CATEGORY	16. ZIP CODE OF RESIDENCE
	K 7 8	

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	1 CU 1	UNK

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

21. TYPE OF DISPOSITION	22. MTF TRANSFERRED TO	23. DATE OF DISPOSITION (YYMMDD)
50		030830

24. CLINIC SVC - ADMITTING	25. MTF TRANSFERRED FROM	26. DATE THIS ADMISSION (YYMMDD)
ABKA		030804

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

FOR LOCAL USE

GSW TO GROIN

Dx 99859
8781
8783
E8789
Proc 6136441
6426444
5822 Trauma
Inj 284

[redacted] b(6)-2

ADM[redacted] Signature, as required) [redacted] CPT MC DR. [redacted]

SIGNATURE OF ADMITTING CLERK [redacted] Sgt, USA

DA FORM 3985 MAR 89

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 EPW
4. SEX M	5. AGE 27	6. RACE UNK	7. RELIGION UNK	8. LENGTH OF SVC —	9. ETS —	10. PREVIOUS ADMISSION N
11. FMP 99		12. SSN [redacted]	13. ORGANIZATION b(6)-4			14. WARD FCW2
15. FLYING STATUS —	16. RATING/ DSG —	17. DEPT./ BEN K78	18. BRANCH/CORPS —	19. UIC/ZIP —		20. TYPE CASE WIA
21. SOURCE OF ADMISSION/AUTHORITY FOR ADMISSION direct from ER				22. HOURS OF ADMISSION 1140	23. CLINIC SERVICE AEAA	
24. NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE UNK			25. TYPE DISPOSITION ~~50~~ 24		26. DATE OF DISPOSITION 13 Aug03	
27a. ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code) UNK			27b. TELEPHONE NO. UNK		28. DATE OF THIS ADMISSION 05Aug03	
29. NAME AND LOCATION OF MEDICAL TREATMENT FACILITY [redacted]					30. DATE OF INITIAL ADMISSION	32. UNITS OF WHOLE BLOOD/ COMPONENT TRANSFUSED

ADMISSION REMARKS

ADMITTING OFFICER

31. SELECTED ADMINISTRATIVE [redacted]

b(2)-2

☐ Check if Continued on Reverse

33. CAUSE OF INJURY

34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES

GSW & open fx ®hand — 817.1

E991.2

79.33

79.63

86.04

86.59

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	8	8

36. Total Days All Facilites

a. ABSENT SICK DAYS	b. OTHER DAYS	c. CONV. LV/COOP CARE DAYS	d. SUPPLEMENTAL CARE DAYS	e. BED DAYS	f. TOTAL SICK DAYS
	b(6)-4				

SIGNATURE OF [redacted] ER

[redacted] PGL [redacted]

MEDCOM - 15806

MEDICAL RECORD | **ABBREVIATED MEDICAL RECORD**

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

5 Aug 03 1300

Ortho

27 y/o RHD ♂ ~ 2 wks s/p GSW (R) hand. ? Hx surrounding events
ø other Tx. Past history, ? fevers
ø other c/o
ø PM/PS/MCL/AH

PHYSICAL EXAMINATION

98.2 90 117/67 A.O.X3

(R) hand wounds to IF MCP area volar & dorsal. obv. necrotic & purulent material, 5 x CR, ø FCE of IF, ↓ LT to all IF
ø TTP o/w, NVI o/w

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

XR highly comminuted/absent IF MCP ± IF MC fx to mid-shaft

A Complete loss MCP IF (R) hand ~ 2 wks out ± ø Tx, obvious infection
P D/w pt (via interpreter) Tx options,

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION
plan rev	05 Aug 03		

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle initial, rank, service, and medical facility)* b(6)-2

[redacted] MAT [redacted]

REGISTER NO. | WARD NO. ICW2

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41CFR) 201-45.506
JANUARY 1987 539-106-01

[redacted]

b(6)-4

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
5 Aug 03	(Op Note)
	Dx (R) hand GSW, infection
	Rx (R) IF Ray resection
	Z. D
	Surgeon [redacted]
	[redacted] b(6)-2
	[redacted]
5Aug03 2020	pt. admitted to ICWZ S/P resection of (R) IF ~ V/S 1630-VSS, Tmax 100.2 - D5½NS @ 20mg KCl infusing @ 125cc/hr into (L) AC 20g IV - (R) hand elevated on blanket and IV pole - pt. oriented & alert - (+) BS - lungs CTA (B) - medicated for pain @ 1850 w/ 1 percocet tab - bulky kerlix lace wrap dressing on (R) hand, thumb, 3rd & 4th finger and pinky visible, good movement, <2 sec cap refill in fingers - pt. given bed bath due to no personal hygiene since in 15 days b(6)-2 [redacted]
5Aug03 21:11	Rec'd c/o pt @ 21:00. Restraints x 2 (L) wrist (R) ankle. PVS WNL per flow sheet. Awake and alert in bed. Skin W/D. PERRLA (+)

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

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

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

REGISTER NO.

WARD NO. ICW

PROGRESS NOTES
Medical Record

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

[redacted] b(6)-4

EPW

b(6)-2 A11

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	LCA (R) HPR S/S, WNL, BS (+) x4. (R) Hand ↑. ACE wrap dsg CDI. (+) ROM (+) <3 sec cap refill (+) sensation (R) hand digits. ∅ c/o pain @ this time will cont. to mon. [redacted] /AW
Addendum	(R) AC PIV infusing LR c̄ 20meq KCL @ 125cc/hr c̄ s/s infection / infiltration [redacted] /AW
0143	c/o pain in (R) hand. 1 Percocet given will mon [redacted]
6August03 0730	Pt. asleep in bed easily aroused by verbal stimuli. VSS. HR Regular, lung sounds clear bilat, bowel sounds (+) x4 quads. (R) hand elevated c̄ Kerlex tied to bed pole. DSG to (R) hand CDI, cap refill <3sec. (+) sensation in all 4 digits. IV in (L) AC infusing @ 125cc/hr of D5½NS c̄ 20 KCl meq. ∅ s/s of infection or infiltration. Pt. ∅ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] /AT
6Aug03 1330	Pt care assumed @ 1300. Pt awake & alert, pt speaks a little English. VSS. (R) Hand elevated c̄ Kerlix tied to bed pole. (+) sensation, <3 cap refill. Lungs CTA and sym BS (+) x4 quads. ↓ Ext c̄ full ROM (+) pulses. IV site to LAC infusing D5½NS c̄ 20 meq KCL. ∅ diff. ∅ complaints voiced @ this time. Will cont to monitor [redacted] /WMC
6Aug03 2120	Pt care assumed @ 2100. Pt awake and alert ∅ c/o pain. Lung sounds CTA, pulses +x4, BS+. IV c̄ 20 meq KCL infusing into (L) AC ∅ s/s infection or infiltration. Dsg on (R) hand CDI (+) pulse and sensation in RUE. Hand elevated c̄ Kerlix, pt c/o pain in middle finger. IV d/c'd @ 22 and 24, continue to monitor. [redacted] /WMC

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

NSN 7540-00-834-4176 600-108

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 Aug 03	0710: Assumed pt care @ 0500. Pt. awake. Afebrile lungs CTA. (+) BS x 4. VSS. (R) arm elevated. Pulses to (R) hand cDT. (+) movement & sensation in fingers. c/o pain to (R) hand. Will continue to monitor [redacted] 91WM6 b(a)-2
7 Aug 1400	O/Pts Op Note Dx (R) hand s/p IF ray resection Rx I-D & wound closure Surgeon [redacted] [redacted] b(a)-2
7 Aug 03 1600	assumed care @ 1300 while pt. was in OR - returned ~ 1545 S/P I&D (R) hand - VSS - D5½NS c 20 meq KCl @ 125 cc/hr infusing into (L) 20g IV - bulky hand dressing on (R) hand, thumb, 3-5th digit visible to lt knuckle, pt. can wiggle fingers, <2 sec capreffill in visible fingers - (+) BS - lungs CTA (B) - c/o pain, medicated c # Percocet @ 1515 in PACU b(a)-2 [redacted] CRNA

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

b(a)-4 [redacted]

EPW

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

b(4)-2 A11

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
0145 8Aug03	Pt care assumed @2100. VSS, a&ox3 3 c/o pain. Lung sounds CTA, pulses + (unable to assess rue), bs+x4. IV running D5 1/2 c̄ 20 meq KCL @125cc/hr. RUE elevated, dsg CDI, no complaints. Pt had I+O today. On IV ABX. No new complaints, will continue to monitor. [redacted] allowing
2200	2 percocet given for pain in (R) hand. [redacted] allowing
080530 Aug03	NURSING ASSESSMENT: Assumed care of pt. Airway intact, breathing even and unlabored, LS clear to all fields (B). Abd soft, nontender, ↓ distention, BS(+)x4. Urine spontaneously. Pt may and neurovascularly intact to (B)LE and (D)LE. (B)UE hanging from IV pole to maintain elevation. (R) hand wrapped c̄ gauze & ACE wrap (only 4 fingers visible, beyond 1st phlangeal joints). Pt can wiggle fingers and they are warm to touch c̄ brisk cap refill. Pulses not palpable 2° dsg. ROM in elbow & shoulder of (B)UE full. [redacted]
080545 Aug03	NURSING NOTE: IV in (L) AC ↓ s/s infection or infiltration. [redacted]
8 AUG 03 1300	- Received PT alert in bed c̄ (−) c/o pain or discomfort, VSS. Hrn. Lung sounds clear bilateral. BS x4. (+) ROM to all extremities - slow c̄ cane & brace. Drsg to (L) Arm CDI. PT has (+) pulse noted RUE, Arm is elevated. IV D5 1/2 c̄ 20 meq running @ 125 cc/hr c̄ (−) s/s of infection or infiltration. PT is resting in bed. Will call to neurosurgery. [redacted]
8 AUG 03 1400	- PT c/o dizziness to (L) side of face. Also states he could not see that well from OS. PT has Pearle, c̄ noted trauma to eye. Will notify MD [redacted]
9Aug03 0140	Pt care assumed @2100. VSS, a&ox3, 5 c/o pain. Lung sounds CTA, bs(+)x4. IVF d/c, SL patent c̄ IV ABX x3. Dsg on RUE CDI, (+) sensation and ability to move fingers. RUE elevated c̄ Kerlix. No new complaints, continue to monitor. [redacted] allowing

b(6)-2 A11

NSN 7540-00-634-4176 600-108

HEALTH RECORD PROGRESS notes ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 August 03 0945	Pt. asleep in bed easily aroused to verbal stimuli c̄ (R) hand elevated on 2 folded blankets & tied up c̄ Kerlex. VSS. HR Regular, bowel sounds (+) x 4 quads, lung sounds clear bilat. PH flushes well c̄ 3cc NS in (L) AC s̄ s/s of infection. (R) hand ace wrap CDI, (+) sensation in digits middle finger slightly painful to the touch, cap refill < 3sec, limited ROM. Pt. s̄ complaints @ this time. All other assessment findings WNL. Will continue to monitor. [redacted] DLT/AN
1130	New IV placed in (L) FA. [redacted]
9 Aug 03 1930	assumed care @ 1300 - VSS - SL patent - IV abx d'c'd and pt. started on Keflex & cipro PO - C/O heartburn p dinner, given mylanta plus 30cc - dsg Δ done by MD today, dry 4x4 c̄ ace wrap, pt. can wiggle fingers, middle finger tender to touch, <2 sec cap refill in (R) fingers [redacted] CR, AN
10 Aug 03 0200	Pt care assumed @ 2100. VSS, a+o x3 s̄ complaints, Lung sounds CTA, pulses palpable x4, bowel. Pt taking PO meds. Dsg on rt CDI, hand elevated, 0 pain. No complaints, will continue to monitor. [redacted] 9 Lum 16
0850	Pt. awake & alert in bed s̄ complaints @ this time. HR Regular, lung sounds clear bilat, bowel sounds (+) x 4 quads. Pt s̄ IV access. Ace wrap to (R) hand CDI, cap refill < 3sec, (+) sensation. Middle finger painful when touched, full ROM in digits. All other assessments WNL. Pt. eating & voiding

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

lew2

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~~

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10Aug03	adequately. will continue to monitor. [redacted]
10Aug03 1930	assumed care @ 1300 - VSS - no c/o pain @ this time - dsg Δ'd on (R) hand, no S/S infection, Sutures intact - pt. had Bm today - ambulated x10 minutes [redacted]
2323	Pt. care assumed @ 2100. VSS. HR Reg. lungs CTA. (R) hand dsg CDI & brisk cap refill, (+) sensation (+) ROM. Pt. c/o pain @ old IV site (L) AC. ∅ S/S infiltration or phlebitis noted. will cont. to monitor. [redacted]
11Aug03	0546 Assume pt care @ 0500. Pt awake and Alert. c/o pain to old IV site (L) AC, warm compress applied. VSS. (R) hand dsg CDI. (+) movement (+) sensation to fingers. cap refill < 3sec. HR reg. lungs CTA. Abd soft BS x4. will cont to monitor [redacted]
11Aug03 1730	assumed care @ 1300 - VSS - medicated c (650mg tylenol PO @ ~1430 for c/o (R) hand pain - dsg Δ'd, sutures intact, small amount of bleeding between sutures next to middle finger, 4x4s placed & ace wrap, pt. can move remaining fingers, middle finger continues to be tender and lacks full ROM, <2 sec cap refill in fingers - (L) bicep has small area of redness above old IV site, BS site area warm to touch and slightly tender [redacted]

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8.11.03 2207.	Pt. care assumed @ 2100. VSS. HR Reg, lungs CTA. BS ⊕ X4. Dsng to (R) hand C.D.I. Fingers (R) hand warm c ⊕ sensation, ⊕ ROM, brisk cap refill. Will cont. to moniton. b(6)-2 [redacted] TAA
12Aug03 0538	Assume pt care @ 0500. VSS. HR reg. lungs CTA. Abd soft non-tender BS×4. No c/o pain. Dsg to (R) hand CD+I. Fingers to (R) hand ⊕ROM ⊕sensation cap refill <2sec. possible discharge today. Will cont to monitor [redacted]
12Aug03 1410	assumed care @ 1300 - VSS - no c/o pain @ this time - dsg CDI - pt. awaiting dr to EPW camp b(6)-2 [redacted] CR
12Aug03 2230	VSS - Afebrile - dsg to (R) hand dry and intact. ∅ c/o pain @ present. Bowel sounds - Lungs CTA B/L Reg eum BS ⊕ X 4 equals Pedal and Radial pulses ×3. cms to upper and lower extremit >3sec. Restraints to lower extremities replaced and secure. [redacted] MC b(6)-2 All

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD Discharge ~~CHRONOLOGICAL RECORD OF MEDICAL CARE~~

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
8/13/03	Summary. Pt dx with pneumo. Pt ambulatory after
8/13/03	stabilized and waited 3. Pt VS stable. Pt sis of distress
	[redacted] b(a)-2

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

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

[redacted]

b(a)-4

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

NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
4 Aug 03	♂ gunshot wound to (R) hand 8 days ago. Unsure
	if bullet passed through. Dressed initially & no further care
NKA	Difficult to move trigger finger.
	O) Observations revealed entrance & exit wounds noted @ ~1st
R 12	knuckle of 2nd metacarpal (trigger finger). Soft tissue is
T 99.2	blown open 2° shock of projectile & trigger finger hangs @ an
P 78	abnormal angle. Neuro appears intact @ this time but diminished
04 Aug 03	X-ray shows distal end of 2nd metacarpal is shattered into numerous
132/84	small fragments, as is the proximal ½ of 1st phalanx.
	A) GSW to hand, distal 2nd metacarpal & proximal phalanx
Meds	shattered
? Bacillin	P) Pt will be placed in holding for tonight & transfer
? Keflex	to CSH in AM
	2030 MS 5mg IM given
	2215 MS 5mg IM given
	~~2230~~ Ancef 1gm IV Now and Ancef 1gm @ 0600
	IV LR @ TKO until next IV ancef.
	b(6)-2 [redacted] 2LT, SP
2220	18g IV to (R) FA x 1 attempt [redacted] b(6)-2
2220	Ancef 1gm IV given over 1h b(6)-2 [redacted]
2315	IV LR started 500cc bag running flow wide open @
	TKO Rate [redacted] b(6)-2

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

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

EPN [redacted]

b(6)-4

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

Gunshot wound to hand

b(a).2
All

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
2315	Pt. transferred to holding — [redacted]
2320	MS 5MG x 1 PRN pain. VO IT [redacted]
0400	Above noted. IV slowed to TKO, patient is resting quietly — [redacted] SPC
0615	Continued NaCl 1000 cc IV infusing @ cc/hr. Ancef 1g IV administered. — [redacted] SPC
0630	Pt ambulated to latrine — [redacted] SPC
0715	Pt refused morning meal — [redacted] SPC
0725	pt discharged from pt holding, transferred to CSH — [redacted] SPC
0745	Pt returned to holding due to Medevac delay. — [redacted] SPC
0910	1000 cc LR IV continued — [redacted] SPC

FPI. LEX. Printed on Recycled Paper

STANDARD FORM 600 (REV. 6-97) BACK

b(2)-2

58-104 7540-01-075-378

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (Patient)

LOG NUMBER | TREATMENT [redacted]

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS (EPW)

CITY | STATE | ZIP CODE

ARRIVAL

DATE (Day, Month, Year): 5 AUG 03 | TIME: 1140

TRANSPORTATION TO FACILITY: MEDEVAC

SEX: ♂ | DUTY/LOCAL PHONE: AREA CODE / NUMBER

AGE: 27 | HOME PHONE: AREA CODE / NUMBER

MILITARY STATUS	YES	NO	N/A
PRP			
FLYING STATUS			

MEDICAL HISTORY OBTAINED FROM

THIRD PARTY INSURANCE	YES	NO
ADDITIONAL INSURANCE		
DD 2568 IN CHART		

NAME OF INSURANCE COMPANY

CURRENT MEDICATIONS: Aciclovir, cystitis

ALLERGIES: Ø NKDA

INJURY OR OCCUPATIONAL ILLNESS	YES	NO	WHEN (Date)
IS THIS AN INJURY?			WHERE
INJURY/SAFETY FORMS			
HOW			

EMERGENCY ROOM VISIT

DATE LAST VISIT | 24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT | COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT: GSW (R) hand

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☒ NON-URGENT

TIME: 1140

INITIALS: [redacted] b(2)-2

VITAL SIGNS

TIME	BP	PULSE	RESP	TEMP	WT
1140	117/67	90	18	98	

LAB ORDERS

✓ CBC/DIFF	ABG	PT/PTT	BHCG/URINE/BLOOD/QUANT
URINE C&S	UA MSCC/CATH		✓ CHEM: MET B
BLOOD C&S X			

X-RAY ORDERS

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

Xray (R) hand

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	COMPLETED BY	TIME	PATIENT'S RESP
1300	Acyclovir 800 PO	[redacted]	1300	Gentamycin IV [redacted]
1200	Bolus - 2L		1300	Ampicillin PCN G IV
1220	Td .5cc IM	[redacted]		
1220	100 Fentanyl			

b(2)-2

DISPOSITION: ☐ HOME ☐ FULL DUTY

MODIFIED DUTY UNTIL

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

RETURN TO DUTY

PATIENT/DISCHARGE INSTRUCTIONS

CONDITION UPON RELEASE: ☒ IMPROVED ☐ UNCHANGED ☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED ▶ TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

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

#[redacted] b(2)-4

EMERGENCY CARE AND TREATMENT (Patient)
Medical Record

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

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

TEST RESULTS

WBC 8.9	SMAC	135	104	7	ABG/PULSE OX			RADIOLOGY	Check if read by radiologist ☐
H/H 13.7/44		4.1	24	.8	SUP O2	PH	PO2	RESULTS xrays ⊕ comminuted fx MCPJ c̄ fbs @ hand	
PLT 256				94	PCO2	SAT	OTHER		
					U/A DIP			EKG INTERPRETATION	
PTT	BHCG	ETOH	GLU		U/A MICRO				

PROVIDER HISTORY/PHYSICAL

27 y.o. ♂ s/p GSW 13 days ago, seen by medico, seen by ? PSB yesterday for ↑ swelling in hand, given Augmentin x 7, eva to CSH. ⊘ F/C ⊘ chest pain. ⊘ other terms

O: AAO x4 in NAD. WSS

HEENT: OP/WP clear/moist neck: s-pole, NP

Extremity: ⊕ hand ⊕ open macerated wound dorsal/volar aspect thenar eminence/base of index/long finger ↓ROM flex/ext, ⊘ grip strength ⊕ pulses/d/c ↓ sensation radial fingers distribution

A/P: GSW to ⊕ hand c̄ infection. Unclear initial care hx.
→ Admit / Abx / Td / wash out ICW2

CONSULT WITH	TIME	ACTION
Ortho		

RESIDENT/MEDICAL STUDENT SIGNATURE [redacted] STAMP

b(6)-2 [redacted]

PROVIDER SIGNATURE [redacted]

DIAGNOSIS

GSW open fx ⊕ hand

CODES

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

[redacted] b(6)-4

EMERGENCY CARE AND TREATMENT *(Doctor)*
Medical Record

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

MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: 27 HEIGHT: WEIGHT: 80 K	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): NKDA 3. PREVIOUS SURGERY [ ] NO [ ] YES (type): Unknown

4. PROPOSED SURGICAL PROCEDURE: Revision GSW/ poss. amputation @ finger - index

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications:
Jewelry removed: yes/no Family waiting: yes/no
Unknown / no translator / chart audit

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL ✓ Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	o Pt. verbalizes any specific anxiety. o Pt. exhibits relaxed body posture.	o Allow pt. to verbalize freely. o Explain OR environment and answer questions regarding surgery. o Offer comfort measures, (e.g., warm blanket, touch) o Explain all nursing procedures before they are done. o Remain with pt. whenever possible. o Maintain family interface.
B. AERATION ✓ Potential for respiratory dysfunction due to sedation; positioning; injury	o PT. will be able to breathe without difficulty during immediate intra-operative phase.	o Offer to elevate head of litter or offer pillow. o Observe pt. while awaiting surgery for signs of distress o Assist anesthesia during intubation and extubation
C. INTEGUMENT ✓ Potential impairment of skin integuity due to bovie pad; position; fluid shift	o PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	o Utilize pressure preventing devices on OR table and accessories. o Check for proper positioning and support to maintain good body alignment. o Pad pressure points. o Place ESU ground pad on non compromised skin surface area. o Keep prep fluids from pooling.

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

#[redacted] b(a) - 4

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION ✓ Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	o Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. o Check that safety straps are correctly applied. o Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. o Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. ✓ Potential impairment of mobility due to sedation; pain; injury E.2. ✓ Potential discomfort due to injury; pain	o Pt. will be transferred to OR table without difficulty. o Pt. will not experience unnecessary physical discomfort.	o Have sufficient people available for transfer. o Insure proper body alignment. o Allow patient to lie in position of comfort while waiting for surgery. o Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. ✓ Disminished visual perception due to being injury; sedation; F.2. ✓ Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures. Ø	o Pt. will be made aware of surroundings prior to anesthesia induction. o Pt. will be transferred safely to OR table. o Pt. will be able to understand instructions. o Minimize danger of injury during intraop period.	o Introduce self. Keep pt. informed as to where he/she is and what is happening. o Inform pt. in which direction to move and assist if necessary. o Speak clearly and slowly. o Address pt. from _____ side. o Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs. Ø	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes. Ø	OTHER NURSING INTERVENTIONS. Or continuation of above interventions. Ø

10. OR NURSING INTER[redacted]NS COMPL[redacted]D/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] LTC 5 Aug 03 DATE

11. POSTOPERATIVE EVALUATION:

Dsg. clean + dry.
Pt. is drowsy; O_2 sat 96% on room air.

b(c)-2 AN

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)	13. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)
[redacted] LTC, AN DATE: 5 Aug 03 TIME: 1320	[redacted] LTC, AN DATE: 5 Aug 03 TIME: 1515

REVERSE OF DA FORM 5179, JUN 91 USAPA V1.01

MEDICAL RECORD [redacted] **INTRAOPER[redacted]OCUMENT** b(a)-2

For use of this form, see AR 40-66, the prop[redacted]gency is th[redacted]he Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA I. Her BY (Albritton) Anesthesia	2. PATIENT I[redacted]ED AND PROCEDURE VERIFIED BY [redacted] CPT/Az
3. DATE 7 Aug 03 TIME PATIENT ARRIVED IN SUITE 1303	4. PATIENT IN [redacted] TIME 1303 NUMBER 1-2

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies: NKDA

6. NURSING PERSONNEL

ASSIGNED SCRUB	SSG [redacted] b(a)-2	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt transferred to OR table, anatomically aligned for surgical procedure & pad under head (B) arms on padded arm boards less 90° & (R) arm on a double arm board padded.

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

COMMENTS:

8. SKIN PREPARATION b(a)-2

HAIR REMOVAL ☐ YES ☒ NO

DONE BY: ☐ OR ☐ NURSING UNIT

METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

COMMENTS:

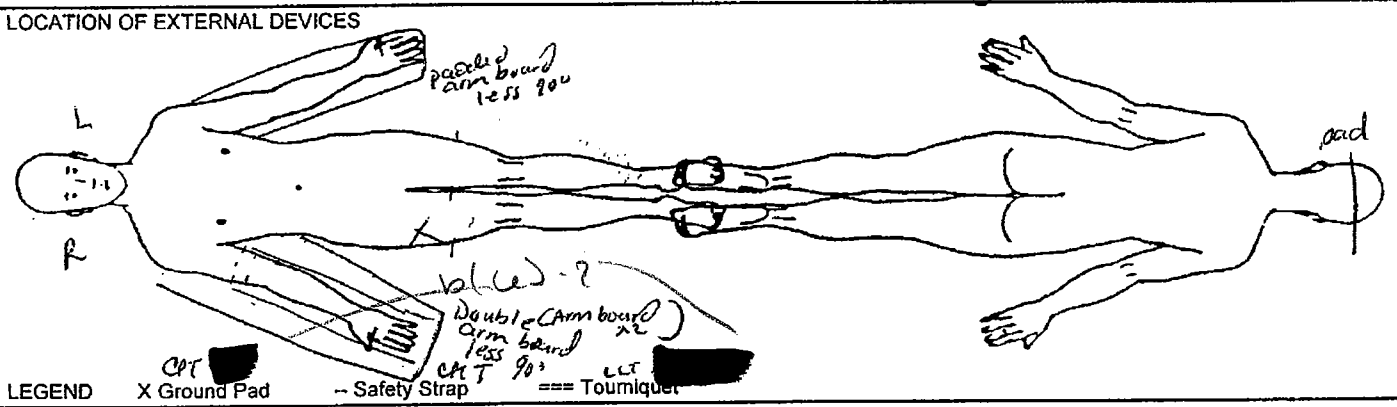
PREP SOLUTION *(Specify)* Betadine/Betadine

SITE (R) Hand BY WHOM: CPT [redacted]

SITE: BY WHOM:

COMMENTS: ∅ pooling of solution noted

9. LOCATION OF EXTERNAL DEVICES



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

10. COUNTS

C = Correct I = Incorrect

			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☐ Yes	☒ No					
Needle Sharp	☐ Yes	☐ No					
Instrument	☐ Yes	☐ No					
Other	☐ Yes	☐ No					

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

#[redacted] b(a)-4

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

☒ ESU NO: #4

GROUND PAD: BRAND Valley lab

LOT NO: 68936 Exp 2005-03

☐ ESU NO:

GROUND PAD: BRAND

LOT NO:

☐ BIPOLAR NO:

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

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

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

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

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type: General

Bovie Pad site intact pre-op yes ; post-op yes Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op N/A ; post-op N/A Not used
Tourniquet Time: Up N/A Down N/A

b (u) - 2 All

20. OPERATION(S) PERFORMED
I + D / wound closure of (R) Hand

21. PATIENT TRANSFERRED TO ICU-2 TIME 1420 METHOD litter c O2

22. REGISTERED NURSE SIGNATURE [redacted] CPT / AN [redacted]

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

MEDCOM - 15823

b(6)-2

MEDICAL RECORD [redacted] **INTRAOPERA[redacted]OCUMENT**

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

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Gurney BY Anesthesia	2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY LTC [redacted]
3. DATE 5 Aug 03 TIME PATIENT ARRIVED IN SUITE 1325	4. PATIENT IN ROOM TIME 1325 [redacted]

5. PREOPERATIVE EMOTIONAL STATUS

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

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	LTC [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

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

COMMENTS: Body maintained in proper alignment

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☒ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☐ RAZOR ☐ CLIP

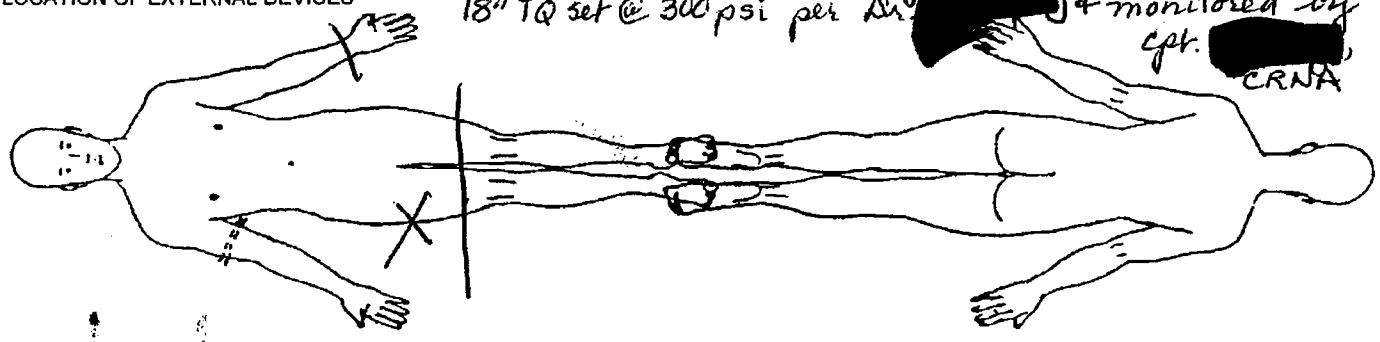
COMMENTS:

PREP SOLUTION *(Specify)*: Betadine soap/sol.
SITE: (R) hand/arm BY WHOM:
SITE: BY WHOM: LTC [redacted]

COMMENTS: No pooling noted

9. LOCATION OF EXTERNAL DEVICES

18" TQ set @ 300 psi per Dr [redacted] + monitored by cpt. [redacted] CRNA



LEGEND X Ground Pad – Safety Strap === Tourniquet

C = Correct I = Incorrect

10. COUNTS		Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☒ Yes ☐ No	✓	C	C	PFC [redacted]	LTC [redacted]
Needle Sharp	☒ Yes ☐ No	✓				
Instrument	☐ Yes ☒ No	/	/	/	/	/
Other	☐ Yes ☒ No	/	/	/	/	/

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

b(6)-4

[redacted]

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

☒ ESU NO: #4 Valleylab Force 2
GROUND PAD: BRAND REM Polyhesive II
LOT NO: 68936 0 2005-03

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

cut: ~~20~~ 30 mf coag: ~~20~~ 30 mf

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

14. MEDICATIONS/ORDERS

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

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO; TYPE(S):
0.9% NaCl -

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

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

16. LABORATORY SPECIMENS

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

17. TUBES, DRAINS/PACKING YES ☐ NO ☒

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

18. DRESSING/IMMOBILIZATION *(Specify)*
fluffs
kerlix roll
4" ACE bandage

19. ADDITIONAL INFORMATION
WC III
Surgeons: Dr [redacted] Anesthesia: Cpt [redacted] esthesia Type: GETA
CRNA

Bovie Pad site intact pre-op clear; post-op clear Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op 300; post-op clear
Tourniquet Time: Up ___ Down ___ 31 min total

b(6)-2

20. OPERATION(S) PERFORMED
Amputation Rt. index finger

21. PATIENT TRANSFERRED TO ICU 2 TIME 1500 METHOD via Gurney

22. REGISTERED NURSE SIGN [redacted] LTC, AN

511-119

NSN 7540-00-634-4

MEDICAL RECORD — VITAL SIGNS RECORD

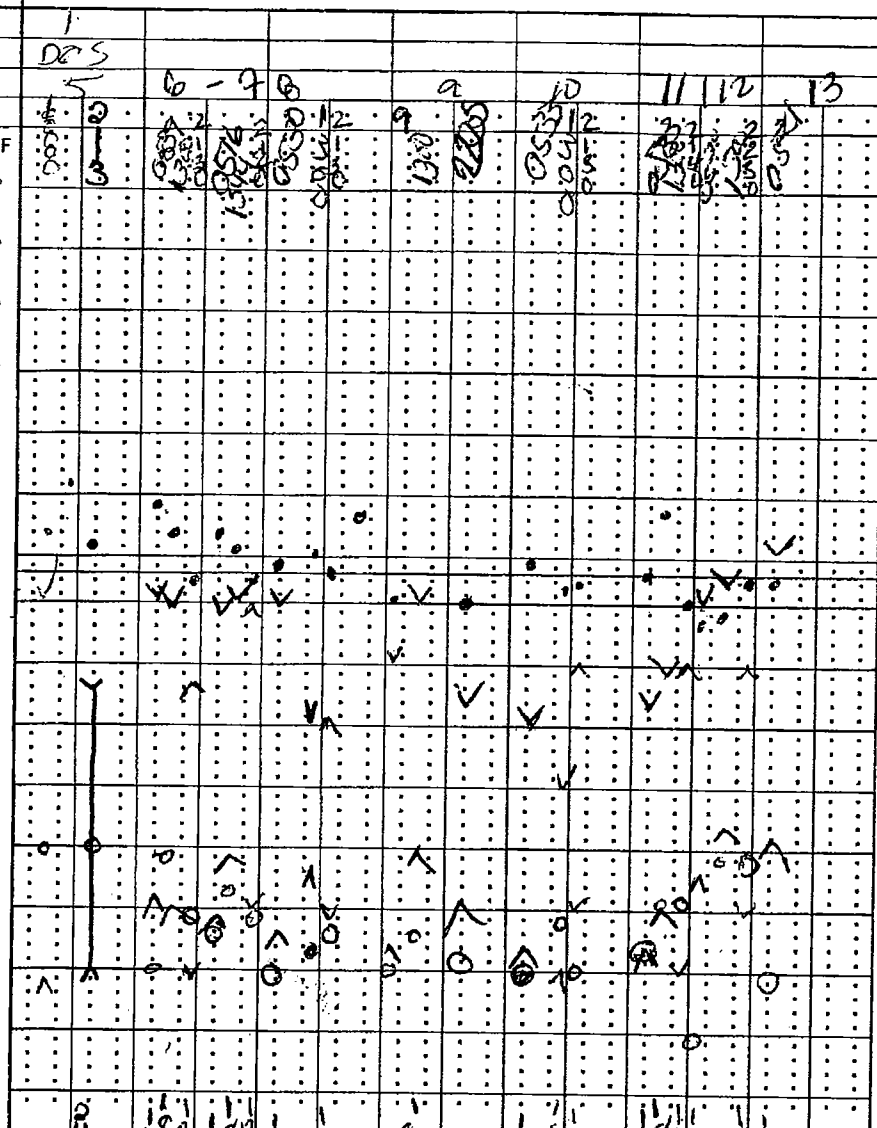
HOSPITAL DAY: 1

POST-OP DAY: DAS

MONTH-YEAR: August 2003 — DAY: 5, 6 – 7, 8, 9, 10, 11, 12, 13

HOUR

PULSE (O) — TEMP. F (•) — TEMP. C



RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: WEIGHT →

Record special data only when so ordered

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

REGISTER NO.

WARD NO. ICU 2

EFW [redacted] b(a)-4

VITAL SIGNS RECORDS

Medical Record

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

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY																	
POST- DAY		4 Aug 83															
MONTH-YEAR	DAY	2030		5 Aug 83													
19	HOUR	2030	2030	0630													

PULSE (O) — TEMP. F (●)

TEMP. F	TEMP. C
105°	40.6°
104°	40.0°
103°	39.4°
102°	38.9°
101°	38.3°
100°	37.8°
99°	37.2°
98.6°	37.0°
98°	36.7°
97°	36.1°
96°	35.6°
95°	35.0°

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

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD		12	16												
BLOOD PRESSURE		132	108												
		84	78												
HEIGHT:	WEIGHT→														
Spo2		98	96												

Record special data only when so ordered

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

REGISTER NO.

WARD NO.

b(6)-4

[redacted]

511-112-01

VITAL SIGNS RECORD

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

Ward/Section: EMT	REQUESTING PHYSICIAN: DR. [redacted] b(a)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: # [redacted] b(a)-4	DATE: 5AUG03 / TIME: 1205	SSN/PSEUDO: # [redacted] b(a)-4

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl

======= PICCOLO =======
05/08/03 12:18
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(a)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	94	73-118	MG/DL
BUN	7	7-22	MG/DL
CRE	0.8	0.6-1.2	MG/DL
CK	310	39-380	U/L
NA+	135	128-145	MMOL/L
K+	4.1	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
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
BIL		0.2-1.6 mg/dl
GGT		5-65 u/l
[illegible]		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
Na^{+}		128-145 mmol/l
[illegible]		3.3-4.7 mmol/l
[illegible]		98-108 mmol/l
CO_2		18-33 mmol/l

REMARKS: b(a)-2

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	5Aug03	

Ward/Section:	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC	8.9	4.8-10.8 x 10^3
RBC	4.94	4.7-6.1 x 10^9
Hgb	13.7	14-18 g/dl (M) 12-16 g/dl (F)
Hct	44.8	42-52% (M) 37-47% (F)
MCV	90.7	80-94 fl (M) 81-99 fl (F)
Plt	256	130-500 x 10^3 verified
Lymph %	29.9	20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

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

Coagulation Studies

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

Urinalysis

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

CSF

Cell Count			
Directigen		Negative	

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

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

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

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

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: b(6)-2 [redacted]	DATE: 5 Aug 03	LAB ID NO.:

Ward/Section:	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
1CW2	[redacted] b(6)-2	
LAST FIRST M: [redacted] b(6)-4	DATE 8Aug	TIME 0200	SSN/PSEUDO SSN:

(i-STAT)

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

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		

PICCOLO
08/08/03 01:40
REFERENCE RANGE: MALE
PATIENT #: [redacted] b(6)-4
METLYTE 8
DISC LOT #: 3141AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	99	73-118	MG/DL
BUN	4*	7-22	MG/DL
CRE	0.7	0.6-1.2	MG/DL
CK	147	39-380	U/L
NA+	137	128-145	MMOL/L
K+	4.4	3.3-4.7	MMOL/L
CL-	104	98-108	MMOL/L
tCO2	24	18-33	MMOL/L

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

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
CO2		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
BIL		0.2-1.6 mg/dl
GGT		5-65 u/l
		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
Na+		128-145 mmol/l
K+		3.3-4.7 mmol/l
Cl-		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS: b(6)-2

REPORTED BY:	DATE:	LAB ID NO.:
[redacted]	8 Aug 03	

Smoker
27/male NKDA

MEDICAL RECORD - ANESTHESIA

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

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

DRUG	(Units)															TOTALS
MIDAZ	(mg)	3				2										5mg
FENT	(mcg)	100		50		25/25	50									250mcg
Propofol	(mg)	150														
Lido	(mg)	50														
	( )															
Succ	(mg)	80														
VOLAT AGENT SEVO	% del	4	2	2	2	1	1	X								
	% e.t.															
AIR	L/Min															
N2O	L/Min															
O2	L/Min	8	2	2	2	2	2	8	8							

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS → 30

TOTAL EBL: MIN

TOTAL URINE: NA

FLUIDS - SUMMARY
CRYSTALLOID- D5½NS 600
COLLOID-
BLOOD-

FLUIDS
LINE site (L) A 20G ☐ Warmed — D5½NS →
☐ Warmed
☐ Warmed
☐ Warmed

LOSSES EST BLOOD LOSS / URINE -

REMARKS
Code drugs with numbers, events with letters
1250 Pre Op Eval
Review → No A.
20G IV → (L) A
1303 OR #1 monitors ↑
Pre O_2 IND/INT
1414 Suction
Agreed to Ext

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 80 (KG) LB

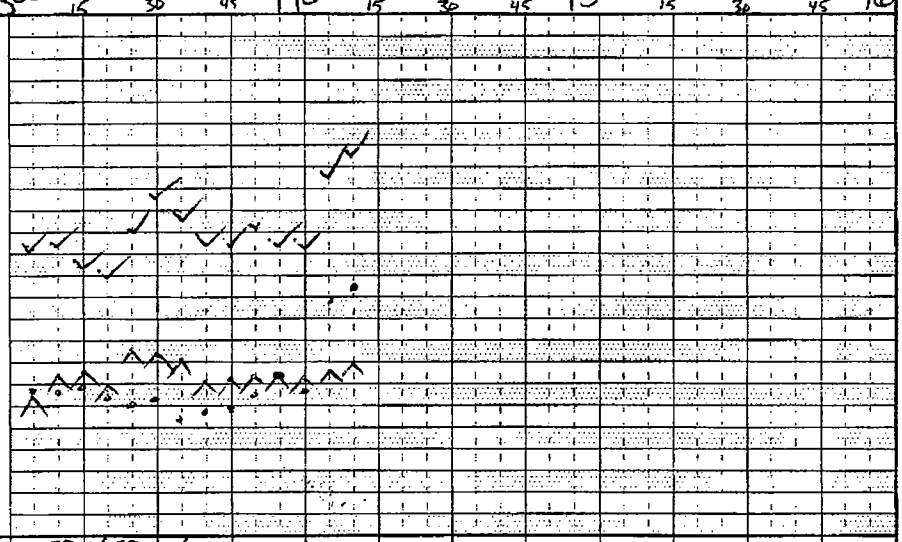
HEMATOCRIT:

INITIAL DATA:
BP- 131/62
HR- 67

EQUIP CHECK (OK) - Y N

PATIENT RECHECK OK for PROCEDURE?
TIME-

TIME 1300 15 30 45 1400 15 30 45 1500 15 30 45 1600



VENTIL

VT - ml	650	650	620				
f - breaths/min	16 8	6 14	6	12	16	14	
Peak inf pres / PEEP	18	18	18				
MODE - S(pon), A(ssist), C(on)	S C	C S	C	S	S	S	

MONITORS/ACCESSORIES

BP/Auto Cuff	ET CO2 (torr)	41	39	60	56	51	56
BP/oth	FIO2 (Frac or %)	70 .85	.85	.86	.85	.86	.86
ART line	SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	ECG	SR	SR	SR	SR	SR	SR
Gas analyzer	TEMP-site	AVAIL →					
	N-M Block (T/4)						
Warming blkt							
Conv warmer							

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

RECOVERY AT
PACU (ICU 2) (Specify)
OTHER
CONDITION: STABLE Room Air
RESP- 20 SpO2- 96
BP- 138/71 HR- 83

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	1250	1303	1430
PROC	Ready	Begin	End
	1310	1324	1413

PROCEDURES and CPT Codes: (R) HAND WD WASH & DRSG & CLOSURE

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*
GETA

PATIENT IDENTIFICATION: *Typed or written entries: Name, Grade/Rate, Medical facility*
b(6)-4
#[redacted]
b(6)-2

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments*
DLX1/MAC3, 8.0 ETT → VC = BBS(=), ETCO2(+) Secured 22cm/lips
Eyes Taped.

SURGEONS [redacted]

ANESTHETIST [redacted]

PROCEDURE OR #1
LOCATION: CSH 28
DATE: 07 Aug 03
PAGE 1 OF

MEDICAL RECORD - ANESTHES[redacted]

For u[redacted]his form, see AR 40-66; the proponent agency [redacted]OTSG

MgSO4 20 mg

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

DRUG	(Units)																
robinul	(mg)	.2	/														
Versed	(mg)	2.5	/ 2.5														
Lidocaine	(mg)	100															
fentanyl	(ucg)	100	/ 150														
propofol	(mg)	200															
Succinylcholine	(mg)	100															
VOLAT AGENT	Sevo % del / % e.t.	X	/ 2	/ 2	/ 1.5	/ 1.5	/ 1.5	/ 1.5	/ 1.5	/ A							
AIR	L/Min																
N2O	L/Min																
O2	L/Min	6	/ 3	/ 3	/ 3	/ 3	/ 3	/ 3	/ 3	/ 6							

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

TOTALS	TOTAL EBL
.2	150
5	
100	TOTAL URINE
250	Ø
200	
100	

FLUIDS - SUMMARY

CRYSTALLOID- 800

COLLOID- Ø

BLOOD- Ø

FLUIDS

LINE site																
18g (L) AC	☐ Warmed	A	—	400/hr	—							400/500	—			
	☐ Warmed															
	☐ Warmed															
	☐ Warmed															

LOSSES

EST BLOOD LOSS								50		100						
URINE -																

REMARKS

Code drugs with numbers, events with letters

1312 pt ID, PREOP Hx COMPLETED (PER FORM 2460)

1325 pm. O2, monitor.

1400 (T) ↑ 300 mmHg

1435 (T) ↓

1458 pt making purposeful mvt: sxn-ext-sxn

1500 TO ICU & [redacted] RN

PHYS STATUS 1 (2) 3 4 5 E

BODY WEIGHT: 80 (KG) LB

HEMATOCRIT: 44

INITIAL DATA:

BP- 128 / 67

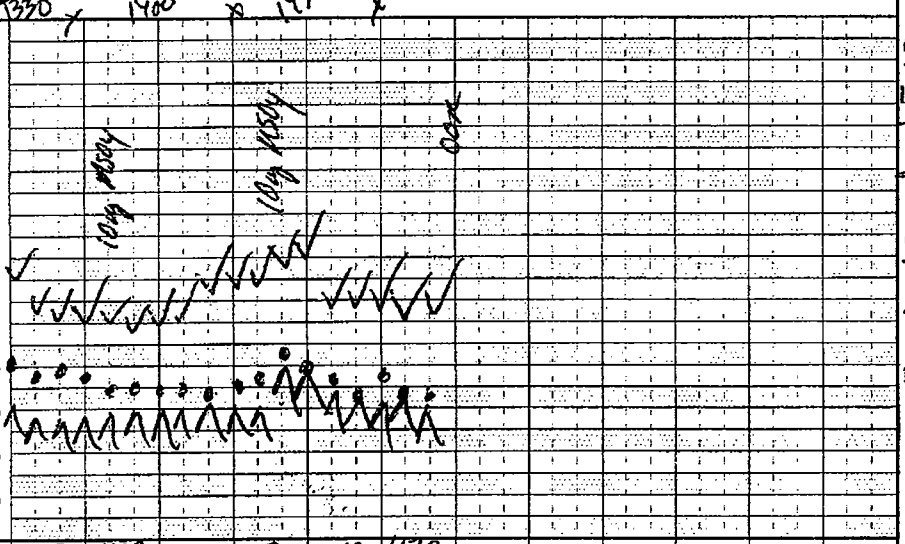
HR- 82

EQUIP CHECK OK?- (Y) N

PATIENT RECHECK OK for PROCEDURE? Y TIME- 1328

TIME 1330 X 1400 X 1430 X

SYMBOLS: BP by cuff V ∧; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—⊤; ANES- X-X; PROC- ⊙-Ø



VENTIL

	1	2	3	4	5	6
VT - ml	850	840	480	180	240	470
f - breaths/min	8	10	6	19	17	17
Peak inf pres / PEEP	18	18	20	/	/	/
MODE - S(pon), A(ssist), C(on)	S-C-	C	A	S	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	32	34	35	58	55	50
BP/oth	✓ FIO2 (Frac or %)	.80	.80	.80	.80	.80	.80
ART line	✓ SpO2 (%)	100	100	100	100	100	100
Steth- PC/ES	✓ ECG	SR	SR	SR	SR	SR	SR
Gas analyzer	✓ TEMP-site	Avail	Skin 34°	—	—	34°	
	✓ N-M Block (T/4)	4/4	0/4	4/4			
Warming blkt							
Conv warmer							

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

RECOVERY AT: 1500

PACU (CU) _____ (Specify)

OTHER _____

CONDITION: T 98.5

RESP- 20 SpO2- 97 RA

BP- 132/72 HR- 81

ANESTHESIA/PROCEDURE TIMES

	Start	Room	End
ANES	1312	1375	1510
	Ready	Begin	End
PROC	1332	1403	1455

PROCEDURES and CPT Codes:

ORIF (R) FINGER

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

#[redacted] b(a)-4

ANESTHETIC TECHNIQUES: *Describe block technique under Remarks*

GETA

AIRWAY MANAGEMENT: *Intubation route, blade, technique, comments* RSI/C, DL #1 C 4 mil, grade I view, #8.0 ETT to 24 @ lip, cuff A, ⊕ETCO2 ⊕BBS, tape to (R) side, OA in place, eyes taped.

SURGEONS:

[redacted] b(a)-2

[redacted] CRNA

PROCEDURE LOCATION: OR 1

DATE: 5 AUG 03

PAGE 1 OF

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 27 DAYS MOS YRS Sex (X) MALE ( ) ~~FEMALE~~

ASA Physical State 1 2 3 4 5 E
WT: 80 KG/LB HT: 70 IN
ALLERGIES: NKDA

PROPOSED PROCEDURE: _____
SURGICAL SERVICE: _____
NPO SINCE: _____

HABITS:
TOBACCO: +
ETOH: ∅
DRUGS: ∅

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Ancef
( ) Pen G
( ) PERC
( ) MSO4
( ) _____

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

LABORATORY STUDIES:

HB/HCT: _____/_____
U/A: _____
OTHER: _____

PREOPERATIVE
PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC
∅

PHYSICAL EXAMINATION
BP ___ HR ___ R ___ T ___
Pain Scale 0-10 _____
HEENT - Teeth _____
Trachea _____
TMJ/Neck _____
Oropharnyx _____
Nares _____
CHEST: _____
CARDIAC: _____
EXTREMITIES: _____
IV Access: _____
Ulnar Filling: _____
BACK: _____
OTHER: _____

NPO Since _____

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): _____ {✓} General: Mask Intubation

INFORMED CONSENT/COUNSELING STATEMENT: Plans, alternatives and risks of anesthesia including death have been explained to and discussed with the pat[redacted]dian. b(6)-2

The patient/le[redacted] and agrees. Questions answered.
Signed: [redacted] Date: 07 AUG 03 Time: 1005 Hrs

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

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) ICW 2

#[redacted] b(6)-4

SEDATION KEY:

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

ANESTHESIA PLAN OF CARE PREPROCEDURAL ASSESSMENT (Sedation/Anesthesia)

Age 27 DAYS MOS YRS Sex (X) MALE ( ) FEMALE

ASA Physical State 1 2 3 4 5 E
WT: 80 KG/LB HT: 70 IN
ALLERGIES: NKDA

PROPOSED PROCEDURE: ORIF (R) Finger
SURGICAL SERVICE: ORTHO
NPO SINCE:

HABITS:
TOBACCO: (+)
ETOH:
DRUGS:

CURRENT MEDICATIONS:
( ) = ordered as premed

( ) Ancef 2g (1200)
( ) Fentanyl 100 mcg
( ) Gent (1300)
( ) PCN (1300)
( )
( )

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

LABORATORY STUDIES:

HB/HCT: _____ / _____
U/A:
OTHER:

13.5	104	7	94
41.1	24	.8	
13.7	256		
8.9	44		

PREOPERATIVE

PAST MEDICAL HISTORY/SYSTEMS REVIEW

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

ASSESSMENT
PAST SURGICAL/ANESTHETIC

PHYSICAL EXAMINATION
BP 105/70 HR 64 R 16 T 97.5
Pain Scale 0-10
HEENT - Teeth intact
Trachea midline
TMJ/Neck 2 FB
Oropharnyx MP III
Nares patent
CHEST: CTA
CARDIAC: S1 S2
EXTREMITIES:
IV Access: 18g (L) AC
Ulnar Filling:
BACK:
OTHER:

NPO Since _____

ANESTHETIC PLAN: { } LOCAL { } MAC { } Regional (Specify): _____ (X) General: Mask Intubation

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

The pati[redacted] understand and agrees. Questions answered. b(6)-2
S[redacted] CRNA Date: 5 Aug 03 Time: 1320 Hrs

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

Signed: _____ Date: _____ Time: _____ Hrs

Patient Identification: (Ward) _____

#[redacted] b(6)-4

SEDATION KEY:

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

[redacted] [redacted]

CLINICAL RECORD - DOCTOR'S ORDERS

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

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

PATIENT IDENTIFICATION
EPW
[redacted]
b(a)-4

NURSING UNIT	ROOM NO.	BED NO.
	24 Vs	0140

DATE OF ORDER: 8 Aug 03 — TIME OF ORDER: 2100 b(a)-2 HOURS

V.O from Dr [redacted] to Spc [redacted]
D/C D5½ c NS c 20 meq KCL
Saline lock (Done)

LIST TIME ORDER NOTED AND SIGN: [redacted] 0700 to 9 Aug 03

9 Aug 03 [redacted] b(a)-2

PATIENT IDENTIFICATION
EPW b(a)-4
[redacted]

NURSING UNIT	ROOM NO.	BED NO.
ICW2	24 Vs	10 0210

DATE OF ORDER: 9 Aug 03 — TIME OF ORDER: 1600 HOURS

D/c Ancefs Gent, Pen [redacted]
Keflex 500 mg po Q2D
Cipro 500 mg po B2D

[redacted] 1600

10 Aug 03 [redacted]

PATIENT IDENTIFICATION
[redacted]
b(a)-4

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER: 12 Aug 03 — TIME OF ORDER: 0900 HOURS

1. D/c to EPW comp
2. Keflex 500 mg po Q2D x [illegible]
3. Sutures out 2 [redacted] WV

[redacted]

b(a)-2

[redacted] prescription [illegible] 0943 12 Aug

PATIENT IDENTIFICATION
[redacted]

NURSING UNIT	ROOM NO.	BED NO.

DATE OF ORDER — TIME OF ORDER — HOURS

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: ICW #2 | ROOM NO.: | BED NO.: 10

DATE OF ORDER: 5 Aug 03 | TIME OF ORDER: _____ HOURS | LIST TIME ORDER NOTED AND SIGN

Post-op s/p [redacted] b(6)-2

Resection (R) / 2A [redacted]

vitals routine

After 24 start elevation [redacted]

RUE AT ALL TIMES

2-3 pillows

Diet regular

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: ICW #2 | ROOM NO.: | BED NO.: 10

DATE OF ORDER | TIME OF ORDER

IVF D5 1/2 NS + 20 KCL @ 125 cc/hr

MRS Ancef 1 g IV q 8 6142Z

Gent 100 mg IV q 6

4101622 P & T 1 p 3 d done

4108022 Pen G 4 mil u q 6

Percocet 1-2 po q 4 PRN

MSO4 2-5 mg IV q 2 PRN

PATIENT IDENTIFICATION

EPW b(6)-4

[redacted]

NURSING UNIT: ICW2 | ROOM NO.: | BED NO.: 10

DATE OF ORDER | TIME OF ORDER _____ HOURS

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

b(6)-2

SRP/done [redacted] SRT/AD

PATIENT IDENTIFICATION

[redacted]

b(6)-4

NURSING UNIT: ICW #2 | ROOM NO.: 24 VS CCC | BED NO.: 8 Aug 03 [redacted]

DATE OF ORDER: 7 Aug 03 | TIME OF ORDER: 0755 _____ HOURS [redacted]

NPO till this afternoon for OR

V.O. Dr [redacted]

7 Aug 1415 b(6)-2 [redacted]

Post-op resume [redacted]

prior orders [redacted] 7 Aug 03 [redacted]

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

[redacted] b(6)-2 A11 [redacted]

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. 02 Yr. 05

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 5	6	7	8	9	10	11	12	13
5	[redacted]	vitals routine	05	/	[redacted]							
			13									
			21									
			/									
5	[redacted]	activity - elevate	05	/	[redacted]							
		(R) arm on 2-3	13									
		pillows @ all times	21									
			/									
5	[redacted]	diet regular	07	/	[redacted]							
			12	/								
			17									
			/									
9	[redacted]	dry dressing Δ to (R) hand QD	16	/	/	/	/	[redacted]				
			/									
			/									

d'c'd 1 Aug 03

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: S/P resection of (R) IF

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

[redacted] b(6)-2 A11 [redacted]

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)				Mo 8 Yr 03
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
5	[redacted]	PB, PO 3rd dose of agent	6	1000	LAB unable to do PT	[redacted]
7	[redacted]	NPO till this afternoon for OR	7	Today	1200	[redacted]
7	[redacted]	resume all previous orders	7	now		[redacted]
12	[redacted]	DC to EPW camp	12	when avail		
12	[redacted]	Sutures out 2 weeks	2 weeks			
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					
	.....					

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

USAPA V1.00

CLINICAL RECORD

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

Mo. ____ Yr. ____

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

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED 8/4	8/5
8/4	[redacted]	Ancef 1g IV	0400	X	[redacted]
		b(6)-2	2230/2200		

ALLERGIES: ☐ YES ☒ NO
nKA

PRIMARY DIAGNOSIS:
gunshot wound (R) hand.

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 1 OCT 78 4677 EDITION OF 1 DEC 77 MAY BE USED.

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													
			8/4 TIME/DATE COMPLETED													
8/4 [redacted]		Morphine Sulphate 5mg pain	2020 SD													
			2215 SD													

(b)-2

☆ U.S.G.P.O.: 1986 - 491-003/43119